Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

DATE	**27 August 2026**
TIME	**9:30 AM - 12:30 PM**
LOCATION	**Dolau Cothi Meeting Room, Corporate Headquarters, Picton Terrace/Microsoft Teams Meeting**

FINANCE AND PERFORMANCE COMMITTEE

27 August 2026

Agenda - 27 August 2026

1 GOVERNANCE

1.1 WELCOME AND APOLOGIES

Michael Imperato (Hywel Dda UHB - Independent Board Member)

1.2 DECLARATION OF INTERESTS

Michael Imperato (Hywel Dda UHB - Independent Board Member)

1.3 MINUTES OF FINANCE AND PERFORMANCE COMMITTEE HELD ON 30 JUNE 2026

Michael Imperato (Hywel Dda UHB - Independent Board Member)

1.4 MINUTES OF EXTRAORDINARY FINANCE AND PERFORMANCE COMMITTEE HELD ON 27 JULY 2026

Michael Imperato (Hywel Dda UHB - Independent Board Member)

1.5 REVIEW OF FINANCE AND PERFORMANCE COMMITTEE TABLE OF ACTIONS

Michael Imperato (Hywel Dda UHB - Independent Board Member)

1.6 FINANCE AND PERFORMANCE COMMITTEE SELF-ASSESSMENT UPDATE REPORT 2025/26

Joanne Wilson (Hywel Dda UHB - Director of Corporate Governance/Board Secretary)

1.7 ASSURANCE AND RISK REPORT

Huw Thomas (Hywel Dda UHB - Director of Finance), Andrew Carruthers (Hywel Dda UHB - Chief Operating Officer), Lee Davies (Hywel Dda UHB - Executive Director of Strategy and Planning), Mark Henwood (Hywel Dda UHB - Executive Medical Director)

2 ANNUAL PLAN 2026/27 AND ESCALATION UPDATE

2.1 ANNUAL PLAN 2026/27 AND ESCALATION PRIORITIES

Shaun Ayres (Hywel Dda UHB - Director of Delivery)

3 ESCALATION RESPONSE – RECOVERY ACTION PLANS AND IMPROVEMENT TRAJECTORIES

3.1 PERFORMANCE DEEP DIVE: RADIOLOGY DEMAND AND CAPACITY AND SERVICE SUSTAINABILITY

Andrew Carruthers (Hywel Dda UHB - Chief Operating Officer)

3.2 FINANCE DEEP DIVE: WORKFORCE GRIP AND CONTROL AND WORKFORCE IMPROVEMENT PROGRAMME

Lisa Gostling (Hywel Dda UHB - Director of Workforce & OD/Deputy CEO)

3.3 FINANCE DEEP DIVE: MEDICAL VARIABLE PAY

Mark Henwood (Hywel Dda UHB - Executive Medical Director)

3.4 FINANCE DEEP DIVE: NURSING VARIABLE PAY

Sharon Daniel (Hywel Dda UHB - Executive Director of Nursing, Quality & Patient Experience)

3.5 FINANCE DEEP DIVE: CLINICAL CARE GROUP SAVINGS PLANS

Andrew Carruthers (Hywel Dda UHB - Chief Operating Officer), Keith Jones (Hywel Dda UHB - Director of Operational Planning & Performance)

4 FINANCE

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Andrew Spratt (Hywel Dda UHB - Deputy Director of Finance), Jennifer Thomas (Hywel Dda UHB - Head of Corporate Reporting and Planning)

4.2 PROCUREMENT SCRUTINY

Gemma Deverill (NWSSP - Procurement)

4.3 PLANNING GOALS UPDATE REPORT

Angharad Lloyd-Probert (Hywel Dda UHB - Senior Project Manager)

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Huw Thomas (Hywel Dda UHB - Director of Finance)

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Ardiana Gjini (Hywel Dda UHB - Executive Director of Public Health), Bruce Bolam (Hywel Dda UHB - Deputy Director Public Health/Consultant in Public Health)

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Huw Thomas (Hywel Dda UHB - Director of Finance)

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Huw Thomas (Hywel Dda UHB - Director of Finance)

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Andrew Spratt (Hywel Dda UHB - Deputy Director of Finance)

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Andrew Spratt (Hywel Dda UHB - Deputy Director of Finance)

7.4 **JCC PLANNING, PERFORMANCE AND FINANCE SUB-COMMITTEE REPORTS**

Huw Thomas (Hywel Dda UHB - Director of Finance)

7.5 **NWSSP SHARED SERVICES PARTNERSHIP COMMITTEE ASSURANCE REPORT**

Huw Thomas (Hywel Dda UHB - Director of Finance)

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Huw Thomas (Hywel Dda UHB - Director of Finance)

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- Tuesday 27 October 2026; 09:30 - 12:30

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9:30 AM,

1 - GOVERNANCE

1.1

1.1 - WELCOME AND APOLOGIES

Michael Imperato (Hywel Dda UHB - Independent Board Member)

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Michael Imperato (Hywel Dda UHB - Independent Board Member)

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1.3 - MINUTES OF FINANCE AND PERFORMANCE COMMITTEE HELD ON 30 JUNE 2026

Michael Imperato (Hywel Dda UHB - Independent Board Member)

For approval

Attachments

Unapproved Minutes FPC 30 June 2026.pdf

Draft Minutes Finance and Performance Committee

Date of Meeting:	**09:30, Tuesday 30 June 2026**
Venue:	**Microsoft Teams/ Picton - Dolau Cothi Meeting Room**

Present:	Michael Imperato (Chair of the Committee and Independent Board Member) Neil Prior (Vice Chair of the Committee and Independent Board Member) Winston Weir (Independent Board Member) Rhodri Evans (Independent Member)
In Attendance:	Huw Thomas (Executive Lead for the Committee and Executive Director of Finance) Andrew Spratt (Deputy Director of Finance) Jennifer Thomas (Head of Corporate Reporting and Planning) Joanne Wilson (Director of Corporate Governance and Board Secretary) Keith Jones (Director of Operational Planning & Performance) Lisa Gostling (Director of Workforce and Organisational Development and Deputy Chief Executive Officer) Mark Henwood (Executive Medical Director) Neil Wooding (Chair of Hywel Dda University Health Board) Shaun Ayres (Director of Delivery) Sian Jenkins (Deputy Director of Finance) Tomos Jones (Audit Wales) Katie Lewis (Committee Services Officer)

Minutes Ref.	Item	Action
FPC (26) 047	**WELCOME AND APOLOGIES** The Chair opened the meeting and noted that the escalation oversight paper would be taken earlier on the agenda to provide context for the later discussions. Members were reminded that presentations should be concise, focus on the two to four key points requiring the Committees attention, and support the Committee's duty to alert, advise, or assure the Board at the end of each item. Apologies were recorded from Mrs Eleanor Marks, Mrs Sharon Daniel, Mr Andrew Carruthers and Mr James Severs. The Chair checked that papers had been received in good time and invited any comments on completeness before moving into formal business of which no comments were received.	
FPC (26) 048	**DECLARATION OF INTERESTS** No interests were declared for this meeting.	

FPC (26) 049 **MINUTES OF FINANCE AND PERFORMANCE COMMITTEE HELD ON 30 APRIL 2026**

The previous minutes were taken as read. The Chair noted their level of detail and invited comments on accuracy or on any matters arising that would not otherwise be covered later in the meeting. No corrections or matters were raised.

Decision: The minutes of the meeting held on 30 April 2026 were **approved**.

FPC (26) 050 **TABLE OF ACTIONS FROM FINANCE AND PERFORMANCE COMMITTEE HELD ON 30 APRIL 2026**

The Committee reviewed the action log from the previous meeting and all actions were reported as complete other than FPC (26) 032 which remained in progress. When queried on the expected timeline, Mr Keith Jones advised that a specific date had not yet been received from the NHS Performance and Improvement Department.

Decision: The Committee **noted** the update provided on the table of actions.

FPC (26) 051

ESCALATION OVERSIGHT AND HIGHLIGHT REPORT

Mr Shaun Ayres highlighted a number of key points for the Committee's consideration. He noted the projected financial position, including a £4.7 million adverse variance against plan, together with the position regarding savings delivery, where approximately £8.7 million of the £42.8 million savings target remained unidentified at this stage.

Mr Ayres drew attention to the fact that the areas where savings gaps existed broadly aligned with those experiencing the greatest performance challenges. He advised that this created a significant challenge in balancing financial recovery and performance improvement, as measures required to enhance performance often necessitated additional capacity and investment, potentially placing further pressure on the financial position. He highlighted urgent and emergency care performance, including pressures associated with patient flow, as an example of an area where investment may be required to address underlying system constraints.

Mr Ayres further emphasised that organisational plans should not be developed in isolation and that workforce, financial and performance plans must be aligned and considered as part of an integrated approach. Whilst each individual plan may appear robust when viewed separately, there was a risk of unintended contradictions emerging if they were not developed and assessed collectively. He therefore urged the Committee to remain mindful

of the interdependencies between plans and to avoid the creation of competing priorities.

In conclusion, Mr Ayres encouraged the Committee to carefully consider the competing demands associated with delivering both financial savings and performance improvements simultaneously. He observed that, in some cases, investment may be required in the short term to generate longer-term financial benefits and support sustainable improvements in performance.

Members requested clarity regarding the areas that should be regarded as the highest priorities and Mr Ayres identified three immediate areas: unscheduled care, including front-door ambulance handovers; cancer, where performance had slipped to 60% or below in the last two months and risked re-escalation; and the broader elective position.

Councillor Rhodri Evans enquired whether Mr Ayres considered that the organisation had the capacity, capability and planning grip required to improve the position. Mr Ayres replied that there was a real gap in operational planning capability, particularly in bringing activity, workforce and finance together into a single delivery model.

In response to queries on the organisation's most significant controllable challenges, Mr Huw Thomas identified three key areas: a mismatch between demand and capacity in services such as radiology and therapies; approximately 200 delayed-transfer of care, equating to around £20m of bed capacity tied up based on an estimated cost of £100,000 per bed; and a continued reliance on variable pay.

Mr Neil Prior and Dr Neil Wooding emphasised the need for a clearer organisational focus over the next three months, noting that continued absorption of a deteriorating position was not sustainable. Members repeatedly returned to the need for a defined route map, greater accountability for delivery, and more emphasis on transformative solutions, alongside short-term measures.

Dr Wooding expressed concern regarding the overall performance position, noting the continued decline across a number of indicators despite the considerable efforts being undertaken by the Senior Leadership Team and staff across the organisation to deliver improvements. He observed that the deterioration in performance had a direct impact on patient experience and emphasised the importance of identifying areas where focused intervention could deliver meaningful improvements.

Dr Wooding questioned whether sufficient organisational focus was being directed towards a small number of priority areas where targeted action could achieve tangible results. He noted that there were examples across the Health Board of teams delivering

strong and consistent performance despite challenging circumstances and suggested that learning could be drawn from these areas of good practice. He further highlighted that areas demonstrating persistent financial overspend and weaker financial control often corresponded with areas experiencing poorer performance, reflecting a concerning and longstanding trend. Dr Wooding suggested that the organisation should seek to identify and prioritise key actions that would have the greatest impact on improving both performance and financial sustainability.

Mr Huw Thomas reiterated the importance of focusing on the three key areas he had identified earlier. In relation to demand and capacity challenges, he highlighted radiology and therapies, noting the wider impact on diagnostic pathways and cancer performance, and the need for targeted action to address underlying capacity constraints. In terms of urgent and emergency care, the significant number of delayed transfers of care requires a more effective approach, given the impact on patient flow and the associated resource implications.

Referring to Radiology, Mr Keith Jones advised that Welsh Government funding for supplementary capacity had been confirmed only to the end of Quarter 1, representing approximately £1.5m less support than in the previous year. He noted that mobile CT and MRI provision was due to cease at the end of Quarter 1; however, a short-term operational decision had been taken to extend arrangements for a further month while wider discussions continued with Welsh Government and NHS Performance and Improvement. Mr Ayres proposed **that a Radiology Plus demand and capacity analysis be presented to the next Committee meeting to quantify the gap across each modality and understand the implications for both performance and delivery of savings targets.** **KJ/AC**

The Committee concluded that the escalation position warranted an alert item for Board, given the lack of a sufficiently clear route map and agreed solutions.

Decision: The Committee:

- **NOTED** and scrutinise the urgent and emergency care de-escalation position (criteria 16 to 18), and the June actions (community streaming hub, front door changes) on which recovery now depends.
- **ACKNOWLEDGED** the May delayed pathways figure as incomplete because of the infection prevention and control ward closures and endorse restating May alongside the June data.
- **SCRUTINISED** the cancer position below the 60% de-escalation floor within the IPAR.
- **CONSIDERED** and **CHALLENGED** the 2026/27 financial position at month 2: £4.7m adverse to plan, a £34.1m savings identification gap against the £42.8m requirement,

and a year end forecast held at £41.0m only by £20.9m of unconverted mitigating actions.

- **REVIEWED** the internal escalation position movements

FPC (26) 052 **ASSURANCE AND RISK REPORT**

Mrs Joanne Wilson presented the key highlights from the Assurance and Risk report, noting one principal risk under review ahead of Board consideration in July and 21 reportable operational risks aligned to the Committee's remit. Since the previous update, four risks had changed, relating to potential cessation of Condition Improvement Funding (CIF) and Regional Integration Funding (RIF), radiology capacity pressures, contract fragility, and estate infrastructure, while 15 risks remained unchanged. Mr Huw Thomas drew attention to the concentration of very high-scoring risks within the Operational Allied Health Professional Clinical Care Group (CCG), advising that these largely stemmed from underlying demand and capacity pressures.

Members challenged both the presentation and the implications of the associated scores. Mr Winston Weir queried whether the concentration of high risks within the Operational Allied Health Professional CCG reflected a different risk appetite or indicated greater underlying service fragility than in other CCG's. H also observed that Risk 2242 lacked sufficient contextual information at headline level to support a clear understanding of the issues involved.

Mr Neil Prior believed that the wording of some risk entries did not provide sufficient assurance that the risks were being managed as proactively as the Committee would expect. Mr Michael Imperato and Mr Weir further observed that a risk score of 25 indicated that the risk was already occurring rather than remaining potential issue, and suggested that greater emphasis should shift be placed on immediate actions, support and interventions required to address the position.

Mrs Wilson clarified that these were operational risks owned and regularly reviewed within services, with sign-off by the relevant CCG Director and Executive Director. Mr Jones added that the risks reported in Operational Allied Health Professionals CCG reflected genuine service fragility rather than a reporting anomaly.

Mr Thomas noted that many of the risk statements attributed the issue primarily as financial pressures, whereas the more fundamental consideration was whether services were organised and managed in the most effective way. The Committee concluded that it could not derive sufficient assurance from the summary level information presented and requested that the highlighted risks be referred back to the relevant CCG's for further challenge and clearer ownership and strengthen accountability.
Mrs Wilson and Mr Jones agreed to revisit the specific high-scoring operational risks raised during discussion and return with clearer challenge, ownership, and operational response. **KJ/JW**

The Committee agreed to advise the Board of the concerns raised.

Decision: The Committee:

- **RECEIVED ASSURANCE** that the principal risks are being refreshed and will be reported to the Board in July; and
- **RECEIVED LIMITED ASSURANCE** from the processes in place to oversee operational risks to ensure these are being managed effectively.

FPC (26) 053 **INTEGRATED PERFORMANCE ASSURANCE REPORT**

Mr Thomas summarised the deteriorating performance position, identifying cancer, urgent and emergency care, and planned care as the areas of the greatest concern. He noted that performance had continued to decline, with therapies 14 week breaches increasing by more than 500 patients in May 2026 and the Health Board remaining the highest-breach organisation in Wales for the past 18 months.

Children and young people's mental health assessment performance within 28 days of referral had fallen to its lowest level since February 2023, whilst child neurodevelopmental assessment performance had improved through outsourced capacity. Within urgent and emergency care, 12-hour performance had deteriorated for a third successive month, and 104 week breaches had also worsened.

Mr Thomas highlighted several positive indicators within the report including delayed outpatient follow-ups, which were 50 per cent lower than the next best performing Health Board in Wales, eye care performance had improved for an eighth consecutive month, and moderate harm incidents and complaints had reduced despite wider system strain.

Cllr Evans queried whether the reduction in complaints reflected a genuine improvement in patient experience or was, at least in part, attributed to changes in the way concerns were being managed under the new regulations. . Mr Mark Henwood advised that that the emphasis on early-resolution had resulted many issues, particularly waiting list enquiries, being addressed through immediate discussion and resolution rather than progressing through the formal complaints process.

Mrs Lisa Gostling drew attention to two major workforce cost pressures with performance implications: agency nursing and long-term sickness absence costing around £29m a year. It was noted that focused work was underway to reduce long-term sickness absence, with estimates indicating that a return towards the lowest previously observed levels could release around £7m

to £9m annually, excluding the additional agency costs associated with covering those absences.

Mr Weir proposed that vaccination and immunisation uptake be revisited through the forward work programme, noting that the Committee required additional context to determine whether performance against target reflected local challenge or issues evident across the wider system.

The Committee considered the report to be a broad advisory overview rather than as a source of full assurance and agreed to advise the Board of the need for greater clarity on the position.

Decision: The Committee **DISCUSSED** the IPAR – Month 2 2026/2027 report and to **RECEIVED LIMITED ASSURANCE** on the operational delivery of mitigating actions to improve performance in the areas that have been categorised as 'alert'.

FPC (26) 054 **PERFORMANCE DEEP DIVE: ALERT AREAS**

Mr Jones explained that the deep dive provides a focus on the alert areas within the performance report and drew out several themes already visible elsewhere in the agenda. While cancer performance had deteriorated, that performance was expected to improve and exceed the 60 per cent threshold in the forthcoming reporting month. He also highlighted an issue with the robustness of the reported eight-week diagnostics position following implementation of the Radiology Plus system in December 2025, saying he did not have confidence in the current reported position and that work was underway to establish the true cause and impact.

Regarding delayed pathways of care and system flow, Cllr Evans queried whether the delayed pathways had not been identified as a key alert area. Mr Imperato concurred, arguing that with around 200 beds occupied by patients experiencing delayed pathways, the scale of the issue should be a central focus of the organisations response.

Mr Jones cautioned against attributing urgent and emergency care challenges into a single cause, acknowledging the complexity of the issues involved. However, he noted that improving performance against internal discharge pathway metrics was beginning into sharper focus the organisations reliance on partner agencies to support patient flow beyond the Health Board. Members stressed that prolonged stays for medically optimised patients remaining were unacceptable, both in terms of quality of care and because of the significant impact on capacity across the system.

Mr Ayres advised that 55 per cent of ambulance handover breaches occur at Glangwili Hospital, with waits frequently extending well beyond 45 minutes, and in many cases over an hour. He suggested that the most appropriate lever for

improvement was patient flow, particularly the back-door pressure created by delayed discharge. Mr Thomas added that data from the Health Board's the 'red and green day' flow system was not yet being fully utilised through governance arrangements, and noted that a significant portion of affected patients were in the last year of their lives, further underlying the importance and urgency of addressing the issue.

Mr Weir expressed concern that the physiotherapy response plan did not yet sufficiently robust to address the scale of the 14 week waiting time breaches.

The Committee requested further work on delayed pathways of care to be prioritised and agreed that this item should be an advise item to the Board.

Decision: The Committee:

- **NOTED** the key challenges and issues currently impacting the performance areas highlighted as Alerts in the Month 2 2026/27 IPAR
- **RECEIVED LIMITED ASSURANCE** from the improvement focus being applied by each relevant Clinical Care Group as reflected in the improvement actions described (within the context of the delivery plans, resources and trajectories approved within the Annual Plan 2026/27)
- **NOTED** the further work underway to review the Radiology breach position and forecast

FPC (26) 055 **NWSSP PERFORMANCE REPORT QUARTER 4 2025/26**

The NWSSP performance report was taken without detailed discussion.

Decision: The Committee **RECEIVED ASSURANCE** from the report.

FPC (26) 056 **UNSCHEDULED EMERGENCY CARE (UEC) BUSINESS CASE: IMPLEMENTATION AND EVALUATION**

Mr Jones explained that the paper had been revised following the In-Committee Board discussion to provide a clear assessment. Based on the modelling presented, ambulance handover performance within 45-minutes was expected to remain around 60% without investment, rather than improve towards 70%. He further advised that the shortlisting and interview preparations had now been paused, with a prolonged delay increasing the risk that the recruitment process would need to be repeated.

Mr Imperato acknowledged that the scenario planning was helpful but questioned what action the Committee was being asked to take beyond noting the consequences. Dr Wooding considered

that the paper clearly set out the cost of deferral but would have welcomed greater clarity on the mitigating actions now proposed. Mr Thomas responded that the Health Board did not yet have assurance that the residual savings gap had been closed, or that red and blue savings schemes would reliably convert into amber and green delivery; therefore, the £4.5m held remained a mitigation against a wider financial risk. Mr Ayres explained that the revised analysis was intended to present the quality, safety, operational and financial consequences collectively, rather than in isolation.

The discussion highlighted the importance of maintaining alignment between organisational priorities and resource allocation. Dr Wooding overserved that, where efficiencies were achieved in one part of the system, opportunities could arise to support improvements in another. He emphasised the value of considering financial recovery and service improvement as complementary objectives.

Mrs Wilson reminded members that the In Committee Board decision remained subject to public ratification. Mr Henwood cautioned that delaying the investment could adversely affect winter resilience , with implications for quality, safety, and workforce costs.

The Committee agreed to report the consequences of deferring the UEC business case as an alert item to the Board.

Decision: The Committee **NOTED** the forecast benefits, associated modelling, providing assurance on the anticipated impact of the UEC Business Case and **CONSIDERED** the implications of deferral, including the material risks of achieving national targets and the CCG's financial recovery trajectory.

FPC (26) 057 **DE-RISKING THE ANNUAL PLAN - SUMMARY OUTPUT FROM IN-COMMITTEE BOARD**

No update was reported for this item.

FPC (26) 058 **FINANCIAL PERFORMANCE ASSURANCE REPORT**

Mr Andrew Spratt presented the key highlights from the Financial Performance assurance report and noted that month 2 remained broadly consistent with month 1, leaving the organisation with approximately a £5.5m deficit run rate each month. The principal driver was that savings delivery remained materially behind the annual plan, alongside continued concerns about the underlying deficit and increasing Welsh Government's scrutiny of the organisation's ability to convert underspends into recurrent savings. In addition, he emphasised that the expected cultural shift from central control to delegated ownership and accountability had not yet translated into the pace of financial improvement required.

Members expressed concern about the seriousness of the financial position. In response to a query from Dr Wooding comparing performance with the same period last year, Mr Spratt advised that the organisation had delivered a higher proportion of its savings target and by the end of Quarter 1, had moved from an overspend to an underspend position. Members noted that If performance did not improve over the next two months, the Board might need to review its forecast maintain credibility with Welsh Government. Mr Prior emphasised that the concerns set out in the report were already significant, while Cllr Evans sought greater clarity on the timescales for any potential escalation of intervention measures.

Members discussed accountability and incentives. Mr Spratt explained that although around £30m of underspend had been identified in the previous year, only about £9m had been converted into committed savings, with the remainder arising from areas that had already demonstrated strong financial management. He noted the need to maximise the conversion of underspends into recurrent savings while ensuring that well-performing services remain appropriately supported and incentivised. Mr Thomas highlighted the need for stronger incentives to support savings delivery, Mr Jones advised that two functions were close to being placed into Level 4 escalation, enabling greater oversight and a clear assessment of the underlying causes of concern.

Members agreed that escalation process should be allowed to run, while emphasising the importance of maintaining pace and momentum. Concerns were raised that the continued slippage would increase the scale of recovery required later in the year. Mr Jones supported using the established escalation framework to provide evidence and clarity on the factors contributing to non-delivery.

The Committee concluded that the seriousness of the financial position and the limited pace of response warranted this item to be an alert matter to the Board.

Decision: The Committee**:**

- **SCRUTINISED** and **CHALLENGED** the current financial forecast, including the reliance on £20.9m of unconfirmed mitigations
- **CHALLENGED** whether the current trajectory is sufficient to close the £34.1m savings gap and improve the underlying deficit position
- **ENDORSED** strengthened escalation and accountability arrangements in areas where delivery is at risk, including those at risk of Level 4 escalation
- **SUPPORTED** immediate actions, where appropriate, to strengthen grip and control over key cost drivers, particularly workforce and demand-led pressures

- **WERE NOT ASSURED** that a credible, time-bound recovery plan is in place to close the savings gap targeted recovery actions are being implemented in all portfolios with Alert or Advise status the new Ways of Working and accountability framework are driving demonstrable improvements in financial control and delivery
- **NOTED** the material risks to financial sustainability, including the current forecast deficit position to the trajectory of the underlying deficit cashflow will run out before the end of March 2027 without additional support from Welsh Government, that has not been confirmed to date

FPC (26) 059 **FINANCE DEEP DIVE: ALERTS (MEDICAL)**

Ms Carly Hill highlighted medical workforce variable pay as a key control issue, noting that a significant proportion of predictable core activity continued to be delivered through variable pay arrangements rather than substantive job plans. Mr Henwood advised that historic job-planning arrangements had contributed to this position and outlined ongoing work to strengthen job planning and improve workforce sustainability through a more consistent all-Wales approach.

Mr Prior contrasted the position with the more developed scenario planning presented earlier on urgent and emergency care, calling for a similarly strategic view approach to workforce challenges. Mr Thomas noted that improved job planning be an important enabler, which would need by service design , greater use of alternative practitioners, and a shift from variable pay into sustainable workforce capacity. Mrs Gostling added that workforce cost improvements alone would not be sufficient without broader service transformation.

Mr Thomas advised that medical additional hours were running at about £2.6mper month, while Mrs Gostling pointed to the need for an overall workforce reduction of around 400 posts through natural attrition and related controls.

The Chair requested a progress update in October on medical workforce implementation, including job planning progress and delivery against the planned timetable. **MH/ CH**

The Committee accepted the current plan for assurance while seeking stronger operational support and a more comprehensive strategic workforce plan.

Decision: The Committee**:**

- **NOTED** the current position**;**
- **ENDORSED** the priority actions and trajectory to shift from variable pay to planned workforce models;
- **ENDORSE** an annual medical workforce review, that feeds into the annual planning cycle;

- **AGREED** that future reporting will focus on delivery of measurable outcomes, specifically:
  - Reduction in variable pay
  - Reduction in agency spend
  - Improved alignment between workforce capacity and demand; and require routine monitoring of progress against defined metrics and trajectory

FPC (26) 060 **FINANCE DEEP DIVE: ALERTS (CONTINUING HEALTHCARE)**

Mr Jones described continuing healthcare commissioned services as a heavily regulated area with limited flexibility once eligibility is established. Members noted some movement in expenditure between months 1 and 2 due to the application of inflationary uplifts however, overall spending growth still compared favourably with the national position and that the current year reflected legacy package growth from earlier periods. Even so, the scale of spend remained material at £69.1m.

Members discussed the sustainability of the current care home market model., Dr Wooding noted that the predominately independent nature of provision resulted in considerable variation and could leave left the Health Board vulnerable, especially in West Wales. Mr Imperato queried whether there was learning from alternative approaches elsewhere, while Mr Thomas suggested the challenges may required a broader review of the care home market and its long-term sustainability, continued efforts to optimise existing arrangements.

Mr Thomas set out the strategic questions more directly whether:

- higher prices or incentives would be needed to support market entry,
- public-sector provision should be reconsidered,
- housing associations or local authorities might form part of the capital solution.

He also observed that care providers appeared to have a better understanding of prevailing rates across Wales than the NHS, highlighting a notable intelligence gap. Mr Prior indicated he would seek to draw on his external networks to further explore the issues affecting the care market. .

The Committee accepted that current controls were being applied within the existing framework however requested a more solution-focused longer-term vision to be presented at a future meeting. (KJ)

Decision: The Committee **RECEIVED ASSURANCE** that measures and controls are in place to ensure only essential Continuing Healthcare expenditure is incurred and aligned with agreed criteria.

FPC (26) 061 **FINANCE DEEP DIVE: ALERTS (CLINICAL CARE GROUP SAVINGS PLANS)**

Members were advised that the item had been deferred. **Mr Jones confirmed that a comprehensive update would be presented to the next meeting.** **KJ**

Decision: The Clinical Care Group savings plan deep dive was deferred to the next meeting.

FPC (26) 062 **INVESTMENT AND BENEFITS REALISATION REPORT**

The Committee reviewed delivery against the strategic investments agreed through the previous planning round. Mr Jones reported that £11.9m had been earmarked in 2025–26, with the principal benefits seen in ophthalmology and radiology. In ophthalmology, the position had improved from 34% to 43% over seven months, against an intended 53% over the full year, while the service was also moving towards a revised skill mix. In radiology, the investment had supported capacity that contributed directly to improvements in cancer waits and eight-week diagnostics.

Members sought assurance that the benefits had been realised in a sufficiently tangible way. Mr Jones advised these were relatively straightforward cause-and-effect investments, with the improvements achieved directly linked to the funded interventions, although some schemes had yet fully matured and further benefits were anticipated. Two investments, acute oncology and legal services, remained partly implemented, with recruitment and training still continuing. The Committee accepted the overall position.

Decision: The Committee:

- **ACKNOWLEDGED** that investment cases for 2025/26 were being progressed through a review and scrutiny process to inform a final approval decision at Formal Executive Team and all decision outcomes have been determined.
- **NOTED** that benefits realisation feedback for strategic investments as outlined.

FPC (26) 063 **PLAN FOR CLOSING THE RESIDUAL DELIVERY GAP TO £41M**

This item was discussed at In-Committee Board meeting.

FPC (26) 064 **BAND 2 AND 3 HEALTHCARE SUPPORT WORKER PAY RE-BANDING UPDATE**

Ms Sian Jenkins presented an update on the national Band 2 and 3 Healthcare Support Worker re-banding outcome. Ms Jenkins explained that the dispute had now concluded and that the Health Board was implementing the resulting budget and establishment

adjustments in 2026–27. The financial effect had shifted over time because the national interpretation developed after the initial modelling, more staff fell within the scope than first anticipated, with a series of detailed pay adjustments continuing after initial payments had been made.

Members understood that the Health Board's immediate focus had been on ensuring staff were paid correctly and on maximising available support from Welsh Government before year-end. The report set out the budgetary impact and the management response, including mitigation through workforce controls and changes to how some Band 2 and Band 3 roles were filled.

Decision: The Committee:

• **ACKNOWLEDGED** the approach taken and reasons for the difference between cost versus funding having arisen.
• **APPROVED** of the approach taken to enable the required £2.8m budget to be delegated, by creating a negative budget, recognising this will require further savings and mitigating actions to afford both within 2026/27 and as part of the Health Boards underlying position.

FPC (26) 065 **PROCUREMENT REPORT**

The Committee was asked to support procurement approvals covering the electronic document and records management system, the oral surgery contract for five years, and the ophthalmology position, with further Welsh Government support to be sought as appropriate. The value-based procurement in healthcare was acknowledged as an important strategic development linked to work with Swansea University and Swansea Bay University Health Board. No substantive challenge was raised and the recommendations for Board approvals were supported.

Decision: The Committee recommended that Board:

- **APPROVE** the award of the Electronic Document and Records Management System (EDRMS) Renewal contract from the 01 September 2026 to the 31 March 2032 with an option to extend to 31 March 2034 at a total contract value of £1,244,903.00 ex VAT. This contract will have onwards submission to HDdUHB Public Board, Velindre NHS Trust (as hosts of NHS Wales Shared Services Partnership) and Welsh Government for approval.
- **APPROVE** the award for Oral Surgery contract for five (5) years from 01 October 2026 to 30 September 2031 with the option to extend for a further five (5) year, by way of three (3) plus two (2) years, with total contract value of £5,060,000.00 ex VAT. This contract will have onwards submission to HDdUHB Public Board, Velindre NHS Trust

(as hosts of NHS Wales Shared Services Partnership) and Welsh Government for approval.

- **APPROVE** the commencement and subsequent award of the procurement process for Outsourcing Ophthalmology contract for up to two (2) years from 01 August 2026 to 31 July 2027 with no option to extend, with total contract value of up to £12,000,000.00 ex VAT. This contract will have onwards submission to HDdUHB Public Board, and Velindre NHS Trust (as hosts of NHS Wales Shared Services Partnership). This requirement does not require Welsh Government approval.
- **APPROVE** the approval and delegated authority arrangements for procurement activity within HDdUHB.

FPC (26) 066 **PROCUREMENT PLAN**

The Procurement Plan was taken without detailed discussion.

Decision: The Committee **NOTED FOR INFORMATION** the Procurement Plan Financial Year 2026/27

FPC (26) 067 **PLANNING GOALS UPDATE REPORT Q1 2026/27**

The Quarter 1 planning goals update was noted without further discussion.

Decision: The Committee **RECEIVED ASSURANCE** and **NOTED** the progress of the Planning Goals which are aligned to it; in order to assure the Board that the Planning Goals are progressing and are on target, and to raise any concerns where a Planning Goal is identified as behind in its status and/or not achieving against its key deliverable.

FOR INFORMATION

FPC (26) 068 **ALL-WALES CAPITAL PROGRAMME 2026/27, CAPITAL RESOURCE LIMIT AND CAPITAL FINANCIAL MANAGEMENT UPDATE**

FPC (26) 069 **JCC PLANNING, PERFORMANCE AND FINANCE SUB-COMMITTEE REPORTS**

FPC (26) 070 **NWSSP PROCUREMENT SERVICES 2025-26 SUMMARY REVIEW**

FPC (26) 071 **FINANCE AND PERFORMANCE COMMITTEE WORK PLAN 2026/27**

DATE OF NEXT MEETING Thursday 27 August 2026

1.4

1.4 - MINUTES OF EXTRAORDINARY FINANCE AND PERFORMANCE COMMITTEE HELD ON 27 JULY 2026

Michael Imperato (Hywel Dda UHB - Independent Board Member)

For approval

Attachments

Unapproved Minutes Extraordinary FPC 27 July 2026.pdf

UNAPPROVED MINUTES OF THE EXTRAORDINARY FINANCE AND PERFORMANCE COMMITTEE MEETING

DATE OF MEETING: **Monday 27 July 2026**

VENUE: **Dolau Cothi Meeting Room, Corporate Headquarters, Picton Terrace/Microsoft Teams Meeting**

PRESENT:
Michael Imperato (Independent Board Member) (Chair) (VC)
Neil Prior (Independent Member) (Vice Chair) (VC)
Rhodri Evans (Independent Member)
Eleanor Marks (HDUHB Vice Chair) (VC)

IN ATTENDANCE:
Andrew Carruthers (Chief Operating Officer)
Lisa Gostling (Director of Workforce & OD/Deputy CEO) (VC)
Siân Jenkins (Deputy Director of Finance)
James Severs (Executive Director of Allied Health Professions and Health Science)
Andrew Spratt (Deputy Director of Finance)
Joanne Wilson (Director of Corporate Governance/Board Secretary) (VC)

Shaun Ayres (Director of Delivery) (VC)
Keith Jones (Director of Operational Planning & Performance)
Urvisha Perez (Audit Wales)
John Jenkins (Committee Services Officer) (Secretariat)

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MINUTES REF.	ITEM	ACTION

FPC(26)072 **WELCOME AND APOLOGIES**

Mr Michael Imperato welcomed all to the Extraordinary Finance and Performance Committee (FPC) meeting.

Apologies had been received from:

- Mr Winston Weir, Independent Member
- Mr Huw Thomas, Executive Director of Finance (Ms Siân Jenkins and Mr Andrew Spratt both in attendance)

FPC(26)073 **DECLARATION OF INTERESTS**

There were no declarations of interest.

FPC(26)074 PLANNED CARE RECOVERY PLAN

Mr Andrew Carruthers introduced the Planned Care Recovery Plan report to the Committee and advised that a significant level of work has been undertaken in a short space of time to produce the report to respond to the request from Welsh Government (WG). He thanked Ms Lisa Humpries, Mr Craig Toutt, Mr Shaun Ayres and Mr Keith Jones for their work in producing the report in a relatively short space of time.

Mr Jones presented the report to the Committee and advised that the report was required to be submitted to WG by 31 July 2026 following presentation to the Board Meeting on 30 July 2026. Mr Jones noted that WG had requested two separate reports. The first, a report on interim recovery measures to eliminate 104-week referral to treatment (RTT) waits and 8-week diagnostic direct access wait breaches, which had been submitted on 20 July 2026 and included the regional component of the recovery plans for orthopaedic and ophthalmology developed regionally with Swansea Bay University Health Board (SBUHB).

Mr Jones clarified that the second report required by WG was a Health Board-approved Planned Care Recovery Plan that detailed all the required pathway transformation, productivity actions and deliverables. The report being presented to the Extraordinary FPC meeting to scrutinise, endorse and approve for onward submission to the Board meeting on 30 July 2026 for approval and submission to WG met this requirement.

It was explained that the Plan outlined the overall approach and described how the in-year delivery gap would be measured and closed, how internal capacity would be maximised through increased productivity and efficiency and that the procurement of external capacity would only be considered when there was evidence that there was little or nothing that could be done internally to close the delivery gap.

Mr Jones noted that the Plan went one step further than describing how the delivery gap would be closed and also demonstrated how measures were being taken to manage overall demand growth in the longer-term.

The Plan was structured to reflect the recently launched national Planned Care Improvement Plan and described where the Health Board was currently sustainable at present and where was a sustainability gap. Mr Jones believed that there was significant detail in the addendum that evidenced references contained within the Plan to describe what was required to bridge the sustainability gap by March 2027 for 104-week RTT and 8-week diagnostic breaches.

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Mr Jones stated that the current indicative cost of £11.6m that was being sought from WG was subject to the quantification of the current challenges relating to the provision of robust radiology data that a Task and Finish Group had been established to investigate and validate the radiology performance data. Mr Jones noted that the Task and Finish Group was working towards a deadline of 31 July 2026 to complete its work and inform a robust performance delivery trajectory for the remainder of 2026/27.

Mr Jones advised that the cost of the radiology recovery was subject to change and was provisional pending the conclusions of the Task and Finish Group.

Mr Jones advised that the Plan highlighted specialities where the sustainability gap was both in-year and where a future regional focus was needed and that some specialities do not currently present a 104-week delivery gap however was considered possible that they may do at a future data.

Mr Jones referenced the overarching governance processes with the operational structure for Planned Care described within four specific workstreams that was necessary for the practicalities of managing the time and capacity of clinical and operational teams with the workstreams and work programmes reflecting the three pillars of Planned Care contained within the national Planned Care Improvement Plan.

Mr Imperato sought clarification on the exact total of the funding that was being requested from WG. Mr Jones advised that the Committee were not being asked to endorse a precise figure with the indicative costings included within the report being provided for context and reference. He added that the Committee was being asked to endorse and approve the broad plan for the year referencing the provisional £11.6m total that was subject to change pending the outcome of the radiology investigation work by the Task and Finish Group and that the Committee were asked to endorse and approve the broader delivery plan.

Mr Imperato believed there should be a focus on trajectories and workforce implications with WG requesting plans be scrutinised by the Committee and the Board with Committee and Board members being held accountable.

Mrs Joanne Wilson advised on the governance process that needed to be followed as per the letters from Welsh Government and added that a written update report to Board would be produced for presentation to the Board meeting on 30 July 2026. **JW**

Mrs Eleanor Marks questioned whether the Health Board had the capacity to implement the Plan and the regional aspects contained within the Plan. Mr Jones advised that how the measures contained within the Plan were assessed against the ambition of the Plan would be reviewed with the measures contained within

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the Plan assessed against the work of the workstreams. Furthermore, the Executive Medical Director was undertaking a leading role in engagement with clinicians from each of the specialities to ensure that there was a commitment to deliver what was expected of the Health Board.

Mrs Marks further expressed concern over the delivery of the Plan and whether the Health Board had the capacity to deliver. Mr Imperato believed that the sustainability gap within the 10 specialities would not be resolved through productivity optimisation alone and that the Health Board needed to be more ambitious on transformation to enable long-term sustainability.

Mr Jones believed that the need to make connections where the capability gap of where demand exceeded capacity was within the same specialities that were identified within the Clinical Services Plan (CSP) where there were fundamental sustainability gaps due to structural issues.

Mr Jones believed that the Plan contained many references to work that was required to be progressed regionally with SBUHB with two areas of orthopaedic and ophthalmology services having foundations established to provide sustainability within the services with the Plan addressing the short-term delivery gap.

Mr Imperato felt that there was a disconnect between the CSP and the Planned Care Recovery Plan. Mr Carruthers advised that WG had requested that the Plan outline how the gap between demand and capacity was addressed and that the Health Board was clear and transparent that more work was required within the two service areas and that WG was not expecting an answer to the problem at this stage, merely a commitment to answer those questions.

Mr Imperato also questioned whether Hywel Dda University Health Board (HDdUHB) and SBUHB had the capacity to undertake the required work. Mr Carruthers advised that SBUHB had recently appointed a data analyst to support the turnaround work within orthopaedic and ophthalmology services with WG having offered HDdUHB support to undertake similar modelling work. Mr Carruthers advised that the data analytics requirements would be progressed in conjunction with the Regional Joint Committee (RJC) with SBUHB.

Cllr Rhodri Evans questioned the diagnostic and theatre productivity data included within the Plan and noted that the Task and Finish Group minutes advised of the possibility that the 8-week diagnostic breaches may not have been reported correctly. Mr Jones advised that the working hypothesis was that the radiology position was not accurate and that the Task and Finish Group was undertaking work to question whether there was consistency in the reporting position of 8-week diagnostic breaches.

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Mr Jones believed that the Committee recognised that the Health Board had a capacity gap within data intelligence and believed that it was an area that the Health Board recognised that it needed to strengthen. Mr Jones advised that the data within the Plan was derived from the expertise that was currently within the Health Board and that the data included was sufficiently robust.

Mr Neil Prior believed that the Plan was comprehensive with sound assumptions that would enable the financial support from WG to be released and questioned whether the Health Board was confident it could implement the proposals contained within the Plan. Mr Carruthers was confident that the Health Board could deliver the proposals that had been presented to Board on 26 March 2026 however recognised that the Health Board simply did not have the resources to enable the delivery gap to be closed.

Mr Carruthers believed that there needed to be additional capacity within the regional space with work being progressed with SBUHB to manage internal capability with it being recognised that there was a challenge between transformational capacity and day-to-day capacity.

Mr Prior questioned if there was a regional plan, was it known what SBUHB were submitting to WG as part of their Planned Care Recovery Plan. Mr Carruthers advised that the regional elements were consistent within both HDdUHB and SBUHB submission.

Mrs Marks believed that the proposed outcomes contained within the Plan were positive however questioned whether the Plan could be more ambitious. Mrs Marks questioned whether there was sufficient capacity within the market to recruit given that all other Health Boards in Wales would be trying to undertake the same outcomes at the same time.

Mr Jones believed that there had been scoping of the market capacity available undertaken and that he was confident that the activity capacity was available although the transformation capacity would be needed to be established over time however the Health Board did not want this to constrain its ambitions.

In response to a question from Mr Imperato on available capacity, Mr Jones advised that capacity solutions for outsourcing and insourcing was predominantly sourced from the independent sector to commission activity to be undertaken on behalf of the Health Board, with it noted these would need to be subject to robust procurement processes.

Mr Imperato questioned whether the same clinical staff were being expected to do more, Mr Jones advised that the additional capacity would be delivered by external providers with contracts already live and in place to utilise despite the challenge of all

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Health Boards in Wales seeking to utilise the same capacity from the market.

Mrs Lisa Gostling believed that the workforce challenges were more internal with using the Health Board's own workforce to do more having an impact on the levels of variable pay. In response to a question from Mr Neil Prior on whether the Plan exacerbated the Health Board's variable pay position, Mr Jones confirmed that it did.

Mrs Gostling noted the conflicting requirements of WG on the need to reduce variable pay and the headcount of the Health Board and the Planned Care Recovery Plan asking what the Health Board required to deliver the Plan. Mrs Gostling believed that the Health Board needed to be clear on what additionality was required and whether it was temporary or what was required to make it sustainable.

In response to a question on whether the impact on variable pay was factored into the Plan, Mr Jones advised that it was within 5 areas of the Planned Care Recovery Plan that the impact was identified as either additional Waiting List Initiative (WLI) additional activity or insourcing.

Mr Jones believed that the nature of the additional work was over and above the core capacity after provision was made for further efficiency with the more activity undertaken internally, the more corresponding costs were added to variable pay.

Mrs Gostling noted that there were actions currently in place to reduce variable pay such as increased efficiency with job planning, rostering and absence management with job appointments through the year also reducing the level of variable pay. Mrs Gostling noted that the actions contained within the Plan would deliver an increase in the levels of variable pay with a need to map both sets of actions to measure the overall change to the levels of variable pay.

Cllr Evans questioned the governance processes and management of risk within the Plan. Mrs Wilson advised that there was further work required on the governance as the diagram within the slides is mixing operational oversight with assurance, this needed to be separated and scrutiny of the plan, subject to approval, to be aligned to a committee.

In response to a question from Mr Imperato on the sustainability of the Plan and whether WG would require longer-term changes to be made, Mr Carruthers advised that the funding was initially non-recurrent to enable immediate recovery by 31 March 2027 before sustainable actions would be required.

Mr Imperato requested a position from the Finance Team on the risks and challenges posed. Mr Andrew Spratt noted that should

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the additional financial support not be granted by WG then the Planned Care Recovery Plan would not progress and that there would be no residual risk. Mr Spratt believed that if WG approved the Plan and provided the funding there would be a need to clearly identify the difference between the impact of core funding and that additional funding on performance as opposed to only understanding the aggregate performance of the two revenue streams.

Mr Imperato questioned how the Health Board would separate the assessment of the impact of core and additional funding. Mr Spratt advised that this would be possible if the impact of both steams was disaggregated to show what was being delivered from core funding and additional funding. Mr Jones believed that there were robust mechanisms in place to manage the process.

Mr Imperato questioned how the levels of variable pay would be measured for its impact on the Health Board's deficit and run rate. Ms Siân Jenkins advised that the Finance Team and Clinical Care Groups (CCGs) were successful in tracking the run rate and believed that the process was straightforward with the only area of weakness considered to be non-pay costs such as theatre stock however the Health Board had improved its ability to track non-pay costs.

In response to a question from Mr Imperato on the impact on risk registers, Mrs Wilson advised that any risk would be included on the Operational Risk Register and undergo the same process for review at Board. Mrs Wilson advised that any new risks identified would be included on the Operational Risk Register and noted that the outcome measures envisaged within the Planned Care Recovery Plan could mitigate and reduce existing risks.

In response to observations from Mrs Marks and Mr Prior on the need for the Plan to be more ambitious and whether requesting additional funding at this point could provide better outcomes in future years, Mr Carruthers noted that measures that increased variable pay and workforce headcount to support transformation were both measures that WG stated that the Health Board should not be undertaking and any proposals to do either would invite and require further scrutiny.

Mr Carruthers believed that the Planned Care Recovery Plan as stated would result in thousands of HDdUHB patients being treated by 31 March 2026 than was anticipated within the 2026/27 Annual Plan and that the Planned Car Recovery Plan was an opportunity to improve the nature of the service provided to patients.

Mr Carruthers believed that the long-term challenge would be how the Health Board increased performance to ensure that the level of performance was sustained at levels not seen since before the Covid-19 pandemic with a fundamental workforce capacity

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challenge needing to be addressed to enable the provision of the level of capacity to reduce the current backlog and to meet current and future demand.

Mr Carruthers believed that the Planned Care Recovery Plan was a robust bid to WG for funding to reduce waiting times and improve access for patients for the next 9 months while the Health Board undertook further work to answer the ambition question and also what work was required to be undertaken on a regional basis.

Mrs Wilson reminded members that the Committee also had oversight for performance and that there was a need to capture the impact of performance for patients. Mrs Wilson also believed that the report needed to be approved by the Committee and not just endorsed.

Mrs Marks believed that while the Plan could be approved and considered through a finance and performance perspective, that there would be quality and safety considerations that would be to be considered at the Quality, Safety and Patient Experience Committee (QSEC), Health and Safety Committee and the People, Organisational Development and Culture Committee (PODCC). Mrs Wilson believed that FPC would be the "home" of oversight of the Planned Care Recovery Plan performance and impact and that consideration on how the impact of the Plan would be scrutinised would be discussed at the Independent Members' (IMs) Chair's Meeting. **JW**

In response to a question from Cllr Evans on whether the outcome of the Task and Finish Group could impact the sum of funding requested from WG, Mr Jones advised that there was a possibility that the amount requested could increase subject to the outcome of the work of the Task and Finish Group to validate the radiology data.

Cllr Evans questioned the correct governance process for amending the amount of funding sought from WG following Board approval on 30 July 2026. Mrs Wilson advised that to change the decision made at Board on 30 July would either require a Chair's Action or would require the recommendation presented to Board for approval on 30 July 2026 to advise that the final sum be delegated to the Chair of the Health Board and Chief Executive to determine. Mrs Wilson advised that she would advise on the correct governance procedure for the recommendation to Board ahead of the submission of the report to Board on 30 July 2026. **JW**

Decision: The Finance and Performance Committee:

- **APPROVED** the Planned Care Delivery and Sustainability Plan for submission to Welsh Government by 31 July 2026 subject to the clarification of the financial consequences of the impact on variable pay, an assessment of the levels of demand and capacity, confirmation on the level of

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transformation capacity required, an assessment of the regional working required and the appropriate governance and data quality oversight; and

- **NOTED** the provisional assessment included in the in-year recovery proposals for Radiology diagnostic capacity and that this is subject to revision pending the outcome of the Radiology Data Task and Finish Group review.

FPC(26)075 DATE OF NEXT MEETING

The next meeting of FPC will be held on Thursday, 27 August 2026.

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1.5

1.5 - REVIEW OF FINANCE AND PERFORMANCE COMMITTEE TABLE OF ACTIONS

Michael Imperato (Hywel Dda UHB - Independent Board Member)

For approval

Attachments

Table of Actions FPC 27 July 2026.pdf

FINANCE AND PERFORMANCE COMMITTEE (FPC)/ PWYLLGOR CYLLID A PHERFFORMIAD
30/06/2026
TABLE OF ACTIONS/TABL GWEITHREDOEDD

Key: AC-Andrew Carruthers; JW-Joanne Wilson; KJ-Keith Jones

MEETING DATE	MINUTE REF	ACTION	LEAD	TIME SCALE	PROGRESS
30/04/2026	FPC(26)032	Q1 2026/27 Planned Care Trajectories • To present findings of NHS Wales Planned Care Optimisation Framework self-assessment to FPC.	KJ	30/06/2026	In progress 10/06/2026: NHS P&I review & assessment of the self-assessment returns submitted by each specialty is awaited. The detailed individual specialty self-assessment templates were not designed by NHS P&I as performance assurance documents. NHS P&I will review submissions from all health boards and provide each organisation with comparative feedback. This will be shared with the Committee. Target date subject to NHS P&I confirmation
30/06/2026	FPC(26)052	Risk and Assurance Report • To revisit the specific high-scoring operational risks raised during discussion and return with clearer challenge, ownership, and operational response.	KJ	27/08/2026	In progress
30/06/2026	FPC(26)059	Finance Alert Medical • To forward plan a progress update in October on medical workforce implementation, including job planning progress and delivery against the planned timetable	AC	27/08/2026	Complete Forward planned for October FPC
27/07/2026	FPC(26)074.01	Planned Care Recovery Plan • To produce a written update for submission to Board meeting on 30 July 2026.	JW	30/07/2026	Complete Complete. JW circulated written report to members by email, 27/07/2026.

MEETING DATE	MINUTE REF	ACTION	LEAD	TIME SCALE	PROGRESS
27/07/2026	FPC(26)074.02	Planned Care Recovery Plan • To discuss scrutiny of separate aspects of Planned Care Recovery Plan (quality and safety) at IMs Chair's Meeting.	JW	27/08/2026	Complete Agreed in the Public Board Meeting held on 30th July 2026 that ongoing scrutiny of the planned care recovery plan, subject to approval by Welsh Government, would be through the Finance and Performance Committee and would need to be a regular feature on the committee work programme.
27/07/2026	FPC(26)074.03	Planned Care Recovery Plan • To review reccomendation process in relation to level of funding sought from WG for Planned Care Recovery Plan report to Board.	JW	30/07/2026	Complete Board approved the plan at its meeting held on 30th July 2026 it was recognised further work n respect of diagnostics and a few other was required in respect of diagnostics and a few other smaller areas. The Board agreed to give final approval via delegated to the Chair and CEO. This delegated authority was enacted on 31.07.26 with the final version of the plan approved. The plan and covering letter was submitted to WG on 31.07.2026 and shared with all board members.

1.6

1.6 - FINANCE AND PERFORMANCE COMMITTEE SELF-ASSESSMENT UPDATE REPORT 2025/26

Joanne Wilson (Hywel Dda UHB - Director of Corporate Governance/Board Secretary)

For assurance

Attachments

FPC Self-Assessment Update Report FPC 27 August 2026.pdf

Pwyllgor Cyllid a Pherfformiad/ Finance and Performance Committee

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	27 August 2026
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Finance and Performance Committee Self-Assessment Update Report 2025/26
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Joanne Wilson, Director of Corporate Governance/Board Secretary
SWYDDOG ADRODD: **REPORTING OFFICER:**	Charlotte Wilmshurst, Assistant Director of Risk and Assurance

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

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The purpose of this report is to provide an update to the actions agreed by the Finance and Performance Committee (FPC) in response to the outcomes from the Committee Self-Assessment 2025/26 process.

Cefndir / Background

In February 2026, the Committee received a report which presented the outcomes of the FPC Self-Assessment 2025/26 process. For FPC, this involved the completion of a short digital form which requested feedback on the following areas:

- Financial Oversight and Stewardship
- Performance Monitoring and Delivery
- Risk Management and Assurance
- Strategic Alignment and Value-Based Healthcare
- Financial Strategy and Long-Term Sustainability

Asesiad / Assessment

The following actions were agreed in response to the outcomes of the FPC Self-Assessment 2025/26:

Area for improvement	By Whom	By When	Update
Ensure report authors receive feedback on the quality of their papers being brought to	Executive Leads	April 2026	A full outline of Chair expectations has been shared with report-writers.

Committee in order to improve and develop. Papers need to have a greater focus on longer term strategic matters alongside operational matters, risks, with clear, corrective actions, that provide assurance.			
Committee Members to further challenge and scrutinise the effectiveness of risk control/mitigation measures for assurance.	FPC Members	April 2026	A refocused agenda, with a targeted deep-dive will facilitate improved scrutiny.
Further develop mechanisms to develop a response to continued escalation when a function is underperforming.	Director of Finance	June 2026	Revised reporting to bring together our escalation reporting, finance and IPAR reporting will facilitate this. The first Level 4 escalation meetings have now been held, and the outcomes will be reported back to the Committee.

Argymhelliad / Recommendation

The Finance and Performance Committee is asked to **TAKE ASSURANCE** from the progress made against the actions being undertaken to improve its effectiveness.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cylch Gorchwyl y Pwyllgor: Committee ToR Reference:	10.5 The Director of Corporate Governance/Board Secretary, on behalf of the Board, shall oversee a process of regular and rigorous self-assessment and evaluation of the Committee's performance and operation including that of any Sub-Committees established. In doing so, account will be taken of the requirements set out in the NHS Effective Board Committees Guide.
Cyfeirnod Cofrestr Risg Datix, Teitl a Sgôr Risg Cyfredol: Datix Risk Register Reference and Score:	Not Applicable

Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	Not Applicable
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	Not Applicable
Amcanion Strategol y BIP: UHB Strategic Objectives:	Not Applicable
Nodau Cynllunio 2026/27 Planning Goals 2026/27	Not Applicable
Hypergyswllt i Amcanion Llesiant HDdUHB 2026 Hyperlink to HDdUHB Well-being Objectives 2026	10. Not Applicable

Model Cymdeithasol ar gyfer Iechyd a Llesiant: (wedi'i gwblhau ar gyfer newid strategol a/neu newidiadau sylweddol i wasanaethau) A Social Model for Health and Wellbeing: (*complete for strategic change and/or significant service changes)*	Not Applicable
Gwybodaeth Ychwanegol: **Further Information:**	
Ar sail tystiolaeth: Evidence Base:	FPC Terms of Reference FPC Self-Assessment digital form results
Rhestr Termau: Glossary of Terms:	Contained within the body of the report
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y cyfarfod hwn: Parties / Committees consulted prior to this meeting:	Director of Corporate Governance

Effaith: (rhaid cwblhau) **Impact: (must be completed)**	
Ariannol / Gwerth am Arian: **Financial / Service:**	No Direct Impacts
Ansawdd / Gofal Claf: **Quality / Patient Care:**	No Direct Impacts
Gweithlu: **Workforce:**	No Direct Impacts
Tegwch Iechyd: **Health Equity:**	No Direct Impacts
Risg: **Risk:**	No Direct Impacts

Cyfreithiol: **Legal:**	No Direct Impacts
Enw Da: **Reputational:**	No Direct Impacts
Gyfrinachedd: **Privacy:**	No Direct Impacts
Cydraddoldeb: **Equality:**	No Direct Impacts

1.7

1.7 - ASSURANCE AND RISK REPORT

Huw Thomas (Hywel Dda UHB - Director of Finance), Andrew Carruthers (Hywel Dda UHB - Chief Operating Officer), Lee Davies (Hywel Dda UHB - Executive Director of Strategy and Planning), Mark Henwood (Hywel Dda UHB - Executive Medical Director)

For assurance

Attachments

Assurance and Risk Report FPC 27 August 2026.pdf

Appendix 1 FPC Corporate Risk Register.pdf

Appendix 2 FPC Overdue Audit and Inspection Recommendations.pdf



GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Assurance and Risk Report

Finance and Performance Committee, 27 August 2026

Situation

This report provides the Finance and Performance Committee (FPC) with the status of the corporate risks, audit and inspections, and Ministerial Directions (MDs).

The Committee is asked to seek assurance from the Lead Executive Directors that there are processes in place to oversee corporate risks to ensure these are being managed effectively, and that audit and inspection recommendations and Ministerial Directions are being implemented by the Health Board.

Principal risks, operational risks and Welsh Health Circulars are reported at alternate meetings and are due to be presented to FPC at its next meeting in October 2026.

Corporate Risks:	Audit and Inspection Reports	Ministerial Directions
3	23	1

Risk Management - Overview

Effective risk management requires a 'monitoring and review' structure to be in place to ensure that risks are effectively identified and assessed, and that appropriate controls and responses are in place.

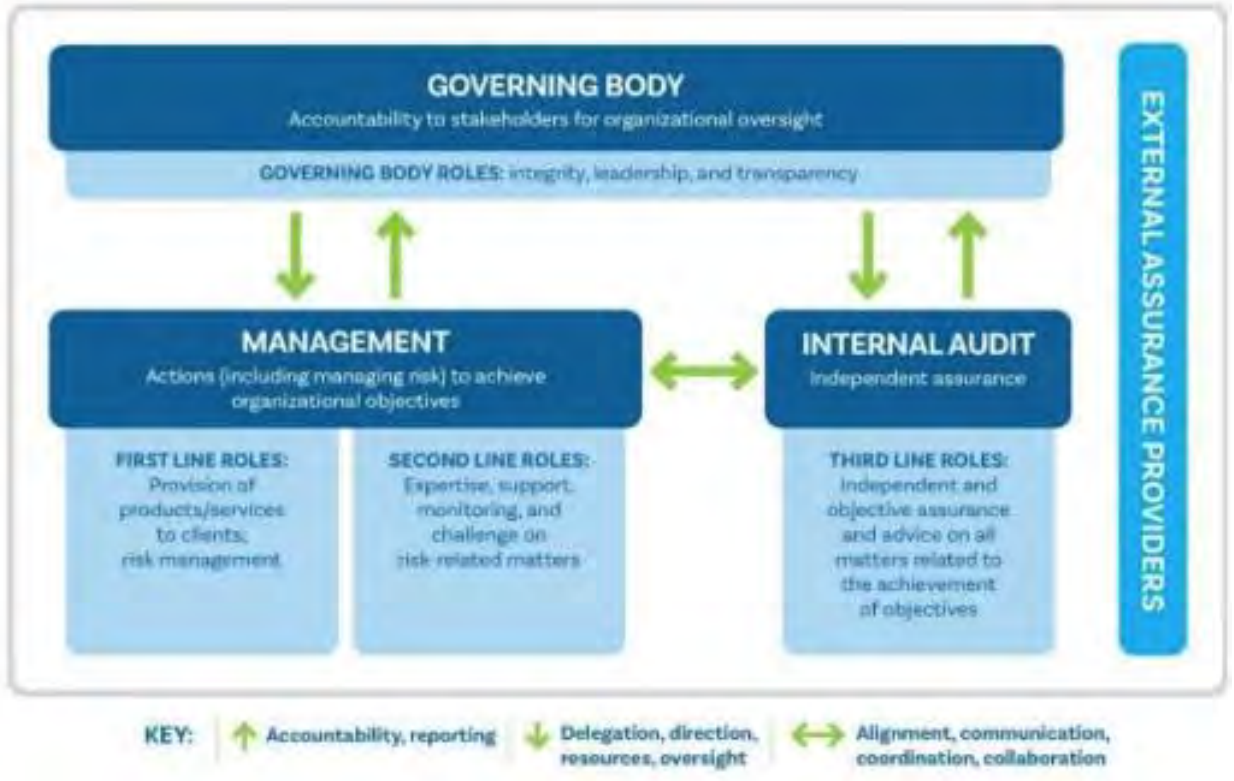
The Health Board's risk management process is recorded via the Datix Risk Register module, and enables risks to be recorded at either Principal, Corporate or Operational level. An escalation process is in place to ensure that risks which require escalation or de-escalation are done via appropriate approval processes and governance arrangements.

The Health Board operates within the widely accepted "Three Lines of Defence" model to ensure the appropriate responsibility is allocate for the management, reporting and escalation of risk.

Risks are aligned to an appropriate Clinical Care Group or Executive Function (hereto referred to as "Functions"), and each has a designated risk lead responsible for reviewing in a timely and comprehensive manner.

The Board's Committees are responsible for the monitoring and scrutiny of corporate and operational risks within their remit and providing assurance to the Board that risks are being managed effectively and report areas of significant concern (for example, where the risk appetite is exceeded, or there is a lack of action).

Committees are also responsible for reviewing risks over tolerance and where appropriate, recommend the 'acceptance' of risks that cannot be brought within risk appetite.



Corporate Risks Assigned to FPC

Hywel Dda Risk Heat Map					
	LIKELIHOOD →				
IMPACT ↓	Rare 1	Unlikely 2	Possible 3	Likely 4	Almost Certain 5
Catastrophic 5				2326	
Major 4			2327 2380		
Moderate 3					
Minor 2					
Negligible 1					

Each risk on the Corporate Risk Register (CRR) has been mapped to a Board level Committee to ensure that risks on the CRR are being managed appropriately, taking into account gaps in controls, planned actions and agreed tolerances, and to provide assurance to the Board through their update report on the management of these risks.

Corporate risks have been aligned to the most appropriate Board level Committee.

These risks have been identified by individual Directors via a top down and bottom-up approach and are either:

- Associated with the delivery of the Health Board objectives; or
- Significant escalated operational risks that are of significant concern

and require corporate oversight and management.

There are 3 corporate risks currently aligned to FPC (out of the 26 that are on the CRR on 22 July 2026).

The following slides provide a summary of the reportable corporate risks aligned to FPC. The Risk Register attached at **Appendix 1** provides full detail of the risk, including control measures in place, a risk action plan to further manage and mitigate the risk, an expected date to achieve the noted Target Risk Score, and sources of assurance.

Corporate Risks Aligned to FPC

The corporate risks aligned to the Committee highlight that the Health Board faces challenges in:

- achieving financial sustainability and delivering the requirements of the financial plan;
- meeting national performance standards and targets whilst managing increasing demand and service pressures; and
- maintaining cancer pathway performance and planned care recovery activity whilst experiencing capacity, workforce and funding constraints.

The potential impact of the risks include:

- increased financial instability and regulatory escalation;
- longer waiting times, poorer patient experience and adverse patient outcomes;
- inability to achieve national performance targets, resulting in increased scrutiny and reputational damage; and
- reduced resilience and sustainability of key services.

Common actions noted across the risks demonstrate the need to:

- strengthen workforce capacity;
- improve productivity and efficiency;
- enhance financial control, savings delivery and accountability; and
- strengthen performance management, governance and assurance arrangements.



Corporate Risks Assigned to FPC

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Risk Reference & Title	Clinical Care Group / Executive Function	Lead Director	Previous Risk Score	Current Risk Score	Target Risk Score (TRS)	Expected Date to Achieve TRS	Included in Annual Plan 2026/27?
2326 – Risk to achieving 26/27 Target Control Total due to underlying deficit, insufficient savings & reliance on non recurrent funding.	Director of Finance	Director of Finance	**20**	**20** ➔ (Reviewed 06/07/26)	**12**	~~30/06/26~~ 30/09/26	N/A - New risk for current financial year, but linked to existing corporate risk re: Annual Planning (2212)

Rationale for Current Risk Score (CRS)

The 2026/27 Financial Plan submitted to Welsh Government (WG) in March 2026 projected a £41m deficit. WG advised that the plan was neither supportable nor acceptable and reiterated its expectation of a £22m deficit. Of the £42.8m savings requirement, only £5.0m was assessed as Amber/Green assured, with a further £6.4m of Blue/Red opportunities yet to be converted into deliverable schemes. Sensitivity analysis forecast a year-end deficit of between £54.3m and £90.5m, requiring a minimum of £13.3m of additional savings.

A 4-Step Financial Improvement Framework was issued on 31 March 2026, followed by Chief Executive reviews in April 2026. An interim update to the Board in May 2026 demonstrated improvement in the financial trajectory, confirmed Executive ownership of variable pay workstreams, and outlined workforce plans across nursing, medical and other staff groups. By June 2026, all open actions had been completed, , and variable pay plans deliverable in-year and evidenced. A credible, recurrent opening baseline was confirmed, and reliance on non-recurrent measures has been addressed. A revised COO Operating Model, including CCG Delivery Agreements aligned to the Levels 1–4 Performance Escalation Framework, was developed and approved by the Formal Executive Team in July 2026. A System Leaders Workshop and Executive-owned delivery programme were also established. WG has been advised that Quarter 2 activity is required to further de-risk delivery of the financial plan.

Corporate Risks Assigned to FPC

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Risk Reference & Title	Clinical Care Group / Executive Function	Lead Director	Previous Risk Score	Current Risk Score	Target Risk Score (TRS)	Expected Date to Achieve TRS	Included in Annual Plan 2026/27?
2326 – Risk to achieving 26/27 Target Control Total due to underlying deficit, insufficient savings & reliance on non recurrent funding.	Director of Finance	Director of Finance	**20**	**20** ➔ (Reviewed 06/07/26)	**12**	30/06/26 30/09/26	N/A - New risk for current financial year, but linked to existing corporate risk re: Annual Planning (2212)

Rationale for Target Risk Score (TRS)

The Target Risk Score (TRS) reflects the position expected once the 4-Step Financial Improvement Framework has been delivered and the supporting control architecture is operating. Pace is essential.

The previous date to achieve the TRS of 30/06/2026 was aligned to the 4-Step Financial Improvement Framework, however this has now passed, and signals that the Health Board has not been able to exert sufficient grip on the largest controllable in-year expenditure line. There is a likelihood that the risk score could increase if the July 2026 position does not signal a run rate improvement closer to our monthly planned deficit. The date to achieve the TRS is therefore extended until 30 September 2026.

Corporate Risks Assigned to FPC

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Risk Reference & Title	Clinical Care Group / Executive Function	Lead Director	Previous Risk Score	Current Risk Score	Target Risk Score (TRS)	Expected Date to Achieve TRS	Included in Annual Plan 2026/27?
2327 – Risk to planned care and RTT recovery in 2026/27 due to demand–capacity gaps, estate fragility and non-recurrent funding	Planned and Specialist Care	Chief Operating Officer	**12**	**12** → (Reviewed 19/06/26)	**9**	31/03/27	N/A - New risk for current financial year, but supersedes previous risk 2104 included in the Annual Plan

Rationale for Current Risk Score (CRS)

The Health Board faces delivery risks in achieving ministerial planned care recovery targets by March 2027 due to combined pressures of cohort demand in key specialties and workforce limitations. Theatre cancellations at Glangwili Hospital (GGH) have further reduced core capacity, particularly impacting Orthopaedics, where additional demand from long-waiting patients persists.

While delivery plans demonstrate progress in outpatient activity, treatment capacity and workforce improvements, gaps remain and performance against planned care milestones continues to underpin the Health Board's Targeted Intervention status.

Estates issues are impacting theatre list cancellations. Regional collaboration with Swansea Bay University Health Board (SBUHB) being actively pursued to expand capacity in Ophthalmology and Orthopaedics, including use of Neath Port Talbot theatres. In the absence of recovery funding, 104-week breaches are predicted in Orthopaedics, Urology, Trauma and Orthopaedics, Ear Nose and Throat (ENT), Ophthalmology and Dermatology. The current risk score is assessed at 12, lower than the inherent risk score, as the Board have accepted the trajectories set out in the Annual Plan.

Corporate Risks Assigned to FPC

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Risk Reference & Title	Clinical Care Group / Executive Function	Lead Director	Previous Risk Score	Current Risk Score	Target Risk Score (TRS)	Expected Date to Achieve TRS	Included in Annual Plan 2026/27?
2327 – Risk to planned care and RTT recovery in 2026/27 due to demand–capacity gaps, estate fragility and non-recurrent funding	Planned and Specialist Care	Chief Operating Officer	**12**	**12** → (Reviewed 19/06/26)	**9**	31/03/27	N/A - New risk for current financial year, but supersedes previous risk 2104 included in the Annual Plan

Rationale for Target Risk Score (TRS)

The TRS of 9 reflects continuing delivery ambitions which remain, despite the workforce and resource limitations reflected in the Annual Plan. Of note, positive progress achieved both in respect of effective demand management and transformation of outpatient pathways has ensured that overall waiting list demand has not grown with waiting list volumes at their lowest level for 2 years.

Opportunities to make further progress towards Ministerial targets in 2026/27 will continue to be explored, including exploration of the regional opportunities referred to.

Corporate Risks Assigned to FPC

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Risk Reference & Title	Clinical Care Group / Executive Function	Lead Director	Current Risk Score	Target Risk Score (TRS)	Expected Date to Achieve TRS	Included in Annual Plan 2026/27?
2380 – Risk to delivery of Single Cancer Pathway performance due to diagnostic capacity gaps, funding uncertainty and pathway fragility	Planned and Specialist Care	Chief Operating Officer	**12** (NEW)	**8**	31/03/27	N/A - New risk for current financial year, but supersedes previous risk 1350 included in the Annual Plan

Rationale for Current Risk Score (CRS)

The service has been de-escalated by WG from Level 4 to Level 1 in terms of Targeted Intervention status as there has been the consistent achievement of the 60% de-escalation criteria since February 2025. As at March 2026 performance was at 60%.

Due to recovery actions within Radiology and Urology, we may see variation in performance as we recover and treat those patients over 62 days. Confirmation of target for March 2027 is 75%, however no health board is achieving this target. Plans are in place for Q1 2026/27 to maintain performance at the planned trajectory set out in the Annual Plan 2026/27.

Rationale for Target Risk Score (TRS)

The aim is to treat patients within target waiting times, which has now been confirmed as 64-66% as per Annual Plan 2026/27.

The TRS will be met if plans to maintain diagnostic capacity, utilising internal allocated funding, are realised. The risk score can be further reduced to 8 once the target of 66% is achieved and maintained for 3 consecutive months. There are underpinning trajectories in place which are monitored on a monthly basis and adherence to those will influence the ability to achi[illegible].

Audits and Inspections - Overview

The Health Board remains in Level 4 status with WG as a result of challenges relating to financial sustainability, strategy and planning, service delivery and organisational performance. Whilst the Health Board has been de-escalated for 'Leadership and Governance' from Level 3 to Level 1, the Health Board must meet the revised criteria:

- Evidence that all recommendations from the Royal Colleges / Health Inspectorate Wales (HIW) and other reviews specific to Hywel Dda University Health Board (HDdUHB) are discharged and either verified or delivered or scheduled for delivery within the Health Board's longer-term improvement plan;
- Support the implementation and realisation of GIRFT and the national programme reviews opportunities;
- Support the implementation and realisation of the three Ps policy, GIRFT, theatre optimisation, CIN optimisation programmes and related national improvement recommendations;
- Financial controls at the health board that are robust in both design and implementation, including a self-assessment against model frameworks, review implementation of the Standing Financial Instructions, internal audit reviews, or other control reviews; and
- Develop a prompt response to any HIW unannounced inspections, Audit Wales and Royal College recommendation, developing and completing action plans that demonstrate sustainable evidence.

All reports from audits, inspections and reviews undertaken across the Health Board are logged and tracked on AMaT (Audit Management and Tracking), with progress updated by relevant service leads against each recommendation, with evidence required to be uploaded to demonstrating progress and implementation, and any barriers to completion clearly noted.

AMaT enables services to directly update progress against all recommendations via one central system, promoting a consistent approach with regards to processes and reporting, improvement in transparency and accountability, supporting services with their governance arrangements, and improvement in information flow. Progress is monitored via the utilisation of a traffic light system based on performance against original completion dates.

Status Category	Definition
Overdue	The recommendation is behind schedule to the timescale provided by the lead officer.
Unable to Complete	The recommendation cannot be implemented due to existing barriers and/or it is no longer relevant/appropriate for the Health Board. Formal sign-off by the CCG/Function Lead is required prior to escalation to the Executive Team for formal approval via operational governance structures.
Pending Decision	The recommendation is pending a decision in order to implement e.g. outcomes of annual planning process, approval of funding requests, outcome of a QIA panel. Committee updates will detail whether the recommendation is overdue or not whilst decision pending.
In Progress	The recommendation is currently in progress, and within the agreed original timeframe for implementation.
Reliant on External Factors	The recommendation is considered to be outside the gift of the Health Board to currently implement, e.g. reliant on an external organisation to implement.
Complete Pending Formal Approval	The Service / Function have completed the recommendation and currently awaiting formal approval to close.
Complete	The recommendation has been confirmed as completed by the CCG / Function Lead and formal approval to close has been received.

Audits and Inspection Reports - Summary

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

The following reports have been assigned to FPC to enable them to undertake the following responsibility set out in their Terms of Reference:

3.1.18 Seek assurances on the requirements arising from the Health Board's regulators, WG and professional bodies

Full detail of recommendations that are overdue are included in **Appendix 2.**

Date of report	Report Issued By	Report Title	Clinical Care Group / Executive Function	Lead Director	Original Completion Date	Revised Completion Date	Number of recommen-dations in original report	Overdue	In Progress	Complete	Complete Pending Formal Approval	Reliant on External Factors	Pending Decision	Unable to Complete	Barriers to Completion
Jan-22	Peer Review	Colorectal Cancer (Third Cycle)	Planned and Specialist Care	Chief Operating Officer	Mar-22	~~Mar-23~~ ~~Mar-24~~ Mar-28	8	0	0	7	0	1	0	0	Awaiting regional approach for Pathology
Sep-22	Peer Review	Getting It Right First Time (GIRFT) - Gynaecology Review	Planned and Specialist Care	Chief Operating Officer	N/K	Sep-26	17	0	0	17	0	0	0	0	No barriers noted – awaiting formal approval to close.
May-23	Peer Review	Getting It Right First Time (GIRFT) General Surgery Review	Planned and Specialist Care	Chief Operating Officer	Sep-23	~~Mar-24~~ ~~Jan-25~~ ~~May-25~~ N/K	22	0	0	15	7	0	0	0	No barriers noted - awaiting formal approval to close.
Aug-23	Peer Review	Getting It Right First Time (GIRFT) Ophthalmology Review	Planned and Specialist Care	Chief Operating Officer	Apr-24	~~Nov-24~~ Jan-27	59	8	0	35	16	0	0	0	Workforce and theatre capacity constraints, service resilience and staffing challenges, and Operational pressures affecting service delivery.
Apr-24	Peer Review	Getting It Right First Time (GIRFT) - Urology Review	Planned and Specialist Care	Chief Operating Officer	Jan-27	Jan-27	29	0	7	19	1	2	0	0	Reliance on roll-out of national Urology coding criteria

Audits and Inspection Reports - Summary

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Date of report	Report Issued By	Report Title	Clinical Care Group / Executive Function	Lead Director	Original Completion Date	Revised Completion Date	Number of recommen-dations in original report	Overdue	In Progress	Complete	Complete Pending Formal Approval	Reliant on External Factors	Pending Decision	Unable to Complete	Barriers to Completion
Jun-24	Peer Review	Getting It Right First Time (GIRFT) - Emergency Medicine – BGH	Community and Integrated Medicine	Chief Operating Officer	Oct-25	N/K	11	2	0	3	6	0	0	0	Financial constraints and Workforce challenges
Jun-24	Peer Review	Getting It Right First Time (GIRFT) - Emergency Medicine - WGH	Community and Integrated Medicine	Chief Operating Officer	Oct-25	~~Oct-25~~ Nov-27	12	2	1	7	0	0	1	1	Financial constraints and Workforce challenges
Jun-24	Peer Review	Getting It Right First Time (GIRFT) - Emergency Medicine - GGH	Community and Integrated Medicine	Chief Operating Officer	Oct-25	~~Oct-25~~ ~~Apr-26~~ N/K	12	0	0	10	2	0	0	0	No barriers noted - awaiting formal approval to close.
Jul-24	Audit Wales	Review of Cost Savings Arrangements – Hywel Dda University Health Board	Director of Strategy and Planning	Director of Strategy and Planning	Mar-25	~~Mar-26~~ N/K	10	0	0	9	0	0	1	0	Awaiting approval to appoint senior service planners.
Oct-24	NHS Wales Executive	NHS Executive Report on Urgent and Emergency Care Opportunities: GGH site	Community and Integrated Medicine	Chief Operating Officer	Nov-25	Oct-26	58	8	0	35	15	0	0	0	No barriers noted

Audits and Inspection Reports - Summary

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Date of report	Report Issued By	Report Title	Clinical Care Group / Executive Function	Lead Director	Original Completion Date	Revised Completion Date	Number of recommen-dations in original report	Overdue	In Progress	Complete	Complete Pending Formal Approval	Reliant on External Factors	Pending Decision	Unable to Complete	Barriers to Completion
Jan-25	Ministerial Advisory Group	Ministerial Advisory Group (MAG) Observations following the site visits of health boards – Hywel Dda UHB - Allied Health Professions and Health Sciences (January 2025)	Operational Allied Health Professions and Health Sciences	Chief Operating Officer	Sep-25	~~Sep-25~~ ~~Jan-26~~ N/K	10	0	0	1	9	0	0	0	No barriers noted - awaiting formal approval to close.
Jan-25	Ministerial Advisory Group	Ministerial Advisory Group (MAG) Observations following the site visits of health boards – Hywel Dda UHB - Planned and Specialist Care (January 2025)	Planned and Specialist Care	Chief Operating Officer	Mar-26	~~Mar-26~~ Sep-26	32	15	0	9	6	2	0	0	Funding and workforce resource constraints.
Jan-25	Ministerial Advisory Group	Ministerial Advisory Group (MAG) - Observations following the site visits of health boards – Hywel Dda UHB- Urgent and Emergency Care (January 2025).	Community & Integrated Medicine	Chief Operating Officer	Mar-26	~~Mar-26~~ Oct-26	15	2	0	12	1	0	0	0	No barriers noted

Audits and Inspection Reports - Summary

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Date of report	Report Issued By	Report Title	Clinical Care Group / Executive Function	Lead Director	Original Completion Date	Revised Completion Date	Number of recommen-dations in original report	Overdue	In Progress	Complete	Complete Pending Formal Approval	Reliant on External Factors	Pending Decision	Unable to Complete	Barriers to Completion
Jan-25	NHS Wales Executive	NHS Executive Report on Urgent and Emergency Care Opportunities: PPH site	Community & Integrated Medicine	Chief Operating Officer	Aug-25	~~Aug-25~~ N/K	19	5	0	14	0	0	0	0	No barriers noted
Mar-25	NHS Wales Executive	NHS Executive Report on Urgent and Emergency Care Opportunities: BGH site	Community & Integrated Medicine	Chief Operating Officer	Apr-26	~~Apr-26~~ N/K	38	1	0	31	6	0	0	0	Pending outcomes of ongoing regional mortality review
Apr-25	Ministerial Advisory Group	A report from the Ministerial Advisory Group on NHS Wales Performance and Productivity	Chief Operating Officer Management	Chief Operating Officer	Mar-26	~~Mar-26~~ Sep-26	11	2	0	1	6	2	0	0	Complexity of patients presenting, workforce constraints
May-25	Audit Wales	Tackling the Planned Care Challenges – Hywel Dda University Health Board	Planned and Specialist Care	Chief Operating Officer	Mar-26	~~Mar-26~~ N/K	6	2	0	2	1	0	0	1	Reliant on outcomes of Ophthalmology CSP
Sep-25	Internal Audit	Validation of Emergency Department Waiting Time Data Final Internal Audit Report 2025/26	Community & Integrated Medicine	Chief Operating Officer	Dec-25	~~Dec-25~~ N/K	6	5	0	1	0	0	0	0	Internal Audit undertaking follow up in Q4 of 2026/27, with outstanding recommendations to be reviewed.

Audits and Inspection Reports - Summary

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Date of report	Report Issued By	Report Title	Clinical Care Group / Executive Function	Lead Director	Original Completion Date	Revised Completion Date	Number of recommen-dations in original report	Overdue	In Progress	Complete	Complete Pending Formal Approval	Reliant on External Factors	Pending Decision	Unable to Complete	Barriers to Completion
Mar-26	Internal Audit	Space Utilisation Final Advisory Report 2025/26 (NEW REPORT)	Director of Strategy and Planning	Director of Strategy and Planning	Aug-27	Aug-27	8	0	4	4	0	0	0	0	No barriers noted – recommendations on track.
Mar-26	Internal Audit	Internal Escalation: Level 3 & 4 Functions Final Internal Audit Report 2025/26 (NEW REPORT)	Director of Finance	Director of Finance	Mar-26	~~Mar-26~~ N/K	7	4	0	3	0	0	0	0	No barriers noted
Apr-26	Internal Audit	Operational Governance Arrangements Final Internal Audit Report 2025/26 (NEW REPORT)	Chief Operating Officer Management	Chief Operating Officer	May-26	~~May-26~~ N/K	4	0	0	0	4	0	0	0	No barriers noted - awaiting formal approval to close.
May-26	Internal Audit	High-Cost Drugs Final Internal Audit Report 2025/26 (NEW REPORT)	Medical Director	Medical Director	Mar-27	Mar-27	7	1	5	0	1	0	0	0	No barriers noted
Jun-26	Internal Audit	WellSky Final (Advisory Report) 2025/26 (NEW REPORT)	Director of Finance	Director of Finance	Jul-26	Jul-26	1	0	1	0	0	0	0	0	No barriers noted – recommendations on track.

Audits and Inspection Reports closed since previous report

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Since the previous report presented to FPC, the following reports have been formally approved as closed:

Report issued by	Report Title	Clinical Care Group/ Executive Function	Lead Director	Original Completion Date	Implementation Date	Number of recommendations in report	Report status
Internal Audit	Financial Management Final Internal Audit Report 2024/25 **(issued Mar 25)**	Director of Finance	Director of Finance	Jan-26	Jun-26 – closed following approval by Internal Audit	**5**	**Complete**
Internal Audit	Continuing Healthcare – Database Maintenance & Finance Processes Final Internal Audit Report 2024/25 (Substantial rating) **(issued June 25)**	Director of Finance	Director of Finance	Oct-25	Apr-26 – closed following approval by Internal Audit	**1**	**Complete**

Implementation of Ministerial Directions

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Ministerial Directives (MDs) are legislative in character as they alter legal rights and duties. MDs are issued by Welsh Ministers and include codes of practice and guidance. In complying with the requirements of various governance codes and the Annual Governance Statement requirements, the Health Board has a duty to provide assurance of compliance with MDs.

The table below shows the number of MDs assigned to each category as of 22 July 2026, summarised over the next slides. Definitions of categories are included in the table below.

Status Category	Definition	Number of MDs
Overdue	The MD is behind schedule to the timescale provided by the lead officer.	1
Unable to Complete	The MD cannot be implemented due to existing barriers and/or it is no longer relevant/appropriate for the Health Board. Formal sign-off by the CCG/Function Lead is required prior to escalation to the Executive Team for formal approval via operational governance structures.	0
Pending Decision	The MD is pending a decision in order to implement e.g. outcomes of annual planning process, approval of funding requests, outcome of a QIA panel. Committee updates will detail whether the recommendation is overdue or not whilst decision pending.	0
In Progress	The MD is currently in progress, and within the agreed original timeframe for implementation.	0
Reliant on External Factors	The MD is considered to be outside the gift of the Health Board to currently implement, e.g. reliant on an external organisation to implement.	0
Complete Pending Formal Approval	CCG / Function have confirmed compliance with the statutory requirements of the MD, and evidence send to relevant Lead Executive for confirmation.	0
Complete	CCG / Function have confirmed compliance with the statutory requirements of the MD, and receipt of approval to close obtained from Lead Executive.	8

MDs included within this report are based on the following criteria:

3.1.18 Seek assurances on the requirements arising from the Health Board's regulators, Welsh Government and professional bodies

Progress updates relating to the implementation of MDs are extracted from the AMAT system.

Ministerial Directions - Overdue

MD	Issued On	Lead CCG / EF	Lead Director	Implementation Date	Progress Status
WG21-59: The Directions to Local Health Boards and NHS Trusts in Wales on the Delivery of Autism Services 2021	26/07/2021	Mental Health and Learning Disabilities	Chief Operating Officer	~~30/03/2026~~ N/K	**Overdue**

The Health Board is exercising its functions in accordance with the relevant provisions of the Code of Practice on the Delivery of Autism Services (2021) with supporting evidence of this uploaded on AMaT. However, lengthy waiting times remain an issue.

WG is fully aware of the lengthy waiting times across Wales, as evidenced within their Neurodivergence Improvement Programme report; and the risk to patients of lengthy waiting times is recognised by the Health Board and is being monitored/managed by the Clinical Care Group with 1 corporate risk and 2 operational risks on the risk register: -

- Corporate Risk 1032 - Risk to the timely diagnosis and treatment of mental health and learning disabilities clients due to demand and capacity, which has a current risk score of 20 (last updated April 2026, noting that this is in the process of being refreshed before being presented to Formal Executive Team);
- Operational Risk 1287 - Risk of clients not being provided with timely interventions due to waiting lists for assessment & diagnosis of ASD, with a current risk score of 20 (updated June 2026);
- Operational Risk 1290 - Risk of increased Adult ADHD waiting list due to referrals exceeding service capacity, with a current risk score of 20 (updated June 2026).

Submitted to Chief Operating Officer for review, however MD not formally approved for closure due to waiting times still breaching. Deputy Chief Operating Officer has requested a full review of the MD in July 2026.

Complete Ministerial Directions

Since the previous report to the Committee, the following MDs have been confirmed as implemented and formally approved as closed (**Complete**):

MD	Issued On	Lead CCG / EF	Lead Director	Implementation Date	Progress Status	Progress Update
WG25-84: Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) (No. 6) Directions 2025	02/12/2025	Primary Care	Chief Operating Officer	14/03/2026	**Complete**	Statement of Financial Entitlement supports the contractual payment mechanisms.
NWSI 2026 No.58: The Primary Medical Services (People Living with Severe Frailty in their own Homes) (Directed Supplementary Service) (Wales) (Amendment) Directions 2026	18/03/2026	Primary Care	Chief Operating Officer	10/04/2026	**Complete**	Global sum arrears paid this month to GP practices to correct error in rate
NWSI 2026 No.47: Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) (No. 3) Directions 2026	10/03/2026	Primary Care	Chief Operating Officer	10/04/2026	**Complete**	MD removes end date for a Service claimed by GP practices to enable ongoing claims.
NWSI 2026 No.71: Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) (No. 4) Directions 2026	31/03/2026	Primary Care	Chief Operating Officer	15/05/2026	**Complete**	Uplift to Global Sum Calculation rate which will apply to GP payments from April 26 onwards

Complete Ministerial Directions

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Since the previous report to the Committee, the following MDs have been confirmed as implemented and formally approved as closed (**Complete**):

MD	Issued On	Lead CCG / EF	Lead Director	Implementation Date	Progress Status	Progress Update
NWSI 2026 No.76: Directions to Local Health Boards as to the Personal Dental Services Statement of Financial Entitlements (Amendment No.2) Directions 2026	07/04/2026	Primary Care	Chief Operating Officer	15/05/2026	**Complete**	MD is for information only. No further action required by Primary Care.
NWSI 2026 No.83: Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) (No. 5) Directions 2026	02/04/2026	Primary Care	Chief Operating Officer	15/05/2026	**Complete**	Changes to payment rates for Access and Achievement under Quality Improvement domain
NWSI-26-116: The Primary Care (Contracted Services: Immunisations) (COVID19) (Wales) Directions 2026	23/06/2026	Primary Care	Chief Operating Officer	20/07/2026	**Complete**	Will be transacted as changes to the current contractual arrangements for the immunisation programmes. Direction informs the process for this year's campaign for GP practices to claim for these vaccinations (using the DHCW WIS system). When the campaign begins we receive a payment schedule every month informing us of totals to pay to practices.
NWSI-26-117: The Primary Care (Contracted Services: Immunisations) (Influenza) (Amendment) Directions 2026	23/06/2026	Primary Care	Chief Operating Officer	20/07/2026	**Complete**	Direction informs the process for this year's campaign for GP practices to claim for these vaccinations (using the DHCW WIS system). When the campaign begins we receive a payment schedule every month informing us of totals to pay to practices.

Recommendations

The Finance and Performance Committee is requested, in relation to the areas presented in this paper, to: -

RISK MANAGEMENT

- **RECEIVE ASSURANCE** that there are processes in place to oversee corporate risks to ensure these are being managed effectively.

AUDITS, INSPECTIONS AND REGULATORY REPORTS

- **RECEIVE ASSURANCE** from the lead Executive Director or Supporting Officer on the management of recommendations raised in audit, inspection and regulatory reports within their area of responsibility, particularly in respect of confirming the full implementation of recommendations, any barriers to delivery and subsequent impacts of non/late delivery, and assurance that the risks associated with these are being managed effectively.

MINISTERIAL DIRECTIONS

- **RECEIVE ASSURANCE** that the Health Board is compliant with the MDs issued by Welsh Government.





DIOGEL | CYNALIADWY | HYGYRCH | CAREDIG

SAFE | SUSTAINABLE | ACCESSIBLE | KIND

GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

Risk Ref	Risk (for more detail see individual risk entries)	Executive Director	Domain	Previous Risk Score	Risk Score Jul-26	Trend	Target Risk Score (tolerable score)	Expected Date of achieving Target Risk Score	Risk on page no...
2326	Risk to achieving 26/27 Target Control Total due to underlying deficit, insufficient savings & reliance on non recurrent funding	Thomas, Huw -	Finance inc. claims	4×5=20	4×5=20	→	3×4=12	6/30/2026	6
2380	Risk to delivery of Single Cancer Pathway performance due to diagnostic capacity gaps, funding uncertainty and pathway fragility	Carruthers, Andrew	Quality/Complaints/Audit	NA	3×4=12	New risk	2×4=8	3/31/2027	11
2327	Risk to planned care and RTT recovery in 2026/27 due to demand-capacity gaps, estate fragility and non recurrent funding	Carruthers, Andrew	Quality/Complaints/Audit	3×4=12	3×4=12	→	3×3=9	3/31/2027	16

RISK SCORING MATRIX

Likelihood x Impact = Risk Score					
		Corporate Risk Description:			
Likelihood	**1**	**2**	**3**	**4**	**5**
Descriptor	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost Certain**
Frequency - How often might it/does it happen? (how many times will the adverse consequence being assessed actually be realised?)	**This will probably never happen/recur (except in very exceptional circumstances).**	**Do not expect it to happen/recur but it is possible that it may do so.**	**It might happen or recur occasionally.**	**It might happen or recur occasionally.**	**It will undoubtedly happen/recur, possibly frequently.**
	Not expected to occur for years.*	Expected to occur at least annually.*	Expected to occur at least monthly.*	Expected to occur at least weekly.*	Expected to occur at least daily.*
	* time-framed descriptors of frequency				
Probability - Will it happen or not? (what is the chance the adverse consequence will occur in a given reference period?)	**(0-5%*)**	**(5-25%*)**	**(25-75%*)**	**(75-95%*)**	**(>95%*)**
	*used to assign a probability score for risks related to time-limited or one off projects or business objectives.				
Risk Impact Domains	**Negligible - 1**	**Minor - 2**	**Moderate - 3**	**Major - 4**	**Catastrophic - 5**
Safety of Patients, Staff or Public	**Minimal injury requiring no/minimal intervention or treatment.**	**Minor injury or illness, requiring minor intervention.**	**Moderate injury requiring professional intervention.**	**Major injury leading to long-term incapacity/disability.**	**Incident leading to death.**
	No time off work.	**Requiring time off work for >3 days**	**Requiring time off work for 4-14 days.**	**Requiring time off work for >14 days.**	**Multiple permanent injuries or irreversible health effects.**
		Increase in length of hospital stay by 1-3 days.	**Increase in length of hospital stay by 4-15 days.**	**Increase in length of hospital stay by >15 days.**	**An event which impacts on a large number of patients.**
			Agency reportable incident.	**Mismanagement of patient care with long-term effects.**	
			An event which impacts on a small number of patients.		
Quality, Complaints or Audit	**Peripheral element of treatment or service suboptimal.**	**Overall treatment or service suboptimal.**	**Treatment or service has significantly reduced effectiveness.**	**Non-compliance with national standards with significant risk to patients if unresolved.**	**Totally unacceptable level or quality of treatment/service.**
	Informal complaint/inquiry.	**Formal complaint.**	**Formal complaint -**	**Multiple complaints/ independent review.**	**Gross failure of patient safety if findings not acted on.**
		Local resolution.	**Escalation.**	**Low achievement of performance/delivery requirements.**	**Inquest/ombudsman inquiry.**
		Single failure to meet internal standards.	**Repeated failure to meet internal standards.**	**Critical report.**	**Gross failure to meet national standards/performance requirements.**
		Minor implications for patient safety if unresolved.	**Major patient safety implications if findings are not acted on.**		
		Reduced performance if unresolved.			

Workforce & OD	Short-term low staffing level that temporarily reduces service quality (< 1 day).	Low staffing level that reduces the service quality.	Late delivery of key objective/ service due to lack of staff.	Uncertain delivery of key objective/service due to lack of staff.	Non-delivery of key objective/service due to lack of staff.
			Unsafe staffing level or competence (>1 day).	Unsafe staffing level or competence (>5 days).	Ongoing unsafe staffing levels or competence.
			Low staff morale.	Loss of key staff.	Loss of several key staff.
			Poor staff attendance for mandatory/key training.	Very low staff morale. No staff attending mandatory/ key training.	No staff attending mandatory training /key training on an ongoing basis.
Statutory Duty or Inspections	No or minimal impact or breach of guidance/ statutory duty.	Breach of statutory legislation.	Single breach in statutory duty.	Enforcement action	Multiple breaches in statutory duty.
		Reduced performance levels if unresolved.	Challenging external recommendations/ improvement notice.	Multiple breaches in statutory duty.	Prosecution.
				Improvement notices.	Complete systems change required.
				Low achievement of performance/delivery requirements.	Low achievement of performance/delivery requirements.
				Critical report.	Severely critical report.
Adverse Publicity or Reputation	Rumours.	Local media coverage – short-term reduction in public confidence. Elements of public expectation not being met.	Local media coverage – long-term reduction in public confidence.	National media coverage with <3 days service well below reasonable public expectation.	National media coverage with >3 days service well below reasonable public expectation. AMs concerned (questions in the Assembly).
	Potential for public concern.				Total loss of public confidence.
Business Objectives or Projects	Insignificant cost increase/ schedule slippage.	<5 per cent over project budget. Schedule slippage.	5–10 per cent over project budget. Schedule slippage.	Non-compliance with national 10–25 per cent over project budget. Schedule slippage. Key objectives not met.	Incident leading >25 per cent over project budget. Schedule slippage. Key objectives not met.
Finance including Claims	Small loss.	Loss of 0.1–0.25 per cent of budget.	Loss of 0.25–0.5 per cent of budget.	Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget.	Non-delivery of key objective/ Loss of >1 per cent of budget.
	Risk of claim remote.	Claim less than £10,000.	Claim(s) between £10,000 and £100,000.	Claim(s) between £100,000 and £1 million.	Failure to meet specification/ slippage
					Claim(s) >£1 million.
Service or Business interruption or disruption	Loss/interruption of >1 hour. Minor disruption.	Loss/interruption of >8 hours.	Loss/interruption of >1 day.	Loss/interruption of >1 week.	Permanent loss of service or facility.
		Some disruption manageable by altered operational routine.	Disruption to a number of operational areas within a location and possible flow onto other locations.	All operational areas of a location compromised. Other locations may be affected.	Total shutdown of operations.
Environmental	Minimal or no impact on the environment.	Minor impact on environment.	Moderate impact on environment.	Major impact on environment.	Catastrophic/critical impact on environment.
Health Equity	Minimal or no impact on our attempts to improve health equity	Minor impact on our attempts to improve health equity or low level of certainty on the impact we are having on health equity	Moderate impact on our attempts to improve health equity or a lack of sufficient information that would demonstrate this. Indications that we are not having a positive impact on health improvement or health equity	Major impact on our attempts to improve health equity. Validated data suggesting that we are not improving the health of the most disadvantaged in our population whilst clearly supporting the least disadvantaged. Validated data suggesting we are having no impact on health improvement or health equity.	Validated data clearly demonstrating a disproportionate widening of health inequalities or a negative impact on health improvement and/or health equity.

RISK MATRIX

IMPACT ↓	LIKELIHOOD →				
	RARE	UNLIKELY	POSSIBLE	LIKELY	ALMOST CERTAIN
	1	2	3	4	5
CATASTROPHIC 5	5	10	15	20	25
MAJOR 4	4	8	12	16	20
MODERATE 3	3	6	9	12	15
MINOR 2	2	4	6	8	10
NEGLIGIBLE 1	1	2	3	4	5

RISK ASSESSMENT - FREQUENCY OF REVIEW

RISK SCORED	DEFINITION	ACTION REQUIRED (GUIDE ONLY)	MINIMUM REVIEW FREQUENCY
15-25	Extreme	Unacceptable. Immediate action must be taken to manage the risk. Control measures should be put into place which will have an effect of reducing the impact of an event or the likelihood of an event occurring. A number of control measures may be required.	This type of risk is considered extreme and should be reviewed and progress on actions updated, at least monthly.
8-12	High	Very unlikely to be acceptable. Significant resources may have to be allocated to reduce the risk. Urgent action should be taken. A number of control measures may be required.	This type of risk is considered high and should be reviewed and progress on actions updated at least bi-monthly.
4-6	Moderate	Not normally acceptable. Efforts should be made to reduce risk, providing this is not disproportionate. Establish more precisely the likelihood & harm as a basis for determining the need for improved measures.	This type of risk is considered moderate and should be reviewed and progress on actions updated at least every six months.
1-3	Low	Risks at this level may be acceptable. If not acceptable, existing controls should be monitored & reviewed. No further action or additional controls are required.	This type of risk is considered low risk and should be reviewed and progress on actions updated at least annually.

Assurance Key:

3 Lines of Defence (Assurance)		
1st Line	Business Management	Tends to be detailed assurance but lack independence
2nd Line	Corporate Oversight	Less detailed but slightly more independent
3rd Line	Independent Assurance	Often less detail but truly independent

Key - Assurance Required	*NB Assurance Map will tell you if you have sufficient sources of assurance not what those sources are telling you*
Detailed review of relevant information	
Medium level review	
Cursory or narrow scope of review	

Key - Control RAG rating	
LOW	Significant concerns over the adequacy/effectiveness of the controls in place in proportion to the risks
MEDIUM	Some areas of concern over the adequacy/effectiveness of the controls in place in proportion to the risks
HIGH	Controls in place assessed as adequate/effective and in proportion to the risk
INSUFFICIENT	Insufficient information at present to judge the adequacy/effectiveness of the controls

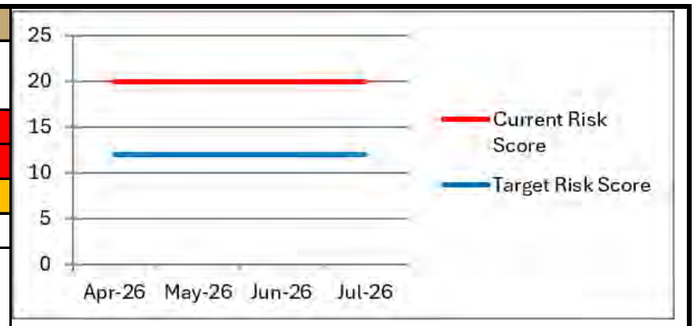
Date Risk Identified:	Apr-26		
Strategic Objective:	1. Thriving Teams and 2. Healthier Communities and 3. Great Care and 4. Positive Futures		

Executive Director Owner:	Thomas, Huw -	**Date of Review:**	Jul-26
Lead Committee:	Finance and Performance Committee	**Date of Next Review:**	Aug-26

Risk ID:	**2326**	**Corporate Risk Description:**	There is a risk that the Health Board does not deliver a 2026/27 financial out-turn within the expected Target Control Total (TCT), and that Welsh Government (WG) is therefore unable to fund the cash consequences of the residual deficit. This is caused by an unsupportable 2026/27 Annual Plan position, with a £41.0m deficit requiring improvement to £22.0m, £42.8m of savings needed to deliver the plan, and a further £19.0m to achieve the Target Control Total. The risk is driven by a large opening run rate deficit of £54.3m to £90.5m, depending on plan delivery, low levels of assured savings against £42.8m requirement, reliance on unconfirmed and non recurrent measures, insufficiently developed variable pay controls, uncosted Planning Framework requirements, and significant unmitigated service risks. This could lead to an impact/affect on the Health Board's ability to meet supplier payments in the final quarter of 2026/27, the need for operational mitigations that may extend patient waiting times and affect performance, reputational damage with WG and other stakeholders, escalation of the finance domain from Targeted Intervention to Special Measures, and potential Level 4 internal

Does this risk link to any Directorate (operational) risks?	2212, 2132, 2148, 2131, 2110, 1869, 1631, 975, 2107, 1906, 1892, 971, 2040, 2124, 2045, 1951, 716, 134, 1775, 1773, 1931, 1646.

Risk Rating:(Likelihood x Impact)	
Domain:	Finance inc. claims
Inherent Risk Score (L x I):	5×5=25
Current Risk Score (L x I):	4×5=20
Target Risk Score (L x I):	3×4=12
Expected Date To Achieve TRS:	6/30/2026
Trend:	⟷



Rationale for CURRENT Risk Score:

The 2026/27 Financial Plan submitted to Welsh Government (WG) in March 2026 projected a £41m deficit. WG advised that the plan was neither supportable nor acceptable and reiterated its expectation of a £22m deficit. Of the £42.8m savings requirement, only £5.0m was assessed as Amber/Green assured, with a further £6.4m of Blue/Red opportunities yet to be converted into deliverable schemes. Sensitivity analysis forecast a year-end deficit of between £54.3m and £90.5m, requiring a minimum of £13.3m of additional savings.
A 4-Step Financial Improvement Framework was issued on 31 March 2026, followed by Chief Executive reviews in April 2026. An interim update to the Board in May 2026 demonstrated improvement in the financial trajectory, confirmed Executive ownership of variable pay workstreams, and outlined workforce plans across nursing, medical and other staff groups. By June 2026, all open actions had been completed, , and variable pay plans deliverable in-year and evidenced. A credible, recurrent opening baseline was confirmed, and reliance on non-recurrent measures has been addressed.
A revised COO Operating Model, including CCG Delivery Agreements aligned to the Levels 1-4 Performance Escalation Framework, was developed and approved by the Formal Executive Team in July 2026. A System Leaders Workshop and Executive-owned delivery programme were also established. WG has been advised that Quarter 2 activity is required to further de-risk delivery of the financial plan.

Rationale for TARGET Risk Score:

The Target Risk Score (TRS) reflects the position expected once the 4-Step Financial Improvement Framework has been delivered and the supporting control architecture is operating. Pace is essential.

The previous date to achieve the TRS of 30/06/2026 was aligned to the 4-Step Financial Improvement Framework, however this has now passed, and signals that the Health Board has not been able to exert sufficient grip on the largest controllable in-year expenditure line. There is a likelihood that the risk score could increase if the July 2026 position does not signal a run rate improvement closer to our monthly planned deficit. The date to achieve the TRS is therefore extended until 30 September 2026.

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	Gaps in CONTROLS			
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
1. Working Day 1 principles retained within the finance function to ensure timely 'Flash reports' to the Executive Team. 2. Timely, relevant and understandable reporting to budget managers, Executives, Committees, Board and WG via QlikSense (live, self-service) and monthly management information packs. 3. Oversight arrangements through Integrated Quality, Financial Performance and Delivery Group, Value and Sustainability Group, and the Healthier Mid and West Wales Group. 4. Executive meetings and the Internal Escalation Framework embedded across the organisation, covering seven domains including Finance. 5. Financial control scrutiny of agency medical, agency AHP, Admin and Clerical and newly created roles for recruitment and procurement. 6. Opportunities compendium framework, updated and shared monthly. 7. Substantive operational structures in place since April 2025, providing managerial clarity and consistent accountability. 8. Business Controlling team alignment to CCG/CSG and Executive Function management structures. 9. CCG Accountability Agreements to be created and issued for 2026/27. 10. Director of Finance 4-Step Financial Improvement Framework cascaded on 31 March 2026 and reviewed by the Executive Team on 8 April 2026. 11. CEO-led review cycle on 22 and 29-30 April 2026 against the 4-Step Framework; Board update on 28 May 2026. 12. Revised COO Operating Model (draft, April 2026) introducing CCG Delivery Agreements covering Quality & Safety, Finance, Workforce, Risk, Performance and Transformation, to be issued by 30 April 2026, and a Performance Escalation Framework (Levels 1 to 4) aligned to a tiered meeting structure. 13. Value Opportunities Catalogue (SBAR, April 2026) covering ten clinical and operational domains and over 25 national enabling actions from the NHS Wales 2026/27 Planning Framework, providing a defined starting set for pathway and productivity improvement. 14. Director of Finance Choices and Value workbook (9 April 2026) consolidating specific cash-out and productivity opportunities across	Material residual gaps in control are: Primary controllable gap: Variable pay (substantive bank, overtime, waiting list initiatives and agency) is the single largest in-year controllable expenditure line. Across nursing, medical and other staff groups, there is not yet a deliverable plan covering the three dimensions of (i) recruitment assurance, (ii) deployment (rostering, sickness management, medical job planning), and (iii) configuration (establishment, service model, site working). Other open gaps: 1. Limited assured savings plans: only £5.0m of Amber/Green against the £42.8m 2026/27 requirement. 2. £6.4m of Blue/Red (unconfirmed) savings ideas not yet converted into deliverable plans. 3. Continued reliance on non-recurrent measures carried from 2025/26. 4. Effective management of beds and patient flow. 5. Effective contract management and oversight of commissioned services. 6. Organisational change delivery capacity, including transformation resourcing and alignment. 7. Revised COO Operating Model remains in draft; CCG Delivery	Nursing - configuration: review and confirm nursing establishments, ward and bed base alignment, skill mix and safe staffing levels. Configuration options to May Board (28 May 2026); decisions confirmed and consequential variable pay release evidenced by 30 June 2026.	Carruthers, Andrew	~~30/06/2026~~ 30/09/2026	Linked to Choices and Value workbook beds-related opportunities and to the Value Opportunities Catalogue. Action not concluded by original quarter 1 deadline, so has been extended to the end of quarter 2, aligned to the target risk score deadline update.
		Medical - deployment: consultant job planning compliance trajectory toward the NHS Wales >90% standard (national deadline 30 September 2026); medical rostering system implementation; sickness absence management; tight controls over waiting list initiative and overtime usage. Interim position to May Board (28 May 2026); deployment plan and early compliance evidence by 30 June 2026.	Henwood, Mr Mark	~~30/06/2026~~ 30/09/2026	Medical rostering programme continues from 2025/26 with further milestones and quantified benefits to be articulated. 30 June 2026 is the Health Board internal deadline; 30 September 2026 remains the national job planning compliance target. Action not concluded by original quarter 1 deadline, so has been extended to the end of quarter 2, aligned to the target risk score deadline update.
		Medical - configuration: review service model, on-call arrangements and site working (including single-site and cross-site consolidation) with consequential release of variable pay requirement. Options to May Board (28 May 2026); preferred direction confirmed by 30 June 2026.	Carruthers, Andrew	~~30/06/2026~~ 30/09/2026	Linked to Choices and Value workbook strategic opportunities (including Bronglais maternity/paediatrics, radiology OOH, pathology site model). Action not concluded by original quarter 1 deadline, so has been extended to the end of quarter 2, aligned to the target risk score deadline update.

beds, theatres, AHP, clinical variation, workforce and strategic opportunities to inform the £41m to £22m trajectory. 15. System Leaders Workshop (Nantgaredig, 15 April 2026) engaging CCG and Deputy leadership on value priorities, the financial outlook and collective capacity for delivery. 16. Financial Accountability Letters issued to all Executive Portfolios and Functional Deputies for return and signing by 31st March 2026.	Agreements not yet issued; Level 4 escalation triggers, finance authority at each operating layer, and the executive team mechanism between Level 3b and CEO are not yet defined. 8. Value Opportunities Catalogue identifies opportunities but is not yet converted into delivery at scale.	Allied Health Professions and Health Sciences: deliver trajectory toward 30% agency reduction against 2025/26 outturn; zero agency in HSW, Admin and Clerical, Estates and Ancillary (national deadline 30 September 2026); AHP Rate Card implementation; sickness absence reduction. Interim position to May Board (28 May 2026); plan fully evidenced by 30 June 2026.	Severs, James	~~30/06/2026~~ 30/09/2026	Targets drawn from NHS Wales 2026/27 Planning Framework. 30 June 2026 is the Health Board cadence deadline for deliverable plans; national zero-agency targets sit at 30 September 2026. Action not concluded by original quarter 1 deadline, so has been extended to the end of quarter 2, aligned to the target risk score deadline update.
		Other staff groups (Admin and Clerical, Estates and Ancillary, Trainees): deliver trajectory toward 30% agency reduction against 2025/26 outturn; zero agency in HSW, Admin and Clerical, Estates and Ancillary (national deadline 30 September 2026); AHP Rate Card implementation; sickness absence reduction. Interim position to May Board (28 May 2026); plan fully evidenced by 30 June 2026.	Gostling, Lisa	~~30/06/2026~~ 30/09/2026	Targets drawn from NHS Wales 2026/27 Planning Framework. 30 June 2026 is the Health Board cadence deadline for deliverable plans; national zero-agency targets sit at 30 September 2026. Action not concluded by original quarter 1 deadline, so has been extended to the end of quarter 2, aligned to the target risk score deadline update.

ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	**Sources of ASSURANCE**	**Type of Assurance (1st, 2nd, 3rd)**	**Required Assurance / Current Level**			**Identified Gaps in Assurance:**	**How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps**	**By Who**	**By When**	**Progress**
Performance against the 2026/27 operational plan and targets through key performance indicators. In-month financial monitoring and forecasting against	Performance against plan monitored through Executive Improving Together meetings, 4-Step Financial Improvement Framework and CCG monthly performance reviews.	1st			Executive Team - 8 April 2026 (4-Step Framework) System Leaders Workshop - 15 April 2026 (Nantgaredig) Chief Executive Reviews - 22 and 29-30 April 2026	Assurance gaps carried into 2026/27: 1. Limited Amber/Green assurance over 2026/27 savings delivery (£5.0m of £42.8m). 2. Outstanding Audit Wales and Internal Audit	Nursing - recruitment assurance: confirm substantive recruitment pipeline and fill rates against funded establishment; reduce routine reliance on on-contract nursing agency; HCSW agency trajectory to zero. Interim position to May Board (28 May 2026); plan fully evidenced by 30 June 2026.	Daniel, Sharon	~~30/06/2026~~ 30/09/2026	Plan to be developed through the April 2026 CEO Review cycle; first cut to May 2026 Board. Action not concluded by original quarter 1 deadline, so has been extended to the end of quarter 2, aligned to the target risk score deadline update.

the £41.0m plan, with trajectory toward the £22.0m improvement target. Implementation of CCG Delivery Agreements and Performance Escalation Framework (Levels 1 to 4).	Finance and Performance Committee oversight of 2026/27 plan delivery and improvement trajectory.	2nd			Finance and Performance Committee 30 April 2026 Board - 28 May 2026 (plan improvement action from £41m to £22m) In-Board Committee 18 June 2026 - opportunity decisions Finance and Performance Committee 30 June 2026 Executive Team 8 July 2026 Senior leadership savings engagement event 9 July 2026 - to progress the pace of savings	recommendations from 2025/26 (operational governance, discharge management, rostering). 3. Delivery of change remains a longstanding issue. 4. WG has rejected the £41m submitted position, so external assurance over plan acceptability is not yet in place. 5. Year 1 Value Opportunities Catalogue excludes digital, primary care, equity, workforce capability and prevention economics, limiting the assurance scope until year 2/3 iterations are developed.	Nursing - recruitment assurance: confirm substantive recruitment pipeline and fill rates against funded establishment; reduce routine reliance on on-contract nursing agency; HCSW agency trajectory to zero. Interim position to May Board (28 May 2026); plan fully evidenced by 30 June 2026.	Daniel, Sharon	~~30/06/2026~~ 30/09/2026	To be progressed through the COO Operating Model and Delivery Agreements (issued by 30 April 2026), with weekly drumbeat thereafter. Action not concluded by original quarter 1 deadline, so has been extended to the end of quarter 2, aligned to the target risk score deadline update.
	Transformation and Financial Report to Board and Finance and Performance Committee.	2nd					Medical - recruitment assurance: confirm substantive and international medical recruitment plans against consultant and SAS vacancies; eliminate off-contract medical agency; enforce Medical Rate Card compliance. Interim position to May Board (28 May 2026); plan fully evidenced by 30 June 2026.	Henwood, Mr Mark	~~30/06/2026~~ 30/09/2026	Medical Rate Card implemented 1 March 2026 (estimated £380k annual cost increase; approved for fairness and governance). Recruitment assurance plan to be developed through April CEO Review cycle. Action not concluded by original quarter 1 deadline, so has been extended to the end of quarter 2, aligned to the target risk score deadline update.
	WG scrutiny through Monthly Monitoring Returns and NHS Exec Financial Planning and Delivery team.	3rd					Operational oversight and control will be consistently embedded following the review and implementation of Phase 2 of the Operational Organisations Change Process (OCP), providing clear, timely and specific escalation interventions for all Clinical Care Groups that are not delivering their targeted financial savings.	Carruthers, Andrew	~~30/06/2026~~ 31/12/2026	The OCP2 task and finish group was formed in Apr26, with expertise from finance, workforce & od, and communications & engagement, chaired by the Deputy COO and meets weekly to review progress across the CCGs, monitor and mitigate emerging risks, and ensure that proposals are being developed in line with the All-Wales OCP. A paper was presented to PODCC in May 2026 providing a progress update and next steps. OCP2 documentation was approved by FET in Jul26 to commence the consultation process, closing 20Jul26, with implementation expected by Dec26.
	Audit Wales Structured Assessment process.	3rd								

Date Risk Identified:	Apr-26		
Strategic Objective:	3. Great Care and 4. Positive Futures		

Executive Director Owner:	Carruthers, Andrew	**Date of Review:**	Jun-26
Lead Committee:	Finance and Performance Committee	**Date of Next Review:**	Aug-26

Risk ID:	**2380**	**Corporate Risk Description:**	There is a risk of the Health Board not being able to maintain the current level of Single Cancer Pathway (SCP) performance between 64-66% (2025/26) as per the Board approved Annual Plan 2026/27, and make further improvement towards the national 75% standard in 2026/27. This is caused by gaps in capacity to meet the expected demand for diagnostics (within radiology, cellular pathology and endoscopy), uncertainty over continuation of Welsh Government non recurrent funding, treatment delays internally due to theatre fragility and at our tertiary centres, compounded by fragility within key tumour sites (urology, lower GI, skin). This could lead to an impact/affect on increased number of patients waiting in excess of 62 days and meeting patient expectations in regard to timely access for appropriate treatment which could potentially lead to poorer outcomes and patient experience, adverse publicity/reduction in stakeholder confidence, and increased scrutiny/escalation from Welsh Government. This could lead to adverse reputational damage as a result of inconsistent performance delivery over time.
Does this risk link to any Directorate (operational) risks?		1223, 114, 111, 1537, 1699, 1722, 1723, 797	

Risk Rating:(Likelihood x Impact)		**No trend information available.**
Domain:	Quality/Complaints/Audit	
Inherent Risk Score (L x I):	5×4=20	
Current Risk Score (L x I):	3×4=12	
Target Risk Score (L x I):	2×4=8	
Expected Date To Achieve TRS:	3/31/2027	
Trend:	*New risk*	

Rationale for CURRENT Risk Score:

The service has been de-escalated by Welsh Government from Level 4 to Level 1 in terms of Targeted Intervention status as there has been the consistent achievement of the 60% de-escalation criteria since February 2025. As at March 2026 performance was at 60%.

Due to recovery actions within radiology and urology we may see variation in performance as we recover and treat those patients over 62 days.

Confirmation of target for March 2027 is 75%, however no health board is achieving this target. Plans are in place for Q1 to maintain performance at the planned trajectory set out in the Annual Plan 2026/27.

Rationale for TARGET Risk Score:

The aim is to treat patients within target waiting times, which has now been confirmed as 64-66% as per Annual Plan 2026/27.

The target risk score will be met if plans to maintain diagnostic capacity, utilising internal allocated funding, are realised. The risk score can be further reduced to a 8 once the target of 66% is achieved and maintained for 3 consecutive months. There are underpinning trajectories in place which are monitored on a monthly basis and adherence to those will influence the ability to achieve the target risk score.

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	Gaps in CONTROLS			
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
Sustainable pathway change with the lower GI pathway (FIT Fecal Immmochemical test, NICE NG12) from primary to secondary care commenced Nov25 resulting in 75% reduction in new outpatient demand, 45% reduction in radiology demand and improvement of straight to test compliance in Q1. Accelerated imaging from Endoscopy to CT within the GI pathway now in place across all sites, reduction time on patient pathway by 23 days Established cancer tracking team in place to allow patients to be proactively tracked through their pathways. A cancer dashboard developed by Informatics with the support of Business Intelligence (BI) SCP funding from the Wales Cancer Network for Cancer Services staff and Service Managers, allowing MDTs to actively monitor tumour site specific patients on a SCP. The health board are using of Quarterly Planning and Monitoring reports developed by the NHS Performance & Improvement. This has facilitates the development of targeted improvement plans per tumour site and subsequent weekly monitoring thus providing assurance of the robustness of plans. Virtual appointments are being undertaken via digital solutions e.g. Attend Anywhere.	Anticipated significant gaps/service fragility within key diagnostic services to address required levels of activity to support SCP Uncertainty on WG recovery funding for 2026/27 Lack of resilience within theatre estate (no decant theatre to manage future fire & estate works) Capacity at tertiary centres causes delays in surgical pathway resulting in patients exceeding 62 days Limited patient tracking resource available for all tumour sites 480 patients (34% of which will be a confirmed cancer and awaiting treatment) waiting in excess of 62 days for either diagnostic or treatment	Agree additional diagnostic capacity for Q2 taking into account the absence of WG recovery allocation.	Humphrey, Lisa	30/06/2026	Progress to be provided at next risk review
		Undertake a full gap analysis between assessed workload and funded establishment within the anaesthetic workforce to stabilise services, reduce risk, and mitigate ongoing variable pay expenditure	Humphrey, Lisa	31/05/2026	Progress to be provided at next risk review
		Producing a full recruitment plan for theatre workforce in line with Nurse Staffing Act and allocation of new investment of £1.4m for 2026/27	Humphrey, Lisa	30/06/2026	Progress to be provided at next risk review

Weekly Cancer Operational Delivery Group (ODG) meetings where services managers are in attendance. The function of this group is to monitor and address service demand, capacity and risk issues. Trajectory performance plans have been developed for each tumour site by the relevant services, with regards to improving performance. This also includes Backlog Trajectory plans on how these improvements will be achieved. Robust Urology diagnostic recovery plan to eliminate patients waiting more than 28 days in place, with committed resource allocation from recovery money in Q1 2026/27. Pilot of Galeas bladder urine test to early diagnosis, surveillance and recurrence monitoring risk stratification in haematuria pathways, and reduce unnecessary cystoscopies, improving patient experience and freeing diagnostic and endoscopy capacity. Monitoring of Urology diagnostic improvement trajectory via Cancer Operational Delivery Group. Agreement to continue outsourcing MRIs for patients on prostate pathway within urology. Cancer Pathway Review to be discussed at the MDT Business meetings and plans put in place to address and improve any bottlenecks or issues. Pathway reviews will also be a standing agenda item on the Planned Care and Cancer Services QSH meeting to ensure governance in line with the new operational structures implemented in April 2025. Process in place to improve component wait times and reduce patients waiting more than 14 day for first Outpatient Appointments (OPA) and 28 days for Diagnostics. One to one escalation meetings held with Cancer ODG leads and Tumour Site Service Managers for tumour sites that require intervention.			

Explore outsourcing for prostatectomies	Humphrey, Lisa	30/06/2026	Progress to be provided at next risk review
Explore reallocation of funding within the Planned Care and Cancer cost centres to increase patient tracking capacity	Humphrey, Lisa	30/06/2026	Progress to be provided at next risk review

Pathway changes in Head and Neck to include Laryngeal Biopsy at first OPA, reducing reliance on pan-endoscopy One stop hysteroscopy in gynaecology across all sites. Health Board wide internal escalation framework now in place to support the monitoring of performance targets. Additional radiology scanning capacity in place for Q1 2026/27. New Endoscopy booking process which tracks all patients referred for an endoscopy on a USC priority. If capacity is identified as a trending breach reason, the Service Management team supports targeted intervention to address these concerns in order to reduce time on patient pathways. Allocation of recovery funding for Q1 for pathology turnaround plan.		Undertake weekly oversight of backlog trajectory plan in place for all tumour sites for Q1 to reduce 180 by March 2027	Humphrey, Lisa	31/03/2027	Progress to be provided at next risk review

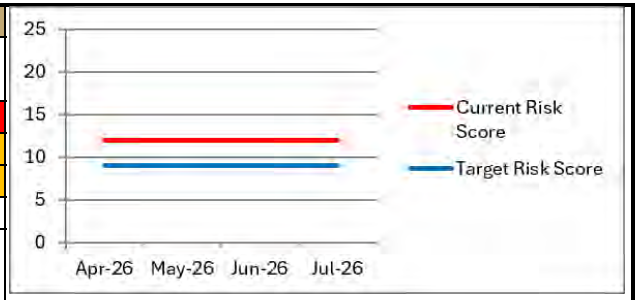
ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps	By Who	By When	Progress
Internal targets - Looking at the performance per tumour site individually that have the biggest impact on overall performance Skin Urology LGI Gynaecology Breast Reducing component waits Patient waiting more than 14 days for first OPA Patients waiting a diagnostic procedure and report more than 28 days Patients with a confirmed diagnosis of cancer waiting more than 62 days	Daily/weekly/monthly/ monitoring arrangements by management	1st			Annual Plan 2026/27 sets out Cancer trajectories for 2026/27 - Board (Mar27)	Currently there is no Cancer Oversight Group (Board) in the Health Board	Establish a HDdUHB Cancer Oversight Group to provide strategic oversight and planning	Goode, Paula	30/06/2026	Progress to be provided at next risk review
	IPAR Performance Report to FPC & Board	2nd					Establish an Internal Clinical Care Group Oversight Rereferral to Treatment and Cancer Group	Goode, Paula	30/06/2026	Progress to be provided at next risk review
	Monthly oversight by NHS Performance & Improvement/WG	3rd								
	Monthly operational oversight via the CCG Integrated Governance Group	1st								

Date Risk Identified:	Apr-26		
Strategic Objective:	2. Healthier Communities and 3. Great Care		

Executive Director Owner:	Carruthers, Andrew	**Date of Review:**	Jun-26
Lead Committee:	Finance and Performance Committee	**Date of Next Review:**	Aug-26

Risk ID:	**2327**	**Corporate Risk Description:**	There is a risk that the Health Board will be unable to fully deliver planned care and RTT recovery trajectories for 2026/27, including sustained improvement in key diagnostic specialties and planned care waiting times, as set out in the Health Board's Annual Plan 2026/27. This is caused by a structural mismatch between demand and capacity that remains after all credible productivity, absence of recovery funding, efficiency, and enabling actions have been exhausted, alongside specific service pressures such as theatre estate disruption at Glangwili, general theatre estate fragility across remain sites and absence of decant theatre, and reliance on nonâ€'recurrent diagnostic stabilisation funding. This could lead to an impact/affect on the Health Board's ability to meet national RTT and diagnostic performance requirements, increased waiting times (including 26-for first outpatient appointment and no patient waiting over 2 years for treatment (104â€'week backlogs), reduced resilience in planned and cancer care pathways, potential reâ€'escalation of national performance interventions, and associated adverse impacts on patient experience, clinical outcomes, and organisational reputation.
Does this risk link to any Directorate (operational) risks?			

Risk Rating:(Likelihood x Impact)	
Domain:	Quality/Complaints/Audit
Inherent Risk Score (L x I):	5×4=20
Current Risk Score (L x I):	3×4=12
Target Risk Score (L x I):	3×3=9
Expected Date To Achieve TRS:	3/31/2027
Trend:	⟷



Rationale for CURRENT Risk Score:

The Health Board faces delivery risks in achieving ministerial planned care recovery targets by March 2027 due to combined pressures of cohort demand in key specialties and workforce limitations. Theatre cancellations at Glangwili General Hospital have further reduced core capacity, particularly impacting Orthopaedics, where additional demand from long-waiting patients persists. While delivery plans demonstrate progress in outpatient activity, treatment capacity, and workforce improvements, gaps remain, and performance against planned care milestones continues to underpin the Health Board's Targeted Intervention status. Estates issues are impacting theatre list cancellations. Regional collaboration with Swansea Bay UHB is being actively pursued to expand capacity in Ophthalmology and Orthopaedics, including the use of Neath Port Talbot theatres. In the absence of recovery funding, 104-week breaches are predicted in Orthopaedics, Urology, T&O, ENT, Ophthalmology and Dermatology. The current risk score is assessed at 12, lower than the inherent risk score, as the Board have accepted the trajectories set out in the Annual Plan.

Rationale for TARGET Risk Score:

The target score of 9 reflects the continuing delivery ambitions which remain, despite the workforce and resource limitations reflected in the Annual Plan. Of note, positive progress achieved both in respect of effective demand management and transformation of outpatient pathways has ensured that overall waiting list demand has not grown with waiting list volumes at their lowest level for 2 years.

Opportunities to make further progress towards the Ministerial targets in 2026/27 will continue to be explored, including exploration of the regional opportunities referred to.

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	Gaps in CONTROLS				
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
# Comprehensive daily management systems in place to manage planned care risks on daily basis including multiple daily multi-site calls in times of escalation. # Prioritised review of patients based on an agreed risk stratification model. # Provision of dedicated elective beds on 3 sites. # The staffing position continues to be monitored on a daily basis in accordance with safe staffing principles. # Delivery plans in place supported by daily, weekly and monthly monitoring arrangements. # Quarterly deep dive reviews of all specialty delivery plans and delivery assumptions to ensure full account of OP transformation and theatre productivity and efficiency opportunities # Escalation plans for acute and community hospitals (within limits of staffing availability). # Outpatient transformation programme in place with a continuing focus on alternatives to face to face delivery of outpatient care to enable increases in care volumes delivered. # Robust sickness absence management arrangements in place. # Quarterly review of job plans, with ongoing recruitment. # Elective care delivery plan developed for inclusion within Annual Delivery Plan. # Elective optimisation improvement programme in place to improve theatre activity productivity and efficiency, including improvements to waiting list scheduling and pre-operative assessment processes # Productive & Effective Elective Care Improvement Plan produced to drive productivity and efficiency improvements # Planned Care Delivery Workstream established, reporting to Integrated Quality, Financial Performance Delivery (IQFPD) fortnightly, as part of revised Targeted Intervention governance arrangements. # South West Wales Regional Orthopaedic Delivery Programme established # South West Wales Regional Ophthalmology Programme # Assurance monitoring arrangements in place via mechanisms including	# Additional Planned Care Recovery proposals developed however no recovery allocation planned in 2026/27 to date (this includes inability to fund insourcing and outsourcing activity in ophthalmology and dermatology) # Lack of resilience within theatre estate (no decant theatre to manage future fire & estate works) # Workforce staffing availability to support further expansion of theatre capacity # Sustainability challenges remain in a number of specialty areas which have been targeted for in-depth review via regional planning programmes for key specialties and the Clinical Services Plan review # Sufficiency of Anaesthetic medical staffing capacity to support existing capacity and further expansion of required operating lists # Widespread adoption of national best practice guidance to improve elective optimisation and utilisation of available operating capacity # Deficiencies within pre-operative	Agreed continuation of ophthalmology outsourcing for Q1, utilising ophthalmology and dermatology underspend with core budget	Humphrey, Lisa	Completed	Q1 activity paused for month of June and beyond in the absence of recovery allocation
		Progress proposal for recruitment of fixed term locum to utilise NPT theatres to mitigate loss of activity as a result of theatre estate issues at block 32 at GGH (c.150 cases)	Humphrey, Lisa	Completed	This program was rejected
		Increase capacity to four primary joints on 90% of Orthopaedic lists (Enabling Actions)	Gregory, Lianne	31/03/2027	In progress
		Producing a full recruitment plan for theatre workforce in line with Nurse Staffing Act and allocation of new investment of £1.4m for 2026/27	Walsby, Alexandra	19/08/2026	In progress
		Complete optimisation framework assessment to address WG 3 top priorities which are referral management, waiting list validation across stages and conversation of follow up activity to new outpatient capacity	Humphrey, Lisa	Completed	Optimisation frameworks complete and submitted
		Develop trajectories of improvement per specialty based on the optimisation framework assessment to identify productivity and efficiency gains	Humphrey, Lisa	Completed	New Trajectories have been produced that improved the board approved position from 5,500 to 3,800
		Develop a model of standardised assessment for the pre-assessment process to streamline pre-assessment and eliminate bottlenecks	Carmody, Sarah	30/09/2026	In progress.

weekly RTT Optimisation Group # Working with Johnson and Johnson to review and develop a model of standardised assessment for the Pre-assessment process # Insourced capacity to support theatre staffing workforce deficits at GGH	assessment process and overall capacity to support required volume of Pre-Operative Assessment Clinic (POAC) assessments # Cessation of PAAR in delivery of waiting list initiatives	Develop mitigation plans for areas that are reliant on PAAR (neurology, outpatients)	Humphrey, Lisa	Completed	Monitoring impact of PAAR cessation during Apr26. Ongoing communication with A4C staff has improved the uptake of agreed additional activity in Q1.
		Continuation of insourcing at GGH theatres utilising £1.6m until established staffing is sustainable	Humphrey, Lisa	31/03/2027	In progress
		To produce outline of aspiration aligned to GIRFT Report with associated timescales with the GIRFT Theatres Implementation Group, chaired by Medical Director, established to produce plan on a page that assesses current position, utilisation, staffing, effectiveness, patient outcomes, quality & safety, and estates.	Humphrey, Lisa	31/03/2027	In progress. Monthly reporting required to Formal Executive Team.
		To undertaken a full gap analysis between assessed workload and funded establishment within the anaesthetic workforce to stabilise services, reduce risk, and mitigate ongoing variable pay expenditure	Humphrey, Lisa	19/08/2026	In progress. No being progressed by Craig Tout Interim GM for Theatres, Aneasthetics and Critical Care

ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level		
	Activity volumes are reported daily on situation reports	1st			
	Daily performance data overseen by service management	1st			
	Delivery Plans overseen by Planned Care Clinical Care Group Integrated Governance Group	1st			

Gaps in ASSURANCES				
Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed Further action necessary to address the gaps	By Who	By When	Progress

	IQFPD	2nd							
	Executive Recovery / Improving Together Sessions	2nd							
	Bi-monthly reports to SPC on progress on delivery plans and outcomes (and to Board via update report)	2nd							
	IPAR Performance Report to SPC & Board	2nd							
	Welsh government Scrutiny via NHS Performance and Improvement	3rd							

Report Issued By	Report Title	Priority Level	Recommendation	Management Response	Recommendation Owner	Original Completion Date	Revised Completion Date	Status Category
Peer Review	Getting It Right First Time (GIRFT) Ophthalmology Review	N/A	R12. Introduce standardised risk (in line with College guidance) and priority ratings for cataract surgery and change waiting list forms to support this	1) Review current waiting list forms and agree clear priority ratings. 2) Develop protocol to align with waiting list forms with clear priority ratings. 3) Implement new waiting list forms.	Nadia Randazzo/ Amorelle Jones	Oct-25	~~Oct-25~~ ~~Jun-26~~ N/K	Overdue
Peer Review	Getting It Right First Time (GIRFT) Ophthalmology Review	N/A	R15. Introduce high flow principles and processes to cataract lists and patients of ANY complexity to drive higher numbers of cases in all lists. Send for patient early enough to ensure they are ready in the anaesthetic room to enter theatre once the last case finished.	1) Review BGH and GGH suitability for high flow lists 2) If environment is not deemed suitable review process for current delivery of complex patients. 3) Review patient pathway and reduce delays with patient arriving in theatre.	Nadia Randazzo/Marta Barreiro Martins	Mar-26	~~Mar-26~~ N/K	Overdue
Peer Review	Getting It Right First Time (GIRFT) Ophthalmology Review	N/A	R17. Non-medical MDT staff admitting the cataract patients should be trained and empowered to mark the eye, check or take consent etc – consider whether to involve the clinical nurse and optometrist practitioners and/or train the day surgery staff. Do not do routine obs on the day.	1) Review staff training to mark the eye with Senior Nurse Manager. 2) Review process for baseline obs	Amorelle Jones/ Marta Barreiro Martins	Apr-24	~~Apr-24~~ ~~Jul-24~~ ~~Dec-24~~ ~~Jul-25~~ N/K	Overdue
Peer Review	Getting It Right First Time (GIRFT) Ophthalmology Review	N/A	R21. Do not have patients climbing on and off a trolley in the operating room - position patients in the anaesthetic room and wheel the patient in and out on trolley or couch.	1) Check if theatre trolleys are fixed in theatres or if surgical trolleys can be wheeled in AVH- BGH- GGH-	Marta Barreiro Martins	Mar-26	~~Mar-26~~ N/K	Overdue
Peer Review	Getting It Right First Time (GIRFT) Ophthalmology Review	N/A	R24. Rationalise cataract surgery to only units that are, or can be changed to be, suitable for high flow. Move other work out of the most suitable units to accommodate this.	1) Move IVT out of AVH OPD back to Pembrokeshire. 2) Move IVT service out of day theatre into AVH OPD. 3) Increase cataract delivery through AVH theatre.	Amorelle Jones/ Marta Barreiro Martins	Mar-26	~~Mar-26~~ N/K	Overdue
Peer Review	Getting It Right First Time (GIRFT) Ophthalmology Review	N/A	R35. Establish staggered patient arrival times to reduce the patient journey time. Explore how discharge process can be shorter.	1) Align staggered arrival times in line with consent in pre-assessment (outlined above). 2) Review of current discharge processes across site and standardise documentation and processes.	Marta Barreiro Martins	Apr-24	~~Dec-24~~ ~~Jul-25~~ Sep-26	Overdue
Peer Review	Getting It Right First Time (GIRFT) Ophthalmology Review	N/A	R46. Review the footprint and usage of all the outpatient areas and create ophthalmology and subspecialist areas with teams and all equipment in one or two area/sites for glaucoma.	1) Review current structure and delivery. 2) Plan new structure and delivery. 3) Commence new structure and delivery. This action may be restricted by cost to implement.	Amorelle Jones/ Marta Barreiro Martins	Mar-26	~~Mar-26~~ N/K	Overdue
Peer Review	Getting It Right First Time (GIRFT) Ophthalmology Review	N/A	R47. Work with the health board and the regional team to find a better outpatient solution, fit for modern ophthalmic care and the longer-term rising population demand which can support training the MDT. Consider all options for the regional collaboration with other relevant health boards.	1) Review where SAS doctors currently support Consultant clinics to identify training opportunities. 2) Develop SAS doctors and non medical staff in line with training needs and liaise with SBUHB for support with development.	Amorelle Jones/ Marta Barreiro Martins	Mar-26	~~Mar-26~~ N/K	Overdue
Audit Wales	Tackling the Planned Care Challenges – Hywel Dda University Health Board	N/A	R1. The Health Board should ensure that updated strategies and plans (A Healthier Mid and West Wales Strategy and the clinical services plan) sufficiently set out a route map to sustainable planned care services. The plan should be costed, with realistic but challenging milestones within it	The Clinical Services Plan programme was established to develop a set of plans for the provision of key services over the medium term. Currently in Phase 3 – Public Consultation. Public consultation will enable the Board to make a formal decision on the nine services in scope, which include Dermatology, Ophthalmology, Urology, Endoscopy, Orthopaedics, and Emergency General Surgery within the Planned Care domain, as well as the potential roles of the hospitals until the full implementation of the 'A Healthier Mid and West Wales' strategy. The results of this consultation and subsequent decisions are planned to be made in Winter 2025. It is therefore anticipated that the adoption of significant actions in relation to implementation plans will commence following this gateway to Phase 4 - Implementation. Anticipated completion date for CSP Phase 3 Board decision: Winter 2025 NLT JAN2026 The refresh of the A Healthier Mid and West Wales has just begun, with initial work to scope what elements need to be revised and where additional matters may need to be included. It is envisioned that a refreshed strategy will be informed by the Clinical Services Plan, as well as set out the scope for any future service transformation that may be required for the future, as the strategy will be refreshed to consider up to 2040 (the existing strategy considered up to 2038). The expectation is that the Discovery phase of the strategy refresh will be concluded by January 2026, with the intention to inform the 1st year of the 3-year plan for 2026/2027, as well as initiate the development of strategic delivery plans (where not already in place) to shape planningprocesses.	Lee Davies	Mar-26	~~Mar-26~~ N/K	Overdue

Report Issued By	Report Title	Priority Level	Recommendation	Management Response	Recommendation Owner	Original Completion Date	Revised Completion Date	Status Category
Audit Wales	Tackling the Planned Care Challenges – Hywel Dda University Health Board	N/A	R5. The Health Board should ensure timely completion of recommendations arising from the Getting It Right First-Time reports	GIRFT recommendations are put onto the AMAT system (Audit Management & Tracking) where recommendations, timescales and completion dates are tracked to ensure timely completion. AMAT progress is scrutinised via the HB performance management arrangements and escalation process, with assurance on progress provided via the Board governance process. Overdue actions are scrutinised by ARAC • Urology GIRFT - there are currently 0 overdue recommendations, 6 on track, 16 complete, 4 partially complete and 3 'external' (outside the gift of the HB currently). • General Surgery GIRFT - there are currently 0 overdue & 21 complete. • Ophthalmology GIRFT – 16 actions are linked to CSP, additional funding or regionalisation, 4 are on track and 39 complete	Paula Goode	Mar-26	~~Mar-26~~ N/K	Overdue
Ministerial Advisory Group (MAG)	Ministerial Advisory Group (MAG) Observations following the site visits of health boards – Hywel Dda UHB - Planned and Specialist Care (January 2025)	N/A	R21. Cataracts per lists to rise to 8 urgently will increase productivity by 100%-125%.	Review theatre efficiencies in GGH/BGH to see where there is a possibility to increase theatre delivery further.	Amorelle Jones	Mar-26	~~Mar-26~~ N/K	Overdue
Ministerial Advisory Group (MAG)	Ministerial Advisory Group (MAG) - Observations following the site visits of health boards – Hywel Dda UHB- Urgent and Emergency Care (January 2025).	N/A	R5. Frailty is challenging. ED staff were not aware of the frailty pathway, despite being award winning. Specific focus on delayed pathways of care in the frailty ward should be prioritised, and improved links between the FAU and the ED to reduce the significant corridor care in the ED.	Undertake a review of the acute and community frailty pathway to join the pathways across the system, with a POCS deep dive on Cadog and Dewi wards (long stay frailty)	Iona Evans	Aug-25	~~Aug-25~~ ~~Feb-26~~ Oct-26	Overdue
Ministerial Advisory Group (MAG)	Ministerial Advisory Group (MAG) - Observations following the site visits of health boards – Hywel Dda UHB- Urgent and Emergency Care (January 2025).	N/A	R5. Frailty is challenging. ED staff were not aware of the frailty pathway, despite being award winning. Specific focus on delayed pathways of care in the frailty ward should be prioritised, and improved links between the FAU and the ED to reduce the significant corridor care in the ED.	Undertake review of Frailty SOP to review current length of stay challenges, pathway of care delays, and to determine immediate actions to improve on pathway review communication	Louisa Standeven	Aug-25	~~Aug-25~~ ~~Feb-26~~ Oct-26	Overdue
Ministerial Advisory Group (MAG)	Ministerial Advisory Group (MAG) - Observations following the site visits of health boards – Hywel Dda UHB- Urgent and Emergency Care (January 2025).	N/A	R6. Executive presence in the ED was reported as low, a survey of staff could be done to gauge if this is consistently felt among staff, and if so look to increase presence of exec team.	Weekly ED big room meetings are in place, chaired by the Executive Director of Nursing. A Glangwili ED staff survey has been undertaken in May 2025, with a review of outcomes to be undertaken and an action plan developed as appropriate. Outcomes will be fed-back to the Clinical Care Group. An additional staff survey is to be scoped and approved.	Louisa Standeven	Jul-25	~~Jul-25~~ Jul-26	Overdue
Ministerial Advisory Group (MAG)	Ministerial Advisory Group (MAG) Observations following the site visits of health boards – Hywel Dda UHB - Planned and Specialist Care (January 2025)	N/A	R1. Ensure maximum productivity at surgical hubs at Amman Valley (ophthalmology) and Prince Phillip (orthopaedics).	Orthopaedics: Wider work is required to undertake a review of theatre workforce models in order to improve theatre efficiencies. Key enablers of this work being theatre staffing and anaesthetics.	Lianne Gregory	Dec-25	~~Dec-25~~ N/K	Overdue
Ministerial Advisory Group (MAG)	Ministerial Advisory Group (MAG) Observations following the site visits of health boards – Hywel Dda UHB - Planned and Specialist Care (January 2025)	N/A	R1. Ensure maximum productivity at surgical hubs at Amman Valley (ophthalmology) and Prince Phillip (orthopaedics).	Orthopaedics: Implement plans for robust 24/7 medical cover for Orthopaedics in PPH	Lianne Gregory	Dec-25	~~Dec-25~~ N/K	Overdue
Ministerial Advisory Group (MAG)	Ministerial Advisory Group (MAG) Observations following the site visits of health boards – Hywel Dda UHB - Planned and Specialist Care (January 2025)	N/A	R2. Maximise Day Case surgery at Withybush supporting Swansea Bay UHB by undertaking in benign upper GI surgery e.g. cholecystectomy, hernia repair etc.	There is capacity in the current theatre template for ambulatory surgery and theatre staff available which is serviced by GA anaesthetics but a full review of HB job plans would be required .Executive team approval to recruit urgently two replacement Consultant appointments of upper GI post that will join the WGH on call rota and undertake their elective surgery at WGH and clinics at GGH	Caroline Lewis	Dec-25	~~Dec-25~~ N/K	Overdue
Ministerial Advisory Group (MAG)	Ministerial Advisory Group (MAG) Observations following the site visits of health boards – Hywel Dda UHB - Planned and Specialist Care (January 2025)	N/A	R3. Ensure day case and IP activity is maximised at Bronglais.	With funding, open and expand further theatre sessions (as noted in Bronglais Strategy and IMTP submission of Nov21). Would need to fully re-scope anaesthetics and theatre staff profile. Would need to scope specialty expansion and procedure baskets	Diane Knight	Oct-25	~~Oct-25~~ N/K	Overdue
Ministerial Advisory Group (MAG)	Ministerial Advisory Group (MAG) Observations following the site visits of health boards – Hywel Dda UHB - Planned and Specialist Care (January 2025)	N/A	R4. Increase productivity by 30% for HVLC cataracts at Glangwili and Amman Valley.	Pilot started in AVH for 8 cataracts per list to roll out to all 3 lists in AVH if successful.	Amorelle Jones	Mar-26	~~Mar-26~~ Sep-26	Overdue
Ministerial Advisory Group (MAG)	Ministerial Advisory Group (MAG) Observations following the site visits of health boards – Hywel Dda UHB - Planned and Specialist Care (January 2025)	N/A	R4. Increase productivity by 30% for HVLC cataracts at Glangwili and Amman Valley.	Review theatre efficiencies in GGH/BGH to see where there is a possibility to increase theatre delivery further.	Amorelle Jones	Mar-26	~~Mar-26~~ Dec-26	Overdue
Ministerial Advisory Group (MAG)	Ministerial Advisory Group (MAG) Observations following the site visits of health boards – Hywel Dda UHB - Planned and Specialist Care (January 2025)	N/A	R6. Increase Intra-vitreal injections to 15 per list and undertaken in procedure rooms	Continue to onboard for 1.3 WTE posts	Amorelle Jones	Mar-26	~~Mar-26~~ N/K	Overdue

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Ministerial Advisory Group (MAG)	Ministerial Advisory Group (MAG) Observations following the site visits of health boards – Hywel Dda UHB - Planned and Specialist Care (January 2025)	N/A	R6. Increase Intra-vitreal injections to 15 per list and undertaken in procedure rooms	Advertise band 7 post when JD has been approved.	Amorelle Jones	Mar-26	~~Mar-26~~ N/K	Overdue
Ministerial Advisory Group (MAG)	Ministerial Advisory Group (MAG) Observations following the site visits of health boards – Hywel Dda UHB - Planned and Specialist Care (January 2025)	N/A	R7. Run Prince Phillip as cold elective orthopaedic hub with ring fenced beds	With funding, open and expand further main theatre sessions. Would need to fully re-scope anaesthetics and theatre staff profile. Would need to scope specialty expansion and procedure baskets. Orthopaedics: Ensure all PPH funded DSU theatre sessions are operational to allow increased scope for delivery of arthroplasty activity in main theatre. This will require filling theatre staffing and anaesthetic vacancies.	Diane Knight	Mar-26	~~Mar-26~~ N/K	Overdue
Ministerial Advisory Group (MAG)	Ministerial Advisory Group (MAG) Observations following the site visits of health boards – Hywel Dda UHB - Planned and Specialist Care (January 2025)	N/A	R8. Encourage cross health board working with orthopaedic surgeons from Swansea Bay HB invited into the hub.	Been implemented in Q3. Not required in Q4 Regional MDT's, close lines of communication and joint operating has been operationalised for Hand and Wrist, Shoulder and Elbow and Foot and Ankle. A regional MDT has also been established for sort tissue knee. Utilisation of PPH by Swansea Bay surgeons will depend on discussions that progress through Regional Programme Board. Utilisation of NPT by Hywel Dda surgeons is currently being explored.	Lianne Gregory	Dec-25	~~Dec-25~~ N/K	Overdue
Ministerial Advisory Group (MAG)	Ministerial Advisory Group (MAG) Observations following the site visits of health boards – Hywel Dda UHB - Planned and Specialist Care (January 2025)	N/A	R12. Improve cataract, orthopaedic and other day case activity to GIRFT and Royal College standards.	Ophthalmology: Pilot started in AVH for 8 cataracts per list to roll out to all 3 lists in AVH if successful.	Amorelle Jones	Mar-26	~~Mar-26~~ N/K	Overdue
Ministerial Advisory Group (MAG)	Ministerial Advisory Group (MAG) Observations following the site visits of health boards – Hywel Dda UHB - Planned and Specialist Care (January 2025)	N/A	R12. Improve cataract, orthopaedic and other day case activity to GIRFT and Royal College standards.	Orthopaedics: Work on list loading and efficiency improvements in line with GIRFT and Royal College standards is underway categorised by various procedure bundles.	Lianne Gregory	Mar-26	~~Mar-26~~ N/K	Overdue
Ministerial Advisory Group (MAG)	Ministerial Advisory Group (MAG) Observations following the site visits of health boards – Hywel Dda UHB - Planned and Specialist Care (January 2025)	N/A	R15. Use GIRFT documents to guide setting up, staffing and running hubs, agree nationally the number of cases per list for at GIRFT standards and support health boards to deliver	Increase volume of cases in Orthopaedics to 4 arthroplasty patients on an all day list. A standby patient has been added with the aim of achieving 4 arthroplasty patients per all day list. Some Consultants are already achieving 4 joints on an all day list whilst others will only achieve this with theatre enablers.	Diane Knight	Mar-26	~~Mar-26~~ N/K	Overdue
Ministerial Advisory Group (MAG)	Ministerial Advisory Group (MAG) Observations following the site visits of health boards – Hywel Dda UHB - Planned and Specialist Care (January 2025)	N/A	R16. Implement best practice in theatre productivity, capped theatre utilisation set at 85%, day case rates combined with RPRP (procedures undertaken outside theatre in procedure rooms) aspire to 85%.	Continue to work with Swansea Bay UHB to consolidate current practice and further scope opportunities via regional working	Diane Knight	Oct-25	~~Oct-25~~ N/K	Overdue
Ministerial Advisory Group (MAG)	Ministerial Advisory Group (MAG) Observations following the site visits of health boards – Hywel Dda UHB - Planned and Specialist Care (January 2025)	N/A	R20. Deliver specific improvements in operational productivity for ophthalmology	Pilot started in AVH for 8 cataracts per list to roll out to all 3 lists in AVH if successful.	Amorelle Jones	Mar-26	~~Mar-26~~ N/K	Overdue
Ministerial Advisory Group (MAG)	Ministerial Advisory Group (MAG) Observations following the site visits of health boards – Hywel Dda UHB - Planned and Specialist Care (January 2025)	N/A	R20. Deliver specific improvements in operational productivity for ophthalmology	Review theatre efficiencies in GGH/BGH to see where there is a possibility to increase theatre delivery further	Amorelle Jones	Mar-26	~~Mar-26~~ Oct-26	Overdue
Ministerial Advisory Group (MAG)	Ministerial Advisory Group (MAG) Observations following the site visits of health boards – Hywel Dda UHB - Planned and Specialist Care (January 2025)	N/A	R21. Cataracts per lists to rise to 8 urgently will increase productivity by 100%-125%.	Started a pilot in AVH for 8 cataracts per list to roll out to all 3 lists in AVH if successful.	Amorelle Jones	Mar-26	~~Mar-26~~ N/K	Overdue
Ministerial Advisory Group (MAG)	Ministerial Advisory Group (MAG) Observations following the site visits of health boards – Hywel Dda UHB - Planned and Specialist Care (January 2025)	N/A	R23. Procedure Rooms: Ensure intra-vitreal procedures are performed in a procedure room.	Identify in a Business Case the requirements needed to run cataracts through AVH theatre 5 days per week.	Amorelle Jones	Dec-25	~~Dec-25~~ Dec-26	Overdue
Ministerial Advisory Group (MAG)	Ministerial Advisory Group (MAG) Observations following the site visits of health boards – Hywel Dda UHB - Planned and Specialist Care (January 2025)	N/A	R29. Conduct an audit of FIT testing to assess its impact and integrate findings into health pathways for further optimisation.	Continue to explore collaborative working across primary and secondary care	Sara Jones / Caroline Lewis	Sep-25	~~Sep-25~~ N/K	Overdue

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Ministerial Advisory Group (MAG)	Ministerial Advisory Group (MAG) Observations following the site visits of health boards – Hywel Dda UHB - Planned and Specialist Care (January 2025)	N/A	R30. Systematically evaluate and implement alternative diagnostic methods such as capsule sponge and nasal endoscopy to reduce demand on conventional services	Cytosponge - To introduce a cytosponge service, dedicated workforce would need to be recruited and trained. The NHS executive have advised that funding may be available in 25/26 - the Health Board is due to meet with the NHS executive clinical lead for cytosponge in June 2025. A service specification document for the rollout of the service has already been developed at a national level and can be adopted within the Health Board. TNE - Explore options to allocate workforce already dedicated to Endoscopy - however, this could result in key Endoscopy staff being pulled from delivery of other service elements which could present a risk to service delivery plans.	Sara Jones	Jul-25	~~Jul-25~~ ~~Mar-26~~ N/K	Overdue
NHS Wales Executive	NHS Executive Report on Urgent and Emergency Care Opportunities: BGH site	N/A	R15. We recommend therefore that the final report for this mortality review is shared with us at the earliest opportunity with an update on any of the actions and recommendations from this.	There is a regional mortality review ongoing.	Karen Brown	Aug-25	~~Aug-25~~ N/K	Overdue
NHS Wales Executive	NHS Executive Report on Urgent and Emergency Care Opportunities: GGH site	N/A	R37. We recommend the HB considers sourcing a larger location for the discharge lounge acknowledging the added value this would bring to system flow.	37. Review Discharge Lounge use/data to determine efficiency and capacity constraints - determine esclation steps if full and no capacity. Discharge Lounge Task and Finish Group to establish more efficient ways of working.	Louisa Standeven	Jul-25	~~Jul-25~~ N/K	Overdue
NHS Wales Executive	NHS Executive Report on Urgent and Emergency Care Opportunities: GGH site	N/A	R38. Consider opening the DL earlier and allow patients being discharged to have their breakfast there prior to leaving the site.	38. Review Discharge Lounge use/data to determine efficiency and capacity constraints - determine esclation steps if full and no capacity. Review of opening times based on activity peaks.	Louisa Standeven	Jul-25	~~Jul-25~~ Oct-26	Overdue
NHS Wales Executive	NHS Executive Report on Urgent and Emergency Care Opportunities: GGH site	N/A	R39.Establish a 'pull' model for Discharge Lounge where staff from the unit actively visit wards to review patients with a definite discharge date the following day.	39. Review Discharge Lounge use/data to determine efficiency and capacity constraints - review of next day discharges (as part of MOD rota).	Louisa Standeven	Jul-25	~~Jul-25~~ Oct-26	Overdue
NHS Wales Executive	NHS Executive Report on Urgent and Emergency Care Opportunities: GGH site	N/A	R40. Ensure all discharge paperwork is completed the day prior to discharge	40. Review Discharge documentation compliance as well as review of DAL completion and sign off. Link in with pharmcy to scope this.	Louisa Standeven	Jul-25	~~Jul-25~~ Oct-26	Overdue
NHS Wales Executive	NHS Executive Report on Urgent and Emergency Care Opportunities: GGH site	N/A	R41. Ensure all patients are spoken to and they are aware of the planned move.	41. review of Discharge Lounge Patient Leaflet	Louisa Standeven	Jul-25	~~Jul-25~~ Oct-26	Overdue
NHS Wales Executive	NHS Executive Report on Urgent and Emergency Care Opportunities: GGH site	N/A	R42. Communicate on ward boards and patient notes clearly that a patient is being transferred to DL early the next day	42. Review of Discharge Documentation and ward use of Discharge Lounge.	Louisa Standeven	Jul-25	~~Jul-25~~ Oct-26	Overdue
NHS Wales Executive	NHS Executive Report on Urgent and Emergency Care Opportunities: GGH site	N/A	R44. Consider supporting additional portering/ HCSW resource to transfer suitable patients, removing the onus from ward staff.	44a. Review of portering capacity to maximise flow.	Louisa Standeven	Jul-25	~~Jul-25~~ Oct-26	Overdue
NHS Wales Executive	NHS Executive Report on Urgent and Emergency Care Opportunities: GGH site	N/A	R44. Consider supporting additional portering/ HCSW resource to transfer suitable patients, removing the onus from ward staff.	44b. Review of Synbiotix data relating to delays in transfer to Discharge Lounge.	Louisa Standeven	Jul-25	~~Jul-25~~ Oct-26	Overdue
NHS Wales Executive	NHS Executive Report on Urgent and Emergency Care Opportunities: GGH site	N/A	R45. If DL is filled to capacity by 8am, this will release some immediate pre ward round capacity into the site each day, this should be achieveable for a 400 bed site.	45. Review Discharge Lounge use/data to determine efficiency and capacity constraints	Louisa Standeven	Jul-25	~~Jul-25~~ Oct-26	Overdue
NHS Wales Executive	NHS Executive Report on Urgent and Emergency Care Opportunities: PPH site	N/A	R6. It is recommended that when there have been 48-hour breaches in AMAU a short investigation is undertaken in collaboration between the AMAU and specialty involved i.e. Respiratory, to review the patient journey as a timeline. This will inform future learning for all departments involved to take forward and share with their teams, again fostering a whole system approach to patient flow.	Action accepted and completed by service	Catrin Rooney (Hywel Dda UHB- Senior Nurse Manager	Aug-25	~~Aug-25~~ N/K	Overdue
NHS Wales Executive	NHS Executive Report on Urgent and Emergency Care Opportunities: PPH site	N/A	R15. When a medical specialty is unable to accept a 'new' patient from AMAU, there should be an escalation to a senior clinical decision maker to review the entire caseload and make a risk-based decision on how to balance the available inpatient capacity against the current level of demand.	Action accepted and completed by service	Robin Ghosal	Aug-25	~~Aug-25~~ N/K	Overdue

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NHS Wales Executive	NHS Executive Report on Urgent and Emergency Care Opportunities: PPH site	N/A	R16. We recommend that a senior clinical decision maker is present at each board round and places an emphasis on exploring alternative options to deliver the clinical care required for each patient outside of a hospital wardthrough a 'deep dive' approach. We have seen evidence of the proactive approach that the Health Board has in utilising the skills of community based clinical services e.g. District Nursing, ACT/CRT and the Carmarthenshire Intermediate Care Team, we feel that these resources could offer additional options to provide an adequate level of care to some patients who would benefit from an earlier discharge home. • Whilst this describes a risk-based approach to clinical decision making, we are cognisant that this would require careful planning and a clear governance structure in order to be successful, this approach is promoted under the 'right patient, right place' ethos that NHS Wales is advocating. • This approach could be embedded with patients at the point of admission by actively starting the discharge planning process and clinical teams identifying the earliest opportunity to facilitate a safe discharge out of hospital utilising a criteria led discharge approach	Awaiting full management response from service to be added to AMaT	Robin Ghosal	Jul-25	~~Jul-25~~ N/K	Overdue
NHS Wales Executive	NHS Executive Report on Urgent and Emergency Care Opportunities: PPH site	N/A	R17. Every clinical specialty should have a cohort of patients who are suitable for criteria led discharge to aid decision making and ensure inpatient capacity is only used for patients who have no other clinically viable option to receive care.	Awaiting full management response from service to be added to AMaT	Robin Ghosal	Jul-25	~~Jul-25~~ N/K	Overdue
NHS Wales Executive	NHS Executive Report on Urgent and Emergency Care Opportunities: PPH site	N/A	R18. It is recommended that the senior leaders within the organisation endorse the implementation of the framework (board rounds) and promote a culture shift within the hospital that sees some current practices and ways of working challenged. Support from senior teams including medical director and chief operating officer is paramount for this to succeed	Awaiting full management response from service to be added to AMaT	Robin Ghosal	Jul-25	~~Jul-25~~ N/K	Overdue
Peer Review	Getting It Right First Time (GIRFT) - Emergency Medicine - BGH		R1. (BGH) The long waits for admission from the ED are undoubtedly causing harm to patients and should be the main focus of any improvement work.	Work to improve hospital flow (as also identified in NHS Exec and 6 goals actions) is underway and has been factored into performance trajectories currently awaiting Executive sign off.	Louise Cullum	N/K	~~Aug-25~~ ~~Dec-25~~ ~~Mar-26~~ N/K	Overdue
Peer Review	Getting It Right First Time (GIRFT) - Emergency Medicine - BGH		R2. (BGH) The delays in ambulance to ED handovers of patients impair the response times for emergency ambulances and thus also cause harm to patients	Immediate release requests are almost always supported especially for red release calls- and any non adherence is investigated and lessons learned are shared- clear communication with ODU in place to support decision making and assessment of pressures in area- with a view to minimising risk. Pre-alerts are also prioritised which in turn would release ambulance capacity- and corridor care (surge) is frequently utilised to support urgent ambulance calls	Claire Davies	Mar-25	~~Mar-25~~ N/K	Overdue
Peer Review	Getting It Right First Time (GIRFT) - Emergency Medicine - WGH		R20. (WGH) There is definitely a case for an increase in SDEC and urgent clinic spaces. The current SDEC is limited in scope and specialties involved. This is an important way of getting more specialty involvement in emergency care and will reduce the proportion of emergency admissions that traverse the ED and the number of admissions.	SDEC is open form 8-8 Fully staffed Approx 60% of the medical take does attend SDEC. Planning for complex streaming at front door. Frailty SDEC – need to de surge unit. Unit to take direct from ED and will start to take referral direct form WAST, therefore, to avoid ED. HOT clinics in medical specialities already in place (manged by the medical Consultants)	Bethan Andrews	Oct-25	~~Oct-25~~ Nov-27	Overdue
Peer Review	Getting It Right First Time (GIRFT) - Emergency Medicine - WGH		R21. (WGH) Transfer arrangements to other hospitals must also be improved. There is no onsite paediatrics, and we were told that visiting paediatricians, working in outpatient clinics, refuse to support the ED in emergency situations. Moreover, children who require transfer to paediatric inpatient units are not accompanied by an anaesthetist, unless an endotracheal tube is in-situ. This lack of support for the ED is unacceptable and does not reflect a positive view of the importance of safe patient care.	Clear pathway already in place for paediatrics. A designated ambulance is on standby outside ED for transfers.	Lyndon Freeman	Oct-25	~~Oct-25~~ N/K	Overdue
Peer Review	Getting It Right First Time (GIRFT) - Emergency Medicine - WGH		R23. (WGH) Data quality must be improved.	Regarding validation of breaches WGH does have admin staff working with the SNM to undertake this request. SNM to ensure clinical team engagement and discussion relating to thematics surrounding breaches and assurance of correct data validation.	Jo Dyer	Oct-25	~~Oct-25~~ Aug-26	Overdue

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Internal Audit	Validation of Emergency Department Waiting Time Data Final Internal Audit Report 2025/26	Medium	R2. Standard Operating Procedure • the SOP does not identify the author, implementation or review dates and we have been unable to identify the source of the SOP. • it is not clear if or when the SOP has been communicated to or how it is accessible to staff. During our site visits some staff were of unaware of the document. • the SOP requires "validated non-breaches" (i.e. where an exemption applies) to be changed to 3:59 wait time but this is not done in practice and not necessary because breach reporting is based on the selected breach flag rather than the time in department.	The SOP will be updated to address the issues identified, and approved by an appropriate forum. The revised SOP will be formally communicated with relevant staff and accessible on the intranet.	Peter Skitt	Nov-25	~~Nov-25~~ N/K	Overdue
Internal Audit	Validation of Emergency Department Waiting Time Data Final Internal Audit Report 2025/26	Medium	R3. Audit Trail WPAS does not have the functionality to evidence or record where an ED attendance/breach has been validated, although the system does maintain an audit trail of amendments made as part of the validation process. Reports of amendments were requested for the sample of 40 ED attendances we reviewed, but we were advised that this could not be provided. This information could support the identification of common errors or areas with frequent errors (both in terms of documenting the ED attendance, and the subsequent validation process) to support learning, enhance data quality and improve the efficiency of breach validation.	The ED attendance reports used for validation will be annotated to identify the records subject to validation. Information Services to provide routine reports of amendments to records as part of the validation process, to facilitate learning and improve data quality.	Peter Skitt	Dec-25	~~Dec-25~~ N/K	Overdue
Internal Audit	Validation of Emergency Department Waiting Time Data Final Internal Audit Report 2025/26	Medium	R4. Requirement for Validation by Clinical Role The SOP states that "all relevant ED clinical notes and information will be reviewed by an ED Unit Manager" (a band 7 clinical role). This is case in GGH and PPH, but in WGH and BGH validation is undertaken by administrative (non-clinical) staff.	The validation process and associated roles and responsibilities as per the SOP will be reassessed to determine the extent of clinical involvement required and ensure appropriate use of clinical time. Training needs of any non-clinical roles involved will be assessed and fulfilled.	Anna Chiffi	Dec-25	~~Dec-25~~ Aug-26	Overdue
Internal Audit	Validation of Emergency Department Waiting Time Data Final Internal Audit Report 2025/26	High	R5. Breach Validation at BGH Validation was reperformed for a sample of 40 breaches across the four sites. Our sample was selected from a WPAS report of ED attendances (pre-validation) during the period 1 May – 7 August 2025. Three instances were identified for BGH where a breach was incorrectly flagged as exempt by the clinician and this had not been corrected as part of validation. It transpired that in these instances the breach reason had not been stipulated by the clinician and where this is the case, the validator is unable to amend the breach flag/reason due to a system access restriction. Analysis of WPAS data for ED attendances (pre-validation) during the period 1st May – 7 August 2025 identified 1225 instances (out of 3244 ED attendances where time in department exceeded 4 hours) where the breach reason for BGH had not been populated by the clinician and therefore the record would not be editable by the validator. We were advised that these records (37.8%) are not validated for this reason. There is a risk that these breaches have been under/over reported to WG.	The system access issue will be escalated to IT to resolve as a matter of urgency, to ensure that 100% breach validation can resume for BGH at the earliest opportunity. The outcome of finding/action 4 may impact on the longer-term validation arrangements.	Peter Skitt	Dec-25	~~Dec-25~~ N/K	Overdue
Internal Audit	Validation of Emergency Department Waiting Time Data Final Internal Audit Report 2025/26	High	R6. Inconsistent Monitoring Arrangements There is no evidence that 4-hour breach data for WGH and BGH is monitored or reported to appropriate forum(s) to aid learning and to improve performance.	The performance monitoring arrangements for GGH and PPH will be implemented for BGH and WGH.	Peter Skitt	Nov-25	~~Nov-25~~ N/K	Overdue
Ministerial Advisory Group (MAG)	A report from the Ministerial Advisory Group on NHS Wales Performance and Productivity	N/A	R4. All health boards should reduce unwarranted variation in treatment waiting times and adopt best practice in theatre management. This can be achieved through the implementation of the existing GIRFT review reports including the theatre reviews. This recommendation should be supported by the establishment of local Theatre Optimisation Boards, with a remit to deliver increased productivity within theatre sessions including the implementation of best practice standards of cases per session, particularly in ophthalmology and orthopaedics (in ophthalmology 8 cataracts in a 4 hour theatre session if a training session and 10 if consultant only, and in elective orthopaedics a minimum requirement of 4 Joints or their equivalent in an all day orthopaedic elective list).	Pilot started in AVH for 8 cataracts per list to roll out to all 3 lists in AVH if successful.	Amorelle Jones	Mar-26	~~Mar-26~~ Sep-26	Overdue

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Ministerial Advisory Group (MAG)	A report from the Ministerial Advisory Group on NHS Wales Performance and Productivity	N/A	R4. All health boards should reduce unwarranted variation in treatment waiting times and adopt best practice in theatre management. This can be achieved through the implementation of the existing GIRFT review reports including the theatre reviews. This recommendation should be supported by the establishment of local Theatre Optimisation Boards, with a remit to deliver increased productivity within theatre sessions including the implementation of best practice standards of cases per session, particularly in ophthalmology and orthopaedics (in ophthalmology 8 cataracts in a 4 hour theatre session if a training session and 10 if consultant only, and in elective orthopaedics a minimum requirement of 4 Joints or their equivalent in an all day orthopaedic elective list).	Review theatre efficiencies in GGH/BGH to see where there is a possibility to increase theatre delivery further.	Amorelle Jones	Mar-26	~~Mar-26~~ Sep-26	Overdue
Ministerial Advisory Group (MAG)	A report from the Ministerial Advisory Group on NHS Wales Performance and Productivity	N/A	R4. All health boards should reduce unwarranted variation in treatment waiting times and adopt best practice in theatre management. This can be achieved through the implementation of the existing GIRFT review reports including the theatre reviews. This recommendation should be supported by the establishment of local Theatre Optimisation Boards, with a remit to deliver increased productivity within theatre sessions including the implementation of best practice standards of cases per session, particularly in ophthalmology and orthopaedics (in ophthalmology 8 cataracts in a 4 hour theatre session if a training session and 10 if consultant only, and in elective orthopaedics a minimum requirement of 4 Joints or their equivalent in an all day orthopaedic elective list).	Increase volume of cases in Orthopaedics to 4 arthroplasty patients on an all day list. A standby patient has been added with the aim of achieving 4 arthroplasty patients per all day list. Some Consultants are already achieving 4 joints on an all day list whilst others will only achieve this with theatre enablers.	Sarah Carmody	Mar-26	~~Mar-26~~ N/K	Overdue
Ministerial Advisory Group (MAG)	A report from the Ministerial Advisory Group on NHS Wales Performance and Productivity	N/A	R4. All health boards should reduce unwarranted variation in treatment waiting times and adopt best practice in theatre management. This can be achieved through the implementation of the existing GIRFT review reports including the theatre reviews. This recommendation should be supported by the establishment of local Theatre Optimisation Boards, with a remit to deliver increased productivity within theatre sessions including the implementation of best practice standards of cases per session, particularly in ophthalmology and orthopaedics (in ophthalmology 8 cataracts in a 4 hour theatre session if a training session and 10 if consultant only, and in elective orthopaedics a minimum requirement of 4 Joints or their equivalent in an all day orthopaedic elective list).	Continue to work with Swansea Bay UHB to consolidate current practice and further scope opportunities via regional working	Sarah Carmody	Oct-25	~~Oct-25~~ N/K	Overdue
Ministerial Advisory Group (MAG)	A report from the Ministerial Advisory Group on NHS Wales Performance and Productivity	N/A	R6. Health Boards should make improvement in processes, partnerships and investment in specific community pathways to reduce delayed pathways of care.	Health Board and Local Authority partners to update and refresh the Regional Pathways of care action plan for the financial year 2026-27. The Regional Pathways of care action plan is an integrated plan between LAs and the Health Board to address Pathway of Care Delays.	Rachel Williams	Mar-26	~~Mar-26~~ N/K	Overdue
Internal Audit	Internal Escalation: Level 3 & 4 Functions Final Internal Audit Report 2025/26	Medium	R2. Sufficient & Appropriate Actions The five functions sampled collectively had 17 domains in in L3 escalation as at September 2025. Review of the Executive Recovery meeting slide packs confirmed that all 12 domains assessed as Alert were included for discussion at the October 2025 meetings. We identified four instances where actions had either not been identified within the slide pack or did not sufficiently address the stated reasons for escalation. Actions were generally considered to be SMART in nature although some exceptions were identified.	Following a review of activity, we have agreed to move to monthly touchpoints with escalated CCGs and build into the Improving Together Executive Collaboration approach. The Terms of Reference will include this requirement.	Huw Thomas	Mar-26	~~Mar-26~~ N/K	Overdue
Internal Audit	Internal Escalation: Level 3 & 4 Functions Final Internal Audit Report 2025/26	Medium	R4. Gap in Domain Review at EITS Review of EITS slide packs noted that for Community & Integrated Medicine the Quality & Safety domain is excluded –we were advised that this is being managed via the CCG Integrated Governance Group meetings (which by design cover all seven domains regardless). The reason for this variation was not clear.	As for Recommendation 2 Following a review of activity, we have agreed to move to monthly touchpoints with escalated CCGs and build into the Improving Together Executive Collaboration approach. The Terms of Reference will include this requirement.	Huw Thomas	Mar-26	~~Mar-26~~ N/K	Overdue

Report Issued By	Report Title	Priority Level	Recommendation	Management Response	Recommendation Owner	Original Completion Date	Revised Completion Date	Status Category
Internal Audit	Internal Escalation: Level 3 & 4 Functions Final Internal Audit Report 2025/26	High	R5. Gaps in Executive Recovery Meetings Executive Recovery meetings should take place monthly where the function has assessed one or more domains as Alert. Across the five functions reviewed, 23 Executive Recovery meetings should have been held during the period July – December 2025*. Only 12 meetings actually took place. The Performance Team, responsible for facilitating the meetings, cited difficulty in scheduling meetings due to availability of senior leadership at both Executive at function level. Furthermore, no meetings had been held since October 2025 (reviewing August/September data) due to EITS in November and service pressures in December, although meetings are scheduled for January/February 2026. *excluding June & November where EITS took place instead	As for Recommendation 2 Following a review of activity, we have agreed to move to monthly touchpoints with escalated CCGs and build into the Improving Together Executive Collaboration approach. The Terms of Reference will include this requirement.	Huw Thomas	Mar-26	~~Mar-26~~ N/K	Overdue
Internal Audit	Internal Escalation: Level 3 & 4 Functions Final Internal Audit Report 2025/26	Medium	R6. Escalation Route for Alerts The Chair of the meeting is required to complete a 3A assessment for each area reviewed, this is captured on the Escalation Meetings Action Tracker. However, it is not clear and we were unable to determine the escalation route for domains assessed as Alert.	As for Recommendation 2 Following a review of activity, we have agreed to move to monthly touchpoints with escalated CCGs and build into the Improving Together Executive Collaboration approach. The Terms of Reference will include this requirement.	Huw Thomas	Mar-26	~~Mar-26~~ N/K	Overdue
Internal Audit	High-Cost Drugs Final Internal Audit Report 2025/26	Medium	R2. Immunoglobulins Nine of our sample (accounting for 75% of the total value of our sample) related to immunoglobulins. Some brands are included on the formulary, those in our sample weren't and we were unable to determine a rationale for this. However, the brands dispensed were confirmed to be in line with all-Wales product selection guidance issued by the all-Wales Immunoglobulin Strategy Group. Hywel Dda is one of two health boards in Wales where immunoglobulins are ordered and dispensed via hospital pharmacies. The health board needs to review its approach to immunoglobulins to decide which should be included on the formulary and whether other formal governance/formulary approval processes are required. This needs to be considered in the context of any national governance arrangements for immunoglobulins.	Supply of immunoglobulins will continue to align with all-Wales product selection guide. Hywel Dda formulary to be updated to reflect the range of products available for use, with clarity on first-line options.	Aled Richards	May-26	~~May-26~~ N/K	Overdue

2

2 - ANNUAL PLAN 2026/27 AND ESCALATION UPDATE

2.1

2.1 - ANNUAL PLAN 2026/27 AND ESCALATION PRIORITIES

Shaun Ayres (Hywel Dda UHB - Director of Delivery)

For assurance

Attachments

Escalation Update FPC 27 August 2026.pdf

Escalation Oversight and Highlight Report

27 August 2026

Lead Executive: Lee Davies - Executive Director of Strategy and Planning

Reporting Officer: Shaun Ayres - Director of Delivery

Purpose and what we have been asked to deliver

One letter sets the requirements and the dates: Nick Wood, Deputy Chief Executive NHS Wales, to Phil Kloer, following the Level 4 Escalation Board of 4 August. Issued on 11 August and reissued on 14 August with one sentence clarified, it is the 14 August text that stands. The charge is deliverability: the absence of sufficiently credible trajectories, and the pace at which change is delivered. Therefore, this pack considers the requirements aligned to the Letter but also the wider agenda.

Area	What Welsh Government requires	By when
Finance and savings	Close the savings gap with full confidence to deliver, and deliver a deficit no worse than the current £41.0m forecast	**End of September**
	Convert the current one-off savings into savings that repeat each year	**End of September**
	Submit an agreed route map to financial stability, and explore opportunities to improve on the £41.0m	**End of September**
	Meet Welsh Government on the final recovery plan to balance before it is taken to Board	**Before 24 September**
Clinical services plan	Submit the Board paper and the implementation plan to Welsh Government	**End of August**
Urgent and emergency care	No more than 680 ambulance handovers over one hour, and no more than 7% of patients staying over twelve hours in our emergency departments	**In each of September and October**
	Revise the profile to reach 75% of handovers within 45 minutes: the current profile is “not acceptable”	**Profile to be revised**
Planned care and diagnostics	Improve the end of year trajectory to an acceptable position: “you remain our greatest risk”	**Ahead of 16 September**
	Submit monthly trajectories to NHS Wales Performance and Improvement	**Submitted 7 August**

The dates. The required actions are set ahead of the next meeting, the accountability review on 16 September, while the finance deadlines fall at the end of that month. Urgent care is reviewed at multiple juncture including at the Escalation Board on 9 November and September and October together.

The standard. The conclusion asks for clear evidence of accelerated improvement and delivery, failing which further consideration will be given to the most appropriate next steps. Delivering both urgent care criteria in September and in October is the route by which de-escalation can be considered.

The position as of July

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

The below represents the current position at a glance. The risk register is shown for context only; the risks are reported through the appropriate committees, but it is important to consider the whole position when looking at any plans.

Finance

£21.6m

deficit in the first four months, £7.9m more than planned

ALERT

Savings

£13.0m

gap against the £42.8m target; £29.8m identified so far

ALERT

Variable pay

£60.2m

a year at the current rate; the 30% ask implies £44.5m

ALERT

Risk register

662

live risks, of which 232 need recruitment or staffing to resolve

CONTEXT

Handovers over 1 hour

532

July, against 680 required in September and October

ALERT

Waits over 12 hours

9.2%

July, against 7% required in September and October

ALERT

Delayed pathways

204

July, against a ceiling of 174; worsening

ALERT

Time to assessment

73 min

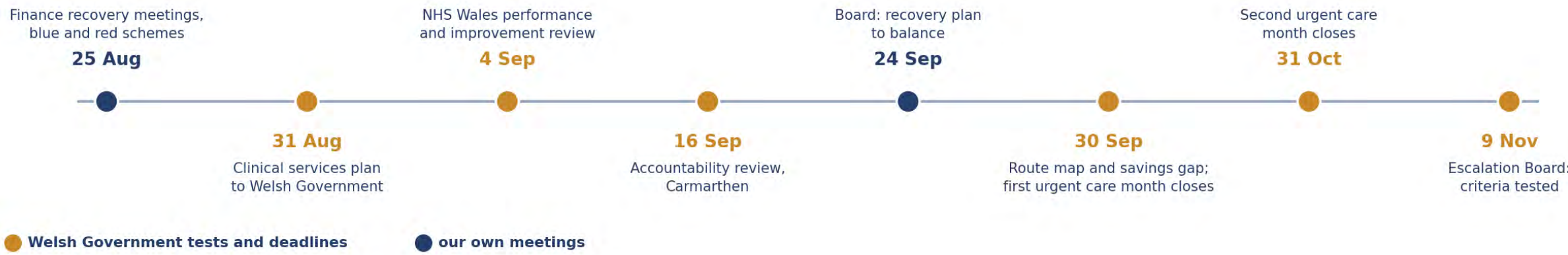
July, against a 60 minute standard; improved

ADVISE

Ten weeks, eight fixed points

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Welsh Government has set the expectations and most of the dates. Gold marks what Welsh Government tests or requirements; navy marks the Health Board deadlines. Two land on the same day: the route map to financial stability and the first urgent care test month both close on 30 September.

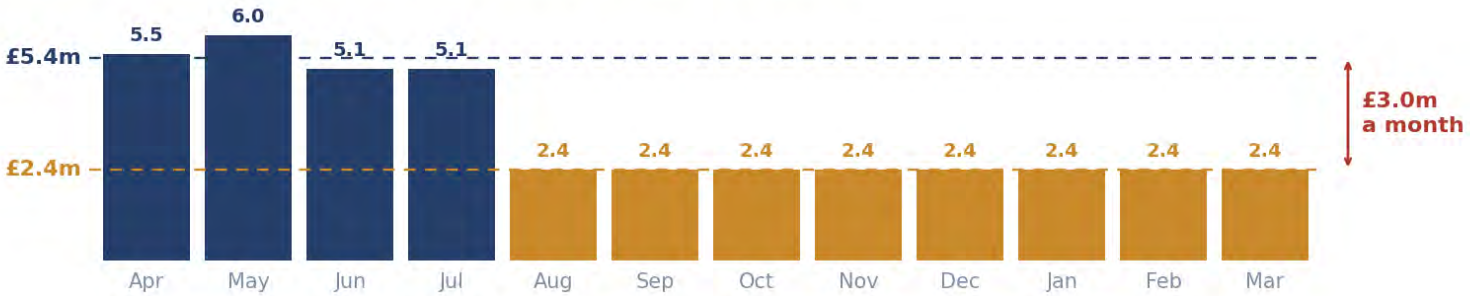


From the run rate to £41.0m

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

ALERT

What we have spent, and what is left to spend



Navy is money already spent, £21.6m in four months. Gold is all that is left for the remaining eight months if the year is to land on £41.0m.

Why the savings improvement did not change what we spend



£8.1m of the £8.8m was underspends and a drugs stock review moved from one column to another. Moving a number between columns does not change what the organisation spends.

Where we are. In the first four months the Health Board spent £21.6m more than we received, an average of £5.4m a month. That average is what this report calls the run rate. The plan for the year is a £41.0m deficit, which leaves £19.4m for the remaining eight months, or £2.4m a month.

The gap. Spending needs to reduce by £3.0m a month, every month from August to March. That is £23.8m across the rest of the year. The finance report makes the same point on its own basis: months 1 to 5 average £5.3m and months 6 to 12 must average £2.0m.

Why savings do not close it on their own. In month 4 the savings position improved by £8.8m. £8.1m of that was money we were already not spending, underspends and a drugs stock review, reclassified as savings. Reclassification moves a number between columns. It does not reduce what we spend, so the run rate does not move.

What that leaves. Set the reclassification aside and the year's expenditure position improved by £1.8m in month 4, from £62.2m to £60.4m before further cost reductions are applied. The distance to £41.0m is measured against the run rate, not against the savings total.

Considerations. Welsh Government requires the savings gap closed with full confidence to deliver by 30 September, one-off savings converted into savings that repeat each year, and options to improve on the £41.0m. The mid-year assessment reports to Board on 24 September and may change the forecast reported at month 6.

One workforce to delivery two requirements

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Both plans are required and are based on a set of workforce assumptions. Therefore, It is the interlock the committee is asked to test and whether the plans are triangulated:

The financial plan requires

- Spend £3.0m a month less than we are spending now, every month to March
- Temporary staffing down £15.7m a year, about a quarter of what we spend on it now
- Vacant posts to stay vacant, because the money they release is holding up the position

Source: The plan behind the £41.0m forecast

The performance plans require

- Emergency department rotas filled at Withybush and Glangwili, on every shift, in September and October
- Between a fifth and a third more CT scanning than we can do now, right through the winter
- More planned care and cancer treatment than we are managing today

Source: The requirements in the letter of 14 August

Both are drawn from the same workforce, in the same weeks

1,048
posts the budget funds that we have not been able to fill

548
still short of a fully staffed rota, even after all temporary cover

232 of 662
risks on our register that need recruitment or staffing to fix

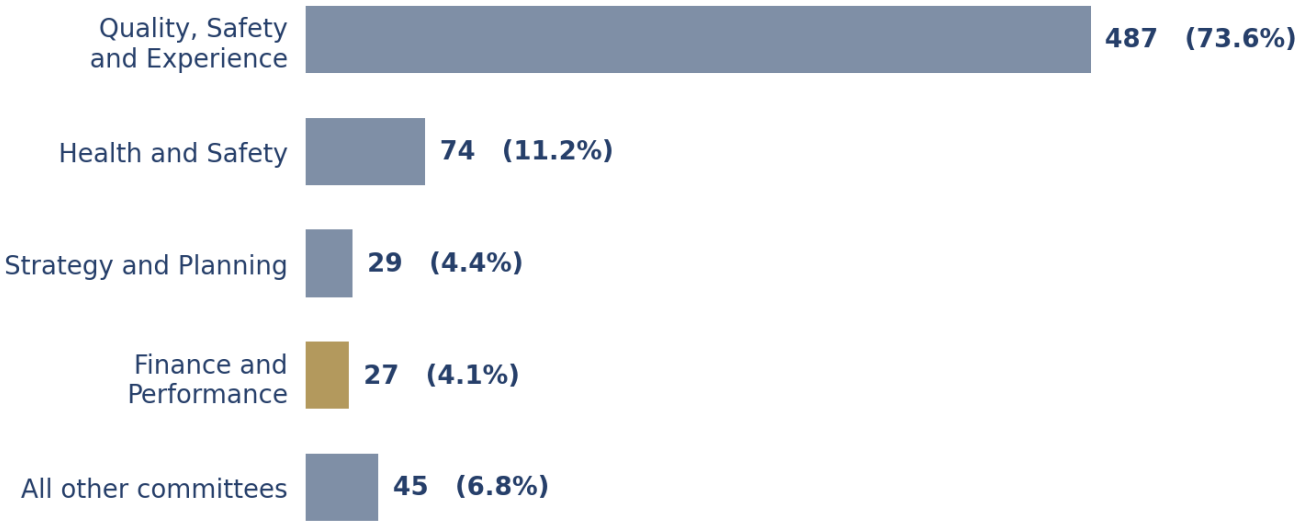
3 of 3
risks we named to Welsh Government are workforce risks

Four clinical care groups carry most of this. Community and Integrated Medicine and Planned and Specialist Care between them hold £8.3m of the £13.0m savings gap, £12.5m of the overspend on day to day running costs, 67 of the most serious risks on our register, and 25 of the 27 risks about urgent care and patient flow. Both are at level 4, our highest internal escalation level. At the first level 4 review the CCGs committed to £10.0m of improvement and have delivered £3.8m. What is asked of them financially and what is asked of them operationally is asked of the same small group of leaders, in the same weeks. The paper poses a question around the 30% reduction in variable pay expenditure (WG planning expectation) and the deliverability of the performance in tantum.

What our own register says about our workforce

The register describes the dependency: 232 of the 662 live risks rely on recruitment or staffing to mitigate. What it does not yet connect is the savings programme to the operational exposure that same staffing carries. However, there are very clear risks aligned to the financial position of the Health Board.

Lead committee for the 662 live risks



What the register does and does not record

19	of the 662 risks mention savings anywhere
1	mention of the word ambulance in 662 risks
59.3%	of open risk actions are overdue
215	median days overdue

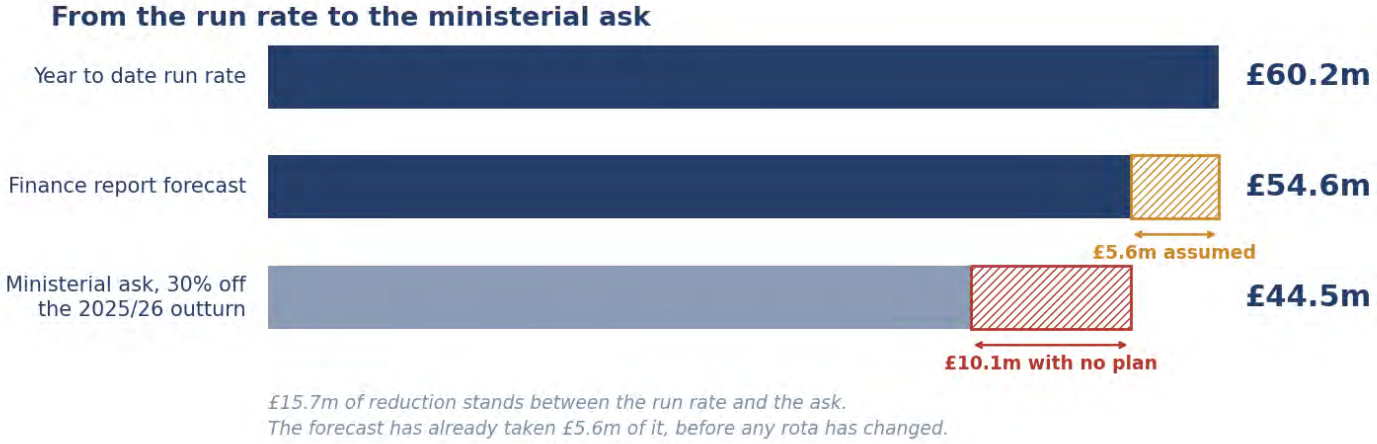
At the Escalation Board on 4 August we named our top three register risks as pathology, ultrasound and emergency department consultant workforce numbers. All three are workforce and capacity risks, and two of them sit in the areas the same letter requires us to improve. We also recorded that we are working internally to triangulated workforce and finance to understand exactly what is included within the funded establishment.. Finance and Performance is lead committee for 27 risks against 487 with Quality, Safety and Experience, and across the whole risk register 59.3% of open actions are overdue at a median of 215 days. A single view/plan connecting savings schemes, staffing dependency and clinical risk is the remedy ahead of the September Board.

Variable pay: what the expenditure highlights

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

ALERT





Position. Variable pay is the cost of temporary staffing: bank, agency, overtime, additional hours and locum cover. On the run rate it costs £60.2m a year with agency, against a combined budget of £19.2m, while permanent pay runs £43.3m below its own budget. Total pay lands £2.3m below a £720.2m budget:.

Basis. This report uses the run rate throughout, which is aligned to the finance report. That report's pay forecast is stated after £19.4m of further cost reductions, £10.5m of it within pay, and reads £9.5m favourable on that basis. Year to date pay is £2.7m adverse..

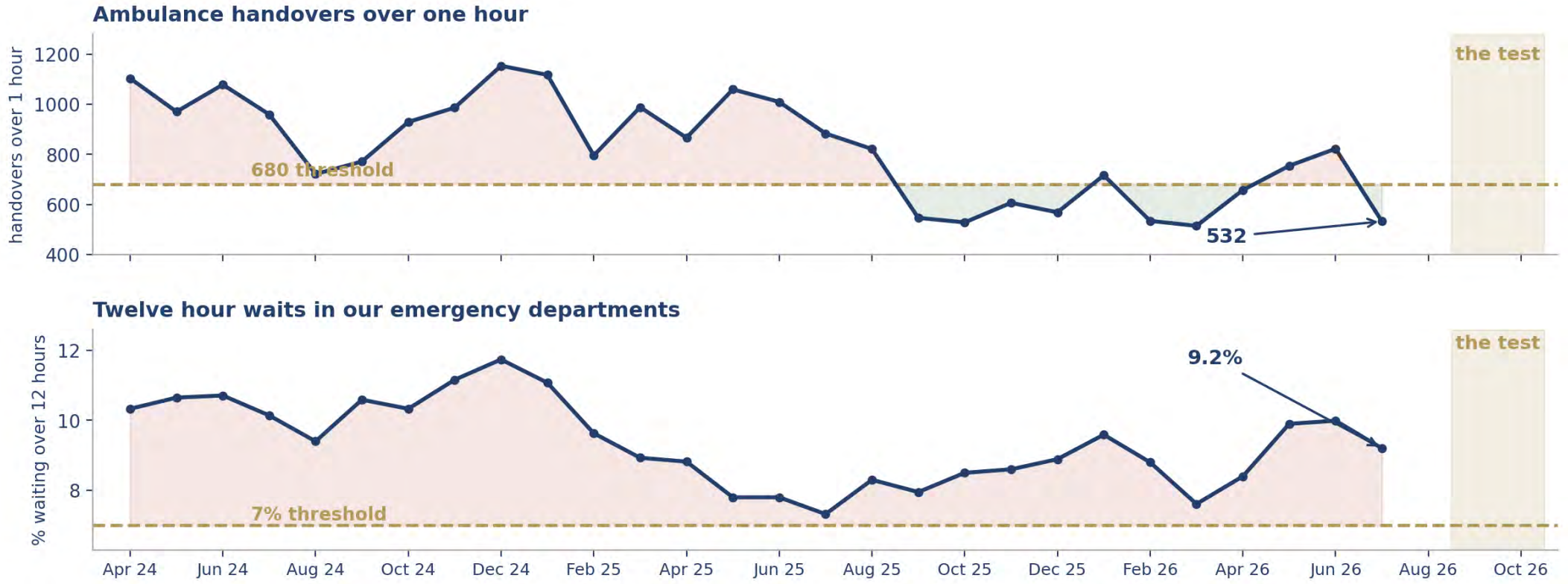
Establishment. Reductions release cash only where a funded vacancy, a roster and the cover being removed line up in the same ward and shift. Community and Integrated Medicine reads as 9.4 medical vacancies but runs 42.5 whole time equivalents above the staffing its budget funds once locum cover is counted, and still holds two extreme emergency department staffing risks. Therefore, being clear on this point will support the committee in understanding how a UEC plan will balance finance, performance and quality?

Considerations. Ministerial priorities require a 30% reduction against the 2025/26 outturn of £63.6m, which implies £44.5m. From the run rate that is £15.7m: £5.6m already assumed inside the forecast and £10.1m with no plan attached. Items 3.2 to 3.4 test both against named rotas.

Urgent Care: the September and October test

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

ALERT

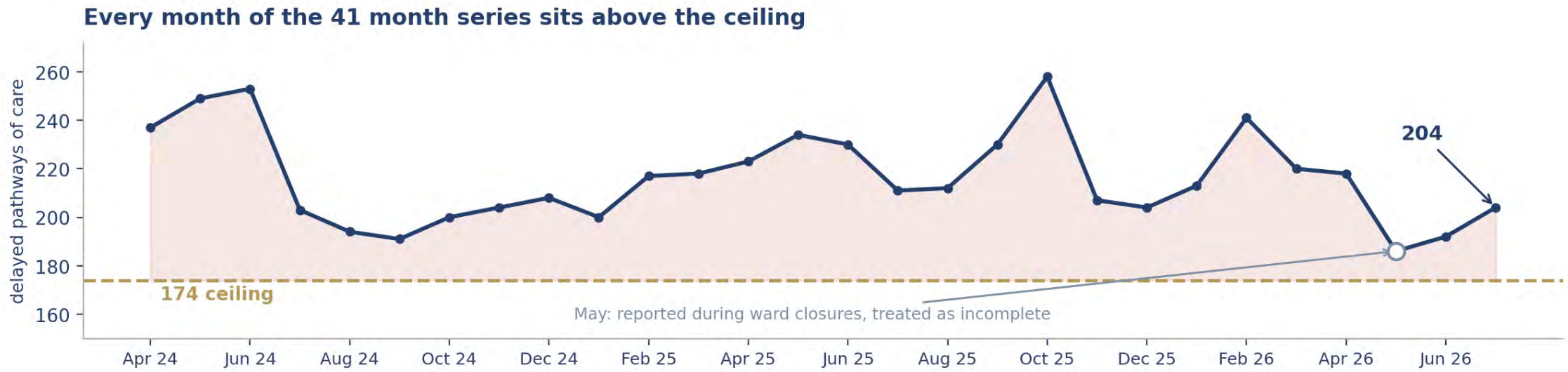


July recorded 532 handovers over one hour and 9.2% of patients waiting over twelve hours, both improved on June. Welsh Government requires no more than 680 handovers and no more than 7% in September and in October, tested at the Escalation Board on 9 November. Across 41 months we have met the handover threshold eight times, all since September 2025; the health board figure has never met the twelve-hour threshold, and the best month recorded is 7.3%. Site variation is the binding constraint: Withybush at 15.8% and Glangwili at 13.4% in July, against Bronglais at 7.0% and Prince Philip at zero. September and October are, in practice, a Withybush and Glangwili test. Two further points sit behind the trajectory: the letter of 14 August records that our current profile to reach 75% of handovers within 45 minutes is not acceptable and requires revision, and the urgent care investment in the annual plan is running late, with item 4.1 reporting a £0.6m benefit from the delay and the agency forecast assuming implementation resumes from September, inside the test window.

Delayed Pathways of Care

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

ALERT



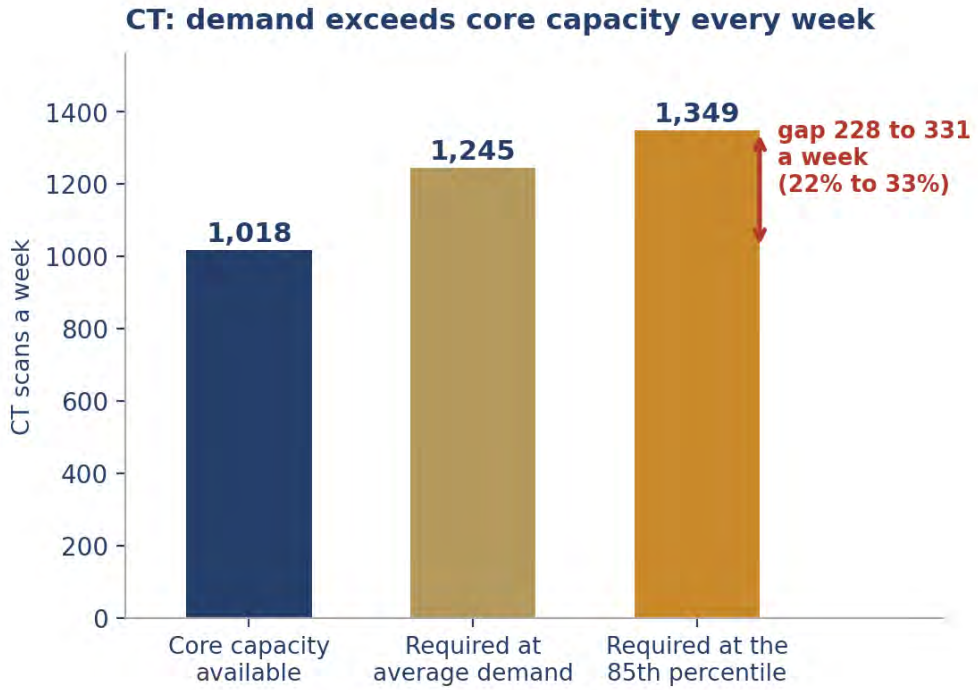
A Delayed Pathway of Care (DPoC) is a patient who no longer require acute hospital but cannot be discharged. This is usually because the care they need next is not yet available. July recorded 204, worse than June. In 41 months of reporting the Health Board have never been at or below the ceiling of 174, and criterion 19 remains at Alert. Two hundred delayed pathways is bed capacity the front door does not have, at exactly the two sites carrying the twelve-hour challenges, so this is the flow constraint sitting behind the urgent care test.

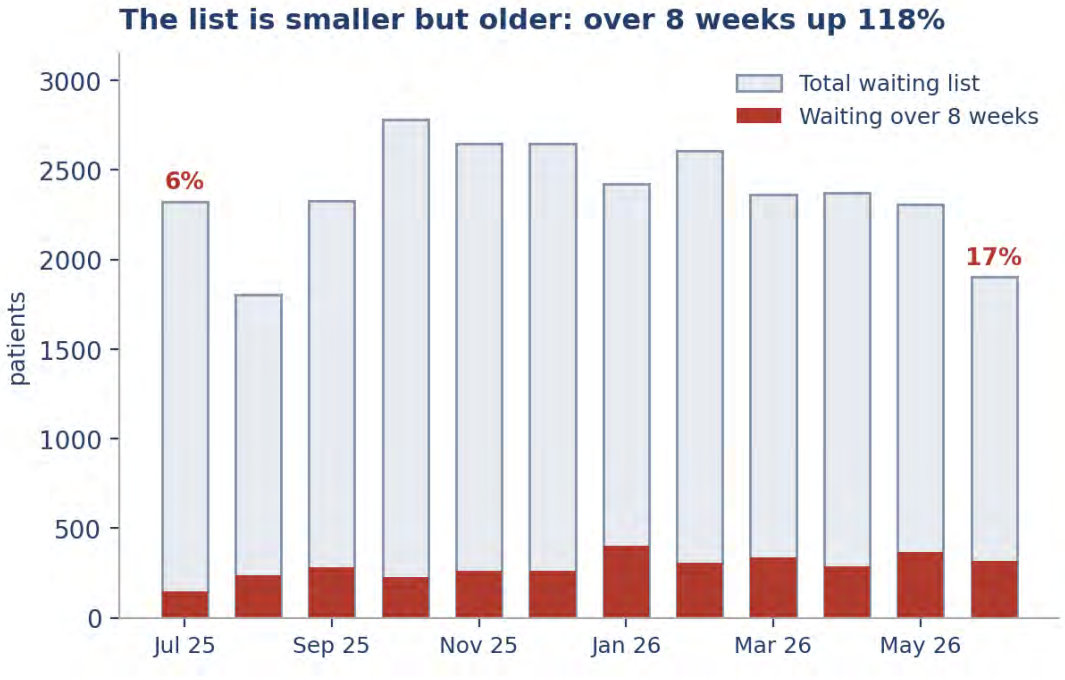
The measure presents the greatest opportunity as highlighted by the structured assessment report. On the 9 December 2025, the structured assessment went to ARAC and highlighted that the average cost per day was circa £500. This resulted in the headline figure of circa £27.741m being lost annually (based on 24/25) to DPoCs. Further, about £2.3m a year of surge staffing, while the routes out of hospital are commissioned and growing: continuing healthcare packages are already circa £3.8m of the 26/27 overspend..

Diagnostics: the radiology gap, quantified

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Ultrasound is one of the three register risks we named to the Escalation Board on 4 August. The letter requires monthly diagnostics trajectories, submitted on 7 August. The demand and capacity work commissioned by the June committee now quantifies the CT position; item 3.1 presents it in full.





CT demand requires 1,245 scans a week on average and 1,349 in a high week; core capacity provides 1,018, a structural gap of 22% to 33% that is currently bridged by outsourcing, premium sessions and waiting. The waiting list has fallen 18% in a year but aged: patients waiting over eight weeks have more than doubled to 316, one in six of the list. Referral behaviour has also shifted since Rad Plus went live in December: urgent referrals now take half of all capacity, squeezing routine work. Planned scanner maintenance takes 29 scanner weeks out between September and next July, overlapping the urgent care test window and winter. The financial read across is direct: radiology outsourcing is £1.8m of the forecast variance, and each unfilled radiology post becomes premium spend. This is the same structure as variable pay, in outsourcing and capital form.

Welsh Government's requirements

The five delivery areas that carry the requirements of the letter of 14 August, each with what it depends on and the risk we have already recorded against it. Read down the third column.

Area	What the plan requires	What it depends on	The recorded risk	Owner and by when
Finance and savings	Savings gap closed with full confidence to deliver; one-off savings converted into savings that repeat; route map to financial stability submitted	£19.4m of further cost reductions turning into confirmed plans, £10.5m of it within pay	Control total and underlying deficit risks both carry the maximum score of 25	Director of Finance; 30 September
Variable pay and agency	Temporary staffing down £15.7m a year to reach the ministerial ask, of which £5.6m is already assumed inside the forecast	Named rotas, funded vacancies and successful permanent recruitment in a labour market our own register recognised that supply and demand are not in equilibrium.	232 of 662 risks depend on recruitment or staffing to mitigate	Director of Workforce/Chief Operating Officer and OD with care groups; items 3.2 to 3.4
Urgent and emergency care	No more than 680 handovers and no more than 7% over twelve hours, in September and in October	Front door rotas held at Withybush and Glangwili, the delayed urgent care investment landing, and flow out of hospital improving from 204 delayed pathways	Two extreme emergency department medical staffing risks, both in Community and Integrated Medicine	Chief Operating Officer; 31 October
Diagnostics	Monthly trajectories delivered and sustained progress towards the eight week maximum wait	CT capacity up 22% to 33% against core, through a 29 week maintenance programme	Ultrasound named to the Escalation Board as one of our top three register risks	Chief Operating Officer; item 3.1
Planned care	End of year trajectory improved to an acceptable position; 104 week waits eliminated	Recovery activity above current levels, and the funding and theatre capacity to buy it	Named by Welsh Government as our greatest risk	Chief Operating Officer; ahead of 16 September

Every one of the five depends on staff we do not currently employ, or on the same staff being available to more than one plan at once. That is what this report asks the committee to test, and it is the question the deep dives at items 3.1 to 5.1 are best placed to answer.

What we are asking of the Committee

Scrutinise - the deliverability of the five areas at slide 12 (within the respective plans), and in particular whether the actions behind the financial plan and the actions behind the performance plans can be delivered in conjunction with each other.

Endorse - a single combined view of savings schemes, staffing dependency and clinical risk to the September Board, so financial and operational exposure are read together.

Consider and challenge - the read across to items 3.1 to 5.1, so assurance is taken on the whole position rather than on each part in isolation.

3

3 - ESCALATION RESPONSE – RECOVERY ACTION PLANS AND IMPROVEMENT TRAJECTORIES

3.1

3.1 - PERFORMANCE DEEP DIVE: RADIOLOGY DEMAND AND CAPACITY AND SERVICE SUSTAINABILITY

Andrew Carruthers (Hywel Dda UHB - Chief Operating Officer)

For assurance

Attachments

Radiology Demand and Capacity Deep Dive FPC 27 August 2026.pdf



GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

Radiology Demand, Capacity and Service Sustainability

Andrew Carruthers, Chief Operating Officer

27 August 2026, Microsoft Teams

RAD+ corrected the measurement; the capacity gap remains

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

DEC 2025 – JUN 2026

Reporting confidence fell

RAD+ exposed inconsistent procedure eligibility and waiting-time logic.

The submitted (Annual Plan) recovery trajectory could not be relied on.

JUN – AUG 2026

The evidence base was validated

The task-and-finish group corrected rules, tested records and rebuilt modality tools.

The review identified no duplicate patient records.

Further national breach reporting guidance awaited re inclusion of patients or scans.

AUG 2026

The residual gap is real

Validated demand still exceeds recurrent capacity in Computed Tomography (CT), Magnetic Resonance Imaging (MRI) and Non-Obstetric Ultrasound (NOUS).

The leadership question is now service sustainability.

WHY DEMAND IS RISING • A&E requests +5.5% Year on Year • inpatient urgent share 21% → 55% • cancer pathways increase CT/MRI dependency

Sources: Radiology T&F group briefing, 31 Jul 2026; Radiology T&F group data insights, 4 Aug 2026; Planned

The Board-approved plan has been submitted to Welsh Government

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

£15.497m package to accelerate treatment, diagnostics and cancer recovery

Total request

£15.497m

£9.036m
Treatment

£6.462m
Diagnostics

Board-approved submission

Radiology package

£4.134m

64% of diagnostics • 27% of total request

Mobile CT and MRI capacity: Creates additional activity and backlog-recovery capacity.

Non-obstetric ultrasound (NOUS) insourcing • 4,786 examinations: Targets the workforce-led ultrasound gap. Modality of greatest risk on delivery.

Reporting and administrative support: Supports delivery and tracking of the recovery plan.

Cancer dependency: £743.6k of the package supports cancer pathways. Urology and Lower Gastrointestinal (GI) carry the greatest pressure.

Modelled outcome

0

>8-week breaches by March 2027

Conditional on

- Capacity mobilising to plan
- NOUS delivery
- Welsh Government funding

Funding not yet confirmed

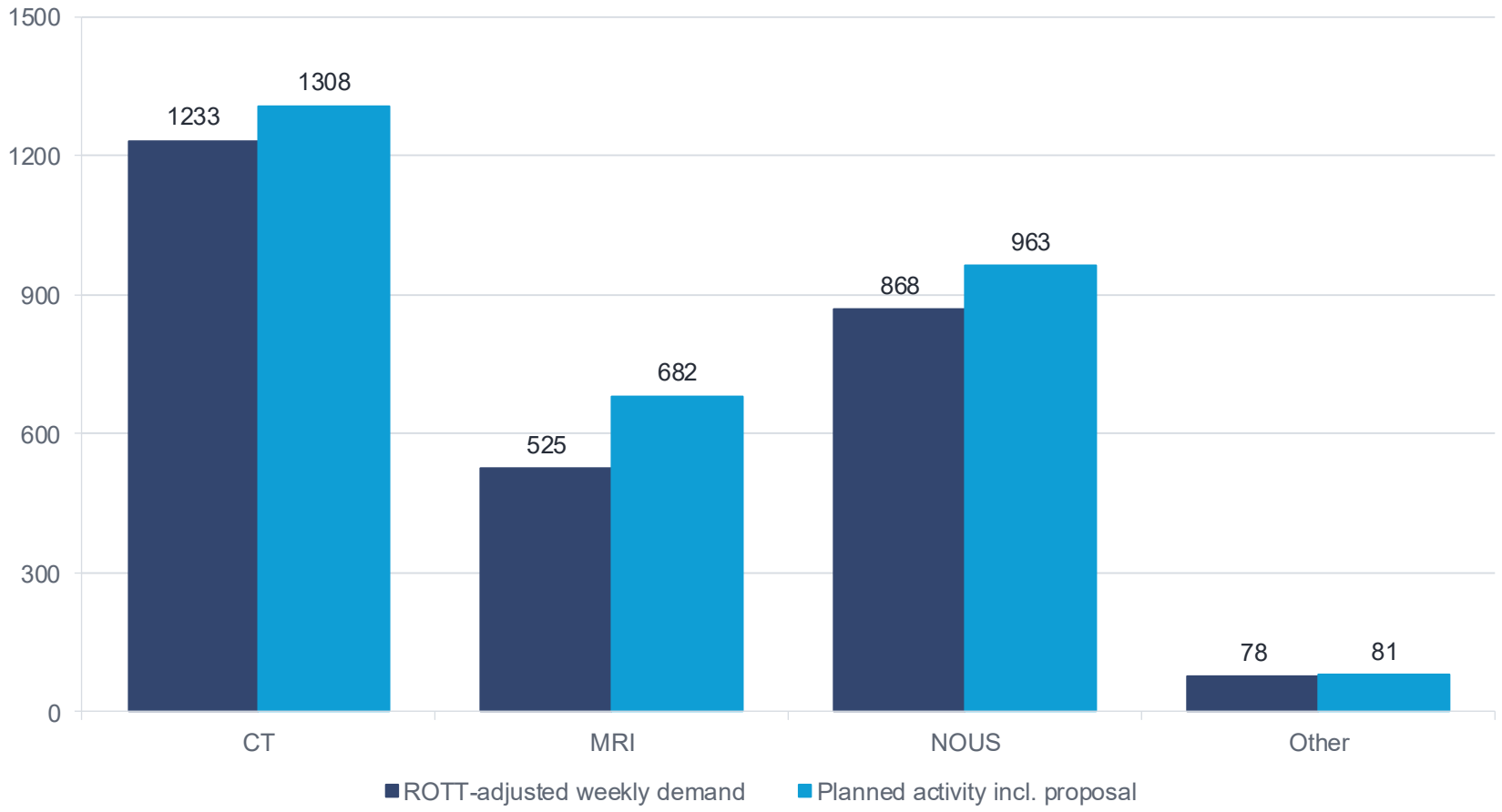
The submission funds the immediate recovery bridge; the recurrent model is addressed through the clinical services strategy.

Sources: Planned Care Delivery & Sustainability Plan 2026/27, pp. 3, 39, 42–43; Board-approved Welsh Gove

The proposed plan closes each modality gap and creates recovery headroom

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Weekly activity after Removal Other Than Treatment (ROTT) adjustments



330

weekly recovery slots created

HEADROOM BY MODALITY

CT	MRI
+75	+157

NOUS	OTHER
+95	+3

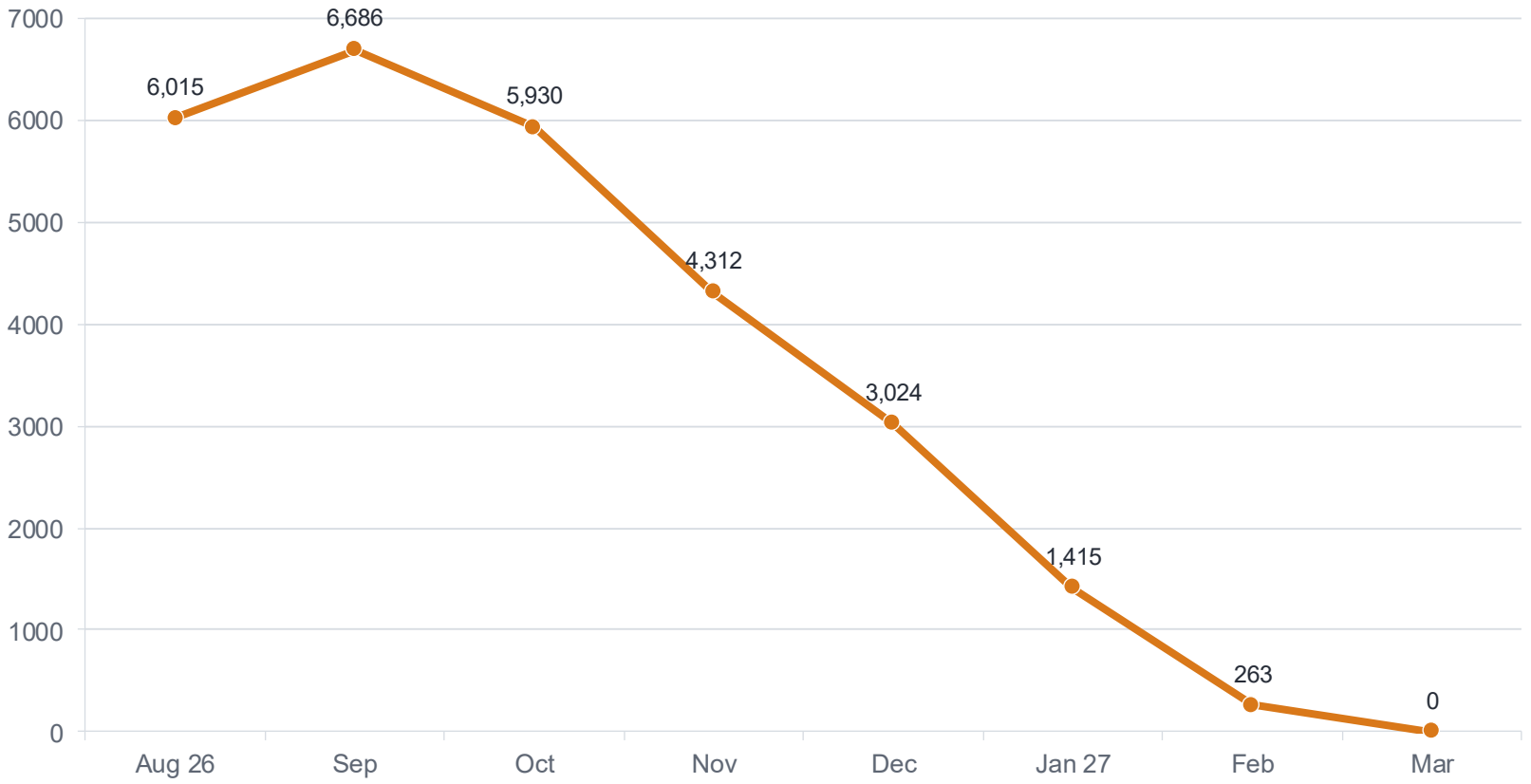
The proposal provides time-limited recovery capacity; it does not establish a recurrent service model.

Source: Radiology trajectories, Jul 2026. Demand is ROTT-adjusted; planned activity includes proposed additi s are rounded.

Proposed capacity clears >8-week breaches by March 2027

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Projected monthly position under workbook assumptions



6,686
modelled peak • Sep 2026

£4.134m
radiology element of Welsh Government funding request

DELIVERY DEPENDENCIES

- CT/MRI capacity from Oct 2026
- 4 WTE NOUS from 26 Oct (high risk of delviery)
- **Funding not yet confirmed**

The trajectory reaches zero only if the intervention timing and delivery assumptions hold.

Sources: Radiology trajectories, Jul 2026; Planned Care Delivery & Sustainability Plan 2026/27. Workbook val e patients.

Radiology enables diagnostic, RTT and cancer recovery

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

The investment

~27%

of the £15.497m in-year proposal

£4.134m
Radiology recovery capacity

One investment • three pathways

Demand is growing faster than capacity

Year-on-year growth • clinically driven, including cancer pathways

RADIOLOGY	MRI	CT
+9.6%	+33.7%	+15.4%

One capacity investment supports three recovery outcomes

DIAGNOSTICS
>8-week waits

RTT
Progression

CANCER
Diagnosis + staging

Sources: Planned Care Delivery & Sustainability Plan 2026/27, pp. 3, 39, 42; Planned Care and Sustainability

The leadership challenge is moving from recovery capacity to a sustainable model

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Now • non-recurrent

1 BRIDGE

- Mobile CT/MRI capacity
- NOUS insourcing
- Clear the >8-week backlog
- Protect RTT and cancer recovery

2026–29 • build the base

2 STABILISE

- Radiology Stabilisation Plan (£8.4m 2025-2029)
- Recruit and retain the workforce
- Improve productivity & utilisation (including CGI opportunities)
- Strengthen equipment resilience

Future • clinical strategy

3 SUSTAIN

- Define the recurrent service model
- Confirm Clinical Services Plan (CSP) configuration and access
- Align workforce, estate and technology
- End routine reliance on temporary capacity
- Dependency on regional solution or not?

Sources: Radiology Stabilisation Plan; feedback from Director of Operational Planning & Performance and Ch 12 Aug 2026.

Committee assurance, support and endorsement

Assure

The modality position is evidence-based

The Committee is asked to assure itself that RAD+ rules and records have been reviewed; residual gaps remain after validation.

Support

The recovery response and dependencies are understood

The Committee is asked to support the trajectory which depends on timely capacity, NOUS delivery and funding confirmation.

Endorse

The Radiology Stabilisation Plan

The Committee is asked to endorse the principle of incremental funding through Annual Planning to maintain delivery of the stabilisation programme into year three.



DIOGEL | CYNALIADWY | HYGYRCH | CAREDIG

SAFE | SUSTAINABLE | ACCESSIBLE | KIND

GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

3.2

3.2 - FINANCE DEEP DIVE: WORKFORCE GRIP AND CONTROL AND WORKFORCE IMPROVEMENT PROGRAMME

Lisa Gostling (Hywel Dda UHB - Director of Workforce & OD/Deputy CEO)

For assurance

Attachments

Finance Deep Dive Workforce Variable Pay FPC 27 August 2026.pdf

Workforce Programme - Medical Workforce Variable Pay.pdf

Workforce Programme Theme 1 - Sickness Absence .pdf

Workforce Programme Theme 2 - Band 7 to 9 Utilisation.pdf

Workforce Programme Theme 3 - Administration and Clerical Workforce.pdf

Workforce Programme Theme 4 - Variable Pay Reduction.pdf

Workforce Programme Theme 5 - Establishment Control.pdf

Financial Grip and Control - Hywel Dda ARAC.pdf

Workforce Programme Theme 6 - OCP.pdf

Pwyllgor Cyllid a Pherfformiad/ Finance and Performance Committee

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	27 August 2026
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Workforce Grip and Control and Workforce Improvement Programme
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Lisa Gostling, Executive Director of Workforce and Organisational Development/Deputy Chief Executive
SWYDDOG ADRODD: **REPORTING OFFICER:**	Lisa Gostling, Executive Director of Workforce and Organisational Development/Deputy Chief Executive

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

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

A number of workforce measures are cause for concern within the Health Board which are impacting on our ability to deliver effective patient care, manage within our resources and ensure we have a sustainable workforce.

- Sickness absence continues to rise with some individuals remaining unwell for extended periods of time, and in some service areas rates as high as 14% are being recorded.
- Variable pay for nursing workforce continues to remain stable, agency has reduced but remaining usage is not further reducing, and hours utilised have been replaced with alternative temporary workers.
- Medical variable pay continues to increase and whilst success for some interventions linked with agency workers are evident the growing use on internal cover requires further scrutiny.
- The removal of in-month underspends expose budget and workforce misalignment and therefore establishments must be reviewed and refreshed.
- An increase in non-recurrent savings creates financial challenge each year and organisational restructures should support the delivery of recurrent savings.
- Bands 7 – 9 have grown at a rate higher than comparators across Wales and an understanding of this growth and therefore what actions if any need to be taken around growth needs to be better understood.

In addition to the above pressures a recent report around Grip and Control was presented to the Audit, Risk and Assurance Committee (ARAC) meeting on 7 May 2026, where a number of workforce specific gaps were highlighted.

The Finance and Performance Committee are asked to take assurance that gaps in controls will be closed alongside delivery of key actions described in the work programmes below.

Cefndir / Background

To meet growing demand and significant financial challenges, the Health Board must make the best possible use of all its resources, particularly its workforce. The programmes outlined in this report are intended to improve workforce sustainability, strengthen productivity and reduce avoidable expenditure, enabling us to protect services and continue investing in patient care. Improving attendance, workforce deployment and establishment management will help us create a more resilient organisation for our staff and the communities we serve. Managers are central to this work: creating capacity, supporting staff and delivering sustainable service improvement.

Following Executive Team discussion, a number of workforce improvement programmes have been identified to improve efficiency, productivity and financial sustainability. This briefing summarises the key workstreams and sets out where managers' support will be required to ensure they are delivered consistently and effectively.

Asesiad / Assessment

A workforce programme has been developed to undertake improvement and financial savings delivery linked to 6 areas which were also highlighted as areas of concern by NHS Performance and Improvement.

These themes are: -

- **Theme 1 – Sickness Absence Management**

  Sickness absence continues to rise, with long-term sickness absence being the main driver. A targeted approach is being taken to ensure that all staff who have been unwell for more than 12 months are actively engaged with Occupational Health, have regular sickness absence reviews in place, and are supported through active discussions about returning to their substantive role, moving to a suitable alternative role, or considering ill-health retirement where appropriate.

  All short-term sickness absence will be managed in accordance with the Attendance at Work Policy and the Programme group will focus initially on the top 10 wards/service areas where the largest reliance on temporary workforce is evident linked to sickness absence. Electronic Staff Records (ESR) audits will also be undertaken for all closed absences, and compliance gaps identified for managers to action. Managers will be expected to work with their workforce representatives to ensure timely reviews are in place and that appropriate action is taken to support attendance improvement.

- **Theme 2 – Band 7 to 9 Workforce Growth**

  Growth in the Band 7 to 9 workforce has highlighted the Health Board as an outlier across Wales. A review will therefore be undertaken across both clinical and non-clinical

roles to assess relevance, alignment and affordability. Where growth is considered to have been excessive, plans will be developed to support reduction over an agreed period. Managers will support this assessment and contribute to any resulting workforce plans.

- **Theme 3 – Administration and Clerical Workforce Growth**

  With effect from 1 September 2026, an external recruitment freeze will be introduced for all administration, clerical and management roles until the end of the financial year. Internal recruitment may continue, subject to careful consideration of the impact of any successful appointment. Where service managers consider a role essential to fill, the Financial Control Group will be re-established to review such requests on an exceptional basis.

- **Theme 4 – Variable Pay Reduction**

  Five sub-programmes will be established to further reduce temporary workforce expenditure, including agency, overtime, bank and additional hours, across the following staff groups:

  - Medical
  - Nursing and Healthcare Support Workers (HCSWs)
  - Ancillary and Estates
  - Allied Health Professions and Health Sciences
  - Administration and Clerical

  These groups will focus on efficient rostering practice and where appropriate targeted recruitment to reduce reliance on temporary workforce arrangements. No unplanned workforce growth will be permitted without approval through an agreed business case authorised by the Executive Team. Managers will support the relevant sub-programmes by ensuring robust rostering, vacancy management and temporary staffing controls are in place within their areas. It is intended in this work to also scope and introduce rostering to areas which require cover across extended working days/hours deem this to be essential.

- **Theme 5 – Workforce Controls (Establishment Control)**

  The Workforce Intelligence and Finance teams will begin a programme to review all establishments and staff in post, with a view to realigning budgets and WTE where appropriate. Once this review has been completed, consideration will be given to enabling establishment control in ESR to ensure vacancies are recruited only into funded establishments. Managers will be engaged in the review process to support the validation of establishment and staff-in-post data.

- **Theme 6 – Recurrent Savings Delivery (Organisational Change Process to deliver recurrent 5% CIP Savings**

All new Organisational Change Policy (OCP) processes will include a workforce impact assessment and a financial impact assessment within the documentation. Prior to formal consultation it will be expected all staff affected by the proposed change have been involved in a pre-OCP engagement exercise, enabling them to contribute to the future shape of the services in which they work. All OCPs will also be required to demonstrate a 5% recurrent cost improvement. Any proposed pay protection or increased travel expenses will also be considered as part of the sign-off process with workforce and finance colleagues. Once supported by both teams, the proposal will be submitted to the Director of Workforce and Organisational Development and the Director of Finance for final financial approval.

Within the work programmes for the six themes all of the outstanding grip and control measures in the paper at **Appendix 1** have been incorporated into the 30, 60 and 90 actions. The only remaining gap in control links to inconsistent mileage and travel allowances. This will be further explored and built into a monthly reporting of high expenditure categories. Also attached are the draft programme outlines which are being constantly updated and will be finalised in the first meetings of each group over coming weeks. An example of a professional specific plan for medical workforce is also attached to support Theme 4.

It is intended the programme plans for the above themes will be reported to future Finance and Performance Committee meetings as required.

Argymhelliad / Recommendation

The Finance and Performance Committee are asked to **RECEIVE ASSURANCE** that work is underway to address the grip and control gaps.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cylch Gorchwyl y Pwyllgor: Committee ToR Reference:	The Committee will, in respect of its provision of advice and assurance to the Board: 3.1.1 Receive assurances on the financial governance and control environment in operation across the Health Board. This will be achieved a programme of deep dive reviews into the following themes, which mirror the national Value and Sustainability Board: 3.1.1.1 Workforce 3.1.1.2 Non-pay and procurement
Cyfeirnod Cofrestr Risg Datix, Teitl a Sgôr Risg Cyfredol: Datix Risk Register Reference and Score:	Numerous risks noting workforce availability and financial
Parthau Ansawdd: Domains of Quality	7. All apply

Quality and Engagement Act (sharepoint.com)	
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	6. All Apply
Amcanion Strategol y BIP: UHB Strategic Objectives:	1. Striving teams 3. Great care
Nodau Cynllunio 2026/27 Planning Goals 2026/27	1. Healthy, Thriving Teams
Hypergyswllt i Amcanion Llesiant HDdUHB 2026 Hyperlink to HDdUHB Well-being Objectives 2026	3. Create people-centred employment and development opportunities that support workforce transformation, reflect the changing needs of 4. Create an inclusive culture where every voice matters, individual needs are considered and staff well-being is promoted and supported 5. Foster a learning culture by sharing knowledge and applying new ways of working that enhance local and global well-being
Model Cymdeithasol ar gyfer Iechyd a Llesiant: (wedi'i gwblhau ar gyfer newid strategol a/neu newidiadau sylweddol i wasanaethau) A Social Model for Health and Wellbeing: (*complete for strategic change and/or significant service changes)*	1. A Social Model for Health and Wellbeing will complement and integrate with other ways of working, values, principles and objectives.
Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	NHS Performance & Improvement workforce analysis Interrogation of ESR, rostering systems and financial systems to cross reference deliverables
Rhestr Termau:	Contained within the body of the report.

Glossary of Terms:	
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y cyfarfod hwn: Parties / Committees consulted prior to this meeting:	People, Organisational Development and Culture Committee (PODCC) Trade Union Colleagues Workforce and Organisational Development Teams Executive Team

Effaith: (rhaid cwblhau) **Impact: (must be completed)**	
Ariannol / Gwerth am Arian: **Financial / Service:**	Reduction in variable pay expenditure Reduction in substantive pay expenditure Improvement in recurrent savings identified
Ansawdd / Gofal Claf: **Quality / Patient Care:**	All variable pay changes will be linked with reducing absence and improving compliance with rosters therefore no impact on quality of patient care. For admin and clerical any impact will be assessed should a risk be identified by managers. Quality Impact Assessment Template
Gweithlu: **Workforce:**	Increased involvement in Organisational change Reduction in sickness absence will ensure staff supported at earlier stages Better work life balance with reduced additional hours Improved equality with high cost agency reduction
Tegwch Iechyd: **Health Equity:**	Not Applicable
Risg: **Risk:**	Risks for each programme have been identified in each programme plan and will be constantly monitored

Cyfreithiol: **Legal:**	None Expected
Enw Da: **Reputational:**	No negative impact expected improvement if reduce variable pay and improve financial position and patient care
Gyfrinachedd: **Privacy:**	Not Applicable
Cydraddoldeb: **Equality:**	Will be undertaken in programme groups • Has EqIA screening been undertaken? /No (if yes, please supply copy, if no please state reason) • Has a full EqIA been undertaken? Yes/No (if yes please supply copy, if no please state reason) <u>Equality Impact Assessment</u>

Workforce Programme Delivery Plan

Project title	**Medical Workforce Model Programme: understanding and right-sizing the medical workforce model**
Executive sponsor	Director of Workforce and Organisational Development/Deputy CEO
Senior responsible owner	Executive Medical Director and Director of Workforce and Organisational Development, with final confirmation through Executive Team/Community and Integrated Medicine Clinical Care Group governance
Project lead	Programme Manager, supported by Medical Workforce, Workforce Planning, Finance, BI/Data, Job Planning, Rostering/Allocate and CCG operational leads
Start date	1 August 2026
Review dates	Day 30: 31 August 2026 | Day 60: 30 September 2026 | Day 90: 30 October 2026
Strategic alignment	Workforce Stabilisation Programme: medical workforce stabilisation, re-patterning and future reconstitution aligned to site requirements, specialty service provision, population need, quality, safety, finance and clinical sustainability.
Project Team	Medical Directorate, Clinical Care Groups, Workforce Planning, Medical Workforce, Finance, BI/Data Analytics, Job Planning, Medical Rostering/Allocate, Planning, Transformation, Public Health and Professional Leads
Expected WTE/£ outcome	Targeted reduction in agency, locum and additional duty hours spend through conversion of appropriate non-recurrent variable pay into recurrent substantive capacity; initial opportunity to analyse £6.8m variable spend above WTE budget and £2.5m overspend.

PROJECT DASHBOARD | 30, 60 AND 90 DAY DELIVERY VIEW			
Project	**Overall outcome**	**Overall RAG [R / A / G]**	**Programme ask**
Day 30: Mandate, governance and engine room • Secure Executive Team approval to establish a formal Health Board medical workforce model programme. • Confirm SRO, clinical, workforce, finance, planning, BI,	**Day 60: Baseline, data quality and spend intelligence** • Build a "good enough" baseline by specialty and site covering funded establishment, staff in post, sessions, cost codes, job plans, rotas, vacancies, locum, agency, additional hours,	**Day 90: Heatmap, stabilisation and design decisions** • Produce a medical workforce fragility heatmap scoring rota gaps, on-call fragility, inpatient cover risk, agency/locum dependency, vacancies, training risk, job planning	**Programme ask / key delivery focus** • Approve the programme as formal Health Board work, linked to workforce programme • Identify team to support with analytics, workforce, finance, job planning and

operational and medical staffing leads. • Agree the programme is a joint quality, safety, finance, operational and clinical sustainability programme. • Set up a bi-weekly delivery group with programme manager, Medical Workforce, Workforce Planning, Finance, BI/data, Allocate, job planning, CCG and Clinical Director representation. • Agree priority specialty selection criteria, including highest locum/agency spend, fragile rotas, consultant or SAS gaps, high operational risk, lost sessions and quality or safety concerns. Status: [R/A/G]	retirements, resignations and retained sessions. • Create a live data quality log for generic cost coding, lost or reduced sessions, inconsistent sessional recording, unmapped locum spend, job plan/service mismatch and rota data not linked to establishment. • Assign each data issue an owner, deadline and decision route. • Analyse the £6.8m variable spend above WTE budget and £2.5m overspend by specialty, site, grade, reason, recurrence and link to rota gaps or lost establishment. • Begin rota, job planning and Allocate reconciliation for priority specialties. **Status:** [R/A/G]	compliance, leadership capacity, quality and safety concerns and financial overspend. • Agree stabilisation plans for highest-risk areas, including substantive conversion options, protection or repurposing of retiring/resigning sessions, targeted recruitment, fixed-term clinical fellow or specialty doctor posts, rota redesign, agency exit plans and job plan reviews. • Create a ranked list of opportunities where recurrent investment could reduce premium temporary spend and improve safety, continuity and value. • Prepare first specialty-level cases for change covering service requirement, population need, standards, demand, rota requirement, spend, workforce risk, quality and safety impact, future options	rostering capacity. • Prioritise the first tranche of fragile specialties rather than attempting to review every specialty at equal depth immediately. • Support transparent clinical engagement: recognise service fragility, reduce dependence on goodwill and protect substantive clinical capability. • Use the first 90 days to stabilise fragile services, build the evidence base and start future model redesign specialty by specialty.

		and implementation route. • Set up clinical design workshops and agree explicit decisions for each priority specialty: stabilise now, redesign before investment, convert temporary spend, stop/reduce unsustainable activity, develop Horizon 2 model or escalate. **Status:** [R/A/G]	

KPI SCORECARD				
Measure	**Baseline**	**Current**	**Target by Day 90**	**Trend / RAG**
Validated workforce baseline by site, specialty, grade, session and cost code	No single trusted baseline	Baseline build to commence	Good-enough baseline completed for first tranche priority specialties	→ A
Medical variable pay and agency spend analysis	£6.8m variable spend above WTE budget and £2.5m overspend to be analysed	Finance/workforce dataset to be established	Analysis by specialty, site, grade, reason code and run-rate completed	→ A
Fragility heatmap for priority services	Fragility currently surfaced through individual escalations	Priority criteria to be agreed	Heatmap reviewed by Programme Board and Executive Team	→ A
Priority specialties with stabilisation plans	Plans not yet standardised	First tranche to be identified	Approved stabilisation actions for highest-risk services	→ A
Job planning, rota and Allocate reconciliation	Variable alignment between job plans, sessions, rotas	Data sources identified	Reconciliation completed for priority services	→ A

	and funded establishment			

PROGRAMME GROUP ATTENTION AREAS		
Top risks **1. [Insert risk]** **2. [Insert risk]** **3. [Insert risk]** Highest score: **[Insert]**	**Mitigations and controls** 1. [Insert mitigation] 2. [Insert mitigation] 3. [Insert mitigation] **Owner:** [Insert]	**Decisions / support required** 1. [Insert decision] 2. [Insert support needed] 3. [Insert escalation] **Due by:** [Insert]

NEXT REPORTING PERIOD			
Priority action	**Owner**	**Due date**	**Success measure**
[Insert]	[Insert]	[Insert]	[Insert]
[Insert]	[Insert]	[Insert]	[Insert]
[Insert]	[Insert]	[Insert]	[Insert]

PROGRAMME DEFINITIONS	
Problem or opportunity	Hywel Dda requires a formal Health Board programme to understand and right-size the medical workforce model across sites and specialties. Current arrangements are creating fragile services, reliance on goodwill, additional hours, locum and agency support, loss of substantive capability through historic cost coding, and insufficient visibility of sessions, rotas, establishment, service demand and population need. The opportunity is to stabilise the current position, re-pattern Horizon 2 service elements and reconstitute a sustainable future medical operating model.
Benefits expected	A single trusted medical workforce baseline; improved data integrity by specialty, site, grade, session, job plan, rota, cost code and funding source; clearer priority risks through a fragility heatmap; reduced dependency on variable pay, agency and locum cover; better alignment between budget, establishment and clinical service requirements; evidence-based specialty cases for change; improved job planning and rota assurance; and a future model informed by population need, Royal College standards, OrgVue/Health Dynamics modelling and mixed medical workforce options.
Success criteria	By Day 90 the programme has an agreed mandate, SRO, governance route, workstreams, priority specialties, delivery timetable, initial baseline dataset, data quality plan, variable pay analysis, rota/job plan reconciliation for priority areas, and first service fragility heatmap. By 12 months the programme has delivered validated baselines, specialty

	stabilisation plans, cases for change, establishment options, benefits reporting, reduced avoidable variable spend trajectory and a forward roadmap for Horizon 2 re-patterning and future operating model reconstitution.
Scope	In scope: medical workforce across Health Board sites and specialties, including on-call and inpatient cover, specialty service provision, job planning, rostering, Allocate data, sessional recording, cost coding, variable pay, agency/locum spend, retirements/resignations, consultant, SAS, resident doctor, locally employed doctor, IMG, PA, ACP and wider multidisciplinary contribution, priority specialty stabilisation, pathway re-patterning and future workforce model design. Out of scope for the first 90 days: full implementation across every specialty, final long-term new hospital operating model decisions, and recurrent investment decisions without completed evidence, modelling and governance approval.
Key dependencies	Executive Team/CIMCG approval; named SRO and programme support; clinical engagement through Medical Directorate, Clinical Directors and CCG leadership; finance, workforce, BI/data analyst, job planning and rostering/Allocate capacity; access to accurate workforce, finance, activity, rota and job plan data; OrgVue/Health Dynamics outputs; agreement of data definitions and coding corrections; alignment with planning, transformation, public health and future clinical strategy; and timely decision-making on stabilisation, redesign and investment choices.

RISKS & MITIGATIONS							
Risk	Cause	Impact if unmanaged	Current score	Mitigation / control	Owner	Target score	Review date
Data quality is insufficient to support robust decisions	Inconsistent specialty coding, generic cost codes, poor sessional recording and disconnected workforce, finance, rota and job planning data.	Incorrect establishment conclusions, weak clinical confidence and delayed investment or redesign decisions.	4 x 4 = 16	Agree data definitions, create a live data quality log, prioritise correction of specialty coding and sessional recording, and sign off baselines with CCGs and Finance.	BI/Data, Workforce Planning and Finance leads	3 x 3 = 9	Day 30 and monthly thereafter

Clinical engagement is inconsistent	Clinical colleagues are sustaining fragile services and may experience programme work as additional pressure unless purpose, benefits and decision routes are clear.	Delay, challenge to recommendations, weak ownership and missed opportunities to redesign services safely.	4 x 3 = 12	Use Clinical Directors as workstream partners, provide transparent specialty-level data, involve clinicians in model design and communicate that the programme is about sustainability, safety and fair evidence-based decisions.	Executive Medical Director, CCG Directors and Clinical Directors	3 x 2 = 6	Day 60 and monthly thereafter
Financial constraints limit conversion of temporary spend into substantive capacity	Recurrent investment decisions may be constrained despite evidence of sustained variable pay, agency and locum expenditure.	Continued reliance on premium temporary staffing, rota fragility and reduced value, continuity, quality and safety.	5 x 4 = 20	Analyse £6.8m variable spend above WTE budget and £2.5m overspend by specialty, site, grade and reason; prioritise investment where safety, sustainability, productivity and value benefits are clear.	Director of Finance, Workforce Planning and Medical Staffing leads	4 x 3 = 12	Day 60 and monthly thereafter

Operational pressures reduce programme capacity and pace	Programme work may be delivered on top of business as usual without dedicated programme management, analytics and workstream capacity.	Programme drift, delayed baseline, slower stabilisation action and reduced confidence from Executive Team and clinical services.	4 x 4 = 16	Secure dedicated programme support, agree workstream leads, establish weekly delivery grip, maintain risk and decision logs, and escalate slippage through Executive governance.	SRO and Programme Manager	3 x 3 = 9	Day 30 and monthly thereafter
Future operating model uncertainty delays necessary stabilisation decisions	Longer-term clinical strategy and new hospital assumptions may create uncertainty about future site and specialty configuration.	Fragile services remain unsupported while awaiting strategic clarity, increasing risk of service collapse or further agency dependency.	4 x 3 = 12	Separate immediate stabilisation from future reconstitution, use adaptable scenario modelling, and require explicit programme board decisions for stabilise now, redesign before investment, convert spend, stop activity or escalate risk.	Executive Medical Director, Planning and Transformation leads	3 x 2 = 6	Day 90 and monthly thereafter

GOVERNANCE, ASSURANCE & ESCALATION

Governance route	Programme delivery group reports to the Medical Workforce Model Programme Board, chaired by the confirmed SRO. Escalation and assurance route to Executive Team/CIMCG, with onward reporting to the relevant Board committee for quality, safety, workforce, finance and clinical sustainability matters. Workstream reporting to cover governance and assurance; data, analytics and modelling; operational stabilisation; job planning, rostering and Allocate; finance and establishment; and future clinical and workforce model design.
Review frequency	Weekly delivery group to maintain grip on actions, risks, decisions and data issues. Monthly Programme Board review of highlight report, KPI dashboard, risk register, decision log, benefits tracker and workstream progress. Day 30, Day 60 and Day 90 formal reviews to confirm mandate, baseline progress, fragility heatmap, stabilisation actions and next-phase priorities.
Escalation triggers	Escalate where there is unmanaged rota or on-call fragility; inpatient cover risk; reliance on agency, locum or additional hours without an exit plan; loss of substantive sessions or inability to advertise substantive posts; material data quality barriers; financial decisions required to convert temporary spend into substantive capacity; risks to training, quality, safety, performance or clinical sustainability; or slippage against Day 30, Day 60 or Day 90 milestones.
Decision points	For each priority specialty the Programme Board should make explicit decisions to stabilise now, redesign before investment, convert repeated temporary spend into substantive capacity, protect or repurpose retiring/resigning sessions, stop or reduce unsustainable activity, develop a Horizon 2 model, or escalate to Executive Team where risk cannot be managed within current resources. Investment decisions should be supported by workforce, finance, activity, job planning, rota and clinical risk evidence.
Assurance evidence	Approved programme mandate and terms of reference; named SRO and workstream leads; delivery plan; risk register; decision log; dependency map; benefits framework; validated workforce baseline by site and specialty; data quality log; variable pay and agency spend analysis; rota, job plan and Allocate reconciliation; service fragility heatmap; specialty stabilisation plans; cases for change; OrgVue/Health Dynamics modelling outputs; monthly KPI dashboard and benefits report.

DAY 90 REVIEW & NEXT STEPS	
Overall delivery assessment	By Day 90 the programme should be in mobilisation and early delivery, with the mandate, SRO, governance route, workstreams and priority specialties agreed. The key test of progress will be whether the programme has moved from individual service escalations to a structured Health Board framework with an initial workforce baseline, first data quality actions, variable pay analysis, rota/job plan reconciliation and a first fragility heatmap to inform stabilisation decisions.
Benefits delivered	Expected Day 90 benefits include clearer Executive visibility of the most fragile site and specialty risks; an agreed first tranche of priority specialties; improved understanding of variable pay, agency, locum and additional duty hours drivers; early identification of coding and sessional recording issues; initial alignment between job plans, rotas,

	Allocate and funded establishment; and a more transparent basis for deciding where to stabilise, redesign or develop specialty-level cases for change.
Outstanding actions	Outstanding actions are likely to include completing validation of the baseline across additional specialties; closing priority data quality issues; developing approved stabilisation plans for the highest-risk services; confirming agency exit opportunities and recurrent investment options; completing the first tranche of specialty cases for change; progressing swim-lane mapping of site-based, networked and community-based activity; and incorporating OrgVue/Health Dynamics outputs into establishment and skill-mix modelling.
Lessons learned	Early learning is expected to show that the programme cannot be delivered through goodwill alone and requires dedicated programme, analytics, finance, workforce and clinical capacity. Data correction should happen alongside delivery rather than as a pre-condition to action. Clinical engagement will be strongest where specialty-level data is transparent, risks are recognised honestly, and decisions are framed around safety, sustainability, fair use of resources and protection of substantive clinical capability.
Recommendation	Continue the programme into the next 9 months with a formal Programme Board, monthly benefits reporting and explicit decision-making for each priority specialty. The recommended next phase is to move from mobilisation into stabilisation and design: approve immediate mitigations for fragile services, complete specialty cases for change, test mixed medical workforce options, convert appropriate temporary spend into substantive capacity where justified, and develop the Horizon 2 re-patterning and future operating model roadmap.

Workforce Programme Delivery Plan – Theme 1

Project title	Absence grip and control:
Executive sponsor	Director of Workforce and Organisational Development/Deputy CEO
Senior responsible owner	To be confirmed through Workforce Programme governance
Project lead	
Start date	1 August 2026
Review dates	Day 30: [date] | Day 60: [date] | Day 90: [date]
Programme Outline	Workforce Stabilisation Programme: absence grip and control, with focus on action, ownership, validation and delivery grip.
Project Team	Workforce team, Occupational Health, Service Managers, Workforce Intelligence Team
Expected WTE/£ outcome	£4.3m @ 5.7% rising to £7.36m @ 5% sick pay opportunity saving 67 wte LTS, plus 14.42wte RN & 15.3wte HCSW. Overall reduction circa 97wte

PROJECT DASHBOARD | 30, 60 AND 90 DAY DELIVERY VIEW			
Project Absence grip and control	**Overall outcome** By Day 90, long-term sickness and priority absence cohorts will have named review actions, occupational health follow-up controls, validated reporting and clear return-to-work or exit plans for all absences over 12 months.	**Overall RAG** **[R / A / G]**	**Programme ask** Confirm owner support across Occupational Health and Heads of Workforce, agree validation report requirements, and escalate barriers to progressing long-term sickness, no pay and half pay cases.
Day 30: Understanding & Quick Wins • Identify delayed processes linked to sickness absence • Review and develop plan for all long-term sickness absences	**Day 60: Implementation of medium term actions** • Complete defined actions for long-term sickness reviews • Commence flu vaccination outreach and proactively invite	**Day 90: Evidence of progress and commencement long term actions** • Evidence reductions in out-of-pay, approaching-no-pay and half-pay sickness numbers	**Key delivery focus** 1. Long-term sickness case review grip 2. Occupational Health report and restriction follow-up 3. Validation of absence reasons, sickness cohorts and vaccination uptake

• Promote as part of maternity risk assessment occupational health physio service • Validate absence reason reporting • Audit & escalate Occ Health reports not opened within 30 days of issue to manager • Rolling plan for sickness absence audits to be undertaken to identify timeliness to enter sickness absence information on ESR. (G&C 3.1.1) • Status: [R/A/G]	all staff for vaccine who have been unwell due to cough, cold and flu. • Follow up process to review all restrictions linked to sickness reviews to ensure timely closure. • Confirm RTW or exit plans for all absences over 12 months • Develop protocol for entering sickness absence into ESR (G&C 3.1.2) • Introduce regular monitoring of annual leave (G&C 3.1.3) **Status:** [R/A/G]	• Reduction in sickness rate movement • Increase flu vaccination uptake • Sickness audits completed for Long term absences • Audit retrospective absences entered on ESR (G&C 3.1.4) • Consider how medical leave will be monitored (G&C 3.1.5) • Sickness audits commenced and outcomes reported into CCG Delivery Meetings **Status:** [R/A/G]	

KPI SCORECARD				
Measure	**Baseline @ 30/6/26**	**Current**	**Target by Day 90**	**Trend / RAG**
In Month Sickness %	6.73%	[Insert]	[Insert]	[↑ / → / ↓] [R/A/G]
Rolling Sickness %	6.80%	[Insert]	[Insert]	[↑ / → / ↓] [R/A/G]
Long Term Sickness %	[Insert]	[Insert]	[Insert]	[↑ / → / ↓] [R/A/G]
Short Term Sickness %	[Insert]	[Insert]	[Insert]	[↑ / → / ↓] [R/A/G]
Flu Vaccination uptake %	[Insert]	[Insert]	[Insert]	[↑ / → / ↓] [R/A/G]
Employment Restrictions in place				

PROGRAMME GROUP ATTENTION AREAS		
Top risks **1. Pembrokeshire County (7.80%) & WGH (8.03%)** **2. Carmarthenshire County (9.02%) & GGH (7.95%)/PPH (9.57%)** **3. Public Health (13.06%)** Highest score: **[Insert]**	**Mitigations and controls** 1. [Insert mitigation] 2. [Insert mitigation] 3. [Insert mitigation] **Owner:** [Insert]	**Decisions / support required** 1. [Insert decision] 2. [Insert support needed] 3. [Insert escalation] **Due by:** [Insert]

NEXT REPORTING PERIOD			
Priority action	**Owner**	**Due date**	**Success measure**
[Insert]	[Insert]	[Insert]	[Insert]
[Insert]	[Insert]	[Insert]	[Insert]
[Insert]	[Insert]	[Insert]	[Insert]

PROGRAMME DEFINITIONS	
Problem or opportunity	The project responds to the need for sharper operational grip on sickness absence, particularly long-term sickness, delayed sickness processes, unopened Occupational Health reports, restriction follow-up, out-of-pay, approaching-no-pay and half-pay cases.
Benefits expected	Expected benefits include clearer case ownership, faster progression of long-term sickness reviews, better use of Occupational Health advice, improved sickness reporting intelligence, increased flu vaccination uptake and stronger controls to support total sickness rate reduction.
Success criteria	Success by Day 90 will be evidenced by defined actions for all long-term sickness cases, efficient use of Occupational Health reports, closure process for temporary role restrictions, validated sickness reason reporting, reductions in priority sickness cohorts and RTW or exit plans for all absences over 12 months.
Scope	In scope: delayed sickness processes, long-term sickness case review, Occupational Health reports, maternity risk assessment links to OH physiotherapy support, cough/cold/flu vaccination outreach, restriction follow-up and priority sickness cohorts. Out of scope: wider absence policy redesign as subject to all Wales policy review process.
Key dependencies	Key dependencies include Occupational Health capacity, Heads of Workforce support, accurate short-term and long-term sickness reason reporting, manager engagement with OH reports, sickness reviews being arranged by managers, flu vaccination access and timely escalation routes for blocked cases.

RISKS & MITIGATIONS							
Risk	Cause	Impact if unmanaged	Current score	Mitigation / control	Owner	Target score	Review date
Operational capacity to progress case reviews at pace	Occ Health, Heads of Workforce and managers may have competing priorities.	Delayed employee processes continue and long-term cases do not progress.	[I x L = score]	Prioritise long-term sickness and priority cohorts; agree named owners; review weekly; escalate blocked cases through Programme	HH	[Insert]	[Insert]
Absence reason data is incomplete or not sufficiently segmented	Short-term and long-term sickness reasons may not be reported consistently.	Actions may not target the right cohorts and benefits cannot be evidenced.	[I x L = score]	Produce and validate sickness reason report split by short-term and long-term absence; agree data owner and reporting rhythm.	TW	[Insert]	[Insert]
Managers do not act on Occupational Health advice promptly	Occupational Health reports may remain unopened or restrictions may not be followed up.	Return-to-work progress stalls and restrictions remain open longer than necessary.	[I x L = score]	Review unopened OH reports over a 30-day period and put follow-up process in place for	HH	[Insert]	[Insert]

				sickness reviews where restrictions are suggested.			
Vaccination outreach does not reach target absence cohort	Staff recently absent with cough, cold or flu may not be proactively invited for flu vaccination.	Opportunity to reduce future preventable absence is missed.	[I x L = score]	Define target cohort, confirm invite route, monitor uptake and report increased flu vaccination uptake as a Day 90 measure.	HH	[Insert]	[Insert]
RTW or exit plans are not completed for absences over 12 months	Complex long-term cases may lack clear progression, decision-making or escalation.	Extended absence continues without clear route to resolution.	[I x L = score]	Establish case-by-case RTW or exit plans for all absences over 12 months, with escalation route for blocked decisions.	HH	[Insert]	[Insert]

HH – Heather Hinkin TW – Tracy Walmsley

GOVERNANCE, ASSURANCE & ESCALATION	
Governance route	Workforce Programme governance, supported by Workforce & OD SLT escalation route
Review frequency	Weekly action review, with fortnightly Workforce & OD SLT review and monthly executive or finance check where escalation is required.
Escalation triggers	Escalate where sickness processes remain delayed, Occupational Health reports are unopened, restrictions are not closed, RTW or exit plans are blocked, or priority sickness cohorts do not show improvement.

Decision points	Day 30: confirm baseline, cohort lists, owners and validation route. Day 60: confirm case review progress, OH follow-up and vaccination outreach. Day 90: confirm sickness cohort movement, total sickness rate movement and RTW or exit plans for absences over 12 months.
Assurance evidence	Action log, short-term and long-term sickness reason report, long-term sickness case review tracker, unopened OH report review, restriction follow-up tracker, flu vaccination uptake report and Day 90 sickness cohort movement summary.

DAY 90 REVIEW & NEXT STEPS	
Overall delivery assessment	At Day 90, assess whether absence grip and control is on track by confirming completion of priority reviews, effectiveness of OH follow-up controls, movement in priority sickness cohorts, increased flu vaccination uptake and completion of RTW or exit plans for all absences over 12 months.
Benefits delivered	Benefits to be evidenced through validated sickness reason reporting, reduced numbers in out-of-pay, approaching-no-pay and half-pay cohorts, total sickness rate movement, increased flu vaccination uptake and completed RTW or exit plans.
Outstanding actions	List any unresolved cases, unopened reports, restriction follow-ups, validation gaps or blocked RTW/exit decisions, with owner and due date.
Lessons learned	Capture which controls created the most traction, where manager support was most effective, where data quality limited progress and which escalation routes need to be retained.
Recommendation	Embed controls into business as usual if evidence demonstrates progress; continue for a further 90 days if cohort movement, validation or RTW/exit planning remains incomplete. Define next set of actions to further reduce absence.

Workforce Programme Delivery Plan – Theme 2

Project title	**Band 7–9 Utilisation Programme**
Executive sponsor	Director of Workforce and Organisational Development/Deputy CEO
Senior responsible owner	Assistant Director of People Planning
Project lead	
Start date	1 August 2026
Review dates	Day 30: [date] | Day 60: [date] | Day 90: [date]
Programme Outline	Workforce Stabilisation Programme: Band 7 to 9 Utilisation, with focus on action, ownership, validation and delivery grip.
Project Team	Workforce Intelligence, Finance, Value Based Healthcare
Expected WTE/£ outcome	Not planned at present outcome may be clarity of resource/skill mix but could result in changes to skill mix in areas.

PROJECT DASHBOARD | 30, 60 AND 90 DAY DELIVERY VIEW			
Project **Band 7–9 utilisation**	**Overall outcome** Clear clinical and corporate review programme established to understand Band 7–9 utilisation, test value, identify controls and agree any viable workforce options including where appropriate VER	**Overall RAG** **[R / A / G]**	**Programme ask** Confirm scope, data cut, working group membership, value assessment approach and decision route for controls.
Day 30: Understanding & Quick Wins • Establish Band 7–9 working group with clinical and corporate workstreams. • Complete initial data cut and deeper analysis of Band 7–9 workforce profile, growth,	**Day 60: Implementation of medium term actions** • Undertake service deep dives across agreed clinical and corporate areas. • Complete assessment of value, contribution and alignment to workplans.	**Day 90: Evidence of progress and commencement long term actions** • Implement agreed controls and protocols for Band 7–9 establishment changes, recruitment and role review. • Complete first cycle of value reviews and confirm options	**Key delivery focus** 1. Develop evidence base and value proposition. 2. Separate clinical and corporate analysis. 3. Translate learning into practical controls, protocols and decision points.

vacancies, costs and deployment. • Agree value assessment criteria and prioritise services for deep dive. Status: [R/A/G]	• Identify early controls and protocols based on learning from the first reviews. **Status:** [R/A/G]	requiring executive decision. • Consider VER where supported by evidence, affordability and service impact assessment. • Establish ongoing monitoring route for utilisation, value and compliance with agreed controls. **Status:** [R/A/G]	

KPI SCORECARD				
Measure	**Baseline**	**Current**	**Target by Day 90**	**Trend / RAG**
Clinical Band 7–9 workforce	Not yet established	To be confirmed at Day 30	Validated data pack available and signed off by Workforce Intelligence and Finance	[↑ / → / ↓] [R/A/G]
Corporate Band 7-9 workforce	0 services reviewed	To be confirmed	Priority deep dives completed with findings and actions recorded	[↑ / → / ↓] [R/A/G]

PROGRAMME GROUP ATTENTION AREAS		
Top risks **Highest score:** To be scored at working group	**Mitigations and controls**	**Decisions / support required**

NEXT REPORTING PERIOD			
Priority action	**Owner**	**Due date**	**Success measure**

PROGRAMME DEFINITIONS	
Problem or opportunity	Band 7–9 utilisation plan is not yet developed. There is a need to define scope, complete a robust workforce and finance data cut, understand clinical and corporate utilisation, and test the value delivered by roles against service, productivity and leadership requirements.
Benefits expected	Improved understanding of Band 7–9 deployment, clearer controls for growth and establishment changes, evidence-based decisions on role value, and options to reduce cost or release productivity where appropriate.
Success criteria	Working group established; data pack validated; clinical and corporate deep dives completed; value proposition agreed; controls and protocols drafted; decision options prepared for approval by Day 90.
Scope	All Band 7–9 roles in agreed clinical and corporate areas, including workforce growth, vacancy, cost, productivity and leadership utilisation. Excludes decisions outside the agreed governance mandate unless escalated.
Key dependencies	Workforce Intelligence data quality, Finance validation, Value Based Healthcare input, operational engagement, clinical and corporate leadership participation, governance decision route and any organisational policy requirements for VER or establishment controls.

RISKS & MITIGATIONS							
Risk	Cause	Impact if unmanaged	Current score	Mitigation / control	Owner	Target score	Review date
Unclear value proposition for Band 7–9 roles	Role contribution, leadership value and productivity impact are not consistently evidenced.	Poorly evidenced decisions, limited delivery grip and risk of challenge from services or staff side.	[I x L = score]	Agree value framework, triangulate workforce, finance and operational evidence, and apply consistently through deep dives.	TW	[Insert]	[Insert]
Loss of focus or disregard for agreed workplan	Competing operational priorities and unclear ownership slow progress.	Actions drift beyond 90 days and controls are not implemented at pace.	[I x L = score]	Fortnightly working group, action log, named owners, escalation	Working group chair	[Insert]	[Insert]

				to W&OD SLT where progress stalls.			
Data quality gaps undermine analysis	Workforce, finance and operational datasets may not align or may be incomplete.	Decisions may be delayed or based on incomplete evidence.	[I x L = score]	Early data validation by Workforce Intelligence and Finance, with issues logged and resolved before formal decision-making.	TW	[Insert]	[Insert]
			[I x L = score]		[Insert]	[Insert]	[Insert]
			[I x L = score]		[Insert]	[Insert]	[Insert]

TW – Tracy Walmsley

GOVERNANCE, ASSURANCE & ESCALATION	
Governance route	Band 7–9 Utilisation Working Group reporting into Workforce Programme Group, with escalation to Executive Team and Finance where approval or strategic decisions are required.
Review frequency	Weekly action tracking during the first 30 days, fortnightly working group review, monthly Workforce Programme Group progress and benefits check.
Escalation triggers	Data cannot be validated; services do not engage in deep dives; proposed controls require executive approval; potential VER options emerge; risks to service quality, safety or workforce relations are identified.
Decision points	Confirm programme scope and working group membership; agree value assessment criteria; approve control protocols; determine whether any VER-related options should be developed further.
Assurance evidence	Validated workforce and finance data pack; clinical and corporate deep-dive outputs; value assessment records; working group action log; decision log; draft controls and protocols.

DAY 90 REVIEW & NEXT STEPS	
Overall delivery assessment	At day 90 have a clear clinical and corporate understanding of Band 7–9 utilisation which has tested value, implemented controls and undertaken actions to change shape including where appropriate VER
Benefits delivered	Clear plan in place for existing roles at band 7 – 9 with clear articulation of how roles at this level are replaced or enhanced within the HB.

Outstanding actions	It is anticipated all actions will be complete but any outstanding actions at day 90 will form of phase 2 of the programme
Lessons learned	Capture which controls created the most traction, where manager support was most effective, where data quality limited progress and which escalation routes need to be retained.
Recommendation	Embed controls into business as usual if evidence demonstrates progress; continue for a further 90 days if cohort movement, validation or plans remain incomplete. Define next set of actions to further develop this cohort of workforce.

Workforce Programme Delivery Plan – Programme 3

Project title	**Admin & Clerical workforce: external recruitment control, exceptions, redeployment and spend reduction**
Executive sponsor	Director of Workforce and Organisational Development/Deputy CEO
Senior responsible owner	To be confirmed through Workforce Programme governance
Project lead	
Start date	1 August 2026
Review dates	Day 30: [date] | Day 60: [date] | Day 90: [date]
Programme Outline	Workforce Stabilisation Programme: Administration and Clerical workforce control, including the six-month external recruitment ban from 1 September 2026, internal recruitment, exception governance, fixed-term/secondment review, redeployment and overtime grip.
Project Team	Workforce and Organisational Development, Trade Union representatives, Communications Team, CCG leads, Recruitment, Finance, operational managers and Workforce Intelligence
Expected WTE/£ outcome	Indicative opportunity to reduce Administration and Clerical WTE and spend, aligned to the stated £1m part-year effect / 67.9 WTE assumption for Administration and Clerical workforce controls; figures require validation through turnover, vacancy and finance analysis.

PROJECT DASHBOARD | 30, 60 AND 90 DAY DELIVERY VIEW			
Project	**Overall outcome**	**Overall RAG [R / A / G]**	**Programme ask**
By Day 30: Set control framework and evidence base • Confirm scope of A&C roles covered by recruitment control. • Agree process and decision route for essential-role exceptions. • Develop communication plan for managers, staff	**By Day 60: Implement recruitment, redeployment and contract controls** • Launch internal recruitment process and exceptions panel/approval route. • Undertake review of fixed-term contracts and secondments, with agreed end, extension or	**By Day 90: Evidence reduction in WTE and spend** • Confirm reduction in external recruitment activity and report exceptions approved. • Demonstrate movement in A&C WTE, vacancy, turnover and spend run-rate.	**Key delivery focus** • Apply recruitment controls consistently while protecting essential service delivery. • Use internal recruitment and redeployment to fill priority A&C roles. • Validate turnover, WTE, overtime and spend

and Trade Union partners. • Establish baseline for A&C vacancies, turnover, fixed-term contracts, secondments and overtime. Status: [R/A/G]	redeployment decisions. • Commence redeployment of individuals into priority A&C roles. • Review overtime for Agenda for Change roles and agree controls by service area. • Consider VER to further support reduction in A&C workforce in targeted areas **Status:** [R/A/G]	• Embed redeployment, internal recruitment and overtime controls into routine governance. • Review workforce impacts, including sickness and staff survey indicators, and agree next phase. • VER process commenced to support reduction **Status:** [R/A/G]	assumptions with Finance and Workforce Intelligence. • Escalate exception decisions, savings risks and service impact quickly through programme governance.

KPI SCORECARD				
Measure	**Baseline**	**Current**	**Target by Day 90**	**Trend / RAG**
A&C WTE			Reduction trajectory aligned to validated 67.9 WTE assumption	[↑ / → / ↓] [R/A/G]
A&C pay spend			Progress toward £1m part-year effect, subject to validation	[↑ / → / ↓] [R/A/G]
Expected turnover based on previous	67.9wte			
External recruitment exceptions	n/a		All exceptions approved through agreed governance route	[↑ / → / ↓] [R/A/G]
Overtime usage in A4C roles			Actioned outcomes reflected in WTE and spend forecast	[↑ / → / ↓] [R/A/G]
Additional Hours Usage			Reduction in avoidable additional hours	[↑ / → / ↓] [R/A/G]

PROGRAMME GROUP ATTENTION AREAS		
Top risks 1. Admin roles support clinical activity eg ward clerks, receptionists	**Mitigations and controls** **Owner:** [Insert]	**Decisions / support required** **Due by:** [Insert]

2. Further depleting already reduced corporate teams Highest score: **[Insert]**		

NEXT REPORTING PERIOD			
Priority action **[Insert]**	**Owner** [Insert]	**Due date** [Insert]	**Success measure** [Insert]
[Insert]	[Insert]	[Insert]	[Insert]
[Insert]	[Insert]	[Insert]	[Insert]

PROGRAMME DEFINITIONS	
Problem or opportunity	A&C workforce growth and spend require grip through a six-month external recruitment ban from 1 September 2026, clear exceptions, stronger internal recruitment, review of fixed-term contracts and secondments, redeployment into priority roles, and overtime control.
Benefits expected	Reduction in A&C WTE and pay spend, improved control of external recruitment, better use of existing staff through redeployment, reduced avoidable overtime, and a validated savings trajectory linked to the £1m PYE / 67.9 WTE assumption.
Success criteria	Exception process approved and in use; internal recruitment route live; fixed-term and secondment review completed; redeployment decisions actioned; overtime baseline and controls agreed; monthly evidence of WTE and spend reduction reported.
Scope	In scope: Admin & Clerical roles, external recruitment, essential-role exceptions, internal recruitment, fixed-term contracts, secondments, redeployment and overtime for Agenda for Change roles. Out of scope: clinical workforce redesign unless directly linked to A&C support arrangements.
Key dependencies	Timely ESR / establishment data, Finance validation, recruitment system controls, operational manager compliance, Trade Union engagement, communications support, and agreed governance route for exceptions and escalations.

RISKS & MITIGATIONS							
Risk	Cause	Impact if unmanaged	Current score	Mitigation / control	Owner	Target score	Review date

Internal vacancies surge and destabilise priority services	External recruitment control increases internal movement without prioritisation	Delayed service delivery, pressure on teams and reduced confidence in the control process	[I x L = score]	Prioritise vacancies, route exceptions through agreed panel, monitor vacancy movement weekly and escalate service-critical pressures.	Service Managers	[Insert]	[Insert]
Expected saving reduced by essential-role exceptions or SMA inputs	Assumptions not fully validated before implementation	Benefits over-stated and delivery confidence weakened	[I x L = score]	Validate turnover, vacancy, WTE & pay spend assumptions with Finance and Workforce Intelligence before reporting benefits.	TW	[Insert]	[Insert]
Increase in sickness, workload pressure or staff survey deterioration	Reduced recruitment or redeployment creates perceived pressure in teams	Morale, retention and absence worsen, offsetting benefits	[I x L = score]	Use clear communications, manager guidance, Trade Union engagement and staff impact monitoring alongside implementation.	[Insert]	[Insert]	[Insert]
			[I x L = score]		[Insert]	[Insert]	[Insert]
			[I x L = score]		[Insert]	[Insert]	[Insert]

GOVERNANCE, ASSURANCE & ESCALATION	
Governance route	Weekly programme grip review, fortnightly Workforce & OD SLT review and monthly Executive / Finance check, with exceptions and risks escalated through agreed Workforce Programme governance.
Review frequency	Weekly action and risk updates; fortnightly SLT review; monthly benefits, WTE and savings validation.

Escalation triggers	Unresolved exception decisions, increasing internal vacancy pressure, adverse sickness or staff experience indicators, unvalidated savings assumptions, or failure to evidence WTE / spend movement by agreed review points.
Decision points	Approve exception process, confirm accountable SRO / project lead, agree baseline and target measures, confirm communications approach and sign off reporting route for A&C workforce controls.
Assurance evidence	Exception log, recruitment activity report, fixed-term / secondment review tracker, redeployment tracker, overtime analysis, WTE and pay spend run-rate, Finance validation and risk / decision log.

DAY 90 REVIEW & NEXT STEPS	
Overall delivery assessment	Assess whether the A&C recruitment control has moved from design to embedded delivery, with clear evidence of exception governance, internal recruitment, redeployment, contract review and movement in WTE / spend trajectory.
Benefits delivered	Benefits to evidence include reduced external recruitment, lower A&C WTE and pay spend trajectory, reduced avoidable overtime, improved redeployment into priority roles and validated progress against the £1m PYE / 67.9 WTE assumption.
Outstanding actions	Outstanding actions are likely to include continued review of exceptions, completion of any remaining fixed-term / secondment decisions, further overtime controls and confirmation of the next phase of workforce control beyond the initial 90-day period.
Lessons learned	Capture learning on data quality, pace of decision-making, manager compliance, staff and Trade Union communications, and whether internal recruitment and redeployment processes are sufficient to maintain service continuity.
Recommendation	Continue, adjust or scale the A&C workforce control approach based on validated WTE, spend, service impact and staff experience evidence; confirm whether the external recruitment control should remain, be refined or transition into a longer-term establishment control arrangement.

Workforce Programme Delivery Plan – Programme 4

Project title	**Variable pay reduction: reduce bank, agency, additional hours and overtime through improved understanding, control and roster grip.**
Executive sponsor	Director of Workforce and Organisational Development/Deputy CEO
Senior responsible owner	To be confirmed through Workforce Programme governance
Project lead	Workforce Intelligence with operational workforce, finance, nursing, medical rostering, facilities, Allied Health Professions and Health Sciences representatives.
Start date	1 August 2026
Review dates	Day 30: 31 August 2026 | Day 60: 30 September 2026 | Day 90: 30 October 2026
Programme Outline	Workforce Stabilisation Programme: variable pay reduction, including agency substantiation, bank, agency, additional hours, overtime and roster management across nursing, medical, facilities, Allied Health Professions and Health Sciences groups.
Project Team	Workforce Intelligence, Finance, Operational Workforce, Nursing and Facilities Rostering, Medical Rostering, Allied Health Professions and Health Sciences leads, CCG/service managers and professional group leads.
Expected WTE/£ outcome	Known quantified opportunities include £800k agency substantiation FYE with no WTE reduction, £1m nurse roster management and 29 WTE nurse roster opportunity. Indicative nursing utilisation range is 98–141 WTE depending on vacancy fill; overall variable pay opportunity noted as £2.3m known and 127–170 WTE, subject to validation.

PROJECT DASHBOARD | 30, 60 AND 90 DAY DELIVERY VIEW			
Project	**Overall outcome** Validated variable pay baseline, stronger roster and approval controls, reduced planned nurse agency reliance, monitored exit plans, and early evidence of reduced variable pay run-rate by Day 90.	**Overall RAG** **[R / A / G]**	**Programme ask**
Day 30: Understanding, controls and quick wins	**Day 60: Implement controls and targeted reduction actions**	**Day 90: Evidence of reduced run-rate and embedded grip**	**Key delivery focus** Turn variable pay intelligence into monthly run-rate

• Confirm by staff group what variable pay is being used, where and why; • map future events such as NQN intake and medical changeover; • identify data gaps and develop first KPIs. • Identify control policies & plans including correct allocation of headroom where in place and that no direct approach is allowed to agencies (G&C 4.1.1, 4.1.2, 5.3.2) • Scope further rollout of rostering to other clinical workforce • Prepare organisation for planned nursing agency ban from 1/11/26 • Job planning guidance in place to align management, education & clinical delivery (G&C 4.3.1) • Job planning in place for all clinical & medical staff (G&C 4.1.4, 4.4.1) • Medical rostering roll out completed and	• Develop sub groups to focus next actions on key issues groups to be medical, nursing, AHP/ Health science & Estates & Facilities • Review control policies including effective roster management, plans and approval levels for all staff groups (G&C 5.1.1, 5.1.3, 5.1.4, 5.7.2, 5.7.3) • confirm decision on rosters for groups not on Allocate, • establish top three actions for each professional group. • Ensure or develop exit plans for agency workers which includes changes which be requested for multiple reasons for usage (G&C 5.6.2) • Mechanism agreed and in place to monitor all exit plans • Audit control processes • Deep dive into shift patterns to determine efficiency	• Removal of weekly pay for remaining workers (G&C 5.2.2) • Exit plans in place, monitored and reviewed (G&C 2.2.3) • control processes audited; • deep dive completed into shift pattern efficiency; • early reduction visible in nursing variable pay and no planned nurse agency usage. • Consider AI to support further understanding/ audits and whether live reporting can be implemented (G&C 2.4.1) • Regular reports produced regarding temporary workforce utilised and financial impact (G&C 2.1.6, 4.1.3) • Exception reports in place to record all requests to pay over (requested & approved) rate card, and off framework usage and those approved (G&C 2.4.2, 5.1.2, 5.2.1, 5.3.1, 5.8.1)	targets, agreed control actions and visible reductions in nursing, medical, facilities and other staff group usage.

regular reports produced and acted on with regards to additional hours duties (G&C 5.6.1) • Top 10 earners report produced bi-monthly and shared with CCG leads (G&C 5.7.1)		• Consider whether it is possible to gather and understand discretionary effort for unpaid work hours (G&C 5.7.4) • EWTD compliance monitoring mechanism developed (G&C 5.7.5)	

KPI SCORECARD				
Measure	**Baseline**	**Current**	**Target by Day 90**	**Trend / RAG**
Variable pay expenditure by staff group, ward/area and CCG	Wte/£		Reduction trajectory agreed and monitored by staff group	[↑ / → / ↓] [R/A/G]
Nursing variable pay reduction	Wte/£		No planned nurse agency and reduction in variable pay run-rate	[↑ / → / ↓] [R/A/G]
Roster compliance and grip	Current roster compliance position to be confirmed	Allocate and local roster data reviewed	Control policies audited and decision made on non-Allocate groups	[↑ / → / ↓] [R/A/G]
Exit plans for agency, bank and additional hours usage	High-usage areas identified	Exit plans developed for priority areas	Exit plans monitored, reviewed and escalated where blocked	[↑ / → / ↓] [R/A/G]
Agency substantiation and conversion % of agency workers	N & %	N & %	Agency substantiation FYE assumption validated and tracked	[↑ / → / ↓] [R/A/G]

PROGRAMME GROUP ATTENTION AREAS		
Top risks 1.	**Mitigations and controls** 1.	**Decisions / support required** 1

Highest score: **[Insert]**		

NEXT REPORTING PERIOD			
Priority action	**Owner**	**Due date**	**Success measure**

PROGRAMME DEFINITIONS	
Problem or opportunity	Variable pay use is spread across bank, agency, additional hours and overtime, with a need to understand by staff group what is being used, where and why, then convert that intelligence into controls, roster grip and reduced run-rate.
Benefits expected	Reduced variable pay expenditure, improved roster control, validated agency substantiation opportunity, reduced nursing variable pay, no planned nurse agency use, and clearer professional group ownership of top reduction actions.
Success criteria	Validated baseline and run-rate; KPIs agreed; data issues and system gaps identified; control policies reviewed; exit plans in place and monitored; audit of control processes completed; shift-pattern efficiency deep dive completed.
Scope	All variable pay schemes, including bank, agency, additional hours and overtime, across nursing, medical, facilities, AHP, Health Sciences and other professional groups where appropriate.
Key dependencies	Finance and workforce data alignment; roster system adoption; NQN recruitment timing; medical changeover; operational capacity; professional group engagement; timely decisions on agency controls and roster coverage for non-Allocate groups.

RISKS & MITIGATIONS							
Risk	Cause	Impact if unmanaged	Current score	Mitigation / control	Owner	Target score	Review date
Inaccurate or incomplete variable pay data leads to incorrect	Disparate finance, workforce and rostering systems; inconsistent coding;	Savings assumptions may be overstated or misdirected; priority areas may	? x ?	Create a single validated view of bank, agency, additional hours and	Workforce Intelligence / Finance		31 August 2026

analysis of usage.	partial updating of roster and agency information.	be missed; confidence in reported benefits reduced.		overtime by staff group, ward/area and CCG; agree data owners and log gaps by Day 30.			
Control policies and roster standards are not applied consistentl y across services.	Local variation in roster practice, inconsistent escalation of additional hours and agency requests, and groups not yet fully covered by Allocate or equivalent controls.	Variable pay run-rate remains high; agency and additional hours become normalised; benefits are delayed or not delivered.		Review control policies and plans by Day 60; confirm decision on roster requiremen ts for groups not on Allocate; audit compliance with approval and escalation processes.	Operation al Workforce / Rostering Leads		30 Septemb er 2026
Planned nursing agency reduction or agency ban is not implement ed at pace.	Insufficient lead-in time, unclear exceptions route, unresolved service concerns, or lack of agreed alternative staffing plans.	Reduction in nursing variable pay is delayed; agency dependency continues; risks to quality, safety or service continuity may increase if controls are applied without alternatives.		Agree agency ban decision and exceptions route by Day 60; align with NQN intake, vacancy plans and high-usage area exit plans; monitor weekly through programme grip.	Nursing / Operation al Workforce / Finance		30 Septembe r 2026
Operational capacity is insufficient to deliver exit plans, audits and shift-	Competing service pressures, limited analytical support, and reliance on local	Actions remain high-level rather than implemente d; exit plans are not sustained;		Prioritise top variable-pay areas only; assign named service leads; use	CCG / Service Managers		30 October 2026

pattern reviews.	teams to progress actions alongside operational delivery.	run-rate reduction is not evidenced by Day 90.		weekly action tracking; escalate blocked capacity or analytical support needs through Workforce & OD SLT.			
Professional group engagement is inconsistent and top three actions are not owned.	Different workforce drivers across nursing, medical, facilities, AHP and Health Sciences; unclear accountability for local action and change in practice.	Controls are perceived as centrally imposed; delivery varies by group; opportunities for bank, overtime and agency reduction are not converted into sustained action.		Ask each professional group to identify its top three reduction actions, owner, KPI and first control point by Day 60; review progress through monthly programme reporting.	Professional Group Leads / Operational Workforce		30 October 2026

GOVERNANCE, ASSURANCE & ESCALATION	
Governance route	Weekly Workforce Programme grip meeting for action tracking, with fortnightly Workforce & OD SLT review for blockers and cross-cutting decisions, and monthly Executive / Finance check for benefits, exceptions and governance reporting.
Review frequency	Weekly update on actions, risks, validation status and run-rate movement; fortnightly review of unresolved issues through Workforce & OD SLT; monthly review of benefits, decisions and escalations with Finance and Executive colleagues.
Escalation triggers	Escalate if data cannot be validated by Day 30, control or roster decisions are not agreed by Day 60, nursing agency reduction plans are blocked, professional group top three actions are not owned, or Day 90 run-rate movement is not evidenced.
Decision points	Confirm planned nursing agency ban from October and exceptions route; decide roster requirements for groups not currently on Allocate; agree the KPI pack, baseline, run-rate reporting frequency and owner sign-off route; determine whether AI or additional analytical support is required.
Assurance evidence	Validated finance and workforce baseline; variable pay dashboard by staff group, ward/area and CCG; data quality log; roster compliance audit; control policy review; exit plan tracker; professional group action log; evidence of run-rate movement and agency substantiation tracking.

DAY 90 REVIEW & NEXT STEPS	
Overall delivery assessment	Assess whether the programme has moved from understanding variable pay usage to active control and measurable reduction. Delivery should be rated against completion of baseline validation, KPI reporting, control decisions, exit plan monitoring, audit evidence and early run-rate movement.
Benefits delivered	Expected Day 90 benefits include a validated variable pay baseline, agreed run-rate targets, visible reduction trajectory in nursing variable pay, no planned nurse agency use where safe and agreed, monitored exit plans for priority areas, and validated agency substantiation opportunity.
Outstanding actions	Outstanding actions likely to include resolving remaining data gaps, completing audit actions, embedding controls in areas not yet fully using Allocate, confirming any unresolved agency exceptions, and sustaining professional group ownership beyond the initial 90-day period.
Lessons learned	Key learning should focus on which data sources were reliable, where system use or coding created gaps, which controls had the strongest impact on run-rate, how well professional group ownership worked, and where escalation routes enabled or slowed delivery.
Recommendation	Continue into a sustained monthly variable pay improvement cycle, with focus on high-usage areas, strengthened roster governance, embedded professional group action plans, finance-validated benefit tracking and escalation of any residual blockers through Workforce & OD SLT and Executive / Finance review.

Workforce Programme Delivery Plan – Programme 5

Project title	**Establishment Control**
Executive sponsor	Director of Workforce and Organisational Development/Deputy CEO
Senior responsible owner	Assistant Director of People Planning
Project lead	Head of Workforce Intelligence
Start date	1 August 2026
Review dates	Day 30: 31 August 2026 | Day 60: 30 September 2026 | Day 90: 30 October 2026
Programme Outline	Establishment Control programme to create a single validated view of funded establishment and staff in post, supported by standard reporting, manager sign-off, fixed-term contract and secondment monitoring, ESR controls and clear escalation routes for unresolved discrepancies.
Project Team	Workforce Intelligence, Finance, Operational Workforce, CCG/service managers and professional group leads.
Expected WTE/£ outcome	Enabler rather than directly delivering savings

PROJECT DASHBOARD | 30, 60 AND 90 DAY DELIVERY VIEW			
Project **Establishment control**	**Overall outcome** By Day 90, the Establishment Control workstream will have an agreed establishment report, a manager sign-off programme, clear guidance for fixed-term contracts and secondments, and a defined mechanism to enable establishment control in ESR.	**Overall RAG** **[R / A / G]**	**Executive ask** Confirm the accountable owner and support leads, endorse the establishment control approach, agree how discrepancies between funded establishment and staff in post will be resolved, and support decisions required to enable ESR-based establishment control.
Day 30: Understanding, controls and quick wins • Scope existing discrepancies between funded	**Day 60: Implement controls and targeted reduction actions** • Develop the establishment	**Day 90: Evidence of reduced run-rate and embedded grip**	**Key delivery focus** 1. Align funded establishment and staff in post 2. Develop establishment reporting and

establishment and staff in post. • Create process for aligning outcomes and confirming decision points (G&C 2.1.1, 2.1.2) • Begin development of the establishment report. (G&C 2.1.4) • Identify fixed-term contracts and secondments requiring monitoring. • Confirm owner, support leads and governance route. • Status: **[R/A/G]**	control toolkit to support positive workforce management and establishment review. (G&C 2.1.3, 2.1.5, 2.2.1 2.2.2) • Reinforce workforce management processes for changes, exits and new starters. (G&C 2.3.1, 2.3.2, 2.3.4, 2.3.5) • Develop guidance for monitoring fixed-term contracts and secondments. (G&C 2.3.3) • Outline the programme for managers to sign off establishments. • Develop the mechanism to enable establishment control in ESR. • **Status:** [R/A/G]	• Put the establishment report in place. • Launch manager establishment sign-off process. • Confirm fixed-term contract and secondment monitoring guidance. • Enable establishment control in ESR or agree implementation route. • Confirm unresolved risks, decisions and next reporting rhythm. **Status:** [R/A/G]	manager sign-off 3. Enable establishment control in ESR and monitor fixed-term contracts and secondments

KPI SCORECARD				
Measure	**Baseline**	**Current**	**Target by Day 90**	**Trend / RAG**
	[Insert]	[Insert]	[Insert]	[↑ / → / ↓] [R/A/G]
	[Insert]	[Insert]	[Insert]	[↑ / → / ↓] [R/A/G]
	[Insert]	[Insert]	[Insert]	[↑ / → / ↓] [R/A/G]
	[Insert]	[Insert]	[Insert]	[↑ / → / ↓] [R/A/G]
	[Insert]	[Insert]	[Insert]	[↑ / → / ↓] [R/A/G]

BOARD ATTENTION AREAS		
Top risks **1. [Insert risk]** **2. [Insert risk]** **3. [Insert risk]** Highest score: **[Insert]**	**Mitigations and controls** 1. [Insert mitigation] 2. [Insert mitigation] 3. [Insert mitigation] **Owner:** [Insert]	**Decisions / support required** 1. [Insert decision] 2. [Insert support needed] 3. [Insert escalation] **Due by:** [Insert]

NEXT REPORTING PERIOD			
Priority action	**Owner**	**Due date**	**Success measure**
[Insert]	[Insert]	[Insert]	[Insert]
[Insert]	[Insert]	[Insert]	[Insert]
[Insert]	[Insert]	[Insert]	[Insert]

PROGRAMME DEFINITIONS	
Problem or opportunity	Establishment Control Is a priority planning area focused on resolving discrepancies between funded establishment and staff in post, creating an establishment report, developing a practical toolkit, strengthening workforce management processes, monitoring fixed-term contracts and secondments, and enabling establishment control in ESR.
Benefits expected	Expected benefits include a single validated view of establishment, clearer controls for establishment changes, stronger manager accountability, improved monitoring of fixed-term contracts and secondments, better alignment between workforce and finance data, and a clearer route for escalation where establishment changes cannot be resolved locally.
Success criteria	Success by Day 90 will be evidenced by an establishment report in place, guidance for fixed-term contracts and secondments agreed, manager sign-off programme outlined, ESR establishment control mechanism progressed, and risks or decisions escalated through the agreed governance route.
Scope	In scope: establishment data review, funded establishment and staff-in-post reconciliation, establishment reporting, manager sign-off, workforce management toolkit, fixed-term contract and secondment monitoring, ESR establishment control and escalation of unresolved discrepancies. Out of scope: broader workforce redesign unless required to resolve agreed establishment control actions.
Key dependencies	Key dependencies include accurate workforce, finance and ESR data; engagement from operational managers; clear approval rules for establishment changes; workforce management process compliance; system support to enable ESR controls; and timely governance decisions where discrepancies or barriers cannot be resolved locally.

RISK & MITIGATIONS							
Risk	Cause	Impact if unmanaged	Current score	Mitigation / control	Owner	Target score	Review date
Establishment control process is time consuming and delays delivery	Reconciling funded establishment, staff in post, manager sign-off and ESR controls may require significant data and operational input.	Progress stalls, reporting remains incomplete and establishment discrepancies continue without resolution.	[I x L = score]	Prioritise high-impact discrepancies, use a standard report and toolkit, agree clear sign-off expectations, and review progress weekly through Workforce Programme governance.	MJ	[Insert]	[Insert]
Managers do not engage with establishment sign-off or process changes	Managers may not prioritise the sign-off process or may be unclear about expectations and decision rights.	Establishments remain unvalidated and changes, exits or new starters may continue outside agreed controls.	[I x L = score]	Provide clear toolkit and guidance, reinforce good workforce management processes, confirm escalation route for non-engagement, and report completion through the review rhythm.	[Insert]	[Insert]	[Insert]
ESR establishment control cannot be enabled at required pace	System capability, configuration, data quality or resource constraints may limit ESR implementation.	Establishment control remains dependent on manual workarounds and assurance may be weaker.	[I x L = score]	Develop ESR control requirements early, confirm feasibility, agree interim manual controls if required, and escalate system constraints	[Insert]	[Insert]	[Insert]

				through Workforce & OD SLT and executive/finance routes.			
Fixed-term contracts and secondments are not monitored consistently	Data may be incomplete or responsibility for monitoring may be unclear.	Temporary workforce arrangements continue without clear review, expiry management or establishment impact assessment.	[I x L = score]	Create guidance for monitoring fixed-term contracts and secondments, agree data owner, build into establishment reporting and review exceptions through governance.	[Insert]	[Insert]	[Insert]
Funded establishment and staff-in-post discrepancies are not resolved	Differences between budgeted establishment and current staffing may lack clear ownership, evidence or decision route.	Financial, workforce and operational plans remain misaligned and establishment decisions are not controlled.	[I x L = score]	Scope discrepancies, agree alignment process, assign owners for unresolved issues and escalate decisions that cannot be resolved through the workstream.	[Insert]	[Insert]	[Insert]

GOVERNANCE, ASSURANCE & ESCALATION	
Governance route	Workforce Programme governance, supported by Workforce & OD SLT escalation route
Review frequency	Weekly action review, with fortnightly Workforce & OD SLT review and monthly executive or finance check where escalation is required.
Escalation triggers	Escalate where Establishment control priority actions remain undefined, owners are not confirmed, validation evidence is unavailable, risks cannot be mitigated, or decisions are required to unblock progress.
Decision points	Day 30: confirm priority actions, owners/support and validation route. Day 60: confirm action progress, risk controls and decisions required. Day 90: confirm evidence, unresolved risks, escalation decisions and next phase.
Assurance evidence	Establishment control action log, owner/support lead record, validation evidence tracker, risks and decisions log, escalation record and Day 90 delivery summary.

DAY 90 REVIEW & NEXT STEPS	
Overall delivery assessment	At Day 90, assess whether Establishment control planning has moved from placeholder responses to a deliverable action plan, with priority actions, owners, validation evidence, risk mitigations and escalation decisions confirmed.
Benefits delivered	Benefits to be evidenced through completed slide 12 planning responses, agreed owners and support leads, validated evidence requirements, visible risks and mitigations, and clear escalation decisions.
Outstanding actions	List any unresolved priority actions, owner gaps, validation gaps, risks, mitigations or blocked decisions, with owner and due date.
Lessons learned	Capture what helped move Establishment control planning from broad intentions to concise, testable actions, where validation was difficult and which escalation routes need to be retained.
Recommendation	Embed the Establishment control plan into the Workforce Programme reporting rhythm if sufficient detail is agreed; continue for a further 90 days if priority actions, validation or decisions remain incomplete.

Financial Grip and Control measures across NHS Wales

Financial Planning and Delivery Directorate

Objective:

To provide organisations with a consolidated schedule setting out the core financial, workforce and procurement grip and control measures to safeguard financial stability during periods of significant financial pressure.

Background:

At M09 2025/26 six health boards in Wales report deficits totalling £206m, (1.9% of the reported Revenue Resource Limit).

Given the scale of the pressure, it is essential that the NHS Wales Finance Function can demonstrate that the financial governance and financial control environment mechanisms are robust and sufficient assurance is received on their effectiveness.

Scope:

The tool is designed to help organisations assess their financial grip and control. It is not an exhaustive list but is predicated on common themes and areas of risk identified through NHS Wales.

The key focus for the grip and control schedule is the practical controls, processes and actions that should be in place in year to avoid excessive or inappropriately approved financial commitments; reduce waste; and improve in year expenditure run-rates. The tool will help organisations to strengthen the underpinning financial governance and control measures that support improved financial performance.

As a first step, the focus has been placed on core financial, workforce and procurement processes and systems. There is more limited literature available on best practice grip and control within specific expenditure areas such as commissioning, CHC and prescribing systems and processes.

Preparation approach:

The schedule has been prepared by Financial Planning and Delivery by examining and consolidating examples from various sources including:-

- Grip and Control presentation report (Financial Planning and Delivery May 2022)
- Financial Grip and Control Checklist (NHS England December 2022)
- Establishment Control (HFMA May 2025)
- Budgetary Framework and Grip and Control Discussions (Directors of Finance Forum July 2024)

Structure of the document:

The schedule includes both **financial controls (in black)** that organisations should have in place and **grip actions (in blue)** that will support the reduction of expenditure run rates.

The financial grip and control measures are categorised across eight themes:- Framework and Guidance, Vacancies, Sickness and Leave, Rostering and Rotas, Bank and Agency, Other Staff Payments, Procurement and Other items.

The document includes both a summary schedule and a detailed schedule. The summary schedule identifies key thematics and the highest impact actions from the detailed schedule.

Other financial governance reference documents:

The checklist may be used in conjunction with:

- HFMA's "Improving NHS financial sustainability: are you getting the basics right?" checklist tool Improving NHS financial sustainability: are you getting the basics right? (hfma.org.uk) – focus on key overarching financial processes such as planning, budget setting, reporting, financial governance, training and development
- Financial Management Maturity Model (NAO January 2010)
- Model Standing Orders, Reservation and Delegation of Powers and Model Standing Financial Instructions – NHS Wales (issued by Welsh Government)
- The Finance Academy's 'Financial Control Procedures Governance Best Practice Principles Guide' - available on the learning and development platform

All are valuable tools to support organisations to consider if they have the controls and processes in place to achieve best value for money.

Completion and next steps:-

Complete the checklist to consider whether the relevant policy or process exists and secondly to consider operational delivery and compliance. This may require input from representatives from several areas workforce, procurement, efficiency, finance and audit.

Agree priority issues and how proposed actions to address the issues identified will be taken forward. This may require assembling a working group including representatives from workforce, procurement, efficiency, finance.

Key findings from the exercise to be shared through the Director of Finance forum to identify any national areas of focus.

Update from Hywel Dda UHB:

The following sections will/have been completed by functional leads. Self-identified 'gaps' have been highlighted in RED text. Following the completion of the national benchmarking exercise across NHS Wales organisations, a consolidated list of gaps will be created and suggestions/recommendations made to update controls where appropriate. Critical gaps will be updated immediately.

Functional completion:

Framework and Guidance:	Finance
Establishment and Vacancies:	Workforce People Management
Sickness and Leave Management:	Workforce People Management
Rostering, Rotas and Job Planning:	Workforce People Planning and Effectiveness
Temporary Staffing:	Workforce People Planning and Effectiveness
Other Staff Payments:	Workforce People Planning and Effectiveness
Procurement:	Procurement
Other Items:	Finance

1. Summary Schedule

Framework and Guidance	Establishment and Vacancies	Sickness and Leave Management	Rostering, Rotas and Job Planning
• Clear and Up to Date Standing Financial Instructions and guidance. • Clear procedures & process notes. • Budget holders and all financial administrators have received up to date training on their roles & responsibilities • Clear governance process for new investment. • Delegation letters issued and signed. • Internal Escalation process in place.	• Ensure robust budgeted establishments are in place and regularly reviewed and reconciled. • Regular vacancy control panel (VCP). • Automated weekly head count tracker. • Ensure managers notify HR of leaving dates. • Review all current vacancies with a view to remove or freeze posts.	• Enforce compliance with the All Wales Sickness policy. • Adherence to the requirements of agreed attendance at work policies and the all-Wales Occupational Health minimum service levels. • Monitor absence and sickness on individual, service line, service and organisation level. • Monitor medical annual leave. • Policies to limit carry forward of significant leave balances	• E-rostering fully deployed. • Rosters approved 12 weeks in advance (as per the Agency workforce reduction programme and control framework). • Contracted hours to be fully rostered. • Job planning policy implemented with > 90% of all Consultants having an agreed job plan in place at all times; and alignment of rota to job capacity plans.

Temporary Staffing	Other Staff Payments	Procurement	Other items
• Temporary Staffing Policy in place. • Clear process for booking, and compliance with process. • Review bank and agency authorisation levels – seniority and consistency across sites. • No off-contract agency & locum. • Auto enrolment for new starters onto the bank. • Review pay rates and consider weekly pay for bank as an incentive. • Ensure appropriate deduction for agency staff breaks.	• Implement prior approval for overtime and enhanced payments. • A monthly 'audit' of the highest overtime earners and expenses claimants. • Non-clinical overtime controls in place. • Enhanced authorisation process for WLIs with clear demonstration that existing Programmed Activities (PAs) have been utilised before WLIs awarded. • Review process in place for additional sessions allocated.	• Monitor use of Single Tender Waivers. • Consolidate a list of supplier discounts. • Robust contract management processes in place. • Enforce the 'No PO No Pay' policy. • Review and reduce those able to requisition and order. • Targeted approach for clinical preference variation (as identified by V&S procurement group).	• Review and ensure all eligible VAT is being reclaimed. • Income management policies to minimise bad debt costs. • Stock management policies to minimise wastage. • Review all credit balances on the Balance sheet for potential over accrual. • Journals are based on latest relevant data and assumptions.

2. Detailed Schedule

1. Framework and Guidance	Controls / Processes in place	Assurance that processes are operational
Clear and Up to Date Standing Financial Instructions • SFIs are up to date and readily accessible to all relevant officers.	Documented policies, Standing Financial Instructions and All-Wales frameworks are in place and approved by the Board. Operational procedures are supported by defined approval thresholds, system controls, segregation of duties and clearly assigned responsibilities. Controls are designed to prevent unauthorised activity, identify variance at the earliest opportunity, and enable timely corrective action.	Assurance is obtained through routine financial and workforce reporting, executive and committee oversight, exception reporting, internal performance reviews and periodic Internal Audit coverage. Compliance is monitored via dashboards, variance analysis and escalation through service and executive governance structures. Gap 1: Subsequent supporting principle documents are not accessible to relevant officers in the same location and are housed locally within functions, e.g. detailed examples of budgeting principles to support the Budgetary Control Financial Control Procedure.
Clear Process Notes • All Financial Control Procedures are up to date; accessible and minimum provision aligns with the Finance Academy best practice guide. (e.g. month end close down processes, financial reforecasts). • All Financial Control Procedures are widely available to all relevant team members. • Adequate training is provided to all relevant staff members to ensure awareness and understanding of relevant financial control procedures.	Documented policies, Standing Financial Instructions and All-Wales frameworks are in place and approved by the Board. Operational procedures are supported by defined approval thresholds, system controls, segregation of duties and clearly assigned responsibilities. Controls are designed to prevent unauthorised activity, identify variance at the earliest opportunity, and enable timely corrective action.	Assurance is obtained through routine financial and workforce reporting, executive and committee oversight, exception reporting, internal performance reviews and periodic Internal Audit coverage. Compliance is monitored via dashboards, variance analysis and escalation through service and executive governance structures. Audits are undertaken to assess management compliance; this can be utilised as a management tool to assess learning needs, compliance or wider system issues. Links to Gap 3

Colour Key:- **financial controls** are black **grip actions** are blue

		Gap 1: Subsequent supporting principle documents are not accessible to relevant officers in the same location and are housed locally within functions, e.g. detailed examples of budgeting principles to support the Budgetary Control Financial Control Procedure. Gap 2: Some training is offered to first time managers via the Managers Passport programme, but this does not systematically cover all employees that enter management posts. Systemic analysis required for grip & control gaps, as training may not be the solution in itself. Gap 3: Periodic refresher training is not currently available to continuously educate all relevant staff members of the controls in place that are to be adhered to.
Roles and Responsibilities • Roles and responsibilities of budget holders clearly defined and clearly communicated, including responsibilities with respect to core budgets, cost reduction element of their budgets and procurement. • Delegation letters have been issued and have been signed. • All budget holders have objectives supporting the delivery of financial objectives in Performance appraisal process. • Budget holders receive training on their roles responsibilities and objectives at reasonable intervals and monitoring of this can be demonstrated. • Consider whether the number of budget holders is appropriate - reduced budget holders can improve control over expenditure.	Documented policies, Standing Financial Instructions and All-Wales frameworks are in place and approved by the Board. Operational procedures are supported by defined approval thresholds, system controls, segregation of duties and clearly assigned responsibilities. Controls are designed to prevent unauthorised activity, identify variance at the earliest opportunity, and enable timely corrective action.	Assurance is obtained through routine financial and workforce reporting, executive and committee oversight, exception reporting, internal performance reviews and periodic Internal Audit coverage. Compliance is monitored via dashboards, variance analysis and escalation through service and executive governance structures. Gap 1: there is not a consistent onward delegation of financial objectives via Performance appraisals as far as currently known.

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	Annual budget delegation Accountability Letters are issued to Executive Directors and Deputies; Functional Leads and Clinical Care Group Directors. This sets out responsibilities and reminds budget holders of the procedures in place that are to be adhered to. A scheme of delegation is in place, with changes approved by Board, and a consistent Oracle sub-scheme of delegation is in place with consistent approval levels and budget holders across all Revenue, Capital and Charitable Fund cost centres.	Gaps 2 and 3 from 1. Framework and Guidance – Clear Process Notes apply.
Investments and Business Cases • Clear Business Case review procedures for reviewing and approving any new projects across the organisation. • The above includes a relevant committee structure where robust review and challenge take place. • Post implementation benefit realisation reviews process in place. • Review previous 12 months of business cases to ensure savings/benefits realisation. • Establish list of ongoing and planned projects and determine what can be ceased or delayed.	Documented policies, Standing Financial Instructions and All-Wales frameworks are in place and approved by the Board. Operational procedures are supported by defined approval thresholds, system controls, segregation of duties and clearly assigned responsibilities. Controls are designed to prevent unauthorised activity, identify variance at the earliest opportunity, and enable timely corrective action. All investment business cases are to be included on an annual basis within the annual financial planning cycle, with the exception of the Nurse Staffing Level reviews, which occur	Assurance is obtained through the annual financial planning cycle, routine financial and workforce reporting, executive and committee oversight, exception reporting, internal performance reviews and periodic Internal Audit coverage. Compliance is monitored via dashboards, variance analysis and escalation through service and executive governance structures. Gap 1: there is an absence of a medium-term plan to provide multi-year strategic direction to business cases. Gap 2: there is a lack of consistency across business cases, with financial benefits being ambiguous in a lot of cases. Further structure and consistency are required, with a regular

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	during a year and are submitted to Board for approval, with central reserve funding allocated to services if approved. Initially, the Financial and Performance Committee scrutinise business cases, before they are submitted to Board for final review and approval/rejection.	organisation process for capturing, reviewing, prioritising and scrutinising them before being submitted for formal scrutiny to the Finance and Performance committee. NB Business Cases do not routinely explore alternative workforce design; to optimise "value" in workforce models. Integration of VBHC as a model for integrated workforce planning may be possible here. Query further gap? Gap 3: Limited evidence of benefits realisation or systematic reviews on historic cases
Internal Escalation • Clear internal escalation processes in place for service areas that are not delivering their financial plans with appropriate financial or non-financial controls or remedial actions applied.	An internal escalation framework is in place, with four levels of escalation across seven domains. Procedures are supported by defined approval thresholds, system controls, segregation of duties and clearly assigned responsibilities. Controls are designed to prevent unauthorised activity, identify variance at the earliest opportunity, and enable timely corrective action.	Assurance is obtained through routine monthly performance reporting, executive and committee oversight, exception reporting, internal reviews and periodic Internal Audit coverage. Compliance is monitored via dashboards, variance analysis and escalation through service and executive governance structures. Gap 1: Repeated examples of continued escalation does not employ an appropriate and timely response to deliver impactful actions to achieve de-escalation. Level 4 is not available presently.

2. People Costs – Establishment and Vacancies	Controls / Processes in place	Assurance that processes are operational

Colour Key:- **financial controls** are black **grip actions** are blue

Policy and Procedure • Criteria in place for annual and other leave (e.g. study and parental leave) to be notified to the organisation and signed off (where applicable) with sufficient notice to minimise impact on rotas. • Processes in place to ensure compliance with the All-Wales Sickness policy - Rigorous sickness policy and procedure is in place and communicated to minimise absences (inc. return to work meeting). • Consider increasing sign off levels for sick leave to ensure transparency.	Documented policies, Standing Financial Instructions and All-Wales frameworks are in place and approved by the Board. Operational procedures are supported by defined approval thresholds, system controls, segregation of duties and clearly assigned responsibilities. Controls are designed to prevent unauthorised activity, identify variance at the earliest opportunity, and enable timely corrective action. Carry Over of annual leave is defined in the Agenda for Change handbook. There is an annual leave carryover proforma on SharePoint. Internal process for communication and completion is handled within the People Planning pillar with communications being issued via Global/Viva Engage. The PowerBI dashboard has a tab for annual leave balances which managers have access to and is updated monthly. Functional leads are sent monthly absence reports by the Workforce Intelligence team in the People Planning pillar. There is an all-Wales Absence Management policy which identifies the key responsibilities of each manager in respect of absence.	Assurance is obtained through routine financial and workforce reporting, executive and committee oversight, exception reporting, internal performance reviews and periodic Internal Audit coverage. Compliance is monitored via dashboards, variance analysis and escalation through service and executive governance structures. Audits are undertaken to ensure compliance to policy; this can be utilised as a management tool to assess learning, compliance or system issues.(Links to Gap 3) Gap 1: Line managers are not consistently using the sickness and annual leave report that are available to them. Gap 2: Line managers are not consistently applying the all-Wales Absence Management policy as identified in the recent internal audit report on sickness absence. Gap 3: There is no process in place to provide assurance that annual leave balances are well managed within the target of 14.6% defined within the Rostering Policy.

Colour Key:- **financial controls** are black **grip actions** are blue

2. People Costs – Establishment and Vacancies	Controls / Processes in place	Assurance that processes are operational
Establishment (Establishment control | HFMA) • Workforce plans are in place, are of a sufficiently granular level of detail (for example, by service, workforce type and substantive/ temporary); and align to approved establishment levels and budget. • Workforce plans are regularly reviewed by service and service leads to ensure compliance with or action to move to compliance against both establishment and budget. • Reconciliation process in place to ensure that WTEs per financial and HR systems reconcile.	Holistic workforce planning is undertaken as part of the annual planning cycle, which focuses on clinical service and staff group. Establishment report in place from Workforce and Finance but not accessible to service users. Monitoring forms part of the WOD escalation framework meetings The Health Board established a Financial control group, and whilst this overarching group has been dissolved, Workforce and OD have retained their own Internal FCG (initially established in October 2025) as part of its own control mechanisms.	Assurance is obtained through routine financial and workforce reporting, executive and committee oversight, exception reporting, internal performance reviews and periodic Internal Audit coverage. Compliance is monitored via dashboards, variance analysis and escalation through service and executive governance structures. Gap 1: Executive Function planning to be undertaken consistently for all. Gap 2: Integration of financial establishment / budget to be included through a collaborative approach to planning with Service, Workforce and Finance, including formally sign-off for WTE plans compared to budgets. This needs to look beyond numbers to skill mix/workforce model design (VBHC may be a helpful mechanism here. Gap 3: Budget holder review of established budgets is inconsistent, with reactive resolution when posts are to be replaced and finance instigate a change due to mis-aligned budgets. Gap 4: Establishment report is not easily accessible to service users and budget holders combining Workforce actual WTE with Finance budgeted WTE.

Colour Key:- **financial controls** are black **grip actions** are blue

2. People Costs – Establishment and Vacancies	Controls / Processes in place	Assurance that processes are operational
		Gap 5: Not all services have a workforce plan in place however, there each CCG and corporate directorate is required to establish its own internal FCG controls before vacancies are approved, as part of the new arrangements from 1st April 2026. Not all arrangements are currently in place. Gap 6: Assurance is needed that the reporting of variable pay usage, previously reported into FSCG group, will be picked up in the new arrangements.

Colour Key:- **financial controls** are black **grip actions** are blue

2. People Costs – Establishment and Vacancies	Controls / Processes in place	Assurance that processes are operational
Vacancy Review (Establishment control | HFMA) • Establish a regular vacancy control panel (VCP) or equivalent to check and challenge recruitment to ensure all vacancies remain within authorised budgetary limits. • Ensure the VCP terms of reference enable flexibility to avoid operationally delaying opportunities for savings and considering clinical need. • Implement an automated weekly head count tracker (temporary and substantive). • Assess the recruitment process and remove blockers/ bottle necks that may lead to higher agency & locum costs. • Review all current vacancies with a view to remove or freeze posts. • Focus on long term/ 6-month vacant posts – can these be removed or re-engineered? • Review the establishment to remove partial posts not required and identify unfunded posts. • Implement non-clinical recruitment freeze unless it can be evidenced that role is business critical or key for financial/ quality and safety improvement.	Documented policies, Standing Financial Instructions and All-Wales frameworks are in place and approved by the Board. Operational procedures are supported by defined approval thresholds, system controls, segregation of duties and clearly assigned responsibilities. Controls are designed to prevent unauthorised activity, identify variance at the earliest opportunity, and enable timely corrective action. Systematic approach to approval with vacancy's routed to Finance for approval or rejection depending on budget availability prior to recruitment episode commencing. Service management deploy internal vacancy panels prior to recruitment episodes being triggered. All Wales KPIs exist for "time to hire" and are included within the PODCC Metrics report for assurance of compliance and reported to the all-Wales Recruitment Modernisation Board. TRAC acts as the compliance tool here for financial authorisation.	Assurance is obtained through routine financial and workforce reporting, executive and committee oversight, exception reporting, internal performance reviews and periodic Internal Audit coverage. Compliance is monitored via dashboards, variance analysis and escalation through service and executive governance structures. The Health Board is consistently exceeding the all-Wales KPIs for "time to hire". Gap 1: Management override can occur within the Service, Finance or Workforce for by-passing the control environment. Gap 2: Manual ESR changes from service managers without timely/appropriate Workforce and Finance review, i.e. re-banding, acting up arrangements. Gap 3: CCGs do not always have exit strategies in place to align with the on-boarding of new staff which results in higher agency and locum costs.

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Leavers • Processes in place to ensure line managers notify HR of leaving dates and any other pay-impacting staff changes in a timely manner to reduce risk of overpayments.	Documented policies, Standing Financial Instructions and All-Wales frameworks are in place and approved by the Board. Operational procedures are supported by defined approval thresholds, system controls, segregation of duties and clearly assigned responsibilities. Controls are designed to prevent unauthorised activity, identify variance at the earliest opportunity, and enable timely corrective action. SMA tool assisting managers for an easy-to-use interface to instigate terminations and reduce overpayments. Payroll issues automated reminders to line managers regarding the monthly payroll cut-off dates, which highlights the importance of new starters, leavers and changes being processed in a timely manner. An example is given in the email of a mid-month leave and the importance of submission before the cut of date for that month.	Assurance is obtained through routine financial and workforce reporting, executive and committee oversight, exception reporting, internal performance reviews and periodic Internal Audit coverage. Compliance is monitored via dashboards, variance analysis and escalation through service and executive governance structures. To ensure monies can be claimed back Recruitment monitor exits of IENs or Medics recruited via the WG programme. Gap 1: Without positive confirmation of employees being marked as present on the ESR system (default assumes employees as present opposed to absent), management inconsistency gives rise to overpayments on a regular basis and lengthy financial disputes with no recovery occurring for a number of cases. Gap 2: HR does not get notified of leavers or pay impacting changes. The manager will input directly into ESR or the SMA App. Gap 3: Who is responsible for monitoring end dates (and then associated actions) for Fixed Term Contracts or Secondments – likely a cost pressure. Gap 4: Termination forms are still being completed late by Line Managers which gives rise to overpayments.

Colour Key:- **financial controls** are black **grip actions** are blue

2. People Costs – Establishment and Vacancies	Controls / Processes in place	Assurance that processes are operational
		Gap 5: Delays in termination forms can lead to lengthy financial disputes with no recovery occurring for a number of cases.
Workforce management monitoring (Establishment control | HFMA) • Process in place to review levels of poorly performing staff and consider options for more rapid improvement and/ or staff exit. • Periodical review of actual temporary staff rates against rates charged to identify and address issues (specific and themes).	Documented policies, Standing Financial Instructions and All-Wales frameworks are in place and approved by the Board. Operational procedures are supported by defined approval thresholds, system controls, segregation of duties and clearly assigned responsibilities. Controls are designed to prevent unauthorised activity, identify variance at the earliest opportunity, and enable timely corrective action. There is an all-Wales policy on Improving Performance at Work for A4C staff and UPSW for M&D staff.	Assurance is obtained through routine financial and workforce reporting, executive and committee oversight, exception reporting, internal performance reviews and periodic Internal Audit coverage. Compliance is monitored via dashboards, variance analysis and escalation through service and executive governance structures. Hywel Dda has been piloting the new Improving Performance at Work policy, and this has resulted in staff progressing through the informal and formal elements of the procedure. Since the pilot, staff have been progressed through the policy. New NHS policy comes into effect across Wales on 1st April 2026 and workshops are being held to roll-out to managers. Gap 1: A comprehensive and live temporary staff reporting is not available to service managers. Gap 2: Services do override rate cards on a daily basis to ensure gaps are filled.

Colour Key:- **financial controls** are black **grip actions** are blue

3. People Costs – Sickness and Leave Management	Controls / Processes in place	Assurance that processes are operational
Monitoring and Reporting • Monitor adherence to the requirements of agreed attendance at work policies and the all-Wales Occupational Health minimum service levels. • Monitor absence and sickness on individual, service line, service and organisation level. • Sickness is regularly reviewed at the board level, and problem areas identified and examined. • There is a set % target for staff off sick at any time and performance is measured against this target. • There is a set % target for staff on leave at any time and performance is measured against this target. • Monitor staff compliance with core organisational HR policies (e.g. annual leave requests, sickness absence) and ensure outliers are identified and addressed through appropriate routes. • Monitor medical annual leave. • Limits to the amount of annual leave, training and other influenceable absences that can be taken at any time. • Global policies for the management of leave to prevent excessive use of annual leave at the end of the year or carry forward of significant balances.	• Clear policies in place for study, parental and sickness leave with notice periods. • Local processes in place (SOPs) for annual leave. • Limits on carry-forward i.e. up to 5 days but should more leave be carried forward due to absence or maternity leave, there is an escalation process to Exec Director level for approval. • Linkage of leave planning to e-rostering to ensure cover and minimise premium costs for staff on Allocate. • The Health Board provides monthly reports on its compliance with the all-Wales Occupational Health minimum service levels which is reported to PODCC. • The PowerBI dashboard has a tab for annual leave balances which managers have access to and is updated monthly.	Board-level review of sickness and leave KPIs by service and inclusion in Improving Together Executive Team led function reviews. Monthly reports indicate that the Health Board is fully meeting the all-Wales Occupational Health minimum standards. A deep dive into the specific reasons for absence e.g. Section 10 have been submitted to PODCC. Gap 1: Inconsistent application of concerns identified in the monthly functional sickness absence report are not being addressed by senior managers when the data indicates more than 5 days to enter sickness absence. Gap 2: There are a number of different routes to entering annual leave i.e. Allocate, ESR, Paper, Email. This inconsistent practice impacts on control measures which are available. Gap 3: Inconsistent monitoring of use of annual leave via PowerBI dashboard by Line Managers and senior leaders. Gap 4: Back-dated sickness or unrecorded leave transactions no escalated with no function lead approvals in place

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		Gap 5: Monitoring of some medical leave is difficult due to leave years being linked to date commenced in service and not financial year.

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4. Rostering, Rotas and Job Planning	Controls / Processes in place	Assurance that processes are operational
General rostering and rotas • E-rostering is fully deployed • Rosters are approved 12 weeks in advance (as per the Agency workforce reduction programme and control framework), and minimal changes to rosters once approved, for all staff grades. • Processes to ensure contracted hours are fully rostered. • Clear timeline for submission of rotas.	The Health Board has a Rostering Policy and includes key performance indicators and a rostering approval process. Compliance with the rostering policy is monitored through: - E-rostering system metrics (approval timelines etc). Executive-level dashboards present: - Roster approval compliance. - Use of bank, agency and locum by roster group. - Correlation between late rota approval and premium staffing costs.	Persistent non-compliance is escalated through: - Workforce escalation forums. - Executive performance reviews. Internal audit reviews are undertaken periodically to assess: - Policy compliance. - Effectiveness of controls. - Reliability of reported data. This is reported through Value & Sustainability and to Professional Leads for Nursing & Medical Workforce through appropriate forums including exception reports identifying rosters not approved within required timescales. Gap 1: There is no process in place to provide assurance that annual leave balances are well managed within the target of 14.6% defined within the Rostering Policy. Gap 2: SOP adherence for annual leave and training controls is inconsistent. Gap 3: Night shift gaps persist despite substantive establishment. Gap 4 Whilst significant progress has been made it is not being sustained and Job Planning compliance and transparency varies between services.

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4. Rostering, Rotas and Job Planning	Controls / Processes in place	Assurance that processes are operational
Robust Nursing Rota Management • Staff levels are matched to patient demand patterns to avoid waits and avoidable admissions. • Weekly monitoring for shift requests vs. shift fill rate and any associated care and safety issues. • Review staffing levels against patient ratios vs current guidelines (inc. safer staffing tools) and provide constructive challenge to clinical leads on achieving efficiency while maintaining quality. • Review specialing policy, approvals, and tracking process to ensure standardised approach linked to patient need/acuity. • Review nursing agency & locum use before, during and after school holiday periods (tests the strength of rota planning). • Review options for: o reduced handover periods; o back-to the ward for nursing management staff for a number of shifts per week; and o specialist nurses to provide a number of clinical shifts on wards to reduce agency & locum bill, cover vacancies, and improve staff rotation.	As above	As above

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4. Rostering, Rotas and Job Planning	Controls / Processes in place	Assurance that processes are operational
Robust Medical Job Planning Management • Job planning policy implemented with > 90% of all Consultants having an agreed job plan in place at all times. • Process in place to ensure alignment of rota to job plans. • Monitoring in place to support Medical Director leadership track medical productivity for example: - o job plan delivery (individual and then team job plans); o PAs over 12. o % Direct Clinical Care; and o theatre/clinic throughput. • Review consultant job planning compliance (assess current level of rollout) to identify opportunities for greater productivity (review of low and high Professional Activity "PA" staff). • Improve transparency of medical workforce holiday planning to core planning teams, linking to theatre and clinic planning. • Review on-call run rate for utilisation trends.	Clear policies for study, parental and sickness leave with notice periods. Rollout of Allocate is progressing; to be completed by June 2026. Metrics/reporting being developed to test efficacy of system/protocols. During 2025/26 job planning was reported as part of the suite of WOD escalation measures.	Reports to Medical Workforce Planning & Stabilisation on progress. Gap 1: Not all Job plans align activity, management duties, education and clinical delivery to funded hours. Gap2: There are no consequences for individuals who do not positively engage in the annual job planning process. Gap 3: The Health Board is yet to agree the parameters of the 52-hours CPD for its staff.
Other Clinical Staff • Review compliance with / introduce Clinical Nurse Specialist and Allied Health Professional job planning process to identify opportunities for greater productivity.		Gap 1: Not all Job plans align activity, management duties, education and clinical delivery to funded hours.

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5. People Costs – Temporary staffing including Bank and Agency & Locum	Controls / Processes in place	Assurance that processes are operational
Policy, procedures, roles and responsibilities • An organisation wide temporary Staffing Policy in place and up to date. • There is a clearly communicated process in place for bank / agency & locum booking. • Monitoring controls in place to monitor compliance with the process for bank / agency & locum booking. • Governance process exists to oversee temporary staffing with clear ToR (either at overall level or by key staffing group e.g. nursing, medical, corporate). • Limit who can authorise bank and agency & locum staff to increase transparency; follow up on all short notice use. • Review consistency of authorisation levels and approach across sites.	• Nursing have a SOP which includes an escalation process for the booking of temporary staff e.g. bank and agency. • Auto-enrolment to bank for eligible staff; medical and A&C banks in place. • No off-framework/ off-contract engagements; self-imposed caps and rate controls. • Long-term agency policy with conversion pathways to substantive/bank. • Nursing have a full variable pay SOP covering all elements including escalation times. Work is on-going to formulate a SOP for medical teams in line with the medical e-rostering rollout.	Reporting through FCSG and Value & Sustainability. Specific Nursing & Medical Forums. Gap 1: Short-notice bookings without proper approval. Gap 2: Off-framework placements under exceptional justifications. Gap 3: Inconsistent authorisation approaches across sites. Gap 4: The Health Board does not have a consistent approach to the management of bank and agency staffing across different professional groups.

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5. People Costs – Temporary staffing including Bank and Agency & Locum	Controls / Processes in place	Assurance that processes are operational
Bank utilisation • All relevant staff groups are auto enrolled on the bank. • Review actual temporary staff rates against rates charged periodically to identify and address issues. • Implemented and promoted a medical bank, and an Administration and Clerical bank. • Promote bank staff as an alternative to agency & locum. • Review pay rates and consider financial incentives for bank staff to increase bank usage, for example consider weekly pay as an incentive.	The Health Board uses STREAM which enables staff to draw down a proportion of pay as need arises during the month. Report due to be considered by the Executive Team on the withdrawal of the weekly payroll due to less than 70 staff members utilising this.	Gap 1: Inconsistent application of the rate cards due to management override for enhanced rates of pay that are not within policy. Gap 2: We run a weekly payroll for less than 70 staff which is inefficient and can lead to overpayments due to the speed of turnaround.
Agency and Locum controls • Robust controls over agency & locum usage for example: - o self-imposed cap on agency & locum expenditure; o senior sign off of agency & locum expenditure. o senior sign off of off-framework expenditure; o clear Board accountability defined and communicated across organisation. o improved communication of planned clinic cancellations to agency/bank teams; and o no direct approach for agency. • Process in place to ensure non-framework or off-contract agency staff are not engaged. • An organisation process in place for long term agency & locum use. • Seek local agreement of agency & locum pay rates with surrounding trusts / explore use of a collaborative bank. • Evaluate opportunities for moving from use of agency & locum to internal organisation resource and / or bank.	Medical Stabilisation group was established in 2025/26 and will continue in 2026/27. Significant progress made to reduce high cost locums.	Gap 1: Inconsistent application of the rate cards due to management override for enhanced rates of pay that are not within policy. Gap 2: there is no preventative control to ensure no direct approach to agencies occur.

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5. People Costs – Temporary staffing including Bank and Agency & Locum	Controls / Processes in place	Assurance that processes are operational
Timesheet and expenses management • Ensure breaks and hours claimed are accounted for correctly in timesheets (i.e. agency workers are only paid for time worked, in accordance with HB policies). • Ensure appropriate deduction for agency & locum staff breaks (lunch). • Ensure mileage claims are only for required intra-site travel.	Yes Yes Yes	
Restrictions on non-clinical temporary staff • Review and implement exit strategies for all non-clinical temporary workers. • Temporary ban on usage of non-clinical agency staff, with exceptions authorised by executive director.	Yes N/A no non-clinical agency staff	
Effective monitoring • Senior leads monitor weekly dashboard summaries of temporary staff usage, cost and trends to provide early warning signs and demonstrate progress with issues arising. • Track number of interims, termination dates, delivery of objectives, and daily rates. Focus on reducing number and costs. Consider options for contract terms that enables the organisation to offer substantive role after x months use: - e.g. offer locums a suitable package to convert from locum to substantive contracts. • Identify medical rotas with the highest use of temporary and bank staff and set out a plan to address • Hold weekly agency & locum meetings across all staffing groups with agency & locum overspends, attended by finance and key stakeholders, to review and control agency & locum expenditure.	Yes – Nursing Yes Yes Yes	Recruitment conversion processes in place: • Temp to Perm • Agency to Perm • Bank to Perm Weekly Recruitment 'Hard to Fill' meetings to ensure proactivity and innovation. Gap 1: There is no comprehensive physical reporting (WTE) of Medical shifts worked with the associated financial costs. Gap 2: clarity is lacking to articulate the nature of the requirement for temporary cover, where a number of issues are commonly conflated resulting in a lack of control surrounding the termination of a temporary worker.

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6. People Costs – Other Staff Payments	Controls / Processes in place	Assurance that processes are operational
Overtime and enhanced payments controls • Ensure breaks and hours claimed are accounted for correctly in timesheets. • Perform a monthly 'audit' of the top 10 highest overtime earners by division. • Implement prior approval for overtime and enhanced payments - monitor and reduce. • For non-clinical staff - implement non-clinical overtime controls to limit expenditure in this area (e.g. Exec director authorisation required).	Expenses system in place which is administered by Shared Services. For corporate teams there is a Time Off In Lieu (TOIL) policy.	Gap 1: No monthly audit of the top 10 highest overtime earners by CCG/Directorate is being undertaken. Gap 2: There is a lack of and inconsistent reconciliation of hours before paying bank or overtime to staff. Gap 3: Lack of understanding of whether the TOIL Policy is being applied before payment of bank or overtime rates. Gap 4: Levels of discretionary effort above contracted hours is not monitored. Gap 5: Compliance with Working Times regulations over a defined reference period i.e. 17 weeks/26 weeks is not undertaken. Documented “opt outs” for the 48-hour week may not be in place or monitored/reviewed. Gap 6: Inconsistent mileage and travel allowance across sites.
Expenses Monitoring • Monthly monitoring of the highest mileage and expenses claimants.		To be introduced in May linked with other measures around high spend controls.

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Waiting List Initiatives (WLIs) controls • Ensure consistent process across organisation including compliance with the WLI rate across the organisation. • Appropriate review process in place for additional sessions allocated. • Enhanced authorisation process for WLIs, with checks are undertaken before WLIs are awarded to ensure that :- o WLIs offer financial benefit or are operationally critical before approving, and o existing Programmed Activities (PAs) have been utilised. • Benchmark WLI rate against other Health Boards.	Yes Planned Care CCG	Gap 1: Management override occurs for rates above cap that are not within policy. Gap 2: Inconsistent mileage and travel allowance across sites.

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7. Procurement	Controls / Processes in place	Assurance that processes are operational
Procurement – Clarity of Roles • Clear documentation and communication of roles between local managers, the procurement function and Shared Services.	• Roles and responsibilities between local managers, the Procurement function, and NWSSP Shared Services are formally defined, version-controlled, and published on the HDdUHB intranet.	• Intranet page link and version history showing last review date.
Procurement - Tender process • Approval limits are periodically and regularly reviewed where appropriate. • All new contracts awarded in compliance with Statutory Regulations and SFIs. • All new contracts (including agency & locum staff) are procured via appropriate tendering procedures to ensure best value for money is attained. • Single Tender Waivers controlled to minimise use. • Whole Life Costings are applied to evaluate tenders. • Appropriate SLAs and T&Cs are applied to ALL contracts to enable appropriate and effective contract management. • Breaches are reported to the relevant Executive Director and included in financial performance monitoring arrangements.	• All procurements are run in accordance with Public Procurement Regulations, Standing Financial Instructions, and internal governance. • The Procurement SMT and Oracle Systems Team review compliance. • All awards go through the Health Board Financial Control Sub-Group (FCG). • Whole-Life Costing (WLC) is applied where appropriate. • Contract award packs with standard T&Cs are issued to named Contract Managers. • Single Tender Waivers (STWs) are tightly controlled, with none approved in the last 12 months due to strengthened scrutiny. • Breaches are escalated to the Deputy Head of Procurement and reported through ARAC.	• SMT/Oracle compliance review logs and sample tender files • FCSG – Procurement agenda item • STW log confirming 0 STWs in the past 12 months. • Contract award pack samples with named Contract Manager acknowledgements. • ARAC papers noting any breaches and actions closed. • Internal audit outcomes on procurement compliance.

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7. Procurement	Controls / Processes in place	Assurance that processes are operational
Procurement – Call Off • Contract pricing is reviewed annually to attain any further increased banding cost advantages through life of contract. • Product catalogues reviewed (both NHS Supply Chain and Local Catalogues) to remove duplicate items on catalogue (e.g. pens) to ensure value for money. • Consolidate a list of supplier discounts and penalties for early / late payments (in alignment with contract register) - set out plans to recover / avoid these and share with accounts payable team to enact.	• Contract pricing is reviewed in line with contract mechanisms to secure banding advantages and value for money. • Catalogue content is actively cleansed to remove duplicates and guide buyers to preferred lines. • Procurement partners with Finance to ensure negotiated discounts are applied and to mitigate late-payment risks.	• Annual/biannual pricing review records and variation notices • Enablement reports showing duplicate item removals and catalogue compliance rate • Evidence of discounts applied on invoices • AP on-time payment KPI trend where relevant to discount realization. Gap 1: Catalogue usage not mandated and therefore is not adhered to consistently.

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7. Procurement	Controls / Processes in place	Assurance that processes are operational
Procurement - Contract management • Robust contract management processes are in place, including a complete and up to date contract register. • Regular contract reviews to ensure SLAs are being met - with specific focus on PFI contracts where relevant. • When contracts expire, these are retendered in accordance with the statutory regulations rather than rolled over and explore options for efficiencies/price reduction. • Contract terms are relative and proportionate to the contract matter and that there is a clear understanding of the risks transferred. • Service specifications are reviewed and ensure SLAs are being achieved or amend where suitable and do not directly affect patient care (e.g. reduce frequency of window cleaning etc.)	• Contract register is maintained locally and aligned to All-Wales registers. • Contract management packs categorize contracts (e.g., critical/strategic/transactional) and set monitoring expectations. • Expiring contracts are proactively recommissioned; rollover is avoided unless justified. • PFI contracts are overseen by NWSSP Specialist Estates Services. • Service specifications and SLAs are reviewed to maintain quality while seeking efficiencies.	• Contract register • Forward look of expiries (next 6–12 months) with sourcing plans • Sample completed contract review minutes/action logs • Evidence of SLA/KPI performance reports and remedial actions • Confirmation of PFI oversight by NWSSP SES and latest review output. Gap 1: a live contract register is not easily accessible to service leads and does not afford proactive triggers to functional leads to highlight upcoming expiry of contracts. Gap 2: periodic and routine contract management reviews are not conducted to review contract KPIs and service compliance by all contract managers, overseen by Procurement.

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7. Procurement	Controls / Processes in place	Assurance that processes are operational
Procurement – Purchase to Pay • Establish a robust purchase ordering (PO) system to enable the implementation of a 'no PO no payment' rule and no retrospective POs, in collaboration with Accounts Payable, to help control expenditure. • Invoices that fail three-way match (PO, goods receipt, invoice) are rejected and returned. Source of error are identified and contract managed appropriately. • Payments are only processed following sign off from the appropriate level. • Sample audit batches for any possible out of policy expenditure. • Continuous review of all open purchase orders that feed the monthly goods received not invoiced (GRNI) accrual for accuracy and appropriateness, ensuring any no longer valid items are removed/closed. • Consider limiting and refining approval limits of requisitioners where appropriate.	• Robust P2P governance is in place via joint AP & Procurement working groups and All-Wales P2P forums. • Three-way match is enforced; invoices failing match are returned per policy. • 'No PO, No Pay' is embedded; retrospective POs are discouraged and tracked. • Breaches are flagged by buyers and reported via ARAC. • Requisitioner numbers and approval limits are being refined, with mandatory training for requesters and approvers.	• P2P dashboards • Retrospective PO logged within ARAC report. • Attendance/ competency records for requisitioner/approver training to be introduced • ARAC reports including policy breaches and closures • Working group minutes with actions completed. Gap 1: Invoices that fail a three-way match are not rejected at source but are held by NWSSP pending service update.
Procurement - Other • Process in place to identify any "off contract" and consultancy expenditure. A strategy in place to review and market test costs to ensure best value. • Contract pipeline clearly identified (and shared with NWSSP) to enable economies of scale. • Ensure the number of purchasing cards in the organisation is right-fitted and balances the process efficiencies against the risk that the use of these bypasses' procurement processes. • Targeted approach for clinical preference variation (as identified by V&S procurement group).	• Regular spend reviews identify off-contract and consultancy spend, enabling rapid short-term contracting and longer-term sourcing plans. • Purchasing cards have been rationalised; Precision Pay is used to reduce risk and improve visibility. • Work is progressing to better align CCGs with Procurement. • A Regional Procurement Nurse is being recruited to lead clinical product standardisation and variation reduction with regional partners (e.g., SBUHB).	• Quarterly spend analysis highlighting off-contract spend; corrective actions and re-routing to contracts. • P-card policy, cardholder list reductions, and Precision Pay usage reports; internal audit results on P-card control. • Clinical variation baseline (e.g., top 10 categories) and standardisation roadmap; post-implementation savings/quality benefits. • Regional collaboration team in place • Regional workplan in draft

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7. Procurement	Controls / Processes in place	Assurance that processes are operational
Procurement – Signalling • Organisation has considered placing a hold on certain items (e.g. external venue hire). Although the savings will be low, can act as a signalling mechanism.	• Non-essential expenditure (e.g., external venue hire) has previously been restricted to signal financial discipline and prioritise clinical operations. • Catalogue expansion (e.g., Lyreco punchout; exploring digital tail-spend catalogue) steers staff to preferred products and controlled routes.	• Communications/policy notice implementing restrictions with effective date • Before/after spend analysis for restricted spend • Catalogue adoption metrics and % of tail spend routed through approved catalogues

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8. Other Items	Controls / Processes in place	Assurance that processes are operational
VAT recovery management • Review latest contracted out services guidance to ensure all eligible VAT is being reclaimed.	• Procurement buyers follow a defined internal process to verify VAT coding on all Purchase Orders, ensuring alignment with COS rules, contract status, and service category. • Specialist VAT advisory support is in place via external partners (EY/KPMG), providing periodic review, challenge, and reclaim submissions to maximise recoverable VAT and ensure compliance with HMRC requirements. • All covered by a VAT Financial Control Procedure.	• Sample audits of POs by Procurement /Finance demonstrate correct COS categorisation and VAT coding accuracy (e.g., % accuracy rate, exceptions log, corrective actions taken). • Compliance and Tax team actively review spend to ensure all eligible VAT is being reclaimed. • External VAT reclaim reports: Regular outputs and assurance letters from EY/KPMG confirming claims submitted, value recovered, areas reviewed, and compliance with HMRC COS guidance. • Joint review meetings between VAT Leads, Finance, and Procurement to monitor reclaim rates, review missed opportunities and validate the accuracy of coding on high-risk categories (e.g., estates, IT, outsourced services). • Ad-hoc re-reviews undertaken (by different advisors) to ensure no areas missed.

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8. Other Items	Controls / Processes in place	Assurance that processes are operational
Income and Debt management • A NHS visitor and migrant cost recovery programme in place. • Bad debt cost management process in place e.g.: - o Ensure debtors categorised logically (e.g. NHS, Non-NHS, Private Patients, Overseas, Salary Sacrifice, Prescriptions, Salary Overpayments, etc.) with agreed risk based, proportionate approach to collection for each category. o Identify strategy for key debtors and set collection targets for team members. o Review processes in place to ensure invoices are issued in real time or as soon as possible. o Consider payment in advance/on delivery where appropriate or the use of pro forma invoices in areas such as private patients backed with settlement facilities available at point of delivery. o Identify and address internal issues that are preventing timely collections i.e. unresponsive / untimely resolution of queries by divisions. o Scrutinise requests to write-off salary overpayments (if historic practice shows these are material). o Ensure prompt referral to external debt recovery agencies where necessary.	• Identification and Charging for Overseas Visitors for NHS Treatment Financial Control Procedure. • Designated Overseas Officer employed by Health Board. • Income and Cash Collection FCP – includes credit control and debt recovery approach for different categories of debtors and referral to debt collection agency as appropriate. • Income Risk Stratification FCP – covers area to consider for all employees who engage with companies to provide a service in return for payment to reduce risk of non-payment.	• Regular training provided to frontline staff regarding use of policy. • Regular monthly reviews of overdue debts are undertaken. • All write-offs where uneconomical to pursue reported to ARAC. • Area of highest interest in relation to recovery of overpayments of salary. All Wales policy in place.

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Stock Management • Ensure appropriate stock rotation processes are in place and being followed to minimise wastage. Agree process with suppliers to swap out short shelf-life items or use consignment. • Review stock level minimum and maximum thresholds in line with current usage to minimise wastage. • Review delivery charges, triggers and schedules and implement changes to reduce any carriage charges where possible (e.g. standing orders, minimum order values, 3 day delivery rather than next day). • Review controls on consignment stock.	• Stock Financial Control Procedure in place. • *Pharmacy has Standard Operating Procedures (SOPs) governing both stock maintenance and stock checking. These SOPs outline clear responsibilities, frequency of checks, documentation requirements, and investigation pathways for discrepancies.* • *Separate monthly checks of the central store areas are also conducted, which ensures all stores, fridges, and other specialist storage spaces are reviewed and signed off.* • *Stock within the robots undergoes monthly short-dated reviews, with expired items removed and destroyed, and short-dated items redistributed where possible.* • *Expiry date checks of stock held outside the robot are reviewed as part of the rolling stock check process mentioned above, and all items within three months of expiry are classed as "short-dated" and logged.* • Robust stock rotation processes are in place across all storage areas to minimise waste and expiry. • *A weekly minimum stock level report is generated and reviewed by procurement teams.* • *A system program reviewing stocks within the robots (KROB) is available.*	• *Functionality within the Pharmacy Stock Control System (WellSky/CareFlow) facilitates this, by generating randomised daily lines for validation. This happens at sites on a daily basis. Any identified discrepancies, expiry issues and stock rotation needs are investigated and actioned, and all documentation are stored locally in dispensaries.* • *The system generates a specific slow moving stock report (KLSOW) to identify slow moving items across the Health Board. This is reviewed centrally on a regular basis and stock redistributed across sites or returned to suppliers (if possible) to minimise stock destruction and wastage.* • Scan4Safety live tracking provides real-time visibility of stock levels, expiries, and usage patterns, enabling proactive identification of slow-moving or excess items and confirming compliance with rotation processes. • Physical stock count undertaken at least annually for areas not covered by an automated process. • *This reviews usage-based recommended minimum and maximum levels within the system, and these are adjusted as necessary by trained staff where*

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	• *At the Pharmacy Services Governance Group meeting, all procurement-related KPIs are presented and reviewed. This includes stock holding levels within each site along with other key indicators such as volume of ordering, receipting and invoicing.* • Minimum and maximum stock thresholds are reviewed regularly and adjusted in line with usage data, clinical demand, new pathways, and service changes to avoid over-stocking and obsolescence. • Delivery schedules, order triggers, and carriage charge structures are reviewed with suppliers to reduce unnecessary charges and optimise delivery frequency (e.g., consolidated weekly deliveries, minimum order values, standing orders, or 3-day delivery options instead of premium next-day services).	*clinically and financially appropriate.* • *This process needs refinement to its functionality as currently it is very challenging due to the manual workload involved and needs resourcing and process support. The regular rolling stock checks mitigate this risk, but this could be more efficient if working appropriately.* • *Current rolling stock checks are held manually on paper within each separate pharmacy department. The team are working on a central electronic process to provide this oversight and improve assurance on the processes.* • *This enables identification of anomalies and opportunities for efficiencies.* • Carriage charge reduction project during financial year 2026/27. • Stock ownership and replenishment controls: The introduction of four dedicated stores staff ensures consistent delivery-to-ward processes, accurate stock rotation, and controlled top-up cycles. Compliance is evidenced through observed practice audits and supervisor sign-off.

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8. Other Items	Controls / Processes in place	Assurance that processes are operational
		• Internal audit / peer review: Results from internal audits or stock spot checks, with actions tracked to completion. Gap 1: operational stocktakes are not conducted on a regular and routine basis, resulting in the annual financial stocktake generating a higher volume of adjustments.

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Estates • Review outliers identified from benchmarking overall running costs for facilities and estates (inc. estates footprint use) (see the VAULT). • Ensure appropriate maintenance schedules in place to ensure asset kept in good working order. • Ensure an estates strategy is in place and regularly reviewed, to include estate rationalisation consideration to determine where savings might be delivered. • Establish list of ongoing and planned estates and maintenance projects and ensure it has been prioritised and has Board approval.	• Data collected through the Estates & Facilities Performance Management returns are available for internal benchmarking purposes. • All Planned Preventative Maintenance Schedules (PPM) are routinely assessed in line with Welsh Health Technical Memorandum (WHTM) requirements and processed using our online Computer Aided Facilities Management (CAFM) system which offers dynamic reporting against benchmarks set for each maintenance schedule. This is reviewed monthly at the Estates Maintenance Operations Governance Group Meeting and again at the Estates Governance Group Meeting. Any concerns are picked up there. Specific disciplines e.g. Electrical Safety and Water Safety are picked up in those meetings are reported into the Health & Safety Compliance Group Meeting and then Health and Safety Committee. • A Property Asset Strategic Plan is in place and provides an overview of existing and planned changes to the HB's estate. • All contractual work in Estates team is tendered in line with procurement and SFIs and utilises framework contractors that have been vetted and approved e.g. Grounds	• Data collection is undertaken in-house and reported annually via NWSSP Specialist Estate Services. • Day to day operational Maintenance & Engineering teams utilise CAFM for PPM schedules daily and report into governance groups for check and challenge as mentioned. • The strategy was endorsed by the Board in May 2023 and covers the period between 2023 to 2026. This strategy will be updated in 2026/27 to align with the HB's refreshed Clinical & Estate Strategic plan. • All Terms of Reference for the aforementioned boards and committees contain explicit purpose and instructions with minutes available to demonstrate compliance.

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8. Other Items	Controls / Processes in place	Assurance that processes are operational
	Maintenance and Lift Inspections. Other planned estates projects report through the Estates Governance Group, Capital Sub-committee and Strategy and Planning Committee for appropriate approvals. Any projects over £1m go to Public Board for formal approval following Executive Team sign off.	
Journal Approvals • Internal journal review process in place and regular accruals and prepayments have been reviewed to ensure they remain current and the method of calculation is based on up-to-date assumptions. • Controls over journals are appropriate including posting authorisation levels, review and sign off process.	• Oracle E-Business Suite – System Access and Ledger Security FCP – includes General Ledger Input Procedures covering Journal processing, postings and approval. • Oracle keeps an automated record of all journals posted which can be linked back to source. • Feeders Control Sheet completed by Core Accounting Team for all external feed journals from outside the Oracle system. • Quarterly extract of all manual and Application Desktop Integrator (ADI) journals selected at random for retrospective approval by the originator's line manager.	• For all 'actual' journals automated posting is active within Oracle and scheduled to meet the organisation's prescribed monthly closedown timetable. Due to the volume of journals and critical path required to meet timetable, Audit Wales has recognised that it is not practical to approve journals before posting and hence review our retrospective journal process as part of the Annual Accounts audit. • All budget journals are posted by the Corporate Reporting Team.

Colour Key:- **financial controls** are black **grip actions** are blue

8. Other Items	Controls / Processes in place	Assurance that processes are operational
Fixed Assets and Capital • Fixed asset register is in place and regularly updated including a fixed asset verification exercise. • Review capital programme for subsequent revenue affordability, deferring, reducing or stopping schemes as appropriate. • Asset lives regularly reviewed to ensure appropriate and that depreciation is consistent with consumption. • Consider reprioritising the capital programme to prioritise spend-to-save projects. • Review assets held on SoFP (buildings, equipment etc) and dispose of any no longer in use or needed. • Consider VfM of ownership options such as lease v purchase.	• Capital Investment FPC – covers capital planning process; how to bid for capital; procedure for capital purchases; monitoring arrangements of capital programme and accounting arrangements for the Fixed Asset Register. • Yes, operated by the Finance Capital Team. • Revenue implications are considered as part of the prioritisation process for capital. It is not the only consideration taken into account when the programme is developed, clinical risk and patient impact are key considerations. • Reviewed annually by the Finance Capital Team as part of the Annual Audit process. • A spend to save allocation has been earmarked in the programme for 24/25, 25/26 and 26/27. • The UHB has an Estates Strategy that reviews estates assets that can be disposed as new projects complete. • The UHB currently has a mixed portfolio of capital developments some in the more traditional build and own category and a few where collaboration with local authority and WG has led to various lease options being developed.	• Three-year cyclical asset verification process – current year (Ceredigion) with 70%+ response rate at 9/3/26. • Subject to Audit. • Large projects are considered by Executive Team, Capital Sub Committee and Strategy and Planning Committee prior to being presented to Board for approval. • Subject to audit. • The split of the UHB discretionary capital is considered by Executive Team, Capital Sub Committee, Strategy and Planning Committee prior to being presented to Board for approval. • All plans and major developments are reported through the Governance process described above.

Colour Key:- **financial controls** are black **grip actions** are blue

8. Other Items	Controls / Processes in place	Assurance that processes are operational
Balance Sheet Review • Ensure all balance sheets are reconciled at appropriate intervals and action is taken to address historical balances. • Monthly assessment of existing provisions to determine whether these can be released during year as opposed to later in the year/year end. • Review all credit balances on the Balance sheet for potential over accrual (e.g. Annual Leave Accrual or GRNI balances).	• Blackline system in place used to perform monthly reconciliations. • Balance sheet accounting principles implemented in year (and documented for clarity in Quarter 3 2025/26). Includes: o proactive assessment on a monthly basis of current provisions to determine whether they can be released in year as opposed to traditional year-end approach. o quarterly review of historic annual adjustments, recognising these are at a point in time and may not be indicative of year-end position.	• Historic balances (particularly in CHC) reviewed and released where not required. • Wellsky balances were assessed as high at 2024/25 year end but due to time and staff constraints the erroneous over accrual was not addressed. • Balance sheet process is still bedding in but improving as staff are becoming more familiar with it. Gap 1: a comprehensive aged balance sheet review does not currently exist.

Colour Key:- **financial controls** are black **grip actions** are blue

Workforce Programme Delivery Plan – Theme 6

Project title	**Organisational Change Process**
Executive sponsor	Director of Workforce and Organisational Development/Deputy CEO
Senior responsible owner	To be confirmed through Workforce Programme governance
Project lead	
Start date	1 August 2026
Review dates	Day 30: [date] | Day 60: [date] | Day 90: [date]
Strategic alignment	Workforce Stabilisation Programme: OCP Process
Project Team	Workforce Team
Expected WTE/£ outcome	5% CIP for all future restructures

PROJECT DASHBOARD | 30, 60 AND 90 DAY DELIVERY VIEW			
Project OCP Process	**Overall outcome** By day 90 the OCP process will have been redesigned to ensure WTE reduction (where appropriate) and 5% CIP evidenced	**Overall RAG** **[R / A / G]**	**Programme ask** Confirm owner and agree KPIs to monitor progress
Day 30: Understanding & Quick Wins • Finance and workforce summary section added into OCP briefing and consultation document • Review of OCP Briefing document undertaken to focus on productivity,	**Day 60: Implementation of medium term actions** • OCP process outline in place to ensure clear stages & timelines developed to support implementation	**Day 90: Evidence of progress and commencement long term actions** • All OCPs ensure recurring CIP saving requirement • All OCPs delivered within minimum timeframes depending on size of restructure	**Key delivery focus** Deliver cost effective OCPs safely and consistently by ensuring financial alignment with clear productivity, transformation and planning alignment.

transformation & planning • Planned approach developed to OCP to ensure strategic in nature • Clear delivery plans in place for all OCPs to ensure timely process			

KPI SCORECARD				
Measure	**Baseline**	**Current**	**Target by Day 90**	**Trend / RAG**
OCPs approved with 5% CIP evidenced				→ A
				→ A
				→ A
				→ A
	[Insert]	[Insert]	[Insert]	[↑ / → / ↓] [R/A/G]

PROGRAMME GROUP ATTENTION AREAS		
Top risks 1**Highest score:**	**Mitigations and controls** 1.	**Decisions / support required** 1

NEXT REPORTING PERIOD			
Priority action	**Owner**	**Due date**	**Success measure**

PROGRAMME DEFINITIONS	
Problem or opportunity	Opportunity to create sustainable recurrent savings plans by introducing 5% CIP requirement for all restructuring processes.
Benefits expected	5% CIP delivery
Success criteria	Savings identified in substantive sustainable way.
Scope	All managerial and leadership OCPs. Further scoping to include whether clinical areas should also include requirement.
Key dependencies	Limited to OCPs being undertaken so won't deliver all required savings.

RISKS & MITIGATIONS							
Risk	Cause	Impact if unmanaged	Current score	Mitigation / control	Owner	Target score	Review date
OCPs do not consistently evidence the required 5% CIP or WTE reduction opportunity.	Financial and workforce assumptions are not consistently built into the OCP briefing, consultation and approval process at the outset.	Missed recurring savings, weak financial assurance, and OCPs progressing without clear productivity, transformation or planning alignment.			Directorate lead with Finance and Workforce support		Day 30 review
OCP briefing documents are not sufficiently focused on productivity, transformation and planning.	Existing OCP templates may focus on structural change rather than the strategic reason for change, benefits, options and measurable improvement.	Weak case for change, limited assurance for decision makers, and reduced ability to demonstrate value, service improvement or alignment with organisational priorities.			Workforce Programme lead		Day 30 review

OCP process is not managed to a clear delivery plan or minimum timescale.	OCP activity is progressed inconsistently across teams, with variable project planning, owner accountability and milestone tracking.	Delays to consultation, approval and implementation; inconsistent staff experience; and reduced confidence in the OCP process.			OCP project owner		Day 30 review
OCPs proceed without sufficient scrutiny of whether change is strategic in nature.	Triggers for OCP initiation are not consistently tested against strategic need, transformation opportunity, workforce plan and affordability.	Unnecessary or poorly scoped restructures, avoidable disruption, limited measurable benefit and increased risk of challenge.			Executive sponsor / SRO		Day 30 review
OCP documentation does not provide consistent assurance for future restructures.	Variation in templates, sign-off information, financial evidence, workforce assumptions and decision records across OCPs.	Inconsistent governance, unclear audit trail, slower approvals and difficulty evidencing delivery of the required 5% CIP for future restructures.			Workforce Programme governance lead		Day 30 review

GOVERNANCE, ASSURANCE & ESCALATION	
Governance route	Workforce Programme governance, supported by Workforce & OD SLT escalation route
Review frequency	Weekly action review, with fortnightly Workforce & OD SLT review and monthly executive or finance check where escalation is required.
Escalation triggers	Escalate OCPs which do not have required savings attached Escalate to Executive Team
Decision points	Approval of final OCP structures with Executive Directors,
Assurance evidence	Sign off of OCP by Directors of Finance & Workforce & OD

DAY 90 REVIEW & NEXT STEPS	
Overall delivery assessment	By Day 90, the OCP process should be operating with a revised briefing and consultation approach that requires each relevant restructure to evidence the 5% CIP opportunity, WTE impact, productivity rationale, transformation alignment and workforce planning assumptions. Delivery should be assessed against whether all active OCPs have a clear owner, delivery plan, minimum timeframe, financial and workforce summary, and escalation route where savings or strategic alignment are not sufficiently evidenced.
Benefits delivered	Revised OCP documentation provides stronger financial and workforce assurance; all relevant OCPs are expected to identify recurring CIP and WTE implications at the outset; productivity, transformation and planning are more clearly embedded in the case for change; delivery plans support more timely and consistent OCP progression; and escalation to Executive Team is clearer where required savings, sign-off or strategic rationale are not confirmed.
Outstanding actions	Confirm whether the 5% CIP requirement should apply beyond managerial and leadership OCPs into relevant clinical areas; complete any remaining updates to the OCP briefing, consultation and approval documentation; finalise the minimum timeframe and delivery plan approach according to the size and complexity of restructure; confirm ongoing governance ownership; and ensure all future OCPs have Finance and Workforce & OD sign-off before progression.
Lessons learned	The OCP process needs early financial and workforce input to avoid proposals progressing without clear savings, WTE impact or affordability evidence. A standardised briefing and gateway approach strengthens consistency, assurance and audit trail. OCPs are more effective when the strategic case for change is tested early against productivity, transformation and workforce planning, rather than being treated only as a structural change process. Clear owners, minimum timescales and escalation points are essential to maintain pace and reduce variation.
Recommendation	Embed the revised OCP process as the standard approach for future managerial and leadership restructures, with Finance and Workforce & OD review at the outset, explicit 5% CIP and WTE assessment, strategic

	gateway scrutiny, agreed delivery plans and Executive Team escalation where savings, affordability or strategic alignment are not evidenced. Subject to Day 90 review, consider extending the requirement to relevant clinical OCPs where appropriate.

3.3

3.3 - FINANCE DEEP DIVE: MEDICAL VARIABLE PAY

Mark Henwood (Hywel Dda UHB - Executive Medical Director)

For assurance

Attachments

Finance Deep Dive Medical Variable Pay FPC 27 August 2026.pdf

Pwyllgor Cyllid a Pherfformiad/ Finance and Performance Committee

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	27 August 2026
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Finance Deep Dive: Medical Variable Pay
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Mark Henwood, Executive Medical Director
SWYDDOG ADRODD: **REPORTING OFFICER:**	Carly Hill, Assistant Director, Medical Directorate

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

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

Medical workforce expenditure is a significant contributor to the Health Board's financial challenge. Analysis of Months 1 to 3 2026/27 expenditure demonstrates a continued reliance on agency staffing and, more significantly, medical variable pay to deliver recurrent services.

The total spend across the first three periods was £7.1m, comprising:

- Variable Pay: £5.43m (77%)
- Agency Spend: £1.67m (23%)

The key financial concern is that variable pay expenditure is being used to sustain predictable and ongoing activity rather than addressing short-term staffing gaps. This indicates a structural workforce affordability issue rather than a temporary resourcing issue.

Cefndir / Background

The Health Board has implemented a number of controls to improve oversight of medical temporary staffing expenditure, including:

- Medical rate card implementation
- Allocate roster deployment
- Medical Workforce Stabilisation Programme
- Enhanced financial and workforce reporting

Whilst agency expenditure remains a financial pressure, recent analysis demonstrates that internal medical variable pay represents the largest component of temporary staffing costs.

A financial deep dive was therefore undertaken to identify the principal drivers of spend, the highest-cost specialties and services, and the opportunities available to reduce expenditure whilst maintaining safe clinical services.

Asesiad / Assessment

OVERALL POSITION

Category	Spend (£m)	% Total
Variable Pay	5.4	76.5%
Medical Agency	1.6	23.5%
Total	7.1	100%

For every £1 spent on agency staffing, approximately £3.30 is spent on internal medical variable pay.

HIGHEST SPENDING AREAS

Total Agency Spend

Clinical Care Group	Spend (£)
Pembrokeshire Integrated System	575,489
Carmarthenshire Integrated System	450,500
Pathology	353,088
Mental Health and Learning Disabilities	191,414
Planned and Specialist Care	131,519

Key agency drivers include:

- Withybush Hospital (WGH) Accident and Emergency Medical Staffing (£296k)
- WGH General Medicine (£279k)
- Glangwili Hospital (GGH) General Medicine (£267k)
- Haematology services across GGH, WGH and Bronglais Hospital (BGH) (£352k)

Service	Number of workers	Number covering vacancy	Clear exit strategy	No clear exit strategy
Haematology	5	4	1	4
Mental Health and Learning Disabilities	3	3	2	1
Planned and Specialist Care	2	0	0	2
Ceredigion Integrated System	1	0	1	0

Carmarthenshire Integrated System - **GGH** - **PPH**	9 3	8 2	9 3	0 0
Pembrokeshire Integrated System	14	13	9	5
Children, Women and Family Health	4	4	4	0

A review identified 41 temporary workers across services, of which 34 (83%) are covering substantive vacancies. Whilst services have identified exit strategies for 29 temporary workers, the maturity and deliverability of these plans vary.

A detailed review is currently being undertaken to assess confidence against each exit plan, including recruitment progress, expected timelines and associated risks. For the 12 workers without a defined exit strategy, a focused review is underway to determine whether expenditure can be reduced through substantive recruitment, rota redesign, service consolidation, alternative workforce models or cessation of non-essential activity. This work forms part of the Medical Workforce Stabilisation Programme and will provide a prioritised action plan for all long-term temporary staffing arrangements.

The greatest concentration of risk lies within Pembrokeshire Integrated System and Haematology, which together account for 75% of workers without a clear exit strategy. Pembrokeshire represent two-thirds of all reported workers, indicating that urgent and unscheduled care remains the largest area of workforce dependency and therefore the greatest opportunity for sustainable cost reduction through recruitment, retention and workforce redesign initiatives.

TOTAL VARIABLE PAY SPEND

Clinical Care Group	Spend (£)
Planned and Specialist Care	2,113,724
Carmarthenshire Integrated System	719,066
Children, Women and Family Health	511,722
Pembrokeshire Integrated System	392,227

HIGHEST COST SPECIALTIES

Clinical Care Group	Spend (£)
Anaesthetics	712,338
General Medicine (multiple sites)	511,000
General Surgery	366,345
Orthopaedics	322,173
Paediatrics	258,386
Obstetrics and Gynaecology	243,658

Key Financial Themes

1. Significant reliance on additional sessions to deliver planned care activity, particularly within Anaesthetics, General Surgery and Orthopaedics. The Planned and Specialist Care Clinical Care Group (CCG) has commenced a programme of work to quantify the proportion of variable pay associated with planned activity to identify opportunities.
2. Embedded use of variable pay within anaesthetics and surgical specialties.
3. Ongoing dependency on agency staffing to maintain emergency medicine and general medicine rotas.
4. Workforce shortages within pathology resulting in sustained premium expenditure.

Financial Opportunity

The analysis suggests that a proportion of current expenditure could be avoided through:

- Job plan redesign and annual review.
- Conversion of recurrent additional sessions into substantive programmed activities.
- Strengthened rate card compliance.
- Reduction in negotiated rates.
- Targeted recruitment to high-cost specialties.
- Workforce redesign across anaesthetics, unscheduled care and pathology.

The themes and opportunities identified through this review should be regarded as indicative rather than exhaustive. The current reporting functionality within Allocate limits the Health Board's ability to fully understand the relationship between roster design, vacancy levels, shift gaps and variable pay expenditure.

A joint programme of work is underway between Medical Workforce and Finance to strengthen reporting arrangements, improve data integrity and develop specialty-level workforce and financial dashboards. This will provide greater assurance regarding the scale of the opportunity and support more effective management intervention.

Not all variable pay is releasable:

- A proportion remains required to manage service fragility, recruitment gaps, and demand instability. The precise proportion has not yet been quantified, and work needs to be undertaken to provide a robust assessment of the realistic releasable opportunity.
- Delivery plans therefore need to be developed to focus on the achievable element of conversion, not total elimination. With the inclusion of workforce actions, financial trajectories, accountable leads, timescales and savings opportunities.
- Service design doesn’t align with the current budget/funded posts.

The Medical Workforce Stabilisation Programme will provide the overarching structure for this work. This incorporates recruitment, retention, rota design, job planning, temporary workforce controls and supporting specialty level financial recovery actions.

Workforce Stabilisation Opportunity

These opportunities have been designed to support the Workforce Stabilisation Programme being developed by the Director of Workforce and Organisational Development and will be monitored and reported into the overarching programme board.

Day 30 – Medical Workforce Baseline and Rota Review (most of this has been completed)

- Complete specialty-by-specialty review of all junior doctor and consultant rotas against service requirements and budgeted establishment.
- Identify all rotas currently operating outside the agreed 6-4-2 scheduling principle and quantify associated premium cost, locum usage and vacancy impact.
- Establish baseline metrics for:
    - Internal locum expenditure.
    - Agency locum expenditure.
    - Additional programmed activities.
    - Waiting list initiative payments.
    - Out-of-hours premium payments.
- Review compliance with medical job plans and identify opportunities to align Direct Critical Care (DCC), Supporting Professional Activities (SPA) and managerial time with service need.
- Establish monthly medical workforce performance dashboard showing:
    - Fill rates.
    - Vacancy rates.
    - Locum utilisation.
    - Exception reporting.
    - European Working Time Directive (EWTD) compliance.
    - 6-4-2 rota compliance.
- Confirm all medical rotas are loaded onto Allocate and roster reports available for management review.

Day 60 – Implement Medical Controls

- Implement agreed 6-4-2 rota model across priority specialties.
- Look to develop a centralised Rota co-ordination and Medical Bank team.
- Review all long-term locum placements and develop substantive recruitment or rota redesign plans.
- Create rota review panels for high-cost specialties (Emergency Department, Medicine, Anaesthetics, Radiology and Psychiatry).
- Reduce premium rate bookings through:
    - Earlier gap identification.
    - Internal bank utilisation.
    - Cross-site workforce deployment.
    - Job plan optimisation.
- Review consultant job plans to ensure sessions match rostered service demand (ensure services are using the service planning leading to job planning model).
- Introduce monthly specialty-level review of:
    - Agency usage.
    - Internal locum spend.
    - Unfilled shifts.
    - Rota compliance.

- Undertake demand and capacity modelling to determine whether current 6-4-2 patterns maximise productive clinical time.

Day 90 – Demonstrable Medical Workforce Improvements

- 95%+ compliance with agreed 6-4-2 rota principles across identified specialties.
- Reduction in medical agency spend against baseline.
- Reduction in internal locum expenditure and ad-hoc shift requests.
- All high-cost specialties operating with agreed recruitment and rota sustainability plans.
- Medical workforce dashboard embedded within monthly performance reviews.
- Exception reporting and EWTD monitoring automated through rostering system.
- Evidence of reduced shift gaps through improved rota design rather than reliance on premium pay solutions.
- Specialty-level variance reports produced showing cost and workforce impact of non-compliance with 6-4-2 scheduling.

Argymhelliad / Recommendation

The Finance and Performance Committee is asked to:

- **NOTE** the findings of the financial deep dive.
- **RECOGNISE** that medical variable pay represents the principal driver of temporary staffing expenditure.
- **ENDORSE** targeted intervention in the highest-spend specialties and services, particularly Anaesthetics, General Medicine and Pathology.
- **REQUIRE** specialty-level recovery plans for the top expenditure areas.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Cyfeirnod Cylch Gorchwyl y Pwyllgor: Committee ToR Reference:	3.1.1 Receive assurances on the financial governance and control environment in operation across the Health Board. This will be achieved a programme of deep dive reviews into the following themes, which mirror the national Value and Sustainability Board: 3.1.1.1 Workforce 3.1.1.2 Non-pay and procurement 3.1.1.3 Medicines value and sustainability 3.1.1.4 Commissioned care 3.1.1.5 Clinical variation and service configuration
Cyfeirnod Cofrestr Risg Datix, Teitl a Sgôr Risg Cyfredol: Datix Risk Register Reference and Score:	1978 'Risk of insufficiently skilled workforce to deliver services due to limited labour market', which includes medical workforce. 2326 'Risk to achieving 26/27 Target Control Total due to underlying deficit, insufficient savings & reliance on non recurrent funding'
Parthau Ansawdd: Domains of Quality	1. Safe 2. Timely

Quality and Engagement Act (sharepoint.com)	6. Person-Centred
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	2. Culture and valuing people 5. Whole systems persepctive
Amcanion Strategol y BIP: UHB Strategic Objectives:	All Strategic Objectives are applicable
Nodau Cynllunio 2026/27 Planning Goals 2026/27	1. Healthy, Thriving Teams 6. Safe, Timely, High Quality Care
Hypergyswllt i Amcanion Llesiant HDdUHB 2026 Hyperlink to HDdUHB Well-being Objectives 2026	3. Create people-centred employment and development opportunities that support workforce transformation, reflect the changing needs of
Model Cymdeithasol ar gyfer Iechyd a Llesiant: (wedi'i gwblhau ar gyfer newid strategol a/neu newidiadau sylweddol i wasanaethau) A Social Model for Health and Wellbeing: (*complete for strategic change and/or significant service changes)*	Not Applicable
Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Not Applicable
Rhestr Termau: Glossary of Terms:	Contained within the body of the report.
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y cyfarfod hwn: Parties / Committees consulted prior to this meeting:	Not Applicable

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: **Financial / Service:**	Financial Impact Service Impact
Ansawdd / Gofal Claf: **Quality / Patient Care:**	Adverse quality and/or patient care outcomes/impacts: Quality Impact Assessment Template
Gweithlu: **Workforce:**	Future Staffing model for Medical Workforce.
Tegwch Iechyd: **Health Equity:**	• Have the potential impacts on health equity been considered? N/A • Has an equity focussed health impact assessment been undertaken N/A Equity-Impact-Assessment-Toolkit
Risg: **Risk:**	Risk identified are as per the risk register.

Cyfreithiol: **Legal:**	Not Applicable
Enw Da: **Reputational:**	Potential for political interest due to continued financial position.
Gyfrinachedd: **Privacy:**	Not Applicable
Cydraddoldeb: **Equality:**	e.g. potential negative/positive impacts identified in the Equality Impact Assessment (EqIA) documentation – follow link below • No (Not required) • No (Not required) Equality Impact Assessment

3.4

3.4 - FINANCE DEEP DIVE: NURSING VARIABLE PAY

Sharon Daniel (Hywel Dda UHB - Executive Director of Nursing, Quality & Patient Experience)

For assurance

Attachments

Finance Deep Dive Nursing Variable Pay FPC 27 August 2026.pdf

Appendix 1 Draft Variable Pay Reduction Programme Action PIan.pdf

Appendix 2 Nursing and Midwifery Variable Pay Reduction Programme Oversight Group Terms of Reference.pdf

Pwyllgor Cyllid a Pherfformiad/ Finance and Performance Committee

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	27 August 2026
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Finance Deep Dive – Nursing and Midwifery Variable Pay
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Sharon Daniel, Executive Director Nursing, Quality and Patient Experience
SWYDDOG ADRODD: **REPORTING OFFICER:**	Janice Cole Williams, Assistant Director of Nursing, Professional Standards

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

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The Nursing/Midwifery Variable Pay Reduction Programme has been established with the ambition of delivering a **£3.4** million reduction during 2026/27 (£1.8m minimum delivery commitment) through targeted interventions addressing the primary drivers of expenditure, including sickness absence, vacancies, agency utilisation, roster efficiency and workforce deployment.

For 2025/26, the Nursing/Midwifery and Health Care/Nursing Support Worker variable pay spend was **£24.2 million** (**£14.4 million** on Nursing and Midwifery and **£9.8 million** Health Care/Nursing Support Worker).

For 2026/27:

- Based on current forecasting (at the end of Month 4 (July), Nursing and Midwifery variable pay expenditure is anticipated to be **£12.7** million, with Health Care Support Worker/Nursing Support Worker expenditure forecast at **£9.7** million, resulting in a total variable pay spend of **£22.4** million. Based on this forecast, this represents a reduction of £**1.8 million (7%)** compared to 2025/26 (minimum delivery commitment) and is linked to the recruitment of the Sept 2026 newly registered nurses/midwives.
- The Nursing/Midwifery Variable Pay Reduction Programme aims to reduce Registered Nursing and Midwifery variable pay expenditure further from the forecasted £**12.7 million** to £**11.961** million and Health Care Support Worker/Nursing Support Worker variable pay expenditure from the forecasted £**9.7** million to £**8.830** million by March 2027.

Chart 1: Year to Date Variable Pay Spend in Health Care Support Workers by Clinical Services Group (up to Month 4 2026/27)

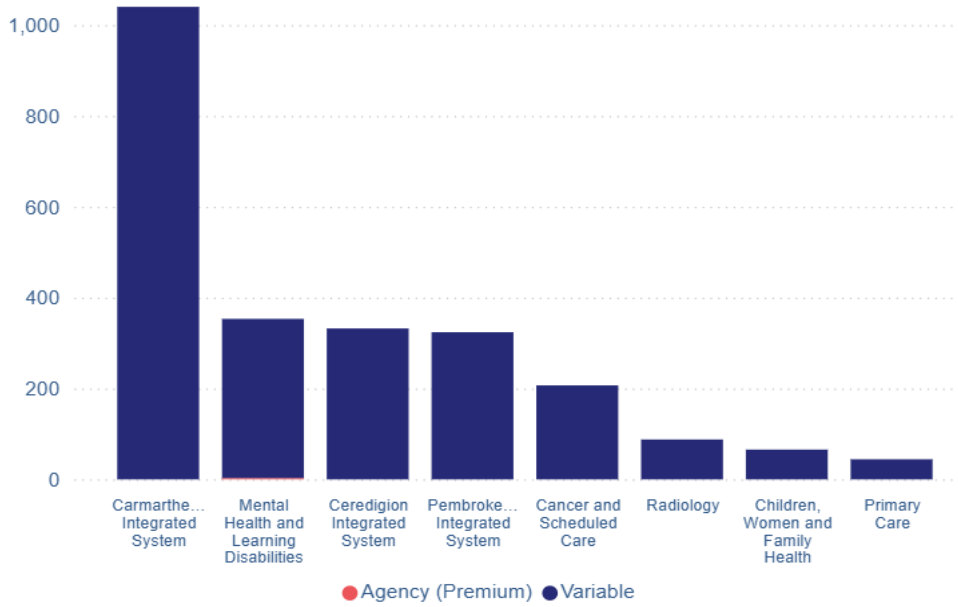
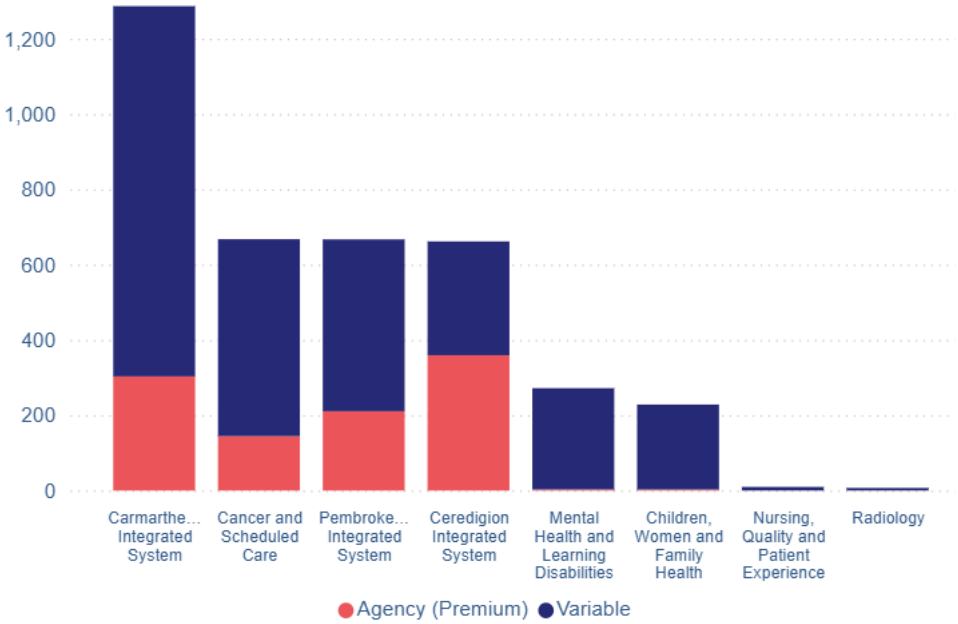


Chart 2: Year to Date Variable Pay Spend in Registered Nursing and Midwifery by Clinical Services Group (up to Month 4 2026/27)



Delivery will be dependent upon successful recruitment, reduction in sickness absence, elimination of support worker agency utilisation, significant reduction in nursing agency utilisation and improvements in roster efficiency and workforce deployment.

Whilst the reduction targets are considered achievable, a level of variable pay expenditure will remain necessary to manage unavoidable workforce pressures associated with statutory nurse staffing requirements, maternity leave, sickness absence, patient acuity, service

demand, and delivery. Progress against delivery trajectories will be monitored monthly through the Variable Pay Reduction Programme governance arrangements.

Cefndir / Background

The Health Board has invested considerable effort since 2023 in reducing reliance on temporary staffing through nursing workforce stabilisation, international recruitment, vacancy reduction, strengthened rostering controls and enhanced governance arrangements.

Since 2023, agency utilisation has reduced by 79%, overtime by 73%, bank utilisation by 38%, Band 5 vacancies by 76.2%, and nursing/midwifery turnover by 49%. These improvements provide assurance that actions implemented to date are delivering measurable and sustainable benefits.

For wards where S25B of the Nurse Staffing Levels (Wales) Act applies there is a statutory duty to ensure that 'all reasonable steps' are taken to maintain nurse staffing levels. The operational steps include:

- "Use of temporary staff from a nursing/midwifery bank appropriate to the skill mix set out in the planned roster
- Use of temporary staff from a nursing agency appropriate to the skill mix set out in the planned roster
- Temporary use of staff from other areas within the organisation
- The temporary closure of beds
- Consideration of patient pathway changes".

The Nursing/Midwifery Variable Pay Reduction Programme embeds:

- the rostering principles issued by Welsh Government in 2026
- incorporates opportunities for shared learning of the SBUHB Nursing and Midwifery Workforce Improvement which has a four-step approach focussing on governance and control, operational management tools, benchmarking and diagnostics, and transformation and model of care.
- aligns workforce supply with patient demand, improves financial discipline, and ensures safe, sustainable staffing.

Asesiad / Assessment

Deep Dive:

Whilst nursing and midwifery and support workers variable pay expenditure remains significant, analysis confirms that current expenditure is predominantly associated with unavoidable workforce pressures, including sickness absence, vacancies, maternity leave, patient acuity, and service demand. The review provides a detailed understanding of these drivers and has informed a targeted improvement programme focused on areas of greatest opportunity and risk.

Key Drivers: The current variable pay expenditure reflects genuine workforce pressures. Analysis identified a substantive nursing and midwifery workforce gap arising from:

- Sickness absence
- Vacancies
- Maternity leave
- Other forms of workforce unavailability
- Surge capacity
- Clinical areas where the service models are not aligned with the current budget / funded posts

Analysis of temporary staffing requests identified that 40% of Registered Nursing/Midwifery demand relates to sickness absence, 32% to vacancies, 11% to patient acuity, 10% to surge capacity, and 4% to maternity leave. Similar analysis within the Nursing Support Worker workforce identified vacancies and sickness absence as the principal drivers of expenditure. Request reasons are taken from the Allocate roster system. It is acknowledged that these reasons may not be consistently accurately recorded within and across areas. It is therefore stressed that reason breakdowns should be considered with some caution. Focussed work to accurately record reasons for shortfalls is ongoing.

Workforce Gap Analysis

The deep dive identified an overall nursing and midwifery workforce gap of 525.21 whole-time equivalent (WTE) (all bands and includes vacancies, maternity leave, and sickness). Temporary staffing currently provides cover equivalent to 210.97 WTE, leaving a residual gap of 314.25 WTE across the workforce.

This analysis demonstrates that variable pay expenditure is largely being incurred to mitigate genuine workforce deficits rather than inefficiencies in workforce management. It also highlights the continuing dependency on temporary staffing to support safe staffing levels across clinical services.

Workforce Stability

As previously noted, sustained improvements have been achieved in workforce stability since 2023. Key improvements include:

- 76.2% reduction in Band 5 vacancies since May 2023
- Recruitment of 296 internationally educated nurses
- 79% reduction in agency utilisation
- 73% reduction in overtime utilisation
- 38% reduction in bank utilisation
- 49% reduction in nursing turnover

These improvements demonstrate that interventions implemented through the Nursing Workforce Stabilisation Programme are delivering measurable benefits and reducing reliance on higher-cost temporary staffing solutions.

Assurance on Governance and Control: The governance arrangements for nursing/midwifery variable pay have strengthened significantly over the last two years.

Key controls now in place include:

- Monthly roster audit programme
- Routine review of roster quality and efficiency
- Internal audit review and subsequent re-audit.
- Strengthened temporary staffing Standard Operating Procedures
- Escalation and authorisation processes for roster sign-off
- Automated agency request forms with full audit trails
- Development of workforce dashboards and performance monitoring tools

These arrangements provide increased transparency, accountability and scrutiny of decisions relating to temporary staffing utilisation and variable pay expenditure.

Assurance on Risks

The deep dive identified several risks that continue to drive reliance on variable pay. These include:

- Sustained sickness absence levels above funded establishment assumptions
- Increasing maternity leave requirements
- Ongoing patient acuity and enhanced observation needs
- Persistent surge activity within emergency and inpatient services
- Unfunded establishment gaps in a small number of clinical areas
- Workforce supply challenges affecting Band 3 Nursing Support Worker recruitment.

The risks are understood, quantified and subject to mitigation plans. Targeted workforce plans, recruitment initiatives, apprenticeship development, and establishment reviews are being progressed to address the underlying causes of expenditure. The complete elimination of variable pay expenditure would create unacceptable risks to patient safety, service delivery, and compliance with statutory staffing duties. A proportion of variable pay will therefore remain necessary while these workforce pressures persist.

FINANCE DELIVERY PLAN

The deep dive has identified further opportunities to reduce expenditure through a structured variable pay reduction programme which includes executive oversight, monthly review, risk management, workforce planning, and operational accountability. Expected outcomes include reduced variable pay, improved staffing stability, improved patient experience and strengthened financial control.

The workstreams include:

Workstream	Aims
Workforce Stability	• Reduce Registered Nurse (RN) sickness from 6.97% (July 2026) to 5.9% by March 2027and to 5% June 2027 (biggest opportunity but with the highest risk) • Reduce Support worker sickness from 10.26% (July 2026) to 9.26% by March 2027 and to 8.5% by June 2027 (the biggest opportunity but with the highest risk)

	• weekly absence clinics; • return to work audits; • long term sickness reviews; • annual leave planning • wellbeing interventions.
Governance and Operational Grip	• Implement workforce hubs, • monthly roster scrutiny, • bank before agency controls, audit trails, • financial trajectories and • executive oversight. • Introduction of a 'temporary workforce calculator' based on the shared learning from Swansea Bay University Health Board (currently being tested in two clinical areas with a view to rolling it out across the Health Board in the autumn)
Vacancy Reduction	• Deploy newly registered nurses, • Fill Band 3 vacancies, • implement apprenticeship routes • Accelerate recruitment processes.
Roster Quality	• Six-week publication standard, • two-stage approval (and escalation process), • compliance monitoring, • reduction of post-publication changes • better use of contracted hours.
Redesign	• Demand-led rosters, • acuity-led deployment, • skill mix reviews, • Safe Care utilisation • review of unfunded establishments. • Consider workforce models that provide greater flexibility e.g. annualised hours, different deployment methods
HCSW Agency Elimination	• Cease Healthcare Support Worker (HCSW) agency use by September 2026 and replace with substantive, bank and apprentice workforce supply.
Flow and Capacity	• Reduce surge demand through discharge improvement, flow coordination, and length of stay reduction plans.

Phase 1 will be targeted at the top 10 variable pay users and phase 2 will target all other areas.

The detailed action plan is available as **Appendix 1**

Programme Metrics

- Registered Nurse/midwife variable pay expenditure (£ and WTE)
- Health Care/Nursing Support Worker variable pay expenditure (£ and WTE)
- Fill/unfilled percentage
- Agency expenditure by staff group
- Bank utilisation by staff group/band
- Overtime utilisation by staff group/band
- Enhanced patient support expenditure

- Vacancy-related temporary staffing expenditure
- Sickness-related temporary staffing expenditure
- HC/NSW agency utilisation
- Registered Nurse agency utilisation
- Time balance report
- Roster publication compliance
- Vacancy trajectory
- Apprenticeship pipeline progress
- Roster audit compliance

Argymhelliad / Recommendation

The Finance and Performance Committee is asked to:

- **NOTE** the analysis and assurance provided regarding the key drivers of Nursing and Support Worker variable pay expenditure;
- **ENDORSE** the Nursing/Midwifery and Support Worker Variable Pay Reduction Programme for 2026/27;
- **SUPPORT** the strengthened governance and performance framework for monitoring delivery.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Cyfeirnod Cylch Gorchwyl y Pwyllgor: Committee ToR Reference:	3.1.1 Receive assurances on the financial governance and control environment in operation across the Health Board. This will be achieved a programme of deep dive reviews into the following themes, which mirror the national Value and Sustainability Board: 3.1.1.1 Workforce 3.1.1.2 Non-pay and procurement 3.1.1.3 Medicines value and sustainability 3.1.1.4 Commissioned care 3.1.1.5 Clinical variation and service configuration
Cyfeirnod Cofrestr Risg Datix, Teitl a Sgôr Risg Cyfredol: Datix Risk Register Reference and Score:	1978 'Risk of insufficiently skilled workforce to deliver services due to limited labour market', which includes medical workforce. 2326 'Risk to achieving 26/27 Target Control Total due to underlying deficit, insufficient savings & reliance on non recurrent funding'
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	1. Safe 2. Timely 6. Person-Centred

Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	5. Whole systems persepctive 2. Culture and valuing people
Amcanion Strategol y BIP: UHB Strategic Objectives:	1. Striving teams
Nodau Cynllunio 2026/27 Planning Goals 2026/27	6. Safe, Timely, High Quality Care
Hypergyswllt i Amcanion Llesiant HDdUHB 2026 Hyperlink to HDdUHB Well-being Objectives 2026	3. Create people-centred employment and development opportunities that support workforce transformation, reflect the changing needs of
Model Cymdeithasol ar gyfer Iechyd a Llesiant: (wedi'i gwblhau ar gyfer newid strategol a/neu newidiadau sylweddol i wasanaethau) A Social Model for Health and Wellbeing: (*complete for strategic change and/or significant service changes)*	Not Applicable
Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Not Applicable
Rhestr Termau: Glossary of Terms:	RN – Registered Nurse HCSW – Health Care Support Worker NSW – Nursing Support Worker
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y cyfarfod hwn: Parties / Committees consulted prior to this meeting:	Not Applicable

Effaith: (rhaid cwblhau)

Impact: (must be completed)	
Ariannol / Gwerth am Arian: **Financial / Service:**	A reduction in variable pay
Ansawdd / Gofal Claf: **Quality / Patient Care:**	The plan set out in the report aims to deliver a reduction in variable pay whilst maintaining patient safety and quality of care
Gweithlu: **Workforce:**	Opportunities for substantive recruitment
Tegwch Iechyd: **Health Equity:**	Not Applicable
Risg: **Risk:**	• Sustained sickness absence levels above funded establishment assumptions. • Increasing maternity leave requirements. • Ongoing patient acuity and enhanced observation needs. • Persistent surge activity within emergency and inpatient services. • Unfunded establishment gaps in a small number of clinical areas. • Workforce supply challenges affecting Band 3 Nursing Support Worker recruitment.
Cyfreithiol: **Legal:**	The plan set out in the report aims to deliver a reduction in variable pay whilst meeting our statutory responsibilities under the Nurse Staffing Levels (Wales) Act
Enw Da: **Reputational:**	Not Applicable
Gyfrinachedd: **Privacy:**	Not Applicable
Cydraddoldeb: **Equality:**	Not Applicable

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

TÎM CYFARWYDDWYR
EXECUTIVE TEAM

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	24 June 2026
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Nursing Variable Pay Reduction Programme 2026/27
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Sharon Daniel, Executive Director Nursing, Quality and Patient Experience
SWYDDOG ADRODD: **REPORTING OFFICER:**	Janice Cole-Williams, Assistant Director of Nursing

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Ar Gyfer Penderfyniad/For Decision

EXECUTIVE SUMMARY

This programme sets out a comprehensive approach to reducing variable pay through strengthened governance, roster quality, workforce redesign, and operational control. The programme aligns workforce supply with patient demand, improves financial discipline, and ensures safe, sustainable staffing. It embeds professional accountability, ensuring that all staffing decisions are clinically justified and evidence based.

1. PROGRAMME GOVERNANCE

Senior Responsible Officer: Executive Director of Nursing (EDoN)
Programme Board: Monthly
Reporting: To Be Agreed
Oversight: Clinical Care Groups and operational delivery forums

Strategic Aim

Reduce variable pay safely by improving workforce design, governance, patient flow, and real-time operational control and strengthen clinical decision-making at all levels

2. KEY PRINCIPLES

- Safety first
- Redeploy before temporary staffing
- Demand-led workforce models
- Real-time decision-making
- Data-driven and clinically justified staffing

3. PROGRAMME KPI FRAMEWORK

- Variable pay as % of total pay
- Roster publication compliance (%)
- Fill rate (substantive vs temporary)
- Sickness absence rate
- % shifts meeting acuity requirement
- Agency utilisation rate
- Bank fill rate
- Net hours balance
- Acuity compliance (where applicable)
- Skill mix compliance
- Escalation justification
- Vacancy WTE

4. KEY RISK STATEMENT

Failure to deliver improvements in roster quality, patient flow, and workforce stability will result in continued reliance on variable pay to compensate for system inefficiencies.

5. DELIVERY PHASES

0–3 months: Governance, controls, rostering standards
3–6 months: Workforce redesign and flow improvements
6–12 months: Optimisation and sustainability

APPENDIX 1

GOVERNANCE & CONTROL – ESTABLISH STRONG GOVERNANCE AND CONTROL

Objectives	Key Actions	Expected Impact

Create system-wide accountability for variable pay decisions
 	
Standardise decision-making and escalation
	Implement clear governance architecture:
	• Clinical Care Groups (Director oversight)
	• Operational delivery forums (to include Head of Nursing/Midwifery, Senior Nurse & Line Manager)
	• Review, revise & implement decision frameworks for:
	  o Recruitment
	  o Temporary staffing approval
	  o Leave approval, including annual, study & special leave
	  o Outline approval process for requests outside of agreed parameters
	• Introduce financial modelling and recovery trajectories
	• Formal bank before agency compliance monitoring
	• Agency request audit trail
	• Overtime usage audit trail
	• All staffing escalation required documented clinical justification
	• Senior Nurse sign off required for deviations
		Reduces unwarranted agency use
		
		Ensures consistent, disciplined decision-making across Clinical Care Groups

Action	Owner	RAG	Next Step
Governance structure	EDoN	Red	Agree governance structure and implement across all Clinical Care Groups
Approval framework	ADNs Professional Standards & Clinical Care Groups	Amber	Review of the SOP Monitor compliance with SOP Enforce bank-before-agency policy
Financial plans	Head of Business Control, Finance	Red	Develop trajectories
Audit and assurance of all temporary staffing decisions	HoNs, Corporate Nursing & CCGs	Amber	Roster audits being undertaken but improvement work required on action planning Strengthen the audit processes around temporary staffing to include review of staffing decisions and escalation appropriateness Monitor compliance with agency request escalation process via MS Forms

OPERATIONAL GRIP

Objectives	Key Actions	Expected Impact

<table>
<tr>
<td>Shift from reactive to proactive management of staffing gaps</td>
<td>

Implement a 3-tier control system:
<table>
<tr><th>Level</th><th>Forum</th><th>Purpose</th></tr>
<tr><td>Operational</td><td>Workforce Hubs (daily)</td><td>Real-time redeployment, gap management & escalation decisions</td></tr>
<tr><td>Operational</td><td>Unavailability Clinics (weekly)</td><td>Scrutinise absence & bank usage</td></tr>
<tr><td>Strategic</td><td>Roster Review Clinics (monthly)</td><td>Forward planning & assurance</td></tr>
</table>

Enforce “redeploy first” rule
Require justification against headroom before approval
Use exception proforma for any above-threshold requests
6-week roster publication standard (target 12 weeks)
Two-stage approval process (manager + senior sign-off)
Monitoring of finalisation compliance
Documentation of escalation outcomes

</td>
<td>

Immediate reduction in avoidable bank/agency shifts
Improved visibility of demand drivers

</td>
</tr>
</table>

Action	Owner	RAG	Next Step
Workforce hubs	HoNs	Amber	Agree ToR and implement

Unavailability clinics	HoNs – CCGs	Amber	Agree ToR and implement
Roster review scrutiny clinics (to include retrospective and prospective roster review)	ADNs - CCGs	Red	Agree ToR and implement
Monthly multidisciplinary roster scrutiny	HoN/operational workforce/rostering team/Finance business partner/ corporate nursing	Amber	Strengthen existing processes
Formal bank-before-agency compliance monitoring	Workforce – Head of resourcing & utilisation	Amber	Develop reports to aid compliance monitoring
Agency request audit trail (automated forms)	HoN Professional Standards and Regulation	Amber	Roll out automated agency form to all areas
Develop a temporary workforce calculator tool	HoN Professional Standards and Regulation	Red	Finalise the calculator and test
Cease the use of HCSW agency	ADN MHLD	Amber	Cease the use of HCSW agency as of Sept 2026

ROSTER QUALITY AND PUBLICATION STANDARDS

Objectives	Key Actions	Expected Impact
Shift from reactive to proactive management of staffing gaps	• 6-week roster publication standard (target 12 weeks)	• Immediate reduction in avoidable bank/agency shifts

	• Two-stage approval process (manager + senior nurse sign-off) which must demonstrate appropriate skill mix • Monitoring of finalisation compliance • Net hours optimisation - ensure contracted hours are utilised before temporary staffing is approved	

Action	Owner	RAG	Next Step
6-week roster publication standard (minimum 6 week - target 12 weeks)	Roster Managers	Amber	Improve
Two-stage approval process	Roster Managers & SNM	Amber	Improve Escalation process via e-rostering team in place
Monitoring of finalisation compliance	Roster Managers	Amber	Improve
Ensure contracted hours are utilised before temporary staffing is authorised	Roster manager/SNM	Amber	Improve Monitor time balances and implement ward level plans to recover any hours owed/owing.
Reduce post-publication amendments	Roster Managers/SNM with support of roster team	Amber	Improve

WORKFORCE REDESIGN

Objectives	Key Actions	Expected Impact
Align workforce to actual demand, not static templates	• Replace flat roster templates with demand-led rosters (i.e. rosters based on e.g. patient numbers, acuity, time of day, historical trends and are adjusted per shift - so rather than a fixed roster it would be changed to reflect the demand - • Shift agency usage from night duty and weekends towards weekdays and morning peaks • Consider introducing RN and HCSW/NSW float roles • Consistent application of 26.9% uplift baseline • Regular nurse staffing reviews to include skill mix reviews including proportion of RNs Where Safecare utilised: • Mandatory twice daily acuity capture (SafeCare) • Link red flags to action and escalation • Use professional judgement alongside tools	• Reduced reliance on temporary staffing • Better productivity from existing workforce • Reduced inappropriate role substitution

Action	Owner	RAG	Next Step
Demand-led roster	HoNs/Corporate Nursing	Red	Scale pilots
26.9% uplift baseline	HoNs	Amber	Apply 26.9% uplift consistently across all areas Improve compliance with 21.3% headroom application (14.6% annual leave, 2.4%

			study leave and 4.3% sick leave
Regular nurse staffing reviews to include skill mix reviews	Nurse Staffing Programme Lead & HoNs	Green	6 monthly for S25B wards √ Agreed nurse staffing work plan for S25A areas Align to benchmark/ standards where available
Ensure twice daily acuity capture where appropriate & required	Ward/Dept Managers & Nurse Staffing Programme Lead	Green	Continue twice daily acuity data capture on all S25B wards (Adults and Paeds) Twice daily acuity data capture on selected S25A areas – CCU, CDU and one mental health ward
		Amber	Extend roll out of safecare to all mental health wards Consider extending roll out of safecare to ACDU, WGH, AMAU PPH and CDU, BGH

WORKFORCE STABILITY

Objectives	Key Actions	Expected Impact

Reduce absence-driven demand (key driver of variable pay)	• Target **sickness absence reduction**
	  o Current baseline (6.8% in month sickness April 2026)
	• Target HCSW/NSW vacancy reduction
	• Implement:
	  o Weekly absence review in clinics
	  o Stronger return-to-work processes
	  o Trigger-based escalation
	• Improve:
	  o Wellbeing support
	  o Workload balance through staffing redesign
	  o Strengthen leave planning discipline
	  o Annual leave smoothing
	  o Reduce peak-time absence
		• Direct reduction in short-notice bank usage
		• Improved roster resilience
		• Ward managers accountable for sickness management
		• Use rostering to balance workload and reduce burnout

Action	Owner	RAG	Next Step
Return to work compliance	Ward/Dept Managers	Amber	Implement sickness management audit tool
Absence triggers	HoNs	Amber	Ensure that these are applied consistently
Annual leave planning	Ward/Dept Managers/SNM	Amber	Improve annual leave planning and sign off
Timely recruitment into HCSW/NSW vacancies	Ward/Dept Manager/SNM	Amber	Reduce the number of HCSW/NSW vacancies.
Explore apprentice route for hard to fill Band 3 NSW vacancies	HoN Professional Standards and Regulation	Amber	Finalise the plan for recruiting apprentices for hard to fill Band 3 NSW posts

PATIENT FLOW

Objectives	Key Actions	Expected Impact

Reduce operational pressure that drives staffing escalation (with a focus on surged beds and UEC work plan)	• Target:
	  o Length of stay reduction
	  o Discharges before noon improvement
	• Address delayed discharge drivers:
	  o Internal processes
	  o External pathway delays
		• Lower bed congestion → lower staffing pressure → reduced variable pay

Action	Owner	RAG	Next Step
Discharge improvement	Clinical Care Groups	Red	Implement plan
Flow coordination	HoNs	Amber	Improve
LOS review	SNM	Amber	Improve
Discharge Before Noon	SNM/Ward Managers	Amber	Improve

6. **CULTURE & LEADERSHIP**

Objectives	Key Actions	Expected Impact

Break "perceived understaffing" cycle	• Strengthen:
	  o Visible leadership (SNM/HoNs/ADN presence)
	• Accountability for operational decisions. Shift from:
	  o Reactive → proactive management
	  o Task-based → outcome-based working
	• Introduce:
		Culture and morale are now a material driver of absence and inefficiency
		
		Standardise flexible working processes
		
		Bilingual Equity

	○ Regular ward forums and communication routes for staff to feedback roster concerns • Embed: ○ Performance management (PADR, training compliance) ○ Shift distribution fairness ○ Welsh language standards compliance	

Action	Owner	RAG	Next Step
Leadership visibility	Clinical Care Groups	Amber	Increase
PADR compliance	Ward/Dept Managers	Amber	Improve >90% - currently 79.5% for nursing & midwifery
Training compliance	Ward/Dept Managers	Amber	Maintain >90% - currently 91.6% for nursing and midwifery
Staff feedback mechanisms	ADN Professional Standards	Red	Introduce structured feedback mechanisms (e.g. surveys, drop-in sessions)

DIGITAL ENABLEMENT

Objectives	Key Actions	Expected Impact

Strengthen Digital & Data Capability	Maximise e-rostering system use Develop real time dashboards (unavailability, staffing acuity	• Real-time decision-making • Transparency • Predictive workforce planning • Improve data visibility

Action	Owner	RAG	Next Step
Maximise e-rostering system use	HoNs/rostering team	Amber	Increase number of areas using e-rostering
Develop real time dashboards (unavailability, bank and agency usage)	Assistant Director of Nursing, Professional Standards and Workforce	Amber	Build on the dashboards already in place

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

TERMS OF REFERENCE

Nursing & Midwifery Variable Pay Reduction Programme Oversight Group

Version	Issued to:	Date	Comments
V1	Nursing & Midwifery Variable Pay Reduction Programme Oversight Group	11/08/2026	

Nursing & Midwifery Variable Pay Reduction Programme Oversight Group

1. Constitution

1.1 The Nursing & Midwifery Variable Pay Reduction Programme Oversight Group has been established to oversee the delivery of the Nursing 7 Midwifery Variable Pay Reduction Programme.

2. Principal Duties

2.1 The purpose of the Nursing Variable Pay Reduction Programme Oversight Group is to provide strategic oversight, challenge, assurance and support for the delivery of the Nursing and Midwifery Variable Pay Reduction Programme.

The Group will:

2.2.1 monitor progress against agreed financial, workforce and operational objectives, ensuring actions deliver sustainable reductions in variable pay expenditure whilst maintaining patient safety, quality of care, workforce wellbeing and compliance with statutory staffing requirements,

3. Operational Responsibilities

3.1 The Group will:

3.1.1 Monitor delivery of the Nursing Variable Pay Reduction Programme and associated savings targets.

3.1.2 Provide assurance that expenditure reduction plans do not adversely impact patient safety, quality, workforce sustainability or statutory staffing requirements.

3.1.3 Oversee delivery of key workstreams including:

- Workforce Stability
- Governance and Operational Grip
- Vacancy Reduction
- Roster Quality
- Workforce Redesign
- HCSW Agency Elimination
- Flow and Capacity

3.1.4 Review risks, barriers and dependencies impacting programme delivery.

3.1.5 Ensure alignment between nursing, workforce and financial recovery plans.

3.1.6 Monitor implementation of agreed controls relating to temporary staffing utilisation.

3.1.7 Escalate significant risks, performance concerns or decisions requiring executive action.

3.1.8 Share learning and best practice across clinical care groups and services

4. Membership

4.1 The membership of the Group shall comprise:

Title
Deputy Director of Nursing, Quality and Patient Safety
Assistant Director of Nursing, Professional Standards & Workforce
Assistant Director of Nursing, Quality & Patient Experience, Community & Integrated Medicine CCG
Assistant Director of Nursing, Quality & Patient Experience, Planned & Specialist Care CCG
Assistant Director of Nursing, Quality & Patient Experience, Mental Health & Learning Disabilities CCG
Director of Midwifery & Professional Governance for Women and Children
Assistant Director of Nursing Assurance & Safeguarding
Deputy Director of Finance
Assistant Director of People Planning
Assistant Director People Management
Head of Nursing, Professional Standards and Regulation
Head of Resourcing & Utilisation
Senior Workforce Manager
Assistant General Manager C&IM CCG (Carms system)
Assistant General Manager C&IM CCG (Pembs system)
Assistant General Manager C&IM CCG (Ceredigion system)
Assistant General Manager Planned & Specialist Care
Head of Adult Mental Health Inpatient wards and Learning Disabilities service
Head of Service – Older adult MH
General Manager Women, Children and Family Health
Staff Partnership representative

4.2 The membership of the Group will be reviewed on an annual basis.

5. Quorum and Attendance

5.1 A quorum shall consist of no less than a third and must include as a minimum the Chair or Vice Chair of the Group.

5.2 Any senior officer of the Hywel Dda University Health Board (HDdUHB) or from a partner organisation may, where appropriate, be invited to attend.

5.3 The Group may also co-opt additional independent external 'experts' from outside the organisation to provide specialist knowledge.

5.4 Should any member be unavailable to attend, they may nominate a deputy to attend in their place, subject to the agreement of the Chair.

5.5 The Group may ask any or all of those who normally attend but who are not members to withdraw to facilitate open and frank discussion of particular matters.

6. Agenda and Papers

6.1 The Group's Secretary is to hold an agenda setting meeting with the Chair and the Group Lead at least **three** weeks before the meeting date.

6.2 The agenda will be based around the Group work plan, identified risks, matters arising from previous meetings, issues emerging throughout the year and requests from Group members. Following approval, the agenda and timetable for receipt of papers will be circulated to all Group members.

6.3 The agenda and papers for meetings will be distributed **seven** days in advance of the meeting.

6.4 The draft minutes and table of actions will be circulated to members within **ten** days to check the accuracy.

6.7 Members must forward amendments to the Group Secretary within the next **seven** days. The Group Secretary will then forward the final version to the Group Chair.

7. Frequency of Meetings

7.1 The Group will meet monthly and shall agree an annual schedule of meetings. Additional meetings will be arranged as determined by the Chair of the Group.

7.2

8. Accountability, Responsibility and Authority

8.1 The Group will be accountable to the XXX Sub-Committee for its performance in exercising the functions set out in these terms of reference.

8.2 The Group shall embed the HDdUHB's vision, corporate standards, priorities and requirements, e.g. equality and human rights, through the conduct of its business.

8.3 The requirements for the conduct of business as set out in HDdUHB's Standing Orders are equally applicable to the operation of the Group.

9. Reporting

9.1 The Group, through its Chair and members, shall work closely with the Board's other committees, including joint/sub committees and groups to provide advice and assurance to the Board

9.2 In doing so, the Group shall contribute to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the Board's overall risk and assurance framework.

9.3 The Group may establish sub-groups or task and finish groups to carry out on its behalf specific aspects of Group business. The Group will receive an update following each sub-groups meetings detailing the business undertaken on its behalf.

9.4 The Group's Chair, supported by the Group Secretary, shall:

9.4.1 Report formally, regularly and on a timely basis to the XXX Sub-Committee on the Group's activities.

9.4.2 Bring to the XXX Sub-Committee's specific attention any significant matters under consideration by the Group.

10. Secretarial Support

10.1 The Group Secretary shall be determined by the Group Lead/ Chair.

11. Review Date

11.1 These terms of reference shall be reviewed on at least an annual basis by the Group for approval by the XXX Sub-Committee.

3.5

3.5 - FINANCE DEEP DIVE: CLINICAL CARE GROUP SAVINGS PLANS

Andrew Carruthers (Hywel Dda UHB - Chief Operating Officer), Keith Jones (Hywel Dda UHB - Director of Operational Planning & Performance)

For assurance

Attachments

Finance Deep Dive CCG Savings Plans FPC 27 August 2026.pdf

Appendix 1 Savings Update.pdf

Pwyllgor Cyllid a Pherfformiad/ Finance and Performance Committee

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	27 August 2026
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Finance Deep Dive: Clinical Care Group Savings Plans
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Andrew Carruthers, Chief Operating Officer
SWYDDOG ADRODD: **REPORTING OFFICER:**	Keith Jones, Director of Operational Planning and Performance

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

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The Finance and Performance Committee is requested to consider savings plan progress to date achieved by Clinical Care Groups (CCGs) and to note the actions required in support of Executive-led Finance Recovery reviews scheduled for 25 August 2026 at which further progress will be assessed.

Cefndir / Background

As of 11 August 2026, the Health Board has identified £35.8m of in-year cash releasing savings. This leaves a Health Board-wide £7.0m gap against the £42.8m savings target.

Of the savings identified, £29.8m is currently rated Green or Amber and considered achieved. A Health Board-wide delivery shortfall of £13.0m remains against required in-year delivery.

There remains a further £11.3m saving opportunity within Blue and Red schemes across both cash releasing and run-rate categories.

Two CCGs (Community and Integrated Medicine CCG and Planned and Specialist Care CCG) have been escalated to Level 4 for finance/savings. Initial Level 4 reviews, led by the Chief Executive Officer, were conducted on 9 July 2026.

A parallel finance-focused Executive-led challenge and recovery process has been established, with all CCGs required to provide further detailed updates on overall finance and savings progress, including updated assessments of Blue and Red schemes, at Finance Recovery review meetings scheduled on 25 August 2026.

Asesiad / Assessment

The slides appended to this paper provide a summary of Health Board and Operations function and CCG progress towards savings target requirements for 2026/27. This report highlights the key issues for consideration.

Progress to August 2026

Since the previous (17 July 2026) update, the Operations portfolio and CCGs in-year cash releasing savings plans have improved by a further £0.96m. Changes by function and CCG are shown in Table 1 below:

Table 1: Operations Function and CCG In-Year Cash Releasing Savings Movement July-Aug 2026:

Function / CCG	Blue	Red	Amber	Green	In Year Total
COO Mgt	0	0	0	313	313
C&IM	-293	1,613	0	-301	1,020
MHLD	0	-61	0	689	628
AH&HS	0	-571	0	1,439	868
P&SC	0	-531	0	562	31
Primary Care	0	0	0	-1,898	-1,898
TOTAL	**-293**	**451**	**0**	**804**	**962**

Notwithstanding positive progress achieved, several schemes have been reclassified with £1.6m within Community Integrated Medicine moving from Green to Red, and removal or reclassification of £1.9m Dental savings following Welsh Government feedback.

Overall Position

The position by CCG is highlighted in Table 2 below:

- Of the £35.8m all BRAG rated in-year cash releasing savings identified Health Board wide, £20.2m lie within the Operations portfolio or CCGs.
- Of the £29.8m Green or Amber in-year cash releasing savings identified, £15.5m lie within the Operations portfolio or CCGs.

Table 2: Operations Function and CCG BRAG rated In-Year Cash Releasing Savings

Delegated Officer (£'000)	Annual Savings Target	In Year Identified Cash Releasing Plans						Full Year Impact	
		Blue	Red	Amber	Green	In Year Total	Variance From Target	Total Savings Identified	Variance From Target
Chief Executive	**-25**		**0**		**124**	**124**	**-149**	**0**	**-25**
Chief Operating Officer	**30,675**	**2,591**	**2,183**	**637**	**14,820**	**20,231**	**10,444**	**25,403**	**5,272**
Chief Operating Officer Management	749	0	0		386	386	363	0	749
Community and Integrated Medicine	12,524	75	1,872		8,012	9,960	2,564	13,430	-906
Mental Health and Learning Disabilities	6,441	0	86		3,002	3,087	3,353	1,093	5,348
Operational Allied Health and Health Sciences	4,848		135		1,680	1,815	3,034	1,334	3,514
Planned and Specialist Care	5,890	100	90	637	1,485	2,312	3,578	4,714	1,176
Primary Care	223	2,416			256	2,671	-2,448	4,831	-4,608
Executive Director of Allied Health Professions and Health Sci	**2,715**	**0**	**100**		**692**	**792**	**1,923**	**752**	**1,963**
Estates and Facilities	2,705	0	100		648	748	1,957	752	1,953
Executive Allied Health Professions and Health Sciences	10				44	44	-34	0	10
Executive Director of Finance	**238**	**0**	**71**	**76**	**422**	**569**	**-330**	**863**	**-625**
Digital	373	0	71	76	239	386	-13	744	-372
Finance	-134				183	183	-317	119	-253
Executive Director of Nursing, Quality and Patient Experience	**0**				**130**	**130**	**-130**	**0**	**0**
Executive Director of Public Health	**131**		**132**		**834**	**966**	**-835**	**0**	**131**
Executive Director of Strategy and Planning	**2,035**			**125**	**989**	**1,114**	**921**	**74**	**1,961**
LTAs with other NHS Providers	1,961			125	530	655	1,306	0	1,961
Strategy and Planning	74				459	459	-385	74	0
Executive Director of Workforce and Organisational Developm	**-481**				**2,902**	**2,902**	**-3,383**	**302**	**-783**
Executive Medical Director	**5,952**		**900**	**361**	**3,068**	**4,329**	**1,623**	**3,420**	**2,532**
Medical	72				202	202	-130	75	-3
Pharmacy and Medicines Management	5,880		900	361	2,867	4,128	1,752	3,345	2,535
Health Board Wide	**1,560**				**4,665**	**4,665**	**-3,105**	**1,546**	**14**
Grand Total	**42,800**	**2,591**	**3,386**	**1,199**	**28,647**	**35,822**	**6,978**	**32,361**	**10,440**
			5,977		**29,846**				

The in-year variance against the Operations function / combined CCG savings target of £30.6m has consequently reduced from £11.4m to £10.4m.

Risk-Adjusted Underspends

In addition to the cash -releasing savings identified in Table 2 above, £5.9m Green/Amber risk-adjusted underspends have been converted into non-recurrent savings to date. Of this total, the Operations functions and CCGs have contributed £5.3m (92%) as illustrated in Table 3 below:

Table 3: Operations Function and CCG Non-Cash Releasing Savings

Delegated Officer (£'000)	Identified Non Cash Releasing Savings					
	Blue	Red	Amber	Green	In Year Total	Full Year Total
Chief Operating Officer	**1,026**	**1,610**	**1,785**	**3,559**	**7,981**	**30,564**
Community and Integrated Medicine	0	923	1,036	1,963	3,922	20,043
Mental Health and Learning Disabilities	93	120			213	570
Operational Allied Health and Health Sciences	0			97	97	3,725
Planned and Specialist Care	933	566	750	1,499	3,749	6,226
Executive Director of Allied Health Professions and Health Sciences	**20**	**0**		**244**	**264**	**763**
Estates and Facilities	20	0		244	264	763
Executive Director of Strategy and Planning		**2,650**			**2,650**	**4,058**
LTAs with other NHS Providers		2,650			2,650	4,058
Executive Medical Director				**300**	**300**	**300**
Pharmacy and Medicines Management				300	300	300
Grand Total	**1,046**	**4,260**	**1,785**	**4,103**	**11,195**	**35,685**

While these schemes do not contribute directly to the £42.8m cash-releasing target, they remain important mitigations against overspending and should be reviewed alongside Blue and Red cash-releasing schemes.

Further Blue / Red Scheme Opportunities:

Alongside existing actions to secure delivery of Green/Amber savings schemes, remaining Blue and Red scheme opportunities (both cash releasing and non-cash releasing run rate

reduction opportunities) represent the principal opportunity to further improve CCG savings delivery during the remainder of FY26/27.

Of the remaining £11.3m saving opportunities within Blue and Red schemes across both cash releasing and non-cash releasing run-rate categories, £7.4m opportunities have been identified by Operations functions / CCGs as summarized in Table 4 below:

Table 4: Operations Function amd CCG Blue/Red Scheme Opportunities (Cash/Non-Cash Releasing)

Function / CCG	Cash Releasing		Non-Cash Releasing		In Year Total
	Blue	Red	Blue	Red	
C&IM	75	1,872	0	923	2,870
MHLD	0	86	93	120	299
AH&HS	0	135	0	0	135
P&SC	100	90	933	566	1,689
Primary Care	2,416	0	0	0	2,416
Total	**2,591**	**2,182**	**1,026**	**1,610**	**7,409**

In preparation for the Executive-led reviews on 25 August 2026, each CCG has been requested to:

- Undertake a scheme-by-scheme review of remaining Blue and Red scheme opportunities, including current RAG status, value, implementation milestones and barriers.
- Provide an evidence-based assessment of deliverability and revised in-year savings forecasts.
- Identify Health Board support required to unblock delivery challenges
- Assess opportunities to accelerate Blue/Red schemes into Amber/Green status before Month 6.
- Identify options to replace non-deliverable Red schemes with alternative recurring savings opportunities.
- Undertake and assessment of recurrent impact, supporting the wider objective of reducing structural financial risk going into 2027/28.

Argymhelliad / Recommendation

The Finance and Performance Committee is asked to:

- **CONSIDER** savings plan progress to date achieved by Clinical Care Groups; and
- **NOTE** the actions required in support of Executive-led Finance Recovery reviews scheduled for 25 August 2026 at which further progress will be assessed.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Cyfeirnod Cylch Gorchwyl y Pwyllgor: Committee ToR Reference:	3.1.1 Receive assurances on the financial governance and control environment in operation across the Health Board. This will be achieved a

	programme of deep dive reviews into the following themes, which mirror the national Value and Sustainability Board: 3.1.1.1 Workforce 3.1.1.2 Non-pay and procurement 3.1.1.3 Medicines value and sustainability 3.1.1.4 Commissioned care 3.1.1.5 Clinical variation and service configuration
Cyfeirnod Cofrestr Risg Datix, Teitl a Sgôr Risg Cyfredol: Datix Risk Register Reference and Score:	2326 'Risk to achieving 26/27 Target Control Total due to underlying deficit, insufficient savings & reliance on non recurrent funding'
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	1. Safe 2. Timely 6. Person-Centred
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	2. Culture and valuing people 5. Whole systems persepctive
Amcanion Strategol y BIP: UHB Strategic Objectives:	1. Striving teams
Nodau Cynllunio 2026/27 Planning Goals 2026/27	6. Safe, Timely, High Quality Care
Hypergyswllt i Amcanion Llesiant HDdUHB 2026 Hyperlink to HDdUHB Well-being Objectives 2026	10. Not Applicable
Model Cymdeithasol ar gyfer Iechyd a Llesiant: (wedi'i gwblhau ar gyfer newid strategol a/neu newidiadau sylweddol i wasanaethau) A Social Model for Health and Wellbeing: (*complete for strategic*	Not Applicable

change and/or significant service changes)	
Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Not Applicable
Rhestr Termau: Glossary of Terms:	Contained within the body of the report.
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y cyfarfod hwn: Parties / Committees consulted prior to this meeting:	Not Applicable

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	Not Applicable
Ansawdd / Gofal Claf: Quality / Patient Care:	Not Applicable
Gweithlu: Workforce:	Not Applicable
Tegwch Iechyd: Health Equity:	Not Applicable
Risg: Risk:	Not Applicable
Cyfreithiol: Legal:	Not Applicable
Enw Da: Reputational:	Not Applicable

Gyfrinachedd: **Privacy:**	Not Applicable
Cydraddoldeb: **Equality:**	Not Applicable



Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

Finance and Performance Committee

Deep Dive: Clinical Care Group Savings Update

27 August 2026

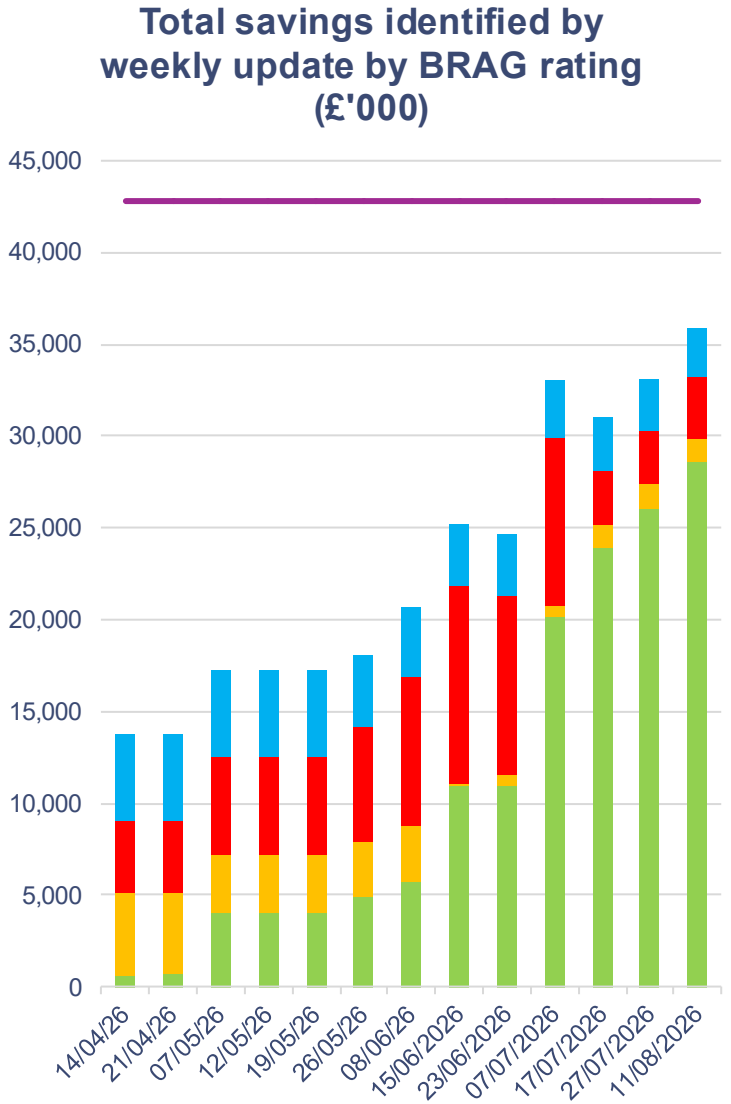
Cash Releasing Savings Summary (£000)

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

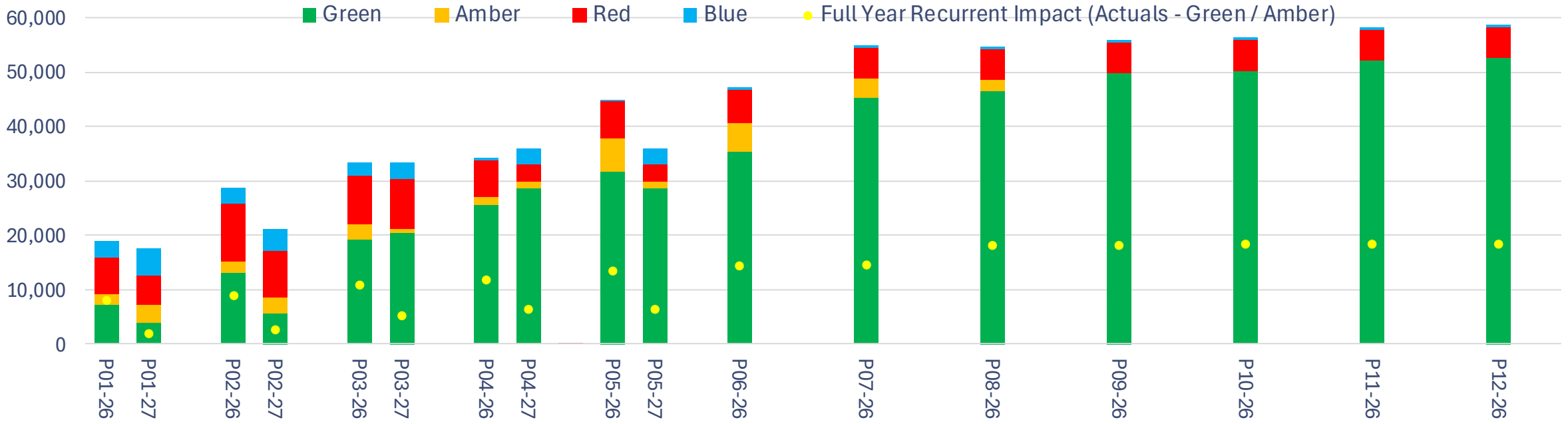
High Level Health Board Summary of Identified Savings (£000)

	Savings Target	In Year Identifed Savings	Variance From Target
All BRAG Rating Savings	42,800	35,822	**6,978**
Transacted Savings (BRAG - Amber and Green) only	42,800	29,846	**12,955**

- To date **£35.8m** of in-year cash releasing savings have been identified, including all BRAG ratings (currently **£7m** short of the £42.8m target). Beyond FY26.27 the full year value of the savings reduces to **£32.4m**, resulting in a full year (recurrent) shortfall of **£10.4m.**
- Of the £35.8m of savings identified to date, **£29.8m** of Green and Amber savings schemes have been achieved with a full year recurrent value of **£32.4m**, across all BRAG ratings.
- Combining the remaining Blue and Red schemes, across Cash Releasing and Run Rate Reduction categories, there is a **total further saving opportunity of £11.3m identified**. Versus a M04 £60.4m end of year Health Board gross deficit forecast, ahead of mitigating actions.
- Following the work in July to convert full-year risk-adjusted underspends over £100k into saving commitments, **£5.8m** of projected underspends have been converted into non recurrent savings. This £5.8m is lower than the anticipated £10.9m following validation with budget holders, plus the decision not to reclassify Dental underspends against ring fenced allocations as savings and instead continue to report these as underspends, linked to Welsh Government feedback.
- In transacting underspends as savings, this has had an equal and opposite impact on the core budget variance, driving up the overspend – thus nil effect to the overall bottom line end of year forecast for the Health Board.
- By Month 6, Executive Directors are asked to review all non recurrent savings and assess if they can be converted to recurrent savings.



Cash Releasing Savings Month on Month Comparison to Prior Year (£000)



What the graph shows

- Cumulative cash releasing savings trajectory by month (FY26/27 vs FY25/26), split by BRAG status. The yellow markers indicate the full-year recurrent impact based on Green/Amber delivery.

Key messages vs last year

- P04-27 reflects improvements in the overall saving position. Compared to the same point last year (P04-26), savings identification are £1.5m higher and savings delivery is £2.9m higher. P05-27, is to date a part month position, therefore not comparable with P05-26. However, savings did step up in P05-26 therefore unless savings improve this month, savings delivery will fall behind last years position.
- Whilst P04 is an improved position, the **structural recurrent delivery risk** remains – Compared to P4 last year, the full year impact of achieved savings at P04-27 is **£5.5m less than P04-26 and reflects a 48% reduction.** This reduction increases the reliance on non-recurrent delivery even further and creates greater risk and pressure going into next year.

Cash Releasing Savings Summary (£000)

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Executive Portfolios, Summary Savings Table: Cash Releasing Savings

		In Year Identified Cash Releasing Plans						Full Year Impact	
Delegated Officer (£'000)	Annual Savings Target	Blue	Red	Amber	Green	In Year Total	Variance From Target	Total Savings Identified	Variance From Target
Chief Executive	-25		0		124	124	**-149**	0	-25
Chief Operating Officer	30,675	2,591	2,183	637	14,820	20,231	**10,444**	25,403	5,272
Executive Director of Allied Health Professions and Health Scienc	2,715	0	100		692	792	**1,923**	752	1,963
Executive Director of Finance	238	0	71	76	422	569	**-330**	863	-625
Executive Director of Nursing, Quality and Patient Experience	0				130	130	**-130**	0	0
Executive Director of Public Health	131		132		834	966	**-835**	0	131
Executive Director of Strategy and Planning	2,035			125	989	1,114	**921**	74	1,961
Executive Director of Workforce and Organisational Development	-481				2,902	2,902	**-3,383**	302	-783
Executive Medical Director	5,952		900	361	3,068	4,329	**1,623**	3,420	2,532
Health Board Wide	1,560				4,665	4,665	**-3,105**	1,546	14
Grand Total	**42,800**	**2,591**	**3,386**	**1,199**	**28,647**	**35,822**	**6,978**	**32,361**	**10,440**

Cash Releasing Savings Breakdown by CCG / Function (£000)

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Delegated Officer (£'000)	Annual Savings Target	In Year Identified Cash Releasing Plans						Full Year Impact	
		Blue	Red	Amber	Green	In Year Total	Variance From Target	Total Savings Identified	Variance From Target
Chief Executive	**-25**		**0**		**124**	**124**	**-149**	**0**	**-25**
Chief Operating Officer	**30,675**	**2,591**	**2,183**	**637**	**14,820**	**20,231**	**10,444**	**25,403**	**5,272**
Chief Operating Officer Management	749	0	0		386	386	363	0	749
Community and Integrated Medicine	12,524	75	1,872		8,012	9,960	2,564	13,430	-906
Mental Health and Learning Disabilities	6,441	0	86		3,002	3,087	3,353	1,093	5,348
Operational Allied Health and Health Sciences	4,848		135		1,680	1,815	3,034	1,334	3,514
Planned and Specialist Care	5,890	100	90	637	1,485	2,312	3,578	4,714	1,176
Primary Care	223	2,416			256	2,671	-2,448	4,831	-4,608
Executive Director of Allied Health Professions and Health Sci	**2,715**	**0**	**100**		**692**	**792**	**1,923**	**752**	**1,963**
Estates and Facilities	2,705	0	100		648	748	1,957	752	1,953
Executive Allied Health Professions and Health Sciences	10				44	44	-34	0	10
Executive Director of Finance	**238**	**0**	**71**	**76**	**422**	**569**	**-330**	**863**	**-625**
Digital	373	0	71	76	239	386	-13	744	-372
Finance	-134				183	183	-317	119	-253
Executive Director of Nursing, Quality and Patient Experience	**0**				**130**	**130**	**-130**	**0**	**0**
Executive Director of Public Health	**131**		**132**		**834**	**966**	**-835**	**0**	**131**
Executive Director of Strategy and Planning	**2,035**			**125**	**989**	**1,114**	**921**	**74**	**1,961**
LTAs with other NHS Providers	1,961			125	530	655	1,306	0	1,961
Strategy and Planning	74				459	459	-385	74	0
Executive Director of Workforce and Organisational Developm	**-481**				**2,902**	**2,902**	**-3,383**	**302**	**-783**
Executive Medical Director	**5,952**		**900**	**361**	**3,068**	**4,329**	**1,623**	**3,420**	**2,532**
Medical	72				202	202	-130	75	-3
Pharmacy and Medicines Management	5,880		900	361	2,867	4,128	1,752	3,345	2,535
Health Board Wide	**1,560**				**4,665**	**4,665**	**-3,105**	**1,546**	**14**
Grand Total	**42,800**	**2,591**	**3,386**	**1,199**	**28,647**	**35,822**	**6,978**	**32,361**	**10,440**
			5,977		**29,846**				

Change in identified cash releasing savings compared to the last update

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Movement between 17th July and 11th August

Delegated Officer (£'000)	In Year Identified Cash Releasing Plans				
	Blue	Red	Amber	Green	In Year Total
Chief Executive	**0**	**0**	**0**	**0**	**0**
Chief Operating Officer	**-293**	**451**	**0**	**804**	**962**
Chief Operating Officer Management	0	0	0	313	313
Community and Integrated Medicine	-293	1,613	0	-301	1,020
Mental Health and Learning Disabilities	0	-61	0	689	628
Operational Allied Health and Health Sciences	0	-571	0	1,439	868
Planned and Specialist Care	0	-531	0	562	31
Primary Care	0	0	0	-1,898	-1,898
Executive Director of Allied Health Professions and Health Sci	**0**	**0**	**0**	**513**	**513**
Estates and Facilities	0	0	0	513	513
Executive Allied Health Professions and Health Sciences	0	0	0	0	0
Executive Director of Finance	**0**	**-9**	**0**	**12**	**3**
Digital	0	-9	0	12	3
Finance	0	0	0	0	0
Executive Director of Nursing, Quality and Patient Experience	**0**	**0**	**0**	**30**	**30**
Executive Director of Public Health	**0**	**0**	**0**	**359**	**359**
Executive Director of Strategy and Planning	**0**	**0**	**0**	**0**	**0**
LTAs with other NHS Providers	0	0	0	0	0
Strategy and Planning	0	0	0	0	0
Executive Director of Workforce and Organisational Developm	**0**	**0**	**0**	**310**	**310**
Executive Medical Director	**0**	**0**	**-69**	**270**	**201**
Medical	0	0	0	0	0
Pharmacy and Medicines Management	0	0	-69	270	201
Health Board Wide	**0**	**0**	**0**	**285**	**285**
Grand Total	**-293**	**442**	**-69**	**2,584**	**2,663**

In respect of cash releasing savings, since the last update:

Amber and Green

- Across all portfolios, **£5.8m** of risk adjusted underspends have been converted to savings.
- Green savings in Community Integrated Medicine have been reclassified as Red **(£1.6m)** and Primary Care Dental savings have been reclassified as forecast underspends following Welsh Government feedback **(£1.9m).**
- Several HB wide provisions have been released and converted to savings **(£0.2m)** and one Pharmacy scheme has moved from Amber to Green **(£0.1m).**

Red and Blues

- On review of the year end forecast for Community Integrated Medicine, savings have been reclassified from Green to Red **(£1.6m).**
- The in-year deliverability of several Reds and Blues schemes have been reassessed and the in-year value reduced including Operational Allied Health and Health Sciences **(0.6m),** Community and integrated Medicine **(0.3m),** Mental Health **(£0.1m)** and Planned and Specialist Care **(£0.6m).**

Split of Identified Savings Between Recurrent and Non-Recurrent

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Delegated Officer (£'000)	Savings Target	Non Recurrent Savings	Recurrent Savings	Total Savings	Gap to In Year Savings Target	% Recurrent
Chief Executive	**-25**	**124**		**124**	**-149**	**-**
Chief Operating Officer	**30,675**	**16,089**	**4,142**	**20,231**	**10,444**	**20%**
Chief Operating Officer Management	749	386	0	386	363	0%
Community and Integrated Medicine	12,524	8,919	1,040	9,960	2,564	10%
Mental Health and Learning Disabilities	6,441	2,972	115	3,087	3,353	4%
Operational Allied Health and Health Sciences	4,848	1,658	156	1,815	3,034	9%
Planned and Specialist Care	5,890	1,898	414	2,312	3,578	18%
Primary Care	223	256	2,416	2,671	-2,448	90%
Executive Director of Allied Health Professions and Health Sciences	**2,715**	**709**	**84**	**792**	**1,923**	**11%**
Estates and Facilities	2,705	665	84	748	1,957	11%
Executive Allied Health Professions and Health Sciences	10	44		44	-34	0%
Executive Director of Finance	**238**	**83**	**485**	**569**	**-330**	**85%**
Digital	373	20	366	386	-13	95%
Finance	-134	64	119	183	-317	65%
Executive Director of Nursing, Quality and Patient Experience	**0**	**130**		**130**	**-130**	**-**
Executive Director of Public Health	**131**	**966**		**966**	**-835**	**0%**
Executive Director of Strategy and Planning	**2,035**	**1,040**	**74**	**1,114**	**921**	**7%**
LTAs with other NHS Providers	1,961	655		655	1,306	0%
Strategy and Planning	74	385	74	459	-385	16%
Executive Director of Workforce and Organisational Development	**-481**	**2,600**	**302**	**2,902**	**-3,383**	**10%**
Executive Medical Director	**5,952**	**909**	**3,420**	**4,329**	**1,623**	**79%**
Medical	72	127	75	202	-130	37%
Pharmacy and Medicines Management	5,880	783	3,345	4,128	1,752	81%
Health Board Wide	**1,560**	**3,136**	**1,529**	**4,665**	**-3,105**	**33%**
Grand Total	**42,800**	**25,787**	**10,035**	**35,822**	**6,978**	**28%**

Non-Cash Releasing Savings (Run Rate Savings)

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

In addition to the cash-releasing savings identified, a further **£11.2m** of non-cash releasing (run-rate) savings has been identified across the Health Board, with a **full-year value of £35.7m**. Whilst these savings do not contribute towards the £42.8m cash-releasing savings target, they will improve the Health Board's underlying financial position and help mitigate existing overspending pressures where schemes move into Amber or Green status.

Amber and Green run-rate schemes now total £5.9m and are reflected in the end of year forecast. Since the last update, the value of identified run rate schemes have reduced by £3.8m with most of the change relating to the closing of Blue schemes within Operational Allied Health and Health Sciences.

Delegated Officer (£'000)	Identified Non Cash Releasing Savings					
	Blue	Red	Amber	Green	In Year Total	Full Year Total
Chief Operating Officer	**1,026**	**1,610**	**1,785**	**3,559**	**7,981**	**30,564**
Community and Integrated Medicine	0	923	1,036	1,963	3,922	20,043
Mental Health and Learning Disabilities	93	120			213	570
Operational Allied Health and Health Sciences	0			97	97	3,725
Planned and Specialist Care	933	566	750	1,499	3,749	6,226
Executive Director of Allied Health Professions and Health Sciences	**20**	**0**		**244**	**264**	**763**
Estates and Facilities	20	0		244	264	763
Executive Director of Strategy and Planning		**2,650**			**2,650**	**4,058**
LTAs with other NHS Providers		2,650			2,650	4,058
Executive Medical Director				**300**	**300**	**300**
Pharmacy and Medicines Management				300	300	300
Grand Total	**1,046**	**4,260**	**1,785**	**4,103**	**11,195**	**35,685**

4

4 - FINANCE

4.1

4.1 - FINANCIAL PERFORMANCE ASSURANCE REPORT

Andrew Spratt (Hywel Dda UHB - Deputy Director of Finance), Jennifer Thomas (Hywel Dda UHB - Head of Corporate Reporting and Planning)

For assurance

Attachments

Finance Report FPC 27 August 2026.pdf

Appendix 1 M4 2026-27 Finance Performance Report.pdf

Pwyllgor Cyllid a Pherfformiad/ Finance and Performance Committee

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	27 August 2026
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Financial Performance Assurance Report – Month 4 2026/27
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Huw Thomas, Exective Director of Finance
SWYDDOG ADRODD: **REPORTING OFFICER:**	Andrew Spratt, Deputy Director of Finance Jennifer Thomas, Head of Corporate Reporting

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

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The purpose of this report is to outline the Health Board's financial position to date, against the Financial Plan and assesses the key financial projections, risks and opportunities for the financial year, including the implications of in-year recurrent delivery for the forthcoming financial year.

Cefndir / Background

Following approval by the Finance and Performance Committee on 24 February 2026, budgets were delegated to Executive Directors and Clinical Care Group and Executive Function leads during March 2026.

At its meeting on 26 March 2026, the Board endorsed and approved submission of the 2026/27 Annual Plan to Welsh Government. The financial plan includes a planned deficit of £41.0m, after delivery of £42.8m savings, and does not meet the statutory duty to break even over a three-year period.

The Board recognised that approving a budget with a planned deficit constituted a novel and contentious action. In line with requirements, the Accountable Officer wrote to the Director General Health, Social Care and Early Years Group in Welsh Government to formally advise of this position.

Welsh Government has confirmed its expectation that the Health Board should plan to deliver, as a minimum, the 2025/26 outturn position of £22.1m. The submitted forecast therefore remains above the target control total, and Welsh Government has stated that the deteriorating finance and performance position is unacceptable and unsupportable.

Ongoing dialogue with Welsh Government continues, with the Health Board required to improve the forecast position beyond the revised Annual Plan deficit and demonstrate a credible route to financial recovery through strengthened savings delivery, grip and control, and routine monitoring through established governance routes.

A dedicated Quarter 1 Financial Recovery and Delivery event was held on 9 July 2026, chaired by the Chief Executive and attended by Executive Directors and senior leaders, to review delivery risks, identify further opportunities and agree accelerated actions to strengthen the financial trajectory. This work will continue throughout Quarter 2, with a particular focus on reducing delivery risk and improving the level of recurrent savings identified.

Whilst the forecast outturn remains aligned to the approved planned deficit of £41.0m, the forecast position is currently under detailed review as part of the Quarter 2 assessment. Should planned improvements not materialise, or delivery confidence reduce, the forecast position will be reviewed accordingly to ensure it remains an accurate, true and fair representation of the financial outlook.

Asesiad / Assessment

Month 4 Summary

- In-month deficit: £5.1m, which is £1.7m adverse to plan.
- Savings gap: £13.0m, with £29.8m identified and delivered against the £42.8m target.
- The reported forecast remains £41.0m but is **assessed as high risk**, as it depends upon £19.4m of further mitigating actions that are not yet sufficiently evidenced or confirmed.

The latest financial position is summarised below and demonstrates continued pressure against the approved plan, with material reliance on further delivery actions and mitigating actions to support the reported forecast position.

Key Driver (£'m)	Current month variance to breakeven	Year to Date variance to breakeven	End of Year forecast to breakeven
Planned Deficit	**3.4**	**13.7**	**41.0**
Unidentified / (Identified) savings gap / (improvement)	2.5	2.8	13.0
Under / (Over) delivery of savings schemes	0.0	0.0	0.0
Core operational variation	(0.8)	5.1	6.4
Gross Forecast	**5.1**	**21.6**	**60.4**
Future Mitigating Actions	0.0	0.0	(19.4)
Reported Position	**5.1**	**21.6**	**41.0**

Appendix 1 provides a detailed assessment of the current financial position, including the assumptions relating to future mitigating actions that are not yet fully identified but are required to deliver the reported financial forecast.

Three-Year Financial Roadmap to Breakeven

Work continues on the development of the Health Board's Three-Year Financial Roadmap to Breakeven, which is intended to provide a credible and sustainable route towards restoring

financial balance whilst supporting delivery of the organisation's strategic and operational priorities.

The roadmap is being developed through a series of structured reviews of the underlying deficit, recurrent expenditure base, demand and capacity assumptions, service productivity opportunities, and the scope for recurrent savings and transformation over the medium term. The emerging position recognises that achieving financial sustainability will require a combination of organisational grip, service redesign, productivity improvement and system-wide support.

The roadmap is currently being refined through ongoing dialogue with NHS Performance and Improvement colleagues, together with Welsh Government officials, to ensure that the assumptions, trajectory and proposed actions are realistic, deliverable and aligned to national expectations. This engagement has provided an opportunity to test the credibility of the emerging approach, consider alternative scenarios and ensure that the Health Board's plans appropriately reflect both operational realities and the wider NHS Wales financial context.

As part of this work, the previously discussed configuration-related deficit remains under consideration as a strategic issue requiring broader discussion. Subject to further refinement, it is anticipated that this position will be presented to Welsh Government as a policy and planning choice for joint consideration, recognising the potential implications for service configuration, financial sustainability and the pace at which breakeven can realistically be achieved. This forms an important component of the medium-term sustainability discussion.

A more detailed version of the Three-Year Financial Roadmap to Breakeven will be presented to the In-Committee Board meeting in September 2026. The session will provide an opportunity to review the emerging strategic options, challenge underlying assumptions and consider the implications of the configuration-related deficit. Subject to Board discussion, the roadmap will then inform the next phase of engagement with Welsh Government and NHS Wales colleagues, supporting the development of an agreed and sustainable trajectory towards financial balance.

Alert (may require discussion)
There is a lack of confidence that any action in place is sufficient to address the issue satisfactorily and/or within the scope of the operational team or executive to resolve. Engagement, action or intervention required.

Mid-Year Financial Position Assessment

Whilst the financial position remains aligned to the planned £41.0m deficit, delivery remains highly challenging. The average monthly deficit of £5.3m reported in Months 1 to 5 would need to reduce to approximately £2.0m per month for the remainder of the year from Month 6. This will require accelerated expenditure reductions. Reflecting the scale of this challenge, the corporate risk relating to delivery of the in-year financial plan has been increased to the highest rating of 25.

Implication:

During August and September, the Finance Function will undertake a detailed review of the likely year-end position, including the extent to which non-recurrent mitigations can be converted into sustainable recurrent improvements from Month 6. The outcome will be reported

to Board on 24 September 2026 and will inform any required revision to the forecast submitted to Welsh Government through the Month 6 financial return.

There is a risk that the organisation's cash position becomes unsustainable if the forecast deteriorates or if further Welsh Government support is not confirmed. This may require implementation of a cash management strategy and continued escalation through established governance routes.

Savings Plan Credibility

- £29.8m of savings have been identified and delivered against the £42.8m target, leaving a £13.0m under-identification gap.
- Of the schemes identified, £28.5m are green and £1.3m are amber.
- Only £6.2m of the identified savings are recurrent, with £23.6m non-recurrent.
- A further £5.7m of full-year underspends have been converted to savings in Month 4.
- Further opportunities remain to convert underspends into recurrent savings, but this has not yet been fully secured.

Implication:
The savings position has improved materially since Month 3, but the remaining £13.0m gap and low recurrent element mean the forecast remains high risk. Without further recurrent delivery, the Health Board's ability to demonstrate a sustainable route to financial recovery and improve external confidence will remain limited.

Underlying Deficit Deterioration

The underlying recurrent deficit is currently assessed at £68.1m, compared with the £40.8m assumption underpinning the Annual Plan. This is distinct from the reported 2026/27 forecast outturn of £41.0m, which includes the benefit of non-recurrent savings and further mitigating actions. The deterioration reflects the low level of recurrent savings currently identified alongside continued core operational pressures.

Implication:

This represents a significant structural imbalance and worsens the Health Board's future financial sustainability. The gap between the planned and assessed underlying deficit increases the scale of recurrent action required in-year and for future planning cycles. A final decision, from relevant Executive Directors, on the conversion of non-recurrent savings to recurrent is expected for Month 6 reporting.

Operational Cost Pressures and Run-Rate Drivers

The key drivers increasing the run rate are:

- Sustained premium workforce expenditure, particularly medical locums, agency, bank, overtime and additional duties.
- Ongoing growth in Continuing Healthcare packages and commissioned care days, reflecting demand-led activity and cost pressures.
- Increased use of outsourced Psychiatric Intensive Care beds within Mental Health and Learning Disabilities, driven by capacity and acuity pressures.

- Continued outsourcing and insourcing pressures across Radiology, Theatres, Dermatology, Anaesthetics, Ophthalmology and Urology.

Implication:

These pressures are compounding the delivery gap, reducing controllability and increasing reliance on non-recurrent mitigations and further unconfirmed reductions. Unless operational grip strengthens and actions are converted into recurrent savings, the organisation's reported forecast will remain high risk. The deliverability of these mitigations will be tested through the Mid-Year Financial Position Assessment and may require a revision to the forecast by the Month 6 deadline if actions are not sufficiently evidenced or delivered.

Urgent and Emergency Care (UEC) and Streamlining Hub Investment Delivery

As part of the approved 2026/27 Annual Plan, investment was agreed to support the implementation of the Urgent and Emergency Care (UEC) and Streamlining Hub initiatives. Whilst these investments remain approved and are expected to proceed following further Board choices and decisions, implementation has been delayed and the associated expenditure is not forecast to materialise in line with the original planned profile. This has generated a non-recurrent in-year financial benefit of £0.6m which is currently supporting the reported financial position.

However, the financial benefit arising from delayed implementation is not reflective of an underlying improvement in financial sustainability and should be considered a temporary consequence of slippage in planned delivery. The investments were approved to support service capacity, patient flow and operational resilience, particularly in preparation for anticipated seasonal pressures and increasing demand across the urgent and emergency care pathway.

Implication:

The current position presents a complex trade-off between short-term financial benefit and the timely delivery of planned service improvements. Whilst the non-recurrent underspend provides temporary support to the financial forecast, prolonged delay may increase operational risk during periods of heightened demand and could impact the Health Board's ability to deliver the intended benefits associated with these investments.

Continued executive oversight is therefore required to clarify the implementation trajectory, expedite delivery where it remains appropriate and achievable, and ensure that any emerging risks to quality, performance or patient outcomes are identified, assessed and managed.

Advise (to monitor)
There are areas of concern where assurance has been taken on actions in place but requires close monitoring. An early warning of an emerging and potentially serious concern.

Accountability, Escalation and Grip

Transition in Governance and Ways of Working.

- A strengthened accountability framework has been introduced, with Executive Directors holding formal accountability for delivery and Clinical Care Group and Executive Function leads responsible for implementing agreed actions within their respective areas.
- Monthly reporting through the Executive Team continues to support oversight and accountability at Executive Level. There is variability in the outcomes in service areas, demonstrated by the need to escalate certain Clinical Care Groups or Executive Functions to either Level 3 or 4.
- The Month 4 Executive update sets out the mid-year forecast assessment timetable, with key checkpoints through August, September and October.
- Community and Integrated Medicine and Planned and Specialist Care remain Level 4 Alert areas, having under-delivered against their initial commitments as part of the CEO and COO Level 4 escalation meeting - £3.8m forecast improvement against a £10.0m commitment.
- An enhanced grip and control self-assessment has been developed internally, building on the national NHS Performance and Improvement framework, and will be shared to all services for completion, with findings and identified gaps to be brought back to a future meeting for review.

Implication:

The revised arrangements provide a clearer framework for accountability, but delivery effectiveness and consistency are not yet fully evidenced. There is a material risk that accountability arrangements are not yet sufficiently embedded to deliver the pace of improvement required. Continued escalation, targeted executive review and clear recovery actions are required in the areas furthest from expectation.

Ministerial Priorities and Enabling Actions

Requirements include:

- 30% reduction in on-contract agency spend and variable pay from the 2025/26 outturn.
- Elimination of off-contract agency.
- Elimination, by 30 September 2026, of all agency Healthcare Support Worker, Admin & Clerical, and Estates & Ancillary staff.
- Reduction in out-of-area placements.
- Delivery of productivity improvements.
- Strengthened workforce planning and sickness management.

Current position

- On-contract agency and premium workforce pressures continue due to service fragility, vacancies and sickness cover, with an increase of 6.7% above previous year.
- Off-contract agency has been reduced to nil.
- Medical locum usage, nursing bank and overtime remain material drivers in Community and Integrated Medicine.
- Admin & Clerical and Estates & Ancillary agency is nil.
- Mental Health and Learning Disabilities continues to experience demand and cost pressures from Healthcare Support Worker agency and outsourced out-of-area

Psychiatric Intensive Care beds, with reduction plans requiring further development and delivery assurance.

Implication:

Delivery against ministerial priorities is mixed. The elimination of off-contract agency is positive, but continued on-contract agency, premium workforce usage and demand-led pressures present ongoing risks to financial credibility and delivery of the recovery trajectory.

Assure (to note)
There is confidence that actions are robust and will be sufficient to address the issue or generally operating effectively. Routine monitoring.

Capital

The capital programme remains forecast to deliver within the Capital Resource Limit. At Month 4, no overspend or underspend risk is currently identified, although delivery will continue to be reviewed throughout the year.

In-Year Investment Decisions

In-year investment decisions made outside the Annual Plan process require appropriate scrutiny and approval through Finance and Performance Committee and onward approval by Board where required. Any financial consequences that cannot be fully mitigated will create an in-year negative central budget reserve and a recurrent funding requirement for future planning. The current summary of in-year investment decisions creating negative reserves of £1.103m part year effect and £1.249m full-year effect is:

Item Description	Part Year Effect	Full Year Effect	Approval status
Band 2/3 Funding shortfall	812	812	Presented to June 2026 Finance and Performance Committee
Resident Doctors contract	291	437	Approved via Chair's Action on 4 June 2026. 8 months, FYE £437k
Nurse Staffing Levels	0	0	Presented to July Public Board, £18k PYE saving, £36k FYE saving
Grand Total	**1,103**	**1,249**	

Argymhelliad / Recommendation

The Finance and Performance Committee is asked to:

- **SCRUTINISE AND CHALLENGE** the Month 4 financial position and reported forecast deficit of £41.0m, recognising that delivery is assessed as high risk and depends upon £19.4m of further mitigating actions that are not yet sufficiently evidenced or confirmed.
- **CHALLENGE** whether the current recovery trajectory is sufficient to close the £13.0m savings identification gap, increase recurrent savings delivery, reduce operating expenditure and address the deterioration in the underlying recurrent deficit.
- **SEEK ASSURANCE** that the mid-year financial position assessment will provide a robust and evidence-based view of the likely year-end outturn, including the

deliverability of further mitigating actions and the scope to convert non-recurrent benefits into sustainable recurrent improvement.

- **SEEK ASSURANCE** that clear and time-bound recovery actions are being implemented across all portfolios with Alert or Advise status, with appropriate operational ownership, executive accountability, capability and capacity.
- **SEEK ASSURANCE** regarding the implementation trajectory for the UEC and Streamlining Hub investments, including the management of associated patient-care, quality, performance and winter-resilience risks.
- **ENDORSE** the use of the mid-year assessment to inform the forecast reported to Welsh Government through the Month 6 financial reporting cycle.
- **RECOGNISE** the material risks to financial sustainability, including the deterioration in the underlying recurrent deficit, reliance on non-recurrent measures, increased corporate risk score and the potential for the cash position to become unsustainable without further Welsh Government support.
- **NOTE** progress in developing the Three-Year Financial Roadmap to Breakeven, its planned consideration by the In-Committee Board in September 2026 and the proposed engagement with Welsh Government on the configuration-related deficit as a policy and planning choice for joint consideration.
- **NOTE** the latest position on in-year investment decisions approved through the relevant governance arrangements.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Cyfeirnod Cylch Gorchwyl y Pwyllgor: Committee ToR Reference:	3.1.5 Receive assurance on the delivery of the financial plan. This will be achieved through scrutiny of the monthly finance report. This report shall ensure clarity in: 3.1.5.1 The reporting of monthly, year to date and forecast financial position alongside operational drivers; 3.1.5.2 Performance against the savings requirement; 3.1.5.3 Performance against other financial metrics, such as cash management, capital management and Public Sector Payment Policy.
Cyfeirnod Cofrestr Risg Datix, Teitl a Sgôr Risg Cyfredol: Datix Risk Register Reference and Score:	2326 (score 25) Risk to achieving 2026/27 Target Control Total due to underlying deficit, insufficient savings & reliance on non-recurrent funding.
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	7. All apply
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	6. All Apply

Amcanion Strategol y BIP: UHB Strategic Objectives:	All Strategic Objectives are applicable
Nodau Cynllunio 2026/27 Planning Goals 2026/27	All Planning Goals Apply
Hypergyswllt i Amcanion Llesiant HDdUHB 2026 Hyperlink to HDdUHB Well-being Objectives 2026	9. All HDdUHB Well-being Objectives apply
Model Cymdeithasol ar gyfer Iechyd a Llesiant: (wedi'i gwblhau ar gyfer newid strategol a/neu newidiadau sylweddol i wasanaethau) A Social Model for Health and Wellbeing: (*complete for strategic change and/or significant service changes)*	Not Applicable
Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Monitoring returns to Welsh Government based on HDdUHB's financial reporting system.
Rhestr Termau: Glossary of Terms:	BGH – Bronglais Hospital CHC – Continuing Healthcare EOY – End of Year FNC – Funded Nursing Care FYE – Full Year Effect GGH – Glangwili Hospital GMS – General Medical Services HSCEY – Health, Social Care and Early Years MHLD – Mental Health & Learning Disabilities NICE – National Institute for Health and Care Excellence OCP – Organisational Change Policy/Process OOH – Out of Hours PPH – Prince Philip Hospital PSPP– Public Sector Payment Policy RTT – Referral to Treatment Time T&O – Trauma & Orthopaedics TCT – Target Control Total

	WG – Welsh Government WGH – Withybush Hospital WRP – Welsh Risk Pool WTE – Whole Time Equivalent YTD – Year to date
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y cyfarfod hwn: Parties / Committees consulted prior to this meeting:	Finance Team Management Team Executive Team

Effaith: (rhaid cwblhau) **Impact: (must be completed)**	
Ariannol / Gwerth am Arian: **Financial / Service:**	Financial implications are inherent within the report.
Ansawdd / Gofal Claf: **Quality / Patient Care:**	The impact on patient care is assessed within the savings schemes.
Gweithlu: **Workforce:**	The report considers the financial implications of our workforce.
Tegwch Iechyd: **Health Equity:**	Financial risks are detailed in the report.
Risg: **Risk:**	HDdUHB has a legal duty to deliver a breakeven financial position over a rolling three-year basis and an administrative requirement to operate within its budget within any given financial year.
Cyfreithiol: **Legal:**	Adverse variance against HDdUHB's financial plan will affect its reputation with Welsh Government, Audit Wales, and with external stakeholders.
Enw Da: **Reputational:**	Not Applicable

Gyfrinachedd: **Privacy:**	Not Applicable
Cydraddoldeb: **Equality:**	Financial implications are inherent within the report.



GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

2026/27 Financial Performance Report
Finance and Performance Committee

Month 04 Reporting – July 2026/27

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Key

Risk Assessment and key performance indicator RAG criteria:

Alert	○	Lack of confidence in current actions to resolve issue; engagement, action or intervention required.
Advise	○	Areas of concern with current actions; assurance taken but close monitoring needed as early warning of potential serious issue.
Assure	○	Confidence that actions are robust and sufficient; routine monitoring only.

Savings BRAG and visual guide:

Current Month	Prior Month	Savings Blue, Red, Amber and Green Schemes (BRAG)
		A potential saving has been identified but is not yet scoped or developed. No detailed plan exists.
		Scheme is under consideration and initial scoping has started, but it is not yet fully developed or approved.
		Scheme has a clear plan, with actions and timelines defined, but delivery is not yet certain (medium risk).
		Implemented or near completion; savings delivery highly confident.



Revenue vs plan variance matrix report RAG indicator criteria:

Matrix Appendices RAG	In-Month Matrix	YTD Matrix	EOY Matrix
Large Positive Variance	>100,000	In-Month range x No. Months	In-Month range annualised
Moderate Positive Variance	50,000 – 99,999	In-Month range x No. Months	In-Month range annualised
Moderate Negative Variance	(99,999) – (50,000)	In-Month range x No. Months	In-Month range annualised
Large Negative Variance	<(100,000)	In-Month range x No. Months	In-Month range annualised

Financial Accountability Status

Background and Context

The Ways of Working consciously sets out to evolve the culture of the organisation away from imposed controls and executive scrutiny, to one of owned delivery, enhanced value and a focus on productivity and efficiency.

Executive Directors assume ultimate accountability for their areas under this approach. The Formal Executive Team receives a monthly update on the status of financial accountability, to ensure the Accountable Officer (CEO) can discharge their duties and hold relevant individuals to account, aligned to the internal escalation framework.

Latest Update

Commitment to deliver a £10m improvement was made in the first Level 4 meeting between CEO and COO, for CIM and P&SC. £3.8m has been converted post validation, leaving a shortfall against the assured commitment of £6.2m. Level 4 remains for COO for these two Clinical Care Groups.

Executive Director Portfolio	Status	Explanation (Number of portfolios and their escalation levels)
Chief Executive	Assure	Delivering breakeven and savings
Chief Operating Officer	Alert (2nd Month)	Continuation of 2 x Level 4 in Community and Integrated Medicine and Planned & Specialist Care (Savings and Breakeven gap), 1 x Level 3, 1 x Level 2, 1 x Level 1
Executive Medical Director	Advise	1 x Level 2 (Savings gap), 1 x Level 1
Executive Director of Nursing, Quality and Patient Experience	Assure	Delivering breakeven and savings
Executive Director of Workforce and Organisational Development	Assure	Delivering breakeven and savings
Executive Director of Finance	Assure	Delivering breakeven and savings
Executive Director of Strategy and Planning	Advise	1 x Level 3 (Savings and Breakeven gap), 1 x Level 1
Executive Director of Public Health	Assure	Delivering breakeven and savings
Executive Director of Allied Health Professions and Health Scien	Advise	1 x Level 3 (Savings and Breakeven gap)

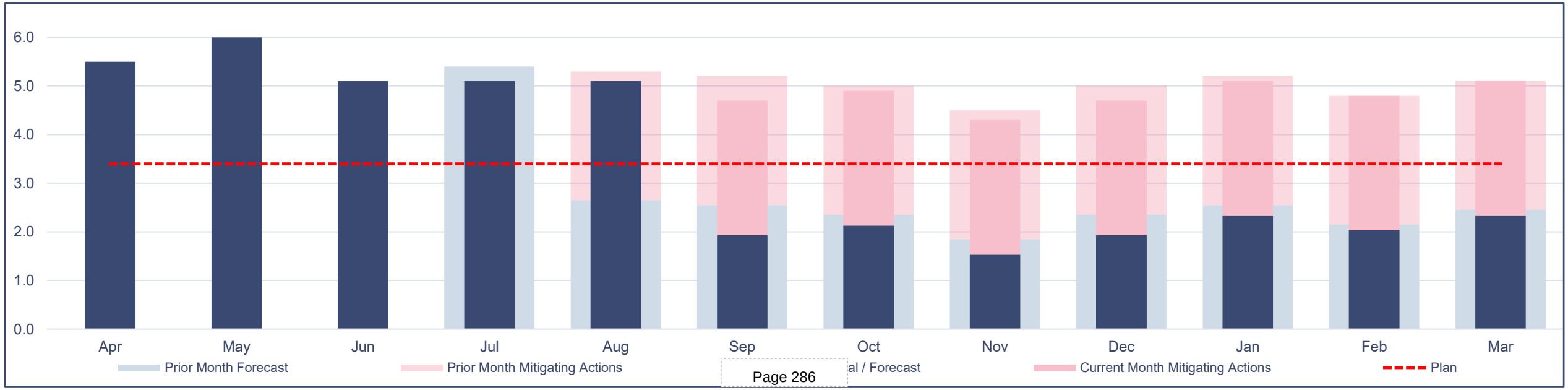
Mid-Year Financial Position Assessment

Key Update

Whilst the financial position remains stable, a significant improvement trajectory is required to achieve the planned £41.0m deficit. The average monthly deficit of £5.3m reported in Months 1 to 5 would need to reduce to £2.0m across the remainder of the year. Achieving this will require accelerated delivery of expenditure reductions, recurrent savings and strengthened operational grip. Reflecting this challenge, the Corporate Risk relating to delivery of the in-year financial plan has been increased to the highest rating of 25.

During August and September, the Finance Function will review the likely year-end position, including the extent to which non-recurrent measures can be converted into sustainable recurrent improvements from Month 6. The outcome will be reported to Board on 24 September and will inform any necessary revision to the forecast submitted to Welsh Government.

12 August	27 August	3 September	16 September	24 September	7 October
Formal Exec Team	**F&P Committee**	**Month 5 Collated**	**Formal Exec Team**	**Board Meeting**	**Formal Exec Team**
Month 4 update, including Level 4 actions impact	Situation and assessment timeline explained	Service teams submit latest plans and forecasts	Month 5 update and likelihood of change	Recommendation to advise Board of changes	Month 6 update and final check-point before WG



Actionable Insights – Top Priority Alerts

Action / Decision	£m	Description	Owner	Status	Due Date
Mid Year Forecast Assessment	**TBC**	The reported deficit, which currently remains the same as the Annual Plan at £41.0m, is going to be reviewed in detail during August and September. If there is no material improvement, or robust plans, the forecast will likely alter.	Andrew Spratt	In-progress	**7 October**
Level 4 escalation actions for CIM and P&SC	**10.0**	As part of the escalation actions for Community and Integrated Medicine (CIM) and Planned and Specialist care (P&SC), there was a commitment for £5m savings each, either as cash releasing savings or run rate reductions. The Month 4 forecast is showing a significant shortfall with £4.0m for CIM and £2.2m for P&SC. This includes a fortuitous £0.6m CIM saving relating to unplanned delays in the delivery of the UEC investment programme.	Andrew Carruthers, Peter Skitt and Paula Goode	Urgent action to identify the savings gap / reduction in end of year forecast, and implement the expected performance improvements through the UEC investment.	**Overdue**
Identification and delivery of robust **savings plans**	**13.0**	Whilst there has been a significant shift in the identification and conversion of underspends, there remains an identification gap to achieve the plan. There is an inequity across services with some over-delivering against target, and others under-delivering.	All Executive Directors, e*xc. Workforce, Finance and CEO*	Ongoing, urgent action to continue as part of de-risking the annual plan	**Overdue**
Medical pay and rostering Additional cover at premium costs	**7.0**	Continuing use of additional medical cover, including premium locum and agency in BGH, WGH, Planned Care and Mental Health. An impact assessment of the adoption and benefit of the rate card is required. The comprehensive use of Allocate also needs to be embedded.	Mark Henwood	Actions to be taken forward from the June Finance and Performance Committee update	**31 August**
Conscious decisions compounding delivery of Annual Plan without formal Governance approval	**1.3** **0.1** **1.4** **0.3** **0.5**	Known decisions have been made outside of the annual planning process: • Anaesthetist rate card extended, increasing Medical costs • Breast consultant over-established – retiree budget should have offset • Out of area MH&LD outsourcing beds – Ministerial Priorities conflict • Patient Flow Unit established without business case approval • First Contact Point Physiotherapy service continuation despite cessation of Cluster funding, exit strategy required where funding will cease.	Mark Henwood Andrew Carruthers Andrew Carruthers Andrew Carruthers Andrew Carruthers	No further extension Confirmation required Review/plan required OCP2 finalisation Defined exit strategies for non recurrent funding	**Overdue**

Mid-Month Improvement Commitment Update

Clinical Care Group (£'m)	Month 3 Savings Gap plus Forecast	Expected Improvements agreed in Level 4 meetings	Month 3 Restated Expectation	Month 4 Savings Gap plus Forecast	Deviation vs Expectation
Planned Deficit	**41.0**	**-**	**41.0**	**41.0**	**-**
Chief Operating Officer Management	**1.2**	**-**	**1.2**	**1.1**	**(0.1)**
Community and Integrated Medicine	**15.1**	**(5.0)**	**10.1**	**14.1**	**4.0**
Mental Health and Learning Disabilities	**5.5**	**-**	**5.5**	**5.3**	**(0.2)**
Operational Allied Health and Health Sciences	**5.5**	**-**	**5.5**	**5.3**	**(0.2)**
Planned and Specialist Care	**9.5**	**(5.0)**	**4.5**	**6.7**	**2.2**
Primary Care	**(10.7)**	**-**	**(10.7)**	**(9.0)**	**1.7**
Executive Functions	**(4.9)**	**-**	**(4.9)**	**(4.1)**	**0.8**
Grand Total	**62.2**	**(10.0)**	**52.2**	**60.4**	**8.2**

CIM and P&SC remain as Level 4 Alerts for the CEO to review with the COO. The CIM UEC investment programme implementation is delayed, impacting performance delivery, but also resulting in a £0.6m fortuitous gain which has been declared as a saving. The deviation would have been £4.6m without this in the above. CIM deterioration is £2.0m within core and £2.0m savings gap vs Level 4 agreed improvement commitment. P&SC improvement of £(1.5)m against core and £3.7m savings gap vs Leve[illegible]mprovement commitment.

Position Overview – Executive Summary

The Health Board's Annual Planned Deficit is £41.0m with an Annual Savings Target of £42.8m. Gross forecast position is £60.4m, with planned mitigating actions of £19.4m to be finalised, to achieve the reported end of year forecast position of £41.0m. Total savings delivery are £29.8m, leaving a savings delivery gap of £13.0m against the savings target.

Financial Management

The in-month financial position is a deficit of £5.1m, which is an adverse variance against the £3.4m deficit plan. This is driven by a core operational underspend of £(0.8)m, offset by a £2.5m under identification of savings, with £1.1m savings identified against the savings target £3.6m.

Key Driver (£'m)	Prior month variance to breakeven	Current month variance to breakeven	Year to Date variance to breakeven	Prior Month End of Year forecast to breakeven	End of Year forecast to breakeven
Planned Deficit	**3.4**	**3.4**	**13.7**	**41.0**	**41.0**
Unidentified / (Identified) savings gap / (improvement)	(4.7)	2.5	2.8	21.8	13.0
Under / (Over) delivery of savings schemes	0.0	0.0	0.0	0.0	0.0
Core operational variation	6.4	(0.8)	5.1	(0.6)	6.4
Gross Forecast	**5.1**	**5.1**	**21.6**	**62.2**	**60.4**
Future Mitigating Actions	0.0	0.0	0.0	(21.2)	(19.4)
Reported Position	**5.1**	**5.1**	**21.6**	**41.0**	**41.0**

Key Measures

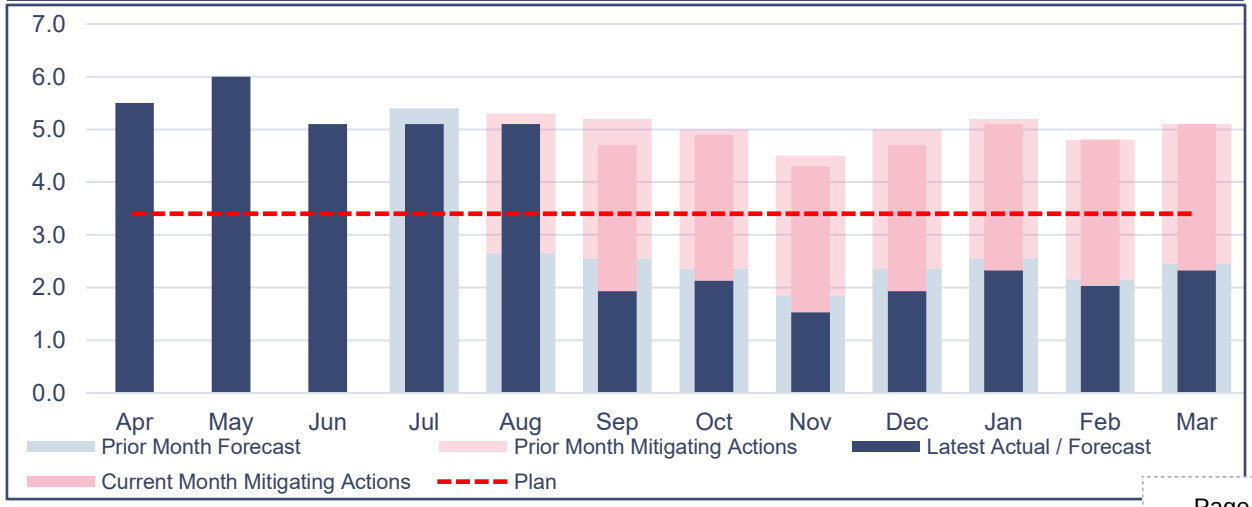
BRAG based on Plan £30.0m (Risk rating = Impact x Likelihood)

Core Operational Variation	**Risk #2326** 5 x 5 = 25	The in-month core operational underspend of £(0.8)m largely relates to the re-categorisation of Primary Care Dental contract savings of £(1.9)m to underspends, offset by Continuing Healthcare packages increase of £0.4m, Medical agency usage to cover sickness and vacancies £0.4m and Theatres outsourcing of activity £0.4m. The £5.9m full year conversion of underspends to savings has given greater visibility to core operational variations of mitigating actions required for managing overspends.
Cash		The Health Board will require strategic cash assistance in-year in line with the forecast deficit and working capital balances.
Savings		Of the annual savings target of £42.8m, £29.8m has been identified and forecast to fully deliver on an in-year basis resulting in a £13.0m under-identification gap. Of the schemes identified, £6.2m are recurrent savings and £23.6m are non-recurrent savings. £5.9m full year underspends have been recognised as savings in Month 4, with a continued action to forecast savings into future periods as well as converting at pace the pipeline schemes into credible Green and Amber plans.
Capital	**N/A**	Delivery against the capital programme is currently assessed as low risk. Capital projects are currently expected to deliver the Capital Resource Limit; this assessment will be kept under review as the year progresses.
Underlying Deficit	**Risk #1199** 5 x 5 = 25	The planned underlying deficit is £40.8m, assuming delivery of £42.8m recurrent savings. £6.4m recurrent savings have been identified, leaving a recurrent savings gap of £36.4m. After recognising £10.3m recurrent mitigating actions and recurrent cost pressures relating to the Healthcare Support Workers re-banding dispute (£0.8m) and GP Resident Doctors contract (£0.4m), the underlying deficit is £68.1m. The organisation acknowledges the need to improve its financial trajectory to achieve breakeven by 2027/28, a requirement of the £26.0m conditionally recu[illegible]gside a commitment to convert non-recurrent savings to recurrent savings by Month 6.

Position Overview – Change from Prior Month

Key Driver (£'m)	Prior Month Reported Position	Current Month Reported Position	Movement
Planned Deficit	**3.4**	**3.4**	**0.0**
Savings gap / (improvement)	(4.7)	2.5	7.2
Under / (Over) delivery of savings schemes	0.0	0.0	0.0
Core Operational Variation	6.4	(0.8)	(7.2)
Gross Forecast	**5.1**	**5.1**	**0.0**
Future Mitigating Actions	0.0	0.0	0.0
Reported Net Position	**5.1**	**5.1**	**0.0**

In-Month Revenue Deficit Trajectory (£'m)



Unidentified Savings Gap (£'m)	Change
Year to date conversion of underspends to savings in prior month	5.3
Primary Care Dental savings reclassified to core operational underspends	1.9
Movement in Unidentified Savings Gap	**7.2**

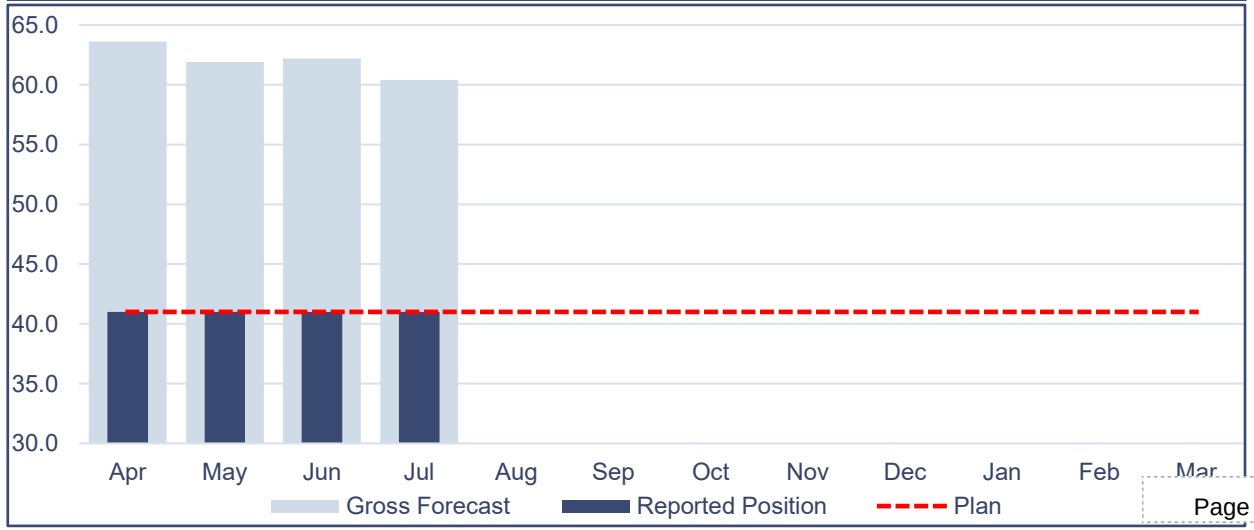
Under / (Over) Delivery of Savings Schemes (£'m)	Change
No change to report	0.0
Movement in Savings Delivery	**0.0**

Core Operational Variation (£'m)	Change
Year to date conversion of underspends to savings in prior month	(5.3)
Primary Care Dental savings reclassified to core operational underspends	(1.9)
Community & Integrated Medicine Nursing enhanced pay rates & bank use	(0.4)
Reduction in Joint Commissioning Committee risk share	(0.4)
Digital programmes increase in contracts expenditure	0.4
Mental Health increase in purchase of outsourced Psychiatric beds demand	0.4
Movement in Core Operational Variation	**(7.2)**

Position Overview – Change from Prior Forecast

Key Driver (£'m)	Prior Month End of Year Forecast	End of Year Forecast	Movement
Planned Deficit	**41.0**	**41.0**	**0.0**
Savings gap / (improvement)	21.8	13.0	(8.8)
Under / (Over) delivery of savings schemes	0.0	0.0	0.0
Core Operational Variation	(0.6)	6.4	7.0
Gross Forecast	**62.2**	**60.4**	**(1.8)**
Future Mitigating Actions	(21.2)	(19.4)	1.8
Reported Net Position	**41.0**	**41.0**	**0.0**

End of Year Revenue Deficit Trajectory (£'m)



Unidentified Savings Gap (£'m)	Change
Full year conversion of core operational underspends to savings	(5.9)
Controlled Drugs Stock Strategic Review	(2.2)
Non delivery of Streaming and Emergency Care investment programmes	(0.6)
Planned Care Ophthalmology & Rheumatology Biosimilar drugs switches	(0.6)
Community and Integrated Medicine Biosimilar prescribing drugs switches	(0.5)
Other savings including £0.3m accountancy gains	(0.5)
Community and Integrated Medicine A&E admission flow rates	(0.4)
Dental contract handbacks prior savings reclassified to core underspends	1.9
Movement in Unidentified Savings Gap	**(8.8)**

Core Operational Variation (£'m)	Change
Full year conversion of core operational underspends to savings	5.9
Controlled Drugs Stock Strategic Review	2.2
Primary Care General Medical Services increase in programme expenditure	1.6
Prescribing Audit Report increase in drugs price and concessions	1.1
Reduction in Joint Commissioning Committee risk share and activity	(0.4)
Planned and Specialist Care Oncology drugs reduction in volume and price	(0.7)
Community & Integrated Medicine Nursing enhanced pay rates & bank use	(0.8)
Dental contract handbacks prior savings reclassified to core underspends	(1.9)
ovement in Core Operational Variation	**7.0**

Financial Summary

In-Month Actual
£113.0m
Variance to Plan **£1.7m**

YTD Actual
£463.3m
Variance to Plan **£7.9m**

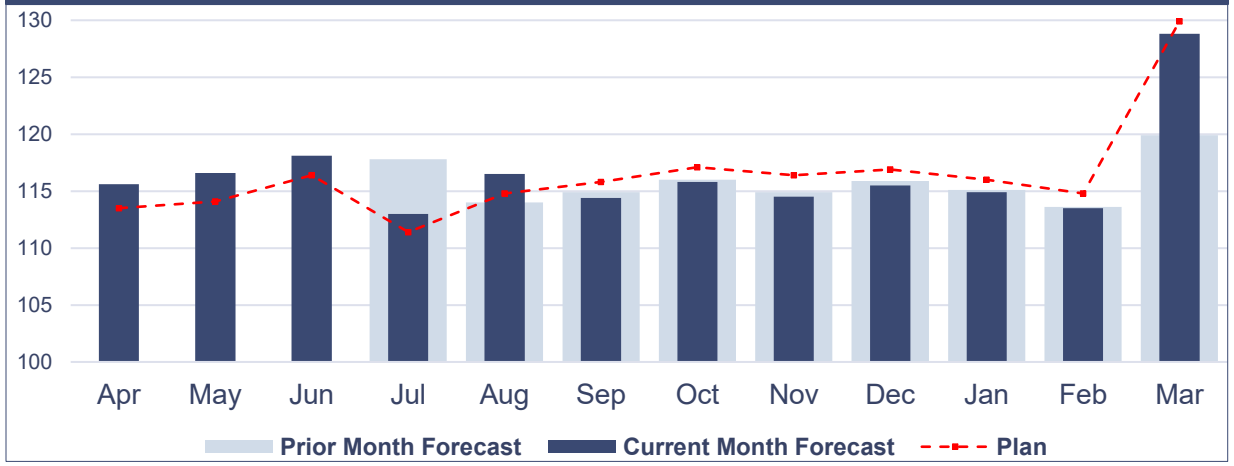
EOY Forecast
£1,397.2m
Variance to Plan **£0.0m**

3-Year Growth
6.4%
2023-24 Outturn **£1,313m***

In-Year Growth
(1.8)%
2025-26 Outturn **£1,422m***

YTD Extrapolation
£1,389.9m
Risk / (Opp) **£(7.4)m**

Net Income and Expenditure (Before Allocations) (£'m)



Expenditure Trajectory Analysis (£'m)	P02-27	P03-27	P04-27	YTD	YTD Extrap.	EoY Forecast	EoY Var	Risk / (Opp)
Pay	**59.6**	**61.0**	**59.5**	**239.3**	**717.9**	**710.6**		**7.4**
Administration and Estates	12.3	12.4	12.2	49.1	147.4	146.9		0.5
Allied Health, Scientists and Other	7.3	7.5	7.5	29.7	89.1	88.4		0.7
Medical and Dental	13.5	14.7	13.9	55.5	166.6	163.6		3.0
Nursing, Midwifery and Clinical Support	26.4	26.4	25.8	104.9	314.8	311.7		3.1
Non Pay	**64.0**	**64.1**	**61.3**	**252.5**	**757.5**	**770.9**		**(13.4)**
Clinical Services and Supplies	4.4	4.7	4.6	17.5	52.5	52.2		0.3
Commissioned Healthcare Services	37.6	37.1	37.0	148.9	446.7	446.5		0.2
Drugs and Prescribing	12.4	13.2	14.2	53.0	158.9	160.8		(1.8)
Other Non-Pay	9.6	9.1	5.5	33.1	99.4	111.5		(12.1)
Income	**(7.0)**	**(7.0)**	**(7.8)**	**(28.5)**	**(85.5)**	**(84.2)**		**(1.3)**
Net Income and Expenditure	**116.6**	**118.1**	**113.0**	**463.3**	**1,389.9**	**1,397.2**		**(7.4)**
Allocations	**110.6**	**112.9**	**108.0**	**441.7**	**1,325.0**	**1,356.2**		**31.3**
Reported Position	**6.0**	**5.1**	**5.1**	**21.6**	**64.9**	**41.0**		**23.9**

Key Information

Month 4, July, deviation, largely due to a decrease in Capital Charges following impairments reduction adjustment £4.0m, with a corresponding reduction in Revenue Resource Limit.

Month 6, September, onwards includes a reduction in expenditure due to planned mitigating actions of £19.4m anticipated within Non Pay £8.9m and Pay £10.5m in line with latest anticipated future savings forecast, resulting in a corresponding risk for Non Pay and Pay due to the future months forecast being lower than year to date expenditure levels seen. Note a significant deviation from prior month forecast in Month 5 as mitigating actions previously assumed to deliver are unlikely to deliver within the required timeframe.

Month 12, March, includes Depreciation and Amortisation Impairments increase in expenditure of £14.1m, with a corresponding increase in Revenue Resource Limit.

Note an opportunity within Drugs and Prescribing due to end of year forecast expenditure being higher than the year to date average due to increase in price from £8.05 to £8.14 per item, alongside increases anticipated within Pharmacy and Medicines Management in August, Month 5, due to increase in drugs price and concessions.in line with May Prescribing Audit Report.

***Outturn adjusted for Notional Pension costs 2025-26 c£42.8m, 2024-25 c£40.3m**

Financial Summary – Key Drivers vs Plan

In-Month

Reported Position
£5.1m
Planned Deficit **£3.4m**
Prior Month Forecast **£5.4m**

Savings Identification Gap
£2.5m
Savings Target **£3.6m**
Total Identified **£1.1m**

Savings Delivery Gap
£0.0m
Savings Delivery **£1.1m**
Prior Month Delivery **£8.3m**

Core Operational Variation
£(0.8)m
Prior Month Variation **£6.4m**

Year to Date

Reported Position
£21.6m
Planned Deficit **£13.7m**

Savings Identification Gap
£2.8m
Savings Target **£14.3m**
Total Identified **£11.5m**

Savings Delivery Gap
£0.0m
Savings Delivery **£11.5m**
Prior Month Delivery **£10.4m**

Core Operational Variation
£5.1m
Prior Month Variation **£6.0m**

End of Year

Reported Position
£41.0m
Planned Deficit **£41.0m**
Prior Annual Forecast **£41.0m**

Savings Identification Gap
£13.0m
Savings Target **£42.8m**
Total Identified **£29.8m**

Savings Delivery Gap
£0.0m
Savings Delivery **£29.8m**
Prior Month Delivery **£21.0m**

Core Operational Variation
£6.4m
Prior Month Variation **£(0.6)m**

Gross Forecast
£60.4m
Prior Gross Forecast **£62.2m**
Mitigating Actions **£19.4m**

Net Risks / (Opportunities)
£2.4m
Prior Month **£3.3m**

Capital Position
£34.6m
Annual Plan **£34.6m**
Prior Annual Forecast **£34.6m**

Underlying Deficit
£68.1m
Annual Plan **£40.8m**
Recognised as Unsustainable

Total Pay Insights

In-Month Actual £59.5m — Variance to Plan **£(0.6)m**

YTD Actual £239.3m — Variance to Plan **£2.7m**

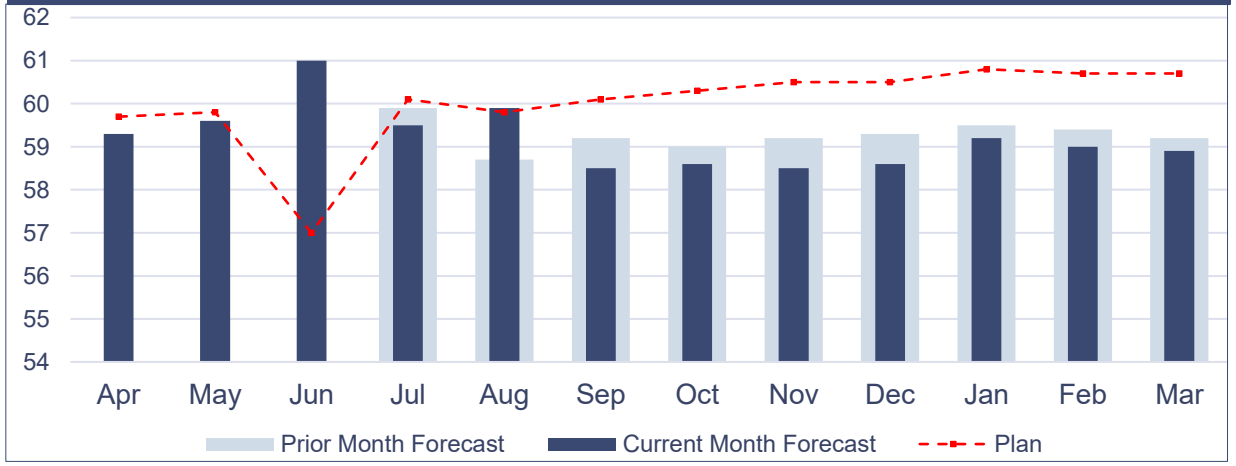
EOY Forecast £710.6m — Variance to Plan **£(9.5)m**

3-Year Growth 18.3% — 2023-24 Outturn **£600.9m***

In-Year Growth 7.2% — 2025-26 Outturn **£662.9m***

YTD Extrapolation £717.9m — Risk / (Opp) **£7.4m**

Expenditure Monthly Trend (£'m)



Expenditure Trajectory Analysis (£'m)	P02-27	P03-27	P04-27	YTD	YTD Extrap.	EoY Forecast	EoY Var	Risk / (Opp)
Substantive	**55.0**	**55.9**	**54.5**	**219.2**	**657.7**	**656.0**		**1.7**
Administration and Estates	12.1	12.0	11.9	47.8	143.4	143.2		0.2
Allied Health, Scientists and Other	7.2	7.3	7.2	28.8	86.4	85.3		1.1
Medical and Dental	11.3	12.2	11.5	46.0	138.0	137.5		0.5
Nursing, Midwifery and Clinical Support	24.5	24.4	23.8	96.6	289.8	290.0		(0.2)
Variable	**3.8**	**4.2**	**4.0**	**16.3**	**48.8**	**43.5**		**5.3**
Administration and Estates	0.3	0.3	0.3	1.3	4.0	3.7		0.3
Allied Health, Scientists and Other	0.2	0.2	0.2	0.7	2.2	2.3		(0.1)
Medical and Dental	1.8	1.9	1.8	7.3	21.8	19.2		2.6
Nursing, Midwifery and Clinical Support	1.6	1.7	1.6	7.0	20.9	18.3		2.6
Agency (Premium)	**0.7**	**0.9**	**1.0**	**3.8**	**11.4**	**11.1**		**0.3**
Administration and Estates	-	-	-	-	-	-		-
Allied Health, Scientists and Other	(0.1)	-	0.1	0.2	0.5	0.8		(0.2)
Medical and Dental	0.5	0.5	0.6	2.3	6.8	6.9		(0.1)
Nursing, Midwifery and Clinical Support	0.3	0.3	0.3	1.4	4.1	3.4		0.7
Total Expenditure	**59.6**	**60.9**	**59.5**	**239.3**	**717.9**	**710.6**		**7.4**
Plan	**59.8**	**57.0**	**60.1**	**236.6**	**709.7**	**720.1**		
Variance to Plan	**(0.2)**	**3.9**	**(0.6)**	**2.7**	**8.2**	**(9.5)**		

Key Information

Month 3, June, increase in expenditure due to year to date payment of the FY26-27 Medical and Dental 3.5% pay award £1.4m, offset by a reduction in the plan relating to the exercise to convert year to date core operational underspends to savings, with £4.8m savings being identified for pay vacancies.

Month 4, July, in-month improvement relating to reduced enhanced pay rates due to May's Bank Holiday Paid in June and bank nurse usage decrease within Community and Integrated Medicine, along with new vacancies in Substantive pay across multiple areas.

Month 5, August, significant deviation from prior month forecast as mitigating actions previously assumed to deliver are unlikely to deliver within the required timeframe.

Month 6, September, onwards includes a reduction in expenditure due to planned mitigating actions of £10.5m anticipated within Substantive £8.6m and Variable £1.9m to deliver from Month 6 to 12, with the reduction in Variable and Agency largely anticipated within Medical and Allied Health. Mitigating actions result in a risk for Pay due to the future months forecast being lower than year to date expenditure levels seen, in particular within Nursing and Medical Variable and Agency pay.

***Outturn adjusted for Notional Pension costs 2025-26 c£42.8m, 2024-25 c£40.3m**

Substantive Insights

In-Month Actual
£54.5m
Variance to Plan **£(3.9)m**

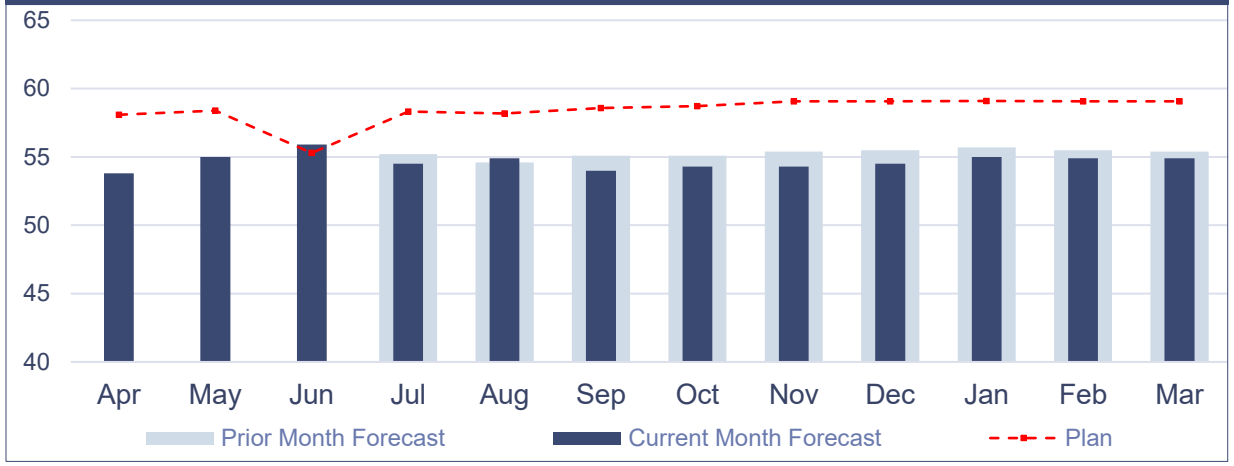
YTD Actual
£219.2m
Variance to Plan **£(10.9)m**

EOY Forecast
£656.0m
Variance to Plan **£(45.0)m**

In-Year Growth
7.2%
2024-25 Outturn **£611.7m**

YTD Extrapolation
£657.7m
Risk / (Opp) **£1.7m**

Expenditure Monthly Trend (£'m)



Expenditure Trajectory Analysis (£'m)	P02-27	P03-27	P04-27	YTD	YTD Extrap.	EoY Forecast	EoY Var	Risk / (Opp)
Pay Groups	**55.0**	**55.9**	**54.5**	**219.2**	**657.7**	**656.0**		**1.7**
Administration and Estates	12.1	12.0	11.9	47.8	143.4	143.2		0.2
Allied Health, Scientists and Other	7.2	7.3	7.2	28.8	86.4	85.3		1.1
Medical and Dental	11.3	12.2	11.5	46.0	138.0	137.5		0.5
Nursing, Midwifery and Clinical Support	24.5	24.4	23.8	96.6	289.8	290.0		(0.2)
Functions	**55.0**	**55.9**	**54.5**	**219.2**	**657.7**	**656.0**		**1.7**
Chief Operating Officer Management	1.2	0.7	0.7	3.4	10.3	9.4		1.0
Community and Integrated Medicine	16.9	17.2	16.8	67.5	202.4	207.6		(5.1)
Mental Health and Learning Disabilities	6.1	6.2	6.1	24.5	73.4	73.7		(0.3)
Operational Allied Health and Health Sciences	5.8	5.9	5.8	23.2	69.6	69.4		0.2
Planned and Specialist Care	13.7	14.4	13.9	55.6	166.9	167.6		(0.7)
Primary Care	1.3	1.4	1.4	5.3	16.0	15.7		0.3
Executive Functions	10.0	10.1	9.7	39.7	119.0	112.6		6.4
Total Expenditure	**55.0**	**55.9**	**54.5**	**219.2**	**657.7**	**656.0**		**1.7**
Plan	**58.4**	**55.3**	**58.3**	**230.1**	**690.3**	**701.0**		
Variance to Plan	**(3.4)**	**0.6**	**(3.9)**	**(10.9)**	**(32.6)**	**(45.0)**		

Key Information

Month 3, June, increase in expenditure due to year to date payment of the FY26-27 Medical and Dental 3.5% pay award £1.4m.

Month 5, August, deviation from prior month forecast as mitigating actions previously assumed to deliver are unlikely to deliver within the required timeframe.

Month 6, September, onwards includes a reduction in expenditure due to planned mitigating actions of £8.6m to deliver from Month 6 to 12. Mitigating actions result in a risk for Pay due to the future months forecast being lower than year to date expenditure levels seen.

Variable Insights

In-Month Actual
£4.0m
Variance to Plan **£2.7m**

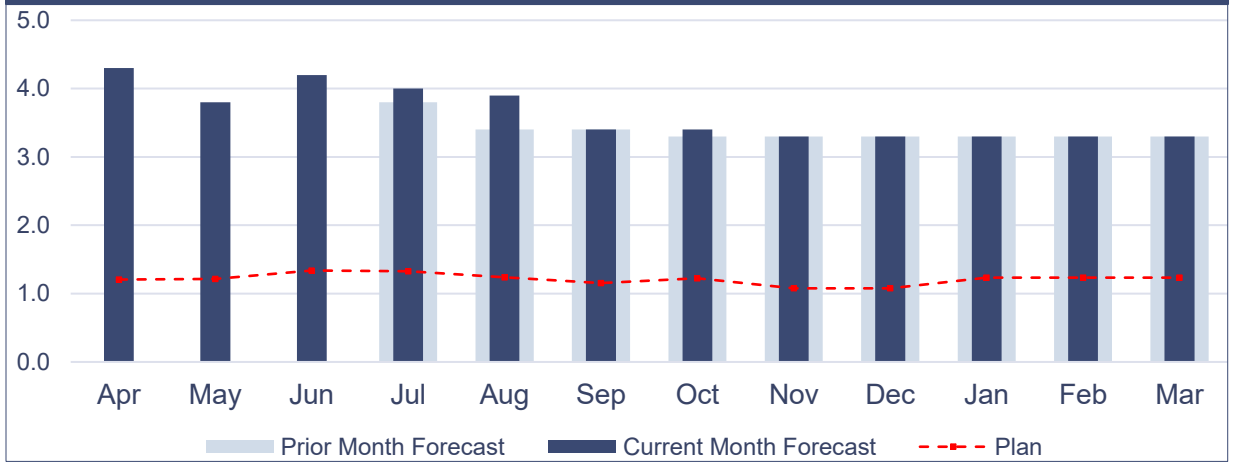
YTD Actual
£16.3m
Variance to Plan **£11.2m**

EOY Forecast
£43.5m
Variance to Plan **£28.9m**

In-Year Growth
(18.2)%
2025-26 Outturn **£53.2m**

YTD Extrapolation
£48.8m
Risk / (Opp) **£5.3m**

Expenditure Monthly Trend (£'m)



Expenditure Trajectory Analysis (£'m)	P02-27	P03-27	P04-27	YTD	YTD Extrap.	EoY Forecast	EoY Var	Risk / (Opp)
Pay Groups	**3.8**	**4.2**	**4.0**	**16.3**	**48.8**	**43.5**		**5.3**
Administration and Estates	0.3	0.3	0.3	1.3	4.0	3.7		0.3
Allied Health, Scientists and Other	0.2	0.2	0.2	0.7	2.2	2.3		(0.1)
Medical and Dental	1.8	1.9	1.8	7.3	21.8	19.2		2.6
Nursing, Midwifery and Clinical Support	1.6	1.7	1.6	7.0	20.9	18.3		2.6
Functions	**3.8**	**4.1**	**4.0**	**16.2**	**48.8**	**43.5**		**5.3**
Chief Operating Officer Management	-	-	-		0.1	0.1		0.0
Community and Integrated Medicine	1.5	1.7	1.5	6.4	19.1	17.9		1.2
Mental Health and Learning Disabilities	0.2	0.2	0.2	0.9	2.6	2.6		(0.0)
Operational Allied Health and Health Sciences	0.3	0.3	0.3	1.0	3.1	3.2		(0.1)
Planned and Specialist Care	1.2	1.3	1.2	5.0	15.0	12.9		2.0
Primary Care	0.3	0.4	0.4	1.6	4.8	5.0		(0.2)
Executive Functions	0.3	0.3	0.5	1.4	4.1	1.7		2.5
Total Expenditure	**3.8**	**4.1**	**4.0**	**16.3**	**48.8**	**43.5**		**5.3**
Plan	**1.2**	**1.3**	**1.3**	**5.1**	**15.3**	**14.6**		
Variance to Plan	**2.6**	**2.8**	**2.7**	**11.2**	**33.6**	**28.9**		

Key Information

Month 2, May, reduction in Bank expenditure due to inability to fill shifts within Community and Integrated Medicine and reduction in patient acuity within Mental Health, alongside reduction in Waiting List Initiative activity within Planned and Specialist Care.

Month 3, June, increase in Variable Pay including bank and overtime usage within Community and Integrated Medicine to cover sickness and fill rota gaps.

Month 4, July, Bank Nurse usage decrease within Community and Integrated Medicine with a reduction in enhanced pay rates in July.

Month 5, August, deviation from prior month forecast as mitigating actions previously assumed to deliver are unlikely to deliver within the required timeframe.

Month 6, September, onwards includes a reduction in expenditure due to planned mitigating actions of £1.9m to deliver from Month 6 to 12, with the reduction in Variable largely anticipated within Medical and Dental. Mitigating actions result in a risk for Pay due to the future months forecast being lower than year to date expenditure levels seen.

Agency Insights

In-Month Actual
£1.0m
Variance to Plan **£0.6m**

YTD Actual
£3.8m
Variance to Plan **£2.4m**

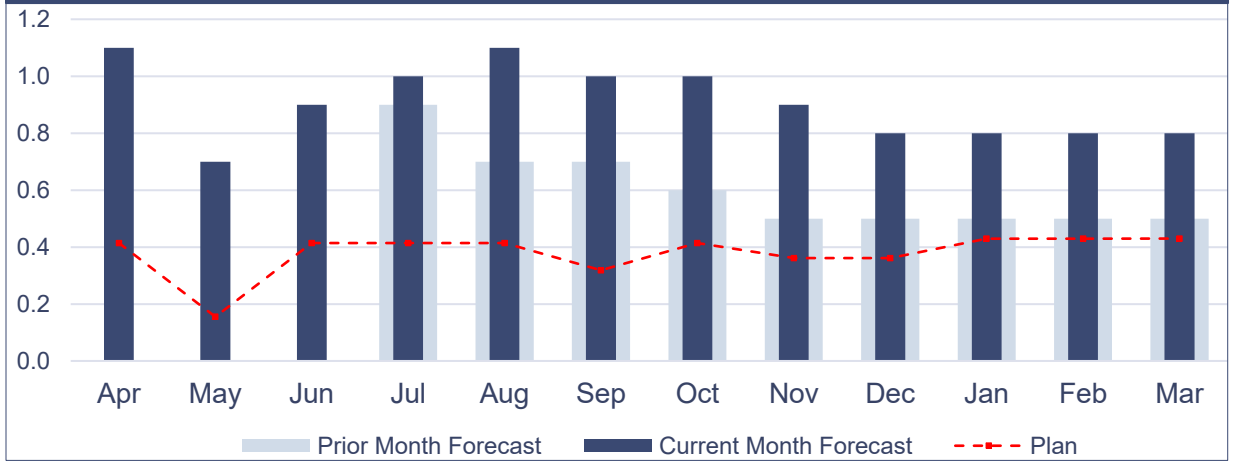
EOY Forecast
£11.1m
Variance to Plan **£6.5m**

3-Year Growth
(66.5)%
2023-24 Outturn **£33.1m**

In-Year Growth
6.7%
2025-26 Outturn **£10.4m**

YTD Extrapolation
£11.4m
Risk / (Opp) **£0.3m**

Expenditure Monthly Trend (£'m)



Expenditure Trajectory Analysis (£'m)	P02-27	P03-27	P04-27	YTD	YTD Extrap.	EoY Forecast	EoY Var	Risk / (Opp)
Pay Groups	**0.7**	**0.9**	**1.0**	**3.8**	**11.4**	**11.1**		**0.3**
Administration and Estates	-	-	-	-	-	-		-
Allied Health, Scientists and Other	(0.1)	-	0.1	0.2	0.5	0.8		(0.2)
Medical and Dental	0.5	0.5	0.6	2.3	6.8	6.9		(0.1)
Nursing, Midwifery and Clinical Support	0.3	0.3	0.3	1.4	4.1	3.4		0.7
Functions	**0.7**	**0.9**	**1.0**	**3.8**	**11.4**	**11.1**		**0.3**
Chief Operating Officer Management	-	-	-	-	-	-		-
Community and Integrated Medicine	0.7	0.7	0.6	2.6	7.9	7.0		0.9
Mental Health and Learning Disabilities	0.1	0.1	0.1	0.3	0.8	0.8		0.0
Operational Allied Health and Health Sciences	0.2	0.1	0.2	0.7	2.0	2.0		0.0
Planned and Specialist Care	0.1	0.1	0.1	0.5	1.5	1.6		(0.1)
Primary Care	-	-	-	-	-	0.1		(0.1)
Executive Functions	(0.3)	-	-	(0.3)	(0.8)	(0.3)		(0.5)
Total Expenditure	**0.7**	**0.9**	**1.0**	**3.8**	**11.4**	**11.1**		**0.3**
Plan	**0.2**	**0.4**	**0.4**	**1.4**	**4.2**	**4.6**		
Variance to Plan	**0.6**	**0.5**	**0.6**	**2.4**	**7.2**	**6.5**		

Key Information

Month 2, May, reduction in Agency expenditure from prior month within Medical and Nursing across various areas, with a reduction in plan following recognition as saving.

Month 5, August, significant deviation from prior month forecast as mitigating actions previously assumed to deliver are unlikely to deliver within the required timeframe.

Month 6, September, onwards no longer include an anticipated reduction in expenditure due to mitigating actions of £1.8m no longer being assumed, due to the limited visibility of the pipeline opportunity plans delivering, therefore currently assumed within substantive instead. This reduction is compounded by an increase in expenditure from Month 6 onwards in Community and Integrated Medicine £0.6m and Planned and Specialist Care £0.6m, in line with Urgent and Emergency Care and Theatres investment plans, alongside both areas seeing continued pressure to fill vacant posts and cover sickness.

Month 9, December, recognises a reduction in Agency expenditure due to the substantive recruitment of International Educated Nurses.

Clinical Services and Supplies Insights

In-Month Actual
£4.6m
Variance to Plan **£0.7m**

YTD Actual
£17.5m
Variance to Plan **£2.1m**

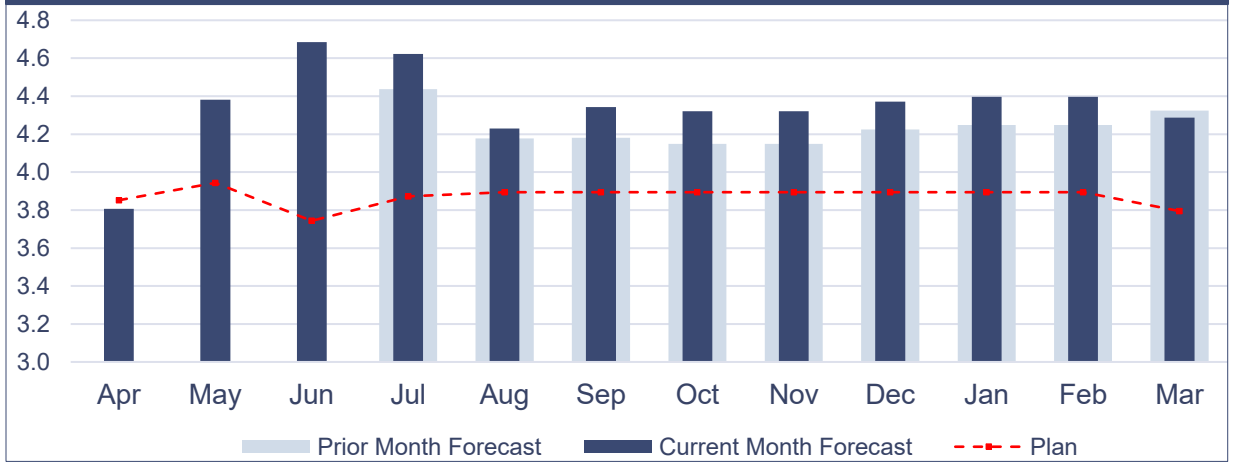
EOY Forecast
£52.1m
Variance to Plan **£5.7m**

3-Year Growth
15.8%
2023-24 Outturn **£45.0m**

In-Year Growth
0.8%
2025-26 Outturn **£51.7m**

YTD Extrapolation
£52.5m
Risk / (Opp) **£0.3m**

Expenditure Monthly Trend (£'m)



Expenditure Trajectory Analysis (£'m)	P02-27	P03-27	P04-27	YTD	YTD Extrap.	EoY Forecast	EoY Var	Risk / (Opp)
Functions	**4.3**	**4.6**	**4.6**	**17.5**	**52.5**	**52.1**		**0.3**
Chief Operating Officer Management	-	0.1	-	0.1	0.4	0.5		(0.1)
Community and Integrated Medicine	1.2	1.2	1.2	4.8	14.4	14.3		-
Mental Health and Learning Disabilities	-	-	-	0.1	0.2	0.2		-
Operational Allied Health and Health Sciences	1.1	1.2	1.1	4.5	13.5	13.7		(0.2)
Planned and Specialist Care	2.0	2.1	2.3	8.0	23.9	23.0		0.9
Primary Care	-	-	-	0.1	0.4	0.3		-
Executive Functions	-	0.1	(0.1)	(0.1)	(0.2)	-		(0.2)
Total Expenditure	**4.3**	**4.6**	**4.6**	**17.5**	**52.5**	**52.1**		**0.3**
Plan	**3.9**	**3.7**	**3.9**	**15.4**	**46.2**	**46.5**		**(0.2)**
Variance to Plan	**0.3**	**0.9**	**0.7**	**2.1**	**6.3**	**5.7**		**0.6**

Key Information

Month 2, May, reflects an increase from prior month driven by Planned and Specialist Care operating theatre consumables including loan kits and insourcing of activity.

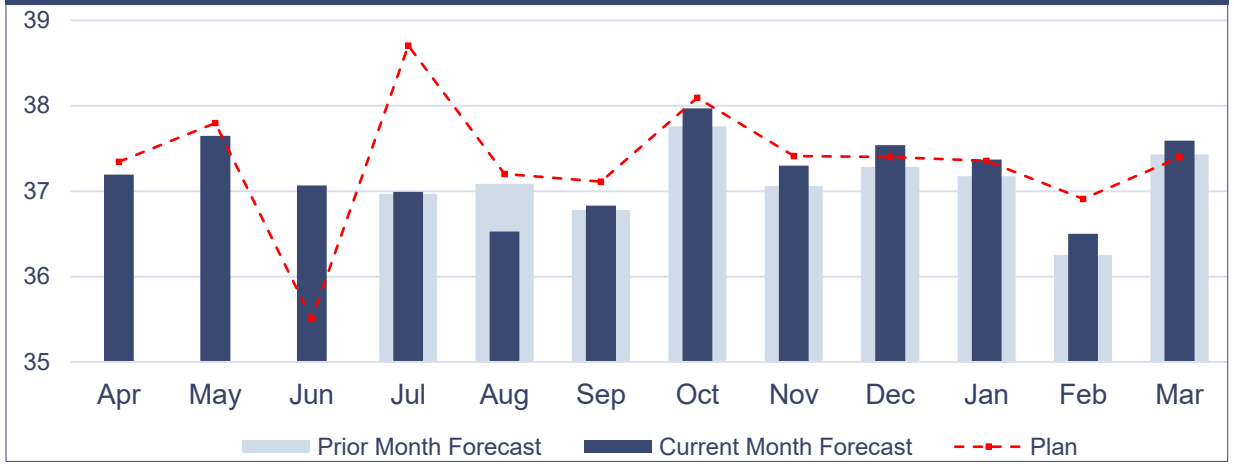
Month 3, June, reflects an increase in Planned and Specialist Care Theatres and Dermatology outsourcing of activity with a further increase in consumables purchases including loan kits and implants, alongside an increase within Operational Allied Health relating to Radiology outsourcing of services.

Note a risk within Planned and Specialist Care due to year to date outsourcing of Theatres activity and other services anticipated to continue at an increased level in Month 4 but not anticipated to continue to the same level from Month 5 onwards. Note an opportunity within Operational Allied Health due to the in-month increase relating to Radiology outsourcing in Month 3 anticipated to continue for future months.

Commissioned Healthcare Services Insights

In-Month Actual	YTD Actual	EOY Forecast	3-Year Growth	In-Year Growth	YTD Extrapolation
£37.0m	£148.9m	£446.5m	15.7%	2.8%	£446.7m
Variance to Plan **£(1.7)m**	Variance to Plan **£(0.5)m**	Variance to Plan **£(1.7)m**	2023-24 Outturn **£385.9m**	2025-26 Outturn **£434.2m**	Risk / (Opp) **£0.3m**

Expenditure Monthly Trend (£'m)



Expenditure Trajectory Analysis (£'m)	P02-27	P03-27	P04-27	YTD	YTD Extrap.	EoY Forecast	EoY Var	Risk / (Opp)
Functions	**37.6**	**37.1**	**37.0**	**148.9**	**446.7**	**446.5**		**0.3**
Chief Operating Officer Management	-	-	-	-	-	-		-
Community and Integrated Medicine	2.8	2.9	2.9	11.6	34.7	34.6		0.1
Mental Health and Learning Disabilities	4.1	3.7	4.1	15.8	47.3	47.4		-
Operational Allied Health and Health Sciences	0.4	0.5	0.4	1.8	5.4	5.5		-
Planned and Specialist Care	0.7	0.7	0.4	2.4	7.2	6.2		1.0
Primary Care	10.4	10.2	10.5	41.6	124.9	127.0		(2.1)
Executive Functions	19.2	19.0	18.6	75.7	227.1	225.8		1.3
Total Expenditure	**37.6**	**37.1**	**37.0**	**148.9**	**446.7**	**446.5**		**0.3**
Plan	**37.8**	**35.5**	**38.7**	**149.3**	**448.0**	**448.2**		**(0.2)**
Variance to Plan	**(0.1)**	**1.6**	**(1.7)**	**(0.5)**	**(1.4)**	**(1.7)**		**0.4**

Key Information

Month 2, May, increase from prior month due to year to date recognition of Pharmaceuticals Company expenditure in line with pass through Joint Commissioning Committee funding, resulting in a corresponding reduction in Month 3, June. Month 3, June, further reduction in expenditure due to Mental Health retrospective correction to Continuing Healthcare package and reduction in Psychiatric Intensive Care Unit Beds demand. Note a reduction in plan due to year to date Primary Care Dental underspends being recognised as savings, resulting in a worsening to the core operational position in Month 3.

Month 4, July, plan increased due to reversal of prior month Primary Care Dental saving to core operational underspends.

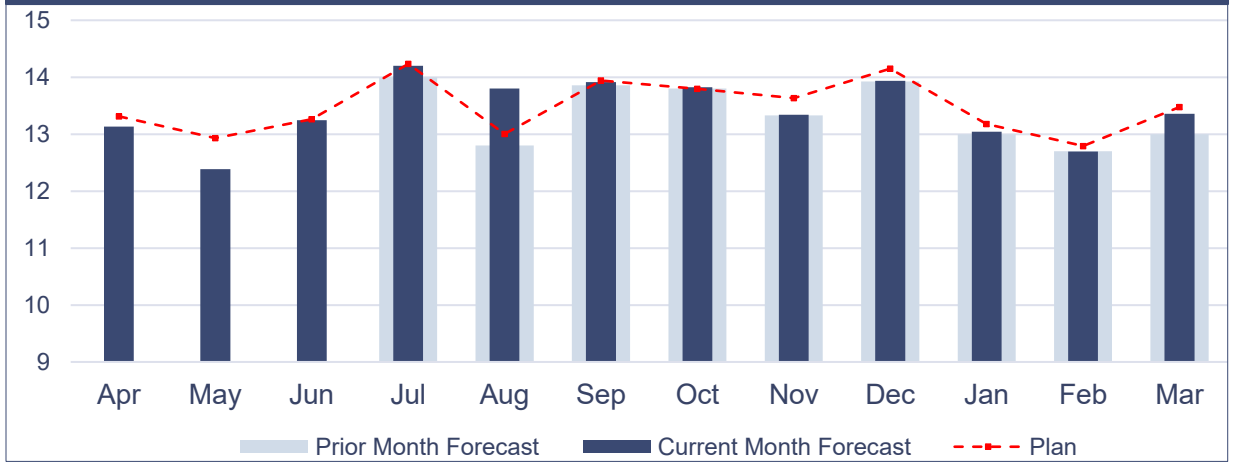
Monthly fluctuations in expenditure largely relating to number of days in the month and therefore the corresponding expenditure of Continuing Healthcare packages, with significant reduction in Month 11, February, and a corresponding increase in Month 12, March. Month 7, October, includes an increase largely relating to Primary Care vaccination programmes.

Note a risk within Executive functions due to the forecast expenditure for future months being lower than the year to date expenditure levels seen, mainly relating to Swansea Bay Long Term Agreement increase in emergency activity not anticipated to continue to the same level in future months. Note a further risk within Planned and Specialist Care due to Ophthalmology outsourcing of services not anticipated to continue to the same level in future months.

Drugs and Prescribing Insights

In-Month Actual	YTD Actual	EOY Forecast	3-Year Growth	In-Year Growth	YTD Extrapolation
£14.2m	£53.0m	£160.8m	8.1%	8.1%	£158.9m
Variance to Plan **£0.0m**	Variance to Plan **£(0.8)m**	Variance to Plan **£(1.0)m**	2023-24 Outturn **£148.7m**	2025-26 Outturn **£148.8m**	Risk / (Opp) **£(1.9)m**

Expenditure Monthly Trend (£'m)



Expenditure Trajectory Analysis (£'m)	P02-27	P03-27	P04-27	YTD	YTD Extrap.	EoY Forecast	EoY Var	Risk / (Opp)
Functions	**12.4**	**13.2**	**14.2**	**53.0**	**158.9**	**160.8**		**(1.9)**
Chief Operating Officer Management	-	-	-	-	-	-		-
Community and Integrated Medicine	1.6	1.7	1.8	6.6	19.9	19.4		0.5
Mental Health and Learning Disabilities	0.1	0.1	0.1	0.4	1.2	1.4		(0.2)
Operational Allied Health and Health Sciences	0.4	0.5	0.5	1.9	5.6	5.9		(0.3)
Planned and Specialist Care	2.9	3.5	3.4	13.0	39.0	38.3		0.7
Primary Care	-	-	-	0.1	0.2	0.2		-
Executive Functions	7.4	7.5	8.4	31.0	93.0	95.6		(2.6)
Total Expenditure	**12.4**	**13.2**	**14.2**	**53.0**	**158.9**	**160.8**		**(1.9)**
Plan	**12.9**	**13.3**	**14.2**	**53.7**	**161.2**	**161.7**		**(0.5)**
Variance to Plan	**(0.6)**	**(0.0)**	**(0.0)**	**(0.8)**	**(2.3)**	**(1.0)**		**(1.3)**

Key Information

Monthly fluctuations in expenditure largely relating to the number of prescribing days in the month and therefore the corresponding expenditure on drugs based on activity.

Increase in expenditure compared to prior month largely due to increase of drug costs in line with Prescribing Audit Report and expected increase in Month 5, August in relation to increase in concession prices on medicines within Pharmacy and Medicines Management.

Forecast drugs underspend largely relating to Ophthalmology differing operating model for outsourcing Intravitreal drugs as opposed to providing the service in-house due to recruitment challenges £(1.6)m, Drugs system process improvement review £(0.6)m, offset by increased Homecare drug costs £0.7m within Community and Integrated Medicine and an increase in prescription volume and price in line with latest May Prescribing Audit Report £0.8m within Pharmacy and Medicines Management.

Other Non-Pay Insights

In-Month Actual
£5.5m
Variance to Plan **£3.3m**

YTD Actual
£33.1m
Variance to Plan **£4.9m**

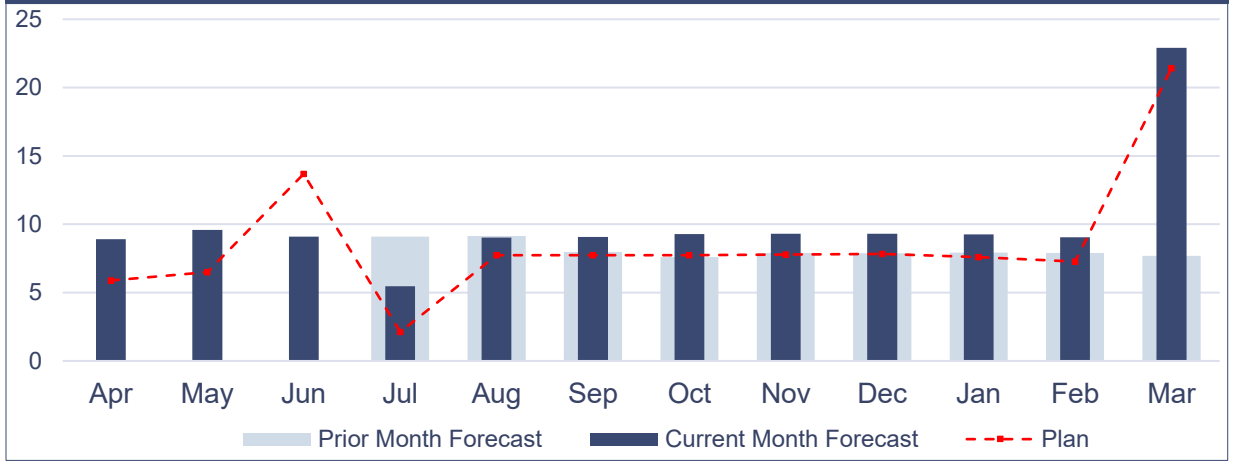
EOY Forecast
£111.5m
Variance to Plan **£8.1m**

3-Year Growth
2.5%
2023-24 Outturn **£108.8m**

In-Year Growth
12.5%
2025-26 Outturn **£99.1m**

YTD Extrapolation
£99.4m
Risk / (Opp) **£(12.2)m**

Expenditure Monthly Trend (£'m)



Expenditure Trajectory Analysis (£'m)	P02-27	P03-27	P04-27	YTD	YTD Extrap.	EoY Forecast	EoY Var	Risk / (Opp)
Functions	**9.6**	**9.1**	**5.5**	**33.1**	**99.4**	**111.5**		**(12.2)**
Chief Operating Officer Management	0.1	0.2	0.2	0.6	1.9	1.9		-
Community and Integrated Medicine	0.8	0.7	0.9	3.4	10.1	9.5		0.6
Mental Health and Learning Disabilities	0.2	0.2	0.2	0.9	2.6	2.5		-
Operational Allied Health and Health Sciences	0.2	0.2	0.2	0.8	2.3	2.5		(0.2)
Planned and Specialist Care	0.4	0.4	0.3	1.3	4.0	3.9		0.1
Primary Care	0.1	0.2	0.1	0.6	1.7	1.4		0.3
Executive Functions	7.7	7.2	3.6	25.6	76.7	89.6		(12.9)
Total Expenditure	**9.6**	**9.1**	**5.5**	**33.1**	**99.4**	**111.5**		**(12.2)**
Plan	**6.5**	**13.7**	**2.1**	**28.2**	**84.5**	**103.3**		**(18.8)**
Variance to Plan	**3.1**	**(4.5)**	**3.3**	**4.9**	**14.8**	**8.1**		**6.7**

Key Information

Month 3, June, includes an increase in plan in-month following the exercise to convert year to date core operational underspends to savings. The majority of the schemes identified relate to pay vacancies £4.8m, Primary Care Dental underspends £1.6m and drugs underspends £0.8m, offset by the savings target assumed within non-pay.

Month 4, July, deviation, largely due to a decrease in Capital Charges, with a corresponding reduction in Revenue Resource Limit.

Month 6, September, onwards includes a reduction in expenditure due to planned mitigating actions of £8.9m anticipated within Non-Pay to deliver from Month 6 to Month 12. Mitigating actions result in a risk for Non Pay due to the future months forecast being lower than year to date expenditure levels seen.

Month 12, March, includes Depreciation and Amortisation Impairments increase in expenditure of £9.0m, with a corresponding increase in Revenue Resource Limit.

Income Insights

In-Month Actual
£7.7m
Variance to Plan **£(0.1)m**

YTD Actual
£28.5m
Variance to Plan **£(0.6)m**

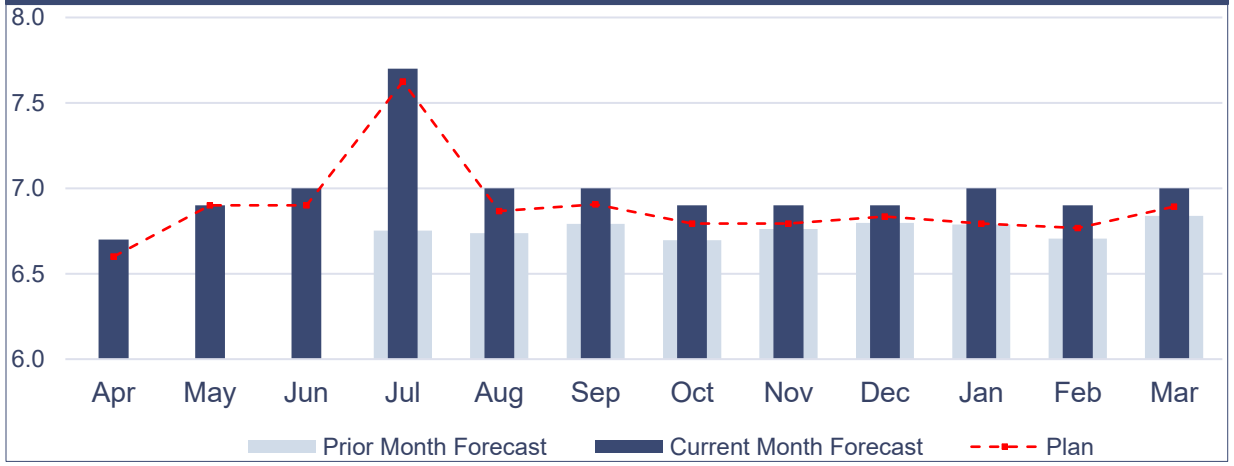
EOY Forecast
£84.2m
Variance to Plan **£(1.7)m**

3-Year Growth
14.2%
2023-24 Outturn **£73.7m**

In-Year Growth
1.6%
2025-26 Outturn **£82.9m**

YTD Extrapolation
£85.5m
(Risk) / Opp **£1.3m**

Income Monthly Trend (£'m)



Income Trajectory Analysis (£'m)	P02-27	P03-27	P04-27	YTD	YTD Extrap.	EoY Forecast	EoY Var	Risk / (Opp)
Functions	**6.9**	**7.0**	**7.7**	**28.5**	**85.5**	**84.2**		**1.3**
Chief Operating Officer Management	-	-	-	0.2	0.5	0.5		-
Community and Integrated Medicine	0.3	0.4	0.3	1.4	4.1	3.9		0.2
Mental Health and Learning Disabilities	0.3	0.3	0.3	1.1	3.2	2.8		0.4
Operational Allied Health and Health Sciences	0.3	0.3	0.3	1.1	3.4	3.4		-
Planned and Specialist Care	0.5	0.5	0.5	2.1	6.2	5.9		0.3
Primary Care	0.2	0.2	0.2	0.8	2.3	2.3		-
Executive Functions	5.3	5.4	6.1	22.0	65.9	65.5		0.4
Total Income	**6.9**	**7.0**	**7.7**	**28.5**	**85.5**	**84.2**		**1.3**
Plan	**6.9**	**6.9**	**7.6**	**27.9**	**83.8**	**82.6**		**1.2**
Variance to Plan	**0.1**	**0.1**	**0.1**	**0.6**	**1.8**	**1.7**		**0.1**

Key Information

Month 2, May, increase in income from prior month due to additional Health Education and Improvement Wales, Non-Contracted activity income and Drugs rebate income.

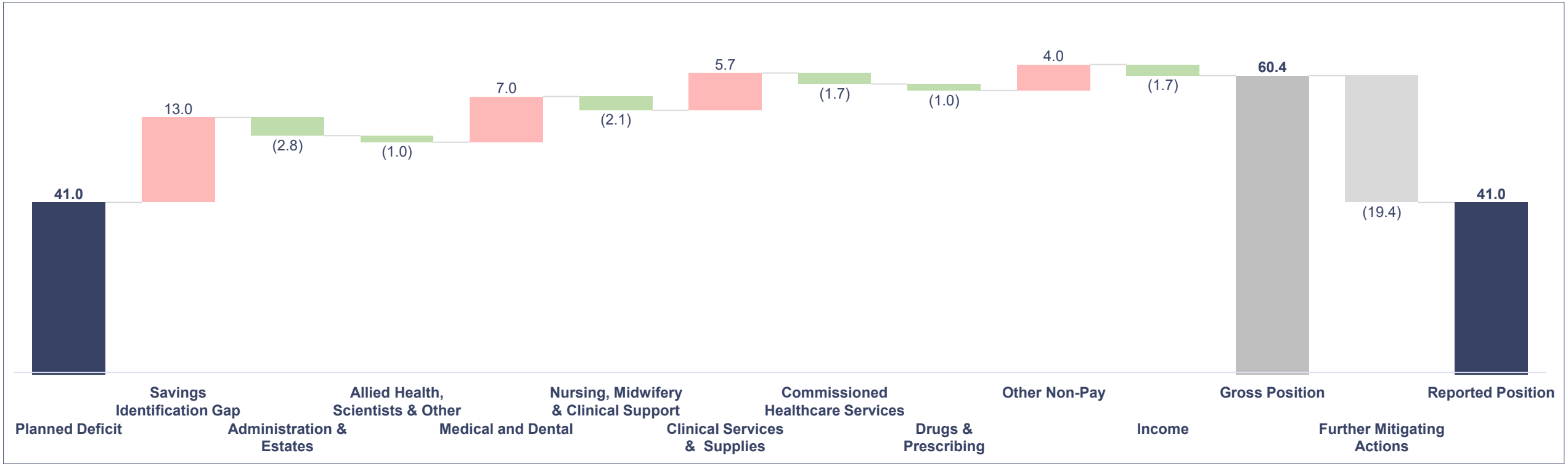
Month 3, June, increase in income from prior month due to further Drugs rebate income.

Month 4, July, onwards increase from prior month forecast largely relate due to Digital Programmes income.

Monthly fluctuations largely relate to variations in Drugs rebate income.

Income overachievement of £1.7m is forecast largely relating to Central Income Non-Contracted Activity income, Digital Programmes income offset by underachievement of Dental Income due to reduced activity and termination of Dental practices contracts.

End of Year – Key Drivers vs Plan



Key Information

Savings Identification Gap – Savings identification of £29.8m against savings target of £42.8m, leaving a savings identification gap of £13.0m.

Administration & Estates – Pay vacancies mainly within Workforce £(1.0)m, Primary Care £(0.7)m and Public Health £(0.6)m.

Medical and Dental – Community and Integrated Medicine high locum usage to cover rota gaps, sickness and vacancies mainly within Pembrokeshire Accident and Emergency unit £2.5m and Carmarthenshire £0.8m. Planned Care dual running of Medical staff within Bronglais Obstetrics, Gynaecology and Paediatrics £1.8m and Medical locum rate card within Anaesthetics, alongside Mental Health £1.0m and Pathology £0.7m locum usage to cover sickness and vacancies.

Clinical Services and Supplies – Outsourcing of Radiology and ultrasound services within Operational Allied Health £2.2m, offset by internal pay vacancies. Theatres, Dermatology, Anaesthetics, Urology and Ophthalmology outsourcing within Planned and Specialist Care £2.2m, and Community and Integrated Medicine purchases relating to insulin pumps, sleeping machines and other consumables £1.3m.

Other Non Pay – Estates and Facilities maintenance expenditure £1.2m, Allied Health dual running of Radiology services and sponsorship expenditure £1.0m and Digital programmes expenditure £0.5m.

End of Year – Key Deviations to Plan

Key Deviation		£'m	Key Information
Gross Planned Deficit		**83.8**	**Before savings requirement of £42.8m**
Savings Delivery		(29.8)	Green and Amber savings plans delivering. Gap of £13.0m vs plan requirement of £42.8m
Overspends	Medical Stabilisation improvements not delivered	7.0	Agency impact for WGH absence and dual running (£2.5m), BGH W&C absence and dual running (£1.8m), MH&LD 4 premium agency (£1.0m), GGH (£0.8m) and Pathology (£0.7m) agency usage
	Continuing Healthcare	5.2	Demand increases on CHC packages (£3.8m), Out of Area Mental Health placements (£1.4m)
	Theatre activity and increased outsourcing	4.9	Planned and Specialist activity above planned levels
	Building Maintenance and repairs	1.8	Estates and Facilities £1.2m, Ceredigion Integrated System £0.6m
	Radiology outsourced services above vacancies	1.8	Double running of Radiology contracts and insourcing of ultrasound services
	Community and Integrated Medicine supplies	1.2	Continuous Positive Airway Pressure, insulin pumps, equipment including hoists
	Band 2/3 banding assumption changes	0.9	Increase in national framework assumptions and additional establishment conversion
	Long Term Agreements	0.9	Non-elective short stay episodes attracting a disproportionate flat rate tariff within Swansea Bay
Underspends	Primary Care	(9.9)	Dental contract handback £(7.9)m and General Medicine Services Supplementary Services £(2.0)m.
	Administrative vacancies	(2.8)	Across the majority of services – consideration for recurrent vacancy factor saving required
	Clinical fill rates (non-medical)	(1.9)	Vacancies and reduced fill rates with Nursing and Allied Health roles
	Income	(1.7)	Central Income £(1.0)m and Digital programmes income £(1.1)m
	Prescribing and Drugs	(1.0)	Annual Plan assumed increases not yet materialised
Gross Position		**60.4**	**Report £41.0m to Welsh Government, with full mitigating actions assumed**
Further Mitigating Actions		(19.4)	Robust plans are yet to be confirmed, but opportunities exceeding the value are being reviewed
Reported Position		**41.0**	

End of Year – Key Performance vs Plan

Clinical Care Groups and Executive Functions (£'m)	Savings Gap to Target	Savings Delivery vs Plan Benefits	Core Operational Variation	Total	Key Information
Planned Deficit				**41.0**	
Chief Operating Officer Management	0.4	0.0	0.7	**1.1**	Savings non delivery plus Voluntary Early Retirement Scheme payments and Physiotherapy First Contact Point pay costs.
Community and Integrated Medicine	4.5	0.0	9.6	**14.1**	Savings non delivery plus continued use of premium Medical locums to cover sickness and vacancies £3.6m, increase in Continuing Healthcare packages £2.5m, and increase in Nursing Bank and Overtime usage £0.9m.
Mental Health and Learning Disabilities	3.4	0.0	1.9	**5.3**	Savings non delivery plus Continuing Healthcare packages £1.2m, purchase of outsourced Psychiatric Intensive Care beds £1.4m, Medical locum usage £1.0m offset by Allied Health and Nursing vacancies £(1.8)m.
Operational Allied Health & Health Sciences	3.2	0.0	2.1	**5.3**	Savings non delivery plus Medical locum usage within Pathology £0.7m, Radiology services outsourcing £2.1m offset by pay vacancies £(1.2)m.
Planned and Specialist Care	3.8	0.0	2.9	**6.7**	Savings non delivery plus Bronglais Medical dual running £1.7m, outsourcing of activity in Theatres, Dermatology, Anaesthetics, Urology and Ophthalmology £2.1m, offset by Ophthalmology drugs underspend £(1.5)m
Primary Care	0.0	0.0	(9.0)	**(9.0)**	Dental contracts handback underspends £(7.9)m and General Medicine Services Supplementary Services underspends £(2.0)m.
Executive Functions	(2.3)	0.0	(1.8)	**(4.1)**	Pay vacancies £(2.6)m, income overachievement £(2.5)m, offset by Estates maintenance £1.2m and Swansea Bay emergency activity increase £0.9m.
Sub Total	**13.0**	**0.0**	**6.4**	**19.4**	
Gross Position				**60.4**	
Further Mitigating Actions				(19.4)	Conversion of opportunities to robust plans required as not yet confirmed
Reported Position				**41.0**	

End of Year – Key Performance vs Plan Executive

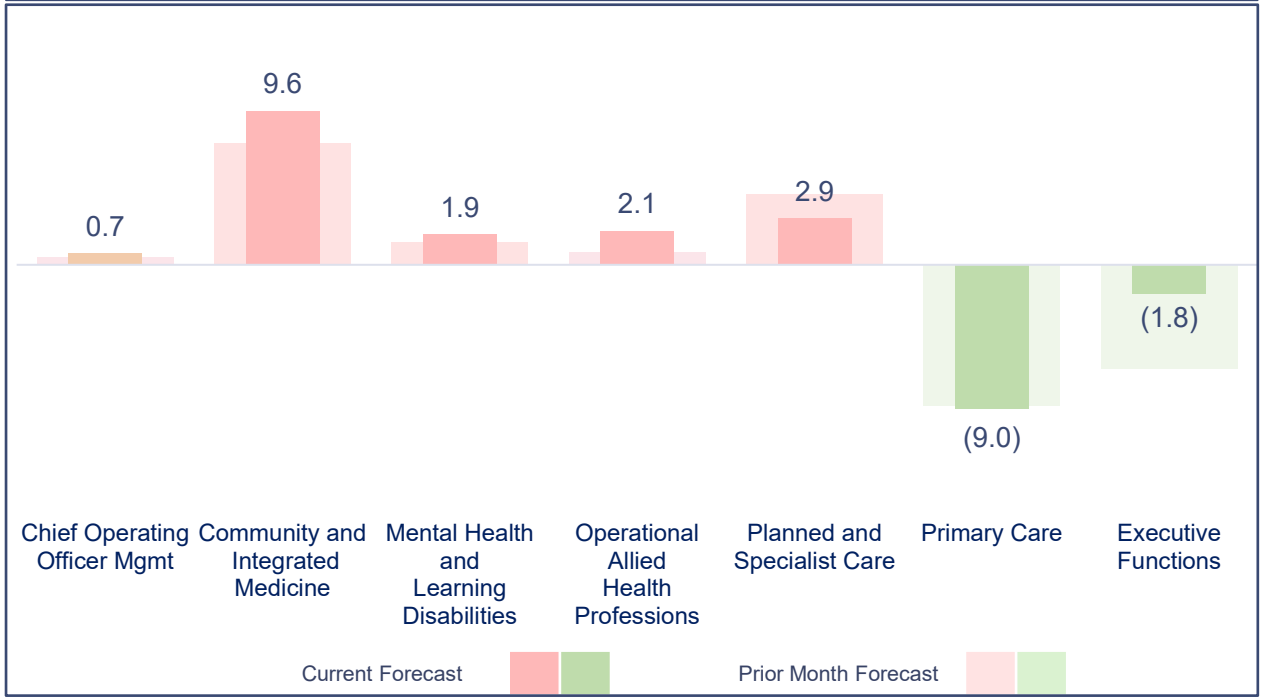
Executive Function (£'m)	Savings Gap to Target	Savings Delivery vs Plan Benefits	Core Operational Variation	Total	Key Information
Chief Executive	(0.1)	0.0	(0.2)	**(0.3)**	Over-achievement of savings target, Admin pay vacancies.
Digital	0.1	0.0	0.0	**0.1**	Under-achievement of savings target.
Estates and Facilities	2.0	0.0	0.9	**2.9**	Under-achievement of savings target, building and maintenance expenditure £1.2m offset by pay vacancies £(0.3)m.
Executive Allied Health	0.0	0.0	0.0	**0.0**	No material deviation.
Finance	(0.3)	0.0	(0.2)	**(0.5)**	Over-achievement of savings target, Admin pay vacancies.
Health Board Wide	(3.2)	0.0	(2.0)	**(5.2)**	Over-achievement of savings target, Drugs system process improvement review £(2.7)m and Central Income overachievement £(1.0)m.
LTA's	1.3	0.0	0.9	**2.2**	Under-achievement of savings target, Swansea Bay emergency activity.
Medical	(0.1)	0.0	(0.1)	**(0.2)**	Over-achievement of savings target, unconfirmed SIFT plans
Nursing	(0.1)	0.0	0.2	**0.1**	Over-achievement of savings target and increased non pay costs.
Pharmacy and Medicines Management	2.6	0.0	1.0	**3.6**	Under-achievement of savings target, increased expenditure relating to increase drugs price in line with May Prescribing Audit Report
Public Health	(0.7)	0.0	(1.1)	**(1.8)**	Over-achievement of savings target, Admin and Nursing pay vacancies
Strategy and Planning	(0.4)	0.0	(0.1)	**(0.5)**	Over-achievement of savings target, Capital redesign income.
Workforce	(3.4)	0.0	(1.1)	**(4.5)**	Over-achievement of savings target, Admin pay vacancies.
Sub Total	**(2.3)**	**0.0**	**(1.8)**	**(4.1)**	

End of Year – Key Performance vs Prior Month

Clinical Care Groups and Executive Functions (£'m)	Savings Gap to Target Movement	Savings Delivery vs Plan Movement	Core Operational Variation Movement	Total Movement	Key Information
Prior Month Forecast				**41.0**	
Chief Operating Officer Management	(0.3)	0.0	0.2	**(0.1)**	Conversion of year to date core underspends to savings in prior month.
Community and Integrated Medicine	(3.0)	0.0	2.0	**(1.0)**	Conversion of year to date core underspends to savings. Purchase of outsourced Psychiatric Intensive Care beds and Medical locum usage.
Mental Health and Learning Disabilities	(0.7)	0.0	0.5	**(0.2)**	Conversion of year to date core underspends to savings in prior month, alongside further Nursing pay underspend savings
Operational Allied Health & Health Sciences	(1.5)	0.0	1.3	**(0.2)**	Conversion of year to date core operational underspends in prior month, alongside further Allied and Nursing pay underspend savings.
Planned and Specialist Care	(1.3)	0.0	(1.5)	**(2.8)**	Conversion of year to date core underspends to savings in prior month. Funding received for Theatres investment and Horizon Scanning drugs.
Primary Care	1.9	0.0	(0.2)	**1.7**	General Medical Services increase in programme expenditure. Note a recategorisation of Dental contract hand back savings to core operational underspends in Month 4 £1.9m.
Executive Functions	(3.9)	0.0	4.7	**0.8**	Conversion of year-to-date core underspends to savings in prior month. Increase in Prescribing Audit Report drugs price £1.0m.
Sub Total	**(8.8)**	**0.0**	**7.0**	**(1.8)**	
Gross Position				**(1.8)**	
Further Mitigating Actions				1.8	
Reported Position				**41.0**	

End of Year – Core Operational Variation

Core Operational Variation (£'m)



Core Operational Variation (£'m)

Portfolio	Pay	Non-Pay	Income	Total
Chief Operating Officer Management	0.7	0.0	0.0	**0.7**
Community and Integrated Medicine	4.5	5.2	(0.1)	**9.6**
Mental Health and Learning Disabilities	(0.8)	2.7	0.0	**1.9**
Operational Allied Health and Health Sciences	(0.3)	2.9	(0.5)	**2.1**
Planned and Specialist Care	0.0	3.3	(0.4)	**2.9**
Primary Care	(0.5)	(10.3)	1.8	**(9.0)**
Executive Functions	(2.6)	3.3	(2.5)	**(1.8)**
Total	**1.0**	**7.1**	**(1.7)**	**6.4**

Key Information

Community and Integrated Medicine Continued Medical locum usage to cover sickness and vacancies £3.5m alongside Nursing bank and overtime usage £0.8m. Continuing Healthcare increase in monthly average of commissioned care days due to additional packages £2.5m and increase in consumables expenditure relating to Continuous Positive Airway Pressure, insulin pumps and equipment including hoists.

Mental Health Continuing Healthcare increase in monthly average commissioned care days due to additional packages £1.2m and increase in purchase of outsourced Psychiatric Intensive Care Beds £1.4m.

Operational Allied Health Dual running of Radiology contracts, alongside outsourcing of Radiology services and insourcing of ultrasound services £2.9m, offset by pay vacancies.

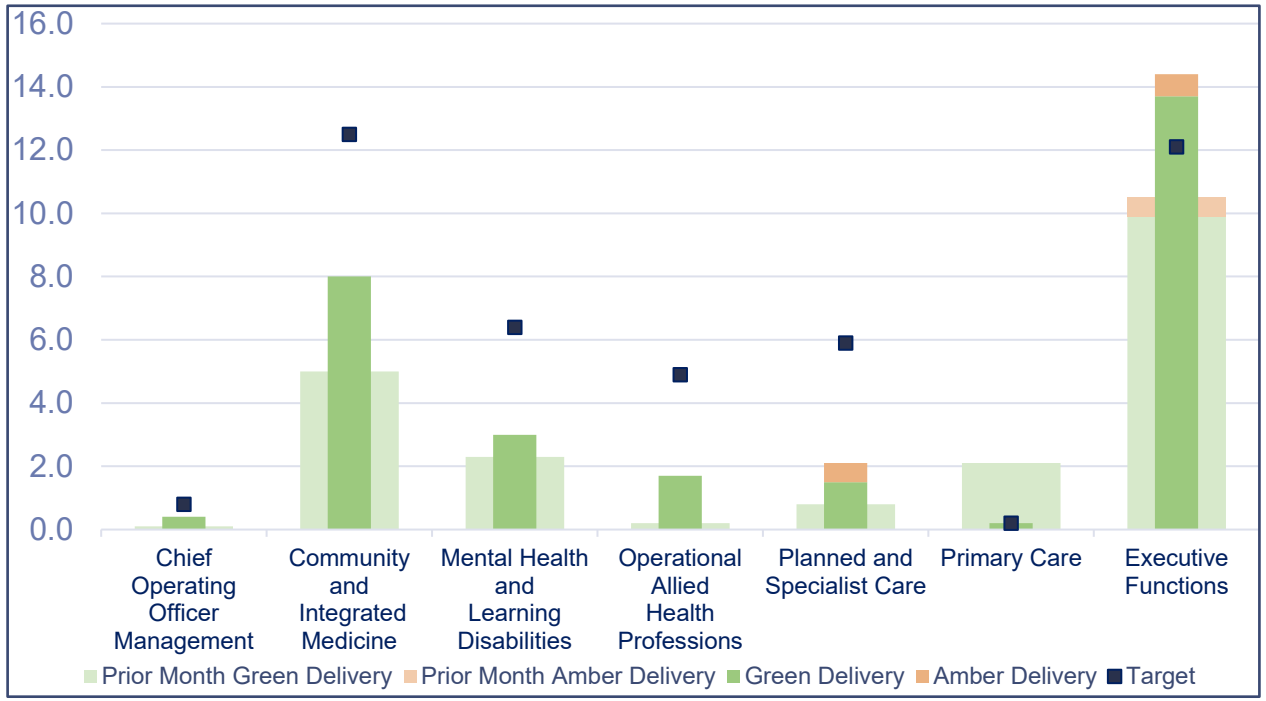
Planned and Specialist Care Increase in Theatres, Dermatology, Anaesthetics, Ophthalmology and Urology outsourcing of activity £3.3m.

Primary Care Dental contracts handback £(7.9)m and General Medicine Services Supplementary Services underspends £(2.0)m, offset by underachievement of Dental income £1.8m.

Executive Functions Estates maintenance expenditure £1.2m, Swansea Bay Long Term Agreement Emergency activity increase £0.9m and Pharmacy and Medicines Management increase in prescribing price of low-value high-volume drugs £0.9m, offset by pay vacancies and income overachievement acr

End of Year – Savings Performance Breakdown

Savings Performance Breakdown (£'m)



Savings Performance Breakdown (£'m)

Portfolio	Target	Plan	Delivery	Gap
Chief Operating Officer Management	0.8	0.4	0.4	0.4
Community and Integrated Medicine	12.5	8.0	8.0	4.5
Mental Health and Learning Disabilities	6.4	3.0	3.0	3.4
Operational Allied Health and Health Sciences	4.9	1.7	1.7	3.2
Planned and Specialist Care	5.9	2.1	2.1	3.8
Primary Care	0.2	0.2	0.2	0.0
Executive Functions	12.1	14.4	14.4	(2.3)
Grand Total	**42.8**	**29.8**	**29.8**	**13.0**

Key Information

Savings identification is £29.8m, with all savings forecast to fully deliver, leaving a savings under-identification gap of £13.0m against the £42.8m target.

The £13.0m under-identification of savings largely relates to Community and Integrated Medicine £4.5m, Mental Health £3.4m, Operational Allied Health £3.2m, Planned and Specialist Care £3.8m, offset by Executive functions over-identification of £(2.3)m. Executive functions over-identification largely relates to Workforce £(3.4)m and Health Board Wide £(3.1)m, offset by under-identification within Pharmacy and Medicines Management £2.7m, Estates and Facilities £2.1m and Long-Term Agreements £1.3m.

Newly identified schemes largely relate to conversion of core operational underspends to savings £5.9m and Controlled Drugs Stock Strategic Review £2.2m. Note a reduction in identified savings within Primary Care following reclassification of prior month Dental contract handbacks from savings to core operational underspends.

Of the schemes identified, £28.5m relate to green schemes, with £1.3m relating t[illegible]nes. £6.2m are recurrent savings with £23.6m being non-recurrent savings.

End of Year – Saving Delivery Performance

Savings

Savings Target
£42.8m
Recurrent = £42.8m
Non-Recurrent = £0.0m

In-Year Recurrent Gap
£36.6m
Target = £42.8m
Delivery = £6.2m

In-Year Non-Recurrent Gap
£(23.6)m
Target = £0.0m
Delivery = £23.6m

Full Year Recurrent Gap
£36.4m
Target = £42.8m
Delivery = £6.4m

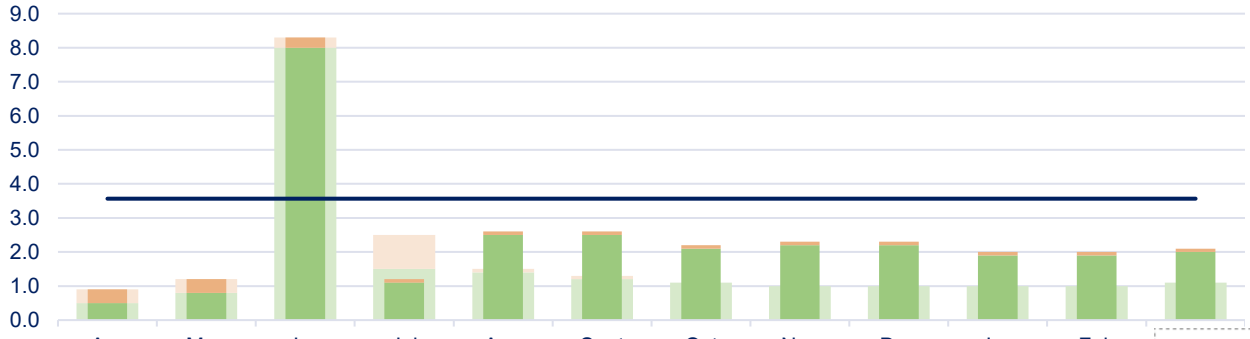
Monthly Trend of Annual In-Year Risk-Assessed Savings Delivery (£'m)



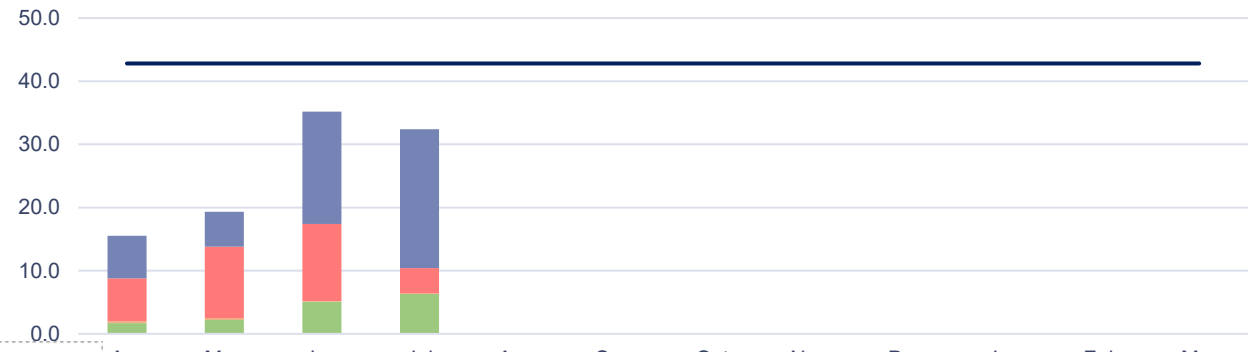
Monthly Trend of Annual In-Year Opportunity, Pipeline & Savings Plans (£'m)



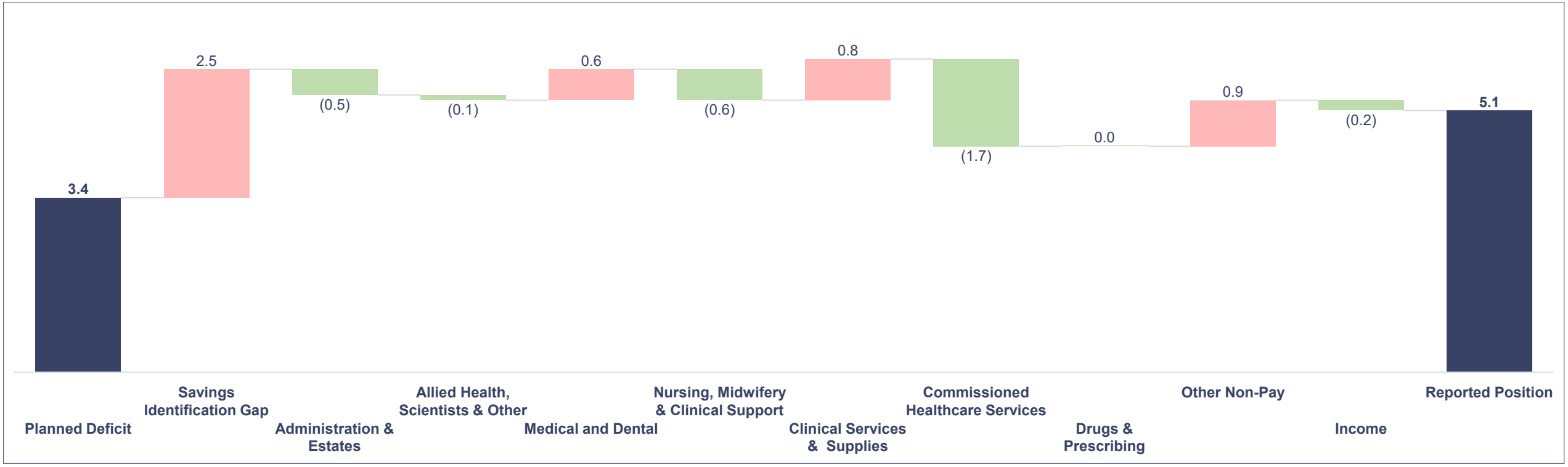
Monthly Profiled Risk-Assessed Savings Delivery (£'m)



Monthly Trend of Annual Recurrent Opportunity, Pipeline & Savings Plans (£'m)



In-Month – Key Drivers vs Plan



Key Information

Savings Identification Gap – Savings identification of £1.1m against savings target of £3.6m, leaving a savings under identification gap of £2.5m, largely impacted by the reclassification of prior month Dental contracts handback savings to core operational underspends £1.9m

Medical and Dental – Community and Integrated Medicine locum usage to cover sickness and vacancies £0.2m and Planned and Specialist Care dual running of staff in Bronglais £0.2m.

Nursing and Midwifery – Community and Integrated Medicine reduction in enhanced pay rates and bank usage £(0.2)m. Vacancies in Mental Health £(0.1)m, Planned Care £(0.1)m and Primary Care £(0.1)m.

Clinical Services & Supplies – Planned and Specialist Care Theatres and Endoscopy outsourcing of activity, alongside increase in consumables purchases relating to loan kits and implants £0.6m. Operational Allied Health outsourcing of Radiology activity and services £0.2m and Community and Integrated Medicine Cardiac and Diabetic consumable purchases £0.1m.

Commissioned Healthcare Services – Primary Care Dental and General Medical Services underspend £(2.4)m, offset by Continuing Healthcare packages £0.4m and Mental Health outsourced beds £0.2m.

Other Non-Pay – Digital programmes increase in contracts expenditure £0.4m, Community and In creases to patient security and transportation costs £0.2m and various other immaterial areas.

In-Month – Key Deviations to Plan

Key Deviation		£'m	Key Information
Gross Planned Deficit		**7.0**	**Before savings requirement of £3.6m**
Savings Delivery		(1.1)	Green and Amber savings plans delivering. Gap of £2.5m vs plan requirement of £3.6m
Overspends	Theatre activity and increased outsourcing	0.7	Planned and Specialist Care activity above planned levels, alongside outsourcing of various services
	Medical Stabilisation improvements not delivered	0.6	Agency usage to cover vacancies and sickness within Community and Integrated Medicine £0.2m, Planned and Specialist Care £0.2m, Mental Health £0.1m and Operational Allied Health £0.1m.
	Continuing Healthcare	0.6	Demand increases on CHC packages and Out of Area Mental Health placements
	Non Pay contracts	0.4	Digital initiative programmes contract expenditure
	Clinical Services and Supplies	0.3	Radiology outsourced services £0.2m, insulin pumps, cardiac and diabetic consumable purchases £0.1m
	Building Maintenance and repairs	0.2	Estates and Facilities £0.1m and Community and Integrated Medicine £0.1m
	Prescribing and Drugs	0.1	Community and Integrated Medicine Homecare Drugs £0.2m, Pharmacy and Medicines Management drugs price and concessions £0.2m, offset by Ophthalmology outsourcing of services £(0.3)m
Underspends	Primary Care	(2.4)	Re-categorisation of prior month Dental Savings from savings to core operational underspends £(1.9)m, Dental contracts handback £(0.3)m and General Medical Services underspend £(0.2)m
	Nursing and Midwifery	(0.6)	Vacancies and reduced enhanced payments and bank usage within Community & Integrated Medicine
	Administrative vacancies	(0.5)	Across many services, mainly within Primary Care £(0.2)m. Continued commitment to convert underspends to savings.
	Income	(0.2)	Central Income overachievement £(0.2)m, Velindre drugs rebates £(0.1)m offset by Dental income £0.1m
Gross Position		**5.1**	

In-Month – Key Performance vs Plan

Clinical Care Groups and Executive Functions (£'m)	Savings Gap to Target	Savings Delivery vs Plan Benefits	Core Operational Variation	Total	Key Information
Annual Plan				**3.4**	**As per plan submitted to Welsh Government**
Chief Operating Officer Management	(0.1)	0.0	0.1	**0.0**	No material deviation to plan
Community and Integrated Medicine	0.5	0.0	0.8	**1.3**	Savings non delivery plus premium Medical agency usage £0.2m, increase in expenditure relating to Homecare drugs £0.2m, patient security and transportation £0.2m and Continuing Healthcare packages £0.2m.
Mental Health and Learning Disabilities	0.2	0.0	0.3	**0.5**	Savings non delivery plus purchase of outsourced Psychiatric Intensive Care Unit beds with increase in demand to 9 patients in-month and continued increase in the number of Continuing Health Care packages.
Operational Allied Health & Health Sciences	0.3	0.0	0.1	**0.4**	Savings non delivery plus Medical variable pay usage within Pathology to cover rota gaps £0.1m. Increase in outsourcing contracts for Radiology services £0.2m, offset by Radiology pay vacancies £(0.2)m.
Planned and Specialist Care	0.4	0.0	0.4	**0.8**	Savings non delivery plus Theatres outsourcing and purchase of loan kits and Endoscopy consumables £0.6m, Medical locum agency usage including dual running and rate card usage £0.2m, offset by additional funding received for Horizon Scanning Drugs expenditure £(0.4)m.
Primary Care	1.8	0.0	(2.5)	**(0.7)**	Dental contracts handback and General Medical Services underspend, alongside delay in Cluster projects, offset by underachievement of Dental income. Savings under delivery in-month due to reclassification of prior month Dental contracts handback savings to underspends £1.9m
Executive Functions	(0.6)	0.0	0.0	**(0.6)**	Controlled Drugs Stock Strategic Review and Workforce pay savings
Sub Total	**2.5**	**0.0**	**(0.8)**	**1.7**	
Gross Position				**5.1**	

In-Month – Key Performance vs Plan Executive

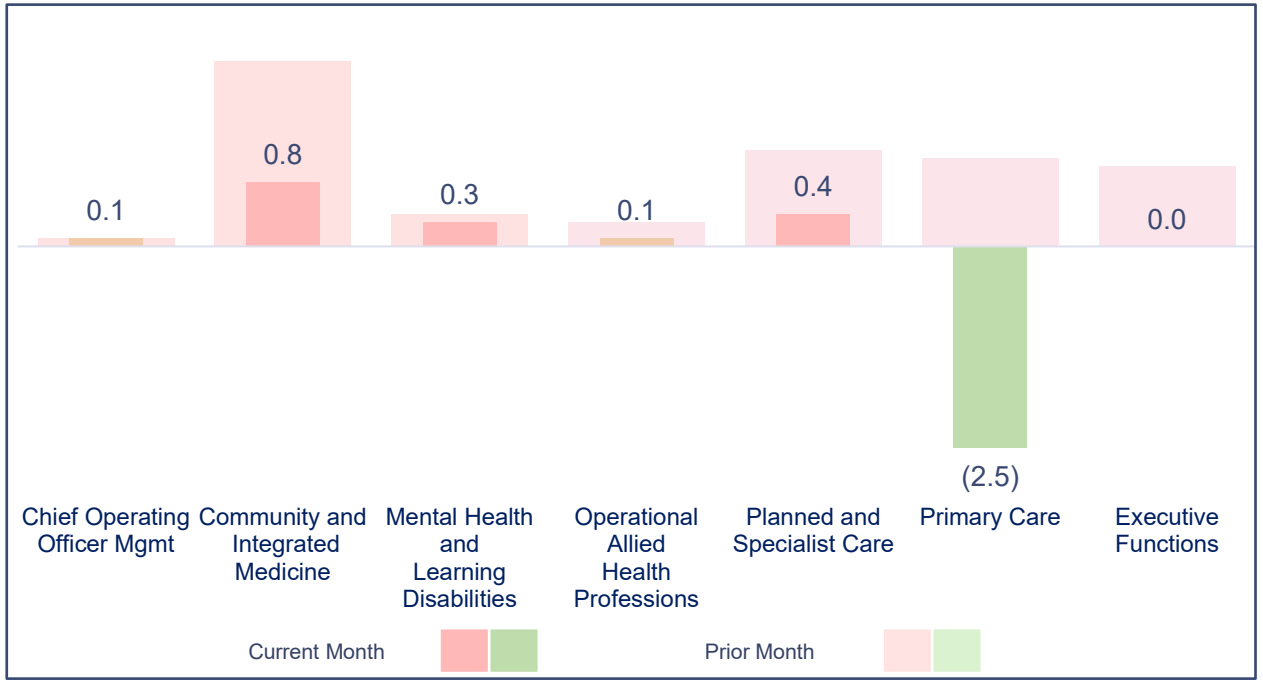
Executive Function (£'m)	Savings Gap to Target	Savings Delivery vs Plan Benefits	Core Operational Variation	Total	Key Information
Chief Executive	0.0	0.0	0.0	**0.0**	No material deviation to plan
Digital	0.0	0.0	0.2	**0.2**	Digital programmes contract expenditure
Estates and Facilities	0.1	0.0	0.0	**0.1**	Under-achieved savings
Executive Allied Health	0.0	0.0	0.0	**0.0**	No material deviation to plan
Finance	0.0	0.0	0.0	**0.0**	No material deviation to plan
Health Board Wide	(0.5)	0.0	(0.3)	**(0.8)**	Controlled Drugs Stock Strategic Review saving, income overachievement
LTA's	0.1	0.0	0.0	**0.1**	Under-achieved savings
Medical	0.0	0.0	0.0	**0.0**	No material deviation to plan
Nursing	0.0	0.0	0.0	**0.0**	No material deviation to plan
Pharmacy and Medicines Management	0.1	0.0	0.3	**0.4**	Horizon Scanning drugs funding issued to other services
Public Health	0.0	0.0	(0.1)	**(0.1)**	Pay vacancies and lower drugs vaccination uptake
Strategy and Planning	0.0	0.0	0.0	**0.0**	No material deviation to plan
Workforce	(0.4)	0.0	(0.1)	**(0.5)**	Recognition of admin pay underspends as savings
Sub Total	**(0.6)**	**0.0**	**0.0**	**(0.6)**	

In-Month – Key Performance vs Prior Month

Clinical Care Groups and Executive Functions (£'m)	Savings Gap to Target Movement	Savings Delivery vs Plan Benefits Movement	Core Operational Variation Movement	Total Movement	Key Information
Planned Deficit				**0.0**	
Chief Operating Officer Management	(0.1)	0.0	0.0	**(0.1)**	Additional saving identified in-month relating to pay underspends.
Community and Integrated Medicine	1.3	0.0	(1.5)	**(0.2)**	Conversion of year to date underspends to savings in prior month. In-month improvement relating to reduced enhanced pay rates and bank nurse usage, offset by increased home care drug expenditure.
Mental Health and Learning Disabilities	0.3	0.0	0.0	**0.3**	Conversion of year to date underspends to savings in prior month. Increase in the number of Psychiatric Intensive Care Unit beds purchased due to increase in demand to 9 patients.
Operational Allied Health & Health Sciences	0.1	0.0	(0.2)	**(0.1)**	Additional drugs rebate income received and additional vacancies.
Planned and Specialist Care	0.3	0.0	(0.8)	**(0.5)**	Reduction in Systemic Anti-Cancer Therapy Oncology activity and funding transferred for Oncology Horizon Scanning drugs expenditure
Primary Care	3.8	0.0	(3.7)	**0.1**	Conversion of year to date underspends to savings in prior month. Dental contract handback savings recategorised to underspends £1.9m.
Executive Functions	1.5	0.0	(1.0)	**0.5**	Conversion of year to date underspends to savings in prior month. Transfer of Horizon Scanning drugs budget to Pathology and Oncology £0.3m, Digital programmes contract expenditure £0.2m
Sub Total	**7.2**	**0.0**	**(7.2)**	**0.0**	
Gross Position				**0.0**	

In-Month – Core Operational Variation

Core Operational Variation (£'m)



Core Operational Variation (£'m)

Clinical Care Group	Pay	Non-Pay	Income	Total
Chief Operating Officer Management	0.0	0.1	0.0	**0.1**
Community and Integrated Medicine	0.1	0.7	0.0	**0.8**
Mental Health and Learning Disabilities	(0.1)	0.4	0.0	**0.3**
Operational Allied Health and Health Sciences	0.0	0.2	(0.1)	**0.1**
Planned and Specialist Care	0.0	0.4	0.0	**0.4**
Primary Care	(0.2)	(2.5)	0.2	**(2.5)**
Executive Functions	(0.4)	0.7	(0.3)	**0.0**
Total	**(0.6)**	**0.0**	**(0.2)**	**(0.8)**

Key Information

Community and Integrated Medicine Continuing Healthcare packages volume increase £0.2m, increase in Homecare drugs expenditure £0.2m, alongside patient security and transportation expenditure £0.2m.

Mental Health High-cost Continuing Healthcare packages and purchase of Psychiatric Intensive Care Unit beds increase in demand to 9 patients in-month £0.2m.

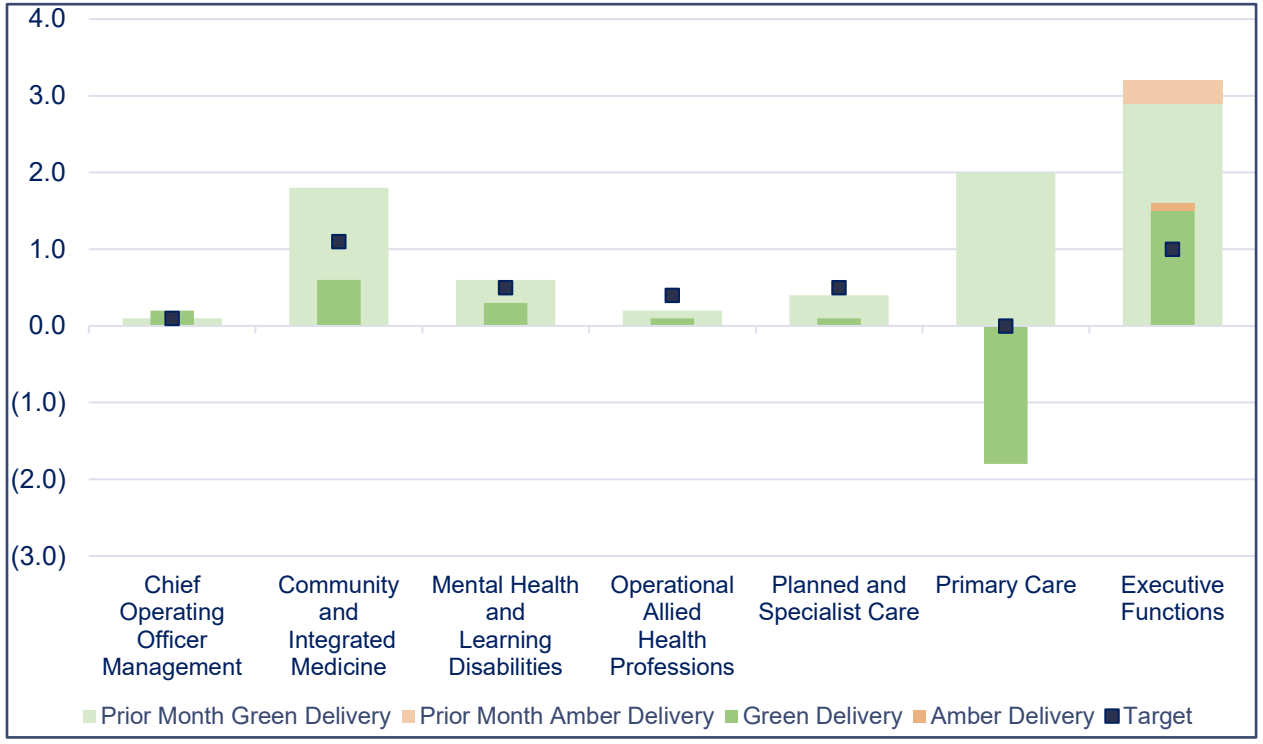
Planned and Specialist Care Theatres outsourcing of activity and purchases of Theatre consumables including loan kits and implants £0.6m, offset by funding received for Horizon Scanning drugs costs £(0.3)m.

Primary Care Dental contracts handback underspend, alongside General Medical supplementary services underspend. Note an improvement in core operational underspend from prior month due to reclassification of Dental contracts handback savings to underspends.

Executive Functions Digital programmes increase in contracts expenditure £0.4m, transfer of Horizon Scanning drugs funding to other services £0.3m, offset by pay vacancies £(0.4)m and income over achievement across various areas £(0.3)m.

In-Month – Savings Performance Breakdown

Savings Delivery vs Target (£'m)



Savings Performance Breakdown (£'m)

Clinical Care Group	Target	Plan	Delivery	Gap
Chief Operating Officer Management	0.1	0.2	0.2	(0.1)
Community and Integrated Medicine	1.1	0.6	0.6	0.5
Mental Health and Learning Disabilities	0.5	0.3	0.3	0.2
Operational Allied Health and Health Sciences	0.4	0.1	0.1	0.3
Planned and Specialist Care	0.5	0.1	0.1	0.4
Primary Care	0.0	(1.8)	(1.8)	1.8
Executive Functions	1.0	1.6	1.6	(0.6)
Grand Total	**3.6**	**1.1**	**1.1**	**2.5**

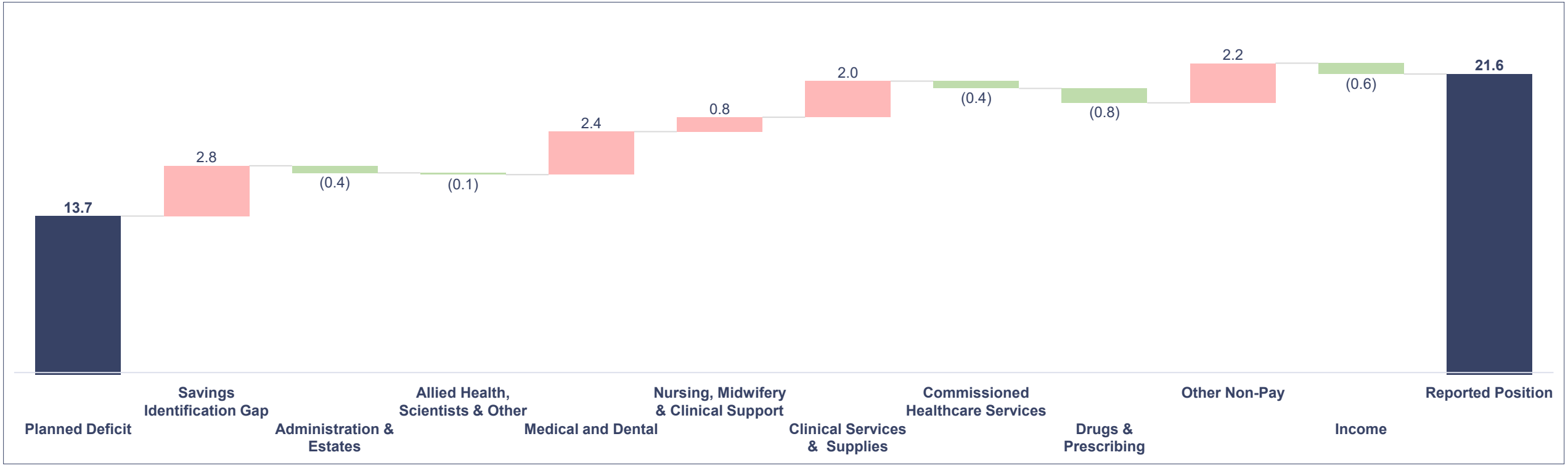
Key Information

Overall savings identification and delivery of £1.1m has been achieved in Month 4, resulting in a £2.5m under-delivery against £3.6m target, with variations across Clinical Care Groups. Note a reduction in identified savings within Primary Care following reclassification of prior month Dental contract handbacks savings to core operational underspends £1.9m. Without this one-off reclassification, savings identification and delivery has significantly improved in Month 4 with £3.0m savings being identified and delivered.

£2.5m under identification of savings largely relates to Primary Care £1.8m, Community and Integrated Medicine £0.5m, Planned and Specialist Care £0.4m, Operational Allied Health and Health Sciences £0.3m, Mental Health £0.2m, offset by over identification within Executive Functions £(0.6)m. Executive Functions includes under identification relating to Pharmacy and Medicines Management £0.2m, Long Term Agreements £0.1m, offset by over identification within Health Board Wide £(0.6)m and Workforce £(0.3)m.

Reduction in savings identification from prior month largely relates to conversion of year [illegible] ends within prior month savings performance.

Year to Date – Key Drivers vs Plan



Key Information

Savings Identification gap – Savings delivery of £11.5m achieved against a target of £14.3m leaving a gap of £2.8m.

Medical & Dental – Community and Integrated Medicine high-cost agency usage to cover sickness and vacancies across Accident and Emergency and General Medicine £1.0m. Medical locum and agency usage including dual-running across Bronglais within Planned and Specialist Care, with continued use of premium rate card £0.9m.

Clinical Services & Supplies – Theatres, Endoscopy, Anaesthetics and Urology outsourcing within Planned and Specialist Care £1.0m, Outsourcing of Radiology services within Operational Allied Health £0.6m and purchase of Cardiac and Diabetic consumables within Community and Integrated Medicine £0.5m.

Commissioned Healthcare Services – Primary Care Dental contract handbacks and General Medical Services underspend £(3.5)m, offset by increase in Continuing Healthcare packages within Mental Health and Community and Integrated Medicine £1.6m, Swansea Bay emergency activity increase £0.8m and Mental Health Psychiatric Intensive Care Unit Beds £0.4m.

Other Non-Pay – Digital initiative programmes contract expenditure £0.7m, Building and Estates maintenance expenditure £0.5m, alongside Building maintenance and repairs, patient security and transportation expenditure within Community and Integrated Medicine £0.4m.

Year to Date – Key Deviations to Plan

Key Deviation		£'m	Key Information
Gross Planned Deficit		**27.9**	**Before savings requirement of £14.3m**
Savings Delivery		(11.5)	Green and Amber savings plans delivery of £11.5m against savings target of £14.3m.
Overspends	Medical Stabilisation improvements not delivered	2.4	Agency impact for vacancies, sickness cover and restricted duties (£1.0m), BGH W&C absence and restricted duties (£0.6m), Anaesthetist rate card extended (£0.3m), MH&LD 4 premium agency (£0.3m)
	Continuing Healthcare	2.0	Demand increases on CHC packages (£1.6m), Out of Area Mental Health placements (£0.4m)
	Theatre activity and increased outsourcing	1.1	Planned and Specialist Care activity above planned levels, alongside outsourcing of various services
	Clinical Services and Supplies	1.1	Radiology outsourced services £0.6m, insulin pumps, cardiac and diabetic consumable purchases £0.5m
	Nursing and Midwifery	0.8	Variable pay bank & overtime to cover sickness and rota gaps, within Community & Integrated Medicine
	Swansea Bay LTA	0.8	Non-elective short stay episodes attracting a disproportionate flat rate tariff
	Building Maintenance and repairs	0.8	Estates and Facilities £0.6m and Ceredigion Integrated System £0.2m
	Non Pay contracts	0.7	Digital initiative programmes contract expenditure
	Band 2/3 banding assumption changes	0.3	Increase in national framework assumptions and additional establishment conversion
Underspends	Primary Care	(2.9)	Dental contracts handback £(1.5)m, General Medical Services underspend £(0.8)m and delay in Primary Care project plans £(0.8)m
	Income	(1.1)	Central Income £(0.4)m, Capital Design recharge income £(0.2)m and Velindre drugs rebates £(0.2)m
	Prescribing and Drugs	(0.8)	Annual Plan assumed price and volume increases not yet materialising
Gross Position		**21.6**	

Year to Date – Key Performance vs Plan

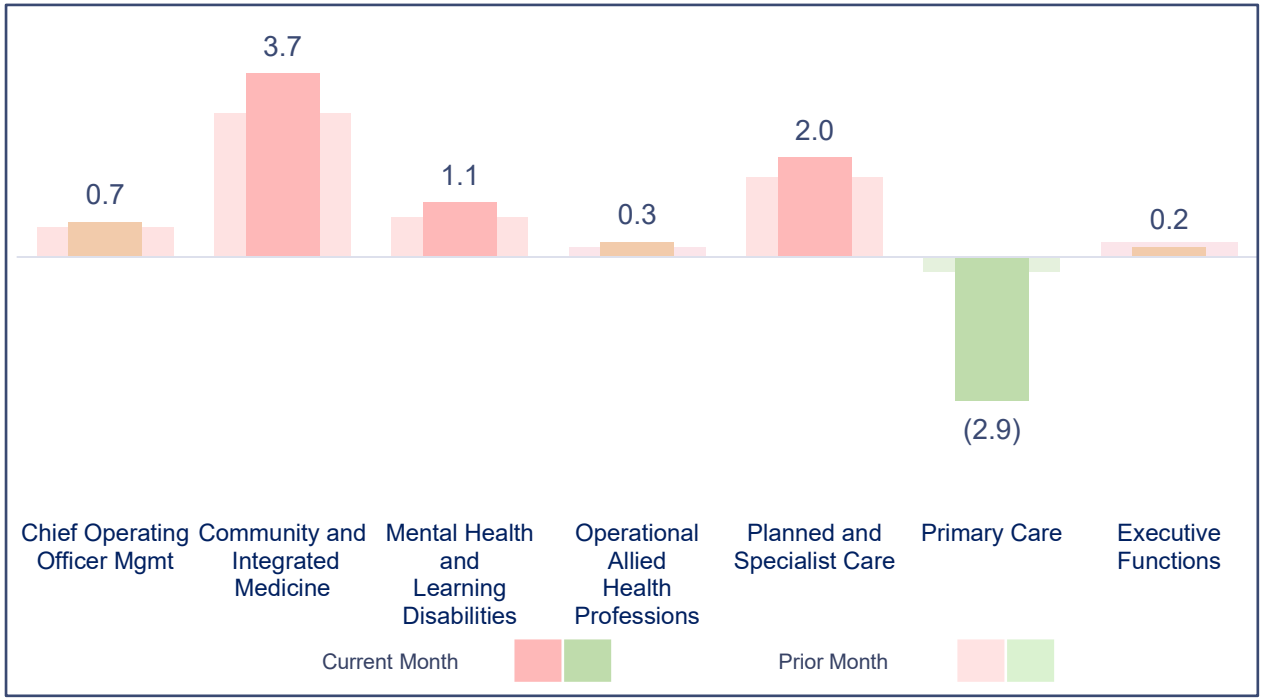
Clinical Care Groups and Executive Functions (£'m)	Savings Gap to Target	Savings Delivery vs Plan Benefits	Core Operational Variation	Total	Key Information
Planned Deficit				**13.7**	
Chief Operating Officer Management	0.0	0.0	0.7	**0.7**	Voluntary Early Retirement Scheme payments.
Community and Integrated Medicine	1.5	0.0	3.7	**5.2**	Savings identification gap £1.5m. Increase in Continuing Healthcare packages volume, Medical locum agency usage to cover sickness and vacancies, and Nursing bank usage with increase in fill rates.
Mental Health and Learning Disabilities	0.6	0.0	1.1	**1.7**	Continuing Healthcare packages volume increase and purchase of Psychiatric Intensive Care Unit beds increase in demand.
Operational Allied Health & Health Sciences	1.2	0.0	0.3	**1.5**	Savings identification gap £1.2m. Medical agency usage within Pathology, Radiology outsourcing of services, offset by Radiology vacancies due to delayed recruitment.
Planned and Specialist Care	1.4	0.0	2.0	**3.4**	Savings identification gap £1.4m. Medical locum and agency usage and dual running, alongside Medical rate card and outsourcing of activity within Ophthalmology, Theatres, Dermatology and Urology.
Primary Care	(0.1)	0.0	(2.9)	**(3.0)**	Dental contract handback, General Medical Services underspend, delay in cluster projects, offset by underachieved Dental income.
Executive Functions	(1.8)	0.0	0.2	**(1.6)**	VAT recovery, drugs review, Workforce & Public Health pay savings. Swansea Bay Emergency Activity increase, Estates maintenance expenditure offset by Central Income over achievement
Sub Total	**2.8**	**0.0**	**5.1**	**7.9**	
Gross Position				**21.6**	

Year to Date – Key Performance vs Plan Executive

Executive Function (£'m)	Savings Gap to Target	Savings Delivery vs Plan Benefits	Core Operational Variation	Total	Key Information
Chief Executive	(0.1)	0.0	0.0	**(0.1)**	No material deviation to plan
Digital	0.1	0.0	0.3	**0.4**	Increase in Digital initiative programmes contract expenditure
Estates and Facilities	0.6	0.0	0.5	**1.1**	Under delivery of savings, Building and Estates maintenance expenditure
Executive Allied Health	0.0	0.0	0.0	**0.0**	No material deviation to plan
Finance	(0.1)	0.0	0.0	**(0.1)**	No material deviation to plan
Health Board Wide	(1.1)	0.0	(0.6)	**(1.7)**	VAT recovery and drugs review saving, Central Income over achievement
LTA's	0.5	0.0	0.8	**1.3**	Under delivery of savings, Swansea Bay Emergency Activity increase
Medical	(0.1)	0.0	(0.1)	**(0.2)**	No material deviation to plan
Nursing	(0.1)	0.0	0.0	**(0.1)**	No material deviation to plan
Pharmacy and Medicines Management	0.6	0.0	(0.1)	**0.5**	Under delivery of savings, offset by reduction in Dapagliflozin spend
Public Health	(0.5)	0.0	(0.2)	**(0.7)**	Pay underspends recognised as savings and lower vaccination uptake
Strategy and Planning	(0.2)	0.0	(0.2)	**(0.4)**	Income overachievement relating to Capital Design recharge income
Workforce	(1.4)	0.0	(0.2)	**(1.6)**	Overachievement of savings relating to pay vacancies
Sub Total	**(1.8)**	**0.0**		**(1.6)**	

Year to Date – Core Operational Variation

Core Operational Variation (£'m)



Core Operational Variation (£'m)

Clinical Care Group	Pay	Non-Pay	Income	Total
Chief Operating Officer Management	0.7	0.0	0.0	**0.7**
Community and Integrated Medicine	1.6	2.1	0.0	**3.7**
Mental Health and Learning Disabilities	0.0	1.1	0.0	**1.1**
Operational Allied Health and Health Sciences	(0.1)	0.6	(0.2)	**0.3**
Planned and Specialist Care	0.9	1.3	(0.2)	**2.0**
Primary Care	0.0	(3.5)	0.6	**(2.9)**
Executive Functions	(0.4)	1.4	(0.8)	**0.2**
Total	**2.7**	**3.0**	**(0.6)**	**5.1**

Key Information

Community and Integrated Medicine Increase in Continuing Healthcare packages volume, continued use of Medical locum usage and Nursing bank usage to cover sickness and vacancies.

Mental Health High-cost Continuing Healthcare packages and purchase of Psychiatric Intensive Care Unit beds.

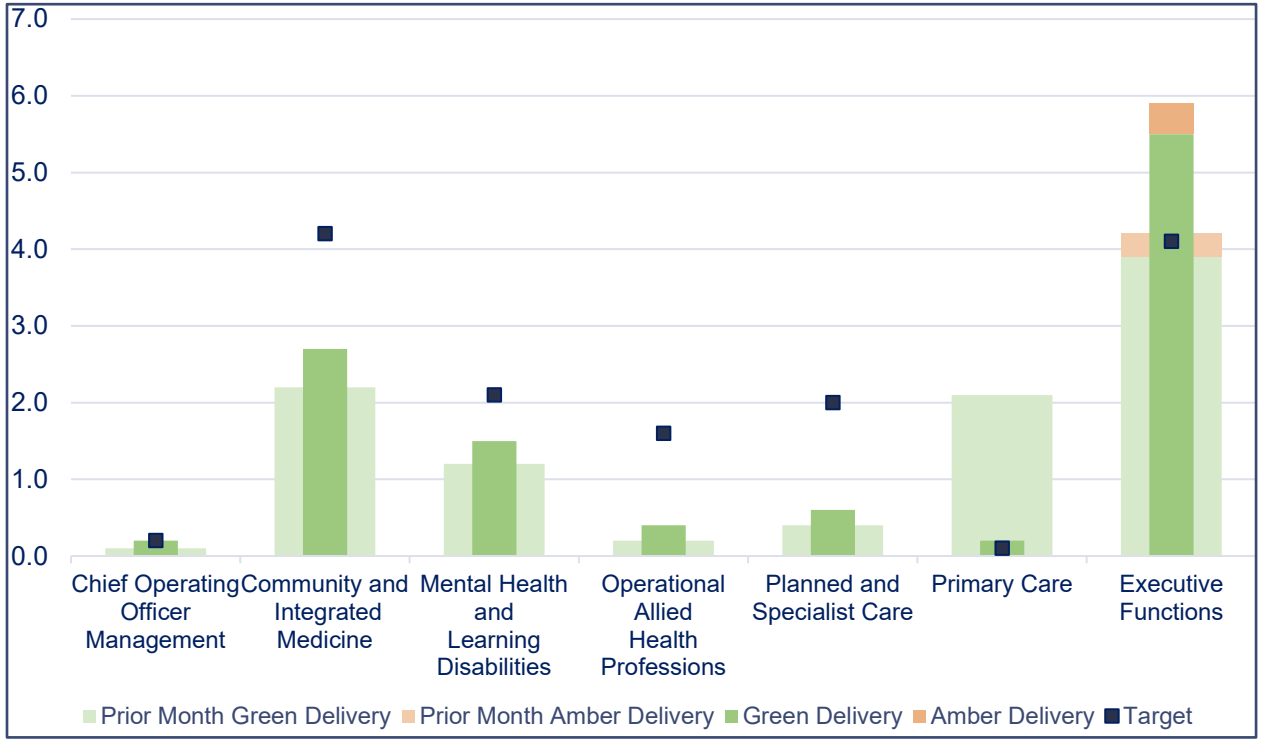
Planned and Specialist Care Medical locum and agency usage including dual-running and rate card usage, and outsourcing activity within Ophthalmology, Theatres and Dermatology.

Primary Care Continued Dental contract handbacks and General Medical Services supplementary services underspends, delay in Primary Care projects, offset by Dental income underachievement. Note an improvement to the core operational performance from prior month following reclassification of prior months dental savings to core operational underspends.

Executive Functions Swansea Bay Emergency activity £0.8m, Digital initiative programmes contract expenditure £0.7m, Estates maintenance contract uplift £0.5m, offset by Central Income overachievement £(0.4)m, Capital redesign income £(0.2)m and Velindre drugs rebate in [illegible] alongside vacancies largely within Digital, Workforce and Nursing £(0.4)m.

Year to Date – Savings Performance Breakdown

Savings Delivery vs Target (£'m)



Savings Performance Breakdown (£'m)

Clinical Care Group	Target	Plan	Delivery	Gap
Chief Operating Officer Management	0.2	0.2	0.2	0.0
Community and Integrated Medicine	4.2	2.7	2.7	1.5
Mental Health and Learning Disabilities	2.1	1.5	1.5	0.6
Operational Allied Health and Health Sciences	1.6	0.4	0.4	1.2
Planned and Specialist Care	2.0	0.6	0.6	1.4
Primary Care	0.1	0.2	0.2	(0.1)
Executive Functions	4.1	5.9	5.9	(1.8)
Grand Total	**14.3**	**11.5**	**11.5**	**2.8**

Key Information

Overall savings identification and delivery of £11.5m, resulting in a £2.8m savings under-identification gap against £14.3m target, with variations across Clinical Care Groups.

Under-identification within Community and Integrated Medicine £1.5m, Planned and Specialist Care £1.4m, Operational Allied Health £1.2m, Mental Health £0.6m, Estates and Facilities £0.6m, Pharmacy and Medicines Management £0.6m, Long Term Agreements £0.5m, offset by over-identification in Workforce £(1.4)m Health Board Wide £(1.2)m.

The identified savings are mainly non-recurrent £9.8m, with only £1.7m being identified as recurrent savings.

Note a reduction in identified savings within Primary Care following reclassification of prior month Dental contract handbacks from savings to core operational underspends.

Capital Performance

Capital

Total Capital Performance

£34.6m

Annual Plan **£34.6m**

All Wales Capital

£26.5m

Annual Plan **£26.5m**

Discretionary Capital

£8.1m

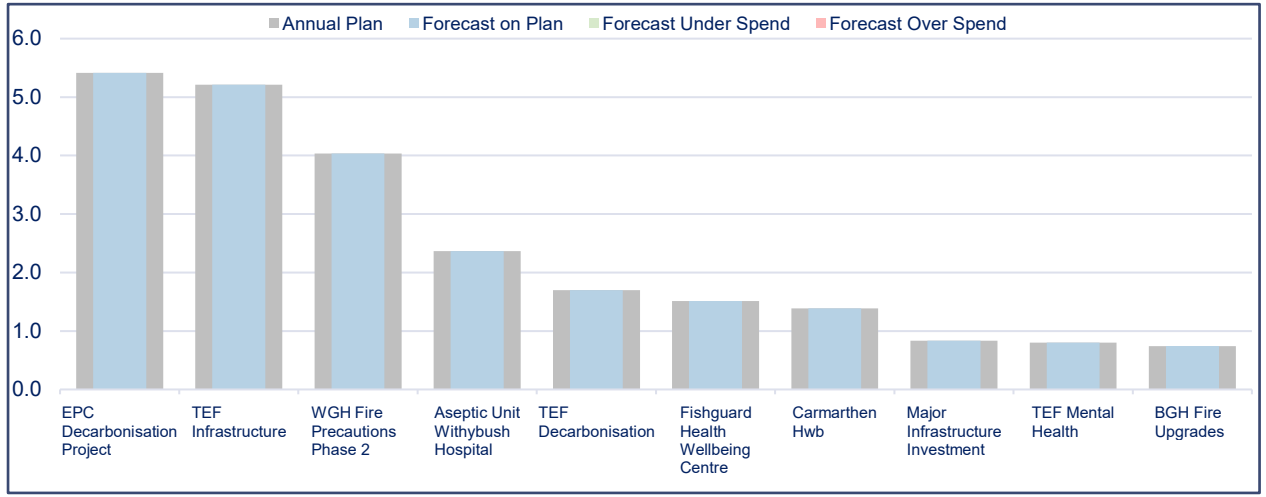
Annual Plan **£8.1m**

IFRS 16

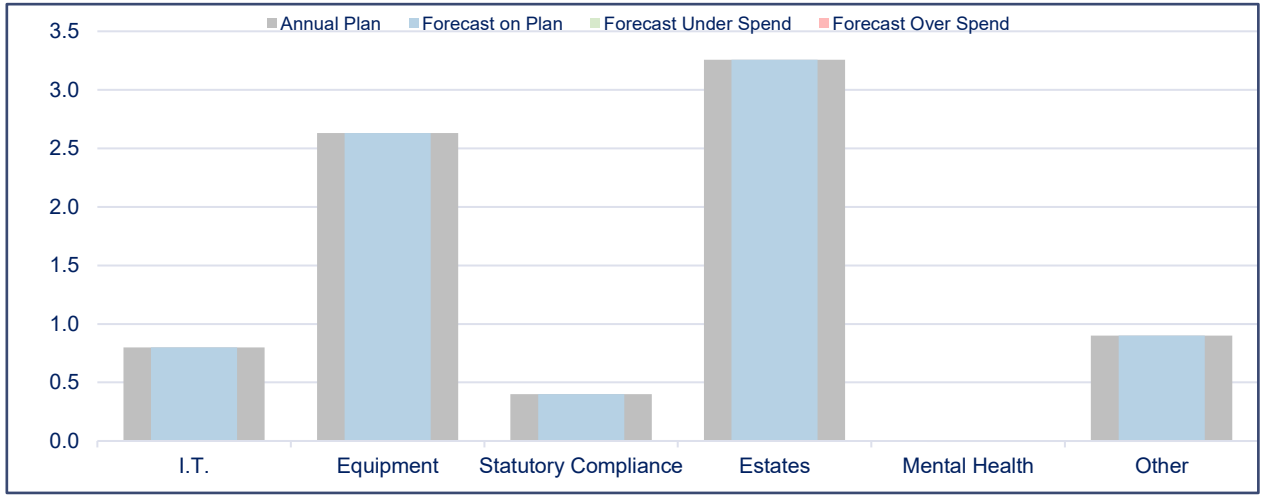
£0.0m

Capital Resource Limit **£0.0m**

All Wales Capital Programme Top 10 Schemes (£'m)



Discretionary Capital Programme Category Summary (£'m)



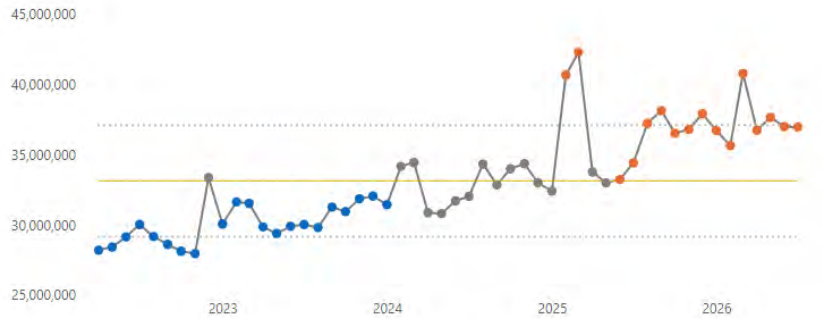
Key Information

Delivery against the capital programme is currently assessed as low risk. Capital projects are currently expected to deliver the Capital Resource Limit; this assessment will be kept under review as the year progresses.

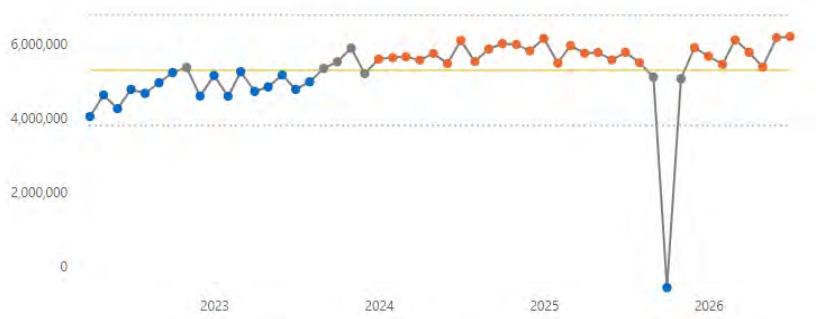
The Capital Programme for the year is comprised of £26.5m All Wales Capital Programme funding and £8.1m discretionary funds. The discretionary value represents the net after adjustments to the gross allocation of £11.2m for contributions to Targeted Estates Fund, the ongoing payback for Picton Terrace, and adjustments relating to prior year outturn.

Trend Analysis – Non-Pay and Income

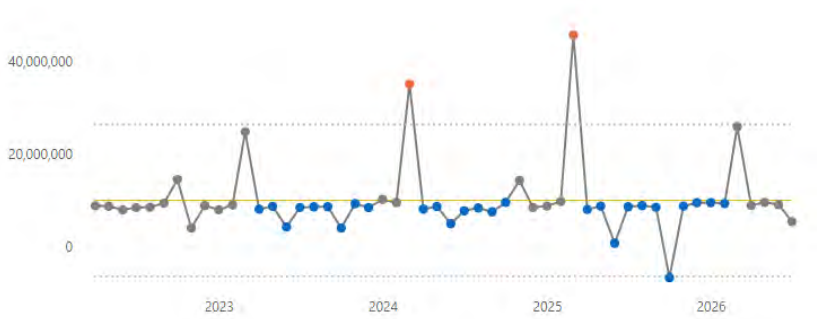
Commissioned Healthcare Services (£)



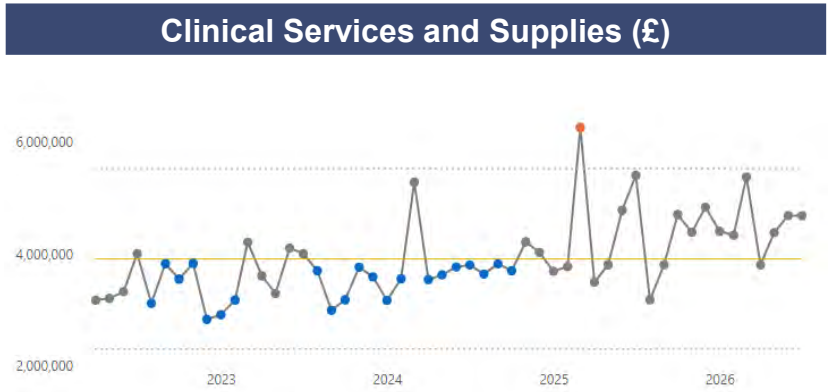
Secondary Care Drugs (£)



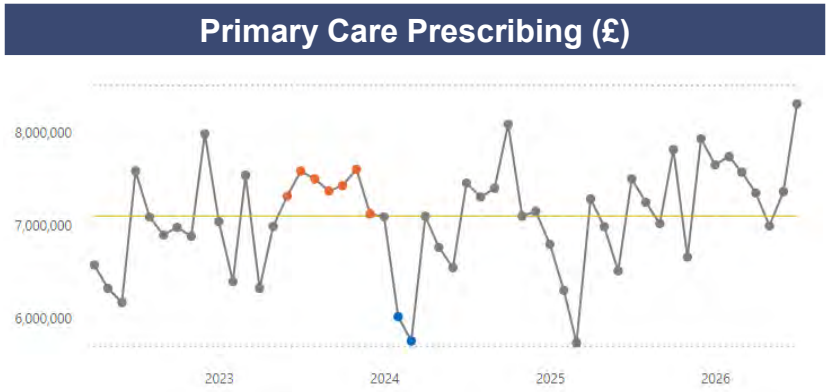
Other Non-Pay (£)



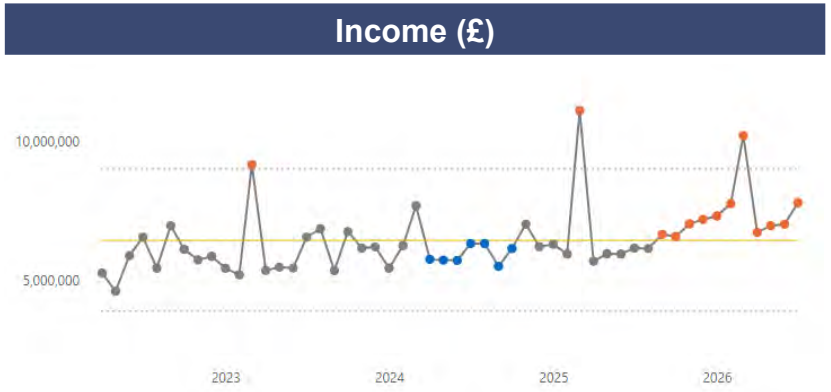
Clinical Services and Supplies (£)



Primary Care Prescribing (£)



Income (£)



Key Information

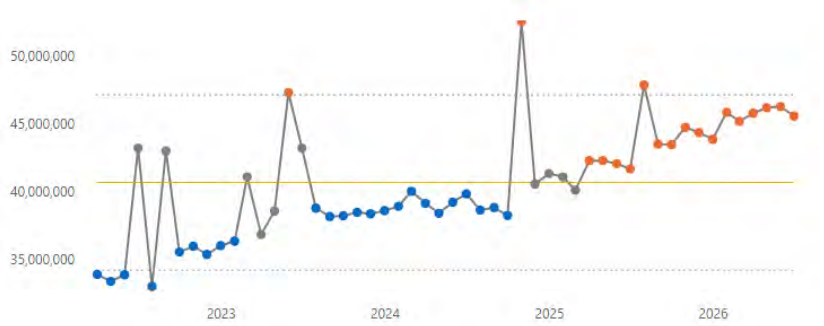
Other Non Pay – Reduction in expenditure in-month relating to Capital Depreciation and Impairments expenditure adjustments, offset by reduction in funding.

Primary Care Prescribing – Increase in prescribing days resulting in increased activity and expenditure, alongside increase in drugs price following latest Prescribing Audit Report and increase in price concessions drugs.

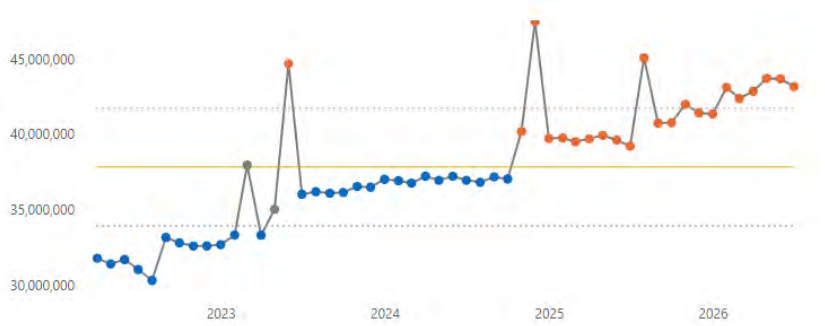
Income – Increase in income in-month relating to Digital Health and Care Wales year to date funding for Digital Prioritisation Improvement Fund programmes £0.5m.

Trend Analysis – Pay Agenda for Change

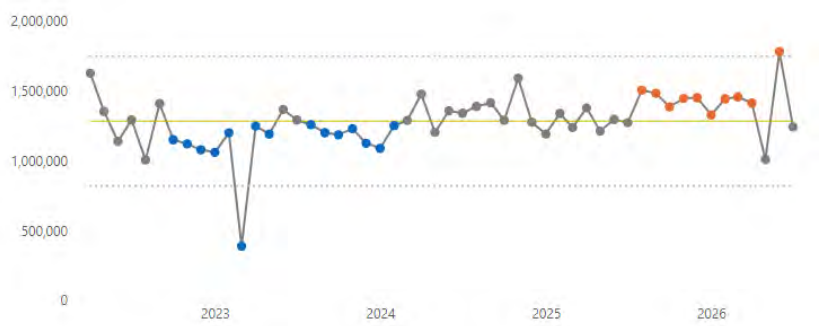
Total (£)



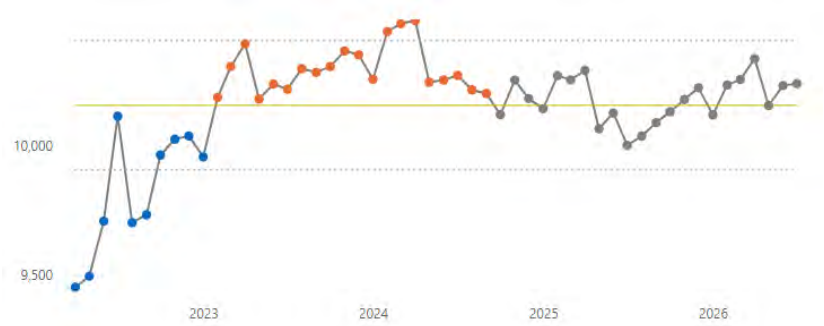
Substantive (£)



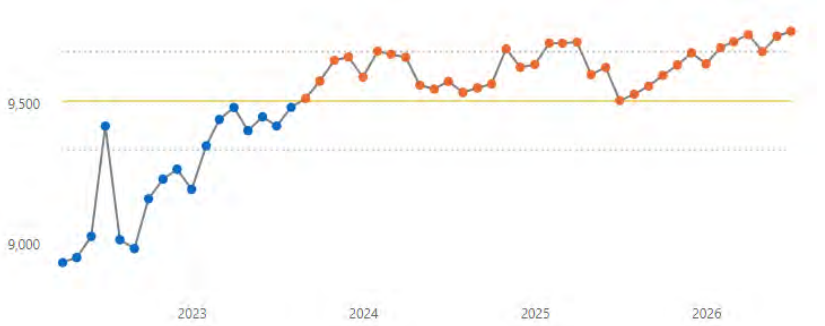
Bank (£)



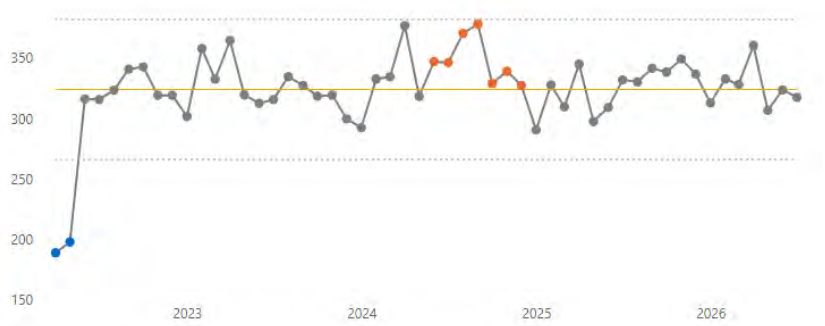
Total (WTE)



Substantive (WTE)



Bank (WTE)



Key Information

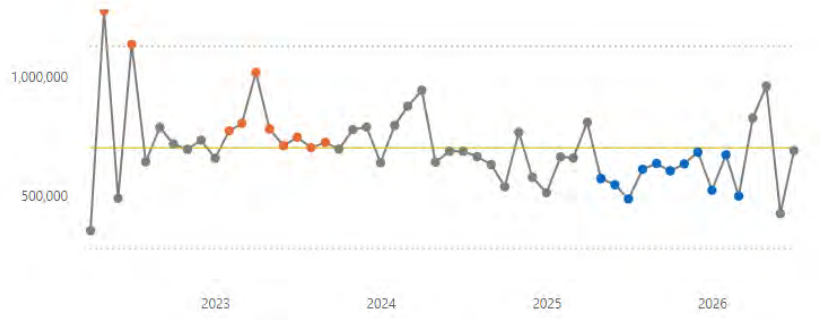
Bank £ and WTE – Reduction of 6.11 Bank WTE largely relating to Nursing and Healthcare Support Workers within Community and Integrated Medicine.

Total WTE – Remains slightly above average, mainly due to the increase in substantive WTE offset by decreases in Overtime and Bank WTE.

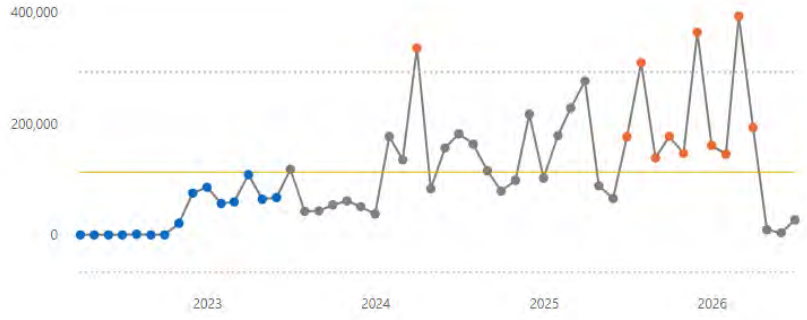
Substantive WTE – Increase in 17 WTE from prior month, increase in 247 WTE from the same period last year – despite this increase there are still pressures due to vacancies and sickness.

Trend Analysis – Pay Agenda for Change

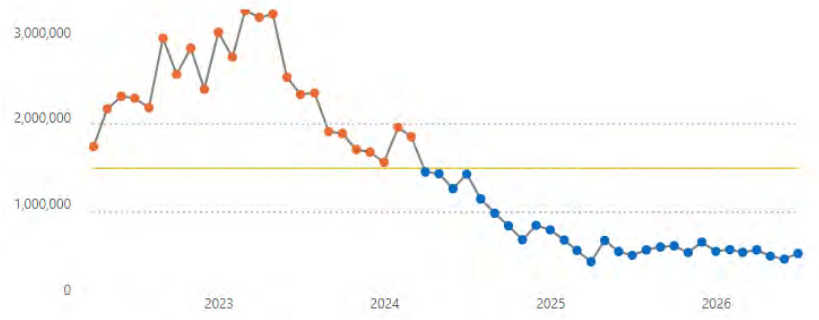
Overtime (£)



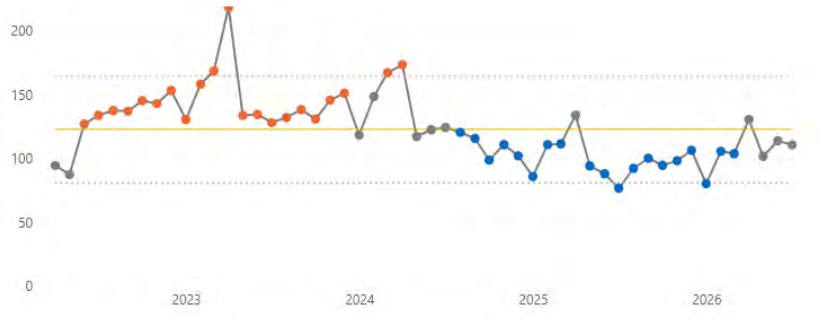
WLI (£)



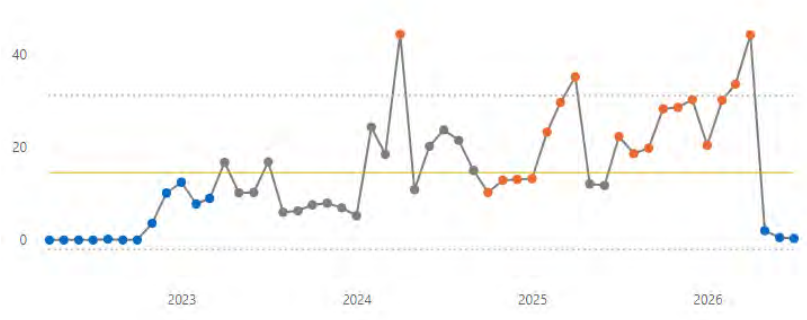
Agency (£)



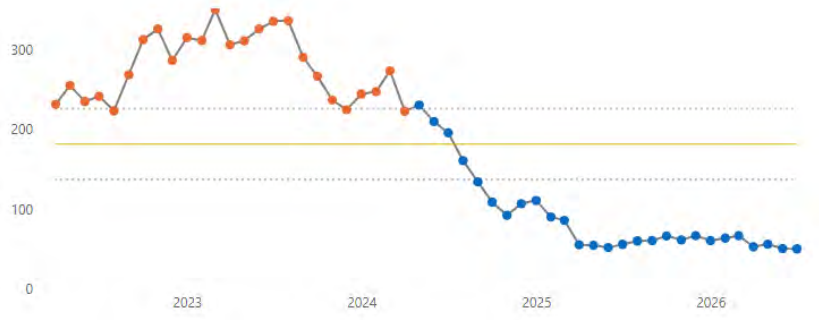
Overtime (WTE)



WLI (WTE)



Agency (WTE)



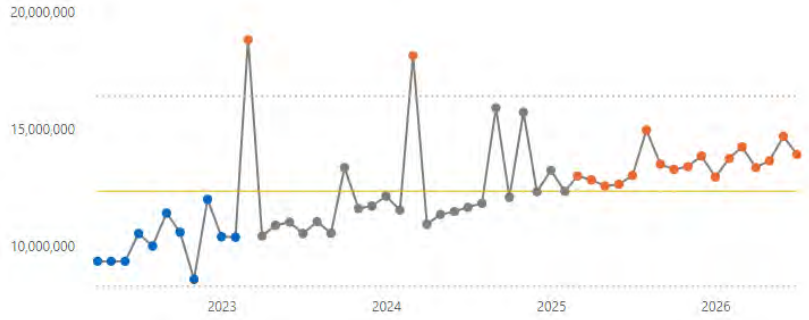
Key Information

Overtime £ and WTE – Increase in Overtime expenditure largely within Community and Integrated Medicine due to vacancies and high sickness level, alongside backdated and retrospective claims. Overall, overtime usage is considerably higher in 2026/27 compared to the average of 2025/26 to cover sickness gaps, as highlighted within the Whole Time Equivalents trend.

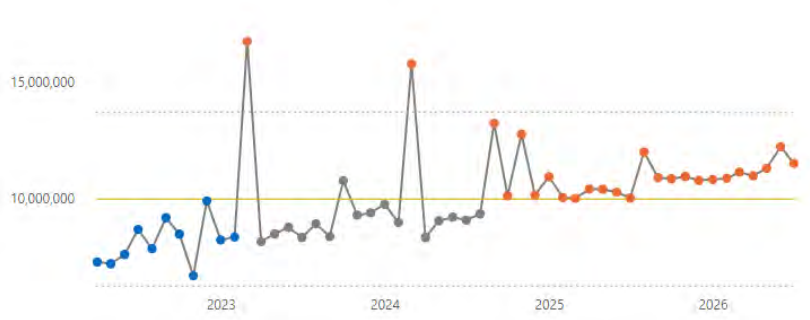
Waiting List Initiative £ and WTE – Reduction from prior year due to significantly less Waiting List Initiative activity being undertaken within Planned and Specialist Care this year. Waiting List Initiative expenditure increased compared to WTE due to retrospective claims relating to prior months.

Trend Analysis – Pay Medical and Dental

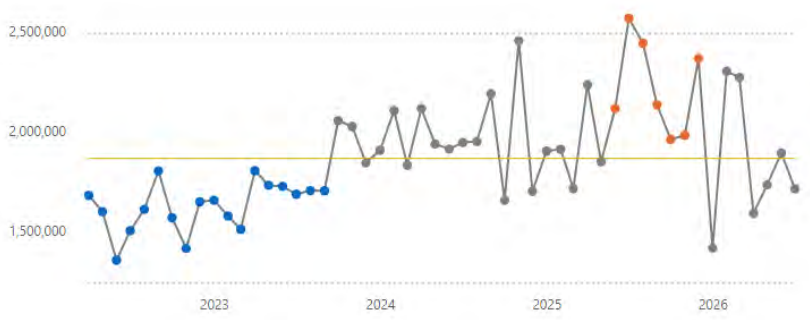
Total (£)



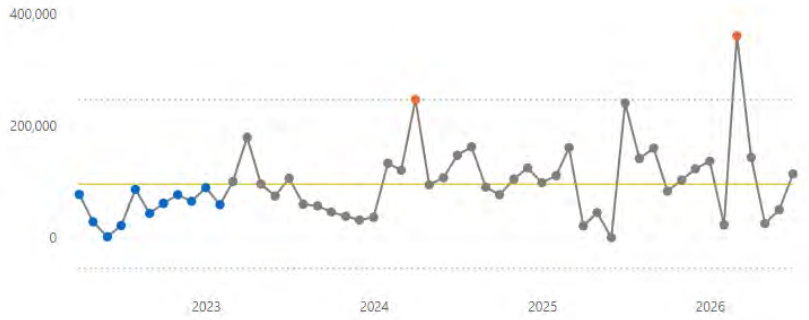
Substantive (£)



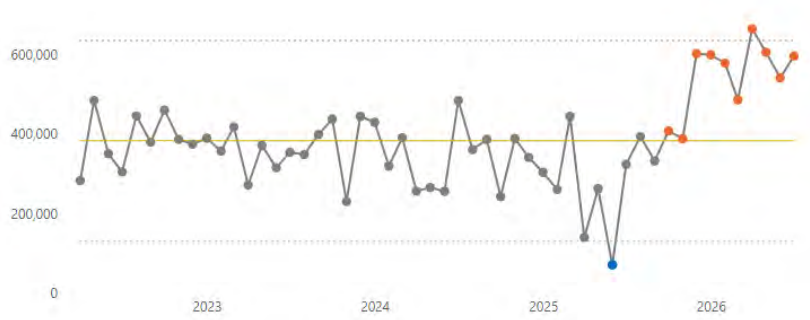
Additional Hours (£)



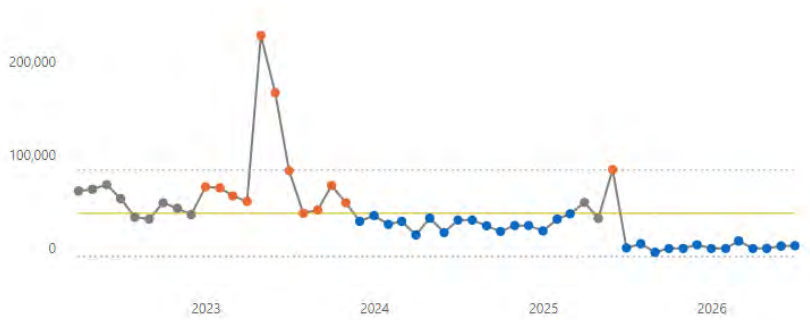
WLI (£)



On Contract Agency Premium (£)



Off Contract Agency Premium (£)



Key Information

Total £ – Reduction in expenditure from prior month largely relating to year to date Medical and Dental pay award arrear payments paid in Month 3.

Substantive £ – Reduction in expenditure from prior month largely relating to year to date Medical and Dental pay award arrear payments paid in Month 3.

Additional Hours £ – Reduction in Additional Duty Hours from prior month largely within Planned and Specialist Care, Mental Health and Community and Integrated Medicine.

Waiting List Initiative £ – Increase from prior month due to retrospective and backdated expenditure relating to prior months within Planned and Specialist Care.

On Contract Agency Premium £ – Slight increase in agency pay expenditure within Menta[illegible]l and Specialist Care and Operational Allied Health.

Staffing Establishment Reports

Ward Staffing Level (WTE) for Nursing and Health Care Support Workers (HCSW)	Total Fill Rate	Total WTE	Substantive WTE	Substantive WTE Vacancy	Variable WTE	Agency (Premium) WTE	Total Over/(Under) Staffed
Chief Operating Officer	**102.2%**	**2,636**	**2,324**	**(279)**	**266**	**44**	**31**
Community and Integrated Medicine	**103.2%**	**1,883**	**1,647**	**(218)**	**195**	**40**	**16**
Carmarthenshire Integrated System	103.5%	1,141	1,002	(107)	125	14	31
Ceredigion Integrated System	107.5%	322	268	(53)	37	16	-
Pembrokeshire Integrated System	99.4%	420	377	(58)	33	10	(15)
Mental Health and Learning Disabilities	**104.7%**	**287**	**236**	**(38)**	**50**	**1**	**13**
Planned and Specialist Care	**96.6%**	**466**	**441**	**(23)**	**21**	**3**	**2**
Cancer and Scheduled Care	94.6%	165	151	(11)	10	3	2
Children, Women and Family Health	97.6%	301	290	(12)	11	-	-
Grand Total	**102.2%**	**2,636**	**2,324**	**(279)**	**266**	**44**	**31**

All Other Staffing Levels (WTE) Excluding Medical and Ward Nursing & HCSWs	Total Fill Rate	Total WTE	Substantive WTE	Substantive WTE Vacancy	Variable WTE	Agency (Premium) WTE	Total Over/(Under) Staffed
Chief Executive	**90.6%**	**89**	**89**	**(6)**	**-**	**-**	**(6)**
Chief Operating Officer	**93.7%**	**5,265**	**5,144**	**(485)**	**111**	**5**	**(364)**
Chief Operating Officer Management	81.6%	132	127	(1)	4	-	3
Community and Integrated Medicine	97.0%	1,417	1,378	(167)	36	2	(127)
Mental Health and Learning Disabilities	90.3%	919	910	(84)	8	-	(75)
Operational Allied Health and Health Sciences	97.2%	1,126	1,096	(75)	30	-	(45)
Planned and Specialist Care	95.0%	1,474	1,441	(119)	28	3	(87)
Primary Care	87.2%	197	192	(39)	5	-	(33)
Executive Director of Allied Health Professions and Health Sciences	**95.2%**	**894**	**838**	**(82)**	**55**	**-**	**(26)**
Executive Director of Finance	**89.9%**	**431**	**425**	**(38)**	**5**	**-**	**(33)**
Executive Director of Nursing, Quality and Patient Experience	**90.9%**	**179**	**177**	**(15)**	**1**	**-**	**(13)**
Executive Director of Public Health	**87.6%**	**141**	**139**	**(40)**	**1**	**-**	**(38)**
Executive Director of Strategy and Planning	**93.9%**	**63**	**63**	**13**	**-**	**-**	**13**
Executive Director of Workforce and Organisational Development	**74.6%**	**219**	**217**	**(79)**	**1**	**-**	**(77)**
Executive Medical Director	**87.0%**	**321**	**319**	**(37)**	**1**	**-**	**(35)**
Grand Total	**90.6%**	**7,602**	**7,411**	**(769)**	**175**	**5**	**(579)**

In-Month – Revenue vs Plan Variance (£'k)

Clinical Care Group and Executive Functions (£'k)	Pay				Non-Pay				Income	Grand Total
	Administration and Estates	Allied Health, Scientists and Other	Medical and Dental	Nursing, Midwifery and Clinical Support	Clinical Services and Supplies	Commissioned Healthcare Services	Drugs and Prescribing	Other Non-Pay	Income	
Chief Executive	**(15)**							**(1)**	**(0)**	**(16)**
Chief Operating Officer	**(235)**	**(16)**	**620**	**(497)**	**757**	**(1,765)**	**(152)**	**355**	**128**	**(807)**
Chief Operating Officer Management	1	40	(18)	1	(30)	13		85	(5)	**86**
Community and Integrated Medicine	(23)	48	238	(189)	150	180	207	169	34	**815**
Mental Health and Learning Disabilities	(13)	(41)	96	(82)	2	392	(16)	5	(1)	**343**
Operational Allied Health and Health Sciences	(7)	(79)	65	(2)	182	(31)	(22)	62	(79)	**90**
Planned and Specialist Care	(19)	3	168	(113)	550	84	(341)	51	45	**429**
Primary Care	(174)	13	70	(112)	(97)	(2,404)	20	(17)	133	**(2,570)**
Executive Director of Allied Health Professions and Health Sciences	**21**	**(15)**		**(3)**	**17**	**2**	**0**	**59**	**(32)**	**50**
Estates and Facilities	9			(3)	17		0	59	(32)	**50**
Executive Allied Health Professions and Health Sciences	12	(15)				2				**0**
Executive Director of Finance	**(117)**	**(70)**	**0**	**(12)**		**63**	**0**	**358**	**(7)**	**215**
Digital	(82)	(70)	0	(12)		64		359	(7)	**252**
Finance	(35)					(1)	0	(1)	0	**(37)**
Executive Director of Nursing, Quality and Patient Experience	**(39)**	**(10)**		**(2)**	**(0)**	**7**		**5**	**6**	**(35)**
Executive Director of Public Health	**(70)**	**(8)**	**(10)**	**(50)**	**3**	**1**	**(56)**	**139**	**0**	**(52)**
Executive Director of Strategy and Planning	**37**	**(0)**	**10**			**(8)**	**0**	**(28)**	**(6)**	**4**
LTAs with other NHS Providers	2					(8)	0	(0)		**(6)**
Strategy and Planning	35	(0)	10			(0)		(28)	(6)	**10**
Executive Director of Workforce and Organisational Development	**(54)**	**(3)**		**(2)**	**2**	**2**	**0**	**(49)**	**(5)**	**(109)**
Executive Medical Director	**(25)**	**69**	**18**	**7**	**(18)**	**5**	**237**	**21**	**(57)**	**257**
Medical	(22)	(4)	18	17	1		0	(63)	13	**(40)**
Pharmacy and Medicines Management	(2)	73		(10)	(20)	5	237	84	(70)	**297**
Health Board Wide	**(14)**	**(8)**	**(70)**	**(9)**	**(10)**	**(17)**	**(44)**	**48**	**(190)**	**(314)**
Planned Deficit								**3,417**		**3,417**
Savings Identification								**2,443**		**2,443**
Grand Total	**(512)**	**(61)**	**568**	**(570)**	**749**	**(1,711)**	**(15)**	**6,765**	**(164)**	**5,052**

Year to Date – Revenue vs Plan Variance (£'k)

Clinical Care Group and Executive Functions (£'k)	Pay				Non-Pay				Income	Grand Total
	Administration and Estates	Allied Health, Scientists and Other	Medical and Dental	Nursing, Midwifery and Clinical Support	Clinical Services and Supplies	Commissioned Healthcare Services	Drugs and Prescribing	Other Non-Pay	Income	
Chief Executive	**(22)**							**(21)**	**(0)**	**(43)**
Chief Operating Officer	**(31)**	**(158)**	**2,608**	**760**	**2,092**	**(1,008)**	**(446)**	**1,009**	**166**	**4,992**
Chief Operating Officer Management	167	168	(13)	357	70	5	0	(50)	(18)	**686**
Community and Integrated Medicine	(37)	146	1,023	539	468	919	301	411	(28)	**3,742**
Mental Health and Learning Disabilities	6	(79)	285	(201)	8	1,120	(44)	36	19	**1,149**
Operational Allied Health and Health Sciences	27	(580)	284	162	608	(85)	(222)	302	(203)	**294**
Planned and Specialist Care	(21)	85	865	15	1,035	531	(536)	249	(202)	**2,021**
Primary Care	(174)	101	164	(112)	(97)	(3,498)	56	61	599	**(2,901)**
Executive Director of Allied Health Professions and Health Sciences	**56**	**(15)**		**(0)**	**17**	**3**	**4**	**522**	**(10)**	**576**
Estates and Facilities	6			(0)	17		4	522	(10)	**538**
Executive Allied Health Professions and Health Sciences	50	(15)				3		0		**38**
Executive Director of Finance	**(256)**	**(2)**	**2**	**47**	**0**	**(194)**	**0**	**687**	**(24)**	**259**
Digital	(221)	(2)	2	47	0	(190)		683	(26)	**292**
Finance	(35)					(4)	0	3	2	**(33)**
Executive Director of Nursing, Quality and Patient Experience	**(39)**	**(10)**		**(2)**	**(1)**	**27**		**34**	**37**	**46**
Executive Director of Public Health	**(70)**	**(7)**	**(10)**	**(51)**	**23**	**(38)**	**(207)**	**135**	**5**	**(221)**
Executive Director of Strategy and Planning	**45**	**(0)**	**36**			**820**	**0**	**(112)**	**(164)**	**625**
LTAs with other NHS Providers	10					822	0	(2)		**830**
Strategy and Planning	35	(0)	36			(2)		(111)	(164)	**(205)**
Executive Director of Workforce and Organisational Development	**(54)**	**(4)**		**(1)**	**8**	**(13)**	**(10)**	**(120)**	**(15)**	**(209)**
Executive Medical Director	**(25)**	**70**	**24**	**75**	**(48)**	**20**	**(41)**	**(33)**	**(173)**	**(130)**
Medical	(22)	(3)	22	68	17		0	(153)	(3)	**(74)**
Pharmacy and Medicines Management	(2)	73	2	8	(66)	20	(41)	120	(170)	**(57)**
Health Board Wide	**(3)**	**(6)**	**(231)**	**10**	**(7)**	**(61)**	**(61)**	**85**	**(413)**	**(687)**
Planned Deficit								**13,667**		**13,667**
Savings Identification								**2,755**		**2,755**
Grand Total	**(399)**	**(132)**	**2,429**	**837**	**2,084**	**(446)**	**(760)**	**18,607**	**(591)**	**21,629**

End of Year – Revenue vs Plan Variance (£'k)

Clinical Care Group and Executive Functions (£'k)	Pay				Non-Pay				Income	Grand Total
	Administration and Estates	Allied Health, Scientists and Other	Medical and Dental	Nursing, Midwifery and Clinical Support	Clinical Services and Supplies	Commissioned Healthcare Services	Drugs and Prescribing	Other Non-Pay	Income	
Chief Executive	**(155)**					**2**		**(14)**	**(2)**	**(169)**
Chief Operating Officer	**(874)**	**(758)**	**7,227**	**(1,970)**	**5,737**	**(2,793)**	**(1,131)**	**2,000**	**880**	**8,318**
Chief Operating Officer Management	90	393	(156)	371	321	15	0	(286)	(29)	**719**
Community and Integrated Medicine	(295)	396	3,575	856	1,304	2,551	717	589	(68)	**9,626**
Mental Health and Learning Disabilities	(28)	(723)	954	(1,037)	24	2,653	(63)	78	53	**1,910**
Operational Allied Health and Health Sciences	(41)	(1,248)	705	319	2,180	(206)	(113)	1,083	(531)	**2,147**
Planned and Specialist Care	108	162	1,778	(2,089)	2,222	2,045	(1,588)	653	(332)	**2,961**
Primary Care	(709)	262	371	(391)	(313)	(9,850)	(84)	(118)	1,787	**(9,045)**
Executive Director of Allied Health Professions and Health Sciences	**(164)**	**(131)**		**(4)**	**0**	**8**	**5**	**1,207**	**(2)**	**920**
Estates and Facilities	(313)			(4)	0		5	1,206	(2)	**893**
Executive Allied Health Professions and Health Sciences	149	(131)				8		1		**27**
Executive Director of Finance	**154**	**175**	**6**	**185**	**0**	**(100)**	**0**	**515**	**(1,122)**	**(187)**
Digital	328	175	6	185	0	(87)		516	(1,126)	**(2)**
Finance	(174)					(14)	0	(1)	4	**(185)**
Executive Director of Nursing, Quality and Patient Experience	**26**	**(91)**		**(23)**	**(2)**	**81**		**74**	**99**	**164**
Executive Director of Public Health	**(629)**	**(71)**	**(91)**	**(454)**	**68**	**(31)**	**(137)**	**220**	**15**	**(1,109)**
Executive Director of Strategy and Planning	**(13)**	**(0)**	**123**		**0**	**916**	**0**	**30**	**(195)**	**862**
LTAs with other NHS Providers	28				0	921	0	(6)		**943**
Strategy and Planning	(41)	(0)	123			(5)		36	(195)	**(82)**
Executive Director of Workforce and Organisational Development	**(997)**	**(30)**	**0**	**(4)**	**24**	**181**	**(31)**	**(224)**	**(52)**	**(1,133)**
Executive Medical Director	**(91)**	**(111)**	**179**	**189**	**(124)**	**41**	**895**	**119**	**(253)**	**845**
Medical	(71)	(42)	178	203	21		1	(352)	(59)	**(122)**
Pharmacy and Medicines Management	(20)	(69)	2	(14)	(145)	41	894	471	(194)	**966**
Health Board Wide	**(1,889)**	**(1,184)**	**(4,189)**	**(3,863)**	**(5)**	**(0)**	**(554)**	**(8,754)**	**(1,025)**	**(21,463)**
Planned Deficit								**41,000**		**41,000**
Savings Identification								**12,954**		**12,954**
Grand Total	**(4,633)**	**(2,201)**	**3,255**	**(5,943)**	**5,699**	**(1,697)**	**(952)**	**49,128**	**(1,656)**	**41,000**

End of Year – Savings Detail (£'k)

Clinical Care Group and Executive Functions (£'k)	Annual Savings Target	In-Year Identified Plans	In-Year Recurrent Delivery	In-Year Non Recurrent Delivery	In-Year Total Forecast Delivery	In-Year Forecast Shortfall	In-Year % Saving vs Budget	Recurrent Forecast Delivery	Recurrent Forecast Shortfall	Recurrent % Saving vs Budget
Chief Executive	**(25)**	**124**	**0**	**124**	**124**	**(149)**	**3.7%**	**0**	**(25)**	**0.0%**
Chief Operating Officer	**30,676**	**15,457**	**1,339**	**14,118**	**15,457**	**15,219**	**2.3%**	**1,430**	**29,246**	**0.2%**
Chief Operating Officer Management	749	386	0	386	386	363	3.0%	0	749	0.0%
Community and Integrated Medicine	12,524	8,012	974	7,038	8,012	4,512	3.3%	1,057	11,467	0.4%
Mental Health and Learning Disabilities	6,442	3,002	30	2,972	3,002	3,440	2.9%	30	6,412	0.0%
Operational Allied Health and Health Sciences	4,849	1,680	22	1,658	1,680	3,169	2.1%	29	4,820	0.0%
Planned and Specialist Care	5,889	2,122	314	1,808	2,122	3,767	1.0%	314	5,575	0.1%
Primary Care	223	256	0	256	256	(33)	2.3%	0	223	0.0%
Executive Director Of Allied Health Professions and Health Sciences	**2,714**	**692**	**9**	**684**	**692**	**2,022**	**1.4%**	**35**	**2,679**	**0.1%**
Estates and Facilities	2,705	648	9	640	648	2,057	1.3%	35	2,670	0.1%
Executive Allied Health Professions and Health Sciences	9	44	0	44	44	(35)	19.2%	0	9	0.0%
Executive Director Of Finance	**239**	**497**	**414**	**83**	**497**	**(258)**	**2.1%**	**467**	**(228)**	**2.0%**
Digital	373	315	295	20	315	58	1.8%	348	25	2.0%
Finance	(134)	183	119	64	183	(317)	3.1%	119	(253)	2.0%
Executive Director Of Nursing, Quality and Patient Experience	**0**	**130**	**0**	**130**	**130**	**(130)**	**1.4%**	**0**	**0**	**0.0%**
Executive Director Of Public Health	**131**	**834**	**0**	**834**	**834**	**(703)**	**12.7%**	**0**	**131**	**0.0%**
Executive Director Of Strategy and Planning	**2,035**	**1,114**	**74**	**1,040**	**1,114**	**921**	**1.8%**	**74**	**1,961**	**0.1%**
LTAs With Other NHS Providers	1,961	655	0	655	655	1,306	1.2%	0	1,961	0.0%
Strategy and Planning	74	459	74	385	459	(385)	12.3%	74	0	2.0%
Executive Director Of Workforce and Organisational Development	**(481)**	**2,902**	**302**	**2,600**	**2,902**	**(3,383)**	**19.1%**	**302**	**(783)**	**2.0%**
Executive Medical Director	**5,951**	**3,429**	**2,520**	**909**	**3,429**	**2,522**	**3.4%**	**2,520**	**3,431**	**2.5%**
Medical	72	202	75	127	202	(130)	4.5%	75	(3)	1.7%
Pharmacy and Medicines Management	5,879	3,228	2,445	783	3,228	2,651	3.4%	2,445	3,434	2.6%
Health Board Wide	**1,560**	**4,665**	**1,529**	**3,136**	**4,665**	**(3,105)**	**12.9%**	**1,546**	**14**	**4.3%**
Grand Total	**42,800**	**29,846**	**6,187**	**23,658**	**29,846**	**12,954**	**3.1%**	**6,375**	**36,425**	**0.7%**

4.2

4.2 - PROCUREMENT SCRUTINY

Gemma Deverill (NWSSP - Procurement)

For assurance

Attachments

Procurement Report FPC 27 August 2026.pdf

Pwyllgor Cyllid a Pherfformiad/ Finance and Performance Committee

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	27 August 2026
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Procurement Report
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Huw Thomas, Executive Director of Finance
SWYDDOG ADRODD: **REPORTING OFFICER:**	Gemma Deverill, Deputy Head of Procurement

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Ar Gyfer Penderfyniad/ For Decision

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The purpose of this report is to inform Members of the outcome of the following procurement exercises which have been undertaken on behalf of Hywel Dda University Health Board (HDdUHB). In line with Welsh Government (WG) approval procedures, the Health Board is required to approve the following new contract, as it has a cumulative contract value in excess of £1m over the term of the contract for HDdUHB.

Cefndir / Background

1. Procurement Outcomes:

a) Rubrik Portfolio Renewal

Proposed Outcome

Duration of Contract	Supplier	Current Annual Contract Value (Ex VAT)	Proposed Annual Value of New Contract (Ex VAT)	Maximum Anticipated Total Value of New Contract (Ex VAT)
01 October 2026 to 30 September 2030 with an option to extend to 30 September 2032	TBC - This will be confirmed post FPC and will be included within the Board paper.	£350,000.00	TBC	£2,100,000.00

b) Telephony Modernisation Subscription Renewal

Proposed Outcome

Duration of Contract	Supplier	Current Annual Contract Value (Ex VAT)	Proposed Annual Value of New Contract (Ex VAT)	Proposed Total Value of New Contract (Ex VAT)
01 October 2026 to 30 September 2028 with an option to extend to 30 September 2029	Maintel Europe Limited	£361,959.70	£333,327.02	Initial Contract Value £666,654.04 Total Inc Extensions £999,981.06

c) Contract Change Notice for The Microsoft Enterprise Agreement

Duration of Contract	Supplier	Current Annual Contract Value (Ex VAT)	Proposed Annual Value of New Contract (Ex VAT)	Proposed Total Value of New Contract (Ex VAT)
14 October 2026 – 13 October 2027	Trustmarque Solutions Limited	£4,651,324.93	£4,907,956.87	£23,513,256.61

Asesiad / Assessment

1. Procurement Outcomes:

a) Proposed outcome for the tender exercise: **Rubrik Portfolio Renewal**

HDdUHB Digital Directorate are looking to award a contract to renew their current Rubrik licence portfolio into one co-termed agreement. Rubrik technology forms a critical component of the Health Board's Cyber Security and Data Protection Framework, providing immutable backup, rapid recovery, ransomware detection, and protection of highly sensitive clinical and corporate data. The solutions are used extensively across the organisation to safeguard confidential patient information and ensure HDdUHB can maintain continuity of services in the event of a cyber incident, system failure, or malicious attack.

Over several years, HDdUHB has procured multiple Rubrik solutions as detailed below under separate contracts to support different elements of its cyber resilience and data protection strategy. These contracts now have varying expiry dates and support arrangements, creating operational complexity and increased administrative overhead. The new contract will co-term these arrangements.

Contract Title	Contract Start Date	Current Contract End Date
Rubrik Backup Licences	01/01/2025	30/09/2026
Rubrik Solution for Medical Records	01/02/2024	31/01/2027
Rubrik Microsoft Office 365 Solution	01/04/2024	31/03/2027
Rubrik Cloud Archive	05/05/2026	04/05/2027

It is important to note the Rubrik Solution for Medical Records may not require renewal following expiry at the end of January 2027 due to the renewal of the Health Board's Electronic Document and Records Management System (EDRMS) which is likely to move these patient records away from on premise storage.

A mini competition exercise has been undertaken utilising the Welsh Government Commercial Delivery (WGCD) Framework Agreement for IT Products and Services (iii) under Lot 2 Software. Confirmation of awarded provider(s) will be included within the Board paper.

The contract term will be from 01 October 2026 to 30 September 2030, with an option to extend until 30 September 2032.

b) Proposed outcome for the tender exercise: **Telephony Modernisation Subscription Renewal**

HDdUHB Digital Directorate is seeking approval to renew its existing telephony modernisation contract with Maintel via a direct award through the CCS Network Services 3 Framework.

The current solution supports around 6,000 telephony devices across the Health Board and includes a fully managed, cloud-hosted Mitel telephony platform. Services provided include hosting, maintenance, updates, disaster recovery, business continuity, performance monitoring, capacity management, and technical support.

The telephony modernisation programme is approximately 90% complete. Significant investment has already been made in migrating from legacy on-premises systems and moving to a different supplier now would require another large-scale migration affecting 6,000 devices, creating additional costs, operational disruption, staff retraining requirements and increased delivery and service risks. Remaining work includes migrating 129 PSTN lines before the national PSTN switch-off at the end of 2026 and replacing the Bronglais General Hospital DECT infrastructure, expected by March 2027 subject to capital funding.

Once the current programme is complete, all telephony services will operate within a single cloud environment, making any future procurement and migration much simpler. Digital Services estimate 12 months to conduct a competitive procurement exercise and a further 12 months for implementation and migration if a new provider is selected. The proposed extension provides sufficient time to complete the current programme and undertake a full competitive procurement process in the future.

The proposed direct award will:

- Maintain continuity of a critical communication service.
- Avoid unnecessary implementation and migration costs.
- Reduce operational risk.

- Deliver a cash-releasing saving of £28,632.68 (ex VAT) in the first year of the contract.

Approval is sought to direct award of the telephony contract to Maintel via the CCS Network Services 3 Framework to enable completion of the telephony modernisation programme, maintain service continuity, and achieve cost savings while preparing for a future competitive procurement exercise.

c) Proposed contract change notice: **The Microsoft Enterprise Agreement**

Digital Health and Care Wales (DHCW) have established a national Microsoft Enterprise Agreement on behalf of NHS Wales organisations. Microsoft technologies form a critical component of the Health Board's digital infrastructure and support a wide range of clinical, operational and corporate systems.

Approval is sought for a Contract Change Notice (CCN) to add 400 Microsoft Windows 10 Extended Security Licences to the existing agreement. The additional licences are required to support the Health Board's Windows 10 asset migration and replacement programme by maintaining security updates, bug fixes and technical support for all Windows 10 assets whilst they are replaced.

The proposed change remains within the original scope and purpose of the contract and will support ongoing digital service delivery.

The proposed value of the CCN is £35,352.00 (excl. VAT), increasing the total contract value to £23,513,256.61 (excl. VAT).

Argymhelliad / Recommendation

The Finance and Performance Committee is asked to scrutinise and recommend for Board to:

- **APPROVE** the award of the Rubrik Portfolio contract renewal from the 01 October 2026 to the 30 September 2030 with an option to extend to 30 September 2032 at a maximum anticipated total contract value of £2,100,000.00 ex VAT. This contract will have onwards submission to HDdUHB Public Board, Velindre NHS Trust (as hosts of NHS Wales Shared Services Partnership).
- **APPROVE** the award of the Telephony Modernisation Subscription Renewal from 01 October 2026 to 30 September 2028 with the option to extend to 30 September 2029 with total contract value of £999,981.06 ex VAT. This contract will have onwards submission to HDdUHB Public Board, Velindre NHS Trust (as hosts of NHS Wales Shared Services Partnership).
- **APPROVE** the Contract Change Notice for the Microsoft Enterprise Agreement increasing the total contract value to £23.513,256.61 ex VAT. This contract will have onwards submission to HDdUHB Public Board, Velindre NHS Trust (as hosts of NHS Wales Shared Services Partnership).

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Cyfeirnod Cylch Gorchwyl y Pwyllgor:	3.1.9 Conduct detailed scrutiny of all aspects of

Committee ToR Reference:	financial performance, the financial implications of significant revenue expenditure (all those over £1million requiring Board approval), business cases (except those that are capital and digital in nature), projects, and proposed investment decisions on behalf of the Board. 3.1.10 Scrutinise major procurements plans and tenders, and provide assurance to the Board as part of its approval process.
Cyfeirnod Cofrestr Risg Datix, Teitl a Sgôr Risg Cyfredol: Datix Risk Register Reference and Score:	Not Applicable
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	7. All apply
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	6. All Apply
Amcanion Strategol y BIP: UHB Strategic Objectives:	All Strategic Objectives are applicable
Nodau Cynllunio 2026/27 Planning Goals 2026/27	All Planning Goals Apply
Hypergyswllt i Amcanion Llesiant HDdUHB 2026 Hyperlink to HDdUHB Well-being Objectives 2026	9. All HDdUHB Well-being Objectives apply
Model Cymdeithasol ar gyfer Iechyd a Llesiant: (wedi'i gwblhau ar gyfer newid strategol a/neu newidiadau sylweddol i wasanaethau) A Social Model for Health and Wellbeing: (*complete for strategic*	Not Applicable

change and/or significant service changes)	
Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Not Applicable
Rhestr Termau: Glossary of Terms:	Not Applicable
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y cyfarfod hwn: Parties / Committees consulted prior to this meeting:	Not Applicable

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	Not Applicable
Ansawdd / Gofal Claf: Quality / Patient Care:	Not Applicable
Gweithlu: Workforce:	Not Applicable
Tegwch Iechyd: Health Equity:	Not Applicable
Risg: Risk:	Not Applicable
Cyfreithiol: Legal:	Not Applicable
Enw Da: Reputational:	Not Applicable

Gyfrinachedd: **Privacy:**	Not Applicable
Cydraddoldeb: **Equality:**	Not Applicable

4.3

4.3 - PLANNING GOALS UPDATE REPORT

Angharad Lloyd-Probert (Hywel Dda UHB - Senior Project Manager)

For assurance

Attachments

Planning Goals Update Report FPC 27 August 2026.pdf

Pwyllgor Cyllid a Pherfformiad/ Finance and Performance Committee

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	27 August 2026
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Planning Goals Update Report
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Huw Thomas, Executive Director of Finance
SWYDDOG ADRODD: **REPORTING OFFICER:**	Angharad Lloyd-Probert, Senior Project Manager (Planning)

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

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The Health Board approved the 2026/27 Annual Plan in March 2026, based on requirements specified in the NHS Wales Planning Framework 2026/29 and against the Escalation Framework, which was subsequently submitted to Welsh Government on 31 March 2026. Since submission, Welsh Government has issued further communication that noted the plan was unacceptable and unsupportable given the expected financial outturn for 2026/27.

For 2026/27, **Planning Goal 6** has been aligned to the Finance and Performance Committee (FPC), namely:

Planning Goal 6: Safe, timely, high-quality care which covers the following previous Planning Objectives. To note **Planning Objective 2** (Financial Roadmap) has not been carried forward for 2026-27 so therefore there is no specific defined Finance Planning Goal for 2026-27.

- **Planning Objective 3**: Urgent and Emergency Care
- **Planning Objective 4:** Planned Care including cancer and diagnostics
- **Planning Objective 5:** Mental Health and Learning Disabilities

As in previous years it is the expectation that FPC will receive an update on the progress made in the development (delivery) of the Planning Goals for onward assurance to the Board through the Board Assurance Framework.

Cefndir / Background

Planning Goals

One key aspect of the Annual Plan remains our Planning Goals (previously referred to as Planning Objectives). Of the eight Planning Goals one is aligned to this Committee: -

- **Planning Goal 6:** Safe, timely, high-quality care

Asesiad / Assessment

The Planning Goals will remain a key element of the Annual Plan for 2026/27.Where there are outstanding actions as part of the 2025/26 plans, these are expected to be carried over into 2026/27 for completion.

Planning Goals

The current status of the Planning Goal aligned to this Committee are: -

Planning Goal	Executive Lead	Status and Key Outcomes
Planning Goal 6: Safe, timely, high-quality care	Chief Operating Officer	Planning Objective 3 **On Track** Update on the Six Goals Programme: • 7-day Clinical Streaming Hub positions recruited, estimated launch date 1 December 2026 • Ambulance 45-minute Plan developed and group established • Trajectories developed and agreed against key Targeted Intervention (TI) metrics • Developed and implemented Deconditioning Early Warning Indicator (DEWI) training resources, Action Bundle and supporting materials • Rolled out the DEWI Tool to 38 wards across the hospital sites • Reviewed and updated staff and patient discharge information in response to feedback • Progressed Clinical Streaming Hub development, including dashboards, reporting and pathway improvements • Implemented Red2Green reporting improvements to support Optimal Hospital Flow • Completed community falls response mapping and progressed agreed improvement actions • Frailty Scoring continues to be actively implemented across the acute sites. • The digital frailty alert system is now live and triggers early clinical awareness and

		response pathways for patients with a frailty score ≥5 at the point of entry (Emergency Department/Minor Injuries Unit). Work is also underway to explore the development of a dashboard to support monitoring, reporting, and service improvement. • A business case is being developed to pilot weekend working for Therapy Assistants, with the aim of enhancing therapy provision and supporting patient flow across the frailty pathway. However, delivery continues to be constrained by workforce, financial, and system pressures, requiring sustained programme oversight. The programme is on track but slightly delayed in some areas.
		Planning Objective 4 (Diagnostics) **Behind** **Activities completed in reporting period** • **Mobile CT Van** – April 26- July 26 – 1658 USC and follow up cancer patients scanned. • **Task and finish group workstream**, 3 themes: Data Quality, Capacity Validation, Demand and Capacity trajectory tools **Activities planned for next milestone and reporting period** • **Mobile CT Van** –August 2026 – 411 patients • **Funding** - July 2026 – request for Planned care delivery and sustainability WG funding £4.1M (8 week waits and improve cancer performance) • **Risks to delivery:** Any delay in decision re 4.1M funding, ability to procure additional capacity, Recruitment of key clinical posts – shortages in both radiographers, sonographers and radiologists. OCP completed August 2026 – posts to be advertised (September) Reliance on locum positions in Non-Obstetric Ultrasound. • **Activities completed in reporting period**

		• **MRI van** – April – August 26 –1485 patients in Q1 • **USS Insourcing** to continue – 1609 patients in Q1 • **Task and finish group workstream**, 3 themes: Data Quality, Capacity Validation, Demand and Capacity trajectory tools **Activities planned for next milestone and reporting period** • **MRI van** – September 2026 – November 2026 – plan to scan 1372 patients in Q2 • **USS Insourcing to continue** – plan to scan 1600 patients in Q2 • **Funding** - If Planned care delivery and sustainability WG funding is agreed, capacity will increase to meet demand and backlog • **Risks to delivery:** Recruitment of key clinical posts – shortages in both radiographers, sonographers and radiologists. OCP completed Aug 26 – posts to be advertised (September) Reliance on locum positions in Non-Obstetric Ultrasound**.**
		Planning Objective 5 **On Track** **Open Access Demonstrator Projects** **Status: On track** • All four demonstrator projects continue to progress towards implementation of the Open Access Mental Health Support Model, with pathway redesign, workforce development and local implementation planning underway. • Staff continue to participate in One at a Time (OAAT) training, supporting workforce readiness and implementation of new care pathways. • Recruitment activity is progressing across demonstrator projects where additional capacity is required to support delivery. • Project leads participating in a national shared learning forum, facilitating the exchange of learning, emerging practice

		and implementation challenges across Wales. • Meeting arranged with Engagement and Communications colleagues to plan communications activity across the wider Clinical Care Group regarding the demonstrator projects. **111 Option 2** **Status: On Track** • Continued work with the Communications Team and the 111 Option 2 service to improve public awareness and promotion of mental health access pathways. • The Ceredigion mental health access pathway continues to be embedded, with ongoing work to support consistent implementation and integration with services. **Psychological Therapies** **Status: In progress** • RTT compliance has improved to 59.4%, demonstrating continued progress towards the Q2 target of 63%. • Referral and discharge activity remains balanced, preventing further waiting list growth. • A 34% reduction in the overall waiting list has been sustained, with improvements across a range of therapy modalities. • Recruitment activity is ongoing, with several appointments progressing through the recruitment process. • Trauma-Focused DBT provision has increased treatment capacity and supports recovery. • Additional capacity is expected from Newly Qualified Practitioners joining from September/October 2026 **Risk:** • Delays in the transition from AA to MEDIO may limit the service's ability to deliver additional therapy groups and could impact future RTT recovery and waiting list reduction.

		• Current modelling suggests a residual backlog of patients waiting up to two years may remain without further intervention. **Patient Flow – Improving MH Inpatient Flow & Reducing Out of Area Beds – Status In progress** • 72-hour crisis admission pathway working group started in July 2026 • Aim to establish a consistent, clinically robust pathway and clear standards • Focus on improving assessment, treatment, discharge planning, and patient flow • Emphasis on multi-disciplinary, multi-agency working and continuity across services • Vanguard work supporting improvements in patient flow and reducing out of area placements **Neurodevelopmental (ND) – Status On Track** • School cluster pilot is enabling multiple assessments to be completed more efficiently in areas with the highest referral rates. • Contract for AI scribe in place for further year with additional functionality. • Children and Young People (CYM) Autistic Spectrum Disorder (ASD) performance exceeds trajectory, with 22.3% assessed within 26 weeks against a Q1 target of 16%. • Advice hubs have been redesigned to fulfil the requirement of an initial appointment, increasing throughput. • Progressing move to Patient Knows Best digital platform to deliver post-diagnostic support and provide electronic means to communicate with CYP/carers/parents. • Working with Paediatrics team to develop joint working. • Additional WG funding of £567,000 secured. Further outsourcing contract awaiting Health Board approval. **Risks / Challenges**

		Demand continues to outstrip capacity. Additional funding received in 26/27 will not bring about the eradication of over 3 year waits without further system change **Learning Disabilities (LD)** **Status: On Track** • Finalise OCP for LD Service Redesign and begin recruitment – Briefing paper has now been signed off by Workforce. A meeting is scheduled with Workforce in August to progress implementation with affected staff and commence recruitment to vacant posts. • Start HEF digitisation rollout planning – HEF implementation continues to progress well, with the Learning Disabilities Service significantly exceeding its planned HEF delivery trajectory. • Confirm GP register validation and AHC support arrangements. – Ongoing work to strengthen GP register validation and improve Annual Health Check (AHC) uptake, Targeted support to practices, alongside coordinated education, and awareness for people with learning disabilities, families, carers, and PHC teams. • Paul Ridd Learning Disability Awareness ESR Training Health Board Compliance rate 94.79% Mental Health and Learning Disabilities rate 98.4% against Q2 trajectory of 95% Health Board Wide. **Suicide and Self Harm – Safe Discharge, Ligature Safety, Multi-Agency Prevention** **Status: On Track** **Safe Discharge** • Performance against the 72-hour discharge follow-up standard was 83% in June 2026, exceeding the Welsh Government target of 80%. • Compliance continues to be monitored weekly and reported to Welsh Government monthly. • Despite reporting challenges associated with exceptional cases, the service

		achieved the national performance target during the reporting period. **Ligature Safety** • Ligature reduction training has continued throughout Q2. Latest data shows 125 staff trained, exceeding the planned trajectory for this stage of delivery. • Band 7 - 7 out of 7 staff has completed training • Band 6 - 8 out of 10 staff has completed the training • Band 5 - 40 out of 59 staff has completed the training • HCSW - 70 staff has completed the training

Argymhelliad / Recommendation

The Finance and Performance Committee is asked **RECEIVE ASSURANCE** and note the progress of the Planning Goals which are aligned to it; in order to assure the Board that the Planning Goals are progressing and are on target, and to raise any concerns where a Planning Goal is identified as behind in its status and/or not achieving against its key deliverables

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Cyfeirnod Cylch Gorchwyl y Pwyllgor: Committee ToR Reference:	3.1.17 Seek assurance on delivery against all Planning Objectives (Appendix 2) aligned to the Committee in accordance with the Board approved timescales, as set out in the Health Board's Annual Plan, considering and scrutinising the plans, including the medium term financial plans, and savings plans, that are developed and implemented, supporting and endorsing these as appropriate.
Cyfeirnod Cofrestr Risg Datix, Teitl a Sgôr Risg Cyfredol: Datix Risk Register Reference and Score:	Not Applicable
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	7. All apply
Galluogwyr Ansawdd: Enablers of Quality:	6. All Apply

Quality and Engagement Act (sharepoint.com)	
Amcanion Strategol y BIP: UHB Strategic Objectives:	All Strategic Objectives are applicable
Nodau Cynllunio 2026/27 Planning Goals 2026/27	6. Safe, Timely, High Quality Care
Hypergyswllt i Amcanion Llesiant HDdUHB 2026 Hyperlink to HDdUHB Well-being Objectives 2026	9. All HDdUHB Well-being Objectives apply
Model Cymdeithasol ar gyfer Iechyd a Llesiant: (wedi'i gwblhau ar gyfer newid strategol a/neu newidiadau sylweddol i wasanaethau) A Social Model for Health and Wellbeing: (*complete for strategic change and/or significant service changes)*	7. All Apply
Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	3 Year Plan and Annual Plan 26-27
Rhestr Termau: Glossary of Terms:	Contained within the body of the report
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y cyfarfod hwn: Parties / Committees consulted prior to this meeting:	Not Applicable

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

Ariannol / Gwerth am Arian: **Financial / Service:**	Any financial impacts and considerations are identified in the report
Ansawdd / Gofal Claf: **Quality / Patient Care:**	Any issues are identified in the report
Gweithlu: **Workforce:**	Any issues are identified in the report
Tegwch Iechyd: **Health Equity:**	Consideration and focus on risk is inherent within the report. A sound system of internal control helps to ensure any risks are identified, assessed and managed.
Risg: **Risk:**	Any issues are identified in the report
Cyfreithiol: **Legal:**	Any financial impacts and considerations are identified in the report
Enw Da: **Reputational:**	Any issues are identified in the report
Gyfrinachedd: **Privacy:**	Not Applicable
Cydraddoldeb: **Equality:**	Not Applicable

5

5 - PERFORMANCE

5.1

5.1 - INTEGRATED PERFORMANCE ASSURANCE REPORT

Huw Thomas (Hywel Dda UHB - Director of Finance)

For assurance

Attachments

IPAR FPC 27 August 2026.pdf

Appendix A M4 August 2026 IPAR Overview.pdf

Pwyllgor Cyllid a Pherfformiad/ Finance and Performance Committee

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	27 August 2026
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Performance Update for Hywel Dda University Health Board – Month 3 2026/27
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Huw Thomas, Executive Director of Finance In association with all Executive Leads
SWYDDOG ADRODD: **REPORTING OFFICER:**	Huw Thomas, Executive Director of Finance

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

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

This report relates to the Month 4, 2026/27 Integrated Performance Assurance Report (IPAR) and the Month 4 Internal Escalation Update.

Integrated Performance Assurance Report (IPAR) – Month 4 2026/27

The IPAR summarises progress against a range of national and local performance measures. The IPAR consists of this SBAR and the following supporting documents:

- IPAR overview – includes a summary, data, issues and actions for the Health Board's key performance improvement measures. Appendix A of the overview gives an indication of the metric types i.e. targeted intervention, performance framework, annual plan etc.
- IPAR dashboard – provides statistical process control (SPC) charts for each of our performance measures. Ahead of the committee meeting, the dashboard will also be made available via the Health Board's internet site.

The health board is in further discussion with Welsh Government and the National Performance and Improvement Team to revise our annual plan trajectories. Once agreed and formalised, they will be included within the IPAR.

Internal Escalation Update: August 2026

This document outlines the escalation levels for each clinical care group and executive function across the health board against our seven improvement domains.

Cefndir / Background

Welsh Government published the 2026/27 NHS Wales Performance Framework in February 2026. Following the health board's recent Accountability and Oversight meeting with Welsh Government, our 2026/27 trajectories are being reviewed. The revised trajectories will be included in the IPAR as soon as they are finalised.

The Our Improving Together Framework was approved by Board in March 2025. It sets out our approach to embedding performance improvement through our organisation. The framework's ultimate aim is to improve outcomes for our patients, staff and population.

Asesiad / Assessment

Performance overview

The key metric summary table below has been revised to reflect changes to the 2026/27 performance framework, ministerial priorities and other local key performance metrics. Additional data, details of key issues and actions being taken to address can be found in the supporting document *IPAR overview*.

Metric	Target	Period	Actual	Variation	Assurance	Trajectory	3A
% sickness absence rate of staff	6.20%	Jul 2026	6.81%	n/a	n/a	n/a	Alert
Pts waiting 14 wks+ for specified therapy (Exc. Audiology)	0	Jul 2026	3,547	Concerning	Missing target	n/a	Alert
Pts waiting 8 wks+ for specified diagnostic	0	Jul 2026	6,651	Concerning	Missing target	n/a	Alert
Patients spending > 12 hours in A&E/MIU Hywel Dda	0	Jul 2026	1,613	Usual	Missing target	n/a	Alert
Number of Pathways of Care delayed discharges	n/a	Jul 2026	204	Usual	n/a	n/a	Alert
Waits over 52 weeks: new outpatient appointment	0	Jul 2026	351	Improving	Missing target	n/a	Alert
Patients waiting 104 weeks+ RTT	0	Jul 2026	504	Improving	Missing target	n/a	Alert
Patients waiting over 52 weeks RTT	0	Jul 2026	12,524	Improving	Missing target	n/a	Alert
Patients waiting 26 weeks+ new outpatient	0	Jul 2026	5,035	Improving	Missing target	n/a	Alert
C. difficile: Number of confirmed cases (in-month)	5	Jul 2026	21	Usual	Hit and miss	n/a	Alert
% pts on single cancer pathway within 62 days	75%	Jun 2026	60%	Improving	Missing target	n/a	Alert
% patients spending <4 hours in A&E/MIU Hywel Dda	95%	Jul 2026	68.1%	Usual	Missing target	n/a	Alert
Ambulance handover > 4 hours Hywel Dda	0	Jul 2026	107	Improving	Missing target	n/a	Alert
Ambulance handovers > 1 hour Hywel Dda	0	Jul 2026	532	Improving	Missing target	n/a	Alert
Ambulance handover > 45 minutes Hywel Dda	0	Jul 2026	672	Improving	Missing target	n/a	Alert
% uptake of RSV vacc - 75+ years	70%	Jun 2026	36.9%	n/a	n/a	n/a	Alert
Median time ambulance emergency category calls	8	Jun 2026	10	n/a	n/a	n/a	Alert
% adult psychological therapy waits <26 weeks	80%	Jun 2026	59.3%	Concerning	Missing target	n/a	Alert
Financial in month deficit	n/a	Jul 2026	£5,052,000	Usual	n/a	Trajectory missed by over 5%	Alert
% R1 eyecare patients waiting within 25% delay to target date	95%	Jun 2026	43.6%	Improving	Missing target	Trajectory missed by over 5%	Advise
% of children who are up to date with scheduled vaccinations by age 5	95%	Mar 2026	87.2%	Usual	Missing target	n/a	Advise
% child neurodevelopment assess waits <26 weeks	80%	Jun 2026	30.3%	Improving	Missing target	n/a	Advise
% therapy interven post LPMHSS assess (age 0-17)	80%	Jun 2026	76.1%	Usual	Hit and miss	n/a	Advise
Pts 12yrs+ with diabetes receiving all 8 NICE care processes	50%	Jul 2026	45.0%	Improving	Missing target	n/a	Advise
% of children receiving HPV by age 15	90%	Mar 2026	79.0%	n/a	n/a	n/a	Advise
% uptake of flu vacc - 65+ years	75%	Mar 2026	71.0%	n/a	n/a	n/a	Advise
Follow-up appts - delayed >100%	11387	Jul 2026	14,232	Improving	Missing target	n/a	Advise
E. coli BSI: Number of hospital onset cases (in-month)	5	Jul 2026	8	Usual	Hit and miss	n/a	Advise
Total days delayed for Pathways of Care delayed discharges	n/a	Jul 2026	5,919	Improving	n/a	n/a	Advise
Median time ambulance arrest category calls	8	Jun 2026	7	n/a	n/a	n/a	Advise
S. aureus (MSSA) BSI: Number of laboratory confirmed cases (in-month)	8	Jul 2026	4	Usual	Hit and miss	n/a	Advise
% MH assess within 28 days (age 0-17)	80%	Jun 2026	83.9%	Usual	Hit and miss	n/a	Assure
% MH assess within 28 days (age 18+)	80%	Jun 2026	95.3%	Usual	Hitting target	n/a	Assure
% therapy interven post LPMHSS assess (age 18+)	80%	Jun 2026	95.8%	Usual	Hitting target	n/a	Assure
Coding: % clinically coded - 1 month post discharge	95%	May 2026	97.3%	Usual	Hit and miss	n/a	Assure

Alert (may require discussion): Lack of confidence any action in place is sufficient to address the issue satisfactorily and/or within the scope of the team/executive to resolve. Engagement, action or intervention required.
Advise (to monitor): There are areas of concern where assurance has been taken on actions in place but requires close monitoring. An early warning of an emerging and potentially serious concern.
Assure (to note): There is confidence that actions are robust and will be sufficient to address the issue or generally operating effectively. Routine monitoring

Triangulating our data: 1st April 2022 to 31st July 2026.

- Quality safety and risk – the number of incidents causing moderate harm or above reported by month is (150) in July 2026, performance has been relatively static since December 2025. July showed a slight decrease in the number of patient falls (209) and medication errors (106) to the previous month. Cases of pressure damage decreased slightly from June (83) to July with (70) cases. There has been a sustained decrease in the number of new complaints received since September 2025 (249) with (51) in July. We continue to have significant numbers of high and extreme risks on the risk register with 575 in July 2026. The number of new infections decreased in July reporting 73 cases (S. aureus = 4 cases, E. coli = 32 cases, C. difficile = 22 cases).
- Workforce – In month, staff sickness decreased slightly to 6.6% in July. Short-term sickness decreased to 1.82% from previously 2% whilst long-term sickness remained static at 4.7%. Note: The sickness metric reported in the alert section of this SBAR includes 12-month rolling data. Nursing and midwifery agency usage continues to remain static since March 2025 (91.72) with July recording 52.81 whole time equivalent (WTE). Rolling 12-month staff turnover percentage has decreased slightly to 6.2%, lowest recorded.

Quality, safety and risk	Best	Worst	Latest	Trend
Reported incidents causing moderate harm or above	131	305	150	
Patient falls	189	301	209	
Medication errors	61	148	106	
Pressure damage developing or worsening during care	54	215	70	
New complaints by month received (	51	249	51	
Number of high and extreme risks (health board & function only)	381	588	575	
Infections: new cases	51	80	73	
Infections: C. difficile cases	8	22	22	
Workforce				
Number of staff/contractor related incidents	98	186	125	
Sickness - short term	1.7%	2.6%	1.8%	
Sickness - long term	3.8%	4.9%	4.7%	
Number of vacancies	To follow			
Staff turnover (12 month rolling)	6.2%	9.8%	6.2%	
Nursing and midwifery vacancies	To follow			
Nursing and midwifery agency (WTE)	52.81	379.79	52.81	
Bank (WTE)	212.99	352.85	307.62	

Internal escalation

Health board internal escalation level overview as at 31 July 2026

1	Reasonable assurance
2	Limited assurance
3	No assurance
4	No assurance and insufficient actions/engagement

	Function	Quality & safety	Governance	Workforce	Finance	Strategy, planning and fragile services	Population Health	Performance
Clinical Care Groups	Community and Integrated Medicine	3	3	3	4	3	2	3
	Chief Operating Officer Management	1	1	2	2	1	1	n/a
	Mental Health and Learning Disabilities	3	1	2	3	3	3	3
	Planned and Specialist Care	3	2	3	4	3	2	3
	Primary Care	2	1	2	1	2	2	3
	Operational Allied Health and Health Sciences	2	1	2	3	3	1	3
Executive Functions	Estates and Facilities	2	1	2	3	1	2	3
	Executive Director of Finance	1	2	1	1	1	2	n/a
	Medical	1	1	2	1	1	2	n/a
	Pharmacy and Medicines Management	1	1	2	2	1	2	n/a
	Executive Director of Nursing, Quality and Patient Experience	1	2	1	1	1	2	3
	Executive Director of Public Health	1	1	3	1	1	1	2
	Executive Director of Strategy and Planning	1	1	1	1	1	3	n/a
	Long Term Agreements (LTAs)	n/a	n/a	n/a	3	n/a	n/a	n/a
	Executive Director of Workforce and Organisational Development	1	1	1	1	1	1	n/a
	Governance and Communication	1	1	1	1	1	2	n/a

Community & Integrated Medicine and Planned & Specialist Care Clinical Care Groups (CCG) were escalated to level 4 for the Finance domain last month and remain at level 4 to date. Community & Integrated Medicine have been escalated up to level 3 for Workforce and Planned & Specialist Care have been escalated up to level 3 for Quality and Safety.

Community & Integrated Medicine is our most concerning CCG, with the function being escalated to level 3 or 4 in 6 out of the 7 improvement domains with very limited signs of improvement. Key issues for the CCG include the management of incidents/complaints, hospital acquired infections, overdue risks & risk actions, overdue audit & inspection recommendations, overspent, significant gap on savings delivery, support for inpatient smokers, business continuity planning, ambulance handover delays, A&E waits and pathway of care delays.

Please see the supporting document *Internal Escalation Update: August 2026* for further details.

Argymhelliad / Recommendation
The Committee is asked to **DISCUSS** the IPAR – Month 4 2026/2027 and internal Escalation report and to **SEEK ASSURANCE** on the operational delivery of mitigating actions to improve performance in the areas that have been categorised as 'alert'.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Cyfeirnod Cylch Gorchwyl y Pwyllgor: Committee ToR Reference:	2.1.1 The financial performance and delivery against Health Board financial plans and objectives and • give early warning of potential performance issues, • make recommendations for action to continuously improve the financial position of the organisation, • focus on the financial impact of in-year and medium-long term plans, the impact of financial issues on service delivery, quality and patient experience, and any specific issues where financial performance is showing deterioration or there are areas of concern. 2.1.2 The overall performance and delivery against Health Board plans and objectives, including delivery of key targets, giving early warning on potential performance issues and making recommendations for action to continuously improve the performance of the organisation and, as required focus on specific issues where performance is showing deterioration or there are issues of concern
Cyfeirnod Cofrestr Risg Datix, Teitl a Sgôr Risg Cyfredol: Datix Risk Register Reference and Score:	Risks are outlined throughout the report.
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	7. All apply
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	6. All Apply

Amcanion Strategol y BIP: UHB Strategic Objectives:	All Strategic Objectives are applicable
Nodau Cynllunio 2026/27 Planning Goals 2026/27	All Planning Goals Apply
Hypergyswllt i Amcanion Llesiant HDdUHB 2026 Hyperlink to HDdUHB Well-being Objectives 2026	9. All HDdUHB Well-being Objectives apply
Model Cymdeithasol ar gyfer Iechyd a Llesiant: (wedi'i gwblhau ar gyfer newid strategol a/neu newidiadau sylweddol i wasanaethau) A Social Model for Health and Wellbeing: (*complete for strategic change and/or significant service changes)*	Not Applicable
Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	2026/2027 NHS Performance Framework
Rhestr Termau: Glossary of Terms:	A&E – Accident and Emergency BGH – Bronglais Hospital ED – Emergency Department GGH – Glangwili Hospital IPAR – Integrated Performance Assurance Report MIU – Minor Injury Unit PPH – Prince Philip Hospital PODCC – People, Organisational Development and Culture Committee SPC – Strategy and Planning Committee FPC – Finance and Performance Committee WAST – Welsh Ambulance Services University NHS Trust WGH – Withybush Hospital
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y cyfarfod hwn: Parties / Committees consulted prior to this meeting:	Operations, Finance, Performance, Quality and Safety, Nursing, Information, Workforce, Mental Health, Therapies and Primary Care Strategy and Planning Committee

	People, Organisational Development and Culture Committee Finance and Performance Committee

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	Better use of resources through integration of reporting methodology
Ansawdd / Gofal Claf: Quality / Patient Care:	Use of key metrics to triangulate and analyse data to support improvement.
Gweithlu: Workforce:	Development of staff through pooling of skills and integration of knowledge
Tegwch Iechyd: Health Equity:	Better use of resources through integration of reporting methodology
Risg: Risk:	Better use of resources through integration of reporting methodology
Cyfreithiol: Legal:	Better use of resources through integration of reporting methodology

Enw Da: **Reputational:**	A number of our national performance measures have been showing concerning trends over a period of time. The SBAR outlines the issues impacting our capacity, which has subsequent impact on our performance. Over time, there is potential for our performance to have an adverse impact on our reputation as a Health Board, which then may impact recruitment and staff morale.
Gyfrinachedd: **Privacy:**	Not Applicable
Cydraddoldeb: **Equality:**	Not Applicable

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

Integrated Performance Assurance Report (IPAR) Overview

As at 31st July 2026



For further details see the latest IPAR dashboard.

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Overview
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Referral to treatment
Ophthalmology R1 (high-risk patients)

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Emergency departments – Hywel Dda
Ambulances – Bronglais Hospital
Emergency departments – Bronglais Hospital
Ambulances – Glangwili Hospital
Emergency departments – Glangwili Hospital
Ambulances – Prince Philip Hospital
Emergency departments – Prince Philip Hospital
Ambulances – Withybush Hospital
Emergency departments – Withybush Hospital
Pathway of Care Delays (PoCD)

Cancer
Single cancer pathway

Mental Health
Mental health assessments within 28 days
Therapeutic interventions following primary mental health assessment
Psychological therapy waits
Neurodevelopmental assessment waits

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E.coli cases and S. Aureus

Workforce
Staff sickness

Finance
Financial Deficit

Appendix A
Summary Metric by Type

Statistical process control (SPC) charts

Why use SPC charts? Anatomy of a SPC chart I al variation within SPC charts Understanding SPC icons

The key metric summary table below has been revised to reflect changes to the 2026/27 performance framework, ministerial priorities and other local key performance metrics and is broken down my metric type in **Appendix A**.
Additional data, details of key issues and actions being taken to address can be found in the supporting document *IPAR overview*.
For data on all performance measures we are tracking, see our IPAR dashboard: Integrated Performance Assurance Report (IPAR) dashboard as at 31st July 2026.

Metric	Target	Period	Actual	Variation	Assurance	Trajectory	3A
% sickness absence rate of staff	6.20%	Jul 2026	6.81%	n/a	n/a	n/a	Alert
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Median time ambulance arrest category calls	8	Jun 2026	7	n/a	n/a	n/a	Advise
S. aureus (MSSA) BSI: Number of laboratory confirmed cases (in-month)	8	Jul 2026	4	Usual	Hit and miss	n/a	Advise
% MH assess within 28 days (age 0-17)	80%	Jun 2026	83.9%	Usual	Hit and miss	n/a	Assure
% MH assess within 28 days (age 18+)	80%	Jun 2026	95.3%	Usual	Hitting target	n/a	Assure
% therapy interven post LPMHSS assess (age 18+)	80%	Jun 2026	95.8%	Usual	Hitting target	n/a	Assure
Coding: % clinically coded - 1 month post discharge	95%	May 2026	97.3%	Usual	Hit and miss	n/a	Assure

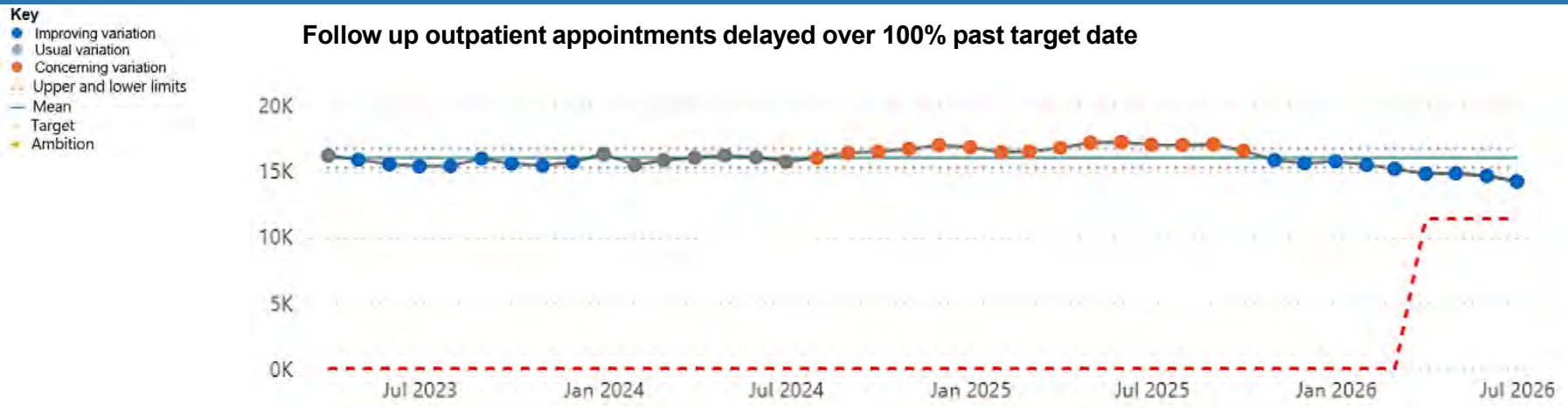
Alert
(may require discussion)
There is a lack of confidence that any action in place is sufficient to address the issue satisfactorily and/or within the scope of the operational team or executive to resolve. Engagement, action or intervention required.

Advise
(to monitor)
There are areas of concern where assurance has been taken on actions in place but requires close monitoring. An early warning of an emerging and potentially serious concern.

Assure
(to note)
There is confidence that actions are robust and will be sufficient to address the issue or generally operating effectively. Routine monitoring.

Delayed follow up appointments

(Enhanced monitoring condition and Ministerial priority)



Performance is showing improving variation with 14,232 follow ups delayed over 100% of their target date at the end of July 2026. This is the best performance we have recorded. The national target is to reduce this position to 11,387 (a 25% reduction from the March 2026 baseline of 15,182).

Key challenges / issues	Key actions / initiatives	Due date
• Initiatives for reducing new outpatient waits have increased follow-up waits as more patients progress through pathways. • Reducing follow up waiting lists continues to be challenging in terms of clinical engagement in some specialties. • Certain specialties have essential follow up pathways and may have additional pressure to reduce significantly due to case mix.	• Outpatient Transformation Programme in place, with targeted actions for each specialty covering all National Planned Care Programme priorities, including referral management, clinical triage, and maximising the use of self-management pathways like See on Symptoms (SoS)/Patient Initiated Follow Up (PIFU). • Specialties are converting all follow up patients waiting from 2024 to SOS/PIFU be end of July with exception of Ophthalmology that have an ongoing program which is delivering sustained reductions and have delivered over 1000 reduction in 2026. • A programme of work to deliver the Outpatient Transformation Programme commenced on 13 July 2026. This programme led by the Clinical care Group (CCG) Associate Medical Director, with support from the Executive Medical Director, to drive transformational change, optimise outpatient pathways, and deliver sustainable improvements in access, productivity, and patient outcomes. • Delayed follow-up wait reduction to below 12,000 supported by national clinical leadership and CIN (Clinical Implementation Network) guidelines was not met at the end of March 2026. However, improvements across many specialties are seen in 2026/27 with increased clinical validation, referring mild glaucoma patients back into primary care and use of CIN guidelines. This continues throughout 2026/27.	31/03/27 31/07/26 30/09/26 31/03/27

Waits over 26 and 52 weeks for a first outpatient appointment

(Enhanced monitoring condition and Ministerial priority)

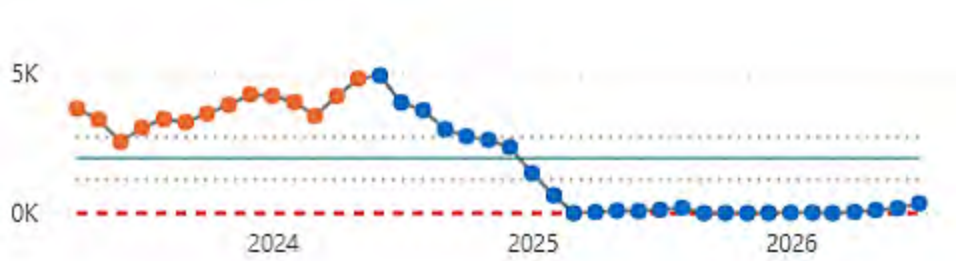
Key
- Improving variation
- Usual variation
- Concerning variation
- Upper and lower limits
- Mean
- Target
- Ambition

Patients waiting >26 weeks for a first outpatient appointment



In July 5,035 patients were waiting over 6 months for a first out-patient appointment in-line with the expected trend in the Annual Plan. The chart is showing improving variation, however breaches have increased for the last 3 months.

Patients waiting >52 weeks for first outpatient appointment



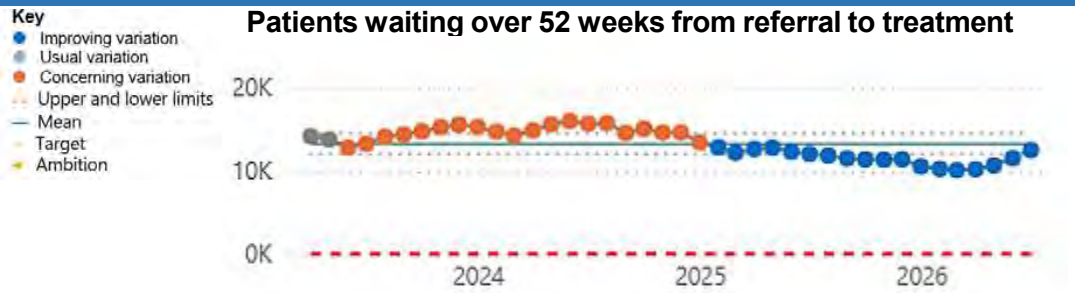
The same 3 month declining trend is present for patients waiting over one year . In July there were 351 patients waiting over 52 weeks for a new out-patient appointment.

Key challenges / issues	Key actions / initiatives	Due date
• The Health Board breached the 52-week outpatient target by a total of 351 in July 2026 with breaches recorded in General Medicine (163), Care of the Elderly (48), Rheumatology (109) and Neurology (31).	• We continue to focus on maintaining waiting time targets in 2026/27 using demand and capacity forecasts to highlight risks and guide funding allocation.	31/03/27
	• The Health Board has submitted its Board-approved Planned Care Delivery and Sustainability Plan 2026/27, setting out a comprehensive recovery and sustainability programme aligned to the national Planned Care, Cancer and Diagnostics Improvement Framework. The Plan demonstrates productivity, transformation and pathway redesign activity already delivered, whilst identifying residual demand and capacity challenges across a small number of specialties and diagnostic services. The submission includes a total recovery funding request of £15.497m, representing the residual investment requirement after productivity and transformation opportunities have been pursued. The Health Board is now awaiting the outcome of the Welsh Government/NHS Wales Performance & Improvement review, while continuing to refine delivery trajectories, maximise further productivity opportunities and progress regional solutions to support 104-week RTT recovery, diagnostic recovery and longer-term service sustainability.	31/08/26
• Colorectal, Vascular, Trauma and Orthopaedics, Gastroenterology, Diabetic Medicine, Rehabilitation, met the 26-week outpatient target in July 2026; however, 4,814 breaches were recorded in total across all specialties. Current performance is within the forecast level reflected in the Annual Plan. This is inline with the forecast breach volumes agreed by the Board via the Annual Plan.	• Performance metrics are reviewed for all outpatient pathways on a weekly basis, with cohorts of 26, 36 and 52 weeks being performance managed across all specialties.	31/03/27
	• Outpatient Transformation Programme in place, with targeted actions for each specialty covering all National Planned Care Programme priorities, including referral management, clinical triage, and maximising the use of self-management pathways like See on Symptoms (SoS)/Patient Initiated Follow Up (PIFU).	31/03/27

Waits over 52 and 104 weeks from referral to treatment (RTT)

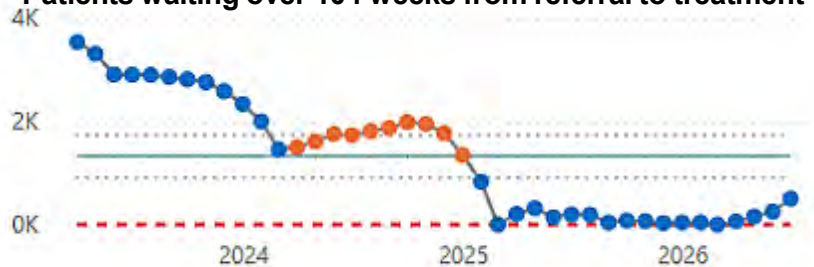
(Enhanced monitoring condition and Ministerial priority)

Patients waiting over 52 weeks from referral to treatment



Following an improving trend up to March this year, breaches have been steadily increasing with a total of 12,524 patients waiting over a year for treatment in July.

Patients waiting over 104 weeks from referral to treatment



Breaches have significantly increased in the last 3 months and are the highest since August 2025. In July there were 504 patients waiting over a year 2 years for treatment..

Key challenges / issues

- There is a demand and capacity gap to be investigated for efficiency and productivity actions to be identified. The Health Board recorded 504 patients waiting over 104-week at the end of July.
- The 104-week RTT rise in breaches rise remain within the forecast maximum level agreed in the Annual Plan. Current performance remains below that forecast trajectory, reflecting the impact of validation, productivity improvements, outpatient transformation and targeted recovery actions. The Health Board has now submitted its Board-approved Planned Care Delivery and Sustainability Plan 2026/27, including a £15.497m recovery funding request, and is awaiting the outcome of the Welsh Government and NHS Wales Performance & Improvement review. Work continues to maximise further productivity opportunities and regional solutions whilst supporting delivery of the agreed recovery trajectory and longer-term service sustainability.
- Patient complexity and co-morbidities affect suitability for outsourced or day-case procedures, affecting treatment timelines.
- Getting It Right First Time (GIRFT) ambitions are influenced by clinical confidence and preoperative process variations across specialties.
- Additional risks include prioritisation of cancer backlogs, and urgent cases consuming rescheduled theatre slots.
- Inpatient/day case activity exceeds pre-pandemic levels, but challenges remain with late starts, early finishes, and fallow (non-utilised) theatre lists due to workforce constraints

Key actions / initiatives

	Due date
• We continue to focus on maintaining waiting time targets in 2026/27, as agreed by the Health Board, by using demand and capacity forecasts to highlight delivery risks.	31/03/27
• The Health Board has submitted its Board-approved Planned Care Delivery and Sustainability Plan 2026/27, setting out a comprehensive recovery and sustainability programme aligned to the national Planned Care, Cancer and Diagnostics Improvement Framework. The Plan demonstrates productivity, transformation and pathway redesign activity already delivered, whilst identifying residual demand and capacity challenges across a small number of specialties and diagnostic services. The submission includes a total recovery funding request of £15.497m, representing the residual investment requirement after productivity and transformation opportunities have been pursued. The Health Board is now awaiting the outcome of the Welsh Government/NHS Wales Performance & Improvement review, while continuing to refine delivery trajectories, maximise further productivity opportunities and progress regional solutions to support 104-week RTT recovery, diagnostic recovery and longer-term service sustainability.	31/08/26
• Theatre Optimisation workstream led by the Clinical Care Group and supported by the Medical Director aims to improve productivity and meet GIRFT standards across specialties. This includes a full staffing review and implementing evidence-based guidelines on appropriate staffing and list loading per procedure bundle with a view to eliminating variation between sites.	30/09/26

Embedded improvement actions

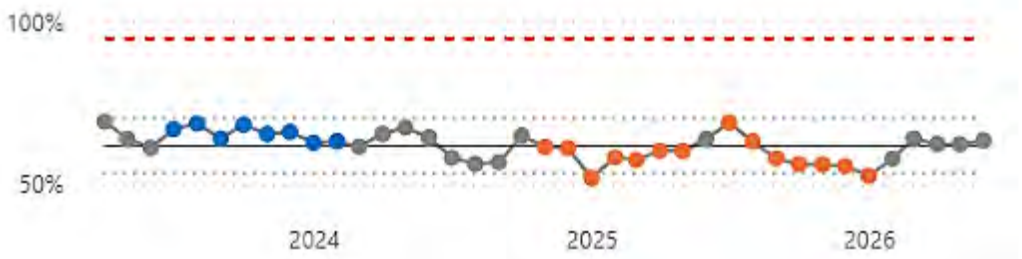
104-week breach volumes were lower than levels forecast in July 2026 due to:

- Additional outsourcing in March 2026, lowering overall cataract waiting times in Ophthalmology to below 100 weeks. This outsourcing continued into May 2026 for any cataract pathway procedures commencing initial treatment with outsourcing provider before the end of March 2026, funded from 2025/26 recovery money.
- Impact of ROTT (removals for reasons other than treatment) in July 2026 were higher than levels modelled in the Annual Pla asts.

Ophthalmology R1 (high-risk patients) performance
(Targeted intervention)

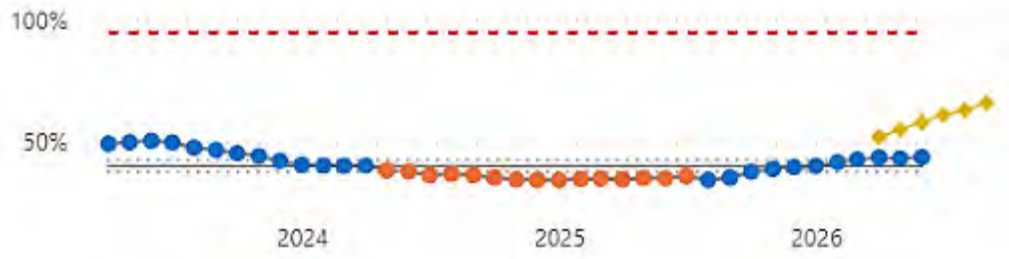
Key
- Improving variation
- Usual variation
- Concerning variation
- Upper and lower limits
- Mean
- Target
- Ambition

% R1 appointments attended which were within their clinical target date or within 25% beyond their clinical target date



Performance has been between 62% and 64% for the last 4 reported months and shows usual variation. Latest data is 63.5% for June 2026.

% R1 appointments waiting within their clinical target date or within 25% beyond their clinical target date

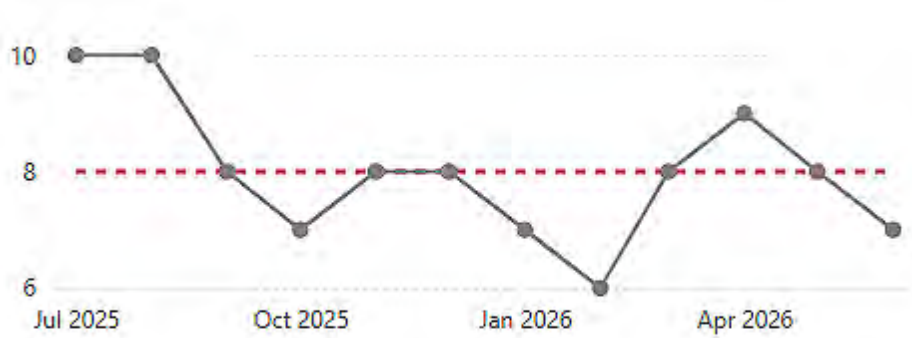


Performance shows improving variation at 43.6% in June 2026, highest performance since November 2023, with incremental improvements since August 2025. However, we are off our recovery trajectory (58%).

Key challenges / issues	Key actions / initiatives	Due date
• The advice from Welsh Government is to focus on patients waiting as these are higher risk. Booking these patients, who have already breached, will improve this trajectory but will directly affect the appointments attended trajectory as patients have already breached. Once corrected, R1 appointments attended will improve as capacity grows and backlog reduces. • Increasing outpatient delivery has been stalled by outpatient staffing and medical records constraints along with staff sickness. • Reduced workforce continues to impact delivery, with vacancies across key delivery roles e.g. Consultant, Associate Specialist and Specialty Doctor (SAS) posts. Recruitment efforts continue • Reduced Specialty Associate Specialist (SAS) capacity from September 2025 to May 2026 resulted in the loss of 10 sessions per week. • One regional consultant post is still vacant. This has impacted the ability for additional outpatient sessions for medical retinopathy patients. • Due to management absence across both administrative and nursing teams resulting from sickness, our ability to proactively support performance and has been temporarily affected; this will be addressed as capacity is restored.	• The actions below are to improve performance in line with the forecast volumes agreed as part of the annual plan process. • Monies awarded to reduce waits for intravitreal (IVT) injections have been used to recruit and train staff, supporting improved performance. Activity is being increased incrementally. A key next step is to expand the IVT service into Amman Valley Hospital (AVH) outpatient settings. Periphery sites are also being scoped to support patients having treatment closer to home (i.e., Debenhams Carmarthen and Cross Hands Integrated Care Centre. • Outpatient staff will be increased to support outpatient activity in the Blue Suite in Glangwili Hospital (GGH). This will allow for the incremental increase in clinic delivery. This requires staff to be recruited and on-boarded in Ophthalmology. • The team are exploring more innovative methods of supporting outpatient activity using Ophthalmology Technicians. • One SAS doctor position is currently out to advert with a Consultant post also being progressed via the NHS recruitment (TRAC) system • The service are working with regional colleagues to create a deliverable sustainable cataract plan for 26/27 whilst also scoping a plan to meet the 104-week RTT target by 1st April 2027.	01/09/26 01/10/26 01/10/26 01/09/26 01/04/27

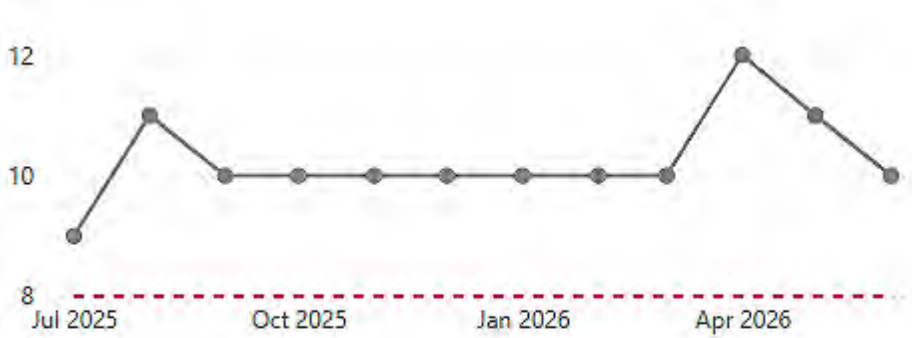
Key
- Improving variation
- Usual variation
- Concerning variation
- Upper and lower limits
- Mean
- Target
- Ambition

Median emergency ambulance response time to purple: arrest category calls



In June, the median response time was 07:17 minutes for ARREST (Purple) Calls. There were 127 ARREST calls. Official WAST data is delayed by 1 additional reporting month.

Median emergency ambulance response time to red: emergency category calls



In June the median response time was 10:08 minutes for RED (Emergency) calls there were 623 calls. Official WAST data is delayed by 1 additional reporting month

Key challenges / issues

- Unverified July performance was 09:27 minutes for arrest (133 incidents) and 10:14 minutes for emergency calls (631 incidents). Overall attended demand in Hywel Dda Health Board area for July 2026 has been above forecast.
- Adverse heat continues to be a pressure for the Trust with associated calls, seen in the deterioration of Arrest performance and of the increase in these type of calls over June 2026.
- Hospital delays in ambulance handover for Welsh Ambulance Service Trust (WAST) ambulance crews, 2,509 hours lost at the 4 acute Hywel Dda hospital sites during July 2026, a slight improvement in performance from June 2026.
- Notification to Handover within 15 minutes was at 37.03% in July for the 4 acute general hospitals, showing slight improvement over June 2026.
- WASTs financial picture from April 2026 has seen overtime reduced, resulting in decisions about cover to maximise performance, and reductions short notice in Unit Hour Production (UHP) from staff absences.

Embedded improvement actions

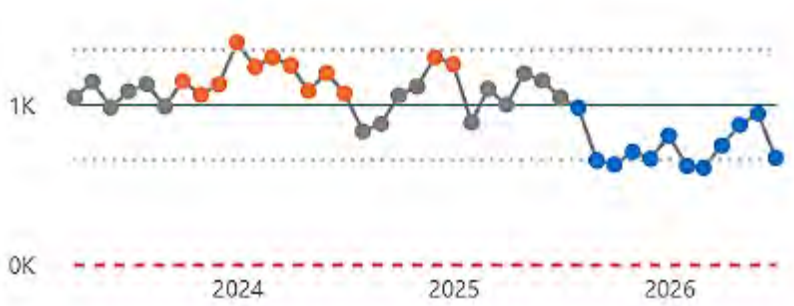
- Ongoing reviews of WAST resource escalation action plan (REAP) which identifies potential service pressures and is a system for managing and mitigating the impacts.
- Dynamic review of demand and area specific pressures using the clinical safety plan. Clinical safety plan provides a framework for WAST to respond to situations where the demand for services is greater than the available resources.
- Same day emergency care (SDEC) access for WAST clinicians. SDEC extended to front door of ED – positive feedback from clinicians. Consultant connect is being in the process of being updated.
- 111 press 2 assisting WAST clinicians to support the management of mental health patients.
- Porth Preseli and Eastgate clinical streaming hubs staffed with Advanced Paramedic Practitioners supporting multidisciplinary approach to admission avoidance and to support equitable coverage in Pembrokeshire and Carmarthenshire. Improvements being made with uplifting cover as additional APPs complete necessary training.
- WAST resourcing reviews and targeted overtime allocation.
- Wait 45 initiative implemented, which will reduce length of ambulance wait times outside emergency departments, and project group now established with Senior Managers to deliver NHS Performance & Improvement actions. These meetings are now weekly for urgent progress.
- WAST managers joining 10 am Patient Flow call from May 2026 to further support integrated working n, furthering joint understanding of risk and flow.

Urgent and Emergency Care – Ambulance and Emergency Departments / Minor Injury Units - Health board wide

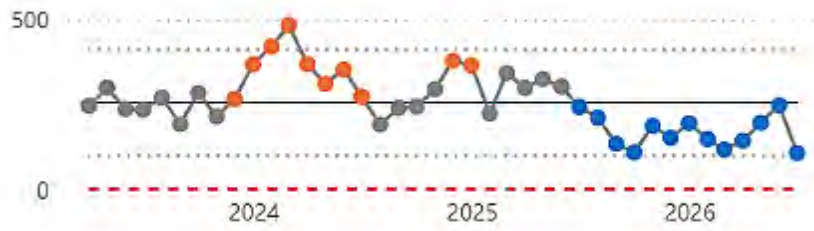
(Targeted intervention and Ministerial priority)



Ambulance handovers taking over 45 minutes



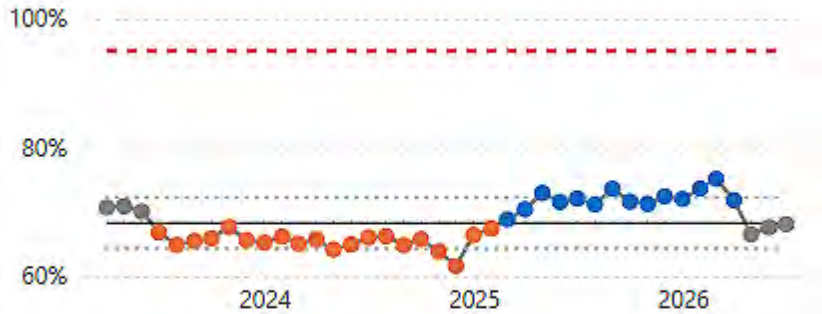
Ambulance handovers taking over 4 hours



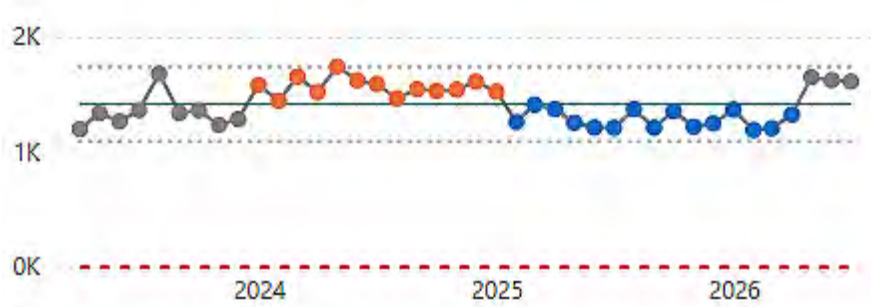
>45 Minutes handovers:
Latest data is showing improving variation, 672 handovers > 45 minutes out of a total of 2,117 handovers.

>4 hours handovers:
Latest data is showing improving variation, 107 handovers > 4 hour out of a total of 2,117, 5%.

Patients waiting less than 4 hours in A&E/MIU



Patients waiting over 12 hours in A&E/MIU



Waits < 4 hours:
Latest data is showing usual variation and performance has improved marginally to 68.08% of patients were seen within 4 hours. 11,888 out of 17,462 new attendances.

Waits > 12 hours:
Latest data is usual variation and performance has slightly improved. 1,613 patients waited over 12 hours, out of 17,462 new attendances, 9.2%.

Key actions / initiatives – tactical urgent and emergency programme

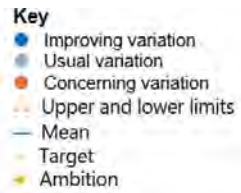
The Urgent and Emergency Care (UEC) Programme delivery is focused on implementing the national Six Goals through a whole-system approach, including strengthening community-based alternatives (e.g. falls response and prevention services), improving front-door streaming and Same Day Emergency Care (SDEC), and reducing avoidable admissions and delays. Central to this is the development of the Seven-Day Clinical Streaming, SDEC, refreshed 45-minute ambulance handover improvements plan and Hospital@Home business case, which builds on pilot evidence and national guidance to transition services from weekday to 7-day provision. This aims to improve patient flow, enhance outcomes, and align with ministerial priorities by enabling earlier intervention, reducing emergency department demand, and supporting a sustainable 'shift-left' model of care across acute and community pathways. Currently the Go-Live date for Seven-Day Clinical Streaming and Hospital@Home is October 2026, and a 7-day SDEC service at WGH being November 2026.

Please see the updates for each of our 4 acute site for the relevant issues faced and key actions we are taking to address:

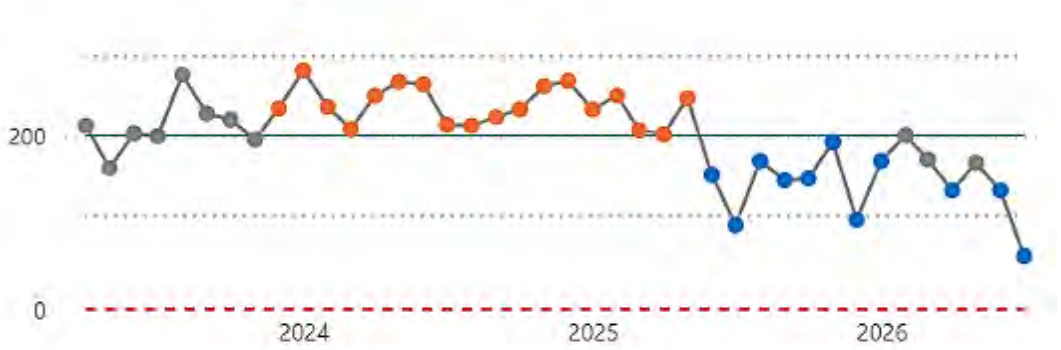
- Bronglais Hospital
- Glangwili Hospital
- Prince Philip Hospital
- Withybush Hospital

Urgent and Emergency Care – Ambulances – Bronglais Hospital

(Targeted intervention and Ministerial priority)

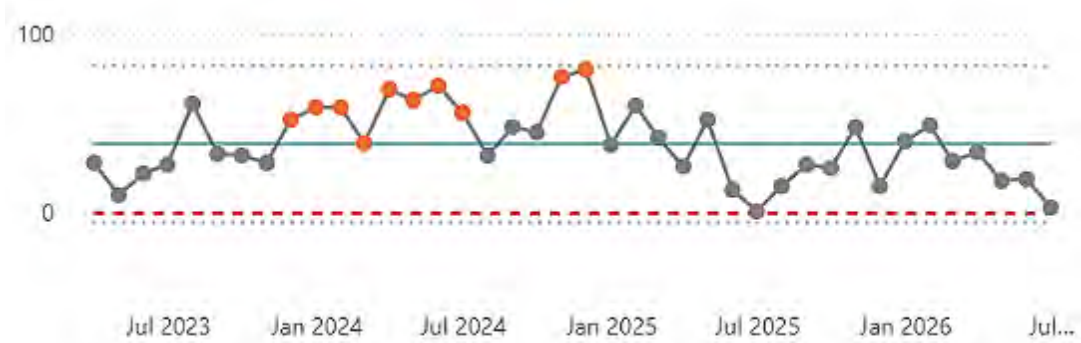


Ambulance handovers taking over 45 minutes



Latest data is showing improving variation. 62 handovers >45 minutes reported out of a total of 362 handovers, 17%.

Ambulance handovers taking over 4 hours



Latest data is showing usual variation. 3 handovers >4 hours was reported out of 362 total handovers 0.8%.

Key challenges / issues

- Emergency Department (ED) crowding leading to a lack of available clinical space.
- High patient acuity and complexity requiring longer assessment times before handover. Extreme Heat events have contributed to increased acuity and has triggered peaks in demand
- Insufficient inpatient bed capacity causing delays in patient flow through the hospital.
- Delayed discharges creating bottlenecks and reducing ED capacity. High levels of clinically optimised patients occupying inpatient beds impacting timely transfers to wards. Delayed transfers of care affecting patient flow - downstream capacity.
- Surges in patient demand (winter pressures, seasonal illnesses, major incidents) causing greater demand than capacity.
- Ambulances arriving in batches of 3 or 4 within a short space of time causes delays.
- Accurately reporting handover times is often a challenge. Requirement of dual pin to ensure handover times are recorded appropriately.
- Limited community capacity and social care packages.
- Sustained emergency demand above available capacity.
- Increase in infection across ward areas resulting in closed beds.
- Limited surge bed capacity across the Acute site.
- Ongoing dual pin challenges with ambulance sign off screen

Key actions / initiatives

Key actions / initiatives	Due date
• Band 8 Senior Nurse Manager appointed and onboarding	01/08/26
• Reconfiguration of the Emergency Department footprint to enhance flow throughout the department – multi disciplinary team (MDT) approach to design.	31/09/26
• ED module for Miya patient flow being introduced	31/10/26
• Close integration with WAST to identify early improvement opportunities and accelerated delivery	31/08/26

Embedded improvement actions

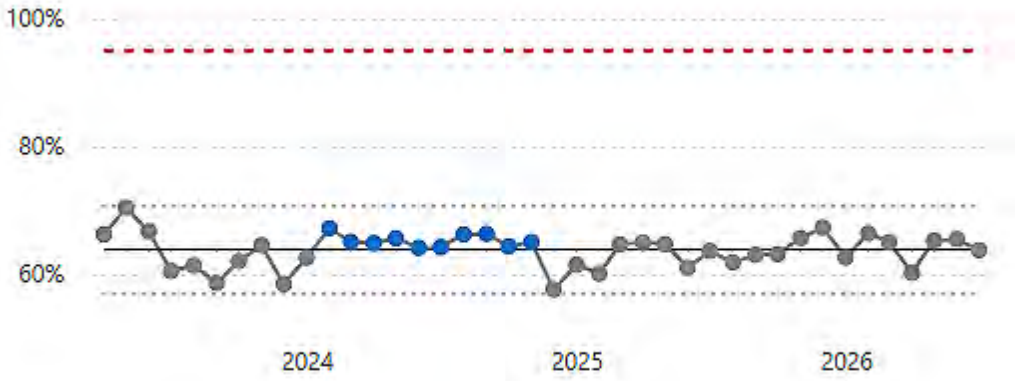
- Increased consultant oversight following appointment of second consultant.
- Enhanced senior ED Navigator oversight through senior sisters.
- Site-wide ward manager meetings with ED Navigators.
- Shared ownership of 45-minute handover performance across Ceredigion Integrated System.
- Senior medical roster review to support decision-making.
- Daily review of clinically optimised patients.
- Real-time senior escalation of ambulance handover performance.
- Enhanced senior clinical decision-making at the front door.
- Newly established weekly MDT touchpoint meeting to review ambulance handover performance, monitor improvement actions, and identify further change ideas, chaired by Assistant General Manager.

Urgent and Emergency Care – Emergency Departments – Bronglais Hospital

(Targeted intervention and Ministerial priority)

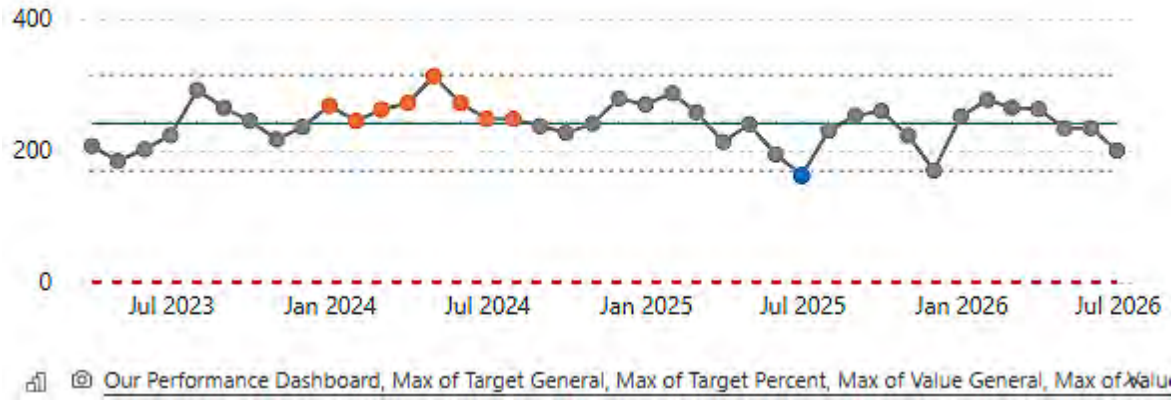


Patients waiting less than 4 hours in A&E/MIU



63.8% latest data, 1,032 breaches out of 2,850 new attendances. Chart is showing usual variation.

Patients waiting over 12 hours in A&E/MIU



200 breaches out of 2,850 new attendances, 7%. The chart is showing usual variation.

Key challenges / issues

- Physical space limitations within the Emergency Department footprint including limited assessment and trolley spaces to absorb ambulance arrivals during peak times leading to overcrowding and corridor usage.
- Limited senior medical workforce across the Ceredigion Acute & Community System can lead to delays in initial assessment, diagnostics and treatment.
- High bed occupancy on wards leading to long lengths of stay and delays in transfers to wards.
- Limited community capacity and social care packages.
- Sustained emergency demand above available capacity.
- Delayed transfers of care affecting patient flow - downstream capacity.
- Increase in infection across ward areas resulting in closed beds.
- Limited surge bed capacity across the Acute site.

Key actions / initiatives

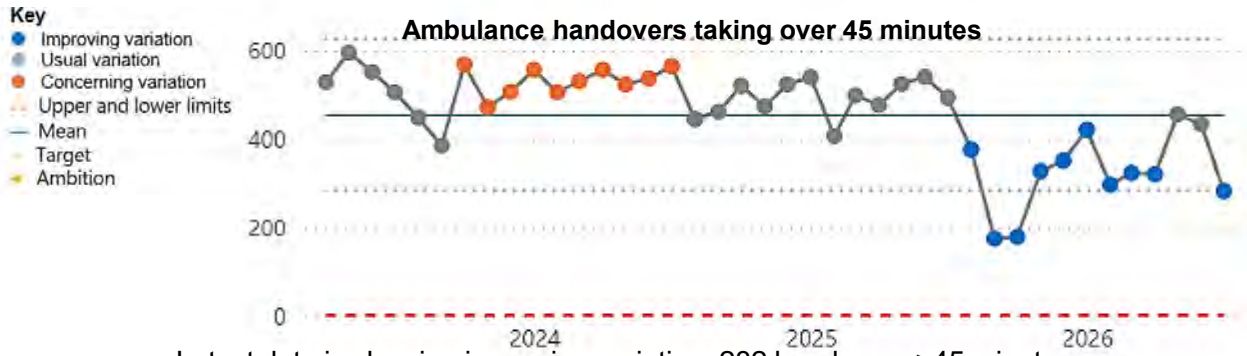
Key actions / initiatives	Due date
• Reconfiguration of the Emergency Department footprint to enhance flow throughout the department - MDT approach to design	31/09/26
• Review of clinical pathways across the Ceredigion Acute & Community System	31/09/26
• Quality Improvement Projects to be initiated across the Emergency Department led by the senior sister team.	01/11/26
• Focussed daily scrutiny on prevention and reduction of 12 hour breaches	31/08/26

Embedded improvement actions

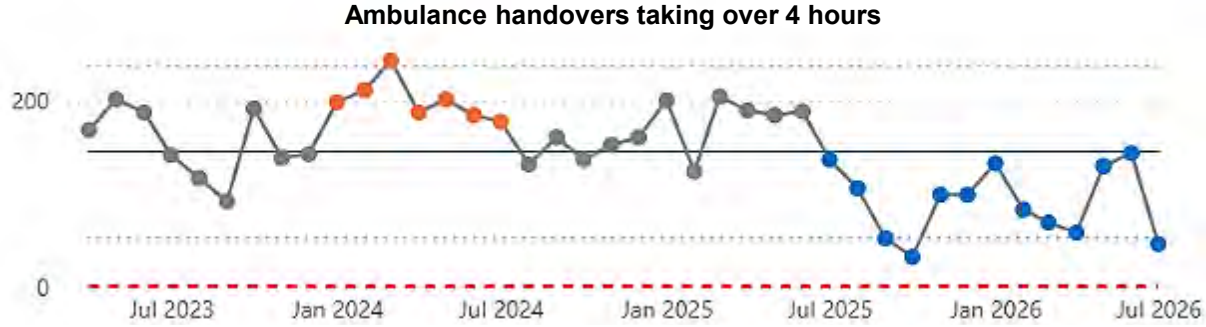
- Successful recruitment of Senior Nurse Manager for the Emergency Department. Start date awaited.
- Increased scrutiny on patients in non clinical areas.
- Review of Your Next Patient
- Daily review of all patients at risk of breaching 12 hours
- Daily review of all clinically optimised patients
- Focus on earlier in the day discharges
- Escalation of delayed pathway of care patients
- artnership working with Local Authority to minimise delays in discharge

Urgent and Emergency Care – Ambulances – Glangwili Hospital

(Targeted intervention and Ministerial priority)



Latest data is showing improving variation. 282 handovers >45 minutes reported out of a total of 805 handovers, 35%.



Latest data is showing improving variation. 46 handovers >4 hours reported out of a total of 805 handovers, 5.7%.

Key challenges / issues

- Although performance has improved, 35% of ambulance handovers (282 of 805) still exceeded 45 minutes, indicating ongoing pressure within patient flow and emergency care pathways.
- Recent improvement needs to be sustained and embedded, as performance remains vulnerable to fluctuations in demand, workforce availability, and bed capacity.
- Delays in discharging medically optimised patients continue to impact inpatient capacity, contributing to ED crowding and longer ambulance handover times.
- Periods of high demand and surge activity can quickly reverse gains, particularly where escalation capacity is limited.
- Continued focus is required on whole-system patient flow, timely admissions, discharges, and effective use of escalation processes to further reduce prolonged handovers.
- Maintaining engagement across acute, community, and partner services remains essential to support continued improvement and reduce variation.

Key actions / initiatives

Key actions / initiatives	Due date
• Continued emphasis on maintaining effective escalation processes, optimising bed utilisation and ensuring available capacity is aligned to periods of peak demand.	31/8/26
• Use of data and statistical process control (SPC) methodology to monitor performance trends, understand variation and support evidence-based operational decision making	31/8/26
• Strengthened focus on whole-system patient flow, including proactive discharge planning, earlier discharge activity and reduction of delays for medically optimised patients.	31/8/26
• Review of ambulance handover performance through operational and executive governance arrangements, with actions tracked and monitored to completion.	30/9/26
• To develop a robust repatriation policy, to return patient back to their local hospitals once the specialist care has ended.	30/9/26
• Approve “Red Line” standard operating procedures in the ED. This is where we can not safely board or surge patients into hospital space/wards.	21/08/26
• Enhance operational oversight and scrutiny of handover delays and breaches, including drawing of themes and trends for learning and opportunities for improvement.	31/12/26
• Continue and strengthen system-wide collaboration with WAST and community partners (including social services) to improve patient flow and reduce ambulance waiting times.	31/12/26

Embedded improvement actions

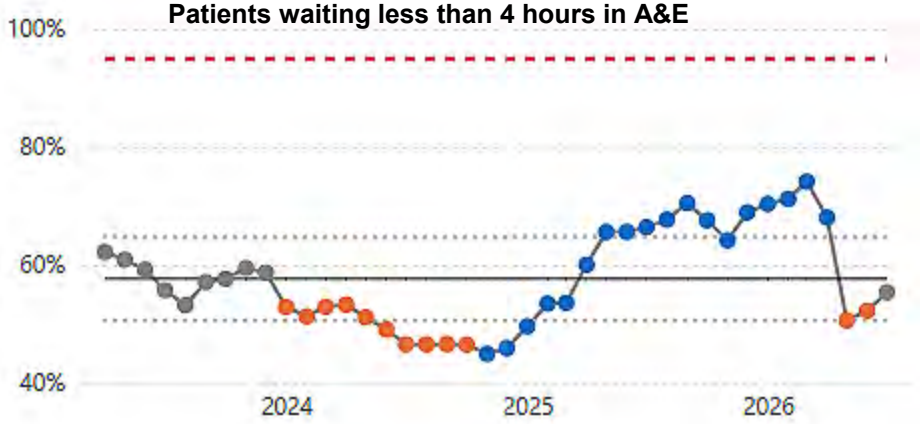
- Continue to monitoring early discharges and the utilisation of the discharge lounge.
- Out of area patient cohort being monitored twice weekly. This enables specialty patient pathways to be managed.
- Clinically optimised patients are reviewed through a structured senior nurse team.
- Escalation process embedded regarding any delay in patent care or patient care pathways delays.
- Same Day Emergency Care (SDEC) team actively "pull" from ED.
- Daily Site Flow Coordination. Site flow calls are embedded to provide real-time oversight of capacity, patient movement, and escalation requirements, ensuring timely [illegible] and prioritisation of transfers

Urgent and Emergency Care – Emergency Departments – Glangwili Hospital

(Targeted intervention and Ministerial priority)

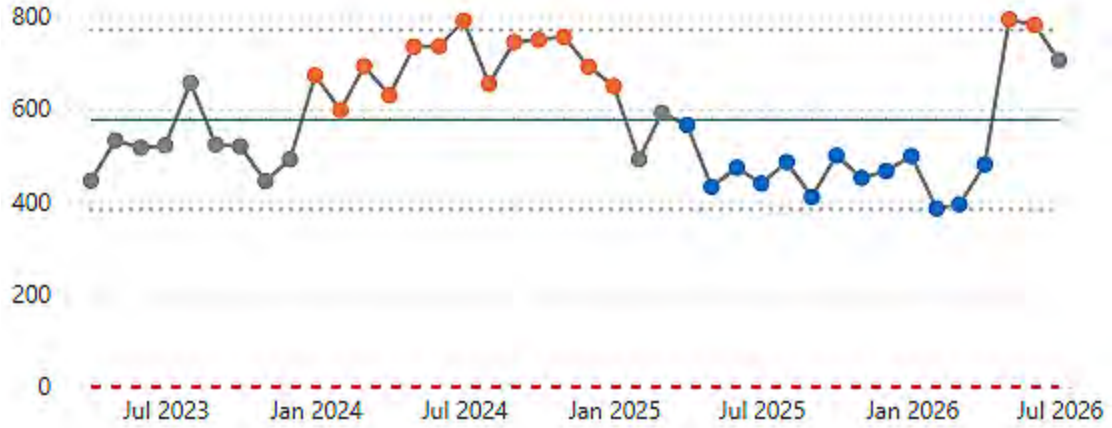


Patients waiting less than 4 hours in A&E



55.4% reported for July, 2,350 breaches out of 5,266 new attendances. Chart is showing usual variation.

Patients waiting over 12 hours in A&E



705 breaches out of 5,266 new attendances, 13.4%. The chart is showing usual variation.

Key challenges / issues

- There was a sharp increase to the number of patients waiting over 12 hours in May 2026. Whilst delays have been stemmed, patient numbers remain high
- Persistent patient flow constraints across the urgent and emergency care pathway continue to impact both 4-hour performance and 12-hour waits.
- Delays in discharge and limited availability of inpatient beds reduce the ability to move patients through the hospital efficiently, contributing to crowding within the Emergency Department.
- Periods of high demand and increased patient acuity place sustained pressure on assessment, treatment and admission processes.
- Workforce pressures, including staffing availability and recruitment challenges, has affect capacity across the pathway.
- Continued levels of ambulatory and admitted patient backlog within the department contribute to longer waits and an increased risk of breaches.
- Despite recent fluctuations, both measures remain significantly below desired performance levels, indicating that system-wide improvement is required rather than isolated operational interventions.

Key actions / initiatives

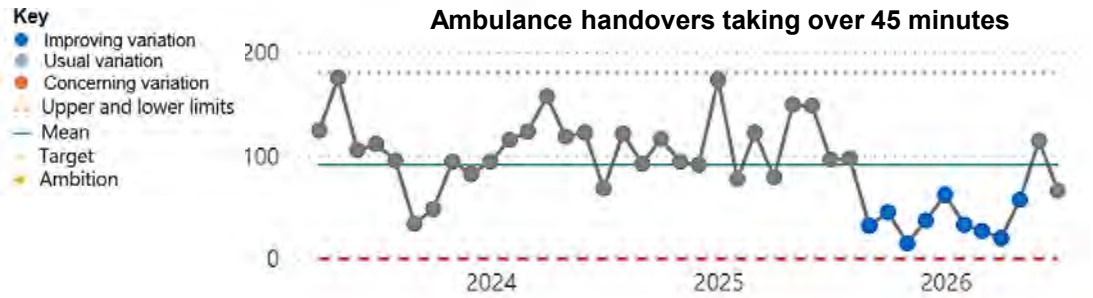
Key actions / initiatives	Due date
• Maintaining focus on discharge planning, escalation management, same-day emergency care, and timely access to specialty beds will be essential to improving patient flow and reducing both 4-hour and 12-hour breaches	30/10/26
• To develop a robust repatriation policy, to return patient back to their local hospitals once the specialist care has ended	30/10/26
• Strengthening Community Pathways. Continued collaboration with the community teams to identify patients suitable for community-based care, enabling earlier discharge and reducing inpatient demand	30/11/26
• Enhance operational oversight and scrutiny of 12-hour delays and breaches in ED, including drawing of themes and trends for learning and opportunities for improvement.	31/12/26

Embedded improvement actions

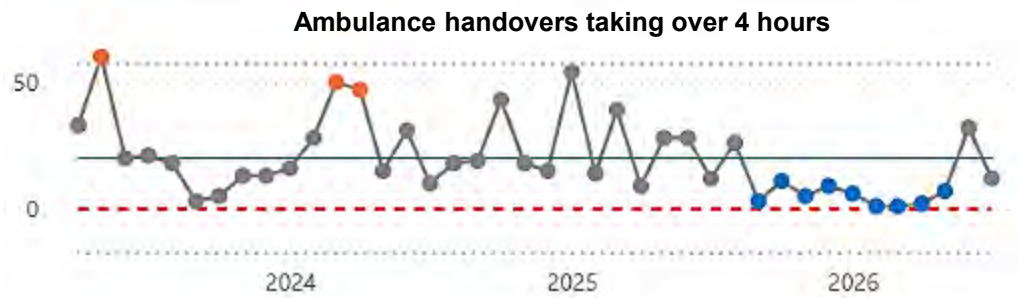
- Continue to monitoring early discharges and the utilisation of the discharge lounge.
- Out of area patient cohort being monitored twice weekly. This enables specialty patient pathways to be managed .
- Clinically optimised patients are reviewed through a structured senior nurse team.
- Escalation process embedded regarding any delay in patent care or patient care pathways delays.
- SDEC team actively "pull" from ED.

Urgent and Emergency Care – Ambulances – Prince Philip Hospital

(Targeted intervention and Ministerial priority)



Latest data is showing usual variation. 66 handovers >45 minutes reported out of a total of 256 handovers, 25.8%.



Latest data is showing usual variation. 12 handovers >4 hours reported out of a total of 256 handovers, 4.7%.

Key challenges / issues

- Key challenges continue to relate to sustained levels of demand, high bed occupancy levels, delayed discharges and workforce pressures. These factors impact bed availability and patient flow across the site, contributing to pressure within the department and assessment areas. Additional challenges include delays associated with complex discharge arrangements, patients accommodated within surge bed areas and maintaining ambulance handover performance during periods of peak demand.
- Demand was exceptionally high during the July month of operational activity at Prince Philip Hospital, resulting in delays. This affected patients through longer waiting times for assessment, treatment and discharge, prolonged stays within the department, and a less timely patient experience overall impact on handover times.
- Adopting boarding system " Our next patient" at the point of admission. Patient boarding is the temporary placement of a patient on a ward that may not be the most clinically appropriate specialty ward when there is insufficient bed capacity in the preferred location. When this capacity is full, it can impact ambulance hand overtime. The boarding process should be supported by clear governance, clinical oversight, and regular review to ensure patient safety and timely transfer to the appropriate specialty ward where possible
- We have continued to handover patients within 45-minute for the majority of our patients, enabling timely transfer of patients from ambulance crews. However, this has increased pressure internally across ward areas, requiring the use of surge capacity to maintain flow.
- Infection Prevention and Control (IPC) issues continued throughout the summer months, requiring the closure of several ward bays, and clinical areas requiring more frequent deep cleans, impacting bed turnaround times. This resulted in several beds being unavailable for use, reducing overall capacity and creating additional pressure on patient flow, admissions and timely placement of patients. However, we are starting to see a reduction in those numbers which is resulting in improved flow.

Key actions / initiatives

Key actions / initiatives	Due date
We mitigate the IPC challenges through regular testing and rapid swabbing of suspected cases. Patients are isolated where appropriate to minimise the risk of transmission and protect bed capacity.	31/08/26

Embedded improvement actions

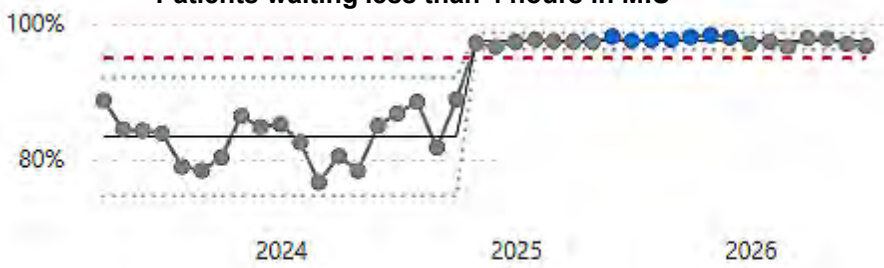
- **Ambulance handovers:** Ambulance handovers: Continue focus on the 45-minute ambulance handover target through close operational oversight, real-time monitoring, and clear escalation processes. The Patient Flow Unit coordinates capacity and demand across sites, enabling earlier identification of pressures, faster decision-making, and timely actions to maintain patient flow and minimise delays.
- **MIU to AMAU transfers:** Medical patients in Minor Injury Unit MIU are prioritised for transfer to AMAU following Registrar referral, ensuring they receive care in the most appropriate setting. Patients are reviewed daily and tracked until transfer. Barriers are escalated promptly, helping improve patient flow, reduce MIU congestion, and protect capacity for urgent injury care.
- **Our Next Patient process:** Multidisciplinary teams actively identify and prepare the next patient for assessment, transfer, admission, or discharge. The 'Our Next Patient' boarding protocol supports early movement into available areas, reducing delays and creating capacity. Escalations are managed through patient flow meetings and the Manager of the Day process to support timely patient placement.

Urgent and Emergency Care – Emergency Departments – Prince Philip Hospital

(Targeted intervention and Ministerial priority)

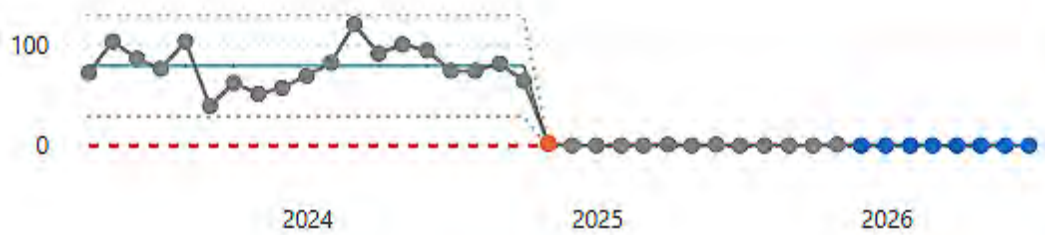


Patients waiting less than 4 hours in MIU



96.7% reported for July, 95 breaches out of 2,884 new attendances. Chart is showing usual variation.

Patients waiting over 12 hours in MIU



Zero breaches out of 2,884 new attendances. Chart is showing improving variation.

Key challenges / issues

Key challenges continue to relate to sustained levels of demand, high bed occupancy levels, delayed discharges and workforce pressures. These factors impact bed availability and patient flow across the site, contributing to pressure within the department and assessment areas. Additional challenges include delays associated with complex discharge arrangements, patients accommodated within surge bed areas and maintaining ambulance handover performance during periods of peak demand.
Demand was exceptionally high during the July month of operational activity at Prince Philip Hospital, resulting in delays. This affected patients through longer waiting times for assessment, treatment and discharge, prolonged stays within the department, and a less timely patient experience overall impact on handover times.

Key actions / initiatives

	Due date
Progress the Urgent Care Centre (UCC) task-and-finish workstreams to develop a sustainable operating model, workforce plan and integrated approach across MIU and SDEC services. Work has continued to focus on the design of future patient pathways, clinical streaming processes, governance arrangements and workforce requirements to ensure the model is responsive to local demand. Collaborative working between teams has strengthened service integration, identified opportunities for role development and skill-mix optimisation, and supported the establishment of a more flexible workforce capable of meeting the needs of the future urgent care system. Recruitment to support the emerging UCC model is progressing well, with three Advanced Nurse Practitioners (ANPs) now in post within the MIU and additional reception staff recruited to strengthen administrative support.	30/11/26

Embedded improvement actions

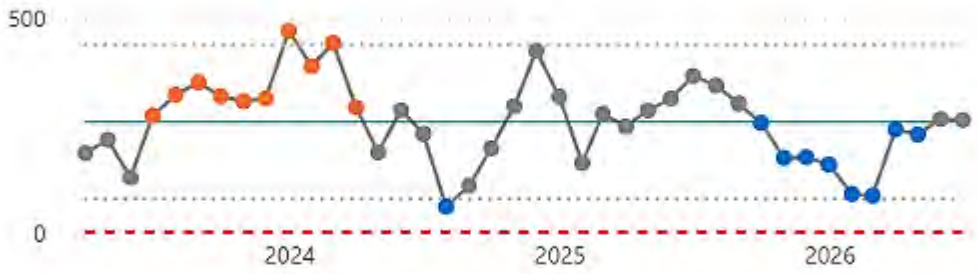
- Daily monitoring of patient presentation types through morning flow meetings has improved operational oversight and supported proactive service planning. Consistent application of the redirection policy has improved patient flow by directing suitable patients to alternative care pathways, reducing unnecessary demand within the department and ensuring clinical resources remain focused on patients requiring urgent and emergency care. This has supported shorter waiting times, improved patient throughput, and better overall departmental performance.
- The reduction in patients presenting with major conditions is likely to have been influenced by a combination of factors, including strengthened community and primary care services, the use of alternative care pathways, improved ambulance triage and streaming processes, and increased utilisation of Same Day Emergency Care (SDEC) services. These initiatives supported patients to receive care in the most appropriate setting, reducing unnecessary attendance and admission whilst ensuring patients with higher-acuity needs continued to access timely hospital care
- Expand General Medicine Hot Clinic capacity through job planning arrangements where clinically and operationally feasible. Consultant-led Hot Clinics have improved patient flow by facilitating early specialist review, supporting safe discharge, reducing admissions, and minimising unnecessary follow-up appointments, thereby releasing capacity within the acute pathway
- Strengthen collaboration with community health, social care and discharge teams to reduce the number of medically optimised patients awaiting discharge and improve patient flow.
- The development of the UCC model is expected to enhance patient flow by reducing unnecessary attendance within acute hospital pathways, increasing the use of ambulatory and same-day care services, and ensuring patients receive care in the most appropriate setting at the earliest opportunity. This work will support improved patient experience, more efficient use of clinical resources, and increased capacity to manage future demand across urgent and emergency care se[illegible] weekly task-and-finish group meetings to develop the future UCC operating model.

Urgent and Emergency Care – Ambulances – Withybush Hospital

(Targeted intervention and Ministerial priority)

Key
- Improving variation
- Usual variation
- Concerning variation
- Upper and lower limits
- Mean
- Target
- Ambition

Ambulance handovers taking over 45 minutes



Latest data is showing usual variation. 262 handovers >45 minutes reported out of a total of 694 handovers, 37.8%.

Ambulance handovers taking over 4 hours



Latest data is showing usual variation. 46 handovers >4 hours reported out of a total of 694 handovers, 6.6%.

Key challenges / issues

- Increased ambulance conveyances received month on month from April 2026.
- Increased overall attendances to ED since the start of the Financial Year 26-27 has also presented a direct challenge to Withybush Hospital's (WGH) ability to support a timely ambulance handover, with increased pressure for treatment space in ED (April 2026 3,872; May 2026 4,099; June 2026 3,958) - compared to 3,733 in March 2026.
- Whole system challenges during July 2026, with restricted system patient flow and increased demand negatively impacting on ambulance handover performance.
- Clinical streaming hub shifts are not always filled, so daily support coverage is not consistent by Advanced Paramedic Practitioner Navigator.

Key actions / initiatives	Due date
• Instigation of ambulance changeover/handover rooms in WGH Emergency Department w/c 22nd June 2026 – supporting WAST with dedicated space for handover of patients at end of shift for ambulance crews	Ongoing trial 31/08/26
• Coordinate with WAST regarding Advanced Paramedic Practitioner Navigator support in our Clinical Streaming Hub (daily presence required)	30/09/26
• Reinforce ring-fenced capacity protocols in Emergency Department	30/09/26

Embedded improvement actions

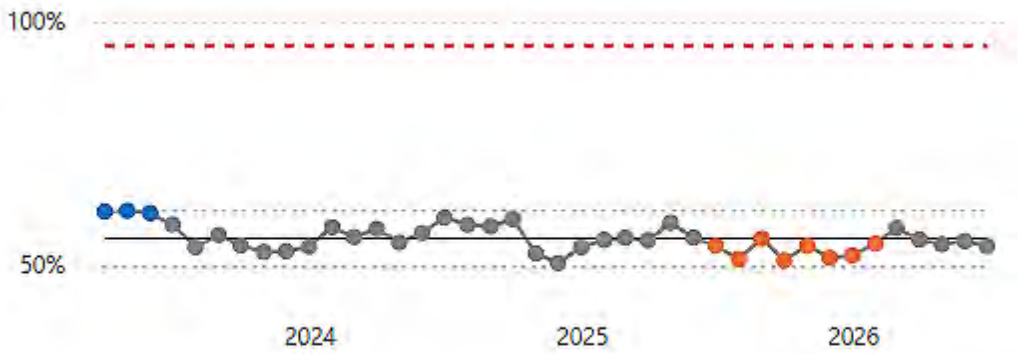
- MIYA flow process (digital bed management)
- Dedicated Band 6 nurse allocated to Rapid Assessment Triage/Pitstop to lead on ambulance handover

Urgent and Emergency Care – Emergency Departments – Withybush Hospital

(Targeted intervention and Ministerial priority)

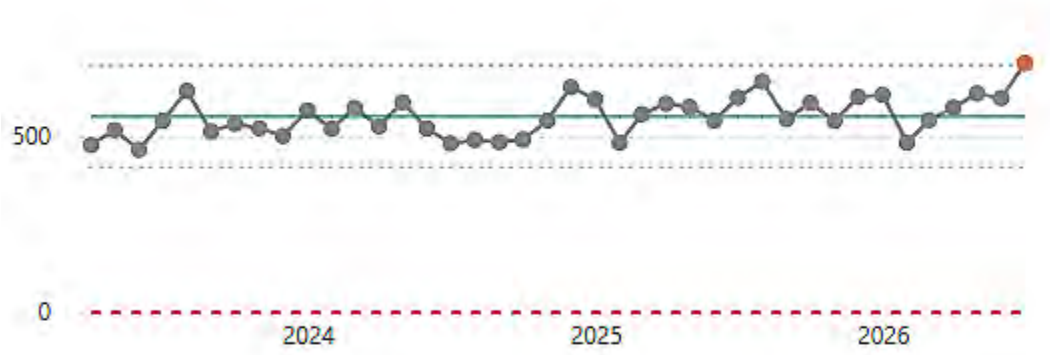
Key
- Improving variation
- Usual variation
- Concerning variation
- Upper and lower limit
- Mean
- Target
- Ambition

Patients waiting less than 4 hours in A&E



53.% reported for July, 2,070 breaches out of 4,481 new attendances. Chart is showing usual variation.

Patients waiting over 12 hours in A&E



708 breaches out of 4,481 new attendances, 15.8%. Chart is showing concerning variation.

Key challenges / issues

- Increased overall attendances to ED since the start of the Financial Year 26-27 has also presented a direct challenge to WGH's ability to support a timely handover, with increased pressure for treatment space in ED (April 2026 3,872; May 2026 4,099; June 2026 3,958) - compared to 3,733 in March 2026.
- Whole system challenges in relation to demand and capacity in Pembrokeshire during July 2026, with restricted system patient flow and increased demand negatively impacting on 4hrs% and patients waiting over 12 hours in ED.
- Additional challenges seen with Mental Health presentations and delays with Mental Health pathways i.e. inpatient bed availability.

Key actions / initiatives

	Due date
• Expand Medical Same Day Emergency Care unit to 12 hours/7 days model	30/11/26
• Deploy senior decision maker role to at front door alongside frailty rapid assessment model	31/12/26
• Drive average patient length of stay (LOS) reduction targeting 0 cases over 50 days LOS – improve flow and admitting capacity	31/01/27

Embedded improvement actions

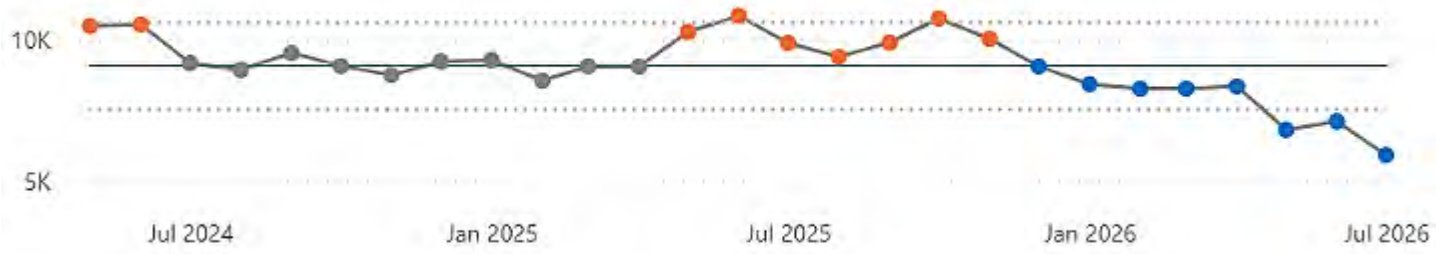
- MIYA flow process
- Direct referrals from WAST into Clinical Streaming Hub, Medical Same Day Emergency Care & Frailty
- Coordinator role in place supporting 4hr% management and correct coding
- Acute medicine and specialty in-reach into ED
- Screening and pull through to Frailty SDEC from ED

Key
- Improving variation
- Usual variation
- Concerning variation
- Upper and lower limits
- Mean
- Target
- Ambition

Total number of pathways of care delayed discharges (non-MH + MH & LD)



Total days delayed for Pathways of Care delayed discharges (non-MH + MH & LD)



- Number of pathway of care delays as at 15th July 2026 census was 204 patients, and the chart shows usual variation.
- The total days delayed for non-mental health decreased in July to 5,401 days from 6,419 in June. Mental health and learning disability delays decreased in July to 518 from 693 in June.
- Assessment delays remain the largest proportion of delays.
- The census count is based on any patients delayed in one of our hospitals, regardless of their area of residence i.e. will include patients living outside of Carmarthenshire, Ceredigion and Pembrokeshire.

Top 10 delay reasons for census count patients (non-MH + MH & LD)

Delay Reason	Carmarthenshire	Ceredigion	Pembrokeshire	Out of Area	Total Patient Count	Total days delayed	Average days delayed
Awaiting start of new community care package funded by social care	18	3	4	3	28	851	30
Awaiting completion of assessment by social care	24	4	5	0	33	808	24
Awaiting reablement community care package	23	2	2	0	27	415	15
Identifying Residential Home	3	1	1	0	5	349	70
Home unsafe and requires attention	3	0	0	1	4	317	79
Awaiting Continuing Healthcare (CHC) Assessment	0	2	4	1	7	313	45
Identifying Dementia residential home	2	1	0	0	3	305	102
Awaiting NH availability	2	3	0	0	5	255	51
Awaiting completion of assessment Nursing	3	1	6	0	10	237	24
Awaiting completion of AHP Allied Health Professional Assessment	5	1	4	0	10	213	21
Other	40	15	16	1	72	1856	26
Totals	**123**	**33**	**42**	**6**	**204**	**5,919**	**29**

Key challenges / issues	Key actions / initiatives	Due date
Non Mental Health: Ongoing wider acute and community system pressures and ambulance handover improvements increasing patient surges and ward boarding. • Staffing shortages, sickness, recruitment issues and maternity leave impacting discharge planning and POCD. Especially within the Carmarthenshire reablement service. • High levels of acuity and frailty across acute and community, patients/family and carers expectations driving the need for nursing, joint and continuing healthcare assessments, as well as social care assessments. • In hospital deconditioning and limited rehabilitation capacity due to the allied health professional (AHP)/ therapy staffing position causing delays to assessments, reablement and discharge care packages. • Housing, homelessness and care home capacity challenges delaying onward placement and discharge. **Mental Health & Learning Difficulties:** Delays reduced from 11 to 10, with performance affected by external capacity pressures (placement availability, housing, funding and social care provision). Current performance reflects system-wide capacity pressures rather than internal process failure. • POCD remains low at 10, reflecting a small number of complex discharge cases. • Older Adult Mental Health (OAMH) accounts for 8 of 10 delays, mainly due to limited specialist placement availability. • One case exceeds 180 days and another 100 days, highlighting complex placement challenges. • Placement, housing, funding and care package issues remain the main causes of discharge delays	**Non Mental Health:** Regional POCD Action plan updated with 5 key actions to progress based on the current system challenges. • Memorandum of Understanding developed between health and local authorities (LA) to support POCD and discharge planning (awaiting sign-off from Carmarthenshire LA). • Deconditioning Early Warning Indicator (DEWI) tool being rolled out across all acute and community wards, in addition to other preventing deconditioning initiatives. • Health Board Working Group established to focus on Rehabilitation pathways/ levels • Focussed improvement plan being developed to support flow in Glangwili Hospital • Working with AHP leads to develop a prioritisation and escalation tool **Mental Health & Learning Difficulties:** Targeted scrutiny of Enlli Ward >100-day POCD and continued improvement plan to strengthen clinical governance process with standardisation across OAMH wards - Senior Clinical Leadership Team. • System-level engagement with LAs and independent sector providers to address residential, nursing and Elderly Mentally Infirm (EMI) dementia placement opportunities and social care to expedite community care packages - clinical leads. • Focused management of Adult Mental Health (AMH) housing-related delays continues, including strengthened multi-agency liaison with LA housing services - clinical leads. • Continued scrutiny of best-interest decision timelines to ensure proportionality, timeliness and alignment with clinical optimisation. • Focused review of AMH homelessness-related delays continues, with strengthened multi-agency liaison involving LA housing services and policing partners. A multi-agency workshop remains in development to reduce recurrence of POCD associated with non-clinical discharge barriers for AMH inpatients - AMH Head of Service / LA Housing / Police.	31/08/26 31/08/26 31/08/26 31/10/26 31/10/26 31/10/26 31/10/26 30/09/26 30/09/26 30/09/26 31/10/26

Embedded improvement actions

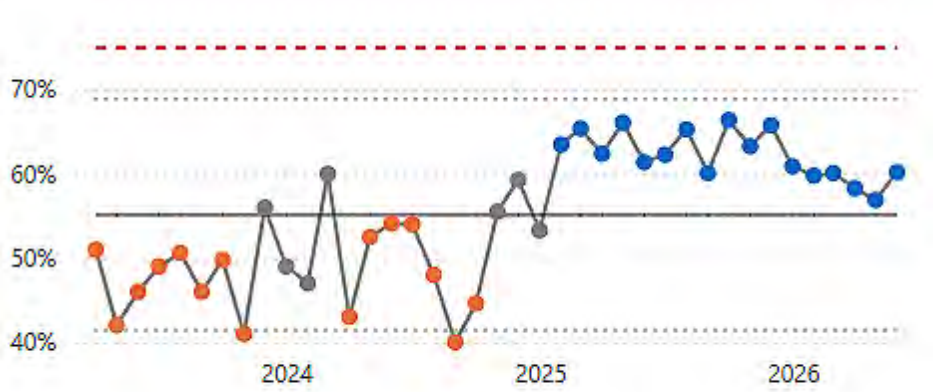
Non Mental Health: Regional West Wales Optimal Flow and Discharge Delivery Group overseeing Optimal Hospital Flow delivery, POCD Action plan and Enhanced Community Care. Acute frailty action group and action plan developed, Deconditioning Oversight Group in place, Trusted Assessor model in mental capacity developed, long stay review meetings in place, increased social worker and reablement capacity from WG funding, strength- based collaborative communication approach being embedded. Electronic Patient Flow system introduced to support flow and discharge planning, working closely with local authority to address issues around housing.

Mental Health & Learning Disabilities: Daily multidisciplinary and multi-agency escalation arrangements embedded across AMH inpatient services, alongside daily QAMH Acute Pathway oversight. Weekly POCD deep-dive and escalation meetings across AMH and OAMH established, supporting senior validation and system escalation. Discharge to Recover and Assess principles embedded, supporting early discharge planning. Dementia Wellbeing stepped-care model established across 20 regional care homes, supporting system flow. Multi-agency working with LA remains embedded, including routine validation of POCD status and shared accountability for delays

Single cancer pathway
(Enhanced monitoring condition and Ministerial priority)

Key
- Improving variation
- Usual variation
- Concerning variation
- Upper and lower limits
- Mean
- Target
- Ambition

% single cancer pathway patients starting treatment within 62 days



In June 2026 performance improved from previous months; 275 patients out of 456 (60.2%) started treatment within 62 days.
It is important to note that not all patients waiting will have a confirmed cancer diagnosis.

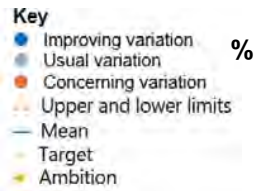
Number of single cancer pathway patients waiting over 62 days



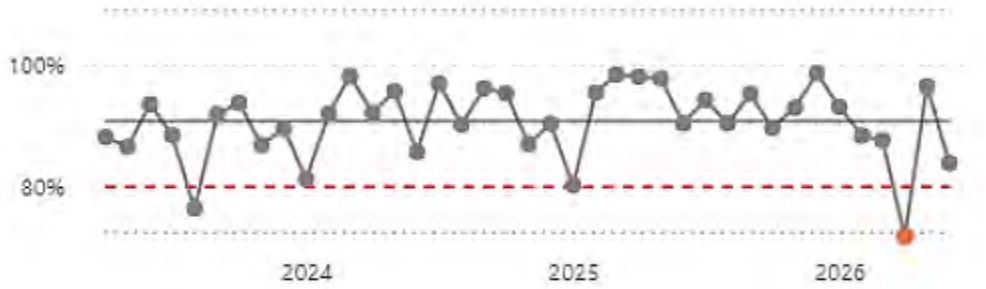
In July 2026, 458 patients were waiting over 62 days on the single cancer pathway, the trajectory has been significantly missed for the last 3 months.

Key challenges / issues	Key actions / initiatives	Due date
Single cancer pathway Activity in June 2026 increased for patients on the single cancer pathway by 3.3% as a result of recovery actions within radiology, pathology and urology.	• Outsourcing MRI for prostate patients started in November 2025, extended for Q1 2026/27. Equates to 20 patients per week with a 3-day turnaround reporting time. The ongoing impact on the waiting times is currently being assessed. • £168k committed via recovery money for Urology Diagnostics for Q2 • Residual recovery funds allocated for Pathology turnaround for Q2	30/09/26 30/09/26 30/09/26
Backlog and Diagnostics July 2026 backlog pathways for patients were predominantly in Urology (214), Gynaecology (64) and Lower Gastrointestinal (49).	• Piloting the use of the Galeas Bladder test was extended to the end of July 2026 and is currently being reviewed. • Outsourcing CT scans equates to 260 scans per month with a 7-day reporting turnaround, extended to end of August 2026	30/09/26 31/08/26
The Planned Care Delivery & Sustainability Plan 2026/27 submitted to Welsh Government on the 31/07/26, requests in-year recovery funding of £15,497,081 part of which seeks to address 7- day turnaround for Radiology and Pathology single cancer pathway diagnostics.	• As concerns remain regarding resourcing of diagnostic recovery actions beyond Q1, a further deep dive review of single cancer pathway performance is being progressed during August 2026. This will inform any further mitigating actions, investment requirements, or service redesign needed to maintain recovery trajectories and achieve national performance expectations	31/08/26

Mental health assessments within 28 days
(Enhanced monitoring condition)

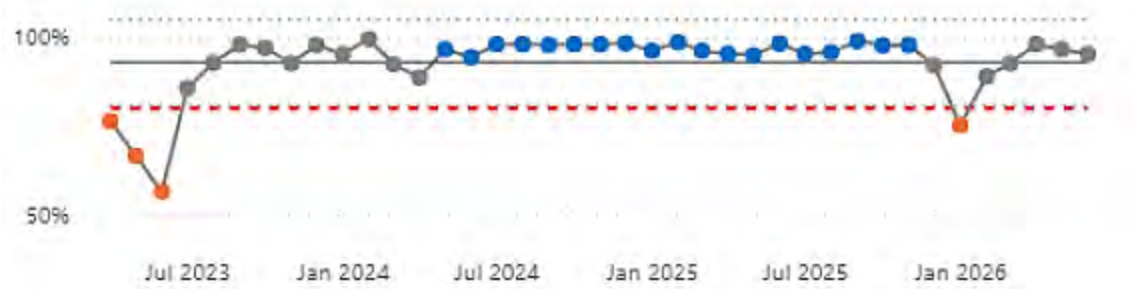


% mental health assessments undertaken within 28 days (persons aged 0-17)



Latest performance of 83.9% is showing usual variation and the target of 80% was met.

% mental health assessments undertaken within 28 days (persons aged 18+)



Latest performance of 95.3% is showing usual variation and the target of 80% was met.

Key challenges / issues

% mental health assessments undertaken within 28 days (persons aged 0-17):
62 assessments were carried out in June, a decrease of 27.1% from May. Performance has continued to exceed target with no anticipated issues.

% mental health assessments undertaken within 28 days (persons aged 18+):
Performance remains high and the service continues to monitor assessment times which can impact on compliance with the target. Two teams are experiencing high volumes of sickness which could impact on compliance over the next month or two.

Key actions / initiatives

Key actions / initiatives	Due date
% mental health assessments undertaken within 28 days (persons aged 0-17): Enabling Quality Improvement in Practice (EQIiP) 'demonstrator project' to move to a more preventative and responsive 'One at a Time' approach as part of implementation of Welsh Government Mental Health strategy.	31/03/27

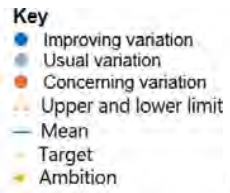
Embedded improvement actions

% mental health assessments undertaken within 28 days (persons aged 0-17):
Strengthen weekly monitoring of capacity and demand, coordinate assessment and intervention resources across localities, and improve the timeliness of follow-up contacts and intervention starts.

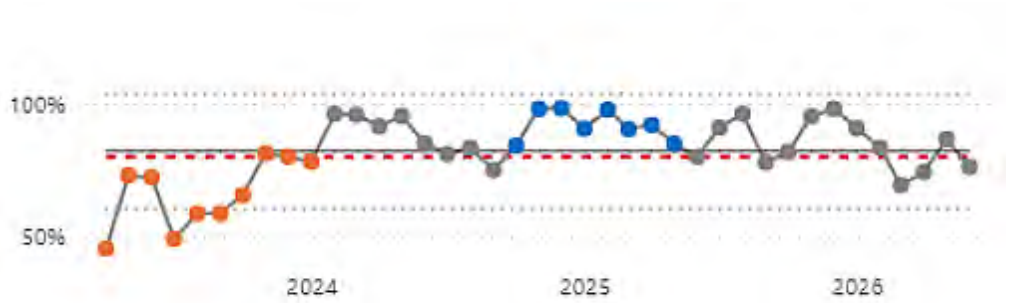
% mental health assessments undertaken within 28 days (persons aged 18+):
All teams are utilising the Primary Care Liaison Service (PCLS) at the point of referral supporting reducing pre Primary Mental Health Support Services at this point of the patient journey.

Therapeutic interventions following primary mental health assessment

(Enhanced monitoring condition)

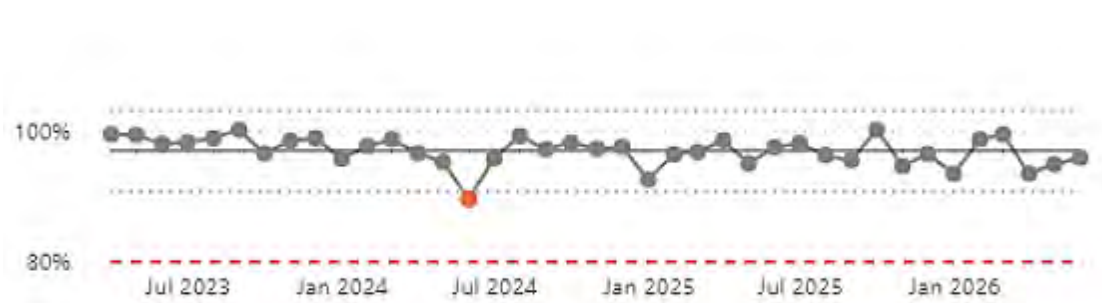


% therapeutic interventions started within 28 days following LPMHSS assessment (persons aged 0-17)



Latest performance of 76.1% is showing usual variation but the target of 80% was not met.

% therapeutic interventions started within 28 days following LPMHSS assessment (persons aged 18+)



Latest performance of 95.8% is showing usual variation and the target of 80% was met.

Key challenges / issues

% therapeutic interventions started within 28 days following LPMHSS (Local Primary Mental Health Support Service) assessment (persons aged 0-17):
Initial therapeutic intervention activity in June showed a 57.8% increase on the previous month, following an increase in assessments in May. However, performance nevertheless fell below target in June due to increased demand before the summer period due to the school exam season, workforce capacity pressures, and appointment delays resulting from family availability and opt-in processes.

% therapeutic interventions started within 28 days following LPMHSS assessment (persons aged 18+):
Compliance continues to exceed target which reflects the team's hard work. Estates access continues to be challenging across the three counties with limited access to GP practices resulting in the use of private accommodation in some areas. Withdrawal of the SPRING trauma intervention programme due to external factors with the provider is being supplemented with Trauma-Focused Cognitive Behavioural Therapy (TF-CBT) to support this requirement. Staff are accessing training when available and the effects of the withdrawal of SPRING are being monitored across Wales.

Key actions / initiatives

Key actions / initiatives	Due date
% therapeutic interventions started within 28 days following LPMHSS assessment (persons aged 0-17): Enabling Quality Improvement in Practice (EQIiP) 'demonstrator project' to move to a more preventative and responsive 'One at a Time' approach as part of implementation of Welsh Government Mental Health strategy.	31/03/27

Embedded improvement actions

% therapeutic interventions started within 28 days following LPMHSS assessment (persons aged 0-17):
Strengthen weekly monitoring of capacity and demand, coordinate assessment and intervention resources across localities, and improve the timeliness of follow-up contacts and intervention starts.

% therapeutic interventions started within 28 days following LPMHSS assessment (persons aged 18+):
Staff endeavour to ensure compliance with the measure by utilising supportive intervention options from third sector, SilverCloud digital options and our Primary Care Liaison Service (PCLS) which is operating across the three counties with positive outcomes of reducing potential referrals to LPMHSS. A focus on group interventions remains; however, as a service we will be reviewing the current treatment menu to ensure effectiveness in treatment options.

Psychological therapy waits
(Performance framework)



Performance in June of 59.3% shows concerning variation and the target of 80% was not met. The last 2 months' trend would need to be sustained for continued positive improvement.

- 485 out of 816 (59.4%) patients were waiting <26 weeks to start an integrated psychological therapy;
- 6 out of 9 (66.7%) were waiting <26 weeks to start an adult psychology assessment;
- 44 out of 76 (57.9%) were waiting <26 weeks to start a learning disability psychology within 26 weeks.

Key challenges / issues

Integrated Psychological Therapies Service (IPTS):
IPTS has achieved a month-on-month improvement resulting in an overall 9.4% increase in quarter 1. Referral and discharge rates remain broadly balanced, resulting in a steady-state flow that limits referral-to-treatment (RTT) improvement despite significant backlog reduction. Recruitment is progressing, but posts won't be in place until October. Risks remain centred upon Attend Anywhere (AA) to MEDIO digital consultation transition. Despite progress made, however, we anticipate a gap in group delivery which will impact on RTT performance over the next quarter.

Learning disabilities (LDs):
Long-term sickness, maternity leave and vacancies, particularly across Pembrokeshire and Ceredigion, are resulting in service fragility which is covered by other areas of the service as needed. There continues to be high demand for complex Court of Protection (CoP) work which is intensive and resource heavy. We are also seeing increased demands on Psychology and Behaviour specialists (P&Bs) for highly specialist complex assessments requiring therapeutic input, complex behaviour challenging assessments and treatment/intervention which contributed to waits over 26 weeks.

Adult Psychology Mental Health (AMH):
Performance for our 26-week target to start an adult psychology assessment continues to improve month on month and is the highest recorded since April 2021. Our waiting list increased in June from 8 to 9 patients.

Key actions / initiatives

Key actions / initiatives	Due date
IPTS:	
• Several staff members have completed training in Dialectical Behaviour Therapy (DBT) for complex post-traumatic stress disorder (PTSD), to strengthen the service's ability to address the trauma waiting list.	31/08/26
LDs:	
• Develop the Memory Clinic pathway and the Behaviour that Challenges pathway which aim to upskill other colleagues to reduce lower-level demands on P&Bs.	31/08/26
• New post approved in Carmarthen to make up for shortfall in hours out for advert.	31/08/26

Embedded improvement actions

IPTS:

- A number of high-intensity, evidence-based interventions have now been embedded within the service model and are demonstrating positive patient outcomes. The introduction of caps on therapy sessions is contributing to improved capacity management.
- Staff are actively engaged in regular supervision to monitor 1:1 waiting lists, and all therapists have aligned job plans to support increased service capacity wherever feasible.

LDs:

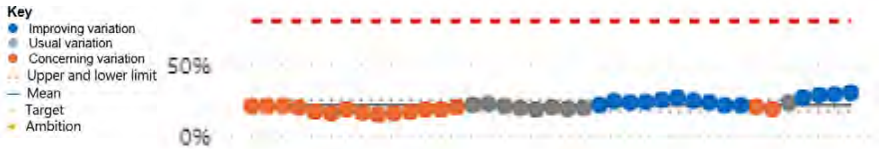
- As part of our organisational change process, we seek to recruit a co-ordinator for CoP cases who can link in with legal services to support writing court reports/managing cases to enable professionals to continue to effectively undertake their clinical roles. We are offering additional training to all staff within the network around CoP work.
- Developing group therapy work with plan to upskill colleagues to develop skills in therapeutic models to support in delivery. Monthly meetings to develop this are in place.
- We are in discussion with Welsh Government about the separate reporting of therapeutic interventions vs Behaviour that Challenges interventions to give greater transparency and oversight.

AMH:

- All four clinicians are providing consultations to other services, decreasing referrals to AMH.
- 'Grow Your Workl[illegible]n place.

Neurodevelopmental assessment waits
(Performance framework)

% children & young people waiting < 26 weeks to start a neurodevelopment assessment



% children & young people waiting < 26 weeks: ASD



% children & young people waiting < 26 weeks: ADHD



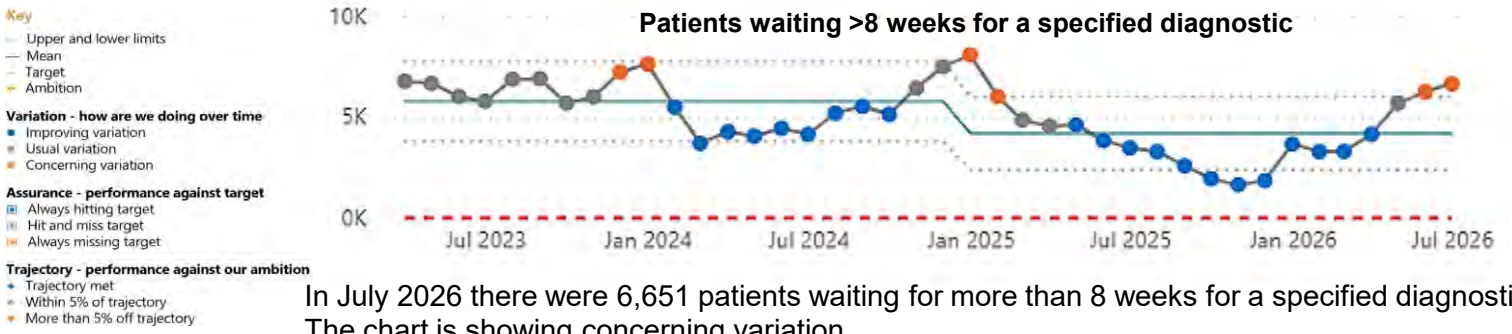
The overarching neurodevelopmental assessment metric is a combined ASD & ADHD position. Performance in June 2026 of 30.3%, shows improving variation but the target of 80% was not met. Performance is driven by ASD, where 751 of 3,315 (22.7%) patients had an ASD assessment < 26 weeks. 661 out of 1,341 (49.3%) patients had an ADHD assessment <26 weeks.

Key challenges / issues	Key actions / initiatives	Due date
Attention Deficit Hyperactivity Disorder (ADHD): The longest current wait for an ADHD assessment is 107 weeks, with 433 individuals waiting over 52 weeks. Referrals into the service have increased by 100%, creating significant pressure on the service and a requirement to expand core capacity to meet performance targets. Despite ongoing efforts, demand continues to exceed available provision, even with a fully established medical workforce. Demand for Quantitative Behavioural (QB) testing, a key component of the diagnostic pathway, also exceeds current capacity. In addition, clinic room availability across all sites remains a challenge. Longer-term solutions are being implemented through the Bandi appeal and the proposed reconfiguration of Puffin Ward.	**ADHD:** • Increase clinic room capacity through the Bandi appeal and reconfiguration of Puffin Ward; • Expand core capacity by increasing access to QB testing and follow-up appointments. Currently, only one device is available across the counties, with a limited number of Healthcare Support Workers trained in its use. While funding opportunities have been explored, securing investment has been challenging due to the ongoing costs associated with licence fees and per-test charges. Alternative options continue to be explored, including QB Check, as a digital solution with the potential to increase access to QB testing across all sites where clinically appropriate; • Continue to optimise clinic utilisation through flexible management and robust job planning; • Explore use of digital solutions, such as Beam Notes, to support assessments and follow-ups and help reduce clinician administrative time; • Options paper submitted to address capacity and demand issues	31/03/27 31/03/27 31/03/27 31/03/27 31/12/26
Autism Spectrum Disorder (ASD): There are 3,315 children and young people (CYP) awaiting an ASD assessment, 2,564 of whom have been waiting over 26 weeks. Referral rates continue to be high with 145 received in May. We are targeting reduction of longest waits to maintain Welsh Government milestones.	**ASD:** Pathway redesign initiatives continue to be developed and progressed including: • Continued familiarisation of functionality within AI scribe package Beam Notes; • Development of 'Patient Knows Best' demo site to enable electronic communication with CYP and carers alongside release of clinical workforce capacity; • Piloting a clinic proposal with paediatric colleagues to streamline pathway for individuals who may require assessments under both services.	 31/03/27 30/09/26 30/09/26

Embedded improvement actions

ASD:
Improvements in performance are underway through:
- an additional outsourcing contract in place for 300 assessments to be completed by the end of November;
- redesign and awareness raising of Advice Hub provision;
- targeted school cluster clinics planned for the start of the new academic term to increase throughput and offer advice to schools with the highest referral rates;
- progression of digital innovation.

Diagnostics waits over 8 weeks
(Enhanced monitoring condition and Ministerial priority)



In July 2026 there were 6,651 patients waiting for more than 8 weeks for a specified diagnostic. The chart is showing concerning variation.

Diagnostic	Latest period	Latest actual	Variation	Assurance
All	July 2026	6,651	●	▣
Radiology		5,397	●	▣
Cardiology		1,098	●	▣
Phys measure		73	●	▣
Endoscopy		51	●	▣
Imaging		28	●	▣
Neurophysiology		4	●	▣

Key challenges / issues

Radiology: Activity increased in July 2026, However, capacity is not meeting demand growth.

- The National Outpatient Appointment Insourcing project increased demand which continues to impact performance. Additionally, Magnetic Resonance Imaging (MRI) & Non-Obstetric Ultrasound (NOUS) demand and breaches surpassed projections developed in 2025/26.
- This has raised concerns regarding the accuracy of the reported breach position via the recently implemented RISP system (Radiology Informatics System Procurement) and the absence of dedicated data analytical capacity to verify data intelligence from the new system. The issue has been escalated for support in further interrogating the RISP system which is being rolled out across Wales.

Endoscopy:

- 51 endoscopy breaches relate to flexi cystoscopy (urology).

Cardiology:

Echo breaches are primarily attributable to longstanding shortfalls in in-house diagnostic capacity, particularly within echocardiography services. Position deteriorated further due to additional capacity losses from short-long term sickness absence and maternity leave. Myocardial Perfusion Scan waiting times increased following a two-week system outage in April 2026, significantly impacting the waiting list. Recovery further constrained by reduced capacity in May 2026 due to Bank Holidays. Consequently, breach position has continued to deteriorate. This remains a highly fragile service and is included on the risk register. The service is dependent on a single consultant, creating a significant risk to service resilience, capacity, and recovery of the waiting list position.

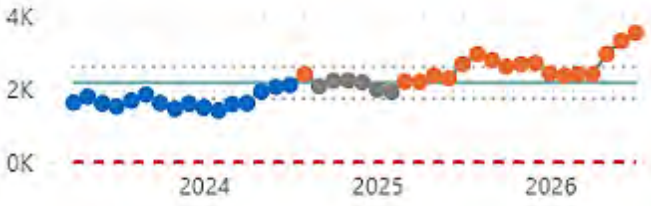
Key actions / initiatives

	Due date
Radiology:	
• NOUS insource contract extended, with additional capacity being sought. Internal staffing (insourcing) ongoing funded by vacancy.	01/11/26
• MRI van extended to March 2027 using core funding (vacancy lag). Welsh Government funding for second van ended 31 March 2026, reducing capacity by 540 patients per month.	31/03/27
• Computed Tomography (CT) van extended to end of August 2026 with additional funding. Capacity for 300 additional urgent suspected cancer patients per month.	31/08/26
• Demand management pathway work underway with physiotherapy, podiatry and maternity to increase capacity via workforce diversification.	30/09/26
• Revised demand & capacity modelling work has been undertaken, completed and Board approved in relation to Welsh Government (WG) 2026/27 Planned care recovery funding requirements. Awaiting decision from WG on funds to increase CT, MRI & NOUS capacity.	31/08/26
• Task & Finish Group established to assess data reporting anomalies linked to the RISP system.	31/08/26
Endoscopy: Gastrointestinal endoscopy performance being sustained through waiting list initiative and insourcing – equating to 4 lists/week to mitigate demand and capacity gap (as a result of a 5% increase in demand in 2026/27).	31/08/26
• Urology to complete additional lists Aug-Sep to accommodate patients waiting over 8 weeks	31/03/27
Cardiology: Plans are in place to procure insourcing activity during August in Bronglais to support a reduction in the breach position. A Situation, Background, Assessment and Recommendation (SBAR) report completed for Care Group consideration. Weekly meetings held with Cardiorespiratory managers on all 4 acute sites working collaboratively to increase confidence with Demand and Capacity plans. For Myocardial Perfusion Scans (MPS), the team is working closely with Radiology colleagues to mitigate risks for long-waiting patients and ensure appropriate clinical prioritisation. Collaborative working is focused on maximising available capacity, managing patient risk, and supporting recovery of the waiting list position.	31/08/27

Therapy waits over 14 weeks
(Enhanced monitoring)

In July there were 3,547 patient waiting over 14 weeks for a specified therapy. The chart is showing concerning variation.

Patients waiting >14 weeks for a specified therapy



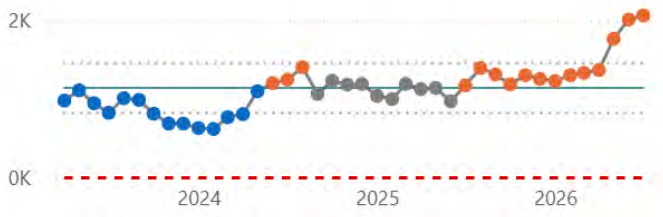
Key
- Upper and lower limits
- Mean
- Target
- Ambition

Variation - how are we doing over time
- Improving variation
- Usual variation
- Concerning variation

Assurance - performance against target
- Always hitting target
- Hit and miss target
- Always missing target

Trajectory - performance against our ambition
- Trajectory met
- Within 5% of trajectory
- More than 5% off trajectory

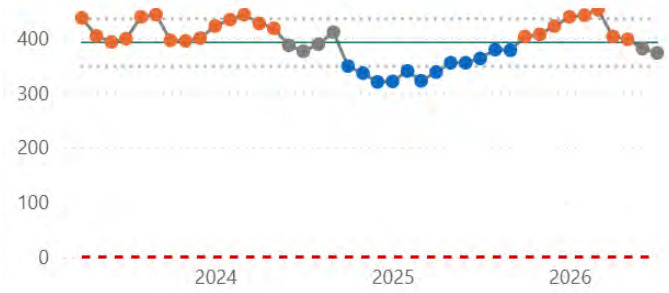
Number of patients waiting 14 weeks plus for Physiotherapy



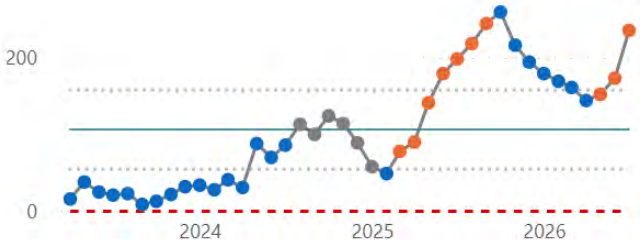
Number of patients waiting 14 weeks plus for Podiatry



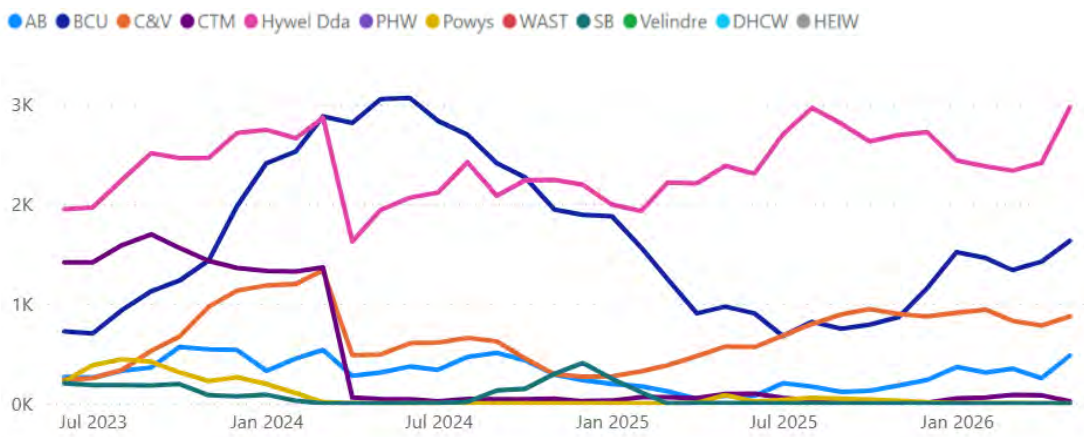
Number of patients waiting 14 weeks plus for Occupational Therapy



Number of patients waiting 14 weeks plus for Dietetics (excluding Weight Management)



Patients waiting 14 weeks or more for a specified therapy: Welsh Health Boards (May 2026)



Therapy	Latest period	Latest actual	Variation	Assurance
All	July 2026	3,547	●	▣
Physiotherapy		2,062	●	▣
Podiatry		827	●	▣
Occupational Therapy		373	●	▣
Dietetics		235	●	▣
Art therapy		30	●	▣
Speech & Language		20	●	▣

Therapy waits over 14 weeks (continued) (Enhanced monitoring)

Key challenges / issues	Key actions / initiatives	Due date
Physiotherapy: 95% of breaches are in Musculoskeletal (MSK). Demand continues to grow and is greater than capacity, driven by shifting work from primary and secondary care toward MSK Physiotherapy services. Demand growth is compounded by: • Increased proportion of urgency in demand (now >50%) in MSK and community services. • Reduced service capacity (staff leave and 3 whole time equivalent (WTE) vacancies, and unavailability of agency/bank to backfill). The service has also not replaced 1.4 WTE vacant posts in line with financial standing instructions that were without budget. **Occupational Therapy (Paediatrics)** Whilst performance continues to be within trajectory the Paediatric Occupational Therapy service is reporting a deterioration in-month. Overall demand has increased by around 40% and whilst the service had some additional capacity this reduced through July 2026 by 1.0 WTE Agenda for Change band 5 and we have further workforce turnover through August and September with further deterioration in referral to treatment (RTT) performance predicted. **Podiatry** In July breaches increased to 827 as per trajectory. New patient referrals have increased by around 40% in the last six years without subsequent increase in capacity, additionally, patient complexity has increased. Podiatry is the first point of contact/triage service for Orthopaedics and Vascular services. To meet modern expectations for timely assessments and interventions, the service now includes 7 Independent Prescribers and 5 Ultra sonographers, achieved through internal reconfiguration. **Dietetics** Paediatric breaches present 98% of nutrition and dietetic breaches (outside of weight management services). Increasing breaches from May 2026 (142) to July 2026 (234) were due to long-term sickness absence and increased demand. The remaining 2% of breaches are likely to continue to increase due to staff turnover, we are awaiting confirmation to recruit into workforce stabilisation posts.	Actions below attempt to reduce breeches where possible but without the required investment in additional posts the forecast is a minimum of 3,229 breaches by March 2027: **Physiotherapy:** • A standard operating procedure for a targeted telephone triage pilot, for patients who could be signposted towards supported self-management in place with further refinement of this process now planned using PDSA (plan-do-study-act) cycles to test the effectiveness of clinical risk stratification and patient activation tools to broaden the scope of the project. **Impact -** The first part of this pilot (tele triage) was completed and did not show efficiency or quality gains to justify continuation on that basis this has now ceased. The risk stratification element has been aligned with Enabling Quality Improvement in Practice (EQIiP) project action. — Complete • Second MSK form validation process to start 01/08/26. Refinement of process following initial pilot. — 30/09/26 • A review of community prioritisation criteria aligned to clinical risk matrix is currently being undertaken. (initial pilot complete in Carmarthenshire, analysis in progress). — 30/09/26 • Three projects being developed through EQIiP program. 1). development of agnostic condition management classes, 2). patient activation and chronicity risk stratification as part of self referral processes, 3). pilot of new model for telemedicine assessment in MSK. — 31/03/27 **Occupational Therapy (Paediatrics)** • Development of Paediatric Sensory Workshop to support universal and targeted offer. Implementation review and further refinement in progress. — 31/12/26 • Development of triage process to improve access and reduce delays and inappropriate referrals coming into the service. — 31/12/26 **Podiatry** • Consultant podiatrist post in development. This will improve treatment flow, governance and waiting times. — 05/10/26 **Dietetics** • Service is reviewing referral criteria and working on plan for e-referrals to reduce administration required for triage allowing more efficiency in clinical time. — 31/08/26 • Measures are in place to tighten referral criteria and improve triage process joining specialist dietetic resource from SCAMHS . — 31/08/26 • Working with Mental Health & Learning Disabilities services on scoping work to allocate resources more appropriately. — 30/09/26

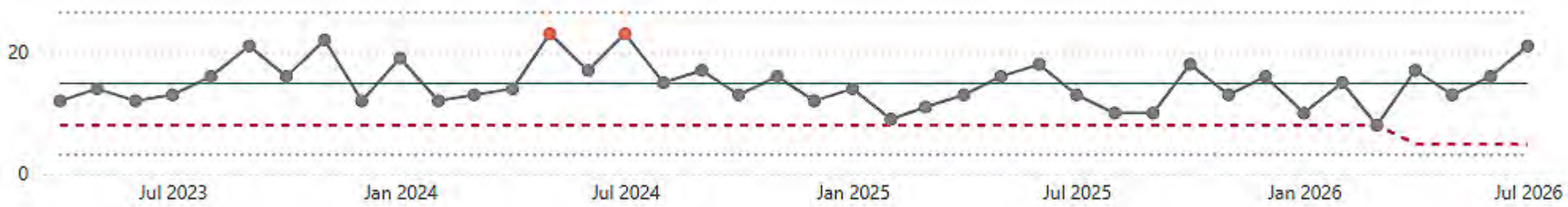
Embedded improvement actions

Podiatry: Demand and capacity in depth review indicated that service was efficient, all staff on 10 session template booked by office with electronic rota together with strong discharge and eligibility procedures in place. Significant skill mixing undertaken. Service review undertaken to strengthen management structure to maximize efficiency. Demand and capacity review indicated that a proposed increase in 3 whole time equivalent staff was required

C. Difficile (all cases)
(Targeted intervention)

Key
- Improving variation
- Usual variation
- Concerning variation
- Upper and lower limits
- Mean
- Target
- Ambition

Number of laboratory confirmed C. difficile cases hospital and community onset (in-month)



Latest performance of 21 cases for July 2026 is showing usual variation.

Key challenges / issues

- Hospital onset infections of C. difficile cases are increasing and remain above target. Several community onset infections have been classified as "community onset, healthcare associated", meaning cases are linked to recent healthcare exposure.
- The Welsh Health Circular Antimicrobial Resistance and Healthcare Associated Infections 2025 to 2027 sets an improvement goal: *to reduce the overall burden of C. difficile infection by at least 25% against the 2024/25 counts.* There were 184 cases (hospital and community onset) of C. difficile in 2024/25, for 2026/27 the HB would need to achieve 138 cases or less to meet the improvement goal. Current year-to-date figures indicate a 15.5% deterioration on the reduction target of 2024/25 (9 cases).
- Antibiotic Stewardship: Inconsistent completion of Start Smart Then Focus (SSTF) audits; vacancies in Antimicrobial Pharmacy team risk affecting stewardship.
- Delayed Infection Prevention Control Actions: Recognition, isolation, and diagnosis delays noted in some cases.
- Environmental Cleaning: Cleaning scores in Glangwili for high-risk wards areas are below the expected standards and further assurance is required for post discharge cleaning.
- Compliance Gaps: Lapses in bare below the elbow standards across staff groups.
- Mandatory Training: Level 2 Infection Prevention Control E-learning compliance at 86.78%- an improvement

Key actions / initiatives	Due date
• Electronic prescribing and medicines administration (ePMA) rollout will support antimicrobial stewardship, intravenous to oral switch for medication will also be revisited alongside this.	01/10/26
• Review of cases for July to assess locations, themes and any cleaning implication that could have contributed to the infection.	31/08/26
• Infection Prevention Indicator Audits completed in Q1 have demonstrated some practice and environmental concerns. Action plans are expected back from services, with some received. The IPC team will support quality improvement.	17/08/26

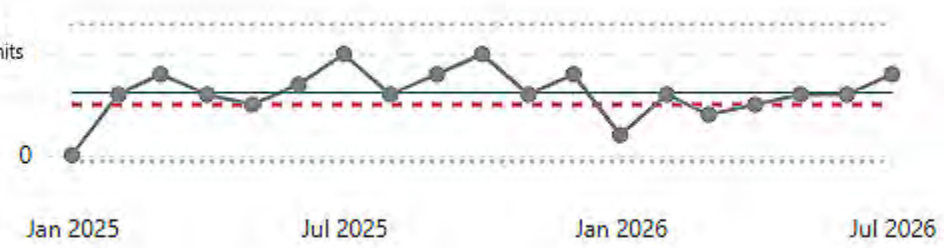
Embedded improvement actions for ALL infection types

- Learning & Governance: Healthcare associated infections cases reviewed monthly.
- Assurance Group learning shared via Clinical Care Groups. Issues escalated through governance structures. This requires all members of the multi-disciplinary team in attendance.
- Monthly hand hygiene audits by Ward Managers, monitored and reviewed.
- Self-assessment by Clinical Care Groups against the Quality Statement for Infection Prevention and Control issued by the Chief Nursing Officer.
- Clinical Care Groups to monitor Aseptic non-touch technique compliance and assessor training offered to clinical areas from infection prevention as well as Fit-testing compliance.

E. coli and S. aureus cases (hospital onset)
(Targeted intervention)



E.coli BSI: Number of hospital onset cases (in-month)



Latest performance of 8 cases for July 2026 is showing usual variation.

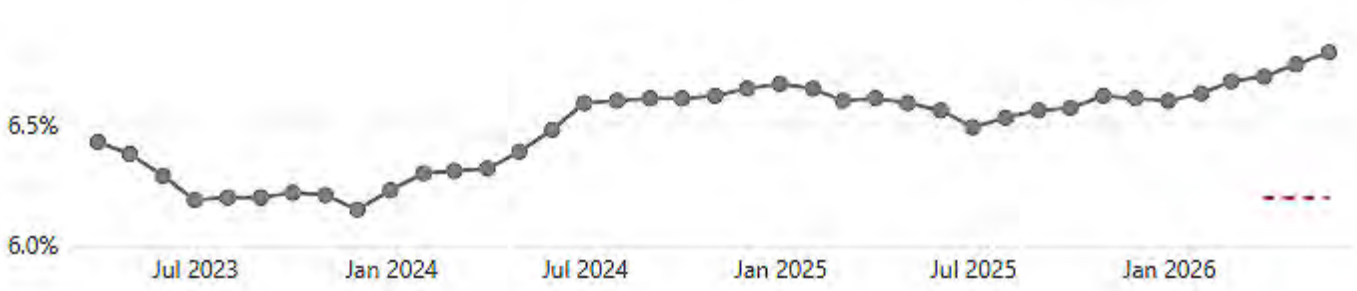
S. aureus (MSSA) BSI: Number of laboratory confirmed cases hospital and community onset (in-month)



Latest performance of 2 cases for July 2026 is showing usual variation.

Key challenges / issues	Key actions / initiatives	Due date
E. coli: • Infections primarily community-onset and linked to urinary tract and some catheter-related. Most cases occur in the 80–89 age group. • The Welsh Health Circular Antimicrobial Resistance and Healthcare Associated Infections 2025 to 2027 sets an improvement goal: *a reduction of at least 10% in cases of hospital onset only E. coli bloodstream infections (BSI) is expected vs the cases in 2024/25*. There were 60 hospital onset cases of E. coli BSI in 2024/25, for 2026/27 the HB would need to achieve 54 cases or less to meet the improvement goal. Current year-to-date figures indicate a 56.3% deterioration on the reduction target of 2024/25 (9 cases). • Non-compliance observed bare-below-the-elbow practices across all staff groups. **S. aureus** • Hospital and community onset MSSA BSI cases have remained broadly stable over the reporting period, fluctuating between 1 and 5 cases per month. • The Welsh Health Circular Antimicrobial Resistance and Healthcare Associated Infections 2025 to 2027 sets an improvement goal: *for Methicillin-susceptible Staphylococcus (MSSA): a decrease of at least 20% compared to the 2024/25 baseline counts for all Health Boards for MSSA for hospital and community onset.* Current year-to-date figures indicate a 9.4% deterioration on the reduction target of 2024/25 (3 cases). • Health Board aseptic non-touch technique compliance for E-learning is at 85.62%.	**E. coli:** • Infection Prevention Indictor Audits outline ward compliance to catheter bundles- action plans awaited back for some areas. • Undertake monthly reviews of all hospital-onset E. coli BSIs to identify avoidable urinary tract infection (UTI) and catheter-related factors, with learning shared through Clinical Care Groups. • Health & Wellbeing booklet for the Older Adult to be utilised with the Public Health Team in public facing forums over the summer. • Hand hygiene validation and observational audits conducted based on senior nurse monthly audits **S. aureus:** • Infection Prevention Indictor Audits to outline ward compliance to peripheral venous catheter bundles- action plans awaited back for some areas. • Health & Wellbeing booklet for the Older Adult to be utilised with the Public Health Team in public facing forums over the summer. • Hand hygiene validation and observational audits conducted based on senior nurse monthly audits	17/08/26 31/08/26 31/08/26 31/08/26 31/08/26 31/08/26 31/08/26

% staff sickness rate (12 months rolling)



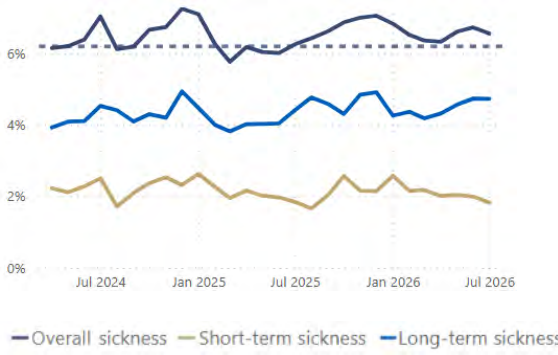
Rolling 12-month staff sickness percentage rate comparisons for July:

- July 2024: 6.59%
- July 2025: 6.49%
- **July 2026: 6.81%**

2026-2027 Rolling 12-month target = 6.2%

% staff sickness rate (in month)

July 2026 (in month) = 6.56%
Short-term sickness = 1.82%
Long-term sickness = 4.73%



Services with 60+ staff with the highest levels of <u>in-month</u> sickness rates in July 2026:

Team	Staff	R12m	In-month
Health Protection – Immunisation Team	66	13.7%	19.1%
PPH - Acute Medical Assessment Unit	75	11.9%	16.9%
PPH - Hotel Services	72	11.8%	15.7%
Sunderland Ward	76	14.5%	14.9%

Key challenges / issues

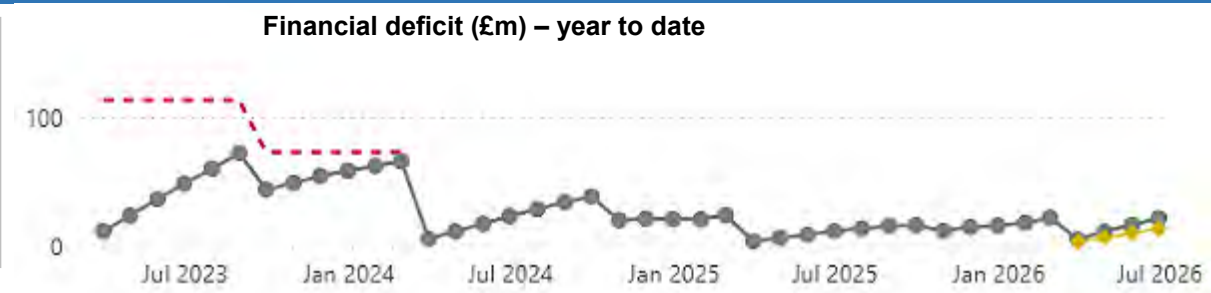
Sickness absence figures for July show a decrease in the monthly absence rate to 6.56%. The Health Board's rolling 12-month sickness absence rate is 6.81%, which is 0.61 percentage points above the organisational target of 6.20%.
Over the last 12 months (August 2025 to July 2026), anxiety, stress, depression and other psychiatric illnesses remained the leading cause of employee absence, consistently accounting for between 32% and 36% of all full-time equivalent (FTE) days lost each month. The proportion peaked at 36.1% in August 2025 and remained above one-third of all absence throughout most of the period, reaching 35.3% in July 2026. This sustained pattern demonstrates that psychological wellbeing continues to be the most significant driver of workforce absence, with mental health-related absences contributing considerably more lost time than any other absence category. The consistency of these figures supports the ongoing requirement for targeted mental health support, early intervention initiatives, and continued investment in staff wellbeing to help reduce the impact on both employees and service delivery.

Embedded improvement actions

A recent workshop took place which focused on the development of an Absence Grip and Control action plan. This is a 90-day workforce stabilisation programme aims at strengthening the management of sickness absence, focusing on long-term sickness cases, Occupational Health (OH) processes, data quality, and manager accountability. The programme seeks to reduce sickness-related costs and workforce loss by ensuring all staff absent for more than 12 months have clear review actions, OH follow-up, and either a return-to-work (RTW) or exit plan.
The first 30 days will focus on establishing control measures, including reviewing all absences over 12 months, validating absence reason data, auditing unopened Occupational Health reports, improving ESR sickness recording, and promoting manager compliance with sickness review processes.
By Day 60, services will be expected to progress actions for long-term sickness cases, improve OH referral timeliness, review employment restrictions, commence targeted flu vaccination outreach, and develop better sickness recording practices.
By Day 90, the programme aims to demonstrate progress through reductions in priority sickness cohorts, improved management of no-pay and half-pay cases, increased flu vaccination uptake, and service-level sickness audits.

Financial deficit
(Targeted intervention)





Key challenges / issues	Key actions / initiatives	Due date
The Health Board's Annual Planned Deficit is £41.0m with an Annual Savings Target of £42.8m. Gross forecast position is £60.4m, with planned mitigating actions of £19.4m to be finalised, to achieve the reported end of year forecast position of £41.0m. Total savings delivery are £29.8m, leaving a savings delivery gap of £13.0m against the savings target. The in-month financial position is a deficit of £5.1m, which is an adverse variance against the £3.4m deficit plan. This is driven by a core operational underspend of £(0.8)m, offset by a £2.5m under identification of savings, with £1.1m savings identified against the savings target £3.6m. The in-month core operational underspend of £(0.8)m largely relates to the re-categorisation of Primary Care Dental contract savings of £(1.9)m to underspends, offset by Continuing Healthcare packages increase of £0.4m, Medical agency usage to cover sickness and vacancies £0.4m and Theatres outsourcing of activity £0.4m. The £5.9m full year conversion of underspends to savings has given greater visibility to core operational variations of mitigating actions required for managing overspends.	**Mid Year Forecast Assessment** - The reported deficit, which currently remains the same as the Annual Plan at £41.0m, is going to be reviewed in detail during August and September. If there is no material improvement, or robust plans, the forecast will likely alter.	07/10/26
	Level 4 escalation actions for Community and Integrated Medicine (CIM) and Planned and Specialist care (P&SC) - Urgent action to identify the savings gap / reduction in end of year forecast and implement the expected performance improvements through the UEC investment.	Overdue
	Identification and delivery of robust savings plans - Ongoing, urgent action to continue as part of de-risking the annual plan	Overdue
	Medical pay and rostering - Additional cover at premium costs. Continuing use of additional medical cover, including premium locum and agency in Bronglais, Withybush, Planned Care and Mental Health. An impact assessment of the adoption and benefit of the rate card is required. The comprehensive use of Allocate also needs to be embedded. Actions to be taken forward from the June Finance and Performance Committee update	31/08/26
	Conscious decisions compounding delivery of Annual Plan without formal Governance approval - Known decisions have been made outside of the annual planning process, all prior agreed actions to be completed and actioned	Overdue

IPAR key metrics by type

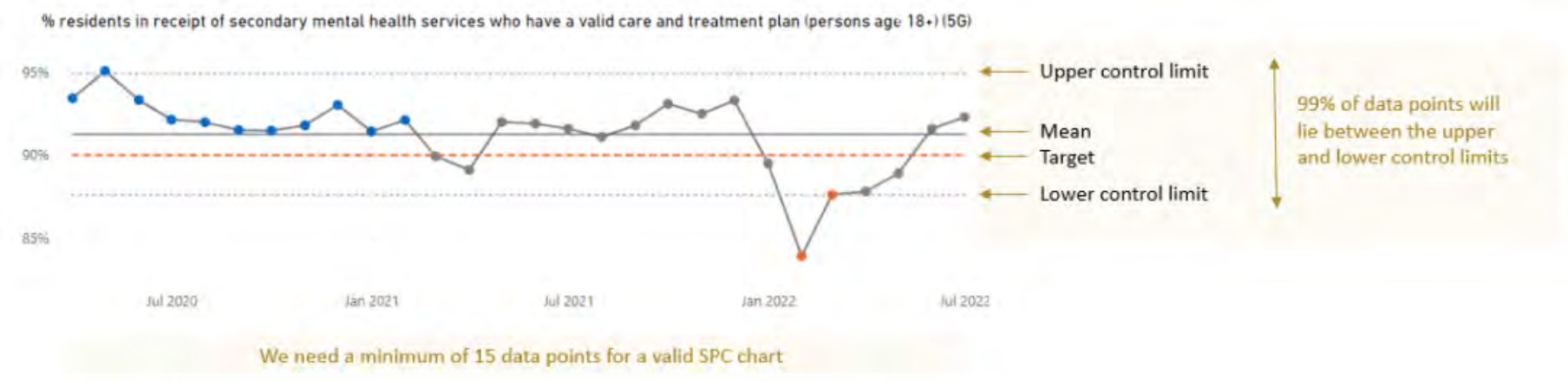
July 2026

Metric ID	Metric name	Annual plan	Enhanced monitoring	Local	Ministerial priority	Performance framework	Targeted intervention
27	C. difficile: Number of confirmed cases (in-month)	Y	-	-	-	Y	Y
51	Coding: % clinically coded - 1 month post discharge	Y	-	-	Y	Y	-
80	Pts waiting 8 wks+ for specified diagnostic	Y	Y	-	Y	Y	-
87	Ambulance handovers > 1 hour Hywel Dda	Y	-	Y	-	-	Y
88	% patients spending <4 hours in A&E/MIU Hywel Dda	-	-	-	-	Y	-
89	Patients spending > 12 hours in A&E/MIU Hywel Dda	Y	-	-	Y	Y	Y
150	Financial in month deficit	Y	-	Y	-	-	Y
155	% sickness absence rate of staff	Y	-	-	-	Y	-
275	% adult psychological therapy waits <26 weeks	-	-	-	-	Y	-
276	% child neurodevelopment assess waits <26 weeks	-	-	-	-	Y	-
277	% pts on single cancer pathway within 62 days	Y	Y	-	Y	Y	-
303	Follow-up appts - delayed >100%	-	Y	-	-	Y	-
320	% MH assess within 28 days (age 0-17)	-	Y	-	-	Y	-
321	% MH assess within 28 days (age 18+)	-	Y	-	-	Y	-
322	% therapy interven post LPMHSS assess (age 0-17)	-	Y	-	-	Y	-
323	% therapy interven post LPMHSS assess (age 18+)	-	Y	-	-	Y	-
433	Patients waiting 104 weeks+ RTT	Y	Y	-	Y	Y	-
443	Waits over 52 weeks: new outpatient appointment	Y	Y	Y	-	-	-
449	Pts 12yrs+ with diabetes receiving all 8 NICE care processes	-	-	Y	Y	-	-
483	Ambulance handover > 4 hours Hywel Dda	-	-	Y	-	-	-
501	Patients waiting over 52 weeks RTT	Y	-	Y	-	-	-
504	% uptake of flu vacc - 65+ years	Y	-	-	-	Y	-
515	Number of Pathways of Care delayed discharges	Y	-	Y	Y	-	Y
525	% of children who are up to date with scheduled vaccinations by age 5	Y	-	-	Y	Y	-
542	% of children receiving HPV by age 15	Y	-	-	Y	Y	-
545	Pts waiting 14 wks+ for specified therapy (Exc. Audiology)	Y	Y	-	-	Y	-
559	Median time ambulance arrest category calls	-	-	-	-	Y	-
560	Median time ambulance emergency category calls	-	-	-	-	Y	-
561	Ambulance handover > 45 minutes Hywel Dda	-	-	-	Y	Y	-
566	% R1 eyecare patients waiting within 25% delay to target date	-	-	-	-	Y	Y
571	% uptake of RSV vacc - 75+ years	-	-	-	-	Y	-
575	Patients waiting 26 weeks+ new outpatient	-	Y	-	-	Y	-
580	E.coli BSI: Number of hospital onset cases (in-month)	Y	-	-	-	Y	Y
581	S. aureus (MSSA) BSI: Number of hospital onset cases (in-month)	Y	-	-	-	Y	Y
588	Total days delayed for Pathways of Care delayed discharges	Y	-	Y	Y	-	-

Why use SPC charts?

- Plotting data over time can inform better decision-making
- There are many factors that impact our performance and therefore month-on-month variation is to be expected
- RAG data in a table can hide what is happening
- SPC charts enable us to determine if changes are showing special cause variation (concerning or indeed improving) or if the changes are within our expected performance range. They also help us easily compare our performance against target.
- There is a strong evidence base to support the use of SPC charts to inform NHS improvement.
- We started using SPC charts for performance reporting to Board and Committee in March 2021. The feedback has been very positive, with SPC charts helping to change the conversation to focus on improvement.

Anatomy of a SPC chart



Rules for special variation within SPC charts

Special variation is change that is unlikely to have happened by chance.

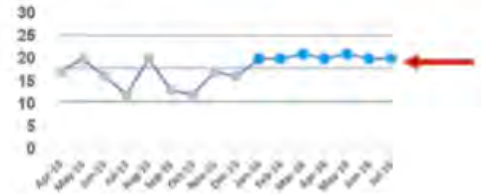
We are using the Making Data Count approach for SPC charts. There are 4 rules:



A single data point outside the process limits



Two out of three points close to the process limit



Shift of 7* or more points above or below the mean line



Run of 7* or more points in ascending/descending order

* A pattern of 7 has a 1 in 128 (0.8%) probability of occurring by chance.

Understanding the SPC icons

Each SPC chart produces 2 types of icons i.e.. one for variation and another for assurance.

Variation How are we doing over time	●	Concerning trend = a decline that is unlikely to have happened by chance
	●	Usual trend = common cause variation / a change that is within our usual limits
	●	Improving trend = an improvement that is unlikely to have happened by chance
Assurance Performance against target	▣	Missing target = will consistently fail target without a service review
	▣	Hit and miss target = Indicates that the Board cannot have sufficient assurance that the target can be consistently achieved over time, and the delivery of the target is particularly sensitive to external factors
	▣	Hitting target = will consistently meet target
Note: remember **blue** is good, orange is **bad**		

5.2

5.2 - NHS WALES SHARED SERVICES PARTNERSHIP PERFORMANCE REPORT Q1 2026/27

Huw Thomas (Hywel Dda UHB - Director of Finance)

For assurance

Attachments

NWSSP Performance Report Q1 2026-27 FPC 27 August 2026.pdf

NWSSP Performance Quarter 1 2026-27 Appendices 1-4.pdf

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Pwyllgor Cyllid a Pherfformiad/ Finance and Performance Committee

DYDDIAD Y CYFARFOD: DATE OF MEETING:	27 August 2026
TEITL YR ADRODDIAD: TITLE OF REPORT:	NHS Wales Shared Services Partnership Performance Report Quarter 1 2026/27
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Huw Thomas, Executive Director of Finance
SWYDDOG ADRODD: REPORTING OFFICER:	Tim John, Head of Accounting and Statutory Reporting

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

ADRODDIAD SCAA SBAR REPORT

Sefyllfa / Situation

The purpose of this report is to provide the Finance and Performance Committee with summary performance data in respect of the services provided by NHS Wales Shared Services Partnership (NWSSP) for the quarter ended 30 June 2026 (Quarter 1 2026/27).

The Finance and Performance Committee is requested to receive an assurance from the content of the NWSSP Performance Report for Quarter 1 2026/27.

Cefndir / Background

The NWSSP is hosted and governed by the Velindre NHS Trust Shared Services Regulations and the Shared Services Partnership Committee (SSPC). The SSPC is hosted by Velindre on behalf of the seven Health Boards, three Trusts and two Special Health Authorities within NHS Wales (the partners) and is responsible for monitoring governance and performance. The required standards for effective governance are outlined within the SSPC's Standing Orders, Values and Standards of Behaviours framework, and associated policies. The partners participate in the SSPC and take collective responsibility for the delivery of the services through a hosting agreement between the partners.

The purpose of the SSPC is to:

- Set the policy and strategy for NWSSP;
- Monitor the delivery of Shared Services, through the Managing Director of NWSSP;
- Seek to improve the approach to delivering Shared Services which are effective, efficient and provide value for money for partners;
- Ensure the efficient and effective leadership direction and control of NWSSP; and

- Ensure a strong focus on delivering savings that can be re-invested in direct patient care.

The Board has approved Standing Orders in relation to the establishment of joint committees. In line with these Standing Orders, Hywel Dda University Health Board (HDdUHB) has established a NWSSP Committee as a joint committee of the Board, the activities of which require reporting to the Board.

Asesiad / Assessment

As part of the approval of Year 1 of the SSPC Integrated Medium Term Plan (IMTP) for 2026-27, the SSPC reviewed its Key Performance Indicators. A number of Lead indicators were identified for each division. There are 21 Lead indicators in total.

Full details of the performance against all Wales agreed KPIs for services provided to HDdUHB are attached (**Appendix 1-3**) with comparison data for the rolling twelve-month period to 30 June 2026.

HDdUHB Specific Key Performance Indicators

In summary, of the 21 Lead indicators for Quarter 1 the performance is as follows:

	Green	Amber	Red	Not Applicable
Quarter 1 2026/27	17		1	3

By exception, the area where performance is not on target is highlighted below:

Accounts Payable – NHS Public Sector Prompt Payment (PSPP)[1]

Performance driven by both HDdUHB and NWSSP shows the organisation missing the following KPI:

- **PSPP Compliance NHS: Target 95%**
  Performance: 78.4% (Red)

What is happening?

PSPP Compliance NHS missed the 95% target during Quarter 1 reporting 78.4%

What is NWSSP doing about it?

[1] Definition of the CBI Prompt Payment Code financial target for NHS bodies:
Payment of at least 95% of non-NHS invoices within 30 calendar days from the receipt of goods or a valid invoice (whichever is later) unless other payment terms have been agreed. NHS bodies must disclosure in their financial statements performance against the measure set out above and also performance on the same basis for NHS invoices (although the latter is not a financial target).

Accounts Payable continues to support NHS and non-NHS PSPP reporting by providing regular updates and invoice on hold data to help address the performance.

Following exploratory discussions between senior Finance and NWSSP colleagues, a three-themed action plan has been developed to improve PSPP compliance. This includes reducing the volume and age profile of Invoices on Hold (IOH), with practical actions now underway around receipting reminders, Scan4Safety opportunities, targeted supplier review, and management of aged items. In addition, raising purchase orders for manual invoices in respect of NHS Wales organisations and Local Authorities is being considered. Ongoing oversight is expected through Senior Finance Group, Non-Pay Group and the Audit and Risk Assurance Committee (ARAC).

The Health Board continues to meet the non-NHS PSPP target which is the required financial target.

All Wales Key Performance Indicators

Performance is reported on an all Wales basis for KPIs that cannot be attributed to a specific health organisation, with comparative data for the rolling twelve-month period to 30 June 2026.

Summary Assessment by NWSSP

The Quarter 1 performance for the organisation was good with 17 out of 18 KPIs showing as green. The time to hire target was achieved in June 2026.

Further action will continue to be taken forward to address the performance in areas of underperformance.

- 1 KPI did not achieve the targets:

This is a combination of NWSSP and Health Board responsibility. NWSSP continues to support the organisation in relation to accounts payable performance.

Appendix 4 shows the outcome measures reporting at the end of June 2026, along with supporting information, to highlight and report the impact and importance of NWSSP services.

Argymhelliad / Recommendation

The Finance and Performance Committee is requested to:

- **RECEIVE ASSURANCE** from the content of the NWSSP Performance Report for Quarter 1 2026/27 that services provided are being delivered to expected standards; and
- **NOTE** the work being developed regarding outcome measures reporting.

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

Cyfeirnod Cylch Gorchwyl y Pwyllgor: Committee ToR Reference:	3.1.11 Commission regular reviews of key contracts, suppliers and partners to ensure they continue to deliver value for money.
Cyfeirnod Cofrestr Risg Datix, Teitl a Sgôr Risg Cyfredol: Datix Risk Register Reference and Score:	Not Applicable
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	Not Applicable
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	Not Applicable
Amcanion Strategol y BIP: UHB Strategic Objectives:	All Strategic Objectives are applicable
Nodau Cynllunio 2026/27 Planning Goals 2026/27	Not Applicable
Hypergyswllt i Amcanion Llesiant HDdUHB 2026 Hyperlink to HDdUHB Well-being Objectives 2026	10. Not Applicable
Model Cymdeithasol ar gyfer Iechyd a Llesiant: (wedi'i gwblhau ar gyfer newid strategol a/neu newidiadau sylweddol i wasanaethau) A Social Model for Health and Wellbeing: (*complete for strategic change and/or significant service changes)*	Not Applicable
Gwybodaeth Ychwanegol: **Further Information:**	

Ar sail tystiolaeth: Evidence Base:	Summary performance data in respect of the services provided by NHS Wales Shared Services Partnership (NWSSP) for the quarter ended 30 June 2026.
Rhestr Termau: Glossary of Terms:	Contained within the body of the report
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y cyfarfod hwn: Parties / Committees consulted prior to this meeting:	Shared Services Partnership Committee (SSPC)

Effaith: (rhaid cwblhau) **Impact: (must be completed)**	
Ariannol / Gwerth am Arian: **Financial / Service:**	NWSSP was established to improve the approach to delivering Shared Services, which are effective, efficient and provide value for money for Partners.
Ansawdd / Gofal Claf: **Quality / Patient Care:**	NWSSP has a remit to focus on delivering savings that can be re-invested in direct patient care.
Gweithlu: **Workforce:**	NWSSP is hosted by Velindre NHS Trust and any workforce implications are dealt with by the Trust.
Tegwch Iechyd: **Health Equity:**	In line with its Standing Orders, the Health Board has established a NWSSP Joint Committee, the activities of which require reporting to the Board.
Risg: **Risk:**	In line with its Standing Orders, the Health Board has established a NWSSP Joint Committee, the activities of which require reporting to the Board.
Cyfreithiol: **Legal:**	Not Applicable

Enw Da: **Reputational:**	Not Applicable
Gyfrinachedd: **Privacy:**	Not Applicable
Cydraddoldeb: **Equality:**	NWSSP was established to improve the approach to delivering Shared Services, which are effective, efficient and provide value for money for Partners.

NWSSP
SUMMARY PERFORMANCE REPORT

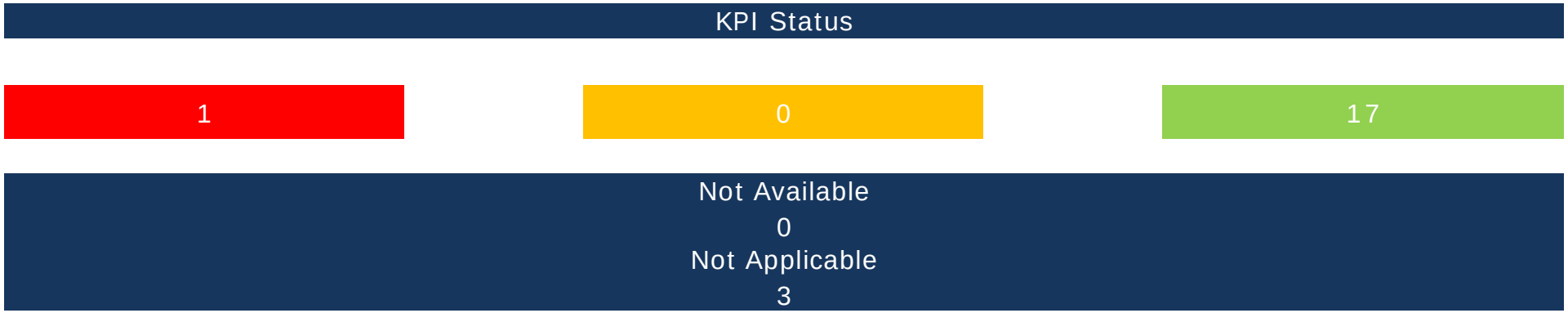
HYWEL DDA
UNIVERSITY HEALTH BOARD

Period 1st April 2026 – 30th June 2026

Delivering Value, Innovation and Excellence through Partnership

GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
Shared Services Partnership

Overview



Points of Contact

Rebecca Nelson – Director of Planning, Performance & Informatics (Rebecca.Nelson2@wales.nhs.uk)
Richard Phillips – Assistant Director of Planning & Performance (Richard.phillips@wales.nhs.uk)

Key Messages

The purpose of this report is to provide summary performance data in respect of the services provided by NHS Wales Shared Services Partnership (NWSSP) for the quarter ended 30th June 2026.

As part of the approval of our Year 1 of our IMTP for 2026-27, the Shared Services Partnership Committee (the Committee) reviewed our Key Performance Indicators. We then identified a number of Lead indicators for each division. There are 21 Lead indicators in total.

The Quarter 1 performance for the organisation was good with 17 out of 18 KPIs showing as green.

The time to hire target was achieved in June.

Further action will continue to be taken forward to address the performance in areas of underperformance.

Of the 1 KPI that did not achieve the targets:

- 1 is a combination of NWSSP and Health Board responsibility.

NWSSP continue to support the organisation in relation to accounts payable performance.

Professional Influence Benefits

The main financial benefits accruing from NWSSP relate to professional influence benefits derived from NWSSP working in partnership with Health Boards and Trusts. These benefits relate to savings and cost avoidance.

- Legal Services – Settled Claims savings, damages and cost savings.
- Procurement Services – Cost reduction, catalogue management etc. (Heads of Procurement discuss with Director of Finance of Health Orgs)
- Specialist Estates Services – Property management/lease/rates negotiated reductions and Build for Wales framework savings.
- Counter Fraud Services – Financial Recoveries and prevention.
- Accounts Payable - statement reconciliation, priority supplier programme (PSP) and the prevention of duplicate payments.

The indicative financial benefits arising in the period April – June 2026 for the organisation is £2.2M with the breakdown in the following table.

Service	YTD Benefit £m
Specialist Estates Services	0.07
Procurement Services	1.84
Legal & Risk Services	0.07
Accounts Payable	0.20
Oxygen Finance – PSP	0.01
Counter Fraud Services*	-
Post Payment Verification	0.00
Total	2.2

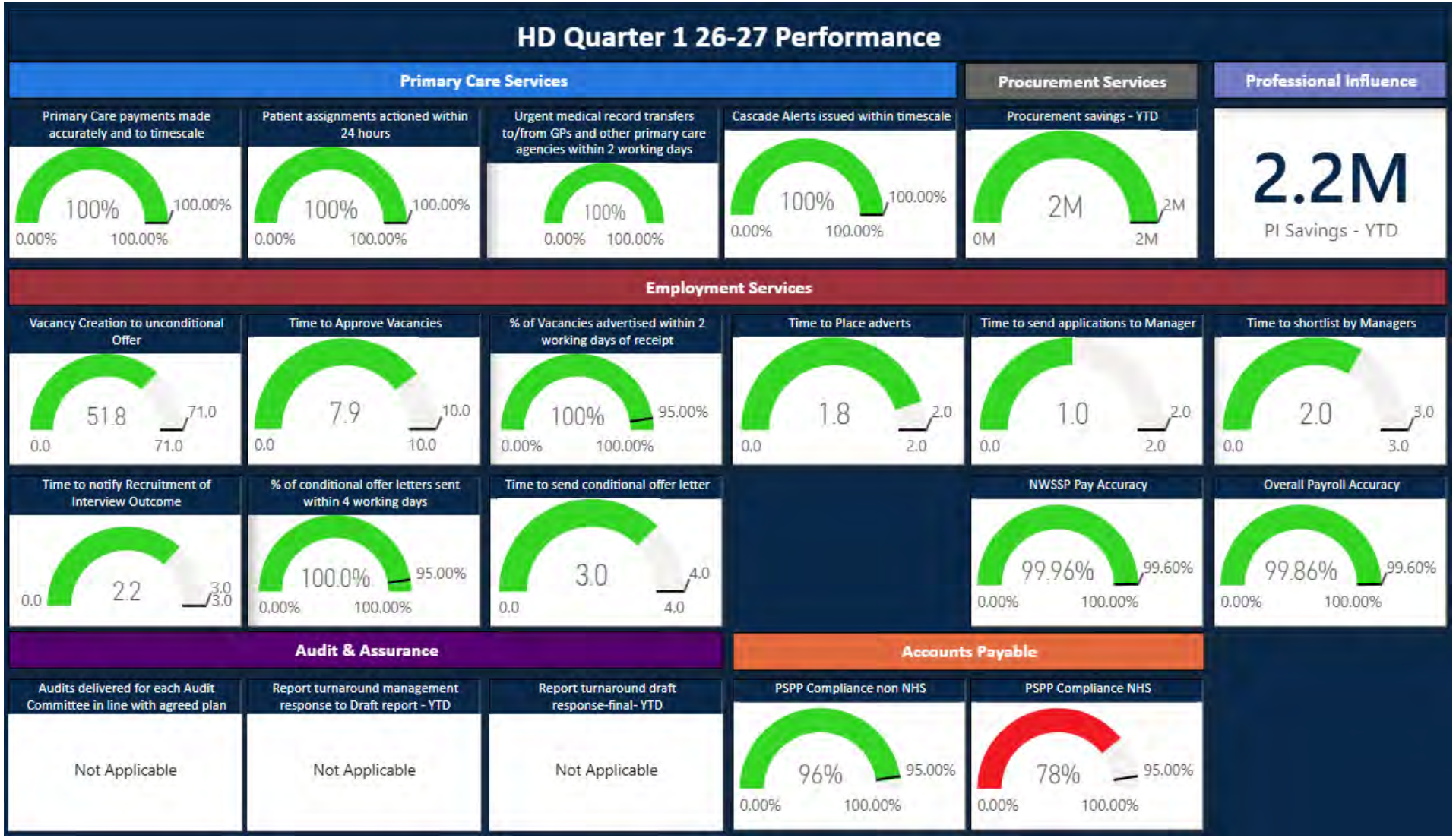
Explanation of Appendices

Appendix 1 provides the June performance for your health organisation against the Lead indicators with comparison data for the rolling twelve-month period to 30th June 2026.

Appendix 2 provides June performance against All Wales KPIs which cannot be attributed to a specific health organisation, these report an All-Wales position with comparison data for the rolling twelve-month period to 30th June 2026.

Appendix 3 highlights the position for all health organisations at the end of June 2026.

Appendix 4 highlights the Outcome measures reporting at the end of June 2026 along with some supporting information.


HD Quarter 1 26-27 Performance
Primary Care Services
Primary Care payments made accurately and to timescale
100%
100.00%
0.00%
100.00%
Patient assignments actioned within 24 hours
100%
100.00%
0.00%
100.00%
Urgent medical record transfers to/from GPs and other primary care agencies within 2 working days
100%
0.00%
100.00%
Cascade Alerts issued within timescale
100%
100.00%
0.00%
100.00%
Procurement Services
Procurement savings - YTD
2M
2M
0M
2M
Professional Influence
2.2M
PI Savings - YTD
Employment Services
Vacancy Creation to unconditional Offer
51.8
71.0
0.0
71.0
Time to Approve Vacancies
7.9
10.0
0.0
10.0
% of Vacancies advertised within 2 working days of receipt
100%
95.00%
0.00%
100.00%
Time to Place adverts
1.8
2.0
0.0
2.0
Time to send applications to Manager
1.0
2.0
0.0
2.0
Time to shortlist by Managers
2.0
3.0
0.0
3.0
Time to notify Recruitment of Interview Outcome
2.2
3.0
3.0
0.0
% of conditional offer letters sent within 4 working days
100.0%
95.00%
0.00%
100.00%
Time to send conditional offer letter
3.0
4.0
0.0
4.0
NWSSP Pay Accuracy
99.96%
99.60%
0.00%
100.00%
Overall Payroll Accuracy
99.86%
99.60%
0.00%
100.00%
Audit & Assurance
Audits delivered for each Audit Committee in line with agreed plan
Not Applicable
Report turnaround management response to Draft report - YTD
Not Applicable
Report turnaround draft response-final- YTD
Not Applicable
Accounts Payable
PSPP Compliance non NHS
96%
95.00%
0.00%
100.00%
PSPP Compliance NHS
78%
95.00%
0.00%
100.00%

Action Plan for Lead Indicators

There was one KPI showing as red for the in-month June position.

There were no KPI's showing as amber for the in-month June position.

Accounts Payable - NHS PSPP

HD High Level - KPIs Jun 26	Target	30/09/2025	31/12/2025	31/03/2026	30/06/2026	Trend
		Accounts Payable				
PSPP Compliance non NHS	95%	96.2%	96.8%	96.6%	96.0%	
PSPP Compliance NHS	95%	85.8%	98.9%	81.6%	78.4%	

What is happening?

PSPP Compliance NHS missed the 95% target during Quarter 1 reporting 78.4%.

What are we doing about it?

Accounts Payable continues to support NHS and non-NHS PSPP reporting by providing regular updates and invoice on hold data to help address the performance.

For Information - The following table highlights the All-Wales performance in relation to P2P as at the end of June 2026.

All Wales Accounts Payable data - March 2026 to June 2026

	AB		BCU		C&V		CTM		DHCW		HEIW		HD		POWYS		PHW		SBU		VEL		WAST		TOTAL	
	End of March	End of June	End of March	End of June	End of March	End of June	End of March	End of June	End of March	End of June	End of March	End of June	End of March	End of June	End of March	End of June	End of March	End of June	End of March	End of June	End of March	End of June	End of March	End of June	End of March	End of June
Number of Invoices on Hold	6,347	6,598	7,299	7,796	6,546	6,243	6,665	5,777	121	111	334	215	3,121	3,324	816	944	910	1,056	4,360	5,197	1,818	1,554	506	562	38,843	39,377
Value of Invoices on Hold £m	17.904	13.954	20.849	23.085	22.489	27.972	24.920	14.619	1.768	44.161	2.192	4.477	15.615	20.346	19.175	17.828	4.251	7.580	17.905	13.300	10.933	15.067	2.665	10.110	160.666	212.499
No of Invoices on hold > 30 days	4,347	4,910	4,910	5,162	4,354	3,891	4,372	4,119	60	72	89	65	1,778	1,913	422	531	497	579	2,575	3,324	1,086	921	192	249	24,682	25,736
%age of invoices disputed		48.9%		33.3%		25.9%		38.3%		50.5%		36.7%		22.7%		39.4%		34.1%		35.2%		39.5%		27.6%		34.7%
Over 30 days %age invoices not in dispute		42.5%		58.1%		65.5%		52.3%		31.9%		4.6%		66.2%		48.4%		51.5%		52.0%		48.1%		55.4%		63.5%
No of invoices on No PO No Pay Hold	927	898	814	870	462	293	862	815	11	15	10	5	106	96	127	173	97	140	699	918	233	148	87	116	4,435	4,487
No of NPNP invoices - Top 15 suppliers	237	276	191	276	100	59	240	275	4	4	1	1	5	6	36	26	2	14	296	373	62	30	12	6	1,186	1,346
No of invoice lines - Receipting hold	4,934	4,337	4,948	5,212	3,484	4,241	5,139	3,773	50	36	30	25	3,400	3,350	493	738	362	510	3,489	3,830	946	659	208	303	27,483	27,014
Priority Supplier - Rebate income - YTD	£37,216	£7,370	£117,600	£17,106	£63,189	£15,167	£105,499	£17,212	£5,376	£1,122	£1,530	£181	£28,834	£5,774	£5,325	£1,361	£4,967	£917	£105,293	£21,303	£61,279	£14,601	£70,894	£12,042	607,002	£114,156

Key

- Deterioration on end of March position
- Same as end of March position
- Improvement end of March position

Appendix 1 – Performance for the period to 30th June 2026

HD High Level - KPIs Jun 26	Target	30/09/2025	31/12/2025	31/03/2026	30/06/2026	Trend
Financial Information						
Professional Influence Savings - YTD		£4.398 m	£7.271 m	£15.181 m	£2.186 m	
Employment Services Payroll Services						
NWSSP Pay Accuracy	99.6%	99.98%	99.99%	99.98%	99.96%	
Overall Pay Accuracy	99.6%	99.91%	99.89%	99.88%	99.86%	
Organisation KPIs Recruitment						
% of vacancy creation to unconditional offer within 71 days		86.6%	86.8%	87.5%	88.5%	
Vacancy creation to unconditional offer	71	52.2	51.4	49.8	51.8	
% of vacancies approved within 10 working		91.5%	84.8%	82.8%	81.5%	
Time to Approve Vacancies	10	5.9	7.8	9.1	7.9	
% of vacancies shortlisted within 3 working		90.4%	90.8%	91.5%	91.7%	
Time to Shortlist by Managers	3	1.7	1.4	1.6	2.0	
% of interview outcomes notified within 3 working		88.5%	79.7%	85.7%	91.3%	
Time to notify Recruitment of Interview Outcome	3	1.6	2.0	1.8	2.2	
NWSSP KPIs Recruitment						
% of Vacancies advertised within 2 working of receipt	95.00%	100.0%	100.0%	100.0%	100.0%	
Time to Place Adverts	2	1.8	1.8	1.9	1.8	
% of applications moved to shortlisting within 2 working of vacancy closing		100.0%	100.0%	100.0%	100.0%	
Time to Send Applications to Manager	2	1.1	1.1	1.1	1.0	
% of conditional offer letters sent within 4 working	95.00%	100.0%	99.3%	100.0%	100.0%	
Time to send Conditional Offer Letter	4	3.6	3.7	3.6	3.3	
Procurement Services						
Procurement savings - YTD		Target £2.046m Actual £3.973m	Target £2.284m Actual £5.300m	Target £2.864m Actual £6.346m	Target £1.712m Actual £1.841m	
Accounts Payable						
PSPP Compliance non NHS	95%	96.2%	96.8%	96.6%	96.0%	
PSPP Compliance NHS	95%	85.8%	98.9%	81.6%	78.4%	
Primary Care Services						
Primary Care payments made accurately and to timescale	100%	100%	100%	100%	100%	
Patient assignments actioned within 24 hours	100%	100%	100%	100%	100%	
Urgent medical record transfers to/from GPs and other Primary Care agencies within 2 working days	100%	100%	100%	100%	100%	
Cascade Alerts issued within timescale	100%	100%	100%	100%	100%	
Audit & Assurance						
Audits reported to agreed Audit Committee (Excluding External Factors)	80%	88%	67%	76%	Not Applicable	
% of audit outputs in progress		27%	14%	21%	6%	
Report turnaround management response to Draft report - YTD	80%	86%	90%	80%	Not Applicable	
Report turnaround draft response-final- YTD	80%	100%	100%	100%	Not Applicable	

Appendix 2 – All Wales Performance for the period to 30th June 2026

ALL WALES KPIs		30/09/2025	31/12/2025	31/03/2026	30/06/2026	Trend
Primary Care Services						
Prescription - Payment Month keying Accuracy rates	99%	99.81%	99.23%	99.70%	99.79%	
Prescriptions processed (Apr)		42m	50m	72m	7m	
Welsh Risk Pool						
Time from submission to consideration by the Learning Advisory Panel	95%	100%	100%	100%	100%	
Time from consideration by the Learning Advisory Panel to presentation to the Welsh Risk Pool Committee	100%	100%	100%	100%	100%	
Holding sufficient Learning Advisory Panel meetings	90%	100%	100%	100%	100%	
Legal and risk						
Advice acknowledgement- 24hrs	90%	100%	100%	100%	100%	
Advice response – within 3 days	90%	100%	100%	100%	100%	
Student Awards						
% of NHS Bursary Applications processed within 20 days	100%	100%	100%	100%	100%	
Student Awards % Calls Handled	95%	98.4%	99.3%	99.3%	99.0%	
CTeS						
P1 incidents raised with the Central Team are responded to within 20 minutes	80%	Not Applicable	Not Applicable	Not Applicable	100%	
BACS Service Point tickets received before 14.00 will be processed the same working day	92%	99%	100%	100%	100%	
Digital Workforce						
DWS % Calls Handled	85%	98%	96%	91%	93%	
SMTL						
% of Monitoring reports completed within 14 days from receipt into the laboratory	91%	100%	100%	100%	100%	
% of Monitoring reports completed within 40 days from receipt into the laboratory	91%	100%	100%	100%	100%	
% delivery of Audited reports on time (Commercial)	92%	100%	100%	100%	100%	
Pharmacy Services						
Complaints	0	0	0	0	0	
Medical Examiner						
Deaths Scrutinised		100%	100%	100%	One Month Reporting Lag	
All Wales Laundry						
Orders dispatched meeting customer standing orders	90%	97%	98%	94%	94%	
Microbiological contact failure points	85%	95%	95%	97%	99%	
Number of pieces of returned linen by customer not meeting quality standards	<100	0	0	0	0	

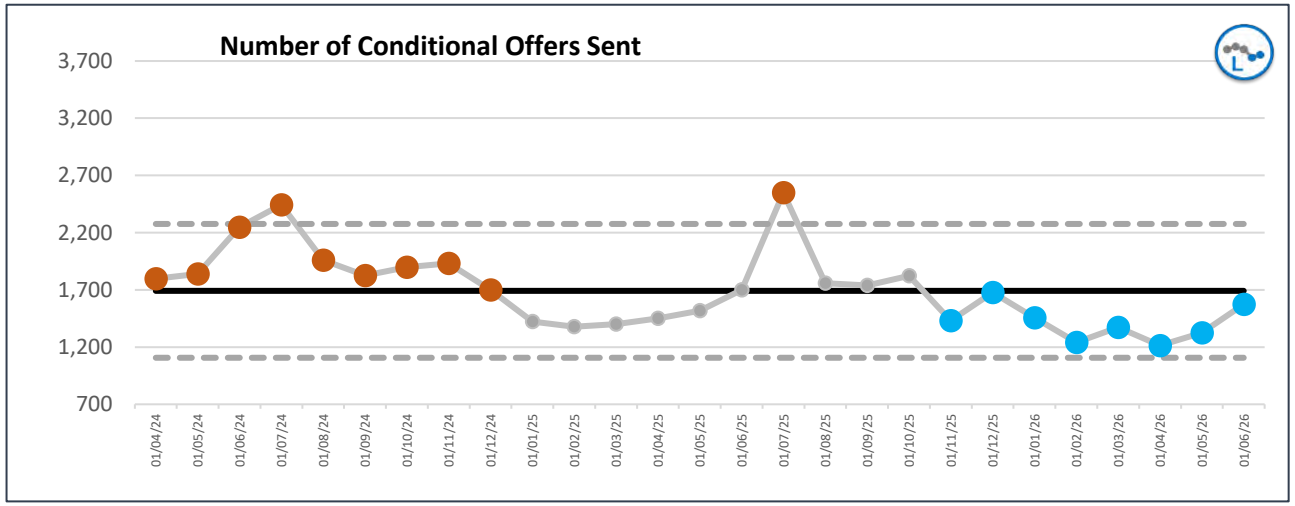
Appendix 3 – Health Org Performance comparison 30th June 2026

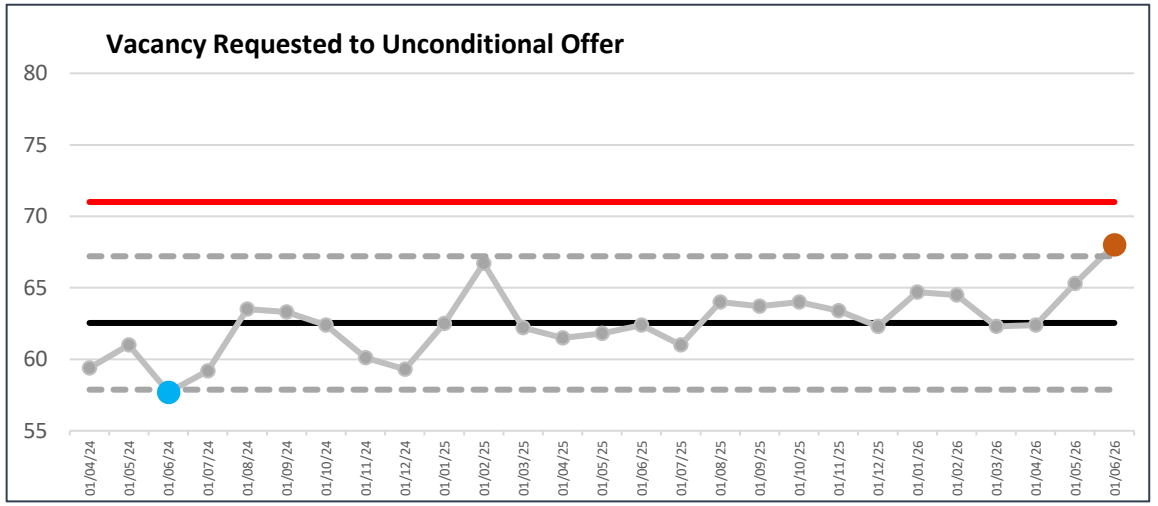
KPIs Jun 26	KFA	Target	SB	AB	BCU	C&V	CTM	HD	PHW	PTHB	VEL	WAST	HEIW	DHCW
HEALTH ORG KPIs Financial Information														
Professional Influence Savings- YTD	Our Value		£4.319 m	£5.998 m	£13.450 m	£5.435 m	£13.868 m	£2.186 m	£0.093 m	£0.185 m	£1.288 m	£0.132 m	£0.015 m	£0.001 m
Employment Services														
Payroll Services														
NWSSP Pay Accuracy	Our Services	99.6%	99.96%	99.98%	99.99%	99.97%	99.96%	99.96%	99.89%	99.97%	100.00%	100.00%	100.00%	100.00%
Overall Pay Accuracy	Our Services	99.6%	99.84%	99.91%	99.89%	99.87%	99.79%	99.86%	99.79%	99.71%	99.88%	99.71%	99.87%	99.96%
Calls Handling % Quarterly Average	Our Services	95%						98.8%						
Orgalisation KPIs Recruitment														
Vacancy creation to unconditional offer	Our Services	71 days	108.8	59.9	60.4	86.3	73.3	51.8	51.7	58.0	56.3	67.3	55.3	119.2
Time to Approve Vacancies	Our Services	10 days	40.8	8.7	5.4	17.0	29.9	7.9	4.4	3.5	0.6	0.9	9.6	Not Applicable
Time to Shortlist by Managers	Our Services	3 days	6.6	5.1	5.4	7.2	6.1	2.0	4.8	5.4	7.8	2.9	7.1	Not Applicable
Time to notify Recruitment of Interview Outcome	Our Services	3 days	7.1	3.1	2.3	3.4	2.1	2.2	3.2	2.9	2.6	1.5	6.1	6.0
NWSSP KPIs Recruitment														
Time to Place Adverts	Our Services	2 days	1.5	1.8	1.5	1.9	1.7	1.8	1.8	1.9	1.6	1.7	1.9	Not Applicable
Time to Send Applications to Manager	Our Services	2 days	1.0	1.0	1.0	1.0	1.0	1.0	1.0	0.8	1.0	1.0	1.0	Not Applicable
Time to send Conditional Offer Letter	Our Services	4 days	3.7	3.7	3.7	3.2	3.6	3.3	3.5	3.4	3.8	3.8	4.0	4.0
Calls Handling % Quarterly Average	Our Services	95%						99.6%						
Procurement Services														
Procurement Savings- YTD	Our Value		Target £3.750m Actual £2.694m	Target £4.285m Actual £5.323m	Target £3.885m Actual £3.972m	Target £5.113m Actual £4.914m	Target £3.072m Actual £2.773m	Target £1.712m Actual £1.841m	Target £0.000m Actual £0.000m	Target £0.174m Actual £0.177m	Target £0.886m Actual £0.919m	Target £0.000m Actual £0.004m	Target £0.005m Actual £0.000m	Target £0.000m Actual £0.000m
Accounts Payable														
Call Handling% - Quarterly Average	Our Services	95%						97.7%						
PSPP Compliance non NHS	Our Services	95%	97.1%	97.0%	92.6%	96.7%	95.5%	96.0%	96.7%	92.7%	96.3%	98.1%	98.1%	99.1%
PSPP Compliance NHS	Our Services	95%	87.5%	95.8%	89.0%	89.6%	83.1%	78.4%	97.2%	78.8%	91.4%	83.7%	98.8%	98.8%
Audit & Assurance														
Audits reported to Agreed Audit Committee (Excluding External Factors)	Our Services	80%	100%	100%	50%	100%	Not Applicable	Not Applicable	100%	100%	100%	100%	100%	100%
% of Audit outputs in progress	Our Services		24%	7%	26%	13%	13%	6%	25%	15%	7%	0%	9%	29%
Report turnaround (15 days) management response to Draft report - YTD	Our Services	80%	Not Applicable	Not Applicable	100%	100%	100%	Not Applicable	Not Applicable	100%	Not Applicable	Not Applicable	100%	Not Applicable
Report turnaround (10 days) draft response-final- YTD	Our Services	80%	Not Applicable	Not Applicable	Not Applicable	100%	Not Applicable	Not Applicable	Not Applicable	100%	Not Applicable	Not Applicable	Not Applicable	Not Applicable
Primary Care Services														
Primary Care payments made accurately and to timescale	Our Services	100%	100%	100%	100%	100%	100%	100%	N/A	100%	N/A	N/A	N/A	N/A
Patient assignments actioned within 24 hours	Our Services	100%	100%	100%	100%	100%	100%	100%	N/A	100%	N/A	N/A	N/A	N/A
Urgent medical record tralsfers to/from GPs and other Primary Care Agencies within 2 working days	Our Services	100%	100%	100%	100%	100%	100%	100%	N/A	100%	N/A	N/A	N/A	N/A
Cascade Alerts Issued within timescale	Our Services	100%	100%	100%	100%	100%	100%	100%	N/A	100%	N/A	N/A	N/A	N/A

Employment Services – Recruitment

For information - All Wales performance in relation to recruitment time to hire for the last 12 months ending June 26.

Recruitment Org	Target	Vacancy Creation to Unconditional Offer												
		Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Trend
AB	71	61	58	62	60	68	63	57	64	63	57	56	60	60	
BCU	71	63	68	64	65	62	62	66	68	70	68	64	59	60	
CV	71	94	102	104	98	107	116	90	95	94	84	94	92	86	
CTM	71	70	71	70	69	71	74	77	76	85	80	80	80	73	
HD	71	50	49	55	52	48	50	51	55	59	50	49	52	52	
HEIW	71	58	63	55	49	49	55	61	58	60	48	49	55	55	
DHCW	71	46	48	59	57	47	47	46	55	56	61	49	70	119	
NWSSP	71	58	42	52	57	54	48	51	55	54	56	57	55	56	
PTHB	71	71	58	68	64	72	78	69	71	62	65	61	65	58	
PHW	71	58	59	55	53	61	61	50	62	50	47	56	67	52	
SBU	71	70	70	80	73	85	79	81	85	92	86	105	112	109	
VEL	71	54	50	57	63	54	44	53	53	55	58	50	51	58	
WAST	71	76	78	63	72	74	88	77	71	75	70	68	61	67	
All Wales	71	62	61	64	64	64	63	62	65	65	62	62	65	68	





Employment Services – Recruitment

The charts below show the Vacancy creation to unconditional offer performance for the individual organisations January – June 26.

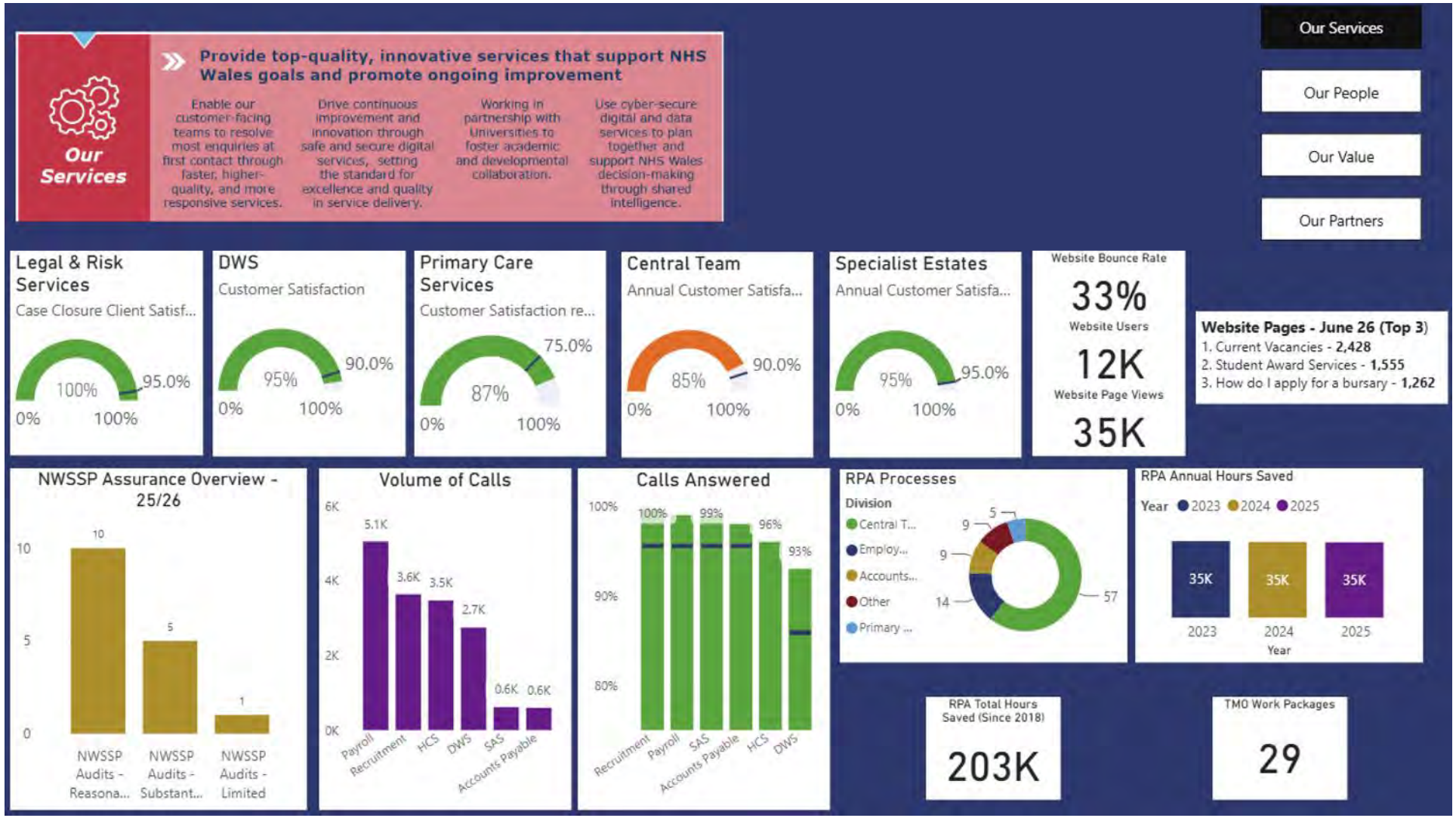


Appendix 4 – Outcome Reporting

Delivering Value, Innovation and Excellence through Partnership

GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
Shared Services Partnership

Our Services



Our People


Our Services
Our People
Our Value
Our Partners
Promote excellence through leadership, wellbeing, inclusivity, and workforce diversity
Our People
Build a capable, high-performing culture that attracts, develops, and retains talented people for the future.
Strengthen recruitment through inclusive language and diverse approaches, ensuring our workforce reflects the communities we serve.
Promote the physical, social, mental, and financial wellbeing of our people to support a healthy and resilient workforce.
Embed a culture of co-production, empowering staff at all levels to shape and improve how we work.
Sickness
Sum of Actual
Sum of Target
April - 26 - Excludes SLE
4%
2%
0%
April
May
June
July
August
September
October
November
December
January
February
March
April
May
June
2025
2026
Month
NHS Wales Staff Survey
NWSSP
All Wales
100%
50%
0%
I am able to make improvem...
I am proud to tell people I w...
I get recognition for good w...
I have a choice in deciding h...
I have opportunit... to improve...
In the last 12 months, have you h...
My organisation takes posit...
The organisation values my ...
There are frequent opportunit...
There are opportunit... for me to d...
Staff Award Submissions
176
116
138
2023
2024
2025
Top 3 Sickness Reasons
1. Anxiety/ stress/ depression/ other psychiatric illness
2. Other musculoskeletal problems
3. Heart, cardiac and circulatory problems
Response Rate - 2025
NWSSP exc SLE
Sum of Actual
100%
50%
0%
93%
91%
69%
51%
43%
41%
36%
35%
35%
33%
25%
22%
19%
19%
HEIW
NHS P&I
DHCW
PHW
WAST
VEL
CTM
C&V
POW
AB
BCU
HDU
SBU
NWSSP
Response Rate 2025 excluding SLE
46%
June 26 - Reasons for Leaving (Excluding SLE) (Top 3)
1. Voluntary
2. Retirement
3. Other
Annual Turnover (Excluding SLE)
9%
Engagement Score - 2025
Sum of Actual
50%
0%
78%
76%
76%
74%
74%
74%
72%
71%
71%
70%
70%
69%
69%
67%
HEIW
NWSSP
VEL
POW
PHW
DHCW
AB
HDU
CTM
SBU
NHS P&I
BCU
C&V
WAST
Engagement Score
76%

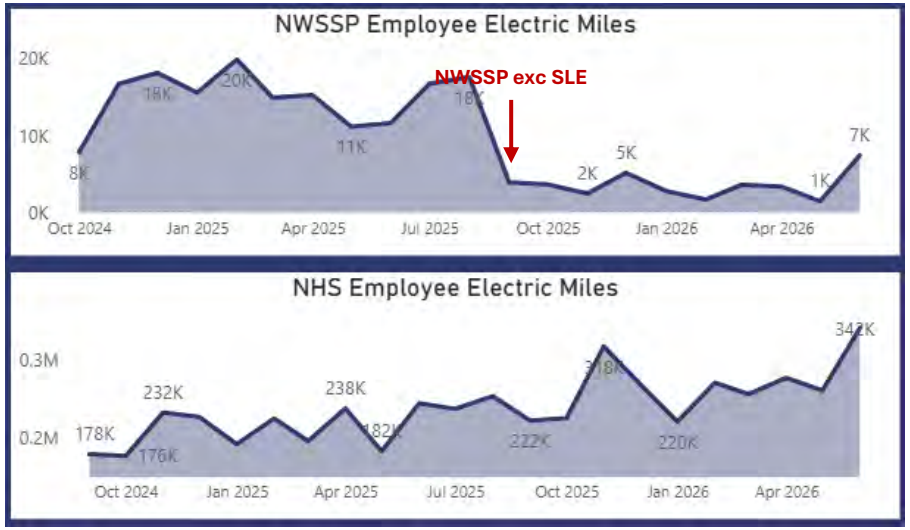
Our Value


Our Value
Increase efficiency, demonstrate value, and improve population health as part of Wales' broader health and care system
Make bold, evidence-based investment decisions through partnership governance to drive transformation and deliver value.
Collaborate across the system to tackle the climate emergency and meet decarbonisation targets.
Use resources efficiently to maximise social, environmental, and economic sustainability.
Identify opportunities to grow investment in the foundational economy across Wales through an inclusive and responsible supply chain.
Our Services
Our People
Our Value
Our Partners
NWSSP Procurement Savings - In Year
2026
£0K
£48K
£53K
NWSSP Procurement Savings - Cost Avoidance
2026
£0
£24K
£0
£ Spend in with Welsh Suppliers (Q4)
£2.33bn
% Spend in with Welsh Suppliers (Q4)
43%
£ Spend in Wales
Year 2023 2024 2025 2026
£2.1bn
£2.1bn
£2.3bn
£2.3bn
% Spend in Wales
Year 2023 2024 2025 2026
44%
43%
44%
43%
NWSSP Employee Electric Miles (% of Total Miles)
24%
NHS Employee Electric Miles (% of Total Miles)
10%
NWSSP Employee Electric Miles
7K
NHS Employee Electric Miles
342K
Travel & Subsistence (Excluding SLE)
(£'s)
60K
40K
20K
21K
50K
52K
32K
17K
2024
2025
2026
Year
Supply Chain Logistics - Electric Miles %
11%
Supply Chain Logistics - Electric Miles Number
50K
0K
22K
17K
22K
52K
30K
44K
38K
Jul 2024
Jan 2025
Jul 2025
Jan 2026
Year
% of Electric Salary Sacrifice Cars
77%
All Wales Salary Sacrifice Cars
6K
4K
3.83K
4.04K
4.15K
4.31K
4.78K
5.39K
Jul 2024
Jan 2025
Jul 2025
Jan 2026

Mileage Claims

For information - The table below provides an overview of the total mileage claims by organisation, along with the proportion that are electric miles in June 26.

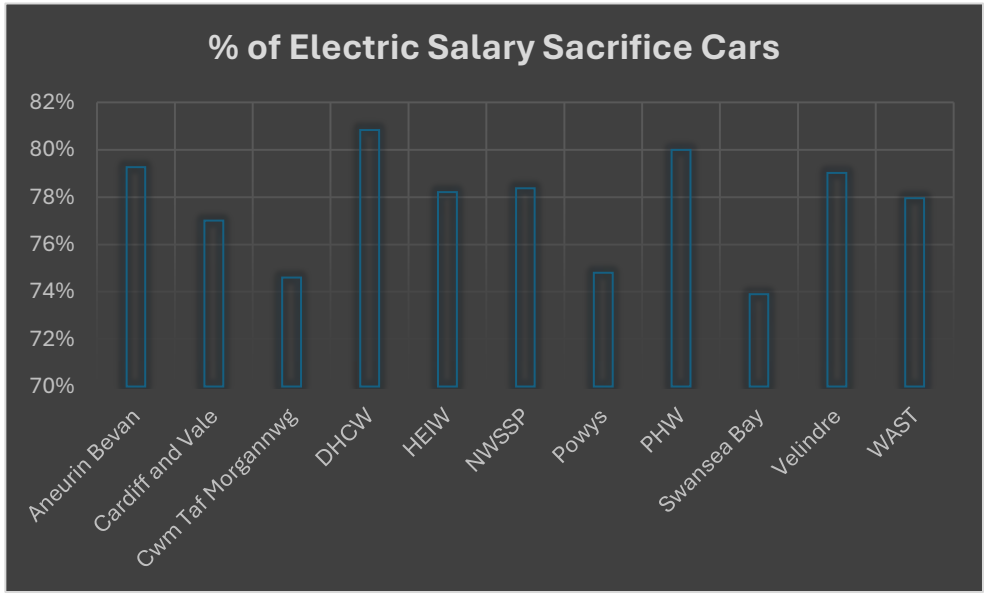
Organisation	Total Miles Claimed	Electric Miles Claimed	Electric Miles %
Cardiff & Vale	200,656	17,228	9%
WAST	157,427	20,354	13%
DHCW	10,990	2,313	21%
CVB	5,798	0	0%
Public Health	61,926	5,871	9%
AB	471,773	48,828	10%
NWSSP SLE	329,755	24,244	7%
NWSSP exc SLE	30,943	7,421	24%
BCU	680,073	86,198	13%
Powys	205,440	15,291	7%
HEIW	12,869	3,206	25%
Hywel Dda	518,410	38,359	7%
Cwm Taf	470,856	40,204	9%
Velindre	24,192	1,702	7%
Swansea Bay	383,321	31,084	8%
Total	3,564,429	342,303	10%



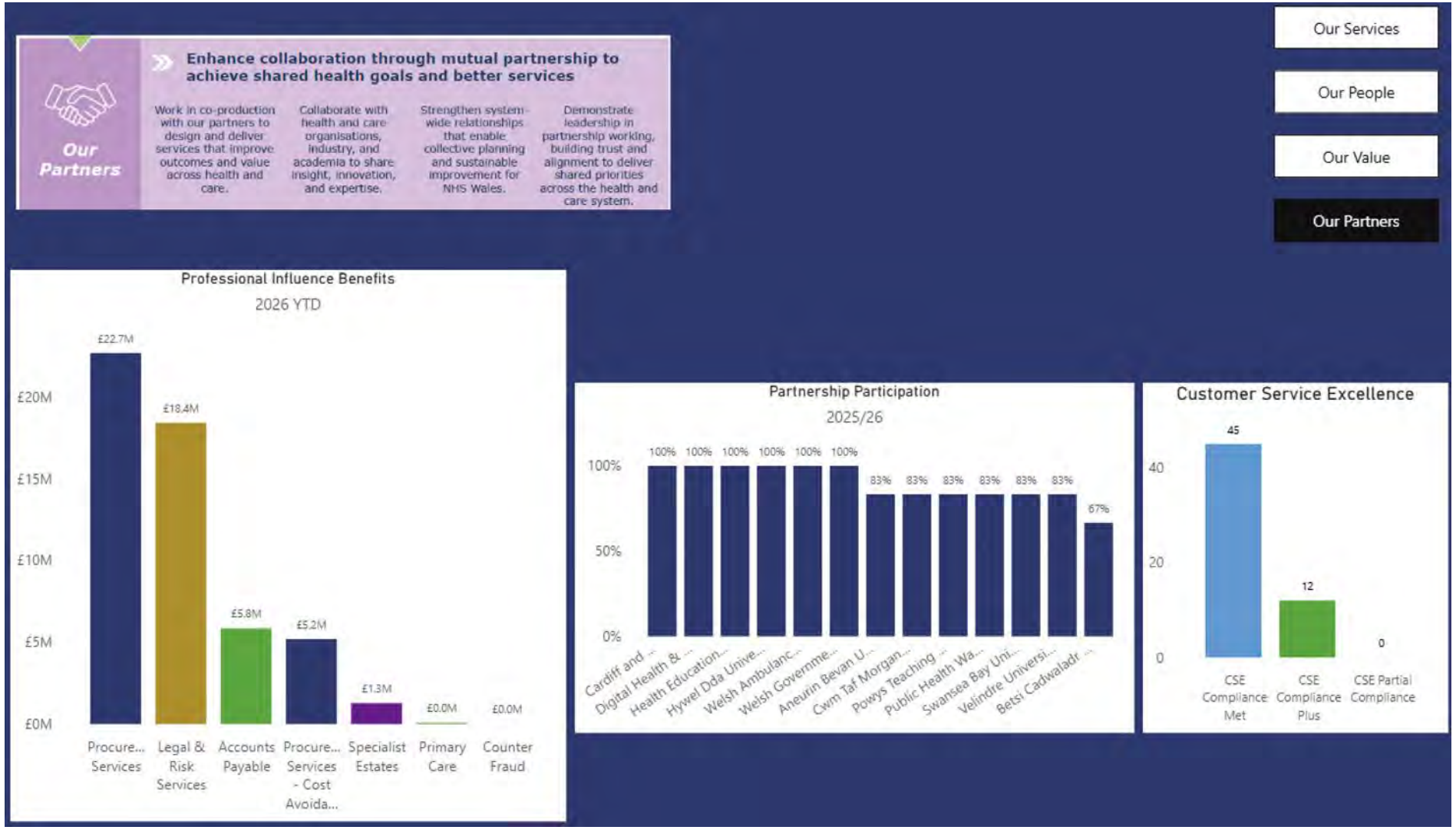
Salary Sacrifice Cars

For information - The table and chart below provide an overview of the total number of vehicles managed under the NWSSP scheme, along with the proportion that are electric as of June 26.

Organisation	Total Cars	Live Electric	Live Hybrid	Live Petrol	% Electric
Aneurin Bevan	**1124**	891	207	26	79%
Cardiff and Vale	**1105**	851	216	38	77%
Cwm Taf Morgannwg	**996**	743	212	41	75%
DHCW	**167**	135	29	3	81%
HEIW	**78**	61	15	2	78%
NWSSP	**370**	290	79	1	78%
Powys	**127**	95	25	7	75%
PHW	**180**	144	32	4	80%
Swansea Bay	**1038**	767	225	46	74%
Velindre	**143**	113	27	3	79%
WAST	**526**	410	104	12	78%
TOTAL	**5854**	**4500**	**1171**	**183**	**77%**



Our Partners



Voice of the Customer

This summary consolidates feedback gathered during recent performance meetings with NHS Health Organisations. It captures recurring themes expressed by stakeholders across divisions, grouped under “Areas of Strength” and “Areas for Consideration.” The intent is to inform continuous improvement efforts, surface emerging opportunities, and celebrate areas of high performance as voiced directly by our partners. The themes are not attributed to individual organisations but reflect collective insight.

Areas of Strength

Theme	Summary of Customer Voice
Strong Working Relationships	Praise for collaborative and supportive engagement with NWSSP teams, particularly in Accounts Payable, **Recruitment**, Audit, **Legal, Single Lead Employer** and Employment Services.
Responsiveness & Timeliness	Acknowledgement of improved responsiveness and timely support in several areas including Audit, Recruitment and **local Procurement**.
System Developments	Positive feedback regarding the usability and usefulness of the SMA application.
Engagement & Communication	Customers feel well engaged, particularly where performance is transparent and support is proactive.
Data Insight	Additional data and insights now shared routinely has received positive feedback and generated meaningful discussion.

Areas of Consideration

Theme	Summary of Customer Voice	What we have done or are doing
Recruitment Efficiency	High applicant volumes causing delays. Desire for automation, AI screening, possible use of filter questions and system usability.	Potential process improvements for handling high-volume recruitment across NHS Wales organisations.
Audit & Assurance Timeliness	Acknowledgement of delays in management responses causing delays to audit report turnaround times. Consider improving communication.	We are now ensuring that target response times are communicated to the service at the start of each audit
Customer Satisfaction Insight	Interest in more qualitative satisfaction data across services where we do not currently report – not just cost or performance metrics.	In development.
System & Process Development	Improvements in internal systems, smarter forms, and innovation in service delivery. **Share best practice with health org colleagues.**	Our Transformation Management Office and service teams are regularly collaborating to identify and implement service improvements, including the use of new technologies such as **Robotic Process Automation (RPA) and Power Automate**.
Benchmarking & Best Practice	Interest in learning from high-performing areas by sharing success stories and comparative performance insights.	We are developing a breakdown of our performance measures by each individual health organisation
Common Approach	**Identify areas where health boards do things differently within their teams and identify good practice suggestions.**	**Work with divisions to identify where processes differ and share examples of good practice**.
Data insight	**Stronger data science capability is needed to support analysis, insights and value realisation across services.**	**Explore how insight is shared across the health organisations.**

Any specific points from the meetings are being picked up with the relevant division separately.

GIG CYMRU NHS WALES | Partneriaeth Cydwasanaethau Shared Services Partnership

Audit & Assurance performance final position for 2025/26.

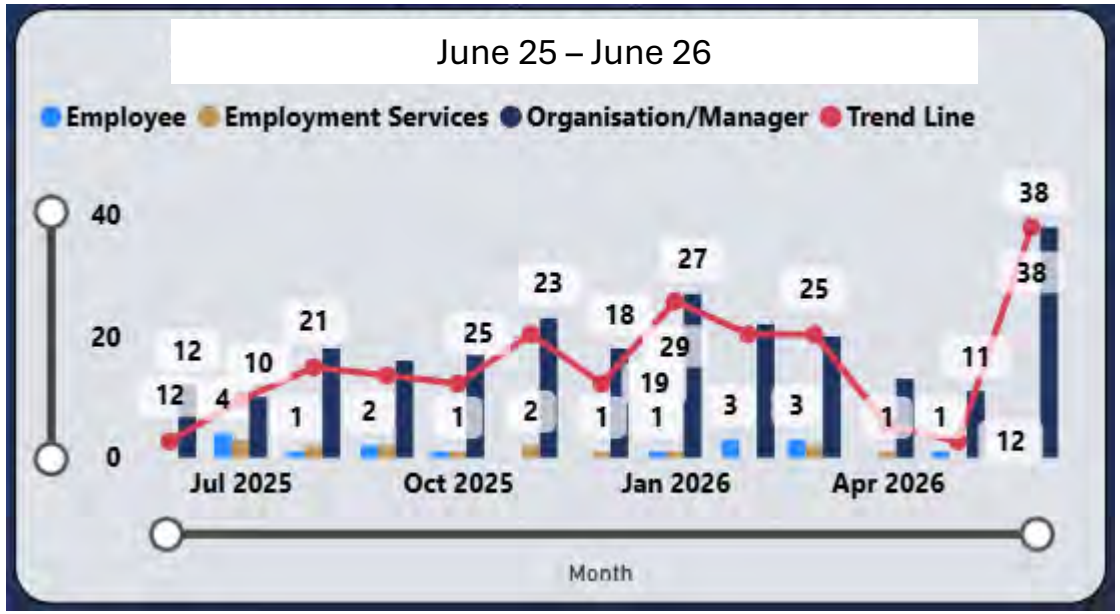
Client	Total Reviews Planned	Audits Reported (Draft/Final)	Audits in Progress	Report turnaround fieldwork to draft reporting [10 days]	Report turnaround management response to draft report [15 days]	Report turnaround draft response to final reporting [10 days]
Aneurin Bevan	25	100.00%	0.00%	100.00%	50.00%	100.00%
Betsi Cadwaladr	34	94.00%	6.00%	100.00%	64.00%	100.00%
Cardiff & Vale	33	97.00%	3.00%	100.00%	70.00%	100.00%
Cwm Taf Morgannwg	29	86.21%	13.79%	100.00%	33.33%	100.00%
DHCW	12	100.00%	0.00%	100.00%	58.00%	100.00%
HEIW	11	100.00%	0.00%	100.00%	81.82%	100.00%
Hywel Dda	29	100.00%	0.00%	100.00%	73.00%	100.00%
NWSSP	16	93.75%	6.25%	100.00%	73.00%	100.00%
PHW	12	100.00%	0.00%	100.00%	91.67%	100.00%
Powys THB	21	95.00%	5.00%	100.00%	84.00%	100.00%
Swansea Bay	26	100.00%	0.00%	85.00%	70.00%	100.00%
Velindre	17	100.00%	0.00%	100.00%	73.00%	100.00%
WAST	20	100.00%	0.00%	80.00%	80.00%	100.00%
Total	**285**	**97.38%**	**2.62%**	**97.31%**	**69.37%**	**100.00%**

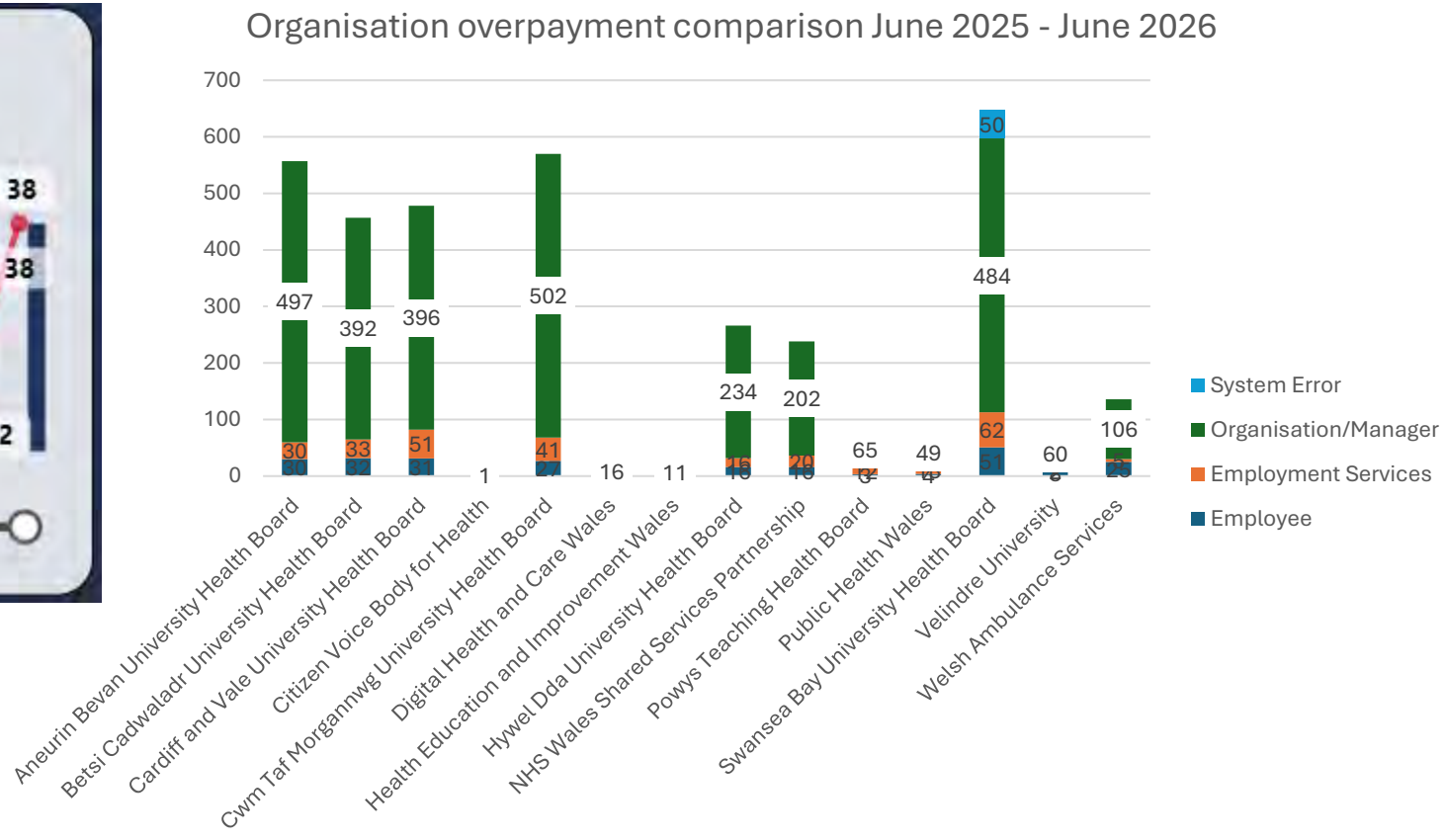
Supporting information for the Procurement savings - The table below provides an overview of the identified cash releasing procurement savings by procurement team for April – June 2026.

HB – Hywel Dda	HDT	
TEAM DELIVERING SAVINGS (APR–JUN)	**Target**	**Actual**
HYWEL DDA PROCUREMENT TEAM	£82,508	£147,260
NATIONAL - CLINICAL	£10,000	£76,799
NATIONAL - ENERGY	-	£3,367
NATIONAL - HOTEL SERVICES AND TEXTILES	£21,848	-
NATIONAL - ICT & OFFICE EQUIPMENT	-	£3,105
NATIONAL - MAINTENANCE	£2,049	£4,531
NATIONAL - MEDICAL	£6,533	£11,981
NATIONAL - PHARMACY	£1,585,036	£1,594,117
NATIONAL - PROVISIONS	£4,326	£143
TOTAL	**£1,712,300**	**£1,841,303**

Payroll Overpayments

For information - The chart below provides a summary of the payroll overpayment volumes for the organisation, based on data from the overpayments dashboard covering the period from June 2025 to June 2026.





Note: The data was recorded as at the end of June .

NWSSP Opportunities – For information

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NWSSP Opportunities

2026/27 work already commenced - The table below summarises the opportunities already under way.

Initiative	Strategic benefit	Impact	Status	Next milestone	Lead	Target Date
Estate rationalisation	Rationalise the estate footprint and secure sustainable accommodation solutions across South East and North Wales.	£ cost saving	Search activity is under way in South East Wales. Engagement with partner organisations is planned to test North Wales options, including Llandudno Junction.	Complete the option appraisal and confirm the preferred estate solution.	Jonathan Nettleton *(Head of Estates and Facilities)*	Q2
Laundry service efficiency review	Improve the sustainability of laundry services through service reconfiguration or external income generation.	Operational efficiency £ income generation	An option appraisal is in progress to assess service consolidation and wider market opportunities.	Conclude the appraisal and identify the recommended delivery model.	Anthony Hayward *(Assistant Director of Laundry Operations)*	Q2
Accounts Payable redesign	Increase efficiency and release capacity through automation and a standardised operating model.	£ Cost saving Operational efficiency	A baseline assessment has been completed and is informing the wider change approach. New Head of Accounts Payable appointed to start in post in October 2026.	Develop the change plan and confirm implementation timetable.	Linsay Payne *(Deputy Director of Finance with responsibility for Accounts Payable)*	Q3/Q4
Fleet optimisation Review	Identify opportunities to improve fleet efficiency, utilisation and value for money.	£ Cost saving Operational efficiency	Delivery is linked to the external review commissioned through the agreed PBC for 2025/26.	Receive the review findings and agree the priority improvement actions.	Jonathan Irvine *(Director of Procurement & Health Courier Services)*	Q2
Payroll modernisation	Modernise payroll delivery and release capacity in advance of the Future Workforce Solution.	£ Cost saving Operational efficiency	Progress is dependent on Swansea Bay's transition to SMA App, which remains a key prerequisite.	Confirm the dependency timeline and agree the scope of modernisation.	Darren Rees *(Deputy Director of Employment Services)*	Q2
Procurement framework access model	Generate additional income through framework access arrangements for non-NHS Wales organisations.	£Income generation	The opportunity has been identified and now requires development into a deliverable commercial model. Engagement has been undertaken with 3rd parties and we are awaiting final confirmation.	Develop the business proposition, pricing approach and implementation plan.	Jonathan Irvine *(Director of Procurement & Health Courier Services)*	Q2

NWSSP Opportunities

2026/27 work already commenced - *Continued*

Initiative	Strategic benefit	Impact	Status	Next milestone	Lead	Target Date
Direct purchasing agreements	Strengthen supply resilience through direct purchasing arrangements with manufacturers. Value and Sustainability on non-pay.	Quality £Cost saving	The opportunity has been identified and is ready for prioritisation and market scoping. Engagement has begun with potential manufacturers.	Confirm priority categories and commence market engagement.	Jonathan Irvine *(Director of Procurement & Health Courier Services)*	Q2
TrAMs programme delivery – Additional benefits	Improve resilience and deliver cash-releasing benefits through the TrAMs programme.	Quality £Cost saving	Delivery is progressing through the existing programme, with South West and North hub projects now mobilised.	Monitor hub delivery milestones and confirm the associated benefit profile. Additional opportunities on ward boxes and pharmacy offerings.	Laura Jayne Keating *(Director of Pharmacy Services)*	Yr 1-3
Future Workforce Solution delivery	Reduce external dependency and streamline transactional HR services through a centralised delivery model.	Operational Efficiency	This work sits within the wider FWS programme and now requires clearer definition of scope and expected benefits.	Confirm scope, dependencies and anticipated service and financial benefits.	Gareth Hardacre *(Director of Workforce, OD and Employment Services)*	Yr 1-3
Oracle Finance point release	Support the Finance Operating Model through improved use of existing Oracle functionality.	Operational Efficiency	The opportunity has been defined and now requires formal agreement of scope and delivery requirements.	Agree the requirements and approve the delivery plan.	Alison Ramsey *(Director of Finance and Corporate Services)*	Q2
Medicines value procurement	Deliver targeted savings through enhanced analytics and more focused medicines procurement.	£Cost savings Quality Operational Efficiency	The opportunity has been identified, with investment required to enable the necessary analytical capability. Awaiting approval of business case by Welsh Government.	Develop the investment case and confirm the benefits profile.	Laura Jayne Keating *(Director of Pharmacy Services)*	Q2
Primary care low vision service	Improve user experience through a more responsive product access model.	Quality £Cost saving	The opportunity has been identified and now requires definition of the operational delivery model.	Confirm the operating model and implementation requirements.	Nicola Phillips *(Director of Primary Care Services)*	Q2

Additional Opportunities - The table below summarises additional opportunities.

Initiative	Strategic benefit	Impact	Status	Lead
Medical workforce recruitment	Consistency of approach across NHS Wales. Alignment with workforce planning including international recruitment.	Quality £Cost Saving Operational Efficiency	A number of WODs have requested that NWSSP consider this opportunity.	Gareth Hardacre *(Director of Workforce, OD and Employment Services)*
All Wales Staff Bank	Easier cover for sickness, vacancies and busy periods. Less reliance on agency. Keeps experienced NHS workers within the service.	Quality £Cost Saving Operational Efficiency	Project scoping exercise established.	Gareth Hardacre *(Director of Workforce, OD and Employment Services)*
Primary Care procurement	Improved compliance with new Procurement Act. Consistency of approach across NHS Wales. Alignment with Community by Design principles. Knowledge of GP practice arrangements and established stakeholder relationships within Primary Care Services.	Quality	Primary Care Directors have raised concerns about compliance driven by capability and capacity concerns in their local teams. A recent Audit Wales report highlighted weaknesses in an isolated case. Lack of capacity within NWSSP to absorb this without additional resource.	Jonathan Irvine *(Director of Procurement & Health Courier Services)* Nicola Phillips *(Director of Primary Care Services)*
Estates procurement	Improved compliance with new Procurement Act. Consistency of approach across NHS Wales. Could be developed on a regional footprint, not necessarily a national footprint.	£Cost saving Operational Efficiency	Lack of capacity within NWSSP to absorb this without additional resource.	Jonathan Irvine *(Director of Procurement & Health Courier Services)* Stuart Douglas *(Director of Specialist Estates Services)*

Additional Opportunities - *Continued*

Initiative	Strategic benefit	Impact	Status	Lead
Local Counter Fraud Services – South West Wales	Regional collaboration model, whilst not mandating a national model. Consistency of approach to service delivery and risk assessment. Resilience in the workforce. Career development opportunities. Aligns with Counter Fraud Strategy for NHS Wales.		Request from DoFs in the South West region for NWSSP to host local counter fraud services under a Lead LCFS. Draft paper prepared by the DoFs shared with NWSSP in June 2026 for further development. Professional leadership and support from the Head of Counter Fraud Wales.	Alison Ramsey *(Director of Finance and Corporate Services)*
Accounts Receivable	Processing consistency with standardised policies for invoicing, credit checks, collections and write-offs. Improved customer experience with a single point of contact. Single source of truth for AR data allowing improved monitoring, benchmarking and analytics.	Operational Efficiency	Early stage of exploration.	Alison Ramsey *(Director of Finance and Corporate Services)*

Longer-term initiatives - The table below summarises longer-term opportunities.

Initiative	Strategic benefit	Impact
All Wales Decontamination Services	Centralisation would reduce bureaucracy and present best service based upon locality and clinical need rather than organisational need. It provides an opportunity to reduce certification and accreditation costs by operating a single quality management system across Wales, thereby reducing the overhead in the maintenance of SOPS, equipment, training, and potentially spreading the costs of third party inspections. It also provides resilience by ensuring that the specialist expertise required is available across the whole of the Welsh NHS rather than being siloed within Health Boards.	Quality £Cost saving Operational Efficiency
Shared Business Services for Wider Public Sector	NWSSP already provides high-quality administrative and professional services across NHS Wales. By widening the scope of our services, NWSSP will be able to generate a public sector distribution back into NHS Wales. Investment may be needed for new systems/process in order to provide services to non-NHS bodies.	£Income generation

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6

6 - FOR APPROVAL

6.1

6.1 - MACMILLAN CANCER SUPPORT NEIGHBOURHOOD INVESTMENT PARTNERSHIP BUSINESS CASE STRATEGIC INTENT

Ardiana Gjini (Hywel Dda UHB - Executive Director of Public Health), Bruce Bolam (Hywel Dda UHB - Deputy Director Public Health/Consultant in Public Health)

For approval

Attachments

Macmillan Partnership Business Case FPC 27 August 2026.pdf

Attachment 1 Macmillan Business Case.pdf

Attachment 2 Modelling Benefits.pdf

Appendix 1 Health Coaching Current Position.pdf

Appendix 2 Brazil Model.pdf

Appendix 3 CHWW Business Case.pdf

Appendix 4 Demonstrator Project Report.pdf

Appendix 5 Communications and Engagement Plan.pdf

Appendix 6 Evidence Reviews and Literature Synthesis.pdf

Appendix 7 Macmillan GANTT Chart.pdf

Appendix 8 Macmillan Funding Agreement Template.pdf

Appendix 9 Macmillan Quality Impact Assessment.pdf

Appendix 10 Macmillan Health Equity Impact Assessment.pdf

Appendix 11 Macmillan Equality Impact Assessment.pdf

Pwyllgor Cyllid a Pherfformiad/ Finance and Performance Committee

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	27 August 2026
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Macmillan Cancer Support Neighbourhood Investment Partnership Business Case
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Dr Ardiana Gjini, Executive Director of Public Health
SWYDDOG ADRODD: **REPORTING OFFICER:**	Dr Bruce Bolam, Deputy Director/Consultant in Public Health Rhian Evans, Principal Project Manager

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Ar Gyfer Penderfyniad/ For Decision

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The Finance and Performance Committee is asked to scrutinise the affordability, value for money, financial risk, delivery confidence and governance route for the Macmillan Cancer Support Neighbourhood Investment Partnership business case (**Attachment 1**). The partnership aims to improve population health, reduce health inequalities, strengthen community resilience and support cancer prevention through a neighbourhood-based model of prevention and early intervention.

The strategic intent of the business case was supported at the 12 August 2026 meeting of Formal Executive Team. However, further assurance is required before the Health Board enters into any binding funding agreement. A staged governance route is therefore proposed.

It is recommended that the 24 September 2026 meeting of Board be asked to approve the strategic intent of the partnership and authorise continued negotiation of the final agreement. This would not authorise execution of the agreement or create a binding financial commitment. The grant agreement would then return to the 27 October 2026 meeting of this Committee for further deliberation. The agreement would then be submitted for final approval at the 26 November 2026 Board meeting.

Cefndir / Background

The partnership has been developed in response to increasing healthcare demand, rising prevalence of cancer and long-term conditions, persistent health inequalities and the need to strengthen prevention and community-based support across Mid and West Wales. The proposal aligns with:

- A Healthier Mid and West Wales Strategy.
- Community by Design.
- The Social Model for Health and Wellbeing.
- The 20four7 Prevention Model.
- Welsh Government prevention priorities.
- Value-Based Healthcare principles.
- Macmillan Cancer Support's Neighbourhood Health Programme.

The business case has been developed by a project team led by Public Health, Primary Care, Value-Based Health Care and Research and Innovation staff, and through workshops and consultation with Macmillan Cancer Support and key internal and external stakeholders, including third sector organisations and local authorities across the three counties in the Hywel Dda University Health Board (HDdUHB) region.

The business case relates to two separate funding streams:

1. **Social Investment Fund (Repayable)**

The business case proposes approximately **£9.35 million of repayable social investment funding** to support programme implementation, workforce development, evaluation and service delivery over a five-year Neighbourhood Prevention Programme. Repayment would be governed through an outcomes-based funding agreement, with payments linked to agreed delivery, outcome and healthcare-utilisation measures and capped at the value of social investment funding received.

2. **Anchor Grant (Non-Repayable)**

The proposal includes approximately **£2 million of non-repayable Anchor Grant funding**, intended to be invested directly by Macmillan Cancer Support into community and third-sector infrastructure, neighbourhood coordination, community development, volunteering programmes, micro-grants and local prevention initiatives, in alignment with the overall partnership objectives. This element does not create a repayment liability for the Health Board.

The total programme value is therefore currently approximately **£11.35 million over five years**, comprising £9.35 million repayable social investment and £2.0 million non-repayable Anchor Grant funding, within a proposed eight-year partnership and repayment framework.

The proposed agreement may create a material future liability over the life of the contract and should therefore return to Board for final approval before execution, following Director of Finance oversight, procurement advice, legal review and completion of due diligence.

Asesiad / Assessment

The business case sets out the core financial, delivery, evaluation and governance architecture for the proposed partnership. The proposed repayable exposure, annual repayment profile, benefits realisation framework, gateway model, programme risks and key mitigations have been developed and scrutinised through Executive review. The principal issues are summarised below.

Financial and Benefits Assessment

The repayable exposure is the £9.35 million social investment element of the partnership, with total outcomes payments capped at the value of funding received. The current business case sets out an indicative annual repayment profile, with payments beginning at approximately £353,000 in Year 2, rising to approximately £834,000 in Year 3, £1.25 million in Year 4 and £1.67 million in Year 5, followed by approximately £1.75 million annually in Years 6 to 8. This extended profile is intended to avoid concentrating repayment during early implementation, when programme costs are being incurred but longer-term utilisation benefits have not yet fully developed.

Financial benefits have been modelled as cost avoidance and moderated future demand growth rather than guaranteed cash-releasing savings. Benefits modelling has been undertaken using two complementary approaches: TriTech's conservative estimate of approximately £5.2 million over five years, based mainly on smoking and alcohol-related interventions, and National Association of Primary Care modelling indicating potential benefits of up to £12.4 million over five years, based on broader assumptions about participant outcomes and reduced healthcare utilisation. The range reflects the inherent uncertainty in prevention modelling and provides an appropriate basis for testing the programme through implementation and evaluation, with payment contingent on benefits realisation.

The proposal should be assessed through a Value-Based Healthcare lens. The question is not whether prevention produces immediate cash-releasing savings, but whether it delivers sufficient value through improved outcomes, reduced inequalities, better experience, stronger community resilience and moderated future demand, relative to the resources and financial exposure involved. This avoids applying a narrower and higher test to prevention than that applied to other investments when they are nationally directed, improve access or quality, or respond to immediate service pressures, even where they may increase recurrent cost.

Evaluation and Benefits Realisation

The business case includes an evaluation framework combining reach, engagement, retention, behavioural outcomes, patient activation, clinical indicators, healthcare utilisation, longer-term disease outcomes and wider outcomes such as wellbeing, social connection and community participation. It also proposes independent evaluation and validation, including matched comparison methods where feasible. These arrangements are intended to reduce uncertainty progressively as the participant cohort and follow-up period increase. The remaining task is to translate this framework into final contractual schedules, including agreed measures, thresholds, validation rules and reporting arrangements.

Governance and Risk

The business case includes a staged implementation model across three neighbourhoods, formal gateway reviews, a programme risk register, separation of the non-repayable Anchor Grant from the repayable social investment element, alignment of recruitment and delivery commitments with confirmed funding, and a proposed programme governance structure. These arrangements provide important controls over implementation, financial exposure and future expansion.

The main outstanding matters are confirmation that the final outcomes methodology and independent validation arrangements are robust; the maximum Health Board liability and annual repayment profile are explicit and affordable; the contractual fallback mechanism is acceptable; gateway, variation, withholding and termination provisions preserve appropriate

Health Board control; workforce and delivery commitments do not run ahead of confirmed funding; procurement and accounting treatment are confirmed; and the final contractual terms remain consistent with the business case and financial parameters approved by Board.

The recommended approval route is for Board on 24 September 2026 to consider the strategic intent of the partnership. This would authorise continued negotiation and development of the agreement but would not authorise execution or create a binding financial commitment. The grant agreement would then return to the 27 October 2026 meeting of this Committee for further deliberation. The agreement would then be submitted for final approval at the 26 November 2026 Board meeting.

Argymhelliad / Recommendation

It is recommended that the Finance and Performance Committee:

- **SUPPORT** the strategic direction of the Macmillan Cancer Support Neighbourhood Investment Partnership.
- **NOTE** that this does not constitute approval of the final business case, funding agreement or any binding financial commitment at this stage.
- **NOTE** that further work is required on the legal, contractual and financial detail before formal approval can be considered.
- **AGREE** that a final business case will return to the next meeting of the Finance and Performance Committee for scrutiny before any onward recommendation to Board.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cylch Gorchwyl y Pwyllgor: Committee ToR Reference:	3.1.9 Conduct detailed scrutiny of all aspects of financial performance, the financial implications of significant revenue expenditure (all those over £1million requiring Board approval), business cases (except those that are capital and digital in nature), projects, and proposed investment decisions on behalf of the Board.
Cyfeirnod Cofrestr Risg Datix, Teitl a Sgôr Risg Cyfredol: Datix Risk Register Reference and Score:	The proposal contributes directly to the mitigation of the following principal risks: Risk 1198, Ability to shift care into the community, current score 16 Risk 1194, Increasing uptake and access to public health interventions, current score 12 Risk 1193, Failure to address health inequalities, current score 9 Risk 1188, Effective leveraging within partnerships, current score 9. It also supports the wider strategic response to Risk 1192, Wrong value set for best health and wellbeing,

	current score 12, by accelerating the shift towards prevention, neighbourhood working and community-based support.
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	7. All apply
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	6. All Apply
Amcanion Strategol y BIP: UHB Strategic Objectives:	All Strategic Objectives are applicable
Nodau Cynllunio 2026/27 Planning Goals 2026/27	3. 20Four7 Population Health 4. Community by Design 5. People First, Digital Always 6. Safe, Timely, High Quality Care 7. Future Orientated
Hypergyswllt i Amcanion Llesiant HDdUHB 2026 Hyperlink to HDdUHB Well-being Objectives 2026	5. Foster a learning culture by sharing knowledge and applying new ways of working that enhance local and global well-being 6. Work with partners and communities to nurture and support everyone to achieve their best well-being 7. Improve health and well-being by focusing on prevention and early intervention, while working in partnership to ensure everyone has equal access to care and opportunities for good health
Model Cymdeithasol ar gyfer Iechyd a Llesiant: (wedi'i gwblhau ar gyfer newid strategol a/neu newidiadau sylweddol i wasanaethau) A Social Model for Health and Wellbeing: (*complete for strategic change and/or significant service changes)*	7. All Apply
Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	**Attachment 1:** Macmillan Cancer Support Neighbourhood Investment Partnership: Business Case; **Attachment 2:** Modelling Benefits; **Appendix 1:** Health Coaching current position; **Appendix 2:** Brazil model; **Appendix 3:** CHWW Business Case; **Appendix 4:** Demonstrator project report; **Appendix 5:** Communications and Engagement Plan; **Appendix 6:** Evidence Reviews and Literature Synthesis; **Appendix 7:** Macmillan GANTT chart;

	Appendix 8: Macmillan Funding Agreement Template; **Appendix 9:** Macmillan Quality Impact Assessment; **Appendix 10:** Macmillan Health Equity Impact Assessment; **Appendix 11:** Macmillan Equality Impact Assessment.
Rhestr Termau: Glossary of Terms:	Please see full business case (**Attachment 1**)
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y cyfarfod hwn: Parties / Committees consulted prior to this meeting:	Development has involved Public Health, Primary Care, Value-Based Health Care, Research & Innovation, Macmillan Cancer Support, local authority partners, peak third sector and patient representation organisations and internal service stakeholders.

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	The programme will provide approximately £11.35 million of investment, comprising £9.35 million of repayable outcomes-based social investment funding and a £2.0 million non-repayable Anchor Grant. The main financial issue is that repayment may need to be funded from future Health Board resources because benefits are expected mainly through broader value, cost avoidance and moderated demand rather than guaranteed cash-releasing savings. Final approval should therefore be subject to confirmation of affordability, source of repayment, accounting treatment, procurement route, capped liability, fallback provisions and Board approval before execution.
Ansawdd / Gofal Claf: Quality / Patient Care:	The programme is expected to have a positive impact on quality and patient care by improving access to personalised, preventive and community-based support. The Quality Impact Assessment is included as Appendix 9 and is being finalised through internal Health Board processes, including completion of the metrics and risk-scoring sections, before final approval.

Gweithlu: **Workforce:**	The proposal includes 17 WTE Health Coaches and programme support, alongside neighbourhood-based Community Health and Wellbeing Worker capacity to be commissioned through the third sector. The principal workforce issue is the management of fixed-term recruitment, supervision, redeployment and exit arrangements, ensuring workforce commitments do not run ahead of confirmed funding and gateway decisions.
Tegwch Iechyd: **Health Equity:**	The programme is explicitly intended to reduce health inequalities by targeting neighbourhoods with higher need, improving access to prevention and early intervention, and strengthening local community assets. An equity-focused impact assessment has been completed and is included as **Appendix 10**.
Risg: **Risk:**	Key risks relate to future financial liability, affordability, benefits realisation, contractual fallback, gateway control, recurrent sustainability, workforce liabilities, delivery capacity and partner alignment. The staged approval route mitigates these risks by separating strategic-intent approval from final contractual approval, allowing further deliberation by the Committee if required and preserving gateway decision-points during programme delivery.
Cyfreithiol: **Legal:**	Further legal and risk advice is being sought because of the novel outcomes-based repayment model. Execution of any binding agreement must remain subject to satisfactory assurance on funding and repayment provisions, liabilities, procurement, data sharing, variation, withholding, gateway, fallback and termination arrangements. The final agreement should return to Board for approval before execution because the proposed contract value and potential liability are material to the Health Board's financial and governance position.

Enw Da: **Reputational:**	The partnership offers a significant reputational opportunity through partnership with Macmillan Cancer Support and visible investment in prevention and communities. Reputational risks include failure to deliver anticipated benefits, unclear public messaging, or entering financial commitments without sufficient assurance.
Gyfrinachedd: **Privacy:**	The programme will involve referral, assessment, outcomes monitoring and information sharing between partners. Data protection, confidentiality, information governance and data sharing arrangements will reflect established Health Board policies and procedures.
Cydraddoldeb: **Equality:**	The proposal is expected to have positive equality impacts by improving access to prevention and support in communities experiencing higher levels of need. An Equality Impact Assessment screening has been undertaken and is provided as Appendix 11. This positive evaluation means it has been unnecessary to complete a full Equality Impact Assessment.

Macmillan Cancer Support Neighbourhood Investment Partnership: Business Case



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Executive Summary

This business case seeks approval for a five-year Neighbourhood Prevention Programme. The programme will help Hywel Dda University Health Board (HDdUHB) improve early intervention, prevention and neighbourhood-based support for people affected by cancer and other long-term health conditions.

Funding from Macmillan Cancer Support will be used to develop, test and evaluate a new Community by Design approach in three high need neighbourhoods across Carmarthenshire, Ceredigion and Pembrokeshire. The programme aims to strengthen local communities, improve access to preventive services, and help people stay healthier for longer, reducing the need for avoidable healthcare interventions.

The programme is aligned with HDdUHB's strategic objectives, Welsh Government priorities, Value-Based Health Care principles and the Macmillan Neighbourhood Health Programme. It responds to the increasing demands on our health services, the growing prevalence of cancer and other long-term conditions and persistent health inequalities by investing in the wider determinants of health and shifting resources upstream towards prevention and community-based solutions.

The programme will be funded through a combination of repayable Macmillan Social Investment funding and a non-repayable Anchor Grant. This provides a unique opportunity to develop, test and evaluate a new model of neighbourhood health that addresses the wider determinants of health whilst strengthening community capacity and resilience.

Proposed Model

The programme consists of three integrated components:

Neighbourhood Prevention Support

- Anchor Grant funding for local neighbourhood asset mapping, coordination and community development initiatives, vital to ensuring the other two components can function effectively.
- Strengthens local community infrastructure to enable sustainable prevention and wellbeing activities at neighbourhood level.
- Macmillan will directly commission and fund the third-sector to deliver this element of the programme, with participant inclusion and exclusion criteria established during service design and implementation.

Community Health and Wellbeing Workers (CHWWs)

- Proactive neighbourhood outreach through relationship-based engagement with households experiencing the greatest disadvantage.
- Earlier identification of unmet need, improved access to services and strengthened community resilience.
- Expected to engage 3,000 residents annually.

Health Coaching

- Personalised behaviour change support focused on smoking cessation, alcohol reduction, diet and physical activity.
- Referrals from primary care, community services and priority access pathways including cancer, cardiovascular, respiratory and diabetes services.
- Expected to support 3,000 individuals annually.
- Identification, referral, triage and participant eligibility processes for this component are outlined on pages 10–11.

The programme will also fund neighbourhood-based training and support for ‘Making Every Contact Count’, together with digital tools to support behaviour change, improve access to services, and enable effective monitoring and evaluation of programme impact.

Expected Benefits

The programme aims to deliver:

- Improved health behaviours and self-management.
- Increased patient activation and wellbeing.
- Earlier identification of need and reduced health inequalities.
- Greater utilisation of community assets and support networks.
- Improved integration between health, care and community services.
- Reduction in avoidable demand on primary, community and acute healthcare services.
- Long-term reductions in preventable disease, including cancer, cardiovascular disease and diabetes.

Evaluation and Benefits Realisation

A comprehensive evaluation will be delivered by the TriTech Institute and the HDdUHB Research and Innovation Team with external advisors from the National Association of Primary Care. This will assess how well the programme is working, including its impact on health outcomes, patient experience, use of services and value for money.

The programme will be introduced in one neighbourhood in each county during the first three years. Each neighbourhood intervention will be established for at least three years, with ongoing evaluation. This phased approach will allow learning from early implementation to shape future investment and delivery decisions for the programme and the region more broadly.

Progress will be measured through a set of jointly agreed key performance indicators and annual evaluation reports. Alongside the formal evaluation, the Programme Board will use a Quality Improvement approach, including Plan-Do-Study-Act (PDSA) cycles, to test changes, learn from experience and refine delivery as the programme develops. This will support continuous improvement, ensure services respond to local needs, and help spread effective practice across all elements of the programme.

Delivery and Governance

The programme will be delivered over five years (October 2026 – September 2031). Whilst comparable programmes are typically funded over three years, a five-year period has been agreed to enable the programme to establish neighbourhood infrastructure, test and refine the model, generate robust evidence of impact and fully assess the medium-term benefits of neighbourhood-based prevention. This extended timeframe will support learning, adaptation, benefits realisation and the development of a sustainable commissioning model.

The programme will be governed through a dedicated Programme Board chaired by the Executive Director of Public Health as Senior Responsible Owner, supported by established partnership, assurance and corporate governance arrangements within HDdUHB documented in the Project Governance section of this business case, below.

Financial Summary

The programme seeks £11.35 million of investment over five years, combining £9.35 million of repayable Social Investment Fund funding with £2 million of non-repayable Anchor Grant funding to scale a population health and prevention model that integrates health coaching, community-based support, digital interventions, workforce development and evaluation, delivering long-term health improvement and sustainable demand reduction across the system. Further detail on the investment profile and funding requirements is provided on page 29 of the business case.

The KPIs that will trigger repayment of the Social Investment Fund are outlined on pages 29–30 of the business case. These measures form the basis of the outcomes framework against which programme performance will be assessed. Discussions with Macmillan regarding the repayment mechanism, including the timing, profile and period over which any repayments would be made by the Health Board should the agreed KPIs be achieved, are ongoing and have not yet been finalised.

The proposed funding model includes a repayable loan component, with repayments commencing in Year 2. Although the programme is forecast to generate substantial financial and non-financial benefits, recurrent funding will be required to support ongoing delivery costs beyond the period of initial investment. In the longer term, consideration should be given to the development of pooled funding arrangements with partner organisations, recognising the broader system-wide benefits generated by the programme and supporting a sustainable funding model.

Background

Strategic alignment

This proposal aligns with HDdUHB's strategic direction, Welsh Government policy, Value-Based Healthcare principles and Macmillan's neighbourhood health ambitions. It supports a shift from reactive care to prevention, early support and community-based action, with a clear focus on reducing inequalities, improving outcomes that matter to people, and easing avoidable demand on NHS services.

In particular, the proposed programme brings together three complementary strategic drivers of the HDdUHB A healthier Mid and West Wales- Healthier Lives, Well Lived strategy:

- **Social Model for Health and Wellbeing** – recognising that health is shaped by social, economic, environmental and community conditions, not healthcare alone.
- **Community by Design** – organising support around neighbourhoods, local assets and resident participation.
- **20four7 Prevention Model** – focusing prevention on the 20% most deprived communities, four major behavioural risk factors and seven priority health areas, including cancer, that can prevent the most avoidable harm in our communities.
- **Delivering Value Based Health Care Across the Life-Course: Our Strategic Approach (2026-2031)** - Priority 3: Build the capacity and capability of staff to apply VBHC across planning and operational priorities

Within this programme, the 20four7 model provides the NHS delivery approach for better neighbourhood working. It provides a platform to bring together integrated health and care teams, community organisations and voluntary sector partners to support prevention, wellbeing and early intervention at a local level. By linking clinical services with community-based support, the model and this proposed programme aims to improve outcomes for local people while reducing avoidable demand on acute services.

Funding context

Social Investment Fund (Repayable Grant)

Macmillan and Social Finance have developed social investment mechanisms that provide up-front investment for new community-based models of care. The funding is designed to help systems shift care from hospitals into neighbourhoods and communities. Repayment is linked to the achievement of agreed outcomes and reductions in health care utilisation.

Key features:

- Provides initial capital to establish new neighbourhood care models;
- Focuses on prevention, anticipatory care and community-based support;
- Repayment is linked to demonstrable improvements and savings, and

- Creates a sustainable mechanism for reinvesting resources back into communities.

Anchor Grant (Non-Repayable)

Alongside its social investment, Macmillan Cancer Support will provide a non-recurrent anchor grant to support the community capacity and local infrastructure needed for effective neighbourhood prevention. The grant will be awarded directly by Macmillan to voluntary community and social enterprise organisations and community partners to fund:

- Community capacity building and organisational development;
- Coordination of local partnerships and neighbourhood networks;
- Small grants for community-led prevention initiatives;
- Workforce, volunteer and peer training and development;
- Strengthening community assets, social connections and local participation, and
- Other enabling activities that improve the sustainability of neighbourhood prevention.

A neighbourhood-based approach

Cancer outcomes are influenced by much more than clinical treatment alone. Supporting people and communities to prevent illness, access help earlier, maintain wellbeing during and after treatment, and remain connected to local sources of support are recognised as critical components of effective, sustainable cancer and other chronic disease care.

Community by Design assumes that services, including those for cancer and other chronic diseases, should be organised around neighbourhoods wherever possible, bringing care, support and decision-making closer to people's homes and communities. Key characteristics of a Community by Design neighbourhood include:

- Community-focused – designed around the needs, strengths and aspirations of local people.
- Locally accessible – residents can reach key services, facilities and community assets easily, preferably through walking, cycling or public transport.
- Integrated services – health, social care, voluntary sector and community services work together around the population's needs.
- Strong sense of place and identity – reflecting local culture, heritage, language and community networks.
- Supports wellbeing and prevention – enabling people to remain healthy, independent and connected within their community.
- Flexible to geography – Neighbourhood boundaries reflect how people live their lives, including travel patterns, natural communities, existing service catchments and local relationships, rather than fixed population thresholds or administrative boundaries.

For the purposes of this business case, a neighbourhood is defined as a place-based community, typically centred around a population that can access most of its daily health, social, community and local services within an accessible and well-connected area. It is characterised by strong social relationships, shared local identity, integrated services, and active participation by and accountability to residents in shaping the places where they live, work and connect.

Implementation will adopt a phased, learning-led approach, commencing in Llanelli as the initial implementation site due to established neighbourhood need, local readiness, and the presence of existing community engagement mechanisms and partner infrastructure. This will enable the programme to mobilise at pace in 2027 while testing and refining the model and generating early learning on workforce development, governance, referral pathways, community engagement, evaluation and integration with wider neighbourhood prevention activity. Subject to agreed decision gates and evaluation findings, the programme will then expand to Pembrokeshire and Ceredigion during Years 2 and 3.

The introduction of Community by Design in Wales has presented an opportunity for Health Boards to consider how Primary Care Clusters can be reconfigured to inform and develop systematic wide change through creating Connected Communities (neighbourhoods). Bringing together professional collaboratives to work around natural population groupings (which will differ from the current Cluster footprints), these will feed up into Integrated System groups which could either be developed on a County wide basis (Pembrokeshire and Ceredigion) or a sub County basis in Carmarthenshire (South and North). Developing the model in this way will support our communities in identifying what is most important to them, as well as driving systematic service change that addresses population health needs and prevention.

Further work needs to be undertaken to agree a methodology for defining the natural population groupings as in a primarily rural Health Board using a population basis with a minimum and maximum number might be prohibitive in allowing for more smaller, rural groupings to occur.

Future implementation will be shaped through community co-design with residents, primary care, local authorities, voluntary sector partners and wider stakeholders. Whilst early analysis suggests that neighbourhoods in Pembrokeshire and Ceredigion should be selected based on population health need, geographical deprivation, delivery readiness and existing community capacity, the precise sequencing, delivery footprints and service model adaptations will be determined locally. This will ensure that each neighbourhood model reflects local assets, community priorities, existing provision and the differing challenges associated with urban, rural and coastal communities.

The phased implementation and investment profile have also been deliberately designed to provide assurance regarding the achievement of the programme's Key Performance Indicators (KPIs) and the repayment of the Social Investment Fund. The gradual expansion from one neighbourhood in Year 1, to two neighbourhoods in Year 2 and three neighbourhoods in Year 3 creates defined delivery milestones against which progress can be assessed, benefits realised and repayments triggered. Each phase is linked to a clear set of operational, clinical and system-

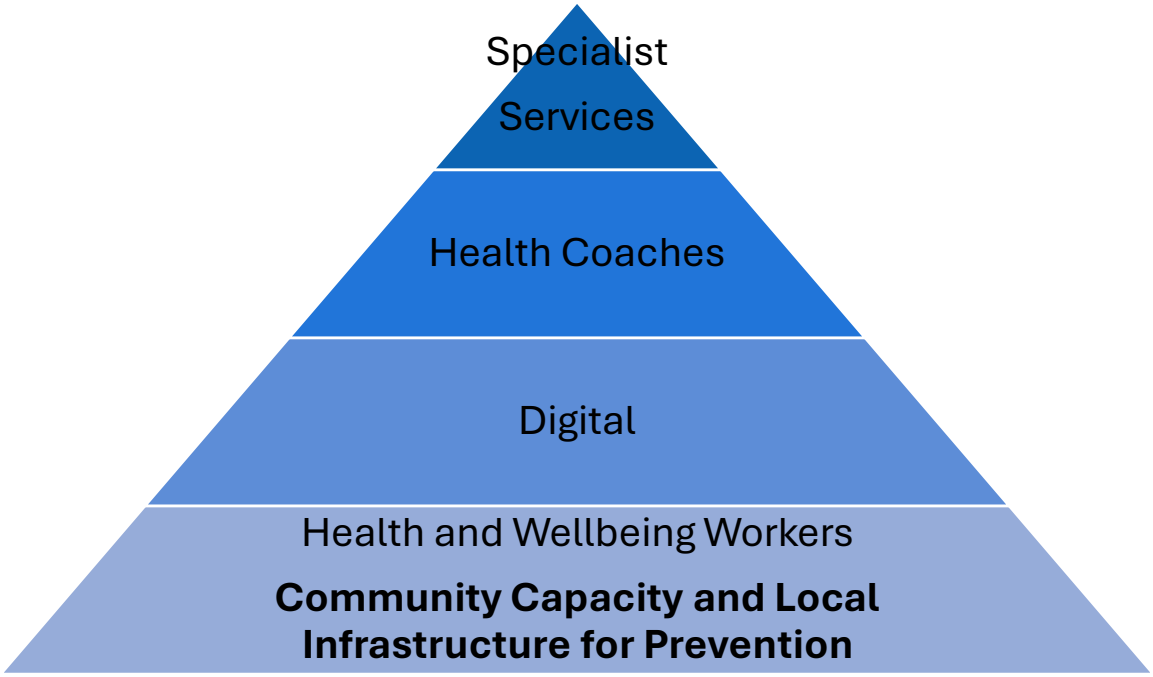
value KPIs, including participation rates, patient activation, improvements in cardiovascular and metabolic risk factors, reductions in healthcare utilisation and independently validated demand avoidance.

An explicit exit strategy has been incorporated into the programme design, with formal gateway reviews at the end of each implementation phase. These gateways will assess delivery performance, KPI achievement, financial performance, realised benefits and organisational readiness for further scale-up. Should the programme fail to demonstrate sufficient progress against agreed milestones, a decision can be taken to pause, redesign or discontinue further rollout, thereby limiting financial exposure and protecting the Social Investment Fund investment. This staged approach provides confidence that investment is released and repaid in line with demonstrable outcomes and ensures robust governance throughout the life of the programme.

This adaptive approach recognises that neighbourhoods across a large and predominantly rural Health Board area are not uniform. Some areas may benefit from town-centred delivery models serving defined neighbourhood clusters, whilst others may require hub-and-spoke, outreach or networked approaches to support more dispersed populations. By combining a common set of principles with local flexibility, the programme will be able to respond to place-specific needs while maintaining a consistent focus on prevention, community wellbeing and reducing health inequalities, including those that may otherwise remain hidden within rural communities.

The Proposed Programme Model

Figure 1 illustrates the relationship between the key components of the programme and how they work together to support neighbourhood-based prevention and wellbeing.



Programme Component 1: Health Coaching

Overview

The Health Coaching Programme will provide structured, personalised support to help people improve their health, reduce modifiable risk factors and manage their wellbeing with greater confidence.

This component builds on two successful HDdUHB initiatives. The Health Coaching Service, developed as an extension of local smoking cessation services, received more than 500 referrals over a 12-month period, with around 50% of participants achieving their primary wellbeing goals. Evaluation identified improvements in confidence, motivation, self-management and sustained behaviour change. Relatedly, a local Lifestyle Medicine programme was selected for development through the nationally recognised Bevan Exemplar Programme and demonstrated improvements in participants' mental wellbeing, confidence, physical activity and social connectedness, with many continuing healthy lifestyle activities and peer-support networks after the programme ended.

The proposed service will support people at risk of poorer outcomes from cancer and other long-term conditions, including those affected by smoking, alcohol use, poor diet, excess weight, low physical activity, low confidence in self-management or wider barriers to health and wellbeing.

Health Coaching is the individual-level behaviour change component of the Neighbourhood Prevention Programme. It will work alongside Community Health and Wellbeing Workers, and existing social prescribing, community assets and specialist services. Its purpose is to turn lifestyle advice into practical, achievable action, based on what matters to the person.

The service will have broad access, but will actively prioritise people with the greatest capacity to benefit. This means people whose outcomes, treatment readiness, quality of life or avoidable healthcare use could improve most through timely, personalised behaviour-change support.

Capacity Modelling

The proposed model is based on a workforce of **17.0 Whole Time Equivalent (WTE) Health Coaches**, **3.0 WTE Health Coach Assistants** and **1.0 WTE band 6 Clinical Lead** supported by appropriate clinical and operational supervision. Capacity assumptions have been informed by pilot learning, existing health coaching services, demand modelling and realistic productivity expectations.

Based on current modelling, the service is expected to receive approximately **4,998 referrals annually**, with an anticipated engagement rate of **80-85%**. Allowing for DNA (Did Not Attend) rates and attrition of **20-25%**, the service is projected to support around **3,060 individuals each year** through a meaningful health coaching intervention over 12 weeks.

Each Health Coach is expected to manage an active caseload of approximately **45-60 individuals** at any one time and deliver around **180 completed interventions**

per WTE per annum. Workforce planning recognises the need to balance direct patient contact with administration, multidisciplinary working, supervision, quality improvement and professional development activities to maintain a safe and effective service.

Activity modelling presented in this business case is based on the assumptions above. However, the number of participants engaged over the length of the five-year program is anticipated to expand significantly with group-based and increasing use of digital approaches, including telephone and video consultations, secure messaging and digital self-management tools. These approaches will increase accessibility, increase productivity and support efficient use of workforce capacity without compromising personalised care.

Sensitivity testing indicates that the proposed workforce can accommodate moderate increases in demand through optimisation of digital delivery and group-based interventions. Ongoing monitoring of referral volumes, caseload complexity, waiting times, DNA rates and outcomes will ensure workforce capacity remains aligned to demand and supports continuous service improvement.

Why it is needed

Many cancer and long-term condition outcomes are influenced by modifiable behavioural risk factors, including smoking, alcohol use, unhealthy weight, poor diet and low physical activity. Around four in ten new cancer cases in Wales were linked to potentially modifiable risk factors, including smoking, overweight and obesity. And this burden is not equally shared: after accounting for age, people living in the most deprived fifth of areas are 1.2 times more likely to get cancer than people living in the least deprived fifth.

Health Coaching provides a practical route to earlier prevention and better self-management. It supports people to set goals, build confidence, address barriers and connect to the right community or specialist support. It is a supported self-management intervention that helps people build knowledge, skills and confidence to become active participants in their care.

Identification, Referral and Triage

Health Coaches will be embedded as part of multidisciplinary teams in primary care, with clear links to cancer and other specialist services and pathways, alongside existing social prescribing and new Community Health and Wellbeing Workers as part of the neighbourhood model. The service will support three broad groups:

1. People at increased risk of avoidable poor outcomes because of modifiable behavioural risk factors.
2. People living with or beyond cancer, where health coaching can support recovery, confidence, wellbeing, treatment readiness and connection to local support.
3. People referred from other priority pathways, including cancer, cardiovascular and planned-care pathways.

Health Coaching will complement, not replace, existing specialist services for smoking cessation, alcohol and other drug treatment, weight management, mental health support, and cancer and other chronic disease management. Participants must:

- Be aged 18 years or over.
- Provide informed consent to participate in the programme.
- Meet one or more lifestyle risk criteria including alcohol risk (AUDIT-C), smoking/vaping, overweight or obesity (BMI), other lifestyle risk factors, or referral from priority pathways including cancer, cardiovascular, respiratory and diabetes.
- Be willing to engage in personalised health coaching.

As the service expands and number of a referrals increase, a RAG approach will be refined and developed to aid prioritisation of those with greatest capacity to benefit.

Red — highest priority / coordinated support

People in this group have high need and high potential benefit, but will require active case management with primary and secondary care services. This may include people with multiple lifestyle risks, cancer-related needs, poorly controlled long-term condition risks, treatment-readiness concerns, repeated avoidable healthcare use, or significant barriers linked to deprivation or wider determinants of health.

Support will include rapid contact, a named Health Coach, a structured assessment, more intensive follow-up and links to CHWWs, social prescribing, community support and / or specialist services.

Amber — priority targeted support

People in this group have clear modifiable risk and a realistic opportunity to improve outcomes through structured coaching. This may include people with one or more significant behavioural risks, early long-term condition risk, cancer prevention or recovery needs, or moderate support needs.

Support will include a structured programme of one-to-one or group coaching, goal setting, behaviour-change planning, community connection and planned follow-up.

Green — open-access / supported self-management

People in this group have lower-complexity needs or are ready to benefit from support following brief advice, digital support, group sessions, MECC conversations, community activities or self-management resources.

Support will include light-touch coaching, digital tools, signposting, group offers and an easy route back into the service if needs increase.

Specialist or urgent needs

Where safeguarding, acute clinical instability, severe mental health crisis or complex substance misuse is identified, Health Coaching will not be the primary intervention at that point. The person will be supported into the appropriate specialist pathway,

with health coaching offered later or alongside specialist care where safe and appropriate.

The triage process ensures individuals receive the most appropriate level of support while enabling effective management of referrals from high-volume prevention and priority pathways.

Personalised Health Coaching

Participants receive an initial assessment followed by a structured programme of support focused on behaviour change and self-management. Each participant works with a Health Coach to identify personal goals, develop action plans and build confidence to make sustainable lifestyle changes.

For people affected by cancer, the offer will focus on practical lifestyle support that complements specialist cancer care, for example reducing cancer-related risk factors while waiting for diagnosis or treatment. The offer will complement specialist cancer services by focusing on prevention, recovery, wellbeing and the wider factors that help people live well before, during and after cancer.

Outputs and outcomes

Consistent Programme Outputs

- Health Coaches embedded within primary care and community settings.
- Standardised triage and referral processes.
- Structured health and lifestyle assessments completed.
- Personalised behaviour change plans developed.
- Referrals and signposting to community and specialist services.
- Ongoing coaching and follow-up support.
- Consistent outcome measurement and evaluation.

Illustrative Service Outputs

Based on pilot activity and projected scale-up, excluding service expansion to group-based and digital interventions:

- Approximately 4,998 referrals annually.
- Around 3,060 individuals supported each year.
- Increased engagement with healthy lifestyle interventions.
- Increased referrals from cancer services and other priority pathways, with approximately 30% of Health Coaching activity supporting cancer prevention, recovery and wellbeing.
- Improved access to preventative and community-based support.
- Increased uptake of behaviour change interventions.

Contribution to Programme Outcomes

This component contributes to the wider prevention programme by delivering:

- Earlier identification of behavioural and lifestyle risk factors.

- Improved health behaviours and self-management.
- Increased patient activation, confidence and resilience.
- Reduced risk of chronic disease development and progression.
- Better support for people living with long-term conditions.
- Improved wellbeing and quality of life.
- Better integration between primary care, community services and specialist pathways.
- Reduced long-term demand on health and care services.
- Stronger prevention and support for priority pathways, with cancer support highlighted through risk reduction, personalised wellbeing support, recovery after treatment, and links to community and specialist services.

Clinical Governance

The Band 6 Clinical Lead will provide professional and operational leadership for the Health Coach workforce, ensuring robust clinical governance arrangements are embedded across the service. The post holder will be responsible for maintaining safe, effective and consistently high-quality delivery of health coaching interventions through regular supervision, competency assessment, audit, and quality assurance processes. They will ensure adherence to organisational policies, information governance requirements, safeguarding procedures, and agreed escalation pathways, while supporting continuous professional development and workforce capability. This dedicated leadership capacity will strengthen oversight, mitigate clinical and operational risks, support service evaluation and improvement, and provide assurance that health coaching services are delivered consistently, safely and in line with the Health Board's policies and procedures.

Digital Enablement

Digital enablement will provide support to the Health Coaching Service and wider Neighbourhood Prevention Programme, building upon existing HDdUHB digital infrastructure and capabilities. This includes the use of REDCap for health coaching data capture, outcome monitoring and service evaluation; integration with existing primary care and GP-facing systems where appropriate; and the ORCHA platform to provide access to clinically reviewed and quality-assured health and wellbeing applications. The programme will also align with and support referral or signposting pathways into established prevention and wellbeing services, including Waiting Well, Keeping Well, smoking cessation, weight management and other population health initiatives.

The digital component will facilitate targeted service improvements through streamlined referral and triage processes, structured and standardised data capture, automated reminders, behaviour-change nudges, follow-up prompts, participant self-management resources and access to approved digital health applications. These capabilities will support Health Coaches in maintaining engagement between sessions, reinforcing agreed goals and outcomes, and managing caseloads efficiently whilst providing a consistent user experience.

Digital tools will complement, rather than replace, face-to-face, telephone, group-based and community-delivered interventions. This blended approach will increase service reach and flexibility while ensuring that individuals who are digitally excluded, have accessibility requirements, or prefer traditional forms of support are not disadvantaged. The programme will adhere to the principles of digital inclusion and equitable access, ensuring that all participants can engage with services in a manner appropriate to their needs. As the programme matures, selected digital capabilities may also be extended to Community Health and Wellbeing Workers, supporting referral tracking, follow-up activity, signposting and outcome monitoring.
Routine data collected through REDCap and related systems will support ongoing monitoring, evaluation, quality improvement and benefits realisation. This will include measurement of activity levels, participant engagement, programme completion rates, Patient Activation Measure (PAM) scores, health and wellbeing outcomes, and healthcare utilisation metrics where appropriate and available. Data insights will inform service development, population health planning and evidence-based decision making across the prevention agenda.

All digital developments will be subject to appropriate governance, assurance and technical review processes. This will include compliance with Information Governance requirements, UK GDPR and NHS Wales data protection standards; completion of Data Protection Impact Assessments where required; and adherence to Health Board records management policies. Appropriate cyber security assessments will be undertaken to ensure alignment with NHS Wales Cyber Resilience standards and organisational security controls. In addition, any new or enhanced digital functionality that may influence clinical decision-making, patient care pathways or the communication of health-related information will be assessed through the Health Board's Clinical Safety Framework, including clinical safety review and hazard assessment where applicable.

Future digital investment will be delivered in a phased and affordable manner, aligned to the Health Board's Digital, Data and Technology Strategy, enterprise architecture principles and wider population health objectives. Development will focus on interoperability, accessibility, data quality, cyber resilience and sustainable service design, whilst maintaining alignment with the Health Board's evolving data platform and strategic direction for integrated digital care.

A key principle of the digital approach will be to place greater control and ownership in the hands of citizens, supporting the Health Board's ambition of **"Patient First, Digital Always"**. Through the use of a Patient Engagement Portal and associated digital tools, individuals will be able to access personalised information, resources, appointments, self-management support, educational content and approved health and wellbeing applications at a time and place convenient to them. This will enable people to take a more active role in managing their own health and wellbeing, supporting behaviour change, prevention and early intervention. Digital engagement capabilities will facilitate two-way communication, timely reminders, progress tracking and access to personalised goals, helping individuals become active participants in their care rather than passive recipients of services. The approach supports the wider strategic objective of delivering more proactive, preventative and person-centred care whilst reducing unnecessary barriers to accessing support.

Future digital investment will be delivered in a phased and affordable manner, aligned to the Health Board's Digital, Data and Technology Strategy and the principles of **Patient First, Digital Always**. Development will focus on empowering citizens through digital engagement, self-service and self-management capabilities, whilst maintaining the highest standards of clinical safety, information governance, cyber resilience, accessibility and interoperability across the wider health and care ecosystem.

Making Every Contact Count Workforce Development

Making Every Contact Count (MECC) will be an additional cross-cutting workforce development enabler of the Neighbourhood Prevention Programme. It will provide a common prevention conversation framework across Health Coaching, CHWWs, community partners and relevant frontline teams, helping staff and volunteers make brief, practical behaviour-change conversations part of everyday contact with residents.

Training, refresher sessions and practical conversation tools will help staff and partners raise risk factors sensitively, promote screening awareness and early help-seeking, and connect people to Health Coaching, CHWWs, smoking cessation, weight management, alcohol support, community assets and specialist pathways.

MECC will support the programme’s cancer prevention and support ambition, including the expectation that around 30% of programme activity is aligned to cancer prevention and people affected by cancer. Activity will be monitored through training uptake, staff confidence, use of brief intervention approaches where recorded, and referrals or signposting into wider prevention support.

Summary

Health Coaching will provide a broad but prioritised prevention and wellbeing offer for people at risk of poorer cancer and long-term condition outcomes. The service will remain open and inclusive, while using a redesigned RAG model to prioritise people with the greatest capacity to benefit.

The component will strengthen prevention, support cancer recovery and wellbeing, improve self-management and connect people to community and specialist support. It will also provide a measurable pathway from individual behaviour change to improved outcomes and reduced avoidable healthcare use over time.

Digital tools and MECC workforce development will support this component by improving referral, follow-up, behaviour-change prompts, self-management support and consistent prevention conversations across Health Coaching, CHWWs and wider neighbourhood partners. Further detail regarding the current Health Coaching service is provided in Appendix 1.

Programme Component 2: Community Health and Wellbeing Workers (CHWWs)

Overview

Community Health and Wellbeing Workers (CHWWs) provide a proactive, relationship-based approach to prevention, working directly with households in communities rather than waiting for people to access services. Operating at neighbourhood level, CHWWs act as trusted connectors between residents, community resources and health and care services, helping to identify unmet need early and support people before issues escalate into crisis. The model complements existing services, including Health Coaching and social prescribing, by providing ongoing engagement, practical support and continuity for residents.

Why it is Needed

Many people living in deprived or underserved communities experience barriers to accessing support and may not engage with traditional health services until problems become more serious. Health inequalities are often driven by wider social, economic and environmental factors that cannot be addressed through clinical care alone.

The CHWW model responds to this challenge by taking a preventative, community-based approach. Through direct neighbourhood outreach and trusted relationships, CHWWs identify health, wellbeing, social and practical needs earlier, improve access to support, strengthen community connections and help communities build resilience and self-management capacity.

The Model

CHWWs work within defined neighbourhoods linked to GP practices and Primary Care clusters, alongside Health Coaches and wider community partners.

Using a structured household engagement approach, CHWWs:

- Proactively engage with households
- Build trusted relationships with residents
- Identify unmet health, wellbeing and social needs
- Support service navigation and access
- Connect people to community, voluntary and statutory services
- Encourage self-management and prevention
- Strengthen community participation and local resilience

The model adopts a whole-household approach, recognising that health and wellbeing are influenced by family, social and community circumstances as well as individual factors.

Delivery Approach

Each CHWW is responsible for a defined locality and works closely with GP practices, Health Coaches, community organisations and other local services. The approach focuses on:

- Early identification of need
- Chronic disease prevention and wellbeing promotion
- Supported referrals and follow-up
- Reducing barriers to access
- Strengthening links between communities and services
- Building community capacity and local solutions

The model is intended to generate long-term relationships within neighbourhoods, creating a visible and trusted presence within communities.

Expected Outputs

System Outputs

- Households proactively contacted and engaged
- Residents supported through personalised interventions
- Needs assessments completed
- Referrals and community connections facilitated
- Increased utilisation of community assets and services
- Improved intelligence regarding local population needs

Community Outputs

- Increased access to preventative support
- Improved uptake of health and wellbeing services
- Greater community participation and connectedness
- Improved confidence and self-management among residents
- Stronger relationships between communities and local services

Illustrative Reach

Based on similar UK services, including Westminster and Cornwall, a team of four CHWWs and a team lead is expected to support around 500 households a year once established. Across three neighbourhood teams, this equates to focused engagement with at least 3,000 people annually, alongside wider community contacts and referrals into tailored health, wellbeing and cancer prevention support.

Contribution to Programme Outcomes

The CHWW model contributes to the wider programme by delivering:

- Earlier identification and management of need
- Improved access to prevention and wellbeing support
- Increased self-management and health confidence
- Reduced social isolation and loneliness
- Improved uptake of screening, immunisation and preventative interventions

- Better connection between residents and community assets
- Reduced avoidable demand on primary, urgent and emergency care services
- Improved understanding of population need and health inequalities

Summary

The Community Health & Wellbeing Workers model offers Hywel Dda University Health Board a practical opportunity to shift from a reactive healthcare model towards a preventative, community-based approach that addresses the root causes of ill health. The programme is designed to reduce avoidable demand on primary and urgent care services by proactively supporting households with issues such as poverty, housing difficulties, social isolation, low health literacy, and access to benefits and community support.

A key benefit for HDdUHB is the potential to release valuable clinical capacity within primary care. The business case highlights that around 20% of GP consultations relate to non-medical issues, equating to an estimated 460,000 consultations annually across the Health Board population. By identifying and addressing these wider determinants of health earlier, CHWWs can reduce repeat GP appointments, improve care navigation, and enable clinicians to focus on patients with complex medical needs.

The programme also supports the Health Board's strategic priorities around prevention, reducing inequalities, and delivering care closer to home. Through proactive engagement with vulnerable and hard-to-reach households, CHWWs can improve access to preventative services including vaccinations, screening programmes, and long-term condition reviews. Evidence from existing UK programmes has demonstrated increased uptake of vaccinations and health checks, alongside reductions in GP consultations.

For HDdUHBs rural and deprived communities, the model offers a mechanism to tackle health inequalities by connecting residents to welfare advice, housing support, employment opportunities, and community resources. This whole-household approach aims to improve wellbeing, reduce loneliness, strengthen self-management of chronic conditions, and increase community resilience.

Beyond direct patient benefits, the CHWWs will generate valuable population insight, helping HDdUHB better understand unmet need within communities and target future resources more effectively. It also supports integrated working between health services, local authorities, voluntary sector organisations, and community partners, strengthening the place-based care agenda. Further information regarding the CHWW model is provided in Appendices 2, 3 and 4.

Programme Component 3: Community Capacity and Local Infrastructure for Prevention

Overview

Community Capacity and Local Infrastructure for Prevention provides the neighbourhood infrastructure needed to enable prevention, wellbeing and early intervention. It connects CHWWs, Health Coaches, residents, community organisations, local assets and statutory services so that prevention activity is coordinated and locally relevant.

The model is not a standalone service. It creates the conditions for prevention activity to flourish in communities, reflecting the Social Model for Health and Wellbeing and the wider social, economic, environmental and community factors that shape health.

Why it is Needed

CHWWs, Health Coaches and wider prevention services depend on strong local infrastructure. Across West Wales, community assets vary in capacity, accessibility and connection to statutory services, limiting opportunities for:

- Early intervention and prevention
- Social prescribing and community referrals
- Volunteering and community participation
- Peer support and community-led activities
- Coordinated support for people and families

This component strengthens the local systems that connect people to support and helps create a more consistent, equitable prevention offer across neighbourhoods.

The Model

The programme combines a consistent infrastructure framework with locally determined priorities, including a cancer prevention and support focus, so communities can respond to local needs within a common approach.

Core Neighbourhood Infrastructure

Every neighbourhood is supported by:

- A Neighbourhood Coordinator function to connect partners and coordinate activity
- Community engagement and co-design processes, such as a locally-appropriate multi-sector forum for engaging residents, patients, community organisations, CHWWs, Health Coaches and statutory partners in shared programme planning
- Community asset and systems mapping

- Community prevention micro-grants
- Communications and participation resources
- A shared learning, monitoring and evaluation framework

Together, these elements provide the foundation for coordinated prevention activity and stronger links between communities and services.

Neighbourhood Prevention Planning and Alignment

Enabled by the Neighbourhood Coordinator function, local partnerships will use community engagement, asset mapping and local intelligence to:

- Understand local strengths, assets and community capacity
- Identify unmet need and health inequalities
- Map relationships across community and statutory services
- Agree locally relevant prevention priorities
- Coordinate action and investment opportunities
- Review and adapt priorities based on learning and changing needs

This will bridge strategic priorities and practical delivery, improving coordination and reducing duplication across programmes.

Flexible Local Delivery

While the core infrastructure is consistent, activities will vary according to local priorities. Partnerships may focus on:

- Strengthening community organisations
- Developing peer support networks
- Recruiting and supporting volunteers
- Improving transport and access to services
- Expanding social prescribing opportunities
- Supporting cancer and other chronic disease carers and targeted population groups
- Developing community hubs and spaces
- Improving outreach, communication and participation

This supports locally owned solutions within a common programme framework.

Expected Outputs

- Consistent System Outputs
- Community Wellbeing Partnerships established
- Local delivery aligned with wider strategies and plans
- Community asset mapping completed
- Community prevention funds distributed
- Regular co-design and learning cycles implemented
- Shared evaluation and learning framework in place
- Illustrative Community Outputs

- New or strengthened community-led initiatives
- Increased volunteering opportunities
- Expanded peer support networks
- Stronger connections between community organisations and local assets
- Contribution to Programme Outcomes

This component strengthens the community conditions required for prevention by supporting:

- Increased community capacity and participation
- Better integration between statutory and community services
- Improved access to community-based support
- Stronger coordination of local assets and services
- Earlier intervention and reduced health inequalities

Summary

Community Capacity and Local Infrastructure for Prevention provides the foundation for sustainable neighbourhood prevention. It brings together residents, community organisations, CHWWs, Health Coaches and statutory partners to strengthen local capacity, improve access to support and support earlier intervention.

Co-production is central to the model. Through engagement, asset mapping and neighbourhood partnerships, residents and partners will shape support around local strengths, needs and priorities while working within a consistent prevention framework.

Anchor Grant funding, paid directly to third-sector organisations and community partners, will strengthen community capacity, local assets, social connections and neighbourhood infrastructure, helping communities build resilience and develop sustainable, locally owned responses to health and wellbeing challenges. Over time, this will support stronger, more connected communities that are better able to prevent ill health, reduce inequalities and improve population wellbeing. Further information regarding the Communication Plan is provided in Appendix 5.

Spread and Scale

The programme has been designed as a scalable neighbourhood prevention model that can be adapted and implemented across diverse communities within HDdUHB and, subject to evaluation findings, more widely across Wales. The phased implementation approach will enable learning from each neighbourhood to inform subsequent delivery, ensuring that effective interventions, governance arrangements and partnership models are refined before wider adoption. Through robust evaluation, quality improvement methodologies and continuous learning cycles, the programme will identify the components that deliver the greatest impact and value. Evidence generated through the programme will support the development of commissioning guidance, implementation resources and workforce models that

facilitate replication and sustainable scale-up. A core principle of future spread and scale will be the promotion of **equitable access to prevention services and outcomes**, ensuring that communities experiencing the greatest levels of deprivation, rurality, exclusion or health inequality are able to benefit from the model. While delivery approaches may vary to reflect local context, the programme will maintain a consistent focus on reducing unwarranted variation, improving equity of service provision and ensuring that all communities have fair access to prevention, wellbeing and community-based support. By combining a consistent core framework with flexibility to respond to local needs, the programme will create a transferable model for reducing health inequalities, strengthening community capacity, improving population health outcomes and supporting a long-term shift towards prevention and neighbourhood-based care.

Benefits Realisation/Resource Releasing Opportunities

The proposed Neighbourhood Prevention Model is expected to deliver measurable benefits across population health, behaviour change, cancer prevention and support, service utilisation and healthcare demand over the short, medium and long term. Approximately 30% of programme activity will be aligned to cancer prevention and support, including reductions in smoking, alcohol-related harm, unhealthy weight and physical inactivity; improved access to screening and early support; and stronger community support for people affected by cancer. The projected outcomes presented below are based on modelling assumptions developed by TriTech, drawing on published literature, evidence reviews, established prevention programmes and the best available data at the time of analysis. These assumptions have been used to estimate participant engagement, sustained behaviour change, reductions in disease risk and the resulting impact on healthcare utilisation. Together, the measures demonstrate the anticipated pathway from participation in preventative interventions to improved health outcomes, reduced incidence of long-term conditions including preventable cancers, and lower demand on primary, community and acute healthcare services. The framework provides a basis for ongoing evaluation and benefits realisation, enabling the programme to assess both immediate improvements in health behaviours and longer-term value through reductions in avoidable healthcare activity and preventable disease burden.

The sensitivity analysis demonstrates a lower and upper range of potential resource-releasing opportunities, reflecting different modelling assumptions. Using the more conservative methodology developed by **Tritech**, the programme is estimated to generate approximately **£5.2 million** in resource release over five years. In contrast, modelling undertaken by the **National Association of Primary Care (NAPC)** suggests that benefits could be as high as **£12.4 million** over the same period. Further information regarding the evidence reviews and literature search is provided in appendix 6.

Tritech Modelling Assumptions

Table 1: Assumed Behaviour Change Maintenance (Relapse) Rates

Relapse rate(who mainatins)										
Type	year 1	year 2	year 3	year 4	year 5	year 6	year 7	year 8	year 9	year 10
Smoking	0.4	0.8	0.9	0.9	0.9	0.9	0.9	0.9	0.9	0.9
Alcohol	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5
Healthy living	0.7	0.7	0.7	0.8	0.9	0.9	0.9	0.9	0.9	0.9

Table 2: Projected Cumulative Behaviour Change Outcomes Over a 10-Year Period

Cumaltive numbers										
Type	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	Year 10
smoking stopped	392	705	987	1241	1469	1675	1860	2026	2176	2311
Alcohol stopped	551	826	964	1033	1067	1084	1093	1097	1099	1101
Healthy living	1125	1912	2463	2904	3300	3657	3979	4268	4528	4763

Table 3: Projected Reductions in NHS Activity and Healthcare Utilisation Attributable to Behaviour Change Interventions

NHS demand reduction (lower)										
Smoking	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	Year 10
GP appointments	783	1410	1974	2482	2939	3350	3720	4053	4353	4622
Outpatient appointments	118	212	296	372	441	502	558	608	653	693
Unscheduled care contacts	20	35	49	62	73	84	93	101	109	116
ED attendances	16	28	39	50	59	67	74	81	87	92
Hospital admissions	8	14	20	25	29	33	37	41	44	46
Alchohol	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	Year 10
GP appointments	2203	3305	3856	4131	4269	4338	4372	4389	4398	4402
Outpatient appointments	110	165	193	207	213	217	219	219	220	220
Unscheduled care contacts	28	41	48	52	53	54	55	55	55	55
ED attendances	33	50	58	62	64	65	66	66	66	66
Hospital admissions	33	50	58	62	64	65	66	66	66	66
Total/year	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	Year 10
GP appointments	2987	4715	5830	6613	7207	7687	8092	8442	8750	9024
Outpatient appointments	228	377	489	579	654	719	777	827	873	913
Unscheduled care contacts	47	77	98	114	127	138	148	156	164	171
ED attendances	49	78	97	112	123	132	140	147	153	158
Hospital admissions	41	64	78	87	93	99	103	106	109	112

	3 year total
GP appointments	13531
Outpatient appointments	1093
Unscheduled care contacts	221
ED attendances	224
Hospital admissions	182

	5 year total
GP appointments	27351
Outpatient appointments	2326
Unscheduled care contacts	462
ED attendances	458
Hospital admissions	362

	10 year total
GP appointments	69347
Outpatient appointments	6436
Unscheduled care contacts	1238
ED attendances	1189
Hospital admissions	892

Table 4: Projected Reduction in Major Long-Term Conditions Attributable to Programme Interventions

3 year prediction	
Cancer reduction	36
CVD reduction	37
Diabetes reduction	261

5 year prediction	
Cancer reduction	77
CVD reduction	80
Diabetes reduction	486

10 year prediction	
Cancer reduction	203
CVD reduction	212
Diabetes reduction	1169

Table 5: Potential Resource Releasing Opportunities from the Tritech Modelling

		3 year total		5 year total		10 year total	
		Activity	£	Activity	£	Activity	£
Smoking/Alcohol	GP appointments	13,532	405,960	27,352	820,560	69,347	2,080,410
	Outpatient appointments	1,094	234,116	2,327	497,978	6,436	1,377,304
	Unscheduled care contacts	222	27,676	463	57,721	1,240	154,587
	ED attendances	224	72,128	459	147,798	1,189	382,858
	Hospital admissions	183	717,818	363	1,423,868	892	3,498,870
	Total	**15,255**	**1,457,698**	**30,964**	**2,947,924**	**79,104**	**7,494,029**
Reduction in Prevelance	Cancer	36	383,652	77	820,589	203	2,163,371
	CVD	37	167,388	80	361,920	212	959,088
	Diabetes	261	596,094	486	1,108,546	1,169	2,665,091
	Total	**334**	**1,147,134**	**643**	**2,291,055**	**1,584**	**5,787,550**
	Total Resource Released		**2,604,832**		**5,238,979**		**13,281,579**

National Association of Primary Care Modelling Assumptions

This KPI Framework sets out a structured approach for measuring programme performance, outcomes and value across the full pathway of care, from initial engagement through to population-level impact. Organised around six stages, Reach and Engagement, Activity, Behaviour Change, Health Improvement, Healthcare Demand, and Population Impact, the framework provides a clear line of sight between programme delivery and the outcomes that matter to individuals, the Health Board and funders. By combining activity, outcome, cost and comparative measures, the framework is designed to support continuous learning, demonstrate value for money, and provide a robust basis for outcomes-based funding and performance management.

Table 6: Cohort-Based Intervention Model provided by the National Association of Primary Care

Cohort	Cohort ideas	Intervention	Hours	Cost per engaged person	Savings per person	FTE/coach time allocation	People supported per year	Total cost	Total benefit	Net benefit	ROI
Red	Recent discharge, recurrent COPD exacerbations, persistent high users, poorly controlled LTCs	Named coach, structured assessment, approximately 6 one-to-one contacts, CHWW and clinical coordination	6.00	£205	£279	**60%**	3,276	£672,000	£913,409	£241,409	1.4
Amber	Significant behavioural risk, early LTC deterioration, pain, anxiety/depression, cancer recovery	Blended one-to-one and group coaching, planned follow-up, community connection	1.50	£51	£93	**20%**	4,368	£224,000	£404,159	£180,159	1.8
Green	Lower-complexity lifestyle risk, rising BMI, moderate anxiety, motivated self-referrers	Digital, group, MECC, community support and easy re-entry	0.12	£4	£22	**20%**	54,600	£224,000	£1,176,755	£952,755	5.3
					Over 1 year		**62,244**	**£1,120,000**	**£2,494,323**	**£1,374,323**	**2.2**
					Over 5 years		**311,220**	**£5,600,000**	**£12,471,617**	**£6,871,617**	**2.2**

Project Costs

Table 7 summarises the estimated costs associated with implementing and sustaining the programme over a five-year period. The investment includes funding for health coaching staff, workforce development, digital support, evaluation, programme management, community health and wellbeing workers, and local prevention infrastructure. Around 30% of funded activity will be planned and monitored as cancer prevention and support activity, including behaviour change support, MECC for cancer prevention, referral pathways from cancer services, community support for people affected by cancer, and local infrastructure that improves access to prevention, screening and wellbeing support. The total investment required is estimated at £8.68 million, comprising £8 million from the Social Investment Fund and £2 million from the Anchor Grant, with expenditure reflecting the phased expansion of services during the early years of implementation.

Table 7: Five-Year Programme Investment Costs by Funding Source

Social Investment Fund (Repayable)	**Year 1**	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Yr 1-5 total**
Health Coaching Staff 1 WTE Band 6 Clinical Lead 17 WTE Band 5 Health Coaches 3 Band 4 Health Coach Assistants	£607,858	£900,651	£1,041,869	£1,041,869	£1,041,869	***£4,634,116***
Community Health and Wellbeing Workers 15 WTE Band 3 CHWW	£176,670	£353,340	£530,010	£530,010	£530,010	***£2,120,040***
Training Costs	£18,500	£18,500	£18,500	£18,500	£18,500	***£92,500***
Making Every Contact Count Training	£50,000	£50,000	£50,000	£50,000	£50,000	***£250,000***
Laptops	£2,834	£2,835	£2,836	0.00	0.00	***£8,505***
National Advisory Function	£10,800	£10,800	£10,800	£10,800	£10,800	***£54,000***
Patient Activation Measures Licences	£47,165	£0	£0	£0	£0	***£47,165***
Digital Support 2 WTE Band 6 Digital Project Managers Digital enablement costs	£200,000	£200,000	£200,000	£200,000	£200,000	***£1,000,000***
Tritech Evaluation	£85,645	£85,645	£85,645	£85,645	£85,645	***£428,225***
Project staff cost 1 WTE Band 7 Project Manager 0.6 WTE Band 6 Project Support 0.2 WTE Band 9 Public Health Consultant	£144,870	£144,870	£144,870	£144,870	£144,870	***£724,350***
Total	£1,344,342	£1,766,641	£2,084,530	£2,081,694	£2,081,694	**£9,358,901**

Anchor Grant (Non-Repayable)	**Year 1**	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Yr 1-5 total**
Community Capacity and Local Infrastructure for prevention	£166,000	£332,000	£499,000	£499,000	£499,000	***£1,995,000***
Total	£166,000	£332,000	£499,000	£499,000	£499,000	**£1,995,000**

Total	**£11,353,901**

Proposed Repayment Plan

The proposed Macmillan Repayment Plan is structured to provide HDdUHB with significant upfront investment to support programme delivery, combining a non-repayable Anchor Grant of £2 million with a repayable Macmillan loan of £9.36 million over the life of the scheme. Repayments are performance-based and linked to the achievement of healthcare consumption reductions, with repayment triggers commencing from Year 2 once 80% of the healthcare consumption reduction modelling is realised. The repayment profile is phased, beginning at 20% in Year 2 (£353k), increasing to 40% in Year 3 (£834k), 60% in Year 4 (£1.25m) and 80% in Year 5 (£1.67m), before reaching full repayment levels from Years 6 to 8 (£1.75m annually). This approach enables HDdUHB to benefit from early investment and implementation support while aligning repayments to the delivery of measurable value and system-wide efficiencies, creating a sustainable model in which financial returns are generated through reduced healthcare utilisation and reinvested into ongoing service transformation.

Table 8: Proposed Repayment Plan

Macmillan Repayment Plan

	Anchor Grant (Non-Repayable)	Macmillan Loan	In Year Repayment %	Hywel Dda Repayment
Year 1	£166,000	£1,344,342		£0
Year 2	£332,000	£1,766,641	20%	£353,328
Year 3	£499,000	£2,084,530	40%	£833,812
Year 4	£499,000	£2,081,694	60%	£1,249,016
Year 5	£499,000	£2,081,694	80%	£1,665,355
Year 6				£1,752,463
Year 7				£1,752,463
Year 8				£1,752,463
Total	**£1,995,000**	**£9,358,901**		**£9,358,901**

Key Performance Indicators

The following measures have been identified to monitor the effectiveness, impact and value of the project, providing a balanced assessment of service activity, participant engagement, cancer prevention and support, clinical outcomes, healthcare utilisation and long-term population health benefits. Reporting will specifically track the programme's expectation that around 30% of activity supports cancer prevention, earlier support and people affected by cancer. Together, the measures will enable the programme to evaluate progress towards its prevention objectives, demonstrate return on investment and support ongoing service improvement and future scaling decisions.

Table 9: Key Performance Indicators, Targets and Reporting Arrangements

Key Performance Indicators (KPI) **Indicators of Service performance which will be reported monthly/ quarterly/ annually.**						
KPI No.	Description	Numerator	Denominator	Target Measure	Frequency of reporting	Responsible Owner
1	Number of people seen by the intervention	Participants enrolled	N/A	Annual target	Monthly	Service Lead
2	Retention rate (%)	Participants completing intervention	Participants enrolled	>=80%	Monthly	Service Lead
3	Improvement in PAM	Participants improving PAM	Participants with PAM scores	Increase in patients classified as PAM >2	Quarterly	Service Lead
4	Reduction in Blood Pressure	Change from baseline	Patients assessed	10 mmhg in systolic (approx.20% reduction in CVD risk)	Quarterly	Service Lead
5	Reduction in HbA1c	Change from baseline	Patients assessed	Below Prediabetic range	Quarterly	Service Lead
6	Reduction in Lipids	Change from baseline	Patients assessed	1 mmol reduction in ldlc (approx.20% reduction in CVD risk)	Quarterly	Service Lead
7	Reduction in BMI	Change from baseline	Patients assessed	Below a 25 kpms	Quarterly	Service Lead
8	GP appointments avoided	Estimated avoided	N/A	Cumulative total	Quarterly	Tritech

9	Outpatient appointments avoided	Estimated avoided	N/A	Cumulative total	Quarterly	Tritech
10	Unscheduled care contacts avoided	Estimated avoided	N/A	Cumulative total	Quarterly	Tritech
11	ED attendances avoided	Estimated avoided	N/A	Cumulative total	Quarterly	Tritech
12	Hospital admissions avoided	Estimated avoided	N/A	Cumulative total	Quarterly	Tritech
13	Cancer cases averted	Predicted cases prevented	N/A	3/5/10 year total	Annually	Tritech
14	Strokes/heart attacks averted	Predicted events prevented	N/A	3/5/10 year total	Annually	Tritech
15	Diabetes cases averted	Predicted cases prevented	N/A	3/5/10 year total	Annually	Tritech

Risks, Assumptions, Issues and Dependencies Log

The successful delivery of the project depends upon effective management of strategic, operational and organisational factors that may influence programme outcomes. This RAID Log provides a high-level framework for identifying and monitoring the key **Risks, Assumptions, Issues and Dependencies** associated with the development, implementation and evaluation of the programme. It supports robust governance by providing visibility of factors that could impact delivery, benefits realisation, timescales, stakeholder engagement and long-term sustainability. The RAID Log will be maintained throughout the programme lifecycle and reviewed through established governance arrangements to support informed decision-making, proactive mitigation and successful delivery of the programme's ambitions to improve population health, reduce health inequalities and shift investment towards prevention and community-based care.

Table 10: Programme RAID Log (Risks, Assumptions, Issues and Dependencies)

ID	Type	Description	Impact	Mitigation / Action	Owner	Status
R1	Risk	Long-term sustainability after funding ends	Loss of services/community trust	Develop sustainability plan and future funding routes	Programme Board	Open
R2	Risk	Failure to demonstrate ROI	Ability to repay investment	Implement robust evaluation and KPI framework	Public Health / Tritech	Open
R3	Risk	Rurality and hidden deprivation not captured	Increased inequalities	Use local intelligence and rural pilots	Public Health	Open
R4	Risk	Duplication with existing services	Confusion and inefficiency	Map services and align roles	Commissioning	Open

R5	Risk	Insufficient co-production and engagement	Reduced uptake and impact	Community reference groups and champions	Programme Manager	Open
A1	Assumption	Macmillan funding and Board approval secured	Programme cannot proceed otherwise	Maintain executive engagement	SRO	Open
I1	Issue	Short timescales for business case	Potential design gaps	Continue consultation during mobilisation	Project Manager	Open
D1	Dependency	Board and funding approvals	Programme start delays	Maintain governance timetable	SRO	Active

Macmillan Commissioning Template

A **Funding Agreement example** is provided in Appendix 8 and is intended to support discussions regarding the proposed funding, commissioning and governance arrangements. This template illustrates a potential framework for partnership working between the parties and demonstrates how investment, outcomes, accountability and programme governance could be structured. However, it remains an indicative document and will require further development, review and negotiation to reflect the agreed service model, financial arrangements, outcomes methodology, governance framework and local legal requirements. As such, the document should be regarded as a working draft rather than a final or binding agreement. Any future agreement will be subject to detailed refinement and approval by all relevant stakeholders and participating organisations.

Monitoring and Evaluation

The programme aims to empower individuals to take greater control of their health, improve quality of life, support long-term condition management, and contribute to a more sustainable and prevention-focused healthcare system. A key part of the Health Coaching programme will be a robust evaluation of the programme each year. The evaluation will be carried out by the Tritech and Innovation team within the Research and Innovation department. The purpose of the of the evaluation will be to understand its impact and value as well as inform funding decisions for each year of the programme running from 2027-2032. A robust health coaching evaluation methodology combines programme design standards, process monitoring, and outcome measures such as patient activation, self-reported changes, and clinical indicators.

Aims and Objectives of the Evaluation

The aims of this evaluation are to understand the effectiveness, impact, feasibility, acceptability, value and cost-consequences of the HDdUHB health coaching programme within HDdUHB, with the following specific objectives:

- Does the programme improve participants' health and wellbeing?
- Does it support sustained behaviour change and self-management?
- Does it increase patient activation and confidence?
- Does it reduce avoidable healthcare utilisation?
- What aspects of the programme are most effective, and for whom?
- Does the programme deliver value for money/ROI?

Health Coaching Evaluation Methodology

The evaluation methodology will be structured around the NHS Quality Framework's four domains, integrate process and outcome measures, and use a mixed-methods approach to capture both measurable changes and lived experiences. This will ensure the evaluation is comprehensive, evidence-informed, and actionable for improving future practice.

Mixed-Methods Approach

The evaluation will adopt a mixed-methods approach, combining quantitative outcome measures with qualitative insights from participants, coaches, and stakeholders. This approach will provide robust evidence of both programme effectiveness and implementation learning to support future service development and commissioning decisions.

Quantitative: Standardised tools for activation, PROMS/PREMS, clinical metrics, service usage, NHS demand factors and satisfaction surveys.

Qualitative: Focus groups, interviews, and open-ended feedback to capture context and lived experience.

Data collection & Assessment criteria

Evidence-based evaluations in health and wellbeing coaching use a multi-indicator approach and will involve several different data sources, such as:

Assessment of Service KPIs- to be developed as part of the service process (focusing on the key deliverables expected by the programme – number of participants etc.

Assessment of Clinical Indicators – assessment of changes in specific clinical outcomes impacted by the service - such as weight, HbA1c, blood pressure, or other relevant clinical data (to be determined by service protocol).

Assessment of general health Indicators – assessment of changes in general health outcomes including patient recorded outcome measures such as PAM score etc. (to be determined by service protocol).

Assessment of Patient Activation – Pre- and post-coaching questionnaires to measure confidence, knowledge, and self-management ability. Measure in place to assess compliance over time with the service.

Assessment of Service utilisation- Measures reflecting the use of a range of different health services over a particular timeframe e.g. over the 12-months after starting to receive health coaching, such as: Number of visits to A&E; Number of inpatient appointments; Number of outpatient appointments; Attendance at appointments; Medication required.

Assessment of service user experience and outcomes – Interviews and focus groups with all service users to understand service effectiveness and experiences of service users.

Assessment of staff experience and outcomes – Interviews, focus groups and regular surveys to help determine - Job-satisfaction, Employee well-being, Absence rate (percentage of working days lost due to sickness or other absence),

Assessment of other key considerations – assessment of the effects of the service on other considerations such as – social and economic benefits, cardon footprint etc.

Assessment of System Outcomes – assessment of changes in service use, adherence, or cost efficiency. This will include staff workflows, process mapping, NHS service utilisation.

Project deliverables

Findings will be reported through quarterly interim reports and a final evaluation report including outcomes, case studies, lessons learned, and recommendations for future development and wider implementation. An end of year evaluation report will be created for each year of the project. The reports will focus on assessing:

Effectiveness

- Does participation in health coaching improve health and wellbeing?
- Does health coaching increase confidence and self-management capabilities?
- Are participants achieving their personal health goals?

Experience

- How do participants experience the coaching process?
- What aspects of the programme are most valued?
- What barriers or facilitators influence engagement?

System Impact

- Does participation reduce demand on healthcare services?
- Does the programme support more appropriate use of NHS services?
- Costs and value/ROI

Sustainability

- Are improvements maintained after programme completion?
- What improvements could be made to maximise programme effectiveness?

The yearly evaluation report(s) will look at recommendations of the previous year's findings and look at incremental improvements.

Continuous Improvement and Learning

Alongside the formal evaluation undertaken by the TriTech and Innovation Team, the Programme Board will adopt a **Quality Improvement (QI) approach** throughout the life of the programme. Using recognised improvement methodologies such as Plan-Do-Study-Act (PDSA) cycles, the programme will continuously test, learn and refine interventions based on emerging evidence, stakeholder feedback and operational experience.

The five-year programme duration provides a unique opportunity to move beyond traditional project delivery and establish a structured learning system that supports continuous improvement. Regular learning reviews will be undertaken across Health Coaching, Community Health and Wellbeing Workers, Community Capacity initiatives and digital services to identify what is working well, where improvements are required and how successful approaches can be scaled across neighbourhoods.

This combined approach of evaluation and quality improvement will enable the programme to:

- Assess impact and return on investment.
- Refine delivery models based on evidence and learning.
- Improve outcomes for individuals and communities.
- Respond to local needs and emerging challenges.
- Support innovation and shared learning across neighbourhoods.
- Build a robust evidence base for future commissioning and sustainability decisions.

Project Governance

The Project will be governed through a dedicated Programme Board chaired by the Executive Director of Public Health, acting as Senior Responsible Owner. The Programme Board will provide strategic leadership, oversight and decision-making, whilst ensuring effective delivery across all workstreams. Partnership oversight will be provided through the Social Model for Health and Wellbeing Steering Committee, with representation from local authorities, County Voluntary Councils and wider system partners. Assurance and escalation arrangements will operate through the Public Health Directorate Senior Leadership Team and the A healthier Mid and West Wales- Healthier Lives, Well Lived governance structure, with onward reporting to the Strategy and Planning Committee and Board as required. This governance framework provides clear accountability, robust partnership engagement and alignment with Hywel Dda University Health Board's corporate governance arrangements.

Table 11: Programme Governance Structure, Roles and Responsibilities

Governance Level	Primary Role	Key Responsibilities
HDdUHB Executive Board & Macmillan Cancer Support Board	Partner Corporate Oversight	Strategic alignment, senior accountability, receipt of assurance
Strategy & Planning Committee	Corporate Scrutiny	Programme oversight, escalation management, strategic approval
A Healthier Mid & West Wales Governance	Executive Scrutiny	System alignment, cross-programme coordination
Value & Sustainability Group	Executive Scrutiny	Value for money assessment
Public Health Directorate SLT	Directorate Assurance & Escalation	Performance oversight, risk and financial management
Social Model for Health & Wellbeing Steering Committee	Regional Partnership Oversight	Collaborative governance, partner alignment, strategic challenge
Programme Board (SRO)	Programme Delivery	Delivery oversight, benefits realisation, workstream management

Project Milestones and Timelines

The programme will be delivered over a five-year period from October 2026 to September 2031. Following funding approval, mobilisation, recruitment and training will take place between October and December 2026. Delivery will commence in Neighbourhood 1 in January 2027, with subsequent neighbourhoods introduced annually in January 2028 and January 2029. This phased approach enables workforce development, continuous evaluation, refinement of referral pathways and progressive benefits realisation before achieving full programme coverage. Years 4 and 5 will focus on consolidating delivery, demonstrating outcomes, realising system benefits and securing recurrent funding mechanisms. Further information on Project Milestones and Timelines is provided in Appendix 7.

Table 12: High Level Timeline

Phase	Key Activities	Timeline
Programme Set-Up & Approval	Approvals, funding agreement, governance arrangements, programme mobilisation	Q3-Q4 2026
Neighbourhood 1 Implementation	Specification, procurement, mobilisation, go-live and delivery	Q1 2027 - Q1 2028
Gateway Review 1	Evaluation and review of Neighbourhood 1 outcomes	Q1-Q2 2028
Neighbourhood 2 Implementation	Specification refresh, procurement, mobilisation, go-live and delivery	Q2 2028 - Q2 2029
Gateway Review 2	Evaluation and review of Neighbourhood 2 outcomes	Q2-Q3 2029
Neighbourhood 3 Implementation	Specification refresh, procurement, mobilisation, go-live and delivery	Q3 2029 - Q2 2030
Gateway Review 3	Programme review and sustainability planning	Q2-Q3 2030
Programme Evaluation & Commissioning Readiness	Benefits realisation, final evaluation, commissioning business case	Q3 2030 - Q1 2031
Commissioning Decision & Closure	Board decision on future commissioning and programme closure	Q2-Q3 2031

Project Exit Strategy

The programme has been designed as a phased, gateway-controlled initiative to minimise financial, operational and reputational risk. Should the programme fail to achieve agreed outcomes, the Health Board will retain the ability to pause, redesign or discontinue delivery.

At the end of Years 1, 2, 3, 4 and 5, TriTech will undertake formal gateway reviews to evaluate programme performance, benefits realisation and value for money. These reviews will provide the evidence base for decisions to continue, expand, modify, pause or discontinue the programme, thereby limiting financial exposure and ensuring investment remains outcome-driven.

A formal review will be initiated if the programme fails to demonstrate satisfactory progress against agreed performance, financial and outcome measures, including KPI delivery, participant engagement, workforce sustainability, benefits realisation and value for money, or where external funding arrangements materially change.

Should the programme fail to demonstrate sufficient benefit to warrant continuation, the Health Board will implement a phased and managed exit strategy that safeguards participants, preserves organisational learning, supports workforce transition and enables community partners to conclude activities in a planned and sustainable manner.

A comprehensive final evaluation will be undertaken to document programme outcomes, benefits realised, lessons learned and best practice. This evidence will inform future neighbourhood prevention initiatives, support organisational learning, and provide recommendations for the future development, commissioning and scaling of prevention-focused services.

Whilst the availability of external funding presents an opportunity to increase workforce capacity through the creation of new posts, it also introduces significant workforce, financial and organisational risks. The fixed-term nature of the funding does not remove the Health Board's employment obligations. Employees appointed to fixed-term contracts will retain statutory employment rights, including protection against redundancy and unfair dismissal once the relevant qualifying periods have been met.

A further important consideration is the proposed duration of the funding. As funding is expected to continue for between four and five years, employees engaged on successive fixed-term contracts may acquire the right to be treated as permanent employees unless the continued use of fixed-term arrangements can be objectively justified. Consequently, the Health Board would remain liable for all associated employment costs and liabilities arising from these posts, including redeployment obligations, redundancy costs (such as contractual redundancy payments, notice pay, accrued annual leave and, where applicable, pension-related costs), together with the risk of employment claims should the funding cease.

Careful consideration should therefore be given to the long-term affordability and sustainability of these roles, as well as the potential expectation that services and staffing established through the funding will continue beyond the funded period. Alternatively, the Health Board must be satisfied that there is a clearly defined exit strategy, adequate provision for any future redundancy liabilities, and a robust business justification for maintaining fixed-term status throughout the life of the programme. Failure to address these issues could expose the Health Board to significant financial, workforce and legal risks extending beyond the period of external funding.

Recommendation

Approval is sought to secure Macmillan investment and establish a neighbourhood-based prevention model that will improve population health, strengthen communities, reduce inequalities and create a more sustainable and prevention-focused health and care system across Hywel Dda University Health Board.

It is recommended that the Board:

1. Approve the Business Case and enter into the necessary agreements with Macmillan and Social Finance to secure the proposed social investment funding and support programme mobilisation. The social investment funding will support the delivery and evaluation of the programme, while the Anchor Grant funding will be paid directly to third-sector partners to support community capacity building, neighbourhood infrastructure, community development, volunteer programmes, micro-grants and local prevention initiatives.

2. Approve the proposed five-year delivery model, recognising that whilst neighbourhood health programmes are typically funded over a three-year period, an extended five-year approach has been agreed to enable the Health Board and partners to establish the model, test and refine interventions, build evidence, demonstrate outcomes and support long-term sustainability.

3. Approve the phased rollout across neighbourhoods, allowing learning and evaluation to inform future implementation and maximise the opportunity for continuous improvement.

4. Approve the proposed programme model, comprising:
- Health Coaching
- Community Health and Wellbeing Workers
- Community Capacity and Local Infrastructure for Prevention
- Making Every Contact Count
- Digital Enablement

5. Approve the governance arrangements, including establishment of a Programme Board chaired by the Executive Director of Public Health as Senior Responsible Owner, supported by partnership, assurance and corporate governance structures.

6. Approve the monitoring, evaluation and benefits realisation framework, ensuring robust measurement of population health outcomes, patient experience, healthcare utilisation, financial benefits and return on investment throughout the programme.

7. Request the development of a sustainability and commissioning plan during the lifetime of the programme to identify opportunities for recurrent funding and long-term integration of successful interventions into mainstream services.

8. The Programme Board should work with local authorities, primary care, community services and third-sector partners to explore and develop **pooled budgeting and joint commissioning arrangements** to support the long-term sustainability of the Community Health and Wellbeing Worker model. The programme should utilise the five-year implementation period to evaluate impact, demonstrate value across organisational boundaries, and build the evidence base required to support recurrent investment and integrated funding arrangements beyond the initial Macmillan investment period.

In the event that pooled funding arrangements cannot be agreed, the Health Board would need to identify recurrent core funding to sustain the model beyond the initial investment period. This would include funding for all three programme components, with ongoing responsibility for these costs resting with the Health Board to ensure continuity of service and delivery of anticipated benefits.

Decision Required

The Board is asked to:

- Approve the Business Case.
- Approve progression to formal funding negotiations with Macmillan and Social Finance.
- Approve the proposed five-year implementation and evaluation period.
- Approve the governance, evaluation and benefits realisation arrangements.
- Support the direct allocation of Anchor Grant funding to third-sector delivery partners to strengthen community assets, neighbourhood infrastructure and prevention capacity.

Appendices

Appendix 1. Health Coaching Current Position and Evaluation Findings
Supports: *Programme Component 1: Health Coaching*

Appendix 2. Brazil Community Health and Wellbeing Worker Model
Supports: *Programme Component 2: Community Health and Wellbeing Workers*

Appendix 3. Community Health and Wellbeing Worker (CHWW) Business Case
Supports: *Programme Component 2: Community Health and Wellbeing Workers*

Appendix 4. Demonstrator Project Evaluation Report
Supports: *Programme Component 2: Community Health and Wellbeing Workers*

Appendix 5. Communications and Engagement Plan
Supports: *Programme Governance*, *Community Capacity and Local Infrastructure for Prevention* and stakeholder engagement arrangements.

Appendix 6. Evidence Reviews and Literature Summary
Supports the evidence base for all three programme components and the assumptions used within the benefits realisation modelling.

Appendix 7. Macmillan GANTT Chart
Supports: *Project milestones and timelines.*

Appendix 8. Macmillan Commissioning Template
Supports: Commissioning arrangements, funding agreements, governance structures, and outcomes-based contracting frameworks.

Appendix 9: Quality Impact Assessment

Appendix 10: Health Equity Impact Assessment

Appendix 11: Equality Impact Assessment

Approval Section

Role	Name	Signature	Date
Senior Responsible Officer	Bruce Bolam	Bruce Bolam	7/08/2026
Digital Lead	Anthony Tracey		31/07/2026
Primary Care Lead	Rhian Bond	Rhian Bond	31/07/2026
Executive Sponsor	Ardiana Gjini		
Patient Representative	Abi Morgan	A Morgan	23/07/2026

Macmillan proposal: Modelling and benefits realisation

1. Executive summary

The modelling was undertaken to test whether the proposed investment could plausibly improve outcomes and moderate future healthcare demand sufficiently to support the Health Board's decision to invest. It is a rapid business-case assessment, not a prediction of guaranteed savings. The quantified results focus narrowly on avoided healthcare utilisation and do not capture the full value of improved health, wellbeing, reduced inequalities or stronger communities.

Two complementary independent modelling perspectives have been used:

- TriTech has modelled a relatively intensive Health Coaching offer, using local service assumptions and principally quantifying smoking- and alcohol-related effects on healthcare utilisation.
- The National Association of Primary Care (NAPC) has modelled a broader mixed-intensity approach across Health Coaching and Community Health and Wellbeing Workers, with intensive support for higher-need groups and lower-cost group, workforce-enabled, community and digital support for a much larger lower-intensity cohort.

The models should not be interpreted as lower and upper confidence limits for the same intervention. They examine different workforce envelopes, service designs, populations and benefit pathways. Their combined value is to identify the conditions under which the programme is more or less likely to deliver value and to inform targeting, delivery design, evaluation, gateway decisions and repayment arrangements.

Headline conclusion

Material demand avoidance is plausible, but its scale depends heavily on who is reached, the intensity and cost of support, sustained behaviour change, and the extent to which delivery evolves from predominantly one-to-one support towards proportionate one-to-few and one-to-many approaches. The modelling therefore supports approval of a controlled learning programme, not reliance on a single financial forecast.

2. Purpose, scope and decision context

The purpose of the modelling is to support an executive decision under uncertainty. It asks whether investment in Health Coaching and Community Health and Wellbeing Workers could plausibly avert future demand and influence future Health Board resource allocation. It does not attempt to value every programme outcome or substitute for prospective evaluation.

The decision standard applied is deliberately demanding. A requirement that prevention should offset its own cost is a higher threshold than the normal NHS cost-effectiveness question of whether the health gained justifies the additional expenditure. Some preventive interventions may be cost avoiding, while many others may still represent good value because they generate more health for the resources used.

For this programme, modelling is most useful when treated as part of a wider assurance system comprising service design, clinical governance, continuous improvement, evaluation, financial monitoring, gateway reviews and contractual controls.

3. The modelling approaches

3.1 Comparison of the two principal models

Feature	TriTech: intensive Health Coaching	NAPC: mixed-intensity strategy
Primary purpose	Estimate healthcare utilisation effects from a locally informed Health Coaching model.	Explore how the intensity mix and breadth of reach could affect overall return.
Modelled input	Health Coaching workforce: 17 WTE Health Coaches, supported by a clinical lead and assistants; modelled workforce cost approximately £4.6m over five years.	32 WTE across Health Coaching and CHWWs; modelled workforce cost approximately £6.8m over five years.
Delivery design	Predominantly intensive, individual Health Coaching, based on current local service assumptions.	Need-stratified Red, Amber and Green cohorts, combining one-to-one, group, MECC, community and digital approaches.
Population reach	Approximately 3,060 completed interventions a year is the core local capacity assumption.	Approximately 3,300 Red, 4,400 Amber and 55,000 Green contacts a year in the broad mixed-intensity scenario.
Benefit pathway	Principally smoking cessation and reduction in harmful alcohol use, translated into estimated healthcare activity avoided.	Top-down estimate of modifiable expenditure and potential impact across a broader programme envelope.
Reported five-year result	Avoided demand equivalent to approximately £5.2m from the reported smoking and alcohol pathways.	Avoided demand equivalent to approximately £13.2m, with substantial dependence on the assumed reach and effectiveness of the Green offer.
Key strength	Uses local pilot and service assumptions; explicitly considers high/low scenarios and relapse.	Shows how targeting and delivery intensity can materially change reach, cost and potential value.
Key limitation	Does not model CHWWs or several wider benefit pathways; some activity categories and disease-event calculations require further assurance.	The broad Green reach and effect assumptions may be optimistic; Health Coaches and CHWWs are treated too interchangeably for final evaluation.

4. What the modelling supports

- Substantial demand avoidance is plausible if the programme reaches the intended populations, achieves sustained behaviour change and adapts delivery to improve reach and productivity.
- Targeting matters. Greater short-term healthcare utilisation effects are more plausible where support reaches people with substantial, modifiable risk and potentially avoidable use of services.
- Intensity matters. A service based entirely on intensive one-to-one support limits reach; a proportionate model can preserve intensive support for higher-need groups while using lower-cost group, workforce-enabled, community and digital approaches for others.
- The quantified estimates understate the full programme value because they do not comprehensively value improved wellbeing, equity, social connection, community capacity or several clinical benefit pathways.
- Evaluation and gateway decisions are more important than apparent precision in the initial modelling because the programme is upstream, multi-component and materially different from business as usual.

Issue	Assurance implication
Attribution	Observed improvements may reflect existing services, wider policy or secular trends as well as the programme. A credible comparator and predefined attribution rules are required.
Target population	The scale of demand avoided depends on who is reached. The same behaviour change may have a different near-term utilisation effect in populations with different baseline risks and service use.
Avoided demand versus cash	Avoided activity may release capacity or moderate future pressure without creating an equivalent cash reduction in existing budgets.
Double counting	Healthcare activity categories and disease-event pathways must not be added together unless overlap has been excluded.
Breadth of benefit	TriTech principally quantifies smoking and alcohol pathways; NAPC applies broader top-down assumptions. Neither fully captures all health, equity and social outcomes.
Green cohort	The NAPC result depends materially on reaching a very large lower-intensity cohort and achieving a meaningful effect at low cost. Both reach and effect require testing.

6. How uncertainty is managed through programme design

The business case does not attempt to eliminate the uncertainty inherent in prevention. It converts uncertainty into a managed delivery and learning process. The programme will not implement a fixed service model for five years. Instead, it will use phased implementation, Plan-Do-Study-Act cycles, embedded evaluation and formal gateways to refine the target population, intervention intensity, workforce allocation and delivery channels.

It is hypothesized that Health Coaching capacity will initially provide personalised support where need and capacity to benefit are greatest. The funded Making Every Contact Count, group and digital components will progressively extend appropriate support from one-to-one towards one-to-few and one-to-many delivery. This is intended to improve reach and productivity while retaining intensive support for people with complex needs and protecting equitable access for people who cannot use digital routes.

This adaptive approach is a direct response to the modelling. It seeks to move delivery over time towards the more favourable combinations of targeting, intensity, reach and unit cost, rather than if the initial service configuration will automatically generate the modelled benefits.

7. Evaluation and gateway framework

The evaluation framework should establish a clear evidence chain from programme reach to longer-term population and service effects. Different evidence should carry different weight as the programme matures.

1. **Reach and equity:** Who is reached, from which neighbourhoods and priority groups, and whether access is equitable.
2. **Delivery and dose:** The type, intensity, duration and completion of one-to-one, group, MECC, community and digital support.
3. **Behaviour and activation:** Changes in smoking, alcohol use, diet, physical activity, patient activation, confidence and self-management.
4. **Clinical and wellbeing outcomes:** Relevant clinical indicators, wellbeing, social connection and outcomes important to participants.

5. **Healthcare utilisation:** Changes in primary, outpatient, urgent, emergency and inpatient use compared with an appropriate matched comparator.
6. **Population and system impact:** Whether intervention neighbourhoods improve relative to comparison areas, together with cost consequences, capacity effects and wider system value.

Early gateway reviews should place greater weight on mobilisation, reach, equity, delivery fidelity, behaviour change and early clinical outcomes. Later gateway and repayment decisions should place increasing weight on independently validated healthcare utilisation and financial effects. Before-and-after comparisons alone should not be treated as sufficient evidence of attribution; matched comparison methods should be used where feasible.

1. BACKGROUND

The Global Burden of Disease study estimates that around one-third of the chronic disease burden is driven by modifiable behavioural risk factors. According to the 2025 National Survey for Wales, among adults aged 16 and over: 10% are current smokers; 62% live with overweight or obesity; 41% do not meet recommended physical activity levels, and 15% consume alcohol at hazardous or harmful levels.

Without further intervention, projections from Public Health Wales suggest these behaviours will significantly contribute to a rise in non-communicable diseases over the next decade, including: a 22% increase in diabetes; a 15% increase in cancer; a 46% increase in heart failure, and a 12% increase in COPD.

Hywel Dda UHB faces rising demand, acute financial pressures, and workforce constraints that challenge the sustainability of reactive, treatment-focused models. In this context, more effective prevention and improved chronic disease management are essential to long-term system sustainability.

This direction is supported nationally. Population health and prevention are core priorities for Welsh Government and NHS Wales, alongside a growing emphasis on digital enablement and the shift to integrated, primary care-led models of care. Regionally, Hywel Dda is committed to earlier intervention, care closer to home, and a shift away from hospital-centric care towards a whole-system model, integrating health and social care and embedding the social model of health in partnership with communities, local authorities, and the third sector.

Achieving this shift will require structured, scalable approaches to behaviour change that are embedded into routine clinical care and effectively connected with existing community infrastructure – a stepped care model of behaviour change.

This proposal builds on a successful local multi-year pilot that emerged from our smoking cessation service in 2022/23 and has evolved to address a broader range of lifestyle behaviours. It provides a practical pathway to further embed prevention into and across services, teams, and communities, while aligning with regional health and wellbeing priorities.

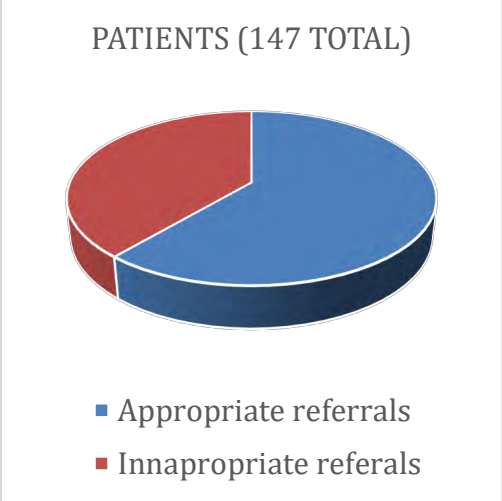
The proposed expansion will build on the successful Lifestyle Medicine pilots delivered within Hywel Dda UHB, which demonstrated the value of combining education across the six pillars of lifestyle medicine with group health coaching, community connector support, peer networks and practical workshops delivered in partnership with community and third-sector organisations. The evaluation showed that participants valued not only the education provided, but also the accountability, confidence, social connection and ongoing support generated through group-based delivery, with many forming lasting peer support networks that continued beyond the programme itself. Participants reported sustained improvements in physical and mental wellbeing,

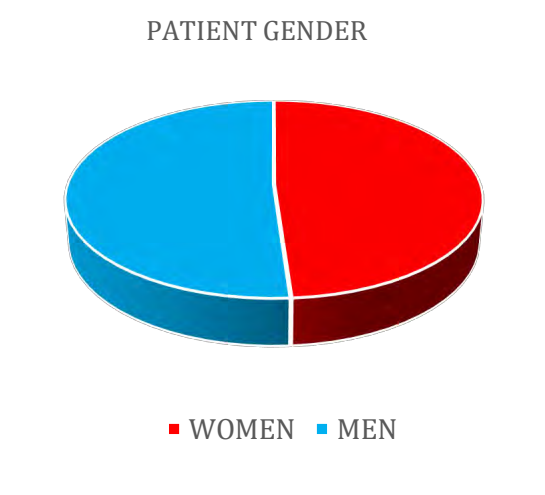
increased confidence to engage in exercise and community activities, and meaningful behaviour change, while case studies demonstrated improvements in weight, blood pressure, blood sugar control and quality of life. The proposed model will therefore combine evidence-based lifestyle medicine education, personalised health coaching, community connector support and partnerships with local organisations to create scalable, sustainable pathways that help people move beyond managing illness towards living healthier, more connected and fulfilling lives.

2. CURRENT SITUATION

Building on the early Health Coach model, a further pilot was established in Ceredigion to begin in January 2026. This re-pilot focused on 5 GP surgeries in Ceredigion over 3 months to establish demand both from Primary Care and from the public.

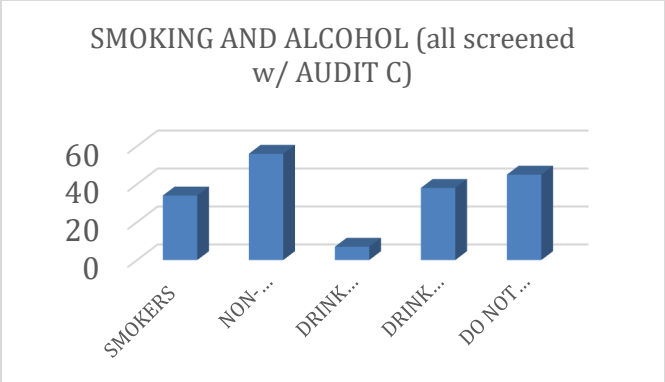
During this time, there were 147 referrals into the service, of which 90 people appropriate and these individuals joined the programme.



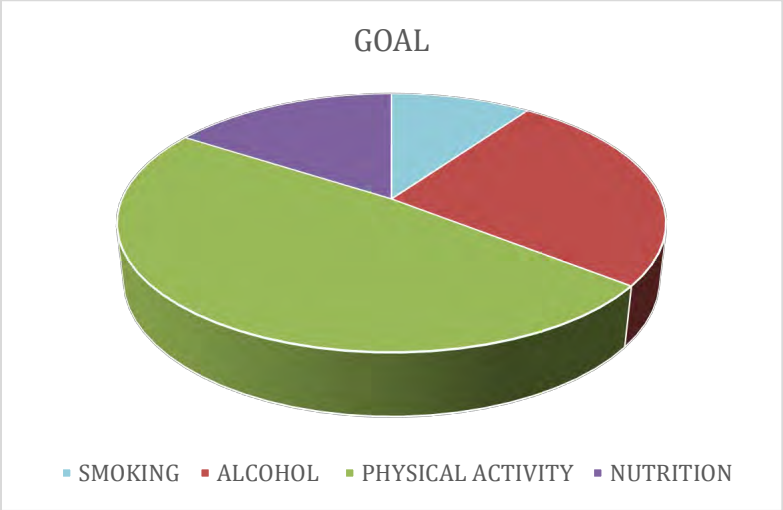


Each person received an initial assessment followed by 11 sessions of support and a range of data was collected as part of the pre-assessment including:

- Smoking status
- Alcohol Consumption (AUDIT C)
- Portions of fruit and vegetables consumed daily (also need to consider frailty markers going forward)
- Minutes of physical activity
- BMI
- Blood Pressure



Further, each individual's key motivator was explored and appropriate support and onward signposting embedded into their care plan.



The Health Coach programme, having shown the impact that it can have in such a short space of time, has been granted funding to expand. Hywel Dda has 7 primary care clusters spread across three counties. The funding will provide a country lead, a health coach for each cluster as well as project support for data, partnership working and training.

3. HEALTH COACH ENHANCEMENT BASED ON DEPRIVATION

GP Surgeries in the Most Deprived Areas of Hywel Dda University Health Board
There is not a single official Hywel Dda list ranking GP surgeries by deprivation, but it is possible can get a good proxy by mapping surgeries onto the Welsh Index of Multiple Deprivation (WIMD) areas in Carmarthenshire, Pembrokeshire and Ceredigion. The most deprived communities within Hywel Dda tend to cluster around Llanelli, parts of the Amman Valley, Pembroke Dock and Milford Haven.
Reference: https://www.gov.wales/welsh-index-multiple-deprivation-2025

Llanelli area (largest concentration of deprivation in Hywel Dda)
These practices serve wards/LSOAs such as Llwynhendy, Glanymor, Tyisha and parts of central Llanelli, which regularly score among the most deprived in west Wales.

- Llwynhendy Health Centre
- Ty Elli Group Practice
- Fairfield Surgery
- Avenue Villa Surgery
- Ash Grove Medical Centre

The Llanelli cluster is recognised by Hywel Dda itself as a major urban primary care locality.

Reference: https://www.tyellihealth.co.uk/about-the-cluster

Amman Gwendraeth
Parts of Ammanford, Garnant and Gwaun-Cae-Gurwen contain significant deprivation, particularly around former mining communities.

- Margaret Street Surgery
- Brynteg Surgery
- Amman Tawe Partnership (GCG) ((3 HC required))

Pembrokeshire
These towns contain some of Pembrokeshire's most deprived LSOAs, especially around dockland and post-industrial neighbourhoods.

- Argyle Medical Group (2 HC)
- Barlow House Surgery
- Robert Street Surgery
- Neyland

Ceredigion
Ceredigion generally has much lower overall deprivation than Carmarthenshire or Pembrokeshire. GOV.WALES notes that Ceredigion had no areas in the most deprived 10% nationally on the WIMD health domain.

- Cardigan Health Centre (GP Surgery)
- Padarn GP Surgery (Aberystwyth, student heavy population)

Reference: https://www.gov.wales/welsh-index-multiple-deprivation-wimd-2025-results-report-health-domain-results-html

Key caveat: Rural deprivation in Hywel Dda is often about poor access to services rather than the classic urban poverty seen in Llanelli. For example, Ceredigion and rural Carmarthenshire score very highly on access to services deprivation despite lower income deprivation.

Reference: https://www.gov.wales/welsh-index-multiple-deprivation-wimd-2025-results-report-access-services-domain-results-html

Enhanced Health Coach Proposal

Based on the data above, it is suggested that each of the surgeries listed has its own Health Coach, working full time in a prevention and early intervention capacity to address the lifestyle issues that contribute to chronic diseases. This would require a further 17 health coaches and, given the demand notably in Carmarthenshire, a second county lead in that area to manage the staff and workload.

Development of health coaches with an RDC setting and Dietetics

The Rapid Diagnostic Clinic for Hywel Dda (held on a Wednesday in Prince Philip Hospital) sees an average of 5 patients per week who are referred directly via their GP when they have vague symptoms of cancer which don't fit specific cancer site pathways. In clinic, patients receive a consultation, examination, scan and diagnosis (aimed to be delivered on the same day). Of these patients, less than 1 in 10 have a confirmed cancer.

Attendance at the RDC clinic and a following negative diagnosis provides a unique and timely opportunity/trigger for patients to consider adopting healthier lifestyles and reduce their risk of developing cancer. The Lead CNS for this service has observed that patients who present at the RDC often have lifestyle habits which could include smoking, alcohol, nutrition, physical activity, emotional wellbeing, sleep, etc. and could indicate that development of a future cancer diagnosis.

Lifestyle issues could be initially identified via the RDC nursing team during triage and the first clinic appointment. The 2 Clinical Nurse Specialists running the service would be trained as motivational health coaches. The Macmillan eHNA tool could be used to help record some of this information. 10 further specialist cancer nurses would also be trained to gradually implement the model across other disciplines.

Where a patient has received a negative diagnosis, the nursing team would contact the patient shortly after the diagnosis to consider addressing some of the lifestyle factors identified via the first clinic appointment. The nursing team would then signpost/refer onto suitable services (third sector, community, etc.).

This approach could also be used where a patient has received a positive cancer diagnosis. Noting that lifestyle change is harder during uncertainty, fear and stress there needs to be clear messaging “This is about supporting you while we find out what’s going on” not “you’ve caused this or done something wrong”.

A key consideration is the role of dietetics both alongside Health Coaches but more specifically, alongside those patients identified via the RDC. Whilst some patients will require weight management services, the more vulnerable may be underweight (likely if they have been referred for a cancer screening process) and appropriate support from a clinician would be vital. With this in mind, there may be more allied health professionals who might be suited to the role (such as physiotherapy or occupational therapy) so some funding should be allocated for their training in the same way as the cancer nursing staff.

TOTAL COSTS

TYPE OF EXPENDITURE	COST
Health Coaching Staff 1 WTE Band 6 Clinical Lead 17 WTE Band 5 Health Coaches 3 Band 4 Health Coach Assistants	***£4,634,116***
Training Costs	***£92,500***
TOTAL	**£4,726,616**

EXPECTED PATIENT NUMBERS

This projection assumes that staff productivity, referral behaviour and patient demand remain consistent as the service expands.

Original Pilot Data

- 2 members of staff
- 147 total referrals over a 3-month period
- 90 patients seen
- 57 referrals did not progress (e.g. inappropriate, declined or otherwise not suitable)

Calculation

- Referrals per staff member over 3 months = 147 ÷ 2 = 73.5
- Annual referrals per staff member = 73.5 × 4 = 294
- Annual referrals for 17 staff = 294 × 17 = 4,998

Projected Annual Activity

Measure	Calculation	Projected Annual Total
Total referrals	294 × 17	4,998
Patients seen	61.2% of referrals	≈3,060
Referrals not progressing	38.8% of referrals	≈1,938

OECD Reviews of Health Systems

Primary Health Care in Brazil



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Foreword

Primary health care in Brazil has a well-organised approach which is the result of sustained commitment to providing high quality primary health care for the whole population. The Family Health Strategy, launched in 1994, has been a key pillar of the efforts to reorganise and strengthen primary health care in Brazil. Since its implementation, a growing share of the Brazilian population can benefit from free access to a community-based approach to preventive and primary health care services. An extensive body of academic research has provided evidence of the key contributions of the Family Health Strategy to the reduction of almost 18 deaths per 1 000 birth in infant mortality rate observed between 1990 and 2019 in Brazil. The programme has also been associated with reduction in mortality and hospitalisations for chronic disease. Recent estimations also show that the implementation of the Family Health Strategy was associated with a reduction of 45% of the standardised hospitalisation rates per 10 000 inhabitants between 2001 and 2016, mostly for primary care conditions such as asthma, gastroenteritis, cardiovascular and cerebrovascular diseases. However, as some challenges are overcome, new ones approach, as Brazilian population ages, population risk factors such as obesity are on the rise, and emerging pandemic threats require resilience and adaptability.

Many features of the primary health care sector in Brazil deserve to be recognised as examples for OECD countries, including the use of multidisciplinary primary care teams called family health teams, and the extensive use of community health agents, which are frontline public health workers. Brazil has also implemented a set of key reforms to improve access to high quality primary health care over the past decades, including the National Programme for Improving Access and Quality of Primary Health Care (PMAQ) and the More Doctors Programme (MDP).

Nevertheless, Brazil still needs to address a number of challenges. Most critically, only 65% of the Brazilian population are covered by family health teams and too many patients bypass primary health care and directly seek care in outpatient specialties and hospitals, notably for conditions that could be more effectively treated at community level. The expansion of primary health care has also been marked by stark disparities across states and municipalities, linked mainly to workforce shortages and imbalances in the distribution of medical doctors. There are also been a rise in the number of elderly patients and an increasing prevalence of chronic non-communicable diseases – including cancer, diabetes and hypertension, which call for effective prevention, early detection and treatment. Lastly, while Brazil has a long history of developing and investing in networks, data, interoperability and skills, progress towards effective use of digital technologies in primary health care has been slow, and fundamentally unequal.

The recent reform agenda for the primary health care sector in Brazil – the *Previne Brasil* programme – has ambitious goals toward improving access, fostering longitudinal and co-ordinated care. While primary health care is mainly a responsibility of municipalities in a decentralised health system, stronger oversight and steering from the federal government, and regional co-ordination and support from state governments will be needed to both improving access and quality, while reducing inequalities. Furthermore, as the programme is just a couple of years short of its 30th anniversary, it is in high need of innovation to get it ready for the challenges of the next 30 years, with better use of digital technology, better use of skills, modern integrated care models, backed by better performance measurements and financial incentives.

This review was prepared by the OECD Secretariat to draw on evidence and best practices from across OECD health care systems to support Brazil in strengthening its primary health care sector, and guarantee it is responsive to people's changing needs, capable of offering preventive, continuous and co-ordinated care equally across the country.

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Acronyms and abbreviations

ADAPS	Agency for the development of primary health care
APS	Atenção Primária à Saúde
ANVISA	National Agency of Sanitary Surveillance
BMI	Body mass index
BRL	Brazilian Real
CAD	Canadian Dollar
CaSAPS	Primary health care service portfolio
CFM	Brazilian Federal Council of Medicine
CGTIC	General Co-ordination of Information and Communications Technology
CHW	Community health worker
CIB	Comissão Intergestores Bipartite
CIT	Comissão Intergestores Tripartite
CQC	Care Quality Commission
CLT	Consolidation of Labor Law
CNS	National Council of Health
CME	Continuous medical education
CNES	National Register of health facilities
CONASS	National Council of State Health Secretaries
CONASEMS	National Council of the Municipal Health Secretaries
COSEMS	State Council of Municipal Health Secretariats
CPG	Clinical practice guideline
DATASUS	Informatics Department of the Sistema Único de Saúde
DENASUS	National Audit Department of Sistema Único de Saúde
DGMP	DigiSUS Gestor – Módulo Planejamento
EHR	Electronic health record
ENADE	National Exam of Student Performance
ESD 28	The Brazilian National Digital Health Strategy 2020-28
ESF	Family Health Strategy
FBG	Fasting blood glucose
FCC	Federal Communications Commission
FCM	Family and community medicine
FHT	Family health team
GESAC	Electronic Government – Citizen Assistance Service
GP	General practitioner
HPV	Human papillomavirus
HSBP	High systolic blood pressure
IBGE	Brazilian Institute of Geography and Statistics
ICT	Information and communication technologies
INCA	National Cancer Institute
INEP	Institute of Educational Studies and Research Anísio Teixeira
LAC	Latin America and the Caribbean

LDCT	Low-dose computed tomography
MACC	Modelo de Atenção às Condições Crônicas
MCTIC	Ministry of Science, Technology and Innovation
MDP	More Doctor Programme
MLA	Medical Licensing Assessment
NASF	Family health support centres
NCD	Non-communicable disease
NHS	National Health Service
OECD	Organisation for Economic Co-operation and Development
PaRIS	Patient-Reported Indicator Surveys
PACS	Community Health Agents Programme
PAHO	Pan American Health Organisation
PAPS	Planificação da Atenção Primária à Saúde
PCAT	Primary health care assessment tool
PHC	Primary health care
PMAQ	National Programme for Improving Primary Health Care Access and Quality
PLAB	Professional and Linguistic Assessments Board
PNAB	Política Nacional de Atenção Básica
P4P	Pay-for-performance
PNIIS	National Policy for Health Information and Informatics
PNS	National Health Plan
QICH	National Programme for Quality Indicators in Community Healthcare
RAS	Health care networks
RNDS	National Health Data Network
RNP	National School and Research Network
RCS	Rural Clinical School
RUTE	Brazilian Telemedicine University Network
SAEM	Accreditation System of Medical Schools
SAPS	Primary Health Care Secretariat
SMART	Sistema de Monitoramento e Avaliação de Resultados do Programa Telessaúde
SBMFC	Brazilian Society of Family and Community Medicine
SINAES	National System for the Evaluation of Higher Education
SISAB	Primary Health Care Information System
SISCAN	Cancer Information System
SISCOLO	Cervical Cancer Information System
SISMAMA	Breast Cancer Information System
SOBRAMFA	Brazilian Society for Family Medicine
SUS	Unified Health System
UBS	Basic health care units
USD	United States Dollar
WHO	World Health Organization

Executive summary

The introduction of the *Sistema Único de Saúde* (SUS) in 1990 has been a major achievement for Brazil in increasing access to health care services and reducing health inequalities. The implementation of the Family Health Strategy, starting in 1994 and aimed at the reorganisation and strengthening of primary health care, has been a key component in this success. Since its implementation, the Brazilian population can benefit from free access to preventive and primary health care services delivered by multi-disciplinary family health teams (FHTs). Over the past two decades, reforms have sought to rebalance service delivery to move away from a health system that was historically very hospital-centric. Remarkably, reforms have focussed on developing modern models of care, introducing a range of quality initiatives and tools for monitoring the activities and quality of care. The expansion of the Family Health Strategy has contributed to measurable improvements in terms of infant mortality rates, maternal health, immunisation uptake and avoidable hospitalisation for chronic conditions. Life expectancy at birth increased by 5.7 years, from 70.2 years in 2000 to 75.9 years in 2019. Infant mortality rate has decreased by 60%, from 30.3 deaths per 1 000 live births in 2000 to 12.4 deaths per 1 000 live births in 2019. The implementation of the Family Health Strategy was associated with a reduction of 45% in hospitalisation rates per 10 000 inhabitants between 2001 and 2016, mostly for primary care conditions such as asthma, gastroenteritis, cardiovascular and cerebrovascular diseases. Brazil also makes spending on primary health care a high priority. In 2019, Brazil dedicated around 16% of its financial resources to primary health care, similar to OECD countries.

Despite this progress, key indicators suggest that Brazil primary health care is not working as effectively. Brazil is facing a dual challenge with still a primary health care system with marked inequalities in access and care quality, and with acute workforce shortages. The growing burden of chronic non-communicable diseases associated with the expansion in exposure to risk factors and rapid population ageing will compound existing challenges. In this context, the Review identifies scope for Brazil to building a stronger primary health care system, and to strengthen existing policies and practices to improve both access and care quality. It provides in-depth review of four priority areas: screening and prevention for major chronic non-communicable diseases, quality of primary health care provision, workforce shortages, and the digital transformation of primary health care in Brazil.

In Brazil, some cancers, hypertension and diabetes have ***screening and prevention strategies***, but more could be done to improve depth and scope of such strategies. Breast and cervical cancer screening is opportunistic and does not happen within a population-based programme designed and managed at federal level. This contributes to low and uneven screening coverage. While breast cancer screening among the target group of women between 50 to 69 years of age increased from 15.2% to 24.2% between 2014 and 2019, it stands below all OECD countries and well below the 58% average in 2019. At the same time, mortality from breast and cervical cancer remains high and has been on the rise over the past decades, signalling shortcomings in terms of prevention, early detection and treatment at early stages. Between 2008 and 2019, breast cancer mortality increased from 19.2 to 20.8 deaths per 100 000 women in Brazil, compared to a decrease across OECD countries. Brazil should thus implement a strong national strategy for cancer prevention and screening, notably by moving towards population-based programmes, with a personalised approach to invite target populations. Improving data systems and health literacy are complementary strategies not to be underestimated to support stronger cancer prevention and screening.

When it comes to screening for hypertension and diabetes, Brazil should further develop disease management pathways with a people centred perspective, integrating all health care providers across different sectors. Family health teams will need to have the right tools, capacities, and incentives to undertake these responsibilities.

There are also clear shortcomings with regards to access to ***high quality primary health care***. Critically, only 65% of the population are covered by FHTs and too many patients bypass primary health care and directly seek care in outpatient specialties and hospitals. These give strong argument to strengthen the gatekeeping system in Brazil with a systematic registration system with FHTs, which will control and orient the patient's into specialist care. At the same time, the federal government will need to play a more prescriptive role to strengthen comprehensiveness of primary health care evenly across the country. To embed a larger range of activities and effective interventions in FHTs, it will be critical to ensure that all municipalities are able to deliver actions and services properly. Introducing economic incentives, alongside appropriate educational programme in prevention, detection, and treatment are key approaches to consider. There are also several opportunities for extending further quality strategies toward primary health care. Particular attention should be given to transparency and the collection of richer performance data. A robust accreditation system that would apply uniformly across the country could help standardise primary health care quality, and to identify areas that may require greater financial and organisational support. The new Agency for the Development of Primary Health Care could act as an inspectorate for primary health care, for example to provide independent and external verification that standards are being met, identify good practice and support weaker centres to improve their standards.

When it comes **to workforce challenges**, Brazil primary health care sector faces acute shortages and imbalance in the distribution of primary health care doctors with a North-South gradient, where North and Northeast regions show a lower density of medical doctors. In addition, little attention has been devoted to building a strong credibility of the primary health care specialty, and to promote workforce quality. In 2018, only 5 486 medical doctors had a specialty training in family and community medicine, representing 1.4% of all specialists in Brazil. Going forward, Brazil needs to implement a coherent workforce planning based on an objective assessment of present and future needs to govern health care human resources, which is currently absent. In tandem, Brazil could look at the experiences of OECD countries to train more rural doctors and to provide both wage and non-wage related financial incentives linked with a return of service obligation. Brazil should take steps to expand the role of nurses and community health workers and explore the potential of task delegation. Perhaps more crucially, there are opportunities to make the primary health care specialty training compulsory for all doctors wishing to practise primary health care, and to implement stronger requirements around continuous medical education.

Brazil's decentralised government creates challenges to digitalising primary health care. Brazil has made strides towards a ***digital transformation*** of primary health care, building on more than a decade of policies to digitalise health care and make better use of health data, and with key investments in networks, data, interoperability and skills. Yet, progress towards effective use of digital primary health care has been slow, and fundamentally unequal, with significant inequalities in the use of digital technologies and tools among health workers and citizens. In 2019, an estimated 78% of PHC units had electronic health record (EHR) systems. Adoption of EHR systems was highest in the South and Southeast regions (at 90% and 83% of facilities in those regions, respectively) compared to the Northeast and North regions (77% and 74% respectively). Other major barriers include human and technical capacities in municipalities, with potential diseconomies of scale resulting from setting responsibilities for digital health at municipal level. Tackling these challenges requires to digitalising all primary health care units and teams, while promoting inclusive connectivity for all Brazilian citizens, especially the most vulnerable. Brazil should also consider establishing a governance structure with clear well-funded mandates at the right levels of government.

Across all these areas, there is scope to strengthen oversight from the federal government and regional co-ordination and support from state governments. Better and stronger co-ordination mechanisms between levels of government have the potential to lessen regional inequalities, and prepare the health system

against systemic shocks, such as the one observed in the COVID-19 pandemic. The Brazilian unified health system (SUS) has had high aspirations since its introduction by the Federal Constitution of 1988, which was the result of a society-wide mobilisation. Primary health care has been a cornerstone of the extension of health care coverage since the beginning of SUS. Continuing to strengthen and modernise primary health care remains the essential lever for the Brazilian health system to realise its potential of effectively achieving universal coverage of high quality services for all Brazilians.

1 Primary health care in Brazil: Assessment and recommendations

Primary health care (PHC) in Brazil has a well-organised approach, the result of sustained commitment to providing high-quality PHC for the entire population. Brazil has introduced a comprehensive package of policies designed to modernise and strengthen PHC. However, a number of key challenges remain, including the increasing prevalence of chronic non-communicable diseases, large disparities across regions in the supply and quality of PHC, and a low and unequal use of digital technologies. This chapter assesses Brazil's PHC system. It considers four topics in detail: screening and prevention for major chronic non-communicable diseases, enhancing the quality of PHC provision, tackling workforce shortages and promoting the digital transformation of PHC in Brazil. It provides a set of recommendations on improving PHC in the country.

Brazil has a relatively well-functioning and well-organised primary health care (PHC) system, the result of sustained commitment to providing high-quality PHC for the whole population. The Family Health Strategy (Estratégia de Saúde da Família [ESF]), one of the largest community-based PHC programmes in the world, has successfully increased population coverage and improved key health outcomes. Since the strategy's launch in 1994, the Brazilian population has enjoyed free access to preventive and PHC services, delivered by multidisciplinary family health teams (FHTs) (Box 1). The expansion of the Family Health Strategy from 1994 has contributed to measurable improvements in infant mortality rates, maternal health, immunisation uptake and avoidable hospitalisation for chronic conditions. For example, infant mortality rates decreased from 30.3 deaths per 1 000 live births in 2000 to 12.4 deaths per 1 000 live births in 2019. Life expectancy at birth increased by 5.7 years between 2000 and 2019, from 70.2 years to 75.9 years. In addition, the Requalifica programme launched in 2011 has led to major public investment to expand the supply and equipment of PHC facilities. Still today, investment in PHC is a high priority for the federal government: in 2020, it allocated a budget of BRL 20.9 billion (Brazilian real) to PHC (USD 3.8 billion), compared to BRL 17.5 billion in 2019 (USD 3.2 billion) (CONASEMS, 2020[1]). In the context of the COVID-19 pandemic, the federal government provided punctual financial and organisational assistance to FHTs to manage COVID-19 cases, and non-COVID-19 patients. These included for example the development of special COVID-19 care centres, the development of safety standards and protocols to manage high-risk patients.

Despite this progress, important challenges lie ahead for Brazil. Only 65% of the population is covered by FHTs. Too many patients bypass PHC, directly seeking care in outpatient specialised clinics and hospitals, notably for conditions that could be more effectively treated at the community level. This is partly the result of structural challenges that make it difficult for FHTs in some municipalities to deliver PHC functions. PHC has traditionally provided few low-complexity procedures and surgeries. In addition, the expansion of PHC has been marked by stark disparities across regions and municipalities. The most vulnerable and remote municipalities of the North and Northeast regions consistently present poorer health outcomes and lower health care quality than the national average. The proportion of hospitalisations owing to conditions that could be more effectively treated in the PHC setting ranges from 24% in the South region to 40% in the North region.. Such disparities stem in part from workforce shortages and imbalances in the distribution of medical doctors in rural and remote areas. Not only does Brazil have too few PHC physicians, but they are also highly concentrated in the South and Southeast regions. Last but not least, as in all OECD countries, Brazil is experiencing a rise in the number of elderly patients and an increasing prevalence of chronic non-communicable diseases, including cancer, diabetes and hypertension (see Box 1). These call for more effective prevention and stronger PHC to manage evolving health needs, and ensure a healthy and active population across the country.

Box 1. Key features of the primary health care sector in Brazil

The Brazilian *Sistema Único de Saúde* (SUS), instituted in 1990 after the approval of the new Brazilian Constitution, is decentralised**.** The Ministry of Health is responsible for the central management of the health system, and **the 5570 municipalities are responsible for the organisation, management and delivery of PHC services**. With federal funding, municipalities have the freedom to hire family health team members according to the population needs and geographic characteristics.

The federal government finances one-third of total PHC costs (33%), with the remaining part being funded predominantly by municipalities (61%). The participation of states is the smallest. **Brazil dedicated around 16.3% of its current health expenditure to PHC**, slightly lower than OECD average (16.6%).

The Brazilian SUS offers preventive services and PHC free of charge to its population. The private sector is supplemental as health plans mainly offer specialist and hospital services, although private health plans have begun to offer access to family doctors.

Multi-professional family health teams (FHTs) are responsible for the delivery of PHC. Each FHT is assigned a geographic area, covering up to 4 000 individuals located in non-overlapping areas. FHTs are responsible for registering every family in their geographic area. As of 2019, there were 43 234 Family Health Teams in Brazil. The FHT includes physicians, nurses, and up to 12 community health workers**.** Other PHC workers can provide additional supports depending on local needs.

FHTs are expected to be the initial contact point for patients having new health needs, although it does not work as a "gatekeeper" and many Brazilian have direct access to outpatient specialties and hospitals. In addition, only about 65% of Brazilians are currently registered with a FHT.

In 2020, there were around 60 000 medical doctors working in PHC, alongside 50 000 nurses and 35 000 dentists in practice in Brazil. Practicing doctors per 1 000 population in 2019 were lower compared to the OECD average, at 2.3 compared to 3.5. While the specialty of family and community medicine was introduced as a clinical and licensed specialty, PHC is mostly delivered by physicians who do not have any specialty or by physicians with a specialty in internal medicine. In 2018, only 5 486 medical doctors had a specialty training in family and community medicine (1.4% of all specialists).

There is a marked disparity in the concentration of doctors in different regions and states, and between state capitals and other parts of states. The Southeast is the region with the highest medical density per inhabitant (with 2.81 per 1 000 population), against 1.16 per 1 000 population in the North and 1.41 in the Northeast.

Table 1.1. Key performance indicators in Brazil and OECD, 2019 (or latest year available)

	Brazil	OECD average
Spending in PHC (% of current health spending)	16.3%	16.6%
Doctors (per 1 000 pop)	2.3	3.5
Nurses (per 1 000 pop)	8	9.1
Life expectancy at birth (years)	75.9 years	81 years
Infant mortality (deaths per 1 000 live births)	12.4	4.2
Smoking (daily smokers, % population aged 15+)	9.8%	16.5%
Alcohol (litres consumed per capita, population aged 15+)	6.1	8.7
Overweight prevalence (age-standardized %)	56.5%	58.4%
Raised blood pressure (% of the pop)	23.3%	20.8%
Raised fasting blood glucose (% of the pop)	8.3%	6.7%
Vaccination rates for DTP 3 (% of children)	83%	94.8%
Breast cancer screening (% of women aged 50-59)	24%	58%
Cervical cancer screening (% of women aged 20-69)	37%	59%
Hospital admission due to CHF and hypertension (Age-sex standardized rate)	167 per 100 000 pop	301 per 100 000 pop
Hospital admission due to diabetes (Age-sex standardized rate)	92 per 100 000 pop	130 per 100 000 pop

Faced with these significant challenges, Brazil has introduced a comprehensive package of policies to modernise and strengthen PHC. Implemented in 2013, the More Doctors Programme (MDP) is considered the world's largest government-led initiative recruiting domestic and foreign physicians to work in PHC settings within municipalities facing difficulties in recruitment and retention. By November 2020, the MDP was responsible for the presence of 16 426 doctors in 3 837 Brazilian municipalities. It has also yielded positive results in terms of investment in PHC facilities, physician availability and health outcomes (Hone et al., 2020[2]; Netto et al., 2018[3]).

Reforms have also focused on developing new models of care, primarily through family health support centres (*Núcleo Ampliado de Saúde da Família* [NASF]*)*, which function as integrated multidisciplinary teams providing a broad range of services to the community. Health care networks (*Redes de Atenção à Saúde* [RAS]) have been developed to integrate health care across different sectors and improve patient-centred care in the country. The National Programme for Improving Primary Health Care Access and Quality (PMAQ) has been a strong tool for monitoring and improving the performance of PHC facilities. Finally, the *Previne Brasil* programme, introduced in 2019, has set ambitious goals, such as introducing a new financing scheme based on a weighted capitation model, a pay-for-performance component and incentives for strategic actions. The weighted capitation payment and associated patient registration system are welcome steps in building a profile of population health needs. The *Previne Brasil* programme has the potential to improve access to PHC and promote longitudinal, co-ordinated care while reducing inequalities between regions. But Brazil still has a way to go before the fruits of this reform are truly felt across the PHC system. First, the country must address several key persisting challenges across the PHC sector:

- Brazil's ambitious reform agenda must be accompanied by a stronger central oversight and a focus on improving health care quality and supporting the most vulnerable municipalities. Central agencies need to play a greater role in this respect, as poorer municipalities have weaker infrastructures and reduced capacities to deliver care than the best-performing areas. At the same time, Brazil needs to underpin quality monitoring and improvement with adequate mechanisms to ensure implementation at all municipal levels; this requires cross-governmental collaboration and co-ordination.
- Brazil should explicitly recognise the central role of FHTs in the prevention, treatment and management of chronic non-communicable diseases, such as diabetes and hypertension. Patients' ability to access specialist care without prior consultation with a FHT suggests that the potential of PHC to lead in health promotion, disease prevention, treatment and follow-up is not being fulfilled.
- Some key quality strategies are underdeveloped or absent from Brazil's PHC sector, including establishing requirements for accreditation, continuous medical education (CME) and compliance with clinical guidelines. Currently, payment systems only timidly reward improvements in the quality of care. Overall, Brazil lacks a support system to ensure continuous improvement in health care quality at the team or facility level.
- Despite the existence of numerous data sources, Brazil's health information systems are insufficient to provide a full picture of the effectiveness and safety of PHC. Most indicators are input and process indicators, such as the number of FHTs, the number of people registered with a FHT, the number of community health workers, or the number of pregnant women receiving prenatal care services. Regarding cancer care, there is no integrated information system based on a registry that allows assessing the effectiveness of current cancer screening protocols and cancer care delivery.
- Little attention has been devoted to enhance the credibility and recognition of the PHC specialty, as well as promote workforce quality. Within PHC, the specialty of PHC (called family and community medicine [FCM]) is the least preferred specialty among physicians. In addition, geographical distribution of medical doctors is inequitable, with acute workforce shortages in rural and remote areas.
- Brazil has made significant inroads in building a foundation for digital PHC, including essential investments in networks, data, interoperability and skills. However, progress in implementing digital technologies in PHC has been slow and fundamentally uneven across the country.

This chapter makes a detailed assessment of Brazil's PHC system and proposes a set of recommendations for improving it. It considers four topics: 1) enhancing the quality of PHC provision,

2) increasing the screening and prevention of major chronic non-communicable diseases, 3) resolving workforce shortages, and 4) advancing the digital transformation of PHC in Brazil.

Policy recommendations for improving primary health care in Brazil

Improve the quality of PHC provision

- Strengthen the gatekeeping system with systematic registration of patients with FHTs, which guide patients into specialist care as needed through a referral system.
- Encourage greater comprehensiveness of PHC by ensuring that all municipalities are able to deliver the actions and health care services defined in the Primary Health Care Portfolio, and encourage compliance with clinical guidelines. Financial incentives could be introduced through existing contracting schemes or the *Previne Brasil* programme.
- Develop educational programmes in disease prevention and early diagnosis through formal frameworks and requirements to undertake CME programmes.
- Collect a richer set of quality indicators on a wider array of preventive activities and management of chronic conditions (such as alcohol consumption, obesity, cancer screening and mental health), including quality of life and patient experiences with PHC; implement a public reporting system to allow patients to monitor the performance of individual FHTs.
- Build accreditation systems around standards of care for all FHTs in order to assess their performance, identify areas that may require improvements and provide support for such improvements. The new Agency for the Development of Primary Health Care could carry out accreditation and provide independent verification that standards are being met, ensuring continuous improvement in health care quality.
- Expand health care networks to prioritise the provision of integrated care for patients with multiple needs. Additional resources, guidelines on establishing and running community care services, and a better use of digital technology are all areas that would benefit from greater steering and oversight by the federal government.

Improve cancer screening coverage and promote early detection of cancer

- Move from opportunistic screening programmes toward population-based screening programmes for breast and cervical cancer, implementing a more personalised approach (e.g. by sending personalised screening invitations to high-risk populations).
- Develop more effective communication strategies and education programmes to improve health literacy and promote the importance of early detection among people with different socio-economic and cultural backgrounds.
- Develop and expand national registries for breast and cervical cancer in order to identify and invite people with a high risk of cancer; monitor and evaluate the effectiveness of screening programmes and cancer care delivery.
- Facilitate deeper analysis of diabetes and hypertension care through a stronger data infrastructure allowing a more comprehensive set of quality measures and feeding back data to FHTs to improve the quality of care.
- Promote the development of disease-management pathways with a people-centred perspective, integrating all health care providers across different sectors; ensure that FHTs have the skills and capacity for screening and management of hypertension and diabetes through expanding the role of other health workers, including nurses and pharmacists.
- Collect and report information on cancer screening at the individual patient level to improve the effectiveness of existing cancer screening programmes and protocols.

Address workforce shortages and reduce imbalance in the distribution of primary care workforce

- Define a clearer workforce management policy to govern human resources for health, based on an objective assessment of present and future needs.
- Increase the number of trained doctors in rural areas to encourage recruitment and retention of medical doctors in underserved areas; provide both wage- and non-wage related financial incentives linked to a service obligation.
- Address workforce gaps by changing the scope of practice for nurses and community health workers so that they help meet health care needs in more remote areas; establish a governance structure that better supports municipalities with insufficient capacities.
- Support the creation of academic FCM departments in all Brazilian medical schools to undertake research in PHC, conveying the specialty's value and promoting it among students.
- Improve the attractiveness of the PHC profession by standardising contractual arrangements for primary care workers. Ensure a more consistent salary scale across the country through stronger oversight and regulation by the federal government, notably using the new Agency for the Development of Primary Health Care
- Introduce a national test at the end of the university period to help standardise the medical curriculum in Brazil, complementing the current accreditations.
- Make specialty training in FCM compulsory for all medical doctors wishing to practise PHC; establish formal requirements for CME and recertification to secure a high-quality workforce. CME should be directed towards key challenges, such as the prevention of risk factors for health and management of chronic conditions.

Advance the digital transformation of PHC

- Set ambitious and clear targets for both reliability and speed of connections as part of existing and future collaborations between the Ministry of Health, other ministries and the National School and Research Network (Rede Nacional de Ensino e Pesquisa [RNP]) to increase Internet connectivity in PHC units.
- Expand the financial payments included in the Connect SUS pilot project in Alagoas to the entire Brazilian territory; condition receipt of financial support to participation by municipal and state officials in capacity-building workshops; develop training specifically targeting senior executives.
- Set ambitious and clear quantitative targets for adoption and use of EHR systems (such as e-SUS AB). Such targets should include the effective use of electronic drug prescribing and the exchange of clinical and administrative data across units.
- Strengthen the role of telecentres as training providers, especially in rural and remote areas, and ensure appropriate funding and technical assistance at all levels of government; develop mobile access to reach those vulnerable groups that are most likely to need PHC.
- Consider aggregating shared services and responsibilities related to digitalisation of PHC at less decentralised levels; Set up dynamic purchasing systems at the federal level, with appropriately funded agencies at the state or regional levels providing municipalities with specialised human resources, purchasing and management services for digital PHC.

1.1. Improving Brazil's primary health care quality and outcomes

1.1.1. Brazil has introduced a number of initiatives to improve the quality of care

Brazil has implemented a set of key reforms over the past decades to improve access to high-quality PHC and develop new models of PHC, primarily through family health support centres. These centres give FHTs greater flexibility in managing their practice according to population health needs, ensuring more co-ordinated and integrated care. The introduction of the health care networks (*Redes de Atençao à Saúde* [RAS]) is also an innovative approach to delivering patient-centred care. The overarching objective is to integrate the organisation, planning and provision of health care services (from PHC, mental health, public health and emergency care, to specialised care and hospital care) at the regional level. RAS are agreed by municipalities and states through interagency commissions (*Comissões Intergestores*) according to population health needs, and local capacities.

A range of quality initiatives have also been introduced since the implementation of the Family Health Strategy in 1994, including the Requalifica programme to expand the availability and equipment of PHC facilities, the PMAQ, and the MDP to recruit and retain PHC professionals. Among the new tools for monitoring the activities and quality of care, the Primary Health Care Information System (SISAB) gathers an impressive number of indicators underpinning PHC, but mostly focuses on input and process indicators such as the number of FHTs, the number of people registered with a FHT, the number of community health workers and the number of pregnant women receiving prenatal care services.

Some clinical guidelines exist. The Ministry of Health has issued several "primary health care notebooks" (*Cadernos de Atencão Básica em Atenção Primária*) to help FHTs improve the delivery of high-quality PHC (Ministério de Saúde, 2021[4]). The notebooks address specific diseases or risk factors, such as care for smokers, arterial hypertension or mental health. While such guidelines are useful, the PHC notebooks are still too narrowly defined and do not meet patients' expectations for integrated health care. Furthermore, information about their effective use is lacking. Implementation is the responsibility of the municipalities, but there is no mechanism at the federal level to monitor compliance, and no systematic incentives for guideline uptake. Given inadequate follow-up observation of diabetes control and blood pressure control for people with hypertension, compliance with clinical practice guidelines is arguably unsatisfactory (Leite Simão et al., 2017[5]; da Silva Rêgo and Radovanovic, 2018[6]). In general, Brazil lacks system-wide support for ensuring continuous improvement in the quality of health care at the team or facility level.

Brazil has also recently committed significant efforts to reforming its federal financing model. The new PHC funding model, Previne Brasil, came into effect in 2020. It includes a weighted capitation component, a pay-for-performance programme, and some incentives for strategic actions and priority areas. The new capitation formula, which allocates resources based on needs, is well-aligned with OECD member countries' policies in this area (e.g. in Chile, Israel, Portugal, New Zealand, the United Kingdom and the Netherlands). The single capitation amount will be applicable to the population registered with FHTs and adjusted for socio-economic, demographic and geographical factors, providing an incentive for FHTs to register the 50 million people who are not yet registered. This is a welcome step to better identify the people linked to each FHT, and encourage more appropriate longitudinal and co-ordinated care. Importantly, the weighted capitation component will ensure that municipalities with higher population needs owing to older populations and less favourable socio-economic situations receive the necessary resources to provide care to everyone. This will limit the risk of increasing inequalities in access to and quality of PHC services.

1.1.2. Despite progress, some concerns about quality persist, and primary health care struggles to deliver its essential functions

Prevention and treatment at the PHC level can still improve. International figures show that breast and cervical cancer screening can progress, and immunisation rates could be higher (Table 1.1). In 2018, 84% of Brazilian children around one year old were vaccinated against measles, below the OECD average (95%). At the same time, simple procedures and surgeries need to be made more widely available in PHC settings. This is both a matter of striving for better safety and care quality, and an economic necessity to avoid unnecessary use of expensive hospital services. Available data show that only 60% of FHTs performed low-complexity procedures or small surgeries – too few if Brazil wants to expand and strengthen the role of PHC.

Inappropriate preventive care and management of chronic diseases has also been highlighted by previous researches. A number of worrying indicators suggest an urgent need for better prevention, especially at a time when the burden of disease is shifting towards chronic diseases. According to the last National Health Survey, 21% of all Brazilians with diagnosed diabetes did not receive medical care in the 12 months prior to the survey. In addition, only 22% of SUS users indicated they had received some recommendations on healthy lifestyles from their family doctor, and less than 40% of public users had a preventive visit in the past two years (Guanais et al., 2019[7]). Significant differences in health care quality also exist across regions, with a north-south gradient where North and Northeast regions show higher hospitalisation rates for chronic conditions. The 2019 National Health Survey shows for example that diabetic patients have higher hospitalisation rates for chronic conditions in the Northeast than in the Southeast, raising some concerns about the effectiveness of local PHC in the North and Northeast regions.

1.1.3. Renew efforts to strengthen key functions of PHC, particularly through stronger gatekeeping and more comprehensive care

Despite clear investment in PHC, too many patients use public speciality units or emergency departments to receive health care services. This is a strong argument for strengthening the gatekeeping system in Brazil, both by enforcing systematic registration with FHTs and establishing a referral system to better control and orient patients into specialist care. This approach is taken internationally, including in Chile, Portugal, Italy and Norway, where strong gatekeeping systems are seen as a way to ensure that patients receive the best possible care for their conditions, achieving greater appropriateness and co-ordination of care. Brazil may consider such a reform in the future to expand the role and expansion of FHTs. This would help build accurate patient registers recognising the central co-ordinating role of FHTs. The implementation of the new *Previne Brasil* programme is a step in the direction of increasing patients' registration with FHTs.

In addition, the scope of PHC services needs to expand to ensure that FHTs are able to deliver essential functions, including continuous and comprehensive care focused on prevention, treatment, diagnostic follow-up and management of chronic conditions. A large range of activities and interventions should be systematically embedded in FHTs. This more comprehensive approach should be underpinned by the delivery of actions defined in the Primary Health Care Portfolio (called CaSAPS), while ensuring that all municipalities are able to deliver such actions and services properly. Incentives for primary care providers to deliver these actions could be introduced through existing contracting schemes with the municipality or the incentive structures outlined in the strategic actions of the *Previne Brasil* programme. The Ministry of Health could also use the *Previne Brasil* pay-for-performance programme to monitor and encourage more systematic compliance with clinical guidelines, in order to embed more effective prevention in FHT practice. At the same time, educational programmes covering the prevention, detection, treatment and management of diseases are key instruments to encourage primary care professionals to fully implement these tasks. Several bodies, such as the National Council of Health Secretaries (CONASS), the National Council of Municipal Secretaries of Health (CONASEMS), the Brazilian Medical Association and the Brazilian Society of Family Medicine, organise trainings, conferences and online learning.

However, a more formal framework for CME that clarifies expectations and helps FHTs meet objectives is required to provide more comprehensive care, in line with the best available evidence.

1.1.4. There exist several opportunities to extend quality strategies targeting PHC

A robust accreditation system, which would apply uniformly and consistently to the primary health care sector nationwide, could be a tool for improving the quality and performance of primary health care in Brazil. Other federalised health systems in the OECD (e.g. in Australia, Canada and the United States) have established PHC accreditation systems. Building an accreditation system for all FHTs in Brazil would make it possible to assess their performance, identify areas for improvement and provide support for such improvement. Since Brazil does not have a National Inspectorate for Health to provide accreditation and independent verification that standards are being met, the new Agency for the Development of Primary Health Care could take on this role. It could, for example, undertake quality monitoring and improvement, and review current practice and performance, and setting standards for performance and reporting. It could also develop tools such as evaluation frameworks, deploy teams to visit and support municipalities with special needs, and redistribute resources when needed. The agency could then be responsible for ensuring continuous improvement in health care quality at the local level, which is currently not – or only timidly – in place.

Perhaps more crucially, a greater transparency and richer set of performance data are needed to drive quality improvement. Brazil already collects a wide range of inputs and process indicators. As part of the new *Previne Brasil* pay-for-performance programme, the country also monitors several indicators on access to PHC, risk factors and quality covering maternal health, child immunisation, breast cancer screening, and management of hypertension and diabetes. While this is an important initiative for quality monitoring, five quality indicators are process indicators, and two indicators are intermediate outcomes measures. This is insufficient. A richer set of quality indicators on a wider array of preventive activities and management of chronic conditions, such as alcohol consumption, obesity, cancer screening, mental health and patients' experiences with PHC, should be a priority and will be critical to ensure that ongoing reforms do not adversely affect quality and outcomes of care. In this respect, Portugal and Israel offer models of comprehensive, actionable indicators supporting quality improvement in primary care.

Brazil might also want to join the OECD Patient-Reported Indicator Surveys (PaRIS) initiative to understand how the outcomes and experiences of care in the country compare with OECD countries. Under PaRIS, countries work together on developing, standardising and implementing a new generation of indicators that measure the outcomes and experiences of health care most important to people. In this regard, the International Survey of People Living with Chronic Conditions under PaRIS will be the first of its kind to assess patients managed in PHC across countries.

1.1.5. Integrated care needs better central support and direction

Given the challenges brought by demographic and epidemiological changes, Brazil urgently needs to shift the focus of health care services to addressing longer episodes of health care needs. While the country is on the right track with the development of the RAS health care networks, this integrated care model is still unevenly implemented nationwide. The challenge should not be underestimated: interactions between different health care providers about patient cases and transitions from one service to another need to be timely, safe and seamless for patients and families. PHC play a key role in achieving this goal.

A lack of guidance and national leadership has resulted in a low and uneven diffusion of RAS across the country. The federal government should consider playing a greater role in steering a more consistent development of RAS, providing additional resources, training programmes, and guidelines on developing and running community care services, and better using information and communication technology (ICT).

Exchanging good experiences and learning from the top-performing regions or facilities is another way to encourage more extensive and ambitious development of these networks.

Better information-sharing and data linkage across care levels, as well as smarter provider-payment mechanisms will be key to ensure a successful rollout of RAS. There exist good examples of payment mechanisms – such as add-on payments, bundled payments and population-based payments – in some OECD countries that incentivise providers from different health sectors to work together effectively. While it may be too early to institute such mechanisms at the moment, Brazil could certainly consider introducing add-on payments or bundled payments in the near future.

1.2. Health screening for chronic non-communicable diseases in Brazil

In Brazil, as in OECD countries, chronic non-communicable diseases (NCDs) such as cancer and cardiovascular diseases are major public health concerns. Cancer mortality is the second cause of death in Brazil. The leading cause of cancer mortality is breast, lung, colorectal and cervical cancer among women, and lung, prostate and colorectal cancer among men. In keeping with trends across OECD countries, cancer mortality rates in Brazil are higher among men than among women, which can be explained at least in part by a higher prevalence of risk factors among men. Many cancers associated with high mortality rates in Brazil – such as prostate, breast, colorectal and lung cancer – feature common risk factors, including obesity, poor lifestyle and physical inactivity.

While the incidence of cancer in Brazil is below the OECD average, cancer mortality has not decreased in recent years. Between 2009 and 2019, Brazil´s cancer mortality oscillated between 161 and 162 deaths per 100 000 people, while the OECD average decreased from 211 to 196 over the same period. The decrease in cancer mortality across OECD countries is related to early diagnosis, which makes a strong argument for building more effective screening schemes in Brazil.

The fifth cause of mortality in Brazil is diabetes, which accounts for 5% of all deaths compared to 3% in OECD countries. Diabetes mortality in Brazil reached 50 deaths per 100 000 people in 2019 – higher than the OECD average of 22 deaths per 100 000 people, and only lower than Mexico and Costa Rica. Fasting blood glucose levels significantly increased over the past decade, suggesting that the burden of diabetes will be significant in the near future. Hypertension, which contributes to the development of more serious cardiovascular problems, is a major risk factor for poor health in Brazil, if not the main one. In 2015, the average prevalence of raised blood pressure in Brazil was 23.3% – higher than the OECD average of 20.8% and the Latin America and the Caribbean average of 21.5%. While Brazil reduced this prevalence by 5.3% between 2005 and 2015, OECD countries decreased it by an average of 16.4% over the same period.

1.2.1. Improving cancer screening and prevention in Brazil

While Brazil has expanded its cancer care system, population coverage remains low

To tackle the burden of cancer, Brazil has developed its cancer care system incrementally over the past decades. It launched the first National Oncology Care Policy in 2005 and set its Strategic Action Plan for Coping with Chronic Non-Communicable Diseases 2011-22, demonstrating its commitment to reducing the burden of cancer. It introduced the National Policy for the Prevention and Control of Cancer in the Health Care Network of People with Chronic Diseases in 2013 to update the national cancer policy and improve access to cancer care. Brazil has also sought to implement quality improvements in its cancer care system by establishing in 2013 the Cancer Information System (SISCAN), which integrates the Cervical Cancer Information Systems (SISCOLO) and the Breast Cancer Information Systems (SISMAMA). Clinical guidelines for early detection of breast cancer were updated in 2015, and national

guidelines for cervical cancer screening in 2016. More importantly, Brazil introduced the PAINEL-Oncology instrument, which helps monitor Law No. 12.732 of 22 November 2012 establishing a 60-day maximum waiting time for the start of treatment for patients with proven malignant neoplasia. While PAINEL-Oncology is key to guarantee access to high-quality cancer care in Brazil, the data presented refer exclusively to users who have a national health card (DATASUS, 2021[8]). Brazil has also developed 17 population-based cancer registries, which provide crucial information about incidence, trends and survival (INCA, 2013[9]).

However, cancer screening in Brazil is opportunistic, managed by each FHT as a result of a recommendation made by a health care provider during a routine medical consultation, or through individual self-referral. Brazil needs to step up its efforts to increase breast cancer screening coverage, notably to improve early diagnosis and reduce mortality. Unlike in many OECD countries, cancer screening does not occur within a population-based programme designed and managed at the central level to reach the bulk of the population at risk. As a result, while coverage for breast cancer screening in Brazil increased from 15.2% in 2014 to 24.2% in 2019 among the target group of women aged 50 to 69 years, it remains very low compared to the OECD average of 58%. Between 2008 and 2019, breast cancer mortality increased by 8.3% in Brazil, whereas it decreased by 10% on average across OECD countries. Breast cancer takes the greatest toll on Brazilian women, with 20.8 deaths per 100 000 females, representing 16.4% of all women's cancer deaths. Moreover, breast cancer survival dropped by more than two years in Brazil between the 2005-09 and 2010-14 periods, whereas it increased by one year in the OECD region. The lack of availability of mammographs, and their uneven distribution across the country, are major problems contributing to late diagnosis of breast cancer in Brazil (Da Costa Vieira, Formenton and Bertolini, 2017[10]). In 2020, Brazil had 13 mammographs per million people, almost half the OECD average of 24.

In a similar vein, cervical cancer screening in Brazil has substantially risen (from 20.5% in 2014 to 37% in 2019), yet it remains well below the OECD average coverage (57%), and below all OECD countries except Costa Rica and Hungary. Worrying evidence points to large social inequalities: access to cervical cancer screening is particularly low among women living in the North, Northeast and Central-West regions, and those with low socio-economic backgrounds (including poorer, less educated, non-white and younger women) (Costa et al., 2018[11]). Cervical cancer mortality in 2019, for its part, was substantially higher in Brazil than the OECD average (7.4 deaths vs. 3.9 deaths per 100 000 women), and cervical cancer survival in Brazil decreased by 11.3% between 2000-04 and 2010-14.

These worrisome trends suggest large room for improvement in Brazil, including through a national strategy for cancer prevention and screening.

Towards population-based screening programmes using a more systematic and personalised approach

In the area of prevention of cervical cancer, the National Immunisation Programme instituted in 2014 the human papillomavirus (HPV) vaccination campaign for girls aged 9 to 13, then expanded to boys aged 11 to 14 in 2017. Following the same trend as in OECD countries, the vaccine is offered under Brazil's Unified Health System (SUS) in PHC facilities and in the context of school-based vaccination campaigns. Cervical cancer screening is performed through a cytopathological examination (Pap smear), offered to women aged 25 to 64 years and repeated every three years. While the three-year periodicity is aligned with World Health Organization (WHO) recommendations, Brazil could learn from OECD countries and move towards a population-based screening programme while introducing HPV-DNA primary testing. This approach is taken internationally (e.g. in Italy and Finland) and recommended by international guidelines, including the European guidelines and American Cancer Society 2020 guidelines. Its implementation would require use of reliable, validated HPV tests in qualified laboratories, accredited by authorised bodies (such as the National Agency of Sanitary Surveillance [ANVISA]) and complying with international standards. Training for health workers is crucial, along with communication strategies for women in target populations. Such a

national strategy should include quality assurance for monitoring cervical cancer screening performance, which the European guidelines define as achieving: (1) an invitation coverage of at least 95% of targeted women; (2) an examination coverage of at least 70% (85% is desirable); and (3) a participation rate of at least 70% (85% is desirable) (von Karsa et al., 2015[12]).

In the area of breast cancer, the Brazilian Ministry of Health recommends a biennial mammogram for women aged 50 to 69 years old as a screening strategy in PHC. Brazil could go beyond this recommendation and develop a population-based breast cancer screening programme, as implemented in several OECD countries (e.g. Australia, France or Portugal). In practice, this would require implementing an effective call-recall structure, devising a screening registry and safeguarding robust quality assurance at all levels. The window of opportunity is large today with the implementation of the *Previne Brasil* strategy, which will improve patients' registration with FHTs. Brazil could take advantage of the patient registration system to develop organised screening programmes that allow identifying the eligible target population in each municipality. The establishment of an organised breast cancer screening programme will require building capacity in primary care teams, including providing health professionals with guidelines and protocols on cancer signs and symptoms to improve diagnostic accuracy, giving them sufficient time to evaluate patients, and training practitioners in how to diagnose cancer and develop reliable referral mechanisms. At the same time, the distribution of mammographs across the country will need to be revisited to achieve a balanced supply matching population needs.

Population-based programmes can go hand in hand with personalised invitations. In this regard, Brazil could adopt a more systematic and personalised approach to inviting target populations. A growing number of OECD countries send a personal invitation letter for cancer screening, systematically issued through a registry, to each individual in the target group. Brazil has no such national initiative, and invitations are only issued at some local levels, depending on the initiative of individual municipalities or FHTs. By contrast, Denmark, Germany and Italy send invitation letters with a fixed appointment date for a mammography. Based on the available evidence, the most effective interventions to increase participation in organised screening programmes include postal and telephone reminders, the primary care physician's signature on the invitation letter and the provision of a scheduled appointment instead of an open appointment (Camilloni et al., 2013[13]). A cost-effectiveness analysis would need to be performed to determine the appropriate interventions in the Brazilian context.

Brazil should develop more systematic monitoring of cancer while using digital health to improve public awareness and health literacy

While Brazil has expanded its cancer information infrastructure (notably with SISCAN, PAINEL-Oncologia and the population-based cancer registry), the main challenges are low coverage, low interconnectedness and lack of feedback. Brazil needs a more comprehensive registry-based information system capable of following each patient individually, to ensure efficient management of screening programmes and cancer care delivery. Such a system is key to identifying target populations and sending personalised invitations and reminders for cancer screening. At the same time, the effectiveness of existing cancer screening protocols in Brazil – such as target groups, screening frequency, methods and cross-population groups – needs to be more systematically assessed. This entails developing integrated information systems to improve the quality of screening programmes, notably through performance benchmarking and feedback to health providers. In fact, provider assessment and feedback have been found to increase coverage for cervical, breast and colorectal cancer screening (Sabatino et al., 2012[14]).

Brazil should also develop further digital health strategies to improve public awareness of cancer prevention, cancer screening and health literacy. The Ministry of Health has implemented some actions since 2002, such as the October Pink Campaign aiming to promote prevention and healthy lifestyles, and overcome the fear or stigma associated with cancer. At the local level, municipalities promote screening through campaigns using local media and social networks. Some good initiatives are also implemented at

municipal levels through the deployment of units to reach very remote and vulnerable communities, and increase access to screening, diagnosis and treatment.

While all these strategies are valuable and should be maintained, Brazil could also develop more effective communication strategies and education programmes to improve health literacy. Local stakeholders, such as health care providers and civil society representatives, should also be consulted to identify specific barriers to screening and address specific needs, particularly among disadvantaged populations (i.e. remote, poor and less educated people). As systematic sharing of information related to cancer is limited – particularly for cancers that are not subject to screening programmes – Brazil could also develop information-sharing strategies to help patients seek care, including cancer diagnostic services. Brazil could learn from Denmark, England and Estonia, which have developed website or e-health platforms that share evidence-based information on cancer, to promote health literacy and help patients seek appropriate and timely health care, including cancer screening, diagnosis and treatment.

1.2.2. Improving screening for hypertension and diabetes

Faced with the rising prevalence of diabetes and hypertension, which are complex and costly diseases, Brazil must strengthen prevention, early detection and treatment. It should prioritise a shift towards disease-management programmes, building capacity for PHC, and improving the data infrastructure underpinning diabetes and hypertension.

Diabetes and hypertension care are improving

In Brazil, as in many OECD countries, diabetes and hypertension are leading causes of morbidity, associated with significant co-morbidities and expenditures. The total mortality of patients with diabetes and hypertension has been falling in Brazil: diabetes mortality decreased by 9.8% between 2007 and 2019, and hypertension prevalence decreased by 5.3% between 2005 and 2015. Low rates of avoidable admissions for diabetes and hypertension in Brazil also suggest relatively good management of these conditions in PHC: in 2019, the rate of hospital admissions for diabetes was 92 patients per 100 000 people (below the OECD average of 130) and 48 patients per 100 000 people for hypertension (less than half the OECD average).

These are all welcome signs of improved prevention and care for diabetes and hypertension. Nevertheless, the available evidence indicates that the diabetes mortality burden will increase by 144% by 2040, becoming the third leading cause of death (Duncan et al., 2020[15]). Hypertension also became the leading risk factor for deaths in 2017 (Nascimento et al., 2020[16]). Given these trends, more efforts are needed to strengthen diabetes and hypertension prevention in the context of PHC. In Brazil, basic health checks and risk screening for chronic diseases rely on FHTs and are predominantly done through opportunistic screenings during health visits. The Ministry of Health has issued several guidelines relating to chronic non-communicable diseases. Screening for hypertension is recommended for adults without the knowledge that they are hypertensive. It suggests screening every two years for people with blood pressure below 120/80 millimetres of mercury (mmHg) and annual screening if systolic blood pressure is between 120 and 139 mmHg or diastolic blood pressure between 80 and 90 mmHg. For diabetes, the guideline recommends screening for asymptomatic adults with sustained blood pressure greater than 135/80 mmHg, but does not apply to other screening criteria, such as obesity, family history or age range. Specific booklets (*Cadernos de atenção básica*) for the management of hypertension and a recent protocol for diabetes also provide guidance for PHC practitioners.

Brazil has sought to improve the quality of diabetes and hypertension care, notably through the PMAQ pay-for-performance system, launched in 2011. As part of PMAQ, the evaluation of FHTs included topics such as early detection of hypertension, laboratory exams for diabetes and prescription refills for users on continued care (e.g. for hypertension and diabetes), without the need to make medical appointments. However, the pay-for-performance component of the new *Previne Brasil* programme only includes two

indicators related to hypertension and diabetes; these only cover follow-up of patients who already have the diseases, and do not address prevention in PHC. It will therefore be paramount in the future to monitor how the new programme influences screening activities for hypertension and diabetes in PHC.

Brazil could learn from OECD countries such as Australia, Estonia, Korea and England that have instigated population-based screening programmes targeting high-risk populations. In Australia, for example, PHC physicians can provide a single health assessment for people aged 45-49 who present at least one risk factor (lifestyle habit or family history) for developing a chronic disease, such as type 2 diabetes or heart disease. The WHO Regional Office for Europe also recommends targeting screening in PHC for patients at risk for developing diabetes or hypertension. If Brazil wants to move in this direction, it will be important to ensure that programmes target high-risk population groups, based on the country's national epidemiology, the characteristics of the health system and a cost-effectiveness analysis.

Improved disease-management pathways and increased workforce capacity in primary health care are essential to better screening and disease management

Chronic disease-management pathways are critical to delivering seamless co-ordinated care for chronic patients. Widely used in some OECD countries to improve care integration and co-ordination, they are associated with cost reductions and better quality of care. In Brazil, the development of two clinical guidelines with explicit pathways of care to guide health professionals in PHC are the only attempts to promote care co-ordination. However, these guidelines do not integrate other care providers or stakeholders (e.g. specialists or patient-support groups) and are not produced in a patient-friendly format.

Brazil should promote disease-management pathways with a people-centred perspective to clearly establish the responsibilities of health professionals at different stages of disease, set quality expectations for chronic diseases such as diabetes and cardiovascular disease, and standardise the quality of care across Brazil. As seen in OECD countries, co-ordinated management approaches enable PHC teams and individual patients to take appropriate actions to manage diabetes and hypertension. Brazil should also ensure that pathways integrate all health care providers across different sectors.

PHC professionals should have the tools and capacities to undertake these responsibilities and tasks. There is scope in Brazil to build capacity for screening and management of hypertension and diabetes through task-shifting or expanding the role of other health workers, including nurses, nutritionists and pharmacists. Nurses could have the capacity and training to conduct an initial patient assessment, including blood-sugar testing in all practices, and collaborating with doctors and other team members in follow-up activities. The benefit of nurse-led-care has already been demonstrated (Maier, Aiken and Busse, 2017[17]; Martínez-González et al., 2015[18]).

Last but not least, integrated patient pathways require adequate payment systems to incentivise multiple health professionals to work together. Brazil could consider experimenting the use of bundled payments for chronic conditions. As implemented in several OECD countries (i.e. the Netherlands, Australia and Canada), bundled payments consist of one payment per patient with a chronic illness to cover the cost of all health care services extended by the full range of providers during a specific time period. Such a system has the potential to incentivise co-ordination of care between providers and ensure a broader range of care. While Brazil has already taken steps to improve PHC funding through weighted capitation, that payment model is not likely to spur care co-ordination and integration for diabetes and hypertension.

Improving the data infrastructure underpinning diabetic and hypertension care should be a priority

Brazil has developed Hiperdia, a specific registration and monitoring system for hypertensive and diabetic patients, which is managed by the Ministry of Health in conjunction with the State and Municipal Health Secretariats. Through Hiperdia, municipalities that are members of the National Pharmaceutical

Assistance Programme for Hypertension and Diabetes Mellitus send information on the registration and monitoring of patients with these diseases. Remarkably, all this information is processed and made available by DATASUS, the health data infrastructure and information system of the Ministry of Health. However, Hiperdia does not collect information on screening, nor is it capable of capturing the pathway of care for each patient (referrals, waiting times, consultations with specialists, laboratory tests and medications). It is also difficult for FHTs to review and act on this information as they do not receive regular feedback, and patients do not have access to their personal health data. There are also some problems linking data with other databases, such as hospitalisation and death registries.

Improving the data infrastructure by linking different data sources should therefore be a priority in Brazil, to help patients and health professionals identify shortcomings and further fine-tune prevention strategies. Health information systems should be expanded so that they provide more and better information to both PHC teams and patients, thereby improving clinical management decisions in primary care and empowering patients to take a leading role in their own prevention and control actions. Data should be systematically fed back to practitioners, and should be used to identify risks or shortcomings. Brazil could learn from OECD countries in developing a strong health information system within a data-governance framework that protects the privacy of patients' health information, as laid out in OECD (2019[19]). A stronger information system would also be crucial to streamlining efforts to identify and invite target populations for hypertension and diabetes screening.

1.3. Addressing workforce challenges in the primary health care sector

Brazil is struggling with a shortage and uneven distribution of medical doctors across regions. The ratio of practising doctors in 2019 was lower in Brazil (2.3 per 1 000 population) than the OECD average (3.5 per 1 000 population). The distribution of medical doctors followed a north-south gradient, where the North and Northeast regions show a lower density of medical doctors. At the same time, FCM is undervalued as a specialty in Brazil. In 2018, only 5 486 medical doctors (1.4% of all specialists in Brazil) had specialty training in FCM. While residents of the North and Northeast have the highest health care needs, less than 20% of all FCM specialists work in these regions. Brazil therefore needs to meet two main challenges: 1) securing a greater number and distribution of primary care doctors; and 2) securing a high-quality workforce.

1.3.1. Securing a greater number and distribution of PHC doctors across the country

The MDP has been successful in strengthening the provision of PHC services in underserved communities

Established in 2013, the MDP is a large-scale health system intervention aiming to strengthen the provision of PHC services in underserved communities. The MDP was designed by the Ministry of Health as a supply-side intervention featuring three objectives: 1) transferring funds to municipalities to strengthen the PHC infrastructure; 2) improving access to and the quality of medical school training; and 3) recruiting Brazilian and foreign physicians to municipalities struggling to recruit and retain doctors. Based on the available evidence, the programme has been successful. Good progress has been made with regard to investing in and renovating the PHC infrastructure, expanding the number of new medical undergraduate vacancies in PHC, and recruiting more than 16 000 physicians from both Brazil and abroad to work exclusively within FHTs. By its fifth year of implementation, the MDP was associated with a 12.2% increase in the number of PHC physicians, with more pronounced effects in municipalities featuring lower levels of physician availability at the start of the programme (Hone et al., 2020[2]). The evidence also mostly suggests that the MDP led to improved access to care and quality of care, as measured by reductions in avoidable hospitalisations for some chronic conditions (Fontes, Conceição and Jacinto, 2018[20]).

While these results are remarkable, the implementation of the MDP has not been without drawbacks. First, there is evidence that the MDP led to the substitution of Brazilian physicians who were already working in communities. Second, only three-quarters of priority municipalities have at least one MDP physician, meaning that community-targeting methods were insufficient to recruit physicians for all priority municipalities. Third, MDP physicians did not have to undergo recertification or revalidation to practise medicine in Brazil. It is also fair to note that despite these positive results, unfilled PHC positions are still the norm in Brazil, with persisting geographic disparities in access to medical training. The North and Northeast regions offer the lowest levels of per capita medical undergraduate positions in the country.

The new *Programa Médicos pelo Brasil*, initiated in 2020 by the federal government to replace the MDP, will continue to increase the provision of medical services in remote or highly vulnerable municipalities as well as promote the training of doctors specialising in FCM. To avoid repeating mistakes, the experience of the MDP can inform the design and implementation of the *Programa Médicos pelo Brasil*. The federal government should focus on community-targeting methods to maximise the recruitment of physicians for all priority municipalities. It should also ensure that the new programme does not lead to a substitution of Brazilian physicians. The introduction of a compulsory revalidation process for all medical licences and the establishment of a two-year specialty programme in FCM as part of the *Programa Médicos pelo Brasil* are certainly positive steps for strengthening PHC.

Complementary solutions to recruit and retain the workforce would make the Programa Médicos pelo Brasil more effective

While Brazil already has many complementary solutions to recruit and retain the PHC workforce, it could learn from international experience on health workforce policies:

- First, as part of the new *Programa Médicos pelo Brasil*, there is scope to train more rural doctors in order to boost numbers and improve retention over the longer term. Extensive international evidence shows that establishing medical education in rural locations leads to increases in the number of medical graduates who will work in rural places over the long term (McGirr, Barnard and Cheek, 2019[21]). Learning from the experiences of OECD countries such as Australia, Canada, England and Norway, Brazil could establish medical education programmes in rural localities. At the same time, it could encourage medical students to gain experience in rural areas, for example, by including a compulsory rural rotation in any medical internship.
- Second, Brazil could make financial and non-financial incentives for medical doctors contingent on practising for a time in underserved communities. As part of the *Programa Médicos pelo Brasil*, physicians in underserved areas will receive financial incentives ranging from BRL 3 000 to BRL 6 000, depending on the location. As implemented in Chile, Germany and Canada, these incentives could be contingent on a return-of-service obligation of two to four years. The federal government will also need to ensure that the various types of financial incentives are received directly by the medical doctors, and not distributed at the discretion of the municipalities. In Chile, the programme combining financial and non-financial incentives with a return-of-service obligation of three to six years has been successful, with the number of applicants exceeding the number of available positions, high satisfaction rates among applicants and high retention rates among the hired doctors (Pena et al., 2010[22]).
- The final option to redress the geographical imbalance of doctors would be to restrict the choice of practice location for PHC doctors. In this respect, Brazil could learn from Turkey, Germany, Norway or some Canadian provinces (e.g. New Brunswick and Quebec), which restrict the choice of location for newly qualified medical doctors. Such a regulatory approach requires careful and coherent workforce planning, which is far from being the case today. In Brazil, unlike in many OECD countries, there is a lack of knowledge of present and future needs for doctors and other health care professionals (Oliveira et al., 2017[23]). Health care workforce planning is not based on

an objective assessment of professionals' characteristics, work processes, the characteristics of the health system in place and the population's health needs.

Boosting the local workforce, changing its scope of practice and making greater use of technology are key levers to cope with health workforce shortages

In many low, middle and high-income countries, task-shifting is a key lever to fill the gap in PHC provision stemming from a lack of PHC doctors (Afobali et al., 2019[24]). While extensive international evidence supports the transfer of roles traditionally performed by doctors to nurses and other allied health professionals, Brazil has not yet experimented with changing the scope of practice and task-shifting among health workers such as nurses and community health workers. As implemented internationally (e.g. in Australia and France), Brazil should capitalise on its large existing nurse training network to expand and recognise the role of advanced practice nurses, who could help manage the care of patients with mild acute diseases and chronic disorders, complementing the practising PHC doctors. Alternatively, advanced practice nurses can be deployed in remote and underserved areas to enhance access to qualified health professionals. Such a policy would require a thorough analysis of current nursing curriculums to further invest in core competencies, including team practice, care co-ordination between and across health sectors, clinical and professional leadership, and quality and safety management (Cassiani et al., 2018[25]). In a similar vein, community health workers – who already play a crucial role in PHC provision in Brazil – could play a bigger role, notably by taking a patient's medical history, conducting basic physical exams, ordering tests and providing counselling on preventive care. This would certainly require investments in training, as well as improved communication between community health workers and other FHT staff.

Improved use of alternatives to face-to-face consultations could be another avenue for coping with PHC doctor shortages and geographical imbalances in Brazil. While telehealth has been used for quite some time, its development and use are patchy. For example, just under 3.5 million telehealth services across all levels of care were registered in Brazil between 2016 and 2019. Of these, 50% occurred in the Southeast, 36% in the South and only 1% in the North, the most deprived region in terms of workforce shortages. A lack of funding, training and equipment for FHTs are factors impeding the use of telehealth services to deliver safe, fast and seamless health care services in Brazil. Scaling up telemedicine in Brazil without compounding existing social divides will require new investment and funding to ensure the effective and equal use of digital technologies in PHC. Brazil will also need to establish a governance structure that better supports municipalities with insufficient resources.

1.3.2. Securing a high-quality workforce through medical education

Beyond the need to address the uneven geographic distribution of primary care physicians, Brazil should focus on three broad areas: 1) increasing the credibility and recognition of the primary care sector; 2) making FCM a mandatory requirement to be allowed to practise primary care; and 3) introducing quality measures to medical education.

Increasing the credibility and recognition of the primary care specialty is a huge challenge in Brazil

While the Family Health Strategy has made access to PHC a priority, the country has not invested sufficiently in enhancing the credibility and recognition of FCM. Several worrying indicators suggest that the FCM specialty is undervalued and is the last option chosen by physicians: in 2018, only 1.5% of recent graduates chose the FCM speciality among the 55 specialities available. The low degree of academic incorporation and low funding in this research area are factors impeding recognition of the specialty (Wenceslau, Sarti and Trindade, 2020[26]; Fontenelle et al., 2020[27]). And yet they are critical to promoting FCM and encouraging students to choose this specialty as their future career, notably by proving that PHC is not a profession that does not require many qualifications. If Brazil wishes to fill the gap in the

PHC workforce, it needs to create academic FCM departments in all medical schools, promote interdisciplinary collaboration with other specialists and encourage mutual respect.

At the same time, making specialty training in FCM compulsory for all medical doctors wishing to practise PHC would be paramount to promote excellence in Brazil, and deliver more effective and patient-centred primary care. The benefits of specialised PHC have already been demonstrated elsewhere (OECD, 2020[28]), notably to address the bulk of patient needs, and provide a stronger focus on prevention and early management of health conditions. Post-training requirements to practise PHC are currently implemented in 22 OECD countries; there is no doubt that such a professionalisation would bring benefits to Brazil.

Last but not least, standardising the contractual arrangements for primary care workers is key to improve the attractiveness of PHC as a profession. Since each municipality defines the level of salaries, bonuses and other payment mechanisms, these arrangements are widely heterogenous across municipalities. Stronger oversight and regulation by the federal government is warranted to ensure consistent salary scales across the country, and it could be important to ensure that smaller municipalities offer similar contracts as larger municipalities. The new Agency for the Development of Primary Health Care could play a role in this regard. Key examples for learning are available internationally. In Turkey, for example, the implementation of the Health Transformation Programme led to family physicians being paid according to national terms and conditions, with more generous salaries and improved working conditions.

Quality measures for medical education should be introduced without delay

While Brazil's Ministry of Health (in partnership with Ministry of Education) regulates medical education nationwide, more could be done to standardise the medical curriculum. The inadequate academic programme, and the gap in the quality of medical education among medical schools, are areas of concern. To achieve greater standardisation of the medical curriculum and teaching, Brazil could introduce a national test at the end of the university period. The national licensing examination would complement the accreditation performed by the National Institute of Educational Studies and Research Anísio Teixeira (INEP) or the Federal Council of Medicine. The national examination has been increasingly used across OECD countries. The United Kingdom is introducing a nationwide Medical Licensing Assessment, which is overseen and regulated by the General Medical Council and will test the core knowledge, skills and behaviours needed to practise medicine. Brazil could learn from the United Kingdom's example.

At the same time, Brazil could take further step to promote workforce quality through stronger requirements for CME. Unlike in many OECD countries, CME is voluntary in Brazil. Not only is this insufficient to guarantee a high standard of competencies for PHC doctors, but it also does not ensure their fitness to practise throughout their career. More needs to be done to help medical doctors maintain their competency and acquire new skills. While a number of bodies, such as CONASS, CONASEM, the Brazilian Medical Association or the Brazilian Society of Family and Community Medicine organise trainings to maintain and update competencies, it is impossible to know whether – and how many – PHC medical doctors have undertaken CME. A stronger regulatory approach is required, for example through a formal CME framework that clarifies the expectations placed on PHC doctors and helps them meet these expectations. Brazil could learn from the United Kingdom and the Netherlands, where CME for PHC doctors is compulsory and linked to recertification: PHC physicians need to demonstrate they have regularly participated in CME activities, and undergo peer evaluation of their professional skills. At the federal level, the Agency for the Development of Primary Health Care could set such requirements and monitor providers' CME compliance. Municipalities could also use the contracting arrangement to actively push PHC doctors to comply with CME requirements and encourage quality improvement. CME requirements should be directed towards the key challenges of the health care system, such as the prevention of risk factors for health (e.g. obesity) and management of chronic conditions (including diabetes).

1.4. Promoting the digital transformation of primary health care in Brazil

1.4.1. Brazil is on the right track for an effecting digital transformation of PHC

Brazil has established a solid foundation for digital PHC by developing strategies at various levels of government, and making key investments in networks, data, interoperability and skills. As a result of the country's use of digital tools and data to enhance the efficiency, transparency and responsiveness of its public institutions to citizen and business demands, Brazil scored above the OECD average on the 2019 Digital Government Index (OECD, 2020[29]).

The Brazilian National Digital Health Strategy 2020-28 (ESD28) builds on more than a decade of policies to digitalise health care and make better use of health data (Ministério da Saúde, 2020[30]), going as far back as the National Policy for Health Information and Informatics of 2004 (PNIIS). Actions within ESD28 focus on three axes: 1) build on existing programmes and initiatives to digitalise health care in Brazil, including the National Health Data Network (RNDS), the Connect SUS (*Conecte SUS*) and Primary Health Unit Computerisation (Informatiza APS) programmes; 2) develop the necessary conditions (e.g. organisational, legal, regulatory) to spur effective collaboration in digital health; and 3) establish a conceptual, normative, educational and technological forum (*espaço de colaboração*) to operationalise collaboration.

A component of the *Previne Brasil* programme, Informatiza APS provides federal funding to FHTs that collect and send data from electronic health record (EHR) systems (Harzheim et al., 2020[31]). The programme also supports training in ICT and data analysis for employees in municipal health departments. In 2020, Connect SUS ran a pilot project in the state of Alagoas that provided additional funding for digitalisation to PHC units that had been unable to digitalise, disbursing more than BRL 5.5 million (USD 1.07 million [United States dollars]) to 97 municipalities (Ministério da Saúde, 2020[32]).

Connect SUS is also seeking to expand the use of health information systems in PHC through its e-SUS APS strategy (also known as e-SUS AB), which seeks to better manage individual health and care, optimise data collection and improve health information (Ministério da Saúde, 2020[33]). The informatics department of SUS (DATASUS) has made various applications available to citizens, frontline care workers and managers. Meanwhile, municipalities are increasingly providing digital services to citizens, with 25% of prefectures allowing patients to book appointments online and consult with a doctor online. Start-ups in telemedicine are flourishing, including Brasil Telemedicina, which produces around 60 000 reports per month and has clients in more than 700 Brazilian cities, and Telelaudo, which has provided more than 4.7 million teleradiology reports to more than 450 hospitals.

As elsewhere, the COVID-19 pandemic has provided further impetus to the digital transformation of health in Brazil. On 15 April 2020, the federal government authorised the use of telemedicine during the COVID-19 pandemic (Law No. 13.989/2020) to ensure continuity of care and protect health care workers. To help PHC units access digital technologies, the Ministry of Health also instituted an exceptional incentive to be paid to municipalities and states for each health team that has not yet been digitalised, budgeting over USD 83.8 million (BRL 432 million) for 2020. The Brazilian Telemedicine University Network (RUTE) also created a special interest group on COVID-19.

1.4.2. An effective digital PHC hinges on addressing three sets of challenges

There is no doubt that Brazil has a solid basis on which to build an effective, equitable and efficient digital PHC. Achieving a successful digital transformation of PHC now hinges on tackling three sets of interconnected challenges: 1) digitalising all PHC units and teams; 2) promoting inclusive connectivity for all Brazilian citizens, especially the most vulnerable; and 3) establishing a governance structure with clear, well-funded mandates at the right levels of government.

Focus on fundamental enablers to increase the digitalisation of PHC

While pockets of excellence exist, progress towards effective use of digital technologies in PHC has been slow and fundamentally unequal: 3 600 PHC units across the nation currently have no computers, and 7 200 have no Internet access. Only 17% of PHC units have Internet speeds over 10 megabytes per second (Mbps), limiting simultaneous use of EHR systems and high-quality video consultations, not to mention remote patient monitoring. Additionally, around 18 000 health care facilities (18% of all facilities) do not have an EHR system, with large regional differences in adoption: in 2019, one in four PHC units still maintained clinical records and patient data in paper format only (CGI.br, 2020[34]). Only 40% of primary care managers consider their ICT equipment to be new and up-to-date, and only 32% believe their Internet connection suits their needs. Around one-third of nurses and physicians reported having completed capacity-building courses in health informatics. COVID-19 has likely accelerated digitalisation, but its true impact remains unclear.

A real digital transformation of PHC in Brazil will not happen without setting two foundations. First, the country must ensure a reliable energy supply and fast connectivity for all PHC units, tackling one of the main barriers to digitalisation reported by municipalities during the recent pilot project in Alagoas. Although previous programmes (e.g. Connected Brazil) have been instrumental in expanding broadband connectivity, it is crucial that these initiatives set ambitious and clear targets for both the reliability and speed of connections in PHC units. It is also important to improve co-operation among governmental entities and across the different levels of government (federal, state and municipal) in implementing broadband connectivity initiatives, building on good practices in OECD countries and beyond.

Second, financial payments included in the Connect SUS pilot project in Alagoas should be consolidated and expanded to the entire Brazilian territory. To ensure the funds are used for their intended purpose, receipt of financial support should be tied to participation by municipal and state officials in capacity-building workshops, especially targeting senior executives. Funding should be linked to explicit targets for the adoption and use of EHR systems (like e-SUS AB), including effective electronic drug prescribing and exchange of clinical and administrative data across units. As PHC units go digital, it will be vital to safeguard operational dependence on digital systems by enforcing appropriate cybersecurity.

Ensuring digital uptake and effective use among the most vulnerable and digitally excluded

Even if Brazil were to break down all barriers to the connectivity and digitalisation of PHC units, significant inequalities among citizens in the use of digital technologies and tools would persist. Nearly 47 million Brazilians did not use the Internet in 2019 (more than 20% of the population). Digital divides are clearly associated with social inequalities, with older Brazilians, those from rural areas, those with lower incomes and those with lower education levels less likely to use the Internet, and more likely to use mobile phones only. As a result, there exists a serious risk that a digital transformation of PHC will compound existing social divides.

An effective digital PHC that reaches all Brazilians is only possible if every citizen is not only connected, but also considered in the design of digital PHC services. Brazil should focus on eliminating digital divides as a foundation for effective digital PHC, strengthening the role of telecentres as providers of training – especially in rural and remote areas – and ensuring appropriate funding and technical assistance at all levels of government. Given the importance of mobile phones as a means of accessing the Internet, it should prioritise a multichannel approach focusing on mobile access among vulnerable groups. Although digital PHC content, services and applications should meet the needs of both health workers and patients, they should specifically target citizens with low digital uptake, with continued efforts to expand patients' access to their personal health information.

Moving from digital PHC strategies to implementation and monitoring

Brazil's decentralised government creates challenges to digitalising PHC. The country's single federal district, 26 states, well over 5 000 municipalities (around 44% of which have under 10 000 inhabitants) and 438 health regions have highly heterogeneous demographics, socio-economic indicators and governance structures. With only around 800 inhabitants, the municipality of Serra da Saudade has the same responsibilities in managing the digitalisation of PHC as the municipality of São Paulo, which numbers over 12 million inhabitants. Decentralisation has many benefits, but it is also creating barriers to the digital transformation of PHC in Brazil to meet the targets set in ESD28.

A major barrier to digital PHC in Brazil is human and technical capacity in municipalities. Setting responsibilities for the digitalisation of PHC at the municipal level across Brazil is likely leading to diseconomies of scale and creating challenges for small municipalities. Brazil could look to examples from New Zealand, England and Portugal for a new model of shared services and responsibilities related to the digitalisation of PHC at less decentralised levels. Building on existing institutions (e.g. Co-ordenação-Geral de Tecnologia da Informação e Comunicações/General Co-ordination of Information and Communications Technology) and experiences, Brazil could explore setting up dynamic purchasing systems at the federal level, with appropriately funded agencies at the state or regional levels providing municipalities with specialised human resources, purchasing and management services for digital PHC.

Brazil has invested significantly in connectivity (e.g. through *Governo Eletrônico – Serviço de Atendimento ao Cidadão*) and software (e.g. e-SUS AB), as well as provided municipalities with support for hardware and training (e.g. Informatiza APS). Yet the ambitious vision set out in ESD28 will likely require both larger and smarter investments, tying financial support to effective and equitable use. Taking into account the magnitude of investments made in more digitally advanced countries, Brazil could review its current investments and consider providing more funding for change management, capacity-building, and monitoring and evaluation. Financial support could be tied to specific milestones in the adoption and use of digital PHC functionalities, starting with key functionalities like ePrescribing, referral management, appointment scheduling and patient access to EHR.

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2 Health care needs and organisation of primary health care in Brazil

The expansion of PHC in Brazil has been remarkable, contributing to significant improvements in many measures of population health over the past decades. SUS prioritisation on PHC permitted to offer services free of charge to the Brazilian population, allowing an easier contact with the health system at the community level through the development of modern multi-disciplinary family health teams. But gains have not been equal across the country, with North and Northeast regions faring worse than South and Southeast regions in terms of health improvements and health outcomes. There has also been a rise in the number of elderly patients and an increasing prevalence of risk factors for health and chronic non-communicable diseases. Tackling these challenges call for more effective PHC, responsive to people's changing needs, capable of offering preventive, continuous and co-ordinated care.

2.1. Introduction

Brazil is a high-middle income country, with a population of 212 million inhabitants in 2020. The country is divided into 26 states and one federal district, with 5 570 municipalities. The states are further organised into five geopolitical regions: North, Northeast, Centre-West, Southeast and South. Health is a universal right for the whole population and a state responsibility since the approval of the new Brazilian constitution in 1988, which established the Unified Health System (Sistema Único de Saúde, SUS) in 1990. The management and financing of SUS is shared between the Federal Ministry of Health, state departments and municipal health departments. In the decentralised health care system, municipalities have the freedom to organise PHC family health teams according to the population needs and geographic characteristics.

Brazil has made investments in PHC a priority to address disparities in access to care and improve health outcomes. The Family Health Strategy, one of the largest community-based PHC programme worldwide, launched in 1994 was successful to increase population coverage and improve health outcomes. The expansion of the Family Health Strategy has contributed to measurable improvements in terms of infant mortality rates, maternal health, immunisation uptake and avoidable hospitalisation. However, PHC in Brazil faces a number of challenges resulting from its vast territory and complex geography, which have made difficult to meet the needs of population living in vulnerable and remote communities. The expansion of PHC has been marked by stark disparities across the states and municipalities, linked mainly to workforce shortages and imbalances in the distribution of medical doctors. There has also been a rise in the number of elderly patients and an increasing prevalence of chronic non-communicable diseases, which call for effective prevention and stronger PHC to better manage the burden of chronic conditions.

This chapter describes the PHC system in Brazil. It starts by analysing the socio-economic context in which the system operates, as well as describing the governance of the PHC sector. The chapter then examines the health care needs of the Brazilian population, and lastly presents the organisation of the PHC sector.

2.2. The socio-economic context for PHC in Brazil

Brazil's government is divided into 26 states and the federal district, and 5 570 municipalities. The states and the federal district are also grouped into five regions: North, Northeast, Central-West, Southeast and South, which are used mainly for statistical purposes and to define the distribution of federal funds. Municipalities are granted the status of federal entities, at the same level as the states. While there is great heterogeneity in the geographical area and population, as well as social and economic indicators, among the subnational jurisdictions, all Brazilian municipalities enjoy the same legal status (OECD/UCLG, 2019[1]). In 2015, 17 municipalities had more than 1 million inhabitants (22% of population). About 44% of municipalities had less than 10 000 inhabitants. Brazil also has 438 health regions, which are made up of municipalities, and are very heterogeneous in their demographics, socio-economic indicators and governance structures (Ministério da Saúde, 2020[2]).

In the recent past, strong economic growth and income distribution programmes were the driving forces for generating significant inequality and poverty reduction in Brazil. However, income inequalities have been rising again in recent years, and there are large regional disparities in prosperity and growth across the country, with North and Northeast regions faring worse than South and Southeast regions. Large inequalities along several dimensions affect health status.

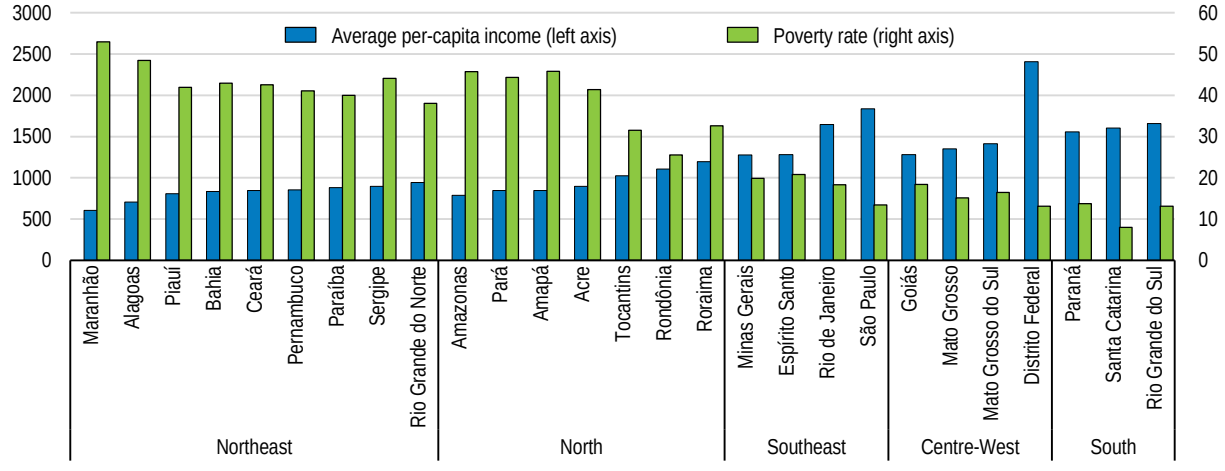
2.2.1. Despite progress, socio-economic inequalities remain a significant problem in Brazil

Brazil has had strong economic growth combined with remarkable social progress over the past two decades. In 2010, Brazil GDP grew by 7.5%, compared to around 3% across OECD countries. Currently social benefits amount to over 15% of GDP, and are characterised by poor targeting if pensions are also included. As a result, poverty rates have been reduced from 41% of the population in 2001 to 19% in 2019.[1] Public programmes have contributed to the decline in poverty rates (OECD, 2020[3]). Recent evidence shows that the *Bolsa Familia* programme alone has reduced poverty rates by 15% (Ferreira de Souza, Osorio and Paiva e Sergei Soares, 2019[4]).

These progresses have also generated reduction in income inequality. From 2001 to 2011, the GINI of income inequality in Brazil dropped continuously from around 58 to 52. However, it has been rising again in recent years, at around 53, and remains a significant problem in Brazil. Currently, the richest 10% of the population earn more than four times as much as the bottom 40% (OECD, 2020[3]).

Regional inequalities are another crucial challenge in Brazil. The distribution of income across Brazilian regions is highly unequal. Average incomes in the Northeast state of Maranhão are less than half of the national average. The opposite holds true for poverty. The poverty rates in the North and Northeast regions are between three to four times higher than the poverty rates in the Southeast, Central-west and South regions (Figure 2.1). Large regional disparities also exist with regards to labour market informality and illiteracy, which are three to four times more common in the poorer North and Northeast regions than in the relatively affluent South and Southeast regions (OECD, 2020[3]). As the social and economic context strongly influences health outcomes, economic disparities across regions are mirrored in health status and health outcomes.

Figure 2.1. Socioeconomic inequalities across regions, 2019



Source: IBGE (2019[5]), Síntese de Indicadores Sociais: uma análise das condições de vida da população.

2.2.2. The management of the Brazilian Unified Health System is decentralised

The principles and structure of Brazil's health care system were conceived in 1988 after the approval of the new Brazilian Constitution that established health as a universal right for the whole population. It became a state responsibility with the establishment of the Unified Health System (Sistema Único de Saúde, SUS). The SUS is structured around three main priorities (Massuda et al., 2020[6]):

- The universal right to comprehensive health care at all levels of complexity (primary, secondary, and tertiary).
- Decentralisation with responsibilities given to the three levels of government: federal, state, and municipal
- Social participation in formulating and monitoring the implementation of health policies through federal, state, and municipal health councils.

The management of SUS is shared across three different levels of governance: Federal Ministry of Health, state departments and municipal health departments. At federal level, the Ministry of Health defines the general objectives of the SUS and sets policy development, planning financing, auditing and control of health policies and health services linked to SUS. It is responsible for the overall co-ordination of the national priorities and actions defines as part of the Multi-Annual Plan 2020-23 and the National Health Plan (Plano Nacional de Saúde, [PNS]) 2020-23. The health related objectives for the Multi-Annual Plan 2020-23 is the expansion of the coverage and resolution of PHC, improving prevention and strengthening of integration between health care services. The PNS 2020-23 elaborates on SUS health policy objectives, with the definition of seven programmes (Ministério da Saúde, 2020[7]):

- Pharmaceutical services in SUS
- Specialised health care services
- PHC
- Scientific, technological and productive development in health
- SUS management and organisation
- Protection, promotion and recovery of indigenous health
- Health surveillance

In the area of PHC, the PNS 2020-23 is structured around three main priorities. First, the expansion of PHC access and of its infrastructure. Second, improvement in the digitalisation of PHC units, with better-integrated data and use of electronic medical records in North and Northeast regions. Third, increasing health promotion and prevention at PHC levels to address risk factors for health (for example nutrition and smoking) and encourage uptake of screening exams (for example cytopathology and mammography exams). The PNS 2020-23 defines 20 objectives in the area of PHC, with specific targets to achieve by 2023 around for example the number of Family Health Teams (both for the general and incarcerated populations), dental care coverage, pregnant women's prenatal consultations, cytopathology and mammography exams coverage, and quality of mental health (Table 2.1).

Table 2.1. The PNS 2020-23 objectives in the area of PHC

	Goals	Indicators	Reference Level	2023 Target
1	Increase to 72% the population coverage of PHC	Population coverage with PHC	63,5%	72,7%
2	Increase to 185 the number of "Doctor's Office at the Street" Teams	Number of "Doctor's Office at the Street" Teams	154	185
3	Increase to 2000 the number of Family Health Units with extended working hours financed by *Saúde na Hora* Programme	Number of Family Health Units functioning on extended working hours financed through the *Saúde na Hora* Programme	264	2 000
4	Increase to 155 the number of reference PHC team targeted at teenagers serving socio-educational measures	Number of PHC reference teams targeted at teenagers serving socio-educational measures	119	155
5	Increase to 677 the number of prison-based health teams	Number of prison-based health teams	357	677
6	Increase the occupation rate of more than 85% for placements offered through federal medical programmes (*Mais Médicos* project + *Médicos pelo Brasil* project)	Occupation rate of offered placements through federal medical programmes	82%	>85%
7	Increase to 80% the share of pregnant women with at least	Percentage of pregnant women with at least 6	40%	80%

	Goals	Indicators	Reference Level	2023 Target
	6 prenatal consultations taking place during the first 20th week of pregnancy	prenatal consultations, taking place during the first 20th week of pregnancy		
8	Increase to 49% the population coverage for Dental Specialties Centres	Percentage of population covered by Dental Specialties Centres	45%	49%
9	Increase to 689 Dental Specialties Centres that have adhered to the Network of care for People with Deficiencies	Number of Dental Specialties Centres that have adhered to the Network of Care for People with Deficiencies	579	689
10	Increase to 46% the population coverage of Dental Health Teams	Percentage of population covered by Dental Health Teams	42%	46%
11	Increase to 3 118 the number of municipalities with Dental Prosthesis Regional Laboratories services	Number of municipalities with Dental Prosthesis Regional Laboratories services	2468	3118
12	Increase to 60% the share of pregnant women with prenatal consultations at PHC who had individual dental appointments with Dental Health Teams	Proportion of pregnant women with dental appointments performed	25%	60%
13	Implement 39 River-based Family Health Units	Number of River-based Family Health Units implemented	19	39
14	Implement out-of-hospital psychosocial service focused at acute situations in 14 capitals	Number of capitals with out-of-hospital psycho-social service focused at acute situations	0	14
15	Reduce to 26 days the average time of psychiatric hospitalisations in medical institutions	Average time of psychiatric hospitalisation	45	26
16	Increase to 1.2% the proportion of alcohol dependents' appointments at the Centres of Psychosocial Care	Percentage of alcohol dependents' appointments at the Centres of Psychosocial Care	0,6%	1,2%
17	Increase at 80% the share of beneficiaries of the *Bolsa Família* Programme who have their health conditions monitored at PHC	Percentage of the *Bolsa Familia* beneficiaries with health conditions monitored at PHC level	76.08%	80%
18	Increase to 48% the share of women aged between 25 and 64 years old that have done a cytopathology exam in the last 3 years	Percentage of women aged between 25 and 64 that did a cytopathology exam in the last 3 years	36%	48%
19	Increase to 35% the share of women aged between 50 and 69 years old that have done a mammography exam in the last 2 years	Percentage of women aged between 50 to 69 years old that have done a mammography exam in the last 2 years	23%	35%
20	Reduce the proportion of caesarean sections to 52.4%	Percentage of caesarean sections	55.7%	52.4%

Source: (Ministério da Saúde, 2020[7]), Plano Nacional De Saúde 2020-2023.

The 26 state governments, through states secretary of health, are responsible for regional governance and the regional health system organisation, co-ordination of strategic programmes, and delivery of specialised health care services that have not been decentralised to municipalities. At local level, 5 570 municipalities, through municipal secretary of health, handle the management of SUS, including co-financing, co-ordination of health programmes, and direct delivery and contracting of health services, including PHC services (Massuda et al., 2020[6]).

The Interfederative Pact of Executive Management allows SUS to have a dynamic functioning through agreements between each federative entity, with the establishment of the following councils or commissions:

- The *Conselho Nacional de Secretários de Saúde* (CONASS) brings together the health secretaries of the states and the Federal District with the purpose of implementing SUS principles, legislation and guidelines into health actions and services. CONASS also allows the exchange of experiences and information among States Secretaries.
- The *Conselho Nacional das Secretarias Municipais de Saúde* (CONASEMS) represents municipal health departments, with the objective of guiding health managers for the provision of PHC services.

- The *Conselho Estadual de Secretarias Municipais de Saúde* (COSEMS) brings together municipal secretaries of health to discuss and co-ordinates strategic health issues.

Box 2.1. The Governance of PHC in Brazil

The *Política Nacional de Atenção Básica* (PNAB) describes the governance of PHC in Brazil, the roles of the main actors and other strategic aspects of the PHC policy. The federal government, the state governments and municipalities are the main actors involved in the governance of PHC in Brazil. The specific competencies of each level of government is foreseen in the Federal Constitution and the PNAB (art. 7, Ord. 2 436).

The formulation of policy priorities and actions for the PHC sector is agreed and approved during the CIT, which is made of representatives from the Ministry of Health, CONASS and CONASEMS. Decisions on the operational, financial and administrative aspects for the management of PHC are taken by consensus.

Within the Ministry of health, the PHC Secretariat (SAPS) (established in 2019 – Decreto nº 9 795) is responsible for defining and co-ordinating the PNAB. It is also responsible for allocating federal resources to finance PHC (on a monthly, regular and automatic basis), providing integrated support to the state and municipal managers, formulating strategies for monitoring and improving PHC quality, establishing national guidelines and providing technical and educational supports for PHC managers and professionals.

The states define decentralised PHC actions, strategies, guidelines, as well as rules for the implementation of the PNAB during the CIB, which is made of representatives from the state secretaries of health and COSEMs. States are expected to allocate financial resources for PHC, monitor PHC actions and care quality in municipalities, verify the quality and consistency of information sent by municipalities. They might also provide institutional support to the municipalities in the process of implementing and monitoring PHC and expanding the Family Health Strategy. States are expected to provide technical and educational instruments to the municipalities to facilitate training and continuous education of PHC managers and professionals.

Municipalities have the main attribution concerning the provision and financing of PHC services. They are responsible for organising, managing and providing services and actions within each territory. Municipalities have to provide support to PHC teams and units in the process of monitoring and expanding the Family Health Strategy. To this end, municipalities select, hire and remunerate the PHC professionals in accordance with the current legislation, and guarantee that PHC teams and units have sufficient material resources, equipment and supplies to deliver PHC services. They might organise effective patient flow within SUS and adopt referral mechanisms to ensure effective care co-ordination. Municipalities should keep the registration of teams, professionals, workload, available services and equipment on a monthly basis in the National Registry System of Health Establishments according to specific regulations. Community participation should also be guaranteed through social control. Lastly, municipalities are required to analyse and verify the quality and consistency of the data collected in the national health information systems to be sent to other spheres of management, use them in the health care planning and disseminate results.

Source: Information provided by Brazilian Ministry of Health.

The *Comissão Intergestores Tripartite* (CIT) and the *Comissão Intergestores Bipartite* (CIB) are important bodies for the development of SUS strategies and resource allocation through collective consensus from the different spheres of government (see Box 2.1). The National Health Council, a collegiate body

composed of government representatives, service providers, health professionals and users, is also involved in the formulation of PHC priorities and actions. The OECD health system review provides a detailed description of these governance bodies (OECD, 2021[8]).

Since the establishment of SUS, Brazil has made substantial progress toward achieving universal health coverage. Virtually all of the population is covered for equal benefits and equal financial protection within the public health sector. Since its inception, a strong focus of SUS was to strengthen the role of PHC to reduce health inequalities and improve access to care, but also to move away from a health system that was historically very hospital-centred.

2.2.3. Brazil makes spending on PHC a priority

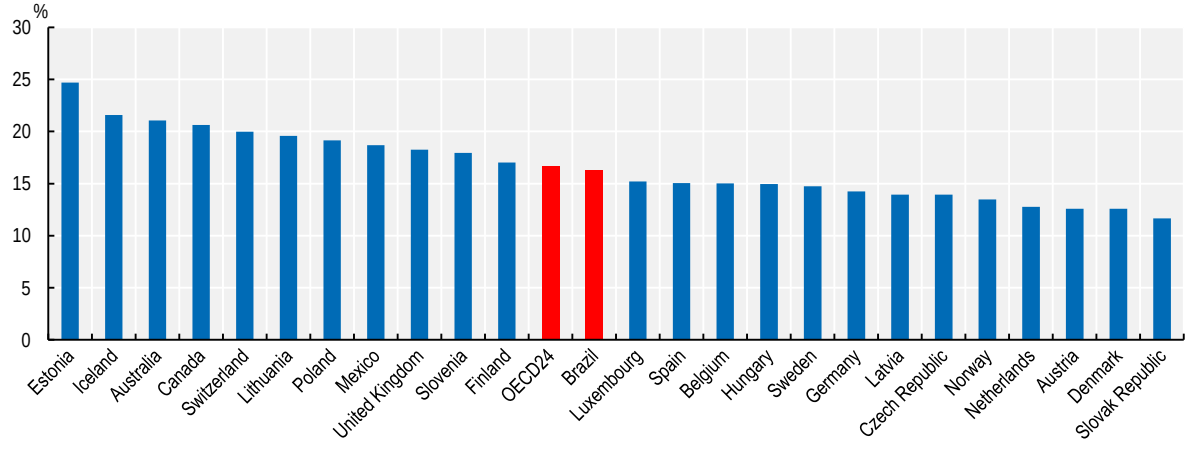
The public system is financed by tax revenues and social contributions from all three levels of government. By law, the federal government is required to spend 15% of net current government income on health, the states are required to spend 12% of total revenue on health, and municipalities are required to spend 15% of total revenue on health (Massuda et al., 2020[9]). It is reported that over the past 30 years, the share of municipal funding has increased to reach nearly one-fourth of their own total revenues on health (Massuda et al., 2020[9]).

Under SUS, the federal government has traditionally financed roughly one-third of total PHC costs (33%), with the remaining part being funded predominantly by municipalities (61%) (Ministério da Saúde/Fundação Oswaldo Cruz, 2018[10]). The participation of states is the smallest, with very few cases where states co-finance policies for PHC.

Analysing the composition of overall health spending in an international context, Brazil seems to make spending on PHC a higher priority than many OECD countries. In 2019, Brazil dedicated around 16% of its financial resources to general outpatient care, dental care, home-based curative care and preventive activities (Figure 2.2).

In 2020, the budget allocated to PHC from the federal government was BRL 20.9 billion, compared to BRL 17.5 billion in 2019 (CONASEMS, 2020[11]). In total, the federal government increased its PHC budget by around BRL 3.4 billion between 2019 and 2020.

Figure 2.2. Spending in PHC as a share of current health spending, 2019 or nearest year



Note: Basic health services combine general outpatient care, dental care, home-based curative care and preventive activities provided regardless of the setting. It can be used as a proxy for PHC for international comparisons.
Source: OECD (2021[12]), *Health Statistics Database*, http://stats.oecd.org; Brazilian Ministry of Health.

2.3. Health care needs of the Brazilian population

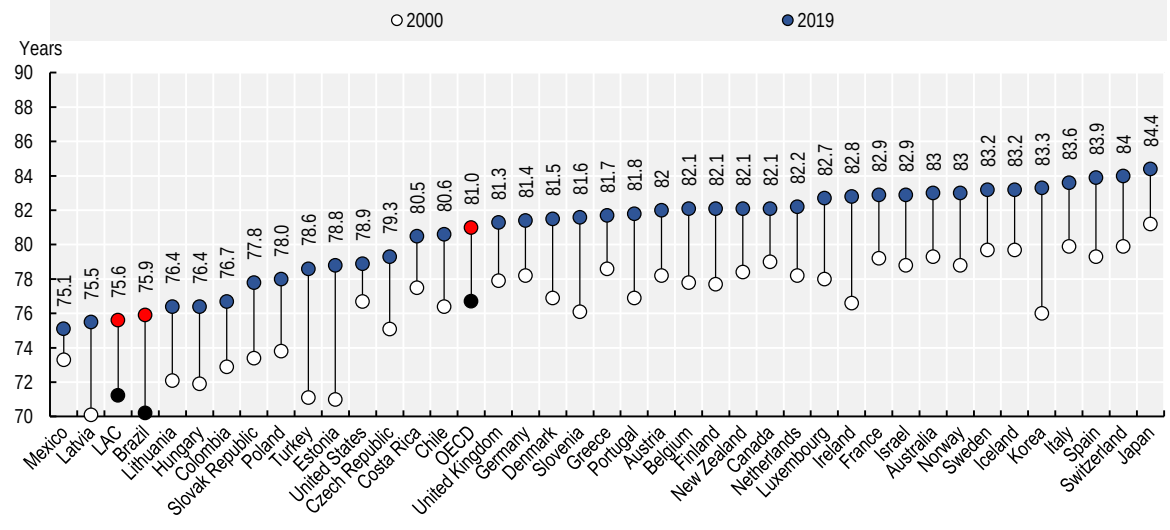
Since SUS inception, Brazil has made significant developments by improving in most of the general population health indicators. Brazil is however undergoing a profound demographic transition. As a result of decrease in fertility and mortality rates, the Brazilian population is rapidly ageing. The rapidly ageing population and increasing risk factors for health in Brazil (notably growing overweight rates) goes hand in hand with an increased prevalence of chronic non-communicable diseases, which call for effective prevention and stronger PHC to better manage the burden of chronic conditions.

2.3.1. Life expectancy at birth has improved in recent years, but is still falling behind other OECD countries

Life expectancy at birth in Brazil increased rapidly over the past decades, but is still five years below the OECD average of 81 years but above the LAC average of 75.6 years (see Figure 2.3). In Brazil, life expectancy at birth increased by more than five years between 2000 and 2019 (rising from 70.2 to 75.9 years), compared to four years across OECD countries. The gap in longevity between Brazil and other OECD countries has shortened from 6.5 years to 5.1 years.

Figure 2.3. Life expectancy at birth in Brazil has increased over the past decades

Life expectancy at birth, among OECD and LAC countries, 2000 and 2019 (or nearest years)



Source: OECD (2021[12]), *Health Statistics Database*, http://stats.oecd.org; World Bank World Development Indicators Online 2021.

Infant mortality rates have decreased from 30.3 deaths per 1 000 live births in 2000 to 12.4 deaths per 1 000 live births in 2019. Despite this decrease, the infant mortality rate in Brazil is still above the OECD average of 4.2 deaths per 1 000 live births. The same is true for maternal mortality rates in Brazil, which have decreased to 60 women per 100 000 live births in 2017 (13 percentage points reduction since 2000), although still higher than the OECD average of 8 per 100 000 live births but lower than the LAC average of 83 (OECD/The World Bank, 2020[13]).

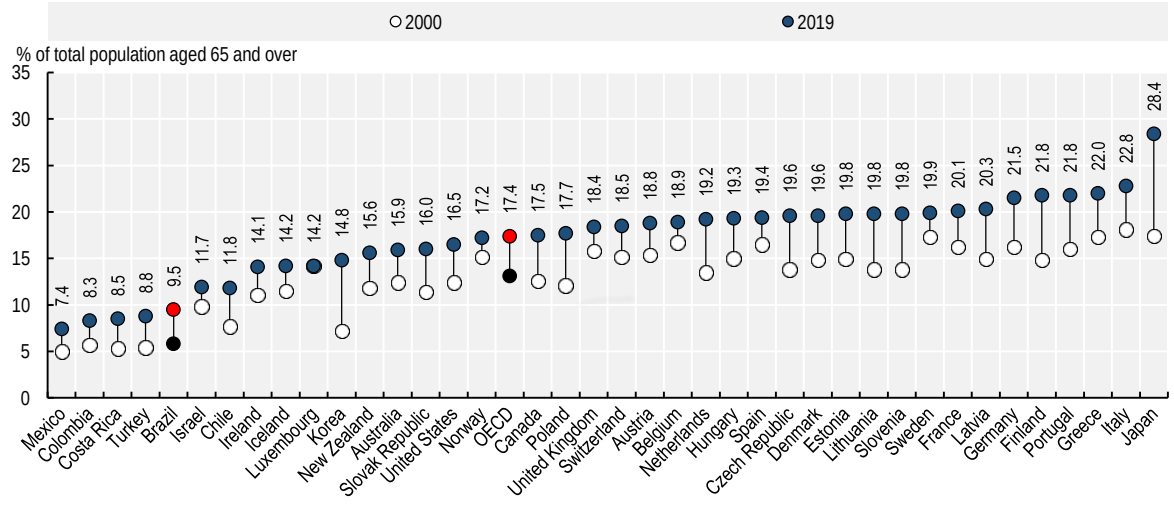
2.3.2. Brazil faces rapid ageing of its population

Brazil, similarly to other OECD countries, is experiencing a demographic transition characterised by a shift from high levels of mortality and fertility to lower levels. The fertility rate fell from 2.9 births per woman in

1990 to 1.7 births per woman in 2019 (OECD, 2021[14]). The combination of falling mortality rates (resulting in increasing life expectancy) and fertility rates causes rapid population ageing. The share of the population aged over 65 years has increased by 65% over the past decade, rising from 5.8% in 2000 to 9.5% in 2019 (Figure 2.4). Across the OECD, the share has increased by 32% over the same period, rising from 13.1 in 2000 to 17.4 in 2019.

Therefore, the dependency ratio (the number of people of working age for every person aged 65 years and more) is projected to substantially decrease by 2050, close to the OECD level. The rapid ageing population has an important impact on the health of the population in Brazil, putting pressure on both the health care systems and the economy.

Figure 2.4. Share of the population aged over 65 years, 2000 and 2019



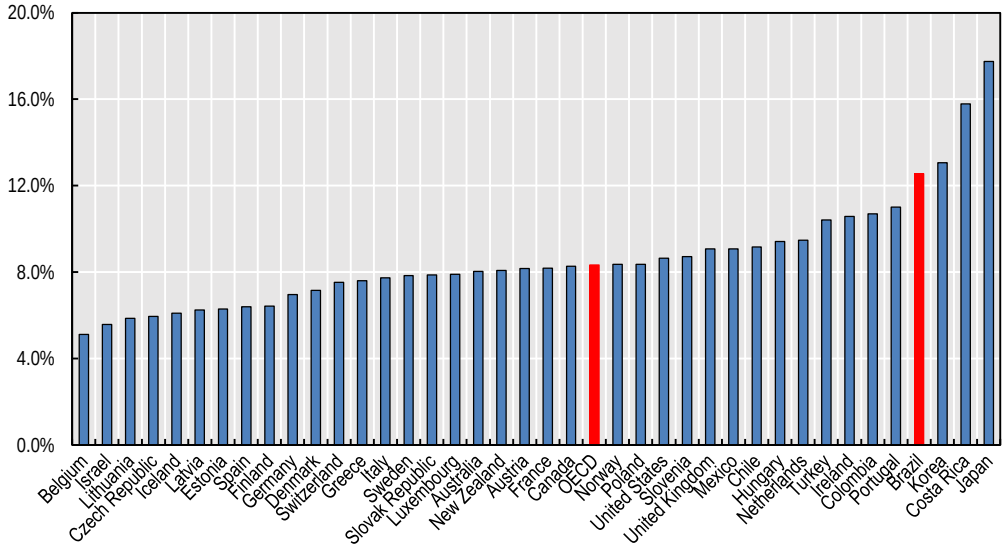
Source: OECD (2021[12]), *Health Statistics Database*, http://stats.oecd.org.

2.3.3. Rapidly increasing risk factors for health and associated ill-health are a major concern

Several risk factors for health give cause for concern in Brazil, including particularly overweight. Being overweight is a major risk factor for various chronic non-communicable diseases including diabetes, cardiovascular diseases and certain cancers. While overweight in Brazil is currently below OECD average, the trend is increasingly upwards. In 2016, estimations show that 56.5% of adults in Brazil were overweight, close to the OECD average of 58.4%. However, Brazil showed the fourth largest change in overweight between 2006 and 2016 with a growth of 13% in the past decade, compared to an increase of 8% across the OECD. This is the third highest growth rates behind Japan, Costa Rica and Korea (Figure 2.5).

Children overweight rates in Brazil are also increasing at a fast rate. In 2016, Brazil had a children overweight rate of 28%, very close to the 28.5% in average amongst OECD countries. Nevertheless, Brazil experienced an increase of 27% between 2006 and 2016, higher than the 15% increase in the OECD. Increasing children overweight rates means higher risk of cardiovascular diseases or diabetes during adult age, putting further pressure on the PHC sector.

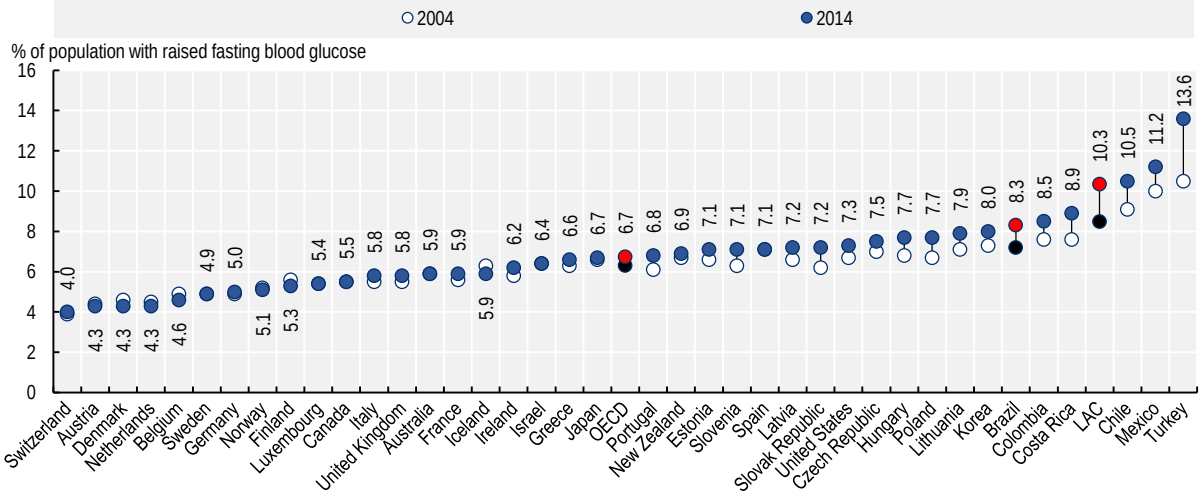
Figure 2.5. Changes in overweight rates among adults between 2016 and 2006



Source: OECD (2021[12]), *Health Statistics Database*, http://stats.oecd.org.

Already, when compared to OECD countries, diabetes represents a higher burden of disease in Brazil. Raised levels of blood sugar can lead to the development of diabetes. Fasting blood glucose (FBG) contributes to diagnose and monitor diabetes. In Brazil, 8.3% of the population had raised FBG in 2014, above the 6.7% average in OECD countries. Importantly, between 2004 and 2014, Brazil recorded one of the largest increase in its population with raised FBG, increasing by 15.3% (Figure 2.6). Only Turkey, Mexico, Chile, Costa Rica and Colombia had larger increases amongst OECD countries, evidencing a worrying trend in Brazil.

Figure 2.6. Raised fasting blood glucose among adults in Brazil and OECD, 2004 and 2014



Source: WHO Global Health Observatory (2017[15]), https://www.who.int/data/gho.

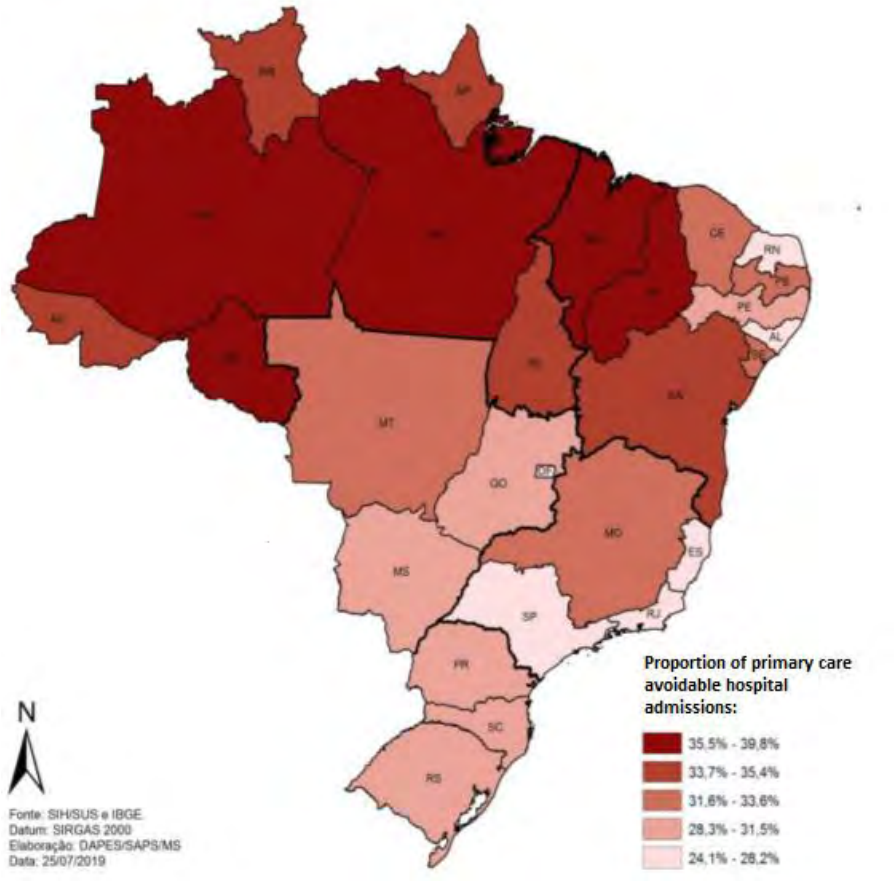
Overall, with increasing risk factors for health, the predominance of chronic non-communicable diseases is growing in Brazil. In 2017, four chronic non-communicable diseases dominated the causes of mortality in Brazil: circulatory system diseases (27%), neoplasms (17%), chronic respiratory diseases (12%), external causes (12%) and diabetes (5%), compared to only two in 1990 (cardiovascular diseases with 27.8%, and neoplasms with 11.4%).

2.3.4. There are large regional differences in health

There are large regional inequalities in health status across Brazil, where the most vulnerable municipalities consistently present poorer health outcomes than national average. While infant mortality rate in Brazil has decreased from 47.1 to 12.4 per 1 000 live births between 1990 and 2019, there are large differences in the magnitude of this reduction across Brazil's regions. The Northeast region showed the most significant decline of 80% in the period, while the lowest degree of reduction occurred in the Centre-west and North regions (reduction of 62%) (Szwarcwald et al., 2020[16]).

Another illustration of regional differences in health can be seen in terms of avoidable hospitalisation for conditions that could be treated in the PHC setting. The proportion of hospitalisations due to conditions that could be more effectively treated in the PHC setting ranges from 24% in the South region to 40% in the North region (Figure 2.7). Such regional differences point out that some remote and vulnerable areas require more attention than others to improve quality of PHC.

Figure 2.7. Share of hospital admissions due to conditions that are treatable in PHC, population aged 60 or more by region, 2019



Source: Ministério da Saúde (2020[2]), Plano Nacional de Saúde 2020-23.

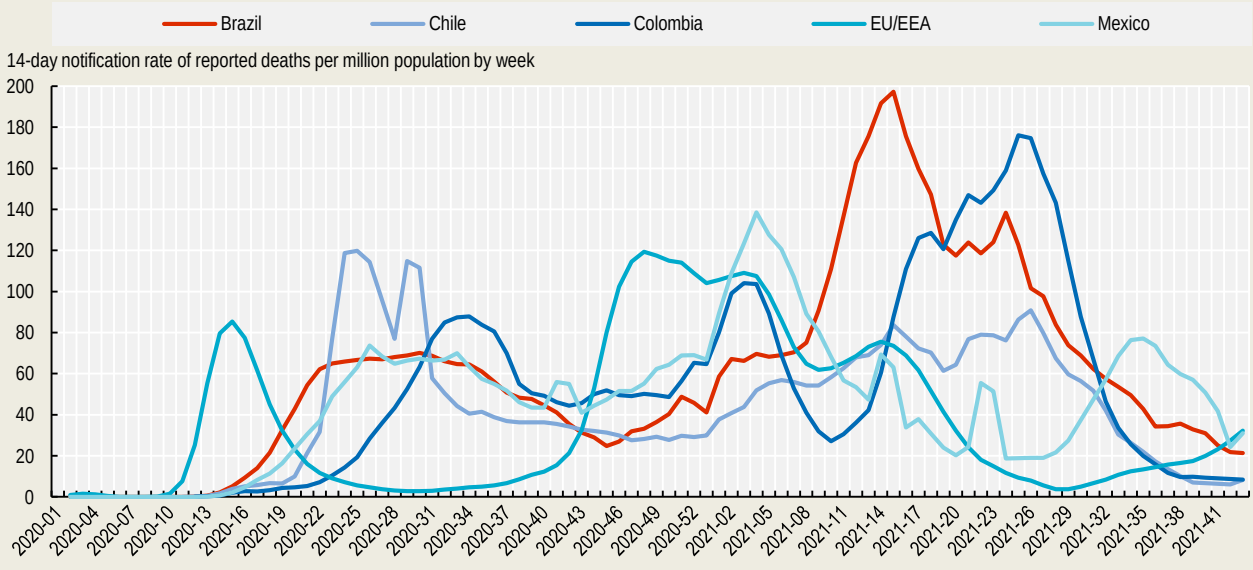
There are also significant inequalities in the rates of vaccination against yellow fever in Brazilian states where vaccination has been recommended, ranging, in 2018, from 21.8% in Sergipe to 100% in the Federal District and Roraima (the national average for all states where vaccination is recommended is 64.1%).

Regional inequalities in health have aggravated the impact of the COVID-19 pandemic and will likely exacerbate health inequalities in the future. The most precarious and vulnerable population are more likely to be affected by the COVID-19 virus, not only because of poor living and working conditions, but also because they are more likely to suffer from comorbidities and risk factors for COVID-19 severity. Mortality rates in the State of Amazonas have been found four-times higher than the national average, particularly among indigenous people (Pires, Carvalho and Rawet, 2020[17]). Box 2.2 presents the impact of COVID-19 on health in Brazil.

Box 2.2. The impact of COVID-19 on health in Brazil

The first case of COVID-19 in Brazil was reported on the 25th of February 2020. Since then, the impact on population health has been large. The total number of registered deaths is above 611 000 as of 17 November 2021 with 41 000 average monthly registered deaths in 2021. This situates COVID-19 as the first cause of death during the pandemic when compared to the average monthly figures for 2015-19 of deaths attributed to other conditions, the highest ones being 30 000 for circulatory diseases, 18 500 for cancers, and 13 000 for diseases of the respiratory system. However, there are scientific basis showing an underreporting of around 22% due to limitations to perform the SARS-CoV-2 screen by RT-PCR test (Carvalho, Boschiero and Marson, 2021[18]).

Figure 2.8. COVID-19 mortality rate evolution in Brazil and selected OECD countries between March 2020 and October 2021



Source: ECDC (2021[19]), *COVID-19 situation updates*.

The mortality epidemic curve in Brazil experienced an increase in cases by early April 2020, reaching the first peak during July 2020, later than what Europe experienced in the early months of the pandemic (Figure 2.8). Then, cases started to reduce but still with high level of virus circulation and mortality rates, similar to other Latin American countries such as Chile, Colombia and Mexico but dissimilar to Europe where mortality was substantially lowered between July and September. By mid-November, cases in Brazil began to rise once again. By the beginning of April 2021, mortality rate in Brazil reached its highest levels since the start of the pandemic and then started to decline.

One of the most important problems in handling the COVID-19 pandemic in Brazil was weaknesses in governance of the health sector. At the federal level, in the first year of the pandemic, four different ministers of health were in office, limiting continuity in the management of the response. Risk communication from federal authorities has also been conflicting and confusing for the population. Brazil is not unique, in that other OECD countries have pursued similar approaches.

As highlighted in Chapter 3, the COVID-19 crisis demonstrates the importance of placing PHC at the core of health systems, both to reduce pressure on health systems and minimise complications and direct deaths from the COVID-19, as well as to maintain ongoing routine care to patients who do not have COVID-19.

2.4. The organisation and structure of the PHC sector

In Brazil, the 5 570 municipalities handle the management, organisation and delivery of PHC. The Family Health Strategy programme launched in 1994 was remarkable. Based on multi-professionals PHC teams (called Family Health Teams), the expansion of the Family Health Strategy led to improvement in health care coverage and health outcomes. SUS prioritisation on PHC permitted an easier contact with health services at the community level.

2.4.1. Municipalities have primary responsibility for managing and delivering PHC

Since the implementation in 1994 of the federal programme called the Family Health Strategy (Estratégia de Saúde da Família – ESF), also known as the Family Health Programme (Programa Saúde da Família), the 5 570 municipalities have primary responsibility for managing and delivering PHC. With federal funding, municipalities have the freedom to organise family health teams according to the population needs and geographic characteristics.

The ESF is a decentralised programme aimed at expanding the PHC system in Brazil toward more co-ordinated, comprehensive and continuous care. The overarching objective was to ensure universal access to health care services for all Brazilians under the overall organisation of SUS (Macinko and Harris, 2015[20]; Castro et al., 2019[21]). The ESF became the main mechanism for expanding coverage to PHC services in Brazil. The ESF resulted in two major shifts. First a shift in priorities, from treating patients with diseases to delivering comprehensive care and preventing diseases through active health promotion. Second a shift in governance, from states to municipalities to allow for greater accountability and more collaboration between the private and public sector.

The ESF is funded through federal transfers but also includes financial contributions from municipalities. As earlier mentioned, the municipalities is the main financing agent of PHC. Smallest municipalities (up to 20 000 inhabitants), where there is no other supply of health care services, spend around 60% of their health expenditure directed towards PHC.

2.4.2. Public PHC is free of charge and is expected to be the initial contact point to SUS

SUS offers preventive services and PHC free of charge. Services that are publicly covered are based on health conditions, clinical and nonclinical procedures, and target population groups. The list of services has been gradually adapted to reflect changes in population health. Treatment and control of major chronic conditions (such as hypertension and diabetes) have been added in the list of services covered (OECD, 2015[22]). The federal Ministry of Health negotiates with state and municipal health secretariats to decide new health care services to be covered by SUS.

PHC provided by the ESF is expected to be the initial contact point for patients having new health needs, although it does not work as a “gatekeeper” and many Brazilian have direct access to outpatient specialties and hospital. For example, the latest Health Information Survey found that around 50% of the diabetic population identified basic health units as their last contact with the health system, 11% used public speciality units in hospitals, 6% public urgent care units and 30% private practices or clinics (IGBE, 2020[23]).

This is unlike many other OECD countries such as Australia, Canada, or the United Kingdom where general practitioners operate as gatekeeper to the health system as a referral is required and compulsory to access to specialist and hospital care (OECD, 2020[24]).

In PHC, private sector is more supplemental as health plans mainly offer specialist and hospital services. However, health plans in the private sector have begun to offer access to family doctors with no co-payment as an alternative to specialist visits (Massuda et al., 2020[9]).

2.4.3. PHC in Brazil is provided by multidisciplinary Family Health Teams

Prior to 1994, the role of PHC and health promotion was limited and services were predominantly delivered in a range of hospitals. As a community-based, large-scale PHC programme, the ESF relies on multi-professional teams called Family Heath Teams (FHTs). Each FHT is assigned a geographic area, covering up to 4 000 individuals located in non-overlapping areas. This helps FHTs to consider social, economic and environmental factors of the catchment area. FHT are responsible for registering every family in their geographic area, and are thus designed to facilitate access to the health care system (Massuda et al., 2020[9]).

A range of different health professionals are involved in PHC delivery. The FHT include physicians, nurses, and up to 12 community health workers. Other PHC workers, including nutritionists, pharmacists, social workers, psychologists, obstetricians and gynaecologists, and public health workers can provide additional support depending on local needs. Oral health teams have been integrated to the FHT in recent years to provide universal and free oral health services to the population. By 2019, there were 43 234 Family Health Teams and 27 564 Oral Health Teams in operation throughout Brazil (Figure 2.9). Solo practice in Brazil is thus becoming scarce, although there is no official registration and reporting of this practice.

This model of service delivery – based on multidisciplinary team – is well aligned with modern approaches to PHC which house multiple professionals with advanced skills working in teams (OECD, 2020[24]). Such models of PHC based on teams or networks of providers were reported by 18 OECD countries in 2018, including Australia, Canada, France, Switzerland or the United States.

FHTs are working in basic health care units (*Unidades Basicas de Saude* – UBS) or other PHC facilities called health clinics, health centres or health posts, and can also receive support from the Family Health Support Centers (*Nucleos de Apoio à Saúde da Familia* – NASFs). NASFs were introduced in 2008 to provide support to between one and nine FHTs. NASF is composed of health and social workers included for example acupuncturists, social workers, physical education professionals, pharmaceuticals, physiotherapists, gynaecologists and obstetricians; homeopathic doctors; nutritionists; paediatricians or psychologists. By 2019, there were 4 487 NASFs in operation throughout Brazil (see also Chapter 4 for a detailed description of NASFs). As of May 2021, there is a total of 50 029 PHC facilities in Brazil, including among other UBS, Health Post and NASFs.

In 2020, the government introduced a new classification of 12 health teams categories (Table 2.2 summarises the various family health teams in Brazil).

Table 2.2. PHC teams in the National Register of Health Facilities CNES, 2020

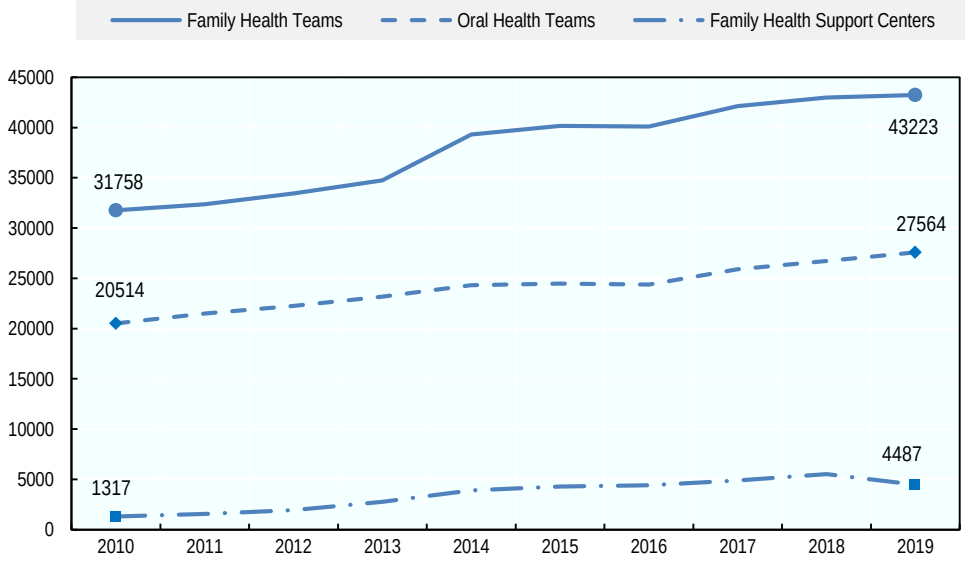
Acronym	Official name	PHC team
EMSI	*Equipe Multidisciplinar de Saúde Indígena*	Multidisciplinary Indigenous Health Team
EMAD I	*Equipe Multidisciplinar de Atenção Domiciliar Tipo I*	Multidisciplinary Team of Home Care type 1
EMAD II	*Equipe Multidisciplinar de Apoio*	Multidisciplinary Team of Home Care type 2
EMAP	*Equipe Multidisciplinar de Atenção Domiciliar Tipo II*	Multidisciplinary Support Team
EAD	*Equipe de Cuidados Domiciliares*	Home Care Team
eSF	*Equipe de Saúde da Família*	Family Health Team
eSB	*Equipe de Saúde Bucal*	Oral Health Team
eNASF-AP	*Equipe do Núcleo Ampliado de Saúde da Família e Atenção Primária*	Extended Family Health and PHC Team
ECR	*Equipe dos Consultórios na Rua*	Outdoors clinics Team
eAPP	*Equipe de Atenção Primária Prisional*	Prison PHC Team
eMAESM	*Equipe Multiprofissional Atenção Especializada em Saúde Mental*	Multi-professional Team Specialised Attention in Mental Health
eAP	*Equipe de Atenção Primária*	PHC Team

The scope of practice of the FHT has gradually increased over the past years to provide proactive preventive care and deliver public health intervention including for instance immunisation programmes and screening programmes (see Chapter 3). Services include not only maternal and child health care services, but also entail preventive care and control and management of chronic non-communicable diseases (Özçelik et al., 2021[25]). The FHT also link patients with social services (such as conditional cash transfer programmes), water and sanitation services, law enforcement, and school programmes (Massuda et al., 2020[9]).

2.4.4. The expansion of the Family Health Strategy has been remarkable, improving health care coverage and health outcomes

In 2019, 98% of the municipalities had adopted the Family Health Strategy model. In 2019, there were 43 223 family health teams, 27 564 oral health teams and 4 487 family health support centres (Figure 2.9), providing care to more than 127 million people (61% of the population). The number of family health teams and oral health teams has increased by respectively 36% and 34% over the past decade. At the same time, the number of NASFs has more than tripled over the past decade (Figure 2.9). As of May 2021, there are more than 50 000 PHC facilities in Brazil where teams can deliver services.

Figure 2.9. The number of Family Health Teams has increased by nearly 40% over the last decade



Source: Information provided by the Brazilian Ministry of Health.

There are strong evidence suggesting that the FHT provides better access and quality than other traditional health posts and centres (Massuda et al., 2020[9]). In a systematic review of the literature examining the impact of the ESF in Brazil, Bastos et al. (2017) show that increasing health care coverage through the expansion of the ESF was consistently associated with improvement in child mortality (Bastos et al., 2017[26]). A longitudinal analysis using panel data show that a 10% increase in FHT coverage was associated with a 4.5% decrease in infant mortality rate, all other things being equal (Macinko, Guanais and Marinho De Souza, 2006[27]).

Among adults, expansion of the ESF was associated with reductions in hospitalisations for diabetes mellitus and respiratory problems (Guanais and MacInko, 2009[28]). Estimations show that the ESF may have contributed to an estimated 126 000 fewer hospitalisations between 1999 and 2002. More recently,

Pinto and Giovanella (2018) show that the implementation of the ESF was associated with a reduction of 45% of the standardised hospitalisation rates per 10 000 inhabitants between 2001 and 2016. The decline was particularly pronounced for hospitalisation due to asthma, gastroenteritis and cardiovascular and cerebrovascular diseases (Pinto and Giovanella, 2018[29]). The implementation of the ESF is also positively associated with a significant reduction in the number of hospitalisations for heart failure and stroke per 10 000 inhabitants from 1998 to 2013 (De Fátima Barros Cavalcante et al., 2018[30]). Better prevention of PHC sensitive conditions, greater follow-up for chronic conditions, improved diagnosis, and easier access to medicines partly explain improvement in health care quality.

In addition to improving health outcomes through better access to care, the SUS made considerable investments to expand the availability and equipment of PHC facilities through the *Requalifica programme*. The programme carries out construction, expansion and refurbishment of the PHC facilities, including the construction of the Basic Fluvial Health Units, providing better conditions for accessing and offering public health actions and services. It also involves actions aimed at the computerisation of PHC, and the qualification of PHC workers (Ministério da Saúde, 2020[2]).

While these are all welcome news, the ESF expansion has also been marked by stark disparities across the states and municipalities (Andrade et al., 2018[31]). The ESF expansion has been heterogeneous across municipalities mainly because of geographic imbalances in the supply of physicians. The lack of PHC physicians in some remote municipalities has been one of the most important barrier to the expansion of the ESF (Andrade et al., 2018[31]).

2.4.5. The role of community health workers is predominant

Following the implementation of the Community Health Agents Programme (PACS), community health workers (CHWs) started to play a crucial role in the Brazilian PHC system. CHWs are frontline public health workers, often members of the communities in which they work. They have valuable knowledge of people needs and are trustful source of information. The implementation of the ESF gave an expanded role of CHWs, at the core of the country's PHC policy (Wadge et al., 2016[32]).

CWHs are integrated members of the FHT. They provide comprehensive PHC supports including clinical triage, supporting chronic disease management, screening uptake, immunisations, providing pre- and postnatal care assistance, health promotion, social determinants, community participation and household data (Wadge et al., 2016[32]). They are expected to resolve many low-level problems such as medication review for chronically ill patients, while referring more complex issues to doctors and nurses of the FHT. At the clinic or health posts, CHWs are also responsible for organising the waiting rooms and appointments for other health workers, and offering educations sessions.

Each CHW is assigned to maximum 150 households in a geographic area, and each household receives at least one visit every month from a dedicated CHW irrespective of needs or demand. Patients are not able to choose their CHW. Monthly visits allow health promotion activities and basic clinical care, checking whether prescriptions have been filled and whether patients have been taking their medications regularly, identifying risk factors for health or other social determinants, but also collecting individual and household level data (Wadge et al., 2016[32]). CHWs also help co-ordinate PHC services with public health efforts.

In 2020, more than 250 000 CWHs served 61% of the population (see Chapter 5), up from 60 000 in 1998. The minimum requirement to become a CHW is to get secondary education, but around two-thirds of them have a professional diploma. CHWs are most often recruited from within their own community. It is a stable and respectful profession and as a result, turnover is low.

A large body of evidence demonstrates the positive impact of CHWs on patient satisfaction and health literacy, notably for low-income and vulnerable groups (Wadge et al., 2016[32]; Grossman-Kahn et al., 2018[33]). CHWs have been key to effectively respond to the Zika virus for instance, providing health advice and incidence reporting. CHWs could thus have played a greater role to support the COVID-19 response.

So far, evidence shows that only an estimated 9% of CHWs have received infection control training and personal protective equipment during the pandemic. They have not been provided with clear guidance about their role in the COVID-19 response. The COVID-19 pandemic has revealed governance issues linked to the health sector, mainly due to a lack of leadership and oversight from the federal government. Risk communication from federal authorities has also been conflicting and confusing for the population and PHC workers, with no overall co-ordination (Lotta et al., 2020[34]).

2.4.6. Municipalities are responsible for hiring health professionals for PHC, with wide variations across the country

In the decentralised health care system, municipalities are responsible for the organisation, management and delivery of PHC services. In 2020, the federal government provided BRL 20.9 billion to the municipalities, which were then responsible for organising and delivering PHC services, by hiring FHT members as civil servants. As each municipality defines the level of salaries for health team members, there are wide wage variations across the country (Massuda et al., 2020[6]).

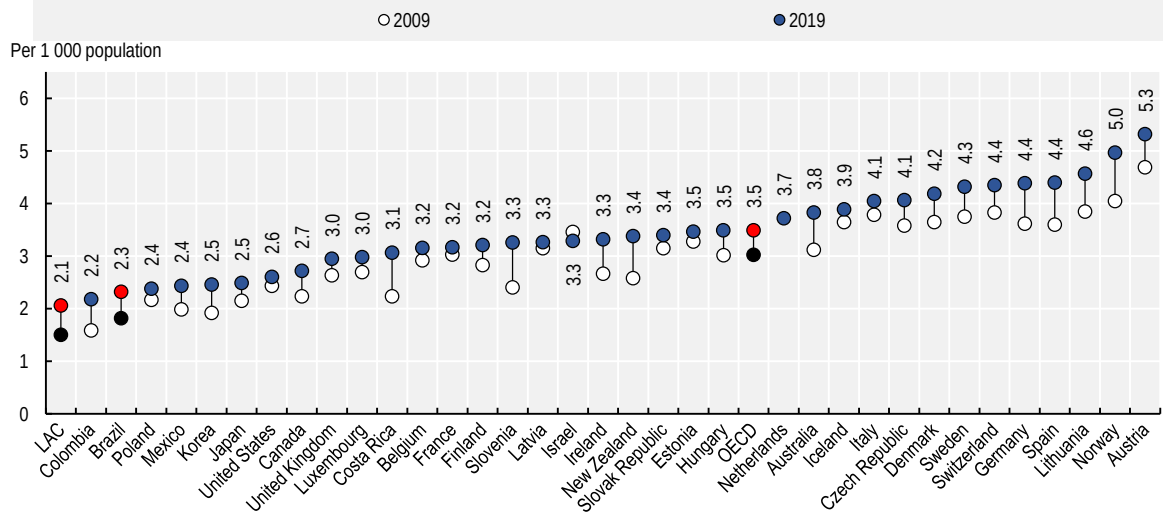
There are three types of possible contractual schemes with the municipality:

- Public officials: there are civil servants hired as statutory workers (there are salaried, with a stable position and there is a ceiling of money to pay them);
- Private workers hired by social organisations, non-profit private NGO (but anecdotal evidence suggests there are forms of corruption under such schemes),
- Private workers hired by Government owned social organisation NGO.

2.4.7. There are too few PHC physicians in Brazil

The number of trained PHC physicians is well below the OECD countries, and of other LAC countries. In Brazil, practicing doctors per 1 000 population in 2019 were very low compared to the OECD average, at 2.3 compared to 3.5 (Figure 2.10). This is among the lowest density, just above Colombia (with 2.2 doctors per 1 000 population) and the LAC average (2.1 doctor per 1 000 population). However, the number of doctors increased by 50% in Brazil over the past decade.

Figure 2.10. Doctors per 1 000 population, 2009 and 2019 (or latest year available)



Source: OECD (2021[12]), *Health Statistics Database*, http://stats.oecd.org; Brazilian Ministry of Health.

At the same time, while the specialty of family and community medicine was introduced as a clinical and licensed specialty, the number of PHC doctors has not increased accordingly. In Brazil, PHC is mostly delivered by physicians who do not have any specialty or by physicians with a specialty in internal medicine (see Chapter 5).

Table 2.3. Distribution of selected medical specialities per regions, 2018

	Physicians with no specialty training	Physicians with specialty training	Internal medicine (*Clinica Medica*)	Family and Community Medicine (*Medicina de Familia e comunidade*)
North	10118	10766	3.4%	4.6%
North East	34461	46162	18.0%	14.8%
South East	91124	153180	52.3%	43.1%
South	20948	47482	17.3%	31.6%
Central West	12828	24708	8.9%	5.8%
Total number	169479	282298	42728	5486
%	37.5% of all doctors	62.5% of all doctors	11.2% of all specialists	1.4% of all specialists

Source: Scheffer et al. (2018[35]), Demographia Médica No Brasil 2018.

In 2020, there are around 60 000 medical doctors working in PHC, alongside 50 000 nurses and 35 000 dentists currently in practice in Brazil. In 2018, only 5 486 medical doctors had a specialty training in family and community medicine, representing only 1.4% of all specialists in Brazil (see Table 2.3). Medical doctors specialised in internal medicine who have some competencies in family medicine to provide PHC, represent 11.2% of all specialists in Brazil. Lastly, there are 169 479 physicians, with no specialty training, representing around 37% of all medical doctors.

2.4.8. The uneven distribution of medical doctors is a major concern in Brazil

There is a marked disparity in the concentration of doctors in different regions and states, and between state capitals and other parts of states. Overall, there are 2.3 doctors per thousand population (Figure 2.10) but there are capitals with more than 12 doctors per thousand population – like Vitória, in Espírito Santo – and in the interior part of the Northeast region or in the Amazon with values below one doctor per thousand inhabitants. The Southeast is the region with the highest medical density per inhabitant (with 2.81 per thousand population), against 1.16 per thousand population in the North and 1.41 in the Northeast (Scheffer et al., 2018[35]).

Among states, the Federal District has the highest density with 4.35 doctors per thousand population, followed by Rio de Janeiro (with 3.55 doctors per thousand population), São Paulo (with 2.81), Rio Grande do South (with 2.56), Espírito Santo (with 2.40), and Minas Gerais (with 2.30). At the other end of the scale, are states of the North and Northeast. Maranhão presents the lowest density of medical doctors with 0.87 doctor per thousand population, followed by Pará with 0.97 doctor per thousand population (Scheffer et al., 2018[35]).

Geographical inequalities in the distribution of medical doctors hold true when looking at physicians with specialty training. Evidence indicates a clustering of PHC specialists in some regions: the best supplied regions are the South and Southeast Regions, followed by the Central-West (Scheffer et al., 2018[35]). Workforce imbalance across regions is analysed in further details in Chapter 5 of this report.

Several nationwide initiatives have attempted to address the imbalances in the distribution of health workers. Brazil introduced several programmes to improve access to medical training in underserved communities, including the 2001 Programme of the Interiorisation for Health Work (Programa de Interiorização do Trabalho em Saúde), the 2011 Programme for Valuing PHC Professionals (Programa de

Valorização dos Profissionais da Atenção) and the 2013 More Doctors Programmes (Programa Mais Médicos).

As described by Chapters 4 and 5 of this report, the More Doctor Programme (MDP) is considered as the world's largest government-led initiative that recruited domestic and foreign physicians to work in PHC settings within municipalities that typically faced difficulties in recruitment and retention. By November 2020, the programme was responsible for the presence of 16 426 doctors in 3 837 Brazilian municipalities. This programme has proven to have positive results, for instance, in terms of investment in PHC facilities, doctors availability and health outcomes (Hone et al., 2020[36]; Netto et al., 2018[37]).

On a less positive note, unfilled medical positions are still common in Brazil, even after the implementation of the MDP. In April 2019, it is estimated that 3 847 public sector medical positions in almost 3 000 municipalities remained unfilled (Scheffer et al., 2018[35]). Unfilled medical positions in the PHC sector certainly impede prevention, early diagnoses, the monitoring of children, pregnancies and the continuation of treatments for those having underlying health conditions.

2.5. Conclusion

In Brazil, the 5 570 municipalities handle the management, organisation and delivery of PHC. SUS offers preventive services and PHC free of charge for its population, based on multidisciplinary family health teams. Overall, the organisation of PHC delivery in Brazil is well aligned with modern approaches to PHC, which house multiple professionals with advanced skills working in teams. SUS prioritisation on PHC also permitted an easier contact with health services at the community level. The implementation of the Family Health Strategy, one of the largest community-based PHC programme worldwide, has contributed to increase population coverage, and led to measurable improvements in terms of infant mortality rates, maternal health, and avoidable hospitalisations. The life expectancy at birth in Brazil increased rapidly over the past decades – faster than across the OECD countries.

Despite major investments to improve access to PHC, health continue to be unequally distributed with people in North and Northeast regions suffering from poorer health outcomes. In part, these disparities are linked to workforce shortages and imbalances in the distribution of medical doctors, as well as lower PHC infrastructure and equipment in North and Northeast regions. There are also been a rise in the number of elderly patients and an increasing prevalence of chronic non-communicable diseases, which call for more effective prevention and stronger PHC to better manage the burden of chronic conditions. Brazil will need to continue to invest in a strong PHC system that is responsive to people's changing needs, capable of offering continuous, proactive and preventive care. The next four chapters set out in detail where changes are needed and how it can be achieved, notably to increase screening and prevention for the main chronic non-communicable diseases (Chapter 3), enhance the quality of PHC provision (Chapter 4), tackle workforce challenges in PHC (Chapter 5) and promote the digitalisation of PHC (Chapter 6).

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Notes

[1] The poverty rates is measured by the poverty headcount ratio at USD 5.50 a day (2011 PPP).

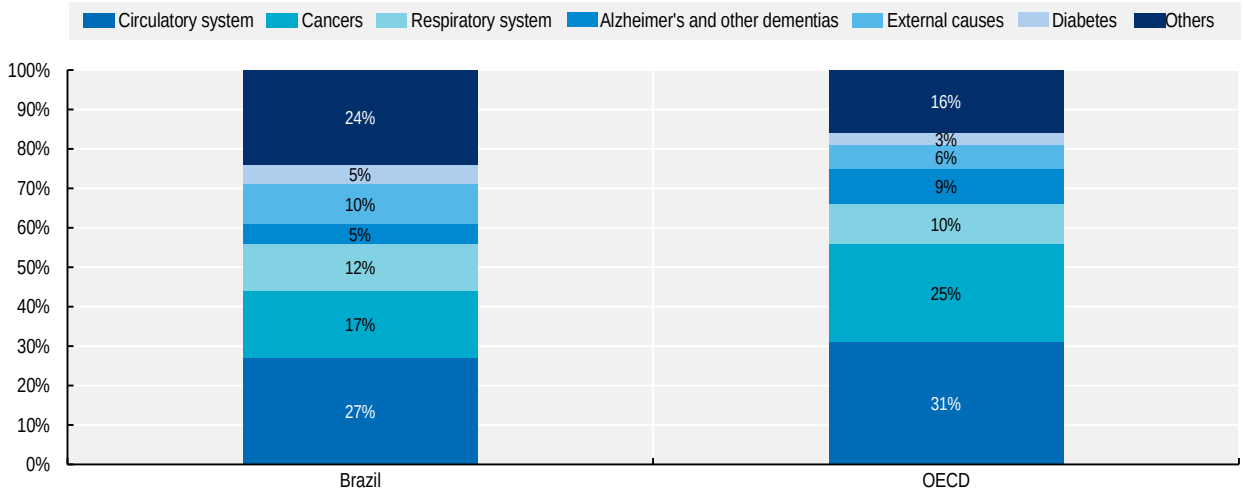
3 Screening in primary health care for the main chronic non-communicable diseases in Brazil

In Brazil, chronic non-communicable diseases such as cancer, diabetes and hypertension are of high public health importance. Brazil has already built mechanisms in the PHC sector to screen for some of the most epidemiologically relevant diseases. Some cancers, hypertension and diabetes have screening and prevention strategies, but more could be done to improve depth and scope of such strategies. Key priorities are to move towards population-based screening programmes for breast and cervical cancer, with a personalised approach and more communication strategies. In the area of diabetes and hypertension, Brazil will need to further develop disease management pathways with a people-centred perspective, integrating all health care providers across different sectors. Family health teams will need to have the right tools, capacities, and incentives to undertake these responsibilities. Last but not least, a more comprehensive information system based on registries, and allowing linking different data sources will also be important.

3.1. Introduction

In Brazil, as in other OECD countries, chronic non-communicable diseases such as cancer and cardiovascular diseases are of high public health importance. Diseases of the circulatory system was the leading cause of death in both Brazil and OECD countries in 2019 representing 27% and 31% of all deaths, respectively, followed by cancer representing 17% and 25% of all deaths. Diabetes in Brazil stands as the fifth cause of mortality with 5% of all deaths, higher than the 3% in OECD countries (Figure 3.1). This reflects the epidemiological transition from communicable to non-communicable diseases, where population ageing largely explains this mortality pattern but the prevalence of different risk factors and the performance of the health system play a relevant role as well.

Figure 3.1. Main causes of mortality in Brazil and the OECD, 2019



Source: OECD (2021[1]), Health Statistics Database, https://www.oecd.org/health/health-data.htm.

In this scenario, Brazil, based on its strong PHC system, has already built mechanisms to screen for some of the most epidemiologically relevant diseases. Some cancers, hypertension and diabetes are on this list, for which screening and prevention strategies have proven to be effective and cost-effective, becoming a very good public health intervention. However, many challenges remain, for instance, related to escalating coverage and expanding to new diseases.

This chapter begins by setting out the current cancer burden in Brazil, while exploring the strengths and weaknesses of Brazil cancer screening system. Next, it analyses the impact of hypertension and diabetes in Brazil's population health and health system, and addresses hypertension and type 2 diabetes screening in PHC as important interventions to control these medical conditions. Throughout the chapter, a series of recommendations on the policy priorities for Brazil when it comes to enhancing screening coverage and promoting early detection of these conditions are provided.

3.2. Cancer in Brazil has been recognised as a major public health challenge but much can be done in terms of prevention in PHC

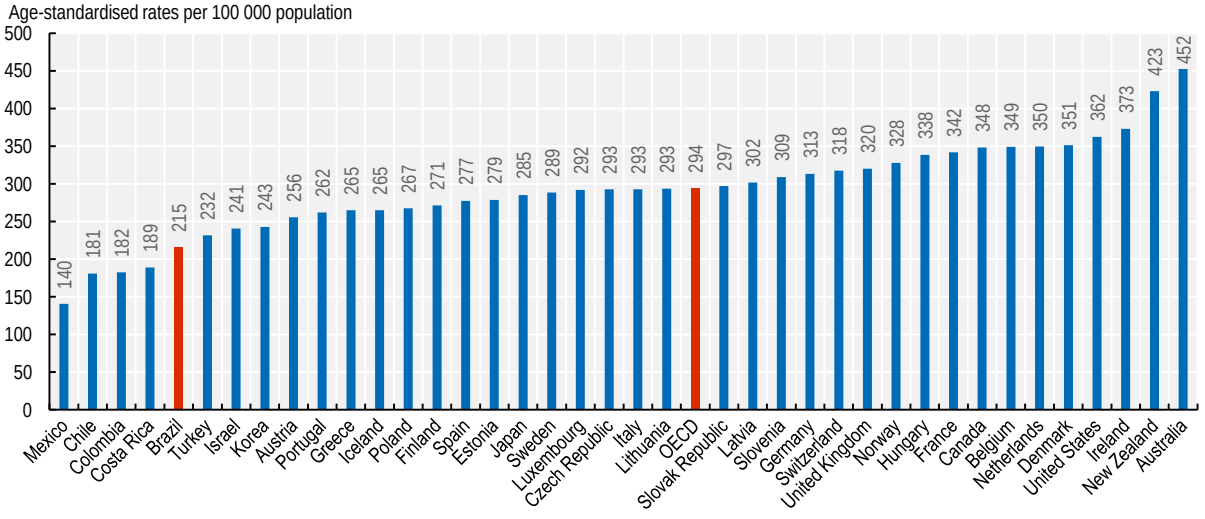
Cancer is the second highest cause of death across OECD countries, but its burden is increasing faster relative to the first cause of death, diseases of the circulatory system. The mortality rate of cardiovascular diseases has declined substantially over recent decades, while cancer mortality has also decreased but at

a slower pace (OECD, 2019[2]). This section summarises the incidence and mortality rates of cancer and their changes over time in Brazil compared to OECD countries to illustrate the relative importance of public health policies in Brazil.

3.2.1. Brazil has a lower cancer incidence than the OECD but mortality has remained stable when it has decreased in the vast majority of OECD countries

Cancer incidence rates vary across OECD countries from over 400 new cases per 100 000 people in Australia and New Zealand, to less than 200 cases in Mexico, Chile, Colombia and Costa Rica. Brazil stands at 215 new cases per 100 000 people, below the OECD average of 294 (Figure 3.2). It is important to notice that cross-country variations in incidence rates reflect differences not only in new cancers occurring each year but also disparities in national cancer screening policies, quality of cancer surveillance and reporting.

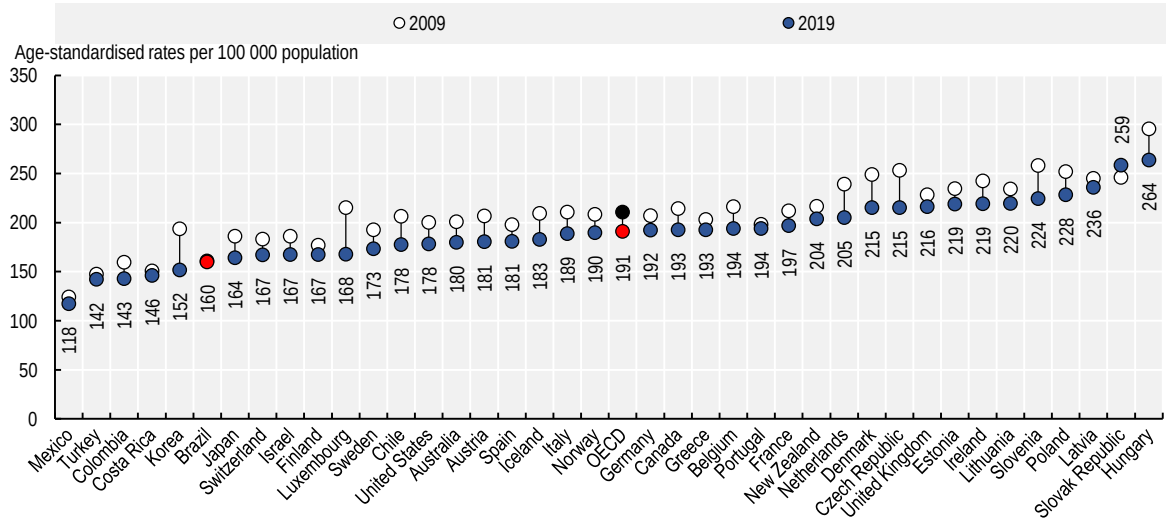
Figure 3.2. All cancer incidence in Brazil and OECD countries, 2020 (estimated)



Source: GLOBOCAN, (2020[3]), International Agency for Research on Cancer (IARC), https://gco.iarc.fr/.

Despite having a relatively low rate of cancer incidence, cancer mortality in Brazil has not been reduced in recent years. Between 2009 and 2019, Brazil´s cancer mortality passed from 161 to 162 deaths per 100 000 people, while the OECD average was reduced from 211 to 196. This decline was observed in most OECD countries, except in Chile and Turkey (Figure 3.3). The decrease of cancer mortality relates to early diagnosis, which puts a strong argument in favour of building effective screening schemes.

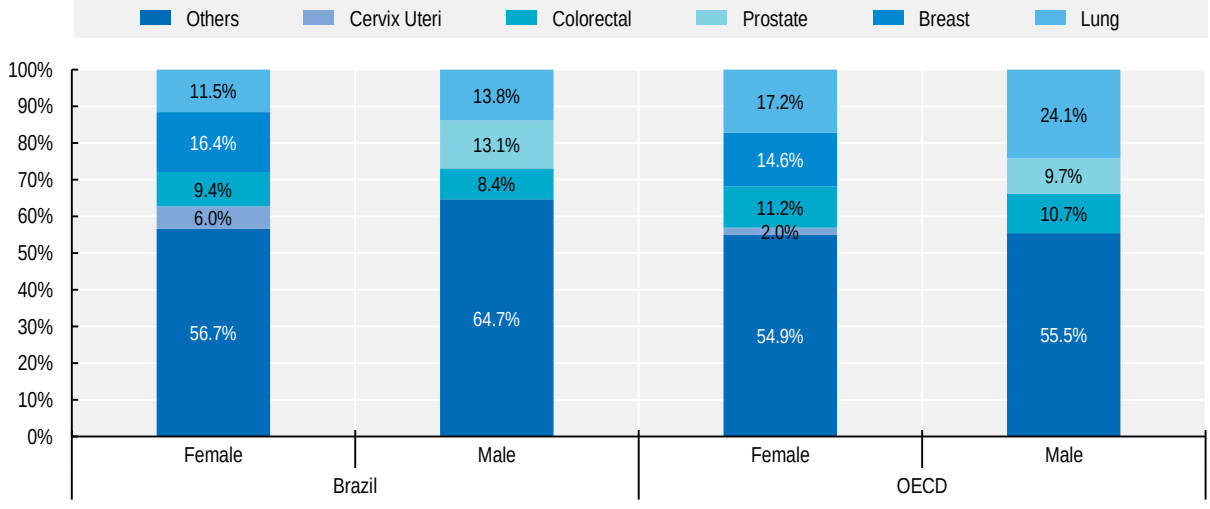
Figure 3.3. Cancer mortality in Brazil and OECD, 2009 and 2019 (or latest available year)



Source: OECD (2021[1]), Health Statistics Database, https://www.oecd.org/health/health-data.htm.

In Brazil, among women, breast cancer takes the largest toll among Brazilian women with 20.6 deaths per 100 000 females, representing 16.4% of all women's cancer deaths in 2019. It is followed by trachea, bronchus and lung cancer with 15.7 deaths per 100 000 females (11.5%); colorectal and anus cancer with 13.1 deaths per 100 000 females (9.4%); and cervical cancer with 7.4 deaths per 100 000 females (6%). In OECD countries, trachea, bronchus and lung cancer are in first place among women and the most relevant difference with Brazil can be found in cervical cancer that only accounts for 2% of all women's cancer deaths. Among men, trachea, bronchus and lung cancer explains the largest number of deaths in both Brazil and the OECD, but the proportion is higher in the latter with 24.1% versus 13.8% in Brazil. Prostate and colorectal and anus cancer are the second and third causes of cancer deaths among Brazil's men, while in the OECD colorectal and anus cancer takes the second place (Figure 3.4).

Figure 3.4. Main causes of cancer mortality by sex in Brazil and OECD countries 2019 (or nearest year)



Note: Colorectal includes colon, rectum and anus cancer. Lung includes trachea, bronchus and lung cancer.
Source: OECD (2021[1]), Health Statistics Database, https://www.oecd.org/health/health-data.htm.

As in OECD countries, age-standardised mortality rates in Brazil due to all cancers are higher among men than among women: 202.8 men's deaths per 100 000 males versus 135.8 women's deaths per 100 000 females. The gender difference in cancer mortality can be explained at least partly by higher prevalence of some risk factors among men.

3.2.2. Breast and cervical cancer have long-standing opportunistic screening programmes delivered mainly through PHC

The control of breast and cervical cancer in Brazil has decades of development, with National Cancer Institute (*Instituto Nacional de Câncer*, INCA) and the Ministry of Health as the main actors in terms of national planning, while PHC in municipalities have had the provision of care role. Importantly, cancer screening in Brazil is opportunistic, meaning that it does not happen within a population-based programme designed and managed at the central level to reach most of the population at risk, but as a result of a recommendation made by a health care provider during a routine medical consultation or by self-referral of individuals. A summary of the main historical developments of breast and cervical cancer screening is presented in Box 3.1.

Box 3.1. Almost 40 years of breast and cervical cancer screening in Brazil

The first actions towards breast and cervical cancer control can be traced back to 1984, when the Program of Integral Assistance to Women's Health (*Programa de Assistência Integral à Saúde da Mulher*), which proposed care beyond the traditional attention to the gravidic-puerperal cycle, included actions for the prevention of these two cancers. In 1986, an Oncology Programme was created and in 1991 was finally hosted in the INCA. In the 1990s and early 2000s, different pilot projects and programmes, mainly for cervical cancer were developed.

In 2005, the Ministry of Health launched the first National Oncology Care Policy (*Política Nacional de Atenção Oncológica*), with emphasis on cervical and breast cancer. The control of these cancers is now a priority on the country's health agenda and it is part of the Strategic Action Plan for Coping with Chronic Non-Communicable Diseases in Brazil, 2011-22 (*Plano de Ações Estratégicas para o Enfrentamento das Doenças Crônicas Não Transmissíveis no Brasil, 2011-22*).

In May 2013 occurred the latest update of the national cancer care policy, instituting the National Policy for the Prevention and Control of Cancer in the Health Care Network of People with Chronic Diseases in SUS (*Política Nacional para a Prevenção e Controle do Câncer, PNPCC, na Rede de Atenção à Saúde das Pessoas com Doenças Crônicas no âmbito do SUS*). That same year, the Cancer Information System (SISCAN) was created, a web platform version that integrates the Cervical Cancer Information Systems (SISCOLO) and Breast Cancer (SISMAMA).

More recently, in 2015 the guidelines for early detection of breast cancer, and in 2016 the national guidelines for cervical cancer screening and a manual for quality management of cytopathology laboratories were published.

Source: INCA (2020[4]).

In Brazil's PHC, cervical cancer screening is performed through a cytopathological examination (Pap smear), which is offered to women aged 25 to 64 years and who have already had sexual activity. The recommended routine for screening in Brazil is to repeat the Pap smear every three years, after two consecutive normal examinations performed at an interval of one year. The repetition in one year after the first test aims to reduce the possibility of a false negative result in the first round of screening. The three-year periodicity is based on the WHO recommendation and the guidelines of most countries with an

organised screening programme (INCA, 2016[5]). Table 3.1 summarises the characteristics of cervical cancer programmes in OECD countries.

Table 3.1. Target age and periodicity of cervical cancer screening in OECD countries, 2019

Every year	Every two years	Every three years	Every five years	Other
Czech Republic (15 and over), Greece (20 and over), Luxembourg (15 and over), Mexico (25-64), the Slovak Republic (23-64)	Australia (20-69), Japan (20 and over), Korea (30 and over), Latvia (25-70), Costa Rica (20-64)	Belgium (25-64), Chile (25-64), Denmark (23-50), France (25-65), Hungary (25-65), Iceland (23-65), Ireland (25-44), Israel (25-64), Italy (25-64), Lithuania (25-60), New Zealand (20-69), Slovenia: (20-64), Spain (30-39), Sweden (23-50), Switzerland (no age limit)	Denmark (51-64), Estonia (30-55), Finland (30-60), the Netherlands (30-60), Ireland (45-60), Norway (25-69), Spain (40-69), Turkey (30-65), England (25-64)	Canada: no periodicity (20-69). Germany: no periodicity (20 and over). USA: Every one, two or three years depending on the insurance coverage (21 and over).

Note: Target women's age in brackets.
Source: OECD (2021[1]), Health Statistics Database, https://www.oecd.org/health/health-data.htm.

As for breast cancer, the Brazilian Ministry of Health recommends a biennial mammogram for women aged 50 to 69 years as screening strategy in PHC. In addition, the Ministry of Health recommends against teaching self-examination as a method of screening, and also against screening using ultrasound, thermography, tomosynthesis and magnetic resonance imaging. To assure an early diagnosis of breast cancer, the Ministry of Health endorses that SUS actors develop awareness strategies, suggests urgent referral to diagnostic breast cancer services of patients with specific red-flag signs, and that all the services are to be provided in the same centre (Ministério da Saúde and INCA, 2017[6]). Table 3.2 summarises the target age and characteristics of breast cancer screening programmes in OECD countries.

Table 3.2. Target age in breast cancer screening programmes, 2018/19

Nationwide population-based		Population-based but not nationwide		Non-population-based
Wider age range (20 years+)	Narrower age range	Wider age range (20 years+)	Narrower age range	Wider age range (20 years+)
Australia (50-69), Belgium (50-69), Denmark (50-69), Finland (50-69), France (50-74), Germany (50-69), Hungary (45-65), Iceland (40-69), Israel (51-74), Korea (40+), Latvia (50-69), Lithuania (50-69), Luxembourg (50-69), the Netherlands (50-75), New Zealand (45-69), Norway (50-69), Poland (50-69), Portugal (45-69), Slovenia (50 69),Spain (50-69), Sweden (50-69)	England (53-69), Estonia (50-65), Ireland (50-64 but 50-69 by 2021), Northern Ireland (53-70), Wales (53-70)	Canada (50-69), Czech Republic (45+), Italy (50-69), Japan (40+), Mexico (50-69), Switzerland (50-70), Turkey (40-69)	Chile (50-64)	Greece (40+), the Slovak Republic (40-69) and United States (40 or 50+)

Note: Target women's age in brackets.
Source: OECD (2021[1]), Health Statistics Database, https://www.oecd.org/health/health-data.htm.

The financing of these screening programmes is made through the Ministry of Health, which allocates resources to federated entities (states and municipalities), with these chiefly municipalities responsible for managing and providing the services. In 2020, a new financing model for PHC (the *Previne Brasil* Programme) was instituted combining financial resources from weighted capitation, pay-for-performance and resources for actions in specific contexts (see Chapter 4 of the report). Within the pay-for-performance component (15% of total funding), one of the seven initial target indicators rewards the teams that perform cervical cancer screening.

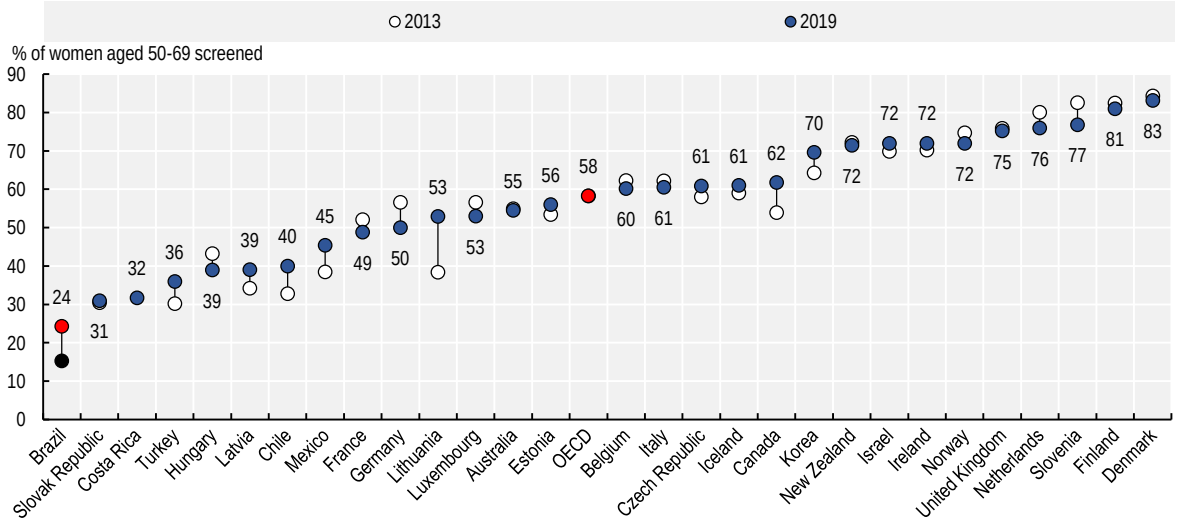
Regarding cancer information system, the PAINEL-Oncology is an instrument developed to monitor Law Nº12.732, of 22 November 2012, which establishes a 60 days maximum waiting time for the start of

treatment for patients with proven malignant neoplasia. The information on PAINEL-oncology refers to the time to start the first oncological treatment calculated from the information of the dates of diagnosis and treatment recorded. It also presents the cases diagnosed through pathological examinations. Cervical and breast cancer diagnosis information has been available since 2013 since the implementation of the Cancer Information System (Sistema de Informação do Câncer, SISCAN). For the other cancers, diagnostic information arising from biopsy or anatomo-pathologic (except for cervical and breast) is available from May 2018, but from other sources it was possible to calculate the time of onset of the first treatment from 2013 as well. The data presented in the PAINEL-oncology refers exclusively to users who have a national health master card (DATASUS, 2021[7]). In addition, a network of 17 Population-Based Cancer Registries, 16 located in capital cities and one of them in a non-capital city, provides crucial information about incidence, trends and survival (INCA, 2013[8]).

3.2.3. Breast and cervical cancer screening needs to drastically increase coverage among target populations

Screening for breast cancer in Brazil has improved in recent years. Between 2014 and 2019, it increased from 15.2% to 24.2% among the target group of women between 50 to 69 years of age. However, breast cancer screening coverage in Brazil is very low when compared to OECD countries, standing below all OECD countries and well below the 58% of average coverage (Figure 3.5).

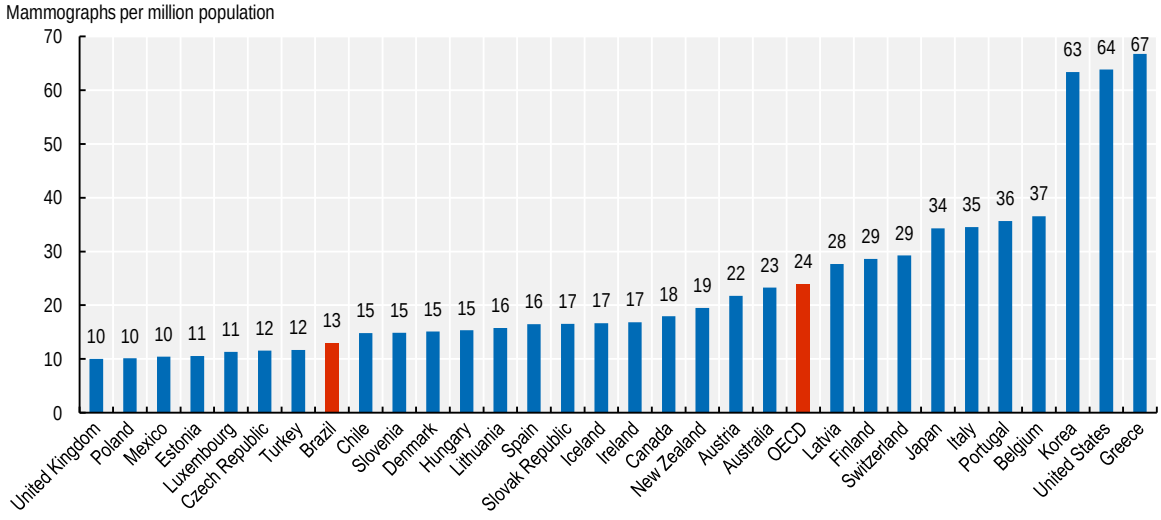
Figure 3.5. Breast cancer screening coverage in Brazil and OECD countries, 2013 and 2019



Note: Programme data is used for all countries. Brazil represent years 2014 and 2019.
Source: Ministry of Health for Brazil; OECD (2021[1]), Health Statistics Database, https://www.oecd.org/health/health-data.htm.

One of the key enablers for conducting breast cancer screening is the availability of mammography machines. In 2020, Brazil had 13 mammography machines per million people, almost half than that of the OECD average of 24 and close to the lowest availability of 10 in Mexico, Poland and the United Kingdom (Figure 3.6). This finding shows that Brazil has space to put more investment into medical technologies aiming to improve equitable access for the population. At the same time, such expansion in access can be accompanied by the development of regulatory frameworks in the areas of registration, assessment and purchasing rules. The existence of updated clinical guidelines for breast cancer screening in Brazil is a step ahead in the necessary task of promoting rational use of diagnostic technologies aiming to reduce the use of unnecessary diagnostic tests and subsequent procedures and treatments.

Figure 3.6. Availability of mammography machines in Brazil and OECD countries, 2019 (or latest year available)



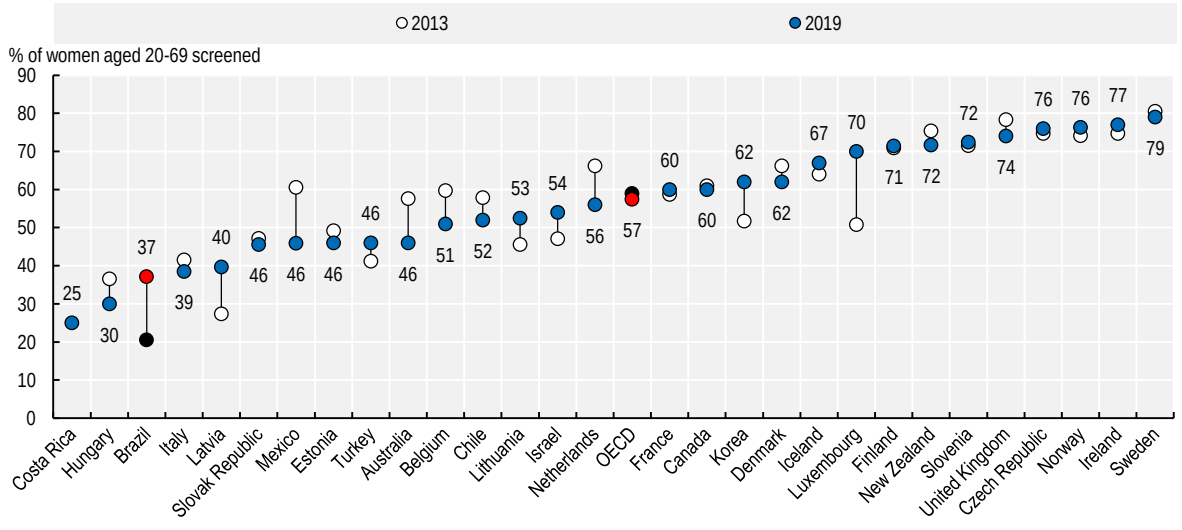
Note: Brazil represents year 2020.
Source: Colégio Brasileiro de Radiologia e Diagnóstico por Imagem; OECD (2021[1]), Health Statistics Database, https://www.oecd.org/health/health-data.htm.

A systematic review including 30 studies identified the main health system factors that led to a late diagnosis of breast cancer in Brazil (Da Costa Vieira, Formenton and Bertolini, 2017[9]). Results highlighted problems related to the distribution of mammography machines, with a higher proportion of unused mammography machines in the North and Northeast of Brazil, and that most mammography occurred in the private sector. Another study analysing the National Health Survey 2013 found that 59.4% of women users of SUS and 83.9% of women with private health insurance declared having a medical request for a mammography. Having private health insurance, higher education level, and being white were positively associated with having this medical request (Silva et al., 2017[10]). These findings highlight some of the problems with the health system organisation and with social inequities found in Brazil.

Cervical cancer screening in Brazil has substantially improved from 20.5% in 2014 to 37% in 2019. Yet, it also remains well below the OECD average coverage of 57% and below all OECD countries, except Costa Rica and Hungary (Figure 3.7).

A study that performed a trend analysis of the cervical cancer screening program's quality indicators in all Brazilian regions and states from 2006 to 2013, found that the estimated target population who underwent Pap testing was lower than that recommended by international guidelines in the North, Northeast and Central-West regions. The trends for this indicator remained stationary over the years in all regions of Brazil. Authors concluded that "the cervical cancer screening programme is still far from efficient" (Costa et al., 2018[11]). Another study using data for 2008 found that rural areas were more likely to have never received a Pap smear screening, while North and Northeast regions showed the highest prevalence of never-screened women. Poorer, less educated, non-white skin colour and younger women were less screened as well, showing the patterns of social inequities (Martínez-Mesa et al., 2013[12]).

Figure 3.7. Cervical cancer screening in Brazil and OECD, 2013 and 2019



Note: Programme data is used. Brazil represent years 2014 and 2019.
Source: Ministry of Health for Brazil; OECD (2021[1]), Health Statistics Database, https://www.oecd.org/health/health-data.htm.

3.2.4. Brazilian society is quite active and key stakeholders are regularly involved in decision making around cancer control issues

Brazil has good examples of stakeholder involvement for cancer policies. Voices of local and regional stakeholders such as municipal and state administrations and health care providers are represented in institutional spaces such as the National Health Council, CONASS and CONASEMS. In addition, representatives of the civil society and users of SUS apply the so-called democratic social control by participating in the National Health Conference, the Councils of Rights and the Councils of Health. The last two have expression at the federal, state and municipal levels (Ministério da Saúde, 2013[13]). Among the topics included, cancer regularly takes part of the agenda.

INCA develops several initiatives to engage civil society. The institution has a Consultative Council (Conselho Consultivo, CONSINCA) with representatives from technical-scientific entities related to cancer prevention and control; SUS service providers; SUS management councils; and SUS users. In recent years, INCA has organised conferences in different parts of the country with women's movements aiming to introduce the issue of cancer control into their working plans. Moreover, INCA has convened meetings with journalists with the objective of discussing the best ways to communicate information related to cancer control, including special meetings with radio managers of the North of Brazil, since in this region radios have a large audience in the population.

"All Together Against Cancer" (*Todos Juntos Contra o Câncer*) (TJCC, 2021[14]) is a civil society movement that brings together representatives of different sectors, such as health managers, medical entities, hospitals, professional associations, researchers, media professionals, patient organisations, and others, committed to guaranteeing the patient's right to universal and equal access to health care. The movement develops several initiatives to assure the implementation of the National Policy for Cancer Prevention and Control, including the areas related to prevention and screening.

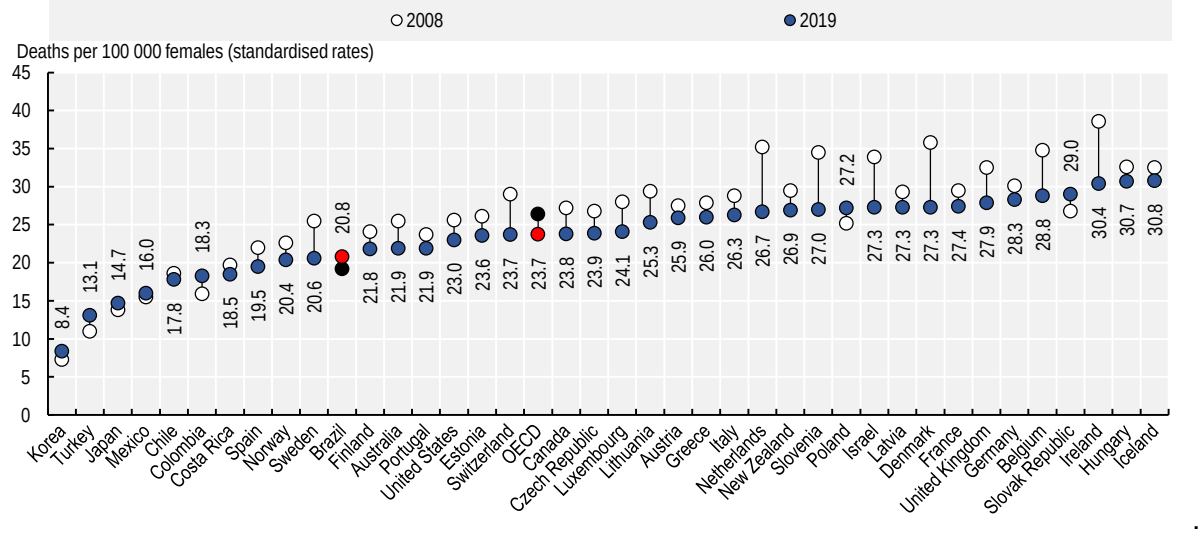
From the private sector, the "System S" carries out actions aimed at supporting promotion, prevention and treatment of cancer. The "System S" refers to nine institutions that are independently managed by business federations and confederations of the main sectors of the economy. Although they provide services of

public interest (e.g. education, social services, transport, etc.), these entities are not linked to any sphere of government, providing them a different space of action.

3.2.5. Despite prevention initiatives, breast and cervical cancer outcomes remain relatively poor with mortality increasing and survival decreasing in recent years

Between 2008 and 2019, breast cancer mortality increased from 19.2 to 20.8 deaths per 100 000 women in Brazil (+8.3%), which is the opposite of what happened as an average amongst OECD countries: a decrease from 26.4 to 23.7 (-10%). Only eight out of the 37 OECD countries experienced a growth in breast cancer mortality, with Turkey, Colombia and Korea having an increase of 15% or more in the period (see Figure 3.8). Despite Brazil's breast cancer mortality is lower than the OECD average, the increasing trend is worrisome.

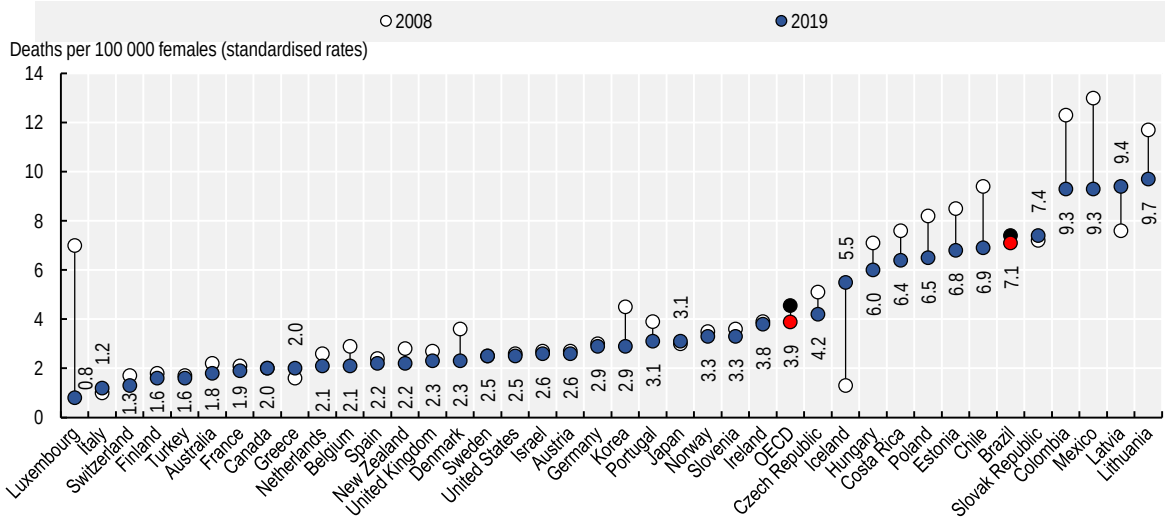
Figure 3.8. Breast cancer mortality in Brazil and OECD countries, 2008 and 2019



Source: OECD (2021[1]), Health Statistics Database, https://www.oecd.org/health/health-data.htm.

The picture for cervical cancer mortality in Brazil seems more problematic. Between 2008 and 2019, mortality remained stable around 7.1 and 7.4 deaths per 100 000 women, compared to a decrease in OECD countries from 4.6 to 3.9 (-14.7%). Only seven out of 37 OECD countries experienced an increase, with Iceland, Greece, Italy and Latvia increasing by 15% or more (see Figure 3.9). In this case, Brazil's cervical cancer mortality is substantially higher than the OECD average.

Figure 3.9. Cervical cancer mortality in Brazil and OECD countries, 2008 and 2019



Source: OECD (2021[1]), Health Statistics Database, https://www.oecd.org/health/health-data.htm.

These worrying trends are also observed in terms of 5-year net cancer survival. In all the selected cancer sites, Brazil has lower survival rates compared to OECD averages. Comparing the 2005-09 and 2010-14 periods, breast cancer survival dropped by more than two years in Brazil, while in the OECD it increased by one year. Colon cancer survival also decreased by more than two years, when in the OECD it increased by almost two years. Cervical cancer survival decreased by 11.3% and lung cancer survival declined by 11% in Brazil between 2000-04 and 2010-14, while in the OECD they both increased by 1.5% and 24.8%, respectively (Table 3.3).

Table 3.3. Trends in survival for breast, cervical, colon and lung cancer in Brazil and the OECD

Five-year net survival, population aged 15 and over

	2000-04	2005-09	2010-14
Brazil Breast	73.4	77.1	74.9
OECD Breast	81.0	83.3	84.3
Brazil Cervical	67.5	62.6	59.9
OECD Cervical	64.5	65.3	65.5
Brazil Colon	44.5	50.6	48.3
OECD Colon	56.1	59.4	61.2
Brazil Lung	9.1	8.5	8.1
OECD Lung	13.7	15.3	17.1

Note: Data for breast cancer considers only female population.
Source: CONCORD programme, London School of Hygiene and Tropical Medicine.

3.2.6. HPV vaccination has been very positive but it can be enhanced

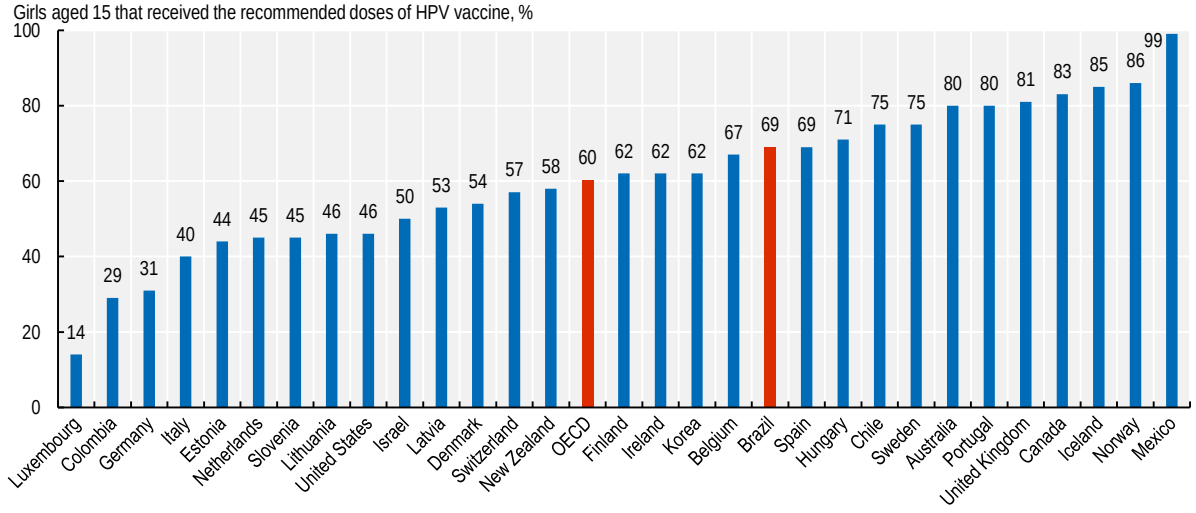
In 2014, the Ministry of Health, through the National Immunization Program, started the vaccination campaign for girls between 9 and 13 years against the Human Papilloma Virus (HPV). In 2017, girls aged 14 and boys between 11 and 14 years old were included as well. The vaccine is quadrivalent, which offers protection against HPV subtypes 6, 11, 16 and 18, preventing diseases such as precancerous lesions, cancer of the cervix, vulva and vagina, anus and genital warts. The vaccine is offered by SUS in

Basic Health Units and in vaccination campaigns in schools. The Practical Guide on HPV – Questions and Answers was launched by the National Immunisation Programme, in collaboration with INCA, seeking to clarify the main doubts on the subject (INCA, 2020[15]).

In 2018, coverage of HPV vaccine in Brazil was 69%, above the OECD average of 60% (see Figure 3.10). However, it is below the target coverage of 80% that was defined by Brazilian authorities (INCA, 2020[15]).

Figure 3.10. Human papilloma virus vaccine coverage in Brazil and OECD countries, 2018

Girls aged 15 that received the recommended doses of HPV vaccine, percentage



Source: Global Health Observatory: Explore a world of health data. (WHO, 2021[16]), https://www.who.int/data/gho.

Although not yet available to be applied, ANVISA has already approved a new vaccine against HPV, which protects against nine types of virus. It is offered for girls from 9 to 14 years old and boys from 11 to 14 years old, for people with HIV – AIDS in the age group of 9 to 26 years old. The vaccination schedule is three doses (interval of 0, 2 and 6 months). Other age groups may have vaccines available at private services, if indicated by their doctors.

3.2.7. A national strategy for cancer prevention and screening in PHC would synergise efforts to improve cancer outcomes in Brazil

Brazil can develop a single national strategy addressing cancer prevention and screening in PHC. Scientific evidence and social participation can be two key guiding principles in order to move towards population-based screening programmes. This strategy can consider the renewal of existing screening programmes for cervical and breast cancer; the expansion to new cancer sites such as colon and lung; the introduction of systematic personalised screening invitation letters and reminders; the redesign of cancer information systems; and the use of information and communication technologies to improve public awareness and health literacy.

Brazil can move towards a population-based cervical cancer screening programme, while introducing HPV-DNA primary testing in PHC settings

In the area of cervical cancer screening, especially after the introduction of the HPV vaccine, Brazil could consider instituting primary testing for the DNA of oncogenic HPV types as novel method for screening.

This would ideally require moving towards a population-based screening programme, further analysing the current epidemiology in the country and conducting a complete health technology assessment to understand the different factors that will determine the efficacy and cost-effectiveness of implementing such an organised programme. It would be important to use reliable, validated HPV tests in qualified laboratories, accredited by authorised accreditation bodies (e.g. ANVISA) and in compliance with international standards. Training for health workers would be another crucial component, along with communication strategies for women in target population.

A recent systematic review focusing in low- and middle-income countries found that cytology-based screening was the least effective and most costly screening method, while self-collected HPV testing was cost-effective when it yielded population coverage gains over other screening methods. The cost of the HPV test and loss to follow-up were also important factors (Mezei et al., 2017[17]). The European guidelines recommend the use of HPV primary testing within an organised, population-based programme for cervical cancer screening, avoiding co-testing (HPV and cytology primary testing) at any given age (von Karsa et al., 2015[18]). The American Cancer Society 2020 guidelines also recommends HPV primary testing as the preferred screening method (Fontham et al., 2020[19]).

Such a national strategy should include quality assurance in monitoring cervical cancer screening performance. The European guidelines define such a performance through achieving: (1) an invitation coverage of at least 95% of the target women; (2) an examination coverage of at least 70% (85% is desirable); and (3) a participation rate of at least 70% (85% is desirable) (von Karsa et al., 2015[18]). Box 3.2 summarises the experience of Finland and Italy with implementing HPV testing.

Box 3.2. HPV primary screening test programme in Finland and Italy

In Finland, women of 30-60 years of age are invited to take part in cervical cancer screening every five years. Some municipalities also invite women aged 25 and/or 65 for screening. About 70% of those invited participate in the screening for cervical cancer. The conventional cervical screening test used in Finland has been the Pap test, while the HPV test is applicable to cervical cancer screening for women over the age of 35. Samples for HPV and Pap are taken from participants in the HPV screening. Following a positive HPV test, the Pap sample is also analysed, after which any further management required is decided. The screening HPV test must meet the requirements of the IARC and WHO. Before being implemented, the validity of new HPV tests must always be verified by comparing them with the most studied HC2 or PCR GP5+/6+ tests. A referral to colposcopy is given to about 1% of the participants. Additionally, about 5% are invited for a follow-up test before the next screening invitation. An annual review provides a comprehensive overview of the Finnish cervical cancer screening programme, presenting information about attendance, outcomes, time series and costs of screening. The history of cervical cancer screening in Finland and its impact on cancer burden is also discussed.

In 2013, based on a health technology assessment report, the Italian Ministry of Health included HPV test every five years as an option for screening programmes for women of over 30 years of age. Stand-alone HPV was defined as primary test, with cytology only to be used as triage test in HPV+ women. Women with negative findings in the cytology analysis are invited for repeat HPV testing after 12 months and referred to colposcopy if still positive. The National Prevention Plan 2014-18 put as an objective the full implementation of HPV-based screening by 2018.

Source: Finnish Cancer Registry (2020[20]), Cervical cancer screening – Syöpärekisteri, https://cancerregistry.fi/screening/cervical-cancer-screening; Ronco (2020[21]), Core elements of the new HPV-based cervical cancer screening programme in Italy, https://www.hpvworld.com/articles/core-elements-of-the-new-hpv-based-cervical-cancer-screening-programme-in-italy.

Self-sampling with HPV testing has been explored as a novel strategy to increase screening coverage and could be considered in Brazil, for instance, within pilot studies. A systematic review including 34 studies, mostly from high-income countries, found greater screening uptake among HPV self-sampling participants compared with standard of care (e.g. Pap smear, visual inspection with acetic acid, clinician-collected HPV testing) (RR: 2.13, 95% CI 1.89 to 2.40). Uptake was higher when HPV self-sampling kits were sent directly to women's homes (RR: 2.27, 95% CI 1.89 to 2.71) or offered door-to-door by a health worker (RR: 2.37, 95% CI 1.12 to 5.03). However, meta-analysis showed no statistically significant difference in linkage to clinical assessment/treatment between arms (RR: 1.12, 95% CI 0.80 to 1.57) (Yeh et al., 2019[22]). The European guidelines state that the clinical accuracy of HPV primary testing on self-collected samples is sufficient to conduct pilot programmes (von Karsa et al., 2015[18]), while the American Cancer Society did not include a recommendation about it because the Food and Drug Administration has not yet approved self-sampling (Fontham et al., 2020[19]).

Brazil already has practical experiences with using HPV-DNA testing for screening. For instance, a study evaluated HPV-DNA screening in São Paulo, including 16 102 women, finding that high-risk HPV-DNA prevalence was 14.9%, whereas cytology abnormalities were found in 7.2% of the women. HPV DNA detected a significant number of patients with premalignant lesions missed by cytology and all 16 cervical intraepithelial neoplasia positive cases were HPV-DNA+. Authors concluded that HPV genotyping may reduce the burden of colposcopic referral and that HPV-DNA testing was shown to be feasible and advantageous over current cytologic screening in the public health system (Levi et al., 2019[23]). Another study conducted in three Brazilian cities found that the most relevant barriers for a more comprehensive screening programme relates to excessive travel required to access clinics, inconvenient service hours, and lack of public education. In addition, cytology had many unsatisfactory results and low positivity, follow-up was incomplete at all steps and laboratories provided delayed cytology and biopsy results (3+ months). Finally, screening clinics did not arrange or track colposcopy referrals; colposcopy clinics received no information from referring clinics, and electronic medical records have not yet replaced paper recordkeeping, leading to errors and loss of medical records (Ribeiro et al., 2018[24]). The identification of these and other barriers would be very important for policy design and an eventual implementation phase.

Breast cancer screening can evolve to a population-based organised programme and more tools can be provided in PHC

As in the vast majority of OECD countries (see Table 3.2), Brazil can develop a population-based breast cancer screening programme. In practice, this would require an effective call-recall structure, device a screening registry and safeguard robust quality assurance at all levels. The current process for population's registration in Brazil's PHC goes in the direction of individually identifying the eligible target population in each area served (e.g. municipalities), so it represents an opportunity for developing organised screening programmes.

The European guidelines on breast cancer screening and diagnosis describes seven characteristics of an organised screening programme (ECIBC, 2020[25]): 1. a policy specifying target population; 2. screening method and interval; 3. an active invitation of the entire target population; 4. a team responsible for overseeing screening centres; 5. a decision structure and responsibility for health care management; 6. a quality assurance system utilising relevant data; and 7. monitoring of cancer occurrence in the target population.

Building capacity in PHC teams would be crucial. As stated by WHO guidelines (WHO, 2017[26]), early diagnosis capacities requires guidelines or protocols and sensitise providers to cancer signs and symptoms to improve diagnostic accuracy; give sufficient time to evaluate patients and train practitioners in how to diagnose cancer including use of medical devices; promote a clear communication between the provider and the patient; and develop reliable referral mechanisms. In addition, mammography machines

distribution across the country should be also revised to achieve a balanced supply according to the population's need.

Brazil could build up from local experiences that have made progress towards an organised screening programme. For instance, a breast cancer organised screening programme in the community of the Andaraí in Rio de Janeiro targeting asymptomatic women aged between 50-69 years from SUS presented a mammographic coverage rate of 70%, suggesting that a population-based screening is feasible (Gioia et al., 2018[27]).

Systematic personalised invitations and reminders from PHC teams could improve cancer screening coverage

As part of population-based organised screening programmes, Brazil could adopt a more systematic and personalised approach in inviting target populations, as has been implemented in many OECD countries. An increasing number of OECD countries send a personal invitation letter for cancer screening to each individual in the target group, issued through a registry in a systematic manner. In Brazil, however, there is no national initiative regarding such invitations, which in practice are only implemented in some local levels depending on the initiative of particular municipalities or PHC teams.

In the majority of OECD countries, the invitation letter includes information on the benefits and potential harms of cancer screening such as false-positive screening results, over-diagnosis and over-treatment, and asks for either signed or verbal informed consent for screening (IARC, 2017[28]). This practice is in accordance with international recommendations as the WHO recommends organised population-based mammography screening programmes to provide information on both benefits and risks of mammography screening so that target women are able to make an informed decision before undergoing mammography (WHO, 2014[29]). In many OECD countries, additional efforts are also made to invite people with positive screening results in the past for follow-up assessment, and in some countries such as Denmark, Finland, Germany, Ireland, Italy, the Netherlands, Spain, Sweden and the United Kingdom, appointment date is fixed for mammography in the letter to further facilitate access to cancer screening (IARC, 2017[28]; ECIBC, 2020[30]).

A systematic review identified the most effective interventions to increase participation in organised screening programmes. Interventions such as postal reminders, telephone reminders, PHC physician's signature on invitation letter, and giving scheduled appointment instead of open appointment were all effective to increase uptake of breast, cervical and colon cancer screening. Mailing a kit for self-sampling cervical specimens increased participation in non-responders as well (Camilloni et al., 2013[31]). Another systematic review found that text messaging (short message service, SMS) appear to moderately increase screening rates for breast and cervical cancer and may have a small effect on colorectal cancer screening (Uy et al., 2017[32]). Future studies would also need to examine the cost associated with each of the invitation options and its impact in order to identify the most appropriate cost-effective strategies that may be different across regions in Brazil.

Screening in Brazil's PHC could explore expanding to sites such as colon and lung cancer

As colorectal and lung cancer are among the most important cancers in the country (see Figure 3.4), Brazil could explore the possibility of creating national screening programmes for these cancer sites.

For colorectal cancer, which represents the third major cause of cancer mortality in Brazil for men and women, opportunistic screening is available. The recommendation in SUS is to prioritise early diagnosis actions and personalised approach for high-risk groups. Recognising Brazil's different epidemiological and health care network realities, further studies are still needed to support the analysis of the feasibility of introducing screening in these different contexts (INCA, 2019[33]).

As reference, an increasing number of OECD countries have introduced population-based colorectal cancer screening programme for free to target population in recent years, and in many of these countries target population is the population of 50s and 60s years of age often with an upper age limit ranging between 64 and 74 (OECD, 2013[34]). The European guidelines recommend "only organised screening programmes should be implemented, as opposed to case-finding or opportunistic screening as only organised programmes can be properly quality assured". It also states that several issues should be considered: the legal framework, the availability and accuracy of epidemiological and demographic data, the availability of quality-assured services for diagnosis and treatment, promotional efforts, a working relationship with the local cancer registry, and follow-up for causes of death at individual level (Malila, Senore and Armaroli, 2012[35]). The United States recommends that adults age 50 to 75 be screened for colorectal cancer, either with stool tests, flexible sigmoidoscopy, colonoscopy, and CT colonography (virtual colonoscopy) (USPSTF, 2021[36]), varying depending on the patient's history and health system availability (Bibbins-Domingo et al., 2016[37]).

In relation to lung cancer, which represent the second cause of cancer deaths in Brazil (see Figure 3.4), general population screening is not currently recommended in the country and any examination should be discussed between the patient and the doctor (INCA, 2020[38]). Lung cancer screening is not common in OECD countries, but it exists in Canada, Japan and the United States. The Canadian Task Force on Preventive Health Care recommends screening for lung cancer with three consecutive annual low-dose computed tomography (LDCT) scans in high-risk individuals adults aged 55-74 years who currently smoke or quit less than 15 years ago, with a smoking history of at least 30 pack-years (CTFPHC, 2016[39]). In Japan, annual chest X-ray is recommended for people aged 40 and over, and sputum cytology is also recommended for smokers aged 50 and over who have smoked more than 600 cigarettes over their lifetime (OECD, 2019[40]). In the United States, the USPSTF released an updated recommendation in March 2021. Lung cancer screening is recommended as an annual screening with LDCT in adults aged 50 to 80 years who have a 20 pack-year smoking history and currently smoke or have quit within the past 15 years. Screening should be discontinued once a person has not smoked for 15 years or develops a health problem that substantially limits life expectancy or the ability or willingness to have curative lung surgery (USPSTF, 2021[36]).

Brazil could develop a thorough evidence-based analysis, including cost-effectiveness studies, to identify the potential harms and benefits of implementing colorectal and/or lung cancer screening in the country, along with appropriate definitions in areas such as eligibility criteria, screening intervals, existing local initiatives, monitoring schemes and quality improvement, infrastructure and equipment, and payment mechanism.

A redesign of cancer information systems can help manage screening programmes more effectively

Brazil has developed a monitoring system for cancer screening (SISCAN), cancer care (PAINEL-Oncologia) and population-level cancer epidemiology (Population-based cancer registry), which provides a good information infrastructure base. In addition, population-based surveys (Vigitel) regularly collect screening coverage and barriers to screening in view of seeking ways to increase screening coverage.

The main challenges for the cancer information infrastructure in Brazil, including screening information, relates to coverage, interconnectedness and feedback. Coverage aims to reach the full extent of the target population for each screening programme (including actions in the private sector). Interconnection challenges relate to linking existing information systems, for which an expansion of the national health card would be fundamental. Feedback to different actors in the health system, importantly to all PHC teams, is crucial to ensure that decisions and actions are informed by regular and updated information.

A comprehensive information system based on registries, capable of following each patient individually, is essential for efficient management of screening programmes and cancer care delivery. It can identify target

population who have and have not participated in the screening programmes, those who are monitored outside of the programme due to their previous diagnosis of cancer and/or genetic predisposition to specific cancer and those who do not consent to do screening. Using such a system, personalised invitations and reminders for cancer screening, which are important for increasing screening coverage, can be sent systematically to target population.

Integrated information systems generate data that need to be analysed periodically to assess the effectiveness of existing cancer screening protocols such as target group, screening frequency and/or methods and across population with different background. Brazil has started producing this data, which is also publicly available on line through DATASUS. Several OECD countries use information around cancer screening to improve quality of screening programmes as well. They provide feedback to individual providers and benchmarking is also possible. A systematic literature review supports these additional efforts as it found that provider assessment and feedback contribute to increased coverage for cervical, breast and colorectal cancer screening (Sabatino et al., 2012[41]).

Better information and communication technologies could improve public awareness and health literacy

Alongside more personalised invitation to cancer screening, Brazil could develop further communication and information-sharing strategies to improve public awareness on cancer prevention and screening and health literacy of the population. Since 2002, the Ministry of Health of Brazil has been investing annually in actions to raise awareness of cancer prevention measures, for instance, through the October Pink Campaign. The campaign consists of lighting buildings and monuments conveying the message "Prevention is necessary", while also promoting healthy lifestyle among women, encouraging HPV vaccination, overcome fear or stigma associated with cancer, among other topics.

Box 3.3. Sundhed.dk, the Danish e-health portal to support transparency and patient empowerment

Sundhed.dk, the Danish e-health portal launched in 2003, is the official website for the public Danish health care services and enables patients and health care professionals to find information and communicate. It is a public internet-based 24/7 portal that collects and distributes health care information among citizens and health care professionals. In a secure part of the portal the patient has access to:

- Personal health data on treatments and notes from hospital records, information about medication, laboratory test results, vaccination data and visits to the general practitioner (GP);
- Various e-services including making appointments with GP's, prescription renewals and electronic communication with the GP;
- Information on waiting times at all public hospitals and ratings of hospitals in terms of patient experienced quality;
- Patient networks and the sundhed.dk handbook for patients.

This portal brings the entire Danish health care sector together and provides an accessible setting for citizens and health care professionals to meet and efficiently exchange information. By serving both the citizens and the health professionals, the portals aim is to enable the two to achieve co-operation based on the same data. This empowers the citizen and gives the health professionals better tools to improve quality in care (OECD, 2013[34]; European Observatory on Health Systems and Policies and Petersen, 2019[42]).

Municipalities, with support from the State and the Federal Government, works to promote screening tests, through campaigns using printed media, social networks and local media. During determined periods in the year, some municipalities implement mobile units, which go to communities in the most distant parts of the country as a mean of increasing screening access, diagnosis and treatment. In addition, INCA has developed manuals or flyers that are sent to PHC teams every year for informing the public in the community and at work about healthy lifestyles to prevent cancer and the importance of early detection for cancer. INCA also develops videos and written material that is publicly disseminated in websites and social media.

As systematic sharing of information related to cancer is limited, particularly for cancer without screening programmes, Brazil could also better develop information-sharing strategies to help patients to seek care, including cancer diagnostic services, at the right place at the right time. In this context, an increasing number of OECD countries have developed information-sharing platforms to better involve and enable patients in taking care of their own health and navigating through health care systems for their conditions. For example, some OECD countries including Denmark (see Box 3.3), England and Estonia have developed a platform such as a website or e-Health account to share evidence-based information on health care for different diseases including cancer throughout patient pathway with a view to promoting health literacy of the population and to support them to seek health care including cancer screening, diagnosis and treatment appropriately in a timely manner.

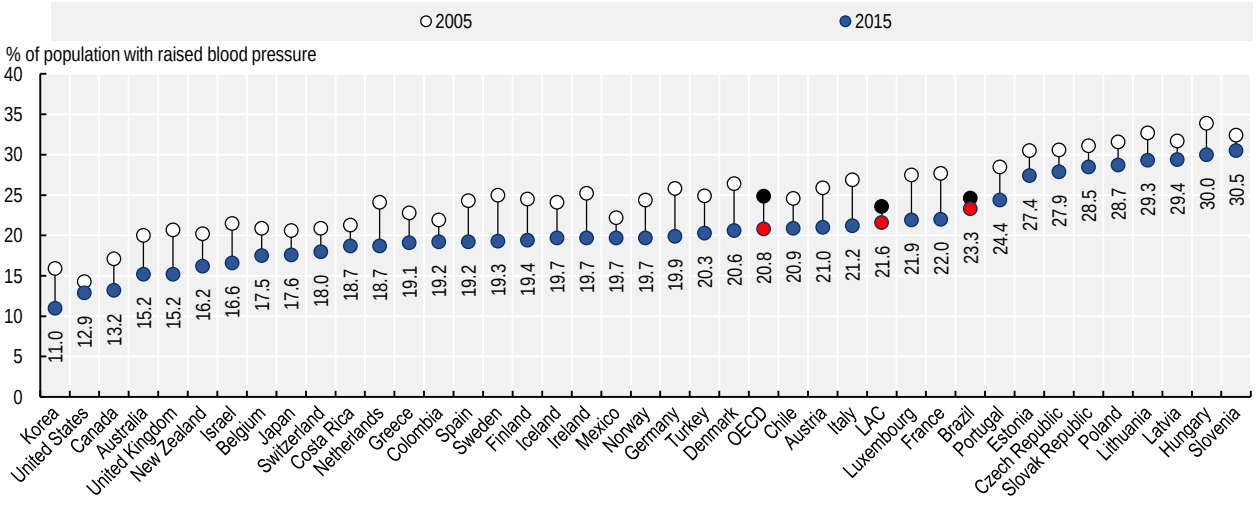
3.3. Screening for hypertension and diabetes can be further strengthened at the PHC level

3.3.1. Hypertension is one of the major health risk factors in Brazil

Hypertension or high blood pressure manifests by causing headaches, nosebleeds or difficulty breathing. If left untreated, hypertension can contribute to the development of more serious cardiovascular problems such as kidney disease, stroke and myocardial infarction. The absence of hypertension is a result of promotion efforts such as physical activity and healthy diets. When hypertension develops, it can be controlled with medication as well as with life style adjustments. This indicator is thus a proxy for both health promotion and medical services, usually delivered in PHC (WHO, 2019[43]).

In 2015, the average prevalence of raised blood pressure in Brazil was 23.3%, higher than the OECD average of 20.8% and the LAC average of 21.6%. Between 2005 and 2015, all OECD countries reduced the prevalence of raised blood pressure with an average of -16.4% reduction. Brazil also reduced this prevalence but only by -5.3%, a decrease lower than all OECD countries (Figure 3.11). Changes in risk factors and improvements in detection and treatment of raised blood pressure have, at least partly, contributed to these general reductions, but other factors such as improvements in early childhood nutrition and year-round availability of fruits and vegetables, might explain it as well (Zhou et al., 2017[44]).

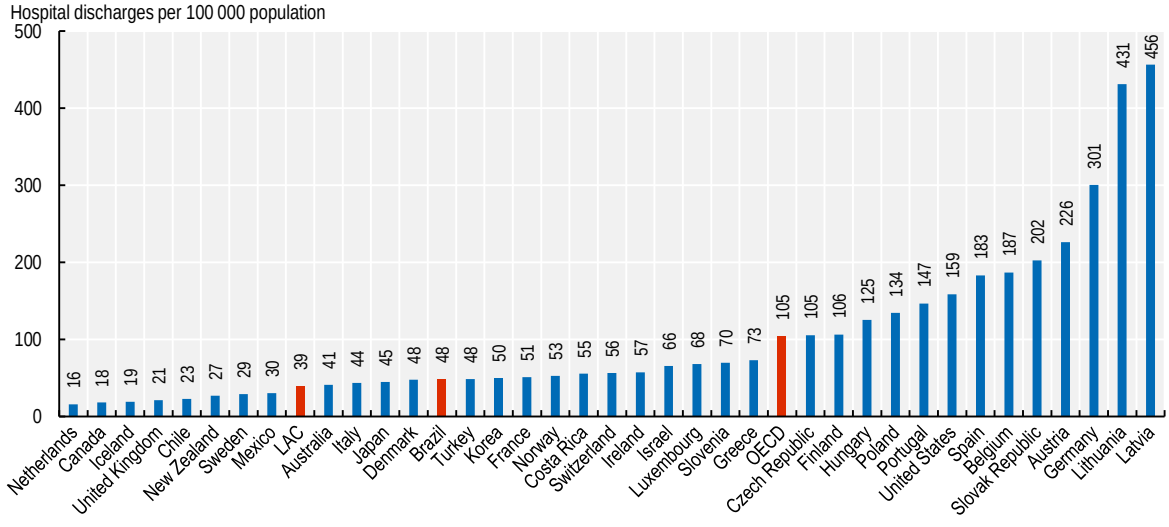
Figure 3.11. Raised blood pressure among adults in Brazil and OECD countries, 2005 and 2015



Note: Raised blood pressure (BP) defined as systolic BP >=140 or diastolic BP >=90. Age-standardised estimate.
Source: Global Health Observatory: Explore a world of health data. (WHO, 2021[16]), https://www.who.int/data/gho.

PHC is expected to keep people well by providing a consistent point of care over the longer term, treating the most common conditions, tailoring and co-ordinating care for those with multiple health care needs and supporting the patient in self-education and self-management. In this way, a good PHC performance can reduce the rates of hospital admissions of several diseases, including hypertension and diabetes. In Brazil, the rate hospital admission due to hypertension was of 48 per 100 000 people in 2019, which is less than half the OECD average of 105 but higher than the LAC average of 39 (Figure 3.12).

Figure 3.12. Hospital admission due to hypertension in Brazil and OECD countries, 2019 (or latest available)



Source: OECD (2021[1]), Health Statistics Database, https://www.oecd.org/health/health-data.htm; Ministry of Health of Brazil.

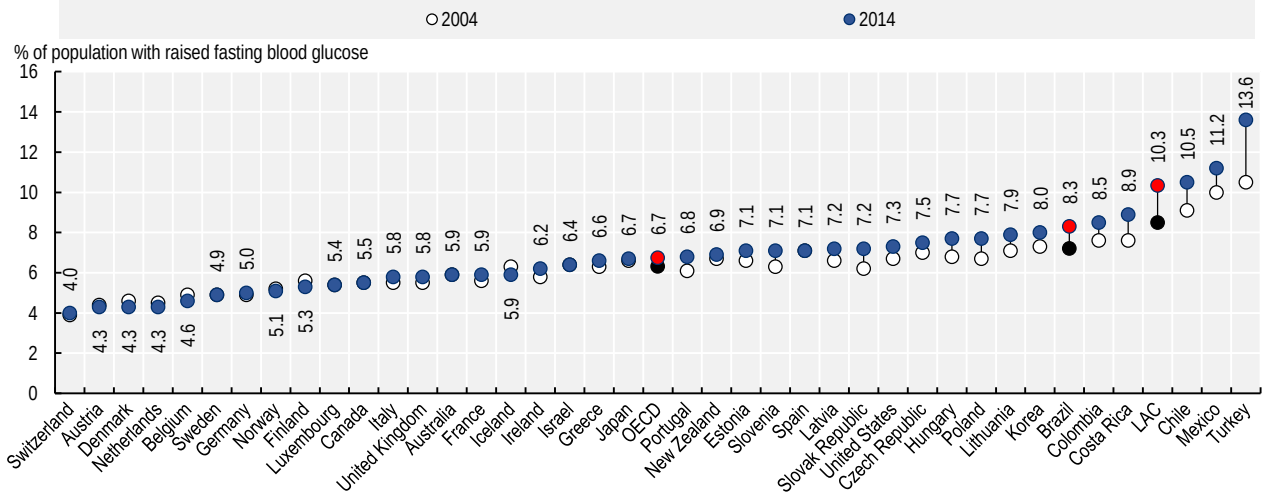
According to a recent study analysing high systolic blood pressure (HSBP) in Brazil, the prevalence of HSBP in 2017 was 18.9%, with an annual 0.4% increase rate, while age-standardised death rates attributable to HSBP decreased from 189.2 (95%UI 168.5-209.2) to 104.8 (95%UI 94.9-114.4) deaths per 100 000 from 1990 to 2017. However, the total number of deaths attributable to HSBP increased by 53.4% and HSBP raised from third to first position, as the leading risk factor for deaths during the period. Regarding total disability-adjusted life-years (DALYs), HSBP raised from fourth in 1990 to second cause in 2017 (Nascimento et al., 2020[45]).

3.3.2. When compared to OECD countries, diabetes represents a higher burden of disease in Brazil

Raised levels of blood sugar can lead to the development of diabetes. Fasting blood glucose (FBG) contributes to diagnose and monitor diabetes, and can be under control because of effective treatment with glucose-lowering medication and as a result of health promotion activities. PHC has a central role in accomplishing these actions (WHO, 2019[43]).

In Brazil, 8.4% of the population had raised FBG in 2014, above the 6.7% average in OECD countries. Importantly, between 2004 and 2014, Brazil recorded one of the largest increases in its population with raised FBG, increasing by 15.3% (Figure 3.13). Only Turkey, Costa Rica, the Slovak Republic and Chile had larger increases amongst OECD countries, evidencing a worrying trend in Brazil.

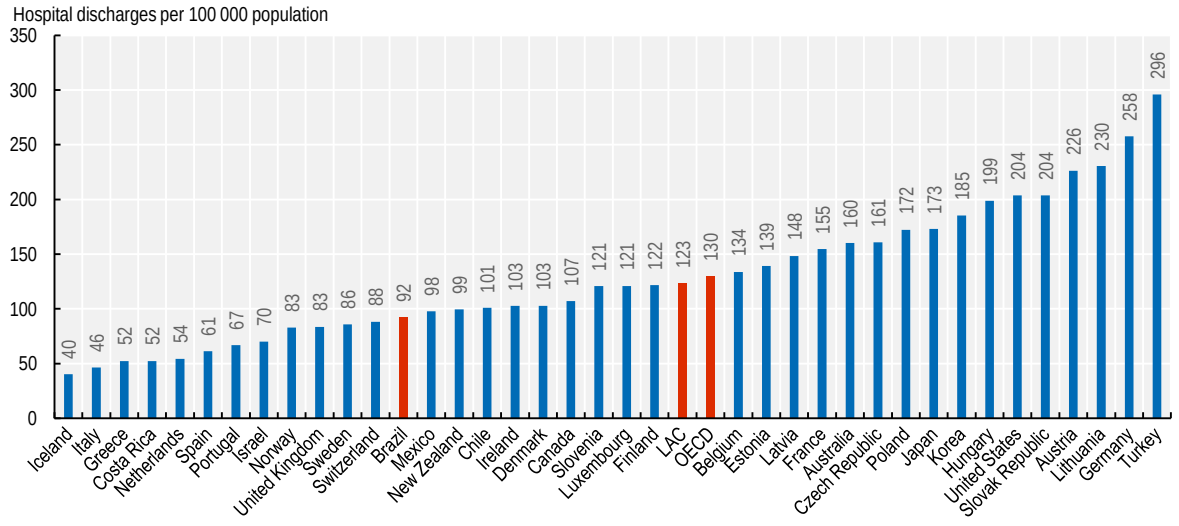
Figure 3.13. Raised fasting blood glucose among adults in Brazil and OECD, 2004 and 2014



Source: Global Health Observatory: Explore a world of health data. (WHO, 2021[16]), https://www.who.int/data/gho.

As stated previously, a well performing PHC can control and reduce the number of hospital admissions due to diabetes. In Brazil, the rate of diabetes hospital admission in 2019 was of 92 admissions per 100 000 people, below the OECD average of 130 and the LAC average of 123 (Figure 3.14). The differences between Brazil and OECD countries in terms of access to hospital care and the profiles of chronic non-communicable disease burden remain as some of factors to be studied more in depth aiming to understand these differences (OECD/The World Bank, 2020[46]).

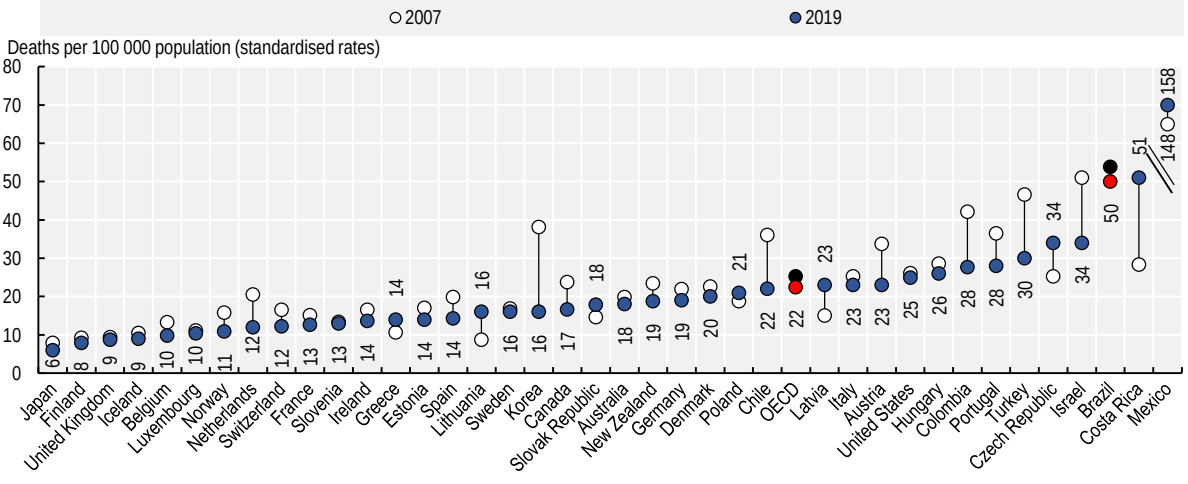
Figure 3.14. Diabetes hospital admission in adults in Brazil and OECD, 2019 (or nearest year)



Source OECD (2021[1]), Health Statistics Database, https://www.oecd.org/health/health-data.htm.

Diabetes mortality in Brazil reached 50 deaths per 100 000 people in 2019, higher than the OECD average of 22 and only lower than Costa Rica and Mexico. Between 2007 and 2019, diabetes mortality was reduced by 9.8%, higher than the average reduction of 7.8% amongst OECD countries (Figure 3.15).

Figure 3.15. Diabetes mortality in Brazil and OECD countries, 2007 and 2019



Source: OECD (2021[1]), Health Statistics Database, https://www.oecd.org/health/health-data.htm.

The impact of diabetes on the Brazilian heath system was further studied by (Quarti Machado Rosa et al., 2018[47]). They found that in 2014, 313 273 hospitalisations were due to diabetes in adults (4.6% of total adult hospitalisation), representing USD 264.9 million. The average cost of an adult hospitalisation due to diabetes was USD 845, 19% higher than hospitalisation without diabetes. Hospitalisations due to cardiovascular diseases related to diabetes accounted for the higher proportion of costs (47.9%), followed by microvascular complications (25.4%) and diabetes per se (18.1%). Another study analysing the burden of diabetes in Brazil, found that the overall estimated prevalence of diabetes in 2017 was 4.4% (95%UI

4.0-4.9%). While the crude prevalence of type 1 diabetes has remained relatively stable from 1990, type 2 prevalence has increased by 30% for males and 26% for females. In 2017, approximately 3.3% of all DALYs were due to diabetes and 5.9% to hyperglycaemia. Diabetes prevalence and mortality were highest in the Northeast region and growing fastest in the North, Northeast, and Central-West regions. Future projections suggested that the diabetes mortality burden will increase by 144% by 2040, more than twice the expected increase in crude disease burden overall (54%). By 2040, diabetes is projected to be Brazil's third leading cause of death and hyperglycaemia its third leading risk factor, in terms of deaths (Duncan et al., 2020[48]).

3.3.3. Hypertension and diabetes screening in Brazil is embedded in a broader PHC check-up programme

Overall, basic health checks and risk screening for chronic diseases in Brazil relies on PHC family health teams, and predominantly on opportunistic screenings. Blood pressure and blood glucose are usually checked during PHC basic check-ups for chronic diseases. These check-ups also include other measures such as cholesterol, screen for cardiovascular disease based on age, family history and risk factors such as body mass index (BMI) that can help diagnose persons at-risk of chronic diseases, or diagnose chronic diseases in their earlier stages when they can be managed with fewer complications.

An official Ministry of Health screening guideline for chronic non-communicable diseases was published in 2010 and it is valid until today (Ministério da Saúde, 2010[49]). For both hypertension and diabetes, screening target populations are quite wide. Screening for hypertension is recommended for adults (over 18 years of age) without the knowledge that they are hypertensive. It suggests screening every two years for people with blood pressure below 120/80 mmHg and annual screening if systolic blood pressure is between 120 and 139 mmHg or diastolic blood pressure between 80 and 90 mmHg. For diabetes, the guideline recommends screening in asymptomatic adults with sustained BP greater than 135/80 mmHg and does not apply to other screening criteria such as obesity, family history or age range. In addition, there are specific booklets (*Cadernos de atenção básica*) for the management of hypertension (Ministério da Saúde, 2013[50]) and a recent protocol for diabetes (CONITEC, 2020[51]), which also consider a screening component. For both diseases, the family health model proposes that trained health professionals work in an interdisciplinary manner, link with service users, and take on responsibility for ensuring the provision of comprehensive health care. For instance, for diabetes this includes from screening, classification, and diagnosis, along with an initial assessment, healthy lifestyle guidance and follow-up medical appointments. It also considers blood glucose control and treatment with or without medication, prevention and management of acute and chronic complications, care of feet and oral health care (Ministério da Saúde, 2013[52]).

A study assessed hypertension care continuum in Brazil's PHC, finding that over one-third of the Brazilian adult population had measured hypertension or prior diagnosis. Nearly 90% of these had recent contact with the health system, but only 65% were aware of their condition. Only 62% of these regularly sought care for hypertension, but of these 92% received treatment. Hypertension control was 33% overall, but increased to 57% among those who passed through all stages of the care continuum, showing the importance of high-performing PHC teams (Macinko, Leventhal and Lima-Costa, 2018[55]).

Regarding health information infrastructure, Brazil developed a specific registration and monitoring system for hypertensive and diabetic patients: HIPERDIA. It is managed by the Ministry of Health, through the Secretariat of Health Care Services, in conjunction with the the State and Municipal Health Secretariats. Municipalities that are members of the National Pharmaceutical Assistance Programme for Hypertension and Diabetes Mellitus send, through the HIPERDIA system, information on the registration and monitoring of patients with these diseases. All this information is processed and made available by DATASUS of the Ministry of Health (Ministério da Saúde, 2021[56]).

Box 3.4. People with pre-existing chronic conditions risk more severe COVID-19 health outcomes

Across OECD countries, people with existing chronic conditions (including cancer, chronic kidney disease, chronic obstructive pulmonary disease, heart conditions, immunocompromised state, diabetes type 2, sickle cell disease and obesity) are the most hard-hit patient population in the COVID-19 pandemic. People with chronic conditions are facing a 'double threat': they are more vulnerable to complications and death from COVID-19, and they experience indirect health effects from disruptions in essential care:

- First, people living with certain chronic conditions are at higher risk of severe COVID-19 symptoms. Early in the pandemic, it was shown in China that older patients and those with chronic conditions were more likely to have a severe to critical COVID-19 condition, to show deterioration of their health condition and to die from COVID-19 (Zhang and et, 2020[53]). Researches in the United States, Italy and the United Kingdom, confirm more severe COVID-19 outcomes and higher risk of hospitalisation among patients having underlying health conditions (OECD, 2021[54]);
- Second, people living with chronic conditions, also face indirect impacts of the pandemic due to disruptions in continuity of care or foregoing care. The lock-down and fears of contamination in waiting rooms have led many patients to forego care, including those who require regular follow-up for chronic diseases, such as cancer (OECD, 2021[54]). For example, in England, urgent referrals from PHC for people with suspected cancers decreased by nearly 80% in comparison with levels before the COVID-19 crisis. In France, the number of cancer diagnoses decreased by 35% to 50% in April 2020, as compared to April 2019. Preventive cancer screenings in the United States for breast cancer, colon cancer, and cervical cancer have also dropped between 86% and 94% in March 2020 compared to average volumes in 2017-19. In Australia, there were around 145°000 fewer screening mammograms conducted by BreastScreen Australia in January to June 2020 compared with January to June 2018.

Strong PHC has the capacity to mitigate these indirect effects during the pandemic, but also to reduce the pressure on the entire health system by providing comprehensive and preventive care.

Source: (OECD, 2021[54]). Strengthening the frontline: How primary health care helps health systems adapt during the COVID-19 pandemic. OECD Policy Responses to Coronavirus (COVID-19).

In the context of the COVID-19 pandemic, and recognising that people with NCDs are at higher risk, the Ministry of Health issued specific guidelines for supporting this group of the population through PHC. The aim was to follow-up of this population with adequate regularity, aiming at clinical stability, reducing the chances of unfavourable outcomes during the pandemic period. Amongst other components, the strategy included the identification, registration and risk stratification of people with obesity, diabetes and/or systemic arterial hypertension through surveillance actions and timely diagnosis of the adherent population. In addition, the early identification and prioritisation of follow-up and monitoring of these individuals with influenza syndrome or with suspected or confirmed COVID-19. The response included multi-professional therapeutic assistance, the prevention of coronavirus transmission in individuals with obesity, diabetes and/or hypertension, and the implementation of intersectorial and community actions for promotion of health, considering the epidemiological situation of COVID-19 in each territory (Ministério da Saúde, 2020[57]). These are all welcome strategies given that people with chronic non-communicable diseases are facing a 'double threat': they are more vulnerable to complications and death from COVID-19, and they experience indirect health effects from disruptions in essential care (Box 3.4).

3.3.4. Quality improvement and pay-for-performance schemes in Brazil's PHC have included hypertension and diabetes management

Checkup activities are part of the PHC Service Portfolio (*Carteira de Serviços da Atenção Primária à Saúde*), which receives financing from the Federal Government transferred to States and Municipalities, with these entities responsible for managing the provision of services. In 2011, the Ministry of Health created the Programme to Improve PHC Access and Quality (PMAQ), aiming at scaling up access and quality of care offered by means of financial incentives directed toward municipal health management, conditioned on formal agreements of commitments and indicator evaluation agreed between PHC teams, municipal health service managers, and the Ministry of Health (see Chapter 4). As part of PMAQ, the evaluation of FHTs included topics such as early detection of hypertension, laboratory exams for diabetes, and prescription refills for users on continued care/programs such as hypertension and diabetes without the need for marking medical appointments.

More recently, the new *Previne Brasil* Programme, implemented in 2020, includes a pay-for-performance component, which rewards performance linked to seven indicators (see Chapter 4). Two of them relates to hypertension and diabetes (Ministério da Saúde, 2020[58]):

- Indicator 6: Percentage of people with hypertension having blood pressure checked in each semester.
- Indicator 7: Percentage of people with diabetes with a request for glycated haemoglobin.

Even though these indicators are not directly related to screening but to the follow-up of patients who already have the disease, it is important to highlight that patients who are diagnosed may benefit from this incentive. However, it would be important to monitor how this programme could influence screening activities for hypertension and diabetes in PHC.

3.3.5. Hypertension and diabetes secondary prevention in Brazil should be revised to improve the efficacy and efficiency of its screening activities

Brazil could develop population-based hypertension and type 2 diabetes screening targeting high-risk population groups

Several OECD countries have health check-ups for chronic conditions, usually targeted at particular groups of the population, undertaken periodically for example every five years, and sometimes provided by health care professionals other than doctors. In Estonia, health check-ups and guidance are provided by family nurses for people aged between 40 and 60 with hypertension or diabetes (Habicht et al., 2018[59]), and in 2007, Korea introduced the National Screening Programme for Transitional Ages, targeting people at age 40 and 66 (Kim et al., 2012[60]). In England, the NHS Health Check was introduced for people aged between 40 and 74 in 2009 and an invitation letter is sent every five years to those who do not already have diabetes, heart disease, or kidney disease or have not had a stroke, in order to screen them for the risk of developing chronic conditions including heart disease, stroke, kidney disease, type 2 diabetes, or dementia (available only for those above 65 and above). This check-up is often undertaken by a nurse or health care assistant (Gmeinder, Morgan and Mueller, 2017[61]; NHS, 2018[62]). Table 3.4 shows the recommendations for hypertension screening from selected evidence-based guidelines along with the latest recommendations in Brazil.

However, a recent review commissioned by WHO Europe found that the available evidence does not support the recommendation on systematic population-level screening for hypertension (Eriksen et al., 2021[66]). Instead of recommending systematic screening, the preferred alternative would be targeting those in PHC who may be at a higher risk owing to age or the presence of a risk factor (i.e. case-finding). In Brazil, a study identifying the main risk factors for developing hypertension found that the prevalence increased with age, low educational level, increased body mass index and abdominal waist, and urinary

sodium excretion (Cipullo et al., 2010[67]). This type of studies in the Brazilian population could help to define the target group in order to guide future hypertension screening recommendations.

Table 3.4. Selected recommendations for high blood pressure screening

	Population group	Screening interval	Persons at increased risk of high BP
Brazil (Ministério da Saúde, 2010[49])	18 years and over, without known hypertension	• Every two years if BP below 120/80 mm Hg. • Every year if systolic BP 120-139 mm Hg or diastolic BP 80-90 mm Hg	None mentioned.
European Society of Cardiology and of Hypertension (Williams et al., 2018[63])	18 years and over	• Every 1-5 years or when opportunity arise if BP below 120/80 mm Hg • Every 3 years if BP 120-129/80-84 mm Hg • Every year if BP 130-139/85-89 mmHg	In older patients (>50 years), more frequent screening should be considered for each BP category.
United States (USPSTF, 2016[64])	18 years and over, without known hypertension	• Annual for adults aged ≥ 40 years and persons at increased risk for high BP. • Adults 18-39 years with BP < 130/85 mm Hg who do not have other risk factors, every 3-5 years.	Have high-normal blood pressure (130-139/85-89 mm Hg); those who are overweight or obese, and African Americans.
WHO HEART guidelines (WHO, 2018[65])	18 years and over, during routine visits to PHC	• Every 1 to 5 years if normal • No mention of other interval	Have had a prior heart attack or stroke; have diabetes; have chronic kidney disease; are obese; use tobacco; have a family history of heart attack or stroke.

Note: BP: Blood pressure.

Table 3.5. Selected recommendations for type 2 diabetes screening

	Population and screening interval	Persons at increased risk of DM2
Brazil (CONITEC, 2020[51])	• All adults over 45 years of age. • Adult overweight (BMI >25 kg/m2) and with one risk factor or moderate CVD risk. • If normal, screen every 3 years. • If pre-diabetes, screen every year.	Sedentary lifestyle; first-degree relative with DM; women with previous pregnancy with a fetus weighing ≥ 4 kg or with a diagnosis of gestational DM; hypertension or antihypertensive use; HDL cholesterol ≤ 35 mg/dL and/or triglycerides ≥ 250 mg/dL; women with polycystic ovarian syndrome; other clinical conditions associated with insulin resistance (e.g. obesity III, acanthosis nigricans); history of CVD.
Canada (Diabetes Canada, 2018[69])	• Screen every 3 years in individuals ≥40 years of age • Screen every 3 years in individuals at high risk according to a risk calculator • Screen earlier and/or more frequently (every 6 to 12 months) in people with additional risk factors for diabetes	First-degree relative with DM2; Member of high-risk population (e.g. African, Arab, Asian, Hispanic, Indigenous or South Asian descent, low socio-economic status); History of prediabetes; History of gestational diabetes; History of delivery of a macrosomic infant; presence of end organ damage associated with diabetes; and presence of vascular risk factors (e.g. smoking), associated diseases (e.g. HIV), and use of drugs associated with diabetes (e.g. statins).
United States (USPSTF, 2015[70])	• Adults aged 40 to 70 years who are overweight or obese. • Every 3 years for adults with normal blood glucose levels.	Family history of diabetes; history of gestational diabetes or polycystic ovarian syndrome; members of certain racial/ethnic groups (e.g. African Americans, American Indians or Alaskan Natives, Asian Americans, Hispanics or Latinos, or Native Hawaiians or Pacific Islanders) may be at increased risk for DM2 at a younger age or at a lower BMI.
WHO HEART guidelines (WHO, 2018[65])	• Adults who are 40+ years old and who are overweight (BMI >25) or obese (BMI >30) • No screening interval mentioned.	Have had a prior heart attack or stroke; have diabetes; have chronic kidney disease; are obese; use tobacco; have a family history of heart attack or stroke.

Note: DM2: diabetes mellitus type 2. BMI: body mass index. CVD: cardiovascular disease.

Similarly as with hypertension, diabetes screening in OECD countries is normally embedded in more general health check-ups. In Australia, for example, PHC physicians can provide health assessment for people who are at risk of developing a chronic disease. This assessment is provided to people aged between 45 and 49 once if they have at least one risk factor (lifestyle habits or a family history) for developing a chronic disease such as type 2 diabetes or heart disease. The assessment is also provided to people aged 75 and over with an interval of 12 months or longer (Department of Health, 2014[68]). In view of reducing the prevalence of lifestyle-related diseases including cancer, cardiovascular diseases and diabetes, Japan introduced the specific health check-up (Tokutei kenshin) to the population aged between 40 and 74 in 2008. All insurers in the Japanese health system are obliged to provide a specific health check-up to people in this age group every year as they are considered to have higher risks of developing lifestyle-related diseases. Insurers need to provide a nationwide standard set of health check-up items (OECD, 2019[40]). Table 3.5 shows the recommendations for diabetes mellitus type 2 screening from selected evidence-based guidelines along with the latest recommendation in Brazil.

According to the most recent scientific evidence, too much screening (e.g. by having a too wide target population) probably will not improve population health outcomes and can be an inefficient use of resources. Therefore, Brazil can aim for well-targeted hypertension and type 2 diabetes screening population-based programmes, based on its national epidemiology, health system characteristics and cost-effectiveness analysis, as an effective way to identify and manage chronic disease.

Strengthen disease management pathways with a people-centred perspective

Hypertension and diabetes screening should be just the first step in a clear disease management pathway in Brazil. Chronic disease management pathways (also called integrated care pathways), which can be embedded on clinical guidelines, should be available for all high prevalence chronic diseases, to give guidance to health care providers and patients over expectations of the care that should be delivered and received. The two existing clinical guidelines in Brazil (Ministério da Saúde, 2013[50]; CONITEC, 2020[51]) represent a very positive step towards developing best practice guidelines with explicit pathways of care. For the moment these pathways are focused on information for health professionals in PHC, but could be expanded to integrate other care providers (for example specialists, or patient-support groups), and be produced in a patient-friendly format.

Pathways of chronic disease care, produced in both patient-facing and clinician-facing formats, should clearly establish the professional responsibilities of health professionals at different stages of disease. These pathways can be used to set quality expectations for chronic diseases such as diabetes and cardiovascular disease, and standardise quality of care across Brazil. The pathways can also be used to clarify expected roles for different care providers. In the area of diabetes, clinical pathways can help by: (1) assisting to systemically evaluate the patient's clinical presentation and risk factors; (2) choosing the most appropriate behavioural and medication interventions; and (3) providing a timeline for patient follow-up and monitoring. In short, clinical pathways will assist in the co-ordination of care and follow-up (Wong, 2017[71]).

Figure 3.16. NHS England RightCare Pathway: Diabetes, summary table



The National Opportunity	5 million with non-diabetic hyperglycaemia Most receive no intervention	940, 000 undiagnosed Type 2 diabetes	>50% of diagnosed receive no structured education within 12 months of diagnosis	60% of Type 1 and 40% of Type 2 are not completing care processes	Few areas have high quality Type 1 services embedded	30% of hospitals don't have multi-disciplinary foot teams	National variation in spend and safety issues on non-elective admissions
Service component	**Risk Detection**	**Diagnosis and Initial Assessment**	**Structured Education Programmes**	**Annual Personalised Care Planning**	**Type 1 Specialist Service**	**Service Referral and key relationships**	**Identification/ Management of admissions by Inpatient diabetes team**
Interventions	Cross Cutting: 1. Shared responsibility and accountability 2. Participation in NATIONAL DIABETES AUDIT 3. Consistent support for patient activation, individual behaviour change, self-management, shared decision making 4. Integrated multi-disciplinary teams						
	NHS Diabetes Prevention Programme	Protocol for diagnostic uncertainty	Education programmes (including personalised advice on nutrition and physical activity)	9 recommended care processes and treatment targets	Type 1 Intensive specialist service	1. Triage to specialist services 2. RCA for major amputations	Inpatient diabetes team, shared records, advice line
Target outcomes	Decreased incidence of Type 2 diabetes	Improved detection	Better diabetes management and reduced complications	Reduced variation in completion of care processes	Reduced risk of Microvascular complications	Year on year reduction on major amputations	Reduction in errors in hospitals, reducing LOS
The evidence	Intensive behaviour change can on average, reduce incidence of Type 2 diabetes by an average of 26%	Diabetes prevalence model for local authorities and CCGs	Improved health outcomes and reduction in the onset of diabetic complications in both Type 1 and Type 2 diabetes	Control of BP, HbA1c and cholesterol reduces risk of macro and micro vascular complications	Type 1 services deliver year on year improvements in blood glucose control	MDFT and supporting pathway reduces risk of complications	Young Type 1 and older Type 2 diabetes patients have higher rates of non-elective admissions

Source: NHS England (2018[72]), NHS RightCare, Diabetes pathway, https://www.england.nhs.uk/rightcare/products/pathways/diabetes-pathway

England has developed more complex pathways, which include expectations at different stages of the disease, the roles for different care providers, key interventions and target outcomes (NHS England, 2018[72]). England's 'NHS RightCare Pathway: Diabetes' includes, for example, an expectation that care planning and an annual review take place for patients with both Type 1 and Type 2 diabetes, and the Pathway includes links to supportive documentation to help with care planning. In England, the expectation is that a lot of diabetes care is provided by multidisciplinary teams in community care settings, and the Pathway includes details of the services that the team would usually provide (patient education, pregnancy advice, foot protection team) (see Figure 3.16).

Alongside establishing clear chronic disease management pathways, there is a need to ensure that other levers within the system are effectively aligned with the pathway. This includes line up payment and reimbursement incentives, as well as ensuring that health professionals have the tools and capacities they need to undertake the responsibilities expected of them.

Create more capacity in PHC for screening and management of hypertension and diabetes through expanding the role of health workers

To strengthen prevention capacity and impact, Brazil should look to increase capacity in PHC. One way that several OECD countries have found to increase capacity relates to task shifting or expanding the role of other health workers (Box 3.5). Exploring whether there are ways for other health workers – for instance nurses, nutritionists or pharmacists – to play a role in delivering some of these key prevention activities is certainly a possibility for Brazil.

Box 3.5. Advanced nurse practitioners and community pharmacists in France

As in other OECD countries, France has extended the role of nurses and pharmacists, which is seen as a key policy lever to improve access in underserved areas where the number of PHC physicians is decreasing. The new decree establishing the profession of Advanced Nurse Practitioner (Infirmière en Pratique Avancée) was issued in June 2018. The Advanced Nurse Practitioner will work within a PHC team to manage patients having chronic conditions and take the lead in prevention and co-ordination.

In parallel, the role of community pharmacists is gradually increasing. Community pharmacists are allowed to perform three rapid diagnostic orientation tests: the capillary blood glucose test for diabetes screening; the oropharyngeal tests for influenza; and the group A streptococcal tonsillitis test. The objective is to determine if antibiotic treatment is necessary and if a visit to the doctor is required for a prescription. The community pharmacist can also participate in punctual screening programmes for chronic obstructive pulmonary disease (COPD). Lastly, pharmacists in France are now allowed to perform flu vaccination.

Source: OECD (2020[78]), Realising the potential of PHC, https://dx.doi.org/10.1787/a92adee4-en.

For example, when it comes to diabetes, nurses could have the capacity and training to conduct an initial assessment of the patient, including ensuring the capacity to do blood sugar testing in all practices and working together with doctors and other team members in follow-up activities. In general terms, nurse-provided care has shown equivalent or better quality of care across a large range of clinical outcome measures for chronic conditions, including diabetes (Maier, Aiken and Busse, 2017[73]). A systematic review found that nurse-led care was at least as effective as physician-led care in providing secondary prevention to patients with chronic conditions, where 84% of outcome parameters showed no statistically significant differences, and for the remaining 16%, secondary prevention outcomes improved in the nurse-group, primarily among patients with diabetes. In this patient group, nurse-led care was superior in preventing the onset of heart disease and it lowered cardiovascular risk (Martínez-González et al., 2015[74]).

Community pharmacists can also be considered for task shifting policies, and in most OECD countries its role has evolved substantially in recent years. Pharmacists can play a key part in giving advice to patients and supporting them to navigate their health needs and manage their care. Recent systematic reviews have shown that pharmacist involvement in care may improve health outcomes for chronic conditions such as diabetes and hypertension (Pousinho et al., 2016[75]), while it can turn to be cost-effective for health systems (Wang, Yeo and Ko, 2016[76]). In Brazil, pharmacists do not seem to have a large presence in PHC teams, even stating that pharmacists' isolation in PHC prevails (Barberato, Scherer and Lacourt, 2019[77]). Therefore, such a policy would require a thorough analysis and planning to define the best way to invest on further introducing community pharmacists in Brazil's PHC teams.

The health information system needs to be developed further to support targeted population-based screening for better monitoring and evaluation

Screening and other health care activities for hypertension and diabetes have the potential of generating a wealth of valuable health information, which could be used both for better managing population health, designing and targeting more effective public health interventions, and for research. However, HIPERDIA, Brazil's health information system for hypertension and diabetes in PHC, does not collect information about screening and it is not capable of capturing the pathway of care for each patient either (e.g. referrals, waiting times, consultations with specialists, laboratory tests, medications, etc.). It is also hard for PHC teams to review and act on this information as they do not receive regular feedback, and patients cannot

have access to his personal health data. It is also difficult for the system to link with other databases such as hospitalisations, death registries, etc.

Many OECD countries have nationally standardised digital medical records and they are able to use up-to-date data for monitoring and evaluation of the health system by automatically extracting data from electronic clinical records. For example, 13 countries including Canada, the Czech Republic, Denmark, Finland, Israel, Korea, New Zealand, Norway, Singapore, Sweden and the United Kingdom (England, Scotland and Wales) regularly link data from different national datasets such as hospital and mental hospital in-patient data, cancer registry data and mortality data. Using these linked data, these countries are able to actively monitor health care quality and health system performance.

In order to monitor and further develop secondary prevention strategies, Brazil needs to develop a health information system, which allows linking different data sources. Experiences of other OECD countries in developing a strong health information system within a data governance framework that protects patients' health information privacy, which is laid out in OECD (2019[79]), would be useful for Brazil in following such paths.

A stronger health information system could also facilitate streamlining the efforts to invite target population for hypertension and diabetes screening. Currently, these screenings are largely opportunistic and there is no information about who is receiving them. Moreover, it is not possible for municipalities or PHC teams to identify whom to send the invitations. The current process for population's registration in Brazil's PHC represents an opportunity for developing organised screening programmes. Brazil could send personalised invitation letters, without duplication, only to those who are in the target population, and not currently undergoing treatment, and to those who have not followed up on worrying results from a previous check-up. These targeted personalised approaches are considered more effective in recruiting people in need of health check-ups (Bunten et al., 2020[80]).

In the future, Brazil could consider bundled payments as a mechanism to improve management of chronic conditions in PHC

Brazil has recently innovated on its payment scheme in PHC with the *Previne Brasil* programme. For the future, another alternative to explore are bundled payments, in particular, for chronic conditions. These consist of one payment per patient with a chronic illness to cover the cost of all health care services provided by the full range of providers during a specific time period. It has been introduced in OECD countries to incentivise co-ordination of care between providers, or provide a broader set of care (e.g. education, regular checks, occasional specific checks). Bundled payments can encourage collaboration within and across care settings, contribute to greater standardisation of care for example by requiring adherence to quality criteria, and can strengthen data availability by requiring the collection of monitoring indicators or integration of data systems across care settings, and control overall costs (OECD, 2016[81]).

Although the design and characteristics of bundled payments differ between OECD countries, the models developed in Australia and Canada could be of particular interest to Brazil and others. In these countries, the bundled payment accounts for patient complexity, which is an important prerequisite to encourage the participation of PHC providers (OECD, 2020[78]).

3.4. Conclusion

In Brazil, all-cancer mortality has not been reduced in the past decade, while breast and cervical cancer have reduced its odds for a longer survival after being diagnosed. This finding goes in the opposite direction from the outcomes obtained in OECD countries, calling for an urgent action to reverse these trends. Although breast and cervical cancer screening have increased in recent years, its coverage remain well

below the recommended standards, limiting its potential to contribute to better cancer outcomes. In order to tackle the burden of cancer, Brazil has strengthened cancer care governance and delivery, however, more still needs to be done, with an emphasis in promotion and prevention of cancer. There is scope to expand the coverage of screening – notably by developing population-based programmes, introducing more systematic personalised invitation for cancer screening, and developing better communication and education strategies by using new technologies. Brazil could also look to expand efforts to new cancer sites such as lung and colorectal, as they represent a high burden of disease, deserving further analysis of the potential benefits of investing in national screening programmes. Meanwhile, developing a more comprehensive monitoring system for cancer screening, with information at the individual level of each patient, would help Brazil in both the administration of the cancer screening programmes (e.g. assuring effective target population coverage) and be a rich source of data to periodically assess the effectiveness of existing cancer screening protocols.

On the other hand, hypertension and diabetes also represent a burden for Brazil's population health and health system. For example, the prevalence of both raised blood pressure and of raised fasting blood glucose is higher than the average of OECD countries. For diabetes, mortality has not been reduced in past years in Brazil, on the contrary to what has been observed in OECD countries. Therefore, Brazil could strengthen its PHC check-up activities by moving towards population-based hypertension and type 2 diabetes screening programmes, targeting well-defined high-risk population groups. This goes in hand with further developing clear disease management pathways, where PHC teams and each individual patient can take appropriate actions to manage its disease. The current clinical guidelines and the registration of patients in PHC are good starting points to continue in this direction. There is also a clear scope for PHC nurses to play a more active role in patient education, screening promotion and disease management, while community pharmacists might be further introduced in targeted actions to manage these chronic conditions. Health information systems needs to be further developed in order to provide more and better information to both PHC teams and patients, which would allow improving clinical management decisions in PHC and will empower patients to take a leading role in its own prevention and control actions.

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4 Quality and outcomes in primary health care

Looking to expand access to high quality PHC, Brazil has taken important steps to improve the distribution of doctors, develop new forms of service organisations, introduce new financing models, and implement a range of quality initiatives, well aligned with the experiences of OECD countries. However, the Brazilian PHC system is still characterised by a relatively low population coverage, large disparities in care quality, and a weak referral system. PHC has also traditionally provided few low-complexity procedures, and is not comprehensive enough to meet evolving patients' needs. Tackling these challenges requires strengthening the gatekeeping system while expanding the range of services provided by family health teams. Efforts are also needed to ensure implementation of quality initiatives throughout the country. Greater guidance and support from the federal government will be necessary to help municipalities with low capacity.

4.1. Introduction

Brazil recognised that a strong PHC is the foundation of a health system that is effective, efficient and responsive to patients 'needs. Over the past decade, Brazil has implemented a wide range of reforms to develop the system accordingly and improve both care quality and the range of services provided by family health teams (FHTs). These include the development of standards of care, guidelines, health care services portfolio, the establishment of pay-for-performance programmes and the production and publication of data underpinning PHC. High level analyses however suggest significant scope for improving the quality and outcomes of PHC service delivery. While the burden of risk factors for health and of chronic conditions is growing in Brazil, compliance with preventive care norms, and the detection and management of chronic conditions give some cause for concern. In addition, PHC has traditionally been characterised by a low supply of health care services, offering few low complexity procedures and surgeries.

This chapter assesses Brazil PHC system with regards to the quality and outcomes of care provided. It starts with an overview of recent reforms to expand PHC and to foster quality improvement. The chapter then points to its performance in examining some indicators of PHC quality across OECD countries. The chapter concludes with some key suggestions to secure higher quality and outcomes of PHC services.

4.2. Recent reforms in PHC in Brazil

Following the implementation of the Family Health Strategy in 1994 (described in Chapter 2), several important reforms were introduced from 2011 to 2019 to continue to expand PHC in Brazil. The reforms intend to restructure PHC through new regulations to improve the distribution of doctors, to develop new forms of service organisation and new financing models for PHC.

4.2.1. Considerable efforts have been made to recruit and retain professionals in more remote areas

Several initiatives have been taken in Brazil over the past decade to recruit and retain professionals in more vulnerable areas. The *Inland Health Care Programme (Programa de Interiorizaçao de Trabalho em Saúde*) implemented from 2001 to 2004 first intended to improve the distribution and training of doctors and nurses in order to ensure their provision in poor and remote parts of the country. However, only 469 doctors joined the programme. Another federal strategy was the Valuing Primary health Programme (*Programa de Valorização da Atenção Básica – PROVAB*) introduced in 2011 to encourage health workers to spend a year working in PHC in areas with a shortage of these professionals (ordinance No. 2, 087, of 1 September 2011). The programme provided for the payment of a federal scholarship of BRL 10 000 a month. The programme also entails a mandatory 12-months theoretical-practical postgraduate course and the completion activity in the PHC units. To guarantee the quality of the service provided, medical doctors were evaluated, on a quarterly basis, by managers and institutions, in addition to conducting self-assessments. Well-evaluated participants received an additional 10% score on their medical residency exam. While the programme helped to attract more doctors in remote areas, the number was not enough to meet the needs of the target municipalities. Medical professionals showed a limited interest for the programme. In 2013, the programme hired 3 800 doctors, who were allocated in 1 300 different municipalities (Pereira et al., 2016[1]).

The Programme *Mais Médicos para o Brasil* (More Doctors Programme [MDP]) was then instituted as a federal government initiatives in 2013 to address shortfalls in the supply of doctors in PHC and diminish regional inequalities in health. The MDP was a supply side intervention with three prongs that complement each other, with a particular emphasis on strengthening PHC provision in underserved communities (Stein and Ferri, 2017[2]; WHO, 2018[3]).:

- (1) Transfer of funds to municipalities to strengthen PHC infrastructure;
- (2) Improving access to and quality of medical school training; and
- (3) Recruitment of Brazilian and foreign physicians to work within FHS teams.

Priority municipalities for participation in the programme were ones with population living in extreme poverty, population living in indigenous reserves, municipalities with very low human development index, or situated in areas of extreme poverty and with rural communities in the Northeast and North Regions (Pereira et al., 2016[1]).

The Ministry of Health paid the monthly salary of doctors enrolled under the programme. The agreement stated that Brazil paid about BRL 10 000 (EUR 2 126; USD 2 321) a month for each professional. Food, lodging and transportation costs were covered by the municipality. Doctors had a three-year contract, renewable once (Biernath, 2020[4]). It is not mandatory for the MDP physicians to take the national competency exam that is required for other physicians to practise medicine in Brazil. Instead, the MDP physicians are required to complete a mandatory three-week training course provided by the Brazilian health authorities before they could be deployed in municipalities. In addition, all MDP physicians are required to attend brief training sessions organised by Brazilian authorities in regular intervals. Online-learning courses are also available to the MDP physicians.

Overall, the MDP led to positive improvements. The programme has allowed to make considerable investment in the infrastructure of PHC units in all participating municipalities with the provision of new equipments and refurbishments (Pereira et al., 2016[1]). More recent evidence confirms that the MDP successfully channelled additional resources for strengthening the PHC infrastructure, with the MDP resources leading to the construction of 3 496 new basic health units and refurbishment of 3 417 units by 2015 (Santos et al., 2017[5]). According to Biernath (2020), more than 26 000 PHC facilities were built or renovated throughout Brazil.

In addition, the MDP have contributed to improvements in access to medical training. Data obtained from the Higher Education Census suggest that the MDP achieved its medium-term objective of expanding the number of new vacancies by 2017. An estimated 92% of the new medical undergraduate vacancies created from 2010 and 2018 took place after the MDP was launched in 2013 (Figueiredo et al., 2021[6]). It allowed to create 11 500 new places for medical training and 12 400 places for medical residency, opened to both Brazilian and foreign doctors (WHO, 2018[3]).

Lastly, evidence shows that the MDP has improved incentives for health professionals to work in underserved areas, and recruiting medical professionals from outside the country. As Brazilians were slow to accept posts in underserved communities (only 938 doctors applied for 15 460 job openings in the first months of the programme) (Biernath, 2020[4]), co-operation agreements between Brazil and Cuba facilitated by the Pan American Health Organization (PAHO) and the World Health Organization (WHO) have ensured an adequate provision of doctor. More than 20 000 Cuban doctors have been mobilised to the Brazilian health system (representing two-third of the professionals who joined the programme) (WHO, 2018[3]). In total, 18 240 job positions were created during the MDP. Among these, 8 332 were filled by Cubans, 4 525 by Brazilians who had graduated locally, 2 824 by Brazilians who had graduated abroad, and 451 by doctors of other nationalities (Biernath, 2020[4]).

Hone and colleagues (2020) suggested that the MDP was associated with a 12% increase in the number of PHC physicians by its fifth year of implementation, with more pronounced effects among municipalities that had lower levels of physician availability at the start of the programme (Hone et al., 2020[7]).

Between 2013 and 2014, the number of municipalities with fewer than 0.1 doctors per thousand inhabitants decreased by 75%, from 374 to 95 (Pereira et al., 2016[1]). More generally, the number of municipalities with a shortage of doctors fell from 1 200 in 2013 to 777 in 2015 (Biernath, 2020[4]).

In addition, the improved supply of medical doctors in remote regions in Brazil had prevented a total of 521 000 hospital admissions in 2015, generating large savings for the Brazilian health system (Biernath, 2020[4]). The MDP led to reductions in adult hospitalisations primarily due to infectious gastroenteritis, bacterial pneumonias, asthma, kidney and urinary infections, and pelvic inflammatory disease (Maffioli et al., 2019[8]), though it fell short of reducing hospitalisations due to other preventable conditions like hypertension (Özçelik et al., 2020[9]). Amenable mortality was also significantly reduced following the MDP, with greater benefits in municipalities prioritised for doctor allocation and where doctor density was low before implementation (Hone et al., 2020[7]). The positive impact of the MDP includes improved patient satisfaction with public health care services and better doctor-patient relationship (Biernath, 2020[4]) (Chapter 5 of this report provides additional details on the MDP).

The More Doctor Programme is still in place today but it will be gradually replaced by a new federal programme called *Programa Médicos pelo Brasil* (see Chapter 5).

4.2.2. New configurations of care have been established to promote greater co-ordination and integration of care

The family health support centres (*Nucleos de Apoio à Saúde da Familia*, NASF) were originally created in 2008 to expand the capacity of the Brazilian health care system to meet the increasing needs of the population, and move from vertical organisations of health care to horizontal modes of organisation.

The 2017 PNAB further encouraged the development of NASF to expand the scope of PHC for users and provide higher resolution of PHC through greater care co-ordination and longitudinally. NASFs were renamed Extended Family Health and PHC Units (NASF-AB). The organisation is structured on a territorial basis, depending on local needs. NASFs-AB should operate in an integrated manner to provide clinical, medical and pedagogical support for the PHC professionals (Barros da Silva, Carlos da Silva and de Araujo Oliveira, 2020[10]). NASFs- AB are multi-disciplinary teams, expected to function in an integrated manner. The overarching objective is to support FHTs and PHC teams for specific populations (Street Offices, river team) through supporting them in the management of health problems, as well as broadening the range of services offered in the community (Ministerio da Saude, 2021[11]).

Three types of NASFs-AB are recognised:

- NASFs-AB 1 includes 5 to 9 FHTs and/or PHC teams for specific populations (street consultancy team, riverside team, and river). Minimun 200 hours per week (minimum 20h and maximum 80h weekly workload)
- NASFs-AB 2 includes 3 to 4 FHTs and/or PHC teams for specific populations (street consultancy team, riverside team, and river). Minimun 120 hours per week (minimum 20h and maximum 40h weekly workload)
- NASFs-AB 3 includes 1 to 2 FHTs and/or PHC teams for specific populations (street consultancy team, riverside team, and river). Minimun 80 hours per week (minimum 20h and maximum 40h weekly workload)

The NASF-AB composition is defined based on the health needs of the territory and the supported family or PHC teams. It can be composed of social workers, physical educators, pharmacists, physiotherapists, speech therapists, nutritionists, psychologists, gynaecologists, obstetricians, psychiatric doctors, geriatric doctors, among others.

Activities carry-out by NASFs-AB include clinical care in the PHC facilities, home visits, multi-sectoral actions, health prevention, health education, case discussions with the teams and joint construction of Unique Therapeutic Projects (Barros da Silva, Carlos da Silva and de Araujo Oliveira, 2020[10]) (Sales et al., 2020[12])). Multi-disciplinary teams working in the NASF-AB have opportunity to share problems,

exchange knowledge and practices, and define together possible interventions through the Community of Practices (Communidad de Practicas).

NASFs are guided by the following priorities:

- It is a team formed by different professions and specialties;
- It is recognised as a specialised support for PHC, but it is not outpatient specialties or hospital service;
- It should be available to support scheduled and emergency health situations;
- It performs actions in collaboration with the FHT or the PHC team to increase the suppply of health services offfered in PHC settings.

Existing evaluations of NASFs-AB show overall positive results (Barros da Silva, Carlos da Silva and de Araujo Oliveira, 2020[10]; Sales et al., 2020[12]). The actions developed by the NASFs were positively perceived by the multi-disciplinary teams. Nurses and physicians acknowledged that the multi-professional formation allowed for a greater provision of services, and with greater co-ordination and communication between the team members (Sales et al., 2020[12]). A NASF team in the city of Recipe (Pernamsbuco, Brazil) has been found to improve the quality of referral, and also to generate greater care co-ordination and continuity (Barros da Silva, Carlos da Silva and de Araujo Oliveira, 2020[10]).

The technical Note of 27 January 2020 presents the new configuration of the Expanded Center for Family Health and Basic Health Care (NASF-AB). Given Brazil's vast territory and the heterogeneity of local environments, this technical note gives the flexibility to municipal managers to organise and define the team composition, the work-week hours, and team arrangements.

Another interesting development in Brazil is the establishment of the health care networks *Rede de Atençao à Saúde* (RAS) (CONASS, 2020[13]). Established in 2011, RAS are large health care networks aimed at reducing health fragmentation. FHTs and PHC teams have a key role to play here, in being identified as the hub to co-ordinate care between and across the health sector.

RAS are similar to territorial communities of health professionals aimed at improving patient-centred care. They are organised by *Regioes de Saúde* (Health Regions) which are agglomerations of municipalities, with the objective of integrating organisation, planning and provision of health care services at regional level (from PHC, mental health, public health, emergency care to specialised care and hospital care). RAS are agreed by Municipalities and States by the *Comissoes Intergestores*, according to population health needs, regional and municipal capacities (in terms of operational structure including support, logistical and governance systems), and the health care model.

There are thematic *Rede de Atençao à Saúde* including:

- Maternal and Child Health Care Network (Rede Cegonha)
- Urgency and Emergency Care Network (Rede de Atençao as Urgencias)
- Health care network for people with chronic diseases (Rede de Atenção à Saúde das Pessoas com Condições Crônicas) – such as cancer, overweight or obesity;
- Health care network for people with disabilities (Rede de Cuidados à Pessoa com Deficiência)
- Mental health care network

CONASS has been actively working on the development of RAS over the past years, notably with the development of *Planificação da Atenção Primária à Saúde* (PAPS) and *Modelo de Atenção às Condições Crônicas* (MACC) (CONASS, 2020[13]; CONASS, 2018[14]). PAPS and MACC provide technical and managerial guidance to support health managers and workers in states and municipalities to establish and organise RAS. PAPS consists of a set of workshops, tutorials and short-term trainings for health professionals and the managerial teams of the states and municipalities. The development of MACC in Brazil is based on the well-known Kaiser Permanente Pyramid Population Management, the Wagner

Chronic Care Model, and the Dahlgren-Whitehead "rainbow model" of social health factors (CONASS, 2018[14]).

The use of PAPS and MACC was piloted across several municipalities, for instance in Curitiba (Parana), Santo Antonio do Monte (Minas Gerais) and Taua (Ceará) (see Box 4.1). Evaluations of pilot programmes have been positive in terms of better management of chronic conditions through greater integration of primary and specialised health care (CONASS, 2018[14]; CONASS, 2020[13]).

Box 4.1. Establishment of RAS in Taua (Ceará)

A new configuration of PHC was developed in the municipality of Tauá (Ceará) with the establishment of a RAS in 2014. The project was led by CONASS in partnership with the Secretary of Health of the State of Ceará, Municipal Secretary of Health of Tauá, School of Public Health of Ceará and Fiocruz Ceará.

The project began through the use of the PAPS that proposes new way of organising health services in this municipality. The development of RAS were also supported by several workshops with the participation of all health professionals, and the use of the MACC to identify at risk population including children under 2 years old, pregnant women, hypertensive and diabetes patients.

Risk stratification was used to better understand the health and risk profiles of the community, to undertake proactive management of patients' needs and define intervention in primary and specialised care before the occurrence of any adverse outcomes.

Teams' actions are based on indicators defined by the management, such as:

- preventive actions for congenital syphilis (early detection of infection for pregnant women, timely notification and treatment of pregnant women and partners, appropriate referral to the maternity)
- updating immunisation for elderly people;
- better monitoring of chronic conditions in line with recommended clinical practice guidelines, and care co-ordination with secondary care for high-risk and very high-risk patients.

Evidence of the impact of this RAS in Ceará is positive, with reduced complication from chronic conditions; reduced mortality rates from cardiovascular disease, improved quality of health care service and greater supply of PHC services.

Sources: CONASS (2020[13]), Estudos sobre a planificaçao de atençao à Saúde no Brasil – 2008 a 2019: uma revisão de escopo.

4.2.3. Brazil has embarked on an important reform to finance PHC

Federal financing of PHC has recently changed with the Ordinance 2 979 (12 November 2019) which defines the *Previne Brasil*. Up until 2019, the federal transfers to the municipalities was based on a mechanism for regular and automatic transfer of federal funds. Every municipality received per capita funds per year to cover the cost of basic health care activities and incentives for implementing programmes recommended by the Brazilian Ministry of Health. Federal transfer consisted essentially of:

- Two capitation components -"PAB Fixo" and "PAB Variável". The PAB Fixo "fixed component" was multiplying a municipality-specific value with the number of residents in the catchment area of municipalities. In 2019, this fixed value varied among municipalities between BRL 23 and 28 depending on some few socio-economic factors such as GDP per capita and the poverty ratio. The variable capitation component depended on the accreditation of FHT, implementation of some

strategies and priority programmes such as the Family Health Strategy or the Community Health Agents Programme;

- A voluntary pay-for-performance bonus based on the National Programme for Improving PHC *Access and Quality* (PMAQ) (described in the next section);

In 2020, a new PHC funding model – *Previne Brasil* – has come into effect. This new funding model substantially modifies the way the federation allocates resources for PHC to the municipalities (Ministério da Saúde, 2019[15]). The objective of the Previne Brasil is to accelerate the expansion of the FHTs (to reach 50 000 FHT by 2022), and to strengthen quality of PHC. The new financing model includes:

- A weighted capitation calculated according to the population registered with the FHT or the PHC team, the socio-economic vulnerability and demographic profile of the registered population, and some geographical factors.
- A Pay-for-performance (P4P) bonuses. The programme is compulsory and focussed on seven priority areas, including prenatal care, women's health, child immunisation and care for chronic conditions (hypertension and diabetes mellitus) (describes in the next section). The P4P programme considers the results of the indicators achieved by the accredited teams and registered in the national register of health facilities.
- Incentives for strategic actions and priority areas, which target 16 programmes (Table 4.1). Actions cover specific characteristics according to the needs of each municipality.

Table 4.1. Incentives for strategic actions in Brazil, 2020

Areas of actions	Actions
Health promotion	Health on the Spot Program, Health at School programme, Academia da Saúde Programme
Dental care	Oral Health Team; Mobile Dental Unit, Dental Specialties Centre, Regional Dental Prosthesis Laboratory
Information and Communication Technology	Computerization of PHC facilities
Medical education	Incentive to municipalities with medical and multi-professional residency
Supporting vulnerable population	Prison PHC Team, Actions for adolescents in situations of deprivation for individual liberty, Ribeirinha FHT, Basic Fluvial Health Unit, Street Office team
Other areas	Community health agents, Microscopist

Source: Ministério da Saúde (2021[16]), Previne Brasil, https://aps.saude.gov.br/gestor/financiamento/incentivosacoes/

The new Brazilian approach to adjust capitation payments in PHC is in line with OECD policies in this area (it is already implemented in Chile, Israel, Portugal, New Zealand, the United Kingdom, or the Netherlands for example). The new capitation formula intends to allocate resources based on needs. The single capitation amount will be applicable to the population registered with family and PHC teams, adjusted for socio-economic, demographic and geographical factors. Low socio-economic status will be identified if people receive benefits from the *Programa Bolsa Familia* or *Beneficio de Prestação Continuada* or have small pensions. The demographic factor identifies children below the age of 6 and people above the age of 64 as those with higher needs. Finally, the municipalities are clustered into five different groups based on their urbanisation using an existing typology from the Brazilian Institute of Geography and Statistics (IBGE).

When it comes to the weighting of patients, the reference patient without low socio-economic status in the age group of 6-64 years registered in the most urban type of municipality (type 1) has a base value of 1. This base value will increase by 30% if the patient has either low socio-economic status or falls outside

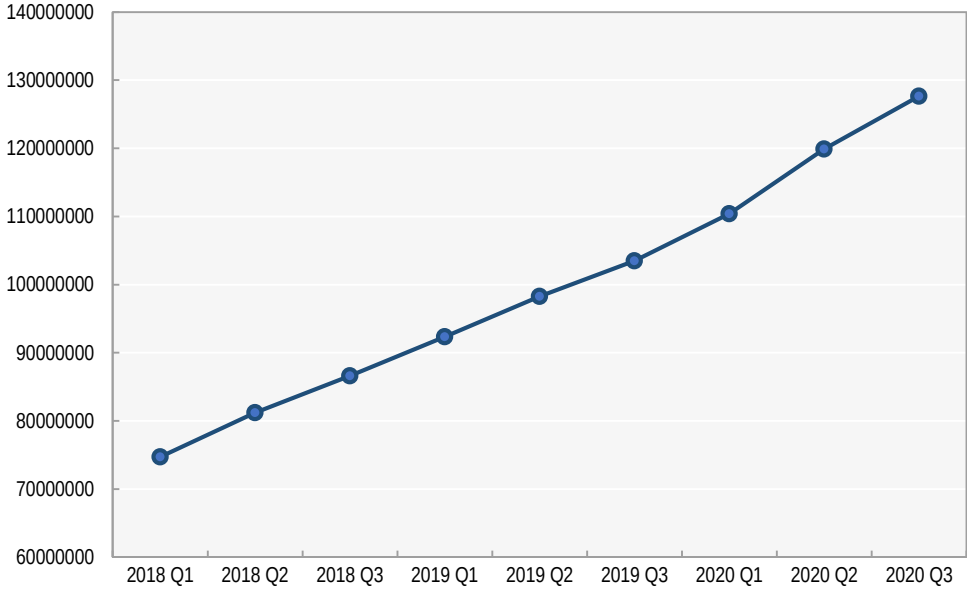
the above-mentioned age group. If a patient is registered in a municipality with medium type of urbanisation (types 2 and 3) the amount received will be multiplied by a factor of 1.45. For the two most rural types of municipalities (types 4 and 5) the amount will be multiplied by a factor of 2. Consequently, the new capitation adjustment is better taking into account differences in need (associated with age) than the previous method. Adjusting the capitated payments according to risk is an important step to make sure municipalities with higher population needs due to higher age and less favourable socio-economic situation receive the resources they need to provide care for everyone. This can limit the risk of increasing inequalities in access to PHC services.

In 2020, the value received by the municipalities from the federation ranged from BRL 51.35 for a patient in middle age (6-64 years) without low socio-economic living in an urban municipality to BRL 133.52 for a patient with either low economic status or an age outside the age bracket 6-64 living in the most rural type of municipality. These calculated amounts can be adjusted downwards if health workers in the FHT lack the required level of qualification.

There are also differences in the registration targets for each FHT based on the degree of urbanisation. In the most urban municipalities, FHTs are expected to register 4 000 people. In the two medium urbanised types of municipalities, this number stands at 2 750. In the most rural municipalities, expectations are that 2 000 people register with FHTs. Variations per FHTs are acceptable within defined limits. The new funding mechanism provides an incentive for FHT to register people in order to include the 50 million people who are not registered yet. Better registration will induce a more adequate identification of people linked to each FHT to encourage more appropriate longitudinal and co-ordinated care.

Already the number of registered people significantly increased since 2018 (Figure 4.1). The number of people registered with a FHT increased by 70% between 2018 and 2020, with around 61% of the population covered by a FHT (reaching 127 million of people registered by November 2020).

Figure 4.1. The number of people registered with a FHT has increased since 2018



Source: Ministério da Saúde (2021[17]), Secretary of Primary Health Care, Individual Records of Family Health Teams.

In 2019, the federal government announced that municipalities will receive BRL 401 million as a financial support for increasing the number of registered people (this will amount to BRL 8 900 for each municipality)

(Ministerio da Saude, 2019[18]). Although several researchers advocate the difficulties for some municipalities to be able to register people with FHTs and the fear of losing federal transfers (Harzheim et al., 2020[19]), it is important to highlight that a more systematic registration system in Brazil will help build a profile of the health needs of the registered population. Registering people with FHTs is a prerequisite for better knowledge and longitudinal monitoring of people. In addition, the threat of receiving discounted capitated amounts if health workers lack the required qualification should encourage municipalities to ensure that health workers are sufficiently qualified.

In 2020, 52% of the budget costs for the provision of PHC was allocated based on weighted capitation, 24% as salaries for community health workers (a subcomponent of the strategic actions), 15% of incentive payments for strategic actions and priority areas and 9% as performance bonuses. In the context of the COVID-19, the federal government decided to maintain the amount of funds received in 2019 for each municipality, and to provide punctual financial assistance to family and PHC teams (Box 4.2 and Table 4.2).

In 2020, the budget allocated to PHC from the federal government was BRL 20.9 billion, compared to BRL 17.5 billion in 2019 (CONASEMS, 2020[20]). In total, the federal government increased its PHC budget by around BRL 3.4 billion between 2019 and 2020.

Box 4.2. Supports provided to family and PHC teams during the COVID-19 pandemic

The Brazilian Federal Government provided punctual financial assistance to family and PHC teams through a series of block grants during the COVID-19 pandemic. These exceptional payments were given on a general basis to ensure a swift and effective PHC to manage COVID-19 cases, and to maintain routine care for non-COVID-19 patients. Municipalities with vulnerable population groups (indigenous groups, or incarcerated individuals) were specifically identified to receive additional funding. Supplementary grants were also given to mental health institutions, with amounts ranging from BRL 28 305 to BRL 400 000, depending on the size and type of psychosocial unit.

Beyond financial support, the Ministry of Health has published multiple guidelines to support family and PHC teams to managing the surge in health care demand while maintaining continuity of care for all patients.

FHTs and PHC facilities are expected to:

- Help diagnose and manage mild COVID-19 patients through testing, and providing care and appropriate exams when available;
- Follow-up people with COVID-19 to help them safely and effectively manage their care at home;
- Facilitate quick and effective referrals to hospitals for deteriorating cases.

As in other OECD countries, special COVID-19 care centres (see Table 4.2) have been established with specific health professionals and equipment to manage patients experiencing mild COVID-19 symptoms. Specific safety standards and protocols were established for high-risk patients. For example, safety protocols for delivery rooms were implemented to ensure staff is asymptomatic. In dental care, a set of ten recommendations were given to municipalities to adapt the delivery of care, including incentivising telemedicine while ensuring the continuity for dental emergencies. Informative campaigns have been developed to provide patient education on COVID-19.

To ensure care continuity, an online tool called “Consultório Virtual de Saúde da Família” has been made available to PHC facilities and FHTs. PHC workers can receive the necessary equipment, training and technical support on a 24 hours basis. PHC workers can also receive psychological support through a telephone helpline.

Table 4.2. Examples of policies introduced in Brazil to maintain care continuity for all patients during the pandemic

	Policy measures
Tele Health	Helpline to assist PHC workers to manage COVID-19 cases
Online teleconsultation platform and TeleSUS	Teleconsultation service to guarantee the continuity of PHC. Around 2 300 professionals were certified to use the system.
COVID-19 Assistance centres	Development of 3 395 centres throughout Brazil. They received special monthly federal funding, ranging from BRL 60 000 to BRL100 000 according to municipal population size.
Community Reference Centers	Community centres responsible for screening suspected COVID-19 cases, providing in-person consultations when necessary, monitoring people at home, testing high-risk patient groups, and disseminating the TeleSUS service. The focus groups for these centres are underprivileged communities and favelas. Around 130 centres were established and BRL 8.2 million spent each month.
COVID-19 contact tracing	Effort aimed at integrating health surveillance and PHC to better identify and follow COVID-19 cases and contacts at local levels
Other use of digital health to maintain access to care for patients with chronic conditions	Three punctual projects implemented in collaboration with the Federal University of Minas Gerais aimed at developing digital platforms to guarantee continuity of care and to provide other digital instruments to reduce referrals to specialist care. The three projects combined amounted to more than BRL 9 million.

Several OECD countries have also expanded PHC to reduce pressure on health systems and minimise complications and direct death from the COVID-19 crisis (OECD, 2021[22]):

- Use of COVID-19 community care facilities to manage patients experiencing mild COVID-19 symptoms, provide patient education on COVID-19 and work in close co-operation with other PHC centres, such as in Iceland, Slovenia and the United Kingdom;
- Expanding home-based programmes to improve access to care for all patients during the crisis and to alleviate pressure on hospitals in Canada, Spain or the United States;
- Leveraging telemedicine to support access to essential services and information. Removal of institutional barriers were required during the first wave of the COVID-19 pandemic, such as expanding insurance benefits to include telemedicine (Estonia), expanding provider payments (Canada and Australia), designing new telemedicine services (Canada and Belgium), and lifting requirements for face-to-face encounters prior to being seen virtually (France).
- Rearranging tasks and responsibilities in PHC, notably to allow community pharmacists to extend prescriptions and prescribe chronic disease medications, such as in France, Portugal or the United States.

Source: Brazilian Ministry of Health; OECD (2021[22]), Strengthening the frontline: How primary health care helps health systems adapt during the COVID-19 pandemic, https://dx.doi.org/10.1787/9a5ae6da-en.

4.2.4. The Agency for the Development of PHC is being established

The Agency for the development of PHC (*ADAPS*) is an autonomous social agency created by the Law 13 958 of December 2019. It is a privately incorporated non-profit organisation. The Agency will promote

the execution of policies for the development of PHC at the national level, including the new *Programa Médicos pelo Brasil* (see Chapter 5).

The advisory Board will consist of 12 representatives: six from the Brazilian Ministry of Health, one from CONASS, one from CONASEMS, one from the Brazilian medical association, one from the federal board of medicine, one from the Brazilian National Federation of Physicians and one from the National Council of Health (CNS).

The ADAPS will be responsible for PHC service provision, professional training and qualification, research and extension, incorporation of health care management technology, monitoring and assessment of health care activities, and execution of the new *Programa Médicos pelo Brasil*. It is expected that the new ADAPS will provide support for actions within the municipalities to execute the PNAB. This is a welcome development to provide support to vulnerable municipalities with low capacities and greater health care needs.

4.3. Brazil has put in place a number of initiatives to support improvements in quality of care

Several initiatives have been introduced within SUS to improve the quality and the performance of PHC in Brazil. These include the development of standards of care and guidelines, of health care services portfolio, of pay-for-performance programmes and the production and publication of data underpinning PHC.

4.3.1. Few institutions are responsible for improving quality of PHC

As mentioned in Chapter 2, the Política Nacional de Atenção Básica (PNAB) describes the aspects of the governance, the roles of different actors and other aspects of policy settings and governance for PHC.

The SUS National Audit Department (DENASUS) performs audits of Municipal Health Secretariats to verify the compliance with the PNAB. Based on auditing activities, DENASUS is also responsible for monitoring compliance with the recommendations from the Ministry of Health. The Department proposes and promotes methods to assist the execution and implementation of policies. It can provide technical and methodological support to the states, the federal district, and the municipalities as part of the SUS National Auditing System. However, DENASUS is a central entity of SUS National Auditing System, and does not work as an inspectorate for health to provide independent verification that standards of care are being met.

4.3.2. Standards of care and guidelines help structure the FHT responses to most health problems

In Brazil, practice clinical guidelines are developed by governmental and non-governmental organisations at municipal, state or federal government levels. The Ministry of Health and some professional and scientific societies such as the Brazilian Medical Association, the Brazilian Society of Diabetes or the Brazilian Society of Cardiology are involved in clinical practice guidelines (CPGs).

There are also the PHC Notebooks[1] (*Cadernos de Atencao Basica en Atencao Primaria*) which are clinical practice guidelines specifically designed for FHTs to improve the delivery of high quality PHC (Ministerio de Saude, 2021[23]). They are produced by CONASS to provide guidance on for example how to better meet the health needs of people, ensuring the diagnosis of morbidity, initiating and monitoring the treatment and control of diseases or risk factors. These guidelines are easily available to FHTs.

Many of the PHC Notebooks address specific diseases or risk factors such as care for the smokers (Cadernos de Atenção Básica 40), obesity (Cadernos de Atenção Básica 38), arterial hypertension

(Cadernos de Atencao Basica 37), diabetes mellitus (Cadernos de Atenção Básica 36) and mental health (Cadernos de Atenção Básica 34).

There is one PHC notebook to address chronic diseases (Cadernos de Atenção Básica 35) published in 2014. The notebook highlights the current importance of chronic conditions, the complexity of such diseases and of interrelated risk factors. It addresses concepts common to several chronic diseases and presents guidelines for the organisation of PHC, for example on health promotion and disease prevention common to tobacco consumption and cardiovascular diseases, or common to tobacco consumption and arterial hypertension. The PHC book presents some risk stratification models, and some case studies to guide health professionals. It also includes strategies for changing habits, promoting healthy eating and practicing physical activity, approaches to building and monitoring care plans and support for self-care (Ministerio de Saude, 2014[24]).

While such guidelines are useful, the PHC notebooks are still too narrowly defined and does not meet patients' expectations on integrated health care. There are too few clinical practice guidelines addressing integration of care for high prevalence chronic diseases (see also Chapter 3). In addition, information about their effective use is lacking. Implementation is the responsibility of the municipalities, but there is no mechanism at federal level to monitor compliance, and no systematic incentives to stimulate guideline uptake. Recent evidence show that compliance to clinical practice guidelines are unsatisfactory given inadequate follow-up observation of diabetes control and blood pressure control for people with hypertension (Leite Simão et al., 2017[25]; da Silva Rêgo and Radovanovic, 2018[26]). Another study shows that the degree of compliance with preventive care norms could be improved in Brazil (Guanais et al., 2019[27]). Less than 50% of men in the target population reported a blood pressure check in the last year and a measurement of cholesterol levels in the last five years.

In addition, while high-quality clinical practice guidelines are critical for improving health care management, some studies have noticed the low quality of CPGs in Brazil. Available evidence shows that around 77% of CPGs were deemed "low quality" (de Godoi Rezende Costa Molino et al., 2016[22]). Factors undermining the quality of CPG included a lack of multi-disciplinary team for the development group, no consideration of patients' preferences, a lack of rigor of development and conflict of interest among other (de Godoi Rezende Costa Molino et al., 2016[22]).

4.3.3. The PHC Portfolio defines the protocols and services offered in PHC

The SAPS established the PHC Portfolio (*Carteira de Serviços da Atenção Primária à Saúde,* CaSAPS). The portfolio defines and presents the procedures and services that should be offered in PHC to reduce the heterogeneity of existing practices between municipalities, but also between PHC units in the same municipality. It helps FHTs to organise themselves in the service routine, and seek appropriate competences and skills to offer the actions and services define in the protocol through several actions such as continuous personal development strategies, monitoring, and evaluation (da Cunha et al., 2020[28]).

The CASAPS is one of the most important tools to support municipalities and FHTs to provide high quality care. The portfolio has already been used in Rio de Janeiro, Curitiba and Florianópolis among other places (da Cunha et al., 2020[28]). Rio de Janeiro developed his own portfolio of PHC services to address the issue of having a high concentration of patients at the secondary and tertiary levels of care seeking low complexity procedures, such as ear washing or nail extraction (Salazar, Campos and Luiza, 2017[29]). This is a source of wasted resources for the health care system, overburdening emergencies and hospitalisation services, and reducing the quality of care for PHC conditions (Salazar, Campos and Luiza, 2017[29]).

The portfolio contains 210 actions and services organised in five groups: "health promotion for adults and elderly" (44 items), "Health care for Children and adolescent's (27 items), "PHC procedures" (17 items), and "Oral health care" (21 items). Each item is associated with recommendations, materials for consultation, and lists of inputs for implementation.

The elaboration of the portfolio is based on a review and evaluation of services implemented in Brazilian cities, and on consultations with several bodies including the Ministry of Health, CONASS, CONASEMS, the Professional Associations of the Brazilian Society of Family and Community Medicine (SBMFC) or the Brazilian Association of Family and Community Nursing (ABEFACO) (da Cunha et al., 2020[28]).

In the municipality of Rio de Janeiro, the use of the Services Portfolio was associated with a better performance compared to other municipalities not using similar portfolio (da Cunha et al., 2020[28]).

While the development of such PHC portfolios contributes to strengthen the attributes of a strong and comprehensive PHC sector, an important challenge relates to the need to have appropriate training for PHC providers to be able to deliver high quality actions and services. FHTs need to have the right and sufficient equipment and capacity to execute the PHC procedures and services.

4.3.4. National Programme for Improving PHC Access and Quality had a positive impact on quality

The federal government introduced a pay-for-performance programme (P4P) for FHTs in 2011 called the National Programme for Improving Access and Quality of PHC (PMAQ-BA in Portuguese). The programme defined standards of care in accordance to the PNAB to evaluate the performance of FHTs towards a wide range of structure, process and outcomes indicators.

Three cycles have taken place (in 2011/2013, 2013/2015 and 2015/2019). Although the programme was voluntary, almost 100% of all FHTs, oral health teams, NASFs and dental specialty centres were registered in the third round of the PMAQ (compared to 71% in round 1 and 91% in round 2).

The indicators selected were infrastructure, management for PHC development, worker appreciation, access and quality of health care and user satisfaction. In the 3rd round, more than 650 indicators were included around structural quality of care (for example availability of drugs and equipment), process of care (for example antenatal care and treatment completion rates), quality of care (for example patient satisfaction), utilisation of health care (patient volume), and management processes (proportion of appointments that are scheduled) (Kovacs et al., 2021[30]).

Certification processes consisted of self- and external assessment of the teams, involving facility assessments, examination of health indicators and interviews with health care professionals, municipal managers and service users. External evaluations were conducted by independent academic institutions by collecting indicators, and by conducting interviews (Macinko, Harris and Rocha, 2017[31]). A mean score was then calculated, and grouped according to the overall human development index for their municipalities to create several strata of similar socio-economic environments.

Each team received the bonus according to its ranking compared to a mean score for their stratum:

- Those at or below the mean score for their stratum received 20% of the bonus;
- Those above the mean received 60% of the bonus;
- Those significantly above the mean receive 100% of the bonus.

From 2011 to August 2018, the Ministry of Health has invested BRL 9.85 billion (USD 2.52 billion). The bonus ranges from BRL 1 700 (USD 434.55) to BRL 11 000 (USD 2 811.79) per team and month based on their performance (de Medeiros et al., 2020[32]).

One important consideration was the fact that each's team score was made publicly available on the Ministry of Health's website. It enhanced transparency and allowed citizens and health managers to see the overall performance of each team and the associated assessments. Each team was compared to municipal, states, and national averages, which helped nurture a quality improvement culture in PHC services.

Available data shows that PMAQ has led to an increase in federal investment for infrastructure, and a large increase in performance incentives (Macinko, Harris and Rocha, 2017[31]). In addition, the PMAQ has been associated with an increase in the provision of care to pregnant women and children under 2 years, with more significant improvement among the worst performing PHC providers (de Medeiros et al., 2020[32]). The positive impact of the PMAQ is also confirmed by a recent evaluation showing positive effects on the quality and access of PHC (Soares and Ramos, 2020[33]). On average, municipalities that adhered to the PMAQ had rates of hospitalisation for chronic conditions 9% inferior to those that did not adhere *ceteris paribus*. The effect of the programme was more pronounced in the Northeast regions of Brazil (rates of hospitalisation for chronic conditions 14% inferior for municipalities that adhered to the programme), and less pronounced for Southeast region (rates of hospitalisation for chronic conditions 5% lower for municipalities that adhered to the programme). Kovacs and al (2021) also showed that existing income inequalities in the delivery of quality PHC were eliminating during the three period of PMAQ implementation, due mainly to the design feature that adjusted financial payments for socio-economic inequalities (poorer municipalities received higher rewards than richer municipalities) (Kovacs et al., 2021[30]).

However, several failures of the programme were noted, including the very large group of indicators used (with almost 900 questions) and a too large focus on structure indicators, with little emphasis on outcomes indicators. According to the Ministry of health, the high number of indicators resulted in monitoring problems and lack of adherence by municipal managers. It is also reported that external evaluation as part of PMAQ was highly criticised, and thus not carried-out by health professionals. Lastly, the payment made by the Ministry of Health were directed towards the municipality and not the FHT. Municipalities were free to provide bonus payments to the team but little is known on the actual practice (Macinko, Harris and Rocha, 2017[31])

Despite these failures, the PMAQ programme had resulted in improvement of quality of PHC, notably because it was possible during the eight years of implementation to monitor improvements in infrastructure, medical supplies, medications and health outcomes.

4.3.5. The Previne Brasil established a new pay-for-performance scheme

With the reform of the PHC financing model, the federal government introduced a new P4P programme in 2020 as part of the *Previne Brasil programme*.

The new P4P programme is compulsory and focussed on fewer priority areas than the previous PMAQ programme. The initial number of indicators used in this programme was set at seven in 2020 and will rise to 21 by 2022.

In 2020, priority is given to prenatal care, women's health, child immunisation and two chronic conditions (hypertension and diabetes mellitus) (Ministério da Saúde, 2019[15]). The selected indicators are:

- Share of pregnant women with six or more prenatal consultations in the first 20 weeks of pregnancy
- Share of pregnant women with tests for syphilis and HIV carried out
- Share of pregnant women with dental examination
- Pap smear test carried out to detect cervical cancer
- Coverage of inactive polio and pentavalent vaccines
- Share of patients diagnosed with hypertension which have their blood pressure measured every six months
- Share of patients with diagnosed diabetes with controlled haemoglobin level.

For each of the seven indicators, weights of 1 or 2 are assigned to calculate the Final Synthetic Indicator. The weights reflect the clinical and epidemiological relevance of the indicator, as well as the level of difficulty in achieving the targets. This translates the effort of managers and teams to carry out actions,

programs and strategies. Table 4.3 presents the overall targets, the targets for 2020 and the weights defined for each indicator.

Table 4.3. Targets and weights assigned for each performance indicator, 2020

	Domains and indicators	Overall targets	Targets for 2020	Weights
Women health	Share of pregnant women with 6 or more prenatal consultations in the first 20 weeks of pregnancy	>=80%	60%	1
	Share of pregnant women with tests for syphilis and HIV carried out	>=95%	60%	1
	Share of pregnant women with dental examination	>=90%	60%	2
	Pap smear test carried out to detect cervical cancer	>=80%	40%	1
Care for children	Coverage of inactive polio and pentavalent vaccines	>=95%	95%	2
Care for chronic diseases	Share of patients diagnosed with hypertension which have their blood pressure measured every 6 months	>=90%	50%	2
	Share of patients with diagnosed diabetes with controlled haemoglobin level.	>=90%	50%	1

Source: Ministério da Saúde (2019[34]), NOTA TÉCNICA Nº 5/2020-DESF/SAPS/MS.

The performance score for each indicator will range from zero to ten, considering the targets for 2020 and the weighting scale. If the result for a given indicator is 30%, while the target is 60% for 2020, the final score for this indicator will be 5.0 (Ministério da Saúde, 2019[34]).

Further indicators to be included in the years 2022 will be discussed after evaluation and will cover the following areas: care for new-borns; care for babies (under 1-year-old); HIV, Tuberculosis, dental care, hepatitis, mental health, breast cancer, multi-professional action, and global measures including patient experience. Patient experience measurement will rely on population-based surveys conducted by the Brazilian Institute of Geography and Statistics (IBGE), which use PHC Assessment Tool (PCATool), the Patient-Doctor Relationship Questionnaire (PDRQ-9) and the Net Promoter Score (NPS) (Ministério da Saúde, 2019[15]).

While all these standards of care are based on scientific evidence, and selected on epidemiological and clinical relevance, there are all process indicators to assess the quality of care delivered.

The P4P programme and related transferred resources correspond to 9% (BRL 1.8 billion) of the budget linked to the *Previne Brasil* Programme. Performance indicators are collected every four months, and bonuses are paid monthly to municipalities based on the performance of their respective teams.

The amount of the performance payment vary according to the classification of team (Ministério da Saùde, 2020[35]). The following performance payment, referring to 100% of the Final Synthetic Indicator, are equivalent to:

- BRL 3 225.00 for the FHT;
- BRL 2 418.75 for the PHC Team Modality II 30h; and
- BRL 1 612.50 for the PHC Team Modality I 20h.

Results are publicly available on the Health Information System for PHC (SIAB) in the form of reports and dashboards, and on the e-Gestor AB web platform so that all municipalities and states can follow and adopt quality improvement strategies (e-Gestor AB, 2021[36]).

4.3.6. The Brazilian Government has invested a lot of efforts in the production and publication of data underpinning PHC

Several initiatives have been implemented to monitor the resources and activities in the PHC sector in Brazil. Within the Ministry of Health, the Department of Health Information (DATASUS) holds several databases including the national register of health facilities (CNES), the National Program of Immunization (SI-PNI), the System for prenatal care (SIPRENATAL) and the PHC Information System (SISAB, previously called SIAB) to mention a few.

The SISAB was established by Ordinance GM/MS N° 1 412 of July 2013 for the financing purpose and for implementing the PNAB. Community health workers collect on a monthly basis health and social data, monitoring of risks groups, priority health problems, child's follow-up, and on certain diseases and risk factors for health including alcoholism, disability, diabetes, epilepsy, hypertension, malaria or tuberculosis (Lopes, Monteiro and Santos, 2020[37]). The SISAB also integrates the information related to social programmes including Health at School Programme (*Saúde na Escola*) or the Health Academy Programme (*Academia da Saúde*).

While the SISAB gathers an impressive amount of indicators underpinning PHC, most indicators are inputs and process indicators including for example the number of FHTs, the number of people registered with a FHT, the number of community health agents, or the number of pregnant women receiving first prenatal care services (SISAB, 2021[38]).

It is fair to note that Brazil has developed some actionable indicators to support quality improvement in PHC, notably through the PMAQ strategy and the newly *Previne Brasil* programme. In 2020, quality indicators designed as part of the P4P programme are process indicators focussing on maternal health, cervical screening programme, immunisation coverage, and management of hypertension and diabetes. Still, they are good measures of the quality of care delivered by each FHT.

Input and process indicators are made publicly available, broken down by Federative Unit and Region, by urban or rural areas and by age group. The data can be presented in various formats such as tables, graphs, maps and technical documents in order to facilitate the interpretation and analysis of the data. This is an important quality initiative in Brazil as open publication promotes transparency within the PHC sector and expand the possibilities for improving care quality. However, the data is not published at more local, granular level. To date, patients are not allowed to monitor activity and quality of PHC at FHT level. Municipal health managers and FHTs have however access to their performance results through the e-Gestor AB portal (e-Gestor AB, 2021[36]).

At the same time, national reports based on the DATASUS databases are publicly available to assess and monitor population health and the health care system. The *Indicadores de Saúde no Brasil: conceitos e aplicações* for example reports data on health expectancy, diseases-specific mortality rates, diseases-specific incidence rates, prevalence of risk factors for health and some health care resources and activities.[2] The 2019 National Health Survey, which was jointly published by the IBGE and the SAPS, focuses in particular on access and use of PHC services.[3] The Survey provides data on access in PHC, it provides some prevalence rates for risk factors for health and some quality indicators around maternal health or cancer screening programmes. Importantly, the PHC module of the survey consisted of 26 items distributed in 10 components based on the PHC Assessment Tool (PCAT) developed by Starfield and Shi (Pinto and Silva, 2021[39]). The use of PCAT allowed to assess the attributes and the characteristics of a strong PHC: first contact access, longitudinal, co-ordination, comprehensiveness, family orientation, and community orientation (the next section of this chapter presents the results of the 2019 National Health Survey). Incorporating a standardised and internationally validated instruments for the evaluation of PHC services is a major step in Brazil to improve the provision of high quality patient centred care. It demonstrates the high political will to strengthen PHC services in Brazil.

It is also important to note that the e-SUS PHC System was developed to be used in multiple computerisation and care settings, ranging from PHC units without computers to those with computers and the internet (Sousa et al., 2019[40]). The e-SUS PHC System is made of two softwares: simplified data collection and individual health records. The simplified data collection has been specifically developed for non-computerised environments. It is a software for entering a set of files that include the work process of FHTs. Today, only around 40% of FHTs do have adopted the individual health records (see also Chapter 6).

While there is lot of data underpinning PHC in Brazil, some studies have noted the poor reliability and quality of the collected information for planning and public decision making (Lopes, Monteiro and Santos, 2020[37]). As municipalities can be penalised with cancellation of their funding resources, the work process is rather motivated by production targets. It is reported that community health workers, responsible for the data collection, have not properly completed the forms because they do not have the knowledge and training to perform the task. So far, these data have not been used to estimate diseases prevalence, characterise the epidemiological profile of the population, assess health status and even more important be linked with other information system. (Lopes, Monteiro and Santos, 2020[37]). This is a challenge also reported by the OECD Brazil Health System review (OECD, 2021[41]).

4.4. Outcomes associated with PHC

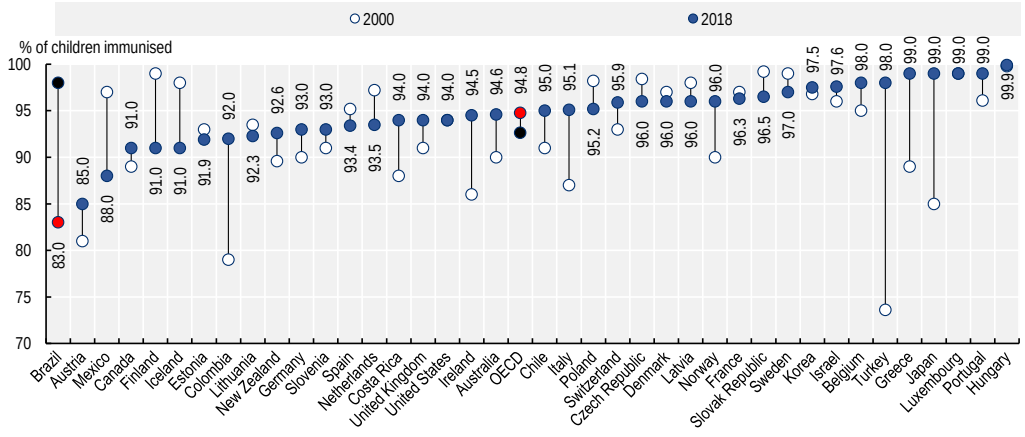
Despite progress, several indicators pertaining to quality of PHC place Brazil among poor performers. PHC in Brazil has traditionally been characterised by providing few low complexity procedures and surgeries. In addition, international figures demonstrate that Brazil lags behind other countries regarding to preventive care and management of chronic conditions. Large regional differences in health care quality also suggest that some remote and vulnerable areas require more attention, more support than others to improve quality of PHC.

4.4.1. Brazil lags behind other countries with regards to preventive care

There is strong evidence that vaccines provide safe and effective protection against diseases such as diphtheria, tetanus, pertussis, measles, and hepatitis B. The proportion of children protected from these diseases can be considered as an indicator of quality in PHC. According to the WHO Global health Observatory, 84% of Brazilian children aged around 1 were vaccinated against measles, below the average in OECD countries (95%). Additionally, 83% of Brazilian children aged around 1 were vaccinated against diphtheria, tetanus, and pertussis, compared with OECD average of 95% (Figure 4.2). In a similar vein, Brazil achieved 83% coverage for vaccination against hepatitis B for children aged around 1, compared with the OECD average of 91%.

There are also significant inequalities in the rates of vaccination against yellow fever in Brazilian states where vaccination has been recommended, ranging, in 2018, from 21.8% in Sergipe to 100% in the Federal District and Roraima (the national average for all states where vaccination is recommended is 64.1%).

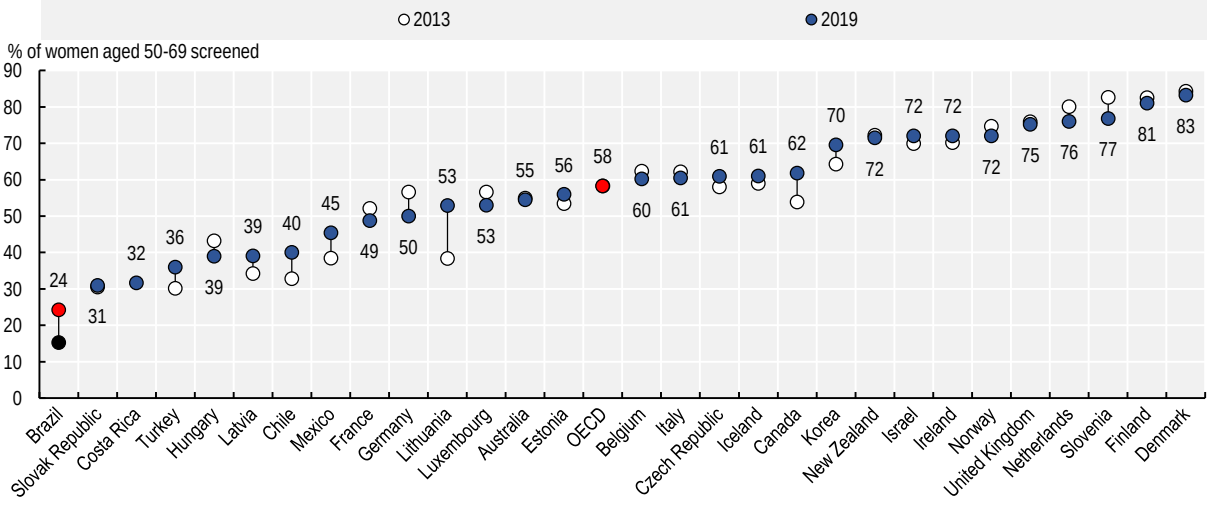
Figure 4.2. Vaccination rates for diphtheria, tetanus toxoid and pertussis (DTP3), children aged around 1, 2000 and 2018 (or latest year available)



Source: OECD (2021[42]), Health Statistics Database, https://www.oecd.org/health/health-data.htm; Brazilian Ministry of Health.

International figures also show that breast and cervical cancer screening needs to improve. Although screening for breast cancer in Brazil has improved in recent years, breast cancer screening coverage in Brazil (at 24%) is very low when compared to OECD countries. Brazil stands below all OECD countries and well below the 58% of average coverage (Figure 4.3). In a similar vein, cervical cancer screening in Brazil stands at 37.1% in 2019, well below the OECD average coverage of 58% (see Chapter 3 on Screening in PHC).

Figure 4.3. Breast cancer screening coverage in Brazil and OECD countries, 2013 and 2019 (or latest year available)



Note: Programme data is used for all countries. Brazil represent years 2014 and 2019.
Source: OECD (2021[42]), Health Statistics Database, https://www.oecd.org/health/health-data.htm; Brazilian Ministry of Health.

Inappropriate preventive care has also been highlighted by previous studies. The use of patient-reported experience measures for the prevention, detection and management of chronic diseases has shown that only around one people over five reported that their PHC physicians sent a reminder for check-up among

SUS users (Guanais et al., 2019[27]). In addition only 22% of SUS users indicated that they had received some recommendation on healthy lifestyles from their family doctor, and less than 40% of public users had a preventive visit in the past two years.

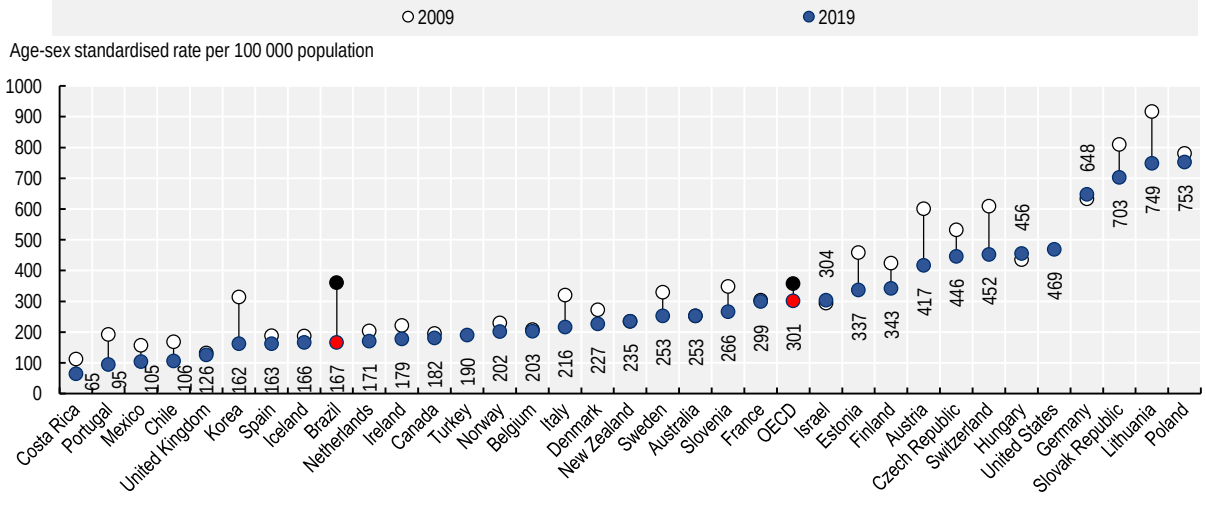
More preventive care is warranted in Brazil at a time when the burden of disease is shifting towards chronic diseases.

4.4.2. Indicators around the management of chronic conditions give some cause for concern

Hospitalisations for chronic conditions, also known as avoidable hospitalisations, are used as an indirect indicator of the overall effectiveness of PHC. There is growing evidence that proactive management of some chronic conditions may prevent or reduce the need for acute hospital admission (OECD, 2020[43]). Ambulatory care sensitive conditions, such as asthma, chronic obstructive pulmonary disease (COPD), congestive heart failure, and diabetes, are conditions for which accessible and effective PHC can generally reduce the risk of complications and prevent the need for hospitalisation. The evidence base for effective treatment for these conditions is well established and much of it can be delivered at a PHC level. Therefore, a high performing PHC system should be able to avoid to a large extent any acute deterioration of the health status of people living with chronic conditions and prevent their admission to hospital.

In Brazil, hospitalisations for chronic conditions are lower than in OECD countries. The rate of diabetes hospital admissions in 2019 was 92 admissions per 100 000 people, below the OECD average of 131 (see Chapter 3). In addition, hospital admission rates for congestive heart failure (CHF) and hypertension are lower in Brazil than the OECD average, but still higher than other LAC countries including Costa Rica, Mexico, or Chile (Figure 4.4).

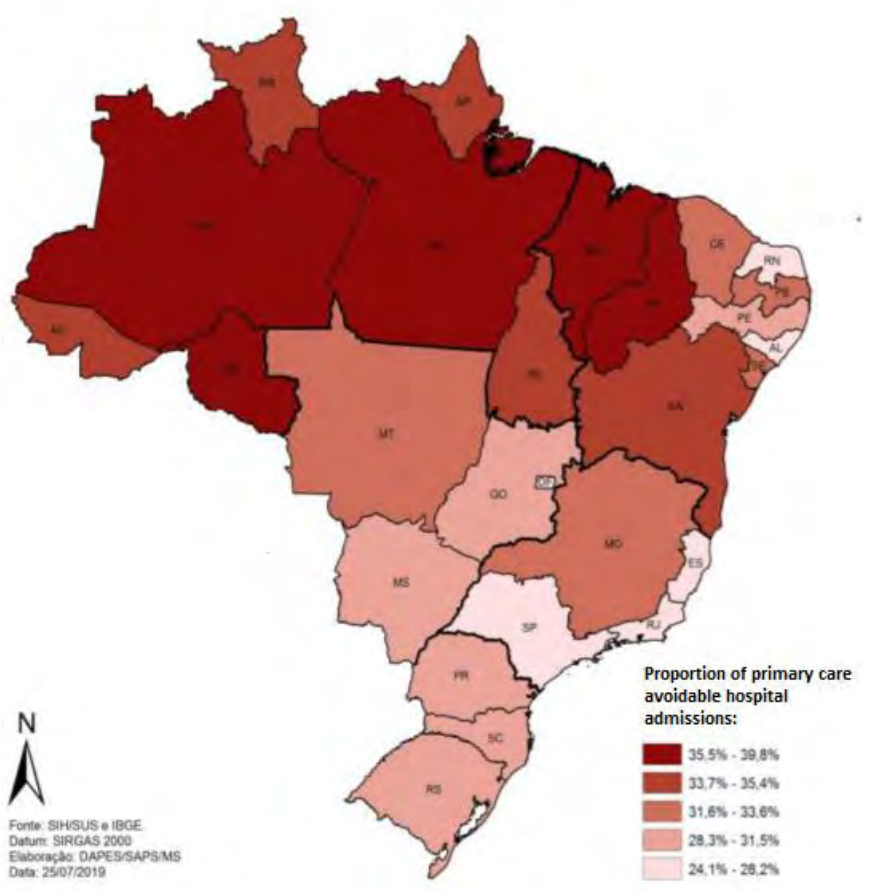
Figure 4.4. Congestive heart failure (CHF) and hypertension hospital admissions in adults, 2009 and 2019 (or latest year available)



Source: OECD (2021[42]), Health Statistics Database, https://www.oecd.org/health/health-data.htm; Brazilian Ministry of Health.

In Brazil, lower rates of avoidable hospital admissions can be the result of a lower prevalence of chronic conditions than across OECD countries. At the same time, whilst the performance is good on average, there are significant differences across regions. There is a North-South gradient where North and Northeast regions show higher hospitalisation rates for chronic conditions (Figure 4.5).

Figure 4.5. Share of hospital admissions due to conditions that are treatable in PHC, population aged 60 or more by region, 2019

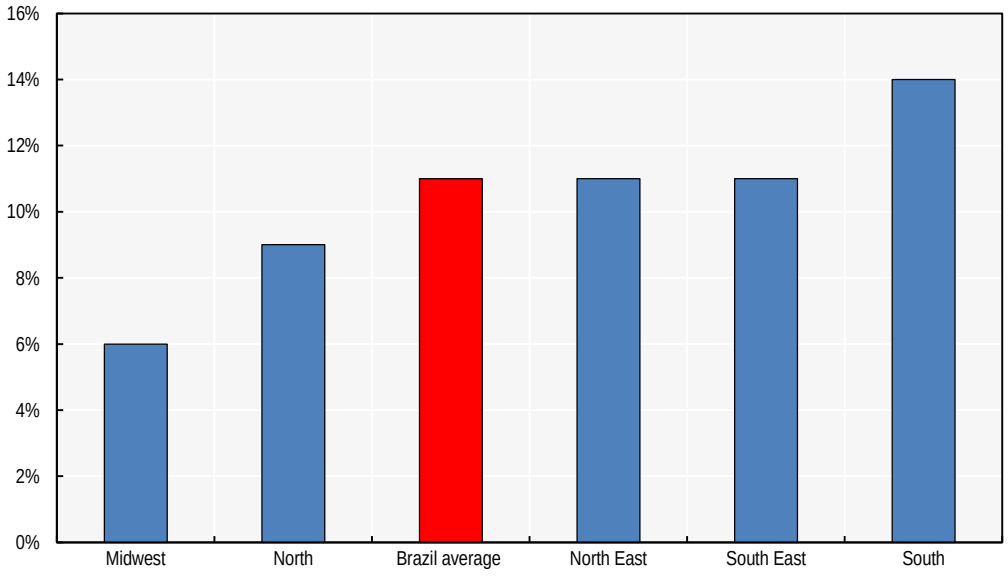


Source: Ministério da Saúde (2020[44]), Plano Nacional de Saúde 2020-23.

The 2019 Health Interview Survey also corroborates the North-South gradient. Accordingly, diabetic patients have a higher likelihood of complications (as measured in hospitalisations) in the Northeast than in the Southeast (IGBE, 2020[45]).

High hospitalisation rates for chronic conditions show that recommended care is not always provided for people with these conditions. This is confirmed by performance indicators reported in the SIAB system. Two indicators relate to whether people with diabetes and hypertension are receiving recommended care or effective management for their conditions. In 2020, only 4% of hypertensive patients had their blood pressure measured every semester, and only 11% of diabetics patients had controlled haemoglobin level (SISAB, 2021[38]). Although such very low performance scores certainly reflect difficulties in recording and monitoring PHC activities by municipalities, it gives some cause for concern. Again, the South and Southeast regions report higher performance score than the North, Northeast and Central-West region regarding to the management of diabetes patients (Figure 4.6).

Figure 4.6. Share of diabetes patients with controlled haemoglobin level, 2020 (Q3)



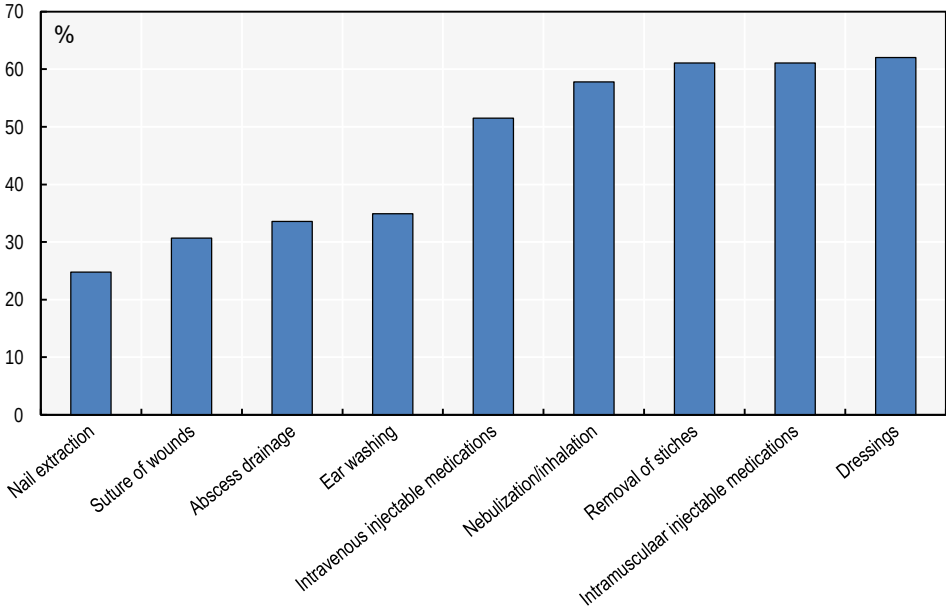
Source: Ministério da Saúde (2021[46]), Secretary of Primary Health Care, Performance indicators by Regions, https://sisab.saude.gov.br/paginas/acessoRestrito/relatorio/federal/indicadores/indicadorPainel.xhtml

Such inequalities in favour of wealthier regions can be explained by a greater supply of PHC services, health workers, equipment and compliance with clinical practice guidelines or standard treatment guidelines. The use of therapeutic guidelines protocol for hypertension, diabetes, tuberculosis, leprosy and mental health service is found to be consistently lower in small geographical areas (Salazar, Campos and Luiza, 2017[47]). Kovacs et al. (2021) also confirmed that FHTs located in poorer areas performed significantly worse than those in richer areas. A PMAQ performance score across 20 income groups has shown that a higher monthly household income of BRL 1 000 was associated with a 1.59 percentage point higher PMAQ score (Macinko, Harris and Rocha, 2017[31]).

4.4.3. Simple procedures and small surgeries are not always provided by family health teams

Simple procedures and surgeries should be widely provided in PHC settings. This is both a matter of striving for better safety and care quality, and an economic necessity. However, available data from the PMAQ programme show that only 62.8% of FHTs performed low complexity procedures or small surgeries in 2012. Worst, only one-third of FHTs performed suture of wounds and abscess drainage. The highest national share for low complexity procedures is around 60% for removal of stiches, dressings, or intramuscular injectable medications (Figure 4.7). Still, this is too few if Brazil wants to increase the responsibility of PHC.

Figure 4.7. PHC has historically offered a low supply of procedures



Source: Adapted from Salazar, Campos and Luiza (2017[47]), The Rio de Janeiro Municipality's Services Portfolio and Health Actions in Primary Care in Brazil, https://doi.org/10.1590/1413-81232017223.33442016.

The low supply of simple procedures and surgeries is a source of care fragmentation and inappropriate referrals to more specialised care. High turnover of medical doctor, inadequate training to practise as PHC physicians, and the lack of equipment or resources are leading factors contributing to the difficulty of performing such procedures for FHTs (Salazar, Campos and Luiza, 2017[47]).

4.4.4. There is scope to improve patient experiences with public PHC services

Recent data from the 2019 National Health survey show that patient experience with PHC in Brazil needs to further improve. PHC obtains an overall score of 5.9 on a scale of 0 to 10, which is below the benchmark value of 6.6 recommended by the PCAT methodology (IBGE, 2019[48]). Some differences appear when considering registered households and non-registered households (Table 4.4). The general score was 6.0 for registered people versus 5.5 for non-registered people. The score was also more favourable among household that received at least one visit from community health workers or other members of the FHT, and for people having chronic conditions. People living in the South region also reported a higher score (6.3) than people living in the North (5.5).

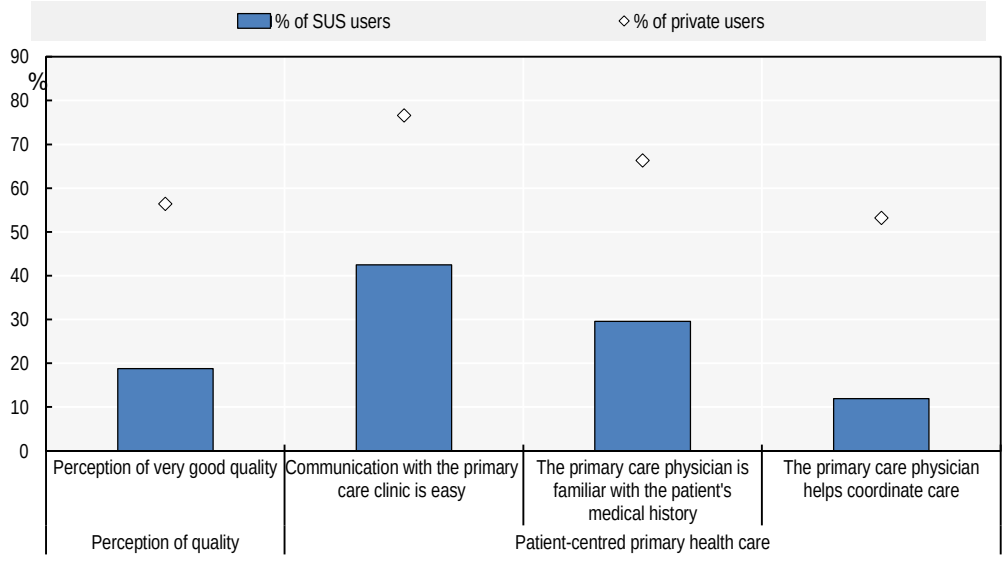
Less recent data looked at people-centeredness of PHC in Brazil. Good provider-patient communication and patient involvement in care and treatment decisions are key dimensions of patient centeredness, alongside the dimension of co-production which entails patients self-management and care co-ordination (OECD, Forthcoming[49]). Results from the PMAQ 2017 cycle showed that around 90% of patients reported that PHC doctors provided easy-to-understand explanation, and involved patients in decisions about care and treatment. An adaptation of the Commonwealth Funds International Health Policy Survey to the LAC context has shown a large variation in patient's experience between public and private users. SUS users were consistently less likely to report a positive experience with PHC compared to private users (Figure 4.8).

Table 4.4. Overall mean score of PHC (value from 0 to 10) depending on individual characteristics

Individual characteristics	Yes	No
Arterial hypertension	6.2	5.7
Diabetes	6.3	5.8
Heart disease	6.4	5.8
Depression	6.1	5.8
Is the household registered at the family health facility	6.0	5.5
Visit from community health workers	6.1	5.7
Overall score per Regions		
North	5.5	
Northeast	5.8	
Southeast	5.8	
South	6.3	
Midwest	5.8	

Source: IBGE (2019[48]), Pesquisa Nacional de Saude in Portuguese: Atenção primária à saúde e informações antropométricas, https://biblioteca.ibge.gov.br/visualizacao/livros/liv101758.pdf

Figure 4.8. SUS users consistently report lower patient experiences with PHC than private users, 2013



Note: Prevalence are adjusted for sex, age, level of education and self-reported health status.
Source: Authors, adapted from Guanais et al. (2019[27]), From the patient's perspective: experiences with primary health care in Latin America and the Caribbean.

4.5. Securing a greater quality dividend from PHC in Brazil

4.5.1. Strengthening the gatekeeping system to better recognise the central role of FHTs

While the overarching objective of the Family Health Strategy was to strengthen access to care, 20 years after its implementation only about 65% of the Brazilian population are currently registered with a FHT. The number of registered people is increasing in recent years following the *Previne Brasil* Programme

(Figure 4.1). Still, this is too low to address the new Brazilian's health care needs characterised by rising burden of chronic conditions and risk factors for health.

In addition, many Brazilians have direct access to outpatient specialties and hospitals for minor conditions that could be treated more effectively in primary are settings. The latest Health Information Survey for example found that around 50% of the diabetic population identified basic health units as their last contact to the health system, 11% used public speciality units in hospitals, 6% public urgent care units and 30% private practices or clinics (IBGE, 2020[50]). The later example confirms that a significant proportion of the population uses public speciality units or emergency departments for provision of chronic services, while these types of conditions are best treated in PHC settings. These give strong arguments to strengthen the gatekeeping system in Brazil with a systematic registration system with FHTs, which better control and orient the patient's into specialist care.

Gatekeeping system with a named PHC doctor or a FHT who provide overall care co-ordination can drive better care for patients, particularly for those having chronic diseases. It refers to the arrangement where a patient is only seen by a hospital specialist if authorised by the PHC physician who is responsible for overseeing and co-ordinating the health needs and providing care. In a recent systematic review of the literature, Sripa, Hayhoe, Garg et al. confirmed that gatekeeping was associated with better quality of care and appropriate referral for further hospital visits and investigation (Sripa et al., 2019[51]). Overall gatekeeping resulted in fewer hospitalisations and use of specialist care, but also led to lower patients satisfaction because it limits patient choice (Sripa et al., 2019[51]). In addition, a systematic registration system allow to build a profile of the health needs of the registered population, which improve care continuity through better patients' relationship to PHC providers (Starfield, Shi and Macinko, 2005[52]; Kringos et al., 2010[53]). Having a PHC physician as a regular source of care consistently show benefits for a variety of health and health related outcomes (Starfield, Shi and Macinko, 2005[52]). It allows for the provision of continuous and comprehensive care, focused on prevention and management of long-term conditions.

Box 4.3. Introducing a compulsory registration system in Norway

While before 2000, Norwegian citizens were able to consult GPs without restrictions, the Regular General Practitioner reform introduced a compulsory registration system. Pilot of the reform was undertaken in four municipalities in 1993 prior to national implementation.

With the reform, the general practitioner became responsible for providing and co-ordinating prevention, investigation and treatment of health care needs. He is also responsible for decisions on the need for referral to secondary care, and link with social security and social services when appropriate. The reform also specified that GPs should engage in public health activities, emergency care, out-of-hours care, and supervise students and doctors in training.

National implementation was a success, with close to 100% of Norwegians now registered with a GP. The scheme has been regarded as one of the most successful public services in Norway, with high satisfaction among both patients and GPs (Svedahl et al., 2019[54])

Source: OECD (2014[55]), *OECD Reviews of Health Care Quality: Norway 2014: Raising Standards*, https://dx.doi.org/10.1787/9789264208469-en.

Some OECD countries have introduced a compulsory registration system to encourage the right care at the right place (Box 4.3). In Norway, the Regular General Practitioner reform introduced in 2000 required all citizens to register with a named general practitioner (GP) of their choice. General practitioners became the usual source of care for people, and are now responsible for co-ordinating individual's prevention,

investigation, and treatment of health care needs. This approach is also taken in Chile, Portugal, and Italy: in these countries, the population are required to register with a PHC physician who control access to secondary health care (OECD, 2020[43]). Strengthening the gatekeeping system by requiring all individuals to register with a FHTs is a reform that Brazil wishes to consider in the future to strengthen the role and accelerate the expansion of the FHTs. This would help build accurate patient registers, and better recognise the central co-ordinating role of FHTs.

4.5.2. Expanding the range of health care services provided by FHTs towards disease prevention, treatment and management of long term conditions

In recognition of the challenges set out in Section 4.4, there is an increasing need to support and encourage FHTs to deliver a modern PHC service. A key function of a modern PHC is the provision of continuous and comprehensive care, focused on health promotion, prevention, treatment, follow-up of diagnoses and management of chronic and long-term conditions.

Previous studies have shown that PHC, when well equipped, can deal with a large range of health problems, including health promotion, preventive care, treatment and follow-up of diagnoses and simple technical procedures (Starfield, Shi and Macinko, 2005[52]; Kringos et al., 2010[53]). A comprehensive scope of PHC services is consistently associated with lower hospitalisation for chronic conditions, improved health outcomes and reduce health inequalities (OECD, 2020[43]; Starfield, Shi and Macinko, 2005[52]; Kringos et al., 2010[53]).

Underpinning greater comprehensiveness of PHC services entails delivering actions defined in the PHC Portfolio, and ensuring that all municipalities are able to properly deliver these actions and health care services. In Rio de Janeiro, the Health Services Portfolio has been found to be an important guiding tool to standardise and improve the range of services offered by FHTs (Salazar, Campos and Luiza, 2017[47]). For all defined procedures, Rio de Janeiro reports better performance than national average or other urban centres. An important policy lever has been the use of management agreements to foster compliance with the Health Services Portfolio. One indicator called “rate of implementation of items of the services portfolio” is monitored quarterly as part of the agreement, which enables to highlight problems in the practice and take corrective actions. Such a good practice could be consolidated nationwide. Another option for consideration, would be to monitor compliance rates with the CaSAPs and link it to financial incentives attributed in the Strategic Actions of the *Previne Brasil* Programme.

In a similar vein, although a number of clinical guidelines are produced in Brazil, there are no requirements and few incentives for FHTs to comply with the standard level of care. There is a risk, then, that these guidelines are not adequately adopted by FHTs. Experiences from OECD countries can be useful for Brazil in its efforts to improve compliance to clinical guidelines. Some OECD countries provide grants to municipalities to encourage compliance with clinical practice guidelines. In Sweden, the central government provides grants to regional governments to encourage guideline implementation (OECD, 2013[56]). New guidelines on dementia, for example, were accompanied by grants to be disbursed to local government, which were then free to use the additional funds as they saw fit. This approach maintains local responsibility for effective implementation, whilst drawing in national resources and support (OECD, 2013[56]). Arguably, the Ministry of Health could use the *Previne Brasil* Programme to monitor and encourage more systematic compliance with clinical guidelines.

At the same time, there is a need to support continuing medical education (CME). As earlier mentioned, a number of bodies such as the CONASS, CONASEM, the Brazilian Medical Association or the Brazilian Society of Family Medicine organise several training, conferences and on-line learning. However, a more formal CME framework which makes clear the expectation upon each FHT members, and supports them to meet it will be required to provide comprehensiveness of PHC services, and in line with the best available evidence.

4.5.3. Quality monitoring and benchmarking within PHC needs to improve

A fundamental element within a strengthened PHC sector is a data infrastructure capable of monitoring and benchmarking PHC activities and outcomes in a consistent way at national, municipal and provider level (OECD, 2020[43]).

Brazil collects several indicators on access to PHC, risk factors and quality for maternal health, child immunisation, breast cancer screening and management of hypertension and diabetes a part of the *Previne Brasil* Programme. While it is an important initiative toward quality monitoring, five quality indicators are process indicators, and only 2 indicators are intermediate outcomes measures. Better measurement of patient outcomes and experiences with PHC needs to be a priority in Brazil.

It will be important for Brazil to collect a richer set of quality indicators on a wider array of preventive activities and management of chronic conditions such as alcohol consumption, obesity, cancer screening or mental health. The experience from Portugal can be helpful to inform Brazil on the development of candidate indicators. Portugal has an extensive quality information infrastructure for PHC, which are collected as part of the contracting arrangements with PHC bodies (OECD, 2015[57]). The indicators provide information to senior management to evaluate performance and achievement, benchmarked against other institutions (OECD, 2015[57]). Indicators are collected across several domains – women's health and family planning; maternal health; child and youth health; hypertension; diabetes; cancer screening; mental health or patient experience (Table 4.5).

Table 4.5. Examples of indicators collected in Portugal

Domains	Indicators
Hypertension	Proportion of clients with hypertension, with at least one record of BMI in the last 12 months
	Proportion of users with hypertension with blood pressure recording in each semester
Diabetes	Proportion of users with diabetes, with at least one foot examination of recorded in the last year
	Proportion of clients with diabetes, with record management regimen (three items) in the last year
	Proportion of clients with diabetes, with consultation of nursing surveillance diabetes in the last year
	Proportion of clients with diabetes, with at least two HgbA1c tests in the past year
	Proportion of clients with diabetes, with the last record HgbA1c lower or equal to 8.0%
	Proportion of users with diabetes, with at least one or at least referencing a record of performing examination of the retina, in the last year
Mental health	Proportion of users aged over 18 years and a diagnosis of depression who were prescribed antidepressant therapy
	Proportion of users aged over 65 years who were not anxiolytics or sedatives or hypnotics prescribed in the period
Screening and prevention	Share of women with mammography in recent two years
	Proportion of users aged years with screening for colon and rectal cancer performed
	Proportion of users aged 14 and over, with quantification of smoking habits in the last three years
	Proportion of users aged over 14 years and with smoking, whom smoking-related consultation was held in the last year
	Proportion of users aged 14 and over, with quantification of alcohol consumption, registered in the last three years
Pharmaceuticals	Proportion of users aged over 75 years, with chronic lower than five prescription drugs
	Proportion of packaging billed drugs that are generic
	Proportion of users aged over 65 years with no prescription trimetazidine in the last year
Patient experience	Proportion of users satisfied or very satisfied
	Number complaints per 1 000 medical consultations conducted by doctors or nurses

Source: OECD (2015[57]), *OECD Reviews of Health Care Quality: Portugal 2015: Raising Standards*, https://dx.doi.org/10.1787/9789264225985-en.

Another best practice example across the OECD is from the National Programme for Quality Indicators in Community Healthcare (QICH). The programme is used to monitor and improve the quality of preventive, diagnostic, and therapeutic PHC services in Israel. The indicators in QICH cover nine clinical areas: health

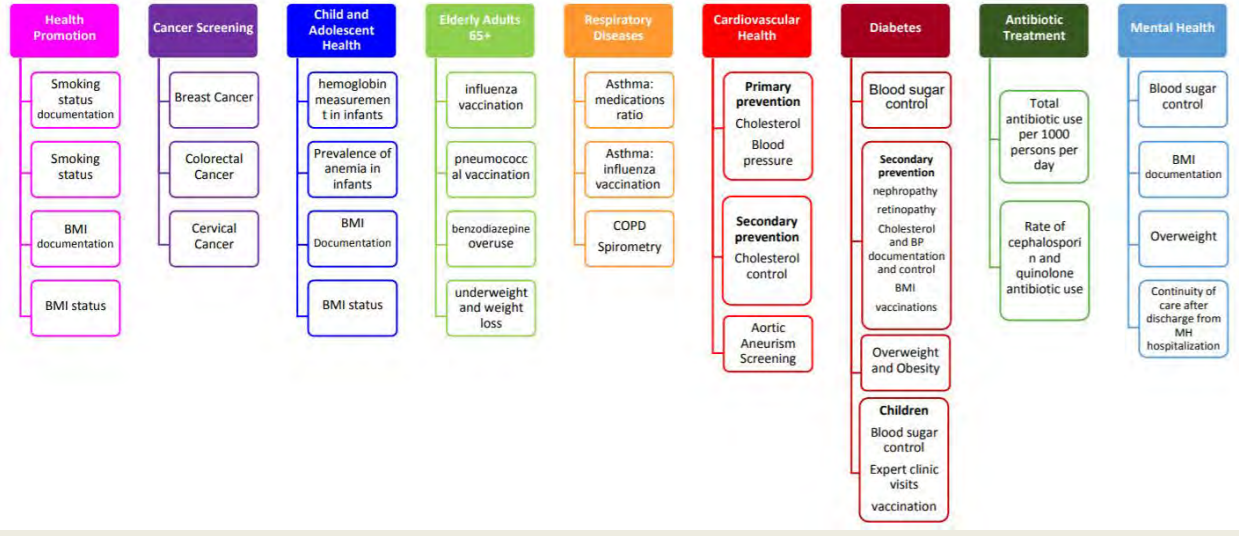
promotion, child and adolescent health, cancer screening (breast, colorectal and cervical cancer), elderly health, respiratory diseases, cardiovascular health, diabetes, antibiotic treatment and mental health. QICH incorporates a focus on primary prevention and management of chronic conditions, as demonstrated by the inclusion of indicators relating to risk factors in the general population, and the focus on COPD and asthma, diabetes, cardiovascular diseases and mental health (Box 4.4). Data quality for QICH is ensured through the use of standard indicator definitions by all health funds, and a systematic data quality audit cycle to ensure validity and comparability. Past evaluations have shown that the quality in community health care has improved over time for almost all categories of care – primary prevention, treatment and effectiveness of care (QICH, 2017[58]). In the area of diabetes care for example, a recent evaluation has found an improvement in most quality indicators (from 53% to 75% for the composite quality score). Declines were noted in rates of blindness, diabetes-related end-stage kidney disease, lower limbs amputations and diabetes-related mortality (Calderon-Margalit et al., 2018[59]). Quality improvements were also observed for elderly health (Podell et al., 2018[60]). The extensive use of electronic health records by health plans are one key successful factor of the QICH.

Regular feedback to providers on quality and outcomes as well as open publication for patients with performance data at municipal level and FHT level could also drive aspiration for continuous improvement. On this front, Brazil will need to improve transparency at granular level, and ensure that patients can monitor activity and quality of PHC at FHT level.

Box 4.4. The National Programme for Quality Indicators in Community Healthcare in Israel

The indicators in QICH cover nine clinical areas: health promotion, child and adolescent health, cancer screening (breast, colorectal and cervical cancer), elderly health, respiratory diseases, cardiovascular health, diabetes, antibiotic treatment and mental health. In total 20-eight indicators are collected (Figure 4.9). These indicators are based on national and international guidelines reflecting the current scientific evidence, international practices, relevance for the Israeli Health care system, and the feasibility of production.

Figure 4.9. The National Programme for Quality Indicators in Community Healthcare



An internal audit is conducted within each health plan, the QICH programme's directorate also performs a data audit, and an external audit is carried-out by a certified external audit. Throughout the auditing

process, methodologies, control processes, documentation, and lessons learned were examined, nurturing a continuous improvement in indicator reporting.

Table 4.6. Performance results at national level for selected indicators, 2017-19

Domains	Indicators	2017	2018	2019
Health promotion	Documentation of BMI components (ages 20-64)	90.33%	89.51%	89.16%
Cancer Screening	Under-screening for cervical cancer (women aged 35-54 who were not screened in the last 5 years)	35.71%	34.64%	32.65%
Child health	Documentation of BMI components in children (age 14-18 years)	74.94%	76.71%	77.54%
Elderly health	Use of long-acting of benzodiazepines in older adults (aged 65 years or older)	2.29%	2.17%	1.88%
Respiratory diseases	Asthma medication ratio (AMR) greater than or equal to 0.5 (ages 5-45 years)	69.71%	70.67%	71.94%
Cardiovascular health	Rate of LDL cholesterol level less than or equal to 160 mg/dL in those at low-risk for heart disease (ages 35-74 years)	90.18%	90.35%	90.49%
Diabetes	Uncontrolled diabetes: HbA1c greater than 9% in individuals with diabetes mellitus (ages 18 years or older)	9.98%	9.60%	9.01%
Antibiotic	Documentation of molecular HCV test among those with a positive serology test	83.34%	85.55%	87.59%
Mental Health	Adequate control of HbA1c in individuals with SMI and diabetes mellitus (ages 18-84 years)	71.15%	71.83%	72.07%

Source: QICH (2017[58]), National Program for Quality Indicators in Community Health Care in Israel, https://en.israelhealthindicators.org/publications.

To support greater patient-centred care, it is also important to collect patient-reported experience measures with PHC (OECD, 2021[61]). This approach is taken internationally. In England for example, the GP Patient Survey assesses patient's experience of health care services provided by GP practices within the National Health Service (NHS) England (OECD, 2020[43]). It assesses experience of access, making appointments, the quality of care received from health care professionals, patient's health and experience of their GP practice. Around 2 million patients registered with a GP practice are surveyed twice a year. The Care Quality Commission uses the results from this survey in their regulation, monitoring, and inspection of GP practices in England. The GP Patient Survey offers a description of each GP practice and its performance based on the latest survey. The analysis tool also provides comparison of performance between GP practices.

In 2017, the OECD launched the Patient-Reported Indicators Surveys (PaRIS) to address the need to understand the outcomes and experiences of people with chronic diseases (Box 4.5) (OECD, 2021[61]). PaRIS is the OECD's Patient-Reported Indicator Surveys initiative where countries work together on developing, standardising and implementing a new generation of indicators that measure the outcomes and experiences of health care that matter most to people. The International Survey of People Living with Chronic Conditions will be the first of its kind to assess the outcomes and experiences of patients managed in PHC across countries. The PaRIS survey aims to fill a critical gap in PHC, by asking about aspects like access to health care, waiting times, as well as quality of life, pain, physical functioning and psychological well-being. The initiative will help open a dialogue with service providers about how to further improve the performance of health services and health systems to become more people-centred. Brazil might want to join the OECD PaRIS survey to understand how the outcomes and experiences of care in Brazil compare with those in OECD countries.

Box 4.5. The OECD PaRIS Survey

In 2017, the OECD launched the Patient-Reported Indicators Surveys (PaRIS) to address the need to understand the outcomes and experiences of people with chronic diseases. PaRIS offers an opportunity for gathering the evidence necessary to transform health care systems into patient-centred systems based on the needs of the people they serve. The initiative includes:

- the collection of validated, standardised, internationally comparable patient-reported indicators in three areas: hip and knee replacements, breast cancer care and mental health care
- the collection of a new set of internationally comparable measures which focus on patients with one or more chronic conditions, who are living in the community, and who are largely treated in PHC or other ambulatory care settings.

Source: OECD (2021[61]), Patient-Reported Indicator Surveys (PaRIS), https://www.oecd.org/health/paris/.

The inclusion of the PCAT Tools in the 2019 National Health Survey is a positive step in Brazil to better understand users' experience with PHC services. This initiative should be maintained over the longer term.

4.5.4. Accreditation system for FHTs could help standardise and improve care quality

To standardise quality across the country, it is warranted to establish accreditation programme for PHC. Accreditation is a control mechanism to assure the quality of health care services, which often feeds into quality improvement (OECD, 2017[63]). It uses explicit standards derived from the best available evidence to assess performance of health care organisation through survey, assessments, or audits. Accreditation is particularly needed when performance data are lacking.

Several OECD countries have established accreditation system in PHC, including Australia, Canada, England, New-Zealand or the United States (Tabrizi and Gharibi, 2019[64]). In these countries, community oriented care, safe-care, high quality care, care continuity and human resource management had the highest priority among accreditation programmes (Tabrizi and Gharibi, 2019[64]).

England's approach to health service accreditation is at the forefront of OECD efforts, and is a model for other health care systems to emulate (Box 4.6). It is unusually comprehensive as it accredits all providers of primary and social care. The accreditation is carry-out by the Care Quality Commission an independent statutory body responsible for registering care providers; monitor, inspect, and rate services, and take action to protect population who use services (Care Quality Commission, 2021[65]). In Australia, the Australian Commission on Safety and Quality in Health Care, in collaboration with the Royal Australian College of General Practitioners, developed the voluntary National General Practice Accreditation Scheme. The Scheme aims to encourage safe and quality general practice in Australia. It involves independent third party review that practices meet the requirements set by the Royal Australian College of General Practitioners, and offer financial incentives to support activities that encourage continuing improvement in quality of care.

A starting point to improving quality in PHC will be to build accreditation system for all FHTs to carry out independent assessment of performance and identify areas that may require improvements. An accreditation system in Brazil could help standardise PHC in municipalities to achieve more consistent quality across the country.

Establishing a national inspectorate for health similar to the Care Quality Commission in England or the Haute Autorité de Santé in France could help to provide independent verification that standards are being met, identify good practice and support weaker centres to improve their standards. The new Agency for

the Development of PHC could also take this role, and act as an inspectorate for PHC. The Agency could for example be responsible for quality monitoring and improvement, and have a prescriptive role in producing overviews of current practice, current performance, and setting standards on performance and performance reporting. It could also develop tools such as evaluation framework, deep dive teams to visit and support municipalities with special needs, and levelling out resources when needed. This Agency could also provide a platform or forum for contact and exchange between municipalities, evaluating innovative practices and consolidating quality initiatives across the country when successful.

Box 4.6. Accreditation system in England is comprehensive

In England, the Care Quality Commission (CQC), an independent statutory body established in 2009, is responsible for the inspection for hospitals, adult social care, general practice, mental health care services, ambulances and community-based services. All providers of regulated activities, including NHS and independent providers, have to register with CQC and follow a set of fundamental standards of safety and quality below which care should never fall. The CQC assesses if providers are meeting these fundamental standards through monitoring and inspection.

The findings of such assessments are shared with the public, and citizens are encouraged to share their experience or report concerns to the CQC.

England's health care system is one of the few in the OECD to have a comprehensive accreditation programme for PHC. By Mars 2020, 7 237 GP services have been inspected and rated, while only 1 461 sites have not. Detailed individual practice inspection reports are publicly available on a website (Figure 4.10). The core services being inspected are urgent and emergency services, medical care, surgery, critical care, maternity and gynaecology, services for children and young people, end of life care, outpatients' services and diagnostic imaging. After inspection, the GP services must respond to areas of concern that was identified, develop an action plan to address them and make improvements. Detailed individual practice inspection reports are publicly available on a website.

Figure 4.10. Example of a CQC inspection in a GP surgery



Source: Care Quality Commission (2021[66]), CQC inspection ratings for GP services, https://www.cqc.org.uk/search/services/doctors-gps?sort=default&distance=15&mode=html.

4.5.5. Designing smarter payment for PHC

The *Previne Brasil* scheme is an important scheme to drive quality improvement in Brazil. In the years to come, it will be important to maintain and even expand the scheme. Compared to other OECD countries, the incentivised priority areas in Brazil have a stronger focus on child and maternal health. In OECD countries, the management of chronic conditions is frequently put at the centre of P4P schemes (OECD, 2020[43]). The *Previne Brasil* programme plans to expand the number of indicators by 2022 to include other indicators around mental health, breast cancer, multi-professional action, and patient experience (Ministério da Saude, 2020[67]). This will be an important step given the rising burden of chronic conditions and the need to address some risk factors for health including obesity. The experience from Portugal or England could inform the development of candidate indicators to be incorporated to the *Previne Brasil* programme.

A second key difference between the Brazilian P4P compared to most OECD P4P schemes is the fact that bonus payments are not made to the individual physician or the structure that he/she works for but to the municipalities that employs him/her, with no obligation for municipalities to pass on their bonuses to staff. This is not common in OECD countries in PHC. Generally, research suggests that P4P schemes with bonus payments aimed directly at professionals are more effective (Eijkenaar et al., 2013[68]).

Table 4.7. New forms of payment for PHC across the OECD

Add-on payments	Bundled payments	Population-based payments
Australia, Austria, Canada, Denmark, France, Germany, Iceland, Israel, Italy, Mexico, Sweden	France, Italy, the Netherlands, Canada, Australia, Belgium	United States (Accountable Care Organisations), Germany (Gesundes Kinzigtal GmbH)

Source: OECD (2020[43]), Realising the Potential of Primary Health Care, https://doi.org/10.1787/a92adee4-en.

Lastly, there are successful experiences across the OECD where innovative forms of payment for PHC have been introduced to encourage greater prevention, management of chronic disease and incentivise providers to effectively work together. Beyond P4P programme, there are three innovative forms of payments across OECD countries (OECD, 2020[43]) (see also Table 4.7):

- Add-on-payments: Additional payments to remunerate specific activities in order to target some dimensions of the care provisions such as establishment of care plans, collaborative care meetings or the provision of patient education. In 2018, 11 OECD countries used add-on payments to pay for co-ordination or prevention. In Denmark, general practitioners get pay-for-co-ordination, notably when they have more responsibility for treatment of chronically ill patients (e.g. diabetes).
- Bundled payments: The objective is to bundle separate health care activities into a single tariff for chronic conditions. The single tariff should cover the cost of all health care services provided by the full range of providers during a specific time period. In this type of arrangement, a group of health care providers is collectively responsible for the delivery of a wide range of activities for a pre-defined population group, typically involving at least PHC and secondary care. Evidence shows that bundled payments lead to better collaboration within and across care settings and can contribute to a greater standardisation of care and to the development of sophisticated IT systems. In 2018, 5 OECD countries used bundle-payments. The Netherlands have for example established bundled payments to care groups for patients diagnosed with Diabetes type 2, COPD and cardio-vascular diseases.
- Population-based payments: This payment scheme is an extension of bundled payment, being not restricted to particular episodes of care or conditions. It consists of one payment made to groups of health providers as well as management companies to cover most health care services for a

defined group of the population. Rather than paying providers in "silos", the money follows the patients across providers, covers most health care services and has a more comprehensive view of population well-being. In 2018, only two OECD countries used population-based payments, including for example the "Gesundes Kinzigtal" Initiative in Germany.

4.5.6. Expand the development of Rede de Atenção à Saúde to promote integrated care

Given the context of an epidemiological transition towards longer lives and increasing prevalence of chronic conditions, an important challenge in Brazil is to shift the focus of health care services towards addressing longer episodes of health care needs. To this end, greater integration between PHC, emergency care, specialist care and social care services is needed. Interactions between various health care providers about patient cases, and transitions from one service to another, should be timely, safe, and seamless for the patient and its family (OECD, Forthcoming[69]). PHC needs to play a key role in achieving this goal.

The impact of integrated care include better access, improved satisfaction for patients and health professionals, more appropriate care, enhanced preventive care, reduced avoidable hospital admissions, prolonged independent living and delayed admission to institutional care, improved health status and quality of life (Nolte and Pitchforth, 2014[70]; Curry and Ham, 2010[71]).

In Brazil, the *Rede de Atençao à Saúde* (RAS) are ambitious health care network aimed at reducing health fragmentation within the Brazilian health system. As earlier mentioned, the implementation of RAS is supported by Planificação da Atenção à Saúde (PAS) and Chronic Conditions Care Model (MACC) developed by CONASS (CONASS, 2020[13]; CONASS, 2018[14]). RAS is included in the scope of the Regioes de Saúde, with technical, logistics and managerial support to encourage effective integration.

However, implementation of RAS in Brazil is challenged by bureaucratic governance model and weak institutional leadership, workforce issues such as inadequate training and qualification toward inter-professional collaboration and co-ordination, a weak information system and payment policies that do support integrated care (Ministério da Saude, 2014[72]). These have resulted in low and uneven diffusion of RAS initiative across the country. Brazil will need to work on these four fronts to promote integrated care and ensure effective implementation of RAS (Box 4.7).

Brazil could learn from other OECD countries, which have embarked on different pathways to operationalise the integration of care, such as the Spain Basque Country with Integrated Care Organisations, the United Kingdom with PHC Networks and the United States with Accountable Care Organisations.

Box 4.7. Promoting integrated care and ensuring effective implementation of RAS in Brazil

Stronger leadership and governance model

The importance of leadership and management for the successful implementation of integrated care as well as integrated care service delivery as already been demonstrated in recent studies (Borgermans and Devroey, 2017[73]). While there is no one size fit all models, consolidated strategies seem often to be developed based on consultations with main stakeholders so that they can be implemented effectively by holding them collectively accountable and committed to achieving the common goals of promoting integrated care delivery.

Better workforce planning and modern educational training

To ensure that PHC workers work together with other health care professionals, there is a need to increase effort to develop appropriate training towards multi-disciplinary teams, case management, and

developing new roles for care co-ordination. In Germany, a national training programme focussing on case management was made available for nurses to strengthen their role in delivering care co-ordination. The Basque country in Spain created new roles such as liaison nurses and referral internists to co-ordinate and organise care. In Australia also, care co-ordinators for cancer patients or patients with chronic long-term conditions have been established to liaise health professionals, interface with the patient's health care team, help arrange health screenings, resolve barriers to accessing the health networks, and source follow-up health education.

Stronger data and information systems

Strong data and information systems are critical to support integrated care. With growing number of patients with complex needs receiving care by various services over long episodes of care, such systems can help improve communication and co-ordination between patients and their providers, increase the accuracy of diagnoses and clinical decision-making, help monitor and deliver appropriate services remotely, and provide patients more access to their health history. In Brazil data linkage remains insufficient, undermining information sharing in the context of integrated care (see (OECD, 2021[41]).

Smarter payment models

Payment models need to incentivise providers from different health sector to effectively work together. Fragmented governance in Brazil may undermine resource allocation across health care, hinder integrated care delivery. At the same time, there are some good providers' payment mechanisms that encourage greater co-ordination and integration of care – such as add-on payments, bundled payments or population-based payment. Add-on payments reward more co-ordinated, safer and effective care, and are widespread across OECD countries in PHC (Table 4.7). Population based payment for example pool into a single payment all services delivered to patients including prevention and treatment across hospitals, primary and long-term care. In the United States, ACO receive a virtual budget for a wide range of services and they are incentivised by shared savings contracts by payers to co-ordinate care across different levels efficiently.

Source: OECD (2020[43]), Realising the Potential of Primary Health Care; OECD (Forthcoming[69]) Strengthening Performance of Integrated Care Delivery across OECD countries.

4.6. Conclusion

Looking to expand access to high quality PHC, Brazil has been taking important steps to improve the distribution of doctors, develop new forms of service organisations and introduce new financing models for PHC. The development of guidelines and health care services portfolio; and the production and publication of data underpinning PHC are also important steps towards ensuring high quality care across the country. All these developments are well aligned with the experiences of OECD countries, and have led to large improvements in access to PHC and population health outcomes.

However, the Brazilian PHC system is still characterised by a relatively low population coverage. A significant proportion of the population also have direct access to outpatient specialties and hospitals for minor conditions, perhaps because PHC has traditionally provided few low complexity procedures and surgeries. Available evidence also points to the need for enhancing the contribution of PHC to prevention and management of chronic conditions, notably in North and Northeast regions which present consistently poorer health care.

These shortcomings give strong arguments to strengthen the gatekeeping system in Brazil with a systematic registration system with FHTs, which will control and orient the patient's into specialist care. This is a prerequisite to accelerate the expansion of FHTs, helping to build a profile of the health needs of the registered population, and better recognise the central co-ordinating role of FHTs. Actions are also needed to support FHTs to deliver a more modern PHC service provision, focused on prevention, treatment, follow-up of diagnoses and management of chronic conditions. The federal government will need to play a more prescriptive role to strengthen comprehensive PHC evenly across the country. These would include ensuring that all municipalities are well equipped and trained to properly deliver actions and services defined in the CaSAPs. There are also opportunities to monitor and encourage compliance with clinical guidelines and CaSAPs using the *Previne Brasil* Programme – either through the Strategic Actions or the P4P component. Collecting a richer set of quality indicators on a wider array of preventive activities and management of chronic conditions (such as alcohol consumption, obesity, cancer screening or mental health, and patient experience) would also support greater patient-centred PHC. An accreditation system in Brazil could help standardise PHC quality – notably in municipalities having low capacity and high vulnerability – to identify areas that may require greater financial and organisational support. The new Agency for the Development of PHC could act as an inspectorate for PHC, for example to provide independent and external verification that standards are being met, identify good practice and support weaker centres to improve their standards.

Going forward, Brazil will have to establish strong oversight and good management, develop appropriate training, alongside strong data and information systems for the successful implementation of RAS. Appropriate payment models would be critical to incentivise providers from different health sectors to effectively work together. While this may come too early at the moment, the introduction of add-on payments or bundled payments is certainly something Brazil could consider in the future.

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[2] See for example http://www.ripsa.org.br/category/publicacoes-ripsa/

[3] Available at https://biblioteca.ibge.gov.br/index.php/biblioteca-catalogo?view=detalhes&id=2101758

5 Workforce challenges in primary health care in Brazil

Brazil is struggling with a shortage and an uneven distribution of medical doctors across regions, compounded with a low credibility and recognition of the PHC specialty. To secure a greater number and distribution of primary care doctors and ensure a high-quality workforce, the first priority for Brazil is to implement a coherent workforce planning based on an objective assessment of present and future needs to govern health care human resources. In tandem, Brazil could look at the experiences of OECD countries to train more rural doctors and to provide both financial and non-financial incentives linked with a return of service obligation. A smarter use of nurses and community health workers is another option to cope with workforce gap. There are also opportunities to make the PHC specialty a mandatory requirement to be allowed to practise PHC, and to implement stronger requirements around continuous medical education.

5.1. Introduction

As many other OECD countries, Brazil is struggling with a shortage and an uneven distribution of medical doctors across regions. Practicing doctors per 1 000 population in 2019 were lower than the OECD average (at 2.3 compared to 3.5), while the distribution of medical doctor followed a North-South gradient where North and Northeast regions show a lower density of medical doctor. At the same time, the specialty of family and community medicine (FCM) is not attractive and undervalued in Brazil. Very few doctors working in PHC have undertaken specialist training. In 2018, only 5 486 medical doctors had a specialty training in FCM, representing 1.4% of all specialists in Brazil. While people living in North and Northeast regions have the highest health care needs, these regions gather less than 20% of all FCM specialists.

In recognition to these challenges, several programmes were implemented by the federal government to reduce the shortage of doctors in prioritised regions; and improve access to and quality of medical training in the country, including the More Doctors Programme (*Mais Médicos para o Brasil*). However, unfilled PHC positions is still the norm in Brazil, gaps in medical education remain between medical schools and geographic disparities in access to medical training persist. The North and Northeast regions offer the lowest levels of per capita medical undergraduate positions in the country.

This chapter examines workforce challenges for the PHC setting in Brazil. Section 5.2 describes the shape of Brazil PHC workforce in terms of the rates and ratios of medical doctors, nurses and community health workers. In Section 5.3, the chapters describes the organisation and quality of medical education in Brazil. In Section 5.4, the chapter then explores ways to improve the geographical distribution of doctors and overcome the issue of shortage of PHC doctors. Section 5.5 considers how to improve the recognition and credibility of the specialty of FCM and points out some key policy levers to strengthen the quality of medical education in Brazil.

5.2. The shape of Brazil's PHC workforce

Brazil's health workforce is characterised by a shortage and a misdistribution of medical doctors that is particularly acute in the North and Northeast of the country. Brazilian figures suggest that medical doctors do not perceive the specialty of PHC, and rural and remote areas, as attractive and prestigious. The shortage and misdistribution of PHC physicians is a common health workforce policy challenges OECD countries face. Concerns about income, opportunities for career development, isolation from peers, as well as educational options for children and professional opportunities for their spouse are leading factors of these challenges.

5.2.1. Physician density in Brazil remains lower than the OECD average, with persistent concerns over geographic distribution

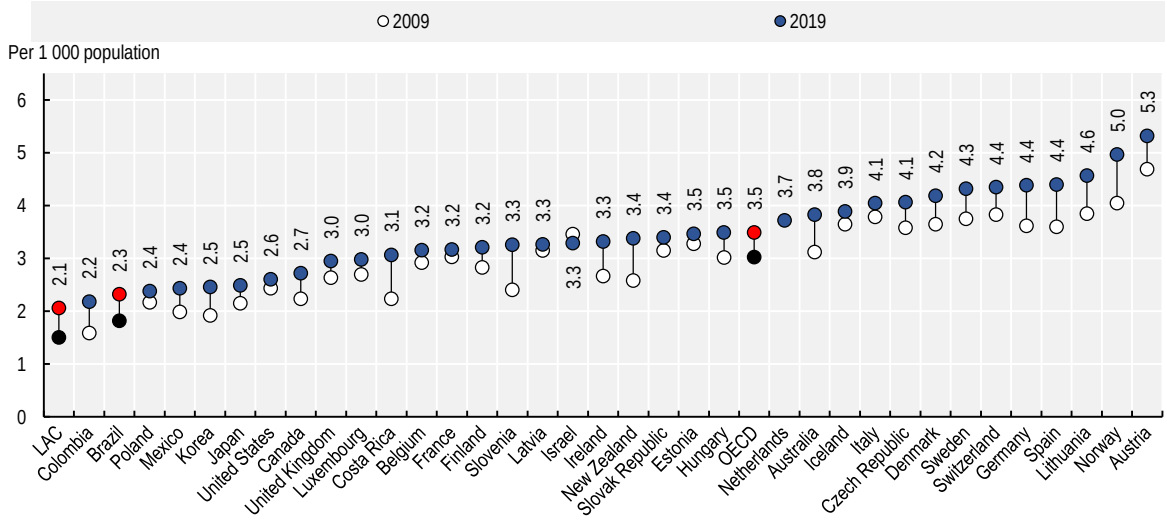
While Brazil has clearly recognised that a strong PHC is the foundation of an effective, efficient and responsive health system, the number of trained PHC physicians is well below OECD countries and of other LAC countries.

In Brazil, practicing doctors per 1 000 population in 2019 were very low compared to the OECD average, at 2.3 compared to 3.5 (Figure 5.1). This is among the lowest density, just above Colombia (with 2.2 doctors per 1 000 population) and the LAC average (2.1 doctors per 1 000 population). However, the number of doctors increased by 50% in Brazil over the past decade.

According to the Ministry of Health, there are around 60 000 medical doctors working in PHC in Brazil. Although a distinct specialty of FCM is established in Brazil, very few doctors working in PHC have undertaken specialist training in FCM. In 2018, only 5 486 medical doctors had a specialty training in FCM, representing only 1.4% of all specialists in Brazil (Scheffer et al., 2018[1]). Medical doctors who specialise

in internal medicine also have some competencies applicable to FCM, but they also represent a small share of specialists (around 11.2%) in Brazil in 2018. Taken together, these figures suggest that Brazil struggles to attract physicians to specialise in PHC. The low attractiveness of the PHC specialties can be linked to a lower recognition, prestige, and remuneration level compared to other specialties.

Figure 5.1. Doctors per 1 000 population, 2009 and 2019 (or latest year available)



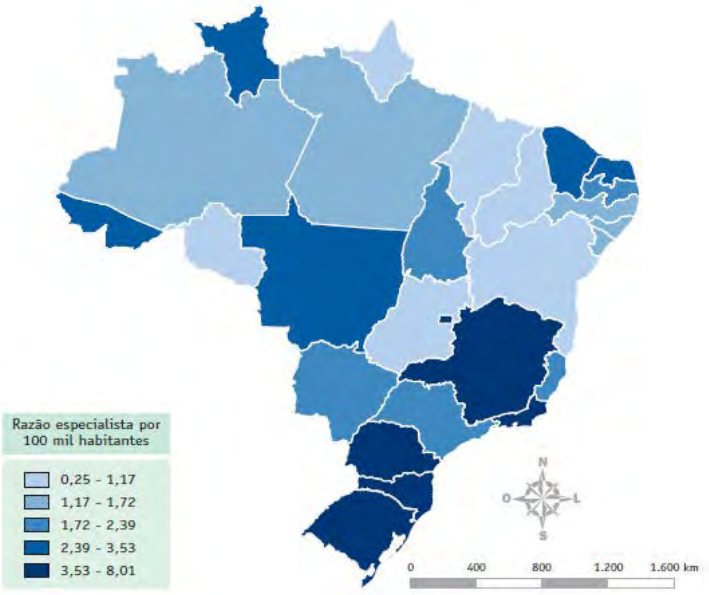
Source: OECD (2021[2]) Health Statistics Database, http://stats.oecd.org; Brazilian Ministry of Health.

Regional differences in the distribution of all physicians is an important concern in Brazil. As in many OECD countries, the number of doctors per capita varies widely across regions. While overall there are 2.3 doctors per thousand population in Brazil, there are capitals with more than 12 doctors per 1 000 population (Vitória, in Espírito Santo for example), and regions with values below one doctor per 1 000 population (the Amazon Region in the North) (Scheffer et al., 2018[1]). The differences between small and large municipalities in Brazil is comparable to other OECD countries.

The uneven distribution of doctors holds true when looking at some specialities, for example for the FCM specialist. Figure 5.2 indicates that some states in the North and Northeast regions have the fewest doctors per population, while the best-supplied region is the South and Southeast regions, followed by the Central-West (Scheffer et al., 2018[1]).

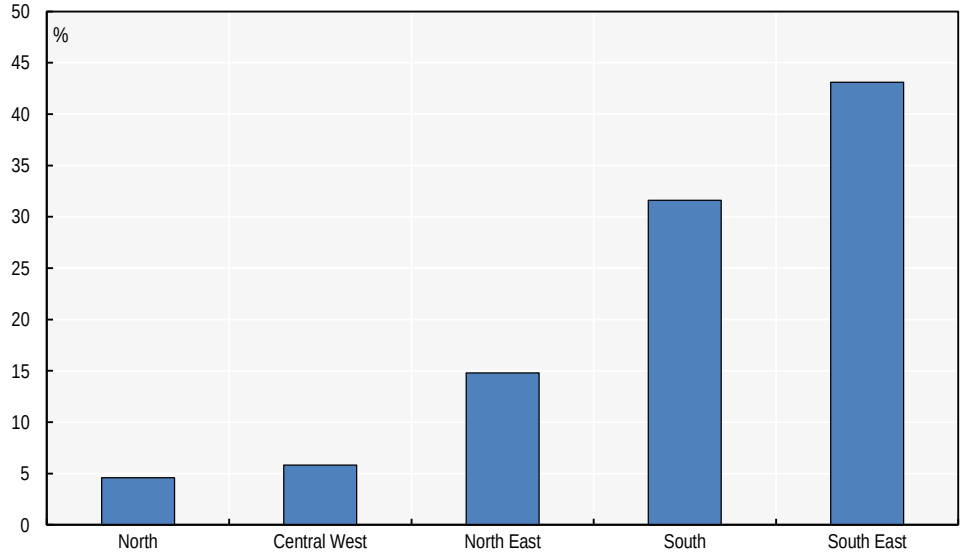
On a state level, the FCM specialist per 1 000 population ratio ranges from 0.4 in Maranhão in the Northeast region to 1.6 in Rio de Janeiro. Overall, the North region of Brazil gather only 4.6% of all FCM specialists, while the South and Southeast regions gather almost 75% of all FCM specialists (Figure 5.3).

Figure 5.2. Density of family and community medicine in Brazil per States, 2018



Source: Scheffer et al. (2018[1]), Demographia Médica No Brasil 2018.

Figure 5.3. Distribution of family and community specialists per regions, 2018



Source: Scheffer et al. (2018[1]), Demographia Médica No Brasil 2018.

Geographical imbalances across different regions in Brazil reflect the concentration of specialised services and physicians' preferences to practise in urban settings. As in many other OECD countries, Brazilian doctors might be reluctant to practise in rural regions or socio-economically challenged urban areas due to concerns about their professional life (including their income, working hours, opportunities for career development, isolation from peers) and social amenities (such as educational options for their children and professional opportunities for their spouse) (OECD, 2019[3]).

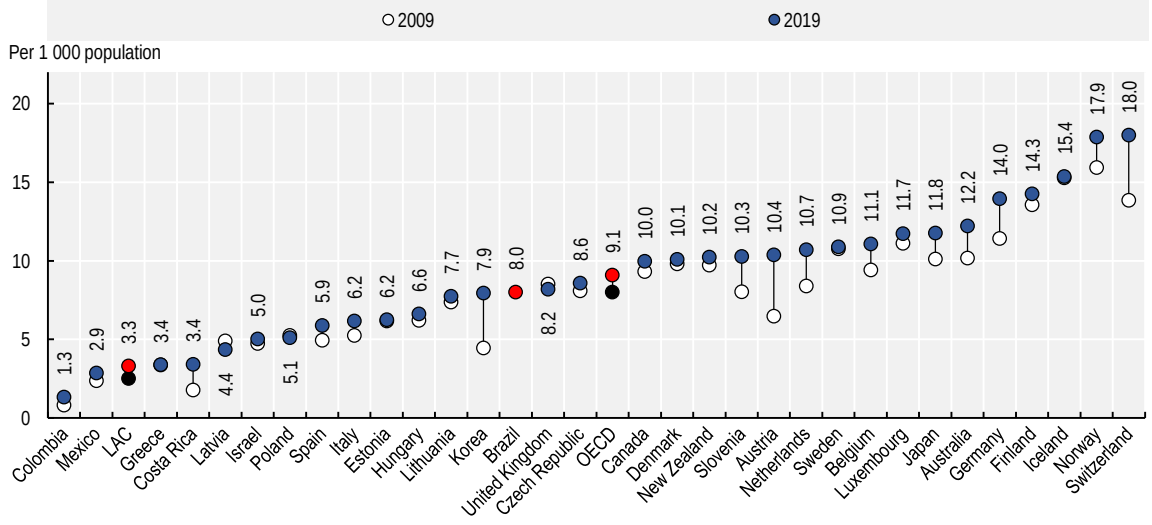
It is also important to note that geographical imbalances in medical doctor (and PHC physicians), is disproportionately experienced by people living in remote and rural areas who have the highest health care needs, and where social vulnerabilities are highest (Oliveira et al., 2017[4]). This means that the PHC sector faces a double challenge of high health care demand and staff shortages, which can lead to inequitable access to care (Barbosa and Cookson, 2019[5]). Shortages and geographical imbalances in workforce need to be addressed as a matter of priority as it can lead to lower health outcomes, lower health care quality and unmet needs for population living in underserved regions (see Chapter 2 and Chapter 4).

5.2.2. Brazil nursing workforce has significantly increased over the past decades

In 2019, Brazil had 414 712 nurses, and annually produced about 50 000 nurses in their undergraduate nursing programmes (Cassiani and Silva, 2019[6]). In the Latin American region, Brazil is the only country that trained nurses in professional master's degree, which grew by 156% in the period 2011-20.

Brazil's nursing workforce has increased over the past decade to reach eight nurses per thousand population in 2019, moving closer to the OECD average of 9.1 (Figure 5.4). This is much higher than the LAC average of 3.3 nurses per 1 000 population. The increase in the volume of nurses is mainly explained by the implementation of new federal regulations, including the creation of specific PHC teams (Riverside team, Health Academy Programmme, the Home care teams among other), requiring nurses.

Figure 5.4. Nurses per 1 000 population, 2009 and 2019 (or latest year available)



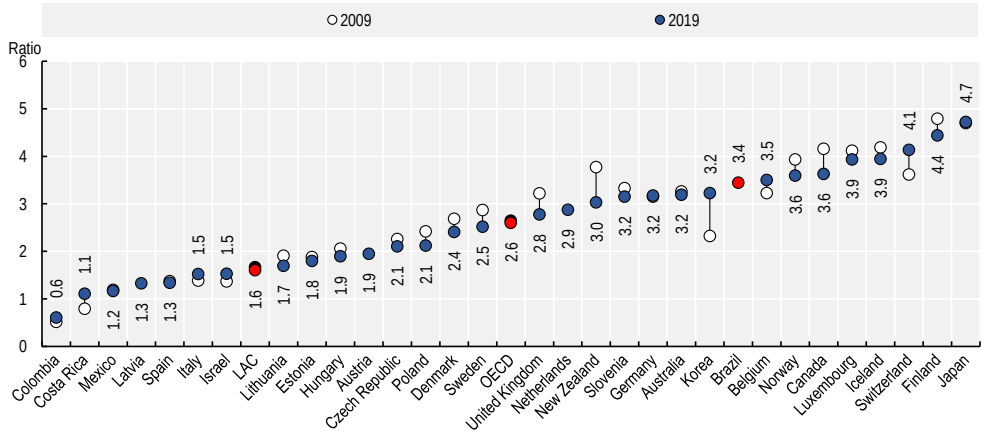
Source: OECD (2021[2]) Health Statistics Database, http://stats.oecd.org; Brazilian Ministry of Health.

The skill-mix – the ratio of nurses to doctor – is relatively higher in Brazil (Figure 5.5) than the OECD and LAC average. Nurses outnumber doctors in Brazil at 3.4 nurses per medical doctor, compared to the OECD average of 2.6 and the LAC average of 1.6.

This is a welcome news to respond to the changing demand for health services. There is a need for a better health professional skill-mix in the context of rapidly ageing populations and rising burden of chronic conditions in Brazil (see Chapter 2). Currently, there is no discussion around the expansion of nursing role or implementing advanced functions for nurses, as it has been introduced with some success in other OECD countries such as Australia, Canada, the United States, the United Kingdom, some Nordic countries, and France more recently. In these countries, advanced practice nurses provide greater support in the care of chronically ill patients and those with complex morbidities, working in co-operation with PHC

doctors and specialists in teams and other health and long-term care settings. Improved interaction and communication between members of FHTs is critical for the success of task shifting and redistribution of roles.

Figure 5.5. Ratio of nurses to doctors, 2009 and 2019 (or latest year available)



Source: OECD (2021[2]) Health Statistics Database, http://stats.oecd.org; Brazilian Ministry of Health.

5.2.3. Community health workers play a crucial role in PHC

Following the implementation of the Community Health Agents Program (PACS), CHWs started to play a crucial role in the Brazilian PHC system. CHW are frontline public health workers, often members of the communities in which they work and have therefore valuable knowledge of people needs and are trustful source of information (Grossman-Kahn et al., 2018[7]; Wadge et al., 2016[8]). While a range of different health professionals are involved in PHC delivery (physicians, nurses, nutritionists, pharmacists or social workers, etc.) (see Chapter 2), there are up to 12 CHWs involved in each FHT. In 2020, more than 250 000 CWHs served 61% of the population, up from 60 000 in 1998. The population covered by CHWs is the highest in the Northeast and North regions (with at least 74% of the population covered by CHWs) (Figure 5.6).

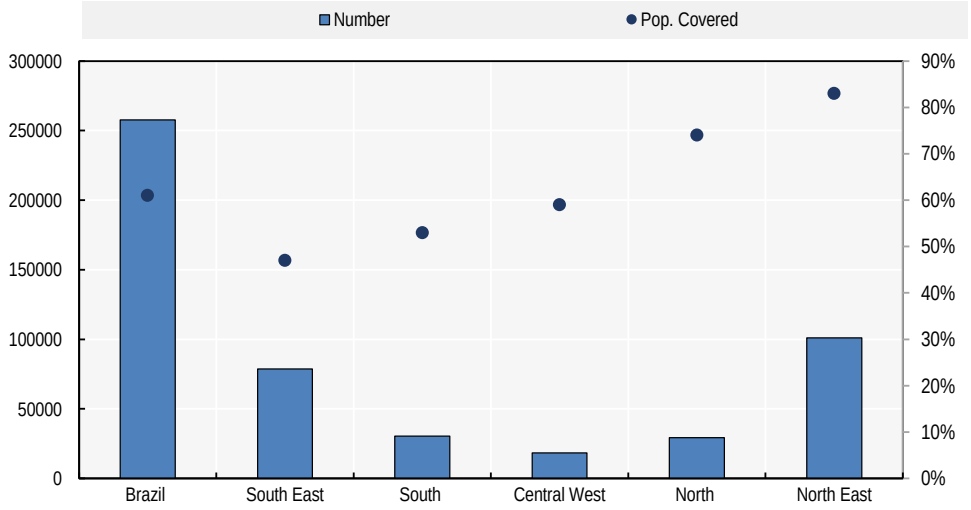
Unlike many OECD countries, in Brazil, CWHs provide a wide range of support for comprehensive PHC services including clinical triage, health promotion, social determinants and household data (Grossman-Kahn et al., 2018[7]). They are expected to resolve many low-level problems such as medication review for patients chronically ill, while referring more complex issues to doctors and nurses of the FHT. CHWs complete between 10-15 home visits a day, and spend between 1-2 hours a day at the clinics doing paperwork, organising the waiting rooms, consultation appointments for other health professionals and offering educational sessions. They are responsible for registering the households in the areas where they work, and help families access other government services such as conditional cash transfers and social services. Within FHTs, each CHW is responsible for 150 families.

The minimum requirement to become a CHW is to get a secondary education, but more than 60% have a professional diploma. Turnover is low as it is a stable and respectful profession (Wadge et al., 2016[8]).

Despite their importance for the provision of PHC services, studies have shown that CHWs do not have many technological supports to operate in the community. Evaluations show that CHWs are effective at improving specific health outcomes and access to health care (Grossman-Kahn et al., 2018[7]), and that it can represent a cost-effective intervention to deliver essential health care services (Vaughan et al., 2015[9]). Yet, available evidence also highlights that, in many remote and vulnerable municipalities, CHWs

are not equipped with mobile phones and tablet computers to enable remote diagnoses and real time communication with the PHC facilities (Wadge et al., 2016[8]).

Figure 5.6. Number of community health workers by regions



Source: Ministério da Saùde (2020[10]), Painéis de Indicadores : Agentes comunitários de saúde, https://sisaps.saude.gov.br/painelsaps/acs

Overall, the COVID-19 pandemic demonstrated the importance of having a skilled and sufficient health workforce to respond swiftly and effectively to the public health crisis. Health professionals (doctors, nurses and community health workers) are at the forefront of the crisis, and the pandemic has put huge pressure on them, affecting their physical and mental health. In Brazil, as well as in OECD countries, investments in human resources for health are critical (see Box 5.1).

Box 5.1. The COVID-19 pandemic demonstrated that investments in human resources for health are critical

Across OECD countries, the pandemic is making pre-existing shortages of doctors and nurses more visible and acute. Shortages of doctors and nurses result from a lack of investment in education and training programmes and in recruitment of new staff and retention of existing staff. These shortages, in turn, resulted in heavy workload and burnout among health workers.

As doctors, nurses and other health professionals mobilised on the frontline to respond to the COVID-19 pandemic, OECD health systems sought ways to increase the number of staff available during the peak of the pandemic and to make the most efficient use of their work. This included recalling inactive and retired health professionals, offering them some short training to update and upgrade their skills (Italy, Portugal, the United Kingdom for example). Other countries mobilised or established a “reserve list” of health workers to deal with the outbreak and reallocate staff across regions (France, Belgium, Ireland and Iceland). COVID-19 has also accelerated innovative roles of health professionals, removing pre-existing structural and institutional barriers and permitting a more efficient use of human capital in the health sector. In Canada, for example, pharmacists have been authorised to extend prescriptions beyond what they were previously allowed to do, and to prescribe certain medications.

Source: OECD/European Union (2020[11]), *Health at a Glance: Europe 2020*, https://doi.org/10.1787/82129230-en.

5.2.4. Health workforce planning is at best very limited in Brazil

In Brazil, the federal agency called *Instituto Nacional de Estudos e Pesquisas Educacionais Anisio Teixeira (*INEP) monitors workforce trends to support policy planning. INEP is also responsible for monitoring and assessing the basic and higher education system, and for promoting the dissemination of indicators and results of evaluation of the education system. The Secretaria de Gestão do Trabalho e da Educação na Saúde (SGTES) at the Ministry of Health is responsible for formulation of policies for health workforce management, training and qualification of health workforce, regulations of health professionals and regulation of the decentralisation process. It was created as the main federal instrument to mobilise and manage health care workforce. It defines the National Human Resources Health Policy for the good performance of SUS, in partnership with the Ministry of Education.

However, there is a lack of knowledge of present and future needs for doctors and other health care professionals in Brazil (Oliveira et al., 2017[4]). Health care workforce planning is not based on an objective assessment based on the characteristics of the professionals (age, and sex), the work processes (productivity, workload), the characteristics of the health system in place (coverage and type of services offered), and population health needs (such as socio-economic and epidemiological profiles).

Rather, existing estimates are built on feasibility concerns, using data comparing ratio of doctors per thousand population between Brazil and other countries to determine a desirable ratio and create targets for improvement (Oliveira et al., 2017[4]). A fixed minimum ratio target can be defined, but without considering the contextual factors described above to make a forecast of anticipated needs and demands, and a simulation of the necessary profiles and possible reform scenarios that would lead to a set of human resources better suited to meet the increasing demand for care.

Box 5.2. The workforce planning in Italy is based on a bottom-up approach

In Italy, there is a bottom-up approach for human resources planning in the Italian Servizio Sanitario Nazionale. Primary responsibility for health workforce planning is at the regional level, with information then fed back to the Ministry of Health, which brings together the data and forecasts from the regional levels, and analyses and validates the results to make appropriate recommendations to the Ministry of Education concerning entry to medical, nursing and other health-related education programmes.

The main objective of the health workforce planning in Italy is to ensure a suitable number of health care professionals in order to satisfy demand and to avoid workforce imbalances in the Servizio Sanitario Nazionale. The Ministry of Health and the regions then agree on the number of students to enter related education and training programmes.

Source: OECD (2014[12]), *OECD Reviews of Health Care Quality: Italy 2014: Raising Standards*, https://doi.org/10.1787/9789264225428-en.

This is unlike many OECD countries such as Italy or the United States, which have strong bases for workforce planning. In the United States, the National Centre for Health Workforce Analysis offers health workforce research, data, tools and projections to inform programme planning and policy making (HRSA, 2021[13]). In Italy, national needs in human resources are established based on regionally reported needs to establish the NHS human resources planning (Box 5.2). It is based on a bottom-up approach where information from the Regions is fed back to the Ministry of Health to make recommendations to the Ministry of Education (OECD, 2014[14]). Experiences from OECD countries can be useful for Brazil in its efforts to define a clearer workforce management policy to govern health care human resources. Brazil already collects municipality-level data on a monthly basis, meaning that the pre-requisite data is already there to inform workforce management. A smarter use of those data is warranted to better understand workforce

challenges in Brazil, including for example the shortage and uneven geographic distribution of doctors. Greater co-ordination between municipalities and federal level could help in this direction.

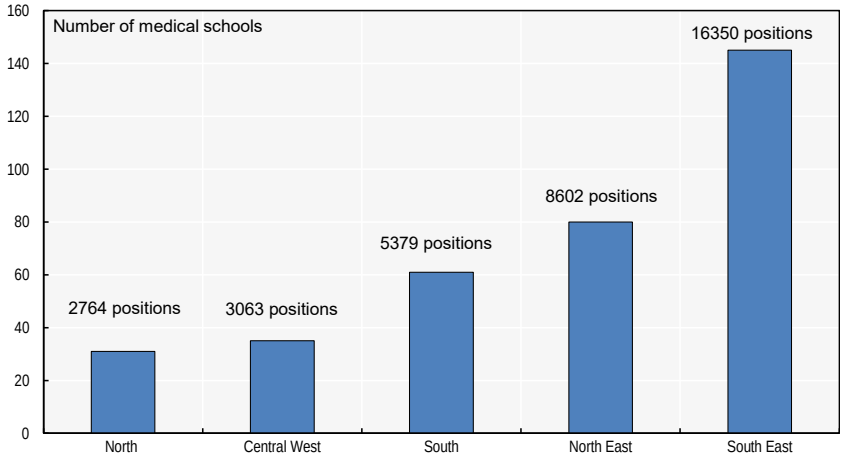
5.3. The organisation and quality of medical education in Brazil

Over the past decades, the number of medical schools has grown exponentially, driven mainly by the opening of private institutions. While some programmes have been set up to improve the medical curriculum toward PHC and achieve consistent quality across curriculums, gaps in medical education remain between medical schools and geographic disparities in access to medical training persist. The North and Northeast regions offer the lowest levels of per capita medical undergraduate positions in the country. Last but not least, the specialty of family and community medicine is undervalued in Brazil, and most doctors working in PHC in Brazil do not have a specialist qualification.

5.3.1. The number of private medical schools has grown exponentially in Brazil

In Brazil, the distribution of medical schools is uneven across the country. In 2020, the Southeast region had the highest distribution of medical schools among all regions (with 145 medical schools and 16 350 positions) (Figure 5.7). The same region concentrates around 45% of all positions in Brazil, with only one-fourth being offered in public institutions. At the other end of the scale, the North region concentrates 8% of all positions in Brazil.

Figure 5.7. Medical schools and positions by Regions, 2020



Source: Escolas Médicas do Brasil (2021[15]), Escolas Médicas do Brasil, https://www.escolasmedicas.com.br/index.php.

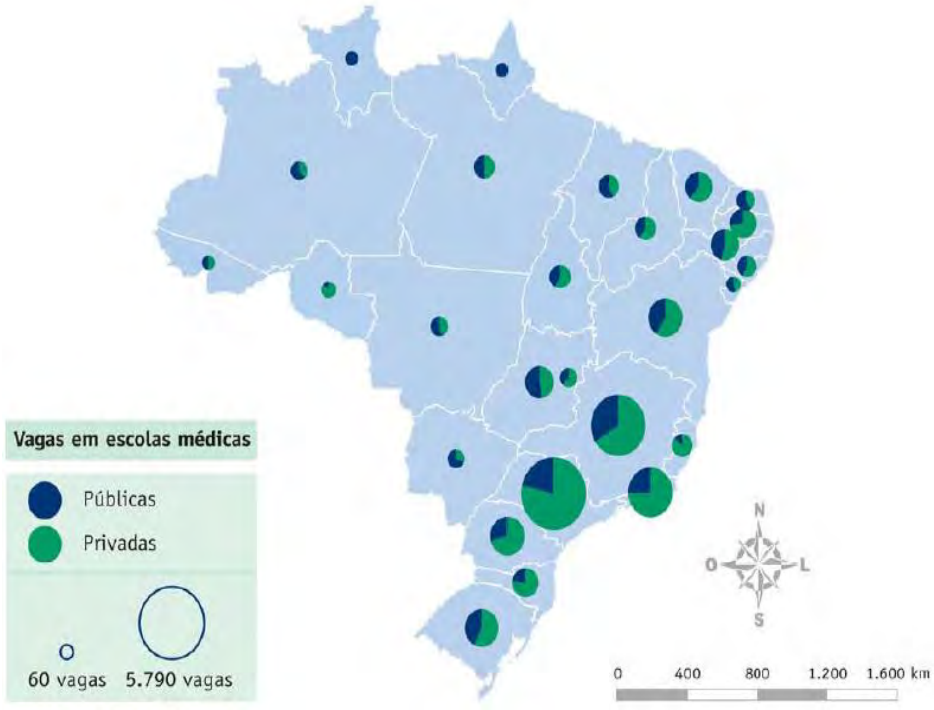
Unlike many OECD countries, medical education in Brazil has been marked by privatisation (Scheffer and Dal Poz, 2015[16]; Scheffer et al., 2018[1]). In addition to being larger in number, private medical schools also offer more places. In 2020, there were 352 medical schools, offering more than 35 000 training positions. Of these schools, 41% were public and 59% private (Escolas Médicas do Brasil, 2021[15]). Public medical schools are free, while tuition at private medical schools varies from USD 700 to USD 2 500 (BRL 3 600 to BRL 13 000) per month (Escolas Médicas do Brasil, 2021[15]). The country has around 14 places in medical schools per 100 000 population.

Throughout the country, public training positions represent 35% of the total training positions. In the South, 33% of training positions are public, in the Northeast 42% are public; in the North 48% are public, and in the Central-West 53% are public. Figure 5.8 presents the distribution of public and private medical schools

by States. In the State of São Paulo – which gathers 20% of training positions – only 21% are public. At the other end of the scale, the States of Roraima and Amapá only have public medical positions.

Private medical schools target niche markets, and generally offer education in more restricted and prestigious areas of knowledge (Scheffer and Dal Poz, 2015[16]; Scheffer et al., 2018[1]). Given that private medical schools charge high entry fees, the current admission system fosters inequality of access to medical school, favouring students from higher socio-economic background that do not specifically wish to work in PHC area and in rural areas.

Figure 5.8. Distribution of public and private medical schools in Brazil, 2018



Source: Scheffer et al. (2018[1]), Demographia Médica No Brasil 2018.

5.3.2. Medical education in Brazil lasts six years

Undergraduate programme in Brazil is similar to many OECD countries. Physicians trained in Brazil follow an undergraduate programme lasting six year. The curriculum is divided into three cycles of two years (Conselho Federal de Medicina, 2020[17]). During the first two years, the *ciclo básico* instruct basic scientific education with activities integrated to several medical specialties, allowing the practical application of such content. The next two years is called *ciclo clinico* with continued courses alongside clinical experience in medical setting (generally hospital setting). The last two year – *ciclo do internato*- focuses on clinical practice, through training in teaching hospitals and clinics. During the *ciclo do internato*, physicians actively participate to the medical practice under the direct supervision of medical schools. There are four six-month clinical rotations through internal medicine, surgery, paediatrics/obstetrics/gynaecology and public health, of which the latter includes exposure to PHC. In Brazil, graduate students are awarded the title of physician (Médico), allowing them to register with the Regional Council of Medicine (*Conselho Regional de Medicina*).

Unlike many other OECD countries (such as Canada, France or Italy), there is no national examination to be placed on a national register and be allowed to practise. Some states have made progress towards the

introduction of an Examination in Medicine, to be registered and allowed to practise. For example, the Regional Council of Medicine of São Paulo (*Conselho Regional de Medicina do Estado de São Paulo*) established that physicians who graduate from 2012 must pass a test to obtain professional registration.

Following the licensing, physicians can work as a "generalist" or choose among various professional path depending on the postgraduate specialisation programme they attend. Specialisation can last two to five years, and take place in a medical school. There are two types of specialisation programme. First, direct access programme where any graduates can apply to examinations for these specialties regardless of training or prior experience. Second, prerequisite programme, where doctors should have already completed a specialty or achieved expertise.

As of February 2019, the Federal Council of Medicine, the Brazilian Medical Association and the National Commission of Medical Residency Brazil recognise 54 specialty programmes (Scheffer et al., 2018[1]). In 2018, among the total number of medical doctors, 169 479 (37.5%) were generalists with no specialty training and 282 298 (62.5%) had a speciality training. Four specialty training concentrate 40% of all specialists in 2018 (Clinica Médica, Pediatria, Cirurgia Geral, and Ginecologia e Obstetricia).

The specialty of FCM is not recognised as a knowledge area by the Federal Agency for Support and Evaluation of Graduate Education. However, the specialty of community general medicine was officially recognised in 1981 by the National Commission on Medical Residency (Giliate Cardoso Coelho, Valeska Holst and Aristides, 2019[18]). The Brazilian Society of Family and Community Medicine (SBMGC) was also created at that time, followed by the creation of the Brazilian Society for Family Medicine (SOBRAMFA) (Box 5.3). Since 2001, the specialty is called Family and Community Medicine, with medical residencies lasting two years. In 2018, there were more than 100 FCM residency programmes in the country, with around 1 600 training positions each year (representing 4.4% of all training position) (Scheffer et al., 2018[1]). Although few in number, some post-graduate programmes in Family and Community Medicine are well known in Brazil such as the Conceicao Hospital Group (with 22 training positions each year), or the Municipal Health Department of Fortaleza in the State of Ceará (with more than 50 training positions each year) (Justino, Luzón Oliver and Palhano de Melo, 2016[19]). Most medical residencies, master's and PhD degrees in FCM are located in the Southeast and South Regions (Fontenelle et al., 2020[20]).

While the number of specialists in FCM increased over time, recent evidence suggests that FCM is still the last option among physicians (Fontenelle et al., 2020[20]). As earlier mentioned, in 2018, only 5 486 medical doctors had a specialty training in FCM, representing only 1.4% of all specialists in Brazil (Scheffer et al., 2018[1]).

Most doctors working in PHC in Brazil do not have a specialist qualification. This is unlike many other OECD countries where medical doctors are required to have a specialty training to be allowed to practise as a PHC doctor. In Canada, for example, physicians must have additional specialist training in family medicine to work in PHC (Ponka et al., 2019[23]). In the United Kingdom, participation in a three-year course is compulsory to practise family medicine. Turkey introduced specialised family medicine training as part of the *Health Transformation Programme* launched in 2005. The reforms sought to reinvigorate the speciality of family medicine, which was first defined in 1983 but failed to embed itself extensively in PHC provision. The reforms defined the Family Medicine core team as comprising a family physician, nurses and professional assistants, to whom a list of named patients was assigned. Family physicians across Turkey are required to deliver a defined set of services, to work to a standard set of norms and are paid according to national terms and conditions. Significant investment has been made to improve working conditions, with more generous salaries than before the reform. In 2018, Turkey's PHC/generalist doctors now comprises 32% of all doctors, above the OECD average of 23% (OECD, 2019[22]).

Box 5.3. The Brazilian Society of Family and Community Medicine (SBMGC) and the Brazilian Society for Family Medicine (SOBRAMFA)

Founded in 1981, the Brazilian Society of Family and Community Medicine aims to promote the principles and values of Family and Community Medicine as an academic discipline, as well as to promote patient-centred care in the clinical practice and the medical education.

The Brazilian Society of Family Medicine is organised around three priorities:

- Prepare future professionals based on patient-centred approach
- Integrate medical students to health services and connect them to the real needs of the population
- Train teachers, educators, and managers to promote academic incorporation of the specialty.

The Brazilian Society for Family Medicine (SOBRAMFA), founded in 1992, also organises several activities to spread the family medicine value among medical students at congresses, academic meetings, family medicine seminars and international meetings. It organises Mini-Fellowship in Family Medicine programme, where students experience family medicine practice by managing patients under the supervision of the SOBAMFA faculty and residents in a range of practice setting. For example, the SOBRAMFA develops guidelines, promote research and provide training and continuous medical education (such as the Miles Programme).

The internship for medical students in undergraduate programme, and the specialty programme focus on follow-up care for chronic patients, health prevention, treatment of multiple comorbidities. It also focuses on geriatric care (care for the elderly who live in communities), palliative care (learning how to care for patients without therapeutic possibility, discuss approach to death, deal with disabilities, and symptom treatment), understanding patient's pathway, learning team work and improving communication, and work in palliative care team.

Source: Janaudis et al. (2009[24]) Academic Family Medicine in Brazil ; SBMFC (Janaudis et al., 2009[24]; SBMFC, 2021[25]).

In the area of nursing, Brazil has several degrees ranging from bachelor degree, master degree to doctoral professional degrees (Cassiani and Silva, 2019[6]; Neto et al., 2018[26]). It is reported that around 50 000 nurses are trained every year (Cassiani and Silva, 2019[6]). An evaluation of nursing training found that the training had a hospital-centric model, with little interdisciplinary integration (Magnago et al., 2017[27]). This is not appropriate to strengthen people-centred primary health care.

CHWs are most often selected by local health committees and have to be literate. The training of community health workers is conducted in regional health schools operated by the national Ministry of Health using curriculum approved by the Ministry of Education (CHW Central, 2018[28]).The curriculum consists of 8 weeks of training from local nurses, followed by 4 weeks of supervised field training. These include training on home visits and on how to conduct a family census, but also on specific priority health care interventions. CHWs are not trained to address health needs, but rather they are trained to recognise health needs and encourage communities to seek care (CHW Central, 2018[28]; Grossman-Kahn et al., 2018[7]). CHWs also receive monthly and quarterly ongoing training.

5.3.3. National evaluation tools and voluntary accreditation facilitate evaluations of the quality of medical education in Brazil

Each medical school in Brazil decides its own curriculum and educational objectives, and implements its own summative and formative assessments of students based on skills, abilities, and curriculum content.

To promote changes in the medical curriculum toward PHC, the Ministry of Education has introduced the Program for the Encouragement of Curricular Changes in Medical Courses (Promed), the National Program for the Reorientation of Health Professional Education (Pró-Saúde), and the National Guidelines for the Curriculum of Health Professional Education. The National Curricular Guidelines of Medical Courses introduced in 2001, then updated in 2014 to support the More Doctor Programme, intends to ensure homogeneity between medical schools across the country (Ferreira et al., 2019[29]).

The curriculum's competencies target three axes: health care, health management and health education, with a focus on collective health and comprehensive care. The updated guidelines aim at moving away from hospital practice, increasing the inclusion of theoretical and practical activities related to collective health and PHC, and improving uptake of activities related to social determinants of health. The overarching objectives encompass (1) promoting patient-centred care, (2) reliance on inter-professional teamwork, and (3) developing shared individual therapeutic plan with the patient (Ferreira et al., 2019[29]). With these programmes, undergraduate students are supposed to be exposed to a more community-based curriculum, although it is difficult to appreciate the impact of these initiatives on the skills of the students (Scheffer and Dal Poz, 2015[16]).

National tools have also been set-up to evaluate medical schools as a result of the sharp increase in medical schools from 1990. The National System for the Evaluation of Higher Education (SINAES, *Sistema Nacional de Avaliação do Ensino Superior*) is responsible for evaluation system to renew, supervise, accredit and reaccredit medical schools (INEP, 2015[30]). The evaluation system consists of three main components:

- Institutional evaluation: performed by self-evaluation and external evaluation by institutional evaluators accredited by the INEP;
- Evaluation of the course and curriculum by teachers, co-ordinators, students, and external evaluators;
- Evaluation of the students entering and finishing the course: through the National Exam of Student Performance (ENADE, Exame Nacional de Desempenho dos Estudantes), which is performed by each schools (Ministerio da Educaçao, 2021[31]). ENADE covers seven areas of knowledge including general medicine, paediatrics, gynaecology and obstetrics surgery, public health, medical ethics and basic sciences. The test results are used to identify areas of good performance and weaknesses in all medical schools. The ENADE gives an indication of the development of competences and skills foreseen in the National Curricular Guidelines of Medical Courses.

The Sistema de Acreditação de Escolas Médicas (Accreditation System of Medical Schools, SAEM) has also been developed by the Conselho Federal de Medicina (CFM, Brazilian Federal Council of Medicine) in 2016 to reaffirm its commitment toward high quality standards for medical education (SAEME, 2021[32]). The accreditation is voluntary and complements the government evaluation procedure. The SAEM is based on the WHO and the WFME Guideline for Accreditation of Basic Medical Education. The accreditation process consists of the completion of online questionnaire covering five standards (Educational Management, Educational Programme, Academic Staff/Faculty, Students, and Educational Resources), data analysis by an evaluation committee; and a visit to the medical school by a team composed of four evaluators, one of them being a student. After this process, the evaluation committee issues a report to the educational institution with the result, which can be classified into three categories: Accredited, Accredited with recommendations of improvement, and Non-Accredited.

National tools and voluntary accreditation allowing to evaluate the quality of medical education is paramount to ensure consistency in the skills and competences of medical doctors across the country, but also to make sure the supply of medical schools and their postgraduate activities reflect the evolving Brazilian health needs. However, the CFM recently noted that, in spite of government initiatives, there are still inadequate academic programmes, inadequate internship offers and that gaps in medical education remain between medical schools (AML, 2019[33]). In addition, comparing the performance of public and

private medical schools, evidence suggests that public medical schools consistently performed better than the private undergraduate medical courses about the ENADE (Scheffer and Dal Poz, 2015[16]). Reinforcing mechanisms to ensure high quality of medical education is thus warranted in Brazil.

5.4. Improving the distribution and supply of PHC doctors in Brazil

To address the shortage of PHC doctors and the uneven geographic distribution of doctors, Brazil implemented several federal programmes including the More Doctors Programme. These efforts contributed to improvements in access to and quality of medical training in Brazil, but geographic disparities in access to medical training persist and unfilled PHC positions remains the norm.

There are three main policy levers to help address the shortages of medical doctors and improving its distribution:

- Training more rural doctors;
- Providing financial and non-financial incentives, while implementing regulations to restrict the freedom of medical doctors (the "stick and carrot approach");
- Promoting innovations in health service delivery, through task-shifting and the use of telemedicine.

They are not mutually exclusive, and may not offer the panacea when implemented in isolation. Previous studies show that these policy levers may have a greater impact if they are used in combination (OECD, 2016[34]).

5.4.1. Large-scale PHC programmes to address maldistribution of PHC physicians

The More Doctors Programme partly addressed the imbalances in the distribution of health workers

Established in 2013, the More Doctors Programme (MDP) is a large-scale health system intervention that aims to strengthen the provision of PHC services in underserved communities, within the framework of the Family Health Strategy (see Chapter 2). The MDP was designed by the Ministry of Health as a supply side intervention with three prongs that complement each other, with a particular emphasis on strengthening PHC provision in underserved communities:

- Transfer of funds to municipalities to strengthen PHC infrastructure;
- Improving access to and quality of medical school training; and
- Recruitment of Brazilian and foreign physicians to work within FHTs.

At the outset, the first two components were envisioned as long-term investments in the overall organisation of the Family Health Strategy. Broadly, the first component aimed at improving the availability and quality of work environments in which the FHT provide care (Santos et al., 2017[35]). The second component focused on enhancing access to and quality of medical training, particularly in communities that have been lagging in attracting and retaining health workers (Figueiredo et al., 2021[36]). In comparison, the third component was initially envisaged as an emergency provision to fill the immediate gaps in PHC physician availability through a large-scale physician recruitment initiative, particularly targeted at municipalities that had difficulty recruiting and retaining doctors (Santos et al., 2017[35]).

The MDP came on the heels of previous nationwide initiatives that attempted to address the imbalances in the distribution of health workers. Prior to the MDP, Brazil introduced several programmes to improve access to medical training in underserved communities, including the 2001 Programme of the Interiorisation for Health Work (*Programa de Interiorização do Trabalho em Saúde*) and the 2011 Programme for Valuing PHC Professionals (*Programa de Valorização dos Profissionais da Atenção –*

PROVAB) (Figueiredo et al., 2021[36]). While these initiatives did not eliminate the underlying drivers of the geographic imbalances in distribution of health workers, they provided valuable experiences and the know-how that informed the design and implementation of the MDP.

The new stream of funding led to a laudable expansion of the Family Health Strategy infrastructure

The first component involved creating a new stream of funding to strengthen the Family Health Strategy physical infrastructure. Municipalities could use the allocated MDP funding to increase the availability and the quality of the existing Family Health Strategy infrastructure on the ground. To receive funding, each municipality was required to submit an application to the MOH for review. Upon approval of their application, municipalities could choose to either refurbish the existing PHC clinics and purchase basic equipment (e.g. autoclaves) or build new facilities (Santos et al., 2017[35]).

Relatively little evidence exists on the impact of this component on the provision of PHC services. Though limited, evidence suggests that the MDP successfully channelled additional resources for strengthening the PHC infrastructure, with the MDP resources leading to the construction of 3 496 new basic health units and refurbishment of 3 417 units by 2015 (Santos et al., 2017[35]). According to Biernath (2020), more than 26 000 PHC facilities were built or renovated throughout Brazil following the implementation of the MDP (Biernath, 2020[37]).The administration of this component was recently halted following a federal funding freeze (Hone et al., 2020[38]).

The MDP contributed to improvements in access to and quality of medical training in Brazil, but geographic disparities persist

Despite previous attempts to improve equitable access to medical training, the geographic distribution of medical schools prior to the MDP were marked by notable disparities. For instance, in 2013, nearly 41% of all medical schools were located in the Southeast Region, compared to only 8.2% in the North and 9.3% in the Central-West regions (Santos et al., 2017[35]). Compounding this challenge, the undergraduate medical curriculum did not adequately emphasise the diverse health needs of the Brazilian population (e.g. population groups residing in rural and remote areas) and PHC competencies in line with the priorities of the SUS (Carvalho, Marques and Silva, 2016[39]).

In recognition, the second component consisted of a set of initiatives that aim to enhance access to and quality of medical education, with an explicit emphasis on alleviating geographic disparities in medical training. The MDP introduced multiple changes in medical education at the same time. First, the education component of the MDP involved the development of new frameworks to regulate the location of new public and private medical schools. Next, the MDP aimed at expanding the number of positions in medical undergraduate institutions by adding nearly 11 500 new positions by 2017 (Santos et al., 2017[35]). Finally, the Programme led to the updating of the national undergraduate curriculum for medical training with more emphasis on PHC provision in line with the SUS priorities.

Early evidence suggests that the MDP may have contributed to improvements in access to medical training. Evaluating the impact of MDP on medical education in Brazil is complicated by the length of time required before the potential impacts on health system performance can become discernible. Yet, data obtained from the Higher Education Census suggests that the MDP achieved its medium-term objective of expanding the number of new positions by 2017. Mirroring this, an estimated 92% of the new medical undergraduate vacancies created from 2010-18 took place after the MDP was launched in 2013 (Figueiredo et al., 2021[36]).

Despite these improvements, geographic disparities in access to medical training persists. Today, the North and Northeast regions continue to offer the lowest levels of per capita medical undergraduate vacancies in the country (Figueiredo et al., 2021[36]).

The recruitment of PHC physicians contributed to enhancing health system performance, but challenges in the implementation of MDP diluted beneficial impacts

The third component involves the roll out of one of the world's largest PHC physician recruitment programme. At its height, the MDP recruited more than 16 000 physicians both from within Brazil and abroad to work exclusively within the FHT. The majority of the MDP physicians were recruits from across 85 countries, mostly from Cuba (Santos et al., 2017[35]). All MDP recruits were selected from physicians who had prior experience in practicing family medicine, but without recertification requirement.

All Brazilian municipalities are eligible to request physicians from the MDP. To receive MDP physicians, municipalities are required to submit an online application to the Ministry of Health for review and approval. The Ministry of Health has the discretion to decide on the number of MDP physicians that will be deployed in the applying municipality. To inform the decisions over MDP physician allocations, the Ministry of Health developed a set of criteria aiming to identify underserved communities across Brazil in congruence with the aims and objectives of the Programme (Box 5.4).

Provider contracting arrangements for MDP physicians differ from contracts typically used by municipalities to hire non-MDP physicians. In general, the FHP physicians are hired directly by municipal governments, with little standardisation of contractual terms across physicians or municipalities. In comparison, the MDP physicians are hired directly by the Ministry of Health through contracts that can be renewed in every three years. Municipal governments are responsible for covering costs associated with transportation, lodging and food. This contracting structure was embedded in the MDP to reduce potential financial barriers that may disincentivise municipalities from joining the Programme. Importantly, municipalities are not allowed to substitute Brazilian physicians that are already practicing within the FHT in their communities with MDP physicians. However, no mechanism has been put in place to monitor any potential physician substitution.

It is not mandatory for the MDP physicians to take the national competency exam that is required for other physicians to practise medicine in Brazil. Instead, the MDP physicians are required to complete a mandatory three-week training course provided by the Brazilian health authorities before they could be deployed in municipalities. In addition, all MDP physicians are required to attend brief training sessions organised by Brazilian authorities in regular intervals. Online-learning courses are also available to the MDP physicians. Once deployed in municipalities, the MDP physicians are assigned to advisors, who are selected from experienced Brazilian health care professionals.

To date, the MDP has been associated with improvements in physician availability, though there is evidence of substitution of Brazilian physicians with the MDP recruits. Hone and colleagues (2020) suggested that the MDP was associated with a 12.2% increase in the number of PHC physicians by its fifth year of implementation, with more pronounced effects among municipalities that had lower levels of physician availability at the start of the Programme (Hone et al., 2020[38]). Despite this, evidence suggests that the MDP also had unintended consequences for human resources for health, with the MDP leading to the substitution of Brazilian physicians who were already working in communities. In their analysis, Hone and colleagues quantified that, in the absence of any substitution of Brazilian physicians with MDP recruits, the MDP could have led to a 30% increase in PHC physician availability, more than double that of the current improvements in physician availability (Hone et al., 2020[38]). This is despite the design feature of the MDP that explicitly prohibited any replacement of Brazilian physicians with MDP physicians.

The impact of MDP on adult and child mortality remains mixed. Hone and colleagues found that the MDP was associated with a modest 1.4% reduction in adult mortality amenable to health care services (Hone et al., 2020[38]). Earlier studies suggested that the MDP fell short of reducing maternal and child mortality (Carrillo and Feres, 2019[45]; Mattos and Mazetto, 2019[46]), despite an attributable rise in the number of FHT consultations attended by physicians (Mattos and Mazetto, 2019[46]). One potential explanation relates to the significant bottlenecks in access to the secondary and tertiary care, suggesting that further progress in maternal and child health may require further improvements in co-ordination of care between different

levels of care (the Brazilian Network for the Surveillance of Severe Maternal Morbidity study group, 2014[47]).

Box 5.4. Defining underserved municipalities within the framework of MDP

The MOH ranks municipalities based on a set of explicitly defined criteria to inform the distribution of MDP physicians (Hone et al., 2020[38]). Criteria used for the MDP are similar to those used in PROVAB, with the two initiatives sharing similar, readily available data sources at the community level (e.g. municipality-level or census tracks within municipalities). In the first five years of the MDP, the Ministry of Health revised the prioritisation criteria twice, but in each iteration, the selected criteria aimed at capturing the socio-economic, health systems and geographic determinants that may reveal the local needs in each community. These indicators included: the proportion of population living in extreme poverty, population size, PHC infrastructure and health worker supply, as well as geographic location (Özçelik et al., 2021[40]).

A substantial fraction of Brazilian municipalities enrolled in the MDP in a relatively short time span, thought the rollout of the Program has not been without challenges. The share of municipalities that received at least one MDP physician expanded from about 20% in 2013 to 69% in 2017 (Özçelik et al., 2021[40]). Over time, participation improved among municipalities that were considered priority for the purposes of the MDP. By 2017, about 76% of priority municipalities had at least one MDP physician. Priority municipalities that did not enrol in the MDP had smaller population density and higher rates of extreme poverty compared to priority municipalities that participated in the MDP. Importantly, this finding is in congruence with earlier evidence suggesting that less densely populated communities with higher levels of poverty also lagged in the expansion of the Family Health Strategy prior to the MDP (Andrade et al., 2018[41]).

It might be warranted to improve the community targeting methods used by the MDP to maximise the potential benefits of the Programme. As experienced by other OECD countries (the United States, Australia, and Canada), the community targeting method has large implications for human resource planning, and this might not be enough recognised in Brazil. In Australia, for example, communities with a shortage of medical practitioners are designated as the *Distribution Priority Areas* on the basis of their demographic and socio-economic status, population size and measures of geographic remoteness. Foreign-trained general practitioners are required to work at least 10 years in communities with DPA designation. In Canada, criteria used to define underserviced communities consider physician to population ratios, demographic and socio-economic status and geographic accessibility. In The United States, the Health Professional Shortage Area designation is determined based on a composite score derived as a combination of health care service provider density, level of poverty, infant mortality rate and the age structure of each community.

Source: Özçelik et al. (2021[40]), Assessing the performance of beneficiary targeting in Brazil's More Doctors Programme, https://doi.org/10.1093/heapol/czaa137; Andrade et al. (2018[41]), Transition to universal primary health care coverage in Brazil:, https://doi.org/10.1371/journal.pone.0201723; Hone et al. (2020[38]), Impact of the Programa Mais médicos (more doctors Programme) on primary care doctor supply and amenable mortality: quasi-experimental study of 5 565 Brazilian municipalities, https://doi.org/10.1186/s12913-020-05716-2. And information taken from Canada (Ministry of Health, 2018[42]), Australia (Australian Government, 2021[43]), and the United States (HRSA, 2021[44]).

Most evidence suggests that the MDP led to improvements in access to care. One study that evaluated the impact of the MDP in its first two years found that the Programme was associated with increases in appointments, consultations, medical referrals and home visits by 5.9%, 9.4%, 12.3%, and 29.7%, respectively (Mattos and Mazetto, 2019[46]). This study also found that the MDP led to a 4.6% reduction in

general hospitalisations. Similarly, the MDP has been shown to improve patient satisfaction (Comes et al., 2016[48]).

The MDP has also been linked with improvements in the quality of care, as measured by reductions in hospitalisations considered to be preventable by timely and adequate access to health care services. Earlier assessments concluded that the MDP resulted in a decrease of about 23 000 hospitalisations due to preventable causes in its first three years, corresponding to about USD 6 185 019.85 in savings from treatment costs (Fontes, Conceição and Jacinto, 2018[49]). The beneficial impacts of the MDP have been shown to accumulate and grow over time. Evidence also shows that the MDP led to reductions in adult hospitalisations primarily due to infectious gastroenteritis, bacterial pneumonias, asthma, kidney and urinary infections, and pelvic inflammatory disease (Maffioli et al., 2019[50]), though it fell short of reducing hospitalisations due other preventable conditions like hypertension (Özçelik et al., 2020[51]).

Evidence on the contributions of MDP for narrowing geographic disparities in population health remains mixed, suggesting that further improvements in community targeting methods may be needed to reap the potential benefits. Hone and colleagues (2020) concluded that the MDP fell short of yielding greater health gains in priority municipalities (Hone et al., 2020[38]). In concordance, another recent study also showed that there has been no discernible differences in hospitalisations due to hypertension between urban and rural municipalities as defined by the Programme (Özçelik et al., 2020[51]). This study also showed that the MDP was linked with reductions in hospitalisations due to cerebrovascular diseases only in urban municipalities. Both studies suggested that further improvements in the community targeting methods used by the MDP may be considered to maximise the potential benefits of the Program.

The new programme Médicos pelo Brasil will gradually replace the MDP

A new programme called Doctors for Brazil (Médicos pelo Brasil, law No. 13.958 of 18 December 2019) was initiated by the new federal government administration. Its purpose is to increase the provision of medical services in places of difficult delivery or of high vulnerability, along with promoting the training of doctors specialising in family and community medicine.

The *Médicos pelo Brasil* programme is expected to gradually replace the *Mais Médicos* programme, in particular by hiring Brazilian trained doctors who have already shown to be scarce or not wanting to go to isolated or underserved areas.

Médicos pelo Brasil and *Mais Médicos* will operate in parallel to guarantee continuity in the supply of health care services. This type of changes represent a governance challenge for the Brazilian health system, which should develop a strategic vision to preserve and amend policies or programmes that have shown to improve outcomes. The MDP should inform the design and implementation of the *Médicos pelo Brasil* programme.

Based on prioritisation criteria, the new programme will expand the number of PHC doctors to 7 500 in the poorest areas of the country, with 60% of the professionals to be hired in the North and Northeast regions. In total, 4 823 municipalities are expected to be part of the programme. To maximise the potential benefits of the new programme, it will be critical to make the prioritisation criteria clear and transparent.

Médicos pelo Brasil has a stronger focus on quality than the MDP, and positive steps have been taken so far:

- Medical licenses have to be recognised for all medical doctors who apply to the programme, either through the registration process for Brazilian students or the revalidation process for foreign-trained medical doctors. The recognition process is the responsibility of the Medical Council and Regional Councils of Medicine.
- The *Médicos pelo Brasil* programme offers two-year specialty training in Family and Community Medicine so that all contracted doctors become specialists in PHC. At the end of the training,

specialists in PHC will have to present a "*Trabalho de Conclusao de Curso*", an analysis of the local health needs of the catchment area where medical doctors work so that improvement and evaluation strategies are being implemented.

- PHC doctors are expected to remain in the Family Health Units where they did the specialty training, and receive a 2-year training grant, which varies according to the municipalities' level of vulnerability. The grant is BRL 12 000 net monthly, and an additional BRL 3 000 bonus for remote locations (those classified as rural and intermediate) or an additional BRL 6 000 for indigenous districts, as well as riverside and river locations. Once qualify as specialist in Family and Community Medicine, they are hired under the Consolidation of Labor Law (CLT) which supposes better working conditions and security at work compared to the *Mais Médicos* programme.

With regards to the tutorial programme, only specialists in family and community medicine or in internal medicine can be selected. Tutors are also hired under the CLT. They will be responsible for serving the population registered to the FHT, and for supervision of other medical doctors who are enrolled in the specialisation training. There are four salary scales, with progression every three years: The first salary level can reach up to BRL 21 000 and, gradually, up to BRL 31 000, considering performance bonus and additional grants depending on the level of vulnerability.

All these changes are promising, representing improvements compared to the Mais Medicos Programme and real opportunities to increase the attractiveness of the PHC specialty (Table 5.1). Strategic thinking toward the community targeting methods is required to make sure that eligible municipalities are effectively enrolled to the new programme.

Table 5.1. Médicos pelo Brasil programme has a greater focus on quality

Mais Medico	*Médicos pelo Brasil*
Scholarship without employment link and for a determined time	Contracting by the CLT with the right to FGTS holidays
Does not require any Brazilian diploma or revalidation	Requirement to have a recognised Brazilian licence or to undertake revalidation of foreign diploma
No requirement to have a formal specialisation degree in PHC	Requirement to pass the speciality training in Family and Community Medicine.
Foreign Medical doctors are not allowed to bring the family to live in Brazil	Foreign Medical doctors are allowed to bring the family to live in Brazil

Source: Brazilian Ministry of Health.

The next two sections present policy responses that could help tackle the uneven distribution of PHC physicians in Brazil.

5.4.2. Changing regulations can help address shortages of medical doctors in some remote areas

Training more rural doctors to boost their numbers

As the MDP, the new *Médicos pelo Brasil* programme sets very promising objectives to improve the supply and the distribution of PHC doctor across the country. As part of the new programme, it will be important to train rural PHC doctors to improve retention over the longer term. International evidence confirm that medical education in rural location led to increases in the number of medical graduates that will work in rural place over the long term (McGirr, Barnard and Cheek, 2019[52]). In congruence, experiences from OECD countries also highlight the importance of having medical studies for PHC professionals be located in local regions such that students are close to their residencies and are incentivised to stay upon successfully completing their training (OECD, 2016[34]).

Box 5.5. The Rural Clinical School Programme in Australia

The Rural Clinical Schools (RCS) Programme was launched in 2000 to enable medical students to undertake the majority of their clinical training in regional areas.

The RCS aim to deliver significant components of the medical curriculum in a rural environment, with students undertaking a year or more of their medical training in a rural location. It entails the following targets (McGirr, Barnard and Cheek, 2019[52]):

- 25% of all medical students to have at least one year of rural clinical training by graduation
- 25% of government-supported medical students to be recruited from a rural background
- All government-supported medical students to have at least 4 weeks of rural placement.

The programme is structured around four broad objectives (Australian Department of Health, 2008[53]):

- Encourage medical students (and medical professionals) to take up a career in rural practice
- Encourage rural health professionals to take up academic positions
- Improve the range of rural health care services in rural communities across Australia
- Strengthen the health workforce in rural communities across Australia.

As of 2018, there were currently 18 RCSs in Australia (McGirr, Barnard and Cheek, 2019[52]). The Rural Clinical Schools Programme has allowed to develop teaching and learning facilities, and student accommodation in dozens of rural and regional locations across Australia. There are positive evidence showing that RCS programme improve retention and recruitment, but also improving the range of quality of health care services in rural area. With this regards, particular specialties that were not available in the community have become available because of a successful appointment by the programme.

Source: McGirr, Barnard and Cheek (2019[52]), The Australian Rural Clinical School (RCS) programme supports rural medical workforce, https://doi.org/10.22605/RRH4971; Australian Department of Health (Australian Department of Health, 2008[53]), Rural Clinical Schools Programme.

Prior experiences from OECD countries, such as Australia, Canada, England or Norway, offer many opportunities for Brazil. For instance, in Australia, the Rural Clinical School (RCS) Programme was launched in 2000 to enable students to undertaken their training in rural areas. The RCS Programme supports 18 rural clinical schools, where it is required that 25% of students enrolled in the medical course have a rural background (McGirr, Barnard and Cheek, 2019[52]). Recent evaluations showed that the RCS Programme was effective in increasing both the recruitment and retention of medical practitioners in rural areas over the long term (McGirr, Barnard and Cheek, 2019[52]). Results show that students who have participated in RCS Programme were 1.5 times as likely to continue practicing medicine in regional and rural locations five years after graduating from medical school (Box 5.5). Other OECD countries established medical programmes in rural localities, such as Canada with the Northern Ontario School of Medicine, England with the Exeter and Playmouth medical school, or Norway with the Tromso's medical school.

Implementing a "stick and carrot" approach

It is important to implement a "stick and carrot" approach to attract and retain PHC doctors in rural areas. This approach consists of combining financial and non-financial incentives for medical doctors with regulations which restrict the freedom of doctors.

Offering financial incentives to compensate for some of the disadvantages in less attractive regions is an important policy option already implemented in many other OECD countries such as in Chile, Germany, Canada or France. Such financial incentives compensate for longer working hours, a less advantageous "business environment" for doctors in underserved areas. They can be either one-off or wage-related financial incentives that are directly directed to the PHC doctors:

- First, there are **non-wage related payments**, which are used to encourage physicians to move to or stay in underserved areas. It is a one-off payment to help facilitate a location choice, and which can be linked with a return of service obligation. Such policies exist in some Canadian provinces. In Ontario, the Northern and Rural Recruitment and Retention Initiative offers grants of between CAD 80 000 and CAD 117 600 for a practice opening in a rural area paid over a four-year period (Ontario Ministry of Health, 2021[54]). The applicant must commit to establish a full-time practice in a community in Northern and very rural areas, and in which they have never previously practiced full-time. The higher the rural index (the more Northern and rural the area), the higher the value of available grant. To encourage both recruitment and retention, the proportion of the grant paid out will be highest in year 1 and year 4. The payment schedule is as follows: Year 1: 40%, Year 2: 15%, Year 3: 15%, Year 4:30%. The province of New Brunswick also offers recruitment incentives to Medical Residents and newly recruited family physicians looking to establish a full-time community-based practice in designated fields. Family Medicine New Brunswick is a new programme that aims to improve patient access, increase collaboration between physicians using technology, and create a better work-life balance for physicians. For the first year, a new physician joining the programme will receive a guaranteed minimum remuneration of CAD 175 000 (New Brunswick Canada, 2021[55]). Similar policies exist in Germany, where states (Länder) offer financial incentives for GPs opening their practice for the first time. In some states, the one-time payment comes with a return-of-service obligation of five to ten years (OECD, 2016[34]).
- Second, there are **wage-related financial incentives**, where physicians in underserved areas receive financial incentives linked to income. These payments aim to compensate rural GPs for a smaller number of patients, longer working hours or challenging working conditions. In the Canadian province of Ontario, the Northern Physician Retention Initiative enables eligible physicians (general practitioners and specialists) in Northern Ontario to receive the equivalent of CAD 7 267.46 retention incentive paid at the end of each fiscal year in which they continue to practise full-time in Northern Ontario (Ontario Ministry of Health, 2021[56]). In France, the Contrat d'Aide à l'Installation des Médecins offers a one-off payment of between EUR 50 000 and 31 250 to help physicians set-up a practice in an underserved region. The payment schedule is 50% upon signature of the CAIM, and 50% one year later (Assurance Maladie, 2020[57]).
- Third, countries can **combine financial and non-financial incentives** to attract and retain physicians in underserved communities. For instance, Chile provides a promising example, where several incentives are combined to attract physicians to work in rural PHC hospital and health centres for a minimum of three years to a maximum of six years (Pena et al., 2010[58]). The programme, called the Chilean Rural Practitioner Programme, entails 1) monetary compensation (direct and indirect financial incentives such as additional compensation depending on the level of isolation, performance bonus, installation and transport costs), 2) education incentives (four week clerkship with physicians, 3) management, environment and social support interventions (paid continuous medical education, additional days for personal reason, and additional week off) and 4) external incentives (better equipment, better connectivity, and internet ad mobile phone access) (Pena et al., 2010[58]). The programme has been found successful: the number of applicants exceeded the number of available positions, high retention rates, and high satisfaction rates from applicants (Pena et al., 2010[58]). While dropouts from the programme are exceptional, around 60% of participants stay for the maximum period (six years).

As part of the *Médicos pelo Brasil* programme, physicians in underserved areas will receive financial incentives of BRL 3 000 when working in "rural and intermediate" areas, and of BRL 6 000 when working in indigenous districts, as well as riverside and river locations. As done in other OECD countries, it could be important to link financial incentives with a return of service obligation of between two and four years. Combining financial and non-financial incentives, and implementing some regulations to restrict the freedom of doctors, as experienced by OECD countries, could also be a good solution to recruit and retain doctors in underserved areas. The federal government will need to ensure that the various types of financial incentives are received by the medical doctors, and not distributed at the discretion of the municipalities.

Restricting the choice of location

A more stringent regulatory measure to redress the geographical imbalance of doctors would be to restrict the choice of practice location for PHC doctors. Brazil could, for example, learn from Turkey, Germany, Norway or some provinces in Canada (New Brunswick, Quebec) where interventions to restrict the choice of location of newly medical doctors have been established. At any rate, such regulatory approach requires careful and coherent workforce planning.

In Germany, self-employed doctors are not allowed to set up their practice and serve public patients in a catchment area that is considered 'overserved' based on a patient-to-doctor ratio. Physicians need to obtain a practice permit to be reimbursed by the statutory health insurance (KBV, 2021[59]). The number of these permits is controlled by the National Association of Statutory Health Insurance Physicians through its 17 state associations. It is mandated by the government to guarantee medical service coverage of the population based on a quota agreed within the self-administration of the German health care system. The service coverage is measured based on the ratio between physicians and inhabitants in each of the 395 planning regions. For GPs, 100% coverage is achieved when the ratio of GP to inhabitant reaches 1:1 617. If the coverage of a region exceed 110%, no further permits are issued (OECD, 2016[34]). In Canada, in the province of Alberta, the Bill 21 proposed that after April 2022 new doctors in the province will be required to obtain practice permits from the government upon completion of residency training. These permits will restrict new doctors to work only in certain regions. Turkey restricts service location choice of new medical graduates who want to work in the public sector. Recent medical schools graduates are required to work for the states for a period of 300 to 500 days after graduation. After this service period however, physicians wants to secure employment in urban areas (Phcpi, 2018[60]).

Such regulatory approaches can be controversial with fears from professional association that designating where doctors should work impede recruitment. In this case, it is important to provide strong financial compensation to medical doctors.

5.4.3. Changing service delivery can help reduce geographical inequalities in access to care

There are several interventions on the supply side to promote the use of innovative health service delivery to provide adequate level of access to PHC in areas with fewer physicians (e.g. through telemedicine or telehealth) or shifting some health service provision from physicians to other health care providers. The strategy is not to train more doctors or to rely on more doctors, but rather to rely on smart information and communication technology and to maximise use of human resources already living in areas where there are shortages of medical doctors. This could constitute a good complement for usual care provided by medical doctors.

Expanding the role of nurses or community health workers

Unlike many other OECD countries, Brazil has not yet experimented with changing scope of practice and task shifting among health workers. More strategic use of the existing rural health workers other than

physicians who are already residing in areas where there are physician shortages will be crucial to meeting health care needs in more remote areas.

Core PHC functions, including comprehensiveness, continuity and co-ordination, can be discharged to health workers other than PHC doctors. In recognition, many OECD countries are moving to change the scope of practice of health professionals as a means of coping with health workforce shortage, which typically involves developing new roles for nurse practitioners and community health workers (OECD, 2020[61]).

International evaluations of task shifting provide conclusive results. Nurse practitioners with proper education and training generally show that they can improve access to services, reduce waiting times and deliver the same quality of care as doctors for services such as routine follow-up of patients with chronic conditions (Maier, Aiken and Busse, 2017[62]). Recent systematic review found that PHC teams that enable nurses to play a more advanced role in service provision (e.g. providing patient education, co-ordination, prevention advice or drug prescription) achieve better patient outcomes and greater patient satisfaction, while reducing hospitalisation (Matthys, Remmen and Van Bogaert, 2017[63]). Moreover, another recent systematic review showed that scaling up reliance on nurse practitioners yielded greater access to care among rural and underserved populations without deteriorating the quality of care (Yang et al., 2020[64]). In low and middle income countries, the implementation of task-shifting has been a key lever to fill the gap in PHC provision due to a lack of PHC doctors (Afobali et al., 2019[65]).

Among OECD members, some countries such as Australia, and more recently France have sought to improve access to PHC by expanding advanced education programmes for nurses. In Australia, remote area nurses are recognised as the backbone of rural and remote PHC. They can work as part of a small team or work independently. With a rotation system, they are available 24 hours a day, seven days a week. They are able to work across diverse care settings, including acute, emergency, aged, palliative, mental health, family and community health care areas (OECD, 2020[61]). Some Jurisdictions in Australia, including Queensland, and Victoria, have also implemented the Rural and Isolated Practice Endorsed Registered Nurse scheme. The scheme permits approved nurses to provide a limited range of medicines, where there is little or no access to PHC. In France, the National Health Strategy 2018-22 promotes more advanced roles for nurses to improve access to care, particularly in areas where there are relatively few doctors (OECD, 2020[61]). The position of advanced practice nurses was legally created in 2018. These nurses provide support in the care of chronically ill patients and those with complex morbidities, working in co-operation with GPs and specialists in PHC teams and other health, and long-term care settings. Their tasks include prevention and screening activities, prescription of complementary exams and renewal or adjustment of medical prescriptions.

Brazil has amongst the most extensive education networks for nurse training in the LAC region. According to the Department of Management of Health Education in Brazil, the number of nursing schools amount to 790 in 2020, with several specialisation programmes being offered. In 2019, there were around 24 master's degrees programme in nursing, constituting powerful training spaces for developing advanced practice nurses (Cassiani and Silva, 2019[6]; Neto et al., 2018[26]).

Brazil can capitalise on its existing nurse training network to expand and recognise the role of advanced practice nurses, which in turn, can help alleviate the persistant workforce shortages in PHC. Advanced practice nurses in Brazil could contribute to the management of care of patients with mild acute diseases and chronic disorders, complementing the already practicing PHC doctors. Alternatively, they can be deployed in remote and underserved areas to help enhance access to qualified health professionals. Such a policy would require a thorough analysis on current nursing curriculums to further invest on core competencies including team practice, care co-ordination between and across health sectors, clinical and professional leadership, quality and safety management among other (Cassiani et al., 2018[66]).

Beyond expanding the role of nurse practitioners, it is also warranted to make the most of community health workers within the Brazilian PHC team. Community health workers already play a crucial role in

PHC provision in Brazil. They are trusted members of the communities in which they work and have valuable knowledge of local health needs. In Brazil, there is scope to expand further their role toward more preventive activities and care management. In Alaska (United States), CHWs are the first point of contact with the health care system for the population living in very remote villages (Box 5.6). There, they provide preventive treatment, chronic care and emergency visits.

In a systematic studies review (Hartzler et al., 2018[67]), community health workers are found to be able to perform three main functions:

- providing clinical services, such as assessment of vital signs, lifestyle advice, and routine examinations aided by remote communication with physicians;
- linking patients with community-based services, such as referrals for transportation or food assistance; and
- providing health education and coaching, to help patients achieve health goals and increase self-efficacy.

With serious workforce gap in Brazil, community health workers could play a bigger role, notably by taking a patient's medical history, conducting basic physical exams, ordering tests, counselling on preventive care. To date, CHWs in Brazil motivate patients to get care and bring test results to patients, check whether patients are taking medications, schedule appointments for individuals with other health professionals and encourage community members to seek care at the clinic (Wadge et al., 2016[68]).

There is further scope to train CHWs in Brazil to directly address health needs and provide some clinical services, aided when necessary by remote communication with PHC doctors. The lack of opportunities to learn and advance in the community health worker role has already been noted elsewhere (Grossman-Kahn et al., 2019[69]). So were the lack of recognition of their work, the poor communication and co-ordination between community health workers and the basic health units, as well as the lack of resources at the basic health units (Grossman-Kahn et al., 2019[69]). Investments in CHW trainings, in streamlined IT systems and improved communication between CHW and other staff from the FHT will help expanding CHW roles.

Box 5.6. CHWs are the first point of contact with the health care system in remote part of the United States

In the United States, community health workers have a key role to address social determinants of health and to promote access to care for vulnerable and hard to reach populations (Hartzler et al., 2018[67]). Community health workers, for example, provide PHC services in remote Alaskan villages, whose population would otherwise have no access to appropriate health care delivery (Golnick et al., 2012[70]). They are the first point of contact with the health care system for the population living in these very remote villages. They work under the supervision of community health practitioners, and there is an integrated referral system that includes physicians, regional hospitals and a tertiary hospital (Golnick et al., 2012[70]). The range of PHC services delivered by community health aides mostly includes care for chronic and preventive treatment, and emergency visits (often for respiratory distress and chest pain).

Furthermore, community health workers played a critical role as frontline health care workers during the first wave of the COVID-19 pandemic. In New York for example, community health workers provided educational sessions to patients with chronic conditions or at risks for chronic conditions to help them manage their conditions. They have also made home-visits, conducted wellness checks over the phone, helped people enrolling in online patient portals and prepared them for tele-health appointments. They served as support in navigating the health care systems, and mitigating fear and correcting misinformation in disadvantaged communities.

Source: Golnick et al. (2012[70]), Innovative primary care delivery in rural Alaska, https://doi.org/10.3402/ijch.v71i0.18543; Hartzler et al. (2018[67])Roles and Functions of Community Health Workers in Primary Care, https://doi.org/10.1370/afm.2208.

Greater use of teleconsultations needs greater funding and new governance model

Improved use of alternatives to face-to-face consultations is another avenue for consideration to cope with PHC doctor shortages and geographical imbalances in Brazil. Telemedicine is used internationally to make PHC services available to patients closer to their home or work. It facilitates communication between patients and medical staff, as well as the transmission of medical records and other data between different locations (OECD, 2020[61]).

Teleconsultation is a very promising way to improve access – both timely and geographically – and to relieve pressure on PHC physicians. Previous studies have shown that telemedicine improves access to care, reduces travelling costs and leads to better equity for rural and indigenous population (Oliviera Hashiguchi, 2020[71]). Nearly 90% of international studies concluded that telemedicine interventions were at least as effective as face-to-face interaction (Oliviera Hashiguchi, 2020[71]). Benefits can be found for preventing and controlling PHC sensitive conditions, like glycaemic control in diabetic patients, fewer hospitalisations for patients with chronic heart failure, effective pain management and effective management of health risk factors including exercise and nutrition (Oliviera Hashiguchi, 2020[71]).

As already detailed in Chapter 6, telehealth has been in use in Brazil for quite some time now, especially in remote areas like the Amazon (Santos et al., 2016[72]). In addition, the Brazil Telehealth Network Programme seeks to expand and improve PHC provision in regions with high social vulnerability, where the supply of health care services is very limited. The programme provides health care professionals that are part of the network both synchronous (real-time) and asynchronous teleconsultations, telediagnostics, second opinions and telelearning (Ministério da Saúde, 2020[73]).

Telehealth services remain under-utilised in Brazil, despite evidence that points to beneficial effects. Available evidence shows that so far implementation of telehealth in PHC in Brazil has been associated

an improvement in child care, diabetes mellitus care, hypertension and women's health (Dos Santos et al., 2019[74]). Despite this, from 2016 to July 2019, just under 3.5 million telehealth services across all levels of care (from tele-consultations to tele-learning sessions) had been registered in Brazil. Of these, 50% had taken place in the Southeast region and 36% in the South region. Only 1% of activities took place in the North region. Out of 26 Brazilian states, only 18 have telehealth centres participating in the network.

In many ways, telehealth initiatives in Brazil are promising, but several factors impede the development of telehealth. These impediments include the lack of funding, the lack of training, the lack of equipment for FHT and a fragmentation of governance mechanisms (see Chapter 6 for more details). Argawal et al. (2020[74]) noted that Brazil lacks guidelines around reimbursement models and regulatory frameworks for telemedicine.

There are successful experience across the OECD, where telemedicine services have been used to expand access to care among rural and remote patients. Canada and Australia are two examples, where large investments have been made to make access to telehealth services a reality:

- In **Ontario, Canada**, the Telemedicine Network includes 120 virtual care systems to connect communities to care across the province (Ontario Telemedicine Network, 2021[76]). In 2017, the Ontario Telemedicine Network supported more than 896 000 visits (Agarwal et al., 2020[75]). The province of Saskatchewan has also been using telehealth technology for over a decade to reach rural and remote locations (Ontario Ministry of Health, 2021[54]). Patients can receive PHC by visiting the nearest telehealth site and meeting with a professional in a virtual exam room. Telehealth can connect to available diagnostic peripherals, such as stethoscopes, vital signs monitors and ultrasound equipment, making real-time diagnosis and patient monitoring possible. In rural and remote areas, telehealth services are particularly used for mental health and addiction appointments, for prescription refills and chronic disease management. In addition, Saskatchewan began piloting remote presence technology for a number of North communities in 2017 (OECD, 2020[61]). The project allows the PHC team in the community to have access to expertise (such as physician, nurse or pharmacist, etc.) on demand. Overall, previous experiences with telemedicine in Ontario (called Champlain BASE) have been shown to be cost-effective for the provision of specialist care. The cost of traditional referral to a specialist provider was, on average, CAD 133.60 per case; versus CAD 47.35 per case for a teleconsultation service on average (Agarwal et al., 2020[75]).
- **Australia** has also made large investment in telehealth services to be used for specific health conditions such as chronic conditions and dermatology for people (OECD, 2015[77]). In the Northern Territory, PHC doctors can be anywhere in Australia, and assist remote nurses and Aboriginal health practitioners to manage chronic disease patients appropriately by reviewing pathology and assessment results, then have case discussions with the local team. They also monitor and advise on other pathology testing. The medical practitioners consist of a group of general practitioners, who have usually previously worked in remote Northern Territory, and have moved away but can continue to provide quality care for remote patients through the use of a web-based electronic patient record with a unique patient identifier. Remote nurses and Aboriginal health practitioners can then contact a doctor who understands the conditions and circumstances they are providing care in. The Australian College of Rural and Remote Medicine also developed Tele-Derm, an online resource enabling rural doctors to receive advice on the diagnosis and management of skin disease. A rural doctor submits a photo of a skin condition, together with information on the patient's history and a possible diagnosis. A dermatologist responds usually within two days with a diagnosis and treatment options. PHC doctors can also access online case studies and education opportunities.

To address workforce shortages through a wider use of telehealth, Brazil will need to establish a governance structure that better support municipalities with insufficient resource capacity. Greater financial

support and adequate training will be required to avoid compounding existing social divides (see Chapter 6).

5.5. Increasing the recognition of the PHC specialty and ensuring high quality of medical education

Beyond addressing the uneven geographic distribution of PHC physician, there is an urgent need to increase the recognition of the PHC specialty and to ensure high quality of medical education in Brazil. Actions are needed in three broad areas:

- Standardising the contractual arrangement of PHC workers, with a more consistent salary scale across the country;
- Improving the academic incorporation of the family and community medicine specialty in graduate and post-graduate programmes to improve its credibility and recognition;
- Introducing quality measures to medical education to secure a high quality PHC workforce through a national licensing examination, making the specialty training in PHC compulsory for all medical doctors wishing to practise PHC, and implementing stronger requirements around continuous medical education.

5.5.1. Standardising the contractual arrangement for PHC workers

There are avenues for Brazil to improve the attractiveness of the PHC profession through a greater standardisation of contractual arrangement outside of the *Médicos pelo Brasil* programme. As each municipalities define the level of salaries, bonuses and other payment mechanisms, there is wide heterogeneity in these arrangements between municipalities. In Brazil, stronger oversight and regulation from the federal government is warranted to ensure consistency across the country. It could be important to make sure that small municipalities offer similar contracts as bigger municipalities, with a more consistent salary scale across the country. The new Agency of the Development of PHC could have a role to play in this direction.

Across OECD countries, Turkey implemented a similar strategy with the Health Transformation Programme launched in 2005. The overarching objective was to strengthen family medicine and PHC, notably through establishing new contractual arrangements for family physicians. Before the Health Transformation Programme, contractual arrangements and roles of family physicians were loosely defined. With the implementation of the health reform, family physicians have started to be paid according to national terms and conditions, and with more generous salaries and improved working conditions.

5.5.2. Improving the credibility and recognition of the specialty of PHC in Brazil

While the Family Health Strategy has made access to PHC a priority, the country has not invested well in building a strong credibility and recognition of the specialty of family and community medicine. In Brazil, the FCM specialty is the last option among physicians. Available evidence shows that the specialty of PHC is the first option for only 1.5% of recent graduates among the 55 specialties (Scheffer et al., 2018[1]). It is important to add that the specialty is not recognised as a knowledge area by the Federal Agency for Support and Evaluation of Graduate Education, meaning that funding research and investment in this research area has traditionally been very low.

The low degree of academic incorporation of the family and community medicine specialty in graduate and post-graduate programme has been found to impede building a strong recognition of this specialty in Brazil (Wenceslau, Sarti and Trindade, 2020[78]; Fontenelle et al., 2020[79]). Few researchers build their carrier

around PHC, and perhaps as a consequence, PHC departments in universities and medical schools are very rare.

A strong academic incorporation is however critical to allow transmission of the specialties' value and allow a practice to be recognised by other health care professions. Without such promotion, it is very difficult to promote FCM among the students and to encourage them to choose this specialty as their future career. Low academic incorporation also reduces scientific production in the area of FCM, and limits it to collective health (Wenceslau, Sarti and Trindade, 2020[78]; Fontenelle et al., 2020[79]). Arguably, the specialty of family and community medicine is undervalued in Brazil, explaining why there is still bottleneck in filling physician vacancies in FHTs. Even with the implementation of the More Doctors programme, which has managed to allocate more than 16 000 new professionals to PHC since 2013, unfilled medical positions in FHTs are still common (Giliate Cardoso Coelho, Valeska Holst and Aristides, 2019[18]).

Serious efforts are needed to counter the misconception that PHC is merely health care for the poor or the marginalised people, that it is a profession without much qualification, a second-rate profession (Justino, Luzón Oliver and Palhano de Melo, 2016[19]). The knowledge, skills, responsibilities and core competencies of the family and community medicine speciality should be evident to all population groups and from all other health care professionals. The creation of academic departments of family and community medicine in all medical schools is a prerequisite to undertake research in PHC, develop clinical guidelines specific to PHC, as well as teach the specialty. Dialogue, inter-disciplinary collaboration with other specialists and mutual respect between health professionals are also key to support this.

When good family and community medicine curriculums are in place for both students and residents, it becomes possible to attract students to this specialty (Blasco et al., 2008[80]). Family physicians who are recognised for their academic competence, leadership and who teach PHC practice with determination can awake a sense of vocation in their students, and will also win prestige among other health care professionals. Strong academic incorporation is also a prerequisite to develop and encourage further continuing medical education for all medical doctors who practice currently with no specialty training, helping to maintain and improve the quality of care.

Brazil could build up from experiences that have allowed to make good steps towards incorporating PHC as a core scientific area in some federal universities. For instance, the Master's Program in PHC at the Federal University of Rio de Janeiro, or the Family Health Master's Programs at the Federal Universities of Ceará and Mato Grosso do Sul. At the same time, Brazil could also build from successful experiences of network of Family Health Professional Master's, which attracted a high number of professionals: the programme of the Family Health Training Northeast Network (RENASF) created in 2009 (RENASF, 2012[81]), and the Family Health Professional Master's (ProfSaúde) created in 2016 (ProfSaúde, 2019[82]). Such good local initiatives could be consolidated by the federal government to design a National Family and Community Medicine postgraduate programme for Brazil.

5.5.3. Introducing quality measures to medical education

Implementing a national licensing examination

While the Ministry of Education in Brazil regulates medical education nation-wide, more could be done to secure standardisation of the medical curriculum in Brazil. The inadequate academic programme and gap in medical education between medical schools is an area of concern.

To achieve greater standardisation of the medical curriculum and teaching across the country, Brazil could introduce a national test at the end of the university period. The implementation of a standardised national exam would replace each final exam in medical schools. The national licensing examination will not replace accreditation performed by the INEP or the CFM, but rather complement it.

A national licensing examination would assess both knowledge and clinical skills of undergraduate students. This is a necessary step to improve the public trust and confidence in physicians. It will make transparent that all medical doctors in Brazil are competent in their clinical skills and medical knowledge. There are several advantages of establishing a national examination (Bajammal et al., 2008[83]):

- First, the use of a standardised national exam is the best way to ensure any medical graduate or practicing doctor in Brazil has achieved at least a common standard of medical knowledge and clinical skills competencies. This would ensure that minimum standards and minimum competencies are met.
- Second, a national examination would act as a tangible and standard measurable outcome to identify areas in need for potential improvement in the curriculum and teaching methods. It could be used to benchmark medical schools across the country, and to correct any potential problem or deficiency in the curriculum or teaching method.
- Third, a national exam could be used as a reliable and transparent measure of candidates' qualification for post-graduate program's application. In other OECD countries such as France and Italy, allocations to specialist schools are determined by the results of the national examination. This approach is seen as a more meritocratic and transparent way to attribute specialist training places.

The national examination has been increasingly used across OECD countries. This is a mandatory requirement to practise medicine in Canada, France, Italy, and just recently in the United Kingdom. While the United Kingdom has relied on external examiners and inspection carry-out by the General Medical Council to assure quality across the United Kingdom medical schools, the country is introducing a Medical Licensing Assessment which will test the core knowledge, skills, and behaviours needed to practise medicine (Box 5.7). The overarching objective is to drive up high standards for medical schools in the United Kingdom (CMC, 2020[84]). Brazil could learn from the United Kingdom's experience in building the Medical Licensing Assessment, and the role played by the General Medical Council.

At the same time, it will be important to ensure that doctors who qualified abroad pass a national licensing examination in order to be eligible to practise in Brazil. This approach is taken internationally – for example in the United States, Canada, France or the United Kingdom. In these countries foreign medical graduates must pass licensing examinations in order to be eligible to practise in the country, and then be able to enrol in a residency programme and pass the post-graduate examination. This system ensures every foreign graduate has at least the minimum competences to function as a physician, according to the licensing body standards of the country. In the United Kingdom, international medical graduates have to pass the Professional and Linguistic Assessments Board (PLAB) test (GMC, 2021[85]). The PLAB Test helps make sure doctors who qualified abroad have the right knowledge and skills to practise medicine in the United Kingdom. From early 2024, international medical graduates will also have to take the MLA if they are applying for registration with a license to practise in the United Kingdom (Box 5.5). In Australia, international medical graduate seeking general registration as a medical practitioner needs to undertake the Standard Pathway which consists of the completion of a written examination (CAT MCQ) and structured clinical examination of the Australian Medical Council (AMC, 2020[86]).

With the new Médicos pelo Brasil programme, the Revalida system will be a compulsory requirement for foreign medical graduates. This is an important step going forward to ensure that all medical doctors who qualified abroad have the right knowledge and skills to practise medicine in Brazil. As in the United Kingdom and Australia, revalidation consists of a theoretical written test and a practical clinical skill test, covering all level of health (primary, secondary, clinical, surgical). It might be warranted to better target the Revalida Test toward specific clinical areas or level of care depending on the profile of each graduate to better recognise their qualifications.

Box 5.7. The United Kingdom is introducing a Medical Licensing Assessment

The United Kingdom has traditionally relied on external examiners – visiting medical educators from other organisation – and General Medical Council inspection to assure quality across UK medical schools. Medical schools used to set their final exam independently in line with the General Medical Council's outcomes for graduates. However, the United Kingdom is introducing a Medical Licensing Assessment (MLA) which will test the core knowledge, skills, and behaviours needed to practise in the country. Medical students graduating in the academic year 2024-25 will need to pass the MLA as part of their medical school degree before they can join the medical register. The MLA test will have two-part: an applied knowledge test that will be computer-based, and a clinical and professional skills assessment. The aim is to provide a standardised mean of assessing all UK doctors, which in turn will help ensure patient safety. The benefit of the new system is, for the first time, to demonstrate that graduates from each medical school have met an agreed standard of proficiency and are well prepared to practise medicine. The work entailed by the MLA will be overseen and regulated by the General Medical Council. This work will consist of:

- Defining the range of professional skills, knowledge and behaviours a candidate needs to have achieved to be ready to practise medicine in the United Kingdom;
- Approve procedures to compile test questions and papers, set standards and run exams;
- Take corrective action if through its quality assurance processes, it considers that standards are not met;
- Be responsible for using information and data from the exams to apply a consistent approach to the assessment of international medical graduates.

Under this agreement, medical schools will continue to develop and deliver their own curricula and prepare students for the MLA, which will be regulated by the General Medical Council.

A process of phased introduction will begin from 2021 with robust testing and piloting, and the assessment will be fully implemented for students graduating from UK medical schools from the academic year 2024/25.

Source: CMC (2020[84]), https://www.gmc-uk.org/news/news-archive/gmc-and-msc-welcome-agreement-on-medical-licensing-assessment-delivery-model

The specialty of family and community medicine should be a mandatory requirement to be allowed to practise PHC in Brazil

As earlier mentioned, most doctors working in FHTs do not have a specialist post graduate training in FCM. Brazil is currently aiming for each FHT to have a FCM specialist with the implementation of the new Doctors for Brazil programme. The new programme will make the specialty training in PHC compulsory for all medical doctor wishing to practise PHC. Arguably, this new programme will help deliver more effective and patient-centred care. The benefits of specialist PHC has already been demonstrated elsewhere: PHC specialists place a stronger emphasis on preventive interventions and early management of health conditions, and are more likely to address the majority of patient's need, as well as to help them to co-ordinate care with other health services contributing to better quality and responsiveness (OECD, 2020[61]).

Currently, at least 22 OECD countries (Australia, Austria, Belgium, Canada, the Czech Republic, Denmark, Estonia, France, Greece, Israel, Italy, Ireland, Latvia, the Netherlands, Norway, Portugal, Slovenia, Spain, Sweden, Switzerland, Turkey and the United Kingdom) have introduced a post-training

requirement to practise PHC. Such a professionalisation of PHC specialists goes along with the formation of professional organisations, scientific research in PHC, or the development of guidelines. This is warranted for driving up quality and patient-centred PHC in Brazil.

Requirements around continuous medical education for PHC medical doctor could be implemented

Continuing medical education (CME) includes the acquisition of new knowledge, skills and approaches considered useful for developing competent and experienced medical practice. It helps medical doctors maintain their competence and acquire new skills throughout their carriers. This is critical to keep practice up-to-date, and to make sure medical doctors possess the skills useful and needed in daily practice to respond to evolving patients' needs.

In Brazil, the Política Nacional de Educação Permanente em Saúde was instituted in 2004 as the main mechanism to encourage continuing professional development. It is based on participatory teaching and learning approaches at the practice level. The overarching objective being to improve the skills and fill gaps in competence according to patients' health needs in daily practice, rather than updating medical knowledge using didactic approaches. While continuing professional development is a good practice to continuously and actively improve the skills and competences of medical doctor, the uptake of this activity within FHTs remains unknown.

In addition, CME is voluntary in Brazil. There is no specific requirement for each medical doctor. The take-up of CME relies upon professional and individual choice, without any regulatory approach, peer evaluation requirement or re-certification requirement. The current system does-not guarantee high standard of competencies for PHC doctors, and does not ensure their fitness to practise throughout a carrier. So far, it is impossible to know whether and how many PHC medical doctors have undertaken CME.

A number of bodies such as the CONASS, CONASEM, the Brazilian Medical Association, the SBMGC or the SOBRAMFA organise several training, conferences and internet-based learning model. These are all valuable approaches. However, a more formal CME framework, which makes clear the expectation upon PHC doctors and supports them to meet it, will constitute a marked improvement. Brazil could introduce strong requirements around CME for PHC physicians, as experienced by other OECD countries including Norway, the Netherlands or the United Kingdom (OECD, 2014[12]). In the United Kingdom and the Netherlands, CME for PHC medical doctor is compulsory and linked to re-certification. PHC physicians need to demonstrate that they have regularly participated in CME activities and there is a peer evaluation regarding professional skills. To be successfully re-certificated, PHC physicians need to achieve at least 50 CME credits per year. Norway use financial incentives to increase compliance with CME requirements. Specialists in PHC are able to charge higher fees for each consultation than regular GPs if they have followed a number of CME courses. This gives strong incentives to comply with national requirement, which in turn improve their competencies and performance.

Experiences from OECD countries could be helpful to inform Brazil on ways to implement requirements and mechanisms to secure compliance to CME requirements. The Agency for the Development of PHC and municipalities could for example add a requirement to demonstrate the attendance or completion of some specific training in the local contracting of PHC doctors. Using the contracting arrangement could actively push PHC doctors toward compliance with CME requirements, and encourage quality improvement. If strong CME requirements are introduced in Brazil, the country should also ensure that CME is directed towards some of the key challenges of the health care system, for example on prevention of risk factors for health and management of chronic conditions.

5.6. Conclusion

In Brazil, problems of shortage of PHC doctors and regional disparities in supply are acute. They are leading factors of lower health outcomes, lower health care quality and can result in unmet health care needs for Brazilian's most remote population. While the implementation of the More Doctor Programme in 2013 led to positive improvements with greater investment in PHC infrastructure, better access to medical training, and increased number of recruitment in underserved communities, more needs to be done to increase and ensure a more even distribution of PHC medical doctors. The new federal programme *Medicos pelo Brazil*, which has a stronger focus on quality than the previous programmes, aims at expanding the number of PHC doctors to 7 500 in the poorest areas. To meet this ambitious target, strategic thinking toward the community targeting methods will be required to make sure that all eligible municipalities are effectively enrolled to the new federal programme.

At the same time, and as informed by the experiences of OECD countries, it will also be important to increase the number of rural trained doctors and to provide both wage- and non-wage related financial incentives – linked for example to a service obligation of between two and four years – to recruit and retain doctors in underserved areas. Restricting the choice of practice location is another strategy to ensure a more even distribution of medical doctors. At any rate, such solutions require careful and coherent workforce planning in Brazil, based on an objective assessment linked to socio-demographic characteristics of medical doctors, their work processes and population health needs.

A smarter use of existing local workforces (nurses and community health workers), and changes in scopes of practice, are innovative ways that Brazil might want to consider in the future. The country should also continue to expand the use of telehealth to facilitate access to PHC in places with fewer physicians. To this end, it will be crucial to establish a governance structure that better supports municipalities with insufficient resource capacity to avoid compounding existing social divides.

While much policy attention has been directed to improving access to PHC, little attention has been devoted to building a strong credibility and recognition of the PHC specialty, and to ensuring high quality and well-skilled medical doctors. Actions to improve the academic incorporation of the FCM specialty in graduate and post-graduate programmes are needed through for example the development of additional family and community medicine departments in medical schools. To secure high quality PHC medical doctors and ensure their fitness to practise throughout their carrier, there are high opportunities to make the specialty training in FCM compulsory for all medical doctors wishing to practise PHC, and to implement stronger requirements around continuous medical education and recertification.

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6 The digital transformation of primary health care in Brazil

Brazil has made strides towards a digital transformation of PHC, building on more than a decade of policies to digitalise health care and make better use of health data, and with key investments in networks, data, interoperability and skills. The COVID-19 pandemic has only provided further impetus. Yet, progress towards effective use of digital PHC has been slow, and fundamentally unequal, with significant inequalities in the use of digital technologies and tools among health workers and citizens. Other major barriers include human and technical capacities in municipalities, with potential diseconomies of scale resulting from setting responsibilities for digital health at municipal level. Tackling these challenges requires: 1) digitalising all PHC units and teams; 2) promoting inclusive connectivity for all Brazilian citizens, especially the most vulnerable; and 3) establishing a governance structure with clear well-funded mandates at the right levels of government.

6.1. Introduction

A digital transformation of health care in Brazil is well underway, propelled by a broader strategy for a digital transformation of the public sector. For some time now, the Government of Brazil has been increasing its use of digital tools and data to make its public institutions more efficient, more transparent and more responsive to citizen and business demands (OECD, 2018[1]). Clear governance and a focus on connectivity, interoperability, open government data and citizen-driven service delivery have resulted in Brazil recently scoring above the OECD average on the 2019 Digital Government Index (OECD, 2020[2]).

Brazil has made significant inroads with respect to building a foundation for digital PHC, from strategies at various levels of government to essential investments in networks, data, interoperability and skills. However, progress towards effective use of digital technologies in PHC has been slow, and fundamentally unequal. Contributing factors include both demand and supply side factors, but also disarticulated governance and insufficient and poorly targeted funding.

This chapter provides an overview of recent initiatives and developments in the digitalisation of PHC in Brazil. Over the last decades, Brazil has been making impressive progress towards a digital transformation of its public sector and its health care services, but progress towards effective use of digital technologies in PHC has been slow, and fundamentally unequal, as discussed in section 6.2. Moreover, as shown in section 6.3, millions of Brazilians are digitally excluded, and there is a risk that a digital transformation of PHC will only compound existing social divides. The chapter concludes with a discussion in section 6.4 of how Brazil's decentralised government, along with the country's heterogeneous regional demographics, socio-economic indicators and governance structures, create challenges to digitalising PHC.

6.2. Overall progress in health system digitalisation but less so in the digitalisation of PHC

The creation of the Brazilian Internet Steering Committee (*CGI.br*) in 1995 to provide strategic guidelines related to the use and development of the Internet in Brazil can only be considered foundational (OECD, 2018[1]). The Committee established the basis for an ecosystem between citizens, the private sector and the public sector. Linked to the Brazilian Internet Steering Committee, and sitting under the Brazilian Network Information Centre (*NIC.br*), the Regional Centre for Studies on the Development of the Information Society (*Cetic.br*) was created in 2005 to monitor the adoption of information and communication (ICT) technologies in Brazil. It has conducted its ICT Households Survey annually since 2005, and has, since 2013, also undertaken the ICT in Health Survey focusing on the infrastructure, availability and use of ICT-based applications in health care facilities in Brazil. These surveys are invaluable and they provide many of the statistics and indicators used in this chapter. Unfortunately, the most recent results predate COVID-19 and thus may not fully reflect the current situation.

6.2.1. The government has made strides with a clear ambition for digital health services

Since 1995, and especially in recent years, Brazil has made impressive progress towards a digital transformation of its public sector. In 2019, more than 500 public services, spanning 29 different entities, were made available through digital channels, leading to reported annual savings of USD 66.9 million[1] (BRL 345 million) (gov.br, 2020[3]). Under its current Digital Government Strategy 2020-22, the government is aiming to offer all of its more than 3 000 public services via digital channels by the end of 2022 (Diário Oficial da União, 2020[4]). Among the existing digital transformation plans of 73 public entities is the Brazilian National Digital Health Strategy 2020-28 (*Estratégia de Saúde para o Brasil para 2028* or *ESD28*).

The *ESD28* (2020[5]) builds on more than a decade of policies to digitalise health care and make better use of health data, going as far back as the National Policy for Health Information and Informatics of 2004 (*Política Nacional de Informação e Informática em Saúde* or *PNIIS*). There has been an acceleration of efforts in more recent years, with the publication of the 2015 *PNIIS*, which is currently being reviewed, the publication in 2017 of the e-Health Strategy for Brasil 2020 (*Estratégia e-Saúde para o Brasil 2020*), and the publication in 2020 of Brazil's National Digital Health Strategy Action, Monitoring and Evaluation Plan (*Plano de Ação, Monitoramento e Avaliação da Estratégia de Saúde Digital para o Brasil 2019-23*). The *ESD28* is also aligned with Brazil's National Health Plan 2020-23 (Ministério da Saúde, 2020[6]).

Actions within the *ESD28* are built around three axes (Ministério da Saúde, 2020[5]). The first axis seeks to build on existing programmes and initiatives to digitalise health care in Brazil, including the National Health Data Network (*Rede Nacional de Dados em Saúde* or *RNDS*), as well as the Connect SUS (*Conecte SUS*) and the *Informatiza APS* programmes (these are described in greater detail below). The second axis looks to develop the necessary conditions (e.g. organisational, legal, regulatory and governance structures) to spur effective collaboration in digital health. The third and final axis will establish a conceptual, normative, educational and technological forum (the so-called *Espaço de Colaboração*) to operationalise collaboration. Training and capacity building for health care workers is a key priority in the implementation of the *ESD28.*

The *ESD28* plan of action has seven priorities (Ministério da Saúde, 2020[5]): 1) governance and leadership, 2) digitalisation of the three levels (primary, secondary and tertiary) of health care provision, 3) supporting health care quality improvements, 4) the patient as the protagonist, 5) human resource training, 6) an environment of interconnectivity, and 7) an innovation ecosystem. The *ESD28* also identifies the main actors and stakeholders, establishing five types of participation (leadership, partnership, sponsorship, contribution, engagement) that are expected of each actor for each action point (see Box 6.1).

Box 6.1. Digitalisation of PHC in the National Digital Health Strategy 2020-28

Action point 2.1.2 of the ESD28 seeks to expand the digitalisation of PHC in Brazil. It is led by the Ministry of Health and the Health Secretaries of Municipalities and States, in partnership with the CONASSEMS and CONASS, with sponsorship from the Federal Government, the National Health Council and the CIT, plus contributions from Associations of Health Professionals, and engagement from Anvisa and ANS. The foundation of this action point is the Primary Health Unit Computerisation Programme (*Programa de Apoio à Informatização e Qualificação dos Dados da Atenção Primária à Saúde*) or *Informatiza APS*, which seeks to digitalise all PHC units and teams in Brazil. New financing schemes (part of *Programa Previne Brasil*) and implementation and training initiatives have been piloted in the state of Alagoas (more detail is provided in the text below). The timeline for full implementation of the action point is December 2022.

Source: Ministério da Saúde (2020[5]), Estratégia de Saúde Digital para o Brasil 2020-28, http://bvsms.saude.gov.br/bvs/publicacoes/estrategia_saude_digital_Brasil.pdf.

There is a comprehensive push for a digital PHC in Brazil

The importance of connecting and digitalizing PHC practices is clear and the potential value added would be very significant (see Box 6.2). Digital health can help PHC be the first point of contact with patients, co-ordinate referrals and follow-up to secondary and tertiary care, and monitor and keep track of community and population-level health risks and conditions (Castle-Clarke and Imison, 2016[7]). The COVID-19 pandemic has made clear there are enormous benefits to digitalising and connecting health care facilities and services.

Box 6.2. A digital transformation can help realise the full potential of PHC

Digital PHC is the use of digital technologies to support PHC (it is a subfield of digital health focusing specifically on PHC). Digital technologies (or information and communication technologies) are electronic tools, systems, devices and resources that generate, store, process and/or transmit data. Digital technologies include devices such as smartphones and computers, as well as intangible products such as software, platforms and algorithms, and can support PHC in a variety of ways.

At the centre of digital PHC is the **electronic health record** or EHR. The EHR is a longitudinal digital record of an individual patient that contains or virtually links together multiple electronic medical records from different institutions and health care settings. As it contains a history of contact with health care providers from any organisation at any level of care, the EHR plays an essential role in helping PHC providers co-ordinate care for individual patients.

An EHR that is complete, accurate, up-to-date, comprehensive, and that can be shared, enables a plethora of digital applications in PHC. An EHR that contains clinical (e.g. medications prescribed), sociodemographic (e.g. employment) and administrative (e.g. insurance) information allows supports many applications, including among many others:

- Targeted **alerts and reminders** to patients (e.g. for screenings or vaccinations).
- Electronic referrals, **ePrescribing** and certifications (e.g. for sick leave).
- Clinical decision making (e.g. medications to avoid given patient allergies).
- **Telemedicine** applications (e.g. video consultations and remote monitoring).
- Mobile health or **mHealth** applications (e.g. smoking cessation and mental health apps).
- Population-level statistics on the prevalence and incidence of diseases and risks.
- Research studies taking into account **real-world data** (e.g. pharmacovigilance).

It is possible to implement some of these applications without a complete EHR system (e.g. telemedicine), however without the EHR, digital technologies will fall short of their potential and will not fully assist PHC.

Source: World Health Organization (2018[8]), Digital technologies: shaping the future of primary health care, https://apps.who.int/iris/bitstream/handle/10665/326573/WHO-HIS-SDS-2018.55-eng.pdf?sequence=1&isAllowed=y; OECD (2019[9]), Health in the 21st Century: Putting Data to Work for Stronger Health Systems, https://dx.doi.org/10.1787/e3b23f8e-en.

The potential benefits of a digital transformation of PHC are also clear in the context of Brazil's National Health Plan 2020-23 (Ministério da Saúde, 2020[6]). Among its objectives are to promote the expansion and effectiveness of PHC services in an integrated and planned fashion, to guarantee access to quality PHC services for all, and to reduce population health risks through prevention, epidemiological surveillance and health promotion.

Brazil has a long history of developing, implementing and using health information systems (Ministério da Saúde, 2017[10]). In 2017, the government launched a public tender, the Primary Health Unit Computerisation Programme, to support the country's PHC units in using electronic health record (EHR) systems by enhancing connectivity, acquiring ICT equipment, and providing technical support and training of health professionals (OECD, 2020[11]). Following concerns from the Federal Court of Accounts regarding the viability of a national rollout, the programme was replaced by Connect SUS. Connect SUS seeks to bring together all the health information of any one citizen under a large data network that can be used to continuously improve health care and decision making. The Connect SUS programme depends on two essential elements: the RNDS and the updated Primary Health Unit Computerisation Programme

(*Programa de Apoio à Informatização e Qualificação dos Dados da Atenção Primária à Saúde* or *Informatiza APS*).

Through the Connect SUS programme, and as part of the *Previne Brasil* programme, the *Informatiza APS* programme provides federal funding (between USD 330 or BRL 1 700 and USD 388 or BRL 2000 per month) to family health teams that are able to collect and send data from electronic health record (EHR) systems (Harzheim et al., 2020[12]). The programme includes the provision of training in ICT and data analysis to public employees in municipal health departments (CGI.br, 2020[13]). The training is jointly organised by the Ministry of Health and the University of Rio Grande do Sul. It consists of 60 hours of training delivered through Telehealth Centres. In order to qualify for support from *Informatiza APS*, family health teams need to have already made investments in digital technologies, have a working EHR system and be able to share data through the PHC Health Information System (the *Sistema de Informação em Saúde para a Atenção Básica* or *SISAB*). Those teams that are eligible may use the funds from *Informatiza APS* to acquire software or hardware, pay for Internet connectivity in UBS, and hire ICT services, among others.

A key eligibility requirement of the *Informatiza APS* programme is that family health units need to already be using digital technologies. However, Connect SUS ran a pilot project in the state of Alagoas between October 2019 and June 2020 that did include an additional financial incentive for PHC units that have not yet been able to digitalise (Ministério da Saúde, 2020[14]). The Alagoas pilot provided a lump sum of between USD 1 649 (BRL 8 500) and USD 1 940 (BRL 10 000) to each municipality in Alagoas for every PHC unit that was not yet digitalised (more than USD 1.07 million or BRL 5.5 million were disbursed to 97 municipalities). In light of the COVID-19 pandemic, the Ministry of Health instituted a time-limited incentive of USD 5 268 (BRL 27 157) to be paid to municipalities and states for each health team that has not yet been digitalised (see Box 6.3). The Ministry of Health is also collaborating with the Ministry of Science, Technology, Innovation and Communications, with support from the National Education and Research Network (*Rede Nacional de Ensino e Pesquisa* or *RNP*), to provide Internet connectivity to 16 000 PHC facilities (CGI.br, 2020[13]).

A key element of Connect SUS focusing specifically in PHC is the e-SUS APS strategy (or *Estratégia e-SUS APS*, often also referred to as *e-SUS AB* for *Atenção Básica*) which seeks to modernise PHC through the use of health information systems, in order to better manage individual health and care, optimise data collection and improve health information (Ministério da Saúde, 2020[6]). The strategy is based on two underlying data collection systems: the simplified data collection system (C*oleta de Dados Simplificada*) and the EHR system (*Prontuário Eletrônico do Cidadão* or *PEC*). Around 56% of family health units that have been digitalised use the *PEC*, while others use third-party EHR systems (Ministério da Saúde, 2020[14]).

The Informatics Department of SUS – typically referred to as DATASUS – has also made various other applications available to citizens, frontline care workers and health care managers (CGI.br, 2020[13]). These include: *MedSUS*, an application that lists all medications approved for use in SUS; *e-Gestor AB*, a platform that combines multiple PHC information systems to facilitate the planning and delivery of health services; and the *Conecte SUS Cidadão* app*,* which builds on a previous version called *Meu digiSUS*¸ which allows citizens to access their personal and clinical data collected from multiple national registries as well as access useful information, such as where are the closest health care facilities and pharmacies. There are also versions of *Conecte SUS* for frontline health workers (*Conecte SUS Profissional*) as well as managers.

Another interesting system is *DigiSUS Gestor – Módulo Planejamento* (*DGMP*), a tool made available to states, the Federal District and municipalities in May of 2019. The *DGMP* allows local managers to register population health targets, annual plans, produce and send reports to the National Health Council, as well as produce annual reports. The Ministry of Health also makes available an Application Programming Interface, or API, that allows different software platforms used by health care facilities to integrate their EHR systems with the *RNDS*, as well as make use of blockchain solutions.

Municipalities are also increasingly providing digital services to citizens (CGI.br, 2020[13]). For example, the São Paulo prefecture has developed an app called *Agenda Fácil* which allows patients to book, confirm and cancel consultations and examinations in the municipality's PHC units. According to the latest ICT Electronic Government Survey (2020[15]), 25% of Brazilian prefectures allow patients to book appointments online and in some cases to be consulted via the Internet.

Start-ups in telemedicine are also becoming increasingly relevant. *Brasil Telemedicina*, founded in 2010, offers online medical services. It produces around 60 000 reports per month and has clients in more than 700 Brazilian cities (Brasil Telemedicina, 2020[16]). Another startup, *Telelaudo*, provides tele radiology services 24 hours a day, seven days a week, and employs 120 radiologists. It has provided more than 4.7 million reports to more than 450 hospitals (Telelaudo, 2021[17]).

Box 6.3. COVID-19 has been a catalyst for digital health and telehealth in Brazil

The federal government authorised on 15 April 2020 the use of telemedicine during the COVID-19 pandemic (through law number 13.989/2020). This enabled continuity of care for patients who may have feared physically visiting health care facilities, but it also protected health care professionals most at risk of serious COVID-19 (such as those with chronic conditions, those who are pregnant and those aged 60 years old and older) (see Chapters 3 and 4). To help PHC units access digital technologies, the Ministry of Health also instituted an exceptional incentive to be paid to municipalities and states for each health team that has not yet been digitalised, budgeting over USD 83.8 million (BRL 432 million) for 2020. The Brazilian Telemedicine University Network (*RUTE*) also created a special interest group on COVID-19.

Artificial intelligence, specifically machine learning algorithms, has also been employed to monitor the spread of SARS-CoV-2 infections and to actively search for individuals who may have been exposed to the virus. Algorithms have been used to predict how the virus will spread further, to assess the clinical outlook of individual patients as well as support decisions concerning the most appropriate treatments, and to manage hospital beds and other resources.

Chatbots and virtual assistants have been used by public authorities to provide accurate information on COVID-19 to populations, and also to collect data that can be used to monitor the spread of the virus. The Ministry of Health created a WhatsApp channel to answer questions from citizens as well as health care professionals, and to fight disinformation. Various states – such as Ceará, Rio Grande de Sul, and Amazonas – have also used digital tools to communicate with their populations and to aid decision making during the pandemic.

This rapid adoption of digital tools is potentially introducing some risks. For example, the emergency approval of telehealth during COVID-19 (law 13.989/2020) does not include any language relating to medical liability, data and information protection and security, medical licensing across states, nor location of medical act for tax purposes. While in some cases, it is clear that other existing laws apply (e.g. with respect to data protection and medical liability), the lack of specific text on these issues may introduce significant uncertainty and lead to lower adoption than would be desirable.

Source: CGI.br (2020[13]), ICT in Health 2019; CGI.br (2020[15]), ICT Electronic Government 2019; Diário Oficial da União (2020[4]) PORTARIA Nº 3.193, DE 27 DE NOVEMBRO DE 2020; Caetano et al. (2020[18]), Challenges and opportunities for telehealth during the COVID-19 pandemic:, https://doi.org/10.1590/0102-311X00088920.

6.2.2. Progress towards digital health has been uneven, especially in PHC

Out of the 40 880 PHC units (from a total of 43 200) that responded to the ICT in Health Survey (2020[13]), it is estimated that 3 600 did not have computers and 7 200 were not connected to the Internet. Internet connection speeds in PHC facilities increased from 2018 to 2019, but still only 17% of PHC units had speeds over 10 Mbps (CGI.br, 2020[13]). Across all health care facilities, only 20% of public facilities had speeds over 10 Mbps compared to 60% of private facilities. The United States Federal Communications Commission (FCC) recommends a minimum speed of 10 Mbps for a small practice with two to four physicians (ONC, 2019[19]). Speeds under 4 Mbps are not recommended if practices want to make simultaneous use of EHR systems and high-quality video consultations, not to mention remote patient monitoring. Because many public PHC facilities are small, these facilities do not actually contract broadband connections themselves, but rather these are procured by municipal and state health secretaries. This could be why almost half (46%) of managers in public health facilities do not know the speed of their broadband connections (CGI.br, 2020[13]).

While health care managers increasingly perceive their ICT equipment and Internet connections to be up-to-date and appropriate, there are marked differences between perceptions of managers in public and private health facilities (CGI.br, 2020[13]). A majority (68%) of managers of private facilities consider their ICT equipment to be new and up-to-date, compared to only 36% of managers in public facilities, and 40% of managers in PHC units. Similarly, 67% of managers in private facilities considered their Internet connection to be appropriate given their needs, compared to only 31% of managers in public health care facilities, and 32% in PHC units. These same patterns are observed among frontline care workers, like physicians and nurses. Across both public and private facilities, managers in non-capital cities were less likely than managers in capitals to consider their ICT equipment and Internet connections were up-to-date and appropriate.

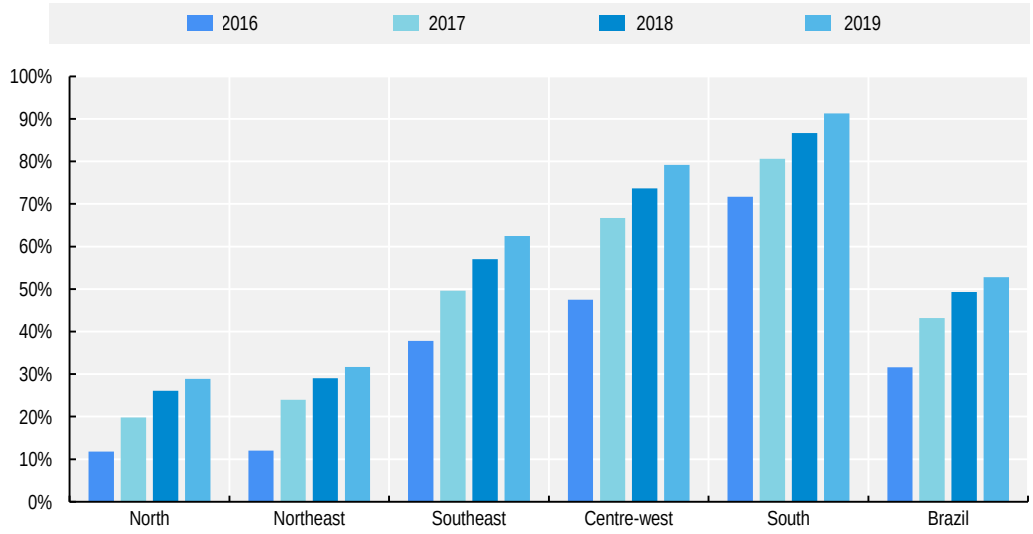
Only 14% of public health care facilities (from large institutions with over 50 beds to smaller PHC practices) had an ICT department, compared to 38% of private facilities (CGI.br, 2020[13]). Among PHC units, 10% had in-house ICT teams. The share of public facilities (16%) that had an information security policy was significantly lower than the share of private facilities with such a policy (44%). Among PHC units, 15% had an information security policy in place. Around 14% of public facilities had adopted data loss protection and prevention tools, compared to 29% of private facilities. The use of information security tools in PHC units was especially underdeveloped, with only 40% of facilities having a firewall, only 27% with encrypted databases, and 16% having data loss prevention tools. Close to a third of PHC units did not have password-protected access to electronic systems.

In 2019, an estimated 82% of all health care facilities and 78% of PHC units had EHR systems (CGI.br, 2020[13]). Around 18 000 health care facilities (or 18% of all facilities) did not have an EHR system, 12 000 of which were public facilities. According to the National Register of Health Establishments (*CNES*), 62% of FHTs were digitalised (using the same definition as that used in *Informatiza APS*), leaving almost 20 000 teams not digitalised (Ministério da Saúde, 2020[14]).

Adoption of EHR systems was highest in the South and Southeast regions (at 90% and 83% of facilities in those regions, respectively) compared to the Northeast and North regions (77% and 74% respectively). Facilities in non-capital cities lagged behind those in capital cities in the use of EHR systems (79% of non-capital facilities compared to 92% of facilities in state capitals). Close to one in every three public facilities, and 25% of all PHC units, still maintained clinical records and patient data only in paper form, compared to one in ten private facilities. In particular, while a majority of physicians in public facilities do use electronic prescribing, 71% of physicians signed their prescriptions by hand, rather than electronically. Between 2016 and 2019, the number of PHC units using EHR systems increased from 13 375 to 21 557, a 61% increase in three years (Ministério da Saúde, 2020[6]). Yet, the evolution has been very unequal across regions of Brazil (see Figure 6.1).

Figure 6.1. Very large inequalities in the use of EHR systems in PHC units

Share of PHC units using EHR systems in Brazilian regions, 2016-19



Source: Ministério da Saúde (2020[6]), Plano Nacional de Saúde 2020-23.

Many of Brazil's indigenous populations are based in the North and Northeast regions where digitalisation is least advanced. Indigenous children under one year old have lower rates of utilisation of medical appointments to monitor their growth and development (Ministério da Saúde, 2020[6]). There are also significant inequalities in the rates of vaccination against yellow fever in Brazilian states where vaccination has been recommended, ranging, in 2018, from 21.8% in Sergipe to 100% in the Federal District and Roraima (the national average for all states where vaccination is recommended is 64.1%).

Digital tools can help tackle these inequalities but the underlying infrastructure needs to be in place. Unfortunately, the rate of digitalisation of PHC units in Brazilian states seems to be inversely proportional to inequalities in health status and need. The share of hospital admissions due to conditions that are treatable in PHC is higher in regions with lower use of EHR systems in PHC units: the North and Northeast regions. Digital PHC could help reduce unnecessary admissions through, for example, better prevention, screening and monitoring of conditions that are treatable in PHC (see Box 6.2), but this cannot happen if the needed enablers – from infrastructure to software to skills – are not in place.

While the majority of health care facilities did have an EHR system in place, the information and data contained within these systems was not always complete, limiting the potential benefits. Decision support capabilities, specifically, were low, with only around a fifth of health facilities (including both large inpatient facilities with more than 50 beds as well as smaller PHC units) having EHR systems that allow, for example, drug allergy and drug dosage alerts (CGI.br, 2020[13]). Only around a third of facilities were capable of sending and receiving discharge reports or clinical information (ibid).

Since 2018, the ICT in Health Survey collects data on how many health care facilities have electronic systems in place to send or receive data directly from electronic systems in other health care facilities (be it PHC practices or hospitals). In both 2018 and 2019, the share of health care facilities that had systems in place to exchange information was 19%, suggesting that interoperability and data exchange remain limited in Brazil (CGI.br, 2020[13]). This is a serious barrier to effective PHC, greatly limiting care continuity and co-ordination.

Around one in five public health care facilities and PHC units offer digital services directly to patients (CGI.br, 2020[13]). These include scheduling appointments (23% of PHC units), exams (20% of units) as well as accessing results online (22% of units). Around one in ten allow patients to access their health record online and 7% of PHC units enable communications with health professionals.

Telehealth has been in use in Brazil for quite some time now, especially in remote areas like the Amazon (Santos et al., 2016[20]). In the rest of the country, however, its use has been very uneven. Around one-fifth of health care facilities provide remote learning (or e-learning) services (CGI.br, 2020[13]): continued education for health care professionals delivered via videoconferencing. The share of PHC units using remote learning is higher, reaching 39%. This is the most frequent use of telehealth, with other applications, such as real-time teleconsultations and remote monitoring, having lower adoption rates. Having said that, PHC units make more use of telehealth that the average health care facility in Brazil, with 35% providing teleconsultations and 25% telediagnosis. For example, remote monitoring has been implemented in less than one in ten facilities.

Unlike with the use of EHR and the Internet, it is public health care facilities that are most active in telehealth networks, with virtually no participation among private providers (CGI.br, 2020[13]). Among public facilities, 32% report being part of state telehealth networks, 19% report being part of the Brazil Telehealth Network Programme (*Programa Nacional Telessaúde Brasil Redes*), and 11% report participating in the Telemedicine University Network (*RUTE*). Among PHC units, the shares were 40%, 23% and 14% for state networks, the Brazil Telehealth Network Programme and *RUTE* respectively. Despite these encouraging figures, 47% of all public health care facilities are not part of any telehealth network.

The Brazil Telehealth Network Programme seeks to expand and improve health care provision, especially through PHC. The programme provides health care professionals that are part of the network both synchronous (real-time) and asynchronous teleconsultations, telediagnostics, second opinions and telelearning (Ministério da Saúde, 2020[6]). In 2015, the SMART (*Sistema de Monitoramento e Avaliação de Resultados do Programa Telessaúde*) system was created to monitor the use of telehealth services in Brazil. From 2016 to July 2019, just under 3.5 million telehealth services (from teleconsultations to telelearning sessions) had been registered by SMART. Of these, 50% had taken place in the Southeast region and 36% in the South region. Only 1% of activities took place in the North region. Out of 26 Brazilian states, only 18 have telehealth centres participating in the network.

Few health care professionals participated in ICT training courses in 2019, according to the latest ICT in Health Survey (2020[13]). Around 36% of nurses and 30% of physicians reported having completed capacity-building courses in health informatics, 8% of nurses and 6% of physicians participated in specialisation courses, and only 1% of nurses and 2% of physicians signed up for master's or doctorate degrees in health informatics.

Notably, around 60% of nurses and 43% of physicians did not perceive any added or reduced workload as a consequence of using computers and the Internet (CGI.br, 2020[13]). Nurses were less likely than physicians to say that computer and Internet use had decreased their workload (17% of nurses compared to 33% of physicians). More broadly, health care professionals has overwhelmingly positive views of the use of electronic systems in their facilities. Around 90% of physicians and nurses considered the implementation of electronic systems improved efficiency in team work. Over 80% agreed that the use of electronic systems resulted in higher quality of care as well as greater efficiency in services.

6.2.3. Effective digital PHC requires a focus on the fundamental enablers

A real digital transformation of PHC in Brazil will not happen without some foundational basics. These basic enablers – individually necessary though not sufficient – include Internet connectivity, appropriate hardware (e.g. computers, tablets, servers, etc.), standards and interoperability for data collection and sharing, software (like EHR systems), ICT security, and, crucially, appropriate training of clinical and

managerial staff, including through change management. All these elements require investments and resources at different levels of government, from the federal government all the way down to the municipalities and family health teams.

Reliable energy supply and fast connectivity are indispensable

Appropriate electricity supply and Internet connectivity are vital. As discussed, a significant number of PHC units do not have an Internet connection and a majority have speeds that are likely insufficient to make simultaneous use of EHR systems, high-quality video consultations and remote patient monitoring. Among the main barriers to digitalisation reported by 12 municipalities in the context of the recent pilot project in Alagoas were unreliable electricity supply and a lack of sufficiently fast broadband (Ministério da Saúde, 2020[14]). In some cases, there were no broadband suppliers (ibid). A 2018 study of 91 electricity suppliers serving 81 million households, found the quality of supply varies across regions, with citizens in remote localities, like the Amazonas, having significantly less stable electricity than someone living in São Paulo (Idec, 2018[21]).

Brazil's geography (nearly eight times the size of France and Spain combined) and sparsely distributed population are certainly challenging for inclusive connectivity (OECD, 2020[22]). The Brazilian Digital Transformation Strategy (E-Digital), along with the Connected Brazil programme, have been instrumental in expanding broadband connectivity (OECD, 2020[11]). Yet, connectivity targets have focused exclusively on schools and have not made explicit mention of concrete connection speeds or reliability. Brazil could explore how rural co-operatives might help bring stable electricity supply and affordable broadband, as done in North Dakota, and build on private sector efforts to connect rural populations in Peru (see Box 6.4).

Box 6.4. Bringing stable electricity supply and Internet connectivity to rural areas

The Dakota Carrier Network: a consortium of small, independent rural companies and co-operatives

Local mutual and co-operative organisations, which were crucial in bringing electrical and telephone services to rural areas of the United States in the 1900s, are now attempting to do the same with Internet connectivity. With more than 200 rural co-operatives are building advanced broadband networks across the country, evidence suggests these networks may be cheaper and faster than private-sector networks (OECD, 2021[23]). In North Dakota, a rural and sparsely populated state, in 2019, rural residents had better connection speeds than average fibre speeds in both rural and urban areas nationwide. This achievement has been credited to the Dakota Carrier Network, an umbrella organisation made up of small, independent rural companies and co-operatives. With financial support via the federal Broadband Technology Opportunities Programme, besides connecting citizens, the organisation is also deploying a dedicated 10 Gbps network to cover health care providers to enable telemedicine and data exchange.

Internet para Todos: A private sector collaboration to bring Internet connectivity to rural Peru

A collaboration between IDB Invest (the private-sector arm of the IDB Group), Telefónica, Facebook and the Development Bank of Latin America (CAF), *Internet para Todos* (Internet for All) is a wholesale operator with a new business model that aims to provide Internet connectivity in rural areas of Peru at a profit (IADB, 2020[24]). The financial institutions provide funding with a long-term vision, while Telefónica makes its infrastructure available to rural operators. By the end of 2021, the company expects to have connected 6 million people in more than 30 000 rural areas. Expansion into other parts of Latin America is being considered, starting in Colombia.

Source: OECD (2021[23]), Delivering Quality Education and Health Care to All, https://dx.doi.org/10.1787/83025c02-en; IADB (2020[24]), https://www.iadb.org/en/improvinglives/internet-para-todos-helping-latin-america-log.

Remote and rural municipalities face significant barriers to dependable and fast connectivity, as well as a stable energy supply. These locations often have more limited resources yet face higher costs from broadband suppliers than better resourced large municipalities in urban areas. Partnerships between the Ministry of Health, the Ministry of Science, Technology and Innovation and the Ministry of Defence to connect PHC units, especially in remote locations, are crucial. It is important to evaluate the impact of these initiatives. For example, the already mentioned programme under the *RNP* that aims to connect 16 000 primary health units is limited to 12 months and does not seem to set concrete targets in terms of connection speeds or reliability. Without adequate Internet connectivity, the poorest and most remote regions of Brazil will be further left behind, with a digital transformation at national level compounding rather than reducing existing regional inequalities.

Purely financial incentives can be helpful but capacity building is still a major barrier

The Connect SUS pilot project in Alagoas provided municipalities with up to USD 1 940 (BRL 10 000) per unconnected PHC unit (Ministério da Saúde, 2020[14]). Despite this, in the period under evaluation, digitalisation in Alagoas lagged behind the average in the Northeast region as well as the overall Brazilian average (ibid). There is no question that financial support is needed to help PHC units and municipalities acquire essential ICT products and services. Yet, the results in Alagoas show financial support alone is not enough. One of the barriers to digitalisation reported by the 12 municipalities in Alagoas was the lack of an implementation team (Ministério da Saúde, 2020[14]).

It is not only digital skills among health care workers that matter, but also the skills, time and ownership needed to drive digitalisation of PHC units. The Alagoas pilot planned to conduct capacity-building workshops in three regions in the State, but due to COVID-19 ended up conducting workshops in only one region. That region (the *1ª Região de Saúde de Alagoas*) was responsible for half of the total increase in digitalisation during the pilot. The workshop trained professionals from 19 municipalities on the installation and use of the *e-SUS AB* EHR system (*PEC*) and other *e-SUS* software, as well as training those professionals attending how they themselves could train their colleagues. Another key activity in the workshop was to establish the timeline and responsibilities for implementation of the EHR system. While there are other reasons for the success of the *1ª Região de Saúde de Alagoas*, such as high degree of urbanisation, it is likely that the capacity-building workshop had a positive impact.

It is not just health care workers but also crucially managers that lead digitalisation of care services. In England, since 2017, the NHS Digital Academy has been training clinical and information technology leaders to support the digital transformation of the NHS. The Academy is delivered through a partnership between Imperial College London, the University of Edinburgh and the Harvard Medical School (Socha-Dietrich, 2021[25]). Its flagship Digital Health Leadership programme combines content in leadership and change management, health informatics and data analytics, health systems and user centred design, as well as citizen informatics, among other subjects. In Brazil, the implementation of the *Programa Educacional em Saúde Digital* is a step in the good direction. The programme was instituted in 2020 by the *Secretaria de Gestão do Trabalho e da Educação na Saúde* and in partnership with the Federal University of Goiás. In 2021, the programme includes specialisation in digital health for both health care workers and health managers at States and Municipal levels.

As mentioned, the EHR system is at the core of digital PHC. It is impossible to send out vaccination alerts, to suggest therapies based on clinical records, and to predict clinical outcomes when patient records are not digitalised. As seen, the large majority of health care facilities, especially smaller PHC practices, do not have decision support and information exchange capabilities within their EHR systems. However, Brazil has shown it is capable of making rapid progress. In just three years (2016-19), the share of public health care facilities with EHR systems capable of (CGI.br, 2020[13]): listing every lab result a patient has had increased from 17% to 41%; listing every patient that is using a specific pharmaceutical went from 18% to 40%; electronic drug prescribing increased from 29% to 51%. These are key functionalities in support of

PHC, especially when it is estimated that the purpose of one in five medical appointments is not clinical but to ask for prescriptions and certificates (Mendes, 2011[26]; Marshall, Shah and Stokes-Lampard, 2018[27]). Tying financing of digital PHC to the use of specific functionalities can be a powerful way to increase adoption (more on this in section 6.4.2).

Box 6.5. Key recommendations to increase digitalisation of PHC units

Ensure reliable energy supply and fast connectivity in all PHC units

- Set ambitious and clear targets for both reliability and speed of connections as part of existing and future collaborations between the Ministry of Health and other ministries and the *RNP* to increase Internet connectivity in PHC units. Improve co-operation among governmental entities and across the different levels of government (federal, state and municipal) for implementation of broadband connectivity initiatives.

Expand digitalisation of PHC units through financial support and capacity building

- Expand financial payments included in the Connect SUS pilot project of Alagoas to the entire Brazilian territory. Condition receipt of financial support to participation of municipal and state officials in capacity-building workshops, and develop training specifically for senior executives. Set ambitious and clear quantitative targets for adoption and use of EHR systems (such as *e-SUS AB*), including effective use of electronic drug prescribing and exchange of clinical and administrative data across units. Emphasise importance of cybersecurity as an inevitable consequence of PHC units' operational dependence on digital systems.

Note: see also recommendations in the *OECD Telecommunications and Broadcasting Review of Brazil 2020* (OECD, 2020[22]) and the *OECD Reviews of Digital Transformation: Going Digital in Brazil* (OECD, 2020[11]), as well as the *Recommendation of the Council on Broadband Connectivity* (OECD, 2021[28]).

6.3. Digital divides pose barriers to an effective digital PHC

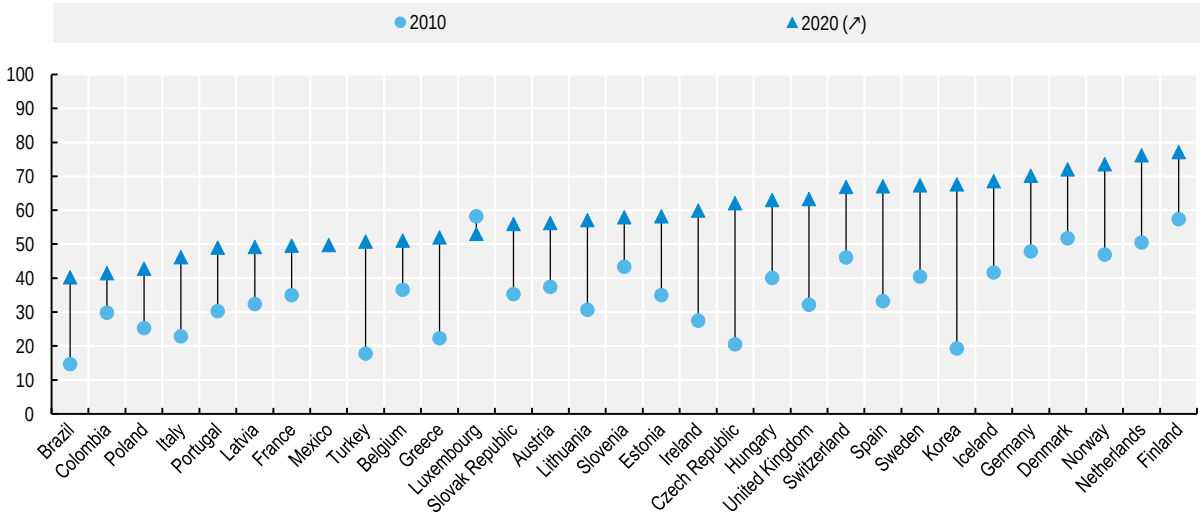
Even if Brazil were to break down all barriers to connectivity and digitalisation of PHC units, there would still persist significant inequalities in the use of digital technologies and tools among its citizens. While the country has made enormous progress in recent years, millions of Brazilians are still digitally excluded, and what is worse there is a clear association between digital and social inequalities in the country. Evidently, digital PHC cannot be effective if populations – especially those that most need it – do not have access to digital services.

6.3.1. Brazilian citizens have never been as connected but clear digital divides persist

According to the most recent ICT Households Survey, in 2019, 50.7 million Brazilian households (or 134 million individuals) had Internet access (corresponding to 71% of all households), an increase of 5.2 million connected households in relation to 2018 (CGI.br, 2020[29]). Brazilians are more connected but also more digitally engaged. More than two in three Internet users aged 16 or over used electronic government services in 2019 (ibid). Between 2010 and 2019, the share of individuals using the Internet to look for health information more than doubled from around 15% in 2010 to 40% in 2019 (see Figure 6.2). Despite these clear improvements, the country ranks below OECD countries in indicators of digital uptake and use, and digital divides tend to reflect "analogue" divides (OECD, 2020[11]; BNDES, 2017[30]).

Figure 6.2. More Brazilians are seeking health information online

Share of individuals using the Internet for seeking health information in the last three months, in 2010 and 2020



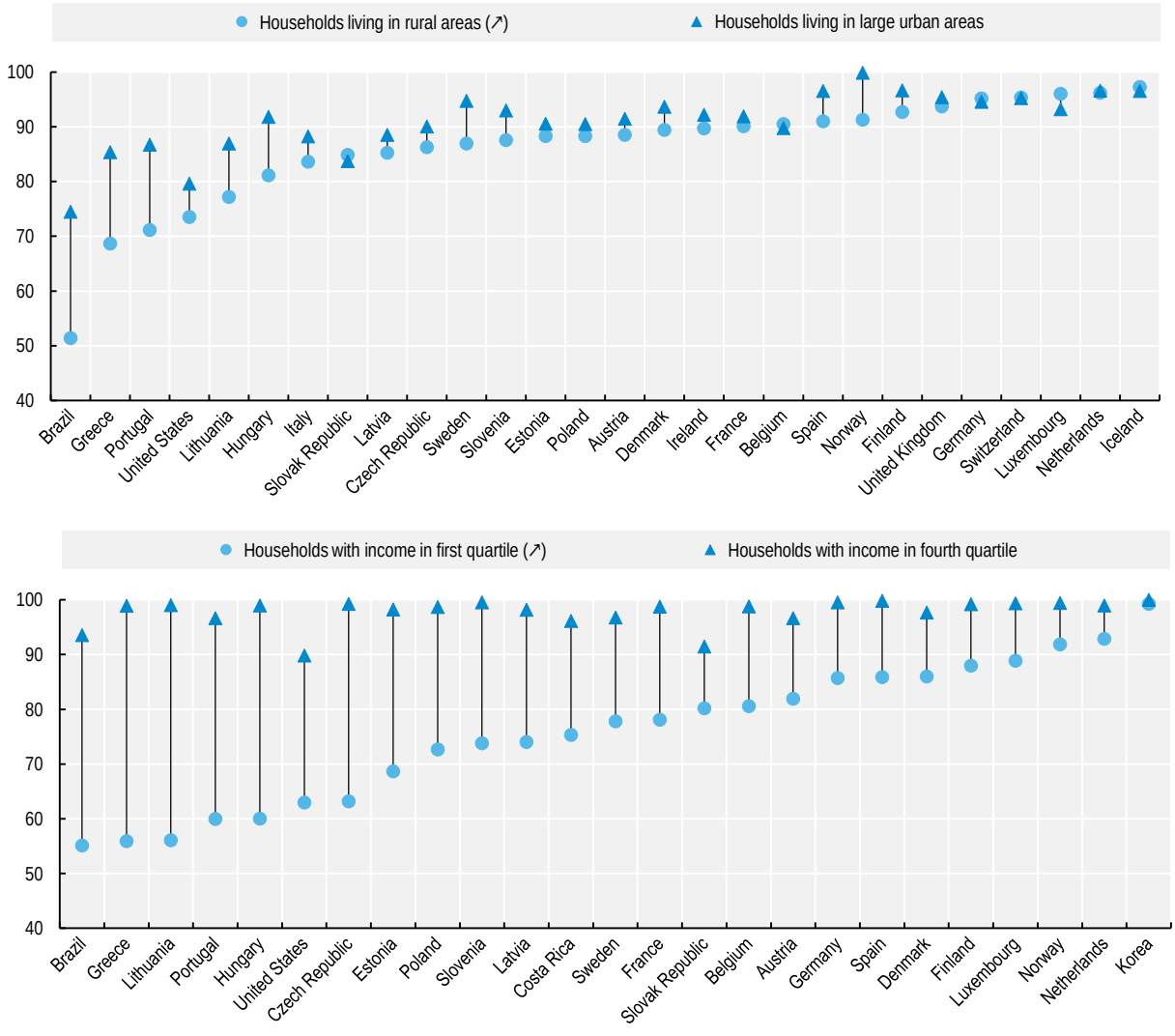
Note: Differences in methodology in Colombia in 2010 and in Korea in 2010 and 2019. Most recent data point for Colombia is for 2018 and for France, Switzerland and Mexico it is 2019 (not 2020). For Brazil specifically, the data are for 2010 and 2020 and are collected by CETIC.
Source: OECD ICT Access and Usage by Households and Individuals (database), http://stats.oecd.org/Index.aspx?DataSetCode=ICT_HH2.

Digital divides mirror social inequalities limiting effective digital PHC provision

There is a clear association between digital and social inequalities in Brazil (see Figure 6.3). Despite important increases in connectivity, nearly 47 million Brazilians did not use the Internet in 2019 (CGI.br, 2020[29]). Among non-users, the large majority had lower education (85%) and lower socio-economic status or SES (95% belonged to classes C and DE[2]). Furthermore, regional disparities in use persist. The difference between the proportion of connected households in the Southeast (75%) and the Northeast (65%) regions is of 10 percentage points (ibid). According to the most recent ICT Households Survey (2020[29]), close to 20 million Brazilian households did not have Internet access in 2019, of which 6.4 million households were from the Northeast region. Households with the lowest SES made up the majority of households without Internet access (13 million households in classes DE did not have access in 2019). In 2019, nearly 35 million were disconnected in urban areas (23%) and 12 million in rural areas (47%).

Figure 6.3. There are important digital divides in Internet access at home

Share of households with broadband Internet access at home, 2020



Note: Differences in methodology for income in Korea, Brazil and the United States, and for rural/urban in the United States only. Data on income for Brazil, the United States, Costa Rica and France are for 2019; data on rurality for Brazil, the United States, France, the United Kingdom and Switzerland are for 2019. For Brazil specifically, the data are collected by CETIC. Income data are collected using ranges in minimum wages. Reported data were aggregated in a way that best fit the distribution into four balanced categories. Income non-response are not included. Areas are defined as urban or rural according to local legislation, as compiled by the NSO. Reported data refer to urban (densely populated) and rural (thinly populated).
Source: OECD ICT Access and Usage by Households and Individuals (database), http://stats.oecd.org/Index.aspx?DataSetCode=ICT_HH2.

As mentioned, in 2019, 40% of Internet users in Brazil searched for information on health or health care services online (CGI.br, 2020[29]). The share of individuals seeking health information on the Internet was lower among those aged 60 years and older, as well as in groups with lower SES (classes DE). Only 23% of Internet users searched for or used public health services (CGI.br, 2020[29]).

While Brazil has made significant progress in implementing digital government services, certain groups of individuals are not taking full advantage. According to the 2019 ICT Household Survey (2020[29]), those less likely to use e-government services include people aged 60 years and older (46% use e-government services compared to 75% of 25 to 34-year-olds), those with lower education levels (46% of those with

elementary education compared to 87% of those with tertiary education), and those from groups with lower SES (48% in classes DE compared to 88% in class A).

6.3.2. Equitable digital PHC starts with ensuring digital uptake and use

It is clear that a digital transformation of PHC can have multiple benefits for populations and individuals, but there is also a risk that digital divides may add to social divides, compounding existing inequalities and deepening social exclusion. With digital divides so clearly aligned with social inequalities in Brazil, there is a serious risk that a digital transformation of PHC will compound existing social divides. An effective digital PHC that reaches all Brazilians is only possible if every citizen is not only connected but can have a say in the design of digital PHC services.

Digital inclusiveness as a foundation for digital PHC for all

Brazil's policies for digital inclusion have focused on bringing the Internet to remote areas and isolated communities (OECD, 2020[11]). This is the case with the Electronic Government – Citizen Assistance Service *(Governo Eletrônico – Serviço de Atendimento ao Cidadão* or *GESAC*) programme, created in 2002 to provide free broadband Internet connections to telecentres, schools, health care units as well as indigenous villages and socially vulnerable communities (OECD, 2018[1]). Other programmes[3] include the Digital Inclusion Programme, the Connected Citizen Project, the One Computer Per Student Project and the Telecentros.BR Programme (OECD, 2018[1]). The Internet for All (*Internet para Todos*) programme is a more recent expansion of the *GESAC*, focusing on subsidising broadband connections for the more than 30 000 localities and districts in Brazil without a connection.

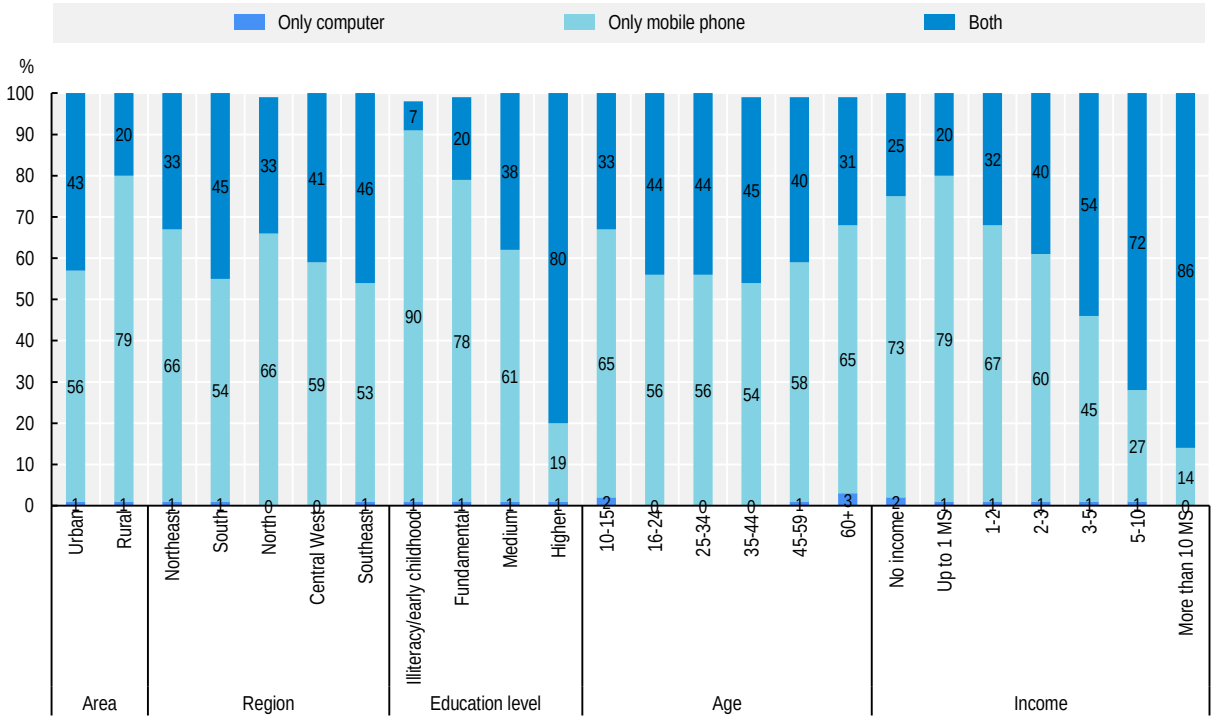
The creation of telecentres throughout Brazil in the 2000s was one of the first initiatives at the federal level to promote digital inclusion (CGI.br, 2020[31]). Telecentres are public spaces that provide computers with an Internet connection free for anyone to access, as well as workshops, courses and training. According to the most recent ICT Public Access Centres 2019 Survey, which gathers information on telecentres, 45% of telecentres were not operational in the three months prior to the data collection, the most cited reason being a lack of computers and Internet connection, followed closely by lack of maintenance and financial resources (CGI.br, 2020[31]). The number of telecentres in use decreased from the previous Survey in 2013, one possible reason being that the original telecentre programme stipulated that after an initial five-year period of support by the federal government, the equipment would be donated to the municipalities (OECD, 2020[11]).

In 2015, the Federal Audit Office (*Tribunal de Contas da União*) reviewed public policies related to digital inclusion, finding difficulties in the co-ordination of the different levels of government, limited previous studies to inform and frame new policies and actions, and no systematic monitoring and evaluation of programmes (Tribunal de Contas da União, 2015[32]). In 2018, the Federal Audit Office again drew attention to the lack of co-ordination across the federal, state and municipal governments, and pointed out that many municipalities do not have any telecentres (Tribunal de Contas da União, 2018[33]).

Many policies and programmes to promote digital literacy and ICT use focus on younger people and on schools, which are undeniably important and will lead to improvements in digital inclusion in the coming decades (OECD, 2020[11]). Yet, it is older people who most need and access PHC (Mendes et al., 2019[34]), and more must be done today to include older Brazilians in the digital transformation. Besides strengthening the role of telecentres as providers of training, especially in rural and remote areas, it is important to develop a multi-channel approach to the inclusion of vulnerable groups who are most likely to need and access PHC. Such an approach cannot ignore the crucial role that mobile phones play as a means to access the Internet for older individuals as well as those from rural areas, those on lower incomes, and those with lower levels of education (see Figure 6.4).

Figure 6.4. Mobile phones are the only means to access the Internet for more vulnerable groups

Older, rural, lower income and lower education groups are more likely to use only mobile phones to access Internet



Note: MS = minimum salary.
Source: *ICT Households 2019: Survey on the Use of Information and Communication Technologies in Brazilian Households* (database), https://cetic.br/en/pesquisa/domicilios/indicadores/ (accessed in March 2021).

Access to mobile broadband is behind the rapid increase in Internet access among the Brazilian population (OECD, 2020[11]). Reliance on mobile connectivity exclusively may prevent some users from accessing more sophisticated services that require higher speeds (e.g. real-time teleconsultations), either because those speeds are not available or data plans are prohibitively expensive. The fact that exclusive use of mobile phones for Internet access is associated with more vulnerable groups could mean that those citizens who most stand to benefit from digital PHC may also be less likely to be able to access it. This is why it is important to adopt a dual strategy of developing new channels to reach these vulnerable groups on mobile platforms, coupled with improvements in high-speed broadband connectivity and digital skills, for example through an expansion of telecentres.

The use of short message service (SMS) and mobile applications to deliver government services is already a reality in many countries, especially in Korea, a country that topped the OECD 2019 Digital Government Index, and where citizens can access government services on their mobile phones. In the United States, the government has set up a mobile first strategy to ensure government services are mobile friendly (United Nations, 2020[35]). In Finland, the government has created a centralised multi-channel one-stop-shop portal that is linked with other specialised portals, thus promoting equity in citizen access to digital government services (ibid).

Adopting a user-driven approach to digital PHC

A *user-driven* approach describes government actions that allow citizens and businesses to indicate and communicate their own needs and, thereby, drive the design of government policies and public services

(OECD, 2020[36]). This requires a shift from a government-centred focus to a user-centred approach that places the needs of users at the core of digital transformation processes and services. A common pitfall of many digital health initiatives is that they fail to adequately engage with health professionals and citizens, leading to products and services that are not relevant to users and add no value (WHO and ITU, 2012[37]).

User needs should be the basis of a digital transformation of PHC. From service design and development through to implementation and monitoring, the user should be present during the entire lifecycle (OECD, 2020[36]). Throughout the process there should be opportunities for feedback and even co-creation. What is key, especially in the Brazilian context, is that a user-driven approach that is accessible and inclusive is also an approach that produces more accessible and inclusive services. Coupled with a strategy to increase digital literacy among citizens, a user-driven approach can engage those citizens that are both most vulnerable and most digitally excluded. Indeed, the now widely used participatory budgeting approach is a Brazilian creation, first implemented in the city of Porto Alegre (OECD, 2019[38]). Participatory budgeting allows citizens a say in how (usually local) budgets are formed and how public moneys are spent. In Porto Alegre, widely seen as a success story, thousands of people have voiced their preferences over the years, affecting how millions of dollars were spent, and importantly – because minorities and vulnerable groups were sometimes overrepresented – shifting public money to where it as most needed (Local Government Association, 2016[39]).

Box 6.6. Key recommendations to promote citizen uptake and use of digital PHC

Focus on eliminating digital divides as a foundation for effective digital PHC

- Strengthen the role of telecentres as providers of training, especially in rural and remote areas, and ensure appropriate funding and technical assistance at all levels of government. In parallel, develop a multi-channel approach that focuses on mobile access to reach vulnerable groups who are most likely to need and access PHC.

Users must be at the centre, if not drivers, of a true digital transformation of PHC

- Develop content, services and applications that meet the needs of both health professionals but especially citizens, particularly those with low digital uptake, e.g. low-educated, low-income and elderly people. Continue to expand patient access to their personal health information.

Note: see also recommendations in the *OECD Reviews of Digital Transformation: Going Digital in Brazil* (OECD, 2020[11]) and the *OECD Digital Government Review of Brazil: Towards the Digital Transformation of the Public Sector* (OECD, 2018[1]), as well as the *Recommendation of the Council on Broadband Connectivity* (OECD, 2021[28]).

6.4. A governance structure that is fit to deliver a digital PHC

Brazil's government is divided into 26 states and the federal district, and well over 5 000 municipalities. Municipalities are granted the status of federal entities, at the same level as the states. While there is great heterogeneity in the geographical area and population, as well as social and economic indicators, among the subnational jurisdictions, all Brazilian municipalities enjoy the same legal status (OECD/UCLG, 2019[40]). In 2015, 17 municipalities had more than 1 million inhabitants (22% of population). About 44% of municipalities had less than 10 000 inhabitants. Brazil also has 438 health regions, which are made up of municipalities, and are also very heterogeneous in their demographics, socio-economic indicators and governance structures (Ministério da Saúde, 2020[6]). Collaboration and co-ordination across these multiple structures is very challenging, yet it is crucial for a successful digital transformation of PHC.

6.4.1. Brazil's decentralised government poses challenges to digital PHC

Decentralisation can have economic and administrative benefits, from services that are better aligned with local needs, to more innovative local experimentation, to economic growth driven by competition and accountability in public services (OECD, 2019[38]). However, there are challenges too. Some of the most relevant drawbacks in the context of a digital transformation of PHC in Brazil include overlapping responsibilities, diseconomies of scale, and lack of human and technical capacities.

A digital transformation of PHC cannot take place without adequate governance arrangements, from leadership and co-ordination to institutional models and resources (OECD, 2020[2]). The *OECD Digital Government Index* sets out four transversal facets that can be used to frame progress towards digital public services, including in PHC (see Box 6.7): a *strategic approach* with a clear vision, objectives, goals and actions; the specific *policy levers* and tools to connect strategies to policy actions; *implementation* capacity that transforms goals and strategies into effective and concrete programmes; and finally *monitoring* activities to take stock of progress and feedback into strategies.

Box 6.7. The OECD Digital Government Index

The OECD Digital Government Index (DGI) is a cornerstone of the OECD work on digital government and public sector data. Built on the OECD Recommendation on Digital Government Strategies, the Index responds to the need for a measurement instrument to track the adoption of digital government policies across OECD member and partner countries. The Digital Government Index draws upon the OECD Digital Government Policy Framework, which characterises a mature digital government as:

- being **digital by design** when governing and leveraging digital technologies to rethink and re-engineer public processes, simplify procedures, and create new channels of communication and engagement with stakeholders;
- being **data-driven** when valuing data as a strategic asset and establishing the governance, access, sharing and re-use mechanisms for improved decision-making and service delivery;
- **acting as platform** when deploying platforms, standards and services to help teams focus on user needs in public service design and delivery;
- being **open by default** when making government data and policy making processes available to the public, within the limits of legislation and in balance with national and public interest;
- being **user-driven** when according a central role to people's needs and convenience in the shaping of processes, services and policies; and by adopting inclusive enabling mechanisms;
- being **proactive** when anticipating people's needs and respond to them rapidly, avoiding the need for cumbersome data and service delivery processes.

Source: OECD (2020[2]), Digital Government Index: 2019 results, https://doi.org/10.1787/4de9f5bb-en.

Brazil's strategic approach is exemplary, embodied in the excellent and comprehensive ESD28. However, like other OECD countries, Brazil has been better at adopting strategies than at promoting and monitoring their implementation. The ESD28 sets out an ambitious vision for digital health in Brazil, but it will be difficult to realise. This is because there are significant risks, as identified in the WHO/ITU *National eHealth Strategy Toolkit* (2012[37]), namely: insufficient and geographically imbalanced resource capacity, scarce funding, too broad of an implementation focus, and unavailability of required infrastructure (this last one has already been discussed in previous sections). To these barriers, one can add a lack of clarity in the assignment of responsibilities across levels of government.

In Brazil, the division of responsibilities is unclear in a number of areas, including in health care (OECD, 2019[38]). This is frequently the case in policy areas that are "shared" across levels of government, as is the case with health care in Brazil. This can result in duplication, cost shifting and scale inefficiencies. The government's 2017 eHealth Strategy noted that initiatives to create a national eHealth architecture had lacked alignment and continuity, leading to frustration, scepticism that such a programme could work and demotivation in tackling the inevitable barriers (Ministério da Saúde, 2017[10]). It was also mentioned that strategies and investments had been traditionally defined and executed in isolation by the federal, state and municipal governments. Despite the existence of high-quality initiatives in digitalising health care, these remained "islands of excellence" due to a lack of integration across levels of government (Ministério da Saúde, 2017[10]).

Small municipalities, especially, face significant barriers to digitalisation of PHC units and teams. Because responsibilities are "shared", the three levels of government are often dependent on each other to implement the actions set out in the ESD28. This can lead to delays in adoption due to holdups in different levels of government (Andrade et al., 2019[41]). Municipalities are responsible for many key steps in digitalising PHC, from purchasing ICT equipment and software to hiring ICT specialists. Smaller municipalities may have limited capacity to manage these processes. One example is the requirement that the contracting of essential services be renewed every five years, which has been flagged as an impediment to the expansion and upkeep of ICT infrastructure (Ministério da Saúde, 2017[10]). It is not uncommon for smaller municipalities, and even larger ones, to not have any long-term ICT planning (Veloso et al., 2011[42]).

Financial commitments have also perhaps not been as ambitious as the agendas set out in previous strategies and in the ESD28. This has led to a situation in which some municipalities are responsible for digitalising PHC services but lack the necessary resources to do so. In other words, these are unfunded mandates (OECD, 2019[38]). Since 2014, the Ministry of Health has provided a monthly payment of USD 117 (BRL 603.38) for PHC units who seek to improve their connectivity (Ministério da Saúde, n.d.[43]). The target was to connect 12 000 units, however only 8 000 had been connected and only 4 800 were sending data back to the Ministry of Health.

More recently, the *Informatiza APS* programme provides monthly support of USD 330 (BRL 1 700) to USD 388 (BRL 2000) to family health teams that are able to collect and send data to central repositories. A key eligibility requirement of the programme is that family health units need to already be using digital technologies. The pilot project in the state of Alagoas has expanded support to include an additional financial incentive for PHC units that have not yet been able to digitalise (a lump sum of between USD 1 649 (BRL 8 500) and USD 1 940 (BRL 10 000) to each municipality in Alagoas for every PHC unit that was not yet digitalised). As this is still a pilot, this form of pre-digitalisation support is not yet available for all municipalities. In light of the COVID-19 pandemic, the Ministry of Health did institute a time-limited incentive of USD 5 268 (BRL 27 157) to be paid to municipalities and states for each health team that has not yet been digitalised, but it is still too early to know what impact this has had on the numbers of PHC units without computers and Internet access.

6.4.2. Moving from digital strategies to implementation and monitoring

Determining which level of government should take over which responsibility related to digitalisation is not without challenge, but it is also of the utmost importance. Clear assignment of responsibilities is crucial for accountability, monitoring and effectiveness of investment (OECD, 2019[38]). Particularly with shared responsibilities, as is the case with health care in Brazil, clarity is all the more important, so that all parties mutually understand what their individual responsibilities are. It is important to avoid multiple co-ordination mechanisms with no clear role in decision-making processes (OECD, 2019[38]). Finally, it is vital to build the necessary capacity to deliver on mandates. This means aligning funding with functional responsibilities

to avoid unfunded mandates, but also encouraging sharing of best practices and specialised knowledge across jurisdictions, making expertise available to all levels independent of size (OECD, 2019[38]).

Setting clear well-funded mandates for digitalisation at the right levels of government

A major barrier to digital PHC in Brazil is human and technical capacity in municipalities. Having more than 5 500 municipalities procure ICT products and services for over 42 000 PHC units every five years is not good practice. Around one in five Brazilian municipalities have less than 5 000 inhabitants, and yet they are responsible for hiring ICT specialists and purchasing ICT products and services, from hardware to software, to connectivity and cybersecurity. Often, municipalities either have no providers to choose from, or face prohibitively high costs. As the pilot project in Alagoas has demonstrated, municipal managers lack the capacity to digitalise, even when financing is provided by federal and state governments (Ministério da Saúde, 2020[14]). Setting responsibilities for digitalisation of PHC at municipal level for all of Brazil is likely leading to diseconomies of scale, and creating challenges for small municipalities that do not have the human and technical capacities.

In OECD countries with small subnational government units, such as the Nordic countries, France, the Slovak Republic and Spain, subnational partnerships, joint authorities and outsourcing are frequently used to create scale economies (OECD, 2019[38]). In the context of digital health, specifically, regional health authorities that bring together smaller jurisdictions and provide shared services to all members are a way to achieve both economies of scale and valuable expertise. For example, in New Zealand, primary health organisations or PHOs, especially larger PHOs like ProCare (which serves 800 000 patients in greater Auckland), offer its member practices a centralised human resource, practice management and procurement service (Varsamis, 2019[44]).

Established in 2005, the English NHS Shared Business Services (SBS) provide a mix of finance and accounting, procurement, digital innovation services, employment services, innovation and technology services, and change management to hundreds of NHS organisations (NHS Shared Business Services, 2020[45]). Through a partnership with the Royal Papworth Hospital NHS Foundation Trust, NHS SBS has developed a digital patient booking system that can be rolled out to all NHS organisations (ibid). Also in the United Kingdom, the NHS GP IT Futures programme will create a new environment for the supply of clinical ICT systems to general practice, including a new online NHS Digital Buying Catalogue to find PHC technology systems and services (NHS Digital, 2020[46]). In Portugal, the Shared Services of the Ministry of Health (*SPMS*) is the Ministry's central purchasing and ICT authority, providing shared services in the areas of purchasing and logistics, financial services, human resources and ICT. Recently, *SPMS* added new electronic dynamic purchasing systems for NHS organisations to procure consultancy services in blockchain, artificial intelligence, telemedicine and mHealth from providers that have been certified (SPMS, 2020[47]).

Brazil could look to these examples from New Zealand, England and Portugal for a new model of shared services for digital PHC. Given the geography, population and population density of Brazil, shared services and responsibilities could be aggregated at the level of the federal government, state governments or even health macro-regions and regions, depending on the specific service being considered. For example, dynamic purchasing systems can be set up by the federal government, building on the experiences of the *Co-ordenação-Geral de Tecnologia da Informação e Comunicações* (CGTIC), which already plans, co-ordinates, supervises and guides ICT investments for the federal government. For smaller states (like Roraima, Amapá and Acre), health macro-regions and bigger health regions could then set up agencies for shared services, providing specialised human resources, purchasing and management services for digital PHC to municipalities.

There are three important policy levers to carry out this regionalisation of competencies for digital PHC:

- First, it is crucial that standards and interoperability remain a central federal responsibility. This does not mean that these should be developed by only the federal government, but it does mean

that states and municipalities should participate in this process rather than lead it. This would ensure that whatever systems are procured by states and municipalities, the ability to share data and patient mobility remain possible throughout Brazil.

- Second, these new mandates need to be adequately funded and responsibilities be clearly set. This would guarantee that the new shared services agencies are both able to execute their responsibilities and accountable for the results.
- Third, local leadership, community participation and local ownership remain essential (OECD, 2019[38]). A new model of shared services needs to have the buy-in and ownership of the municipalities and PHC units it is supposed to serve.

Larger and smarter investments are needed to deliver on ambitious digital health strategies

Digitalisation requires investments in infrastructure and connectivity (e.g. high speed broadband), in hardware (e.g. computers), software (e.g. EHR systems), specialised human resources (ICT specialists), user training (e.g. digital literacy of professionals and patients), and importantly, though often neglected, change management and implementation. Brazil has invested significantly in connectivity (e.g. *GESAC*) and software (e.g. *e-SUS AB*), as well as providing support for hardware and training (e.g. *Informatiza APS*). However, as seen in previous sections, substantial numbers of PHC units and teams, as well as citizens, remain disconnected, and thus unable to benefit from a digital transformation of PHC. The vision set out in ESD28 and previous digital health strategies requires both larger and smarter investments, tying financial support to effective and equitable use.

The International Telecommunication Union has recently estimated that connecting every Brazilian to the Internet would cost USD 11.1 billion (ITU, 2020[48]). Brazil's Connect SUS programme is likely to involve total investments of USD 0.77-1.16 billion (BRL 4-6 billion) over five years (OECD, 2020[11]). In 2019, according to the World Bank Group, Brazil had a population of 211 million and a gross domestic product (GDP) of USD 1.84 trillion. By comparison, in Sweden, a country that in 2019 had just over 10.2 million inhabitants and a GDP of USD 530 billion, the country's 21 regions invest around USD 1.2 billion annually in health care ICT (U.S. Department of Commerce, 2020[49]). Only 1% of Swedish drug prescriptions are issued in paper format (ibid).

As previously discussed, Brazil instituted an exceptional incentive for municipalities and states digitalise PHC units, budgeting over USD 83.8 million (BRL 432 million) for 2020 (Diário Oficial da União, 2020[50]). In the United States, the FCC's Emergency Broadband Benefit is a USD 3.2 billion progamme to support households struggling to pay for internet service during the pandemic, providing monthly discounts towards broadband service, as well as one-time discounts to purchase equipment like laptops or tablets, with higher discounts on Tribal lands (FCC, 2021[51]). The FCC's COVID-19 Telehealth Program provides USD 200 million in immediate support to nonprofit and public eligible health care providers responding to the COVID-19 pandemic by fully funding their telecommunications services, information services, and devices necessary to provide critical connected care services (FCC, 2021[52]).

While it is challenging to compare investments across different geographies, populations and economies, it is helpful to place financial commitments across countries in the contexts of their digital health strategies. The Brazilian ESD28 sets out an ambitious agenda, including milestones for the achievement of certain capabilities (e.g. ePrescribing by December 2022). Looking to the order of magnitude of investments in countries that have already achieved these milestones is a practical way to assess whether current investments are sufficient. As an example, in the United Kingdom, a USD 33.3 million (GBP 26 million) national fund has been set up to have all NHS doctors, nurses and other clinical staff on e-rostering systems by 2021 (GOV.UK, 2021[53]). E-rostering, which allows clinicians to select shifts digitally, providing them with more flexibility and more efficient work schedules, is just one capability.

Investments should also be comprehensive in their scope. It is often the case that one of the most important steps in implementing new technologies – change management and support for implementation – is not

appropriately funded (Varsamis, 2019[44]). As the pilot project in Alagoas illustrates, it is possible to have buy-in from municipalities, provide funding, and still have limited adoption. While support in the form of capacity building is undoubtedly important, it might need to be combined with financial support for lost productivity and service disruption during periods of change and adaptation (Bakhai et al., 2019[54]).

It is not just the magnitude of investments that matters. Conditions for accessing these funds by the beneficiaries can promote, or hinder, the adoption and everyday use of digital technologies. Tying financial support to the use of specific functionalities or programmes can be a way to target investments and increase their effectiveness. The *Informatiza APS* programme already does this by conditioning eligibility for financial support to the reporting of data to the *SISAB*, but it can potentially go further. The Australian Practice Incentives Program (PIP) eHealth Incentive encourages practices to adopt key digital services, from patient records to secure messaging capabilities (to communicate with both patients and other practices), to ePrescribing, among others (Australian Government, 2016[55]).

Finally, while a digital transformation of PHC has enormous potential (see Box 6.2), there is little high-quality evidence regarding recent digital-first PHC models, such as the one being implemented in the United Kingdom (Rodgers et al., 2019[56]). It is important that funds be made available for continuous monitoring and evaluation of digitalisation in PHC in Brazil.

Box 6.8. Key recommendations for a co-ordinated well-funded digital PHC

Set clear well-funded mandates for digitalisation at the right levels of government

- Consider aggregating shared services and responsibilities related to digitalisation of PHC at less decentralised levels. Build on experiences of the *CGTIC* to explore setting up dynamic purchasing systems at federal level, with appropriately funded agencies at state or regional level providing specialised human resources, purchasing and management services for digital PHC to municipalities.

Make larger and smarter investments to promote baseline digital PHC services for all

- Review magnitude of investments needed to deliver on vision of ESD28, including funding for change management, capacity building, and monitoring and evaluation. Tie financial support to specific milestones in the adoption and use of digital PHC functionalities, starting with ePrescribing, referral management, appointment scheduling and patient access to EHR.

Note: see also recommendations in *Making decentralisation work: A handbook for policy makers* (OECD, 2019[38]) and in the *OECD Digital Government Review of Brazil: Towards the Digital Transformation of the Public Sector* (OECD, 2018[1]).

6.5. Conclusion

Over the last decades, Brazil has been making impressive progress towards a digital transformation of its public sector, and is aiming to offer all of its more than 3 000 public services via digital channels by the end of 2022 as part of its Digital Government Strategy 2020-22. The country has made significant inroads also in building a foundation for digital PHC, with successive ambitious and comprehensive digital health strategies, coupled with vital investments in hardware, interoperability and skills. However, progress towards effective use of digital technologies in PHC has been slow, and fundamentally unequal. Thousands of PHC units have no computers or Internet access. Only 17% of PHC units have speeds over 10 Mbps. Around 18 000 health care facilities (or 18% of all facilities) do not have an EHR system.

The COVID-19 pandemic has likely accelerated the adoption of digital technologies but its true impact remains unclear for now.

At the same time, and despite significant progress in recent years, millions of Brazilians are still digitally excluded. More than two in three Internet users aged 16 or over used electronic government services in 2019, and the share of individuals using the Internet to look for health information more than doubled between 2010 and 2019. However, nearly 47 million Brazilians did not use the Internet in 2019. Digital divides are also clearly associated with social inequalities, with older Brazilians, those from rural areas, those with lower incomes and lower education levels all less likely to use the Internet, and more likely to use mobile phones only. There is thus a serious risk that a digital transformation of PHC will only compound existing social divides.

Against this backdrop, Brazil's decentralised government creates challenges to digitalising PHC. The country's 26 states, one federal district, well over 5 000 municipalities (around 44% of which had less than 10 000 inhabitants), and 438 health regions are very heterogeneous in their demographics, socio-economic indicators and governance structures. The municipality of Serra da Saudade, with around 800 inhabitants, has the same responsibilities to manage the digitalisation of PHC as the municipality of São Paulo, with its over 12 million inhabitants. There are significant risks for the country's ambitious strategy for digital health, including insufficient and geographically imbalanced resource capacity, scarce funding, too broad of an implementation focus, and unavailability of required infrastructure.

Brazil has established a solid basis on which to build an effective, equitable and efficient digital PHC. But, to do so, it must tackle three sets of interconnected challenges: digitalisation of all PHC units and teams; digital inclusion for all Brazilian citizens, especially those that are most vulnerable; and a governance structure that is fit to deliver a digital transformation of PHC, by setting clear well-funded mandates at the right levels of government.

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Notes

[1] Here and throughout this chapter, an exchange rate of BRL 5.155/USD for the year 2020 from https://stats.oecd.org.

[2] The 2020 Brazilian Criteria for Economic Classification (*Critério de Classificação Econômica Brasil*) defines six classes (A, B1, B2, C1, C2, DE) of socio-economic stratificaiton based on a system of points that aggregates survey data on wealth, living conditions, education and income. Category A represents a higher socio-economic status.

[3] See also Table 3.1. in (OECD, 2020[11]).

OECD Reviews of Health Systems

Primary Health Care in Brazil

Primary health care in Brazil is well-organised, the result of sustained commitment to providing high quality primary health care for the whole population. Brazil has implemented a set of reforms over the past decades to improve the distribution of doctors, develop new forms of service organisation, introduce new financing models, and implement a range of quality improvement initiatives. This review uses internationally recognised indicators and policy frameworks to examine the performance of primary health care in Brazil. While the review points to notable successes, Brazil continues to face challenges as its population ages, risk factors such as obesity are on the rise, and emerging pandemic threats require resilience and adaptability. The report points to key actions that Brazil should consider in the coming years to strengthen performance of primary health care, especially screening and prevention for major non-communicable diseases, improve quality of primary health care provision, address workforce shortages and pursue a digital transformation. A companion publication with a health system review of Brazil examines the main challenges and approaches needed to improve the performance of the Brazilian health system.

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Community Health and Wellbeing Worker Business Case

Centre for Social Innovation

GIG CYMRU NHS WALES | Perfformiad a Gwella Performance and Improvement

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1. Executive Summary

Approval is sought for a **two-year £523,432** (£261,716 per annum) **Community Health & Wellbeing Worker (CHWW) pathfinder** in West Wales, representing a targeted system intervention to reduce avoidable demand on health and care services by addressing the underlying social, economic and environmental drivers of poor health and wellbeing.

The pathfinder will establish an initial CHWW team linked to the Ty Elli Practice Group as a first implementation site, forming part of a wider West Wales model across Carmarthenshire and Pembrokeshire.

The programme is expected to contribute to measurable system and population benefits, including:

- Reduction in non-medical GP consultations
- Reduction in unscheduled care interactions
- Improved wellbeing and reduced loneliness
- Improved self-management of long-term conditions
- Optimal access to benefits
- Increased childhood and adult immunisation

Unlike traditional service expansion, this proposal does not add capacity into existing reactive pathways. Instead, it introduces a proactive, community-based mechanism that reduces demand at source by identifying and addressing unmet need earlier.

Health and wellbeing outcomes are shaped not only by healthcare access but by a complex interaction of social, economic and environmental factors, including poverty, social isolation, unemployment, education, housing and community cohesion.

Traditional health services often struggle to address these wider determinants because they operate primarily through clinical pathways and referral-based models. In Hywel Dda, an estimated 460,000 GP consultations per year relate to non-medical need. Even a modest reduction in this demand would release significant clinical capacity and reduce pressure across primary and urgent care services.

This proposal developed by the Centre for Social Innovation at the request of Hywel Dda Public Health directly addresses this pressure by shifting the model of care upstream, introducing proactive, household-based engagement that identifies need earlier, builds trust within communities, and supports sustained interaction with a coordinated coalition of services.

The Community Health & Wellbeing Worker (CHWW) model offers a proven, preventative and community-based approach: a community-embedded workforce focused on proactive engagement, early identification of need and connection to existing services.

In West Wales, this model is further strengthened through partnership with the Centre for Social Innovation (CfSI), by applying a whole-household approach that addresses interconnected issues including housing, education, employment and social isolation, with the aim of building long-term resilience and reducing reliance on reactive public services.

The model has strong international precedent through the Brazilian Family Health Strategy, with over 300,000 workers supporting approximately 70% of the population and has been successfully adapted within the UK through programmes such as those in Westminster and Cornwall.

Evidence from these programmes demonstrates:

- Improved engagement with preventative services,
- Increased uptake of vaccination and screening,
- Reductions in demand on primary care services.

The proposed West Wales model will deploy four CHWWs in Llanelli through established voluntary sector partners, working as part of a coordinated, multi-agency coalition spanning primary care, public health, local authorities, education provision, voluntary sector partners and community assets, reflecting the reality that the drivers of demand do not sit within a single service boundary.

Importantly, the model introduces a proactive neighbourhood-based outreach function that complements and strengthens existing services rather than duplicating them, improving engagement, continuity and outcomes for individuals with complex or unmet needs.

The programme is supported by a nationally established infrastructure through the National Association of Primary Care (NAPC), providing training, digital tools and evaluation capability, reducing implementation risk and enabling rapid mobilisation.

This pathfinder will test how the model can be effectively delivered within the West Wales context and generate robust evaluation evidence to inform future commissioning decisions.

Approval is therefore sought to implement a two-year, £523,432 pathfinder that will test a scalable, evidence-based model capable of reducing system demand, improving population outcomes and strengthening the long-term sustainability of health and care services across West Wales.

The scale and nature of these challenges within West Wales are illustrated below.

CHALLENGES facing Health & Wellbeing in West Wales

Demographic change, health inequalities and rural access challenges are increasing pressure on health, social and community care services across West Wales.

LIVING LONGER WITH COMPLEX NEEDS



1 in 4 residents aged **65+**

85+ population projected to increase **28%** by **2030**

HEALTH INEQUALITIES

Up to **9+ years** difference in life expectancy between the **most** and **least** deprived communities



DEMAND



~460,000 GP consultations per year relate to non-medical need

Rising demand for health, care and community services driven by **ageing population** and increasing prevalence of **long term conditions**

RURAL COMMUNITIES



Large rural geography with **dispersed communities** creates challenges for **service access** and **delivery**



POPULATION

388,000 residents



Carmarthenshire ~ 49%
Pembrokeshire ~ 33%
Ceredigion ~ 18%

WIDER DETERMINANTS OF HEALTH



Key drivers:

- **poverty** and financial **insecurity**
- **social isolation**
- housing **quality**
- **unemployment** and economic inactivity

These challenges highlight the need for **community-based** approaches that build **trust**, strengthen **prevention**, improve **engagement** with services and **support** earlier intervention

Data Sources: Office for National Statistics (ONS) Mid-Year Population Estimates; ONS Subnational Population Projections (2020-based); StatsWales; Public Health Wales Observatory; Welsh Index of Multiple Deprivation (Welsh Government); Hywel Dda Population Needs Assessment

2. Strategic Case

2.1. The Case for Change

Across Wales there is growing recognition that the current health and social care system is under increasing pressure from rising demand, workforce constraints and widening health inequalities. Many services are currently configured to respond to crisis or deterioration, rather than supporting individuals and families earlier in their health and wellbeing journeys.

Key challenges in Wales include:

- High levels of deprivation in many communities
- Rurality and transport barriers
- Social isolation and loneliness
- Mental health pressures and long waiting lists
- An ageing population with increasing multimorbidity
- Cultural and societal risk factors

The World Health Organisation has identified that factors such as poverty, poor housing, social isolation, low health literacy and chronic stress exert a far greater influence on population health, driving long term conditions, multimorbidity and unscheduled care. Addressing these upstream drivers is therefore critical to improving outcomes, reducing inequalities and relieving pressure on health services.

2.1.1. Determinants of Health

Fixed

1. *Biological Factors* (we are largely born with). Examples include:
   - Age
   - Sex
   - Genetic inheritance

Modifiable

2. *Individual Lifestyle Factors* (How people live day to day) - often the focus of traditional health interventions but are strongly shaped by wider conditions. Examples include:
   - Smoking and alcohol use
   - Diet and nutrition
   - Physical activity
   - Sleep patterns
   - Medication adherence

Such lifestyle “choices” are constrained by income, housing, employment, education, and stress.

3. *Social and Community Networks* (The relationships around people). Social connection is a powerful protective factor for health, examples include:
   - Family and household support
   - Social isolation or loneliness
   - Community cohesion
   - Informal carers and peer support
   - Trust in services and institutions

The health impact of this factor includes links to mental health outcomes, influencing self-care and health-seeking behaviours.

4. *Living and Working Conditions* (The core drivers of health inequalities). Often has the largest impact on population health. Examples include:
   - Housing quality (damp, cold, overcrowding)
   - Employment status and job security
   - Income and financial stress
   - Education and skills
   - Transport access
   - Digital access and literacy
   - Access to green space and safe environments

These aspects typically explain why health inequalities persist even when healthcare access is universal.

5. *Wider Socio Economic, Cultural, and Environmental Conditions* (The outer system context) and shape the other determinants. These include:
   - Poverty and inequality
   - Economic policy and welfare systems
   - Education systems
   - Urban planning and transport policy
   - Climate and environmental quality
   - Cultural norms and discrimination
   - National and local policy decisions

This is where prevention has the highest leverage, but often the longest time horizon.

These drivers sit largely outside traditional clinical pathways yet account for a significant proportion of repeat demand, placing sustained pressure on primary care, urgent care and wider services. GPs often act as the default point of access when wider support systems are unavailable, resulting in avoidable demand and pressure within primary care.

Evidence consistently shows that clinical services alone cannot resolve these challenges. A survey of GPs[1] (Citizens Advice 2015) suggested that significant proportion of demand presented to GPs relates to social, psychological, and practical issues that fall outside traditional medical responses, yet strongly influence health outcomes:

[1] CitizensAdvice_AVeryGeneralPractice_May2015.pdf
https://www.citizensadvice.org.uk.cach3.com/Global/CitizensAdvice/Public%20services%20publications/CitizensAdvice_AVeryGeneralPractice_May2015.pdf

Around 20% of GP consultation time is spent on non-medical issues[2] (Hood et al, 2015). These issues most commonly include:

- Housing problems
- Benefits and financial stress
- Employment issues
- Relationship and family stress
- Loneliness and social isolation

The estimated total population for Hywel Dda University Health Board is 385,600. The NHS Strategy Unit states that the average consultation rate in UK General practice is 5.5-6.5 consultations per person per annum, with rural and older populations (like HDUHB) tend to be at the higher end of this range.

Illustration for Hywel Dda University Health Board

> **386,000 population x6 consultations = 2,316,000 total consultations of which 20% (463,000) are likely being utilised for non-medical issues.**

GPs reported these issues reduce time available for clinical care and frequently re-present because they are not medically resolvable.

Welsh Government and Public Health Wales policy recognise that most health outcomes are driven by social, economic and environmental factors, not healthcare alone. A non-medical approach, "Social Prescribing" has been developing since 2016, with the aim to support holistic health, wellbeing and social needs. For example, it includes connecting people to groups and services within a community to reduce loneliness, improve mental health and address long-term conditions.

Key timeline for social prescribing in Wales:

- Government commitment (2016)
- Wales Social Prescribing Research Network (2018)
- National Framework for Social Prescribing (2023)

2.1.2 From determinants to delivery: Social Prescribing and CHWWs

The determinants of health outlined above demonstrate that a significant proportion of demand within health services is driven by non-medical need. These factors – including housing, financial insecurity, social isolation and low confidence – cannot be resolved through clinical intervention alone, yet frequently present within primary care and urgent care settings.

In Wales, social prescribing has emerged as an important mechanism to address these wider determinants. It provides a structured pathway to identify non-medical needs and connect individuals

[2] Hood, C. M., K. P. Gennuso, G. R. Swain, and B. B. Catlin. 2016. County health rankings: Relationships between determinant factors and health outcomes. *American Journal of Preventive Medicine* 50(2):129-135. https://doi.org/10.1016/j.amepre.2015.08.024

to community-based support. This includes services such as welfare advice, community groups, employment support and mental wellbeing services.

However, social prescribing is primarily a referral-based model. It typically relies on individuals presenting to services, after which they are signposted or referred onwards. While effective, this approach can be limited where:

- needs are complex or multiple
- individuals lack confidence or trust to engage
- people disengage after referral
- programmes are time or use limited

- issues fluctuate or persist over time

The Community Health & Wellbeing Worker (CHWW) model strengthens this approach by introducing a proactive, relationship-based workforce. Rather than waiting for individuals to present, CHWWs engage directly with households and communities, building trust, identifying need earlier and supporting sustained engagement with a range of services.

CHWWs therefore provide a complementary function to social prescribing, addressing its key limitations by:

- proactively identifying unmet need before escalation
- building longitudinal, trust-based relationships with residents
- supporting individuals to navigate services, rather than simply referring
- maintaining continuity of support for people with complex or changing needs
- encouraging individual connections and community cohesion

This distinction is critical. Social prescribing identifies support and answers the question: "**What services are available?**" CHWWs enable the change and answers: "**Who will walk alongside this person to achieve change?**". By combining both approaches, the model moves from signposting to sustained behaviour change and improved outcomes.

By combining the strengths of social prescribing with proactive community outreach, the CHWW model creates a more complete and effective approach to addressing the social determinants of health and reducing avoidable demand on health and care services. Therefore, it is not an alternative to existing services, but a critical enhancement that strengthens their effectiveness and potentially reduces the long-term pressures on those services.

Taken together, these factors create a strong case for a proactive, relationship-based model in West Wales. CHWWs provide that function by building trusted relationships with households, identifying unmet need earlier and connecting people to the wider coalition of services that can support health, wellbeing and longer-term resilience. This is particularly important in West Wales, where rurality, isolation, deprivation and fragmented access to services can make referral-based models alone insufficient.

This integrated approach reflects growing evidence that relationship-based community outreach is one of the most effective ways of reaching individuals who are least likely to engage with services until needs escalate. Many existing services operate through referral-based pathways, meaning individuals

typically receive support only once needs have already been identified, often during periods of crisis or deterioration.

CHWWs address this gap by providing proactive engagement within neighbourhoods, identifying unmet needs earlier and strengthening connections between residents and existing services. The model also aligns strongly with the principles of *A Healthier Wales* and the *Wellbeing of Future Generations Act*, supporting prevention, integration and community-based care.

Social Innovation Approach (CfSI Contribution)

The model is further enhanced through collaboration with the Centre for Social Innovation (CfSI), which brings a distinct approach focused on addressing systemic barriers and enabling long-term behavioural and societal change.

While the CHWW model is already proven in improving engagement and reducing demand, the CfSI approach strengthens this by:

- Taking a whole-household perspective rather than focusing solely on individual needs,
- Addressing interconnected issues such as housing, education, employment and social isolation alongside health,
- Supporting behaviour change through sustained, trust-based relationships within communities,
- Enabling communities to become more connected and resilient, reducing long-term reliance on public services.

This approach represents a shift from traditional service models, where individuals are expected to identify problems and seek help, towards a proactive model where support is brought into the home and tailored to the realities of people's lives. By combining proven CHWW delivery with social innovation principles, the programme aims not only to improve individual outcomes but to test how community-based models can contribute to wider system transformation and long-term population health improvement.

The proposed model has been intentionally designed as a coalition-based approach rather than a standalone service. It brings together primary care, public health, local authorities, voluntary and community sector partners, academic evaluation, and wider community assets such as housing, education, training and employment support. This coalition model reflects the reality that the barriers affecting households do not sit neatly within one service boundary and therefore require a coordinated, relationship-based response across the wider system.

2.2. Evidence and Precedent

The CHWW model is supported by substantial international precedent and a growing body of evidence from UK implementation demonstrating its effectiveness in strengthening prevention and community engagement. There are currently 24 live CHWW sites across England, employing approximately 192 workers, supported through the NAPC national programme. This demonstrates that the model is not experimental, but a proven, scalable intervention adapted successfully across multiple contexts.

2.2.1. International Origins – Brazil

The CHWW model originates from Brazil's Family Health Strategy, introduced in the early 1990s as part of major national health system reform designed to strengthen prevention and community-based care.

The programme embeds community health workers within neighbourhoods to provide proactive household engagement, health promotion and connection to primary care services.

The programme now includes:

- over 300,000 community health workers
- coverage of approximately 70% of the Brazilian population

This represents one of the largest community-based public health workforces in the world.

Evidence from Brazil demonstrates significant improvements in population health outcomes, including:

- increased vaccination uptake,
- improvements in maternal and child health,
- improvements in chronic disease management,
- reductions in preventable hospital admissions.

The Brazilian experience demonstrates that community-based health workers can play a transformative role in strengthening prevention and improving access to care at scale.

2.2.2. UK Implementation – Westminster

The first UK adaptation of the model was introduced in Westminster in 2021 with support from the National Association of Primary Care. This programme applied the core principles of the Brazilian model within a UK primary care context, focusing on proactive household engagement in areas experiencing high levels of health inequality.

Peer-reviewed research (Junghans, 2023) evaluating the Westminster programme demonstrated significant improvements in engagement with preventative health services.

Households receiving visits from Community Health & Wellbeing Workers experienced:

- 40% higher uptake of prevention opportunities,
- 47% higher vaccination uptake,
- 82% higher participation in screening and NHS health checks,
- 7.4% reduction in GP consultations.

These outcomes were achieved in communities with historically low engagement with preventative health services. The findings demonstrate that proactive, relationship-based outreach can significantly improve preventative health engagement while reducing demand on primary care services.

Importantly, the model works because it combines health promotion with broader social support, recognising that barriers to health engagement often arise from wider social circumstances rather than lack of clinical services.

2.2.3. Cornwall Programme

The most relevant UK comparator for West Wales is the programme delivered in Cornwall through Volunteer Cornwall.

The programme initially launched with 10 Community Health & Wellbeing Workers and has since expanded significantly. It now includes approximately 55 workers operating across the county, working through voluntary sector organisations and integrated with primary care and community services. Each

worker typically supports around 120 households, building long-term relationships with residents and helping them access health and wellbeing services.

Cornwall shares many characteristics with West Wales, including:

- rural and dispersed communities,
- pockets of deprivation and health inequality,
- strong voluntary sector infrastructure,
- close working between health, local government and community organisations.

These similarities make Cornwall a particularly relevant example of how the CHWW model can be successfully implemented in rural and mixed population settings. Learning from the Cornwall programme also demonstrates the effectiveness of delivering the workforce through voluntary sector organisations, which are often best placed to build trust and engage with communities.

2.2.4. Relevance to West Wales

Taken together, the evidence from Brazil, Westminster and Cornwall demonstrates that the Community Health & Wellbeing Worker model can:

- strengthen prevention and early intervention,
- improve engagement with health and wellbeing services,
- reach individuals who may not otherwise access support,
- reduce demand on reactive health services.

The success of the model across both urban and rural contexts provides a strong foundation for testing the approach within West Wales. The proposed deployment will therefore build on international evidence and UK learning to assess how the model can be effectively adapted and delivered within the Welsh health and social care context.

2.2.5. Workforce Sustainability and Local Economic Impact

A key strength of the Community Health & Wellbeing Worker (CHWW) model is its ability to establish a sustainable, locally rooted workforce that contributes not only to health and wellbeing outcomes, but also to skills development and economic participation within communities.

The proposed West Wales model will utilise nationally recognised training pathways through the National Association of Primary Care (NAPC) to ensure rapid mobilisation and consistent workforce capability from the outset.

Building on this, the model is designed to support long-term workforce sustainability through regional capability and national alignment. This includes partnership with the University of Wales Trinity Saint David (UWTSD) to develop locally delivered training provision, alongside early engagement with Health Education and Improvement Wales (HEIW) to explore alignment with emerging national workforce pathways, including the potential development of a pan-Wales apprenticeship model informed by the Therapy Assistant Practitioner (TAP) approach.

This integrated approach positions the CHWW model as both a delivery intervention and a workforce development mechanism, enabling:

- accessible entry routes into health, social care and community-based careers
- workforce development aligned to local population need and system demand

- structured progression pathways into health, social care and specialist community roles
- improved recruitment and retention through locally rooted employment opportunities

Importantly, the model recognises that the CHWW role itself represents a skilled and sustainable career, supporting both progression where desired and long-term role stability where appropriate.

This approach directly aligns with Welsh Government priorities relating to community-based workforce models, economic participation and regional skills development, particularly in rural and underserved areas, and strengthens the case for scalability across Wales.

2.2.6. Strategic Fit

The proposed pathfinder aligns strongly with Welsh policy direction, including:

A Healthier Wales
- prevention and early intervention
- care closer to home
- integrated services across sectors.

Public Health Priorities
- improving access to preventative support
- tackling health inequalities
- strengthening community resilience.

Neighbourhood and Place-Based Care
- supporting collaboration between health, local government and voluntary sector partners.

2.2.6 Innovation and Future Development

The programme will also explore opportunities to enhance the CHWW model through technology and innovation, including the potential future use of digital tools such as remote monitoring, wearables or home-based sensors where appropriate.

These elements will not form part of the core pathfinder delivery but will be considered as part of the evaluation and future development of the CfSI model, ensuring that innovation is introduced in a controlled and evidence-based way.

3. Benefits

3.1. Benefit of Community Health and Wellbeing programmes

While the most immediate measurable impacts are likely to be seen in primary care demand, wellbeing and urgent care avoidance, the full benefit of the model is wider. The programme is designed to support a coalition of services, with impacts anticipated across health, social care, community resilience, access to entitlements, education, training and employment support.

Primary Care Capacity & Demand (Short–Medium Term)

A. Reduction in GP consultations for non-medical need (Workforce liberation)

- Fewer repeat GP appointments driven by:
    - loneliness
    - stress/anxiety
    - housing/financial problems
    - low-confidence self-management

B. GP time released (Workforce liberation)

- Fewer short, non-clinical consultations
- Improved focus on:
    - complex clinical need
    - multimorbidity
    - continuity

2. Urgent & Emergency Care (Medium Term)

A. Reduced escalation into urgent care

- Earlier intervention prevents:
    - anxiety-driven ED attendances
    - deterioration of LTCs
    - crisis presentations

B. Avoided hospital admissions

- Reduced admissions for ambulatory care sensitive conditions (ACSCs)
- Better adherence to care plans

3. Mental Wellbeing & Psychosocial Outcomes (Short Term)

A. Improved wellbeing scores

What changes

- Improved wellbeing, reduced loneliness and strengthened community connection

B. Reduced reliance on crisis mental health routes

- Fewer GP visits for stress-related symptoms
- Better coping skills and support networks

4. Long-Term Condition Management (Medium Term)

A. Improved engagement & adherence

- Better attendance at:
    - reviews
    - diagnostics

  - monitoring
- Improved self-management behaviour

B. Slower deterioration trajectories

- Reduced volatility in conditions with strong social drivers

5. Prevention & Early Intervention (Medium–Long Term)

A. Earlier risk detection

- Issues identified **before they become clinical**
- Safeguarding and welfare risks surfaced early

B. Falls and frailty prevention

- Improved confidence and mobility
- Reduced fear-driven inactivity

6. Workforce Experience & Sustainability (Short Term)

A. GP and practice team experience

- Reduced moral distress from "unfixable" problems
- Improved sense of system support

B. Reduced "failure demand"

- Fewer repeated contacts for same unresolved issues

7. Population Insight & System Intelligence

A. Better understanding of unmet need

What changes

- Rich, real-world insight into:
  - housing issues
  - poverty markers
  - isolation patterns
  - societal shifts

3.2. Alignment of benefit to Hywel Dda University Health Board priorities

HDUHB Priority	CHWW Contribution	Measurable Alignment
Move from a sickness service to a wellness	• Early identification of social and wellbeing risks	• Reduced crisis presentations • Improved wellbeing scores

and prevention-focused system	• Prevention of escalation into clinical crises • Behaviour change support in real-world context	• Earlier support before service thresholds
Sustainable primary care and reduced unplanned demand	• Diverts non-medical demand from GPs • Reduces repeat, unresolved attendances • Releases GP capacity for complex clinical need	• Reduction in GP attendances for CHWW cohort • GP hours released (capacity equivalent) • Reduced ED/urgent contacts over time
Tackling inequalities across rurality and deprivation	• Proactive outreach into hard-to-reach households • Support for housing, poverty, isolation, digital exclusion • Relationship-based engagement in deprived areas	• Improved engagement in previously under-engaged groups • Reduced inequality in access to support • Population insight to target investment
Better support for frailty, multimorbidity and Long-Term Conditions	• Supports adherence and attendance • Reduces volatility and deterioration • Addresses social drivers of LTC outcomes	• Improved LTC review attendance • Reduced exacerbation-driven contacts • Fewer preventable admissions
Whole-system integration with local authorities and voluntary sector	• Acts as connective tissue between sectors • Strengthens social prescribing effectiveness • Provides local intelligence to clusters	• Increased joint working activity • Improved MDT flow • Better use of community assets

3.3. Benefit Realisation

Outcome measurement will utilise validated tools such as MYCaW (Measure Yourself Concerns and Wellbeing), a widely used patient-reported outcome measure developed in primary care and community settings (Paterson et al., 2008; Polley et al., 2017), supported through the National Association of Primary Care (NAPC) national offer. This ensures a consistent, standardised approach to capturing patient-reported outcomes alongside system-level metrics, strengthening the robustness and comparability of evaluation findings. In addition to health service impacts, the evaluation will assess wider coalition outcomes including household resilience, community connection, access to entitlements, engagement with training or employment support, and the effectiveness of whole-household approaches in sustaining change.

Dimension	Benefit	KPI	Measure	Data Source	Timeframe
Primary Care Capacity & Demand	Reduced non-medical GP consultations	% reduction in GP attendances for CHWW cohort	GP appointments per patient (pre vs post)	GP practice systems (EMIS/Vision)	3–6 months
	Reduced repeat attendance	% of frequent attenders (top decile)	Number of contacts per frequent attender	Practice BI / audit	6–12 months
	GP capacity released	GP hours released (capacity equivalent)	Appointments avoided × 10 mins	Derived metric	6–12 months
Mental Wellbeing & Psychosocial Outcomes	Improved wellbeing	Change in MYCaW / ONS-4 score	Pre- / post- engagement score	CHWW outcome collection	6–12 weeks
	Reduced loneliness	% reporting reduced loneliness	Loneliness scale (e.g. UCLA-3)	CHWW assessment	3–6 months
	Reduced stress-related demand	Reduction in GP anxiety/stress codes	Rate per 1,000	GP systems	6–12 months
Urgent & Emergency Care Avoidance	Reduced crises use	ED attendances per CHWW cohort	Rate per 1,000	ED dataset	6–18 months
	Reduced conveyances	Ambulance conveyances avoided	Call-out/conveyance rate	WAST data	6–18 months
	ACSC admission prevention	Emergency admissions for ACSCs	COPD, HF, falls	PEDW	12–24 months
Long-Term Condition Management	Improved engagement	DNA rate for LTC reviews	% DNAs	GP systems	6–12 months
	Improved self-management	Attendance at monitoring	HbA1c / BP reviews attended	Audit	6–12 months
	Fewer exacerbations	Unplanned contacts	Contacts per patient	GP / ED	12–24 months
Prevention, Frailty & Falls	Reduced falls risk	Falls per CHWW older cohort	Rate per 1,000	Community datasets	12–24 months
	Early frailty identification	% identified pre-crisis	Frailty flags raised	MDT records	6–12 months
	Delayed escalation	Time to crisis	Months to first urgent contact	Longitudinal review	12–24 months
Workforce Experience & System Sustainability	Improved GP experience	Qualitative feedback	Survey / narrative	GP cluster feedback	3–6 months
	Reduced failure demand	Repeat attendance rate	Same-issue recontacts	Practice audit	6–12 months

	Better MDT functioning	Perceived value of CHWW	MDT feedback	MDT survey	6 months
Population Insight & Place-Based Intelligence	Better insight into unmet need	Thematic issue reporting	Housing, loneliness, poverty themes	CHWW reporting	Ongoing
	Targeted prevention	Actions informed by insight	Changes to local interventions	Programme review	12 months
	Improved cross-sector working	Joint actions with LA/VCSE	Number of joint interventions	Programme log	Ongoing
Other	Increased access to entitlements	% of eligible households with a completed benefits check	Benefit claims submitted monthly	CHWW assessment	6–12 months
	Increased childhood coverage	% of children with MMR dose 1 by 2nd birthday and % with 2 doses by age 5	MMR1 coverage at age 2 and MMR2 coverage at age 5	PHW / WIS / Practice baseline	12-24 months
	Adult Flu uptake	% vaccinated among target population e.g. over 65s and those with LTCs	Flu vaccinations	PHW / WIS / Practice baseline	12-24 months

4. Economic Case

4.1. Overview

The purpose of the Economic Case is to demonstrate that the proposed Community Health & Wellbeing Worker (CHWW) deployment represents the most effective and efficient use of public resources to address the identified gap in proactive community engagement and prevention support.

The analysis considers how best to strengthen early identification of need and improve engagement with health, social care and community services across West Wales.

The options appraisal therefore examines alternative approaches to improving preventative engagement and reducing demand on reactive services, before identifying the preferred option.

4.2. Options Considered

Three delivery options were considered.

Option 1 – Do Nothing
Under this option, no new intervention would be introduced, and existing services would continue to operate within their current models. This option would avoid additional expenditure in the short term but would fail to address the underlying system challenges identified in the Strategic Case.

Existing services primarily operate through referral-based pathways, meaning support is typically provided only once individuals have already presented to services or experienced deterioration in their circumstances. As a result, opportunities for earlier intervention and prevention are often missed, contributing to avoidable pressure on primary care, urgent care and social care services.

Maintaining the status quo would therefore perpetuate:

- reactive service models,
- increasing demand on healthcare services,
- persistent health and social inequalities,
- missed opportunities for preventative engagement.
- disengagement and dissatisfaction.

This option would not contribute to system transformation or prevention objectives and is therefore not considered a viable long-term approach.

Option 2 – Expand Existing Referral-Based Services
This option would involve increasing capacity within existing services such as community connectors or social prescribing roles. These services play an important role in supporting individuals to access community-based wellbeing support once a need has been identified. However, expanding these services alone would not address the fundamental gap identified in the Strategic Case.

These roles typically rely on referrals from primary care or other professionals, meaning they engage individuals only after their engagement or when needs have already been recognised. While expanding these roles may improve access to support for individuals already within the system, it would not introduce the proactive neighbourhood-based outreach function that is central to the CHWW model.

As a result, this option would have limited ability to:

- identify unmet need earlier,
- engage residents who are not currently accessing services,
- build trusted relationships within communities.

Although beneficial, this option would primarily strengthen reactive pathways rather than delivering a preventative community engagement model.

Option 3 – Community Health & Wellbeing Worker Model (Preferred Option)
This option introduces a dedicated workforce focused on proactive community engagement, early identification of need and connection to existing services.

The CHWW model differs fundamentally from traditional service models. Rather than waiting for individuals to present to services, Community Health & Wellbeing Workers actively engage with residents within neighbourhoods, building trusted relationships and identifying a wide spectrum of emerging needs before they escalate.

This proactive approach enables the workforce to:

- reach individuals who may not otherwise engage with services,
- support earlier intervention across health, social care and community support,

- strengthen connections between residents and existing services,
- address wider determinants of health including employment, education and social isolation.
- encourage and strengthen community cohesion.

International evidence from the Brazilian Family Health Strategy, together with UK experience such as Westminster and Cornwall, demonstrates that this model can increase engagement with preventative health services while reducing demand on reactive healthcare provision.

4.3. Value for Money Considerations

The proposed CHWW deployment represents a high-value, preventative investment when compared with the costs associated with reactive healthcare interventions.

For example:

- a GP consultation typically costs approximately £40[3],
- an emergency department attendance costs approximately £110 - £565,
- an emergency hospital admission may cost between £1,500 and £3,500[4].

If 5% of the 480 households (24 households) experience one fewer GP consultation per year, this equates to ~£960 in direct cost avoidance (24 × £40)

If 10% of households (48 households) avoid one GP consultation, this equates to ~£1,920 annually

These illustrative figures represent only a small proportion of potential impact and exclude wider system effects such as reduced repeat attendance, avoided escalation, and improved workforce productivity.

More significant value is expected to arise from reduced repeat demand, improved care navigation, and avoided escalation into urgent and emergency care, which will be evaluated through the programme's monitoring framework. This aligns with national learning from NAPC-supported sites, where impact is demonstrated through multi-domain system value rather than a single cost-saving metric.

This approach presents a prudent, evidence-aligned view of value rather than relying on high-impact but less predictable assumptions such as avoided admissions.

4.4. Wider Social and Economic Benefits

In addition to potential health system impacts, the CHWW model supports wider social outcomes by addressing the social determinants of health. These include:

- improved engagement with employment and training opportunities,
- increased participation in community activities,
- reduced social isolation,

[3] *Source: Curtis & Burns (2023) Unit Costs of Health and Social Care; NHS England National Cost Collection 2022/23*
[4] NHS England (2023) *National Cost Collection for the NHS 2022/23*

- improved access to education and youth services.

These wider benefits contribute to broader public sector objectives relating to economic participation, community resilience and social inclusion.

4.5. Preferred Option

Based on the analysis above, Option 3 – the Community Health & Wellbeing Worker model, represents the preferred option.

This option offers the strongest alignment with strategic priorities for prevention, community engagement and early intervention while providing a practical and evidence-informed approach to addressing the identified gap in proactive outreach.

The proposed deployment will allow the model to be tested within the West Wales context and generate robust evidence to inform future commissioning decisions and potential wider adoption.

Option 3 is the only option that introduces a proactive, preventative mechanism into the system, addressing root causes rather than increasing capacity within existing reactive pathways.

5. Commercial Case

5.1. Overview

The Community Health & Wellbeing Worker pathfinder will be delivered through a partnership-based commissioning model involving voluntary sector delivery partners and central programme coordination. This approach reflects the importance of community trust, local intelligence and established voluntary sector networks in successfully implementing the CHWW model. This coalition-based delivery model is a defining feature of the proposal, enabling coordinated, whole-system support that no single organisation could deliver in isolation.

The proposed commercial model has been informed by learning from existing programmes, particularly the Volunteer Cornwall Community Health & Wellbeing Worker programme, which has demonstrated the effectiveness of delivering the workforce through voluntary sector organisations embedded within local communities. This model enables the programme to combine the credibility and reach of community-based organisations with the oversight and consistency provided by central programme coordination.

5.2. Delivery Model

The delivery model is designed to operate across a coalition of partners, combining the reach of voluntary sector organisations, the legitimacy and pathways of primary care, the strategic coordination of public health, the wider support offer of local authorities, and the research and development capability of CfSI and UWTSD.

The programme will adopt a hybrid delivery model, comprising:

- local delivery through third sector organisations,
- central coordination of programme principles, standards and evaluation.

This model has been selected because voluntary sector organisations are uniquely positioned to:

- recruit workers with strong community connections,
- build trusted relationships with residents,
- engage effectively with local community groups and networks,
- navigate the local service landscape.

Community-based delivery is a core feature of successful Community Health Worker models internationally and has been identified as a key factor in building trust and engagement within communities.

Local delivery partners will be identified and appointed based on their ability to deliver the CHWW model effectively within their communities, rather than being limited to a predefined set of organisations. This ensures the model remains flexible, locally responsive and aligned to existing community assets.

Potential delivery partners may include established voluntary sector organisations, housing associations, community anchor organisations or other place-based providers with strong local presence, trusted relationships and the operational capability to support workforce delivery.

Organisations such as Carmarthenshire Association of Voluntary Services (CAVS) and local housing associations represent examples of the type of partner well positioned to deliver this model. However, partner selection will be based on best fit against defined criteria, including:

- demonstrated community reach and trust within target populations,
- experience of delivering community-based or outreach services,
- ability to support safeguarding, supervision and lone working,
- existing relationships across health, social care and community networks,
- capacity to host and operationally manage the workforce.

This approach ensures that delivery is rooted in the strongest available local infrastructure, supports collaboration with existing partners, and enables the model to adapt to local context and opportunities as the programme develops. These organisations will host the Community Health & Wellbeing Workers and provide operational management and supervision.

Additionally, by leveraging existing national training, digital and evaluation support provided through NAPC, this model avoids the need to develop new infrastructure locally.

5.3. Market Capability

The voluntary sector in West Wales has a well-established infrastructure supporting community engagement and partnership working across the health and social care system.

Organisations such as CAVS and PAVS already play a central role in coordinating voluntary and community sector activity across their respective counties.

These organisations provide:

- established relationships with community organisations and residents,

- experience of delivering community-based programmes,
- local knowledge of community needs and assets,
- established governance and safeguarding arrangements.

Utilising these organisations therefore reduces delivery risk by building on existing capability and trusted community networks.

5.4. Commissioning Approach

The programme will utilise grant or service-level agreement (SLA) arrangements with voluntary sector partners to support delivery of the workforce. This approach reflects the collaborative nature of the programme and aligns with existing partnership arrangements between statutory organisations and the voluntary sector.

Service agreements will define:

- workforce numbers and deployment areas,
- responsibilities for recruitment and workforce management,
- safeguarding and governance requirements,
- reporting and monitoring arrangements,
- participation in programme evaluation.

These agreements will ensure clear accountability for delivery while maintaining the flexibility required to respond to local community needs.

5.5. Workforce Development Model

The proposed delivery model includes a phased approach to workforce development, balancing national consistency with long-term local sustainability.

In the initial phase, training and accreditation will be delivered through the National Association of Primary Care (NAPC), providing access to established Level 3 qualifications, structured learning pathways and national best practice. This enables rapid mobilisation of the pathfinder using proven training infrastructure and supports consistency with existing UK delivery models.

In parallel, the programme will work in partnership with the University of Wales Trinity Saint David (UWTSD), to explore the development of a locally delivered training model, building regional capability and reducing reliance on external provision over time. This includes early engagement with Health Education and Improvement Wales (HEIW) to explore alignment with national workforce development priorities and the potential development of a pan-Wales apprenticeship pathway for Community Health & Wellbeing Workers, informed by the Therapy Assistant Practitioner (TAP) model developed by UWTSD and Hywel Dda University Health Board.

This phased approach ensures:

- rapid mobilisation of the pathfinder through existing national infrastructure,
- development of a sustainable local training pipeline,
- alignment with regional workforce and skills strategies.

Over time, this creates the potential for West Wales to act as a regional hub for CHWW training and development, supporting future scale-up and standardisation of the model across Wales.

5.6. Central Programme Coordination

While delivery will be local, the principles and standards of the CHWW model will be coordinated centrally to ensure consistency across delivery areas. Central coordination responsibilities will include:

- defining the core CHWW role and operating model,
- supporting the recruitment process,
- establishing training and workforce development standards,
- coordinating programme evaluation and reporting,
- facilitating shared learning between delivery partners.

This structure ensures that the programme maintains a consistent model of delivery while allowing local partners the flexibility to adapt engagement approaches based on community context.

5.7. Value for Money

Delivering the programme through voluntary sector partners offers several potential efficiencies, including:

- lower organisational overheads compared with statutory delivery,
- access to existing community networks and infrastructure,
- established local recruitment pipelines,
- flexibility in workforce deployment.

These factors contribute to a cost-effective delivery model while ensuring strong community engagement and reducing implementation risk.

5.8. Contract Management

Delivery partners will operate under agreed service-level arrangements that define:

- programme objectives,
- workforce deployment expectations,
- reporting requirements,
- safeguarding standards,
- participation in evaluation activity.

Programme management and oversight will be provided through the governance structure described in the Management Case.

5.9. Future Commercial Considerations

The pathfinder phase will provide an opportunity to test the delivery model and assess its scalability. If successful, future commissioning options may include:

- expansion of the workforce or through additional voluntary sector partners,
- integration within place-based health and wellbeing programmes,
- wider regional or national implementation.
- additional innovations and services targeting community building.

The deployment will therefore provide valuable learning regarding the most effective commissioning and delivery model for Community Health & Wellbeing Workers within Wales.

5.10. National Support Offer

The programme will initially utilise support from the National Association of Primary Care (NAPC), which provides a nationally developed infrastructure to support Community Health & Wellbeing Worker programmes.

The NAPC offer represents a bundled package of support that would otherwise require local development and includes:

- Accredited training pathways (Level 3 Certificate and Apprenticeship), supporting workforce capability and professionalisation – *full details are included in 6.4.1 National Training and Accreditation Offer,*
- A bespoke case management system (Octolink) to enable structured recording of activity, caseload management and reporting,
- Access to validated evaluation tools (e.g. MYCaW) to support consistent measurement of patient-reported outcomes,
- Participation in a national peer network enabling shared learning across CHWW programmes,
- Quarterly learning workshops and an annual national conference, supporting continuous development and dissemination of best practice.

The cost associated with this national support offer is approximately £15,000 per annum.

This represents good value for money, as it:

- avoids the need to develop training, digital infrastructure and evaluation tools locally,
- ensures alignment with established national models and best practice,
- strengthens the robustness of evaluation and evidence generation,
- supports consistency and scalability of the model across Wales.

The inclusion of the NAPC offer therefore reduces delivery risk, accelerates implementation and enhances the ability of the pathfinder to generate meaningful and transferable learning. Without this national infrastructure, equivalent capability would need to be developed locally at significantly higher cost and risk.

6. Financial Case – Indicative Cost Model

6.1. Community Health & Wellbeing Worker Pathfinder (West Wales) Overview

The purpose of the Financial Case is to demonstrate that the proposed Community Health & Wellbeing Worker (CHWW) deployment represents a realistic, proportionate and affordable investment aligned with the scale and objectives of the proposed pathfinder programme.

The pathfinder will deploy four Community Health & Wellbeing Workers (Band 4 equivalent) across Carmarthenshire, delivered through voluntary sector partners and a central programme coordinator.

The total estimated annual programme cost, for 2026/27, is £268,173. All financial modelling, including cost-per-household and value-for-money calculations, is based on this consistent annual figure.

This cost includes workforce salaries, programme management, training, infrastructure and programme coordination. All financial assumptions are aligned to national benchmarks (NAPC modelling and NHS Agenda for Change pay scales) and have been standardised across the document to ensure internal consistency and transparency.

6.2. Workforce Costs

Community Health & Wellbeing Workers are proposed at Band 4 equivalent level, reflecting the level of responsibility required to work independently within communities while navigating across health, social care and community services. The Welsh model reflects a higher-skilled workforce aligned to complexity, safeguarding and multi-agency working.

Typical Band 4 salary range (Agenda for Change): £27,898 - £30,615

For financial planning purposes a midpoint salary has been used to estimate workforce costs.

Salary Assumptions

Item	Cost per annum	Total cost per annum
Salary (Band 4 midpoint)	£27,898	
Employer on costs (NI, pension approx. 25-30%)	£ 7,650	
Total annual employment cost	**£38,265**	
Total Community Health & Wellbeing Worker x4		**£153,024**

Total workforce cost: approximately £153,024 per year

6.2.2 Banding rationale

Banding for Community Health & Wellbeing Workers has been informed by national learning and NHS Wales comparators. Earlier pilots in England utilised Band 2 roles; however, these were largely driven by affordability rather than role requirements.

Evidence from NAPC and existing sites indicates that lower banding limits recruitment, retention and the ability to deliver the full model.

The CHWW role requires:

- independent working within communities,
- safeguarding awareness and lone working,
- behaviour change and motivational support,
- navigation across health, social care and community services,
- management of a defined household caseload.

Benchmarking against NHS Wales roles indicates Band 3 represents the minimum appropriate banding, with Band 4 justified where the role includes caseload responsibility, structured assessment and MDT contribution.

The proposed model therefore adopts a Band 4 equivalent to ensure workforce capability, delivery quality and sustainability.

6.3. Team Management Co-ordination

Operational delivery of the Community Health & Wellbeing Worker (CHWW) model will be managed locally through third sector partner organisations, who will retain responsibility for day-to-day line management, safeguarding arrangements and employment responsibilities for the workforce.

Given the community-based nature of the role, Community Health & Wellbeing Workers will regularly operate independently within neighbourhoods and households. Experience from the Cornwall programme and similar community health worker models demonstrates that this type of outreach role requires strong local leadership, safeguarding support and professional supervision to ensure safe delivery and maintain workforce wellbeing.

A 1.0 FTE Team Lead role is therefore included within the programme structure to provide leadership, coordination and practical support to the CHWW workforce. The Team Lead role has been sized proportionately to the initial deployment (4 CHWWs), with scope to scale as the model expands.

This role will work closely with voluntary sector partners and local health services and will support:

- leadership and professional support for Community Health & Wellbeing Workers,
- safeguarding oversight and escalation of complex situations,
- support for lone working arrangements and workforce wellbeing,
- coordination with GP practices and local health services,
- establishing honorary arrangements such as with GP practices where required to enable appropriate integration with primary care teams,
- ensuring workers maintain compliance with key governance requirements such as GDPR and information governance protocols
- supporting community engagement activities, including facilitating community-based initiatives such as coffee mornings and outreach sessions,
- maintaining morale and professional development within the CHWW workforce through regular supervision and peer support.

The Community Health & Wellbeing Worker role involves engaging with individuals and families experiencing complex social and health challenges. Strong leadership and support structures are therefore essential to ensure that workers are well supported, confident in their role and able to sustain effective community engagement over time. This Team Lead role will help ensure the workforce operates safely, remains connected to local services and maintains the strong relational approach that is central to the CHWW model.

Typical Band 6 salary range (Agenda for Change): £39,263 - £47,280

For financial planning purposes a midpoint salary has been used to estimate workforce costs.

Management Cost

Role	Cost per annum	Total cost per annum
Team Lead Manager (Band 6 equivalent)	£41,437	
Employer on costs (NI, pension approx. ~27.5%)	£11,425	
Total Management cost (1.0 FTE)		**£52,862**

Total Management cost: approximately £52,862 per year

6.4. Training and Workforce Development

Community Health & Wellbeing Workers require an initial training and induction programme covering:

- Safeguarding
- community engagement
- health promotion
- system navigation
- motivational interviewing / health coaching
- lone working and safety.

Where possible, existing training provision within partner organisations and national programmes will be utilised to minimise additional costs. Based on comparable community workforce training programmes within the NHS and voluntary sector, an estimated training cost of approximately £1,000–£1,500 per worker has been assumed.

Estimated Training Costs

Item	Cost	Total cost per annum
Initial training and induction (per worker)	£1,500	
Training cost for 4 workers		**£6,000**

Total Training cost: approximately £6000

6.4.1. National Training and Accreditation Offer

To ensure consistency, quality and sustainability of the Community Health & Wellbeing Worker (CHWW) workforce, nationally recognised training pathways are available through the National Association of Primary Care (NAPC).

Two structured education routes are available:

- **Level 3 Certificate in Community Health and Wellbeing (Royal Society for Public Health)**
  A structured 120-hour programme providing core competencies in community engagement, health improvement, safeguarding and system navigation.

- **Level 3 Apprenticeship in Community Health and Wellbeing (360 hours)**
  A nationally recognised apprenticeship programme delivered across the four UK nations, incorporating the Level 3 certificate alongside broader workforce development.

Both routes:

- Are nationally recognised qualifications
- Provide consistency of workforce capability
- Support professionalisation of the role
- Enable scalability across Wales

The availability of these established training pathways reduces the need for local programme development and ensures alignment with best practice emerging from UK programmes.

6.5. Programme Infrastructure

Additional operational costs are required to support delivery of the programme and enable Community Health & Wellbeing Workers to operate safely and effectively within communities. These costs reflect typical requirements for community-based workforce programmes and include equipment, travel, monitoring infrastructure, and the systems required to support safe lone working and safeguarding practice.

Detailed infrastructure costs will be refined during implementation with delivery partners, but the above estimates provide a prudent allowance for safe and effective delivery of the initial deployment.

These include:

- **IT and Equipment** - This estimate is based on typical equipment costs for community-based workers requiring mobile working capability, including laptops or tablets, mobile phones and basic software access.
- **Travel expenses** - Travel costs are based on typical mileage reimbursement rates for community-based roles, recognising the rural geography of West Wales and the requirement for workers to travel between communities and households.
- **Monitoring and evaluation tools** - Monitoring and evaluation tools will support structured collection of activity data, outcome measures and evaluation outputs required to assess the effectiveness of the pathfinder.
- **Safeguarding and lone-worker systems** - As Community Health & Wellbeing Workers will be operating within community settings and, at times, undertaking home visits, provision is required for safeguarding support and lone-worker arrangements. This may include lone-worker devices or apps, check-in systems, incident reporting arrangements, DBS processing, and safeguarding process support within host organisations.

Infrastructure Estimate

Item	Total Annual Cost
IT and equipment	£4,000
Travel and community engagement	£8,000
Monitoring and evaluation tools	£5,000

Safeguarding and lone-worker systems	£3,000
Total infrastructure cost	**£20,000**

Total infrastructure cost: £20,000

6.6. Central Programme Coordination

Central programme coordination will be required to ensure that the Community Health & Wellbeing Worker (CHWW) model is implemented consistently across delivery areas and that learning from the pathfinder is captured effectively to inform future commissioning decisions.

This function will focus on strategic programme support rather than operational workforce management, as day-to-day line management and supervision of Community Health & Wellbeing Workers will be undertaken locally by the voluntary sector delivery partners.

Central programme coordination will support:

- programme oversight and coordination across partner organisations,
- development and implementation of the monitoring and evaluation framework,
- collation and analysis of programme activity and outcome data,
- generation of evidence to inform future commissioning decisions,
- coordination of reporting to programme governance structures,
- dissemination of learning and best practice emerging from the pathfinder.

This coordination will be delivered through a proportionate allocation of time from a Band 7 Project Manager, reflecting the level of programme management expertise required to support a multi-partner initiative involving health, voluntary sector and academic partners.

For the purposes of financial planning, an allocation equivalent to approximately 0.25 Full Time Equivalent (FTE) has been assumed to support programme coordination, monitoring and evaluation activities.

This approach ensures that appropriate programme oversight and evidence generation capability is in place while maintaining a proportionate and cost-effective level of programme infrastructure for a pathfinder of this scale.

Role	Cost per annum	Total cost per annum
Project Manager (Band 7 equivalent)	£51,027	
Employer on costs (NI, pension approx. 16.25%)	£8.292	
Total Project Co-ordination cost (0.25 FTE)		**£14,830**

Total Project Co-ordination cost: £14,830

6.7. Total Estimated Deployment Cost

Cost Category	Estimated Cost
Workforce (4 CHWWs)	£153,024
Team management	£52,862

Training	£6,000
NAPC	£15,000
Infrastructure	£20,000
Central coordination	£14,830
Total cost	£261,716

Total Estimated Annual Project Cost: £261,716

6.8. Cost Per Household Coverage

Based on comparable programmes (Cornwall and Westminster):

- each CHWW typically supports approximately 120 households
- four workers would therefore support approximately 480 households

Estimated cost per household: £261,716 ÷ 480 households ≈ **£545 per household per year**

This represents a relatively modest investment in preventative community engagement compared with the costs associated with reactive healthcare services.

6.9. Relative Cost Comparison

Community Health & Wellbeing Workers represent a cost-effective preventative workforce.

Approximate NHS activity costs include:

Activity	Approx Cost
GP consultation	£40
A&E attendance	£110 - £565
Emergency hospital admission	£1,600–£3,500

As stated in Section 2, it is estimated that 20% of GP consultation time is spent on non-medical issues and that for Hywel Dda University Health Board, this equates to over 460,000 GP consultations.

Applying this methodology to Ty Elli Practice (over 14,000 patients registered), this estimates nearly 17,000 non-medical consultations, equal to nearly £700,000.

6.10. Wider System Value

In addition to potential reductions in healthcare utilisation, the programme may also generate wider social value through:

- improved employment engagement,
- reduced social isolation,
- improved mental wellbeing,
- stronger community resilience.

These benefits align closely with the objectives of place-based health and wellbeing systems and the principles of the Wellbeing of Future Generations Act.

6.11. Benchmarking Against UK Delivery Models

The proposed cost model aligns with national delivery experience from existing Community Health & Wellbeing Worker programmes.

NAPC modelling based on UK pathfinder sites indicates a typical annual cost of approximately £215,000 for a team comprising:

- 4 Community Health & Wellbeing Workers,
- 1 Team Manager,
- Associated infrastructure, training and support.

The proposed West Wales model (£261,716) reflects:

- Use of Band 4 workforce (higher than Band 2 in England models),
- Inclusion of enhanced governance, safeguarding and evaluation requirements,
- Rural delivery considerations (travel and infrastructure).

This demonstrates that the proposed model is:

- Consistent with national benchmarks,
- Realistic in cost assumptions,
- Appropriately adjusted for the Welsh context.

6.12. Financial Summary

The proposed Community Health & Wellbeing Worker deployment represents a modest and proportionate investment relative to wider system costs while offering the potential to:

- strengthen prevention,
- reduce inequalities,
- improve engagement with health and wellbeing services,
- reduce demand on reactive services.

The estimated annual programme cost of approximately £261,716 therefore represents a realistic and proportionate investment to test the model within the West Wales context. Over two years, this equates to a total investment of £523,432

7. Management Case

7.1. Governance and Programme Management

Effective governance and programme management are critical to ensuring the successful implementation and evaluation of the Community Health & Wellbeing Worker (CHWW) deployment.

Given the breadth of services this model is intended to support, governance will need to provide assurance not only over delivery of the CHWW workforce itself, but also over coordination across the wider coalition of partners involved in prevention, community support and household resilience.

The programme will operate within a structured governance and delivery framework designed to provide clear accountability, effective oversight and strong partnership working across health, local government, academia and voluntary sector organisations. It builds on established delivery models and existing partnerships, reducing implementation risk and enabling rapid mobilisation.

This governance model ensures that the programme benefits from strategic leadership, operational coordination and community-based delivery capability.

7.2. Strategic Partnerships

The Centre for Social Innovation (CfSI) will act as a strategic partner supporting model design, innovation and evaluation, rather than as a contracted delivery provider of CHWW services. Operational delivery of the workforce will be commissioned through voluntary sector organisations via grant or SLA arrangements.

The CfSI will play a key role in shaping the model beyond traditional service delivery, supporting:

- development of innovative, community-led approaches to health and wellbeing,
- identification of systemic barriers affecting communities,
- design of approaches that support long-term behavioural and societal change,
- evaluation of wider impacts beyond traditional health metrics, including community resilience and social outcomes.

This ensures that the programme not only delivers immediate service benefits but also generates learning on how public services can evolve to better support communities in the long term. Where CfSI provides support to the programme (e.g. model development, evaluation design or innovation), this will be delivered through a clearly defined partnership arrangement aligned to governance and procurement requirements.

This ensures a clear distinction between strategic design, delivery, and commissioning responsibilities.

7.3. Senior Responsible Owner

The programme will operate under a Senior Responsible Owner at Executive Director level will be appointed. The SRO will hold overall accountability for the programme and will be responsible for:

- strategic leadership of the programme
- ensuring alignment with national public health priorities
- oversight of programme performance and delivery
- management of strategic risks
- reporting progress to senior stakeholders and funding bodies.

The SRO will provide clear executive accountability, ensuring delivery remains aligned to strategic priorities and that risks, performance and outcomes are actively managed throughout the pathfinder lifecycle.

7.4. Programme Board

Strategic oversight of the programme will be provided through a Programme Board, which will provide assurance that the pathfinder is being delivered effectively and in accordance with agreed objectives.

The Programme Board will monitor:

- programme delivery and milestones
- financial performance
- risk management
- evaluation progress.

The Programme Board will also ensure that the programme remains aligned with regional and national strategic priorities.

Membership of the Programme Board will include representatives from:

- Public Health Wales
- Hywel Dda University Health Board
- Centre for Social Innovation (University of Wales Trinity Saint David)
- Voluntary Sector
- local authority partners.

The Programme Board will meet quarterly to review progress, risks and programme performance.

7.5. Project Management

Day-to-day coordination of the programme will be undertaken by a Project Manager, who will be responsible for ensuring that implementation progresses effectively across all partner organisations.

Key responsibilities of the Project Manager include:

- coordinating recruitment and workforce development,
- supporting integration with health, social care and community services,
- maintaining the programme risk register,
- monitoring programme performance,
- coordinating monitoring, reporting and evaluation.

The Project Manager will report to the Senior Responsible Owner and Programme Board, ensuring that delivery issues can be escalated and addressed promptly.

7.6. Operational Delivery

Operational delivery of the programme will be undertaken through third sector partner organisations, which will host and manage the Community Health & Wellbeing Workers.

Local delivery partners could include:

- Carmarthenshire Association of Voluntary Services,

- Housing Association

These organisations will be responsible for:

- recruitment of Community Health & Wellbeing Workers,
- day-to-day line management and supervision,
- safeguarding oversight,
- supporting integration with local services and community organisations.

The voluntary sector is particularly well placed to deliver this workforce due to its strong community presence, established networks and local intelligence regarding community needs.

7.7 Workforce Development and Career Pathways

A structured workforce development approach will be implemented to support recruitment, retention and progression of Community Health & Wellbeing Workers.

This will include:

- access to nationally recognised Level 3 qualifications through NAPC (certificate or apprenticeship routes),
- ongoing professional development supported through peer networks and supervision structures,
- exploration of accredited training delivery through UWTSD to support long-term sustainability.

The programme will also work with partners to define clear career pathways, enabling CHWWs to progress into wider roles across health, social care and community services where appropriate, while also recognising and supporting the CHWW role as a valuable standalone career.

This approach supports both workforce retention and system integration, ensuring that skills developed through the programme contribute to the wider health and care workforce over time.

The model also provides a sustainable workforce solution, creating local employment opportunities and structured pathways into health and social care careers.

7.8 Risk Management

The following risks have been informed by learning from existing Community Health & Wellbeing Worker programmes (including Cornwall and Westminster), as well as wider experience from social prescribing and community-based delivery models. This ensures that risks reflect real-world implementation challenges rather than theoretical assumptions.

Risk	Likelihood	Impact	Mitigation
Workforce recruitment and retention challenges	Medium–High	High	Early engagement with Voluntary Care Sector partners; targeted local recruitment; flexible role design; clear career pathways (NAPC → UWTSD); strong supervision model (Team Lead); learning from Cornwall shows retention improves with peer support and local identity

Role ambiguity and duplication with existing services (e.g. social prescribing, community connectors)	Medium	High	Clear role definition and comms; onboarding with GP clusters and MDTs; pathway mapping; positioning CHWW as *complementary (proactive + relational)* not duplicative; learning from Westminster highlights need for clarity early
Limited engagement or buy-in from primary care	Medium	High	Early GP engagement via Ty Elli cluster; identify clinical champion; demonstrate workload benefit (non-medical demand reduction); regular feedback loops; align to cluster priorities
Data sharing and access barriers (Digital systems, IG constraints)	Medium	High	Early IG engagement; DPIA and data sharing agreements; use anonymised/aggregate data where required; phased access model;
Difficulty demonstrating measurable impact (attribution challenge)	Medium	High	Built-in evaluation design with comparator group; pre/post analysis; use of validated tools (MYCaW); academic partner support (UWTSD/CfSI); mixed-methods approach to capture both quantitative and qualitative impact
Over-reliance on individual CHWW relationships (model fragility)	Medium	Medium–High	Standardised training and operating model (NAPC); shared case management system (Octolink); team-based supervision
Safeguarding risk in community-based lone working	Low–Medium	High	Lone worker systems; safeguarding training; clear escalation pathways; Team Lead oversight; alignment with existing safeguarding frameworks
Inconsistent delivery across partners / variation in quality	Medium	Medium	Standardised training and induction; central coordination; peer network (NAPC); regular review and learning sessions; use of common tools (Octolink, MYCaW)
Demand exceeds capacity (early success risk)	Medium	Medium–High	Clear cohort definition (Ty Elli focus); phased onboarding; prioritisation criteria; regular caseload review; learning from Cornwall shows demand grows quickly once model is visible
Community mistrust or low engagement in target populations	Low–Medium	High	Recruit locally embedded workforce; partner with trusted organisations; relationship-first approach; no referral threshold barrier; learning from Westminster shows trust-building is critical in first 3–6 months
Insufficient integration with wider system (LA, housing, benefits)	Medium	High	Coalition model; formal partner engagement; Programme Board representation; pathway mapping; CHWW role explicitly includes “joining the dots” across services
Financial sustainability beyond pathfinder unclear	Medium	High	Clear evaluation framework; cost-per-household model; early engagement with commissioners; demonstrate value through

			multiple benefit domains (health + social + economic)
Digital / data tool adoption challenges (Octolink, MYCaW)	Low–Medium	Medium	Training via NAPC; simple user workflows; ongoing support; phased implementation; avoid overburdening workforce with data collection
Programme perceived as "pilot that doesn't scale"	Medium	Medium–High	Design with scalability in mind; standardised model; national alignment (NAPC); local workforce pipeline (UWTSD); early documentation of model and learning
Role drift into statutory or backlog functions	Medium	Medium	Clear role definition; maintain prevention focus; regular scope review through Programme governance

Risks will be actively managed through the programme governance structure. A risk register will be maintained by the Project Manager and reviewed regularly by the Programme Board.

Where risks cannot be resolved at programme level they will be escalated to the Senior Responsible Owner for resolution.

7.9 Monitoring and Evaluation

A structured monitoring and evaluation framework will be implemented to ensure that the pathfinder generates robust evidence to inform future commissioning decisions.

Performance monitoring will include:

- workforce activity metrics,
- community engagement levels,
- service referral and connection rates,
- preventative health engagement,
- qualitative feedback from residents and partners.

These measures will enable the programme to track early outcomes, identify learning and refine the delivery model during the pathfinder phase.

To strengthen attribution of impact, the evaluation will incorporate a comparator approach. This will include:

- Comparison with a matched population within the same GP cluster not receiving CHWW support (e.g. similar demographic and deprivation profile),
- Pre- and post-intervention analysis for the CHWW cohort,
- Trend comparison against baseline practice-level activity data.

This approach will enable differentiation between programme impact and natural variation in demand over time, strengthening the robustness of findings and supporting future commissioning decisions.

In addition to standard health and service utilisation metrics, the evaluation will also consider wider social and community outcomes, including:

- changes in household resilience and self-sufficiency,
- levels of social connection and community participation,
- barriers to accessing services and how these are overcome,
- the effectiveness of relationship-based approaches in driving behaviour change.

This broader evaluation approach, supported by CfSI and academic partners from the University of Wales Trinity Saint David, will provide deeper insight into how community-based models can contribute to long-term system transformation while strengthening the overall evidence base generated by the programme.

7.10 Programme Assurance

Programme assurance will be provided through regular performance reporting to the Programme Board and Senior Responsible Owner.

This will ensure that:

- delivery remains aligned with programme objectives,
- risks are identified and managed early,
- learning from the pathfinder is captured effectively.

This assurance framework will support informed decision making regarding the future commissioning and potential scaling of the CHWW model.

8 Conclusion

This business case presents a clear opportunity to implement a proven, evidence-based model that addresses one of the most significant and persistent challenges facing the health and care system: avoidable demand driven by unmet social and community need.

International evidence from Brazil and emerging UK experience in areas such as Westminster and Cornwall demonstrate the potential for this workforce to significantly increase engagement with preventative health services while reducing demand on reactive healthcare provision.

The proposed West Wales pathfinder provides a practical and proportionate opportunity to test how this model can be implemented within the Welsh context while strengthening collaboration across health, social care and community services.

By combining locally embedded voluntary sector delivery with central programme coordination and academic evaluation, the pathfinder will generate valuable learning to inform potential future commissioning decisions across Wales.

This represents a strategic opportunity to test a scalable model for prevention, community resilience and system sustainability. Approval will enable West Wales to lead the development of a new, integrated approach to health and wellbeing that can inform future policy and commissioning across Wales.

8.7 Recommendation

It is recommended that approval is granted to proceed with the Community Health & Wellbeing Worker pathfinder in West Wales. This represents a low-cost, high-impact intervention that directly addresses one of the most significant drivers of demand within the health and care system.

This will enable:

- recruitment of four Community Health & Wellbeing Workers (Band 4 equivalent),
- recruitment of a Team Leader (Band 6 equivalent)
- initial deployment through the Ty Elli Practice Group across Carmarthenshire,
- delivery through third sector partners,
- implementation of a structured monitoring and evaluation framework.

The pathfinder will generate evidence to inform future commissioning decisions regarding the potential expansion of Community Health & Wellbeing Workers across Wales.

8.8 Decision Required

Approval is sought for:

1. Implementation of the Community Health & Wellbeing Worker pathfinder in West Wales.
2. Deployment of four Community Health & Wellbeing Workers through voluntary sector delivery partners.
3. Allocation of the proposed pathfinder budget of approximately £261,716 for the first year of delivery, within an overall two-year investment of £523,432
4. Establishment of the governance and evaluation framework outlined in this business case.

8.9 Next Steps

Subject to approval, the following next steps will be undertaken:

- establishment of programme governance arrangements
- finalisation of service-level agreements with delivery partners
- recruitment and onboarding of Community Health & Wellbeing Workers
- implementation of training and induction
- launch of pathfinder delivery within target communities.

The programme will commence within six months of approval, with evaluation findings informing future commissioning decisions.

Addendum A: Clarifications on Workforce Banding, Return of Investment and Scale

Purpose

This addendum provides clarification on workforce banding, return on investment (ROI) and model scale to support decision-making and ensure alignment with national evidence and delivery experience.

Workforce Banding (Rationale and Benchmarking)

Community Health & Wellbeing Workers (CHWWs)

The proposed banding for Community Health & Wellbeing Workers has been informed by:

- Learning from existing UK CHWW programmes supported by the National Association of Primary Care (NAPC)
- Benchmarking against NHS Wales community-facing roles
- The functional requirements of the role within the West Wales model

Early CHWW pilots in England utilised Band 2 roles, largely driven by affordability constraints rather than the requirements of the model. Evidence from these programmes indicates that lower banding:

- restricts recruitment to candidates with limited experience
- impacts confidence and autonomy in community settings
- reduces effectiveness in navigating complex systems
- contributes to higher turnover and reduced continuity

As the model has matured, Band 3 has emerged as the minimum recommended level, with many programmes adopting higher banding where the role includes greater responsibility.

The CHWW role in West Wales requires:

- independent community-based working
- proactive household engagement
- safeguarding awareness
- navigation across health, social care and community services
- longitudinal relationship management

Benchmarking against NHS Wales roles indicates that Band 3 aligns with entry-level community support roles, while Band 4 is appropriate where the role includes caseload management, structured assessment and multi-agency coordination.

The proposed Band 4 equivalent therefore reflects the level of autonomy, responsibility and system navigation required to deliver the model effectively and sustainably. This approach also supports longer-term workforce sustainability through alignment with emerging national workforce pathways, including early discussions with Health Education and Improvement Wales (HEIW) regarding potential apprenticeship development.

Team Lead

The original proposal included a Band 7 Team Lead role. Following further review and benchmarking, this has been refined to ensure proportionality to the scale of the initial deployment.

The team role will:

- provide leadership and professional support to CHWWs
- oversee safeguarding and lone working arrangements
- act as a key interface with GP practices and local services
- support integration across partner organisations
- maintain workforce wellbeing and performance
- coordinate local delivery alongside central programme support

A Band 6 equivalent is considered proportionate for the scale of the initial deployment, providing sufficient seniority to manage safeguarding, workforce supervision and multi-agency coordination, without over-specifying the role relative to team size.

Return on Investment (Measurement Approach)

The CHWW model delivers value across multiple parts of the system and should not be assessed against a single cost-saving metric.

Key value domains include:

1. **Acute Demand Reduction**
   - Reduced A&E attendances
   - Reduced non-elective admissions
   - Potential reductions in length of stay
2. **Primary Care Impact**
   - Reduction in avoidable GP consultations
   - Improved targeting of clinical time towards higher-need patients
   - Reduction in repeat attendance (“failure demand”)
3. **Prevention and Early Intervention**
   - Increased vaccination uptake
   - Increased screening participation
   - Earlier identification of health and social needs
4. **System Efficiency**
   - Reduced missed appointments (DNA rates)
   - Increased uptake of community and voluntary sector services
   - Improved service navigation and utilisation
5. **Patient Outcomes and Experience**
   - Improved wellbeing (e.g. MYCaW outcomes)
   - Increased patient activation and confidence
   - Strengthened trust and engagement with services
6. **Wider Determinants and Social Value**
   - Improved access to housing, benefits and employment support
   - Reduced social isolation
   - Increased community resilience

ROI will be presented as:

- cost per household supported,
- cost relative to avoided or reduced demand,
- system-wide value across health, social care and community services.

This approach avoids reliance on a single high-impact metric (e.g. avoided hospital admissions) and reflects national experience that most value is realised through reduced repeat demand, improved care navigation and avoided escalation, rather than isolated high-cost events.

Illustrative scenario modelling, included within this Business Case, demonstrates that even small reductions in demand (e.g. reduced GP consultations across a proportion of households) begin to offset programme costs, while wider system benefits provide additional value.

Scale and Evidence Base (National Context)

UK Delivery

The CHWW model is now an established and scaling approach within the UK.

- 24 live sites across England delivery includes Westminster, Cornwall and multiple London and regional sites,
- Approximately 192 CHWWs currently deployed,
- Supported through the NAPC national programme.

Across these sites, consistent patterns are emerging, including:

- improved engagement with preventative services,
- earlier identification of need,
- increased uptake of vaccination and screening,
- reduced pressure on primary and urgent care services.

This level of adoption demonstrates that the model is established and scalable, rather than experimental, reducing implementation risk for West Wales.

International evidence (Brazil):

The strongest international evidence comes from Brazil's Family Health Strategy, one of the largest community-based health programmes globally.

- Over 300,000 community health workers,
- Coverage of approximately 70% of the population.

Published evaluations have demonstrated:

- sustained reductions in hospitalisation rates,
- improved chronic disease management,
- increased vaccination uptake,
- improvements in maternal and child health outcomes.

Reported outcomes also include:

- 34% reduction in cardiovascular mortality,
- 31% reduction in stroke mortality.

Implications for West Wales

This evidence demonstrates that:

- the CHWW model is proven, not experimental,
- the model is adaptable across urban and rural settings,
- impact is consistent across multiple domains of health and wellbeing,
- effectiveness increases with scale, integration and maturity.

The proposed West Wales pathfinder therefore represents:

- a low-risk, evidence-informed deployment,
- aligned with established national and international models,
- capable of generating robust, locally relevant evidence to inform future commissioning decisions.

Conclusion

This addendum reinforces that:

- Band 4 CHWW roles and Band 6 Team Lead roles are proportionate and evidence-based within NHS Wales context,
- Return on investment should be understood as multi-domain system value rather than a single financial metric,
- The CHWW model is already established at scale across the UK and internationally, with a strong and growing evidence base.

Taken together, this confirms that the proposed West Wales model is appropriately costed, proportionately staffed, and represents a credible, low-risk and evidence-informed investment aligned to prevention, system sustainability and community-based care.

Demonstrator project report of Measure Yourself Concerns and Wellbeing®, demographic data and outcome measures analysis for the CHWW project - Year One

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June 2024

Disclaimer: The views expressed in this report are those of the authors and do not represent those of the Cornwall and Isles of Scilly Integrated Care Board or Volunteer Cornwall.

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Meaningful Measures Ltd provides innovative person-centred evaluation, audit and research solutions. Our mission is to enable people's own voices to shape the understanding and improvement of health and wellbeing services around the world.

Dr Marie Polley is the Co-Director of Meaningful Measures Ltd and Co-Founder and past Co-Chair of the Social Prescribing Network. Marie has worked in biomedical cancer research and has developed good practice in evaluating the impact of integrative approaches to support people with cancer. In 2016 Marie co-founded and co-chaired the Social Prescribing Network and led a social movement around the use of non-medical activities to support people's wider determinants of health. Marie writes extensively on social prescribing and how to develop inclusive ways of researching and evaluating the impact of person-centred services. Marie provides advice to senior leaders, Members of Parliament and the House of Lords, key stakeholders, researchers and organisations around the world, in the field of social prescribing and person-centered approaches to health.

Dr Helen Seers, is Co-Director Meaningful Measures Ltd. Helen is an experimental psychologist by training and has worked extensively with voluntary community and social enterprise organisations to support them to understand and communicate the impact of their work. Previously, as Head of Research and Evaluation at Penny Brohn UK Helen led a highly successful evaluation team who innovated a mixed-methods evaluation evidence base for the integrative healthcare charity. Helen is a visiting Research Fellow at the University of the West of England and is part of the Health

Foundation's Q Community, supporting the work of the Evaluation Special Interest Group. Helen is also a chartered member of the British Psychological Society, and a member of the Research Council for Complementary Medicine, the Southwest Evaluator Forum, and the UK Evaluation Society.

Sonya Elnaschie, is the Research Associate and Social Media Coordinator for Meaningful Measures Ltd. Sonya has bachelor's degrees in Physiotherapy from the University of Southampton and Herbal Medicine from the University of Westminster and has worked in a variety of clinical settings. She was previously on the steering committee of the Social Prescribing Network, was the network coordinator and supported the development and delivery of several of their conferences. Her work with Meaningful Measures Ltd allows her to combine her interest in the use of non-medical activities to support people's wider determinants of health and research. Sonya is a member of the Chartered Society of Physiotherapists, the Health and Care Professions Council and the National Institute of Medical Herbalists. Sonya is also the co-founder of Bee Happy Babies LLP which aims to make infant massage and its benefits more accessible.

Executive summary

In the UK, the Office of National Statistics calculates that 4.7 million people live in poverty. Deprivation has severe impacts on physical and mental health, and this puts a strain on public services which are already overstretched. Some areas of Cornwall and Isle of Scilly are in the top 10% most deprived areas in England.

In February 2023 Cornwall and Isles of Scilly Integrated Care System introduced teams of "Community Health and Wellbeing Workers" (CHWW) to support underserved communities with the aim of building relationships and identifying people's needs. The initial pilot has now been extended to run for a minimum five years, working in the Kerrier area of Cornwall, and extending to Penwith, Bodmin and Liskeard. There is an aim to have a total of 50-60 CHWWs in post by Autumn 2024.

CHWW's encourage householders to initially identify their biggest concern and then work with them to reduce or remove that concern. Since Autumn 2023 Measure Yourself Concerns and Wellbeing® (MYCaW) data has been collected to show the impact of the CHWW. MYCaW is a validated individualised questionnaire designed for evaluating holistic and personalised approaches to supporting people and is accredited by NHS England for supported self-management services (such as social prescribing). MYCaW provides qualitative (written concerns) and quantitative (score change on 0 to 6 scale) data. MYCaW data analysis for this project is reported to demonstrate the initial impact of the CHWW project.

Aim:

To analyse all data on the initial and follow-up MYCaW forms from the CHWW project, as well as any relevant available demographic data about the project recipients.

To carry out a comparison of commonly used outcome measures with concerns documented from MYCaW data.

Method:

MYCaW data was gathered by CHWW teams during their home visits. The first MYCaW was carried out after a CHWW had got to know the resident and was applied after at least the third meeting. Follow-up MYCaW data was captured 3 months later.

Results:

Demographics:

N=211, the modal age was 35-44 years old, 60% of the sample was female. Nearly 80% of residents lived in either St Austell or Newquay.

Measure Yourself Concerns and Wellbeing® score changes:

Score changes for all people with baseline and paired follow-up scores were analysed. The lower the score the better the rating of the severity of a concern or wellbeing status. Overall, the data suggest that most people who were supported by the service, their concerns and wellbeing improved as a result.

Average MYCaW change scores for Concern 1 (-2.6, n=147; p≤0.001) Concern 2 (-2.4, n=130; p≤0.001) and Wellbeing (-1.8, n=147; p≤0.001) showed a large improvement at follow-up and were statistically significant.

91% and 88% of Concern 1 and 2 score changes (respectively) and 90% of the wellbeing score changes met the threshold for minimal important difference. This result is extremely high for percentage improvements compared to other MYCaW datasets.

What do the MYCaW concerns tell us?

412 concerns were reported when combining Concern 1 and Concern 2. Concerns were coded using an existing established framework by Meaningful Measures Ltd based on other existing national data sets.

The top 5 individual concern categories reported were Finances, Housing, Mental health, loneliness and isolation and access to food.

Nearly 50% of all concerns were practical ones, (e.g. problems with finance, housing, managing the household admin, managing to look after ones-self, social justice and safety issues, work and training, school and education and carer burden). Around 25% of concerns related to a broad range of mental and emotional issues.

What else is going on in your life?

MYCaW also asks people if there is anything else going on in their life that is important, besides the concerns they have nominated. 130 people recorded a total of 139 other things going on in their life. 42% of events were positive in nature most frequently an improvement in their finances or work situation (it was implied that the CHWWs had helped get benefit payments sorted or enable job finding). 49% of events were negative in nature. The most frequent negative issue was ongoing issues with physical and mental health (20%) and this often related to issues with long term conditions and pain.

What is important about the support you have received? 142/212 people responded to this question, providing 202 things that were important about the support they received from the CHWWs. The most frequent response (38%) related to the support, understanding and provided by the CHWWs as well as the encouragement to make changes or improvements.

Conclusion:

The first aim of the demonstrator report was to investigate the MYCaW score changes and understand the types of concerns people experience, as well as what aspects of the CHWW support are important to them.

Average changes in MYCaW scores after receiving support from the CHWWs were very large and highly statistically significant. A comparison group is needed for this to ascertain how much change is attributable to the CHWW intervention. Qualitative data patterns showed that the top concerns were: Finances, housing, mental health, loneliness & isolation and access to food. The demonstrator report shows that the CHWW project is a highly successful and valuable service supporting people in Cornwall and IoS to access what are considered their basic needs and rights to appropriate finance, housing, food and support with their physical and mental health. We conclude that this service should be continued, and more data collected to establish the longer-term impacts on the current residents.



The second aim of the evaluation was to carry out a comparison of commonly used outcome measures informed by the types of concerns documented from MYCaW data. The most often picked MYCaW super-category was “practical concerns” and most of these concerns related to the social determinants of health. Other outcome measures for health and wellbeing may not be able to reach all of the areas that MYCaW reaches, especially in terms of social determinants of health. We provide a summary review of the most useful measures, those which are short, free, sensitive and provide economic value data which could partner with MYCaW (suggestions include: SF-36, ONS4, EQ5D, and Dialogue+).

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1.0 Introduction

1.1 Background

The number of people experiencing deprivation (people struggling to afford to meet their most basic physical needs to stay warm, dry, clean and fed), has increased by 148% from 2017 to 2022. 3.8 million people experienced destitution in 2022, including around one million children[1]. Deprivation has severe impacts on physical and mental health and this puts a strain on public services which are already overstretched[2]. Improvements in life expectancy have been shown to have stalled, and for women in the most deprived 10% of areas life expectancy has declined. The health gap has grown between wealthy and deprived areas[3].



In 2024 the County of Cornwall and IoS faces significant challenges with deprivation for its population. Salaries in Cornwall and IoS are about 80% of the national average, contributing to poverty among families and children[4]. Some areas in Cornwall and IoS are in the top 10% most deprived areas in England[5]. NHS England are keen to support projects that tackle deprivation and health inequalities.

In 2023 an innovative project to help tackle inequalities was launched within the NHS Cornwall and Isles of Scilly Integrated Care System. This project was the introduction of teams of "Community Health and Wellbeing Workers" (CHWW). The CHWW

[1] Firzpatrick, S. et al. (2023) Destitution in the UK 2023, Rowntree Foundation, https://www.jrf.org.uk/deep-poverty-and-destitution/destitution-in-the-uk-2023

[2] Bestwick, M. and Schmuecker, K. (2024) The impact of hardship on primary schools and primary healthcare. York: Joseph Rowntree Foundation.

[3] Marmot M, Allen J, Boyce T, Goldblatt P, Morrison J. Health Equity in England: The Marmot Review 10 Years On. Institute of Health Equity; 2020 (health.org.uk/publications/reports/the-marmot-review-10-years-on).

[4] https://www.local.gov.uk/case-studies/responding-cost-living-challenges-cornwall-council

[5] https://transformation-cornwall.org.uk/resources/cornwall-council-index-of-multiple-deprivation-imd-2019-and-2015-cornwall-reports

initiative is based on the successful "Brazilian Family Health Strategy"[6, 7] developed in the 1990s. The CHWW role involves proactively going door-to-door in underserved communities with the aim of building relationships and identifying people's needs. This model will also identify people who are not engaging in healthcare services and often excluded from them. The teams will actively encourage residents to register with a GP to enable them to take part in vaccinations, screening and other healthy behaviours.

Since 2019, the National Association of Primary Care alongside Imperial College London have been working together to support the implementation and spread of this in many areas in the UK[8]. This model was firstly tested in the London borough of Westminster[9] and spread to Bridgewater, Calderdale, Wandsworth, Oxford, and North Wales[6], amongst other areas.

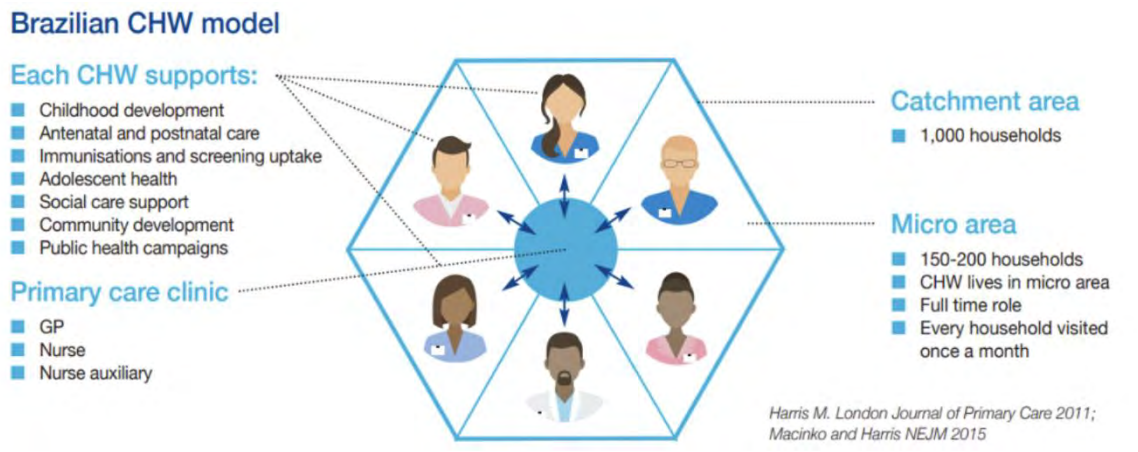


Figure 1. Brazilian Community Health Worker model.

6 Johnson, C.D., Noyes, J., Haines, A. et al. Learning from the Brazilian Community Health Worker Model in North Wales. Global Health 9, 25 (2013). https://doi.org/10.1186/1744-8603-9-25

7 Junghans, C., Antonacci, G., Williams, A. et al. Learning from the universal, proactive outreach of the Brazilian Community Health Worker model: impact of a Community Health and Wellbeing Worker initiative on vaccination, cancer screening and NHS health check uptake in a deprived community in the UK. BMC Health Serv Res 23, 1092 (2023). https://doi.org/10.1186/s12913-023-10084-8

8 https://napc.co.uk/community-health-and-wellbeing-workers/

9 Dallera. G, Antonacci. G, Junghens C, Harris M. (2022). Measuring the impact of the Community Health and Well-being Worker initiative in Westminster on immunisation, screening, NHS Health Check uptake, and GP consultation rates. Report commissioned by Westminster City Council. Oct 2022



Within Cornwall and IoS there was an initial starter pilot in February 2023 that recruited 10 CHWW in four locations in the Central Cornwall Integrated Care Area (ICA). This involved working with the voluntary sector in three areas and a Primary Care Network (PCN) in the fourth. Teams of CHWWs are now being rolled out in the 10% most deprived areas within Cornwall and IoS. Initial work has been reported on in a qualitative evaluation[10] investigating how the CHWW project got off the ground, how CHWWs were recruited and trained. This work did not investigate any of the impact of the CHWW work on residents. The initial report found many positive aspects of the project and also identified some areas of learning. One of these areas was the need to have a clear understanding between the CHWW role and the social prescribing link worker roles, and that elements of best practice in social prescribing could be echoed in the CHWW role.

The initial pilot that started in February 2023 has been extended to run for a minimum five years with a larger workforce of CHWW[11]. As part of the extension, in January 2024, a team of 22 CHWWs were appointed in the Kerrier area of Cornwall. With the further investment from Cornwall and Isles of Scilly Integrated Care Board, CHWW teams are now developing in Penwith, Bodmin and Liskeard. There is an aim to have a total of 50-60 CHWWs in post by the Autumn of 2024[12].

1.2 Logistical details of the current CHWW project

CHWWs work within the ICS, so while they are part of the primary care team, they are also integrated into the wider health and social care system and local communities allowing them to quickly connect with all relevant services for their householders.

[10] John Tredinnick-Rowe, Richard Byng, Tamsyn Brown et al. Piloting a Community Health and Well-being Worker Model in Cornwall: a guide for implementation and spread, 29 March 2024, PREPRINT (Version 1) available at Research Square [https://doi.org/10.21203/rs.3.rs-4144720/v1]

[11] https://www.volunteercornwall.org.uk/how-we-help/in-the-community/chww#CHWWNews

[12] https://cios.icb.nhs.uk/2024/03/06/cornwalls-success-with-community-health-and-wellbeing-workers/

Depending on caseloads and working hours (full or part time), the CHWWs are each appointed around 120 households to support and build long term relationships with whole families following the principles of comprehensive intergenerational, hyperlocal, universal and integrated .

CHWWs are recruited locally based on the knowledge of the local community. Recruitment is not qualifications based, but instead focused on a candidates' ability to build relationships and to understand a community[13]. CHWW staff also work alongside those in social prescribing link worker roles.

In Cornwall and IoS, CHWWs typically meet people within their own homes, or within the local community (e.g. a café or community hub). Part of the CHWW's role is to encourage householders to initially identify their biggest concern and then work with them to reduce or remove that concern. Since Autumn 2023 the CHWW project has been collecting Measure Yourself Concerns and Wellbeing® (MYCaW) data to show the impact of the CHWW.

1.3 What is the Measure Yourself Concerns and Wellbeing® (MYCaW) tool?

The MYCaW questionnaire is a validated individualised questionnaire designed for evaluating holistic and personalised approaches to supporting people and is accredited by NHS England for supported self-management services (such as social prescribing). MYCaW only takes a few minutes to complete and can routinely be incorporated into a consultation to understand and prioritise what a person most wants support with. MYCaW allows a more rigorous approach to capturing the voice of residents beyond the anecdotal.

First form - Each person writes down the one or two things that concerns them the most, that they want help with, in a box. These concerns can relate to any area of a person's life and are rated for severity using a simple numerical Likert scale and a person's wellbeing is also scored.

[13] See video: https://www.youtube.com/watch?v=HMXOnbCEfi0

At follow-up - the original concerns are rescored, and wellbeing is rescored. Two further questions ask if anything else important is happening in a person's life and what has been most important about the service received. These questions are useful for identifying confounding variables which may affect concerns and wellbeing score changes, as well as capturing what the residents value about the support they are receiving.

MYCaW will capture concerns that are medically related, but more often people report concerns that affect their biopsychosocial wellbeing. People also report practical concerns around finance, housing, job status, concerns about their future, their life purpose, relationships and carer burden. All of these concerns may impact a person's overall wellbeing, yet, many of these topics are not routinely recorded.

There are several coding frameworks for MYCaW which sit behind this tool allowing researchers the ability to easily categorise the qualitative data captured by the tool. Quantitative data can be analysed to track score changes and work out the percentage of people making a clinically relevant change to their concerns and wellbeing and assess the statistical relevance of the mean score changes.

MYCaW can be accessed as a paper or digital version and a licence is required from www.meaningfulmeasures.co.uk to use the tool.

1.4 Aim of report

- To analyse all data on the initial and follow-up MYCaW forms from the CHWW project, as well as any relevant available demographic data about the project recipients.
- To carry out a comparison of commonly used outcome measures with concerns documented from MYCaW data. (Please see Appendix 1 at the end of the report for this).



2.0 Methods

Data was gathered by the CHWW teams during their home visits. The first MYCaW was presented to an individual once a CHWW had got to know the resident, it was not necessarily administered at the first meeting, but was applied after at least the third meeting. Follow up MYCaW data was captured 3 months later (however, this time frame was not rigid, and it may vary by several weeks per participant). If someone wished to leave the project then a follow-up MYCaW was administered.

MYCaW data was held in a centralised excel sheet which CHWW added their information to.

Anonymised service data including demographics and MYCaW data was sent to Meaningful Measures Ltd in a password protected excel file. The data file was checked and cleaned then converted into a data file for IBM SPSS Statistics version 29.0.1.0 (171).

2.1 Analysis of Demographic data

All demographics were calculated as percentage frequencies.

2.2 Analysis of Measure Yourself concerns and Wellbeing® concern types

The MYCaW concerns were analysed for the whole dataset. To do this, all the first and second concerns were combined. They were initially coded, using the personalised care coding framework devised by Meaningful Measures Ltd. This was reviewed by a second researcher and a final version agreed. The proportion of concerns in each theme and category was then calculated to enable visual representation in the results section of this report.

2.3 Analysis of score changes

The mean score changes and accompanying standard deviation for MYCaW Concern 1, Concern 2 and Wellbeing were calculated. To determine if the overall change in

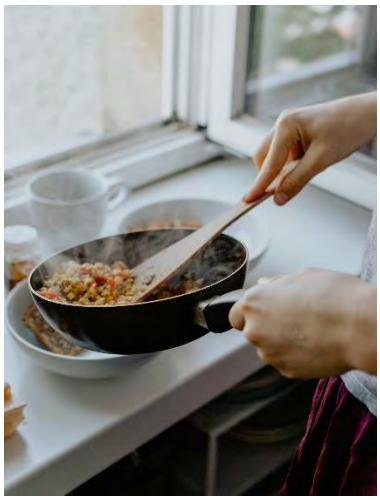
Concerns and wellbeing scores was statistically significant, a paired samples 2-way T-Test was carried out on all concerns scores that had a baseline and follow-up score. This meant that all Concern or Wellbeing scores that did not have a follow-up score were omitted from this calculation.

Finally, the percentage of scores that met the minimal threshold of change to signify an important difference were calculated. This includes scores that met the improvement threshold of 1 point and scores that met the deterioration threshold of 1 point. This level of changes (minimal important difference) is the level of change needed for a demonstrable difference to be experienced by the participant.

3.0 Results

3.1 Demographics

211 people's data was available to analyse. Demographic data on age, gender and area of Cornwall were all analysed. Figure 2 shows the range of ages that engaged in the CHWW service. Approximately a quarter of all residents were between 35-44 years old. 18% of residents were between 55-64 years old and 15% were between 70-89 years old. There was a very large range between the youngest and oldest residents e.g.15-19 years old through to 95 -99 years old.



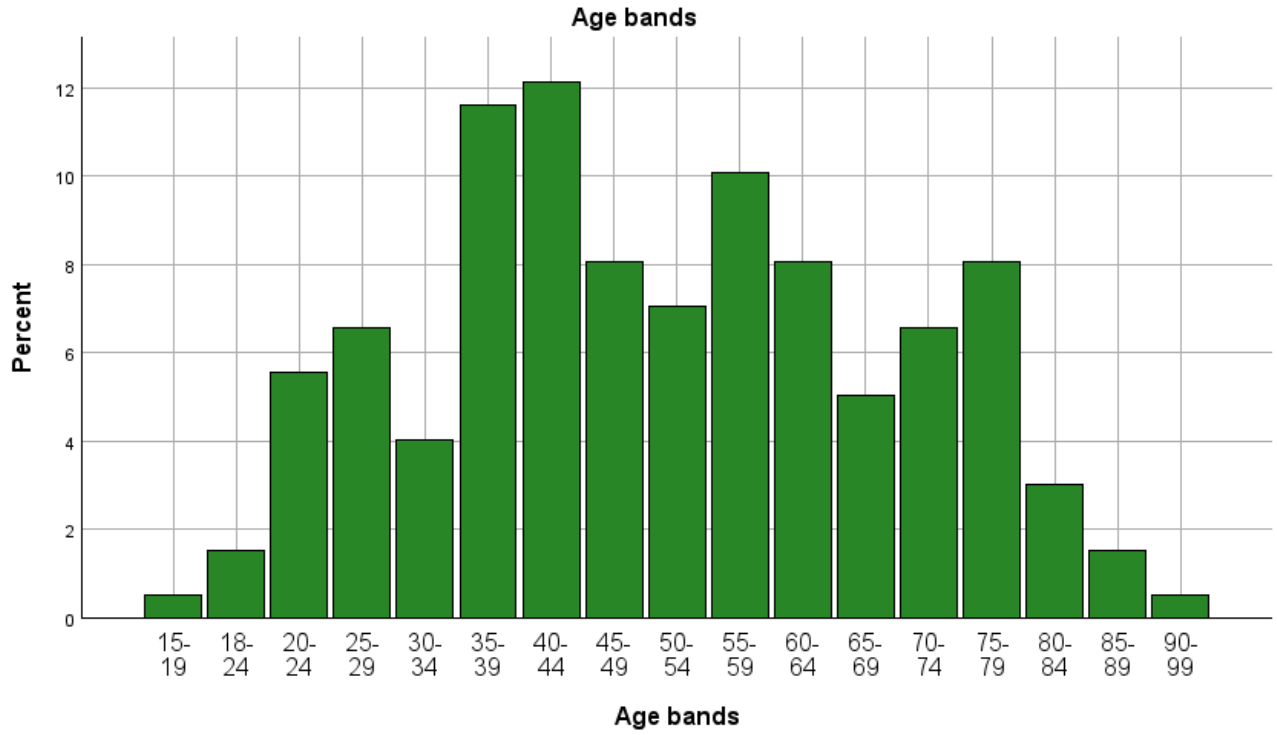


Figure 2. Range of ages of CHWW residents.

As shown in Table 1 below, the CHWW service engaged with a significantly higher proportion of females (60%) compared to males (29%). Nearly 80% of residents lived in either St Austell or Newquay, which is expected as 60% of the overall CHWW resource is located in these two locations.

Category		***(%) whole dataset N=211***
Gender (n=190)	*Male*	*29%*
	Female	*60%*
	Binary or Trans	*1%*
	Not stated	*10%*
Area of Cornwall	*Newquay*	*42%*
	St Austell	*36%*
	Falmouth	*13%*
	Truro	*10%*

Who completes the MYCaW form?	*CHWW supporting a resident*	*66%*
	Resident on their own	*33%*
	Carer about themselves	*0.5%*
	Carer supporting a Resident	*0%*
Type of consultation	*Face-to-face*	*76%*
	Via phone or video	*7%*
	Not stated	*18%*

Table 1. Summary of demographic and consultation information (note percentages may not add to 100% due to rounding).

3.2 How was the MYCaW form complete and by whom?

We recommend that MYCaW is completed by the residents themselves, but that is not always possible for a variety of reasons. We therefore also recommend that a professional can complete the form for the resident ensuring that they write down verbatim how a resident describes their concerns. Sometimes the person completing the form is a carer supporting the resident and occasionally they are a carer completing it form themselves.

In Table 1 it shows that two thirds of the MYCaW forms were completed by the CHWWs supporting the residents and one third of MYCaW forms were completed by the residents themselves.

It can be useful to know what type of consultation was carried out, e.g., was it face-to-face, via phone, online etc. Face-to-face was by far the most frequent consultation method (76%).

3.3 Measure Yourself Concerns and Wellbeing® score changes

All evaluation entries that had baseline scores and matching follow up scores were deemed to have 'paired' data and were used in the analysis of MYCaW© Concerns and Wellbeing score changes. For the analysis of Concern 1 score changes there were 147/211 (70%) paired data entries to analyse. Concern 2 is an optional part of the questionnaire and there are always fewer entries for Concern 2 compared to Concern 1. There were 130/211 sets of paired data for Concern 2. 148/211 people provided a baseline and follow-up wellbeing score.

Table 2 outlines the score changes, statistical significance levels and the relevance of these score changes. Both MYCaW Concerns scores and Wellbeing scores showed an average reduction in the severity at follow-up. To determine if these score changes were down to change or were likely to have been influenced by the support from the CHWWs, a two-tailed, paired T-Test was carried out. All score changes were highly statistically significant, meaning that there was a less than 5% probability that the score changes were due to chance.

MYCaW©	Baseline score (±SD)	Follow-up score (±SD)	Score change (±SD)	P value	% minimal positive important difference	% minimal negative important difference
Concern 1 (n=147)	5.4 (±0.8)	2.8 (±1.5)	-2.6 (±1.6)	≤0.001	91%	1%
Concern 2 (n=130)	5.3 (±0.8)	2.9 (±1.5)	-2.4 (±1.5)	≤0.001	88%	3%
Wellbeing (n=148)	4.8 (±1.1)	3.0 (±1.2)	-1.8 (±1.3)	≤0.001	90%	4%

Table 2. Summary of the MYCaW scores and changes over time. A negative score change denotes an improvement.

To further understand the relevance of the score changes we calculated what proportion of score changes met the minimum threshold level of change. This level of changes (minimal important difference) is the level of change needed for a demonstrable difference to be experienced by the participant. It is similar to asking the question *"so what does the score change really mean?"*

We can see that 91% and 88% of the Concern 1 and 2 score changes (respectively) met this positive threshold level, and 90% of the wellbeing score changes. These are extremely high percentage improvements compared to other MYCaW datasets. Overall, the average scores indicate that for the vast majority of people who were supported by the service, their concerns and wellbeing improved as a result.

To ensure that these results are fully representative of the people who complete baseline MYCaW questionnaires it is important to collect as much follow up data as possible. This score data presented here represents 70% of everyone who had taken part in this demonstrator project at the time data was submitted for analysis to Meaningful Measures Ltd. As the service is ongoing, there will be a proportion of people who hadn't had chance to have their follow up data collected before it was analysed as an arbitrary cut-off point was agreed upon. This largely explains why the data is not 100% representative of the residents using the service. Some people may not want to be followed up, and often people may move, return to work or just be unavailable for a further consultation, when the follow-up data needs to be collected.

3.4 Analysis of Measure Yourself Concerns and Wellbeing® concerns

Data for 211 people was received by Meaningful Measures Ltd to analyse. For the qualitative analysis of the concerns, there were a total of 412 concerns provided when combining Concern 1 and Concern 2. All of the concerns stated were coded using an existing framework of concerns developed by Meaningful Measures Ltd. This framework was based on over 2,500 concerns from people around the UK using personalised care services.

Initially all concerns are designated a theme and the proportion of concerns in each theme is shown in the pie chart below - Figure 3.

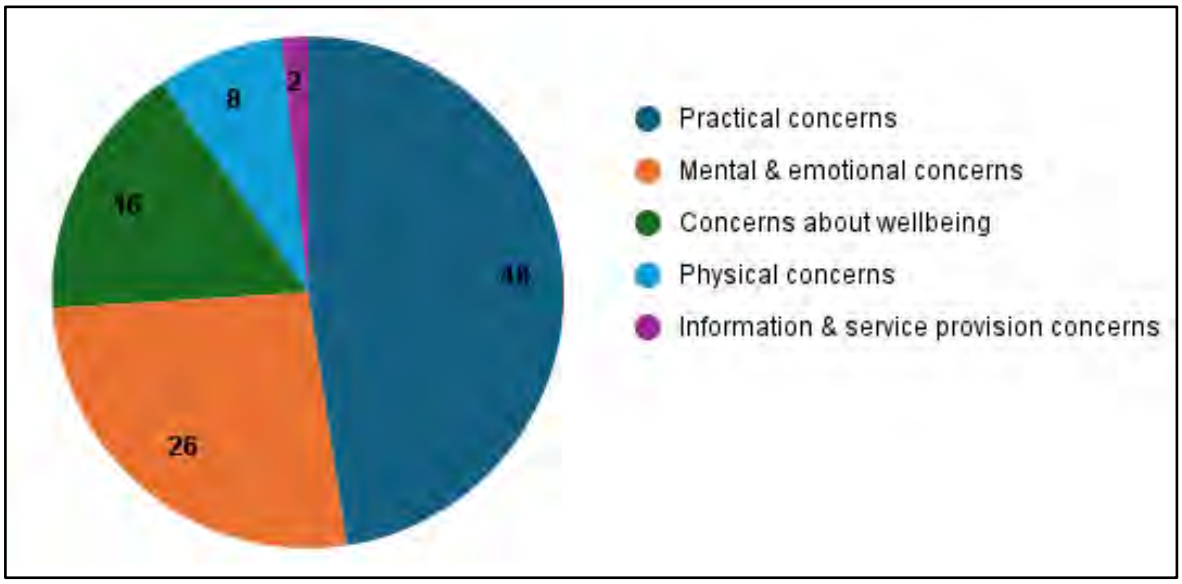


Figure 3. The percentage frequency of concerns falling in each main theme.

Almost half of the concerns were practical ones, which included problems with finance, housing, managing the household admin, managing to look after ones-self, social justice and safety issues, work & training, school and education and carer burden. A quarter of concerns related to a broad range of mental and emotional issues.

Across the whole dataset we identified the top 5 individual concern categories reported - shown below in Table 3. It is worth noting that most of these concerns are social determinants of health and it is, therefore, not surprising that people's mental health is being affected.



Category	n (%)
Finances	68 (17%)
Housing	52 (13%)
Mental health	40 (10%)
Loneliness and isolation	28 (7%)
Access to food	22 (5%)

Table 3. The top 5 concerns most frequently reported.

3.4.1 Practical Concerns

The theme about practical concerns was split into 8 specific categories. Figure 4 shows the breakdown of the frequency of concerns in each category. Below is some description and examples of concerns in each of the categories.

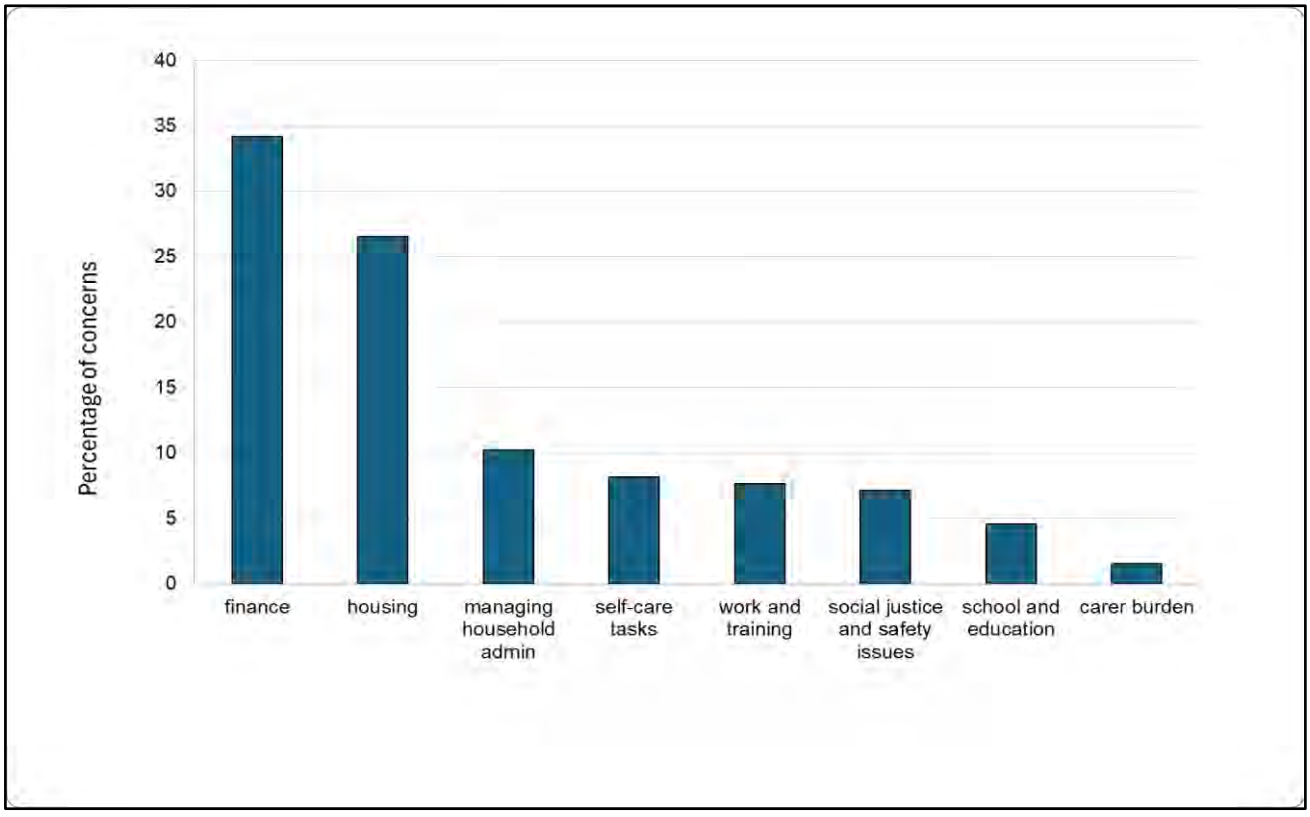


Figure 4. Breakdown of practical concerns.

3.4.1.1 Financial concerns

The most frequent practical concerns (n=67, 34%), were finance based. Approximately 45% of all finance concerns did not specify what the actual finance concerns related to but stated 'concerned about finances' or 'finances' / 'finance support' / 'financial struggles'.

25% of people with financial concerns were in debt, with a range of organisations including the housing association, energy companies, DWP, council tax, or water company e.g.

"My Council Tax bill - keep getting threatened with the bailiffs, but I just can't afford it"

"Bedroom Tax, [housing association] and DWP all stressing me out. They all reckon I owe them money!"

"Electric bill, they changed how I paid it & I have ended up in debt with it now. I want to go back to how it was before, I knew where I was"

Some people weren't in debt but were finding it hard to make ends meet

"Am struggling to afford food for my family."

About 20% of people with financial concerns needed help accessing benefits and welfare payments, such as attendance allowance, carers allowance, personal independent payments or support for their children e.g.,

"I feel like a really bad Mum, I am trying to get my youngest the support he needs. He needs Nursery and his portage, they won't fund both"

3.4.1.2 Housing concerns

26% (n=52) of practical concerns related to housing. Approximately 20% of these concerns just stated ‘housing’ so it was not clear what the specific issue was.

27% of the housing concerns related to the state of housing, where repairs were needed, people had no flooring, mould growing on the walls and often issues with their heating.

“The damp and mould in my flat is making me ill. It effects my asthma. Can't open the windows, might let rats in again”.

“I'm so cold. Just can't get warm. Heating boiler has been condemned. I had a heart attack every February for past 6 years due to the cold”.

“Having problems with my flat, landlord turns the heating off when he leaves for months”.

A further 27% of the housing concerns related to wanting to change where a person lived - some people were living in overcrowded conditions, and others wanted a smaller house or a house to suit their additional access needs. Some people wanted to move closer to family, others wanted to move away from the negative impact of their family. A small number of people were homeless, in emergency accommodation or had been served with Section 21 eviction notices.

“Overcrowding in housing, want a house near to mum to help support with childcare and health”

“Moving to a bungalow as my partner has to sleep downstairs”

“Housing - need new home that's accessible for just me. Restricted on what I can eat, when I can use bathroom/wash clothes etc by [family member]”.

Just over 15% of people had housing concerns relating to furniture. Most people needed items of furniture for themselves or their children or babies. A few people needed help to clear out and declutter.

3.4.1.3 Concerns with managing the household admin

10% of people with practical concerns were struggling to manage their household admin. Some concerns were quite general, stating 'form filling' whereas other concerns gave a more detailed picture of some people were overwhelmed with the paperwork that had built up, or where they needed support to apply for particular things, e.g. a blue badge or PIP payments.

"I need help with lots of bills and paperwork, it's all overwhelming."

"I need help accessing my ID like birth cert or bank statements."

"I need to apply for PIP but keep putting it off."

3.4.1.4 Concerns about self-care task

7% of the practical concerns were about the ability of people to care for themselves. Some concerns stated that more support at home was needed, other concerns explained that people needed help with cooking, cleaning or accessing their medication, because of a disability or due to the impact of having treatment for a health condition. As well as looking after the house, some people needed support with their gardens which were overgrown.

"I need help to cook as I have a disability and can't use kitchen equipment."

"I need help with cleaning, since my prostate cancer I have remained unwell and can no longer bend to pick things up and clean things."

"I cannot get to the pharmacy and need my medication delivered, I cannot be without it. Can you help? I get anxious making calls."

3.4.1.5 Concerns about Work and Training

7% of practical concerns were about getting a job. Most people just wanted to find a job to have some income. A few people mentioned wanting a job that they could enjoy or would align with their personal values. Some people were also concerned about their level of confidence, feeling that they wanted to improve their confidence to get back to work.

"Looking for apprenticeship."

"Not enjoying my current work environment. Affecting my mental and emotional health."

"Confidence building to re-enter employment."

3.4.1.6 Concerns relating to social justice and safety issues

There were a discrete set of concerns in this theme about social justice and safety. These concerns included concerns about neighbours selling drugs, being antisocial and crime in their buildings, - to the point that people were scared to leave their house or put their bins out. Other people mentioned issues with abuse from family and care workers and sexual harassment.

"My last support worker owes me money and has my house and car keys".

"Problems with neighbours keeping us housebound".

"Recent abuse and related court case".

3.4.1.7 Concerns about school and education

5% of people's practical concerns related to education - several people wanted advice about furthering their education, one person wanted to complete their studies.

Several people had concerns about their children not being settled at school or skipping school.

“Adult education advice.”

“Children struggling with behaviour and attendance at school.”

3.4.1.8 Carer burden

This was only mentioned by a few people, who wanted to be healthier to manage their caring role better or who were concerned how to protect themselves from the person they were caring for.

Overall, the theme of practical concerns has demonstrated a very diverse range of concerns that the CHWWs have recorded during their consultation. Whilst finance and housing were by far the most frequently mentioned concerns, the concerns ranged from ones about crime and safety, education, employment, carer burden, the ability to look after oneself or the home. In the next section we explore the mental and emotional concerns. It is highly likely that some of the practical concerns are causing mental and emotional concerns.

3.4.2 Mental and Emotional Concerns

These types of concerns were expressed by 26% of all the residents and are detailed in Figure 5. The categories will be explained in more detail below.

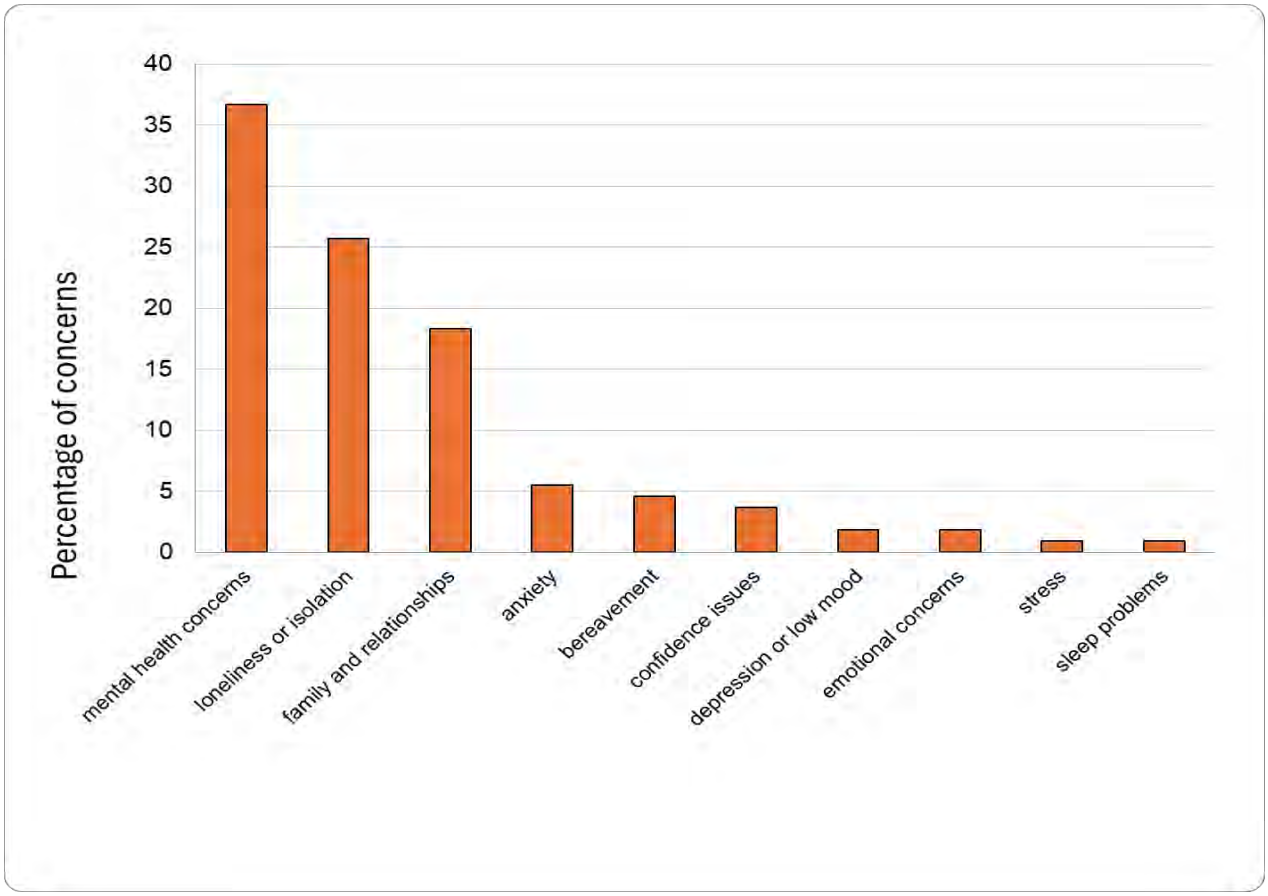


Figure 5. Breakdown of Mental and Emotional Concerns.

3.4.2.1 Mental Health (In general)

The most common category (36%) related to general mental health concerns. Here nearly two thirds of concerns just stated: 'mental health' or 'mental health support'. Where there was more detail, some people explained what was causing their mental health issues e.g.

"Mental wellbeing due to a difficult couple of months."

"Mental health due to housing and family."

"Mental health surrounding finances."

Some people had experienced childhood or past trauma which was still affecting their mental health, others stated conditions such as agoraphobia were impacting their mental health.

A few people also detailed the impact that their poor mental health was having on them, such as starting to self-harm or attempt suicide.

“Things get too much for me and I cut myself.”

“My mental health is bad and I'm finding it hard to do things at home.”

“I feel really useless & helpless, wellbeing is up and down”

3.4.2.2 Loneliness or Isolation

About one quarter of issues in the mental and emotional concerns theme were due to loneliness or isolation. About one third of this group reported they were ‘lonely’ and two thirds mentioned isolation.

“I feel really alone. My daughter is at Uni and I feel alone.”

“I am lonely and isolated, I worry no one knows I exist.”

“Feeling isolated and trapped in flat.”

3.4.2.3 Family and Relationships

This was the third largest reported category of concerns for the mental and emotional theme. Some people were experiencing conflict within the family, and others were concerned for their partners.

“Worried about [name], if something every happens to her I'd be lost.”

Some people were worried about their school aged children whilst other people were worried about their adult children who were in unhealthy relationships, or experiencing homelessness.

“I'm worried about my eldest. It's hard to get him out and about. Can be a struggle getting him to school.”

“I'm really worried about my daughter and baby grandson. She is in rehab at the moment. Worried about her ex getting back in contact with her.”

3.4.2.3 Anxiety

A discrete and small group of people mentioned their main concerns was anxiety - sometimes stating what type of anxiety it was e.g.,

“Bad social anxiety and I have anxiety going places.”

3.4.2.4 Bereavement, depression, confidence issues, stress, emotional concerns and concerns about sleep

All of these remaining concern categories were all only mentioned three or four times and are self-explanatory.

3.4.3 Concerns about wellbeing

This theme of concerns was expressed by 16% of residents and relates to concerns that directly affect a person's wellbeing. The two most frequently report concerns related to access to food and to social interaction. The theme will be explained in more detail below, the frequency of concerns in this section are shown in Figure 6 below.

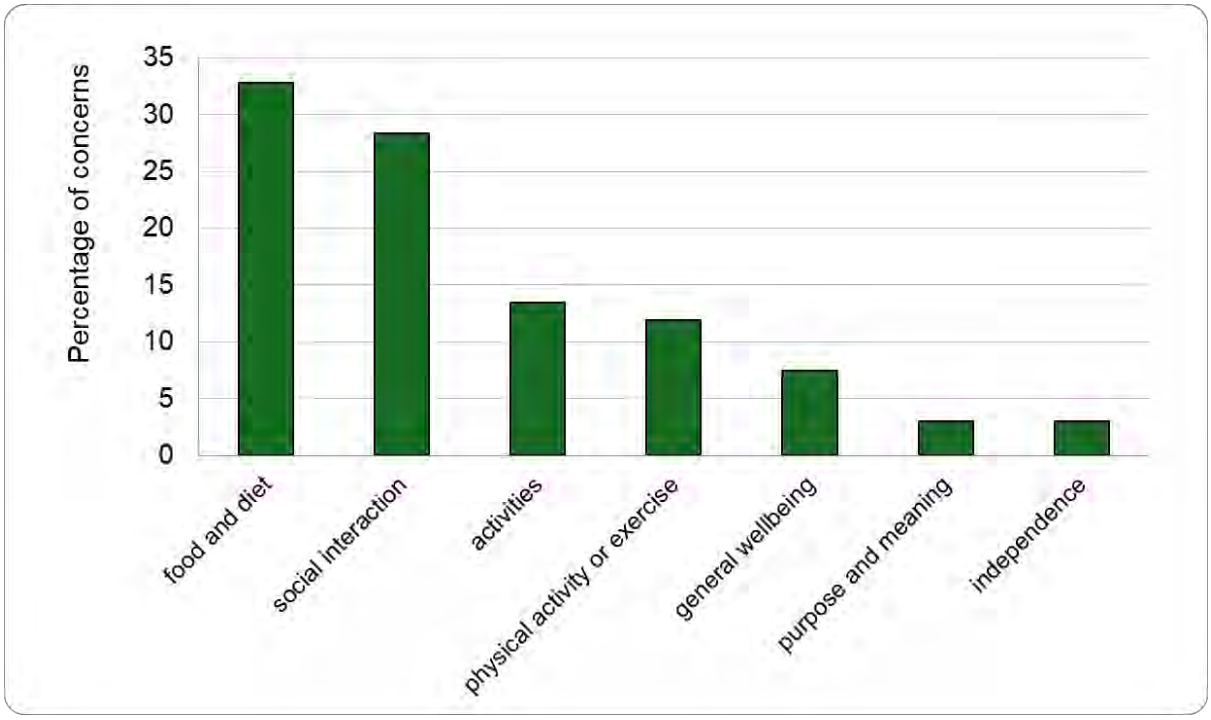


Figure 6. Breakdown of concerns about wellbeing.

3.4.3.1 Food and diet

For many people who nominated food as their concern, they needed support to access food and get enough food for everyone in their household to eat. A couple of people needed a cooker or were unmotivated to cook whilst living on their own.

"Am struggling to afford food for my family."

"Haven't got enough food for my family."

"I need a cooker. I need to be able to cook for and with my daughter. It's awful not having a cooker."

3.4.3.2 Social Interaction

Most people in this category wanted to increase the amount of social interaction they were having, which included needing support to find appropriate groups to join and or to have people to talk to regularly, which may not necessarily be through a community group but could be via a befriender

"I want to be more social and do something for myself."

“Find some more social connections.”

3.4.3.3 Activities

In a similar vein to the social interaction category, another group of people specifically wanted to join a group to do an activity either for themselves or for their child.

“Help accessing toddler groups.”

3.4.3.4 Physical activities or exercise

The small group of people in this category wanted to start physical activities such as going to the gym, so they could improve their strength and get fitter.

“Need to go to the gym. It's good for my RA. Need to get stronger.”

3.4.3.5 General Wellbeing, Purpose and meaning, Independence

There were only a few mentions of each of these categories of concerns and they are reasonably self-explanatory. Some people just wanted to feel healthier or happier, and generally have better wellbeing. A couple of people were concerned about their purpose in life and sense of belonging, and a couple of people’s concerns related to their level of independence.

“I want to feel happier.”

“I want to start my own business. I need a sense of purpose again.”

“Remain independent.”

3.4.4 Concerns about physical health

Only 8% of residents put concerns about their physical health as their priority. It is likely that the residents are experiencing far more physical concerns but that the concerns about finances, access to food and housing were a greater priority.

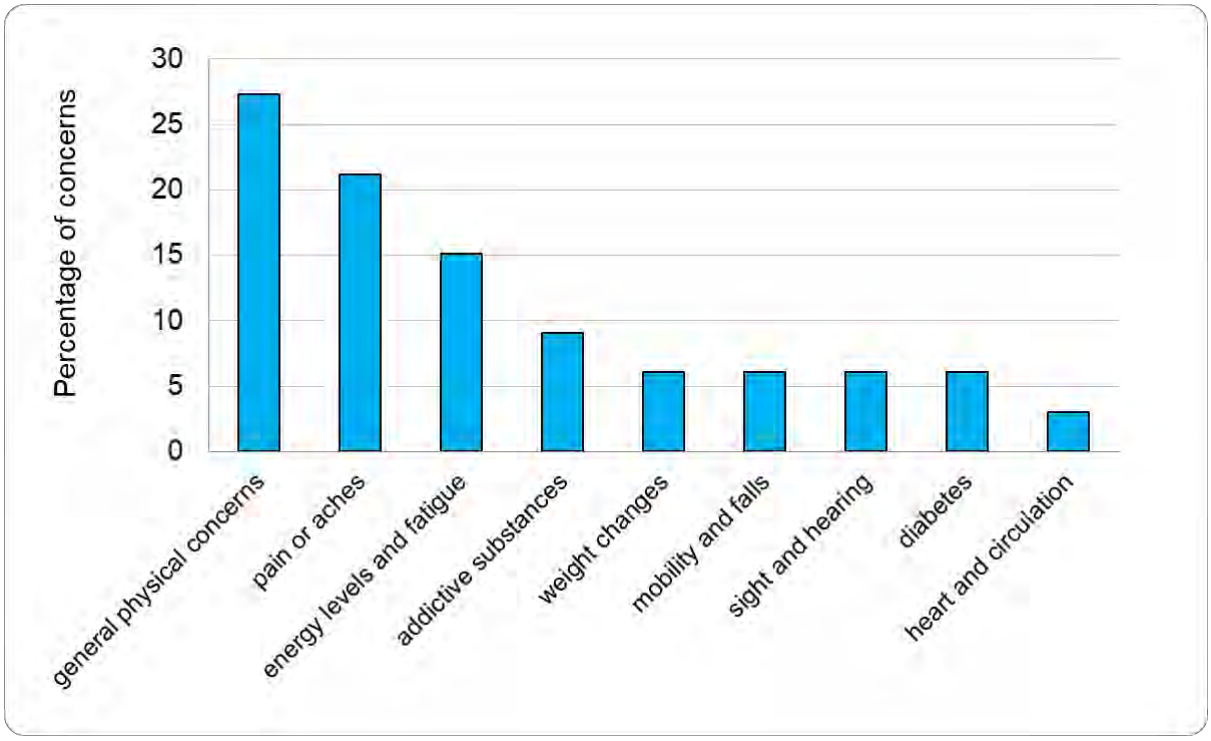


Figure 7. Breakdown of concerns about physical health.

For the largest group of people in the sample, these concerns were described just as 'health concerns' so there wasn't enough detail to discern what they related to specifically.

There were then a range of physical concerns about weight, suffering with low energy levels and pain,

"Would like to lose weight as I think it will help me with my social anxiety."

"I don't want to feel so tired and in pain all the time."

Other concerns each mentioned by one or two people related to issues with mobility, diabetes, sight, addiction.

"I am struggling with mobility and accessing activities."

"Diabetes and knowing what to eat."

"I am losing my sight and need help at home."

"I drink a lot of alcohol, I need some help to cut down so I don't fall as much."

3.4.5 Concerns about information and service provision

The final theme of categories relates to people needing specific support or information about particular services.

Only seven people had their priority concerns in this theme. Generally, people wanted very specific information about services e.g. support about adoption, support after a stroke, information on how to get a dentist, find a chiropodist and information about autism services.

3.5 What else is going on in your life?

On the follow up MYCaW form, we ask people if there is anything else going on in their life that is important, besides the concerns they have nominated. This data identifies other 'confounding variables' that can affect score changes and give more insight into the reality of residents. Of the 211 people who completed MYCaW, 130 (62%) people recorded a total of 139 other things going on in their life.

We can split the additional issues into positive and negative events, to give a sense of challenges still faced or improvements that are happening. Table 6 below shows that 42% of additional events were positive in nature, 49% were negative in nature. It was not clear whether the remaining 9% of comments were positive or negative in nature.

The biggest positive change for people (9%) was improvement in their finances or work situation. It was implied that the CHWWs had helped get benefit payments sorted, but predominantly people had either found a job that they were happy with or were actively looking for work now.

residents were also trying to improve their wellbeing through diet and physical activity (6%), were actively improving their environment (6%) and were benefiting from the increased support from the CHWWs as well as friends and family (6%). A further 6% of residents were getting more social activity and connections. All of these situations are known to have a positive impact on a person's health and wellbeing.

Sadly, the most frequent negative issue was ongoing issues with physical and mental health (20%) and this often related to issues with long term conditions and pain. A further 9% of residents were struggling with their finances and work issues, e.g., lack of work. The rest of the additional issues having a negative impact can be seen at the bottom of Table 6 below.

Research previously carried out has shown that in many cases where negative additional issues exist, it can make the overall score changes smaller for concerns and for wellbeing. Conversely where additional situations are positive, people may have larger score changes. We have not carried out this analysis for this piece of work, but please note that the MYCaW score changes are already showing a large effect size, so it is likely that these additional issues are not impacting the scores too much.

Impact	**Category**	**n=139 (%)**	**example quotes**
Positive impact	*Work or finance*	*9 %*	*"CHWW 's got me attendance allowance and HHSF to purchase some white goods". "returning to work"*
	Awareness of own wellbeing	*6*	*"I have made changes to my diet and stuck to this which has helped with my pain".*
	Positive change in environment	*6*	*"Really starting to get things sorted now with the decluttering and decorating. Slowly but surely, but I feel better mentally the more I do. We will have a much nicer home after all this".*
	Increased support	*6*	*"Your support has helped me to believe in myself more. Putting me in touch with The People Hub has really helped too"*

	Increased social activity	*6*	*I have made many social connections, through the neurodiversity group, chill and chat and i have even performed with my guitar for a singer at a concert. i have also started a level 2 autism awareness course which is very interesting".*
	Taking physical activity or exercise	*3*	*"Going to the gym is really helping - I am feeling stronger and I am managing to pay for it now at the reduced rate. I had to continue, because it does me good, mentally and physically"*
	Improved family situation	*3*	*"feel better now that my child is at nursery is at nursery".*
	receiving support from health professionals	*3*	*"getting help with pain management"*
Negative impact	*Continuing issues with health and long term conditions*	*20%*	*"I have depression and chronic back pain, so some days I cannot do anything. I don't even get up. It's so bad. I want to be doing things but I can't when I am in so much pain".*
	Work or finance	*9%*	*"Loss of employment".* *"rent arrears"*
	Family issues	*6%*	*"Fathers mental health concerns"*
	loneliness and negative wellbeing issues	*4%*	*"loneliness"* *"Things just get on top of me. Everything seems to go wrong. Haven't been taking my medication".*
	Negative change in environment	*4%*	*"Currently homeless and trying to find myself a flat".*
	Bereavement	*3%*	*"Recent bereavement over my wife, sometimes I am still very sad and lonely".*
	Carer burden	*3%*	*"I have a son with autism and a wife who suffers with seizures. I do worry about my son when we are no longer around".*

Table 4. What other things are going on in your life? - split by positive and negative impact.

3.6 What is important about the support you have received?

The final follow-up question on MYCaW asks what a person found most important about the service or support they received. 142/212 people responded to this question, stating 202 things that were important about the support they received from the CHWWs. Responses were categorised and are displayed in Figure 8 below.

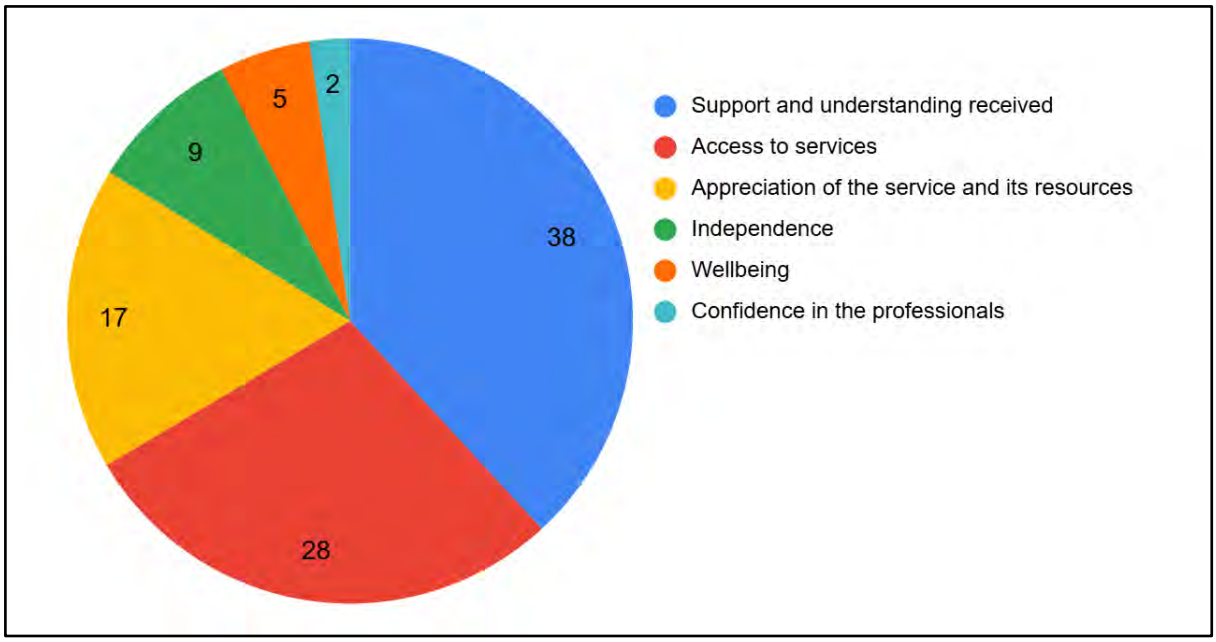


Figure 8. Percentage responses for people in response to "What was the most important thing about the service?".

3.6.1 Support and understanding received

The most frequent response (38%) related to the support, understanding and provided by the CHWWs as well as the encouragement to make changes or improvements. Many householders were really appreciative of having CHWW to talk with, who listened to them and believed them. For many people this has helped them trust the CHWWs in a way that they don't normally trust professionals.

"It got things sorted, but so much more to do. I don't trust easily, but I can talk to you."

“Having someone call in to see me just to check in and have a chat has been really great. My dog loves seeing the CHWW too as she never sees anyone else! I am very grateful!”

“I really do appreciate the time you spend listening to me going on about my funny little ways and my family issues. I don't have anyone else who can give me this time.”

3.6.2 Access to services and organisations

The second most frequently appreciated aspect of the CHWW service was getting access to services and additional support organisations. Often this included getting more financial advice and support as well as support regarding housing issues or the housing association. Additionally, people were put in touch with organisation that would provide social activities. Furthermore, several people are grateful that they now have a source of support they can contact in the future if they need it again.

“Having financial support has been so helpful, I could not have done this on my own. I was getting depressed and exasperated by paying bills and worrying about debt. The CHWW changed all that for me.”

“The Help I got from the CHWW has made a huge difference. They got me in touch with Safer Truro, and secured my home which made me feel a lot safer. I was listened to and helped immediately. Even helping me reduce some of my bills. I can't thank them enough.”

“Good to know support is there if I need it.”

3.6.3 General Appreciation of the Service

Many people appreciated the service in general citing a range of things they valued about it e.g.

“Having someone to listen and believe me. The CHWW met me at home and walked with me to groups and built up my confidence. Being able to be part of a social group again at my age, and getting to know my neighbours. All this would not have happened without the CHWW.”

There was a lot of appreciation for the availability of the access to the CHWW service, whether it be the home visits, the drop-in sessions that were provided or the regular contact that people had with the CHWWs

“The help I received from the CHWW has been a real help in my life. Knowing they are there open-ended if I need them, knowing they are on the end of the phone. I can rely on them to turn up when I feel everyone else lets me down.”

“Being able to drop in to session.”

“Someone who wanted to help me and actually actioned it! Being able to have the appointment at home, because I probably would have cancelled if it wasn't.”

3.6.4 Being more Independent

A small group of people (9%) were very clear that the support from the CHWWs had given them motivation and independence which in some cases has led to them being more active and having a much better social life.

“Giving me the confidence to do things myself and encouraging me and making me feel like I've got this! The wheelie bin numbers you got me helped too - people know which bin is mine now and they haven't taken it”.

“I am hardly ever home now, I go out a lot, have made friends and even played my guitar on stage with a band. My life has changed a lot really”.

The final areas mentioned by a few people related to them having improved wellbeing in general and also their trust in the professionals that they are working with now.

Overall, this section of data shows that the CHWW service is accessible to people, and the CHWWs are able to develop trusting relationships with the residents who are then going on to share their concerns and receive the support they need.

4.0 Discussion

This analysis aimed to understand the types of concerns that people wanted support with when using the CHWW service. Furthermore, we wanted to understand if there was any impact of the CHWWs that could be discerned from the MYCaW data.

As a proof of concept, the concerns collected alongside the score changes in concerns and wellbeing at follow-up show that this is an extremely valued and important service in Cornwall and IoS.

The types of concerns being recorded were predominantly those associated with the most basic of needs such as having access to food, financial issues and debt, problems with housing conditions and issues with social welfare and crime - it is well documented that people who are the most socioeconomically deprived have more of these issues which are associated with poverty and destitution. The findings of this report make for very sober reading and show the difficult lives of people living in Cornwall and IoS. This report echoes the issues of deprivation and destitution outlined in the introduction.

The average changes in MYCaW scores after receiving support from the CHWWs were very large and highly statistically significant. Whilst we can't attribute all of the change in scores to the CHWW service (a comparison group is needed for this), it is clear from the additional follow-up questions, that there are several key aspects to the service that are important to the residents.



Firstly, people appreciated the style of access to the service, having home visits, as well as drop-in session and continuity of support. A key enabler appears to be the ability of the CHWWs to establish trust with the householders, which led to them feeling they could talk to the CHWWs. Trust was further developed as people felt they were genuinely being listened to and then getting the support they needed. The type of support needed was often financial in nature, as well as helping people sort out

housing issues, and get out to social activities. Another aspect mentioned several times was that the CHWWs accompanied people to their activities for the first time and that they did what they said they were going to do.

It was noticed on the data collection spreadsheets that CHWWs from different locations may enter different information into the spreadsheet - particularly when reporting who completed the MYCaW form and the type of consultation. For future data collection and analysis, particularly with a larger dataset, it would be beneficial to add a drop-down menu choice on some of these questions, making it easier and quicker for data to be entered and improving the overall consistency of data collection.

Other tweaks to the data collection include ensuring that the concerns are written down as the residents talks about them, instead of just summarising their concerns with one or two words. There is a lot of detail which helps to demonstrate what matters to people and how the service is helping which is lost if a CHWW summarises the concern with one or two words only.

Finally, all scores should only be a whole number however there were some scores that were not whole numbers and therefore it is important that all CHWWs are clear on ensuring whole numbers only are entered.

5.0 Conclusion

The data analysis here shows that the CHWW project is a highly successful and valuable service supporting the poorest people in Cornwall and IoS to access what are considered their basic needs and rights to appropriate finance, housing, food and support with their physical and mental health. Given the statistical significance of the MYCaW score changes we conclude that this service should be continued, and more data collected to establish the longer-term impacts on the current residents.

6.0 Appendix 1: Discussion of Measures

In terms of the second aim of the evaluation, the data obtained from the MYCaW analysis can possibly indicate where other person reported outcome measures may be used going forwards. The most often picked MYCaW super-category was “practical concerns” and here the main issues were: problems with finance, housing, managing the household admin, managing to look after ones-self, social justice and safety issues, work and training, school and education and carer burden. Most of these concerns are social determinants of health. Other outcome measures for health and wellbeing may not be able to reach all of the areas that MYCaW reaches, especially in terms of social determinants of health. Table 5 below is adapted from Polley et al. (2020)[14] which reviewed outcome measures for social prescribing. It is hoped that this information helps the reader in working out best ways forwards with outcome measures which may accompany MYCaW. Most useful measures are those which are short, free, sensitive and provide economic value data (the best tools are coloured in green).

There are several tools that can be used to derive economic data that we have listed below. The caveat here is that you want to use a tool that measures changes in the broad range of domains identified via MYCaW. If you only capture data on a proportion of domains that we know are relevant to residents, the score changes may not be statistically significant at follow-up and may not accurately represent the impact of the CHWW service. The ensuing economic calculations may also, therefore, not accurately represent the service. This would be seen as a false negative result.

Going forwards, therefore, it is important to test out any other outcome measures you are using to see if they are sensitive to the change your residents are experiencing. The change in wellbeing score from the MYCaW data would be a good benchmark for comparison. We know that people are rating their wellbeing as improving on average,

14 https://www.london.gov.uk/sites/default/files/a_guide_to_selecting_outcomes_measures_in_social_prescribing_final.pdf

therefore, any other tool monitoring wellbeing or quality of life should also pick up this change. If it doesn't then it may not be suitable for your residents.

Another point to consider is maximising the amount of follow-up data captured. The higher the proportion of people who have baseline and follow up scores, the more representative your data is. Many studies have shown economic calculations to show return on investment, but the follow up data represented less than 50% of all residents. The conclusions, therefore, should read that in those 50% of residents there is a positive return on investment. But if the other 50% did not show a return on investment, overall the final result could be very different - but it remains unknown. Aiming for at least an 80% representation with follow-up data would be acceptable. Maximising the amount of follow-up collected data is always a good investment of time when evaluating services!

Finally, note that we have not included outcome measures that are specific to conditions or situations, e.g. pain or loneliness as people's concerns are far ranging. If you want to use an outcome measure that is specific to a condition or situation, e.g. loneliness or mental health, you could use the MYCaW concerns to guide you on when to use the other tool. For example, if people say their main concerns relate to their mental health, then a mental health scale would be appropriate. Similarly you could use a loneliness scale on people who have identified concerns about loneliness. This is a slightly more complicated approach to monitoring outcomes and requires buy-in from and training for those administering the outcome measures.

Table 5 Comparison of outcome measures used to monitor wellbeing or Health Related Quality of Life

Tool	Description	Licence	Notes
Measure Yourself Concerns and Wellbeing (MYCaW)	Concerns and Wellbeing. Person centred data. In line with the findings of this report	Yes, currently in place with the Cornwall & Isles of Scilly ICA	Suggest to use this ongoing as it reaches all areas of need and experience in the community. Provides personalised data. Does not provide economic value data (although may do in future).

36-Item Short Form Health Survey (SF-36)	36 items measuring eight domains of health: physical and mental aspects, including physical functioning, role limitations, pain, general health, vitality, social functioning, and emotional well-being.	No, free tool	Researchers often use the SF-36 to evaluate health-related quality of life and determine the cost-effectiveness of health treatments in health economics. Does not provide personalised data.
Office for National Statistics personal wellbeing scale (ONS4)	The Office for National Statistics (ONS) uses a set of four questions to assess personal well-being, often referred to as the ONS4. These questions capture three types of well-being: evaluative, eudemonic, and affective experience.	No, free tool	This tool is useful as you can benchmark against national datasets to show how a particular population compares. Some questions may be triggering in a negative way. Does not provide personalised data. Can be used in some economic analysis, but does not provide QUALYs
EQ-5D (EQ-53-3L) European Quality of Life 5 Dimensions 3 Level Version	Tool assesses five dimensions of health: mobility, self-care, usual activities, pain/discomfort, and anxiety/depression.	No, free tool	Perceived by some to be a bit reductionist and the domains do not cover the determinants of health very well. Does not provide personalised data. Can provide economic values, can be used to calculate QUALYs
DIALOGUE +	The DIALOG scale consists of 11 questions. People rate their satisfaction on a 7-point scale with eight life domains (such as relationships, daily activities, and housing) and three treatment aspects (like medication and	No, free tool; available within the NHS, also available via an app.	Does not provide personalised data. Does not provide economic value data. The tool is used to help mainly with mental health issues.

	therapy). Tool also extends beyond the scale and allows people to discuss concerns and then addressed them in in a four-step approach (understand, identify, explore and agree action).		
The Quality of Life Scale (QOLS)	The Quality of Life Scale (QOLS) is a 15-item instrument that measures five conceptual domains: material and physical well-being, relationships with other people, social, community and civic activities, personal development and fulfilment, and recreation.	Free for students, fees apply for other projects	Used for long term illness, but can be used in non-illness contexts. Does not provide personalised data. Does not provide economic value data.
Patient Reported Outcomes Measurement Information System (PROMIS)	PROMIS is a system of highly reliable, precise measures that assess patient-reported health measures. Domains are: physical, mental, and social well-being.	No, free tool	Sensitive and adaptable, and applicable widely to lots of different contexts. Does not provide personalised data. Does not provide economic value data.

Report End

Communications and Engagement Plan – Macmillan Project

Background

Hywel Dda University Health Board (HDdUHB), in partnership with Macmillan Cancer Support and a wide range of statutory, voluntary and community sector organisations, is developing a Neighbourhood Prevention Programme to improve health and wellbeing outcomes and reduce health inequalities across Mid and West Wales. The programme responds to increasing levels of cancer and long-term conditions, rising pressures on health and care services, and the need to strengthen prevention, early intervention and community-based support.

The programme will deliver a neighbourhood-based model comprising **Health Coaches**, **Community Health and Wellbeing Workers**, and **Community Capacity and Local Infrastructure for Prevention**. Together, these components will support individuals to improve their health and wellbeing, identify and address unmet need earlier, strengthen community resilience, and improve access to local support and services. The programme is aligned with the principles of Community by Design, the Social Model of Health and Value-Based Healthcare, A healthier Mid and West Wales- Healthier Lives, Well Lived recognising that health outcomes are influenced by social, economic and environmental factors as well as clinical care.

Subject to approval by the Board at **Hywel Dda University Health Board and Macmillan**, mobilisation is anticipated from autumn 2026, followed by phased implementation Health Board wide.

This Communications and Engagement Plan set out the approach to engaging stakeholders, partners and communities throughout programme development, mobilisation and implementation. Recognising that the programme will evolve through learning, co-production and local delivery, a **continuous engagement approach** will be adopted to ensure stakeholders remain informed, involved and able to influence delivery. Regular engagement and feedback mechanisms will be used throughout the life of the programme to support continuous improvement, strengthen local ownership, and maximise the long-term sustainability and impact of the programme.

Engagement methods

Method	Rationale
Engagement period	A period of engagement will take place from July 2026 – September 2031
Broad Approach	Communications and engagement activity will be delivered as a continuous and phased programme throughout the development, mobilisation, implementation and evaluation of the Neighbourhood Prevention Programme. The approach recognises that the model will evolve over time through co-production, learning and continuous improvement, requiring ongoing engagement with stakeholders, partners and communities. During the business case development phase, engagement will focus primarily on internal stakeholders, strategic partners and potential delivery organisations to inform programme design and secure organisational commitment. Subject to approval by Hywel Dda University Health Board and Macmillan Cancer Support, communications and engagement activity will expand to include staff, partner organisations, communities, elected members and the wider public through a coordinated programme of stakeholder engagement, community involvement, media activity and digital communications. A neighbourhood-based co-production approach will be adopted throughout implementation, ensuring that local communities and partners help shape delivery within each neighbourhood while maintaining a consistent programme framework: • **October–December 2026:** Co-produce and mobilise **Neighbourhood 1** with local stakeholders, communities and partners. • **January 2027: Neighbourhood 1 goes live.** • **2027:** Continuous engagement, learning and evaluation to inform refinement of the model while **co-designing Neighbourhood 2**. • **January 2028: Neighbourhood 2 goes live.** • **2028:** Ongoing engagement, evaluation and shared learning across Neighbourhoods 1 and 2 while **co-designing Neighbourhood 3**. • **January 2029: Neighbourhood 3 goes live**, achieving full programme implementation.

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- **2029–2031:** Two years of continuous engagement, evaluation and benefits realisation to test, refine and demonstrate the effectiveness, impact and sustainability of the neighbourhood prevention model.

This continuous engagement approach will ensure that stakeholders remain informed and involved, communities will have meaningful opportunities to influence local delivery, and learning from each phase is used to improve subsequent implementation. It will support local ownership, strengthen partnerships and help build the evidence required to demonstrate and sustain the model over the longer term.
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<tr><td>Targeted Engagement</td><td>Specific activity for the project will include:

<table>
<tr><th>Stakeholder</th><th>Activity</th></tr>
<tr><td>Macmillan</td><td>Programme meetings</td></tr>
<tr><td>Hywel Dda Executive</td><td>Executive briefings</td></tr>
<tr><td>Public Health</td><td>Design workshops</td></tr>
<tr><td>Primary Care</td><td>Cluster engagement</td></tr>
<tr><td>Local Authorities</td><td>Partnership meetings</td></tr>
<tr><td>Third Sector</td><td>Co-design sessions</td></tr>
<tr><td>Regional Partnership Board</td><td>Strategic updates</td></tr>
<tr><td>Community organisations</td><td>Local engagement sessions</td></tr>
<tr><td>Staff</td><td>Internal communications</td></tr>
<tr><td>Communities</td><td>Co-production</td></tr>
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Activity log

Pre-engagement activity				
Date	**Event / Activity**	**Staff / resourcing required**	**Comments**	**Achieved by**
June 2026	Stakeholder mapping / confirm stakeholder list	RE/JB		1/7/ 2026
June 2026	Draft focused communications and engagement plan	RE/JB	Draft to be included with Business Case	20/7/26
July 2026	Stakeholder workshops with third and statutory sector	JB/BB/RE		24/7/26

Phase 1 – Business Case Development
Purpose – build understanding and confidence in the proposed model, test assumptions and secure support for the business case
Engagement commences – July - August

Date	Event / Activity	Staff / resourcing required	Comments	Achieved by
July	Develop communications pack (programme overview, FAQs, key messages)	BB/JB		July
	Develop stakeholder narrative and key messages	Programme team		July
	Stakeholder workshops	JB		15/7/26
	Executive briefings	RE/BB		Ongoing/July
	Socialise the emerging model with strategic stakeholders	BB/JB	Key contacts – Local Authority	July
	Steering group meetings	BB/RE/FJ		Ongoing
	One -to- one conversations with key partners	BB/JB		7/8/26
	Draft business case	RE		20/7/26
	Develop governance proposals	Programme team		
	Agree communications approach for mobilisation	BB/RE		September

Phase 2 – Mobilisation and service design for neighbourhood 1				
Date	**Event / Activity**	**Staff / resourcing required**	**Comments**	**Achieved by**
Oct-Dec 2026	Partner workshops	Public Health/Programme lead	Focus of engagement: • Confirm delivery sites/neighbourhoods • Agree governance arrangements • Develop implementation timetable • Establish local implementation groups	November
	Clinical engagement with GP surgeries	Public Health/Programme lead/Primary Care lead		
	Community sector engagement	Programme lead/CVC representatives/Community partnerships lead		
	Local authority engagement	Public Health/Programme lead/Local Authority partners		
	Develop implementation plan and timeline	Public Health/Programme lead		
	Communications toolkit	Public Health/ Communications lead/Programme lead		
	Recruitment planning + commissioning structure for external elements	Public Health/ Communications lead/Programme lead		
	Brand development	Public Health/ Communications lead/Programme lead		
	Planning for launch	Public Health/ Communications lead/Programme lead		

Phase 2 – Mobilisation and service design for neighbourhood 1					
Date	**Audience**	**Engagement**	**Staff / resourcing required**	**Comments**	**Achieved by**
Oct-Dec 2026	Clusters	• Cluster meetings • Clinical workshops • Operational planning • Referral pathway design • Staff communications	Programme lead/ Primary care lead	Purpose of engagement: • Build ownership of the model • Refine service model • Agree implementation • Ensure integration • Prepare workforce	December 2026
	Primary care managers		Programme lead/ Primary care lead		
	Practice managers		Programme lead/ Primary care lead		
	Health Coaches		Programme lead/ Primary care lead		
	Community teams		Programme lead/ Primary care lead		
	People living with and beyond cancer		Programme lead/ Primary care lead		
	Carers		Programme lead/ Primary care lead		
	Underserved groups		Programme lead/ Primary care lead		
	Volunteers		Programme lead/ Primary care lead		

Phase 2 – Mobilisation and service design for neighbourhood 1					
Date	**Audience**	**Engagement**	**Staff / resourcing required**	**Comments**	**Achieved by**
Community Health & Wellbeing Workers					
Oct-Dec 2026	Communities	• Community workshops • Local listening events • Asset mapping • Co-design sessions • Community reference groups • Partnership meetings	Public Health/Programme lead/Community partnerships lead/CVC representatives/Local Authority partners	Purpose: Engagement to support operational design plus community codesign	December 2026
	Community leaders				
	Third sector				
	Local authorities				
	Community connector teams				
	Housing associations				
	Social prescribing teams				
	People living with and beyond cancer				
	Carers				
	Underserved groups				
	Volunteers				

Local neighbourhood infrastructure					
Date	**Audience**	**Engagement**	**Staff / resourcing required**	**Comments**	**Achieved by**
Oct-Dec 2026	CVCs Third sector organisations – including social enterprises, charities Town and Community Councils Community groups Volunteers Local Authorities Anchor organisations Regional Partnership Board People living with and beyond cancer Carers Underserved groups	• Partnership forums • Coproduction workshops • community conversations • mapping existing provision • grant design workshops • governance arrangements • local planning sessions	Public Health/Programme lead/Community partnerships lead/CVC representatives/Local Authority partners	Purpose: Engagement to support broader strategic and community engagement to shape investment, governance and delivery Key: Mapping of existing assets and identifying gaps to underpin investment decisions	December 2027

Phase 3 – Mobilisation and service design for neighbourhood 2				
Date	**Event / Activity**	**Staff / resourcing required**	**Comments**	**Achieved by**
Jan-Dec 2027	Partner workshops	Public Health/Programme lead	Focus of engagement: • Confirm delivery sites/neighbourhoods • Agree governance arrangements • Develop implementation timetable • Establish local implementation groups	December 2027
	Clinical engagement with GP surgeries	Public Health/Programme lead/Primary Care lead		
	Community sector engagement	Programme lead/CVC representatives/Community partnerships lead		
	Local authority engagement	Public Health/Programme lead/Local Authority partners		
	Develop implementation plan and timeline	Public Health/Programme lead		
	Communications toolkit	Public Health/ Communications lead/Programme lead		
	Recruitment planning + commissioning structure for external elements	Public Health/ Communications lead/Programme lead		
	Brand development	Public Health/ Communications lead/Programme lead		
	Planning for launch	Public Health/ Communications lead/Programme lead		

Phase 3 – Mobilisation and service design for neighbourhood 2					
Date	**Audience**	**Engagement**	**Staff / resourcing required**	**Comments**	**Achieved by**
Jan-Dec 2027	Clusters	• Cluster meetings • Clinical workshops • Operational planning • Referral pathway design • Staff communications	Programme lead/ Primary care lead	Purpose of engagement: • Build ownership of the model • Refine service model • Agree implementation • Ensure integration • Prepare workforce	December 2027
	Primary care managers		Programme lead/ Primary care lead		
	Practice managers		Programme lead/ Primary care lead		
	Health Coaches		Programme lead/ Primary care lead		
	Community teams		Programme lead/ Primary care lead		
	People living with and beyond cancer		Programme lead/ Primary care lead		
	Carers		Programme lead/ Primary care lead		
	Underserved groups		Programme lead/ Primary care lead		
	Volunteers		Programme lead/ Primary care lead		

Phase 3 – Mobilisation and service design for neighbourhood 2					
Date	**Audience**	**Engagement**	**Staff / resourcing required**	**Comments**	**Achieved by**
Community Health & Wellbeing Workers					
Jan-Dec 2027	Communities	• Community workshops • Local listening events • Asset mapping • Co-design sessions • Community reference groups • Partnership meetings	Public Health/Programme lead/Community partnerships lead/CVC representatives/Local Authority partners	Purpose: Engagement to support operational design plus community codesign	December 2027
	Community leaders				
	Third sector				
	Local authorities				
	Community connector teams				
	Housing associations				
	Social prescribing teams				
	People living with and beyond cancer				
	Carers				
	Underserved groups				
	Volunteers				

Local neighbourhood infrastructure					
Date	**Audience**	**Engagement**	**Staff / resourcing required**	**Comments**	**Achieved by**
Jan-Dec 2027	CVCs Third sector organisations – including social enterprises, charities Town and Community Councils Community groups Volunteers Local Authorities Anchor organisations Regional Partnership Board People living with and beyond cancer Carers Underserved groups	• Partnership forums • Coproduction workshops • community conversations • mapping existing provision • grant design workshops • governance arrangements • local planning sessions	Public Health/Programme lead/Community partnerships lead/CVC representatives/Local Authority partners	Purpose: Engagement to support broader strategic and community engagement to shape investment, governance and delivery Key: Mapping of existing assets and identifying gaps to underpin investment decisions	December 2027

Phase 4 – Mobilisation and service design for neighbourhood 3				
Date	**Event / Activity**	**Staff / resourcing required**	**Comments**	**Achieved by**
Jan-Dec 2028	Partner workshops	Public Health/Programme lead	Focus of engagement: • Confirm delivery sites/neighbourhoods • Agree governance arrangements • Develop implementation timetable • Establish local implementation groups	December 2028
	Clinical engagement with GP surgeries	Public Health/Programme lead/Primary Care lead		
	Community sector engagement	Programme lead/CVC representatives/Community partnerships lead		
	Local authority engagement	Public Health/Programme lead/Local Authority partners		
	Develop implementation plan and timeline	Public Health/Programme lead		
	Communications toolkit	Public Health/ Communications lead/Programme lead		
	Recruitment planning + commissioning structure for external elements	Public Health/ Communications lead/Programme lead		
	Brand development	Public Health/ Communications lead/Programme lead		
	Planning for launch	Public Health/ Communications lead/Programme lead		

Phase 4 – Mobilisation and service design for neighbourhood 3					
Date	**Audience**	**Engagement**	**Staff / resourcing required**	**Comments**	**Achieved by**
Jan-Dec 2028	Clusters	• Cluster meetings • Clinical workshops • Operational planning • Referral pathway design • Staff communications	Programme lead/ Primary care lead	Purpose of engagement: • Build ownership of the model • Refine service model • Agree implementation • Ensure integration • Prepare workforce	December 2028
	Primary care managers		Programme lead/ Primary care lead		
	Practice managers		Programme lead/ Primary care lead		
	Health Coaches		Programme lead/ Primary care lead		
	Community teams		Programme lead/ Primary care lead		
	People living with and beyond cancer		Programme lead/ Primary care lead		
	Carers		Programme lead/ Primary care lead		
	Underserved groups		Programme lead/ Primary care lead		
	Volunteers		Programme lead/ Primary care lead		

Phase 4 – Mobilisation and service design for neighbourhood 3					
Date	**Audience**	**Engagement**	**Staff / resourcing required**	**Comments**	**Achieved by**
Community Health & Wellbeing Workers					
Jan-Dec 2028	Communities	• Community workshops • Local listening events • Asset mapping • Co-design sessions • Community reference groups • Partnership meetings	Public Health/Programme lead/Community partnerships lead/CVC representatives/Local Authority partners	Purpose: Engagement to support operational design plus community codesign	December 2028
	Community leaders				
	Third sector				
	Local authorities				
	Community connector teams				
	Housing associations				
	Social prescribing teams				
	People living with and beyond cancer				
	Carers				
	Underserved groups				
	Volunteers				

Local neighbourhood infrastructure					
Date	**Audience**	**Engagement**	**Staff / resourcing required**	**Comments**	**Achieved by**
Jan-Dec 2028	CVCs Third sector organisations – including social enterprises, charities Town and Community Councils Community groups Volunteers Local Authorities Anchor organisations Regional Partnership Board People living with and beyond cancer Carers Underserved groups	• Partnership forums • Coproduction workshops • community conversations • mapping existing provision • grant design workshops • governance arrangements • local planning sessions	Public Health/Programme lead/Community partnerships lead/CVC representatives/Local Authority partners	Purpose: Engagement to support broader strategic and community engagement to shape investment, governance and delivery Key: Mapping of existing assets and identifying gaps to underpin investment decisions	December 2028

Phase 5 – Public launch & communications October 2026 – September 2031 Key: Neighbourhood 1 (N1), Neighbourhood 2 (N2), Neighbourhood 3 (N3)				
Date	**Event / Activity**	**Staff / resourcing required**	**Comments**	**Achieved by**
Jan 2027 – N1 Jan 2028 – N2 Jan 2029 – N3	Communications preparation and stakeholder engagement	Public Health/Programme lead/Communication lead/Partnership development lead	Key activities to include: • develop partner communications toolkit • stakeholder briefing pack • elected member briefing • community information materials • website resources (key messages, FAQs, downloadable materials)	Jan 2027 – N1 Jan 2028 – N2 Jan 2029 – N3
	Launch and awareness raising		Key activities to include: • launch event with partners • press releases • local media campaign • social media launch activity • videos – (launch/promotional content)	
	Ongoing engagement		Key activities to include: • website (ongoing programme information and updates) • social media (ongoing updates engagement and amplification) • case studies and staff stories • partner communications toolkit (ongoing use and updates)	

Evidence reviews and literature synthesis

Scoping searches on health coaching and community health and wellbeing workers (CHWWs)

Two scoping searches were undertaken by a librarian in May 2026 to support preliminary work for this proposal.

HEALTH COACHING

A search of the internet identified the NHS England *Workforce Development Framework for Health and Wellbeing Coaches*, which contains potentially relevant references. Additional searches were conducted in Epistemonikos (a database of systematic reviews), the Health Management Information Consortium (HMIC), and MEDLINE. In total, one hundred and eight references were identified.

NHS England (2023) *Workforce development framework for health and wellbeing coaches*. London: NHS England. Available at: https://www.england.nhs.uk/long-read/workforce-development-framework-for-health-and-wellbeing-coaches/ (Accessed: May 2026).

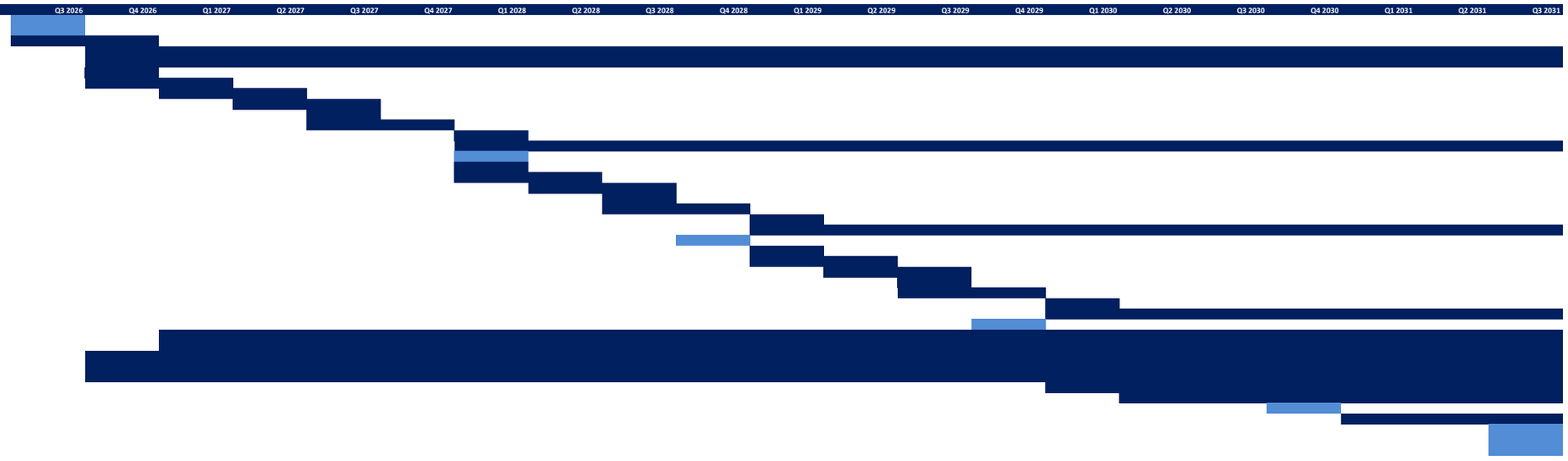
COMMUNITY HEALTH AND WELLBEING WORKERS (CHWWs)

A search of the internet exploring links between CHWWs and deprivation retrieved several relevant papers. This was followed by a search of the Health Management Information Consortium (HMIC), which identified a further three papers. Further searches were undertaken in the MEDLINE and Embase databases, identifying further studies; however, the majority were conducted outside the United Kingdom. MEDLINE uses a broad definition of community health workers, whereas Embase lacks a specific subject heading; therefore, the following phrase search was employed to help define CHWWs:

A total of two hundred and seventy-one references were identified.

Macmillan Neighbourhood Prevention Programme

Workstream	Owner	Dependency	RAG
Board Approval	SRO/Board	-	
Macmillan Approval	SRO/Macmillan	-	
Funding Agreement	SRO	Approvals	
Programme Board	SRO	Funding	
Governance Reporting	PMO	Programme Board	
Staff Training	PMO	Funding	
N1 CHWW Specification	Public Health	Funding	
N1 Market Engagement	Procurement	Specification	
N1 Tender	Procurement	Engagement	
N1 Contract Award	Board	Tender	
N1 Provider Mobilisation	Provider	Award	
N1 Go Live	PMO	Mobilisation	
N1 Delivery	PMO	Go Live	
Gateway 1	Board	N1 Evaluation	
N2 Specification Refresh	Public Health	Gateway 1	
N2 Market Engagement	PMO	Spec	
N2 Tender	Procurement	Engagement	
N2 Contract Award	Board	Tender	
N2 Staff Training	Provider	Award	
N2 Go Live	PMO	Mobilisation	
N2 Delivery	PMO	Go Live	
Gateway 2	Public Health	N2 Evaluation	
N3 Specification Refresh	Public Health	Gateway 2	
N3 Market Engagement	Procurement	Spec	
N3 Tender	Procurement	Engagement	
N3 Contract Award	Board	Tender	
N3 Staff Training	Provider	Award	
N3 Go Live	PMO	Mobilisation	
N3 Delivery	PMO	Go Live	
Gateway 3	Public Health	Full Review	
Health Coaching	Public Health	Mobilisation	
Community Infrastructure	Partners	Mobilisation	
Digital Enablement	Digital	Mobilisation	
MECC	Public Health	Mobilisation	
Communications & Engagement	Comms	Mobilisation	
Benefits Realisation	TriTech	N3 Live	
Sustainability Planning	Executive	Gateway 3	
Gateway 4	Public Health	Commissioning Readiness	
Commissioning Business Case	Executive	Gateway 4	
Final Evaluation	TriTech	Gateway 4	
Commissioning Decision	Board	Final Evaluation	
Programme Closure	PMO	Decision	



THIS AGREEMENT is made on

BETWEEN:

(1) **MACMILLAN CANCER SUPPORT,** a charity registered in England and Wales (registration number 261017), Scotland (registration number SC039907) and the Isle of Man (registration number 604), and a company limited by guarantee with registered number 02400969 whose registered office is 3rd Floor, Bronze Building, The Forge, 105 Sumner Street, London, SE1 9HZ (the **Investor**); and

(2) **[HEALTH AND SOCIAL CARE TRUSTS, HSCT]** a statutory NHS organisation whose registered office is NHS [ ] (the **Commissioner**);

(the **parties**, each a **party**).

WHEREAS

(A) The Investor has a long history of providing transformational support for health and social care. It now wishes to undertake social investments to assist and support organisations that are seeking to shift care closer to home and to work with partners to develop a social investment programme that will act as a tool for sustainable transformation in neighbourhoods.

(B) The Commissioner is the statutory NHS body responsible for the provision of primary, community, mental health and acute hospital services to meet the needs of the # million people living in [geography].

(C) The Investor and the Commissioner wish to work together and enter into a social impact outcome funding agreement ("Agreement") in relation to the provision of certain neighbourhood transformation services in accordance with the terms of this Agreement.

IT IS AGREED as follows:

1. Definitions and Interpretation

Conditions Precedent	means the conditions listed in clause 5.1;
Data Protection Legislation	means the Data Protection Act 2018, the UK General Data Protection Regulation, and all applicable laws and regulations relating to the processing of personal data and privacy and any regulations or secondary legislation made thereunder, in each case as amended or replaced from time to time;
Funded Programme Period	means the Funding Start Date to the Funding End Date;
Funding	means the funding of up to £10,000,000 to cover the Programme Costs over the Funded Programme Period that will be provided by the Investor to the Commissioner in accordance with this Agreement;
Funding End Date	Means 31st December 2028;

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Funding Instalment	shall be as defined in clause 4;
Funding Period	means each funding period set out in clause 4.1;
Funding Start Date	means 1st January 2026;
Improvement Plan	shall be as defined in clause 10;
Key Performance Indicators	means the schedule attached at Appendix 2 that sets out the Key Performance Indicators and quality markers required for the Service to be evaluated, including frequency and format in which such information is required;
Operational Group	means the working group that will be established for the Programme comprising representatives of the Investor, the Commissioner and the Service Providers;
Outcomes	means the outcomes achieved from the Service;
Outcomes Methodology	means the methodology for calculating Outcomes Payments set out in Appendix 1;
Outcomes Payment	means any outcomes payment that may be payable by the Commissioner to the Investor as calculated in accordance with the Outcomes Methodology and as defined in Appendix 1;
Outcomes Period	means each of the periods as detailed in clause 7.7, the last of which ends on the date which is twelve (12) months after the end of the Funded Programme Period;
Programme	means the programme to promote and deliver the Service over the Funded Programme Period;
Programme Board	means the board that will be established for the Programme comprising accountable representatives from the Commissioner, the Investor and the Service Providers;
Programme Budget	means the detailed budget for each year of the Programme set out in Appendix 3 that totals £10,000,000 and includes all the anticipated costs required to promote and deliver the Service in accordance with the Service Specification and this Agreement;
Programme Costs	means the actual costs required to promote and deliver the Service in accordance with the Service Specification and this Agreement;
Programme Milestones	means the milestones for the Programme set out in Appendix 4;

Qualifying Service Patient	Shall be defined in Appendix 1:
Service	means the proposed service known as the [ ] that aims to [reduce the number of Unplanned Bed Days] for the Target Cohort by implementing a new integrated model for […] in [geography].
Service Agreement	means the contract variation letter and the relevant standard NHS contract, to be signed, prior to service commencement, between the Commissioner and the Service Provider whereby the Service Provider agrees to provide the Service;
Service Patient	means each person in the Target Cohort who uses the Service during the Funded Programme Period;
Service Provider	means […] whose registered office is […];
Service Specification	means the specification for the Service attached at Appendix 5;
Shared Aims	means the matters set out in clause 2;
Target Cohort	means those aged 18 and […] in the geographical area covered by the Commissioner;
[Unplanned Hospital Bed Day	means as defined in Appendix 6].

1.1. In this Agreement, unless otherwise specified:

1.1.1. references to clauses, subclauses, paragraphs and subparagraphs are to clauses, subclauses, paragraphs and subparagraphs of this Agreement;
1.1.2. a reference to any statute or statutory provision shall be construed as a reference to the same as it may have been, or may from time to time be, amended, modified or reenacted;
1.1.3. any reference to a day (including within the phrase working day) shall mean a period of 24 hours running from midnight to midnight;
1.1.4. a reference to any other document referred to in this Agreement is a reference to that other document as amended, restated, varied, novated or supplemented from time to time; and
1.1.5. the expressions “including”, “includes” and “include” have the meaning as if followed by “without limitation”.

1.2. All headings and titles are inserted for convenience only. They are to be ignored in the interpretation of this Agreement.

2. Shared Aims

2.1. The purpose of this Agreement is to provide a common basis for all parties to implement the Programme in a manner that best ensures the intended outcomes

are achieved, as well as to provide for the management and coordination of any remedies or disputes that may arise.

2.2. The parties agree that their aims for the Programme include:

2.2.1. demonstrating the system benefit delivered by the Programme such that the NHS or another appropriate body takes on the funding of the Programme to enable it to continue beyond the end of the Funded Programme Period; and

2.2.2. ensuring that everyone in the Target Cohort has the opportunity to benefit from the Service and that no-one within the Target Cohort will be discriminated against when using the Service, including on grounds of gender, race, disability, age, sexual orientation, religion, belief, gender reassignment, pregnancy, maternity or marital or civil partnership status.

2.3. The parties agree that the successful implementation of the Programme will depend on the ability of the Investor and Commissioner effectively to co-ordinate and combine their expertise, manpower and resources in order to deliver an integrated approach to service provision. To this end, the parties agree to develop a close working relationship between each other at all appropriate levels, based upon openness and trust in a transparent information and data sharing environment. The Commissioner shall ensure that the Service Provider is compliant with this provision.

3. Commissioner Undertakings

3.1. Recognising the interdependencies between this Agreement, the Service Specification, Service Agreement, Programme Budget and the Shared Aims, the Commissioner warrants and undertakes throughout the term of this Agreement:

3.1.1. that the Service Specification and Service Agreement is fit for purpose and consistent with the Commissioner's requirements for delivery according to the agreed business case for the Service;

3.1.2. that the Service Specification and Service Agreement is fully consistent and does not conflict with the terms of this Agreement;

3.1.3. that the Programme Budget contains all the anticipated costs required to promote and deliver the Service in accordance with the Service Specification and this Agreement;

3.1.4. that the Commissioner, Service Provider and Investor have the appropriate information governance and sharing agreements in place to enable the Investor and the Commissioner to monitor Outcomes and the Key Performance Indicators in accordance with this Agreement;

3.1.5. that the Funding will be used solely to pay for Programme Costs in accordance with the Programme Budget over the Funded Programme Period and not for any other purpose;

3.1.6. not to amend the Service Agreement, Service Specification, Service Agreement or Programme Budget without the Investor's prior written approval, and to make any request to make any such amendment to the Investor in reasonable time (and at least 30 days) before the proposed amendment would come into effect; and

3.1.7. that it has the power to enter into, deliver and perform this Agreement and the transactions contemplated by it, and it has obtained all authorisations necessary to enable it to enter into and comply with this Agreement.

3.2. The Commissioner further warrants and undertakes that it will, and will procure that the Service Provider will:

3.2.1. promote proactively and monitor referrals into the Service, taking appropriate action to increase referrals as necessary;
3.2.2. make a meaningful contribution to the pre-marketing and marketing of the Service to enable relevant stakeholders (e.g. GPs/Out of Hours services) to engage with the Programme;
3.2.3. keep, and ensure that relevant parties keep, full, true and accurate records relating to the Programme, Outcomes and referrals and ensure that the Investor is given sufficient information from such records to enable the Investor to perform their roles and exercise their rights under this Agreement;
3.2.4. comply with all applicable laws in relation to the Programme and to comply with anti-bribery, corruption and tax evasion laws and codes, including adopting and enforcing appropriate policies and procedures to prevent anti-bribery, corruption and tax evasion in accordance with relevant legislation and government guidance;
3.2.5. ensure that the information regarding the Programme provided to the Investor is complete, true and accurate, and not misleading in any material respect.

4. Funding

4.1. Subject to the Conditions Precedent being satisfied and remaining satisfied on the first date of each Funding Period, and subject to the provisions of this clause 4 and clause 7.9, the Investor will provide the Funding to the Commissioner for the following periods in instalments (each a **Funding Instalment**). The actual amount of each Funding Instalment will be calculated in accordance with the rest of this clause 4, the following amounts are indicative only and amounts calculated in accordance with clause 4.2 shall prevail:

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Funding Period (dates inclusive)	Indicative Amount
1 January 2026 – 31 March 2026	£833,337
1 April 2026 – 30 June 2026	£833,333
1 July 2026 – 30 September 2026	£833,333
1 October 2026 – 31 December 2026	£833,333
1 January 2027 – 31 March 2027	£833,333
1 April 2027 – 30 June 2027	£833,333
1 July 2027 – 30 September 2027	£833,333
1 October 2027 – 31 December 2027	£833,333
1 January 2028 – 31 March 2028	£833,333
1 April 2028 – 30 June 2028	£833,333
1 July 2028 – 30 September 2028	£833,333
1 October 2028 – 30 December 2028	£833,333

4.2. Within 30 days of the end of each Funding Period, the Commissioner will:

4.2.1. submit a statement of costs to the Investor to show a breakdown of the Programme Costs that it and / or the Service Provider has incurred in respect of such period (**relevant costs**); and

4.2.2. notify the Investor of the amount of the relevant Funding Instalment, being the amount of the relevant costs, all in a form satisfactory to the Investor.

4.3. Also, within 30 days of the end of each Funding Period, the Commissioner will send the Investor a valid invoice for the Funding Instalment. Subject to clause 5, the Investor will then pay such amount to the Commissioner within 30 days of receipt.

4.4. In the event that any statement of costs submitted under clause 4.2 indicates that not all the Funding is required or that more funding is required to deliver the Programme, the Investor and the Commissioner will work together to agree whether the amount of the Funding and future Funding Instalments should be amended accordingly.

4.5. No amendment to the amount of the Funding may be made without the Investor's prior written approval.

4.6. In the event that the Commissioner wishes the Service Provider to continue to provide the Service after the Funding End Date, the parties will work collaboratively to consider options for further funding. The aim would be for such options to be considered in principle by the date which is six (6) months prior to the Funding End Date. For the avoidance of doubt, nothing in this Agreement obliges the Investor to provide further funding or payments in addition to the Funding, including for any overspend or additional costs incurred by the Commissioner or to make up any shortfall in funding from elsewhere.

5. Conditions Precedent

5.1. The Investor shall not be obliged to provide any Funding Instalment to the Commissioner unless:

5.1.1. the Investor has agreed the Service Specification and the Service Agreement;
5.1.2. The Investor has received appropriate confirmation from the Service Provider that they are aware of the Investor's role in relation to the Programme and they will give due consideration to the Investor's views;
5.1.3. any Improvement Plan has been implemented and adhered to by the Service Provider within 28 days of being agreed;
5.1.4. the applicable Programme Milestones have been met or, failing which, the parties have agreed in writing that achievement was near enough and/or to amend one or more of such milestones, in which case any withheld Funding Instalment will be paid once the applicable Programme Milestone(s) are achieved;
5.1.5. there is no unremedied breach of any of the Commissioner's warranties, undertakings or other obligations under this Agreement;
5.1.6. there is no unremedied breach of any of the Service Provider's warranties, undertakings or other obligations under the Service Agreement;
5.1.7. there is currently outstanding no investigation or inadequate rating from the Care Quality Commission in respect of the Service;
5.1.8. the Commissioner has provided the Investor with a breakdown of the total Programme Costs that it has incurred in relation to the Service in respect of the relevant Funding Period; and
5.1.9. the Investor has received a valid invoice from the Commissioner for the Funding Instalment in accordance with this Agreement.

5.2. In the event that any or all of the Conditions Precedent are not met, the Investor may, in its absolute discretion, withhold or reduce any Funding Instalments that have not yet been provided to the Commissioner. The Investor will inform the Commissioner as soon as reasonably practicable if it is aware this step is being considered so the Commissioner has an opportunity to remedy the issue.

6. Outcomes Reporting

6.1. The Commissioner will, and will procure that the Service Provider will:

6.1.1 monitor the Outcomes and Key Performance Indicators as set out in Appendix 2 on a monthly basis, including through the use of a dashboard that will be built and operated by the Commissioner;
6.1.2 provide, and will ensure that the Service Provider provide, to the Commissioner the necessary data for the dashboard using the Reporting Schedule within two months of the month end unless otherwise specified in the Reporting Schedule. The Commissioner will collate and analyse such data and share reports on a monthly basis with relevant stakeholder groups including the Programme Board and Operational Group to assist in the performance management of the Programme;

6.1.3 ensure the data provided to the Commissioner is as accurate as possible, and will further ensure that any additional metrics or case studies as may be agreed are provided on a timely basis to evaluate impact and support service development and learning;

6.1.4 be responsible for reporting on Outcomes and the Key Performance Indicators.

6.2. Subject to clauses 14 (Publicity) and 16 (Data Sharing), the Investor will be entitled to disclose the information it receives in relation to Outcomes to an independent validator appointed by the Investor to ascertain whether (i) the relevant outcomes have been recorded accurately; and/or (ii) the quality of evidence is sufficient for reasonable certainty that the relevant outcome has been achieved.

7. Payment Dependent on Outcomes

7.1 Subject to clause 7.3 and clause 12 (term and termination), the Commissioner will make payments to the Investor solely on the basis of Outcomes. For the avoidance of doubt, the total amount of Outcomes Payments payable to the Investor will not exceed the total amount of Funding received by the Commissioner under this Agreement.

7.2 In respect of each Outcomes Period, based on the data provided under this Agreement, the Commissioner will calculate in accordance with the Outcomes Methodology the amount of any Outcomes Payment that may be due. Investor will be entitled to check the amount of any Outcomes Payment and request clarification or verification, if necessary, provided that if the Investor does not query such amount within 30 days of being notified by the Commissioner, the amount will be deemed to be agreed.

7.3 In respect of each of the first [six] Outcomes Periods, the total Outcomes Payments payable by the Commissioner to the Investor will be restricted to an amount equal to the total Funding provided by the Investor for the same period (See Appendix 1 Outcomes Methodology)

That is provided that any Outcomes Payment due in excess of this amount (the **Excess**) will only be payable to the Investor in the event that the sum of all the restricted Outcomes Payments payable to the Investor in respect of the first [six] Outcomes Periods is less than the sum of the total Funding for the same periods provided by the Investor under this Agreement (the shortfall being the **Initial Shortfall**).

In such event, the Investor will submit after the end of the first [six] Outcomes Periods an invoice from the Investor for an amount which is the lesser of the amount of the accumulated Excess and the amount of the Initial Shortfall and the Commissioner will pay such amount within 30 days of issue.

7.4 If, following payment to the Investor of part or all of the Excess under clause 7.3, the amount paid by the Commissioner to the Investor is still less than the total Funding provided by the Investor under this Agreement (the **Continuing Shortfall**), two further Outcomes Payments will be payable by the Commissioner in respect of the two final Outcomes Periods. Such payments will be restricted to the amount required to enable the Investor to recover such Continuing Shortfall.
Service Patients for whom outcomes are calculated, will only include those who use

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the service during the Funded Programme Period who die during the two final Outcome Periods.

7.5 The Investor will be entitled to check the data provided under this Agreement and request clarification or verification from the Commissioner, if necessary, provided that if the Investor does not query such data within 30 days of receipt, it will be deemed to be agreed.

7.6 Following the Commissioner's calculation of an Outcomes Payment under clause 7.2, the Investor will submit an invoice for the amount payable by the Commissioner and the Commissioner will pay such amount within 30 days of issue.

7.7 The anticipated invoice and payment timetable is as follows:

Outcomes Period (inclusive)	Investor invoice	Commissioner payment
1 January 2026 – 30 June 2026	30 September 2026	31 October 2026
1 July 2026 – 31 December 2026	31 March 2027	30 April 2027
1 January 2027 – 30 June 2027	30 September 2027	31 October 2027
1 July 2027 – 31 December 2027	31 March 2028	30 April 2028
1 January 2028 – 30 June 2028	30 September 2028	31 October 2028
1 July 2028 – 31 December 2028	31 March 2029	30 April 2029
*1 January 2025 – 31 December 2028	31 March 2020	30 April 2029
**1 January 2028 – 30 June 2029	30 September 2029	31 October 2029
**1 July 2029 – 31 December 2029	31 March 2030	30 April 2030

*Applicable where there is Excess to repay Initial Shortfall (clause 7.3)
**Applicable where there is a Continuing Shortfall (clause 7.4)

7.8 In the event that any party considers that the Outcomes Methodology no longer remains appropriate and/or it proves not possible accurately to measure the outcomes required to calculate the Outcomes Payments, it will notify the other parties in writing. Such notification will include the reasons for its views and, if appropriate, propose an alternative methodology. Each of the other parties will respond to such notice within fourteen (14) days of receipt stating whether or not it agrees. If any party does not agree, the parties will promptly enter into good faith discussions with a view to agreeing an amended Outcomes Methodology or proposing and agreeing an alternative suitable proxy for reduced healthcare expenditure based on changes in activity.

7.9 If no amendment to the Outcome Methodology or alternative suitable proxy can be agreed within thirty (30) days of one party giving notice to the others under clause 7.8 such that this Agreement can no longer be based on Outcomes, the repayment mechanism will default to a fixed repayment to the Investor and the Investor will not be required to provide any further Funding to the Commissioner. Such repayment will total an amount equal to the total Funding provided to the Commissioner by the Investor from the Funding Start Date to the date of repayment less the sum of all Outcomes Payments received by the Investor up until the date of repayment. The Commissioner will make

such payment in equal quarterly instalments over the period remaining until the Funding End Date.

7.10 No amendment to the Outcomes Methodology may be made without the Investor's nor the Commissioner's prior written approval.

8 Arrangements beyond the final Outcomes Period

8.1 In the event that, at the end of the final Outcomes Period and after the Investor has received any amounts from the Commissioner that may be due under clauses 7.3 and 7.4 to recover any Initial Shortfall and Continuing Shortfall, the total amount of Outcomes Payments paid to the Investor for all the Outcomes Periods is still less than the total Funding provided by the Investor to the Commissioner (the shortfall being the **Final Shortfall**), and if the Service is continued beyond the end of the Funded Programme Period, this Agreement will be automatically varied to enable the Commissioner to make further payments to the Investor until either the Investor has recovered the Final Shortfall or the date which is two (2) years after the end of the Funded Programme Period (whichever is the sooner). Such payments will be calculated in accordance with the Outcomes Methodology and at a rate to be reasonably approved by the Investor provided that, before making any such payments, the Commissioner will be entitled to deduct the costs paid to the Service Provider for providing the Service during such extension period (to the extent that evidence of which is provided to the Investor). Service Patients for whom outcomes are calculated, are those who use the service and die in the Final Shortfall Outcomes Period.

Final Shortfall Outcomes Period (inclusive)	**Investor invoice**	**Commissioner payment**
1 January 2029 – 31 December 2029	31 March 2029	30 April 2029
1 January 2030 – 31 December 2030	31 March 2031	30 April 2031

9. Programme Governance

9.1 A structure of Programme Board and Operational Group has been agreed to ensure sufficient oversight and support for the Programme from the Investor, the Commissioner and the Service Provider. The Terms of Reference (ToR) for each will be agreed in accordance with the Programme Milestones.

9.2 The Programme Board will provide strategic oversight and have ultimate accountability for the Programme and be a point of escalation and support for the Operational Group. It will meet bi-monthly for the first 6 months and then quarterly to discuss the Programme. Such discussions will include:

9.2.1 the performance of the Programme;
9.2.2 approving and reviewing annual development plans and budgets for the Programme prepared by the Operational Group;
9.2.3 opportunities to improve collaboration between the parties and the Service Provider;
9.2.4 opportunities to improve promotion and delivery of the Service and achieve better outcomes for Service users;

9.2.5 the quality and nature of information provided by the Commissioner;
9.2.6 assistance with resolving any disputes between the Commissioner and the Investor;
9.2.7 learning, to enable knowledge sharing across the system and wider end of life care community.

9.3 The Operational Group will oversee the operational management of the Programme and report to the Programme Board. It will meet monthly (unless otherwise agreed), make recommendations on operational issues, take forward any recommendations or actions on operational issues required by the Programme Board and report on progress against actions to the Programme Board, highlighting risks, issues and mitigations as required.

10 Improvement Plan

10.1 In the event of failure by the Service Provider to meet one or more of the Key Performance Indicators or Programme Milestones, or if the Investor considers for any other reason that the performance of the Service Provider in providing the Service or the quality of information reported by the Service Provider is inadequate, the Commissioner will procure that the Service Provider will work with the Operational Group to agree a plan to improve performance and/or the quality of information (the **Improvement Plan**). The Commissioner will procure that the Service Provider implements and adheres to the Improvement Plan within 28 days of such agreement.

10.2 The Improvement Plan will be approved, reviewed and amended, if necessary, at subsequent meetings of the Programme Board.

10.3 The Investor and the Commissioner will, and the Commissioner will procure that the Service Provider will, provide at least 7 days before any meeting all information that it reasonably believes to be relevant and any other information reasonably requested by another party to inform the process and discussion.

10.4 The Commissioner will, and will procure that the Service Provider will, attend and co-operate with any and all Programme Board, Operational Group and other meetings held pursuant to this Agreement.

10.5 For the avoidance of doubt, the processes set out in clauses 9 and 10 shall be separate and in addition to any performance review processes set out in the Service Specification and Service Agreement, and are without prejudice to any other rights that the Investor may have in relation to this Agreement.

11 General Assistance

11.1 The Investor and the Commissioner each undertake to work with each other, and the Commissioner undertakes to procure that the Service Provider works with the Investor and the Commissioner, to ensure that the Service optimises positive impact on patient care and value to the health and care system, including, but not limited to, looking for the Service to develop over time to respond to:

11.1.1 best clinical and operational practice;

11.1.2 learning from operations and impact over time;
11.1.3 changes in other parts of the local health and care system and enhanced scope for integration; and
11.1.4 challenges in the delivery of the Service and anticipated impact or savings.

11.2 The Investor and the Commissioner will, and the Commissioner will procure that the Service Provider will, immediately disclose to each other any matter or information that may have a material impact on the Programme.

12 Term and Termination

12.1 Unless terminated earlier or extended in accordance with its terms, and without prejudice to clause 7, this Agreement will terminate six (6) months after the end of the final Outcomes Period.

12.2 The Investor or the Commissioner may terminate this Agreement on giving not less than six (6) months' written notice to the other parties provided that if mutually agreed between the parties the notice period may be less than six (6) months.

12.3 This Agreement will automatically terminate in the event that the Commissioner ceases to commission the Service from the Service Provider. In the event that the Commissioner ceases to commission a substantial part (but not all) of the Service from the Service Provider, it will immediately notify the Investor and the Investor will have the right to terminate this Agreement with immediate effect by giving written notice to the other parties.

12.4 The Investor may terminate this Agreement with immediate effect by giving written notice to the other parties if the Commissioner or Service Provider:

12.4.1 commits any act which results in the Investor being brought into disrepute, or breaching any of its charitable objects or social investment duties;
12.4.2 transfers to another person, suspends (or threatens to suspend) or ceases (or threatens to cease) to carry on, all or a substantial part of its operations; or
12.4.3 takes any action or has any action taken in relation to it in connection with its entering administration, insolvency processes, provisional liquidation or any composition or arrangement with its creditors, or has a receiver appointed to any of its assets.

12.5 Termination of this Agreement shall be without prejudice to any accrued rights or obligations of the parties. Upon termination of this Agreement for any reason, the Commissioner will immediately pay any Outcomes Payments or other amounts that may be outstanding, including any Outcomes Payments and other amounts that may have accrued but remain unpaid as at the date of termination.

12.6 The parties' rights and obligations with regard to information sharing and confidentiality shall survive any termination of this Agreement for a period of five (5) years.

13 Disputes

13.1 The parties will each use reasonable endeavours to resolve any dispute that arises under this Agreement through a prompt, good faith discussion at a managerial level appropriate to the dispute in question.

13.2 In the event that a dispute is not resolved within five (5) days of it having been referred to a managerial level for discussion then any party may refer the dispute for resolution to an executive lead of each party with sufficient authority to make a decision on its behalf. Such executive leads will meet for discussion within ten (10) days or at a time that the parties agree as soon after as possible.

13.3 If the dispute is not resolved within ten (10) days of escalation to executive leads, the parties will apply for mediation at the Centre for Effective Dispute Resolution (CEDR) and will use their reasonable endeavours to conclude any such mediation as soon as possible.

14 Publicity and learning

14.1 The parties will agree together all publicity and press announcements in relation to the Programme and this Agreement and will not make any such publicity or press announcements without the other parties' agreement. Such announcements shall include any naming/badging of the Service and/or publicising the names of any professionals working in the Service.

14.2 The parties acknowledge that an important aim of the Programme and this Agreement is to share learning and will seek to be open and share learning by mutual consent where appropriate. The Investor will be entitled to use learning from the Programme and this Agreement in relation to other end of life care or health related services.

15 Contract variations

15.1 Any party may request in writing to the other parties an amendment to this Agreement. The other parties shall be required to respond to such request within 30 days of receipt by setting out their comments on the requested amendment including on cost, feasibility, other implications and why, if applicable, it does not accept such amendment request. No party is obliged to agree any amendment to this Agreement.

15.2 Amendments to this Agreement will only be effective if in writing and signed by the authorised representatives of the Investor and Commissioner.

16 Data sharing

16.1 The parties will comply with all applicable requirements of the Data Protection Legislation. This clause 16 is in addition to, and does not relieve, remove or replace, a party's obligations under the Data Protection Legislation.

16.2 The parties acknowledge that for the purposes of the Data Protection Legislation, the Investor is not the processor or controller of any personal data processed in the course of the Programme, unless otherwise agreed in writing.

16.3 If the Investor and the Commissioner agree there is a need to share personal data with the Investor, the relevant parties will enter into a separate data sharing agreement.

17 Freedom of Information

17.1 The parties acknowledge that the Commissioner may be subject to the requirements of the Freedom of Information Act 2000 ("FOIA") and the Environmental Information Regulations 2004. The Investor will assist and co-operate with the Commissioner to enable the Commissioner to comply with any relevant information request.

17.2 The Commissioner will be responsible for determining at its absolute discretion whether commercially sensitive information and/or any other information:

17.2.1 is exempt from disclosure in accordance with the provisions of the FOIA or the Environmental Information Regulations 2004;
17.2.2 should be disclosed in response to an information request; and
17.2.3 in no event shall the Investor respond directly to an information request unless expressly authorised to do so by the Commissioner.

17.3 The parties acknowledge that the Commissioner may, acting in accordance with regulations under FOIA or the Environmental Information Regulations, disclose information:

17.3.1 without consulting with the other parties; or
17.3.2 following consultation with the other parties having taken their views into account.

17.4 The Investor will ensure that all information produced by it in the course of this collaboration is retained for disclosure for a period of six years after this Agreement is terminated. The Investor will permit the Commissioner to inspect on reasonable notice such relevant records as it may reasonably request from time to time.

17.5 The Investor acknowledges that any lists or schedules provided by it defining confidential information are of indicative value only. The Commissioner may nevertheless be obliged to disclose confidential information to meet statutory, legal, or parliamentary obligations.

18 Outcomes Records

18.1 The parties are committed to gaining a deep understanding of impact at an individual patient level to inform both service development and wider learning.

18.2 In accordance with the Programme Milestones, the Commissioner will procure that the Service Provider will undertake clinical reviews of random selections of patients who have been accepted into and supported by the Service and share these findings with the Programme Board and Operational Group.

19 Force Majeure

19.1 If any party acting in good faith, reasonably determines that, as a consequence of an act of God, governmental act, war, Covid-19 or other pandemic, epidemic, strike, national or local lockdown, the Service cannot operate as anticipated and/or the Investor cannot provide the Funding, it will notify the other parties whereupon the parties will consider in good faith other means of enabling the Programme or Funding to continue and the Investor will endeavour to continue to provide the support, however they will not be obliged to do so. In such event, any party will be entitled to request a variation to this Agreement and the terms of clause 15 (contract variations) shall apply.

20 Confidentiality

20.1 The terms of this Agreement are confidential and, except as required by law or as permitted in this Agreement, no party shall be entitled to disclose such terms to any other person except their professional advisers without the express prior written consent of the other parties.

21 Liability

21.1 As between the parties, the parties agree that the Commissioner is solely responsible for the Programme. Subject to clause 21.3, the Investor shall not be required to pay more than the total Funding, and the Investor does not accept liability for any consequences, whether direct or indirect, that may arise in connection with the Programme or otherwise from the use or withdrawal of any Funding or for any liability arising out of the acts or omissions of any person involved in the Programme (including without limitation the Commissioner and the Service Provider). The Commissioner shall ensure that the Service provider has appropriate insurance and indemnity arrangements in place and shall indemnify the Investor against any liability incurred by the Investor as a result of any claim against the Investor by the Service Provider.

21.2 Subject to clause 21.3, no party will be liable to another party for any loss of profits (other than, for the avoidance of doubt, the payment of Outcome Payments), loss of use, loss of production, increased operating costs, loss of business, loss of business opportunity, or goodwill or any other consequential or indirect loss of any nature, in connection with this agreement whether arising in tort or on any other basis

21.3 Nothing in this Agreement shall exclude or restrict the liability of any party:

21.3.1 for death or personal injury resulting from its negligence;
21.3.2 for fraud or fraudulent misrepresentation; or
21.3.3 in any other circumstances where liability may not be limited or excluded under any applicable law.

22 No Waiver

22.1 Any failure to exercise or delay by a party in exercising a right or remedy arising in connection with this Agreement or by law shall not constitute a waiver of such right or remedy or of any other rights or remedies. No waiver shall be effective unless

in writing and signed by the relevant party or on its behalf by a duly authorised representative. A waiver of a right or remedy on one occasion shall not constitute a waiver of the same right or remedy in the future.

23 No Partnership

23.1 Nothing in this Agreement shall be:

23.1.1 deemed to constitute a partnership, joint venture, representative or agency relationship between the parties; (or between the parties and the Service Provider); or

23.1.2 construed or have effect as constituting any relationship of employer and employee between the parties (or between the parties and the Service Provider).

23.2 No party shall have the authority to bind or pledge the credit of, or oblige another party in any way without obtaining such other party's prior written consent.

24 Notices

24.1 The contact details for the parties are:

The Investor:	Macmillan Cancer Support 3rd Floor, Bronze Building, The Forge, 105 Sumner Street, London, SE1 9HZ For the attention of: Steven McIntosh, Chief Partnership Officer Tel: 07875724088 Email:smcintosh@macmillan.org.uk For the attention of: Head of Legal Email: legalenquiries@macmillan.org.uk
The Commissioner:	[…] […] For the attention of: […] Tel:[...] Email: […]

24.2 All notifications and other communications under this Agreement will be in writing (which includes email).

24.3 Any party may change its contact details by notice to the other parties. Such change of contact details shall take effect five (5) days after they have been notified to the other parties.

24.4 Any notice or communication shall be deemed to have been received:

24.4.1 if delivered by hand, on signature of a delivery receipt or at the time the notice or communication is left at the proper address;

24.4.2 if sent by pre-paid first-class post or other next day delivery service, at 9.00 am on the second business day after posting or at the time recorded by the delivery service if earlier;

24.4.3 if sent by email, on the day of transmission if sent before 4.00 pm on the day of transmission (if a business day) or if not at 9.00 am on the next business day after transmission.

25 Assignment

25.1 No party may assign, novate or otherwise transfer its rights and liabilities under this Agreement without the consent of the other parties, not to be unreasonably withheld.

26 Miscellaneous

26.1 No one other than a party to this Agreement, their successors and permitted assignees, shall have any right to enforce any of its terms.

26.2 This Agreement constitutes the entire agreement between the parties in respect of the Programme and the Service and supersedes and extinguishes all previous agreements, promises, assurances, warranties, representations and understandings between them, whether written or oral, relating to its subject matter.

26.3 This Agreement may be executed in any number of counterparts, each of which when executed and delivered shall constitute a duplicate original, but all the counterparts shall together constitute the one agreement.

26.4 This Agreement and any dispute or claim (including non-contractual disputes or claims) arising out of or in connection with it or its subject matter or formation shall be governed by and construed in accordance with the law of England and Wales.

26.5 Each party irrevocably agrees that the courts of England and Wales shall have exclusive jurisdiction to settle any dispute or claim (including non-contractual disputes or claims) arising out of or in connection with this Agreement or its subject matter or formation.

Macmillan Confidential

This Agreement has been entered into by the following duly authorised representatives of the parties on the date stated at the beginning of it.

Signed by
for and on behalf of
MACMILLAN CANCER SUPPORT ……..

Signed by
for and on behalf of
NHS […] ……

Macmillan Confidential

APPENDIX 1 - Outcomes Methodology

APPENDIX 2 - Key Performance Indicators

APPENDIX 3 - Programme Budget

APPENDIX 4 - Programme Milestones

APPENDIX 5 - Service Specification

APPENDIX 6 - Baseline Methodology

Macmillan Confidential

Duty of Quality
Quality-driven decision-making tool

Part 1 - Quality Impact Assessment Toolkit

Overview & Guidance

This assessment should be completed to quantify potential impacts on quality or safety aspects (positive and negative), from any strategic decisions e.g. policy decisions, business cases, service improvements and changes, or efficiency savings projects that will affect operational services.

When completing the assessment consider the impact that the change will bring about in the long term. Also consider any impacts that might occur whilst the change is being implemented. For example, the project may be to introduce a new clinical pathway into an existing team, this will reduce waiting times for patients and result in smaller caseloads which are both long-term positive impacts. However, to introduce the new pathway staff working arrangement will need to change which may increase staff turnover resulting in patient waiting times for treatment increasing both are short term negative impacts. The QIA should reflect both the short-term and long-term impacts.

For the approval process and to ensure you are using the current version of the tool, please visit the QIA SharePoint page https://nhswales365.sharepoint.com/sites/HDD_Nursing-assurance-and-safety/SitePages/Quality-Impact-Assessment.aspx

The tool once approved by the Clinical Care Group Trumvirate e.g. Service Director, Assistant Director of Quality, Safety and Patient Experience and Associate Medical Director, should be submitted to patient.safety@wales.nhs.uk for consideration at the QIA Panel. The dates for the panel and submission deadlines are published on the QIA SharePoint page.

Strategic Decision / Organisational Activity / Project Title:	**Macmillan Cancer Support Neighbourhood Investment Partnership**
Name and role of lead:	**Bruce Bolam, Bethan Lewis, Craig Jones**
Clinical Care Group	**Public Health Directorate**

Description of Strategic Decision / Project:	
Broadly outline what is being proposed and the decision that needs to be made	This business case proposes a five-year Neighbourhood Prevention Programme, funded through Macmillan Cancer Support, to deliver neighbourhood-based prevention and wellbeing support through Health Coaching, Community Health and Wellbeing Workers, and investment in community capacity and local infrastructure. The programme aims to improve population health, reduce health inequalities, strengthen communities, and reduce avoidable demand on health and care services. The decision required is for approval of the business case and progression to formal funding, implementation, governance, and evaluation arrangements.
Why is the proposal / decision needed	The proposal is needed to improve prevention, early intervention and community-based support for people affected by cancer and other long-term conditions. It will help address health inequalities, improve population wellbeing, strengthen community resilience and support a shift from reactive healthcare to preventative, value-based Healthcare.
What are the drivers and influencing factors around the decision to be made? (e.g. legislation, national policy, professional body guidance, cost savings, ministerial priorities, quality standards, incidents etc)	The proposal is driven by increasing demand on NHS services, rising prevalence of cancer and other long-term conditions, and persistent health inequalities across the Hywel Dda population. It aligns with Welsh Government priorities for prevention and population health, Value-Based Healthcare principles, the HDdUHB A Healthier Mid and West Wales strategy, the Social Model for Health and Wellbeing, Community by Design, and the 20four7 Prevention Model. The programme is also supported by a significant investment opportunity from Macmillan Cancer Support and is intended to improve health outcomes, strengthen communities, and reduce avoidable healthcare utilisation through earlier intervention and prevention
Who is directly affected by this proposal / decision? Please also consider people who may be indirectly affected	Directly affected groups include people living in the three neighbourhoods selected for the programme, particularly those affected by cancer, long-term conditions, lifestyle-related risk factors, and those living in areas of greater deprivation. Patients accessing Health Coaching services, Community Health and Wellbeing Worker support, and community-based prevention initiatives will be directly impacted by the proposed model. Indirectly affected groups include carers and families, primary care teams, community and voluntary sector organisations, local authority partners, cancer services, wider health and care staff, and the broader population who may benefit from improved community infrastructure, prevention services, and reduced pressure on NHS services.
How have you engaged with the people affected? If you have not yet engaged, what are your plans?	Engagement has commenced during the development of the business case and has included stakeholder mapping, executive briefings, steering group discussions, stakeholder workshops, and engagement with statutory, voluntary sector and community partners. The business case has also been reviewed and signed off by a patient representative to ensure the patient perspective has informed the proposal. A comprehensive Communications and Engagement Plan has been developed which sets out a continuous programme of engagement from July 2026 to September 2031. Subject to approval, this will include co-production with local communities, people living with and beyond cancer, carers, underserved groups, primary care teams, third-sector organisations and local authority partners through workshops, listening events, community reference groups, asset mapping and co-design sessions to shape implementation and ongoing service development.
How does the proposal / decision impact on delivery of the organisation's strategic objectives or ministerial priorities?	The proposal directly supports Hywel Dda University Health Board's strategic objective to deliver A Healthier Mid and West Wales by shifting the focus from reactive healthcare towards prevention, early intervention and community-based support. It aligns with the Health Board's Social Model for Health and Wellbeing, Community by Design approach, and 20four7 Prevention Model, with a strong focus on reducing health inequalities, improving population wellbeing and supporting value-based healthcare.
Is the proposal / decision planned to be temporary or permanent?	The proposal is a five-year programme running from October 2026 to September 2031, funded through Macmillan social investment and grant funding. Whilst the initial funding is time-limited, the programme is intended to demonstrate value, evaluate impact and develop sustainable commissioning arrangements beyond the funding period. This includes exploring pooled budgets and joint commissioning arrangements with key stakeholders to support the long-term sustainability of successful neighbourhood prevention services.

	Yes / No
Has this Quality Impact Assessment been completed in collaboration with the clinical team(s) that the project will affect?	Planned and Specialist Care Clinical Care Group; Community and Integrated Medicine Clinical Care Group; Primary Care Clinical Care Group

QUALITY IMPACT ASSESSMENT

Area		IMPACT	Opportunity / Consequence Rating*	*IIA Matrix			Monitoring and Management of impacts	
				Consequence	Likilhood	Total Score	How will these impacts be monitored? Specify the metric you will use, the current baseline, triggers for escalation	Mitigating actions of negative impacts
Note - you can select more than one box per area if change may have multiple impacts e.g. both positive and negative		*Description of the impact for each area (the impact mabe positive and/or negative)*						
Safe	How does this decision ensure that our health care system is a high quality, highly reliable and safe system that avoids preventable harm, maximising the things that go right and learning from when things go wrong to prevent them occurring again? How does this decision ensure that people's health, safety and welfare are actively promoted and protected?	This proposal is expected to have a positive impact by improving prevention, enabling earlier identification of health and wellbeing needs, and providing proactive support to reduce avoidable harm and health inequalities. It will strengthen access to community-based services, improve self-management, and support people to stay healthier for longer. A robust monitoring, evaluation and quality improvement framework will support continuous learning and service improvement, helping to maximise positive outcomes and respond to emerging issues. The programme promotes and protects people's health, safety and welfare by improving access to preventative support, strengthening community resilience, and enhancing coordination between health, care and community services.	** positive rating			0	*Metric* - *Current Baseline (date)* - *Trigger for escalation* -	
			** negative rating			0	*Metric* - *Current Baseline (date)* - *Trigger for escalation* -	
Timely	How does this decision ensure that people have access to the high-quality advice, guidance and care they need quickly and easily, in the right place, first time?	This proposal is expected to have a positive impact by improving access to preventative support and neighbourhood-based services, enabling people to receive advice, guidance and support earlier and closer to home. Health Coaching, Community Health and Wellbeing Workers, and strengthened community infrastructure will help people access the right support at the right time, improve navigation of services, and reduce barriers to care. The programme will also strengthen integration between health, care and community services, making it easier for people to access coordinated support tailored to their needs.This proposal is expected to have a positive impact by targeting support towards people and communities with the greatest health needs, particularly those experiencing deprivation and at higher risk of cancer and other long-term conditions. Prioritisation and triage processes will help ensure individuals receive support and access to services according to their level of need and clinical priority.	** positive rating			0	*Metric* - *Current Baseline (date)* - *Trigger for escalation* -	
	How does this decision ensure we care for those with the greatest health need first, and where treatment is identified as necessary, we treat people based on their identified and agreed clinical priority?		** negative rating			0	*Metric* - *Current Baseline (date)* - *Trigger for escalation* -	
Effective	How does this decision ensure care and treatment reflects evidence-based best practice?	This proposal is expected to have a positive impact by implementing evidence-based approaches to prevention, behaviour change, community outreach and supported self-management. The programme has been designed using learning from existing Hywel Dda initiatives, established prevention models, published evidence, and best practice in neighbourhood health and value-based healthcare. It also includes a robust evaluation and quality improvement framework to continuously assess effectiveness and refine delivery based on emerging evidence and learning. This proposal is expected to have a positive impact by providing personalised, person-centred support through Health Coaching, Community Health and Wellbeing Workers, and community-based services. The programme focuses on what matters to individuals, helping them improve their health, wellbeing and self-management while connecting them to the most appropriate support to achieve outcomes that are important to them.	** positive rating			0	*Metric* - *Current Baseline (date)* - *Trigger for escalation* -	
	How does this decision ensure people receive the right care to achieve the optimal outcomes possible for them and that matter to them?		** negative rating			0	*Metric* - *Current Baseline (date)* - *Trigger for escalation* -	

Efficient	How does this decision ensure we take a value-based approach to improve outcomes that matter most to people in a way that is as sustainable as possible and avoids waste?	This proposal is expected to have a positive impact by taking a value-based approach that focuses on prevention, wellbeing and outcomes that matter to people. By investing in early intervention, self-management and community-based support, the programme aims to improve health outcomes, reduce health inequalities and avoid unnecessary demand on healthcare services, supporting more sustainable use of resources and reducing waste.	** positive rating			0	*Metric* - *Current Baseline (date)* - *Trigger for escalation* -	
	How does this decision ensure that there is the most effective use of resources to achieve best value in an efficient way?	This proposal is expected to have a positive impact by investing in prevention and early intervention to reduce avoidable demand on health services and improve long-term outcomes. The programme will use a combination of Health Coaching, Community Health and Wellbeing Workers and community-based support to make the best use of available resources, while a robust evaluation and benefits realisation framework will ensure value for money and inform future investment decisions.	** negative rating			0	*Metric* - *Current Baseline (date)* - *Trigger for escalation* -	
Equitable	How does this decision ensure that everyone is provided with an equal opportunity to attain their full potential for a healthy life which does not vary in quality because of personal protected characteristics; the organisation that provides care; or location where care is delivered?	Has an Equality Impact Assessment been undertaken? Yes/No Has an Equity Health Impact Assessment been undertaken? Yes/No Please reflect a summary of the conclusion of the Equality Impact Assessment and the Equality Health Impact Assessment Guidance can be found on SharePoint	** positive rating			0	*Metric* - *Current Baseline (date)* - *Trigger for escalation* -	
			** negative rating			0	*Metric* - *Current Baseline (date)* - *Trigger for escalation* -	
Person-centred	How does this decision ensure people's needs are met and that their preferences, needs and values guide decision-making that is made in partnership between individuals and the workforce?	This proposal is expected to have a positive impact by adopting a person-centred approach that focuses on what matters to individuals. Through personalised Health Coaching, community-based support and co-production, people will be supported to identify their own goals, improve self-management and access services that reflect their needs, preferences and circumstances. The programme also promotes partnership working between individuals, communities and professionals to support shared decision-making and improved outcomes.	** positive rating			0	*Metric* - *Current Baseline (date)* - *Trigger for escalation* -	
	How does this decision ensure people and their families are at the centre of decisions, seeing them as experts working alongside professionals to get the best outcome and experience?	This proposal is expected to have a positive impact by adopting a co-produced, person-centred approach that recognises individuals and families as partners in their care. Through personalised Health Coaching, Community Health and Wellbeing Workers and community-led design, people will be supported to identify what matters most to them and make informed decisions about their health and wellbeing in partnership with professionals.	** negative rating			0	*Metric* - *Current Baseline (date)* - *Trigger for escalation* -	

Considered and supported by (in line with Scheme of Delegation):	Name	Supported	Comments (if applicable)	Date
Clinical Service Group				
General Manager				
Head of Nursing				
Clinical Lead				
Clinical Care Group				
Service Director				
Assistant Director of Quality, Safety and Patient Experience				
Associate Medical Director				

Other Executive Function (if outside of a CCG e.g. corporate function)				
Director				

QIA Panel Use Only

Considered and supported by:	**Name**	**Supported**	**Comments (if applicable)**	**Date**
Deputy Director of Health Science	Jon Arthur			
Head of Strategic Partnerships (or nominated deputy)	Anna Bird / Helen Sullivan			
Associate Medical Director for Quality and Safety	Subhamay Ghosh			
Interim Assistant Director of Nursing, Assurance & Safegauarding	Cathie Steele			
Consultant in Public Health Medicine	Michael Thomas			

Considered and approved by Clinical Executive:	**Name**	**Supported**	**Comments (if applicable)**	**Date**
Director of Nursing, Quality and Patient Experience	Sharon Daniel			
Medical Director	Mark Henwood			
Director of Allied Health and Health Science	James Severs			

Date presented to panel	
Chair of Panel	
Notes of panel discussion	
If supported by QIA panel, what is the recommended frequency for review	**Note:** QIA must be reviewed if there is a trigger for escalation is met **Date for review recommended by QIA panel:**

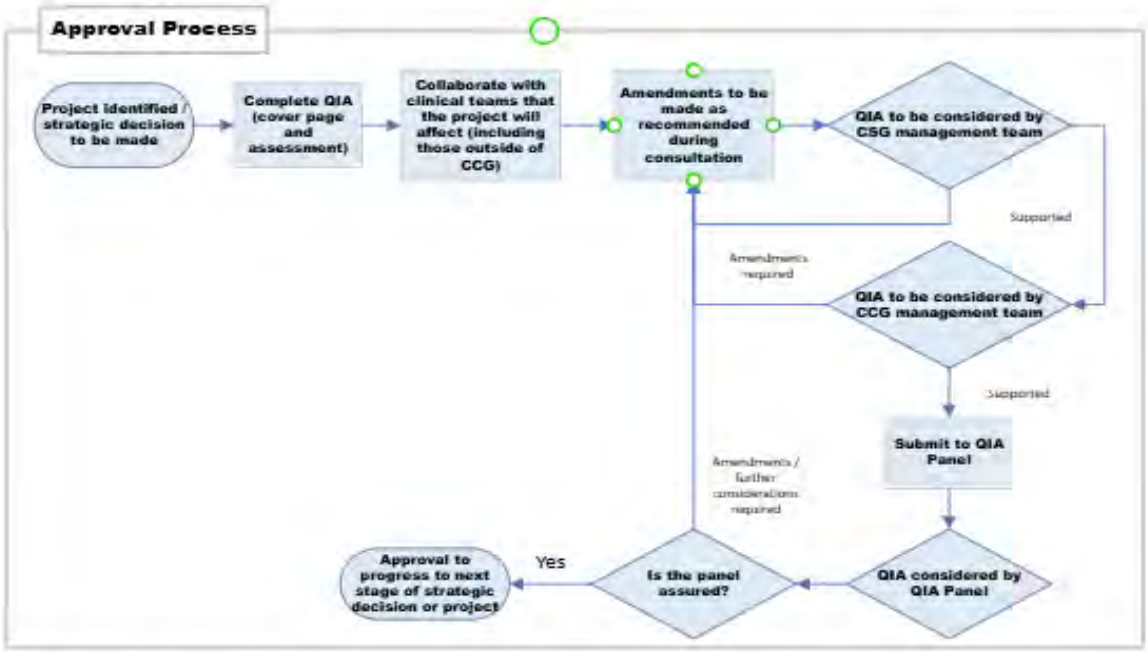
IMPACT MATRIX

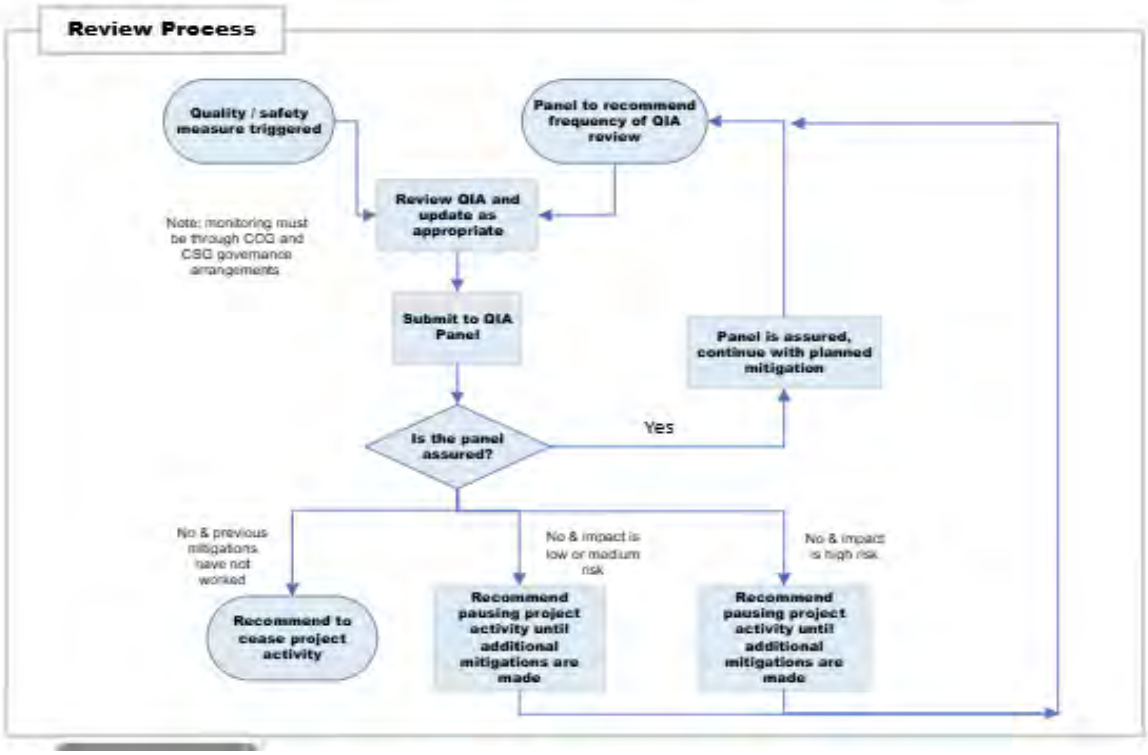
LIKELIHOOD		
1	Rare	Not expected to occur for years. Will occur in exceptional circumstances.
2	Unlikely	Expected to occur at least annually. Unlikely to occur
3	Possible	Expected to occur at least monthly. Reasonable chance of occuring.
4	Likely	Expected to occur at least weekly. Likely to occur.
5	Almost Certain	Expected to occur at least daily. More than likely to occur.

LIKELIHOOD	OPPORTUNITY					IMPACT				
	5	4	3	2	1	-1	-2	-3	-4	-5
5	25	20	15	10	5	-5	-10	-15	-20	-25
4	20	16	12	8	4	-4	-8	-12	-16	-20
3	15	12	9	6	3	-3	-6	-9	-12	-15
2	10	8	6	4	2	-2	-4	-6	-8	-10
1	5	4	3	2	1	-1	-2	-3	-4	-5

CATEGORY			
	Excellent opportunity		Extreme risk
	Good opportunity		High risk
	Moderate opportunity		Moderate risk
	Minor opportunity		Low risk

OPPORTUNITY AND IMPACT			
IMPACT	**SCORE**		**The proposed change is anticipated to lead to the following level of opportunity and/or impact:**
Positive	**5**	Excellence	Multiple enhanced benefits including excellent improvement in access, experience and/or outcomes. Outstanding reduction in health inequalities by narrowing the gap in access, experience and/or outcomes between people with protected characteristic(s) and the general population. Leading to consistently improved standards of experience and an enhancement of public confidence. Significant improvements to service delivery, performance, financial and workforce sustainability.
	4	Major	Major benefit leading to long term improvements and access, experience and /or outcomes. Major reduction in health inequalities by narrowing the gap in access, experience and /or outcomes between people with protected characteristic(s) and the general population. Benefits include improvements in management of patients with long term effects and compliance with national standards. Substantial improvements to service delivery, performance, financial and workforce sustainability
	3	Moderate	Moderate benefits requiring professional intervention with moderate improvement in access, experience and /or outcomes. Moderate reduction in health inequalities by narrowing the gap in access, experience and /or outcomes between people with protected characteristic(s) and the general population. Moderate improvements to service delivery, performance, financial and workforce sustainability.
	2	Minor	Minor improvement in access, experience and /or outcomes for people. Minor reduction in health inequalities by narrowing the gap in access, experience and /or outcomes between people with protected characteristic(s) and the general population. Minor improvements to service delivery, performance, financial and workforce sustainability.
	1	Negligible	Negligible improvement in access, experience and /or outcomes for people with this protected characteristic. Negligible reduction in health inequalities by narrowing the gap in access, experience and /or outcomes between people with protected characteristic(s) and the general population. Neglible improvements to service delivery, performance, financial and workforce sustainability.
Negative	**-1**	Negligible	Negligible negative impact on access, experience and /or outcomes for people. Negligible increase in health inequalities by widening the gap in access, experience and /or outcomes between people with protected characteristic(s) and the general population. Potential to result in minimal injury requiring no/minimal intervention or treatment, peripheral element of treatment suboptimal and/or informal complaint/inquiry. Negligible negative impacts to service delivery, performance, financial and workforce sustainability.
	-2	Minor	Minor negative impact on access, experience and /or outcomes for people . Minor increase in health inequalities by widening the gap in access, experience and /or outcomes between people with thi protected characteristic(s) and the general population. Potential to result in minor injury or illness requiring minor intervention, formal complaint and overall treatment suboptimal. Minor negative impacts to service delivery, performance, financial and workforce sustainability.
	-3	Moderate	Moderate negative impact on access, experience and /or outcomes for people. Moderate increase in health inequalities by widening the gap in access, experience and /or outcomes between people with protected characteristic(s) and the general population. Potential to result in moderate injury requiring professional intervention, formal complaint and failure to meet internal standards. Moderate negative impacts to service delivery, performance, financial and workforce sustainability.
	-4	Major	Major negative impact on access, experience and /or outcomes for people. Major increase in health inequalities by widening the gap in access, experience and /or outcomes between people with protected characteristic(s) and the general population. Potential to lead to major injury leading to long-term incapacity/disability, multiple complaints/independent review and critical report. Major negative impacts to service delivery, performance, financial and workforce sustainability.
	-5	Catastrophic	Catastrophic negative impact on access, experience and /or outcomes for people with this protected characteristic. Catastrophic increase in health inequalities by widening the gap in access, experience and /or outcomes between people with protected characteristic(s) and the general population. Potential to result in incident leading to death, multiple permanent injuries or irreversible health effects, an event which impacts on a large number of patients, totally unacceptable level or effectiveness of treatment, gross failure of safety and does not meet required standards. Significant negative impacts to service delivery, performance, financial and workforce sustainability.


Approval Process
Project identified / strategic decision to be made
Complete QIA (cover page and assessment)
Collaborate with clinical teams that the project will affect (including those outside of CCG)
Amendments to be made as recommended during consultation
QIA to be considered by CSG management team
Supported
Amendments required
QIA to be considered by CCG management team
Supported
Submit to QIA Panel
Amendments / further considerations required
QIA considered by QIA Panel
Is the panel assured?
Yes
Approval to progress to next stage of strategic decision or project


Review Process
Quality / safety measure triggered
Panel to recommend frequency of QIA review
Review QIA and update as appropriate
Note: monitoring must be through CCG and CSG governance arrangements
Submit to QIA Panel
Panel is assured, continue with planned mitigation
Is the panel assured?
Yes
No & previous mitigations have not worked
No & impact is low or medium risk
No & impact is high risk
Recommend to cease project activity
Recommend pausing project activity until additional mitigations are made
Recommend pausing project activity until additional mitigations are made

EQUITY IMPACT ASSESSMENT TOOLKIT



Developed by:

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Dr. Ardiana Gjini, Executive Director of Public Health
Dr. Jo McCarthy, Consultant in Public Health Medicine

Special thanks to the Primary Care Division, Public Health Wales

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INTRODUCTION:

Population health and wellbeing can be influenced by wider socio-economic and environmental factors and their impact vary considerably across different population groups as defined by age, sex, geography and deprivation.

Health equity is a fundamental principle that recognises that everyone deserves the opportunity to achieve their full health potential. However, inequalities in health outcomes continue to persist, disproportionally affecting marginalised and underserved individuals and communities.

WHY DOES HEALTH EQUITY MATTER?

Everyone has the right to live a healthy life, but systemic barriers and injustices such as where you were born, level of education, adverse childhood experiences, community cohesion and access to quality education and housing often prevent certain individuals and population groups from accessing the resources and opportunities they need to achieve optimal health.

Promoting health equity can also lead to better health outcomes for all, as improving overall access to quality healthcare and services can improve population health.

Equity is the absence of avoidable, unfair or remediable differences among groups of people, whether those groups are defined socially, economically, demographically or geographically or by other means of stratification.

World Health Organisation



The route to achieving equity will not be accomplished through treating everyone equally. It will be achieved by treating everyone justly according to their circumstances.

Race Matters Institute

HEALTH INEQUALITIES MAY BE DRIVEN BY:

- Different experiences and distribution of the wider determinants of health or structural factors. For example, the environment, community life, income or housing. In other words, the social economic and environmental conditions in which people live, work and play.
- Different exposure to social, economic and environmental stressors and adversities. These affect states of mind from an early age and throughout life. Stress and psychological wellbeing directly affect resilience, health conditions and health behaviours.
- Differences in health behaviours or other risk factors between groups, for example smoking, diet, and physical activity levels have different social distributions. Health behaviours may be influenced by wider determinants of health, like income.
- Unequal access to or experience of health and other services between social groups.

AIM & OBJECTIVES

To promote fairness, justice and equity in healthcare delivery to improve health outcomes for all

- Identify and understand the social determinants of health that contribute to health disparities.
- Assess the potential impact of health care policies, programmes and services on marginalised and vulnerable populations
- Assess the effectiveness of interventions in reducing health inequities and inequalities
- Engage with community members and stakeholders to ensure their perspectives and experiences are considered
- Develop recommendations and strategies to address identified disparities and promote equitable access to services
- Promote transparency and accountability in decision making processes

Links to Statutory Requirements and Policy

A Healthier Wales: Long term plan for health and social care
Wellbing of Future Generations (Wales) Act 2016
Socio-economic Duty
Equalty Act 2010
Social Services & Welling (Wales) Act 2014
The Primary Care Model for Wales
Welsh Language Standards
NHS Continuing Healthcare Framework
NHS Planning Framework 2022-2025
Digital Health and Care Wales: Equality & Diversity Policy
Public Health (Wales) Act 2017 (legislation.gov.uk)

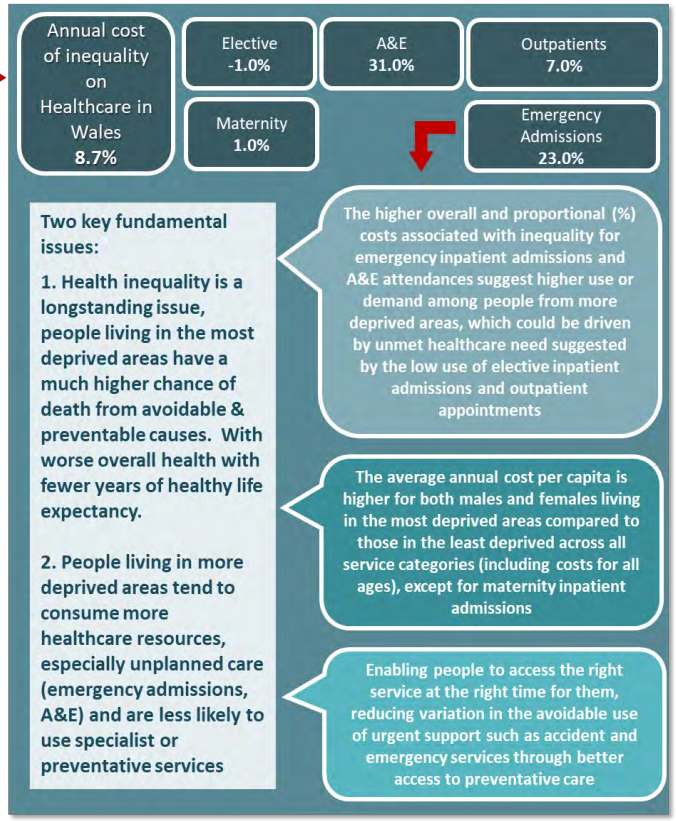
DEFINITIONS

INEQUALITY refers to differences in outcomes between different groups of people, often due to factors such as income, education, race, gender or geographic location. These differences can lead to unequal access to healthcare, education, employment and other essential services leading to a cycle of poverty and social exclusion. Inequality can perpetuate social divisions and create barriers to social mobility. Addressing inequality requires a focus on the social determinants of health and implementing policies and interventions that aim to reduce disparities and promote equity and inclusivity.



EQUITY is the concept of fairness and justice in the distribution of resources and opportunities, with a focus on addressing the needs and circumstances of individuals to ensure everyone has an equal chance to succeed. It involves recognising and acknowledging the systematic barriers that contribute to inequality and highlights the principle of ensuring that all individuals have equal access to services and opportunities to achieve their full potential regardless of their social or economic status. It is about addressing the root causes of inequalities and working towards eliminating barriers to and improving access and quality for all populations.

HEALTHCARE COSTS ATTRIBUTABLE TO INEQUALITIES



IN THE CONTEXT OF THIS TOOLKIT PROPOSAL IS USED AS AN UMBRELLA TERM TO DESCRIBE A NUMBER OF ACTIONS AND ACTIVITIES INCLUDING STRATEGY DEVELOPMENT AS WELL AS POLICY, PROGRAMME AND PROJECT DEVELOPMENT/REVIEW.

ACTION: DESCRIBE THE CONTEXT AND CONTENT OF THE PROPOSAL, INCLUDING STAKEHOLDERS.

PROGRAMME/OPTION TITLE:	Neighbourhood Prevention and Cancer Support Programme
PROGRAMME/OPTION LEAD:	Dr. Bruce Bolam
TEAM/DEPARTMENT:	Public Health

BACKGROUND AND SCOPE (Please describe your proposal/project including background information, aims and objectives)

Hywel Dda University Health Board (HDdUHB), regional public and third sector partners are committed to a social model for health, recognising that health and wellbeing are shaped by social, economic and environmental conditions, not just illness or medical care. This includes recognition of the need to develop place-based integrated service models that meet specific community needs.

HDdUHB wants to put this approach into practice through the 20four7 prevention model. This means focusing support on the most deprived communities, addressing the main preventable risk factors for poor health (smoking, poor diet, harmful alcohol use and physical inactivity) and applying this work across seven priority areas, including cancer.

West Wales already has strong partnerships that can support better health and wellbeing. This proposal aims to build on those strengths by developing a coordinated neighbourhood model for rural communities, connecting prevention, community support, clinical services and local assets. This is important because one in three people in Wales live in rural areas. The proposal therefore offers an opportunity to test a Welsh neighbourhood-based model: one designed around the realities of smaller rural towns and dispersed populations, access barriers and local community strengths.

A three-year investment would allow partners to test and improve the model, gather evidence of impact, and lead change enabling longer-term funding. The aim is to improve cancer outcomes, reduce inequalities and strengthen community resilience in West Wales.

A proposal is being developed by HDdUHB, Macmillan Cancer Support and regional partners and communities to explore the use of social investment through the Neighbourhood Transformation Fund. The proposed three-year programme would act as a catalyst for system transformation, providing opportunity to develop, implement and evaluate and integrated neighbourhood model focused on cancer prevention, early intervention and wider population health improvement.

The programme would support implementation and testing of:

- Community Health & Wellbeing Workers
- Health Coaching and Lifestyle Medicine
- Community Capacity and Neighbourhood Infrastructure

Alongside direct service delivery, the investment would support community engagement, partnership development, workforce capability, project management and evaluation, and the strengthening of local neighbourhood infrastructure. The intention is to build clear evidence of impact, value and return on investment, creating a stronger basis for sustained action through Health Board investment, pooled budgets and wider partnership funding across West Wales. The learning would also have wider national relevance, including for other rural areas.

This work is led by Public Health, supported by the VBHC Team, with a Project Group established to develop a full business case for submission in September 2026.

DOES THIS PROPOSAL CONSIDER STRENGTHENING AND EXPANDING PARTNERSHIPS TO IMPROVE HEALTH EQUITY?
Produce a list which shows who the stakeholders are and their role in the proposal (e.g. advisor on local issues, specialist, those directly affected by the proposal)



	IMPACT				
	NO ENGAGEMENT	SOME ENGAGEMENT	FULL ENGAGEMENT	**UNKNOWN** (E.G. Not yet considered as part of the proposal)	**MITIGATION** (if any groups are not engaged how you to intend to improve the situation?)
Are service users engaged?			X		
Are healthcare professional/practitioners engaged?			X		
Are healthcare and community leaders engaged?			X		

STAKEHOLDERS (please add partners below):

NAME	ORGANISATION	ROLE	PLEASE DESCRIBE HOW WILL THESE STAKEHOLDERS BE ENGAGED IN THE EIA? (E.G. WORKSHOP, FOCUS GROUPS, INTERVIEWS)

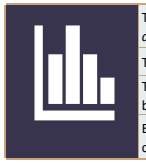
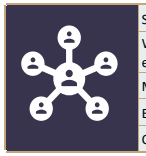
ACTION: USE THE LIST BELOW TO IDENTIFY THE INTENDED TARGET POPULATION FOR THIS PROPOSAL AND IDENTIFY THOSE THAT MAY BE EXCLUDED



WILL THIS PROPOSAL AFFECT THE WHOLE POPULATION, OR WILL THERE BE A DIFFERENTIAL IMPACT ACROSS SUB-GROUPS?	WILL THE IMPACT BE …				Do you know how to identify your population? (Yes/ No/ Not sure)	SUPPORTING EVIDENCE: What data do you have to help you understand your population/ patient profile? What additional data do you need?
	NEGATIVE	NEUTRAL	POSITIVE	UNKNOWN (E.G. Not yet considered as part of an option or specific project, pathway)		
Populations living in the most deprived communities. (see the WIMD tab)			x			
Rural Populations			x			
Those who miss appointment on a regular basis or are lost to follow-up?			x			
Those who access emergency services or A&E on a regular basis for non-urgent care that could be managed in the community?			x			
Those with Protected Characteristics under the Equality Act 2010						
- Age			x			
- Disability		x				
- Sex (male/female)		x				
- Marriage and Civil Partnership		x				
- Race & Ethnicity		x				
- Pregnancy & Maternity		x				
- Sexual Orientation		x				
- Religion or Belief		x				
- Gender Reassignment		x				
Vulnerable and Inclusion Health Groups						
People who are experiencing or are at risk of homelessness (may also include those in temporary accommodation or care leavers)			x			
People with drug and alcohol dependence			x			
Vulnerable migrants, refugees, asylum seekers, undocumented migrants			x			
Gypsy, Roma, and Traveller communities			x			
People in contact with the justice system		x				
Victims of modern slavery		x				
Sex workers		x				
Other Groups						
Welsh Language		x				
Carers		x				
Veterans		x				
Other Groups (Please list below):						

Please see DATA SOURCES tab to access information on how to identify your local population and other statistics

ACTION: USE THIS CHECKLIST TO ASSESS ANY POTENTIAL LINKS BETWEEN THE PROPOSAL, HEALTH AND EQUITY. USE THE RECOMMENDATIONS TABLE TO DETERMINE IF A COMPREHENSIVE EIA IS REQUIRED.

EQUITY IMPACT ASSESSMENT - CHECKLIST	Yes	Unsure	No
DOES THIS PROPOSAL CONSIDER ACCESS FOR...			
 Populations living in the most deprived communities (consider communities in the most deprived 20% of WIMD)?	x		
Those with protected characteristics (Equality Act, 2010)?	x		
Vulnerable and inclusion health groups *(e.g. homeless, gypsy, Roma and traveller communities, sex workers, people in contact with the justice system*)?	x		
Rural populations?	x		
Those who miss appointments on a regular basis?	x		
Those who access urgent care on a regular basis for conditions that could be managed in the community?	x		
WILL THIS PROPOSAL ADDRESS PREVENTION ...			
 Through assessing the specific health risks and needs of our most vulnerable populations	x		
By raising awareness of risk factors for certain health conditions, promoting healthy lifestyles and improving the availability of preventative health services (e.g. vaccinations, health check-ups)	x		
Through promoting screening and early detection and addressing disparities in uptake/coverage between groups	x		
Through improving care for those already suffering from chronic conditions (e.g. improving access and support mechanisms, monitoring outcomes in key groups)	x		
DOES THIS APPROACH OPTIMISE INTERVENTIONS AND ASSESS EFFECTIVENESS ...			
 Through using data to understand key factors in the local population that may contribute to poor health or high service utilisation. *(e.g. an ageing population, areas of deprivation, higher prevalence of lifestyle risk factors)* ?	x		
Through monitoring service utilisation to assess healthcare service use by various characteristics?	x		
Through systematically assessing impact on inequalities and monitoring changes over time? (e.g. pilot testing, evaluation, research, establishing benchmarks)	x		
Ensuring resource /financial implications of the programme/intervention/option in terms of workforce demand, skills, training and programme costs are considered?	x		
DOES THIS APPROACH CONSIDER PARTNERSHIPS AND SOCIAL ACCEPTABILITY THROUGH...			
 Strengthening and expanding partnerships to enhance health equity? (e.g. multi-sectoral, community working)	x		
Working with those that are likely to be affected by the outcome to ensure they are engaged in the process? (e.g. Collaboration, coproduction, engagement)	x		
Making a commitment to health equity through the development of inclusive policy and practice that is fair and transparent?	x		
Ensuring that organisations and teams understand their responsibilities to tackling inequalities?	x		
Collecting data to monitor patient experience?	x		
COULD THIS APPROACH WIDEN INEQUALITIES BY...			
 Not tackling the full spectrum of causes (e.g. behavioural risk factors, social determinants)?			x
Not being co-designed (e.g. engaging stakeholders)?			x
Relying on professional led interventions (e.g. can reinforce existing structures & barriers)?			x
Not recognising the economic impact of ill health and treatment (e.g. travel cost, time off work)?			x
Failing to ensure that health information is delivered in a way that empowers people to make informed decisions to meet their needs? (e.g. Health literacy, communications strategy)			x

RECOMMENDATIONS: **Decisions should be based on the nature of the impact (e.g. a specific population groups or those with certain conditions are excluded etc). Which of the following recommendations apply to your initial assessment using the Rapid HEIA**

RECOMMENDATION 1. There is likely to be only negligible or small health impacts following the implementation of this proposal. The effect is expected to be small and will not have an impact on equity	**There is no need to adjust the proposal or to proceed to the comprehensive EIA. It may be useful to think about how this proposal will be monitored over time and what actions should be taken if a differences in health outcomes occur.**
RECOMMENDATION 2. There is likely to be some potential effect as a result of the proposal. There is no need to adjust the proposal or to proceed with a full Health Equity Impact Assessment.	**There is no need to adjust the proposal or to proceed with the comprehensive EIA, however, it is important to think about the key areas where a potential difference in outcomes may occur e.g. some groups have not been fully considered or there has been a lack of engagement with partners/service users). Ensure you develop a strategy to monitor health outcomes and consider what actions should be taken if a difference in health outcomes occur.**
RECOMMENDATION 3. There is likely to be a significant effect on health outcomes. Further analysis should be undertaken to address difference in health outcomes and unmet needs.	**Go to STEP 4 and complete the comprehensive EQUITY IMPACT ASSESSMENT**

Who is completing this EIA :

	IMPACT OF THE PROPOSAL	NO	YES	NOT APPLICABLE	Supporting evidence / potential effect on equity and inequalities. Be explicit and include any expert advice, data or literature you have used to make your judgement.	PRIORITISING THE EQUITY IMPACT (Review findings and discussions with stakeholders and service users to determine if the impact is likely to be positive/negative and short/longer term)						MITIGATION: Identify ways to reduce any negative impacts (if possible) and highlight these in your EIA report. For example consider service design and who is currently being reached. See MITIGATION and BARRIERS & FACILITATORS tabs in this document
						The impact is likely to be NEGATIVE	NO IMPACT	The impact is likely to be POSITIVE	Is the impact likely to be			
									Short term	Medium Term	Long Term	
ACCESS	Does this proposal consider the impact on those living in the most deprived communities? (see Population Impact tab and WIMD tab)											
	Does this proposal consider the impact on rural communities and people living within those communities?											
	Affordability - has an assessment of the cost of the service been undertaken (e.g. travel, time off work), including any potential barriers for low income individuals?											
	Availability of services - Has an evaluation of operating hours, and availability of appointments been undertaken, ensuring they align with community needs?											
	Accessibility - has an analysis of the physical location of services been undertaken including access to transport links and travel time.											
	Does the proposal meet the cultural and linguistic needs of diverse populations?											
	Will there be a change in demand or access to services as a result of this proposal? e.g., Primary Care, Secondary Care, Community Services, Social Services etc.											
	Digital Access - Have telehealth options or digital platforms for accessing services, especially for those with mobility or transportation issues been considered?											
RELEVANCE TO NEEDS	Has a review of data from any health, wellbeing or community needs assessment been undertaken to ensure the proposal addresses identified health challenges/needs in the population?											
	Has feedback from community members, healthcare professionals and local organisations been considered/included (Stakeholder Engagement)?											
	Is the proposal aligned to local and national health priorities and strategic plans relating to wellbeing assessments, PSB/RPB, health improvement plans etc.											
	Is the proposal aligned to the specific demographic and health needs of the target population? (e.g. age, ethnicity, culture) - Reference Equality Impact Assessments, EIA Checklist)											
EFFECTIVENESS	Does this proposal consider equity and alignment across services and organisations? (people often use a variety of services to support their care)											
	Has an assessment been undertaken to understand how the proposal will integrate with existing services and pathways to improve continuity of care? E.g. children's services across primary, secondary and community settings											
	Have criteria for monitoring the effectiveness of the proposal been developed to measure outcomes e.g. admissions, recovery rates, length of stay, patient satisfaction? Can this be analysed by key characteristics (e.g. deprivation, age, ethnicity)?											
	Is service use (for this proposal) monitored to assess utilisation by various characteristics (e.g. minority groups, sex, deprivation).											
	Does this proposal strengthen community approaches *(e.g. drawing on existing human and material resources in the community - assets)*											
	Has (or will) the economic impact of the proposal in terms of cost savings, resource utilisation and return on investment been considered?											
SOCIAL ACCEPTABILITY	Have community attitudes and perceptions towards the proposal been considered and how has this been undertaken?											
	Has support from key stakeholders (e.g. healthcare providers, community organisation and local authorities) been considered?											
	Is the proposal likely to generate public concern? E.g., potential environmental impact, move services away from a particular group.											
	Will this proposal ensure that those that are likely to be affected by the outcomes are engaged in the process? E.g. vulnerable groups											
	Does this proposal support people to make informed choices about their care (e.g. increasing knowledge of options available)											
	Will this proposal make a commitment to health equity by developing/reinforcing organisational values through clear leadership and the development and application of policy to ensure equity if considered in all policies											

DATA SOURCES

Link to PHW Public Health Outcomes Framework
Public Health Outcomes Framework (2022) - Public Health Wales (nhs.wales)

ARCH Health Needs Assessment
ARCH Health Needs Assessment

Deprivation data:
WIMD - Explore (gov.wales)
WIMD - Hywel Dda University Health Board (gov.wales)

Welsh Index of Multiple Deprivation (WIMD) 2025 results report [HTML] | GOV.WALES

Click on the links below to access population profile data by Unitary Authority, Community or Middle Super output Area:
Pembrokeshire (W06000009) - ONS
Ceredigion (W06000008) - ONS
Carmarthenshire (W06000010) - ONS

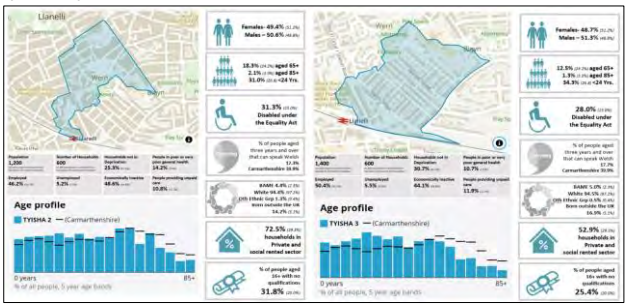
The Welsh Index of Multiple Deprivation (WIMD) is an official measure of relative deprivation for small areas in Wales. It ranks areas from 1 (most deprived) to 1909 (least deprived) and is designed to identify areas with the highest concentrations of different types of deprivation.

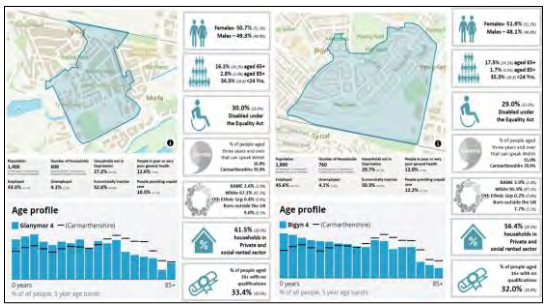
The profiles below are based on the previous release of WIMD data. For the most recent updates got to
Welsh Index of Multiple Deprivation (WIMD) 2025 results report [HTML] | GOV.WALES

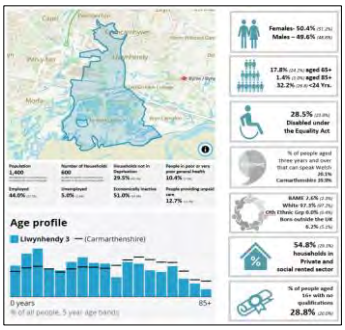
WIMD Indicator data from 2019

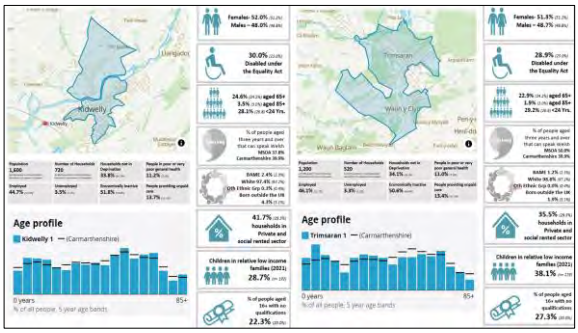
Communities in the most deprived 20% WIMD (RANK)

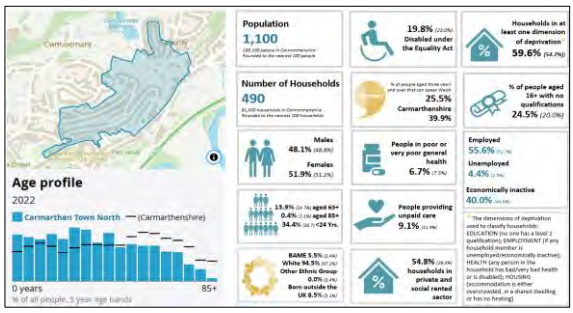
CARMARTHENSHIRE



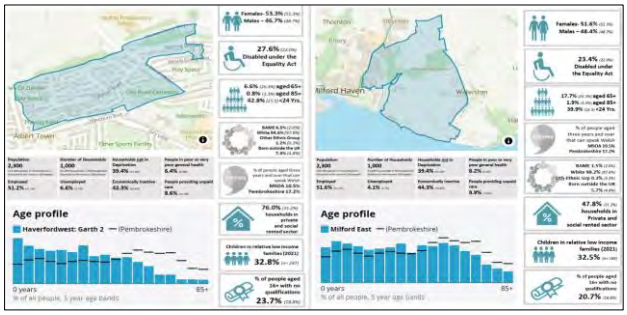


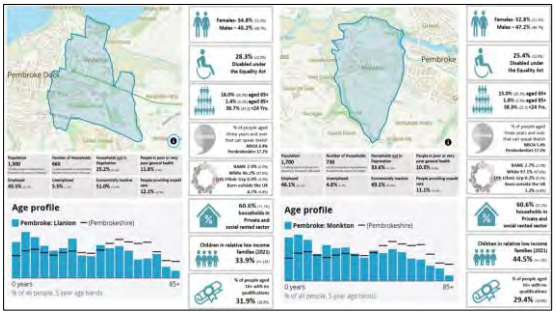


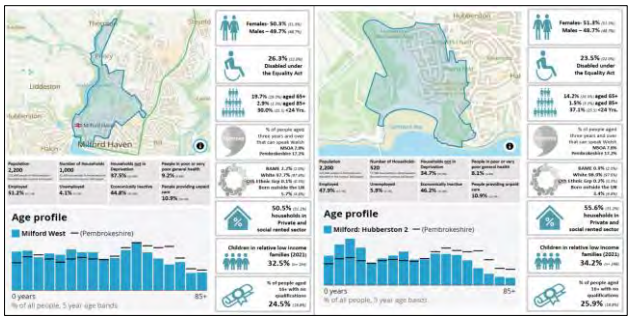


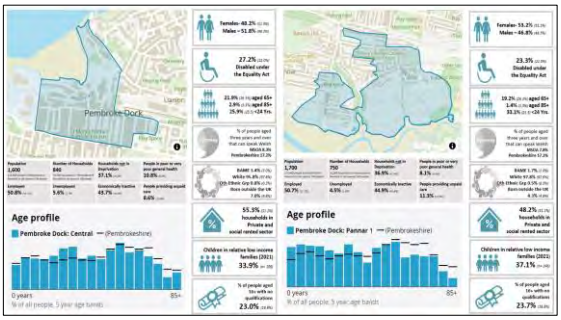


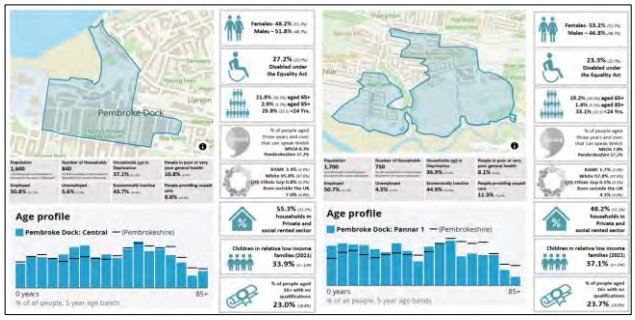
PEMBROKESHIRE



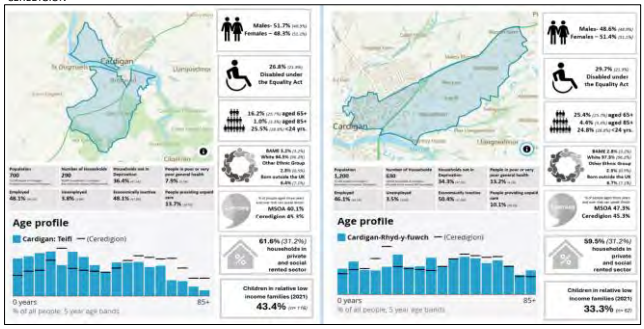



Milford Haven
Age profile
Milford West — (Pembrokeshire)
Milford: Hubberston 2 — (Pembrokeshire)


Pembroke Dock
Age profile
Pembroke Dock: Central — (Pembrokeshire)
Pembroke Dock: Pannar 1 — (Pembrokeshire)


Pembroke Dock
Age profile
Pembroke Dock: Central — (Pembrokeshire)
Pembroke Dock: Pannar 1 — (Pembrokeshire)

CEREDIGION


Cardigan
Age profile
Cardigan: Teifi — (Ceredigion)
Cardigan-Rhyd-y-fuwch — (Ceredigion)

Use the table below to think about mitigation strategies to ensure interventions are effectively designed, at the intervention and organisational level and across sectors to ensure access to relevant groups and resources.

Intervention	Organisation	Alignment/Collaboration
Modifications that support or supplement a reduction in health inequities:	**Modifications that support a reduction in health inequities:**	**With complementary initiatives that might help reduce inequities**
Interventions and approaches that support access to programmes/services e.g. time and location	Population Health assessment (to understand needs and prioritise action)	Internal to the organisation
Stakeholder engagement & Co-design. Priority group participation in the service development, programme delivery or policy implementation	Surveillance - establish systems to monitor health outcomes by demographic groups, allowing for targeted interventions to address identified gaps.	local agencies and other services - partner with local organisations to provide support (e.g. housing issues, addressing risk factors)
Reducing barriers to those who can benefit most from the service e.g. time, location etc	Research and knowledge exchange	Local, regional and national stakeholders
Provision of additional supports e.g. Expand telehealth services to allow remote areas to consult with healthcare providers without the need for travel.	Programme evaluation	Integrated care models and pathways
Communication plan - to raise awareness of heath issues or promote awareness of services. Create easy to understand resources to teach individuals how to navigate the healthcare system and manage their health.	Staff education and development - educate providers on the unique health challenges faced by specific population and strategies to reduce disparities in care.	
	Internal policies and procedures	

Addressing health equity in healthcare settings requires a multi-level approach that recognises the complex interplay of facilitators and barriers. By identifying and leveraging facilitators while working to mitigate the barriers, healthcare organisations could make a significant contribution toward achieving health equity for all

In planning your EIA think about some of the barriers and facilitators that may have an impact on implementing this proposal

FACILITATORS

SYSTEM LEVEL	ORGANISATIONAL LEVEL	OPERATIONAL LEVEL
• Mandated use of the tools (e.g. Public Health (Wales) Act, 2017 • Policy frameworks – NHS long-term plans that emphasis reducing inequalities provide a framework for action. • Funding/ grants aimed at addressing health inequalities. • Increased political and public awareness about health equity – this can be used to pressure healthcare systems to prioritise these concerns • Embed health equity into performance management incentives • National/regional inequality targets	• Leaderships commitment – a strong commitment from healthcare leaders and management to prioritise health equity and drive organisational change. • Training and education for staff on health equity principles and cultural competency to enhance understanding and implementation • Interdisciplinary collaboration across departments and specialties to support a more comprehensive approach to health equity, • Integrate health equity metrics into performance evaluations and organisational aims.	• Community engagement through actively involving community members in the design and delivery of health services that can lead to more equitable outcomes • Develop targeted programmes that address the specific needs of diverse populations. • Use technology including telehealth and digital health solutions to improve access to care for underserved populations. • Implement systems for collecting feedback from patients about their health care experiences and identify gaps and inform improvements.

BARRIERS

SYSTEM LEVEL	ORGANISATIONAL LEVEL	OPERATIONAL LEVEL
• Fragmentation of services and a lack of co-ordination between health and social care or primary and secondary care can hinder comprehensive approaches to health equity. • Insufficient data on health inequalities can make it difficult to identify needs and measure progress. • Resource constraints and budget cuts can restrict the ability to implement programmes focussed on health equity. • Policy inconsistencies including variability in health equity policies across different regions can lead to unequal implementation and outcomes. • Political pressures to adopt programmes or policies without equity consideration.	• Lack of organisational commitment and readiness and a resistance to change • Siloed decision-making which can limit sharing of best practice and collaborative approaches to addressing health inequalities • Lack of training and awareness among staff regarding health equity concepts • Competing priorities • Lack of buy in from top management • Lack of discussion on the importance of applying health equity approaches at management level.	• Access issues – including transportation, language and cultural differences can prevent marginalised groups from accessing healthcare services • Limited workforce diversity which may result in a lack of cultural competency necessary to effectively engage with diverse populations • Administrative burdens including a lack of resources (financial/human) • Short-term focus especially on immediate outcomes rather than long-term equity goals • Capacity of the health care sector to conduct research, access different types of information and analyse data. • Lack of data to support consensus • Time constraints

Equality Impact Assessment (EqIA) Screening Template

When to complete an EqIA Screening

An EqIA Screening Template must be completed when reviewing, changing and developing procedures/ proposals/ projects/ policies. This is a first step and is used to consider whether there are any negative impacts that may arise.

Purpose of an EqIA Screening Template

The purpose of this short exercise is to ensure that you have shown appropriate due regard when considering the impact for people with protected characteristics in your decision making. The screening process is designed to help you consider the circumstances and to inform evidence-based decisions.

If the proposal is of a significant nature and it is apparent from the outset that a full EqIA will be required, then it is not necessary to complete this Screening Template, you can proceed to complete the full EqIA.

If no negative impacts are identified following completion of the EqIA screening then it is not necessary to undertake a full EqIA however, the decision and justification must be clearly recorded in this document.

On completion of the Screening Template:

- Ensure that all the white boxes within the screening are completed.
- Ensure that the Procedure/ Project/ Proposal/ Policy owner has signed and dated the Screening Template.
- Send a copy of the completed template along with the related policy or project proposal to Inclusion.hdd@wales.nhs.uk for the Diversity & Inclusion Team to review.
- Each Screening Template will be reviewed by the Diversity & Inclusion Team and feedback will be provided to the Procedure/ Project/ Proposal/ Policy owner. This may include recommendations for further action to inform robust decision-making.

Support

For further support please visit the EqIA Sharepoint or contact:
Email: Inclusion.hdd@wales.nhs.uk
Tel: 01554 899055

Director and Directorate	Ardiana Gjini – Executive Director of Public Health
Service Area	Public Health

Title of Procedure, Project, Proposal, Policy being screened:	Neighbourhood Prevention and Cancer Support Programme

Description of the Procedure/ Project/ Proposal/ Policy being screened (including key aims and objectives)

Hywel Dda University Health Board (HDdUHB), regional public and third sector partners are committed to a social model for health, recognising that health and wellbeing are shaped by social, economic and environmental conditions, not just illness or medical care. This includes recognition of the need to develop place-based integrated service models that meet specific community needs.

HDdUHB wants to put this approach into practice through the 20four7 prevention model. This means focusing support on the most deprived communities, addressing the main preventable risk factors for poor health (smoking, poor diet, harmful alcohol use and physical inactivity) and applying this work across seven priority areas, including cancer.

West Wales already has strong partnerships that can support better health and wellbeing. This proposal aims to build on those strengths by developing a coordinated neighbourhood model for rural communities, connecting prevention, community support, clinical services and local assets. This is important because one in three people in Wales live in rural areas. The proposal therefore offers an opportunity to test a Welsh neighbourhood-based model: one designed around the realities of smaller rural towns and dispersed populations, access barriers and local community strengths.

A three-year investment would allow partners to test and improve the model, gather evidence of impact, and lead change enabling longer-term funding. The aim is to improve cancer outcomes, reduce inequalities and strengthen community resilience in West Wales.

A proposal is being developed by HDdUHB, Macmillan Cancer Support and regional partners and communities to explore the use of social investment through the Neighbourhood Transformation Fund. The proposed three-year programme would act as a catalyst for system transformation, providing opportunity to develop, implement and evaluate and integrated neighbourhood model focused on cancer prevention, early intervention and wider population health improvement.

The programme would support implementation and testing of:

- Community Health & Wellbeing Workers
- Health Coaching and Lifestyle Medicine
- Community Capacity and Neighbourhood Infrastructure

Alongside direct service delivery, the investment would support community engagement, partnership development, workforce capability, project management and evaluation, and the strengthening of local neighbourhood infrastructure. The intention is to build clear evidence of impact, value and return on investment, creating a stronger basis for sustained action through Health Board investment, pooled budgets and wider partnership funding across West Wales. The learning would also have wider national relevance, including for other rural areas.

This work is led by Public Health, supported by the VBHC Team, with a Project Group established to develop a full business case for submission in September 2026.

Evidence considered (including staff and population data, relevant research, expert and community knowledge etc.)

Scoping searches on health coaching and community health and wellbeing workers (CHWWs)

Two scoping searches were undertaken by a librarian in May 2026 to support preliminary work for this proposal.

HEALTH COACHING
A search of the internet identified the NHS England *Workforce Development Framework for Health and Wellbeing Coaches*, which contains potentially relevant references. Additional searches were conducted in Epistemonikos (a database of systematic reviews), the Health Management Information Consortium (HMIC), and MEDLINE. In total, one hundred and eight references were identified.
NHS England (2023) *Workforce development framework for health and wellbeing coaches*. London: NHS England. Available at: https://www.england.nhs.uk/long-read/workforce-development-framework-for-health-and-wellbeing-coaches/ (Accessed: May 2026).

COMMUNITY HEALTH AND WELLBEING WORKERS (CHWWs)
A search of the internet exploring links between CHWWs and deprivation retrieved several relevant papers. This was followed by a search of the Health Management Information Consortium (HMIC), which identified a further three papers. Further searches were undertaken in the MEDLINE and Embase databases, identifying further studies; however, the majority were conducted outside the United Kingdom. MEDLINE uses a broad definition of community health workers, whereas Embase lacks a specific subject heading; therefore, the following phrase search was employed to help define CHWWs:
A total of two hundred and seventy-one references were identified.

Assess which protected characteristics will potentially be affected by the proposal in the table below (please ✓ the relevant box to confirm positive, negative or no impact)**.**

If at any point a negative impact has been identified (actual or potential), you do not need to proceed with the completion of this form, as a full EqIA must be undertaken: Equality Impact Assessments (EqIAs) (sharepoint.com)

Age Is it likely to affect older and younger people in different ways or affect one age group and not another?					
Positive Impact	✓	Negative Impact		No Impact	
Justification of impact identified: The programme is designed to improve access to cancer prevention, early intervention, health coaching and community-based support within rural communities. Older people are more likely to be affected by cancer and long-term health conditions and may face barriers to accessing services due to isolation, transport difficulties or limited local provision. Younger people and working-age adults may also benefit from improved access to prevention, health promotion and lifestyle support aimed at reducing future cancer risk. By delivering neighbourhood-based support and strengthening community infrastructure, the					

programme has the potential to improve health outcomes, increase access to services and reduce inequalities across different age groups.

Disability
Is it likely to affect those with a physical disability, learning disability, sensory loss or impairment, mental health conditions, long-term medical conditions such as diabetes?

Positive Impact		Negative Impact		No Impact	✓

Justification of impact identified:

There is no evidence to suggest that the programme will discriminate against or disadvantage anyone because of a disability, including physical disability, learning disability, sensory impairment, mental health condition, or long-term medical condition.

Gender Reassignment
Is it likely to affect those who either:

- Have undergone, intend to undergo or are currently undergoing gender reassignment.
- Do not intend to undergo medical treatment but wish to live in a different gender from their gender at birth

Positive Impact		Negative Impact		No Impact	✓

Justification of impact identified:

There is no evidence to suggest that the programme will discriminate against or disadvantage anyone because of their gender. The programme is expected to apply equally and is not anticipated to affect men and women differently.

Marriage / Civil Partnership
Under the Equality Act, the characteristic of Marriage and Civil Partnerships is only protected in the workplace/ employment.
Is it likely to affect those who are married or in a Civil Partnership? This means someone who is legally married or in a civil partnership.

Positive Impact		Negative Impact		No Impact	✓

Justification of impact identified:

This group is only in relation to workplace and employment and therefore has no relevance when using this programme. The proposal is not expected to affect people differently based on this protected characteristic.

Pregnancy and Maternity
Is it likely to affect those who are pregnant or have recently had a baby? Maternity covers the period of 26 weeks after having a baby, whether or not they are on Maternity Leave.

Positive Impact		Negative Impact		No Impact	✓

Justification of impact identified:

There is no evidence to suggest that the programme will discriminate against or disadvantage people who are pregnant or who have recently had a baby. The proposal is not expected to affect access, experience or outcomes differently for this group.

Race / Ethnicity
Is it likely to affect people of a different race, nationality, colour, culture or ethnic origin including non-English / Welsh speakers, Gypsies/Travellers, asylum seekers and migrant workers?

Positive Impact		Negative Impact		No Impact	✓

Justification of impact identified:

There is no evidence to suggest that the programme will discriminate against or disadvantage people because of race, nationality, colour, culture, ethnic origin, or

language. Consideration should continue to be given to communication needs, including Welsh language and accessible information where relevant.

Religion or Belief
Is it likely to affect people who have a religion or belief? The term 'religion' includes a religious or philosophical belief.

Positive Impact		Negative Impact		No Impact	✓

Justification of impact identified:

There is no evidence to suggest that the programme will discriminate against or disadvantage people because of their religion, belief, or philosophical belief. The proposal is not expected to affect people differently on this basis.

Sex
Is it likely to affect people who are mostly male or female. Where it applies to both equally does it affect one differently to the other?

Positive Impact		Negative Impact		No Impact	✓

Justification of impact identified:

There is no evidence to suggest that the programme will discriminate against or disadvantage anyone because of their sex. The programme is expected to apply equally and is not anticipated to affect men and women differently.

Sexual Orientation
Whether a person's sexual attraction is towards their own sex, the opposite sex or either.

Positive Impact		Negative Impact		No Impact	✓

Justification of impact identified:

There is no evidence to suggest that the programme will discriminate against or disadvantage people because of their sexual orientation. The proposal is not expected to affect people differently on this basis.

Armed Forces Community
Consider whether this impacts on members of the Armed Forces and their families, whose health needs may be impacted long after they have left the Armed Forces and returned to civilian life. Also consider their unique experiences when accessing and using day-to-day public and private services compared to the general population. It could be through 'unfamiliarity with civilian life, or frequent moves around the country and the subsequent difficulties in maintaining support networks, for example, members of the Armed Forces can find accessing such goods and services challenging.'

For a comprehensive guide to the Armed Forces Covenant Duty and supporting resource please see:
Armed-Forces-Covenant-duty-statutory-guidance

Positive Impact		Negative Impact		No Impact	✓

Justification of impact identified:

There is no evidence to suggest that the programme will discriminate against or disadvantage members of the Armed Forces Community, including serving personnel, reservists, veterans and their families. The programme is not expected to create barriers linked to Service life, such as frequent relocation, unfamiliarity with civilian services, or difficulties maintaining support networks.

Socio Economic Duty
Consider those on low income, economically inactive, unemployed or unable to work due to ill-health. Also consider people living in areas known to exhibit poor economic and/or health indicators and individuals who are unable to access services and facilities. Food / fuel poverty and personal or household debt should also be considered.

For a comprehensive guide to the Socio-Economic Duty in Wales and supporting resources please see: more-equal-wales-socio-economic-duty					
Positive Impact	✓	Negative Impact		No Impact	
Justification of impact identified: The programme has the potential to have a positive impact on people experiencing socio-economic disadvantage by supporting improved access, experience and/or outcomes for individuals and communities who may face barriers linked to ill-health, food poverty or living in areas with poorer economic and health indicators. Implementation will consider how the programme can support fair access and reduce inequality of outcome where possible. Any emerging evidence of unequal access or disadvantage for socio-economically disadvantaged groups will be monitored and addressed through programme governance arrangements.					
Welsh Language Is it likely to impact on opportunities for people to use the Welsh language? The Welsh language should be treated no less favourably than the English language.					
Positive Impact		Negative Impact		No Impact	✓
Justification of impact identified: There is no evidence to suggest that the programme will negatively impact opportunities for people to use the Welsh language. The Welsh language will continue to be treated no less favourably than the English language, and bilingual communication requirements will be considered where relevant. If the programme involves public-facing materials, engagement, communication, training, digital content or service delivery, Welsh language requirements will be reviewed to ensure compliance with organisational Welsh language duties and standards.					

If a negative impact has been identified, you are not required to complete this form as a full EqIA must be undertaken. A full EqIA template and guidance can be found on the following link: Equality Impact Assessments (EqIAs) (sharepoint.com)

Screening Completed by:	Name	Felix Johnbritto
	Title	Project Manager
	Contact details	Felix.Johnbritto2@wales.nhs.uk
	Date	20/07/2026
Screening Authorised by: (Directorate level owner of the procedures/ proposals/ projects/ policy)	Name	Bruce Bolam
	Title	Deputy Director of Public Health
	Contact details	Bruce.Bolam@wales.nhs.uk
	Date	22/07/2026
Guidance has been provided by Diversity & Inclusion Team:	Name	Alan Winter
	Title	Senior Diversity & Inclusion Officer
	Contact details	Alan.winter@wales.nhs.uk
	Date	24/7/2026
Diversity and Inclusion Team additional Comments:		

Please note: The D&I team will save a copy of the completed form for reference. If any changes are made after the date of review, it is the directorate's responsibility to update the EqIA and inform the D&I team.

6.2

6.2 - FINANCIAL PROCEDURES

Huw Thomas (Hywel Dda UHB - Director of Finance)

For approval

Attachments

Financial Procedures FPC 27 August 2026.pdf

FP066 Losses and Special Payments Procedure.pdf

FP066 EqIA.pdf

FP090 Retention of Financial Records Procedure.pdf

FP090 EqIA.pdf

Pwyllgor Cyllid a Pherfformiad/ Finance and Performance Committee

DYDDIAD Y CYFARFOD: DATE OF MEETING:	27 August 2026
TEITL YR ADRODDIAD: TITLE OF REPORT:	Financial Procedures
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Huw Thomas, Executive Director of Finance
SWYDDOG ADRODD: REPORTING OFFICER:	Tim John, Head of Accounting and Statutory Reporting

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Ar Gyfer Penderfyniad/ For Decision

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

Each year planned reviews are undertaken of the financial procedures operated by Hywel Dda University Health Board (HDdUHB). The procedures, which set out the main financial system controls, are reviewed in terms of:

- Relevance
- Best practice
- Audit recommendations
- System change
- Health Board policy

The Finance and Performance Committee can take assurance that there is a robust review process in place in respect of financial procedures.

Cefndir / Background

The following procedures have been reviewed and are presented to the Finance and Performance Committee for approval:

- **Financial Procedure 066** – Losses and Special Payments
- **Financial Procedure 090 –** Retention of Financial Records

The purpose of these documents is to outline the key processes to be followed by Health Board staff in connection with the above-named financial procedures and to set out associated roles and responsibilities.

Asesiad / Assessment

- **Financial Procedure 066** – Losses and Special Payments
- **Financial Procedure 090 –** Retention of Financial Records

The financial procedures are covered by a specific Financial Procedures Equality Impact Assessment (EqIA) with no negative impact.

Argymhelliad / Recommendation

The Finance and Performance Committee is asked to **APPROVE** the following updated financial procedures:

- **Financial Procedure 066** – Losses and Special Payments
- **Financial Procedure 090 –** Retention of Financial Records

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Cyfeirnod Cylch Gorchwyl y Pwyllgor: Committee ToR Reference:	3.13 Review and approve financial procedures on behalf of the Health Board
Cyfeirnod Cofrestr Risg Datix, Teitl a Sgôr Risg Cyfredol: Datix Risk Register Reference and Score:	Not Applicable
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	Not Applicable
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	Not Applicable
Amcanion Strategol y BIP: UHB Strategic Objectives:	All Strategic Objectives are applicable
Nodau Cynllunio 2026/27 Planning Goals 2026/27	Not Applicable

Hypergyswllt i Amcanion Llesiant HDdUHB 2026 Hyperlink to HDdUHB Well-being Objectives 2026	10. Not Applicable
Model Cymdeithasol ar gyfer Iechyd a Llesiant: (wedi'i gwblhau ar gyfer newid strategol a/neu newidiadau sylweddol i wasanaethau) A Social Model for Health and Wellbeing: (*complete for strategic change and/or significant service changes)*	Not Applicable
Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Previous procedures, internal audit report recommendations, standing financial instructions.
Rhestr Termau: Glossary of Terms:	Contained within the body of the report.
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y cyfarfod hwn: Parties / Committees consulted prior to this meeting:	HDdUHB Finance HDdUHB Local Counter Fraud Service

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	Financial procedures are required to ensure sound financial control.
Ansawdd / Gofal Claf: Quality / Patient Care:	Not Applicable
Gweithlu: Workforce:	Not Applicable
Tegwch Iechyd: Health Equity:	Not Applicable

Risg: **Risk:**	Financial procedures are required to ensure good governance and therefore minimise risk.
Cyfreithiol: **Legal:**	Not Applicable
Enw Da: **Reputational:**	Financial procedures are required to ensure good governance and sound financial control.
Gyfrinachedd: **Privacy:**	Not Applicable
Cydraddoldeb: **Equality:**	EqIA has been undertaken with no negative impacts on those with protected characteristics.

Losses and Special Payments Procedure

Procedure information

Procedure number: 066

Classification:
Financial

Supersedes:
Previous Versions

Local Safety Standard for Invasive Procedures (LOCSSIP) reference:
N/A

National Safety Standards for Invasive Procedures (NatSSIPs) standards:
N/A

Version number:
5

Date of Equality Impact Assessment:
21/10/2022

Approval information

Approved by: Finance and Performance Committee

Date of approval: [to be completed]

Date made active: [to be completed]

Review date: [to be completed]

Summary of document:
This document provides a clear process to be followed for identifying, reporting, recording and investigating all losses occurring within the Health Board, except those relating to Clinical Negligence or Personal Injury which are dealt with through the Claims Management Policy.

Scope:
Hywel Dda University Health Board wide.

To be read in conjunction with:
Standing Orders Hywel Dda University Local Health Board (opens in new tab)
Standing Financial Instructions (opens in new tab)
815 - Counter Fraud, Bribery and Corruption Policy (opens in new tab)
Financial Procedures (opens in new tab)

Patient information:
1.Patient Information Library
2. NHS111Wales

Owning group:
Finance Directorate
10/11/2022

Executive Director job title:
Director of Finance

Reviews and updates:
1.0 – New Procedure
2.0 – Revised
3.0 – Revised

Keywords
Losses, Special, Payments

Glossary of terms
NHS – National Health Service
Losses and Special Payments RegisterUK – United Kingdom
EEA - European Economic Area

FRAUD, BRIBERY AND CORRUPTION

All staff are required to comply with the Health Board's policies and procedures, including the Counter Fraud, Bribery and Corruption Policy and the Standards of Behaviour Policy, and to apply best practice in order to prevent fraud, bribery, corruption and inappropriate conduct. Staff must act honestly, declare relevant interests, avoid conflicts of interest, safeguard public funds and Health Board property, and remain alert to circumstances that may indicate misuse, concealment or deliberate loss.

All staff have a duty to notify the Local Counter Fraud Department of any suspected fraud, bribery, corruption, dishonesty, deliberate concealment, false claim, conflict of interest, abuse of position, inappropriate action or breach of the Standards of Behaviour Policy that may affect a loss, special payment or write-off. Staff are protected by the AW Raising Concerns (Whistleblowing) Policy (opens in a new tab). Anyone who suspects fraud or has any concerns relating to fraud, bribery or corruption can make a referral by contacting the Counter Fraud Department by any of the following methods:

- Telephoning local Counter Fraud Specialists on either 0791 063736 or 07980 919347
- Telephoning the local Counter Fraud office on 01267 266268
- Emailing: HDUHB.CounterFraudTeam.HDD@wales.nhs.uk
- Making an online referral at https://reportfraud.cfa.nhs.uk or
- Making an anonymous referral by telephoning Crimestoppers on 0800 028 40 60.

Staff should refer to the Counter Fraud, Bribery and Corruption Policy for further information.

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Introduction
This procedure details the processes to follow for the reporting of all Losses and Special Payments.

Scope
The financial procedure is Health Board wide.

Aim
The aim of this document is to:
- Ensure that a sound system exists for identifying, reporting, recording and investigating all losses/special payments occurring within the Health Board, except those relating to Clinical Negligence or Personal Injury which are dealt with through the Claims Management Policy.

Objectives
The aim of this document will be achieved by the following objectives:
- Ensure the effective recording, reporting and investigation of all losses in a timely manner.

Definition and Principles of Losses and Special Payments
Losses and special payments are items that the Welsh Government would not have contemplated when it agreed funds for NHS Wales or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments, and special notation in the accounts to draw them to the attention of the Welsh Government. They are divided into different categories, which govern the way each individual case is handled. This guidance is not applicable to any losses or special payments that arise from inter NHS Wales transactions.

In considering losses and special payments, it is always important to look beyond whether the proposed write off or payment represents value for money. The need for corrective action must also be carefully assessed to minimise the number and cost of future cases and to ensure lessons learned are embedded across the organisation.

NHS Wales Health Bodies do not have unlimited powers to make special payments or to write-off losses. They must obtain written approval of the Welsh Government H&SSG Finance Director before writing-off a loss or making, or undertaking to make, any special payment that exceeds their delegated limit. Where cover is provided through the Welsh Risk Pool, the delegated limits apply to the gross loss suffered by the NHS Wales body and the Welsh Risk Pool, but again net of any amount recovered or covered by insurance and excluding any defence or administrative cost.

All Health Board employees have a general responsibility for the security of Health Board property and for minimising the risk of loss. Service Delivery Managers have additional responsibility for the security of patients' property and monies where it has been deposited for safe custody in accordance with the Patient Property and Monies procedure, 078 - Patient Property and Monies Financial Procedure (opens in new tab).

Managers have a responsibility to notify their Heads of Department, Service Managers, Service Delivery Managers, Directorate General Manager and Director of Finance in writing off of all losses, using the appropriate documentation outlined in this procedure.

This financial control procedure incorporates the principles set out in the Welsh Government Manual for Losses and Special Payments.

The Manual includes the Welsh Government's delegated authority to HBs to approve payment and write off losses within specified limits. Any write offs and all payments made by Hywel Dda University Health Board will be compliant with these instructions.

The Manual also describes the different categories of loss and special payments that may arise for Health Bodies. These are detailed in Appendix 1 of this procedure. On discovering a loss or considering a special payment Hywel Dda University Health Board will take the appropriate action as set out in the Manual.

All losses and special payments must be managed in accordance with the Health Board's Standing Financial Instructions, Scheme of Delegation and the current Welsh Government Losses and Special Payments Manual. Where any inconsistency arises, Welsh Government guidance shall take precedence.

The Audit and Risk Assurance Committee of the Health Board will be adequately informed to ensure it is in a position to make proper decisions with regards to the following key points:

- The nature of the case and the circumstances in which it arose,
- What recovery action has been taken, if any,
- Reasons why the write–off or special payment should be approved by the Board (if the case falls within the level of delegated limits given to Health Board), or the Health and Social Care Department – Resource Directorate in Welsh Government,
- Whether legal advice has been sought, and if so, its content,
- Whether fraud, bribery, corruption, theft, deliberate concealment, abuse of position, undeclared interests, conflicts of interest, dereliction of duty, failure of supervision or breach of the Standards of Behaviour Policy is involved,
- Whether appropriate legal and/or disciplinary action has been taken, and if not, why not,
- Whether investigation has shown defects in existing systems of control and, if so, what remedy is proposed,
- Whether any general lessons emerge which are of benefit to other NHS Health bodies,
- The Health Board will ensure that approval of case write-off is obtained from either the Health Board's Audit and Risk Assurance Committee or Welsh Government depending on the level of delegation given to Health bodies,
- The Health Board will close the case once all reasonable action pertaining to the case has been taken, including recovery action, counter fraud referral where appropriate, disciplinary or legal action where required, completion of agreed control improvements, and recording of lessons learned.

Roles and Responsibilities

	Procedure	Responsible party
1	**Notify the Police, Welsh Government, Chief Executive and Counter Fraud of losses where relevant**	**Director of Finance**
2	**Ensure all managers implement financial and other related management controls to promptly detect any losses**	**Director of Finance**
3	**Approve ex gratia payments in line with the delegated authorisation limit**	**Director of Finance,**
4	**Maintain the computerised losses and special payments register held on a Losses and Special Payments Register**	**Director of Finance**
5	**Report all losses over £5,000 to the Audit and Risk Assurance Committee**	**Director of Finance**
6	**Report all losses in line with this procedure**	**Service Managers, Heads of Department, Service Delivery Managers and Directorate General Managers**
7	**Approve ex gratia payments in line with the delegated authorisation limit**	**Service Managers, Heads of Department, Service Delivery Managers and Directorate General Managers**
8	**Ensure internal controls are in place to promptly detect any losses**	**Service Managers, Heads of Department, Service Delivery Managers and Directorate General Managers**
9	**Undertake a full management investigation where losses have occurred**	**Service Managers, Heads of Department, Service Delivery Managers and Directorate General Managers**
10	**Processing of payments once authorised**	**Financial Accounting**

Recording, Reporting and Investigation of Losses

Reporting and Investigation of Losses

Any employee or officer discovering or suspecting a loss of any kind must either immediately inform their head of department or line manager, who must immediately inform the Chief Executive or the appropriate officer under the scheme of delegation and/or the Director of Finance.

Where a criminal offence is suspected, the Director of Finance shall immediately inform the Police if theft or arson is involved. If the case involves suspicion of fraud and corruption, then the Director of Finance must inform the Local Counter Fraud Specialist and Counter Fraud Service Wales, in accordance with the Welsh Government's directions to NHS Bodies on counter fraud measures. The Director of Finance or the Local Counter Fraud Specialist must notify the Audit and Risk Assurance Committee, the External Auditor and Welsh Government via Counter Fraud Service Wales.

The Audit and Risk Assurance Committee shall approve the writing off of losses (including bad debts, or the making of special payments) within delegated limits at each committee meeting

Losses are divided into the following categories in accordance with the Welsh Government Losses and Special Payments Manual:

- Category 1 – Losses of cash
- Category 2 – Fruitless payments
- Category 3 – Bad debts and claims abandoned
- Category 4 – Damage to buildings, their fittings, furniture and equipment and loss of equipment and property in stores and in use (see additional detail below)
- Category 5 – Theft of IT equipment

All losses reported should have sufficient details attached as to the circumstances surrounding the loss. Such details should include where appropriate; statements from members of staff, date of loss, cause (if known), its value based either on historic or replacement value, a description of the items, model number etc., together with recommended preventative action which could be taken to prevent a recurrence.

Loss or Damage to Health Board Property

All incidents which result in loss or damage to Health Board Property should be reported promptly by a Manager to the Director of Finance using the Loss or Damage to Health Board Property Form (See Appendix 2). Refer to the flowchart (See Appendix 5) to assist with the approval of any claims.

A Datix incident record must also be created for all loss, damage or theft of Health Board property as soon as the incident is identified. The Datix reference must be included on the Loss or Damage to Health Board Property Form and a copy of the Datix report attached when the matter is submitted to the Director of Finance. This ensures there is a clear audit trail, supports timely investigation, enables risk and trend analysis, and helps the Health Board identify any control weaknesses or preventative actions required.

This covers cases including:

Culpable causes e.g. suspected or proven theft or criminal damage (including arson), fraud or sabotage (whether proved or suspected), neglect of duty or gross carelessness.

- Other causes, for example:

- Losses by fire (other than arson);
- Losses by weather damage or by accident proved on due enquiry to be beyond the control of any reasonable person;

- Losses due to deterioration in use and deterioration in store due to some defect in administration such as:
  - Over provisioning
  - Retention of excess or obsolete stocks
  - Storage of items with a known shelf life in quantities greater than could be turned over within that life
  - Failure to turn over stocks in proper sequence; and
  - Failure to set and to observe property standards to keep stock in good condition.

In the case of buildings, the amount to be written off depends on whether the building is repaired. If a decision is made not to repair it, the amount to be written off is the value of the building (or part) and lost contents immediately prior to the incident. If it is repaired, the amount to be written off is either the cost of repair to the building and contents, or the estimated value of the contents if destroyed, less any sum received from the sale of scrap.

In the case of vehicles, the amount to be written off is either;
- The cost of repairs to the vehicle (if readily ascertainable) less any sums recovered from an insurance company or other party should be treated as a stores loss.
- Payments to an insurance company or other party should be treated as compensation payments (made under legal obligations).
- If the vehicle is a total loss the amount to be written off is the value immediately prior to the accident less any sum received from the sale of scrap.

Unless there are special features or circumstances justifying exceptional treatment, all losses of bedding and linen in use should be valued at 50% of the current replacement cost. Where stores losses and write-offs occur they should be valued at book value less net disposal proceeds.

Where equipment on loan to patients is lost or becomes valueless in circumstances not justifying recovery of the cost, it should be treated in the same way as articles that have deteriorated in use. Failure to recover a sum due to be paid by a patient should be treated as a bad debt.

Loss or Damage to Personal Property
All incidents which result in loss or damage of personal property should be reported promptly by a Manager to the Director of Finance. Where no ex gratia payment is to be made, losses forms are not required.

To initiate the claim procedure, the claimant will need to complete Personal Property Form PP1 (See Appendix 3) and submit this form to the Manager where the incident occurred.

The Manager will need to investigate the details stated in the PP1 form and decide on the recommended course of action, whether the Health Board is liable for the loss, and ultimately whether or not to authorise an ex gratia payment. It is also important to note that any payment should be made on an indemnity basis.

If an ex gratia payment is to be made, an Approval for Payment of ex gratia Compensation Form (See Appendix 4) should be completed by a Manager and authorised in accordance with the delegated authorisation limits stated in section 'Delegated Authorisation Limits'.

When determining the value of the payment to be made, a reasonable value may need to be offered taking into account the age of the item. The Head of Department will also need to consider taking appropriate action to reduce the risk of similar incidents occurring in the future.

When submitting a claim to the Director of Finance please ensure the following is included:

- PP1 form (completed by the claimant)
- PP2 form (completed by the Manager and authorised in line with the Health Board's delegated authorisation limits)
- Evidence to substantiate the amount claimed
- Copy of the Datix report

Once the claim has been fully authorised, the Losses and Compensation Accounting Officer will arrange for the ex gratia payment to be processed and record the loss on the Health Board's Losses and Special Payments Register (Losses and Special Payments Register). Refer to the flowchart (See Appendix 5) to assist with the approval of any claims.

Loss or Damage to Personal Property (Staff)

Ex gratia payments to staff for the loss or damage to their personal property follows the procedure above, but may only be made when all the following criteria apply:

- The incident occurs during the course of their employment;
- The articles lost or damaged were reasonably carried during the course of their employment;
- The articles are sufficiently robust for the treatment they might reasonably be expected to bear;
- The loss or damage is not due to the officer's own negligence; and
- The loss or damage is not covered by insurance or by any provision for free replacement.

Where the article can be repaired the payment should cover the actual cost of repair. However, where it is lost or damaged beyond repair the value of the property immediately before the incident should be paid (the cost of replacement less the estimated amount by which the property had depreciated since purchase). Refer to the flowchart (See Appendix 5) to assist with the approval of any claims.

Recording of Losses

All losses and special payments identified by Hywel Dda University Health Board shall be recorded on a Losses and Special Payments Registerin accordance with Welsh Government guidance.

The main control procedures to be followed by Hywel Dda University Health Board in administrating the Losses and Special Payments Register system are set out below:

- The Health Board will register any losses and special payments cases onto the Losses and Special Payments Register system on a case-by-case basis;
- The Health Board will nominate a named individual to be its case system administrator;
- The Health Board will formally transfer structured settlement cases to the Welsh Risk Pool once approval to settle on a structured basis has been secured from Welsh Government (legal responsibility will continue to lie with the Health Board);

- The Health Board will regularly monitor its cases on the Losses and Special Payments Register to ensure the system is accurately maintained and that they are always fully appraised of the status of each case.

Special Payments
Special payments are those defined as such in the Welsh Government Losses and Special Payments Manual.

In practice, the vast majority of special payments made by the Health Board will be in respect of compensation payments for Clinical Negligence and Personal Injury claims which are dealt with separately under the Claims Management Policy. This procedure outlines the process to be followed for payments for other minor claims. Special payments are categorised as follows:

- Compensation payments made under legal obligation
- Extra contractual payments to contractors
- Ex gratia payments
- Loss of personal effects
- Personal injury and other negligence and injury cases
- Other cases e.g settlements on termination of employment, special severance payments
- Maladministration
- Patient referrals outside of the UK, the European Economic Area (EEA) and Switzerland
- Extra statutory or extra regulatory payments
- Voluntary Early Release Scheme

Clinical Negligence and Personal Injury

Claims for alleged Clinical Negligence and Personal Injury should be dealt with through the Health Board's Claims Management Policy and recorded on the Losses and Special Payments Register. Refer to the flowchart (See Appendix 5) to assist with the approval of any claims.

Delegated Authorisation Limits

The Welsh Government Manual for Losses and Special Payments specifies the Health Board's delegated authorisation limits by type of loss (See Appendix 1).

The delegated limit for approving ex gratia payments for personal property claims within directorates is as follows:

- Up to £250 – Directorate Managers
- Up to £1,000 – General Managers
- Up to £1,500 – Head of Accounting & Statutory Reporting
- Above £1,500 – Director of Finance

It should be noted where Welsh Government approval is required to write-off any Loss or Special Payment, the loss should not be recorded in the Register until approval has been received. Welsh Government will allocate a loss reference number, which should be recorded within the Health Board's Losses and Special Payments Register, and identified as such on the annual return submitted to Welsh Government.

Monitoring and Review

The monitoring and review of this procedure is the responsibility of the Accounting and Statutory Reporting Team within the Finance Directorate. This procedure will be reviewed every three years or sooner where changes to legislation, Welsh Government guidance, Standing Financial Instructions, organisational arrangements or identified best practice require amendment.

Appendix 1 – Delegated Limits

The delegated limits relate to the requirement for NHS Wales health bodies to obtain approval for write-off of the loss or special payment.

	CATEGORY OF LOSS/SPECIAL PAYMENT	DELEGATED LIMITS (£)
	Losses (except in respect of primary care provider services)	
1)	Loss of cash due to:	
a.	theft, fraud, etc	50,000
b.	overpayment of salaries, wages, fees and allowances	50,000
c.	other causes, including foreign exchange losses, un-vouched or incompletely vouched payments, overpayments other than those included under 1(b), and physical losses of cash and cash equivalents arising through fire, accident or similar causes	50,000
2)	Fruitless payments (including abandoned capital schemes)	250,000
3)	Bad debts and claims abandoned:	
a.	private patients (Sections 65 and 66 NHS Act 1977)	50,000
b.	overseas visitors (Section 121 NHS Act 1977)	50,000
c.	cases other than a-b	50,000
4)	Damage to buildings, their fittings, furniture and equipment and loss of equipment and property in stores and in use due to:	
a.	culpable causes eg, theft, fraud, arson or sabotage whether proved or suspected, neglect of duty or gross carelessness	50,000
b.	other causes	50,000
	Special payments (except in respect of primary care provider services)	
5)	Compensation payments made under legal obligation	FULL *
6)	Extra contractual payments to contractors	50,000
7)	Ex gratia payments	
a.	to patients and staff for loss of personal effects	50,000

b.	for clinical negligence (negotiated settlements following legal advice) where the guidance relating to such payments has been applied	1,000,000 including plaintiff's costs, defence costs and other payments *
c.	for personal injury claims involving negligence where legal advice obtained and relevant guidance has been applied	1,000,000 including plaintiff's costs, defence costs and other payments *
d.	other clinical negligence cases and personal injury claims	50,000 *
e.	other, except cases for maladministration where there was no financial loss by claimant	50,000
f.	maladministration where there was no financial loss by claimant	NIL
g.	patient referrals outside the UK and EEA guidelines	NIL

*** For all clinical negligence and personal injury cases (including court cases) the use of periodical payments should be considered for any settlement (exclusive of legal costs) involving costs to the NHS of £250,000 or more, or for lower awards when this represents good value for money. Proposed out of Court periodical payment awards require approval from the WG H&SSG Finance Department.**

8)	Extra statutory and extra regulatory payments	NIL

Losses and special payments in respect of provision of primary care provider services

Losses			**Limit**
			£
9)	a.	Losses due to overpayments to practitioners of fees, allowances or salary	
		i. involving fraud	1,000
		ii. other	1,000
	b.	unvouched or incompletely vouched payments	1,000
10)	Claims abandoned		1,000

Special Payments

11)	Ex gratia payments		1,000
12)	Extra statutory and extra regulatory payments		
	a.	to pharmacist contractors for drugs supplied in good faith in respect of forged, etc, prescriptions forms	1,000
	b.	excusal of statutory charges for replacement dentures in certain circumstances	up to appropriate maximum statutory charge
	c.	other	NIL

Losses: Fraud cases under investigation

13)	a.	Losses in cases investigated by the health body in respect of prescription fraud.	1,000
	b.	Losses in cases investigated by the health body in respect of dental fraud.	1,000
	c.	Losses in cases investigated by the health body in respect of ophthalmic fraud.	1,000

Appendix 2 – Loss or Damage to Health Board Property Form

DATIX Case Reference (Attach a copy of the DATIX report):

State the date and location of the incident

State the reason for the loss or damage and the circumstances in which it arose

Record the item(s) and value(s) based either on historic or replacement value(s)

Is the value of the loss reduced by insurance?

Was theft involved? If so, have the police been informed?

What actions have been taken, including any legal action to cover the loss?

Did an investigation show defects in existing systems of control and, if so, what remedy is proposed?

Approved by (Manager):

Signature			
Print Name		Date	/ /
Position			

This form is to be submitted to the Director of Finance

Appendix 3 – Form PP1 – Loss or Damage to Personal Property

This form is to be completed by the claimant

Personal Details

Name:

Address:
Postcode:

Telephone Number:	

At the time of the occurrence please indicate whether you were (please circle):

Patient	Visitor	Staff Member

Incident Details

Please state where the incident occurred:

Ward / Department	
Hospital / Premises	

Date of Occurrence	/ /	Approximate Time	

Details of loss or damage caused:

If personal articles / possessions were lost or damaged, please state:

Item Description	Date Purchased	Approximate cost at date of purchase	Cost of repair (where applicable)
	/ /	£	£
	/ /	£	£
	/ /	£	£
	/ /	£	£
	/ /	£	£

Attach documentation to substantiate the cost of replacement or repair (eg official quotations, invoices, receipts etc). Failure to provide documentation may result in no payment.

Do you have a personal insurance policy against which a claim could be made?	Yes		No	

Additional Information

I confirm that the information provided is true and accurate to the best of my knowledge.

Signature		Date	

Print Name	

Please submit this form to the Directorate / General Manager where the incident occurred

Appendix 4 – Form PP2 – Approval for Payment of Ex Gratia Compensation

This form is to be completed by the Directorate / General Manager

DATIX Case Reference (Attach a copy of the DATIX report):

Facts of the case

Was an investigation undertaken at the time of the incident?

Has an objective account of the incident been compiled, and contact established with relevant staff in post at the time?

Was theft involved? If so, have the police been informed?

Has appropriate legal advice been sought?

Reason for proposed ex gratia payment

Did an investigation show defects in existing systems of control and, if so, what remedy is proposed?

Has any recommendation been discussed at a Risk Management Group meeting?

Recommended payment amount

£

Authorisation (Complete for all payments)

Recommended by:

Signature			
Print Name		Date	/ /
Position			

Authorisation (Complete for all payments)

Recommended Endorsed by (Directorate Manager):

Signature			
Print Name		Date	/ /
Position			

Additional authorisation (Complete for all payments > £250)

Approved by (General Manager):

Signature			
Print Name		Date	/ /
Position			

Additional authorisation (Complete for all payments > £1,000)

Approved by (Head of Accounting & Statutory Reporting):

Signature			
Print Name		Date	/ /

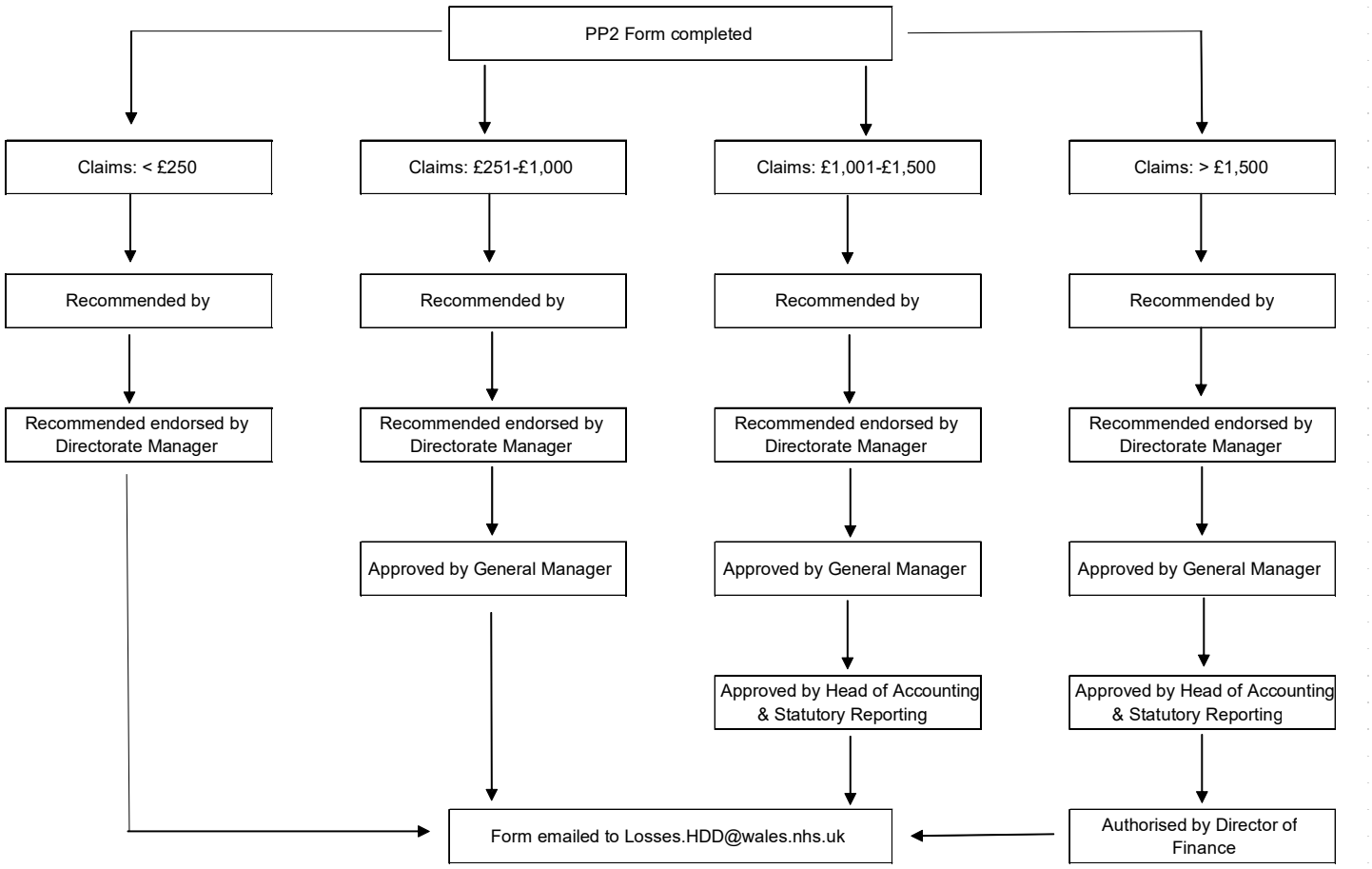
Position	

Additional authorisation (Complete for all payments > £1,500)

Approved by (Director of Finance):

Signature			
Print Name		Date	/ /
Position			

Once approved and ready for payment, this form is to be submitted (with a copy of Form PP1) to the Losses and Compensation Officer, Financial Accounts, Ty Gorwel, Building 14, St David's Park, Jobs Well Road, Carmarthen, SA31 3HB.


PP2 Form completed
Claims: < £250
Claims: £251-£1,000
Claims: £1,001-£1,500
Claims: > £1,500
Recommended by
Recommended by
Recommended by
Recommended by
Recommended endorsed by Directorate Manager
Recommended endorsed by Directorate Manager
Recommended endorsed by Directorate Manager
Recommended endorsed by Directorate Manager
Approved by General Manager
Approved by General Manager
Approved by General Manager
Approved by Head of Accounting & Statutory Reporting
Approved by Head of Accounting & Statutory Reporting
Form emailed to Losses.HDD@wales.nhs.uk
Authorised by Director of Finance

Equality Impact Assessment (EqIA) Screening Template

When to complete an EqIA Screening

An EqIA Screening Template must be completed when reviewing, changing and developing procedures/ proposals/ projects/ policies. This is a first step and is used to consider whether there are any negative impacts that may arise.

Purpose of an EqIA Screening Template

The purpose of this short exercise is to ensure that you have shown appropriate due regard when considering the impact for people with protected characteristics in your decision making. The screening process is designed to help you consider the circumstances and to inform evidence-based decisions.

If the proposal is of a significant nature and it is apparent from the outset that a full EqIA will be required, then it is not necessary to complete this Screening Template, you can proceed to complete the full EqIA.

If no negative impacts are identified following completion of the EqIA screening then it is not necessary to undertake a full EqIA however, the decision and justification must be clearly recorded in this document.

On completion of the Screening Template:

- Ensure that all the white boxes within the screening are completed.
- Ensure that the Procedure/ Project/ Proposal/ Policy owner has signed and dated the Screening Template.
- Send a copy of the completed template along with the related policy or project proposal to Inclusion.hdd@wales.nhs.uk for the Diversity & Inclusion Team to review.
- Each Screening Template will be reviewed by the Diversity & Inclusion Team and feedback will be provided to the Procedure/ Project/ Proposal/ Policy owner. This may include recommendations for further action to inform robust decision-making.

Support

For further support please visit the EqIA Sharepoint or contact:
Email: Inclusion.hdd@wales.nhs.uk
Tel: 01554 899055

Director and Directorate	Huw Thomas, Finance
Service Area	Hywel Dda University Health Board wide

Title of Procedure, Project, Proposal, Policy being screened:	066 - Losses and Special Payments

Description of the Procedure/ Project/ Proposal/ Policy being screened (including key aims and objectives)

The aim of this document is to ensure that a sound system exists for identifying, reporting, recording and investigating all losses/special payments occurring within the Health Board.

The aim of this document will be achieved by the following objectives:

- Ensure the effective recording, reporting and investigation of all losses in a timely manner.

Evidence considered (including staff and population data, relevant research, expert and community knowledge etc.)

- Standing Orders Hywel Dda University Local Health
- Standing Financial Instructions
- Counter Fraud, Bribery and Corruption Policy
- Financial Procedures

Assess which protected characteristics will potentially be affected by the proposal in the table below (please ✓ the relevant box to confirm positive, negative or no impact)**.**

If at any point a negative impact has been identified (actual or potential), you do not need to proceed with the completion of this form, as a full EqIA must be undertaken: Equality Impact Assessments (EqIAs) (sharepoint.com)

Age
Is it likely to affect older and younger people in different ways or affect one age group and not another?

Positive Impact		Negative Impact		No Impact	✓

Justification of impact identified:
The processes to be followed for losses and special payments will have no impact on people of different age groups.

Disability
Is it likely to affect those with a physical disability, learning disability, sensory loss or impairment, mental health conditions, long-term medical conditions such as diabetes?

Positive Impact		Negative Impact		No Impact	✓

Justification of impact identified:
The processes to be followed for losses and special payments will no impact on those with a disability.

Gender Reassignment
Is it likely to affect those who either:

- Have undergone, intend to undergo or are currently undergoing gender reassignment.
- Do not intend to undergo medical treatment but wish to live in a different gender from their gender at birth

Positive Impact		Negative Impact		No Impact	✓

Justification of impact identified:
The processes to be followed for losses and special payments will have no impact on those who have undergone gender reassignment.

Marriage / Civil Partnership
Under the Equality Act, the characteristic of Marriage and Civil Partnerships is only protected in the workplace/ employment.
Is it likely to affect those who are married or in a Civil Partnership? This means someone who is legally married or in a civil partnership.

Positive Impact		Negative Impact		No Impact	✓

Justification of impact identified:
This group is in relation to workplace and employment only and is therefore not relevant for this policy.

Pregnancy and Maternity
Is it likely to affect those who are pregnant or have recently had a baby? Maternity covers the period of 26 weeks after having a baby, whether or not they are on Maternity Leave.

Positive Impact		Negative Impact		No Impact	✓

Justification of impact identified:
The processes to be followed for losses and special payments will have no impact on those who are pregnant or have recently had a baby.

Race / Ethnicity
Is it likely to affect people of a different race, nationality, colour, culture or ethnic origin including non-English / Welsh speakers, Gypsies/Travellers, asylum seekers and migrant workers?

Positive Impact		Negative Impact		No Impact	✓

Justification of impact identified:
The processes to be followed for losses and special payments will have no impact on people of different race or ethnicity.

Religion or Belief
Is it likely to affect people who have a religion or belief? The term 'religion' includes a religious or philosophical belief.

Positive Impact		Negative Impact		No Impact	✓
Justification of impact identified: The processes to be followed for losses and special payments will have no impact on people who have a religion or belief.					
Sex Is it likely to affect people who are mostly male or female. Where it applies to both equally does it affect one differently to the other?					
Positive Impact		Negative Impact		No Impact	✓
Justification of impact identified: The processes to be followed for losses and special payments will have no impact on one sex more than the other.					
Sexual Orientation Whether a person's sexual attraction is towards their own sex, the opposite sex or either.					
Positive Impact		Negative Impact		No Impact	✓
Justification of impact identified: The processes to be followed for losses and special payments will have no impact on individuals regardless of their sexual orientation.					
Armed Forces Community Consider whether this impacts on members of the Armed Forces and their families, whose health needs may be impacted long after they have left the Armed Forces and returned to civilian life. Also consider their unique experiences when accessing and using day-to-day public and private services compared to the general population. It could be through 'unfamiliarity with civilian life, or frequent moves around the country and the subsequent difficulties in maintaining support networks, for example, members of the Armed Forces can find accessing such goods and services challenging.' For a comprehensive guide to the Armed Forces Covenant Duty and supporting resource please see: **Armed-Forces-Covenant-duty-statutory-guidance**					
Positive Impact		Negative Impact		No Impact	✓
Justification of impact identified: The processes to be followed for losses and special payments will have no impact on members of the Armed Forces and their families.					
Socio Economic Duty Consider those on low income, economically inactive, unemployed or unable to work due to ill-health. Also consider people living in areas known to exhibit poor economic and/or health indicators and individuals who are unable to access services and facilities. Food / fuel poverty and personal or household debt should also be considered. For a comprehensive guide to the Socio-Economic Duty in Wales and supporting resources please see: more-equal-wales-socio-economic-duty					
Positive Impact		Negative Impact		No Impact	✓
Justification of impact identified: The processes to be followed for losses and special payments will have no impact on individuals of different socio economic groups.					
Welsh Language Is it likely to impact on opportunities for people to use the Welsh language? The Welsh language should be treated no less favourably than the English language.					
Positive Impact		Negative Impact		No Impact	✓

Justification of impact identified: The processes to be followed for losses and special payments will have no impact on opportunities for people to use the Welsh language.

If a negative impact has been identified, you are not required to complete this form as a full EqIA must be undertaken. A full EqIA template and guidance can be found on the following link: Equality Impact Assessments (EqIAs) (sharepoint.com)

Screening Completed by:	Name	Sarah Morgan
	Title	Finance Analyst
	Contact details	sarah.morgan16@wales.nhs.uk
	Date	07/08/26
Screening Authorised by: (Directorate level owner of the procedures/ proposals/ projects/ policy)	Name	Tim John
	Title	Head of Accounting and Statutory Reporting
	Contact details	Timothy.john@wales.nhs.uk
	Date	07.08.26
Guidance has been provided by Diversity & Inclusion Team:	Name	Kylie Daniels
	Title	Senior Diversity and Inclusion Officer
	Contact details	Kylie.daniels@Wales.nhs.uk
	Date	12/08/2026
Diversity and Inclusion Team additional Comments:		

Please note: The D&I team will save a copy of the completed form for reference. If any changes are made after the date of review, it is the directorate's responsibility to update the EqIA and inform the D&I team.

RETENTION OF FINANCIAL RECORDS PROCEDURE

Procedure information

Procedure number: 090 FP 12/01

Classification:

Financial

Supersedes:

Version 3

National Safety Standards for Invasive Procedures (NatSSIPs) standards:

Not applicable

Version number:

4

Date of Equality Impact Assessment:

07/2023

Approval information

Approved by:

Finance and Performance Committee

Date of approval: [to be completed]
Click or tap to enter a date.
Date made active: [to be completed]
Enter date made active (completion by policy team)

Review date: [to be completed]
Enter review date

Enter review date (normally three years from approval date)

Summary of document:

The purpose of this document is to outline the key processes to be followed by Health Board staff in connection with the retention of financial records and to set out associated roles and responsibilities.

Scope:

The procedure applies to all Health Board staff.

To be read in conjunction with:

Standing Orders and Standing Financial Instructions
Other Financial Procedures and Records Management Policy

Patient information:

Patient Information Library

Owning group:

Finance and Performance Committee
Date signed off by owning group

Executive Director job title:

Director of Finance

Reviews and updates:

Version 4

Keywords:

Retention of records

Glossary of terms

Term	Definition
DoH	Department of Health
NWSSP	NHS Wales Shared Services Partnership

FRAUD, BRIBERY AND CORRUPTION

All staff are required to comply with the Health Board's policies and procedures, including the Counter Fraud, Bribery and Corruption Policy and the Standards of Behaviour Policy, and to apply best practice in order to prevent fraud, bribery, corruption and inappropriate conduct. Staff must act honestly, declare relevant interests, avoid conflicts of interest, safeguard public funds and Health Board property, and remain alert to circumstances that may indicate misuse, concealment or deliberate loss.

All staff have a duty to notify the Local Counter Fraud Department of any suspected fraud, bribery, corruption, dishonesty, deliberate concealment, false claim, conflict of interest, abuse of position, inappropriate action or breach of the Standards of Behaviour Policy that may affect a loss, special payment or write-off. Staff are protected by the AW Raising Concerns (Whistleblowing) Policy (opens in a new tab). Anyone who suspects fraud or has any concerns relating to fraud, bribery or corruption can make a referral by contacting the Counter Fraud Department by any of the following methods:

- Telephoning local Counter Fraud Specialists on either 0791 063736 or 07980 919347
- Telephoning the local Counter Fraud office on 01267 266268
- Emailing: HDUHB.CounterFraudTeam.HDD@wales.nhs.uk
- Making an online referral at https://reportfraud.cfa.nhs.uk or
- Making an anonymous referral by telephoning Crimestoppers on 0800 028 40 60.

Staff should refer to the Counter Fraud, Bribery and Corruption Policy for further information.

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INTRODUCTION & AIM

Records of the NHS and its predecessor bodies are subject to the Public Records Act 1958, which imposes a statutory duty of care directly upon all individuals who have direct responsibility for any such records. This document defines the procedures that shall be in place to manage the retention of Hywel Dda University Health Board's (HDdUHB) financial records. This procedure also applies equally to digital, electronic, and emailed based financial records, including those held in corporate systems, shared drives and personal inboxes where business records are retained.

OBJECTIVES

To ensure financial probity and clarity of accountability in the organisation. To ensure compliance with statutory, regulatory, audit, and data protection requirements, including the UK GDPR and Data Protection Act 2018.

PRINCIPLES

Due to legislation, enactment and regulations, various financial records should not be destroyed until a stipulated period has elapsed.

Records may be retained for longer than the minimum period. However large amounts of documents should not be retained for long periods of time in excess of the limits specified below without good reason.

Retention periods defined within this document represent minimum requirements. Where litigation, investigation, audit, or other legal proceedings are ongoing or anticipated, records must be retained until the matter is fully concluded, regardless of standard retention periods.

Records should be kept in a structured orderly manner with a log maintained of the location of each item.

Each record store shall be the responsibility of a named designated officer. This officer shall check the store in question on, at least, an annual basis to ensure it is being maintained in an orderly manner.

All records must be stored securely and in accordance with information governance and confidentiality requirements.

PERIODS OF RETENTION

In order to ensure that all financial and supporting records are maintained for the appropriate period in order for HDdUHB to discharge its statutory and audit requirements, the main reference for periods of required retention is Records Management Code of Practice for Health and Social Care 2022, published by the Welsh Government and notified through Welsh Health Circular WHC/2022/008. Organisations should also remember that records containing personal information are subject to the UK General Data Protection Regulation (UK GDPR), the Data Protection Act 2018 and any subsequent amendments. Personal data should only be retained for as long as necessary and in accordance with applicable information governance requirements.

This procedure will tie in with HDdUHB's Records Management policy and be regularly updated to take account of any changes.

Where discrepancies arise between this procedure and national guidance, the Records Management Code of Practice shall take precedence.

In general, financial records should be retained for a minimum of 6 years after the end of the financial year to which they relate, in line with Limitation Act and HMRC requirements, unless otherwise specified.

HDdUHB's required periods of retention are as laid down in Appendix 1: 'Periods of Retention'.

The periods shown relate to financial years i.e. records should be retained to 31 March of the year in question, not simply the day/month to which they relate.

DISPOSAL

Once identified as no longer required to be kept due to statutory requirement or administrative need and they have no long term historical or research value, records should be destroyed.

Records must be disposed of using secure and approved methods appropriate to their classification:

- Paper records: cross-cut shredding or approved confidential waste contractor
- Electronic records: secure deletion from systems, including removal from backups where applicable

All disposals must be documented in a Disposal Log including record type, date, method of destruction, and authorising officer.

Disposal must be authorised by a designated responsible officer in line with local governance arrangements.

INTERPRETATION

Any uncertainty or questions regarding the interpretation of this procedure and the above circular shall be referred to the Director of Finance.

Advice may also be sought from the Records Management or Information Governance teams where appropriate.

AUDIT

The Internal Audit programme shall, from time to time, provide for random checks to ensure this procedure is being adhered to.

Compliance with this procedure may also be monitored through Information Governance reviews and external audit processes.

GOVERNANCE AND RESPONSIBILITIES

- Director of Finance: overall ownership of this procedure
- Records Management / Information Governance: oversight and compliance monitoring
- Budget Holders / Managers: ensuring adherence within their areas
- All Staff: responsibility for correct handling and retention of records

RISK STATEMENT

Failure to comply with this procedure may result in breaches of statutory obligations, audit failures, financial penalties, or reputational damage to the Health Board.

APPENDIX 1 - PERIODS OF RETENTION

Record Type	Retention Period	Legal / Policy Basis	Disposal
Bank Statements	6 years after end of financial year	HMRC / Limitation Act	Confidential destruction
Audit Reports	6 years minimum	Audit evidence / governance	Confidential destruction
Expenses Claims	6 years	HMRC	Confidential destruction
Contracts (non-sealed)	6 years after termination	Limitation Act	Confidential destruction
Contracts (sealed)	Minimum 15 years	Legal best practice	Confidential destruction
PFI Records	Duration of contract + 6 years	Contractual / audit	Confidential destruction
Invoices	6 years	HMRC	Confidential destruction
Payroll Records	10 years after termination	HMRC / pensions	Confidential destruction

Any categories not explicitly listed should default to a 6-year minimum retention period unless defined by statutory requirement.

Equality Impact Assessment (EqIA) Screening Template

When to complete an EqIA Screening

An EqIA Screening Template must be completed when reviewing, changing and developing procedures/ proposals/ projects/ policies. This is a first step and is used to consider whether there are any negative impacts that may arise.

Purpose of an EqIA Screening Template

The purpose of this short exercise is to ensure that you have shown appropriate due regard when considering the impact for people with protected characteristics in your decision making. The screening process is designed to help you consider the circumstances and to inform evidence-based decisions.

If the proposal is of a significant nature and it is apparent from the outset that a full EqIA will be required, then it is not necessary to complete this Screening Template, you can proceed to complete the full EqIA.

If no negative impacts are identified following completion of the EqIA screening then it is not necessary to undertake a full EqIA however, the decision and justification must be clearly recorded in this document.

On completion of the Screening Template:

- Ensure that all the white boxes within the screening are completed.
- Ensure that the Procedure/ Project/ Proposal/ Policy owner has signed and dated the Screening Template.
- Send a copy of the completed template along with the related policy or project proposal to Inclusion.hdd@wales.nhs.uk for the Diversity & Inclusion Team to review.
- Each Screening Template will be reviewed by the Diversity & Inclusion Team and feedback will be provided to the Procedure/ Project/ Proposal/ Policy owner. This may include recommendations for further action to inform robust decision-making.

Support

For further support please visit the EqIA Sharepoint or contact:
Email: Inclusion.hdd@wales.nhs.uk
Tel: 01554 899055

Director and Directorate	Huw Thomas, Finance
Service Area	Hywel Dda University Health Board wide

Title of Procedure, Project, Proposal, Policy being screened:	090 – Retention of Financial Records

Description of the Procedure/ Project/ Proposal/ Policy being screened (including key aims and objectives)

This document defines the procedures that shall be in place to manage the retention of Hywel Dda University Health Board's financial records. This procedure applies equally to digital, electronic, and emailed based financial records, including those held in corporate systems, shared drives and personal inboxes where business records are retained.

The aim of this document will be achieved by the following objectives:

- To ensure financial probity and clarity of accountability in the organisation.
- To ensure compliance with statutory, regulatory, audit, and data protection requirements, including the UK GDPR and Data Protection Act 2018.

Evidence considered (including staff and population data, relevant research, expert and community knowledge etc.)

- Standing Orders Hywel Dda University Local Health
- Standing Financial Instructions
- Counter Fraud, Bribery and Corruption Policy
- Financial Procedures
- Records Management Code of Practice for Health and Social Care 2022
- UK General Data Protection Regulation (UK GDPR)
- Data Protection Act 2018

Assess which protected characteristics will potentially be affected by the proposal in the table below (please ✓ the relevant box to confirm positive, negative or no impact)**.**

If at any point a negative impact has been identified (actual or potential), you do not need to proceed with the completion of this form, as a full EqIA must be undertaken: Equality Impact Assessments (EqIAs) (sharepoint.com)

Age Is it likely to affect older and younger people in different ways or affect one age group and not another?					
Positive Impact		Negative Impact		No Impact	✓
Justification of impact identified: The processes to be followed by staff in connection with retention of financial records will have no impact on people of different age groups.					
Disability Is it likely to affect those with a physical disability, learning disability, sensory loss or impairment, mental health conditions, long-term medical conditions such as diabetes?					
Positive Impact		Negative Impact		No Impact	✓
Justification of impact identified: The processes to be followed by staff in connection with retention of financial records will no impact on those with a disability.					
Gender Reassignment Is it likely to affect those who either: • Have undergone, intend to undergo or are currently undergoing gender reassignment. • Do not intend to undergo medical treatment but wish to live in a different gender from their gender at birth					
Positive Impact		Negative Impact		No Impact	✓
Justification of impact identified: The processes to be followed by staff in connection with retention of financial records will have no impact on those who have undergone gender reassignment.					
Marriage / Civil Partnership Under the Equality Act, the characteristic of Marriage and Civil Partnerships is only protected in the workplace/ employment. Is it likely to affect those who are married or in a Civil Partnership? This means someone who is legally married or in a civil partnership.					
Positive Impact		Negative Impact		No Impact	✓
Justification of impact identified: This group is in relation to workplace and employment only and is therefore not relevant for this policy.					
Pregnancy and Maternity Is it likely to affect those who are pregnant or have recently had a baby? Maternity covers the period of 26 weeks after having a baby, whether or not they are on Maternity Leave.					
Positive Impact		Negative Impact		No Impact	✓
Justification of impact identified: The processes to be followed by staff in connection with retention of records will have no impact on those who are pregnant or have recently had a baby.					
Race / Ethnicity Is it likely to affect people of a different race, nationality, colour, culture or ethnic origin including non-English / Welsh speakers, Gypsies/Travellers, asylum seekers and migrant workers?					
Positive Impact		Negative Impact		No Impact	✓

Justification of impact identified:
The processes to be followed by staff in connection with retention of financial records will have no impact on people of different race or ethnicity.

Religion or Belief
Is it likely to affect people who have a religion or belief? The term 'religion' includes a religious or philosophical belief.

Positive Impact		Negative Impact		No Impact	✓

Justification of impact identified:
The processes to be followed by staff in connection with retention of financial records will have no impact on people who have a religion or belief.

Sex
Is it likely to affect people who are mostly male or female. Where it applies to both equally does it affect one differently to the other?

Positive Impact		Negative Impact		No Impact	✓

Justification of impact identified:
The processes to be followed by staff in connection with retention of financial records will have no impact on one sex more than the other.

Sexual Orientation
Whether a person's sexual attraction is towards their own sex, the opposite sex or either.

Positive Impact		Negative Impact		No Impact	✓

Justification of impact identified:
The processes to be followed by staff in connection with retention of financial records will have no impact on individuals regardless of their sexual orientation.

Armed Forces Community
Consider whether this impacts on members of the Armed Forces and their families, whose health needs may be impacted long after they have left the Armed Forces and returned to civilian life. Also consider their unique experiences when accessing and using day-to-day public and private services compared to the general population. It could be through 'unfamiliarity with civilian life, or frequent moves around the country and the subsequent difficulties in maintaining support networks, for example, members of the Armed Forces can find accessing such goods and services challenging.'

For a comprehensive guide to the Armed Forces Covenant Duty and supporting resource please see:
Armed-Forces-Covenant-duty-statutory-guidance

Positive Impact		Negative Impact		No Impact	✓

Justification of impact identified:
The processes to be followed by staff in connection with retention of financial records will have no impact on members of the Armed Forces and their families.

Socio Economic Duty
Consider those on low income, economically inactive, unemployed or unable to work due to ill-health. Also consider people living in areas known to exhibit poor economic and/or health indicators and individuals who are unable to access services and facilities. Food / fuel poverty and personal or household debt should also be considered.

For a comprehensive guide to the Socio-Economic Duty in Wales and supporting resources please see:
more-equal-wales-socio-economic-duty

Positive Impact		Negative Impact		No Impact	✓

Justification of impact identified:
The processes to be followed by staff in connection with retention of financial records will have no impact on individuals of different socio economic groups.

Welsh Language Is it likely to impact on opportunities for people to use the Welsh language? The Welsh language should be treated no less favourably than the English language.					
Positive Impact		Negative Impact		No Impact	✓
Justification of impact identified: The processes to be followed by staff in connection with retention of financial records will have no impact on opportunities for people to use the Welsh language.					

If a negative impact has been identified, you are not required to complete this form as a full EqIA must be undertaken. A full EqIA template and guidance can be found on the following link: Equality Impact Assessments (EqIAs) (sharepoint.com)

Screening Completed by:	Name	Sarah Morgan
	Title	Financial Analyst
	Contact details	sarah.morgan16@wales.nhs.uk
	Date	07/08/26
Screening Authorised by: (Directorate level owner of the procedures/ proposals/ projects/ policy)	Name	Tim John
	Title	Head of Accounting and Statutory Reporting
	Contact details	Timothy.john@wales.nhs.uk
	Date	07.08.26
Guidance has been provided by Diversity & Inclusion Team:	Name	Kylie Daniels
	Title	Senior Diversity and Inclusion Officer
	Contact details	Kylie.daniels@wales.nhs.uk
	Date	12/08/2026
Diversity and Inclusion Team additional Comments:		

Please note: The D&I team will save a copy of the completed form for reference. If any changes are made after the date of review, it is the directorate's responsibility to update the EqIA and inform the D&I team.

7

7 - FOR INFORMATION

7.1

7.1 - ALL-WALES CAPITAL PROGRAMME 2026/27, CAPITAL RESOURCE LIMIT AND CAPITAL FINANCIAL MANAGEMENT UPDATE

Huw Thomas (Hywel Dda UHB - Director of Finance)

For information

Attachments

Capital Update FPC 27 August 2026.pdf

Pwyllgor Cyllid a Pherfformiad/ Finance and Performance Committee

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	27 August 2026
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	All-Wales Capital Programme 2026/27, Capital Resources Limit and Capital Financial Management
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Huw Thomas, Executive Director of Finance
SWYDDOG ADRODD: **REPORTING OFFICER:**	Sarah Welsby, Head of Capital and Special Projects

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

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

This update report is presented to the Finance and Performance Committee to:

- Note the 2026/27 Capital Resource Limit (CRL)
- Note the project updates

Cefndir / Background

This report provides and update on the CRL for 2026/27

Asesiad / Assessment

Capital Resource Limit 2026/27

The CRL for 2026/27 has been issued with the following allocations:

Allocation	£'m
All Wales Capital Programme (AWCP)	26.502
Discretionary Programme* (DCP)	8.087
Total	**34.589**

***The Health Board received DCP of £11.228m in 2026/27. A contribution of £2.011m has been made towards the Targeted Estates Fund schemes within AWCP and a contribution of £0.11m towards the refurbishment costs of Picton Terrace. A further £1.02m has been paid back to the AWCP to account for capital scheme slippages in 2025/26.**

There have been no additions or other amendments to the CRL since the last report.

Capital Expenditure Plan

The following table shows the capital expenditure plan for 2026/27 with expenditure incurred to date:

Scheme	Planned Spend 2026/27 £m	Cumulative Spend Apr-Jul £m	Spend July £m	Remaining balance £m
AWCP				
Withybush - Fire Enforcement and Associated Works - Phase 2	4.034	0.878	0.171	3.156
Bronglais - Fire Precaution Upgrade Works - Fees	0.741	0.379	0.191	0.362
Year End Funding – October 2024 – Pentre Awel	0.250	0.011	0.002	0.239
Aseptic Unit, Withybush Hospital	2.364	0.799	0.222	1.565
TEF - Fire	0.644	0.018	0.003	0.626
TEF - Infrastructure	5.214	0.940	0.343	4.274
TEF - Decarbonisation	1.699	0.026	0.018	1.673
TEF - Mental Health	0.759	0.085	0.148	0.674
TEF - Decontamination	0.157	0.145	0.077	0.012
Decarbonisation Project	5.416	3.339	0.213	2.077
Diagnostics equipment - DEXA scanner	0.628	0.033	0.004	0.595
Major Infrastructure Investment Plan, Phase 1 BJC Fees	0.834	0.109	0.052	0.725
Commercial Research Delivery Equipment Call Funding	0.024	0.018	0.000	0.006
Mental Health Quality and Safety Schemes 2026-27	0.515	0.026	0.002	0.489
Carmarthen Hwb - Equipment and Fit-out costs	1.385	0.117	0.018	1.268
Fishguard Health and Wellbeing Centre	1.513	0.000	-0.011*	1.513
Bandi Children Centre	0.325	0.006	0.005	0.319
Sub-total AWCP	**26.502**	**6.929**	**1.458**	**19.573**
Discretionary				
I.T.	0.800	0.350	0.034	0.450
Equipment	2.638	0.237	0.141	2.401

Statutory Compliance	0.450	0.060	0.031	0.390
Estates	3.332	0.389	0.278	2.943
Other	0.867	0.117	0.045	0.750
Sub-total Discretionary	**8.087**	**1.153**	**0.529**	**6.934**
TOTAL	**34.589**	**8.082**	**1.987**	**26.507**

*negative in month spend due to reclassification of costs

Further details on the revenue consequences of these schemes are noted in Appendix 1.

Risks to delivery of Capital Programme

The TEF (Targeted Estates Fund) Project team have flagged a risk of overspend of £0.245m in relation to the Withybush Hospital (WGH) and Prince Philip Hospital (PPH) Generator schemes, part of the TEF Infrastructure heading.

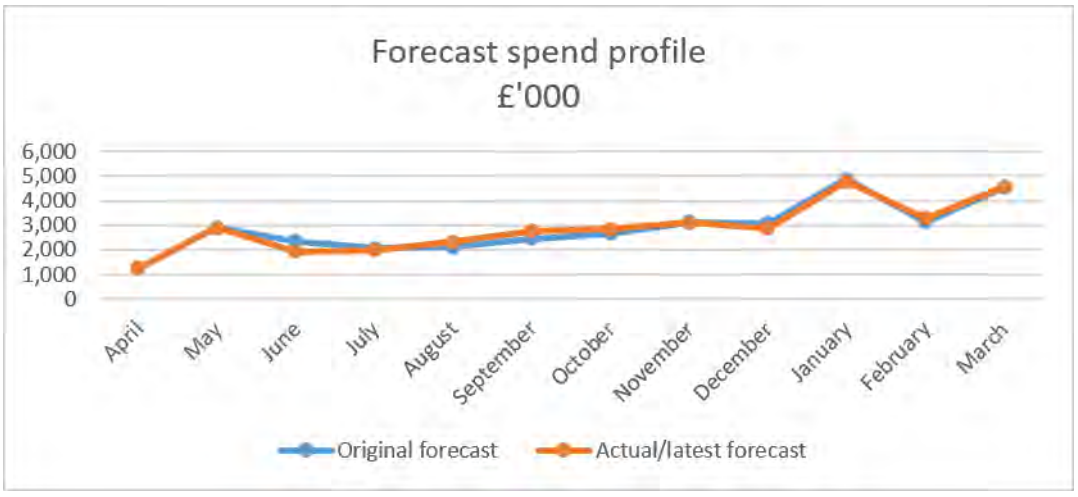
To mitigate this, a request to transfer funds from the TEF Decarbonisation has been submitted to WG; the PPH Solar Farm scheme which is part of that stream is now not progressing therefore the transfer is from that scheme.

Expenditure Profile Forecast

The below graph indicates that capital spend is expected to remain fairly consistent until December with an increase in spend between January and March.

Expenditure to date has broadly followed forecast; June expenditure was approximately £0.4m below forecast due to several smaller underspends against All Wales Capital Programme schemes.

Progress will be monitored on a monthly basis with corrective actions taken where material slippages are identified.



CAPITAL SCHEME UPDATES (SCHEMES GREATER THAN £1M)

Withybush Hospital Fire Enforcement and Associated Works – Phase 2

Phase 2 of the major Fire Precaution Upgrade works started on site in January 2026, with programme completion expected October 2027. Current indications are that the scheme is forecast to remain within the current year allocation.

Bronglais Hospital Fire Precautions Upgrade Works – Fees

A business case is in development for fire precaution upgrade works to the Main Hospital building and Core Blocks. This is due to be submitted to Welsh Government at the end of 2026.

Aseptic Unit – Withybush Hospital

A sustainable compliant Aseptic Unit will be built at Withybush Hospital in advance of the development of a South-West Regional Aseptic Unit. This will ensure that the facilities and delivery of aseptic services within Hywel Dda will meet the required regulatory standards. Whilst there has been a slight delay to the original completion date, the scheme is progressing well with commissioning and occupation of the new unit due to occur towards the end of 2026.

Decarbonisation Project

Funding has been provided towards several energy performance improvements across Health Board sites. The scheme is progressing well with an expected completion date of February 2027.

Carmarthen Hwb

This project is led by Carmarthenshire County Council, in partnership with the Health Board and University of Wales Trinity St David. A number of services will be co-located within the building which are currently being delivered across a number of different locations.
Funding has been provided to the Health Board for equipment, furniture and digital items. Occupation of the building is forecast to occur in March 2027. There is a risk that some expenditure related to commissioning will slip into the next financial year, this has been flagged to Welsh Government.

Fishguard Health and Wellbeing Centre

Fees have been received to develop a business case for an Integrated Health and Wellbeing Centre in Fishguard working in partnership with Pembrokeshire County Council and other Public Service Board partners. This will include a longer-term solution for the existing Fishguard Healthcare Centre and support local delivery of services for the North Coastal Integrated Community Network.

Bandi Childrens Centre

A business case is being produced to redevelop a Childrens Centre in the Carmarthen area in partnership with Carmarthenshire County Council and the Bandi Charity Trustees. This would create a multipurpose facility to develop outpatients and day care services for children with medical and disabling conditions.

Argymhelliad / Recommendation The Finance and Performance Committee is asked to **NOTE** the contents of this report and take assurance on the delivery of the capital programme within 2026/27.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Cyfeirnod Cylch Gorchwyl y Pwyllgor: Committee ToR Reference:	3.1.5 Receive assurance on the delivery of the financial plan. This will be achieved through scrutiny of the monthly finance report. This report shall ensure clarity in: 3.5.3 Performance against other financial metrics, such as cash management, capital management and Public Sector Payment Policy.
Cyfeirnod Cofrestr Risg Datix, Teitl a Sgôr Risg Cyfredol: Datix Risk Register Reference and Score:	Corporate Risk 1196 - not be able to provide safe, sustainable, accessible and kind services. This is caused by insufficient investment to ensure we have appropriate facilities, medical equipment and digital infrastructure of an appropriate standard. Score 16
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	7. All apply
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	6. All Apply
Amcanion Strategol y BIP: UHB Strategic Objectives:	All Strategic Objectives are applicable
Nodau Cynllunio 2026/27 Planning Goals 2026/27	All Planning Goals Apply

Hypergyswllt i Amcanion Llesiant HDdUHB 2026 Hyperlink to HDdUHB Well-being Objectives 2026	9. All HDdUHB Well-being Objectives apply
Model Cymdeithasol ar gyfer Iechyd a Llesiant: (wedi'i gwblhau ar gyfer newid strategol a/neu newidiadau sylweddol i wasanaethau) A Social Model for Health and Wellbeing: (*complete for strategic change and/or significant service changes)*	Not Applicable
Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Capital Allocation and prioritisation process. Capital Investment procedure and all relevant Welsh Government guidance.
Rhestr Termau: Glossary of Terms:	Contained within the body of the report.
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y cyfarfod hwn: Parties / Committees consulted prior to this meeting:	Capital Monitoring Forum Capital Planning Group Individual Project Boards of Capital Schemes Welsh Government Capital Review Meeting Capital Sub-Committee

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	Capital values noted within the report. Included within individual business cases and Capital prioritisation process.
Ansawdd / Gofal Claf: Quality / Patient Care:	Included within individual business cases and Capital prioritisation process
Gweithlu: Workforce:	Included within individual business cases and Capital prioritisation process

Tegwch Iechyd: **Health Equity:**	Risk assessment process is integral to the capital prioritisation process and the management of capital planning within HDdUHB
Risg: **Risk:**	Included within individual business cases and Capital prioritisation process
Cyfreithiol: **Legal:**	Included within individual business cases and Capital prioritisation process
Enw Da: **Reputational:**	Included within individual business cases and Capital prioritisation process
Gyfrinachedd: **Privacy:**	Included within individual business cases and Capital prioritisation process
Cydraddoldeb: **Equality:**	Capital values noted within the report. Included within individual business cases and Capital prioritisation process.

7.2

7.2 - NHS WALES AWARDS 2026

Andrew Spratt (Hywel Dda UHB - Deputy Director of Finance)

For information

Attachments

NHS Wales Awards 2026 Poster - Hywel Dda CYM.pdf

NHS Wales Awards 2026 Poster - Hywel Dda ENG.pdf

Gwneud data yn fwy hygyrch ar gyfer gwelliant sy'n cael ei yrru gan ddata: nodi a mynd i'r afael â mannau problemus cyn gynted â phosibl

Gwobr wybodaeth

Golwg unigol ac ymddiriedol ar berfformiad a diogelwch sy'n helpu timau i weithredu'n gynharach, rheoli risg yn rhagweithiol a gwella canlyniadau.



1. **Data yn ddarnau**
   Systemau niferus a gweledegd anghyson
2. **Strwythur trefnu unigol**
   Mae hierarchaeth canolfannau costau ariannol yn cysylltu lefel leol â lefel y Bwrdd.
3. **Ein dangosfyrddau**
   Mae ein Perfformiad a'n Diogelwch yn troi data yn fewnwelediad hygyrch.
4. **Fframwaith uwchgyfeirio**
   Lefelau sicrwydd, sbardunau a chamau gweithredu isgyfeirio clir
5. **Gweithredu â ffocws**
   Ymyrraeth gynharach, perchnogaeth gryfach a chanlyniadau gwell

Cyd-destun a her

- Tynnodd pwysau perfformiad yn sgil y pandemig ac Ymyrraeth Dargededig sylw at yr angen am ddefnydd cryfach a mwy rhagweithiol o wybodaeth.
- Roedd yn rhaid i staff gael mynediad at ddata o systemau niferus, gan leihau gweledegd ac oedi penderfyniadau.
- Roedd y materion sylfaenol yn cynnwys digwyddiadau a chwynion a oedd wedi bod ar agor ers amser maith, camau risg hwyr a chydymffurfiaeth ag arfarniadau islaw'r safonau disgwyliedig.

Ymagwedd a chamau a gymerwyd

- Safonwyd data yn darnau gan ddefnyddio hierarchaeth canolfannau costau ariannol, gan gysylltu safbwyntiau'r ward, y tîm, y gyfarwyddiaeth a'r Bwrdd.
- Cyd–ddylunio ein dangosfyrddau Perfformiad a Diogelwch, gan ddod â ffynonellau data allweddol at flaenau bysedd y staff: digwyddiadau, cwynion, risgiau, arfarniadau, gwyliau blynyddol, salwch, sgiliau craidd, caffael, cyllid, defnyddio asiantaethau, a lefelau staffio.
- Wedi ymgorffori fframwaith uwchgyfeirio'r Tîm Gweithredol fel bod lefelau sicrwydd, sbardunau a chamau gweithredu i leihau'r lefel uwchgyfeirio yn weladwy ac yn gyson.
- Cefnogwyd y defnydd drwy hyfforddiant agored, sesiynau wedi'u recordio, cymorth pwrpasol i dimau a rhaglenni arweinyddiaeth/gwella.

Effaith a chanlyniadau

- Creodd y dangosfyrddau ffynhonnell wirionedd unigol a dibynadwy ar draws grwpiau gofal clinigol, cyfarwyddiaethau corfforaethol, y Tîm Gweithredol a'r Bwrdd.
- Gall timau nodi mannau problemus sy'n dod i'r amlwg yn gynharach, canolbwyntio sgyrsiau ar yr hyn sy'n bwysig, a gweithredu gydag atebolrwydd cliriach.
- Mae'r rhaglen wedi cryfhau goruchwyliaeth sefydliadol ac wedi cefnogi dysgu cynt, rheoli risg yn fwy rhagweithiol a gwell cefnogaeth ar gyfer gofal diogel ac effeithiol.

Dysgu a phrif bwyntiau

- Nid yw data yn unig yn gwella gwasanaethau: mae gwelliant yn digwydd pan fydd mewnwelediad yn cael ei berchnogi, ei drafod a'i weithredu.
- Mae adborth defnyddwyr, data ymgysylltu dangosfwrdd a monitro tueddiadau wedi mireinio cynnwys ac wedi tynnu sylw at faterion ansawdd data.
- Byddai cynnwys rhai timau yn gynharach a sicrhau ansawdd data yn gynharach wedi cryfhau'r ddarpariaeth ymhellach.

Gwelliannau mesuradwy

Wedi mwy na haneru
Oedran cyfartalog digwyddiadau agored
Cyfrannu at ddysgu a gwelliant mwy amserol.

Wedi mwy na haneru
Amser datrys cwynion
Cefnogi profiad cleifion sy'n ymateb yn well.

Wedi mwy na haneru
Camau risg hwyr
Cynyddu'r sicrwydd bod risgiau'n cael eu rheoli'n weithredol.

68% → 81%
Cydymffurfiaeth â gwerthusiadau staff
Gwella cyfran y staff sydd wedi cael arfarniad yn ddiweddar.

Beth nesaf a pham ei fod yn bwysig ar lefel genedlaethol

- Ychwanegu setiau data pellach, gan gynnwys archwiliadau ac arolygiadau, parhad busnes, arolwg staff a phrofiad cleifion.
- Cynyddu awtomeiddio i leihau tasgau llaw, cryfhau ansawdd data a darparu mewnwelediad cyflymach.
- Mae'r dull yn addas i'w ehangu ar draws GIG Cymru gan ei fod yn defnyddio offer sydd ar gael yn eang, trefniadau llywodraethu safonol a setiau data cenedlaethol.

Y prif bwynt: Mae'r gwaith hwn wedi trawsnewid gwybodaeth yn welliannau ar raddfa eang — gan greu un darlun dibynadwy o berfformiad a diogelwch, a helpu timau i weithredu'n gynt, dysgu'n gyflymach a gwella gofal.

GIG CYMRU NHS WALES

Gwobrau GIG Cymru 2026

The NHS Wales Awards 2026

Making data more accessible for data-led improvement: identifying and addressing hotspots at the earliest opportunity

Information award

A single, trusted view of performance and safety that helps teams act earlier, manage risk proactively and improve outcomes.



1. **Fragmented data** — Multiple systems and inconsistent visibility
2. **Single organising structure** — Finance cost-centre hierarchy links local to Board level
3. **Our dashboards** — Our Performance and Our Safety turn data into accessible insight
4. **Escalation framework** — Clear assurance levels, triggers and de-escalation actions
5. **Focused action** — Earlier intervention, stronger ownership and better outcomes

Context and challenge

- Post-pandemic performance pressures and Targeted Intervention highlighted the need for stronger, more proactive use of information.
- Staff had to access data from multiple systems, reducing visibility and delaying decisions.
- Baseline issues included long-open incidents and complaints, overdue risk actions and appraisal compliance below expected standards.

Approach and actions taken

- Standardised fragmented data using the finance cost-centre hierarchy, linking ward, team, directorate and Board views.
- Co-designed Our Performance and Our Safety dashboards, bringing together key data sources at staff's fingertips: incidents, complaints, risks, appraisals, annual leave, sickness, core skills, procurement, finance, agency use, staffing levels.
- Embedded the Executive Team escalation framework so assurance levels, triggers and de-escalation actions are visible and consistent.
- Supported uptake through open training, recorded sessions, bespoke team support and leadership/improvement programmes.

Impact and outcomes

- The dashboards created a single, trusted source of truth across clinical care groups, corporate directorates, Executive Team and Board.
- Teams can identify emerging hotspots earlier, focus conversations on what matters and act with clearer accountability.
- Programme has strengthened organisational oversight and supported faster learning, more proactive risk management and better support for safe, effective care.

Learning and key takeaways

- Data alone does not improve services: improvement happens when insight is owned, discussed and acted upon.
- User feedback, dashboard engagement data and trend monitoring refined content and highlighted data-quality issues.
- Earlier involvement of some teams and earlier data quality assurance would have strengthened delivery further.

Measurable improvements

- ✓ **More than halved** — **Average age of open incidents** — Contributing to timelier learning and improvement.
- ✓ **More than halved** — **Complaint resolution time** — Supporting more responsive patient experience.
- ✓ **More than halved** — **Overdue risk actions** — Increasing assurance that risks are actively managed.
- ✓ **68% → 81%** — **Staff appraisal compliance** — Improving the proportion of staff with recent appraisal.

What next and why it matters nationally

- Add further datasets including audits & inspections, business continuity, staff survey and patient experience.
- Increase automation to reduce manual handling, strengthen data quality and provide faster insight.
- The approach is scalable across NHS Wales because it uses widely available tools, standard governance and national datasets.

Key takeaway: This work has turned information into improvement at scale — creating one trusted view of performance and safety, helping teams act earlier, learn faster and improve care.

GIG CYMRU NHS WALES

Gwobrau GIG Cymru 2026

The NHS Wales Awards 2026

7.3

7.3 - FINANCE AND PERFORMANCE TEAM NHS WALES AWARDS 2026 FINALISTS

Andrew Spratt (Hywel Dda UHB - Deputy Director of Finance)

For information

Attachments

NHS Wales Awards 2026 Combined Finance and Performance Nominations.pdf

NHS Wales Award 2026 Hywel Dda Finance Poster English.pdf

NHS Wales Awards 2026

Combined Finance and Performance Team Nominations

Information paper for the Finance and Performance Committee

Context and background

This paper brings together two Hywel Dda University Health Board finalist nominations for the NHS Wales Awards 2026. It is presented to the Finance and Performance Committee for information, to recognise the work undertaken by the Finance and Performance teams and to provide members with a consistent account of the aims, improvement approaches, outcomes, learning and next steps described in each nomination.

The Finance Team nomination, “Rebuilding Trust in Finance: A Cultural Change Journey with Lasting Impact for Hywel Dda Finance”, has been shortlisted in the NHS Wales Team Culture Award category. The Performance Team nomination, “Making data more accessible for data-led improvement: identifying and addressing hotspots at the earliest opportunity”, has been shortlisted in the NHS Wales Information Award category.

For consistency, both nominations are set out under the same headings used in the original Finance nomination. The Finance nomination appears first, followed by the Performance Team nomination.

Purpose

The Committee is asked to note the two finalist nominations and the improvement work, reported outcomes and learning described within them.

1. Finance Team nomination

Category

NHS Wales Awards 2026: NHS Wales Team Culture Award

Title/Summary

Rebuilding Trust in Finance: A Cultural Change Journey with Lasting Impact for Hywel Dda Finance

What was the aim of the improvement project?

Improve staff engagement and stakeholder satisfaction and turnover by 20% by March 2026, transforming finance into an innovative, insight-led partner.

How did you know an improvement was needed?

The improvement journey was prioritised in response to a building concern that the existing finance culture was limiting its own effectiveness and engagement.

Historically, the function was perceived as transactional and compliance-focused, with limited visibility of value-adding insights. Baseline feedback from internal stakeholder engagement and informal discussions highlighted inconsistent relationships with operational teams and low confidence in finance as a strategic partner. Staff survey results also indicated opportunities to improve engagement, with lower scores in areas such as involvement, communication and feeling valued, alongside turnover levels above organisational expectations.

Quantitatively, early internal pulse surveys and stakeholder feedback suggested satisfaction levels below desired benchmarks, with variation across teams. Qualitative evidence reinforced this, with recurring themes including limited accessibility of finance, insufficient forward-looking insight, and variable quality of business partnering.

The need for change was further driven by increasing financial pressures, the requirement for stronger financial grip and control, and the expectation, both locally and nationally, that finance should enable better decision-making and support service transformation.

This aligned to the Duty of Quality, particularly in:

- Culture and leadership, requiring compassionate, inclusive and high-performing teams.
- Timely and effective care, supported by better decision-making and use of resources.
- Learning and improvement, embedding continuous improvement and innovation.

Without a deliberate cultural shift, the finance function risked remaining reactive and undervalued. The programme was therefore essential to build an engaged workforce, improve stakeholder confidence, and position finance as an innovative, insight-led partner contributing to high-quality, sustainable services.

What did you decide to do and who did you involve?

A structured, improvement programme-level approach was taken, drawing on industry best-practice transformation work, improvement methodology and strong Workforce and Organisational Development support.

A formal governance structure was established to drive delivery, including Finance transformation development days, workstream leads aligned to key priority areas, and regular reporting into senior leadership forums, locally and nationally. This ensured clear accountability, pace and visible leadership of cultural change.

The programme adopted a recognised continuous improvement approach, using iterative cycles of engagement, testing and refinement. The diagnostic baseline and roadmap identified priority capabilities, including business partnering, insight and leadership behaviours, which were translated into targeted actions and measurable outcomes aligned to the “True North” ambition.

Workforce and Organisational Development were integral partners, co-designing and facilitating:

- Leadership development programmes focused on compassionate, values-led leadership.
- Team workshops to define expected behaviours and what good looks like.
- Coaching and structured engagement to embed change locally.

Finance staff contributed through workshops, pulse surveys and reflective sessions. Operational and clinical stakeholders were engaged through feedback sessions and business partnering forums, while regular open forums created safe spaces for honest dialogue and continuous feedback. This inclusive approach ensured the programme was co-created and owned by the workforce and stakeholders.

A key enabler was the strengthening of the apprenticeship pipeline and study support offer, providing clearer access to professional accountancy qualifications, protected development conversations and structured career support.

What changes did you test and what results did you get?

The programme embedded the Plan, Do, Check/Study, Act approach, informed by diagnostics and continuous staff and stakeholder feedback.

Plan: The baseline assessment highlighted inconsistent business partnering, limited insight, variable engagement and inconsistent approaches and processes. Measurable indicators were agreed using staff survey elements and turnover rates.

Do: Targeted changes included embedding finance staff within operational teams, co-designed leadership and behavioural development with Workforce and Organisational Development, and more forward-looking, insight-led reporting.

Check/Study: Impact was assessed through pulse surveys, stakeholder feedback and performance indicators. The nomination reports improved accessibility of finance, increased stakeholder confidence and positive movement in staff engagement, particularly communication, involvement and feeling valued. Enhanced reporting supported earlier identification of financial risks and more informed decision-making.

Act: Learning informed refinement and scaling. Pilots showed that role clarity and behavioural expectations were as important as proximity, leading to stronger definition of business partnering roles. Leadership interventions showed the importance of consistent behaviours, which were embedded into performance and development processes. Insight-led reporting was standardised following positive feedback.

Further practical developments included more actionable financial insight within reporting cycles and a deliberate apprenticeship and early-careers pipeline to support succession planning and future finance capability.

What was the outcome of all the changes you made?

The nomination reports a measurable and sustained shift in culture, capability and organisational impact, with benefits for staff and stakeholders.

For staff, surveys and pulse checks showed positive movement towards the 20% target in communication, involvement and feeling valued. Feedback described a more open, inclusive and psychologically safe culture. Turnover reduced in key teams and recruitment attraction improved.

For organisational stakeholders, qualitative feedback indicated that finance was increasingly seen as accessible, collaborative and value-adding, with greater demand for finance involvement in planning and decision-making.

For the organisation, the shift to an insight-led approach strengthened financial grip and control through earlier identification of risks, more robust forecasting and improved alignment between financial and operational plans.

For patients and service users, the nomination described an indirect benefit through better financial insight, collaboration and resource prioritisation in support of sustainable, timely and effective services.

Overall, the change repositioned finance as an innovative, insight-led partner, delivering cultural and organisational benefits.

What did you learn?

Sustainable culture change requires equal focus on leadership, behaviours, capability and structure, not only process redesign. Diagnostics, governance and partnership with Workforce and Organisational Development provided a clear framework, but change accelerated when it was co-created with staff and stakeholders.

Leadership visibility and consistency were critical. Embedding change through recruitment, appraisal and development was also essential to sustaining progress. The programme combined quantitative evidence, including survey scores, turnover and stakeholder feedback, with qualitative insight from pulse checks and open forums.

The nomination identified three areas that could have been stronger: clearer baseline metrics at an earlier stage, earlier stakeholder engagement to define expectations, and earlier investment in digital and analytical capability.

What will you do next?

The next phase will focus on embedding, scaling and spreading the cultural and capability improvements across four priority areas:

- Financial grip and control.
- Planning and forecasting capability.
- Business partnering.
- Digital and analytical capability.

Behaviours and expectations will continue to be integrated into recruitment, appraisal and leadership development. Learning is also being shared through regional Finance Operating Model discussions, creating opportunities to standardise effective practice and support wider collaboration across NHS Wales.

Why does your project deserve to win the category you have entered?

The nomination describes a sustained, evidence-based transformation in how a large corporate function fosters teamwork, collaboration and value. It addresses behaviours, leadership and relationships alongside process and capability, and reports improvements in staff engagement, turnover and stakeholder satisfaction.

The programme combines structured transformation, a clear “True North” ambition, Workforce and Organisational Development-led cultural development and continuous improvement methodology. Its impact extends to organisational decision support, resource allocation, risk identification and financial management. The model is intended to be transferable and scalable through regional and NHS Wales collaboration.

2. Performance Team nomination

Category

NHS Wales Awards 2026: NHS Wales Information Award

Title/Summary

Making data more accessible for data-led improvement: identifying and addressing hotspots at the earliest opportunity

What was the aim of the improvement project?

To create a single, trusted and accessible view of performance and safety information that enables teams to identify emerging hotspots earlier, manage risk proactively, strengthen accountability and improve outcomes.

How did you know an improvement was needed?

Post-pandemic performance pressures and Targeted Intervention highlighted the need for stronger and more proactive use of information. Staff had to access information from multiple systems, which reduced visibility and delayed decision-making.

The baseline position included long-open incidents and complaints, overdue risk actions and staff appraisal compliance below expected standards. Fragmented data and inconsistent visibility made it harder for teams and leaders to identify areas requiring attention and take timely action.

What did you decide to do and who did you involve?

The team standardised fragmented information using the finance cost-centre hierarchy, linking ward, team, directorate and Board-level views through a single organising structure.

The Our Performance and Our Safety dashboards were co-designed to bring together key information at staff's fingertips, including incidents, complaints, risks, appraisals, annual leave, sickness, core skills, procurement, finance, agency use and staffing levels.

The Executive Team escalation framework was embedded so that assurance levels, triggers and de-escalation actions were visible and applied consistently. Uptake was supported through open training, recorded sessions, bespoke team support and leadership and improvement programmes.

What changes did you test and what results did you get?

The work tested a progression from fragmented information to a single organising structure, accessible dashboards, a visible escalation framework and more focused action. User feedback, dashboard engagement data and trend monitoring were used to refine the content and identify data-quality issues.

The nomination poster reports the following measurable improvements:

- The average age of open incidents more than halved.
- Complaint resolution time more than halved.
- Overdue risk actions more than halved.
- Staff appraisal compliance improved from 68% to 81%.

What was the outcome of all the changes you made?

The dashboards created a single, trusted source of information across clinical care groups, corporate directorates, Executive Team and Board. Teams were better able to identify emerging hotspots earlier, focus conversations on what mattered and act with clearer accountability.

The programme strengthened organisational oversight and supported faster learning, more proactive risk management and better support for safe and effective care. The central outcome was a more accessible view of performance and safety that helped teams act earlier and manage risk more proactively.

What did you learn?

The principal learning was that data alone does not improve services. Improvement happens when insight is owned, discussed and acted upon. User feedback, dashboard engagement data and trend monitoring helped refine the content and highlighted data-quality issues.

The nomination also identified that earlier involvement of some teams and earlier data-quality assurance would have strengthened delivery further.

What will you do next?

The next phase will add further datasets, including audits and inspections, business continuity, staff survey and patient experience information. The team also plans to increase automation to reduce manual handling, strengthen data quality and provide faster insight.

The approach is considered scalable across NHS Wales because it uses widely available tools, standard governance and national datasets.

Why does your project deserve to win the category you have entered?

The project has turned information into improvement at scale by creating one trusted view of performance and safety. It brings fragmented information together, connects it to a consistent escalation framework and helps teams identify hotspots earlier, learn faster and take focused action.

The reported improvements in incident age, complaint resolution, overdue risk actions and appraisal compliance demonstrate practical organisational impact. The approach also has wider relevance because it uses accessible tools, common governance arrangements and datasets that can support learning and spread across NHS Wales.

Committee conclusion

The two nominations provide complementary examples of improvement. The Finance nomination focuses on culture, leadership, capability and the role of finance as an insight-led partner. The Performance nomination focuses on accessible information, consistent escalation and earlier action. Both demonstrate the importance of combining reliable evidence with clear ownership, collaboration and continuous learning.

The Finance and Performance Committee is asked to note the two finalist nominations and recognise the contribution of the teams involved.

Rebuilding Trust in Finance:
A Cultural Change Journey with Lasting Impact for Hywel Dda Finance

NHS Wales Team Culture Award

Cultural change journey built with people, not done to people – creating a trusted and sustainable Finance team that helps others make better decisions.



Why change was needed

From Transactional to Trusted

Finance was viewed as transactional, compliance-focused and not always involved early in decision-making – a value focus change was needed.

Staff engagement and stakeholder confidence needed to improve. With increasing financial pressures, we recognised the need to transform our culture, strengthen relationships and become a valued strategic partner.

Our 'True North'

A Shared Vision Guided by Ethics

Our ambition was simple:

- Improve staff engagement
- Improve stakeholder satisfaction
- Reduce turnover and improve job satisfaction
- Build a more inclusive and supportive culture
- Create an innovative, insight-led finance function

Together, we set out to make finance a trusted partner that helps improve services and outcomes.

Co-creating a change culture

Change Built With People

A co-created programme across all staff within the function. By listening, learning and working together, we created lasting ownership of change.

Staff, leaders, Workforce and Organisational Development colleagues and stakeholders helped design the solution through workshops, surveys, open forums, coaching and leadership development.



Continuous improvement in action

Learn > Test > Improve > Repeat

Using the Plan–Do–Check–Act approach, we continuously tested and refined our new ways of working.

We embedded finance teams more closely with services, strengthened leadership behaviours, improved processes and developed more forward-looking, insightful reporting to support better decision making.



The difference we made

Staff Turnover
73% reduction
Improvement from 19% to 5%

Staff Survey
21% benefit
Satisfaction gain from 55% to 66%

Engagement
Improvement
Co-creation of priority objectives

Insight Led
Forward looking
Consistent service owned forecasts

What next and why it matters

Local Change to National Impact

This is not just a finance story. It shows how any service can rebuild trust, improve staff experience and support better decisions by combining culture, insight and continuous improvement.

Our approach is already being shared regionally, demonstrating how cultural change in corporate services can deliver lasting benefits for staff, organisations and patients.



Better Culture. Better Decisions. Better Outcomes.

Key learning: inclusive and compassionate leadership, co-created with staff and stakeholders, can transform culture and improve organisational value.

GIG CYMRU NHS WALES

Gwobrau GIG Cymru 2026

The NHS Wales Awards 2026

Making data more accessible for data-led improvement: identifying and addressing hotspots at the earliest opportunity

Information award

A single, trusted view of performance and safety that helps teams act earlier, manage risk proactively and improve outcomes.



1. **Fragmented data** — Multiple systems and inconsistent visibility
2. **Single organising structure** — Finance cost-centre hierarchy links local to Board level
3. **Our dashboards** — Our Performance and Our Safety turn data into accessible insight
4. **Escalation framework** — Clear assurance levels, triggers and de-escalation actions
5. **Focused action** — Earlier intervention, stronger ownership and better outcomes

Context and challenge

- Post-pandemic performance pressures and Targeted Intervention highlighted the need for stronger, more proactive use of information.
- Staff had to access data from multiple systems, reducing visibility and delaying decisions.
- Baseline issues included long-open incidents and complaints, overdue risk actions and appraisal compliance below expected standards.

Approach and actions taken

- Standardised fragmented data using the finance cost-centre hierarchy, linking ward, team, directorate and Board views.
- Co-designed Our Performance and Our Safety dashboards, bringing together key data sources at staff's fingertips: incidents, complaints, risks, appraisals, annual leave, sickness, core skills, procurement, finance, agency use, staffing levels.
- Embedded the Executive Team escalation framework so assurance levels, triggers and de-escalation actions are visible and consistent.
- Supported uptake through open training, recorded sessions, bespoke team support and leadership/improvement programmes.

Impact and outcomes

- The dashboards created a single, trusted source of truth across clinical care groups, corporate directorates, Executive Team and Board.
- Teams can identify emerging hotspots earlier, focus conversations on what matters and act with clearer accountability.
- Programme has strengthened organisational oversight and supported faster learning, more proactive risk management and better support for safe, effective care.

Learning and key takeaways

- Data alone does not improve services: improvement happens when insight is owned, discussed and acted upon.
- User feedback, dashboard engagement data and trend monitoring refined content and highlighted data-quality issues.
- Earlier involvement of some teams and earlier data quality assurance would have strengthened delivery further.

Measurable improvements

- ✓ **More than halved** — **Average age of open incidents** — Contributing to timelier learning and improvement.
- ✓ **More than halved** — **Complaint resolution time** — Supporting more responsive patient experience.
- ✓ **More than halved** — **Overdue risk actions** — Increasing assurance that risks are actively managed.
- ✓ **68% → 81%** — **Staff appraisal compliance** — Improving the proportion of staff with recent appraisal.

What next and why it matters nationally

- Add further datasets including audits & inspections, business continuity, staff survey and patient experience.
- Increase automation to reduce manual handling, strengthen data quality and provide faster insight.
- The approach is scalable across NHS Wales because it uses widely available tools, standard governance and national datasets.

Key takeaway: This work has turned information into improvement at scale — creating one trusted view of performance and safety, helping teams act earlier, learn faster and improve care.

GIG CYMRU NHS WALES

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The NHS Wales Awards 2026

7.4

7.4 - JCC PLANNING, PERFORMANCE AND FINANCE SUB-COMMITTEE REPORTS

Huw Thomas (Hywel Dda UHB - Director of Finance)

For information

Attachments

PPF Highlight Report 2 July 2026.pdf

Joint Commissioning Committee

Highlight Report from the Planning, Performance and Finance Sub-Committee

Dyddiad y Cyfarfod / Date of Meeting	21/07/2026
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author	Maxine Evans, Assurance & Risk Officer, NWJCC
Cyflwynydd yr Adroddiad / Report Presenter	Paul Worthington, PPF Chair and Lay Member, NWJCC
Noddwr yr Adroddiad / Report Sponsor	George Galletly, Director of Corporate Planning and Strategy, NWJCC Stacey Taylor, Director of Finance and Value, NWJCC

Pwrpas yr Adroddiad / Report Purpose	For Assurance

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	Date	Outcome
Health Boards	Various	Noted

1. SITUATION/BACKGROUND

This report has been prepared to provide NWJCC Joint Committee Members with a summary of the key issues considered by the NHS Wales Planning, Performance and Finance (PPF) Sub-Committee at its public meeting on 2 July 2026.

Key highlights from the meeting are reported in Section 2.

2. HIGHLIGHT REPORT

Links to reports highlighted - July 2026 - Planning, Performance and Finance Sub-Committee

Status	Update
Alert / Escalate	• The Committee received the PPF Sub-Committee's assigned risks from the NWJCC Operational Risk Register as of 31 May 2026. After PPF scrutiny and review, the NWJCC will receive the May 2026 risk register at its July 2026 meeting. Particular focus was given on the re-description of the new Emergency Ambulance Service risk. The shift towards a more commissioner-focused articulation was acknowledged, however concerns were raised that the proposed wording placed insufficient emphasis on patient outcomes and potential patient harm. Whilst financial, reputational, legal and regulatory consequences were relevant to the NWJCC as a commissioner, the primary narrative should also reflect commissioning for better patient outcomes. The Sub-Committee agreed that the wording of the ambulance risk would be refined before submission to the Joint Committee, ensuring that it reflected the NWJCC's levers as a commissioner whilst maintaining a clear patient-outcome focus.
Advise	• The Sub-Committee received the NWJCC Finance Report – Month 2 2026/27. The reported year-to-date position was an underspend of £361k, with a forecast year-end benefit of just under £0.5m. The report noted delivery against plan at Month 2, while recognising the limited robustness of early-year data and forecasting. It was agreed that the most recent available data should be used for future Sub-Committee and Joint Committee reporting. The outcome of the arbitration process with Cardiff and Vale University Health Board (CVUHB) was advised, noting that Welsh Government (WG) had confirmed that the Joint Committee decision should be upheld in relation to the 2% savings requirement, while also making clear that arbitration between NHS Wales organisations should be avoided in future. The need for earlier collaborative planning and stronger relationships to prevent recurrence will be a priority for 2026/27. • The NWJCC Combined Operational Performance Report – Month 2 2026/27 was received. The following was highlighted:

Status	Update
	o The Sub-Committee requested that future reports should include the most up-to-date information available, recognising that different data sets may be available at different points in the reporting cycle. o It was noted that neonatal services had been de-escalated to Level 0 following the May quality assurance meeting and cardiac surgery at CVUHB UHB had been escalated to Level 2 due to an increasing waiting list and delays in receiving an action plan. o The Sub-Committee were advised that there are currently no 104-week waits across commissioned specialties, however forward projections to identify any future risks were requested. o Concerns about ambulance performance reporting under the new clinical model was raised. It was agreed that additional statistical process control (SPC) charts and more meaningful input, output and outcome measures would be developed, and the colour coding of Non-Emergency Patient Transport Services (NEPTS) metrics would also be reviewed to ensure red and green indicators reflected whether movements were positive or negative. o It was advised that a stipulation of the WG Planned Care Funding will require Health Boards (HBs) to improve theatre efficiencies before the additional funding could be accessed. • The Sub-Committee received an update on the development of the NWJCC Integrated Medium-Term Plan (IMTP) 2027-30. Members were advised that work had begun on commissioning intentions and a revised clinical prioritisation approach, and that early engagement with HBs had commenced. It was noted that the national clinical strategy would be an important dependency, although timescales suggested it may not be available in time to fully inform the IMTP.
Assure	• NWJCC Risk Management and Assurance Framework – The Sub-Committee endorsed the Risk Management Procedure, Joint Committee Assurance Framework (JAF), Risk Appetite Statement and strategic risk reporting arrangements for onward consideration by the Joint Committee. Members welcomed the strengthened approach to strategic risk management and assurance and were pleased with the progress made to strengthen Risk Management. It was acknowledged that the risk appetite would require ongoing

Status	Update
	collective discussion with Chief Executives, lay members and executive colleagues, and may evolve over time. • The Financial Sustainability Review was received, outlining the current status of savings initiatives. This was the first in a series of updates to provide transparency on allocations, opportunities and slippage. The importance of pace and rigour, particularly given the challenging national financial context and the expectations of HB partners was highlighted. It was noted that the current pipeline is not yet where it needs to be, with too many schemes rated red or amber and insufficient schemes rated green. This will be a priority for the NWJCC Senior Leadership Team to urgently review the pipeline, convert green schemes into cash-releasing benefits, identify further opportunities and strengthen grip on expenditure controls. • The NWJCC Annual Plan 2026-27 delivery update was received focussing on the strategic priority areas, service reviews, deep dives and enabling projects. Members noted that some delivery confidence ratings were medium, largely due to data availability, analytical capability and capacity. It was recognised that the NWJCC was developing a new way of working and that HB engagement would be essential, both to secure analytical support where possible, and to ensure collective ownership of difficult prioritisation decisions, noting the need to balance patient outcomes with affordability in the current financial climate, acknowledging that some planned initiatives may need to be paused or reconsidered. • The Sub-Committee received a verbal update on the grip and control work requested by NHS Performance and Improvement and WG Directors of Finance. A self-assessment had been completed against the relevant elements of the best practice framework, and further work would be undertaken to define good grip and control for the NWJCC as a maturing commissioning organisation. It was agreed that future updates will be reported through the Sub-Committee, with internal audit reporting providing assurance to the host body audit committee.
Inform	• The Sub-Committee received a verbal update on the NWJCC Strategy Development, noting that it would be informed by the NWJCC strategic reviews, deep dives, the three-year IMTP and alignment where possible with the emerging national clinical strategy. The importance of the NWJCC's role in a

Status	Update
	once-for-Wales collaborative commissioning space was reiterated. • The Sub-Committee received a verbal update on the annual review of committee effectiveness. Feedback had been shared with the chairs of the committees, and proposed actions would be developed for inclusion in an action plan for approval by the Joint Committee. • Forward Plan of Business – The Sub-Committee reviewed and noted the 2026–27 Forward Plan.
Appendices	None.

3. ASSESSMENT

Objectives / Strategy	
Dolen i Amcan (au) Strategol CBC Link to JCC Strategic Objectives(s)	Maximise Value
	Ensure Quality; Reduce Duplication; Improve Equity & Population Health; Facilitate Integration
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals 150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)	A Resilient Wales
	A Healthier Wales
Dolen i Hwyluswyr Ansawdd (Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) / Link to Enablers of Quality (Duty of Quality Statutory Guidance (gov.wales))	Leadership
	Culture and Valuing People; Learning, Improvement and Research; Whole-systems Perspective
Dolen i Feysydd Ansawdd (Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) / Link to Domains of Quality (Duty of Quality Statutory Guidance (gov.wales))	Effective
	Efficient; Equitable; Person-centred; Timely; Safe
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable

Impact Assessment		
Ansawdd *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /* Quality *Have you undertaken a Quality Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below: This is a summary of the latest meeting of the JCC
Cydraddoldeb *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb? /* Equality *Have you undertaken an Equality Impact Assessment Screening?*	Yes: ☒	No: ☒
	Outcome for Equality (delete as appropriate): ~~POSITIVE/~~NEUTRAL~~/NEGATIVE~~ Outcome for Welsh Language (delete as appropriate): ~~POSITIVE/~~NEUTRAL~~/NEGATIVE~~	If no, please include rationale below: This is a summary of the latest meeting of the JCC
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw da / Reputational	There is no direct impact on the reputation of the Joint Committee as a result of the activity outlined in this report.	
Effaith Adnoddau *(Pobl /Ariannol) /* Resource Impact *(People / Financial)*	Yes (Include further detail below)	
	The performance of the services will be used to develop the IMTP and identify the areas where resources may be required.	

4. RECOMMENDATIONS

The members of the Joint Commissioning Committee are asked to:

- Receive the report as assurance.

7.5

7.5 - NWSSP SHARED SERVICES PARTNERSHIP COMMITTEE ASSURANCE REPORT

Huw Thomas (Hywel Dda UHB - Director of Finance)

For information

Attachments

NWSSP SSPC Assurance Report 14 May 2026 and 25 June 2026.pdf

ASSURANCE REPORT
NHS WALES SHARED SERVICES PARTNERSHIP COMMITTEE

Reporting Committee	Shared Services Partnership Committee (SSPC)
Chaired by	Huw Thomas, Executive Director of Finance at Hywel Dda University Health Board and Vice Chair of SSPC
Lead Executive	Neil Frow OBE, Managing Director, NWSSP
Author and Contact Details	Roxann Davies, Corporate Services Manager and James Quance, Assistant Director of Corporate Services
Date of Meeting	14 May 2026

Summary of key matters including achievements and progress considered by the Committee and any related decisions made

Managing Director**'s Update Report** - The Managing Director presented a comprehensive update on key developments across NWSSP since the previous meeting, highlighting continued organisational maturity and impact as the organisation marked its 15-year anniversary, with sustained delivery of value, innovation and partnership across NHS Wales. Governance and accountability arrangements remain under development through the Implementation Group, supported by ongoing engagement, alongside positive external visibility following the Chief Executive's visit to IP5.

A balanced financial position was confirmed (subject to audit), including delivery of the £6m savings requirement to NHS Wales and Welsh Government, alongside full utilisation of capital funding to support strategic infrastructure, digital, estates, decarbonisation and resilience priorities. Ongoing focus on the Welsh Risk Pool was noted, supported by Welsh Government investment, with further work required to address emerging reimbursement pressures.

An update was provided in relation to development of key national programmes including Transforming Access to Medicines (TrAMS) and the Future Workforce Solution. While positive progress was noted in TrAMS, including advancements across regional hub developments and digital solutions, risks remain in relation to organisational approvals and Welsh Government sign-off, with potential delays linked to the formation of the new government. The Future Workforce Solution programme continues at pace but is impacted by external dependencies, including delays in documentation and outstanding clarity on system functionality.

Reasonable assurance was reported for the Single Lead Employer model following internal audit, with improvement required in specific operational areas, particularly sickness management processes, which the Committee noted as a shared responsibility. Significant risks associated with Resident Doctors' contract reform were highlighted, including operational, financial and compliance implications, with further detailed scrutiny provided to the Committee in the deep dive presentation.

The overarching report provided the Committee with updates across a broad portfolio, including Transforming Access to Medicines (TrAMS), Radiopharmacy and the Hub Programme; the NHS Wales Influenza Vaccination Programme; Primary Care Services;

Laundry Services; decarbonisation and adaptation activity; engagement and leadership activity; and awards and recognition.

In addition, the Committee was advised of the most recent developments in relation to senior appointments, including the appointment of Dr Martin Edwards as Medical Director, following the retirement of Dr Ruth Alcolado in March 2026; ongoing recruitment to the Deputy Medical Director role; and progress in the Chair's recruitment process, with interviews scheduled for 15 June 2026. Confirmation is awaited regarding Tracy Myhill OBE remaining in post until 30 June 2026.

The Committee NOTED and DISCUSSED the Managing Director's Update Report.

Deep Dive Presentations

Implementation of the Resident Doctor Contract Reform - The Committee received a detailed presentation on the implementation of the Resident Doctor contract reform, noting progress across a range of workstreams in line with a challenging timetable for the August 2026 go-live date. This included advancements in system development, contractual negotiations, policy development and organisational engagement. It was noted that the majority of contractual terms have been agreed with the British Medical Association (BMA), with final documentation nearing publication, and that associated policies are progressing through governance arrangements. The e-rostering system remains a key dependency, with revised timelines and interim arrangements in place to mitigate risks and support ongoing delivery. Variability in organisational readiness was recognised, alongside continued work to ensure compliance with rota requirements and to evidence workforce needs.

Key risks were highlighted in relation to workforce capacity, financial implications and the requirement for additional staffing to accommodate reduced working hours under the new contract. Mitigating actions, including enhanced workforce planning, bank usage and continued scrutiny of additionality requirements, were noted. The Committee was advised that programme governance arrangements are robust, supported by an active risk register and clear escalation processes.

Further assurance was provided through evidence of improved engagement across organisations, positive recruitment fill rates and progress in system solutions to support transition. Committee Members raised a number of queries relating to governance coverage, readiness assurance, benefits realisation, rota impact assessment and workforce additionality. It was confirmed that readiness is being monitored through structured processes and regular reporting, with post-implementation evaluation planned to assess outcomes and inform future phases.

Radiopharmacy at IP5 - The Committee received a presentation on the development of the new Radiopharmacy facility at IP5, noting significant progress and the successful completion and handover of the purpose-built facility in April. Commissioning is currently underway, with the programme progressing through a structured internal qualification phase to ensure that the facility, equipment, processes and workforce meet all required regulatory and operational standards. The specialised nature of Radiopharmacy services was acknowledged, including the complexity of manufacturing short shelf-life medicines and the requirement for robust quality assurance, safety and distribution processes. The comprehensive design of the facility, incorporating clean room environments, specialist equipment and controlled workflows aligned to stringent regulatory requirements was recognised.

The complex regulatory landscape was highlighted, with oversight from multiple bodies, and the need to ensure full compliance across environmental, staff safety and medicines regulation standards including updates to various licenses. The qualification process includes detailed testing and validation prior to progression to operational use. Plans for service implementation remain on-track for summer 2026, with a phased approach to go-live. Initial service delivery will be limited to Aneurin Bevan University Health Board to support workforce training and operational readiness, before scaling to a broader all-Wales service. Arrangements to maintain continuity of supply during transition, including collaboration with Swansea Bay University Health Board, were also noted.

Additionally, the Committee observed the virtual tour of the facility, providing assurance regarding the infrastructure, layout and technical capabilities supporting delivery.

The Committee NOTED the updates provided in relation to the implementation of the Resident Doctor Contract Reform and Radiopharmacy at IP5.

Items for Approval

NWSSP Performance Management Framework – The Committee DISCUSSED and APPROVED the application of the Performance Management Framework as set out in the paper and NOTED that elements may be subject to change pending revisions to Welsh Government accountability arrangements. The Committee was assured that arrangements are established and operating as intended, supported by regular and comprehensive performance reporting. The Framework provides clear oversight, aligned reporting and ongoing engagement with NHS Wales organisations, underpinned by defined governance principles and accountability through the Managing Director, as Accountable Officer.

NWSSP Duty of Quality Annual Report 2025–26 - The Committee APPROVED the NWSSP Duty of Quality Annual Report 2025–26, noting continued maturity in the organisation's approach to quality, with strengthened governance, enhanced visibility and a clear focus on delivering measurable outcomes across NHS Wales. The proportionate, system-wide approach to quality management was recognised, alongside ongoing development of an overarching quality management system to support continuous improvement.

Items for Noting

Chair's Appointment - The Committee NOTED the update regarding the Chair's appointment process, including progress and confirmation of interviews scheduled for 15 June 2026, with final shortlisting feedback awaited and interim arrangements in place, with the current Chair agreeing to remain in post to ensure continuity.

Finance, Performance, People, Programme and Governance Updates

Finance Report – The Committee noted the draft financial position for 2025/26, subject to audit, confirming the revenue position closed broadly in line with forecast, achieving a small surplus of £9k. Savings of £6.7m were delivered, including £0.7m applied to the National Insurance funding shortfall, with the remaining £6m returned to partners. Capital expenditure of £11.7m was achieved and delivery of key capital investments was noted, including Radiopharmacy developments and estates decarbonisation schemes, such as solar panels, electric vehicle infrastructure and hot water reclamation. The Welsh Risk Pool outturn of £192m was reported in line with forecast, supported by Welsh Government funding and Risk Share Agreement contributions, with continued growth in liabilities highlighted, including a £246m increase in provisions to £1.957bn and contingent liabilities

rising to £1.2bn. Committee Members acknowledged the achievement of a balanced position while noting the scale of Welsh Risk Pool liabilities as a significant system pressure.

People and Organisational Development (POD) Report – The Committee noted the updated reporting format and the latest workforce position, with sickness absence remaining broadly stable, albeit above target in some areas, and turnover slightly above the NHS Wales average but trending downward and aligned with comparable organisations. Strong performance was noted in key areas, including PADR compliance at 85.62%, and time to hire remaining well within target, at approximately 55 days. Continued progress was reported across learning uptake, corporate induction improvements and workforce planning, supported by enhanced data and improved leavers' feedback, through increased response rates. It was confirmed that areas requiring improvement have been escalated to divisional Senior Management Teams, for action.

Performance Information Report – The Committee noted overall performance against key performance indicators for the period December 2025 to March 2026, with strong performance reported and ongoing engagement with organisations through quarterly reporting arrangements. It was highlighted that this represents the final year of reporting in the current format ahead of revised strategic objectives for 2026/27. Three indicators were reported as amber, including Audit and Assurance turnaround performance, impacted by delays in management responses, and customer satisfaction measures within Digital Workforce Solutions and Central Team e-Business Services, with contributory factors including system migration issues, staffing pressures and challenging scoring thresholds. Mitigations were noted as in place, with continued focus on partnership working and benchmarking to support improvement.

Outcome Measures Report – The Committee noted performance against outcome measures aligned to NWSSP's strategic objectives, with enhancements to reporting including increased use of statistical process control and expanded operational and customer metrics. Strong performance was reported across most service areas, with customer satisfaction targets achieved, as noted above. Increased operational activity was highlighted, including call volumes of approximately 17,000, meeting performance targets. Workforce indicators remained stable, with turnover aligned to sector benchmarks, and value measures demonstrated continued contribution to the foundational economy, with 44% of spend with Welsh suppliers. The inclusion of 'Voice of the Customer' appendix provided assurance through a summary of individual customer conversations, demonstrating that urgent matters are addressed promptly while highlighting key themes emerging from customer feedback.

Transformation Management Office (TMO) Update Report – The Committee noted the update on the TMO portfolio, including a refined approach to benefits realisation to strengthen reporting of value and impact. The portfolio currently comprises 17 projects, 2 programmes and 6 service improvement initiatives, with the majority of activity aligned to All Wales priorities. Generally positive delivery was reported, with key updates including completion of the TrAMS Radiopharmacy project and transition to post-project evaluation, improved progress within the Welsh General Ophthalmic Services (WGOS) contract reform programme, and ongoing delays to the Legal and Risk case management system, due to technical stabilisation issues. Assurance was provided that risks and mitigations are actively managed and that overall delivery remains within expected parameters.

Draft NWSSP Annual Governance Statement (AGS) 2025–26 – The Committee noted the draft publication, recognising its importance within the organisation's assurance framework and its role in providing transparency to the Committee, Velindre University

NHS Trust (as host) and wider stakeholders. The AGS reflects governance, risk management and internal control arrangements, including consideration of the Welsh Government-commissioned Independent Review of Accountability & Governance and a balanced assessment of strengths and areas for development. Committee Members were invited to provide further comments ahead of finalisation and approval, at NWSSP Audit Committee on 15 June 2026.

NWSSP Corporate Risk Register – The Committee noted the current position within a dynamic operating environment, with 17 risks for action identified including six rated red and 11 amber. Key red-rated risks relate to cyber security, pharmaceutical supply, delivery of Radiopharmacy and TrAMS developments, financial and workforce pressures, the Future Workforce Solution and Welsh Risk Pool forecasting. It was noted that certain risks are being maintained within risk appetite where full mitigation is not achievable, with ongoing monitoring and management actions in place. Assurance was provided that Committee business is aligned to the NWSSP Corporate Risk Register, supporting focused scrutiny and forward planning, with further detailed consideration of cyber security risks scheduled for a future meeting.

The Committee DISCUSSED and NOTED the above Reports.

Items for Information

The Committee received the following items for information:

- Finance Monitoring Returns (Month 12 of 2025-26)
- Personal Protective Equipment (PPE) Report
- Audit Wales Audit Assurance Arrangements for NWSSP 2025-26
- NWSSP Internal Audit Plan, Mandate and Charter 2026-27
- NWSSP Counter Fraud Plan 2026-27
- SSPC Forward Plan 2026-27

Part B - Private

The Committee NOTED and ENDORSED the proposed approach as set out in the Welsh Risk Pool Update.

Extraordinary (Private) Meeting of the SSPC Held on 25 June 2026

At its extraordinary meeting on 25 June 2026, the Committee (SSPC) NOTED that the appointment process for the new Chair had been undertaken in accordance with the SSPC Standing Orders and APPROVED the recommendation of the appointment panel chaired by an Independent Assessor appointed by Welsh Government.

Matters requiring Board/Committee level consideration and/or approval

The Board is asked to NOTE the work of the Shared Services Partnership Committee.

Date of Next Meeting	Thursday 16 July 2026, 10.00am to 12.00pm

7.6

7.6 - FINANCE AND PERFORMANCE COMMITTEE WORK PLAN 2026/27

Huw Thomas (Hywel Dda UHB - Director of Finance)

For information

Attachments

FPC Work Plan 2026-27.pdf

FINANCE AND PERFORMANCE COMMITTEE WORK PLAN APRIL 2026 – MARCH 2027

Currently, Finance and Performance Committee (FPC) meets bi-monthly. Based on this, the following table represents a proposal to incorporate the duties as outlined in the Committee's Terms of Reference into a basic work plan April 2026 – March 2027.

AGENDA ITEM/ ISSUE	Lead	Responsible Officer	Purpose	30 Apr 2026	30 Jun 2026	27 July 2026	27 Aug 2026	27 Oct 2026	15 Dec 2026	23 Feb 2027
GOVERNANCE										
Welcome and Apologies	Chair	All		✓	✓	✓	✓	✓	✓	✓
Declarations of Interests	Chair	CSO		✓	✓	✓	✓	✓	✓	✓
Minutes from previous meeting	Chair	CSO	Approval	✓	✓		✓	✓	✓	✓
Table of Actions (ToAs)	Chair	CSO	Approval	✓	✓		✓	✓	✓	✓
FPC Terms of Reference (TORs) Review (12.1)	Chair	JW	Approval						✓	
FPC Annual Report 2025/26 (10.4.1)	Chair	HT	Approval	✓						
Self-Assessment of Committee Effectiveness: Outcome Report (10.5)	Chair	JW	Assurance							✓
Self-Assessment of Committee Effectiveness: Six-Month Review (10.5)	Chair	JW	Assurance				✓			
Assurance and Risk Report (3.1.18 & 3.1.19)	CW	RW	Assurance	✓	✓		✓	✓	✓	✓
ESCALATION OVERVIEW										
Escalation Oversight and Highlight Report (3.1.8) [From 27 Aug 2026: Annual Plan 2026/27 and Escalation Update]	SA	SA	Assurance	✓	✓		✓	✓	✓	✓
ESCALATION RESPONSE – RECOVERY ACTIONS AND IMPROVEMENT TRAJECTORIES (Areas to be agreed at Agenda Setting)										
Hospital Flow Processes	AC	AC	Assurance	✓				✓		

AGENDA ITEM/ ISSUE	Lead	Responsible Officer	Purpose	30 Apr 2026	30 Jun 2026	27 July 2026	27 Aug 2026	27 Oct 2026	15 Dec 2026	23 Feb 2027
Q1 2026/27 Planned Care Trajectories	AC	AC	Assurance	✓						
Enabling Actions: Value and Opportunities	HT	HT	Assurance	✓						
Q1 2026/27 Financial Trajectory	HT	HT	Assurance	✓						
De-risking the Annual Plan – Board Choices and Savings Considerations	SA	SA	Assurance		✓					
Radiology Demand and Capacity and Innovation	AC	AC	Assurance				✓			
Performance Deep Dive: Clinical Care Group Savings Plan	AC	KJ	Assurance				✓			
Finance Deep Dive: Medical Variable Pay	MH	MH	Assurance				✓			
Finance Deep Dive: Nursing Medical Pay	SD	SD	Assurance				✓			
Finance Deep Dive: Other Medical Pay	LG	LG	Assurance				✓			
Planned Care Plan	AC	AC	Assurance					✓		
FINANCE										
Financial Performance Assurance Report (3.1.5) to include: • Deficit Drivers Annual Refresh (3.1.2) • Financial Outlook 2025/26 (3.1.5) • Financial Recovery/In-Year Savings Programme (3.1.5) • Risks on delivery of key financial targets key income sources & contractual safeguards (3.1.7)	HT	AS	Assurance	✓	✓		✓	✓	✓	✓
Financial Plan and Strategy (3.1.4)	HT	AS	Assurance	✓						

AGENDA ITEM/ ISSUE	Lead	Responsible Officer	Purpose	30 Apr 2026	30 Jun 2026	27 July 2026	27 Aug 2026	27 Oct 2026	15 Dec 2026	23 Feb 2027
(Investments and) Benefits Realisation Report (3.1.13)	HT	SJ	Assurance	✓	✓					
Planning for 2027/28 (3.1.4)	HT	HT	Assurance						✓	
Financial Systems Assurance Report (3.1.6)	HT	AS	Assurance							
Finance Targeted Intervention Actions (3.1.8)	HT	SA	Assurance	Incorporated within Escalation Oversight and Highlight Report						
Value and Enabling Actions	HT	HT	Assurance		✓					
Plan for Closing the Residual Delivery Gap to £41m	LD/AC/JS	LD/AC/JS	Assurance		✓					
Resident Doctor Contract Implementation	LG/AC/MH	LG/AC/MH	Assurance		✓					
Band 2/3 Healthcare Support Worker Pay Re-banding Update	SJ	SJ	Assurance		✓					
Financial Grip and Control Assessment	HT	HT	Assurance		✓					
Procurement Plan (3.1.10)	HT	GD	Assurance		✓					
Contract Management	HT	GD	Assurance	✓						
Procurement Scrutiny (3.1.10 & 3.1.13) • Review any investment/disinvestment	HT	GD	Assurance	✓	✓		✓	✓	✓	✓
Planning Goals [prev. Objectives] Update Report (3.1.17)	HT	ALP	Assurance	✓ Q4/Closure	✓ Q1			✓ Q2		✓ Q3
Contracts Assurance Report (3.1.11 &12)	HT		Assurance							
Balance Sheet Report (3.1.5)	HT	AS	Assurance		✓					✓
Deep Dive: Risk Landscape of Health Board Financial Position	HT	HT	Assurance	✓						

AGENDA ITEM/ ISSUE	Lead	Responsible Officer	Purpose	30 Apr 2026	30 Jun 2026	27 July 2026	27 Aug 2026	27 Oct 2026	15 Dec 2026	23 Feb 2027
Deep Dive: Financial Alerts (Medical, Continuing Healthcare, Clinical Care Group Savings Plans)	MH/AC	MH/AC	Assurance		✓					
PERFORMANCE										
Integrated Performance Assurance Report (IPAR) (3.1.14)	HT	SH	Assurance	✓	✓		✓	✓	✓	✓
Performance Deep Dive: Alert Areas	AC	AC	Assurance		✓					
Performance Management Framework (3.1.14)	HT	HT	Assurance							
NHS Wales Shared Services Partnership (NWSSP) Performance Report 2025/26 (quarterly) (3.1.16)	HT	RD	Assurance		✓ (Q4)		✓ (Q1)		✓ (Q2)	✓ (Q3)
Public Sector Emissions Reporting	HT	DW	Assurance					✓		
Planned Care Recovery Plan	AC	AC	Assurance			✓				
FOR APPROVAL										
Financial Procedures (3.1.21)	HT	TJ	Approval	✓	✓		✓	✓	✓	✓
Policies (as required) (3.1.22)	All	All	Approval	✓	✓		✓	✓		✓
Business Cases (as and when required for scrutiny before onward ratification at Board) (3.1.9)	HT	HT	Approval	✓	✓		✓	✓	✓	✓
• UEC Business Case: Implementation and Evaluation	AC	AC	Approval		✓					
• Macmillan Cancer Support Neighbourhood Investment	AG	BB	Approval				✓			

AGENDA ITEM/ ISSUE	Lead	Responsible Officer	Purpose	30 Apr 2026	30 Jun 2026	27 July 2026	27 Aug 2026	27 Oct 2026	15 Dec 2026	23 Feb 2027
Partnership Business Case										
FOR INFORMATION										
All-Wales Capital Programme 2026/27, CRL and Capital Financial Management Update (3.5.3)	HT	RD	Information	✓	✓		✓	✓	✓	✓
JCC Planning, Performance and Finance Sub-Committee Reports (3.1.20)	HT	JM	Information	✓	✓		✓	✓	✓	✓
NWSSP Shared Services Partnership Committee Assurance Report	HT	HT	Information				✓	✓	✓	✓
NWSSP Procurement Services 2025-26 Summary Review	HT	HT	Information		✓					
Finance and Performance Committee Work Plan 2025/26	Chair	Chair	Information	✓	✓		✓	✓	✓	✓
COMMITTEE ADMINISTRATION										
Agenda setting meeting with Chair & Exec Lead (at least 6 weeks before the meeting)	CSO	N/A	N/A	✓	✓	✓	✓	✓	✓	✓
Draft agenda to go to Executive Team	CSO	N/A	N/A	✓	✓	✓	✓	✓	✓	✓
Call for papers (at least 6 weeks before the meeting to receive papers at least 14 days before the meeting	CSO	N/A	N/A	✓	✓	✓	✓	✓	✓	✓
Disseminate agenda/papers 7 days prior to meeting	CSO	N/A	N/A	✓	✓	✓	✓	✓	✓	✓

AGENDA ITEM/ ISSUE	Lead	Responsible Officer	Purpose	30 Apr 2026	30 Jun 2026	27 July 2026	27 Aug 2026	27 Oct 2026	15 Dec 2026	23 Feb 2027
Issue a draft TOA within two days of the meeting	CSO	N/A	N/A	✓	✓	✓	✓	✓	✓	✓
Circulate minutes and TOA to the Lead Director within 7 days of meeting	CSO	N/A	N/A	✓	✓	✓	✓	✓	✓	✓
Issue minutes and TOA to Members (including the Committee Chair) following Lead Director review	CSO	N/A	N/A	✓	✓	✓	✓	✓	✓	✓

Chair: Michael Imperato **Vice Chair:** Anna Lewis **Lead Executive:** Huw Thomas

HT	Huw Thomas	**MH**	Mark Henwood	**LD**	Lee Davies	**JW**	Joanne Wilson
LG	Lisa Gostling	**SA**	Shaun Ayres	**AS**	Andrew Spratt	**SJ**	Sian Jenkins
DW	Daniel Warm	**RD**	Rhian Davies	**GD**	Gemma Deverill	**KJ**	Keith Jones
AJ	Amorelle Jones	**SHi**	Steph Hire	**DB**	Debra Bennett	**LC**	Liz Carroll
AL	Angela Lodwick	**HTy**	Helen Tyler (JCC)	**SH**	Sally Havard	**VC**	Vicky Coppack
TJ	Timothy John	**JM**	Jacqueline Maunder (JCC)	**RW**	Rachel Williams	**ALP**	Angharad Lloyd-Probert
CSO	Committee Service Officer	**D**	Deferred				

8

8 - ANY OTHER BUSINESS

9

9 - DATE OF NEXT MEETING

- Tuesday 27 October 2026; 09:30 - 12:30

10

10 - IN COMMITTEE SESSION