

Agenda

10:45 - 10:50
5 min

1. PRELIMINARY MATTERS

-  0. SBUHB Board Agenda 24 September 2026.pdf (4 pages)
-  0. Agenda Bwrdd BIPBA 24 Medi 2026.pdf (4 pages)

1.1. Introduction

For Noting Chair

1.2. Welcome and Apologies

For Noting Chair

1.3. Declarations of Interest

For Assurance Chair

10:50 - 11:15
25 min

2. MAIN AGENDA

2.1. Chief Executive's Report

For Assurance Chief Executive Officer

-  2.1 CEO Report (September 2026).pdf (16 pages)

2.2. Risk Report

For Assurance Director of Corporate Governance

-  2.2 Risk Report (September 2026).pdf (8 pages)

11:15 - 11:30
15 min

3. PATIENT/STAFF EXPERIENCE

3.1. Patient Story

For Assurance Executive Director of Nursing and Patient Experience

- Perinatal Services

11:30 - 13:00
90 min

4. SETTING STRATEGIC DIRECTION

4.1. Population Health Committee Key Issues Report

For Assurance Committee Chair

-  4.1 Population Health 3As Key Issues Report (September 2026).pdf (4 pages)

4.2. Planning and Partnerships Report

For Assurance Executive Director of Planning and Partnerships

- Sustainability report

 4.2 Planning & Partnerships Report.pdf (13 pages)

4.3. Winter Preparedness Plan

For Approval Interim Chief Operating Officer

 4.3 SBUHB Board Winter Preparedness Plan 2026 - 27.pdf (11 pages)

4.4. Mental Health Stabilisation Plan

For Approval Executive Director of Planning and Partnerships / Interim Executive Director of Finance

 4.4 MH Estates Stabilisation PBC.pdf (9 pages)

COMFORT BREAK: 12:30pm – 1:00pm (30-MINUTES)

13:00 - 15:10
130 min

5. IN YEAR DELIVERY: QUALITY, SAFETY, PERFORMANCE AND RESOURCES

5.1. Performance and Finance Committee Key Issues Report

For Assurance Committee Chair

5.1.1. July 2026

 5.1i Performance and Finance 3As Key Issues Report (July 2026).pdf (5 pages)

5.1.2. August 2026

 5.1ii Performance and Finance 3As Key Issues Report (August 2026).pdf (7 pages)

5.2. Integrated Performance Report

For Assurance Executive Directors

 5.2 WG Oversight Escalation Update and SBUHB IPR.pdf (5 pages)

5.3. Finance Report

For Assurance Interim Executive Director of Finance

 5.3 Finance Report (Month 05 2026-27).pdf (15 pages)

5.4. Quality and Safety Committee Key Issues Report

For Assurance Committee Chair

 5.4 Quality & Safety 3As Key Issues Report (August 2026).pdf (8 pages)

5.5. Perinatal Services

For Assurance

5.5.1. Perinatal Committee Report

Executive Director of Nursing and Patient Experience

 5.5i Perinatal Committee Report (August 2026).pdf (33 pages)

5.5.2. Progress Against PIP Report

Executive Director of Nursing and Patient Experience

 5.5ii Perinatal Improvement Plan Report.pdf (15 pages)

5.5.3. Next Steps from Oversight Panel Review

Chair of Oversight Panel

 5.5iii Oversight Panel report (September 2026) FINAL.pdf (5 pages)

5.5.4. Path to Better Beginnings

Chief Nursing Officer, WG

COMFORT BREAK: 3:00pm – 3:10pm (10-MINUTES)

15:10 - 15:35 6. PEOPLE

25 min

6.1. Workforce and OD Committee Key Issues Report

For Assurance *Committee Chair*

 6.1 Workforce & OD 3As Key Issues Report (August 2026).pdf (3 pages)

6.2. Workforce Resilience Report

For Assurance *Executive Director of Workforce and OD*

 6.2 Workforce Resilience Report.pdf (16 pages)

15:35 - 16:25 7. GOVERNANCE

50 min

7.1. Audit Committee Key Issues Report

For Assurance *Committee Chair*

 7.1 Audit 3As Key Issues Report (September 2026).pdf (4 pages)

7.2. Digital, Data, Research and Innovation Committee Key Issues Report

For Assurance *Committee Chair*

 7.2 Digital, Data, Research and Innovation 3As Key Issues Report (September 2026).pdf (3 pages)

7.3. Corporate Governance Report

For Assurance *Director of Corporate Governance*

- **Declarations process**
- **Update on the Public Affairs Strategy**
- **Committee Changes**

 7.3 Corporate Governance Report.pdf (20 pages)

7.4. Welsh Language Standards Report

For Assurance *Executive Director of Nursing and Patient Experience*

 7.4 Annual WLS Report.pdf (6 pages)

7.5. Board Advisory Groups Report

For Assurance *Chairs of Advisory Groups*

 7.5 Board Advisory Groups Report.pdf (6 pages)

7.5.1. Health Board Partnership Forum

 7.5i Appendix 1 - Key Issues report HBPF (September 2026).pdf (6 pages)

7.5.2. Health Professionals Forum

 7.5ii Appendix 2 - HPF Board Report (September 2026).pdf (3 pages)

 7.5iii Appendix 3 - HPF Terms of Reference 2026-27.pdf (7 pages)

7.5.3. Stakeholder Reference Group

 7.5iv Appendix 4 SRG Key issues highlight report.pdf (2 pages)

7.6. Chair's Report

For Assurance *Chair*

 7.6 Chair's Report (September 2026).pdf (5 pages)

7.7. Minutes of the previous SBUHB Public Board meetings

For Approval *Director of Corporate Governance*

7.7.1. 30 July 2026

 7.7i Cofnodion Bwrdd BIPBA 30 Gorffennaf 2026 (DRAFFT HEB EU CADARNHAU).pdf (51 pages)

 7.7i SBUHB Board Minutes 30 July 2026 (UNCONFIRMED DRAFT).pdf (49 pages)

7.8. Action Log

For Assurance *Director of Corporate Governance*

 7.8 SBUHB Board Log 2025-26 (September 2026).pdf (4 pages)

16:25 - 16:30 8. ITEMS FOR DISCUSSION

5 min

8.1. Any Other Business

For Discussion *Chair*

8.2. Review of meeting effectiveness

For Discussion *Chair*

16:30 - 16:30 9. Next SBUHB Public Board Meeting: Thursday 26 November 2026

0 min

For Noting *Chair*



SBUHB PUBLIC BOARD MEETING

Thursday 24 September 2026

10:45am – 4:30pm

Millennium Room, SBU HQ

AGENDA

Item No:	Item Title	Lead	Timings	Purpose
PART 1. PRELIMINARY MATTERS				
1.1	In accordance with the provision of Section 1(2) of the Public Bodies (Admissions to Meetings) Act 1960 it was resolved that representatives of the press and other members of the public were excluded from the first part of the meeting on the grounds that it would be prejudicial to the public interest due to the confidential nature of the business transacted. This section of the meeting has already been held in private session.	Chair	10:45am	For Noting
1.2	Welcome and Apologies			
1.3	Declarations of Interest			
PART 2. MAIN AGENDA				
2.1	Chief Executive’s Report	Chief Executive Officer	10:50am	For Assurance
2.2	Risk Report	Director of Corporate Governance	11:05am	For Assurance
PART 3. PATIENT/STAFF EXPERIENCE				
3.1	Patient Story Perinatal Services	Executive Director of Nursing and Patient Experience	11:15am	For Assurance



PART 4. SETTING STRATEGIC DIRECTION

4.1	Population Health Committee Key Issues Report	Committee Chair	11:30pm	For Assurance
4.2	Planning and Partnerships Report Sustainability report	Executive Director of Planning and Partnerships	11:35am	For Assurance
4.3	Winter Preparedness Plan	Interim Chief Operating Officer	11:50am	For Approval
4.4	Mental Health Stabilisation Plan	Executive Director of Planning and Partnerships / Interim Executive Director of Finance	12:10pm	For Approval

COMFORT BREAK: 12:30pm – 1:00pm (30-MINUTES)

PART 5. IN YEAR DELIVERY: QUALITY, SAFETY, PERFORMANCE AND RESOURCES

5.1	Performance and Finance Committee Key Issues Report - July 2026 - August 2026	Committee Chair	1:00pm	For Assurance
5.2	Integrated Performance Report	Executive Directors	1:15pm	For Assurance
5.3	Finance Report	Interim Executive Director of Finance	1:40pm	For Assurance
5.4	Quality and Safety Committee Key Issues Report	Committee Chair	2:10pm	For Assurance
5.5	Perinatal Services - Perinatal Committee Report - Progress Against PIP Report - Next Steps from Oversight Panel Review - Path to Better Beginnings	Executive Director of Nursing and Patient Experience. Oversight Panel Chair (iii). Chief Nursing Officer, WG (iv).	2:15pm	For Assurance

COMFORT BREAK: 3:00pm – 3:10pm (10-MINUTES)



PART 6. PEOPLE

6.1	Workforce and OD Committee Key Issues Report	Committee Chair	3:10pm	For Assurance
6.2	Workforce Resilience Report	Executive Director of Workforce and OD	3:15pm	For Assurance

PART 7. GOVERNANCE

7.1	Audit Committee Key Issues Report	Committee Chair	3:35pm	For Assurance
7.2	Digital, Data, Research and Innovation Committee Key Issues Report	Committee Chair	3:40pm	For Assurance
7.3	Corporate Governance Report - Declarations process - Update on the Public Affairs Strategy - Committee Changes	Director of Corporate Governance	3:45pm	For Assurance
7.4	Welsh Language Standards Report	Executive Director of Nursing and Patient Experience	4:00pm	For Assurance
7.5	Board Advisory Groups Report i. Health Board Partnership Forum (3 September 2026) ii. Health Professionals Forum (13 August 2026) iii. Stakeholder Reference Group (17 September 2026)	Chairs of Advisory Groups	4:10pm	For Assurance
7.6	Chair's Report	Chair	4:15pm	For Assurance
7.7	Minutes of the previous SBUHB Public Board meetings: i. 30 July 2026	Director of Corporate Governance	4:20pm	For Approval
7.8	Action Log	Director of Corporate Governance	4:25pm	For Assurance

PART 8. ITEMS FOR DISCUSSION



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Bae Abertawe
Swansea Bay University
Health Board

8.1	Any Other Business	Chair	4:30pm	For Discussion
8.2	Review of Meeting Effectiveness	Chair		For Discussion
Next SBUHB Public Board Meeting: Thursday 26 November 2026				



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CYFARFOD BWRDD CYHOEDDUS BIPBA

Dydd Iau 24 Medi 2026

10:45am – 4:30pm

Ystafell y Mileniwm, Pencadlys PBA

AGENDA

Rhif yr Eitem:	Enw'r Eitem	Arweinydd	Amseria dau	Diben
RHAN 1. MATERION RHAGARWEINIOL				
1.1	Yn unol â darpariaeth Adran 1(2) o Ddeddf Cyrff Cyhoeddus (Derbyniadau i Gyfarfodydd) 1960, penderfynwyd y dylid gwahardd cynrychiolwyr y wasg ac aelodau eraill o'r cyhoedd o ran gyntaf y cyfarfod ar y sail y byddai'n niweidiol i fuddiant y cyhoedd oherwydd natur gyfrinachol y busnes a drafodwyd. Mae'r rhan hon o'r cyfarfod eisoes wedi'i chynnal mewn sesiwn breifat.	Cadeirydd	10:45am	I'w Nodi
1.2	Croeso ac Ymddiheuriadau			
1.3	Datganiadau o Fuddiannau			
RHAN 2. PRIF AGENDA				
2.1	Adroddiad y Prif Swyddog Gweithredol	Prif Swyddog Gweithredol	10:50am	Er Sicrwydd
2.2	Adroddiad Risg	Cyfarwyddwr Llywodraethu Corfforaethol	11:05am	Er Sicrwydd
RHAN 3. PROFIAD CLEIFION/STAFF				
3.1	Stori'r Claf Gwasanaethau Amenedigol	Cyfarwyddwr Gweithredol Nyrsio a Phrofiad y Claf	11:15am	Er Sicrwydd



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Tudalen **1** o **4**
Bwrdd Cyhoeddus



RHAN 4. PENNU CYFEIRIAD STRATEGOL

4.1	Adroddiad Materion Allweddol Pwyllgor Iechyd y Boblogaeth	Cadeirydd y Pwyllgor	11:30pm	Er Sicrwydd
4.2	Adroddiad Cynllunio a Phartneriaethau Adroddiad Cynaliadwyedd	Cyfarwyddwr Gweithredol Cynllunio a Phartneriaethau	11:35am	Er Sicrwydd
4.3	Cynllun Parodrwydd ar gyfer y Gaeaf	Prif Swyddog Gweithredu	11:50am	I'w Gymeradwyo
4.4	Cynllun Sefydlogi Iechyd Meddwl	Cyfarwyddwr Gweithredol Cynllunio a Phartneriaethau / Cyfarwyddwr Gweithredol Cyllid Dros Dro	12:10pm	I'w Gymeradwyo

EGWYL CYSUR: 12:30pm – 13:00pm (30-MUNUD)

RHAN 5. CYFLAWNIAD Y FLWYDDYN: ANSAWDD, DIOGELWCH, PERFFORMIAD AC ADNODDAU

5.1	Adroddiad Materion Allweddol y Pwyllgor Perfformiad a Chyllid i. Gorffennaf 2026 ii. Awst 2026	Cadeirydd y Pwyllgor	1:00pm	Er Sicrwydd
5.2	Adroddiad Perfformiad Integredig	Cyfarwyddwyr Gweithredol	1:15pm	Er Sicrwydd
5.3	Adroddiad Cyllid	Cyfarwyddwr Gweithredol Cyllid Dros Dro	1:40pm	Er Sicrwydd
5.4	Adroddiad Materion Allweddol y Pwyllgor Ansawdd a Diogelwch	Cadeirydd y Pwyllgor	2:10pm	Er Sicrwydd
5.5	Gwasanaethau Amenedigol i. Adroddiad y Pwyllgor Amenedigol ii. Adroddiad Cynnydd yn Erbyn PIP	Cyfarwyddwr Gweithredol Nyrsio a Phrofiad y Claf.	2:15pm	Er Sicrwydd



	iii. Camau Nesaf o Adolygiad y Panel Goruchwylio	Cadeirydd y Panel Goruchwylio (iii).		
	iv. Llwybr i Ddechreuadau Gwell	Prif Swyddog Nyrsio, LIC (iv).		

EGWYL CYSUR: 3:00pm – 3:10pm (10-MUNUD)

RHAN 6. POBL

6.1	Adroddiad Materion Allweddol y Pwyllgor Gweithlu a Datblygu Sefydliadol	Cadeirydd y Pwyllgor	3:10pm	Er Sicrwydd
6.2	Adroddiad Chwarterol ar Wytnwch y Gweithlu	Cyfarwyddwr Gweithredol y Gweithlu a Datblygu Sefydliadol	3:15pm	Er Sicrwydd

RHAN 7. LLYWODRAETHU

7.1	Adroddiad Materion Allweddol y Pwyllgor Archwilio	Cadeirydd y Pwyllgor	3:35pm	Er Sicrwydd
7.2	Adroddiad Materion Allweddol y Pwyllgor Digidol, Data, Ymchwil ac Arloesi	Cadeirydd y Pwyllgor	3:40pm	Er Sicrwydd
7.3	Adroddiad Llywodraethu Corfforaethol - Proses Datganiadau o Fuddiant - Diweddariad ar y Strategaeth Materion Cyhoeddus - Newidiadau i'r Pwyllgor	Cyfarwyddwr Llywodraethu Corfforaethol	3:45pm	Er Sicrwydd
7.4	Adroddiad Safonau'r Iaith Gymraeg	Cyfarwyddwr Gweithredol Nyrsio a Phrofiad y Claf	4:00pm	Er Sicrwydd
7.5	Adroddiad Grwpiau Ymgynghorol y Bwrdd i. Fforwm Partneriaeth y Bwrdd Iechyd (3 Medi 2026) ii. Fforwm Gweithwyr Proffesiynol Iechyd (13 Awst 2026) iii. Grŵp Cyfeirio Rhanddeiliaid (17 Medi 2026)	Cadeiryddion Grwpiau Ymgynghorol	4:10pm	Er Sicrwydd



7.6	Adroddiad y Cadeirydd	Cadeirydd	4:15pm	Er Sicrwydd
7.7	Cofnodion cyfarfodydd blaenorol Bwrdd Cyhoeddus BIPBA: i. 30 Gorffennaf 2026	Cyfarwyddwr Llywodraethu Corfforaethol	4:20pm	I'w Gymeradwyo
7.8	Cofnod Gweithredu	Cyfarwyddwr Llywodraethu Corfforaethol	4:25pm	Er Sicrwydd

RHAN 8. EITEMAU I'W TRAFOD

8.1	Unrhyw Fusnes Arall	Cadeirydd	5:00pm	I'w Drafod
8.2	Adolygiad o effeithiolrwydd cyfarfodydd	Cadeirydd		I'w Drafod

Cyfarfod Bwrdd Cyhoeddus nesaf BIPBA: Dydd Iau 26 Tachwedd 2026



Meeting Date	24 September 2026	Agenda Item	2.1
Name of Meeting	SBUHB Board		
Report Title	Chief Executive Officer’s Report		
Report Author	Chief Executive Officer		
Report Sponsor	Chief Executive Officer		
Presented by	Abigail Harris, Chief Executive Officer		
Freedom of Information	Open		
FoI Closed detail	If closed, choose detail		
Impact Assessment Summary Outcome		IA Completion date	
N/A		Click or tap to enter a date.	
Purpose of the Report	For Assurance		
Report Summary; detailing any action required			
This report provides the Board with an assurance update on our key strategic programmes, escalation position, operational risks and matters requiring Board awareness or approval since the July Board meeting. It covers progress on maternity and neonatal services, planned care and cancer, urgent and emergency care, finance, mental health transformation, <i>Transforming for the Future</i> and <i>Organised for Success</i>. It also provides updates on Wales Fertility Institute, Gorseinon Hospital, the Ombudsman Special Report, the Pharmaceutical Needs Assessment, reflections on the Cardiff and Vale independent review, the Regional Joint Committee, consultant appointments and the Llais service change proforma.			
Key Issues			
Key issues and risks requiring Board oversight:			
• Finance, strategy and planning remain a significant organisational risk with focused work to de-risk the position. A separate report on today’s Board agenda sets out the latest Month 5 financial position, the forecast position and the plan to balance. • Urgent and emergency care remains under sustained pressure, with risks around ambulance handover, long waits, discharge flow and access to alternatives to Emergency Department (ED) Services requiring continued whole system focus and winter readiness. There are improvements in key areas including 4 hour and 12 waits in ED and discharge from acute inpatient care before 12 noon. • Planned care long-wait delivery remains a strength, but delivery confidence depends on maintaining productivity, reducing			



fragility and improving diagnostics and priority specialty pathways.

- Cancer performance remains below the level required, with backlog and diagnostic pressures continuing to affect delivery confidence. A clinically led Cancer Improvement Programme is being brought forward to strengthen whole-system oversight and delivery. Next month will see the impact of the external pathology activity that has been commissioned to address significant diagnostic delays within the cancer pathway.
- Maternity and neonatal services continue to demonstrate progress through the Perinatal Improvement Programme, with continued focus on embedding sustainable improvements and addressing residual workforce, culture, operating model and configuration risks. Further work is being undertaken to strengthen our engagement work and how we use the insights from engagement and feedback to inform continued service improvement.
- Mental health transformation is progressing, including strengthened programme governance, quality and safety reporting, workforce planning, estates stabilisation, service redesign and engagement. Adult Mental Health remains a Welsh Government Service of Concern due to residual quality, safety, estate and workforce risks. Today's Board includes the business case for our inpatient estate stabilisation plan for adult MH services (and consolidation of improvements in older persons mental health in patient bed provision).
- *Transforming for the Future* and *Organised for Success* remain key strategic enablers, with current work focused on future clinical service models, structured engagement, leadership appointments, readiness arrangements and alignment of corporate enabling services. Key milestones in both programmes of work will be reached during September and October.
- Several strategic and compliance matters require Board awareness, including the temporary pause to new activity at the Wales Fertility Institute, the Gorseinon Hospital engagement process, the Ombudsman Special Report, the Pharmaceutical Needs Assessment, reflections on the Cardiff and Vale independent review, and the adoption of the All-Wales Llais service change proforma.

**Decision / Action
required**

Yes

Recommendations





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Health Board

Members are asked to:

- **RECEIVE** the report for **ASSURANCE**.
- **CONSIDER** the progress, risks and actions set out in relation to the Health Board's areas of escalation, priority programmes and risks.
- **CONSIDER** the Public Service Ombudsman's Public Interest Report and findings.
- **APPROVE** adoption of the All-Wales Llais service change proforma for future service change engagement, replacing the previous local bespoke version while retaining flexibility to include Swansea Bay-specific context where required.
- **APPROVE** the final Pharmaceutical Needs Assessment and authorise its publication.



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3 of 16
SBUHB Board
Thursday, 24 September 2026



CHIEF EXECUTIVE OFFICER'S REPORT

1. INTRODUCTION

September marks the end of Quarter 2 and the midpoint of the financial year. It is an important point at which to assess delivery against the Annual Plan commitments agreed in April 2026, the expectations set through the last Welsh Government Escalation Board and the priorities of the Board, and the actions required for the remainder of the year. We are taking stock against the Quarter 2 expectations relating to delivery grip, financial recovery, planned care and cancer, urgent and emergency care, and sustainable improvement in areas of escalation to ensure we remain on track to deliver the end of year commitments set out in our Annual Plan.

The first half of the year has been challenging, with sustained operational pressure, periods of extreme weather and continuing financial risk. At the same time, we have continued to strengthen governance, accountability and delivery arrangements across priority programmes, including maternity and neonatal services, planned care and cancer, urgent and emergency care, mental health transformation, *Transforming for the Future* and *Organised for Success*.

As we move into the second half of the year, we are also beginning to look ahead to the development of the Health Board's Annual Plan for 2027/28. Planning is a continuous process, but this is the point at which we will begin to test the assumptions, choices and delivery requirements that will shape next year's plan.

Early draft planning assumptions are being developed to support consistent planning across service, workforce, finance, digital, estates and transformation. These remain provisional and will need to be considered through Executive Team, informed by the Welsh Government planning framework and confirmed allocation, before being brought back to Board.

While the detail is still being worked through, the emerging context is clear. We expect to need to test scenarios such as flat cash and a reducing real-terms resource envelope, alongside continued financial pressure, rising demand, workforce affordability, and the need for sustained productivity improvement and transformation, rather than assuming additional capacity or unfunded growth.

We remain in a high level of Welsh Government escalation, with monthly Performance Reviews with NHS Wales Performance and Improvement and bimonthly Escalation Boards with Welsh Government. The next meeting

on 8 October 2026 will be a combined mid-year Accountability Review and Escalation Board, providing an important checkpoint on delivery, escalation and organisational risk. This report therefore provides an assurance update on progress since the last Board meeting, the key risks that remain, and the actions we are taking to strengthen delivery.

Overall, the Health Board is stabilising, and we are consolidating on the work undertaken in the first half of the year, with key metrics moving in the right direction, albeit not yet on a sustainable footing in every area. This is building a stronger platform on which to move into 2027/2028.

2. OUR PRIORITY PROGRAMMES – KEY UPDATES

2.1 Improving maternity and neonatal services (Targeted Intervention – Level 4)

Maternity and neonatal services remain in Targeted Intervention, with continued focus on delivering the Perinatal Improvement Programme, strengthening assurance and embedding sustainable improvements in safety, experience and outcomes.

The final Perinatal Improvement Programme was agreed by the Independent Oversight Panel and the Health Board in July 2026, with 70% of recommendations reported as delivered to date. This brings together the response to the Independent Review, Family Led Review, Llais feedback, Independent Oversight Panel assessment and wider learning into a single delivery framework.

Progress is evident across governance, Board oversight, the maternity and neonatal dashboard, risk review, training compliance and clinical leadership. A number of criteria are complete, while ongoing work continues on sustainability conditions, learning from LRI/NRIs, complaints and concerns, family engagement through PMRT processes, staffing, PROMs/PREMs and culture.

The next phase is about demonstrating that the programme is not only progressing actions but reducing risk in practice. A scorecard is being developed to map the ten thematic recommendations to key metrics and will be presented to Board in September 2026. The Board will continue to receive regular assurance through the established quality, safety and perinatal governance routes. Amalgamated reporting of the Perinatal Improvement Programme and Perinatal Committee will be developed in Quarter 3, to bring together the impact of the programme on operational and “business-as-usual” outcomes and metrics, including key safety, quality and experience indicators.

In relation to the single site working, a case for change is being developed, which will need to form part of both the Clinical Services Plan and the Infrastructure Strategic Plan. The Board accepts the need to set out an explicit plan for this, with clear timelines.

2.2 Maintaining momentum with planned care and cancer improvement (Enhanced Monitoring – Level 3 planned care; Targeted Intervention – Level 4 cancer)

Planned care long-wait performance remains a relative area of strength, with continued focus on maintaining delivery, reducing fragility and improving productivity across priority specialties and diagnostics.

The Planned Care Plan was supported by the Board in July for onward submission to Welsh Government. Since then, we have received confirmation of a first tranche allocation of £4.6million from the Planned Care Recovery Fund 2026–27, aligned to the priorities set out in the Plan. This is a positive development and reflects constructive feedback from Welsh Government and NHS Performance and Improvement colleagues on the quality, coherence and maturity of the submission. The allocation is subject to clear conditions, including demonstrating additionality, maintaining core delivery, evidencing continued productivity improvement and delivering against agreed activity and trajectories. Productivity and performance metrics have been submitted covering treat in turn, theatre efficiency/session utilisation and GIRFT compliance, and a clinical and administrative validation plan is being finalised for internal sign-off through Planned Care Board at the end of September. We have received notification of the second tranche of planned care funding – which brings the total funding being made available to us to £8,317,686 (against a plan submitted with indicative resourcing implications of circa £20 million). Work is being finalised to set out in detail delivery within our core funding and the additional allocation.

Cancer performance remains fragile and continues to require sustained organisational focus. The July 2026 Single Cancer Pathway performance deteriorated to 45% compared with a trajectory of 57% and remains below the Welsh Government de-escalation requirement. The cancer backlog stood at 673 patients at the end of August, against a trajectory of 317, more than double the planned level.

The main constraint is pathology capacity. Cellular pathology outsourcing has been delayed and is now expected to commence at the end of August / early September. Pathology reporting recovery and clearing cellular

pathology are central to the cancer recovery actions and will impact positively on the September performance. The year end trajectory and recovery plan has been shared with NHS Performance and Improvement.

Recovery actions are progressing through tumour-site recovery plans, reduction of outpatient and inpatient component waits, pathology reporting recovery, improved application of urgent suspected cancer criteria, theatre productivity improvement, additional capacity for priority pathways and strengthened skin cancer leadership. The proposed Executive-led Cancer Improvement Programme will provide a whole-system approach to improving outcomes, performance and sustainability.

2.3 Emergency and urgent care (Targeted Intervention – Level 4)

Urgent and emergency care remains under significant pressure and continues to carry material patient safety, performance and whole-system flow risk.

The most recent reporting continues to indicate pressure across ambulance handover, long waits, time to clinical decision-maker review, discharge flow and alternatives to Emergency Department attendance. These pressures are interdependent and reflect the continuing impact of demand, acute flow, discharge constraints and limited alternatives to ED at times of peak pressure.

Our actions continue to focus on Call Before Conveyance, Single Point of Access pathways, falls response, direct specialty referral routes, improved ED decision-making processes, resident doctor rota redesign, ambulatory pathway testing and optimal hospital flow. These are intended to reduce avoidable attendance and conveyance, improve pull from ED and support earlier discharge.

However, delivery remains dependent on whole-system flow, discharge capacity, workforce availability, clinical risk appetite, community alternatives and sustained operational discipline. The Board should note that improvements in ambulance handover, 12-hour waits and time to clinical decision-maker review are interdependent and cannot be delivered through Emergency Department action alone. There are some small improvements in the 4- and 12-hour ED waits and discharges before mid-day have increased in line with our plan. Overall Pathways of Care Delays are in line with our Annual Plan trajectory and number of bed-days lost due to delays is falling.

Winter planning and severe weather planning will continue to prioritise admission avoidance, discharge, flow, escalation management, resilience of critical infrastructure and support for vulnerable patients and staff. The

latest iteration of the Winter Plan is presented for the Board's consideration as a separate agenda item.

2.4 Finance, strategy and planning (Targeted Intervention – Level 4)

Finance, strategy and planning remain a significant organisational risk. At Month 5, we remain above the planned deficit trajectory, and savings delivery remains below the level required, with a significant proportion of savings delivered to date on a non-recurrent basis. The overspend in Month 5 reflects a stabilising position.

The Board will receive a separate report on today's agenda setting out the latest Month 5 financial position, the forecast position and the plan to balance. This report therefore does not duplicate that detail, but notes that delivery of the financial plan remains a central area of Executive and Board focus.

2.5 Mental health transformation and improvement

Mental health services continue to show evidence of progress. Welsh Government has de-escalated Child and Adolescent Mental Health Services to Level 1 following sustained improvement against the agreed performance and outcomes criteria, and Caswell Clinic has been de-escalated by the NHS Wales Joint Commissioning Committee from Level 3 to Level 2.

The Mental Health Transformation Programme has also strengthened during the reporting period. A new Executive Lead and Programme Board Chair are in place, workstream governance has been refreshed, and progress has been made on quality and safety reporting, workforce planning, estates stabilisation, service redesign, informatics and engagement. A lived experience event is planned for September and the Regional Partnership Board governance route for community redesign is being progressed.

Adult Mental Health, however, remains a Welsh Government Service of Concern due to residual quality and safety risks, particularly relating to the condition and suitability of the estate, ligature and environmental risks, workforce capacity, patient experience and the sustainability of current mitigations. Welsh Government has recognised the progress made through the transformation programme, but further assurance is required that risks are being managed holistically across immediate stabilisation, service redesign and the longer-term estate solution.

A key enabler is the proposed short-term estates stabilisation plan, which will be presented to Board for approval today and for onward submission

to Welsh Government. This is an important step in reducing immediate estate-related risk, but it will not remove residual risk completely. The next phase will therefore focus on securing the stabilisation plan, strengthening workforce and quality assurance, progressing digital and service redesign work, and aligning the longer-term solution to the National Mental Health Plan.

The Mental Health and Learning Disabilities Service Group is working at pace to recruit to nursing posts agreed as part of the acute ward nursing establishment review. This will reduce agency and bank spend and will improve performance in key areas such as sickness absence, patient experience and key quality areas.

2.6 Transforming for the Future (T4F)

Work on *Transforming for the Future* continues as the Health Board's long-term clinical services plan. Current work is focused on shaping the future model of care, preparing for structured engagement with staff, partners, patients and communities, and identifying the key enablers required to support sustainable change, including workforce, digital, estates, place and partnerships.

Since the successful Clinical Leadership Event held on 1 July, we have had three Clinical Reference Group Working Groups and a Third Sector event both in support of developing the future model of care.

The Chair and I also presented to Swansea Council Members' away day as part of early partner engagement. This provided an opportunity to describe the direction of travel, listen to members' views and reinforce the importance of partnership working as the programme moves towards more structured engagement.

2.7 Organised for Success (O4S)

Organised for Success remains a critical enabler of delivery, accountability and the future operating model. Executive Board has supported revised sequencing for Phases 2F–H, enabling newly appointed leadership teams to shape the future Care Group operating model and strengthening ownership of organisational change. Phase 2F has now completed, with Service Group engagement concluded and Board approval secured, allowing progression to leadership appointments.

The next phase will focus on completing the organisational change processes for triumvirate leadership posts, concluding internal appointments, launching open recruitment for remaining leadership roles, re-establishing readiness arrangements and reviewing corporate enabling services so they align to the developing Care Group structure.



Key risks relate to the timely completion of leadership appointments, maintaining organisational capacity for change alongside strategic programmes and ensuring enabling services are aligned to support the new model. These risks are being actively managed through established programme governance arrangements.

Delivery remains on track to implement the new structure from April 2027.

3. STRATEGIC UPDATES AND RISKS FOR BOARD AWARENESS

3.1 Wales Fertility Institute

We have been working to resolve the workforce challenges that led to the temporary pause in new IVF treatment activity at the Wales Fertility Institute. Subject to final operational confirmation, the service is now preparing to resume in a phased way from Tuesday 22 September 2026.

The temporary pause commenced on Tuesday 25 August 2026 as a result of workforce challenges in key areas. At the time, we indicated that the pause was expected to last for up to four weeks. Patients who had already started treatment continued to receive their care as planned during this period, and there has been no impact on gametes or embryos in storage.

Approximately 20 patients were already undergoing treatment and continued to do so. More than 400 patients with treatment plans who had not yet started treatment were affected by the pause, along with more than 200 patients on the waiting list who had not yet started treatment and did not yet have a treatment plan in place. The Health Board will write to patients over the coming days and into next week to confirm the latest position and the phased approach to resuming activity.

We recognise how concerning this pause may have been for patients and are sorry for the upset and anguish caused by the delay. Affected patients continue to have access to counselling support and a route to contact the senior WFI team. We will continue to work closely with the NHS Wales Joint Commissioning Committee to strengthen resilience and support the safe, phased restoration of the service.

3.2 Gorseinon Hospital

Since the last report, we have moved into the formal engagement phase on the proposal to transfer inpatient beds from Gorseinon West Ward to Singleton Hospital and to continue developing Gorseinon Hospital as a community healthcare facility. The engagement is being undertaken in partnership with Llais and will involve patients, carers, the public, elected representatives and partner organisations.

The engagement will run until midnight on 19 October, with opportunities to respond in writing, by email, through a response form, via social media and through both face-to-face and online drop-in events. The outcome of the engagement, including all responses received, will be considered by Llais and the Health Board in November before any final decision is made.

The Board is asked to note that the current position remains a proposal, and that the outcome of engagement will determine whether the proposed changes can proceed, whether mitigating action is required, or whether further public consultation is needed.

3.3 Public Interest Report - Ombudsman

The Public Services Ombudsman for Wales has issued a Special Report (available in the Reading Room) relating to a historical orthopaedic waiting list management case, where the patient's Referral to Treatment clock had been reset incorrectly and this had not been communicated to the patient. The Health Board accepts the findings and recommendations in full.

The recommendations relating to apology and dissemination of learning have been completed. The Special Report was issued because the recommendations relating to an independent re-audit of orthopaedic waiting lists and enhanced RTT training were not completed within the original timescales. This was primarily due to the time taken to secure an appropriate independent audit route and to resolve the supporting audit approach.

We have now commissioned an independent audit of orthopaedic waiting list management, supported by Internal Audit, to provide assurance that no other patients have been adversely affected by similar issues and to identify and implement any required remedial action.

Work is also underway to strengthen processes and training, including clearer documentation of fitness-for-surgery decisions, improved patient communication, enhanced pre-assessment and optimisation pathways, and updated RTT training materials informed by the learning from this case.

Board oversight is in place, with progress being monitored against the Ombudsman's required milestones and assurance reports to continue until all recommendations have been fully implemented. We have formally committed to delivering all outstanding actions and providing evidence of completion to the Ombudsman within the agreed timescales.

3.4 Community Pharmacy Services Pharmaceutical Needs Assessment

The Population Health Committee has considered the draft Pharmaceutical Needs Assessment 2026, which is subject to statutory consultation ahead of publication by 1 October 2026.

The assessment has not identified current or future gaps in pharmaceutical service provision, including out-of-hours access, although reliance on a limited number of providers during late evening periods will continue to be monitored as a resilience issue.

The consultation concluded on 11 September 2026. The assessment indicates that pharmaceutical provision across Swansea Bay is sufficient to meet current and anticipated population need, with 90 community pharmacies serving the Health Board population and all pharmacies participating in the Clinical Community Pharmacy Service the responses have been considered.

The Board is asked to approve the final PNA and authorise its publication to enable compliance with statutory requirements by 1 October 2026.

3.5 Reflections on the Cardiff and Vale Independent Report

The independent review of Cardiff and Vale University Health Board provides an important opportunity for Swansea Bay to reflect on our own governance, leadership, culture, planning and delivery arrangements. This is not a direct comparison or a formal assessment of Swansea Bay, but a focused opportunity to consider whether similar issues could arise here, what evidence supports our current level of assurance, and where further strengthening may be required.

At a high level, the themes in the report reflect challenges faced across the wider NHS, including Board assurance, risk management, clinical governance, speaking up, organisational culture, leadership cohesion, delivery discipline, staff engagement and the need for clear strategic priorities. Within Swansea Bay, related actions are already underway, including *Organised for Success*, *Transforming for the Future*, the development of the Performance and Accountability Framework, the Delivery Unit, stakeholder 360 work with the Good Governance Institute and the planned governance review from Board to ward.

Our initial reflection is that the key question is not simply whether governance structures exist, but whether they are consistently enabling concerns to be raised early, risks to be owned clearly, decisions to be made at pace, and learning to be shared across the organisation. We will continue to use the Cardiff and Vale review as a learning tool and will use the Executive Team timeout on 23 October to reflect collectively on the key themes, test our own assurance and identify any further actions required.

3.6 Regional Joint Committee

Work on the agreed Regional Joint Committee (RJC) priorities and programmes has continued to progress during the reporting period. Regional sub-groups and programme teams have maintained delivery momentum, progressing key development, implementation and planning activities aligned to the RJC work programme and objectives. Ongoing oversight arrangements remain in place to monitor progress, manage risks and issues, and support delivery across the regional portfolio. This reflects the RJC's continued focus on strengthening regional collaboration, governance and system-wide improvement.

In response to Internal Audit's recent review of the Committee's governance arrangements which found that these were operating effectively in supporting oversight, reporting and decision-making across both Health Boards, the Terms of Reference for the Committee will be reviewed and those of its sub-groups will be formalised and standardised in order to further strengthen consistency and maturity across the governance landscape.

A further update on progress, risks, opportunities and key programme deliverables will be considered by the Regional Joint Committee at its next meeting on 13 October 2026, providing formal assurance on progress against the agreed work programme. A comprehensive Regional Joint Committee update will subsequently be presented to both Health Boards through the normal Board reporting arrangements at the next Board cycle in November 2026.

A joint executive team away-day for the Swansea Bay and Hywel Dda executive teams was very constructive and enabled the teams to identify the opportunities to go further in our endeavours to deliver services on a regional footprint where it makes sense to do so. Acute eye care, orthopaedics, pathology and radiology remain key areas of focus. A 12-month appointment (initially) of a joint Research, Development and Innovation Director will enable us to accelerate our ambitions to be a research-active health board, with innovation as a key driver for service improvements and a key pillar of our work with our three regional university partners. The Chairs and CEOs of both health boards recently met with the Vice Chancellors of the three university and there is a strong commitment to strengthen our collaboration in a number of key areas.

3.7 Building the Executive Team

Recruitment processes for permanent appointments to four executive director posts are underway - chief operating office (incorporating executive director of primary care and mental health), executive medical

director, executive finance and digital director and executive public health director. Interviews are due to take place in October and November. The new post of Board level Mental Health and Learning Disability Director is also being recruited to. This role will lead on the continued transformation at Board level of these services. The Executive Director of Allied Health Professionals and Health Science is being recruited to on an interim basis and will be advertised early in the New Year.

3.8 Confirmed consultant appointments

Since the July Board meeting, we have confirmed 14 consultant appointments across a range of specialties and corporate medical leadership roles, including oral and maxillofacial surgery, emergency medicine, adult mental health, ophthalmology, anaesthetics, histopathology, paediatrics, oncology, public health, intensive care and learning disability services.

The appointments are predominantly replacement or planned cover posts, including maternity and locum arrangements, supporting service stability, continuity and resilience across key clinical areas. Two appointments are new posts: a Consultant Clinical Academic in Oncology and Data Science, funded by Health and Care Research Wales, and the Guardian for Safe and Flexible Working, established in line with the new Resident Doctor contract. Both appointees were existing Swansea Bay consultants.

All consultant recruitment continues to be subject to appropriate scrutiny, with new posts requiring a clear business case and alignment to service, quality, workforce and financial requirements.

Post Title	New / Replacement	Start Date	Rationale for new post
Consultant Surgeon - Oral & Maxillofacial Surgery (Orthognathic)	Replacement	10/08/2026	
Consultant in Emergency Medicine	Replacement	01/09/2026	
Specialty Attachment Lead for Subspecialties in Medicine and Surgery	Replacement	27/07/2026	
Consultant Psychiatrist - Adult Mental Health - Community Mental Health Team - Forge Centre	Replacement	01/09/2026	
Locum Consultant Ophthalmologist - Medical Retina	Replacement	10/08/2026	



Locum Consultant Anaesthetist	Replacement - Maternity	10/08/2026	
Locum Consultant Histopathologist (Medacs)	Replacement	10/08/2026	
Consultant in General Paediatrics	Replacement	03/08/2026	
Consultant Clinical Academic in Oncology and Data Science	New	01/09/2026	Funding from Health and Care Research Wales. Appointment was a consultant already working in SBUHB
Guardian for Safe and Flexible Working	New	01/08/2026	New post in line with new Resident Doctor contract. Appointment was a consultant already working in SBUHB
Consultant in Public Health Medicine	Replacement	01/09/2026	
Locum Consultant General Paediatrician	Replacement - Maternity	02/09/2026	
Locum Consultant Intensive Care	Replacement	03/08/2026	
Locum Consultant Psychiatrist Learning Disability Services	Replacement	01/09/2026	

3.9 Llais Proforma

Historically, the Health Board has used a bespoke proforma for service change engagement, developed in discussion with Llais and previously approved by the Board.

Llais has now introduced an All-Wales proforma to support greater consistency in how service change proposals are described, assessed and discussed with communities. The Board is asked to approve adoption of the All-Wales proforma for future service change engagement, replacing the local bespoke version, while ensuring that any Swansea Bay-specific context or additional information required can still be included where appropriate.

4.0 Organ Donation Week

Organ Donation week falls in the week of our Board meeting, so it is an opportune moment to reflect on this important area of work. Our Organ

Donation Committee provides the oversight of our arrangements for supporting organ donation, working closely with NHS Blood and Transplant Services which operates across England and Wales.

Our 2025-2026 Organ Donation Annual Report will be going to Quality and Safety Committee in October, but it is useful to share some of the key headline figures, and to thank our teams for supporting patients and their families with organ donation conversations and procedures. We know this makes a huge difference to the lives of people – those whose donations are a life-changing gift to those in receive of donated organs.

- 86 patients were referred to the NHS Blood and Transplant's organ donations services team;
- 38 of which met the referral criteria and could be included in the potential donor audit.
- From this, there were **12 consented donors**, of which all **12** were able to donate, benefiting **30** patients across the UK, with **19 kidneys** and **11 livers**. In addition, **12 corneas** were received by NHS Blood and Transplant eye banks.



Meeting Date	24 September 2026	Agenda Item	2.2
Name of Meeting	SBUHB Board		
Report Title	Risk Report		
Report Author	Neil Thomas, Assistant Head of Risk & Assurance		
Report Sponsor	Director of Corporate Governance		
Presented by	Hazel Lloyd, Director of Corporate Governance		
Freedom of Information	Open		
FoI Closed detail	If closed, choose detail		
Impact Assessment Summary Outcome		IA Completion date	
N/A		Click or tap to enter a date.	
Purpose of the Report	For Assurance		
Report Summary; detailing any action required			
This report provides the Health Board with information to support assurance on the effectiveness of the Health Board's risk management framework. In particular, the report provides an update on Board-level risk registers – the Strategic Risk Register (SRR) and Corporate Risk Register (CRR) – and arrangements to support the detailed scrutiny of risk management by Board Committees.			
Key Issues			
The Board risk registers have been reviewed and revised by Directors during July and August. Three workforce risks have been added to the Strategic Risk Register under the objectives of '<i>The health board is a great place to work where staff feel valued and work together towards a common goal</i>' and '<i>The health board is a resilient, financially sustainable and responsible organisation</i>'. There are now 12 strategic risks within the Board Strategic Risk Register. Seven risks have been added to the Corporate Risk Register, resulting in a total number of 36 risks. The register now incorporates additional corporate workforce risks, informed by those within the operational risk registers of services, and risks relating to engagement within perinatal services, hosted services, and performance delivery during organisational change. The report provides assurance on the oversight of established risks by Board Committees and indicates the next dates for review of those remaining.			



An amended draft Risk Appetite Statement is presented for consideration and adoption by the Board.

**Decision / Action
required**

No

Recommendations

Members are asked to:

- **RECEIVE** for **ASSURANCE** the information presented in this report and its supporting appendices.
- **CONSIDER** any further assurance needs.
- **CONSIDER** the draft Risk Appetite Statement for adoption.



RISK REPORT

1. INTRODUCTION

This report provides the Health Board with information to support assurance on the effectiveness of the Health Board's risk management framework. In particular, the report provides an update on Board-level risk registers – the Strategic Risk Register (SRR) and Corporate Risk Register (CRR) – and arrangements to support the detailed scrutiny of risk management by Board Committees.

2. BACKGROUND

The Strategic Risk Register (SRR) summarises the principal risks to the Health Board (at the strategic level) that could impact successful delivery of one of the organisation's five strategic objectives, typically over medium to long-term timeframes ('horizons 2 - 3').

The Corporate Risk Register (CRR) records high level corporate or operational risks, escalated by services to Executive / Corporate Director level and agreed for oversight at Board / Committee level. The timescales within which these risks are anticipated to impact are typically short to medium term ('horizon 1 - 2'). The decision to escalate to the CRR is informed by consideration of the level of risk against the Health Board's appetite statement and set criteria as set out in the Risk Management policy.

3. GOVERNANCE AND RISK ISSUES

3.1 Strategic Risk Register (SRR) Update

The SRR has been subject to a further cycle of review by Board Directors in August 2026. Three additional workforce risks have been added:

- 4.1 Staff Health & Wellbeing and Organisational Performance
- 4.2 Culture
- 5.2 Workforce (Sustainability)

The SRR contains 12 risks currently. Table 1 below sets out the risks linked to the Health Board's five strategic objectives and the programmes/strategies in place to mitigate the risks (please see glossary at end of this report for abbreviations).



Table 1

Strategic Objectives	Strategic Objective 1	Strategic Objective 2	Strategic Objective 3	Strategic Objective 4	Strategic Objective 5
→	People of Swansea Bay live healthier, fairer and more prosperous lives	Care is high quality, safe, efficient and delivers the best possible outcomes for people in partnerships	Care is delivered in partnership with our communities in safe and appropriate settings, supported by innovation	The health board is a great place to work where all staff feel valued and work together towards a common goal	The health board is a resilient, sustainable and responsible organisation
→	Level 16 •Population Health Approaches to Address Health Inequity, PHC Level 12 •Partnerships & Collaboration, Board	Level 16 •Quality, Safety & Patient Outcomes, QSC •Mental Health, QSC •Perinatal Service, QSC •Access to Services, PFC	Level 20 •Estates, PFC Level 15 •Digital, DDRIC	Level 12 4.1 Staff Health & Wellbeing and Organisational Performance, WODC 4.4 Culture, WODC	Level 25 •Recovery & Sustainability, PFC Level 20 5.2 Workforce (Sustainability), WODC
→	• Population Health Strategy	• Perinatal Programme • Mental Health Transformation Programme • Access to Service Programmes (Cancer/Unscheduled Care/Planned Care)	• Estates Strategy • Digital Strategy	• Organised for Success Programme	• Recovery & Sustainability Programme

As part of future cycles of review and update, further narrative will be sought in support of the overall assurance levels indicated for the risks.

3.2 Corporate Risk Register (CRR) Update

The CRR has been subject to further cycles of review by Board Directors in July and August 2026. Seven additional risks have been added:

- 118: Perinatal Engagement
- 119: Hosted Services
- 120: A&C Staff Recruitment Restrictions
- 121: Health & Safety of Staff
- 122: Staffing Models
- 123: Nurse Staffing Levels/Templates
- 124: Organisational Change



The CRR, summary provided in Table 2, now contains 36 risks. One risk, that relates to cyber security, is deemed sensitive; this is overseen by the Executive Team and considered at the in-committee session of the Board and Digital, Data, Research & Innovation Committee.

Table 2

Strategic Objectives	Strategic Objective 1	Strategic Objective 2	Strategic Objective 3	Strategic Objective 4	Strategic Objective 5
→	People of Swansea Bay live healthier, fairer and more prosperous lives	Care is high quality, safe, efficient and delivers the best possible outcomes for people in partnerships	Care is delivered in partnership with our communities in safe and appropriate settings, supported by innovation	The health board is a great place to work where all staff feel valued and work together towards a common goal	The health board is a resilient, sustainable and responsible organisation
Corporate risks linked to the Strategic Objectives →	Level 12 100 Partnerships & Collaboration, PHC Level 8 52 Statutory Compliance: Engagement & Impact Assessment, PFC	Level 20 4 Healthcare Acquired Infection, QSC 66 Access to Systemic Anti-Cancer Therapy (SACT), QSC 80 Clinically Optimised Patients QSC 110 Access to Cancer Care, PFC 116 Maternity Services Site, QSC 117 Timely UEC, PFC Level 16 111 Listening to People, QSC 118 Perinatal Engagement, QSC Level 12 109 Access to Planned Care, PFC 119 Hosted Services, QSC	Level 20 60 Cyber Security and Resilience, DDRIC 104 Clinical Coding Completeness, DDRIC 115 MHL D Estate, PFC Level 16 36 Paper Record Storage, DDRI 64 H&S Infrastructure, QSC 105 LIMS, DDRI 108 WCCIS/Connecting Care, DDRI 121 Staff H & Safety, WODC Level 15 113 Sustainability of Digital Services, DDRIC Level 12 120 A&C Recruitment, WODC	Level 20 89 Healthcare Nursing Staff Levels (HMPS), WODC 114 MHL D Staffing, WODC Level 12 3 Recruitment of Consultant Medical and Dental Staff, WODC 122 Staffing Models, WODC 123 Nurse Staffing Levels / Templates, WODC	Level 25 92 Finance forecast deficit, PFC Level 20 90 Subject Access Request, DDRIC 96 Failure to Develop an Approvable IMTP, PFC 106 Emissions Reduction, PFC 107 Emergency Preparedness, PFC Level 16 85 Non-Compliance with ALN Act, QSC Level 12 53 Welsh Language Standards, HB WLG 93 Finance Capital Funds, PFC 124 Organisational Change, WODC

The Corporate Risk Register is underpinned by operational risk registers and an escalation process.

3.3 Committee Oversight of CRR Risks

Board Committees receive regular reports on their allocated risks above appetite, and these set out the key steps in place/required to manage risk to an acceptable level. Reports also include updates on those risks below appetite, in recognition of the Board's aspiration to reduce risks further. All risks have been received by Committees within the last three months except for the newest risks and those allocated to the Digital Data Research & Innovations Committee, which will receive its risks in

September 2026, providing assurance that all established risks will have received recent Committee scrutiny.

3.4 Risk Appetite

A refreshed, draft risk appetite statement has been circulated to Executive Directors and Independent Members previously. A revised draft has been included in the Reading Room for consideration by Board.

As part of the scrutiny of risks undertaken by Committees, it is our future intention to use the 3A reports to Board as a mechanism to highlight key changes to risks with respect to the Board's risk appetite.

Risk target scores, which reflect the levels of risk anticipated as result of controls and the completion of additional management actions, do not always match the Health Board's greater ambition to reduce risk further. As part of the agenda setting for Committee meetings, Board level risks above appetite with target scores that match current scores will be highlighted to support the commissioning of 'deep dive' reports from risk owners to understand barriers to reduction and explore risks in greater depth where required.

4. FINANCIAL IMPLICATIONS

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

5. RECOMMENDATIONS

Members are asked to:

- **RECEIVE** for **ASSURANCE** the information presented in this report and its supporting appendices.
- **CONSIDER** any further assurance needs.
- **CONSIDER** the draft Risk Appetite Statement for adoption.



Governance and Assurance		
Strategic Objectives		
Strategic Objectives <i>(please choose which is impacted)</i>	People of Swansea Bay live healthier, fairer and more prosperous lives	☒
	Care is high quality, safe, efficient and delivers the best possible outcomes for people in partnerships	☒
	Care is delivered in partnership with our communities in safe and appropriate setting, supported by innovation	☒
	The health board is a great place to work where staff feel valued and work together towards a common goal	☒
	The health board is a resilient, sustainable and responsible organisation	☒
Health and Care Standards		
Standards <i>(please choose which applies)</i>	Safe Care	☒
	Timely Care	☒
	Effective Care	☒
	Efficient Care	☒
	Equitable care	☒
	Person-centred Care	☒
	Staff and Resources	☒
Enablers <i>(please choose which applies)</i>	Whole Systems Approach	☒
	Leadership	☒
	Workforce	☒
	Culture	☒
	Information	☒
	Learning, Improvement and Research	☒
Quality, Safety and Patient Experience		
Ensuring the organisation has robust risk management arrangements that ensure organisational risks are captured, assessed, monitored and managed, supports the quality, safety & experience of patients receiving care and staff working in the UHB.		
Financial Implications		
This report does not present any matters for decision with financial implications. There may be financial implications arising from actions required to improvement the treatment of risks entered on the HBRR. Where this is the case they are highlighted within individual risk register entries for information.		
Legal Implications (including equality and diversity assessment)		
It is essential that the Board has robust arrangements in place to assess, capture and mitigate risks faced by the organisation, as failure to do so could have legal implications for the UHB.		



Staffing Implications

All staff have a responsibility for promoting risk management, adhering to SBUHB policies and have a personal responsibility for patients' safety as well as their own and colleague's health and safety. Executive Directors/Service Group Directors are responsible for the review of their operational risks and escalation of those requiring board-level oversight SBUHB.

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

The board level risk registers present the framework within which SBUHB assesses existing and future emerging risks, and how it plans to manage and prepare for those risks.

Report History

This report updates on risk matters received in July 2026.

Appendices

Appendix 1 – Risks On A Page (Aug 2026)

Available in the Reading Room:

- Strategic Risk Register (SRR)
- Corporate Risk Register (CRR)
- Draft Risk Appetite Statement (Sep 2026)

Glossary of Abbreviations

Committees:

AC	Audit Committee
DDRIC	Digital, Data, Research & Innovation
PFC	Performance & Finance
PHC	Population Health
QSC	Quality & Safety
WODC	Workforce & Organisational Development



POPULATION HEALTH COMMITTEE Key Issues Report

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

Date of Committee meeting:		8 September 2026
Members Present:		Three members were present at the Population Health Committee: Stephen Spill, Nicola Matthews, Nuria Zolle.
Quoracy:		YES
Group/Committee Chair:		Stephen Spill, Population Health Committee Chair.
Report Submitted by:		Corporate Governance.
Report Signed off by:		Stephen Spill, Population Health Committee Chair. Hugo Van Woerden, Interim Director of Public Health.
Date of Board receiving the report:		24 September 2026
1.	Agenda	The Population Health Committee convenes quarterly, and the agenda, relevant documents, and minutes from the meetings are accessible on the SBUHB website .
2.	Alert	The Committee is alerting the Board to the following items (2):
	Minute Reference: 46/26	Prevention and Primary Care Priorities: Cardiovascular Disease (CVD) Prevention: The Committee agreed to alert the Board to the potential impact of organisational reprioritisation associated with delivery of the £65m savings programme, noting that reduced programme management support may slow progress on elements of the CVD prevention programme and wider preventative transformation activity.



	Minute Reference: 48/26	• Diabetes Progress Report: The Committee agreed to alert the Board that the wider Diabetes Redesign Programme has been paused until at least the end of the financial year as part of organisational reprioritisation. Members highlighted the importance of ensuring Board awareness of the delay to transformation activity, including development of the community diabetes model and wider pathway redesign work.
3.	Assurance	The Committee is assuring the Board on the following items (8):
	Minute Reference: 44/26	• Breastfeeding Policy Update: The Committee received assurance regarding development of a Health Board-wide Breastfeeding Policy, improving breastfeeding rates, and targeted work to reduce inequalities in breastfeeding outcomes.
	Minute Reference: 45/26	• Child Measurement Programme: The Committee received assurance regarding ongoing partnership working through schools, Public Services Boards and the Healthy Weight Healthy Wales Programme to address childhood obesity and wider determinants of health.
	Minute Reference: 46/26	• Prevention and Primary Care Priorities: CVD: The Committee received assurance that core CVD prevention activity continues through established primary care pathways and partnerships despite reduced transformation support.
	Minute Reference: 47/26	• Horizon Scanning Report: The Committee received assurance that Public Health colleagues continue to monitor emerging policy, prevention and population health developments and maintain strategic oversight of future risks and opportunities.
	Minute Reference: 49/26	• Green Wards Initiative: The Committee received assurance regarding progress of the Green Wards Initiative, including development of a structured sustainability accreditation framework and strong organisational engagement.



	Minute Reference: 50/26	• Pharmaceutical Needs Assessment (PNA): The Committee received assurance that pharmaceutical provision across the Health Board remains sufficient to meet identified population needs and that no unmet pharmaceutical need has been identified through the assessment process.
	Minute Reference: 51/26	• Wellbeing of Future Generations Objectives: The Committee received assurance regarding progress in embedding the principles of the Wellbeing of Future Generations Act through organisational strategy, sustainability programmes and partnership arrangements.
	Minute Reference: 54/26	• Committee Risk Register: The Committee received assurance that Population Health strategic and corporate risks continue to be actively monitored and reviewed through established risk management processes.
4.	Advise	The Committee is advising the Board on the following items (4):
	Minute Reference: 46/26	• Prevention and Primary Care Priorities: CVD Prevention: The Committee agreed to advise the Board on the impact of Delivery Unit reprioritisation on preventative transformation programmes and the potential implications for the pace of preventative activity, whilst noting that core prevention work remains ongoing.
	Minute Reference: 52/26	• Marmot Initiative in Neath Port Talbot: The Committee agreed to advise the Board on progress being made through the Marmot Initiative and the opportunities it presents to strengthen action on health inequalities through collaborative partnership working and place-based approaches.
	Minute Reference: 53/26	• Committee Effectiveness Self-Assessment: The Committee agreed to advise the Board that the self-assessment demonstrated a positive level of Committee effectiveness whilst identifying a small number of areas for continued development, with improvement actions already underway.



	Minute Reference: 42/26	• Vaccine Equity Strategy Annual Report: The Committee agreed to advise the Board on the successful delivery of Year One of the Vaccine Equity Strategy and the progress made in addressing vaccination inequalities through intelligence-led planning, community engagement and targeted interventions. The Committee noted that workforce capacity and recruitment challenges, alongside the increasing number of vaccination programmes and eligible cohorts, continued to place pressure on available resources and would require ongoing monitoring.
5.	Review of Risks	The Population Health Committee will keep the Board updated on any developments regarding risks in relation to the above matters.
6.	Sharing of learning	None identified during the meeting.
7.	Actions to be considered by Board	None identified by the Committee Members.



Meeting Date	24 September 2026	Agenda Item	4.2
Name of Meeting	SBUHB Board		
Report Title	Planning & Partnerships Update		
Report Author	Marie Davies, Executive Director of Planning, Partnerships & Performance Karen Stapleton, Deputy Director of Planning, Partnerships & Performance Hannah Roan, Assistant Director of Planning, Partnerships & Performance (Commissioning & Sustainability) Kelly Gillings, West Glamorgan Regional Transformation Programme Director		
Report Sponsor	Executive Director of Planning and Partnership		
Presented by	Marie Davies, Executive Director of Planning, Partnerships & Performance		
Freedom of Information	Open		
FoI Closed detail	If closed, choose detail		
Impact Assessment Summary Outcome		IA Completion date	
N/A		Click or tap to enter a date.	
Purpose of the Report	For Assurance		
Report Summary; detailing any action required			
This report provides an overview of the key activities and outputs relating to Strategic and Integrated Service Planning, Commissioning, Partnerships, Sustainability and Emergency Preparedness, Resilience and Response (EPRR) and Recovery Planning both within the Health Board and with our wider partners. Its purpose is largely to provide the Board with both oversight and assurance to ensure alignment with national policy and Health Board strategic objectives in order to meet the current and future needs of our population and patients and, in doing so, to ensure that we work in meaningful partnership with our communities and key stakeholders. The report also outlines, where appropriate, the evolving planning structures, process and outputs and the local, regional and national planning reporting and assurance frameworks and outputs.			



Key Issues

The areas covered in this report reflect the Executive portfolio priorities:

- Strategy & Strategic Programmes
 - Organisational Strategy
 - Transforming for the Future: Our Clinical Services Strategic Plan
- Annual Plan (Integrated Medium-Term Plan)
- Partnership Plans
 - West Glamorgan Regional Partnership Board
 - Public Services Boards
 - Regional Specialised Services Provider Planning Partnership (RSSPPP) with Cardiff & Vale UHB
 - Swansea Bay City Deal
- Sustainability & Climate Change
- Emergency Preparedness Resilience and Response (EPRR) and Recovery

Decision / Action required

No

Recommendations

Members are asked to:

- **CONSIDER** and **AGREE** the items as requested through the report.

PLANNING & PARTNERSHIPS UPDATE

1. INTRODUCTION

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

2. BACKGROUND

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

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

3. STRATEGY AND STRATEGIC PROGRAMMES

3.1 Transforming For The Future (T4F): Our Clinical Services Strategic Plan

The Transforming for the Future programme continues to progress in line with the agreed programme approach and timeline. Following Board consideration in July 2026, the programme has moved into the next phase of model development, focused on translating the agreed Principles for Change into a clinically-led Future Model of Care. Work is being undertaken across the seven areas of care, alongside development of the key enabling frameworks required to support long-term service sustainability and transformation. See more detail at **Appendix 1**.

The Board can **take assurance** that the Transforming for the Future programme has successfully transitioned from the principles and engagement phase into detailed model development, with appropriate clinical leadership, stakeholder involvement and enabling workstreams in place to support production of the Health Board's Clinical Services Strategic Plan. Transforming for the Future will provide the context and direction for the really radical, transformative service change that is essential to be able to provide sustainable services that meet our population's need.



4. ANNUAL PLAN/IMTP

This section provides an update on delivery of the 2026/27 Annual Plan, development of the 2027/28 planning cycle and the strengthening of governance arrangements supporting a challenging and robust approach to allocating our resources in

4.1 Annual Plan 2026/27

Work continues to strengthen the current, un-approvable annual plan, submitted to Welsh Government in June 2026, to:

- deliver our breakthrough objectives,
- continue to address our performance challenges in line with the Welsh Government Performance Framework, with specific focus on those services/functions where the health board is in escalated performance monitoring
- ensure our continuously developing system and service group delivery plans take appropriately balanced account of both performance priorities and service risk
- substantially and sustainably improve our financial position to deliver, as a minimum, our forecast control total by year end.

Significant risks relating to financial recovery, workforce capacity, urgent and emergency care performance, delivery of savings and transformation programmes have been identified and are being actively managed through our integrated performance management governance processes i.e:

- System/Transformation Programmes (e.g. Planned Care, UEC, Mental Health)
- Recovery and Sustainability Programmes
- Service Group Performance Reviews.

The delivery trajectories for service performance standards, quality & safety, workforce and finance are reported through the Integrated Performance Report and supplementary dashboards to the nominated board committees in line with the Board's Performance and Assurance Framework.

Welsh Government has recognised improvements in the quality of the Annual Plan and associated governance arrangements, whilst continuing to highlight concerns regarding financial sustainability and performance trajectories. Work is continuing with all Board colleagues, Welsh Government and NHS Performance and Improvement to strengthen delivery confidence, improve organisational performance and establish a credible pathway towards financial balance.

4.2 Annual Plan 2027/28

Work is continuing to drive a more radical but integrated, data-driven approach to ensure that our plan for 2027-28 builds on lessons learned from the current planning cycle and, in particular, feedback from the Board's Independent Members and Welsh Government. We aim to strengthen the alignment between planning governance for service delivery, performance improvement, financial sustainability and long-term transformation. The Quarter 2 Integrated Planning and Performance Review will provide a formal gateway into the 2027/28 planning cycle, ensuring delivery performance from the current year informs our approach for accelerated and recurrent financial and performance improvement, identifies transformation priorities and supports our commitment to return to balance.

A refreshed process and timeline to deliver a credible plan for submission in March for 2027-28 will be shared at the next Board meeting. The Planning Framework for 2027-28 is unlikely to be issued by Welsh Government until late November/early December, but the work is ongoing in the health board to populate the Framework when it is published.

4.3 Planning and Finance Assurance Group (PFAG)

During 2026/27, the Planning and Finance Assurance Group arrangements have been strengthened to support more robust scrutiny, prioritisation and governance of proposals to reallocate revenue to enable priority performance improvement and/or reduce expenditure run rate. **Appendix 2** highlights key changes and improvements to the process and governance.

Board are asked to **take assurance** that the strengthened PFAG framework provides greater Executive ownership and accountability to ensure that any resource allocation proposals are subject to robust scrutiny, clear prioritisation, affordability assessment and ongoing monitoring of expected benefits.

5. PARTNERSHIP PLANNING (REGIONAL AND LOCAL)

The Health Board actively contributes to statutory and formal partnerships, including the West Glamorgan Regional Partnership Board and Public Service Boards. As a key partner, SBUHB must demonstrate effective collaboration in line with Statutory Guidance, fostering strong relationships that support long-term sustainability across the region.

The following provides an update on progress delivered and future priorities to support the Health Board in its continued commitment to partnerships and collaboration.

5.1 West Glamorgan Regional Partnership Board (WGRPB)

The last Regional Partnership Board meeting was held on 7th July 2026, and a full RPB programme level update is provided in **Appendix 3**.

At the Regional Partnership Board meeting, the Annual Report for 2025/26 was endorsed for submission to Welsh Government as per legislative requirements the report can be viewed here: [Annual Report - West Glamorgan Regional Partnership](#)

5.1.1 Progress with WGRPB Area Plan Priority Areas

The West Glamorgan Regional Partnership Board continues to progress delivery of its Area Plan priorities through the priority programmes:

- Older People (aligned with the UHB UEC Programme)
- Transforming Complex Care (aligned with the UHB CHC Programme)
- Mental Health (aligned with the the UHB's Mental Health Transformation Programme)
- Carers

Current activity is focused on a small number of high-priority areas where regional collaboration is required to address system pressures, improve outcomes and support sustainable models of care. This includes strengthening hospital discharge and community support arrangements, progressing regional approaches to joint funding and commissioning, improving support for unpaid carers, and establishing partnership governance for the redesign of community mental health services. These programmes are increasingly focused on delivery and implementation, with a strong emphasis on prevention, early intervention, community-based support and reducing reliance on acute and specialist services.

During the reporting period, significant progress has been made in agreeing key regional models, governance arrangements and work programmes that will support more consistent approaches across partners. Priorities over the coming months include implementation of the strengthened discharge and urgent care arrangements, testing of new regional joint funding processes, delivery planning for the refreshed Unpaid Carers Strategy, and mobilisation of the regional mental health programme. Collectively, these developments are intended to strengthen partnership working, improve system flow, support people closer to home and provide a stronger platform for future service transformation.

5.2 Public Services Boards

Both PSBs have now published their Annual Reports and are available online, [Swansea Public Services Board Annual Report 2025-26 - Swansea](#) and [Neath Port Talbot Public Services Board Annual Report 2026](#). The



reports are an opportunity to reflect on progress made against the PSB well-being plans and set-out the vision for the year ahead. The Health Board remain engaged in delivering the PSB Wellbeing Objectives identified and outlined below are some examples of activity during the last quarter:

- The Neath Port Talbot Public Service Board met on the 14th of July and through strong partnership working, population health and health equity were given a clear platform. This included a session on the Marmot approach with contributions from the Swansea Bay Public Health Team and the Institute for Health Equity. This programme of work is supported by funding secured through Welsh Government.
- A progress update was also provided by the Swansea Bay Public Health Team on the Tata Health Impact Assessment, with funding secured to deliver this work through the Tata Transition Board. Partners welcomed the progress made to date and the collaborative approach being taken to support fairer health outcomes during the Tata transition, with support from a range of partner organisations helping to drive this work forward.
- In addition, the climate & adaptation steering group have received the findings of a NPT commissioned project, to be followed by a data review exercise;
- The Swansea Public Service Board met formally in April and is scheduled to meet again in October. Key programmes of work continue to be progressed including the launch of the [Resilient Swansea Strategy](#) in July, and Swansea are looking to run a series of climate cafes from the Autumn;
- The Swansea PSB Partnerships Forum on 14 September will focus on support for people in Dyfatty, with the Health Board contributing through its work at Dyfatty Junction to improve access to services and support for the local community;
- The Health Board will host the annual PSB event, Walking in Our Shoes on the 15th of October. The agenda will focus on showcasing Health Board initiatives aligned to achieving the principles of the Well-being of Future Generations (Wales) Act 2015.

5.3 Regional And Specialised Services Provider Planning Partnership (RSSPPP)

The RSSPPP continues to provide a joint forum between Swansea Bay UHB and Cardiff and Vale UHB to support collaborative planning and delivery of specialised services across South Wales. The following sections highlight the key priorities and proposed actions for the Health Board.

South Wales Blood and Marrow Transplant Programme - The South Wales Blood and Marrow Transplant Programme remains subject to deferred JACIE reaccreditation following identification of workforce,



governance, quality management and infrastructure deficiencies. A corrective action plan has been submitted and the programme is awaiting the final accreditation decision. Board **is alerted** to the risks relating to securing recurrent workforce investment and completing the remaining compliance actions required to sustain transplant and CAR-T services in South Wales.

Tertiary Services Planning - RSSPPP has agreed to develop a joint tertiary services delivery plan for Swansea Bay UHB and Cardiff and Vale UHB to support a coordinated and sustainable approach to specialised services planning. The timeline for completion was initially Quarter 3 2026/27 but given the national discussions led by NNHS P&I and NWJCC on specialised services its been agreed to pause work until there is further clarity on the national work. Progress is however continuing the baseline assessments to ensure we have our own internal positions clearly articulated.

6. SUSTAINABILITY & CLIMATE CHANGE

The Sustainability and Climate portfolio has continued to make positive progress during the reporting period, supporting delivery of the Health Board's Climate Action Plan and wider organisational objectives. The annual carbon emissions return for 2025/26 has been submitted to Welsh Government (**Appendix 5**), providing an enhanced understanding of the Health Board's carbon footprint and informing future decarbonisation priorities.

Total reported emissions increased by 30.8% in 2025/26 compared with 2024/25, primarily attributable to improved supply chain emissions reporting and enhanced data quality. Of this increase, the supply chain emissions account for 85% of our carbon footprint - the carbon intensity of healthcare supply chains present ongoing challenges to achieving long-term decarbonisation ambition. More encouragingly, emissions directly controlled by the Health Board have continued to reduce, with Scope 1 and Scope 2 emissions reducing by a combined 24.6% against the 2018/19 baseline, exceeding the NHS Wales target of a 16% reduction by 2025. This reflects sustained progress in estate energy efficiency, renewable energy generation, fleet improvements and clinically led reductions in anaesthetic gas emissions.

The Health Board has also strengthened its understanding of climate resilience through a staff heat survey conducted during the summer heat event, generating over 2,700 responses. The findings provide valuable insight into the impact of extreme heat on staff, patients and service delivery and will inform future adaptation planning.

In August 2026 the Health Board has responded to the Future Generations Commissioner's letter on 'Heatwave and extreme weather preparedness and response' to provide assurance on our current plans and arrangements for responding to extreme weather events, our lessons learnt from recent events and additional measures to be put in place to strengthen preparedness for future events.

Positive progress has also been made in supporting the Foundational Economy agenda. During 2025/26, 40.6% of reportable expenditure was with suppliers headquartered in Wales, with over 75% of foundational economy spend retained within the Health Board footprint, supporting local businesses, communities and economic resilience.

The Health Board has worked collaboratively with the Royal Society for the Protection of Birds (RSPB) to develop and launch locally tailored Nature Prescription resources, creating new opportunities to support prevention, wellbeing and nature-based approaches to healthcare. The next phase of work will focus on promoting and embedding the initiative across a wider range of services to maximise uptake and patient benefit.

Priorities for the remainder of 2026/27 will focus on strengthening delivery of the Climate Action Plan, embedding sustainability and climate considerations within strategic decision-making, and identifying opportunities to reduce emissions associated with procurement, clinical practice and service delivery, particularly within the supply chain.

The findings from the heat survey will be used to develop and implement practical adaptation measures to improve resilience ahead of future heat events, supporting safer environments for patients, staff and services.

Further opportunities are being explored to support sustainability, financial efficiency and quality improvement, including the potential implementation of the "Needless Needles" initiative, expansion of renewable energy opportunities and continued development of clinically led sustainability programmes. Delivery of these initiatives will require continued collaboration across the Health Board and with external partners.

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

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

Governance Statement -EPRR arrangements are managed corporately, operationally and through established Executive governance structures in line with the Health Board's statutory duties under the Civil Contingencies

Act 2004. This report is presented for Board Assurance. No approvals or decisions are currently required, and all activity remains within delegated authority.

Strategic Position -The Health Board continues to maintain statutory emergency preparedness, resilience, response, and recovery arrangements. Assurance has been obtained through governance oversight, exercising, organisational learning, business continuity development and partnership working across local, regional, and national resilience forums.

During the reporting period, July – August 2026, the Health Board has completed significant review work relating to Major Incident, Pandemic Response and Severe Weather arrangements, incorporating learning from Exercise ECHO 3, (Major Incident Exercise) and the July 2026 Extreme Heat response and subsequent debrief.

Key Developments - progress include:

- Revision of Pandemic Response arrangements and planned organisational testing; Exercise Pandemic Flux on the 2nd September 2026.
- Review and update of Major Incident procedures.
- Ongoing organisational interdependency mapping to strengthen resilience assurance.
- Progression of protective security preparedness and Martyn's Law planning.
- Continued alignment with NHS Wales resilience developments and South Wales Local Resilience Forum priorities.

Board Assurance

The Board is asked to **take assurance** on the Health Board's emergency preparedness, resilience, response, and recovery arrangements and to note the key strategic resilience risks and mitigating actions: progress against organisational resilience priorities and that no approvals are currently required and that any future matters requiring escalation will be brought forward through the appropriate governance arrangements.

8. WINTER PREPAREDNESS PLAN

Winter Preparedness planning is being led by the Chief Operating Officer as SRO. The draft Regional Self-Assessment and Assurance Template was developed collaboratively with partners and submitted to NHS Performance and Improvement (NHS P&I) in line with the 27th of August deadline. The Health Board is awaiting feedback and the release of the national winter modelling assumptions. The Winter Preparedness Operational plan is currently being taken through Health Board and regional governance, prior

to submission to NHS P&I on the 25th September. The plan remains iterative and will continue to be refined during September and October, including Winter Sprint arrangements and assessment of potential investment opportunities. Current activity is focused on maintaining patient flow, protecting hospital capacity, supporting timely discharge and strengthening system resilience throughout the winter period.

9. RECOMMENDATIONS

Members are asked to:

- **CONSIDER** and **AGREE** the items as requested through the report.



Governance and Assurance		
Strategic Objectives		
Strategic Objectives <i>(please choose which is impacted)</i>	People of Swansea Bay live healthier, fairer and more prosperous lives	☒
	Care is high quality, safe, efficient and delivers the best possible outcomes for people in partnerships	☒
	Care is delivered in partnership with our communities in safe and appropriate setting, supported by innovation	☒
	The health board is a great place to work where staff feel valued and work together towards a common goal	☒
	The health board is a resilient, sustainable and responsible organisation	☒
Health and Care Standards		
Standards <i>(please choose which applies)</i>	Safe Care	☒
	Timely Care	☒
	Effective Care	☒
	Efficient Care	☒
	Equitable care	☒
	Person-centred Care	☒
	Staff and Resources	☒
Enablers <i>(please choose which applies)</i>	Whole Systems Approach	☒
	Leadership	☒
	Workforce	☒
	Culture	☒
	Information	☒
	Learning, Improvement and Research	☒
Quality, Safety and Patient Experience		
The content of this report describes the planning process and approach that will ensure an appropriate and integrated focus and approach to delivering improvements in quality, safety and patient experience.		
Financial Implications		
The content of this report describes the planning process and approach that will support an approach, both strategic and tactical, that aims to deliver our target control total in 3 years.		
Legal Implications (including equality and diversity assessment)		
There are no immediate direct legal implications arising from this report although all service changes – strategic and tactical – will be subject to equality, health and quality impact assessments.		



Staffing Implications

The content of this report describes the planning process and approach that will ensure an appropriate and integrated approach to workforce planning at both strategic and tactical level and in collaboration with our partners.

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

Our wellbeing objectives and ways of working, as described in the Wellbeing of Future Generations legislation, are reflected in our planning guidance and documentation for both our IMTP and strategic plans.

Report History

The first Planning & Partnerships report was submitted to the Health Board for information and discussion on 29th May 2025.

Appendices

Appendix 1 – Transforming for the Future (T4F): Our Clinical Services Strategic Plan

Appendix 2 – Planning and Finance Assurance Group (PFAG)

Appendix 3 – WGRPB Area Plan and Action Plan Priorities 2026-27

Appendix 4 – Drug and Alcohol Leadership Board (DALB) Annual Report

Appendix 5 – Annual Carbon Emissions Return 2025-26



Meeting Date	24 September 2026	Agenda Item	4.3
Name of Meeting	SBUHB Board		
Report Title	Winter Planning 2026/27		
Report Author	Heledd Bingham, Strategic Planning Manager Alison Gallagher Associate COO – UEC.		
Report Sponsor	Chief Operating Officer		
Presented by	Jon Scott, Chief Operating Officer		
Freedom of Information	Open		
FoI Closed detail	If closed, choose detail		
Impact Assessment Summary Outcome		IA Completion date	
		Click or tap to enter a date.	
Purpose of the Report	For Approval		
Report Summary; detailing any action required			
This paper seeks Board approval of the West Glamorgan Winter Preparedness Plan 2026/27 and the associated Regional Self-Assessment and Assurance Template for submission to NHS Wales Performance and Improvement. The plan sets out the current regional approach to maintaining urgent and emergency care resilience, supporting patient flow, protecting capacity, and mitigating the impact of winter pressures across health and social care. The plan is supported by the Health Board's Emergency Preparedness, Resilience and Response (EPRR) and Business Continuity Management (BCM) arrangements to ensure organisational readiness for seasonal pressures and wider disruptive incidents. The Board should note that the plan remains subject to further refinement following receipt of national modelling assumptions and feedback from NHS Wales P&I. Key areas still being finalised include Winter Sprint arrangements, post-Christmas recovery planning, and the assessment of the financial implications for winter. The principal residual risks are acute capacity, discharge flow, community and social care capacity, workforce resilience, severe weather and infrastructure disruption, increased business continuity incidents arising from sustained operational pressures, and the absence of confirmed additional winter funding. As with 2025 – 2026, the planning assumption is that there is no additional external funding to support the winter planning requirements.			
Key Issues			
• Approval is sought for the West Glamorgan Winter Preparedness Plan 2026/27 and associated self-assessment template. • The plan should be considered the current regional framework, subject to further refinement following national modelling and NHS Wales P&I feedback. • The Health Board is entering winter from a position of sustained operational pressure, with existing risks around capacity, flow,			



discharge and workforce. Surge capacity remains open from 2025 – 2026 winter period, although bed-flexing remains an element of the plan requiring further refinement.

- Key elements remain in development, including the Winter Sprint, post-Christmas recovery sprint, final modelling assumptions and potential investment proposals.
- Delivery will need to be managed within existing resources unless additional funding becomes available.
- A clear action plan with owners, timescales and governance routes is required to support implementation and assurance.

**Decision / Action
required**

Yes

Recommendations

Members are asked to:

- **ENDORSE** the direction of travel set out in the Winter Plan, recognising that the plan remains dynamic and will continue to be strengthened over the coming months as the detailed operational plan for winter is further developed and finalised.
- **TAKE COGNISANCE** of the Regional Self-Assessment and Assurance Template which will be submitted to NHS Wales Performance and Improvement, subject to final updates following receipt of national modelling assumptions and NHS Wales P&I feedback.
- **DELEGATE AUTHORITY** to the Chief Operating Officer, in consultation with the Chief Executive and relevant Executive Directors, to approve non-material updates required before final submission.
- **BE AWARE** that key elements remain in development, including Winter Sprint arrangements, post-Christmas recovery planning, bed modelling assumptions and any investment proposals.
- **BE AWARE** of the ongoing work on bed configuration as part of the wider programme of work on Urgent and Emergency Care and the Clinical Services Plan, including the actions being taken to secure operational improvements in the effective and efficient use of beds to meet patients' needs.
- **ACCEPT** the need for longer-term right-sizing of beds and services, recognising that while immediate operational improvements are being progressed, a more fundamental assessment of capacity, configuration and service models will be required and will take longer to deliver.



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Bwrdd Iechyd Prifysgol
Bae Abertawe
Swansea Bay University
Health Board

WINTER PLANNING 2026/2027

1. INTRODUCTION

This report seeks Board approval of the West Glamorgan Winter Preparedness Plan 2026/27 and the associated Regional Self-Assessment and Assurance Template for submission to NHS Wales Performance and Improvement.

The Board is asked to approve the plan as the current regional framework for winter preparedness, recognising that the plan will continue to be refined as national modelling assumptions, NHS Wales P&I feedback, and further operational requirements are confirmed.

The plan reflects key learning points from last year's winter experience, with particular focus on improving patient flow, strengthening discharge arrangements, maintaining community capacity and ensuring effective operational oversight during periods of sustained pressure. The Board can be assured that these lessons have been incorporated into the operational priorities and delivery arrangements set out within the plan.

We know that the winter experience is impacted by a number of factors including severity of 'flu and other seasonal respiratory infections; impact on staff sickness absence; adverse weather – with early projections of increased extreme weather likely, with risks of flooding, periods of very cold weather that could all adversely impact service continuity. These broader issues sit within the wider organisational risk landscape, supported through the Health Board's established EPRR and Business Continuity Management frameworks. Preparedness activity is aligned with national resilience requirements and planning assumptions, supported through NHS Wales and multi-agency resilience arrangements, including those coordinated through Local Resilience Forums.

To support the winter period, the Welsh Government System Resilience and Response Group will be re-established to provide strategic oversight of NHS and social care system pressures and resilience. The forthcoming 7th Edition of the Wales Resilience Outlook will also inform planning activity by identifying key medium-term risks and emerging trends, enabling preparedness efforts to be prioritised and targeted appropriately. This resource will be used alongside existing risk assessments and planning arrangements to support strategic decision-making and readiness across the Health Board.



Iechyd gwell
Gofal gwell
Bywyd gwell

Better health
Better care
Better lives



2. BACKGROUND

2.1 Welsh Government Requirements

Welsh Government and NHS Wales P&I have introduced a revised Winter Preparedness framework for 2026/27 focused on improving patient flow, reducing escalation, strengthening community resilience and maintaining safe and effective urgent and emergency care throughout the winter period. The framework requires completion of a Regional Self-Assessment and Assurance Template, supported by regional winter preparedness plans and assessment against both a "most likely" and "extreme pressure" scenario. The final regional submission is due by 25 September 2026.

A Welsh Government Mandated Winter Sprint will take place from the 7th – 21st of December.

The SRO for Winter Planning has also mandated that a post-Christmas recovery Sprint will take place from the 4th – 18th of January. Detailed delivery plans for the December Winter Sprint and January post-Christmas recovery sprint will be developed during September and October, with oversight through the Winter Planning Group and UEC Programme Board.

2.2 Regional Approach

Development of the regional plan has been undertaken collaboratively through established partnership arrangements. Jon Scott, Chief Operating Officer, has been appointed as Senior Responsible Officer (SRO) for Winter Preparedness 2026/27.

A Winter Planning Group has been established to co-ordinate development of the Health Board winter response, whilst the wider regional plan continues to be developed collaboratively with the Local Authorities through the Regional Partnership Board arrangements.

Oversight is provided through the Urgent and Emergency Care Programme Board (UEC) and the Regional Older Person's Programme Board.

It is important to note that the development of this plan is taking place within a challenging operational environment. The Health Board continues to experience periods of sustained operational pressure, including several Business Continuity Incidents (BCIs), and is operating with significant flow and capacity constraints across the system.

Delivery of the Winter Preparedness Plan is dependent upon a whole-system approach and continued collaboration across all Health Board services, two Local Authorities, WAST, and third-sector partners.

These priorities continue to be progressed through the established UEC Programme and regional partnership arrangements and focus on:

- Flow and Discharge
- Admission Avoidance
- Urgent and Emergency Care Performance
- Vaccination and prevention

Increasing respiratory vaccination uptake has been identified as a breakthrough objective for Winter 2026/27. The Health Board and partners will work closely with primary care contractors, community services and wider partners to maximise uptake amongst eligible populations and reduce the variation currently seen between the most and least deprived communities. This forms an important component of the region's approach to prevention, community resilience and demand management over the winter period.

SBU bed modelling has been completed and is informing planning assumptions. Welsh Government modelling (worse and most likely scenarios) will be released in September. Current forecasts indicate that medical and renal bed demand is likely to exceed the Health Board's available capacity of 407 beds throughout the winter period, with an shortfall of around 128 beds (80th percentile) and peak gaps of up to 140 beds during January and February. Winter planning actions have been developed to mitigate this anticipated capacity gap and reduce the impact on patient flow and urgent care performance, these are outlined within the body of the report and in the plan.

At the time of writing, feedback on the draft Regional Self-Assessment and Assurance Template submitted to NHS P&I has not yet been received and the national modelling assumptions have not yet been issued.

The plan is therefore presented for approval as the current planning framework, rather than as a static final document. Any material changes arising from national modelling, NHS Wales P&I feedback, or further assessment of investment requirements will be escalated through the appropriate governance route.

2.3 Operational and Escalation Arrangements

Through the regional partnership arrangements, like previous winters, the Health Board will agree structured and coordinated operational and escalation processes which will be focussed on improving visibility, accountability and responsiveness.

Daily system oversight arrangements and escalation triggers will be enacted as required through the site and system command arrangements. Regional escalation with local authorities and WAST will remain in place as previous years.

A refreshed and strengthened daily site and bed meeting will be in place to coordinate actions across the Health Board to ensure flow between sites and equity of response in times of escalation.

The arrangements for 2026/27 will strengthen system grip and enable a more proactive approach to managing flow.

2.4 Emergency Preparedness and Business Continuity

The Health Board's winter preparedness approach is supported by established EPRR and Business Continuity arrangements. Seasonal risks including severe weather, loss of utilities, cyber disruption, infectious disease outbreaks and workforce shortages are monitored through existing resilience governance arrangements.

Assurance of preparedness is provided through:

- Annual review and exercising of Major Incident and Business Continuity Plans.
- Participation in both NHS and multi-agency preparedness arrangements.
- Monitoring of organisational risks through resilience governance structures.
- Coordination of operational response arrangements should escalation from business continuity incident to major/critical incident response be required.
- Ongoing preparedness work to support critical services, workforce resilience and infrastructure resilience throughout the winter period.



3. GOVERNANCE AND RISK ISSUES

3.1 Governance

The Winter Preparedness Plan and national templates are being developed jointly across the West Glamorgan region.

Monitoring and oversight will be provided through:

Internally:

- Winter Planning Group/ UEC Operational Group.
- Urgent and Emergency Care Programme Board.

Regionally:

- Older Person's Programme Board.
- Integrated Health and Social Care Group

The draft Regional Self-Assessment and Regional Assurance Template were submitted to NHS Wales Performance and Improvement on the 27 August 2026 following Executive Board approval and Older Person's Board approval. Further assurance, scenario testing and development of operational arrangements will take place during September and October, once issued by NHS P&I.

The Winter Preparedness Plan, completed templates, and supporting operational arrangements have been presented for Board approval, in line with NHS Wales timescales.

General seasonal preparedness linked to current resilience risks will be overseen within local, regional and national EPRR governance arrangements.

3.2 Risks

Risks associated with winter preparedness are being reviewed within the Health Board's Risk Management policy.

Risks identified include:

1. Acute capacity and bed gap
2. Discharge Flow
3. Community, domiciliary and care home capacity
4. Service availability during Christmas and New Year
5. Workforce resilience
6. Respiratory infections and vaccination uptake
7. Funding

8. Impact on planned care and cancer
9. Business Continuity, Resilience and Major Incidents

Mitigations for each of these risks are being developed within the Health Board and with partners. Many of these risks already exist within current risk registers and have established plans for mitigation and improvement. However, as the plan shows the bed gap remains significant at present requiring multi-agency response for resolution. The current governance arrangements exist to support resolution of this gap.

4. OPEN AUDIT RECOMMENDATIONS

Not applicable.

5. FINANCIAL IMPLICATIONS

Welsh Government has advised that no additional funding has been identified for Winter Preparedness 2026/27 and therefore delivery will largely be achieved through existing services, resources and programmes, internal arrangements and operational escalation. This mirrors the approach taken in Winter 2025/26, where all actions were undertaken within existing resources and organisational budgets across SBU and the two local authorities.

The absence of confirmed additional winter funding creates a material delivery risk. Delivery of the plan will need to be achieved through existing services, re-prioritisation and deployment of resources to mitigate the operational risks identified. Any additional schemes or investment proposals will require Executive Board approval before implementation and will need to be considered within the overall financial plan, delivery of which remains a critical priority.

Work is on-going through the UEC programme and regional programme to focus on key priorities and undertake tests of change during August to improve system flow.

There is potential opportunity to secure funding through the Regional Partnership arrangements to increase community resilience and support patient discharge and transfer. This will be agreed through the Older Person's Board.



6. RECOMMENDATION

Members are asked to:

- **ENDORSE** the direction of travel set out in the Winter Plan, recognising that the plan remains dynamic and will continue to be strengthened over the coming months as the detailed operational plan for winter is further developed and finalised.
- **TAKE COGNISANCE** of the Regional Self-Assessment and Assurance Template which will be submitted to NHS Wales Performance and Improvement, subject to final updates following receipt of national modelling assumptions and NHS Wales P&I feedback.
- **DELEGATE AUTHORITY** to the Chief Operating Officer, in consultation with the Chief Executive and relevant Executive Directors, to approve non-material updates required before final submission.
- **BE AWARE** that key elements remain in development, including Winter Sprint arrangements, post-Christmas recovery planning, bed modelling assumptions and any investment proposals.
- **BE AWARE** of the ongoing work on bed configuration as part of the wider programme of work on Urgent and Emergency Care and the Clinical Services Plan, including the actions being taken to secure operational improvements in the effective and efficient use of beds to meet patients' needs.
- **ACCEPT** the need for longer-term right-sizing of beds and services, recognising that while immediate operational improvements are being progressed, a more fundamental assessment of capacity, configuration and service models will be required and will take longer to deliver.



Governance and Assurance		
Strategic Objectives		
Strategic Objectives <i>(please choose which is impacted)</i>	People of Swansea Bay live healthier, fairer and more prosperous lives	☒
	Care is high quality, safe, efficient and delivers the best possible outcomes for people in partnerships	☒
	Care is delivered in partnership with our communities in safe and appropriate setting, supported by innovation	☒
	The health board is a great place to work where staff feel valued and work together towards a common goal	☒
	The health board is a resilient, sustainable and responsible organisation	☒
Health and Care Standards		
Standards <i>(please choose which applies)</i>	Safe Care	☒
	Timely Care	☒
	Effective Care	☒
	Efficient Care	☒
	Equitable care	☒
	Person-centred Care	☒
	Staff and Resources	☒
Enablers <i>(please choose which applies)</i>	Whole Systems Approach	☒
	Leadership	☒
	Workforce	☒
	Culture	☐
	Information	☐
	Learning, Improvement and Research	☐
Quality, Safety and Patient Experience		
Outlined in the body of the report		
Financial Implications		
Relevant Financial implications are outlined in the body of the report.		
Legal Implications (including equality and diversity assessment)		
None known		
Staffing Implications		
None known		
Long Term Implications (including the impact of the Well-being of Future Generations (Wales) Act 2015)		



The detail within the report aligns to the 5 Ways of Working and the delivery of integrated services and collaboration across the region.

Report History

Winter Planning 2026/27 – Executive Board August 2026.

Appendices

Appendix 1: West Glamorgan Winter Preparedness Plan 2026/27

Appendix 2: National Self-Assessment and Assurance Template



Meeting Date	24 September 2026	Agenda Item	4.4
Name of Meeting	SBUHB Board		
Report Title	Mental Health Estate Stabilisation Technical Programme Business Case		
Report Author	Dermot Nolan, Interim Service Group Director for Mental Health and LD Delivery Unit Mark Parsons, Assistance Director of Capital Planning – Finance Directorate Heather Edwards, Business Planning Manager		
Report Sponsor	Executive Director of Planning and Partnership		
Presented by	Executive Director of Planning and Partnership		
Freedom of Information	Open		
FoI Closed detail	Not applicable		
Impact Assessment Summary Outcome		IA Completion date	
		Click or tap to enter a date.	
Purpose of the Report	For Approval		
Report Summary; detailing any action required			
This paper seeks Health Board approval of the Mental Health Estate Stabilisation Technical Programme Business Case prior to submission to Welsh Government. The programme requests £27.885m capital funding to stabilise priority risks across Cefn Coed Hospital, Tonna Hospital and Neath Port Talbot Hospital Mental Health inpatient estate, improving safety, infrastructure resilience, patient experience and regulatory compliance, while a longer-term estates solution is developed. The business case includes the repurposing of part of Ysbryd y Coed – this would be subject to the outcome of public engagement on its future use.			
Key Issues			
The current estate presents immediate quality, safety, ligature, infrastructure and business continuity risks, reflected in Health Board risk registers and HIW findings. The short to medium term option is a pragmatic do-minimum stabilisation programme, including service diversions at Cefn Coed and anti-ligature/environmental improvements across Cefn Coed, Tonna and Neath Port Talbot. The programme supports safer care, service consolidation, improved staff working environments, reduced backlog risk and alignment with Welsh Government mental health and estates priorities.			
Decision / Action required	Yes		



Recommendations

Members are asked to:

- **APPROVE** the Mental Health Estate Stabilisation Technical Programme Business Case as the Health Board's short to medium term estate stabilisation response and associated decisions on the Option 3 Implementation Plan to allow for submission to Welsh Government, seeking £27.885m capital support from the All-Wales Capital Programme.
- **ACKNOWLEDGE** that the programme reduces immediate estate-related quality, safety, infrastructure and business continuity risks, while residual risks will remain pending delivery of a longer-term mental health estate solution.
- **BE AWARE** that the element relating to repurposing part of Ysbryd y Coed would be subject to the outcome of an engagement process around its future use. The engagement process would benefit from clarity around the funding of any proposed changes, should the submission to WG be successful.
- **DELEGATE AUTHORITY** to the Chief Executive Officer to approve and issue the full public engagement materials associated with the use of Ysbryd y Coed (Celyn Ward) outside the formal Board meeting cycle, subject to appropriate executive, clinical and governance review.



MENTAL HEALTH ESTATE STABILISATION TECHNICAL PROGRAMME BUSINESS CASE

1. INTRODUCTION

This report seeks Health Board approval of the Mental Health Estate Stabilisation Technical Programme Business Case (TPBC) and its proposed submission to Welsh Government. The Technical Programme Business Case sets out a short to medium term stabilisation programme for key elements of the Mental Health estate at Cefn Coed Hospital, Tonna Hospital and Neath Port Talbot Hospital, responding to immediate quality, safety, ligature, infrastructure and business continuity risks. The business case includes the repurposing of part of Ysbryd y Coed – implementing this would be subject to the outcome of public engagement on its future use.

2. BACKGROUND

The Health Board's Adult Acute and Older Persons' Mental Health estate includes some of the oldest operational inpatient accommodation in Wales. A Strategic Outline Case was submitted to Welsh Government in October 2023 to address the need for a long-term fit-for-purpose solution; however, progression to Outline Business Case stage is subject to a pause due to competing capital priorities. Welsh Government has acknowledged the improvements made to date, while recognising that significant and immediate quality and safety risks remain.

Following a number of Service of Concern meetings with Welsh Government and NHS Wales Performance & Improvement between February and May 2026, agreement was reached with the Welsh Government Capital and Estates team on the business case process to undertake 3 main projects for urgent estates and service stabilisation works:

- Service Diversions, Cefn Coed Hospital
- Anti-Ligature Improvements, Cefn Coed, Tonna and Neath Port Talbot Hospitals
- Relocation of Ward F, Neath Port Talbot Hospital and PICU, Princess of Wales Hospital to the Celyn Ward in Cefn Coed Hospital (subject to public engagement on the future use of Celyn Ward)

This TPBC sets out the high-level plan for delivery of these projects. Approval of this case by Welsh Government would then allow a number of business cases to be produced (see Appendix 3)

The programme responds directly to concerns identified through Health Inspectorate Wales inspections, independent ligature risk assessments and the Health Board's risk management arrangements. It will improve ward environments, strengthen infrastructure resilience, reduce risks associated with redundant and derelict parts of the Cefn Coed site, and support the consolidation of adult acute mental health services. Option 3, a do-minimum stabilisation programme, is the most achievable interim response, while the Health Board continues to work towards a sustainable long-term mental health estates model.

The Mental Health Transformation Board has overseen the development of the Technical Programme Business Case; work on the other workstreams (service model in light with national programme, workforce modernisation, digital transformation and estates and infrastructure) will continue and inform the development of each stage of the business case process. Staff and service user engagement remains a central tenet of all elements of the Mental Health Transformation Programme and will be important in progressing the technical programme business case and associated business cases.

3. GOVERNANCE AND RISK ISSUES

The programme is designed to reduce significant quality, safety, health and safety, infrastructure and business continuity risks across the Mental Health estate. Key risks include: ligature and environmental risks within inpatient wards, ageing utilities and services supporting Tawe Clinic, unauthorised access to redundant areas of Cefn Coed Hospital, asbestos-related risks, fire separation issues and the operational vulnerability of services delivered from older estate. These risks are reflected in Strategic Risk Register ID 2.7 and Corporate Risk Register ID 115.

Delivery of the proposed programme will mitigate, but not fully eliminate, estate-related risks. Residual risks will remain around the appropriateness of some of the wards for modern therapeutic mental health care provision, ongoing security, fire, vandalism and trespass risks associated with the redundant parts of Cefn Coed Hospital, pending a longer-term estate solution. The detailed design and delivery stages will include consideration of EDI, Welsh language and accessibility considerations, with the programme intended to improve equity of access to safer, more therapeutic inpatient environments.

Furthermore, a detailed Integrated Impact Assessment will inform discussions with Llais regarding the public engagement approach required to agree the repurposing of part of Ysbryd y Coed (Celyn Ward). The Board will consider the outcome of this engagement

4. OPEN AUDIT RECOMMENDATIONS

No specific open audit recommendations have been identified within the Technical Programme Business Case. The programme does, however, respond to regulatory and assurance concerns, including HIW findings, independent ligature risk assessments and Health Board risk register entries relating to the condition, configuration and safety of the Mental Health estate.

5. FINANCIAL IMPLICATIONS

The TPBC Case seeks Welsh Government capital support of £27.885m, including non-recoverable VAT and Optimism Bias. The capital estimate includes: works costs, non-works costs, fees, equipment, planning contingency and Optimism Bias, with no allowance for inflation. These costs are indicative pre-design and tender estimates.

Once Welsh Government approves the Programme Business Case, work will commence on a number of fully designed and tendered business cases as per the Option 3 Implementation Plan (See Appendix 3). This preferred implementation plan will require a number of decisions, yet to be agreed.

- Health Board will need to proceed at risk with design of Derwen Ward at approximately £200k from August 2026 (commenced).
- Section 136 suite to locate to Tawe Clinic (subject to final test to fit design) in 2026-27 using approved £421k Welsh Government Mental Health Quality and Safety capital funding rather than to Ward F, NPT.
- Seclusion Suite planning for Ward F using approved £210k WG TEF capital funding to pause (waiting on final tender from PFI) and instead form part of Celyn redevelopment (subject to outcome of public engagement).
- A review of Ward F Anti-Ligature works, should ward F move to Celyn by April 2029.

Estimated Capital Costs	£000 incl. non-recoverable VAT & OB
Works Costs	17,283



Non-Works Costs	1.107
Fees	3,216
Equipment Costs	232
Planning Contingency	2,931
Sub Total	24,769
Optimism Bias	3,838
Sub Total	28,607
Less recoverable VAT	-721
Base Project Cost	27,885

The recurring revenue costs will be managed within existing resource and in this way the business case is revenue resource neutral.

The Health Board's preferred procurement route is delivery through the Southwest Wales Framework via mini competition, with a number of fully tendered business cases to be developed for approval. The indicative programme assumes Technical Programme Business Case submission to Welsh Government in September 2026 and approval by November 2026.

6. RECOMMENDATION

The Health Board is asked to approve and endorse the Mental Health Estate Stabilisation Technical Programme Business Case for submission to Welsh Government, acknowledging the requirement for £27.885m capital funding and the need to progress at pace, to reduce immediate estate-related risks across Cefn Coed, Tonna and Neath Port Talbot mental health inpatient services. Board approval is sought on the understanding that, should the business case be successful, implementation would be subject to the outcome of a public engagement process that will commence when the funding position is clear.

The Mental Health Transformation Board has endorsed the Technical Programme Business Case, and, whilst timescales for completing all phases of the work reflect the shortest timescale possible to address the issues whilst maintaining service delivery to our patients, there is an ongoing need to mitigate the risks associated with current service facilities.

Members are asked to:

- **APPROVE** the Mental Health Estate Stabilisation Technical Programme Business Case as the Health Board's short to medium term estate stabilisation solution and associated decisions on the



Option 3 Implementation Plan, to allow for submission to Welsh Government seeking £27.885m capital support from the All-Wales Capital Programme.

- **ACKNOWLEDGE** that the programme reduces immediate estate-related quality, safety, infrastructure and business continuity risks, while residual risks will remain pending delivery of a longer-term mental health estate solution.
- **BE AWARE** that the element relating to repurposing part of Ysbryd y Coed will be subject to the outcome of an engagement process around its future use. The engagement process will benefit from clarity around the funding of any proposed changes should the submission to WG be successful.
- **DELEGATE AUTHORITY** to the Chief Executive Officer to approve and issue the full public engagement materials associated with the use of Ysbryd y Coed (Celyn Ward) outside the formal Board meeting cycle, subject to appropriate executive, clinical and governance review.



Governance and Assurance		
Strategic Objectives		
Strategic Objectives <i>(please choose which is impacted)</i>	People of Swansea Bay live healthier, fairer and more prosperous lives	☒
	Care is high quality, safe, efficient and delivers the best possible outcomes for people in partnerships	☒
	Care is delivered in partnership with our communities in safe and appropriate setting, supported by innovation	☐
	The health board is a great place to work where staff feel valued and work together towards a common goal	☐
	The health board is a resilient, sustainable and responsible organisation	☐
Health and Care Standards		
Standards <i>(please choose which applies)</i>	Safe Care	☐
	Timely Care	☐
	Effective Care	☒
	Efficient Care	☒
	Equitable care	☒
	Person-centred Care	☐
	Staff and Resources	☐
Enablers <i>(please choose which applies)</i>	Whole Systems Approach	☐
	Leadership	☐
	Workforce	☐
	Culture	☐
	Information	☐
	Learning, Improvement and Research	☐
Quality, Safety and Patient Experience		
The programme is designed to reduce significant quality, safety, health and safety, infrastructure and business continuity risks across the Mental Health estate.		
Financial Implications		
The recurring revenue costs will be managed within existing resource and in this way the business case is revenue resource neutral.		
Legal Implications (including equality and diversity assessment)		
Duty of care - Residual risks will remain, including ongoing security, fire, vandalism and trespass risks associated with the redundant parts of Cefn Coed Hospital pending a longer-term estate solution.		
Staffing Implications		



N/A

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

Equality, Welsh language and accessibility considerations will be considered through the detailed design and delivery stages, with the programme intended to improve equity of access to safer, more therapeutic inpatient environments. In addition, should the funding be secured, the implementation of the element relating to the future use of Ysbryd y Coed (Celyn Ward) will be subject to public engagement which will be informed by an Integrated Impact Assessment.

Report History

Mental Health Transformation Programme Board 22 July 2026 – Agreed
Capital Management Group – Agreed via Chairs Actions (ratification CMG 16 September 2026)

Executive Board 12 August 2026 – Agreed

Performance and Finance Committee - Endorsed

Appendices

Technical Programme Business Case & Appendices

Appendix 1 - Technical Programme Business Case (TPBC)

Appendix 2 – TPBC supporting appendices



PERFORMANCE AND FINANCE COMMITTEE Key Issues Report

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

Date of Committee meeting:	28 July 2026
Members Present:	Four Members were present at the Performance and Finance Committee, Patricia Price, Committee Chair, Independent Member, Jean Church, Independent Member, Reena Owen, Independent Member. Steve Spill, Vice Chair
Quoracy:	YES
Group/Committee Chair:	Patricia Price, Performance and Finance Committee Chair.
Report Submitted by:	Corporate Governance.
Report Signed off by:	Patricia Price, Performance and Finance Committee Chair Claire Osmundsen-Little, Interim Director of Finance.
Date of Board receiving the report:	24 September 2026.

1.	Agenda	The Performance and Finance Committee convenes monthly, and the agenda, relevant documents, and minutes from the meetings are accessible on the SBUHB website .
2.	Alert	The Committee is alerting the Board to the following items (6):
	Minute Reference: 115/26	Service Group Financial Position: Neath Port Talbot/Singleton (NPTS): The Committee agreed to alert the Board to the significant financial risks within the Service Group. Members noted a Quarter One deficit of £6.25m above plan and a forecast year-end deficit of £12.6m above plan. The Committee expressed significant concern regarding the forecast savings shortfall of £15.8m,



Minute Reference: 115/26	medical workforce affordability pressures and ongoing non-pay expenditure risks. Members recognised that the scale of the remaining savings requirement presented a substantial financial risk and required continued monitoring. • Service Group Financial Position: Morriston: The Committee agreed to alert the Board to the Service Group's adverse financial position, noting a Quarter One deficit of £3.9m above plan and a forecast year-end deficit of £14m above plan. Members expressed concern regarding the forecast savings shortfall of £13m and the associated recurrent challenge of £14.8m. The Committee recognised that delivery of recurrent savings remained a significant risk requiring ongoing scrutiny and welcomed the work being undertaken with Executive Senior Reporting Officer (SRO) Theme Leads to strengthen recovery arrangements.
Minute Reference: 116/26	• Month Three Financial Position: The Committee agreed to alert the Board that savings delivery remained a significant organisational risk. Members noted that year-to-date savings of £5.8m had been delivered against a target of £16.3m, resulting in a savings shortfall of £10.5m. Whilst operational benefits of £6.4m had partially mitigated the position, the Committee remained concerned regarding the organisation's ability to convert opportunities into cash-releasing savings and requested enhanced scrutiny of the highest-risk savings themes.
Minute Reference: 118/26	• Recovery and Sustainability (R&S) Board Update: The Committee wished to alert the Board that savings delivery continued to represent a critical organisational risk. Members noted that savings delivery stood at £5.8m against a Quarter One target of £16.25m and expressed concern regarding the organisation's capacity to convert opportunities into recurrent financial benefits at the pace required. The Committee remained not assured regarding delivery of the £65m savings programme at this stage.



	Minute Reference: 120/26	• Escalation Report and Integrated Performance Report (Month Three): The Committee wished to alert the Board to continuing concerns regarding cancer performance, Urgent and Emergency Care, Healthcare Associated Infections, stroke services, Neurodevelopmental Disorders, Psychological Therapies, Adults Placed Out of County, and planned care outpatient and diagnostic performance. Members noted that mitigation plans were in place but agreed that these areas should remain subject to continued scrutiny until sustained improvement is demonstrated.
	Minute Reference: 124/26	• Strategic Risk Register: The Committee wished to alert the Board that the Access to Services risk remained a significant concern, particularly in relation to Urgent and Emergency Care and Cancer Services. Members also noted that the target score for the Financial Deficit risk remained at 25 to reflect current confidence levels and ongoing financial pressures.
3.	Assurance	The Committee is assuring the Board on the following items (3):
	Minute Reference: 118/26	• R&S Board Update: The Committee received assurance regarding strengthened governance arrangements supporting the R&S Programme. Members noted enhanced accountabilities and escalation processes linked to executive-led savings themes, governance improvements, stronger programme management arrangements and a £6m increase in the savings pipeline. Whilst assurance was received regarding governance arrangements, members remained concerned regarding savings delivery.
	Minute Reference: 122/26	• Capital and Estate Strategy: The Committee received assurance that major capital schemes continued to be subject to scrutiny through the Capital, Land and Assets Sub-Committee and noted plans to undertake a comprehensive baseline assessment, supported by external expertise, to inform the refresh of the Estate



	Minute Reference: 124/26	Strategy. Members were assured that appropriate governance arrangements remained in place for capital planning and estate management. • Strategic Risk Register: The Committee received assurance that mitigating actions, revised timelines and updated control assurance assessments had been incorporated within the Strategic Risk Register. Members also noted that the Financial Deficit risk would continue to be reviewed as savings delivery trends and financial performance become clearer.
4.	Advise Minute Reference: 117/26 Minute Reference: 121/26	The Committee is advising the Board on the following items (3): • Mental Health and Learning Disabilities Invest to Save Business Case: The Committee agreed to advise the Board that it supported the proposal to establish a safe nursing cohort as part of the wider transformation programme. Members noted the anticipated benefits including improved patient safety and experience, a more sustainable nursing workforce, improved recruitment and retention, and enhanced clinical leadership. The Committee requested ongoing monitoring of benefits realisation. PFC noted that the changes will be self-financing and asked that benefits to ensure this is realised are also monitored including removal of Band 5 over establishment and variable pay reduction. • Clinically Optimised Patients and Delayed Discharges: The Committee agreed to advise the Board that continued focus should be maintained on reducing delayed discharges and Clinically Optimised Patients through strengthened partnership working and increased intermediate care capacity. Members recognised the significant impact that delays continue to have on patient outcomes, patient flow, quality of care and organisational performance.



	Minute Reference: 122/26	• Capital and Estate Strategy: The Committee agreed to advise the Board that the Estate Strategy should be refreshed to ensure alignment with the emerging Clinical Strategy and wider organisational priorities. Members noted the importance of addressing backlog maintenance requirements, financial pressures, environmental responsibilities and future service planning requirements. It was noted planned works would be funded from the Estates budget.
5.	Review of Risks	The Performance and Finance Committee will keep the Board updated on any developments regarding risks in relation to the above matters.
6.	Sharing of learning	None identified during the meeting.
7.	Actions to be considered by Board	• APPROVE the Fifth Linear Accelerator (LINAC) Business Case to support increasing demand for cancer treatment services and enable additional treatment capacity across the region. The Committee supported the proposal and agreed to recommend approval to the Board. • NOTE the Committee's request for Board-level deep dive reviews into executive-led savings themes with the highest savings shortfalls against plan, including Medical Workforce, Planned Care, Nursing Workforce and Procurement.



PERFORMANCE AND FINANCE COMMITTEE Key Issues Report

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

Date of Committee meeting:	25 August 2026.
Members Present:	Three members were present at the Performance and Finance Committee, Patricia Price, Committee Chair, Independent Member, Jean Church, Independent Member, Steve Spill, Vice Chair.
Quoracy:	YES
Group/Committee Chair:	Patricia Price, Performance and Finance Committee Chair.
Report Submitted by:	Corporate Governance.
Report Signed off by:	Patricia Price, Performance and Finance Committee Chair Claire Osmundsen-Little, Interim Director of Finance.
Date of Board receiving the report:	24 September 2026.

1.	Agenda	The Performance and Finance Committee convenes monthly, and the agenda, relevant documents, and minutes from the meetings are accessible on the SBUHB website .
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2.	Alert	The Committee is alerting the Board to the following items (6):
	Minute Reference: 133/26	Service Group Financial Position - Mental Health & Learning Disabilities (MH&LD): The Committee agreed to alert the Board to the increased forecast deficit within the MH&LD Service Group, arising predominantly from workforce and variable pay pressures, Continuing Healthcare growth, adult mental health out-of-area placements and challenges in delivering savings targets. Members highlighted the need for



		continued scrutiny of actions to reduce out-of-area placements and requested ongoing monitoring of benefits realisation associated with Home Treatment Team investment and nurse staffing initiatives
	Minute Reference: 134/26	• Month Four Financial Position: The Committee agreed to alert the Board that, whilst financial performance and recovery arrangements had improved, the pace of improvement remained insufficient to mitigate the Health Board's significant financial risk. Members highlighted the challenge of achieving the agreed target of £65m savings in green by the end of September 2026 and emphasised the need to accelerate delivery of recurrent savings, convert amber schemes to green and strengthen the savings pipeline.
	Minute Reference: 135/26	• Recovery & Sustainability (R&S) Board Update: The Committee agreed to alert the Board that savings delivery was improving but remained below the pace required to achieve the Health Board's financial objectives. Members noted significant financial risk associated with delivery of the £65m savings requirement, ongoing reliance on non-recurrent measures and dependencies relating to workforce initiatives, vacancy management, reductions in levels of staff sickness and absence and variable pay, and programme delivery capacity
	Minute Reference: 136/26	• Continuing Healthcare (CHC) Performance including Direct Payments, Transformation and Quarter One Performance Report: The Committee agreed to alert the Board that Continuing Healthcare continued to experience significant financial and operational pressures arising from increasing demand, growing case complexity, provider inflation, market capacity constraints and delays to reviews. Members highlighted the risk that demand growth could outpace the benefits delivered through review and right-sizing activity
	Minute Reference: 137/26	• Escalation Report and Integrated Performance Report (IPR) (Month Four): The



	Minute Reference: 139/26	Committee agreed to alert the Board to continued performance challenges and risks relating to Urgent and Emergency Care (UEC), Cancer performance, deterioration in Ophthalmology performance, workforce pressures and sickness absence levels, and the Health Board's financial position and delivery of savings against plan. • Delivery Unit Overview: The Committee agreed to alert the Board that Delivery Unit capacity remained a significant risk given the scale and pace of the Health Board's financial recovery requirements. Members noted that only a proportion of active projects were directly contributing to delivery of the £65m savings programme and highlighted the need for continued prioritisation and redeployment of resources.
3.	Assurance	The Committee is assuring the Board on the following items (9): • Morriston Service Group Governance Internal Audit Referral: The Committee received assurance that actions arising from the Internal Audit review were being progressed, that the Morriston Service Group Management Board had been reinstated and that ongoing oversight would be maintained through routine performance management arrangements and Audit Wales follow-up activity. • Strategic Risk Referral: The Committee received assurance that strengthened controls, escalation arrangements and oversight mechanisms were now in place to support financial performance and recovery planning, and that financial sustainability risks continued to be actively monitored through established governance processes. • Service Group Financial Position: Primary, Community & Therapies (PCT): The Committee received assurance that the PCT Service Group had improved its forecast financial position, strengthened savings performance and maintained robust arrangements to monitor delivery, whilst
	Minute Reference: 131/26	
	Minute Reference: 131/26	
	Minute Reference: 133/26	



		continuing to develop recurrent savings opportunities. • CHC Performance including Direct Payments, Transformation and Quarter One Performance Report: The Committee received assurance that a comprehensive transformation programme remained in place, supported by improved review processes, strengthened commissioning arrangements, implementation of the ADAM case management system and continued partnership working with Local Authorities. • Escalation Report and IPR (Month Four): The Committee received assurance that planned care performance continued to improve, recovery work remained underway across Cancer, UEC, Workforce and Recovery Programmes, the IPR continued to provide comprehensive organisational oversight, and Annual Plan monitoring arrangements continued to strengthen. • Medicines Management Performance: The Committee received assurance that Medicines Management performance remained strong, continued to contribute positively to the R&S Programme and that savings schemes and medicines optimisation arrangements were progressing in line with expectations. • Delivery Unit Overview: The Committee received assurance that a structured review of Delivery Unit capability had been completed, governance arrangements were strengthening, additional temporary resources had been secured and work was progressing to align programmes, Project Initiation Documents and finance information within a single management framework. • Operational Estates Update: The Committee received assurance that the Estates Organisational Change Programme was strengthening operational resilience and workforce stability, improving management information through the Computer-Aided Facilities Management (CAFM) system, and
	Minute Reference: 136/26	
	Minute Reference: 137/26	
	Minute Reference: 138/26	
	Minute Reference: 139/26	
	Minute Reference: 140/26	



	Minute Reference: 141/26	ensuring capital investment remained focused on high-risk maintenance and business continuity priorities. • Committee Effectiveness Self-Assessment: The Committee received assurance that the self-assessment findings were positive overall, that no significant governance concerns had been identified and that the Committee continued to operate effectively in delivering its oversight, scrutiny and assurance responsibilities.
4.	Advise Minute Reference: 133/26 Minute Reference: 135/26 Minute Reference: 136/26	The Committee is advising the Board on the following items (7): • Service Group Financial Position - PCT: The Committee agreed to advise the Board of the continued reliance on non-recurrent savings and the implications this presents for the underlying deficit position moving into 2027-28. Members also highlighted workforce pressures, dental income challenges and increased looked-after children's costs. • R&S Board Update: The Committee advised that demonstrable delivery and realisation of financial benefits should remain the primary measure of success. Members highlighted the need to accelerate savings delivery, improve benefits realisation, strengthen recurrent savings opportunities and maintain robust oversight of risks, dependencies and programme outcomes. • CHC Performance including Direct Payments, Transformation and Quarter One Performance Report: The Committee advised that Continuing Healthcare remains a significant area of financial risk requiring continued oversight and scrutiny. Members highlighted the importance of maintaining transformation momentum, strengthening commissioning and contracting arrangements, and ensuring successful implementation of the ADAM system to support demand management and financial sustainability.



	Minute Reference: 137/26 Minute Reference: 138/26 Minute Reference: 139/26 Minute Reference: 140/26	• Escalation Report and IPR (Month Four): The Committee advised that continued oversight should be maintained in relation to UEC, Cancer, Ophthalmology, Workforce and financial recovery performance. Members also highlighted the importance of workforce sustainability and realisation of benefits from transformation programmes. • Medicines Management Performance: The Committee advised the Board of risks associated with increasing medicines expenditure, particularly high-cost medicines in cancer and weight management services, alongside workforce pressures and national prescribing factors. Members further advised that Medicines Management remains an important contributor to financial recovery and that opportunities to strengthen medicines optimisation should continue to be explored. • Delivery Unit Overview: The Committee advised that strengthening Delivery Unit capability and capacity remains fundamental to the successful delivery of the R&S Programme and wider financial recovery ambitions. Members highlighted the importance of programme prioritisation, the Programme Management Office (PMO) development, workforce redeployment and a single coordinated programme management framework. • Operational Estates Update: The Committee advised the Board of ongoing recruitment challenges across specialist Estates roles, concerns relating to elements of the MH&LD estate, maintenance arrangements and compliance assurance activities. Members highlighted the importance of continued investment in workforce capacity, backlog maintenance and infrastructure resilience.
5.	Review of Risks	The Performance and Finance Committee will keep the Board updated on any developments regarding risks in relation to the above matters.



6.	Sharing of learning	None identified during the meeting.
7.	Actions to be considered by Board	None identified during the meeting.



Meeting Date	24 September 2026	Agenda Item	5.2
Name of Meeting	SBUHB Board		
Report Title	Welsh Government (WG) Oversight and Escalation Update and SBUHB Integrated Performance Report		
Report Author	Meghann Protheroe, Head of Health Board Performance		
Report Sponsor Presented by	Executive Director of Planning and Partnership Marie Davies, Executive Director of Planning and Partnership		
Freedom of Information	Open		
FoI Closed detail	If closed, choose detail		
Impact Assessment Summary Outcome		IA Completion date	
Not required (assurance/update paper; no decision requested)		Click or tap to enter a date.	
Purpose of the Report	For Assurance		
Report Summary; detailing any action required			
To provide the Board with a summary of the performance and outcomes issues for the services escalated as part of WG Oversight and Escalation Framework, along with a general update of the Health Boards Performance against the Key Breakthrough Objectives.			
Key Issues			
The attached Integrated Performance report (IPR) is a routine report that provides an overview of how the Health Board is performing against the National Delivery measures and key local quality and safety measures. The IPR includes an update against three priority areas for the Health Board: 1. Welsh Government Escalation criteria 2. Performance against the Health Boards Breakthrough Objectives 3. Performance against the NHS Wales Performance Framework 2026-27 The IPR will develop iteratively over time, to include relevant trajectories for the areas outlined above, along with key driver metrics where available.			
Decision / Action required	No		
Recommendations			
Members are asked to: • CONSIDER the monthly update in respect of performance against escalation measures and de-escalation criteria. • ACKNOWLEDGE and DISCUSS the Health Board performance against key measures and targets. • ACKNOWLEDGE the formal de-escalation of CAMHS from Level 3 to Level 1 in August 2026			



WELSH GOVERNMENT OVERSIGHT AND ESCALATION UPDATE AND INTEGRATED PERFORMANCE REPORT

1. INTRODUCTION

The current report provides an update against all levels of Oversight and Escalation of services within Swansea Bay University Health Board (SBUHB) and includes:

Performance against Areas of Targeted Intervention (Level 4)

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

Performance against Areas of Enhanced Monitoring (Level 3)

- Planned Care

Welsh Government provided formal de-escalation notification on 19 August for the CAMHS service, moving from Level 3 Enhanced Monitoring to Level 1, following continuous achievement of the de-escalation performance targets.

The report also provides detailed updates against the organisations priority measures as outlined in the Performance and Accountability Framework:

- Welsh Government Escalation criteria
- Performance against the Health Board's Breakthrough Objectives

2. BACKGROUND

SB UHB is currently at an escalated level of monitoring for performance and outcomes in a number of areas of service, ranging from 'enhanced monitoring' to 'targeted intervention'. The services listed in the introduction of this report are referenced in the elevated escalation.

The Chief Operating Officer is the Senior Responsible Officer (SRO) for targeted intervention and each work programme is supported by senior management and clinical leads. Summarised updates against the escalation levels are provided throughout this report.



3. PERFORMANCE AGAINST THE AREAS ESCALATED UNDER THE WELSH GOVERNMENT OVERSIGHT & ESCALATION FRAMEWORK

Detailed updates against the escalated areas are included in Section 1 in the Integrated Performance Report in **Appendix 1**.

4. INTEGRATED PERFORMANCE REPORT

As outlined in the updated Performance and Accountability Framework, the IPR provides detailed updates against the:

- 1) Welsh Government Escalation criteria
- 2) Performance against the Health Board's Breakthrough Objectives

The remaining measures, outlined in the NHS Performance Framework 2026-27 are provided for ease of reference, along with agreed local measures.

The updated format of the IPR aims to address the key queries below, to give the Board appropriate assurance :

1. Are we on track against the Annual Plan, escalation requirements and strategic objectives?
2. Where are we off track, and is the issue improving, deteriorating or stable?
3. Is there a credible recovery plan, with named ownership and milestones?
4. What level of assurance is available: substantial, reasonable, limited or none?
5. What are the wider risks that arise and what mitigations are in place?

Work continues to ensure key trajectories and driver metrics are included for all priority metrics where available. Future reports will also contain updated escalation and assurance status, with areas subject to internal escalation reported against as a priority measure where required.

5. RECOMMENDATION

Members are asked to:

- **CONSIDER** the monthly update in respect of performance against escalation measures and de-escalation criteria.
- **ACKNOWLEDGE** and **DISCUSS** the Health Board performance against key measures and targets
- **ACKNOWLEDGE** the formal de-escalation of CAMHS from Level 3 to Level 1 in August 2026.



Governance and Assurance		
Strategic Objectives		
Strategic Objectives <i>(please choose which is impacted)</i>	People of Swansea Bay live healthier, fairer and more prosperous lives	☒
	Care is high quality, safe, efficient and delivers the best possible outcomes for people in partnerships	☒
	Care is delivered in partnership with our communities in safe and appropriate setting, supported by innovation	☒
	The health board is a great place to work where staff feel valued and work together towards a common goal	☒
	The health board is a resilient, sustainable and responsible organisation	☒
Health and Care Standards		
Standards <i>(please choose which applies)</i>	Safe Care	☒
	Timely Care	☒
	Effective Care	☒
	Efficient Care	☒
	Equitable care	☒
	Person-centred Care	☒
	Staff and Resources	☒
Enablers <i>(please choose which applies)</i>	Whole Systems Approach	☒
	Leadership	☒
	Workforce	☒
	Culture	☒
	Information	☒
	Learning, Improvement and Research	☒
Quality, Safety and Patient Experience		
Outlined within the body of the paper but in summary considerable backlog of patients awaiting a diagnostic and treatment services across a range of services. Issues of harm in relation to high levels of HCAs noted.		
Financial Implications		
The paper provides brief insights into the monthly financial performance experienced by the organisation and any key pressures which must be noted.		
Legal Implications (including equality and diversity assessment)		
None identified		
Staffing Implications		
The paper outlines the current performance and pressures experienced by staff which is presented in sickness, training and financial figures.		



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

The paper outline the current performance against the Key Performance Indicators for Population Health in SBUHB

Report History

This report is a bi-monthly report and was previously presented in the July 2026 Board Meeting.

Appendices

Appendix 1: Integrated Performance Report



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Better health
Better care
Better lives

5 of 5
SBUHB Board
Thursday, 24 September 2026



Meeting Date	24 September 2026	Agenda Item	5.3
Name of Meeting	SBUHB Board		
Report Title	Financial Report – Month 05 2026/27		
Report Author	Samantha Moss, Deputy Director of Finance Gemma Pearson, Finance Business Partner Crystal Davies, Principal Finance Manager		
Report Sponsor	Executive Director of Finance		
Presented by	Claire Osmundsen-Little, Interim Director of Finance		
Freedom of Information	Open		
FoI Closed detail	If closed, choose detail		
Impact Assessment Summary Outcome		IA Completion date	
N/A		Click or tap to enter a date.	
Purpose of the Report	For Assurance		
Report Summary; detailing any action required			
The report advises the Board of the Health Board on the financial position for Month 05 2026/27 (August 2026) and risks regarding the current forecast revenue year end outturn. It also sets out the financial recovery plan to tackling the deficit and balancing the plan.			
TKey Issues			
The report invites the Board to consider and discuss the detailed revenue analysis of the financial position for Month 05 2025/26 (August 2026). The report includes a summary of the key drivers of the revenue position either at Service level or by expenditure type (i.e. Non-Pay/Pay). The report details the actions required to return the financial plan to balance. The report invites the Board to consider the cash position, key balance sheet movements and the capital position. Risk have been considered on the basis of the information provided within the report and the score updated where necessary. Whilst the key messages are provided within the main body of the report, further information, including the financial recovery assumptions, are provided in the accompanying Annex.			



**Decision / Action
required**

No

Recommendations

Members are asked to:

- **ACKNOWLEDGE** the 2026/27 Financial Plan, and the Health Board's and Welsh Government's inability to approve it given the planned deficit of £76.6m
- **CONSIDER** and comment upon the Health Board's financial performance for Month 05 2026/27, including cash, capital and balance sheet.
- **SUPPORT** the implementation of the actions to address the red and pipeline savings gap and assessed position to reach the £76.6m plan.
- **DISCUSS** the risks to the position at Month 05.
- **DETERMINE** any additional action.

FINANCIAL REPORT – MONTH 05 2026/27

1. INTRODUCTION

The report invites the Board to consider the detailed analysis of the Month 5 (August 2026) revenue financial position, along with Cash and Capital.

2. BACKGROUND

The Health Board has two key statutory duties to achieve:

- To submit an Integrated Medium-Term Plan (IMTP) to secure compliance with breakeven over 3 years.**

2024/25 3-year plan submitted

2025/26 3-year plan submitted

2026/27 3-year plan submitted

The Health Board plans to achieve its target control total of £17m deficit, as part of its 2026/27 -2028/29 plan and is working on the action necessary to achieve this. Currently it will fail to meet this in 2026/27 as its plan will not breakeven over 3 years.

- To achieve financial breakeven over a rolling three-year period, which commenced on 1st April 2024 and will end on 31st March 2027.**

2024/25 Deficit Control Total £43.7m achieved

2025/26 Deficit Control Total £53.2m achieved

2026/27 Deficit Plan Draft £76.6m

The Health Board will fail to achieve this Statutory Duty.

Summary of Performance against Key Financial Targets

Financial KPIs: To ensure that net operating costs do not exceed the revenue resource limit set by Welsh Government	Value £'000
Reported in-month financial position – deficit/(surplus)	6.001
Reported cumulative financial position – deficit/(surplus)	35.266
Capital KPIs: To ensure that costs do not exceed the capital resource limit set by Welsh Government	Value £'000
Reported year to date financial position – deficit/(surplus)	(1.152)
Forecast outturn financial position – deficit/(surplus) (prior to additional allocations)	(4.010)



Financial KPIs: To ensure that net operating costs do not exceed the revenue resource limit set by Welsh Government	Value £'000
PSPP Target: To pay a minimum of 95% of all non NHS creditors within 30 days of receipt of goods or a valid invoice	Value %
Cumulative year to date % of invoices paid within 30 days (by number)	96.7%

3. FINANCIAL PLAN

The Annual Plan submitted to Welsh Government on 31 March 2026 for assessment and scrutiny included a financial assessment, as summarised in the table below:

Elements	2026/27 Deficit Plan at 31 March 2026 £'m
ULD Assessment 2025/26 into 2026/27	108.4
Growth / Inflation	40.5
Commissioner/Provider	5.2
Gross Plan Exc New 2026/27 Allocations	154.1
WG funding uplift 2026/27	(12.5)
2026/27 Savings Target	(65.0)
2026/27 Financial Plan Deficit	76.6

The Health Board accepts that this financial assessment is not acceptable or supportable to the Board or Welsh Government as it does not meet the statutory duties of the Health Board. A strengthened reiteration was submitted to Welsh Government 1 July 2026 which included the assessed savings position at that point; the Health Board is continuing its work on finalising the detailed delivery plan in respect of the £65.0m savings target set out in the draft plan submitted in March, along with mitigations against the recognised £10m risks.

The Health Board's actual performance against the planned deficit shows that, at the end of Month 5, the reported deficit in-month is £6.0m, which is £0.4m below the planned position. The table below provides the reconciliation of £6.0m Month 5 variance and the split between performance against operational budget and performance against savings target, with the second table reconciling the movements both in-month and YTD.



Health Board Wide Position		YTD @ Mth 5 £M	Profile				
			Mth 1 £M	Mth 2 £M	Mth 3 £M	Mth 4 £M	Mth 5 £M
1. Operational Performance	Plan	59.0	11.8	11.8	11.8	11.8	11.8
	Actual	49.3	9.5	9.6	10.0	9.8	10.4
	Variance	(9.7)	(2.3)	(2.2)	(1.8)	(2.0)	(1.4)
2. Savings Performance	Plan	(27.1)	(5.4)	(5.4)	(5.4)	(5.4)	(5.4)
	Actual	(14.1)	(1.0)	(1.9)	(2.9)	(3.8)	(4.4)
	Variance	13.0	4.4	3.5	2.5	1.6	1.0
2. Overall HB Performance	Plan	31.9	6.4	6.4	6.4	6.4	6.4
	Actual	35.3	8.5	7.7	7.1	6.0	6.0
	Variance	3.4	2.1	1.3	0.7	(0.4)	(0.4)

	Month 5 Based on £76.6m Plan £M	YTD Based on £76.6m Plan £M
Month 5 Plan	6.4	32.0
Non delivery of required savings	1.0	13.0
Operational variation		
2026/27 Slippage Inflation & Growth	(1.1)	(5.2)
Grip & Control Vacancies	(1.1)	(5.3)
Grip & Control Variable Pay movement	0.4	0.1
Primary Care Prescribing - NCSO	0.2	0.7
CHC Below Budget	0.0	(0.3)
Other Non-Pay	0.2	0.3
Month 5 Outturn	6.0	35.4
Variance To Plan	(0.4)	3.4

Cumulatively the Health Board is operating above the £76.6m deficit plan by £3.4m at the end of Month 5. Certainty on the delivery of the balance of savings of £23.7m is essential and hence the need to strengthen the pipeline and continue the reduction in expenditure in future months.

Given the financial position, actions to mitigate growth and generate further stretched savings are being undertaken. Progress on these plans are part of the Recovery & Sustainability Board and work that the Delivery Unit is supporting.

4. BACKGROUND – Financial Performance

FINANCIAL REPORT REVENUE – MONTH 05

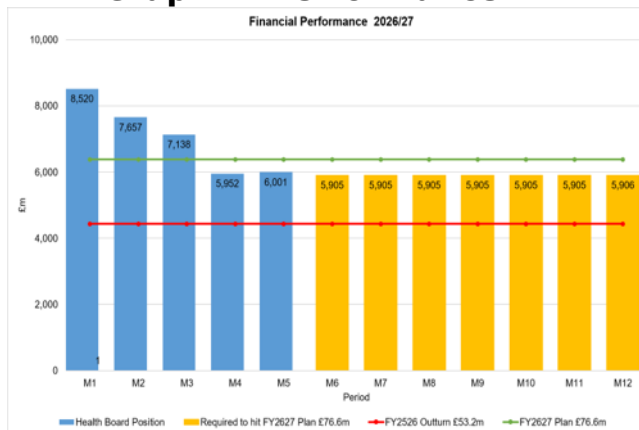
At Month 5 there was an In-Month overspend of £6.0m, which is £0.4m better than the planned deficit of £6.4m (£76.6m/12).

With regard to the overall financial performance, Graph 1 below reflects the actual financial performance in each month, with the orange bars reflecting the performance required to achieve the original plan of £76.6m. Graph 2

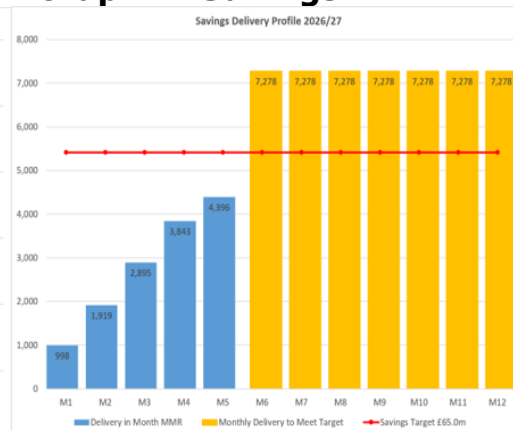


outlines the savings delivered to date as the blue bars against the monthly target set (red line), and the orange bars reflect the level of savings required in future months to achieve the £65m target aligned to the £76.6m plan.

Graph 1: Performance



Graph 2: Savings



KEY DRIVERS OF THE IN-MONTH POSITION

The key movements from plan of the Month 5 position are summarised in second table reported in Section 1 above. Further detail at a Health Board level of expenditure on Income, Pay and Non-Pay, is provided within Annex 1.

5. KEY AREAS FOR CONSIDERATION

5.1 SAVINGS DELIVERY

Full details on savings are provided Annex 1, but in summary the in-month delivery in Month 5, was £4.4m against a target of £5.4m and remains the key driver of the Health Board overspend. YTD delivery is £14.1m against a target of £27.1m.

5.2 CAPITAL

The approved Capital Resource Limit (CRL) value issued on 2nd September is £55.697m. The approved CRL value includes Discretionary Capital and schemes under the All-Wales Capital Programme.

Outturn Performance

The forecast outturn shows an underspend position of £4.010m in relation to the high-risk schemes below.



Scheme	£m / Risk Level	Narrative
HCF - Dan y Deri	2.000 / High	We raised the risk to high in the month 4 returns and formally requested the return of £2m this year, to be re-provided next year. Following discussions with the WG Capital & Estates team, we are liaising with the West Glamorgan RPB and WG HCF team to facilitate this CRL adjustment.
Vascular Hybrid Theatre at Morriston Hospital, Swansea	0.950 / High	Following on from a previous return of funding in the in the M3 MMR and discussions at the CRM, we can now confirm further savings as the scheme nears completion. Savings on the roof top plant unit, due to design amendments enabling fitting on to a smaller footprint. Re-engineering around AHU/fire suppression also enabled savings. Due to some uncertainty of the ground works, costs were included in the business case but not required. The main works following delivery of the modular units to site was completed in late August and we are currently progressing through commissioning and imaging equipment installation. Due to the fortunate weather conditions during the modular install, there were less abortive visits than anticipated. Overall, the scheme has been very positive.
Reinstatement of Taith Newydd Low Secure Unit at Glanrhyd, Bridgend	0.400 / High	Following on from a previous return of funding in the M3 MMR and discussions at the CRM, we can now confirm this scheme will be further underspent following confirmation that renewal of fibre cable was not required. Working with NWSSP-SES, we were able to amend the sprinkler package to reduce the amount of



Scheme	£m / Risk Level	Narrative
		works required, while retaining resilience.
Replacement Diagnostic and Treatment Equipment 2025-26	0.420 / High	Following on from the M4 MMR, we can now confirm this scheme will be underspent following the receipt of tenders and the cost of the machine was lower than expected. Work is due to start on site in September.
Digital X-Ray Rooms, Morriston Hospital	0.240 / High	Following on from the M4 MMR, we can now confirm this scheme will be underspent following the receipt of tenders. Work is due to start on site in September.

Any variances are linked to planned contributions from discretionary and in some instances payback of prior year fees.

Capital Disposals

There are no property disposals planned for 2026/27.

5.3 BALANCE SHEET

The key issues in respect of the statement of financial position movements are as follow:

- The inventory value has increased from £12.786m at the end of July 2026 to £12.812m at the end of August 2026, an increase of £0.026m.
- There has been an increase in trade receivables from £308.823m at the end of July 2026 to £320.278m at the end of August 2026, an increase of £11.455m. This relates to an increase in NHS Debtors of £9.222m, an increase in the WRP (Welsh Risk Pool) debtor of £5.472m, a decrease in WGA (Whole Government Accounts) debtor of £0.366m, a decrease in VAT debtor of £1.773m and a decrease in other current assets of £1.483m.
- The closing August 2026 cash balance of £5.663m



- The trade and other payables figure saw a decrease from £237.035m at the end of July 2026, to £230.098m at the end of August 2026, a decrease of £6.937m. This comprises a decrease in Accruals and RBNI (received but not invoiced).
- Provisions saw an increase of £5.217m from £238.913m at the end of July 2026 to £244.130m at the end of August 2026. This increase relates mainly to Clinical Negligence of £5.829m, a decrease of £0.265m and £0.288m in Redress and defence fees respectively.

5.4 CASH

As at the end of August 2026, the Health Board had a cash balance of £5.663m, which is within a reasonable tolerance for the Health Board.

The forecast cash deficit is £75m. The difference between the £75m forecast cash deficit and the Forecast I&E deficit plan/cash figure, reflects the £1.434m of Revenue cash to reimburse capital cash, and the movement in the working capital balances.

The cash movements during August 2026 were:

	£'000	£'000
Forecast I&E Deficit		- 76,600
Reimbursement from Revenue to Capital	1,434	
Movement in Working Capital balances	- 2,585	
		- 1,151
Opening Cash Balance		2,751
Forecast Cash Deficit		- 75,000

In order to manage the balance of cash between Revenue and Capital, we have been drawing down CRL funding in such a way, as to ensure that it not only clears any prior "owing" between Revenue and Capital, but also to ensure that we are no drawing down ahead of need. We are managing this on a monthly basis. The net capital cumulative funding position as at M5 is £2.190m.

The cash flow is currently updated daily and a full review of the cash forecast is currently being undertaken monthly, to ensure that any changes to our cash requirements, can be communicated in a timely manner to WG.

The Health Board awaits the annual technical guidance from WG on the process for requesting Strategic and Working Capital Cash during Q3/Q4 of 2026/27.

5.5 PUBLIC SECTOR PAYMENT POLICY (PSPP)

The Health Board achieved the 95% PSPP target, with the % of Non-NHS Invoices Paid within 30 Days as at Month 5 being 96.7%.



NHS payment compliance for invoices paid within 30 days was, however, below 95% with the performance at Month 5 being 88.2%. The Health Board remains focussed on improving PSPP compliance for NHS invoices and ensuring that performance remains above 95% for non-NHS invoices.

5.6 FURTHER FOCUS IN MONTH TO SUPPORT 2026/27 OUTTURN

The financial recovery requires as a minimum recurrent savings of £65m within this financial year. At month 5 total savings totalled £41.3m, of which £29.4m are recurrent and this translates into £39m full year recurrent savings leaving a gap of £16m yet to substantiate this year. To outturn as a minimum with a £76.6m deficit and close the gap in recurrent savings the following three areas of increased focus are being taken;

- 1) Continue to convert £25m identified opportunities and monitor delivery supported by the delivery unit. Prioritising the recurrent savings gap.
- 2) Maintain operational spend grip and control with weekly run rate oversight supported by weekly limits for both Pay and Non Pay.
- 3) Start the translation of the opportunities list for 2027/28 delivery.

The actions will be underpinned by additional scrutiny of absence, with new approaches being considered to manage absence and improve staff well-being.

5.7 TACKLING THE DEFICIT AND RECOVERY PLAN TO BALANCE

During the month, a detailed financial analysis has been undertaken: to update the calculation on the current underlying financial gap, to identify the areas of productivity improvement and to set out a clear financial recovery plan to balance. There is detailed work underway on the deficit drivers and the key areas of transformation to improve quality, productivity and sustainability of the way that care is delivered. This demonstrates the need for radical redesign and reprioritisation of services and the role of improving asset utilisation and digitalise delivery. The choices and options for consideration are being refined, for further consideration in the October Board Development session. These will then be shared with and discussed with NHS P&I and Welsh Government over the next quarter to inform the plan for 2027/28.

5.8 BUDGET SETTING PROCESS

In May, budget letters were issued to all 67 identified Senior Leaders along with invites to attend a budget holder training session with additional procurement training. The return of the signed letters and Budget Holder

access to the QlikSense finance dashboard is being tracked and reported within Annex 1, Appendix 2-3.

6. GOVERNANCE AND RISK ISSUES

Two Board level financial risks:

1. Achieving financial plan (HBR92) with the key elements as follows: -

- Risk of delivery of savings quantum
- Risk of operational overspend being in excess of funding available agreed via the Financial Plan
- Risk of commitment of reserves (e.g. NICE) being above reserves available.
- Risk of achieving the actions and options outlined in the 2025/26 Financial Recovery & Sustainability Assessment.

Given the improvement needed to the monthly performance and the current status of savings to achieve the draft deficit plan of £76.6m, it is recommended that the Health Board Corporate Risk Register continues to reflect a **risk score of 25**.

2. **Availability of capital (HBR93).** This risk was re-opened in 2022/23 given the reduction in discretionary capital allocation. Due to the additional capital funding provided during 2024/25 the risk score was reduced to 12. The score was increased in June 2025 to reflect risks regarding Emergency Department and Adult Acute Mental Health. However, following further assessment at start Quarter 4 2025/26 and based on funding received the risk score **reduced to 12**, which is the recommendation for Q2 2026/27.

For Month 5 the key risks to the delivery of the Deficit Plan reported to WG in the MMR, linked to HBR92 are detailed below:

- **Delivery of savings:** The Health Board has identified £41.3m of Green and Amber savings and whilst it continues to scrutinise delivery of these via the Recovery & Sustainability Board (chaired by the CEO), the role of the Delivery Unit is to quickly translate these plans to deliverable schemes in year, supported by the Finance Team. The Health Board has also identified further opportunities (currently in Red or Pipeline, to support the delivery of the £65m target). Combining the Green/Amber and those remaining Red/Pipeline, there is a greater level of confidence in total delivery of £54m savings (85%) (assuming LTA performance remains consistent) and as such £10m has been reflected as risk in the



table at this point on planned mitigations yet to be finalised, with £3.6m on unplanned mitigations requiring redress.

- **Non-Delivery Actions to Mitigate Growth/Inflation:** Growth pressures above plan level should be mitigated by the identification of mitigating actions, in addition to the planned savings delivery. The Health Board acknowledges that this is challenging in the context of the savings position. A review of the assessed risk was completed at the end of Q1; following a Month 5 outturn position of £2.1m relating to CHC, we have estimated the total remaining risk for CHC in 2026/27 of £2.9m.
- **Energy Risk provided by NWSSP:** Not all the energy requirements for 2026/27 have been purchased in advance. The assessment provided by NWSSP on 07/09/26 highlighted a risk of £0.798m, an increase from previous risk of £0.498m. This will be updated based on the data from NWSSP; however the Health Board is not yet seeing these pressures materialise within the position.
- **Resident Doctor Contract Changes:** The contractual changes will be phased from August 2026 to August 2028. Initial assessment suggested there is a risk of between £2m – £2.5m. A report is being prepared to assess the implications and look at risks and mitigations for the Board.
- **Primary Care Prescribing (NCSO's):** Assuming the current pressures, which have seen an increase of £0.236m per month from previous financial years, continue for remaining 7 months of 2026/27, the total pressure from NCSO is £2.6m.
- **NEW Month 5 GPOOH National Pay and Terms of Engagement Framework:** There are currently no standardised national terms and conditions governing the engagement of GPs working in Out of Hours services across NHS Wales. This has contributed to variation in rates of pay, competition between organisations, and increasing employment tribunal risk, particularly in relation to worker status and holiday pay claims. In response, a national tripartite process involving NHS Wales Employers, Welsh Government and the British Medical Association (BMA) have developed draft worker terms of engagement, a proposed national pay scale, worker enhancement rates, a consultancy agreement for contractors, and a revised employment status assessment process. The initial assessment of this by the HB has indicated a potential cost pressure of £0.176m, which is above the Annual Plan assumptions.
- **NEW Out of Area Placements (Temporary Adult Mental Health placements):** Original £76.6m plan had an assumed level of Out of Area Mental Health Placements, which would taper off to zero during Q3 of 2026/27. During the opening 4 months of 2026/27 the number of patients had reduced to 9, which is below the target of 11 recognised by WG. However, during August there was a stepped increase in the numbers of patients requiring Out of Area Placements, with the majority detained under the Mental Health Act. During August the number reached a peak of 32. Since then the MH/LD Service Group has been

working on supporting discharge and by the last week of August there were plans in place to discharge 13 during September. However, this level remains above the level within the original plan. With the Health Board unlikely to reach the original financial planning assumptions of zero, and assuming the levels will not be lower than 11 at any point in the remainder of 2026/27, an indicative value for the risk, above the original planning assumption, has now been included in the MMR. This is based on an average of 11 patients per month above plan at a cost of £1k per day. This will be reviewed monthly based on the number of admissions and planned discharges untaken within each month.

7. RECOMMENDATION

Members are asked to:

- **ACKNOWLEDGE** the 2026/27 Financial Plan, and the Health Board's and Welsh Government's inability to approve it given the planned deficit of £76.6m.
- **CONSIDER** and comment upon the Health Board's financial performance for Month 05 2026/27 including cash, capital and balance sheet.
- **SUPPORT** the approach to tackling the deficit and the financial recovery plan to balance.
- **CONSIDER** the risks to the position at Month 05.
- **DETERMINE** any further action.



Governance and Assurance		
Strategic Objectives		
Strategic Objectives (please choose which is impacted)	People of Swansea Bay live healthier, fairer and more prosperous lives	☐
	Care is high quality, safe, efficient and delivers the best possible outcomes for people in partnerships	☐
	Care is delivered in partnership with our communities in safe and appropriate setting, supported by innovation	☐
	The health board is a great place to work where staff feel valued and work together towards a common goal	☐
	The health board is a resilient, sustainable and responsible organisation	☒
Health and Care Standards		
Standards (please choose which applies)	Safe Care	☐
	Timely Care	☐
	Effective Care	☐
	Efficient Care	☒
	Equitable care	☐
	Person-centred Care	☐
	Staff and Resources	☐
Enablers (please choose which applies)	Whole Systems Approach	☒
	Leadership	☐
	Workforce	☐
	Culture	☐
	Information	☐
	Learning, Improvement and Research	☐
Quality, Safety and Patient Experience		
Financial Governance supports quality, safety, and patient experience.		
Financial Implications		
The Board is reporting a forecast year-end deficit financial outturn.		
Legal Implications (including equality and diversity assessment)		
No implications		
Staffing Implications		
No implications		
Long Term Implications (including the impact of the Well-being of Future Generations (Wales) Act 2015)		
No implications		



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Report History

Updates on the financial position are provided at every meeting.

Appendices

Annex 1 – Detail on Financial Position @ Month 5



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Gofal gwell
Bywyd gwell

Better health
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Better lives

15 of 15
SBUHB Board
Thursday, 24 September 2026



QUALITY AND SAFETY COMMITTEE Key Issues Report

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

Date of Committee meeting:	6 August 2026
Members Present:	Three Members were present at the Quality and Safety Committee, Jean Church, Committee Chair, Steve Spill Independent Member, Cllr Nicola Matthews, Independent Member.
Quoracy:	Yes
Group/Committee Chair:	Jean Church, Quality and Safety Committee Chair
Report Submitted by:	Corporate Governance.
Report Signed off by:	Jean Church, Committee Chair Elizabeth Rix, Director of Nursing and Patient Experience.
Date of Board receiving the report:	September 2026.

1.	Agenda	The Quality and Safety Committee convenes bi-monthly, and the agenda, relevant documents, and minutes from the meetings are accessible on the SBUHB website .
2.	Alert Minute Reference: 93/26	The Committee is alerting the Board to the following items (4): Perinatal Committee Report - Ongoing system pressures, including workforce capacity, postnatal flow, and demand related to acuity and mode of birth (particularly caesarean associated neonatal admissions); - High-level risks that remain under active management, including paediatric radiology capacity, training delivery constraints (MoNET), and wider service configuration challenges (e.g. two-site working and critical care access);



	Minute Reference: 97/26	• Transitional risks associated with digital implementation and national system dependencies, including data quality, survey limitations, and reporting consistency; • The need to maintain focus on equity of access, consistency of escalation, and timeliness of care, as identified through Health Inspectorate Wales (HIW) and internal review processes; • The service continues to provide safe, compassionate and high-quality care, with no immediate safety concerns identified, and a strong focus on continuous improvement. External Inspections • The Health Board's draft report submitted to Health Inspectorate Wales (HIW) relating to Low Secure Services (Taith Newydd) at Glanrhyd was not accepted and required further enhancements. The revision of the Report is in hand with the Service Group; • Final reports from HIW following inspections of Caswell Clinic and Ward D Morriston have now been published and our subsequent improvement plan submissions have been accepted by HIW; • Publication is pending on further inspections: the Joint Inspection of Community Learning Disability Services in Neath and Ward 3 Singleton.
	Minute Reference: 101/26	Health and Safety Management Report • Concern noted that following a recent visit by Mid and West Wales Fire and Safety Rescue Service to Singleton Hospital "Letters of Fire Safety Matters for breach in compartmentation in Theatre environment" were issued. Total Fire Safety Risk Assessment compliance currently equates to 34%. • Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) reflected poor compliance in 2025/26 reporting 35.5%, 31 incidents, 20 out of time reporting. • In-patient falls in two Neath Port Talbot Hospital and Mental Health wards were identified as areas of potential concern and services have been asked to provide further detail on work to understand and address the deteriorating position in these two areas. Controlled drugs incidents in a community pharmacy was flagged as an area of concern by



	Minute Reference: 103/26	Primary Care Community and Therapies, there are external investigations underway to review this position. - Overdue incident rates have increased in Neath Port Talbot Singleton and work is underway to address this. Urgent and Emergency Care - Board is alerted to the fact that this Report was not presented to the Quality & Safety Committee and will be referred to the October meeting.
3.	Assurance	
	Minute Reference: 93/26	The Committee is assuring the Board on the following items (6): Perinatal Committee Report - Robust governance and oversight arrangements are in place, including real time monitoring, multidisciplinary review, and clear escalation pathways from ward to Board. - All risks are actively managed with no overdue actions; with delivery aligned to planned milestones and supported through structured improvement programmes; - There is clear evidence of learning being translated into practice, with improvements in safety, patient experience, and clinical outcomes supported by ongoing audit, thematic review, and workforce development; - The Health Inspectorate Wales (HIW) improvement plan is approved, published, and actively progressing, with strengthened oversight ensuring delivery and closure of actions.
	Minute Reference: 94/26	Mental Health Transformation Programme (MHTP) The MHLD Quality & Safety Dashboard is now operational providing the foundation for a strengthened assurance framework together with the agreed Key Lines of Enquiry (KLoE) the latter driving the Key Performance Indicators (KPIs); the current level of assurance remains constrained by the maturity of data collection processes and continued reliance on manual reporting in several key areas.



	Minute Reference: 96/26 Minute Reference: 98/26 Minute Reference: 99/26	- The MHTP has delivered progress in improving quality and safety across its various workstreams. Workforce and estates-related risks are now reflected on the Strategic and Corporate Risk Registers for executive oversight. Risk Register - The Committee worked through both the Strategic and Corporate Risk Registers (SRR/CRR) reviewing timelines against when the Risk was first opened and last reviewed also posing the question as to whether greater ambition should be considered in setting/achieving timelines. Specifically, the Committee requested: - A more informed update be brought back on actions being taken to address the Breaches identified in May in regard to Datix NO 1834 Access to Systemic Anti-Cancer Therapy (SACT). Mortuary Assessment against external reviews - Both Fuller and Ockenden Reports identified failures of governance, oversight, communication and organisational learning associated with Post-Death Care Pathways; existing Mortuary Governance arrangements provide assurance against many recommendations contained within the reports; - The Mortuary Management Team has reviewed the relevant findings and identified the key improvement priorities applicable to local services; - Further work will focus on evidencing compliance, strengthening quality assurance systems and embedding organisational learning across Mortuary post-death care pathways. - Work is ongoing to complete the Gap Analysis of Phase 2 of the Fuller Inquiry after which the report will be finalised by the Mortuary Service Management Team. COVID-19 - The Board is asked to be assured that the approved governance arrangements provide a clear route for receipt, allocation, monitoring and escalation of Covid-19 Public Inquiry and Public
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	Minute Reference: 104/26	Accounts Committee recommendations relevant to quality, safety and organisational learning. Quality and Safety Performance Report - In terms of the Breakthrough Objectives concerns were raised specifically around: - Single Cancer Pathway dropped again in June to 54% versus a 76% target – a full report will be presented at October Quality and Safety Committee; - Staff sickness rates up to 7.37%; - Targeted Intervention objectives appear to be making very slow progress with HCAI's, Cancer, CAMHS and Planned Care; - Bowel screening rates dropped from 71% to 61%; - A number of initiatives to address this underperformance are set to deliver by the end of August e.g. Pathology waiting list management; - Ophthalmology dropped below Welsh Government de-escalation for the first time in 2 years.
4.	Advise	
	Minute Reference: 92/26	The Committee is advising the Board on the following items (7): Quality and Safety Group Q&S approved the Annual Duty of Quality and Annual Welsh Language Reports and recommended escalation to Board.
	Minute Reference: 93/26	Perinatal Committee Report - There has been sustained progress across maternity and neonatal services, with improved governance, strengthened multidisciplinary working and enhanced safety systems evidenced through Health Inspectorate Wales (HIW) findings, workforce compliance, and quality metrics; - Targeted quality improvement programmes (e.g. ASTRA, bedside respiratory support, digital systems such as BadgerNet and computerised CTG) are being implemented to address key drivers of risk and variation. The Directorate has



	Minute Reference: 94/26	been selected as an NHS Wales Quality Management System (QMS) Prototype site, receiving 18 months of national coaching and support to embed a sustainable quality-driven learning system and further strengthen the integration of quality planning, assurance, control and improvement across the service; • Data systems are undergoing a period of transition and validation, and whilst this may impact completeness in the short term, this work is critical to strengthening long-term assurance and insight. Mental Health Transformation Programme (MHTP) • The Quality and Safety workstream of the Mental Health Transformation Programme updated Terms of Reference and agreed objectives for the next phase of work include: ○ Improve reporting and oversight of quality, safety and performance indicators within the MHLD Service Group; ○ Ensure equitable access to, and provision of, physical healthcare monitoring for patients with a mental health condition; ○ Undertake a full impact assessment of the implementation of reporting dashboards within the MHLD Service Group; ○ Promote a culture of continuous improvement and learning and working in collaboration with NHS Wales Performance and Improvement (P&I) to implement the Quality Maturity System (QMS) Maturity Matrix; ○ Thematic reviews and identification of learning outcomes for key quality, safety and performance indicators, including incidents, complaints, concerns, PROMS and PREMS for Adult Mental Health services; ○ Ensure processes and procedures are in place to deliver consistent clinical practice to reduce variation and improve decision-making; ○ Improve understanding of quality and safety within MH&LD Service Group through effective communication, learning events and staff training and development.
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Minute Reference: 100/26	Controlled Drugs Governance and Assurance Report • The appointment of a new Controlled Drug Accountable Officer who confirmed that following the recent Internal Audit Report (reasonable assurance given) a management response is in place and there are no overdue actions. Board is asked to note a slippage in relation to the education and training programme caused by revision necessary to deliver a more robust and sustainable approach; • With reference to Objective 6 of the Audit Report: appropriate oversight of controlled drugs within the Health Board including incidents; the development of the Datix reporting dashboard has helped support data collection. AMaT outcomes and associated action plans are becoming embedded in the Service Group Governance meetings.
Minute Reference: 101/26	Health and Safety Management Report • One-hour Fire Warden Training Sessions are not mandated to specific staff working in higher risk environments and no formal training needs analysis has been undertaken to identify key personnel who should be trained – this would be a key function of the Fire Safety Manager; • There is a poor safety culture permeating the Organisation that requires individuals to more fully understand their Health & Safety responsibilities, to undertake further training, as well as the need to implement a structured programme of safety and awareness briefings. It is recommended this matter be referred to the Workforce and Organisational Development Committee.
Minute Reference: 92/26	Quality and Safety Group • Revised Terms of Reference for the Quality and Safety Group (QSG) were agreed. The new version reflects the inclusion of the Listening to People Programme Board; • A Quality Insights and Improvement Group has been established to strengthen how information is used across our quality management arrangements.



5.	Review of Risks	The Quality & Safety Committee will continue to monitor the risks outlined above through its routine governance, assurance and performance oversight arrangements and will keep the Board informed of any significant changes requiring escalation
6.	Sharing of learning	Learning has been identified through external inspection findings, HIW improvement planning, mortuary governance reviews, Mental Health Transformation Programme workstreams and organisational quality improvement initiatives, with arrangements in place to ensure learning is translated into practice across services.
7.	Actions to be considered by Board	None identified during the meeting.



Meeting Date	24 September 2026	Agenda Item	5.5i
Name of Meeting	SBUHB Board		
Report Title	Perinatal Committee Report		
Report Author	Kathyrn Greaves – Director of Midwifery Sujoy Banerjee – Associate Service Group Medical Director - CYPWH		
Report Sponsor	Executive Director of Nursing and Patient Experience		
Presented by	Elizabeth Rix, Executive Director of Nursing and Patient Experience		
Freedom of Information	Open		
FoI Closed detail	If closed, choose detail		
Impact Assessment Summary Outcome		IA Completion date	
The report demonstrates continued progress in strengthening governance, quality, safety and patient experience across maternity and neonatal services. Robust assurance arrangements remain in place, with no immediate patient safety concerns identified. Residual risks relating to workforce sustainability, specialist capacity and digital transition continue to be actively managed through established governance structures. The Committee can take moderate assurance that effective controls, improvement programmes and mitigation plans are in place to support ongoing quality and service resilience.		18 August 2026	
Purpose of the Report	For Assurance		
Report Summary; detailing any action required			
The Health Board recognises that every woman, birthing person, baby and family using our perinatal services deserves consistently safe, high-quality and compassionate care.			
While most experiences are positive, we are acutely aware that even a single instance where care falls short is one too many. This report is therefore grounded in a commitment to transparency, learning and improvement, ensuring that every voice and every experience continue to shape and strengthen our service.			
The purpose of the paper is to provide the Board with an update from the Perinatal Committee providing assurance and information relating to the risks to quality, safety, and patient experience in maternity and neonatal services, with escalation of any key areas of concern.			
The August Perinatal Committee report provides an update on quality, safety, patient experience, workforce, governance and service sustainability using July			



2026 data. The service continues to operate safely with robust governance arrangements in place, although residual risks remain in relation to workforce sustainability, specialist capacity, digital reporting transition and timeliness of complex review processes. Positive assurance is demonstrated through maintained service delivery, strong training compliance across most staff groups, effective infection prevention controls, structured incident and mortality review processes, active patient engagement and mature risk oversight.

Key Issues

Perinatal Services continue to provide safe care with robust governance, quality assurance and improvement arrangements in place across maternity and neonatal services. July performance demonstrates positive assurance in relation to infection prevention and control, statutory and mandatory training compliance, mortality review processes, patient experience activity and risk oversight. The service remains focused on learning, continuous improvement and the delivery of safe, compassionate and evidence-based care.

The Committee should note that several risks remain under active management, primarily relating to workforce sustainability, specialist service capacity, timeliness of some review processes and the ongoing transition to BadgerNet reporting. Whilst mitigating actions are in place and services continue to operate safely; these risks require continued oversight through established governance and escalation arrangements.

Overall, the Committee can take moderate assurance that effective controls are in place, key risks are understood and actively managed, and improvement activity continues across all domains of the Perinatal Quality and Safety Framework.

Decision / Action required

Yes, Impact Assessment included

Recommendations

Members are asked to:

BE ADVISED THAT;

- Perinatal Services continue to provide safe care within a context of ongoing workforce fragility, specialist capacity constraints, digital transition and wider system dependencies.
- July 2026 data demonstrate areas of positive assurance, including maintained service delivery, strong training compliance across most workforce groups, effective infection prevention arrangements and active governance oversight.
- Digital reporting remains in transition following BadgerNet implementation, and some metrics should continue to be interpreted with caution while data validation and reporting optimisation are completed.

BE ASSURED THAT;

- Governance arrangements remain in place across maternity and neonatal services, with incident review, mortality review, patient experience, risk





management and improvement activity monitored through established structures.

- Infection prevention and control performance remains strong, with no reported *C. difficile*, *E. coli*, *Staphylococcus aureus* or *Pseudomonas* bacteraemia cases in July across maternity and neonatal services.
- Patient feedback continues to be actively reviewed and used to inform service improvement, with positive feedback evident alongside clear themes for improvement.
- The proposed serial growth scan pathway would preserve enhanced surveillance for women and babies with identified or emerging clinical concerns.

BE ALERTED TO;

- Ongoing workforce sustainability risks across maternity, neonatal nursing and neonatal medical rotas.
- Ongoing specialist service risks, including paediatric radiology support, MoNET training, neonatal transport and sonography capacity.
- Review timeliness pressures in relation to incidents, ATAIN reviews, PMRT reports and concerns where external dependencies or senior approval are required.
- The need to maintain careful oversight of digital data quality during the transition to BadgerNet-enabled reporting.

The service continues to provide safe, compassionate and high-quality care, with no immediate safety concerns identified, and a strong focus on continuous improvement.

PERINATAL COMMITTEE REPORT

1. INTRODUCTION

The Health Board recognises that every woman, birthing person, baby and family using our perinatal services deserves consistently safe, high-quality and compassionate care.

While most experiences are positive, we are acutely aware that even a single instance where care falls short is one too many. This report is therefore grounded in a commitment to transparency, learning and improvement, ensuring that every voice and every experience continue to shape and strengthen our service.

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

2. BACKGROUND

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

This report marks the first anniversary of the Perinatal Committee and the establishment of a strengthened ward-to-Board reporting model. Together, these have delivered a step-change in governance, improving visibility, multidisciplinary oversight, and timely escalation of risk.

Over the past year, the Committee has matured into a key assurance forum, strengthening data transparency, supporting shared learning, and enabling more responsive decision-making. The ward-to-Board approach has ensured that the voices of staff, women and families are reflected at executive level, reinforcing a culture of openness, safety and continuous improvement.

This milestone reflects meaningful progress and provides a strong foundation for continued development aligned to national standards and organisational priorities.

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

Perinatal Committee and Perinatal Improvement Programme Board reporting are aligned to ensure complementary oversight; business-as-usual performance and improvement delivery are reported through respective routes, with shared visibility to Executive and Board to support robust governance and assurance.

3. GOVERNANCE AND RISK ISSUES

Key updates from Perinatal Committee

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

Data quality note: Following implementation of the BadgerNet Electronic Patient Record system in May 2026, further progress has been made in validating performance metrics and strengthening reporting arrangements. Some indicators continue to require quality assurance and reconciliation whilst reporting systems mature. Existing governance and operational oversight arrangements remain in place to provide assurance during this transition period.

Summary

Theme	Position	Assurance	Rationale
Clinical Outcomes	Stable	Moderate	Strong clinical outcomes are demonstrated across available indicators. Assurance is moderated by the limited availability of national benchmarking data for some metrics; however, local trend analysis and governance oversight provide confidence in performance.
Safety & Governance	Stable	Moderate	Robust governance arrangements operating effectively; some review timeliness and audit actions remain.
Experience & Engagement	Improving	Moderate	Strong engagement and improvement mechanisms in place; ongoing themes continue to require monitoring.
Workforce & Training	Stable with Risks	Moderate	Training compliance is positive; workforce sustainability and specialist capacity remain strategic risks.
Quality Improvement	Improving	Moderate	Improvement programmes are progressing well, but benefits continue to be realised and embedded.
Digital Transformation	Progressing	Moderate	Successful implementation of BadgerNet, with ongoing work required to achieve full reporting maturity.

The Perinatal Committee can provide Moderate Assurance across maternity and neonatal services. Evidence demonstrates that governance arrangements, quality management systems, risk management processes and improvement programmes are operating effectively and continue to support safe care delivery. Positive assurance is demonstrated through favourable clinical outcomes, robust mortality and incident review processes, effective infection prevention controls, active patient engagement and sustained quality improvement activity.

Residual risks remain in relation to workforce sustainability, specialist workforce capacity, sonography provision, digital reporting maturity and the timeliness of

some review processes. These risks are well understood, subject to active mitigation and regularly monitored through established governance structures. The Committee is satisfied that current controls are appropriate and effective, but further improvement activity is required before Significant Assurance could reasonably be claimed.

Understanding the Assurance Levels

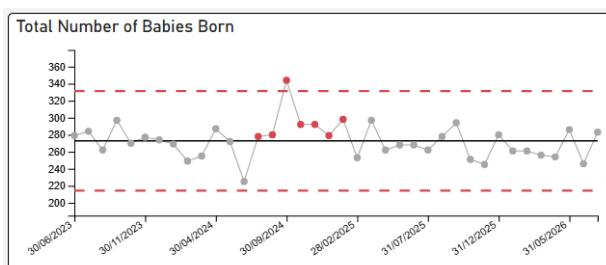
The Perinatal Committee has adopted a structured assurance methodology informed by the Healthcare Improvement Scotland Assurance Framework. Assurance ratings are assigned based on the strength of evidence available, the effectiveness of controls in place, and the level of residual risk remaining after mitigation.

Assurance Level	What this means
Significant Assurance	Strong evidence from multiple sources demonstrates that systems and controls are achieving their intended purpose. Any residual risks are low and do not materially affect delivery of safe, effective services.
Moderate Assurance	Controls are operating effectively and key risks are understood and actively managed. However, residual risks remain that require ongoing monitoring, mitigation and reporting.
Limited Assurance	Some controls are in place, but significant gaps, weaknesses or unresolved risks remain. Further action and closer oversight are required.
No Assurance	There is insufficient evidence to demonstrate that controls are effective or that risks are managed appropriately. Immediate action is required.

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

What are we measuring?

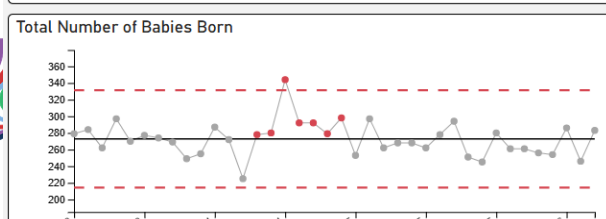
The proportion of babies born by planned and emergency caesarean section. Monitoring birth mode helps us understand clinical complexity, women's choices and service demand.

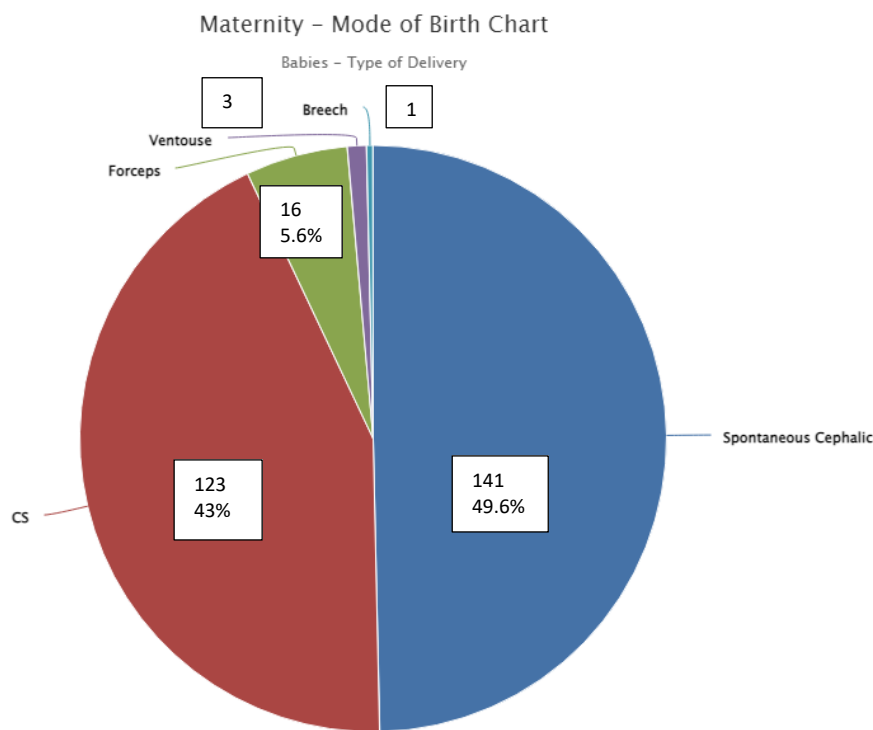


July Birth rate

277 Women gave birth.

284 Babies were born.





N.B. At this time we are unable to split the caesarean section data by planned and unplanned until validation of Badger data has completed. Expected by end of August 2026.

How are we performing?

The Health Board's overall caesarean section rate is 43%, which is consistent with national trends showing increasing rates of planned caesarean birth across the UK. Emergency caesarean section rates remain in line with national expectations. Following implementation of the BadgerNet electronic patient record, there is a temporary pause in the publication of some dashboard metrics whilst data mapping, validation and reporting processes are refined. This reflects the complexity of the new dataset and the transition from legacy systems to a digital platform. Work is progressing at pace with Digital colleagues to restore full reporting capability and provide assurance that future metrics accurately reflect service activity, demand, capacity, quality and outcomes. In the interim, existing governance arrangements and local monitoring processes remain in place to support operational oversight and risk management.

What are we doing to improve?

A dedicated Caesarean Section Working Group is overseeing capacity, reviewing pathways and developing a new BadgerNet-enabled booking system to support informed choice, improve planning and strengthen safety.

Board Assurance



The service continues to monitor birth choices, clinical outcomes and theatre capacity closely, with no immediate safety concerns identified.

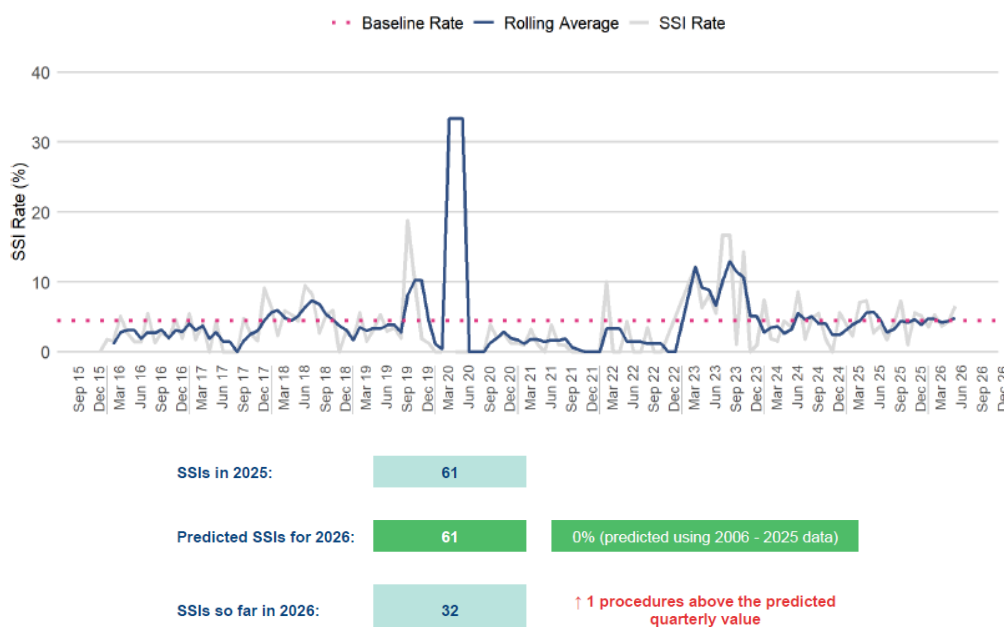
3.2 Surgical Site Infection:

What are we measuring?

Surgical site infections following caesarean birth.

Hospital and health board data from 01 Jul 2025 - 30 Jun 2026

	SSI Rate	Change	Valid data
Singleton			
Q3 2025 - Q2 2026	4.39%	↓2.23%	100%
Q3 2022 - Q2 2025 *	4.49%		85.86%
SBUHB			
Q3 2025 - Q2 2026	4.39%	↓2.23%	100%
Q3 2022 - Q2 2025 *	4.49%		85.86%



How are we performing?

Infection rates remain low and overall infection prevention performance across maternity and neonatal services remains strong. No cases of *C. difficile*, *E. coli*, *Staphylococcus aureus* or *Pseudomonas bacteraemia* were reported during this period.

What are we doing to improve?

Work has focused on improving infection surveillance, strengthening referral pathways and standardising infection reporting processes.

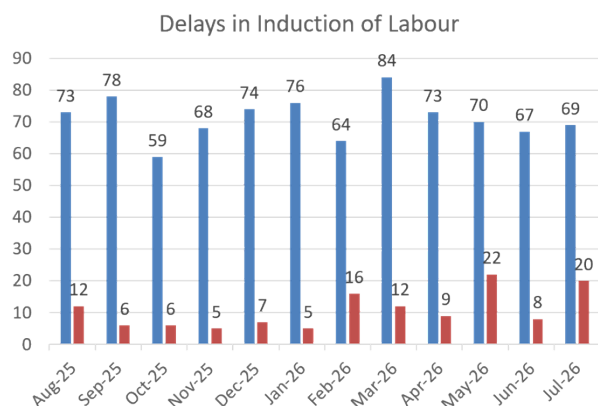
Board Assurance

Robust infection control measures are in place, with ongoing monitoring and learning supporting safe care delivery.



3.3 Induction of Labour delays

Delays in Induction of Labour – Activity over 12 months



What are we measuring?

The number of women who experience delays when induction of labour is planned.

How are we performing?

A small number of induction delays continue to occur, usually during periods of high clinical demand. No reported delays during this period resulted in clinical harm or incidents.

What are we doing to improve?

The service continues to review delays, improve risk assessment processes and strengthen patient flow across maternity services. Learning from incidents and feedback is informing ongoing improvement work.

Board Assurance

Delays are actively monitored and managed, with senior oversight and escalation processes in place to maintain safe care.

3.4 Extended Perinatal Mortality and Morbidity

All stillbirths, late fetal losses and neonatal deaths are reported to MBRRACE-UK, ensuring robust national surveillance and benchmarking of perinatal outcomes. Each case undergoes detailed internal review, and where appropriate, external scrutiny via the Perinatal Mortality Review Tool (PMRT). This supports identification of modifiable factors, strengthens organisational learning, and enables meaningful engagement with families, who are offered the opportunity to contribute to the review process with a dedicated point of contact.

We recognise that the loss of a baby has a profound and lasting impact on women, families and staff, and remain committed to providing compassionate care alongside robust, safe clinical services that seek to minimise harm and prevent avoidable loss wherever possible.

The most recent published MBRRACE data demonstrates an improving position. The crude perinatal mortality rate reduced from 7.49 per 1,000 births in 2023 to 5.73 per 1,000 births in 2024. The stabilised and adjusted rate for 2024 is 5.46 per 1,000 births, which is in line with the average for comparable UK organisations, indicating a stable and benchmarked performance.

There is no new national data available for this reporting period. MBRRACE reports are published on a lag basis, with 2025 birth data expected in Quarter 3/4 of 2026/27. In the interim, local surveillance and PMRT processes continue to provide ongoing oversight, assurance, and opportunities for continuous learning and improvement.

3.4.1 Stillbirths from January 2026

The service recognises that the death of a baby is a deeply devastating and life-changing experience for women, families, and the staff who care for them. We remain committed to providing compassionate, personalised support while ensuring robust, safe clinical services that seek to minimise harm and prevent avoidable loss wherever possible.

What are we measuring?

Stillbirths and neonatal deaths, alongside learning from reviews of each baby's care.

How are we performing?

Nationally reported data shows the Health Board's perinatal mortality rates remain in line with comparable organisations and have improved over recent years. Between January and June 2026, three stillbirths and four neonatal deaths were reported, of which two were inborn (babies born in Swansea) which is expected for a service of this size and complexity. The Health Board stillbirth crude rate for 2025 is 3.7 per thousand births and our 12-month rolling crude rate (August 2025 – July 2026) is 2.6 per 1000 births. 2025 crude Neonatal death rate 1.23/1000 and rolling crude 12-month crude rate is 1.63 per 1000 births. Routine validation of mortality data remains ongoing. As a result, the reported 12-month crude mortality rate remains provisional and may be subject to revision following completion of the data assurance process.

Every case undergoes detailed multidisciplinary review, and families are supported throughout the process.

What are we doing to improve?

Learning from reviews continues to strengthen care through improved fetal growth surveillance, escalation of maternal deterioration and clinical decision-making. Computerised fetal monitoring and enhanced training have also been introduced. Whilst limitations in external participation within clinical reviews are recognised across Wales, the Health Board continues to actively pursue opportunities to strengthen externality through collaboration with regional and national partners.

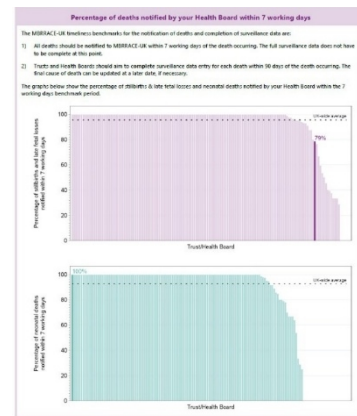
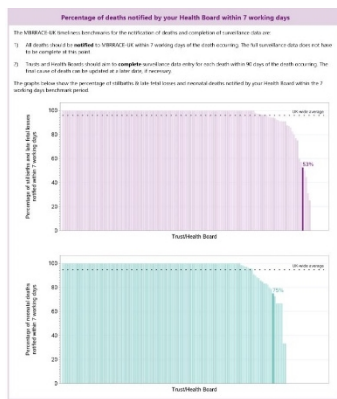
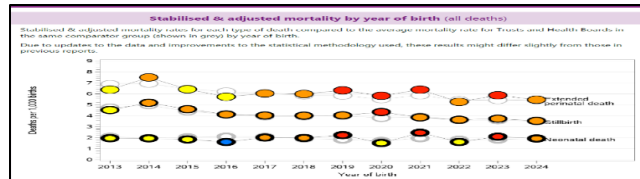


This remains an important area of development to support robust assurance, independent challenge and continuous improvement.

Board Assurance

The service remains committed to compassionate family engagement, robust investigation and continuous learning to reduce avoidable harm.

Figure: 11 year running stabilised and adjusted mortality rates for SBUHB including latest published year 2024. Note SBUHB separated from POW in 2019 resulting in reduction in births attributable to SBUHB (Data source MBRRACE UK)



2023

5. Data reporting			
Completeness of key data items for DEATHS AT YOUR HEALTH BOARD			
It is vital that complete, accurate data is reported to MBRRACE UK. For births in 2023, we received 97% of information on key data items for the deaths which occurred within your Health Board.			
The tables below provide details of completeness for key items in the data collection form. While the rest of this report concerns babies born within your Health Board, these tables show the overall completeness of data for deaths at your Health Board no matter where they were born. The percentage of data reported is given for each item, together with a coloured diamond denoting the level of completeness.			
● less than 70.0% complete ● 97.0% to 99.9% complete ● 70.0% to 84.9% complete ● 100% complete ● 85.0% to 96.9% complete			
These data items have been assessed as they are all readily available and essential to the accurate reporting of extended perinatal mortality for your Health Board. For these items scoring red, orange or yellow it is essential that completeness is improved. Achieving this may well require collaboration with receiving and referring units.			
Mother's details		Birth	
Name	100.0% ●	Type of onset of labour	88.0% ●
Postcode of residence	100.0% ●	Actual place of birth	96.8% ●
Ethnicity	97.0% ●	Date and time of birth	99.5% ●
Age	100.0% ●	Final mode of birth	96.0% ●
Pregnancy and antenatal care (note 1)		Baby's outcomes	
Smoking	92.0% ●	Date death confirmed (note 2)	100.0% ●
Body mass index	97.0% ●	Whether alive at onset of care (note 2)	100.0% ●
Intended type of care at booking	100.0% ●	Whether admitted to NICU (note 3)	99.4% ●
Estimated date of delivery	95.5% ●	Main cause of death	96.0% ●
			97.4% ●
Baby's characteristics		Completeness	
Birth weight	100.0% ●		
Gestational age at birth	98.0% ●		
	96.0% ●		
	99.0% ●		

Note 1: Excluding mothers reported as never booked.
Note 2: This data item is collected for stillbirths only.
Note 3: This data item is collected for neonatal deaths only.

2024

5. Data reporting			
Completeness of key data items for DEATHS AT YOUR HEALTH BOARD			
It is vital that complete, accurate data is reported to MBRRACE UK. For births in 2024, we received 100% of information on key data items for the deaths which occurred within your Health Board.			
The tables below provide details of completeness for key items in the data collection form. While the rest of this report concerns babies born within your Health Board, these tables show the overall completeness of data for deaths at your Health Board no matter where they were born. The percentage of data reported is given for each item, together with a coloured diamond denoting the level of completeness.			
● less than 70.0% complete ● 97.0% to 99.9% complete ● 70.0% to 84.9% complete ● 100% complete ● 85.0% to 96.9% complete			
These data items have been assessed as they are all readily available and essential to the accurate reporting of extended perinatal mortality for your Health Board. We are pleased to report that 100% of the data items were completed for deaths reported by your Health Board. Thank you for help and support.			
Mother's details		Birth	
Name	100.0% ●	Type of onset of labour	100.0% ●
Postcode of residence	100.0% ●	Actual place of birth	99.0% ●
Ethnicity	98.0% ●	Date and time of birth	100.0% ●
Age	97.0% ●	Final mode of birth	99.5% ●
Pregnancy and antenatal care (note 1)		Baby's outcomes	
Smoking	100.0% ●	Date death confirmed (note 2)	100.0% ●
Body mass index	97.0% ●	Whether alive at onset of care (note 2)	100.0% ●
Intended type of care at booking	100.0% ●	Whether admitted to NICU (note 3)	99.0% ●
Estimated date of delivery	96.0% ●	Main cause of death	100.0% ●
			97.0% ●
Baby's characteristics		Completeness	
Birth weight	100.0% ●		
Gestational age at birth	98.0% ●		
	96.0% ●		
	99.0% ●		

Note 1: Excluding mothers reported as never booked.
Note 2: This data item is collected for stillbirths only.
Note 3: This data item is collected for neonatal deaths only.

3.5 Hypoxic-Ischemic Encephalopathy (HIE) from January – December 2025

What are we measuring?



Hypoxic-Ischaemic Encephalopathy (HIE) is a rare but serious condition caused by reduced oxygen supply to a baby around the time of birth. Monitoring HIE helps us understand how effectively we identify and respond to babies who may be at risk during labour and birth.

How are we performing?

Incidence of moderate and severe hypoxic ischaemic encephalopathy (HIE) has remained low during 2026 to date, with ongoing review through established governance processes.

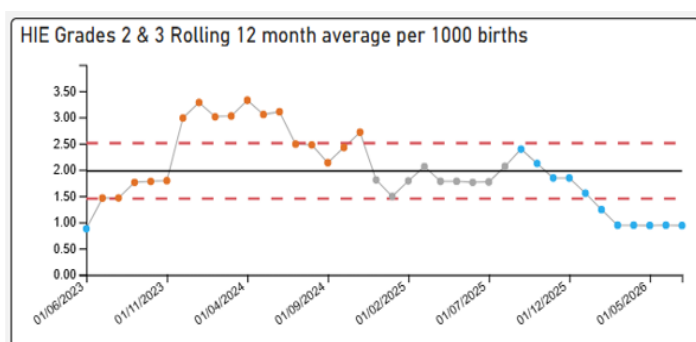
The Health Board's rolling 12-month HIE rate has reduced significantly over the past two years and remains below previously reported national rates, demonstrating sustained improvement in this important safety measure.

What are we doing to improve?

Every case of HIE is reviewed through a multidisciplinary process to identify learning and improvement opportunities. Learning from previous reviews has led to the implementation of computerised CTG monitoring, enhanced fetal surveillance training, and strengthened escalation processes to support the early recognition of fetal compromise and timely decision-making in labour.

Board Assurance

Learning continues to be translated into practice through targeted safety improvements, with ongoing monitoring and oversight supporting the delivery of safe, high-quality maternity care.



HIE IN 2026

As observed, there are 8 plots below centre line of 2.1 therefore showing a SHIFT in data. This is a strong example of non-random variation; suggesting the system is being influenced by something other than just common cause.

This data is not impacted by implementation of Maternity BadgerNet

Monitoring will continue

HIE 2 and 3 rolling 12-month average – 0.94/1000

The absolute 2025 HIE rate (Jan-December) were 1.68/1000 births.

3.6 Triage Metrics

What are we measuring?



We monitor how quickly women are assessed when they contact or attend maternity triage services. Timely assessment is important to ensure women receive the right advice, care and treatment when they need it.

How are we performing?

Since implementation in November 2024 our BSOTS compliance for initial review has been stable at or above the performance criteria of >90%. Demand for triage services remains high and attendance levels are stable. Most women continue to be assessed within the expected timeframe, 77% of women met the 15-minute triage standard in June 2026. This is understood to reflect a combination of operational pressures, increased demand associated with the Single Point of Access model, and the transition to BadgerNet digital reporting. June represents the first full month of reporting through BadgerNet, and ongoing data validation work is underway. The service has recognised and escalated these challenges, with targeted operational and digital actions in place to improve performance oversight, data quality and timely access to care.

Antenatal Assessment Unit Feedback

Caring, Professional and Reassuring Staff

The most consistent theme across all responses is the quality of staff interactions.

Women described staff as:

Kind, lovely, helpful, professional, fantastic, reassuring.

All respondents who commented on their interaction with midwives felt listened to and understood, contributing to positive experiences and confidence in the care provided.

High Satisfaction with Care

Most respondents reported being very satisfied with the advice received and the outcome of their contact with AAU.

Women felt:

Their concerns were taken seriously.

Appropriate reassurance was provided.

Decisions about assessment and care were clearly explained.

Supported throughout their pregnancy journey.

Several respondents stated they would not change anything about their experience.

Positive Telephone Contact

Most women found contacting AAU easy, particularly when using the direct telephone number. The direct line appears to be valued by those who have access to it.

Telephone Accessibility

One respondent reported significant difficulty reaching the service, describing repeated unanswered calls before eventually accessing support through another route.

Telephone Menu Navigation

One respondent felt the automated menu system was too long and could be frustrating, particularly in urgent situations or during labour.

Communication During Waiting Times

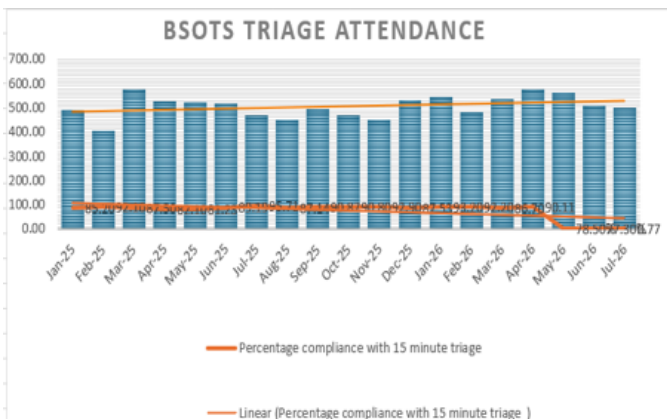
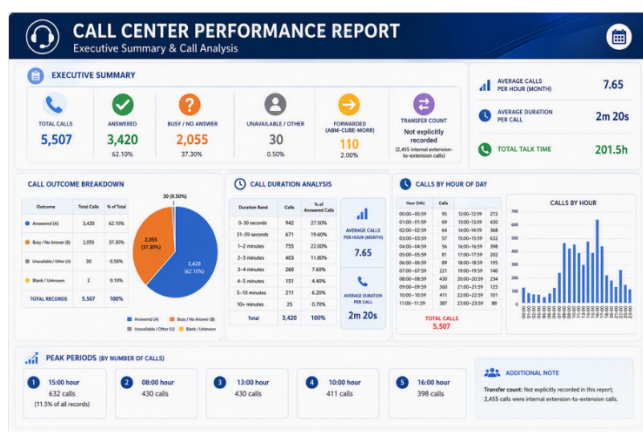
One respondent described waiting over an hour for assessment and felt there was limited communication regarding delays.

Patient Comfort While Waiting

One respondent reported being offered water which was not subsequently provided, suggesting an opportunity to strengthen attention to comfort measures for women waiting to be seen.

What are we doing to improve?

The service has introduced a single point of telephone access for maternity care, making it easier for women to access advice and support. Work is ongoing to improve call handling capacity, strengthen digital reporting, validate data quality and better understand demand across the service. Feedback from women and families is also being used to inform service improvements.

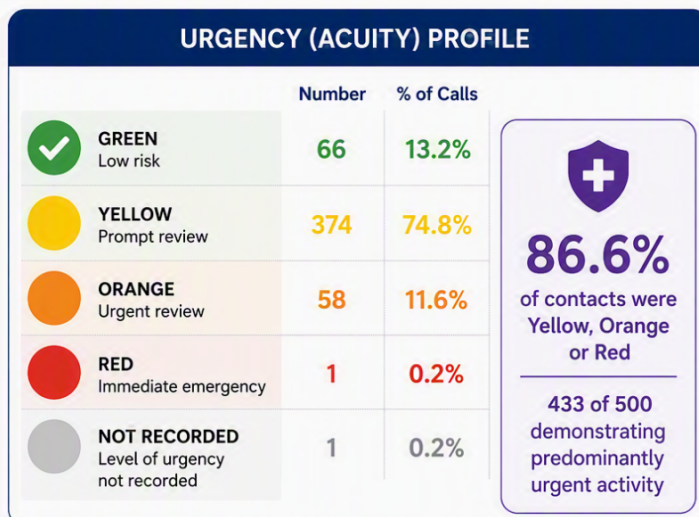
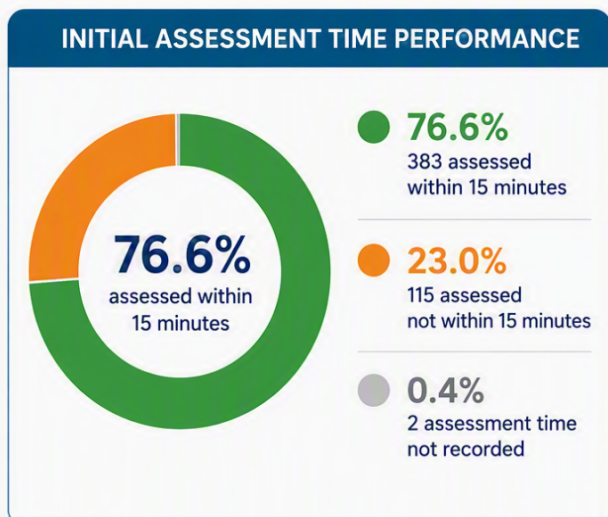


Board Assurance

Maternity triage services continue to provide safe and timely assessment of women, supported by robust clinical oversight, improved access arrangements and ongoing service improvement activity.

INITIAL TRIAGE ASSESSMENT – JULY 2026

Total Attendances: 500



KEY MESSAGE

86.6% (433/500) of triage contacts were Yellow, Orange or Red, demonstrating that the service is managing predominantly urgent presentations.



DATA SOURCE

Initial Triage Assessment
July 2026

Percentages may not total 100% due to rounding.

3.7 Third and fourth-degree tears

What are we measuring?

We monitor severe perineal tears that can occur during vaginal birth. These injuries can have a significant impact on a woman's physical recovery and wellbeing, making prevention, early identification and treatment important measures of maternity care quality.





How are we performing?

Performance remains within the expected national range and has improved compared to the previous year. The Health Board's rate in 2025 was 3.37%, compared with 4.08% in 2024, and remains consistent with national benchmarking data. Recent variation is within normal expected limits and there are no current concerns regarding performance.

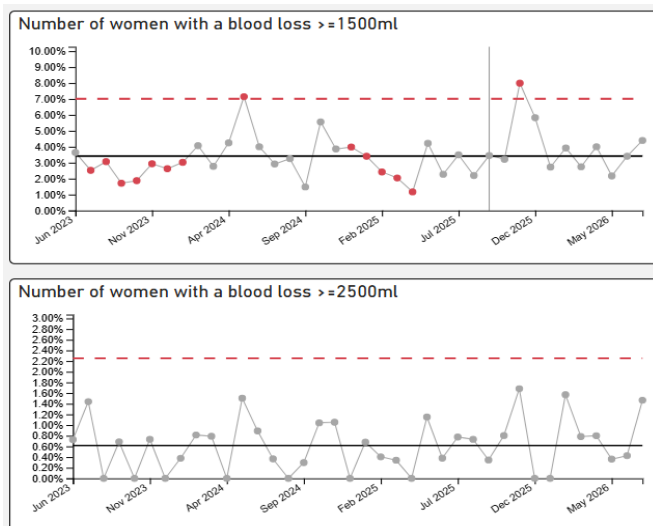
What are we doing to improve?

The service continues to review all severe tears and monitor trends through the Maternity Dashboard. Audit work focuses on births associated with a higher risk of perineal trauma, including instrumental births, to support learning and identify opportunities for improvement. The services compliance with PROMPT training for these births remains at or above expected compliance rates. The introduction of BadgerNet will provide enhanced data analysis, helping the service better understand risk factors and target improvement activity.

Board Assurance

Performance is improving and remains in line with national expectations. Ongoing monitoring, audit and quality improvement work provide assurance that risks are identified early, and learning is translated into practice.

3.8 Postpartum Haemorrhage



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

July 2026 – PPH >1500ml rate is 4.41% and PPH >2500ml is 1.47%

What are we measuring?

We monitor cases of significant bleeding following birth, known as postpartum haemorrhage (PPH). This is an important measure of maternity safety as severe bleeding can have a significant impact on a woman's recovery and, in rare cases, can become life-threatening if not recognised and treated promptly.

How are we performing?



Performance remains favourable when compared with national benchmarks. The Health Board's postpartum haemorrhage rate reduced from 3.51 per 1,000 births in 2024 to 2.49 per 1,000 births in 2025, which is below the latest published national rate. During this reporting period, all identified cases were reviewed and managed appropriately, with no concerns identified regarding the quality of care provided.

What are we doing to improve?

All cases of significant postpartum haemorrhage continue to be reviewed through established multidisciplinary governance processes to identify learning opportunities and support continuous improvement. Ongoing monitoring, clinical surveillance and the transition to enhanced digital reporting through BadgerNet will strengthen oversight and support further improvements in the quality and reliability of data.

Board Assurance

The service continues to demonstrate safe management of postpartum haemorrhage, with performance remaining below national benchmarks and robust monitoring, review and assurance arrangements in place.

Performance remains within expected variation and below national benchmarks; robust oversight continues during data transition, with no immediate safety concerns identified.

3.9 Maternal Intensive Care Unit (ICU) Admissions

What are we measuring?

We monitor the number of women who require admission to an Intensive Care Unit (ICU) or other higher-acuity care settings during pregnancy or after birth. This helps us understand the severity of maternal illness and provides assurance that women who become seriously unwell receive timely specialist care.

How are we performing?

Maternal intensive care admissions remain rare. There have been no maternal ICU admissions since September 2024. One recent admission following caesarean birth and significant postpartum haemorrhage was managed appropriately, with established escalation and clinical care processes followed throughout.

What are we doing to improve?

The service maintains clear pathways for identifying and escalating women who require higher levels of care, supported by close collaboration between maternity, intensive care and emergency care teams. All admissions are reviewed through established governance processes to identify learning and ensure continuous improvement. Real-time monitoring arrangements provide additional oversight of women receiving care outside maternity services.

Board Assurance

Robust joint SOP embedded in practice, escalation pathways, effective multidisciplinary working and strong governance arrangements provide assurance

that women requiring critical care receive safe and timely treatment, with no immediate concerns identified.

3.10 Learning from Safety Incidents

What are we measuring?

Safety incidents, investigations, learning outcomes and implementation of improvement actions.

How are we performing?

Incident reporting continues to demonstrate a positive culture of openness and learning. Governance processes remain robust and there has been continued improvement in the review and closure of incidents.

Learning themes remain broadly consistent with previous reporting and relate to communication, escalation, clinical documentation, care pathway compliance and service pressures.

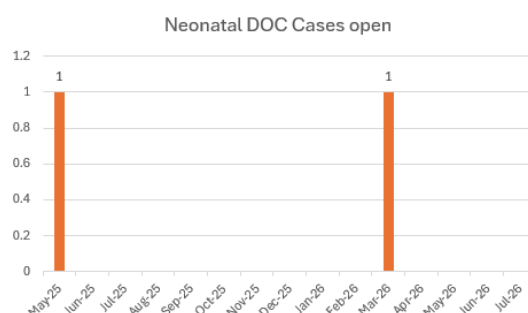
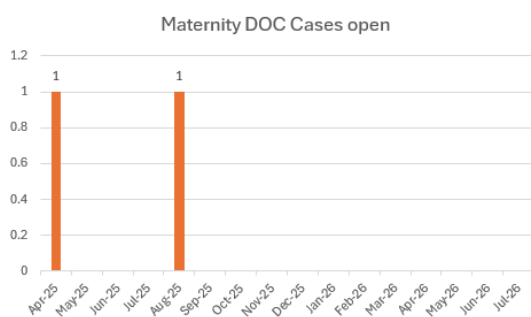
What are we doing to improve?

Learning continues to be disseminated through governance forums, safety huddles, multidisciplinary reviews, professional leadership meetings and education programmes. Improvement actions are monitored through established governance processes to ensure sustainable practice change.

Board Assurance

The Committee can be assured that incidents continue to be identified, reviewed and acted upon appropriately, with evidence of learning being translated into service improvement.

Perinatal DoC cases – as of 01.06.2026

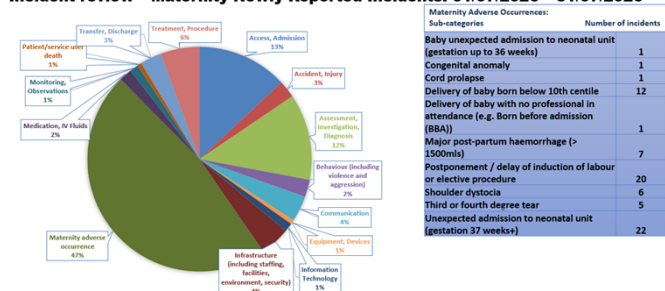


A further break down of incidents in relation trigger categories can be seen in the chart below:

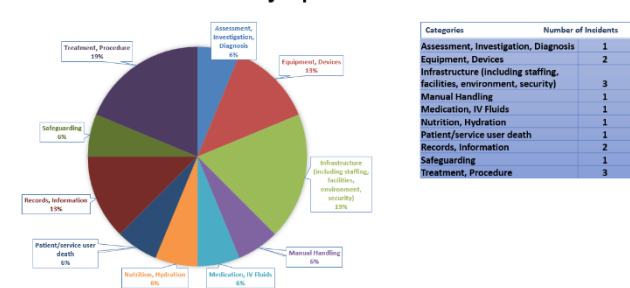
Types of incidents – Perinatal Services – 01/05/26 -31/05/2026



Incident review – Maternity Newly Reported Incidents: 01/07/2026 – 31/07/2026



Incident review – Neonatal Newly Reported Incidents: 01/07/2026 – 31/07/2026



3.11 Patient Feedback and Experience

Patient Feedback and Experience

What are we measuring?

Feedback from women, families and partners regarding their experiences of maternity and neonatal care.

How are we performing?

Overall patient feedback remains positive, with women and families consistently describing care as compassionate, professional and supportive.

Themes identified through patient feedback continue to relate to communication, waiting times, induction of labour experience, postnatal care and access to services.

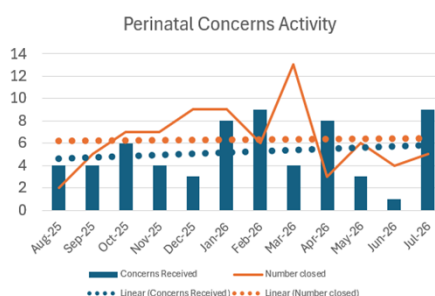
What are we doing to improve?

A coordinated patient experience improvement programme remains in place with actions linked to feedback themes. Work continues through the Maternity Experience Action Plan, community engagement activity and targeted service improvement initiatives.

Board Assurance

The service continues to actively seek, listen to and respond to feedback, ensuring that the voices of women and families directly influence service development and improvement.

Perinatal Concerns Outstanding – As at 03.08.2026



- Perinatal Services have 9 open concerns – 2 of which are currently overdue:-
- 1 response awaited from External Investigation Team response (chased)
- 1 response awaiting Paediatric approval



3.11.1 Engagement with Diverse Communities – Maternity Services

What are we measuring?

How well maternity and neonatal services listen to, understand and respond to the needs of people from all communities, particularly those who may experience poorer outcomes or barriers to accessing care.

How are we performing?

Partnerships with community organisations continue to grow, helping the service engage with a broader and more diverse range of women and families. Feedback from communities is increasingly informing service development, with improvements in accessibility, representation and inclusive care approaches.

What are we doing to improve?

The service is expanding engagement with underrepresented communities, strengthening culturally responsive care, improving access to information and developing targeted initiatives to support inclusion. This work is helping to ensure that services are designed with, rather than for, the communities they serve.

Board Assurance

The service demonstrates a strong commitment to reducing inequalities and improving equity of access, experience and outcomes, supported by meaningful engagement, co-production and ongoing improvement activity.

3.11.2 Equity, Inclusion and Community Engagement

What are we measuring?

How effectively we engage with diverse communities, partners and families to ensure maternity and neonatal services are inclusive, representative and shaped by lived experience.

How are we performing?

Engagement activity has continued to expand, with new and strengthened partnerships helping to ensure a broader range of voices contribute to service improvement. Community engagement has increased through initiatives such as Visible Voices and partnerships with organisations including the Mothers and Toddlers Foundation and Chinese in Wales. Digital engagement has also grown, with refreshed social media platforms and educational resources helping families access information and support more easily.

What are we doing to improve?

We are continuing to strengthen opportunities for co-production and participation. Current work includes the development of inclusive educational resources, culturally representative clinical imagery, expansion of digital engagement platforms, and the development of projects to improve representation and personalised care. Feedback from women, families and community partners is being used to inform service



design, communication and improvement priorities. Governance arrangements have also been strengthened through a single maternity experience action log that tracks and monitors actions arising from engagement activity.

Visible Voices Project Update

- Engagement has been completed with 8 community groups, with 49 survey responses received.
- Key themes identified through both family and staff feedback have been collated and shared with the artist Lauren Rebbeck to inform development of the artwork.
- The artist has also been provided with photographs of maternity environments, the Swansea area and staff uniforms to support accurate and locally representative illustrations.
- Discussions have taken place regarding potential artwork locations and formats, considering how individual pieces could best reflect and complement the spaces in which they are displayed.
- Many options for artwork discussed based on family and staff feedback. One option discussed was a story-style montage representing and IVF journey, which could be displayed within the antenatal clinic.
- The artist has now received the full feedback and supporting information required to begin developing the artwork.
- Next Steps: Awaiting the artist's first draft illustrations for review and feedback.

Board Assurance

There is increasing evidence that women, families and community partners are influencing service development and improvement. Strong governance, growing community partnerships and a coordinated engagement approach provide assurance that equity, inclusion and lived experience remain central to service delivery and future planning.

Engagement Spotlight – Strengthening Partner Voice

In collaboration with community organisations and families, the service is developing more inclusive patient information and educational resources. This includes work to improve the representation of caesarean wound healing across diverse skin tones, supported by clinical experts, community partners and people with lived experience. The project demonstrates our commitment to co-production, health equity and ensuring information reflects the diverse communities we serve. Plans are in place to make these resources available through digital platforms, BadgerNet and clinical environments.

3.12 Digital Transformation – BadgerNet

What are we measuring?

The implementation and maturity of the BadgerNet Electronic Patient Record and the quality of performance reporting.

How are we performing?

BadgerNet implementation continues to progress successfully. Data validation and reporting development remain ongoing, reflecting the complexity of transitioning from legacy systems to a fully digital environment.

Some performance indicators continue to require validation and should therefore be interpreted with caution during this transitional phase.



What are we doing to improve?

Work continues with Digital Services and system suppliers to enhance data quality, reporting functionality and dashboard development. Additional validation processes have been implemented to strengthen confidence in future metric reporting.

Board Assurance

The Committee can be assured that governance arrangements remain robust throughout the digital transition and that existing safety, quality and operational oversight processes continue to provide assurance.

3.13 A Skilled and Supported Workforce

What are we measuring?

How we ensure staff receive the training, education and support needed to provide safe, compassionate and effective care.

How are we performing?

Most maternity and neonatal staff continue to complete the training required for their role, with compliance levels remaining above national expectations in most areas. This provides assurance that women and babies are cared for by teams with the knowledge and skills required to respond to both routine and complex situations.

What are we doing to improve?

We continue to invest in staff development through simulation, specialist education, leadership development and mandatory training programmes. Where gaps are identified, targeted improvement plans are put in place to support teams and ensure compliance is restored quickly.

Board Assurance

Our workforce continues to demonstrate a strong commitment to learning and professional development, helping to ensure women, babies and families receive safe, high-quality care delivered by skilled and competent teams.

Workforce – Establishments and Vacancies – July 2026

Grade	Establishment (WTE)	Vacancy
Consultant	11	0
Speciality Doctor	15	1.4 (Tier 2) →
BA Nurse Practitioner	4	0
BB Nurse Practitioner	2	0

Speciality	Band	Funded WTE	Vacancy (WTE)	Required RAPH Standard WTE	Shortfall WTE
Speech & Language Therapy	7	0.5	0.0	1.5	1.0
Dietetics	7	0.5	0.5	1.8	1.3
Physiotherapy	7	0.5	0.0	1.85	1.35
Occupational Therapy	7	0.5	0.0	1.45	0.95
Psychology	8b	0.5	0.0	3.24	2.74
TOTAL	-	2.5	0.5	9.84	7.34

Band	Establishment (WTE)	Vacancy (WTE)
7	13.92	0 ↓
6	32.09	10.57 ↓
5	35.38	Over 14.64 →
4	3.41	0.96 →
3	2	0
2 HCSW	2.40	1.6 →
2 Admin	2.84	0

- Band 6 posts -1.0 wte to be externally advertised and 8.96 wte under Annex 21 internal interview day set 19 Aug 11 applicants.
- Awaiting update from Service Group regarding Neonatal Ward Assistant that is with Executive Panel

Workforce – Establishments and Vacancies – July 2026

Grade	Establishment (WTE)	Vacancy
Consultant	22	0
Speciality Registrar	13	0

Band	Establishment (WTE)	Vacancy (WTE)
Neath	3.57	0
Singleton	7.83	1 →

Band	Establishment (WTE)	Vacancy (WTE)
Band 7	8	0
Band 6	37.48	0.31
Band 3 (MSW)	5.69	0.45
Band 3 (MCA)	6.8	1.8

Band	Establishment (WTE)	Vacancy (WTE)
7	12.96	1.28 →
6	74.36	11.32 ↓
5	17.72	→
4	8.53	2.13 →
3	25.59	4.68 →
2	5.69	1.69 →

Newly Qualified Midwives commence in service at band 5 with progression to band 6 expected. The current over establishment at band 5 will reduce the band 6 vacancy.

Appointment of 4 Middle Grades & 1x Oba & Gyna Consultant



Perinatal workforce Training and Compliance – July 2026

Statutory and Mandatory Training	June 25	July 25	Aug 25	Sept 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26	Mar 26	Apr 26	May 26	June 26	Jul 26
* Welsh Government Target														
Medical Staff														
Obstetric	78%	91%	85.4%	81%	81.0%	85.4%	88.95%	89.95%	89.95%	88.32%	89.98%	89.98%	91.40%	90.38%
Neonatal	87.1%	86%	84.8%	76.3%	80.4%	88.63%	88.92%	88.92%	93.14%	94.12%	95.89%	95.89%	94.74%	95.36%
Additional Clinical Services														
Maternity	92.9%	94%	93.5%	91.5%	91.5%	93.0%	93.0%	91.73%	91.73%	91.51%	91.11%	91.11%	93.84%	92.87%
Neonatal	100%	100%	100%	97.3%	97.3%	97.3%	97.3%	97.37%	97.37%	93.42%	94.74%	94.74%	96.05%	98.68%
Nursing and Midwifery														
Maternity	95.5%	96%	96.1%	94.8%	94.8%	95.4%	95.4%	94.92%	94.92%	92.95%	95.01%	95.01%	95.16%	94.89%
Neonatal	95.2%	95%	95.6%	92.4%	92.4%	95.2%	95.2%	95.81%	94.49%	93.33%	95.89%	93.33%	96.41%	96.83%

Workforce – Training Compliance – July 2026

Maternity Training	Sept 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26	Mar 26	Apr 26	May 26	Jun 26	Jul 26
Obstetric Medical Staff	100%/91%	95%	95%	95%	96%	95%	96%	97%	98%	98%	98%
Midwifery	97%	95%	91%	91%	97%	97%	96%	97%	96%	97%	95%
Anaesthetics	100%	100%	98%	98%	98%	97%	98%	97%	98%	98%	95%
Community PROMPT			90%	93%	94%	94%	97%	97%	97%	96%	95%
Fetal Surveillance	99%	88%	98%	98%	98%	98%	100%	99%	99%	99%	97% (95%)
Maternity Workshop			14%	20%	32%	39%	45%	52%	57%	63%	66%
NLS	96%	94%	94%	96%	97%	97%	97%	98%	97%	97%	98%
Gap Grow											
Obstetric	71%	71%	88%	100%	100%	100%	92%	100%	100%	100%	
Midwives	80%	90%	87%	87%	90%	92%	85%	87%	87%	92%	91%
Safeguarding											
Safeguarding People (7/21)											
Midwives	96.23%										
Obstetricians	87.76%										

Workforce – Training Compliance – July 2026

NLS	Sept 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26	Mar 26	Apr 26	May 26	Jun 26	Jul 26
Nursing	95%	88%	88%	87%	87%	87%	92%	92%	92%	92%	92%
Consultants	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Junior - Tier 1	95.9%	96.0%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Junior - Tier 2	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Nurses Qualified in Specialty	Sept 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26	Mar 26	Apr 26	May 26	Jun 26	Jul 26
Module 1	58.0%	58.0%	58.0%	58.0%	58.0%	58.0%	58.0%	58.0%	58.0%	58.0%	58.0%
Module 2	58.0%	58.0%	58.0%	58.0%	58.0%	58.0%	58.0%	58.0%	58.0%	58.0%	58.0%

NLS figures will improve in March 2026, with two scheduled training courses.

MoNET Training	Compliance end of June
Consultants	0%
T1 + T2	0%
SNRP	0%
Band 7	0%
Band 6	0%
Band 5	0%
Total	0%

QIS figures unchanged.
5 neonatal nurses currently completing the QIS modules at 50% study leave due to staffing pressures. Planning to offer more places next year at risk.

MoNET training 0% due to plan new programme originally scheduled for January 2026. Training day's have been cancelled in since January, with predicted cancellation until January 2027.



3.14 Workforce Sustainability and Service Resilience

What are we measuring?

The availability, capability and sustainability of the maternity and neonatal workforce required to deliver safe care.

How are we performing?

Workforce challenges remain the most significant operational risk facing perinatal services. Vacancy levels, workforce unavailability and specialist workforce dependencies continue to place pressure on service delivery, although mitigation plans remain effective and no immediate safety concerns have been identified.

Recruitment activity continues across maternity, neonatal and specialist workforce groups. Temporary staffing arrangements, flexible deployment and risk-based escalation processes continue to support safe service delivery.

What are we doing to improve?

The service continues to progress recruitment activity, workforce planning initiatives and targeted retention programmes. Work is also underway to strengthen workforce sustainability through development of temporary staffing solutions, enhanced training opportunities and longer-term workforce planning aligned to service demand.

Board Assurance

Whilst workforce sustainability remains a significant organisational risk, mitigation measures remain effective and services continue to operate safely with appropriate governance, escalation and oversight arrangements in place.

3.15 Safe Care Environments





What are we measuring?

How effectively we prevent and control infection across maternity and neonatal services to keep women, babies, families and staff safe.

How are we performing?

The service continues to perform well against infection prevention standards, with high levels of compliance and no significant infection concerns identified during this reporting period. Audit results demonstrate continued improvement and sustained focus on maintaining safe clinical environments.

Infection prevention and control – July 2026

Compliance with national cleaning standards in line with national standards Compliance with hand hygiene audits in line with national standards

Ward	Nov 25	Dec 25	Jan 26	Feb 26	Mar 26	Apr 26	May 26	Jun 26	Jul - 26
NICU	97.9 %	97.9 %	97.9 %	97.9 %	97.9 %	97.9 %	97.9 %	97.9 %	100 %
Labour Ward	87.5 %	97.9 %	100 %	95.8 %	100 %	95.8 %	100 %	100 %	91.9 %
Antenatal	93.8 %	100 %	95.8 %	93.8 %	93.8 %	93.8 %	100 %	89.6 %	91.5 %
Ward 20/Post Natal	95.8 %	95.8 %	100 %	100 %	100 %	97.9 %	93.8 %	100 %	100 %
Ward 5 (SCBU)	98.8 %	97.9 %	95.8 %	95.8 %	95.8 %	93.8 %	97.9 %	97.9 %	93.8 %
NPT BC	100 %	Not done	100 %	100 %	100 %	100 %	100 %	100 %	100 %
Bay BC	97.8 %	95.6 %	97.8 %	97.8 %	100 %	97.8 %	97.8 %	100 %	97.8 %
Sing ANC	97.9 %	97.9 %	97.9 %	100 %	100 %	97.9 %	100 %	97.9 %	100 %
NPT ANC	Not done	100 %	100 %	100 %	100 %	100 %	100 %	100 %	100 %

Ward	Nov 25	Dec 25	Jan 26	Feb 26	Mar 26	Apr 26	May 26	Jun 26	Jul - 26
NICU	96.8 %	80 %	100 %	97.4 %	77.8 % Rot 100 %	100 %	96.9 %	93.1 %	100 %
Labour Ward	100 %	97.5 %	100 %	100 %	Not done	100 %	96.4 %	100 %	97.8 %
Antenatal	100 %	97.5 %	100 %	100 %	100 %	100 %	100 %	100 %	100 %
Ward 20/Post Natal	100 %	100 %	100 %	97.2 %	96.3 %	100 %	100 %	100 %	Not done
Ward 5 (SCBU)	100 %	97.2 %	100 %	96.7 %	100 %	100 %	96.2 %	100 %	97.3 %
NPT BC	100 %	100 %	100 %	100 %	100 %	100 %	100 %	98.3 %	100 %
Bay BC	97.8 %	100 %	97.6 %	100 %	97.8 %	100 %	95.6 %	100 %	97.1 %
Sing ANC	100 %	100 %	96.7 %	100 %	100 %	100 %	100 %	100 %	100 %
NPT ANC	Not done	100 %	100 %	100 %	100 %	100 %	100 %	100 %	100 %

What are we doing to improve?

We continue to monitor infection prevention practices through regular audits, staff training and improvement programmes. Where opportunities for improvement are identified, actions are implemented promptly and monitored through established governance arrangements. A recent audit identified a significant deterioration in compliance within an area that has historically demonstrated consistently strong performance. This result is recognised as an outlier when viewed against previous assurance activity and does not reflect the ward's usual standards. A detailed review has been undertaken to understand the factors contributing to this variation, and a targeted improvement plan has been implemented. Enhanced leadership oversight, increased audit frequency, spot-checks, and focused reinforcement of expected standards are now in place to provide assurance that improvements are being embedded and sustained. The position will continue to be closely monitored through established governance arrangements and reported through the assurance framework.

Board Assurance

Strong infection prevention arrangements remain in place, providing assurance that women and babies continue to receive care in safe and well-managed clinical environments.

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

What are we measuring?

NNAP and PERIPrem Cymru provide assurance on the quality and consistency of care delivered to preterm and vulnerable babies. These measures assess whether babies receive evidence-based interventions known to improve neonatal outcomes, including delivery of the PERIPrem optimisation bundle and timely provision of breastmilk following birth. They help us understand how effectively the neonatal service delivers key elements of high-quality neonatal care and identify opportunities for improvement.

How are we performing?

There are no new NNAP audit findings to report this period, and performance remains consistent with previous reporting. The next formal NNAP Cymru update is expected later in 2026. Current PERIPrem performance remains reassuring, with most pathway measures continuing to perform at or above expected levels, demonstrating sustained delivery of evidence-based care. The PERIPrem bundle optimisation score for June was 74%, reflecting continued strong performance across the neonatal pathway. Early breastmilk provision within six hours of birth increased from 71% in May to 50% in June based on available data; however, these results should be interpreted cautiously as data collection remains incomplete and further validation is required. Overall, performance remains robust and there is no indication of a wider performance concern currently.

What are we doing to improve?

The service continues to actively monitor performance across all NNAP and PERIPrem measures and reviews cases through established governance arrangements. Work is ongoing to complete outstanding case analysis, strengthen data collection processes and improve reporting completeness following recent data transitions. Focus continues to be placed on optimising delivery of the PERIPrem care bundle and improving early breastmilk provision for preterm babies. This work will provide more comprehensive assurance regarding pathway performance and support identification of any additional improvement opportunities.

Board Assurance

Performance across the neonatal optimisation pathway remains strong and consistent with previous reporting. Most care measures continue to perform at or above expected levels, providing assurance that evidence-based neonatal interventions are being delivered reliably. Whilst some data validation and outstanding case review remain in progress, there are currently no concerns indicating deterioration in care quality, and robust governance arrangements remain in place to monitor performance and support ongoing improvement.



PERIPrem - July 2026

July 2026

6 Infants

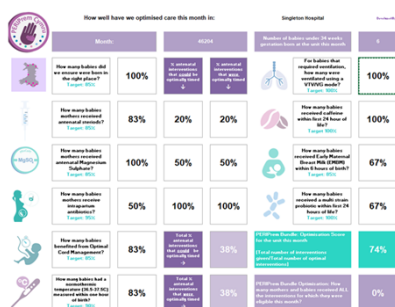
- 2 x 28 - 32w6
- 3x 32 - 34w6
- 3x 32 - 35w6

4 were EM LSCS

- 1 x 28/40 ex utero transfer from PCH, Gross fetal hydrops identified day of delivery (unable to optimise)
- 2 x (twins) background of PROM - Path CTG twin 1
- 1 x APH no optimisation, surviving twin, Congenital anomaly other twin (planned comfort care after birth)

2 were SVD

- 74% of infants received the whole PERIPrem bundle



3.17 Avoiding Term Admission into Neonatal services.

What are we measuring?

We monitor the number of babies born at term who require admission to the neonatal unit. Reducing avoidable admissions is important as it helps keep mothers and babies together, supports early bonding and breastfeeding, and ensures neonatal care is focused on babies who require specialist support.

How are we performing?

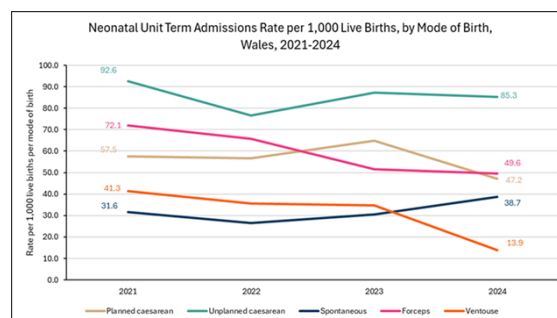
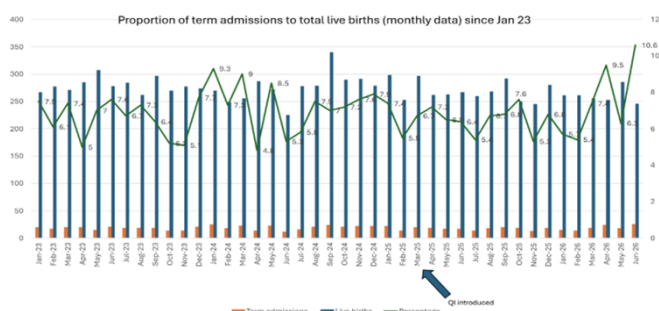
The service continues to review term admissions in real time, and the monitoring process has now moved into business-as-usual governance arrangements. Analysis shows that respiratory distress remains the most common reason for admission, with approximately 70% of these admissions occurring in babies born following planned caesarean birth. This has provided valuable insight into the main drivers of neonatal admission and supports targeted improvement activity.

What are we doing to improve?

A focused quality improvement programme has been implemented to reduce avoidable neonatal admissions related to respiratory distress. Since April, babies requiring respiratory support following birth have been offered high-flow oxygen therapy at the bedside for up to one hour before a decision is made regarding neonatal admission. This approach aims to support babies in remaining with their mothers wherever it is safe to do so, reducing unnecessary separation and improving the early family experience. The service continues to review admissions, analyse contributing factors and identify further opportunities for improvement.

Board Assurance

The service has a clear understanding of the key drivers of term neonatal admission and has implemented targeted improvement actions to address them. Real-time monitoring, routine review and focused quality improvement activity provide assurance that avoidable admissions are being actively addressed, with a continued focus on keeping mothers and babies together whenever clinically appropriate.



3.18 Risk Register

What are we measuring?

Strategic and operational risks affecting maternity and neonatal services.

How are we performing?

The risk profile remains stable with risks reviewed routinely through established governance processes. Key risks continue to relate to workforce sustainability, specialist workforce capacity, neonatal medical staffing, sonography capacity, national training dependencies and service demand.

A new risk relating to ultrasound surveillance capacity has been added to reflect increasing demand and workforce pressures.

What are we doing to improve?

Mitigation plans remain in place for all principal risks and continue to be monitored through Perinatal Committee, Quality and Safety Committee and Perinatal Improvement Programme governance arrangements.

Board Assurance

The Committee can be assured that risks are well understood, appropriately escalated and actively managed through established governance structures.

3.19 Quality Improvement Approach, Methodology and Programmes

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

A detailed plan was presented in the January 2026 report to QSC and Board, further updates will be represented in the report as these are formulated and once able to report outcomes and impact. This also applies to any quality improvement programmes which was presented in January.

3.20 National Awards.

Swansea Bay University Health Board's maternity and neonatal services continue to demonstrate excellence through strong patient validated recognition and

organisational accolades. In the past year, the service has secured multiple acknowledgements that reinforce its commitment to high quality, compassionate and continuously improving care.

A multi-disciplinary and multi-professional team at Swansea Bay have been shortlisted for their work on psychological safety and speaking up in maternity services. The team developed a practical workshop based on feedback from the clinical teams to address an important area of patient safety. The HSJ Awards are prestigious national patient safety awards and we are delighted that the work of this team has been recognised and considered for these awards.

Their work spanned working at two points in a professional's journey: bringing student midwives and medical students together through interprofessional simulation creating a space within our existing multi-professional workforce education to explore civility, hierarchy, psychological safety, active bystander approaches and speaking up. The team also drew on service-user experience with input from the Maternity, Neonatal Voices Partnership to bring the perspective of women and birthing people in the educational work.

Early evaluation of their work from our teams has been encouraging, including around confidence to speak up, communication and perceptions and being heard when it matters.

3.21 HIW Inspection Summary – Singleton Maternity Services (Feb 2026)

What are we measuring?

We monitor progress against findings and recommendations arising from Healthcare Inspectorate Wales (HIW) inspections. This includes assessing compliance with regulatory requirements, monitoring delivery of improvement actions and ensuring that learning is translated into sustainable improvements in safety, quality, governance and patient experience. The aim is to provide assurance that services continue to improve and meet the standards expected by women, babies, families and regulators.

How are we performing?

The HIW improvement plan has been approved, published and is actively progressing through established governance arrangements. Inspection findings identified several strengths across maternity and neonatal services, alongside opportunities for improvement, many of which were already recognised through existing governance and quality processes. Progress continues to be demonstrated across governance, workforce compliance, risk management, escalation arrangements and quality improvement activity. Oversight of actions has been strengthened through the ward-to-Board reporting model and Perinatal Committee governance arrangements.

What are we doing to improve?

A comprehensive improvement programme is in place to deliver the HIW action plan. This includes strengthening governance systems, enhancing quality management processes, improving escalation arrangements, developing workforce capability, embedding learning through audit and review, and improving consistency of care and documentation. Delivery is supported through the Perinatal Improvement Programme, Perinatal Committee, Quality and Safety Committee and wider Health Board governance structures. Progress is routinely monitored, with actions tracked against agreed milestones and subject to executive oversight.

Board Assurance

The Board can be assured that the HIW improvement plan is actively progressing and supported by strengthened governance, oversight and accountability arrangements. There is clear evidence that inspection findings have been incorporated into existing improvement programmes, with learning translated into measurable changes across maternity and neonatal services. No overdue actions have been identified, and ongoing monitoring provides assurance that improvements are being embedded into routine practice and service delivery.

4. OPEN AUDIT RECOMMENDATIONS

Open audit recommendations relate primarily to system strengthening rather than concerns about unsafe care.

The Perinatal Committee maintains oversight of a small number of open audit related actions arising from internal reviews, external assurance activity and national audit programmes (including MBRRACE UK and NMPA), together with recommendations emerging from the Independent Review and All Wales Perinatal Assurance processes.

These recommendations are embedded within the Perinatal Improvement Programme and are tracked through established governance arrangements, with clear executive ownership, defined milestones and progress reporting via the Perinatal Improvement Programme Executive Board and Perinatal Committee.

Current open actions focus on:

- strengthening digital infrastructure and interoperability (including implementation of computerised CTG and optimisation of BadgerNet functionality);
- improving reliability and completeness of data capture and reporting (e.g. surgical site infection surveillance and demographic data completeness);
- enhancing consistency of clinical pathways and escalation processes through training, audit and quality improvement activity;
- further embedding learning from audit and review into education, supervision and multidisciplinary practice.

The Board can be assured that there are no outstanding audit recommendations indicating immediate risk to patient safety, and that all open actions are actively managed within the agreed improvement programme, with progress subject to routine scrutiny and escalation through Quality and Safety Committee where required.

• **FINANCIAL IMPLICATIONS**

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

• **RECOMMENDATION**

BE ADVISED THAT;

- Perinatal Services continue to provide safe care within a context of ongoing workforce fragility, specialist capacity constraints, digital transition and wider system dependencies.
- July 2026 data demonstrate areas of positive assurance, including maintained service delivery, strong training compliance across most workforce groups, effective infection prevention arrangements and active governance oversight.
- Digital reporting remains in transition following BadgerNet implementation, and some metrics should continue to be interpreted with caution while data validation and reporting optimisation are completed.

BE ASSURED THAT;

- Governance arrangements remain in place across maternity and neonatal services, with incident review, mortality review, patient experience, risk management and improvement activity monitored through established structures.
- Infection prevention and control performance remains strong, with no reported *C. difficile*, *E. coli*, *Staphylococcus aureus* or *Pseudomonas* bacteraemia cases in July across maternity and neonatal services.
- Patient feedback continues to be actively reviewed and used to inform service improvement, with positive feedback evident alongside clear themes for improvement.
- The proposed serial growth scan pathway would preserve enhanced surveillance for women and babies with identified or emerging clinical concerns.

BE ALERTED TO;

- Ongoing workforce sustainability risks across maternity, neonatal nursing and neonatal medical rotas.
- Ongoing specialist service risks, including paediatric radiology support, MoNET training, neonatal transport and sonography capacity.
- Review timeliness pressures in relation to incidents, ATAIN reviews, PMRT reports and concerns where external dependencies or senior approval are required.

- The need to maintain careful oversight of digital data quality during the transition to BadgerNet-enabled reporting.

DECISION REQUIRED;

- To approve the revised serial fetal growth surveillance pathway from routine 3-weekly to 4-weekly scanning for women on a routine surveillance pathway where there is no identified clinical concern for fetal wellbeing.
- To approve the amendment to smoking-related growth scan eligibility so that serial growth surveillance is offered to women identified as smokers at booking, rather than based on smoking status at conception.
- To support the introduction of uterine artery Doppler assessment at the routine 20-week fetal anomaly scan, subject to workforce training, competency assessment and operational implementation arrangements.
- To note that recruitment to vacant sonography capacity must continue and that the pathway change should not be interpreted as justification for establishment reduction.

The service continues to provide safe, compassionate and high-quality care, with no immediate safety concerns identified, and a strong focus on continuous improvement.



Governance and Assurance

Strategic Objectives

Strategic Objectives (please choose which is impacted)	People of Swansea Bay live healthier, fairer and more prosperous lives	☒
	Care is high quality, safe, efficient and delivers the best possible outcomes for people in partnerships	☒
	Care is delivered in partnership with our communities in safe and appropriate setting, supported by innovation	☒
	The health board is a great place to work where staff feel valued and work together towards a common goal	☒
	The health board is a resilient, sustainable and responsible organisation	☒

Health and Care Standards

Standards (please choose which applies)	Safe Care	☒
	Timely Care	☒
	Effective Care	☒
	Efficient Care	☒
	Equitable care	☒
	Person-centred Care	☒
	Staff and Resources	☒
Enablers (please choose which applies)	Whole Systems Approach	☒
	Leadership	☒
	Workforce	☒
	Culture	☒
	Information	☒
	Learning, Improvement and Research	☒

Quality, Safety and Patient Experience

The Perinatal Committee reports directly to the Quality and Safety Committee and is noted through Service Group Quality, Safety and Risk Group and Senior Leadership Team governance arrangements.

The Committee continues to receive assurance relating to clinical outcomes, safety, patient experience, workforce, governance, risk and service sustainability. The Committee remains assured that established governance arrangements support oversight of quality, safety and patient experience across maternity and neonatal services.

Financial Implications

Whilst no immediate financial implications arise directly from this report, several areas continue to have potential resource implications, including workforce sustainability, implementation of the Perinatal Improvement Programme, digital transformation activities and ultrasound service



capacity. Recruitment to vacant sonography and specialist workforce posts remains essential to support long-term service sustainability.

Legal Implications (including equality and diversity assessment)

No specific legal implications are identified within this report.

The proposed amendments to the Serial Growth Scan Surveillance Pathway have been developed following review of available evidence, benchmarking and risk assessment processes. Equality and Quality Impact Assessments have been completed or are being progressed through the appropriate governance arrangements.

Staffing Implications

Workforce sustainability remains one of the principal risks for maternity and neonatal services. Challenges remain in relation to maternity, neonatal and specialist workforce capacity, including sonography services, neonatal medical staffing and recruitment to substantive vacancies.

Mitigations remain in place, including flexible deployment, temporary staffing solutions, recruitment activity and workforce planning. No current staffing risks require escalation beyond existing governance arrangements; however, workforce sustainability remains subject to ongoing monitoring and oversight.

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

The work of the Perinatal Committee and Perinatal Improvement Programme continues to deliver significant long-term benefits for women, babies, families, communities and staff.

The actions contained within this report contribute to:

A Healthier Wales

Through continued focus on reducing avoidable harm, improving maternity and neonatal outcomes, strengthening fetal surveillance, enhancing patient experience and supporting earlier intervention.

A More Equal Wales

Through targeted engagement with diverse communities, reduction of health inequalities, culturally responsive care and equitable access to services.

A Wales of Cohesive Communities

Through co-production, enhanced patient engagement, partnership working and incorporation of lived experience into service development.

A Resilient Wales

Through workforce sustainability planning, digital transformation, strengthened quality management systems, improvement science and robust governance arrangements.



A Prosperous Wales

Through prevention, quality improvement, efficient use of resources, reduction of avoidable harm and development of sustainable service models that support long-term healthcare value.

Collectively, the improvement activity described within this report reflects a preventative, collaborative and long-term approach to improving outcomes for women, babies and families whilst supporting sustainable service delivery and fulfilling the organisation's responsibilities under the Well-being of Future Generations (Wales) Act 2015.

Report History

The Perinatal Committee reports directly to the Quality and Safety Committee and is noted through Service Group Quality, Safety and Risk Group and Senior Leadership Team governance arrangements.

Previous report: July 2026

Current report: August 2026

Appendices

Appendix 1: August Perinatal Dashboard (July 2026 Data)

Appendix 2: Review of Serial Growth Scan Surveillance Pathway (Decision Paper)



Meeting Date	24 September 2026	Agenda Item	5.5ii
Name of Meeting	SBUHB Board		
Report Title	Perinatal Improvement Plan Report		
Report Author	Programme Lead – Perinatal Improvement, Ffion Green		
Report Sponsor	Executive Director of Nursing and Patient Experience		
Presented by	Executive Director of Nursing and Patient Experience, Elizabeth Rix		
Freedom of Information	Open		
FoI Closed detail	If closed, choose detail		
Impact Assessment Summary Outcome		IA Completion date	
N/A		Click or tap to enter a date.	
Purpose of the Report	For Assurance		
Report Summary; detailing any action required			
The purpose of the paper is to: • Present an update on the Perinatal Improvement Plan, which addresses the implementation of each of the recommendations of the SBUHB Independent Review of Maternity and Neonatal Services; and • Details the progress made since the Review's publication.			
Key Issues			
• The paper provides progress to date on addressing the improvements outlined in our Perinatal Improvement Plan. • Highlights the outstanding actions needed to deliver the Review recommendations and present a detailed plan and how the organisation will achieve the improvements needed.			
Decision / Action required	No		
Recommendations			
Members are asked to: BE ASSURED; • The organisation has a comprehensive plan to address the recommendations of the SBUHB Independent Review of Maternity and Neonatal Services, Family Led Review of Maternity Services, and "Having a baby in Neath Port Talbot and Swansea Report" Llais Report and any actions required from the All-Wales Assessment of Perinatal Services. • Continued sustainable progress made since the publication of the Independent Review on key safety actions, including: ◦ Significant and sustained improvements in clinical outcomes for mothers and babies			



- A full-developed staffing model across all staff groups has improved workforce numbers and governance routes, including assurance, alert and escalation for staffing levels are embed as business-as-usual.
- Improved incident management, ensuring women, babies and families' voices are at the heart of investigations and reviews, with learning embedded in the service.
- Significant mitigation and improved process management has been implemented to manage the inherent risk of two-site work (Perinatal Services and Critical Care are not co-located).
- Maternity triage model implemented, tested and evolving based on staff and family feedback.
- Perinatal staff and other key services (including Critical Care) have been trained in key clinical safety interventions, including Early Warning Scores systems for both mothers and babies.
- Dashboard of key safety, workforce and feedback metrics embedded into business as usual. Underpinned by benchmarking against national datasets to provide oversight against best practice.
- Unification of Maternity and Neonatal Services under the umbrella of Perinatal Services has aligned the service and its reporting, providing a unified route for reporting via Perinatal Committee, through to Board level.
- Established and embedded governance and assurance structure for the Perinatal Improvement Plan and Perinatal business-as-usual, from Ward to Board. Underpinned by visible leadership including appointments to new leadership roles on a permanent basis.
- Quality improvement approaches are becoming increasingly embedded in the organisation providing a foundation for a learning culture.

BE ALERTED TO;

- **Two-site working:** While significant progress has been made in strengthening arrangements for women requiring care in non-maternity settings, including a number of Standard Operating Policies specifically outlining processes and escalation to admissions of pregnant women into non-maternity sites and workforce remodelling, there remains an inherent risk to this model of operation. Options for reconfiguration of service are being considered as part of the Transforming for the Future Programme.
- **Maternity Triage:** The 'Path to Safer Beginnings in Wales', published February 2026, has recommended the establishment of a national single point of access triage service for pregnant women, to be coordinated by the Welsh Ambulance Service Trust.





As such, the development of a standalone SBUHB model will not be continued. To mitigate risk while the national service is implemented, a 24/7 clinical triage unit has been established. The service offers advice by phone and in-person, women and their families can access timely advice about any concerns and be referred and signposted appropriately. Since the last report, a review of maternity triage has confirmed that the Single Point of Access line is supporting timely advice and appropriate signposting for women and families. The review also identified ongoing pressures around call volumes, telephone functionality and triage capacity. A Task and Finish Group is being established to oversee further mitigations, strengthen monitoring and support continued improvement, including the appointment of a dedicated triage telephone midwife role, and will report to Perinatal Committee for assurance.

- **Paediatric radiology:** Outsourcing of paediatric radiology provision for plain film x-ray as an interim mitigation measure has been live since February 2026. Cranial Ultrasound Scans are undertaken by the Neonatal team, underpinned by a Quality Assurance system. Provision for performing and interpreting other Ultrasound Scans and upper Gastro-Intestinal (GI) Contrast studies happens with support from Adult Radiology. There are system-wide national challenges in relation to paediatric radiology and there is a need for potential regional solution to provide long term assurance and sustainability of service provision, and discussions are ongoing with Cardiff and Vale University Health Board and the commissioners to explore suitable options.
- The Maternity and Neonatal Engagement, Insight and Coproduction Strategy has been drafted and will be further refined followed feedback from the Independent Oversight Panel. The next phase will include seeking engagement and feedback from partners including Llais, and development of a costed plan for engagement delivery.



PERINATAL IMPROVEMENT PLAN REPORT

1. INTRODUCTION

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

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

The report explains the changes that have been made and the differences women, babies and their families can expect when they receive Perinatal care (also known as Maternal and Neonatal care) in Swansea Bay.

2. BACKGROUND

2.1 The path to Perinatal Improvement

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

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

The Independent Review identified 10 priority recommendations as follows:

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





6. Improvements in governance processes
7. Attendance for all maternity staff for fetal monitoring training
8. Develop and implement a robust process for booking and prioritising women undergoing induction of labour.
9. Review and revise all policies and procedures within the maternity and neonatal service.
10. Develop and implement a wider engagement plan.

Due to the importance of the Perinatal Improvement Programme, Executive/Corporate Directors are named leads on the workstreams, with responsibility for strategic director and planning. Named leads within the Service Delivery Groups will ensure coordination of the operational activities necessary. These are described in detail in the Perinatal Improvement Plan (Appendix 1), but the Workstreams are summarised as follows:

- Workstream 1: Clinical Critical Safety Actions
- Workstream 2: Family Engagement
- Workstream 3: Workforce / leadership / education and training
- Workstream 4: Governance

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

2.2 Alignment of the Perinatal Improvement Plan with other national reviews

The Perinatal Improvement Plan is a live document and will evolve to incorporate findings and best practices from future local and national reviews. Since the previous update to Board in July 2026, a formal gap analysis has been completed and is appended to this paper (Appendix 1).

The gap analysis shows that the Perinatal Improvement Plan is well aligned to the national actions highlighted in the Ockenden and Amos Reports, with clear action already underway across governance, family engagement, learning from incidents, clinical safety pathways, workforce and culture, digital records, inclusion and Board assurance. The Plan demonstrates strengthened governance through routine Perinatal Committee, Quality & Safety Committee and Board reporting; delivery of key safety improvements such as single point of access maternity triage, the

Birmingham Symptom Specific Obstetric Triage System (BSOTS) model, Maternity Early Warning Score (MEWS) and Newborn Early Warning Trigger and Track 2 (NEWTT2), Badgernet digital records, Make Safe processes and reciprocal review arrangements; and a clear focus on listening to women and families through the Engagement, Insight & Coproduction Strategy, feedback mapping and always-on engagement.

The principal gap is not the absence of action, but the need to complete actions on trauma-informed psychological support, continuity of care, and anti-racism as an explicit safety priority. Proposals for the development of embedded Maternity and Neonatal Psychology-Led Therapeutic Service progressing through Service Group governance. The Director of Midwifery is leading the development of a Perinatal Strategic Framework which will include our plans for continuity of care and an in-depth understanding for future planning for our population's needs. We have begun to address equity, inclusion and discrimination within the Perinatal Improvement Plan, listening to the lived experience of women and families that experience barriers to accessing healthcare. We intend to strengthen the plan by making anti-racism explicit, measurable and governed as a patient safety priority. The Perinatal Services team are working with the Public Health team to better understand health inequalities in our population, including analysis of outcomes, incidents, complaints, access, experience and intervention rates by ethnicity and other protected characteristics.

3. GOVERNANCE AND RISK ISSUES

3.1 The Perinatal Improvement Plan Scorecard and outcome data and key critical safety metrics for the period July 2025 to July 2026

In response to the recommendation from the Independent Oversight Panel Chair in July 2026's Board meeting, a Perinatal Improvement Plan Scorecard (Appendix 2) has been developed, supported by outcome data and key critical safety metrics (Appendix 3), to enable clear tracking of actions and how we measure the associated outcomes and describing the difference made in the 12 months since the report was published. The scorecard uses up to three key metrics to highlight progress against the ten thematic recommendations of the Independent Review of Maternity and Neonatal Services in Swansea Bay. This strengthens our reporting by providing a clearer, evidence-based view of progress, impact and areas requiring continued focus. The scorecard is supplemented by an abridged reporting format against the four workstreams of the Perinatal Improvement Plan, linking actions to outcomes, metrics and the difference being made for women, babies, families and staff (Appendix 4). Narrative



progress against the four workstreams is provided in the next section of this report.

Progress against critical safety recommendations (Workstream 1)

We continue to make significant progress against the recommendations for critical safety. Since the July 2026 Board update, further progress has been made, with a continued focus on maternity triage, two-site working, clinical escalation, learning from incidents and safe delivery of care for women who present in non-maternity settings.

A review of the maternity triage service was completed in July 2026, drawing together feedback from clinical staff, patient and family experience, and activity data following implementation of the Single Point of Access line. This has confirmed that the model is positively supporting women to access timely advice and appropriate signposting, while also identifying areas requiring further mitigation, including call volumes, telephone system functionality, use of direct departmental numbers and the impact of call handling on clinical triage capacity. In response, a number of actions have already been completed, including reinforcing the use of the Single Point of Access number, removing alternative telephone numbers from the Health Board website and reviewing caller messaging. A Task and Finish Group is being established and led by the Head of Midwifery to oversee further improvement, including monitoring call volumes, triage breaches, Single Point of Access utilisation, digital reporting, telephone system issues and implementation of a dedicated triage telephone midwife role (estimated to be in post by March 2027). A plan has been developed and will be report to Perinatal Committee for assurance. This provides clearer operational oversight and assurance that risks are being identified, escalated and managed while national maternity triage arrangements are developed.

Progress has also continued in strengthening arrangements for women requiring care in non-maternity settings to address the inherent risk of two-site model. This includes the obstetrics and gynaecology rota remodelling, and will strengthen out-of-hours support, enhance middle-grade cover and improve clinical resilience for women presenting across both sites. The implementation of the new rota has been delayed to January 2027 (from September 2026) as there are outstanding vacancies in the revised structure. An information campaign has begun to enable staff on non-maternity sites better informed and understand escalation routes when a pregnant woman attends their service, ensuring consistent care provision and escalation processes. Longer-term options for the configuration of Perinatal Services are being considered as part of the wider Clinical Services Plan, with options due to be presented in a standalone paper to Board in September 2026. This reflects the Health Board's recognition that, although extensive mitigations are in place, the inherent risks associated with two-

site working require continued strategic oversight and longer-term service planning. Together, these actions demonstrate sustained progress in moving from immediate risk mitigation towards a more systematic, evidence-based and sustainable approach to clinical safety improvement across Perinatal Services.

3.3 Family Engagement (Workstream 2)

Family engagement remains a central component of the Perinatal Improvement Plan, recognising that women and families did not always feel listened to or involved in decisions about their care. Since the July 2026 Board update, progress has continued in strengthening the way we gather, understand and act on feedback from women, families and communities. The Maternity and Neonatal Engagement, Insight and Coproduction Strategy (Appendix 5) has been revised to provide clearer priorities, metrics and delivery arrangements, including a specific focus on how families are involved in investigations, reviews and complaints. This strengthens the connection between lived experience, learning and service improvement, and provides clearer assurance that feedback is being used to shape change. Following feedback from the Independent Oversight Panel, the Strategy will be further refined followed feedback. The next phase will include seeking engagement and feedback from partners including Llais, and development of a costed plan for engagement delivery. An update will be presented at the November 2026 Board Meeting.

Further work has also progressed to support more systematic learning across the organisation. Scoping has been completed for the establishment of an organisation-wide Learning Group, with the inaugural meeting planned for September 2026. This will provide a more structured mechanism for triangulating learning from complaints, incidents, concerns, claims, patient experience, safeguarding, mortality, audit and external reviews, ensuring that themes are identified and acted upon more consistently. This is an important step in strengthening both “floor-to-Board” and “Board-to-floor” assurance, by ensuring that the voices of women, families and staff are visible within governance discussions and inform future improvement priorities.

The principles of engagement and coproduction are also being applied to specific service developments, including work on maternal weight management. Engagement insight, lived experience and population health intelligence are being used to shape the development of a future offer, supported by grant funding, so that services are better aligned to the needs of women and communities who may experience barriers to accessing care. While progress has been made, we recognise that embedding a mature and inclusive approach to engagement will take time, particularly in ensuring that all communities are represented and that feedback is consistently

translated into visible action. The continued focus will be on developing an “always-on” engagement model, improving the triangulation of insight and demonstrating clearly how women and families’ experiences influence service design, decision-making and improvement and the refined Engagement Strategy will describe the route for delivery.

3.4 Workforce, Leadership, Education and Training (Workstream 3)

Workforce, leadership, education and training remain key enablers of sustainable improvement across Perinatal Services. Since the July 2026 Board update, progress has continued in strengthening culture, leadership, staff experience and the education offer for staff working across maternity and neonatal services. Following the delivery Multidisciplinary Team Development Programme co-designed and initially supported by Professor Michael West, a medium-term review of the impact of the pilot programme using the “DEEP” evaluation methodology will be delivered in November 2026. In the interim, a scoping and mapping map exercise of existing multidisciplinary development and leadership training provision undertaken by our Organisational Development Team is nearing completion. The review will dovetail with the DEEP evaluation and highlight areas of overlap to avoid duplication in the next phases of the programme development.

The updated business case for an embedded Maternity and Neonatal Psychology-Led Therapeutic Service is progressing through Service Group governance, supporting our ambition to provide more trauma-informed care for women, families and staff. This will help strengthen emotional safety, improve compassionate care and respond to the findings of the Independent Review, which highlighted the importance of psychological safety and trauma-informed support.

Work has also progressed on launching the Perinatal Services Staff Education Wellbeing and Retention (SEWR) Plan, a focused, prioritised and deliverable programme of work to improve staff experience, health, wellbeing and retention across Perinatal & Gynaecology Services. The Plan will be tested and refined during Quarter 3 2026/27, underpinned by a working group made up of staff from across all staff groups in Perinatal Service.

In parallel, preparations have continued for the rollout of the Rate My Shift six-month pilot, with the final training, coaching and communications arrangements agreed ahead of implementation in October 2026. This will provide a more responsive mechanism for understanding staff experience in real time and triangulating feedback with workforce data, acuity, absence, demand and other quality and safety intelligence. Together, these

actions support development of a more resilient, skilled and supported workforce, strengthen psychological safety and provide clearer Board assurance that workforce and culture improvements are being actively linked to the quality and safety of care for women, babies and families.

3.5 Governance (Workstream 4)

Governance remains a central workstream within the Perinatal Improvement Plan, ensuring that delivery of the recommendations is supported by clear oversight, accountability, risk management and evidence of impact. Since the July 2026 Board update, progress has continued in strengthening the governance arrangements that support Board assurance, service-level scrutiny and learning from incidents, concerns, complaints and reviews. Work has progressed to bring together Perinatal reporting arrangements, including the development of a Perinatal Improvement Plan Scorecard and revised workstream reporting format, so that actions, outcome measures, risks and the difference being made for women, babies, families and staff can be more clearly triangulated and presented to Board.

Further progress has been made in strengthening the quality and oversight of investigations and reviews. We have scoped additional external expert clinical input to support Perinatal Mortality Review Tool (PMRT) reviews and, where appropriate, provide independent clinical review of serious incidents or equivalent cases, to improve our ability to provide women and families with a timely response and apply any learning where care could have been delivered differently to improve safety or experience. A clearer process has also been developed to identify triggers for independent reviews into investigations and concerns, strengthening consistency, transparency and escalation and is being formally reviewed for implementation. Thematic learning from reviews continues to be shared through formal governance routes, immediate safety actions, informal briefings and staff communications, including the monthly "Risky Business" newsletter. Month-by-month oversight data on investigations and PMRT reviews is reported through Perinatal Committee, supporting clearer assurance on timeliness, family engagement, overdue reviews and learning themes.

Work has also continued to strengthen the management of clinical guidance and assurance reporting. Resolution has been confirmed for outstanding architecture issues relating to the guidelines tracker, supporting improved visibility of locally owned maternity and neonatal guidelines, national guidance adoption and evidence of implementation. Formal reviews of governance arrangements for the Perinatal Improvement Plan are scheduled for October 2026 and April 2027 to test whether the governance model remains effective following the planned conclusion of Independent Oversight Panel arrangements. Together, these actions demonstrate

continued progress in embedding a stronger governance, learning and assurance framework, with a clear focus on ensuring that concerns are identified, escalated and acted upon, and that Board reporting provides meaningful assurance on the quality, safety and experience of Perinatal Services.

Next steps:

A small number of strategic risks remain. The most significant is the inherent risk associated with the current two-site model for maternity, neonatal and critical care services, despite extensive mitigation measures and workforce remodelling. Other areas requiring continued focus include development of a sustainable long-term paediatric radiology solution, implementation of national maternity triage arrangements, continued embedding of new processes and governance systems, and ensuring sufficient workforce capacity to sustain improvement. Options relating to the longer-term configuration of Perinatal Services are presented to the Board in September 2026 as part of the wider Clinical Services Plan.

Overall, the programme is demonstrating sustained progress, governance and assurance arrangements are providing effective oversight of delivery and risk, and that improvement activity remains focused on achieving safer, more compassionate and higher-quality care for women, babies and their families.

4. OPEN AUDIT RECOMMENDATIONS

Open audit recommendations are to system strengthening rather than safety concerns. They are embedded within the Perinatal Improvement Programme, with clear governance, executive oversight and routine reporting. Current focus includes digital infrastructure, data quality, pathway consistency and embedding learning into practice. The Board can be assured that actions are actively managed with appropriate scrutiny and escalation.

5. FINANCIAL IMPLICATIONS

As noted in report, there may be financial implications linked to the Perinatal Improvement Plan. The developments will be subject to usual Health Board scrutiny processes and will follow these routes accordingly.

6. RECOMMENDATION

BE ASSURED;

- The organisation has a comprehensive plan to address the recommendations of the SBUHB Independent Review of Maternity and Neonatal Services, Family Led Review of Maternity Services, and



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Bae Abertawe
Swansea Bay University
Health Board

"Having a baby in Neath Port Talbot and Swansea Report" Llais Report and any actions required from the All-Wales Assessment of Perinatal Services.

- Continued sustainable progress made since the publication of the Independent Review on key safety actions, including:
 - Significant and sustained improvements in clinical outcomes for mothers and babies
 - A full-developed staffing model across all staff groups has improved workforce numbers and governance routes, including assurance, alert and escalation for staffing levels are embed as business-as-usual.
 - Improved incident management, ensuring women, babies and families' voices are at the heart of investigations and reviews, with learning embedded in the service.
 - Significant mitigation and improved process management has been implemented to manage the inherent risk of two-site work (Perinatal Services and Critical Care are not co-located).
 - Maternity triage model implemented, tested and evolving based on staff and family feedback.
 - Perinatal staff and other key services (including Critical Care) have been trained in key clinical safety interventions, including Early Warning Scores systems for both mothers and babies.
 - Dashboard of key safety, workforce and feedback metrics embedded into business as usual. Underpinned by benchmarking against national datasets to provide oversight against best practice.
 - Unification of Maternity and Neonatal Services under the umbrella of Perinatal Services has aligned the service and its reporting, providing a unified route for reporting via Perinatal Committee, through to Board level.
 - Established and embedded governance and assurance structure for the Perinatal Improvement Plan and Perinatal business-as-usual, from Ward to Board.. Underpinned by visible leadership including appointments to new leadership roles on a permanent basis.
 - Quality improvement approaches are becoming increasingly embedded in the organisation providing a foundation for a learning culture.



Iechyd gwell
Gofal gwell
Bywyd gwell

Better health
Better care
Better lives

12 of 15
SBUHB Board
Thursday, 24 September 2026



BE ALERTED TO;

- **Two-site working:** While significant progress has been made in strengthening arrangements for women requiring care in non-maternity settings, including a number of Standard Operating Policies specifically outlining processes and escalation to admissions of pregnant women into non-maternity sites and workforce remodelling, there remains an inherent risk to this model of operation. Options for reconfiguration of service are being considered as part of the Transforming for the Future Programme.
- **Maternity Triage:** The 'Path to Safer Beginnings in Wales', published February 2026, has recommended the establishment of a national single point of access triage service for pregnant women, to be coordinated by the Welsh Ambulance Service Trust. As such, the development of a standalone SBUHB model will not be continued. To mitigate risk while the national service is implemented, a 24/7 clinical triage unit has been established. The service offers advice by phone and in-person, women and their families can access timely advice about any concerns and be referred and signposted appropriately. Since the last report, a review of maternity triage has confirmed that the Single Point of Access line is supporting timely advice and appropriate signposting for women and families. The review also identified ongoing pressures around call volumes, telephone functionality and triage capacity. A Task and Finish Group is being established to oversee further mitigations, strengthen monitoring and support continued improvement, including the appointment of a dedicated triage telephone midwife role.
- **Paediatric radiology:** Outsourcing of paediatric radiology provision for plain film x-ray as an interim mitigation measure has been live since February 2026. Cranial Ultrasound Scans are undertaken by the Neonatal team, underpinned by a Quality Assurance system. Provision for performing and interpreting other Ultrasound Scans and upper Gastro-Intestinal (GI) Contrast studies happens with support from Adult Radiology. There are system-wide national challenges in relation to paediatric radiology and there is a need for potential regional solution to provide long term assurance and sustainability of service provision, and discussions are ongoing with Cardiff and Vale University Health Board and the commissioners to explore suitable options.



Governance and Assurance		
Strategic Objectives		
Strategic Objectives <i>(please choose which is impacted)</i>	People of Swansea Bay live healthier, fairer and more prosperous lives	☒
	Care is high quality, safe, efficient and delivers the best possible outcomes for people in partnerships	☒
	Care is delivered in partnership with our communities in safe and appropriate setting, supported by innovation	☒
	The health board is a great place to work where staff feel valued and work together towards a common goal	☒
	The health board is a resilient, sustainable and responsible organisation	☒
Health and Care Standards		
Standards <i>(please choose which applies)</i>	Safe Care	☒
	Timely Care	☒
	Effective Care	☒
	Efficient Care	☒
	Equitable care	☒
	Person-centred Care	☒
	Staff and Resources	☒
Enablers <i>(please choose which applies)</i>	Whole Systems Approach	☒
	Leadership	☒
	Workforce	☒
	Culture	☒
	Information	☒
	Learning, Improvement and Research	☒
Quality, Safety and Patient Experience		
The health board is dedicated to ensuring that pregnancy and childbirth is a safe and positive experience for all service users in order to support healthy life choices and to give children the best start in life. This requires safe and effective maternity and neonatal services. The actions identified within this paper will support us in achieving these goals.		
Financial Implications		
As noted in report, there may be financial implications linked to the Perinatal Improvement Plan. The developments will be subject to usual Health Board scrutiny processes and will follow these routes accordingly.		
Legal Implications (including equality and diversity assessment)		
There are no legal implications associated with the report.		
Staffing Implications		
There are some staffing implications noted in the report, linked to training and workforce alignment.		



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

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

Report History

Oversight of Quality and Outcomes in Maternity and Neonatal Services (27 March 2025)

Perinatal Committee and Independent Review Update Report (25 September 2025)

Perinatal Report (27 November 2025)

Perinatal Improvement Plan Report (29 January 2026)

Perinatal Improvement Plan update (In Committee) (28 May 2026)

Perinatal Improvement Plan Report (30 July 2026)

Appendices

Appendix 1: Gap analysis Perinatal Improvement Plan Amos Ockenden

Appendix 2: Perinatal Improvement Plan Scorecard

Appendix 3: Perinatal Outcomes and Critical Safety Measures

Appendix 4: Perinatal Improvement Plan Workstream Update Board Sep 2026

Appendix 5: Maternity and Neonatal Engagement, Insight and Coproduction Strategy

Meeting Date	24 September 2026	Agenda Item	5.5iii	
Name of Meeting	SBUHB Board			
Report Title	Independent Review of Maternity and Neonatal Services Oversight Panel Report: September 2026			
Report Author	Denise Chaffer, Oversight Panel chair			
Presented by	Denise Chaffer, Oversight Panel chair.			
Freedom of Information	Open			
Purpose of the Report	The purpose of this report is to: • Provide feedback from the final Oversight Panel meeting on the progress of SBUHB improvements, and the next steps agreed for continued oversight of the plan.			
Key Issues	• The Oversight Panel met on 14 September to consider papers provided by SBUHB related to: (i) queries raised at their previous meeting, (ii) the new format for reporting maternity and neonatal outcomes to the Board; (iii) an update on progress of the improvement plan since the July 2026 Board meeting; and (iv) an updated patient/family and community engagement strategy paper. • The Panel acknowledged the significant improvement in the quality of the papers shared and the considerable progress in implementation of actions and improvements since the publication of the report. There is still further work to do in relation to the patient, family and community engagement strategy. • Provides the Oversight Panel's responses to outstanding queries. • The offer of further support from some of the Panel members in relation to supporting the engagement strategy and further development of the maternity and neonatal outcomes reporting score card for the board.			
Specific Action Required <i>(please choose one only)</i>	Information	Discussion	Assurance	Approval
	☐	☐	☒	☐
Recommendations	Members are asked to: • CONSIDER and DISCUSS the update provided in the attached Oversight Panel report.			

	• CONSIDER the Panel's views on the SBUHB response to a number of queries. • BE AWARE the Welsh Government observer will continue in her role and remain in regular contact with SBUHB until March 2027.
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BOARD UPDATE FROM INDEPENDENT REVIEW OF MATERNITY AND NEONATAL SERVICES OVERSIGHT PANEL – SEPTEMBER 2026

1. Introduction

The Oversight Panel (OP) had their final formal meeting on Monday 14 September 2026. They discussed papers which Swansea Bay University Health Board (SBUHB) had shared with them. These included a response from SBUHB to queries raised at their previous meeting, the new format for reporting maternity and neonatal outcomes to the Board, and an update on progress of the improvement plan since the July 2026 Board meeting. The OP also received an updated paper relating the patient/family and community engagement strategy, which the OP felt needed more time to consider, and have suggested this comes to November board meeting as a standalone agenda item for sign off.

The OP acknowledged the significant improvement in the quality of the papers shared. There has been considerable progress in implementation of actions and improvements from a number of work stream themes since the publication of the report.

There were also a number of recommendations for the Welsh Government which were accepted in full by the Minister in July 2025, we have requested an update on the progress of these as many of these will also help SBUHB in further progressing their actions.

2. Response to outstanding queries from the OP

The key areas related to:

- **Review of the triage processes and clinical staff involvement**

The response from SBUHB describes further work which has taken place with the clinical teams in mapping the process and identifying some of the risks and impacts, the OP recommend the need for some further actions to mitigate the risks particularly in relation to any dropped calls.

- **Increasing awareness on the Morriston site of both the Report and the Improvement Plan.**

SBUHB have undertaken some awareness raising on the Morriston site, and the OP recommend some further staff group forums to give the opportunity for staff engagement and consideration of how the report impacts in wider clinical areas.

- **Greater details in relation to the securing of external independent expertise to support case investigations.**

The OP members suggested this still requires greater clarity and detail in how this is being implemented. Also note this was also an All Wales recommendation in terms of supporting this.

- **The need to provide greater clarity on priorities, outcome and process measures/ key metrics with improvement data monitored over time.**
- **Use of recognised quality improvement (QI) methodology to support improvement.**

Further detail on metrics have been provided, this requires greater detail in some areas, for example the patient/family/community engagement work stream (see below). Whilst SBUHB are accessing QI methodology to support their improvement work, the OP felt there were further opportunities where this approach could be utilised.

- **Safety Risks related to two site working**

The Oversight Panel are aware SBUHB are exploring the risks and mitigations in more detail and discussions with the Welsh Government.

3. Patient/family/community engagement strategy

The OP members received an update draft of the engagement strategy. The members felt they needed more time to consider this and recommend further work which includes greater clarity in prioritisation and resourcing of key actions, agreeing responsibilities between strategic and delivery teams, highlighting closer working with other agencies, such as Llais, Maternity Voices partnerships etc and further detail re metrics to track progress.

The OP members felt it was important to highlight as part of the strategy the wider engagement activities that have taken place since the report was published, some examples of which include:

- Appointment of Family Experience Midwife, working in partnership with the Diverse Outreach Workers teams in Swansea and Neath Port Talbot Community Voluntary Services and the Maternity and Neonatal Voices Partnership (MNVP)
- Targeted outreach undertaken with community and faith groups, voluntary sector organisations, and specialist support networks, including neurodivergent, deaf, Muslim, and ethnically diverse communities.
- Maternity triage service - a pilot engagement approach has been implemented to capture family experience and inform improvement.

- Development of a single report of data produced with thematic learnings and insights from women, babies and families underway.

4. Board reporting of maternity and neonatal outcome measures.

SBUHB shared their newly developed score card, this helpfully shares the progress in improving a range of safety critical outcome data measures since the report was published. The OP have given some feedback on how this can be further improved to provide a highlight report for the Board, with some additional narrative to support the graphs, and one of the OP members has offered to provide some further support the SBUHB to develop this further. This would also support the wider All Wales recommendations and would have the potential to provide a template for other health boards to consider.

5. Ongoing oversight and assurance

SBUHB have committed to continue with their executive programme board which is chaired by their Chief Executive which will continue to provide oversight of the ongoing improvement plan. The perinatal committee and the clinical governance committee will continue to meet and report regularly to the Board. Ann Gow (observer for the Welsh Government) will continue in her role and remain in regular contact with SBUHB until March 2027.

6. Next steps

Whilst the formal role of the oversight panel has concluded, the Chair together with others from the panel will continue to provide additional support for the family and community engagement strategy and also the clinical outcome data report until the end of Nov 2026.



WORKFORCE AND OD COMMITTEE Key Issues Report

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

Date of Committee meeting:	20 August 2026
Members Present:	Three Members: Andrew Griffiths, Anne-Louise Ferguson and Nicola Matthews.
Quoracy:	Yes
Group/Committee Chair:	Andrew Griffiths, Committee Chair
Report Submitted by:	Corporate Governance.
Report Signed off by:	Andrew Griffiths, Committee Chair
Date of Board receiving the report:	24 September 2026

1.	Agenda	The Workforce and OD Committee convenes every other month, and the agenda, relevant documents, and minutes from the meetings are accessible on the SBUHB website .
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2.	Alert	Following the June meeting the Committee is alerting the Board to the following items (2):
	Minute Reference: 78/26	Morriston Hospital; key workforce risks, progress against staff survey action plan, performance against key workforce metrics: High levels of sickness absence, particularly stress-related absence, continued to present a significant workforce challenge and required sustained organisational focus to support staff wellbeing and improve attendance.
	Minute Reference: 84/26	Organised for Success Programme Updates: The organisational pressures associated with implementation of the Organising for Success programme and the need for continued staff engagement, communication and support throughout the organisational change process.



3. Assurance	Minute Reference: 79/26 Minute Reference: 80/26 Minute Reference: 83/26 Minute Reference: 85/26 Minute Reference: 88/26	The Committee is assuring the Board on the following items (5): Mental Health Workforce Assurance report: Progress was being made in implementing the Mental Health Workforce Assurance Programme, supported by detailed establishment reviews, approval of additional nursing investment, ongoing recruitment activity, and measures to improve workforce sustainability and reduce reliance on variable pay. Workforce and OD Strategic Risks: The Workforce and OD Strategic and Corporate Risk Registers had been reviewed and strengthened, with clear mitigation plans in place to manage workforce-related risks and support effective risk oversight. Variable Pay Plan 2026/2027: Progress was being made against the Strategic Workforce Plan, supported by strengthened workforce governance arrangements, robust vacancy controls, and enhanced oversight of variable pay expenditure. Deep dive into pillar 1 of the people strategy - Engaged, Motivated and Healthy: Progress was being made in delivering Pillar 1 of the People Strategy, supported by improved PADR compliance, strengthened governance arrangements, and the development of a Health Board-wide approach to staff engagement and staff experience. Consultant Job Planning: Consultant job planning compliance remained above the Welsh Government target, supported by robust governance and monitoring arrangements, with significant progress made in addressing Internal Audit recommendations and ongoing oversight maintained against this key workforce measure.
4. Advise	Minute Reference: 79/26	The Committee is advising the Board on the following items (5): Mental Health Workforce Assurance report: Delivery of the full workforce model would require a phased



	Minute Reference: 80/26	approach, continued engagement with commissioners and partner organisations, and further workforce transformation to address ongoing staffing pressures across Mental Health and Learning Disability services.
	Minute Reference: 83/26	Workforce and OD Strategic Risks: The Culture Strategic Risk and the Admin and Clerical Recruitment Review Corporate Risk should continue to be monitored and reviewed to ensure that risk ratings remain appropriate and reflective of current controls, progress and emerging risks.
	Minute Reference: 85/26	Variable Pay Plan 2026/2027: Continued delivery of workforce savings will require ongoing workforce transformation, service redesign, and sustained action to reduce variable pay expenditure and associated workforce pressures.
	Minute Reference: 85/26	Deep dive into pillar 1 of the people strategy - Engaged, Motivated and Healthy: Continued focus was required to improve staff engagement, increase staff survey participation, and demonstrate meaningful and measurable improvements arising from staff feedback.
	Minute Reference: 85/26	Health Education and Improvement Wales (HEIW) quality assurance report for perinatal and gynaecology: Learning from the service's successful culture improvement programme should continue to be shared across the wider organisation, particularly in relation to compassionate leadership, psychological safety, civility, and effective mechanisms for raising concerns.
5.	Review of Risks	The Workforce and OD Committee will keep the Board updated on any developments regarding risks in relation to the above matters.
6.	Sharing of learning	None identified during the meeting.
7.	Actions to be considered by Board	None identified during the meeting.



Meeting Date	24 September 2025	Agenda Item	6.2
Name of Meeting	SBUHB Board		
Report Title	Workforce Resilience Report - Improving Staff Wellbeing and Reducing Sickness Absence		
Report Author	Paul Dunning, Professional Head of Staff Health and Wellbeing		
Report Sponsor	Executive Director of Workforce and Organisational Development		
Presented by	Tina Ricketts, Executive Director of Workforce and Organisational Development		
Freedom of Information	Open		
FoI Closed detail	If closed, choose detail		
Impact Assessment Summary Outcome		IA Completion date	
		Click or tap to enter a date.	
Purpose of the Report	For Assurance		
Report Summary; detailing any action required			
To provide the Board with assurance regarding the significant programme of work underway to support the organisational objective of improving staff wellbeing and resilience, including addressing high sickness absence.			
To outline the findings from the recent Best Practice Review and current related workforce data and seek approval of a series of strategic workstreams aimed at addressing the root causes of absence to deliver sustainable improvements in workforce attendance, wellbeing and organisational performance.			
Key Issues			
- A comprehensive improvement programme is underway, including leadership development, work-related stress prevention, musculoskeletal health support and attendance management initiatives. Despite this, sickness absence remains high at 8.22% in July 2026 (in-month) so further focused action is being undertaken to support staff presenteeism and address continued high levels of staff absence from work. - Sickness absence is estimated to have cost the Health Board approximately £41.7 million between August 2025 to July 2026. It is a key factor in the slow progress with reducing variable pay to within the parameters set out in the recovery and sustainability programme.			



- Staff absence is driven by several factors – including challenging operational environments – pressurised service areas and cultural challenges.
- Mental health and musculoskeletal conditions remain the leading causes of long-term sickness absence.
- Leadership and line management capability and capacity are key factors in reducing absence and improving staff wellbeing.

**Decision / Action
required**

Yes

Recommendations

Members are asked to:

- **CONSIDER** the work undertaken to date reducing sickness absence and improving attendance management arrangements.
- **RECEIVE ASSURANCE** that a comprehensive programme of work is in place addressing both attendance management and wider organisational determinants of absence.
- **APPROVE** the proposed strategic workstreams and cross-organisational approach to improve staff wellbeing and reduce sickness absence.



WORKFORCE RESILIENCE REPORT - IMPROVING STAFF WELLBEING AND REDUCING SICKNESS ABSENCE

1. INTRODUCTION

This report sets out the Health Board's approach to reducing sickness absence and improving workforce wellbeing by addressing both attendance management processes and the wider organisational, workforce and population health factors that influence attendance at work. It provides assurance on progress made to date, presents evidence from organisational data and the multi-disciplinary Best Practice Review, identifies key governance risks and outlines a programme of actions designed to deliver sustainable improvements in workforce attendance, staff wellbeing and organisational performance.

High performing organisations generally experience lower levels of staff absenteeism due to sickness and higher staff engagement scores. These are priorities for the Health Board and align with our strategic objective of being a great place to work and ensuring we achieve service and financial sustainability.

2. BACKGROUND

Reducing sickness absence within the Health Board remains a complex challenge influenced by factors both within and beyond the workplace. As a major employer serving communities with high levels of deprivation and long-term illness and health inequalities, many of our staff experience the same health challenges as the population they care for. Access to timely healthcare can also be impacted by NHS waiting lists, potentially delaying diagnosis, treatment and recovery.

The Health Board has a 12-month rolling sickness absence rate of 7.4%, which is 0.9 percentage points higher than the NHS Wales average of 6.5% and is the third highest rate in Wales, behind only WAST (8.1%) and Cwm Taf Morgannwg UHB (7.6%). While Swansea Bay's turnover rate of 7.8% is broadly in line with the NHS Wales average of 7.6%, our sickness absence rate remains above the national average, indicating a continuing challenge in reducing workforce absence.

Wider societal and workforce factors continue to affect employee health and attendance, including cost of living pressures, caring responsibilities, mental health concerns, an ageing workforce and increasing service demands and changing public expectations. These pressures have been further amplified by organisational change, operational pressures and the continued challenge of delivering services within a sustainable financial environment.



The Health Board's multidisciplinary Best Practice Review concluded that sickness absence should not be viewed solely as an attendance management issue. Whilst effective attendance management processes remain important, evidence suggests that sustained reductions in sickness absence require a broader organisational response that addresses workforce wellbeing, leadership capability, staff engagement, organisational culture, workload pressures and workforce capacity.

Over the last year the Health Board has delivered a significant programme of work to improve attendance, including strengthened governance arrangements, Service Group improvement plans, attendance audits, hotspot reviews, manager training, enhanced performance oversight and continued service developments within Occupational Health and Staff Wellbeing services.

This work directly supports delivery of the Health Board's Organisational Strategy, People Strategy and Annual Plan by supporting improvements to workforce availability, strengthening compassionate leadership, supporting staff wellbeing and contributing to safe and sustainable service delivery. This reflects our organisation values of caring for each other, working together and always improving.

We need to build on the approaches already underway and build to enhance them, targeting support and trialling new approaches to ensure we see more rapid and sustainable improvements.

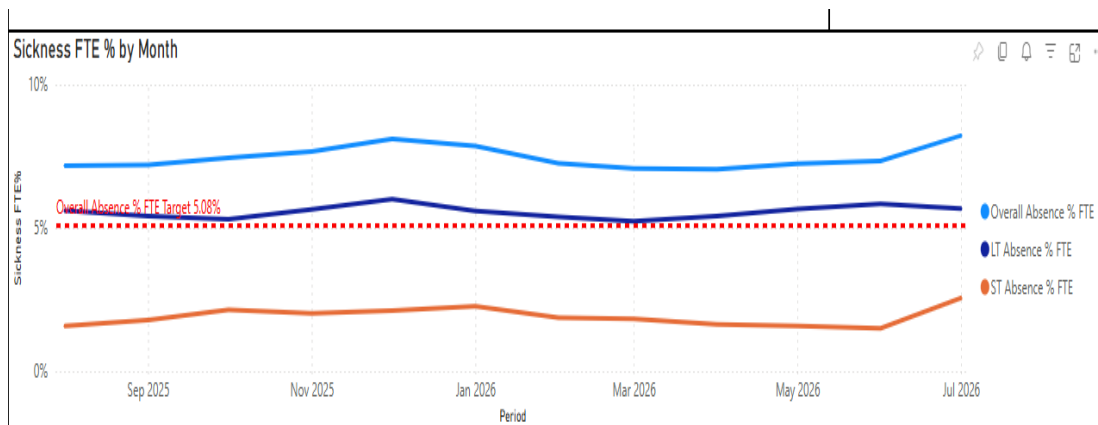
3. GOVERNANCE AND RISK ISSUES

Long-term sickness absence continues to account for most of the time lost and remains the principal driver, whilst short-term absence has varied between 1.5% and 2.55%. ESR data continues to identify stress, anxiety and depression as the major contributor to sickness absence, accounting for 34% of long-term absence and 4% of short-term absence. Musculoskeletal conditions account for 12% of long-term absence (back problems 3% and other musculoskeletal problems 9%).

Sustainable improvement will therefore depend largely on reducing long-term absence through prevention/earlier intervention, effective case management and timely rehabilitation support.



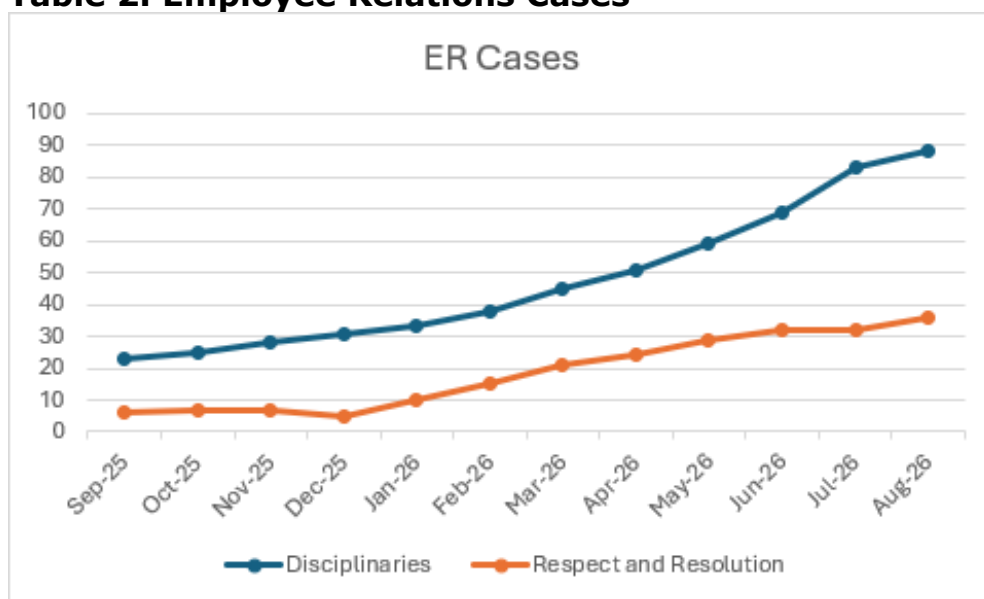
Table 1. Sickness FTE % by Month



The increase in July 2026 sickness absence to 8.22% may have been influenced by periods of extreme heat. More than 2,500 responses were received to the Health Board's Heat Impact Survey, indicating possible significant workforce impact due to heat related issues including sleep disruption, fatigue, dehydration and exacerbation of existing health conditions. Early indications suggest that other NHS organisations experienced similar challenges during this period.

A range of workforce intelligence indicators suggest increasing organisational pressure; employee relations activity has increased substantially over the last year (see Table 2). These trends may indicate growing workplace pressures, conflict and management challenges and can be viewed as indicators of organisational health.

Table 2. Employee Relations Cases



The 2025 NHS Wales Staff Survey identified strengths in team working and line management but reported deterioration in work-life balance, development opportunities and health and safety climate. Although burnout levels reduced compared with 2024, findings continue to highlight pressures affecting staff wellbeing, engagement and experience.

Demand for Occupational Health and Staff Wellbeing services has increased significantly, reflecting growing workforce health needs. Staff Wellbeing referrals continue to rise by around 14% annually, with approximately 75% relating to mental health and emotional wellbeing. Evaluation data demonstrates the effectiveness of early intervention, with 53% of referrals accessing support while at work and 70% reporting it helped them remain in work. Among the 47% referred during sickness absence, 82% believed the service supported an earlier return to work. Additionally, 59% of staff accessing support while in work reported improved productivity. Other preventative initiatives include the Staff Trauma Support Pathway, TRiM, Staff Health Checks and support for carers.

Occupational Health referrals have also increased substantially and now exceed available service capacity, resulting in breaches of some Welsh Government performance targets. This demonstrates greater utilisation of support services but also highlights capacity pressures that may affect timely intervention, rehabilitation and return-to-work support.

Evidence from higher-performing organisations suggests that sustainable reductions in sickness absence are supported by strong leadership, compassionate management, effective workforce planning, rapid access to wellbeing services, high employee engagement and positive workplace cultures.

Sickness absence remains one of the most significant workforce risks facing the Health Board, impacting service delivery, workforce sustainability, financial performance, patient experience and staff wellbeing.

The principal risks requiring Board oversight are:

- Continued high sickness absence impacting workforce availability, service delivery and organisational performance.



- Increasing workforce pressures resulting from vacancies, workload demand and the loss of organisational knowledge and experience.
- Organisational change occurring within an environment of increasing employee relations activity, workforce pressure and uncertainty.
 - Increasing demand for Occupational Health and Staff Wellbeing services resulting in capacity pressures and breaches of key performance indicators.
 - Persistently elevated levels of stress-related and musculoskeletal absence despite evidence-based, targeted interventions.
 - Inconsistent management capability, reducing the effectiveness of early intervention and preventative support.
- Failure to address the wider determinants of attendance, limiting the effectiveness of traditional attendance management approaches.
- Climate-related risks, including future extreme weather events affecting staff health and attendance.

The review highlighted that sickness absence is frequently symptomatic of wider organisational challenges rather than solely individual health issues. Failure to address these wider factors risks ongoing absence, increased presenteeism, reduced productivity, use of temporary staffing solutions, deterioration in staff engagement and continued pressure on service delivery, further exacerbating increased sickness absence.

Strong evidence demonstrates that good line management is a key determinant of employee health and wellbeing, with supportive managers associated with lower sickness absence, improved employee engagement and better organisational outcomes. Variability in management practice therefore represents a significant organisational risk. The recently introduced NHS Leadership and Management Framework [Leadership and Management Framework](#) provides an important opportunity to strengthen leadership capability and address factors associated with sickness absence and supports and embeds the evidence-base that 'good work is good for health'.

Strategic Aim and Outcomes

In response to the above, a strategic sickness absence reduction programme is proposed that will include several strategic, cross-organisational workstreams aimed at creating a healthier, more resilient workforce and deliver a sustained reduction in sickness absence without compromising fairness, inclusion or staff trust. The programme will pursue five outcomes: (1) achieve the 2026/27 breakthrough objective of below 6.09%, supported by Service Group trajectories; (2) reduce long-term lost time and recurrence; (3) improve timely return-to-work

conversations, case reviews and workplace adjustments; (4) reduce stress-related and musculoskeletal absence in identified hotspots; and (5) reduce avoidable variable-pay and productivity costs attributable to absence.

To underpin this, our intentional cultural change programme is strategically aligned to the formation of the care groups and will support the Health Board in building a high-performing, compassionate and values-driven culture. The programme combines leadership development, quality improvement methods and staff engagement to strengthen trust between leaders and staff, improve psychological safety and speaking-up practices. It will also enhance learning and continuous improvement and empower teams to take ownership of local solutions. Through clear accountability, coaching-focused leadership and data-driven decision-making, the programme aims to create sustainable organisation-wide cultural change that will improve staff experience, outcomes for patients and the communities we serve.

It is suggested this programme will form part of the recovery & sustainability programme and be overseen by the workforce programme board and will deliver:

- **Focused operational grip:** monthly executive review of the highest-absence services, with recovery trajectories, case-level assurance and rapid escalation of barriers.
- **Long-term absence pathway:** early manager contact, timely occupational health input, multidisciplinary review of complex cases, adjustment passports, phased return and redeployment where appropriate.
- **Manager standard:** mandatory capability development, practical toolkits, coaching and quality assurance of return-to-work and formal review conversations.
- **Stress prevention:** application of the work-related stress risk assessment at team level, using workload, control, support, relationships, role and change as the core diagnostic domains.
- **Musculoskeletal prevention and rehabilitation:** improved access to ergonomic assessment, manual-handling refreshers after prolonged absence, rapid access to physiotherapy and role-specific rehabilitation.



- **Data and digital improvement:** improve ESR coding completeness, automate prompts and dashboards, and complete an options appraisal for a digital attendance management solution before any procurement decision.

Delivery will be evidence-led, compassionate and equitable; focused on prevention and early intervention, owned by operational leaders, delivered in social partnership, targeted according to risk and need and governed through transparent measures of outcome, process, experience and financial benefit. The programme will include targeted action to support ward managers to manage daily sickness absence. The Delivery Unit are currently scoping a time-limited digital workforce management solution that provides a single point of access to report absence on day one. If implemented, it will help managers proactively monitor, manage and reduce sickness absence by providing real-time absence reporting with related policy prompts. It enables early intervention for musculoskeletal and mental health-related absences, enhanced manager accountability, stronger policy compliance and better workforce intelligence to support staff wellbeing and service delivery. It is anticipated this would take 3-6 months to implement and supports the strategic objectives of being a great place to work and enabling sustained improvements in staff wellbeing/reducing sickness absence. We are also scoping out a model that will enable a centralised team to provide an initial response to absence reporting to identify opportunities to keep staff in work and prevent absence.

Strategic Programme

Eight workstreams will operate within four connected programme pillars. This consolidation reduces duplication and ensures that each intervention contributes directly to agreed outcomes. Each workstream will have an executive sponsor, accountable lead, baseline, trajectory, milestones, dependencies, equality considerations and quantified benefits. Service Groups will translate the corporate framework into local improvement plans for their highest-risk areas.



Pillar	Workstreams	Strategic contribution
1. Consistent attendance management	Attendance Management Digital enablement	Reliable data, timely action, high-quality return-to-work conversations, active long-term case management and consistent policy application.
2. Prevention and early health support	Stress, Anxiety and Depression Musculoskeletal Health	Risk assessment, early access to support, workplace adjustments, rehabilitation and prevention of recurrence.
3. Healthy work and inclusive leadership	Line Management and Wellbeing Employment Relations and Organisational Change	Compassionate and accountable leadership, psychological safety, early conflict resolution and well-managed change.
4. Workforce and population determinants	Ageing Workforce and Caring Responsibilities Cost of Living; Public and Population Health	Targeted, equitable support informed by workforce demographics, wider determinants and staff health needs.

Governance, Delivery and Accountability

The Executive Director of Workforce and OD will act as Senior Responsible Owner, supported by an executive programme board with operational, workforce, finance, occupational health, public health, digital, staff-side and equality representation. Service Group triumvirates will own local delivery and benefits. Progress will be reported monthly to the Executive Team, quarterly to the Workforce and OD Committee, and to the Board through the integrated performance framework. Material risks will be linked to the Board Assurance Framework and escalated through existing performance arrangements.



Action plan for delivery

Confirm and implement model for sickness absence reduction	Oct 2026	Executive Director of Workforce and OD with Service Group Directors	Define trajectories in place with monthly reporting by Service Group and cost-centre category
Procure digital attendance management tool	Oct 2026	Executive Director of Workforce and OD & Head of delivery Unit	Project management plan and evaluation.
Undertake scoping for central absence reporting team	Oct 2026	Executive Director of Workforce and OD	Scope evidence base for centralised reporting absence management team and pilot
Complete review of all priority long-term sickness absence cases	Oct/ Nov 2026	HR Business Partners with Service Group leadership teams	priority cases classified with clear next actions, barriers, assurance rating and escalation route.
Implement strengthened short-term sickness review and core controls	Dec 2026	Service Group Directors and line managers, supported by Workforce and OD	Return-to-work compliance, sickness tracker completion and trigger management reported monthly.
Launch targeted stress, wellbeing and musculoskeletal prevention interventions in hotspot areas	Dec 2026	Occupational Health and Staff Wellbeing with Service Group leadership teams	Evidence of interventions in the highest-risk areas and reporting on uptake, impact and barriers.
Provide Board update on delivery, impact and residual risk against March 2027 breakthrough objective	Jan 2027	Executive Director of Workforce and OD	Board receives trajectory, assurance rating, benefits assessment and recommended next phase.



Other considerations related to the programme:

- **Rapid access to treatment:** explore faster access to physiotherapy, diagnostics, talking therapies and selected planned care where delayed treatment is prolonging absence, subject to clear clinical and equality criteria.
- **Stay-at-work service:** provide early self-referral and manager-referral support for staff at risk of absence, combining rapid functional assessment with a personalised support plan.
- **Complex-case multidisciplinary panels:** introduce time-limited reviews for prolonged or complex cases involving managers, Workforce, Occupational Health and relevant clinical expertise, with agreed decision points and escalation routes.
- **Return-to-work coordination:** assign a named coordinator for selected long-term cases and use individual plans covering duties, hours, adjustments, reviews and relapse prevention.
- **Reasonable-adjustment passport:** create a portable record of agreed adjustments to support individuals if they transfer to other departments within the Health Board. This will also include transfer of specialist equipment.
- **Healthy roster and fatigue review:** examine consecutive shifts, night work, overtime, missed breaks, annual leave and short-notice changes in priority services.
- **Post-incident recovery protocol:** establish consistent follow-up after violence, trauma, serious incidents or difficult employee-relations processes, including immediate support, delayed check-in and escalation where required.
- **Hotspot team recovery interventions:** undertake short diagnostic reviews of workload, vacancies, leadership, rostering, conflict, facilities and staff experience, followed by co-designed 90-day recovery plans.
- **Manager practice accreditation:** assess managers' ability to apply policy, hold supportive conversations, assess work-related stress and implement adjustments, rather than relying on training attendance alone.
- **Independent case-quality audits:** sample cases quarterly to test timeliness, quality of contact, adjustment consideration, equality compliance and employee experience.
- **Return-to-work experience measure:** use a short confidential survey following return to identify themes and variation by service and workforce group.





Key Governance Risks

The principal risks requiring Board oversight are:

1. Continued high absence affecting workforce availability, service delivery, quality and financial performance.
2. Organisational change, workforce shortages and workload pressures increasing stress, conflict and absence.
3. Variable management capability leading to inconsistent early intervention, staff experience and policy application.
4. Stress-related and musculoskeletal absence remaining persistently high despite targeted support.
5. Wider health, demographic and environmental factors limiting the impact of attendance-management measures alone.

Mitigating Actions

Mitigation will be delivered through the four programme pillars, phased implementation, Service Group recovery plans, strengthened leadership and management practice, targeted health interventions, improved data and regular executive and Board assurance.

4. OPEN AUDIT RECOMMENDATIONS

Any open audit recommendations relating to attendance management, workforce data, occupational health or managerial compliance will be mapped into the programme during mobilisation. Internal Audit should be invited to advise on the assurance framework and, if appropriate, undertake a follow-up review once controls are embedded.

5. FINANCIAL IMPLICATIONS

Sickness absence continues to have a major financial impact through lost productivity, temporary staffing, service disruption and management time. Workforce Dashboard data estimates sickness absence cost the Health Board £41.7 million between August 2025 and July 2026. This represents a significant opportunity cost. A 1% reduction in sickness absence could save around £5.96 million annually, while a 2% reduction could release approximately £11.9 million, alongside increasing workforce capacity and service resilience.

A financial baseline and benefits-realisation plan will be developed during mobilisation of the above programme of work, covering intervention costs, productive time recovered and reductions in bank and agency spending. Existing resources will be prioritised and any requirement for



additional investment, such as digital solutions or clinical support, will be subject to a separate business case and affordability assessment, including equality impacts and expected return on investment.

6. RECOMMENDATION

Members are asked to:

- **CONSIDER** the work undertaken to date reducing sickness absence and improving attendance management arrangements.
- **RECEIVE ASSURANCE** that a comprehensive programme of work is in place addressing both attendance management and wider organisational determinants of absence.
- **APPROVE** the proposed strategic workstreams and cross-organisational approach to improve staff wellbeing and reduce sickness absence.



Governance and Assurance		
Strategic Objectives		
Strategic Objectives <i>(please choose which is impacted)</i>	People of Swansea Bay live healthier, fairer and more prosperous lives	☒
	Care is high quality, safe, efficient and delivers the best possible outcomes for people in partnerships	☐
	Care is delivered in partnership with our communities in safe and appropriate setting, supported by innovation	☐
	The health board is a great place to work where staff feel valued and work together towards a common goal	☒
	The health board is a resilient, sustainable and responsible organisation	☐
Health and Care Standards		
Standards <i>(please choose which applies)</i>	Safe Care	☐
	Timely Care	☐
	Effective Care	☐
	Efficient Care	☐
	Equitable care	☐
	Person-centred Care	☐
	Staff and Resources	☒
Enablers <i>(please choose which applies)</i>	Whole Systems Approach	☐
	Leadership	☒
	Workforce	☒
	Culture	☒
	Information	☐
	Learning, Improvement and Research	☐
Quality, Safety and Patient Experience		
Reducing sickness absence and strengthening workforce wellbeing will improve workforce availability, continuity of care and team stability, supporting safer and high-quality services/outcomes for patients.		
Financial Implications		
As explained in the paper		
Legal Implications (including equality and diversity assessment)		
The recommendations within this report support the Health Board's statutory responsibilities to provide a safe working environment, promote employee health and wellbeing, manage attendance fairly and consistently and comply with relevant employment, health and safety, equality and data protection legislation		
Staffing Implications		



This report has significant workforce implications, as reducing sickness absence and improving attendance at work will increase workforce availability, reduce pressure on teams, improve continuity of service delivery and support the Health Board's ability to meet operational demands.

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

This report supports the **Well-being of Future Generations (Wales) Act 2015** by adopting a long-term, preventative and collaborative approach to reducing sickness absence and improving workforce wellbeing. The proposed actions focus on addressing the root causes of absence, strengthening leadership and management capability, improving staff health and wellbeing, and enhancing organisational resilience to deliver sustainable benefits for the workforce, patients and the wider Health Board.

The report demonstrates the **Five Ways of Working** through:

- **Long-term:** Focusing on sustainable reductions in sickness absence by addressing workforce health, organisational culture, leadership capability and workforce wellbeing rather than solely attendance management processes.
- **Prevention:** Investing in early intervention, Occupational Health, Staff Wellbeing services, mental health support and preventative initiatives to reduce future absence and improve workforce resilience.
- **Integration:** Aligning attendance improvement activity with the Organisational Strategy, People Strategy, Annual Plan, workforce wellbeing objectives and service delivery priorities.
- **Collaboration:** Promoting partnership working across Workforce, Occupational Health, Staff Wellbeing, Public Health, Staff-side representatives and operational services to address the wider determinants of attendance.
- **Involvement:** Utilising staff survey findings, workforce intelligence, focus groups and employee feedback to ensure that improvement actions are informed by staff experience and organisational need.

Collectively, these approaches support the Health Board's contribution to a healthier, more resilient workforce and the wider wellbeing goals for Wales.

Report History

Annual report to Board.

Appendices

None





AUDIT COMMITTEE Key Issues Report

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

Date of Committee meeting:		10 September 2026
Members Present:		THREE Members were present at the Audit Committee: Nuria Zolle, Andrew Griffiths, and Steve Spill.
Quoracy:		Yes
Group/Committee Chair:		Nuria Zolle, Audit Committee
Report Submitted by:		Corporate Governance
Report Signed off by:		Nuria Zolle, Audit Committee Chair Hazel Lloyd, Director of Corporate Governance
Date of Board receiving the report:		24 September 2026
1.	Agenda	The Audit Committee convenes bi-monthly, and the agenda, relevant documents, and minutes from the meetings are accessible on the SBUHB website .
2.	Alert	The Committee is alerting the Board to the following items (1); • Discharge Planning Deep Dive – Progress had been made in strengthening discharge arrangements but the deep dive identified continuing evidence of drift, limited organisational grip and gaps in prioritisation. Further assurance was required on leadership, ownership and the delivery of a comprehensive end-to-end approach, including the Integrated Discharge Hub and Clinically Optimised Patient flow arrangements. The Committee requested a further report demonstrating sustained improvement and an integrated response to relevant audit recommendations.
3.	Assurance	The Committee is assuring the Board on the following items (5): • Strategic and Corporate Risk Register - The Committee reviewed the July 2026 Strategic and



		Corporate Risk Registers. Assurance was provided that controls and actions were in place to manage risks and, where lower target scores have been set, to move risks towards those targets. Further work was required to evidence the effectiveness of controls, strengthen consistency of scoring and ensure appropriate scrutiny of risks that remain above appetite. • Partnership Governance and Assurance Tracker - The Committee was assured that the Partnership Tracker was being used as an effective governance and assurance tool, was subject to quarterly review and updated through an agreed process managed by the Partnerships Team. • Financial Control Procedure 15; Fixed Asset Verification - The Committee approved the revised Financial Control Procedure for fixed-asset verification. The new digital approach, using a Microsoft Power App, photographic evidence and existing QR codes, was welcomed as a more efficient and robust method of verification. Both Internal Audit and Audit Wales confirmed that they were supportive of the proposed approach • Internal Audit Reports- The Committee received four Internal Audit reports, each providing Reasonable Assurance: Medical Variable Pay, Capital Systems, External Inspections and Professional Concerns. The Committee was assured by the progress reported and management's acceptance of the recommendations, while noting priority findings requiring continued oversight. Relevant findings will be shared with the Performance and Finance Committee and Workforce and OD Committee. • Clinical Audit Annual Report - The Committee was assured that strengthened governance, reporting and digital systems were now in place to support clinical audit across the Health Board. Improvements include clearer oversight, enhanced visibility of audit activity and a stronger focus on
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		demonstrating how audit findings lead to changes in practice, patient care and organisational learning. Further assurance on the delivery and sustainability of improvements will be considered through the Quality and Safety Committee.
4.	Advise	The Committee is advising the Board on the following items (6): • Declarations of Interest, Gifts, Hospitality and Sponsorship - The Committee sought assurance on the consideration of conflicts of interest, the recording of declined offers, repeated offers from the same sources, charitable donations and the cumulative risk associated with gifts, hospitality and sponsorship. The registers will return to the Committee on a six-monthly basis. • Procurement Report - The Committee reviewed the procurement report and requested an action plan setting out how retrospective actions and repeated use of single quotation and single tender arrangements will be reduced. Further analysis was required by service group, alongside strengthened challenge of value for money, conflicts of interest, contract planning and the risk of reliance on individual suppliers. The treatment and recording of commercial grants and sponsorship would also be reviewed. • Internal Audit Progress Report - The Committee approved the proposed changes to the Internal Audit programme and noted that delivery remained on track. However, the Committee expressed concern about the pace of implementation of higher and medium-priority recommendations and requested clearer reporting on the recovery trajectory, timely clearance of reports and demonstrable progress in addressing overdue recommendations. • Audit Wales Estates Review - The Committee noted the positive findings relating to estates governance, capital prioritisation and Board oversight, while recognising continuing concerns regarding health and safety compliance, estate



		condition, workforce capacity and assurance over statutory requirements. The Committee requested strengthened milestones and assurance arrangements, particularly in relation to immediate compliance risks, and agreed that the report should be shared with the Performance and Finance Committee and Workforce and OD Committee. • Counter Fraud Arrangements - The Committee approved the proposed introduction of the Fraud Prevented Figure methodology in future Counter Fraud reports. The Board is advised that work is continuing to identify and record fraud risks on the Health Board's risk system, allocate them to appropriate risk owners and ensure that relevant committees, including Workforce and OD, receive appropriate information and assurance • Hosted Agencies Assurance Reports - The Committee noted risks affecting hosted services, including vehicle availability within the Emergency Medical Retrieval Transfer Service (EMRTS), limitations in national trauma data and the potential loss of the overnight trauma desk. Assurance was provided that the Trauma and Spinal Network risks were now recorded on the Health Board's risk system. Further work was required to ensure clear ownership, escalation and integrated oversight of risks arising through hosted services and partnership arrangements.
5.	Review of Risks	The Audit Committee will keep the Board updated on any developments regarding risks in relation to the above matters.
6.	Sharing of learning	None identified during the meeting.
7.	Actions to be considered by Board	Consider the alerts (1), assurances (5) and advice (6) mentioned above.



DDRI COMMITTEE Key Issues Report

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

Date of Committee meeting:	17 September 2026
Members Present:	Four Members: Andrew Griffiths, Jean Church, Charlotte Rees and Nuria Zolle
Quoracy:	Yes
Group/Committee Chair:	Andrew Griffiths, Committee Chair
Report Submitted by:	Corporate Governance.
Report Signed off by:	Andrew Griffiths, Committee Chair
Date of Board receiving the report:	24 September 2026
1. Agenda	The DDRI Committee convenes every other month, and the agenda, relevant documents, and minutes from the meetings are accessible on the SBUHB website .
2. Alert	Following the September meeting the Committee is alerting the Board to the following items (0).
3. Assurance	Following the September meeting the Committee is assuring the Board to the following items (2):
Minute Reference: 79/26	Business Intelligence and Analytics: Continued focus be maintained on addressing legacy system challenges, improving data quality and the consistency of data definitions, and strengthening analytical capacity to support organisational priorities, informed decision-making and effective performance management.
Minute Reference: 78/26	Operational Performance: There were ongoing concerns regarding delays in the implementation of fire



		suppression measures within the Neath Port Talbot Hospital data centre and advised that mitigating actions continue to be closely monitored until a permanent solution was delivered. Members highlighted the importance of maintaining operational resilience and reducing risk to critical digital infrastructure during the interim period.
4.	Advise	Following the September meeting the Committee is advising the Board to the following items (3):
	Minute Reference:70/26	Research and Development Strategy: The Committee <i>Endorsed</i> the three-year Research and Development Strategy and advised the Board of its support, noting the importance of strengthening implementation planning, performance measures and alignment with emerging regional research arrangements.
	Minute Reference:71/26	Research and Development Annual Report: The Committee <i>Endorsed</i> the Research and Development Annual Report and advised the Board of its support, recognising the breadth of research activity undertaken across the Health Board and the value of continuing to demonstrate research impact, outcomes and benefits in future reporting.
	Minute Reference: 75/26	Committee Risk Register: There were ongoing concerns relating to several long-standing risks, including paper record storage and clinical coding, and highlighted increasing operational pressures associated with Subject Access Requests and Freedom of Information requests. Members advised that these issues may require further organisational consideration to ensure risks were effectively managed and sufficient capacity is maintained to meet statutory obligations.
	Minute Reference: 76/26	Clinical Coding update: Clinical coding performance remained below the national target due to ongoing capacity constraints, with a persistent backlog continuing to present an operational risk. Members expressed concern regarding the organisation's ability to achieve full compliance without additional intervention or investment and emphasised the importance of sustained action to address performance and capacity challenges.



	Minute Reference: 77/26	AI Governance Plan: AI governance and assurance arrangements could become fragmented as a result of the Committee restructuring and advised that clear accountability, oversight and organisational controls be maintained to ensure the safe, effective and coordinated adoption of AI technologies across the Health Board.
5.	Review of Risks	The DDRI Committee will keep the Board updated on any developments regarding risks in relation to the above matters.
6.	Sharing of learning	None identified during the meeting.
7.	Actions to be considered by Board	None identified during the meeting.



Meeting Date	24 September 2026	Agenda Item	7.3
Name of Meeting	SBUHB Board		
Report Title	Corporate Governance Report		
Report Author	Carys Richards, Senior Corporate Governance Manager		
Report Sponsor	Director of Corporate Governance		
Presented by	Hazel Lloyd, Director of Corporate Governance		
Freedom of Information	Open		
FoI Closed detail	If closed, choose detail		
Impact Assessment Summary Outcome		IA Completion date	
Not applicable.		Click or tap to enter a date.	
Purpose of the Report	For Assurance		
Report Summary; detailing any action required			
To report on Corporate Governance matters arising since the previous Board meeting.			
Key Issues			
The Corporate Governance report provides the Board with a comprehensive update on key governance matters since the last meeting, which includes the following items as standard: • Matters considered In-Committee at the previous Board meeting; • Welsh Health Circulars (Appendix 1); • Common Seal Register (Appendix 2); • Board Work Programme 2026-27 (Appendix 3). And any additional updates to key workstreams: • Declarations process update; • Update on the Public Affairs Strategy (item 7.3i); • Review of Board Committee arrangements; • Board business tracker			
Decision / Action required	Yes		
Recommendations			
Members are asked to: • RECEIVE for ASSURANCE; - The matters considered In-Committee at the July 2026 Board meeting; - Welsh Health Circulars; - The Common Seal Register; - Board Work Programme 2026-27; - Declarations process update;			



- Update on the Public Affairs Strategy (item 7.3i);
- **CONSIDER** the update on the review of Board Committee arrangements and;
 - **APPROVE** the proposed changes to the Committee structure, including the reduction from ten to eight Board Committees;
 - **APPROVE** the establishment of Capital, Land and Assets, as a formal sub-committee of the Planning, Partnerships and Population Health Committee;
 - **APPROVE** the incorporation of Mental Health Legislation business into the Quality and Safety Committee three times a year;
 - **AGREE** to receive revised Terms of Reference, cycles of business and reporting arrangements in the November Board to reflect, subject to Board approval, the revised Committee structure;
- **BE AWARE** that a Board business tracker will now be used to monitor Board business, utilising an Early Warning Alert system.



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Health Board

CORPORATE GOVERNANCE REPORT

1. INTRODUCTION

The Corporate Governance report is tabled at each public Board meeting to provide an update on all governance related matters arising since the previous Board meeting.

2. BACKGROUND

The Board will receive a number of updates on Corporate Governance items, all of which are detailed within this report and accompanied by any supporting documentation.

A number of standard items are brought to the attention of Board at each Board meeting, along with any additional items that may need, either Board approval or to provide assurance to the Board.

3. GOVERNANCE AND RISK ISSUES

3.1 The Corporate Governance report provides the Board with a comprehensive update on key governance matters since the last meeting, which includes the following standard items received for **ASSURANCE** at each Board meeting:

3.1.1 Matters Considered In-Committee

In accordance with Standing Orders, SBUHB reports matters considered in private session, to the next available public meeting of the Board.

The July 2026 In-Committee Board session included updates on the following:

- Gorseinon Update
- Perinatal Report
- Mental Health update
 - Ward F Investigation progress report
 - Stabilisation Plan Service Changes – verbal update
- Risk Report (Private Risks)
 - Wider Risk
- The composite In-Committee Chairs Report;
- And a number of commercially sensitive or legally privileged items reserved for Board Approval;
 - i. High Value Cases
 - ii. 5th Linear Accelerator (LINAC) Contract Award



Iechyd gwell
Gofal gwell
Bywyd gwell

Better health
Better care
Better lives

3 of 20
SBUHB Board
Thursday, 24 September 2026

3.1.2 Welsh Health Circulars (WHCs)

Welsh Government issues WHCs around specific topics; these are available on the [Welsh Government website](#), including details on the risks and governance issues. The items issued within the current reporting timeframe are included within **Appendix 1**.

3.1.3 Common Seal Register

In-line with our Standing Orders, the Board receives a report on the affixing of the Common Seal. **Appendix 2** sets out the latest position.

3.1.4 Board Work Programme

The Board receives a copy of its annual Work Programme reflecting the most current position of all organisational-wide items and the timescale for reporting into Board, as at **Appendix 3**.

3.1.5 Declarations process update

The purpose of this update on the organisational-wide Declarations process is to provide assurance to the Board on the transfer of the current paper based process over to a more resilient digital system.

Work has recently been completed on transferring the following declaration forms from the Standards of Business Conduct policy onto the MS Forms platform, supported by SharePoint Lists automation;

- Declarations of Interest (incl Secondary Employment);
- Gifts, Hospitality and Sponsorship;
- Honoraria and Miscellaneous Payments, and
- Private Clinical Work.

The work, being led by the Corporate Governance Team in collaboration with digital colleagues, is currently in the testing phase and expected to be finalised and rolled out across the organisation by the start of October 2026, accompanied by a Standard Operating Procedure, and guidance for all staff through targeted engagement across departmental e-news letters and staff bulletins. As a result, the Standards of Business Conduct policy is currently under review to reflect the changes.

Once implemented, the digital declaration forms will be accessible to all staff via the Corporate Governance Hub, improving

accessibility and the efficiency of data collection, monitoring and reporting arrangements.

This will strengthen overall governance processes and provide additional assurance regarding the management and oversight of the Health Board's declaration position in line with its statutory requirements, which includes the publishing of up-to-date declaration registers on the website throughout the financial year.

3.1.6 Update on the Public Affairs Strategy (item 7.3i)

The purpose of this paper is to update the Board on the implementation of the Public Affairs Strategy approved in March 2026, including political briefings, proactive visits, local authority engagement and arrangements for managing political visit requests.

3.1.7 Proposed Changes to Board Committee Arrangements

This section provides the Board with an update on the review of the Health Board's Committee arrangements and seeks approval for the proposed revised Committee structure. The review has been undertaken as part of the Board's wider commitment to strengthen governance, accountability, reduce duplication and ensure Committee business is aligned to the Health Board's strategic priorities, principal risks and sources of assurance.

The proposed changes are intended to reduce the number of standing Board Committees from ten to eight, whilst maintaining appropriate oversight of statutory, regulatory, quality, safety, performance, finance, workforce, population health, partnership and assurance responsibilities. The proposed changes are set out below.

- The Population Health Committee will become the Planning, Partnerships and Population Health Committee, providing clearer oversight of strategy, partnerships, population health, digital enablement, capital, land and assets, and regional planning interfaces.
- Capital, Land and Assets arrangements will become a formal sub-committee of the Planning, Partnerships and Population Health Committee.
- The Digital, Data, Research and Innovation Committee will be stepped down as a separate Committee.



- Digital will be incorporated into the Planning, Partnerships and Population Health Committee as a key strategic enabler.
- Research will be incorporated into the Regional Joint Committee, reflecting the developing collaboration with Hywel Dda University Health Board and the wider South West Wales agenda.
- The Mental Health Legislation Committee will be stepped down as a separate Committee, with focused Mental Health Legislation business incorporated into the Quality and Safety Committee three times a year.
- Data and performance intelligence will be embedded across Committees, with Committee Chairs agreeing the relevant dashboards for their portfolios.
- The Workforce and Organisational Development Committee will be reframed as the Workforce and Culture Committee, strengthening the Board's focus on culture, leadership, workforce sustainability and organisational development.

There are no additional financial implications arising directly from the proposed changes. The main governance risk relates to ensuring that responsibilities transferred from Committees being stepped down are clearly reflected in updated Terms of Reference, Committee work programmes, reporting routes and dashboards. This will be mitigated through a structured implementation plan, including revised Terms of Reference for Board approval where required, refreshed cycles of business, and continued oversight by the Director of Corporate Governance.

Subject to Board approval, the Table below summarises the Committees reporting to the Board, together with their meeting frequency and Lead Executive or Corporate Director arrangements.



Board		
Committee reporting to the Board	Frequency	Lead Executive / Corporate Director
Remuneration and Terms of Service Committee	Monthly	Chief Executive
Performance and Finance Committee	Monthly	Executive Director of Finance/Chief Operating Officer
Audit Committee	Bi-monthly	Director of Corporate Governance
Quality and Safety Committee	Bi-monthly	Executive Director of Nursing / Executive Medical Director
Workforce and Culture Committee	Bi-monthly	Executive Director of Workforce
Planning, Partnerships and Population Health Committee	Quarterly	Executive Director of Planning and Partnerships / Executive Director of Public Health
Charitable Funds Committee	Quarterly	Executive Director of Finance/Director of Communications, Insights & Engagement
Regional Joint Committee	Quarterly	Chief Executive

3.1.8 Early Warning Alert: Business Due Back to Board

As at the completion of the September Board meeting the Board action log will include an early warning alert system to strengthen oversight of business agreed to return to Board. This will identify items that are due, at risk of delay or overdue, and will link each item to the relevant Lead Executive, agreed return date, current Red Amber Green (RAG) status, assurance required and escalation route. The purpose is to ensure that commitments made through Board and Committee business remain visible, actively managed and escalated where delay may affect statutory compliance, strategic risk, quality, safety, finance, regulatory response or public confidence.

Alert Triggers

Triggers to be aware of when updating an action that will inform how they are presented to Board are:

- A report, decision paper, assurance update, closure report or revised plan was promised to return to Board.
- The item in question is due within the next two Board cycles but is not yet confirmed on the Work Programme.
- The agreed return date has passed, or there is no confirmed revised date.



- The delay affects statutory compliance, regulatory response, strategic risk, quality, safety, finance or public confidence.

RAG Assessment and Escalation

The scoring rating system that will be implemented by the Governance team against each action on the log going forward:

Rating	Definition	Required Action
Green	Scheduled, owned and progressing to the agreed Board cycle.	Maintain oversight through the action log and forward work programme.
Amber	Due soon, not scheduled, evidence incomplete or delivery confidence uncertain.	Lead Executive to confirm readiness, revised timing and assurance evidence.
Red	Overdue, unscheduled, no agreed revised date or material governance risk identified.	Escalate to Chair, Chief Executive, relevant Committee Chair and Board by exception.

Business Due Back Tracker

A visual tracker will be compiled incorporating the metrics below, on all Board business, not inclusive to action log items and shared monthly at the Executive Board meeting for regular review, ensuring items are monitored and continue to progress:

Original Board Date	Item Due Back	Lead	Due Date	RAG	Risk if Delayed	Next Step
Date	Subject / commitment	Executive lead	Board cycle	G/A/R	Impact on assurance, risk or compliance	Bring forward / defer / escalate / close

Governance Review Route

Following each Board, the Governance team will review the minutes, Action Log, Committee 3A reports and Work Programme to identify any commitment due to return to Board. The Business Tracker is updated and shared at Executive Board; whereby items, specifically Amber, are reviewed with the Lead Executive. Items that remain Red are escalated to the Chair and Chief Executive, with Board receiving an exception report where required.

Board Assurance



The Board can take assurance that business agreed for return remains subject to active governance oversight, with clear ownership, agreed timelines, RAG-rated escalation and visibility of any material risk arising from delay.

4. OPEN AUDIT RECOMMENDATIONS

There are currently no open Audit recommendations impacted by the items within this report.

5. FINANCIAL IMPLICATIONS

There are no financial implications arising within this report.

6. RECOMMENDATIONS

Members are asked to:

- **RECEIVE** for **ASSURANCE**:
 - The matters considered In-Committee at the July 2026 Board meeting;
 - Welsh Health Circulars;
 - The Common Seal Register;
 - Board Work Programme 2026-27;
 - Declarations process update
 - Update on the Public Affairs Strategy
- **CONSIDER** the update on the review of Board Committee arrangements and;
 - **APPROVE** the proposed changes to the Committee structure, including the reduction from ten to eight Board Committees;
 - **APPROVE** the establishment of Capital, Land and Assets, as a formal sub-committee of the Planning, Partnerships and Population Health Committee;
 - **APPROVE** the incorporation of Mental Health Legislation business into the Quality and Safety Committee three times a year;
 - **AGREE** to receive revised Terms of Reference, cycles of business and reporting arrangements in the November Board to reflect, subject to Board approval, the revised Committee structure;
- **BE AWARE** that a Board business tracker will now be used to monitor Board business, utilising an Early Warning Alert system.



Governance and Assurance		
Strategic Objectives		
Strategic Objectives <i>(please choose which is impacted)</i>	People of Swansea Bay live healthier, fairer and more prosperous lives	☐
	Care is high quality, safe, efficient and delivers the best possible outcomes for people in partnerships	☐
	Care is delivered in partnership with our communities in safe and appropriate setting, supported by innovation	☐
	The health board is a great place to work where staff feel valued and work together towards a common goal	☐
	The health board is a resilient, sustainable and responsible organisation	☒
Health and Care Standards		
Standards <i>(please choose which applies)</i>	Safe Care	☐
	Timely Care	☐
	Effective Care	☐
	Efficient Care	☐
	Equitable care	☐
	Person-centred Care	☐
	Staff and Resources	☒
Enablers <i>(please choose which applies)</i>	Whole Systems Approach	☐
	Leadership	☐
	Workforce	☐
	Culture	☐
	Information	☒
	Learning, Improvement and Research	☐
Quality, Safety and Patient Experience		
Welsh health circulars provide advice, guidance and information relating to changes in process or services which work to enhance services.		
Financial Implications		
There are no financial implications associated with this report.		
Legal Implications (including equality and diversity assessment)		
Any legal implications relating to Welsh health circulars would be identified in the individual documents.		
Staffing Implications		
There are no staffing implications contained with this report.		
Long Term Implications (including the impact of the Well-being of Future Generations (Wales) Act 2015)		
Welsh health circulars provide advice, guidance and information relating to changes in process or services which work to enhance the way in		



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which NHS Wales organisation's function and would therefore potentially have individual long-term impacts.

Report History

This report is a standard item on the Board's Cycle of Business.

Appendices

- Welsh Health Circulars (Appendix 1)
- Common Seal Register (Appendix 2)
- Board Work Programme 2026-27 (Appendix 3)
- Update on the Public Affairs Strategy (item 7.3i)



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Appendix 1: WELSH HEALTH CIRCULARS

WHC Number and Title	Date Received by Email	Recipients Taking Action
WHC/2026/26 - An urgent time-limited Meningococcal B (MenB) vaccination programme in response to recent outbreaks.	16/07/26	Chief Executives, Health Boards/Trusts Vaccination Operational Leads, Health Boards/Trusts Medical Directors, Health Boards/Trusts Directors of Primary Care, Health Boards/Trusts Nurse Executive Directors, Health Boards/Trusts Chief Pharmacists, Health Boards/Trusts Directors of Public Health, Health Boards/Trusts Directors of Therapies and Health Science Health Boards/Trusts National Director Health Protection and Screening Services/ Executive Medical Director, Public Health Wales Nurse Director, Public Health Wales Head of Vaccine Preventable Disease Programme, Public Health Wales Director of Vaccine Delivery, Vaccination Programme Wales, NHS Wales Performance and Improvement General Practitioner Committee, Wales General Practitioners Community Pharmacies Community Pharmacy Wales Digital Health Care Wales
WHC/2026/023 - Expansion of Pneumococcal Vaccine Eligibility to People Experiencing	28/07/26	Chief Executives, Health Boards/Trusts Immunisation Leads, Health Boards/Trusts Immunisation Coordinators, Health Boards Vaccination Operational Leads, Health Boards/Trusts Occupational Health Leads, Health Boards/Trusts Medical Directors, Health Boards/Trusts Directors of Primary Care, Health Boards/Trusts



WHC Number and Title	Date Received by Email	Recipients Taking Action
		Nurse Executive Directors, Health Boards/Trusts Directors of Therapies and Health Sciences, Health Boards/Trusts Chief Pharmacists, Health Boards/Trusts Directors of Public Health, Health Boards/Trusts Heads of Maternity Services, Health Boards/Trusts Directors of Workforce and Organisational Development, Health Boards/Trusts Executive Director of Public Health, Public Health Wales Nurse Director, Public Health Wales Head Vaccine Preventable Disease Programme, Public Health Wales Director of Vaccination Delivery, Vaccination Programme Wales, NHS Wales Performance and Improvement General Practitioners Community Pharmacists Digital Health and Care Wales
WHC/2026/029 - Introduction of Clesrovimab (Enflonsia) as an additional product for RSV passive immunisation in at-risk infants	03/08/26	Chief Executives, Health Boards/Trusts Immunisation Leads, Health Boards/Trusts Immunisation Coordinators, Health Boards Vaccination Operational Leads, Health Boards/Trusts Medical Directors, Health Boards/Trusts Directors of Primary Care, Health Boards/Trusts Nurse Executive Directors, Health Boards/Trusts Chief Pharmacists, Health Boards/Trusts Directors of Public Health, Health Boards/Trusts Executive Director of Public Health, Public Health Wales Head Vaccine Preventable Disease Programme, Public Health Wales Director of Vaccine Delivery, Vaccination Programme Wales, NHS Executive.



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WHC Number and Title	Date Received by Email	Recipients Taking Action
		Community Paediatricians, Health Boards Heads of Midwifery, Health boards / Trusts. Midwifery teams, Health Boards Secondary Care Paediatricians, Health Boards Consultant Virologists, Health Boards Health Protection teams, Health Boards General Practitioner Committee, Wales General practitioners Digital Health and Care Wales.
WHC/2026/027 - Update to 'Safety netting discharge leaflets for adults and children	26/08/26	Health Board Medical Directors, Executive Directors of Nursing, Heads of Emergency Departments, Clinical Directors, Sepsis leads



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Appendix 2: COMMON SEAL REGISTER

Document Number	Date Signed	Document Details
57.65	10.08.26	Deed of Settlement
58.26	07/09/26	NEC4 Professional Services Contract (PSC) Option A Mechanical And Electrical Designer Services DR Room 6 Replacement, Singleton
59.26	07/09/26	Call Off Contract For Project Manager Building For Wales 2 Lot 2 The South West Wales Regional Cellular Pathology Centre In The Campus Swansea University
60.26	07/09/26	Renewal Lease By Reference To An Existing Lease relating to Premises at Singleton Hospital, Swansea
61.26	07/09/26	NEC4 Engineering and Construction Short Contract in relation to Window And Door Replacement Cwmbwrla Clinic
62.26	07/09/26	Call Off Contract For Cost Advisor Building For Wales 2 Lot 2 The South West Wales Regional Cellular Pathology Centre In The Bay Campus At Swansea University
63.26	07/09/26	Call Off Contract For Cost Advisor Building For Wales 2 Lot 2 The South West Wales Regional Cellular Pathology Centre In The Bay Campus At Swansea University



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Document Number	Date Signed	Document Details
64.26	07/09/26	Grant Agreement for Neath Port Talbot Local Nature Partnership Biodiversity Grant Scheme ICwtsh Natur Project for biodiversity improvements at the Children's Centre, Neath Port Talbot Hospital



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Appendix 3: BOARD WORK PROGRAMME 2026-27

Topic	Lead	Authors / Supporting Colleagues / Detail	May-26	(Accounts)	Jul-26	Sep-26	Nov-26	Jan-27	Mar-27
Preliminary Matters									
Patient/Staff Story	Director of Nursing and Patient Experience	Agenda specific							
Minutes of the Previous Meeting	Director of Corporate Governance								
Action Log	Director of Corporate Governance								
Chair's Report	Chair (verbal)								
Chief Executive's Report	Director of Corporate Governance								
Quality, Safety and Performance									
Committee Key Issue Reports (3As)	Director of Corporate Governance								
Maternity and Neonatal	Director of Corporate Governance	IN-COMMITTEE							
Mental Health Transformation Programme update	Chief Executive Officer	When requested			?	?	?	?	?
Perinatal Service (incls: Perinatal Committee Report)	Director of Nursing and Patient Experience	When requested incls: Perinatal Oversight Panel Report							



Topic	Lead	Authors / Supporting Colleagues / Detail	May-26	(Accounts)	Jul-26	Sep-26	Nov-26	Jan-27	Mar-27
Risk Register	Director of Corporate Governance								
Board Assurance Framework	Director of Corporate Governance								
Annual Report and Governance Statement	Director of Corporate Governance								
Annual Accounts and ISA260	Director of Finance								
Healthcare Inspectorate Wales Annual Report 2024-25	Director of Nursing and Patient Experience								
Strategic Items									
Discretionary Capital Plan	Director of Strategy								
Budget and Financial Allocations	Director of Finance								
Major Incident Plan	Director of Strategy								
Progress report on Estates Strategy	Director of Finance and Performance								
Progress report on Population Health Strategy	Director of Public Health								*
Digital Strategy	Director of Digital								
Planning and Partnerships	Director of Planning								*
Winter Plan	Chief Operating Officer								



Topic	Lead	Authors / Supporting Colleagues / Detail	May-26	(Accounts)	Jul-26	Sep-26	Nov-26	Jan-27	Mar-27
Mental Health Transformation Report	Chief Operating Officer	As requested by CEO 29/09							
People									
Quarterly workforce resilience report	Director of Workforce and OD								
Governance									
Corporate Governance Report	Director of Corporate Governance								
Welsh Language Standards	Director of Corporate Governance								
Review of Standing Orders	Director of Corporate Governance								
Annual Report	Director of Corporate Governance								
Accountability Report	Director of Corporate Governance								
Advisory Group Report (incl 3x Group Key Issues Reports)	Director of Corporate Governance								
Structured Assessment and Audit Letter	Director of Corporate Governance								
Items Already Considered by Committees									
Finance Report	Director of Finance								





Topic	Lead	Authors / Supporting Colleagues / Detail	May-26	(Accounts)	Jul-26	Sep-26	Nov-26	Jan-27	Mar-27
Performance Report	Director of Finance								
Escalation Report	Chief Operating Officer	Reporting through the IPR as above							
Nurse Staffing Levels (Wales) Act 2016	Director of Nursing and Patient Experience								
Planning and Partnerships Report	Executive Director of Planning and Partnerships	Includes quarterly updates: Progress Against the Annual Plan	Qtr4		Qtr1		Qtr2		Qtr3
Primary Care									
May – Dental report	Chief Operating Officer								
July – GMS	Chief Operating Officer								
September – Community Pharmacy	Chief Operating Officer								
November – Optometry	Chief Operating Officer								
January – HMP Swansea / Phlebotomy	Chief Operating Officer								
March – District Nursing	Chief Operating Officer								



Meeting Date	24 September 2026	Agenda Item	7.4
Name of Meeting	SBUHB Board		
Report Title	Welsh Language Performance Report 2026		
Report Author	Welsh Language Lead – Jordan Morgan-Hughes		
Report Sponsor	Executive Director of Nursing and Patient Experience		
Presented by	Liz Rix, Executive Director of Nursing and Patient Experience		
Freedom of Information	Open		
FoI Closed detail	If closed, choose detail		
Impact Assessment Summary Outcome		IA Completion date	
Not Applicable.		Click or tap to enter a date.	
Purpose of the Report	For Approval		
Report Summary; detailing any action required			
The Welsh Language Performance Report 2025/26 highlights Swansea Bay University Health Board’s continued commitment to delivering safe, person-centred bilingual healthcare and improving compliance with the Welsh Language Standards. Key achievements include progress in priority clinical services, expanded Welsh language learning opportunities, strengthened recruitment and governance processes, and successful engagement initiatives such as the Urdd Eisteddfod and staff learning programmes. The report evidences growing organisational recognition that language is integral to quality of care and patient outcomes. Overall compliance remains strong, with 75% of standards rated as having a high level of assurance, and no Welsh language complaints received during the year. The report also sets out priorities for 2026/27, focusing on leadership, patient experience, workforce development and expanding Welsh-medium clinical provision.			
Key Issues			
The Annual Welsh Language Performance Report gives detail on the progress made across the organisation to offer improved experiences for our patients that need to access services in Welsh. Highlights from the report include:			



- Continued strengthening compliance with the Welsh Language Standards by embedding Welsh language considerations within quality, safety and person-centred care.
- Delivered further progress against the five-year Welsh-medium services plan, particularly in Mental Health, Learning Disabilities and Speech and Language Therapy.
- Expanded Welsh language workforce development, with over 160 staff participating in Welsh language learning and confidence-building programmes.
- Strengthened governance, recruitment and workforce planning processes to improve the organisation's capacity to meet Welsh language needs.
- Increased the visibility of Welsh through staff engagement, partnership initiatives and national events, while maintaining strong compliance, with 75% of standards rated as high assurance and no complaints received.

**Decision / Action
required**

No

Recommendations

Members are asked to:

- **APPROVE** the report for publication.



WELSH LANGUAGE PERFORMANCE REPORT 2026

1. INTRODUCTION

The appended report satisfies our obligations under standard 120 of our Welsh Language Standards compliance notice. Each financial year, we must publish a report which details the way in which we have complied with the standards. This report must be published no later than 30 September each year.

2. BACKGROUND

The report provides evidence of positive progress, including strengthened governance arrangements, increased Welsh language training activity, implementation of a five-year plan to expand Welsh-medium clinical provision, and improved controls for recruitment compliance.

Patient feedback and workforce development activity also provide evidence of growing organisational maturity in recognising the relationship between language, quality and patient experience. While the report suggests opportunities for further improvement, particularly in relation to workforce language data, Welsh language awareness training compliance and increasing the availability of Welsh-medium services in some areas, clear actions and measurable priorities have been identified to address these challenges.

The Committee is therefore asked to take assurance from the progress highlighted within the report and support the proposed priorities for 2026/27, which are intended to strengthen bilingual service provision, improve workforce planning and further embed Welsh language considerations within the Health Board's quality and improvement agenda.

3. GOVERNANCE AND RISK ISSUES

There are some governance and risk issues raised in the report that the committee should note:

A. Incomplete workforce language skills data

- For the reporting period, only 57.54% of staff had recorded at least one Welsh language competency.
- 42.46% of staff had not recorded their language skills.
- Workforce planning, recruitment decisions and service capacity assessments are therefore being made using incomplete information
Risk: The Health Board cannot reliably demonstrate it understands its capacity to deliver Welsh-medium services or implement the Active Offer. This creates assurance and compliance risks against More Than Just Words and Welsh Language Standards.



B. Recruitment process may not be identifying Welsh-essential posts robustly

The report notes:

- 1,254 posts advertised.
- Only 2 were Welsh Essential.
- 1,208 were Welsh Desirable.
- The report identifies this as a future priority and states a more systematic approach is required.

Risk: Health Board is unable to demonstrate a process for assessing linguistic requirements of posts. Welsh being routinely categorised as "desirable" rather than assessed against patient need and current service capacity/ability.

4. OPEN AUDIT RECOMMENDATIONS

Not applicable

5. FINANCIAL IMPLICATIONS

Failing to publish the Welsh language Performance report by 30 September 2026 could result in enforcement action, leading to financial penalties.

6. RECOMMENDATION

Members are asked to:

- **APPROVE** the report for publication.



Governance and Assurance		
Strategic Objectives		
Strategic Objectives <i>(please choose which is impacted)</i>	People of Swansea Bay live healthier, fairer and more prosperous lives	☒
	Care is high quality, safe, efficient and delivers the best possible outcomes for people in partnerships	☒
	Care is delivered in partnership with our communities in safe and appropriate setting, supported by innovation	☐
	The health board is a great place to work where staff feel valued and work together towards a common goal	☐
	The health board is a resilient, sustainable and responsible organisation	☐
Health and Care Standards		
Standards <i>(please choose which applies)</i>	Safe Care	☒
	Timely Care	☐
	Effective Care	☒
	Efficient Care	☐
	Equitable care	☒
	Person-centred Care	☒
	Staff and Resources	☒
Enablers <i>(please choose which applies)</i>	Whole Systems Approach	☒
	Leadership	☒
	Workforce	☒
	Culture	☒
	Information	☐
	Learning, Improvement and Research	☐
Quality, Safety and Patient Experience		
Failure to consider the preferred language options of patients, and/or to provide care via the medium of that preferred language, may have a detrimental effect on the quality of the care provided, and on the overall patient experience.		
Financial Implications		
Failure to comply with relevant Welsh Language Standards may result in sanction by the Welsh Language Commissioner, including financial penalty.		
Legal Implications (including equality and diversity assessment)		
Failure to comply with relevant Welsh Language Standards may leave the Health Board open to complaints, and investigations and sanction by the Welsh Language Commissioner.		
Staffing Implications		



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The Health Board has a statutory duty to facilitate and promote the use of the Welsh language amongst its staff, and to record and report on their Welsh Language abilities.

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

The Welsh language is a cross-cutting issue and is relevant to all seven well-being objectives of the Well-being of Future Generations Act. It is of particular relevance to Theme 7: A Wales of vibrant culture and thriving Welsh language.

Report History

Welsh Language Planning and Development Group 28/07/2026
Quality and Safety Committee 06/08/2026

Appendices

Appendix 1 - Welsh Language Performance Report 2026



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Meeting Date	24 September 2026	Agenda Item	7.5
Name of Meeting	SBUHB Board		
Report Title	Board Advisory Groups Report		
Report Author	Claire Mulcahy, Corporate Governance Manager		
Report Sponsor	Director of Corporate Governance		
Presented by	Hazel Lloyd, Director of Corporate Governance		
Freedom of Information	Open		
FoI Closed detail	If closed, choose detail		
Impact Assessment Summary Outcome		IA Completion date	
N/A		Click or tap to enter a date.	
Purpose of the Report	For Assurance		
Report Summary; detailing any action required			
The purpose of the report is to provide the Board with an update from its Advisory Groups.			
Key Issues			
The Board has three Advisory Groups: - Health Board Partnership Forum; - Health Professionals Forum; and - Stakeholder Reference Group In-line with our Standing Orders, each Advisory Group submits a report to the Board, summarising the discussions that took place at each meeting held since the last Board meeting.			
Decision / Action required	No		
Recommendations			
Members are asked to: • RECEIVE for ASSURANCE the discussions from the: i. Health Board Partnership Forum; ii. Health Professionals Forum; iii. Stakeholder Reference Group; • APPROVE the revised Health Professionals Forum Terms of Reference, as at Appendix 3; • APPROVE the appointment for the SRG Vice Chair role, as at Appendix 4.			

THE BOARD ADVISORY GROUPS REPORT

1. INTRODUCTION

The purpose of the report is to provide the Board with an update from its Advisory Groups.

2. BACKGROUND

The Board has three Advisory Groups and in-line with our Standing Orders each forum submits a report to Board following each meeting; this report covers the main issues from the:

- i. Health Board Partnership Forum held on 3 September 2026
- ii. Health Professionals Forum held on 13 August 2026
- iii. Stakeholder Reference Group held on 17 September 2026

3. GOVERNANCE AND RISK ISSUES

(i) Health Board Partnership Forum

The following topics were covered at the meeting;

- Transforming for the Future
- Organised for Success
- Extreme Heat and Emergency Preparedness Resilience and Response
- Martyn's Law
- Violence prevention and reduction
- Social Media Guidance
- Menopause Action Plan
- Student streamlining/Ward transformation programme

The full report is set out in **Appendix 1**.

(ii) Health Professionals Forum

At the meeting on the 13 August 2026, the forum considered the following strategic and transformational matters;

- Transforming for the Future,
- implementation of the Planned Care Recovery and Cancer Improvement Programmes,
- Organising for Success and the
- Forum's forward work programme.

- Professional highlight reports were received from Allied Health Professions, Restorative Dentistry, and Nursing and Midwifery.

The full report is set out in **Appendix 2**.

The Board is asked to **APPROVE** the revised Health Professionals Forum Terms of Reference. The terms of reference are attached as **Appendix 3**

(iii) Stakeholder Reference Group

The Stakeholder Reference Group met on the 17 September 2026 and received an update on the following areas;

- Listening to People
- Hybrid mail
- Planned Care Improvement Plan and Cancer Improvement Plan
- Gorseinon Hospital

The Stakeholder Reference Group received a nomination for the Vice Chair role which was agreed in principle subject to Board approval.

The Board is asked to **APPROVE** the appointment for the SRG Vice Chair role.

The full report is set out in **Appendix 4**.

4. OPEN AUDIT RECOMMENDATIONS

There are currently no open Audit recommendations impacted by the items within this report.

5. FINANCIAL IMPLICATIONS

There are no financial implications, as these are not decision-making groups/fora.

6. RECOMMENDATIONS

Members are asked to:

- **RECEIVE** for **ASSURANCE** the discussions from the:
 - i. Health Board Partnership Forum on 3 September 2026;
 - ii. Health Professionals Forum on 13 August 2026;
 - iii. Stakeholder Reference Group on 17 September 2026;



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- **APPROVE** the revised Health Professionals Forum Terms of Reference, as at **Appendix 3**;
- **APPROVE** the appointment for the SRG Vice Chair role, as at **Appendix 4**.



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Governance and Assurance		
Strategic Objectives		
Strategic Objectives (please choose which is impacted)	People of Swansea Bay live healthier, fairer and more prosperous lives	☐
	Care is high quality, safe, efficient and delivers the best possible outcomes for people in partnerships	☒
	Care is delivered in partnership with our communities in safe and appropriate setting, supported by innovation	☐
	The health board is a great place to work where staff feel valued and work together towards a common goal	☐
	The health board is a resilient, sustainable and responsible organisation	☒
Health and Care Standards		
Standards (please choose which applies)	Safe Care	☐
	Timely Care	☐
	Effective Care	☐
	Efficient Care	☐
	Equitable care	☒
	Person-centred Care	☐
	Staff and Resources	☒
Enablers (please choose which applies)	Whole Systems Approach	☐
	Leadership	☐
	Workforce	☒
	Culture	☐
	Information	☒
	Learning, Improvement and Research	☐
Quality, Safety and Patient Experience		
The Advisory Groups, amongst other areas, consider the quality and safety of services from patient and staff perspectives. They also consider the experience of patients and staff. These reports provide assurance to the board that effective scrutiny is taking place to ensure quality, safety, patient and staff experience are of the right level.		
Financial Implications		
There are no financial implications associated with this report.		
Legal Implications (including equality and diversity assessment)		
There are no legal implications but the Health Board has a statutory duty to have these advisory groups within its governance structure.		
Staffing Implications		



While there are no staffing implications to the report, there may be staffing issues included in the highlight report from the Health Board Partnership Forum.

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

The Groups have a strategic focus to their agendas and provide a view on the future plans which will support delivery of the Health Board's short, medium & long-term plans.

Report History

This report is a standard item on the board's business cycle.

Appendices

Appendix 1; Health Board Partnership Forum report;
Appendix 2; Health Professionals Forum report;
Appendix 3; Health Professionals Forum Terms of Reference;
Appendix 4; Stakeholder Reference Group report.



Meeting Date	24 September 2026	Agenda Item	
Name of Meeting	SBUHB Board		
Report Title	Key Issues - Health Board Partnership Forum		
Report Author	Kim Clee Workforce Manager		
Report Sponsor	Executive Director of Workforce and Organisational Development		
Presented by	Tina Ricketts- Executive Director of Workforce and OD		
Freedom of Information	Open		
FoI Closed detail	If closed, choose detail		
Impact Assessment Summary Outcome		IA Completion date	
Not required		Click or tap to enter a date.	
Purpose of the Report	For Assurance		
Report Summary; detailing any action required			
Summary of matters considered by the Health Board Partnership Forum at its meeting on 3 rd September 2026.			
Key Issues			
The follow topics were covered at the meeting: • Transforming for the Future • Organised for Success • Extreme Heat and Emergency Preparedness Resilience and Response • Martyn's Law • Violence prevention and reduction • Social Media Guidance • Menopause Action Plan • Student streamlining/Ward transformation programme			
Decision / Action required	No		
Recommendations			
Members are asked to receive the report for assurance.			



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Key Issues- Health Board Partnership Forum

1. INTRODUCTION

This report provides a summary of matters considered by the Health Board Partnership Forum at its meeting on 3rd September 2026.

2. ITEMS FOR INFORMATION

2.1 Transforming for the Future

An update was received on progress on Transforming for the Future (the Clinical Services Strategic Plan). Engagement activity has included workshops with over 100 participants including clinicians, third sector partners and neighbouring health boards to define what good services look like. These engagement events are continuing, and all data will be used to develop the model of care.

Revised principles emphasise care closer to home, system-wide working, affordability, reducing duplication, prevention, equity and digital enablement and empowering people to stay well and manage their health and wellbeing.

Discussion highlighted community-based care, workforce implications, children and maternity services, regional collaboration and links to Community by Design.

2.2 Organised for Success

An update was received on progress in relation to the Organised for Success programme. In relation to the transition from service groups to care groups, recruitment is underway to appoint to the leadership positions, and the programme remains on track for implementation of the new care group arrangements from April 2027, with a shadow operating model from January 2027.

2.3 Extreme Heat and Emergency Preparedness Resilience and Response (EPRR)

A presentation was received on lessons learned from the summer heatwave response. The Severe Weather policy is one of a suite of policies contained within the EPRR framework by which the health board prepares for, responds to and recovers from emergencies including severe weather incidents. The formal debrief in relation to the hot weather identified that extreme heat should no longer be viewed as an exceptional event, but as a recurring organisational risk.



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Key themes identified as organisational responsibilities included climate adaptation, estate resilience, public health, workforce wellbeing, business continuity, protection of vulnerable patients and strengthened recovery planning to ensure business continuity.

2.4 Martyn's Law

A presentation was received providing an overview of the Terrorism (Protection of Premises) Act 2025 (also known as Martyn's Law). This was introduced after the Manchester Arena bombing and is designed to ensure that security around large venues is enhanced to prevent incidents in future. Preparatory work is underway across Health Board sites, including risk assessments, emergency procedures, site security arrangements and governance requirements ahead of implementation in April 2027.

2.5 Violence Reduction and Prevention

An update was received on the new Violence Prevention and Reduction Policy, which includes a three-stage letter process to give warning to those who are presenting with violent/abusive behaviour, an outline of the Criminal Justice Act powers, workforce training proposals and improved systems for identifying and managing repeat incidents of violence and aggression.

2.6 Social Media Guidance

The guidance document was shared. This is intended to support staff and provide guidance in terms of managing patients who wish to record their consultations or where members of the public post information about their care on social media.

The guidance was discussed and agreed in partnership via the Subgroup of the Health Board Partnership Forum.

2.8 Menopause Action Plan

An update was provided on work underway to develop a Menopause action plan as required by the Employment Rights Act 2025. Initially work is underway to establish what resources are already in place to support staff and then identify anything else that should in the action plan.

Support already in place includes Menopause Champions, a dedicated Menopause page on the intranet, regular Menopause Cafes, awareness workshops for managers and availability of lighter weight uniforms.

3. ITEMS FOR DISCUSSION

3.1 Ward Transformation Programme /Student Streamlining

An update was given on progress in relation to the ward transformation programme including reviews of inpatient staffing models using evidence and benchmarking. Early indicators show positive quality outcomes. Discussion covered workforce impact, healthcare support worker concerns, staff engagement and recruitment of newly qualified nurses. It was recognised that there is a need for continued communication and support for those staff affected. It was acknowledged that it will take some time for the culture to change within the wards to recognise the new arrangements.

The restructuring of the nursing workforce is mitigating, to a limited extent, the issue of identifying roles for our newly qualified nurses as there is an increase in registered nursing staff and reduction in non-registered HCSWs. However, there is still an ongoing national issue with finding roles for all newly qualified nurses. There was a concern that this shortage of nursing posts was leading to some resentment towards our overseas nurses. The Health Board reiterated its zero-tolerance approach to racism and encouraged reporting through established processes. Actions to strengthen communications, support and awareness were supported.

4. GOVERNANCE AND RISK ISSUES

There is no significantly increased level of risk for the Health Board in relation to the content of this report.

5. OPEN AUDIT RECOMMENDATIONS

There are no related open audit recommendations.

6. FINANCIAL IMPLICATIONS

There are no financial implications.



7. RECOMMENDATION

Members are asked to receive the report for assurance.

Governance and Assurance		
Strategic Objectives		
Strategic Objectives (please choose which is impacted)	People of Swansea Bay live healthier, fairer, and more prosperous lives	☐
	Care is high quality, safe, efficient and delivers the best possible outcomes for people in partnerships	☐
	Care is delivered in partnership with our communities in safe and appropriate setting, supported by innovation	☐
	The health board is a great place to work where staff feel valued and work together towards a common goal	☒
	The health board is a resilient, sustainable and responsible organisation	☐
Health and Care Standards		
Standards (please choose which applies)	Safe Care	☐
	Timely Care	☐
	Effective Care	☐
	Efficient Care	☐
	Equitable care	☐
	Person-centred Care	☐
	Staff and Resources	☒
Enablers (please choose which applies)	Whole Systems Approach	☐
	Leadership	☐
	Workforce	☐
	Culture	☐
	Information	☐
	Learning, Improvement and Research	☐
Quality, Safety and Patient Experience		
A fully engaged workforce will ensure higher standards of care.		
Financial Implications		
There are no financial implications in relation to this update report.		
Legal Implications (including equality and diversity assessment)		
There are no legal implications in relation to this update report.		



Staffing Implications
As set out in the report.
Long Term Implications (including the impact of the Well-being of Future Generations (Wales) Act 2015)
None
Report History
Appendices

		Agenda Item	
SBUHB Board 24 th September 2026			
Freedom of Information Status		Open	
Reporting Committee	Health Professionals Forum		
Author	Kate Morgan, Head of Corporate Governance (& FOIA Lead) and Helen Annandale Clinical Director of Allied Health Professionals & Audiology- Chair of Health Professionals Forum		
Lead Executive Director	Elizabeth Rix, Executive Director of Nursing & Patient Experience		
Date of meetings	13th August 2026		
Summary of matters considered by the Health Professionals Forum			
Overview The Health Professionals Forum met on 13th August 2026 and considered a number of strategic and transformational matters, including Transforming for the Future, implementation of the Planned Care Recovery and Cancer Improvement Programmes, Organising for Success and the Forum’s forward work programme. Members considered the implications for patient outcomes, quality and safety, workforce sustainability and professional leadership, and emphasised the importance of continued meaningful multi-professional engagement as future service models are developed. The Forum received a written update on Transforming for the Future. Members welcomed evidence that previous advice from the Forum had influenced the inclusion of research and innovation within the agreed principles for change. Members emphasised the need for broad professional representation across the emerging models of care, including appropriate involvement from primary and community care, pharmacy and specialist professional services. The scheduled presentation on the Planned Care Recovery Plan did not take place. The Forum nevertheless discussed the importance of meaningful multi-professional involvement in both the Planned Care Recovery and Cancer Improvement Programmes. A fuller update on both programmes will be received at the next meeting, including consideration of how the contribution and requirements of smaller specialist services are reflected within programme delivery.			

The Forum reviewed and endorsed the revised Terms of Reference for submission to the Board for approval. Members noted that, although local amendments had been incorporated, the overall framework was nationally prescribed and that more substantive changes would require review at an all-Wales level.

Professional highlight reports were received from Allied Health Professions, Restorative Dentistry, and Nursing and Midwifery. These highlighted positive developments in professional recognition, education and training, recruitment, equipment investment and leadership development. They also identified cross-cutting concerns relating to workforce fragility within particular specialist services, recruitment and retention, succession planning and professional leadership capacity.

Key Assurance Points

- The Forum continues to strengthen its role in providing structured, multi-professional advice to the Board on strategic transformation, workforce sustainability, quality and service delivery.
- Previous advice from the Forum contributed to the inclusion of research and innovation within the agreed Transforming for the Future principles.
- Professional groups remain actively engaged in major transformation and improvement programmes, although the Forum emphasised the need for this engagement to be early, meaningful and inclusive of smaller specialist services.
- The professional highlight reporting process is improving the visibility of good practice, emerging professional risks and cross-cutting workforce issues.
- The Forum endorsed its revised Terms of Reference for submission to the Board for approval.

Key risks and issues/matters of concern of which the board needs to be made aware:

Key Risks and Issues for Board Awareness

- Professional leadership and succession: The Forum highlighted the need for timely and substantive succession arrangements following senior professional leadership retirements. Maintaining visible and effective professional leadership is particularly important during the current period of organisational and service transformation.
- Workforce sustainability: Recruitment, retention and training-pipeline challenges are affecting particular specialist services, including dental nursing, pharmacy and some specialist AHP, nursing and Healthcare Science areas. The Forum noted that these pressures vary between professions but can create significant service vulnerability where teams are small or specialist expertise is limited.
- Professional involvement in transformation: The Forum emphasised the importance of early and meaningful multi-professional involvement in Transforming for the Future, Organising for Success, Planned Care Recovery and Cancer Improvement, so that emerging arrangements are clinically informed and sustainable.
- Visibility of smaller specialist services: Members highlighted a risk that smaller specialist services, including those outside traditional operational or outpatient structures, may not have equitable access to operational management support,

digital intelligence and transformation capacity. This should be explicitly considered as programmes move into implementation. • Quality during financial and organisational change: The Forum agreed that its distinctive contribution should be to advise the Board on the implications of financial recovery and organisational change for quality and patient outcomes.	
Delegated action by the forum:	
The Forum agreed the following delegated action: • The Forum endorsed the revised Terms of Reference and agreed that they should be submitted to the Board for formal approval, recognising that, while a number of local amendments had been incorporated, substantive changes would require national review. Recommendation to the Board The Board is asked to: • note the key assurance matters, risks and issues highlighted by the Health Professionals Forum; and • approve the revised Health Professionals Forum Terms of Reference attached at Appendix 1.	
Reports and presentations were received from:	
Ffion Ansari, Matthew Locke, Sarah Gigg (Ann Milligan presented) and Sharron Price	
Highlights reporting into this forum:	
Across the professional highlight reports, the Forum identified three key themes: • Workforce sustainability and recruitment challenges within specialist professional groups. • Professional leadership capacity and succession planning, particularly within Therapies, Health Sciences and specialist services. • Strong professional engagement in major transformation programmes, including Planned Care Recovery, Cancer Improvement and Transforming for the Future.	
Matters referred to other committees	
None identified	
Date of next Health Professionals Forum	08 October 2026

Health Professionals Forum

Terms of Reference & Operating
Arrangements

2026-27

1 INTRODUCTION

- 1.1 The Health Board's (HB's) Standing Orders provide that "The Board has a statutory duty to take account of representations made by persons who represent the interests of the communities it serves, its staff and health professionals. To help discharge this duty, the Board may and, where directed by the Welsh Government must, appoint Advisory Forums to the Health Board to provide advice to the Board in the exercise of its functions. The Board's commitment to openness and transparency in the conduct of all its business extends equally to the work carried out by others to advise it in the conduct of its business."
- 1.2 The Board's Advisory Forums include a Stakeholder Reference Group, Health Professionals Forum and Local Partnership Forum.
- 1.3 In line with Standing Orders, the Board shall establish and operate an Advisory Forum to be known as the **Health Professionals Forum (HPF)**. The detailed terms of reference and operating arrangements set by the Board in respect of this Forum are set out below.
- 1.4 These Terms of Reference should be read in conjunction with Section 4.11 of Standing Orders.

2 PURPOSE

- 2.1 The purpose of the HPF is to:
 - Provide a balanced, multi disciplinary view of professional issues to advise the Board on local strategy and delivery. Its role does not include consideration of professional terms and conditions of service.
 - Facilitate engagement and debate amongst the wide range of clinical interests within the HB's area of activity, with the aim of reaching and presenting a cohesive and balanced professional perspective to inform the HB's decision making.
 - Offer advice and feedback to the Board

3 DELEGATED POWERS AND AUTHORITY

- 3.1 The HPF is an Advisory Forum and therefore has no delegated powers.

Sub Fora

- 3.2 The Forum may [subject to the approval of the HB Board] establish task and finish groups or sub fora to carry out on its behalf specific aspects of its function.

4 MEMBERSHIP

Members

- 4.1 Membership will comprise:

- Chair: Appointed with Board approval; The Chair will be an Associate Member of the Board
- Vice Chair: Selected by the Forum
- Members: The membership of the Health Professionals Forum reflects the structure of the seven health Statutory Professional Advisory Committees set up in accordance with Section 190 of the NHS (Wales) Act 2006. Membership of the Health Professionals Forum shall therefore comprise the following eleven (11) members:

Welsh Medical Committee

- Primary and Community Care Medical representative
- Mental Health Medical representative
- Specialist and Tertiary Care medical representative

Welsh Nursing and Midwifery Committee

- Community Nursing and Midwifery representative
- Hospital Nursing and Midwifery representative

Welsh Allied Health Professions Advisory Committee

- Therapies representative

Welsh Scientific Advisory Committee

- Scientific representative

Welsh Optometric Committee

- Optometry representative

Welsh Dental Committee

- Dental representative

Welsh Pharmaceutical Committee

- Hospital Pharmacists representative
- Community Pharmacists representative

In order to facilitate an exchange of information, professional leads from the following service areas will also be named members of the forum:

1. Allied Health professionals
2. Dental
3. Health Science
4. Nursing
5. Medical
6. Midwifery
7. Pharmacy

These professional leads will contribute as subject matter experts drawing on professional knowledge and networks, rather than acting as formally mandated representatives of their professions. These leads will identify a named deputy wherever possible to ensure continuity of attendance and contribution.

- 4.2 In attendance: Executive Directors will attend as required to discuss work within their portfolios where the advice of the HPF is being sought.
- The Board Chair Vice Chair, Independent Members and the Chief Executive shall attend HPF meetings as and when necessary
- 4.3 By invitation: The Forum Chair may extend invitations to attend Forum meetings as required to the following:
- Task and Finish or sub-Forum members
 - Leads from Clusters/ Clinical Teams across the Health Board
 - Others from within or outside the organisation who the Forum should attend, taking account of the matters under consideration at each meeting.
- Secretariat**
- 4.4 Secretary: As determined by the Director of Corporate Governance.

Member Appointments

- 4.5 Appointments to the Health Professionals Forum shall be made by the Board, based upon nominations received from the relevant professional Forum, and in accordance with any specific requirements or directions made by Welsh Government.
- 4.6 Members shall be appointed for a period specified by the Board, but for no longer than 4 years in any one term. Those members can be reappointed but may not serve a total period of more than 8 years consecutively
- 4.7 Detailed arrangements for the appointment process for the Chair and Vice Chair, resignation, suspension and removal of HPF members is set out in Section 4.15 and 4.16 of Standing Orders
- 4.8 Terms and conditions of appointment, (including any remuneration and reimbursement) in respect of HPF members are determined by the Board, based upon the recommendation of the HB Chair {and, where appropriate on the basis of advice from the HB's Remuneration and Terms of Service Committee}.

Support to HPF Members

The LHB's Director of Corporate Governance, on behalf of the Chair, will ensure that the Forum is properly equipped to carry out its role by:

- co-ordinating and facilitating any appropriate induction and organisational development activity;
- ensuring the provision of governance advice and support to the Forum Chair on

the conduct of its business and its relationship with the Health Board and others;

- ensuring the provision of secretariat support for Forum meetings;
- ensuring that the Forum receives the information it needs on a timely basis; and
- facilitating effective reporting to the Board
- enabling the Board to gain assurance that the conduct of business within the HPF accords with the governance and operating framework it has set.

5 FORUM MEETINGS

Quorum

- 5.1 At least four members must be present to ensure the quorum of the Forum, one of whom should be the Forum Chair or Vice-Chair. Depending on the subject matter of the meeting adequate representation from that particular professional group must be present.

Frequency of Meetings

- 5.2 The forum shall meet at least quarterly and otherwise as the Chair of the Forum deems necessary.

6 RELATIONSHIPS & ACCOUNTABILITIES WITH THE BOARD AND ITS COMMITTEES/FORUMS

- 6.1 The HPF's main link with the Board is through the HPF Chair's membership of the Board as an Associate Member.
- 6.2 The Board may determine that designated Board members or Health Board staff should be in attendance at Advisory Forum meetings. The HPF's Chair may also request the attendance of Board members or Health Board staff, subject to the agreement of the Health Board Chair.
- 6.3 The Board will determine the arrangements for any joint meetings between the Board and the Forum.
- 6.4 The Board's Chair will meet with the HPF Chair on a regular basis to discuss the HPF's activities and operation.

The Health Board Chair, on the advice of the Chief Executive and/or Director of Corporate Governance, may recommend that the Board afford direct right of access to any professional group, in the following, exceptional circumstances:

- where the Forum recommends that a matter should be presented to the Board by a particular professional grouping e.g., due to the specialist nature of the issues concerned; or
- where a professional group has demonstrated that the Forum has not

afforded it due consideration in the determination of its advice to the Board on a particular issue, or

The Board may itself determine that it wishes to seek the views of a particular professional grouping on a specific matter, in accordance with Standing Order 6.5.7.

7 RELATIONSHIPS BETWEEN THE HPF AND OTHERS

7.1 The HPF shall:

- Ensure effective links and relationships with other advisory Forums;
- Ensure its role, responsibilities and activities are known and understood by others; and
- Take care to avoid unnecessary duplication of activity with other bodies/Forums with an interest in the planning and provision of NHS services.

7.2 The Forum Chair will be a member of the National Professional Advisory Forum.

8 REPORTING AND ASSURANCE ARRANGEMENTS

8.1 The Forum Chair shall:

- Report formally, regularly and on a timely basis to the Board on the Forum's activities. This includes verbal updates on activity and, where required the submission of minutes and written reports;
- Bring to the Board's specific attention any significant matters under consideration by the Forum;

8.2 The Board may also require the HPF Chair to report upon the HPF's activities at public meetings, e.g., AGM, or to community partners and other stakeholders, where this is considered appropriate.

The Health Board may specifically request advice and feedback from the Forum on any aspect of its business, and the Forum may also offer advice and feedback even if not specifically requested by the Health Board. The Forum may provide advice to the Board:

- At Board meetings, through the HPF Chair's participation as Associate Member;
- In written advice; and
- In any other form specified by the Board.

9 APPLICABILITY OF STANDING ORDERS TO HPF BUSINESS

9.1 The requirements for the conduct of business as set out in the Health Board's Standing Orders are equally applicable to the operation of the Forum, except in the following areas:

10 REVIEW

- 10.1 These terms of reference and operating arrangements shall be reviewed annually by the HPF with reference to the Board.



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		Agenda Item	7.5iv
Stakeholder Reference Group			
Freedom of Information Status		Open	
Reporting Committee	Board		
Author	Joanne Abbott Davies, Assistant Director of DICE Nicola O’Sullivan, Head of Engagement		
Lead Executive Director (s)	Richard Thomas, Director of DICE		
Date of meeting	17 September 2026		
Summary of matters considered by the Stakeholder Reference Group at its meeting on 17 July, 2026			
Health Board Update The Stakeholder Reference Group received an update which included the following: • Staff vaccination campaign • Research and innovation • Thirlwall Inquiry • Transforming for the Future • Operational performance and finance			
Membership Update and Nomination of Vice Chair No nominations were received for the remaining Equality Dimensions roles. The Chair agreed to attend a future Regional Third Sector Health Social Care and Wellbeing meeting to reiterate the importance of the SRG and encourage people to put themselves forward for the roles. A nomination was received for the Vice Chair role and SRG agreed in principle subject to Health Board agreement.			
Presentation on the Swansea Bay Patient Portal / Hybrid Mail Members received an update on the development of the Swansa Bay Patient Portal and its integration with the NHS Wales app. The presentation focused on (i) take-up, (ii) the information patients are able to access including appointment letters, and (iii) future campaign plans to encourage greater uptake of the NHS Wales App and Patient Portal.			
Presentation on the Sustainable Planned Care Programme Members received an overview of the Sustainable Planned Care Programme which aims to reduce long waits, improve diagnostics and redesign patient pathways. They were briefed on the strong focus being placed on productivity, pathway			

redesign, outpatient transformation and digital solutions. While Welsh Government funding has been secured to support planned care recovery and transformation, not all proposals received funding therefore some risks remain. Presentation on Listening to People SRG members requested an update on Listening to People which replaced the Putting Things Right arrangements from April 2026. Members were briefed on and discussed: • Listening discussions being held with people who raise concerns. • Concerns being resolved through early resolution where appropriate • Investigation timescales being agreed according to complexity. • Accessibility, advocacy and communication requirements being assessed from the outset. • Training programmes being delivered to support implementation.	
Key risks and issues/matters of concern of which the board needs to be made aware:	
None	
Delegated action by the committee:	
SRG agreed a Deputy Chair subject to Board approval; which would be sought at the 24 September 2026 Board meeting.	
Main sources of information received:	
Reports and papers from Health Board.	
Highlights from sub-groups reporting into this committee:	
N/A	
Matters referred to other committees	
None	
Date of next meeting	01 November 2026



Meeting Date	24 September 2026	Agenda Item	7.6
Name of Meeting	SBUHB Board		
Report Title	Chair’s Report		
Report Author	Ebony Smith, Executive Support Manager		
Report Sponsor	Jan Williams, Chair		
Presented by	Jan Williams, Chair		
Freedom of Information	Open		
FoI Closed detail	If closed, choose detail		
Impact Assessment Summary Outcome		IA Completion date	
N/A		Click or tap to enter a date.	
Purpose of the Report	For Assurance		
Report Summary; detailing any action required			
The purpose of the report is to advise the Board of the Chair’s key activities, since the last formal Board meeting in July 2026.			
Key Issues			
The report provides an update on the following: • External Relationships • Site visits			
Decision / Action required	No		
Recommendations			
Members are asked to: • TAKE COGNISANCE OF the activities of the Chair since the last Board meeting in July 2026.			



CHAIR'S REPORT

1. INTRODUCTION

The purpose of this report is to advise the Board of the Chair's key activities since the last formal Board meeting in July 2026.

2. BACKGROUND

Each meeting, the Chair briefs the Board on key activities since the last meeting. The Chair also uses the opportunity to provide verbal updates, if appropriate.

3. GOVERNANCE AND RISK ISSUES

Areas of focus since July include:

Recruitment

- Independent Member sifting & interviews (General & Community) – 5 August & 9 September

Visits

- Chair Visit to ED, Morriston Hospital – 2 September
- Visit to PET Scanner Centre with leader & CE of Swansea Council, Cllr Rob Stewart & Martin Nicholls (Swansea Council) – 3 September
- Visit to HMP Prison, Swansea – 8 September
- Visit to Ward T, Morriston Hospital – 17 September

External relationships

MSs / MPs:

- MS/MP Briefing sessions – 21 August & 18 September

Local Authorities:

- Chair & CEO Presentation to Swansea Council CMT/Cabinet Away Day – 27 August
- Regular meeting with Cllr Steve Hunt, Leader, Neath Port Talbot Council – 7 September
- Joint Leadership Meeting of Swansea Bay UHB, NPT Council & Swansea Council – 21 September



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Joint working:

- Regular joint meeting of Chairs & CEOs, Swansea Bay UHB & Hywel Dda UHB – 17 August
- South West Wales Region Universities & Regional Joint Committee Introduction/Briefing – 20 August
- Chair meeting with Sara Moseley, Chair, Velindre NHS Trust – 2 September
- Chairs & CEOs, Swansea Bay UHB & Hywel Dda UHB, RJC preparation & agenda setting (ahead of RJC on 13 October) – 3 September
- Joint meeting of Chairs & CEOs, Swansea Bay UHB & Llais – 21 September
- Chair & CEO meeting with Chair & Chief Commissioner, NWJCC – 22 September
- Chairs Peer Group Meeting – 22 September
- Welsh Risk Pool Committee Meeting – 23 September

Events:

- Swansea Bay University Health Board Donor Family Afternoon Tea, The Mansion House, Swansea – 22 September

Other Meetings to note:

- Jan Williams & Tom Haslam, Director, Audit Wales, introductory meeting – 3 August
- Chair & CEO meeting with Maternity & Neonatal Services Chair of Oversight Panel and Ministerial observer on the Panel – 27 August
- Regular checks in with Good Governance Institute (GGI) – 3 September & 16 September

4. RECOMMENDATION

Members are asked to:

- **TAKE COGNISANCE OF** the activities of the Chair since the last Board meeting in July 2026.



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Thursday, 24 September 2026



Governance and Assurance		
Strategic Objectives		
Strategic Objectives <i>(please choose which is impacted)</i>	People of Swansea Bay live healthier, fairer and more prosperous lives	☒
	Care is high quality, safe, efficient and delivers the best possible outcomes for people in partnerships	☒
	Care is delivered in partnership with our communities in safe and appropriate setting, supported by innovation	☒
	The health board is a great place to work where staff feel valued and work together towards a common goal	☒
	The health board is a resilient, sustainable and responsible organisation	☒
Health and Care Standards		
Standards <i>(please choose which applies)</i>	Safe Care	☒
	Timely Care	☒
	Effective Care	☒
	Efficient Care	☒
	Equitable care	☒
	Person-centred Care	☒
	Staff and Resources	☒
Enablers <i>(please choose which applies)</i>	Whole Systems Approach	☒
	Leadership	☒
	Workforce	☒
	Culture	☒
	Information	☒
	Learning, Improvement and Research	☒
Quality, Safety and Patient Experience		
Quality, safety and patient experience are one of the board's main priorities. The role of the Chair is to ensure mechanisms are in place to deliver these both internally and through working with partners.		
Financial Implications		
There are no financial implications to consider except as outlined for Chair's action.		
Legal Implications (including equality and diversity assessment)		
There are no legal implications.		
Staffing Implications		
There are no staffing implications.		



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

The Chair has responsibility for ensuring a robust board and governance structure is in place to secure the long-term future of the organisation.

Report History

Standing agenda item for the board.

Appendices

N/A



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Bwrdd Iechyd Prifysgol Bae Abertawe (BIPBA)
Cofnodion Cyfarfod y Bwrdd a gynhaliwyd ar
30 Gorffennaf 2026 am 10:45am

Yn Bresennol		
Jan Williams	(JW)	Cadeirydd
Abigail Harris	(AH)	Prif Swyddog Gweithredol
Jean Church	(JC)	Aelod Annibynnol
Marie Davies	(MD)	Cyfarwyddwr Gweithredol Cynllunio a Phartneriaethau
Andrew Griffiths	(AG)	Aelod Annibynnol
Raj Krishnan	(RK)	Cyfarwyddwr Meddygol Gweithredol Dros Dro
Claire Osmundsen-Little	(COL)	Cyfarwyddwr Gweithredol Dros Dro Cyllid a Pherfformiad
Reena Owen	(RO)	Aelod Annibynnol
Patricia Price	(PP)	Aelod Annibynnol
Charlotte Rees	(CR)	Aelod Annibynnol
Liz Rix	(LR)	Cyfarwyddwr Gweithredol Nyrsio a Phrofiad y Claf
Stephen Spill	(SS)	Is-gadeirydd
Hugo Van Woerden	(HVW)	Cyfarwyddwr Gweithredol Dros Dro Iechyd y Cyhoedd
Nuria Zolle	(NZ)	Aelod Annibynnol

Yn Bresennol		
Helen Annandale	(HA)	Cadeirydd Fforwm y Gweithwyr Proffesiynol ym maes Iechyd
Sujoy Banerjee	(SB)	Neonatolegydd Ymgynghorol (Ar gyfer eitem 5.3 ar yr Agenda)
Denise Chaffer	(DC)	Cadeirydd y Panel Goruchwylio Mamolaeth a Newyddenedigol (Ar gyfer eitem 5.3 ar yr Agenda)
Pat Dunmore	(PD)	Cadeirydd y Grŵp Cyfeirio Rhanddeiliaid
Amy English	(AE)	Cyfarwyddwr Rhanbarthol Dros Dro, Llais
Kathy Greaves	(KG)	Cyfarwyddwr Clinigol Bydwreigiaeth (Ar gyfer eitem 5.3 ar yr Agenda)
Ffion Green	(FG)	Arweinydd Rhaglen: Nyrsio Corfforaethol a Phrofiad y Claf (Ar gyfer eitem 5.3 ar yr Agenda)
Paul Harry	(PH)	Pennaeth Cyllid: Gwybodaeth Gwasanaeth (Ar gyfer eitem 4.5 ar yr Agenda)



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Tudalen **1** o **51**
Bwrdd Cyhoeddus



Matthew John	(MJ)	Cyfarwyddwr Digidol
Alun Llewelyn	(AL)	Aelod Cyswllt o'r Bwrdd
Hazel Lloyd	(HL)	Cyfarwyddwr Llywodraethu Corfforaethol
Andrew Nelson	(AN)	Cyfarwyddwr Perfformiad a Deallusrwydd Busnes (Ar gyfer eitem 4.5 ar yr Agenda)
Emma Owen	(EO)	Cyfarwyddwr Cynorthwyol y Gweithlu a Datblygu Sefydliadol
Hannah Parsons	(HP)	Cyfarwyddwr Cynorthwyol Gweithrediadau (Ar gyfer eitem 4.5 ar yr Agenda)
Carys Richards	(CER)	Uwch Reolwr Llywodraethu Corfforaethol
Heather Richards	(HR)	Cadeirydd Fforwm Partneriaeth y Bwrdd Iechyd
Jon Scott	(JS)	Cyfarwyddwr Dros Dro yr Uned Gyflawni
Richard Thomas	(RT)	Cyfarwyddwr Mewnwelediad, Cyfathrebu ac Ymgysylltu
Craige Wilson	(CW)	Dirprwy Brif Swyddog Gweithredu

Ymddiheuriadau

Anne-Louise Ferguson	(ALF)	Aelod Annibynnol
Deb Lewis	(DL)	Prif Swyddog Gweithredu/Cyfarwyddwr Gweithredol Dros Dro Gofal Sylfaenol a Chymunedol ac Iechyd Meddwl ac Anableddau Dysgu
Nicola Mathews	(NM)	Aelod Annibynnol
Theresa Ogbekhiulu	(TO)	Aelod Cyswllt o'r Bwrdd
Tina Ricketts	(TR)	Cyfarwyddwr Gweithredol y Gweithlu a Datblygu Sefydliadol

Arsylwi wyneb yn wyneb

Arwel Roberts	Cynorthwydd Cyngor yn y Cyngor Osteopathig Cyffredinol (GOsC)
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Acronymau

Acronym	Diffiniad	Cyfeirnod y Munud
AAA	Rhybudd, Cyngori, Sicrhau	122/26
AC	Y Pwyllgor Archwilio	114/26; 118/26; 122/26; 134/26
AGM	Cyfarfod Cyffredinol Blynnyddol	116/26
AI	Deallusrwydd Artiffisial	116/26
APB	Bwrdd Cynllunio Ardal	117/26
ASTRA	Osgoi Derbyniadau Anadlol Tymor Byr i'r Uned Newyddenedigol	124/26





BJC	Achos Cyfiawnhad Busnes	119/26; 121/26
BSOTS	System Brysbennu Obstetreg sy'n Benodol i Symptomau Birmingham	124/26
CAMHS	Gwasanaethau Iechyd Meddwl Plant a'r Glasoed	122/26
C.diff	Clostridioides difficile	122/26
CEMT	Tîm Rheoli Prif Weithredwyr	117/26
CHC	Gofal Iechyd Parhaus y GIG	123/26
CT	Tomograffeg Gyfrifiadurol	122/26
CTG	Cardiotocograffeg	124/26
DALB	Bwrdd Arweinyddiaeth Cyffuriau ac Alcohol	117/26
DDRIC	Pwyllgor Digidol, Data, Ymchwil ac Arloesi	116/26; 122/26
DU	Yr Uned Gyflawni	121/26; 123/26
ED	Adran Achosion Brys	113/26; 122/26
EPRR	Parodrwydd, Gwydnwch ac Ymateb Brys	117/26
HAIs	Heintiau sy'n Gysylltiedig â Gofal Iechyd	122/26
BI	Bwrdd Iechyd	114/26; 120/26
BIPHDd	Bwrdd Iechyd Prifysgol Hywel Dda	118/26; 119/26
HIE	Enseffalopathi Hypocsig-Isgemig	124/26
AGIC	Arolygiaeth Gofal Iechyd Cymru	124/26
CEF	Carchar Ei Fawrhydi	114/26
HPR	Prif Risg y Bwrdd Iechyd	123/26
IPC	Atal a Rheoli Heintiau	122/26
IPR	Adroddiad Perfformiad Integredig	122/26
IV	Mewnwythiennol	122/26
JCC	Cydbwyllgor Comisiynu	115/26; 117/26; 122/26
DPA	Dangosyddion Perfformiad Allweddol	124/26
LINAC	Cyflymydd Llinol	119/26
LTAs	Cytundebau Hirdymor	117/26
MBBRACE	Mamau a Babanod: Lleihau Risg Drwy Archwiliadau ac Ymholiadau Cyfrinachol	124/26
MNVP	Partneriaeth Lleisiau Mamolaeth a Newyddenedigol	124/26
MoNET	Addysg a Hyfforddiant Newyddenedigol Aml-broffesiynol	124/26
NHSPI	Perfformiad a Gwella GIG Cymru	120/26; 121/26; 122/26



CNPT	Castell-nedd Port Talbot	117/26; 120/26; 124/26
PFC	Pwyllgor Perfformiad a Chyllid	119/26; 120/26; 122/26; 123/26
PFAG	Grŵp Sicrwydd Cynllunio a Chyllid	119/26
PHC	Pwyllgor Iechyd y Boblogaeth	122/26
PID	Dogfen Dechrau Prosiect	118/26
Ch1	Chwarter 1	117/26
Ch3	Chwarter 3	122/26; 123/26
Ch4	Chwarter 4	123/26
QI	Gwella Ansawdd	124/26
QSC	Y Pwyllgor Ansawdd a Diogelwch	122/26; 124/26
RJC	Cydbwyllgor Rhanbarthol	118/26
Rio	System Cofnodion Cleifion Electronig (EPR)	121/26
RPB	Bwrdd Partneriaeth Rhanbarthol	121/26
BIPBA	Bwrdd Iechyd Prifysgol Bae Abertawe	Teitl
SLAs	Cytundebau Lefel Gwasanaeth	118/26
SPOA	Pwynt Mynediad Unigol	124/26
LIC	Llywodraeth Cymru	113/26; 116/26; 117/26; 120/26; 121/26; 122/26; 123/26; 124/26
WODC	Pwyllgor y Gweithlu a Datblygu Sefydliadol	114/26; 123/26; 138/26
WTE	Cyferwerth ag Amser Llawn	110/26; 122/26

Dechreuodd y cyfarfod am 10:43.

Cyfeirnod y Cofnod:	Eitem ar yr Agenda
RHAN 1. MATERION RHAGARWEINIOL	
1.1 CROESO A SYLWADAU CYFLWYNIADOL	
110/26	Agorodd JW y cyfarfod drwy estyn croeso cynnes i bawb a oedd yn bresennol, ac i'r rhai a oedd yn gwylio, cyfarfod y Bwrdd.



	Fel Corff Llywodraethu un o sefydliadau mwyaf y DU, y Bwrdd oedd â'r lefel uchaf o ran gwneud penderfyniadau, gyda rheolaeth dros: £1.8bn o arian cyhoeddus, cyflogaeth 14,500 o staff cyfwerth ag amser llawn (WTE), a'r gwasanaethau iechyd a gofal ar gyfer tua 400,000 o bobl ar draws Abertawe a Chastell-nedd Port Talbot, ac ar gyfer poblogaethau llawer mwy ar gyfer gwasanaethau arbenigol a rhanbarthol. Roedd BIPBA yn gorff strategol iechyd poblogaeth, gyda dyletswydd statudol i hyrwyddo ac amddiffyn iechyd y cyhoedd ac i atal clefydau. Roedd agenda'r cyfarfod yn cwmpasu lled cyfrifoldebau'r Bwrdd; roedd llywodraeth agored yn bwysig, a rhoddodd y cyfarfod blatfform i'r Bwrdd ddal ei hun yn atebol i'r cyhoedd ac i egluro'r rhesymeg dros benderfyniadau a wnaed yn cwmpasu'r tair cyfnod amser y bu'r Bwrdd yn gweithio ynddynt: y tymor hir, y tymor canolig a'r tymor byr. Yna, mapiodd JW eitemau allweddol yr agenda yn erbyn cyfrifoldebau'r Bwrdd o ran: pennu cyfeiriad strategol; pennu'r awydd am risg a goruchwyllo risgiau strategol; meithrin a chynnal partneriaethau strategol; goruchwyllo'r gwaith o gyflawni'r cynllun blynyddol; arfer llywodraethu da; a phennu naws a diwylliant y sefydliad. Roedd y Bwrdd eisiau i staff ddod i'r gwaith a bod yn nhw eu hunain yn gwbl ddilys, a gwybod y gallent leisio unrhyw bryderon yn ddiogel.
1.2 Ymddiheuriadau dros Absenoldeb	
111/26	Roedd Deb Lewis, Tina Ricketts, Theresa Ogbekhiulu, Anne-Louise Ferguson, a Nicola Matthews wedi cynnig ymddiheuriadau.
1.3 Datganiad o Fuddiannau	
112/26	Nid oedd unrhyw ddatganiadau o fuddiant y tu allan i'r rhai sydd eisoes ar y Gofrestr Datganiadau Buddiant.
RHAN 2. PRIF AGENDA	
2.1 Adroddiad y Prif Weithredwr	
113/26	Cyfeiriodd AH at y diweddariad manwl a ddarparwyd yn ei hadroddiad a thynnodd sylw penodol at y canlynol:



- Gwasanaethau gofal brys a gofal heb ei drefnu; roedd y rhain yn parhau i gael eu dwysáu a diolchodd AH i'r holl staff ar draws y sefydliad am eu hymdrechion eithriadol yn ystod yr amodau tywydd eithafol dros yr wythnosau diwethaf. Roedd y rhain wedi cyfrannu at y lefelau uchaf o weithgarwch Adran Achosion Brys (AB) a gofnodwyd erioed; roedd cofnodi'r hyn a ddysgwyd o ymateb y gwasanaeth yn bwysig, o ystyried y rhagolygon o dywydd eithafol pellach. Roedd NM wedi gofyn cwestiwn am staff yn yr Adran Achosion Brys, gan fod 18 mis wedi mynd heibio ers cyfarfod y Bwrdd â staff allweddol yr Adran Achosion Brys. Nododd AH y trefniadau sydd ar waith i ymgysylltu â staff. Ym mis Medi, byddai gan y Bwrdd y cyfle i adolygu Cynllun Gaeaf 2026/27, gan gynnwys gweithredu'r targed trosglwyddo ambiwlansys o fewn 45 munud.

- Ysbyty Gorseinon: Ym mis Medi 2025, roedd y Bwrdd wedi cymeradwyo newid gwasanaeth dros dro i adleoli gwelyau cleifion mewnol yng Ngorseinon i ysbyty Singleton; roedd hyn yn destun estyniad chwe mis ym mis Chwefror 2026 ac roedd AH bellach yn ceisio cymeradwyaeth y Bwrdd i ymestyn hyn tan fis Tachwedd 2026, i gefnogi cwblhau ymarfer ymgysylltu ac ymgynghori gofynnol.

Ymddiheurodd AH ar ran y Weithrediaeth am rywfaint o lithriad yn erbyn amserlenni a cherrig milltir; cyfeiriodd at yr ymweliadau cadarnhaol a'r sgysiau anffurfiol gyda'r gymuned leol a chydawgleidyddion lleol a diolchodd i NM am hwyluso'r cyfleoedd hyn. Gwnaeth AH sylwadau ar y defnydd dros dro o'r ward i gynnal clinigau a gwasanaethau ychwanegol. Mynegodd ei diolch i AE o Llais am ei chynghor ar y broses ymgysylltu a gofynnodd i'r Bwrdd ddirprwyo'r gwaith o lofnodi'r deunydd ymgysylltu iddi, ar ôl ymgynghori â JW.

- Yr ymrwymiad i gyflawni'r Cynllun Blynyddol ar gyfer 2026/27; cydnabu rôl y Weithrediaeth wrth gryfhau'r ddarpariaeth a sicrhau digon o gapasiti i gyflawni ar raddfa ac ar gyflymder; roedd hyn yn cynnwys ffocws ar flaenoriaethu cyflawniadau allweddol.

Diolchodd JW i AH a gwahoddodd sylwadau a chwestiynau.

Cyfeiriodd PP at yr angen i wella llif a'r heriau a achosir gan hyn, gyda 234 o gleifion a oedd wedi'u optimeiddio'n glinigol yn destun oedi wrth eu rhyddhau; roedd hyn yn cynnwys 17% o'r sylfaen gwelyau. Achosodd y sefyllfa bresennol niwed y gellid bod wedi'i osgoi i'r cleifion hynny nad oeddent angen gofal clinigol mwyach ac ychwanegodd at gostau



gwasanaeth. Cydnabu PP y gwaith helaeth gyda phartneriaid awdurdodau lleol a'r trydydd sector ond daeth i'r casgliad bod yr amser wedi dod i LIC gymryd camau gweithredu ar lefel genedlaethol.

Ychwanegodd AH a MD fanylion am y gwaith sy'n mynd rhagddo gyda phartneriaid lleol a sefydlu grŵp cenedlaethol sy'n edrych ar integreiddio gwasanaethau cymunedol, o dan ymbarél polisi Cymuned trwy Ddylunio.

Cefnogodd JS ddull cenedlaethol; i rannu dysgu a nodi tir cyffredin; tynnodd ef a CW sylw at y gostyngiad yn nifer y cleifion sydd wedi'u optimeiddio'n glinigol, i lawr i 152 ar adeg y cyfarfod a'r isaf yn y cyfnod diweddar. Pwysleisiodd y ddau yr angen i ganolbwyntio ar lwybr tuag i lawr, gyda'r grŵp cenedlaethol bellach yn ei le i oruchwylio newid ar lefel y system.

Croesawodd JC sefydlu grŵp cenedlaethol; nododd y cyllid a ddarparwyd yn flaenorol gan Lywodraeth Cymru i gefnogi camau gweithredu penodol e.e. lleihau rhestrau aros, y fenter Ymgynghoriad Cyntaf, gan gydnabod manteision y cyllid. Byddai angen i unrhyw gyllid pellach ganolbwyntio ar lwybrau cleifion cyfan er mwyn osgoi unrhyw heriau ychwanegol ar bwyntiau penodol ar hyd y llwybr.

Gwnaeth y Bwrdd y canlynol:

- **DERBYNIWYD** yr adroddiad a **CHYMERODD SICRWYDD** o'r trafodaethau ar y meysydd allweddol o uwchgyfeirio, pwysau gweithredol, a risg strategol.
- **CYMERADWYWYD** estyniad i'r trosglwyddiad dros dro presennol o'r gwelyau cleifion mewnol a ddarparwyd yn flaenorol yn ysbyty Gorseinon, i ysbyty Singleton, tan ddiwedd mis Tachwedd 2026. Byddai hyn yn cefnogi proses ymgysylltu lawn a chydymffurfiol, cyn i'r Bwrdd wneud penderfyniad terfynol yn ei gyfarfod ym mis Tachwedd 2026.
- **DIRPRWYO AWDURDOD** i AH i gymeradwyo a chyhoeddi'r deunyddiau ymgysylltu cyhoeddus llawn y tu allan i gylch cyfarfodydd y Bwrdd, mewn ymgynghoriad â JW ac yn amodol ar adolygiadau Gweithredol, clinigol a llywodraethu priodol.
- **YN COFNODI** ei ddiolch i NM am ei gwaith yn ymgysylltu â'r gymuned leol dros y flwyddyn ddiwethaf ac yn cefnogi Geraint Bowen (GB), rheolwr safle ysbyty Gorseinon, a'r tîm ar lawr gwlad



yn yr ysbyty. Roedd y Bwrdd yn ddyledus i GB a'r tîm lleol am bopeth a wnaethant i sicrhau bod ysbyty Gorseinon yn parhau i fod yn ganolfan gymunedol fywiog.

2.2 Adroddiad Risg

114/26

Wrth gyflwyno'r eitem hon, cyfeiriodd JW at rôl y Bwrdd wrth osod yr awydd i gymryd risg strategol, pennu a goruchwyllo risgiau lefel strategol. Gwahoddodd HL i roi diweddariad.

Tynnodd HL sylw at naw risg a nodir yn y Gofrestr Risg Strategol; yn dilyn diweddariad diweddar, byddai'r Bwrdd Gweithredol yn eu hystyried ar 12 Awst 2026, cyn eu hystyried gan y Pwyllgor Gweithlu a Datblygu Sefydliadol (WODC) ar 20 Awst gyda'u cyflwyno ymlaen i gyfarfod y Bwrdd ym mis Medi. Roedd 29 o risgiau corfforaethol, ac roedd 17 ohonynt uwchlaw archwaeth risg y Bwrdd.

Diolchodd JW i HL a'i tîm am eu gwaith ar bob agwedd ar risg; gwahoddodd sylwadau.

Cyfeiriodd PP at sylwadau cynharach AH a'r angen i fframio risg yng nghyd-destun graddfa'r system gyfan o newid sydd ar y gweill a'r sefyllfa ariannol heriol. Roedd gan y Bwrdd agenda newid a gwella sylweddol ar draws ystod o wasanaethau, a gallai maint enfawr hyn, ynddo'i hun, arwain at risg cyflawni system; cynigiodd PP gynnwys risg cyflawni gweithredol system gyfan yn y Gofrestr Risg Strategol, gyda lliniariadau a gwelliannau disgwyledig wedi'u mynegi'n glir.

Cefnogodd NZ yr angen i ddisgrifio risg weithredol system gyfan eang, gan gasglu'r holl newidiadau a risgiau gwasanaeth, a'r rhyngweithiadau. Roedd angen sicrwydd ar y Bwrdd a'i Bwyllgorau yn seiliedig ar dystiolaeth o effaith, yn hytrach nag ar gamau gweithredu unigol. Roedd y Pwyllgor Archwilio (AC) wedi trafod y mater hwn ac wedi croesawu'r gwelliannau diweddar i'r Cofrestrau Risg; tynnodd NZ sylw at yr angen am fwy o waith ar oruchwyliaeth draws-bwyllgor o risgiau system gyfan.

Wrth ymateb, croesawodd AH y drafodaeth, gan ddweud bod y Weithrediaeth hefyd wedi trafod y mater hwn. Cydnabu cyfarwyddwyr gweithredol fod y capasiti a'r gallu i gyflawni yn heriol, o ystyried ehangder a graddfa'r trawsnewid gwasanaeth sydd ar y gweill, gyda rhai oediadau'n arwain at newidiadau i amserlenni a chyflawni yn erbyn



cerrig milltir. Byddai *Trefnu i Lwyddo* yn cynorthwyo i lunio'r gweithlu, gyda'r capasiti a'r gallu cywir, yn y lleoedd cywir, ac ar y lefel gywir. Roedd cyflwyno'r model arweinyddiaeth dan arweiniad clinigol yn hanfodol, gyda gwaith ar y gweill i gefnogi arweinyddiaeth glinigol ar draws y BÎ.

Mynegodd JC bryder ynghylch nifer y newidiadau i amserlenni, weithiau o fisoedd neu hyd yn oed flywyddyn. Ychwanegodd JW fanylion am risg yr oedd NM wedi'i hamlygu yn dyddio'n ôl i 2022; roedd hyn yn ymwneud â lefelau staffio yng Ngharchar EF Abertawe ac nid oedd yn risg y gallai'r Bwrdd ei liniaru ar ei ben ei hun. Cytunodd LR i adolygu'r risg benodol hon; byddai'r Weithrediaeth hefyd yn gweithio ar y dull cyfan o broffilio'r amserlenni ar gyfer lliniaru risg.

Cam Gweithredu: LR/Cyfarwyddwyr Gweithredol

Wrth grynhoi'r drafodaeth, myfyriodd JW ar nodi a lliniaru risgiau sefydliadol yn agored ac yn atebol. Roedd cam nesaf rheoli risg effeithiol yn cynnwys cwmpasu risg cyflawni gweithredol system gyfan a'r goblygiadau risg strategol cysylltiedig. Byddai adolygiad y Weithrediaeth o flaenoriaethau yn eistedd ochr yn ochr â hyn ac yn llywio ailosodiad risgiau strategol, corfforaethol a gweithredol. Byddai gweithdy traws-bwyllgor pellach yn myfyrio ar y dull o graffu a goruchwylio risg cyflawni gweithredol y system gyfan.

Gwnaeth y Bwrdd y canlynol:

- **DERBYNIWYD** er **SICRWYDD** yr adroddiad a'r atodiadau ategol.
- **CYDNABU'r** y cynnydd a wnaed a'r arfer da o ran nodi a lliniaru risg.
- **CYTUNWYD** i ychwanegu risg cyflawni gweithredol system gyfan at y Gofrestr Risg Strategol, gan adlewyrchu'r goblygiadau strategol.
- **CYTUNWYD** i dderbyn adroddiad diweddarau yng nghyfarfod y Bwrdd ym mis Medi 2026, yn nodi canlyniad yr adolygiad ar lefel Weithredol o flaenoriaethau gwasanaeth a'r risgiau canlyniadol ar lefel strategol, corfforaethol a gweithredol.



- **CYTUNWYD** i gynnull gweithdy traws-bwyllgor ar graffu a goruchwyllo risg cyflawni gweithredol y system gyfan.

RHAN 3. PROFIAD CLEIFION/STAFF

3.1 Stori'r Claf

115/26

Cyflwynodd LR Huw, claf dialysis. Wrth siarad yn y Gymraeg, disgrifiodd Huw

cefnidir ei gyflwr, y pryder yr oedd hyn wedi'i greu a'r ffordd yr oedd yr ymgynghorydd a'r tîm dialysis wedi rhoi pob gofal a chefnogaeth iddo. Rhoddodd yr opsiwn 'gofal personol' fwy o ryddid iddo ac roedd y gallu i siarad â'r tîm yn y Gymraeg yn fantais fawr, o safbwynt Huw.

Pwysleisiodd LR bwysigrwydd helpu Huw i aros yn annibynnol a'i helpu i sgwrsio yn ei iaith gyntaf. Roedd y gwasanaeth dialysis arennol yn wasanaeth rhanbarthol, ac roedd De-orllewin Cymru yn gartref i nifer fawr o siaradwyr Cymraeg, ac roedd pob un ohonynt yn gwerthfawrogi sgwrsio yn eu dewis iaith.

Gofynnodd RO a oedd BIPBA yn cynnal cofrestr o staff sy'n siarad ieithoedd eraill ac a allai wirfoddoli eu gwasanaethau, pe bai angen; gallai hyn fod yn ddewis arall defnyddiol i'r Llinell Iaith. Roedd RO eisoes wedi sôn am hyn wrth TR, a fyddai'n archwilio hyn ymhellach.

Cam Gweithredu: TR

Dywedodd AH fod y Cydbwyllgor Comisiynu (JCC) wedi comisiynu'r gwasanaeth dialysis arennol. Roedd Huw wedi rhannu ei stori yng nghyfarfod diwethaf y JCC.

Croesawodd JS y stori a bod Huw wedi disgrifio ei hun fel 'perthyn i'r Uned'; gyda staff yn mynd allan o'u ffordd i roi gofal a chefnogaeth ychwanegol iddo.

Gofynnodd JW i LR estyn diolch y Bwrdd i Huw ac i staff yr Uned Dialysis Arennol.



DERBYNIODD y Bwrdd Stori'r Claf er **SICRWYDD**.

RHAN 4. PENNU CYFEIRIAD STRATEGOL

4.1 Trawsnewid ar gyfer y Dyfodol

116/26

Cyfeiriodd MD at y papur a ddarparwyd; roedd hwn yn rhoi'r wybodaeth ddiweddaraf am y rhaglen o waith ymgysylltu a ddechreuodd yn 2025 ar y Cynllun Clinigol strategol *Trawsnewid ar gyfer y Dyfodol*. Tynnodd sylw at y canlynol:

- Cymhlethdod y rhaglen, sy'n cynnwys amrywiaeth o randdeiliaid a phwysigrwydd sefydlu sylfeini cadarn; tynnodd MD sylw hefyd at y cynnydd hyd yma.
- Mae'r rhaglen o weithdai clinigol ar y gweill, i ddechrau poblogi a disgrifio'r modelau clinigol a lefelau gofal.
- Arweinyddiaeth LIC ar ddatblygu cynllun clinigol cenedlaethol; mae'n bosibl y byddai'r amserlen ddisgwyliedig ar gyfer cwblhau – Ebrill 2027 – yn destun oedi, gyda'r goblygiadau canlyniadol i amserlenni BIPBA yn symud o Fedi 2026 i Ebrill 2027.

Diolchodd JW i MD a gwahoddodd sylwadau a chwestiynau:

Gofynnodd NZ am gyraeddadwyedd yr amserlenni a'r cerrig milltir; tynnodd sylw at y risgiau a cheisiodd sicrwydd ynghylch proses flaenoriaethu.

Cyfeiriodd AG hefyd at: yr angen i reoli'r amserlenni ochr yn ochr â rhaglenni trawsnewidiol eraill sydd ar y gweill, y broses ailadroddus a fabwysiadwyd a'r posibilrwydd o ddatblygu enghraifft ymarferol o'r egwyddorion ar waith. Wrth ymateb, croesawodd MD yr awgrym hwn a chytunodd i'w ystyried ymhellach.

Cam Gweithredu: MD



O ran trawsnewid digidol, gofynnodd JC a oedd cyfleoedd i gynnwys opsiynau deallusrwydd artiffisial (AI). Cadarnhaodd MD y byddai hyn yn ffurfio galluogwr hollbwysig fel rhan o'r bensaernïaeth ddigidol ehangach.

Adleisiodd CO-L y pwynt uchod, gan ystyried deallusrwydd artiffisial ac ystadau fel dau alluogwr sylfaenol. Cadarnhaodd yr AG fod y Pwyllgor Digidol, Data, Ymchwil ac Arloesi (DDRIC) yn datblygu'r agenda hon.

Cam Gweithredu: AG

Cynigiodd RO gynnwys yn benodol y gostyngiad mewn anghydraddoldebau iechyd fel egwyddor. Esboniodd MD y syniad y tu ôl i'r geiriad presennol o 'fynediad teg at wasanaethau diogel ac effeithiol'. Cymerodd JW farn y cyfarfod; gwrthodwyd hyn o blaid cynnwys egwyddor benodol mewn perthynas ag anghydraddoldebau iechyd a gofynnodd JW i'r MD a'r RO gytuno ar ffurf geiriad i adlewyrchu hyn.

Gofynnodd PP am eglurder ynghylch yr amlen adnoddau a'r angen i gynllunio ar gyfer dychwelyd i gydbwysedd ariannol yn 2028/29. Amlinellodd MD y dull o ddyrannu a defnyddio adnoddau a phwysigrwydd modelu galw a chapasiti cadarn i lywio'r 'symudiad adnoddau i'r chwith'.

Aeth JW ymlaen gan gyfeirio at yr angen am ddull 'cwrs bywyd' o ddyrannu adnoddau mewnol, pwynt yr oedd PP a JC wedi'i godi o'r blaen.

Amlinellodd CO-L y gwaith sydd ar y gweill ar gostio gwasanaethau; byddai hyn yn cynyddu tryloywder ynghylch dyrannu adnoddau a, thros amser, yn mapio ar draws i ganlyniadau gwasanaethau. Byddai costau gwasanaethau manwl yn cefnogi'r symudiad i wasanaethau sylfaenol a chymunedol ac i ffwrdd o fodel costio sefydliadol.

Adeiladodd AH ar y cysyniad 'cwrs bywyd' a chynghorodd fod y 100 arweinydd gorau yn cydnabod yr angen i fapio'r strategaeth ariannol tymor hwy yn erbyn y cysyniad hwn.



Atgoffodd PD y cyfarfod fod y Bwrdd, yn y Cyfarfod Cyffredinol Blynnyddol (CCB), wedi cytuno i newid ffurf y ferf sy'n sail i'r egwyddorion o 'dylai' i 'bydd'. Cytunodd MD i wneud y newid hwn.

Cam Gweithredu: MD

Pwysleisiodd RT bwysigrwydd cymhwyso'r egwyddorion i'r holl waith trawsnewidiol sydd ar y gweill, gan gynnwys y gwaith ar wasanaethau mamolaeth a newyddenedigol, iechyd meddwl, canser, a gofal heb ei drefnu.

Gwnaeth y Bwrdd y canlynol:

- **YSTYRIODD** y cynnydd a wnaed o ran cyflawni'r rhaglen Trawsnewid ar gyfer y Dyfodol.
- **CYDNABU** byddai'r oedi wrth i Lywodraeth ddatblygu'r Cynllun Clinigol Cenedlaethol yn effeithio ar yr amserlen ar gyfer cwblhau'r cynllun strategol lleol o Dachwedd 2026 i Ebrill 2027.
- **CYDNABU'R** egwyddorion arfaethedig ar gyfer newid, yn amodol ar gynnwys egwyddor benodol ynghylch lleihau anghydraddoldebau iechyd, a'r newid yn ffurf y ferf o 'dylai' i 'bydd'.
- **CYTUNWYD** i gymhwyso'r egwyddorion i bob rhaglen drawsnewid.
- **CYTUNWYD** i wneud mwy o waith ar fodelu dyrannu adnoddau ar sail 'cwrs oes'.

4.2 Adroddiad Cynllunio a Phartneriaethau

- **Strategaeth a Chynllun Cyflawni Cyffuriau ac Alcohol APB**
- **CYDNABOD Adroddiad Blynnyddol EPRR GIG Cymru 2025/26 cyn ei gyflwyno i Lywodraeth Cymru**

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Cyfeiriodd MD at y papurau manwl a ddarparwyd; tynnodd sylw penodol at:

- Adroddiad i'r Bwrdd ar gyflawniad Ch1 yn erbyn Cynllun Blynnyddol 2026/27.
- Y gymeradwyaeth a geisir ar gyfer gwaith Bwrdd Arweinyddiaeth Cyffuriau ac Alcohol (DALB), a ddatblygwyd mewn ymateb i adroddiad Comisiwn Cyffuriau 2025.



- Gweithredu adolygiad perfformiad integredig misol, ffurfiol ar gyfer pob Cytundeb Hirdymor (LTA), ar gyfer y JCC, ac ar gyfer byrddau iechyd comisiynu.
- Yr angen i gymeradwyo adroddiad blynyddol Parodrwydd, Cydnerthedd ac Ymateb i Argyfwng (EPPR) a'r atodiadau atodol; roedd hyn yn gofyn am gymeradwyaeth y Bwrdd cyn ei gyflwyno i'r Llywodraeth.

Diolchodd JW i MD a gwahoddodd sylwadau a chwestiynau.

Gwnaeth HVW sylwadau ar yr 2000 o ymatebion i'r Arolwg Gwres; byddai'r rhain yn darparu gwybodaeth werthfawr am dywydd eithafol. Diolchodd JW i HVW am ystyried y mater pwysig hwn a gofynnodd i MD ychwanegu manylion am gamau gweithredu lleol a chenedlaethol ynghylch addasrwydd i'r hinsawdd.

Disgrifiodd MD y bensaerniaeth leol berthnasol ar waith, gyda pholisi tywydd garw wedi'i ddiweddarau allan ar gyfer ymgysylltu mewnol. O ran addasu i'r hinsawdd yn ehangach, cyfeiriodd MD at y cynllun addasu a oedd yn cefnogi lliniaru risg, gan gynnwys meysydd fel llifogydd, tywydd garw a newid hinsawdd. Cytunodd AH i godi goblygiadau tywydd eithafol ar gyfer gwariant cyfalaf presennol a gwariant cyfalaf yn y dyfodol yng nghyfarfod nesaf Tîm Rheoli'r Prif Weithredwyr (CEMT).

Cam Gweithredu: AH

Crynhodd CW ei bresenoldeb diweddar mewn dadfrifio cenedlaethol ar y gwres eithafol.

Cyfeiriodd HVW at waith y Grŵp Awyru; roedd y rhain yn cwmpasu materion gan gynnwys llogi unedau aerdymheru ac unrhyw oblygiadau a gofynion rheoli heintiau. Gofynnodd JW i HVW rannu hyn gydag AH ar gyfer cyfarfod CEMT.

Cam Gweithredu: HVW

Gofynnodd JC dair cwestiwn: (i) effaith diffyg o £6.3m y JCC ac unrhyw risgiau comisiynu sy'n deillio o Gynghrair Gwasanaeth Cyffuriau ac



Alcohol Abertawe a Chastell-nedd Port Talbot; (ii) y mesurau canlyniad a'r mesurau perfformiad a gymhwysir gan y Bwrdd Cynllunio Ardal (APB); a (iii) y mesurau sydd ar waith i fynd i'r afael â'r gweithlu a'r gallu i alw ar draws yr ystod o wasanaethau a ddarperir.

Gofynnodd SS am fynediad at wasanaethau camddefnyddio sylweddau ac am eglurder ynghylch y ddarpariaeth o'r rhain.

Wrth ymateb i'r ddau set o gwestiynau, cynghorodd MD:

- Byddai BIPBA yn cael rhybudd ymlaen llaw o unrhyw oblygiadau refeniw posibl sy'n gysylltiedig â chynlluniau'r Bwrdd Cynllunio Ardal; byddai angen cymeradwyo'r rhain cyn eu gweithredu.
- Daeth adnoddau APB o nifer o ffynonellau; roedd ymrwymiad i archwilio ailgynllunio'r llwybr gan ddefnyddio'r amlen refeniw bresennol.
- Roedd dangosfwrdd cynhwysfawr ar waith, i'w ddefnyddio gan y DALB, wrth adolygu perfformiad bob chwarter. Cytunodd MD i roi gwybodaeth i JC am hyn, ac i ddilyn ymholiad SS ynghylch mynediad at y gwasanaeth.

Cam Gweithredu: MD

- O ran diffyg cyllido'r JCC, cynghorodd MD fod 2025/26 wedi ffurfio blwyddyn drawsnewid, gan wneud gofynion comisiynwyr a darparwyr yn fwy heriol. Roedd trafodaethau pellach ar y gweill yn ystod y flwyddyn ar lefel Weithredol i archwilio meysydd risg comisiynwyr a darparwyr.
- Wrth ryddhau staff ar gyfer hyfforddiant, cydnabu MD fod hyn yn heriol ond cadarnhaodd ymgysylltiad da ac archwilio cyfleoedd amgen.

Cyfeiriodd AH at bresenoldeb cadeirydd a phrif gomisiynydd y JCC yng nghyfarfod y Bwrdd ym mis Medi 2026. Byddai hyn yn rhoi cyfle i drafod materion comisiynwyr a darparwyr.

Gwnaeth RO sylwadau ar yr angen i ailwampio'r fethodoleg LTA bresennol, o ystyried bod y model presennol bellach wedi dyddio.



Cadarnhaodd CO-L y bwriad i ddarparu adroddiad i gyfarfod PFC ym mis Medi, fel ymarfer ail-linellu'r sylfaen. Ychwanegodd AH fanylion am gyfathrebu â byrddau iechyd cyfagos.

Cyfeiriodd AL at y model Cynghrair sydd ar waith ar gyfer gwasanaethau cyffuriau ac alcohol; roedd Pwyllgor Craffu Gwasanaethau Cymdeithasol Castell-nedd Port Talbot (CNPT) wedi ystyried adroddiad diweddar ac wedi cydnabod y cynnydd a wnaed. Roedd o'r farn y byddai budd i'r Bwrdd o ystyried yr un math o adroddiad.

Cam Gweithredu: MD

Myfyriodd JW ar ehangder y deunydd a'r diweddariadau a oedd wedi'u cynnwys yn yr adroddiad; gofynnodd i'r AH/MD edrych ar y fformat a phenderfynu ar y fformat gorau posibl ar gyfer adrodd i'r Bwrdd llawn.

Cam Gweithredu: AH/MD

Gwnaeth y Bwrdd y canlynol:

- **YSTYRIED** a **CHYTUNODD** yr eitemau fel y gofynnwyd yn yr adroddiad.
- **CADARNHAWYD:**
 - Adroddiad Blynnyddol EPRR GIG Cymru 2025/26 cyn ei gyflwyno i Lywodraeth Cymru (**Atodiad 7**).
 - Fframwaith Methiant Aml-Gyfleustodau Colli Cyfleustodau (nwy, trydan, dŵr) BIPBA (**Atodiad 8**).
 - Rhaglen waith Cyffuriau ac Alcohol
- **DERBYNIWYD** er **SICRWYDD:**
 - Y safbwynt a amlinellwyd ar wydnwch, risgiau a blaenoriaethau sefydliadol.
 - Parhau i ymgorffori dull cydnertheddd-drwy-ddylunio a'r camau gweithredu i fynd i'r afael â gwendidau allweddol y system.

4.3 Cynllun y Rhaglen Ganser

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Gwnaeth JS sylwadau ar y papur a ddarparwyd, fel a ganlyn:





- Cynigiodd Fframwaith Gwella Cancer a sefydlu Rhaglen Gwella Cancer ffurfiol a noddir gan y Weithrediaeth, a noddir gan y Cyfarwyddwr Meddygol; byddai hyn yn adeiladu ar y Cynllun Gwella Cancer a gyflwynwyd yng nghyfarfod y Bwrdd ym mis Mehefin 2026.
- Parhaodd y gwaith adfer gweithredol uniongyrchol hwnnw, yn enwedig ar gynlluniau gwella safle tiwmor, adferiad patholeg, diagnosteg, a gwella llwybrau. Roedd y papur yn adlewyrchu dull ehangach o gydlynw gwelliant cancer ar draws: atal, diagnosis cynharach, diagnosteg, triniaeth, gweithlu, gofal personol, ymchwil ac anghydraddoldebau, gyda ffocws ar y pum i ddeng mlynedd nesaf.
- Roedd gwella'r llwybr cancer a amheuir yn hanfodol er mwyn gwella canlyniadau hirdymor cyffredinol; roedd yn galw am ddull system gyfan.
- Ceisiwyd cymeradwyaeth y Bwrdd ar gyfer y Fframwaith a chymeradwyaeth y Rhaglen Gwella Cancer a noddwyd gan y Weithrediaeth. Byddai Dogfen Cychwyn Rhaglen (PID) yn cynnwys trefniadau llywodraethu manwl a chynllun gweithredu.
- Roedd adroddiad perfformiad cancer gan Archwilio Cymru wedi'i gyhoeddi'r diwrnod cyn cyfarfod y Bwrdd; byddai cyfarfod y Pwyllgor Archwilio (AC) ym mis Medi yn ei ystyried, er bod adolygiad cychwynnol o'r adroddiad wedi dangos bod y dull arfaethedig o weithredu gan BIPBA yn cyd-fynd â'r gofynion.
- Byddai'r rhaglen yn darparu pont rhwng gwaith adfer uniongyrchol a thrawsnewid gwasanaeth hirdymor.

Diolchodd AH i JS ac estynnodd ei diolch i Hannah Parsons am ei gwaith yn datblygu'r camau gweithredu arfaethedig, wedi'u llywio gan weithdy a gynhaliwyd yn gynharach yn 2026. Byddai'r rhaglen yn adlewyrchu'r gofynion cyflawni yn ystod y flwyddyn a'r gofyniad ehangach, tymor hwy i yrru newid mewn gwasanaethau, gyda symudiad i atal ar draws gwasanaethau gofal sylfaenol ac eilaidd, gan ystyried yr agenda ecwiti. Cefnogodd HVW y dull llwybr cyfan hwn, gan gynnwys atal, canfod a thrin.

Aeth AH ymlaen i gyfeirio at y gwaith sy'n gysylltiedig â chanser a gynlluniwyd trwy'r Cyd-bwyllgor Rhanbarthol (RJC) gyda Bwrdd Iechyd Prifysgol Hywel Dda (BIPHDd).



Cododd yr Arolygwr Cyffredinol y posibilrwydd o symud oddi wrth Gytundebau Lefel Gwasanaeth (SLAs) tuag at ddull LTA: byddai hyn yn dileu anomaledau mewn mynediad at dreialon clinigol. Cadarnhaodd RK y bwriad i adolygu Cytundebau Lefel Gwasanaeth.

Gwnaeth JW sylwadau ar y model ariannu presennol ar gyfer Canolfan Canser De-orllewin Cymru; cyfeiriodd at yr angen i ymgysylltu â byrddau iechyd eraill i rannu'r risg ariannol a phenderfynu ar gyfrannau ariannu mwy cymesur.

Wrth ymateb, adroddodd y CO-L ar y trafodaethau lefel ranbarthol a oedd wedi dechrau; tynnodd AH sylw at gyfeiriad Archwilio Cymru at yr angen am gynllun cancer wedi'i gostio; byddai'r Weithrediaeth yn codi hyn mewn cyfarfod sydd i ddod gyda'u cydweithwyr yn BIPHDd.

Croesawodd JW y trafodaethau lefel Weithredol sydd ar y gweill gyda BIPHDd ac edrychodd ymlaen at gael y wybodaeth ddiweddaraf am y cynnydd.

Gwnaeth y Bwrdd y canlynol:

- **YSTYRIODD** y cynnydd a wnaed ers papur y Bwrdd Gweithredol ym mis Mehefin 2026 wrth ddatblygu dull BIPBA ar gyfer gwella cancer, gan gynnwys datblygu cynlluniau gwella safle tiwmor a ffrydiau gwaith ategol eraill.
- **CYDNABU'r** angen i adeiladu ar y camau adferiad uniongyrchol a nodir yn y Cynllun Gwella Llwybr Canser Unigol drwy ddull ehangach, cydlynol o wella canlyniadau cancer.
- **CYDNABU'r** Fframwaith Gwella Canser arfaethedig fel y strwythur sylfaenol ar gyfer y Rhaglen Gwella Canser.
- **CYMERADWYODD** sefydlu Rhaglen Gwella Canser ffurfiol a noddur gan y Weithrediaeth, gyda'r Cyfarwyddwr Meddygol yn gweithredu fel Noddwr Gweithredol.
- **CEFNOGODD** datblygiad Dogfen Cychwyn Rhaglen, yn nodi'r trefniadau llywodraethu manwl, gofynion cymorth y rhaglen a'r cynllun gweithredu i'w hystyried yn y dyfodol gan y Bwrdd.

4.4 Achos Cyfiawnhad Busnes Sed Cyflymydd Llinol (LINAC) (BJC)



119/26	Crynhodd MD y cefndir i'r angen am gapasiti LINAC ychwanegol; adroddodd fod PFC wedi craffu ar ddogfennaeth y BJC a chadarnhaodd PP fod aelodau'r PFC wedi cymryd digon o sicrwydd. O ran y goblygiadau refeniw, cyngorodd CO-L y byddai'r rhain yn gymwys o 2027/28 ac y byddent yn rhan o'r dyraniad refeniw a'r gyllidebu ar gyfer gofal a gynlluniwyd. Roedd y dyraniad hwnnw hefyd yn cynllunio ar gyfer chweched a seithfed LINACS, ond heb unrhyw gyllid refeniw cyfredol wedi'i nodi ar hyn o bryd. Gwnaeth y Bwrdd y canlynol: • CYMERADWYDD y BJC i geisio £6.832m gan Lywodraeth Cymru a £2.8m o wariant refeniw cylchol, wedi'i rannu'n gyfartal (£1.4m yr un) gyda Bwrdd Iechyd Prifysgol Hywel Dda. • CYDNABU BOD y Grŵp Sicrwydd Cynllunio a Chyllid (PFAG) wedi craffu ar ddogfennaeth y BJC. Ar 24 Mehefin 2026, cytunodd Bwrdd Gweithredol Bae Abertawe i gynnwys y costau refeniw gwerth £1.4m yn y broses ariannu gofal a gynlluniwyd gwerth £34m. • YSTYRIWYD difrifoldeb diogelwch a chanlyniadau niweidiol i gleifion pe na bai datblygiad y ^{5ed} Linac yn mynd rhagddo ar gyflymder. • YSTYRIWYD y byncer 6ed / 7fed a'r newid posibl yn y safle o ran BJC2. • CEFNOGODD bwriad i ddatblygu'r dewisiadau a'r opsiynau ar gyfer byncer sengl a dwbl yn fanylach.
4.5 Gofal a Gynlluniwyd	
120/26	Diolchodd JW i AN, HP, a PH am y gwaith sylweddol a oedd yn sail i'r cynllun; gwahoddodd CW i grynhoi'r Rhaglen Adferiad Gofal a Gynlluniwyd arfaethedig (y Cynllun). Cyfeiriodd CW at becyn helaeth o sleidiau a thynnodd sylw at y canlynol: • Diben y Cynllun, a ddatblygwyd mewn ymateb i ofynion LIC i ddarparu rhaglen gofal a gynlluniwyd gynaliadwy; roedd cynaliadwyedd i'r dyfodol yn hanfodol.



- Bod y Cynllun yn adeiladu ar y cynllun dros dro ar 104 wythnos, a gyflwynwyd i'r Llywodraeth ar 19 Gorffennaf; roedd hyn wedi cael adborth cadarnhaol. Roedd y Cynllun a gyflwynwyd i'r Bwrdd yn adeiladu ar y cyflwyniad hwnnw ar 19 Gorffennaf ac yn nodi rhaglen gyflawni strategol a chynaliadwy.
- Eglurder canllawiau LIC ynghylch defnyddio capasiti presennol, gyda buddsoddiad ychwanegol yn cael ei ofyn dim ond i lenwi bylchau gwasanaeth amlwg.
- Tri philer y rhaglen gofal a gynlluniwyd a oedd yn sail i'r Cynllun: (i) atgyfeirio a diagnosis cynnar; (ii) capasiti, cynhyrchiant a thriniaeth; a (iii) dilyniant, gwyliadwriaeth a byw'n dda. Y themâu allweddol a ddatblygwyd, ac a seiliwyd ar y pileri hyn, oedd: adferiad cynaliadwy; optimeiddio llwybrau llawfeddygol; trawsnewid gweithgaredd cleifion allanol; galluogi digidol; cynyddu cynhyrchiant i'r eithaf, cryfhau gwaith cleifion; a buddsoddiad.
- Y cais am gyllid; roedd hyn yn cyfuno gofynion capasiti gweddilliol a buddsoddiad trawsnewidiol, gyda buddsoddiad o bosibl yn gwrthbwysu capasiti gweddilliol, ar ôl ei optimeiddio a'i fesur yn llawn.
- Cyfleoedd, fel y'u nodir yn y set sleidiau, ar draws theatrau, cleifion allanol, y gweithlu, diagnosteg, digidol, cyfleoedd rhanbarthol, ac enillion cynhyrchiant.
- Gwaith pellach, yn amodol ar gymeradwyaeth y Bwrdd, i ddarparu sicrwydd parhaus manwl a llywodraethu priodol; byddai hyn yn cynnwys eglurder ar gerrig milltir cyflawni, gwireddu buddion, ac adrodd perfformiad penodol a ddangosai gyfeiriad y daith.
- Y risgiau sy'n gysylltiedig â'r rhaglen, gan gynnwys adnoddau ac ymgysylltu â'r gweithlu i gyflawni'r enillion capasiti a chynhyrchiant a nodwyd. Roedd twf posibl yn y galw hefyd yn gwarantu lliniaru penodol.

Diolchodd JW i CW ac yna trodd at PP, fel cadeirydd PFC.

Roedd PP yn cydnabod ac yn gwerthfawrogi'r gwaith manwl a oedd ynghlwm wrth ddatblygu'r Cynllun, mewn amserlen gyfyngedig iawn. Roedd yn cynnwys dadansoddiad credadwy o alw a chapasiti, gyda thystiolaeth o welliannau cynhyrchiant, a chyfleoedd ar gyfer gweithio



rhanbarthol. Roedd y sylfaen dystiolaeth yn gynhwysfawr, gyda chlinigwyr yn ymwneud â chraffu ar gostau craffu NHSPI ar gyfer arbenigeddau craidd a gwasanaethau canser. Roedd y buddsoddiad gofynnol ar gyfer 2026/27 tua £20.7m i £23.8m, i gwmpasu'r toriadau 52 wythnos a 104 wythnos. Roedd y gofyn ariannol yn fwy na'r hyn a oedd yn seiliedig ar gyfran o'r boblogaeth yn unig; efallai na fydd LIC felly'n cytuno ar y cyllid llawn a byddai angen proses flaenoriaethu gadarn ar BIPBA.

Roedd PFC hefyd wedi ystyried argaeledd y gweithlu a'r camau lliniaru a gynigiwyd; roedd y rhain yn ymwneud â chynllunio gweithlu cadarn a chyfleoedd ar gyfer cynllunio rhanbarthol mewn meysydd strategol allweddol, gan gynnwys anestheteg. Cymerodd PFC sicrwydd hefyd ynghylch argaeledd sesiynau allanol.

Croesawodd PP y ffocws ar atebion cynaliadwy hirdymor, yn hytrach nag ar brynu capasiti ychwanegol anghylchol. Roedd rhai arbedion cynhyrchiant eisoes yn rhan o'r gofyniad arbedion o £65m a byddai'n bwysig osgoi cyfrif ddwywaith.

Roedd aelodau'r PP a'r PFC yn glir ynghylch y gofynion llywodraethu, yn seiliedig ar ddealltwriaeth lawn o'r sefyllfa sylfaenol a thargedau, cerrig milltir a llwybrau penodol. Rhaid i allbynnau fod yn destun olrhain penodol, gyda threfniadau atebolrwydd ac uwchgyfeirio wedi'u halinio.

Daeth PP i ben drwy dynnu sylw at y cyllid anghylchol sydd ar gael gan Lywodraeth Cymru; roedd hyn yn cyfyngu ar ddatblygu cynllun cynaliadwy.

Diolchodd JW i PP a gwahoddodd aelodau eraill y PFC i wneud sylwadau.

Cefnogodd JC sylwadau PP yn llwyr ac ychwanegodd ei diolch am yr holl waith a oedd ynghlwm wrth lunio'r Cynllun; croesawodd y manylion a nodwyd ynddo ac roedd yn fodlon cymryd sicrwydd.

Gofynnodd JW i HVW wneud sylwadau ar y ffaith bod y costau ariannol yn fwy na chyfran y boblogaeth. Tynnodd HVW sylw at lefelau amddifadedd ar draws dalgylch BIPBA, gan dynnu sylw at nifer uchel yr



achosion o anabledd a salwch hirdymor, yn enwedig yng Nghastell-nedd Port Talbot. Roedd un arolwg diweddar wedi nodi bod gan yr ardal hon lefel uwch o anabledd nag mewn unrhyw awdurdod lleol yn Lloegr; roedd proffil oedran y boblogaeth yn ffactor arall.

Cyfeiriodd AL at y pocedi sylweddol o amddifadedd yng Nghastell-nedd Port Talbot; roedd hyn yn ffactor a adlewyrchwyd yn nyroniad cyllid yr awdurdod lleol gan LIC. Gallai'r BI a'r awdurdod lleol gydweithio i gasglu'r ystadegau fel gwybodaeth gyd-destunol gefndirol hanfodol, cyfeiriodd AL hefyd at strategaethau gwrth-dlodi sydd ar waith a oedd yn cyd-fynd yn agos ag agenda iechyd y boblogaeth.

Yna gwahoddodd JW AH i wneud sylwadau.

Mynegodd AH ei diolch i'r tîm am ddatblygu'r Cynllun cynhwysfawr a darparu'r sail dystiolaeth. Croesawodd ymrwymiad cynnar Llywodraeth Cymru i barhau â'r cyllid a phwysleisiodd bwysigrwydd dysgu gan eraill. Roedd AH hefyd yn ymwybodol o'r angen i alinio gwaith lleol a chenedlaethol. Cyngorodd fod y gwerth gorau o'r buddsoddiad yn dibynnu ar ddyroniad cylchol. Roedd y Bwrdd Adfer a Chynaliadwyedd hefyd wedi craffu ar waith Deloitte ar gyfleoedd effeithlonrwydd rhyddhau arian parod i wneud y mwyaf o'r effaith ac wedi cynnwys y gwaith hwn yn y Cynllun.

Aeth AH ymlaen i ddiolch i HVW am ei ddadansoddiad o'r dangosyddion iechyd poblogaeth hyn a fyddai'n effeithio ar ofynion adnoddau. Gwnaeth sylwadau ar berthnasedd penodol y dadansoddiad ar gyfer defnyddio gwasanaethau cancer. Roedd cysylltiad clir rhwng y gwaith hwn a'r Cynllun Gwella Cancer; byddai ymgysylltiad llawn clinigwyr yn sicrhau bod y Rhaglen Adferiad Gofal a Gynlluniwyd yn cynnwys yr holl ystadegau cancer perthnasol.

Diolchodd JW i bawb am y drafodaeth gyfoethog a llawn gwybodaeth ar gyflwyniad pwysig. Ailadroddodd ddiolchiadau'r Bwrdd i bawb a oedd yn rhan o gynhyrchu'r Cynllun. Byddai hi, AH a HL yn adolygu'r system graffu a goruchwylio gyfan o'r Cynllun, ar lefel y Pwyllgor a'r Bwrdd.

Cam Gweithredu: JW/AH/HL



Gwnaeth y Bwrdd y canlynol:

- **DERBYNIWYD** a **CHYMERADWYD** y Cynllun Adferiad Gofal a gynlluniwyd Cynaliadwy 2026/27 a'r gofynion ariannu cysylltiedig, a gyflwynwyd mewn ymateb i ofynion Llywodraeth Cymru.
- **CYDNABU'r** dull strategol a nodir yn y Cynllun, gan gydnabod y pwyslais ar ddefnyddio cyfleoedd cynhyrchiant, trawsnewid, digidol a rhanbarthol cyn ceisio buddsoddiad rheolaidd ychwanegol.
- **CEFNOGODD** y blaenoriaethau buddsoddi arfaethedig, gan gydnabod bod y gofyniad ariannu yn adlewyrchu'r ddau:
 - y bwlch capasiti cylchol gweddilliol sy'n ofynnol i gyflawni'r llwybrau gofal a gynlluniwyd drwy'r model gweithredu presennol; ac
 - y buddsoddiad trawsnewidiol sydd ei angen i sicrhau gwelliant cynaliadwy mewn cynhyrchiant, canlyniadau cleifion a sefyllfa ariannol hirdymor.
- **CYDNABU** bod cyflawni'r Cynllun yn ddibynol ar benderfyniadau cyllido LIC ac, yn absenoldeb cyllid llawn, efallai y bydd angen i'r Bwrdd adolygu llwybrau cyflawni, amserlenni gweithredu a'r risgiau cysylltiedig.
- **CYDNABU'R** prif risgiau cyflawni a'r lliniariadau a nodir yn y Cynllun, gan gynnwys argaeledd y gweithlu, pwysau gweithredol, cyflawni cynhyrchiant, twf yn y galw a dibyniaethau rhanbarthol.
- **DIRPRWYO** awdurdod i'r Prif Weithredwr, ar ôl ymgynghori â'r Cadeirydd, i gymeradwyo unrhyw ddiwygiadau bach sy'n ofynnol yn dilyn trafodaeth y Bwrdd neu eglurhad dilynol gan Lywodraeth Cymru, ar yr amod nad oedd y rhain yn newid cyfeiriad strategol na rhagdybiaethau ariannu'r Cynllun yn sylweddol.
- **CYTUNWYD** ar adroddiadau cynnydd rheolaidd drwy'r trefniadau llywodraethu sefydledig, gan gynnwys cyflawni yn erbyn llwybrau, gwelliannau cynhyrchiant, gwireddu buddion, perfformiad ariannol a risg.

Ar ôl dychwelyd o seibiant byr, amlinellodd JW y defnydd o ddarpariaeth yr Agenda Gydlynad, o ystyried nifer yr eitemau arwyddocaol ar yr agenda.

4.6 Rhaglen Trawsnewid Iechyd Meddwl





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Wrth gyflwyno'r eitem hon, hysbysodd AH y Bwrdd fod Mel Walker (MW), yr Ymgynghorydd Strategol Arbenigol Allanol, bellach wedi cwblhau ei chomisiwn. Ar ran y Bwrdd, estynnodd AH ei diolchgarwch i MW am ei chyngor a'i harweiniad arbenigol i'r Bwrdd ar raddfa'r her iechyd meddwl, ac am ei gwaith yn cefnogi'r Grŵp Gwasanaeth gyda'i thaith wella hyd yn hyn.

Gan droi at y papur, adroddodd AH ei fod yn nodi adroddiad cynnydd ar bob agwedd ar y rhaglen drawsnewid ac ar y pum ffrwd waith sy'n rhan ohono. Tynnodd sylw at y canlynol:

- Uwchraddio'r gwasanaeth i un o 'wasanaeth sy'n peri pryder' yn hydref 2024; galluogodd hyn i BIPBA gael mynediad at gymorth ychwanegol.
- Cynnydd ar draws y pum ffrwd waith a'r sefyllfa ar bob un fel rhan o'r cynllun sefydlogi:
 - Cynhyrchu'r dangosfwrdd ansawdd a diogelwch, y cyntaf yng Nghymru; byddai hwn yn gweithredu fel dangosfwrdd byw, gan roi'r cyfleuster i BIPBA olrhain gwelliant a chynnydd.
 - Roedd y gwaith sy'n mynd rhagddo drwy'r ffrwd waith ystadau, yn canolbwyntio ar y tair gorwel amser, i wella'r amgylchedd ac ymgymryd ag adnewyddu, tra bod y gwasanaeth yn parhau i weithredu bron ar ei gapasiti llawn.
 - Gwelliannau i'r gweithlu i (i) sicrhau maint cywir y tîm triniaeth argyfwng yn y cartref ac atal derbyniadau diangen, a (ii) gwella nyrsio yn y wardiau gofal i oedolion. Byddai buddsoddiad ychwanegol yn digwydd ar sail buddsoddi i arbed, drwy leihau derbyniadau a lleoliadau y gellir eu hosgoi y tu allan i GIG Cymru.
 - Gwaith parhaus ar wybodeg.
- Parhaodd RT i weithio'n agos gyda'r Grŵp Gwasanaeth i sicrhau (i) bod proses yn cael ei hymgorffori i sicrhau ymgysylltiad a chydgyhyrchu parhaus ym mhob datblygiad gwasanaeth, a (ii) bod proses ymgysylltu ffurfiol yn cael ei rhedeg ochr yn ochr â gwaith cyfathrebu ynghylch ailgynllunio gwasanaeth.
- Roedd TO, fel aelod cyswllt newydd o'r Bwrdd (Cynhwysiant a Pherthyn), wedi gofyn am ymgysylltu â'r rhaglen hon i ganolbwyntio ar fynediad i'r boblogaeth fwyafrifol fyd-eang; cyfeiriodd AH at gyfarfod sydd ar ddod gyda chydweithwyr



awdurdod lleol Castell-nedd Port Talbot ar hyn a byddai'n gwahodd TO i fynychu.

- Aliniad llawn y rhaglen â'r model sy'n sail i'r model gwasanaeth cenedlaethol. Roedd hyn yn canolbwyntio ar gefnogi anghenion unigol mewn modd amserol, waeth ble y cânt eu cyflwyno. Byddai hefyd yn sicrhau asesiad amserol ochr yn ochr ag unrhyw ymyriadau therapiwtig angenrheidiol. Roedd Llywodraeth Cymru o'r farn y byddai'r model hwn yn gweld gostyngiad mewn gwelyau aciwt.
- Rôl arwyddocaol digidol fel elfen sylfaenol i gydrannau'r rhaglen.
- Yr Achos Cyfiawnhad Busnes (BJC) i gefnogi cyfalaf ar gyfer ail gam y cynllun sefydlogi; roedd gwaith ar y gweill a byddai'r Bwrdd yn ei ystyried mewn cyfarfod yn y dyfodol. Byddai'n hwyluso'r defnydd gorau posibl o gapasiti a chydgrynhoi gwasanaethau ar lai o safleoedd.
- Y trydydd gorwel amser/yr ateb parhaol tymor hwy i ddarpariaeth aciwt; roedd hyn bellach yn destun ystyriaeth dan arweiniad cenedlaethol a byddai'n cynnwys pob gwely iechyd meddwl i oedolion, yr uned mam a baban a gwasanaeth pobl hŷn.
- Y gwaith ar lefel genedlaethol ar wasanaethau pobl ifanc; byddai cyfarfodydd y Bwrdd ym mis Medi a mis Tachwedd yn cynnwys y wybodaeth ddiweddaraf am y gwaith hwn.
- Sefydlu swydd iechyd meddwl ar lefel y Bwrdd; byddai hyn yn disodli'r rôl a gyflawnwyd gan MW, a oedd wedi cytuno i weithredu fel asesydd allanol i'r panel cyfweld.
- Y gefnogaeth groesawgar gan MD a'i thîm, ynghyd â chefnogaeth uwch gan dîm yr Uned Gyflawni (DU).
- Y gwaith pellach sydd ei angen ar adnoddau i lywio'r ddealltwriaeth o incwm a dderbynnir drwy'r broses ddyrannu gyffredinol a'r hyn a dderbynnir ar gyfer gwasanaethau a gomisiynwyd. Byddai'r gwaith hwn yn cofnodi ac yn adlewyrchu cyfanswm cost darparu gwasanaethau iechyd meddwl.

Diolchodd JW i AH am y diweddariad manwl a gwahoddodd gwestiynau a sylwadau.

Cadarnhaodd MD fod y Bwrdd Partneriaeth Rhanbarthol yn awyddus i ymgysylltu ag elfennau ailgynllunio gwasanaethau sy'n gysylltiedig â'r



gymuned; croesawodd y dull partneriaeth hwn a byddai'n sicrhau rhyngwyneb cyflawn â'r rhaglen drawsnewid.

Pwysleisiodd SS bwysigrwydd trefnu gwahanol gydrannau'r rhaglen i sicrhau'r ddarpariaeth orau posibl; yn ei farn ef byddai nifer y lleoliadau y tu allan i'r ardal yn parhau nes cwblhau ailgynllunio'r gwasanaeth cymunedol. Gallai fod oedi amser ac roedd hynny'n ffactor allweddol.

Cwestiynodd SS y disgwyliad ynghylch niwtraliaeth cost. Cyngorodd AH y byddai'r gostyngiad yn nifer y lleoliadau y tu allan i'r ardal yn darparu budd ariannol, ochr yn ochr â gostyngiad mewn costau cyflog amrywiol ac ym maint cywir y gweithlu parhaol. Byddai TR yn mynd i'r afael â hyn drwy ddarn penodol o waith.

Roedd AH yn cydnabod yr heriau i staff o ran bodloni gofynion gweithredol o ddydd i ddydd tra hefyd yn trawsnewid y gwasanaeth mewn modd amserol.

Gwnaeth SS sylwadau pellach ar ansicrwydd lleoliadau y tu allan i'r ardal a cheisiodd gadarnhad y byddai lleoliadau o'r fath yn parhau yn y tymor byr, os oes angen, nes bod newidiadau i'r model staffio yn cael eu gweithredu. Cydnabu y byddai hyn yn y pen draw yn darparu model costio mwy cadarn. Sicrhaodd AH SS ar y pwynt hwn.

Rhoddodd MJ y wybodaeth ddiweddaraf am RIO; roedd hyn yn mynd rhagddo'n dda ond byddai angen buddsoddiad gan Lywodraeth Cymru ar gyfer caffael ar gyfer y cam nesaf.

Gofynnodd PP am fonitro manteision y cynnig buddsoddi i arbed, gan gynnwys yr effaith ar gyflog amrywiol. Gofynnodd JW i PFC oruchwylio hyn.

Cam Gweithredu: PP/CO-L

Cadarnhaodd JW y byddai hi ac AH yn ysgrifennu'n ffurfiol at MW yn mynegi diolch am ei chefnogaeth, ei chyngor a'i harweiniad. Cadarnhaodd JW hefyd y byddai'r Bwrdd yn parhau â'i drafodaethau mewn cyfarfodydd i ddod.



Cam Gweithredu: JW/AH

Gwnaeth y Bwrdd y canlynol:

- **YSTYRIODD** y cynnydd a wnaed drwy'r Rhaglen Trawsnewid Iechyd Meddwl.
- **YSTYRIODD** y datblygiadau yn ymwneud â llywodraethu, adrodd ar ansawdd a diogelwch, a threfniadau partneriaeth.
- **YSTYRIODD** ganlyniad y trafodaethau gyda Llywodraeth Cymru a'r GIGSPI ar yr ystâd iechyd meddwl.
- **CYMERODD SICRWYDD GAN** reolaeth barhaus risgiau ansawdd, diogelwch ac ystad o fewn gwasanaethau Iechyd Meddwl.
- **CYMERADWYODD** y symudiad i gam 2 o'r Rhaglen Trawsnewid Iechyd Meddwl.

RHAN 5. CYFLAWNIAD Y FLWYDDYN: ANSAWDD, DIOGELWCH, PERFFORMIAD AC ADNODDAU

5.1 Adroddiad Perfformiad Integredig

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Amlinellodd MD y fformat newydd ar gyfer yr Adroddiad Perfformiad Integredig (IPR), gyda'r rhybuddion gan gadeiryddion y Pwyllgor yn ymddangos mewn mannau priodol. Newid prawf oedd hwn, er bod y craffu a'r goruchwyliaeth fanwl ar lefel y Pwyllgor wedi aros yr un fath.

Yna gwahoddodd MD y prif Weithredwyr i roi'r wybodaeth ddiweddaraf am eu meysydd cyfrifoldeb.

Iechyd y Boblogaeth

Gwnaeth HVW sylwadau ar:

- Gwaith a chynnydd parhaus ar y ddau amcan arloesol.
- Pedwar rhybudd a godwyd drwy'r Pwyllgor Iechyd y Boblogaeth (PHC):
 - Pwysigrwydd strategol Asesiad Effaith Iechyd Tata ar gyfer cynllunio tymor canolig;



- Y cyfyngiadau adnoddau parhaus;
- Y risgiau cynaliadwyedd sy'n gysylltiedig â chyllid grant tymor byr;
- Cydraddoldeb data ar gyfer gofal lliniarol a gofal diwedd oes.

Ychwanegodd SS fanylion am Asesiad Effaith Iechyd Tata; dylai proses gynllunio BIPBA gynnwys prif effaith hyn.

Ansawdd a Diogelwch

Cynghorodd RK:

- O ran heintiau sy'n gysylltiedig â gofal iechyd (HAIs), parhaodd yr her sylweddol ar C.diff. Y ffactorau allweddol a gyfrannodd oedd: llif cleifion, lefelau uchel o lenwi gwelyau, a'r effeithiau ar brosesau glanhau a dadheintio.
- Fodd bynnag, roedd stiwardiaeth gwrthficrobaidd yn gryf gyda'r gyfradd rhagnodi gwrthfotigau isaf yng Nghymru a'r gyfradd gofal sylfaenol yn gostwng yn gyflymach na chyfartaledd Cymru. Gofal eilaidd oedd yr ail isaf o ran rhagnodi gwrthfotigau sbectrwm eang.
- Roedd cyfarfodydd craffu ar waith gyda Grwpiau Gwasanaeth unigol ar gyfer E.coli ac ar gyfer Klebsiella.
- Parhaodd cydymffurfiaeth â newid o wrthfotig mewnwythiennol (IV) i wrthfotigau geneuol i wella, gan adlewyrchu cydymffurfiaeth â gofynion Atal a Rheoli Heintiau (IPC) a hyfforddiant gorfodol.
- Roedd gan bob grŵp gwasanaeth dargedau i gyflawni yn eu herbyn.

Gwasanaethau Amenedigol

O ran radioleg, tynnodd RK sylw at broblemau gydag adrodd ar sganiau 20 wythnos. Roedd hon yn broblem ledled Cymru ac roedd Llywodraeth Cymru a'r GIG yn ymwybodol ohoni.

Hyfywedd Meinwe

Cyfeiriodd LR at yr amcan arloesol hwn, gan gyfeirio at y canlynol:

- Y gyfradd uchaf ar draws byrddau iechyd GIG Cymru; roedd BIPBA wedi ymrwymo i ostyngiad o 30% yn ystod y flwyddyn.



- Yr heriau wrth osod llinell sylfaen ar gyfer y targed hwn; nid oedd y set ddata yn cynnwys maes gorfodol ar osgoiadwyedd, gyda'r angen canlyniadol i gynnal adolygiad data â llaw.
- Cynnydd mewn briwiau pwysau, sy'n gysylltiedig ag amseroedd y galw brig mewn ysbytai aciwt; byddai grŵp strategol yn defnyddio archwiliad i lywio rhaglen addysg staff.
- Gwaith ar y gweill i ddychwelyd i dîm hyfywedd meinwe canolog, i yrru gwelliant; roedd adnabod difrod wserau pwysau yn ddigidol bellach ar gael, gyda dilysu trwy ffotograffiaeth; roedd Digital Cymru yn cefnogi'r gwaith hwn.

Ar faterion QSC, tynnodd LR sylw at y canlynol:

- Y croniad o gwynion cleifion; roedd hyn yn ymwneud â'r broses Gweithio i Wella; roedd gan bob Grŵp Gwasanaeth gynllun clir bellach i ddileu'r croniad.
- Roedd Gwrandio ar Gleifion yn gweithredu'n dda; roedd yn cynnig datrysiad cynnar ac roedd hyn wedi arwain at ostyngiad o 38% mewn cwynion ffurfiol.
- Pryderon sicrwydd ynghylch diogelwch tân. Cadarnhaodd CO-L gytundeb ar gynllun adnoddau i liniaru risgiau, gyda chamau gweithredu wedi'u cynllunio i fynd i'r afael â materion eraill, yn bennaf yn safleoedd Treforys a Singleton. Roedd y sgoriau risg wedi gostwng o 20 i 16 ar sail y gwaith a oedd ar y gweill, a'r cynllun manwl.

Perfformiad Gweithredol a Gofal a gynlluniwyd

Tynnodd CW sylw at y canlynol:

- Cynnal arosiadau 52 a 104 wythnos; fodd bynnag, heb fuddsoddiad parhaus, byddai'r sefyllfa'n dirywio.
- Gwelliant bach ym mherfformiad canser ym mis Mehefin, i fyny i 54% ar ôl pedwar mis o'i gymharu â ffigur blaenorol o 46%. Roedd y gwaith sydd heb ei wneud bellach wedi sefydlogi ond byddai'n parhau i gyflwyno heriau, yn gysylltiedig â phatholeg gellog. Dylai Ch3 ymlaen weld gwelliant.



- Gwelliannau mewn diagnosteg, yn enwedig mewn radioleg, oherwydd dychweliad sonograffwyr.
- Y drafodaeth fanwl ar wasanaethau strôc yn PFC.
- Tuedd ar i lawr mewn lleoliadau y tu allan i'r ardal, rhywfaint o salwch tymor byr mewn Gwasanaethau Iechyd Meddwl Plant a Phobl Ifanc (CAMHS); roedd hyn wedi arwain at ostyngiad ym mis Mehefin a ddylai wella ym mis Gorffennaf.

O ran rhybuddion, myfyriodd JC ar y canlynol:

- Y risg sy'n gysylltiedig â gweithio ar ddau safle ar gyfer mamolaeth a newyddenedigol; mae'r Gofrestr Risg Gorfforaethol bellach yn cynnwys y risg hon. Roedd yn parhau i fod yn flaenoriaeth strategol ar gyfer cyflunio gwasanaethau amenedigol yn y dyfodol.
- Gofynnir i'r Grŵp Gwasanaeth Iechyd Meddwl ac Anabledd Dysgu am ddiweddariad brys ar gamau gweithredu i fynd i'r afael â'r argymhellion sy'n weddill ar gyfer Clinig Caswell a'r rhesymau dros yr oedi wrth gau. Wrth ymateb, cyfeiriodd AH at y wybodaeth a nodwyd yn y pecyn sleidiau, gan nodi'r camau gweithredu i gyflawni'r gwelliannau gofynnol, fel y cytunwyd gyda'r JCC. Crynhodd AH y trafodaethau gyda'r JCC; roedd y rhain yn cynnwys goblygiadau gweithredol darparu gwasanaethau o gyfleusterau sy'n eiddo i fwrdd iechyd arall. Roedd gan y JCC adolygiad cyflym o wasanaethau diogelwch canolog ac isel ar y gweill; byddai hyn yn adrodd ymhen blwyddyn.

Gofal Brys a Gofal mewn Argyfwng

Cyfeiriodd JS at:

- Y targed a'r rhybudd torri tir newydd ar gyfer aros 12 awr, gyda gofyniad i gyflawni gostyngiad o 10% mewn arosiadau 12 awr o linell sylfaen o 1350. Er gwaethaf gwelliannau yn niferoedd y llif a'r gollyngiadau, roedd y nifer hwn yn cynyddu.
- Nid oedd y gostyngiad yn nifer y cleifion a oedd wedi'u optimeiddio'n glinigol wedi arwain at welliant yn llif cleifion trwy Adran Achosion Brys Treforys. Bu'n rhaid cyflymu'r camau a gyflwynwyd hyd yma i gwmpasu pob ward. Roedd niferoedd rhyddhau penwythnos yn parhau'n isel; roedd tîm rhyddhau



penwythnos bellach ar waith, i leihau oedi o ddydd Iau hyd at ddydd Llun.

- Roedd camau rheoli gwelyau cynharach yn effeithio ar y trosglwyddiad 45 munud, gyda'r sefyllfa bresennol yn 75.4% yn erbyn targed o 80%.
- Roedd camau gweithredu penodol yr Adran Achosion Brys yn cynnwys: parthau, eglurder ynghylch cylch gwaith yr ymgynghorydd â gofal, cyfarfodydd perfformiad wythnosol i yrru gwelliant, yr wythnos ailosod arfaethedig ym mis Awst, a chyflymu'r amser aros i ymgynghori.

O ran rhybuddion, rhoddodd CW fanylion pellach am yr agenda cleifion sydd wedi'i optimeiddio'n glinigol a'r cynlluniau i baratoi ar gyfer y gaeaf.

Y gweithlu

EO wedi tynnu sylw at:

- Absenoldeb oherwydd salwch, targed arloesol; roedd y sefyllfa'n parhau i fod yn heriol, gyda lefelau absenoldeb oherwydd salwch yn cynyddu dros y misoedd diwethaf. Adlewyrchwyd hyn ledled Cymru, gyda sefydlu Grŵp Gorchwyl Cymru gyfan. Parhaodd BIPBA i fod wedi ymrwymo i drefniadau llywodraethu cadarn a chefnogi arweinwyr gwasanaeth i weithredu a rheoli'r prosesau absenoldeb oherwydd salwch yn effeithiol.

Rhybuddion yn canolbwyntio ar y Cynllun Gweithlu Strategol a Threfnu i Lwyddo.. Nododd EO, sef 1.3%, mai BIPBA oedd â'r twf cyflog isaf yng Nghymru.

Cadarnhaodd CO-L fod y broses rheoli swyddi gwag yn cael effaith a byddai angen i'r afael â chyflawni yn erbyn lleihau nifer y staff barhau. Mewn ymateb i ymholiad gan JW, cytunodd y CO-L i ddarparu sesiwn frifio, fel rhan o'r Adroddiad Cyllid, ar gysoni gostyngiad mewn cyflogaeth cyfwerth ag amser llawn (WTE) a chynnydd yn y bil cyflog.

Cam Gweithredu: CO-L

Llywodraethu



Cyfeiriodd HL at ddau adroddiad y Pwyllgor Archwilio, un ar adroddiad Llywodraethu sicrwydd cyfyngedig ar gyfer Grŵp Gwasanaeth Treforys; roedd yr ail yn ymwneud â chanfyddiadau Archwilio Cymru ar benodiadau Cyfarwyddwyr Gweithredol. Cadarnhaodd HL fod yr holl gamau gweithredu perthnasol wedi'u cwblhau.

Gwasanaethau Strôc

Tynnodd MD sylw at gyflwyniad i'r PFC ar wasanaethau strôc. Parhaodd PP i gael pryderon ynghylch y data, a oedd yn ymddangos yn dangos heriau ledled Cymru. Parhaodd y gwelliannau llwybr strôc presennol ond roedd y gafael yn heriol. Roedd y PFC wedi gofyn am ragor o fanylion ynghylch cynigion i wella'r llwybr ar gyfer sganio CT a chlustnodi capasiti ar gyfer strôc. Cydnabu PFC y gwaith rhanbarthol sydd ar y gweill ar fynediad i ymgynghorwyr strôc 24/7.

Mynegodd JC ei phryder ynghylch nifer y materion a godwyd ynghylch gwasanaethau strôc, yn enwedig yng nghyd-destun dull rhanbarthol. Cyngorodd y byddai QSC yn dychwelyd at yr agenda hon, gan ategu craffu'r PFC, trwy ganolbwyntio'n benodol ar ôl troed y gwasanaeth rhanbarthol.

Cam Gweithredu: JC/LR/MD

Wrth grynhoi'r drafodaeth, tynnodd JW sylw at nifer y cyfeiriadau at gywirdeb, cyflawnrwydd ac amseroldeb data. Gofynnodd i'r MD/CO-L drefnu'r rhain a'u hanfon ymlaen at y DDRIC i'w hystyried.

Cam Gweithredu: MD/CO-L

Nododd JW y byddai'r broses adrodd AAA sefydledig yn dychwelyd yng nghyfarfod y Bwrdd ym mis Medi, yn amodol ar fireinio ymhellach y cydlynid rhwng fformatau adrodd IPR ac AAA.

Gwnaeth y Bwrdd y canlynol:

- **YSTYRIODD** y diweddariad misol mewn perthynas â pherfformiad yn erbyn mesurau uwchgyfeirio a meini prawf dad-ddwysáu.
- **CYDNABU** a **THRAFODWYD** perfformiad BIPBA yn erbyn mesurau a thargedau allweddol.



- **YSTYRIODD** y diweddariad penodol i'r gwasanaeth ar berfformiad Strôc a CHEFNOGI gwaith parhaus PFC a QSC.
- **YSTYRIODD** y diweddariadau a ddarparwyd gan y Cyfarwyddwyr Gweithredol mewn ymateb i'r RHYBUDDION gan Bwyllgorau'r Bwrdd a **CHEFNOGODD** y camau gweithredu cysylltiedig.
- **CEFNOGODD** y dychweliad ym mis Medi i'r fformat sefydledig o adrodd AAA, wedi'i fireinio i osgoi dyblygu gyda'r IPR.

5.2 Adroddiad Cyllid

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Cyflwynodd CO-L yr adroddiad ar y sefyllfa ariannol, gan dynnu sylw at:

- Cefndir y cynllun tair blynedd a gyflwynwyd ar gyfer 2026/2029; roedd y diffyg o £76.6m ar gyfer 2026/27 yn golygu na allai'r bwrdd iechyd na LIC gymeradwyo'r cynllun, gan ei fod yn torri gofynion statudol.
- Y diffyg yn ystod y mis ar gyfer Mis 03 o 2026/27, o £7.1m, gyda diffyg hyd yma o £23.3m yn ystod y flwyddyn. Roedd tanwariant cyfalaf cymedrol o £645k hyd yma yn y flwyddyn, gyda chydymffurfiaeth diffyg cyflog yn rhagori ar darged polisi taliadau'r sector cyhoeddus o 95%.
- Bod sefyllfa Mis 03 yn parhau'n gyson â chyfeiriad cyffredinol y daith, er bod y duedd o ran cyflawni'r sefyllfa a ragwelwyd o arbedion o £65m yn destun pryder. Gyda diffyg o £7.1m, roedd sefyllfa Mis 03 £0.8m yn uwch na'r disgwyl.
- Y diffyg yn y ddarpariaeth o arbedion; roedd targed Mis 03 yn £5.4m, ac dim ond £2.9m ohono a ddaeth i'r amlwg, gan adael diffyg o £10.4m yn Ch1 (targed o £16.3m yn erbyn darpariaeth o arbedion o £5.8m). Y diffyg hwn oedd y prif reswm dros y sefyllfa ariannol ym Mis 03 o hyd.
- Sawl ffactor gweithredol a effeithiodd ar y swydd:
 - Cynyddodd gwariant Gofal Iechyd Parhaus y GIG (CHC) yn ystod y mis, yn enwedig ar gyfer iechyd meddwl ac anableddau dysgu, o ran nifer y cleifion a'r gost gyfartalog. Roedd twf CHC yn faes risg ac fe'i cynhwyswyd yn y sefyllfa risg a ragwelwyd.
 - Roedd costau presgripsiynu wedi creu pwysau o £0.3m yn ystod y mis, a achoswyd gan brinder a chostau caffael uchel.
 - Lleoliadau dros dro i oedolion; gostyngodd y rhain o ran nifer y mis, o 18 i 11, ond gyda budd ariannol cyfyngedig.



- Symudiad cadarnhaol yn ystod y mis, gyda gostyngiad mewn cyflog amrywiol o £4.7m i £4.4m.
- Cwblhau contract ymgynghori allanol ac effaith perfformiad LTA ffafriol.
- Y gwaith sylweddol sydd ar y gweill drwy'r rhaglen Adferiad a Chynaliadwyedd a'r biblinell gyfleoedd.
- Cyfarfodydd cyllid bob pythefnos gyda phob Grŵp Gwasanaeth; roedd y rhain wedi creu cyfleoedd arbed ychwanegol o £6 miliwn i'w hychwanegu at y traciwr.
- Yn ystod cyfarfodydd wythnosol y Weithrediaeth, roedd y rhain yn cynnwys goruchwyliaeth agos ar gyflog amrywiol, rheolaethau nad ydynt yn gysylltiedig â chyflog, cyfyngiadau cyflog, a chyfleoedd pellach i gryfhau'r biblinell gyflawni.
- Yr angen am gyflymder wrth yrru cyfleoedd cyflawni.
- Tanwariant bach o £0.9m ar gyfalaf, gyda'r balans arian parod yn sefydlog ar £3.821m; roedd y rhain o fewn lefelau goddefgarwch.
- Risg ariannol Roedd HPR 92 yn parhau i fod yn un o'r risgiau uchaf i'r HB, gyda sgôr o 25.
- Y prif risgiau i gyflawni'r cynllun ariannol; roedd y rhain yn parhau i gynnwys: cyflawni'r rhaglen arbedion; pwysau parhaus ar GIP; pwysau rhagnodi gofal sylfaenol; effeithiau posibl y contract meddyg preswyl; anweddolrwydd costau ynni; a phwysau gweithredol ehangach a oedd yn fwy na'r cyllid sydd ar gael. Er gwaethaf y gwaith sydd ar y gweill, roedd y lefel sylweddol o risg yn parhau o fewn y coch ac yn yr arfaeth ac yn yr arbedion.
- Rhagolwg manwl ar gyfer diwedd y flwyddyn; roedd PFC wedi derbyn hwn yn ei gyfarfod ar 28 Gorffennaf 2026, ac roedd gan NHSPI graffu wythnosol ar waith.

Wrth grynhoi'r sefyllfa, cynghorodd y CO-L fod y Bwrdd yn parhau i fod dan her ariannol, gyda'r sefyllfa sylfaenol yn cael ei dominyddu gan faint yr her arbedion, y pwysau cost a nodwyd eisoes, a'r angen i gyflymu'r broses o gyflawni cynlluniau adfer presennol.

Diolchodd JW i CO-L a gwahoddodd PP i roi cyngor y PFC. Amlygodd PP:

- Datblygiadau cynllun arbedion; roedd 48%, sy'n cyfateb i £30.9m, yn wyrdd neu'n ambr, gyda rhagolwg diwedd blwyddyn o £40.9m; roedd 75% (£30.7m) o hyn yn arbedion cylchol. Ar y gyfradd hon, byddai diwedd y flwyddyn yn gweld BIPBA £34.3m yn is na'r gwerth sy'n ofynnol i gefnogi'r cynllun wrth symud i mewn i 2027/28.



- Diffyg cyfredol o £24m yn ystod y flwyddyn; roedd rhaid i'r arbedion llawn o £65m fod ar waith erbyn diwedd yr ail chwarter, ac roedd yr her hon yn sylweddol. Awgrymodd PP y dylai'r PFC neu'r Bwrdd gynnal ymchwiliadau manwl ddechrau Awst/Medi ar y themâu canlynol: gweithlu meddygol, gofal a gynlluniwyd, gweithlu nyrsio, a chaffael.
- Y risg hollol allweddol o ran darparu gwasanaethau; chwiliodd PFC am broffil diwedd blwyddyn o'r sefyllfa ofynnol, gan broffilio'r sefyllfa arbedion ar sail thema, cynllun wrth gynllun, gyda chysylltiadau clir rhwng diffyg cyflawni ac atebolrwydd.
- Sicrwydd y PFC ar y prosesau llywodraethu sydd ar waith i atal unrhyw gyfrif ddwywaith.
- Yr angen am sicrwydd ynghylch y biblinell gyfleoedd lawn, gan gynnwys y sail ar gyfer adnabod, hyder yn y ddarpariaeth, gofynion cyflwyno fesul cam disgwylledig, dibyniaethau allweddol, ac asesiad/blaenoriaethu'r arbedion. Roedd hyn yn hanfodol, gan fod cyflawni ym Mlynnyddoedd 2 a 3 yn dibynnu ar gyflawni arbedion yn 2026/27. Byddai'r ddibyniaeth bresennol ar arbedion anghylchol yn ystod y flwyddyn yn gwneud cyflawni yn y blynnyddoedd i ddod hyd yn oed yn fwy heriol.
- Sicrwydd y PFC ar brosesau llywodraethu, atebolrwydd gwell ac uwchgyfeirio, i gyd yn deillio o'r adroddiad Adferiad a Chynaliadwyedd.
- Ystyriaeth y PFC o lythyr diweddar gan Lywodraeth Cymru; roedd y ceisiadau'n cyd-fynd â'r rhai a nodwyd gan y Pwyllgor.

Cynghorodd PP, ar hyn o bryd, na allai PFC gymryd sicrwydd y byddai'r gofyniad arbed llawn o £65m yn cael ei gyflawni; roedd yn parhau i fod yn risg hollbwysig ac yn destun craffu parhaus.

Diolchodd JW i aelodau'r PP a'r PFC am eu cyngor; gwahoddodd JS i wneud sylwadau pellach ar yr agenda gyflawni; cynghorodd mai cyflawni arbedion yn erbyn y cynlluniau a nodwyd oedd y prif fater o hyd; byddai'r DU yn cynnig cefnogaeth lawn i'r Grwpiau Gwasanaeth. Cafodd bylchau wrth nodi cyfleoedd i wella effaith hefyd.



Roedd y DU wedi adolygu capasiti a gallu, er mwyn nodi'r arbenigedd a'r adnoddau sydd eu hangen i gefnogi'r gwaith o gyflawni arbedion yn uniongyrchol. Pwysleisiodd (i) fod cyflawni yn 'fusnes i bawb' a (ii) bod yn rhaid canolbwyntio ar gyflawni ac nid yn unig ar y sefyllfa ariannol a'r gofyniad arbedion. Roedd angen ariannu cynigion buddsoddi i achub ac adeiladu ar y mecanweithiau ymgysylltu sefydliad cyfan sydd ar waith.

Diolchodd JW i JS a gwahoddodd SS i wneud sylwadau.

Cefnogodd SS sylwadau a dadansoddiad PP. Roedd o'r farn ei bod yn debygol y byddai BIPBA yn cyrraedd yr arbedion o £65m yn y misoedd nesaf ond yn rhy hwyr yn y flwyddyn i wireddu'r effaith lawn. Byddai'r ddibyniaeth ar opsiynau anghylchol i yrru'r ddarpariaeth yn gwaethygu'r heriau yn 2026/27, ac roedd rhai targedau arbed allweddol yn dal i fod yn brin o fesur.

Eglurodd RO safbwynt WODC; er bod niferoedd staffio wedi lleihau, gyda'r twf isaf mewn cyflogau ledled Cymru, parhaodd costau cyflogau i godi, er ar gyfradd is nag o'r blaen. Roedd cyflog amrywiol hefyd wedi lleihau, ac roedd hyn, gan ystyried maint cywir y gweithlu, yn hanfodol i gyflawni arbedion rheolaidd. Fodd bynnag, roedd rhai Grwpiau Gwasanaeth wedi nodi eu hanawsterau wrth nodi'r arbedion hyn.

Dywedodd PP fod gan Grŵp Gwasanaeth Castell-nedd Port Talbot Singleton ddiffyg o £15.7m a bod gan Grŵp Gwasanaeth Treforys ddiffyg o £14.8m.

Pwysleisiodd JC yr angen i symud i ffwrdd o arbedion anghylchol, gan eiriol dros adolygiad o ddefnydd y gyllideb yn ystod y flwyddyn, er mwyn osgoi dibyniaeth ar arbedion tua diwedd y flwyddyn. Roedd hi'n cefnogi dull 'arbedion maint', yn hytrach na dibynnu ar Grwpiau Gwasanaeth unigol.

Cyfeiriodd NZ at sylwadau JS a nododd Trefnu i Lwyddo fel prif ysgogydd wrth alinio cydlyniant diwylliannol ac atebolrwydd ariannol ledled y sefydliad.



Croesawodd AH y pwyntiau defnyddiol a godwyd. Myfyriodd ar y gwaith a wnaed eisoes ar newid diwylliannol a'r angen i ysgogi atebolrwydd ar gyfer rheoli gwasanaethau a rheolaeth ariannol; roedd ymgysylltu â'r Fforwm Partneriaeth Iechyd (HPF) wedi cefnogi hyn, yn ogystal â hyfforddiant staff ac ymgysylltu mwy â'r sesiynau ymgysylltu staff 'Gofynnwch i Abi' rheolaidd. Roedd y sesiwn ddiweddaraf wedi cynnwys trafodaethau agored ac uniongyrchol gyda staff ar faint cywir y gweithlu. Roedd TR hefyd yn gweithio ar newid diwylliannol sefydliadol. Byddai partneriaid busnes cyllid yn gweithio gydag arweinwyr Grŵp Gwasanaeth yn helpu i yrru trywydd y gweithlu i lawr. Byddai gwaith dwys a wneir drwy gydol mis Awst yn sbarduno datblygiad y biblinell, gyda chanlyniadau'n amlwg ym mis Medi.

Diolchodd JW i'r aelodau am eu barn a'u sylwadau; gwahoddodd RT i ystyried sut i ymgysylltu â'r sefydliad cyfan, gyda negeseuon wedi'u teilwra ar draws yr holl staff a'r Grwpiau Gwasanaeth. Yna crynhodd y sefyllfa, gan gydnabod y ffyrdd yr oedd BIPBA mewn sefyllfa well yn 2026/27 nag yn y blynyddoedd blaenorol, a'r heriau parhaus:

- Y gydnabyddiaeth ar lefel y Bwrdd a'r Gweithgor bod y sefyllfa bresennol yn annerbyniol ac yn anghefnogol.
- Y cynnydd mewn atebolrwydd sy'n deillio o'r Fframwaith Perfformiad ac Atebolrwydd.
- Datblygu piblinell o gyfleoedd, gyda rheolaethau, llywodraethu cryfach, a rheoli rhaglenni.
- Yr adolygiad presennol o drefniadau gweithredu, i gryfhau capasiti, gallu, atebolrwydd, a ffocws ar gyflawni.
- Er gwaethaf y rheolaethau ychwanegol hyn, nid oedd y Bwrdd mewn sefyllfa ar hyn o bryd i gymryd sicrwydd y byddai'r gofyniad arbedion o £65 miliwn yn cael ei gyflawni.
- Cyngor y PFC ar risg cyflawni critigol ynghylch trosi cyfleoedd yn arbedion sy'n rhyddhau arian parod, er gwaethaf atebolrwydd clir a chefnogaeth yr Uned Gyflawni; roedd risgiau'n gysylltiedig â'r capasiti a'r gallu sydd eu hangen i gyflawni ar y raddfa a'r cyflymder gofynnol.



- Argymhelliad y PFC i gynnal ymchwiliadau manwl ar sail thematig i'r gweithlu meddygol, gofal a gynlluniwyd, y gweithlu nyrsio, a chaffael. Awgrymodd JW ddefnyddio mecanweithiau presennol i gynnal yr ymchwiliadau dwfn drwy gydol mis Awst, gan adrodd yn ôl i'r PFC ym mis Medi.
- Effaith sefyllfa Mis 04 ar y camau gweithredu sydd eu hangen yn Ch3 a Ch4.

Yna dychwelodd JW at RT am ei gyngor proffesiynol ar negeseuon.

Cynghorodd RT ddull cytbwys o negeseua, gan gydnabod pa mor galed yr oedd staff yn gweithio, tra ar yr un pryd yn glir bod graddfa'r arbedion oedd eu hangen yn galw ar y gweithlu i wneud pethau'n wahanol. Amlinellodd y tri phrif lwybr a ddefnyddir ar gyfer cyfathrebu â staff: ar lefel rheoli yn seiliedig ar atebolrwyddau; negeseuon corfforaethol; a negeseuon ymgyrchoedd penodol. Cynigiodd gamau gweithredu ar draws y tri chyfle i ysgogi ymgysylltiad a chymell staff i ymateb a chymryd perchnogaeth o'r her, gyda ffocws penodol ar negeseuon corfforaethol yn y cyfnod cyn mis Medi.

Cam Gweithredu: RT

Gwnaeth y Bwrdd y canlynol:

- **CYDNABU** hynny, o ystyried y diffyg ariannol, nad oedd modd cefnogi Cynllun Blynnyddol 2026/27, ac nad oedd yn dderbyniol; roedd yn golygu na allai'r Bwrdd gymeradwyo'r Cynllun, safbwynt a rannwyd gan Lywodraeth Cymru.
- **DERBYNIWYD** cyngor y PFC, o ystyried y risgiau sy'n gysylltiedig ag adnabod a chyflawni arbedion, na allai'r Bwrdd gymryd sicrwydd y byddai'r gofyniad arbed llawn o £65m yn cael ei gyflawni ar hyn o bryd.
- **ADOLYGWYD** y sefyllfa ariannol fel yr oedd ym Mis 03, a'r risgiau sy'n deillio o hynny; pwysleisiodd aelodau'r Bwrdd yr angen brys i gyflymu'r broses o drosi cyfleoedd piblinell yn arbedion sy'n rhyddhau arian parod, yn unol â'r adroddiad llawn.
- **CYTUNWYD** i gynnal ymchwiliadau manwl yn ystod mis Awst, i'r gweithlu meddygol, y gweithlu nyrsio, caffael a gofal a gynlluniwyd.
- **YSTYRIWYD** a rhoi sylwadau ar berfformiad ariannol BIPBA o ran arian parod, cyfalaf a thaflen fantolen.



- **CYTUNWYD** ar y dull a amlinellwyd gan RT i ddilyn dull tair llinyn ar gyfer negeseuon sefydliadol.
- **YSTYRIWYD** y llythyr diweddaraf gan Lywodraeth Cymru a **CHYTUNODD** ar y camau nesaf ar y cynllun adfer ariannol.

5.3 Gwasanaethau Amenedigol

- i. Adroddiad y Pwyllgor Amenedigol
- ii. Adroddiad y Panel Goruchwylio Amenedigol
- iii. Cynllun Gwella

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i. Adroddiad y Pwyllgor Amenedigol

Estynnodd JW groeso cynnes i FG, KG, SB, a DC.

Atgoffodd LR y Bwrdd o'i ystyriaeth flwyddyn yn ôl o'r adroddiad Adolygiad Annibynnol a luniwyd gan y Panel Goruchwylio, yr Adolygiad dan Arweiniad Teuluoedd, ac adroddiad Llais. Drwy gydol y flwyddyn ddiwethaf, roedd y tîm wedi gweithio'n ddiflino i lunio adroddiad y Pwyllgor Amenedigol i ddarparu'r agoredrwydd, y tryloywder a'r atebolrwydd gorau posibl. Roedd cynnwys yr adroddiad yn ddeinamig a byddai'n destun mireinio parhaus.

LR wedi'i amlygu:

- Gwelliannau amlwg ar draws dangosyddion ansawdd a diogelwch, wedi'u cefnogi gan lywodraethu cryfach.
- Cydnabyddiaeth Arolygiaeth Gofal Iechyd Cymru (AGIC) o gynnydd ar draws systemau diogelwch, arweinyddiaeth, prosesau uwchgyfeirio, a gwaith tîm amlddisgyblaethol.
- Ni adroddwyd am unrhyw achosion o enseffalopathi isgemig hypocsig (HIE) yn 2026, gyda gostyngiad cynaliadwy wedi'i adrodd dros amser.
- Gwelliannau parhaus yn ffigurau marwolaethau amenedigol, yn unol â sefydliadau cymharol ledled y DU.
- Adrodd MBBRACE cadarn.
- Cydymffurfiaeth gref â hyfforddiant statudol a gorfodol, gan ragori ar darged LIC o 85%, gyda gwelliannau yng nghydymffurfiaeth y



gweithlu meddygol. Roedd sefyllfa BIPBA yn gryf o'i gymharu â byrddau iechyd eraill Cymru.

- Pwysau ar y gweithlu meddygol a bydwreigiaeth; roedd y rhain yn cael eu rheoli'n ddyddiol, gyda chefnogaeth hyblygrwydd ac addasrwydd y tîm. Cafodd bylchau yn y gweithlu eu cau heb effaith andwyol ar y gwasanaeth.
- Bodlonrwydd cadarnhaol gan ffrindiau a theulu. Byddai ymgysylltu a chydgyhyrchu parhaus gyda chymunedau lleol yn gwella'r ddealltwriaeth o anghenion menywod a theuluoedd.
- Sefydlu un pwynt mynediad (SPOA) ar gyfer mamolaeth, gyda staff mamolaeth ymroddedig; roedd hwn yn waith sy'n mynd rhagddo gyda mwy i'w wneud i optimeiddio trin galwadau.
- Y broses system brysbennu obstetrig benodol i Birmingham (BSOTS), a ddefnyddir i fonitro'r system brysbennu.
- Ffocws parhaus ar y gweithlu ac ar bwysau capasiti, yn enwedig mewn wardiau ôl-enedigol, wedi'i yrru'n rhannol gan y cynnydd mewn toriadau Cesaraidd.
- Gwelliannau parhaus i radioleg bediatrig, gyda chamau lliniaru ar waith fel cam cychwynnol.
- Y risgiau parhaus sy'n gysylltiedig â gweithio ar ddau safle; mae'r Gofrestr Risg Gorfforaethol wedi cofnodi'r rhain ynghyd ag archwiliad cyfredol o opsiynau strategol ar gyfer y dyfodol.
- Rôl adroddiad y Pwyllgor Amenedigol wrth hysbysu a sicrhau'r Bwrdd, tra hefyd yn darparu cyfle heriol i yrru gwelliannau. Estynnodd LR ei diolch i'r tîm am eu rôl wrth greu a llunio'r adroddiad.

Diolchodd JW i LR a gwahoddodd JC i wneud sylwadau, fel cadeirydd QSC. Wrth ymateb, croesawodd JC y dull systematig a gymerwyd i ddadansoddi'r data sydd ar gael, gan geisio tystiolaeth i lywio ac asesu canlyniadau. Roedd nifer fach o argymhellion yn parhau i fod heb eu gweithredu, gan gynnwys cryfhau cyfathrebu â theuluoedd. Mae'r gwaith pwysig a wnaed dros y flwyddyn ddiwethaf wedi helpu QSC i ystyried y dull cyfan o wella ansawdd (GA). Croesawodd JC hefyd y rhyngweithio cadarnhaol rhwng y Panel Goruchwylio a'r tîm.



Diolchodd JW i JC am ei chraffu a dywedodd y byddai TO yn gweithio gyda'r rhaglen Amenedigol, gan edrych ar ymatebolrwydd diwylliannol.

Gwahoddodd JW gwestiynau.

O ran brysbennu, ceisiodd RO sicrwydd ynghylch effeithiolrwydd y SPOA ar gyfer y gwasanaeth brysbennu ac a oedd y rolau a'r disgwyliadau'n glir. Cydnabu JW bwysigrwydd y pwynt hwn a gwahoddodd KG i wneud sylwadau ar y sefyllfa bresennol, ynghyd â chynlluniau ar gyfer gwella yn y dyfodol.

Cynghorodd KG fod y SPOA yn ganlyniad gwaith gwella manwl; roedd yn fecanwaith ychwanegol gwerthfawr, gyda'r nod o sicrhau y gallai menywod gael mynediad at y math cywir o gymorth ar yr amser iawn. Yn dilyn gweithredu BSOTS, a gwblhawyd ym mis Tachwedd 2025, roedd tîm ymroddedig o fydwragedd â'r sgiliau priodol bellach yn cefnogi'r system flaenoriaethu. Roedd y Fydwraig Profiad Iechyd Menywod yn arolygu defnyddwyr y system i benderfynu a oedd unrhyw anawsterau wrth lywio'r opsiynau dewislen sydd ar gael. Roedd KG yn cydnabod bod opsiynau'r ddewislen yn hir, er bod menywod a oedd yn defnyddio'r system yn gyffredinol yn ei chael hi'n hawdd i lywio drwyddi. Byddai gwaith yn parhau i fireinio'r system a diweddarau staff yn unol â hynny.

Gofynnodd AG am yr integreiddio rhwng system SPOA a BadgerNet. Cadarnhaodd KG fod BadgerNet yn gofnod electronig cyfan ar gyfer cleifion mamolaeth, gyda modiwl penodol wedi'i gynnwys ar gyfer BSOTS. Defnyddiodd bydwagedd y model hwn i fewnbynnu gwybodaeth am alwadau brysbennu yn uniongyrchol i system fyw. Galluogodd hyn atgyfeiriad priodol ar gyfer pob menyw a allai fod angen ymyriadau clinigol, yn dibynnu ar eu problem.

Gwnaeth y Bwrdd y canlynol:

DERBYN CYNGOR AR Y CANLYNOL:

- Y cynnydd parhaus ar draws gwasanaethau mamolaeth a newyddenedigol, gyda llywodraethu gwell, gweithio amlddisgyblaethol cryfach, a systemau diogelwch gwell a ddangosir drwy ganfyddiadau AGIC, cydymffurfiaeth y gweithlu, a metrigau ansawdd.



- Gweithredu rhaglenni gwella ansawdd wedi'u targedu (e.e., ASTRA, cefnogaeth anadlol wrth ochr y gwely yn ystod clampio llinyn y llinyn wedi'i ohirio ar gyfer genedigaethau cynamserol, systemau digidol fel BadgerNet a CTG cyfrifiadurol) i fynd i'r afael â phrif ffactorau risg ac amrywiad.
- Systemau data; roedd y rhain yn mynd trwy gyfnod o drawsnewid a dilysu; er y gallai newidiadau effeithio ar gyflawnrwydd yn y tymor byr, roedd y gwaith hwn yn hanfodol.

CYMERODD SICRHAU AR:

- Y trefniadau llywodraethu a goruchwylio cadarn sydd ar waith gan gynnwys monitro amser real, adolygiad amlddisgyblaethol, a llwybrau uwchgyfeirio clir o'r ward i'r Bwrdd.
- Rheoli'r holl risg yn weithredol heb unrhyw gamau gweithredu hwyr, a'r ddarpariaeth wedi'i halinio â cherrig milltir cynlluniedig, wedi'i chefnogi drwy raglenni gwella strwythuredig.
- Y dystiolaeth glir o drosi dysgu yn ymarfer. a datblygu'r gweithlu.
- Cymeradwyaeth cynllun gwella AGIC, wedi'i gyhoeddi, ac yn mynd rhagddo'n weithredol, gyda goruchwyliaeth gryfach yn sicrhau cyflawni a chwblhau camau gweithredu.

CYMERWYD RHYBUDDION AR:

- Pwysau parhaus ar y system, gan gynnwys capasiti'r gweithlu, llif ôl-enedigol, a galw sy'n gysylltiedig ag aciwtedd a dull geni (yn enwedig derbyniadau newyddenedigol sy'n gysylltiedig â thoriadau Cesaraidd).
- Risgiau lefel uchel a oedd yn parhau i fod dan reolaeth weithredol, gan gynnwys capasiti radioleg pediatriig, cyfyngiadau ar ddarparu hyfforddiant (MoNET), a heriau ehangach o ran ffurfweddu gwasanaethau (e.e. gweithio ar ddau safle a mynediad at ofal critigol).
- Risgiau trosglwyddol sy'n gysylltiedig â gweithredu digidol a dibyniaethau ar systemau cenedlaethol, gan gynnwys ansawdd data, cyfyngiadau arolygon, a chysondeb adrodd.
- Yr angen i gynnal ffocws ar degwch mynediad, cysondeb wrth uwchgyfeirio, ac amseroldeb gofal, fel y nodwyd drwy AGIC a phrosesau adolygu mewnol.

ii. Adroddiad y Panel Goruchwylio Amenedigol



Croesawodd JW DC i'r cyfarfod, gan gydnabod y garreg filltir bwysig o ran gwella gwasanaethau ers yr Adolygiad Annibynnol a gyhoeddwyd flwyddyn yn ôl. Diolchodd DC i'r Bwrdd am y cyfle i fynychu'r cyfarfod a thynnodd sylw at:

- Yr ymweliadau safle clinigol a gynhaliwyd ym mis Mehefin 2026 i ysbytai Treforys a Singleton ac i'r Ganolfan Geni annibynnol yn ysbyty Castell-nedd Port Talbot. Dilynwyd hyn gan Gynhadledd fach yn ddiweddarach yn y dydd gyda gweithdai wedi'u hwyluso a archwiliodd feysydd y Cynllun Gwella (y Cynllun).
- Yn dilyn yr ymweliadau â'r safleoedd, roedd yn rhaid i'r Panel Goruchwylio ystyried y Cynllun a'r adborth o'r gweithdai. Yna roedd y DC ac aelodau'r panel wedi cyfarfod ag LR ac arweinwyr y llif gwaith mewnol.
- Nododd y Cynllun raddfa'r gwelliant a gyflawnwyd, fel y'i mesurwyd yn erbyn argymhellion yr adolygiadau unigol; rhaid i'r broses hon barhau gyda'r Cynllun yn ddogfen ddeinamig, yn esblygu wrth i'r daith wella barhau. Dylai adolygiadau a gynhelir yng Nghymru a Lloegr lywio gwaith parhaus, fel y dylai adolygiad Nottingham. Byddai angen i'r Bwrdd gadw'r rhain ac adolygiadau eraill mewn cof, er mwyn nodi unrhyw ddysgu ychwanegol.
- Dogfen ddiweddar gan GIG Lloegr ar frysennu; byddai hon yn offeryn gwerthfawr i gefnogi gwelliant parhaus, ac roedd tîm BIPBA yn ymwybodol ohoni.
- Bodlonrwydd y Panel Goruchwylio bod y Cynllun yn darparu digon o ddyfnder a sicrwydd i ganiatáu i'r Bwrdd ei gymeradwyo. Wrth wneud hynny, dylai'r Bwrdd ymrwymo i barhau â'r daith wella.
- Swm y naratif yn y Cynllun; dylai adroddiadau cynnydd fod yn fwy ffocws. Argymhellodd y Panel Goruchwylio y dylai'r Bwrdd ystyried data canlyniadau dros y flwyddyn ddiwethaf, wedi'i gasglu fel adroddiad cryno a oedd yn tynnu sylw at fesurau canlyniad allweddol a metrigau allweddol.
- Brysbennu; roedd angen monitro parhaus ar y Bwrdd i sicrhau ei hun nad oedd unrhyw ganlyniadau anfwriadol. Y metrigau allweddol yn hyn o beth oedd: (i) nifer y galwadau a gollwyd; (ii) nifer yr ymyriadau i'r bydwagedd brysbennu ac effaith y rheini ar brofiad y claf; a (iii) nifer y galwadau gan bobl o gefndir amrywiol. Y metrigau hyn, ynghyd ag adborth amser real. Byddai'n darparu mewnwelediadau gwerthfawr.
- Ymgysylltu â theuluoedd; roedd angen gwaith pellach, gan gynnwys ar gyd-gynhyrchu, wedi'i ategu gan Ddangosyddion



Perfformiad Allweddol (KPIs) mwy cadarn. Dylai'r Bwrdd hefyd fanteisio ar y cyfle i gydweithio'n agosach â Llais ac elusennau.

- Yr angen i godi ymwybyddiaeth ar safle Treforys a'r cyfleoedd ehangach y gallai hyn eu cynnig.
- Y risgiau o weithio ar ddau safle; roedd DC wedi nodi'r rhain mewn llythyr ar wahân at JW ac AH. Cefnogodd y Panel Goruchwylio'r camau lliniaru sylweddol yn y Cynllun ond cydnabu na fyddai'r rhain yn lleihau'r risg yn llwyr.
- Mae'r Panel Goruchwylio yn cynnig datblygu adroddiadau mwy craff a mwy ffocws sy'n canolbwyntio ar y meysydd sydd angen sicrwydd.

Ar ran y Bwrdd, estynnodd JW ddiolchiadau diolchgar i DC a'r Panel Goruchwylio am yr adborth. O ran gweithio ar ddau safle, cynghorodd y byddai'r Bwrdd yn ystyried yr achos dros newid yn ei gyfarfod ym mis Medi 2026. Croesawodd JW hefyd y cynnig o gefnogaeth i symleiddio'r broses adrodd, gyda ffocws ar fetrigau allweddol.

Yna derbyniodd aelodau'r Bwrdd y camau nesaf a gynigiwyd gan y Panel; gwahoddodd JW DC i ddychwelyd i gyfarfod y Bwrdd ym mis Medi cyn i'r Panel Goruchwylio gamu i lawr. Byddai hyn yn caniatáu i DC adolygu'r camau nesaf.

Yna gwahoddodd JW AE, ar ran Llais, i wneud sylwadau ar y Cynllun a'r cynnydd hyd yma.

Croesawodd AE y cyfle a chofnododd gydnabyddiaeth Llais o'r ymdrech a'r cynnydd sylweddol a wnaed dros y flwyddyn ddiwethaf, a wnaed yn ysbryd agoredrwydd ac atebolrwydd. Cydnabu hefyd rôl arwyddocaol y Panel Goruchwylio, a QSC. Roedd Llais wrth ei fodd yn gweld y gwelliannau sylweddol a'r trefniadau llywodraethu cryfach, gyda thystiolaeth o ofal cynhwysfawr, teg a diogel.

Croesawodd LR yr adborth ac edrychodd ymlaen at ddatblygu Rhwydwaith Partneriaeth Lleisiau Mamolaeth a Newyddenedigol (MNVP) yr oedd Llais yn ei gynnal ar gyfer Cymru.

Diolchodd AH i DC am yr adborth, gan gadarnhau y byddai'r tîm yn gweithredu ar ei phwyntiau ychwanegol, er mwyn parhau i gryfhau'r gwasanaeth. Myfyriodd ar y daith dros y flwyddyn ddiwethaf ac ailadroddodd yr ymddiheuriadau diamod a wnaeth y Bwrdd am



brofiadau a chanlyniadau gwael. Estynnodd AH ei diolch hefyd i AE a Llais am y cynnig o fewnbwn parhaus ac atgyfnerthodd yr ymrwymiad i wrando, mewn amser real, ar fenywod a'u profiadau.

Yna cyfeiriodd AH at y symudiad o Grwpiau Gwasanaeth i Grwpiau Gofal, gyda grŵp penodol ar gyfer plant, menywod a theuluoedd; byddai hyn yn hwyluso ffocws parhaus ar y gwasanaeth a'r ymrwymiad i welliant parhaus. Estynnodd AH ei diolch personol i DC ac aelodau'r Panel Goruchwyllo.

iii. Cynllun Gwella

Tynnodd LR sylw at y llythyr ar flaen y Cynllun Gwella (y Cynllun) yr oedd hi ac RK wedi'i lofnodi; cydnabu'r gwaith sylweddol a wnaeth RK yn ystod dyddiau cynnar datblygu'r Cynllun ac wedi hynny. Roedd ymrwymiad clir i wrando, i ddysgu, ac i wella. Roedd y Cynllun eisoes wedi gwneud cynnydd sylweddol a byddai'n parhau i wneud hynny.

Roedd y Cynllun yn cynnwys yr argymhellion o: holl adroddiadau ac ymweliadau'r Panel Goruchwyllo; o Llais; o AGIC; o'r Asesiad Cymru Gyfan; ac o'r Adolygiad dan Arweiniad Teuluoedd. Roedd dadansoddiad bylchau ar y gweill yn erbyn argymhellion Ockendon ac adolygiad Amos yn Lloegr. Byddai'r Bwrdd yn derbyn canlyniad hyn yng nghyfarfod mis Medi.

Cam Gweithredu: LR

Cydnabu LR nad oedd yn bosibl dadwneud y niwed a'r gofid a achoswyd i rai teuluoedd; ymrwymodd i barhau i ymgysylltu â chymuned Bae Abertawe ac i archwilio gwahanol ffyrdd o wneud hynny, gan gynnwys trwy gyd-gynhyrchu. Roedd y timau mamolaeth a newyddenedigol yn ymgysylltu'n llawn â'r agenda gwella ac roedd ganddynt uchelgais ac angerdd i ddarparu'r gwasanaethau gorau a'r profiadau gorau posibl.

Ymhlith y gwelliannau a gyflawnwyd eisoes roedd: y broses brysbennu 24/7; sgoriau rhybuddio cynnar; cydymffurfiaeth â hyfforddiant; presenoldeb gwell gan feddygon ymgynghorol yn y gweithlu; cyflwyno proses flaenoriaethu ar gyfer sefydlu esgor; buddsoddiad yn y gweithlu;



datblygu arweinyddiaeth amlddisgyblaethol; a gwaith i gryfhau diogelwch seicolegol staff.

Cydnabu LR sylwadau DC ar lefel y manylder a oedd wedi'i gynnwys yn y Cynllun; byddai'n symleiddio adroddiadau yn y dyfodol ac yn cynnwys metrigau sy'n gysylltiedig â gwelliant. Estynnodd LR ei diolch i FG, KG, SB ac RK am eu cefnogaeth barhaus yn ystod cyfnod heriol, ynghyd â'u hangerdd a'u huchelgais.

Croesawodd SB gefnogaeth cydweithwyr dros y flwyddyn ddiwethaf, gyda dysgu unigol a dysgu system yn digwydd; fe helpodd y cyfan i gyflawni gwelliant parhaus mewn gwasanaethau. Ychwanegodd KG ei hymrwymiad i gyflawni'r Cynllun.

Daeth JW â'r trafodaethau i ben drwy gofnodi diolch y Bwrdd i DC a'r Panel Goruchwylio, i SB, KG a'r gwasanaeth mamolaeth a newyddenedigol cyfan.

Gwnaeth y Bwrdd y canlynol:

- **CYMERADWYDD** y Cynllun Gwella Amenedigol wedi'i ddiweddarau (Atodiad 1).
- **CYMERODD SICRWYDD O'R CANLYNOL:**
 - Y cynllun cynhwysfawr sydd ar waith i fynd i'r afael ag argymhellion Adolygiad Annibynnol BIPBA o Wasanaethau Mamolaeth a Newyddenedigol, yr Adolygiad o Wasanaethau Mamolaeth dan Arweiniad Teuluoedd, ac Adroddiad Llais "Cael babi yng Nghastell-nedd Port Talbot ac Abertawe", ynghyd ag unrhyw gamau gweithredu sy'n ofynnol o'r Asesiad Cymru Gyfan o Wasanaethau Amenedigol.
 - Y cynnydd cynaliadwy parhaus a wnaed ers cyhoeddi'r Adolygiad Annibynnol ar gamau diogelwch allweddol.
 - Seiliwyd y Cynllun ar strwythur llywodraethu a sicrwydd cadarn.
- **CYMERODD RHYBUDDION AR:**
 - **Gweithio ar ddau safle:** Er cydnabod y cynnydd sylweddol a wnaed o ran cryfhau trefniadau ar gyfer menywod sydd angen gofal mewn lleoliadau nad ydynt yn lleoliadau mamolaeth, gan



gynnwys nifer o Bolisiau Gweithredu Safonol (sy'n amlinellu'n benodol y prosesau a'r cynnydd, ar gyfer derbyn menywod beichiog i safleoedd nad ydynt yn lleoliadau mamolaeth) ac ailfodelu'r gweithlu, roedd risg gynhenid yn parhau i fod yn rhan o'r model gweithredu hwn. Byddai'r Bwrdd yn derbyn opsiynau ar gyfer ad-drefnu gwasanaethau yng nghyfarfod mis Medi 2026.

- **Brysbennu Mamolaeth:** Argymhellodd 'Llwybr at Ddechreuadau Diogelach yng Nghymru', a gyhoeddwyd ym mis Chwefror 2026, sefydlu gwasanaeth brysbennu pwynt mynediad sengl cenedlaethol ar gyfer menywod beichiog, wedi'i gydlynu gan Ymddiriedolaeth Gwasanaeth Ambiwlans Cymru. O ystyried hyn, ni fyddai BIPBA yn parhau i ddatblygu model BIPBA annibynnol. Er mwyn lliniaru risg tan weithredu'r model brysbennu cenedlaethol, roedd y bwrdd iechyd wedi sefydlu uned brysbennu clinigol 24/7. Roedd y gwasanaeth yn cynnig cyngor dros y ffôn ac yn bersonol; gallai menywod a'u teuluoedd gael cyngor amserol am unrhyw bryderon, gydag atgyfeiriadau a chyfeiriadau priodol. Byddai hyn yn gwella diogelwch cleifion, profiadau cleifion ac yn gwella ansawdd a chanlyniadau. Roedd yr uned brysbennu mamolaeth, a elwir yn Uned Asesu Cynenedigol, wedi'i staffio gan ddwy fydwraig a oedd wedi'u hyfforddi mewn brysbennu mamolaeth; fodd bynnag, roeddent hefyd yn gofalu am gleifion a oedd yn dod yn bersonol. Os bydd galwyr yn profi oedi cyn ymateb bydwraig ar unwaith, byddai aelod o'r staff gweinyddol yn ateb ac yn gofyn i'r galwr aros. Yn yr achosion hyn, pe bai'r fydwraig brysbennu'n nodi oedi posibl estynedig, byddai'r staff gweinyddol (ar rota 24/7 yn cefnogi'r gwasanaeth) yn rhoi'r broses uwchgyfeirio ar waith ac yn cysylltu â Chydlynnydd y Ward Geni i gael cymorth.
- **Radioleg pediatrig:** Aeth allanoli darpariaeth radioleg pediatrig ar gyfer pelydr-x ffilm plaen fel mesur lliniaru dros dro yn fyw ym mis Chwefror 2026. Roedd heriau cenedlaethol ar draws y system o ran radioleg; byddai ateb rhanbarthol yn darparu sicrwydd hirdymor a chynaliadwyedd o ran darpariaeth gwasanaeth. Roedd trafodaethau'n parhau gyda Bwrdd Iechyd Prifysgol Caerdydd a'r Fro i archwilio opsiynau addas.



RHAN 6. LLYWODRAETHU

6.1 Adroddiad Llywodraethu Corfforaethol

125/26

Crynhodd HL gydrannau'r adroddiad Llywodraethu, gan gyfeirio'n benodol at yr angen am gymeradwyaeth y Bwrdd ar y Pwyllgor Telerau Gwasanaeth Taliadau wedi'u diweddaru.

Gwnaeth y Bwrdd y canlynol:

- **DERBYN** er **SICRWYDD**:
 - Y materion a ystyriwyd yn y Pwyllgor yng nghyfarfod y Bwrdd ym mis Mai 2026;
 - Cylchlythyrau Iechyd Cymru;
 - Cofrestr y Sêl Gyffredin;
 - Rhaglen Waith y Bwrdd 2026-27;
- **CYMERADWYDD** Cylch Gorchwyl diwygiedig y Pwyllgor Tâl a Thelerau Gwasanaeth, i'w weithredu o 1 Medi 2026.

RHAN 7. AGENDA GYDSYNIO

7.1 Cofnod o Gyfarfodydd Blaenorol Bwrdd BIPBA

- 28 Mai 2026
- 25 Mehefin 2026 (Arbennig)

126/26

CYMERADWYDD y Bwrdd y cofnodion fel cofnod gwir a chywir o'r cyfarfodydd ar:

- 28 Mai 2026
- 25 Mehefin 2026 (Arbennig)

7.2 Log Gweithredu

127/26

DERBYNIODD y Bwrdd y diweddariadau Cofnod Gweithredu er **SICRWYDD**.

7.3 Adroddiad Grwpiau Cyngori'r Bwrdd

- Fforwm Partneriaeth y Bwrdd Iechyd



ii. Fforwm Gweithwyr Proffesiynol Iechyd

iii. Grŵp Adnoddau Rhanddeiliaid

128/26

Gwnaeth y Bwrdd y canlynol:

DERBYN trafodaethau'r

- i. Fforwm Partneriaeth y Bwrdd Iechyd a gynhaliwyd ar 9 Gorffennaf 2026.
- ii. Fforwm Gweithwyr Proffesiynol Iechyd a gynhaliwyd ar 11 Mehefin 2026.
- iii. Grŵp Cyfeirio Rhanddeiliaid a gynhaliwyd ar 16 Gorffennaf 2026.

7.4 Adroddiad y Cadeirydd

129/26

CYMERODD y Bwrdd SYLW o weithgareddau'r Cadeirydd ers cyfarfod diwethaf y Bwrdd ar 28 Mai 2026.

7.5 Adroddiad Materion Allweddol Pwyllgor Iechyd y Boblogaeth

130/26

DERBYNIODD y Bwrdd yr Adroddiad Materion Allweddol er SICRWYDD .

7.6 Adroddiad Materion Allweddol y Pwyllgor Perfformiad a Chyllid

- i. **Mai 2026**
- ii. **Mehefin 2026**

131/26

DERBYNIODD y Bwrdd yr Adroddiad Materion Allweddol er SICRWYDD .

7.7 Adroddiad Materion Allweddol y Pwyllgor Ansawdd a Diogelwch

132/26

DERBYNIODD y Bwrdd yr Adroddiad Materion Allweddol er **SICRWYDD.**

7.8 Adroddiad Materion Allweddol y Pwyllgor Gweithlu a Datblygu Sefydliadol



133/26	DERBYNIODD y Bwrdd yr Adroddiad Materion Allweddol er SICRWYDD .
7.9 Adroddiad Materion Allweddol y Pwyllgor Archwilio i. Mehefin 2026 (Arbennig) ii. Mehefin 2026	
134/26	DERBYNIODD y Bwrdd yr Adroddiad Materion Allweddol er SICRWYDD .
7.10 Adroddiad Materion Allweddol y Pwyllgor Cronfeydd Elusennol	
135/26	DERBYNIODD y Bwrdd yr Adroddiad Materion Allweddol er SICRWYDD .
RHAN 8. EITEMAU I'W TRAFOD	
8.1 Unrhyw Fusnes Arall	
136/26	Doedd dim.
8.2 Adolygiad o Effeithiolrwydd Cyfarfodydd	
137/26	Nid oedd unrhyw adroddiadwr ar gyfer y cyfarfod. Gofynnodd JW i'r mynychwyr anfon unrhyw adborth ati hi neu HL drwy e-bost.
8.3 Sylwadau i Gloi	
138/26	Cyn cau'r cyfarfod, nododd JW mai dyma oedd cyfarfod olaf RO fel Aelod Annibynnol o'r Bwrdd, gan ei bod wedi cwblhau dau dymor gwasanaeth llawn. Ar ran y Bwrdd, diolchodd JW i RO am ei wyth mlynedd o wasanaeth cyhoeddus perffaith, am ei chyngor doeth, ei chyngor a'i harweiniad ar draws agenda'r Bwrdd, ac am ei gwaith diwyd ar lefel y Pwyllgor. Tynnodd JW sylw penodol at rôl RO fel cadeirydd WODC a diolchodd iddi



am y ffordd yr oedd hi wedi datblygu ei rôl a'r arfer da yr oedd hi wedi'i gyflwyno.

Ymunodd holl aelodau'r Bwrdd â JW i ddymuno'n dda i RO ar gyfer y dyfodol.

Cyfarfod nesaf Bwrdd BIPBA: Dydd Iau 24 Medi 2026

Daeth y cyfarfod i ben am 16:07.

DRAFT



Swansea Bay University Health Board (SBUHB)
Minutes of the Board Meeting held on
30 July 2026 at 10:45am

Present

Jan Williams	(JW)	Chair
Abigail Harris	(AH)	Chief Executive Officer
Jean Church	(JC)	Independent Member
Marie Davies	(MD)	Executive Director of Planning and Partnerships
Andrew Griffiths	(AG)	Independent Member
Raj Krishnan	(RK)	Interim Executive Medical Director
Claire Osmundsen-Little	(COL)	Interim Executive Director of Finance and Performance
Reena Owen	(RO)	Independent Member
Patricia Price	(PP)	Independent Member
Charlotte Rees	(CR)	Independent Member
Liz Rix	(LR)	Executive Director of Nursing and Patient Experience
Stephen Spill	(SS)	Vice Chair
Hugo Van Woerden	(HVW)	Interim Executive Director of Public Health
Nuria Zolle	(NZ)	Independent Member

In Attendance

Helen Annandale	(HA)	Chair of the Health Professionals Forum
Sujoy Banerjee	(SB)	Consultant Neonatologist (For Agenda item 5.3)
Denise Chaffer	(DC)	Maternity and Neonatal Oversight Panel Chair (For Agenda item 5.3)
Pat Dunmore	(PD)	Chair of the Stakeholder Reference Group
Amy English	(AE)	Interim Regional Director, Llais
Kathy Greaves	(KG)	Clinical Director Midwifery (For Agenda item 5.3)
Ffion Green	(FG)	Programme Lead: Corporate Nursing and Patient Experience (For Agenda item 5.3)
Paul Harry	(PH)	Head of Finance: Service Intelligence (For Agenda item 4.5)
Matthew John	(MJ)	Director of Digital
Alun Llewelyn	(AL)	Associate Board Member
Hazel Lloyd	(HL)	Director of Corporate Governance



Andrew Nelson	(AN)	Director of Performance and Business Intelligence (For Agenda item 4.5)
Emma Owen	(EO)	Assistant Director of Workforce and Organisational Development
Hannah Parsons	(HP)	Assistant Director of Operations (For Agenda item 4.5)
Carys Richards	(CER)	Senior Corporate Governance Manager
Heather Richards	(HR)	Health Board Partnership Forum Chair
Jon Scott	(JS)	Interim Delivery Unit Director
Richard Thomas	(RT)	Director of Insight, Communications and Engagement
Craige Wilson	(CW)	Deputy Chief Operating Officer

Apologies

Anne-Louise Ferguson	(ALF)	Independent Member
Deb Lewis	(DL)	Chief Operating Officer/ Interim Executive Director of Primary Care & Community and Mental Health & Learning Disabilities
Nicola Mathews	(NM)	Independent Member
Theresa Ogbekhiulu	(TO)	Associate Board Member
Tina Ricketts	(TR)	Executive Director of Workforce and Organisational Development

Observing in-person

Arwel Roberts	Council Associate at the General Osteopathic Council (GOsC)
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Acronyms

Acronym	Definition	Minute Reference
AAA	Alert, Advise, Assure	122/26
AC	Audit Committee	114/26; 118/26; 122/26; 134/26
AGM	Annual General Meeting	116/26
AI	Artificial Intelligence	116/26
APB	Area Planning Board	117/26
ASTRA	Avoiding Short-Term Respiratory Admissions to the Neonatal Unit	124/26
BJC	Business Justification Case	119/26; 121/26
BSOTS	Birmingham Symptom-specific Obstetric Triage System	124/26



CAMHS	Child and Adolescent Mental Health Services	122/26
C.diff	Clostridioides difficile	122/26
CEMT	Chief Executives Management Team	117/26
CHC	Continuing NHS Healthcare	123/26
CT	Computed Tomography	122/26
CTG	Cardiotocography	124/26
DALB	Drug and Alcohol Leadership Board	117/26
DDRIC	Digital, Data, Research and Innovation Committee	116/26; 122/26
DU	Delivery Unit	121/26; 123/26
ED	Emergency Department	113/26; 122/26
EPRR	Emergency Preparedness, Resilience and Response	117/26
HAIs	Healthcare Associated Infections	122/26
HB	Health Board	114/26; 120/26
H DUHB	Hywel Dda University Health Board	118/26; 119/26
HIE	Hypoxic Ischaemic Encephalopathy	124/26
HIW	Healthcare Inspectorate Wales	124/26
HMP	His Majesty's Prison	114/26
HPR	Health Board Principal Risk	123/26
IPC	Infection Prevention and Control	122/26
IPR	Integrated Performance Report	122/26
IV	Intravenous	122/26
JCC	Joint Commissioning Committee	115/26; 117/26; 122/26
KPIs	Key Performance Indicators	124/26
LINAC	Linear Accelerator	119/26
LTAs	Long-Term Agreements	117/26
MBBRACE	Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries	124/26
MNVP	Maternity and Neonatal Voices Partnership	124/26
MoNET	Multi-professional Neonatal Education and Training	124/26
NHSPI	NHS Performance and Improvement	120/26; 121/26; 122/26
NPT	Neath Port Talbot	117/26; 120/26; 124/26
PFC	Performance and Finance Committee	119/26; 120/26; 122/26; 123/26
PFAG	Planning and Finance Assurance Group	119/26



PHC	Population Health Committee	122/26
PID	Project Initiation Document	118/26
Q1	Quarter 1	117/26
Q3	Quarter 3	122/26; 123/26
Q4	Quarter 4	123/26
QI	Quality Improvement	124/26
QSC	Quality and Safety Committee	122/26; 124/26
RJC	Regional Joint Committee	118/26
Rio	Electronic Patient Record (EPR) system	121/26
RPB	Regional Partnership Board	121/26
SBUHB	Swansea Bay University Health Board	Title
SLAs	Service Level Agreements	118/26
SPOA	Single Point of Access	124/26
WG	Welsh Government	113/26; 116/26; 117/26; 120/26; 121/26; 122/26; 123/26; 124/26
WODC	Workforce and Organisational Development Committee	114/26; 123/26; 138/26
WTE	Whole Time Equivalent	110/26; 122/26

The meeting began at 10:43.

Minute Ref:	Agenda Item
PART 1. PRELIMINARY MATTERS	
1.1 Welcome and Introductory Remarks	
110/26	JW opened the meeting by extending a warm welcome to everyone attending, and to those observing, the Board meeting. As the Governing Body of one of the largest UK organisations, the Board constituted the highest level of decision making, with stewardship of: £1.8bn of public money, the employment of 14,500 whole time equivalent (WTE) staff, and the health and care services for approximately 400,000 people across Swansea and Neath Port Talbot, and for much larger populations for specialist and regional services.



	SBUHB was a strategic population health body, with a statutory duty to promote and protect public health and to prevent disease. The agenda for the meeting covered the breadth of the Board's responsibilities; open government was important, and the meeting provided the Board with a platform to hold itself accountable to the public and to explain the rationale for decisions taken covering the three time horizons in which the Board worked: the long, medium and short term. JW then mapped the key agenda items against the Board's responsibilities for: strategic direction setting; setting the risk appetite and overseeing strategic risks; building and sustaining strategic partnerships; oversight of delivery against the in-year plan; practising good governance; and setting the tone and culture of the organisation. The Board wanted staff to come to work and be their best authentic selves and to know that they could speak up safely in respect of any concerns.
1.2 Apologies for Absence	
111/26	Deb Lewis, Tina Ricketts, Theresa Ogbekhiulu, Anne-Louise Ferguson, and Nicola Matthews had tendered apologies.
1.3 Declaration of Interests	
112/26	There were no declarations of interest outside those already on the Declarations of Interest Register.
PART 2. MAIN AGENDA	
2.1 Chief Executive's Report	
113/26	AH referred to the detailed update provided in her report and drew particular attention to: • Emergency and unscheduled care services; these remained in escalation and AH thanked all staff across the organisation for their extraordinary efforts during the extreme weather conditions over recent weeks. These had contributed to the highest levels of



Emergency Department (ED) activity ever recorded; capturing the learning from the service response was important, given the forecast of further extreme weather. NM had asked a question about staff in the ED, as 18 months had elapsed since the Board meeting with key ED staff. AH set out the arrangements in place to engage with staff. In September, the Board would have the opportunity to review the 2026/27 Winter Plan, including the implementation of the 45-minute ambulance handover target.

- Gorseinon Hospital: In September 2025, the Board had approved a temporary service change to relocate in-patient beds at Gorseinon to Singleton hospital; this was subject to a six-month extension in February 2026 and AH now sought Board approval to extend this until November 2026, to support the completion of a required engagement and consultation exercise.

AH extended her apologies on behalf of the Executive for some slippage against timescales and milestones; she referenced the positive visits and informal conversations with the local community and with local politicians and extended her thanks to NM for facilitating these opportunities. AH commented on the temporary use of the ward accommodation to host additional clinics and services. She extended her thanks to AE from Llais for her advice on the engagement process and asked the Board to delegate the sign off of the engagement material to her, in consultation with JW.

- The commitment to delivering the Annual Plan for 2026/27; she recognised the role of the Executive in strengthening delivery and ensuring sufficient capacity to deliver at scale and pace; this included a focus on the prioritisation of key deliverables.

JW thanked AH and invited comments and questions.

PP referred to the need to improve flow and the challenges this posed, with 234 clinically optimised patients subject to delayed discharge; this comprised 17% of the bed base. The current position caused avoidable harm to those patients who no longer needed clinical care and added to service costs. PP acknowledged the extensive work with local authority and third sector partners but concluded that the time had come for WG to take action at a national level.

AH and MD added detail on the work underway with local partners and the setting up of a national group looking at the integration of community-based services, under the policy umbrella of Community by Design.



JS supported a national approach; to share learning and identify common ground; he and CW highlighted the reduction in the number of clinically optimised patients, down to 152 at the time of the meeting and the lowest in recent times. Both emphasised the need to focus on a downward trajectory, with the national group now in place to oversee a system-level change.

JC welcomed the establishment of a national group; she noted funding provided previously by WG to support specific actions e.g. waiting list reductions First Consultation initiative, acknowledging the benefits of the funding. Any further funding would need to focus on whole patient pathways to avoid any additional challenges at specific points along the pathway.

The Board:

- **RECEIVED** the report and **TOOK ASSURANCE** from the discussions on the key areas of escalation, operational pressures, and strategic risk.
- **APPROVED** an extension to the current temporary transfer of the inpatient beds previously provided at Gorseinon hospital, to Singleton hospital, until the end of November 2026. This would support a full and compliant engagement process, prior to the Board making a final decision at its November 2026 meeting.
- **DELEGATED AUTHORITY** to AH to approve and issue the full public engagement materials outside the Board meeting cycle, in consultation with JW and subject to appropriate Executive, clinical, and governance reviews.
- **PLACED ON RECORD** its thanks to NM for her work in engaging with the local community over the last year and in supporting Geraint Bowen (GB), Gorseinon hospital site manager, and the team on the ground at the hospital. The Board owed GB and the local team a debt of gratitude for everything they had done to ensure that Gorseinon hospital continued its role as a vibrant community hub.

2.2 Risk Report



114/26	Introducing this item, JW referenced the Board's role in setting the strategic risk appetite, determining and overseeing strategic level risks. She invited HL to provide an update. HL drew attention to nine risks set out in the Strategic Risk Register; following a recent update the Executive Board would consider them on 12 August 2026, before consideration by the Workforce and Organisational Development Committee (WODC) on 20 August with onward submission to the September Board meeting. There were 29 corporate risks, 17 of which were above the Board's risk appetite. JW thanked HL and her team for their work on all aspects of risk; she invited comments. PP referred to AH's earlier comments and the need to frame risk in the context of the whole system scale of change underway and the challenging financial position. The Board had a significant change and improvement agenda across a range of services, and the sheer scale of this could, of itself, lead to a system delivery risk; PP proposed the inclusion of a whole system operational delivery risk in the Strategic Risk Register, with clearly articulated mitigations and expected improvements. NZ supported the need to describe a broad, whole system operational risk, collating all the service changes and risks, and the interactions. The Board and its Committees needed assurance based on evidence of impact, rather than on individual actions. The Audit Committee (AC) had discussed this issue and welcomed the recent improvements to the Risk Registers; NZ highlighted the need for more work on cross-Committee oversight of whole system risks. Responding, AH welcomed the discussion, advising that the Executive had also discussed this issue. Executive directors acknowledged that delivery capacity and capability was challenging, given the breadth and scale of service transformation underway, with some delays resulting in changes to timelines and delivery against milestones. <i>Organised for Success</i> would assist in shaping the workforce, with the right capacity and capability, in the right places, and at the right level. The introduction of the clinically led leadership model was fundamental, with work underway to support clinical leadership across the HB.
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JC expressed concern at the number of changes to timelines, sometimes by months or even a year. JW added detail on a risk NM had highlighted going back to 2022; this concerned staffing levels in HMP Swansea and was not a risk that the Board could mitigate alone. LR agreed to review this specific risk; the Executive would also work on the whole approach to profiling the timelines for risk mitigation.

Action: LR/Executive Directors

Summarising the discussion, JW reflected on the open and accountable identification and mitigation of organisational risks. The next stage of effective risk management involved the scoping of a whole system operational delivery risk and the associated strategic risk implications. The Executive review of priorities would sit alongside this and would inform the reset of strategic, corporate and operational risks. A further cross-Committee workshop would reflect on the approach to scrutiny and oversight of whole system operational delivery risk.

The Board:

- **RECEIVED** for **ASSURANCE** the report and supporting appendices.
- **ACKNOWLEDGED** the progress made and good practice in risk identification and mitigation.
- **AGREED** to add a whole system operational delivery risk to the Strategic Risk Register, reflecting the strategic implications.
- **AGREED** to receive an update report at the September 2026 Board meeting, setting out the outcome of the Executive-level review of service priorities and consequent risks at strategic, corporate and operational level.
- **AGREED** to convene a cross-Committee workshop on scrutiny and oversight of whole system operational delivery risk.

PART 3. PATIENT/STAFF EXPERIENCE

3.1 Patient Story

115/26

LR introduced Huw, a dialysis patient. Speaking in Welsh, Huw described





the background to his condition, the worry this had generated and the way in which the consultant and the dialysis team had afforded him every care and support. The 'self-care' option gave him more freedom and the ability to speak with the team in Welsh was a major plus point, from Huw's perspective.

LR stressed the importance of helping Huw to remain independent and to help him converse in his first language. The renal dialysis service was a regional service, and Southwest Wales was home to a large number of Welsh speakers., all of whom valued conversing in their preferred language.

RO asked whether SBUHB maintained a register of staff who spoke other languages and who could volunteer their services, should that be necessary; this could be a helpful alternative to Language Line. RO had already mentioned this to TR, who would explore this further.

Action: TR

AH advised that the Joint Commissioning Committee (JCC) commissioned the renal dialysis service. Huw had shared his story at the last JCC meeting.

JS welcomed the story and that Huw described himself as 'belonging to the Unit'; with staff going out of their way to give him additional care and support.

JW asked LR to extend the Board's thanks to Huw and to the staff of the Renal Dialysis Unit.

The Board **RECEIVED** the Patient Story for **ASSURANCE**.

PART 4. SETTING STRATEGIC DIRECTION

4.1 Transforming for the Future



116/26

MD referred to the paper provided; this provided an update on the programme of engagement work that began in 2025 on the strategic Clinical Plan *Transforming for the Future*. She drew attention to:

- The complexity of the programme, involving a range of stakeholders and the importance of establishing firm foundations; MD also highlighted progress to date.
- The programme of clinical workshops underway, to begin populating and describing the clinical models and levels of care.
- WG leadership of the development of a national clinical plan; the expected timeline for completion – April 2027 – would possibly be subject to delay, with the consequent implications for the SBUHB timelines moving from September 2026 to April 2027.

JW thanked MD and invited comments and questions:

NZ asked about the achievability of the timelines and milestones; she highlighted the risks and sought assurance on a prioritisation process.

AG also referred to: the need to manage the timelines alongside other transformational programmes underway, the iterative process adopted and the possibility of developing a worked example of the principles in practice. Responding, MD welcomed this suggestion and agreed to consider it further.

Action: MD

On digital transformation, JC asked whether there were opportunities to include artificial intelligence (AI) options. MD confirmed that this would form a critical enabler as part of the wider digital architecture.

CO-L echoed the above point, viewing AI and estates as two fundamental enablers. AG confirmed that the Digital, Data, Research and Innovation Committee (DDRIC) was progressing this agenda.

Action: AG



RO proposed the specific inclusion of the reduction in health inequalities as a principle. MD explained the thinking behind the current wording of 'fair access to safe and effective services'. JW took the view of the meeting; this fell in favour of including a specific principle in respect of health inequalities and JW asked MD and RO to agree a form of words to reflect this.

PP asked for clarity around the resource envelope and the need to plan for a return to financial balance in 2028/29. MD outlined the approach to resource allocation and utilisation and the importance of robust demand and capacity modelling to inform the 'resource shift left'.

JW followed on with reference to the need for a 'life course' approach to internal resource allocation, a point that PP and JC had raised previously.

CO-L outlined the work underway on service costing; this would increase transparency around resource allocation and, over time, map across to service outcomes. Detailed service costings would support the shift to primary and community services and away from an institutional costing model.

AH built on the 'life course' concept and advised that the top 100 leaders recognised the need to map the longer-term financial strategy against this concept.

PD reminded the meeting that, at the Annual General Meeting (AGM), the Board had agreed to change the form of verb underpinning the principles from 'should' to 'will'. MD agreed to make this change.

Action: MD

RT emphasised the importance of applying the principles to all transformational work underway, including that on maternity and neonatal services, mental health, cancer, and unscheduled care.

The Board:



	• CONSIDERED the progress made in delivering the Transforming for the Future programme. • ACKNOWLEDGED that the delay in WG developing the National Clinical Plan would impact on the timeline for completion of the local strategic plan from November 2026 to April 2027. • ENDORSED the proposed principles for change, subject to the inclusion of a specific principle around the reduction in health inequalities, and the change in the form of verb from 'should' to 'will'. • AGREED to apply the principles to all transformation programmes. • AGREED to undertake more work on resource allocation modelling on a 'life course' basis.
4.2 Planning and Partnerships Report • APB Drug and Alcohol Strategy and Delivery Plan • ENDORSE The NHS Wales EPRR Annual Report 2025/26 prior to submission to Welsh Government	
117/26	MD referred to the detailed papers provided; she drew particular attention to: • A report for the Board on Q1 delivery against the 2026/27 Annual Plan. • The endorsement sought for the work of the Drug and Alcohol Leadership Board (DALB), developed in response to the 2025 Drugs Commission report. • The implementation of a formal, monthly integrated performance review for all Long-Term Agreements (LTAs), for the JCC, and for commissioning health boards. • The need for sign off of the Emergency Preparedness, Resilience and Response (EPPR) annual report and supplementary appendices; this required Board approval before submission to WG. JW thanked MD and invited comments and questions. HVW commented on the 2000 responses to the Heat Survey; these would provide valuable information on extreme weather. JW thanked



HVW for considering this important matter and asked MD to add detail on local and national actions around climate adaptability.

MD described the relevant local architecture in operation, with an updated adverse weather policy out for internal engagement. On wider climate adaptation, MD referred to the adaptation plan that supported risk mitigation, including areas such as flooding, adverse weather and climate change. AH agreed to raise the implications of extreme weather for existing and future capital expenditure at the next Chief Executives Management Team (CEMT) meeting.

Action: AH

CW summarised his recent attendance at a national debrief on the extreme heat.

HVW referred to the work of the Ventilation Group; these covered issues including the hiring of air conditioning units and any infection control implications and requirements. JW asked HVW to share this with AH for the CEMT meeting.

Action: HVW

JC posed three questions: (i) the impact of the JCC £6.3m deficit and any commissioning risks resulting from the Swansea and Neath Port Talbot Drug and Alcohol Service Alliance; (ii) the outcome measures and performance measures applied by the Area Planning Board (APB); and (iii) the measures in hand to address workforce and demand capability across the range of services provided.

SS asked about access to substance misuse services and for clarity on the provision of these.

Responding to both sets of questions, MD advised that:



- SBUHB would have advance notice of any potential revenue implications associated with the APB plans; these would need approval before implementation.
- APB resourcing came from a number of sources; there was a commitment to explore redesign of the pathway using the current revenue envelope.
- A comprehensive dashboard was in place, for use by the DALB, when reviewing performance on a quarterly basis. MD agreed to provide JC with information on this, and to follow up SS query on service access.

Action: MD

- On the JCC funding deficit, MD advised that 2025/26 had formed a transition year, making both commissioner and provider requirements more challenging. Further discussions were underway in-year at Executive level to explore both commissioner and provider areas of risk.
- On staff release for training, MD recognised that this was challenging but confirmed good engagement and the exploration of alternative opportunities.

AH referenced the attendance at the September 2026 Board meeting of the JCC chair and chief commissioner. This would provide the opportunity to discuss both commissioner and provider issues.

RO commented on the need to overhaul the current LTA methodology, given that the existing model was now outdated. CO-L confirmed the intention to provide a report to the September PFC meeting, as a re-baselining exercise. AH added detail on communications with neighbouring health boards.

AL referred to the Alliance model in place for drug and alcohol services; the Neath Port Talbot (NPT) Social Services Scrutiny Committee had considered a recent report and acknowledged the progress made. He thought that there would be benefit for the Board in considering the same type of report.



	Action: MD JW reflected on the breadth of material and updates included in the report; she asked AH/MD to look at the format and determine the optimum format for reporting to the full Board. Action: AH/MD The Board: • CONSIDERED and AGREED the items as requested through the report. • ENDORSED: ○ The NHS Wales EPRR Annual Report 2025/26 prior to submission to Welsh Government (Appendix 7). ○ The SBUHB Loss of Utilities, (gas, electricity, water) Multi-Utility Failure Framework (Appendix 8). ○ The Drug and Alcohol work programme • RECEIVED for ASSURANCE: ○ The position outlined on organisational resilience, risks and priorities. ○ The continued embedding of a resilience-by-design approach and the actions to address key system fragilities.
4.3 Cancer Programme Plan	
118/26	JS commented on the paper provided, as follows: • It proposed a Cancer Improvement Framework and the establishment of a formal Executive sponsored Cancer Improvement Programme, sponsored by the Medical Director; this would build upon the Cancer Improvement Plan presented at the June 2026 Board meeting. • That immediate operational recovery work continued, particularly on tumour site improvement plans, pathology recovery, diagnostics, and pathway improvement. The paper reflected a broader approach to coordinating cancer improvement across: prevention, earlier diagnosis. diagnostics, treatment, workforce,



personalized care, research and inequalities, with a focus on the next five to ten years.

- Improving the suspected cancer pathway was essential to improve overall long-term outcomes; it called for a whole system approach.
- Board endorsement was sought for the Framework and approval of the Executive sponsored Cancer Improvement Programme. A Programme Initiation Document (PID) would include detailed governance arrangements and an implementation plan.
- A cancer performance report from Audit Wales had issued the day prior to the Board meeting; the September Audit Committee (AC) meeting would consider it, although an initial review of the report indicated that the proposed SBUHB approach aligned with the requirements.
- The programme would provide a bridge between immediate recovery work and long-term service transformation.

AH thanked JS and extended her thanks to Hannah Parsons for her work in developing the proposed actions, informed by a workshop held earlier in 2026. The programme would reflect the in-year delivery requirements and the broader, longer-term requirement to drive service change, with a shift to prevention across both primary and secondary care services, taking into account the equity agenda. HVW supported this whole pathway approach, including prevention, detection and treatment.

AH went on to refer to the cancer related work planned through the Regional Joint Committee (RJC) with Hywel Dda University Health Board (HDUHB).

AG raised the prospect of moving away from Service Level Agreements (SLAs) towards an LTA approach: this would remove anomalies in access to clinical trials. RK confirmed the intention to review SLAs.

JW commented on the current funding model for the Southwest Wales Cancer Centre; she referenced the need to engage other health boards in sharing the financial risk and determining more proportionate funding shares.

Responding, CO-L reported on the regional level discussions that had begun; AH highlighted the Audit Wales reference to the need for a



	costed cancer plan; the Executive would raise this at a forthcoming meeting with their colleagues in HDUHB. JW welcomed the Executive level discussions underway with HDUHB and looked forward to an update on progress. The Board: • CONSIDERED the progress made since the June 2026 Executive Board paper in developing the SBUHB approach to cancer improvement, including the development of tumour-site improvement plans and other supporting workstreams. • RECOGNISED the need to build on the immediate recovery actions set out in the Single Cancer Pathway Improvement Plan through a broader, coordinated approach to improving cancer outcomes. • ENDORSED the proposed Cancer Improvement Framework as the underpinning structure for the Cancer Improvement Programme. • APPROVED the establishment of a formal Executive-sponsored Cancer Improvement Programme, with the Medical Director acting as Executive Sponsor. • SUPPORTED the development of a Programme Initiation Document, setting out the detailed governance arrangements, programme support requirements and implementation plan for future consideration by the Board.
4.4 5th Linear Accelerator (LINAC) Business Justification Case (BJC)	
119/26	MD summarised the background to the need for additional LINAC capacity; she reported that PFC had scrutinised the BJC documentation and PP confirmed that PFC members had taken sufficient assurance. On the revenue implications, CO-L advised that these would apply from 2027/28 and would feature in the planned care revenue allocation and budgeting. That allocation also planned sixth and seventh LINACS, but with no current revenue funding identified at this stage. The Board:



- **APPROVED** the BJC to seek £6.832m from the Welsh Government and £2.8m recurring revenue expenditure, divided equally (£1.4m each) with Hywel Dda University Health Board.
- **ACKNOWLEDGED THAT** the Planning and Finance Assurance Group (PFAG) had scrutinized the BJC documentation. On 24 June 2026, the Swansea Bay Executive Board had agreed to include the £1.4m revenue costs in the £34m planned care funding process.
- **CONSIDERED** the seriousness of adverse patient safety and outcomes should the 5th Linac development not proceed at pace.
- **CONSIDERED** the 6th/7th bunker and the potential change in position regarding BJC2.
- **SUPPORTED** the intention to develop the choices and options for a single and double bunker in greater detail.

4.5 Planned Care

120/26

JW thanked AN, HP, and PH for the significant work that underpinned the plan.; she invited CW to summarise the proposed Planned Care Recovery Programme (the Plan).

CW referred to an extensive slide pack and highlighted:

- The purpose of the Plan, developed in response to WG requirements to provide a sustainable planned care programme; sustainability into the future was essential.
- That the Plan built upon the interim plan on 104 weeks, submitted to WG on 19 July; this had gained positive feedback. The Plan presented to the Board built on that 19 July submission and set out a sustainable, strategic delivery programme.
- The clarity of WG guidance around the use of existing capacity, with additional investment requested only to meet demonstrable service gaps.
- The three pillars of the planned care programme that underpinned the Plan: (i) referral and early diagnosis; (ii) capacity, productivity and treatment; and (iii) follow up, surveillance and living well. The key themes developed, and based on these pillars, were: sustained recovery; optimizing surgical pathways; transformation of outpatient activity; digital



enablement; maximizing productivity, strengthening patient work; and investment.

- The funding request; this combined residual capacity requirements and transformational investment, with investment possibly offsetting residual capacity, once fully optimised and quantified.
- Opportunities, as set out in the slide deck, across theatres, outpatients, the workforce, diagnostics, digital, regional opportunities, and productivity gains.
- Further work, subject to Board approval, to provide detailed ongoing assurance and appropriate governance; this would include clarity on delivery milestones, benefits realization, and explicit performance reporting that demonstrated the direction of travel.
- The risks associated with the programme, including resourcing and workforce engagement to deliver the capacity and productivity gains identified. Possible growth in demand also warranted specific mitigation.

JW thanked CW and then turned to PP, as chair of PFC.

PP recognised and appreciated the detailed work involved in developing the Plan, in a very limited timescale. It included a credible analysis of demand and capacity, with evidence of productivity improvements, and opportunities for regional working. The evidence base was comprehensive, with clinicians engaged in the scrutiny of costs NHSPI scrutiny for core specialties and cancer services. The ask for 2026/27 investment was around £20.7m to £23.8m, to cover both the 52-week and 104-week breaches. The financial ask exceeded that based solely on a population share; WG may not therefore agree the full funding and SBUHB would need a robust prioritisation process.

PFC had also considered workforce availability and the mitigating actions proposed; these concerned robust workforce planning and opportunities for regional planning in key strategic areas, including anaesthetics. PFC also took assurance on the availability of outsourced sessions.



PP welcomed the focus on long term sustainable solutions, rather than on the purchasing of non-recurrent additional capacity. Some productivity savings already formed part of the £65m savings requirement and it would be important to avoid double counting.

PP and PFC members were clear on the governance requirements, based on a full understanding of the baseline position and explicit targets, milestones and trajectories. Outputs must be subject to explicit tracking, with aligned accountability and escalation arrangements.

PP concluded by drawing attention to the non-recurrent funding available from WG; this constrained the development of a sustainable plan.

JW thanked PP and invited other PFC members to comment.

JC fully supported PPs comments and added her thanks for all the work involved in compiling the Plan; she welcomed the detail set out in it and was content to take assurance.

JW asked HVW to comment on the fact that the financial costs exceeded the population share. HVW highlighted the levels of deprivation across the SBUHB catchment area, singling out the high prevalence of disability and long-term illness, particularly in Neath Port Talbot. One recent survey had identified that this area had a higher level of disability than in any local authority in England; the age profile of the population was another factor.

AL referred to the significant pockets of deprivation in Neath Port Talbot; this was a factor reflected in the local authority's funding allocation from WG. The HB and local authority could work together to collate the statistics as essential background contextual information, AL also referred to anti-poverty strategies in place that aligned closely with the population health agenda.

JW then invited AH to comment.



AH expressed her thanks to the team for developing the comprehensive Plan and providing the evidence base. She welcomed WG's early commitment to continue funding and stressed the importance of learning from others. AH was also mindful of the need to align local and national work. She advised that best value from the investment depended on a recurrent allocation. The Recovery and Sustainability Board had also scrutinised the Deloitte work on cash releasing efficiency opportunities to optimise the impact and included this work in the Plan.

AH went on to thank HVW for his analysis of these population health indicators that would impact on resource requirements. She commented on the specific relevance of the analysis for utilisation of cancer services. There was a clear read across from this work to the Cancer Improvement Plan; the full engagement of clinicians would ensure that the Planned Care Recovery Programme included all relevant cancer statistics.

JW thanked everyone for the rich, informative discussion on a major submission. She restated the Board's thanks to all involved in the production of the Plan. She, AH and HL would review the whole system scrutiny and oversight of the Plan, at both Committee and Board level.

Action: JW/AH/HL

The Board:

- **RECEIVED** and **APPROVED** the Sustainable Planned Care Recovery Plan 2026/27 and the associated funding requirements, submitted in response to Welsh Government requirements.
- **ENDORSED** the strategic approach set out in the Plan, recognizing the emphasis on exhausting productivity, transformation, digital and regional opportunities before seeking additional recurrent investment.
- **SUPPORTED** the proposed investment priorities, acknowledging that the funding requirement reflected both:
 - the residual recurrent capacity gap required to deliver the planned care trajectories through the current operating model; and



	- the transformational investment required to deliver a sustainable improvement in productivity, patient outcomes and long-term financial position. • RECOGNISED that delivery of the Plan was dependent on WG funding decisions and that, in the absence of full funding, the Board might need to review delivery trajectories, implementation timescales and associated risks. • ACKNOWLEDGED the principal delivery risks and mitigations set out in the Plan, including workforce availability, operational pressures, productivity delivery, demand growth and regional dependencies. • DELEGATED authority to the Chief Executive, in consultation with the Chair, to approve any minor amendments required following Board discussion or subsequent Welsh Government clarification, provided that these did not materially alter the strategic direction or funding assumptions of the Plan. • AGREED regular progress reports through the established governance arrangements, including delivery against trajectories, productivity improvements, benefits realisation, financial performance and risk.
On return from a short break, JW outlined the use of the Consent Agenda provision, given the number of significant items on the agenda.	
4.6 Mental Health Transformation Programme	
121/26	Introducing this item, AH advised the Board that Mel Walker (MW), the External Specialist Strategic Advisor, had now completed her commission. On behalf of the Board, AH extended her grateful thanks to MW for her expert advice and guidance to the Board on the scale of the mental health challenge, and for her work in supporting the Service Group with its improvement journey to date. Turning to the paper, AH reported that it set out a progress report on all aspects of the transformation programme and of the constituent five workstreams. She drew attention to: • The escalation of the service to one of 'service of concern' in the autumn of 2024; this enabled SBUHB to access additional support.



- Progress across the five workstreams and the position on each as part of the stabilization plan:
 - The production of the quality and safety dashboard, a first in Wales; this would operate as a live dashboard, giving SBUHB the facility to track improvement and progress.
 - The work underway via the estates workstream, focused on the three time horizons, to improve the environment and undertake refurbishment, whilst the service continued to operate at almost full capacity.
 - Workforce enhancements to (i) right size the crisis home treatment team and prevent unnecessary admissions, and (ii) enhance nursing in the adult care wards. Additional investment would take place on an invest to save basis, through a reduction in avoidable admissions and placements outside NHS Wales.
 - Continued work on informatics.
- RT continued to work closely with the Service Group to ensure (i) the embedding of a process to ensure continuous engagement and co-production into all service development, and (ii) the running of a formal engagement process alongside communications work around service redesign.
- TO, as an incoming associate Board member (Inclusion and Belonging) had asked to engage with this programme to focus on access for the global majority population; AH referenced a forthcoming meeting with Neath Port Talbot local authority colleagues on this and she would invite TO to attend.
- The full alignment of the programme with the model underpinning the national service model. This centered on supporting individual needs in a timely manner, irrespective of the place of presentation. It would also ensure a timely assessment alongside any necessary therapeutic interventions. WG took the view that this model would see a reduction in acute beds.
- The significant role of digital as fundamental to the programme components.
- The Business Justification Case (BJC) to support capital for the second stage of the stabilization plan; work was underway and the Board would consider it at a future meeting. It would facilitate



the optimum use of capacity and service consolidation on fewer sites.

- The third time horizon/the longer-term permanent solution to acute provision; this was now subject to nationally led consideration and would include all adult mental health beds, the mother and baby unit and older people's service.
- The national level work on young people's services; the September and November Board meetings would include updates on this work.
- The establishment of a Board level mental health post; this would replace the role undertaken by MW, who had agreed to act as external assessor to the interview panel.
- The welcome support from MD and her team, along with senior support from the Delivery Unit (DU) team.
- The further work required on resourcing to inform the understanding of income received through the general allocation process and that received for commissioned services. This work would capture and reflect the total cost of delivering mental health services.

JW thanked AH for the detailed update and invited questions and comments.

MD confirmed that the RPB was keen to engage with community related service redesign components; she welcomed this partnership approach and would ensure a complete interface with the transformation programme.

SS emphasised the importance of sequencing the various components of the programme to ensure optimum delivery; in his view the volume of out of area placements would continue until the completion of the community service redesign. There could be a time lag and that was a key factor.

SS questioned the expectation around cost neutrality. AH advised that the reduction in the number of out of area placements would provide a financial benefit, alongside a reduction in variable pay costs and in the



right sizing of the permanent workforce. TR would address this through a specific piece of work.

AH recognised the challenges for staff in meeting day to day operational requirements whilst also transforming the service in a timely way.

SS commented further on the unpredictability of out of area placements and sought confirmation that such placements would continue in the short term, if necessary, until the implementation of changes to the staffing model. He recognised that ultimately this would provide a more robust costing model. AH assured SS on this point.

MJ provided an update on RIO; this was progressing well but procurement for the next stage would require WG investment.

PP asked about monitoring the benefits of the invest to save proposal, including the impact on variable pay. JW asked PFC to oversee this.

Action: PP/CO-L

JW confirmed that she and AH would write formally to MW expressing thanks for her support, advice and guidance. JW also confirmed that the Board would continue its deliberations in forthcoming meetings.

Action: JW/AH

The Board:

- **CONSIDERED** progress made through the Mental Health Transformation Programme.
- **CONSIDERED** the developments relating to governance, quality and safety reporting, and partnership arrangements.
- **CONSIDERED** the outcome of discussions with WG and NHSPI on the mental health estate.
- **TOOK ASSURANCE FROM** the ongoing management of quality, safety and estate risks within Mental Health services.



- **APPROVED** the move to phase 2 of the Mental Health Transformation Programme.

PART 5. IN YEAR DELIVERY: QUALITY, SAFETY, PERFORMANCE AND RESOURCES

5.1 Integrated Performance Report

122/26

MD outlined the changed format for the Integrated Performance Report (IPR), with the alerts from the Committee chairs featuring at appropriate points. This was a trial change, although the detailed scrutiny and oversight at Committee level remained unchanged.

MD then invited the lead Executives to provide an update on their areas of responsibility.

Population Health

HVW commented on:

- Ongoing work and progress on the two breakthrough objectives.
- Four alerts raised through the Population Health Committee (PHC):
 - The strategic importance of the Tata Health Impact Assessment for medium term planning;
 - The ongoing resource constraints;
 - The sustainability risks associated with short term grant funding;
 - Equity of data for palliative and end of life care.

SS added detail on the Tata Health Impact Assessment; the SBUHB planning process should include the major impact of this.

Quality and Safety

RK advised that:

- On healthcare associated infections (HAIs), the significant challenge on C.diff continued. Key contributing factors were: patient flow, high bed occupancy, and the effects on cleaning and decontamination processes.



- Antimicrobial stewardship, however, was strong with the lowest antibiotic prescribing rate in Wales and the primary care rate falling faster than the Wales average. Secondary care was the second lowest broad spectrum antibiotic prescriber.
- Scrutiny meetings were in place with individual Service Groups for E.coli and for Klebsiella.
- Intravenous (IV) to oral antibiotic switch compliance continued to improve, reflecting adherence to Infection Prevention and Control (IPC) requirements and to mandatory training.
- Each service group had targets to deliver against.

Perinatal Services

On radiology, RK highlighted issues with 20-week scan reporting. This was an issue across Wales and both WG and NHSPI were aware of it.

Tissue Viability

LR referred to this breakthrough objective, referencing:

- The highest incidence across NHS Wales health boards; SBUHB was committed to an in-year reduction of 30%.
- The challenges in setting a baseline for this target; the data set did not include a mandated field on avoidability, with the resultant need to conduct a manual data review.
- Increases in pressure ulcers, linked to the times of peak demand in acute hospitals; a strategic group would use audit to inform a staff education programme.
- Work underway to return to a centralized tissue viability team, to drive improvement; digital identification of pressure ulcer damage was now available, with validation through photography; Digital Cymru was supporting this work.

On QSC matters, LR highlighted:

- The backlog of patient complaints; this related to the former Putting Things Right process; each Service Group now had a clear plan to eradicate the backlog.



- Listening to Patients was operating well; it offered early resolution and this had resulted in a reduction of 38% in formal complaints.
- Assurance concerns on fire safety. CO-L confirmed agreement on a resourcing plan to mitigate risks, with actions planned to address other issues, mainly at the Morriston and Singleton sites. The risk scores had reduced from 20 to 16 on the basis of the work underway, and the detailed plan.

Operational Performance and Planned Care

CW highlighted:

- The maintenance of 52 and 104 week waits; however, without continued investment, the position would deteriorate.
- A slight improvement in cancer performance in June, up to 54% at four months against a previous figure of 46%. The backlog had now stabilized but would continue to pose challenges, linked to cellular pathology. Q3 onwards should see an improvement.
- Improvements in diagnostics, particularly in radiology, due to the return of sonographers.
- The detailed discussion on stroke services at PFC.
- A downward trend in out of area placements, some short-term sickness in Child and Adolescent Mental Health Services (CAMHS); this had led to a dip in June that should recover in July.

On alerts, JC reflected on:

- The risk associated with the two-site working for maternity and neonatal; the Corporate Risk Register now included this risk. It remained a strategic priority for the future configuration of perinatal services.
- The ask of the Mental Health and Learning Disability Service Group for an urgent update on actions to address the outstanding Caswell Clinic recommendations and the reasons for the delays in closure. Responding, AH referred to information set out in the slide deck pack, setting out the actions to deliver the required improvements, as agreed with the JCC. AH summarised the discussions with the JCC; these included the operational implications of providing services from facilities owned by



another health board. The JCC had a rapid review of both medium and low secure services underway; this would report in a year.

Urgent and Emergency Care

JS referred to:

- The 12-hour wait breakthrough target and alert, with a requirement to deliver a 10% reduction in 12 hour waits from a baseline of 1350. Despite improvements in flow and discharge numbers, this number was increasing.
- The reduction in clinically optimised patients had not resulted in an improvement in patient flow through Morriston ED. Actions introduced to date had to accelerate to cover all wards. Weekend discharge numbers remained low; a weekend discharge team was now in place, to reduce delays from Thursday through to Monday.
- Earlier bed management actions were impacting on the 45-minute handover, with the current position at 75.4% against a target of 80%.
- ED specific actions included: zoning, clarity on the consultant in charge remit, weekly performance meetings to drive improvement, the proposed reset week in August, and accelerating the wait to consultation time.

On alerts, CW provided further detail on the clinically optimised patient agenda and the plans to prepare for winter.

Workforce

EO highlighted:

- Sickness absence, a breakthrough target; the position remained challenging, with levels of sickness absence increasing over recent months. This was mirrored across Wales, with the setting up of an all-Wales Task Group. SBUHB remained committed to robust governance arrangements and supporting service leaders to implement and manage the sickness absence processes effectively.



Alerts centred on the Strategic Workforce Plan and Organised for Success. EO indicated that, at 1.3%, SBUHB had the lowest pay growth in Wales.

CO-L confirmed that the vacancy control process was having an effect and the grip on delivery against headcount reduction would need to continue. In response to a query from JW, CO-L agreed to provide a briefing, as part of the Finance Report, on reconciling a reduction in whole time equivalent (WTE) employees and an increase in the pay bill

Action: CO-L

Governance

HL referred to two AC reports, one on a limited assurance Governance report for the Morriston Service Group; the second concerned Audit Wales findings on Executive Director appointments. HL confirmed the completion of all relevant actions.

Stroke Services

MD highlighted a presentation to PFC on stroke services. PP continued to have concerns about the data, which appeared to show challenges across Wales. Current stroke pathway improvements continued but traction was challenging. The PFC had asked for further detail on proposals to improve the pathway for CT scanning and ring fencing of stroke capacity. PFC acknowledged the regional work underway on 24/7 stroke consultant access.

JC expressed her concern about the number of issues raised around stroke services, particularly in the context of a regional approach. She advised that QSC would return to this agenda, supplementing the PFC scrutiny, through a specific focus on the regional service footprint.

Action: JC/LR/MD

Summarising the discussion, JW drew attention to the number of references to data accuracy, completeness, and timeliness. She asked MD/CO-L to schedule these and forward to the DDRIC for consideration.

Action: MD/CO-L



JW indicated that the established AAA reporting process would return in the September Board, subject to the further refinement of the alignment between the IPR and AAA report formats.

The Board:

- **CONSIDERED** the monthly update in respect of performance against escalation measures and de-escalation criteria.
- **ACKNOWLEDGED** and **DISCUSSED** SBUHB performance against key measures and targets.
- **CONSIDERED** the service specific update of Stroke performance and **SUPPORTED** the ongoing work of both PFC and QSC.
- **CONSIDERED** the updates provided by the Executive Directors in response to the ALERTS from the Committees of the Board and **SUPPORTED** the associated actions.
- **SUPPORTED** the return in the September Board to the established format of AAA reporting, refined to avoid duplication with the IPR.

5.2 Finance Report

123/26

CO-L introduced the report on the financial position, highlighting:

- The background to the submitted three-year plan for 2026/2029; the deficit of £76.6m for 2026/27 meant that neither the health board nor WG could approve the plan, as it breached statutory requirements.
- The in-month deficit for Month 03 of 2026/27, of £7.1m, with a year-to-date deficit of £23.3m. There was a modest capital underspend of £645k for year to date, with non-pay compliance exceeding the public sector payment policy target of 95%.
- That the Month 03 position remained consistent with the overall direction of travel, although the trend in achieving the forecast position of £65m savings was of concern. At £7.1m deficit, the Month 03 position was £0.8m higher than expected.
- The shortfall in delivery of savings; the Month 03 target stood at £5.4m, of which only £2.9m had materialized, leaving a Q1 shortfall of £10.4m (£16.3m target against delivery of £5.8m)



savings). This shortfall remained the principal reason for the financial position as at Month 03.

- Several operational factors that affected the position:
 - Continuing NHS Healthcare (CHC) spend increased in-month, particularly for mental health and learning disabilities, in both patient numbers and average cost. CHC growth was an area of risk and was included in the forecast risk position.
 - Prescribing costs had generated a £0.3m pressure in month, caused by shortages and high procurement costs.
 - Temporary adult placements; these reduced in number in month, from 18 to 11, but with a limited financial benefit.
 - A positive movement in-month, with a reduction in variable pay from £4.7m to £4.4m.
 - The conclusion of an external consultancy contract and the impact of favorable LTA performance.
- The significant work underway via the Recovery and Sustainability programme and the opportunities pipeline.
- Fortnightly finance meetings with each Service Group; these had generated an additional £6m of savings opportunities to add to the tracker.
- The weekly Executive meetings, these included close oversight on variable pay, non-pay controls, pay restrictions, and further opportunities to strengthen the delivery pipeline.
- The need for pace in driving delivery opportunities.
- A small underspend of £0.9m on capital, with the cash balance stable at £3.821m; these were within tolerance levels.
- Finance risk HPR 92 remained one of the highest risks for the HB, scored at 25.
- The principal risks to delivering the financial plan; these continued to include: delivering the savings programme; ongoing CHC pressures; primary care prescribing pressures; the potential impacts of the resident doctor contract; energy cost volatility; and wider operational pressures that exceeded the available funding. Despite work underway the substantial level of risk remained within the red and in pipeline savings.
- A detailed year end forecast; PFC had received this at its 28 July 2026 meeting, and NHSPI had weekly scrutiny in place.

Summarising the position, CO-L advised that the Board remained financially challenged, with the underlying position dominated by the scale of the savings challenge, the cost pressures already set out, and the need to accelerate the delivery of existing recovery plans.



JW thanked CO-L and invited PP to provide the advice of the PFC. PP highlighted:

- Savings plan developments; 48%, equivalent to £30.9m, were at green or amber, with a year-end forecast of £40.9m; 75% (£30.7m) of this was recurrent savings. At this rate, the year-end would see SBUHB at £34.3m below the value required to support the plan moving into 2027/28.
- A current in-year shortfall of £24m; the full £65m savings had to be in place by the end of Q2, and this challenge was significant. PP suggested PFC or the Board undertaking deep dives in early August/September on the themes of: medical workforce, planned care, nursing workforce, and procurement.
- The absolutely key risk around service delivery; PFC looked for a year-end profile of the required position, profiling of the savings position on a themed, scheme by scheme basis, with clear links between non-delivery and accountability.
- PFC assurance on the governance processes in place to prevent any double counting.
- The need for assurance on the full opportunity pipeline, including the basis for identification, confidence in delivery, expected phasing requirements, key dependencies, and the assessment/prioritization of the savings. This was essential, as delivery in Years 2 and 3 depended on savings delivery in 2026/27. The current reliance on non-recurring in-year savings would make delivery in future years even more challenging.
- PFC assurance on governance processes, enhanced accountabilities and escalation, all derived from the Recovery and Sustainability report.
- PFC consideration of a recent letter from WG; the requests aligned with those that the Committee had identified.

PP advised that at this stage, PFC could not take assurance on delivery of the full £65m savings requirement; it remained a critical risk and was subject to ongoing scrutiny.



JW thanked PP and PFC members for their advice; she invited JS to comment further on the delivery agenda; he advised that savings delivery against the schemes identified remained the key issue; the DU would offer full support to the Service Groups. Gaps in identifying improvement opportunities also had an impact.

The DU had reviewed capacity and capability, to identify the expertise and resources required to directly support the delivery of savings. He emphasised (i) that delivery was 'everyone's business' and (ii) the focus must be on delivery and not only on the financial position and the savings requirement. There was a need to fund invest to save proposals and to build on whole organisation engagement mechanisms in place.

JW thanked JS and invited SS to comment.

SS supported PPs comments and analysis. He thought it likely that SBUHB would reach the £65m savings in the coming months but too late in the year to realise the full effect. The reliance on non-recurrent options to drive delivery would compound the challenges in 2026/27, and some key savings targets still lacked quantification.

RO clarified the WODC position; whilst staffing numbers had reduced, with the lowest growth in pay across Wales, pay costs continued to rise, albeit at a lower rate than previously. Variable pay had also reduced, and this, taking into account right sizing the workforce, was essential to the delivery of recurrent savings. However, some Service Groups had signalled their difficulties in identifying these savings.

PP advised that Neath Port Talbot Singleton Service Group had a shortfall of £15.7m and Morriston Service Group a shortfall of £14.8m.

JC emphasised the need to move away from non-recurrent savings, advocating a review of in-year budget utilisation, to avoid a reliance on savings towards year-end. She supported an 'economies of scale' approach, rather than relying on individual Service Groups.

NZ referred to JS' comments and identified Organised for Success as a key driver in aligning organisation wide cultural cohesion and financial accountability.



AH welcomed the helpful points raised. She reflected on the work already undertaken on cultural change and the need to drive accountability for both service and financial management; engagement with the Health Partnership Forum (HPF) had supported this, as had staff training and greater engagement with the regular 'Ask Abi' staff engagement sessions. The most recent session had included open and direct discussions with staff on right sizing the workforce. TR was also working on organisational cultural change. Finance business partners working with Service Group leaders would help to drive down the workforce trajectory. Intensive work undertaken throughout August would drive pipeline development, with outcomes evident in September.

JW thanked members for their views and comments; she invited RT to consider how to engage the whole organisation, with tailored messaging across all staff and Service Groups. She then summarised the position, acknowledging the ways in which SBUHB was better placed in 2026/27 than in previous years, and the ongoing challenges:

- The recognition at both Board and WG level that the current position was unacceptable and unsupportable.
- The increased accountability resulting from the Performance and Accountability Framework.
- The development of a pipeline of opportunities, with controls, strengthened governance, and programme management.
- The current review of operating arrangements, to strengthen capacity, capability, accountability, and a focus on delivery.
- Despite these additional controls, the Board was not in a position at this stage to take assurance on delivery of the £65m savings requirement.
- PFC advice on a critical delivery risk around converting opportunities into cash releasing savings, despite clear accountabilities and DU support; there were risks associated with the capacity and capability required to deliver at the required scale and pace.



- The PFC recommendation to undertake deep dives on a thematic basis into medical workforce, planned care, nursing workforce, and procurement. JW suggested the use of existing mechanisms to conduct the deep dives throughout August, reporting back to the PFC in September.
- The impact of the Month 04 position on the actions required in Q3 and Q4.

JW then returned to RT for his professional advice on messaging.

RT advised a balanced approach to messaging, recognising how hard staff were working, whilst at the same time being clear that the scale of savings required called on the workforce to do things differently. He outlined the three main routes used for communication with staff: at management level based on accountabilities; corporate messaging; and specific campaign messaging. He proposed actions across all three opportunities to drive engagement and motivate staff to respond and take ownership of the challenge, with a specific focus on corporate messaging in the lead into September.

Action: RT

The Board:

- **ACKNOWLEDGED** that, given the financial deficit, the 2026/27 Annual Plan was unsupportable, and unacceptable; it meant that the Board could not approve the Plan, a position that WG shared.
- **ACCEPTED** the advice of PFC that, given the risks associated with savings identification and delivery, the Board could not take assurance on delivery of the full £65m savings requirement at this stage.
- **REVIEWED** the financial position as at Month 03, and the resulting risks; Board members emphasized the urgent need to accelerate the conversion of pipeline opportunities into cash releasing savings, in line with the full report.
- **AGREED** to conduct deep dives during August, into medical workforce, nursing workforce, procurement and planned care.
- **CONSIDERED** and commented on the SBUHB financial performance in respect of cash, capital and balance sheet.
- **AGREED** the approach outlined by RT to follow a three-strand approach to organisational messaging.



- **CONSIDERED** the latest letter from WG and **AGREED** the next steps on the financial recovery plan.

5.3 Perinatal Services

- Perinatal Committee Report**
- Perinatal Oversight Panel Report**
- Improvement Plan**

124/26

i. Perinatal Committee Report

JW extended a warm welcome to FG, KG, SB, and DC.

LR reminded the Board of its consideration a year ago of the Independent Review report compiled by the Oversight Panel, the Family Led Review, and the Llais report. Throughout the last year, the team had worked tirelessly to shape the Perinatal Committee report to provide optimum openness, transparency and accountability. The report was dynamic in content and would be subject to ongoing refinement.

LR highlighted:

- Demonstrable improvements across quality and safety indicators, supported by stronger governance.
- Healthcare Inspectorate Wales (HIW) recognition of progress across safety systems, leadership, escalation processes, and multidisciplinary team working.
- No cases of hypoxic ischaemic encephalopathy (HIE) reported in 2026, with a sustained reduction reported over time.
- Continued improvements in perinatal mortality figures, in line with comparable UK wide organisations.
- Robust MBBRACE reporting.
- Strong statutory and mandatory training compliance, exceeding the WG target of 85%, with improvements in medical workforce compliance. The SBUHB position was strong compared with other Welsh health boards.
- Medical and midwifery workforce pressures; these were managed on a daily basis, supported by flexibility and the adaptability of



the team. Workforce gaps were covered without adverse impact on the service.

- Positive friends and family satisfaction. Continuing engagement and co-production with local communities would enhance the understanding of the needs of women and families
- The establishment of a single point of access (SPOA) for maternity, with dedicated maternity staff; this was work in progress with more to do on optimizing call handling.
- The Birmingham specific obstetric triage system (BSOTS) process, used to monitor the triage system.
- A continued focus on the workforce and on capacity pressures, particularly in post-natal wards, driven in part by the rise in Caesarean sections.
- Continued improvements to paediatric radiology, with mitigating actions in place as an initial step.
- The continued risks associated with two-site working; the Corporate Risk Register captured these with current exploration of strategic options for the future.
- The role of the Perinatal Committee report in informing and assuring the Board, whilst also providing a challenge opportunity to drive improvements. LR extended her thanks to the team for their role in creating and shaping the report.

JW thanked LR and invited JC to comment, as chair of QSC. Responding, JC welcomed the systematic approach taken to analysing the available data, seeking evidence to inform and assess outcomes. A small number of recommendations remained outstanding, including the strengthening of communications with families. The important work undertaken over the last year had helped QSC to consider the whole approach to quality improvement (QI). JC also welcomed the positive interaction between the Oversight Panel and the team.

JW thanked JC for her scrutiny and advised that TO would be working with the Perinatal programme, looking at cultural responsiveness.

JW invited questions.



On triage, RO sought assurance on the effectiveness of the SPOA for the triage service and whether roles and expectations were clear. JW acknowledged the importance of this point and invited KG to comment on the current position, together with plans for future improvement.

KG advised that the SPOA was the result of detailed improvement work; it was a valuable additional mechanism, aimed at ensuring that women could access the right kind of help at the right time. Following BSOTS implementation, completed in November 2025, a dedicated team of appropriately skilled midwives now supported the triage system. The Women's Health Experience Midwife was surveying system users to determine any difficulties in navigating the menu options available. KG recognised that the menu options were lengthy, although generally women using the system found it easy to navigate. Work would continue on refining the system and updating staff accordingly.

AG asked about the integration between the SPOA system and BadgerNet. KG confirmed that BadgerNet was a whole maternity electronic patient record, with a specific module included for BSOTS. Midwives accessed this model to input information about triage calls directly on to a live system. This enabled appropriate referral for each woman who might require clinical interventions, depending on their issue.

The Board:

TOOK ADVICE ON:

- The sustained progress across maternity and neonatal services, with improved governance, strengthened multidisciplinary working, and enhanced safety systems evidenced through HIW findings, workforce compliance, and quality metrics.
- The implementation of targeted quality improvement programmes (e.g., ASTRA, bedside respiratory support during delayed cord clamping for preterm births, digital systems such as BadgerNet and computerised CTG) to address key drivers of risk and variation.
- Data systems; these were undergoing a period of transition and validation; whilst changes may impact on completeness in the short term, this work was critical.



TOOK ASSURANCE ON:

- The robust governance and oversight arrangements in place including real-time monitoring, multidisciplinary review, and clear escalation pathways from ward to Board.
- The active management of all risk with no overdue actions, and delivery aligned to planned milestones, supported through structured improvement programmes.
- The clear evidence of the translation of learning into practice. and workforce development.
- The approval of the HIW improvement plan, published, and actively progressing, with strengthened oversight ensuring delivery and closure of actions.

TOOK ALERTS ON:

- Ongoing system pressures, including workforce capacity, postnatal flow, and demand related to acuity and mode of birth (particularly caesarean-associated neonatal admissions).
- High-level risks that remained under active management, including paediatric radiology capacity, training delivery constraints (MoNET), and wider service configuration challenges (e.g. two-site working and critical care access).
- Transitional risks associated with digital implementation and national system dependencies, including data quality, survey limitations, and reporting consistency.
- The need to maintain focus on equity of access, consistency of escalation, and timeliness of care, as identified through HIW and internal review processes.

ii. Perinatal Oversight Panel Report

JW welcomed DC to the meeting, recognising the major milestone in service improvement since the Independent Review reported a year ago. DC thanked the Board for the opportunity to attend the meeting and drew attention to:

- The clinical site visits undertaken in June 2026 to both Morriston and Singleton hospitals and to the stand-alone Birthing Centre in Neath Port Talbot hospital. A mini-Conference followed later in the day with facilitated workshops that explored areas of the Improvement Plan (the Plan).



- Following the site visits, the Oversight Panel had to consider the Plan and the feedback from the workshops. DC and panel members had then met with LR and the in-house workstream leads.
- The Plan set out the scale of improvement achieved, as measured against the individual review recommendations; this process must continue with the Plan being a dynamic document, evolving as the improvement journey continued. Reviews undertaken both in Wales and England should inform ongoing work, as should the Nottingham review. The Board would need to keep these and other reviews in mind, to identify any additional learning.
- A recent NHS England document on triage; this would be a valuable tool to support ongoing improvement, and the SBUHB team was aware of it.
- The Oversight Panel's satisfaction that the Plan provided enough depth and assurance to allow the Board to sign it off. In doing so the Board should commit itself to continuing the improvement journey.
- The amount of narrative in the Plan; progress reports should be more focused. The Oversight Panel recommended the Board to consider outcomes data over the past year, collated as a summary report that highlighted key outcome measures and key metrics.
- Triage; the Board needed ongoing monitoring to assure itself that there were no unintended consequences. Key metrics in this respect were: (i) the number of dropped calls; (ii) the number of interruptions for the triage midwives and the impact of those on patient experience; and (iii) the number of calls from people of a diverse background. These metrics, along with real time feedback. Would provide valuable insights.
- Engagement with families; further work was needed, including on co-production, underpinned by more robust Key Performance Indicators (KPIs). The Board should also take the opportunity to work more closely with Llais and charities more closely.
- The need for awareness raising at the Morriston site and the broader opportunities that this could offer.
- The risks of two site working; DC had set these out in a separate letter to JW and AH. The Oversight Panel backed the significant mitigating actions in the Plan but recognised that these would not reduce the risk completely.
- The Oversight Panel offer to develop sharper more focused reports that focused on the areas requiring assurance.



On behalf of the Board, JW extended grateful thanks to DC and the Oversight Panel for the feedback. On two-site working, she advised that the Board would consider the case for change at its September 2026 meeting. JW also welcomed the offer of support to streamline the reporting process, with a focus on key metrics.

Board members then accepted the next steps that the Panel had proposed; JW invited DC to return to the September Board meeting before the Oversight Panel stepped down. This would allow DC to review the next steps.

JW then invited AE, on behalf of Llais, to comment on the Plan and progress to date.

AE welcomed the opportunity and placed on record Llais recognition of the significant effort and progress made over the last year, undertaken in the spirit of openness and accountability. She also acknowledged the significant role of the Oversight Panel, and of QSC. Llais was delighted to see the significant improvements and strengthened governance arrangements, with evidence of comprehensive, equitable and safe care.

LR welcomed the feedback and looked forward to developing the Maternity and Neonatal Voices Partnership (MNVP) Network that Llais was hosting for Wales.

AH thanked DC for the feedback, confirming that the team would action her additional points, to continue to strengthen the service. She reflected on the journey over the past year and reiterated the unreserved apologies the Board had made for poor experiences and outcomes. AH extended her thanks also to AE and Llais for the offer of continued input and reinforced the commitment to listen, in real time, to women and their experiences.

AH then referred to the move to Care Groups from Service Groups, with a specific group for children, women and families; this would facilitate an ongoing focus on the service and the commitment to continuous improvement. AH extended her personal thanks to DC and the Oversight Panel members.



iii. Improvement Plan

LR drew attention to the letter at the front of the Improvement Plan (the Plan) that she and RK had signed; she acknowledged the significant work that RK undertook in the early days of developing the Plan and subsequently. There was a clear commitment to listen, to learn, and to improve. The Plan had already driven significant progress and would continue to do so.

The Plan included the recommendations from: all Oversight Panel reports and visits; from Llais; from HIW; from the all-Wales Assessment; and from the Family Led Review. A gap analysis was underway against the Ockendon recommendations and the Amos review in England. The Board would receive the result of this at the September meeting.

Action: LR

LR acknowledged that it was not possible to undo the harm and distress caused to some families; she committed to continuing to engage with the Swansea Bay community and to explore different ways of doing that, including through co-production. The maternity and neonatal teams were fully engaged on the improvement agenda and had ambition and passion to deliver the best services and the best experiences possible.

Improvements already delivered included: the 24/7 triage process; early warning scores; training compliance; enhanced consultant workforce presence; the introduction of an induction of labour prioritisation process; an investment in the workforce; multidisciplinary leadership development; and work to strengthen the psychological safety of staff.

LR recognised DC's comments on the level of detail included in the Plan; she would streamline future reports and include improvement-related metrics. LR extended her thanks to FG, KG, SB and RK for their continued support during a testing time, together with their passion and ambition.



SB welcomed the support of colleagues over the past year, with both individual and system learning taking place; it all helped to deliver ongoing service improvement. KG added her commitment to delivering the Plan.

JW concluded the discussions by placing on record the Board's thanks to DC and the Oversight Panel, to SB, KG and the whole maternity and neonatal service.

The Board:

- **APPROVED** the updated Perinatal Improvement Plan (Appendix 1).
- **TOOK ASSURANCE FROM:**
 - The comprehensive plan in place to address the recommendations of the SBUHB Independent Review of Maternity and Neonatal Services, the Family Led Review of Maternity Services, and "Having a baby in Neath Port Talbot and Swansea Report" Llais Report, together with any actions required from the All-Wales Assessment of Perinatal Services.
 - The continuing sustainable progress made since the publication of the Independent Review on key safety actions.
 - The underpinning of the Plan by a robust governance and assurance structure.
- **TOOK ALERTS ON:**
 - **Two-site working:** While acknowledging the significant progress made in strengthening arrangements for women requiring care in non-maternity settings, including a number of Standard Operating Policies (specifically outlining the processes and escalation, for admissions of pregnant women into non-maternity sites) and workforce remodelling, there remained an inherent risk in this model of operation. The Board would receive options for service reconfiguration at the September 2026 meeting.
 - **Maternity Triage:** The 'Path to Safer Beginnings in Wales', published February 2026, recommended the establishment of a national single point of access triage service for pregnant women, co-ordinated by the Welsh Ambulance Service Trust.



Given this, SBUHB would not continue the development of a standalone SBUHB model. To mitigate risk until the implementation of the national triage model, the health board had set up a 24/7 clinical triage unit. The service offered advice by phone and in-person; women and their families could access timely advice about any concerns, with appropriate referral and signposting. This would improve patient safety, patient experiences and improve quality and outcomes. The maternity triage unit, known as the Antenatal Assessment Unit, was staffed by two midwives trained in maternity triage; however, they also looked after patients presenting in-person. In the event of callers experiencing a delay in an immediate midwifery response, a member of the administrative staff would answer and ask the caller to hold. In these instances, if the triage midwife flagged a potentially extended delay, the administrative staff (on a 24/7 rota supporting the service) would enact the escalation process and contact the Labour Ward Coordinator for assistance.

- **Paediatric radiology:** Outsourcing of paediatric radiology provision for plain film x-ray as an interim mitigation measure went live in February 2026. There were system-wide national challenges in respect of radiology; a regional solution would provide long term assurance and sustainability of service provision. Discussions were ongoing with Cardiff and Vale University Health Board to explore suitable options.

PART 6. GOVERNANCE

6.1 Corporate Governance Report

125/26

HL summarised the components of the Governance report, referring specifically to the need for Board approval on the updated Remuneration Terms of Service Committee.

The Board:

- **RECEIVED for ASSURANCE:**
 - The matters considered In-Committee at the May 2026 Board meeting;
 - Welsh Health Circulars;



- The Common Seal Register;
- Board Work Programme 2026-27.
- **APPROVED** the revised Remuneration and Terms of Service Committee Terms of Reference, for implementation from 1 September 2026.

PART 7. CONSENT AGENDA

7.1 Minutes of Previous SBUHB Board Meetings

- i. **28 May 2026**
- ii. **25 June 2026 (Special)**

126/26

The Board **APPROVED** the minutes as a true and accurate record of the meetings on:

- i. 28 May 2026
- ii. 25 June 2026 (Special)

7.2 Action Log

127/26

The Board **RECEIVED** the Action Log updates for **ASSURANCE**.

7.3 Board Advisory Groups Report

- i. **Health Board Partnership Forum**
- ii. **Health Professionals Forum**
- iii. **Stakeholder Reference Group**

128/26

The Board:

RECEIVED the discussions of the

- i. Health Board Partnership Forum held on 9 July 2026.
- ii. Health Professionals Forum held on the 11 June 2026.
- iii. Stakeholder Reference Group held on 16 July 2026.

7.4 Chair's Report



129/26	The Board TOOK COGNISANCE of the Chair's activities since the last Board meeting on 28 May 2026.
7.5 Population Health Committee Key Issues Report	
130/26	The Board RECEIVED the Key Issues Report for ASSURANCE .
7.6 Performance and Finance Committee Key Issues Report i. May 2026 ii. June 2026	
131/26	The Board RECEIVED the Key Issues Report for ASSURANCE .
7.7 Quality and Safety Committee Key Issues Report	
132/26	The Board RECEIVED the Key Issues Report for ASSURANCE .
7.8 Workforce and OD Committee Key Issues Report	
133/26	The Board RECEIVED the Key Issues Report for ASSURANCE .
7.9 Audit Committee Key Issues Report i. June 2026 (Special) ii. June 2026	
134/26	The Board RECEIVED the Key Issues Report for ASSURANCE .
7.10 Charitable Funds Committee Key Issues Report	
135/26	The Board RECEIVED the Key Issues Report for ASSURANCE .
PART 8. ITEMS FOR DISCUSSION	



8.1 Any Other Business

136/26	There was none.
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8.2 Review of Meeting Effectiveness

137/26	There had been no rapporteur for the meeting. JW asked attendees to email any feedback to her or HL.
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8.3 Closing Remarks

138/26	Before closing the meeting, JW indicated this was the last meeting for RO as an Independent Member of the Board, as she had completed two full terms of service. On behalf of the Board, JW thanked RO for her eight years of consummate public service, for her wise counsel, advice and guidance across the breadth of the Board agenda, and for her diligent work at Committee level. JW drew specific attention to RO's role as chair of WODC and thanked her for the way in which she had developed its role and the good practice that she had introduced. All Board members joined JW in wishing RO well for the future.
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Next SBUHB Board Meeting: Thursday 24 September 2026

The meeting concluded at 16:07.

SBUHB Board Log

Meeting Date	Type of Meeting	Minute Ref	Agenda Item (Number & Title)	Narrative	Assigned to (individual)	Supporting (additional staff members)	Update	Status
28/05/2026	Public Board	075/26	4.3 Integrated Performance Report Assurance Framework WG Oversight and Escalation update	LR referred to urgent referrals for patients who may be waiting; she suggested asking each specialty how they contacted patients on their waiting lists, agreeing to undertake this and report back as part of a wider cancer services report. This should form part of the referral to treatment (RTT) pathway.	Executive Director of Nursing and Patient Experience (LR)			Open
30/07/2026	Public Board	122/26	5.1 IPR - Stroke services	Summarising the discussion, JW drew attention to the number of references to data accuracy, completeness, and timeliness. She asked MD/COL to schedule these and forward to the DDRIC for consideration.	Executive Director of Planning and Partnership (MD)	COL	DDRI has been stood down and all remaining committees will be responsible for their own digital agendas.	Underway (with update)
30/07/2026	Public Board	117/26	4.2 Planning and Partnerships Report	JW reflected on the breadth of material and updates included in the report; she asked AH/MD to look at the format and determine the optimum format for reporting to the full Board.	Executive Director of Planning and Partnership (MD)	AH	MD is developing a new look report, with September's report the last one in the current format. The new focus will be on providing Board assurance around items such as key achievements and risks, organisational compliance and any actions/deadlines the Board should be aware of, the Health Board's position and ongoing work.	Underway (with update)
30/07/2026	Public Board	122/26	5.1 IPR - Workforce	CO-L confirmed that the vacancy control process was having an effect and the grip on delivery against headcount reduction would need to continue. In response to a query from JW, CO-L agreed to provide a briefing, as part of the Finance Report, on reconciling a reduction in whole time equivalent (WTE) employees and an increase in the pay bill.	Executive Director of Finance (Interim COL)		14/09 SM: additional data has been incorporated into the Mth 5 Finance Annex (appendix 7) however work will continue to assess whether there is anything further that can be provided to support the request.	Underway (with update)
28/05/2026	Public Board	067/26	1.4 Chief Executive's Report	NM asked about staff morale in the Emergency Department (ED) given that some time had elapsed since the Board had met with staff. AH, LR and JS reported ongoing focus, particularly on patient flow, successful recruitment, and positive staff feedback. JW proposed follow-up engagement with staff, as part of an ongoing programme of meetings with staff groups, as part of the priority communications plan.	Director of Insight, Communications and Engagement (RT)		Internal element of Autumn campaign to support discharge and flow already launched and underway. 3 resources available via the intranet: (Video) Three wards piloted Optimal Hospital Flow...this is what happened / (bulletin) Reducing delays through Red to Green and Home for Lunch – why we're focusing on flow / (bulletin) Reducing delays and the risk of harm to patients in the community and at our front doors Campaign will iterate through different phases. Future phases in design stage with campaign brief developed. Next phase to go live in October.	Underway (with update)
30/07/2026	Public Board	116/26	4.1 Transforming for the Future	NZ asked about the achievability of the timelines and milestones; she highlighted the risks and sought assurance on a prioritisation process. AG also referred to; the need to manage the timelines alongside other transformational programmes underway, the iterative process adopted and the possibility of developing a worked example of the principles in practice. Responding, MD welcomed this suggestion and agreed to consider it further.	Executive Director of Planning and Partnership (MD)		FA - 08/09 The Transforming for the Future Programme and CSP continue to be delivered through a phased and iterative approach. Timescales are being reviewed regularly and have been amended to reflect both the publication of the National Clinical Plan and Local Elections in May 2027. As the Future model of care emerges the team will use the principles to test the model and will share the process outcomes with Board.	Underway (with update)
30/07/2026	Public Board	116/26	4.1 Transforming for the Future	AH built on the 'life course' concept and advised that the top 100 leaders recognised the need to map the longer-term financial strategy against this concept. PD reminded the meeting that, at the Annual General Meeting (AGM), the Board had agreed to change the form of verb underpinning the principles from 'should' to 'will'. MD agreed to make this change.	Executive Director of Planning and Partnership (MD)		FA - 08/09 Principles have been amended to 'will' from 'should'. Stage 2 of T4F development will specifically be looking at the required enablers to deliver the model of care. This will include the financial strategy necessary.	Underway (with update)
30/07/2026	Public Board	123/26	5.2 Finance report	RT advised a balanced approach to messaging, recognising how hard staff were working, whilst at the same time being clear that the scale of savings required called on the workforce to do things differently. He outlined the three main routes used for communication with staff: at management level based on accountabilities; corporate messaging; and specific campaign messaging. He proposed actions across all three opportunities to drive engagement and motivate staff to respond and take ownership of the challenge, with a specific focus on corporate messaging in the lead into September.	Director of Insight, Communications and Engagement (RT)		Corporate messaging ongoing via channels such as Team Brief, Ask Abi, Midweek Message. Refreshed 'Making every £ count' campaign being prepared in conjunction with the Delivery Unit. Based on feeding back staff generated money saving ideas in order to show we can do it and encourage further suggestions. Campaign due to go live in October.	Underway (with update)

SBUHB Board Log

Meeting Date	Type of Meeting	Minute Ref	Agenda Item (Number & Title)	Narrative	Assigned to (individual)	Supporting (additional staff members)	Update	Status
30/07/2026	Public Board	117/26	4.2 Planning and Partnerships Report	CW summarised his recent attendance at a national debrief on the extreme heat. HVW referred to the work of the Ventilation Group; these covered issues including the hiring of air conditioning units and any infection control implications and requirements. JW asked HVW to share this with AH for the CEMT meeting.	Deputy Executive Director of Public Health (HVW)		03/09 HVW - Paper has been compiled and will be sent to CEO for submission to next CEMT meeting in October 2026.	Underway (with update)
30/07/2026	Public Board	117/26	4.2 Planning and Partnerships Report	A comprehensive dashboard was in place, for use by the DALB, when reviewing performance on a quarterly basis. MD agreed to provide JC with information on this, and to follow up SS query on service access.	Executive Director of Planning and Partnership (MD)		Update 08.09.26: DALB maintains a comprehensive performance dashboard that includes activity measures, such as referrals and attendance, alongside outcome measures, including mortality data and service user feedback. The dashboard is currently hosted on Neath Port Talbot Council's server and is therefore not accessible to staff outside the Council. A copy of the 2025/26 DALB Annual Report will be shared with Board Members at the September Health Board meeting. In addition, the DALB team will introduce a quarterly reporting arrangement, providing updates on key performance indicators and progress against the actions set out within the Strategy. Development of GP Shared Care Arrangements Improving access to GP shared care arrangements is being progressed through the development of the clinical services component of the Alliance Model for drug and alcohol services. A transformation programme has been established, including a dedicated Task and Finish Group focused on low-level prescribing services. This workstream will incorporate the development of GP shared care arrangements as part of the future service model. The Task and Finish Groups will be responsible for developing the detailed proposals, assessing risks and options, and identifying the implementation requirements necessary to support a business case and inform future Health Board decision-making. The programme is expected to be completed by end of 2026/27, enabling the new service model to be commissioned and mobilised during 2027/28.	Underway (with update)
30/07/2026	Public Board	117/26	4.2 Planning and Partnerships Report	AL referred to the Alliance model in place for drug and alcohol services; the Neath Port Talbot (NPT) Social Services Scrutiny Committee had considered a recent report and acknowledged the progress made. He thought that there would be benefit for the Board in considering the same type of report.	Executive Director of Planning and Partnership (MD)		Update 08.09.26: This action will be progressed through the development and implementation of quarterly DALB reporting arrangements to Health Board that should provide assurance on performance against key indicators and delivery of the actions set out within the Strategy in response to the recommendations of the Drugs Commission Report.	Underway (with update)
30/07/2026	Public Board	122/26	5.1 IPR - Stroke services	JC expressed her concern about the number of issues raised around stroke services, particularly in the context of a regional approach. She advised that QSC would return to this agenda, supplementing the PFC scrutiny, through a specific focus on the regional service footprint.	General IM (Jean Church)		07/09 JC - Raised with the Interim Chief Operating Officer and Executive Director of Nursing and Patient Experience who will formulate an informed Improvement Plan. This matter already raised with the Service Group in the recent Performance Review.	Underway (with update)
30/07/2026	Public Board	115/26	3.1 Patient Story	RO asked whether SBUHB maintained a register of staff who spoke other languages and who could volunteer their services, should that be necessary; this could be a helpful alternative to Language Line. RO had already mentioned this to TR, who would explore this further.	Executive Director of Workforce and OD (TR)		This is not currently recorded on the ESR system. Employee's consent would be needed to retain a record of their language skills and we would need evidence of the level of language skills that members of staff have before offering this service to patients. The Director of Workforce will connect with other Health Board's to see if there is opportunity to take this forward.	Underway (with update)
28/05/2026	Public Board	075/26	4.3 Integrated Performance Report Performance Assurance Framework WG Oversight and Escalation update	ALF referred to the report looking at culture and workforce-related performance, in addition to patient focused services. JW reflected on the depth and detail of the revised report and asked for further consideration of matters that should come to full Board, and those more appropriate for Committee level oversight.	Executive Director of Planning and Partnership (MD)	HL	29/07 - The updated Performance and Assurance Framework has now identified the lead committees for assurance against appropriate performance targets that now provide AAA reports to Board and only alert on issues requiring Board consideration. The Board Level report now provides assurance on areas of escalation, UHB breakthrough objectives, WG priorities and UHB-specified areas of focus.	Underway (with update)
28/05/2026	Public Board	078/26	4.6 Perinatal Services Perinatal Committee Report	On the number of mothers who birthed at the Birthing Unit, AH confirmed that the dashboard had identified 12 in the last month (April 2026). LR commented on the 24/7 basis staffing for the Birthing Unit and the need to ensure maintenance of midwifery skills through sufficient access to delivering babies. She suggested that QSC should consider a report.	General IM (Jean Church)	LR	Added to the QSC Work Programme for October	Underway (with update)

SBUHB Board Log

Meeting Date	Type of Meeting	Minute Ref	Agenda Item (Number & Title)	Narrative	Assigned to (individual)	Supporting (additional staff members)	Update	Status
28/05/2026	Public Board	077/26	4.5 Quality and Safety Committee Key Issues Report	JC asked about possible digital dashboard opportunities to support effective management. The different data sources and perspectives often meant that there was no single understanding of the figures or how to best manage the process. She asked whether a digital programme could assist in sense checking the validity of information.	Executive Director of Planning and Partnership (MD)		24/07 MJ moved this action to MD after discussions with her and Lee Morgan on how the BI Team can take this forward.	Underway (with update)
28/05/2026	Public Board	079/26	Dental Update	JW asked the Population Health Committee (PHC) to consider the issue of equity and access and the risk of widening inequity for dental services, and PFC to consider the financial modelling implications.	Finance IM (Pat Price)	COL	On the Agenda for P&FC in October 2026. 08/09 The Dental Services: Equity of Access and Health Inequalities paper was originally included in the September PHC call for papers. However, Sharon Miller suggested prioritising a Pharmacy Needs Assessment update instead. The dental update was deferred to December 2026 for Population Health Committee.	Underway (with update)
28/05/2026	Public Board	067/26	1.4 Chief Executive's Report	JW asked JS to produce a report for the Audit Committee (AC) on the DU structure, priorities, and contribution to grip and control, alongside improved outcomes.	Delivery Unit Director (JS)		This was deferred from September and is now going to Audit Committee in November 2026.	Underway (with update)
28/05/2026	Public Board	070/26	3.1 Planning and Partnerships Report	JW acknowledged the breadth of planning work in the papers provided and summarised the discussion and the actions underway. The Executive agreed to review the resources available to the team, particularly in respect of CHC. Action: AH/Executive team.	Chief Executive Officer (AH)		16/07 AO - Capacity review of the centralised commissioning function is underway, incorporating Deloitte review recommendations. Priority is recruitment to the vacant Contract Manager post, alongside assessment of Direct Payment resource requirements and anticipated efficiencies from the new CHC/Complex Care Digital Case Management System. Target date- December	Underway (with update)
28/05/2026	Public Board	076/26	Finance Report	NM asked about communication of the financial position and the consequences for budget holders who did not stay within their allocation. CO-L set out the different means of communication and information cascades; she also summarised the learning made available to budget holders. Some had not yet signed their accountability letters and this was under review. JW asked RO, as chair of WODCOM, if the Committee could explore the reasons for reluctance to sign the letters and the barriers that may require some organisational development support.	Community IM (Reena Owen)	TR	Re-scheduled for WOD Committee in October 2026.	Underway (with update)
25/06/2026	Special Public Board	108/26	5.1 Stakeholder Feedback Report	AH welcomed the report and the many positive findings. She acknowledged the need to strengthen some aspects of engagement, building on the provisions already in place to increase Board and Executive level visibility. The Executive would consider the recommendations, produce an action plan and report back to the Board through the planning and partnerships report.	Chief Executive Officer (AH)	MD	16/07 AO - This will be discussed at the next Executive timeout in October and that resultant actions would feed into a Board Effectiveness Action Plan overseen through Audit Committee.	Underway (with update)
26/03/2026	Public Board	043/26	4.1 Performance and Finance Committee Key Issues Report	JW asked JC and LR to scope the basis of a review format making use of anonymised patient case studies and engaging with WAST counterparts to conduct a joint learning exercise. Action: JC/LR/RK	General IM (Jean Church)		25/06 - Angharad Higgins (AH) has developed draft terms for the review by our SBUHB Stroke team. As yet, WAST have not confirmed their engagement in this work, albeit further chasing action has been undertaken. As soon as a contact from WAST is identified, we can agree terms and timescales for the review. Regular updates from AH are received. 23/04 - CJC requested advice from COO on 23/4/26 regarding appropriate WAST contact. ER now following through to ascertain relevant contact details.	Underway (with update)
29/01/2026	Public Board	005/26	1.5 RISK REPORT	JC reflected on the number of dashboard-related developments underway, many required at a national level; she suggested asking the Digital, Data, Research and Innovation Committee (DDRIC) to produce an organisation-wide reference map, setting out the strategic requirements underpinning each. Board members supported this and JW and remitted the matter to DDRIC. Action: AG/MJ	Executive Director of Planning and Partnership (MD)	Action previously owned by - Director of Digital (MJ)	03/09 - MJ transferred the action to MD. 25/05 - JC has had no further updates as yet. MJ and JC have had a detailed follow up conversation. The requirement is for an Infographic that provides a representation of the dashboards that are available at a local, regional and national level and categorised by themes e.g. by service group. A mock-up is being developed and will be discussed further with JC by Mid April for endorsement.	Underway (with update)

SBUHB Board Log

Meeting Date	Type of Meeting	Minute Ref	Agenda Item (Number & Title)	Narrative	Assigned to (individual)	Supporting (additional staff members)	Update	Status
29/01/2026	Public Board	011/26	4.3 INTEGRATED PERFORMANCE REPORT	JC expressed concern at the lack of traction in improving some services, citing endoscopy as an example. When performance did not improve in the way intended, she asked about 'outside the box' thinking. One example concerned the water ingress in Ty Meddwl. DG outlined discussions with the landlord and the need for a roof replacement. Following on from JCs point, NZ asked about providing alternative premises for the mental health teams, rather than reducing outpatient activity, until the end of April. DL agreed to explore this. Action: DL	Chief Operating Officer (DL)		24/07 Dermot Nolan - We put alternative temporary accommodation measures in place so the service continued to function (these included Garngoch, children centre at NPTH etc). These couldn't be sustained long term, so we worked with capital planning leads and have now secured a new premises in Swansea for CAMHs which is less cost for the lease than Ty Meddwl. Capital estates leads are taking this through the HB process for approval, and they have served notice to the landlord of Ty Meddwl who has not engaged through the escalation.	Underway (with update)
25/09/2025	Public Board	165/25	4.7 COMMUNITY PHARMACY	SBUHB did not hold information on the translation facilities at individual community pharmacy level, but all pharmacies could access language line translation services JW asked SM to review the ways in which SBUHB could improve its records on language options available in community pharmacy settings.	Chief Operating Officer (DL)	Sharon Miller, Associate Service Group Director	19/11 SM In discussion with community pharmacy Wales (CPW) we are planning to undertake a baseline assessment of community pharmacies against the recently issued all Wales communication standards. This is expected to take place, following discussion in the new year.	Underway (with update)
27/11/2025	Public Board	198/25	4.2 INTEGRATED PERFORMANCE REPORT - ANNUAL PLAN PROGRESS (QTR 2)	On stroke services, DL advised that a National Stroke Standards benchmarking exercise was underway; she would share the outcome from that with the Board. Action: DL	Chief Operating Officer (DL)		Standards are yet to be published and unlikely to be available before the end of March 2026.	Underway (with update)