CYFARFOD BWRDD PRIFYSGOL IECHYD
UNIVERSITY HEALTH BOARD MEETING

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	27 March 2025
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Performance Update for Hywel Dda University Health Board – Month 11 2024/2025
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Huw Thomas, Executive Director of Finance In association with all Executive Leads
SWYDDOG ADRODD: **REPORTING OFFICER:**	Huw Thomas, Executive Director of Finance

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

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

This report relates to the Month 11, 2024/25 Integrated Performance Assurance Report (IPAR) which summarises progress against a range of national and local performance measures. This month's IPAR update consists of this SBAR and an IPAR dashboard. An IPAR overview update will be produced bi-monthly for committees.

The IPAR dashboard which includes data and charts for all performance measures can be accessed via: Integrated Performance Assurance Report (IPAR) dashboard as at 28th February 2025. Ahead of the Board meeting, the dashboard will also be made available via our internet site.

A new performance framework has been developed. Our Improving Together Framework brings together content from the previous Improving Together and Escalation frameworks. It also reflects the organisational structural changes following the introduction of our new Clinical Care Groups. The escalation process has been enhanced to realign accountability to Executive Directors and Clinical Care Group Directors. A more stringent process has also been identified for those areas that are escalated and not making the required improvements. The new Our Improving Together Framework is included as a supporting document (Appendix B).

A summary of the Statistical Process Control (SPC) chart icons is included below.

Variation How are we doing over time	■	Concerning trend = a decline that is unlikely to have happened by chance
	■	Usual trend = common cause variation / a change that is within our usual limits
	■	Improving trend = an improvement that is unlikely to have happened by chance
Assurance Performance against target	▣	Missing target = will consistently fail target without a service review
	▣	Hit and miss target = Indicates that the Board cannot have sufficient assurance that the target can be consistently achieved over time, and the delivery of the target is particularly sensitive to external factors
	▣	Hitting target = will consistently meet target

If assistance is required in navigating the IPAR dashboard, please contact the Performance Team:
GenericAccount.PerformanceManagement@wales.nhs.uk.

Cefndir / Background

In February 2024, Welsh Government published the 2024/25 NHS Wales Performance Framework. The framework outlines the Ministerial priorities for this financial year, along with key targets.

Welsh Government published the 2025/26 NHS Wales Performance Framework in January 2025. Amendments from the 2024/25 framework are:

- Audiology metric split into adult patient waits >14 weeks and children >6 weeks;
- Removed from Framework - Percentage of calls ended following WAST telephone assessment (Hear and Treat);
- Removed from Framework but continued to be reported in the IPAR dashboard - Number of patients waiting more than 52 weeks for referral to treatment;
- Qualitative reports have been removed from the Framework.

Asesiad / Assessment

We have adopted the '3As assessment' approach to highlight either an alert, advise or assure status for each of our key performance measures. Please refer to the latest Integrated Performance Assurance Report (IPAR) dashboard for data and charts for all performance measures.

Alert (may require discussion)
There is a lack of confidence that any action in place is sufficient to address the issue satisfactorily and/or within the scope of the operational team or executive to resolve. Engagement, action or intervention required.

Ophthalmology – In January 2025, 908 out of 1,750 (51.9%) high-risk (R1) patients attended appointments within their clinically assigned target date* or within 25% beyond that date and performance shows concerning variation (Target = 95%). The decline in performance to the lowest level in almost 6 years is due to the loss of clinics and intravitreal injections experienced over the holiday period as some R1 capacity in January 2025 had to be utilised for patients displaced from their December 2024 appointments, who had already breached their target date.

Actions being progressed to support performance improvement include a shared approach between hospital and community-based Optometrist eye care teams, improvements to the glaucoma pathway, recruitment and training. Furthermore, a step increase to intravitreal injection (IVT) pathway capacity is underway, inclusive of shorter-term outsourcing of a cohort of IVT patients along with planned recurrent investment in HDdUHB service capacity through 2025/26 which is expected to positively impact overall R1 performance. It is anticipated that these improvements will contribute to an overall improvement in R1 performance beyond the 2024/25 65% TI threshold during the next 12 months. February 2025 performance is expected to recover to 58%.

*Nationally agreed timeframe = clinically assigned target date or within 25% beyond that date.

Cancer – Following 3 months of improved performance, there was a decline in January 2025 with 53.3% of patients (161 out of 302) starting treatment within 62 days from referral, against the 60% trajectory. This predominantly reflected an increase in treatment volumes of patients in the 62 day+ backlog during January 2025. In February 2025, there were 482 patients waiting over 62 days to start treatment, against the trajectory of 328. The highest number of waits continues to be for Urology (167) and Lower GI (126). Confirmed positive diagnoses of cancer are not expected for a significant proportion of the patients in February and these volumes are expected to reduce as a result of increased Radiology CT imaging capacity during February and March 2025. Early data for February 2025 performance indicates recovery above the 60% threshold. Recovery plans include additional capacity for diagnostic pathways which are expected to improve performance in line with the 65% trajectory for the end of March 2025. The latest outpatient appointment data is showing a continued reduction for patients waiting over 14 days.

Staff sickness – 12-month rolling sickness remains high at 6.65% in February 2025. Anxiety, stress and depression continues to account for the highest reasons for absence across the majority of our directorates. The Workforce teams have been assisting Directorates, in particular Estates and Facilities and Unscheduled Care, to undertake deep dives into the absence data and have supported the implementation of targeted and bespoke action plans with the services for each specific area of concern.

Staff engagement – the overall score for staff engagement is showing special cause concerning variation at 70.4%. This is below the mean of 73% since monthly staff surveys began. Special cause concerning variation is also reported for the response to 'I am proud to tell people I work for Hywel Dda'. Strategies to help build staff engagement and instigate feelings of pride from working for Hywel Dda include; staff recognition and appreciation programmes, promoting a positive and supportive work environment, providing professional development, opportunities for growth and leadership programmes such as LEAP (Leadership Engagement with Awesome People).

Diagnostics waits 8 weeks and over – Whilst breaches reduced by 25% (2,051 patients) in February 2025, total breaches remained high at 6,017 patients and the trajectory of 311 was not met. Breaches recorded were at the lowest level reported since October 2024. Performance is showing common cause variation with performance largely driven by continuing challenges in Radiology:

- Radiology: Breaches reduced by 1,603 patients in line with recovery actions agreed in December 2024 and are forecast to further improve to circa 5,000 breaches by March 2025. However, concerning variation remains present on the SPC chart. Breaches driven by waits for CT, MRI and Non-Obstetric Ultrasound Scan (NOUS). Demand is currently exceeding capacity for timely investigations and reporting. Available resourced capacity is being prioritised for cancer and inpatient demand. Welsh Government recovery funding utilised in February 2025 to increase capacity.
    - NOUS insourcing commenced and planned to continue into the new financial year subject to funding.
    - Locum Radiographers were recruited for CT on 15/02/2025.
    - Mobile MRI solution extended and planned to continue into the new financial year subject to funding.
    - Advertisement and appointment of trainee Sonographers under annex 21 rules also commenced.

- Endoscopy: 88 breaches in February 2025. Improving variation is showing on the SPC chart. Short term sickness and gaps in the establishment caused theatre nursing staff challenges. An additional five sessions per week are being run to uplift core capacity and seven designated sessions to reduce backlog. A productivity dashboard has been developed and is being utilised to identify ongoing opportunities to improve utilisation of capacity. Endoscopy and Cardiology recovery plans in place and expected to achieve zero 8-week breach performance by March 2025.
- Cardiology: 265 breaches in February 2025. Improving variation is showing on the SPC chart. Planned insourcing is addressing the Echocardiogram gaps. Ambulatory monitoring breach position continues to recover with-in house management of demand and capacity. Transoesophageal echocardiogram (TOE) and dobutamine stress echo (DSE) breach positions are recovering. Exercise tolerance testing (ETT) breach position is also recovering. The plan to achieve a breach free position by end of the financial year 2024/25 is on track.

Therapies waits 14 weeks and over – Breaches reduced to 1,932 in February 2025, however, all services except occupational therapy and speech and language therapy show concerning variation. Services with the highest number of breaches are detailed below:

- Physiotherapy: 1,000 breaches, over half of the therapies total. Demand is greater than capacity and recruitment challenges within Musculoskeletal (MSK). A targeted workforce campaign has been initiated along with development of a bank system for band 5 and 6 registrants. Within budget agency recruitment underway to support some service vacancies until 8 June 2025. MSK telephone triage pilot in process to signpost patients toward self-care resources - summary report April 2025.
- Podiatry: 485 breaches. Impacted by recruitment issues and chronic vascular/diabetic foot pathology demand. Actions to address include staff skill mixing, recruitment to vacancies and waiting list management including open access clinics and telephone triage.
- Occupational therapy: 340 breaches. Majority of breaches in paediatrics due to backlog and demand and further impacted by sickness and staff resignation which will impact performance until March 2025. A focus on prioritising caseloads continues, sickness is being managed as per policy, and recruitment is underway to address capacity shortfalls from April 2025.
- Art therapy: 52 breaches and special cause concerning variation, with increases for five consecutive months. One therapist covers the whole of the Health Board, impacting capacity, although delivery is supported through groups where possible to mitigate this. A new art group for 8 clients will commence on 25 March 2025, running until June 2025, with a further group planned in September 2025. In line with Integrated Psychological Therapy Service (IPTS), all clients waiting on the Art Therapy wait list have been offered groups as part of the ongoing waiting list management.

The directorate is currently off trajectory but undertaking demand and capacity modelling to achieve or revise trajectories. Short term measures have been put in place including appointment of agency staff, recruitment to newly qualified graduates across disciplines and increased scrutiny of waiting time performance. These actions are expected to reduce breach volumes but trajectories are volatile due to impact of any changes of workforce availability.

Audiology waits 14 weeks and over – 1,711 breaches in February 2025 (concerning variation). Issues include a large backlog coupled with workforce deficits, significant short-term and long-term sickness, staff vacancies (awaiting approval to advertise) and supporting a previously revised ENT rota. The fragile status of the Audiology service is under review. Actions underway include regular monitoring of the clinic template, a move to Patient Initiated Follow Ups (PIFU) to replace face to face appointments and release capacity (still awaiting sign off from the Quality Improvement Assessment Team) and approval to advertise staff vacancies.

Child neurodevelopmental waits - in January 2025, the overarching metric is showing common cause variation, with 19.7% having a neurodevelopmental assessment within 26 weeks, missing trajectory of 29%. Autism Spectrum Disorder (ASD) was 14.2%, and Attention Deficit Hyperactivity Disorder (ADHD) was 47.1%.

The 26-week target for ADHD assessments is showing improving variation. ASD performance has been consistently below 20% since September 2022 and continues to show concerning variation, with demand far outstripping our capacity to assess patients for ASD. We had an average of 116 referrals per month in 2024 compared to 20 per month in 2016. Clinical posts to support ASD assessments have now been recruited into and we have implemented a skill mix into teams to attract more interest in specialist roles and to promote a 'grow your own' culture.

Ambulance red calls responses < 8 mins - 52.7% in February 2025, target is 65%. Performance is showing expected (common cause) variation and performance trend has improved the last couple of months. Mitigation of risks via weekly reviews of WAST resource escalation action plan; Dynamic review of demand and area specific pressures; Advanced Paramedic Practitioners supporting multidisciplinary approach to admission avoidance.

Ambulance handovers

- The number of handovers taking longer than 1 hour in February 2025 reduced to 795 and overall performance shows common cause (expected) variation and the trajectory of 846 was met. PPH and WGH are driving this improvement, whilst BGH and GGH are still showing concerning variation.
- Handovers taking more than 4 hours during February were 223. Performance is showing expected (common cause) variation overall. All sites are showing common cause (expected) variation.
- Risk mitigation actions: Red and Amber 1 ambulance release plans, Advanced Paramedic Practitioner within Clinical Streaming Hub reviewing ambulance incident call stack, for admission avoidance.

4 hour and 12-hour A&E/MIU patient delays

- No significant change in February for overarching Health Board performance position. Concerning performance trends continue for patients spending less than 4 hours in A&E/MIU (67.4%) or those spending longer than 12 hours (1,260).
- The percentage performance of patients seen within 4 hours is slowly starting to increase since December 2024, but this trend will need to be sustained across all sites.
- Since November 2024, GGH has continuing to reduce the number of patients waiting over 12 hours (491) and met the February trajectory (505). Likewise, at WGH, these patient numbers have been decreasing for 2 months.
- Since the MIU model was changed in October 2024, PPH met the 4-hour target (95%) for past four months and is showing improving variation and met trajectory for the eighth successive month for 12-hour patient delays, with zero reported in February 2025. The TI de-escalation criteria to reduce the percentage of patients waiting over 12 hours to no more than 7% has been met.

- Risk mitigation actions: Same Day Emergency Care (SDEC) units continue to support and be developed; Boarding protocol in place and the wards will take patients from the ED prior to the discharge patient leaving the ward; Hot Clinics (referral outlet for on call doctors, out of hours and a clinic that allows patients to return through SDEC not onto a ward) continue to run which facilitates early discharges and follow up review. PPH are currently piloting SDEC weekend support to further reduce admissions. GGH trialled Medical Same Day Emergency Care (SDEC) service during perfect week (w/c 21/01/25) within the current staffing model, and plan to review in March 2025.

Advise (to monitor)
There are areas of concern where assurance has been taken on actions in place but requires close monitoring. An early warning of an emerging and potentially serious concern.

Pathway of Care Delays (POCD)

- Performance is showing improving variation. Census count delays increased during February 2025 to 217, and the total number of days delayed for our non-mental health patients increased to 7,847 days from 7,797 days previously. Assessment delays remain the largest proportion of delays.
- Formal arrangements between senior Health Board and Local Authority partners within the region are being reviewed. Oversight of POCD established within the 6 Goals for Urgent and Emergency Care workstream 3. A standardised regional process is required for monitoring and escalation of patients who have a length of stay of over 7 days to prevent them becoming delayed by our system.

Planned Care – as at February 2025, special cause improving variation continues, with:

- 638 new outpatient waits over 52 weeks, a reduction for the eighth consecutive month, ahead of trajectory (815) and the lowest breaches in over 4 years. 98.8% of patients waited less than 52 weeks for an outpatient appointment, showing continual improvement towards the TI de-escalation criteria of 100%. Delivery plan forecasts delivery of zero breaches by the end of March 2025.
- 829 Referral to Treatment (RTT) waits over 104 weeks, a reduction for four consecutive months and the lowest recorded in over three years, although trajectory (620) was not met. 99.1% of patients waited less than 104 weeks for RTT, showing continual improvement towards the TI de-escalation criteria of 100%. Whilst delivery plans across all specialties are in place to support treatment of all patients waiting 104 weeks by the end of March 2025, a residual delivery risk of circa 30 patients remains in orthopaedics despite additional internal, insource and outsource solutions being secured.
- 12,842 RTT waits over 52 weeks, the lowest since June 2023. 86.5% of patients waited less than 52 weeks for RTT and the TI de-escalation criteria of 80% continues to be met.
- 16,445 follow ups delayed over 100% of their target date. Whilst breaches remain below those recorded at the other large health boards, there has been minimal change in the overall volume of patients delayed beyond 100% year to date. All specialties are reviewing national Clinical Implementation Network (CIN) guidance, See On Symptoms (SOS)/Patient Initiated Follow Ups (PIFU) opportunities and validating those delayed the longest to help drive improvements.

Psychological therapy – the percentage of adults receiving a psychological therapy within 26 weeks is showing improving variation in the Integrated Psychological Therapies Service and Learning Disabilities with common cause variation in Adult Psychology. The overall trajectory for January 2025 was exceeded with compliance of 64.5% (target is 80%). Performance has dropped for the third consecutive month and by over 11% since October 2024. This is due to the scheduling of group sessions. Moving forward, the timetable for group interventions are being planned as 'rolling' groups rather than commencing and ending in blocks to prevent this dip in performance between groups.

Healthcare Associated Infections
Total S. aureus and C. difficile case numbers are higher to date than the same period in the last financial year. However, E. coli cases are fewer than the same period, last financial year.

- C. difficile infections – In month cases are showing expected (common cause) variation in February. 173 cases within the Health Board this financial year to date compared to 169 reported at the same point for 2023/24. Population rates per 100,000 are reducing. The TI de-escalation criteria of reducing hospital onset cases by 25% was met in February (4).

  An improvement group has been established with the Deputy Medical Director chairing. Continued use of DiffX and HPV disinfection, review of practices, hand hygiene audits, environmental audits and C. difficile transmission teaching provided to mitigate. Assurance meetings are held monthly on each site to review each hospital onset. Action plans developed with services focusing on Infection Prevention practice.

- E. coli infections - In month cases are showing expected (common cause) variation in February. Population rates per 100,000 increased slightly. The TI de-escalation criteria of reducing hospital onset cases by 25% was met in February (5). Continued education of staff around catheter and device care. Assurance meetings are held monthly on each site to review each hospital onset.

- S. aureus infections – in month cases are showing expected (common cause) variation in February. Population rates per 100,000 increased slightly. The TI de-escalation criteria of reducing hospital onset cases by 25% was not met in February (4). Peripheral vascular catheter bundle compliance monitored, with an emphasis on devices being removed at the earliest opportunity. Assurance meetings are held monthly on each site to review each hospital onset.

Assure (to note)
There is confidence that actions are robust and will be sufficient to address the issue or generally operating effectively. Routine monitoring.

Mental health – all part 1a and 1b measures for adults and children met target and trajectory in January 2025. All part 1a and 1b measures are showing improving variation with the exception of adult interventions starting within 28 days following assessment, which is showing expected (common cause) variation. The targeted Intervention de-escalation criteria of Local Primary Mental Health Support Services assessments undertaken; children and young people therapeutic interventions started within 28 days and those having a valid care treatment plan, continue to be met.

Personal Appraisal Development Review within 12 months: is showing improving variation. In February 2025, 83.65% compliance was achieved (target 85%). Continuous improvement has been made since our lowest compliance of 62% in April 2022.

Triangulating our data: February 2025

- Quality safety and risk – the number of incidents causing moderate harm or above reported by month continues to decrease since November 2024 (February 2025: 1,082). There were 186 patient falls, the lowest recorded to date. Medication errors decreased with 92 cases. We continue to have significant numbers of high and extreme risks on the risk register with 468 this month. Number of new complaints received by month have decreased since last month's spike of 188 to 130 in February. The number of new infection cases was 67, only 9 of which were C. difficile. The majority of new cases were E. coli (35) and S. aureus (14).
- Workforce – In month, staff sickness reduced slightly to 6.2% and long-term sickness to 4.0%. There was a small decrease in short term sickness 2.3%. Note: the sickness metric reported in the alert section of this SBAR includes 12 month rolling data. During February, nursing and midwifery agency usage continued to reduce, with 60.97 whole time equivalents (WTE), lowest rate recorded.
- Finance – Comparing February 2025 to February 2024, our agency spend reduced by 68% (£1.363m) and bank spend increased by 7% (£87k) during the same period.

Quality, safety and risk	Best	Worst	Latest	Trend
Reported incidents causing moderate harm or above	130	314	130	
Patient falls	186	302	186	
Medication errors	71	151	92	
Pressure damage developing or worsening during care	75	216	95	
New complaints by month received (ward level not available)	109	226	130	
Number of high and extreme risks (health board & directorate only)	381	492	468	
Infections: new cases	53	84	67	
Infections: C. difficile cases	9	23	9	
Workforce				
Number of staff/contractor related incidents	100	212	108	
Sickness - short term	1.7%	3.6%	2.3%	
Sickness - long term	3.3%	4.9%	4.0%	
Number of vacancies	To follow			
Staff turnover (12 month rolling)	7.3%	9.8%	8.1%	
Nursing and midwifery vacancies	To follow			
Nursing and midwifery agency (WTE)	101.43	379.79	101.43	
Bank (WTE)	212.99	352.85	318.13	
Financial recovery				
Agency spend	£645,019	£3,491,731	£645,019	
Bank spend	£872,933	£1,628,320	£1,340,584	

Escalation: February 2025

A summary of the internal escalation status of each of our directorates is included in the table below. Directorates have been assessed across the six domains of Quality, Governance, Workforce, Finance, Strategy and Planning, Fragile Services and Performance and Outcomes. The escalation assessment criteria can be found in Appendix A.

As outlined in the Situation section, the new Our Performance Improving Framework will be introduced for 2025/26. As part of the framework, escalation levels will be assigned at the new Clinical Care Group level from our month 1 IPAR report (May) onwards.

Escalation overview
February 2025

KEY

1 Reasonable assurance | 2 Limited assurance | 3 No assurance

	Directorate	Quality	Governance	Workforce	Finance, Strategy and Planning	Fragile Services	Performance & Outcomes
Director of Operations	Director of Operations	1	3	2	3	1	n/a
	Facilities	2	3	3	3	1	3
	Mental Health & Learning Disabilities	3	3	2	3	2	3
	Cancer & Oncology	1	1	2	3	1	3
	Pathology	1	3	2	3	2	n/a
	Radiology	2	1	2	3	3	3
	Planned Care (incl. Audiology and Endoscopy)	2	3	2	3	3	3
	Bronglais Hospital	2	3	2	1	2	3
	Glangwili Hospital	3	1	2	3	3	3
	Prince Philip Hospital	2	1	2	3	1	3
	Withybush Hospital	3	2	2	3	2	3
	Women & Children	2	3	2	3	2	3
Director of Primary, Community and LTC	Carmarthenshire County	2	1	2	3	1	3
	Ceredigion County	2	1	2	1	1	3
	Pembrokeshire County	2	1	2	3	1	3
	Primary Care	2	3	2	1	2	3
	Primary Care Management	1	1	2	1	1	n/a
	Medicines Management	1	2	2	3	2	n/a
Other	Director of Therapies and Health Sciences	2	1	2	3	1	3
	Director of Finance	1	2	2	1	2	n/a
	Director of Nursing	1	1	2	2	1	3
	Director of Public Health	1	1	2	1	1	2
	Director of Strategy and Planning	1	2	1	1	1	n/a
	Director of Workforce & OD	1	1	1	1	1	n/a
	Medical Directorate	1	3	1	1	1	n/a
	Corporate Services	1	1	2	1	1	n/a

Escalation changes from January 2025 to February 2025

Domain	Escalated up ↑	Escalated down ↓
Quality	Ceredigion County (now L2)	Bronglais Hospital (now L2) Prince Philip Hospital (now L2)
Governance	Bronglais Hospital (now L3) Director of Operations (now L3) Medical Directorate (now L3) Withybush Hospital (now L2)	Radiology (now L1)
Workforce	Cancer & Oncology (now L2)	-
Finance, Strategy and Planning	-	Director of Strategy and Planning (now L1)
Fragile Services	Radiology (now L3)	-
Performance & Outcomes	-	-

Our four directorates with the highest levels of escalation are Mental Health and Learning Disabilities, Planned Care, Glangwili Hospital and Facilities. The escalation levels and key points to note for each of these directorates are summarised below. Directorates with concerning levels of escalation (level 3s) are having monthly contacts with Executive Directors to discuss actions being taken to address the escalation issues. Corporate directorates are being asked by Executive Team members to support the challenged directorates where a need is identified.

Mental Health and Learning Disabilities

Since August 2024, the Mental Health and Learning Disabilities directorate had the highest level (3) of escalation across the 6 domains, with no change to escalation levels from the previous month.

Escalation domain	Jan 25	Feb 25	Change	Notes
Quality	3	3	↔	60% escalation assurance. Overdue HIW and peer review actions need to be addressed. Incidents and complaints need to be managed more efficiently.
Governance	3	3	↔	Audit and inspection recommendations need to be implemented within timescales.
Workforce	2	2	↔	High levels of sickness and turnover, overdue pay progressions and job planning compliance need to be addressed.
Finance, Strategy & Planning	3	3	↔	Recurrent savings needs to be identified.
Fragile Services	2	2	↔	Robust plan needed for ASD and inpatient services.
Performance and Outcomes	3	3	↔	ASD performance continues be significantly below target.

Planned Care

The Planned Care directorate are on level 3 escalation overall for 4 domains for the fifth consecutive month, however 2 measures within the performance domain have been de-escalated to level 2 i.e. patients waiting over 52 weeks for a new outpatient appointment and waits over 104 weeks from referral to treatment.

Escalation domain	Jan 25	Feb 25	Change	Notes
Quality	2	2	↔	73% escalation assurance. Areas that need to be addressed: incidents open over 120 days, and complaints open over 30 days and awaiting comments from service.
Governance	3	3	↔	Improvement needed in compliance for completing audit and inspection actions. Directorate also need to ensure 90% of Welsh Health Circulars implemented within timescale.
Workforce	2	2	↔	Improved compliance needed for PADRs, sickness, mandatory training, staff turnover, overdue pay progressions and job planning.
Finance, Strategy & Planning	3	3	↔	Directorate need to deliver a balanced position by year end and 5% recurrent savings.
Fragile Services	3	3	↔	More sustainable plans required for: critical care (PPH), emergency general surgery (WGH & GGH), ophthalmology consultant on-call rota, anaesthetics medical workforce, provision of 7 day a week Trauma unit (GGH).
Performance and Outcomes	3	3	↔	R1 eye care and delayed follow-up appointments = level 3. 52 weeks for a first outpatient and 104 weeks from referral to treatment have been de-escalated to level 2.

Glangwili Hospital

No significant change since last month, the directorate is in level 3 escalation for 4 out of the 6 domains.

Escalation domain	Jan 25	Feb 25	Change	Notes
Quality	3	3	↔	59% escalation assurance. Areas for improvement: incident management, complaint management and timely investigation and learning demonstrated from pressure damage and medication errors
Governance	1	1	↔	
Workforce	2	2	↔	Improved compliance needed for PADRs, sickness, turnover, outstanding pay progressions and job planning.
Finance, Strategy & Planning	3	3	↔	Directorate need to deliver a balanced position by year end and 5% recurrent savings.
Fragile Services	3	3	↔	A&E staffing: plan needed for more resilient medical staffing.
Performance and Outcomes	3	3	↔	Improvements needed in ambulance handover delays and reducing the number of patients waiting over 12 hours in A&E.

Facilities and Estates

No significant change since last month, the directorate is in level 3 escalation for 4 out of the 6 domains.

Escalation domain	Jan 25	Feb 25	Change	Notes
Quality	2	2	↔	88% escalation assurance Internal audit actions need to be completed and overdue HIW actions need to be addressed and closed.
Governance	3	3	↔	Audit and inspection recommendations need to be implemented within timescales. Governance arrangements need to be strengthened within the directorate.
Workforce	3	3	↔	Improvements needed for PADRs, mandatory training, sickness, turnover and pay progressions.
Finance, Strategy & Planning	3	3	↔	Directorate need to deliver a balanced position by year end and 5% recurrent savings.
Fragile Services	1	1	↔	
Performance and Outcomes	3	3	↔	Consistent cleaning audits need to be undertaken across all sites and targets achieved, particularly in high-risk areas.

Argymhelliad / Recommendation

The Board is asked to **DISCUSS** the IPAR – Month 11 2024/25 report and to **SEEK ASSURANCE** on the operational delivery of mitigating actions to improve performance in the areas that have been categorised as ‘alert’.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Risks are outlined throughout the report
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	7. All apply
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	6. All Apply
Amcanion Strategol y BIP: UHB Strategic Objectives:	All Strategic Objectives are applicable
Amcanion Cynllunio Planning Objectives	All Planning Objectives Apply
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022	9. All HDdUHB Well-being Objectives apply

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	2024/2025 NHS Performance Framework
Rhestr Termau: Glossary of Terms:	A&E – Accident and Emergency BGH – Bronglais General Hospital ED – Emergency Department GGH – Glangwili General Hospital IPAR – Integrated Performance Assurance Report MIU – Minor Injury Unit PPH – Prince Philip Hospital PODCC – People, Organisational Development and Culture Committee SDODC – Strategic Development and Operational Delivery Committee SRC – Sustainable Resources Committee WAST – Welsh Ambulance Services University NHS Trust WGH – Withybush General Hospital
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol:	Operations, Finance, Performance, Quality and Safety, Nursing, Information, Workforce, Mental Health, Therapies and Primary Care

Parties / Committees consulted prior to University Health Board:	Strategic Development and Operational Delivery Committee People, Organisational Development and Culture Committee Sustainable Resources Committee

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	Better use of resources through integration of reporting methodology Integrated Impact Assessment Template
Ansawdd / Gofal Claf: Quality / Patient Care:	Use of key metrics to triangulate and analyse data to support improvement. Integrated Impact Assessment Template
Gweithlu: Workforce:	Development of staff through pooling of skills and integration of knowledge Integrated Impact Assessment Template
Risg: Risk:	Better use of resources through integration of reporting methodology Integrated Impact Assessment Template
Cyfreithiol: Legal:	Better use of resources through integration of reporting methodology Integrated Impact Assessment Template
Enw Da: Reputational:	A number of our national performance measures have been showing concerning trends over a period of time. The SBAR outlines the issues impacting our capacity, which has subsequent impact on our performance. Over time, there is potential for our performance to have an adverse impact on our reputation as a health board, which then may impact recruitment and staff morale. Integrated Impact Assessment Template
Gyfrinachedd: Privacy:	N/A Integrated Impact Assessment Template
Cydraddoldeb: Equality:	N/A Equality Impact Assessment

Appendix A: Escalation criteria

	Quality	Governance	Workforce	Finance, Strategy & Planning	Fragile Services	Performance & Outcomes
	Director of Nursing	Director of Corporate Governance	Director of Workforce and OD	Director of Finance Director of Strategic Planning	Director of Strategic Planning Director of Nursing	Director of Operations
Level 1	**Reasonable assurance that there are no significant concerns within the directorate.**					
Level 2	**Limited assurance that the directorate:**					
	Is managing the following issues appropriately, in terms of the scale, significance, timeliness and quality of response: 1. Incidents 2. Concerns 3. Complaints 4. Medical Examiner 5. Duty of Candour 6. HIW/CIW 7. Quality and Equality Impact assessments (where applicable)	Is managing the following issues appropriately, in terms of the scale, significance, timeliness and quality of response: 1. Risks 2. Audits / inspections / WHCs / Ministerial Directions 3. Board / Committee actions 4. FoI and corporate correspondence 5. Policies (where applicable)	Is managing the following issues appropriately, in terms of the scale, significance, timeliness and quality of response: 1. Bullying and harassment, difficult working relationships or complaints 2. Sickness 3. PADRs 4. Turnover 5. Mandatory training 6. Career development 7. Rosters & job plans	Will: 1. Operate within budget or deliver a recovery plan which will return to budget in year. 2. Identify and delivery recurrent savings to the level required. 3. Has a triangulated plan to operate services effectively for the year.	Will manage the risk of a service failure occurring within the next six months through robust mitigating plans.	Will achieve target performance, with the trajectory missed for over 2 months.
Level 3	**No assurance that the directorate:**					
	Is managing the following issues appropriately, in terms of the scale, significance, timeliness and quality of response: 1. Incidents 2. Concerns 3. Complaints 4. Medical Examiner 5. Duty of Candour 6. HIW/CIW 7. Quality and Equality Impact assessments (where applicable)	Is managing the following issues appropriately, in terms of the scale, significance, timeliness and quality of response: 1. Risks 2. Audits / inspections / WHCs / Ministerial Directions 3. Board / Committee actions 4. FoI and corporate correspondence 5. Policies (where applicable) 6. Quality governance	Is managing the following issues appropriately, in terms of the scale, significance, timeliness and quality of response: 1. Bullying and harassment, difficult working relationships or complaints 2. Sickness 3. PADRs 4. Turnover 5. Mandatory training 6. Career development 7. Rosters & job plans	Will: 1. Operate within budget or deliver a recovery plan which will return to budget in year. 2. Identify and delivery recurrent savings to the level required. 3. Has a triangulated plan to operate services effectively for the year.	Will manage the risk of a service failure occurring within the next six months through robust mitigating plans.	Will achieve target performance, with the target and improvement trajectory being consistently missed.

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

Our Improving Together Framework

March 2025

Contents

1. Introduction

Our Improving Together Framework sets out our approach to embedding performance improvement through our organisation. The framework is enabled by data at every level to support decision making and to drive service change with the ultimate aim of improving outcomes for our patients, staff and our population. Its successful implementation will help us to focus on what is important and enable us to provide services which are effective and efficient.

Improvements will be focused around seven key domains:

- Quality and safety
- Governance
- Workforce
- Finance
- Strategy, planning and fragile services
- Population health
- Performance and outcomes

See section *3. Improvement domains* for further details.

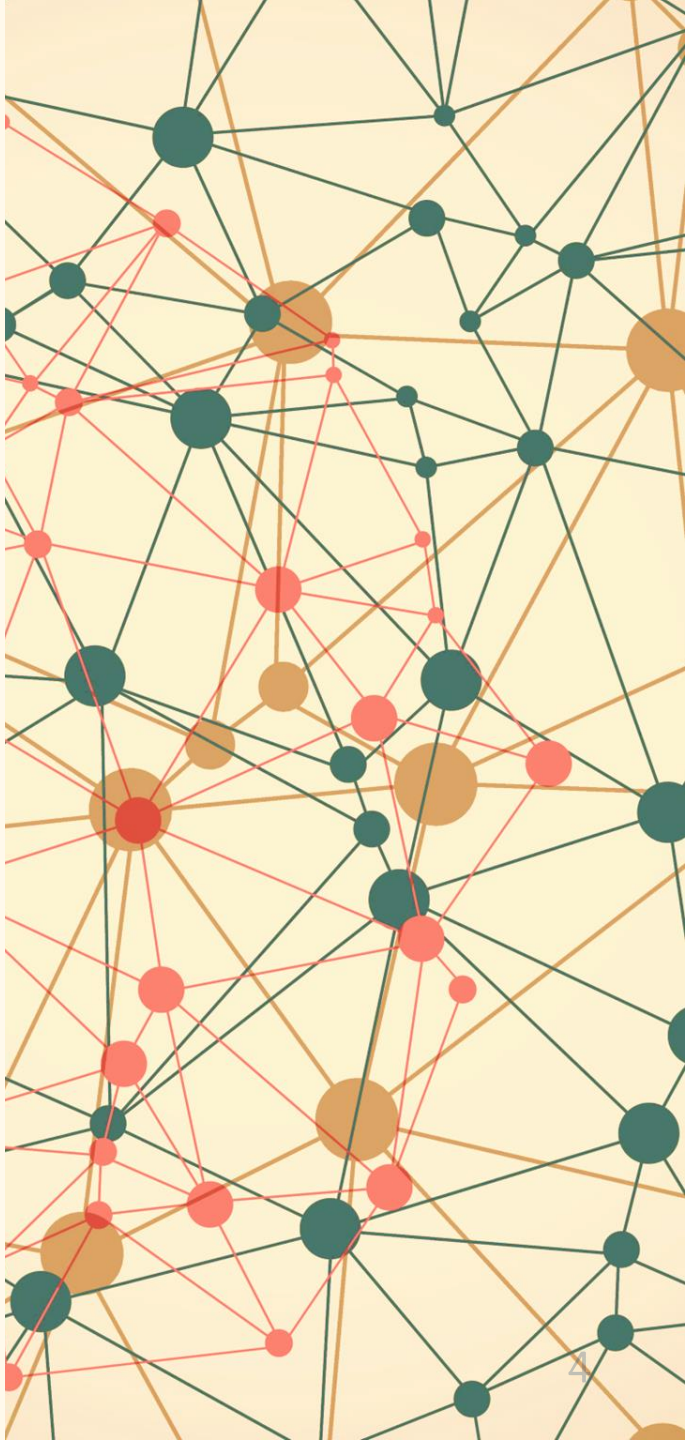
This framework applies to staff working across our whole organisation. We all have a role to play in identifying opportunities for improvement, and in enacting them. Managers must take an active lead to review their performance and implement improvement actions when needed. Staff need to work together to improve services, outcomes and health for patients, staff and our population.

Owner	Executive Director of Finance
Owning group	Integrated Quality, Finance and Performance Delivery Group

2. Aims

The Our Improving Together Framework aims to:

- Provide clarity on the performance improvement arrangements and roles and responsibilities at all levels within our organisation.
- Assess performance against key metrics and trajectories. Areas where we must deliver improvement are outlined in the NHS Wales Performance Framework and Planning Framework.
- Focus resources and improvement efforts in required areas to enable us to achieve our objectives.
- Provide alignment between performance, planning, value, activity, quality, workforce, risk management and finance to identify areas of improvement
- Use our data to allow for early and rapid triangulation and resolution of issues from a variety of sources, including quality data, patient and staff feedback.
- Provide an opportunity to listen and learn from teams throughout the organisation and identify key steps to enact change to improve our services and patient experience.



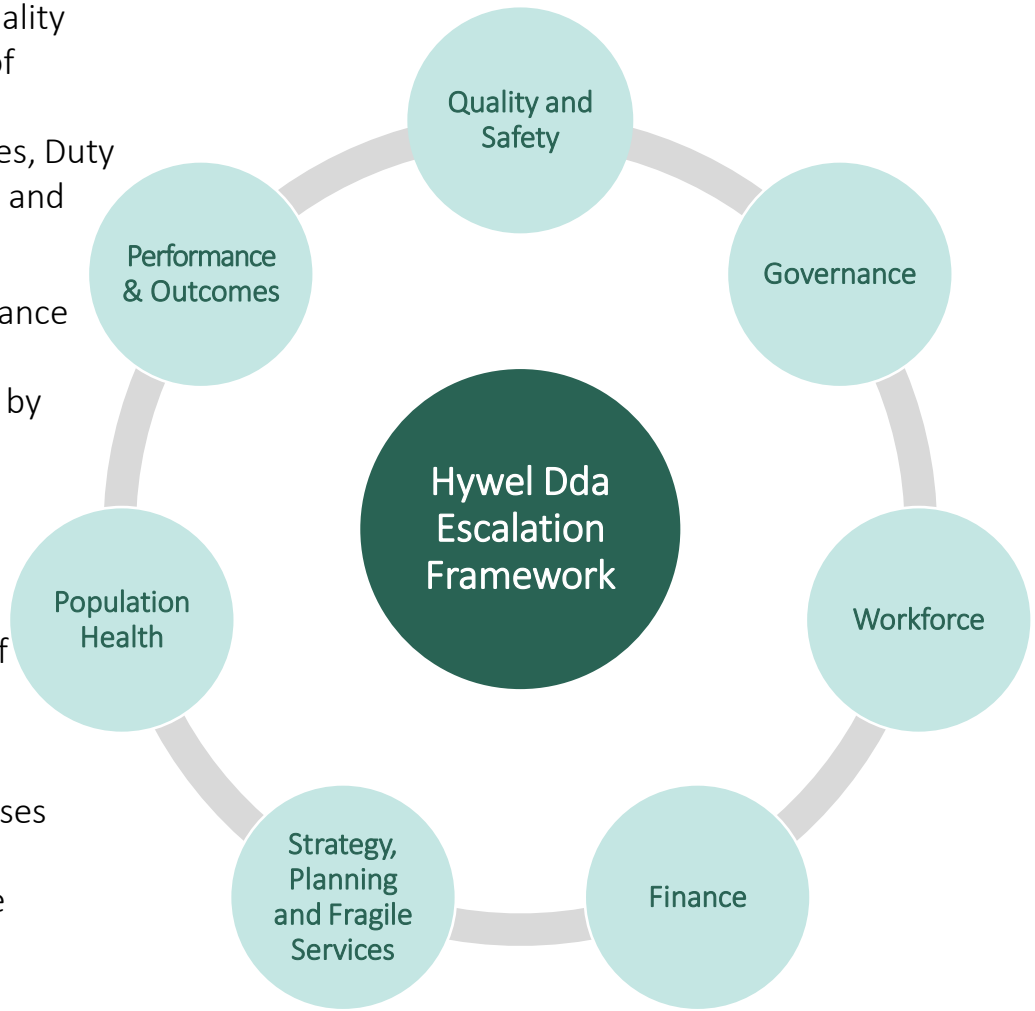
3. Improvement domains

Quality and Safety: Focuses on the level of quality assurance which is calculated using a range of quality and safety metrics e.g. patient safety incidents, complaints, medical examiner issues, Duty of Candour, deteriorating patients, infections and patient satisfaction.

Performance & Outcomes: Evaluates performance against key targets and agreed improvement trajectories. Escalation levels are determined by the extent of underperformance and the effectiveness of recovery plans.

Population Health: Determines if opportunities are being taken to encourage patients to embrace healthier lifestyles, and if we are resilient as an organisation to future challenges.

Strategy, Planning and Fragile Services: Assesses if a triangulated plan is available to operate services effectively for the year. Evaluates the sustainability and resilience of services, considering factors such as staffing, patient safety, and service continuity. Escalation levels are based on the level of risk to service delivery and the effectiveness of mitigating actions.



Governance: Assesses the effectiveness of quality governance, risk management, audit and inspection compliance, and decision-making processes. Escalation levels are determined by the regularity and quoracy of meetings, outstanding actions, and the timeliness of policy updates.

Workforce: Evaluates sickness absence rates, employee relations cases, mandatory training compliance, and adherence to the career framework. Escalation levels are based on the number of unresolved employment issues e.g. relation cases, pay progression, sickness absence rates, and compliance with training and career development requirements.

Finance: Focuses on financial performance, including overspend, budget management, and the credibility of recovery plans. Escalation levels are determined by the extent of overspend, the robustness of financial plans, and the effectiveness of savings initiatives.

4. Accessing key data and resources

Key data resources

Data is a key enabler for performance improvement. We can use our data to take positive action to improve.

- Our Performance dashboard - brings together performance, activity, quality, workforce, risk and finance information. This allows for rapid triangulation of data.
- Our Safety dashboard - helps to identify potential patient safety issues, triangulate data at an operational level, support deep dives, compare directorates, services and wards/teams and identify any concerning outliers.
- Integrated Performance Assurance Report (IPAR) dashboard - we have identified key areas where we want to make improvements and areas where we are doing well and want to maintain this or make further improvements. The IPAR dashboard shows our progress against these key areas.
- Board Assurance Framework (BAF) dashboard (accessible through the Board papers) - outlines the key outcomes and proxy indicators aligned to each strategic objective.
- Information Reporting Intelligence System (IRIS) - is the front door to the data held by our Information Services teams.

We are working on further dashboards: including, “Our activity”; “Our productivity”; “Our outcomes” and “Our population health”. We hope these will be available by Summer 2025.

Other useful resources

- Problem solving tools – teams are encouraged to use problem solving tools to break down any problem and help find ways to resolve.
- NHS Wales performance framework 2025 to 2026 – sets out Welsh Government’s key strategic priorities for NHS Wales in 2025/26.
- NHS Wales planning framework 2024 to 2027 – defines Welsh Government’s planning expectations from NHS Wales for 2024-2027.

5. Health board structure

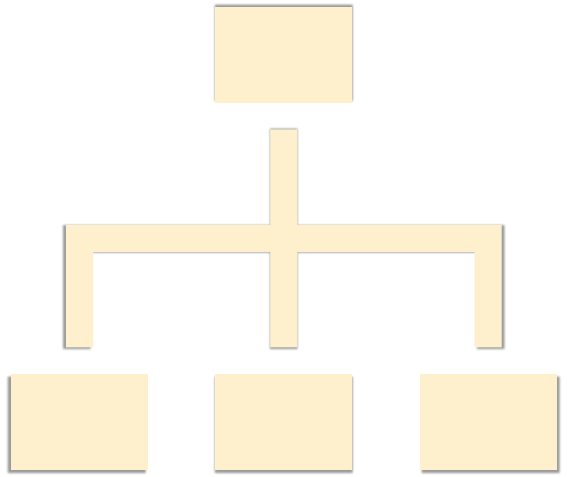
There are 9 Executive Directorates within the health board:

- Chief Executive
- Chief Operating Officer
- Executive Director of Nursing, Quality and Patient Experience
- Executive Medical Director
- Executive Director of Allied Health Professions and Health Science
- Executive Director of Public Health
- Executive Director of Workforce and Organisational Development
- Executive Director of Finance
- Executive Director of Strategy and Planning

Due to the breadth of areas covered by the Chief Operating Officer's portfolio, the directorate has been further divided into seven Clinical Care Groups:

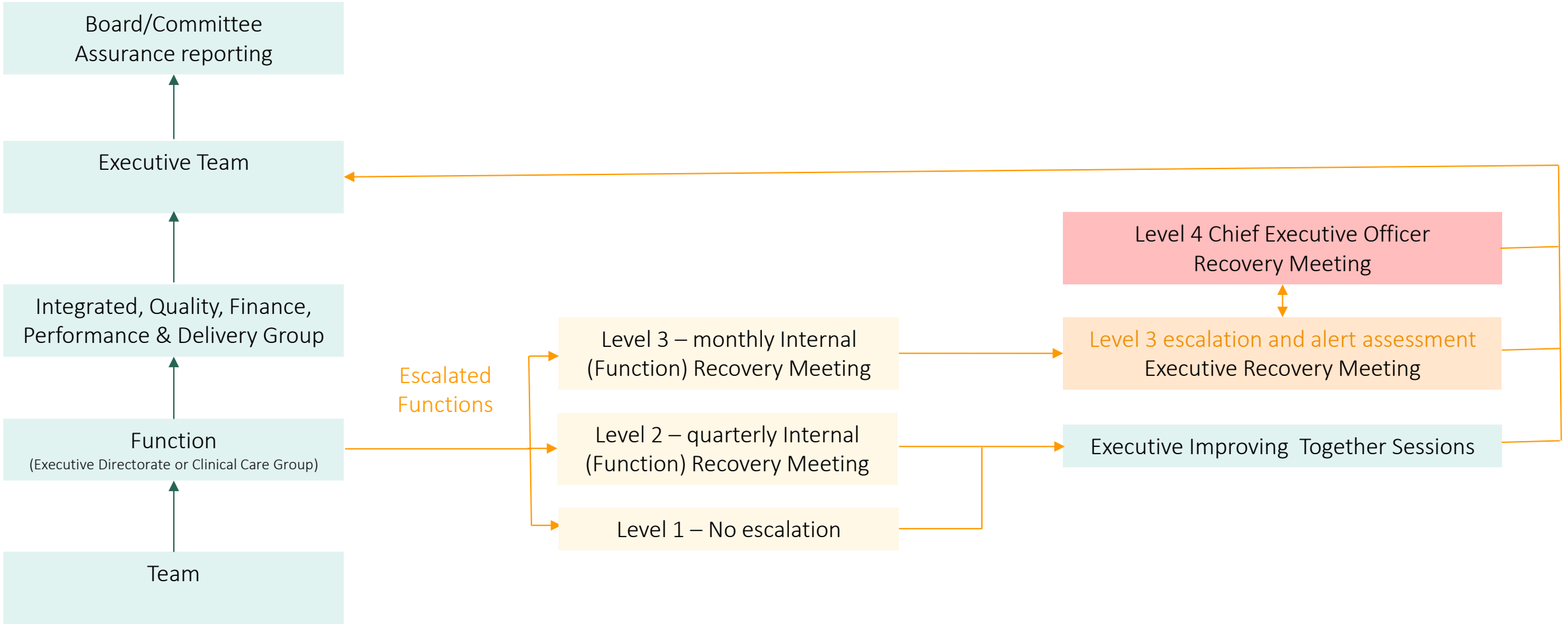
- Estates & Facilities
- Mental Health & Learning Disabilities
- Community & Integrated Medicine
- Operational Allied Health & Health Science
- Planned & Specialist Care
- Primary Care, Community Strategy and Long Term Care
- Chief Operating Officer Management
  (Pending changes to reallocate responsibilities)

Note: the term 'function' is used in this document to mean Executive Directorate or Clinical Care Group.



6. Governance and reporting

The organogram shows the health board's performance improvement and escalation governance arrangements feeding into Executive Team, Committee and Board.



7. Compassionate leadership

CORE PRINCIPLES

Presence and attentiveness
Be fully present and attentive when interacting with team members. Listen actively to understand their perspectives, concerns, and needs.

Empathy and insight
Strive to understand the experiences, emotions, and challenges faced by team members. This involves putting oneself in their shoes and appreciating their viewpoints.

Emotional connection
Connect emotionally with team members, showing genuine care and concern for their well-being. This helps build trust and strengthens relationships.

Support and assistance
Actively help team members by providing the necessary resources, support, and encouragement. This includes removing obstacles that hinder their performance and growth.

HOW WE IMPLEMENT

- **Create a supportive environment:** Foster a culture of support, where team members feel valued and understood. Encourage open communication and psychological safety, allowing staff to express concerns without fear of judgment.
- **Develop a shared vision:** Collaborate with team members to create a shared vision and common goals. Ensure that the vision aligns with the values and mission of the organisation.
- **Empower and develop others:** Provide opportunities for professional growth and development. Empower team members by delegating responsibilities and encouraging autonomy.
- **Promote collaboration and teamwork:** Encourage teamwork and collaboration across different departments and levels. Facilitate cross-functional projects and initiatives to build a sense of unity and collective purpose.
- **Recognise and appreciate contributions:** Regularly acknowledge and celebrate individual and team achievements. Show appreciation for the hard work and dedication of team members.
- **Balance compassion with accountability:** Maintain high standards and accountability while being compassionate and understanding. Address performance issues constructively, focusing on solutions and improvement rather than blame.

BENEFITS

Enhanced well-being
Improves the overall well-being and job satisfaction of employees.

Increased engagement
Boosts employee engagement, motivation, and commitment to the organisation.

Better performance
Leads to higher levels of performance and productivity.

Stronger relationships
Fosters stronger, more trusting relationships between leaders and team members.

Positive culture
Cultivates a positive and supportive organisational culture that attracts and retains talent.

8a. Performance improvement arrangements
Board and committees

Board

- The Board is responsible for setting the strategy, allocating resources, setting the organisational leadership tone, and for gaining assurance that our performance meets the requirements of our strategy.
- The Board has overall oversight of our performance.
- The Board Assurance Framework outlines the key outcomes and proxy indicators that we are planning to achieve as a health board. They provide an understanding of whether our actions as a health board are having the desired impact on the Strategic Objectives. The Board Assurance Framework is presented to Board three times a year.
- The Board and key committees also review the Integrated Performance Assurance Report (IPAR) monthly, alternating between Committee and Board. The IPAR outlines our performance against key national and locally agreed performance indicators. The national performance indicators are outlined in the NHS Wales Performance Framework (see section 4. Accessing key data and resources for more details).

Committees

Committees hold a governance/assurance role on behalf of the Board and scrutinise areas of concern, escalating those which need to be drawn to the Board's attention.

Reported to	Board	Board/Committee
Report name	Board Assurance Framework (BAF)	Integrated Performance Assurance Report (IPAR)
Purpose	Monitors progress against our strategic objectives and outcomes	Outlines our performance against key national and locally agreed performance indicators
Frequency	Every 4 months (March, July and November)	Monthly, alternating between Board and Committee
Supporting tools	• BAF dashboard	• IPAR dashboard • Our Performance dashboard • Our Safety dashboard

8b. Performance improvement arrangements
Executive Team

Role of the Executive Team

The key responsibilities of the Executive Team include, but are not limited to, providing strategic leadership, ensuring the health board operates within its budget, improving the quality of care provided, creating a positive work environment for staff and effective communication with stakeholders e.g. other health boards, Welsh Government, staff, patients and the public.

Chief Executive Officer

The Chief Executive Officer is responsible for the overall management of the organisation including ensuring that financial and quality of service responsibilities are achieved within available resources and identifying opportunities for improvement and ensuring those opportunities are taken.

Board Assurance Framework (BAF)

The Executive Team will review the BAF prior to Board meetings. This will provide an opportunity to consider the key data presented in the BAF and have a discussion around what actions need to be implemented to achieve our strategic objectives. The following will be discussed as part of the review:

- Measures: are they are moving in the right direction
- Principal Risks: Review risks and their mitigation
- Discuss the need for further planning objectives to address any matters arising from the measure or risk discussion, to ensure we continue to progress towards our strategic objectives

Other Executive Team members

- The Director of Finance is the named Executive Director with responsibility for establishing and managing the performance framework.
- Each Executive Team member is responsible for delivering their performance targets within their respective directorates. They will also chair their own Executive Improving Together Session(s) – see section 8e. Functions for more details.
- Executive leads for each of the 7 domains detailed in section 3 are:
  - Governance: Director of Corporate Governance/Board Secretary
  - Quality and safety: Director of Nursing, Quality and Patient Experience
  - Workforce: Director of Workforce and Organisational Development
  - Finance: Director of Finance
  - Strategy, planning and fragile services: Director of Strategy and Planning
  - Population health: Director of Public Health
  - Performance and outcomes: Chief Operating Officer

8c. Performance improvement arrangements

Integrated Quality, Financial Performance and Delivery Group

The Integrated Quality, Financial, Performance and Delivery (IQFPD) Group is a subgroup of the health board's Executive Team. The purpose of IQFPD is to ensure the effective planning and delivery of all elements of the Health Board's Annual Plan, and oversee delivery and performance across the organisation, including the associated risks and issues, within a robust operational governance framework.

Key responsibilities

- Consider themes and issues that arise through the health board's performance review process (EITS and Recovery Meetings). This includes consideration of any support requirements for services and teams, as well as reviewing the format of those sessions.
- Where a Corporate Directorate or Clinical Care Group (function) is not delivering against the national/Health Board target for any of the management metrics set (see Appendix A for more details), these will be flagged as part of the health board's escalation process (see section 9. Escalation for further details).
- To oversee the setting of the improvement trajectories by Corporate Directorates and monitor accordingly.

Membership

- Chief Operating Officer (Chair)
- Executive Director of Allied Health Professionals and Health Science (Vice-Chair)
- Executive Director of Strategy and Planning
- Executive Medical Director
- Executive Director of Nursing, Quality and Patient Experience
- Executive Director of Finance
- Deputy Director of Finance
- Associate Director of People Management
- Director of Primary Care, Community Strategy and Long Term Care
- Director of Operational Planning & Performance
- Deputy Chief Operating Officer
- Planned and Specialist Care Clinical Care Group Service Director
- Mental Health & Learning Disabilities Clinical Care Group Service Director
- Community and Integrated Medicine Clinical Care Group Service Director
- Allied Health and Health Science Clinical Care Group Service Director
- Primary Care Clinical Care Group Service Director
- Estates and Facilities Group Service Director
- Assistant Director of Assurance & Risk
- Head of Performance
- Targeted Intervention Programme Lead

8d. Performance improvement arrangements

Executive Improving Together Sessions

Executive Improving Together Sessions (EITS) ensure that each function (executive directorate and clinical care group) across the health board are making progress towards their key priorities and support is provided to help unblock issues where needed. EITS are held twice each financial year (June and November). The sessions provide dedicated time for function leads to meet with their Executive Director and Corporate Executive Directors to:

- Outline the priorities/goals for the year, in line with the annual plan.
- Outline current challenges and support required.
- Flag data insights (highlights or lowlights) for the health board's key performance metrics. See Appendix A for further details.

Membership

- Chair – Executive Team member with responsibility for the function being reviewed
- Executive Team
  - Director of Finance (executive lead for Performance)
  - Chief Operating Officer
  - Director of Nursing, Quality and Patient Experience
  - Director of Workforce and OD
  - Medical Director/Deputy CEO
  - Director of Strategy and Planning
  - Director of Corporate Governance/Board Secretary

  There is an open invitation to all other Executives who would wish to attend as appropriate. A minimum of 3 Executive Directors (or their nominated deputies) is required for each session to be quorate.
- Function senior managers and clinical leads
- Finance Business Partners
- Performance Team – also responsible for facilitating the sessions

Purpose	Monitor each the progress for each Function (Executive Directorate/Clinical Care Group) against the health board's key priorities and address any areas of concern.
Frequency	Six-monthly (June and November)
Supporting tools	• IPAR dashboard • Our Performance dashboard • Our Safety dashboard

3A assessments

During the EITS meetings, the Chair in consultation with Executive Team colleagues (or their nominated deputies), will assign one of the following assessments for each agenda item:

Assure	To note	There is confidence that actions are robust and will be sufficient to address the issue or generally operating effectively. Routine monitoring.
Advise	To monitor	There are areas of concern where assurance has been taken on actions in place but requires close monitoring. An early warning of an emerging and potentially serious concern.
Alert	May require discussion	There is a lack of confidence that any action in place is sufficient to address the issue satisfactorily and/or within the scope of the operational team or executive to resolve. Engagement, action or intervention required.

For further details on EITS, see the supporting EITS - Ways of Working document (health board staff only).

8e. Performance improvement arrangements

Functions (Executive Directorates and Clinical Care Groups)

The director or nominated deputy within each function (executive directorate and clinical care group) is responsible for meeting regularly with service leads, monitoring performance and working with staff to unblock issues and drive forward improvements.

Setting expectations

The function's senior management must encourage all teams to set their vision, identify key improvement metrics, hold regular improvement meetings, take action to solve problems and to share successful ideas with other teams across the health board.

Function Recovery Meetings

If a function is escalated in any of the 7 key improvement domains, the function's director or nominated deputy are required to hold monthly recovery meetings. For further details on escalation and recovery meetings, see section 9. Escalation.

8f. Performance improvement arrangements

Our Teams

Each team, ward and service across the health board is required to:

Set their team vision

Identify the team's vision and goals and consider how they align to the health board's strategic objectives.

Identify improvement metrics

Set key improvement metrics aligned to their vision and utilise data and information to identify opportunities for improvement.

Hold improvement meetings

Provide an opportunity for teams to come together and have regular improvement and problem-solving discussions, utilising a coaching style approach to probe the data, develop solutions and embed continuous improvement.

Problem solve

Teams are empowered and have the autonomy to test new improvement ideas and monitor the impact. Examples of improvement tools can be found via this link.

Adopt and share

Learn and share ideas and initiatives with other teams across the health board.

9. Escalation

Each month, the lead Executive Director for each domain (or their nominated deputy) will review the progress of each function (Executive Directorate or Clinical Care Group) against the key improvement metrics for that domain (see Appendix A for details).

Lead Executive Director for each domain

- Governance: Director of Corporate Governance/Board Secretary
- Quality and safety: Director of Nursing, Quality and Patient Experience
- Workforce: Director of Workforce and Organisational Development
- Finance: Director of Finance
- Strategy, planning and fragile services: Director of Strategy and Planning
- Population health: Director of Public Health
- Performance: Chief Operating Officer

Escalation levels

The lead Executive (or nominated deputy) will assign one of the escalation levels below for their domain for each function. Function leads can replicate internally the escalation process for each of their services/teams if they so wish.

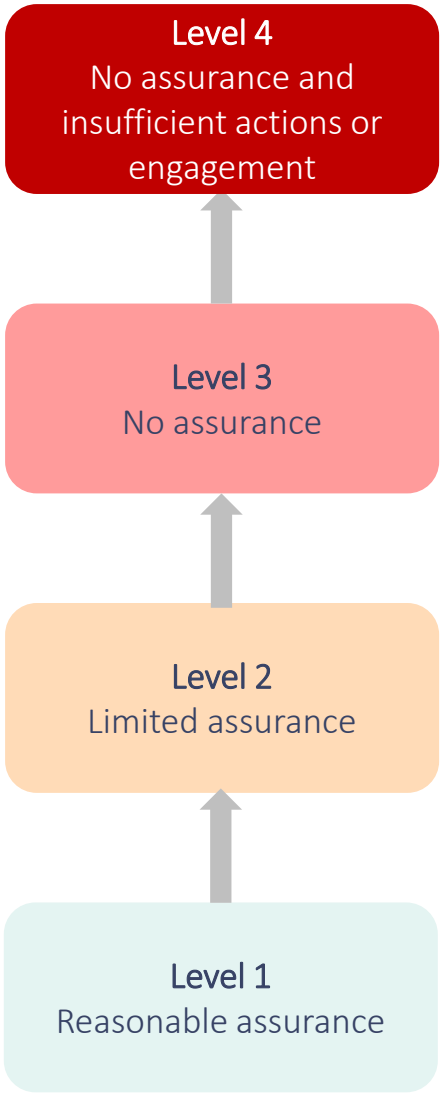
Level 1: Reasonable assurance that the function can meet prescribed targets in a given domain within the year

Level 2: Limited assurance that the function can meet prescribed targets in a given domain within the year

Level 3: No assurance that the function can meet prescribed targets in a given domain within the year OR insufficient engagement with Targeted Intervention objectives

Level 4: No assurance that the function can meet prescribed targets in a given domain within the year, with insufficient actions or engagement in place to secure recovery

Escalation expectations



For Level 4, the Executive for the escalated function alongside the triumvirate senior management for a Clinical Care Group and the Domain Lead Executives will attend a one-off **Chief Executive Officer CEO Recovery Meeting** with the Chief Executive, supported by the Director of Finance as the Executive Lead for performance to determine next steps.

For Level 3, Level 1 is supplemented by:

- A monthly **Internal Recovery Meeting** held within the function. Chaired by the Executive Director with Deputy Director support from Domain Leads. This will determine a 3A assessment (see page 14 for details), with areas in Alert escalated to a meeting with the Executives.
- A monthly **Executive Recovery Meeting** with Domain Lead Executives. The Executive Director for the escalated function will attend alongside selected colleagues from the function. Executive support for recovery will be sought. This meeting will be chaired by the Director of Finance as lead for performance.

For Level 2, Level 1 is supplemented by quarterly **Internal Recovery Meetings** held within the function. These will be Chaired by the Executive Director for the escalated function, with Deputy Director support from Domain Leads.

At Level 1, each function will have twice yearly **Executive Improving Together** meetings (EITs). The sessions will be chaired by the Executive Director for the function.

Targeted Intervention non-compliance

In 2024, the health board was escalated into Targeted Intervention (escalation level 4) by Welsh Government. This highlights Welsh Government's concerns on the ability of the organisation to deliver safe and effective care within our given resources. Unless improvement actions are taken to meet the de-escalation criteria given to us by Welsh Government, the health board will be placed into special measures, level 5 of the national escalation framework.

If a function repeatedly fails to submit or implement their required Targeted Intervention actions, they will automatically be escalated to Level 3 (no assurance) and will need to added a monthly Executive Recovery meeting. If no improvement is seen in the next cycle of Targeted Intervention updates, the function will be escalated to a Level 4 CEO (or deputy CEO) Recovery meeting.

Executive Recovery Meetings

Executive Recovery Meetings are only needed for functions at Level 3 escalation and assigned an Alert assessment from their Internal Recovery Meeting or are non-compliant with Targeted Intervention actions.

A register will be developed of temporary support (e.g. project management, analysis, digital) that can be made available from existing staff to help functions unblock issues.

For further details on the escalation process, see the supporting Escalation - Ways of Working document (health board staff only).

Membership

- Chair - Director of Finance (Executive lead for Performance)
- Executive Team
  - Chief Operating Officer
  - Director of Nursing, Quality and Patient Experience
  - Director of Workforce and OD
  - Medical Director
  - Director of Strategy and Planning
  - Director of Corporate Governance
  - Targeted Intervention (TI) Programme Lead

  Open invitation to all other Executives who want to attend as appropriate. A minimum of 3 Executive Directors (or their nominated deputies) is required for each session to be quorate.
- Function senior managers and clinical leads
- Other corporate support as required by the function
- Performance Team – also responsible for facilitating the sessions

Function Recovery Meetings

If a function is escalated in any of the 7 key improvement domains, the function's director or nominated deputy are required to hold Function Recovery Meetings to identify exactly where the issues are within the function, reasons the issues have occurred, and actions being taken to address.

Functions at level 2 escalation will need to hold quarterly recovery meetings.

Functions and level 3 escalation will hold monthly recovery meetings. During the meeting, each escalated item must be given a 3A assessment (assure, advise alert – see p.14 for further details). Areas having an assure or advise assessment will continue to be reviewed and managed within the function. However, areas with an alert assessment will be referred for a discussion with Executive Team members at an Executive Recovery meeting.

Appendix A – key performance metrics for our improvement domains

Quality & Safety	Governance	Workforce	Finance	Strategy, Planning and Fragile Services	Population Health	Performance and Outcomes
Assurance the directorate is managing the following appropriately, in terms of the scale, significance, timeliness and quality of response: 1. Incidents 2. Complaints 3. Duty of Candour 4. HIW/CIW 5. Deteriorating patients 6. Patient experience	Assurance the directorate is managing the following appropriately, in terms of the scale, significance, timeliness and quality of response: 1. Risks 2. Audits/ inspections 3. WHCs/ Ministerial Directions 4. Governance arrangements 5. Policies 6. Freedom of information	Assurance the directorate is managing the following appropriately, in terms of the scale, significance, timeliness and quality of response: 1. Employee relations cases 2. Sickness 3. PADRs 4. Turnover 5. Mandatory training 6. Overdue pay progressions 7. Rosters & job plans (includes agency use)	Assurance the directorate will: 1. Operate within budget or deliver a recovery plan which will return to budget in year. 2. Identify and delivery recurrent savings to the level required.	Assurance the directorate will manage the risk of a service failure occurring within the next six months through robust mitigating plans. Has a triangulated plan to operate services effectively for the year.	Determines staff if opportunities are being taken to encourage patients to embrace healthier lifestyles or to ensure that our population is resilient to future challenges.	Assurance the directorate will meet improvement trajectories to achieve target performance.