ARAC – 11th February 2025

Targeted Intervention Progress Report

Introduction

Key Highlights

- **Positive TI Audit -** The recent internal audit of Targeted Intervention arrangements provides assurance that the Health Board governance and oversight is reasonable. Furthermore, there are only 2 recommendations with 1 recommendation expected to be closed imminently.
- **Robust Governance -** The organisation has well-established reporting structures, ensuring that both progress and any lack of delivery are clearly highlighted and escalated.
- **Alignment with Welsh Government Feedback -** Our self-assessment of TI criteria is closely aligned to Welsh Government observations, demonstrating a consistent understanding of risks and progress.
- **Capacity/Capability Note -** Despite the robust governance frameworks, there remains a risk linked to resourcing the escalation role, currently reliant on a single individual.
- **Next Maturity Matrix Review -** Following last year's self-assessment in Q4 2023–24, the next full review of governance maturity is planned for Q4 2024–25 to align with end-of-year progress on the annual plan

Criteria 36 - Effective Oversight and Scrutiny

Reporting Group: TI Coordination Group | **Committee**: ARAC | **Status**: Assure **Executive Lead**: Joanne Wilson

- **Summary of Current Status/Positive Audit Note -** Internal Audit findings confirm the Board and Committees maintain regular, open scrutiny (e.g. IPAR, Risk Register, Q&S Dashboards, Clinical Services Plan updates, GIRFT).
- **TI Pack Scrutiny -** TI packs are thoroughly reviewed across relevant committees, focusing on the de-escalation criteria.
- **Moving Forward -** Newly streamlined reports, with explicit reference to which committees own which TI criteria, bolster Board-level oversight and transparency.

Next Steps/Actions

1. **Embed Reporting Format -** Continue refining the six specific TI actions at ARAC.
2. **Summarise Assurances -** Provide brief updates from other committees to ARAC for overarching assurance.
3. **Committee Restructure -** Implement new Board Committee structure by April 2025 (approved in January 2025).

Evidence/Assurance - Internal Audit Report 2024/25 (favourable assurance on governance & reporting). Structured Assessment 2024 (notes openness and transparency).

Risk - (**Capacity**) **-** Reliance on a single point (Programme Director) for escalation oversight is being monitored.

Criteria 37 - Board's Duty of Quality in Decision-Making

Reporting Group: TI Coordination Group | **Committee**: ARAC | **Status**: Advise **Executive Lead**: Sharon Daniel

Summary of Current Status - Clinical Fragility - Board decisions on temporary service changes are underpinned by Quality Impact Assessments.

Positive Audit Note - Audit feedback acknowledges the Board has a clear focus on patient safety and quality; however, further alignment across all pathways is needed.

Next Review - The next Maturity Matrix reassessment in Q4 2024–25 will consider any improvements in how quality data is integrated for all services (not just those in the CSP), using the new dashboard developed by the performance team.

Next Steps/Actions

1. **Deepen Integration -** Strengthen frameworks so that workforce, finance, resilience, and quality data are considered together for all services.
2. **Timelier Sight of Service Issues -** Ensure robust risk identification so the Board is not 'forced' into decisions on short notice.

Evidence/Assurance

- Complaints & Claims data (ongoing monthly).
- Risk Registers reflecting service fragility.
- QIAs for recent Board decisions (e.g. PPH MIU changes).

Risk - (**Capacity/Timing) -** Insufficient early sight of potential service issues if underlying risk assessments lag.

Criteria 38 - Programme and Performance Management Structure

Reporting Group: TI Coordination Group | **Committee**: ARAC | **Status**: Advise **Executive Lead**: Lee Davies

Summary of Current Status

- **Audit & WG Feedback -** Positive progress in setting up structures; the new 100-day planning cycle helped clarify objectives, but there was inconsistent directorate engagement.
- **Capability/Capacity Risk -** A single Programme Director for TI escalation places strains on delivering the scale of change needed.
- **Governance Strength -** The next Internal Audit (scheduled by end of March 2025) will assess if new frameworks (Care Groups) for urgent care, cancer, and diagnostics delivery are adequately robust.

Next Steps/Actions

1. **Escalation Process -** Formal route for non-engagement to be agreed between the Programme Director TI and CEO/Deputy CEO (by 28 Feb 2025).
2. **Resource Review -** Assess if additional support is needed to address capacity constraints within the agreed programmes

Evidence/Assurance

- 100-day cycle post-programme review.
- Draft Internal Audit Report 2024/25 (Objective 1).
- WG feedback (21 January 2025).

Risk - **Single Point of Dependency**: Limited staff to coordinate cross-organisational transformation.

Criteria 39 - Risk Management Arrangements

Reporting Group: TI Coordination Group | **Committee**: ARAC | **Status**: Advise **Executive Lead**: Joanne Wilson (with COO involvement)

Summary of Current Status

- **Robust Corporate Governance**: Internal Audit and Structured Assessments consistently confirm mature strategic and corporate risk management.
- **Operational Governance Gaps -** Capacity issues at the operational level can hamper timely action on identified risks.
- **Planned Improvements -** A revised operational governance structure—led by the COO—is scheduled for April 2025 to align front-line risk processes with strategic oversight.

Next Steps/Actions

1. **Support COO**: Ensure consistent governance across all directorates, bridging any operational vs. corporate gaps.
2. **Risk Mitigation Plans**: Develop more detailed, actionable mitigation plans for high-level risks, ensuring capacity is in place to deliver them.

Evidence/Assurance

- Corporate Risk Register, Datix, and Board Assurance Framework. Structured Assessment 2024 (mature approach to strategic and corporate risks).

Risk - **Operational Variability -** Some services lack dedicated capacity to fully address or escalate risks in a timely manner.

Criteria 40 - Governance and Assurance Systems

Reporting Group: TI Coordination Group | **Committee**: ARAC | **Status**: Advise **Executive Lead**: Lee Davies

Summary of Current Status

- **Positive -** New governance structures facilitate clearer escalation of performance, quality, and resource issues.
- **Challenges -** Despite well-defined frameworks, some areas (e.g. cancer, diagnostics) are not improving as hoped, indicating potential system gaps or under-resourcing.
- **Audit Alignment -** The Internal Audit will also assess how effectively these structures drive performance improvements in 2024–25.

Next Steps/Actions

1. **Effectiveness Review -** Conduct a formal evaluation of how the governance frameworks support actual performance gains.
2. **Directorate Engagement -** Reinforce directorate-level accountability for meeting performance milestones.

Evidence/Assurance

- TI packs, committee reports.
- Ongoing Internal Audit and Maturity Matrix reviews.

Risk

- **Limited Improvement Trajectory -** If the frameworks are not universally adopted or fully resourced, performance in critical areas is likely to deteriorate or not improve in line with expectations.

Criteria 41 – Maturity Matrix Self-Assessment

Reporting Group: TI Coordination Group | **Committee**: ARAC | **Status**: Advise **Executive Lead**: Lee Davies

Summary of Current Status

- **First Self-Assessment (Q4 2023–24) -** Completed last year, providing a baseline of governance maturity.
- **Next Self-Assessment (Q4 2024–25) -** Planned for the end of this financial year to align with the close of the 2024–25 annual plan, capturing progress on key improvement actions.
- **Reasonable Assurance -** The TI Audit compliments this approach, acknowledging that the Health Board proactively reviews governance maturity rather than relying solely on external audit findings.

Next Steps/Actions

1. **End-of-Year Reassessment -** Repeat the self-assessment in Q4 2024–25, focusing on capacity, capability, and how effectively we address known fragmentation.
2. **Link to TI Delivery -** Ensure the maturity matrix directly informs strategic and operational planning for 2025–26.

Evidence/Assurance

- Governance Maturity Matrix from Q4 2023–24.
- Future Maturity Matrix outputs (Q4 2024–25).
- Welsh Government and Internal Audit feedback (January 2025).

Risk

- **Capacity -** If the single TI Programme Director remains the only escalation lead, the maturity improvements identified may not be realised at scale.

ARAC’s Visibility across Targeted Intervention

Why this approach?

ARAC needs better visibility of key “Alert” criteria but does not require a deep review of all 55 items.

Key proposal

1. Focus on “Alert” - Present only criteria at “Alert” status, grouped by the committee responsible.
2. Brief explanations on request - If ARAC needs more detail, a short update can be provided for any “Alert” criterion.
3. Regular summaries - ARAC will receive an “Alert” summary at agreed intervals, ensuring consistent oversight of the most urgent issues.

Outcome

- ARAC gains a high-level understanding of major risks.
- Committees continue to handle detailed scrutiny of each criterion.

Alert Criteria by Committee

Sustainable Resources Committee (SRC)

- Criterion 3: Annual plan with Board approval showing a substantial financial improvement trajectory that meets or exceeds the target control total.

ARAC’s Visibility across Targeted intervention

Strategic Development & Operational Delivery Committee (SDODC)

- Criterion 4: Submission of an acceptable annual plan in line with the current planning framework.
- Criterion 6: Board clarity on the organisation’s strategic vision.
- Criterion 8: Delivery of annual plan commitments, especially ministerial priorities.
- Criterion 13: Maintain 60% Single Cancer Pathway (SCP) performance for three consecutive months.
- Criterion 17: Achieve a 15% reduction in follow-ups delayed by 100%, for three consecutive months, then maintain for three more (based on the November 2023 baseline).
- Criterion 18: Ensure 65% of R1 ophthalmology patients are seen within or no more than 25% over their target date, sustained for three months.
- Criterion 24: Reduce ambulance handovers over one hour by 11% for three consecutive months, then maintain for another three (based on Oct–Dec 2023 baseline).
- Criterion 25: Continue progress toward no more than 7% of patients waiting over 12 hours at each site and across the Health Board.
- Criterion 26: Ensure median time from ED arrival to assessment by a clinical decision maker is no more than 60 minutes.
- Criterion 27: Achieve a 5% continuous reduction in delayed care pathways for three consecutive months, then maintain for a further three (based on Oct–Dec 2023 baseline).

ARAC's Visibility across Targeted intervention

Quality, Safety & Experience Committee (QSEC)

- Criterion 34: Demonstrate that all external recommendations (Royal Colleges, HIW, etc.) are discharged, verified, or scheduled under the longer-term improvement plan.
- Criterion 52: Provide an effective response to external reports (Audit Wales, Ombudsman, Royal Colleges, HIW), leading to sustainable improvements.

People, Organisational Development & Culture Committee (PODCC)

- Criterion 45: Develop a sustainable workforce (improved retention, fewer vacancies, less agency use) and review workforce/clinician job plans annually to meet the annual plan requirements.

Conclusion

Conclusion & Next Steps

- **Positive Internal Audit -** Overall, the Health Board's governance and escalation frameworks for TI have been deemed robust, which should provide a reasonable confidence to both Board members and Welsh Government that the correct mechanisms are in place.

- **Targeted Focus -** Specific criteria remain on 'Advise' due to gaps in achieving consistent programme delivery, capacity constraints, and the need for further integration of data/oversight.

- **Moving Forward -** The April 2025 operational governance structure changes, plus the Q4 2024–25 self-assessment, offer clear opportunities to address these gaps and strengthen the Board's overall assurance position.

Action	Reporting Group	Committee	Status	Executive Lead	Summary of Current Status	Lead Executive Response (if applicabl	Documented Plan and	Actions Outstanding	Evidence and Assuranc	Risk
Effective oversight and scrutiny of current service provision consistently being provided by the Board and the appropriate Committee as demonstrated by Committee and Board papers.	TI coordination group	ARAC	Assure	Joanne Wilson	Regular reports provided to Board and Committees include IPAR, Risk Register, Q&S Dashboard, Clinical Services Plan Updates, Deep Dive reports on specific issues, updates on GIRFT reports. Furthermore, the Targeted Intervention (TI) pack undergoes thorough scrutiny at committee level, with robust and regular discussions across relevant committees. Significant progress has been made to ensure that each committee focuses on the de-escalation criteria relevant to its remit, particularly within the Sustainable Resources Committee and the Strategic Development and Operational Delivery Committee. From the Draft Internal Audit Report 2024/25 (Objective 1, Key Findings on Governance & Reporting Arrangements): Following feedback from independent members at ARAC meetings, further actions regarding summary information on the assurance of scrutiny and monitoring of TI progress of other committees be provided in future escalation reports to ARAC and the TI governance arrangement of QSEC require addressing.	Positive feedback has been received by AW in Structured Assessment 2024 regarding the Health Board's openness and transparency in its reporting. The Board will be considering a new Committee structure at its meeting on 30 January 2025, with implementation planned from April 2025.	Board Committee Structure - Jan25 Board 1. Structuring reports by the six specific TI actions under ARAC's remit, ensuring that each action is clearly tracked, monitored, and reported. In addition, summary assurance from other committees will also to be provided – (complete) 2. Highlighting any variance or potential	Committee reporting in Dec/Jan25	Structured Assessment 2025 Committee Self Assessment feedback	N/A
Evidence of Board considering the Duty of Quality to inform their decision making and evaluating their compliance with the Duty.	TI coordination group	ARAC	Advise	Sharon Daniel	While there is clinical data supporting fragility within the CSP's scope, including complaints, claims, and cost implications, services outside this scope lack the same comprehensive oversight. A more cohesive model—integrating workforce pressures, financial assessments, service resilience, and patient accessibility—would help frame the Board's understanding and response to fragile services more effectively. This remains a priority to ensure alignment across all fragile pathways, especially in light of emerging configuration challenges.		1. CSP Updates, detailing areas of fragility. (On Track - on-going) 2. Complaints & Claims Data, regularly reported to relevant committees (On-Track -monthy)			No risk identified
Effective programme and performance management structure is in place which defines objectives of the improvement work has plans which show how the work is delivered and what barriers could impact on delivery of outcomes; structures have effective open and transparent reporting with effective Board oversight and a clear performance and delivery framework that drives improvement.	TI coordination group	ARAC	Advise	Lee Davies	Recent governance improvements have provided a strong foundation, with clear objectives defined across various programmes. However, translating these objectives into consistent delivery remains a challenge. While progress has been noted in financial delivery, limited improvement has been seen in areas such as cancer, urgent care, and diagnostics. In some cases, deterioration has highlighted gaps in the effectiveness of the performance and programme delivery framework. **Welsh Government Feedback (21 January 2025)** Welsh Government acknowledged our positive progress in meeting 2024–25 objectives but emphasised the importance of having adequate capacity and capability to deliver our 2025–26 annual plan. They underlined the need for sufficient organisational planning and oversight, given the scale and complexity of upcoming programmes. **Internal Audit Findings** From the Draft Internal Audit Report 2024/25 (Objective 1): A 100-day planning and delivery cycle of key programmes was introduced to aid in the planning, execution and oversight of critical change initiatives by 1st October 2024. The delivery cycle was supported by a documented enhanced scrutiny and rapid escalation process. Of the six programmes identified, a post-programme review (undertaken by the Programme Director of Targeted Intervention) identified missing key information within three of the programmes, whilst there was little engagement from some directorates and services that resulted in no plan being presented or developed. Directorate and Service Engagement The post 100-day planning and delivery programme review (undertaken by the Programme Director of Targeted Intervention) identified missing key information within three of the programmes and little engagement from some directorates and services that resulted in no plan being presented or developed, impacting on the Health Board's ability to deliver TI actions.	A review of the effectiveness of the new governance arrangements will be undertaken by Internal Audit, expected to be completed in March 25	**Action - Formal Escalation Process for Non-Engagement -** To address the incomplete plans and limited engagement in certain programmes, a formal escalation route between the Programme Director of Targeted Intervention and the CEO/Deputy CEO will be established. This process ensures that any directorate or service failing to provide complete, timely plans will be escalated for support and accountability. **Target Implementation**			No risk identified
Risk management arrangements are in place for identifying, recording managing risks across the organisation. Board is sighted on key risks and areas of concern on a regular basis and is able to offer constructive scrutiny on performance and effective oversight and scrutiny of fragile services provided by QSEC and Board.	TI coordination group	ARAC	Advise	Joanne Wilson	Risk management arrangements are embedded across the organisation, with robust processes for identifying, recording, and managing risks. This framework is built on a well-established set of tools, such as the Board Assurance Framwork, Corporate Risk Register and Datix, complemented by structured directorate escalation meetings. These meetings cover six key risk areas, ensuring a comprehensive assessment of performance variations and emerging challenges. This systematic approach aims to promote a proactive culture of risk identification, where issues can be identified and addressed early. The Board is consistently sighted on key risks and areas of concern through well-defined reporting lines, including the Quality, Safety, and Experience Committee (QSE), the Targeted Intervention (TI) Coordination Group, and the Audit and Risk Assurance Committee (ARAC). These governance structures allow the Board to engage in constructive scrutiny of performance and risk, providing effective oversight, especially in the management of fragile and high-risk services. This approach allows the Board to fulfil its role not only in terms of monitoring but also in challenging and supporting the development of mitigation strategies. Despite these established processes, challenges remain in ensuring that recorded risks transition smoothly from identification to active mitigation. It has been observed that while risks are being systematically recorded, there is sometimes a lack of capacity to manage the risks and the actionable plans tied to these risks. This gap can be addressed by focusing on the development of risk management plans that contain specific deliverables , measurable milestones, and clearly assigned responsibilities (subject to capacity) that are linked to the Health Board's agreed objectives. Strengthening these aspects will enhance the link between risk identification and tangible mitigation outcomes, promoting a more cohesive approach to risk management across the Health Board. Operational oversight has recently been improved through internal escalation processes that help identify operational issues and risks in a timely manner. However, governance arrangements at the operational level remain inconsistent, particularly across the Operations Directorate. The inconsistencies identified are currently being addressed through the introduction of a new operational governance structure. This revised structure, expected to be implemented by April 2025, will be led by the Chief Operating Officer, whose support will be crucial to ensure consistent application and monitoring across all operational teams. The objective is to align operational governance standards with the mature corporate governance practices already demonstrated by the Health Board, thus promoting a unified standard of governance across all tiers of the organisation. The corporate governance arrangements within the Health Board are mature and robust, a conclusion consistently reinforced through structured assessments. These assessments highlight that strategic and corporate risks are well-monitored, and there is a continuous effort to ensure alignment between strategic intentions and operational actions. However, to support future governance resilience, it will be crucial to focus on embedding consistent governance practices across all operational functions. This will ensure a consistent flow of information, from front-line operational risks to strategic oversight by the Board, thereby enhancing the Health Board's capacity to manage both immediate and long-term challenges.	Mature and robust corporate governance arrangements in place, with further work to develop consistent governance arrangements in the Operations Directorate	Support the Chief Operating Officer to implement consistent operational governance arrangements (Apr25)	Support the Chief Operating Officer to implement consistent operational governance arrangements (Apr25)	Structured Assessment 2024 - the Board continues to have a mature approach to overseeing strategic and corporate risks and risk management arrangements.	N/A

Clear governance and assurance systems in place with performance (quality resource activity/outcomes) issues escalated appropriately through clear structures and processes.	TI coordination group	ARAC	Advise	Lee Davies	As above, the new governance arrangements are now well established and provide the mechanisms for seeking assurance and escalating as required. A review is required of the effectiveness of these mechanisms as, in areas like cancer, urgent care, and diagnostics, we've observed not only limited improvement but in some cases, a deterioration, highlighting potential gaps in the effectiveness of our programme and performance management. Although the structure defines objectives, the framework is not yet supporting the level of oversight required to ensure consistent delivery against these objectives.	As above	No risk identified
Self-assessment against an agreed governance maturity matrix with evidence the agreed level.	TI coordination group	ARAC	Advise	Lee Davies	The Health Board undertook a self-assessment against an agreed governance maturity matrix in Q4 of 2023-24, providing a realistic view of the organisation's current position regarding governance maturity. This assessment has been crucial, particularly given the broader context of the annual plan recovery work undertaken during the summer of 2023 and the strategic preparations for the 2024-25 planning cycle. It offered a critical lens through which governance practices were evaluated, enabling an honest appraisal of strengths and areas needing enhancement. The maturity matrix framework provided clear insights, which have informed the Health Board's subsequent approach to improving its governance maturity. The assessment did not exist in isolation; rather, it has become a key reference point for ongoing organisational improvements. It has ensured that governance practices are continuously reassessed, with findings feeding into the decision-making processes to strengthen governance structures, align roles and responsibilities, and provide a clear direction for ongoing enhancement activities. In a manner similar to the Health Board's handling of the 56 de-escalation criteria under the Targeted Intervention (TI) framework, the maturity matrix serves as both a strategic and operational tool that reinforces decision-making processes. These processes ensure that both strategic and operational planning governance arrangements are not only reactive but also proactive, with an emphasis on anticipating challenges, promoting best practices, and ensuring alignment across critical areas of focus. The maturity matrix is thus integral to the Health Board's structured approach to organisational improvement, helping to drive alignment between strategic goals and operational practices. Regular reassessments of governance maturity are conducted throughout the year to adapt to emerging challenges and priorities. This continuous assessment cycle allows the Health Board to remain agile, capable of responding to both internal and external pressures, while still maintaining alignment with its strategic objectives. By leveraging the insights gained through the maturity matrix and aligning them with the strategic priorities identified in the 2025-26 annual plan, the Health Board aims to ensure that its governance arrangements not only meet current needs but are also future-ready. The next maturity matrix reassessment will take place following the completion of the 2025-26 annual plan. This reassessment will help to ensure that planning practices remain relevant and aligned with the evolving needs of the organisation. Furthermore, this will service as an improvement process ensures that governance structures are not static but evolve in tandem with the changing operational landscape and strategic ambitions of the Health Board. At the Welsh Government meeting on 21 January 2025, officials noted good progress for the 2024–25 objectives but emphasised the need for adequate capacity and capability to deliver the 2025–26 annual plan. This feedback is directly relevant to Criterion 41 because the next governance maturity matrix self-assessment will: Consider whether the capacity and capability challenges flagged by Welsh Government have been addressed, ensuring the organisation's governance is robust enough to execute complex programmes and mitigate emerging risks.	A further assessment will be made following the completion of the annual for 2025-26 (April 25)	N/A

Canolfan Staff 1
Staff Base 1

1. Finance, strategy and planning
2. Performance and outcomes
3. Fragile services
4. Governance
5. Leadership, capability and culture
6. Quality of care

Escalation Domains

Targeted Intervention Meeting

Hywel Dda University Health Board

21 January 2025

Hywel Dda University Health Board - Key Achievements to Date Summary

Executive Leadership and Governance

Leadership Stabilisation

- Successful appointment of permanent Chief Executive Officer (Professor Philip Kloer) and Deputy Chief Executive (Lisa Gostling)
- Completion of 11 key operational leadership appointments strengthening management capability across the Health Board
- Plans underway for permanent appointments to Executive Medical Director and Director of Nursing, Quality & Patient Experience roles

Governance Excellence

- Positive 2024 Structured Assessment with only three recommendations, highlighting strong corporate arrangements despite period of significant change
- Maintained robust Board and committee effectiveness with clear focus on transparency and continuous improvement
- Strengthened escalation arrangements for high-risk matters to Board level
- Implementation of new Internal Escalation Framework providing comprehensive assessment across six key domains

Financial Management and Control

Financial Grip

- Significant improvement in financial position, exemplified by reduction from £49.0m forecast deficit in Month 1 to £28.0m in Month 9
- Successful delivery of savings schemes with identification gap reduced to just £0.2m by Month 9
- Substantial reduction in agency spend, particularly in nursing, with nurse agency costs at three-year low

Hywel Dda University Health Board - Key Achievements to Date Summary

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Variable Pay Control

- Elimination of off-framework nursing agency usage since June 2023
- Reduction in agency usage from 253 WTE (March 2023) to 104 WTE (October 2024)
- Cessation of planned nurse agency usage from November 2024 (except Bronglais General Hospital and Emergency Departments)

Workforce Stabilisation

Nursing Workforce

- Successful onboarding of 296 Internationally Educated Nurses
- Significant reduction in Band 5 nursing vacancies to near normal business levels
- Notable improvement in staff development with PADR completion rate increasing to 82.1%

Leadership Development

- Delivery of eight LEAP (Leadership Engagement with Awesome People) cohorts benefiting 92 senior leaders
- Establishment of 37-strong coaching network with 15 cohorts of 'The Coach Approach' programme delivered
- Launch of comprehensive online INFORM management resource programme

Hywel Dda University Health Board - Key Achievements to Date Summary

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

Service Improvements

Digital Transformation

- Implementation of new Patient Hub enabling digital patient communications
- Successful deployment of Electronic Document Management system with 400,000 patient records digitised
- Progress on Electronic Prescribing Medicine Administration and Electronic Observations projects

Quality and Patient Experience

- Maintained above 90% Friends and Family Test scores
- Development of comprehensive Quality Improvement Strategic Framework
- Progress on implementing Nurse Staffing Levels (Wales) Act with robust twice-yearly reviews

Clinical Services Planning

- Advancement from Options Development to Consultation phase of Clinical Services Plan
- Progress in Primary Care and Community Strategic Plan development
- Successful implementation of 50-Day Challenge and Winter Measures improving patient flow

Hywel Dda University Health Board - Key Achievements to Date Summary

Equality and Inclusion

- Implementation of new Strategic Equality Plan and Objectives
- Launch of Anti-Racism e-learning module with Board leadership commitment
- Development of local LGBTQ+ Action Plan with enhanced staff training and awareness programmes

Challenges and forward focus

Whilst recognising these achievements, the Health Board acknowledges ongoing challenges including:

- Need to further reduce sickness absence rates (currently 6.61% against 4.79% target)
- Continued work required on financial sustainability
- Ongoing focus on reducing waiting times and improving emergency care performance

The Health Board maintains a balanced approach to improvement, building on successes whilst actively addressing areas requiring further development.

Escalation status overview

Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

Escalation status levels overview as of 31 December 2024

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

Our most challenged directorates (alert assessments):

- **Mental Health and Learning Disabilities** - significant gaps in savings plans, governance concerns for investigating complaints & incidents, overdue pay progressions, medical staff job planning and neurodevelopmental assessment capacity.
- **Planned Care** - governance concerns for investigating incidents, lack of compliance with external recommendations and WHCs, savings requirements for 2024/25 not met and 2025/26 savings requirement also at risk.
- **Radiology** – governance concerns for investigating incidents and reviewing risks, lack of compliance with HIW recommendations, end of year forecast of overspend, 2024/25 & 2025/26 savings not identified and demand outstripping capacity which is impacting on performance across cancer and other pathways.
- **Facilities** - strengthening needed of management/support capacity, poor compliance for workforce related measures, inconsistency in cleanliness audits of high-risk areas, variable pay spend need to be addressed and recurrent savings for 2025/26 not yet identified.
- **Glangwili Hospital** - overspend forecast and savings requirement not fully identified, clinical staffing and vacancy concerns in A&E and high numbers of ambulance delays and A&E wait breaches.

Widespread issues within the Finance domain (17 directorates level 3) and the Performance domain (16 directorates level 3).

Details of escalation status trends, escalation reasons and de-escalation criteria can be accessed via the Our Performance dashboard.

Domain 1: Finance, strategy and planning

Summary of Recent Progress (TI Criteria - 3)

GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

The Health Board has signalled an improved financial position, as reported in Month 9, going beyond the restated planned deficit and aligned target control total. This follows improvements in savings delivery, core underspends and a £32.5m funding allocation. Since the last meeting in September 2024, the below table summarises the improvements made.

Recent recovery actions have focused on the following to de-risk the financial plan:

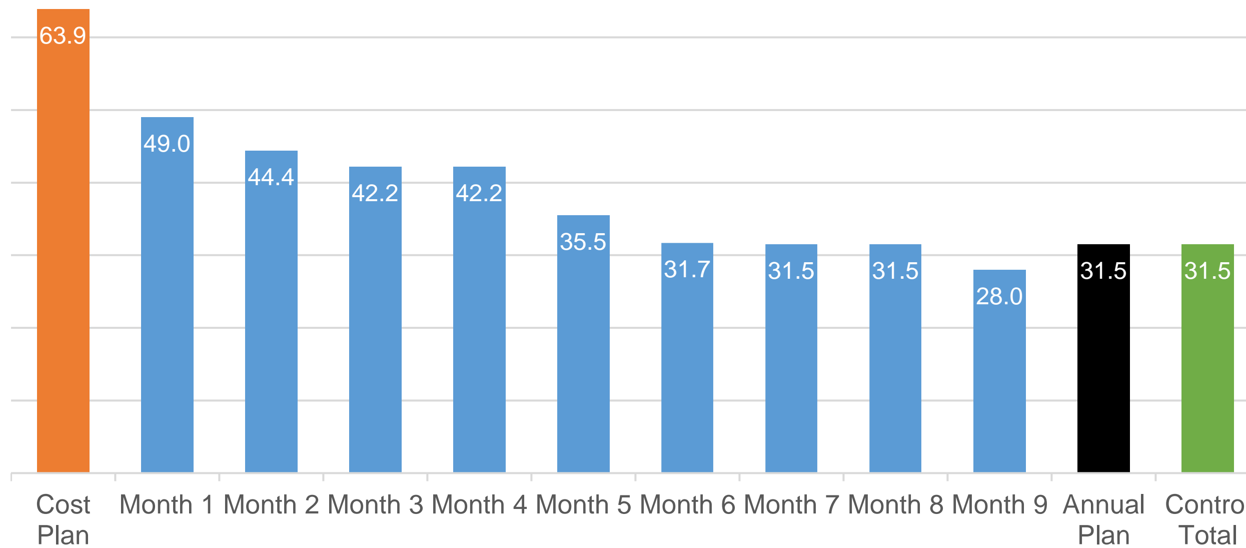
- Converting opportunity ideas (blue and red) at pace into credible and deliverable schemes (amber and green);
- Focused grip and control maintained through the internal escalation framework and the Financial Control Sub Group;
- Continued strides to onboard internationally recruited nurses to improve stability of wards and reduce the reliance on agency;
- Support directorates through the internal escalation framework, some of which continue to not have improvements plans in place;
- Identifying directorate savings including the implementation and delivery of plans to start before the end of this financial year.

Driver (£m) (Month 5 numbers restated for new funding)	**Month 5 Forecast**	**Month 9 Forecast**
Planned deficit	**31.5**	**31.5**
Unidentified / (Identified) savings gap / (improvement)	4.3	0.2
Under / (Over) Delivery of Savings Schemes	1.3	1.3
Core Operational Variation	(1.6)	(5.0)
Gross forecast	**35.5**	**28.0**
Future mitigating actions required to deliver Reported Planned Deficit	(4.0)	N/A (Improved beyond plan)

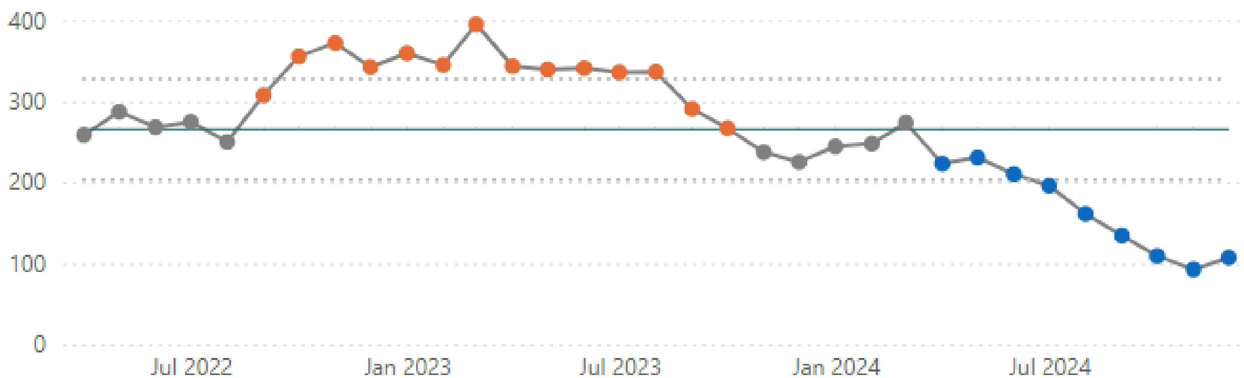
Progress Across the Year

- The Health Board has shown an improving trend across the whole of this financial year thus far. The reported forecast has improved from £49.0m in Month 1 to £28.0m in Month 9 – a change of £21.0m.
- Savings identification of Green and Amber schemes has improved from a shortfall of £24.0m in Month 1, to a shortfall of only £0.2m in Month 9.
- At the Health Board level, core budget performance remains broadly on track, with some non-recurrent underspends supporting the improvements made.
- A key success has been the Nurse Stabilisation programme and focus on reducing reliance on nurse agency with a sustainable workforce development programme. Nurse agency costs have dropped to a three-year low (not adjusted for inflation) with the final intake still to embed with BGH.

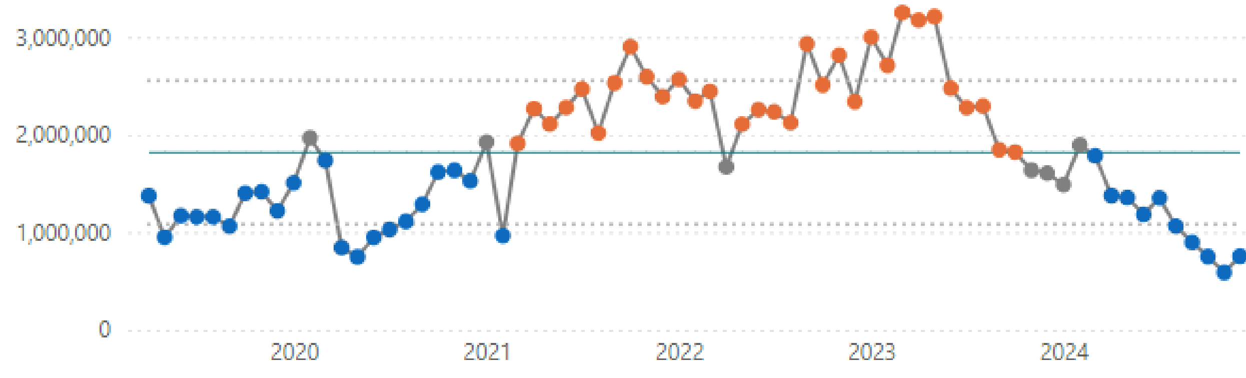
End of Year Gross Forecast Deficit (£'m)



Nurse Agency Resourcing (Whole Time Equivalent)



Nurse Agency Expenditure (£'m)



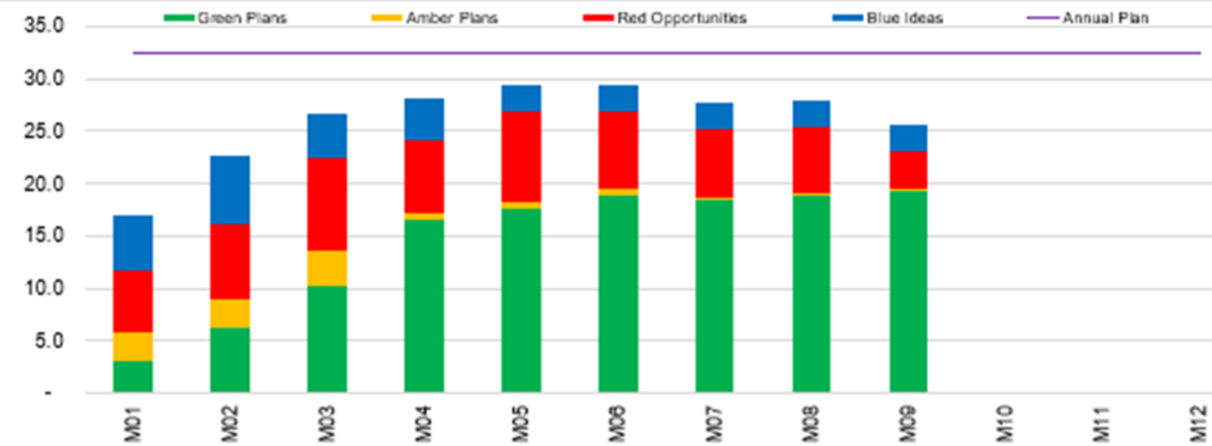
Savings Delivery Performance

- 2024/25 has experienced a step change, year on year, in the delivery of savings.
- As at Month 9, there is only a £0.2m identification gap remaining – to be closed in Jan/Feb.
- Actual delivery is £1.3m below the planned benefits of the schemes identified to date.
- A slowing trend is experienced, however, for ideas to be accepted from the opportunity's framework.

Annual Savings Movement (£m)	Month 5	Month 9	Change
Savings identification	28.1	32.2	4.1
In-year savings delivery	26.8	30.9	4.1
Unidentified savings gaps	4.3	0.2	4.1
Savings delivery vs identified savings	1.3	1.3	-

Monthly Trend of Annual In-Year Opportunity, Pipeline & Savings Plans (£'m)

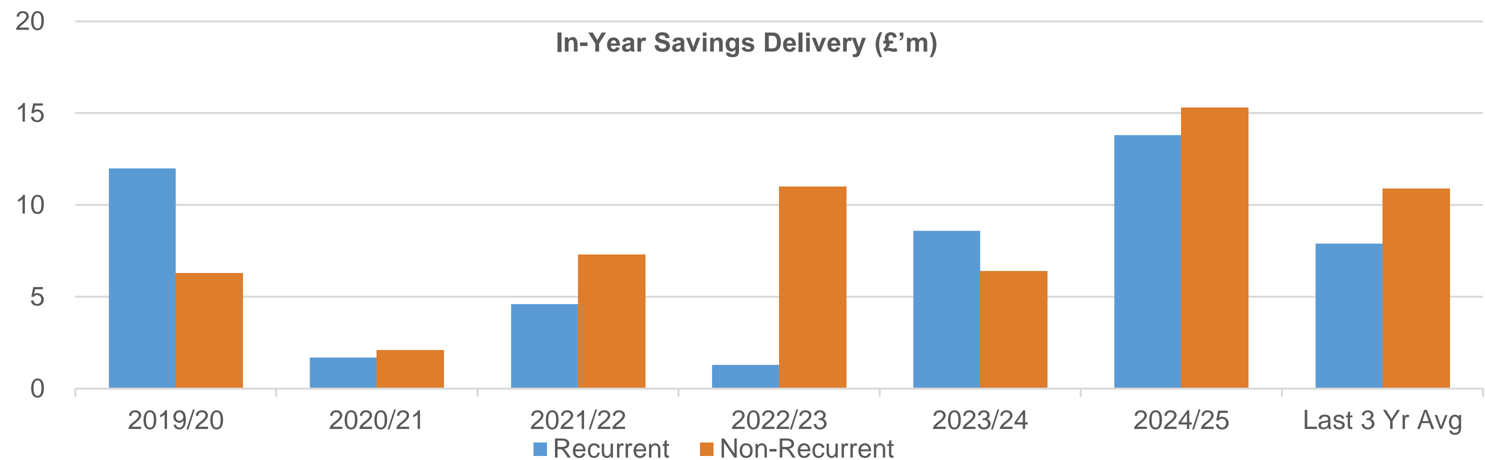
Monthly Trend of Annual Recurrent Opportunity, Pipeline & Savings Plans (£'m)

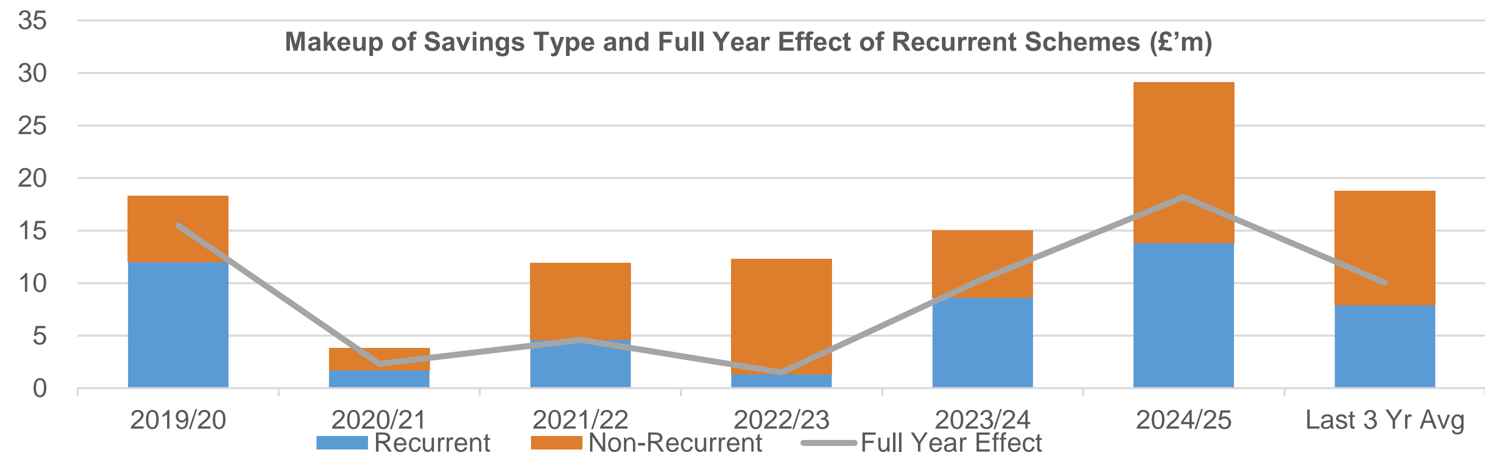


Reliance on Non-Recurrent Actions

As part of the Annual Plan deliberations the impact on the underlying deficit is being reviewed. Due to the reliance on non-recurrent savings and underspends a significant opening delivery gap exists in next year's financial plan if not addressed. The carried forward impact into the underlying deficit starting point for the 2025/26 financial plan will include, as a minimum, the 2024/25 outturn (currently £28.0m), the recurrent savings gap (currently £13.8m) and directorate underspends that are not signalling an ongoing underspend (currently £8.6m).

Underspending Directorates	£'m
Mental Health and Learning Disabilities	1.3
Director of Operations Management	0.2
Planned Care	0.4
Women and Children	0.1
Carmarthenshire Community	0.6
Pembrokeshire Community	0.7
Ceredigion Community	0.3
Primary Care	3.0
LTAs with other NHS Providers	0.1
Public Health	0.9
Therapies	0.2
Corporate Functions	0.8
Total	**8.6**





Forward Focus

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Two-year approach to savings aspirations are set based on the carried forward recurrent residual delivery from 2024/25 of a 5% non-ring fenced budget reduction, plus an additional 1.5% non-ring fenced budget reduction adjusted for 2024/25 delivery, to address the underlying deficit concerns.

Allocation of savings targets for technical efficiencies to directorates. Executives will lead on five key efficiency, productivity and value themes aligned to the de-escalation criteria and existing governance arrangements.

Individual Directorate delivery will continue to be overseen through the Directorate Improving Together (DIT) structure and escalation meetings and health board wide delivery at the Integrated Quality, Finance, Planning and Delivery (IQFPD) forum.

Theme	Areas
Theme 1: Place £3.0m	•Community strategy •Home based care strategy •Acute bed configuration and surge management
Theme 2: People £4.2m	•Nurse and medical rostering •International recruitment for hard to fill roles •Variable pay controls & removal of agency
Theme 3: Enablers £11.0m	•Primary and Secondary care prescribing reviews •Digital transformation •Procurement and cheaper alternatives
Theme 4: Quality, Outcomes and Value £9.4m	•Services embedding prevention & inequalities •Continuing health care packages •Embedding value throughout pathways •MH&LD sustainable model and strategy
Theme 5: Clinical Service Models £7.6m	•Primary Care strategy including access •Out of Hours model to triage appropriately •Clinical Service Plans •Commissioning / Repatriation agreements
Minimum opportunity available totals £35.2m	**Note:** all values are indicative based internal efficiency reviews, benchmarking or other assessments. These figures do not include all technical efficiencies managed locally, which should be brought forward from budget holders.

Domain 3: Fragile services

25/26 Planning Process

October 2024 - Strategic Launch & Parameters

- Comprehensive strategic launch event (10th October) setting Year 2 Targeted Intervention parameters
- Detailed financial framework including 6.5% savings requirement - 5% in 24/25 and 1.5% in 25/26 (6.5% total over 2 years)
- Performance trajectory expectations across all domains
- Quality and safety standards requirements
- Cross-system transformation priorities

Early directorate engagement and planning initiation documents requiring:

- Initial financial modelling and assumptions
- Baseline capacity and demand assessments
- Workforce sustainability requirements
- Service transformation opportunities

November 2024 - System Integration & Dependencies

- Major system-wide workshop (11th November)
- Cross-directorate dependency mapping
- Critical interface identification
- Resource alignment requirements
- Risk identification and mitigation

25/26 Planning Process

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Intensive planning development

- Diagnostic capacity modelling
- Therapy resource requirements
- Critical care implications
- Workforce models and movement impacts
- Estate utilisation assessments

December 2024 - Detailed Challenge & Refinement

Comprehensive written feedback to all directorates checking and challenging:

- Assumption validation requirements
- Interdependency resolution needs
- Timeline deliverability assessment
- Resource availability confirmation
- Performance improvement trajectories

Multiple challenge sessions focusing on:

- Financial profiling and phasing including Workforce assumptions and considerations
- Activity delivery assumptions over laid with any Quality impact assessments and Risk mitigation approaches

25/26 Planning Process

January 2025 - Final Assurance & Submission

Final plan development (due on 24th January) with the following expectations:

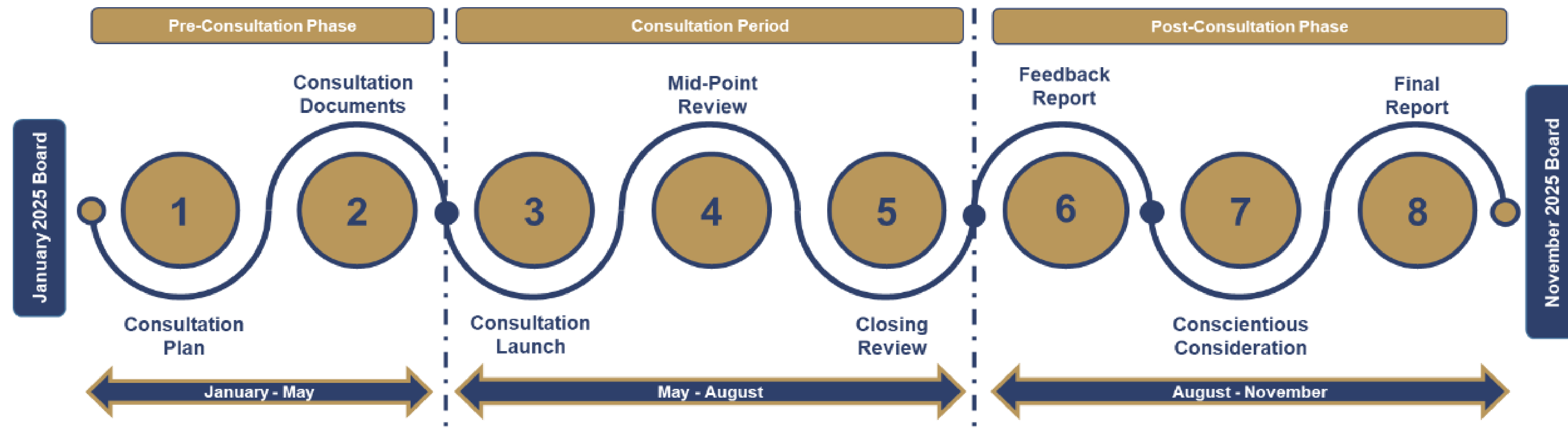
- Full financial profiling and modelling
- Detailed workforce plans
- Clear performance trajectories
- Comprehensive risk mitigation
- System dependency mapping

Systematic assurance process covering:

- **Financial deliverability –** Each directorate needs to demonstrate how they can make their savings and manage within their financial resources
- **Operational sustainability –** activity modelling including capacity planning and workforce alignment
- **Workforce availability** – clear alignment between annual plans and the availability of workforce and/or different workforce models
- **Quality impact –** ensuring all savings and/or proposed changes have or are scheduled to have a QIA before any changes are approved
- **Strategic alignment –** to TI Objectives (year 2) and both the Planning and Performance Frameworks 2025-28
- **Risk management –** using the risk register, how do the directorate annual plans address or potentially create any operational and organisational risks so that any changes can be based on fully informed decisions

Planning
Clinical Services Plan

- CSP has moved from Options Development (Phase 2) to Consultation planning ahead of a decision on the future provision of services within the Clinical Services Plan (Phase 3)
- Work is currently being undertaken to develop a consultation plan to support the delivery of Phase 3, with the scope and mandate for consultation to be agreed in January Board.
- The engagement period is expected to run from the end of May following launch of consultation at Board until August.
- The analysis and conscientious consideration of consultation findings will take place between August and November.
- Should there be a large number of consultation responses, the consultation findings may need to go to a later Board date to allow for full analysis of consultation responses.



Fragile Services

Stroke Services

Annual Plan (Short-Term) actions

- Potential *temporary relocation* of acute stroke from Glangwili General Hospital (GGH) to Prince Philip Hospital (PPH) to bolster resilience.
- Aim - Reduce duplication, strengthen out-of-hours cover, and improve stroke outcomes (SSNAP metrics).

Workforce and capacity

- Reviewing critical staff requirements (e.g. medical, nursing, therapy) to ensure safe rotas.
- Funding and organisational change processes (OCP) in early 2025/26 if approved by the Board.

Clinical Services Plan (medium-term) alignment - consultation (May–August 2025)

- Will test longer-term configurations for stroke, reflecting public, clinical, and stakeholder views.
- Ensures that any short-term measures dovetail with final CSP solutions, including potential centralisation or networked models. However, it is recognised that any temporary changes through the annual plan could change again post consultation and engagement.
- Board oversight will incorporate performance monitoring (e.g. door-to-needle times, length of stay) to demonstrate improvement or prompt further adjustment.

Fragile Services

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Diagnostic Services (Radiology)

Annual Plan (Short-Term) Actions -Demand and Capacity Gaps

- Initial plans indicate that there are circa 14,576 **CT** and 7732 **MRI** exams p.a. shortfall, plus significant ultrasound gaps.
- Immediate measures include additional scanning sessions, continued **Everlight** out-of-hours support, and targeted mobile/locum capacity.

Workforce challenges

- Critical radiologist and sonographer shortages; reliance on external reporting services.
- Exploring invest-to-save approaches to recruit permanent staff and reduce outsourcing. However, the issue is around the actual workforce and whether the number of WTEs the Health Board requires is achievable from a recruitment perspective (unlikely to be achieved in 1 year)

Clinical Services Plan (Medium-Term) Alignment

- Service reconfiguration: Possible centralised models or shared regional solutions for advanced diagnostics.
- Longer-Term investment: CSP outcomes will inform capital and workforce planning to address structural gaps.
- Stakeholder engagement: Input from staff, patients, and partner organisations will shape service design, ensuring sustainable capacity for cancer, planned, and urgent pathways.

Fragile Services

Key takeaways/next steps

1. **Immediate priorities** (Annual Plan): Address urgent fragilities in Stroke and Radiology to protect patient safety, manage risk, and optimise existing resources.

2. **Long-term strategy** (CSP): Public consultation in 2025 will refine service models. Interim changes remain flexible, with final decisions subject to formal approval.

3. **Assurance to Welsh Government**: The Health Board is balancing short-term resilience with long-term vision, ensuring all temporary changes align with the overarching strategy and consultation outcomes.

Planning and Outcomes

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Targeted Intervention and Fragile Services: assurance on current challenges and long-term direction

1. Strategic context

A Healthier Mid and West Wales (AHMWW) – six years of evolution (TI Criteria 6)

Originally agreed in 2018 to address longstanding workforce, financial, and estate fragilities, including an ageing hospital configuration and rising maintenance backlog.

Notable but partial progress has been made (e.g. centralisation of paediatrics at Glangwili Hospital [GGH], ring-fenced elective capacity in Prince Philip Hospital [PPH]); however, fundamental sustainability risks remain.

Infrastructure and capital realities:

Rising construction costs (e.g. +30% in Cross Hands) and urgent fire/RAAC works have constrained transformative investment in acute capacity.

Backlog maintenance has increased from £60m to over £255m (with £42m in high-risk issues), meaning large portions of capital have simply maintained service continuity rather than improved the patient environment or expanded capacity.

2. Fragile Services: medium-term solutions (TI Criteria - 7 and 35)

Clinical Services Plan (CSP) – phase 1 and 2:

Nine services identified as high priority for consolidation or redesign to ensure viability; capital investment could facilitate reconfiguration and address critical risks across the Health Board

Planning and Outcomes

Further initial considerations around site-specific approaches could include:

- Glangwili Hospital (GGH) - Evolving as the main acute and emergency centre, requiring targeted investments for capacity and backlog maintenance.
- Prince Philip Hospital (PPH) - Acute medicine, frailty care, and elective surgery; potential to expand as a regional centre for Orthopaedics.
- Withybush Hospital (WGH) - Continues to build on its frailty model and short-stay elective capacity, aligning with the longer-term strategic vision of a phased transition to a community-focused site.
- Bronglais Hospital (BGH) - Provides vital rural services for mid Wales. A networked model utilising digital technology and integrated pathways will underpin its sustainability.

3. Longer-term strategic alignment (TI Criteria 6)

Extended timeline for major infrastructure:

A long-term strategic solution is unlikely to be operational before 2033, potentially stretching to the mid or late 2030s.

This imposes the need for a revised roadmap, balancing the requirement for phased capital investment and urgent service reconfiguration to sustain quality.

Planning and Outcomes

Capital feasibility and service transformation:

- Inflation has added £163m to original cost estimates since the 2022 Programme Business Case, raising questions about phasing and scope.
- Interim upgrades (e.g. essential maintenance, site repurposing) will be key to bridging the gap until new infrastructure is delivered.

Primary & Community Strategic Plan:
Emphasises building more robust community hubs (Aberaeron, Cardigan, Cross Hands, Fishguard) and digital-first models of care, reducing unnecessary acute admissions (needed to support long term population health demographics and trends).

4. Assurance of a multi-horizon approach

Current challenges and TI response:
The Board recognises the TI delivery expectations across the 6 domains in order to meet TI de-escalation thresholds, which is being monitored through robust governance structures.

Medium-term service sustainability:
The CSP's focus on consolidation and networked service delivery offers a more resilient model, ensuring that fragile services can continue safely until major capital developments.

Long-term strategy and refresh:
With the new hospital timeline extended, the Health Board will refresh AHMWW, considering post-COVID realities, emerging technologies (AI, robotics), and closer regional collaboration to address shared pressures.

Planning and Outcomes

5. Embedding a Population Health approach

Population Health Management (PHM) framework:

We are expanding our lens to prevent ill-health and promote wellness at a population level, not simply treat individuals. This involves tackling the '20-4-7' elements (focusing on the most deprived 20%, four main risk factors - smoking, alcohol, nutrition, physical activity and seven major disease areas such as CVD, Cancer, and Diabetes). An obese patient, for example, can cost the NHS twice as much as a non-obese patient underscoring the economic and clinical imperative of prevention.

Programme-focused prevention:

Discussions are underway across Directorates to shape a Population Health Planning Objective for 2025/26, including the potential for integrated preventive programmes (e.g. tackling alcohol and drug misuse, each £1 invested yielding up to £3–£4 return on investment). We aim to bring this into mainstream planning, aligning performance and quality metrics with population health outcomes—for instance, embedding population health indicators into our IPAR and Directorate 'Improving Together' sessions.

Anchor institution role:

As a major employer and service provider, the Board has the opportunity to influence social determinants of health, reduce local health inequalities, and work with Public Services Boards (PSBs) and Regional Partnership Boards (RPBs). Leveraging this role ensures a far-reaching approach: from shaping local education and workforce initiatives to integrating prevention across health and care pathways.

Driving equity and value:

Improved allocative efficiency means directing resources to where they yield the greatest benefit - both in cost and clinical outcomes. For example, investing in smoking cessation or mental health early interventions can reduce acute admissions and long-term complications. By proactively managing population cohorts rather than waiting for reactive care - our system stands to reduce unwarranted variation, achieve better clinical outcomes, and reduce overall spend.

Bwrdd Iechyd Prifysgol Hywel Dda
University Health Board

1. Finance, strategy and planning

2. Performance and outcomes

3. Fragile services

4. Governance

5. Leadership, capability and culture

6. Quality of care

Escalation Domains

Domain 6: Quality of care

Quality and Outcomes

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Hospital-Onset HCAI Performance: C. diff, Staph aureus, and E. coli (TI criteria 50)

Current performance and challenges

C. difficile (C. diff)

Baseline: 8; Target: 6. Recent Average: 5 cases over the last three months, including a low of 4 cases in both August and September—below the threshold.
Key challenge: Sustaining this improvement long-term while continuing to embed the relevant cleaning, antimicrobial stewardship, and competency-based training programmes.

Staph aureus

Baseline: 3; Target: 2. Recent Three-Month Average: 4, though the latest month returned to 3 (baseline).
Key challenge: Fluctuating rates, with occasional peaks (e.g. April, June); consistent three-month compliance has yet to be achieved.

E. coli

Baseline: 7; Target: 5. Recent Average: 5, aligning with the target but not yet consistently below it. July rose briefly to 7, underscoring the need to stabilise performance.
Key challenge: Close to target but requires robust infection prevention measures to ensure no further upward drift.

Overarching challenge

Although recent trends show positive improvement particularly for C. diff and E. coli the service must maintain these gains across all sites, ensuring Staph aureus fluctuations are addressed and actions remain sustainable, to ensure long term solutions.

Quality and Outcomes

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Mitigating actions

- **IPC Training, Education, and Oversight** - ANTT (Aseptic Non-Touch Technique) Competency: Mandating 85% or greater compliance via ESR-based training, with ANTT assessors identified for each area. Monitoring at site/directorate levels to track and escalate any shortfalls. Mandatory Training Compliance - Target 85% for IPC Level 1 and 2, ensuring staff can recognise and mitigate infection risks. Reviewing content/delivery methods, especially where repeated themes are identified (e.g. poor hand hygiene). Establishing an IPC champion in each ward or service, providing leadership, local training, and quick escalation of concerns.
- **Root Cause Analysis (RCA) and Learning** - HCAI Assurance Group Meetings - Ensuring each service presents RCA findings/action plans for hospital-onset cases, with monitoring via Datix. Recurring IPC issues (e.g. specific ward-based practices) flagged at quarterly reviews to shape targeted interventions. Involving clinicians in RCA discussions and improvement plans, reinforcing accountability for antimicrobial prescribing, device management, etc.
- **Focused Quality Improvement (QI) Approach** - Establishment of a C. diff Improvement Group chaired by senior clinical leads, developing action plans and reporting to QSEC or the IPSSSG. Antimicrobial Stewardship (AMS) "Start Smart Then Focus" audits championed by the Medical Director and pharmacy teams, with results fed back to prescribers. Regular Grand Rounds/teaching sessions to reinforce prescribing best practices and reduce inappropriate antibiotic use.
- **Targeted Site-by-Site Intervention** - Phased Improvement each acute site has specific training, audit, and environmental review actions designed to stabilise IPC compliance. Environmental & Cleaning Standards to include Implementation of DiffX, UV, and HPV cleaning technologies across all sites, with training records monitored. Annual deep-cleaning programme for wards, ensuring evidence of routine cleaning schedules for both nursing and hotel services.
- **Monitoring & Governance** - Weekly/Monthly IPC Huddles to track new HCAIs, escalate outbreak concerns, and review action plan progress. Utilise surveillance and data such as WPAS bed management and epidemiological data to identify transmission patterns, enabling prompt outbreak responses. Reporting to Board-Level Committees including QSEC (Quality, Safety & Experience Committee) and Board receive regular updates on infection rates, training compliance, and progress against improvement metrics.

Quality and Outcomes

Forward look

- Stabilisation and sustainability - C. diff and E. coli are currently meeting or trending near targets. Ongoing vigilance is needed to keep them there. Staph aureus remains slightly above target; a further sustained focus on hand hygiene, invasive device management, and consistent embedding of ANTT is planned.
- Strengthened ICS collaboration - Greater partnership with Hotel Facilities (cleanliness standards) and Public Health (outbreak management, cross-site learning) to maintain compliance beyond immediate interventions.
- Long-Term QI infrastructure - Dedicated IPC champion network, robust RCA processes, and AMS audits continue, ensuring learning from each case is embedded in practice.

Conclusion

Recent data underscores a positive trajectory for C. diff and E. coli, reflecting successful implementation of training, enhanced auditing, and improved cleaning protocols. Staph aureus remains the main HCAI still exceeding its target. By driving sustained QI efforts, maintaining high compliance with training (ANTT, hand hygiene, antimicrobial stewardship), and expanding oversight at ward/service level, the Health Board is positioned to achieve the required reduction in all three key HCAI metrics and sustain these gains over the longer term.

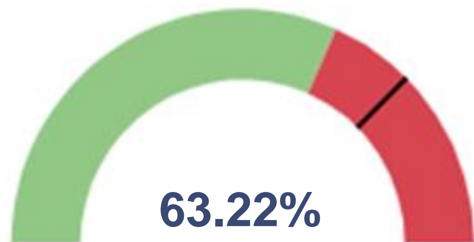
Quality and Safety: Complaints Response

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

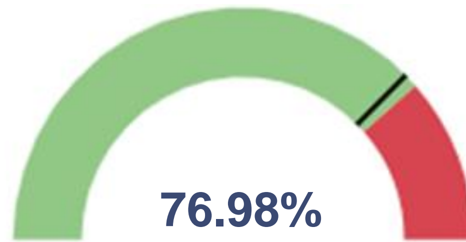
Proportion of complaints settled within 30 days

Improved performance remains on an improvement trajectory with performance above the All-Wales average.

Hywel Dda UHB proportion of complaints settled within 30 days (financial year 2023-24)



Hywel Dda UHB proportion of complaints settled within 30 days (financial year 2024-25)



Data extract from Beacon Dashboard

Proportion of complaints settled through Early Resolution

From 1 November 2024, the Board approved an increase in the time allowed to respond to an early resolution case of 5 working days.

New triage arrangements are having a positive impact and improved patient / complainant experience.

The PTR cases have reduced further in December, as highlighted below and now number are less than half of what they were in Q1 of this year.

Concerns Management/Investigation workshop for senior leaders held on 31 October, in preparation for new PTR implementation 2025 (involving NHSE and WRP).

Received	Managed through PTR
April	200
May	207
June	218
July	226
August	179
September	168
October	205
November	144
December	100
Total	1647

Quality and Safety

Service user feedback and experience – (TI criteria 36)

Current performance and challenges

Patient Experience Data Integration:

- Recent rollout incorporating CIVICA, Datix, and FFT feedback into escalation and improvement meetings.
- FFT Scores: Consistently above 90%, with a high volume of feedback.
- Positive Assurance: Favourable Ombudsman feedback and 'significant assurance' rating from the Welsh Risk Pool audit.
- Complaints response: 76% of complaints were closed within the 30-working day target timescale advised in the Putting Things Right Regulations.

Learning from the Ombudsman

Three new investigations have been commenced by the Ombudsman in the period October-November 2024. There have been 12 decisions not to investigate. Two final reports were received which were both partly upheld.

Mitigating actions

- Quality Improvement (QI) Integration
- Adding patient experience metrics into directorate packs and the patient safety dashboard.
- Linking Datix/CIVICA insights directly to QI cycles.
- Maintaining high engagement
- Ongoing reporting to the Board and committees.
- Sustaining productive collaboration with the Ombudsman and WRP

Quality and Outcomes

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Forward look

Full utilisation of feedback:
As data becomes fully integrated, directorates can better use real-time insights for service improvements.

Strong satisfaction levels:
Continuing the 90%+ FFT rating and high response volume provides in-depth patient perspectives.

Conclusion

Embedding feedback data within daily decision-making and maintaining strong external assurance positions Hywel Dda to improve the quality of services in line with patient needs and expectations.

Domain 2: Performance and outcomes

Performance and outcomes - exceptions

Performance de-escalation summary

Latest position key

- Goal achieved
- Making good progress towards goal
- Minimal progress made or decline from previous month
- Same as baseline or worse

	Measure	De-escalation criteria	Baseline	Goal	Latest position																				
					Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24
Planned Care and Cancer	% single cancer pathway patients starting treatment within 62 days	60% for 3 consecutive months	50%	60%	51%	42%	46%	49%	51%	46%	50%	41%	56%	49%	47%	60%	43%	53%	54%	54%	48.0%	40.0%	44.6%	56%	n/a
	% patients waiting less than 52 weeks for new outpatient appointment	100% for 3 consecutive months	94%	100%	93.6%	94.2%	95.6%	94.8%	94.3%	94.6%	94.0%	93.4%	92.7%	92.8%	93.1%	93.8%	92.5%	91.5%	91.3%	92.9%	93.4%	94.6%	95.0%	95.1%	95.6%
	% patients waiting less than 104 weeks from referral to treatment	100% for 3 consecutive months	97%	100%	96.5%	96.7%	97.1%	97.1%	97.1%	97.1%	97.2%	97.2%	97.4%	97.6%	97.9%	98.5%	98.4%	98.3%	98.2%	98.2%	98.1%	98.1%	97.9%	97.9%	98.1%
	% patients waiting less than 52 weeks from referral to treatment	80% for 3 consecutive months	85%	80%	85.8%	86.1%	87.1%	86.5%	85.7%	85.6%	85.2%	84.7%	84.2%	84.5%	84.9%	85.1%	84.3%	83.7%	83.4%	83.7%	83.7%	84.9%	84.2%	84.6%	84.7%
	Number of patients delayed by 100% for their follow up appointment	15% reduction 3 consecutive months, maintained for 3 months	15,419	9,469	16,181	15,867	15,526	15,377	15,399	15,957	15,571	15,419	15,668	16,310	15,478	15,829	16,028	16,201	16,062	15,714	16,015	16,381	16,481	16,682	16,976
	% R1 ophthalmology patients waiting no longer than 25% of target date	65% for 3 consecutive months	45%	65%	49.1%	49.7%	50.4%	49.6%	47.5%	46.6%	45.2%	44.0%	42.1%	40.5%	40.1%	40.0%	40.1%	38.1%	37.7%	36.1%	36.7%	36.0%	35.0%	34.0%	n/a
	% patients waiting less than 8 weeks for a diagnostic endoscopy	80% for 3 consecutive months	28%	80%	26.8%	27.6%	28.5%	28.9%	24.7%	24.8%	27.8%	26.9%	25.3%	27.0%	31.9%	37.0%	35.8%	34.4%	34.5%	44.0%	36.1%	44.1%	55.3%	57.3%	64.0%
	% patients waiting less than 8 weeks for a Non-obstetric ultrasound (NOUS)	80% for 3 consecutive months	73%	80%	75.8%	70.2%	72.7%	74.1%	67.5%	67.8%	73.3%	68.4%	63.1%	60.6%	70.3%	79.0%	77.5%	81.8%	84.7%	85.9%	77.0%	75.0%	73.4%	67.4%	61.0%
	% patients waiting less than 8 weeks for a non-cardiac MRI	80% for 3 consecutive months	75%	80%	55.1%	63.1%	78.7%	84.3%	70.7%	67.6%	74.6%	69.5%	61.5%	54.4%	65.2%	78.5%	71.7%	66.0%	63.6%	65.2%	57.1%	54.2%	60.9%	49.8%	42.5%
	% patients waiting less than 14 weeks for a specific therapy (excluding Audiology and Weight Management Service)	85% for 3 consecutive months	75%	85%	83.7%	83.3%	85.4%	86.6%	85.3%	84.1%	86.1%	87.4%	86.2%	86.8%	87.8%	86.9%	81.8%	78.9%	78.3%	77.6%	74.6%	78.2%	76.9%	76.1%	77.0%
UEC	Ambulance handovers taking over 1 hour	11% reduction 3 consecutive months, maintained for 3 months	964	680	901	993	863	944	980	854	1,019	915	959	1,245	1,124	1,192	1,103	970	1078	959	721	771	929	986	1,153
	Median time from arrival at ED to assessment by a clinical decision maker (mins) *	60	58	60	57	57	58	71	71	70	65	58	67	64	64	67	65	73	75	74	73	69	73	87	89
	% patients waiting over 12 hours in an emergency department	Continuous improvement towards no more than 7%	9%	7%	8.6%	8.6%	8.2%	8.9%	10.9%	9.2%	9.2%	9.0%	9.7%	11.7%	10.8%	11.3%	10.3%	10.6%	10.7%	10.1%	9.4%	10.6%	10.3%	11.2%	11.7%
	Number of delayed pathways of care	5% reduction 3 consecutive months, maintained for 3 months	203	174	278	230	247	256	238	222	192	227	190	207	212	220	237	249	253	203	194	191	200	204	208
CAMHS	% 0-17 year olds LPMHSS assessments undertaken <28 days	80%	92%	80%	88.2%	86.6%	93.5%	88.5%	76.5%	91.9%	93.8%	86.9%	89.6%	81.3%	92.0%	98.2%	92.2%	95.7%	85.7%	97.0%	90.2%	96.2%	95.3%	87.0%	n/a
	% 0-17 year olds therapeutic interventions started <28 days	65%	59%	65%	45.2%	72.9%	72.2%	48.9%	58.5%	58.5%	65.5%	81.3%	80.0%	78.0%	96.2%	95.8%	91.5%	95.3%	85.1%	81.0%	83.3%	75.0%	84.1%	98.1%	n/a
	% 0-17 year olds having secondary mental health services with valid care treatment plan	80%	95%	80%	100%	100%	100%	97.0%	95.2%	95.5%	93.2%	92.7%	92.9%	91.1%	92.1%	88.4%	93.5%	90.9%	95.0%	91.6%	89.8%	89.9%	90.6%	93.6%	n/a
Infections	Number of hospital onset C.difficile infections	25% reduction, maintained for 3 months	8	6	7	6	3	9	8	5	8	10	6	10	7	7	6	8	11	7	4	4	7	8	6
	Number of hospital onset Staph aureus infections	33% reduction, maintained for 3 months	3	2	3	3	3	3	2	2	4	3	2	4	1	5	7	1	4	3	5	3	0	2	3
	Number of hospital onset E.coli infections	25% reduction, maintained for 3 months	7	5	3	9	5	8	3	3	5	12	3	2	5	4	4	4	3	7	4	5	4	9	5

Performance and outcomes - exceptions

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Single Cancer Pathway (SCP) (TI criteria 13)

Current performance and challenges

Recent performance has risen from a low of 40% (September) to 56% in November. Target: 60% compliance for three consecutive months (currently not achieved).

Key pressure points

- Urology and Lower GI - account for approximately 45% of overall breaches.
- Diagnostic constraints - (e.g., limited endoscopy, MRI capacity) and high referral volumes slow investigations.
- Pathway complexity - Multi-site service delivery, along with workforce and estate issues, creates bottlenecks in some tumour specialties.

Mitigating actions

- Targeted backlog reduction - including additional clinics and theatre sessions: Focused on the highest-pressure tumour sites (Urology, Lower GI) to expedite patient pathways. Outsourcing: Specific outsourcing arrangements to address overflow in diagnostics (endoscopy/imaging) and high-volume treatments (where feasible).
- Diagnostics and pathway optimisation extended Endoscopy sessions - Weekend/evening capacity where staffing allows, aiming to reduce wait times for Lower GI. Radiology Expansion: Exploring mobile MRI or outsourced scanning to relieve bottlenecks.

Performance and outcomes - exceptions

Performance Huddles & Tracking - Weekly or bi-weekly tumour-site huddles to escalate individual cases at risk of breaching.

Alignment with National Optimal Pathways - Earlier Triage & Referral: Ensuring patients are fast-tracked to the right specialty from the outset. Standardised Pathway Review: Working with clinical leads to identify and eliminate non-value-adding steps, reducing overall wait times.

Workforce & Service Development - Recruitment- Boosting specialist staff in oncology, radiology, and endoscopy to increase capacity (where possible). Skill-Mix Expansion: Training and development of advanced nurse practitioners and non-medical endoscopists to offset consultant shortfalls.

Conclusion

The SCP has shown an upward trend from 40% to 56%, demonstrating that action plans are having a positive impact. However, closing the gap to 60% for three consecutive months requires continued focus on the biggest breach contributors (Urology, Lower GI), diagnostic expansion, and systematic pathway reviews to streamline the journey from referral to treatment.

52 Weeks for New Outpatients (TI criteria 14)

Current performance

- 95–96% of patients seen within 52 weeks (baseline: 94%, target: 100%).

Key challenges

Residual backlog in specific specialities (e.g., ENT, T&O) persists. Achieving 100% requires further capacity and efficient scheduling.

Mitigating actions

- Weekend/evening clinics focused on specialty pressures (e.g., ENT, T&O).
- Remote and virtual appointments to increase throughput where clinically appropriate.
- Robust administrative validation to ensure accurate waiting list data and reduce DNAs (Did Not Attends).

Performance and outcomes - exceptions

104 Weeks RTT (TI Criteria 15)

Current performance

98% of patients within 104 weeks, close to the 100% target.

Key challenges

Remaining 2-year waiters concentrated in **T&O, ENT, and Urology**. Workforce gaps and theatre capacity limit rapid clearance of these complex cases.

Mitigating actions

- Outsourcing packages (e.g., orthopaedic cases) to independent providers.
- Additional theatre sessions - (weekends/evenings) in high-volume areas.
- Daily validation - of near-breach patients to prioritise scheduling.

52 Weeks RTT at 80% (TI Criteria 16)

Current performance

Consistently **84–85%**, surpassing the 80% target.

Key challenges

Occasional dips near 85% do not fundamentally threaten compliance but highlight capacity tightness in certain specialties.

Mitigating actions

Potential de-escalation given consistent over-performance.

Ongoing focus

on-going validation and scheduling to preserve capacity and retain performance above 80%.

Performance and outcomes - exceptions

Delayed Follow-Up >100% (TI Criteria 17)

Current performance

Average **16,000** patients delayed by over 100% (target: 9,469).

Key challenges

Large follow-up backlogs in Ophthalmology, ENT, and other specialties with high demand. Limited clinic capacity and administrative complexities (re-booking, validation) slow improvements.

Mitigating actions

- Focused additional clinics (weekends or evenings) for longest-wait patients.
- Use of virtual follow-ups where safe, freeing up in-person slots.
- Automation/validation drives to ensure accurate follow-up lists and identify any patients who no longer need appointments.

Ophthalmology R1 Patients (TI Criteria 18)

Current performance

36–37%, far below the **65%** target (and 95% national standard).

Key challenges

Fragile service: Nine sites, workforce shortages, ageing equipment. High-volume Glaucoma and Intravitreal caseloads exceeding capacity.

Mitigating actions

Potential centralisation under the Clinical Services Plan (CSP) with options appraisal and stakeholder engagement. Further work with Swansea Bay being scoped.

- Weekend/evening clinics - and recruitment of non-medical injectors to increase IVT throughput.
- Partnership with community optometrists - to manage lower-risk patients and redirect capacity to R1.

Performance and outcomes - exceptions

All Diagnostics (<8 Weeks) (TI Criteria 19)

Current performance

Overall performance still below **80%**, though endoscopy has improved significantly (see TI Criteria 20).

Key challenges

- Staffing shortages in radiology and ultrasound.
- Equipment - constraints limit scanning capacity (MRI, ultrasound).

Mitigating actions

- Extended or weekend scanning sessions for imaging (where staff are available).
- Outsourcing certain diagnostics (MRI, CT) to address peaks in demand.
- Strategic review of diagnostic capacity (including potential service reconfiguration) under the CSP.

Endoscopy (<8 Weeks) (TI Criteria 20)

Current Performance

Improved from **27%** to **64%**, yet under the **80%** target.

Key challenges

Endoscopist shortages and limited suite availability. High GI demand, driven by screening programmes and urgent referrals.

Mitigating actions

- Mobile endoscopy units and additional in-house sessions.
- Outsourcing capacity (where feasible) to reduce the backlog.
- Standardised booking and triage to prioritise urgent/suspicious cases first.

Performance and outcomes - exceptions

NOUS & Non-Cardiac MRI (<8 Weeks) (TI Criteria 21)

Current performance

NOUS down to **61.0%** (Dec-24) from 75.8%. **MRI** at **42.5%** (Dec-24), reflecting a steep fall from 78.7%.

Key challenges

Radiographer/sonographer shortages. Ageing scanners and limited scanning-room capacity, especially at peak times.

Mitigating actions

- Extended scanning hours (evenings/weekends) if staffing available.
- Exploring outsourcing arrangements for MRI scans.
- CSP process to consider radiology options and focus on sustainability with option appraisal and engagement.

Therapy Waiting Times (TI Criteria 22)

Current performance

77% seen within 14 weeks, down from 87%. Target is 85%.

Key challenges

Staffing gaps in physiotherapy, occupational therapy, speech & language.

Mitigating actions

- Weekend/extended sessions to reduce waiting lists.
- Remote or group-based therapy (e.g., virtual physio classes) for appropriate cases.
- Administrative triage to prioritise highest clinical need, discharge non-attenders promptly.

Performance and outcomes - exceptions

Ambulance Handover Delays (>1hr) (TI criteria 24)

Current performance

In December 2024, there were 1,153 over-one-hour ambulance handovers, exceeding the monthly target of 839. Glangwili General Hospital (GGH) showed a minor percentage improvement (from 57.3% to 56.5%), but overall pressures remain high across sites (e.g. Withybush, Prince Philip).

Key challenges

- Front-door bottlenecks - ED overcrowding and limited downstream bed capacity prolong ambulance offloads.
- Demand and Capacity mismatch - demand is exceeding capacity which can impact triage and admissions, causing ambulance queues.
- Variability across sites - each site faces different estate limits, staffing models, and escalation processes.

Mitigating actions

- 50-Day Challenge & Winter Measures - Embedding the Optimal Hospital Flow Framework (Red2Green, D2RA) and extending 7-day working to reduce bed pressures and enable quicker ED admissions from ambulances. Investment of £2.5m in winter resilience for additional staff and discharge capacity.

Local site plans

GGH 12-week plan (fortnightly reviews, weekly 'Big Room') targeting front-door processes and SDEC expansions. Boarding protocols refined across sites to relieve ED congestion in high-escalation scenarios.

6 Goals for UEC - Goal 3 (SDEC) Diverts suitable patients from ED, speeding ambulance offloads. Goal 4 Enhanced collaboration with WAST to streamline handover handshakes and offload processes.

Performance and outcomes - exceptions

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12-Hour ED Waits (TI criteria 25)

Current performance

December 2024 recorded 1,543 >12-hour breaches (target: 1,137), roughly 10% of attendances, above the 7% goal. GGH remains the most challenged site, although other acute sites also reported high volumes due to winter demand.

Key challenges

- Overcrowding in ED: Inadequate space and slow flow for admissions/discharges.
- Winter surge: Seasonal increases in respiratory and unscheduled care presentations exacerbate crowding.

Mitigating actions

- 50-Day Challenge and Winter Plans - Scheme 1 (Optimal Flow) and Scheme 2 (7-day H&SC) ensure faster weekend discharges, reducing Monday surges that overflow into 12-hour waits. Focus on community falls response and high-risk cohort management (Schemes 6, 10) to prevent avoidable ED attendances.
- Local Site Initiatives - GGH 12-week plan: Expanding SDEC, surgical triage, and Criteria Led Discharge to boost throughput. Other sites improving discharge lounge use and refining escalation protocols (boarding, bed reallocation) to reduce ED backlog.
- 6 Goals for UEC - Goal 5 (Optimal Flow): Embedding daily board rounds, early identification of medically optimised patients, and discharge lounge utilisation to free up ED space. Goal 3 (SDEC): Same Day Emergency Care models in Prince Philip, Withybush, Bronglais to reduce unnecessary ED stays.

Performance and outcomes - exceptions

Median Time to ED Clinical Assessment (≤ 60 Minutes) (TI Criteria 26)

Current performance

Three-month average at 72 minutes, with December 2024 peaking at 89 minutes (highest in the last year). Historically strong performance below 60 minutes now compromised by overcrowding and staffing challenges.

Key challenges

- ED congestion - High ambulance handovers and limited admissions capacity delay triage/assessment.
- Workforce availability – Emergency Medicine shortfalls, inability to expand triage teams at busy periods.
- Peaks in demand - Winter/respiratory surges and rising ED attendances inflate first-assessment wait times.

Mitigating actions

- ED Quality Statement (EDQS) Action Plan - Standardised triage pathways, routine safety huddles, and rapid escalation protocols to expedite initial clinical review. National Six Goals Team ED Improvement Toolkit supporting consistent triage and 'redirection' for non-urgent attendances.
- 50-Day Challenge & Winter Measures - Schemes 1 & 2 (Optimal Flow, 7-day working) reducing ED holds by enabling earlier discharges and bed availability. Schemes 6 & 10 tackling out-of-hospital falls and high-risk cohorts, reducing front-door overload.
- Local Site Plans - GGH 12-week plan - Expanding SDEC to shift suitable cases out of ED, and introducing Criteria Led Discharge for faster bed turnover. Adjusted rostering and nurse-led triage expansions in Bronglais, Prince Philip, Withybush to increase capacity for early assessment.

Performance and outcomes - exceptions

Delayed Pathways of Care (DPOC) (TI Criteria 27)

Current performance

Baseline: 203; 5% reduction target: 174. December 2024 recorded 208, with a three-month average of 204, still above target.

Key challenges

- Winter pressures lead to bed shortages and slower discharges for patients needing social care packages or community rehab placements.
- Complex cases - Multi-agency involvement (health, social care, therapy) often prolongs transitions.

Mitigating actions

- Red2Green, Criteria Led Discharge (CLD), D2RA - Aiming to shorten each inpatient journey, focusing on daily board rounds and escalations for any delay. Strengthening 7-day working with local authorities to prevent weekend backlogs.
- Focus on Long Stays - Weekly reviews of top 20 longest stays (>21 days) across sites, removing administrative or supply obstacles (e.g. care packages, home adaptations). Cross-site ‘flow huddles’ to coordinate bed capacity and expedite transfers.
- 50-Day Challenge - Scheme 5 - System-wide review of 21–28-day LOS and top 20 outliers, speeding up approvals and decisions for discharge. Additional winter funds used to secure extra community beds or staff for reablement services.

Domains 4 and 5: Governance and leadership

Leadership

Executive recruitment:

CEO appointed. Recruitment plans being finalised to imminently advertise and appoint to Director of Nursing, Quality & Patient Experience and Medical Director roles

Staff Survey:

- 8% improvement in engagement with 20% response rate.
- Key message to staff from CEO and reminders via 'Tim Hywel Dda' Sessions plus engagement threads on Viva Engage.
- Widespread drop-in clinics with staff and share point all contributed to increased engagement.
- Awaiting detailed results of the survey to enable feedback into the organisation.

Leadership development:

- LEAP programme continues with five cohorts completed and 3 in progress. Evaluation from first two show it is exceeding its delivery expectations.
- Three cohorts of New Consultant Programme have been delivered.
- 37 qualified coaches in place with 15 cohorts of the Coach Approach programme delivered

Leadership

Operational Services structure

- 11 key appointments made as part of organisational change process.
- In addition to the 11, following introduction of tailored recruitment programme for all senior leadership roles, a further four senior leader appointments have been made.
- OD development plan being developed for whole team to commence when all appointments made

Staff engagement

- An average of 22% of leavers complete exit interviews
- 73% average engagement score for monthly Board outcome survey
- 1050 staff completed Culture Survey which enables development of localized people culture plans for directorates.
- Speak up – make meaningful change, launched October 2024 with wide array of communications to support our staff.

Governance

Structured Assessment 2024 – key findings

Positive report with only three recommendations issued. Key finding related to corporate governance arrangements include the following:

- Whilst managing a period of significant change, the Board and its committees continue to work well, maintaining a clear focus on public transparency, good governance, continuous improvement and hearing from patients and staff.
- The Health Board has maintained robust arrangements to support the effective conduct of Board and committee business.
- Board and committee meetings continue to be conducted appropriately and effectively, with strengthened arrangements to escalate high-risk matters to the Board.
- The Board and its committees receive good quality, timely papers, which the Health Board is continuing to strengthen as part of ongoing improvement.
- The Board is managing a significant period of change well and is taking positive steps to ensure it remains cohesive and effective through Board development opportunities and arrangements for continuous improvement.
- The Health Board continues to have appropriate arrangements for corporate oversight of risk, performance, tracking recommendations, and the quality and safety of services. The performance management framework however needs to be updated to reflect current performance arrangements, and more frequent updates on the implementation of the Quality Improvement Strategic Framework should be provided.

Further work underway to strengthen operational governance arrangements - scheduled to be implemented by April 2025

Refreshed Board Committee structure to be considered by Board in January 2025 - scheduled to be implemented by April 2025

Board and Committee Effectiveness Programme for 2024/25 currently underway

Cyfarwyddwr Cyffredinol Grŵp Iechyd, Gofal Cymdeithasol a'r Blynyddoedd Cynnar / Prif Weithredwr GIG Cymru

Director General Health, Social Care & Early Years Group / NHS Wales Chief Executive

Llywodraeth Cymru
Welsh Government

Dr Philip Kloer
Chief Executive
Hywel Dda University Health Board

Our Ref: JP/GE/SB

29 January 2025

Dear Phil

Targeted Intervention meeting

This letter follows our meeting on 21 January 2025, which is part of the review process linked to your targeted intervention status. Thank you for the slide pack received in advance of the meeting, these form an important part of the record. Apologies were noted from Sue Tranka, Pushpinder Mangat, and Helen Arthur.

Confirmation was received during the meeting that all actions from the previous meeting had been completed.

You started the meeting with a general update on a number of points as follows:

- Recruitment is underway for the Medical Director and Director of Nursing
- Good progress has been made on reducing the financial deficit, supported in part by the reduction in nursing agency usage.
- Challenges remain from a workforce point of view with increases seen in short and long-term sickness rates.
- Organisational development work continues across the health board
- A strategic partner for digital transformation has been appointed
- Pressures within the emergency department and the urgent and emergency care system through the winter period are a real concern.
- You are confident of improving the year-end financial position against the financial control target of £31.5 million and your latest deficit forecast was £28 million.

Finance and Planning

Good progress has been made over the last few months since our last meeting. We discussed the requirement to break even by year three of the three-year planning

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framework in order for the health board to retain the additional conditional recurrent funding issued this year.

I expect you to work closely with Welsh Government and the finance team of the NHS Executive to review your reliance of non-recurrent versus recurrent savings and the conditions associated with additional Welsh Government funding.

You confirmed that there is good progress around the TI action plan with only five actions left to complete from the 17 identified.

You explained that as part of this year's planning cycle a number of workshops have been held across the organisation to drive the planning, development of finance, performance, and quality plans within the individual directorates. Finalised plans from each of the directorates will be submitted by 24 January, with the aim of developing triangulated plans across workforce, finance and quality performance.

Your plan will ensure that the challenges associated with radiology reporting are resolved with appropriate models in place. The plan will also take the appropriate population health focus to prevent ill-health whilst treating patients.

Consultation on the clinical service plan will take place in May 2025. This will include a focus on stroke, critical care and emergency surgery service models.

We would appreciate early notification of any urgent temporary service changes. We discussed the limitations of the urgent service change guidance, and you agreed to provide examples where the guidance is proving problematic so that this can be reviewed.

The joint committee between Hywel Dda and Swansea Bay University Health Boards held its first meeting on 15 January 2025 and is supported by joint working groups for orthopaedics, ophthalmology, diagnostics and some parts of the cancer pathway.

Quality and Safety

Progress had been made against the healthcare acquired infection since the last meeting. C. diff and E. coli had met the de-escalation target, but Staph aureus had not. In support of this you have changed some of the products used for environmental disinfection which has had a positive impact. It is crucial you continue to monitor the standards of cleanliness across all services.

Some improvement has been made related to complaints handling and resolution and you felt that there is room for further improvement.

You have achieved a 50% reduction of your national reported incidents in year along with improvements in your incident management.

Performance and Outcomes

After several disappointing months, progress has been made against your cancer pathway with performance in November being 56% and you anticipate achieving 58% in December. It is important that you focus on the improvements in the cancer pathway to achieve of 70% by the end of March 2025.

You are confident in achieving the 52-week required outpatient position. There are 50-100 orthopaedic patients at risk of not being treated within 104 weeks by the end of March 2025, but you are actively looking for a solution for these patients. Ophthalmology remains an area of concern, both for clinical sustainability and performance.

I am concerned about your diagnostic plan as there does not appear to be a sustainable plan to clear the backlog. Discussions were ongoing internally on how you could secure the required capacity. Plans are in place to address the therapies backlog.

We discussed the challenges facing gynaecology cancer performance which is extremely poor - below 20%, I expect this position to improve urgently over the coming months. *(Post meeting note: an update was provided to the Welsh Government on steps being taken to improve performance).*

Urgent and Emergency Care

We noted that ambulance handover times and long waits at emergency departments were deteriorating again, even though you have a comprehensive improvement plan, including various levels of support and programmes in place – this is a real concern.

You highlighted that the streaming hub at Bronglais hospital seems to be having a positive impact in terms of conveyance and admission avoidance. The Cardigan SDEC is also having a positive impact and will continue to be open until the end of March 2025. Feedback has been very positive with approx. 70 – 80% of patients being diverted from attending Glangwili emergency department. Pathways of care delays are static and bed day utilisation was reducing – there needs to be a real focus in these areas.

Governance and Leadership

The Organisational Change Programme and structure is progressing well, and the majority of the service directors will be in post by 3 February, with the final two vacancies filled by the end of March 2025. I look forward to receiving an up-to-date structure when all posts have been filled.

Summary

This had been a helpful discussion around the processes and systems in place to support improvement within the health board. I expect to see performance improved for cancer, planned care, urgent and emergency care and healthcare acquired infections.

You have made progress against your financial position; the health board will need to continue its efforts in reducing its forecast deficit both in-year and on a recurrent basis. I expect you to have a clear route map to financial balance which reverses the deteriorating trajectory of the financial position. We agreed the following actions:

- Health board to provide early warning advice on any urgent service changes
- Welsh Government officials to review the urgent service changes guidance following the examples to be shared by the health board.
- The health board to share a copy of an up-to-date structure
- Health board to provide an update on improvements to the gynae-oncology pathway (received)

Please thank your team for the discussion and information provided. I look forward to seeing progress at the next meeting.

Yours sincerely

Judith Paget CBE

Attendance

List of attendees and noted apologies	
Health Board	**Welsh Government**
Dr Philip Kloer	Judith Paget - Chair
Andrew Carruthers	Nick Wood
Joanne Wilson	Jeremy Griffith
Shaun Ayres	Hywel Jones
Huw Thomas	Olivia Shorrocks
Lee Davies	Samia Edmonds
Lisa Gostling	Richard Desir
Sharon Daniel	Heather Payne
Helen Mitchell	Gaynor Evans - Secretariat
Apologies	
	Pushpinder Mangat
	Helen Arthur
	Sue Tranka