

**PWYLLGOR ARCHWILIO A SICRWYDD RISG
AUDIT AND RISK ASSURANCE COMMITTEE**

DYDDIAD Y CYFARFOD: DATE OF MEETING:	13 August 2024
TEITL YR ADRODDIAD: TITLE OF REPORT:	Escalation Status Update
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Lee Davies, Executive Director of Strategy and Planning Prof Philip Kloer, Chief Executive Officer (Interim)
SWYDDOG ADRODD: REPORTING OFFICER:	Shaun Ayres, Programme Director for Targeted Intervention / Deputy Director of Operational Planning

Pwrpas yr Adroddiad (dewiswch fel yn addas)

Purpose of the Report (select as appropriate)

Er Sicrwydd/For Assurance

ADRODDIAD SCAA

SBAR REPORT

Sefyllfa / Situation

Hywel Dda University Health Board is currently contending with significant financial and operational challenges, as highlighted in the recent accountability letter from Welsh Government dated 26 July 2024. This letter underscores the Board's inability to submit a balanced Integrated Medium-Term Plan (IMTP) for 2024-27, with a forecast deficit for 2024-25 standing at £64 million. This deficit substantially exceeds the target control total set in 2023/24 of £44.8m, presenting a critical financial risk. Welsh Government has emphatically reiterated the necessity for the Board to take immediate and further actions to reduce this deficit, emphasising the urgency and gravity of the situation.

The Annual Plan for 2024-2025 has been deemed neither acceptable nor approvable by Welsh Government, necessitating urgent revision and improvement. The health board is currently £10.7 million off the £64 million deficit target set out in its annual plan, with expectations to go even further in deficit reduction. This gap presents an immediate and pressing challenge that requires swift and decisive action.

In response, the Health Board has initiated several steps to address these challenges. These include developing clear action plans for 14 criteria currently flagged as 'Alert' across various domains, including financial planning, performance and outcomes, planned care, urgent and emergency care, and quality of care. Six key programmes aimed at financial sustainability and service improvement have been initiated: Alternative Care Provision, Carmarthenshire Improvement Plan, Medical Variable Pay, Mental Health and Learning Disabilities, Critical Care, and EMS Contract Reviews. These programmes are now subject to a rigorous 100-Day Planning and Delivery Cycle, with a firm operationalisation deadline of 1 October 2024, to ensure they deliver measurable and timely outcomes.

The recent Welsh Government letter reinforces the need for continued and intensified efforts to meet financial targets and improve critical service areas, particularly in urgent care and cancer services. The Targeted Intervention director is in discussions with operational colleagues about running a one to three-day sprint session to generate tangible outputs that can bridge the financial gap and potentially exceed it.

Regular monitoring and updates are being provided through the new Executive Team governance structure and the Internal Escalation Framework to ensure alignment with the stringent expectations set forth by Welsh Government. The Board must now demonstrate substantial and rapid progress across multiple fronts to meet these expectations and work towards de-escalation from Targeted Intervention status.

Cefndir / Background

Hywel Dda University Health Board has been operating under Targeted Intervention (TI) status since September 2022 for Finance and Planning, however, on the 23 January 2024 the entire Health Board was escalated to level 4 Targeted Intervention. This in turn now necessitate close monitoring and improvement across six key domains: Finance, Strategy and Planning; Performance and Outcomes; Fragile Services; Governance; Leadership, Capability and Culture; and Quality of Care. This escalation came as a result of persistent challenges in financial sustainability, service delivery, and organisational performance.

The health board was unable to submit a balanced Integrated Medium-Term Plan (IMTP) for 2024-27 as required by legislation, instead submitting an Annual Plan for 2024-25. This plan, along with subsequent information requested by Welsh Government, has been subject to scrutiny, resulting in the accountability letter received on 26 July 2024. The letter highlighted that the Annual Plan does not deliver the control total and remains unacceptable, emphasising the need for urgent and substantial improvement.

To address these challenges and meet the expectations set by Welsh Government, the health board has already implemented several key initiatives:

1. Comprehensive Monitoring Framework - A robust process covering all 56 de-escalation criteria across six domains, enabling real-time tracking and reporting. This framework allows for weekly and even daily updates, ensuring the Board and its committees have a clear, up-to-date view of the organisation's performance against TI criteria.
2. New Governance Structure - Executive Team arrangements, including the TI Coordination Group and specialised reporting groups (Value and Sustainability, Integrated Quality, Finance and Performance Delivery (IQFPD), and A Healthier Mid and West Wales (AHMWW)), provide clear oversight and accountability for the TI process. This structure ensures that progress against TI criteria is regularly reviewed and reported at all levels of the organisation.
3. Internal Escalation Framework - A standardised approach to monitoring directorate performance across key areas including Quality, Governance, Workforce, Fragile Services, Finance/Strategy/Planning, and Performance/Outcomes. This framework allows for both escalation and de-escalation of directorates based on performance.
4. Six Key Programmes - The health board has initiated six key programmes to drive improvement: Alternative Care Provision, Carmarthenshire Improvement Plan, Medical Variable Pay, Mental Health and Learning Disabilities, Critical Care, and EMS Contract Reviews. These programmes are at various stages of development and implementation, with some showing strong progress while others require urgent attention.
5. 100-Day Programme Cycle - Designed to streamline the planning and execution of key initiatives within the Health Board. This approach focuses on early identification of

indicators, tracking progress every 10 days, and prioritising addressing gaps rather than completed tasks.

6. Financial Improvement Initiatives - These include the development of a comprehensive financial roadmap, engagement of directorates through Rapid Improvement sessions, and initiation of targeted change programmes aimed at operational efficiencies and financial sustainability.
7. Clinical Services Plan - Work is progressing on the development of a sustainable clinical services plan, which is crucial for ensuring the medium to long-term viability and quality of services across the health board.

Despite these efforts, significant challenges persist, particularly in relation to the financial position and certain performance areas. The health board's forecast deficit of £64m remains substantially above the target control total of £44.8m, and urgent action is required to bridge this gap. Performance issues continue in areas such as urgent and emergency care, with targets for ambulance handovers and ED waiting times not being met.

The health board has achieved some notable successes, particularly in mental health services, where consistent achievement of the 80% target for LPMHSS assessments has led to formal de-escalation by Welsh Government for Part 1A of mental health targets. Additionally, the implementation of leadership development programmes and positive staff engagement survey results demonstrate progress in organisational culture and capability.

However, the recent directorate escalation meetings have highlighted ongoing challenges, with several directorates being escalated up in various domains, particularly in Finance, Strategy and Planning. This escalation is largely due to the absence of identified savings, highlighting the pervasive nature of the financial challenges across the organisation

Asesiad / Assessment

Hywel Dda University Health Board has implemented a robust and comprehensive framework to monitor its progress under Targeted Intervention (TI). This system covers all 56 de-escalation criteria across six key domains: Finance, Strategy and Planning; Performance and Outcomes; Fragile Services; Governance; Leadership, Capability and Culture; and Quality of Care. The framework allows for real-time tracking and reporting, with updates sometimes occurring daily. This approach ensures that the Board and its committees have a clear, up-to-date view of the organisation's performance against TI criteria.

The new Executive Team governance structure, including the TI Coordination Group and specialised reporting groups, provides strong oversight and clear lines of accountability. The Internal Escalation Framework offers a standardised approach to monitoring directorate performance across key areas. This governance approach ensures that progress against TI criteria is regularly reviewed and reported at all levels of the organisation.

In response to the 14 alerts identified, we have developed clear actions and plans. For each alert, there is either an established action plan or one currently in development, demonstrating our commitment to addressing these critical areas. Specifically, these actions encompass a range of targeted initiatives, including the Rapid Improvement Together sessions, financial roadmap alignment, and focused efforts in improving clinical and operational efficiencies. For example, the Financial Roadmap is designed to align cost reduction efforts with strategic goals, ensuring directorates are challenged to meet their

savings targets through a comprehensive compendium of opportunities. The escalation framework and internal monitoring mechanisms allow us to regularly review and adapt these plans to ensure their ongoing relevance and effectiveness. Additionally, some programmes are still in the development phase but have clear timelines and milestones to ensure they contribute effectively in future cycles.

There have been some notable successes. In particular, mental health services have shown significant improvement, consistently achieving the 80% target for LPMHSS assessments within 28 days. This progress has led to de-escalation by Welsh Government for Part 1A of mental health targets, demonstrating the organisation's capability to make and sustain meaningful progress when focused efforts are applied.

However, the recent accountability letter from Welsh Government highlights serious ongoing concerns. The health board's forecast deficit of £64m remains substantially adrift of the target control total set in 2023/24. The letter makes it clear that the Annual Plan for 2024-25 is neither acceptable nor approvable, and that Welsh Government expects the health board to go much further in reducing the deficit. This is not a new expectation, but a strong restatement of existing requirements.

Currently, the Health Board is £10.7 million off the £64 million deficit target set out in its annual plan. Recognising the urgency of this situation, the TI director is in discussions with operational colleagues about running a one to three-day sprint session, utilising methodology similar to that employed in the clinical services plan. The aim is to generate tangible outputs that can bring the deficit back to the £64 million target. It's important to note that while Welsh Government expects further improvement beyond this figure, the immediate priority is to achieve what was set out in the plan.

The health board has always been clear that the financial recovery to achieving the control total of £44.8m will be a two-year approach. The health board is committed to going as far as possible in reducing the deficit, but this must be considered in the context of the current position. Achieving the residual £10.7 million (to the £64m in the 24/25 annual plan) reduction presents a significant challenge, and the proposed sprint session is an important step in addressing this gap.

Moreover, the health board has initiated six additional programmes as part of our broader improvement efforts, supplementing the actions from the sprint session discussed earlier. These programmes target key areas such as financial sustainability, service delivery improvements, and operational efficiency enhancements. For instance, the Alternative Care Provision programme, aligned with the Six Goals Programme and focusing on reducing reliance on acute beds, is designed to provide alternative care pathways. The Carmarthenshire Improvement Plan is similarly aligned with the Six Goals Programme, ensuring a strategic approach to improving care delivery and operational efficiency. The Medical Variable Pay programme, while aiming to stabilise and reduce medical agency staffing costs, involves a multi-year, multi-faceted approach with clear timelines and deliverables set out for each workstream. Similarly, the EMS Contract Reviews and other initiatives are designed with clear implementation dates and milestones, ensuring they contribute to both immediate and long-term goals. Not all these programmes are expected to deliver full results within this financial year; instead, they are structured to provide sustainable improvements over a longer 2-year period, contributing to the wider objective of achieving our £44.8m control total at the end of 25/26. However, it is important to note that this has not been accepted by Welsh Government at this stage.

These efforts represent a comprehensive approach to mitigating the identified risks and addressing the financial challenges outlined in the Welsh Government letter. This multi-faceted response ensures that we are not only trying to meet the immediate expectations but also laying a sustainable foundation for long-term financial and service sustainability across all domains of the Targeted Intervention framework. Regular updates and rigorous oversight by the relevant committees ensure that progress is continually tracked, and any necessary adjustments are promptly made. While we recognise the necessity of taking at least another £10.7 million out to meet the annual plan target of a deficit position of £64m, these steps are part of our broader commitment to achieving and sustaining the control total, as stipulated by Welsh Government, and ensuring that we move towards an approvable and sustainable financial position.

Importantly, these initiatives were already in train before receiving the recent letter from Welsh Government, which provides assurance that we have been proactively addressing the scale of the challenge. The letter reinforces the urgency and importance of these actions, with the health board able to take an element of confidence that the measures we have in place are appropriate and necessary. Our ongoing efforts reflect a deep understanding of the financial pressures and a commitment to driving improvements that will ensure both financial and service sustainability.

Additionally, it is crucial to acknowledge that there are significant concerns about our performance in urgent care and cancer. These areas present considerable challenges in meeting both the TI de-escalation criteria and the commitments outlined in our Annual Plan. The recent letter from Welsh Government underscores the necessity for substantial improvements in these domains. Specifically, we are expected to achieve a 30% reduction in ambulance patient handovers over one hour by December 2024, and a further reduction by March 2025. Additionally, the target for the percentage of patients waiting over 12 hours in emergency departments is a 20% reduction by September 2024, with a further 20% reduction by March 2025. For cancer care, we must achieve 60% of patients starting first definitive treatment within 62 days by December 2024, and 70% by March 2025. These issues are at the forefront of our operational focus, and targeted actions are being prioritised to address these gaps urgently.

The health board's ability to provide regular, transparent updates on all Welsh Government Targeted Intervention (TI) criteria is a notable strength, demonstrating a commitment to improvement. This comprehensive monitoring and reporting system provides a strong foundation, offering regular updates on progress towards delivering intended outcomes. Where targets are not being met, clear action plans are in place and regularly reviewed. The success in mental health services exemplifies the organisation's potential to achieve and maintain improvements when focused efforts are applied.

However, the health board faces significant challenges in delivering intended outcomes across all TI criteria, particularly in financial sustainability and certain performance areas. The Audit Committee should be acutely aware that substantial improvements are still needed in many areas, with the financial situation remaining a critical concern. Welsh Government expectations, as restated in a recent letter, are not currently being met. This situation requires continued focus, innovative solutions and potentially accelerated efforts to address these challenges and make substantial progress towards overall de-escalation from TI status.

The recent Welsh Government letter makes it unequivocally clear that much more progress is needed urgently across multiple fronts. While the proposed sprint session to address the £10.7 million gap demonstrates the organisation's commitment to tackling these challenges

head-on, it is evident that sustained, intensive effort will be required to meet and exceed the expectations set by Welsh Government. In conclusion, whilst the health board has established robust processes for monitoring its performance under Targeted Intervention, it is struggling to deliver the required improvements, especially financially. The road ahead demands continued dedication and innovative approaches to overcome these hurdles and achieve the desired outcomes.

Argymhelliad / Recommendation

- The committee is asked to note and take assurance from the actions being taken in response to the Targeted Intervention (TI), including the development of clear plans for the 14 identified criteria flagged as 'Alert' and the initiation of six key programmes focused on financial sustainability and service improvement.
- The committee is asked to acknowledge the seriousness of the current financial and operational challenges as outlined in the recent Welsh Government letter. The Health Board is facing significant difficulties in achieving the targets set out in the Annual Plan for 2024-25, emphasising the urgency for intensified and immediate actions to address the forecast deficit and improve performance in critical areas such as urgent care and cancer services.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	Appendix 1 De-escalation criteria for governance 3. 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
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Not Applicable
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	7. All apply
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	6. All Apply
Amcanion Strategol y BIP: UHB Strategic Objectives:	All Strategic Objectives are applicable

Amcanion Cynllunio Planning Objectives	All Planning Objectives Apply
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2021- 2022	10. Not Applicable Choose an item. Choose an item. Choose an item.

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Contained within the body of report and attached.
Rhestr Termau: Glossary of Terms:	Contained within the body of report.
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Archwilio a Sicrwydd Risg Parties / Committees consulted prior to Audit and Risk Assurance Committee:	- All Committees and Board have been consulted given the breadth and depth of Targeted Intervention

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	This is a key component in the delivery of the Integrated plan for the period 2024/25.
Ansawdd / Gofal Claf: Quality / Patient Care:	This is a key component in the delivery of the Integrated plan for the period 2024/25.
Gweithlu: Workforce:	This is a key component in the delivery of the Integrated plan for the period 2024/25.
Risg: Risk:	Risks will be assessed as part of the ongoing process of both the derisking of the 2024/25 Plan, Targeted Intervention programme and their subsequent monitoring.
Cyfreithiol: Legal:	As above
Enw Da: Reputational:	Hywel Dda University Health Board needs to meet the targets set in order to maintain a good reputation with Welsh Government, together with our stakeholders, including our staff.
Gyfrinachedd: Privacy:	Not Applicable
Cydraddoldeb: Equality:	Consideration of Equality legislation and impact is a fundamental part of the planning of service delivery changes and improvements.



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1. Finance,
strategy and
planning

2.
Performance
and
outcomes

6. Quality of
care

**Escalation
Domains**

3. Fragile
services

5.
Leadership,
capability
and culture

4.
Governance

Hywel Dda University Health Board Targeted Intervention Progress Report July 2024

Contents



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Hywel Dda
University Health Board

- 1 TI roles and responsibilities
- 2 Domain 1: Finance, Planning and Strategy
- 3 Domain 2: Performance and outcomes
- 4 Domain 3: Fragile services
- 5 Domain 4: Governance
- 6 Domain 5: Leadership, capability and culture
- 7 Domain 6: Quality of care
- 8 Directorate escalation

Alerts



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	Criteria	Reporting Group	Committee	Status	Action
3	Annual plan developed with board approval demonstrating a substantial financial improvement trajectory to deliver as a minimum the target control total.	Value and Sustainability	SRC	Alert	<ul style="list-style-type: none"> - Financial Roadmap – aligned to the roadmap, there are several programmes of change which has a clear focus on delivering cost reduction - Directorates are challenged via the Rapid Improving Together session regarding their savings challenge - A compendium of opportunities has been shared with the Directorates and via the savings process each Directorate is expected to work through the opportunities and the four gateways
4	Submission of an acceptable annual plan in line with the current planning framework.	TI coordination group	SDODC	Alert	<ul style="list-style-type: none"> - Development of a comprehensive financial roadmap to align with strategic goals, addressing cost reduction and efficiency improvements (Finance Strategy and Planning). - Engagement of directorates through Rapid Improvement sessions to identify and execute savings opportunities, ensuring financial targets are met (Performance and Outcomes). - Initiation of targeted change programmes aimed at operational efficiencies and financial sustainability, monitored regularly . - Strengthened governance and oversight structures to ensure progress and accountability, with regular updates to the Board and Welsh Government (Governance). - Implementation of leadership development and staff engagement programmes to support sustainable service delivery (Leadership Capability and Culture). - Focus on quality improvement initiatives to enhance patient care and meet regulatory standards (Quality of Care).
8	Delivery of commitments set out within the annual plan particularly in relation to the ministerial priorities.	IQFPD	SDODC	Alert	<ul style="list-style-type: none"> - Monitored and challenged through IQFPD . IQFPD is set up to deliver the intentions and commitments in the Annual Plan - Reported through Domain 2 with the TI Framework pack or the Integrated Performance Report. - There are currently performance challenges in achieving Cancer, UEC and DPOCs
15	100% of open pathways to be waiting less than 104 weeks and maintained for 3 months.	IQFPD	SDODC	Alert	<ul style="list-style-type: none"> - Monitored and challenged through IQFPD - Current Trajectory does not deliver all stage 4, 104 weeks as there remains a gap of 567 in Orthopaedics - Regional solutions and delivery being explored, but at present, there is no clear plan to remedy the current projected breaches in orthopaedics

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Criteria	Reporting Group	Committee	Status	Action/Status
<p>17 15% reduction in the number of patients delayed by 100% for their follow-up appointment in three consecutive months and maintained for 3 months (Based on the November 2023 baseline.)</p>	IQFPD	SDODC	Alert	<ul style="list-style-type: none"> - Continue focussed validation approach - Review latest National Pathways to identify further opportunities (CIN, INNU, SOS or PIFU)Continue roll out WGOS 4 Primary Care management for Glaucoma, Diabetic Retinopathy and Medical Retina (circa 5-10k patients) - Operational focus on booking in turn/100% delayed cohort prioritisation Finalising Deep Dive specialty specific improvement plans - Review consistency of specialties below 20% SOS/PIFU Dx rate - Review OPD throughput to ensure capacity is maximised - Review Virtual opportunities across all specialties/UP Strategy led by Clinical Director (NHS Wales Deputy Planned Care Clinical Lead)
<p>18 65% R1 ophthalmology patient pathways to be waiting within or no longer than 25% of their target date for an outpatient appointment and maintained for 3 months.</p>	IQFPD	SDODC	Alert	<ul style="list-style-type: none"> - Focus on increasing R1 capacity with new SAS doctors commencing clinics in August/September 2024 - Roll out of WGOS 4 end of August 2024 to reduce referrals & increase capacity for R1 - Introduction of one stop process moving cataract patients to stage 4 which will give a true reflection of the R1 position, enabling more focused booking by true clinical priority - The one stop process will ensure cataract patients are removed from general clinics ensuring more capacity in clinic for R1 delivery - x1 substantive consultant and x1 locum consultant post currently being shortlisted to improve workforce position
<p>24 A continuous reduction of ambulance handovers over an hour of at least 11% in three consecutive months and maintained for 3 months (Based on the Oct-Dec 2023 baseline).</p>	IQFPD	SDODC	Alert	<ul style="list-style-type: none"> - Monitored and challenged through IQFPD . IQFPD is set up to deliver the intentions and commitments in the Annual Plan - 6 Goals Programme developing plans through the 4 workstreams to support the delivery of this target through the respective County Operational Plans. - At present, there is no clear plan or trajectory to support this TI performance target.
<p>25 Continuous improvement towards no more than 7% of patients waiting over 12 hours at each individual site and across the health board.</p>	IQFPD	SDODC	Alert	<ul style="list-style-type: none"> - Monitored and challenged through IQFPD . IQFPD is set up to deliver the intentions and commitments in the Annual Plan - 6 Goals Programme developing plans through the 4 workstreams to support the delivery of this target through the respective County Operational Plans - Except for PPH, this remains a challenged position across GGH, BGH and WGH

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Criteria	Reporting Group	Committee	Status	Action/Status
26 Median time from arrival at an emergency department to assessment by a clinical decision maker should not exceed 60 minutes.	IQFPD	SDODC	Alert	<ul style="list-style-type: none"> - Monitored and challenged through IQFPD . IQFPD is set up to deliver the intentions and commitments in the Annual Plan - 6 Goals Programme developing plans through the 4 workstreams to support the delivery of this target through the respective County Operational Plans - Against the target of 60, the HB position in June 24 is 75
27 A continuous reduction in delayed pathways of care of 5% for three consecutive months and then maintained for three months (based on Oct-Dec 2023 baseline).	IQFPD	SDODC	Alert	<ul style="list-style-type: none"> - Monitored and challenged through IQFPD . IQFPD is set up to deliver the intentions and commitments in the Annual Plan - 6 Goals Programme developing plans through the 4 workstreams namely Hospital at Home to support the delivery of this target through the respective County Operational Plans - The current de-escalation target is 174, however, this is currently off-track with the last 3 months average being 243.
34 Evidence that all recommendations from the Royal Colleges HIW and other reviews specific to Hywel Dda UHB are discharged and either verified or delivered or scheduled for delivery within the health board's longer-term improvement plan.	IQFPD	QSEAC	Alert	<ul style="list-style-type: none"> - Review and document the process to ensure recommendations from the Royal Colleges, HIW, and other specific reviews are correctly discharged. - Utilise the Quality Governance Framework and involve IQFPD to ensure the creation and implementation of clear action plans, with defined milestones and outcomes. - Regularly update with demonstrable evidence via the operational governance arrangements to ensure all actions are integrated into the health board's long-term improvement plan. - Schedule regular reviews and audits to verify the discharge of recommendations and adherence to the improvement plan, reporting findings via the Quality & Governance arrangements.
45 Plans are in place to develop a sustainable workforce resulting in improved staff retention and staff well-being a reduction in the number of vacancies and the number of interim and agency staff. Workforce plans and clinician job plans are reviewed annually to ensure that the organisation can deliver the requirements of the annual plan.	Value and Sustainability	PODC	Alert	<ul style="list-style-type: none"> - Monitored and overseen via the Value and Sustainability Group, to ensure that the commitments in the current annual plan are delivered ; whilst ensuring there is a focus on 25/26. - Both the Nurse Stabilisation and Reduction in Medica Variable Pay programmes will be responsible for delivering a reduction in agency and variable pay. The nurse stabilisation programme is firmly established and has clear plans to deliver agency reductions year on year.

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University Health Board

Criteria	Reporting Group	Committee	Status	Action/Status
51 70% of complaints that had final reply (Reg 24) / interim reply (Reg 26) to be closed less than 30 working days of concern received.	IQFPD	QSEAC	Alert	<ul style="list-style-type: none"> - Develop and implement a trajectory to achieve the 70% closure rate target. - Screen complaints rigorously to ensure only appropriate cases are closed within the timeframe. - Monitor current average closure rate, which is 62%, and identify areas for improvement. - Report monthly on progress towards achieving the 70% target, with detailed action plans for any shortfalls.
52 Effective response from the health board to external reports and reviews including those from Audit Wales the Ombudsman Royal Colleges and HIW resulting in sustainable improvements.	IQFPD	QSEAC	Alert	<ul style="list-style-type: none"> - Utilise the Quality Governance Framework to provide demonstrable evidence of acceptance and embedding of improvements both at Directorate/Care Group levels and in practice. - Quality Safety Intelligence sub-group within IQFPD to regularly review the status of action plans, and Directorates/Care Groups to monitor the implementation of actions and concerns. - Ensure clinical executives and their deputies meet fortnightly to review progress and address any emerging issues with Directorates/Care Groups

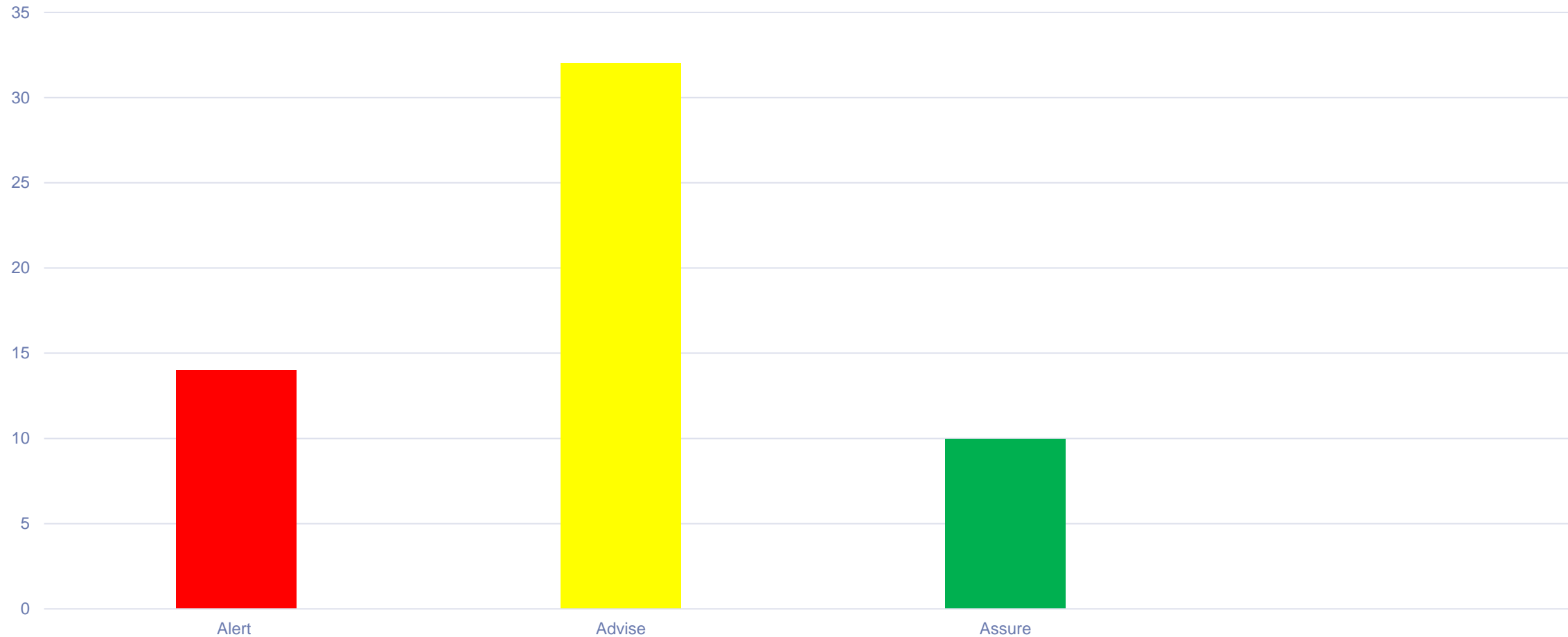
TI progress July 2024



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Current Status of the 56 De-escalation Criteria





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University Health Board



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and
outcomes

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care

Escalation
Domains

3. Fragile
services

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capability
and culture

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Approach to TI and revised arrangements

Definitions



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Assurance Level	
Assurance Level: High = Assure	<ul style="list-style-type: none">• There is strong evidence that the criteria are being met or exceeded.• Actions are robust and effectively addressing the issue.• No significant concerns exist, and performance is consistently on target.
Assurance Level: Moderate = Advise	<ul style="list-style-type: none">• There is partial evidence that the criteria are being met.• Actions are in place but require close monitoring and additional efforts.
Assurance Level: Low = Alert	<ul style="list-style-type: none">• There is little or no evidence that the criteria are being met.• Actions are insufficient or not effectively addressing the issue.• Significant concerns exist, and there is a high risk of not meeting targets.

TI responsibilities



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University Health Board

Action	Lead	Committee	RAG Status	Comments
1 Appoint an SRO(s) for the overall escalation and each domain if considered necessary and appropriate project leads.	CEO	ARAC	Assure	Complete - Director of Strategy and Planning appointed as SRO
2 Have board ownership and oversight with a clear governance structure, ensure that the Board is appraised of the escalation plan and evidence regular progress updates to the Board on progress against de-escalation criteria.	SRO	ARAC	Assure	The de-escalation criteria is clearly set out and aligned to leads and committees. All current alerts have clear actions and/or plans
3 Agree the Targeted Intervention plan(s) and commit sufficient resources to ensure that the plan deliverables are achieved.	CEO	ARAC	Advise	Some not all resources have yet been identified
4 Provide monthly progress reports and evidence against the escalation plan to Welsh Government/NHS Wales Executive as required.	SRO	ARAC	Assure	Yes, this TI Framework is a live document and is updated daily/weekly/monthly and then shared as required.
5 Strengthen the formal review mechanisms to support urgency in delivering confidence and improvement to the overall position.	DOF	ARAC	Assure	



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Hywel Dda
University Health Board



1. Finance,
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and
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care

Escalation
Domains

3. Fragile
services

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Domain 1: Finance, strategy and planning

Domain 1: Finance, Planning and Strategy



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Criteria	Reporting Group	Committee	Status	Comments
1 The health board must demonstrate that there are robust financial governance and robust financial control environment in place with risks minimised.	Value and Sustainability	SRC	Advise	Additional measures introduced.
2 Substantial progress to be made in delivering the targeted intervention action plan including actions to improve the organisation's understanding of the existing deficit and key drivers and development and realisation of opportunities.	Value and Sustainability	SRC	Advise	Further work undertaken on the opportunities to underpin the financial route map but continues to be raised as a concern by WG.
3 Annual plan developed with board approval demonstrating a substantial financial improvement trajectory to deliver as a minimum the target control total.	Value and Sustainability	SRC	Alert	Annual plan does not deliver the control total.
4 Submission of an acceptable annual plan in line with the current planning framework.	TI coordination group	SDODC	Alert	Annual plan remains unacceptable.
5 Evidence of integrated planning across the organisation which supports the development of a coherent and deliverable annual plan.	TI coordination group	SDODC	Advise	This remains on-going and through the annual plan and TI workshop, the integrated planning process will be enhanced
6 Board clarity on the strategic vision for the organisation.	AHMWW	SDODC	Advise	Agreed strategy in place, AHMWW, however PBC not yet endorsed by WG and therefore strategic plan remains uncertain.

Domain 1: Finance, Planning and Strategy

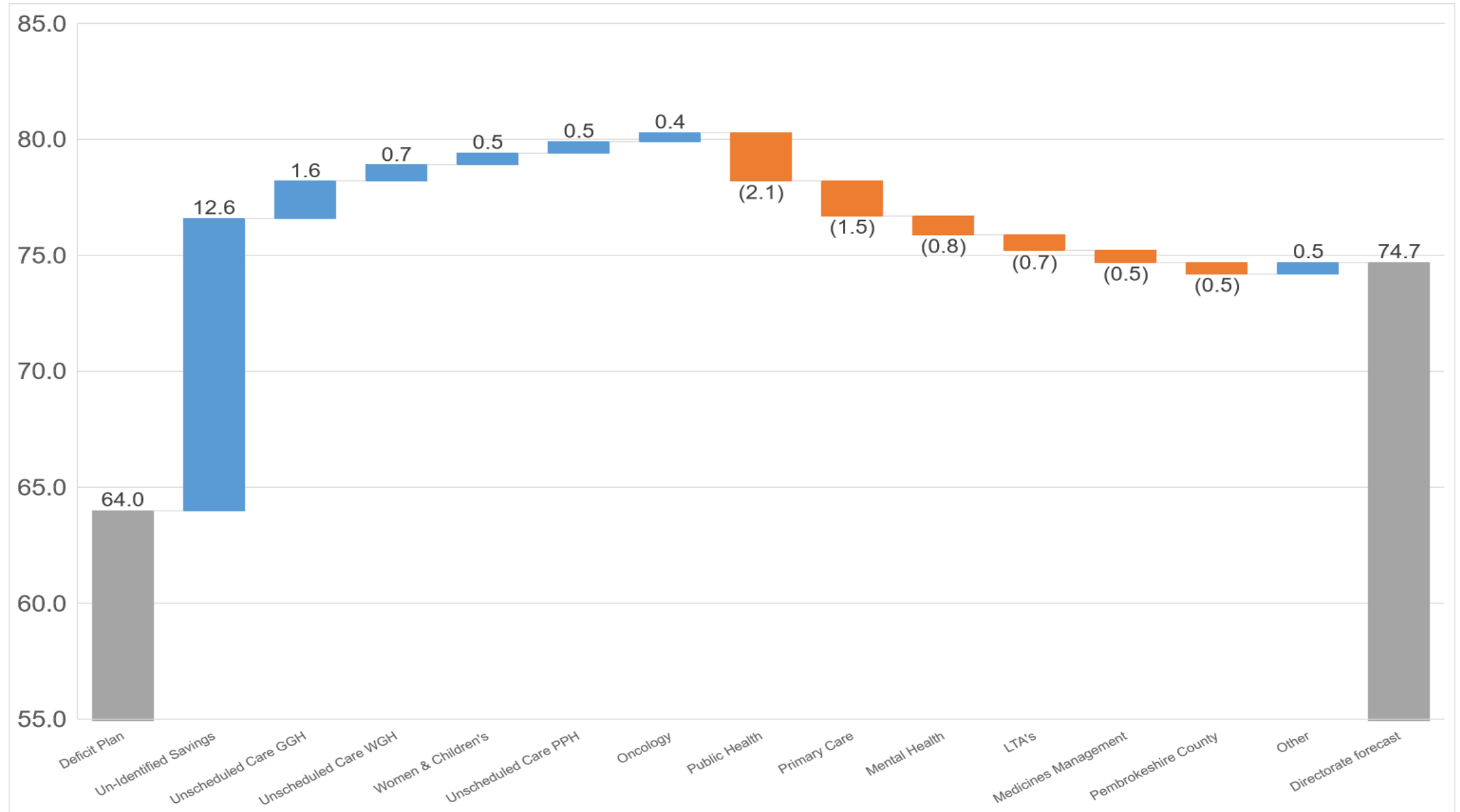


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Criteria	Reporting Group	Committee	Status	Comments
7 Evidence of a clear roadmap and implementation of the health board's Clinical Services Plan.	AHMWW	SDODC	Advise	Work on the CSP is progressing but remains in development phase.
8 Delivery of commitments set out within the annual plan, particularly in relation to the ministerial priorities.	IQFPD	SDODC	Alert	Currently significant challenges in Urgent and Emergency Care, Cancer and Diagnostics. Orthopaedics remains an outlier to achieving stage 104 week waits.
9 Significant progress on a clinical services plan.	AHMWW	SDODC	Advise	Work on the CSP is progressing but remains in development phase.
10 Sustained improvements in delivery of the plan throughout the year.	IQFPD	SDODC	Advise	There are several improvements, however the status may need to be reviewed in September 2024.
11 Welsh Government's confidence in delivery based on an assessment against the planning maturity matrix and planning quadrant.	TI coordination group	SDODC	Advise	Our position has shown improvement; however, this is finely poised and may require revision in September 2024
12 Establishment of a Joint Committee with Swansea Bay UHB and demonstrate improved regional collaboration where required to ensure continued safety, quality and ongoing viability and sustainability of regional services; including orthopaedics and ophthalmology.	Executive team	BOARD	Advise	The joint committee is currently being established with the relevant executives meeting to discuss both the sustainability and prioritisation of services.

End of Year: Key Directorates (£'m)



Savings

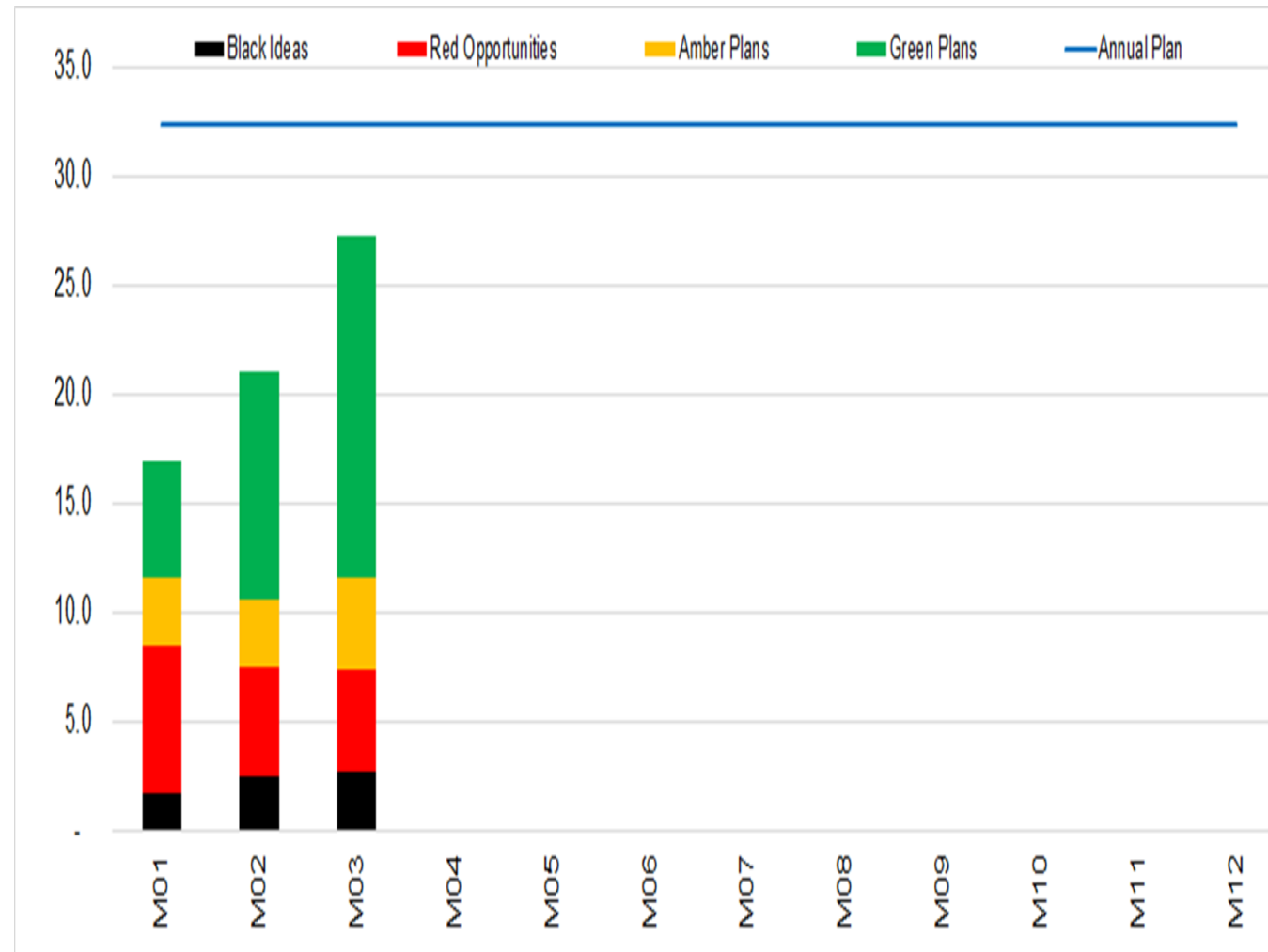


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Through the planning process there has been some progress in generating a higher value of saving plans and progress along the BRAG ratings, with a reduction in black schemes as they have converted to RAG. As schemes are rejected from the black status, the total value identified may reduce over the coming month.

On review of schemes at the outset of the new financial year, some specific red and black schemes have been closed, recognising wider interdependencies across services and to align with latest plans. The value of green and amber schemes continues to increase



Overview of the 100-Day Programme Cycle



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Overview

- The 100-Day Programme Cycle is designed to streamline the planning and execution of key initiatives within our Health Board.
- Objective: To ensure clear deliverables, accountability, and consistent progress tracking, enabling rapid and sustainable improvements.

Purpose of the Framework:

- Early Identification of Indicators - Focus on identifying and setting clear, measurable deliverables early in the cycle.
- Tracking Progress - Every 10 days, assess progress against the defined deliverables to ensure alignment with overall goals.
- Focus on Gaps - Prioritise addressing what's missing rather than completed tasks to maintain focus and drive continuous improvement.

Approach

- The Programme Director of Targeted Intervention will meet with each SRO for 30 minutes every week to track progress.
- These meetings ensure continuous oversight and support, facilitating prompt resolution of issues and maintaining momentum
- The framework supports the 'what' and 'when' of deliverables, but not the 'how,' allowing each programme to deliver in a manner that best suits their approach and needs. This flexibility ensures that each programme can present their progress and outcomes in a way that supports their respective methodologies and approaches

Overview of the 100-Day Programme Cycle



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Key Phases and Milestones:

Day 10: Define Deliverables

- Document specific, measurable deliverables.
- Ensure alignment with strategic objectives.
- Engage stakeholders for early input.

Day 20: Sustainable Change Plan

- Present a detailed plan for sustainable changes.
- Outline methods for embedding changes into daily operations.
- Define metrics to measure sustainability.

Day 30: Alternative Service Provision Model

- Present new service models (if applicable).
- Include resource requirements and expected impacts on patient care.

Day 45: Integration into Operational Plans

- Ensure deliverables are integrated into relevant operational plans.
- Establish timelines and resource allocation plans.

Overview of the 100-Day Programme Cycle



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Day 60: Benefit Realisation Plan

- Develop a comprehensive plan for realising expected benefits.
- Provide bi-weekly progress updates on benefit realisation.

Day 90: Formal Review Points

- Facilitate review sessions to assess progress.
- Maintain a decision log and capture lessons learned.

Alternative Care Provision (Aligned Via the 6 Goals Programme) – SRO Peter Skitt



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Day 1-20 Status Update	Next Steps (By Day 30)	Confidence Level – Alert
<ul style="list-style-type: none"> - Pembrokeshire Plan - Closure of 25 beds scheduled to be completed by 30th September 2024 (11 of 25 already reduced). - Carmarthenshire Operational Plan - Key schemes identified, Medical Day Unit, ED Nurse Recruitment, Surgical SDEC & SDU, Repatriation Database, and reduction of Level 1 patients in ITU. <p>3As Reports:</p> <ul style="list-style-type: none"> - H@H Workstream - Establishment of a working group and initial steps towards defining the H@H model. - Safe Hospital Care Workstream - Identified need for Redirection policy and boarding capacity review, progress on optimal flow plans. - Crisis Response Workstream - Developing a best practice model for CSH, addressing data analysis needs. - Front Door Workstream - Mitigating delays due to workstream lead appointments. 	<ul style="list-style-type: none"> - Specific Measurable Deliverables - Document specific deliverables with concrete outputs, outcomes, financial impacts, and quality improvements. Establish clear timelines and bi-weekly progress reporting. - Sustainable Change Plan - Develop a detailed sustainable change plan outlining specific changes, their intended impact, methods for embedding changes, metrics for sustainability, and ensuring operational teams can maintain changes post-programme. - Stakeholder Engagement Plan - Create a comprehensive stakeholder engagement plan including identification of key stakeholders, engagement methods, feedback collection, and continuous engagement. - Operational Plan Integration - Ensure programme deliverables are integrated into relevant operational plans, mapping to operational objectives, establishing timelines, developing resource plans, and identifying operational leads. - Cross-Functional Alignment Plan - Present a cross-functional alignment plan and facilitate bi-weekly reviews to ensure ongoing alignment and collaborative problem-solving. - Benefit Realisation Planning - Develop a comprehensive benefit realisation plan and provide bi-weekly updates on progress towards benefit realisation. 	<p>The confidence level is currently low. Significant challenges include:</p> <ul style="list-style-type: none"> - Clear, documented deliverables with timelines are missing. - Comprehensive plans outlining specific changes and their impacts are not yet in place. - Ensuring deliverables are integrated into operational plans is critical and currently lacking. - The lack of defined models of care for alternative capacity presents a major risk.

Medical Variable Pay – SRO Carly Hill



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Day 1-30 Status Update	Next Steps (By Day 45)	Confidence Level - Assure
<ul style="list-style-type: none">- The SRO have successfully defined and documented specific, measurable deliverables by Day 10. These include clear goals related to variable pay, job descriptions, e-rostering, job planning, international medical recruitment, and the medical rate card.- Milestones for 30, 60, and 90 days have been clearly established by Day 20. These milestones are in place, and the preliminary assessment suggests they are achievable.- A detailed sustainable change plan was presented by Day 20. These plans are structured and linked to our operational objectives.- The SRO/Programme has begun to engage with directorates to consider alternative service provision models, though further detail and operational clarity are required.	<ul style="list-style-type: none">- Verify that the established milestones are realistic and generalisable across different operational contexts, ensuring they are reflected within respective operational plans.- Confirm that the detailed sustainable change plans within the spreadsheet align fully with our operational resources and timelines.- Provide further operational clarity and details on the implementation of alternative service provision models (if or where appropriate) to ensure they are integrated within our overall operational plans.- Cross-reference our programme deliverables with operational plans to validate timelines, resource allocations, and responsibilities.	<ul style="list-style-type: none">- Based on the submissions, the Executive team can have a high-level confidence in this scheme because significant steps have been taken to ensure it is on track. The clear definition of deliverables, establishment of realistic milestones, structured change plans, and initial engagement with directorates on alternative models all contribute to a solid foundation for success. Continuous monitoring and updates by the Value and Sustainability Group will ensure alignment with our strategic and operational intent. This well-organised and thoroughly planned approach gives assurance that we are moving in the right direction and will achieve our objectives by the 1st of October.

Carmarthenshire Improvement Plan (Aligned via the 6 Goals Programme) – SRO Mandy Davies



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Day 1- 20 Status Update	Next Steps (By Day 30)	Confidence Level – Alert
<ul style="list-style-type: none"> - No Formal Submission - No documentation has been submitted; information was extrapolated from the Carmarthenshire Rapid Improving Together session and directorate escalation meetings. - Initial Identifications - Key deliverables and recurrent savings opportunities were identified. - Stakeholder Engagement - Initial engagement with stakeholders and setting up monitoring groups for specific areas such as Pathways of Care Delays (POCD).. - Clarity on SRO Role - Significant confusion exists around the SRO's role in driving delivery versus pulling the programme together. This ambiguity poses a risk to the overall responsibility for programme delivery and integration with other key areas such as the 107-bed Alternative capacity and critical care. 	<ul style="list-style-type: none"> - Define and Document Specific Deliverables - Establish concrete measurable deliverables with clear financial impacts and patient outcomes. - Create Detailed Timelines - Develop and communicate detailed timelines for each deliverable. - Clarify Data Assumptions - Ensure data assumptions, including virtual admissions and admission avoidance, are clear and data sources are reliable. - Establish Metrics and Monitoring - Define specific metrics for patient flow improvements, waiting time reductions, and patient satisfaction. Set up a structured format for bi-weekly progress updates. - Comprehensive Stakeholder Engagement - Develop and implement a comprehensive stakeholder engagement plan to ensure buy-in and collaboration. - Financial Impact Analysis - Provide a detailed financial impact analysis, including expected cost savings and efficiency gains. - Clarify SRO Responsibilities - Clearly define the SRO's responsibilities to ensure effective programme delivery and integration with other critical areas. 	<ul style="list-style-type: none"> - Progress has been made in identifying deliverables and engaging stakeholders. However, significant confusion around the SRO's role and lack of formal submissions hinder progress. It is crucial to define measurable outcomes, integrate financial impacts into programme documentation, develop clear timelines, establish robust progress reporting, and clarify SRO responsibilities to stay on track for a successful go-live on the 1st of October.

Mental Health and Learning Disabilities – SRO

Liz Carroll



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Day 1- 20 Status Update

- No Presentation or Documentation Delivered by Day 20 - There were no actionable plans or documentation presented by the MH&LD team.
- No Progress Made - Despite expectations and agreements on the Directorate having an outline plan, there has been no tangible progress or updates provided.

Next Steps (By Day 30)

- Inpatient Services - Identify and implement cost-saving measures linked to variable pay.
- Continuing Healthcare (CHC) - Analyse key areas of spend and explore cost-reduction opportunities.
- Section 136 Liaison Services - Develop a sustainable and financially viable service, considering its impact on other system parts.

Confidence Level – Alert

The MH&LD programme must urgently focus on creating and presenting actionable plans to address the need for recurrent saving plans. A comprehensive update covering all aspects of the first 1-30 days as set out in the 100-Day Planning and Delivery Cycle Framework is required by Day 30.

EMS Contract Reviews – SRO Gareth Rees



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Day 1- 20 Status Update	Next Steps (By Day 30)	Confidence Level – Alert
<ul style="list-style-type: none">- Cardiac Care Transfer Service (Jumbulance) completed 922 journeys in 2023, averaging 3 journeys per day, operating seven days a week from 09:00 to 21:00.- PPH EMS Support Vehicle transported 909 patients from Llanelli postcodes to GGH A&E in 2023, averaging 2.5 patients per day.- WGH Maternity Service DAV undertakes an average of 758 transfers per year, about 2 patients per day, operating 24/7.	<p>The following challenges have been raised based on the content of the updated paper:</p> <p>Current Gaps:</p> <ul style="list-style-type: none">- Lack of detailed, specific measurable deliverables and timelines.- Absence of comprehensive sustainable change plans to optimise service efficiency and cost-effectiveness.- Missing formal service specifications and investment parameters for evaluating effectiveness and productivity.- No comprehensive stakeholder engagement plans identifying key groups, engagement methods, and feedback mechanisms.- Unclear on how dedicated vehicles averaging 2-3 journeys per day over 12 and 24 hours results in no productivity of efficiency opportunity (especially for the Jumbulance and EMS vehicle)	<ul style="list-style-type: none">- Despite the low utilisation rates (2-3 patients per day across three vehicles), there is currently no recognition that these figures present an opportunity for optimisation. Immediate action is required to address this and to ensure these services are aligned with strategic objectives and cost-efficiency, aiming for successful delivery by the 1st of October.

Critical Care – SRO Keith Jones



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Day 1- 30 Status Update	Next Steps (By Day 45)	Confidence Level – Assure
<ul style="list-style-type: none"> - The plan sets clear financial and operational targets, aiming for £1.4 million in savings for 2024/25 and £2.8 million in full-year effect. - Data-driven decision-making is supported by comprehensive data from ICNARC and other sources. - Stakeholder engagement involves critical care medical and nursing teams and hospital management, ensuring diverse expertise and insights. - A phased approach to reducing bed capacity is practical and manageable, allowing for adjustments based on initial outcomes. - Developing a detailed sustainable change plan by Day 20 ensures changes are embedded into daily operations. - The plan proactively identifies risks and outlines mitigating actions, with regular reviews and bi-weekly updates. - Integration with the UEC improvement workstream enhances patient flow, reduces length of stay, and improves patient outcomes. 	<ul style="list-style-type: none"> - Establish Clear Measurable Milestones for 30, 60, and 90 Days: - 30 Days: Complete initial data analysis, finalise protocols for patient transfer, and agree on initial bed reduction plans. - 60 Days: Implement the first phase of bed reductions, commence staff training, and initiate stakeholder engagement activities. - 90 Days: Review and adjust the implemented changes, finalise the detailed sustainable change plan, and ensure all operational teams are prepared for full implementation. - Complete final Data Analysis (By Day 40): Ensure the analysis of nurse utilisation data versus occupancy/levels of care is completed and incorporated into the sustainable change plan. - Develop a Cross-Functional Alignment Plan (By Day 35): Finalise a cross-functional alignment plan detailing key interdependencies, decision-making processes, and joint performance metrics. 	<ul style="list-style-type: none"> - The Critical Care Reduction Plan presents a structured and well-documented approach that aligns with the organisation's objectives. Most elements required for successful delivery by 1st October are in place. The next steps outlined will ensure the plan remains on track, addressing any outstanding gaps and enhancing the project's likelihood of success.



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1. Finance,
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2.
Performance
and
outcomes

6. Quality of
care

**Escalation
Domains**

3. Fragile
services

5. Leadership,
capability and
culture

4.
Governance

Domain 2: Performance and outcomes

Baseline position and Current Performance against TI



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	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
Hywel Dda	Ambulance handovers taking over 1 hour - Hywel Dda	11% reduction 3 consecutive months, maintained for 3 months	915	680	901	993	863	944	980	854	1,019	915	959	1,245	1,124	1,192	1,103	970	1,078
	% patients waiting over 12 hours in an emergency department - Hywel Dda	Continuous improvement towards no more than 7%	9.0%	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%	10.7%	10.7%
	Median time from arrival at ED to assessment by a clinical decision maker (mins) - Hywel Dda	60	58	60	57	57	58	71	71	70	65	58	67	64	64	67	65	73	75
	Number of delayed pathways of care - Hywel Dda	5% reduction 3 consecutive months, maintained for 3 months	227	174	278	230	247	256	238	222	192	227	190	207	212	220	237	247	245
Bronglais	Ambulance handovers taking over 1 hour - Bronglais Hospital	11% reduction 3 consecutive months, maintained for 3 months	158	122	175	121	165	165	229	194	184	158	179	237	213	182	211	240	233
	% patients waiting over 12 hours in an emergency department - Bronglais Hospital	Continuous improvement towards no more than 7%	7.0%	7.0%	8.6%	6.7%	7.7%	8.5%	10.9%	10.5%	9.3%	8.9%	10.3%	12.2%	10.8%	10.1%	10.9%	10.8%	11.0%
	Median time from arrival at ED to assessment by a clinical decision maker (mins) - Bronglais Hospital	60	58	60	58	52	54	79	80	98	75	58	83	62	55	66	69	71	67
Glangwili	Ambulance handovers taking over 1 hour - Glangwili Hospital	11% reduction 3 consecutive months, maintained for 3 months	429	326	471	534	514	458	397	337	515	429	445	503	461	490	498	468	480
	% patients waiting over 12 hours in an emergency department - Glangwili Hospital	Continuous improvement towards no more than 7%	7.0%	7%	10.4%	11.7%	11.6%	11.6%	15.0%	12.3%	11.8%	10.7%	11.7%	15.8%	14.7%	16.1%	14.1%	15.1%	15.9%
	Median time from arrival at ED to assessment by a clinical decision maker (mins) - Glangwili Hospital	60	58	60	55	57	57	62	57	57	55	49	51	58	64	61	60	69	76
Prince Philip	Ambulance handovers taking over 1 hour - Prince Philip Hospital	11% reduction 3 consecutive months, maintained for 3 months	82	43	102	157	84	85	74	22	35	82	67	79	97	112	143	106	104
	% patients waiting over 12 hours in an emergency department - Prince Philip Hospital	Continuous improvement towards no more than 7%	7.0%	7%	3.0%	3.5%	2.9%	2.9%	3.8%	1.5%	2.4%	2.1%	2.4%	2.9%	3.6%	4.5%	3.4%	3.4%	3.5%
Withybush	Ambulance handovers taking over 1 hour - Withybush Hospital	11% reduction 3 consecutive months, maintained for 3 months	246	188	156	181	100	236	280	301	285	246	268	426	353	408	251	156	261
	% patients waiting over 12 hours in an emergency department - Withybush Hospital	Continuous improvement towards no more than 7%	7.0%	7%	13.7%	13.6%	12.3%	14.1%	16.5%	14.5%	15.3%	16.2%	15.7%	17.5%	16.1%	16.3%	15.0%	14.9%	13.9%
	Median time from arrival at ED to assessment by a clinical decision maker (mins) - Withybush Hospital	60	58	60	58	59	65	78	89	78	76	77	89	77	72	81	70	85	83
DPoC	Number of delayed pathways of care - Carmarthenshire	5% reduction 3 consecutive months, maintained for 3 months	108	93	149	130	147	144	126	117	98	128	98	106	117	113	119	135	125
	Number of delayed pathways of care - Ceredigion	5% reduction 3 consecutive months, maintained for 3 months	35	30	47	24	36	35	39	38	37	30	39	46	38	43	54	41	34
	Number of delayed pathways of care - Pembrokeshire	5% reduction 3 consecutive months, maintained for 3 months	53	45	82	74	61	75	64	59	55	59	45	46	56	62	63	71	66



Goal achieved



Making good progress towards goal



Minimal progress made or decline from previous month



Same as baseline or worse

Domain 2: Performance and outcomes

Planned care and cancer



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Criteria	Reporting Group	Committee	Status	Comments
13 60% performance maintained for 3 months against the SCP target.	IQFPD	SDODC	Advise	Agreed improvement trajectory delivers this criteria.
14 100% of open outpatient pathways to be waiting less than 52 weeks and maintained for 3 months.	IQFPD	SDODC	Advise	Agreed improvement trajectory delivers this criteria.
15 100% of open pathways to be waiting less than 104 weeks and maintained for 3 months.	IQFPD	SDODC	Alert	Current plan delivers 104 weeks for all services except Orthopaedics.
16 80% of open pathways to be waiting less than 52 weeks and maintained for 3 months.	IQFPD	SDODC	Assure	Criteria being achieved.
17 15% reduction in the number of patients delayed by 100% for their follow up appointment in three consecutive months and maintained for 3 months (Based on the November 2023 baseline.)	IQFPD	SDODC	Alert	Actions and Plans set out within the Alerts
18 65% R1 ophthalmology patient pathways to be waiting within or no longer than 25% of their target date for an outpatient appointment and maintained for 3 months.	IQFPD	SDODC	Alert	Actions and Plans set out within the Alerts

Domain 2: Performance and outcomes

Planned care and cancer



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Criteria	Reporting Group	Committee	Status	Comments
19 80% of patients waiting for a diagnostic test to be waiting less than 8 weeks and maintained for 3 months.	IQFPD	SDODC	Advise	Agreed improvement trajectory delivers this criteria.
20 80% of patients waiting for a diagnostic endoscopy to be waiting less than 8 weeks and maintained for 3 months.	IQFPD	SDODC	Advise	Agreed improvement trajectory delivers this criteria.
21 80% of patients waiting for a NOUS and non-cardiac MRI to be waiting less than 8 weeks and maintained for 3 months.	IQFPD	SDODC	Advise	Agreed improvement trajectory delivers this criteria.
22 85% of patients waiting for therapies to be waiting less than 14 weeks and maintained for 3 months.	IQFPD	SDODC	Advise	Agreed improvement trajectory delivers this criteria.
23 Improving ratings from service user feedback experience responses and evidence of use of Datix and CIVICA data to inform quality improvement processes and the experience of patients and their families.	IQFPD	QSEAC	Advise	Do we have trajectories and plans for this?

Domain 2: Performance and outcomes

Urgent and emergency care



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Criteria	Reporting Group	Committee	Status	Comments
24 A continuous reduction of ambulance handovers over an hour of at least 11% in three consecutive months and maintained for 3 months (Based on the Oct-Dec 2023 baseline).	IQFPD	SDODC	Alert	Current actual performance is a significant concern and is negatively deviating from the set trajectories
25 Continuous improvement towards no more than 7% of patients waiting over 12 hours at each individual site and across the health board.	IQFPD	SDODC	Alert	Remains a significant challenge. Whilst improvement actions identified, this has not to date translated in a clear operational plan
26 Median time from arrival at an emergency department to assessment by a clinical decision maker should not exceed 60 minutes.	IQFPD	SDODC	Alert	No current operational plan in place
27 A continuous reduction in delayed pathways of care of 5% for three consecutive months and then maintained for three months (based on Oct-Dec 23 baseline).	IQFPD	SDODC	Alert	Remains significantly above plan with no operational plans in place
28 Improving ratings from service user feedback experience responses and evidence of use of Datix and CIVICA data to inform quality improvement processes and the experience of patients and their families.	IQFPD	SDODC		

Domain 2: Performance and outcomes

Mental health



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Criteria	Reporting Group	Committee	Status	Comments
29 80% of LPMHSS mental health assessments undertaken within 28 days from the date of receipt of referral.	IQFPD	SDODC	Assure	Welsh Government have de-escalated the Health Board for Part 1 of assessments
30 65% of therapeutic interventions started within 28 days following an assessment by LPMHSS.	IQPFD	SDODC	Assure	Criteria being achieved
31 80% of HB residents in receipt of secondary mental health services who have a valid care and treatment plan.	IQFPD	SDODC	Assure	Criteria being achieved



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1. Finance,
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planning

2.
Performance
and
outcomes

**Escalation
Domains**

3. Fragile
services

6. Quality of
care

5.
Leadership,
capability
and culture

4.
Governance

Domain 3: Fragile services

Domain 3: Fragile services



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Criteria	Reporting Group	Committee	Status	Comments
32 Evidence that the health board has the appropriate mechanism to understand the drivers behind a fragile service through the triangulation of key data points, including staffing levels, staff and patient feedback, concerns, incidents, stakeholder feedback (HIW, AW, HMC, RC, Llais etc), mortality reviews, duty of quality/candour, infection protection control, performance, clinical and medical leadership.	IQFPD	QSEAC	Advise	Update on fragile services framework presented at QSEAC in April
33 Fragile services (including but not limited to stroke, primary care, orthopaedics and ophthalmology) are supported by strong clinical leadership, have an effective integrated improvement plan, project management structure and effective transformation support. Where appropriate key performance metrics will be agreed.	IQFPD	QSEAC	Advise	Stroke, orthopaedics, ophthalmology and primary care are supported through Clinical Services Plan and Primary and Community strategy programmes. Support for other services to be established as part of framework above.
34 Evidence that all recommendations from the Royal Colleges, HIW and other reviews specific to Hywel Dda UHB are discharged and either verified or delivered or scheduled for delivery within the health board's longer-term improvement plan.	IQFPD	QSEAC	Alert	Further work required to establish the position against recommendations.
35 Evidence that the Board is sighted on fragile services and has a robust response to these issues that is being addressed by the health board.	IQFPD	QSEAC	Advise	Clinical Services Plan presented regularly at Public Board. Work on the fragile services framework to be presented at future Board.



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Domain 4: Governance



Criteria	Reporting Group	Committee	Status	Comments
36 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	<ul style="list-style-type: none"> Refreshed approach to Committee self-assessment feeding into the Board Development Programme IM reflective sessions following every meeting Operational risks are reviewed by Committees every other meeting Ministerial priorities are aligned to Committee
37 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	<ul style="list-style-type: none"> QIA process approve by QSEC and is being implemented with QIA Panels taking place
38 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	

Criteria	Reporting Group	Committee	Status	Comments
39 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 QSE and Board.	TI coordination group	ARAC	Advise	<ul style="list-style-type: none"> Defined process in place for reporting risks to Board and Committees
40 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	<ul style="list-style-type: none"> New Executive Team governance arrangements in place New Internal Escalation Framework in place Further work required on strengthening operational governance arrangements linked to new operational directorate structure
41 Self-assessment against an agreed governance maturity matrix with evidence the agreed level.	TI coordination group	ARAC	Advise	<ul style="list-style-type: none"> Board Effectiveness Self-Assessment undertaken in April 2024, feeding into the Board Development Programme, reporting to ARAC and Board in May & July 2024 Following feed-back a more detailed maturity matrix to be developed reflecting the 6 domains of TI and core roles of Board



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1. Finance,
strategy and
planning

2.
Performance
and
outcomes

6. Quality of
care

**Escalation
Domains**

3. Fragile
services

5.
Leadership,
capability
and culture

4.
Governance

Domain 5: Leadership, capability and culture

Leadership, capability and culture



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Criteria	Reporting Group	Committee	Status	Comments
42 A full and substantive Executive Director Team, with a clear organisational structure in place with robust succession and development plans in place to ensure adequate capacity and capability in all areas of the organisation to deliver high quality, sustainable care.	TI coordination group	PODC	Advise	<ul style="list-style-type: none"> Board succession is being addressed through board development session with both IM and Executive directors with recent time out sessions held Robust performance management framework being introduced for Executive Directors with objectives set for 2024/2025 and personal development plans identified
43 Effective leadership programmes are in place to support the ongoing development of leadership and management skills at all levels / professions to strengthen management maturity. Evaluation of the impact of these programmes including decision making, use of equality impact assessment, safeguarding and participant feedback.	TI coordination group	PODC	Assure	<ul style="list-style-type: none"> 4 cohorts of LEAP leadership programme in train with second cohort graduating recently Second new consultant cohort has commenced on the programme
44 Positive staff engagement in NHS Wales surveys.	TI coordination group	PODC	Assure	<ul style="list-style-type: none"> Staff survey results have been considered in partnership with staff side Local implementation plans being developed for consideration at the next staff partnership forum Cultural progression report approved for the last 12 months approved at PODC in April 2024

Leadership, capability and culture



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Criteria	Reporting Group	Committee	Status	Comments
45 Plans are in place to develop a sustainable workforce resulted in improved staff retention and staff well-being, a reduction in the number of vacancies and the number of interim and agency staff, workforce plans and clinician job plans are reviewed annually to ensure that the organisation can deliver the requirements of the annual plan	Value and Sustainable	PODC	Alert	<ul style="list-style-type: none"> Workforce plan complied as part of the annual plan and retention plans are in place for nursing and medical staff with AHP retention group being established from June Plan in place regarding job plans – monitored by ARAC
46 Whether the people who use services, the public, staff and external partners are engaged and involved to support high quality sustainable services, demonstrated by local surveys showing increasing confidence in the leadership and awareness of strategies.	TI coordination group	SDODC	Assure	<ul style="list-style-type: none"> Full details in the culture progression report 38% of leavers have an exit interview 76% engagement rate with board outcome survey (Feb 2024)
47 Clinical change is led and driven forward by clinical leaders at all levels of the organisation.	TI coordination group	PODC	Advise	<ul style="list-style-type: none"> Interim Medical Director held a medical leadership forum (April 2024) to discuss challenging organisational agenda and expectation of clinical leaders in organisation change

Leadership, capability and culture



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Criteria	Reporting Group	Committee	Status	Comments
48 A culture of listening, learning, and improving is embedded throughout the organisation based on early and rapid triangulation and resolution of issues from a variety of sources, including quality, mortality, staffing levels, patient outcomes, user and staff feedback	TI coordination group	QSEAC	Advise	<ul style="list-style-type: none"> Development of a quality surveillance group led by Clinical Executives is being established to further embed triangulation of data and information
49 Effective use of data to help demonstrate improvements in leadership	TI coordination group	PODC	ASSURE	<ul style="list-style-type: none"> Full details in the culture progression report



1. Finance,
strategy and
planning

2.
Performance
and
outcomes

6. Quality of
care

**Escalation
Domains**

3. Fragile
services

5.
Leadership,
capability
and culture

4.
Governance

Domain 6: Quality of care



Criteria	Reporting Group	Committee	Status	Comments
<p>50</p> <p>Stabilisation of the increased trajectory of cases of HCAI and evidence of continuous improvement accompanied by a strong QI approach and plan that has oversight and monitoring by board Quality Safety Committee and Board</p> <p>The health board to have a clear improvement plan based on a root cause analysis to address the issue of hospital onset HCAIs.</p> <ul style="list-style-type: none"> • C-Diff: reduce the number of hospital onset infections by 25% and maintain for 3 months (from a baseline of the average number of cases in quarter 3 of 8 cases to no more than 6 per month) • Staph aureus: reduce the number of hospital onset infections by 33% and maintain for 3 months (from a baseline of the average number of cases in quarter 3 of 3 cases to no more than 2 per month) • E-coli: reduce the number of hospital onset infections by 25% and maintain for 3 months (from a baseline of the average number of cases in quarter 3 of 7 cases to no more than 5 per month) 	IQFPD	QSEAC	Advise	
<p>51</p> <p>70% of complaints that had final reply (Reg 24) / interim reply (Reg 26) to be closed less than 30 working days of concern received</p>	IQFPD	QSEAC	Alert	The actions and plans are set out in the Alerts section

Quality of care



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Criteria	Reporting Group	Committee	Status	Comments
52 Effective response from the health board to external reports and reviews including those from Audit Wales, the Ombudsman, Royal Colleges and HIW resulting in sustainable improvements.	IQFPD	QSEAC	Alert	The actions and plans are set out in the Alerts section
53 Demonstrate how service user and staff experience/involvement is being used to improve quality processes and inform service development across the organisation.	IQFPD	QSEAC	Advise	
54 Demonstrate the progress made against implementing the requirements of the Duty of Candour and Duty of Quality including the embedding of the Care and Quality Standards through the organisation from Board to service area delivery	IQFPD	QSEAC	Advise	
55 Oversight of safeguarding arrangements to ensure the board have sufficient, meaningful assurance that organisation is delivering against its safeguarding statutory responsibilities.	IQFPD	QSEAC	Assure	

Quality of care



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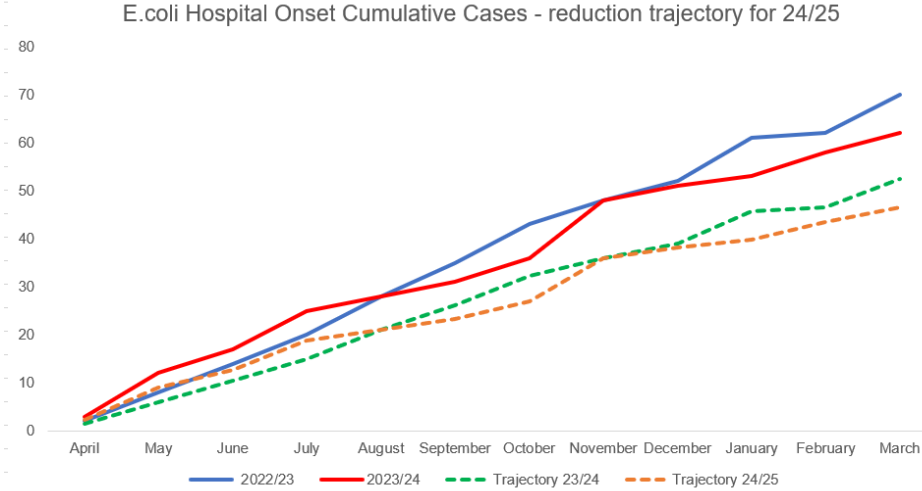
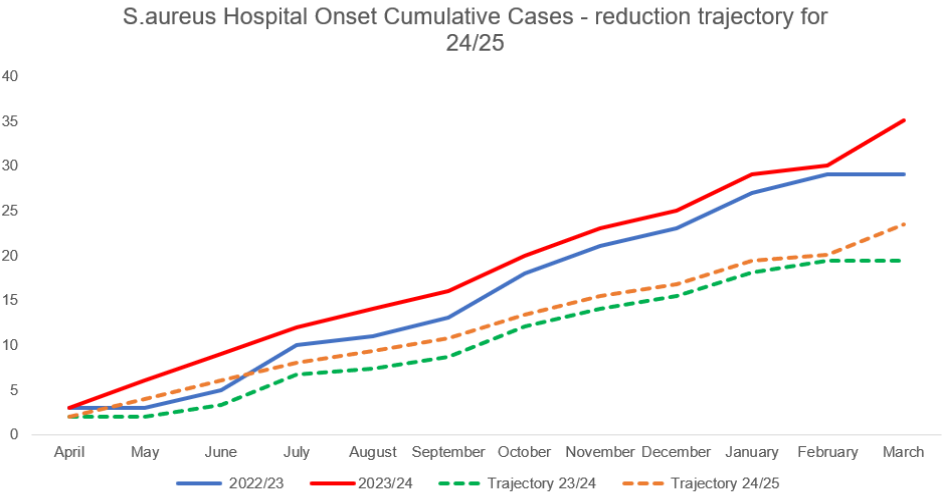
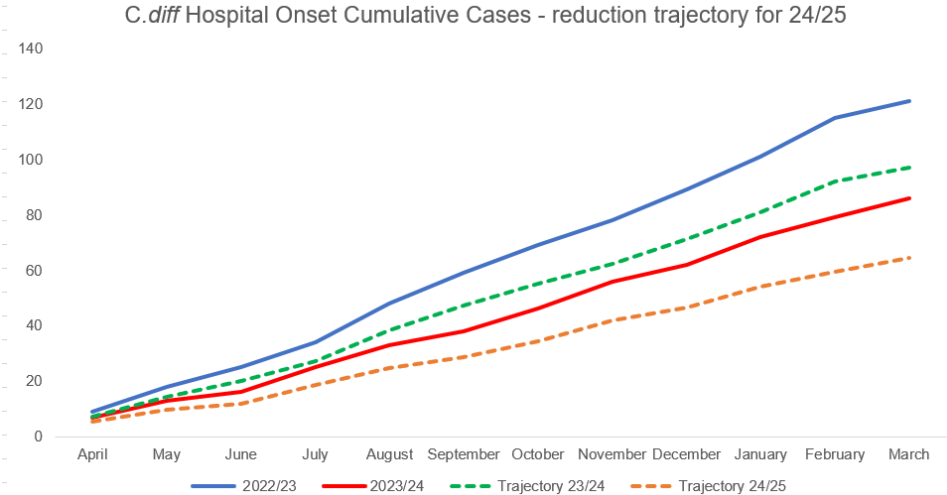
Criteria	Reporting Group	Committee	Status	Comments
56 Use of National Clinical Audit and Outcome Review Programme and Value in Health dashboards to support quality improvement and address unwarranted variation in care. (including the use of patient and staff feedback to influence service design).	IQFPD	QSEAC	Advise	

HCAI trajectories 2024/25



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Escalation meetings exception report

June 2024

Overview



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- The current escalation overview for the Directorates as of June 24
- Sites and Planned Care - High escalation (3) in critical domains
- Facilities - Major challenges in quality, governance, and workforce.
- Mental Health & LD - Financial instability and challenging performance. However, it is noteworthy that MH&LD have been formally deescalated by WG for Part 1 A
- Radiology & Pathology - Financial and governance challenges
- Key Domains - Widespread issues within key domains in quality (9), finance (13), and performance across directorates (11).

Escalation overview Jun-24

KEY

1 Reasonable assurance 2 Limited assurance 3 No assurance

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

Directorates Escalated Down



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The below represents the positive improvements within several Directorates below:

Directorate	Domain	May-24	Jun-24	De-escalated
Bronglais Hospital	Governance	3	2	Y
Cancer & Oncology	Governance	3	2	Y
Carmarthenshire County	Workforce	2	1	Y
Ceredigion County	Workforce	2	1	Y
Ceredigion County	Finance, Strategy and Planning	3	2	Y
Corporate Services	Governance	2	1	Y
Director of Finance	Governance	3	2	Y
Director of Nursing	Performance & Outcomes	3	2	Y
Director of Public Health	Governance	3	1	Y
Director of Public Health	Workforce	2	1	Y
Director of Strategy and Planning	Governance	3	1	Y
Director of Therapies and Health Sciences	Governance	3	1	Y
Glangwili Hospital	Governance	2	1	Y
Glangwili Hospital	Workforce	2	1	Y
Medical Directorate	Governance	3	2	Y
Medical Directorate	Performance & Outcomes	3	2	Y
Medicines Management	Governance	3	1	Y
Medicines Management	Workforce	2	1	Y
Mental Health & Learning Disabilities	Workforce	2	1	Y
Pathology	Governance	3	1	Y
Planned Care (incl. Audiology and Endoscopy)	Finance, Strategy and Planning	3	2	Y
Primary Care	Governance	2	1	Y
Primary Care	Workforce	2	1	Y
Primary Care	Performance & Outcomes	2	1	Y
Primary Care Management	Governance		2	Y
Primary Care Management	Workforce	2	1	Y
Prince Philip Hospital	Governance	2	1	Y
Radiology	Governance	3	1	Y
Withybush Hospital	Governance	3	2	Y
Women & Children	Workforce	2	1	Y

Directorates Escalated Up



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- Following the Directorate Escalation meetings throughout June. The Directorates below have been escalated within several domains
- The majority have been escalated due to the absence of identified savings

Directorate	Domain	May-24	Jun-24	Escalated up
Cancer & Oncology	Finance, Strategy and Planning	1	2	Y
Director of Operations	Governance	1	3	Y
Director of Therapies and Health Sciences	Finance, Strategy and Planning	2	3	Y
Medicines Management	Finance, Strategy and Planning	1	3	Y
Mental Health & Learning Disabilities	Fragile Services	1	2	Y
Pathology	Finance, Strategy and Planning	2	3	Y
Planned Care (incl. Audiology and Endoscopy)	Governance	2	3	Y
Primary Care Management	Finance, Strategy and Planning	1	2	Y
Withybush Hospital	Finance, Strategy and Planning	2	3	Y
Facilities	Finance, Strategy and Planning	2	3	Y

Directorates Escalated Up- Reasons



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Directorate	Domain	Reason for Escalation
Cancer & Oncology	Finance, Strategy and Planning	Limited assurance that 5% recurrent savings can be delivered while maintaining a balanced in-year position.
Director of Operations	Governance	Significant governance issues with 15 risks, 7 (47%) overdue for review, and 1 overdue by more than a month. 44% of actions on risk plans are overdue. Audit and Inspections have 7 reports with 24 recommendations, 18 (75%) overdue, and 11 (46%) overdue by more than 6 months.
Director of Therapies and Health Sciences	Finance, Strategy and Planning	No assurance that 5% recurrent savings can be delivered while maintaining a balanced in-year position.
Medicines Management	Finance, Strategy and Planning	No assurance that 5% recurrent savings can be delivered while maintaining a balanced in-year position.
Mental Health & Learning Disabilities	Fragile Services	Neurodevelopment services demand significantly outweighs capacity. Inpatient services heavily reliant on variable pay and consultant goodwill.
Pathology	Finance, Strategy and Planning	No assurance that 5% recurrent savings can be delivered while maintaining a balanced in-year position.

Directorates Escalated Up- Reasons



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Directorate	Domain	Reason for Escalation
Planned Care (incl. Audiology and Endoscopy)	Governance	75 risks, 64 (45%) overdue for review, 78% of actions on risk plans overdue. 10 reports with 78 recommendations, 72 (98%) overdue, 21 (27%) overdue by more than 6 months. Notable issues with Welsh Health Circulars and QIAs in progress.
Primary Care Management	Finance, Strategy and Planning	Limited assurance that 5% recurrent savings can be delivered while maintaining a balanced in-year position.
Withybush Hospital	Finance, Strategy and Planning	No assurance that 5% recurrent savings can be delivered while maintaining a balanced in-year position.
Facilities	Finance, Strategy and Planning	Limited assurance that 5% recurrent savings can be delivered while maintaining a balanced in-year position.

Actions Arising out of Welsh Government TI Meetings



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Action Log			
Action	Owner	Deadline	Action Lead
Health board to provide an update on HIW overdue inspections to Olivia Shorrocks.	Health Board	August meeting.	Sharon Daniels
Health board to provide an update on Reg 28 following arthroplasty MDT on 19 July.	Health Board	August meeting.	Andrew Carruthers
Health board to provide an update on Reg 28 relating to processes in emergency departments.	Health Board	August meeting.	Andrew Carruthers
Health board to share action plan and feedback on progress of the limited assurance report for cleaning standards.	Health Board	August meeting.	Andrew Carruthers
The health board agreed to provide an update on the audiology waiting list.	Health Board	August meeting.	Andrew Carruthers
The health board would investigate the numbers going to straight to test and provide an update at the next meeting.	Health Board	August meeting.	Andrew Carruthers
Health board to feedback evaluation of the psychological group therapy sessions.	Health Board	August meeting.	Andrew Carruthers
It was agreed that mental health and CAMHS be removed from the TI agenda for August.	Welsh Government	August meeting.	
The health board to provide an update on C Diff performance at Bronglais in October.	Health Board	October meeting.	Sharon Daniels

Future meetings



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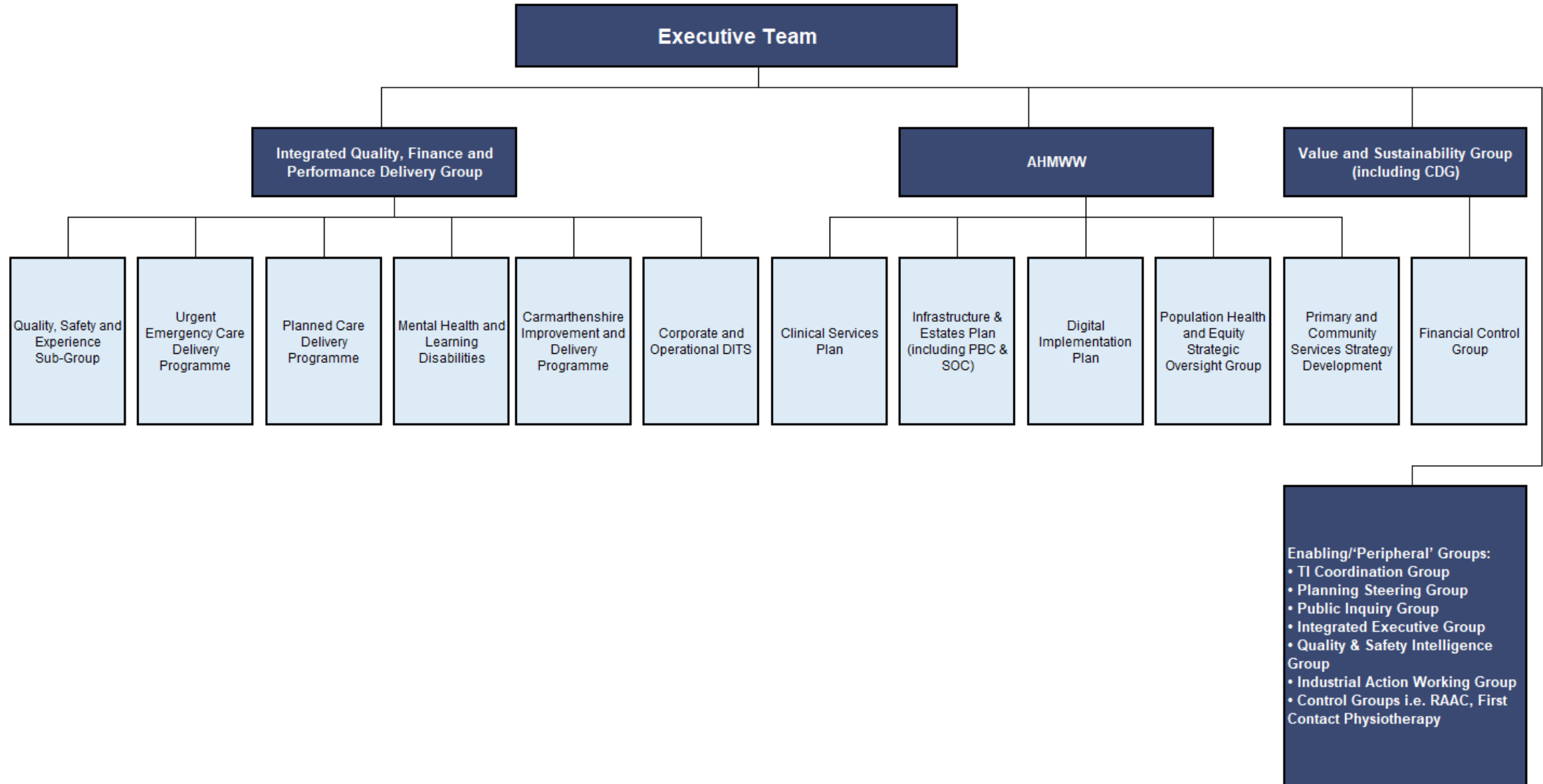
Date	Timings	Directorate
27/06/2024	13:00 - 14:30	Ceredigion system
	14:45 - 16:15	Pembrokeshire system
04/07/2024	09:00 - 10:00	Facilities
	10:15 - 11:15	Women and Children
	11:30 - 13:30	Primary Care
	14:00 - 15:00	Therapies
12/07/2024	13:00 - 14:00	Diagnostics
	14:15 - 15:45	Carmarthenshire system
01/08/2024	09:00 - 10:30	MH&LD
	10:45 - 12.15	Pembrokeshire system
	13:00 - 14:30	Planned Care
	14:45 - 16:15	Ceredigion system
	16:30 - 17:30	Facilities
15/08/2024	13:00 - 14:00	Women and Children
	14:15 - 15:45	Therapies
	16:00 - 17:00	Diagnostics
05/09/2024	09:00 - 10:30	MH&LD
	10:45 -12:15	Planned Care
	13:30 - 15:00	Carmarthenshire system
	15:15 - 16:45	Pembrokeshire system
12/09/2024	13:00 - 14:30	Ceredigion system
	14:45 - 15:45	Facilities
03/10/2024	09:00 - 11:00	Primary Care

New Executive Team Governance Arrangements



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- **Executive Team:** Provides strategic oversight and decision-making for the TI process
- **TI Coordination Group:** Coordinates and manages the Health Board's response to the TI framework

Reporting Groups:

- **Value and Sustainability:** Focuses on financial improvement and sustainability initiatives (Planning Objectives 1 & 2)
- **Integrated Quality, Finance and Performance Delivery (IQFPD):** Oversees performance management and delivery of the Annual Plan/IMTP (Planning Objectives 3, 4 & 5)
- **A Healthier Mid and West Wales (AHMWW):** Ensures delivery of the Health Board's strategy and associated programmes (Planning Objectives 6, 7, 8, 9 & 10)

Mapping of TI domains to the new arrangements



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Domain	Reporting group	Programme (PO)	Committee
Overall	Executive Team	All POs	ARAC
B1: Finance intervention	Value and sustainability	PO 1, PO 2	SRC
B1: Planning intervention	TI coordination group	All	SDOD
B1: Strategy intervention	AHMWW	PO 6, 7 & 8	SDOD
B1: Regional planning	IQPFD	PO 4	SDOD
B2: Performance and outcomes	IQPFD	PO 3, 4 & 5	SDOD
B3: Fragile services	AHMWW	PO 6, 7	SDOD
B4: Governance	TI coordination group	N/A	ARAC
B5: Leadership, capability and culture	TI coordination group	N/A	PODCC
B6: Quality of care	IQPFD	All	QSEC

TI Coordination Group - outputs and outcomes



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Objectives:

Coordinate and oversee all Targeted Intervention actions across the Health Board

- Establish strong governance mechanisms and ensure accountability in all domains
- Align interventions strategically and manage them effectively with clear responsibility and accountability

Outcomes:

Ensure consistent and robust oversight by the Board and its Committees through:

- Continuous updates and communications to the Executive Team and Welsh Government
- Reinforce governance structure, ensure strategic directives are followed, and address performance issues

Domains:

- Governance (D5): Embed robust governance structures, refresh risk management framework, and conduct governance maturity assessments

Maturity Matrix Alignment:

- Systems and Processes for Performance, Accountability, and Improvement (D7): Develop systems to enhance performance management and accountability, align the organisation, and embed sustainable change



Objectives:

- Establish a sustainable financial framework supporting long-term goals
- Create a financial roadmap addressing challenges and aligning with strategy
- Integrate financial strategies with clinical and operational needs

Outcomes:

- Create and maintain a board-approved financial roadmap
- Implement targeted saving schemes and cost control measures
- Stabilise workforce costs through programmes such as nurse stabilisation programmes
- Enhance financial oversight through the Finance Control Group

Domains:

- Financial management and sustainability (D1): Develop financial approaches ensuring long-term viability
- Workforce development (D6): Integrate workforce planning with financial strategies

Maturity Matrix Alignment:

- Realistic and Deliverable (D6): Ensure plans are realistic and achievable
- Systems and Processes for Performance, Accountability, and Improvement (D7): Develop financial governance systems enhancing accountability

Objectives:

- Ensure high-quality, financially sustainable clinical services
- Align services with 'A Healthier Mid and West Wales' strategic directives
- Provide strategic oversight of the Clinical Services Plan
- Integrate clinical needs, financial planning, and infrastructure
- Future-proof services to adapt to health demands within budget

Outcomes:

- Regular updates of Clinical Services Plan to align with needs and goals
- Integration of service delivery with sustainable financial strategies
- Development of estate and infrastructure plans for efficient operations
- Implementation of strategic improvements to enhance outcomes and sustainability

Domains:

- Clinical strategy and oversight (D2, D4, D7): Craft a cohesive, feasible, and effective clinical strategy

Maturity Matrix Alignment:

- Strategy Development (D1): Ensure comprehensive and sustainable Clinical Services Plan
- Dynamic and Engaged Planning (D3): Foster dynamic planning aligned with needs and goals
- Operational Planning (D4): Align strategies with operational and financial plans for efficient delivery

Objectives:

- Achieve in-year delivery of Annual Plan targets
- Integrate ministerial priorities and Planning Objectives into operations
- Ensure adoption of best practices, quality management, and resource allocation

Outcomes:

- Consistently achieve performance and financial targets
- Implement quality improvement initiatives improving patient outcomes
- Establish effective governance and accountability mechanisms
- Strategically adopt best practices enhancing service quality and efficiency

Domains:

- Quality management (D7), operational performance (D3), strategic planning and governance (D2, D5)

Maturity Matrix Alignment:

- Dynamic and Engaged Planning (D3): Adaptable and responsive planning
- Operational Planning (D4): Align operations with financial planning and resources
- Best Practice Approach to Improvement (D5): Integrate best practices into operations
- Realistic and Deliverable (D6): Create achievable plans aligned with priorities and goals
- Systems and Processes for Performance, Accountability, and Improvement (D7): Enhance performance management and governance systems

Internal Escalation Framework



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

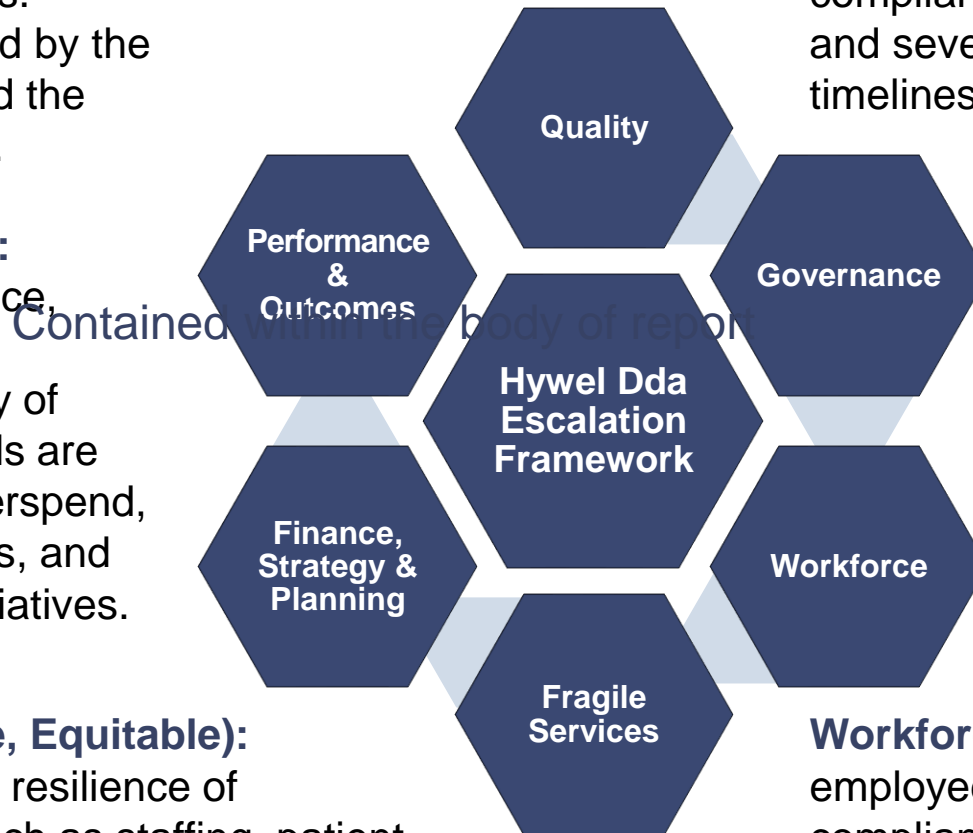
Finance, Strategy & Planning: Focuses on financial performance, including overspend, budget management, and the credibility of recovery plans. Escalation levels are determined by the extent of overspend, the robustness of financial plans, and the effectiveness of savings initiatives.

Fragile Services (Timely, Safe, Equitable): Assesses the sustainability and resilience of services, considering factors such as staffing, patient safety, and service continuity. Escalation levels are based on the level of risk to service delivery and the effectiveness of mitigating actions.

Quality: Focuses on patient safety incidents, complaints, medical examiner issues, and Duty of Candour compliance. Escalation levels are based on the number and severity of incidents, open complaints, and the timeliness of Duty of Candour processes.

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

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



**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
Interim Chief Executive
Hywel Dda University Health Board
Corporate Offices
Ystwyth Building
Hafan Derwen,
St Davids Park
Jobswell Road
Carmarthen
SA31 3BB

Our Ref: JP/MR/SB

12 July 2024

Dear Phil

NHS Oversight and Escalation Arrangements

In line with the NHS oversight and escalation framework, escalation levels are considered at least twice a year. This includes an assessment of each health organisation against the six escalation domains, and discussions with partners around the current issues, concerns and progress since the last review.

I am writing to confirm that following a recent meeting, the escalation status of your organisation will remain unchanged at level 4 - targeted intervention.

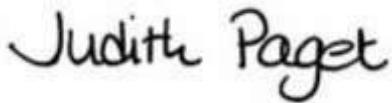
Although there is no change to the escalation status, I would like to highlight some concerns that were raised:

- The current finance position and forecast deficit for 2024/25 for the health board is considerably above where we expect it to be and not in line with the targeted intervention de-escalation requirements. This is resulting in concerns about the ability of the health board to deliver its plan and meet the previously set target control total.
- The reason for cost growth, which are the highest in Wales, and the ability of the health board to resolve this in year.
- Cancer performance remains considerably below expected levels and there is a real need to reduce the backlog of patients waiting over 62 days.

- Urgent and emergency care, particularly related to ambulance handovers, 4 and 12 hour waits.
- The need to progress with the clinical services plan as this is essential to support the development of your fragile services – although colleagues recognised that this had progressed well over the last few months.
- The need to progress regional working with Swansea Bay and other partners.
- Your decision-making and processes require improvement – this is recognised in the Board self-assessment.
- Staff survey response rate was the lowest in Wales, with challenging findings and you need a firm plan to respond to these results.

Welsh Government colleagues will continue to provide the necessary support and advice, including regular escalation, JET and IQPD meetings with subject specific discussions as and when considered necessary.

Yours sincerely

A handwritten signature in black ink that reads "Judith Paget". The signature is written in a cursive, slightly slanted style.

Judith Paget CBE

**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**

Professor Phil Kloer
Interim Chief Executive
Hywel Dda University Health Board
Corporate Offices
Ystwyth Building, Hafan Derwen
St David's Park, Jobswell Road
Carmarthen
SA31 3BB
Philip.Kloer@wales.nhs.uk

26 July 2024

Dear Phil

Annual Plan 2024-2025: Accountability Conditions

I note that your Board was unable to submit a balanced integrated medium-term plan (IMTP) for 2024-27 in line with section 175(2A) of the National Health Service (Wales) Act 2006 (as amended by NHS Finance (Wales) Act 2014) and in accordance with the NHS Planning Framework.

Your Board has submitted an **Annual Plan for 2024-25**. Following an initial review, additional information was requested by 31 May to further strengthen the delivery of the priorities and address the financial position as a matter of urgency.

Your plan, subsequent submission and scrutiny session confirms your forecast deficit position of £64m. Whilst you have taken some action to de-risk your savings plan, you have outlined residual risks to delivery and an inability to further improve on that position at this stage. Your submission and forecast deficit is noted, but still remains substantially adrift of the target control total set in 2023/24. You are expected to go further in terms of reducing the current forecast deficit position as an absolute minimum given the opportunities to do so which were fed back in the scrutiny session, make significant progress with the agreed de-escalation criteria, and ensure a clear route-map is in place to delivering the target control total set in 2023/24.

I expect organisations to deliver the commitments set out within their plans, particularly in relation to the Ministerial priorities. The organisation should continue to progress improvements of a clear improved financial position and key trajectories.

Organisations must lever improved efficiency and productivity to continue with significant efforts in order to achieve financial and service sustainability that will deliver demonstrable benefits and patient outcome for the allocation uplift provided to organisations this year.

There are a number of further areas which were identified as accountability conditions through the formal review of your plan:

- Further derisk your financial plan to ensure the declared savings are delivered in-year and further improvement delivered;
- Continue to adopt the Value and Sustainability Board programmes, maximise opportunities for efficiency and productivity;
- Review where the organisation is an outlier on cost growth and deliver opportunities to address this where appropriate;
- Progress regional solutions, working collaboratively with partners; and
- Progress on developing a clinical services plan, which also addresses the organisations opportunities for service sustainability and financial improvement, working with key partners.

The Cabinet Secretary for Health and Social Care has set some additional in-year Key Performance Indicators (KPIs) – Annex 1. Resources must be identified to support delivery in these areas, while maintaining overall financial improvement. In addition, should in-year expectations be required this will be communicated to you and your organisation will still be expected to deliver in line with quality statements.

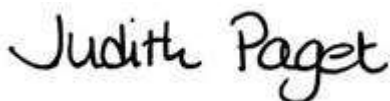
I expect the Board to scrutinise the plan and ensure that progress is monitored effectively over the forthcoming year. A copy of your Board updates setting out progress of the plan during the year, should be forwarded on a quarterly basis to HSS-PlanningTeam@gov.wales. This should be accompanied by a refreshed Minimum Data Set (MDS) making clear any changes to the trajectories and goals at each quarter.

Accountability conditions and the delivery of plans will also form the agenda for our Joint Executive Team (JET) meetings going forward. Performance and delivery discussions on areas of priority and risk will continue to be scrutinised via the regular Integrated Quality Planning and Delivery (IQPD) meetings and those that the NHS Planning Team have with planners. Where this necessitates any material changes to the plan in year, you will be required to advise me of these changes through an 'Accountable Officer' letter.

The health board will be formally notified separately of the outcome of any associated escalation and intervention discussions following the next round of Tripartite meetings.

I trust that this letter provides clarity on our expectations, but should you have any queries then please do not hesitate to contact me.

Yours sincerely



Judith Paget CBE

cc: Nick Wood, Deputy Chief Executive, NHS Wales
Samia Edmonds, Director of Strategic Planning
Hywel Jones, Director of Finance
Jeremy Griffith, Director of Operations

Annex 1

Key Performance Indicators

Key Performance Indicators	Definition and Target
Urgent and Emergency Care	<p>Number of patients who spend 12 hours or more in all major and minor emergency care facilities from arrival to admission, transfer or discharge</p> <p>March 2024 baseline 20% Reduction by September 2024 Further 20% Reduction by March 2025</p> <p>Number of ambulance patient handovers over 1 hour</p> <p>March 2024 baseline 30% Reduction by December 2024</p>
Cancer	<p>Percentage of Patients starting first definitive cancer treatment within 62 days from point of suspicion (regardless of the referral route)</p> <p>60% performance by December 2024 70% performance by March 2025</p>
Diagnostics	<p>Number of patients waiting more than 8 weeks for a specified diagnostic.</p> <p>95% to be zero by December 2024</p>
Elective Care	<p>Number of patients waiting over 52 weeks for a new outpatient appointment</p> <p>March 2024 baseline 40% reduction by end of September 2024 Zero by March 2025</p> <p>Number of patients waiting more than 104 weeks for referral to treatment</p> <p>Zero by end of December 2024</p>
Mental Health	<p>Percentage of therapeutic interventions started within (up to and including) 28 days following an assessment by LPMHSS for people aged 16 years.</p> <p>Percentage of therapeutic interventions started within (up to and including) 28 days following an assessment by LPMHSS for adults aged 18 years or over.</p> <p>80% for both by December 2024</p>