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

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

Escalation Domains

ARAC – 15th April 2025

Targeted Intervention Progress Report

Introduction

Key Highlights

- **Governance Structure Transformation -** The Board approved a new Committee structure in January 2025, to be implemented from April 2025, with Clinical Care Groups (CCGs) replacing the directorate-based approach.
- **Positive External Validation -** Structured Assessment 2024 and Internal Audit feedback confirm robust corporate governance arrangements and a mature approach to risk management. Further reinforced by being de-escalated by Welsh Government for Governance and Leadership
- **Self-Assessment Enhancement -** A comprehensive seven-step process has been developed for the 2025/26 maturity matrix assessment, directly addressing prior audit recommendations.
- **Standardised Reporting -** Significant progress in standardising TI reporting across committees, with each committee now focusing on relevant de-escalation criteria.
- **Implementation Challenges -** While governance frameworks are well established, translating these into consistent service delivery improvements remains challenging, particularly in areas like cancer, urgent care, and diagnostics.

Criteria 36 - Effective Oversight and Scrutiny

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

Summary of Current Status

- **Strong Board and Committee Oversight -** Regular reports provided to Board and Committees include IPAR, Risk Register, Quality & Safety Dashboard, Clinical Services Plan updates, and GIRFT reports.
- **Enhanced Committee Focus -** Each committee now focuses on the de-escalation criteria relevant to its remit, particularly within Finance and Performance Committee and Strategy and Planning Committee.
- **Strengthened Governance Model -** The new Clinical Care Group model will implement Integrated Governance Groups (IGGs) meeting fortnightly to examine planning, performance, finance, people, quality, and safety matters.
- **Structured TI Reporting -** Standardised approaches to reporting on TI are now in place across all Health Board committees, with improved summary information for ARAC.

Next Steps/Actions

1. **Clinical Care Group Implementation -** Complete the phased implementation of the CCG model with appropriate support mechanisms from April 2025.
2. **Committee Structure Transition -** Fully implement the new Board Committee structure approved in January 2025.
3. **Embedding Consistent Reporting -** Continue the structured reporting by the six specific TI actions under ARAC's remit, ensuring each action is clearly tracked, monitored, and reported.

Evidence/Assurance - Structured Assessment 2024 - noting the Health Board's openness and transparency in reporting. Board approval of new Committee structure (January 2025 Board meeting). Committee Self-Assessment feedback. Committee reports

Risk - No significant risks identified for this criterion.

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

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

Summary of Current Status

- **Quality Impact Assessment Process -** The Health Board has progressed its approach to the Duty of Quality through the QIA process for all service changes, particularly within the Clinical Services Plan.
- **Evidence-Based Decision Making -** Board consistently examines quality implications when considering service changes, as demonstrated in the November 2024 Board papers.
- **Upcoming Public Consultation -** The planned CSP consultation phase (May-August 2025) will further strengthen quality considerations by gathering patient and stakeholder insights.
- **Scope for Improvement -** While the CSP services have comprehensive clinical data supporting fragility assessments, services outside this scope lack the same oversight.

Next Steps/Actions

1. **Regular CSP Updates -** Continue providing detailed updates on areas of fragility (ongoing).
2. **Complaints & Claims Data Monitoring -** Maintain regular reporting to relevant committees (monthly).
3. **Risk Register Monitoring -** Continue to reflect service fragility and associated mitigations where applicable (ongoing).
4. **Integrated Approach Development -** Develop a more cohesive model integrating workforce pressures, financial assessments, service resilience, and patient accessibility.

Evidence/Assurance - CSP Updates detailing areas of fragility. Complaints & Claims Data regularly reported to committees. Risk Registers reflecting service fragility

Risk - No specific risks identified for this criterion.

Criteria 38 - Programme and Performance Management Structure

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

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

Summary of Current Status

- **Mixed Improvement Picture -** While progress has been noted in financial delivery, limited improvement has been seen in areas such as urgent care, with cancer and diagnostics remaining challenging and reliant on additional resources
- **Welsh Government Feedback -** In January 2025, WG acknowledged positive progress but emphasised the importance of having adequate capacity and capability to deliver the 2025-26 annual plan.
- **Enhanced Accountability Model -** The Clinical Care Group model aims to address delivery challenges by placing accountability closer to clinical teams and creating greater scrutiny, ownership, and transparency.
- **Performance Tracking Framework -** Each service now has clear KPIs linked to TI de-escalation criteria with monthly tracking through the Improving Together framework.

Next Steps/Actions

1. **Establish Formal Escalation Process -** Implement a formal escalation route between the Director of Delivery and the CEO/Deputy CEO for non-engagement (by 28 February 2025). – **Completed** under the revised Escalation Framework for 25/26
2. **Resource Allocation Review -** Prioritise resources to areas most critical for de-escalation, quality, and safety. **By the end of April 2025** (post annual plan approval)
3. **Effectiveness Review -** Complete the Internal Audit review of the effectiveness of the new governance arrangements.

Evidence/Assurance - Welsh Government Feedback (21 January 2025). Welsh Government Feedback (March 2025). Internal Audit review (pending completion). Maturity Matrix (Scheduled for Board in July 2025).

Risk - Delivery Capacity - There is a risk around the ambition of the annual plan and the wider health board resources to ensure delivery, particularly in challenged areas like cancer, diagnostics and urgent care.

Criteria 39 - Risk Management Arrangements

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

Summary of Current Status

- **Mature Risk Framework -** Risk management arrangements are embedded across the organisation, with robust processes for identifying, recording, and managing risks through the Board Assurance Framework, Corporate Risk Register, and Datix.
- **Board Oversight -** The Board has agreed its risk appetite (Jan 2025) and approach to risk tolerance (Mar 2025), providing a clear framework for determining acceptable risk levels.
- **Implementation Gap -** Despite established processes, challenges remain in ensuring that recorded risks transition smoothly from identification to active mitigation, particularly at the operational level.
- **Operational Governance Improvement -** A new operational governance structure, led by the COO, is expected to be implemented by April 2025 to address inconsistencies in operational risk management.

Next Steps/Actions

1. **Support COO Implementation -** Support the Chief Operating Officer to implement consistent operational governance arrangements by April 2025.
2. **Risk Mitigation Enhancement -** Focus on developing risk management plans with specific deliverables, measurable milestones, and clearly assigned responsibilities.
3. **Operational-Strategic Alignment -** Embed consistent governance practices across all operational functions to ensure a consistent flow of information from front-line risks to Board oversight

Evidence/Assurance - **Structured Assessment 2024** - confirming the Board's mature approach to overseeing strategic and corporate risks. New risk appetite statement and tolerance approach

Risk - No specific risks identified for this criterion. However, it is clear that the implementation of the CCG structure is fundamental across a number of the TI Criteria.

Criteria 40 - Governance and Assurance Systems

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

Summary of Current Status

- **Established Governance Mechanisms -** New governance arrangements are well established and provide mechanisms for seeking assurance and escalation as required.
- **Performance Challenges -** In areas like cancer, urgent care, and diagnostics, limited improvement or deterioration highlights potential gaps in the effectiveness of programme and performance management oversight (this is likely linked to Criteria 38).
- **Aligned Committee Structure -** Board-approved Committee structure (January 2025) aligns with the six domains of Targeted Intervention, ensuring clear accountability for de-escalation criteria.
- **Early Warning System -** A dashboard of leading indicators has been developed to enable early identification of delivery risks before they manifest in performance metrics.

Next Steps/Actions

1. **Effectiveness Review -** Schedule a comprehensive review of the new governance arrangements for Q2 2025/26, focusing on escalation processes in challenged performance areas.
2. **Resource Alignment -** Ensure teams responsible for delivering key improvements have sufficient capacity and capability to meet ambitious targets.
3. **Performance Monitoring Enhancement -** Strengthen the connection between governance frameworks and actual performance improvement.

Evidence/Assurance - Board approval of Committee structure (January 2025). Audit Scheduled for September 2025. Leading indicators dashboard implementation

Risk - No specific risks identified for this criterion. However, if the actions are not followed, this is likely to lead to a delivery risk.

Criteria 41 – Maturity Matrix Self-Assessment

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

Summary of Current Status

- **Prior Self-Assessment -** The Health Board completed a self-assessment against the governance maturity matrix in Q4 of 2023-24, providing a realistic view of governance maturity. This will allow the Health Board to take a view around how much we have progressed in the last 12 months.
- **Enhanced Assessment Process -** A comprehensive seven-step process has been developed for the 2025/26 assessment, running from March to July 2025, including stakeholder engagement, WG feedback integration, and formal Board approval.
- **Continuous Improvement Approach -** Regular reassessments of governance maturity are conducted throughout the year to adapt to emerging challenges and priorities.
- **Welsh Government Feedback Incorporation -** The next assessment will address WG feedback from January/March 2025 and the 2025-26 annual plan feedback, thus ensuring a 360 view across all stakeholders.

Next Steps/Actions

1. **Complete Annual Plan -** Finalise the annual plan for 2025-26 by April 2025, setting the stage for the subsequent maturity assessment. – Completed
2. **Evidence Gathering -** Begin the comprehensive review of internal documents, operational plans, and strategy alignment (March-April 2025). **– Commenced 80% completed**
3. **Stakeholder Engagement -** Implement the sequential stakeholder engagement process beginning with Clinical, Operational, and Corporate teams (May 2025).
4. **Board Approval -** Present the completed maturity assessment to the Board for formal approval (31 July 2025).

Evidence/Assurance - Maturity Matrix from Q4 2023-24. Detailed seven-step process for 2025/26 assessment. Welsh Government feedback (January, March and Annual Plan likely to be May 25)

Risk - No specific risks identified for this criterion.

ARAC’s Visibility across Targeted Intervention

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

Why this approach?
ARAC needs better visibility of key “Alert” criteria but does not require a deep review of all 56 items.

Key proposal

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

Outcome

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

Alert Criteria by Committee

Sustainable Resources Committee (SRC) – Finance and Performance Committee

- Criterion 3: Annual plan with Board approval showing a substantial financial improvement trajectory that meets or exceeds the target control total. – this criteria is likely to be satisfied now and subject to agreement may move to advise?

ARAC's Visibility across Targeted intervention

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

Strategic Development and Operational Delivery Committee (SDODC) – Strategy and Planning Committee

- **Criterion 4:** Submission of an acceptable annual plan in line with the current planning framework. This criterion is likely to be satisfied now and subject to agreement may move to advise?
- **Criterion 8:** Delivery of annual plan commitments, especially ministerial priorities. This needs to be addressed in Q1 around de-risking a number of key areas in the plan, so remains at alert.
- **Criterion 13:** Maintain 60% Single Cancer Pathway (SCP) performance for three consecutive months. Remains at alert, subject to February and March performance.
- **Criterion 17:** Achieve a 15% reduction in follow-ups delayed by 100%, for three consecutive months, then maintain for three more.
- **Criterion 18:** Ensure 65% of R1 ophthalmology patients are seen within or no more than 25% over their target date, sustained for three months. Set out in the annual plan, however, need more concrete plans with milestones and deliverables
- **Criterion 24:** Reduce ambulance handovers over one hour by 11% for three consecutive months, then maintain for another three. This is the biggest risk in terms of the Health Board achieving de-escalation, the current plans do not achieve the 680 1- hour ambulance handover TI expectation.
- **Criterion 25:** Continue progress toward no more than 7% of patients waiting over 12 hours at each site and across the Health Board. As with criterion 24 this remains extremely challenged in 25/26
- **Criterion 26:** Ensure median time from ED arrival to assessment by a clinical decision maker is no more than 60 minutes. Same as Criterion 24 and 25.
- **Criterion 27:** Achieve a 5% continuous reduction in delayed care pathways for three consecutive months, then maintain for a further three. The Annual Plan does have a trajectory to achieve this criterion. However, the latest performance data suggests this will be a challenge unless there is a material step change in the current DPOCs (linked to six goals)

ARAC’s Visibility across Targeted intervention

Quality, Safety and Experience Committee (QSEC)

- Criterion 34: Demonstrate that all external recommendations (Royal Colleges, HIW, etc.) are discharged, verified, or scheduled under the longer-term improvement plan. This criterion is now likely to be de-escalated to advise, given the significant improvement in this area.
- Criterion 52: Provide an effective response to external reports, leading to sustainable improvements. This criterion is also likely to be stepped down to advise as set out in the QESC slides.

People, Organisational Development and Culture Committee (PODCC)

- Criterion 45: Develop a sustainable workforce and review workforce/clinician job plans annually to meet the annual plan requirements. This will be reviewed in April 25 as the annual plan and recent audit shows high compliance 87% (Job Planning) audit, so it is likely this will move to Assure.

Conclusion

Conclusion & Next Steps

- **Governance Framework Implementation -** The Health Board is making significant progress in strengthening governance through the implementation of the new Committee structure and Clinical Care Group model from April 2025.

- **Consistent Operational Governance -** A key focus remains on establishing consistent operational governance arrangements, particularly in supporting the COO to implement standardised approaches across all operational teams.

- **Effectiveness Evaluation -** A comprehensive review of the new governance arrangements is planned for Q2 2025/26 to assess whether they are delivering the intended improvements in performance, particularly in challenged areas.

- **Maturity Assessment -** The enhanced seven-step process for the 2025/26 maturity matrix assessment will provide a robust evaluation of governance arrangements, with Board approval scheduled for July 2025.

- **Capacity and Capability Focus -** In line with Welsh Government feedback, ensuring adequate capacity and capability to deliver the ambitious annual plan remains a priority, requiring careful resource allocation and prioritisation. Furthermore, this is consistent with the need to de-risk a number of areas in Q1, such as UEC and the identification and work up of all savings to achieve the £19m recurrent requirement

Criteria	Action	Status	Executive Lead	Summary of Current Status	Lead Executive Response (if applicable)	Documented Plan and Dates for Delivery (Evidence)	Actions Outstanding	Evidence and Assurance	Risk
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.	Assure	Joanne Wilson	Regular reports provided to Board and Committees include IPAR, Risk Register, Q&S Dashboard, Clinical Services Plan Updates, Deep Dive reports on specific issues, updates on GIRFT reports. Furthermore, the Targeted Intervention (TI) pack undergoes thorough scrutiny at committee level, with robust and regular discussions across relevant committees. Significant progress has been made to ensure that each committee focuses on the de-escalation criteria relevant to its remit, particularly within the Sustainable Resources Committee (or as amended to the Finance and Performance Committee) and the Strategic Development and Operational Delivery Committee (or as amended to the Strategy and Planning Committee). From the Draft Internal Audit Report 2024/25 (Objective 1, Key Findings on Governance & Reporting Arrangements): Following feedback from independent members at ARAC meetings, further actions regarding summary information on the assurance of scrutiny and monitoring of TI progress of other committees be provided in future escalation reports to ARAC and the TI governance arrangement of QSEC require addressing have been addressed (see Feb25 TI update to ARAC). Standardised reporting on TI taking place across the Health Board's committees. The new Clinical Care Group (CCG) model planned for implementation in April 2025 aims to further strengthen governance through Integrated Governance Groups (IGGs) that will meet fortnightly to examine planning, performance, Finance, people, quality, health and safety matters. This represents a planned transition from our current directorate-based approach, with preparatory work underway to ensure smooth implementation. While this transition represents a significant organisational change that will require time to fully embed, it is designed to provide greater cohesion across related clinical services and strengthen local ownership of care pathways while maintaining robust Health Board-wide oversight. A phased implementation approach with appropriate support mechanisms will be critical to its success.	Positive feedback has been received by AW in Structured Assessment 2024 regarding the Health Board's openness and transparency in its reporting. The Board approved a new Committee structure at its meeting on 30 January 2025, with implementation planned from April 2025.	Board Committee Structure - Jan25 Board 1. Structuring reports by the six specific TI actions under ARAC's remit, ensuring that each action is clearly tracked, monitored, and reported. In addition, summary assurance from other committees will also to be provided – (complete) 2. Highlighting any variance or potential non-compliance promptly. Where there is any indication that performance, quality, or governance arrangements do not align with TI criteria, ARAC will be duly notified so that corrective measures can be enacted swiftly and robust oversight can be maintained. (complete) 3. The approach to QESC follows the same reporting and assurance framework as other committees. Where criteria fall within QESC's remit, regular updates will be submitted, detailing progress, evidence-based outcomes, assurance ratings, and any further actions required. This consistent process ensures that each committee, QESC included, receives transparent and comprehensive updates on the organisation's performance against TI requirements (February 2025) (complete)	Committee reporting in Dec/Jan25	Structured Assessment 2025 Committee Self Assessment feedback Committee reports	N/A
37	Evidence of Board considering the Duty of Quality to inform their decision making and evaluating their compliance with the Duty.	Advise	Sharon Daniel	While there is clinical data supporting fragility within the CSP's scope, including complaints, claims, and cost implications, services outside this scope lack the same comprehensive oversight. A more cohesive model—integrating workforce pressures, financial assessments, service resilience, and patient accessibility—would help frame the Board's understanding and response to fragile services more effectively. This remains a priority to ensure alignment across all fragile pathways, especially in light of emerging configuration challenges. The Board has progressed its approach to the Duty of Quality through the Quality Impact Assessment (QIA) process for all service changes, particularly within the Clinical Services Plan. Evidence shows that the Board consistently examines quality implications when considering service changes, as demonstrated in the November 2024 Board papers where options for nine clinical services under the CSP were evaluated with explicit quality considerations. The planned consultation phase (May-August 2025) will further strengthen this by gathering patient and stakeholder insights on quality impacts. However, we recognise the need for a more consistent approach across all services, especially those outside the CSP scope. The newly implemented Clinical Care Group structure will support this by embedding quality oversight at service level through bi-weekly governance meetings from April 2025.		1. CSP Updates, detailing areas of fragility. (On Track -on-going) 2. Complaints & Claims Data, regularly reported to relevant committees (On-Track - monthy) 3. Risk Registers where applicable, reflecting service fragility and associated mitigations. (On-Track - on-going)			No risk identified
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.	Advise	Lee Davies	Recent governance improvements have provided a strong foundation, with clear objectives defined across various programmes. However, translating these objectives into consistent delivery remains a challenge. While progress has been noted in financial delivery, limited improvement has been seen in areas such as cancer, urgent care, and diagnostics. In some cases, deterioration has highlighted gaps in the effectiveness of the performance and programme delivery framework. Welsh Government Feedback (21 January 2025) Welsh Government acknowledged our positive progress in meeting 2024–25 objectives but emphasised the importance of having adequate capacity and capability to deliver our 2025–26 annual plan. They underlined the need for sufficient organisational planning and oversight, given the scale and complexity of upcoming programmes. The planned introduction of the Clinical Care Group model from April 2025 aims to address previous delivery challenges by placing accountability closer to clinical teams and creating greater scrutiny, ownership and transparency. Each CCG will be led by a senior "triumvirate" spanning managerial, medical, and nursing roles, with collective accountability for service quality, performance, workforce, and financial outcomes. To address the performance gaps noted by Welsh Government (particularly in cancer, urgent care, and diagnostics), each service now has clear key performance indicators linked to TI de-escalation criteria with monthly performance tracking through the Improving Together framework. However, it is recognised that delivering against these ambitious trajectories will require appropriate resources and capacity, which presents an ongoing challenge given the current financial constraints. The allocation of resources will need to be agreed and prioritised to areas most critical for de-escalation, quality and safety , but ongoing assessment of capacity to deliver will be essential. A key consideration for the successful implementation of this structure will be ensuring teams have the necessary resources, training and transitional support to adapt to new ways of working while maintaining operational delivery during this period of change. However, there is inevitably a risk around the ambition of the annual plan and the wider health board resources to ensure delivery.	A review of the effectiveness of the new governance arrangements will be undertaken by Internal Audit, expected to be completed in March 25	**Action - Formal Escalation Process for Non-Engagement -** To address the incomplete plans and limited engagement in certain programmes, a formal escalation route between the Programme Director of Targeted Intervention and the CEO/Deputy CEO will be established. This process ensures that any directorate or service failing to provide complete, timely plans will be escalated for support and accountability. **Target Implementation Date: 28 February 2025.**			No risk identified
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 QSEC and Board.	Advise	Joanne Wilson	Risk management arrangements are embedded across the organisation, with robust processes for identifying, recording, and managing risks. This framework is built on a well-established set of tools, such as the Board Assurance Framwork, Corporate Risk Register and Datix, complemented by structured directorate escalation meetings. These meetings cover six key risk areas, ensuring a comprehensive assessment of performance variations and emerging challenges. This systematic approach aims to promote a proactive culture of risk identification, where issues can be identified and addressed early. The Board have agreed its risk appetite (Jan25) and approach to risk tolerance (Mar25). The Board is consistently sighted on key risks and areas of concern through well-defined reporting lines, including the Quality, Safety, and Experience Committee (QSEC), the Targeted Intervention (TI) Coordination Group, and the Audit and Risk Assurance Committee (ARAC). These governance structures allow the Board to engage in constructive scrutiny of performance and risk, providing effective oversight, especially in the management of fragile and high-risk services. This approach allows the Board to fulfil its role not only in terms of monitoring but also in challenging and supporting the development of mitigation strategies. Despite these established processes, challenges remain in ensuring that recorded risks transition smoothly from identification to active mitigation. It has been observed that while risks are being systematically recorded, there is sometimes a lack of capacity to manage the risks and the actionable plans tied to these risks. This gap can be addressed by focusing on the development of risk management plans that contain specific deliverables , measurable milestones, and clearly assigned responsibilities (subject to capacity) that are linked to the Health Board's agreed objectives. Strengthening these aspects will enhance the link between risk identification and tangible mitigation outcomes, promoting a more cohesive approach to risk management across the Health Board. The implementation of the Clinical Care Group model from April 2025 aims to further enhance risk management by integrating risk identification and management at service level. Each CCG's fortnightly Integrated Governance Group meetings are designed to ensure emerging risks are identified and addressed promptly, with clear escalation routes to the Integrated Quality, Finance & Performance Delivery Group where needed. This is intended to address the previously identified gap between risk identification and active mitigation, creating more responsive risk management closer to service delivery. The Board's newly approved risk appetite statement (January 2025) and risk tolerance approach (March 2025) provide a clear framework for determining acceptable risk levels, ensuring consistency in risk assessment and management across the organisation. Operational oversight has recently been improved through internal escalation processes that help identify operational issues and risks in a timely manner. However, governance arrangements at the operational level remain inconsistent, particularly across the Operations Directorate. The inconsistencies identified are currently being addressed through the introduction of a new operational governance structure. This revised structure, expected to be implemented by April 2025, will be led by the Chief Operating Officer, whose support will be crucial to ensure consistent application and monitoring across all operational teams. The objective is to align operational governance standards with the mature corporate governance practices already demonstrated by the Health Board, thus promoting a unified standard of governance across all tiers of the organisation. Risk Management is also included in the new standardised operational governance arrangements which are also expected to be implemented in April 2025. The corporate governance arrangements within the Health Board are mature and robust, a conclusion consistently reinforced through structured assessments. These assessments highlight that strategic and corporate risks are well-monitored, and there is a continuous effort to ensure alignment between strategic intentions and operational actions. However, to support future governance resilience, it will be crucial to focus on embedding consistent governance practices across all operational functions. This will ensure a consistent flow of information, from front-line operational risks to strategic oversight by the Board, thereby enhancing the Health Board's capacity to manage both immediate and long-term challenges.	Mature and robust corporate governance arrangements in place, with further work to develop consistent governance arrangements in the Operations Directorate	Support the Chief Operating Officer to implement consistent operational governance arrangements (Apr25)	Support the Chief Operating Officer to implement consistent operational governance arrangements - (Apr25)	Structured Assessment 2024 - the Board continues to have a mature approach to overseeing strategic and corporate risks and risk management arrangements.	N/A
40	Clear governance and assurance systems in place with performance (quality resource activity/outcomes) issues escalated appropriately through clear structures and processes.	Advise	Lee Davies	As above, the new governance arrangements are now well established and provide the mechanisms for seeking assurance and escalating as required. A review is required of the effectiveness of these mechanisms as, in areas like cancer, urgent care, and diagnostics, we've observed limited improvement but in some cases, a deterioration, highlighting potential gaps in the effectiveness of our programme and performance management. Although the structure defines objectives, the framework is not yet supporting the level of oversight required to ensure consistent delivery against these objectives. The new governance arrangements are now well-established, with the Board approved Committee structure (January 2025) being implemented from April 2025. This structure aligns with the six domains of Targeted Intervention, ensuring clear accountability for de-escalation criteria. The Clinical Care Group governance model aims to further strengthen this by creating consistent operational governance through standardised Integrated Governance Groups, addressing the previously identified inconsistencies in operational governance. To evaluate effectiveness, a comprehensive review of the new governance arrangements is scheduled for Q2 2025/26, with a particular focus on whether escalation processes are functioning effectively in areas like cancer, urgent care and diagnostics where performance challenges persist. A dashboard of leading indicators has been developed to enable early identification of delivery risks before they manifest in performance metrics. Successful implementation of these governance arrangements will require careful attention to resource allocation, ensuring that teams responsible for delivering key improvements have sufficient capacity and capability to meet the ambitious targets set in the Annual Plan. This remains a challenge in the current financial environment but is essential to the effectiveness of the governance framework.	As above				No risk identified

41	Self-assessment against an agreed governance maturity matrix with evidence the agreed level.	Advise	Lee Davies	The Health Board undertook a self-assessment against an agreed governance maturity matrix in Q4 of 2023-24, providing a realistic view of the organisation's current position regarding governance maturity. This assessment has been crucial, particularly given the broader context of the annual plan recovery work undertaken during the summer of 2023 and the strategic preparations for the 2024-25 planning cycle. It offered a critical lens through which governance practices were evaluated, enabling an honest appraisal of strengths and areas needing enhancement. The maturity matrix framework provided clear insights, which have informed the Health Board's subsequent approach to improving its governance maturity. The assessment did not exist in isolation; rather, it has become a key reference point for ongoing organisational improvements. It has ensured that governance practices are continuously reassessed, with findings feeding into the decision-making processes to strengthen governance structures, align roles and responsibilities, and provide a clear direction for ongoing enhancement activities. In a manner similar to the Health Board's handling of the 56 de-escalation criteria under the Targeted Intervention (TI) framework, the maturity matrix serves as both a strategic and operational tool that reinforces decision-making processes. These processes ensure that both strategic and operational planning governance arrangements are not only reactive but also proactive, with an emphasis on anticipating challenges, promoting best practices, and ensuring alignment across critical areas of focus. The maturity matrix is thus integral to the Health Board's structured approach to organisational improvement, helping to drive alignment between strategic goals and operational practices. For the 2025/26 maturity matrix assessment, a significantly enhanced seven-step process has been developed, running from March to August 2025. This comprehensive approach includes: 1. Initial evidence gathering (March-April) - A thorough review of internal documents, operational plans, strategy alignment, and previous assessments to ensure robust evidence across all nine maturity domains. 2. Sequential stakeholder engagement (May) - Beginning with Clinical, Operational and Corporate teams (12-13 May), followed by Executive assessment (14 May), ensuring multiple perspectives are captured. 3. Integration of Welsh Government feedback (May-June) - Incorporating formal WG responses to the Annual Plan and all TI correspondence throughout 24/25 to ensure alignment with external expectations. 4. Consolidation (June) - Reassessment based on integrated feedback with detailed narrative justifications and evidence for each maturity score. 5. Committee scrutiny (June-July) - Formal review by the Strategy and Planning Committee (1 July) with recommendations for Board consideration. 6. Board approval (31 July) - Submission for formal approval with comprehensive documentation of Board feedback. 7. Submission to Welsh Government (Early August) - Final submission with full supporting evidence. This structured approach directly addresses prior audit recommendations regarding evidence usage and Board oversight while ensuring the maturity assessment reflects not just planning processes but broader organisational capabilities. Regular reassessments of governance maturity are conducted throughout the year to adapt to emerging challenges and priorities. This continuous assessment cycle allows the Health Board to remain agile, capable of responding to both internal and external pressures, while still maintaining alignment with its strategic objectives. By leveraging the insights gained through the maturity matrix and aligning them with the strategic priorities identified in the 2025-26 annual plan, the Health Board aims to ensure that its governance arrangements not only meet current needs but are also future-ready. The next maturity matrix reassessment will take place following the completion of the 2025-26 annual plan. This reassessment will help to ensure that planning practices remain relevant and aligned with the evolving needs of the organisation. Furthermore, this will service as an improvement process ensures that governance structures are not static but evolve in tandem with the changing operational landscape and strategic ambitions of the Health Board.	A further assessment will be made following the completion of the annual for 2025-26 (April 25)				N/A

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

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

Llywodraeth Cymru
Welsh Government

Dr Philip Kloer
Chief Executive
Hywel Dda University Health Board

Our Ref: JP/GE/SB

9 April 2025

Dear Phil

Quarterly escalation meeting

This was our first formal escalation meeting since the recent de-escalation announcements when we confirmed the following escalation status:

- Level 4 for finance, strategy and planning, performance and outcomes related to urgent and emergency care, cancer and quality of care related to HCAIs and fragile services
- Level 3 for performance and outcomes related to planned care, CAMHS and leadership and governance

The changes in the escalation status are in line with our improving confidence in the organisation and reflect the increasing confidence we have that the Board is in a position to implement the required changes. It is essential that this improvement journey continues into the new financial year. A refreshed escalation framework will be shared with you shortly.

Apologies were noted from Shaun Ayres and Sharon Daniel from the health board and Alex Slade from the Welsh Government. Thank you for the slide pack, that was received in advance of the meeting, this forms an important part of the meeting record. All actions from the previous meeting had been completed

Finance and planning

The health board expect to deliver an end-of-year deficit of £24m against a control total target of £31.5m, this is a significant improvement from the start of the year. This has been realised following the reduction in nursing agency costs and a number of non-recurrent savings. It is important that this improvement continues. You confirmed that the financial trajectory for next year includes a higher savings requirement and that there are plans at different stages of development to achieve the £19m recurrent savings. You continue to de-

Parc Cathays ● Cathays Park
Caerdydd ● Cardiff
CF10 3NQ

Judith.Paget001@gov.wales

Gwefan ● website: www.gov.wales

risk your plan and acknowledge that improvement beyond the £31.5m control target is required.

You are in the final stages of producing the consultation documentation related to your clinical service plan. A 3-month consultation period will commence at the end of May 2025, and the consultation outcomes will be shared with the board in November 2025. You are also in the process of refreshing '*A Healthier Mid and West Wales*', focusing on the route of delivery rather than a fundamental change to the strategy.

The board agreed at their meeting on 27 March 2025 to progress to consultation on the MIU at Prince Philip Hospital at the end of April 2025. I look forward to the outcome of the consultation.

Your Board approved the annual plan at its last meeting, this has now been submitted to Welsh Government. We will assess the plan, and feedback will be provided in due course.

Fragile Services

Your presentation focused on the challenges facing the ophthalmology service. Whilst progress has been made on the cataract pathways and all 104-week waits have been eliminated, there are challenges related to clinical pathways, including IVT, medical retina and glaucoma and the on-call rota remains fragile. We discussed a number of solutions that are being implemented, and you were confident that these would result in the R1 compliance improving to 65% over the next 12 months. We discussed the importance of developing a regional service with Swansea Bay UHB to ensure resilience and a sustainable model.

Quality and Safety

Whilst you are confident that there are improved processes related to healthcare acquired infections since the last meeting, performance against the C. diff and E. coli measures has not improved. You confirmed that environmental disinfection is a focus across each site along with aseptic non-touch technique and the implementation of the 'gloves off' campaign will have an impact. There are regular weekly meetings with microbiology and epidemiology to ensure that this focus remains.

Improvements to the complaints handling and resolution process has seen performance increase from 63% in March 2024 to 77% in March 2025. Early resolution to complaints has had a positive impact on patient experience. You agreed to provide an update on how the health board would accommodate the new PTR regulations.

In relation to death certification, the health board was an outlier across England and Wales with delays of up to 14 days. You acknowledged there were delays at different stages of the process but there was good engagement with the Medical Examiner service.

Performance and outcomes

Following the dip in performance for the cancer pathway in January 2025, performance had improved in February, and you anticipate improving to 60% in March 2025, and in your annual plan have indicated a compliance of 80% by March 2026. It is important you continue to remove the backlog whilst improving performance.

Urgent and emergency care remains your biggest challenge with performance data showing concerning trends.

You are in the process of evaluating the impact of the seven-days a week services including the three streaming hubs. I would appreciate an update on the SDUC at Cardigan once you have completed the evaluation exercise at the end of quarter one 2025/26.

I note the DEXA scan waits are now starting to reduce, and that you have plans in place with Swansea Bay UHB for that improvement to continue. I would like an update on the length of the longest wait and the trajectory to ensure that compliance is within 8 weeks.

On planned care, good progress has been made to achieve zero 104-week breaches, this must be maintained and further improvements made. I understand that you will be focusing on theatre efficiency as part of your key objectives going forward.

From a CAMHS perspective, your challenge relates to ASD and neurodiversity. I note a paper was submitted to your Board meeting on 27 March describing a new model which will speed up the assessment process.

Governance and Leadership

You confirmed the transition to your new operational structure of a Clinical Care Group (CCG) occurred on 1 April 2025 and that you had recruited to most of the senior posts. A phased implementation plan is in place from April – September 2025. You will be undertaking an ongoing evaluation, including a scheduled internal audit in September 2025 of the new governance arrangements.

Any other business

Welsh Government received an early warning notice on 1 April highlighting an issue with paediatric medical workforce, with three consultants currently off the rota. You confirmed the use of agency doctors to cover the rota and that an escalation process is in place.

Summary

This had been a helpful discussion around the processes and systems in place to support improvement within the health board following the de-escalation of planned care, CAMHS and for leadership and governance. I expect to see performance improvements continue across all areas.

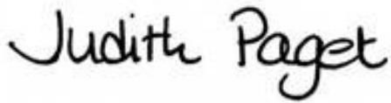
You have made progress against your financial position; the health board will need to continue its efforts in reducing its forecast deficit both in-year and on a recurrent basis. We agreed the following actions:

- An update following the consultation on the MIU at Prince Philip Hospital at the end of April 2025.
- Health board agreed to provide an update on the implementation of the new complaints PTR regulations.
- Health board to provide an update on the SDUC at Cardigan once evaluation exercise at the end of quarter one 2025/26 be completed.

- Health board to provide an update on the longest DEXA wait time. *(post meeting note, information received from Lee Davies 7 April 2025)*

I look forward to seeing further progress at the next meeting.

Yours sincerely



Judith Paget CBE

Attendance

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