



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

Date **26 August 2025**
Time **9:30 AM - 1:00 PM**
Location **Ystwyth Boardroom/Microsoft Teams Meeting**

Finance and Performance Committee Meeting

26 August 2025

Agenda - 26 August 2025

1 GOVERNANCE

9:30 AM, 0 min

1.1 WELCOME AND APOLOGIES

9:30 AM, 0 min

Michael Imperato (Hywel Dda UHB - Independent Board Member)

1.2 DECLARATION OF INTERESTS

9:30 AM, 0 min

Michael Imperato (Hywel Dda UHB - Independent Board Member)

1.3 MINUTES OF FINANCE AND PERFORMANCE COMMITTEE HELD ON 26 JUNE 2025

9:30 AM, 5 min

Michael Imperato (Hywel Dda UHB - Independent Board Member)

1.4 TABLE OF ACTIONS FROM FINANCE AND PERFORMANCE COMMITTEE HELD ON 26 JUNE 2025

9:35 AM, 0 min

Michael Imperato (Hywel Dda UHB - Independent Board Member)

1.5 SELF-ASSESSMENT OF COMMITTEE EFFECTIVENESS: SIX-MONTH REVIEW

9:35 AM, 5 min

Michael Imperato (Hywel Dda UHB - Independent Board Member)

1.6 ASSURANCE ON GOVERNANCE ARRANGEMENTS

9:40 AM, 15 min

Andrew Spratt (Hywel Dda UHB - Deputy Director of Finance)

1.7 FINANCE AND PERFORMANCE COMMITTEE TERMS OF REFERENCE

9:55 AM, 0 min

Michael Imperato (Hywel Dda UHB - Independent Board Member)

2

ESCALATION OVERVIEW

9:55 AM, 0 min

2.1

ESCALATION OVERSIGHT AND HIGHLIGHT REPORT

9:55 AM, 20 min

Shaun Ayres (Hywel Dda UHB - Director of Delivery)

3

ESCALATION RESPONSE – RECOVERY ACTION PLANS AND IMPROVEMENT TRAJECTORIES

10:15 AM, 0 min

3.1

CLINICAL CARE GROUP FINANCIAL SAVINGS

10:15 AM, 15 min

Andrew Carruthers (Hywel Dda UHB - Chief Operating Officer)

3.2

COMMUNITY AND INTEGRATED MEDICINE PERFORMANCE AND PRODUCTIVITY

10:30 AM, 15 min

Andrew Carruthers (Hywel Dda UHB - Chief Operating Officer)

3.3

PLANNED CARE AND CANCER PERFORMANCE AND PRODUCTIVITY

10:45 AM, 15 min

Andrew Carruthers (Hywel Dda UHB - Chief Operating Officer)

3.4

RADIOLOGY UPDATE

11:00 AM, 15 min

Andrew Carruthers (Hywel Dda UHB - Chief Operating Officer)

4

FINANCE

11:15 AM, 0 min

4.1

FINANCIAL PERFORMANCE ASSURANCE REPORT

11:15 AM, 30 min

Andrew Spratt (Hywel Dda UHB - Deputy Director of Finance)

4.2

INVESTMENT AND BENEFITS REALISATION REPORT

11:45 AM, 20 min

Sian Jenkins (Hywel Dda UHB - Deputy Director of Finance)

4.3 PLANNING OBJECTIVES UPDATE REPORT

12:05 PM, 5 min

Andrew Spratt (Hywel Dda UHB - Deputy Director of Finance)

4.4 PROCUREMENT PLAN AND SCRUTINY

12:10 PM, 10 min

Andrew Spratt (Hywel Dda UHB - Deputy Director of Finance)

4.5 ALL-WALES CAPITAL PROGRAMME 2025/26, CAPITAL RESOURCE LIMIT AND CAPITAL FINANCIAL MANAGEMENT UPDATE

12:20 PM, 0 min

Andrew Spratt (Hywel Dda UHB - Deputy Director of Finance)

5 PERFORMANCE

12:20 PM, 0 min

5.1 INTEGRATED PERFORMANCE ASSURANCE REPORT

12:20 PM, 15 min

Anthony Tracey (Hywel Dda UHB - Digital Director)

5.2 NWSSP PERFORMANCE REPORT QUARTER 1 2025/26

12:35 PM, 0 min

Andrew Spratt (Hywel Dda UHB - Deputy Director of Finance)

6 FOR APPROVAL

12:35 PM, 0 min

6.1 BUSINESS CASE: URGENT AND EMERGENCY CARE TRANSFORMATION

12:35 PM, 0 min

Andrew Carruthers (Hywel Dda UHB - Chief Operating Officer)

6.2 FINANCIAL PROCEDURES

12:35 PM, 10 min

Andrew Spratt (Hywel Dda UHB - Deputy Director of Finance)

6.3 POLICIES

12:45 PM, 5 min
Andrew Carruthers (Hywel Dda UHB - Chief Operating Officer)

7 FOR INFORMATION

12:50 PM, 0 min

7.1 JCC PLANNING, PERFORMANCE AND FINANCE SUB-COMMITTEE REPORTS

12:50 PM, 5 min
Andrew Spratt (Hywel Dda UHB - Deputy Director of Finance)

7.2 FINANCE AND PERFORMANCE COMMITTEE WORK PLAN 2025/26

12:55 PM, 5 min
Michael Imperato (Hywel Dda UHB - Independent Board Member)

8 ANY OTHER BUSINESS

1:00 PM, 0 min

9 DATE OF NEXT MEETING

1:00 PM, 0 min

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1 - GOVERNANCE

1.1

9:30 AM, 0 Mins

1.1 - WELCOME AND APOLOGIES

*Michael Imperato
(Hywel Dda UHB -
Independent Board
Member)*

1.2

9:30 AM, 0 Mins

1.2 - DECLARATION OF INTERESTS

***Michael Imperato
(Hywel Dda UHB -
Independent Board
Member)***

1.3

9:30 AM, 5 Mins

1.3 - MINUTES OF FINANCE AND
PERFORMANCE COMMITTEE HELD ON 26
JUNE 2025

*Michael Imperato
(Hywel Dda UHB -
Independent Board
Member)*

| For approval

Attachments

[2025-06-26 - Virtual Finance and Performance Committee Meeting - Minutes.pdf](#)

UNAPPROVED MINUTES OF THE FINANCE AND PERFORMANCE MEETING

DATE OF MEETING: 9:30 AM, Thursday 26 June 2025

VENUE: Microsoft Teams Meeting

PRESENT: Michael Imperato (Hywel Dda UHB - Independent Board Member) (Chair) (VC)
Anna Lewis (Hywel Dda UHB – Independent Member) (Vice Chair) (VC)
Rhodri Evans (Hywel Dda UHB – Independent Member) (VC)
Eleanor Marks (Hywel Dda UHB - HDUHB Vice Chair) (VC)
Winston Weir (Hywel Dda UHB - Independent Board Member) (VC)

IN ATTENDANCE: Andrew Carruthers (Hywel Dda UHB - Chief Operating Officer) (VC)
Eiry Edmunds (Hywel Dda UHB – Deputy Medical Director) (VC)
Richard Jenkins (Hywel Dda UHB - Assistant Finance Director Commissioning, BI & Value) (VC)
Keith Jones (Hywel Dda UHB - Director of Operational Planning & Performance) (VC)
Julia McCarthy (Hywel Dda UHB - Head of Long Term Care) (VC) (part)
Jill Paterson (Hywel Dda Health Board - Director of Primary Care, Community and Long Term Care) (VC)
James Severs (Hywel Dda UHB - Executive Director of Allied Health Professions and Health Science) (VC)
Andrew Spratt (Hywel Dda UHB – Deputy Director of Finance) (VC)
Huw Thomas (Hywel Dda UHB - Director of Finance) (VC)
Jennifer Thomas (Hywel Dda UHB - Senior Finance Business Partner (Accounting & Statutory and Reporting)) (VC)
Joanne Wilson (Hywel Dda UHB - Director of Corporate Governance/Board Secretary) (VC) (part)
Tomos Jones (Audit Wales) (observing) (VC)
John Jenkins (Hywel Dda UHB - Committee Services Officer) (Secretariat) (VC)

MINUTES REF.	ITEM	ACTION

FPC(25)20	WELCOME AND APOLOGIES

Mr Michael Imperato welcomed all to the Finance and Performance Committee (FPC) meeting.

Apologies had been received from:

- Mrs Sharon Daniel, Executive Director of Nursing, Quality and Patient Experience

- Mr Mark Henwood, Executive Medical Director (Ms Eiry Edmunds, Deputy Medical Director, deputising)
- Mr Shaun Ayres, Director of Delivery

FPC(25)21

DECLARATION OF INTERESTS

Minute FPC(25)38 ('Discharge to Assess'): Councillor Rhodri Evans declared an interest as an elected member of a local authority.

FPC(25)22

MINUTES OF FINANCE AND PERFORMANCE COMMITTEE HELD ON 29 APRIL 2025

The minutes of the Finance and Performance Committee (FPC) meeting held on 29 April 2025 were reviewed and agreed as an accurate record of proceedings subject to the correction to include the attendance of Cllr. Rhodri Evans.

Decision: The minutes of the Finance and Performance Committee meeting held on the 29 April 2025 were **APPROVED** as a correct record of proceedings.

FPC(25)23

TABLE OF ACTIONS FROM FINANCE AND PERFORMANCE COMMITTEE HELD ON 29 APRIL 2025

The Table of Actions from the FPC meeting held on 29 April 2025 was reviewed and noted that all actions were complete.

Decision: The Finance and Performance Committee **REVIEWED** and **NOTED** the Table of Actions from the Finance and Performance Committee meeting held on 29 April 2025.

FPC(25)24

CORPORATE RISKS

Mr Huw Thomas presented the Corporate Risk Register (CRR) to FPC and advised that there were two new risks that had been added to the CRR:

- Risk 2086 – Risk that the cash consequences of the Health Board deficit cannot be covered by Welsh Government (WG) should it exceed our Target Control Total (TCT)

- Risk 1350 – Risk of not meeting the 80% Single Cancer Pathway (SCP) waiting times target for March 2026 due to diagnostics capacity and delays at tertiary centre

Mr Thomas advised that Risk 2086 was a refreshed iteration of Risk 1843 that had been closed as it applied to 2024/25 with the new risk refreshed and reassessed for the new financial year. Mr Thomas advised that the Health Board's annual plan would deliver the TCT of £31.5m with on-going dialogue between the Health Board and WG on the acceptability of the £31.5m annual deficit figure with a response required from the Health Board to WG by 30 June 2025 on improvements that were required to that total with a requirement to attain an annual deficit figure of £24m with WG having requested an outline of what choices, actions and options that the Health Board are considering to deliver the £24m position.

Mr Thomas advised that the choices and actions were those that were within the gift of the Health Board to make with options being those for WG consideration. Mr Thomas advised that these were currently under discussion by the Executive Team and would be reported within the formal governance space for consideration.

Mr Thomas advised that Risk 2086 had been assessed with a risk score of 20 with a target risk score of 12 with the gap relating to the challenge of assuring the outcomes of the trajectory of savings delivery.

In response to a question from Mrs Eleanor Marks on whether Hywel Dda University Health Board (HDdUHB) was in a similar position to other Health Boards within Wales to have their TCT reduced by WG, Mr Thomas advised that there were four other Health Boards in a similar position to HDdUHB who did not have a balanced financial projection and three Health Board having a declared balance position however have an adverse trajectory that they needed to reverse to return to balance. Mr Thomas believed that the reduction in HDdUHB's TCT was reasonable and a course that the Health Board would subscribe to as part of the path to reach a break-even position.

In response to a question from Mr Winston Weir on whether a response had been prepared to Mrs Judith Paget's letter dated 6 June 2025 to the Health Board, Mr Thomas advised that a draft response had been produced with the final letter to be shared with FPC at a later date and that the response assumed the Health Board would deliver on its £31.5m TCT, with approximately £1.5m of choices within the investment proposals previously presented to Board to defer a number of those investments. Mr Thomas advised that there were approximately £2m of benefits that were above what was contained within the annual plan, mainly within Medicines Management, that had seen improvement towards the end of 2024/25 and a further £1m improvement in the Health Board's nursing agency trajectory. Mr Thomas advised that these

improvements resulted in a projected £28m deficit position through choices and actions that were within the Health Board's gift to make.

Mr Thomas believed that to close the gap between £28m and the £24m target improved position would have significant repercussions for the Health Board locally with the options to be discussed with WG on securing alternative funding streams through WG and gave the example of £2.2m of radiology and endoscopy funding that the Health Board had allocated that if WG chose to fund through a planned care recovery route would give the Health Board a benefit to its bottom line.

In response to a question from Mr Imperato on the governance process and oversight of the choices, options and actions contained within the response to WG, Mr Thomas advised that the original annual plan had been subject to Board and Board Committee scrutiny and approval and the proposed changes to that plan would require similar oversight and advised that he would discuss with the Professor Philip Kloer and Mrs Joanne Wilson the proper governance route to review the proposed changes.

HT

Mr Andrew Carruthers advised that Risk 1350 had been reviewed following the closure of the previous delivery year and updated to consider the current delivery year and presented as a new risk with the finance link to the previous risk being the decision of the Health Board to support the SCP through a significant investment in radiology that would form part of the Health Board's discussions with WG relating to investment choices that the Health Board had made given that any decision not to invest in response to the financial ask of WG would have a major impact on performance.

Mr Carruthers advised that the risk related to the attainment of the 80% SCP waiting times target by the end of March 2026 and was driven by the fragility of services such as those contained within the Clinical Services Plan such as dermatology and urology having a consequence for pathway delivery.

Mr Carruthers advised that there was a plan in place with a trajectory to attain the 80% target by the end of Q4 2025/26 with improvements to the trajectory being exhibited to date with two consecutive months reported above the 60% target to achieve the targeted intervention (TI) de-escalation criteria with high confidence that a third consecutive month would be achieved. Mr Carruthers believed that the trajectory would remain within the 60%-70% range with improvement plans in place and progressing to enable to attainment of the 80% performance target by the end of Q4 2025/26.

Decision: The Finance and Performance Committee:

- **RECEIVED ASSURANCE** that all identified controls are in place and working effectively; and

- **RECEIVED ASSURANCE** that all planned actions will be implemented within stated timescales and will reduce the risk further and/or mitigate the impact if the risk materialises.

FPC(25)25

OPERATIONAL RISKS

Mr Thomas presented the Operation Risk Register (ORR) to FPC.

In response to a question from Mrs Marks on the significant financial risk relating to cancer and mental health on whether the quality of services was not being impacted by the financial pressures and whether the Health Board were projected to deliver the expected savings, Mr Thomas advised that all financial choices undertaken by the Health Board were subject to both quality impact assessments (QIA) and equality impact assessments (EqIA) that were undertaken independently of the financial and operational domains.

Mr Carruthers believed that there was clarity within the clinical care groups (CCGs) that the Health Board needed to be creative and innovative in seeking opportunities to improve the savings delivery position that equally did not negatively impact quality and safety and that the QIA process ensured that the Health Board never knowingly make a decision knowing that it would result in a diminution of quality. Mr Thomas believed that he was less concerned with the explicit decisions made by the Health Board that went through the QIA process and was more concerned about the implied choices that were less implicit that would be more of a challenge to capture through the QIA process. Mr Carruthers agreed that there were decisions made daily within an operational setting that would undergo a risk assessment however would not be subject to the rigour of a full QIA.

Mr Carruthers believed that the quality and safety impact of the real-time decisions made were subjected to checks and balances through the Integrated Quality, Finance and Performance Delivery (IQFPD) Group that could triangulate the data on a monthly basis that would detect any impact on quality and safety being made as a result of those incremental decisions would be highlighted through the review of the data received from services.

In response to a question from Mrs Marks on the balance between quality and finance, Mr Thomas believed that by having finance and performance considered by the same Board Committee provided the governance space to ensure a rounded discussion with the QIA process providing assurance over the impact of quality of the explicit decisions made and the implicit operational decisions made with the need to ensure the appropriate connection between FPC and the Quality, Safety and Experience Committee (QSEC).

Mrs Joanne Wilson joined the meeting

In response to a question from Ms Anna Lewis on Risk 1646 – Risk of overspending against funding allocated for external test service level agreements (SLAs) due to increased workload/costs (Pathology), Mr Carruthers advised that Pathology Services previously sat within a service group and were often sidelined by other pressures however now sat within the Allied Health Professions and Health Science CCG that enabled pathology to have a stronger voice within the service conversation that enabled a more effective management of the risk.

In response to a question from Ms Lewis on Risk 1906 – Risk of not achieving savings targets within our annual plan due to ongoing service demand (Pembrokeshire Integrated System), Mr Carruthers advised that while the risk referred only to Pembrokeshire, Mr Carruthers advised that the whole budget for the individual specialities across the Health Board were held within the county budget and related to the whole organisation and related to how the budget sat within the Health Board hierarchy as opposed to being a Pembrokeshire-only issue.

Decision: The Finance and Performance Committee:

- **RECEIVED ASSURANCE** that all identified controls are in place and working effectively; and
- **RECEIVED ASSURANCE** that all planned actions will be implemented within stated timescales and will reduce the risk further and/or mitigate the impact if the risk materialises.

FPC(25)26

EXTERNAL ESCALATION

Mr Thomas presented the external Escalation Report to FPC and advised that the finance element of the escalation report had been covered within the CRR item previously discussed in the meeting. Mr Thomas advised of the challenges experienced within urgent and emergency care (UEC) and ambulance handover performance, the time to clinical assessment and delayed packages of care criteria with a significant level of work being undertaken on system change with dedicated analytical support being required to model the level of system change necessary and that that analysis needed to quantify the capacity expansion, demand reduction, and operational redesign required to deliver exponential improvement beyond current capability.

Mr Thomas repeated the assurance received from Mr Carruthers on the SCP performance that had seen three consecutive months of performance above the TI de-escalation criteria however

highlighted the alert relating to R1 ophthalmology performance where there had been a deterioration in performance.

Mr Thomas advised that there had been zero 104-week referral to treatment (RTT) breaches maintained for three consecutive months however comprehensive analysis had revealed sustainability concerns that moved the criterion from an 'assure' to an 'advise' to the Committee.

Mr Thomas advised that the internal response would be addressed through the deep dive into the thematic reviews of finance and performance.

Decision: The Finance and Performance Committee **NOTED** the Escalation Status Progress Report

FPC(25)27

THEMATIC REVIEWS OF FINANCE AND PERFORMANCE

Mr Carruthers presented the deep dive into the thematic reviews of the CCG performance and finance progress to FPC and advised that a summary of the key issues relating to performance and finance for each CCG. Mr Carruthers believed that the CCGs had within the last four to five weeks got a grip on the savings issues within their domains and progressed savings plans to identify the total value of savings schemes against their savings target and the in-year delivery of green and amber savings schemes with the CCGs having added approximately £6m of green savings schemes.

Mr Carruthers advised that the challenge that a significant proportion of the savings schemes were non-recurrent where CCGs had undertaken deliberate actions through their financial control procedures to hold spending or choose not to spend as conscious actions taken to mitigate the savings position while reviewing their savings plans to formulate a robust recurrent savings plan.

Mr Carruthers advised that following the last round of Executive Improving Together sessions (EITs), discussions had been undertaken with the Allied Health Professions and Health Science CCG as their savings requirements were considered a significant challenge and were requested to ensure that plans were in place to ensure that they break even and mitigate any overspends that they were currently forecasted to incur given their risk of overspending and under-identification of savings.

Mr Carruthers advised that Mr Gareth Rees had been tasked with performing the role of a 'critical friend' as a programme manager to provide an independent assessment advisor to review identified savings schemes to ensure that there were clear actions and timelines identified to convert red and blue savings schemes to

green and amber and form part of the forecasted savings delivery position for 2025/26.

Mr Carruthers advised that there were a number of areas within the operational directorate that were currently in a break-even financial position or were underspending against their core budgets that Mr Carruthers believed indicated that CCGs were undertaking ownership and accountability of the financial plan within the revised operational structure in addition to ensuring that delivering improvements to services and ensuring quality, safety and performance.

Mr Carruthers provided an overview of the performance and finance aspects of each of the four CCGs:

Community and Integrated Medicine CCG

Performance: Mr Carruthers advised that the most significant areas of performance within the Community and Integrated Medicine CCG related to UEC and ambulance handover delays. Mr Carruthers advised that a UEC Accelerated Transformation programme to progress the reshaping and redesign of the Health Board's UEC system with the key components relating to the increase of the Health Board's service coverage to seven days a week and how the Health Board influences the public in how to access UEC services and a more robust and coordinated process of navigating UEC to manage demand and capacity across the system with an Operational Delivery Unit (ODU) being designed to achieve those objectives with proposals for both seven day a week streaming hub and the ODU being presented to Executive Team in July 2025.

In response to a question from Cllr Evans on the reporting timeline, Mr Carruthers advised that there was a monthly reporting period with Mr Rees having been asked to undertake contact with the CCGs within that timeframe to monitor the assessment of the actions expected to be undertaken.

Finance: Mr Carruthers advised that the CCG has achieved an in-month cumulative breakeven position against its allocated operating budget which contrasted with historical trends in budget performance for the constituent elements of the CCG structure. Mr Carruthers advised that there was a significant challenge within the Carmarthenshire System with discussions held with Mr Thomas on how the Carmarthenshire System could be supported within the internal escalation space and believed that there was significant opportunity for the Carmarthenshire System to align their opportunities to the work being undertaken within the UEC pathway to improve the efficiency and productivity to match their resources and level of demand and capacity.

In response to a question from Mrs Marks on the timeline and what actions could be expected and by when, Mr Carruthers did

not believe that the required level of granularity had been developed with the CCGs at present to enable the production of anticipated timelines. Mr Carruthers conceded that this was a weakness at present and had requested work be undertaken to enable the charting of timelines and actions. Mr Thomas believed that there was a significant level of work being undertaken to transform UEC however there was an inability to translate that work into plans to deliver improvements within the Carmarthenshire element of the system. Mr Thomas believed that improvements within the Pembrokeshire and Ceredigion Systems had been successful and acknowledged that Carmarthenshire was the more complex part of the UEC system given its involvement within most pathways that go through Glangwili Hospital (GGH).

Planned and Specialist Care CCG

Performance: Mr Carruthers believed that the most significant risk within the Planned and Specialist Care CCG domain related to the ministerial priorities of RTT and the 104-week wait for treatment and the 52-week maximum wait for outpatients. Mr Carruthers advised that there were a number of breaches of the 104-week wait at the end of Q1 2025/26 of 163 patients. Mr Carruthers advised that the main driver of the breaches was as a consequence of theatre staffing availability at GGH due to sickness and workforce challenges. Mr Carruthers advised that there was in discussions with WG and a recovery plan had been developed to ensure the position was recovered during Q2 2025/26.

Mr Carruthers advised that there had been a deterioration ophthalmology R1 performance that featured within the TI escalation status with Mr Carruthers expressing concern of the quality and safety of the intravitreal therapy (IVT) pathway with actions currently being undertaken to increase injection capacity. In response to a question from Cllr Evans on recruitment, Mr Keith Jones advised that within the R1 recovery plan, the delivery of injections was a non-medical activity with the recovery plan was predicated on recruiting nurse injectors to expand injection capacity with recruitment in progress to deliver the increased capacity and while the recruitment was in progress, external outsourcing capacity was being utilised to undertake IVT injections.

Finance: Mr Carruthers advised that the combined impact of a £0.1m cumulative overspend position against the Planned and Specialist Care CCG allocated operating budget and partial delivery of planned savings placed the CCG at £0.6m above its target financial position as at Month 2 2025/26.

Operational Allied Health and Health Sciences CCG

Performance: Mr Carruthers advised that the two main performance areas within the Operational Allied Health and Health

Sciences CCG were part of the TI escalation were Radiology Direct Access Diagnostic maximum 8-week wait, and the therapies maximum 14-week wait. Mr Carruthers advised that the plan agreed by Board to stabilise the radiology service with outsourced-commissioned activity utilised to maintain the required level of capacity pending recruitment into the radiology service for computed tomography (CT), magnetic resonance imaging (MRI) and ultrasound scanning capacity that had resulted in significant improvements within cancer scanning and reporting times.

Mr Carruthers advised that discussions were on-going with WG on how cancer performance could be improved to enable the delivery of the zero eight-week waits by the end of March 2025 and advised that the current plan did not deliver that performance. Mr Carruthers advised that WG were supportive of the need to develop a solution that did deliver on the cancer performance target.

Mr Carruthers believed that the therapies performance was a more challenging position that had seen continuous deterioration due to the significant demand and capacity gap that existed within the service. Mr Carruthers advised that there was detailed work on-going within each sub-specialty within the therapies service to develop robust demand and capacity plans with actions to close the gap between the two and had requested WG support by means of recovery monies.

In response to a question from Mrs Marks on the need to clearly state specific actions and timeframes, Mr Carruthers advised that future reporting would include the requested actions and timescales.

Finance: Mr Carruthers advised that he and Mr Thomas had met with the CCG within the last week to discuss their savings and to stress that the focus for the CCG was to ensure that they did not overspend and expressed concern that the CCGs current response to a challenged workforce position was to reduce the level of service provision that Mr Carruthers believed could have a detrimental impact on quality and safety. Mr Carruthers believed that there was further work required to understand the levels of demand and capacity by sub-speciality to ascertain what was required to support inpatient ward areas, community services and the elective pathway.

In response to a question from Cllr Evans on the progress made against the TI de-escalation criteria, Mr Jones advised that there had been a 40% reduction in the number of patients waiting more than eight weeks between 1 January 2025 to the present date as a consequence of the non-recurrent investments made in Q4 2024/25. Mr Jones advised that the overall position of patients waiting less than eight weeks was between 60% and 70% against the target of 85% through the impact of recurrent investment made in Q1 2025/26.

Mental Health and Learning Disabilities CCG

Performance: Mr Carruthers highlighted the attainment of the TI de-escalation criteria for mental health assessments within 28 days for 0 to 17-year-old and 18-year-old and over and therapeutic interventions for 0 to 17-year-olds and 18 years old and over. Mr Carruthers advised that the two areas of performance concern were waits for psychological therapies, where there had been challenges experienced to the establishment of the scaling up of therapy group models however there had been improvement within the past 12 months with further improvement anticipated, and within neurodevelopmental services where the autistic spectrum disorder (ASD) pilot that had previously been presented to Board not delivering the improved performance outcomes anticipated. Mr Carruthers advised that a revised terms of reference for an alternative pilot scheme was due to be presented to the Integrated Quality, Financial Performance and Delivery (IQFPD) Group on 9 July 2025.

Finance: Mr Carruthers believed that there was potential for further savings benefit within mental health services that would convert from savings plans to delivered savings within Q2 2025/26 and believed that the significant challenge was to deliver recurrent savings within a service that consistently underspent whilst addressing service challenges and pressures with a fragile workforce and advised that work had been undertaken with Swansea Bay University Health Board (SBUHB) to refresh HDdUHD's short and medium term plans for mental health and learning disabilities (MHL) services.

Decision: The Finance and Performance Committee **RECEIVED** and **NOTED** the Thematic Review of Finance and Performance Deep Dive.

FPC(25)28 INTERNAL ESCALATION

Mr Thomas presented the Internal Escalation Update to FPC to provide an escalation assessment within both the finance and performance domains within the CCGs and Executive Functions.

In response to a question from Ms Lewis on the reporting mechanism for escalation purposes compared to a wider assessment of performance, Mr Thomas advised that the internal escalation reporting mechanism was deliberately intended to be reductionist as to provide a clear and transparent method of assessment that when broadened out became more subjective and that as a starting point the aim of the internal escalation assessment was to provide a baseline measurement of each component within each domain. Mr Thomas advised that FPC

would focus on the finance and performance domains and believed that there would be merit on presenting the internal escalation report to other Board Committees to scrutinise the domains within each relevant Board Committee's remit.

In response to a question from Mrs Marks on whether the internal escalation report provided a wider comprehensive analysis of each component and referred to the workforce domain within MHL D being within Level 2 of internal escalation despite the service being a fragile service with recruitment challenges, Mr Thomas advised that the level of escalation was based on a mathematic calculations to quantify for escalation purposes as opposed to qualifying the characteristics of the service for its culture of fragility however noted that the fragility of the service was being detected within other domains such as finance and performance where MHL D was at Level 3 of internal escalation.

Decision: The Finance and Performance Committee **NOTED** the Internal Escalation Update Report.

FPC(25)29

MONTH 2 2025/26 FINANCE REPORT

Mr Andrew Spratt presented the Month 2 2025/26 Finance Report and advised that Month 2 had seen a reported overspend of £2.7m against an annual plan target of £2.6m. Mr Spratt believed this to be a positive position at the current stage of the financial year however recognised that there was a significant savings gap that indicated that while the Health Board was in a strong position with core budget performance however there was significant opportunity to take positive decisions and choices to develop a plan to deliver savings.

Mr Spratt believed that there was a need to focus on the proactive conversion of the run-rate and conversion of savings schemes within Q2 2025/26.

Mr Spratt advised that the current end-of-year forecast position was a £57.6m annual deficit that was £26.1m adrift of the Health Board's £31.5m planned deficit and noted the incongruous position of the Health Board delivering its financial plan on a month-by-month basis however predicting to increase expenditure that was not being offset by any savings being committed to, highlighting the urgent need to deliver savings plans to ensure that expenditure does not increase from current levels.

Ms Eiry Edmunds left the meeting

Mr Spratt believed that the Health Board's cost base was in a satisfactory position however advised that should the Health Board wish to increase expenditure greater than currently planned then then a commensurate level of savings would need to be

delivered to maintain the current position. Mr Spratt believed that this was an improved position for the Health Board at this stage of the year compared to previous years when the challenge was to control expenditure.

Mr Spratt advised that for a savings scheme to be categorised as green or amber it had had to be subject to a rigorous internal assessment process where it was considered to be assured that the savings value would be fully delivered. Mr Spratt cautioned that the current quantum of blue and red savings schemes were close to the Health Board's savings target, the Health Board historically struggled to convert those blue and red savings schemes into fully deliverable savings schemes with historically 25% of blue schemes and 50% of red schemes being converted into deliverable schemes.

Mr Spratt advised that due to the over-reliance on non-recurrent savings schemes the Health Board's underlying deficit position was at risk of further deterioration and that work was required to be undertaken this year ahead of the following year planning cycle. Mr Spratt believed that the underlying deficit hangover needed to be resolved ahead of the new planning round to enable the attainment of the WG requirement for the Health Board to achieve a break-even financial position by the end of 2027/28 so that the Health Board continued to receive the conditionally-recurrent additional funding that was predicated on maintaining a trajectory to attain break-even within the required time scale.

Mr Spratt highlighted the letter received from Mrs Judith Paget on 6 June 2025 on the challenge from WG to the Health Board's annual plan and the need for the Health Board to articulate the demonstrable benefits to any local investment choices taken by the Health Board.

Mr Spratt advised that there was concern regarding the Health Board's medical pay costs and advised that the medical stabilisation programme was considered critical to reducing expenditure on short-term medical locum and agency usage that would be a focus for the Health Board with an aim to replicate the success for the nursing stabilisation programme to deliver the ministerial priority to reduce agency usage within all staff groups.

Mr Spratt highlighted to the Committee of the Health Board's cash position that was considered a risk given the Health Board's planned deficit was £31.5m, there would be a requirement for strategic cash and working capital balances to enable payment of all creditors in February and March 2026. Mr Spratt advised that cash requirements would be assessed throughout the current financial year, with any strategic cash request being required to be submitted to WG in November 2025.

Mr Spratt assured the Committee that there was no risk foreseen of underspending within the Capital Resource Limit (CRL) at this

stage of the financial year. Mr Spratt confirmed that all of the 2025/26 budget delegation accountability letters had been signed and returned.

In response to a question from Mrs Marks on whether there was any concern relating to cash, Mr Thomas advised that while current trajectories and run-rate provided assurance that the Health Board would meet its £31.5m TCT, pressures to increase expenditure within areas of the Health Board necessitated an increase in savings to be delivered to offset any increased expenditure. Mr Thomas advised that without delivering on planned savings there would be a risk to cash in Month 12 2025/26.

Mr Thomas believed that it was a challenge for the Health Board to undertake any investment while having a deficit starting position as the view of WG was that the Health Board was undertaking investment with money that it did not have.

Mr Thomas believed that previously the production of a medium-term financial road map had been challenging however the recent UK Government Comprehensive Spending Review had provided an indication of a level of additional expenditure on health of 3% above inflation although the consequence of the additional funding into WG and onto the Health Board was uncertain at present. Mr Thomas believed that whatever the future financial allocation uplift would be, the Health Board was in practice already spending any future financial uplift in the current financial year with the first choice for any additional financial uplift to be considered should be to improve the Health Board's bottom line given that the nature of the £26m recurrent funding being conditional on achieving a break-even position by the end of 2027/28.

Decision: The Finance and Performance Committee:

- **NOTED** that the Health Board's Deficit plan is £31.5m, with a savings target of £44.4m, and the aspiration is to improve beyond this in the coming months, in-line with WG expectations.
- **SCRUTINISED** the progress of savings actions to bridge the recurrent and non-recurrent savings gap from those Executive portfolios that have yet to identify their full target.
- **RECEIVED ASSURANCE** that there are sufficiently robust plans in place to eliminate the use of all off-contract agency immediately, and reliance on Healthcare Support Worker on-contract agency by the deadlines set in the Ministerial Priorities.
- **DISCUSSED** the 6 June 2025 feedback received from Welsh Government, stating the Health Boards Annual Plan is unsupportable and unacceptable, and by 30 June 2025 to submit detailed actions to deliver a forecast position in 2025/26 that maintains the outturn position of 2024/25 which is a deficit of £24.1m.

- **SCRUTINISED** the benefits being proposed or delivered by the planned and unplanned investments.
- **RECEIVED ASSURANCE** that the net core budget performance remains in-line with the annual plan, except for Medical and Dental pay expenditure which is highlighted as an Alert.
- **ACKNOWLEDGED** the risk of conditionally recurrent funding being withdrawn linked to Welsh Governments feedback on the Annual Plan.
- **ACKNOWLEDGED** that an underlying deficit assessment has been undertaken and that will only be reduced by robust recurrent savings delivery improvements.
- **ACKNOWLEDGED** that all Budget Delegation Accountable Officer letters have now been signed.

FPC(25)30

SAVINGS AND INVESTMENT REPORT

Mr Richard Jenkins presented the Savings and Investment Summary Report to the Committee and advised that the Health Board currently had a savings plan for 2025/26 to deliver £44m of savings of which £28m was currently identified savings, leaving a £16.5m savings gap.

Mr Jenkins advised that of the £28m of identified savings, £14.8m were classified as green and amber schemes and £13.2m classed as blue and red which posed a risk to the end-of-year forecast position with the blue and red savings schemes needing to be converted to green and amber to provide assurance of the deliverability of the savings plan.

Mr Jenkins advised that £8.8m of the £28m identified savings was non-recurrent and believed that the Health Board needed to maximise its level of recurrent savings to aid the 2026/27 financial position and the trajectory towards break even.

Mr Jenkins advised that £19m of the £28m identified savings was cash-releasing with work required to be undertaken to maximise the support for the Health Board's cash position for the remainder of the 2025/26 financial year.

Ms Eiry Edmunds joined the meeting

In response to an observation from Mrs Marks that it was nearly the end of Q1 2025/26 and that for every month that passes, the burden of in-month savings requires accumulates over the remainder of the year, Mr Thomas believed that by the time FPC met in August 2025 there needed to be step change in conversion and delivery of savings. In response to observations by Mr Imperato and Cllr Evans, it was agreed that future Savings and Investment reports would contain clear timescales for the expected delivery of actions such as the conversion of savings.

HT

Mr Jenkins advised that the total value of investments contained within the annual plan was £11.85m of which £5.76 was currently approved with the recurrent cost of the investments being £6.5m with £6m of the total investments currently unapproved. Mr Thomas advised that the Committee could be assured that all investment proposals while having been approved in principle by the Board were subject to a robust scrutiny process before the funding was released to the organisation

Decision: The Finance and Performance Committee:

- **NOTED** that there is regular assessment of the savings position to facilitate active discussion and assess progress.
- **RECEIVED ASSURANCE** from the Executive Delegated Officer portfolios and Clinical Care Groups which remain adrift from delivery of the required savings target for 2025/26 that they have sufficient actions in place to identify and delivery adequate saving plans to achieve the target.
- **ACKNOWLEDGED** that investment cases for 2025/26 are being progressed through a review and scrutiny process to inform a final approval decision at Formal Executive Team. Also, that this process has incorporated the consideration of essential proposals to enable key quality and safety priorities for the Health Board in respect of fire enforcement notices and review of nursing workforce in particular areas.

FPC(25)31

PLANNING OBJECTIVES UPDATE REPORT Q1 2025/26

Mr Thomas presented the Planning Objectives (PO) Update Report for Q1 2025/26 to the Committee and advised that PO2 ('Financial Recovery and Roadmap') was on track and highlighted the Comprehensive Spending Review discussion earlier in the meeting and advised that an assessment of the actions that could be un strategic assessment of the Health Board's medium-term financial recovery. Mr Thomas advised that this would be discussed by Executive Team in July 2025 and presented to Board on 27 November 2025. Mr Thomas advised that it would be presented to FPC ahead of consideration at Board.

HT

Mr Thomas advised that an update on PO3 ('Urgent and Emergency Care'), PO4 ('Planned Care including cancer and diagnostics') and PO5 ('Mental Health and Learning Disabilities') had been fully covered by the thematic review.

Decision: The Finance and Performance Committee **RECEIVED ASSURANCE** on the current position in regard to the progress of the Planning Objectives aligned to the Finance and Performance Committee, in order to assure the Board that the Planning Objectives are progressing and are on target.

Mr Thomas presented the Procurement Report to the Committee and advised that there was one item that required the approval of the Committee for onward submission to the Board for the All Wales Fresh Non-Prepared and Prepared Fruit, Vegetables and Salad and noted the recommendation for the award of two lots to Dole Food Services and WR Bishop.

Mr Thomas advised that an assessment of the opportunity to maximise social and local value of the Health Board's procurement and advised that while Dole Food Services was not a local supplier they did utilise local suppliers within their supply chain.

In response to a question from Cllr Evans on the inclusion of provision of food to Tregaron Community Hospital, Mr Thomas advised that the contract was based on usage as opposed to the procurement of a block sum of provision.

Decision: The Finance and Performance Committee scrutinised and recommend for Board to:

- **APPROVE** the award of Fresh Non-Prepared and Prepared Fruit, Vegetables and Salad to the above providers for the period 1 January 2026 to 31 December 2028, with an option to extend for a further twelve (12) months. This contract will have onwards submission to Board and Velindre NHS Trust (as hosts of NHS Wales Shared Services Partnership).

Mr Thomas presented the Welsh Health Circulars (WHCs) to provide an update on progress in relation to the implementation of WHCs which come under the remit of SRC.

There were no questions from members of the Committee.

Decision: The Finance and Performance Committee:

- **NOTED** the re-alignment of Welsh Health Circulars reportable to the Finance and Performance Committee in line with revised governance arrangements as approved by Board at its meeting in January 2025.
- **RECEIVED ASSURANCE**, or otherwise, from the lead Executive Director or Supporting Officer on the management of Welsh Health Circulars within their area of responsibility, particularly in respect of understanding when the Welsh Health Circular will be delivered, any barriers to delivery, impacts of non/late delivery and assurance that

the risks associated with these are being managed effectively.

FPC(25)34

MINISTERIAL DIRECTIONS

Mr Thomas presented the Ministerial Directions (MD) to provide the Committee with a status update and assurance that all NHS Non-Statutory Instruments (NSIs), otherwise known as MDs received from WG have been implemented and adopted by HDdUHB.

There were no questions from members of the Committee.

Decision: The Finance and Performance Committee **RECEIVED ASSURANCE** that Hywel Dda University Health Board is compliant with the Non-Statutory Instruments (Ministerial Directions) issued by WG between 1 February 2025 and 12 June 2025.

FPC(25)35

ALL-WALES CAPITAL PROGRAMME 2025/26, CAPITAL RESOURCE LIMIT AND CAPITAL FINANCIAL MANAGEMENT UPDATE

Mr Thomas presented the All-Wales Capital Programme, the 2025/26 CRL and Capital Financial Management Update to the Committee and advised that there was reasonable assurance over the Health Board's CRL position.

There were no questions from members of the Committee.

Decision: The Finance and Performance Committee:

- **NOTED** the 2025/26 Capital Resource Limit (CRL)
- **NOTED** the project updates

FPC(25)36

INTEGRATED PERFORMANCE ASSURANCE REPORT

Mr Thomas presented the Integrated Performance Assurance Report (IPAR) to the Committee and advised that there had been a reassessment of how the assurance was provided in relation to performance to provide a triangulated assessment of performance to provide assurance.

Mr Thomas highlighted the areas of the IPAR that had not been discussed previously in the meeting and advised that the number of C. difficile confirmed cases per month was alerted to the attention of the Committee. Ms Lewis advised that monitoring of

C. difficile was overseen by the Quality, Safety and Experience Committee (QSEC). Mr Thomas highlighted the alert to the Committee relating to the sickness absence rate of staff.

In response to an observation from Ms Lewis on the role of the IPAR to provide assurance that there was a rigorous process in place to collect, analyse and use service data that was reported clearly, Mr Thomas believed that the IPAR provided management oversight control of performance

Decision: The Finance and Performance Committee:

- **DISCUSSED** the IPAR – Month 2 2025/2026 Report
- **RECEIVED ASSURANCE** on the operational delivery of mitigating actions to improve performance in the areas that have been categorised as 'alert'.

FPC(25)37

NWSSP PERFORMANCE REPORT QUARTER 4 2024/25

Mr Thomas presented the NHS Wales Shared Services Partnership (NWSSP) Performance Q4 2024/25 Report to the Committee providing a summary of the services NWSSP provides for the Health Board.

In response to a question from Mr Imperato on the funding of NWSSP, Mr Thomas advised that NWSSP was funded directly by WG and the only costs incurred by the Health Board were for any additional work that the Health Board requested NWSSP undertake on behalf of the Health Board.

Decision: The Finance and Performance Committee:

- **RECEIVED ASSURANCE** from the content of the NWSSP Performance Report for Quarter 4 2024/25 that services provided are being delivered to expected standards; and
- **NOTED** the work being developed regarding outcome measures reporting.

FPC(25)38

DISCHARGE TO ASSESS

Ms Julia McCarthy joined the meeting

Miss Jill Paterson presented the Discharge to Assess (D2A) Review to the Committee and advised that the report was being presented to the Committee following a request made by the previous Strategic Development and Operational Delivery Committee (SDODC) to further understand the financial impact of D2A to the Health Board.

Miss Paterson advised that the D2A process had been developed by a number of Health Boards in Wales during the COVID-19 pandemic as a means of rapidly discharging patients from a hospital setting, however at present HDdUHB was the only Health Board in Wales still utilising the pathway.

Miss Paterson advised that the pathway was for individuals with a perceived complex health need that would result in a need for continuing healthcare (CHC) whereby the individual would be moved from a hospital setting to a care home setting for the assessment to be undertaken within two weeks with the responsible party providing the funding should the individual be assessed as not meeting the criteria for CHC.

Miss Paterson advised that the review had identified that there were significant delays by local authorities to take responsibility for individuals who were assessed as being ineligible for CHC following assessment with 30% of individuals transferred to care home beds being eligible for CHC funding resulting in additional costs for the Health Board. Miss Paterson highlighted that in Pembrokeshire there were 14 patients costing the Health Board £168k that the Health Board were continuing to fund.

Miss Paterson advised that a report had been presented to operational groups and the Integrated Executive Group (IEG) with local authority partners to determine whether to revert to the arrangements that were in place prior to the COVID-19 pandemic, and it was agreed to undertake a pilot scheme that commenced in August 2024 to undertake the CHC assessments within the hospital setting prior to any discharge. Miss Paterson advised that there had been no agreement from local authorities with a report to be presented to IEG to attempt to receive a commitment from local authority partners for agreement on a future pathway.

In response to a question from Mrs Marks on what the recommended actions were, Miss Paterson advised that there were no recommendations attached to the report as the Committee was not being asked to make a decision and the purpose of the report was to explore the financial implications ahead of consideration by IEG. Ms McCarthy believed that it was in the best interests of the patient to be assessed within the community setting as a better indication of the healthcare needs of the individual was better assessed in a less acute environment. Ms McCarthy believed that it was disproportionate for the Health Board to fully-fund all the individuals.

Ms McCarthy advised that SBUHB and Powys Health Teaching Board (PHTB) undertook a proportionate assessment of individuals that had been agreed with the relevant local authorities that where there was an assessment of nursing need then that need would be commissioned by the Health Board.

HT/JW

Mr Thomas believed that as the pilot was undertaken in August 2024 there was a need for Executive Team to undertake a consideration of the learning from the process and to make a decision that would support a resolution at IEG.

Ms Julia McCarthy left the meeting

Decision: The Finance and Performance Committee **NOTED** the review of the Discharge to Assess pilot.

FPC(25)39

OPHTHALMOLOGY PERFORMANCE: GETTING IT RIGHT FIRST TIME UPDATE

Mr Carruthers presented the Ophthalmology Performance Getting It Right First Time (GIRFT) Update to the Committee on the progress of the GIRFT Ophthalmology review recommendations as previously there were a significant number of actions that were still open with lengthy review dates attached to the actions.

Mr Carruthers advised that work had been undertaken with Mr Mark Henwood and Mrs Wilson to review all the open recommendations that resulted in a number of actions having been closed with only 9 of the 59 recommended actions remaining open. Mrs Wilson advised that a rigorous review process had been undertaken with clinical involvement.

Decision: The Finance and Performance Committee:

- **RECEIVED ASSURANCE** from the recommendations closed to date;
- **RECEIVED ASSURANCE** on the recommendations being reviewed and progressed currently; and
- **RECEIVED ASSURANCE** on the future plans to address the outstanding recommendations.

FPC(25)40

POLICY AND PROCEDURES

Mr Thomas presented the review of Financial Procedures and advised that there was one financial procedure, FP1032 - Treatment of Private Patients - Control of Admission and Collection of Income, that was due for review in June 2025.

Mr Thomas advised that due to the ongoing organisational change process (OCP) within the Health Board Operations, which impacted on the process and procedure, approval was sought to defer the review the review and present an updated procedure to the Committee for approval at the October 2025 FPC meeting.

There were no questions from members of the Committee.

Decision: The Finance and Performance Committee **APPROVED** an extension to the review date of the following procedure:

- FP 1032 - Treatment of Private Patients - Control of Admission and Collection of Income

FPC(25)41

JCC PLANNING, PERFORMANCE AND FINANCE SUB-COMMITTEE REPORTS

Mr Thomas presented the Joint Commissioning Committee (JCC) Planning, Performance and Finance Sub-Committee highlight report from its meeting on 20 May 2025 for information.

There were no questions from members of the Committee.

Decision: The Finance and Performance Committee **NOTED** the highlight report from the Joint Commissioning Committee Planning, Performance and Finance Sub-Committee meeting on 20 May 2025.

FPC(25)42

AUDIT WALES COST SAVINGS ARRANGEMENTS

Mr Thomas presented the Audit Wales Cost Savings Arrangements checklist to the Committee for information.

There were no questions from members of the Committee.

Decision: The Finance and Performance Committee **NOTED** the Audit Wales Cost Savings Arrangements Checklist.

FPC(25)43

FINANCE AND PERFORMANCE COMMITTEE WORK PLAN 2025/26

Mr Imperato presented the FPC Annual Work Plan for 2025/26 to the Committee for review.

There were no questions from members of the Committee.

Decision: The Finance and Performance Committee **NOTED** the Committee Work Plan 2025/26.

FPC(25)44

ANY OTHER BUSINESS

There was no other business transacted at the meeting.

FPC(25)45

DATE OF NEXT MEETING

The next meeting of FPC will be held on Tuesday 26 August 2025.

UNAPPROVED

1.4

9:35 AM, 0 Mins

1.4 - TABLE OF ACTIONS FROM FINANCE
AND PERFORMANCE COMMITTEE HELD
ON 26 JUNE 2025

*Michael Imperato
(Hywel Dda UHB -
Independent Board
Member)*

| For approval

Attachments

FPC Table of Actions 26 June 2025.pdf



FINANCE AND PERFORMANCE COMMITTEE / PWYLLGOR CYLLID A PHERFFORMIAD

26 JUNE 2025

TABLE OF ACTIONS / TABL GWEITHREDOEDD

Minute No.	Meeting Date	Subject	Action	Lead	Timescale	Progress/Date Achieved
FPC(25)24	26 June 2025	Corporate Risk Register	To discuss with PK and JW the correct governance route to oversee proposed changes to annual plan contained within response to WG letter of 6 June 2025.	HT	26 August 2025	Complete. Changes to the Annual Plan will be presented to Board on 31 July 2025 ahead of an assessment of the revised financial projection submitted to WG in August 2025.
FPC(25)27	26 June 2025	Thematic Review of Finance and Performance	To include specific actions and timescales within future reporting of the thematic review of finance and performance.	AC	26 August 2025	Complete. Specific actions and timescales to be included within revised Escalation Response – Recovery Action Plans and Improvement Trajectories” section from 27 August 2025 FPC meeting onwards.
FPC(25)30	26 June 2025	Savings and Investment Report	To include timescales for expected delivery of savings actions within future reports.	HT	27 August 2025	Complete. Timescales to be included in Savings and Investment Report from 27 August 2025 FPC meeting onwards.
FPC(25)31	26 June 2025	Planning Objectives Update Report Q1 2025/26	To present a report on the medium-term financial recovery assessment ahead of submission to Board on 27 November 2025.	HT	27 November 2025	Complete. Added to Finance and Performance Committee Work Plan for 21 October 2025

Minute No.	Meeting Date	Subject	Action	Lead	Timescale	Progress/Date Achieved
FPC(25)38	26 June 2025	Discharge to Assess	To undertake an Executive discussion on the Discharge to Assess pilot to determine a position to take to IEG.	HT/JW	26 August 2025	Complete. Scheduled within the Value and Sustainability Group work plan and addressed through the 2026/27 Planning Framework.

1.5

9:35 AM, 5 Mins

1.5 - SELF-ASSESSMENT OF COMMITTEE EFFECTIVENESS: SIX-MONTH REVIEW

*Michael Imperato
(Hywel Dda UHB -
Independent Board
Member)*

| For assurance

Attachments

FPC Self-Assessment 6 Month Review FPC 26 August 2025.pdf



PWYLLGOR CYLLID A PHERFFORMIAD
FINANCE AND PERFORMANCE COMMITTEE

DYDDIAD Y CYFARFOD: DATE OF MEETING:	26 August 2025
TEITL YR ADRODDIAD: TITLE OF REPORT:	Committee Self-Assessment Outcome Report 2024/25 – Progress Update
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Huw Thomas, Director of Finance
SWYDDOG ADRODD: REPORTING OFFICER:	Joanne Wilson, Director of Corporate Governance/Board Secretary Charlotte Wilmshurst, Assistant Director of Assurance and Risk

Pwrpas yr Adroddiad (dewiswch fel yn addas)

Purpose of the Report (select as appropriate)

Er Sicrwydd/For Assurance

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The purpose of this report is to provide an update to the Finance and Performance Committee (FPC) on the actions agreed by the Sustainable Resources Committee (SRC) in response to the outcomes from the SRC Self-Assessment 2024/25 process.

Cefndir / Background

At its meeting on 25 February 2025, SRC received a [report](#) which presented the outcomes of the SRC Self-Assessment 2024/25 process. For SRC, this involved:

- Short digital form which requested feedback on the following areas:
 - Governance and administration
 - Committee's inputs
 - Conduct of Committee meetings
 - Interface with other Committees, including the Board
 - Committee's impact
 - Individual role on Committee

The feedback from this form was considered alongside other information, such as:

- Matters alerted to the Board
- Independent Member (IM) reflective sessions
- Auditor and regulator feedback

Feedback from the 2023/24 Committee Effectiveness assessments highlighted the need for clearer Committee purposes, understood across the organisation. In response, the Health Board undertook a review of its governance arrangements to better align Committees with the six domains of targeted intervention and strengthen focus on digital, finance, performance, and strategic planning.

Following this, the Board agreed on 30 January 2025 to dis-establish SRC and establish a new Finance and Performance Committee (FPC) from 1 April 2025, to strengthen the Health Board's focus on 'finance' and 'operational delivery'.

Asesiad / Assessment

The following actions were agreed in response to the outcomes of the SRC Self-Assessment 2024/25, which are now being taken forward by FPC:

Action	By whom	By when	Progress
To provide report writing and presenting guidance to operational teams as part of the implementation of the Operational Governance Structure (This will include reducing the level of operational detail in reports, the importance of including outcome data in reports and how to present papers to Committees).	Director of Corporate Governance	Complete	Corporate Governance training, which includes report writing, with Clinical Care Groups is currently underway. Three out of the five CCGs (MHLD, Estates and Facilities, Community and Integrated Medicine) have already received training. This will also form part of the new managers training (band 3-7) which is scheduled to start in early 2026.
Consider including suggested areas of focus for 2025/26 on Committee Workplan.	Director of Corporate Governance/ Committee Services Officer	Complete	Discussed at agenda setting meetings.
Strengthen the Board's focus on strategic digital issues through the creation of a new Digital, Data and Innovation Committee.	Director of Corporate Governance	Complete	The Digital, Data and Innovation Committee has been established as of 1 April 2025.

These actions have been reviewed in light of the changes to the new Committee Structure.

Argymhelliad / Recommendation

The Finance and Performance Committee is asked to **RECEIVE ASSURANCE** from the progress made against the actions being undertaken to improve its effectiveness.

Amcanion: (rhaid cwblhau)

Objectives: (must be completed)

Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	10.5 The Director of Corporate Governance/Board Secretary, on behalf of the Board, shall oversee a process of regular and rigorous self-assessment and evaluation of the Committee's performance and operation including that of any Sub-Committees established. In doing so, account will be taken of the requirements set out in the NHS Effective Board Committees Guide.
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)	Not Applicable
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	Not Applicable
Amcanion Strategol y BIP: UHB Strategic Objectives:	Not Applicable
Amcanion Cynllunio Planning Objectives	Not Applicable
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022	10. Not Applicable

Gwybodaeth Ychwanegol:

Further Information:

Ar sail tystiolaeth: Evidence Base:	FPC Terms of Reference SRC/FPC Self-Assessment digital form results Auditor and Regulator feedback through Structured Assessment and Internal Audit reports
Rhestr Termiau:	Included within the report

Glossary of Terms:	
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Cyllid a Pherfformiad Parties / Committees consulted prior to Finance and Performance Committee:	Director of Corporate Governance/Board Secretary

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	No Direct Impact
Ansawdd / Gofal Claf: Quality / Patient Care:	An effective FPC should seek out areas of system weakness and facilitate an organisational culture that drives financial improvement, strong financial governance and improved performance.
Gweithlu: Workforce:	No Direct Impact
Risg: Risk:	An effective FPC should drive improvement through scrutiny and challenge on the effective and efficient management of risks relating to financial performance and delivery.
Cyfreithiol: Legal:	No Direct Impact
Enw Da: Reputational:	No Direct Impact
Gyfrinachedd: Privacy:	No Direct Impact
Cydraddoldeb: Equality:	No Direct Impact

1.6 - ASSURANCE ON GOVERNANCE ARRANGEMENTS

Andrew Spratt
(Hywel Dda UHB -
Deputy Director of
Finance)

| For assurance

Attachments

[Assurance on Governance Arrangements Report FPC 26 August 2025.pdf](#)

[Appendix 1 FPC Principal Risk Register.pdf](#)

[Appendix 2 FPC Corporate Risk Register.pdf](#)

[Appendix 3 FPC Operational Risk Register.pdf](#)

[Appendix 4 FPC Audit and Inspections.pdf](#)



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Assurance and Risk Report

Finance and Performance Committee, 26 August 2025

Situation



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This report provides the Finance and Performance Committee (FPC) with the current status of the risks, audits and inspections recommendations, Welsh Health Circulars (WHCs) and Ministerial Directions (MDs) within its remit. The Committee is asked to seek assurance from the Lead Executive Directors that risks are being managed effectively, and that recommendations from audit and inspections, WHCs and MDs are being implemented by the Hywel Dda University Health Board (HDdUHB).

Principal Risks:

1

Corporate Risks:

3

Operational Risks

15

Audit and Inspection
Reports

14

Welsh Health Circulars

1

Ministerial Directions

2

Risk Management - Overview



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Effective risk management requires a ‘monitoring and review’ structure to be in place to ensure that risks are effectively identified and assessed, and that appropriate controls and responses are in place.

The Health Board’s risk management process is recorded via the Datix Risk Register module, and enables risks to be recorded at either Principal, Corporate or Operational level. An escalation process is in place to ensure that risks which require escalation or de-escalation are done via appropriate approval processes and governance arrangements.

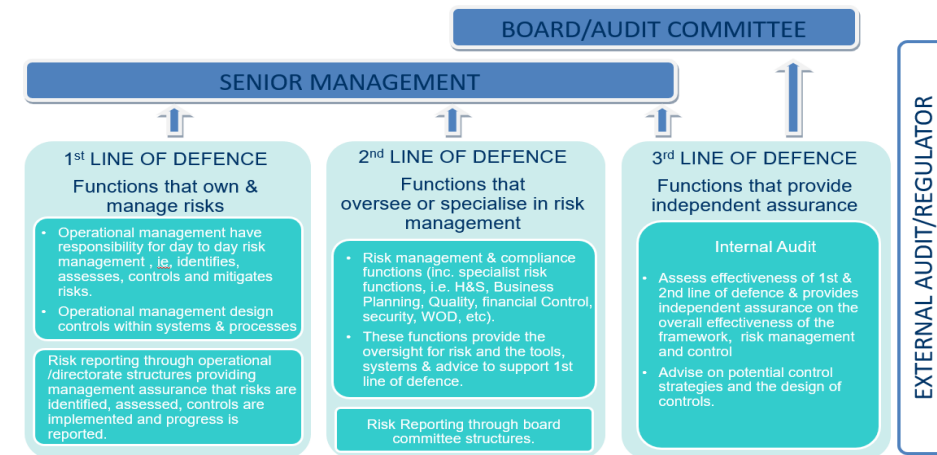
The Health Board operates within the widely accepted “Three Lines of Defence” model to ensure the appropriate responsibility is allocated for the management, reporting and escalation of risk.

Risks are aligned to an appropriate Clinical Care Group or Executive Function (hereto referred to as “Functions”), and each has a designated risk lead responsible for reviewing in a timely and comprehensive manner.

The Board’s Committees are responsible for the monitoring and scrutiny of corporate and operational risks within their remit and providing assurance to the Board that risks are being managed effectively and report areas of significant concern (for example, where the risk appetite is exceeded, or there is a lack of action).

Committees are also responsible for reviewing risks over tolerance and where appropriate, recommend the ‘acceptance’ of risks that cannot be brought within risk appetite.

A revised approach to risk tolerance was agreed by the Board at its meeting in March 2025 to reflect the organisation’s readiness to bear the risk after risk treatment, in order to achieve its objectives. Risk leads are required to provide a rationale for the target risk score (TRS), and an expected date when the target risk score (TRS) will be achieved. These are mandatory fields on Datix as of 1 July 2025, and therefore where risks do not currently have this detail, risk leads will be asked to provide by the next report to FPC.



Principal Risks Assigned to FPC



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Each risk on the Principal Risk Register (PRR) has been mapped to a Board level Committee to ensure that risks on the PRR are being managed appropriately, taking into account gaps in controls, planned actions and agreed tolerances, and to provide assurance to the Board through their update report on the management of these risks.

Following the implementation of new Board Committee structure on 1 April 2025, principal risks have been re-aligned to the most appropriate Board level Committee.

These risks have been identified by the Executive Team via a top down and bottom-up approach and are associated with the delivery of the Health Board's strategic (long-term) objectives.

There is 1 principal risk currently aligned to FPC (out of the 15 that are currently on the PRR).

The following slide provides a summary of the reportable principal risk aligned to FPC.

The risk register attached at **Appendix 1**, provides full detail of the risk, including control measures in place, a risk action plan to further manage and mitigate the risk, and sources of assurance.

Principal Risks assigned to FPC



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Risk Reference & Title	Lead Director	Current Risk Score	Target Risk Score (TRS)	Expected Date to Achieve TRS
1199 - Achieving financial sustainability	Director of Finance	25 → (Reviewed 30/05/25)	8	TBC

Rationale for Current Risk Score

The significant underlying financial deficit in the current and future years is likely to result in the Health Board being unable to meet its cash obligations as they fall due and presents a going concern risk. Early indications from Welsh Government (WG) is that the WG are unable to support both the revenue and cash implications. With the Health Board reporting a significant in-year and recurrent underlying deficit, WG initially escalated the Health Board into Targeted Intervention during October 2022, on the grounds of planning and financial performance, and in January 2024, the whole organisation was escalated into targeted intervention. The recurrent funding position confirmed by WG leaves a significant gap based upon draft iterations of the financial plan, with strategic and operational changes required in an attempt to erode the financial deficit. The Health Board's underlying deficit is now well understood and articulated, with clear decisions tracked that have been made by budget holders that exceed their delegated limits. There is a need to not only shift resources to more appropriate settings but provide care at considerably lower cost. Significant workforce constraints remain; and the planning function remains small with significant opportunities to develop.

Rationale for Target Risk Score (TRS)

Achieving financial balance on a three-year rolling basis is a statutory requirement for the Board, and a clear requirement from the Board and WG. Strategic and operational planning in an integrated Health Board is inherently complex leading to potential disconnections between demand, operational capacity planning; workforce planning and financial planning. Given the challenge in delivering the savings required over a number of years, and the implications of this in the medium term, it is unlikely that the Health Board will achieve a risk which is in line with the tolerable risk for the year. Consequently, the target risk score exceeds the tolerable risk at this point. This is not an acceptable position, and further work is ongoing to manage this risk.

Corporate Risks Assigned to FPC



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Hywel Dda Risk Heat Map					
	LIKELIHOOD →				
Impact ↓	Rare 1	Unlikely 2	Possible 3	Likely 4	Almost Certain 5
Catastrophic 5				2086 (New)	
Major 4			2104 (New)	1350 →	
Moderate 3					
Minor 2					
Negligible 1					

Each risk on the Corporate Risk Register (CRR) has been mapped to a Board level Committee to ensure that risks on the CRR are being managed appropriately, taking into account gaps in controls, planned actions and agreed tolerances, and to provide assurance to the Board through their update report on the management of these risks.

Following the implementation of new Board Committee structure on 1 April 2025, corporate risks have been re-aligned to the most appropriate Board level Committee, with this report being the first report of corporate risks assigned to FPC.

These risks have been identified by individual Directors via a top down and bottom-up approach and are either:

- Associated with the delivery of the Health Board objectives; or
- Significant escalated operational risks that are of significant concern and require corporate oversight and management.

There are 3 risks currently aligned to FPC (out of the 20 that are currently on the CRR).

The following slide provides a summary of the reportable corporate risks aligned to FPC. The Risk Register attached at **Appendix 2**, provides full detail of the risk, including control measures in place, a risk action plan to further manage and mitigate the risk, and sources of assurance.

Corporate Risks assigned to FPC – New Risk



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Risk Reference & Title	Lead Director	Current Risk Score	Target Risk Score (TRS)	Expected Date to Achieve TRS
2104 - Risk to delivery of Ministerial Priorities relating to planned care recovery ambitions 25/26 due to demand exceeding capacity	Chief Operating Officer	12 NEW (Reviewed 25/07/2025)	9	30/09/25

Rationale for Current Risk Score

The combined impact of cohort demand in key specialties and workforce limitations risk full achievement of ministerial planned care recovery targets by March 2026. Theatre cancellations due to Glangwili Hospital (GGH) staff shortages have negatively impacted core capacity, and additional demand in longer waiting patients (cohort) verses recurrent demand in Orthopaedics. Recovery funding for 2025/26 has been prioritised for areas where high level Demand & Capacity (D&C) modelling identified capacity gaps. The Annual Plan for 2025/26 highlighted delivery risks in Ear, Nose and Throat, Rheumatology, Ophthalmology, Dermatology, Gynaecology, Urology and Cardiology, with WG recovery allocation (£2.8m) split accordingly to progress delivery solutions in these areas. Additional risks to delivery have arisen during Q1 2025/26 in General and Geriatric medicine. Whilst 2025/26 delivery plans reflect positive progress in increasing outpatient activity and treatment capacity, the Annual Plan signalled expected delivery gaps in the above specialties. Health Board performance of planned care delivery milestones is a feature of its Targeted Intervention escalation status. Opportunities have been explored to maximise capacity with Swansea Bay University Health Board in Ophthalmology and Orthopaedics. Both specialties have been prioritised for active exploration of regional solutions including utilising Neath Port Talbot theatres for Orthopaedic activity. Breach volumes in respect of the Stage 1 52 weeks are expected to be resolved by March 2026. Forecast breach volumes in respect of the Total Pathway 104-week target remain in Orthopaedics in Quarter 1 although monthly breach performance shows continued improvement.

Rationale for Target Risk Score (TRS)

The TRS of 9 reflects the continuing delivery ambitions which remain, despite workforce and resource limitations reflected in the Annual Plan. Positive progress achieved in respect of effective demand management and transformation of outpatient pathways has ensured that overall waiting list demand has not grown with waiting list volumes at their lowest level for 2 years. This offers positive indications for future improvements in waiting times in 2025/26 onwards. The care group propose to be in balance by Quarter 2. Opportunities to make further progress towards the Ministerial targets in 2025/26 will continue to be explored, including exploration of the regional opportunities referred to.

Corporate Risks assigned to FPC

Risk Reference & Title	Lead Director	Current Risk Score	Target Risk Score (TRS)	Expected Date to Achieve TRS
2086 - Risk that the cash consequences of the Health Board deficit cannot be covered by WG should it exceed our Target Control Total	Director of Finance	20 → (Reviewed 06/08/25)	12	31/12/25

Rationale for Current Risk Score

The Board endorsed and approved the submission of the annual plan to WG in March 2025, noting that the financial plan doesn't deliver against our statutory requirement to break-even. It recognised that the forecast financial outturn remained in-line with the target control total (TCT) set by WG of £31.5m, but a worsening position compared to the 2024/25 financial outturn. This followed a period of scrutiny through the Sustainable Resources Committee, Board Seminar and Public Board meetings in Q4 2024/25. Correspondence received from WG during Q1 of 2025/26 confirmed that our plan is not supportable, with a revised and clear requirement to achieve a TCT of £24m. The focus is therefore:

1. To improve the assurance over recurrent and non-recurrent savings delivery to achieve the original plan of £31.5m, and the now revised annual plan of £30.0m;
2. To take choices to reduce the position further to £24m. This requires actions to be taken over August and September for a Board Seminar in September 2025 and submit our actions for improvement to WG by 11 September.

As at Month 4 2025/26, savings identification was at £26.9m, with some operational cost pressures arising from medical staffing, the management of Long-Term Arrangements (LTAs) and clinical services and supplies within planned care and hospital sites.

Rationale for Target Risk Score (TRS)

The Health Board had a historic challenge of controlling its cost base and delivering change. While significant improvements have been made to our control environment, significant challenges remain in our change management capabilities. These need to be addressed to achieve the target risk score.

By 11 September 2025, the Executive Team are seeking to de-risk the financial plan to ensure its successful delivery. It is at this date we would envisage the current risk score being reduced to 16 if the savings gap has been materially closed with robust and deliverable schemes.

By 31 October 2025, the Executive Team are seeking to have fully de-risked the financial plan to ensure its successful delivery, in order to allow the organisation to focus on planning for delivery of the medium-term financial roadmap into 2026/27.

Corporate Risks assigned to FPC

Risk Reference & Title	Lead Director	Current Risk Score	Target Risk Score (TRS)	Expected Date to Achieve TRS
1350 - Risk of not meeting the 80% Single Cancer Pathway (SCP) waiting times target for March 2026 due to diagnostics capacity and delays at tertiary Centre	Chief Operating Officer	16 → (Reviewed 25/07/25)	12	31/03/26

Rationale for Current Risk Score
The service has been de-escalated by WG from Level 4 to Level 3 in terms of Targeted Intervention status as there has been the consistent achievement of the 60% de-escalation criteria since February 2025. As at June month end, the service achieved 61.4%. Due to recovery actions within radiology and urology we may see variation in performance as we recover and treat those patients over 62 days, therefore the risk remains that cancer performance will not achieve 80% compliance by March 2026.
Rationale for Target Risk Score (TRS)
The aim is to treat patients within target waiting times, which has now been confirmed as 80% non-adjusted March 2026. The tolerance level will be met if plans to increase diagnostic capacity, utilising allocated recovery funding are realised. When the target of 60% for 3 consecutive months is achieved the risk score can be reduced to a 12. The risk score can be further reduced to an 8 once the target of 80% is achieved. There are underpinning trajectories in place which are monitored monthly and adherence to those will influence the ability to achieve the target risk score.

Operational Risks assigned to FPC



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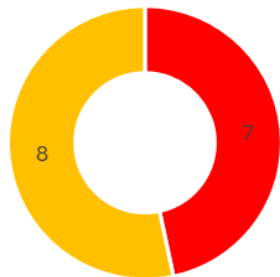
16 operational risks on Datix are aligned to FPC, all of which are within review date.

Of these, 15 have been identified as reportable to FPC based on the following criteria:

- FPC has been selected by the risk lead as the 'Assuring Committee' on Datix;
- Risks have been identified at operational level (previously Service and Directorate level) on Datix risk module;
- The current risk score is 'extreme' or 'high'; and
- The current risk score is either equal to or exceeds the target risk score.

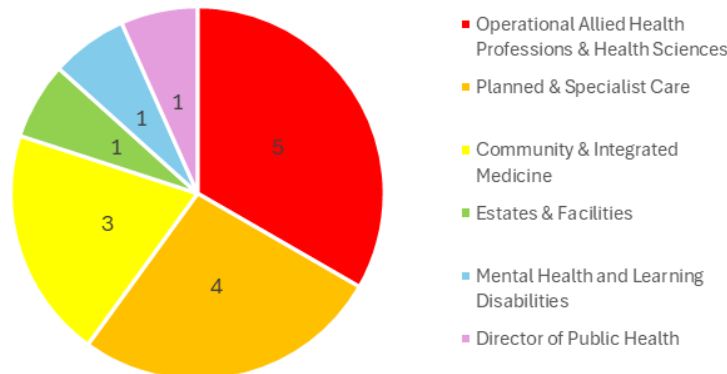
The following slides summarise the operational risks aligned to FPC. The Risk Register attached at **Appendix 3**, provides full detail of each risk, including control measures in place and the risk action plan to further manage and mitigate the risk.

Current Level of Risks assigned to FPC

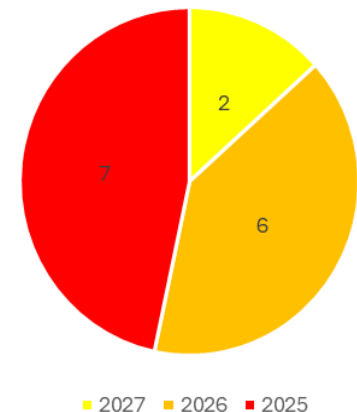


- EXTREME (RED) Risks (based on 'Current Risk Score')
- HIGH (AMBER) Risks (based on 'Current Risk Score')

Risks split out by Clinical Care Group/Executive Function



Risks by Target Risk Score Expected Date (Year)



Operational Risks Reportable to FPC



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Risk Reference & Title	Overseeing Clinical Care Group / Executive Function	Lead Director	Current Risk Score*	Target Risk Score	Expected Date to Achieve Target Risk Score	Date of last risk review
2110 - Risk of not achieving savings targets for 2025/26 due to significant, strategic change required across whole CCGs	Community & Integrated Medicine	Chief Operating Officer	20 NEW	16	31/10/2025	10/07/2025
1631 - If the delegation of budget manager responsibilities are unmet then finances will be adversely affected	Operational Allied Health Professions & Health Sciences	Chief Operating Officer	20 ↓	15	31/03/2026	11/07/2025
975 - Risk of failure to remain within allocated budget due to financial constraints (Estates & Facilities).	Estates & Facilities	Director of Allied Health Professions and Health Sciences	20 →	10	31/03/2026	22/07/2025
2107 - Risk of physiotherapy financial overspend due to unfunded respiratory on call services.	Operational Allied Health Professions & Health Sciences	Chief Operating Officer	16 NEW	2	31/03/2026	09/07/2025
1906 - Risk of not achieving savings targets within our annual plan due to ongoing service demand	Community & Integrated Medicine	Chief Operating Officer	16 →	12	31/10/2025	29/07/2025
1892 - Risk of not achieving savings targets due to continued expenditure without mitigating savings plans	Operational Allied Health Professions & Health Sciences	Chief Operating Officer	16 →	12	31/03/2026	04/07/2025

Operational Risks Reportable to FPC



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Risk Reference & Title	Overseeing Clinical Care Group / Executive Function	Lead Director	Current Risk Score*	Target Risk Score	Expected Date to Achieve Target Risk Score	Date of last risk review
971 - Risk of failure to remain within allocated budget over the medium term due to financial constraints (MH&LD).	Mental Health and Learning Disabilities	Chief Operating Officer	16 →	3	31/03/2026	10/07/2025
2124 - Risk of being unable to identify recurrent savings required due to spend on ad-hoc pay and non-pay	Planned & Specialist Care	Chief Operating Officer	12 NEW	4	31/03/2026	25/07/2025
2065 - Risk of not achieving the WG performance measure for CO validated quit attempts due to capacity and accessibility challenges	Director of Public Health	Director of Public Health	12 →	8	31/03/2027	24/07/2025
1951 - Risk of overspend against Specialist Palliative Care budget due to potential withdrawal of funding for permanent posts	Community & Integrated Medicine	Chief Operating Officer	12 →	4	29/08/2025	01/07/2025
1488 - Risk of major service disruption if decontamination equipment fails at BGH due to age	Planned & Specialist Care	Chief Operating Officer	12 ↓	8	31/03/2027	17/07/2025
1084 - Risk of unsustainable surgical rota in PPH due to reliance on locum doctors	Planned & Specialist Care	Chief Operating Officer	12 →	3	31/12/2025	17/07/2025

Operational Risks Reportable to FPC



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Risk Reference & Title	Overseeing Clinical Care Group / Executive Function	Lead Director	Current Risk Score*	Target Risk Score	Expected Date to Achieve Target Risk Score	Date of last risk review
2095 - Risk to delivery of urgent and suspected cancer hysteroscopy diagnostic pathway	Planned & Specialist Care	Chief Operating Officer	8 NEW	4	30/09/2025	17/06/2025
1646 - Risk of cost pressure (external test service level agreements PHW) due to increased workload/costs	Operational Allied Health Professions & Health Sciences	Chief Operating Officer	8 →	8	23/04/2025	24/07/2025

Audits and Inspections - Overview

The Health Board remains in Targeted Intervention (TI) (Level 4) status with Welsh Government (WG) as a result of challenges relating to financial sustainability, strategy and planning, service delivery and organisational performance. Whilst the Health Board has been de-escalated for ‘Governance’ from TI (Level 4) to Enhanced Monitoring (Level 3), the Health Board has to meet the revised set criteria:

- Evidence that all recommendations from the Royal Colleges / Health Inspectorate Wales (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 (*TI criteria 12*); and
- Demonstrate a prompt response to any HIW inspections, concerns, incidents, never-events, coroners requests and regulation 28s (*TI criteria 38*) – *which has replaced the previous criteria of ‘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.’*
- The Board acts on, and addresses appropriately, concerns raised through NHS regulators such as HIW.

All reports from audits, inspections and reviews undertaken across the Health Board are logged and tracked on AMaT (Audit Management and Tracking), with progress updated by relevant service leads against each recommendation, with evidence required to be uploaded to demonstrating progress and implementation.

AMaT enables services to directly update progress against all recommendations via one central system, promoting a consistent approach with regards to processes and reporting, improvement in transparency and accountability, supporting services with their governance arrangements, and improvement in information flow. Progress is monitored via the utilisation of a traffic light system based on performance against original completion dates.

Status	Explanation
Green	Recommendation has been confirmed as completed by the service / directorate lead (<i>AMaT Status: Complete and awaiting approval / Fully Complete</i>)
Amber	Recommendation is currently in progress, and within the agreed original timeframe for implementation (<i>AMaT Status: Partially Complete / In Progress</i>)
Red	Recommendation is in progress, but has exceeded its agreed original timeframe for implementation (i.e. overdue) (<i>AMaT Status: Overdue / Partially Complete (Overdue)</i>)
External	Recommendations considered to be outside the gift of the Health Board to currently implement, e.g. reliant on an external organisation. Due to current system limitations, the action title has been amended to include the phrase “external” to denote this status.

Recommendations that have exceeded original timescales, along with the management responses management response, completion dates and barriers to implementation as provided by the lead officer on AMaT are

Audits and Inspection Reports assigned to FPC



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The following reports have been assigned to FPC to enable them to undertake the following responsibility set out in their Terms of Reference:

3.1.19 Seek assurances on the requirements arising from the Health Board's regulators, Welsh Government and professional bodies.

Date of report	Report issued by	Report Title	Clinical Care Group/ Executive Function	Lead Director	Original Completion Date	Revised Completion Date	Number of recommendations in original report	Red (behind schedule)	Amber (on schedule)	Green (complete)	External Recs	Any Barriers to Completion Noted?
Aug-23	Peer Review	Getting It Right First Time (GIRFT) Ophthalmology Review	Planned and Specialist Care	Chief Operating Officer	Apr-24	~~Nov-24~~ Jan-27	59	0	9	50	0	Linked to Clinical Services Plan (CSP) in GGH and BGH
Hun-24	Peer Review	Getting It Right First Time (GIRFT) - Emergency Medicine	Community & Integrated Medicine	Chief Operating Officer	Oct-25	Oct-25	35	17	11	7	0	Awaiting outcome of CSP and, capital funding from WG.
Jun-23	Peer Review	Peer Review (external review) of Hywel Dda University Health Board (HDUHB) of care delivery to people with epilepsy and learning disability	Mental Health & Learning Disabilities	Chief Operating Officer	Jun-24	~~Jun-24~~ ~~Jul-25~~ Oct-25	16	1	0	15	0	None noted
Jan-22	Peer Review	Colorectal Cancer (Third Cycle), issued January 2022	Planned & Specialist Care	Chief Operating Officer	Mar-22	~~Mar-23~~ ~~Mar-24~~ Mar-28	8	0	0	7	1	Awaiting regional approach
Sep-22	Peer Review	Getting It Right First Time (GIRFT) - Gynaecology Review - September 2022	Planned & Specialist Care	Chief Operating Officer	N/K	Sep-26	17	6	0	10	1	Engagement required with stakeholders outside the Clinical Care Group (CCG)
Apr-24	Peer Review	Getting It Right First Time (GIRFT) - Urology Review	Planned & Specialist Care	Chief Operating Officer	Jan-27	Jan-27	29	2	6	18	3	Linked to CSP, and reliance on the National Urology Clinical Implementation Network (CIN) rolling out agreed Coding criteria.

Audits and Inspection Reports assigned to FPC



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Date of report	Report issued by	Report Title	Clinical Care Group/ Executive Function	Lead Director	Original Completion Date	Revised Completion Date	Number of recommendations in original report	Red (behind schedule)	Amber (on schedule)	Green (complete)	External Recs	Any Barriers to Completion Noted?
May-23	Peer Review	Getting It Right First Time (GIRFT) General Surgery Review	Planned & Specialist Care	Chief Operating Officer	Sep-23	Mar-24 Jan-25 May-25 N/K	22	0	0	22	0	Requires engagement from another Health Board and establishing a regional solution
Jun-25	Internal Audit	Continuing Healthcare – Database Maintenance & Finance Processes Final Internal Audit Report 2024/25 (Substantial rating)	Director of Finance	Director of Finance	Oct-25	Oct-25	1	0	1	0	0	None noted
Jan-25	Ministerial Advisory Group (MAG)	Ministerial Advisory Group (MAG) Observations following the site visits of health boards – Hywel Dda UHB - Planned and Specialist Care (January 2025)	Planned & Specialist Care	Chief Operating Officer	Mar-26	Mar-26	32	0	24	6	2	Dependent on recruitment and funding being agreed through the Annual Planning process, awaiting outcome of tender process for standardised PAC process and pathway.
Jan-25	Ministerial Advisory Group (MAG)	Ministerial Advisory Group (MAG) Observations following the site visits of health boards – Hywel Dda UHB - Allied Health Professions and Health Sciences (January 2025)	Operational Allied Health Professions and Health Sciences	Chief Operating Officer	Sep-25	Sep-25	10	0	7	3	0	Capacity issues, new plans being developed via the Network with Swansea Bay UHB.

Audits and Inspection Reports assigned to FPC



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Date of report	Report issued by	Report Title	Clinical Care Group/ Executive Function	Lead Director	Original Completion Date	Revised Completion Date	Number of recommendations in original report	Red (behind schedule)	Amber (on schedule)	Green (complete)	External Recs	Any Barriers to Completion Noted?
Jan-25	Ministerial Advisory Group (MAG)	Ministerial Advisory Group (MAG) - Observations following the site visits of health boards – Hywel Dda UHB- Urgent and Emergency Care (January 2025).	Community & Integrated Medicine	Chief Operating Officer	Mar-26	Mar-26	15	0	14	1	0	OCP Phase 2 recruitment
Oct-24	NHS Wales Executive	NHS Executive Report on Urgent and Emergency Care Opportunities: GGH site	Community & Integrated Medicine	Chief Operating Officer	Nov-25	Nov-25	58	0	58	0	0	None noted
Mar-25	NHS Wales Executive	NHS Executive Report on Urgent and Emergency Care Opportunities: BGH site	Community & Integrated Medicine	Chief Operating Officer	Apr-26	Apr-26	38	0	38	0	0	None noted



Welsh Health Circulars (WHCs) provide a streamlined, transparent and traceable method of communication between NHS Wales and NHS organisations relating to different areas such as estates, finance, governance, health professional letters, information governance, quality and safety, legislation, planning, performance and delivery, policy, public health, research, science, and workforce. WHCs are published on the [Welsh Government website](#).

Committees have responsibility to seek assurance that the Health Board is compliant with WHCs and that these are implemented in line with stated/agreed timescales, and where this has not been possible, to receive assurance the impacts resulting from late or non-delivery are understood and managed appropriately.

Where WHCs are not clear in terms of implementation timescales, leads are requested to provide the planned date for implementation by the Health Board. The following RAG status is applied to WHCs:

- **Red** = behind schedule to the timescale provided by the Lead officer, or a plan (with date for implementation) is not yet in place
- **Amber** = a plan is in place and on schedule to be completed by the timescale provided by the Lead Officer
- **Green** = completed
- **Blue** = External i.e., the means to achieve compliance is currently outside the gift of the Health Board.

WHCs included within this report are based on the following criteria:

3.1.19 Seek assurances on the requirements arising from the Health Board's regulators, Welsh Government and professional bodies

Progress updates relating to the implementation of WHCs are extracted from the AMaT system.

Welsh Health Circulars assigned to FPC

Since the previous report to FPC, the following WHC has been implemented (Green):

WHC Ref	Name of WHC	Date Issued	Lead Director	Update
012-25	Interim Amendments to the Model Standing Financial Instructions Chapter 11 for Local Health Boards and NHS Trusts in Wales, and Chapter 12 for Health Education and Improvement Wales (HEIW) and Digital Health and Care Wales (DHCW) online link not available	29/05/2025	Director of Corporate Governance/ Board Secretary	The Health Board’s Standing Financial Instructions have been updated with support from Finance colleagues, and approval by Board on 31 July 2025.

Ministerial Directions- Overview



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Acts of Parliament, Acts of Senedd Cymru, Assembly Measures and Assembly Acts enable Welsh Ministers to develop more detailed legislation, known as secondary or subordinate legislation, usually by means of Statutory Instruments (SI).

Non-Statutory Instruments (NSI) are legislative in character; they alter legal rights and duties; however, they are not SIs. NSIs, which are issued by Welsh Ministers, include codes of practice and guidance.

In complying with the requirements of various governance codes and the Annual Governance Statement requirements, HDdUHB has a duty to provide assurance of compliance with the NSIs.

MDs that potentially form part of the process of approving expenditure of public money have been realigned to DDIC to receive a regular assurance report on compliance.

The following RAG status is applied to MDs:

- **Red** = behind schedule to the timescale provided by the Lead officer, or a plan (with date for implementation) is not yet in place
- **Amber** = a plan is in place and on schedule to be completed by the timescale provided by the Lead Officer
- **Green** = completed
- **Blue** = External i.e., the means to achieve compliance is currently outside the gift of the Health Board.

MDs included within this report are based on the following criteria:

3.1.19 Seek assurances on the requirements arising from the Health Board's regulators, Welsh Government and professional bodies

Progress updates relating to the implementation of MDs are extracted from the AMAT system.

Ministerial Directions assigned to FPC



GIG
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NHS
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The following Ministerial Direction has been received and confirmed as having a plan in place and being on schedule to be completed by the timescale provided (**Amber**):

Direction Number	Name of Direction	Date issued	Lead Director	Update
WG21-59	The Directions to Local Health Boards and NHS Trusts in Wales on the Delivery of Autism Services 2021	26/07/2021	Chief Operating Officer	This Ministerial Direction is currently being implemented, with an implementation date of October 2025. The health board continues to work with the Regional Partnership Board (RPB) in the development and delivery of the Code of Practice Implementation Plan which requires a multi-agency response to address the recommendations outlined in the code.

Ministerial Directions assigned to FPC



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Since the previous report to FPC, the following MDs have been confirmed as implemented (**Green**):

Direction Number	Name of Direction	Date issued	Lead Director	Update
WG25-33	Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) (No. 3) Directions 2025	09/06/2025	Director of Finance	Confirmation received from NHS Wales Shared Services Partnership (NWSSP) that MD has been complied with.

The committee is requested, in relation to the areas presented in this paper, to:

RISK MANAGEMENT

- **RECEIVE ASSURANCE** that identified controls are in place and working effectively;
- **RECEIVE ASSURANCE** that all planned actions are credible and deliverable, and in line with agreed plans, and will be implemented within stated timescales and will reduce risks further and/or mitigate the impact should risks materialise; and
- **CHALLENGE** where assurances are inadequate Acts of Parliament, Acts of Senedd Cymru, Assembly Measures and Assembly Acts enable Welsh Ministers to develop more detailed legislation, known as secondary or subordinate legislation, usually by means of Statutory Instruments (SI).

AUDITS, INSPECTIONS AND REGULATORY REPORTS

- **RECEIVE ASSURANCE** from the lead Executive Director or Supporting Officer on the management of recommendations raised in audit, inspection and regulatory reports within their area of responsibility, particularly in respect of confirming the full implementation of recommendations with any barriers to delivery noted.

WELSH HEALTH CIRCULARS

- **RECEIVE ASSURANCE**, or otherwise, from the lead Executive Director or Supporting Officer on the management of WHCs within their area of responsibility, particularly in respect of understanding when the WHC will be delivered, any barriers to delivery, impacts of non/late delivery and assurance that the risks associated with these are being managed effectively.

MINISTERIAL DIRECTIONS

- **RECEIVE ASSURANCE** that the Health Board is compliant with the NSIs (MDs) issued by Welsh Government.



DIOGEL | CYNALIADWY | HYGYRCH | CAREDIG
SAFE | SUSTAINABLE | ACCESSIBLE | KIND



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University Health Board

Risk Ref	Risk (for more detail see individual risk entries)	Executive Director	Domain	Previous Risk Score	Risk Score Jun-25	Trend	Target Risk Score (tolerable score)	Expected Date of achieving Target Risk Score
1199	Achieving financial sustainability	Thomas, Huw -	Finance inc. claims	5×5=25	5×5=25	→	2×4=8	TBC

Risk Ref	Strategic Objectives	Risk Title (for more detail see individual risk entries)	Executive Director	Controls	Domain	Current Risk Score (L x I)	Target Risk Score (L x I) (tolerable score)	Performance Indicators	Assurance from What? (sources/providers of assurance) L1, L2 & L3 (see below key)	Latest paper	Assurance Sufficient? (Y/N)	Control RAG rating (see below key)	Risk on page no...
1199	6. Sustainable use of resources	Achieving financial sustainability	Thomas, Huw -	Considerable business intelligence available on where our expenditure differs from the rest of Wales - eg comparisons at service, site and condition level to understand in detail where we utilise resources, and identify opportunities to change the way we deliver services Long term financial model - with a view to crafting a long term strategic financial plan - currently being constructed, setting out key actions and policy / operational changes necessary to become more financially sustainable A Planning Steering Group is in place to co-ordinate activities across key corporate functions. Operational grip and control currently being strengthened, through Executive-led groups tackling specific issues eg use of high cost agency staff, transformation of urgent / emergency care etc The Planning Team are embedded within the operational management structures across the organisation.	Finance inc. claims	5×5=25	2×4=8	See Our Outcomes section on the BAF Dashboard Operational agreement to underlying deficit assessment. Welsh Government accept and approved Integrated Medium Term Plan (IMTP). Plan in place to develop a long-term financial plan. High level financial assessment of A Healthier Mid and West Wales in place.	Analysts engaged and have produced a bed opportunity analysis with consistent conclusions to the internal work (L1) Financial Reporting to Sustainable Resources Committee (L2) Integrated Quality, Finance, Performance and Delivery Group (reporting to Executive Team) oversee in-year delivery of financial performance and savings delivery (L2) Value and Sustainability Group (reporting to Executive Team) oversees opportunities which inform medium term financial roadmap (L2) Planning Objectives overseen by Sustainable Resources Committee (L2) Structured Assessment 2023	Annual Plan Update 2024/25 - SRC & Board Seminar (Feb24) Developing a roadmap to financial balance - SRC (Jun23) Medium term financial strategy- Board Seminar (Jun23) Annual Plan Update 2024/25 - Board Seminar (Feb24) Financial Strategy and Roadmap Update 2025/26 - SRC (Dec25) Annual Plan and Strategy Update 2025/26 - Board Seminar (Feb25)	Y		

				New Executive team governance and escalation structure and reporting groups (Value & Sustainability, A Healthier Mid and West Wales, and Integrated Quality, Finance, and Performance Delivery) to improve financial control and long term sustainability. Oversight provided into ET by the Targeted Intervention Coordination Group. Improving together aligned to an internal escalation framework - a programme to embed a quality management system to ensure consistency of approach in addressing quality and service improvement throughout the organisation. Agile Digital Business Group - a Group which reports into the Finance Committee which scrutinises business cases on digital investment to allow a rapid allocation, allocate resources promptly, learn from previous business case implementations and disinvest if appropriate. Value Based Health and Care Group: which ensures that the Health Board's rollout and deployment of VBHC is in line with plans and will facilitate the shift of resources over time.			(L3)		Annual Plan and Strategy Update 2025/26 - SRC (Feb25)		

1196	5. Safe, sustainable, accessible and kind care	Insufficient investment in facilities/equipment/digital infrastructure	Davies, Lee	Annual programme of replacement in place for equipment, IT and Estates which follows a prioritisation process. When possible, aligning replacement equipment to large All Wales Capital schemes to minimise the impact on discretionary capital within the UHB. Completion of the medical devices inventory by the operational management team which helps in the prioritisation of available funds. Communication with Welsh Government via Planning Framework and IMTP (Infrastructure & Investment Enabling Plans) including the prioritised 10 year capital plan and regular dialogue through Capital Review meetings. Preparation of priority lists for equipment, Estates and IM&T in the event of notification of additional capital funds from Welsh Government i.e. in year slippage and to enable where possible, the preparation of forward plans. This is also addressed through the identification of high priority	Business objectives/projects	5×4=20	2×3=6	See Our Outcomes section on the Dashboard	Development of Integrated Assurance and Approval Plan in support of PBC and SOC (L1) Governance structure to oversee delivery of the Business Cases (L1) Oversight by A Healthier Mid and West Wales Group which reports into Executive Team with Assurance sought by Strategy and Planning Committee (L2) Internal Audit Programme aligned to Business Case Development (L3) Internal Audit AHMWW Programme Forward Look Governance Review (L3) Gateway review of PBC and SOC by WG Assurance Hub (L3)	PCB - Implementing the Healthier Mid and West Wales Strategy - Board (Jan23, Mar23, May23, Jul23 & Sep23) & SDCODC (Apr23, Jun23, Aug23 & Jan24) AHMWW PBC Programme Group Update - Board Seminar (Apr22) TMH Update - Board Seminar (Jun22) Executive Team - Apr22 Planning Objectives Update (Planning) - SDODC ((Jun22, Oct22, Feb23, Jun23, Oct23, Feb24 & Jun24)	Y		

			issues through the annual planning cycle. Implementation of the Digital Strategy which is also funding dependant. A governance structure has been established with the Director of Strategy and Planning as SRO to develop the business cases required in support of the Health and Care Strategy, A Healthier Mid and West Wales. It is likely that all the capital mitigations for the over arching risk will be interim solutions only pending the major infrastructure investment plans to ensure the sustainability of the health and care strategy. Programme Business Case (PBC) for Business Continuity supported in principle by WG and funding for first phase BJC developments. Funding for Community Schemes are being progressed via the Integration and Rebalancing Fund (IRCF). Co-production of 10 Year Capital Investment Plan with the RPB.				Pentre Awel Update - SDODC (Dec23) DCP Update - SDODC (every meeting) Forward Look Governance Review - ARAC (Feb23) Regular reporting to Board and Board Seminar		

1197	5. Safe, sustainable, accessible and kind care	Implementing models of care that do not deliver our strategy	Davies, Lee	Healthier Mid and West Wales Strategy approved by Board Nov18. Delivery Groups and processes: 1. Programme Business Cases (PBC) steering groups 2. Cluster groups & locality plans 3. Regional Partnership Board, ARCH and other regional/national collaboratives 4. AHMWW Group, reporting to Executive Team, with underpinning governance structure overseeing alignment and delivery of the strategy working through a sub group structure of 6 Sub Groups including a Strategic Refresh Group. Assurance provided to Board via scrutiny of delivery of the above by relevant assurance committees.	Business objectives/projects	4×4=16	1×4=4	See Our Outcomes section in the BAF Dashboard	AHMWW Group reporting to Executive Team (L2) Board and Committee oversight of Planning Objectives (L2) QSEC to measure harms (L2) WG Gateway process re accessing capital (L2) Internal Audit reviews of Major Capital Programme (L3) Audit Wales Structured Assessment Process review delivery of Health Board Strategy & Planning (L3)	PBC - Implementing the Healthier Mid and West Wales Strategy - Board (Jul24) Annual Plan 2023/24 Update - Board (Jan25) Refreshing the Healthier Mid and West Wales Strategy - Board (Jan25)	Y		

1185	1. Putting people at the heart of everything we do, 2. Working together to be the best we can be	Consistent and meaningful engagement through our workforce	Davies, Lee	"Skills to Deliver Engagement Two additional posts were added to the Engagement team in early 2023. However, these roles have, due to staff departure and financial pressure, have been held. Recruitment to the Head of Engagement is currently underway in October 2024, with additional posts to follow. Additional resource has been requested to enable engagement during CSP. Expert engagement team in place with ongoing training needs reviewed regularly. Operational engagement lead for each county. Engagement training provided to operational on an ad hoc/as required basis. Organisational Structures to Support the Delivery of Engagement Stakeholder Reference Group provide oversight/ input from an advisory group perspective around key HB priorities. Close working relationship with Llais.	Business objectives/projects	4×4=16	2×3=6	See Our Outcomes section on the BAF Dashboard	Management process in place to monitor Engagement Team objectives (L1) Key projects / programmes of work will be provided with advice, guidance and support around the design and delivery of robust engagement plans (and where required consultation plans) (L1) Reflective review of the engagement to ensure learning from the process is recorded and influences future work. This will include a programme / project group review to inform future learning and delivery of engagement. The operational reflection by the Engagement Team will form part of the team's learning log, to ensure there is continuous improvement embedded within engagement practice. Ongoing process in place (L1)	Continuous Engagement Plan - Board (May22)	N		

			Voices of Children and Young People's Group established Newly established 'improving the use of feedback across the organisation' group to explore how the triangulation of feedback from different parts of the organisation including engagement, corporate office, communications, diversity and inclusion, quality improvement, transformation, patient experience and workforce and organisational development can be used to inform key pieces of work around service change. Engagement mechanisms to support the delivery of continuous engagement across the organisation include: - provision of engagement, advice, guidance and support around continuous engagement and consultation to services across the HB - management of the Siarad Iechyd / Talking Health involvement and engagement scheme - management of the stakeholder management system Tractivity - Management of the online engagement tool Have Your Say (EngagementHQ) - advice, guidance, support around the planning and delivery of traditional engagement methods			SRG used a oversight assurance mechanism (L2) For major pieces of engagement and consultation work sign off will be via Board (L2) Where contentious engagement / consultation is identified the organisation can seek external advice and guidance through Consultation Institute to minimise risk of judicial review (L3) The Health Board and Llais have key duties around changes to health services. Changes to health services should be presented to the CHC at Services Planning Committee (L3)				

1198	6. Sustainable use of resources	Ability to shift care in the community	Carruthers, Andrew	Transformation Steering Group (TSG) & Strategic Enabling Group (SEG) to support strategic innovation and development in the UHB. Operations Innovation 'Board' (new Silver) to aid planning to optimal level, with workstreams and system overarching group. 5 Facet Survey completed in 2022 to establish a baseline for the GMS estate. CHC and UHB Protocol for managing low level service change. All Business Cases need to be taken through Transformation Steering Group. Plan on a page developed and included in the Health Board's Annual Plan 2024/25 for clusters. WHC (18) 025 - Improving Value through Allocative & Technical Efficiency: A Financial Framework to Support Secondary Acute Services Shift to Community/Primary Service Delivery confirmed as	Business objectives/projects	4×4=16	2×4=8	See Our Outcomes section in the BAF Dashboard	Lightfoot Viewer for urgent care to track improvements (L1), County Management Systems Leadership Forum focus on performance and delivery (L1), Locality Leads meeting oversee integrated locality development (L1), Primary Care & Long Term Care SMT meeting (L1), Regional Partnership Fund Group (L2), Board Seminar discussions (L2), Delivery of Planning Objectives overseen by Executive Team and Board Committees (L2),	TMH Update - Board (May22). Three Year Draft Plan for Children's Services - Board (Jul21). PCB- Implementing the Healthier Mid and West Wales Strategy - Board (Nov23). Implementing the Healthier Mid and West Wales Strategy - Board - (Jan23).	N		

1186	o, 2. Working together to be the best we can be, 3. Striving to deliver and develop excellent services	Attract, retain and develop staff with the right skills	Gostling, Lisa	A flexible and responsive recruitment process. A multidisciplinary approach to clinical education. A comprehensive package that enables local people to know what and how they can access workforce development initiatives in the Health Board HR policies (including those for employee relations) in place with programme of review Training programmes in place (a suite of programmes covering management and leadership, Making a Difference, etc) County workforce teams/OD Relationship Managers/Workforce Planners in place to provide workforce support to services (covering sickness absence, etc) Staff Well-being Service and Psychological Service in place Regular contact with Trade Union	Workforce/OD	3×5=15	2×5=10	See Our Outcomes section on BAF Dashboard	Workforce Leadership Group review progress of planning objectives, measures and staff feedback in detail (L1) Pulse surveys sampling 1000 employees each month, selecting different staff each month (L1) SSPEG oversees people planning and education development (L2) Oversight of Delivery of planning objectives, measures and staff feedback at People, OD & Culture Committee (L2) Staff Partnership Forum (L2) Medical Engagement scale feedback (L3) IA PADR Follow up - Reasonable (May-20) (L3)	Approach to Workforce Planning Paper (including WAO reports) and Workforce Risk Paper and Planning Objectives Update - PODCC (Oct23) Discovery Report: Understanding the Staff Experience in HDUHB during 2020-21 COVID-19 Pandemic - Board (Sep21) Workforce Planning Report provided to every other PODCC meeting (latest February 2025) Delivery Against Planning Objectives Aligned to the People, Organisational	N		

1. Putting people at the heart of everything we do			representatives/Staff Partnership forums				Internal Audit on Workforce Planning - Substantial (Apr22) (L3)	Development and Culture Committee (May 2025)		
			Annual NHS staff surveys providing feedback from staff							
			Separate clinical education programmes in place				Wales Audit on Workforce Planning (Report Sep23) (L3)			
			Apprenticeship programme and work experience programmes in place				Strategic Workforce Planning Forum (oversight of education commissioning) and People Profession Plans			
			Grow your Own programmes in place				SPPEG (Strategic People Planning & Education Group)			
			Leadership development programmes in place							
			Internal and External talent programmes							
			Directorate Improving Together Sessions aligned with Internal Escalation Framework							
			Strategic Workforce Planning Forum (oversight of education commissioning) and People Profession Plans							
			SPPEG (Strategic People Planning & Education Group)							

1194	4. The best health and wellbeing for our individuals, families and our communities	Increasing uptake and access to public health interventions	Gjini, Ardiana	National screening programmes in place (including Breast, Bowel, Cervical, DES, AAA, new-born, etc). These programmes are national services, planned, delivered, monitored and quality assured by PHW, also the quality improvement sits with PHW. Local initiatives in place such as Cervical Screening and Refugees, and Barriers to Screening Uptake in Carers. Vaccination and immunisation programme in place, and recently has seen significant changes with introduction of national immunisation framework (NIF). Vaccination and Immunisation as programmes are planned in line with WG policy. Local health protection service in place. Local and National health promotion initiatives. Multi-agency Health Protection and Co-ordination Group established (with operational delivery groups for adult immunisation, infant and pregnancy immunisation and respiratory immunisation, school age immunisation, occupational immunisation) Tobacco Control Group in place. Area Planning Board (Alcohol and Substance Misuse).	Health Equity	4×3=12	2×2=4	See Our Outcomes section on the BAF Dashboard Wellbeing, Public Health Outcome and Health Inequality, Deprivation metrics to aid baseline setting to map progress	Population health measures collected by Public Health Wales (vaccinations, screening, etc) (L1) Oversight of delivery of delivery of Planning Objectives at Executive Team and SDODC (L2) A Healthier Mid and West Wales Group (L2) All Wales Wellbeing and Public Health Outcome indicators published by PHW Observatory. QA responsibility of PHW. Relevant ONS data - published resources. Other ad hoc published works/resources from various recognised and credible bodies/foundations (L3)		N		

1191	3. Striving to deliver and develop excellent services	Underestimation of Excellence	Henwood, Mr Mark	# Quality Assurance System including Clinical effectiveness # Process re NICE and professional guidance. # National & Local Clinical Audits Programme # Peer Reviews # Healthcare standards # Major cause of harm # National Quality setting. # AMAT system in place to monitor NICE compliance # TSG to learn from best in World. # Advisory Board. # Clinical Director for Clinical Effectiveness - role to secure clinical engagement. # Monitoring system in place for NICE guidance. # QSEC Approved Research & Development (RDI) Strategy with Implementation Plan # Research & Innovation Sub Committee with strengthened membership for improved scrutiny # Strengthened RDI Management Team # Partnership and collaborative working initiatives - some joint funded posts and research and innovation projects in place. # University partnership arrangements in	Business objectives/projects	3×4=12	2×3=6	See Our Outcomes section on the BAF Dashboard	# Participation in the NICE Welsh Health Network where specific guidelines are proposed for review on a national basis - to provide benchmark information (L1) # Senior management Team meeting monitor delivery of RDI activities and RDI Strategy/Plan (L1) # VBHC Programme Plan for rollout of PROM/PREM collection and capture of resource utilisation (L1) # Medical Leadership Forum (L2) # VBHC facilitated Service Review Meetings with operational and clinical staff followed by presentation to Executive colleagues for action (L2) # Reporting through the Effective Clinical Practice Advisory Panel and Clinical Standards and Guidelines Group (L2) # Alignment with Health Board	Update ECPAP Reports to QSEC (Oct23) Effective Clinical Practice Strategic Plan for ratification to ECPAP (Sep22) Effective Clinical Practice Delivery Plan to ECPAP (Dec22)	N		

			place. # Strategic Enabling Groups # Value Based Health Care Sponsoring Group # Value Based Health Care Programme Team # National Value Based Health Care Community of Practice # Improving Together Programme # Regular attendance at Directorate/ County Quality and Governance Groups to improve engagement on clinical effectiveness # Establishment of the Clinical Standards and Guidelines Group as a forum to support better engagement with service areas and promote excellence through a focus on clinical effectiveness standards and guidelines and support from teams across the quality system to identify gaps and improve services. # Multi-Professional Clinical Workshop, led by Clinical Executives				Quality and Governance Groups (L2) # Responses to letters from Welsh Government (DCMO) relating to specific guidelines (L2) # RDI Sub Committee & HCRW monitor delivery of RDI Strategy/Plan (L2) # Board Committees & Executive Team (through its reporting groups) oversee delivery of Planning Objectives (L2) # Annual Performance Review by WG/HCRW (L3) # RDI Activity overseen by UK RD - Peer Review to review arrangements in place for research activities (L3) # IA on NICE Guidelines Follow-up (Reasonable Assurance) (L3) IA on Job Planning - May24 (Limited Assurance) (L3) # HCRW Annual Review of R&D (awaiting final report - positive verbal feedback to date) (L3)			

1192	4. The best health and wellbeing for our individuals, families and our communities	Wrong value set for best health and well-being	Gjini, Ardiana	Statutory member of Public Service Boards (PSBs) with statutory members undertaken a Wellbeing Assessments in 2022, with a set of wellbeing objectives agreed by each of the PSBs the Board in March 2023 setting actions for partners to implement Key member of Regional Partnership Board (RPB) Engagement underpinning the Healthier Mid and West Wales Strategy Equality Impact Assessments, consultation and engagement undertaken on service change Patient participation groups in place for some services, eg maternity, respiratory Close links between services and voluntary sector groups, eg AgeConcern, MIND Speaking to people re outcomes (Prog7 of Trans Fund) Together for change (supporting community led programme)	Health Equity	3×4=12	2×4=8	See Our Outcomes section in the BAF Dashboard	Population health measures collected by Public Health Wales (vaccinations, screening, etc) (L1) Tracking of crude mortality, risk-adjusted mortality and other data (L1) Oversight of delivery of Planning Objectives undertaken by Assurance Committees (L2) Overseeing the development of Wellbeing Assessment as statutory member of PSB (L2) Oversight of Programme 7 of transformation fund by RPB (L2) Oversight of delivery of New Hospital Programme Business Case by SDODC (L2) SRG advisory role to the Board (L2)	PO Update Report to Committees (Feb24)	N		

				Relationship with Llais (2 weekly meeting with Chair and CEO and bi-monthly planning meetings) Community engagement and outreach work with disadvantaged/vulnerable groups Stakeholder Reference Group Staff Partnership Forum Development and sign up to the principles of the Social Model for Health & Wellbeing Charter in the region by all partners RPB Preventions Board ownership of elements of the Social Model for Health & Wellbeing				Director of Public Health Annual Report to Board (L2)				

1193	4. The best health and wellbeing for our individuals, families and our communities	Broadening or failure to address health inequalities	Gjini, Ardiana	Health inequalities is embedded across public health teams, working closer with the planning and CSP work. HB Planning Objectives on Health Population setting plan of work for 2024/25. Population Health and Strategic Equity Oversight Group working across the HB and strategic partners. Strategic Plan for Health Improvement and Wellbeing (3 year plan) going to Board for approval in July 2024. Immunisations Equities Strategy in place. Development of Health Equities Framework for Health Services. PSB Wellbeing Plans in place, developed and agreed by Public Service Boards identifying key priorities for population well-being (the self-assessments and new objectives were set in Apr23). Community Development Outreach Team engage with minority ethnic communities and those who face barriers to accessing health and care services.	Health Equity	3×3=9	2×1=2	See Our Outcomes section of the BAF Dashboard Wellbeing, Public Health Outcome and Health Inequality, Deprivation metrics to aid baseline setting to map progress	Oversight of delivery of delivery of Planning Objectives at Executive Team and SDODC (L2) Population Health and Strategic Equity Oversight Group (L2) Health Equity Group in place engage with different groups for feedback on service and wider inequities (L2) All Wales wellbeing and Public Health Outcome indicators published by PHW Observatory. QA responsibility of PHW Relevant ONS data - published sources. Other ad hoc published works/resources from various recognised and credible bodies/foundations (L3)		N		

1188	2. Working together to be the best we can be	Effective leveraging within partnerships	Gjini, Ardiana	The Health Board is a key member of strategic and statutory partnership groups, including Regional Partnership Board and Public Service Board. The Health Board approved a Partnership Governance Framework and Toolkit in September 2017 to provide a mechanism to ensure effective arrangements are in place for the governance of partnerships. Representatives on strategic partnerships groups to provide regular updates to the Board/Executive Team. ARCH Recovery and Strategic Delivery Plans Digital strategy Regular formal and informal contact with local authority partners via CEO/Chair and Integrated Executive Group Research, development and innovation strategy	Business objectives/projects	3×3=9	1×3=3	See Our Outcomes section in BAF Dashboard	Statutory Partnerships Update to Board (L2) Chief Executive and Chair Reports to Board (L2) ARCH Reports to Strategic Development and Operational Planning Committee (SDODC) (L2) Delivery of Planning Objectives are being overseen by Executive Team and Board Committees (L2)	Strategic Partnerships Update every Board (May24)	N		

1189	3. Striving to deliver and develop excellent services	Timely and sufficient learning, innovation and improvement	Daniel, Sharon	Risk Management Framework and Board Assurance Framework (BAF) Established governance structures Established Assurance Trackers for audits, inspectorates & regulators, Welsh Health Circulars, Ministerial Directions Healthcare Standards (HCS) 6 Domains of Quality embedded within governance framework to improve clinical quality and patient experience Research, Development and Innovation Strategy approved by QSEC The Improving Together programme which aims to shift the organisation from one that manages performance to one that manages quality and embeds an improvement culture into all of its working arrangements Quality framework, with the Enabling Quality Improvement in Practice (EQIIP) programme, improvement coach development programme and access to supporting resources/ teams (QIST/ VBHC/	Business objectives/projects	3×3=9	1×3=3	See Our Outcomes section of BAF Dashboard	Tracker Performance reports issued to Lead Directors on bi-monthly basis (L1) Committee oversight of delivery of WHCs and MDs (L2) ARAC oversight of Audit Tracker (L2) RD&I Sub Committee overseeing delivery and success of RDI Strategy (L2) IQPFDP overseeing quality performance (L2) Quality Impact Assessment Panel reporting to QSEC (L2) Quality and Safety Intelligence Group (L2) Internal Quality & Engagement Act Implementation Group (L2) Directorate Improving	Tracker Report - every ARAC Strategic Business intelligence - Board (Aug21)	N		

				TPO/ PMO/ OD/ workforce/ R&D etc) Effective clinical practice (Clinical Audit, Clinical Standards and Guidance, Clinical Written Control Documents, Mortality Reviews etc) OD Cultural Plans A comprehensive range of Leadership Development pathways in place to create cohorts of leaders (includes Medical Leadership Programme, Clinical Leads Forum, Consultant Programme, HEIW Clinical Leadership Programme, LEAP, CLIMB and increased coaching capacity) Quality Impact Assessment process and panel and Quality Safety Intelligence Group				Together Sessions aligned to the internal Escalation Framework (Bi-monthly) (L2) IA Health and Care Standards to review adequate procedures in place to ensure, and monitor, effective utilisation of the standards to improve clinical quality and patient experience - Reasonable Assurance (Feb21) (L3) AW & IA Plan includes annual review of risk management arrangements & BAF (L3)				

1195	5. Safe, sustainable, accessible and kind care	Comprehensive early indicators of shortfalls in safety	Daniel, Sharon	Range of performance measures/metrics in place Updated Datix Incident reporting system Standardised approach through a standard agenda in Quality Governance meetings CIVICA system is available and being rolled out to gain feedback to let us know issues in services Range of different mechanisms to capture feedback from service users and staff Speak Up Arrangements are in place, however further developing required in light of the Speak Up Framework as issued by Welsh Government in October 2023 Listening and Learning Sub-Committee Quality, Safety and Experience Committee Clinical Audit Programme Quality Safety Intelligence Group	Quality/Complaints/Audit	3×3=9	2×4=8	See Our Outcomes section of the BAF Dashboard	Quality and Safety Intelligence Group (L2) Directorate Quality Governance Meetings in place (L2) Patient and staff feedback (L2) Harms Dashboard is reported monthly to Formal Executive team with Our Performance and other intelligence for triangulation of data (L2) Improving Together performance sessions with clinical and corporate directorates aligned to the Internal Escalation Framework (L2) Performance reports through power BI and Committee reports (L2) PTHB/HDUHB LTA/CQPR	Patient Experience Report - every Board (May24) Healthcare Contracting Update - SRC (Aug22) QIA - QSEC (Oct 23) Quality and Commissioning Update - QSEC (Oct 23)	N		

			External reports (HIW, HSE, MWWFRS, Peer Reviews, etc) Mortality Reviews and Medical Examiners Service National Accreditation Standards for service specifications 6 Domains as noted in the Duty of Quality Act (STEEEP) PROMS and PREMs in identified services Directorate and Service Quality Governance Meetings established Directorate Improving Together Sessions Increased quality element of commissioned services from external organisations Harms Dashboard and our Performance Dashboard in place to facilitate triangulation of data with other intelligence, eg weekly hot and happening meetings. Quality Impact Assessments process now in place Quality Management System now in place Increased use of AMAT across the Health Board to track the implementation of recommendations raised.			Meeting and Hywel Dda & SBU (SLA & LTA) Meetings to review quality aspects from commissioning arrangements (L2) Commissioning arrangements overseen by Sustainable Resources Committee (SRC) (L2) GIRFT Reports reported to QSEC (L2) Quality Impact Assessments and Panel (L2) HIW patient complaints (L3) Quality Governance Follow up Report (Oct21) (L3) Annual Structured Assessments by Audit Wales (L3) Internal audit on Safety Indicators (Reasonable Assurance (L3) Internal Audit plans which include reviewing Quality Governance (L3)				

1184	1. Putting people at the heart of everything we do	Measuring how we improve patient and workforce experience	Daniel, Sharon	Central Communication Hub in place with workstreams established supporting 27 operational teams in communicating with patients Central Communication Hub lead appointed Civica system capturing feedback from patients implemented, with significant roll out across services Change mechanisms established through improvement and transformation programmes with direct impact on how clinical services are structured linked to CSP Organisational Development Relationship Managers to influence the culture change journey and support the creation of transformational and compassionate culture within the Health Board, and actively work with services Methodology to manage change with services to facilitate clinical engagement and pace of delivery (Engagement Team, Quality Improvement Team and	Finance inc. claims	2×4=8	2×2=4	See Our Outcomes section of BAF Dashboard	Pulse surveys sampling 1000 employees each month, selecting different staff each month (L1) Communication Hub and WLSP Steering Group overseeing delivery of the plan and the workstreams (L2) Improving Together performance sessions with clinical and corporate directorates aligned to the Internal Escalation Framework (L2) Formal Executive Team review and triangulate data from the Harms Dashboard, Our Performance Dashboards and other intelligence (L2) Communication Hub Steering Group (L2) Executive Team, through its reporting groups, oversee	Single Point of Contact Report - Board (Mar21) Patient Experience Report - every Board (May24) Periodic update reports to Executive Team on the impact of the Communication Hub and WLSP Staff Feedback Reports - PODCC QIA reported to QSEC (Sep23)	Y		

			Transformation Team) underpinned by the Safe Care Collaborative and 6 Goals Urgent and Emergency Care programme of work			delivery of Planning Objectives (L2)			
			Waiting List Support Programme (WLSP) Plan with workstreams established to support continued engagement with clinical staff and services following the National 3 Ps policy and directly supporting patients on waiting lists			Board Committee oversight of Planning Objectives (L2)			
			WLSP Phased Iterative Implementation Plan which is regularly reviewed			Patient Experience Report to every Board (L2)			
			Ongoing evaluation of WLSP now in place following initial evaluation to inform programme development			Listening and Learning Sub Committee oversight of patient experience (L2)			
			Power BI Performance dashboards on IRIS			Periodic reporting of engagement index survey results to People, OD and Culture Committee and Board (from Nov21) (L2)			
			Engagement in place with Llais Cymru (formal and informal arrangements in place)			Public Service Ombudsman for Wales Reports (L3)			
			Staff Partnership Forum (UHB and County Partnership Forums)			HIW Inspection Reports and Complaints, including implementation of recommendations(L3)			
			Mechanism in place to ensure charitable funding applications demonstrate impact						

			running applications demonstrate impact through agreed evaluation and metrics Engagement Team facilitate stakeholder events to capture population feedback on consultations and key workstreams Harms Dashboard and our Performance Dashboard in place to facilitate triangulation of data with other intelligence, eg weekly quality intelligence / surveillance meetings Health Board wide Improving Together Sessions in place, which utilise dashboards Staff Surveys and Pulse Surveys undertaken regularly to evaluate staff experience, and reported to People, Organisational Development and Culture Committee Quality Impact Assessments introduced and reported to Quality, Safety and Experience Committee							

1200	6. Sustainable use of resources	Maximising social value	Thomas, Huw -	Health Board active participation within the Public Service Boards across Hywel Dda UHB region. Local Needs Analysis has been completed based on the Wellbeing Goals. A Social Value framework has been developed with strands in workforce, facilities and estates, procurement. Decarbonisation plan in place, with its own risk assessment. Annual carbon reporting underway to WG.	Health Equity	2×3=6	2×3=6	Local expenditure is a key measure which is being tracked through the 'Our performance' dashboard.	Delivery of Planning Objectives overseen by Executive Team, and its supporting structure, and Board Committees (L2) Board meetings to consider the outcome measure (Our positive impact on society is maximised) (L2) Local measures are in place and used within the procurement space to ensure that decisions consider social value implications. (L2)	Social Value Workshop - SEG (Oct21) Social Value Workshop - SRC (Dec21) Public value action plan (004) (May23) Public Values Framework strategy (June23)	N		

Assurance Key:

3 Lines of Defence (Assurance)		
1st Line	Business Management	Tends to be detailed assurance but lack independence
2nd Line	Corporate Oversight	Less detailed but slightly more independent
3rd Line	Independent Assurance	Often less detail but truly independent

Key - Assurance Required		<i>NB Assurance Map will tell you if you have sufficient sources of assurance not what those sources are telling you</i>
	Detailed review of relevant information	
	Medium level review	
	Cursory or narrow scope of review	

Key - Control RAG rating	
LOW	Significant concerns over the adequacy/effectiveness of the controls in place in proportion to the risks
MEDIUM	Some areas of concern over the adequacy/effectiveness of the controls in place in proportion to the risks
HIGH	Controls in place assessed as adequate/effective and in proportion to the risk
INSUFFICIENT	Insufficient information at present to judge the adequacy/effectiveness of the controls

Date Risk Identified:	Jun-21
Strategic Objective:	6. Sustainable use of resources

Executive Director Owner:	Thomas, Huw -	Date of Review:	May-25
Lead Committee:	Finance and Performance Committee	Date of Next Review:	Jul-25

Risk ID:	1199	Principal Risk Description:	There is a risk that the Health Board does not develop or deliver a credible plan to achieve financial sustainability, or undertake the necessary actions identified in that plan. This is caused by insufficient identification of deliverable savings schemes; non-delivery of agreed savings schemes; change programmes not sufficiently resourced or well-managed; or changes made to services which do not result in financial benefits as they address unmet demand or have unintended consequences. Our financial performance - coupled with insufficient emphasis on planning - has led to the Health Board being placed into the "Targeted Intervention" category of NHS Wales Escalation and Intervention Arrangements. This could lead to an impact/affect on potential reputational impacts, as well as lead to consequences for retention of the workforce, staff morale, poor patient experience and poorer value healthcare with a reduction of confidence from our stakeholders.
Does this risk link to any Directorate (operational) risks?			

Risk Rating:(Likelihood x Impact)		Current Risk Score Target Risk Score Tolerance Level
Domain:	Finance inc. claims	
Inherent Risk Score (L x I):	5×5=25	
Current Risk Score (L x I):	5×5=25	
Target Risk Score (L x I):	2×4=8	
Expected Date To Achieve TRS:		
Trend:		↔

Rationale for CURRENT Risk Score:

Issues have been raised over the ability of the Health Board to plan at a strategic and operational level for a number of years. The Health Board's performance over the last year has demonstrated a significant improvement in the ability to operationally plan and a developing maturity within the organisation. However, the Health Board's financial deficit has significantly deteriorated; significant workforce constraints remain; and the planning function remains small with significant opportunities to develop. These issues are exacerbated given the Health Board's financial deficit, with the need to not only shift resources to more appropriate settings, but provide care at considerably lower cost. The Health Board's underlying deficit is now well understood and articulated, with clear decisions tracked that have been made by budget holders that exceed their delegated limits.

The underlying deficit remains a significant concern with a recurrent delivery gap, which will adversely impact future planning cycles, moving the health board further away from the target control total expectations of Welsh Government.

The significant underlying financial deficit in the current and future years is likely to result in the Health Board being unable to meet its cash obligations as they fall due and presents a going concern risk. Early indications from WG is that the WG are unable to support both the revenue and cash implications. With the Health Board reporting a significant in-year and recurrent underlying deficit, WG initially escalated the Health Board into Targeted Intervention during October 2022, on the grounds of planning and financial performance, however in January 2024, the whole organisation was escalated into targeted intervention. The recurrent funding position confirmed by WG leaves a significant gap based upon draft iterations of the financial plan, with strategic and operational changes required in an attempt to erode the financial deficit.

Rationale for TARGET Risk Score:

Achieving financial balance on a three-year rolling basis is a statutory requirement for the Board, and a clear requirement from the Board and Welsh Government. Strategic and operational planning in an integrated Health Board is inherently complex leading to potential disconnections between demand, operational capacity planning; workforce planning and financial planning. Given the challenge in delivering the savings required over a number of years, and the implications of this in the medium term, it is unlikely that the Health Board will achieve a risk which is in line with the tolerable risk for the year. Consequently, the target risk score exceeds the tolerable risk at this point. This is not an acceptable position, and further work is ongoing to manage this risk.

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	Gaps in CONTROLS				
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	How and when the Gap in control be addressed	By Who	By When	Progress
Considerable business intelligence available on where our expenditure differs from the rest of Wales - eg comparisons at service, site and condition level to understand in detail where we utilise resources, and identify opportunities to change the way we deliver services Long term financial model - with a view to crafting a long term strategic financial plan - currently being constructed, setting out key actions and policy / operational changes necessary to become more financially sustainable A Planning Steering Group is in place to co-ordinate activities across key corporate functions. Operational grip and control currently being strengthened, through Executive-led groups tackling specific issues eg use of high cost agency staff, transformation of urgent / emergency care etc The Planning Team are embedded within the operational management structures across the organisation. New Executive team governance and escalation structure and reporting groups (Value & Sustainability, A Healthier Mid and West Wales, and Integrated Quality, Finance, and Performance Delivery) to improve financial control and long term sustainability. Oversight provided into ET by the Targeted Intervention Coordination Group. Improving together aligned to an internal escalation framework - a programme to embed a quality management system to ensure consistency of approach in addressing quality and service improvement throughout the organisation. Agile Digital Business Group - a Group which reports into the Finance Committee which scrutinises business cases on digital investment to allow a rapid allocation, allocate resources promptly, learn from previous	Recovery of planned care activity - coupled with increasing complexity of patients presenting acutely ill - means that there is a lack of focus and ambition across the organisation on ensuring we live within the financial and staffing resources available. Conversion of the Opportunities Framework, Savings Framework and Value for Money Framework into deliverable recurrent savings schemes is not apparent. Focus from TI is on in-year recovery, and at best consideration of the next 12 months financial performance; development of a long term strategic plan would help move to a more strategic approach to managing resources. Two TI actions that remain in-progress are highlighted by WG as organisational challenges to ensure clear plans and delivery mechanisms are in place, monitoring and reviewing actions, to ensure financial challenges are mitigated, coupled with the balance on service. safety and quality.	To achieve workforce sustainability through the delivery of workforce planning, recruitment, retention, and development, and effectiveness initiatives. 1. Develop a Workforce Plan which sets out actions to achieve a balance between workforce demand and supply, supporting workforce stabilisation. 2. Delivery of a targeted Recruitment Plan which will reduce reliance on high cost agency staff through substantive recruitment (supply-side) supporting the Workforce Plan. 3. Delivery of a Retention Plan to support the supply-side elements of the Workforce Plan and underpin workforce stabilisation. 4. Delivery of a Workforce Education and Development Plan which supports the pipeline (supply-side) for staff progression. (PO 1)	Gostling, Lisa	31/03/2025	On track as per highlight report presented to PODCC in May 2025.
		To oversee financial recovery and develop a long term financial route map (PO2)	Thomas, Huw -	~~31/03/2025~~ 01/10/2025	On track as per highlight report presented to FPC in June 2025. Whilst the Roadmap had been developed, a refresh is being taken to a Board Seminar in September 2025 to gain further input and align it to clinical and operational plans in readiness for the 2026/27 planning cycle.

business case implementations and disinvest if appropriate.

Value Based Health and Care Group: which ensures that the Health Board's rollout and deployment of VBHC is in line with plans and will facilitate the shift of resources over time.

Transforming Urgent and Emergency Care (TUEC) Programme - TUEC / Implement the Six Goals To develop and implement a plan to by March 2024 to deliver Ministerial priorities by 2026 1. Delivery and Implementation of a 24/7 Urgent Care Service, accessible via 111 Wales, to support improved access and GMS sustainability. 2. Implementation of Same Day Emergency Care services /direct access pathways. 3. Improving patient flow through the acute sites. 4. Develop a strategy for our Alternative Care Provision to support care closer to home. 5. Minimise delays in hospital discharge due to assessment-related issues within Pathways of Care. 6. Improve the effectiveness and efficiency of community services, with an emphasis on avoiding unnecessary hospital admissions and facilitating timely discharges. (PO 3)	Carruthers, Andrew	31/03/2025	On track as per highlight report presented to FPC in June 2025.
Improve Planned Care and Cancer performance, with a focus on reducing the longest waits, and reduce the 8 week wait for diagnostics. (PO4)	Carruthers, Andrew	31/03/2025	Behind as per highlight report presented to FPC in June 2025.
Mental Health and Learning Disabilities service improvement though: 1. Mental Health Recovery Programme Optimisation 2. Section 136 3. Redesign the End-to-End Inpatient and Community Pathway (PO 5)	Carruthers, Andrew	31/03/2025	On track as per highlight report presented to FPC in June 2025.
To provide a set of plans for key clinical services to address critical sustainability risks up to the future hospital network. (PO 6)	Davies, Lee	31/03/2025	On track as per highlight report presented to SPC in June 2025.
Develop a Primary Care and Community Strategy which is inclusive of: - Enhancement of Primary Care Services - Integration of Technological Solutions - Workforce Development - Infrastructure and Estate Development - Alignment with Community Services (PO 7)	Paterson, Jill	31/03/2025	On track as per highlight report presented to SPC in June 2025.

		Progress against Business Case process for Implementation of A Healthier Mid and West Wales Strategy & Estates Rationalisation - Modernisation and rationalisation scheme year 1-4 implementation (PO 8)	Davies, Lee	31/03/2025	Behind schedule as per highlight report presented to SPC in June 2025.
		Implement the Digital Strategic Plan A. To appoint a Commercial Transformation Partner arrangement to support with the implementation of large-scale digital transformation projects across the Health Board and the region B. To work with WG to secure funding for the roll-out of ePMA, and a patient flow and e-observation system. C. To implement the following key system developments: 1. Welsh Intensive Care Information System, 2. PROMs and PREMs system & 3. Hybrid print and post. D. To ensure that future planning is progressed for the following key system developments: 1. Re-procurement of the Laboratory Information Management System, 2. The Integrated Eye Care Electronic Health Record, 3. Development of a Community Information System & 4. Development of Maternity and Paediatric record systems. (PO 9)	Thomas, Huw -	31/03/2025	Complete as per highlight report presented to DDIC in April 2025.

ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls)	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance	Required Assurance			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed Further action necessary to address the gaps	By Who	By When	Progress
		(1st, 2nd, 3rd)	 Current Level							
See Our Outcomes section on the BAF Dashboard Operational agreement to underlying deficit assessment.	Analysts engaged and have produced a bed opportunity analysis with consistent conclusions to the internal work	1st			Annual Plan Update 2024/25 - SRC & Board Seminar (Feb24) Developing a roadmap to	None identified.				

Welsh Government accept and approved Integrated Medium Term Plan (IMTP). Plan in place to develop a long-term financial plan. High level financial assessment of A Healthier Mid and West Wales in place.	Financial Reporting to Sustainable Resources Committee	2nd			financial balance - SRC (Jun23)				
	Integrated Quality, Finance, Performance and Delivery Group (reporting to Executive Team) oversee in-year delivery of financial performance and savings delivery	2nd			Medium term financial strategy- Board Seminar (Jun23)				
					Annual Plan Update 2024/25 - Board Seminar (Feb24)				
	Value and Sustainability Group (reporting to Executive Team) oversees opportunities which inform medium term financial roadmap	2nd			Financial Strategy and Roadmap Update 2025/26 - SRC (Dec25)				
	Planning Objectives overseen by Sustainable Resources Committee	2nd			Annual Plan and Strategy Update 2025/26 - Board Seminar (Feb25)				
	Structured Assessment 2023	3rd			Annual Plan and Strategy Update 2025/26 - SRC (Feb25)				

Risk Ref	Risk (for more detail see individual risk entries)	Executive Director	Domain	Previous Risk Score	Risk Score Jul-25	Trend	Target Risk Score (tolerable score)	Expected Date of achieving Target Risk Score
2086	Risk that the cash consequences of the Health Board deficit cannot be covered by WG should it exceed our Target Control Total	Thomas, Huw -	Finance inc. claims	4×5=20	4×5=20	→	3×4=12	31/10/2025
1350	Risk of not meeting the 80% SCP waiting times target for March 2026 due to diagnostics capacity and delays at tertiary centre	Carruthers, Andrew	Quality/Complaints/Audit	4×4=16	4×4=16	→	2×4=8	31/03/2026
2104	Risk to delivery of Ministerial Priorities relating to planned care recovery ambitions 25/26 due to demand exceeding capacity	Carruthers, Andrew	Safety - Patient, Staff or Public	NA	3×4=12	New risk	3×3=9	30/09/2025

RISK SCORING MATRIX

Likelihood x Impact = Risk Score					
Likelihood	1	2	3	4	5
Descriptor	Rare	Unlikely	Possible	Likely	Almost Certain
Frequency - How often might it/does it happen? (how many times will the adverse consequence being assessed actually be realised?)	This will probably never happen/recur (except in very exceptional circumstances).	Do not expect it to happen/recur but it is possible that it may do so.	It might happen or recur occasionally.	It might happen or recur occasionally.	It will undoubtedly happen/recur, possibly frequently.
	Not expected to occur for years.*	Expected to occur at least annually.*	Expected to occur at least monthly.*	Expected to occur at least weekly.*	Expected to occur at least daily.*
* time-framed descriptors of frequency					
Probability - Will it happen or not? (what is the chance the adverse consequence will occur in a given reference period?)	(0-5%*)	(5-25%*)	(25-75%*)	(75-95%*)	(>95%*)
*used to assign a probability score for risks related to time-limited or one off projects or business objectives.					
Risk Impact Domains	Negligible - 1	Minor - 2	Moderate - 3	Major - 4	Catastrophic - 5
Safety of Patients, Staff or Public	Minimal injury requiring no/minimal intervention or treatment.	Minor injury or illness, requiring minor intervention.	Moderate injury requiring professional intervention.	Major injury leading to long-term incapacity/disability.	Incident leading to death.
	No time off work.	Requiring time off work for >3 days	Requiring time off work for 4-14 days.	Requiring time off work for >14 days.	Multiple permanent injuries or irreversible health effects.
		Increase in length of hospital stay by 1-3 days.	Increase in length of hospital stay by 4-15 days. Agency reportable incident. An event which impacts on a small number of patients.	Increase in length of hospital stay by >15 days. Mismanagement of patient care with long-term effects.	An event which impacts on a large number of patients.
Quality, Complaints or Audit	Peripheral element of treatment or service suboptimal.	Overall treatment or service suboptimal.	Treatment or service has significantly reduced effectiveness.	Non-compliance with national standards with significant risk to patients if unresolved.	Totally unacceptable level or quality of treatment/service.
	Informal complaint/inquiry.	Formal complaint.	Formal complaint -	Multiple complaints/ independent review.	Gross failure of patient safety if findings not acted on.
		Local resolution.	Escalation.	Low achievement of performance/delivery requirements.	Inquest/ombudsman inquiry.
		Single failure to meet internal standards.	Repeated failure to meet internal standards.	Critical report.	Gross failure to meet national standards/performance requirements.
		Minor implications for patient safety if unresolved. Reduced performance if unresolved.	Major patient safety implications if findings are not acted on.		

CORPORATE RISK REGISTER SUMMARY JULY 2025

Workforce & OD	Short-term low staffing level that temporarily reduces service quality (< 1 day).	Low staffing level that reduces the service quality.	Late delivery of key objective/ service due to lack of staff.	Uncertain delivery of key objective/service due to lack of staff.	Non-delivery of key objective/service due to lack of staff.
			Unsafe staffing level or competence (>1 day).	Unsafe staffing level or competence (>5 days).	Ongoing unsafe staffing levels or competence.
			Low staff morale.	Loss of key staff.	Loss of several key staff.
			Poor staff attendance for mandatory/key training.	Very low staff morale. No staff attending mandatory/ key training.	No staff attending mandatory training /key training on an ongoing basis.
Statutory Duty or Inspections	No or minimal impact or breach of guidance/ statutory duty.	Breach of statutory legislation. Reduced performance levels if unresolved.	Single breach in statutory duty.	Enforcement action	Multiple breaches in statutory duty.
			Challenging external recommendations/ improvement notice.	Multiple breaches in statutory duty. Improvement notices.	Prosecution. Complete systems change required.
				Low achievement of performance/delivery requirements.	Low achievement of performance/delivery requirements.
				Critical report.	Severely critical report.
Adverse Publicity or Reputation	Rumours.	Local media coverage – short-term reduction in public confidence. Elements of public expectation not being met.	Local media coverage – long-term reduction in public confidence.	National media coverage with <3 days service well below reasonable public expectation.	National media coverage with >3 days service well below reasonable public expectation. AMs concerned (questions in the Assembly).
	Potential for public concern.				Total loss of public confidence.
Business Objectives or Projects	Insignificant cost increase/ schedule slippage.	<5 per cent over project budget. Schedule slippage.	5–10 per cent over project budget. Schedule slippage.	Non-compliance with national 10–25 per cent over project budget. Schedule slippage. Key objectives not met.	Incident leading >25 per cent over project budget. Schedule slippage. Key objectives not met.
Finance including Claims	Small loss.	Loss of 0.1–0.25 per cent of budget.	Loss of 0.25–0.5 per cent of budget.	Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget.	Non-delivery of key objective/ Loss of >1 per cent of budget.
	Risk of claim remote.	Claim less than £10,000.	Claim(s) between £10,000 and £100,000.	Claim(s) between £100,000 and £1 million.	Failure to meet specification/ slippage Claim(s) >£1 million.
Service or Business interruption or disruption	Loss/interruption of >1 hour. Minor disruption.	Loss/interruption of >8 hours.	Loss/interruption of >1 day.	Loss/interruption of >1 week.	Permanent loss of service or facility.
		Some disruption manageable by altered operational routine.	Disruption to a number of operational areas within a location and possible flow onto other locations.	All operational areas of a location compromised. Other locations may be affected.	Total shutdown of operations.
Environmental	Minimal or no impact on the environment.	Minor impact on environment.	Moderate impact on environment.	Major impact on environment.	Catastrophic/critical impact on environment.
Health Equity	Minimal or no impact on our attempts to improve health equity	Minor impact on our attempts to improve health equity or low level of certainty on the impact we are having on health equity	Moderate impact on our attempts to improve health equity or a lack of sufficient information that would demonstrate this. Indications that we are not having a positive impact on health improvement or health equity	Major impact on our attempts to improve health equity. Validated data suggesting that we are not improving the health of the most disadvantaged in our population whilst clearly supporting the least disadvantaged. Validated data suggesting we are having no impact on health improvement or health equity.	Validated data clearly demonstrating a disproportionate widening of health inequalities or a negative impact on health improvement and/or health equity.

RISK MATRIX

	LIKELIHOOD →				
IMPACT ↓	RARE	UNLIKELY	POSSIBLE	LIKELY	ALMOST CERTAIN
	1	2	3	4	5
CATASTROPHIC 5	5	10	15	20	25
MAJOR 4	4	8	12	16	20
MODERATE 3	3	6	9	12	15
MINOR 2	2	4	6	8	10
NEGLIGIBLE 1	1	2	3	4	5

RISK ASSESSMENT - FREQUENCY OF REVIEW

RISK SCORED	DEFINITION	ACTION REQUIRED (GUIDE ONLY)	MINIMUM REVIEW FREQUENCY
15-25	Extreme	Unacceptable. Immediate action must be taken to manage the risk. Control measures should be put into place which will have an effect of reducing the impact of an event or the likelihood of an event occurring. A number of control measures may be required.	This type of risk is considered extreme and should be reviewed and progress on actions updated, at least monthly.
8-12	High	Very unlikely to be acceptable. Significant resources may have to be allocated to reduce the risk. Urgent action should be taken. A number of control measures may be required.	This type of risk is considered high and should be reviewed and progress on actions updated at least bi-monthly.
4-6	Moderate	Not normally acceptable. Efforts should be made to reduce risk, providing this is not disproportionate. Establish more precisely the likelihood & harm as a basis for determining the need for improved measures.	This type of risk is considered moderate and should be reviewed and progress on actions updated at least every six months.
1-3	Low	Risks at this level may be acceptable. If not acceptable, existing controls should be monitored & reviewed. No further action or additional controls are required.	This type of risk is considered low risk and should be reviewed and progress on actions updated at least annually.

Assurance Key:

3 Lines of Defence (Assurance)		
1st Line	Business Management	Tends to be detailed assurance but lack independence
2nd Line	Corporate Oversight	Less detailed but slightly more independent
3rd Line	Independent Assurance	Often less detail but truly independent

Key - Assurance Required		<i>NB Assurance Map will tell you if you have sufficient sources of assurance not what those sources are telling you</i>
	Detailed review of relevant information	
	Medium level review	
	Cursory or narrow scope of review	

Key - Control RAG rating	
LOW	Significant concerns over the adequacy/effectiveness of the controls in place in proportion to the risks
MEDIUM	Some areas of concern over the adequacy/effectiveness of the controls in place in proportion to the risks
HIGH	Controls in place assessed as adequate/effective and in proportion to the risk
INSUFFICIENT	Insufficient information at present to judge the adequacy/effectiveness of the controls

Date Risk Identified:	Apr-25
Strategic Objective:	6. Sustainable use of resources

Executive Director Owner:	Thomas, Huw -	Date of Review:	Aug-25
Lead Committee:	Finance and Performance Committee	Date of Next Review:	Sep-25

Risk ID: 2086	Corporate Risk Description:	There is a risk that Welsh Government are unable to fund the cash consequences of our deficit should it exceed our Target Control Total (TCT) of £24m, which is the level indicated of cash coverage available. This is caused by the Health Board's potential inability to achieve its required total savings of £52m for 2025/26 due to 1. insufficient conversion of the £19m operational and clinical determined recurrent savings plans into deliverable actions 2. insufficient conversion of required £31m non-recurrent savings into budgets in the year 3. the requirement to deliver further £2m of savings to address the Health Board's National Insurance shortfall 4. the requirement to reduce investments by £1.5m This could lead to an impact/affect on our ability to meet our statutory targets, but exceeding the TCT would also mean that: 1. We will have insufficient cash available to make payments to suppliers in March 2026; 2. We will have to take actions which may have a detrimental impact on our performance measures, and may mean patients having to wait longer for care; 3. Our reputation with Welsh Government and other stakeholders is adversely affected; 4. Further escalation for finance from Targeted Intervention to Special Measures; 5. Our conditionally-recurrent funding of £26.0m being withdrawn by Welsh Government, impacting our ability to reach a sustainable medium term financial position.
Does this risk link to any Directorate (operational) risks?	1719, 1906, 1892, 1854, 1631, 1544, 1530, 975, 8888, 1788, 871, 1876, 1616	

Risk Rating:(Likelihood x Impact)		Current Risk Score: 20 Target Risk Score: 12 Tolerance Level: 8
Domain:	Finance inc. claims	
Inherent Risk Score (L x I):	5×5=25	
Current Risk Score (L x I):	4×5=20	
Target Risk Score (L x I):	3×4=12	
Expected Date To Achieve TRS:	31/10/2025	
Trend:	New risk	

Rationale for CURRENT Risk Score:

The Board endorsed and approved the submission of the annual plan to Welsh Government in March 25, noting that the financial plan doesn't deliver against our statutory requirement to break-even. It recognised that the forecast financial outturn remained in-line with the target control total (TCT) set by WG of £31.5m, but a worsening position compared to the 2024/25 financial outturn. This followed a period of scrutiny through the Sustainable Resources Committee, Board Seminar and Public Board meetings.

Correspondence received from WG during Q1 of 2025/26 confirmed that our plan is not supportable, with a revised and clear requirement to achieve a TCT of £24m. The focus is therefore:

1. To improve the assurance over recurrent and non-recurrent savings delivery to achieve the original plan of £31.5m, and the now revised annual plan of £30.0m;
2. To take choices to reduce the position further to £24m. This requires actions to be taken over August and September for a Board Seminar in September 2025 and submit our actions for improvement to Welsh Government by 11 September.

As at Month 4 2025/26, savings identification was at £26.9m, with some operational cost pressures arising from medical staffing, the management of LTAs and Clinical Services and Supplies within Planned Care and Hospital sites.

Rationale for TARGET Risk Score:

The Health Board had a historic challenge of controlling its cost base and delivering change. While significant improvements have been made to our control environment, significant challenges remain in our change management capabilities. These need to be addressed to achieve the target risk score.

By 11 September 2025, the Executive Team are seeking to de-risk the financial plan to ensure its successful delivery. It is at this date we would envisage the current risk score being reduced to 16 if the savings gap has been materially closed with robust and deliverable schemes.

By 31 October 2025, the Executive Team are seeking to have fully de-risked the financial plan to ensure its successful delivery, in order to allow the organisation to focus on planning for delivery of the medium term financial roadmap into 2026/27.

Key CONTROLS Currently in Place:

(The existing controls and processes in place to manage the risk)

1. Working Day 1 principles adopted within the finance function to ensure timely 'Flash reports' provided to the Executive Team.
2. Timely, relevant and understandable reporting provided to budget managers, Executives, Committees, Board and Welsh Government. This will be available live for self-service budget holders via QlikSense and monthly for management information packs.
3. Oversight arrangements in place through Integrated Quality, Financial Performance and Delivery Group, Value and Sustainability Group and the Healthier Mid and West Wales Group.
4. Executive Improving Together meetings and the Escalation Framework embedded across the organisation, which focuses on seven key domains, including Finance as one.
5. Financial Control Sub Group weekly scrutiny of agency medical, agency AHP, Admin and Clerical and newly created roles for recruitment and procurement.
6. Opportunities framework in place to identify areas of improvement potential across the Health Board, updated and shared monthly.
7. New operational structures in place since April 2025, providing managerial clarity and consistency that was not in place in historically.

Gaps in CONTROLS

Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)

- There remain areas where there are gaps in controls. These are:
1. The effective management of rostering;
 2. The effective management of beds;
 3. Effective contract management arrangements;
 4. Oversight arrangements over commissioned services.
- There is also a significant gap in the organisation's ability to deliver change.

How and when the Gap in control be addressed	By Who	By When	Progress
Further action necessary to address the controls gaps			
The implementation of a rostering system across medical staff, and the extension of rostering to other staff groups.	Hill, Carly	31/07/2025-30/11/2025	Progress update to be provided at next risk review
Operational adoption of the new patient flow system across the Health Board.	Tracey, Anthony	31/01/2026	Progress is on plan to roll out by October 2025.
Agreement and universal implementation of one consistent medical rate card spanning all locations and all services to align the rates of pay paid to staff irrelevant of specific circumstances.	Henwood, Mr Mark	31/01/2026	Progress update to be provided at next risk review
Agreement and universal implementation of one consistent AHP rate card spanning all locations and all services to align the rates of pay paid to staff irrelevant of specific circumstances.	Severs, James	30/09/2025	Progress update to be provided at next risk review

8. Aligned finance support via the Business Controlling team to support, scrutinise and advise CCG/CSG and Executive Function management structures. 9. Accountability agreements issued in March 2025, all signed and returned.		Finalise the implementation of the substantive operational management structure via the ongoing COO OCP, ensuring all audit recommendations are completed and accountability structures are consistently deployed.	Carruthers, Andrew	30/06/2025-31/07/2025-31/12/2025	Updates to Structured Assessment recommendations raised by Audit Wales have been confirmed as completed in June 2025, and will be submitted to Audit Wales for review in July 2025. Consistent deployment of governance arrangements are monitored via the Health Board's Internal Escalation Framework, and a review of the effectiveness of these arrangements is planned to be undertaken by Internal Audit during Q2/Q3 for evidencing the completion of the further action required. Action date has been revised to reflect the completion of noted internal audit.
		Consideration of the organisation's change management capacity and alignment of change and transformation management resources.	Gostling, Lisa	31/08/2025	Progress update to be provided at next risk review
		Embed a monthly routine within the Clinical Care Group and Executive Functions business meetings for the Compendium of Variation, creating a summary report for inclusion within the Financial Performance Report for Executive Team, Financial and Performance Committee and Board.	Jenkins, Sian	30/09/2025	Progress update to be provided at next risk review
		Further actions and choices to be taken based on discussion at Board in July which could deliver £6m of further savings. This requires QIAs to be delivered by 15 August for F&P consideration in August; a Board Seminar in September and submission to WG by 11 September.	Thomas, Huw	30/09/2025	In order to fully progress this action, input is required from all Executive Leads

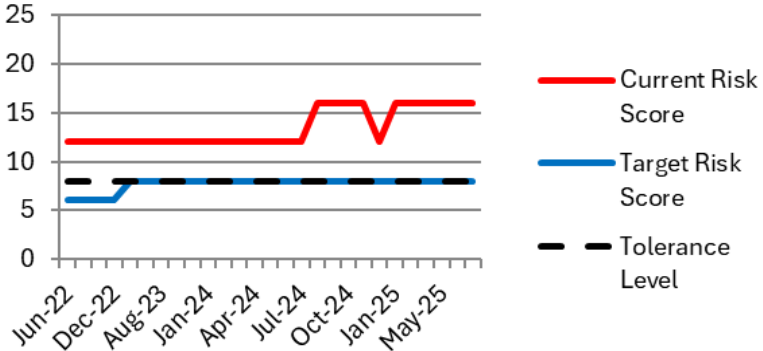
ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls)	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed Further action necessary to address the gaps	By Who	By When	Progress
Performance against operational plans and targets through Performance KPIs	Performance against plan monitored through Executive Improving Together Meetings.	1st				Delivery of limited assurance audit reports. Particularly, in areas which have a financial impact: 1. Discharge management; 2. Bed management; 3. Nursing and healthcare support worker roster management. 4. Medical roster management.	Closure of audit recommendations arising from Discharge Management and Management of Bed Capacity internal audits	Carruthers, Andrew	31/07/2025-30/09/2025	Follow Up report presented to ARAC in June 2025, with one action outstanding with timescales to be confirmed by Anna Chiffi.
In-month financial monitoring and forecasting for the remainder of the financial year	Finance and Performance Committee oversight of current performance	2nd					Closure of audit recommendations arising from Nursing roster management audit	Daniel, Sharon	30/05/2025-31/08/2025	Service have confirmed that all actions have been implemented, and currently awaiting formal approval by internal audit to close. Follow-up audit being presented to ARAC in August 2025.
	Transformation & Financial Report to Board & Finance and Performance Committee	2nd					Determination of change management capacity through alignment of resources across corporate functions.	Gostling, Lisa	31/08/2025	Progress update to be provided at next risk review
	WG scrutiny through revised Monthly Monitoring Returns (specific supplementary templates) and through NHS Exec Financial Planning and Delivery team	3rd				Delivery of change is a longstanding issue for the Health Board.				
	Audit Wales Structured Assessment process	3rd								

Date Risk Identified:	Feb-22
Strategic Objective:	5. Safe and sustainable and accessible and kind care

Executive Director Owner:	Carruthers, Andrew	Date of Review:	Jul-25
Lead Committee:	Finance and Performance Committee	Date of Next Review:	Aug-25

Risk ID:	1350	Corporate Risk Description:	There is a risk of the Health Board not being able to meet the 80% target by March 2026 for waiting times in the ministerial measures for the Single Cancer Pathway (SCP). This is caused by reduced capacity to meet the expected demand for diagnostics and treatment delays at our tertiary centre, and the fragility within key tumour sites. This could lead to an impact/affect on an increased number of patients waiting in excess of 62 days and meeting patient expectations in regard to timely access for appropriate treatment which could potentially lead to poorer outcomes and patient experience, adverse publicity/reduction in stakeholder confidence, and increased scrutiny/escalation from Welsh Government. This could lead to adverse reputational damage as a result of inconsistent performance delivery over time.
Does this risk link to any Directorate (operational) risks?			1223, 114, 111, 1537, 1699, 1722, 1723, 797

Risk Rating:(Likelihood x Impact)	
Domain:	Quality/Complaints/Audit
Inherent Risk Score (L x I):	5×4=20
Current Risk Score (L x I):	4×4=16
Target Risk Score (L x I):	2×4=8
Expected Date To Achieve TRS:	31/03/2026
Trend:	



25
20
15
10
5
0

Jun-22 Dec-22 Aug-23 Jan-24 Apr-24 Jul-24 Oct-24 Jan-25 May-25

Current Risk Score

Target Risk Score

Tolerance Level

Date	Current Risk Score	Target Risk Score	Tolerance Level
Jun-22	12	8	8
Dec-22	12	8	8
Aug-23	12	8	8
Jan-24	12	8	8
Apr-24	12	8	8
Jul-24	16	8	8
Oct-24	14	8	8
Jan-25	16	8	8
May-25	16	8	8

Rationale for CURRENT Risk Score:
The service has been de-escalated by Welsh Government from Level 4 to Level 3 in terms of Targeted Intervention status as there has been the consistent achievement of the 60% de-escalation criteria since February 2025. As at June month end, the service achieved 61.4%. Due to recovery actions within radiology and urology we may see variation in performance as we recover and treat those patients over 62 days, therefore the risk remains that cancer performance will not achieve 80% compliance by March 2026.

Rationale for TARGET Risk Score:
The aim is to treat patients within target waiting times, which has now been confirmed as 80% non-adjusted March 2026. The tolerance level will be met if plans to increase diagnostic capacity, utilising allocated recovery funding are realised. When the target of 60% for 3 consecutive months is achieved the risk score can be reduced to a 12. The risk score can be further reduced to a 8 once the target of 80% is achieved. There are underpinning trajectories in place which are monitored on a monthly basis and adherence to those will influence the ability to achieve the target risk score.

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	Gaps in CONTROLS				
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	How and when the Gap in control be addressed	By Who	By When	Progress
# Accelerated imaging from Endoscopy to CT within the GI pathway now in place across all sites, reduction time on patient pathway by 23 days # Fully established cancer tracking team in place to allow patients to be proactively tracked through their pathways. # A new cancer dashboard developed by Informatics with the support of Business Intelligence (BI) SCP funding from the Wales Cancer Network. This is now live with access for Cancer Services staff and Service Managers, allowing MDTs to actively monitor tumour site specific patients on a SCP. # The health board are using of Quarterly Planning and Monitoring reports developed by the NHS Executive since July 23. This has facilitates the development of targeted improvement plans per tumour site and subsequent weekly monitoring thus providing assurance of the robustness of plans. # Virtual appointments are being undertaken via digital solutions e.g. Attend Anywhere. # Weekly Cancer Operational Delivery Group (ODG) meetings where services managers are in attendance. The function of this group is to monitor and address service demand, capacity and risk issues. # Monthly performance meetings with Welsh Government. # Trajectory performance plans have been developed for each tumour site by the relevant services, with regards to improving performance. This also includes Backlog Trajectory plans on how these improvements will be achieved. # Robust Urology diagnostic recovery plan to eliminate patients waiting more than 28 days in place, with committed resource allocation from recovery money. Monitoring of Urology diagnostic improvement trajectory via Cancer Operational Delivery Group. # Cancer Pathway Review to be discussed at the MDT Business meetings and plans put in place to address and improve any bottlenecks or issues. Pathway reviews will also be a standing agenda item on the Planned Care and Cancer Services QSH meeting to ensure governance in line with the new operational structures implemented in April 2025. # Process in place to improve component wait times and reduce patients waiting more than 14 day for first Outpatient Appointments (OPA) and 28 days for Diagnostics. # One to one escalation meetings held with Cancer ODG leads and Tumour Site Service Managers for tumour sites that require intervention. # New Endoscopy booking process which tracks all patients referred for an endoscopy on a USC priority. If capacity is identified as a trending breach reason, the Service Management team supports targeted intervention to	Anticipated significant gaps/service fragility within key diagnostic services to address required levels of activity to support SCP.	Work with multidisciplinary team to reallocate FIT pathway to primary care in line with NOP and rest of Wales	Humphrey, Lisa	30/06/2025-30/09/2025	Planning complete, moved to implementation/working with Primary care
	Need for the implementation of new, streamlined optimal clinical pathways to reduce diagnostic demand and expedite assessment pathways.	Establish accelerated Neck lump pathway to reduce diagnostic pathway	Lewis, Caroline	31/12/2024-31/10/2025	To be implemented as part of the agreed Radiology investment 25/26
		Work with NHSE to review referral rates and patterns within primary care to reduce and refine demand to secondary care	Humphrey, Lisa	30/06/2025-30/09/2025	Mapping in progress
		Due to increased demand for dermatology treatments the service need to aquire 2 additional MOP Treatment areas	Wisdom, Ceri	Completed	SBAR being presented to the Care Group Board meeting in June.
		Highest volume of patients awaiting Urology diagnostic procedures. Urgent action required to reduce overall volumes and volumes waiting over 28 days.	Griffiths, Neil	Completed	Detailed demand capacity planning to include the RTT component to identify the actual demand capacity gap to inform the options for solution

reason, the service management team supports targeted intervention to address these concerns in order to reduce time on patient pathways. # One Stop Hysteroscopy within Gynaecology implemented in May 2024 at Bronglais General Hospital, with plan to implement across all sites during Q1 of 2025/26. # Pathway changes in Head and Neck to include Laryngeal Biopsy at first OPA, reducing reliance on pan-endoscopy # Health Board wide internal escalation framework now in place to support the monitoring of performance targets, with a TI de-escalation target of 60% for three months. *Additional radiology reporting sessions in place agreed for 2025/26. *Skin treatment recovery plan in place to end June 25 to reduce overall treatment volumes. To be reviewed quarterly.		reduce Urology diagnostic volume by 100 patients by reducing cystoscopy and prostate awaiting MRI	Griffiths, Neil	31/08/2025	in progress

ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls)	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance  Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed Further action necessary to address the gaps	By Who	By When	Progress
Internal targets - Looking at the performance per tumour site individually that have the biggest impact on overall performance Skin Urology LGI Gynaecology Breast	Daily/weekly/monthly/ monitoring arrangements by management	1st			* Implementation of Single Cancer Pathway Report - BPPAC - Feb20 * COVID-19 Impact on Cancer Services - Board - May20 * Cancer Indicated to	None identified.	Establish Operational improvement group to track improvement projects in line with NOP and Annual Plans	Goode, Paula	Completed	Plans to establish a Cancer Transformation Task and Finish group which reports into the CCG transformation hub. On hold due to formation of Care Group structure
	IPAR Performance Report to S&PC & Board	2nd								

Reducing component waits Patient waiting more than 14 days for first OPA Patients waiting a diagnostic procedure and report more than 28 days Patients with a confirmed diagnosis of cancer waiting more than 62 days	Monthly oversight by NHS Executive/WG	3rd			Updated to QSEAC Jun20 & OpQSESC Jul20 * Risk 633 QSEAC - Feb21 & Aug21 * IPAR Report - Board - Nov22				
	Revised Governance arrangements in place since April 2025 with matters escalated when required via the CCGs governance arrangement								

CORPORATE RISK REGISTER SUMMARY JULY 2025

Date Risk Identified:	Apr-25
Strategic Objective:	

Executive Director Owner:	Carruthers, Andrew	Date of Review:	Jul-25
Lead Committee:	Finance and Performance Committee	Date of Next Review:	Sep-25

Risk ID:	2104	Corporate Risk Description:	There is a risk of non-delivery of planned care ministerial targets by March 2026. This is caused by a mismatch between demand and current/forecast capacity in key specialties, workforce limitations, and the impact of the Health Boards' financial forecast for 2025/26, which limits the amount of recovery funding agreed by the Board to ensure full achievement of the respective ministerial delivery targets (No patients waiting over 52 weeks for their first outpatient appointment and no patients waiting over 2 years from referral to treatment). This could lead to an impact/affect on the quality of care provided to patients, significant clinical deterioration, delays in care and poorer outcomes, increasing pressure of adverse publicity/reduction in stakeholder confidence, and increased scrutiny from regulators.
Does this risk link to any Directorate (operational) risks?			

Risk Rating:(Likelihood x Impact)		No trend information available.
Domain:	Safety - Patient, Staff or Public	
Inherent Risk Score (L x I):	5×4=20	
Current Risk Score (L x I):	3×4=12	
Target Risk Score (L x I):	3×3=9	
Expected Date To Achieve TRS:	30/09/2025	
Trend:	New risk	

Rationale for CURRENT Risk Score:

The combined impact of cohort demand in key specialties and workforce limitations all pose a risk to full achievement of ministerial planned care recovery targets by March 2026. Additionally, Theatre cancellations due to staff shortages in Glangwili General Hospital have negatively impacted core capacity. Specifically in Orthopaedics there is an additional demand in longer waiting patients (cohort) verses recurrent demand.

Recovery funding for 25/26 has been prioritised for areas where high level Demand & Capacity (D&C) modelling identified capacity gaps. The Annual Plan, approved by the Board in March 2025 highlighted delivery risks in Ear, Nose and Throat and Rheumatology (Stage 1) and Ophthalmology, Dermatology, Gynaecology, Urology and Cardiology at S4. The Welsh Government recovery allocation (£2.8m) has been split accordingly to progress delivery solutions in these areas. Since approval of the annual plan additional risks to delivery have arisen in General and Geriatric medicine.

Whilst delivery plans for 2025/26 reflect positive progress in increasing outpatient activity & treatment capacity, underpinned by planned improvements in workforce availability and operational productivity and efficiency, the Annual Plan signalled expected delivery gaps in the above specialties. Health Board performance in respect of planned care delivery milestones is also a key feature of its escalation to Targeted Intervention status.

Opportunities have been explored to maximise capacity across Hywel Dda University Health Board and Swansea Bay University Health Board in Ophthalmology and Orthopaedics to support further recovery of waiting times. Both specialties have been prioritised for active exploration of regional solutions, in partnership with Swansea Bay University Health Board (SBUHB), to expand available capacity and address forecast shortfalls against anticipated demand including the utilisation of Neath Port Talbot theatres for Orthopaedic activity.

Notwithstanding these delivery risks, breach volumes in respect of the Stage 1 52 weeks are expected to be resolved by March 2026. Forecast breach volumes in respect of the Total Pathway 104 week target remain in Orthopaedics in Q1 although monthly breach performance shows continued improvement after Q2.

Taking the above into account, the current risk score is assessed to be lower than the inherent risk score due to the significant progress achieved in the past 12 months in improving waiting times, and, whilst delivery risks remain, the current risk score has been scored a 12.

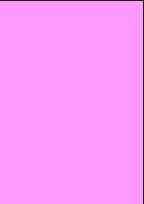
Rationale for TARGET Risk Score:

The target score of 9 reflects the continuing delivery ambitions which remain, despite the workforce and resource limitations reflected in the Annual Plan. Of note, positive progress achieved both in respect of effective demand management and transformation of outpatient pathways has ensured that overall waiting list demand has not grown with waiting list volumes at their lowest level for 2 years. This offers positive indications for future improvements in waiting times in 2025/26 onwards. The care group propose to be in balance by Q2.

Opportunities to make further progress towards the Ministerial targets in 2025/26 will continue to be explored, including exploration of the regional opportunities referred to.

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	Gaps in CONTROLS				
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	How and when the Gap in control be addressed	By Who	By When	Progress
# Comprehensive daily management systems in place to manage planned care risks on daily basis including multiple daily multi-site calls in times of escalation. # Prioritised review of patients based on an agreed risk stratification model. # Provision of dedicated elective beds on 3 sites. # The staffing position continues to be monitored on a daily basis in accordance with safe staffing principles. # Delivery plans in place supported by daily, weekly and monthly monitoring arrangements. # Quarterly deep dive reviews of all specialty delivery plans and delivery assumptions to ensure full account of OP transformation and theatre productivity and efficiency opportunities # Escalation plans for acute and community hospitals (within limits of staffing availability). # Outpatient transformation programme in place with a continuing focus on alternatives to face to face delivery of outpatient care to enable increases in care volumes delivered. # Robust sickness absence management arrangements in place. # Quarterly review of job plans, with ongoing recruitment. # Elective care delivery plan developed for inclusion within Annual Delivery Plan. # Additional Planned Care Recovery proposals developed to utilise the additional recovery funding committed by the Board	# Workforce staffing availability to support further expansion of theatre capacity	Recommence insourcing / outsourcing solutions in July 2025/26 within Orthopaedics and to remain in place for duration of Q2 2025/26	Humphrey, Lisa	Completed	Agreed start date 1st August 2025
	# Sufficiency of Anaesthetic medical staffing capacity to support further expansion of required operating lists.	To establish utilisation of NPT theatres as part of joint regional working	Humphrey, Lisa	31/08/2025	Progress update to be provided at next risk review
	# Sustainability challenges remain in a number of specialty areas which have been targeted for in-depth review via regional planning programmes for key specialties and the Clinical Services Plan review.	Maximise GIRFT recommendations to increase capacity to four joints per list within Orthopaedics	Gregory, Lianne	30/09/2025	Progress update to be provided at next risk review
	# Widespread adoption of national best practice guidance to improve elective optimisation and utilisation of available operating capacity	Insourcing theatre staffing within GGH theatres for four lists ENT, and two lists Ophthalmology to commence in July 2025 and to remain throughout Q2	Humphrey, Lisa	30/09/2025	Progress update to be provided at next risk review
	# Deficiencies within pre-operative assessment process and overall capacity to support required volume of Pre-Operative Assessment Clinic (POAC) assessments	Outsource tonsilectomies - 43 cases to commence in July 2025 and to remain throughout Q2	Lewis, Caroline	30/09/2025	Progress update to be provided at next risk review
		Outsource ocular plastics within Ophthalmology to commence in July 2025, and to remain throughout Q2	Coppack, Victoria	30/09/2025	Progress update to be provided at next risk review

# Elective optimisation improvement programme in place to improve theatre activity productivity and efficiency, including improvements to waiting list scheduling and pre-operative assessment processes # Productive & Effective Elective Care Improvement Plan produced to drive productivity and efficiency improvements # Planned Care Delivery Workstream established, reporting to Integrated Quality, Financial Performance Delivery (IQFPD) fortnightly, as part of revised Targeted Intervention governance arrangements. # South West Wales Regional Orthopaedic Delivery Programme established # South West Wales Regional Ophthalmology Programme # Assurance monitoring arrangements in place via mechanisms including weekly RTT Watchtower and monthly reviews with NHSE # AI based assessment tool, enhancing risk stratification of patients to be assessed by the POAC (Pre Operative Assessment Clinic) service, enabling improved management of demand and prioritisation of patients to be clinical assessed. # Additional outsource & insource solutions in place to supplement capacity in orthopaedics and ophthalmology.		Q2 recovery actions being pursued to mitigate specialty specific delivery risks in Stage 1 Care of the Elderly (COTE)	Goode, Paula	31/08/2025	Progress update to be provided at next risk review

ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls)	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance  Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed Further action necessary to address the gaps	By Who	By When	Progress
A suite of planned care metrics have been developed to measure the system performance.	Activity volumes are reported daily on situation reports	1st			Annual Plan 2025/26 Monthly performance is reported at each executive meeting, the Finance and Performance Committee and WG IPQD. Various Theatre papers have been to Board for discussion.	None				
	Daily performance data overseen by service management	1st								
	Delivery Plans overseen by Acute Services Triumvirate	1st								
	Bi-monthly reports to SDODC on progress on delivery plans and outcomes (and to Board via update report)	2nd								
	IPAR Performance Report to SDODC & Board	2nd								
	Welsh Government IQFPD & Enhanced Monitoring Meetings	3rd								

Risk Ref	Clinical Care Group / Executive Function	Clinical Service Group / Executive Function Service	Clinical Service Sub-Group / Executive Function Service	Executive Director	Clinical Care Group Director / Executive Function Lead	Clinical Service Group Lead / Executive Function Service Lead	Clinical Service Sub-Group Lead / Executive Function Service Lead	Date risk identified	Risk Statement	Existing Control Measures Currently in Place	Domain	Current Likelihood	Current Impact	Current Risk Score	Rationale for Current Risk Score	Additional Risk Action Required	By Whom	By When	Progress Update on Risk Actions	Lead Committee	Target Likelihood	Target Impact	Target Risk Score (tolerable score)	Rationale for Target Risk Score	Date expected to achieve target risk score	Detailed Risk Decision	Review date
975	Estates & Facilities	Estates & Facilities	E&F: Directorate Team	Severs, James	Chiffi, Simon	Chiffi, Simon	Chiffi, Simon	01-May-20	There is a risk of that the Estates & Facilities Clinical Care Group will be unable to achieve the required financial target savings in year. This is caused by 1. Inability to identify and deliver robust and realistic recurrent savings plans. 2. Inability to manage the impact on the underlying deficit of resulting non-delivery of the recurrent savings requirement. 3. Inability to identify and implement opportunities in such a way that the financial gains are realised and an improvement trajectory is achieved. 4. Identify and manage or mitigate cost pressures that threaten the Directorates position for the year, driven by the age of the estate and continual improvements to cleaning standards requirements, additional revenue due to RAAC issues. 5. From other related inflationary factors affecting budgets (external costs). 6. Ongoing resource pressures in Facilities. 7. Wider HB financial pressures and greater scrutiny of spend. This will lead to an impact/affect on a significant long term detrimental impact on the Health Board's financial sustainability and service deliverability. Risk location, Health Board wide.	Finance Business Partners work closely with budget holders to support informed decision making and ensure that there is sufficient focus on the financial implications of operational pressures and mitigating actions. The monthly finance cycle reviews the movement in month and forecasts the remainder of the year, ensuring the Health Board has regular updates on the Directorates financial position. Monthly establishments reviews within the service to ensure pay position is understood and actions are taking promptly, supported by Finance colleagues where appropriate. Care Group meetings now established where all service leads attend to ensure more scrutiny on financial positions and discuss potential savings strategies. The establishment of the care groups with greater emphasis on financial scrutiny will help to support financial stability over time.	Finance inc. claims	4	5	20	Key drivers include RAAC, maintenance overspend and provision cost increases. Maintenance overspend will be the focus of the Monthly establishments reviews going forward. The Directorate, Finance Business Partners and other supporting functions will enhance cost analysis cost review process and put controls into place to better understand and manage costs on an ongoing basis. Nature of aging estate means that dynamic failures are happening on a week by week basis therefore increasing non pay unforeseen overspend. Increase in statutory obligations faced by the Department.	Budget holders to work closely with finance Business Control colleagues to support informed decision making and ensure that there is sufficient focus on the financial implications of operational pressures and mitigating actions	Chiffi, Simon	31/08/2024-30/11/2024 31/03/2025-30/09/2025	This is a key focus as part of new care group establishments.	Finance and Performance Committee	2	5	10	Discussed at meeting of 22nd July - SC to consider and update at next review.	31/03/2026	Treat	22-Jul-25

Risk Ref	Clinical Care Group / Executive Function	Clinical Service Group / Executive Function Service	Clinical Service Sub-Group / Executive Function Service	Executive Director	Clinical Care Group Director / Executive Function Lead	Clinical Service Group Lead / Executive Function Service Lead	Clinical Service Sub-Group Lead / Executive Function Service Lead	Date risk identified	Risk Statement	Existing Control Measures Currently in Place	Domain	Current Likelihood	Current Impact	Current Risk Score	Rationale for Current Risk Score	Additional Risk Action Required	By Whom	By When	Progress Update on Risk Actions	Lead Committee	Target Likelihood	Target Impact	Target Risk Score (tolerable score)	Rationale for Target Risk Score	Date expected to achieve target risk score	Detailed Risk Decision	Review date
1631	Operational Allied Health Professions & Health Sciences	Allied Health Professions and Health Sciences	Allied Health Professions and Health Sciences	Carruthers, Andrew	Quarrie, Sara	Quarrie, Sara	Quarrie, Sara	28-Mar-23	There is a risk of that the obligations of the Delegation of budget manager responsibilities for the 2025/26 financial year will not be achieved This is caused by Inadequate budget to meet organisational demands and increasing unit cost prices / SLA costs This will lead to an impact/affect on Clinical Governance - Non-compliance with national standards with significant risk to patients if unresolved. Multiple complaints/ independent review. Low achievement of performance/delivery requirements. Critical report. Workforce - Late delivery of key objective/ service due to lack of staff. Unsafe staffing level or competence (>1 day). Low staff morale. Poor staff attendance for mandatory/key training. Finance - Non-delivery of key objective/ Loss of >1 per cent of budget Reputational Risk location, Health Board wide.	Budget holder 1-1 meetings with finance team (monthly) Forecast meetings monthly with CCG leadership and Finance CCG led finance meeting with finance team and each budget holder (monthly) CCG FCG weekly (vacancy control admin and new roles) Formally clarifying and escalation of cost pressures to executives via iQFPDG	Finance inc. claims	4	5	20	Finance - Non-delivery of key objective/ Loss of >1 per cent of budget (5). Likelihood / Probability - 75-95% (4)	Ensure that all requests relating to additional resource expenditure or allocation by budget holders are presented to and agreed at Therapy Operational Group with management team including workforce and finance colleagues There is a financial risk associated with claims due to malpractice, failure to provide or poor care provision. All agreed claims with known financial impact to be discussed at Therapy QSEAR meeting and learning disseminated Risk of delivering our financial control total and required savings plans Risk to be redrafted with guidance from FBP to align with new CCG structure. M4 saving meetings with each HoS to identify further mitigation for cost pressures and savings. Demand and capacity service review Podiatry M5 saving meetings with each HoS to identify further mitigation for cost pressures and savings.	Reed, Lance Reed, Lance Bradburn, Jo Quarrie, Sara Quarrie, Sara Mulroy, Mike Quarrie, Sara	Completed Completed Completed Completed 30/09/2025 29/08/2025	Process established at Therapy Operational Group 18.04.23. Introduction of Financial control total process within departments and therapy operational group following Financial Control Total letter from CEO All agreed claims with known financial impact to be discussed at Therapy QSEAR meeting and learning disseminated Draft financial savings plan in place, predicated upon budget holders delivering cash releasing recurring efficiencies against existing budgets, primarily via workforce redesign Meeting to be scheduled to redraft new risk. Updated risk. 04/07/2025 - New action 11.07.2025 - M4 meetings completed. 11/07/2025 - New action 11/07 - New action	Finance and Performance Committee	3	5	15	Finance - Non-delivery of key objective/ Loss of >1 per cent of budget (5). Likelihood / Probability - 25-75% (3)	31/03/2026	Treat	11-Jul-25

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2110	Community & Integrated Medicine	Carmarthenshire Integrated System	Carmarthenshire Integrated System	Carruthers, Andrew	Skitt, Peter	Perry, Sarah	Perry, Sarah	10-Jul-25	There is a risk of of Carmarthenshire Integrated System will be unable to achieve the financial target savings for 25/26. This is caused by being unable to identify the full savings as a result of requiring significant, strategic change required across the whole Clinical Care Groups. This will lead to an impact/affect on the Health Board's overall financial position and ability to adhere to our financial plan. Health Board remaining in Targeted Intervention (TI). Risk location, Carmarthenshire.	Finance team work closely with budget holders to support informed decision making and ensure that there is sufficient focus on the financial implications of operational pressures and mitigating actions. Clinical Care Group Financial Control Group in place which scrutinises all new and replacement posts. Monthly Business and Performance meetings to review financial outturns and sign-off of the year-end Forecast, with the Finance Business Controller, focusing on mitigating actions and consequence to reduce spend. Opportunities Framework, refreshed to identify alternative ways of working that may result in cost reductions/formal savings schemes identified. Monthly financial scrutiny meetings with senior nurses in order to gain assurance over budget management and scrutinise variable pay. Variable Pay weekly scrutiny meetings and monthly Variable Pay analysis meeting chaired by the Hospital Director.	Finance inc. claims	4	5	20	Risk remains extreme due to continued use of variable pay, locum and agency use due to workforce gaps, medical recruitment and continued surge and overcrowding in some key clinical areas such as Emergency Dept (ED). The system requires time to realise and deliver the savings due to strategic, high level decisions to be made. The HEIW GGH June 2025 report highlighted additional doctors required to manage the workload and linked to risk to 2089 (risk of losing deanery doctors).	Annual plan to be revised with external scrutiny to the CCG. Communication of newly agreed rate card for Junior Doctors Complete action plan response raised from the HEIW GGH June 2025 report.	Bancroft, Stuart	31/07/2025	In progress	Finance and Performance Committee	4	4	16	The system requires time to realise and deliver the savings due to strategic, high-level decisions to be made. Whilst the system is required to realise savings it must balance this with patient safety and quality of services, and other requirements of TI. Target date of October 2025 aligned with the next Executive Improving Together Sessions (EITS).	31/10/2025	Treat	10-Jul-25

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2107	Operational Allied Health Professions & Health Sciences	AHP&HS: Physiotherapy	AHP&HS: Physiotherapy	Carruthers, Andrew	Quarrie, Sara	Davies, John	Davies, John	09-Jul-25	There is a risk of There is a risk of physiotherapy budget overspend. This is estimated to be £100,000 per year which constitutes on call availability payments , hours worked, travel claims. This is caused by This is caused by the unfunded service delivery of four Emergency respiratory on call services at all 4 DGH sites. This will lead to an impact/affect on This could lead to insufficient financial recovery or if no funding is sourced. There is likely to be reduction in waiting times recovery in planned care msk, paediatrics, lymphoedema and community services, if Mon-Fri core budget is utilised to fund out of hours emergency services. Risk location, Health Board wide.	on call costs are minimised through the development of highly skilled staff second on call rotas are only implemented when workload is exceptional and this is approved by senior physiotherapy managers. on call claims are scrutinised by respiratory and service leads. trends in inappropriate call outs are identified and wards / individuals are educated on appropriate inclusion criteria for the service. twilight shifts are in place in GGH to reduce call out rates as staff are on site in the early evening. work undertaken is now only urgent respiratory work that cannot be left until the next working day. work is underway to explore merging rotas in Carmarthenshire which may reduce costs slightly.	Finance inc. claims	4	4	16	Physiotherapy is currently overspent with an predicted end of year overspend if funding is not received to deliver on 4 on call rotas. Absorbing these costs within the budget will result in further risks to planned care capacity It is not clinically viable to withdraw on call services as this service maintains life.						Finance and Performance Committee	2	1	2	There will be no financial / clinical or quality risks for the physiotherapy service if the on-call rotas are fully funded	31/03/2026	Treat	09-Jul-25

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971	Mental Health and Learning Disabilities	Mental Health and Learning Disabilities	MHLD	Carruthers, Andrew	Carroll, Mrs Liz	Carroll, Mrs Liz	Carroll, Mrs Liz	01-May-20	There is a risk of the MH&LD Directorate failing to remain within their allocated budget over the medium term. This is caused by the inability to either: Identify and deliver robust and realistic recurrent savings plans. Manage the impact on the underlying deficit of resulting non delivery of the recurrent savings requirement. Identify and implement opportunities in such a way that the financial gains are realised and an improvement trajectory is achieved. This will lead to an impact/affect on a significant long term detrimental impact on the Health Board's financial sustainability. Risk location, Health Board wide.	Finance Business Partners work closely with budget holders to support informed decision making and ensure that there is sufficient focus on the financial implications of operational pressures and mitigating actions. There are regular financial reviews where this risk is considered, including a monthly financial review of the Directorate's in-month performance, a monthly update of our full year annual forecast and an annual update of our following year financial plan. Risk Register is a standing agenda item at BP&PAG on a bi-monthly basis. End of month meeting with Directorate Finance Business Partner, KPI meetings and individual Head of Service meetings are also forums for monitoring the position and informing and managing the forecast. Mechanism in place to draw down funding to service cost codes inline with original bids. Weekly key performance meetings in place for areas working outside of allocated budgets in collaboration with Senior Finance Business Partner. MHLD is in Escalation for Finance due to the lack of a 6.5% recurrent savings plan. Directorate are meeting weekly to progress plans. Directorate also attend Health Boards Integrated Quality Financial Performance Delivery Group (IQFPDG).	Finance inc. claims	4	4	16	As at June 2025, the Clinical Care Group are only able to provide a work in progress figure for the end of year forecast as Finance Colleagues are in the process of finalising this by 5th June 2025. Presently, this is estimated to be a Â£487,000 overspend. The Clinical Care Group will endeavour to work towards a break even position whilst also looking at further non recurrent/recurrent saving opportunities.	Leon Popham to review impact of CHC uplift reserve on position and determine treatment and risk level on an ongoing basis. To provide an update for Executive Team to clarify the budget setting process and allocation for FY 2024/25. Following Executive Director led recovery workshops on the 26th of July and the 9th of August the Directorate were tasked to consider the impact on services should variable pay be eliminated. The ask also involved service reconfiguration on this basis. Work to identify recurrent savings for 25-26 underway. First phase to be transacted by end of February 2025.	Popham, Leon Carroll, Mrs Liz Carroll, Mrs Liz Carroll, Mrs Liz Carroll, Mrs Liz	Completed Completed 31/03/2025-31/03/2026 Completed	Review undertaken as part of ongoing budget processes. While action unresolved, this will be picked up as part of the new action noted for the risk in September 2023. CHC overspend neutralised for 2024/25 allocation through £1.9M uplift relating to 2022/23 and operational driver funding remaining pressure. Directorate have undertaken to identify £2.6M of non-recurrent savings for 2024/25 for underspend in pay position, with a view of identifying recurrent saving 2025/26. The CCG continue to work with Corporate services to strengthen Nurse Bank capacity/eliminate spend. Further options being explored through international recruitment for Medical staff. Directorate joined Wales trip to India. Medical staff have reduced overspend in month 7 by £32K, No Ceredigion medical staff, Justification was sort from FCG who signed off Agency medical staff until March 2025, so remains a risk. Additional funding of £2.4m has been allocated with an associated recruitment plan. Completed	Finance and Performance Committee	1	3	3	Working towards a position where 6.5% savings are identified and to remain within budget.	31/03/2026	Treat	10-Jul-25

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1892	Operational Allied Health Professions & Health Sciences	AHP&HS: Radiology	AHP&HS: Radiology	Carruthers, Andrew	Quarrie, Sara	Roberts-Davies, Gail	Roberts-Davies, Gail	26-Jul-24	There is a risk of that Radiology will not achieve projected savings targets. This is caused by unidentified savings plans to reduce expenditure in the directorate. This will lead to an impact/affect on the Health Board's overall financial position and ability to adhere to our financial plan. Risk location, Health Board wide.	1. Monthly meetings with Head of Radiology, Site Leads and Finance Business Partner to oversee progress on saving plan workstreams 2. Introduction of 5/5 locum consultants to undertake reporting and emergency duty sessions to reduce outsourcing, via a graded approach of most costly elements of outsourcing, including out of hrs rotas to cover busiest times. 3. Scrutiny of individual budgets by finance and Head of Radiology to capture any erroneous spend 4. All vacancy proposed by sites to be approved by Head of Radiology prior to finance Trac sign off or application for FCG approval as appropriate. 5. Other cost avoidance measures, e.g. increased additional reporting sessions for HB consultants utilised in place of outsourcing at higher cost to maintain and improve quality and performance.	Finance inc. claims	4	4	16	Recurrent and non-recurrent savings were identified, however these did not achieve the 5% expected. The budget position at M12 24-25 for Radiology was Â£92k underspent (provisional figure)with savings of Â£669k achieved. As of 09/04/2025 Radiology investment in workforce has been agreed and is currently subject to case scrutiny by the Executive Team. The Allied Health Professions and Health Sciences CCG has an opening savings position of Â£3.744m to be achieved in 25-26, of this Â£873k is the opening savings target for Radiology.	To review historic charges for Powys patients attending Hywel Dda with a view to arranging an SLA and understand LTA arrangements.	Roberts-Davies, Gail	04/04/2025-31/03/2026	Due to staff availability this has not progressed at the pace intended and will now be completed by March-25. VBHC team are still working on a pricing structure which aligns with that done at other Health Boards across Wales. The VBHC team advised on the 23/12/2024 that they are awaiting information from informatics to progress the work. Informatics are making progress, however the requested information would not be available until the new year. Update from VBHC team as of 11/02/2025: We're currently working with Chris James from Data Development to move this piece of work forward, using the template from AB as a guide as theirs is tried and tested. What we have discovered is that there are some inconsistencies in the data that we hold and in what AB hold. Chris is going to make contact with Sarah Procter as he thinks that with her help, they will be able to clear up the inconsistencies so that we can move this forward. This action will form part of the savings opportunity for the 25/26 financial year and will be progressed via the new CCG structure, therefore timeline extended.	Finance and Performance Committee	3	4	12	Likelihood reduce therefore reduce in score	31/03/2026	Treat	04-Jul-25

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																To scope the feasibility of and any potential savings from changing the current on-call arrangements for Radiographers to a shift system across the four main sites.	Roberts-Davies, Gail	Completed	This is progressing but is very complex so will take longer to deliver. In line with the annual plan, the first step will be to increase the numbers of MRI and CT Radiographers and reporting Radiologists via investment to extend the working day and week to increase capacity and reduce variable pay and improve VFM. Shift systems in these areas is not possible at this time due to the low numbers of existing staff.								
																Recruit a fourth locum Radiologist to enact the proposed level of savings from reduction in outsourcing	Roberts-Davies, Gail	Completed	Action complete								

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																Explore opportunities for income from dental practices referring for OPT examinations	Roberts-Davies, Gail	04/04/2025-31/03/2026	Discussed at TI meeting August 2024 and responded to the collective submission for permission from WG on 21/1/2024. Awaiting feedback following this. Feb 2025 update- GRD has received queries from SN- due to discuss on 26/02/2025. This will be taken forward to the 25/26 financial year and progressed via the new CCG structure.								
																Review charges which constitute the historic SLA with SBUHB for Medical Physics Services to ascertain potential opportunities.	Roberts-Davies, Gail	Completed	The review ascertained that historically Radiology have been charged for Medical Physics Support to Theatre and Community Dental Services. This has been since separated out and costs past on to the respective services.								
																To review cardiac catheter consumables and ascertain if less expensive alternatives can be purchased.	Roberts-Davies, Gail	Completed	Action complete								
																Provide mitigating actions for the projected EOY overspend at Month 3 of £39.5K	Roberts-Davies, Gail	Completed	Mitigating Action was provided to the Monthly Radiology Escalation Meeting								
																To formulate savings scheme plans for the 25/26 financial year	Roberts-Davies, Gail	30/05/2025 31/10/2025	Savings plan to be reviewed in September 2025								

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1906	Community & Integrated Medicine	Pembrokeshire Integrated System	Withybush General Hospital: WGH	Carruthers, Andrew	Skitt, Peter	Andrews, Bethan	Johns, Helen	16-Aug-24	There is a risk of that the Directorate will overspend against its delegated budget and declared savings plans. This is caused by Multiple factors including: - Demand exceeding capacity on site, resulting in reliance on nursing agency to staff surge beds - Inability to decrease the numbers in Emergency Department leading to increased Registered Nursing roster filled by agency shifts - High cost Locum cover filling vacant Medical roles - Rising drugs costs, particularly biologics usage. This will lead to an impact/affect on remaining within Statutory Financial Duty in year and the inability to de-escalate from Welsh Government's Target Intervention status. Risk location, Withybush General Hospital.	Finance Business Partners work closely with budget holders to support informed decision making and ensure that there is sufficient focus on the financial implications of operational pressures and mitigating actions. Monthly finance meetings to review financial outturns and sign-off of the year-end Forecast, with the Finance Business Partner, focusing on mitigating actions and consequence to reduce spend. Opportunities Framework, refreshed to identify alternative ways of working that may result in cost reductions/formal savings schemes identified. Monthly financial scrutiny meetings with senior nurses in order to gain assurance over budget management and scrutinise variable pay. Whilst plans are in place to remove more beds (Puffin ward in August) and integrate Internationally Educated Nurses (IENs) and Newly Qualified Nurses (NQN) into the Withybush General Hospital workforce, these will not come into effect until September 2024 with the full effect in the next financial year reducing all ward nursing variable pay.	Finance inc. claims	4	4	16	June 25: Advised by finance to keep risk the same currently. July: Risk remains extreme due to continued use of variable pay, locum and agency use due to workforce gaps, medical recruitment and continued surge and overcrowding in some key clinical areas such as Emergency Dept (ED). The system requires time to realise and deliver the savings due to strategic, high level decisions to be made.	5% reduction in costs of revenue within annual plan. reduction of in patient beds by 25 since pre RAAC. Puffin ward now closed Recruitment of newly qualified nurses and international nurses. Recruitment of medical staffing to reduce reliance on locums.	Bethan Andrews,	30/09/2024 31.10.25	ongoing, on plan for the savings. completed ongoing Recruitment continues were required. recruitment continues as required to reduce reliance. Recruitment continues	Finance and Performance Committee	3	4	12	The system requires time to realise and deliver the savings due to strategic, high-level decisions to be made. Whilst the system is required to realise savings must balance this with patient safety and quality of services and other requirements of TI. Target date of October 2025 aligned with the next Executive Improving Together Sessions (EITS)	31/10/2025		29-Jul-25

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1084	Planned & Specialist Care	Cancer & Scheduled Care	Scheduled Care: General Surgery	Carruthers, Andrew	Goode, Paula	Humphrey, Lisa	Lewis, Caroline	13-Jul-20	There is a risk of to the sustainability of the surgical out of hours rota in PPH. This is caused by The elective service for USC pathway patients being moved to PPH during covid. There was no additional funding provided to support an additional on-call resident doctor and SAS Level rota at PPH. This is a cost pressure on the General Surgery cost code 0009 budget. This will lead to an impact/affect on the protected delivery of the quality elective service provided at PPH for breast, colorectal and urology patients. with a post-operative facility of an Enhanced Care Unit (ECU). This service needs to remain at PPH, due unscheduled care and theatre staffing pressures at GGH. Risk location, Prince Philip Hospital.	The service manager along with support from a locum consultant manages the rota to ensure that there is sufficient cover. The rota cover at PPH entails the below: F1 resident doctors, 8am-4pm Monday to Friday - Covered as part of the GGH F1 rota, this costs the service travelling, taxi and accommodation at PPH. Locum cover is also sourced during sickness and annual leave as is required for daily ward cover. F2/CT resident doctors, 8am-4pm Saturday, Sunday and bank holidays - Covered entirely by medical bank locums at the standard bank rate. SAS Level 8am-5pm Monday to Friday, for ward rounds and assist in theatres. This allocated as part of the GGH SAS rota this costs the service travelling, taxi and accommodation at PPH. Locum cover is also sourced during sickness and annual leave as is required for daily ward cover. SAS Level out of hours cover 5pm - 8am, Monday to Friday and 24 hrs cover at weekends and bank holidays. Covered entirely by medical bank locums at the standard bank rate. Consultant cover is provided by the GGH Surgical consultant on call.	Workforce/OD	4	3	12	The risk score has increased to reflect the pressure being felt by the GGH SAS level doctors and the difficulty in sustaining the GGH and PPH rotas by the service team and locum consultant. If cover is not sourced, there is a risk to surgery being cancelled for USC patients. The risk rating reflects the financial implications to recruiting to these posts as they are not in the service budget. It also reflects the need to sustain this service at PPH. This service is mainly used to treat patients on the cancer pathway. Moving the service back to GGH will put patients at significant risk of cancellation due to unscheduled care pressures. The service are assessing options on the impact and resourcing challenge identified as part of their delivery of this years plan.	Request agreement for 3 RMO posts to be advertised for PPH. Seek funding to make the posts permanent to ensure a sustainable elective pathway at PPH. Service under CSP programme for long term service provision. Await outcome of CSP programme. Service team and finance business partner to establish the current locum cost to consider conversion into posts. Small task and finish group to be set up to meet and discuss what a new rota to cover both sites would look like.	Lewis, Caroline	Completed	There is currently one clinical fellow in post, on a 12 month fixed term contract. This is a cost pressure on the service. This is because there is no longer a Covid cost code. The rest of the cover is provided by medical bank doctors at the locum rate as per rate card. The whole rota is a cost pressure on the service. Action completed as no escalated to exec and no funding to recruit. Await CSP developments Task and finish group established	Finance and Performance Committee	1	3	3	The target risk score will be achieved when the workforce has been sufficiently increased and funded, to provide a safe and sustainable SAS Level cover for both PPH and GGH. The alternative is to return the service as it stands in PPH, to GGH. The target risk score would only be achieved with sufficient theatre capacity and protected elective beds at GGH.	31/12/2025	Treat	17-Jul-25

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1951	Community & Integrated Medicine	Carmarthenshire Integrated System	Carmarthenshire County	Carruthers, Andrew	Skitt, Peter	Perry, Sarah	Jenkins, Angharad	31-Mar-24	There is a risk of overspend against the Specialist Palliative Care budget. This is caused by the potential withdrawal of funding from Ty Bryn Gwyn Trustees for permanent posts. Historically a decision was made that staff would be appointed 'at risk', given permanent contracts with these permanent posts being funded by Ty Bryn Gwyn Trustees (year on year funding). The posts are: 1 Specialty Doctor and 0.5 Clinical Nurse Specialist Palliative Care. This will lead to an impact/affect on the stability of the budget within specialist palliative care. It will also impact on recruitment into the team as the service will need to balance the books and this will have a negative effect upon service delivery. Risk location, Carmarthenshire.	Regular meetings are held with the Trustees to discuss what their priorities are and to inform them of the Health Board's position. Recent recruitment has converted permanent posts into fixed term in order to minimise the impact on the budget.	Finance inc. claims	3	4	12	The risk remains high because the decision-making remains with the Trustees - the Health Board has no control over this and therefore there is no assurance that funding will be secured in the future (year on year funding). As staff leave we are recruiting into temporary positions rather than permanent to reduce the risk.	To submit the business case and an SBAR outlining our work with the Trustees for Executive Team approval. Awaiting full report from finance business partner regarding current status of posts (including fixed term/secondments) so that recommendations can be made to the HoN and System GM.	Jenkins, Angharad	Completed	Closed completed. New action	Finance and Performance Committee	1	4	4	Business case cycle now in process with the trustees to review and agree funding streams and priorities on an annual basis.	29/08/2025	Treat	01-Jul-25

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2124	Planned & Specialist Care	Children, Women & Family Health	Children, Women and Family Health	Carruthers, Andrew	Goode, Paula	Owen, Tracy	Owen, Tracy	01-Apr-25	There is a risk of that 1. the Children, Women and Family Health Clinical Service Group will be unable to identify the level of recurrent savings in-year required (£3.6m) which includes under delivery of savings in 24/25. 2. further risk of CSG being overspent as due to ad-hoc variable pay. This is caused by 1. fragile services requiring service planning and wider Health Board engagement to enact service change within the financial year. 2. fragile services and workforce pressures driving spend on ad-hoc variable pay. This will lead to an impact/affect on a worsening of the overall financial position of the Health Board. Risk location, Health Board wide.	Finance Business Partner assigned to the Clinical Service Group, with weekly meetings in place with Clinical Service Group management, and ad hoc meetings as and when required 2. Weekly review of nursing and medical staff rotas 3. Regular job planning reviews 4. Weekly Operational team meetings 5. Monthly Clinical Service Group Business meetings 6. Continual onboarding of substantive locum staff in order to reduce reliance on premium locum staff and spend 6. We are reducing the O&G spend and working with Medical Sustainability project 7. Scrutiny of budget/Savings schemes via TI escalation meetings	Finance inc. claims	3	4	12	CIP tracker in place and monitored monthly for progress and shared with Clinical Care Group at the Business Planning and Performance monthly meetings. Monthly meeting take place with the Commissioning team are monitoring progress of SLA reviews.	Remodel Paediatric medical rotas at consultant and SAS levels to reduce variable pay Continue to progress CIP schemes identified with CW&FH	Davies, Nick	31/12/2025	Work in progress, required in readiness for allocate medical rostering in progress	Finance and Performance Committee	2	2	4	If all schemes are achieved then the risk will reduce however if partial schemes achieved it will improve the financial position however the full savings target will not be met for 25/26.	31/03/2026	Treat	25-Jul-25

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2065	Director of Public Health	Public Health -	Public Health: Health Improvement & Wellbeing	Gjini, Ardiana	Dainton, Joanna	Hughes, Lisa -	Hughes, Lisa -	15-Jan-25	There is a risk of Hywel Dda University Health Board will not achieve the NHS Wales performance measure of 40% of adult smokers who make a quit attempt being CO validated This is caused by •Service delivery model changes following Covid which resulted in a move to telephone support •Loss of dedicated rooms and venues for locality teams on the hospital sites •A need to train new staff commencing work after the service delivery model changes •Delay in purchase and distribution of monitors and consumables •Issues with on site storage of monitors and consumables •Increase in patients choosing telephone support over face to face meetings •Rurality issues including venue provision for low numbers and travel costs This will lead to an impact/affect	- Secured an increase in venues across the 3 counties - CO monitors supply to other HB professionals with access to vulnerable clients eg. Oxygen assessment nurses, mental health professionals, maternity and respiratory nurses - input into a national pharmacy service level agreement to enable local pharmacies to co validate with patients. All local pharmacists have been provided with CO monitors and have a dedicated practitioner to support and train as appropriate - Trained admin to encourage assessments to be booked into face to face venues rather than telephone support. Hybrid model of working	Quality/Complaints/Audit	3	4	12	There is still a possible likelihood of not achieving targets.	Scoping further community and outpatient clinics to maximise CO validating sessions	Hughes, Lisa -	Completed	Validation figure has increased from 8% - 21.2% SWOT Analysis & Action Plan developed to improve CO validation rates	Finance and Performance Committee	2	4	8	Target risk score of 8 due to likelihood score of 2 (unlikely) due to the uptake national target being 40%	31/03/2027	Treat	24-Jul-25

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									on •Reduced Productivity: Increasing face-to-face support will reduce practitioner productivity, leading to longer waiting times for appointments. •Decreased Treated Smoker Numbers: Shifting staff capacity to face-to-face CO validation and travel will reduce the number of treated smokers. •Higher Costs and Admin Time: Ensuring accessible venues across a large geographical area will increase costs and require significant administrative time for sourcing, booking, organizing payment, and covering staff sickness. •Lower Productivity at Venues: Staff at venues are less productive, and appointments are more prone to no-shows and cancellations. Weekly sessions need to be booked, leading to higher dropout rates compared to telephone support. •Additional Costs: There will be increased costs associated with room hire, travel, consumables, and additional CO monitors for staff. •Patient Choice: Vulnerable patients or those with caring responsibilities or chronic diseases may face challenges if telephone support is reduced.																				
									Risk location, Health Board wide.																				

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1488	Planned & Specialist Care	Cancer & Scheduled Care	Scheduled Care: Endoscopy	Carruthers, Andrew	Goode, Paula	Humphrey, Lisa	Edwards, Sara	26-Sep-22	There is a risk of of frequent decontamination equipment failure within the endoscopy unit, causing delays in the return of decontaminated endoscopes to front facing patients services requiring the use of flexible endos This is caused by One endoscope washer disinfecter and drying cabinet were originally installed and commissioned in 2009, and are now 13 years in service and therefore 4 years beyond the recommended life cycle of 8 years. A second endoscope washer disinfecter was added to augment capacity issues at Bronglais Hospital in 2014 and is nearing its 8 year recommended life cycle. This will lead to an impact/affect on The majority of endoscope decontamination equipment at Bronglais Hospital is now 4 years beyond its recommended life cycle of 8 years and fail on a not infrequent basis, causing delays in the return of decontaminated endoscopes to front facing patient services requiring the use of flexible endoscopes. As the equipment becomes older, it will become more problematic, and will inevitably present more significant impacts, which will have an effect on Referral to Treatment Time Performance. These equipment failures causes avoidable delays in the supply of decontaminated flexible endoscopes to	1. Regular servicing of current decontamination equipment. 2. Decontamination trained estate staff supporting daily with breakdowns and maintenance of decontamination equipment 3. Contract in place for current decontamination equipment inclusive of breakdown cover and engineer can attend hours within 48 hours	Service/Business interruption/disruption	3	4	12	Impact on service remains high risk as interruption in provision impacts on Urgent Suspected Cancer Pathway and emergency patients. Likelihood is often impacting for a 24-hour period but potentially could result in loss of service for a longer period if engineers are unable to attend or unable to source parts for repair in short timescale. Reviewed and risk updated.	Develop feasibility case for transfer of decontamination facility from the endoscopy unit to central HSDU within Bronglais. The proposed centralisation project will ensure the replacement of aging decontamination equipment to provide a more efficient turnaround of endoscopes, improving the provision of this service to endoscopy. This will ensure lists are running efficiently and ensure the patient pathway is improved. One endoscope washer disinfecter and drying cabinet were originally installed and commissioned in 2009, and are now 13 years in service and therefore 4 years beyond the recommended life cycle of 8 years. A second endoscope washer disinfecter was added to augment capacity issues at Bronglais Hospital in 2014 and is nearing its 8 year recommended life cycle.	Edwards, Sara	Completed	Feasibility case has been developed and presented to Gareth Rees and Keith Jones. Further actions to be progressed - including development of a PID document to be sent to the Board.	Finance and Performance Committee	2	4	8	Impact on service remains high risk as interruption in provision impacts on Urgent Suspected Cancer Pathway and emergency patients. Likelihood is often impacting for a 24-hour period but potentially could result in loss of service for a longer period if engineers are unable to attend or unable to source parts for repair in short timescale. The funding received nationally will address this but the plan will require 6-12months to implement at minimum.	31/03/2027	Treat	17-Jul-25
															Monthly meetings with BGH HSDU to support current arrangements whilst feasibility case is being developed.	Edwards, Sara	Completed	Monthly meetings in place.									
															SDM to get an update from HSDU service re. the outcome of the feasibility case.	Edwards, Sara	Completed	Capital bid submitted to National Decontamination Group									

Risk Ref	Clinical Care Group / Executive Function	Clinical Service Group / Executive Function Service Lead	Clinical Service Sub-Group / Executive Function Service Lead	Executive Director	Clinical Care Group Director / Executive Function Lead	Clinical Service Group Lead / Executive Function Service Lead	Clinical Service Sub-Group Lead / Executive Function Service Lead	Date risk Identified	Risk Statement	Existing Control Measures Currently in Place	Domain	Current Likelihood	Current Impact	Current Risk Score	Rationale for Current Risk Score	Additional Risk Action Required	By Whom	By When	Progress Update on Risk Actions	Lead Committee	Target Likelihood	Target Impact	Target Risk Score (tolerable score)	Rationale for Target Risk Score	Date expected to achieve target risk score	Detailed Risk Decision	Review date
									endoscopy, theatres, outpatient departments, cardiology and intensive care units, and therefore create operational difficulties for patient endoscope procedures Due to the use of Peracetic Acid within the decontamination process, there is often a strong smell of peracetic acid within the current endoscopy unit, which on occasions can be intrusive. The current air handling unit is insufficient in removing this odour. JAG accreditation was originally deferred due to this concern until actions were put in place to eliminate this smell. Should the endoscope decontamination equipment remain within the endoscopy department there is a possibility that JAG accreditation could be withdrawn. This would have an impact on junior doctors training as all endoscopy units must be JAG accredited for training. Furthermore compliance with Welsh Government recommendations would also be of concern as it is now recommended that endoscope decontamination units are centralised into HSDU departments and managed by decontamination staff.								Edwards, Sara	31/07/2026	CSP programme								
															Await decision from National Decontamination Group re: funding to transfer decontamination from the endoscopy unit to HSDU	Flear, Philip	30/03/2027	Funding approved via National Decontamination Team - Awaiting next steps from John Prendergast									

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2095	Planned & Specialist Care	Children, Women & Family Health	CW&FH: Gynaecology	Carruthers, Andrew	Goode, Paula	Owen, Tracy	Davies, Nick	16-Dec-24	There is a risk of to the delivery of gynaecological hysteroscopy services at Glangwili site. This is caused by The malfunction of the hysteroscopy camera- in a device which is out of maintenance contract / warranty and is now considered obsolete. This will lead to an impact/affect on women needing timely diagnosis of gynaecological illness to include cancer- which in turn may adversely affect patient outcomes and HB performance. Risk location, Glangwili General Hospital.	Ability to access alternate equipment from theatre services.	Safety - Patient, Staff or Public	2	4	8	Lack of access to equipment is having a negative impact on capacity for patients needing urgent hysteroscopy. Unable to prevent risk of damage to the theatre device while being transported between departments	Procurement of replacement Mediscan HD system as per quotation ref SQU328972	Davies, Nick	30/09/2025	17.6.25- Quotation received (05.3.25) and accepted by central ops team ref CO230 for capital funding consideration/ allocation	Finance and Performance Committee	1	4	4	Dedicated equipment with associated warranty and support will mitigate this risk to level 4- and the risk would subsequently be closed.	30/09/2025	Treat	17-Jun-25

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1646	Operational Allied Health Professions & Health Sciences	AHP&HS: Pathology	AHP&HS: Pathology	Carruthers, Andrew	Quarrie, Sara	Jones*, Dylan	Jones*, Dylan	24-Jan-23	There is a risk of of overspending against funding allocated for external tests. There is also a risk to the health board if funding for COVID/respiratory testing is not supported by Welsh Government funding. This is caused by increased workload sent for testing and changes in test repertoire resulting in higher costs. This will lead to an impact/affect on financial overspend. Risk location, Health Board wide.	1. Regular SLA meetings to review spend 2. Reviewed external testing sites 3. Clinical Scientist test vetting 4. Demand management in place to prevent sending duplicate samples.	Finance inc. claims	4	2	8	This remains a significant financial risk for Pathology as the increase in high cost tests (genetic/ genomic tests) and general workload growth has resulted in considerable overspend. Currently we have no firm process in place to scrutinise and agree what new tests are introduced and/or if there are changes in protocol that creates variations to test frequency and volumes. A Value Based Healthcare (VBHC) steering group is in the process of being established to review new tests and changes in protocols that may have an impact to Pathology. The group will also look at key tests that the service has identified as opportunities to either reduce unwarranted testing or may have benefits to other areas. The service is also working closely with Swansea Bay University Health Board (SBU) as part of the Regional Pathology Programme at opportunities to repatriate tests to the region so they can be performed at reduced cost.	Regional collaboration providing opportunities to repatriate tests. Review main SLAs to look at repatriating service Standardising clinical haematology processes, reducing send away tests Establish VBHC Steering Group to review demand optimisation opportunities within Pathology. Review Public Health Wales SLA CMR data. To look at test costs and volumes.	Peters, Lee	Completed	On going and linked to the ARCH Regional Solution. discussions ongoing. 05/06/2024 - update, exploring opportunities with SBU in laboratory medicine workstream. ongoing 31/05/25 - teicoplanin being reviewed to bring in house as a regional test. this is now being discussed in SBU CIG with both HD and SBU representatives FIT, MPO and PR3 testing being considered for repatriation 5.4.24 - linked to ARCH regional solution 31/1/25 - these tests are now being discussed in CIG meetings by HD and SBU representatives. Continually reviewing opportunities to standardise processes. Looking at subspecialising the service in the future. 30/1/24 - reviewed send away tests. haemoglobinopathy being reviewed to bring house 5.4.24 - new managed service now in place Steering group established and workstreams identified to progress demand optimisation work. 5.4.24 - ongoing. SLAs being scrutinised to check they deliver value for HB etc. Several tests have been challenged.	Finance and Performance Committee	4	2	8	The risk has been mitigated a far as it can within the means of the Pathology service. There are no further actions possible at this time. Monthly SLA reviews are no in place and the service is now challenging areas where there is potential overspend. It has been proposed that this risk remains open, but with a tolerated score of 8.	23/04/2025	Treat	24-Jul-25

Inspection Title	Recommendation	Action	Clinical Care Group/Executive Function	Lead Director	Original Due Date	Current Due Date	Barriers
Peer Review - Getting It Right First Time (GIRFT) - Emergency Medicine June 2024	R1. (BGH) The long waits for admission from the ED are undoubtedly causing harm to patients and should be the main focus of any improvement work.	Work to improve hospital flow (as also identified in NHS Exec and 6 goals actions) is underway and has been factored into performance trajectories currently awaiting Executive sign off.	Community & Integrated Medicine	Chief Operating Officer	28/02/2025	28/02/2025	Fragmented care pathways and lack of community capacity. Estate - ageing infrastructure and lack of physical capacity in BGH Undeveloped digital systems Inadequate workforce - delayed decision making, inefficiencies, delayed diagnostics Financial barriers, Ceredigion is currently 509K over Month 2
Peer Review - Getting It Right First Time (GIRFT) - Emergency Medicine June 2024	R1. (BGH) The long waits for admission from the ED are undoubtedly causing harm to patients and should be the main focus of any improvement work.	Revision of nurse staffing position underway to support dedicated triage and ambulance bay nurses to enhance care offered at times of handover delay/ support handover into RATS area- paper for Exec Team currently being prepared (06/03/25)	Community & Integrated Medicine	Chief Operating Officer	31/03/2025	31/03/2025	
Peer Review - Getting It Right First Time (GIRFT) - Emergency Medicine June 2024	R2. (BGH) The delays in ambulance to ED handovers of patients impair the response times for emergency ambulances and thus also cause harm to patients	Work to introduce a discharge lounge has now been proposed for 2025/26 with a view to supporting up to 6 patients per day who currently would be delayed on wards – this will have a positive impact on flow.	Community & Integrated Medicine	Chief Operating Officer	28/02/2025	31/07/2025	
Peer Review - Getting It Right First Time (GIRFT) - Emergency Medicine June 2024	R2. (BGH) The delays in ambulance to ED handovers of patients impair the response times for emergency ambulances and thus also cause harm to patients	A review of hospital flow (to include re-allocation of ward spaces) is due in 2025/26 to minimise bed clocking within the trauma / surgical pathway beds- which will improve emergency pathway access.	Community & Integrated Medicine	Chief Operating Officer	28/02/2025	28/02/2025	If funding is not released this will delay things further.
Peer Review - Getting It Right First Time (GIRFT) - Emergency Medicine June 2024	R4. (BGH) The lack of ED senior medical staff must be addressed. However, the future viability of the department may require a different model in the long-term	Consultant lead currently employed on a locum basis (only 1 wte). This is currently subject to recruitment to substantiate the post.	Community & Integrated Medicine	Chief Operating Officer	28/02/2025	28/02/2025	
Peer Review - Getting It Right First Time (GIRFT) - Emergency Medicine June 2024	R4. (BGH) The lack of ED senior medical staff must be addressed. However, the future viability of the department may require a different model in the long-term	Interim County Director has instigated a review of ED staffing models in March 2025 with a view to generating a proposal to increase consultant cover.	Community & Integrated Medicine	Chief Operating Officer	31/03/2025	31/03/2025	
Peer Review - Getting It Right First Time (GIRFT) - Emergency Medicine June 2024	R5. (BGH) The high catchment attendance level suggests that there are poor alternatives to ED attendance in the local area, probably including primary care	There is no significant local health provision with the exception of primary care services and the 111 system along with community nursing teams. In the south of the county, a Same Day Urgent Care (SDUC) facility has been introduced. The ambition is to launch a phased SDUC model from Aberaeron ICC- which will have a positive benefit/ reduction in ED attendances, and this has been considered in planning and trajectory assumptions for the 2025/6 financial year. Ceredigion is currently supported by a streaming hub- in line with the SDUC expansion, development of a HB wide streaming facility will improve patient flow by signposting to more appropriate resources. Decision making on a HB basis will ensure consistency in approach to advice offered to patients following clinical assessment of need.	Community & Integrated Medicine	Chief Operating Officer	28/02/2025	28/02/2025	
Peer Review - Getting It Right First Time (GIRFT) - Emergency Medicine June 2024	R8. (BGH) There are no housekeepers, dedicated porters or several other non-clinical roles in the ED. With a relative shortage of nursing and other clinical staff, it makes no sense not to have a wide range of supporting non-clinical staff.	2 dedicated domestic assistants currently deployed within dept. Budgetary constraints prevent dedicated porter and housekeeper appointments. Review of nurse staffing position is a priority in terms of any financial considerations at this time	Community & Integrated Medicine	Chief Operating Officer	31/03/2025	31/03/2025	

Inspection Title	Recommendation	Action	Clinical Care Group/Executive Function	Lead Director	Original Due Date	Current Due Date	Barriers
Peer Review - Getting It Right First Time (GIRFT) - Emergency Medicine June 2024	R11. (BGH) Patients with strokes get a very timely and efficient service at Bronglais Hospital. It seems a great shame that plans are now in place to move these patients south to Withybush Hospital for their rehabilitation. This will undoubtedly cause inconvenience to many elderly relatives.	The clinical services plan for HDUHB stroke services is currently out to public consultation. While options are being finalised, and there are no currently preferred solutions	Community & Integrated Medicine	Chief Operating Officer	28/02/2025	28/02/2025	
Peer Review - Getting It Right First Time (GIRFT) - Emergency Medicine June 2024	R17. (WGH) The lack of ED senior medical staff must be addressed	Review of medical workforce required Need Healthboard collaboration	Community & Integrated Medicine	Chief Operating Officer	28/02/2025	28/02/2025	
Peer Review - Getting It Right First Time (GIRFT) - Emergency Medicine June 2024	R18. (WGH) The relatively high number of hospital admissions per WTE consultant (all health board consultants) suggests that there is an insufficient senior medical workforce to “power” the hospital beds in a timely and efficient way that ensures good patient flow.	Review of medical workforce required Need Healthboard collaboration	Community & Integrated Medicine	Chief Operating Officer	28/02/2025	28/02/2025	
Peer Review - Getting It Right First Time (GIRFT) - Emergency Medicine June 2024	R24. (GGH) The ED is small and cramped and desperately needs more space, if it is to accommodate large numbers of patients waiting for a hospital bed. However, better patient outflow from the ED is obviously required. The current situation is clearly causing increased risk and harm to patients and is distressing for staff.	Review of ED space completed. Limited capacity within existing footprint. Exploring alternative space within Medical Day (Podiatry) to support increased medical take away from ED. Front Door T&F Group implemented with alternative options being explored.	Community & Integrated Medicine	Chief Operating Officer	31/05/2025	30/05/2025	Capital Funding (WG)
Peer Review - Getting It Right First Time (GIRFT) - Emergency Medicine June 2024	R24. (GGH) The ED is small and cramped and desperately needs more space, if it is to accommodate large numbers of patients waiting for a hospital bed. However, better patient outflow from the ED is obviously required. The current situation is clearly causing increased risk and harm to patients and is distressing for staff.	Review of current GGH space (ED/CDU/MDU and external environment) to explore additionality/re-purpose of space to support and reduce impact at front door (ED).	Community & Integrated Medicine	Chief Operating Officer	16/05/2025	16/05/2025	Workforce challenges/culture/resistant to change/ environmental factors/ equipment.
Peer Review - Getting It Right First Time (GIRFT) - Emergency Medicine June 2024	R25. (GGH) The ED is used by the hospital as a general waiting room for all specialties and input to the ED by inpatient specialists is poor. The implementation of Internal professional standards is urgently required.	Speciality Pathway Reviews underway. Surgical SDEC (Phase 1 Complete). Pilot of Trauma Ambulatory Care Unit underway. Review of Urology, ENT & Gynae Pathways. Internal Professional Standards have been disseminated by Deputy Medical Director. Formal monitoring arrangements to be agreed. Deputy Medical Director currently aligning speciality specific pathways from ED in line with professional standards.	Community & Integrated Medicine	Chief Operating Officer	31/05/2025	31/05/2025	

Inspection Title	Recommendation	Action	Clinical Care Group/Executive Function	Lead Director	Original Due Date	Current Due Date	Barriers
Peer Review - Getting It Right First Time (GIRFT) - Emergency Medicine June 2024	R27. (GGH) Ambulances wait outside the ED for long periods.	Boarding protocol implemented with patients boarded against predicted discharges. Safety Huddles, Patient Flow review. Emergency Pressures and Escalation Policy (489) Role of the Senior Nurse Manager, Clinical Site Manager and 'Manager of the Day' strengthened, supporting key escalation of actions, status and risk. Optimal Flow Framework implementation: - ~~I~~ OS Reviews & Escalation process review - ~~B~~ oard round monitoring & Frontier usage - ~~C~~ riteria Led Discharge - ~~R~~ epatriation Database - ~~P~~ OCD monitoring Initiatives to facilitate admission avoidance: - ~~S~~ treaming Hub - ~~V~~ irtual Ward - ~~R~~ e-direction Policy (Draft) - ~~P~~ erfect week (Jan 25) completed with some initiatives adopted as business as usual (GP medical take via SDEC). - ~~O~~ ptimised Weekend working Pilot planned (22/23 March). Weekly Big Room Advertising for a 6th Acute Physician to enable SDEC, CDU and Medical Liaison in ED rotation to provide sufficient medical cover across the front door. Recruitment process instigated.	Community & Integrated Medicine	Chief Operating Officer	30/06/2025	30/06/2025	
Peer Review - Getting It Right First Time (GIRFT) - Emergency Medicine June 2024	R28. (GGH) The departmental configuration makes imaging difficult to access in a timely way. However, the suspected cauda equina syndrome (CES) pathway is good	Review completed and ED & SDEC radiology request prioritisation agreed – requires further measurement of data to determine impact. OOH Cauda Equina pathway review being undertaken.	Community & Integrated Medicine	Chief Operating Officer	31/05/2025	31/05/2025	
Peer Review - Getting It Right First Time (GIRFT) - Emergency Medicine June 2024	R29. (GGH) Training opportunities are poor.	ED Big Room. Training Needs Analysis underway ED Practice Educator in place. Weekly Roster efficiency monitoring – monitoring of Study Leave compliance.	Community & Integrated Medicine	Chief Operating Officer	31/05/2025	31/05/2025	
Peer Review - Getting It Right First Time (GIRFT) - Emergency Medicine June 2024	R31. (GGH) SDEC will take GP referrals (and some ambulance referrals) directly but closes at 8pm and only accepts new patients up to 5pm. There is a poor flow of patients to SDEC from the ED.	Change in pathway for medical referrals from GP to GGH SDEC (embedded since perfect week). SOP being updated. Optimised Weekend working Pilot planned (22/23 March) will include SDEC	Community & Integrated Medicine	Chief Operating Officer	30/06/2025	30/06/2025	
Peer Review - Getting It Right First Time (GIRFT) - Emergency Medicine June 2024	R32. (GGH) The co-located MIU is ENP-led, with patients streamed from the ED reception. The out-of hours primary care centre will not accept patients from the ED	OOH's primary will accept patients as per re-direction policy – pending sign off.	Community & Integrated Medicine	Chief Operating Officer	31/05/2025	31/05/2025	
Peer Review - Getting It Right First Time (GIRFT) - Emergency Medicine June 2024	R33. (GGH) The shortage of senior medical staff and registered nurses must be addressed.	ED Consultant Recruitment – process underway. Safe Staffing Review (RN) has been progressed over last 18 months with key recruitment. Further reviews planned (B2/B3)	Community & Integrated Medicine	Chief Operating Officer	30/06/2025	30/06/2025	

Inspection Title	Recommendation	Action	Clinical Care Group/Executive Function	Lead Director	Original Due Date	Current Due Date	Barriers
Peer Review - Getting It Right First Time (GIRFT) - Emergency Medicine June 2024	R35. (GGH) Data quality must be improved.	ED Breach Validation assurance in progress. Review data quality and validity.	Community & Integrated Medicine	Chief Operating Officer	31/05/2025	31/05/2025	
Peer Review - Getting It Right First Time (GIRFT) - Urology Review	R17. Addressing the waiting time for men with lower urinary tract symptoms should be a priority for the Health Board. This is an area where networking between Health Boards is also vital as HDUHB could lead on this initiative and support neighboring cancer centres with a movement of benign work. Investment is require to increase the number of surgical modalities that are available for men requiring BOO surgery. Nurse-led, one-stop assessment is part of an exemplar model and this will require investment in staff.	Prioritise waiting times for men with lower urinary tract symptoms	Planned & Specialist Care	Chief Operating Officer	31/12/2024	31/12/2024	
Peer Review - Getting It Right First Time (GIRFT) - Urology Review	R20. There needs to be clear protocols in place for the common urological emergencies. As a minimum, these should include pathways for urosepsis, hematuria, acute ureteric colic, urinary retention and epididymo-orchitis.	Develop clear protocols in place for the common urological emergencies.	Planned & Specialist Care	Chief Operating Officer	31/12/2024	31/12/2024	
Peer Review - Getting It Right First Time (GIRFT) - Urology Review	R26. Swansea Robotic Surgery. The HDUHB team should be involved in decision-making regarding the future model for provision of robotically-assisted surgery. Consideration should be given to the workforce requirements and whether there are joint opportunities to train and or appoint surgical staff.	(EXTERNAL) HDUHB team to be involved in decision-making regarding the future model for provision of robotically-assisted surgery.	Planned & Specialist Care	Chief Operating Officer	31/12/2024	31/12/2024	
Peer Review (external review) of Hywel Dda University Health Board (HDUHB) of care delivery to people with epilepsy and learning disability	As part of understanding of the challenges within the service, a multi-stakeholder survey was conducted which has yet to be analysed. There were 37 replies in the first round and three in the second round. The results of these will form a baseline on the current understanding and expectations of the service. These could be presented to all stakeholders including experts by experience. To use the results of the survey to empower workshops involving all stakeholders including experts by experience to discuss meaningful change. The same survey i.e., the Purple Light Toolkit could be rolled out in another 12-18 months' time to understand how things have changed locally in the community and what are the critical gaps remaining. (Medium term plan (6 months to a year))	To liaise with research and development colleagues to establish the stakeholder's current understanding and expectations of the service.	Mental Health and Learning Disabilities	Chief Operating Officer	29/03/2024	29/03/2024	

Inspection Title	Recommendation	Action	Clinical Care Group/Executive Function	Lead Director	Original Due Date	Current Due Date	Barriers
Peer Review Getting It Right First Time (GIRFT) - Gynaecology Review - September 2022	HDUHB to establish a robust mechanism for capturing procedure level data of in-patient, day case and out-patient (ambulatory) procedures in gynaecology. HDUHB should also develop a mechanism to capture diagnostic procedure coded operations of emergency Surgery (management of ovarian cysts, miscarriage/ectopic pregnancy and sepsis requiring surgery). This will be a recommendation in our all Wales Report.	Awaiting management response from service	Planned & Specialist Care	Chief Operating Officer	30/09/2022	30/09/2022	
Peer Review Getting It Right First Time (GIRFT) - Gynaecology Review - September 2022	HDUHB to develop a relationship between clinical coders and consultants to improve data capture. HDUHB also to consider arranging regular meetings to review a sample of operation notes and develop an improvement strategy.	Awaiting management response from service	Planned & Specialist Care	Chief Operating Officer	30/09/2022	30/09/2022	
Peer Review Getting It Right First Time (GIRFT) - Gynaecology Review - September 2022	HDUHB to encourage the development of minimal access and vaginal surgery for benign and malignant conditions where appropriate and open abdominal surgery for a decreasing proportion with the emphasis on reducing length of stay for gynaecological inpatients along the lines of the BADS targets and the GIRFT “top decile” performance. This should include post-operative catheterisation.	Awaiting management response from service	Planned & Specialist Care	Chief Operating Officer	30/09/2022	30/09/2022	
Peer Review Getting It Right First Time (GIRFT) - Gynaecology Review - September 2022	. HDUHB to review consultant job plans to facilitate two consultant operating for situations where there may be a skills gap and or significant risk of surgical complications to improve surgical confidence and the learning of techniques such as minimal access surgery	Action is complete	Planned & Specialist Care	Chief Operating Officer	30/09/2022	30/09/2022	
Peer Review Getting It Right First Time (GIRFT) - Gynaecology Review - September 2022	HDUHB to undertake a review of the therapeutic pathway of early pregnancy complications in order to improve timely management of care. The availability of staff able to perform ultrasound scanning to be included in this review.	Awaiting management response from service	Planned & Specialist Care	Chief Operating Officer	30/09/2022	30/09/2022	
Peer Review Getting It Right First Time (GIRFT) - Gynaecology Review - September 2022	HDUHB to undertake a review of emergency readmission within 30 days for patients (less than 50 years) receiving hysterectomy for benign condition readmission rates especially at WGH and develop an improvement strategy.	Action is complete	Planned & Specialist Care	Chief Operating Officer	30/09/2022	30/09/2022	

1.7

9:55 AM, 0 Mins

1.7 - FINANCE AND PERFORMANCE COMMITTEE TERMS OF REFERENCE

***Michael Imperato
(Hywel Dda UHB -
Independent Board
Member)***

| For approval

Attachments

[Terms of Reference FPC 26 August 2025.pdf](#)

[Appendix 1 Finance and Performance Committee Terms of Reference V3.pdf](#)



**PWYLLGOR CYLLID A PHERFFORMIAD
FINANCE AND PERFORMANCE COMMITTEE**

DYDDIAD Y CYFARFOD: DATE OF MEETING:	28 August 2025
TEITL YR ADRODDIAD: TITLE OF REPORT:	Finance and Performance Committee Terms of Reference
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Huw Thomas, Executive Director of Finance
SWYDDOG ADRODD: REPORTING OFFICER:	Joanne Wilson, Director of Corporate Governance/Board Secretary Charlotte Wilmshurst, Assistant Director of Assurance and Risk

Pwrpas yr Adroddiad (dewiswch fel yn addas)

Purpose of the Report (select as appropriate)

Ar Gyfer Penderfyniad/For Decision

**ADRODDIAD SCAA
SBAR REPORT**

Sefyllfa / Situation

The purpose of this paper is to ensure that the new Finance and Performance Committee has clear terms of reference which detail its purpose, boundaries, role, composition and operating arrangements.

Cefndir / Background

According to its terms of reference, the Committee must review its terms of reference and operating arrangements on at least an annual basis to ensure they remain fit for purpose. These must be subsequently approved by the Board and will form part of the Health Board's Standing Orders.

Asesiad / Assessment

The Committee last reviewed its terms of reference and operating arrangements in April 2025, and these were subsequently approved by the Board, on 31 July 2025. The Finance and Performance Committee Terms of Reference and operating arrangements (**Appendix 1**) have been reviewed since Board approval on 31 July 2025, and one minor change and amendment to terms has been made. This is clearly marked on Appendix 1 and relates to the following:

Section	What has changed?	Why?
3.1.22	Operational Responsibilities - Section added.	To align with standard wording used across all Committee Terms of Reference, ensuring consistency, as follows: "Approve relevant corporate

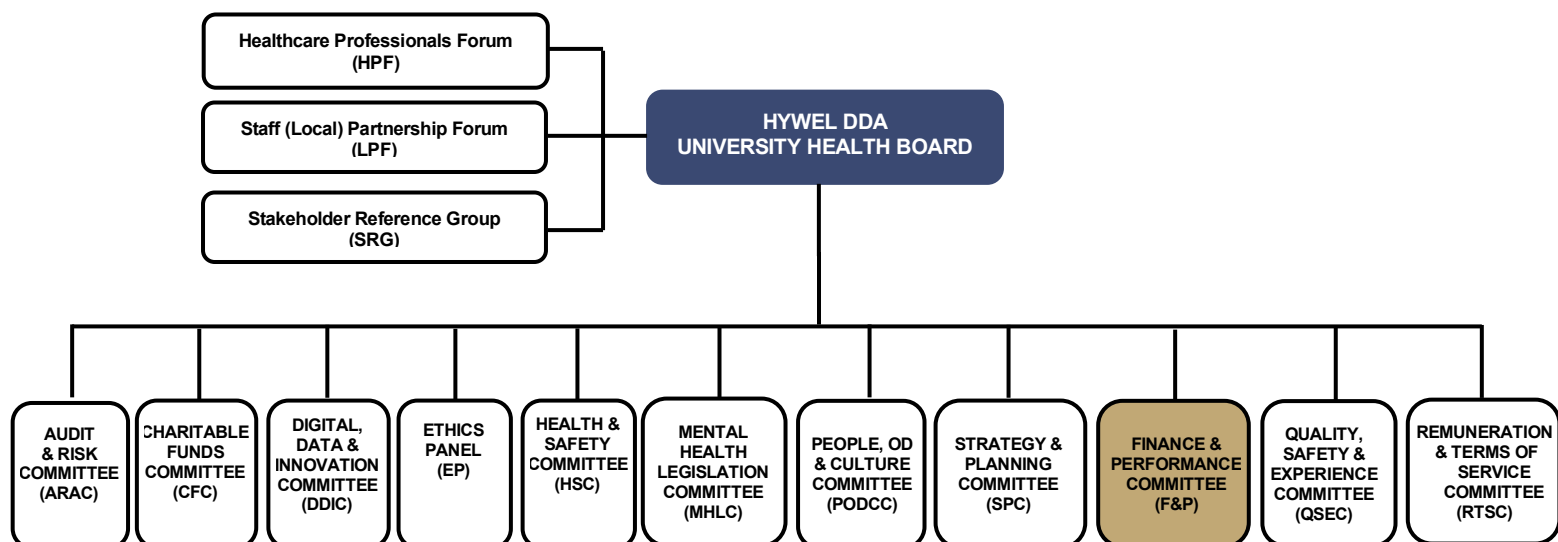
		<i>policies and plans within the scope of the Committee”.</i>
<u>Argymhelliad / Recommendation</u>		
The Finance and Performance Committee are asked to APPROVE the Finance and Performance Committee's Terms of Reference (version 3) for onward ratification by the Board on 25 September 2025.		

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	12.1 These terms of reference and operating arrangements shall be reviewed on at least an annual basis by the Committee for approval by the Board.
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)	Not Applicable
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	1. Leadership
Amcanion Strategol y BIP: UHB Strategic Objectives:	Not Applicable
Amcanion Cynllunio Planning Objectives	Not Applicable
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022	10. Not Applicable

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Standing Orders
Rhestr Termiau: Glossary of Terms:	Contained within the body of the report

Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Cyllid a Pherfformiad Parties / Committees consulted prior to Finance and Performance Committee:	Director of Corporate Governance/Board Secretary Executive Director of Finance

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	No direct impacts
Ansawdd / Gofal Claf: Quality / Patient Care:	Not Applicable
Gweithlu: Workforce:	Not Applicable
Risg: Risk:	Not Applicable
Cyfreithiol: Legal:	Not Applicable
Enw Da: Reputational:	Not Applicable
Gyfrinachedd: Privacy:	Not Applicable
Cydraddoldeb: Equality:	Not Applicable



TERMS OF REFERENCE

FINANCE AND PERFORMANCE COMMITTEE

Version	Issued to:	Date	Comments
V1	Board	30/01/2025	Approved
V2	Finance and Performance Committee	29/04/2025	Approved
V2	Board	31/07/2025	Approved
V3	Finance and Performance Committee	28/08/2025	For approval

FINANCE AND PERFORMANCE COMMITTEE

1. Constitution

- 1.1 The Finance and Performance Committee (the Committee) was established as a Committee of the Hywel Dda University Local Health Board (the Health Board) and constituted from 1 April 2025.

2. Principal Duties

- 2.1 The purpose of the Finance and Performance Committee is to provide *advice* and *assurance* to the Board on the following:
- 2.1.1 The financial performance and delivery against Health Board financial plans and objectives and
- give early warning of potential performance issues,
 - make recommendations for action to continuously improve the financial position of the organisation,
 - focus on the financial impact of in-year and medium-long term plans, the impact of financial issues on service delivery, quality and patient experience, and any specific issues where financial performance is showing deterioration or there are areas of concern.
- 2.1.2 The overall performance and delivery against Health Board plans and objectives, including delivery of key targets, giving early warning on potential performance issues and making recommendations for action to continuously improve the performance of the organisation and, as required focus on specific issues where performance is showing deterioration or there are issues of concern.

3. Operational Responsibilities

- 3.1 The Committee will, in respect of its provision of advice and assurance to the Board:
- 3.1.1 Receive assurances on the financial governance and control environment in operation across the Health Board. This will be achieved a programme of deep dive reviews into the following themes, which mirror the national Value and Sustainability Board:
- 3.1.1.1 Workforce
 - 3.1.1.2 Non-pay and procurement
 - 3.1.1.3 Medicines value and sustainability
 - 3.1.1.4 Commissioned care
 - 3.1.1.5 Clinical variation and service configuration
- 3.1.2 Receive an understanding of the existing deficit and key drivers. This will be achieved through scrutiny of an annually refreshed report on the drivers of the deficit.

- 3.1.3 Receive assurance on the development and realisation of opportunities. This will be achieved through scrutiny of the bi-monthly savings and opportunities report to the Committee.
- 3.1.4 Receive assurance on the development of a clear financial strategic plan. This will be achieved through scrutiny of a medium term financial recovery plan which demonstrates clear alignment into the in-year financial plan.
- 3.1.5 Receive assurance on the delivery of the financial plan. This will be achieved through scrutiny of the monthly finance report. This report shall ensure clarity in:
 - 3.1.5.1 The reporting of monthly, year to date and forecast financial position alongside operational drivers;
 - 3.1.5.2 Performance against the savings requirement;
 - 3.1.5.3 Performance against other financial metrics, such as cash management, capital management and Public Sector Payment Policy.
- 3.1.6 Seek assurance that financial systems are robustly embedded.
- 3.1.7 Maintain oversight of, and obtain assurances on, key financial risks. This includes risks against the delivery of Health Board financial targets, the robustness of key income sources and contractual safeguards.
- 3.1.8 Receive assurance on the delivery against the areas of targeted intervention (Appendix 1), and the required elements for de-escalation, that are aligned to the Committee.
- 3.1.9 Conduct detailed scrutiny of all aspects of financial performance, the financial implications of significant revenue expenditure (all those over £1million requiring Board approval), business cases (except those that are capital and digital in nature), projects, and proposed investment decisions on behalf of the Board.
- 3.1.10 Scrutinise major procurements plans and tenders, and provide assurance to the Board as part of its approval process.
- 3.1.11 Commission regular reviews of key contracts, suppliers and partners to ensure they continue to deliver value for money.
- 3.1.12 Seek assurance on the reporting and monitoring of contracts with providers such as Swansea Bay and Cardiff and Vale, focusing on financial performance, over and under performance, and providing regular financial updates.
- 3.1.13 Review any investment/ disinvestment strategy, including Procurement and Contracting Strategy, maintaining oversight of the investments and disinvestments, ensuring compliance with policies by:
 - 3.1.13.1 Establishing the overall methodology, processes and controls which govern investments and disinvestments, including the prioritisation of decisions;
 - 3.1.13.2 Ensuring that robust processes are followed; and

3.1.13.3 Evaluating, scrutinising and monitoring subsequent investments/disinvestments.

- 3.1.14 Subject to the Board's direction and approval, develop and regularly review the performance management framework and reporting approach, ensuring that it includes meaningful, appropriate, integrated and timely performance data and clear commentary relating to the totality of the services for which the Board is responsible.
- 3.1.15 Seek assurance on the development and implementation of a comprehensive approach to performance delivery and quality management, to incorporate all performance requirements set by the Board, WG, regulators and inspectors, that enables all staff with managerial responsibility to strive for excellence whilst effectively delivering the basics.
- 3.1.16 Scrutinise the performance reports (including those related to external providers) prepared for submission to the Board, ensure exception reports are provided where performance is off track, and undertake deep dives into areas of performance as directed by the Board to seek assurance that appropriate action is being taken when performance against set targets deteriorates, and to support and promote continuous improvement in service delivery.
- 3.1.17 Seek assurance on delivery against all Planning Objectives (Appendix 2) aligned to the Committee in accordance with the Board approved timescales, as set out in the Health Board's Annual Plan, considering and scrutinising the plans, including the medium term financial plans, and savings plans, that are developed and implemented, supporting and endorsing these as appropriate.
- 3.1.18 Seek assurances on the requirements arising from the Health Board's regulators, Welsh Government and professional bodies.
- 3.1.19 Seek assurance that the management of risks within the Corporate Risk Register (CRR) and Directorate Risk Registers (including for hosted services and through partnerships and Joint Committees as appropriate) aligned to the Committee and its sub-committees, and report any areas of significant concern e.g. where risk tolerance is exceeded, lack of timely action. Where risks cannot be brought within the Health Board's risk appetite/tolerance, recommend acceptance of risks to the Board.
- 3.1.20 Receive assurance through Sub-Committee Update Reports and other management/task & finish group reports that risks relating to their areas are being effectively managed across the whole of the Health Board's activities (including for hosted services and through partnerships and Joint Committees as appropriate).
- 3.1.21 Review and approve financial procedures on behalf of the Health Board.
- 3.1.22 Approve relevant corporate policies and plans within the scope of the Committee.

3.1.23 Review and approve the annual work plans for any Sub-Committee which has delegated responsibility from the Finance and Performance Committee and oversee delivery.

4. Membership

4.1 The membership of the Committee shall comprise:

Member
Independent Member (Chair)
Independent Member (Vice-Chair)
3 x Independent Members

4.2 The following should attend Committee meetings:

In Attendance
Executive Director of Finance
A Clinical Executive Director
Chief Operating Officer
Director of Primary Care, Community & Long Term Care
Other Lead Executives to be invited to attend for relevant Planning Objectives aligned to the Committee or relevant agenda items.

4.3 The membership of the Committee will be reviewed on an annual basis.

5. Quorum and Attendance

- 5.1 A quorum shall consist of no less than two of the membership and must include as a minimum the Chair or Vice Chair of the Committee, and one other Independent Member(s), together with the Director of Finance, or deputy, and a Clinical Executive Director and a Chief Operating Officer or deputy.
- 5.2 The membership of the Committee shall be determined by the Board, based on the recommendation of the Health Board – taking into account the balance of skills and expertise necessary to deliver the Committee's remit and subject to any specific requirements or directions made by the Welsh Government.
- 5.3 Any senior officer of the Health Board or from a partner organisation may, where appropriate, be invited to attend, for either all or part of a meeting to assist with discussions on a particular matter.
- 5.4 The Committee may also co-opt additional independent external 'experts' from outside the organisation to provide specialist skills.
- 5.5 Should any officer Member be unavailable to attend, they may nominate a deputy, with full voting rights, to attend in their place subject to the agreement of the Chair.

- 5.6 The Chairman of the Health Board reserves the right to attend any of the Committee's meetings as an ex officio member.
- 5.7 The Head of Internal Audit shall have unrestricted and confidential access to the Chair of the Committee.
- 5.8 The Chair of the Committee shall have reasonable access to Executive Directors and other relevant senior staff.
- 5.9 The Committee may ask any or all of those who normally attend but who are not Members to withdraw to facilitate open and frank discussion of particular matters.

6. Agenda and Papers

- 6.1 The Committee Secretary is to hold an agenda setting meeting with the Chair and the Lead Director (Executive Director of Finance) at least **six** weeks before the meeting date.
- 6.2 The agenda will be based around the Committee work plan, identified risks matters arising from previous meetings, issues emerging throughout the year and requests from Committee Members. Following approval, the agenda and timetable for request of papers will be circulated to Committee Members.
- 6.3 All papers must be approved by the relevant Lead Director.
- 6.4 The agenda and papers for meetings will be distributed **seven** days in advance of the meeting.
- 6.5 A draft Table of Actions will be issued within **two** days of the meeting. The minutes and Table of Actions action log will be circulated to the Lead Director within **seven** days to check the accuracy, prior to sending to Members (including the Committee Chair) to review within the next **seven** days.
- 6.6 Members must forward amendments to the Committee Secretary within the next seven calendar days. The Committee Secretary will then forward the final version to the Committee Chair for approval.

7. In Committee

- 7.1 The Committee can operate with an In Committee function to receive updates on the management of sensitive and/or confidential information.

8. Frequency of Meetings

- 8.1 The Committee will meet bi-monthly and shall agree an annual schedule of meetings. Additional meetings will be arranged as determined by the Chair of the Committee in discussion with the Lead Executive.

- 8.2 The Chair of the Committee, in discussion with the Committee Secretary, shall determine the time and the place of meetings of the Committee and procedures of such meetings.

9. Accountability, Responsibility and Authority

- 9.1 Although the Board has delegated authority to the Committee for the exercise of certain functions as set out within these terms of reference, it retains overall responsibility for ensuring the quality and safety of healthcare for its citizens through the effective governance of the organisation.
- 9.2 The Committee is directly accountable to the Board for its performance in exercising the functions set out in these terms of reference.
- 9.3 The Committee shall embed the Health Board's vision, corporate standards, priorities and requirements, e.g. equality and human rights, through the conduct of its business.
- 9.4 The requirements for the conduct of business as set out in the Health Board's Standing Orders are equally applicable to the operation of the Committee.

10. Reporting

- 10.1 The Committee, through its Chair and Members, shall work closely with the Board's other Committees, including joint and Sub-Committees and groups to provide advice and assurance to the Board through the:
- 10.1.1 Joint planning and co-ordination of Board and Committee business.
 - 10.1.2 Sharing of information
- 10.2 In doing so, the Committee shall contribute to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the Board's overall risk and assurance framework.
- 10.3 The Committee, may, subject to the approval of the Board, establish Sub-Committees or task and finish groups to carry out on its behalf specific aspects of Committee business. The Committee will receive an update following each meeting providing an assurance on business undertaken on its behalf.
- 10.4 The Committee Chair, supported by the Committee Secretary, shall:
- 10.4.1 Report formally, regularly and on a timely basis to the Board on the Committee's activities. This includes the submission of a Committee update report, as well as the presentation of an Annual Report within **six** weeks of the financial year.
 - 10.4.2 Bring to the Board's specific attention any significant matter under consideration by the Committee.
 - 10.4.3 Ensure appropriate escalation arrangements are in place to alert the Health Board Chair, Chief Executive or Chairs of other relevant Committees of any urgent/critical matters that may compromise patient care and affect the operation and/or reputation of the Health Board.



- 10.5 The Director of Corporate Governance/Board Secretary, on behalf of the Board, shall oversee a process of regular and rigorous self-assessment and evaluation of the Committee's performance and operation including that of any Sub-Committees established. In doing so, account will be taken of the requirements set out in the NHS Effective Board Committees Guide.

11. Secretarial Support

- 11.1 The Committee Secretary shall be determined by the Director of Corporate Governance/Board Secretary.

12. Review Date

- 12.1 These terms of reference and operating arrangements shall be reviewed on at least an annual basis by the Committee for approval by the Board.

Appendix 1: Targeted Intervention areas relating to financial intervention and focus

The **finance intervention and focus** whilst in targeted intervention covers the following five areas and the health board will be required to action and demonstrate areas as highlighted below:

1. Financial governance and control environment

- The financial governance framework at the health board is robust in both design and implementation, including a self-assessment against best practice frameworks.
- The financial committee structure is clearly articulated and addresses key risks.
- Financial reports and supplementary presentations include the analysis and narrative explanation required to enable management and board to discharge their duties.
- Financial controls at the health board are robust in both design and implementation, including a self-assessment against model frameworks, review implementation of the Standing Financial Instructions, internal audit reviews or other control reviews.
- The finance function has the necessary capacity and capability to support the needs of the wider organisation.
- Budget holders and managers are held to account for delivering their financial plans.
- That as a result of the above, it has developed and is delivering an action plan to improve the financial governance and financial control environment.

2. Understanding the existing deficit and key drivers

- There is a clear understanding of the cost drivers and investment decisions responsible for the growth in deficit across the organisation, including an explicit breakdown by key service area and cost driver.
- It has reviewed prior year investments to assess whether the planned benefits have been delivered.
- Has a robust process for challenging underlying deficits reported at local divisional levels.
- The drivers and investment decisions responsible for the growth in workforce are well understood; are reviewed for ongoing value; and are monitored through the Integrated Performance Report.
- The integrated performance reports clearly identify and monitor metrics against key activity cost drivers;
- That as a result of the above there are triangulated approaches to identify and deliver actions to improve efficiency and maximise the use of resources.

3. Development and realisation of opportunities

- Has a clear process and approach across the organisation to support the identification, delivery and monitoring of all savings schemes.

- Development of a comprehensive opportunities framework with a constant pipeline of opportunities, and establish clear roles and responsibilities for developing opportunities into saving schemes and subsequent delivery of these saving schemes.
- Is translating national opportunities identified through the Value and Sustainability Board into local savings.
- Has clear policies and processes in place to enable budget holders and managers to realise and deliver identified savings schemes.
- Value based health care principles have been embedded across the organisation.

4. Clear financial plan and strategy

- An integrated and triangulated plan, with clear and realistic planning assumptions to deliver a (recurrent) breakeven position over the medium-term, with a clear roadmap and key milestones for delivery.
- A clear engagement plan to communicate the necessity for financial improvement across the organisation.

5. Delivery of Plan

- It is delivering clear improvement in the planned financial trajectory for 2024/25 (i.e. significant progress towards delivery of the Target Control Total), including further progress around identification and delivery of recurring opportunities.

De-escalation criteria for finance

1. The health board must demonstrate that there are robust financial governance and robust financial control environment in place with risks minimised.
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.
3. Annual plan developed with board approval demonstrating a substantial financial improvement trajectory to deliver as a minimum the target control total. 60% performance maintained for 3 months against the SCP target.

The **performance and outcomes intervention and focus** whilst in targeted intervention covers the following areas and the health board will be required to action and demonstrate areas as highlighted below:

1. Establish baseline and agree improvement plans

- Undertake a current situation report to highlight the baseline and opportunities. This will be repeated at agreed milestones to provide assurance to Welsh Government and the Board that progress is being made or where further interventions are required.

- Review, for assurance purposes, progress the health board has made against previous external and internal reviews and implementation plans with a performance lens.
- Consolidate previous performance reviews and improvement plans into one core document, reducing the risk of duplication, with the intention of adding value to a clear way forward.
- Ensure that recovery and improvement plans are in place and that agreed priorities are being implemented, in accordance with evidence-based practice and national requirements.

2. Implement improvement plans

- Improve unscheduled care performance to ensure that patients access safe, timely and clinically effective unscheduled care services, reducing waiting times, delays and improving quality.
- Improve access to planned care with reduced waiting times in line with national requirements.
- Improve the timeliness of access to cancer services and demonstrate improved compliance with the suspected cancer pathway, prioritising improvement in the most at risk tumour sites.
- Ensure that cancer backlog reduces to agreed levels and site-specific plans are in place for tumour sites of concern.
- Implement an outpatient's transformation plan that supports a move towards the requirements of the planned care programme.
- Deliver activity in line with agreed trajectories and implement any necessary changes where performance falls below trajectory.

3. Work with national programmes and respond to external reviews such as GIRFT

- Work with and implement the recommendations from national programmes including but not limited to Strategic Programme of Primary Care, Six Goals for Emergency Care, Planned Care Improvement and the National Diagnostic and Endoscopy Programmes.
- Support the implementation and realisation of the GIRFT opportunities as highlighted through the programme reviews.
- Develop and implement an integrated approach to theatre scheduling and management, working with the GIRFT programme to develop and embed the agreed theatre reporting metrics on a bi-weekly basis.
- Develop agreed plans in response to the GIRFT speciality reviews and recommendations.
- Develop a prompt response to any HIW unannounced inspections, Audit Wales and Royal College recommendation, developing and completing action plans that demonstrate sustainable evidence.

4. Communications and engagement

- Ensure there are plans in place for all long waiters with a clear communication strategy with appropriate support to keep them well.
- Implement the requirements of the three Ps policy.
- Ensure that patients are clear where they can and should access support, signposting away from emergency services.

- Ensure that the benefits of new pathways such as straight to test, primary care management, self-management and see on symptoms pathways are communicated effectively.

De-escalation criteria for performance and outcomes

De-escalation criteria are set out below and should be maintained for at least 3 months before de-escalation will be considered. De-escalation will be to the next level of the escalation framework. Performance data will be enhanced by a monthly progress report from the health board across a range of measures.

Planned Care and Cancer

1. 100% of open outpatient pathways to be waiting less than 52 weeks and maintained for 3 months.
2. 100% of open pathways to be waiting less than 104 weeks and maintained for 3 months.
3. 80% of open pathways to be waiting less than 52 weeks and maintained for 3 months.
4. 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.)
5. 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.
6. 80% of patients waiting for a diagnostic test to be waiting less than 8 weeks and maintained for 3 months.
7. 80% of patients waiting for a diagnostic endoscopy to be waiting less than 8 weeks and maintained for 3 months.
8. 80% of patients waiting for a NOUS and non-cardiac MRI to be waiting less than 8 weeks and maintained for 3 months.
9. 85% of patients waiting for therapies to be waiting less than 14 weeks and maintained for 3 months.

Urgent and Emergency Care

1. 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).
2. Continuous improvement towards no more than 7% of patients waiting over 12 hours at each individual site and across the health board.

The above metrics, and monthly reports will form the basis of an assessment by the Welsh Government and NHS Executive as to the confidence levels of the health board's ability to maintain and sustain improvements.

Appendix 2: Finance and Performance Committee Planning Objectives 2025/26

Planning Objective		Lead	Class
2	Financial recovery and route map	Executive Director of Finance	Statutory duty
3	Transforming urgent and emergency care	Chief Operating Officer	Ministerial priority
4	Planned care, diagnostics and cancer	Chief Operating Officer	Ministerial priority
5	Mental health and CAHMS	Chief Operating Officer	Ministerial priority

2 - ESCALATION OVERVIEW

2.1

9:55 AM, 20 Mins

2.1 - ESCALATION OVERSIGHT AND HIGHLIGHT REPORT

**Shaun Ayres (Hywel
Dda UHB - Director
of Delivery)**

| For assurance

Attachments

[Escalation Oversight and Highlight Report FPC 26 August 2025.pdf](#)

[Appendix 1 July 2025 Escalation Meeting Correspondence.pdf](#)



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Escalation Oversight and Highlight Report

Finance and Performance Committee, 26 August 2025

Headlines



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Areas to highlight	Metrics	Update	3A
Finance: CCG Savings Plans	End of year forecast 2025/26 savings	£47.6m deficit against a £30.0m revised plan £19.5m gap, all within CCG areas with Executive Functions having achieved their targets, as a minimum on an in-year basis.	Alert Alert
Performance: Planned & Specialist Care	Single cancer pathway (TI level 3) High risk eye care patients (TI level 3) New outpatient waits under 52 weeks (TI level 3) Waits under 26 weeks RTT (TI level 3) Waits under 104 weeks RTT (TI level 3) Follow-up delays over 100% (TI level 3)	61.4% against 63% TI target. Diagnostic expansion needed 34.9% against 65% TI target. Patient safety implications Above 99.8% since March 25 64% against 75% TI target. Embedded improvements evident 99.8% against 100% TI target. Concerning trend Increased by 2% to 17,011. Strategic transformation needed	Advise Alert Advise Advise Advise Alert
Performance: Community & Integrated Medicine	Ambulance handovers over 1 hour (TI level 4) Waits over 12 hours in ED (TI level 4) Median time to assessment in ED (TI level 4) Delayed pathways of care	883 against 680 TI target. National ask reducing to 45 minutes 7.3% against <=7% TI target. Variation at site level (GGH & WGH) 80 minutes against 60 minute TI target. Deteriorated since May 25 211 against 174 TI target. Strategic transformation needed	Alert Advise Alert Alert
Performance: Operational Allied Health & Health Science	Radiology waits over 8 weeks	High breaches are a key driver for the single cancer pathway	Advise

Acronyms

ED = Emergency department
TI = Targeted Intervention

GGH = Glangwili Hospital
WGH = Withyb

RTT = Referral to treatment

This paper brings together the finance position, targeted intervention (TI) de-escalation criteria and operational performance into a single, coherent narrative. As of Month 4 2025/26, the Health Board is forecasting a £47.6m deficit against a £30.0m revised plan, while resetting organisational expectation to deliver an outturn deficit of £24.0m in line with Welsh Government's expectation to at least maintain the 2024/25 outturn (£24.1m). Savings of £26.9m have been identified (58% of the £46.4m target), leaving a £19.5m gap and a particular weakness in recurrent delivery (£11.6m vs £19.0m target). A time bound assurance route has been set, which include 15 August (QIAs from Executive leads), 18 August (papers to Committee), 26 August (Committee scrutiny), 9 September (In Committee Board), 11 September (CEO update and Month 5 submission).

Operationally, Single Cancer Pathway (SCP) performance sits at 61.4% (June) against a 63% Level 3 target (Annual Plan trajectory 68%), with the backlog now 535 (July) Radiology and Urology diagnostics are the main constraint and the near-term lever. Mobilisation is under way (MRI, LATP biopsies, flexible cystoscopy, weekend sessions), with throughput gains expected late Q2/early Q3 if workforce holds. Planned care remains cautiously positive for long wait eradication (Stage 1 >52 weeks), supported by Board approved First Outpatient delivery (from 23 August 2025) and a draft insourcing route; Ophthalmology remains the principal fragility due to workforce gaps. In urgent and emergency care, the Health Board has improved Emergency Department (ED) >12h waits towards ≤7% at Health Board level, but site level variation at Withybush Hospital (WGH) and Glangwili Hospital (WGH), and median time to assessment (Health Board 80 minutes vs 60 target) mean de-escalation thresholds are unlikely in the next 2–3 months without site specific step change; ambulance handovers remain materially above the TI threshold (target 680, July 883) with a stricter 45 minute requirement due from October 2025. Delayed Pathways of Care (DPoC) are also above target and lack sustained ≥5% monthly reductions.

Appendix 1 – Letter from Mrs Judith Paget, dated 18 August 2025, following Quarterly TI Meeting between Hywel Dda University Health Board (HDdUHB) and Welsh Government on 29 July 2025.

Month 4 Finance Update (focus on De-escalation Criterion 3)



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Lead Executive - Huw Thomas

Summary

At Month 4 the gross forecast outturn is £47.6m deficit against the £30.0m revised plan, with a core operational underspend of (£1.9m). Savings identified total £26.9m (58% of the £46.4m target), leaving an identification gap of £19.5m. The recurrent element is £11.6m against a £19.0m target (gap £7.4m), with non-recurrent at £15.3m against £27.4m (gap £12.1m). In line with Welsh Government's revised expectations to at least maintain the 2024/25 outturn (£24.1m deficit), organisational expectation is reset to deliver an outturn deficit of £24.0m, thus a requirement to improve on both the revised £30.0m plan and the prior £31.5m forecast cited in the 25/26 annual plan.

Key Cost Drivers Medical pay analysis shows additional hours averaging £2.2m per month, off-contract agency trending down toward zero but on-contract agency remaining variable (£0.2m per month), and locum doctors now 25.8% of total medical expenditure, underlining the need to embed rate card and roster controls. External commissioning shows Swansea Bay University Health Board (SBUHB) Long-Term Agreement (LTA) £0.583m over budget year-to-date driven by uncoded non-elective activity, Welsh Joint Commissioning Committee (WJCC) underperforming on activity (£0.299m) but partially offset by All-Wales risk share of £0.2m year-to-date, and Cardiff and Vale University Health Board (CVUHB) LTA £0.137m over due to high-cost drugs.

QIA-Assessed Improvement Options

To bridge from £30.0m to £24.0m, Executives are bringing forward a QIA-assessed menu (£22.5m gross options), allowing selection of a balanced package to secure the additional £6m improvement. Prominent considerations include pausing overtime to March (£5.1m), reducing or eliminating on-contract agency (£4.9m) alongside off-contract agency (£0.45m), a recruitment freeze for non-patient facing roles via attrition (£2.188m), delaying planned Mental Health and Learning Disabilities (MHLD) recruitment (£1.9m), non-renewal of selected contracts and digital licences (£1.3m), pausing Radiology growth (£1.3m), and deferring selected NICE drug implementations to 2026/27 (£1.3m).

Month 4 Finance update (focus on De-escalation Criterion 3)



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Why Alert?

- Material movement required from both the revised £31.5m plan and the current £30.0m forecast
- Welsh Government explicitly highlighted the disconnect between in-month savings delivered and future months' forecasts
- £19.5m gap all within Clinical Care Group (CCG) areas with Executive Functions having achieved their targets as a minimum on an in-year basis
- Credibility of delivery hinges on closing disconnect between in-month savings delivered and future months' forecasts

Criterion 21 - Single Cancer Pathway

63% Performance for 3 Consecutive Months (Level 3)



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Lead Executive - Andrew Carruthers

Current Performance

Current performance sits at 61.4% (June) against 63% Level 3 target (Annual Plan trajectory 68%), with the backlog now 535 (July). The health board achieved de-escalation to Level 3 monitoring following sustained performance above 60% from February through June 2025, however this brings an elevated performance threshold of **63%** rather than the previous 60%. Performance data shows 63.5% in February, 65.4% in March, 62.4% in April, 66.1% in May, and 61.4% in June 2025. Performance variation across tumour sites remains substantial, with urological pathways at 14% and skin pathways at 97%.

Operational Context

Mobilisation under way includes MRI capacity increasing by 336 scans annually (28 per month) through outsourcing from September, Local Anaesthetic Transperineal Prostate (LATP) biopsy expansion of 260 procedures annually (22 per month), flexible cystoscopy improvement of 898 procedures annually (75 per month), and nurse-delivered LATP adding 210 procedures annually (17 per month). Five weekend biopsy sessions covering 45 patients are scheduled for August 2025. Radiology has received provisional recurrent investment for 2025/26, though implementation timelines extend beyond the immediate performance period.

Why Advise?

- Performance trajectory shows capability to achieve 63% but inconsistent delivery month-to-month
- June performance below Level 3 threshold and dependency on diagnostic expansion programmes not yet fully operational
- Primary constraint links to diagnostic capacity, particularly in radiology, where CT and MRI availability limits pathway progression
- Concern around the current backlog which has increased

Criterion 14 - R1 Ophthalmology

65% Within Target (Level 3)



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Current Performance

Performance remains at 34.9% in July 2025, effectively unchanged from 34.0% in November 2024. This represents a 30-percentage point gap to the 65% threshold with no improvement trajectory over eight months. The workforce position includes two consultant vacancies representing 20-25% of establishment capacity, three Specialty, Associate Specialist, and Specialist (SAS) doctor vacancies with three staff onboarding but requiring supervision before independent practice, and documented nursing shortfalls affecting clinic efficiency.

Operational Context

Current mitigations include protected R1 slots in all clinics, waiting list initiatives dependent on existing staff overtime, validation to identify highest-risk patients, and Welsh General Ophthalmic Services (WGOS) pathways reducing referral rates (glaucoma 8.96%, medical retina 12.09%). Regional consultant posts are proposed but face standard recruitment timelines of 6-12 months to realise any impact.

Why Alert?

- Static performance despite planned interventions, severe workforce gaps, and patient safety implications where delays risk irreversible sight loss
- Service prioritisation of emergency care and intravitreal therapy displaces R1 capacity, creating systematic deferral of risk-stratified patients
- Clinic cancellations due to staffing mean planned capacity is not fully delivered

Criterion 26 - 100% of Outpatient Pathways Waiting Less Than 52 Weeks (Level 3)



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Current Performance

Performance data demonstrates sustained delivery above 99.8% from March through July 2025, with 100% achieved in March 2025 followed by consistent performance between 99.8% and 99.9%. The September 2025 cohort tracking identifies 2,812 patients who will breach 52 weeks if not seen before month end (August), with ophthalmology accounting for 1,712 patients (61%) and orthopaedics contributing 868 patients (31%).

Operational Context

While percentage compliance appears strong, the volume of patients requiring active management to prevent breaches indicates operational pressure. The concentration in two specialties creates specific vulnerability, particularly given ophthalmology's documented workforce constraints including two consultant vacancies and three SAS doctor gaps. The Welsh Government First Outpatient plan commencing 23 August 2025 provides the primary strategic intervention, supported by insourcing arrangements currently at draft tender stage.

Why Advise?

- Sustained percentage achievement provides confidence in operational processes
- Volume of patients requiring active management to prevent breaches indicates operational pressure
- Concentration in two specialties creates specific vulnerability, particularly given ophthalmology's documented workforce constraints

Criterion 27 - Continuous Improvement Towards 75% of Outpatient Pathways Under 26 Weeks (Level 3)



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Current Performance

Performance has improved from 60.5% in November 2024 to 64.0% in July 2025, demonstrating a 3.5 percentage point gain over eight months. The improvement rate averages 0.44 percentage points per month, projecting achievement of the 75% target by August 2027 if maintained. The trajectory shows consistent month-on-month gains without significant volatility, indicating embedded improvement processes, however, this level of improvement would take nearly 2 years to achieve this ask (on the current trajectory)

Why Advise?

- Continuous improvement requirement satisfied with steady progress demonstrated over eight months
- 11-percentage point gap to target requires sustained focus, but consistent trajectory provides confidence in eventual achievement
- Embedded improvement processes evidenced by consistent month-on-month gains without significant volatility

Criterion 28 - 100% of Pathways Waiting Less Than 104 Weeks (Level 3)



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Performance shows 100% in March 2025, followed by 99.8% in April, 99.7% in May, and 99.8% in both June and July. However, underlying data reveals concerning trends. The September 2025 cohort tracking identifies 1,792 patients at risk of breaching if not treated before month end. Q1 actual performance showed 198 patients breached the standard, with ophthalmology contributing 101 breaches, ENT 60, and general medicine 24. The Q2 projection of 84 breaches, while improved, remains significantly above the zero-tolerance expectation.

Operational Context

The management of 1,792 at-risk patients requires treating approximately 200-250 patients weekly to maintain compliance, against routine surgical capacity of 150-180 procedures weekly across all specialties. Current performance depends on continuous re-prioritisation, pulling patients forward immediately before breach dates. Specific risks include 22 ENT patients where outsourcing remains unconfirmed and 18 plastics patients with theatre-dependent mitigation under development. The interdependency with diagnostic delays, MRI compliance is also critical at around 59%; this can prevent patient progression even where there is available treatment capacity.

Why Advise?

- While percentage compliance remains high, volume of at-risk patients and concentration in challenged specialties indicates significant operational risk
- Dependency on unconfirmed mitigations for ENT and plastics patients creates delivery uncertainty
- Core demand and capacity has a mismatch, with outsourcing/insourcing plans aimed at mitigating 104-week breaches

Criterion 30: 12% Reduction in Follow-up Delays Over 100% Level 3



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Current Performance

Performance shows deterioration from the November 2024 baseline of 16,682 patients to 17,011 in July 2025, representing a 2% increase against the required 12% reduction. The target of 14,680 patients requires a reduction of 2,331 from current levels. Weekly data shows continued net increases, with urology adding 169 patients in a single week while gastroenterology achieved marginal reduction of 45 patients.

Operational Context

The fundamental imbalance between follow-up demand and capacity persists despite monitoring and targeted interventions. Year-on-year comparison shows increase from 28,222 delayed patients in June 2024 to 29,747 in June 2025, indicating a likely systematic capacity deficit rather than operational inefficiency. The variation between specialties suggests localised solutions exist but cannot compensate for system-wide constraints.

Why Alert?

- Deteriorating trajectory contrary to criterion requirements with 2% increase versus required 12% reduction
- Fundamental imbalance between follow-up demand and capacity persists despite monitoring and targeted interventions
- Year-on-year comparison shows increase from 28,222 delayed patients in June 2024 to 29,747 in June 2025

Criterion 15 - Ambulance Handovers Over One Hour - 11% Reduction Target – Level 4



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Current Performance

July 2025 data records 883 ambulance handovers exceeding one hour against the Targeted Intervention threshold of 680, representing a breach of 203 handovers (30% above target). The de-escalation requirement demands an 11% reduction for three consecutive months, then maintained for three months from the Q3 2023/24 baseline average of 964. Performance trajectory shows 1,009 in May 2025, improving to 883 in July 2025, demonstrating improvement but not at the required 11% monthly rate. The current position represents an 8.4% reduction from baseline, falling short of sustained de-escalation requirements.

Operational Context

The 883 handovers represent approximately 900 hours of lost ambulance capacity monthly, effectively removing several ambulances from continuous service. Site-specific performance reveals Bronglais Hospital (BGH) achieving 67 handovers against a target of 122, demonstrating 45% better-than-target performance and proving operational excellence is achievable. The correlation with Pathways of Care Delays at 211 against a target of 174 creates compound effects where discharge blockages cascade through the entire emergency system.

Improvement Actions

The Urgent Emergency Care (UEC) Accelerated Transformation Programme and Six Goals highlight multiple interventions including the "Your Next Patient" initiative launching 1 September 2025, daily DPOC reviews at Silver command level, establishment of accelerator teams for complex discharges, and engagement with Welsh Ambulance Service Trust (WAST) on pre-alert and redirection criteria. The programme targets achieving less than 45-minute handovers consistently, progressing towards the 15-minute standard.

Criterion 15 - Ambulance Handovers Over One Hour - 11% Reduction Target – Level 4



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Why Alert?

- 30% breach above target and failure to achieve consistent 11% monthly reductions prevents achievement of de-escalation criteria
- 883 handovers represent approximately 900 hours of lost ambulance capacity monthly
- National ask reducing to 45 minutes from October 2025; therefore, a significant risk in managing demand

Criterion 16 - Emergency Department 12-Hour Waits - 7% Maximum – Level 4



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Lead Executive - Andrew Carruthers

Current Performance

July 2025 performance shows 7.3% of patients waiting over 12 hours in emergency departments, marginally above the 7% de-escalation threshold. The trajectory demonstrates significant improvement from 12.8% in March 2025 to current levels, showing continuous improvement as required. June performance achieved 7.8%, with July showing further progress towards compliance. Site variation remains substantial with Prince Philip Hospital (PPH) achieving approximately 2% whilst other sites range between 10-15%. It should be noted that the recent 0% breaches at PPH is affecting (positive variance) within the Health Board's 12-hour breaches.

Operational Context

The July 2025 position of 7.3% represents approximately 730 patients experiencing extreme delays monthly across all emergency departments. The fivefold variation between sites indicates that local operational practices rather than systemic constraints drive performance. The documented improvements in waiting room oversight, including registered nurse allocation and regular observations at all sites, demonstrate enhanced safety management despite breaches.

Why Advise?

- 0.3 percentage point breach above threshold, combined with demonstrated continuous improvement from 12.8% to 7.3%
- Fivefold variation between sites indicates that local operational practices rather than systemic constraints drive performance
- PPH's 2 to 0% performance supports target achievability

Criterion 17: Time to Clinical Assessment - 60 Minutes

Maximum – Level 4



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Current Performance

July 2025 data shows median time to clinical assessment at 80 minutes, 33% above the 60-minute target. Performance has deteriorated from 70 minutes in May to 80 minutes in July, contrary to the continuous improvement requirement. The November 2023 baseline of 58 minutes demonstrates the health board previously achieved compliance, making current performance particularly concerning. Site variation shows Bronglais Hospital (BGH) at 76 minutes, whilst WGH deteriorated from achieving 59 minutes in May to 76 minutes in June 2025.

Operational Context

The 20-minute delay beyond target represents approximately 5,000 additional patient-hours of waiting monthly before clinical assessment. This delay occurs at the critical decision point where streaming to alternative pathways could decompress emergency departments. The deteriorating trajectory despite documented interventions suggests workforce constraints and flow blockages override operational improvements.

Why Alert?

- 33% breach above target, deteriorating trajectory from May 2025 to July 2025
- Movement away from previously achieved compliance in November 2023 indicates systemic failure
- 20-minute delay beyond target represents approximately 5,000 additional patient-hours of waiting monthly

Criterion 18 - Pathways of Care Delays

5% Reduction Target



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Current Performance

July 2025 records 211 delayed pathways of care against a target of 174, representing 21% above the required level. The de-escalation criterion requires a 5% reduction for three consecutive months from the Q3 2023/24 baseline average of 203. Current performance shows deterioration rather than improvement, with numbers increasing from 200 in December 2024 to 211 in July 2025. The trajectory shows no months achieving the required 5% reduction, let alone three consecutive months.

Operational Context

The 211 delays represent patients medically fit for discharge occupying acute beds, creating the fundamental constraint across all emergency pathways. These delays directly cause the cascade of ambulance handover delays, emergency department congestion, and assessment delays. The Regional Pathways of Care Delays Integrated Action Plan submitted to national level acknowledges the multi-agency nature requiring health and social care integration.

Why Alert?

- 21% breach above target, deteriorating trajectory contrary to reduction requirements
- 211 delays represent patients medically fit for discharge occupying acute beds, creating the fundamental constraint across all emergency pathways
- Direct causation of ambulance handover delays, emergency department congestion, and assessment delays



Lead Executive - Andrew Carruthers

Current Performance

Performance for Children and Adolescent Mental Health Services (CAMHS) Autistic Spectrum Disorder (ASD) assessments shows significant deterioration with only 15.6% of patients (535 out of 3,436) waiting less than 26 weeks to start a neurodevelopment assessment as of June 2025, against the 80% target threshold. This represents 2,901 patients (84.4%) waiting more than 26 weeks. The trajectory demonstrates sustained decline from approximately 25-30% performance in 2022 to current levels, indicating a 64.4 percentage point gap to target with no improvement evident over the three-year period.

Operational Context

The service has received £980k ringfenced funding through the Neurodivergence Improvement Programme (NDIP2025-27) with priorities to eradicate three-year waits by 2026. Current mitigations include ongoing outsourcing arrangements, radical service re-design incorporating stepped care approaches, and weekly Task and Finish group monitoring. However, representations from the service state that significant operational constraints persist including insufficient administrative support from vacant posts and sickness absence, alongside risk of funding cessation for outsourcing during transformation.

Why Alert?

- Sustained deteriorating trajectory over three years with 64.4 percentage point gap to 80% target affecting 2,901 children and young people
- Risk of outsourcing funding cessation whilst transformation remains incomplete, creating service fragility during critical improvement period
- Commitment to eliminate three-year waits by 2026 requires immediate transformational intervention beyond current operational adjustments

The Finance and Performance Committee is asked to: -

1. **NOTE** the reset £24.0m outturn expectation and the £6m improvement required from the revised plan, with particular focus on closing the £19.5m savings gap that falls entirely within CCG areas and improving the recurrent versus non-recurrent split from current £11.6m to £19.0m target.
2. **SCRUTINISE** the QIA-assessed savings menu (£22.5m gross options) including pausing overtime to March (£5.1m), reducing on-contract agency (£4.9m), and recruitment freeze for non-patient facing roles (£2.188m) and agree next steps.
3. **SEEK ASSURANCE** - on immediate action for R1 Ophthalmology given static 34.9% performance where delays risk irreversible sight loss, including regional workforce solutions and service reconfiguration options beyond local management.
4. **SEEK ASSURANCE** - on site-specific recovery plans for Withybush Hospital and Glangwili Hospital to achieve ambulance handover targets (currently 883 versus 680 threshold representing 30% breach) and ED 12-hour performance (7.3% versus 7% target), with weekly oversight and readiness for 45-minute handover standard from October 2025.
5. **SEEK ASSURANCE** - that delayed pathways of care reduction plans address the fundamental constraint of 211 medically fit patients occupying acute beds (21% above 174 target) that directly causes the cascade of ambulance handover delays and emergency department congestion across the entire system.
6. **SEEK ASSURANCE** - on immediate escalation measures for CAMHS ASD assessment performance given sustained three-year deterioration to 15.6% against 80% target affecting 2,901 children; and **APPROVE** a comprehensive deep-dive review at the next Committee meeting if August 2025 performance fails to demonstrate improvement.



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**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

philip.kloer@wales.nhs.uk

Our Ref: JP/MR/HP

18 August 2025

Dear Phil

Quarterly escalation meeting

Thank you for attending the quarterly escalation meeting on the 29 July 2025, along with members of your Executive team, and for providing the slides which provided a helpful overview ahead of the meeting. These slides form an important part of the meeting record.

This was our first 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, and quality of care related to HCAs and fragile services.
- Level 3 for performance and outcomes related to planned care and cancer and leadership and governance.

The changes in the escalation status are in line with our improving confidence in the organisation and that the Board is able to implement the required changes. It is essential that this improvement journey continues. A refreshed escalation framework has been shared with you for comment.

Apologies were noted from Huw Thomas, Sharon Daniel, Ardiana Gjini, Mark Henwood and James Severs from the health board and Sue Tranka, Helen Arthur, Samia Edmonds and Olivia Shorrocks from Welsh Government.

All actions from the previous meeting had been completed or would be picked up in this discussion

Finance and planning

Your initial plan aimed to deliver the control total of £31.5m, which included £44m of savings. You have been able to de-risk some elements during quarter 1 and are taking a paper to your July Board advising of a revised end of year position of £30m deficit. Whilst this is positive progress, it does remain above the expectation of delivery of the 2024/25 outturn of a £24m deficit as a minimum. You continue to drive savings, including reduction in agency spend, and your green savings plan was at £22m in month 3. You recognise there is a continued reliance on non-recurrent savings. You are working with colleagues in NHS P&I to develop a plan that delivers balance in three years.

Our assessment is that the £24m deficit position is deliverable and expect confirmation on how you will deliver that by 31 July. You highlighted there were a few schemes in place, but a full impact assessment was required before confirmation could be provided and you were trying to strike the right balance between finance, performance, quality and workforce. It is important that you set out the steps you are taking to confirm the outturn as soon as possible. We require clarity on your outturn for this year by 11 September.

You confirmed the reassessment against the planning maturity matrix had been completed and will be presented to the July Board meeting. Since the last review, the score for strategy development had reduced, noting there was still no long-term plan for health services across west Wales. There had been a good discussion at the planning committee and the maturity matrix will be used to support Board seminars.

You have started the 2026/27 planning process with the intention of agreeing a three-year IMTP.

Your assessment against the enabling actions, is that the majority have been assessed as either green or amber, with two red related to theatres and ambulance handover. On theatres, there are workforce issues in Glangwili, as well as sickness and this is an area you are focussing on. On ambulance handover, you recognise there is further work to do around streaming and redirection of patients. Plans have been developed, and you are expecting both areas to move to amber and green in due course.

The Clinical Services Plan (CSP) consultation has reached the mid-point review with over 1,600 responses, with a similar number attending health board events. There have been over 600 staff attending engagement sessions. The outcomes at present include some alternative options coming through, which will be tested once the consultation period closes. The main areas of concern relate to how far patients will have to travel and timeliness of access to services.

As part of the CSP, you have been in close contact with Swansea Bay UHB regarding the development of regional services with the next joint Committee scheduled for the middle of August. You also have input from the Mid Wales Committee, and you have recently taken the CEO lead for the Mid Wales Executive.

The Prince Philip MIU consultation has now closed, with over 700 responses received. Both Llais and the local action group SOSPAN have been involved from the start. You will be taking proposals to the September Board meeting.

Urgent and Emergency Care (UEC)

UEC is the most challenged performance area and is a significant area of focus for the health board for both performance and quality and patient experience. There are a number

of actions in place to improve ambulance handover, and there has been some improvement seen in Bronglais, but challenges are considerable in Withybush and Glangwili. Handover performance in Glangwili is one of the worst in Wales. This is an area you are looking to learn from others on and have been in contact with colleagues from Swansea Bay and Cwm Taf Morgannwg University Health Boards.

The length of time patients spend in the emergency department is also of concern. There is good clinical leadership, and you recognise there are a number of patients that could be managed differently. A paper went to the July Board on UEC transformation, including extending the SDEC model to 12 hours a day, 365 days a year and to develop a seven-day streaming model. There has been progress on workforce stabilisation, though not in delayed pathways of care. You confirmed a round table discussion with local authority partners was scheduled for the start of September to discuss winter and agree a memorandum of understanding.

Fragile Services

Stroke is part of the CSP discussion, and you are having discussions with Powys teaching Health Board, Swansea Bay University Health Board and Betsi Cadwaladr University Health Board about the appropriate patient flows, pathways and the comprehensive stroke unit for the region.

The aim is to deliver high quality services and the CSP had prompted a lot of debate, with the public recognising that having four units does not provide the right care. There has been a geographical divide on the responses received at present, with different views being offered. You recognise the current provision is not ideal and there is further work to do.

Quality and Safety

The health board continues to report an improved position for HCAs, but above the de-escalation criteria. There are detailed plans in place and an intensive focus on IPC. It was noted there is a seasonality issue with c-difficile and a time lag in relation to when antibiotics were used and the impact of c-difficile. There has been an issue with accessing FMT over the last couple of months and you are in discussions around setting up a FMT manufacturing plant in Wales. You are exploring the opportunity of using technical hygienists, particularly in the ED and Welsh Government colleagues are interested to discuss this further. You expected to see improvements in HCAs from September.

You continue to work collaboratively with Swansea Bay on hand hygiene and have changed the disinfectant being used across the health board. You reported there are two areas of work on-going, one with Dr Mike Simmons around the introduction of probiotic cleaners and with Tri Tech and University of Dundee around the introduction of UV222. We will be interested to hear the progress of this work.

Performance and outcomes

It was disappointing to see there were 104-week breaches at the end of June. There are pressures in orthopaedics and recovery plans are in place and you expect to achieve zero breaches at the end of quarter 2, although there are challenges in a couple of specialities. There has been progress in radiology, though there are still nearly 3,500 open pathways over eight weeks. There has also been an improvement in reporting times. There is a challenge in flexi-cystoscopy from urgent cancer referrals, but all other endoscopy was at eight weeks.

Cancer performance is being maintained over 60%. The backlog reduction has not had as much impact as I would like to see and there must be a focus in this area.

Governance and Leadership

There is now a full Executive team in place following the appointment of the Medical Director. The operational structure is now in place, with the senior posts in place with the exception of the Associate Medical Directors, which are to be advertised shortly. You are now moving on to phase 2 and to the filling of the roles below. The Clinical Care Groups are at an early stage of development. The early observations are this structure has been welcomed by staff, though there had been some reservation, and the new structure is supported by an OD programme of work. You highlighted you are open to receiving and listening to feedback from staff.

Summary

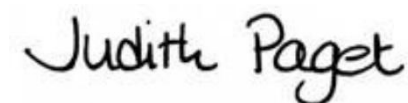
There has been progress seen in some areas that resulted in the recent de-escalation. The main areas of concern and challenge remain around finance and UEC. It is important on the finance side that you deliver the Cabinet Secretary's ask and the presentation of your savings as per Hywel's request. On UEC, you recognise the challenge over the coming 60 days in preparation for 45-minute handover from October and in improving the flow in the EDs and preparing the staff. I will be keen to see an improving position for HCAs in the coming months.

We agreed the following actions:

- Clarity on 2025/26 outturn by 11 September 2025.
- Robust plans for delivering the 45 minute handover from October.
- Focus on reducing the backlog of patients waiting over 62 days for the cancer treatment to commence.
- An update on the plans to reduce delayed pathways of care and winter preparations following the round table discussion with local authority partners.

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
Shaun Ayres	Hywel Jones
Andrew Spratt	Jamie Kaijaks
Lee Davies	Gillian Knight
Lisa Gostling	Martyn Rees
Joanne Wilson	Gaynor Evans
Tracey Gauci	
Bethan Lewis	
Apologies	
Mark Henwood	Helen Arthur
Sharon Daniel	Samia Edmonds
James Severs	Olivia Shorrocks
Huw Thomas	Sue Tranka
Ardiana Gjini	

3 - ESCALATION RESPONSE – RECOVERY ACTION PLANS AND IMPROVEMENT TRAJECTORIES

3.1

10:15 AM, 15 Mins

3.1 - CLINICAL CARE GROUP FINANCIAL SAVINGS

Andrew Carruthers
(Hywel Dda UHB -
Chief Operating
Officer)

| For assurance

Attachments

[Clinical Care Group Financial Services FPC 26 August 2025.pdf](#)

[Appendix 1 Clinical Care Group Savings.pdf](#)



PWYLLGOR CYLLID A PHERFFORMIAD
FINANCE AND PERFORMANCE COMMITTEE

DYDDIAD Y CYFARFOD: DATE OF MEETING:	26 August 2025
TEITL YR ADRODDIAD: TITLE OF REPORT:	Clinical Care Group Financial Savings
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Andrew Carruthers, Chief Operating officer
SWYDDOG ADRODD: REPORTING OFFICER:	Keith Jones, Director of Operational Planning and Performance

Pwrpas yr Adroddiad (dewiswch fel yn addas)

Purpose of the Report (select as appropriate)

Ar Gyfer Trafodaeth/For Discussion

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The Committee is requested to consider the progress achieved by Clinical Care Groups (CCGs) in respect of confirmed savings plans as at M4 and to note the additional opportunities being explored by CCGs to further improve this position.

Cefndir / Background

The Health Board approved an Annual Plan on 27 March 2025 which represented a planned deficit of £31.5m. This includes provision for investments totalling £11.9m, expected recurrent savings of £19.0m, plus a non-recurrent benefit of underspends and non-recurrent savings of £25.4m. Therefore, total savings delivery for the year of £44.4m. Subsequently in July the Board has approved a revision to the Annual Plan and a restated recurrent saving requirement of £46.4m.

The anticipated savings delivery was spread across the Health Board on the basis of all budget areas delivering a combination of 5% savings in 2024/25 plus a further 1.5% in 2025/26. Recognising that recurrent saving delivery was achieved to some extent through 2024/25, the remaining balance of 5% was carried forward for each budget area. As a result, the savings delivery required for the Chief Operating Officer portfolio is £39.0m. These figures remain unchanged by the revision to the Annual Plan and increased savings requirement.

Asesiad / Assessment

Savings Delivery to Month 4

Against the target of £39.0m, in year plans total £21.9m factoring in blue, red, amber and green (BRAG), recurrent and non-recurrent schemes. The full year estimate of recurrent schemes is £17.1m across all BRAG categories.

Despite significant operational pressures experienced by Clinical Care Groups (CCGs), confirmed in year delivery in respect of amber and green cash releasing schemes has increased since M3 by £2.1m, from £14.9m to £17.0m at M4. This progress has been achieved despite:

- Pressures on surge capacity across Pembrokeshire and Carmarthenshire
- Deteriorating medical staffing workforce availability
- Increased RTT delivery costs to mitigate the operational impact of theatre cancellations due to significant theatre staffing workforce challenges

The latest profile of cash releasing schemes across all BRAG categories, by CCG, is illustrated in the table below:

Delegated Officer (£'000)	Annual Savings Target	In Year Identified Blue	Cash Releasing Plans (Recurrent and Non-Recurrent) Red	Amber	Green	Total	Variance From Target
Chief Operating Officer	39,048	631	4,302	938	16,064	21,934	17,114
Chief Operating Officer Management	762				371	371	391
Community and Integrated Medicine	10,482	100	2,269		3,693	6,062	4,420
Mental Health and Learning Disabilities	5,851	500	392		3,180	4,072	1,779
Operational Allied Health and Health Sciences	3,785		26		459	485	3,300
Planned and Specialist Care	11,639	31	1,204	70	6,234	7,539	4,100
Primary Care, Community Strategy and Long Term Care	6,529		410	868	2,128	3,405	3,124

N.B. Figures presented reflect M04 finance reporting.

Green and Amber Schemes

Alongside the priority focus on closing the current gap to the total savings target for services within the Chief Operating Officer's service portfolio, individual CCG's have also continued to focus on expenditure controls within operating budgets. Within the total green savings schemes, a portion of this value has been realised through the approved principle to routinely transact pay related underspends through the monthly cycle, totalling £2.4m between April and July 2025. This reflects the increased grip and control applied by CCGs in managing their operating budgets.

The summary table below presents the scale of savings generated through this process:

Delegated Officer (£'000)	M01- M04 Total	M01-M04 Average
Chief Operating Officer	2,365	591
Chief Operating Officer Management	371	93
Community and Integrated Medicine	126	31
Mental Health and Learning Disabilities	200	50
Operational Allied Health and Health Sciences	0	0
Planned and Specialist Care	742	185
Primary Care, Community Strategy and Long Term Care	928	232

Current Blue and Red Schemes

The current list of red and blue schemes identified by CCGs are included in **Appendix 1**. These represent a potential £4.9m opportunity in year.

Progress updates are provided through CCG Executive Improving Together (EITs) and Recovery meetings. During July, supported by finance colleagues, CCGs have commenced the process of completing mini-Project Initiation Document (PID) template for blue and red schemes to ensure clarity and ownership of actions required. Due to the combined impact of annual leave of Service Directors and System/Directorate General Managers (and increased service fragility in some CCGs due to sickness absence), return rates of completed mini-PID

templates as at the end of July were low, with PIDs for 56 blue and red schemes awaiting return.

Of those returns received thus far, outcomes are reflected in the BRAG figures above (£0.6m blue total and £4.3m red total) and noted below:

- Planned and Specialist Care CCG have converted four schemes from blue and red to green (2 relating to drug switches and 2 relating to theatres), reprofiled 13 schemes reducing the in-year value and have closed one scheme.
- Mental Health and Learning Disabilities CCG have replaced three red schemes with a green scheme of higher value, plus a further red scheme has moved to green with a higher value compared to the original estimate. These schemes all relate to timing of recruitment plans and incurring associated costs. One blue scheme has been closed.
- Operational Allied Health and Health Sciences have deferred the start date on 4 schemes. In recognition of the workforce and related capacity challenges across its service areas, the CCG has been encouraged via Executive Recovery reviews to focus its efforts on actions to resolve its forecast budget deficit position given the extent to which the CCG budget reflects pay costs.

Additional Opportunities

Further to the profile of cash releasing schemes confirmed as at M4, CCGs have continued to review additional opportunities, beyond the current schedule of blue and red savings schemes, including consideration of run rate contributions to the in-year savings target along with non-cash releasing opportunities.

When these additional opportunities are added to the profile of cash-releasing schemes confirmed as at M4, the BRAG savings profile for each CCG is as shown in the table below:

	Annual Savings Target	In Year - Blue	In Year - Red	In Year - Amber	In Year Green	Total In Year	Variance From Target	Total Full Year
Chief Operating Officer	39,048	1,181	4,700	1,012	18,455	25,348	13,700	24,123
Chief Operating Officer Management	762				371	371	391	0
Community and Integrated Medicine	10,482	150	2,668	41	4,855	7,714	2,768	9,972
Mental Health and Learning Disabilities	5,851	1,000	392		3,180	4,572	1,279	2,904
Operational Allied Health and Health Sciences	3,785		26		459	485	3,300	760
Planned and Specialist Care	11,639	31	1,204	103	6,799	8,137	3,502	7,994
Primary Care, Community Strategy and LT Care	6,529		410	868	2,791	4,068	2,461	2,494

This would represent a further in-year improvement of £3.4m over the cash-releasing profile of schemes confirmed as at M4, totalling £25.3m in-year delivery. Of these additional opportunities totalling £3.4m, £2.9m are cash-releasing, with £0.5m of non-cash releasing Mental Health and Learning Disabilities (MHLd) opportunities also identified.

This would leave an in-year variance of £13.7m from the combined CCG 2025/26 target of £39m. The full year impact of these additional opportunities would rise to £24.1m.

These additional opportunities are subject to review with the Executive Team via the current round of Executive Recovery and /or EITS reviews. The impact of transacting run rate savings will also need to be triangulated with the CCG financial forecasts.

Additional Expenditure Reduction Actions

In recognition of the Welsh Government requirement for the Health Board to achieve an outturn financial deficit of £24m, the Executive Team has identified a range of additional, potential expenditure reduction opportunities totalling £22.5m in year. Each CCG has been requested to impact assess these opportunities, where applicable to the CCG budget, utilising the Quality Impact Assessment (QIA) methodology to inform the extent of any realisable expenditure reduction opportunities and associated risks to quality, safety and performance delivery.

All CCGs have been requested to complete these assessments by 15 August 2025, the outcome of which will be reported to the Committee on 26 August 2025.

Argymhelliad / Recommendation

The Committee is requested to **NOTE** the further progress achieved by Clinical Care Groups in respect of confirmed savings plans as at M04 and the additional opportunities being explored by Clinical Care Groups to further improve this position.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	3.1.1 Receive assurances on the financial governance and control environment in operation across the Health Board. This will be achieved a programme of deep dive reviews into the following themes, which mirror the national Value and Sustainability Board.
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)	4. Efficient
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	Not Applicable
Amcanion Strategol y BIP: UHB Strategic Objectives:	6. Sustainable use of resources
Amcanion Cynllunio Planning Objectives	2 Financial recovery and route map

Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022	10. Not Applicable

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Contained within the body of the report.
Rhestr Termiau: Glossary of Terms:	Contained within the body of the report.
Partion / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Adnoddau Cynaliadwy: Parties / Committees consulted prior to Sustainable Resources Committee:	Clinical Care Groups

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	Contained within the body of the report.
Ansawdd / Gofal Claf: Quality / Patient Care:	Not Applicable
Gweithlu: Workforce:	Not Applicable
Risg: Risk:	Not Applicable
Cyfreithiol: Legal:	Not Applicable

Enw Da: Reputational:	Health Board financial stewardship.
Gyfrinachedd: Privacy:	Not Applicable
Cydraddoldeb: Equality:	Not Applicable

Appendix: Blue and Red Saving Schemes

Level 4 Desc	Level 5 Desc	Scheme Name	Recurrent	RAG	Values £'000	
					In Year Plan	Full Year Pla
Community and Integrated Medicine	Carmarthenshire Integrated System	Impact of Emergency General Surgery (Scheduled Care Scheme on GGH)	Recurrent	Blue	0	0
Community and Integrated Medicine	Carmarthenshire Integrated System	Review of CCU capacity in Carmarthenshire	Recurrent	Blue	0	0
Community and Integrated Medicine	Carmarthenshire Integrated System	Evaluation of opportunity to provide alternative care provision for LCH	Recurrent	Blue	0	0
Community and Integrated Medicine	Carmarthenshire Integrated System	Review DN and ART support in to residential homes	Recurrent	Blue	0	0
Community and Integrated Medicine	Carmarthenshire Integrated System	Community vision development Eastgate model and 50 day challenge	Recurrent	Blue	0	0
Community and Integrated Medicine	Carmarthenshire Integrated System	Review SLA of Ty Bryngwyn and responsible owner	Recurrent	Blue	0	0
Community and Integrated Medicine	Carmarthenshire Integrated System	Review operating model of community hospitals	Recurrent	Blue	0	0
Community and Integrated Medicine	Carmarthenshire Integrated System	LOS reduction and associated bed efficiencies - GGH (2 year plan)	Recurrent	Blue	100	400
Community and Integrated Medicine	Carmarthenshire Integrated System	Review the bereavement service GGH	Recurrent	Red	0	0
Community and Integrated Medicine	Carmarthenshire Integrated System	Review operating model of community hospitals	Recurrent	Red	11	15
Community and Integrated Medicine	Carmarthenshire Integrated System	Biosimilar switches for USC	Recurrent	Red	19	25
Community and Integrated Medicine	Carmarthenshire Integrated System	Admin review	Recurrent	Red	21	28
Community and Integrated Medicine	Carmarthenshire Integrated System	WARD 6 PPH (orthopaedic) capacity review	Recurrent	Red	40	80
Community and Integrated Medicine	Carmarthenshire Integrated System	Reduction in variable pay for Doctors from changing the front door model PPH	Recurrent	Red	54	72
Community and Integrated Medicine	Carmarthenshire Integrated System	Communication Hub - Admin reconciliation (year 2)	Recurrent	Red	75	100
Community and Integrated Medicine	Carmarthenshire Integrated System	Reduction in variable pay for Doctors from changing the front door model GGH	Recurrent	Red	90	120
Community and Integrated Medicine	Carmarthenshire Integrated System	LOS reduction and associated bed efficiencies - PPH (2 year plan)	Recurrent	Red	100	200
Community and Integrated Medicine	Carmarthenshire Integrated System	MIU Future Model PPH	Recurrent	Red	294	504
Community and Integrated Medicine	Carmarthenshire Integrated System	Relocation of stroke services to PPH to align to CSP.	Recurrent	Red	526	2,105
Community and Integrated Medicine	Carmarthenshire Integrated System	Review Preseli ward (15 bed surgical ward GGH) - med and surical outliers	Recurrent	Red	700	1,400
Community and Integrated Medicine	Pembrokeshire Integrated System	Impact of Emergency General Surgery review WGH	Recurrent	Blue	0	0
Community and Integrated Medicine	Pembrokeshire Integrated System	Development of the Ambulatory Trauma Pathway from GGH to Withybush	Recurrent	Blue	0	0
Community and Integrated Medicine	Pembrokeshire Integrated System	Community Nursing OCP	Recurrent	Red	0	0
Community and Integrated Medicine	Pembrokeshire Integrated System	Optimise utilisation of Community Estate	Recurrent	Red	13	15
Community and Integrated Medicine	Pembrokeshire Integrated System	Optimise utilisation of Community Estate	Recurrent	Red	29	35
Community and Integrated Medicine	Pembrokeshire Integrated System	Deep dive of medical rotas	Recurrent	Red	85	85
Community and Integrated Medicine	Pembrokeshire Integrated System	Contract review of Community inpatient beds	Recurrent	Red	212	425
Community and Integrated Medicine Total					2,369	5,609

Level 4 Desc	Level 5 Desc	Scheme Name	Recurrent	RAG	Values £'000	
					In Year Plan	Full Year Plan
Planned and Specialist Care	Cancer and Scheduled Care	Theatres: Review PPH ICU	Recurrent	Blue	0	0
Planned and Specialist Care	Cancer and Scheduled Care	Centralisation of Trauma Care (South of HDUHB): T&O On Call rota amalgamation GGH/WGH	Recurrent	Blue	0	0
Planned and Specialist Care	Cancer and Scheduled Care	Theatres: Review WGH Main Theatre 4 Pay	Recurrent	Blue	0	0
Planned and Specialist Care	Cancer and Scheduled Care	Theatres: Review NCEPOD / TRAUMA theatre weekend service	Recurrent	Blue	0	0
Planned and Specialist Care	Cancer and Scheduled Care	Theatres: Review NCEPOD / TRAUMA weekend service	Recurrent	Blue	0	0
Planned and Specialist Care	Cancer and Scheduled Care	CSP; centralise ENT GGH	Recurrent	Blue	0	0
Planned and Specialist Care	Cancer and Scheduled Care	Theatres: WGH Withdrawal of out of hours staffing - Theatres - review NCEPOD / TRAUMA	Recurrent	Blue	0	0
Planned and Specialist Care	Cancer and Scheduled Care	Theatres: Review and reconfigure of DSU South theatre and patient flow ward areas and DSU Amman Valley theatre and ward areas.	Recurrent	Blue	31	122
Planned and Specialist Care	Cancer and Scheduled Care	Nursing variable pay opportunity	Recurrent	Red	0	360
Planned and Specialist Care	Cancer and Scheduled Care	Enhanced Critical Care model PPH, in line with National Guidelines	Recurrent	Red	0	200
Planned and Specialist Care	Cancer and Scheduled Care	CSP; General Surgery: Review Emergency Surgery (ES) at WGH. Also targets medical agency use within Planned Care (all agency doctors are Gen Surgery)	Recurrent	Red	0	0
Planned and Specialist Care	Cancer and Scheduled Care	Outpatient Transformation	Recurrent	Red	292	500
Planned and Specialist Care	Cancer and Scheduled Care	Medical Stabilisation: Opportunity £7m across clinical group, balance to existing transacted saving	Recurrent	Red	875	3,500
Planned and Specialist Care	Children, Women and Family Health	BGH Service provision changes for O&G, Maternity & Paediatrics	Recurrent	Blue	0	0
Planned and Specialist Care	Children, Women and Family Health	Medical workforce O&G (Rec/Cash Releasing)	Recurrent	Red	0	145
Planned and Specialist Care	Children, Women and Family Health	Repatriation of PAS from SBU LTA	Recurrent	Red	0	0
Planned and Specialist Care	Children, Women and Family Health	Review tripartite agreement with Garreglwyd for CCC provision (Rec/Cash Releasing)	Recurrent	Red	38	150
Planned and Specialist Care Total					1,235	4,977

Level 4 Desc	Level 5 Desc	Scheme Name	Recurrent	RAG	Values £'000	
					In Year Plan	Full Year Plan
Mental Health and Learning Disabilities	Mental Health and Learning Disabilities	Admin savings	Recurrent	Blue	0	0
Mental Health and Learning Disabilities	Mental Health and Learning Disabilities	Review legacy CHC LA package agreements	Recurrent	Blue	250	500
Mental Health and Learning Disabilities	Mental Health and Learning Disabilities	Review of CHC accruals for LAs	Non Recurrent	Blue	250	0
Mental Health and Learning Disabilities	Mental Health and Learning Disabilities	Ref 159 continued - MHLd non-recurrent pay savings (Oct-Mar)	Non Recurrent	Red	392	0
Mental Health and Learning Disabilities Total					892	500
Operational Allied Health and Health Sciences	Pathology	Reduction to Agency Locum	Recurrent	Red	0	90
Operational Allied Health and Health Sciences	Pathology	OOH Service	Recurrent	Red	0	56
Operational Allied Health and Health Sciences	Pathology	Outsourced Income	Recurrent	Red	0	50
Operational Allied Health and Health Sciences	Pathology	Haem Drug Biosimilar	Recurrent	Red	26	105
Operational Allied Health and Health Sciences Total					26	301
Primary Care, Community Strategy and Long Term Care	Pharmacy and Medicines Management	Dimethyl fumarate	Recurrent	Red	110	110
Primary Care, Community Strategy and Long Term Care	Pharmacy and Medicines Management	Bosutinib	Recurrent	Red	113	113
Primary Care, Community Strategy and Long Term Care	Pharmacy and Medicines Management	Bulk purchase of chemotherapy	Recurrent	Red	188	188
Primary Care, Community Strategy and Long Term Care Total					410	410

3.2

10:30 AM, 15 Mins

3.2 - COMMUNITY AND INTEGRATED MEDICINE PERFORMANCE AND PRODUCTIVITY

Andrew Carruthers
(Hywel Dda UHB -
Chief Operating
Officer)

| For assurance

Attachments

[Community and Integrated Medicine Performance and Productivity FPC 26 Augus~.pdf](#)



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board



Community and Integrated Medicine Performance and Productivity

Finance and Performance Committee, 26 August 2025



The Finance and Performance Committee is requested to consider current progress and further actions currently being progressed by the Community and Integrated Medicine Clinical Care Group (CCG) and its constituent Site/System Leadership Teams to support improvements in Urgent and Emergency Care (UEC) performance and productivity.

Community and Integrated Medicine: Performance and Productivity Overview



GIG
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Hywel Dda
University Health Board

- **Slide 4** provides a 1-page summary of current Health Board and local Site/System UEC performance, in comparison to targeted intervention (TI) de-escalation criteria.
- **Slides 5 – 9** provide an overview of Health Board and local Site/System performance in respect of the following key UEC performance and productivity metrics:
 - Ambulance patient handover performance
 - Time to assessment
 - 12 Hour Emergency Department (ED) waits
 - Same Day Emergency Care (SDEC) activity and impact
 - Delayed Pathways of Care (DPoCs)
- In July 2025, positive progress was noted in respect of ambulance handover performance, patients waiting longer than 12 hours in ED, utilisation and impact of SDECs, and DPoCs. However, performance remains outside TI de-escalation criteria.
- Performance in respect of time to clinical assessment in ED Performance remains variable with no site achieving the 60 min de-escalation criteria.

C&IM Performance & Productivity Overview:

UEC De-escalation Summary

	Measure	De-escalation criteria	Baseline	Baseline	Goal	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25
Hywel Dda	Ambulance handovers taking over 1 hour - Hywel Dda	11% reduction 3 consecutive months, maintained for 3 months	964	Baseline (average Q3 23/24)	680	1,192	1,103	970	1,078	959	721	771	929	986	1,153	1,117	795	988	866	1,059	1,009	883
	% patients waiting over 12 hours in an emergency department - Hywel Dda	Continuous improvement towards no more than 7%	9.0%	Nov-23	7%	11.3%	10.3%	10.7%	10.7%	10.1%	9.4%	10.6%	10.3%	11.2%	11.7%	11.1%	9.6%	8.9%	8.8%	7.8%	7.8%	7.3%
	Median time from arrival at ED to assessment by a clinical decision maker (mins) - Hywel Dda	60	58	Nov-23	60	67	65	73	75	74	73	69	73	87	89	70	75	76	79	70	78	80
	Number of delayed pathways of care - Hywel Dda	5% reduction 3 consecutive months	203	Baseline (average Q3 23/24)	174	220	237	249	253	203	194	191	200	204	208	200	217	218	223	234	230	211
Bronglais	Ambulance handovers taking over 1 hour - Bronglais Hospital	11% reduction 3 consecutive months, maintained for 3 months	174	Baseline (average Q3 23/24)	122	182	211	240	233	192	180	191	198	231	238	196	220	176	159	209	126	67
	% patients waiting over 12 hours in an emergency department - Bronglais Hospital	Continuous improvement towards no more than 7%	8.9%	Nov-23	7.0%	10.1%	10.9%	10.8%	11.0%	9.6%	9.2%	9.6%	8.5%	9.2%	11.8%	12.0%	12.8%	10.2%	8.1%	8.6%	7.7%	5.9%
	Median time from arrival at ED to assessment by a clinical decision maker (mins) - Bronglais Hospital	60	58	Nov-23	60	66	69	71	67	67	64	57	73	78	91	75	79	79	74	71	83	76
Glangwili	Ambulance handovers taking over 1 hour - Glangwili Hospital	11% reduction 3 consecutive months, maintained for 3 months	463	Baseline (average Q3 23/24)	326	490	498	468	480	527	394	412	471	419	472	495	372	458	427	476	487	428
	% patients waiting over 12 hours in an emergency department - Glangwili Hospital	Continuous improvement towards no more than 7%	10.7%	Nov-23	7%	16.1%	14.1%	15.1%	15.9%	17.3%	14.7%	17.5%	17.0%	17.3%	15.2%	15.1%	12.3%	12.4%	12.1%	8.9%	10.1%	8.7%
	Median time from arrival at ED to assessment by a clinical decision maker (mins) - Glangwili Hospital	60	49	Nov-23	60	61	60	69	76	84	82	79	84	97	89	68	77	77	87	78	75	78
Prince Philip	Ambulance handovers taking over 1 hour - Prince Philip Hospital	11% reduction 3 consecutive months, maintained for 3 months	61	Baseline (average Q3 23/24)	43	112	143	106	104	53	102	76	101	75	68	153	65	110	61	130	123	75
	% patients waiting over 12 hours in an emergency department - Prince Philip Hospital	Continuous improvement towards no more than 7%	2.1%	Nov-23	7%	4.5%	3.4%	3.4%	3.5%	2.6%	2.8%	3.1%	2.6%	0.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Withybush	Ambulance handovers taking over 1 hour - Withybush Hospital	11% reduction 3 consecutive months, maintained for 3 months	266	Baseline (average Q3 23/24)	188	408	251	156	261	187	45	92	159	261	375	273	138	244	219	244	273	313
	% patients waiting over 12 hours in an emergency department - Withybush Hospital	Continuous improvement towards no more than 7%	16.2%	Nov-23	7%	16.3%	15.0%	14.9%	13.9%	12.4%	12.4%	13.5%	13.6%	16.3%	18.9%	19.0%	15.5%	15.0%	15.7%	15.0%	14.0%	15.3%
	Median time from arrival at ED to assessment by a clinical decision maker (mins) - Withybush Hospital	60	77	Nov-23	60	81	70	85	83	70	72	70	62	80	87	70	70	74	73	59	76	87
DPoC	Number of delayed pathways of care - Carmarthenshire	5% reduction 3 consecutive months, maintained for 3 months	108	Baseline (average Q3 23/24)	103	113	119	134	133	94	116	97	119	118	113	101	118	102	106	127	110	107
	Number of delayed pathways of care - Ceredigion	5% reduction 3 consecutive months, maintained for 3 months	35	Baseline (average Q3 23/24)	33	43	54	44	38	37	28	27	23	33	21	36	34	49	32	34	40	33
	Number of delayed pathways of care - Pembrokeshire	5% reduction 3 consecutive months, maintained for 3 months	53	Baseline (average Q3 23/24)	50	62	63	70	72	65	45	57	52	45	67	54	59	62	77	68	76	65

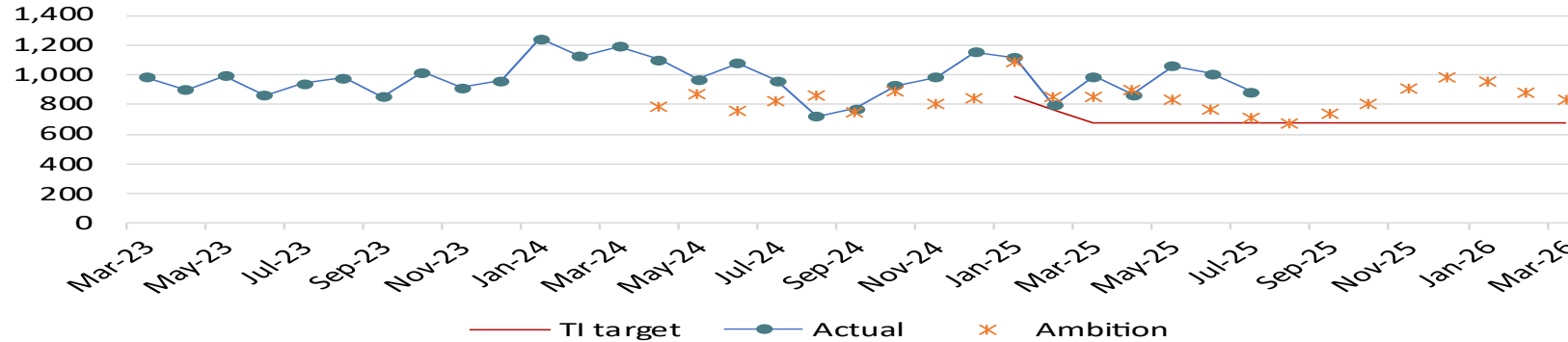
Performance and Productivity: Ambulance Patient Handovers < 1 hour



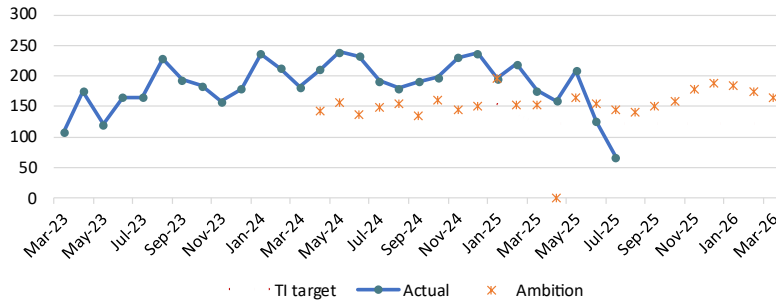
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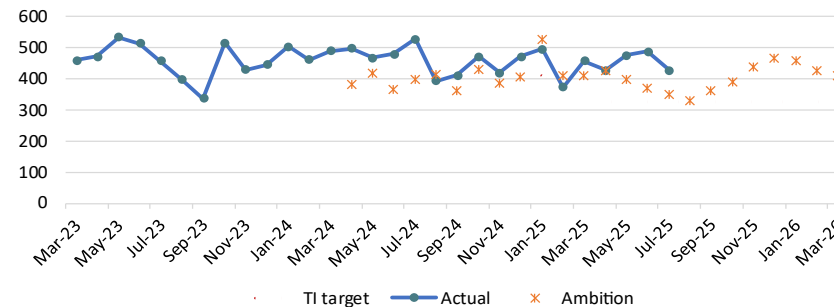
Ambulance handovers taking over 1 hour- Hywel Dda



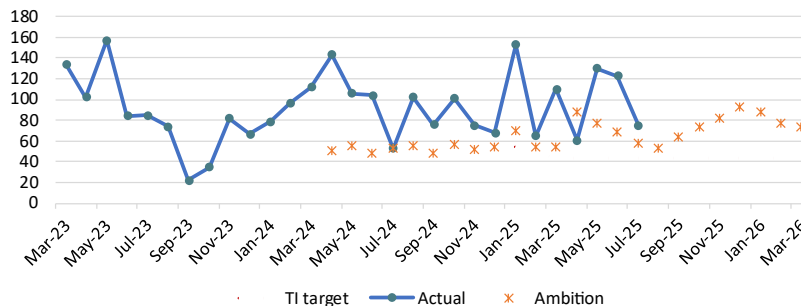
Ambulance handovers taking over 1 hour- Bronglais Hospital



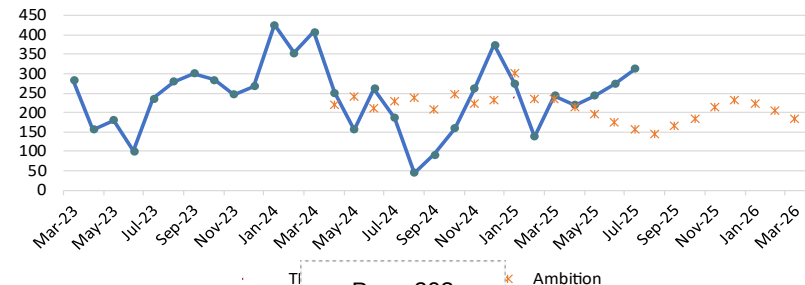
Ambulance handovers taking over 1 hour- Glangwili Hospital



Ambulance handovers taking over 1 hour- Prince Philip Hospital



Ambulance handovers taking over 1 hour- Wwithybush Hospital



- Ambulance >1hr handovers for July 25 improved for the second consecutive month.
- However, the recorded number of **883** delays remains above the monthly TI target of 680.
- 3 out of 4 sites showed improvement with the most notable progress achieved at Bronglais Hospital (BGH) with **67** ambulance >1hr handovers recorded. This was significantly below the July Annual Plan ambition of 145 and TI target of 122.

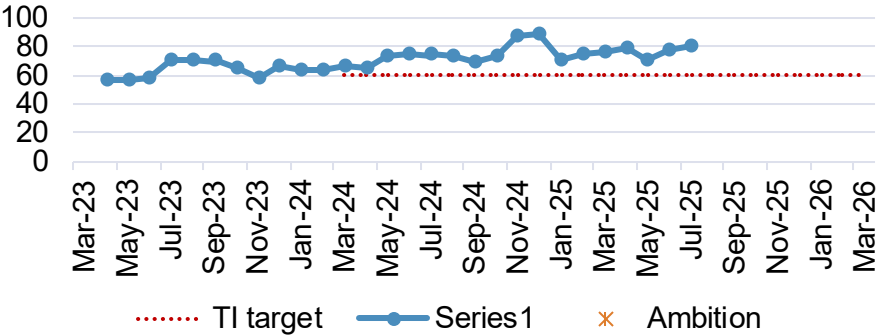
Performance and Productivity: Time to Clinical Assessment in ED



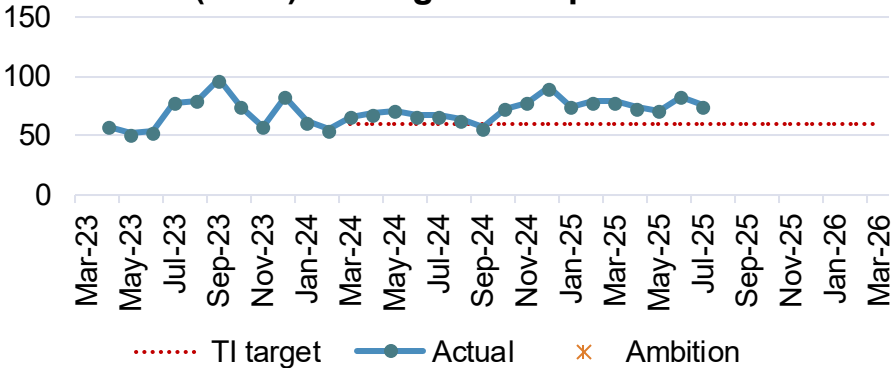
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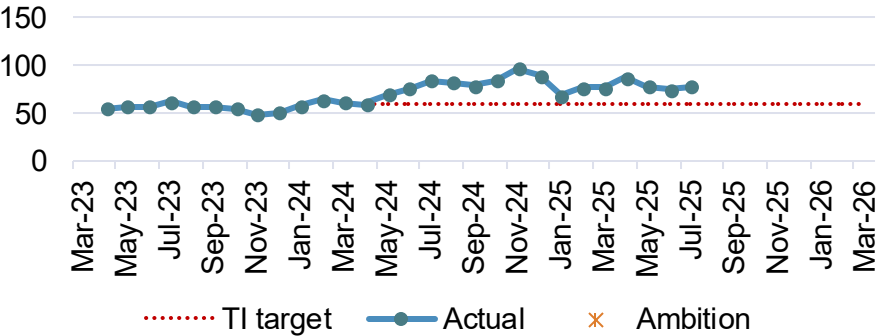
Median time from arrival at ED to
assessment by a clinical decision maker
(mins) - Hywel Dda



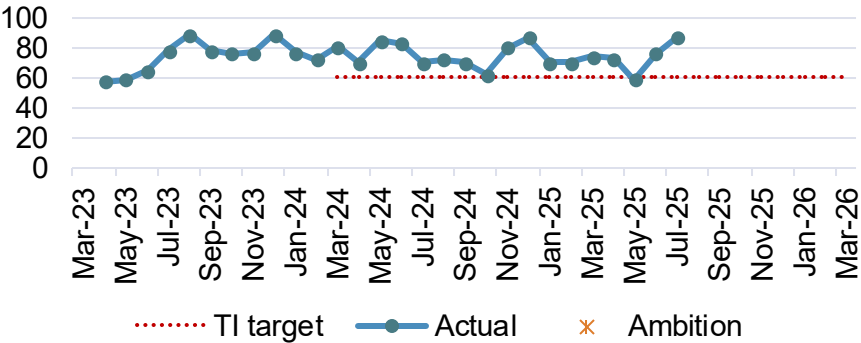
Median time from arrival at ED to
assessment by a clinical decision maker
(mins) - Bronglais Hospital



Median time from arrival at ED to
assessment by a clinical decision maker
(mins) - Glangwili Hospital



Median time from arrival at ED to
assessment by a clinical decision maker
(mins) - Withybush Hospital

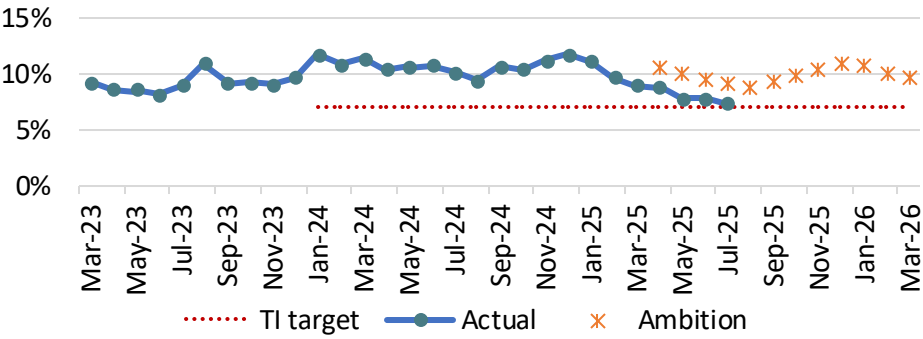


- Performance remains variable with no site achieving the 60 min de-escalation criteria
- Performance in July 2025 averaged **80 mins** - BGH achieved the best performance of the 4 sites (**76 mins** average.)
- Performance continues to be impacted by ED workforce availability challenges and space constraints to assess patients due to excess capacity pressures within EDs

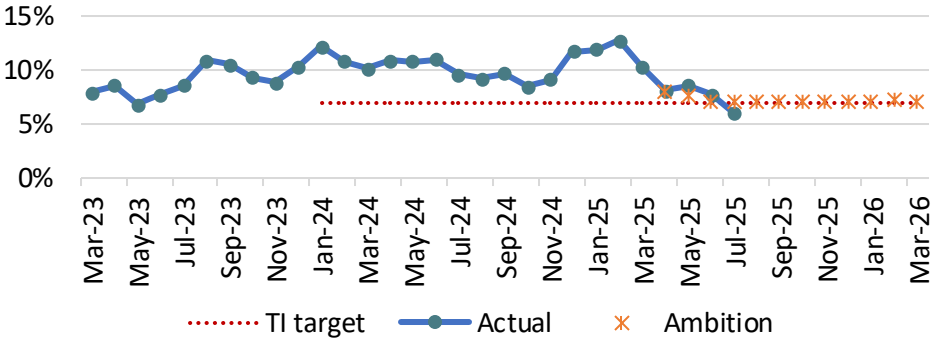
Performance and Productivity:

% Patients Waiting Over 12 Hours in an Emergency Department

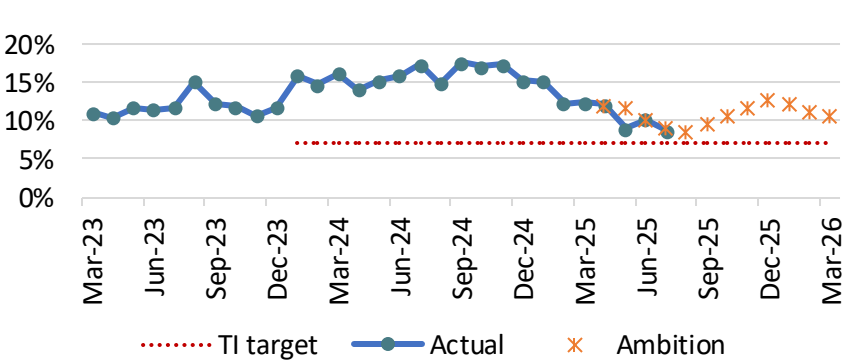
% patients waiting over 12 hours in an emergency department - Hywel Dda



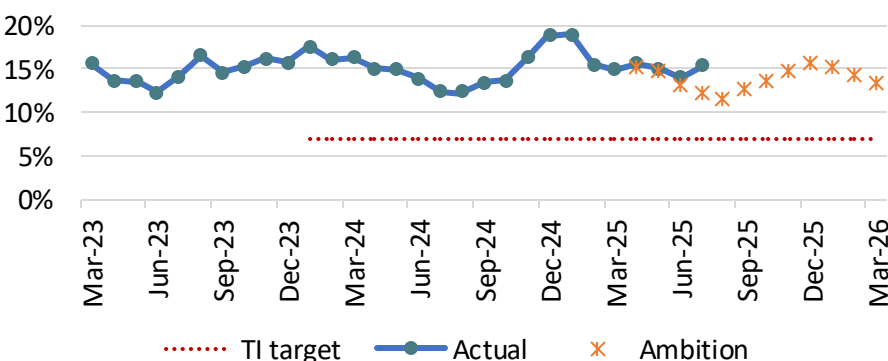
% patients waiting over 12 hours in an emergency department - Bronglais Hospital



% patients waiting over 12 hours in an emergency department - Glangwili Hospital

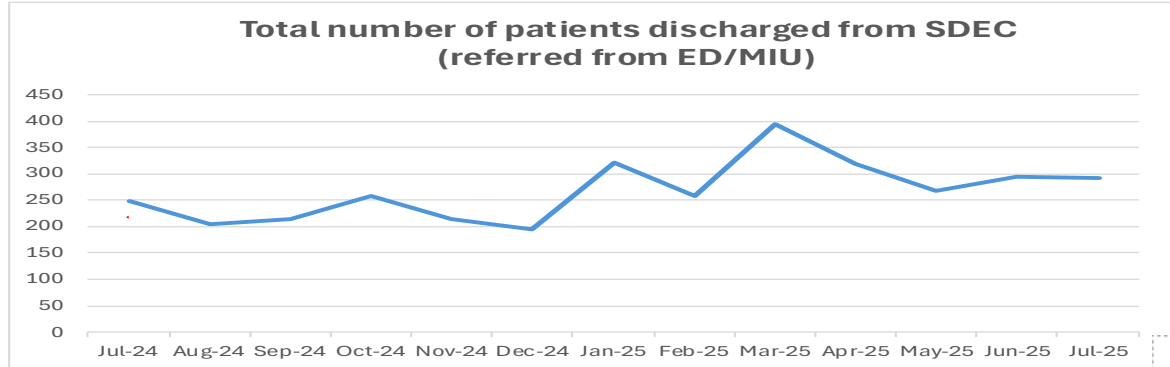
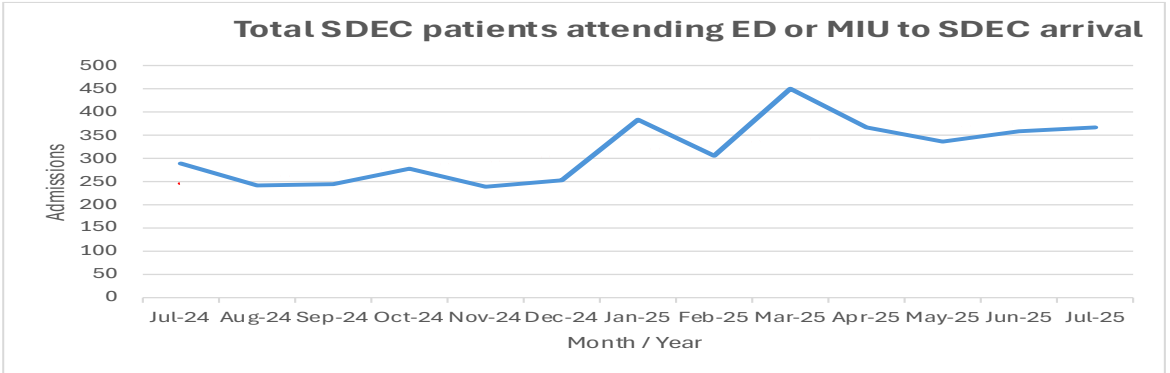
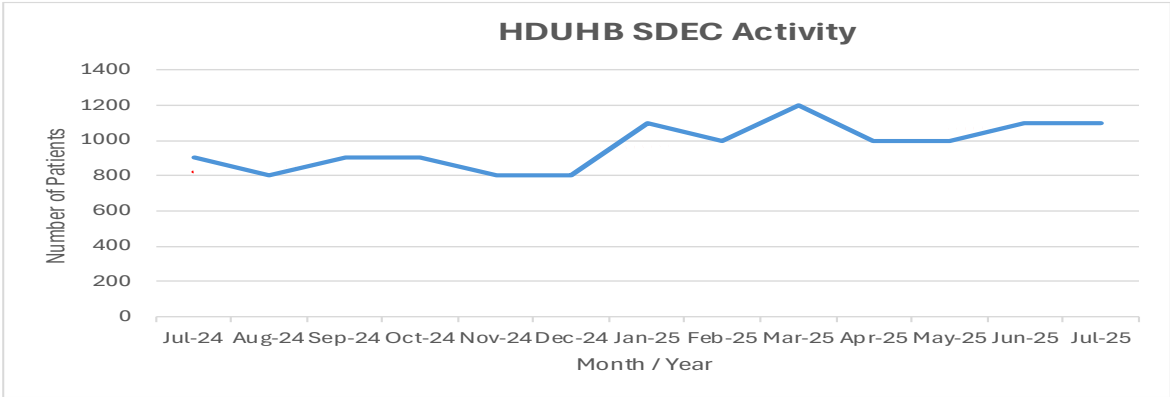


% patients waiting over 12 hours in an emergency department - Wwithybush Hospital



- Performance has shown a consistent trend in improvement over the past 8 months, reducing from a peak of 11.7% in Dec 2024 to 7.3% in July 2025
- Latest performance is 0.3% above the TI de-escalation criteria and represents the best (lowest) monthly performance since the COVID-19 pandemic
- However, significant variation was noted ranging from 5.3% at BGH to 15.3% at Wwithybush Hospital (WGH)
- The recent overall trend towards improvement at GGH in respect of the measure continued, with 8.7% patients staying > 12 hrs (the best performance since the pandemic)

Performance and Productivity: SDEC Utilisation



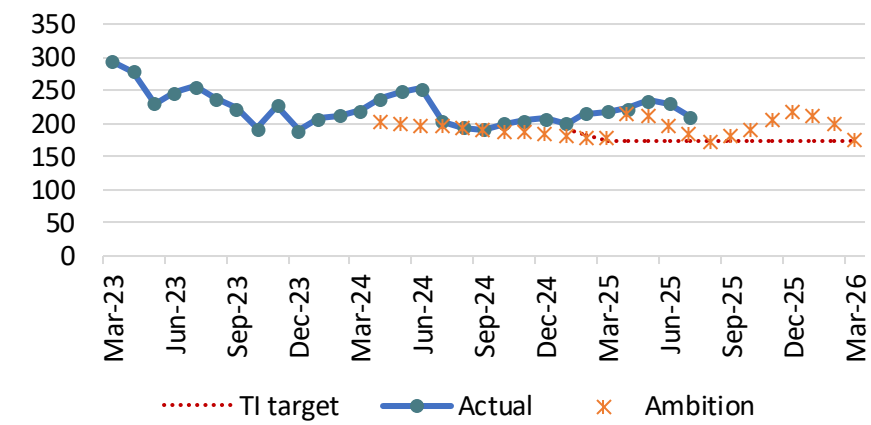
The July 2025 data shows a slight increase in SDEC activity, continuing the increasing trendline for SDEC activity in the Health Board over the last year. The impact of the surgical SDEC in GGH and additional weekend opening hours have contributed to this position.

The overall trend in the number of patients being pulled from EDs/Minor Injury Units (MIUs) into SDECs is increasing, although variability was noted at the end of 2024/25. The numbers of patients leaving the same day from SDECs across the Health Board shows a similar pattern.

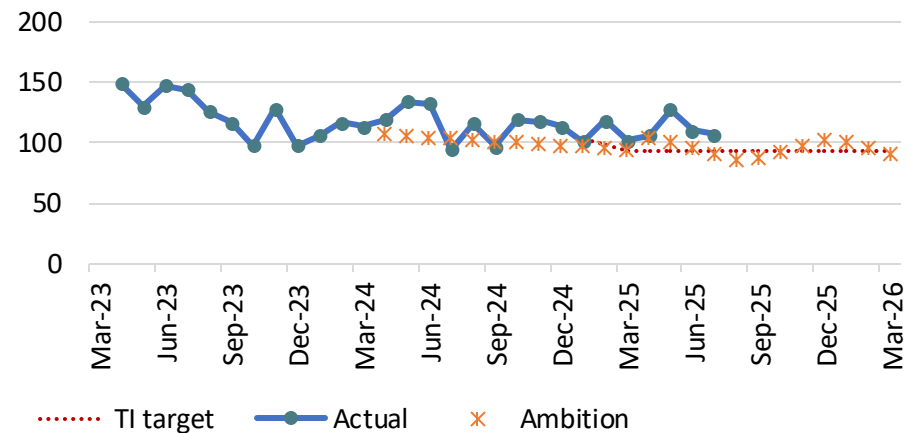
Overall, this indicates positive growth for SDECs in Hywel Dda over the last year, the units are seeing more patients, pulling more from EDs and MIUs to relive pressure in the system, and preventing admission where not necessary. The digital ward and hospital at home initiatives have in part been an enabler for this, allowing SDECs to monitor and manage patients in the community more effectively to avoid admission

Performance and Productivity: Delayed Pathways of Care (DPoC):

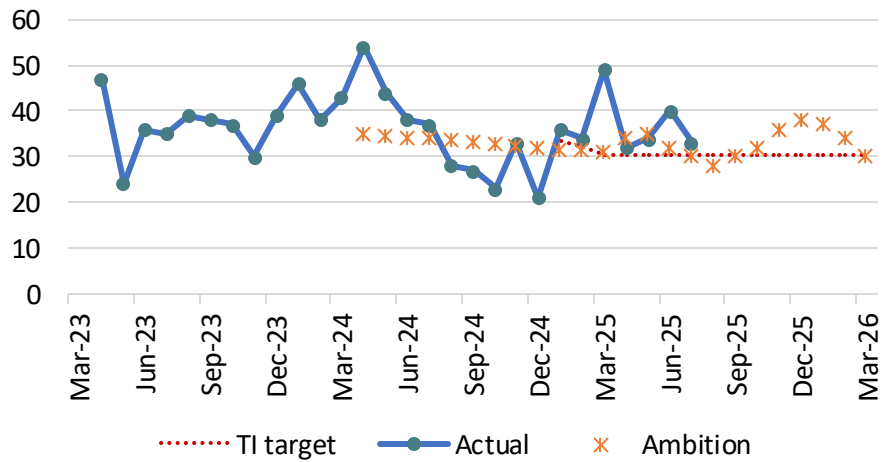
Number of delayed pathways of care - Hywel Dda



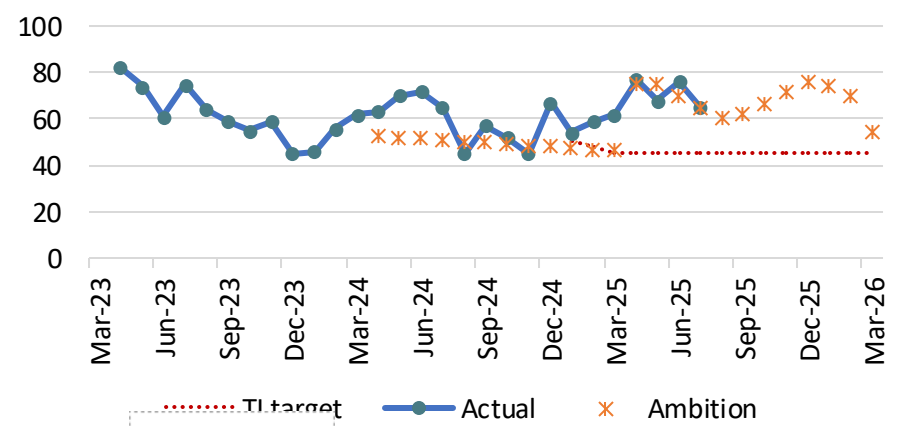
Number of delayed pathways of care - Carmarthenshire



Number of delayed pathways of care - Ceredigion



Number of delayed pathways of care - Pembrokeshire



- DPOCs saw a more significant improvement in July 2025 (reduced to 211) after the small improvement in June 2025.
- The follows a period of sustained increase in DPOCs earlier in the calendar year
- Improvements were noted in all 3 county systems, with each system exceeding the required 5% improvement threshold in the month.
- DPOCs in Carmarthenshire have improved by 16% over the past 2 months

Performance and Productivity: Further Improvement Actions



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- In May 2025, the Executive Team commissioned a UEC Accelerated Transformation Programme, designed to deliver a step change improvement in UEC performance by October 2025. The primary aim of the programme is to minimise attendance at an ED by providing appropriate, alternative pathways for patients.
- In October 2025, a revised ambulance handover performance expectation comes into effect, with the mandatory handover of all emergency ambulances within a maximum of 45 minutes from arrival
- The following slides provide a summary of the key Site/System specific improvement actions currently being progressed along with a System Wide coordinated action plan designed to support effective implementation of the 45min max ambulance handover requirement by 1 October 2025.
- To enable the above, the recent positive progress achieved by the CCG in respect of ambulance handover performance, patients waiting longer than 12 hours in ED, utilisation & impact of SDECs, and delayed pathways of care will need to be sustained and further supported by the actions reflected on the following slides.

Performance and Productivity

Current Site-Specific Operational Actions:



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Glangwili Hospital		Target Date	Prince Philip Hospital		Target date
- Health Board Repatriation Document to be developed and agreed at Clinical Care Group. - Expansion of Same Day Emergency Care (SDEC) footprint with capital funding, with weekly project group in place. - Review of perfect week initiatives to be evaluated with a view to identify potential funding sources. - Teifi Trauma Ambulatory Care Unit pilot data to be reviewed with consideration to operationalising as daily practice.		30/09/25	- SDEC (Same Day Emergency Care) supporting AMAU/MIU to reduce pressure at the front door. Weekend cover is also being scoped when required during busy periods and staffing levels allow. - Newly appointed locum consultant for SDEC to support weekly hot clinics. This allows for prompt treatment of patients through SDEC which supports flow and admission avoidance. - Consultant Connect being introduced to use operationally within SDEC to further support effectiveness of the department. Go Live Aug 25-this commences end of Aug which will allow direct contact into medical doctor in SDEC for advice/referrals. - Use of hospital @ home to create a wraparound service enabling community GPs to refer directly into SDEC, to treat and then refer patients back into hospital @ home support admission avoidance.		30/09/25
		30/03/26			30/08/25
		31/08/25			30/08/25
		30/09/25			30/08/25
Bronglais Hospital		Target Date	Withybush Hospital		Target Date
- Dedicated RAaT provision at the front door enabling timely assessment – nursing model needs signing off by Executive Team. - Review of current discharge and flow pathways with proposal for full revamp of Porth Gofal and patient flow processes encompassing a number of Quality Improvement projects. - Establish accelerator team to focus on discharges – escalation of delays to System General Manager. - Flow ownership (Flow Champion to be established) – from whiteboard to ward - Training to be delivered by Informatics team on accuracy of data. Awaiting roll out.		01/10/25	- Prioritising early discharge, utilising the discharge lounge to full capacity - Re –design of the daily clinical and operational oversight teams - Senior medical team now secured in ED (3-month pilot), aim to have senior decision making and leadership managing the medical boarding patients in ED - IP&C nurse participating in the site meetings, supporting in rapid access to screening - Local site protocol to de-surge the assessments units, to maintain the flow out of ED and avoid ED attendances.		01/09/25
		31/09/25			01/09/25
		01/09/25			11/09/25
		01/10/25			30/08/25
		01/10/25			30/09/25

Performance and Productivity: 45 Minute Ambulance

Additional System-wide 45 min Ambulance Handover Action Plan



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Action	Expected impact	Support needed/limiting factors	Owner	By When
Health Board initiative Your Next Patient and continuous flow launched	Reduce handover delays by ensuring immediate allocation of patients to clinical areas	Endorsement and oversight from Clinical Executives	Site / System Leadership Teams	01/09/2025
Development of Health Board Internal Professional Standards	Create consistent escalation and operational response framework across all acute sites	Senior clinical leadership support for rollout and compliance monitoring	Site / System Clinical Leads	01/11/2025
Implementation of Regional Integrated Pathways of Care Delay Plan	Improve flow between acute, community, and social care to reduce hospital delays	Partnership working with regional partners and local authorities	CCG	From 30/09/25
Ambulance redirection	Divert non-urgent cases to alternative care settings, reducing ED pressure	Clinical Executive endorsement; operational coordination with WAST	Site / System Leadership Teams	30/09/25
Implementation of ED / MIU Redirection Policy	Reduce inappropriate ED attendances and optimise use of MIUs	Endorsement from Clinical Executives	Site /System Leadership Teams	30/09/25
Criteria-led discharge to support out-of-hours/weekend discharges	Increase discharges before midday to release beds earlier	Support investment in one additional middle grade on the weekends focused on discharges	Site / System Leadership Teams	30/09/25
Optimal use of discharge lounges to facilitate early discharges	Improve patient flow and reduce ED congestion		Site / System Leadership Teams	30/09/25
Testing of additional senior medical / clinical presence at ED front door	Provide early senior clinical input to streaming, improve patient navigation, and accelerate ambulance handovers	Workforce allocation; evaluation of pilot outcomes	Pembs & Ceredigion Site / System Leadership Teams	30/09/25
Protecting assessment units	Preserve flow through short-stay areas and avoid backflow into ED	Executive support – Silver and Gold command activation	Site / System Leadership Teams	02/09/2025
7 days per week Operational Delivery Unit (ODU) to focus on handover delays across the Health Board.	Health Board wide operational oversight and coordination of flow and handover delays	Commitment to release staff from each Site / System Leadership Team	CCG	30/09/25



The Committee is requested to **RECEIVE ASSURANCE** from recent progress achieved, and further actions currently being progressed by the Community and Integrated Medicine CCG and its constituent Site/System Leadership Teams to support improvements in UEC performance and productivity.



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3.3

10:45 AM, 15 Mins

3.3 - PLANNED CARE AND CANCER PERFORMANCE AND PRODUCTIVITY

Andrew Carruthers
(Hywel Dda UHB -
Chief Operating
Officer)

| For assurance

Attachments

Planned Care and Cancer Performance and Productivity FPC 26 August 2025.pdf



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Planned and Cancer Care Performance and Productivity

Finance and Performance Committee, 26 August 2025



The Finance and Performance Committee is requested to consider current progress and further actions currently being led by the Planned and Specialist Care CCG (with support of other CCGs) to enable improvements in planned care and cancer performance and productivity.

Planned and Cancer Care:

Planned Care and Cancer De-escalation Summary



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Measure	De-escalation criteria	Baseline	Baseline	Goal																	
					Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25
% patients starting first definitive cancer treatment within 62 days from point of suspicion	60% for 3 consecutive months	50%	Baseline Oct -23	60%	60%	43%	53%	54%	54%	48.0%	40.0%	44.6%	56%	59%	53%	63.5%	65.4%	62.4%	66.1%	61.4%	n/a
% open pathways waiting less than 52 weeks for a new outpatient appointment	100% for 3 consecutive months	95%	Nov-24	100%	93.8%	92.5%	91.5%	91.3%	92.9%	93.4%	94.6%	95.0%	95.1%	95.6%	97.3%	98.8%	100.0%	99.9%	99.8%	99.9%	99.8%
% open pathways waiting less than 26 weeks for referral to treatment	75% for 3 consecutive months	60%	Nov-24	75%	59.1%	58.3%	57.5%	58.8%	59.1%	58.3%	59.5%	59.8%	60.5%	59.9%	60.6%	61.6%	62.4%	62.2%	61.5%	63.0%	64.0%
% open pathways waiting less than 104 weeks for referral to treatment	100% for 3 consecutive months	98%	Nov-24	100%	98.5%	98.4%	98.3%	98.2%	98.2%	98.1%	98.1%	97.9%	97.9%	98.1%	98.6%	99.1%	100.0%	99.8%	99.7%	99.8%	99.8%
% open pathways waiting less than 36 weeks for referral to treatment	80% for 3 consecutive months	71%	Nov-24	80%	70.1%	69.9%	69.4%	69.6%	69.3%	69.2%	71.1%	71.0%	71.1%	71.3%	72%	73%	74%	73%	73%	74%	75%
Number of patients waiting for a follow up outpatient appointment delayed by over 100%	12% reduction 3 consecutive months, maintained for 3 months	16,682	Nov-24	11,368	15,829	16,028	16,201	16,062	15,714	16,015	16,381	16,481	16,682	16,976	16,818	16,445	16,504	16,775	17,167	17,203	17,011
% ophthalmology R1 patient pathways waiting within their clinical target date or within 25% beyond their clinical target date	65% for 3 consecutive months	34%	Nov-24	65%	40.0%	40.1%	38.1%	37.7%	36.1%	36.7%	36.0%	35.0%	34.0%	34.2%	34.2%	34.6%	35.0%	34.0%	35.0%	34.9%	n/a
% patients waiting less than 8 weeks for diagnostic test - diagnostic endoscopy	85% for 3 consecutive months	57%	Nov-24	85%	37.0%	35.8%	34.4%	34.5%	44.0%	36.1%	44.1%	55.3%	57.3%	64.0%	75.3%	88.9%	91.7%	91.2%	85.3%	82.4%	83.3%

Planned Care Performance: Latest Referral-To-Treatment Performance



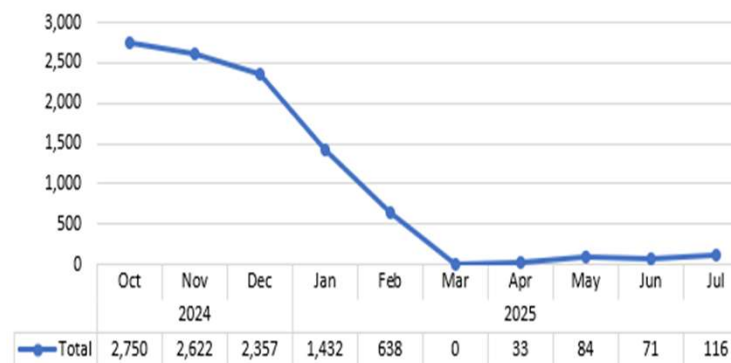
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New outpatient waits over 1 year

Specialty	Jun-25	Jul-25	Difference
Geriatric Medicine	62	74	12 ↑
Ophthalmology	0	34	34 ↑
General Medicine	9	8	-1 ↓
Grand Total	71	116	45 ↑

New outpatient waits over 1 year

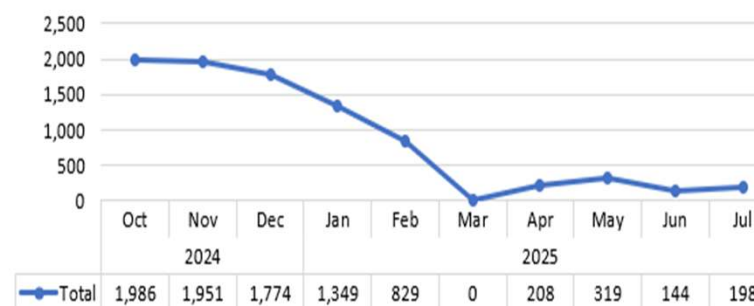


- 116 Stage 1 52-week breaches in July 2025 (an increase of 45 over June 2025).
- The majority of Stage 1 breaches (82) relate to Geriatric/General Medicine, reflecting delivery challenges in the osteoporosis pathway. 34 Ophthalmology breaches were also reported due to reduced clinical capacity in July 2025 that are expected to recover to zero by end of Q2 2025/26.
- Total Pathway (maximum 104-week wait) breaches increased by 54 in-month to a total of 198 breaches, with the largest volumes in orthopaedics and ENT (which are a direct consequence of cancelled sessions at Glangwili Hospital (GGH) due to the deteriorating theatre staffing position)

RTT waits over 2 years

Specialty	Jun-25	Jul-25	Difference
Trauma & Orthopaedics	75	101	26 ↑
ENT	45	60	15 ↑
General Medicine	18	24	6 ↑
Dermatology	1	7	6 ↑
Ophthalmology	5	4	-1 ↓
Vascular	0	1	1 ↑
Geriatric Medicine	0	1	1 ↑
Grand Total	144	198	54 ↑

RTT waits over 2 years



Planned Care Performance: Referral-To-Treatment Recovery Actions



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Target	Specialty	Action	Impact	Target Date
Stage 1 (52 weeks)	Gen/Geriatric Med	Confirmation of recovery plan to include onboarding of 2 additional doctors and support from Fracture Liaison Nursing team	Required recovery during Q3.	31/08/25
	Multi Specialty	National OPA insource initiative to commence - will reduce OP waiting volumes by circa 15,000 patients in HDUHB by March 2026	Will also enable reduction in waiting times to circa 26 weeks	31/08/25
Total Pathway (104 weeks)	ENT	- Insourcing of theatre staff to maintain core capacity at GGH - Outsourcing on tonsillectomy cases - Internal WLIs	Reduction of breaches to circa 20 by end Q2 and zero through Q3	- Commenced - Commenced - Commenced
	Orthopaedics	- Insourcing of weekend theatre lists - Weekend WLIs - Access to Neath Port Talbot operating capacity	Expect to resolve all breaches by end Q2	- Commenced - Commenced 30/09/25
	Ophthalmology	Outsourcing of cataract lists	Expect to resolve all breaches by end Q2	Commenced
	Gen/Geriatric Med	Confirmation of recovery plan to include onboarding of 2 additional doctors and support from Fracture Liaison Nursing team	Required recovery by end Q2.	31/08/25
	Other specialties	No specific recovery actions required	Required recovery by end Q2.	n/a

Planned Care Performance: Endoscopy Diagnostics 8-Week Performance



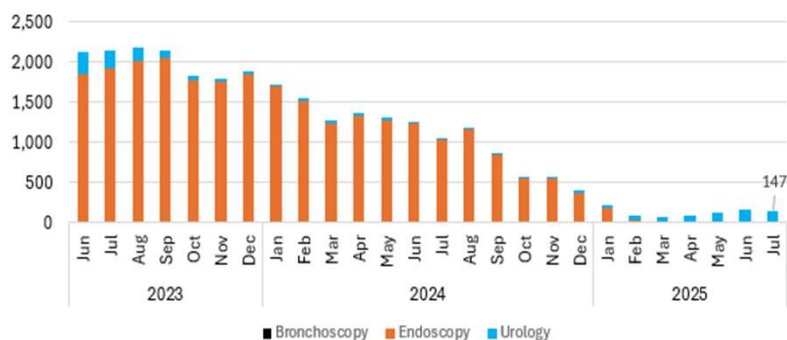
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- In July 2025, no patients waited over 8 weeks for a Bronchoscopy or Endoscopy diagnostic
- 147 out of 295 (49.8%) of Urology (Flexible Cystoscopy) patients waited beyond 8 weeks for their procedure. This is an improvement compared to June 2025

Data as at Jul-25

Service	<8 wks	8+ wks	% over 8 weeks
Bronchoscopy	3	0	0.0%
Endoscopy	583	0	0.0%
Urology	148	147	49.8%
Grand total	734	147	16.7%



Flexible Cystoscopy Recovery Actions (to enable recovery during Q3)

Target Date

Additional cystoscopy capacity scheduled in WGH DSU.

31/08/25

Expand Endoscopy D&C dashboard to include Flexible Cystoscopy to facilitate informed planning

30/09/25

CNS double vetting USC cases to downgrade where appropriate and balance referral to reduce demand

30/08/25

Ongoing clinical validation of long waiting cases

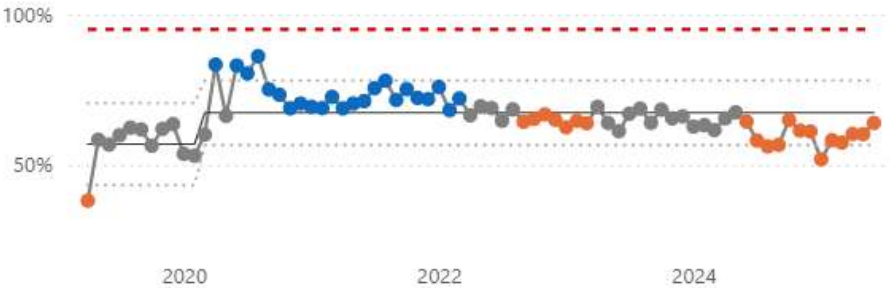
30/08/25

New Urology Consultant started in July can provide additional capacity if lists become available

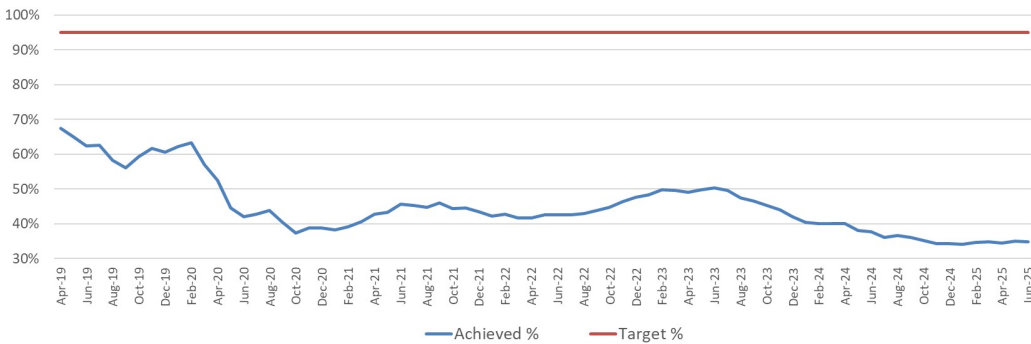
30/09/25

Planned Care Performance: Ophthalmology R1 Performance

% R1 appointments attended which were within their clinical target date or within 25% beyond their clinical target date



% R1 patients waiting within their clinical target date or within 25% beyond their clinical target date



R1 patients waiting:

- Performance has been static at 34-35% since Autumn 2024
- Reflects significant workforce challenges within IVT & glaucoma pathways

R1 appointments attended:

- Conversely performance is improving as a consequence of IVT and glaucoma recovery actions with June performance at its highest level since October 2024
- Provisional July performance suggests a further improvement to 69% (highest since August 2023) and the actual volume attending within target was the second highest in 5 years

Ophthalmology R1 Performance Improvement Actions (to enable recovery of R1 patients waiting above 60% by Q4)	Target Date
Continue IVT outsource solutions & WLI clinics whilst internal recruitment supported by recurrent investment progresses	31/08/25
Continue implementation of IVT and Glaucoma service expansion, recruitment & training plans through Q3 and Q4	31/03/26
Commence recruitment of 2 x regional consultant posts (with special interest in Medical Retina)	30/09/25
On-board newly recruited replacement Specialty Doctors	31/10/25

Planned Care Productivity and Performance

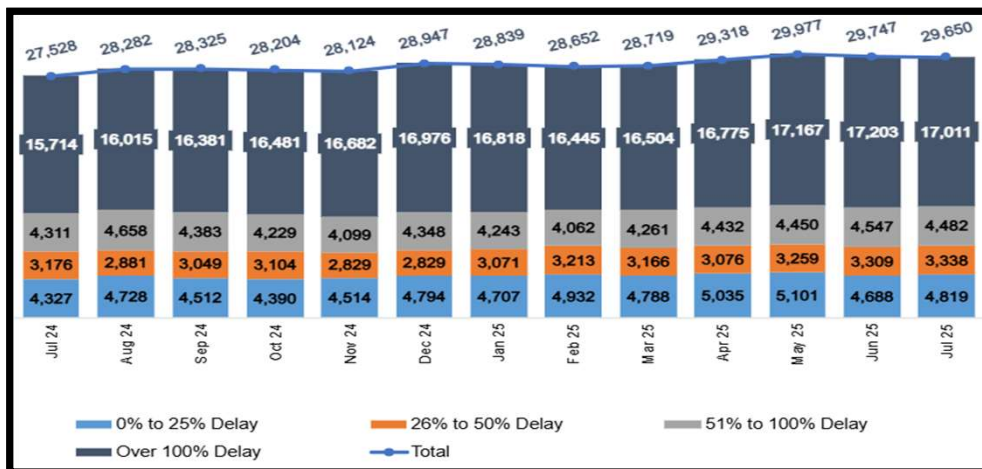
Delayed Follow Ups and Outpatient Transformation



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- Performance relatively static over past 2 years
- Small improvement in 100% delayed in July 2025 (-192)
- Hywel Dda University Health Board (HDdUHB) follow up waiting lists are significantly lower than other Health Boards – circa 17% of HDdUHB resident population – represents strong clinical triage focus in most specialties and proactive use of alternative See-on-Symptoms(SoS)/ Patient-Initiated Follow-Up (PIFU) approaches
- HDdUHB has lowest volume of 100% delayed patients than other Health Boards



- Health Board combined discharge & SoS/PIFU performance exceeds 50%
- Majority of 100% delayed follow up are historical 2 year+ waits (subject to clinical validation re ongoing care requirements)
- Targeted improvement metrics applied to all specialties to support improvement to TI improvement threshold by March 2026

Delayed Follow Up Recovery Actions (to enable recovery to TI target by March 2026)	Target Date
Progress Outpatient & Ambulatory Care Transformation Programme improvement actions launched by CCG May 2025	31/03/26
Implementation Plan agreed to apply national Clinical Implementation Network (CIN) outpatient guidance in all CIN specialties	30/03/26
Application of revised NHS Wales Access Policy and strict adherence to protocols for management of DNAs	30/08/25
Prioritise application of SoS/PIFU pathways in specialties where uptake is low.	31/12/25
Incremental application of the CIN guidance to the historical cohort of 2 year+ follow-up patients (either discharge or transfer to SoS/PIFU pathways)	31/12/25

Planned Care Productivity: Theatre Utilisation



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Actual Sessions

5,017

Average Session
Hours

4.56

Avg Operating
Hours per session

4.24

Avg Procs per
session

3.53

Avg Turnaround
Mins

9.29

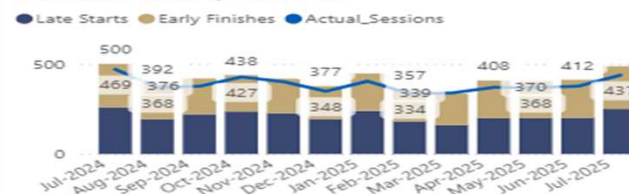


GWASANAETHAU DIGIDOL
Digital Services

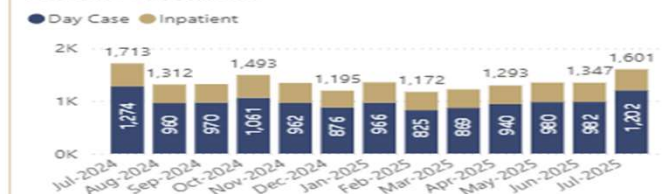
Theatre Time Utilisation



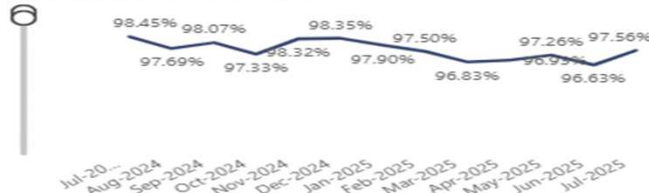
Late Starts/Early Finishes



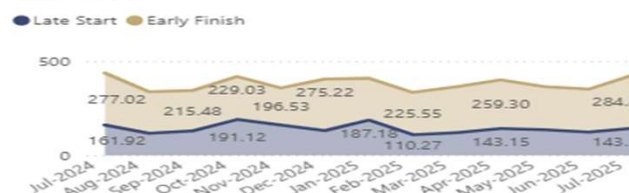
Actual Procedures



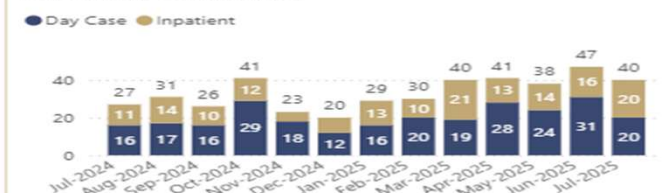
Procedure Performance



Lost Hours



Cancelled Procedures



- Positive improving trend in procedures delivered per month
- Welcome reduction in cancelled procedures in July 2025
- Theatre time utilisation relatively static at low-80% range
- Late starts generally lower than 2024 but scope for improvement
- Increasing trend of early finishes in recent months

Theatre Utilisation Improvement Action (to enable improvement during Q3/Q4)

New Theatre Utilisation Improvement Programme to be launched within CC August 2025, chaired by Associate Medical Director.

Target
Date

31/08/25

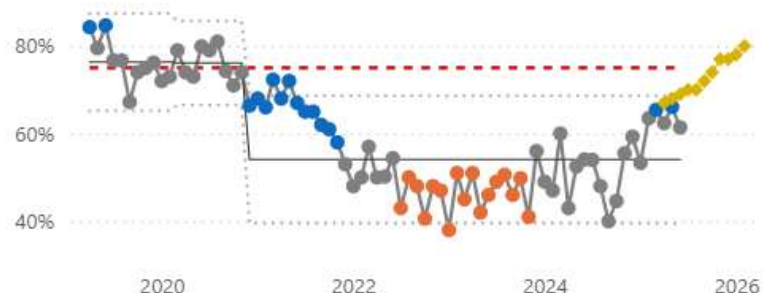
Cancer Care Performance: Latest Single Cancer Pathway Performance



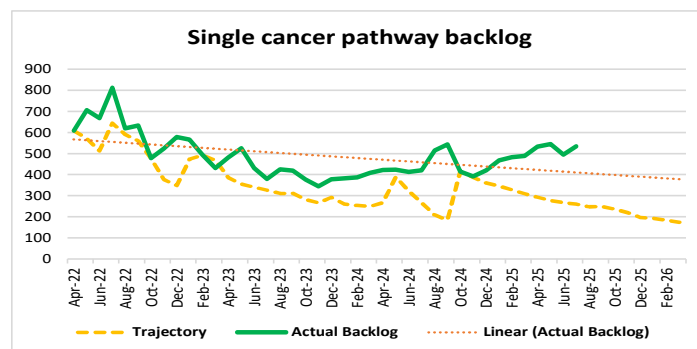
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% single cancer pathway patients starting treatment within 62 days



Number of single cancer pathway patients waiting over 62 days



- June 25 performance **61.4%** - fifth consecutive month with performance above the former TI de-escalation threshold (60%). The Health Board has been de-escalated to Level 3 for Cancer performance.
- Positive Underlying pathway indicators:
 - Continual reduction in overall outpatient pathway volume
 - Continued decrease of all diagnostic volumes in the Urology pathway in line with the agreed improvement plan to reduce the overall volume by 100 patients by the end of July 2025
 - Volume of patients waiting for treatment continues to decrease
- However, increase in backlog July 2025 by 40 patients (535) predominantly in Lower Gastrointestinal and Urology.

Cancer Care Performance: Further SCP Recovery Actions



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Specialty	Action	Impact	Target Date
Gynaecology	Embed implementation of the One stop model for PMB Hysteroscopy Implemented following commencement at WGH.in July	Reduced diagnostic timelines	31/08/25
Lower GI	Continue planning for implementation of FIT pathway within primary care	Reduced diagnostic demand	30/11/25
Urology	- Monitor impact of PSA Follow-Up Capacity Plan and utilise capacity for new SCP patients. - Implement agreed GP Referral Standardisation: Criteria for (PSA history, DRE, urine dipstick); GP education ongoing. - LATP Biopsy Expansion: +260 procedures/year via new equipment and clinic slots. New ultrasound machine in WGH, precision point kit, additional clinic lists. 5 weekend sessions (45 patients) planned by end of August. - MRI Expansion (linked to PROSTAD/CRUK Prostate pathway improvement plan): +336 scans/year with dedicated sessions being progressed. Outsourcing 16 scans with 3-day reporting turnaround. Tender underway (mid-late August) for commencement in September. - Flexi Cystoscopy Expansion: +898 procedures/year through increased capacity and nurse-consented/ list efficiency improvements. Targeting the maintenance of USC Flexi capacity at the 85th percentile of weekly demand. 55 patients per week. In place and monitored weekly. Flexi Cystoscopy currently sub 100 patients (circa 70) as per the plan for end of July. - Nurse-Delivered LATP: +210 procedures/year. Goal: Enable CNS to independently deliver LATP biopsies. Status: In Progress. First full lists underway in August	- Reduced OPA waits - Reduced diagnostic demand - Reduced diagnostic timelines - Reduced diagnostic timelines - Reduced diagnostic timelines - Reduced diagnostic timelines	30/09/25 30/09/25 31/08/25 30/09/25 31/08/25 31/08/25



The Finance and Performance Committee is requested to **RECEIVE ASSURANCE** from recent progress achieved, and further actions currently being progressed by the Planned and Specialist Care CCG, with support from other CCGs, to enable improvements in planned care and cancer performance and productivity.



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3.4

11:00 AM, 15 Mins

3.4 - RADIOLOGY UPDATE

Andrew Carruthers
(Hywel Dda UHB -
Chief Operating
Officer)

| For assurance

Attachments

[Radiology Update FPC 26 August 2025.pdf](#)

[Appendix 1 Radiology Update.pdf](#)



PWYLLGOR CYLLID A PHERFFORMIAD
FINANCE AND PERFORMANCE COMMITTEE

DYDDIAD Y CYFARFOD: DATE OF MEETING:	26 August 2025
TEITL YR ADRODDIAD: TITLE OF REPORT:	Radiology Update
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Andrew Carruthers, Chief Operating Officer
SWYDDOG ADRODD: REPORTING OFFICER:	Keith Jones, Director of Operational Planning and Performance

Pwrpas yr Adroddiad (dewiswch fel yn addas)

Purpose of the Report (select as appropriate)

Er Sicrwydd/For Assurance

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The Finance and Performance Committee is requested to note progress to date in implementing the Radiology Service Stabilisation and Transformation Plan and resultant improvements in Radiology Service performance year to date, and to note the further actions planned during the remainder of 2025/26.

Cefndir / Background

The Hywel Dda University Health Board (HDdUHB) Annual Plan for 2025/26, approved by the Board in March 2025, set out a three-year strategy to stabilise and transform Radiology services in response to historical and forecast patterns of rising demand. This included a recurrent allocation of £3.4m earmarked for 2025/26, to enable essential groundwork to be laid in improvements in Single Cancer Pathway (SCP) backlog clearance and meeting recurrent SCP demand, along with measured improvements to 8-week diagnostic access performance.

By committing this recurrent support, the Annual Plan acknowledged that further additional non-recurrent financial support would be required to enable full recovery of 8-week performance back to target level (zero patients waiting > 8-weeks for diagnostic investigation) by March 2026.

To enable immediate improvements in 2025/26, application of the £3.4m of recurrent funding was prioritised to support:

- Improved SCP diagnostic turnaround times, significantly reducing reporting delays for cancer patients.
- Reduced imaging waiting times for urgent / post-treatment cancer pathway patients
- Increased capacity, expanding CT, MRI, and non-obstetric ultrasound (NOUS) capacity through a combination of outsourcing, insourcing, and mobile diagnostics,
- Workforce stabilisation - using the recurrent funding to recruit and retain key clinical and support staff, easing reliance on expensive ad hoc solutions.

In support of the above, the Operational Allied Health and Health Sciences Clinical Care Group (OAH&HS CCG) developed an implementation plan which was approved by the Executive Team in May 2025.

In July 2025, HDdUHB received confirmation from Welsh Government (WG) of a non-recurrent recovery allocation of £1.4m to support further progress towards achievement of a maximum 8-week waiting time for direct access diagnostic referrals. In response, a draft delivery plan has been submitted to WG for consideration.

This paper provides the Committee with an update in respect of:

- Progress with delivery of the implementation plan,
- Consequential performance improvements in respect of the 8-week target, SCP and other urgent/non SCP cancer pathway imaging and reporting turnaround times
- Next steps in progressing further, additional recovery solutions in respect of the diagnostic maximum 8 week waiting time target.

Asesiad / Assessment

RADIOLOGY STABILISATION AND TRANSFORMATION PLAN – IMPLEMENTATION PROGRESS

The above plan set out a phased, multi-year recruitment strategy encompassing radiographers, support workers, specialist radiologists, and administrative posts, alongside shorter-term non-recurrent actions to address the more immediate performance and delivery challenges within the service.

The plan also included proposals to strengthen the Radiology service leadership structure to enable greater support for staff within the service.

The supporting implementation plan is structured in two parts:

Workforce Sustainability Plan (£1.512m)

Progress with the workforce development & recruitment elements of the implementation plan have not progressed as rapidly as initially planned due to a number of factors including:

- Failure to attract applicants for key sonographer and radiographer posts after the initial recruitment round
- Consideration of the requirement to apply the HDdUHB Organisational Change Policy (OCP) for some senior posts within the proposed Radiology service management structure
- Longer than anticipated timelines to recruit to medical posts identified within the plan.

The attached slide pack illustrates progress to Month 4 in respect of the workforce sustainability element of the plan and the reprofiled expenditure plan for the remainder of the year.

To mitigate the adverse service impact of slower than anticipated progress with recruitment to key medical posts, the CCG plans to continue utilisation of external reporting capacity via Everlight within an agreed financial limit of £50k per month.

Non-Recurrent Service Recovery Solutions

In anticipation that workforce development and recruitment solutions would not impact immediately from April 2025, the plan set out proposals to invest in a range of non-recurrent additional capacity solutions, including:

- Commissioning of additional mobile MRI capacity
- Commission of additional NOUS insource capacity (via the independent sector)
- Additional internal capacity supported by locum and/or variable pay
- Continued utilisation of external reporting capacity via Everlight

The attached slide pack at **Appendix 1** illustrates progress to Month 4 in respect of the non-recurrent service recovery solutions element of the plan and the profiled expenditure plan for the remainder of the year.

It can be noted that reliance on external reporting capacity via Everlight was temporarily increased in Month 4, to mitigate slower than anticipated progress in recruiting additional medical capacity. This will be managed within a revised expenditure limit of £40k per month through the remainder of 2025/26.

RADIOLOGY PERFORMANCE

Maximum 8-Week Direct Access Diagnostic Target

As a direct consequence of actions taken by the CCG to prioritise non-recurrent delivery solutions during Months 1 to 4 2025/26, Radiology diagnostic direct access (maximum 8-week wait) performance has continued to improve year to date with 3,123 breaches reported in July 2025. Whilst 8-week+ breaches remain high, this represents a reduction of 3,985 reported breaches from a peak of 7,108 breaches in January 2025, which represents a 56% performance improvement over the period.

The trend in Radiology diagnostic direct access 8-week breach improvement over the period is shown in the attached slide pack.

Single Cancer Pathway Imaging and Reporting

There is no formal historical reporting mechanism within the Health Board to measure imaging and reporting turnaround times for patients on the SCP or other non-SCP cancer / urgent pathways.

To monitor waiting times, the CCG utilises data drawn from the Radiology Report Archive and Discovery System (RADIS) Radiology reporting system to assess comparative waiting times for imaging and reporting turnaround times for patients on these respective pathways.

The tables below illustrate latest longest scan and reporting timelines for SCP patients and those non-SCP cancer / urgent pathways.

Single Cancer Pathway (SCP) Imaging & Reporting Timelines

Modality	Scans	Reports	Total TaT
CT	3-4 weeks	7 days	4-5 weeks
MRI	3-4 weeks	7 days	4-5 weeks
USS	3-4 weeks		3-4 weeks
CXR	<7 days	1 day	<7 days

Non SCP Cancer / Urgent Imaging & Reporting Timelines

Modality	Scans	Reports	Total TaT
CT	5-6 weeks	7 days	6-7 weeks
MRI	8 weeks	15 days	10 weeks
USS	8 weeks		8 weeks
CXR	<7 days	1 day	

NB USS scans are reported at the time scans are undertaken

For SCP patients:

- reporting timelines have improved to within 7 days, which represents a significant improvement on SCP reporting turnaround times during 2024/25 which exceeded 5 weeks.
- Longest scan waiting times are currently 3-4 weeks. At the end of March 2025, 375 SCP patients were awaiting scans without a booked date. This has reduced to 42 patients at the end of July 2025, representing an 89% improvement.

For non-SCP cancer/urgent pathway patients:

- Longest reporting timelines have reduced to within 7 days for CT and 15 days for MRI, compared to waits in excess of 5 weeks during 2024/25
- Longest scan waiting times have reduced to within 8 weeks, compared to waits in excess of 20 weeks during 2024/25. At the end of March 2025, 1,167 SCP patients were awaiting scans without a booked date. This has reduced to 290 patients at the end of July 2025, representing a 75% improvement.

The improving position in respect of imaging and reporting timelines for SCP and other non-SCP cancer/urgent pathway patients is a direct consequence of the actions taken by the CCG to mobilise the range of recovery solutions reflected in the Radiology Stabilisation and Transformation Plan referenced above.

As a result of progress achieved in reducing the backlog of non SCP/urgent cancer pathway patients awaiting scans, it is anticipated that the capacity prioritised towards this objective during Months 1-4 2025/26 will be partially rebalanced during the remainder of the year and contribute to further improvements in SCP scan waiting times in support of the Health Board's overall SCP performance improvement ambitions.

Additional 8-Week Diagnostic Recovery Support

In July 2025, the Health Board was advised by Welsh Government (WG) of an additional diagnostic recovery financial allocation of £1.4m to support further improvements in 8-week target performance. A proposed delivery plan and supporting trajectories for each modality has been submitted to WG. These are shown in the attached slide pack.

This additional allocation is being utilised to resource:

- An additional mobile MRI solution
- Additional CT scanning & reporting capacity
- Additional Non-Obstetric Ultrasound (NOUS) insource capacity.

Whilst this additional recovery allocation is expected to support full recovery of 8-week breaches in MRI and CT modalities, a potential delivery risk of up to 798 patients remains in the Radiology NOUS pathway due to concerns about sufficiency of independent sector insource capacity to manage the additional volumes required by March 2026. Additional commissioning opportunities for further NOUS capacity solutions are currently being explored with support of the NWSSP Procurement team.

Next Steps

The attached slide pack includes a summary of key actions being pursued by the CCG to further progress improvements in respect of workforce sustainability, non-recurrent solutions, SCP performance and 8-week diagnostic performance.

Argymhelliad / Recommendation

The Finance and Performance Committee is requested to:

- **NOTE** progress to date in implementing the Radiology Service Stabilisation and Transformation Plan for 2025/26
- **RECEIVE ASSURANCE** from the progress achieved by the Operational Allied Health and Health Sciences Clinical Care Group (OAH&HS CCG) in improving Radiology service performance year to date; and
- **NOTE** the further actions planned during the remainder of 2025/26.

Amcanion: (rhaid cwblhau)

Objectives: (must be completed)

Committee ToR Reference:
Cyfeirnod Cylch Gorchwyl y Pwyllgor:

2.1.2 The overall performance and delivery against Health Board plans and objectives, including delivery of key targets, giving early warning on potential performance issues and making recommendations for action to continuously improve the performance of the organisation and, as required focus on specific issues where

	performance is showing deterioration or there are issues of concern.
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	CRR 797 (20) CRR 1350 (16)
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	1. Safe 2. Timely 3. Effective 6. Person-Centred
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	6. All Apply
Amcanion Strategol y BIP: UHB Strategic Objectives:	3. Striving to deliver and develop excellent services 5. Safe sustainable, accessible and kind care 6. Sustainable use of resources
Amcanion Cynllunio Planning Objectives	4 Planned care, diagnostics and cancer Recovery
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022	4. Improve Population Health through prevention and early intervention, supporting people to live happy and healthy lives

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Reflected in report
Rhestr Termiau: Glossary of Terms:	Reflected in report
Partion / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Adnoddau Cynaliadwy: Parties / Committees consulted prior to Sustainable Resources Committee:	Operational Allied Health and Health Sciences Clinical Care Group

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	Contained within the report.

Ansawdd / Gofal Claf: Quality / Patient Care:	Contained within the report.
Gweithlu: Workforce:	Contained within the report.
Risg: Risk:	Contained within the report.
Cyfreithiol: Legal:	Not Applicable
Enw Da: Reputational:	Reputational risk due to Health Board performance and quality and safety risks.
Gyfrinachedd: Privacy:	Not Applicable
Cydraddoldeb: Equality:	Not Applicable



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Radiology Update

Finance and Performance Committee, 26 August 2025

Radiology Stabilisation and Transformation Plan

Workforce Sustainability Plan – Progress Month 4



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Actuals	Wte	P01-26	P02-26	P03-26	P04-26	P05-26	P06-26	P07-26	P08-26	P09-26	P10-26	P11-26	P12-26	Grand Total
Outsourcing - Everlight Reporting - BAU balance until recruitment						50,000	50,000	50,000	50,000	50,000	50,000	50,000	50,000	400,000
Maintenance Contract at Tenby				40,000										40,000
Consumables - recharged from all sites		37,500	37,500	37,500	37,500	37,500	37,500	37,500	37,500	37,500	37,500	37,500	37,500	450,000
Drugs - recharged from all sites		22,917	22,917	22,917	22,917	22,917	22,917	22,917	22,917	22,917	22,917	22,917	22,917	275,004
														0
Recruitment of Band 4 Admin - interviewing 1st Aug	1.00							2,841	2,841	2,841	2,841	2,841	2,841	17,045
Recruitment of Band 5/6 staff	5.00							20,118	20,118	20,118	20,118	20,118	20,118	120,705
Recruitment of Band 7	1.00									4,988	4,988	4,988	4,988	19,951
Recruitment of Band 8a	2.50										14,547	14,547	14,547	43,641
Recruitment of Band 8b	1.00										6,746	6,746	6,746	20,239
Recruitment of Consultant / Locum staff									25,000	25,000	25,000	25,000	26,193	126,193
Other Non Pay														0
Grand Total	10.50	60,417	60,417	100,417	60,417	110,417	110,417	133,375	158,375	163,363	184,656	184,656	185,849	1,512,777

Radiology Stabilisation and Transformation Plan

Non-Recurrent Service Recovery Solutions – Progress Month 4



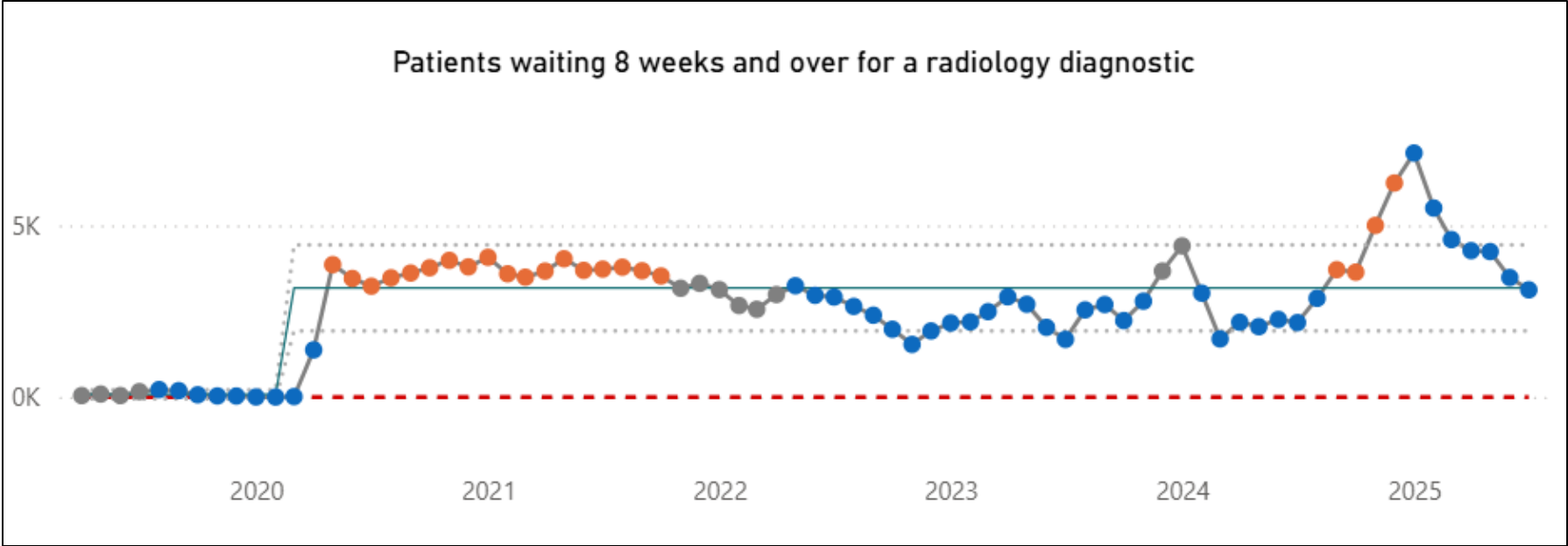
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Actuals	Wte	P01-26	P02-26	P03-26	P04-26	P05-26	P06-26	P07-26	P08-26	P09-26	P10-26	P11-26	P12-26	Grand Total
MRI Mobile Van	Compleo	60,667	60,667	60,667	56,000	60,667	60,667	60,667	60,667	60,667	60,667	60,667	60,667	723,337
Outsourcing - Everlight Reporting	Everlight	57,663	85,819	90,000	209,485	40,000	40,000	40,000	40,000	40,000	40,000	40,000	40,000	762,967
Insourcing - Globe - Ultrasound	Globe	14,897	23,195	26,852	16,333	20,000	20,000	20,000	20,000	20,000	20,000	20,000	20,000	241,276
Locum costs	Pay		4,755	4,134	4,207	4,000	4,000	4,000	4,000	4,000				33,096
Additional Duties / Hours	Pay			8,728	9,086	10,000	10,000	10,000	10,000	10,000	10,000	10,000	10,000	97,814
Recruitment of Consultant / Locum staff														0
Other Non-Pay													28,734	28,734
		174,43												
Grand Total	-	133,227	6	190,380	295,111	134,667	134,667	134,667	134,667	134,667	130,667	130,667	159,401	1,887,223

Radiology Performance

8-Week Diagnostic Direct Access Waiting Time Target – M4 Progress

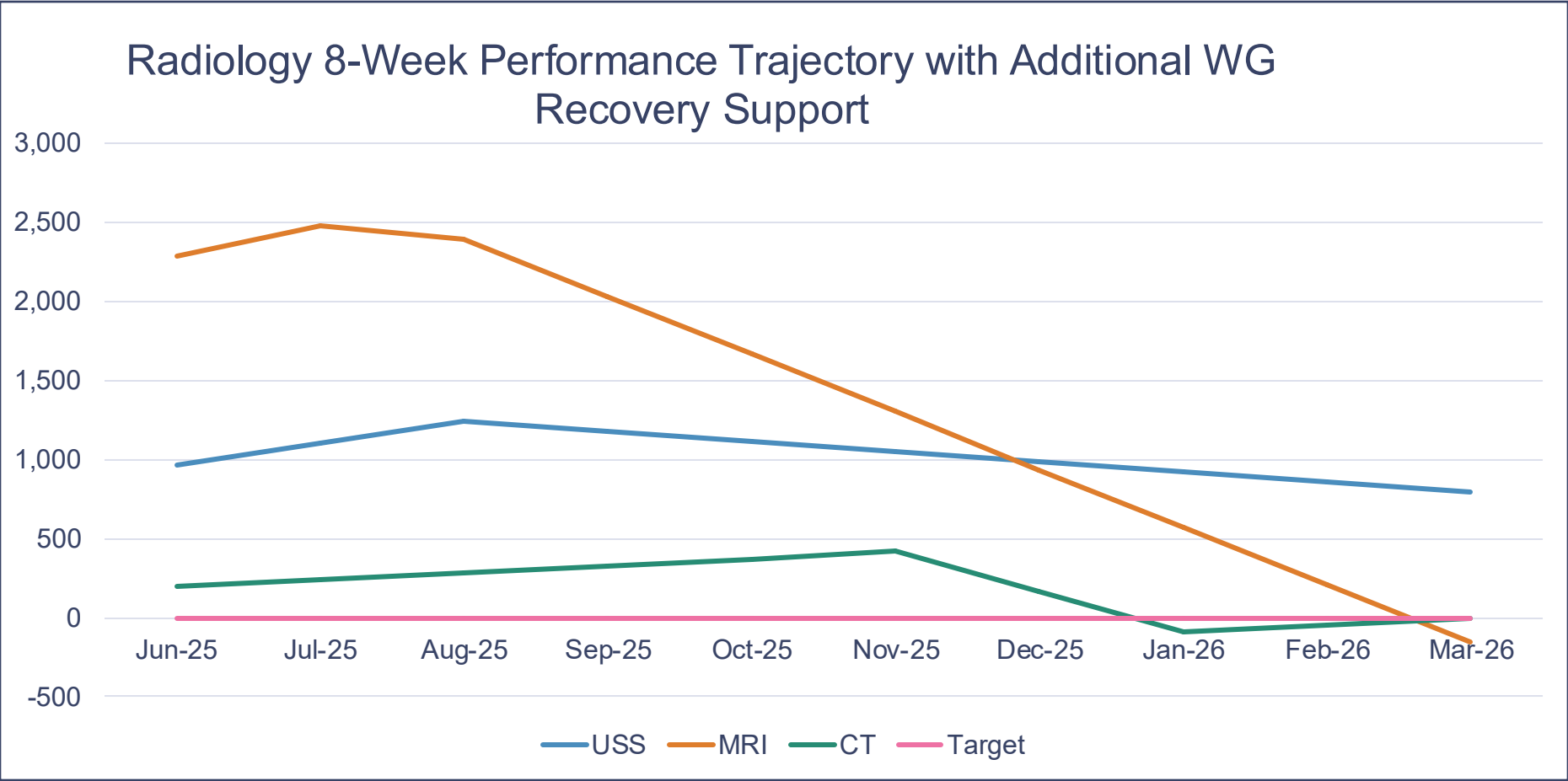


- Performance during 2025/26 versus historical trend
- Illustrates recovery progress during 2025 following sharp rise in breach volumes during 2024
- Reduction of 3,985 breaches since January 2025 (56% improvement)
- 3,123 breaches (July 2025)
- Performance remains significantly above target level (zero breaches)

Radiology Performance

8-Week Diagnostic Recovery Trajectory 2025/26

Impact of additional recovery actions supported by WG recovery allocation



- CT & MRI expected to recover to zero breaches by March 2026
- Delivery risk (circa 798 breaches) in NOUS due to concerns re insource supplier capacity

Radiology Stabilisation and Transformation

Further Actions



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Theme	Action	Target Date
Workforce Sustainability	• Commence second round recruitment process for key sonographer and radiographer posts	1 August 2025
	• Commence recruitment process for 2.0 WTE consultant posts following confirmation of approved job description.	30 Sept 2025
	• Complete OCP for senior leadership posts within the service	30 Sept 2025
Non-Recurrent Solutions	• Continue outsourcing of reporting activity within agreed expenditure limits in absence of additional medical posts	31 March 2026
Radiology Performance	• Re-balance CT and MRI imaging and reporting capacity between non-SCP cancer/urgent and SCP pathways to drive further SCP performance improvements	30 Sept 2025
Recovery Plan	• Explore alternative/additional NOUS insource commissioning opportunities to supplement capacity already secured	30 Sept 2025



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4 - FINANCE

4.1 - FINANCIAL PERFORMANCE ASSURANCE REPORT

Andrew Spratt
(Hywel Dda UHB -
Deputy Director of
Finance)

| For assurance

Attachments

[Financial Performance Assurance Report M4 2025-26 FPC 26 August 2025.pdf](#)

[Appendix 1 M4 2025-26 Financial Performance Report.pdf](#)

[Appendix 2 Options to Achieve £24m.pdf](#)



PWYLLGOR CYLLID A PHERFFORMIAD
FINANCE AND PERFORMANCE COMMITTEE

DYDDIAD Y CYFARFOD: DATE OF MEETING:	26 August 2025
TEITL YR ADRODDIAD: TITLE OF REPORT:	Financial Performance Assurance Report – Month 4 2025/26
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Huw Thomas, Director of Finance
SWYDDOG ADRODD: REPORTING OFFICER:	Andrew Spratt, Deputy Director of Finance Jennifer Thomas, Head of Corporate Reporting

Pwrpas yr Adroddiad (dewiswch fel yn addas)

Purpose of the Report (select as appropriate)

Ar Gyfer Trafodaeth/For Discussion

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The purpose of this report is to outline the Health Board's financial position to date against the Annual Financial Plan and assesses the key financial projections, risks and opportunities for the financial year, including the implications of in-year recurrent delivery for the forthcoming financial year.

Cefndir / Background

The Board recognises that approving a budget which included a planned deficit was a 'novel and contentious action' and, as such, the Accountable Officer wrote to the Director General Health, Social Care and Early Years Group in Welsh Government (WG) to advise them of this action in line with requirements.

Following the approval gained at the Sustainable Resources Committee on 25 February 2025, the delegation of budgets was made to Executive Directors and Clinical Care Group (CCG) / Executive Function leads, in March 2025.

The Board, at its meeting on the 27 March 2025, endorsed and approved the submission of the annual plan to WG, noting that the financial plan does not deliver against our statutory requirement to break-even and recognising the planned financial outturn remains in-line with the target control total (TCT) set by WG with a deficit of £31.5m, but is a worsening position compared to the 2024/25 financial outturn of £24.1m. The 2025/26 financial plan represented a planned deficit of £31.5m, after the delivery of £44.4m of savings, split between £19.0m of recurrent and £25.4m of non-recurrent.

The Board, at its meeting on the 31 July 2025, endorsed and approved a revised annual plan financial deficit of £30.0m, having made decisions to increase the savings target, defer originally planned investments and recognise changing national funding assumptions.

The WG expectation is that the Health Board should plan to deliver, as a minimum, the 2024/25 financial outturn of £24.1m, and ongoing dialogue continues with an expectation that the Health Board further improves its financial forecast beyond the revised annual plan deficit.

Asesiad / Assessment

Financial position

- The in-month financial position as at Month 4 is a deficit of £2.6m, which is an adverse deviation against the £2.1m in-month deficit plan. The deficit plan for Month 4 includes a year-to-date retrospective improvement of 4/12ths of the £1.5m annual plan improvement; £0.5m. This is further explained in **Appendix 1**.
- The core operational variance is an overspend of £0.5m with the in-month savings target of £4.4m being fully identified and delivered.
- The forecast year-end financial position is a £30.0m deficit, in-line with the revised annual plan.
- The year-to-date non-recurrent delivery of savings is significantly higher than those projected by the services for the remainder of the year, so there is a £17.6m conversation expectation from the current run rate to be able to deliver the planned deficit of £30.0m, recovering the adverse deviation from the year-to-date financial position.
- The following table summarises the key drivers, with full analysis included within **Appendix 1**.

Key Driver (£'m)	Current month variance to breakeven	Year to Date variance to breakeven	End of Year forecast to breakeven
Planned Deficit	2.1	10.0	30.0
Unidentified / (Identified) savings gap / (improvement)	0.0	2.4	19.5
Under / (Over) delivery of savings schemes	0.0	0.0	0.0
Core operational variation	0.5	(0.7)	(1.9)
Gross Forecast	2.6	11.7	47.6
Conversion of current run rate	0.0	0.0	(17.6)
Reported Position	2.6	11.7	30.0

Next steps in aspiring to achieve a £24.0m forecast deficit

Following further correspondents between WG and the Health Board, the Chief Executive wrote to the Director General Health, Social Care and Early Years Group, setting out the approach and timeline to reviewing further financial improvements aspiring to achieve the WG expectation of maintaining the 2024/25 financial outturn for 2025/26.

This is summarised as follows with the Board having tasked the Executives with providing updated financial options with an integrated impact assessment for each of the further opportunity improvements listed in the £22.5m expenditure grouped options shared with the Board in the meeting on 31 July 2025, by:

- **15 August** – deadline for Executives to submit their integrated impact assessment for their assigned themes and the revised and refined financial impacts/opportunities
- **18 August** – papers issued, inclusive of these further improvement options, for Finance and Performance Committee
- **26 August** – Finance and Performance Committee to scrutinise and consider the options put forward by Executives

- **9 September** – In-Committee Board to review Executives recommendations and conclude forward actions
- **11 September** – CEO to write to Director General with an update on progress made towards the 2024/25 outturn
- **11 September** – Finance team to submit updated Savings plans, as agreed by the organisation and in-line with Welsh Government definitions, as part of the Month 5 reporting submission

The choices and actions being proposed to achieve this are compiled within **Appendix 2**, for the Committees consideration and discussion.

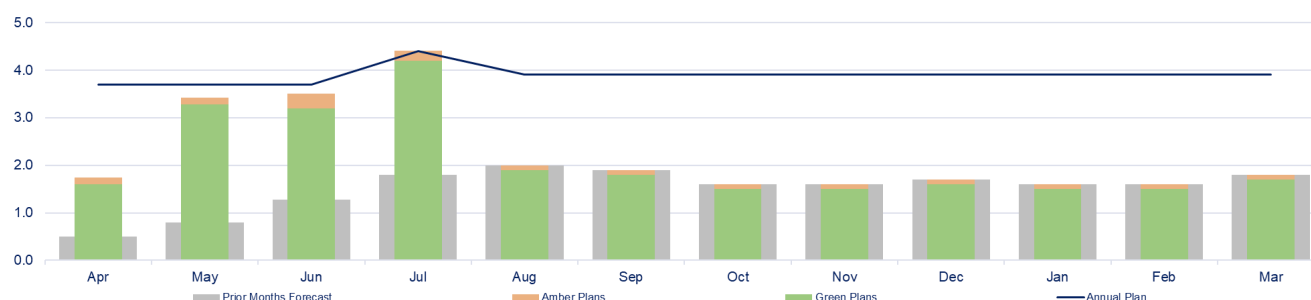
Alert (may require discussion)

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

Review of in-year savings reporting

At the start of the financial year, to expedite budget holders to declare savings proactively, a non-recurrent underspend savings principle was agreed by Executives. This principle was to ensure that any pay savings were declared within the month they occurred, at the latest, and were not used to offset unrelated overspends.

Whilst this principle has worked as expected, a proactive approach to declaring savings has not yet materialised from some budget holders, and there is a significant gap between the month on month saving delivery and that forecast for remaining periods in the year. The following graph shows that each month's actual savings consistently exceeds the prior month's forecast.



The Health Board continues to signal a savings gap, currently £19.5m, which does not represent the delivery to date, and therefore significant net mitigating actions are required, currently £17.6m. This has been raised formally by WG and is signalling a credibility issue related to the organisations inability to plan and manage its finances proactively.

In readiness for Month 5 reporting, a proposal is being drafted, for consideration by the Executives, to recognise a generic health board wide saving scheme to increase the level of future savings to that being demonstrated and evidenced from the year-to-date position. This would likely close the gap by circa £12m and provide a more appropriate and realistic assessment of the financial performance for the organisation.

This would still allow full transparency for the progress made by service areas towards their savings targets, and escalation arrangements will be continued to ensure all areas are developing robust plans, at pace, to close their gaps and ensure a proactive approach is being taken.

Savings delivery

- While the Core operational variation is showing as an underspend, the main issue driving the gross forecast is the unidentified savings gap of £19.5m.
- Of the revised annual savings target of £46.4m, £26.9m has been identified on an in-year basis, with all projected to fully deliver. Recurrent schemes identified total £11.6m with the balance of £15.3m being non-recurrent.
- There is a significant identification gap for savings schemes across Clinical Care Groups. The end of year key performance breakdown per Clinical Care Group (CCG) / Executive Function is detailed in **Appendix 1**, showing the unidentified savings gap across all CCG's, but most notably Community and Integrated Medicine £6.8m, Planned and Specialist Care £5.3m and Primary Care and Community Strategy £3.5m.
- There is a disconnect month on month with in-month delivery of savings and those forecast in future periods. This has been highlighted by Welsh Government as a credibility issue for the Health Board, who expect a comprehensive update by 11 September 2025 as part of the Month 3 Monthly Monitoring Return submission.
- Identification and delivery of robust recurrent and non-recurrent savings plans into future months, avoiding a disconnect between the in-month savings delivery and future projected savings is required.
- Given the significant identification gap for robust deliverable savings schemes across some portfolios, further escalation for the Finance domain is likely due to risk associated with delivering the annual plan equitably across services.

Impact of savings delivery on the underlying deficit

- The underlying deficit as part of the financial planning cycle is £58.5m, which assumes £19.0m of recurrent savings delivery. As at Month 4 £11.6m of recurrent full year effect schemes have delivered, resulting in an underlying deficit of £65.7m with a full year recurrent savings identification gap of £7.4m compared to the annual plan.
- This does not support the organisations required trajectory to achieve financial breakeven as part of the conditional recurrent funding criteria by 2027/28.

Welsh Risk Pool

NWSSP have written to Health Boards in July 2025 to highlight a potential risk that risk share arrangements may be invoked for the Welsh Risk Pool, where claim settlement volumes have increased during 2025/26. The Health Board's impact of this is current estimated to be £4.1m, which would result in a review of the reported financial forecast.

Advise (to monitor)

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

Cash

Given the Health Board's revised annual plan deficit is £30.0m, there will be a requirement for strategic cash and working capital balances to enable payment of all creditors in February and March 2026. Cash requirements will be assessed throughout the financial year, and the strategic cash request will be required to be submitted to WG in November 2025. It is currently

assumed that the 2024/25 financial outturn of £24.1m deficit would be supported, leaving a potential risk of £5.9m.

Ministerial Priorities

Contained within 'Ministerial Enablers: Annex 2' are specific requirements setting out what the Health Board must take further action on, to reduce the amount it spends on variable pay and premium agency, and has set out the following mandate on an adopt or explain basis:

- Deliver a further continued and sustained reduction in agency expenditure, with a target 30% reduction in 2025/26 from 2024/25 outturn, and ensuring no off-contract expenditure;
- Ensure a reduction in agency spend on Healthcare Support Worker, Admin and Clerical, and Estates and Ancillary staff to zero by 30 September 2025.

There has been positive action evidenced and delivered in achieving a 30% reduction in on-contract agency expenditure, with no off-contract agency used from 28 July 2025. Mental Health and Learning Disabilities are the only area using Healthcare Support Worker agency, with plans to eliminate by September 2025 in progress but not yet assured.

Assure (to note)

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

Capital

There is currently no risk foreseen of underspending of the Capital Resource Limit (CRL) at this stage of the financial year. Capital plans will be reviewed in continuously and updates provided appropriately.

Grip and control measures

- An internal escalation framework has been revised and implemented, aligned to the Clinical Care Group and Executive Functions. Escalation meetings have been undertaken for all escalated services. These services have received a clear message regarding the need to deliver financial recovery plans to convert savings opportunities into deliverable plans.
- Grip and control measures covering recruitment, training and procurement, overseen through the Financial Control Sub-Group (FCSG), chaired by the Executive Director of Finance, are providing scrutiny to current vacancies, with a sense of control permeating across the organisation, resulting in improvements to the financial bottom line.
- Additional controls are being sought relating to pay affecting change requests with the introduction of an automated solution for recording, tracking and approving requests into NWSSP Payroll, which FCSG will oversee when available.

Unapproved investments

With WG feedback of the Annual Plan being unsupportable, investment cases have gone through a rigorous scrutiny process via the executive leads and at the point of submitting this paper, only two investments are outstanding due to awaiting a formal paper for approval

totalling £0.7m. A further £1.5m of investments have been deferred or removed to enable delivery of the improved annual plan of £30.0m, and £2.0m in relation to Band 2/3 pay dispute remains in central reserves until finalisation of the workforce validation process.

Argymhelliad / Recommendation

The Finance and Performance Committee is asked to:

- **NOTE** that the Health Board's revised annual plan deficit is £30.0m, with a savings target of £46.4m, and the aspiration is to improve beyond this in the coming months, in-line with WG expectations.
- **SEEK ASSURANCE** on progress of savings actions to bridge the recurrent and non-recurrent savings gap from those Executive portfolios that have yet to identify their full target.
- **SEEK ASSURANCE** there are sufficiently robust plans in place to eliminate the use of all Healthcare Support Worker agency by the 30 September 2025 deadline set in the Ministerial Priorities.
- **DISCUSS AND CONSIDER** the further choices and actions being proposed to achieve an additional financial improvement by the 11 September 2025 Welsh Government deadline, contained within Appendix 2.
- **ACKNOWLEDGE** that a proposal is being drafted to revise the approach taken for declaring future savings plans, due to the lack of a proactive approach to date across service areas.
- **ACKNOWLEDGE** that an underlying deficit assessment has been undertaken and that will only be reduced via robust recurrent savings delivery improvements.

Amcanion: (rhaid cwblhau)

Objectives: (must be completed)

Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	3.1.5 Receive assurance on the delivery of the financial plan. This will be achieved through scrutiny of the monthly finance report. This report shall ensure clarity in: 3.1.5.1 The reporting of monthly, year to date and forecast financial position alongside operational drivers; 3.1.5.2 Performance against the savings requirement; 3.1.5.3 Performance against other financial metrics, such as cash management, capital management and Public Sector Payment Policy.
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	2086 (score 20) Risk of the Health Board not being able to meet the statutory requirement of breaking even in 2025/26 due to significant deficit position.
Parthau Ansawdd: Domains of Quality	7. All apply

Quality and Engagement Act (sharepoint.com)	
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	6. All Apply
Amcanion Strategol y BIP: UHB Strategic Objectives:	All Strategic Objectives are applicable
Amcanion Cynllunio Planning Objectives	All Planning Objectives Apply
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022	9. All HDdUHB Well-being Objectives apply

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Monitoring returns to Welsh Government based on HDdUHB's financial reporting system.
Rhestr Termiau: Glossary of Terms:	BGH – Bronglais Hospital CHC – Continuing Healthcare EOY – End of Year FNC – Funded Nursing Care FYE – Full Year Effect GGH – Glangwili Hospital GMS – General Medical Services HSCEY – Health, Social Care and Early Years MHLD – Mental Health & Learning Disabilities NICE – National Institute for Health and Care Excellence OCP – Organisational Change Policy/Process OOH – Out of Hours PPH – Prince Philip Hospital PSPP – Public Sector Payment Policy RTT – Referral to Treatment Time T&O – Trauma & Orthopaedics TCT – Target Control Total WG – Welsh Government WGH – Withybush Hospital WRP – Welsh Risk Pool WTE – Whole Time Equivalent YTD – Year to date
Partion / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Adnoddau Cynaliadwy:	Finance Team Management Team Executive Team

Parties / Committees consulted prior to Sustainable Resources Committee:	

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	Financial implications are inherent within the report.
Ansawdd / Gofal Claf: Quality / Patient Care:	The impact on patient care is assessed within the savings schemes.
Gweithlu: Workforce:	The report considers the financial implications of our workforce.
Risg: Risk:	Financial risks are detailed in the report.
Cyfreithiol: Legal:	HDdUHB has a legal duty to deliver a breakeven financial position over a rolling three-year basis and an administrative requirement to operate within its budget within any given financial year.
Enw Da: Reputational:	Adverse variance against HDdUHB's financial plan will affect its reputation with Welsh Government, Audit Wales, and with external stakeholders.
Gyfrinachedd: Privacy:	Not Applicable.
Cydraddoldeb: Equality:	Not Applicable.



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2025/26 Financial Performance Report

Finance and Performance Committee

Month 4 July 2025/26

Revised Annual Plan: Deficit Change



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The revised annual plan deficit of £30.0m, improved from £31.5m, can be summarised in the following table being transacted as part of the Month 4 reporting cycle profiled into months:

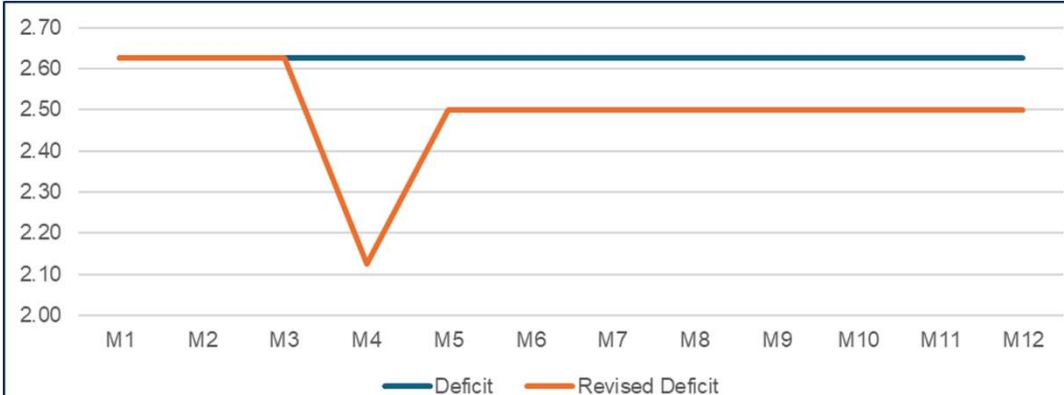
Monthly Profile £'m	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12	Total
Original Deficit*	2.6	2.6	2.6	2.6	2.6	2.6	2.6	2.6	2.6	2.6	2.6	2.6	31.5
Revised Deficit*	2.6	2.6	2.6	2.1	2.5	2.5	2.5	2.5	2.5	2.5	2.5	2.5	30.0

Key Comments

- Prior Months 1-3 remain unchanged
- Month 4 includes a year to date catch up of £0.5m for Months 1-3. Approach
- The new monthly deficit from Month 5 onwards will be £2.5m per month
- Investment deferment £(1.5)m, Savings £(2.0)m and National Insurance Contributions £2.0m, have all been treated equally in profile in agreed with Welsh Government

*Please note above revised deficit include rounded figures

Revised Deficit Change (£'m)



Revised Annual Plan: Savings Target Change



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The revised annual plan savings target of £46.4m, increased from £44.4m, can be summarised in the following table being transacted as part of the Month 4 reporting cycle profiled into months:

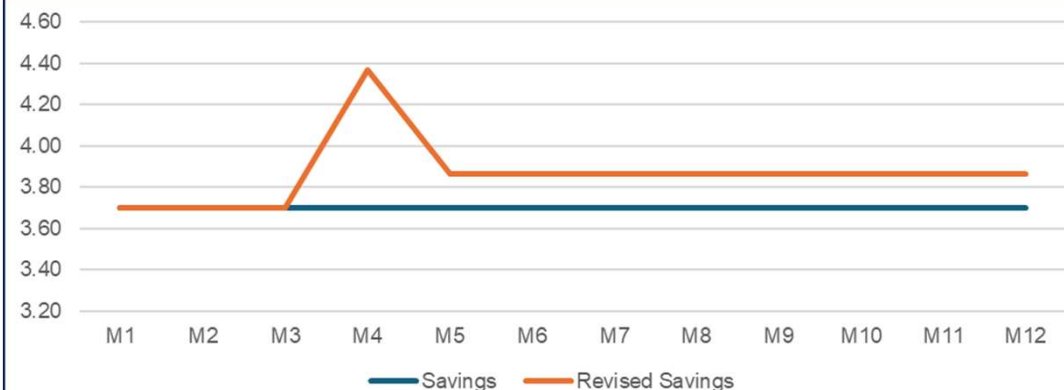
Monthly Change £'m	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12	Total
Original Savings Target*	3.7	3.7	3.7	3.7	3.7	3.7	3.7	3.7	3.7	3.7	3.7	3.7	44.4
Revised Savings Target*	3.7	3.7	3.7	4.4	3.9	3.9	3.9	3.9	3.9	3.9	3.9	3.9	46.4

Key Comments

- Prior Months 1-3 remain unchanged
- Month 4 includes a year to date catch up of £0.6m for Months 1-3
- The new monthly savings target from Month 5 onwards will be £3.9m per month
- Savings tracker has been amended to reflect the revised target of £46.4m (£19.0m recurrent, £27.4m non recurrent)
- Savings plans are identified for the whole £2.0m

*Please note above revised deficit include rounded figures

Savings Target Change (£'m)



Executive Summary



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The Health Board's Revised Annual Planned Deficit is £30.0m with a Revised Savings Target of £46.4m. The gross end of year forecast is £47.6m, which exceeds the Revised Annual Planned Deficit and Target Control Total. Total Savings Identified to date are £26.9m, leaving a gap of £19.5m against the Revised Annual Savings Target of £46.4m.

Financial Management	The in-month financial position is a deficit of £2.6m, which is a worsening against the £2.1m in-month deficit plan. The core operational variance is £0.5m with the in-month savings target of £4.4m being fully identified and delivered. The financial run rate is on track to achieve plan but increases in expenditure and a savings delivery gap are forecast in future periods. Mitigating actions of £17.6m are therefore required, with further action required to improve beyond the Revised Annual Plan to £24.0m in line with Welsh Government expectation.					
	Key Driver (£'m)	Prior month variance to breakeven	Current month variance to breakeven	Year to Date variance to breakeven	Prior Month End of Year forecast to breakeven	End of Year forecast to breakeven
	Planned Deficit	2.6	2.1	10.0	31.5	30.0
	Unidentified / (Identified) savings gap / (improvement)	0.2	0.0	2.4	22.3	19.5
	Under / (Over) delivery of savings schemes	0.0	0.0	0.0	0.0	0.0
	Core operational variation	(0.3)	0.5	(0.7)	(5.1)	(1.9)
	Gross Forecast	2.5	2.6	11.7	48.7	47.6
	Conversion of current run rate	0.0	0.0	0.0	(17.2)	(17.6)
	Reported Position	2.5	2.6	11.7	31.5	30.0
Key Measures (Risk rating = Impact x Likelihood)	Core Operational Variation		Despite a worsening in Month 4, core budget performance remains on plan, with the organisation's aspiration being to improve beyond the planned deficit in the coming months, aligned to the quarter 2 executives focus of de-risking the deficit further to £24.0m in line with Welsh Government expectation.			
	Cash	Risk #2086 5 x 4 = 20	Given the Health Board's planned deficit is £30.0m, there will be a strategic cash requirement in line with our forecast deficit and working capital balances. The risk for cash has changed to red this month due to the previously assuming WG would cover cash requirements up to the TCT, however, the clarity of message from WG now suggests there is a consequential risk and cash funding will not exceed £24.0m.			
	Savings		Of the revised annual savings target of £46.4m, £26.9m has been identified on an in-year basis resulting in an under identification of £19.5m, all of which are projected to fully deliver. Recurrent schemes identified total £11.6m against plan of £19.0m, with the balance of £15.3m being non-recurrent against the revised plan of £27.4m. Year to date non-recurrent savings indicate further savings can be achieved, with the current run rate supporting the ability to deliver savings if expenditure does not increase.			
	Capital		The risk of underspending against the capital resource limit is low at this stage of the financial year.			
	Underlying Deficit	Risk #1199 5 x 5 = 25	The underlying deficit calculated as part of the planning cycle is £58.5m, which assumes £19.0m of recurrent savings delivery. As at Month 4 £11.6m of recurrent full year effect schemes have delivered, resulting in an underlying deficit of £65.7m with a full year recurrent savings identification gap of £7.4m. This does not support the organisations required trajectory to achieve financial breakeven as part of the conditional recurrent funding criteria by 2027/28; delivery commitments are required urgently.			

Movements from Prior Reported Position



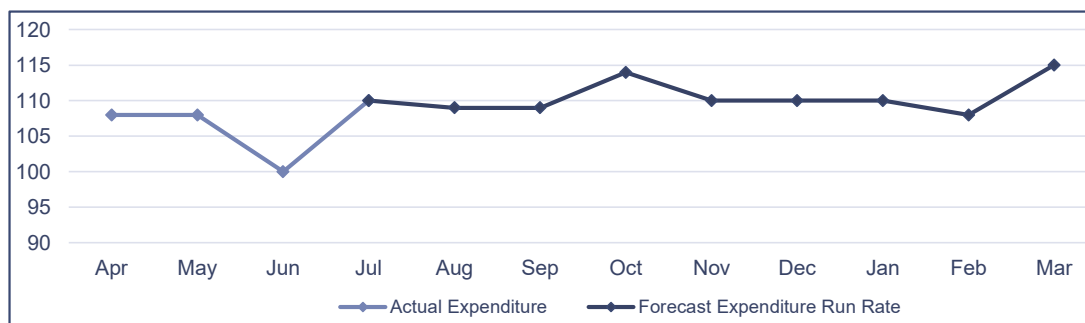
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Key Driver (£'m)	Prior Month End of Year Forecast	End of Year Forecast	Movement in Forecast
Planned Deficit	31.5	30.0	(1.5)
Unidentified savings gap	22.3	19.5	(2.8)
Under / (Over) delivery of savings schemes	0.0	0.0	0.0
Core Operational Variation	(5.1)	(1.9)	3.2
Gross Forecast	48.7	47.6	(1.1)
Conversion of current run rate	(17.2)	(17.6)	(0.4)
Reported Net Position	31.5	30.0	(1.5)

Monthly Actual and Forecasted Expenditure Run-Rate £'m

The forecast revenue run-rate trajectory reflects the revised planned deficit position of £30.0m. Month 3 Amortisation of Capital Expenditure has reduced circa £8.0m



Unidentified Savings Gap (£'m)	Change
Revised Savings Target change	2.0
In-month underspend savings conversion	(1.5)
Newly identified schemes	(2.2)
Blue/Red converted to Amber/Green savings schemes	(1.1)
Movement in Unidentified Savings Gap	(2.8)

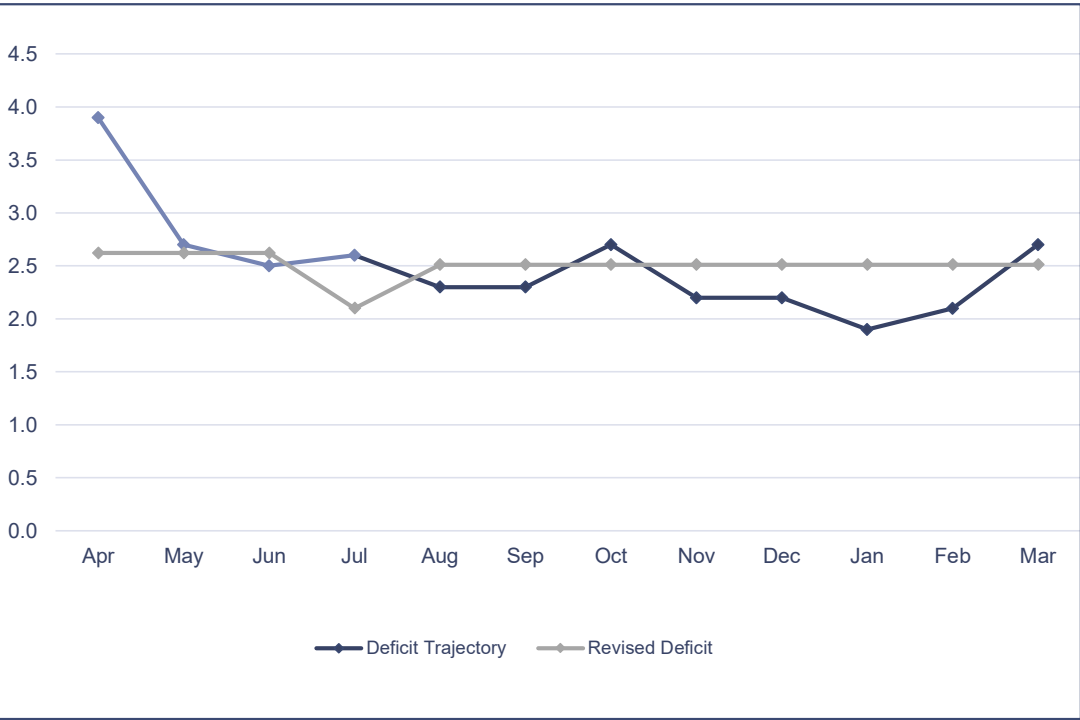
Under / (Over) Delivery of Savings Schemes (£'m)	Change
No change to report	0.0
Movement in Savings Delivery	0.0

Core Operational Variation (£'m)	Change
Commissioned Healthcare Services incl. high-cost CHC packages & beds	3.3
Clinical Services and Supplies due to increased Theatre activity	2.6
Continuation of vacancies across various Pay Staff groups	(2.7)
Movement in Core Operational Variation	3.2

Revenue and Cash Trajectory

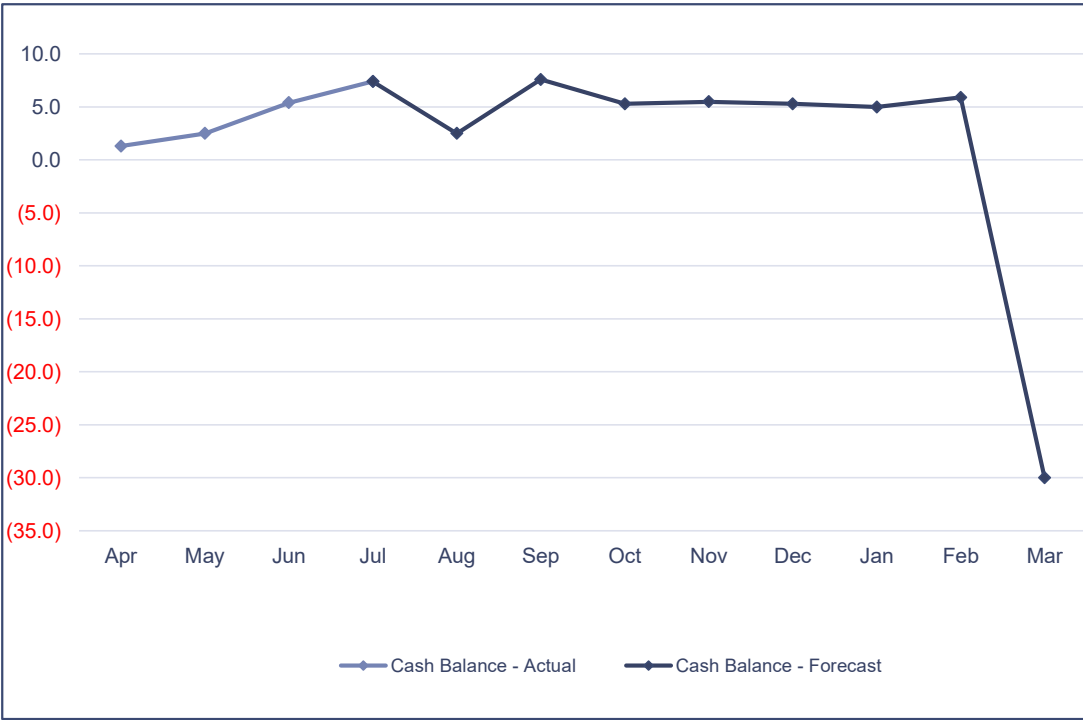
Revenue Deficit Trajectory (£'m)

At our Public Board meeting on 31 July, the Board made the decision to submit a revised, and improved, financial annual plan deficit of £30.0m. This was based on a £2.0m increase to savings delivery, a £1.5m reduction in our planned investments and a £2.0m shortfall in funding assumptions. The forecasted outturn for the year is a deficit of £30.0m, which is in line with the revised planned deficit.



Cash Flow Trajectory (£'m)

We will be working with Welsh Government to understand cash available and whether in line with our control total of £24.0m we can assume this as a pending cash allocation, albeit subject to a strategic cash request later in the year, leaving our current cash risk more accurately reflected as £6.0m.



Executive Insight, Next Steps and Actions



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Action / Decision	Description	Owner	Status	Due Date
Savings Delivery – Identification and delivery of robust recurrent and non-recurrent savings plans into future months, avoiding a disconnect between the in-month savings delivery and future projected savings	There is a significant identification gap for savings schemes across Clinical Care Groups. Escalation for the Finance domain is likely due to risk associated with delivering the £30.0m revised annual plan equitably across services. There is a disconnect month on month with in-month delivery of savings and those forecast of future periods. This has been highlighted by Welsh Government as a credibility issue for the health board, who expect a comprehensive update. See slide ref #1.	Executive Directors and Deputies	Outstanding, urgent action required as part of de-risking the annual plan	Overdue – should have concluded by the end of quarter 1
£30.0m to £24.0m further savings options	Timeline in place for Executive Directors to coordinate responses across their themes and portfolios, to generate QIA'd options to further improve the financial forecast to meet Welsh Governments expectations and revised TI de-escalation criteria. See slide ref #2.	Executive Directors	In progress	11 September (Month 5 MMR submission)
Medical Pay – Additional cover and premium	Continued use of additional medical cover, including premium locum and agency in BGH, Planned Care and Mental Health. Required: roster management, consistent rate card implementation and exit strategies for reliance on premium cover linked to sustainability service delivery plans. See slide ref #3.	Clinical Care Group Service Directors for those areas noted	Update required for timelines on Medical Stabilisation Programme	Overdue
LTAs and Commissioning – review of activity undertaken	Long Term Agreement increase in activity in Swansea Bay Health Board £0.5m. See slide ref #4.	Executive Director of Planning	Update to be given	20 August 2025
CCG Management – urgent review of super-numery management	Over-establishment of management posts within new CCG structure with significant financial impact. Annual cost = c.£0.9m across 9.2 WTE. Required: accelerate and conclude phase 2 process.	Chief Operating Officer	Update required, with original action created in Month 1	20 August 2025

1. Savings Delivery vs Prior Month Forecasts



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Savings

Savings Target

£46.4m

Recurrent = £19m
Non-Recurrent = £27.4m

Savings Delivery

£26.9m

Recurrent = £11.6m
Non-Recurrent = £15.3m

Prior Month Forecast

£22.1m

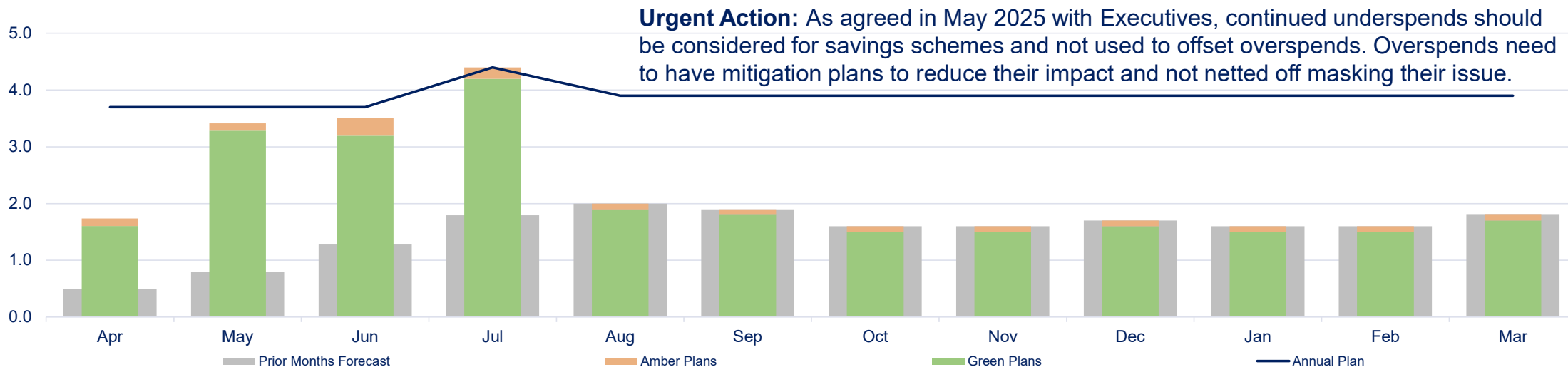
Recurrent = £10.7m
Non-Recurrent = £11.4m

Deviation to Forecast

£4.8m

Recurrent = £0.9m
Non-Recurrent = £3.9m

Monthly Profiled Risk-Assessed In-Year Savings Delivery (£'m)



Savings schemes are not being identified proactively; are being delivered on a month-by-month basis. This does not allow for clear understanding of how the annual plan is being de-risked. Delivery is primarily achieved by the conversion of underspends into non recurrent savings plans. Each month this means that identification and delivery of savings is over-achieving against the prior month's forecast of the latest month as these are not factored into future forecasts. The identification and delivery of robust recurrent and non-recurrent savings plans into future months is required urgently.

2. £30.0m to £24.0m Further Savings Options



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The Health Board has submitted a revised annual financial plan to Welsh Government as part of the Month 4 reporting submission, having agreed it at the Public Board meeting on 31 July 2025. Whilst this demonstrates an improvement, **Welsh Government** have provided clarity of their **expectations**; the 2024/25 outturn.

Welsh Government expect **absolute confidence** in the actions to **deliver a deficit of £30.0m**, and a **robust understanding of the actions** that could be taken to maintain the 2024/25 outturn position of a **£24.1m deficit**, all **by 11 September 2025** as part of the Month 5 reporting submission.

The **Board have tasked the Executives** with providing updated **financial options with an integrated impact assessment** for each of the further opportunity improvements listed in the £22.5m expenditure grouped options, by:

- **15 August** – deadline for Executives to submit their integrated impact assessment for their assigned themes
- **18 August** – papers issued, inclusive of these further improvement options, for Finance and Performance Committee
- **26 August** – Finance and Performance Committee to scrutinise and consider the options put forward by Executives
- **9 September** – In-Committee Board to review Executives recommendations and conclude forward actions
- **11 September** – CEO to write to Director General with an update on progress made towards the 2024/25 outturn
- **11 September** – Finance team to submit updated Savings plans, as agreed by the organisation and in-line with Welsh Government definitions, as part of the Month 5 reporting submission

3. Medical Pay Analysis



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Medical Pay Analysis Breakdown (£'m)		P01	P02	P03	P04
Substantive	Base Costs	10.4	9.9	10.2	10.0
	Enhancements	0.0	0.2	0.0	0.0
Variable	Additional Hours	2.2	1.8	2.1	2.6
	Waiting List Initiative	0.1	0.0	0.1	0.1
Agency (Premium)	Agency - Off Contract	0.1	0.1	0.1	0.0
	Agency - On Contract	0.1	0.3	0.1	0.3
Total Actual Expenditure		12.9	12.3	12.6	13.0
Total Budget		12.3	12.3	12.6	12.4
Total Variance		0.6	0.0	0.0	0.6

CCG Medical Variances to Plan (£'m)		P01	P02	P03	P04
Chief Operating Officer Management		(0.1)	0.0	0.0	0.1
Community and Integrated Medicine		0.4	(0.2)	0.0	0.2
Mental Health and Learning Disabilities		0.1	0.1	0.1	0.1
Operational Allied Health and Health Sciences		0.0	0.0	(0.2)	0.0
Planned and Specialist Care		0.2	(0.1)	0.1	0.1
Primary Care, Community Strategy and LTC		0.0	0.2	0.0	0.1
Total Variance		0.6	0.0	0.0	0.6

Substantive

£10.0m

Average = £10.1m
76.5% of Medical Pay

Variable

£2.7m

Average = £2.3m
21.1% of Medical Pay

Agency (Premium)

£0.3m

Average = £0.3m
2.4% of Medical Pay

Key Summary

- Total medical pay expenditure is indicating a concerning trend, driven by both increased reliance on variable and agency use.
- The medical stabilisation programme, whilst a priority for 2025/26, has yet to fully embed consistent financial improvements harnessing Allocate and Rate Cards.
- Additional hours average £2.2 million per month, with the main contributors being Cancer and Scheduled Care (£0.7m), Primary Care (£0.5m), and Carmarthenshire Integrated System (£0.3m). Month 4 costs include retrospective shift claims from prior periods, highlighting variability in the timing of claims submission.
- Agency Expenditure shows a positive trend in reducing Off-Contract usage, with a trajectory towards zero. However, On-Contract agency spend remains variable, averaging £0.2m per month.
- Community and Integrated Medicine is the primary contributor to the rise in Additional Hours this month, with expenditure increasing by £0.3m to £0.9m. This is largely driven by use of Locum Consultants and Locum Specialty Doctors.
- Locum Doctors now represent 25.8% of total Medical expenditure, highlighting the continued pressure on the workforce and the need for sustainable staffing solutions.

4. LTAs and Commissioning



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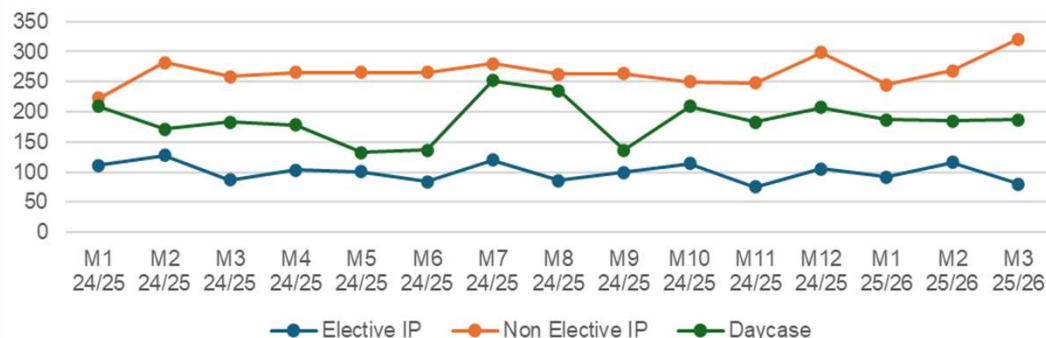
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Swansea Bay Activity:

As at Month 4 2025/26 YTD, our LTA with Swansea Bay UHB as provider is over budget by £583k, this is driven by an increase in non elective activity in 2025/26.

Swansea Bay UHB activity by month and POD (M1 2024/25 to M3 2025/26) is as per the below graph:

Swansea Bay UHB Activity POD

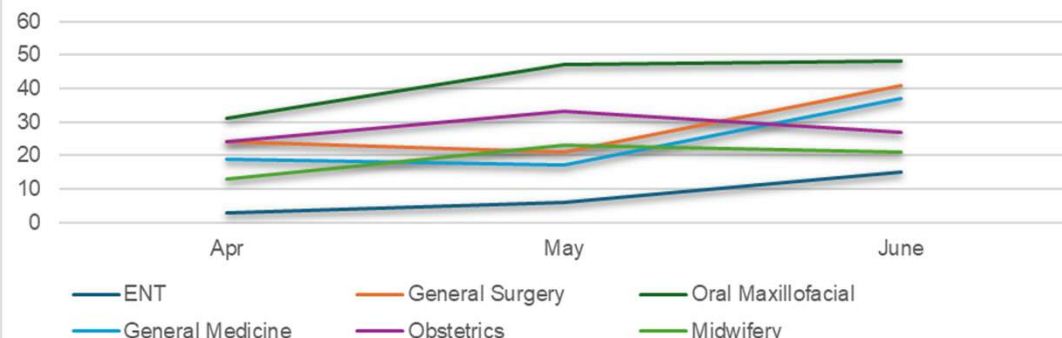


Swansea Bay Emergency Activity:

The Swansea Bay UHB non elective activity increase is in General Surgery, ENT, Oral Maxillofacial, General Medicine and Obstetrics. This increase in activity is currently uncoded, therefore it is not yet possible to further understand the demand growth.

Within the Swansea Bay UHB M3 LTA report, all 189 non elective patients in these specialties were uncoded, as were 122 of the 147 patients treated in May and 80 of the 114 patients treated in April.

Swansea Bay UHB LTA Emergency Activity



Other Providers:

- The WJCC as provider is under budget by £(299)k, the under performance on activity is partially offset by the WJCC all Wales risk share, which is £200k M4 2025/26 YTD (£600k FOT 2025/26, based upon latest available information to M3 2025/26)
- The LTA with Cardiff & Vale UHB as provider is over budget by £137k, this is driven by High Cost Drugs for tumours, leukaemia and transplant drugs.

End of Year: Financial Position Summary



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Headline

Reported Position

£30.0m



Revised Annual Plan = £30.0m
Prior Annual Forecast = £31.5m

Savings Identification Gap

£19.5m



Savings Target = £46.4m
Total Identified = £26.9m

Capital Position

£34.5m



Annual Plan = £34.5m
Prior Annual Forecast = £28.9m

Underlying Deficit

£65.7m



Annual Plan = £58.5m

Pay

Total Pay

£663.9m



Plan = £666.5m
Prior Annual Forecast = £667.2m

Substantive

£605.3m



Plan = £643.8m
Prior Annual Forecast = £610.2m

Variable

£50.8m



Plan = £18.6m
Prior Annual Forecast = £49.5m

Agency (Premium)

£7.8m



Plan = £4.1m
Prior Annual Forecast = £7.5m

Non-Pay

Primary Care Drugs

£85.7m



Plan = £85.6m
Prior Annual Forecast = £85.5m

Secondary Care Drugs

£73.4m



Plan = £75.9m
Prior Annual Forecast = £75.2m

Continuing Healthcare

£68.3m



Plan = £63.0m
Prior Annual Forecast = £67.5m

Clinical Services & Supplies

£50.1m



Plan = £48.1m
Prior Annual Forecast = £46.4m

Key Drivers

The **Month 4** end of year forecast financial position, is a **deficit of £30.0m**, which is in line with the revised Annual Deficit Plan of £30.0m. The **core operational variance to plan is £(1.9)m**, with the annual **savings** target of £46.4m being **under-identified by £19.5m**, and all current identified savings schemes of £26.9m being fully delivered. Future **mitigating actions** identification requirement to deliver a deficit position of £30.0m is **£(17.6)m**. Improvements to deliver the mitigating actions and go beyond the £30.0m deficit plan is now the focus of the organisation in the coming months.

End of Year: Key Drivers vs Plan



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Spend Category	£'m	Supporting Information
Planned Deficit	30.0	As per Annual Plan submission to Welsh Government
Savings Identification Gap / (Surplus)	19.5	Savings identification of £26.9m against £46.4m target
Income	(1.6)	Income overachievement for Bowel and Breast Screening, Wet age-related macular degeneration, Flying Start, Health Education and Improvement Wales within Children and Women, Radiology and Therapies.
Clinical Services and Supplies	2.0	Purchase of incontinence products within Community and Integrated Medicine and additional consumables for Theatres and Orthopaedics within Planned and Specialist Care due to increased activity.
Commissioned Healthcare Services	(1.9)	Dental contracts underspend, offset by insourcing within Planned and Specialist Care, Psychiatric Intensive Care beds from the Independent Sector and high-cost Continuing Health Care packages within Mental Health.
Drugs and Prescribing	(2.4)	Oncology and Ophthalmology drugs underspend due to delayed presentation of new NICE funded drugs. Activity growth of 12.5% year to date, but cost per patient decreased by 14.8% from prior year.
Other Non-Pay	4.5	Maintenance price increase on external suppliers' contracts, software licences fees, energy price increase and laundry service cost pressure. Premises, legal, travel and transport costs and license fees across areas.
Administration and Estates	(2.7)	Continued Administration & Clerical vacancies, particularly across Operational Directorates where savings have yet to be fully identified, thus recruitment is re-prioritised through Financial Control Subgroup.
Allied Health, Scientists and Other	(1.6)	Vacancies within Mental Health, Primary Care and other Operational areas, offset by agency and variable pay pressures within Operational Allied Health.
Medical and Dental	4.0	Premium costs to cover vacancies within Mental Health, Community and Integrated Medicine, Planned and Specialist Care and Primary Care.
Nursing, Midwifery and Clinical Support	(2.2)	Continued Nursing vacancies within Mental Health and Community and Integrated Medicine offset by increased variable pay in Glangwili & Prince Philip General Hospitals.
Gross Position	47.6	
Conversion of Current Run Rate	(17.6)	Intervention required across CCGs to deliver savings targets, with Executive Functions already over delivering.
Reported Position	30.0	

End of Year: Key Performance Breakdown



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Clinical Care Group (£'m)	Savings Gap to Target	Savings Delivery vs Plan Benefits	Core Operational Variation	Total Savings and Core Performance
Chief Operating Officer Management	0.4	0.0	(0.4)	0.0
Community and Integrated Medicine	6.8	0.0	0.0	6.8
Mental Health and Learning Disabilities	2.7	0.0	0.1	2.8
Operational Allied Health and Health Sciences	3.3	0.0	0.0	3.3
Planned and Specialist Care	5.3	0.0	0.4	5.7
Primary Care, Community Strategy and Long Term Care	3.5	0.0	(4.1)	(0.6)
Executive Functions	(2.5)	0.0	2.1	(0.4)
Sub Total	19.5	0.0	(1.9)	17.6
Planned Deficit				30.0
Gross Position				47.6
Conversion of Current Run Rate				(17.6)
Reported Position				30.0

End of Year: Saving Delivery Performance

Savings

Savings Target

£46.4m

Recurrent = £19.0m
Non-Recurrent = £27.4m

In-Year Recurrent Gap

£7.4m

Target = £19.0m
Delivery = £11.6m

In-Year Non-Recurrent Gap

£12.1m

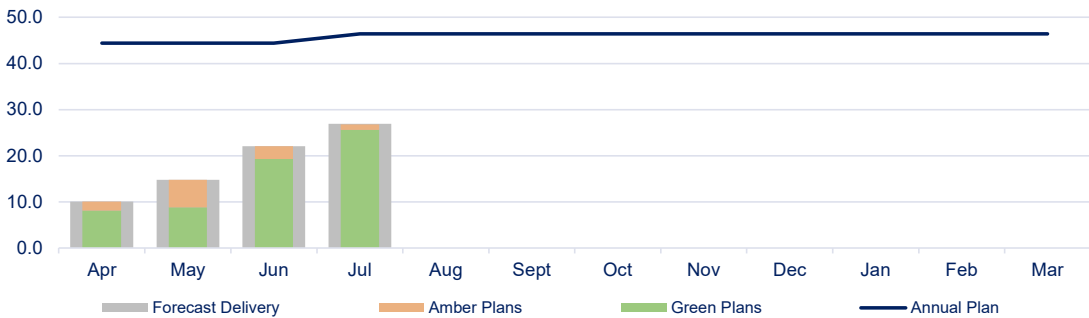
Target = £27.4m
Delivery = £15.3m

Full Year Recurrent Gap

£7.1m

Target = £19.0m
Delivery = £11.9m

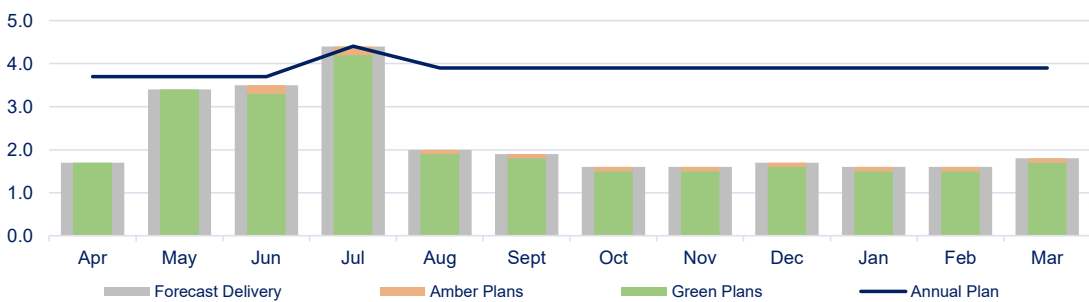
Monthly Trend of Annual In-Year Risk-Assessed Savings Delivery (£'m)



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



Monthly Profiled Risk-Assessed Savings Delivery (£'m)



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



End of Year: Savings Performance Breakdown

Savings

Savings Target

£46.4m

Revised Annual Plan = £46.4m

Savings Identification

£26.9m

58% of Savings Target

Savings Delivery

£26.9m

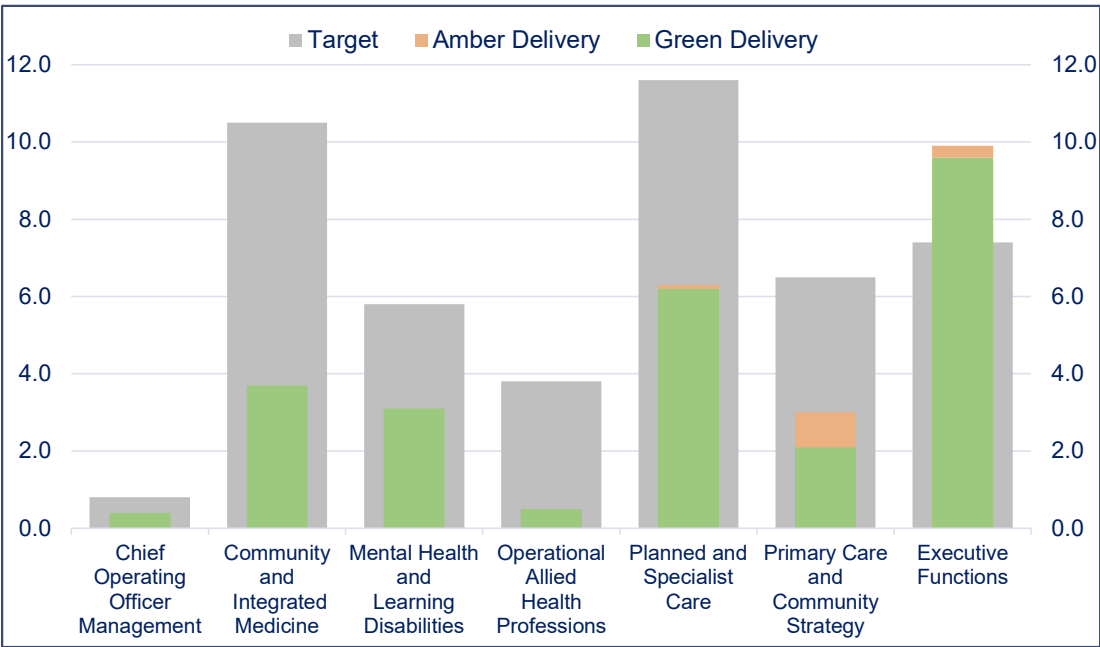
Recurrent = £11.6m
Non-Recurrent = £15.3m

Savings Gap to Target

£19.5m

42% of Savings Target

Savings Delivery vs Target (£'m)



Savings Performance Breakdown (£'m)

Clinical Care Group	Target	Plan	Delivery	Gap
Chief Operating Officer Management	0.8	0.4	0.4	0.4
Community and Integrated Medicine	10.5	3.7	3.7	6.8
Mental Health and Learning Disabilities	5.8	3.1	3.1	2.7
Operational Allied Health and Health Sciences	3.8	0.5	0.5	3.3
Planned and Specialist Care	11.6	6.3	6.3	5.3
Primary Care, Community Strategy and LTC	6.5	3.0	3.0	3.5
Executive Functions	7.4	9.9	9.9	(2.5)
Grand Total	46.4	26.9	26.9	19.5

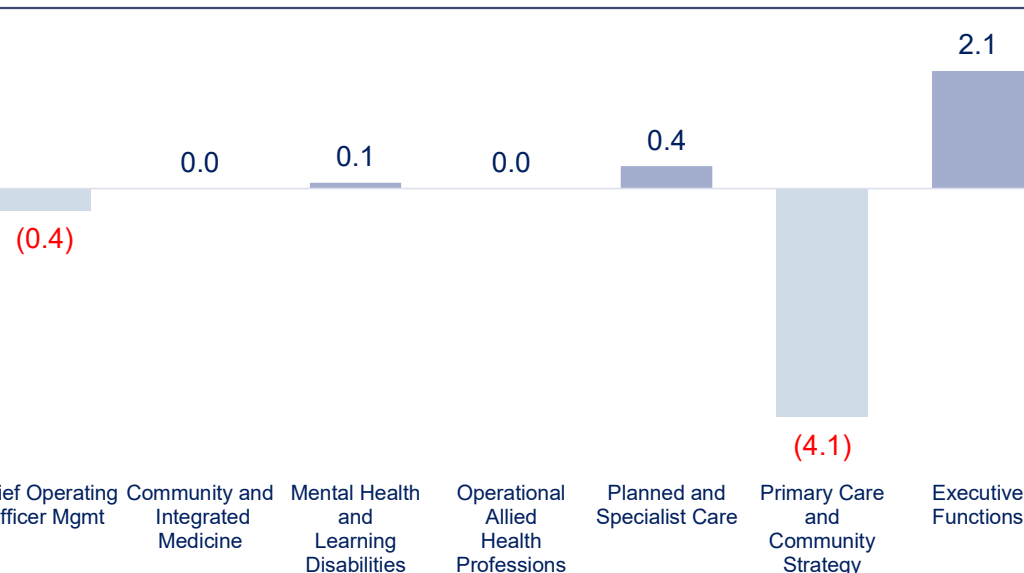
End of Year: Core Operational Variation



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Core Operational Variation (£'m)



Core Operational Variation (£'m)

Clinical Care Group	Pay	Non-Pay	Income	Total
Chief Operating Officer Management	(0.3)	(0.1)	0.0	(0.4)
Community and Integrated Medicine	(0.4)	0.5	(0.1)	0.0
Mental Health and Learning Disabilities	(1.1)	1.2	0.0	0.1
Operational Allied Health and Health Sciences	0.2	0.6	(0.8)	0.0
Planned and Specialist Care	0.4	0.9	(0.9)	0.4
Primary Care, Community Strategy and LTC	(0.3)	(4.2)	0.4	(4.1)
Executive Functions	(1.1)	3.4	(0.2)	2.1
Total	(2.6)	2.3	(1.6)	(1.9)

The **core operational variance to plan is a surplus of £(1.9)m**, with the main drivers being:

- Chief Operating Officer Management vacancies within Pay.
- Community and Integrated Medicine additional spend on Incontinence Products, offset by continued vacancies within Pay.
- Mental Health and Learning Disabilities high-cost Continuing Healthcare packages and purchase of Psychiatric Intensive Care Unit beds from the Independent Sector. Medical and Dental ongoing usage of Locums offset by continued vacancies within Nursing and Allied Health.
- Operational Allied Health lab equipment and Podiatry consumables expenditure, offset by Bowel and Breast Screening and Renal Testing income overachievement.
- Planned and Specialist Care Pay and Theatre consumables expenditure due to increased activity. Bowel Screening and Wet age-related macular degeneration income.
- Primary Care Dental Contracts underspend handed back to the Health Board offset by under-delivery of patient income.
- Executive Functions maintenance price increase on external suppliers' contracts, software licences fees, energy price increase and laundry service cost pressure within Estates and Facilities. Premises, legal, license, travel and transport costs, offset by continuation of vacancies across various areas.

In-Month: Financial Position Summary



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Headline

Reported Position

£2.6m



Annual Plan = £2.1m
Prior Month Forecast = £2.6m

Savings Identification Gap

£0.0m



Savings Target = £4.4m
Total Identified = £4.4m

Savings Delivery Gap

£0.0m



Savings Delivery = £4.4m
Prior Month Delivery = £3.5m

Core Operational Variation

£0.5m



Prior Month Variation = £(0.3)m

Pay

Total Pay

£54.6m



Plan = £55.4m
Prior Month Actual = £54.7m

Substantive

£49.2m



Plan = £53.3m
Prior Month Actual = 49.9m

Variable

£4.7m



Plan = £1.8m
Prior Month Actual = £4.2m

Agency (Premium)

£0.7m



Plan = £0.3m
Prior Month Actual = £0.6m

Non-Pay

Primary Care Drugs

£7.5m



Plan = £7.5m
Prior Month Actual = £6.5m

Secondary Care Drugs

£5.8m



Plan = £6.3m
Prior Month Actual = £5.6m

Continuing Healthcare

£5.5m



Plan = £5.3m
Prior Month Actual = £5.5m

Clinical Services & Supplies

£5.4m



Plan = £4.0m
Prior Month Actual = £4.8m

Key Drivers

The Month 4 financial position is a **deficit of £2.6m**, which is a £0.5m worsening against the in-month **Deficit Plan of £2.1m**. The **core operational variance to plan is £0.5m**, with the in-month **savings** target of £4.4m being fully identified and all savings schemes identified of £4.4m being fully delivered.

In-Month: Key Drivers vs Plan



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Spend Category	£'m	Supporting Information
Planned Deficit	2.1	Revised in-month deficit plan for Month 4, in line with year-to-date deficit of £10.0m
Savings Identification Gap / (Surplus)	0.0	In-month identification of £4.4m against revised in-month target of £4.4m
Income	(0.2)	Over-achievement of income relating to Bronglais Sexual Assault Referral Centre, Substance Misuse income, Health Education Improvement Wales income and Occupational Therapy income.
Clinical Services and Supplies	1.4	Increases to theatre consumables including implants, surgical instruments and theatre drapes due to increased Orthopaedic and operating theatres activity. Increased expenditure of incontinence products in Carmarthenshire.
Commissioned Healthcare Services	0.2	Increased activity relating to Swansea Bay Long Term Agreement, and high-cost Continuing Healthcare packages and independent sector Psychiatric Intensive Care Unit beds within Mental Health.
Drugs and Prescribing	(0.5)	Oncology drugs underspend due to reduced activity and price increases patient being lower than planned, but with increases still expected later in the year.
Other Non-Pay	0.4	Backdated Clinical Negligence and Personal Injury Claims received from NWSSP and increased premises and rental costs.
Administration and Estates	(0.8)	Continued Administration & Clerical vacancies, particularly across operational areas where savings schemes have yet to be fully identified, thus recruitment is re-prioritised through the Financial Control Sub-Group.
Allied Health, Scientists and Other	(0.3)	Allied Health underspend within Primary Care due to year-to-date Cluster funding received to offset prior month costs.
Medical and Dental	0.6	Ongoing Medical and Dental pressures across Unscheduled Care, Mental Health and Primary due to premium costs in addition to cover for ongoing vacancies, in addition to retrospective claims for June.
Nursing, Midwifery and Clinical Support	(0.3)	Nursing underspend within Primary Care due to year-to-date Cluster funding received to offset prior month costs. Community and Integrated Medicine and Mental Health underspend due to vacancies.
Reported Position	2.6	

In-Month: Key Performance Breakdown



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Clinical Care Group (£'m)	Savings Gap to Target	Savings Delivery vs Plan Benefits	Core Operational Variation	Total Savings and Core Performance
Chief Operating Officer Management	(0.2)	0.0	(0.1)	(0.3)
Community and Integrated Medicine	0.6	0.0	0.2	0.8
Mental Health and Learning Disabilities	0.0	0.0	0.2	0.2
Operational Allied Health and Health Sciences	0.3	0.0	(0.1)	0.2
Planned and Specialist Care	0.2	0.0	0.3	0.5
Primary Care, Community Strategy and Long Term Care	0.0	0.0	(0.3)	(0.3)
Executive Functions	(0.9)	0.0	0.3	(0.6)
Sub Total	0.0	0.0	0.5	0.5
Planned Deficit				2.1
Reported Position				2.6

In-Month: Savings

Savings

Savings Target

£4.4m

Recurrent = £1.6m
Non-Recurrent = £2.8m

Savings Identification

£4.4m

100% of Savings Target

Savings Delivery

£4.4m

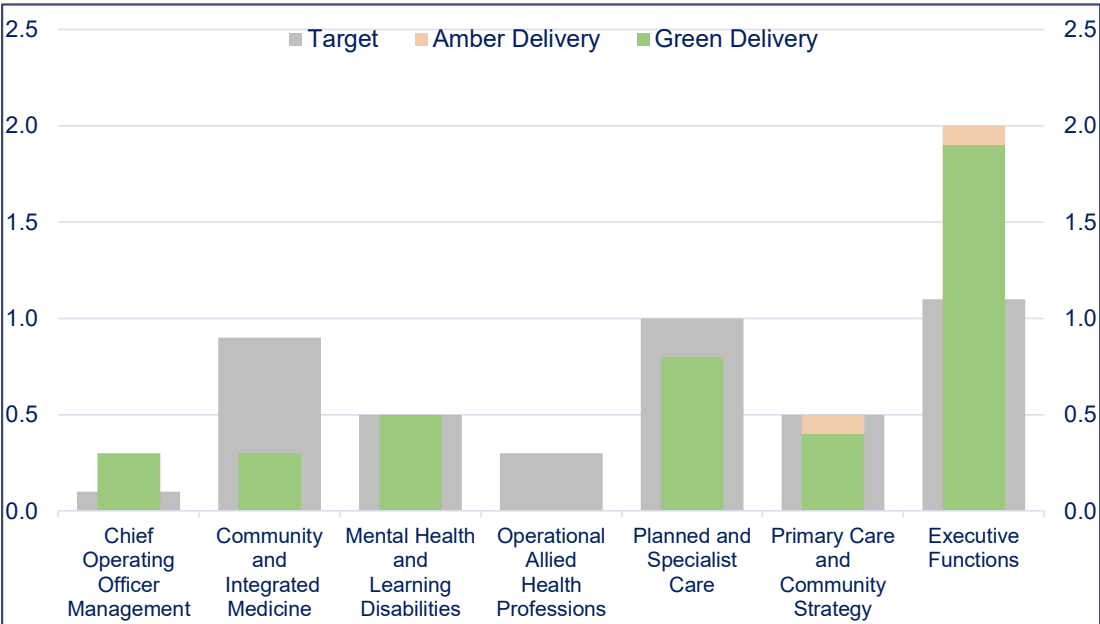
Recurrent = £1.3m
Non-Recurrent = £3.1m

Savings Gap to Target

£0.0m

0% Under Identified against Target

Savings Delivery vs Target (£'m)



Savings Performance Breakdown (£'m)

Clinical Care Group	Target	Plan	Delivery	Gap
Chief Operating Officer Management	0.1	0.3	0.3	(0.2)
Community and Integrated Medicine	0.9	0.3	0.3	0.6
Mental Health and Learning Disabilities	0.5	0.5	0.5	0.0
Operational Allied Health and Health Sciences	0.3	0.0	0.0	0.3
Planned and Specialist Care	1.0	0.8	0.8	0.2
Primary Care and Community Strategy	0.5	0.5	0.5	0.0
Executive Functions	1.1	2.0	2.0	(0.9)
Grand Total	4.4	4.4	4.4	0.0

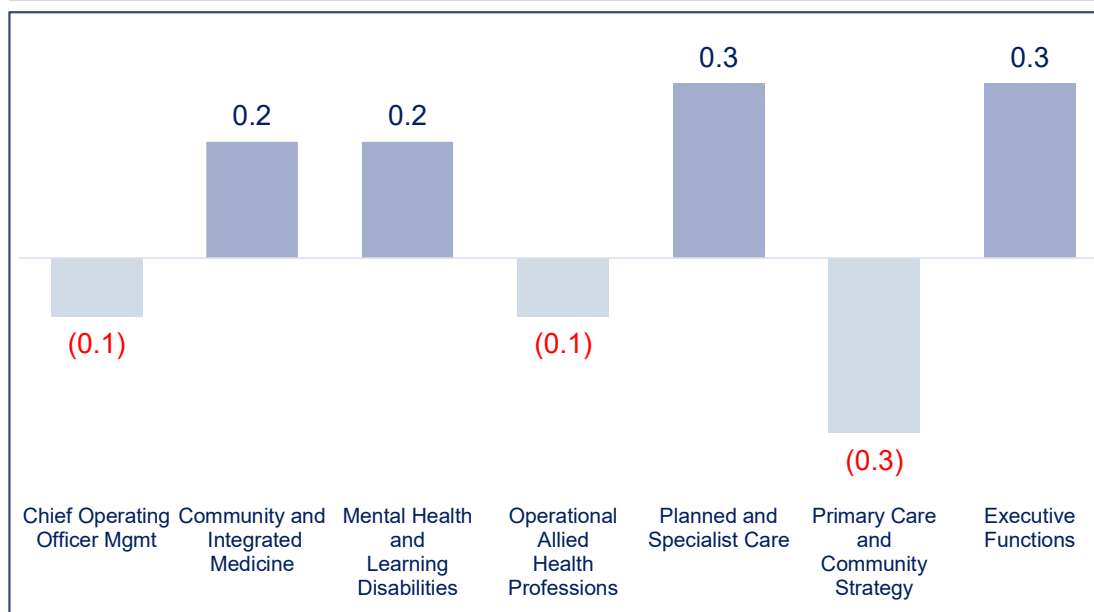
In-Month: Core Operational Variation



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Core Operational Variation (£'m)



Core Operational Variation (£'m)

Clinical Care Group	Pay	Non-Pay	Income	Total
Chief Operating Officer Management	0.0	(0.1)	0.0	(0.1)
Community and Integrated Medicine	0.0	0.3	(0.1)	0.2
Mental Health and Learning Disabilities	0.0	0.2	0.0	0.2
Operational Allied Health and Health Sciences	0.0	(0.1)	0.0	(0.1)
Planned and Specialist Care	0.0	0.3	0.0	0.3
Primary Care, Community Strategy and LTC	(0.3)	0.0	0.0	(0.3)
Executive Functions	(0.5)	0.9	(0.1)	0.3
Total	(0.8)	1.5	(0.2)	0.5

The core operational variance to plan is £0.5m, main drivers being:

- Purchase of incontinence Clinical Service & Supplies products, additional Continuing Healthcare packages, Interim Care Bed costs and premises and rental costs within Community and Integrated Medicine.
- High cost CHC packages and independent sector Psychiatric Intensive Care Unit beds within in Mental Health and Learning Disabilities.
- Additional activity, partly relating to Waiting Lists resulting in increased Theatre consumable costs, particularly relating to Orthopaedic inpatient activity within Planned and Specialist Care.
- Clusters Pay underspend in-month due to year to date funding received to cover prior months costs in Primary Care and Community Strategy.
- Long Term Agreements and Bad Debt, Losses & Negligence provision claims within Executive functions, offset by continued vacancies within Pay.

Year to Date: Financial Position Summary



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Headline

Reported Position

£11.7m ●

Annual Plan = £10.0m

Savings Identification Gap

£2.4m ●

Savings Target = £15.4m
Total Identified = £13.0m

Savings Delivery Gap

£0.0m ●

Savings Delivery = £13.0m
Prior Month Delivery = £8.7m

Core Operational Variation

£(0.7)m ●

Prior Month Variation = £(1.2)m

Pay

Total Pay

£219.3m ●

Plan = £219.6m

Substantive

£199.5m ●

Plan = £211.8m

Variable

£17.1m ●

Plan = £6.4m

Agency (Premium)

£2.7m ●

Plan = £1.4m

Non-Pay

Primary Care Drugs

£28.3m ●

Plan = £28.4m

Secondary Care Drugs

£23.4m ●

Plan = £24.8m

Continuing Healthcare

£21.5m ●

Plan = £20.9m

Clinical Services & Supplies

£17.7m ●

Plan = £15.9m

Key Drivers

The Month 4 year to date financial position is a **deficit of £11.7m**, which is a worsening against the year to date **Deficit Plan of £10.0m**. The **core operational variance to plan is £(0.7)m**, with the year to date **savings target** of £15.4m being **under-identified by £2.4m**, and all savings schemes identified of £13.0m being fully delivered.

Year to Date: Key Drivers vs Plan



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Spend Category	£'m	Supporting Information
Planned Deficit	10.0	Revised in-month Deficit Plan for Month 4, in line with YTD Deficit of £10.0m
Savings Identification Gap / (Surplus)	2.4	In-month identification of £4.4m against revised in-month target of £4.4m
Income	(0.5)	Income overachievement relating to Secondment income, Health Education Improvement Wales, Flying Start, Velindre Drug Rebates, Bowel and Breast Screening, Renal Testing and Wet age-related macular degeneration.
Clinical Services and Supplies	1.8	Increases to theatre consumables including implants, surgical instruments and theatre drapes due to increased Orthopaedic and operating theatres activity. Increased expenditure of incontinence products in Carmarthenshire.
Commissioned Healthcare Services	(1.6)	Primary Care Dental contracts handed back to the Health Board, offset by Swansea Bay Long Term Agreement increased activity, high-cost Continuing Healthcare packages and independent sector beds within Mental Health.
Drugs and Prescribing	(1.5)	Oncology drugs underspend due to price increases being lower than planned, and NICE treatments increases expected later in the year.
Other Non-Pay	1.3	Legal services within Nursing, Planned and Specialist Theatre Services and Critical Care Costs, backdated Clinical Negligence and Personal Injury Claims received from NWSSP and increased premises and rental costs.
Administration and Estates	(1.1)	Continuation of Administration and Clerical vacancies, particularly across Estates and Facilities and operational directorates.
Allied Health, Scientists and Other	(0.1)	Allied Health vacancies within Mental Health and Learning Disabilities and Community and Integrated Medicine, offset by over-establishment within Operational Allied Health Professions and Health Scientists.
Medical and Dental	1.5	Premium costs to cover vacancies within Mental Health, Primary Care, Community and Integrated Medicine and Women and Children, and double cover of Medical Rotas due to sickness, absences and retrospective claims.
Nursing, Midwifery and Clinical Support	(0.4)	Vacancies within Theatre Services in Planned and Specialist Care, and Pembrokeshire and Ceredigion within Community and Integrated Medicine
Reported Position	11.7	

Year to Date: Key Performance Breakdown



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Clinical Care Group (£'m)	Savings Gap to Target	Savings Delivery vs Plan Benefits	Core Operational Variation	Total Savings and Core Performance
Chief Operating Officer Management	(0.2)	0.0	(0.4)	(0.6)
Community and Integrated Medicine	2.0	0.0	0.0	2.0
Mental Health and Learning Disabilities	0.0	0.0	0.6	0.6
Operational Allied Health and Health Sciences	1.1	0.0	0.3	1.4
Planned and Specialist Care	1.7	0.0	(0.8)	0.9
Primary Care, Community Strategy and Long Term Care	0.5	0.0	(1.0)	(0.5)
Executive Functions	(2.7)	0.0	0.6	(2.1)
Sub Total	2.4	0.0	(0.7)	1.7
Planned Deficit				10.0
Reported Position				11.7

Year to Date: Savings

Savings

Savings Target

£15.4m

Annual Plan = £46.4m

Savings Identification

£13.0m

84% of Savings Target

Savings Delivery

£13.0m

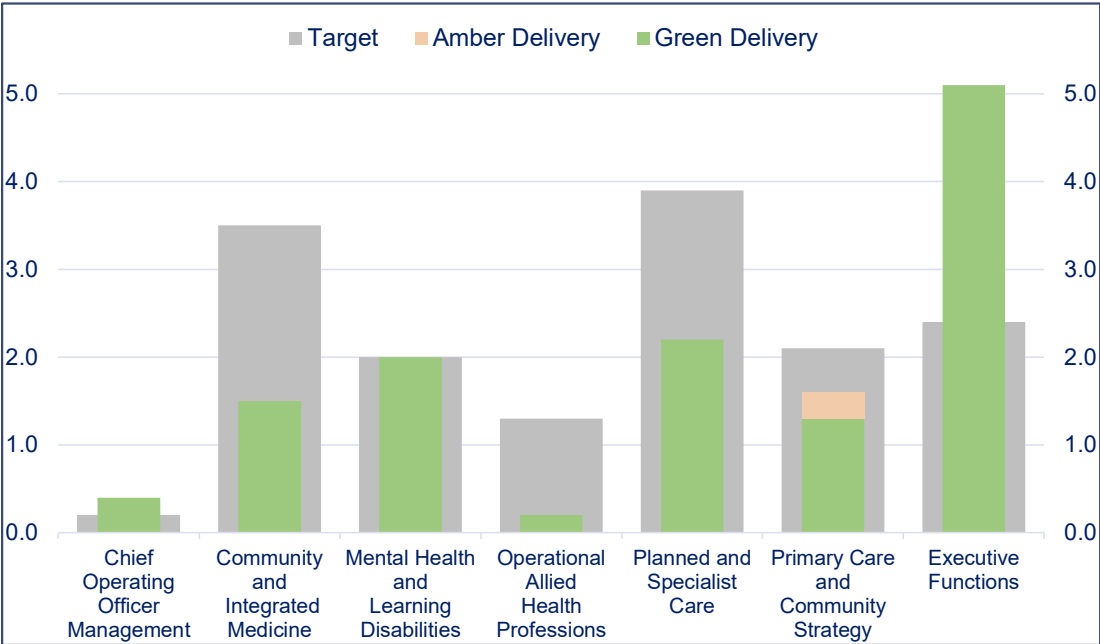
Recurrent = £3.7m
Non-Recurrent = £9.3m

Savings Gap to Target

£2.4m

16% of Savings Target

Savings Delivery vs Target (£'m)



Savings Performance Breakdown (£'m)

Clinical Care Group	Target	Plan	Delivery	Gap
Chief Operating Officer Management	0.2	0.4	0.4	(0.2)
Community and Integrated Medicine	3.5	1.5	1.5	2.0
Mental Health and Learning Disabilities	2.0	2.0	2.0	0.0
Operational Allied Health and Health Sciences	1.3	0.2	0.2	1.1
Planned and Specialist Care	3.9	2.2	2.2	1.7
Primary Care, Community Strategy and LTC	2.1	1.6	1.6	0.5
Executive Functions	2.4	5.1	5.1	(2.7)
Grand Total	15.4	13.0	13.0	2.4

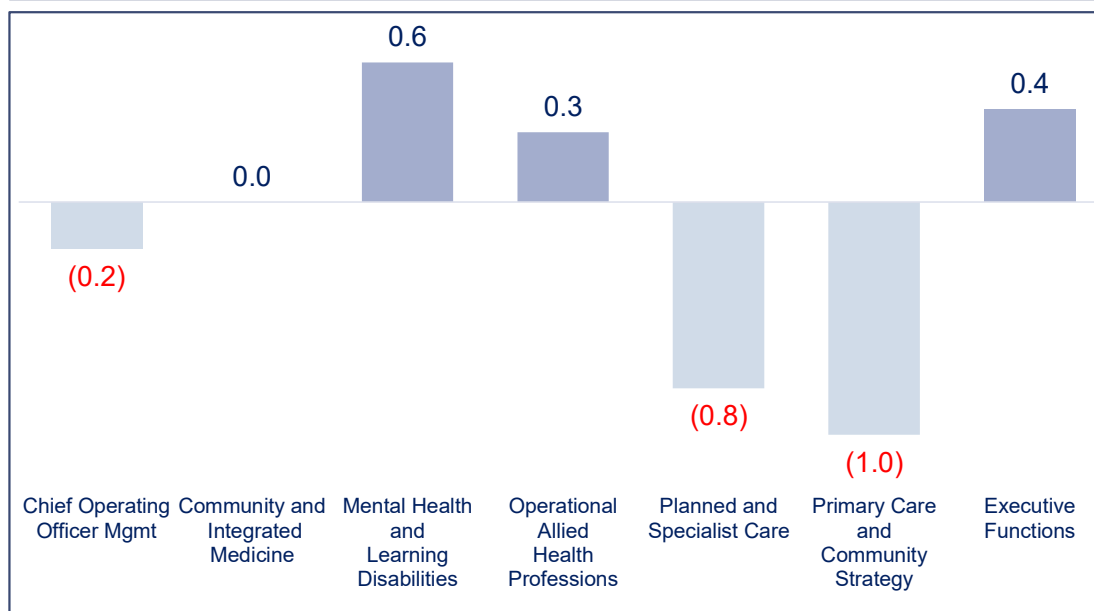
Year to Date: Core Operational Variation



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Core Operational Variation (£'m)



Core Operational Variation (£'m)

Clinical Care Group	Pay	Non-Pay	Income	Total
Chief Operating Officer Management	(0.1)	(0.1)	0.0	(0.2)
Community and Integrated Medicine	(0.1)	0.2	(0.1)	0.0
Mental Health and Learning Disabilities	0.0	0.6	0.0	0.6
Operational Allied Health and Health Sciences	0.2	0.3	(0.2)	0.3
Planned and Specialist Care	(0.1)	(0.4)	(0.3)	(0.8)
Primary Care, Community Strategy and LTC	0.3	(1.5)	0.2	(1.0)
Executive Functions	(0.4)	0.9	(0.1)	0.4
Total	(0.2)	0.0	(0.5)	(0.7)

The core operational variance to plan is £(0.7)m, main drivers being:

- High cost Continuing Healthcare packages and independent sector Psychiatric Intensive Care Unit beds within Mental Health.
- Use of Radiology external contractor to meet demand in Operational Allied Health and Health Sciences.
- Oncology & Ophthalmology drugs underspend due growth increases lower than planned, with increases due later in the year. within Planned and Specialist Care.
- Continued Dental Contracts underspend within Primary Care, Community Strategy and Long Term Care.
- Increase in activity relating to Swansea Bay Long Term Agreements within Executive Functions.

Capital Performance

Capital

Total Capital Performance

£34.5m

Annual Plan = £34.4m

All Wales Capital

£27.3m

Annual Plan = £27.3m

Discretionary Capital

£6.9m

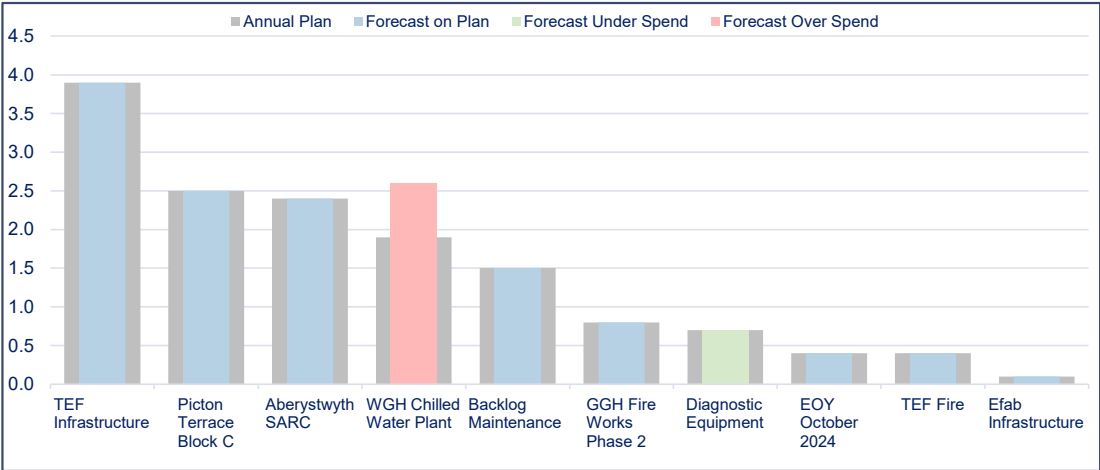
Annual Plan = £6.9m

IFRS 16

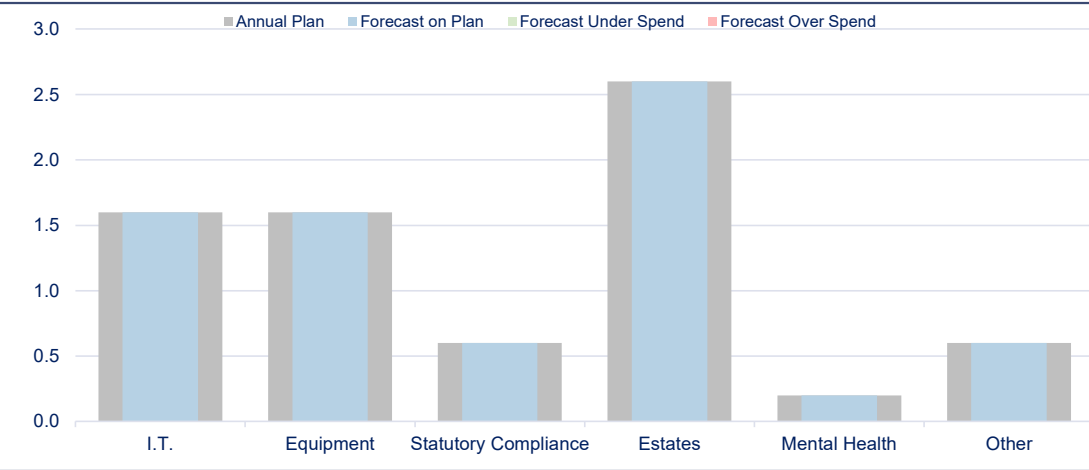
£0.3m

Capital Resource Limit = £0.3m

All Wales Capital Programme Top 10 Schemes (£'m)



Discretionary Capital Programme Category Summary (£'m)



Delivery against the capital programme is currently low risk.

Spend on the WGH Chilled water plant and diagnostic equipment have been combined under one scheme which explains the adverse and favourable variances against those schemes.

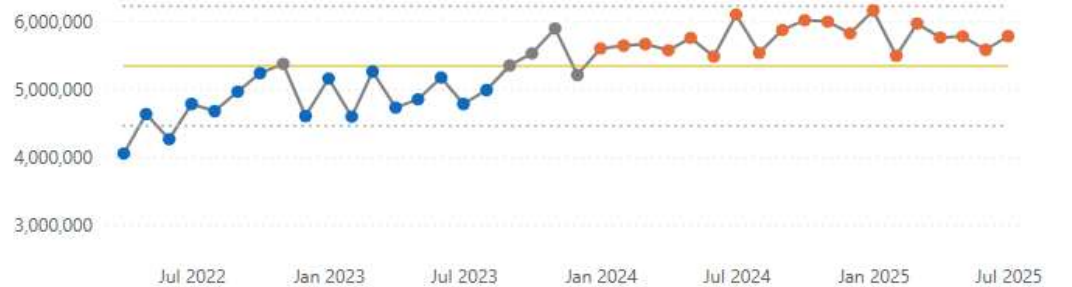
Trend Analysis: Non-Pay

Continuing Healthcare Expenditure (£'m)



Net increase in Continuing Healthcare packages, and cost pressures in-month particularly within Mental Health and Learning Disabilities.

Secondary Care Drugs Expenditure (£'m)



Increase in Oncology drugs due to 19.5% increase to drugs costs per patient.

Primary Care Prescribing Expenditure (£'m)



Despite decreasing levels in the volume of prescriptions in Q4 of 24/25, prescribing has returned to increased volume in Q2 of 25/26, with an increase from prior month in Month 4.

Clinical Services and Supplies (£'m)



Expenditure in Month 4 has increased by £1.0m compared to expenditure in Month 3 mainly due to increased Theatre activity and purchase of incontinence products within Community.

Trend Analysis: Pay – Agenda for Change

Total (WTE)



There has been an increase of 551 Total WTE since April 2022.

Total (£'m)



Total Pay spend has increased by circa £8.0m, from £34.0m in April 2022 to £42.0m in July 2025.

Substantive (WTE)



There has been an increase of 579 Substantive WTE since April 2022.

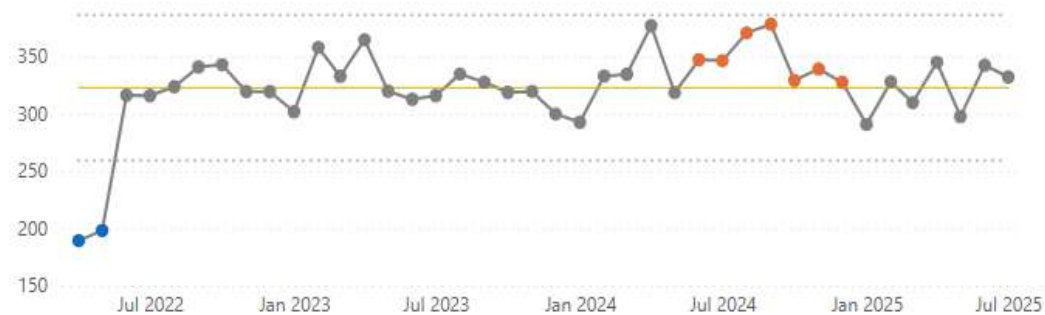
Substantive (£'m)



Substantive Pay spend has increased by circa £7.0m, from £32.0m in April 2022 to £39.0m in July 2025.

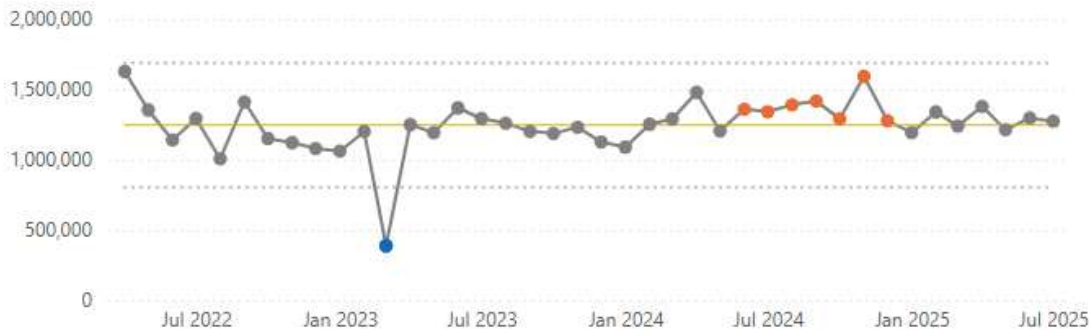
Trend Analysis: Pay – Agenda for Change

Bank (WTE)



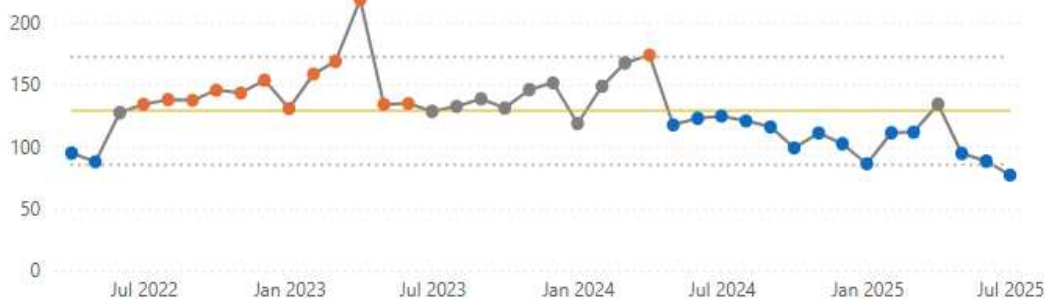
There has been an overall increase of 143 Bank WTE since April 2022. There has been a reduction in Bank usage in Month 4, with a reduction of 10 WTE from prior month.

Bank (£'m)



Bank spend in Month 4 is £1.3m, which is in line with Month 3. This is an overall reduction compared to the £1.6m Bank expenditure in April 2022.

Overtime (WTE)



The Overtime WTE reported in Month 4 is 77. This is a reduction of 11 WTE compared to prior month.

Overtime (£'m)



Overtime spend in Month 4 is £485k, which is a slight reduction in spend from Month 3. This is however is an overall increase to the £352k Overtime expenditure in April 2022.

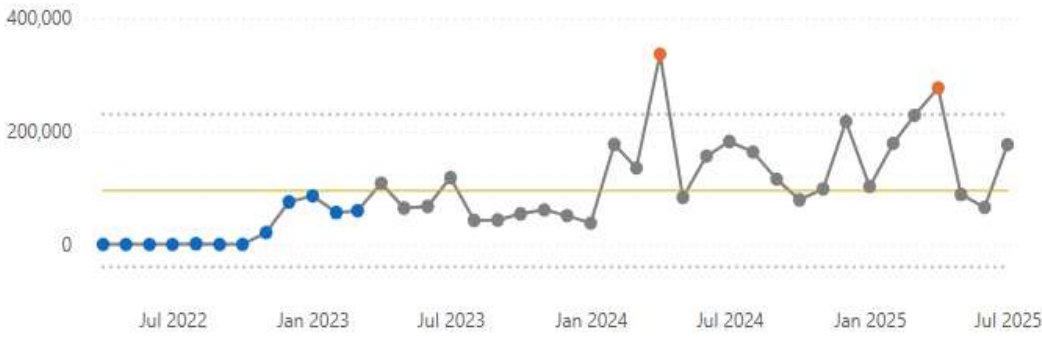
Trend Analysis: Pay – Agenda for Change

Waiting List Initiative (WTE)



Month 4 Waiting List Initiative WTE is 22 which is an increase of 10 WTE from the prior month due to increased Theatre activity within Planned and Specialist Care.

Waiting List Initiative (£'m)



Waiting List Initiative spend in Month 4 is £176k, which is an increase of £110k compared to the spend in Month 3 due to increased Theatre activity within Planned and Specialist Care.

Agency Premium (WTE)



The Agency Premium WTE in Month 4 is 56 WTE, which is a reduction of 176 Agency WTE since April 2022.

Agency Premium (£'m)



Agency spend in Month 4 is £407k, which is a reduction of £43k from prior month. This is an overall reduction of £1,263k compared to the £1,670k Agency spend in April 2022.

Trend Analysis: Pay – Medical and Dental

Total (£'m)



Total Medical and Dental Pay Spend has increased by circa £3.0m from April 2022 expenditure levels.

Substantive (£'m)



Substantive Spend has increased from £6.9m in April 2022 to £10.0m in Month 4.

Variable (£'m)



Medical Variable Pay has increased from £1.8m in April 2022, to £2.7m in July 2025. Month 4 has seen an increase of £0.5m Medical Variable spend from Month 3.

Agency Premium (£'m)



Month 4 Agency Premium Medical expenditure is £325k which is an increase of £169k compared to the prior month.

Trend Analysis: Pay – Medical and Dental

Additional Hours (£'m)



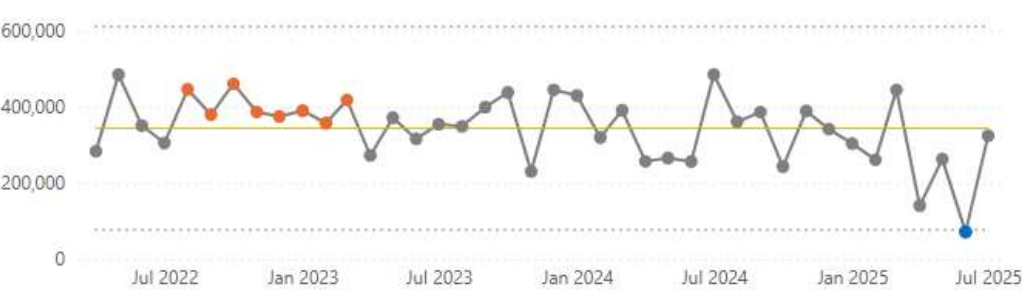
There has been an overall increase in Medical Additional Hours spend from £1.7m in May 2022 to £2.5m in July 2025. Month 4 saw a £0.4m increase in expenditure from Month 3.

Waiting List Initiative (£'m)



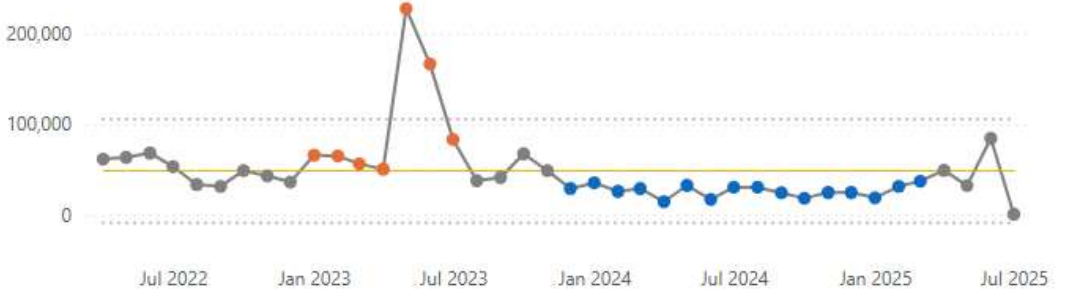
The expenditure for Waiting List Initiative in Month 4 is £241k, which is an increase from Month 3 due to additional Theatre activity in Planned and Specialist Care.

On Contract Agency Premium (£'m)



On Contract Agency Premium expenditure in Month 4 is £324k, which is an increase of £252k from the prior month.

Off Contract Agency Premium (£'m)



Off Contract Agency Premium saw a reduction of £83k spend compared to the prior month.

Establishment Reports: Nursing and Healthcare Support Worker Ward Staffing



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	Ward Staffing Level (WTE) for Nursing and Health Care Support Workers (HCSW)						
	Total Fill Rate	Total WTE	Substantive WTE	Substantive WTE Vacancy	Variable WTE	Agency (Premium) WTE	Total Over/(Under) Staffed
Chief Operating Officer	100.3%	2,611	2,302	(302)	264	45	7
Community and Integrated Medicine	101.5%	1,895	1,661	(207)	192	42	28
Carmarthenshire Integrated System	102.7%	1,147	998	(119)	134	15	30
Ceredigion Integrated System	103.0%	312	268	(35)	25	19	9
Pembrokeshire Integrated System	97.4%	436	394	(53)	33	8	(11)
Mental Health and Learning Disabilities	105.8%	274	222	(37)	52	1	15
Mental Health and Learning Disabilities	105.8%	274	222	(37)	52	1	15
Planned and Specialist Care	92.5%	441	420	(57)	19	2	(36)
Cancer and Scheduled Care	86.7%	149	141	(32)	7	2	(23)
Children, Women and Family Health	95.7%	292	279	(26)	13	0	(13)
Grand Total	100.3%	2,611	2,302	(302)	264	45	7

Establishment Reports: Non-Ward Staffing, excluding Medical



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	All Other Staffing Levels (WTE) Excluding Medical and Ward Nursing & HCSWs						
	Total Fill Rate	Total WTE	Substantive WTE	Substantive WTE Vacancy	Variable WTE	Agency (Premium) WTE	Total Over/(Under) Staffed
Chief Executive	95.4%	90	90	(4)	-	-	(4)
Chief Operating Officer	93.3%	5,447	5,333	(507)	103	11	(393)
Chief Operating Officer Management	84.9%	217	216	(39)	1	-	(38)
Community and Integrated Medicine	95.7%	1,304	1,274	(89)	28	2	(58)
Mental Health and Learning Disabilities	91.4%	911	901	(96)	10	-	(86)
Operational Allied Health and Health Sciences	95.5%	1,087	1,069	(69)	18	-	(51)
Planned and Specialist Care	93.9%	1,414	1,364	(141)	40	9	(91)
Primary Care, Community Strategy and Long Term Care	88.3%	514	508	(74)	6	-	(68)
Executive Director of Allied Health Professions and Health Sciences	96.1%	886	828	(94)	59	-	(36)
Estates and Facilities	96.2%	883	825	(94)	59	-	(35)
Executive Allied Health Professions and Health Sciences	81.5%	3	3	(1)	-	-	(1)
Executive Director of Finance	89.8%	299	294	(38)	4	-	(34)
Digital	89.8%	207	203	(28)	4	-	(24)
Finance	89.8%	92	92	(10)	-	-	(10)
Executive Director of Nursing, Quality and Patient Experience	85.8%	166	165	(29)	1	-	(28)
Executive Director of Public Health	88.2%	130	130	(18)	0	-	(17)
Executive Director of Strategy and Planning	92.6%	34	34	(3)	-	-	(3)
Executive Director of Workforce and Organisational Development	80.0%	232	232	(58)	-	-	(58)
Executive Medical Director	90.6%	106	106	(11)	-	-	(11)
Grand Total	92.7%	7,391	7,212	(763)	167	11	(584)

In-Month: Revenue Position Variance to Budget (£'k)



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	Pay				Non Pay				Income	Grand Total
	Administration and Estates	Allied Health, Scientists and Other	Medical and Dental	Nursing, Midwifery and Clinical Support	Clinical Services and Supplies	Commissioned Healthcare Services	Drugs and Prescribing	Other Non-Pay	Income	
Chief Executive	(2)				0	(1)		(27)	0	(30)
Chief Operating Officer	(288)	(221)	551	(382)	1,363	(407)	(479)	119	(50)	205
Chief Operating Officer Management	(133)	58	54	5	(8)	(3)		(104)	78	(52)
Community and Integrated Medicine	(68)	(32)	213	(99)	126	69	(18)	133	(87)	239
Mental Health and Learning Disabilities	(11)	(11)	80	(84)	(1)	241	(58)	18	5	178
Operational Allied Health and Health Sciences	4	36	4	(32)	16	(31)	(43)	(35)	(53)	(134)
Planned and Specialist Care	(40)	(33)	75	(2)	1,227	(633)	(335)	51	(52)	258
Primary Care, Community Strategy and Long Term Care	(41)	(239)	124	(171)	3	(51)	(24)	55	60	(284)
Executive Director of Allied Health Professions and Health Sciences	(170)	(15)		(4)	2	(0)	0	133	(59)	(112)
Estates and Facilities	(181)			(4)	2		0	133	(59)	(109)
Executive Allied Health Professions and Health Sciences	11	(15)				(0)				(3)
Executive Director of Finance	(18)	0	22	(3)		(39)	0	(142)	(42)	(222)
Digital	(18)	0	22	(3)		(28)		(145)	(40)	(213)
Finance	0					(11)	0	3	(1)	(9)
Executive Director of Nursing, Quality and Patient Experience	(65)	(22)	(0)	58	(0)	20		10	(5)	(5)
Executive Director of Public Health	(11)	13	(14)	(8)	(2)	(1)	14	56	(35)	12
Executive Director of Strategy and Planning	(7)	(0)	3			673	0	(17)	(9)	643
LTAs with other NHS Providers	4					674	0	(0)		677
Strategy and Planning	(11)	(0)	3			(1)		(17)	(9)	(34)
Executive Director of Workforce and Organisational Development	(87)	(7)	(0)	95	1	(39)	(3)	(58)	(11)	(111)
Executive Medical Director	(9)	1	(8)	(6)	(8)		0	(31)	5	(55)
Health Board Wide	(166)			(30)	3	29	(18)	366	12	196
Planned Deficit								2,125		2,125
Savings Identification								3		3
Grand Total	(824)	(251)	553	(281)	1,359	234	(486)	2,537	(192)	2,648

Year to Date: Revenue Position Variance to Budget (£'k)



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	Pay				Non Pay				Income	Grand Total
	Administration and Estates	Allied Health, Scientists and Other	Medical and Dental	Nursing, Midwifery and Clinical Support	Clinical Services and Supplies	Commissioned Healthcare Services	Drugs and Prescribing	Other Non-Pay	Income	
Chief Executive	(1)				0	(5)		2	1	(3)
Chief Operating Officer	(571)	(152)	1,451	(513)	1,601	(1,634)	(1,848)	1,011	(482)	(1,136)
Chief Operating Officer Management	(94)	(12)		24	36	(1)		(216)	37	(227)
Community and Integrated Medicine	(347)	(101)	470	(147)	48	(69)	(193)	459	(83)	37
Mental Health and Learning Disabilities	(61)	(230)	303	(39)	(6)	779	(114)	15	(8)	638
Operational Allied Health and Health Sciences	26	299	(130)	64	291	22	(26)	19	(234)	332
Planned and Specialist Care	(18)	(87)	281	(266)	1,224	(331)	(1,526)	224	(352)	(850)
Primary Care, Community Strategy and Long Term Care	(77)	(21)	527	(149)	8	(2,034)	11	510	159	(1,066)
Executive Director of Allied Health Professions and Health Sciences	(181)	(58)	9	(8)	7	(0)	2	127	69	(34)
Estates and Facilities	(226)		9	(8)	7		2	126	69	(21)
Executive Allied Health Professions and Health Sciences	46	(58)				(0)		1		(12)
Executive Director of Finance	(57)	0	24	(3)	0	(235)	0	(108)	(14)	(394)
Digital	(29)	0	24	(3)	0	(190)		(139)	(14)	(352)
Finance	(28)					(45)	0	32	(1)	(42)
Executive Director of Nursing, Quality and Patient Experience	(163)	(29)	0	131	(1)	49		74	37	97
Executive Director of Public Health	(36)	61	(56)	(60)	(15)	(19)	(146)	274	(78)	(76)
Executive Director of Strategy and Planning	(42)	41	0			347	2	(53)	(34)	260
LTAs with other NHS Providers	9					350	2	(1)		360
Strategy and Planning	(52)	41	0			(3)		(52)	(34)	(100)
Executive Director of Workforce and Organisational Development	(89)	(7)	0	95	1	(171)	(5)	(10)	(23)	(209)
Executive Medical Director	9	6	29	(13)	5		(0)	(144)	3	(105)
Health Board Wide	(9)			(30)	221	51	490	162	(23)	861
Planned Deficit								10,000		10,000
Savings Identification								2,444		2,444
Grand Total	(1,140)	(139)	1,459	(402)	1,819	(1,619)	(1,506)	13,778	(544)	11,706

End of Year: Revenue Position Variance to Budget (£'k)



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	Pay				Non Pay				Income	Grand Total
	Administration and Estates	Allied Health, Scientists and Other	Medical and Dental	Nursing, Midwifery and Clinical Support	Clinical Services and Supplies	Commissioned Healthcare Services	Drugs and Prescribing	Other Non-Pay	Income	
Chief Executive	16				0	(8)		15	2	25
Chief Operating Officer	(1,935)	(1,248)	3,924	(2,149)	1,805	(2,192)	(3,028)	2,263	(1,363)	(3,922)
Chief Operating Officer Management	(411)	38	(5)	36	71	(24)		(110)	28	(378)
Community and Integrated Medicine	(879)	2	1,033	(514)	526	(85)	(860)	955	(130)	49
Mental Health and Learning Disabilities	(246)	(619)	920	(1,150)	(6)	1,298	(144)	15	43	111
Operational Allied Health and Health Sciences	63	286	(408)	226	333	175	(67)	146	(802)	(48)
Planned and Specialist Care	(80)	(215)	944	(197)	1,096	1,375	(2,214)	610	(874)	445
Primary Care, Community Strategy and Long Term Care	(382)	(741)	1,442	(550)	(215)	(4,930)	257	647	371	(4,101)
Executive Director of Allied Health Professions and Health Sciences	172	(175)	31	(26)	21	0	7	1,557	(0)	1,587
Estates and Facilities	35		31	(26)	21		7	1,556	(0)	1,622
Executive Allied Health Professions and Health Sciences	138	(175)				0		2		(35)
Executive Director of Finance	(156)	(63)	50	(74)	0	(427)	0	426	(1)	(244)
Digital	86	(63)	50	(74)	0	(292)		293	(1)	(1)
Finance	(242)					(134)	0	133	(0)	(243)
Executive Director of Nursing, Quality and Patient Experience	(424)	(89)	0	112	(4)	146		296	80	118
Executive Director of Public Health	(127)	166	(167)	(127)	(46)	(58)	201	(14)	(204)	(377)
Executive Director of Strategy and Planning	(197)	41	4		4	583	2	(47)	(102)	287
LTAs with other NHS Providers	38				4	593	2	(5)		632
Strategy and Planning	(235)	41	4			(10)		(42)	(102)	(345)
Executive Director of Workforce and Organisational Development	44	(280)	(29)	134	4	(79)	(14)	89	(1)	(131)
Executive Medical Director	(24)	11	147	(81)	14		(0)	(340)	90	(184)
Health Board Wide	(29)		0	(30)	243	111	470	(17,358)	(62)	(16,654)
Planned Deficit								30,000		30,000
Savings Identification								19,496		19,496
Grand Total	(2,661)	(1,636)	3,960	(2,241)	2,040	(1,924)	(2,362)	36,384	(1,561)	30,000

End of Year: Savings Detail (£'k)

Delegated Officer (£'000)	Annual Savings Target	In-Year Identified Plans	In-Year Recurrent Delivery	In-Year Non Recurrent Delivery	In-Year Total Forecast Delivery	In-Year Forecast Shortfall	In-Year % Saving vs Budget	Recurrent Forecast Delivery	Recurrent Forecast Shortfall	Recurrent % Saving vs Budget
Chief Executive	38	255	38	217	255	(217)	 7.5%	38	(0)	 1.1%
Chief Executive	38	255	38	217	255	(217)	 7.5%	38	(0)	 1.1%
Chief Operating Officer	39,046	17,001	8,914	8,087	17,001	22,045	 2.2%	9,010	30,037	 1.2%
Chief Operating Officer Management	762	371	0	371	371	391	 2.9%	0	762	 0.0%
Community and Integrated Medicine	10,483	3,693	2,771	922	3,693	6,790	 1.5%	2,815	7,668	 1.2%
Mental Health and Learning Disabilities	5,851	3,180	1,257	1,924	3,180	2,671	 3.1%	1,257	4,594	 1.2%
Operational Allied Health and Health Sciences	3,785	459	459	0	459	3,326	 0.6%	459	3,326	 0.6%
Planned and Specialist Care	11,638	6,304	2,361	3,943	6,304	5,334	 3.0%	2,396	9,242	 1.1%
Primary Care, Community Strategy and Long Term Care	6,529	2,995	2,068	928	2,995	3,533	 2.8%	2,084	4,445	 1.9%
Executive Director Of Allied Health Professions and Health Sciences	2,063	342	342	0	342	1,722	 0.7%	342	1,722	 0.7%
Estates and Facilities	2,053	342	342	0	342	1,712	 0.7%	342	1,712	 0.7%
Executive Allied Health Professions and Health Sciences	10	0	0	0	0	10	 0.0%	0	10	 0.0%
Executive Director Of Finance	377	1,079	468	611	1,079	(702)	 4.6%	501	(124)	 2.2%
Digital	271	818	384	434	818	(548)	 4.7%	417	(147)	 2.4%
Finance	106	261	84	177	261	(155)	 4.4%	84	22	 1.4%
Executive Director Of Nursing, Quality and Patient Experience	243	426	201	225	426	(183)	 4.6%	243	0	 2.6%
Nursing, Quality and Patient Experience	243	426	201	225	426	(183)	 4.6%	243	0	 2.6%
Executive Director Of Public Health	107	730	107	623	730	(623)	 11.1%	107	(0)	 1.6%
Public Health	107	730	107	623	730	(623)	 11.1%	107	(0)	 1.6%
Executive Director Of Strategy and Planning	1,902	871	61	810	871	1,031	 1.4%	61	1,841	 0.1%
LTA'S With Other NHS Providers	1,841	483	0	483	483	1,358	 0.8%	0	1,841	 0.0%
Strategy and Planning	61	388	61	327	388	(328)	 10.4%	61	(0)	 1.6%
Executive Director Of Workforce and Organisational Development	247	1,176	247	929	1,176	(929)	 7.8%	247	(1)	 1.6%
Workforce and Organisational Development	247	1,176	247	929	1,176	(929)	 7.8%	247	(1)	 1.6%
Executive Medical Director	74	74	74	0	74	(0)	 1.7%	74	(0)	 1.7%
Medical	74	74	74	0	74	(0)	 1.7%	74	(0)	 1.7%
Health Board Wide	2,303	4,949	1,197	3,752	4,949	(2,646)	 13.6%	1,264	1,039	 3.5%
Grand Total	46,400	26,904	11,648	15,255	26,904	19,497	 2.8%	11,886	34,514	 1.2%



PWYLLGOR CYLLID A PHERFFORMIAD FINANCE AND PERFORMANCE COMMITTEE

DYDDIAD Y CYFARFOD: DATE OF MEETING:	26 August 2025
TEITL YR ADRODDIAD: TITLE OF REPORT:	M4 Financial Performance Assurance Report Appendix 2: Options to Achieve £24m
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Huw Thomas, Director of Finance
SWYDDOG ADRODD: REPORTING OFFICER:	Siân Jenkins, Deputy Director of Finance

Pwrpas yr Adroddiad (dewiswch fel yn addas)

Purpose of the Report (select as appropriate)

Ar Gyfer Trafodaeth/For Discussion

ADRODDIAD SCAA SBAR REPORT

Sefyllfa / Situation

At the Board meeting on 31 July 2025 a list of options was presented which framed potential routes to curtail spend in a bid to improve the financial forecast outturn for 2025/26 to £24m. This paper provides an update on progress in assessing these options in respect of Quality Impact Assessments (QIAs) and associated financial assessment by budget holders.

Cefndir / Background

Following further correspondence between Welsh Government (WG) and the Health Board, the Chief Executive wrote to the Director General Health, Social Care and Early Years Group, setting out the approach and timeline to reviewing further financial improvements aspiring to achieve the WG expectation of maintaining the 2024/25 financial outturn for 2025/26.

This is summarised as follows with the Board having tasked the Executives with providing updated financial options with an integrated impact assessment for each of the further opportunity improvements listed in the £22.5m expenditure grouped options shared with the Board in the meeting on 31 July 2025, by:

- **15 August** – deadline for Executives to submit their integrated impact assessment for their assigned themes and the revised and refined financial impacts/opportunities
- **18 August** – papers issued, inclusive of these further improvement options, for Finance and Performance Committee
- **26 August** – Finance and Performance Committee to scrutinise and consider the options put forward by Executives
- **9 September** – In-Committee Board to review Executives recommendations and conclude forward actions
- **11 September** – CEO to write to Director General with an update on progress made towards the 2024/25 outturn

- **11 September** – Finance team to submit updated Savings plans, as agreed by the organisation and in-line with Welsh Government definitions, as part of the Month 5 reporting submission

Since the Board meeting on 31 July 2025, dialogue and correspondence with WG has progressed. The latest letter from the Director General is included at the end of this document for awareness.

The Health Board is required to provide confirmation by 11 September 2025, aligned with the Month 5 monitoring return submission, demonstrating 100% confidence in savings and mitigating actions to deliver the expected outturn position. A meeting has been scheduled for 11 September at Cathays Park where the following must be presented:

- Month 5 monitoring submission with detailed actions to deliver £24.0m deficit
- Detailed actions and confidence assessment for all savings and mitigations
- Assessment of all currently uncommitted expenditure with monthly profile
- Breakdown of non-delivery areas against initial plan with mitigating actions
- Any discretionary choices being made by the Board and their impact on delivery
- Detail of expenditure control mechanisms supporting an improving run rate

Asesiad / Assessment

In line with the steps framed to the Board in July, budget holders were tasked with completing a Quality Impact Assessment (QIA) and financial assessments to develop the understanding of impacts associated with the list of cost reducing options totalling £22.5m. The deadline for receipt of updates was 15 August 2025.

Tables 1 and 2 frame the results to date.

The volume of QIAs involved is extensive and an initial QIA panel convened 18 August 2025; a second panel is scheduled for the afternoon 26 August 2025 to complete the exercise. Recognising that services will approach this assessment with caution and will have a reluctance to compromise patient care and performance, it is apparent that the majority of options generate a negative impact through the QIA process which has limited the associated financial savings to support the £24m ask.

Table 1: Statement of QIA responses and QIA Panel discussions to date

	QIA Submission	QIA Panel 15/08/2025	QIA Panel 26/08/2025	QIA Panel Feedback	Finance Assessment	Financial Opportunity £000
Chief Executive	Partial	No	Yes		Yes	142
Chief Operating Officer						
Chief Operating Officer Management	No	No	No		No	No submission
Community and Integrated Medicine	Yes	No	Yes		No	No submission
Mental Health and Learning Disabilities	Yes	Yes	N/A	Rejected or status quo	No	No submission
Operational Allied Health and Health Sciences	Yes	Yes	N/A	Rejected or status quo	Yes	0
Planned and Specialist Care	Yes	Yes	N/A	Rejected or status quo	Yes	0
Primary Care, Community Strategy and Long Term Care	Yes	No	Yes		No	No submission
Executive Director of Allied Health Professions and Health Sciences						
Estates and Facilities	No	No	Yes		No	No submission
Executive Allied Health Professions and Health Sciences	No	No	No		No	No submission
Executive Director of Finance						
Digital	Yes	No	Yes		Yes	0
Finance	Yes	No	Yes		Yes	76
Executive Director of Nursing, Quality and Patient Experience	No	No	No		No	No submission
Executive Director of Public Health	No	No	Yes		Yes	122
Executive Director of Strategy and Planning						
LTAs with other NHS Providers	Yes	No	Yes		Yes	70
Strategy and Planning	Yes	Yes	N/A	Requested further info	No	No submission
Executive Director of Workforce and Organisational Development	Yes	Yes	N/A	Inconclusive	No	No submission
Executive Medical Director	Yes	Yes	N/A	Supported	Yes	100
Health Board Wide	Yes	No	Yes		Yes	224

Table 2: Statement of the financial opportunity framed to date, noting that the QIA Panel has yet to review some submissions which currently frame a financial opportunity.

Scheme	Original Opportunity £000	BH Assessed Opportunity £000	QIA Comments/Status
Pause all overtime (1)	5,100		QIA Panel - need patient facing/non-patient facing split, have existing processes, reduce rather than eliminate
Reduce / eliminate on-contract agency (2)	4,900		QIA Panel - have existing processes, reduce rather than eliminate
Recruitment freeze – non-patient-facing roles (3)	2,188	319	QIA Panel - patient facing via FCSG, non-clinical variable depending on the role
MHLD: delay recruitment to approved posts (4)	1,900		QIA Panel - negative impact, not supported
Non-renewal of contracts / licences (5)	1,300		Digital QIA assessment - negative impact, rejected. QIA panel to review
Pause Radiology activity increases (6)	1,300		QIA Panel - negative impact, not supported
Delay NICE drugs implementation to 26/27 (7)	1,300		QIA Panel to review submission 26/08/25
MHLD: pause neuro-developmental outsourcing (8)	600		QIA Panel - negative impact, not supported
Reduce Strategic Planning budget (9)	500		QIA Panel - not conclusive, further information required
Recovery Plan / WL funding to cost of delivery (10)	500		QIA Panel - negative impact, not supported
Local-authority shared costs – respite care (11)	450		QIA Panel - not conclusive, further information required
Reduce / eliminate off-contract agency (12)	450		QIA Panel - support elimination of off-contract agency with exceptions via FCSG process. Latest position - no off-contract agency across the Health Board, confirming this is reflected in forecasts for M05 reporting.
Equipment / stores – recover LA share (13)	400		No submission
Dental recovery – consciously delay activity (14)	300		QIA Panel to review submission 26/08/25
Modular Health Records – pause investment (15)	300		Digital QIA assessment - negative impact, rejected. QIA panel to review
RIF slippage – reduce HB match funding (16)	240		No submission
Stop stationery / non-clinical requisitions (17)	200	106	QIA Panel to review submission 26/08/25. Pan Health Board financials included, assumed 5% reduction in CCGs (as element of non-clinical) and 50% reduction in Executive Functions.
Hold 25/26 LTA activity to budget (18)	140	70	Alternative scheme presented. QIA Panel to review submission 26/08/25
Tritech – release surplus funds (19)	100	100	QIA Panel - feedback incorrect template submitted, confirmed supported
Cease non-essential minor works (20)	100		QIA Panel to review submission 26/08/25
Pause non-essential non-clinical equipment (21)	80	118	QIA Panel to review submission 26/08/25. Pan Health Board financials included, assumed 5% reduction in CCGs (as element of non-clinical) and 50% reduction in Executive Functions
Mandate virtual meetings for travelling staff (22)	80	1	QIA Panel - not conclusive
Pause non-statutory & CPD training (23)	75		No submission Health Board wide submission to date
2025/26 LTA position adjustment (24)	0		Saving realised £457k against existing scheme, pressure of offsetting risk share to be reviewed
HB-wide ban on travel (25)	TBC	21	No submission Health Board wide submission to date
Review temporary staff < 2 years' service (26)	TBC		No submission Health Board wide submission to date
Capital bid process – revenue saving focus (27)	TBC		No submission Health Board wide submission to date
Total	22,503	735	

Please note, this is a live process, the tables reflect the position as of 21 August 2025.

The challenge posed by the conflict of financial savings versus impact was discussed at the latest Formal Executive Team meeting 20 August 2025. The reality of continuing to balance quality, safety, performance and finances, in a climate of increased expectations is a significant challenge and it is very difficult to frame further cost improvements, to go beyond the planned deficit of £30m, without consequence.

The QIA process to date has demonstrated the challenge for budget holders to forgo the resulting capacity and delivery, in response to the financial options to deliver further financial savings. Mindful that there will be certain areas of provision which pose a greater and lesser negative impact, the discussion at Formal Executive Team concluded that an expectation needed to be framed whereby a proportion of the various opportunities must be delivered across budgets. That is, each Clinical Care Group (CCG) or Corporate Directorate will need to determine how it can deliver a proportion of the opportunity for their area, as relevant to their budget. For example, a CCG may need to take out 30% of on-contract agency spend. Illustrative figures have been included in Table 3; these will need to be considered and likely refined as the QIA progresses.

Table 3: Illustrative assessment of proportionate requirement to deliver reduced spend across budgets

Opportunity Theme	Opportunity Total Value £000	Delivery Required 30% £000
Workforce	14,693	4,408
Digital	1,600	480
Performance	2,400	720
Procurement controls	280	84
Partnerships	1,090	327
Primary Care	300	90
NICE / medicines	1,300	390
LTAs	140	42
Capital expenditure	200	60
Wider strategy	500	150
Invest-to-Save	0	0
Total	22,503	6,751

Building on progress to date, the Formal Executive Team agreed the following next steps.

- Further QIA panel 26 August 2025 to review remaining QIA submissions. As part of this discussion, the list of £22.5m options will be considered and assessed to provide a ranking of least impact to most negative impact for patients.
- Integrated Quality Finance Performance and Delivery Group meeting 27/08/25 to be turned over to discussions to review any aspects of the QIA process with CCGs directly. Also to start to frame potential next steps in respect of delivery of the £22.5m options.
- Building on the list of £22.5m options and illustrative values presented in Table 3, determine the scale of delivery required across each item to support achievement of £24m outturn, taking into account the risk profile of the various opportunities.
- To support the delivery of the prescribed saving requirements, a set of principles will be developed to steer budget holders in considering their delivery options, for example in respect of criteria to manage staff travel restrictions and areas of performance to prioritise over others.
- To develop a communication plan, to be activated following a Board decision, which confirms the ask of budget holders and frames the supporting principles.

The output of this work will inform the Additional In Committee Board meeting on 9 September 2025 for decision.

Argymhelliad / Recommendation

[Contained within main SBAR]

The Finance and Performance Committee is requested to **DISCUSS** and **CONSIDER** the further choices and actions being proposed to achieve an additional financial improvement by the 11 September 2025 Welsh Government deadline.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**

Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	3.1.5 Receive assurance on the delivery of the financial plan. This will be achieved through

	scrutiny of the monthly finance report. This report shall ensure clarity in: 3.1.5.1 The reporting of monthly, year to date and forecast financial position alongside operational drivers; 3.1.5.2 Performance against the savings requirement; 3.1.5.3 Performance against other financial metrics, such as cash management, capital management and Public Sector Payment Policy.
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	2086 (score 20) Risk of the Health Board not being able to meet the statutory requirement of breaking even in 2025/26 due to significant deficit position.
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	7. All apply
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	6. All Apply
Amcanion Strategol y BIP: UHB Strategic Objectives:	All Strategic Objectives are applicable
Amcanion Cynllunio Planning Objectives	All Planning Objectives Apply
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022	9. All HDdUHB Well-being Objectives apply

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Monitoring returns to Welsh Government based on HDdUHB's financial reporting system.
Rhestr Termiau: Glossary of Terms:	BGH – Bronglais Hospital CHC – Continuing Healthcare EOY – End of Year FNC – Funded Nursing Care FYE – Full Year Effect GGH – Glangwili Hospital GMS – General Medical Services HSCEY – Health, Social Care and Early Years MHLD – Mental Health & Learning Disabilities

	NICE – National Institute for Health and Care Excellence OCP – Organisational Change Policy/Process OOH – Out of Hours PPH – Prince Philip Hospital PSPP– Public Sector Payment Policy RTT – Referral to Treatment Time T&O – Trauma & Orthopaedics TCT – Target Control Total WG – Welsh Government WGH – Withybush Hospital WRP – Welsh Risk Pool WTE – Whole Time Equivalent YTD – Year to date
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Adnoddau Cynaliadwy: Parties / Committees consulted prior to Sustainable Resources Committee:	Finance Team Management Team Executive Team

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	Financial implications are inherent within the report.
Ansawdd / Gofal Claf: Quality / Patient Care:	The impact on patient care is assessed within the savings schemes.
Gweithlu: Workforce:	The report considers the financial implications of our workforce.
Risg: Risk:	Financial risks are detailed in the report.
Cyfreithiol: Legal:	HDdUHB has a legal duty to deliver a breakeven financial position over a rolling three-year basis and an administrative requirement to operate within its budget within any given financial year.
Enw Da: Reputational:	Adverse variance against HDdUHB's financial plan will affect its reputation with Welsh Government, Audit Wales, and with external stakeholders.

Gyfrinachedd: Privacy:	Not Applicable.
Cydraddoldeb: Equality:	Not Applicable.

**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**

Phil Kloer
Chief Executive
Hywel Dda University Health Board

Philip.Kloer@wales.nhs.uk

Our Ref: PK/HJ/HP

18 August 2025

Dear Phil,

2025/26 Annual Plan & Financial Position

Thank you for your submissions on 18th July and 31st July in response to the requirements set out by the Cabinet Secretary at the meeting on the 10th of July with Chairs and CEO's of the four health boards forecasting deficits.

The expectation was that there was absolute clarity and confidence in the actions and deliverables required to achieve your current forecast by 18th of July. Further, that you needed to set out by 31st July the detailed actions that would be taken to achieve and maintain your forecast 2024/25 outturn position of a £24m deficit.

The Cabinet Secretary and I were disappointed that the responses received did not fully meet this expectation. This response addresses both your letter to me and correspondence from Neil to the Cabinet Secretary.

The improvement in your forecast to a £30m deficit however is acknowledged, as is the confirmation this absorbs the £2m Employers National Insurance contribution funding shortfall.

Thank you for sharing the summary of the options being considered by the Board and for setting out the essence of your Board debate. It is recognised that the delivery expectation presents challenges and the need to balance the considerations in your letter alongside financial delivery.

I must reinforce however, that actions are required, for you as a Health board, to deliver a £24m forecast outturn position, which is the delivery requirement set by Welsh Government. The ability for health boards to deliver the forecast expectations set out and planned in the Welsh Government position is a critical requirement. If this cannot be achieved, then



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consideration will have to be given for other revenue support funding that is being provided, and future allocations, as to whether these can continue to be provided.

You'll be aware that Welsh Government has set NHS bodies a deadline of 11th of September and the month 5 monitoring return submission to receive confirmation of 100% confidence in savings and mitigating actions to deliver the expected outturn position. This aligns to the process, Board and Committee timescales, that you have stated in your letter. I expect therefore to receive confirmation in writing on the 11th of September of your actions to deliver a £24m forecast deficit outturn and detail confidence in its delivery.

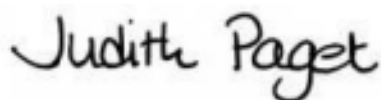
Given the importance and profile of this requirement, I also want to meet with you and respective Directors of Finance, on Thursday 11th of September in Cathays Park to review the substance of your position in detail. At that meeting I expect to receive at a minimum an update and review of:

- Your 11th September month 5 monitoring submission and detailed actions of how you will deliver a £24m deficit.
- The detailed actions and confidence in delivering all savings and mitigations.
- An assessment of all currently uncommitted expenditure and monthly profile.
- A breakdown of non-delivery areas against your initial plan and mitigating actions.
- Any further discretionary choices being made by the Board and how this feature in your submission and delivery expectations.
- The detail of the expenditure control mechanisms that you have in place to support an improving run rate.

If further clarification is needed on this requirement, please liaise with Hywel Jones for the necessary support as required.

I hope this is clear. The Cabinet Secretary has asked to be kept appraised on progress and will be considering this further with your Chair at their next interaction.

Yours sincerely



Judith Paget CBE

Copied to:
Neil Wooding
Hywel Jones
Huw Thomas

4.2

11:45 AM, 20 Mins

4.2 - INVESTMENT AND BENEFITS REALISATION REPORT

*Sian Jenkins (Hywel
Dda UHB - Deputy
Director of Finance)*

| For assurance

Attachments

[Investment and Benefits Realisation Report FPC 26 August 2025.pdf](#)

[Appendix 1 Investment Cases Update.pdf](#)



PWYLLGOR CYLLID A PHERFFORMIAD
FINANCE AND PERFORMANCE COMMITTEE

DYDDIAD Y CYFARFOD: DATE OF MEETING:	26 August 2025
TEITL YR ADRODDIAD: TITLE OF REPORT:	Investment and Benefits Realisation Report
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Huw Thomas, Director of Finance
SWYDDOG ADRODD: REPORTING OFFICER:	Sian Jenkins, Deputy Director of Finance

Pwrpas yr Adroddiad (dewiswch fel yn addas)

Purpose of the Report (select as appropriate)

Er Sicrwydd/For Assurance

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The purpose of this report is to provide an update on the status of investment cases. At this stage the investment cases are only recently approved therefore the benefits realisation has not been assessed.

Cefndir / Background

Hywel Dda University Health Board (HDdUHB) approved an Annual Plan on 27 March 2025 which represented a planned deficit of £31.5m. This includes provision for investments totalling £11.9m, expected recurrent savings of £19.0m, plus a non-recurrent benefit of underspends and non-recurrent savings of £25.4m. Therefore, total savings delivery for the year of £44.4m.

Recognising that appropriate scrutiny of investment plans is required ahead of final approval being granted, the Annual Plan earmarked funding to support a number of priority proposals which had been highlighted through the planning cycle, total value £11.9m. These cases have been routed through an investment scrutiny process lead by representatives of the Finance, Operations, Planning, Workforce functions, with recommendations reported through to Executive Team for decision.

Asesiad / Assessment

Investments

Within the Annual Plan, £11.9m was supported to afford priority investment cases, these plans are being scrutinised ahead of formal approval and award of funding. To date £8.0m has been approved on a recurrent basis, with a level of slippage identified in respect of in year spend for 2025/26 as a result of recruitment timescales and lead in times.

- **Process** – the cases included in the annual plan were split into 3 batches and a process of desktop review, feedback, follow up meetings and recommendations to Formal Executive Team. The intention had been to conclude the review process by early June, however, to ensure robust cases are presented to Executive Team it has been necessary to allow more time for further work to be done on some cases. A handful of additional cases were also referred into the scrutiny process by Executive Directors.
- **Status** – all submitted cases have been through the initial review process. Latest plans to be approved include nursing workforce for Mental Health and Learning Disabilities and the stabilisation of the Legal Service. Included in **Appendix 1** is a status update across all of the investment cases.
 - One area earmarked for investment has had funding confirmed by Welsh Government, this will support medical recruitment and has released £0.2m recurrently as a saving scheme.
 - Recognising the financial challenge within the organisation, in reviewing options to improve the financial plan, some of the original provision for investment has been reviewed, £0.6m has been released recurrently as saving schemes.
 - Two further additional cases have directed into the process in respect of Emergency Department nursing at Glangwili Hospital (GGH) and Bronglais Hospital (BGH). Further work is being undertaken to ensure a complete financial assessment is reflected within the plans, plus consideration of the Urgent and Emergency Care (UEC) programme and associated impact on appropriate capacity and nursing workforce implications.
- **Next steps** – the focus of the scrutiny process remains to complete the review of the original cases for 2025/26. This process has provided positive learning which the panel are keen to apply in framing the process for the 2026/27 planning cycle. This includes development of a standardised template for proposals, to include delivery milestones and benefits realisation, also the timeline for investments to be considered, to ensure there is scrutiny of plans ahead of proposals being prioritised within the Annual Plan.

Recognising that of the 2025/26 investments, cases are only recently being granted approval, therefore further updates on delivery and benefits realised will be provided subsequently.

Whilst outcomes remain to be confirmed for some cases, the associated funding is being reviewed on a monthly basis and factored into the financial position as appropriate.

Assure (to note)

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

Argymhelliad / Recommendation

The Finance and Performance Committee is asked to:

- **RECEIVE ASSURANCE** that investment cases for 2025/26 are being progressed through a review and scrutiny process to inform a final approval decision at Formal Executive Team. Also that this process has incorporated the consideration of essential proposals to enable key quality and safety priorities for the Health Board in respect of fire enforcement notices and review of nursing workforce in particular areas; and
- **NOTE** that the process for investment cases is being reviewed to inform the 2026/27 annual planning cycle in a bid to standardise the approach both in respect of business cases and benefits realisation.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	3.1.3 Receive assurance on the development and realisation of opportunities. This will be achieved through scrutiny of the bi-monthly savings and opportunities report to the Committee. 3.1.13 Review any investment/disinvestment strategy, including Procurement and Contracting Strategy, maintaining oversight of the investments and disinvestments, ensuring compliance with policies by: 3.1.13.1 Establishing the overall methodology, processes and controls which govern investments and disinvestments, including the prioritisation of decisions; 3.1.13.2 Ensuring that robust processes are followed; and 3.1.13.3 Evaluating, scrutinising and monitoring subsequent investments/ disinvestments.
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	2086 (score 20) Risk of the Health Board not being able to meet the statutory requirement of breaking even in 2025/26 due to significant deficit position.
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	7. All apply
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	6. All Apply
Amcanion Strategol y BIP: UHB Strategic Objectives:	All Strategic Objectives are applicable
Amcanion Cynllunio Planning Objectives	All Planning Objectives Apply
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022	9. All HDdUHB Well-being Objectives apply

Gwybodaeth Ychwanegol:
Further Information:

Ar sail tystiolaeth: Evidence Base:	Monitoring returns to Welsh Government based on HDdUHB's financial reporting system.
Rhestr Termiau: Glossary of Terms:	BGH – Bronglais Hospital CHC – Continuing Healthcare EOY – End of Year FNC – Funded Nursing Care FYE – Full Year Effect GGH – Glangwili Hospital GMS – General Medical Services HSCEY – Health, Social Care and Early Years MHLDD – Mental Health & Learning Disabilities NICE – National Institute for Health and Care Excellence OCP – Organisational Change Policy/Process OOH – Out of Hours PPH – Prince Philip Hospital PSPP – Public Sector Payment Policy RTT – Referral to Treatment Time T&O – Trauma & Orthopaedics TCT – Target Control Total WG – Welsh Government WGH – Withybush Hospital WRP – Welsh Risk Pool WTE – Whole Time Equivalent YTD – Year to date
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Adnoddau Cynaliadwy: Parties / Committees consulted prior to Sustainable Resources Committee:	Finance Team Management Team Executive Team

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	Financial implications are inherent within the report.
Ansawdd / Gofal Claf: Quality / Patient Care:	The impact on patient care is assessed within the savings schemes.
Gweithlu: Workforce:	The report considers the financial implications of our workforce.

Risg: Risk:	Financial risks are detailed in the report.
Cyfreithiol: Legal:	HDdUHB has a legal duty to deliver a breakeven financial position over a rolling three-year basis and an administrative requirement to operate within its budget within any given financial year.
Enw Da: Reputational:	Adverse variance against HDdUHB's financial plan will affect its reputation with Welsh Government, Audit Wales, and with external stakeholders.
Gyfrinachedd: Privacy:	Not Applicable
Cydraddoldeb: Equality:	Not Applicable.



GIG
CYMRU
NHS
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Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board



Appendix 1: Investment Cases Update Finance and Performance Committee

26 August 2025

2025/26 Investment Cases Update (1 of 3)

Key Commentary

Priority cases within the 2025/26 Annual Plan for which investment funding was supported, have been progressing through an internal review and scrutiny process during Q1.

- All cases have been through the initial review process
- To date 13 cases have been approved through Formal Executive Team
- 1 case has been updated and resubmitted for the scrutiny process to continue
- Updated proposals for 4 cases are awaited.

The status update of each proposal in respect of the investment scrutiny process is outlined below and across the following 2 slides.

Annual Plan Category	CCG / Directorate	Description	Annual Plan Provision £	Approved 25/26 £	Approved Recurrent £	Status	Formal Executive Team consideration
Local Future Investments	Planned and Specialist Care	Acute Oncology Service (AOS) provision improvement	398,013	174,407	398,013	Approved	16/04/2025
Local Future Investments	Planned and Specialist Care	Ophthalmology IVT recovery plan - clinic staffing capacity	350,000	350,000	350,000	Approved	16/04/2025
Local Future Investments	Planned and Specialist Care	Ophthalmology IVT recovery plan - drug consumption	1,300,000	1,300,000	1,300,000	Approved	16/04/2025
Local Future Investments	Planned and Specialist Care	Endoscopy	700,000	439,796	475,719	Approved	16/04/2025
Local Future Investments	Allied Health and Health Scientists	Radiology diagnostic improvement	1,500,000	1,500,000	1,500,000	Recommendation made to Execs. Subsequent follow up to finalise approval. Approved	16/04/2025
Local Future Investments	Digital	Modular Electronic Health Record	1,800,000	1,540,000	1,800,000	Recommendation made to Execs. Subsequent follow up to finalise approval. Approved	16/04/2025
Local Pre-Commitment	Estates and Facilities	Additional fire wardens required at WGH	178,000	153,922	178,000	Approved	21/05/2025
Local Pre-Commitment	Director of Nursing	Legal Service	324,945	269,842	324,945	Approved	21/05/2025

Annual Plan Category	CCG / Directorate	Description	Annual Plan Provision £	Approved 25/26 £	Approved Recurrent £	Status	Formal Executive Team consideration
Local Pre-Commitment	Medical Director	VBHC - Heart Failure	624,000	0	0	Exec recommendation made. Exec ask to service that savings assessment re-visited, reassess and determine future, VBHC funding extended to June 30th, potential cessation of scheme 30/09/25. Value & Sustainability Group received update report July and concluded cessation of the service and VBHC funding 30/09/25. Options in respect of service mitigation plans to come back to Value & Sustainability Group in August. Financial reserve converted to a non-recurrent saving scheme.	21/05/2025
Local Pre-Commitment	Estates and Facilities	RAAC revenue pressure	150,000	150,000	150,000	Approved	04/06/2025
Not included in the financial plan	Estates and Facilities	Additional fire wardens required at GGH	0	153,922	205,000	Approved	04/06/2025
Not included in the financial plan	Estates and Facilities	Additional fire wardens required at WGH	0	0	205,000	Approved (costs start Sept '26)	04/06/2025
Not included in the financial plan	Director of Public Health	Health Coaches - pursuing VBHC funding initially	0			Linked to VBHC funding to pilot. Progressed through batch 2, further work required, updated proposal submitted - scrutiny process to recommence. Exec decision to pause potential investment until latter stages of 25/26, non-recurrent saving to be transacted month on month in the interim.	TBC
Not included in the financial plan	Community and Integrated Medicine	GGH ED Nursing	0			Deferred, pending paper	TBC
Not included in the financial plan	Community and Integrated Medicine	BGH EUCC Nursing	0			Deferred, pending paper. Paper submitted and queries raised for clarity, in particular link to UEC programme.	TBC

2025/26 Investment Cases Update (3 of 3)

Annual Plan Category	CCG / Directorate	Description	Annual Plan Provision £	Approved 25/26 £	Approved Recurrent £	Status	Formal Executive Team consideration
Local Pre-Commitment	Director of Workforce	International Recruitment (Medical)	200,000	0	0	Deferred, awaiting paper. Subsequent confirmation of WG funding to support recruitment. No investment required, funding reserve released as a recurrent saving scheme.	N/A
Local Pre-Commitment	Estates and Facilities	Maintenance Volume	400,000	0	0	Deferred, awaiting paper. Exec decision to release funding reserve, recognising new leadership arrangements for CCG and need for wider review of function to inform an investment plan. Any subsequent proposal will feed in through planning cycle. Funding reserve released as a recurrent saving scheme.	N/A
Local Future Investments	Director of Public Health	Child Obesity PH	300,000	80,000		Progressed through batch 2, require greater clarity ahead of making recommendation, awaiting paper. Exec decision to pause potential investment until latter stages of 25/26, non-recurrent saving to be transacted month on month in the interim. Non-recurrent funding allocated to support dietician capacity for selective eating disorders.	TBC
Local Future Investments	Central Reserves	Nurse Staffing 25b Provisional Autumn 2024 Review	380,030	164,551	164,551	Progressed directly through Executive Team, Spring Review 25b. Approved	N/A
Local Future Investments	Central Reserves	Band 2/3 HCSW Pay Dispute	2,261,379			National/HR/corporate nursing process will determine appropriate costs, not an investment case per se. Provision scaled back from £2.3m to £2.0m.	N/A
Local Future Investments	Central Reserves	Nurse Staffing 25a Provisional MH&LD	988,657	988,657	988,657	Progressed directly through Executive Team. Approved	N/A
Total			11,855,024				
Approved Total				7,265,097	8,039,885		

4.3 - PLANNING OBJECTIVES UPDATE REPORT

Andrew Spratt
(Hywel Dda UHB -
Deputy Director of
Finance)

| For assurance

Attachments

[Planning Objective Update Report FPC 26 August 2025.pdf](#)

[Annex 1 Planning Objectives 2025-26 Plans on a Page.pdf](#)

[Annex 2 Planning Objectives 2025-26 Highlight Report.pdf](#)



**PWYLLGOR CYLLID A PHERFFORMIAD
FINANCE AND PERFORMANCE COMMITTEE**

DYDDIAD Y CYFARFOD: DATE OF MEETING:	26 August 2025
TEITL YR ADRODDIAD: TITLE OF REPORT:	Planning Objectives Update Report
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Huw Thomas, Director of Finance
SWYDDOG ADRODD: REPORTING OFFICER:	Angharad Lloyd-Probert, Senior Project Manager (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

A set of 10 Planning Objectives have been developed and reviewed through Quarter 1 of 2025/26 as an integral part of the Hywel Dda University Health Board's (HDdUHB) Annual Plan for 2025/26. The POs set out the aims of the organisation, for example, the horizon that HDdUHB is driving towards over the long term, as well as a set of specific, measurable actions, which move the organisation towards that horizon over the next year.

For 2025/26, four Planning Objectives have been aligned to the Finance and Performance Committee (FPC), namely:

- **Planning Objective 2:** Financial recovery and roadmap
- **Planning Objective 3:** Urgent and Emergency Care
- **Planning Objective 4:** Planned Care including cancer and diagnostics
- **Planning Objective 5:** Mental Health and Learning Disabilities

As in previous years it is the expectation that FPC will receive an update on the progress made in the development (delivery) of the Planning Objectives for onward assurance to the Board through the Board Assurance Framework.

Cefndir / Background

The Planning Objectives are the bedrock of our Annual Plan for 2025/26, and this report is presented as both an update on the key elements of Planning Objectives 2,3,4 and 5 through the development of a 'Plan on a Page; and to demonstrate where progress has been made in delivering them through Quarter 1 2025/26.

The description and specific measurable actions of the Planning Objectives through the respective Plans on a Page, can be found in **Annex 1**. The Planning Objectives have been presented to the Committee for approval.

Asesiad / Assessment

The Planning Objectives remain a key element of the Annual Plan for 2025/26, and as noted in the FPC update on 26 June 2025, a Plan on a Page has been developed for each of the four Planning Objectives that are aligned to the Committee these are detailed in **Annex 1**. The updated position on 2025/26 Planning Objectives are detailed in the Highlight Reports at **Annex 2**.

Planning Objective	Executive Lead	Updated position on 2025/26 Planning Objectives
2: Financial Recovery and Roadmap	Director of Finance	On Track
3: Urgent and Emergency Care	Director of Operations	On Track
4: Planned Care including Cancer and Diagnostics	Director of Operations	On Track
5: Mental Health and Learning Disabilities	Director of Operations	On Track

For **PO2, Financial Recovery and Roadmap**, this is On Track. Progress has been made in meeting the agreed milestones and establishing the guiding principles that will shape the financial elements of the organisations 2026/29 planning cycle. Engagement sessions initially sharing the concept and principles have been completed in-line with the planned timelines, with a strategic milestone approach agreed in principle.

For **PO3, Urgent and Emergency Care**, this is currently On Track. The majority of deliverables against the portfolio of work are complete, A minority remain behind due to resource, but mitigations are in place to address.

For **PO4, Planned Care including Cancer and Diagnostics**, the overarching progress is On Track, with the three individual components being:

- RTT – On Track
- Diagnostics – On Track
- Cancer – On Track

For **PO5, Mental Health and Learning Disabilities**, this is On Track with the overarching progress On Track, with progress having been made in a number of key areas, although there is acknowledgement that there is more to do.

Argymhelliad / Recommendation

The Finance and Performance Committee is asked to:

- **NOTE** the current position of the four Planning Objectives which are aligned to it; and
- **RECEIVE ASSURANCE** on the current position in regard to the progress, in order to assure the Board that the Planning Objectives are progressing and are on target, and to raise any

concerns where a Planning Objectives is identified as behind in its status or not achieving against its key deliverables.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	3.1.17 Seek assurance on delivery against all Planning Objectives aligned to the Committee in accordance with the Board approved timescales, as set out in the Health Board's Annual Plan, considering and scrutinising the plans, including the medium term financial plans, and savings plans, that are developed and implemented, supporting and endorsing these as appropriate
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:	3. Striving to deliver and develop excellent services 5. Safe sustainable, accessible and kind care 6. Sustainable use of resources
Amcanion Cynllunio Planning Objectives	2 Financial recovery and route map 3 Transforming Urgent and Emergency Care programme 4 Planned care, diagnostics and cancer Recovery 5 Mental health and CAHMS
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022	9. All HDdUHB Well-being Objectives apply

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Annual Plan 2025/26
Rhestr Termau: Glossary of Terms:	Contained within the body of the report.
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board	Public Board - March 2025 (acceptance of 2025/26 Planning Objectives being developed through Quarter 1 2025/26 as part of the Annual Plan)

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	Any financial impacts and considerations are identified in the report.
Ansawdd / Gofal Claf: Quality / Patient Care:	Any issues are identified in the report.
Gweithlu: Workforce:	Any issues are identified in the report.
Risg: Risk:	Consideration and focus on risk is inherent within the report. A sound system of internal control helps to ensure any risks are identified, assessed and managed.
Cyfreithiol: Legal:	Any issues are identified in the report.
Enw Da: Reputational:	Any issues are identified in the report.
Gyfrinachedd: Privacy:	Not Applicable
Cydraddoldeb: Equality:	Not Applicable

PLANNING OBJECTIVE: Planning Objective 2 – Financial recovery and route map**PLANNING OBJECTIVE SCOPE (What are you aiming to achieve in 2025/26)**

An organisationally agreed financial roadmap that reduces our deficit, on a non-recurrent basis as a minimum, to breakeven by no later than 2027/28, in-line with expectations that have been set by Welsh Government as part of conditions attached to the £26.0m conditionally recurrent funding received in 2024/25.

PROJECT GOVERNANCE**Responsible Officers**

Executive Lead: Huw Thomas (HT)

Strategic Lead: Andrew Spratt (AS), Sian Jenkins (SJ),
Shaun Ayres (SA)

Delivery Leads: Richard Jenkins (RJ), Jennifer Thomas (JT), Leon Popham (LP), Andrew Lewis (AL), Carwen Jarman (CJ)

Programme oversight through: Board Seminar(s)

Governance through: Finance and Performance Committee, Planning Cycle

Delivery through: Executive Team, Value & Sustainability Group, Planning Steering Group

KEY DELIVERABLES***MEASURES***

KEY ACTIONS*	BY WHOM	BY WHEN	QUANTIFIABLE OUTCOME*:	TRAJECTORY OVER NEXT 12 MONTHS:	HOW AND WHEN WILL DATA BE COLLECTED, VERIFIED
Launch, to the Senior Finance Team, a plan and methodology to generate an agreed structure/template for pre-population	AS	13/06/25	Template structure covering three years in place	Complete by deadline	As noted
Include initial draft of key components for macro price increases and income assumptions	JT	04/07/25	Assessments submitted for each item as listed in the agreed structure	Complete by deadline	As noted
Include initial draft of key components for local and national investments	AL, CJ, LP	04/07/25	Assessments submitted for each item as listed in the agreed structure	Complete by deadline	As noted
Include initial draft of key components for savings, opportunities and financial ideas for improvements not yet agreed with budget holders	AL, CJ, LP	04/07/25	Assessments submitted for each item as listed in the agreed structure	Complete by deadline	As noted
Socialisation of draft plan with Executive Team	HT	10/07/25	Formal session and discussion occurred, but with actions and deadlines agreed for any amendments	Complete by deadline	As noted
Embed approach within Planning Cycle	AS, SA	30/07/25	Embed the Executive Team actions within the Planning Cycle timetable.	Complete by deadline	As noted

Engage with Clinical Care Group Triumvirates, update and design through Planning cycle				SJ	14/11/25	Formal session and discussion occurred, but with actions and deadlines agreed for any amendments	Complete by deadline	As noted	
Submit Three Year Financial Roadmap as part of the 2026-29 Planning Cycle submission to Welsh Government				HT	31/03/26	Submission completed and recognised by Welsh Government, which isn't deemed to be 'not supportable' or 'not approval'	Complete by deadline	As noted	
RISKS	RISK DESCRIPTION			LIKELIHOOD	IMPACT	SCORE	MITIGATING ACTIONS		
	Sufficient financial opportunities to allow any net expenditure increase trajectories to be offset by savings			Medium	High	3/5	Ensure a comprehensive approach is taken to idea generation, reviewing all of expenditure and income areas, and not limited to only those ideas/opportunities that have received formal agreement from service leads		
	Clinical and Operational engagement			High	High	5/5	- Clinical Services Plan to be embedded within the Planning Cycle - Planning Cycle to include triangulation milestones for Performance, Workforce and Finance - Final submission to WG to include Clinical Operational plans supporting the savings opportunities included within the roadmap		
LINKS TO	BOARD ASSURANCE FRAMEWORK	HB RISK REGISTER					OTHER PLANNING OBJECTIVES	MINISTERIAL &/OR LOCAL PRIORITY	OTHER, EG, AHMWW
	1199	Achieving financial sustainability					Strategy	Ministerial	

PLANNING OBJECTIVE - PO3 - TUEC

PLANNING OBJECTIVE SCOPE: To deliver the Six Goals Programme Plan and Accelerated Transformation Programme for UEC.

PROJECT GOVERNANCE**Responsible Officers**

Executive Lead: Andrew Carruthers

Strategic Lead: Peter Skitt

Delivery Leads: Thomas Alexander

Programme oversight through: Integrated Operational Group

Governance through: IQFPD

Delivery through: Six Goals/Accelerated Transformation Programme Workstreams

KEY DELIVERABLES***MEASURES*****KEY ACTIONS***

(The accelerated Transformation Programme Actions are listed below as the focus for the next 12 months. Further detailed actions relating to Six Goals can be found within the Programme Plan):

Programme plan available on request

BY WHOM**BY WHEN****QUANTIFIABLE OUTCOME*:****TRAJECTORY OVER NEXT 12 MONTHS:****HOW AND WHEN WILL DATA BE COLLECTED, VERIFIED**

Access – Development of a 7-day Clinical Streaming Hub, Scheduling process for Unscheduled Care and Urgent Primary Care response within 2 hours.

Peter Skitt

October 2025

- A continuous reduction of ambulance handovers over an hour of at least 11% in three consecutive months and maintained for 3 months (Based on agreed baseline).
- Continuous improvement towards no more than 7% of patients waiting over 12 hours at each individual site and across the health board.

De-escalation criteria Tracking spreadsheet 25-26 available on request

Monthly basis through the performance team.

Environment – Improvement of A&E environment	Janice Cole-Williams	July 2025	Assessment of health board response and handling of concerns, complaints, incidents and patient experience feedback related to UEC.	N/A	Monthly basis through the performance team.
Flow	John Evans	October 2025	- Continuous improvement in the median time from arrival at an emergency department to assessment by a clinical decision maker should not exceed to achieve a maximum of 60 minutes. - A continuous reduction in delayed pathways of care (with a focus on those caused by assessment issues) of 5% for three consecutive months and then maintained for three months (based on agreed baseline).	De-escalation criteria Tracking spreadsheet 25-26 available on request	Monthly basis through the performance team.

RISKS	RISK DESCRIPTION			LIKELIHOOD	IMPACT	SCORE	MITIGATING ACTIONS		
	Risk Register spreadsheet 25-26 available on request								
							•		
							•		
LINKS TO	BOARD ASSURANCE FRAMEWORK	HB RISK REGISTER	OTHER PLANNING OBJECTIVES					MINISTERIAL &/OR LOCAL PRIORITY	OTHER, EG, AHMWW

		As above		Ministerial Priorities for UEC: UEC1: Implement effective Community Based Falls Response Services. To enhance outcomes and experience for those who fall by improving initial response times, reducing the risk of long lies and ensuring service users access community falls pathways when appropriate UEC2: Implement a robust 'Single Point of Access' (SPOA) for UEC. Create in each health board area that simplifies access to services by offering clinicians advice and guidance to support onward referral, ensuring patients get the right care for their needs quickly and safely, to improve patient outcomes regardless of where they present UEC3: Implement an Acute Front Door Frailty Service at all acute hospitals. Integrated with community frailty services - that ensure that older people with	National Six Goals Programme Accelerated Transformation Programme

				frailty are diverted to the most appropriate services within the hospital as quickly as possible and, where possible, discharged home on the same day UEC4: Implement the Welsh Health Circular - Ambulance Patient Handover Guidance. To ensure timely transfer of patients from ambulance crews to emergency department staff UEC5: Implement actions described in the Optimal Hospital Flow Framework. To ensure people who possess a clinical need for admission to hospital are discharged home when	

PLANNING OBJECTIVE - PO 4 Planned Care (Cancer)

PLANNING OBJECTIVE SCOPE (What are you aiming to achieve in 2025/26 **80% of patients on a USC Pathway will receive their first definitive treatment with 62 days from their point of suspicion - Performance**)

PROJECT GOVERNANCE Responsible Officers Executive Lead: Andrew Carruthers Strategic Lead: Paula Goode Delivery Leads: Service SDMs	Programme oversight through: Governance through: Delivery through:

KEY DELIVERABLES*			MEASURES*		
KEY ACTIONS*	BY WHOM	BY WHEN	QUANTIFIABLE OUTCOME*:	TRAJECTORY OVER NEXT 12 MONTHS:	HOW AND WHEN WILL DATA BE COLLECTED, VERIFIED
Eliminate patients waiting over 14 days for first OPA	Lisa Humphrey	31.3.26	0 patients waiting over 14 days for 1 st OPA	0 patients waiting over 14 days for 1 st OPA by 31.3.26	Via the Quarterly monitoring report
** % Reduction of patients waiting for a diagnostic procedure over 28 days enhance	Lisa Humphrey	31.3.26	reduction in patients waiting over 28 days for diagnostic investigations	50% Reduction by 31.3.26	Via the Quarterly monitoring report
**% reduction of patients waiting over 62 days at treatment stage NB theses are those with confirmed diagnosis of cancer	Lisa Humphrey	31.3.26	Reduce number of breaches	55% backlog reduction by 31.3.26	Via Daily PTL
Reduce overall volume of patients waiting over 62 days to tolerance volume to achieve 80% on SCP (backlog)	Lisa Humphrey	31.3.26	Reduce backlog volume	55% backlog reduction by 31.3.26	Via Daily PTL

RISKS	RISK DESCRIPTION	LIKELIHOOD	IMPACT	SCORE	MITIGATING ACTIONS
	Risks predominantly associated with fragile service / workforce profile in key specialties – limited resilience to sickness/absence:				
	Radiology	5	4	20	Radiology investment plan 25/26 – stabilises but does not improve fragility.

	Recruitment and Training of Radiologists to undertake the MRI scanning and reporting		4	5	20	Radiology investment plan 25/26 – stabilises but does not improve fragility			
	Delay in cameras being circulated to Primary Care due to delays in the training programme for GPs		2	3	12	Working with Dermatology CIN to provide a training programme for each Primary Care cluster			
	Urology								
LINKS TO	BOARD ASSURANCE FRAMEWORK	HB RISK REGISTER				OTHER PLANNING OBJECTIVES	MINISTERIAL &/OR LOCAL PRIORITY	OTHER, EG, AHMWW	
		Corporate Risk 1350- Risk of not meeting the 80% SCP waiting times target by March 2026 due to diagnostics capacity and delays at tertiary centre							
		Operational 1547 – Risk of being unable to provide quality and timely radiology service due to workforce challenges and consultant deficit.							

PLANNING OBJECTIVE - PO 4 Planned Care (Cancer)

PLANNING OBJECTIVE SCOPE (What are you aiming to achieve in 2025/26) 80% of patients on a USC Pathway will receive their first definitive treatment within 62 days from their point of suspicion by March 26 – LGI

PROJECT GOVERNANCE Responsible Officers Executive Lead: Strategic Lead: Delivery Leads:			Programme oversight through: Governance through: Delivery through:		
KEY DELIVERABLES*			MEASURES*		
KEY ACTIONS*	BY WHOM	BY WHEN	QUANTIFIABLE OUTCOME*:	TRAJECTORY OVER NEXT 12 MONTHS:	HOW AND WHEN WILL DATA BE COLLECTED, VERIFIED
Transfer the faecal immunochemical testing (FIT) service from Secondary to Primary Care in line with the lower GI National Optimal Pathway.	Sara Edwards / Caroline Lewis	30/09/2025	Eradicate current FIT testing timeline as part of the SCP (currently averaging between 7-21 days) – where the current point of suspicion is tracked from Primary Care referral into secondary care (where the FIT service currently sits). Moving the service from secondary to primary care will eradicate the FIT testing timeline from the SCP.	Reduction of an average 7-21 days from the lower GI SCP pathway (from when the service is transferred and clock start date for the pathway is adapted).	Via SCP performance team.

Increase endoscopist capacity in line with 25% increase in Bowel Screening Wales (BSW) optimisation roll-out in October 2024.				Sara Edwards	31/03/2026	Improved compliance against the 28 day target as part of the SCP.	1.5 additional sessions per week agreed within consultant (screening endoscopist) job plans. WLI's are being used in the short term to bridge core capacity gap. The NHS executive are working to develop a patient tracking list explicitly for BSW – to support the development of a recovery plan with a defined improvement trajectory.	Via new NHS Executive dashboard for BSW performance and the data from the SCP performance team.
Prepare a case for investment into colon capsule endoscopy				Sara Edwards		No confirmed funding for this proposal.		
Leasing of 3 LuminEye Endoscopy Digital Rigid Sigmoidoscope.				Caroline Lewis		No confirmed funding for this proposal.		
RISKS	RISK DESCRIPTION	LIKELIHOOD	IMPACT	SCORE	MITIGATING ACTIONS			
	Endoscopist workforce supply: Whilst core capacity levels are in line with demand volumes for USC/U/R, any unplanned absences present a risk to continue delivery of both USC and 8-week diagnostic performance.	3	4	12	- Clinical endoscopist applications submitted to the National Endoscopy Programme in June 2025 – core funding available from within the endoscopy budget to support 1 new clinical endoscopist trainee to commence colonoscopy training in September 2025. This will support plans to increase endoscopist supply within the HB. - Continue to review consultant job plans and opportunities to increase endoscopy sessions where possible.			

	Endoscopy nursing establishment: deficits in the endoscopy nursing establishment at GGH present a risk to sustained delivery of endoscopy activity.		3	3	9	Funding confirmed and received via the annual plan 25/26 to uplift the nursing establishment in June 2025. Recruitment is in progress.			
	Screening colonoscopist supply: given the small pool of screening colonoscopists within the HB, opportunities to increase core capacity to accommodate the 25% increase in BSW demand have all been exhausted.		3	4	12	BSW funding as part of the LTA is being used to cover the cost of WLI's to bridge the current capacity gap experienced.			
LINKS TO	BOARD ASSURANCE FRAMEWORK	HB RISK REGISTER				OTHER PLANNING OBJECTIVES	MINISTERIAL &/OR LOCAL PRIORITY	OTHER, EG, AHMWW	
		1959 – Risk to delivery of BSW services in line with standards							
		1580 – Endoscopist provision							
		1383 – Nursing establishment							

PLANNING OBJECTIVE - PO 4 Planned Care (Cancer)

PLANNING OBJECTIVE SCOPE (What are you aiming to achieve in 2025/26) 80% of patients on a USC Pathway will receive their first definitive treatment within 62 days from their point of suspicion by March 26 – Lung

PROJECT GOVERNANCE Responsible Officers Executive Lead: Strategic Lead: Delivery Leads:			Programme oversight through: Governance through: Delivery through:		
KEY DELIVERABLES*			MEASURES*		
KEY ACTIONS*	BY WHOM	BY WHEN	QUANTIFIABLE OUTCOME*:	TRAJECTORY OVER NEXT 12 MONTHS:	HOW AND WHEN WILL DATA BE COLLECTED, VERIFIED
The introduction of radial endobronchial ultrasound (rEBUS) will significantly reduce reliance on CT-guided biopsies, cutting diagnostic waiting times and improving access for those requiring radical treatment	RG	ongoing	Service progressing well with high demand, this is impacting the CTGBx list positively although that remains long. There have been 27 patients since the End of December 2024 when the service commenced and of those 15 results have been positive.	If the demand continues to grow and capacity becomes an issue there is already a plan to train 2 further consultants to provide this diagnostic.	Radial EBUS Waiting List
GP Chest X-Ray to CT (inc Hot Reporting)	SP/EC	ongoing	Reduction of wait from CXR to CT.	Same day by September 25	PTL
CTGBx Funding has been agreed for an interventional radiologist post to be advertised in August/Sept 2025. The clinical service plan includes additional interventional staff and estates in all options	SP/GRD	31.3.25	Waiting time request to biopsy	31/3/2026– 2 weeks	Radiology Dashboard /PTL

RISKS	RISK DESCRIPTION		LIKELIHOOD	IMPACT	SCORE	MITIGATING ACTIONS			
	Radiology workforce fragility		5	4	20	• Radiology investment plan 25/26 – stabilises but does not improve fragility.			
	Lack of equipment replacement funding		4	4	16	• RAG ratings for each equipment collated for WAG approval. •			
	Estates Infrastructure affecting replacement of equipment		3	4	12	• Electrical infrastructure is affecting replacement of the single HD gamma camera at WGH – WAG have been given costs as highest priority for replacement.			
	Single scanners on multiple sites		5	5	25	Breakdown causes delays – other sites used, mobile solutions and additional patient transport.			
LINKS TO		Corporate 797 -Risk to the ability to deliver ultrasound services due to workforce pressures							
		Corporate 684 – Risk to the timely investment and replacement of radiology equipment and supporting infrastructure.							
		Operational 1547 – Risk of being unable to provide quality and timely radiology service due to workforce challenges and consultant deficit.							
		Operational 1223 – Risk of unsustainable radiology on-call rota due to staff shortage and increased activity.							

PLANNING OBJECTIVE - PO 4 Planned Care (Cancer)										
PLANNING OBJECTIVE SCOPE (What are you aiming to achieve in 2025/26) 80% of patients on a USC Pathway will receive their first definitive treatment within 62 days from their point of suspicion by March 26 - Skin										
PROJECT GOVERNANCE Responsible Officers Executive Lead: Strategic Lead: Delivery Leads:				Programme oversight through: Governance through: Delivery through:						
KEY DELIVERABLES*						MEASURES*				
KEY ACTIONS*				BY WHOM	BY WHEN	QUANTIFIABLE OUTCOME*:	TRAJECTORY OVER NEXT 12 MONTHS:	HOW AND WHEN WILL DATA BE COLLECTED, VERIFIED		
Dermoscopic attachments and cameras to be circulated in Primary Care to support referrals will improve triage for urgent suspected skin cancer, reducing in-person clinic pressure while maintaining diagnostic accuracy.				Ceri Wisdom	Sept 25	Number of referrals accepted	3% reduction in USC referrals	Data collected monthly and verified via Dermatology CIN		
Commencing teledermoscopy for USC patients in Q1.				Ceri Wisdom	April 25	USC teledermoscopy clinics x3 per month	20% discharge rate for USC patients	Monthly and verified by Consultants at ABUHB		
RISKS	RISK DESCRIPTION		LIKELIHOOD	IMPACT	SCORE	MITIGATING ACTIONS				
	Delay in cameras being circulated to Primary Care due to delays in the training programme for GPs		2	3	12	• Working with Dermatology CIN to provide a training programme for each Primary Care cluster				
						•				
LINKS TO	BOARD ASSURANCE FRAMEWORK	HB RISK REGISTER				OTHER PLANNING OBJECTIVES		MINISTERIAL &/OR LOCAL PRIORITY	OTHER, EG, AHMWW	
		1837 Insufficient MOP (minor operative procedures) capacity in the HB								

		747			
		Unsustainable services due to Consultant vacancies			

PLANNING OBJECTIVE - PO 4 Planned Care (Cancer)

PLANNING OBJECTIVE SCOPE (What are you aiming to achieve in 2025/26) **80% of patients on a USC Pathway will receive their first definitive treatment within 62 days from their point of suspicion by March 26 – Urology**

PROJECT GOVERNANCE

Responsible Officers

Executive Lead:

Strategic Lead:

Delivery Leads:

Programme oversight through:

Governance through:

Delivery through:

KEY DELIVERABLES***MEASURES*****KEY ACTIONS*****BY WHOM****BY WHEN****QUANTIFIABLE OUTCOME*:****TRAJECTORY OVER NEXT 12 MONTHS:****HOW AND WHEN WILL DATA BE COLLECTED, VERIFIED**

Ensuring stable outpatient capacity while introducing measures to improve access to MRI through the PROSTAD pathway. This will reduce the time taken to reach biopsy decisions, shortening referral-to-diagnosis times by up to four weeks.

Neil Griffiths

End of Qtr 2 2025

Dependant on the delivery of additional availability of Radiologists to deliver and same day report on 12 STT MRI per week.

April – Sept 4 per week. Qtr 3 onwards 12 per week.

Weekly through Cancer Tracking Team.

Increased provision of local anaesthetic trans-perineal (LATP) biopsies will help meet growing demand

Neil Griffiths

Stage 1 March 2025
Stage 2 August 2025

Capacity for 20 LATP per week

12 per week March to August rising to 20 per week from end of August 2025

Weekly through Waiting List team and Cancer tracking team.

Increase capacity for flexi cystoscopy by 30% by increasing nurse cystoscopist by 1 WTE Bladder pathway Additional nurse-led cystoscopy services will provide a 30% uplift in capacity, enabling patients to be seen more quickly.

Neil Griffiths

June 2025

Ringfenced Flexi USC capacity or 55 per week. This represents the 85% of demand measured over a 13 week period

25 per week in April rising to 55 per week in June and sustained ongoing.

Weekly through Waiting List team and Cancer tracking team.

Increased MRI access and expanded LATP biopsy capacity will be in place by the end of quarter 2 2025.				Neil Griffiths	End of Qtr 2 2025	Dependant on the delivery of additional availability of Radiologists to deliver and same day report on 12 STT MRI per week.	April – Sept 4 per week. Qtr 3 onwards 12 per week.	Weekly through Cancer Tracking Team.	
RISKS	RISK DESCRIPTION		LIKELIHOOD	IMPACT	SCORE	MITIGATING ACTIONS			
						•			
	Recruitment and Training of Radiologists to undertake the MRI scanning and reporting		4	5	20	•			
LINKS TO	BOARD ASSURANCE FRAMEWORK	HB RISK REGISTER				OTHER PLANNING OBJECTIVES		MINISTERIAL &/OR LOCAL PRIORITY	OTHER, EG, AHMWW

PLANNING OBJECTIVE - PO 4 Planned Care (Cancer)

PLANNING OBJECTIVE SCOPE (What are you aiming to achieve in 2025/26) 80% of patients on a USC Pathway will receive their first definitive treatment within 62 days from their point of suspicion by March 26 – Gynaecology

PROJECT GOVERNANCE

Responsible Officers

Executive Lead:

Strategic Lead:

Delivery Leads:

Programme oversight through:

Governance through:

Delivery through:

KEY DELIVERABLES***MEASURES*****KEY ACTIONS*****BY WHOM****BY WHEN****QUANTIFIABLE OUTCOME*:****TRAJECTORY OVER NEXT 12 MONTHS:****HOW AND WHEN WILL DATA BE COLLECTED, VERIFIED**

Development and launch of a third one stop clinic offer for the diagnosis of suspected endometrial cancer patients in Glangwili General hospital, to create a further 8 see, scan and biopsy patient slots weekly – fully embedded by commencement of Q1 25/26.

Gynaecology Service Team, clinical team, NHS exec, Radiology, IT and Theatre teams

June 2025

The action has changed to developing an addition 2 clinics which creates capacity for additional 16 patients.

Clinics went live week commencing 2nd June

Continue to deliver as Business as usual

This will be available via the cancer dashboard

Development and launch of a fourth one stop clinic offer for the diagnosis of suspected endometrial cancer patients in Withybush General Hospital, to create a further 8 see, scan and biopsy patient slots weekly – fully embedded by commencement of Q1 25/26.

Gynaecology Service Team, clinical team, NHS exec, sexual health, radiology and IT

July 2025

The action has changed to developing an addition 2 clinics which creates capacity for additional 16 patients.

Thursday will start 26th June with the Tuesday clinic date to follow

Continue to deliver as Business as usual for the Thursday clinic

Tuesday clinic date to be confirmed (Target by end of July 2025)

This will be available via the cancer dashboard

Continued engagement with planned care services to develop and pilot an in-service pre-operative, pre-assessment system to limit the delay's this has on single cancer pathway patients awaiting diagnosis procedure or treatment under general anaesthetic.			Gynaecology Service Team and clinical team and anaesthetic team	September 2024	After conversations with the Anaesthetic team in Hywel Dda this is currently not an option to develop in Gynaecology		
Increase capacity of benign irregular bleeding on HRT clinic offers in line with the current community-based clinic offer.			Gynaecology Service Team and clinical team	Q4		Plan to increase capacity for Bleeding on HRT by streamline gynaecology outpatients. Planning work to commence from August 2025.	
Develop a one stop model for ovarian cancer diagnosis with an aim to pilot by Q4 25/26.			Gynaecology Service Team and clinical team	April 2025	After discussions with the clinical team this not something we can develop within the service.		
Development an implementation of dedicated triage team for single cancer pathway patient referrals – fully embedded by commencement of Q1 25/26.			Gynaecology Service Team and clinical team		Key action to be amended to creating a E-Referral worklist for PMB referral		
RISKS	RISK DESCRIPTION		LIKELIHOOD	IMPACT	SCORE	MITIGATING ACTIONS	
	ID 2095 – Risk to delivery of urgent and suspected cancer hysteroscopy diagnostic pathway		Inherently 3, current 2, Target 1	4	8	Capitol funded equipment replacement – order raised 17.06.25	
LINKS TO	BOARD ASSURANCE FRAMEWORK	HB RISK REGISTER				OTHER PLANNING OBJECTIVES	MINISTERIAL &/OR LOCAL PRIORITY

PLANNING OBJECTIVE - PO 4 Planned Care (Cancer)

PLANNING OBJECTIVE SCOPE (What are you aiming to achieve in 2025/26) **80% of patients on a USC Pathway will receive their first definitive treatment within 62 days from their point of suspicion by March 26 – Head & Neck**

PROJECT GOVERNANCE Responsible Officers Executive Lead: Strategic Lead: Delivery Leads:	Programme oversight through: Governance through: Delivery through:

KEY DELIVERABLES*			MEASURES*		
KEY ACTIONS*	BY WHOM	BY WHEN	QUANTIFIABLE OUTCOME*:	TRAJECTORY OVER NEXT 12 MONTHS:	HOW AND WHEN WILL DATA BE COLLECTED, VERIFIED
Implement a dedicated Neck Lump Clinic with the support of a Head & Neck Radiologist. A dedicated Neck Lump clinic would allow the patients to receive an Ultrasound Guided Biopsy alongside their First OPA	Lynwen Williams	Oct 25	Reduction in patients awaiting Ultrasound guided biopsies.	4 weeks from the start date of the Radiologist to reduce the waiting list from 10 to 0. Advertising the post in July 2025.	Via Cancer PTL. Internal monitoring.
Purchase of Trans-nasal oesophagoscopy Scope for OPD minor procedures.	Lynwen Williams	Complete	TNO patients receive diagnostics in OPD. Reduction in Main Theatre Pan endoscopy procedures.	Capacity to diagnose up to 5 patients per clinic. Expected reduction of 30% of patients requiring main theatre diagnostics.	Audit the patient pathways of those receiving TNO scope in OPD, and conversion rate.

RISKS	RISK DESCRIPTION	LIKELIHOOD	IMPACT	SCORE	MITIGATING ACTIONS
	Radiology workforce fragility	5	4	20	Radiology investment plan 25/26 – stabilises but does not improve fragility.

LINKS TO	BOARD ASSURANCE FRAMEWORK	HB RISK REGISTER	OTHER PLANNING OBJECTIVES	MINISTERIAL &/OR LOCAL PRIORITY	OTHER, EG, AHMWW

PLANNING OBJECTIVE - PO 4 Planned Care (Cancer)

PLANNING OBJECTIVE SCOPE (What are you aiming to achieve in 2025/26) **80% of patients on a USC Pathway will receive their first definitive treatment within 62 days from their point of suspicion by March 26 - Radiology**

PROJECT GOVERNANCE

Responsible Officers

Executive Lead:

Strategic Lead:

Delivery Leads:

Programme oversight through:

Governance through:

Delivery through:

KEY DELIVERABLES***MEASURES*****KEY ACTIONS*****BY WHOM****BY WHEN****QUANTIFIABLE OUTCOME*:****TRAJECTORY OVER NEXT 12 MONTHS:****HOW AND WHEN WILL DATA BE COLLECTED, VERIFIED**

Reduce radiology waiting volume across all modalities

SP/GRD

31/3/25

Number of booked and complete patients

Reduction of 50% waiting by 31/3/26

Radiology dashboard

Achieve turnaround time of investigation performed to 7 days from point of referral

SP/GRD

14 days – sept 25

Request to scan time

14 days – September 25. Reduction to 7 days requires additional funding/scanners.

Radiology dashboard

Reduce turnaround time of time to report to 7 days

SP/GRD

30/9/25

SCP scan to report under 7 days

31/3/25 – 10 days
30.4.25 – 10 days
31.5.25 – 10 days
30.6.25 – 10 days
31.7.25 – 9 days
31.8.25 – 8 days
30.9.25 – 7 days

Radiology dashboard

50% reduction for patients on an SCP pathway waiting a radiological investigation

SP/GRD

31/3/25

Number of booked and complete patients

Reduction of 50% waiting by 31/3/26

Radiology dashboard

Implement Radiology Investment Plan:
Clear Single Cancer Pathway imaging backlog by September 25

SP/GRD

31/9/25

No backlog patients awaiting radiology.

September 26 – 0
March 26 - 0

PTL.

Reduce overall waiting time for Single Cancer Pathway Patients to 14 days.				SP/GRD	14 days – sept 25	Request to scan time	14 days – September 25. Reduction to 7 days requires additional funding/scanners.	Radiology dashboard	
RISKS	RISK DESCRIPTION		LIKELIHOOD	IMPACT	SCORE	MITIGATING ACTIONS			
	Radiology workforce fragility		5	4	20	• Radiology investment plan 25/26 – stabilises but does not improve fragility.			
	Lack of equipment replacement funding		4	4	16	• RAG ratings for each equipment collated for WAG approval.			
	Estates Infrastructure affecting replacement of equipment		3	4	12	• Electrical infrastructure is affecting replacement of the single HD gamma camera at WGH – WAG have been given costs as highest priority for replacement.			
	Single scanners on multiple sites		5	5	25	• Breakdown causes delays – other sites used, mobile solutions and additional patient transport.			
LINKS TO	BOARD ASSURANCE FRAMEWORK	HB RISK REGISTER				OTHER PLANNING OBJECTIVES		MINISTERIAL &/OR LOCAL PRIORITY	OTHER, EG, AHMWW
		Corporate 797 -Risk to the ability to deliver ultrasound services due to workforce pressures							
		Corporate 684 – Risk to the timely investment and replacement of radiology equipment and supporting infrastructure.							
		Operational 1547 – Risk of being unable to provide quality and timely radiology service due to workforce challenges and consultant deficit.							
		Operational 1223 – Risk of unsustainable radiology on-call rota due to staff shortage and increased activity.							

PLANNING OBJECTIVE - PO 4 Planned Care (Cancer)

PLANNING OBJECTIVE SCOPE (What are you aiming to achieve in 2025/26) Provision of a 7 day, four site Acute Oncology CNS presence in Hywel Dda in line with National Specification for AOS in NHS Wales- AOS

PROJECT GOVERNANCE Responsible Officers Executive Lead: Strategic Lead: Delivery Leads:	Programme oversight through: Governance through: Delivery through:

KEY DELIVERABLES*			MEASURES*		
KEY ACTIONS*	BY WHOM	BY WHEN	QUANTIFIABLE OUTCOME*:	TRAJECTORY OVER NEXT 12 MONTHS:	HOW AND WHEN WILL DATA BE COLLECTED, VERIFIED
Provision of a 7 day, four site Acute Oncology CNS presence in Hywel Dda in line with National Specification for AOS in NHS Wales	Ceri Wisdom/Gina Beard	March 31 st 2026	Recruitment of 2 WTE Band 6 CNS Recruitment of 2 WTE Band 7 CNS	By end of Q2 By end of Q4	March 31 st 2026 Data will be collected from ESR
Clinical Leadership for AOS in line with National Specification for AOS in NHS Wales and Royal College of Physicians Wales report "Cancer Care at the Front Door"	Ceri Wisdom	June 30 th 2025	Identification and appointment of Clinical Lead for AOS	Professor Woodhouse appointed April 1 st 2025 – key action achieved	WPAS Clinics
Provision of a fully established acute oncology/haematology triage service for Hywel Dda	Ceri Wisdom	December 31 st 2025	Recruitment of 2 WTE Band 6 CNS – plus training and upskilling	By end of Q3	March 31 st 2026 Data will be collected from ESR and training records

Identify an effective clinical model for an immunotherapy toxicity management Service for Hywel Dda and write a business case (Service Improvement Project in progress)				Ceri Wisdom	March 31st 2026	Broad clinical pathway in place Internal sub-pathways in place (cardiology/gastro/dermatology etc) Annual plan submission for Band 8a ACP with Band 4 coordinator support scoped out for annual plan submission 2026/27	By end of Q2 By end of Q3 By end of Q4	March 31 st 2026 Data will be collected from AOS Sharepoint
RISKS	RISK DESCRIPTION		LIKELIHOOD	IMPACT	SCORE	MITIGATING ACTIONS		
	Delay in recruiting band 6 and 7 CNS posts	2	5	10	• Working through the FCSG process to put the post on TRAC			
	Delay in funding and recruitment for Band 8A and Band 4 posy in relation to immunotherapy toxicity	3	5	15	• Submission on Annual Plan 2026/27 • Pathways already in place			
LINKS TO	BOARD ASSURANCE FRAMEWORK	HB RISK REGISTER				OTHER PLANNING OBJECTIVES	MINISTERIAL &/OR LOCAL PRIORITY	OTHER, EG, AHMWW
		Ref: 1905 Risk of deterioration of acutely unwell patients on SACT while accessing acute admission and inpatient services. The complexity of anti-cancer treatments carry potentially life-threatening toxicities, that can present initially as vague symptoms but deteriorate rapidly if not fully realised and appropriately managed by the acute clinical teams						

PLANNING OBJECTIVE - PLANNING OBJECTIVE - PO 4 Planned Care								
PLANNING OBJECTIVE SCOPE (What are you aiming to achieve in 2025/26)								
PROJECT GOVERNANCE Responsible Officers Executive Lead: Andrew Carruthers Strategic Lead: Paula Goode Delivery Leads: Service SDMs				Programme oversight through: RTT Optimisation Group Governance through: Clinical Care Group Business Committee for Planned Care & Cancer Services Delivery through: RTT Optimisation Group				
KEY DELIVERABLES*					MEASURES*			
KEY ACTIONS*				BY WHOM	BY WHEN	QUANTIFIABLE OUTCOME*:	TRAJECTORY OVER NEXT 12 MONTHS:	HOW AND WHEN WILL DATA BE COLLECTED, VERIFIED
Achievement of 100% compliance for patients waiting over 52 weeks for their new outpatient appointment				Lisa Humphrey	31 st March 2026	No patients waiting over 52 weeks for their first outpatient appointment.	No patients waiting over 52 weeks for their first outpatient appointment.	Via quarterly monitoring report & monthly IPAR report.
Achievement of 100% compliance for patients waiting under 104 weeks from referral to treatment (save for Ophthalmology)				Lisa Humphrey	31 st March 2026	No patients waiting over 104 weeks from referral to treatment (save for Ophthalmology)	No patients waiting over 104 weeks from referral to treatment (save for Ophthalmology)	Via quarterly monitoring report & monthly IPAR report.
Achievement of 65% compliance in Ophthalmology: % R1 eyecare appointments attended in target or 25% delay				Lisa Humphrey	31 st March 2026	65% of R1 eyecare appointments attended are in target or 25% delay.		
RISKS	RISK DESCRIPTION	LIKELIHOOD	IMPACT	SCORE	MITIGATING ACTIONS			
	Risks predominantly associated with fragile service / workforce profile in key specialties – limited resilience to sickness/absence:							
	Radiology	5	4	20	• Radiology investment plan 25/26			
	Other diagnostics (i.e., Endoscopy)	5	4	20	• Endoscopy investment plan 25/26			
	Ongoing payment of PAAR rate	5	4	20	• Approval being sought from Execs. Paper completed.			
	Theatre stability	5	4	20	• Additional management support / Insourcing support			

LINKS TO	BOARD ASSURANCE FRAMEWORK	HB RISK REGISTER	OTHER PLANNING OBJECTIVES	MINISTERIAL &/OR LOCAL PRIORITY	OTHER, EG, AHMWW
		1664 Risk to ophthalmology service delivery due to a national shortage of Consultant Ophthalmologists and the inability to recruit			
		1580 Risk to endoscopy service provision due to challenges in recruiting consultant gastro / endoscopists			
		2104 Risk to delivery of Ministerial priorities relating to planned care recovery ambitions 25/26 due to demand exceeding capacity.			

PLANNING OBJECTIVE - PO5 – Mental Health

PLANNING OBJECTIVE SCOPE (What are you aiming to achieve in 2025/26)

Clinical Services Plan - A programme of work to develop a Clinical Services Plan, as agreed by [Board in March 2023](#), in response to service fragilities and based on the principles of care that is safe, sustainable, accessible, and kind. The development of a Clinical Services Plan is also an action within the Targeted Intervention requirements of Welsh Government.

- To provide a set of plans for key clinical services to address critical sustainability risks up to the new hospital network.
- Improve performance around children's ASD waiting time targets
- Integrate the Adult ADHD and Adult Autism service – create a SPOA in line with ministerial priorities
- Continue work integrating children's ADHD and ASD services to create a SPOA in line with ministerial priorities
- To provide a set of plans for key clinical services to address critical sustainability risks up to the new hospital network
- Deliver improvements to CAMHS set out in NHS Wales CAMHS Service Specification (July 2024) and HIW, CIW & Estyn Joint Review

PROJECT GOVERNANCE Responsible Officers Executive Lead: Andrew Carruthers Strategic Lead: Lee Davies Delivery Leads: Liz Carroll			Programme oversight through: Finance and Performance Committee Governance through: MHL D IGG Delivery through: Children's ASD Services Performance Improvement Task and Finish group & MHL D CCG IGG (PPP B & QSHS)		
KEY DELIVERABLES*			MEASURES*		
KEY ACTIONS*	BY WHOM	BY WHEN	QUANTIFIABLE OUTCOME*:	TRAJECTORY OVER NEXT 12 MONTHS:	HOW AND WHEN WILL DATA BE COLLECTED, VERIFIED
Finalise S136 Place of Safety paper.	Liz Carroll	September 2025	Completion of multi-agency options appraisal	Complete	Board July 2025
Eradicate over 3-year waits through outsourcing and values-based approaches to diagnostic assessment.	Catherine Vaughan/ Children's ND service	March 2026	No CYP waiting more than 3 years	Awaiting trajectory	
Improve performance by 40%	Catherine Vaughan/ Children's ND service	March 2026	Performance 40%	Monthly performance reporting	

Stabilise workforce and re-design service model to include needs-led, whole system, stepped approaches.		Catherine Vaughan/ Children’s ND service	March 2026	Service re-design		
Implement digital innovation across all service areas – piloting digital platforms in partnership with WG and Centre for Digital Public services and exploring digital innovation with commercial and private sector.		Catherine Vaughan	March 2026	Digital platform (Magic Notes) will have been tried and tested All services will be paper-less		
Strengthen regional partnership working via ND strategic group and subsequent delivery groups to include colleagues from Public Health Wales.		Catherine Vaughan/ ND services (all-ages)	March 2026	Regional strategic plan for ND		
Complete process mapping exercise of Adult ADHD and ASD (IAS) services; Complete data cleanse of Adult ADHD waiting list; ensure operational processes align; dual diagnosis training of all clinicians within service; development of pre and post diagnostic support Adult ADHD service.		Catherine Vaughan/ Adult ADHD and IAS	March 2026	Service re-design and SPOA		
Prepare and present paper at CYP working group to progress alignment of children’s ADHD and ASD services.		Catherine Vaughan/ Lyndon freeman	July 2025	Implement agreed action		
Standardise CAMHS access times through implantation of UK Mental Health Triage Scale for all referrals to CAMHS.		Alastair Wakely	March 2026	100% referrals triaged using scale	By due date.	
Enhance transparency and improve communication and partnership working with parents, CYP and GP Clusters.		Alastair Wakely	March 2026	Clearer, published access criteria. Revised letter templates. GP Cluster roadshow.	By due date.	
Implement care planning for all non-Part 2 children and young people in CAMHS; increase consistency of CTP implementation across CAMHS.		Alastair Wakely	March 2026	80% with a care plan. % adherence to CTP Consensus Statement.	By due date.	
Review 24/7 CAMHS Crisis provision to increase Alternative to Admission and same-day access for all Crisis referrals.		Alastair Wakely	October 2025	Paper to MHLD IGG BPPP.	By due date.	
RISKS	RISK DESCRIPTION	LIKELIHOOD	IMPACT	SCORE	MITIGATING ACTIONS	

	There is a risk of insufficient programme resource (operational and project management) to progress all the projects in the desired timeframe		4	4	16	Reallocation of existing staff – monitor and be prepared to manage a decision deferral from Q3 25/26 to Q4 25/26.			
	There is a risk of public and political opposition to the programme if the plans are perceived as objectionable		4	4	16	Process follows the guidance from HICO and based on proven experience gained from the Paediatrics process.			
	There is a risk of insufficient workforce to deliver the preferred solutions		3	4	12	Plans need to be developed in recognition of the constraints.			
LINKS TO	BOARD ASSURANCE FRAMEWORK	HB RISK REGISTER				OTHER PLANNING OBJECTIVES	MINISTERIAL &/OR LOCAL PRIORITY	OTHER, EG, AHMWW	
		Corporate risk 1032 Operational Risk 1287 Operational risk 1290				Neuro-divergence Improvement Programme; NHS Executive Performance and Improvement			

Planning Objective: PO 2 Financial Road Map

Executive Lead: Huw Thomas

Reporting Period: Quarter 1 2025/26

Overall status: ~~Complete~~ / ~~Ahead~~ / ~~On-track~~ / ~~Behind~~

Rationale for overall status (please provide a brief summary of current progress indicating any key highlights or potential barriers to delivery): Draft completed, shared to Exec Team and NHS P&I Finance

Progress against planned outcomes / trajectories / milestones (please provide SPC/data charts and an explanation of any variances):

Progressing to agreed milestones and establishing the guiding principles that will shape the financial elements of the organisations 2026/29 planning cycle. Engagement sessions initially sharing the concept and principles have been completed in-line with the planned timelines, with a strategic milestone approach agreed in principle.

Activities completed in previous reporting period

- Methodology and plan established, to refresh the Financial Roadmap
- Update of previous Roadmap with new intelligence
- Creation of a strategic set of financial milestones that underpin the Roadmap
- Engagement across the senior finance leadership team to create, critique and revise assumptions
- Shared with the Executive Team in July 2025
- Held a workshop with NHS Performance and Improvement Financial Planning & Delivery to explain, share and agree a collaborative review approach moving forward

Activities planned for next milestone and reporting period

- Embed the strategic financial milestones within the organisations planning cycle for 2026/29
- Engage with CCG Triumvirates to reflect appropriate changes to the Roadmap
- Review and reflect appropriate changes following further workshops with NHS Performance and Improvement Financial Planning & Delivery
- November 2025 Board meeting will be a further engagement milestone, with all elements being reviewed for updates

Any other Comments

Matters for information:

Feedback from NHS Performance and Improvement was complimentary as to the approach, the financial milestones and the granularity of modelling assumptions.

Risks to delivery:

Sufficient financial opportunities are implemented by the organisation to allow any net expenditure increase trajectories to be offset by savings. Support from Clinical and Operational management.

Any other comments:

N/A

Planning Objective: PO 3- TUEC

Executive Lead: Andrew Carruthers

Reporting Period: Q1 2025

Overall status: On-track
Rationale for overall status (please provide a brief summary of current progress indicating any key highlights or potential barriers to delivery):
Majority of deliverables against the portfolio of work are complete, A minority remain behind due to resource, but mitigations are in place to address.

Progress against planned outcomes / trajectories / milestones (please provide SPC/data charts and an explanation of any variances): [Please see Slide 2, Programme Metrics, Quarter One 2025.](#)

Activities completed in previous reporting period

- UEC Accelerated Transformation Programme Established
- Evaluation for 7-Day Clinical and SDEC services developed and circulated
- Business Case for 7-Day Clinical and SDEC services developed and submitted to FET
- Business Case for Tenby SDUC developed and submitted to Welsh Govt.
- Operational Delivery Unit under development and SBAR submitted to FET
- Ambulance handover workshop held, and plan developed with WAST and HB operational/Clinical Leads.
- Regional PoCD Integrated Action Plan Submitted
- Hospital Site Environmental groups set up and plans developed which focus on hydration/nutrition, privacy/dignity, communication, cleanliness
- A draft ‘Clinically Optimised’ guidance paper developed to support staff understanding
- Development of the ED / MIU Redirection Policy.
- Online [Discharge Toolkit](#) has been launched to consolidate key discharge resources and guidance
- Piloting a patient information discharge booklet to set expectations on patient discharge
- Criteria Led Discharge guidance developed.

Activities planned for next milestone and reporting period (Q2)
Six Goals 25/26 Programme Plan:

- Programme Plan documents available on request

Key priority: Implementation of the HDdUHB Ambulance Patient Handover Assurance Plan

Patient Handover Assurance Plan available on request

UEC Accelerated Transformation Programme PIDs and ToRs:

Programme PIDs and ToRs documents available on request

Any other Comments

Matters for information:
National Six Goals monies (non-recurrent till Match 2026) are being released to support work in falls in Care Homes and Single Point of Access. Indicative costs have already been requested, and business cases will be worked up in August for Care Home training and Transport to support Clinical Streaming Hubs

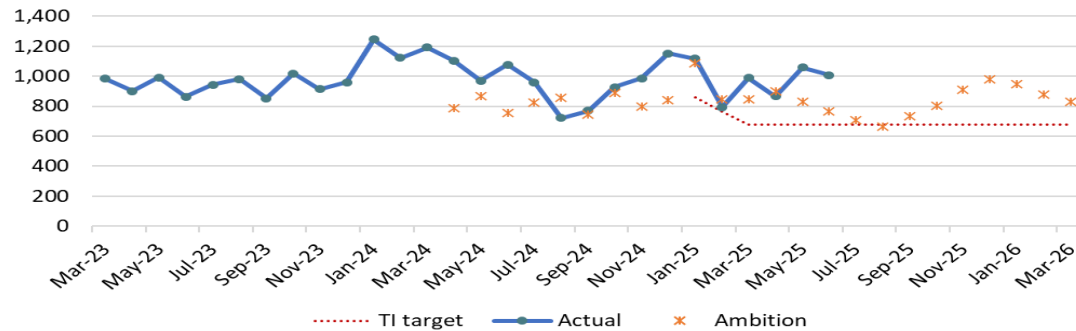
Risks to delivery:

- The Unscheduled care Risk remains the most challenging Risk for the care group and the transformation required will be a resource challenge as we move forward at pace to achieve a different model prior to next winter
- Funding for the model will need to be pump-primed, with the expectation that the 7-day service will become self-sustaining within a year of operation. A detailed plan will need to be developed which clearly demonstrates the cost shift from acute to community services which will go to financial scrutiny group at the end of August and be submitted for Board in early September. UEC Clinical and Operational Leads will need to be involved and sign off plan but there is a risk that given Annual Leave over the summer period and short timescale for development this could be delayed.

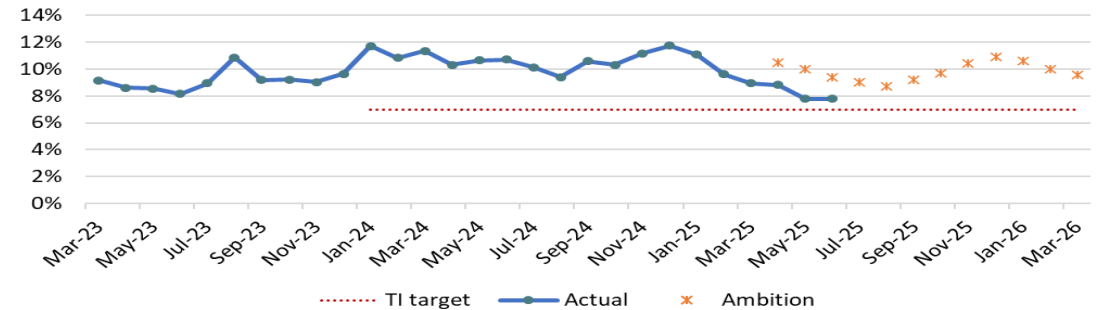
Programme Metrics, Quarter One 2025



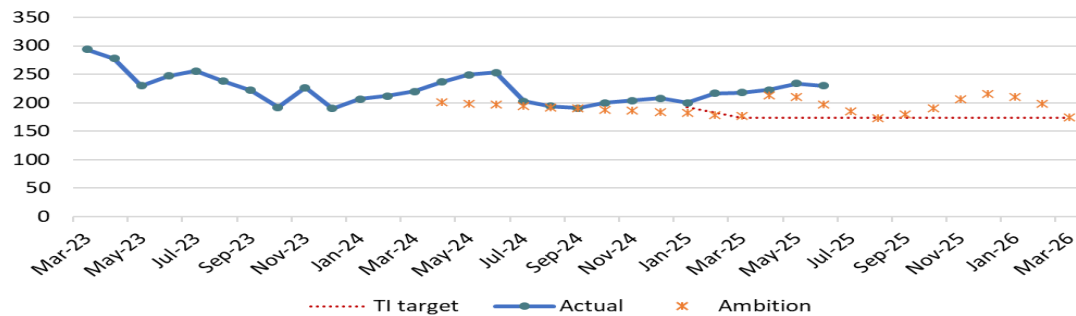
Ambulance handovers taking over 1 hour - Hywel Dda



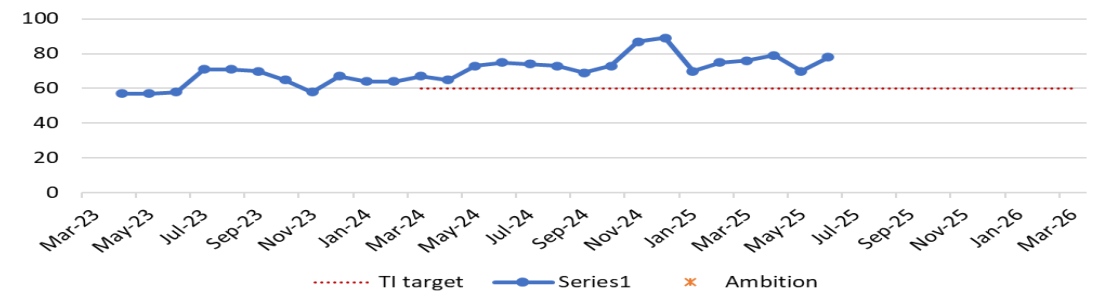
% patients waiting over 12 hours in an emergency department - Hywel Dda



Number of delayed pathways of care - Hywel Dda



Median time from arrival at ED to assessment by a clinical decision maker (mins) - Hywel Dda



Targeted Intervention targets are not met for June 2025 across Hywel Dda.

- Improvements in 12 hour wait performance in Q1 mean that Annual Plan targets and May and June achieved 8%, just below the TI target of 7%. Concern remains around and increasing trend in Pathways of Care Delays which indicate an increasing trend for Q1.
- Ambulance handover >1hr indicate a rising trend for Q1, mainly driven through performance from Glangwili and Withybush hospitals.
- An improvement in May is indicated for Time to Clinical Assessment at EDs, but in June the position worsened again. GGH has seen an improving position in this metric in Q1 but still remains significantly over TI target of 60 mins, and WGH met TI targets for this domain in May (59mins) but in June has slipped back to 76mins, a significant deterioration.
- Although a static trend was indicated for Q1 for PoCD, concern remains that the Health Board does not meet for this metric

Planning Objective: PO4 Planned Care

Executive Lead: Andrew Carruthers

Reporting Period: Q1 (25/26)

Overall status: On Track

Rationale for overall status (please provide a summary of current progress indicating any key highlights or potential barriers to delivery)

Progress against planned outcomes / trajectories / milestones (please provide SPC/data charts and an explanation of any variances):

- In June 2025 there were 71 patients waiting over 52 weeks for their OPD appointment. These are within Care of the Elderly and General Medicine where capacity issues for osteoporosis patients present an ongoing capacity issue. Improvement plans are being developed into quarter 2 to recover predicted breaches.
- In June 2025 there were 144 patients over 104 weeks from referral to treatment.
- In June 2025, 60.25% of Ophthalmology appointments attended were within a patient's clinical target date (or within 25% beyond their target date).

Activities completed in previous reporting period

- Recovery is supported by outpatient modernisation plans including maximisation of self-management pathways such as See on Symptoms (SoS)/Patient Initiated Follow Up (PIFU).
- Demand and capacity trajectories anticipate this target being maintained in most specialties.
- Recurrent recovery monies are being prioritised for areas that anticipate breaches
- Active management and triage of referrals has resulted in no waiting list growth.
- Recent waiting list initiatives for end of year targets contribute to the increase in follow up waiting lists as more patients are processed through their pathways.

Activities planned for next milestone and reporting period

- Recovery plans being progressed in ENT & Ophthalmology (Ocular Plastics) . These plans include insourcing of theatre staff to secure core capacity and mitigate cancellations, outsourcing of tonsillectomy procedures and delivery of additional lists to recover backlogs
- Recovery plan in place to support recovery of quarter 1 orthopaedic breaches
- Key focus on maintaining waiting times targets into 2025/26 using capacity and demand forecasts to highlight risk areas in each specialty, with a view to allocate any additional funding to appropriate specialties.
- There is a refreshed Theatre Optimisation and Efficiency workstream led by the new Clinical Care Group to promote further improvements in theatre productivity across all specialties and achievement of GIRFT standards.

Any other Comments

Matters for information: Performance is reported monthly within the Integrated Performance Assurance Report (IPAR), Welsh Government Integrated Quality Performance and Delivery (IPQD). Additional scrutiny undertaken via weekly scrutiny meetings & external WG meetings.

Risks to delivery: Staffing due to national shortages. Demand exceeding capacity including additional cancer demand spikes.

Any other comments: N/A

Planning Objective:PO 4 Planned Care (CANCER) 80% of patients on a USC pathway will receive their first definitive treatment within 62 days from their point of suspicion.

Executive Lead: Andrew Carruthers

Reporting Period: April – June 25

Overall status: Complete / Ahead / **On-track** / Behind

Rationale for overall status (please provide a brief summary of current progress indicating any key highlights or potential barriers to delivery)Performance over the past 4 months has been above 60% in line with the TI de-escalation criteria. The health board has been de-escalated from level 4 to level 3 for Cancer performance.

Progress against planned outcomes / trajectories / milestones (please provide SPC/data charts and an explanation of any variances):

	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Predicted Performance	65%	67%	68%	69%	70%	70%	72%	74%	77%	77%	78%	80%
Actual Performance	62.5%	66.1%										

Activities completed in previous reporting period

- 1 Commenced Teledermoscopy for USC patients April 25
- 2 Increased provision of local anaesthetic trans-perineal (LATP) biopsies will help meet growing demand
- 3 Increase capacity for flexi cystoscopy by 30% by increasing nurse cystoscopist by 1 WTE Bladder pathway Additional nurse-led cystoscopy services will provide a 30% uplift in capacity, enabling patients to be seen more quickly.
- 4 Development and launch of a third one stop clinic offer for the diagnosis of suspected endometrial cancer patients in Glangwili General hospital, to create a further 8 see, scan and biopsy patient slots weekly – fully embedded by commencement of Q1 25/26. Implemented 1.6.25
- 5 Clinical Leadership for AOS in line with National Specification for AOS in NHS Wales and Royal College of Physicians Wales report "Cancer Care at the Front Door"

Activities planned for next milestone and reporting period

- 1 Transfer the faecal immunochemical testing (FIT) service from Secondary to Primary Care in line with the lower GI National Optimal Pathway.30.9.25
- 2 Dermoscopic attachments and cameras to be circulated in Primary Care to support referrals will improve triage for urgent suspected skin cancer, reducing in-person clinic pressure while maintaining diagnostic accuracy.
- 3 Ensuring stable outpatient capacity while introducing measures to improve access to MRI through the PROSTAD pathway. This will reduce the time taken to reach biopsy decisions, shortening referral-to-diagnosis times by up to four weeks.
- 4 Increased MRI access and expanded LATP biopsy capacity will be in place by the end of quarter 2 2025.
- 5 Development and launch of a fourth one stop clinic offer for the diagnosis of suspected endometrial cancer patients in Witybush General Hospital, to create a further 8 see, scan and biopsy patient slots weekly – fully embedded by commencement of Q2 25/26.
- 6 Achieve turnaround time of radiology investigation performed to 7 days from point of referral. Reduce turnaround time of time to report to 7 days
- 7 Implement Radiology Investment Plan: Clear Single Cancer Pathway imaging backlog by September 25. Reduce overall waiting time for Single pathway Patients to 14 days.

Any other Comments

Matters for information:

Risks to delivery:

- Risk of not meeting the 80% SCP waiting times target by March 2026 due to diagnostics capacity and delays at tertiary centre.
- Risk of being unable to provide quality and timely radiology service due to workforce challenges and consultant deficit.
- Risk to delivery of BSW services in line with standards
- Endoscopist provision and nursing establishment
- Risk to the timely investment and replacement of radiology equipment and supporting infrastructure and to provide quality and timely radiology service due to workforce challenges and consultant deficit.
- Insufficient MOP (minor operative procedures) capacity in the HB and Unsustainable skin services due to Consultant vacancies
- Risk of deterioration of acutely unwell patients on SACT while accessing acute admission and inpatient services. The complexity of anti-cancer treatments carry potentially life-threatening toxicities, that can present initially as vague symptoms but deteriorate rapidly if not fully realised and appropriately managed by the acute clinical teams

Any other comments:

Performance over the past 4 months has been above 60% in line with the TI de-escalation criteria. The health board has been de-escalated from level 4 to level 3 for Cancer performance.

Planning Objective 5 – Mental Health and Learning Disabilities

Executive Lead: Andrew Carruthers, Chief Operating Officer

Reporting Period: Q1 2025/26

Overall status: On-track

Rationale for overall status (please provide a brief summary of current progress indicating any key highlights or potential barriers to delivery)

Progress against planned outcomes / trajectories / milestones (please provide SPC/data charts and an explanation of any variances):

Art Therapy - is a limited resource with 1.0wte covering 3 counties. All clients on the waiting list have been offered a supportive group interventions along with the therapist running Art Therapy groups to reduce the wait times as much as possible.

Psychological therapy – The service has now commenced a prudent and tiered approach to high intensity intervention to support the increase in demand with a focus on groups as the initial intervention. Digital options continue to be explored, whilst caps in sessions in place with treatment groups for Childhood Trauma, OCD, stabilisation programme and Self Esteem groups coming online over the next 2 months.

Child neurodevelopmental waits: The overarching neurodevelopmental assessment metric is a combined ASD & ADHD position with the latter reported by Childrens Services. Childrens ASD performance in June 2025 of 25.2%, shows common cause variation but the target of 80% was not met. Performance is driven by ASD, where 535 of 3,436 (15.6%) patients had an ASD assessment < 26 weeks. Demand for assessment for continues to increase year on year, ranging from an average of 20 referrals per month (2016) to 114 per month (2025) with longest wait times approximately 3.6 years. Workforce constraints and timeliness of diagnostic assessment training have a significant impact. ASD task and finish group, Chaired by CCG Service Director now in place to over-see 3 year improvement plan, involving stabilising and increasing workforce, outsourcing, service re-design, digital innovation and strategic stakeholder engagement and partnership working.

Adult neurodevelopmental waits: Adult ASD total waiting list is 2134 with a compliance of 14.5% waiting less than 26 weeks with a gradual drop in compliance seen over the 6 months prior to June. For Adult ADHD, the total waiting list has worsened, with 4529 now waiting assessment, an increase from the previous 4110 reported in April. This is due to a backlog of referrals being processed and triaged and added to waiting list. 658 adults are waiting to start treatment and trial medication.

Activities completed in previous reporting period

- 1. Workforce Stabilisation plan for Inpatient Services approved by Execs and phased implementation in progress including creation of a dedicated establishment to underpin Section 136 provision. Location options for ongoing 136 provision due to be discussed at Board in July – this was deferred to the Quality Safety Committee in August.
- 2. 111 Option 2 is operational 24/7 and its further development as a single point of assessment on hold until location of current PPH discharge lounge returned to MH&LD estate. Discussions ongoing with colleagues at PPH.

Activities planned for next milestone and reporting period

- 1 Deliver additional outsourced children's neurodevelopmental assessments
- 2 Review job plans and implementation of stepped care model in adult psychological therapies

Any other Comments

Matters for information:

- Temporary service change diverting routine MH referrals from GPS to 111 option 2 in Ceredigion supported by board to facilitate timelier access to mental health assessment and reduce waiting times.
- 72 hour follow up following discharge from adult inpatient consistently 100% achievement throughout reporting period.

Risks to delivery:

Delays in improvement work to Ty Bryn to enable LD service to be relocated from Penlan.

4.4

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4.4 - PROCUREMENT PLAN AND SCRUTINY

*Andrew Spratt
(Hywel Dda UHB -
Deputy Director of
Finance)*

| For assurance

Attachments

Procurement Plan and Scrutiny FPC 26 August 2025.pdf



PWYLLGOR CYLLID A PHERFFORMIAD
FINANCE AND PERFORMANCE COMMITTEE

DYDDIAD Y CYFARFOD: DATE OF MEETING:	26 August 2025
TEITL YR ADRODDIAD: TITLE OF REPORT:	Procurement Report
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Huw Thomas, Director of Finance
SWYDDOG ADRODD: REPORTING OFFICER:	Gemma Deverill, Deputy Head of Procurement

Pwrpas yr Adroddiad (dewiswch fel yn addas)

Purpose of the Report (select as appropriate)

Ar Gyfer Penderfyniad/For Decision

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The purpose of this report is to inform Members of the:

1. Procurement Plan for Financial Year 2025/26
2. Outcome of the procurement exercises which have been undertaken on behalf of Hywel Dda University Health Board (HDdUHB). In line with Welsh Government approval procedures, the Health Board is required to approve the following new contracts, as they have each have a cumulative contract value in excess of £1m over the term of the contract for HDdUHB.

Cefndir / Background

1. Procurement Plan for Financial Year 2025/26

Savings Target	Q1 Target	Q1 Actual	Q2 Target
£2,000,000	£156,637	£200,994	£272,346

2. Approve Award of Histopathology Managed Service Contract (MSC) Renewal

Proposed outcome

Duration of Contract	Proposed Supplier (s)	Current Annual Local Contract Value	Proposed Annual Value of New Contract	Proposed Total Value of New Contract
01/12/2025–30/11/2029 with no option to extend	Leica Microsystems UK Ltd	£300,919.10 ex VAT	£586,129.95 ex VAT	£2,344,519.81 ex VAT

3. Outsourcing of Ophthalmology Services – Mobile Theatres (Stage 4 - Cataracts)

Proposed outcome

Duration of Contract	Proposed Supplier (s)	Current Annual Local Contract Value	Proposed Annual Value of New Contract	Proposed Total Value of New Contract (including extension option)
1 November 2025 – 31 March 2026 with an option to extend for a further 12 months to 31 March 2027.	SpaMedica	N/A	£2,500,00.00 ex VAT	£6,000,000.00 ex VAT.

4. Renewal of the National Care Homes Framework Agreement

Proposed outcome

Duration of Contract	Proposed Supplier (s)	Current Annual Local Contract Value	Proposed Annual Value of New Contract	Proposed Total Value of New Contract (including extension option)
1 April 2026 – 31 March 2034.	To Be Confirmed upon Award of Framework Agreement	£8,806,220.59	To Be Confirmed upon Award of Framework Agreement	To Be Confirmed upon Award of Framework Agreement

Asesiad / Assessment

1. PROCUREMENT PLAN

This paper outlines the Health Board's Procurement Plan for FY25/26, detailing key strategic projects, regulatory changes, governance developments, and operational priorities.

The plan aligns with the Health Board's wider objectives on transformation, compliance and foundational economy. Committee members are asked to note the priorities, risks, and planned mitigations outlined herein.

Strategic Procurement Priorities

A number of critical procurement projects are scheduled for FY25/26, supporting transformation, service sustainability, and statutory compliance:

- Substance Misuse Services
- Glangwili General Hospital (GGH) Fire Safety Scheme
- Managed Print Services Re-procurement

- Video Consultation
- Construction Framework (SBU/HDD collaboration)
- Pest Control Service (SBU/HDD collaboration)
- In-sourcing and Out-sourcing Initiatives

These projects are being delivered in collaboration with clinical, estates, and operational leads to ensure alignment with the Health Board's overarching strategic aims.

Standardisation and Efficiency Initiatives

Work continues to drive savings and operational efficiencies through product and service standardisation:

- Advanced Energy – Value Voucher Deployment
- Diathermy Equipment Rationalisation
- Braun Infusion Route Switch

These initiatives support clinical effectiveness, reduce unwarranted variation, and contribute to financial sustainability.

Legislative and Governance Changes

The Procurement Act 2023 came into force during February 2025, with key implications:

- Greater flexibility and transparency in procedures
- Emphasis on early planning and robust route-to-market justifications

Procurement activity occurring outside the local Procurement team must now meet governance standards, including:

- Adherence to procurement regulations and policy (e.g., standstill periods, publication of notices)
- Central annual reporting within the Health Board

Engagement is underway with Estates and Commissioning; staff-wide guidance will follow. This initiative ensures consistent compliance and reporting across all directorates. For example:

Revised capital procurement requirements include:

- Mandatory outcome reporting post-implementation
- Public Contract Award Notices
- Strengthened internal governance to ensure compliance

Provider Selection Regime (PSR Wales) applies to all clinical and commissioning procurements, regardless of framework origin. Key elements to consider include:

- Defined evaluation criteria
- Mandatory standstill periods
- Application to framework call-offs and direct awards

Compliance and Risk Management

There has been a notable increase in urgent and unplanned procurement requests, which is undermining governance and contributing to:

- Delays in contract delivery
- Rising instances of Standing Financial Instructions (SFI) breaches
- Missed opportunities for strategic procurement input

Mitigation: Earlier service engagement and clearer accountability for procurement planning is being highlighted to all service users.

Contract Management Improvement Programme

Following internal audit recommendations, a joint Finance and Procurement programme is underway to strengthen contract management, key actions are as follows:

- Ensure the existing Procurement workplan, Finance Service Level Agreement and Long-Term Agreement register are adopted to provide assurance of a formal and comprehensive list of all Health Board contracts, including contract manager details
- Contract Management toolkits are shared to service users upon contract award
- Training and support will be provided to contract owners

All activity is aligned with NWSSP's All-Wales Contract Management Framework.

Foundational Economy Commitment

In line with Welsh Government priorities, the Health Board remains committed to supporting the local economy via procurement policy:

- Promotion of local contractors, SMEs, and third-sector partners
- Encouraging subcontracting to Wales-based organisations
- 43% of non-pay expenditure in 2023–24 was with Welsh-headquartered businesses

A new dashboard developed by NWSSP Sustainability Team enables better visibility of local spend by category and supplier. This will strengthen reporting capability, provide more detailed insight on current supply chains, encourage regional and All Wales alignment and a strategic overview on our local supply network.

Decarbonisation and Carbon Reduction Planning

In support of Welsh Government Net Zero ambitions and in line with Procurement Policy Note (PPN) 06/21 and Welsh Procurement Policy Note (WPPN) 06/21, NWSSP has introduced strengthened requirements around carbon reporting and reduction planning.

Emissions calculation methodologies are categorised into three tiers, based on data quality:

- Tier 1: Least accurate – based on general spend data
- Tier 2: Moderate accuracy – based on specific supplier-provided data
- Tier 3: Most accurate – based on primary activity and emission data

To align with Tier 2 methodologies and improve carbon visibility across public sector contracts:

- Carbon Reduction Plans (CRPs) are now mandatory for all procurements over £5 million (ex VAT) / £6 million (inc VAT) over the contract lifetime.
- CRPs are assessed on a pass/fail basis as part of the procurement process.
- While not compulsory, CRPs will also be requested for all contracts over £25,000, to support improved emissions reporting and supplier engagement.

This approach supports NWSSP and the Health Board's ability to measure, report, and reduce embedded carbon emissions in line with Net Zero public sector targets.

Performance and Financial Impact, Year to Date:

Quarter 1 Procurement Metrics:

- Cash-Releasing Savings: £200,994
- Cost Avoidance: £43,088
- Income Generation: £65,281

2. APPROVE AWARD OF HISTOPATHOLOGY MANAGED SERVICE CONTRACT RENEWAL

HDdUHB Cellular Pathology department are seeking to award a contract to appoint Leica Microsystems UK Ltd to deliver their managed service contract (MSC) including equipment, consumables, middleware, training and maintenance at their consolidated laboratory in Glangwili Hospital (GGH).

The MSC supports the diagnosis and study of diseases by examining tissue samples/biopsies under a microscope to identify abnormalities. The MSC will facilitate the upgrade of existing aged equipment to more modern equipment, along with the implementation of an advanced specimen tracking system which will provide additional safety measures and mitigate any risk of specimens going missing. The following equipment will be replaced under the MSC:

- 2x cassette printers
- 7x fully automated microtomes
- 1x state of the art immunohistochemistry staining platform – Bond Prime
- Patient specimen tracking system - Cerebro

The equipment allows for virtual histological images to be reviewed remotely by consultant pathologists, shortening the reporting period, which supports the Health Board's digital transformation strategy and reducing patient waiting times. The approach fosters integration and resilience of pathology services across the health board, region and nationally, therefore eliminating the need for time-consuming and costly physical slide transport.

A direct award process was initiated via the NHS Supply Chain Framework Agreement for Laboratory Diagnostics, Point of Care Testing and Pathology Managed Services (2023/S 000-028831). This route maximises the lifecycle of current equipment within the laboratory and avoid the cost associated with replacing equipment halfway through their lifecycle.

Whilst the long-term strategy in the region is to merge similar pathology requirements between HDdUHB and Swansea Bay University Health Board (SBUHB) under the ARCH project, current

diverging equipping requirements and lack of aligned specification has resulted in HDdUHB and SBUHB direct awarding their requirements separately. However, the aim during the contract period is to develop a common specification to enable a joint regional contract.

Whilst there are alternative managed service providers in the market, there is a six-month implementation period to account for, during which a revalidation exercise will be required to verify new equipment and antibodies. The risk of higher costs due to equipment replacement and/or refresh has also been considered, which the Finance Business Partner has advised is not within the Service's budget at this time.

The Service has also identified further areas within cellular pathology, including maintenance, which could be incorporated into the contract, which would benefit from the VAT recovery that is available for MSCs. This would result in further savings across the contract period.

The contract term will be from the 1 December 2025 and will run for a four year period to the 30 November 2029 with no option to extend.

3. OUTSOURCING OF OPHTHALMOLOGY SERVICES – MOBILE THEATRES (STAGE 4 - CATARACTS)

HDdUHB Scheduled Care Directorate is seeking to award a contract to appoint SpaMedica to deliver an Outsourced Mobile Theatre Ophthalmology solution for cataracts procedures.

The Health Board has been allocated funding this year to deliver the upon Welsh Government targets with regards to referral to treatment times (RTT) and reducing waiting list initiatives (WLI).

Welsh Government are committed to reducing RTT; RTT is the time taken from referral by a GP to hospital for treatment, and includes time spent waiting for any hospital appointments, tests, scans, and other procedures that may be needed. Welsh Government RTT targets include that 95% of patients referred for planned care should be seen within 26 weeks, and 100% seen within 36 weeks.

To support with the Health Board's aim to treat patients closer to home, this contract will allow for a mobile theatre solution to facilitate treatment from a site in Carmarthen, rather than from SpaMedica's site in Swansea.

Following an Expression of Interest (EOI) exercise whereby SpaMedica was the only response received, a procurement has been undertaken utilising the Countess of Chester Hospital (COCH) Off-Site Surgical & Medical Capacity Solution's Multi Supplier National Dynamic Purchasing System (DPS), reference DPS01/OSMCS/18/IB.

The contract term is expected to be from the 1st of November 2025 and will run for an initial five month period to the 31 March 2026 with an option to extend for a further one year to the 31 March 2027 with a total contract budget (including extensions) of £6,000,000.00.

Please note this is a zero-commitment contract, service levels and Key Performance Indicators (KPIs) will be established within the mini competition documents and agreed with the successful provider to be reported on monthly.

4. RENEWAL OF THE NATIONAL CARE HOMES FRAMEWORK AGREEMENT

The All-Wales Commissioning (AW Commissioning) Team seek the Health Board's approval to proceed with the renewal of the National Care Homes Framework Agreement.

In October 2016, NHS Wales Local Health Boards, in collaboration with Welsh Local Authorities successfully concluded the procurement for a Framework Agreement for the provision of Services by independent providers to younger adults (18+) in mental health and learning disabilities care homes and care homes with nursing. The framework agreement is due to expire on the 31 March 2026.

The proposed framework agreement will be structured under a lotting process, to include:

Lot 1 - Care home mental health and learning disabilities with continuous staffing

Lot 2 - Care home with nursing mental health and learning disabilities with continuous staffing

There will be a number of key changes for the new framework agreement. AW Commissioning and members of the Joint Commissioning Committee (JCC) have undertaken engagement with various stakeholders, with the following key areas of change engaged upon:

- Procurement regulation
- Pricing model
- Quality assurance rating system
- Removal of the Commissioning Care Assurance and Performance System (CCAPS)

Procurement Regulations

The renewal of the framework agreement will be procured under The Health Services (Provider Selection Regime) (Wales) Regulations 2025 (PSR Wales). As a consequence of this change, only social care services that meet the PSR Wales conditions regarding a 'mixed procurement' can be called off the future framework agreement.

NHS Wales will no longer be able to have a collaborative framework agreement with Welsh Local Authorities.

Pricing Model

Providers will be required to submit core weekly pricing, as with the current framework agreement. However, where additional services are called off by Commissioners, providers will be required to submit hourly rate for staff. Pricing will be subject to a pre-determined cap in line with inflation.

Quality Assurance Rating System

From April 2025 all care home services in Wales will receive published rating from Care Inspectorate Wales (CIW). The regulatory bodies rating will allow an instant view of a providers' care home quality of care which will facilitate appropriate choice of a care service that is best for the resident.

Moving forward, instead of accessing the Commissioning Care Assurance and Performance System (CCAPS) to verify the 'Q rating' of a provider, Commissioners will instead access such information from the CIW web page.

Removal of the Commissioning Care Assurance and Performance System (CCAPS)

In light of the reduced involvement of the JCC team, in conjunction with the management of the future care home framework agreement, the CCAPS will be replaced with an alternate system that will be managed by AW Commissioning and be as accessible in terms of retrieval of pertinent detail with regards to placing a resident within an appropriate care home.

Argymhelliad / Recommendation

The Finance and Performance Committee is asked to scrutinise and recommend for Board to:

- **NOTE** and **ENDORSE** the Procurement Plan for the Financial Year 2025/26
- **APPROVE** the award of a Histopathology Managed Service Contract Renewal to Leica Microsystems UK Ltd for the period 1 December 2025 to 30 November 2029, with no option to extend. This contract will have onwards submission to Hywel Dda University Health Board Public Board and Velindre NHS Trust (as hosts of NHS Wales Shared Services Partnership).
- **APPROVE** the award of an Outsourcing of Ophthalmology Services – Mobile Theatres (Stage 4 - Cataracts) contract to SpaMedica for the period 1 November 2025 to 31 March 2025, with the option to extend for a further one year. This contract will have onwards submission to Hywel Dda University Health Board Public Board, Velindre NHS Trust (as hosts of NHS Wales Shared Services Partnership), as well as to Welsh Government for approval.
- **APPROVE** the Renewal of the National Care Homes Framework Agreement. This Procurement will be undertaken by AW Commissioning to establish a framework agreement. Award of the framework agreement will have onwards submission to Hywel Dda University Health Board Public Board, Velindre NHS Trust (as hosts of NHS Wales Shared Services Partnership), as well as to Welsh Government for approval, on completion of the procurement.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	3.1.9 Conduct detailed scrutiny of all aspects of financial performance, the financial implications of significant revenue expenditure (all those over £1million requiring Board approval), business cases (except those that are capital and digital in nature), projects, and proposed investment decisions on behalf of the Board. 3.1.10 Scrutinise major procurements plans and tenders, and provide assurance to the Board as part of its approval process.
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	Not Applicable
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022	9. All HDdUHB Well-being Objectives apply

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Not Applicable
Rhestr Termiau: Glossary of Terms:	Not Applicable
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Adnoddau Cynaliadwy: Parties / Committees consulted prior to Sustainable Resources Committee:	Not Applicable

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	Not Applicable
Ansawdd / Gofal Claf: Quality / Patient Care:	Not Applicable
Gweithlu: Workforce:	Not Applicable
Risg: Risk:	Not Applicable

Cyfreithiol: Legal:	Not Applicable
Enw Da: Reputational:	Not Applicable
Gyfrinachedd: Privacy:	Not Applicable
Cydraddoldeb: Equality:	Not Applicable

4.5

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**4.5 - ALL-WALES CAPITAL PROGRAMME
2025/26, CAPITAL RESOURCE LIMIT AND
CAPITAL FINANCIAL MANAGEMENT
UPDATE**

***Andrew Spratt
(Hywel Dda UHB -
Deputy Director of
Finance)***

| For information

Attachments

[Capital Update FPC 26 August 2025.pdf](#)



PWYLLGOR CYLLID A PHERFFORMIAD
FINANCE AND PERFORMANCE COMMITTEE

DYDDIAD Y CYFARFOD: DATE OF MEETING:	26 August 2025
TEITL YR ADRODDIAD: TITLE OF REPORT:	All-Wales Capital Programme 2025/26, Capital Resource Limit and Capital Financial Management
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Huw Thomas, Director of Finance
SWYDDOG ADRODD: REPORTING OFFICER:	Sarah Welsby, Senior Finance Business Partner Planning and Major Projects

Pwrpas yr Adroddiad (dewiswch fel yn addas) Purpose of the Report (select as appropriate)
Er Gwybodaeth/For Information

ADRODDIAD SCAA

SBAR REPORT

Sefyllfa / Situation

This update report is presented to the Finance and Performance Committee to:

- Note the 2025/26 Capital Resource Limit (CRL)
- Note the project updates

Cefndir / Background

This report provides an update on the CRL for 2025/26.

Asesiad / Assessment

CAPITAL RESOURCE LIMIT 2025/26

The CRL for 2025/26 has been issued with the following allocations:

Allocation	£'m
All Wales Capital Programme (AWCP)	27.300
Discretionary Programme* (DCP)	6.850
IFRS 16 Leases	0.281
Total	34.431

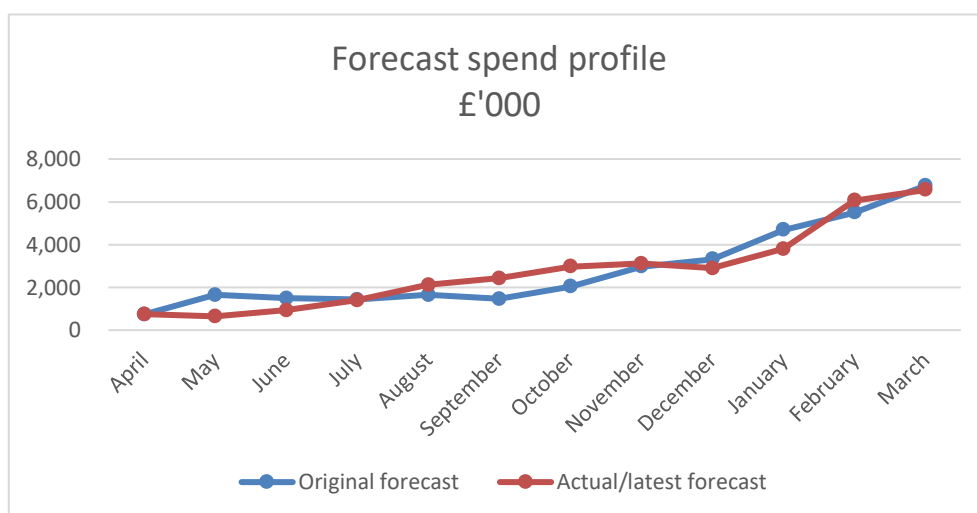
*The Health Board received DCP of £10m in 2025/26. A contribution of £2.205m has been made towards the Targeted Estates Fund schemes within AWCP. A further £0.945m has been paid back to the AWCP to account for capital scheme slippages in 2024/25.

Since the last report the following amendments have been made to the CRL:

Scheme	£m	Description
Digital Priorities Investment Fund (DPIF) - Radiology Informatics System Programme (RISP)	0.429	Funding to support the implementation of the new Radiology Informatics System.
Digital Maternity Cymru System Programme 2025/26	0.100	Funding to support the roll out of The National Digital Maternity Programme
Non-Radiology Ultrasound Replacement	0.761	Ultrasound replacement programme
Aseptic Unit, Withybush Hospital	3.553	Funding provided following approval of the business case for the Aseptic Unit at Withybush
Targeted Estates Fund (TEF)	0.526	Additional Targeted Estates Fund (TEF) funding
IFRS 16 Leases	0.281	Funding for capitalisation of leases
Total	5.650	

EXPENDITURE PROFILE FORECAST

The below chart shows current forecast expenditure compared with the original forecast. Expenditure for July 2025 was in line with the forecast. Expenditure for June was lower than the forecasts for the Picton Terrace scheme and the discretionary programme; no risks to delivery for these by 31 March 2026 have been flagged by relevant project managers.



CAPITAL EXPENDITURE PLAN

The following table shows the capital expenditure plan for 2025/26 with expenditure incurred to date:

Scheme	Planned Spend 2025/26 £m	Cumulative Spend Apr-July £m	Spend July £m	Remaining balance £m
AWCP				
Glangwili - Fire Enforcement works - Phase 2 - Fees	0.779	0.387	0.275	0.392
Backlog Maintenance – (slippage from 2024-25)	1.468	0.301	0.076	1.167
Aberystwyth Sexual Assault Referral Centre	2.367	1.262	0.450	1.105
Block C, Picton Terrace, Carmarthenshire	2.488	0.314	0.260	2.174
Diagnostic Equipment - WGH Fluro & Chilled Water Plant	2.570	0.017	0.005	2.553
EFAB - Infrastructure	0.127	0.004	0.000	0.123
EOY Funding 24/25 – (Pentre Awel)	0.400	0.070	0.002	0.330
Targeted Estates Fund (TEF) - Fire	0.414	0.000	0.000	0.414
TEF - Infrastructure	4.480	0.000	0.000	4.480
TEF - Decarbonisation	0.300	0.000	0.000	0.300
TEF - Mental Health	0.834	0.001	0.001	0.833
TEF - Infection Prevention Control	0.569	0.231	0.046	0.338
TEF - Decontamination	0.576	0.000	0.000	0.576
Carmarthen Hwb - Equipment and Fit-out costs	3.518	0.000	0.000	3.518
Fishguard Health and Wellbeing Centre	1.567	0.017	0.006	1.550
DPIF - Digital Maternity Cymru System Programme 2025/26	0.100	0.000	0.000	0.100
Non-Radiology Ultrasound Replacement	0.761	0.000	0.000	0.761
DPIF – (RISP)	0.429	0.000	0.000	0.429
Aseptic Unit, Withybush Hospital	3.553	0.001	0.001	3.552
Sub-total AWCP	27.300	2.605	1.122	24.695
Discretionary				
IT	1.639	0.253	0.022	1.386

Equipment	1.614	0.474	0.119	1.140
Estates – Statutory	0.450	0.039	0.019	0.411
Estates Infrastructure	2.274	0.052	0.044	2.222
Mental Health	0.228	0.000	0.000	0.228
Other	0.645	0.281	0.067	0.364
Sub-total Discretionary	6.850	1.099	0.271	5.751
IFRS 16	0.281	0.000	0.000	0.281
TOTAL	34.431	3.704	1.393	30.727

Further details on the revenue consequences of these schemes are noted in **Appendix 1**.

CAPITAL SCHEME UPDATES (SCHEMES GREATER THAN £1M)

Withybush Fluoroscopy and Chiller

Works to replace the Fluoroscopy scanner and chilled water plant are due to commence in September 2025.

Aberystwyth Sexual Assault Referral Centre (SARC)

This project will provide sustainable ISO accredited infrastructure for the delivery of SARC services in Aberystwyth. Following WG approval of the business case for the Aberystwyth SARC, £3.354m funding has been provided with work started in January 2025 and construction work expected to complete in September 2025 (representing a two week delay to original programme). The project is currently within budget.

Cross Hands Health and Wellbeing Centre

Discussions are on-going with WG to review the reduced scope of the project to ensure that it is deliverable within the budgetary envelope available.

Picton Terrace

Funding has been provided by Welsh Government to develop Corporate Headquarters within Carmarthen which is expected to be in occupation by the end of the financial year. This will rationalise the Health Board estate by reducing a number of freehold and leasehold properties which are currently being occupied.

Carmarthen Hwb

This project is led by Carmarthenshire County Council, in partnership with the Health Board and University of Wales Trinity St David. A number of services will be co-located within the building which are currently being delivered across a number of different locations. Funding has been provided to the Health Board for equipment and digital. Work is progressing well and is expected to complete by the end of this financial year.

Fishguard Health and Wellbeing Centre

Funding has been provided to develop a Business Case for the development of Fishguard Health and Wellbeing Centre. This will include a longer-term solution for the existing Fishguard

Healthcare Centre and support local delivery of services for the North Integrated Community Network.

Aseptic Unit Withybush Hospital

A sustainable compliant Aseptic Unit will be built at Withybush Hospital in advance of the development of a South-West Regional Aseptic Unit. This will ensure that the facilities and delivery of aseptic services within Hywel Dda will meet the required regulatory standards.

Argymhelliad / Recommendation

The Finance and Performance Committee is asked to:-

- **NOTE** the 2025/26 Capital Resource Limit (CRL); and
- **NOTE** the project update.

Amcanion: (rhaid cwblhau)

Objectives: (must be completed)

Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	3.1.5 Receive assurance on the delivery of the financial plan. This will be achieved through scrutiny of the monthly finance report. This report shall ensure clarity in: 3.5.3 Performance against other financial metrics, such as cash management, capital management and Public Sector Payment Policy.
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Corporate Risk 1196 - not be able to provide safe, sustainable, accessible and kind services. This is caused by insufficient investment to ensure we have appropriate facilities, medical equipment and digital infrastructure of an appropriate standard. Score 16
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:	3. Striving to deliver and develop excellent services 6. Sustainable use of resources

Amcanion Cynllunio Planning Objectives	7 Primary and community strategic plan 8 Estates plans 9 Digital plan
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022	9. All HDdUHB Well-being Objectives apply

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Capital Allocation and prioritisation process. Capital Investment procedure and all relevant Welsh Government guidance.
Rhestr Termiau: Glossary of Terms:	Explanation of terms is included in the main body of the report.
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Adnoddau Cynaliadwy: Parties / Committees consulted prior to Sustainable Resources Committee:	Capital Monitoring Forum Capital Planning Group Individual Project Boards of Capital Schemes Welsh Government Capital Review Meeting Capital Sub-Committee

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	Capital values noted within the report. Included within individual business cases and Capital prioritisation process.
Ansawdd / Gofal Claf: Quality / Patient Care:	Included within individual business cases and Capital prioritisation process
Gweithlu: Workforce:	Included within individual business cases and Capital prioritisation process
Risg: Risk:	Risk assessment process is integral to the capital prioritisation process and the management of capital planning within HDdUHB

Cyfreithiol: Legal:	Included within individual business cases and Capital prioritisation process
Enw Da: Reputational:	Included within individual business cases and Capital prioritisation process
Gyfrinachedd: Privacy:	Included within individual business cases and Capital prioritisation process
Cydraddoldeb: Equality:	Included within individual business cases and Capital prioritisation process

APPENDIX 1

Revenue Consequences of Capital Schemes

The below table summarises the revenue consequences of capital schemes of which funding has been received in 2025/26:

Scheme	Total £'m	Additional £'m	Costs included in current budgets (replacements) £'m
AWCP			
Glangwili - Fire Enforcement works - Phase 2 - Fees	0.00	0.00	0.00
Backlog Maintenance - 2024-25	0.00	0.00	0.00
Diagnostic Equipment - WBH Fluro & Chilled Water Plant	0.00	0.00	0.00
Aberystwyth Sexual Assault Referral Centre	0.00	0.00	0.00
Block C, Picton Terrace, Carmarthenshire	Occupation expected to generate efficiencies of at least £100k through rationalisation of freehold and leasehold estate.		
Efab - Infrastructure	0.00	0.00	0.00
EOY Funding 24/25 - Pentre Awel	0.48	0.48	0.00
TEF - Fire	0.00	0.00	0.00
TEF - Infrastructure	0.00	0.00	0.00
TEF - Decarbonisation	0.00	0.00	0.00
TEF - Mental Health	0.00	0.00	0.00
TEF - Infection Prevention Control	0.00	0.00	0.00
TEF - Decontamination	0.00	0.00	0.00
DPIF (Digital Priorities Investment Fund) - RISP	Business Case approved by Board in 2023. Minimal additional revenue costs expected over the life of the contract.		
Digital Maternity Cymru System Programme 2025/26	Business Case approved by March '2025 Board. Project expected to generate a net revenue saving through cost avoidance / efficiency.		
Non-Radiology Ultrasound Replacement	0.08	0.00	0.08
Aseptic Unit, Withybush Hospital	Efficiencies of at least £0.033m will be generated		
Carmarthen Hwb - Equipment and Fit-out costs	0.45	0.45	0.00
Fishguard Health and Wellbeing Centre	Business case under development – revenue consequences of project not yet known		
Sub-total AWCP	1.01	0.93	0.08
Discretionary			
IT	0.00	0.00	0.00
Equipment	0.18	0.00	0.18
Estates – Statutory	0.00	0.00	0.00
Estates Infrastructure	0.00	0.00	0.00
Other	0.00	0.00	0.00
Sub-total Discretionary	0.18	0.00	0.18

TOTAL	1.19	0.93	0.26

The above table shows the total revenue costs as a consequence of capital expenditure in 2025-26 as £1.19m. Total additional costs are estimated at £0.93m and costs assumed to be included in current revenue budgets, as they are equipment replacements, totals £0.26m.

The following assumptions were made: -

- Medical Equipment replacement assumed at 10% of capital cost.
- Any Estates work to existing buildings are assumed to be revenue neutral unless the building footprint increases or changes significantly.
- Some capital investments will lead to longer term revenue savings (such as decarbonisation initiatives and digital investment); however, it has been assumed that these will be included as a part of directorate savings plans.

5 - PERFORMANCE

5.1 - INTEGRATED PERFORMANCE ASSURANCE REPORT

*Anthony Tracey
(Hywel Dda UHB -
Digital Director)*

| For assurance

Attachments

[IPAR M4 August 2025 FPC 26 August 2025.pdf](#)

[Appendix 1 IPAR Overview M4 August 2025.pdf](#)

[Appendix 2 EITS Thematic Review June and July 2025.pdf](#)



**PWYLLGOR CYLLID A PHERFFORMIAD
FINANCE AND PERFORMANCE COMMITTEE**

DYDDIAD Y CYFARFOD: DATE OF MEETING:	26 August 2025
TEITL YR ADRODDIAD: TITLE OF REPORT:	Performance Update for Hywel Dda University Health Board – Month 4 2025/2026
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Huw Thomas, Director of Finance In association with all Executive Leads
SWYDDOG ADRODD: REPORTING OFFICER:	Huw Thomas, Director of Finance

Pwrpas yr Adroddiad (dewiswch fel yn addas)

Purpose of the Report (select as appropriate)

Ar Gyfer Trafodaeth/For Discussion

**ADRODDIAD SCAA
SBAR REPORT**

Sefyllfa / Situation

This report relates to the Month 4, 2025/26 Integrated Performance Assurance Report (IPAR) which summarises progress against a range of national and local performance measures. The IPAR consists of this SBAR and the following supporting documents:

- IPAR overview – includes data, issues and actions for the health board's key performance improvement measures, attached as **Appendix 1**.
- IPAR dashboard – provides statistical process control (SPC) charts for each of our performance measures. The dashboard can be accessed via the Integrated Performance Assurance Report (IPAR) dashboard as of 31 July 2025 via our [internet site](#).

We have adopted the '3As assessment' approach to highlight either an alert, advise or assure status for each of our key performance metrics:

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

In addition to the IPAR submission, there is an Executive Improving Together Sessions (EITS) Thematic Report, attached as **Appendix 2**. This report summarises the EITS meetings held in June and July 2025 and outlines the key issues, actions and key achievements.

Please note:

- Ambulance red calls responses < 8 mins - due to [changes to the call categories](#) introduced in July 2025, this metric has been stood down. Two new metrics will be introduced in August by the Welsh Ambulance Service Trust and will be reported in M5 IPAR report.
- Referral To Treatment (RTT): data for the period April 2025 to June 2025 has been resubmitted to Welsh Government due to a slight under reporting of waits for physiotherapy and podiatry. This resulted in an addition of 500 patients per month to the overall waiting list. These patients have been waiting a relatively short time and therefore did not breach the RTT waiting times performance targets.
- Revised improvement trajectories are being developed since the appointment of 2 speciality and specialist doctors in June for % R1 appointments attended which were within their clinical target date or within 25% beyond their clinical target date. These are planned to be reported for the next Board meeting.
- The Audiology national data submission was originally planned for August 2025 however there is insufficient assurance around data quality as highlighted in a recent review. Data cleansing is required and will take considerable resources and time to achieve. The Clinical care group (CCG) are seeking Executive approval to either delay submission until early 2026 or send a provisional data submission with caveats to address the robustness of the data.
- Patient experience metrics - data for two additional measures from the new national survey have been added: 'I was able to communicate in my preferred language' and 'I have received a positive overall experience'.
- Dental access: Prompted by the Ministerial Delivery Expectations 2025/26, data for the percentages of children and adults regularly accessing NHS primary dental care within 24 months has been updated to March 2025.
- The sickness target has been revised to 6.6%, in-line with improvement against the 2024/2025 baseline.

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

Cefndir / Background

Welsh Government published the [2025/26 NHS Wales Performance Framework](#) in January 2025. The framework outlines the Ministerial priorities for this financial year, along with key targets.

Asesiad / Assessment

Performance overview

The table below summarises the latest position for the 2025/26 ministerial priorities and our local key performance metrics. Additional data, details of key issues and actions being taken to address all of the metrics above can be found in the supporting document *IPAR overview*.

Metric	Target	Period	Actual	Variation	Assurance	Trajectory	3A
Ambulance handovers > 1 hour Hywel Dda	0	Jul 2025	883	Concerning	Missing target	Trajectory missed by over 5%	Alert
Ambulance handover > 4 hours Hywel Dda	0	Jul 2025	243	Usual	Missing target	Trajectory missed by over 5%	Alert
% patients spending <4 hours in A&E/MIU Hywel Dda	95%	Jul 2025	72.1%	Usual	Missing target	n/a	Alert
Patients spending > 12 hours in A&E/MIU Hywel Dda	0	Jul 2025	1,211	Concerning	Missing target	n/a	Alert
Number of Pathways of Care delayed discharges	n/a	Jul 2025	211	Usual	n/a	Trajectory missed by over 5%	Alert
% R1 eyecare appts attended in target or 25% delay	95%	Jun 2025	64.0%	Concerning	Missing target	n/a	Alert
% child neurodevelopment assess waits <26 weeks	80%	Jun 2025	25.2%	Improving	Missing target	n/a	Alert
% adult psychological therapy waits <26 weeks	80%	Jun 2025	53.1%	Concerning	Missing target	n/a	Alert
Pts waiting 14 wks+ for specified therapy (Exc. Audiology)	0	Jul 2025	2,699	Concerning	Missing target	n/a	Alert
Financial in month deficit	n/a	Jul 2025	£2,646,000	Usual	n/a	Trajectory missed by over 5%	Alert
C. difficile: Number of confirmed cases (in-month)	8	Jul 2025	13	Usual	Hit and miss	n/a	Alert
E. coli: Number of confirmed cases (in-month)	21	Jul 2025	38	Usual	Hit and miss	n/a	Alert
% uptake of flu vacc - 65+ years	75%	Mar 2025	64.9%	n/a	n/a	n/a	Alert
% Autumn 2024 COVID booster uptake for eligible residents	75%	Feb 2025	45.7%	n/a	n/a	n/a	Alert
% Spring COVID booster uptake for eligible residents	75%	Jun 2025	39.0%	n/a	n/a	n/a	Alert
% children accessing dental within 24 months	n/a	Mar 2025	49.2%	Usual	n/a	n/a	Alert
% adults accessing dental within 24 months	n/a	Mar 2025	27.7%	Concerning	n/a	n/a	Alert
% pts on single cancer pathway within 62 days	75%	Jun 2025	61%	Usual	Missing target	Trajectory missed by over 5%	Advise
Pts waiting 8 wks+ for specified diagnostic	0	Jul 2025	3,481	Improving	Missing target	n/a	Advise
Waits over 52 weeks: new outpatient appointment	0	Jul 2025	116	Improving	Missing target	n/a	Advise
Patients waiting 104 weeks+ RTT	0	Jul 2025	198	Improving	Missing target	n/a	Advise
Patients waiting over 52 weeks RTT	0	Jul 2025	12,060	Improving	Missing target	n/a	Advise
S. aureus: Number of confirmed cases (in-month)	6	Jul 2025	13	Usual	Hit and miss	n/a	Advise
Pts 12yrs+ with diabetes receiving all 8 NICE care processes	n/a	Jul 2025	44.2%	Improving	n/a	n/a	Advise
Follow-up appts - delayed >100%	0	Jul 2025	17,011	Improving	Missing target	n/a	Advise
% sickness absence rate of staff	6.60%	Jul 2025	6.50%	Concerning	Hitting target	n/a	Advise
% therapy interven post LPMHSS assess (age 0-17)	80%	Jun 2025	80.0%	Improving	Hit and miss	n/a	Advise
% of children who are up to date with scheduled vaccinations by age 5	95%	Mar 2025	85.6%	n/a	n/a	n/a	Advise
% of children receiving HPV by age 15	90%	Mar 2025	74.1%	n/a	n/a	n/a	Advise
% of practices achieving National Access Standards	100%	Mar 2025	95.7%	n/a	n/a	n/a	Advise
% MH assess within 28 days (age 0-17)	80%	Jun 2025	90.4%	Improving	Hit and miss	n/a	Assure
% MH assess within 28 days (age 18+)	80%	Jun 2025	98.3%	Improving	Hit and miss	n/a	Assure
% therapy interven post LPMHSS assess (age 18+)	80%	Jun 2025	97.4%	Usual	Hitting target	n/a	Assure
Consultations delivered through PIPS	n/a	May 2025	2,627	Improving	n/a	Trajectory met	Assure

Triangulating our data: 1st April 2022 to 31st July 2025.

- **Quality safety and risk** – there was an increase in the number of incidents causing moderate harm or above reported by month in July 2025 with 168 compared to 166 in June. Numbers have been increasing since April 2025. The number of patient falls decreased slightly in July to 213 from 221 the previous month. Numbers have been static in the low 200s since February 2025. There was a decrease in medication errors recorded in July 2025, 104 compared to previous the month of 144. Six of these are severe level. We continue to have significant numbers of high and extreme risks on the risk register with 475 in July 2025. The number of new complaints received decreased slightly from the previous month to 200 in July. The number of new infection cases increased in July 2025 to 76. 37 of these cases were E. coli and 15 were S. aureus.
- **Workforce** – In month, staff sickness increased slightly to 6.3% in July 2025 from 6.0% in June. Long-term sickness was 4.4% and short-term sickness was 1.8%. Note: the sickness metric reported in the alert section of this SBAR includes 12 month rolling data. During July nursing and midwifery agency usage continued to decrease with 22.5 whole time equivalents (WTE).

Quality, safety and risk	Best		Worst	Latest	Trend
Reported incidents causing moderate harm or above	126		305	168	
Patient falls	189		301	213	
Medication errors	61		144	104	
Pressure damage developing or worsening during care	58		216	93	
New complaints by month received (ward level not available)	109		226	200	
Number of high and extreme risks (health board & function only)	379		491	475	
Infections: new cases	53		84	76	
Infections: C. difficile cases	9		23	14	
Workforce					
Number of staff/contractor related incidents	98		184	159	
Sickness - short term	1.7%		2.8%	1.8%	
Sickness - long term	3.3%		4.9%	4.4%	
Number of vacancies	To follow				
Staff turnover (12 month rolling)	7.3%		9.8%	7.5%	
Nursing and midwifery vacancies	To follow				
Nursing and midwifery agency (WTE)	56.33		379.79	56.33	
Bank (WTE)	212.99		352.85	318.47	

Argymhelliad / Recommendation

The Finance and Performance Committee is asked to **DISCUSS** the IPAR – Month 4 2025/2026 report and to **SEEK ASSURANCE** on the operational delivery of mitigating actions to improve performance in the areas that have been categorised as ‘alert’.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**

Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	2.1.1 The financial performance and delivery against Health Board financial plans and objectives and; • Give early warning of potential performance issues, • Make recommendations for action to continuously improve the financial position of the organisation, • Focus on the financial impact of in-year and medium-long term plans, the impact of financial issues on service delivery, quality and patient experience, and any specific issues where financial performance is showing deterioration or there are areas of concern. 2.1.2 The overall performance and delivery against Health Board plans and objectives, including delivery of key targets, giving early warning on potential performance issues and making recommendations for action to continuously improve the performance of the organisation and, as required focus on specific issues where performance is showing deterioration or there are issues of concern.
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Risks are outlined throughout the report
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	7. All apply
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	6. All Apply

Amcanion Strategol y BIP: UHB Strategic Objectives:	All Strategic Objectives are applicable
Amcanion Cynllunio Planning Objectives	All Planning Objectives Apply
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022	9. All HDdUHB Well-being Objectives apply

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	2025/2026 NHS Performance Framework
Rhestr Termiau: Glossary of Terms:	Contained within the body of the report
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Cyllid a Pherfformiad Parties / Committees consulted prior to Finance and Performance Committee:	Finance, Performance, internal Escalation process

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	Better use of resources through integration of reporting methodology
Ansawdd / Gofal Claf: Quality / Patient Care:	Use of key metrics to triangulate and analyse data to support improvement
Gweithlu: Workforce:	Development of staff through pooling of skills and integration of knowledge
Risg: Risk:	Better use of resources through integration of reporting methodology

Cyfreithiol: Legal:	Better use of resources through integration of reporting methodology
Enw Da: Reputational:	Yes
Gyfrinachedd: Privacy:	Not Applicable
Cydraddoldeb: Equality:	Not Applicable



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

Integrated Performance Assurance Report (IPAR) Overview

As at 31st July 2025

For further details see the 'System measures' section of the latest [IPAR dashboard](#).



Overview

[Key improvement measure summary](#)

Planned care

[Outpatients – new and follow-ups](#)

[Referral to treatment](#)

[Ophthalmology R1 \(high-risk patients\)](#)

Urgent and emergency care

[Ambulances – Hywel Dda](#)

[Emergency departments – Hywel Dda](#)

[Ambulances – Bronglais Hospital](#)

[Emergency departments – Bronglais Hospital](#)

[Ambulances – Glangwili Hospital](#)

[Emergency departments – Glangwili Hospital](#)

[Ambulances – Prince Philip Hospital](#)

[Emergency departments – Prince Philip Hospital](#)

[Ambulances – Withybush Hospital](#)

[Emergency departments – Withybush Hospital](#)

[Pathway of Care Delays \(PoCD\)](#)

Cancer

[Single cancer pathway](#)

Mental Health

[Mental health assessments within 28 days](#)

[Therapeutic interventions following primary mental health assessment](#)

[Psychological therapy waits](#)

[Neurodevelopmental assessment waits](#)

Diagnostics and therapies

[Diagnostic waits over 8 weeks](#)

[Therapy waits over 14 weeks](#)

Infections

[C. difficile and E.coli cases](#)

[S. Aureus](#)

Workforce and finance

[Staff sickness](#)

[Financial deficit](#)

Statistical process control (SPC) charts

[Why use SPC charts?](#)

[Anatomy of a SPC chart](#)

Page 385

[Natural variation within SPC charts](#)

[Understanding SPC icons](#)

This document summarises performance against our key improvement measures for 2025/26. This includes measures relating to our enhanced monitoring from Welsh Government, along with the Minister for Health and Social Care’s priorities for this financial year. We have also included measures for delayed ways of care, nurses in post and financial balance as these measures have a significant impact on our performance in other areas.

For data on all performance measures we are tracking, see our IPAR dashboard:
[Integrated Performance Assurance Report \(IPAR\) dashboard as at 31st July 2025](#)

Metric	Target	Period	Actual	Variation	Assurance	Trajectory	3A
Ambulance handovers > 1 hour Hywel Dda	0	Jul 2025	883	Concerning	Missing target	Trajectory missed by over 5%	Alert
Ambulance handover > 4 hours Hywel Dda	0	Jul 2025	243	Usual	Missing target	Trajectory missed by over 5%	Alert
% patients spending <4 hours in A&E/MIU Hywel Dda	95%	Jul 2025	72.1%	Usual	Missing target	n/a	Alert
Patients spending > 12 hours in A&E/MIU Hywel Dda	0	Jul 2025	1,211	Concerning	Missing target	n/a	Alert
Number of Pathways of Care delayed discharges	n/a	Jul 2025	211	Usual	n/a	Trajectory missed by over 5%	Alert
% R1 eyecare appts attended in target or 25% delay	95%	Jun 2025	64.0%	Concerning	Missing target	n/a	Alert
% child neurodevelopment assess waits <26 weeks	80%	Jun 2025	25.2%	Improving	Missing target	n/a	Alert
% adult psychological therapy waits <26 weeks	80%	Jun 2025	53.1%	Concerning	Missing target	n/a	Alert
Pts waiting 14 wks+ for specified therapy (Exc. Audiology)	0	Jul 2025	2,699	Concerning	Missing target	n/a	Alert
Financial in month deficit	n/a	Jul 2025	£2,646,000	Usual	n/a	Trajectory missed by over 5%	Alert
C. difficile: Number of confirmed cases (in-month)	8	Jul 2025	13	Usual	Hit and miss	n/a	Alert
E. coli: Number of confirmed cases (in-month)	21	Jul 2025	38	Usual	Hit and miss	n/a	Alert
% uptake of flu vacc - 65+ years	75%	Mar 2025	64.9%	n/a	n/a	n/a	Alert
% Autumn 2024 COVID booster uptake for eligible residents	75%	Feb 2025	45.7%	n/a	n/a	n/a	Alert
% Spring COVID booster uptake for eligible residents	75%	Jun 2025	39.0%	n/a	n/a	n/a	Alert
% children accessing dental within 24 months	n/a	Mar 2025	49.2%	Usual	n/a	n/a	Alert
% adults accessing dental within 24 months	n/a	Mar 2025	27.7%	Concerning	n/a	n/a	Alert
% pts on single cancer pathway within 62 days	75%	Jun 2025	61%	Usual	Missing target	Trajectory missed by over 5%	Advise
Pts waiting 8 wks+ for specified diagnostic	0	Jul 2025	3,481	Improving	Missing target	n/a	Advise
Waits over 52 weeks: new outpatient appointment	0	Jul 2025	116	Improving	Missing target	n/a	Advise
Patients waiting 104 weeks+ RTT	0	Jul 2025	198	Improving	Missing target	n/a	Advise
Patients waiting over 52 weeks RTT	0	Jul 2025	12,060	Improving	Missing target	n/a	Advise
S. aureus: Number of confirmed cases (in-month)	6	Jul 2025	13	Usual	Hit and miss	n/a	Advise
Pts 12yrs+ with diabetes receiving all 8 NICE care processes	n/a	Jul 2025	44.2%	Improving	n/a	n/a	Advise
Follow-up appts - delayed >100%	0	Jul 2025	17,011	Improving	Missing target	n/a	Advise
% sickness absence rate of staff	6.60%	Jul 2025	6.50%	Concerning	Hitting target	n/a	Advise
% therapy interven post LPMHSS assess (age 0-17)	80%	Jun 2025	80.0%	Improving	Hit and miss	n/a	Advise
% of children who are up to date with scheduled vaccinations by age 5	95%	Mar 2025	85.6%	n/a	n/a	n/a	Advise
% of children receiving HPV by age 15	90%	Mar 2025	74.1%	n/a	n/a	n/a	Advise
% of practices achieving National Access Standards	100%	Mar 2025	95.7%	n/a	n/a	n/a	Advise
% MH assess within 28 days (age 0-17)	80%	Jun 2025	90.4%	Improving	Hit and miss	n/a	Assure
% MH assess within 28 days (age 18+)	80%	Jun 2025	98.3%	Improving	Hit and miss	n/a	Assure
% therapy interven post LPMHSS assess (age 18+)	80%	Jun 2025	97.4%	Usual	Hitting target	n/a	Assure
Consultations delivered through PIPS	n/a	May 2025	2,627	Improving	n/a	Trajectory met	Assure

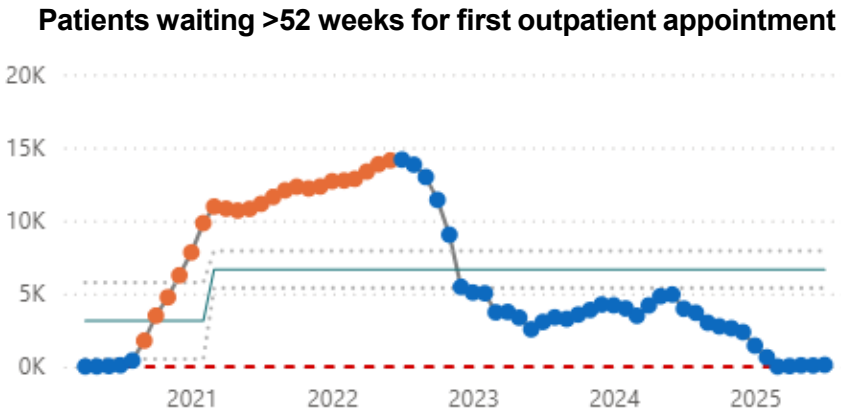
Alert
(may require discussion)
There is a lack of confidence that any action in place is sufficient to address the issue satisfactorily and/or within the scope of the operational team or executive to resolve. Engagement, action or intervention required.

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

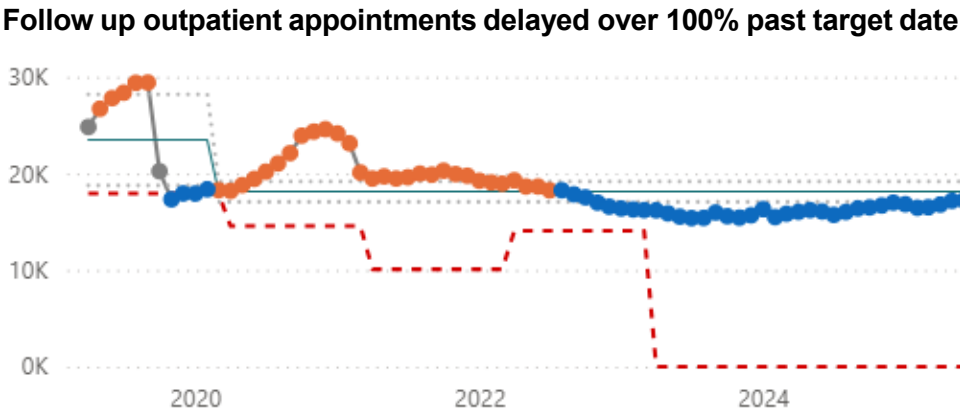
Assure
(to note)
There is confidence that actions are robust and will be sufficient to address the issue or generally operating effectively. Routine monitoring.

Key

- Improving variation
- Usual variation
- Concerning variation
- Upper and lower limits
- Mean
- Target
- Ambition



Breaches have risen for four consecutive months to 116 in July 2025. Breaches are within geriatric and general medicine (82), and ophthalmology (34).



Follow ups delayed over 100% of their target date reduced to 17,011 in July 2025.

Key challenges / issues

- July 2025, 52-week outpatient breaches are in elderly care and general medicine, driven by ongoing osteoporosis capacity issues; and ophthalmology due to requirement to prioritise urgent patients due to sickness and clinical vacancies. Recovery plans are in development for Quarter 2 (Q2).
- 52-week outpatient waits have significantly reduced from the June 2024 peak (4,930). Most specialties are expected to maintain targets, with recovery funding prioritised for ENT, Neurology, and Rheumatology.
- Active management and triage of referrals has resulted in no waiting list growth, whilst a large reduction in 36-week new outpatient breaches since June 2024 signifies positive indications for further recovery in future.
- Initiatives for reducing new outpatient waits have increased follow-up waits as more patients progress through pathways.

Key actions / initiatives

- 52-week outpatient target met in July 2025 across all specialties except general medicine and elderly care and ophthalmology; Q2 plans aim to clear remaining breaches by September.
- Outpatient Transformation programme in place, with targeted actions for each specialty covering all National Planned Care Programme priorities, including referral management, clinical triage, and maximising the use of self-management pathways like See on Symptoms (SoS)/Patient Initiated Follow Up (PIFU).
- Delayed follow-up wait reduction to below 9,000 supported by national clinical leadership and CIN (Clinical Implementation Network) guidelines.
- 2025/26 demand and capacity plans used within all Planned Care services and aim for zero patients waiting over 36 weeks in key specialties, optimising capacity and forecasting.
- Local plan to deliver 15k+ additional appointments contributes to NHS Wales' goal of reducing outpatient waits by 200,000 by March 2026, with a focus on reducing breaches to 26 weeks in most specialties.

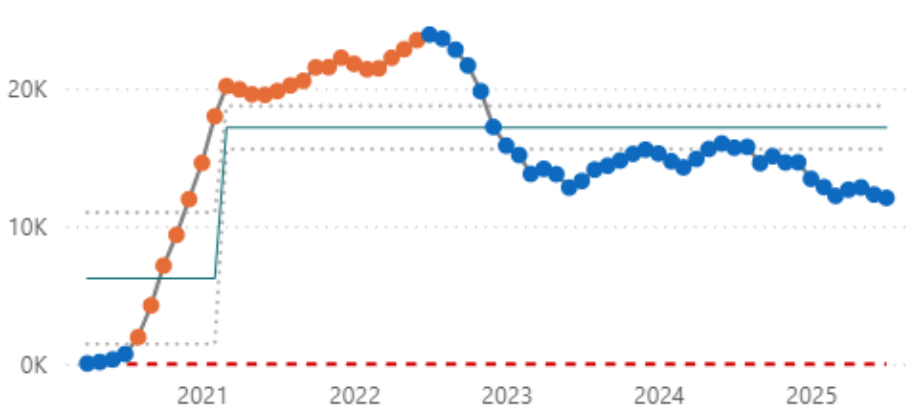
Due date

- 30/09/25
- 31/03/26
- 31/03/26
- 31/03/26
- 31/03/26

Key

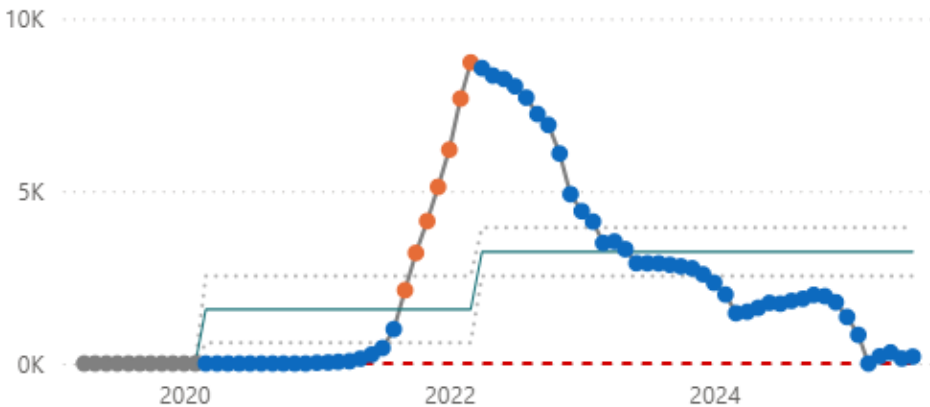
- Improving variation
- Usual variation
- Concerning variation
- Upper and lower limits
- Mean
- Target
- Ambition

Patients waiting over 52 weeks from referral to treatment



Performance shows improving variation with 12,060 breaches in July 2025, the lowest number of breaches since December 2020.

Patients waiting over 104 weeks from referral to treatment



Improving performance is showing, however, target (0) has not been met for four months. July 2025 shows 198 breaches, which are mainly within orthopaedics (101) and ENT (60).

Key challenges / issues

- Most specialties, including large volumes of Cataracts and Arthroplasty, are on track to recover by end of Quarter 2 (Q2), but ENT and Ophthalmology face risks due to theatre staffing and cancellations.
- July 2025 breaches are mainly due to limited theatre capacity and ongoing challenges with staffing and funding.
- Patient complexity and co-morbidities affect suitability for outsourced or day-case procedures, impacting treatment timelines.
- Getting It Right First Time (GIRFT) ambitions are influenced by clinical confidence and pre-op process variations across specialties.
- Additional risks include prioritisation of cancer backlogs, regional vascular capacity issues, and urgent cases consuming rescheduled theatre slots.
- Inpatient/day case activity exceeds pre-pandemic levels, but challenges remain with late starts, early finishes, and fallow lists due to workforce constraints.
- 99.9% of Hywel Dda patients will be treated within two years, with a 16% reduction in 36-week RTT breaches since June 2024.

Key actions / initiatives

- Recovery plans in ENT and Ophthalmology (Ocular Plastics) include insourcing theatre staff, outsourcing tonsillectomies, and additional lists to address Quarter 1 (Q1) backlogs.
- Orthopaedic recovery plan targets resolution of Q1 breaches by September 2025.
- Focus on maintaining waiting time targets in 2025/26 using demand and capacity forecasts to highlight risks and guide funding allocation.
- Theatre Optimisation workstream led by the Clinical Care Group aims to improve productivity and meet GIRFT standards across specialties.
- Recovery plans in general medicine and care of the elderly include doctor onboarding and Fracture Liaison Services (FLS) nursing support to address Q1 backlogs.

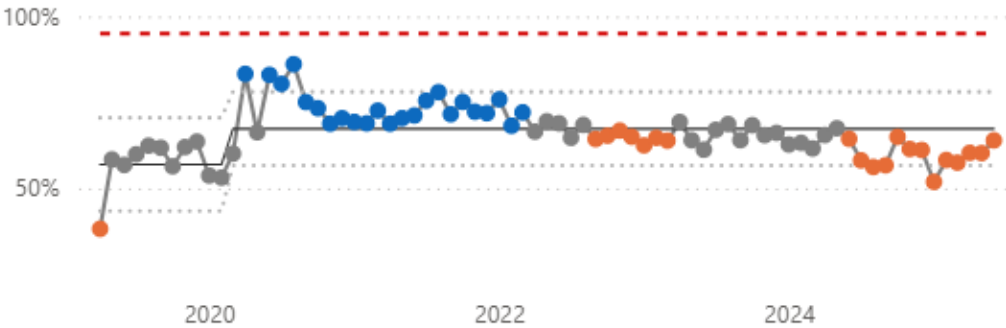
Due date

- 30/09/25
- 30/09/25
- 31/03/26
- 31/03/26
- 30/09/25

Key

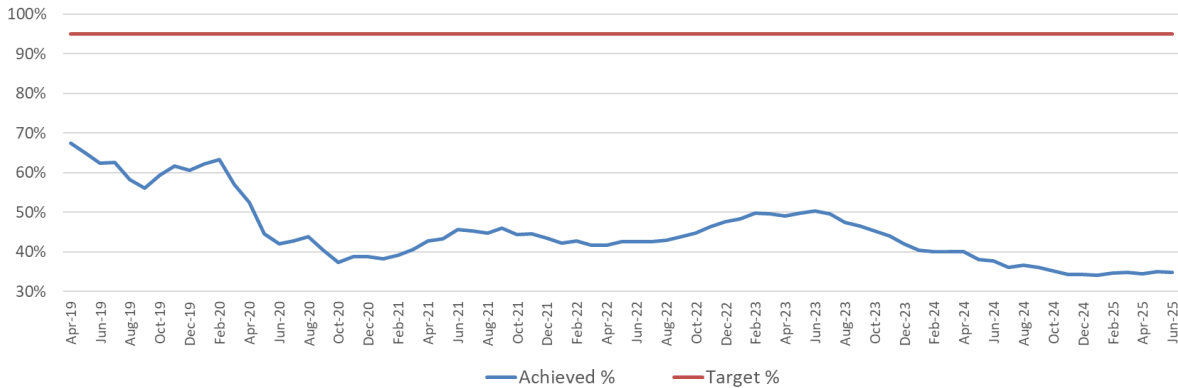
- Improving variation
- Usual variation
- Concerning variation
- Upper and lower limits
- Mean
- Target
- Ambition

% R1 appointments attended which were within their clinical target date or within 25% beyond their clinical target date



Data shows concerning variation in June 2025, with 1,118 out of 1,748 (64%) high-risk (R1) patients attending appointments within a 25% delay to their target date (Target = 95%). June’s data is the best recorded since October 2024.

% R1 patients waiting within their clinical target date or within 25% beyond their clinical target date

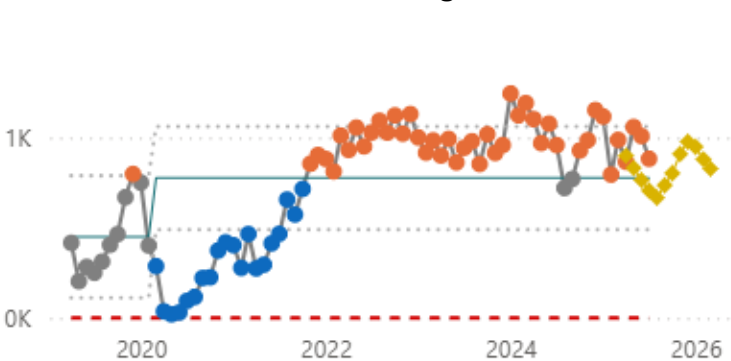


In June 2025, 6,483 out of 18,583 (34.9%) high-risk (R1) patients were waiting within a 25% delay to their clinically assigned target date (Target = 95%). Performance has been steady at between 34.2% and 35.1% since October 2024.

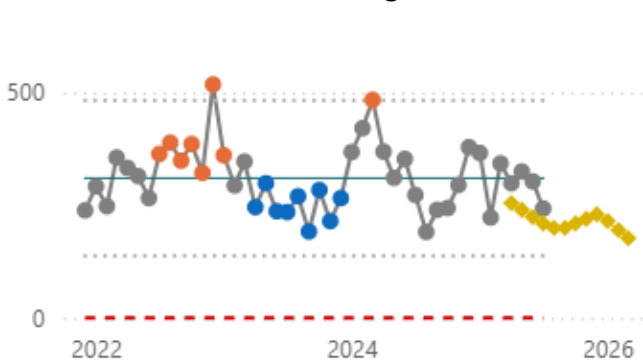
Key challenges / issues	Key actions / initiatives	Due date
- Gaps in Specialty and Specialist (SAS) doctor rotas continue, affecting clinic delivery. 3 SAS doctors are onboarding. Additional duty hours continue to cover emergency work. - Recruiting to the consultant posts is historically challenging. The solution to develop 2 regional posts via a Situation, Background, Assessment and Recommendation (SBAR) report has been approved by the Clinical Care Group (CCG). - Recruitment to the posts identified in the Eye Care Measures (R1) SBAR has been approved. Waiting list initiatives (WLI) for R1 delivery continue and Intravitreal Injections continue to be supported by an outsourcing contract. - Reduced clinics due to gaps in workforce continue. Where possible additional WLI clinics are delivered. - Clinic delivery continues to be restricted due to estates. Reducing sites and increasing delivery on fewer sites will ensure staff can be trained and properly supervised to work to the top of their licence.	The 2 consultant regional posts have been submitted to Financial Control Sub-Group (FCSG) for approval.	13/08/25
	There are 3 SAS doctors currently onboarding.	30/11/25
	1 SAS post has gone to FCSG for agency to help deliver services whilst SAS posts are onboarding.	13/08/25
	Regional solutions for Age Related Macular degeneration (AMD), Glaucoma, Cataract and Vitreoretinal sub-specialties continues to be worked through with actions from each sub-specialty meeting to develop services.	31/11/25
	Protected R1 capacity continues and additional R1 delivery has been secured through WLI.	Completed
	The additional posts for the increased delivery of the Intravitreal pathway advertised on Trac recruitment system.	31/11/25
	Internal solutions for Intravitreal injections (IVT) delivery continue to assist with delivery.	31/03/26
	External outsourcing for IVT delivery continues whilst the workforce is recruited to develop sustainable services.	31/03/26
	External solutions for cataract delivery continue to maintain the 104 week wait.	31/03/26
	Insourcing delivery of Vitreoretinal and Glaucoma patients has commenced.	04/08/25

Key
● Improving variation
● Usual variation
● Concerning variation
-- Upper and lower limits
— Mean
— Target
● Ambition

Ambulance handovers taking over 1 hour

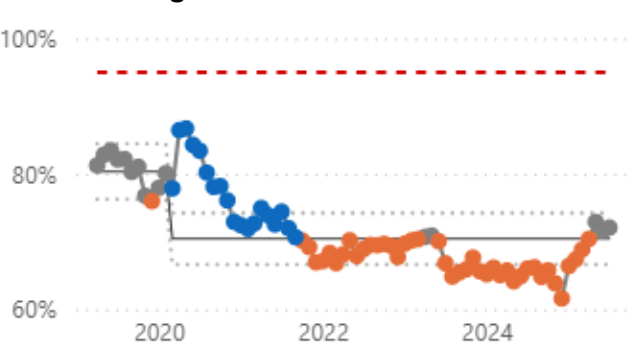


Ambulance handovers taking over 4 hours

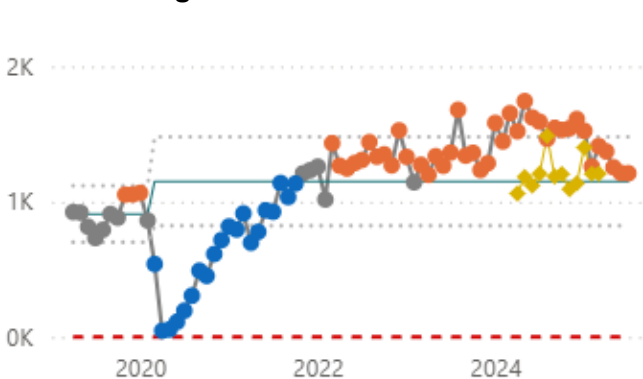


>1 hour handovers:
Latest data is showing concerning variation
883handovers > 1 hour out of a total of 2,188 handovers.
>4 hours handovers:
Latest data is showing common cause (expected)
variation. 243 handovers > 4 hour out of a total of 2,188,
11%.

Patients waiting less than 4 hours in A&E/MIU



Patients waiting over 12 hours in A&E/MIU



Waits < 4 hours:
Latest data is showing common cause (expected)
variation.
72% of patients were seen within 4 hours, 11,927 out of
16,548 new attendances.
Waits > 12 hours:
Latest data is showing cause for concern variation.
1,211 patients waited over 12 hours, out of 16,548 new
attendances, 7%.

Key actions / initiatives – tactical urgent and emergency programme

Due date

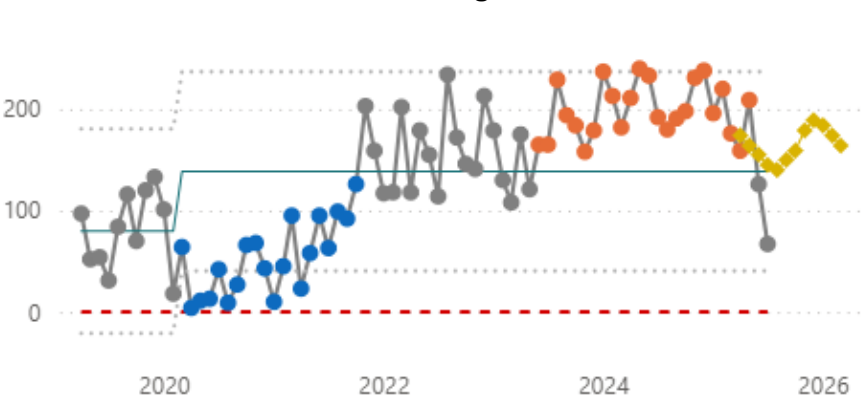
In response to long-standing performance challenges within Urgent and Emergency Care (UEC) which has resulted in sub-optimal patient experience and performance, the Executive Team has issued a series of instructions to be enacted at pace (by October 2025) in order to deliver a step change improvement, known as the UEC Accelerated Transformation Programme. The primary aim of the programme is to minimise attendance at an ED by providing appropriate, alternative pathways for patients.

- Please see the updates for each of our 4 acute site for the relevant issues faced and key actions we are taking to address:
- [Bronglais Hospital](#)
 - [Glangwili Hospital](#)
 - [Prince Philip Hospital](#)
 - [Withybush Hospital](#)

Key

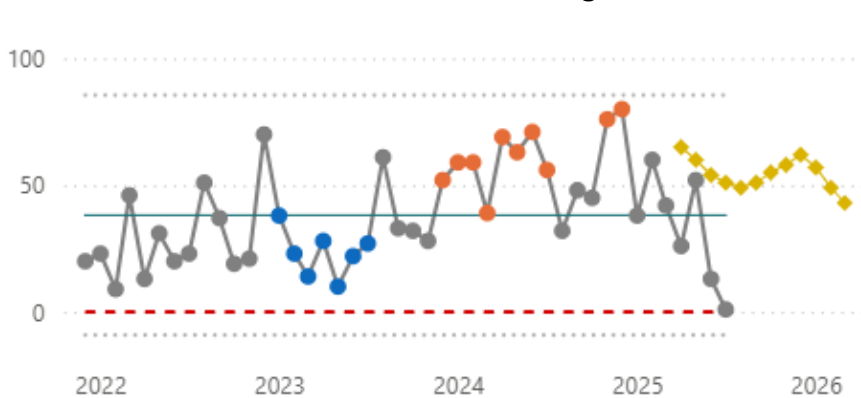
- Improving variation
- Usual variation
- Concerning variation
- Upper and lower limits
- Mean
- Target
- Ambition

Ambulance handovers taking over 1 hour



Latest data is showing common cause (expected) variation.
67 handovers >1 hours reported out of a total of 377 handovers, 18%.

Ambulance handovers taking over 4 hours



Latest data is showing common cause (expected) variation.
1 handover >4 hours was reported out of 377 total handovers 0.3%.

Key challenges / issues

- Rapid Assessment and Treatment (RAaT) provision can be impacted by lack of nursing staff to support the area – it is recognised that the majority of ambulance red release calls are almost always supported.
- Reduced capacity and patients in corridor within the ED is a regular occurrence due to limited flow through the system.
- Surge capacity and boarding opportunities are in situ across the acute site to support timely ambulance handover. Space however, is limited.
- Ongoing staffing challenges.
- Self-presenters can be prioritised based on clinical acuity.

Key actions / initiatives

- Dedicated RAaT provision at the front door enabling timely assessment – nursing model needs signing off by Executive Team.
- Review of current discharge and flow pathways with proposal for full revamp of Porth Gofal and patient flow processes encompassing a number of Quality Improvement projects.
- 45 minute ambulance handover – action plan processes in place now (RAaT/Short Stay Triage) to ensure handovers take place within expected timeframe.
- Establish accelerator team to focus on discharges – escalation of delays to System General Manager.
- Launch "Your Next Patient." This patient flow model schedules two moves every hour from the emergency department to specialty wards where possible.
- Criteria Led Discharge – pilot on ward to be agreed and undertaken as Quality Improvement project.
- Engage with Welsh Ambulance Service Trust on pre alert and redirection criteria/no convey protocols. Aim is to redirect patients to prevent arrivals at hospital.
- Health Board Operational Delivery Group currently developing robust plan to deliver an operational 7 days per week. Operational Delivery Unit (ODU) to focus on handover delays across the Health Board.
- Y Bwa continues to support site pressures following decant of Meurig ward, review has been undertaken to establish model of care. Expectation is to maintain use of Y Bwa.
- Surge capacity and boarding available as part of escalation actions.
- Short Stay area within the Emergency Department is not being bedded to ensure continuation of flow.
- Daily Delaye

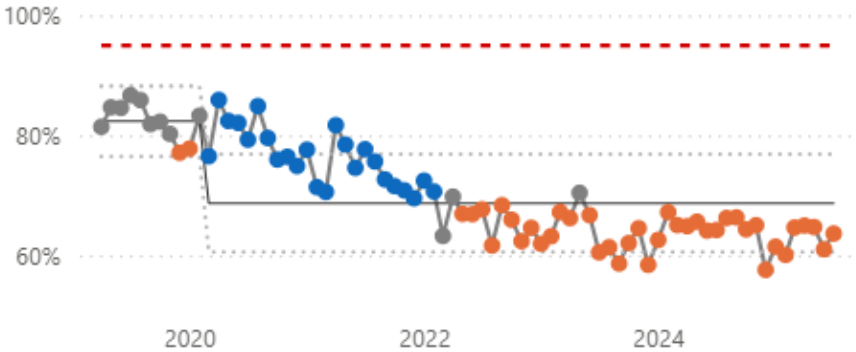
Due date

- 01/10/25
- 31/09/25
- 01/10/25
- 01/09/25
- 01/10/25
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- 01/10/25
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- Live
- Live
- Live
- Live

Key

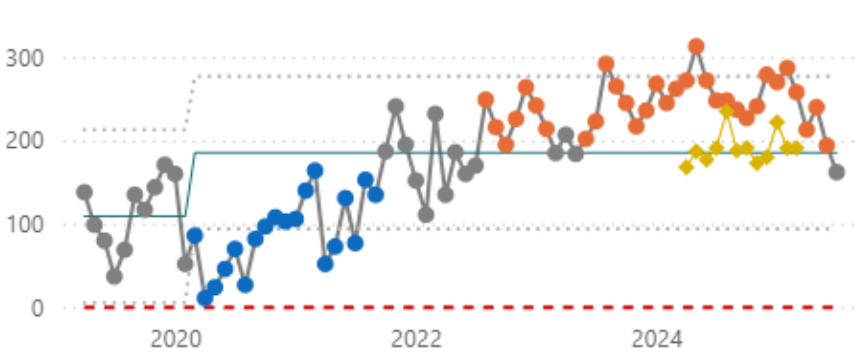
- Improving variation
- Usual variation
- Concerning variation
- Upper and lower limits
- Mean
- Target
- Ambition

Patients waiting less than 4 hours in A&E



64% reported for July, 995 breaches out of 2,739 new attendances. Chart is showing a concerning performance trend.

Patients waiting over 12 hours in A&E



162 breaches out of 2,739 new attendances, 6%. The chart is showing common cause (expected) variation

Key challenges / issues

- 4 hours waits continue to be a challenge and are related to the constraints outlined in relation to the 1 and 4 hour ambulance handover position.
- High number of clinically optimised patients across the acute site.
- High inpatient acuity.
- Delays in, earlier in the day discharges, this can be due to additional investigations being requested, awaiting doctor review, transport etc.
- Limited opportunities to board and surge. Boarding options are now regular surge areas. Boarding protocols (where patients are moved to wards early where discharges and query discharges are predicted). Surge beds are opened to meet increased demand.
- Pathway of Care delays at BGH – for July census count there were a total of 22 patients delayed, with the top 3 themes relating to “Awaiting completion of assessment by social care” and “Awaiting completion of best interest decision” and “Awaiting continuing health care assessment.”

Key actions / initiatives

- Health Board Medical stabilisation task and finish group established to review current medical rotas. BGH ED is one of the priority areas.
- Optimal Hospital flow workstreams across Ceredigion System, focus on reduction of delays, early moves to ED, early discharges from wards and clinical decisions unit . Reduction of Pathway of Care Delays
- Flow ownership (Flow Champion to be established) – from whiteboard to ward
- Training to be delivered by informatics on accuracy of data. Awaiting roll out.
- Clinical Streaming Hub 5 days a week, with view to expand to 7 days
- Same day urgent care model to be explored for Aberaeron and Aberystwyth
- RAaT model in place supporting circa 10 attenders a day.
- Boarding policy operational
- Short Stay assessment in place – no bedding rule being adhered to.
- North Outreach Team attending Board Rounds on the acute site. Integration with Frailty//ED and Acute Medics to proactively pull patients for digital ward.
- Senior Leadership presence to support actions to reduce delays.
- Board rounds

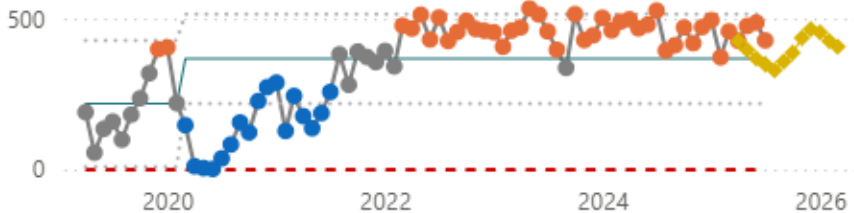
Due date

- 01/10/25
- 01/10/25
- 01/10/25
- 01/10/25
- 01/11/25
- 01/12/25
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- Live

Key

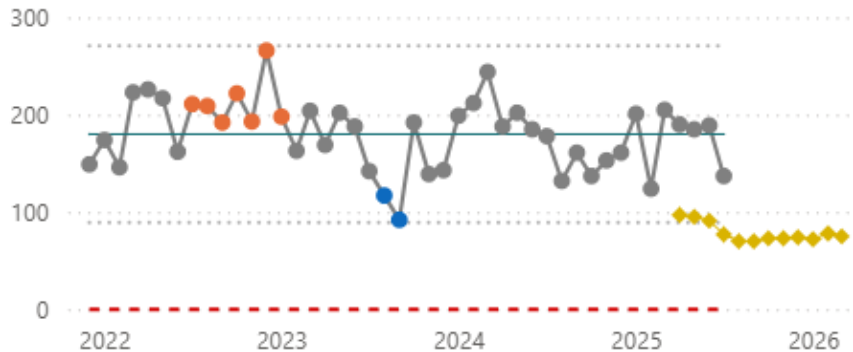
- Improving variation
- Usual variation
- Concerning variation
- Upper and lower limits
- Mean
- Target
- Ambition

Ambulance handovers taking over 1 hour



Latest data is showing concerning variation. 428 handovers >1 hours reported out of a total of 866 handovers, 49%.

Ambulance handovers taking over 4 hours



Latest data is showing common cause (expected) variation. 137 handovers >4 hours reported out of a total of 866 handovers, 16%.

Key challenges / issues

- Patient flow from the Emergency Department (ED) continues to remain challenging with high acuity and high volume of patients awaiting a ward bed who are held in the ED.
- High volume of ambulance attenders presenting at front door with delays experienced due to patient flow challenges.
- Surge capacity around nursing bay limits handover space availability.
- Acuity of self-presentations can often need to be prioritised clinically.
- Provision of numerous specialty pathways for patients across the Health Board.
- High acuity of ambulance presenters not being fit to sit.
- Advanced Paramedic Practitioner (APP) fill rates are below 100% due to resource being required at scenes.
- Despite boarding policy in place on daily basis, flow continues to be challenging with all ward areas on full surge on ward and treatment areas.

Key actions / initiatives

- Health Board Repatriation Document to be developed and agreed at Clinical Care Group.
- Expansion of Same Day Emergency Care (SDEC) footprint with capital funding, with weekly project group in place.
- Health Board Operational Delivery Group currently developing robust plan to deliver an operational 7 days per week Operational Delivery Unit (ODU) to focus on handover delays across the Health Board.
- Review of perfect week initiatives to be evaluated with a view to identify potential funding sources.
- Continued focus on achieving 15 minute handover for ambulance attenders.
- Development and Implementation of "Your Next Patient" Standard Operating Procedures to ensure that each patient arrives at the right ward, at the right time and under the care of the most appropriate team.
- Rapid assessment pitstop staffed by triage trained nurses.
- Boarding policy active on daily basis to create early flow against discharges

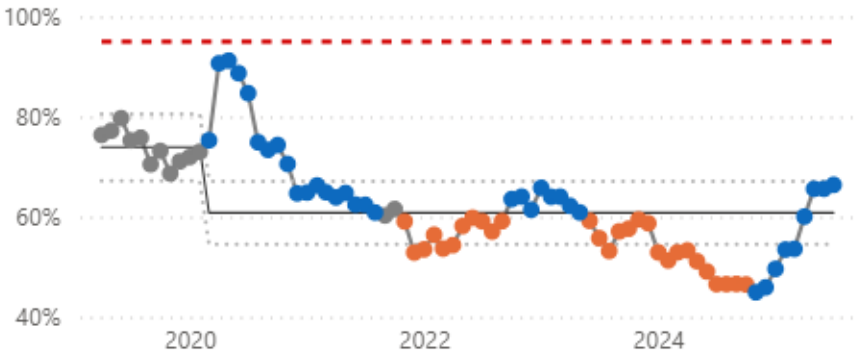
Due date

- 30/09/2025
- 30/03/2026
- 31/10/2025
- 31/08/2025
- 31/08/2025
- 30/09/2025
- Live
- Live

Key

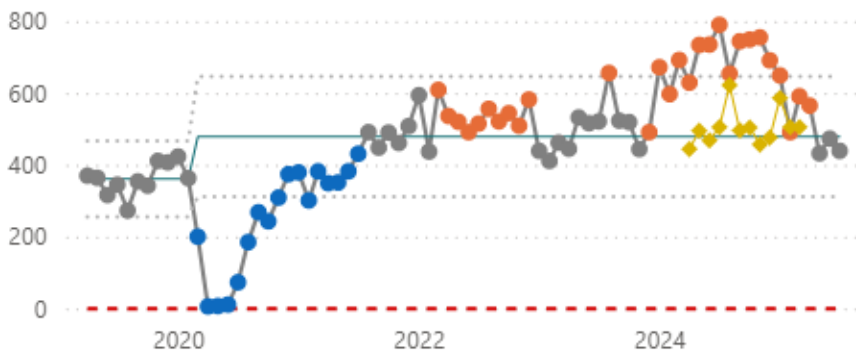
- Improving variation
- Usual variation
- Concerning variation
- Upper and lower limits
- Mean
- Target
- Ambition

Patients waiting less than 4 hours in A&E



66% reported for July, 1,703 breaches out of 5,068 new attendances. Chart is showing improving performance trend.

Patients waiting over 12 hours in A&E



439 breaches out of 5,068 new attendances, 9%. Chart is showing common cause (expected) variation.

Key challenges / issues

- Increasing volume of attenders seen through Glangwili Front door with limited capacity for see and treat rooms due to large volume of patients awaiting beds in the Hospital.
- Data quality around breach validation is improving and has contributed to the improved performance on the 4 hour target.
- Patient flow from the Emergency Department continues to remain challenging with high acuity and high volume of patients awaiting a bed contributing to 12 hour performance.

Key actions / initiatives

- Front door proposal discussions ongoing as to options to maximise throughput through Same Day Emergency Care/ Acute Medical Assessment Unit (AMAU) facility. Weekly project team in place.
- Teifi Trauma Ambulatory Care Unit pilot data to be reviewed with consideration to operationalising as daily practice.
- Reviewing revised staffing model to deliver 7 day Same Day Emergency Care and Clinical Streaming Hub Models.
- Rapid triage and assessment in place by Senior ED Clinician where possible to enable early senior decision making and turnaround.
- Medical and Surgical SDECs fully functional and accepting GP and Emergency Department referrals.
- Development and implementation of "Your Next Patient" to decant from ED when able to do so.

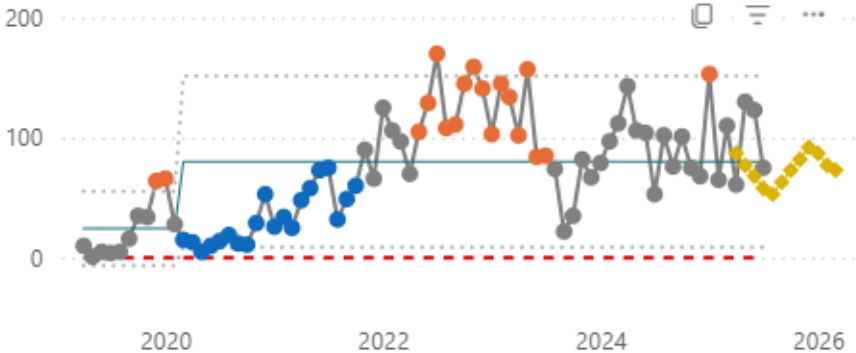
Due date

- 31/03/2026
- Daily/
30/09/2025
31/10/2025
- Live
- Live
- 30/09/2025

Key

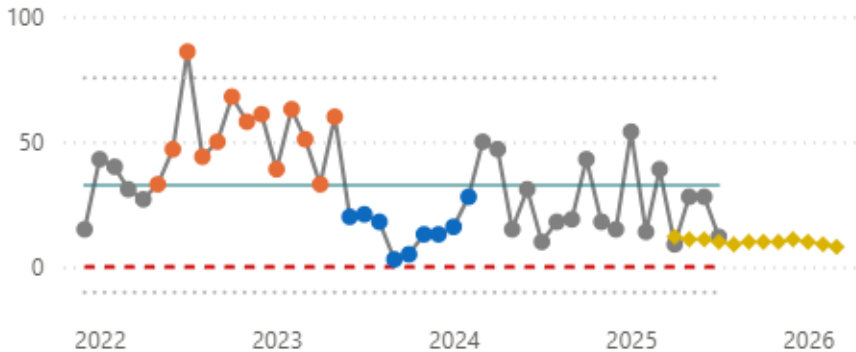
- Improving variation
- Usual variation
- Concerning variation
- Upper and lower limits
- Mean
- Target
- Ambition

Ambulance handovers taking over 1 hour



Latest data is showing common cause (expected) variation. 75 handovers >1 hours reported out of a total of 234 handovers, 32%.

Ambulance handovers taking over 4 hours



Latest data is showing common cause (expected) variation. 12 handovers >4 hours reported out of a total of 234 handovers, 5%.

Key challenges / issues

- Continued 'Front Door ' pressures resulting in very limited capacity due to continuing IP & C issues (infection, prevention and control) which reduces the ability to surge in areas we would normally. Ambulances conveying to the site during July decreased slightly resulting in our 1 hour handover performance improving.
- Prioritisation of medical patients in MIU to come across to AMAU remains which limits capacity for ambulances. This is further compounded by patients being admitted from SDEC and self presenting GP referrals.
- Across Carmarthenshire- Advanced Paramedic Practitioner fill rate within the Clinical Streaming Hub remains a challenge and as a result, acute site does experience an increase in ambulance conveyances.
- Boarding protocols (where patients are moved to wards early where discharges and query discharges are predicted) initiated at site escalation points through patient flow meetings and manager of the day escalation although patient flow out of hospital continues to be compromised with limited community bed availability.

Key actions / initiatives

- SDEC (Same Day Emergency Care) supporting AMAU/MIU to reduce pressure at the front door. Weekend cover is also being scoped when required during busy periods and staffing levels allow.
- Front Door Model (where patients needs are identified via a multidisciplinary team) is operational to expedite discharge home including interface frailty service.
- Health Board Operational Delivery group currently developing plans to deliver a 7 Day model to focus on whole system flow with senior decision making. PPH is included in these plans which are currently going through our financial approval process.
- Immediate ambulance release requests are almost always supported
- All ward areas operate a full capacity with additional patients in surge areas to maintain flow when required
- Clear communication channels with the Operational Delivery Unit (ODU) in the WAST to support decision making with a view to minimise risk as part of hospital flow. WAST attend our bed flow meetings.

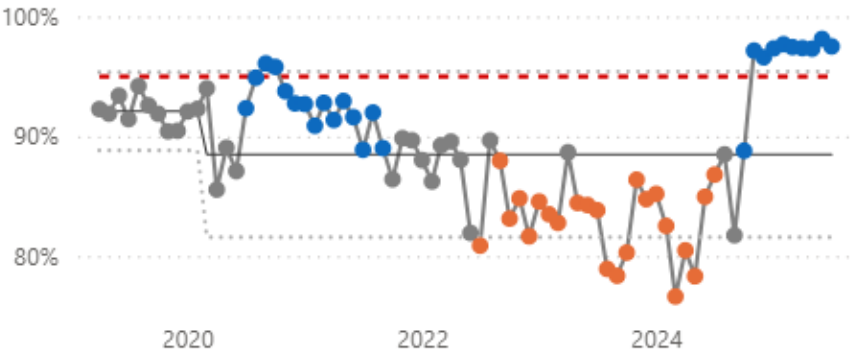
Due date

- 30/09/25
- 30/09/25
- 31/10/25
- Live
- Live
- Live

Key

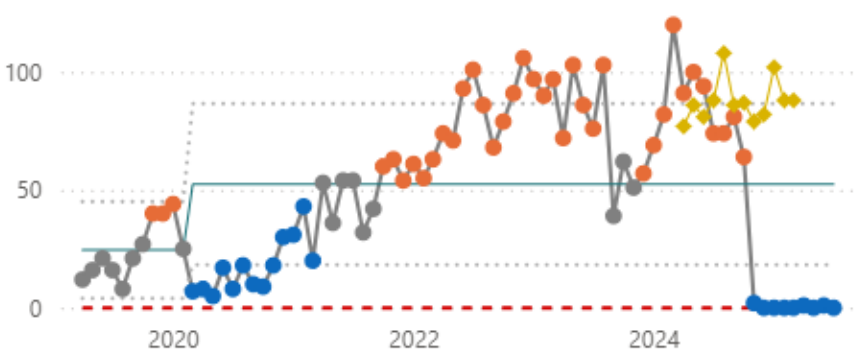
- Improving variation
- Usual variation
- Concerning variation
- Upper and lower limits
- Mean
- Target
- Ambition

Patients waiting less than 4 hours in MIU



98% reported for July, 65 breaches out of 2,606 new attendances. Chart is showing improving variation performance trend

Patients waiting over 12 hours in MIU



Zero breaches out of 2,606 new attendances. Chart is showing improving performance trend.

Key challenges / issues

- Our Minor Injury Unit (MIU) new patient attendances has returned to similar levels prior to closing overnight (November 24) but there is a significant drop in patients presenting with a major complaint within that total- Only 19% of patients who presented had a medical complaint. Patients who require admission following triage are handed over to the medical team in AMAU ward. Our 4 hour performance remains high
- Patients who are medically optimised, who are no longer requiring medical intervention needing discharge support due to complex needs remains a challenge with around 40 patients per day. This does have an impact on patient flow throughout the hospital resulting in delays in patients in MIU who require an inpatient bed

Key actions / initiatives

- Newly appointed locum consultant for SDEC supports weekly hot clinics. This allows for prompt treatment of patients through SDEC which supports flow and admission avoidance.
- Consultant Connect being introduced to use operationally within SDEC to further support effectiveness of the department. Go Live Aug 25-this commences end of Aug which will allow direct contact into medical doctor in SDEC for advice/referrals.
- Ongoing work with community colleagues on early discharge planning. Use of hospital @ home to create a wraparound service enabling community GPs to refer directly into SDEC, to treat and then refer patients back into hospital @ home support admission avoidance. Recent data has shown little numbers requiring an inpatient stay and are supported in their home.

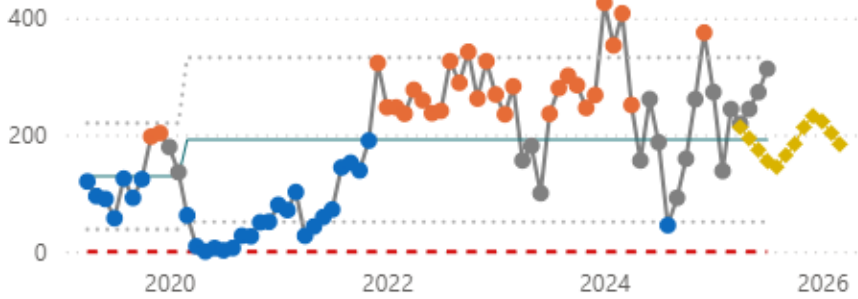
Due date

- 31/8/25
- 31/8/25
- Live

Key

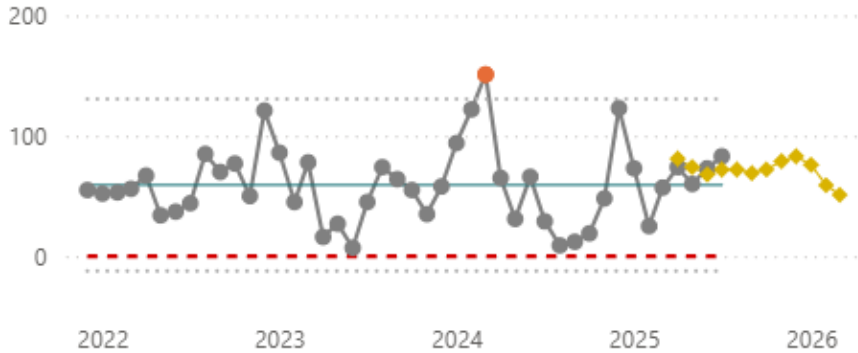
- Improving variation
- Usual variation
- Concerning variation
- Upper and lower limits
- Mean
- Target
- Ambition

Ambulance handovers taking over 1 hour



Latest data is showing common cause (expected) variation. 313 handovers >1 hour reported out of a total of 711 handovers, 44%.

Ambulance handovers taking over 4 hours



Latest data is showing common cause (expected) variation. 93 handovers >4 hours reported out of a total of 711 handovers, 11%.

Key challenges / issues

- WGH have found it very challenging to handover the ambulances in a timely manner.
- The ED remains over crowded and pressurised with lack of space to see and treat patients.
- The acuity of the walk-in patients at times are higher than some of the patients being conveyed by the ambulance, which means these patients will take clinical priority over the patients in the ambulances.
- Poor patient flow out of the department to the wards.
- Patients attend the department that should be seen by alternate health care professionals in the community.
- Increase pressure in ED noted from patients requiring mental health support.
- There have been some senior workforce challenges.
- Infection Prevention and Control (IP&C) constrains delaying flow out of the département.

Key actions / initiatives

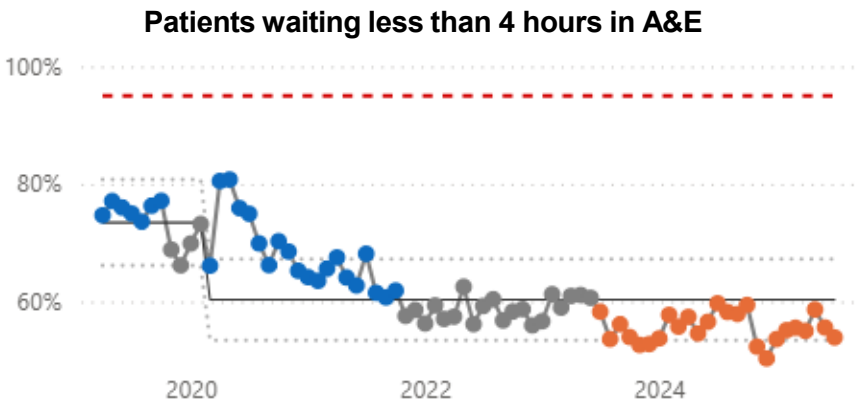
- Launching the "Your "Next Patient" initiative, 2 patients transferred from ED to the wards before 10am
- New initiative of handing over the ambulances within 45mins
- Prioritising early discharge, utilising the discharge lounge to full capacity
- Setting up a joint planning meeting with WGH and Welsh Ambulance Service Trust, to review and learn from each other
- Re –design of the daily clinical and operational oversight teams

Due date

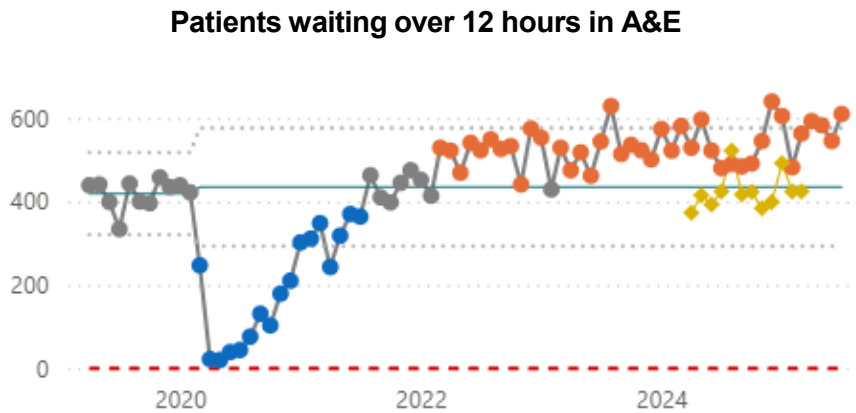
- 01/09/25
- 01/10/25
- 01/09/25
- 01/10/25
- 01/09/25

Key

- Improving variation
- Usual variation
- Concerning variation
- Upper and lower limits
- Mean
- Target
- Ambition



54% reported for July, 1,833 breaches out of 3, 976 new attendances. Chart is showing a concerning performance trend.



610 breaches out of 3,976 new attendances, 15%. Chart is showing concerning performance trend.

• Key challenges / issues

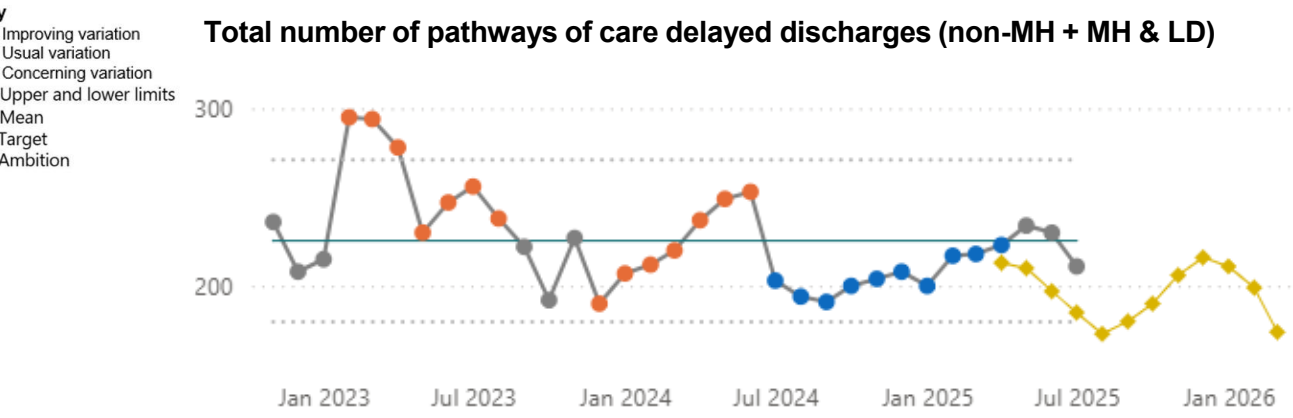
- WGH have too many medical patient waiting in ED for in-patient beds.
- IP&C constrains delaying flow out of the département.
- At present our demand outweighs our capacity regarding in-patients beds.
- WGH clinically ready to leave patients numbers are increasing. The patient length of stay over 7 days is also increasing.
- Due to the constant surge within the hospital, our discharge profile is inadequate to balance the demand profile of the site.
- Poor weekend discharge profile pushes further pressure into the week.

• Key actions / initiatives

- Senior medical team now secured in ED (3-month pilot), aim to have senior decision making and leadership managing the medical boarding patients in ED
- IP&C nurse participating in the site meetings, supporting in rapid access to screening
- Develop a criteria led discharge ethos to support out of hours/weekend discharges
- To de-surge the assessments units, to maintain the flow out of ED and avoid ED attendances.

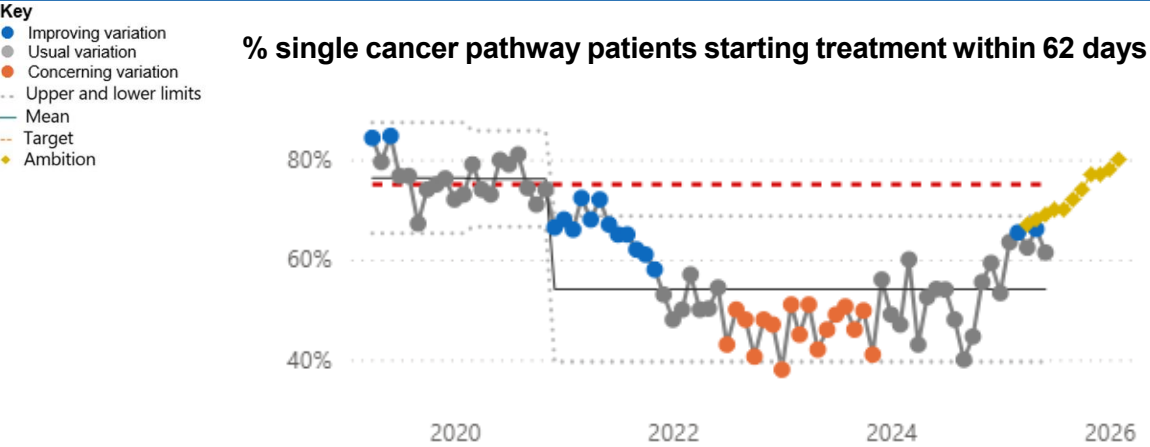
• Due date

- 11/09/25
- Completed
- 30/09/25
- 1/09/25



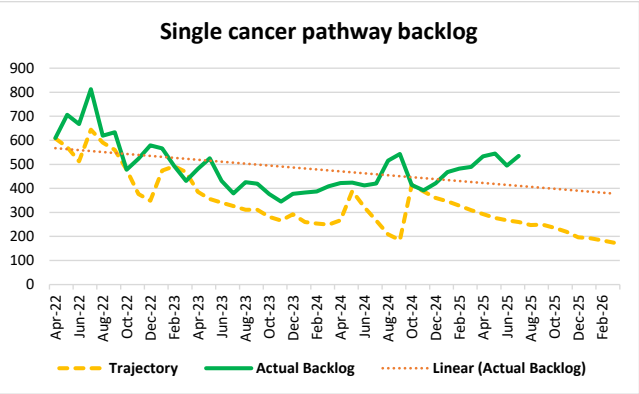
- Number of census count delays decreased in July with 211 patients and chart shows common cause variation.
- The total days delayed for non-mental health decreased in July to 8,844 days.
- Mental health and learning disability delays also decreased in July to 1,022.
- Assessment delays remain the largest proportion of delays.
- The census count is based on any patient regardless of area of residency delayed within our hospitals and will include patients from outside of the 3 HDUHB Local Authority areas.

Key Challenges / Issues	Key actions / initiatives	Due date
Non-mental health: • Significant challenges over the last month accessing social care assessments (n=40 up from n=20 in June) across all 3 local authorities (LA). Ongoing challenges in the provision of new community care packages funded by social care (n= 23 but an improved position from June n=32), and reablement community care packages (n=25), and Continuing Health Care community care packages (n=5). • Availability of residential and nursing care (including dementia) homes remain an issue across the region as well as housing related issues (n=14). Improving position in relation the healthcare assessments for nursing (n=10) and AHP (n=6) compared to June. Mental health: The Mental Health & Learning Disability Clinical Care Group, Pathway of Care Delay (PoCD) census count for July 2025, improved by 7 to 17, this figure includes 7 discharges from last month, 10 who remain PoCD from the last count and 7 new patients identified as medically optimised. The patients are categorised as follows- Older adult 11 reduction of 4, adult 6, reduction of 2 and 0 for learning disability which is an improvement of 1. The position in respect of patients who have a length of stay over the 90 and100 day threshold for Mental Health are 2 on 90, 3 over 100 which is an improvement of 3 and 0 patients over 300.	Non-mental health: • Regional Delayed Pathways of Care Action plan developed and submitted- including actions against local authorities funding allocation to support Delayed Pathways of Care (focus on increased reablement and social worker access and availability). • Improvement plan against Discharge to Recover and Assess (D2RA) pathway measures . • Strength- based collaborative communication training programme with health and LA leaders and staff . • Ongoing work around preventing deconditioning, Trusted Assessor models around mental capacity assessments and interprofessional standards. Mental health: • In summary, there are 17 medically optimised patients on in-patient wards, which is a significant improvement and provides some assurance in respect of revised processes that have been implemented since May 2025, there is a workshop on the 23/7/25 to consider other strategies and review data collection. Revised processes consisted of frequency of meetings increased to weekly, membership widened to ensure local authority and medical attendance and the agenda reviewed so that all aspects of patient flow management were addressed.	31/07/25 30/09/25 30/11/25 30/11/25 31/08/25



Performance was 61.4% in June 2025 against the trajectory of 68%. Urology has the highest volume of patients waiting over 62 days (199 in June 2025).

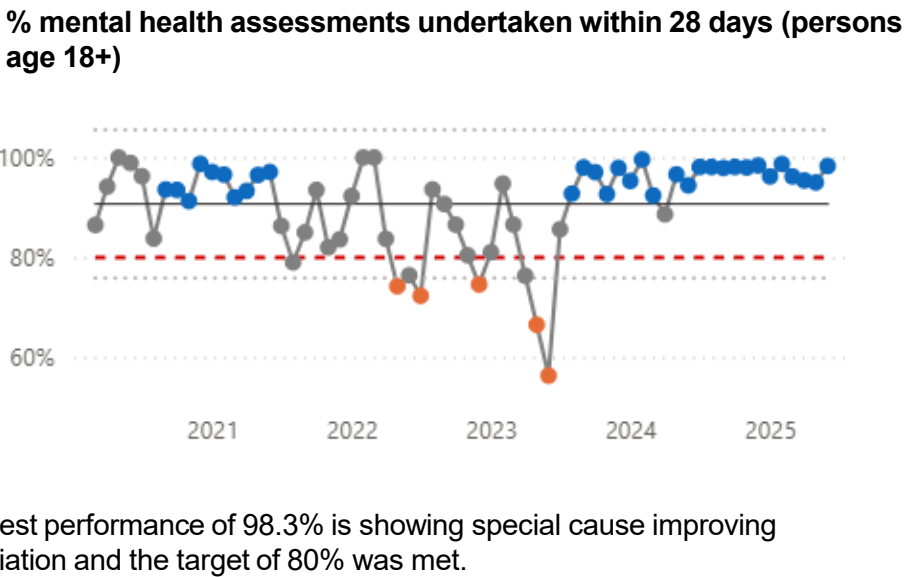
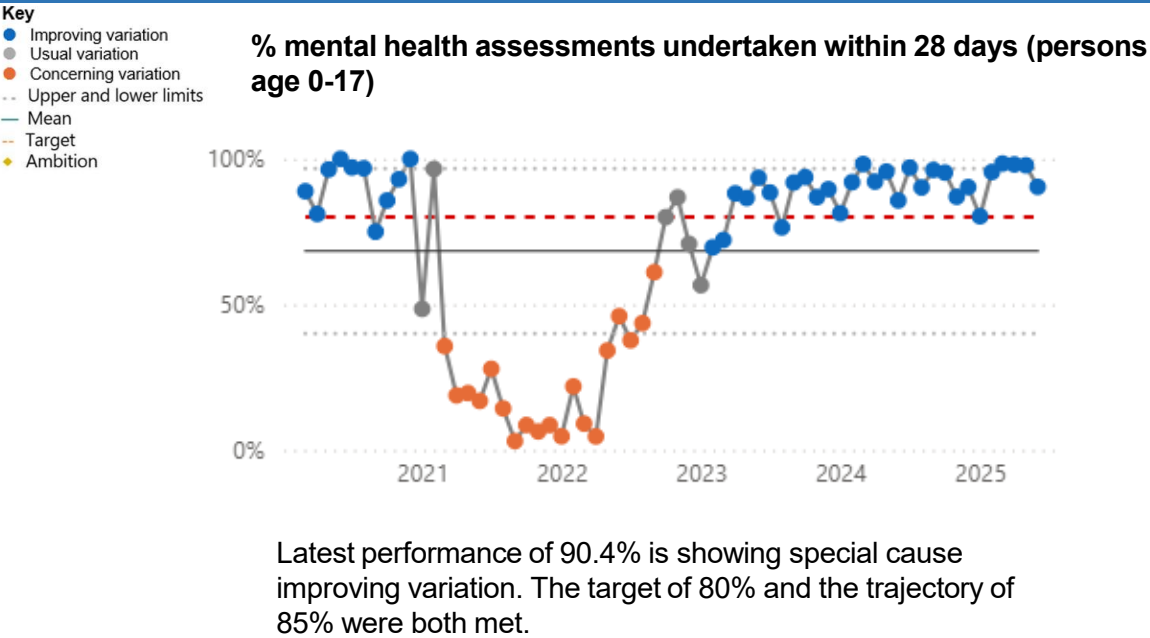
Number of single cancer pathway patients waiting over 62 days



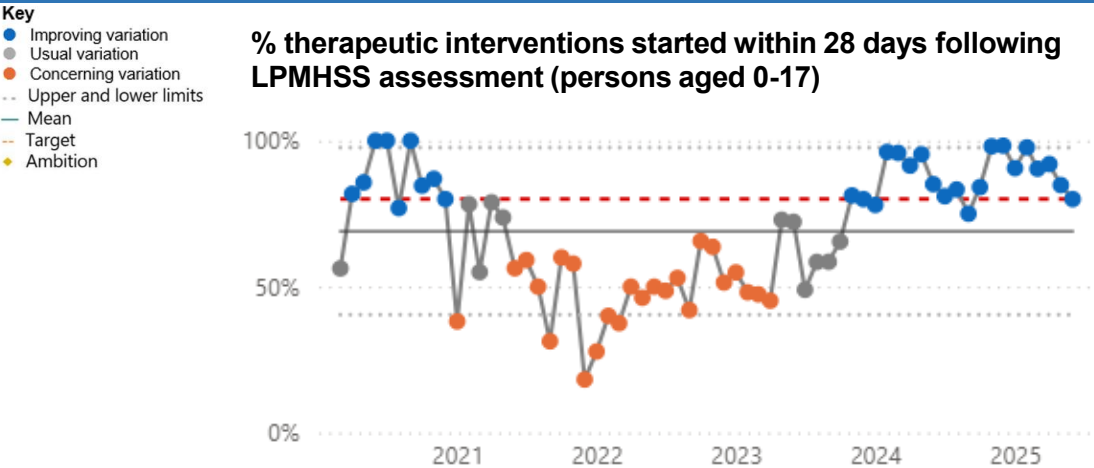
There were 535 patients waiting over 62 days in July 2025, the trajectory has not been met since October 2024.

NOTE: Patients are either awaiting treatment or are going through the diagnostic phase of the pathway. Not all patients in the diagnostic phase will go on to have a confirmed cancer diagnosis.

Key challenges / issues	Key actions / initiatives	Due date
Single cancer pathway Overall treatment activity is lower than previous months and therefore more patients were treated out of target than the months before. In June 2025, 149 patients who were waiting over 62 days were treated, first treatments rates decreased by a total of 86 patients. 237 patients started treatment within 62 days with 149 patients waiting over 62 days. Fragility in Radiology remains a key risk to delivery. Recurrent investment in Radiology provisionally agreed for 2025/26.	Diagnostics: Additional resources prioritised for 6 additional sessions per week for CT scanning and reporting will remain in place for 2025/26. Urology: Flexi Cystoscopy - currently 170 patients waiting on open pathways, additional planned activity will see a reduction in the waiting list of 10 per week. By end of July (reportable 7th August), will see a waiting list of under 100 patients. This will have a positive influence on the Urology backlog. Robust improvement plans agreed for Urology diagnostics for 2025/26.	31/03/26 31/08/25
Backlog Risks to meeting trajectory are predominantly associated with fragile service/workforce profile in key specialties (Radiology, Dermatology and Urology) which have limited resilience to sickness/absence.	Skin: Focus on increasing treatment capacity within Dermatology during Q2 2025/26 to mitigate the increase in activity in the earlier part of the pathway. Faecal immunochemical test : Pathway realigned to Primary Care, planned implementation November 2025	30/09/25 30/11/25

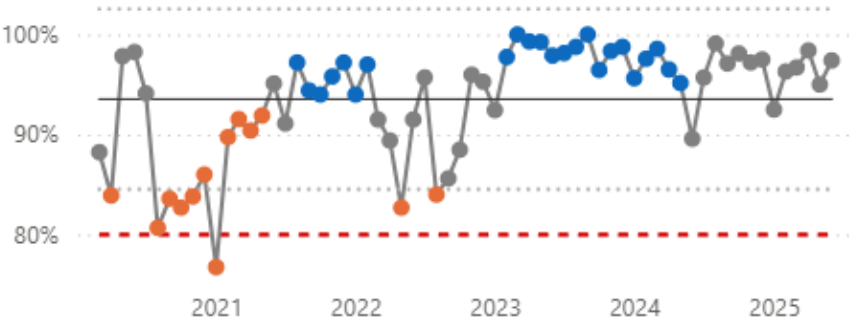


Key challenges / issues	Key actions / initiatives	Due date
% mental health assessments undertaken within 28 days (persons age 0-17): 47 of 52 assessments were undertaken within target in June. There continue to be significant workforce challenges in the largest under 18 Local Primary Mental Health Support Service team, with increased maternity leave (3 staff in one team) and long-term sickness. We anticipate continued compliance despite this, but this may be closer to the 80% target rather than the current 90%+ figures.	% mental health assessments undertaken within 28 days (persons age 0-17): A registered staff member vacancy has now been put out for advert. We have recruited a nurse under the 'Grow Your Own' scheme to start in September/October.	31/08/25 31/10/25
% mental health assessments undertaken within 28 days (persons age 18+): Due to the limited time period to achieve the target, if patients are unable to make the initial assessment date, the follow up appointment can fall outside the allocated timeframe.	% mental health assessments undertaken within 28 days (persons age 18+): Ensure an effective administration process is in place and vital support to ensure that the service remains compliant with the target.	31/07/25



Latest performance of 80% is showing special cause improving variation. The target of 80% was met but performance was below our trajectory of 85%.

% therapeutic interventions started within 28 days following LPMHSS assessment (persons aged 18+)



Latest performance of 97.4% is showing common cause variation and the target of 80% was met.

Key challenges / issues

% therapeutic interventions started within 28 days following LPMHSS (Local Primary Mental Health Support Service) assessment (persons aged 0-17):
24 of 30 interventions commenced within target in June. This metric has shown a decline in recent months due to staff absence relating to three staff on maternity leave and one on long term sickness. We anticipate a possible breach on this metric in the coming two months whilst recruitment is underway.

% therapeutic interventions started within 28 days following LPMHSS assessment (persons aged 18+):
Staff endeavour to ensure compliance with the measure targets. The Primary Care Liaison Service is now operating across the three counties with positive outcomes of reducing potential referrals to the LPMHSS. Estates access continues to be challenging across the three counties.

Key actions / initiatives

% therapeutic interventions started within 28 days following LPMHSS assessment (persons aged 0-17):
A registered staff member vacancy is now put out for advert.
We have recruited a nurse under the 'Grow Your Own' scheme to start in September/October.

% therapeutic interventions started within 28 days following LPMHSS assessment (persons aged 18+):
Groups are now underway in the LPMHSS to ensure compliance along with increased support through digital options.

Due date

31/08/25
31/10/25

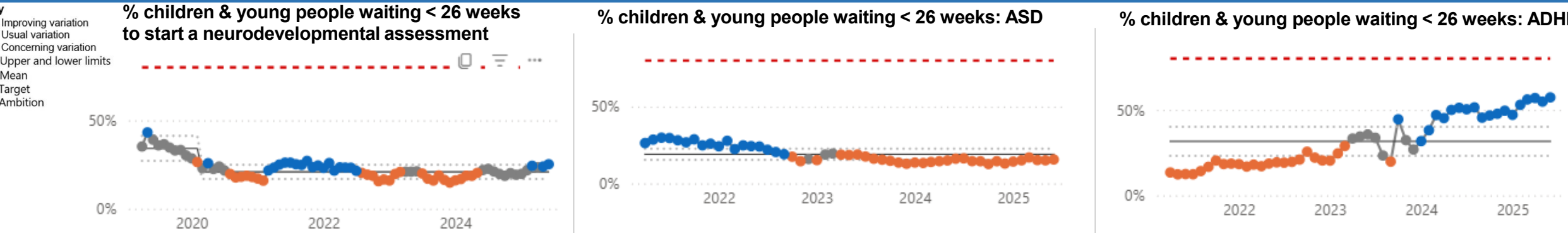
31/08/25



Performance in June of 53.1% shows concerning variation and the target of 80% was not met.

- 389 out of 705 (55.2%) patients were waiting <26 weeks to start an integrated psychological therapy;
- 4 out of 10 (40%) were waiting <26 weeks to start an adult psychology assessment;
- 31 out of 82 (37.8%) were waiting <26 weeks to start a learning disability psychology within 26 weeks.

Key challenges / issues	Key actions / initiatives	Due date
Integrated Psychological Therapies Service (IPTs): Activity remains high within the service with 102 clients commencing therapy in June. Phase 1 and 2 of the roll-out of group therapies allowed all those offered a group the option of remaining on the waiting list to access their agreed 1:1 therapy as originally assessed. This has resulted in a high number of 1:1 sessions being offered being taken up by those patients who have received the group offer (accepted or declined) which has contributed to recent month on month reduction to the RTT target. Phase 3 will only offer 1:1 sessions where a group therapy is not assessed as clinically appropriate with caps in sessions in place.	IPTS: Phase 2 roll-out of group therapies has ended with phase 3 commencing which supports a prudent and tiered approach to high intervention. This will be key to supporting the increase in demand; however, this is a cultural shift that requires effective support. Treatment groups for childhood trauma, OCD, stabilisation programme and self esteem are in the process of being rolled-out online. The introduction of these groups has significantly reduced waiting times, reduced pressure on other services within the Health Board and ensures that the service is abiding by Prudent Healthcare principles. Further digital options are being explored to support waiting times.	30/08/25 30/09/25
Adult Psychology: The Adult Psychology Mental Health (AMH) waiting list continued to improve in June both in terms of waiting time target and number of people waiting. A large geographical area can mean that access is limited in some areas particularly if client requires face to face intervention as opposed to remote.	Adult Psychology: All four clinicians are providing consultations to other services decreasing referrals to AMH. Grow Your Workforce plans are in place. A whole-time equivalent vacancy has been recruited to and expected to commence in September 2025. This is based in an area where there is currently no community provision.	31/03/26 31/03/26 30/09/25
Learning disabilities (LDs): Long term sickness and vacancies in the team are affecting capacity and impact on waiting times, as well as intensive work and court reports required for the increasing complex Court of Protection (CoP) cases.	Learning disabilities: A project is underway to scope under 18s that will potentially require a specialist LD service which will include pathways for earlier identification, education and engagement with families in children’s services regarding the changes of legislation/transition from children to adult services including court of protection and the Best Interest process. The new service model has a role for a co-ordinator for CoP cases who can link in with legal to support writing court reports/managing cases to enable professionals to continue to effectively undertake their clinical roles. This will be rec	30/11/25



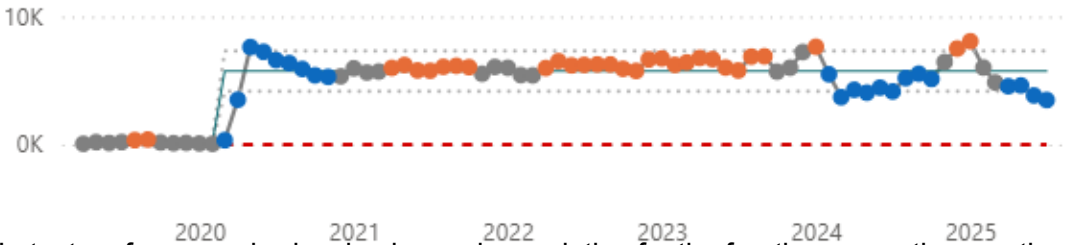
The overarching neurodevelopmental assessment metric is a combined ASD & ADHD position. Performance in June 2025 of 25.2% shows improving special cause variation but the target of 80% was not met. Performance is driven by ASD, where 535 of 3,436 (15.6%) patients were waiting for an assessment <26 weeks. 594 of 1,037 (57.3%) were waiting for an ADHD assessment <26 weeks.

Key challenges / issues	Key actions / initiative	Due date
Autism Spectrum Disorder (ASD): The current waiting list for an ASD assessment stands at 3,436 with longest wait times approximately 3.5 years in June 2025, reduced from 4.75 years. Demand for assessment remains high with referrals averaging 114 per month. This is approximately 3 times higher than current service capacity. Staff vacancies, sickness absence, maternity leave, annual leave and availability of diagnostic assessment training impact significantly on this small service, affecting output. All-Wales Procurement controls across Health Boards impede timely outsourcing to help tackle waiting lists.	ASD: Bi-weekly ASD task and finish groups to progress 3-year improvement plan and re-design of service. Monthly monitoring meetings with NHS Executive in place. Value-based, person-centred approaches being implemented to improve efficiency. Rapid access to diagnosis pilot – progress review in October 2025 A stakeholder mapping exercise is scheduled on 26th August 2025.	31/03/26 31/10/25 26/08/25
Attention Deficit Hyperactivity Disorder (ADHD): There is a significant and continued uplift in ADHD demand which considerably outweighs core capacity. In the last two years the service has seen a 100% increase in ADHD referrals, from approximately 28 per month in 2023/24 to 56 in 2024/25. Core capacity within the service is 40 per month. Further issues are: - Insufficient provision of appropriate clinical outpatient space - Quantitative Behavioural (QB) test equipment, with currently one QB device serving all counties across Hywel Dda - Lack of Psychology support for children and young people within the service - Lack of support services to provide a multidisciplinary team (MDT) approach within Hywel Dda. Community Paediatricians are independently responsible for ADHD diagnosis (with use of tools, such as CONNORS and QB).	ADHD: Potential to increase clinic room capacity through the Bandi appeal and reconfiguration of Puffin Ward. Increase core capacity through provision of additional (QB) tests and follow up sessions. There is currently only one device available to carry these out across the counties and limited Healthcare support workers (HCSW) are trained to use these. Funding streams are being sought to support the purchase of additional devices and would require additional recruitment. The service is exploring the use of 'The Portsmouth Model' which, if found to be suitable, may reduce delays in diagnosis and demand on QB testing. Currently being tested by Carmarthenshire County Council. The Portsmouth Model is a profiling tool which can be used to understand CYP needs and there is a potential if successful this will reduce demand on the Community Paeds service. This is a longer-term objective as is currently at trial stage. The service have recruited a substantive Community Paediatrician to the BGH vacancy, we are hopeful that they and this will increase core capacity.	31/03/27 31/12/25 31/03/26 31/10/25

Key

- Upper and lower limits
 - Mean
 - - - Target
 - Ambition
- Variation - how are we doing over time
- Improving variation
 - Usual variation
 - Concerning variation
- Assurance - performance against target
- Always hitting target
 - Hit and miss target
 - Always missing target
- Trajectory - performance against our ambition
- Trajectory met
 - Within 5% of trajectory
 - More than 5% off trajectory

Patients waiting >8 weeks for a specified diagnostic



Latest performance is showing improving variation for the fourth consecutive month, with 3,481 breaches recorded in July 2025.

Diagnostic	Latest period	Latest actual	Variation	Assurance	Trajectory
All	July 2025	3,481	●	□	n/a
Radiology		3,123	●	□	n/a
Cardiology		161	●	□	n/a
Endoscopy		147	●	□	n/a
Imaging		28	●	□	n/a
Phys measure		22	●	□	n/a
Neurophysiology		0	●	□	n/a

Key challenges / issues

Radiology:

- Demand exceeding capacity for timely investigations and reporting. Cancer and inpatient reporting is being prioritised.
- Decrease of 358 breaches from M3.
- Current breaches Computed Tomography (CT) 145 (-52) Magnetic Resonance Imaging (MRI) 2083 (-204), Non-obstetric Ultrasound (NOUS) 863 (-102), with 3150 breaches in total.
- 2,321 Urgent Suspected Cancer (USC) requests in month, 172 more than Jun 25. 15,642 requests received in total, 820 more than in Jun 25.

Endoscopy:

- Endoscopy theatre nursing staff fragility (particular to Glangwili due to short term sickness and gaps in the nursing establishment.
- Ongoing capital replacement programme for old/fragile endoscope equipment.
- Demand for Flexible Cystoscopy is greater than capacity. 1 list (20 Patients) per week

Cardiology:

- 125 Radiology Cardiac Myocardial Perfusion Imaging breaches and 76 Cardiac CT at end of July 2025.
- 32 Echo breach this month due to one vacancy.
- 3 Dobutamine Stress Echocardiograms escalated 17 June, Consultant-led diagnostics. 2x List were cancelled. Procedure room being used to surge inpatient's and another due to annual leave.

Key actions / initiatives

- £1.4m awarded by Welsh Government to reduce breaches to 0 by end of Mar 2026.
- NOUS via insourcing re-commenced in February 2025 and is continuing until November 2025 (end of contract). Will be extended to March 2026 with the additional funds received. Procurement contract with current insourcing company being extended.
- CT: Locum Radiographers continuing until November 2025, until two substantive appointments. A CT van will be procured for 6-8 weeks in Nov/Dec. This will ensure the breaches for CT reached.
- MRI- staffed MRI mobile solution commenced 09/01/25 and is continuing until March 2026. An additional mobile van will commence at GGH on 18 August 2025 until March 2026. The activity from both vans will ensure the breach position is 0 on March 2026.
- Endoscopy delivery plan in place to achieve zero breach performance by March 2026.
- Awaiting onboarding and recruitment checks of one WTE to Glangwili following interview.
- Urology Service monitoring list fulfilment rates daily with Waiting List team.
- High Volume, Low Complexity diagnostic weekend Check Flexi Lists planned for Sept/Oct/November (20-30 Check Flexi patients per month)
- Working with Endoscopy Service to develop IT/Data monitoring for the Flexi Cystoscopies to map out demand/capacity across both services.
- A Longer- term plan is in development to reduce Myocardial Perfusion Imaging waiting list. This includes commissioning additional CT Coronary Angiography capacity at Withybush with the first list scheduled for 26 August. In addition, the Health Board allocated further Welsh Government recovery funding to support targeted actions aimed at achieving zero breach performance by March 2026. Plans to outsource are also being urgently progressed to further support this objective.
- Additional insourcing for Echo arranged for August and September to decrease breach position.

Due date

- Complete 31/3/26
- 31/3/26
- 31/3/26
- 31/3/26
- 31/8/25
- 30/9/25
- 30/9/25
- 30/9/25
- 31/3/25
- 31/9/25

Patients waiting >14 weeks for a specified therapy

Latest performance in July 2025 shows concerning variation and the highest number of breaches recorded.
Of note, breaches in podiatry and dietetics have seen dramatic increases in breaches since February 2025.

Key

- Upper and lower limits
- Mean
- Target
- Ambition

Variation - how are we doing over time

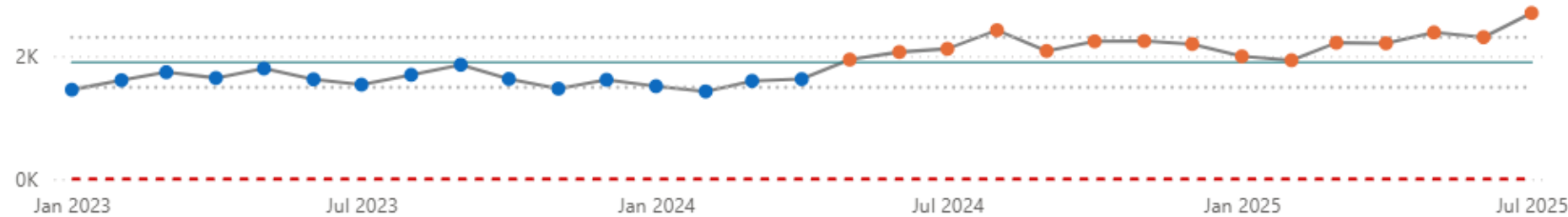
- Improving variation
- Usual variation
- Concerning variation

Assurance - performance against target

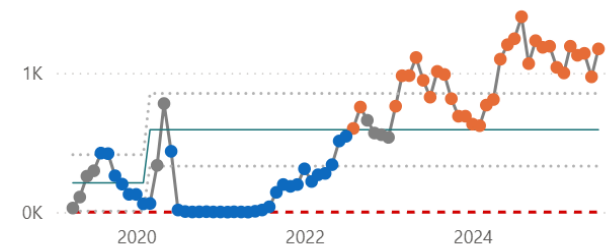
- Always hitting target
- Hit and miss target
- Always missing target

Trajectory - performance against our ambition

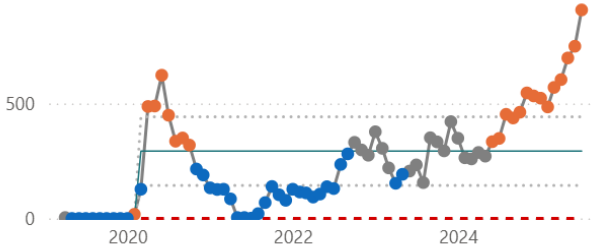
- Trajectory met
- Within 5% of trajectory
- More than 5% off trajectory



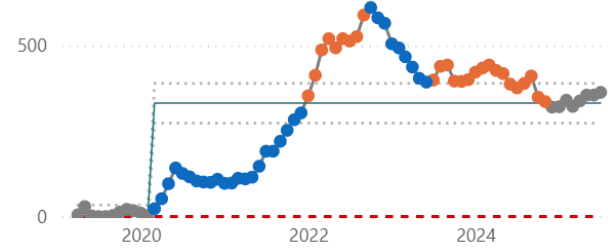
Number of patients waiting 14 weeks plus for Physiotherapy



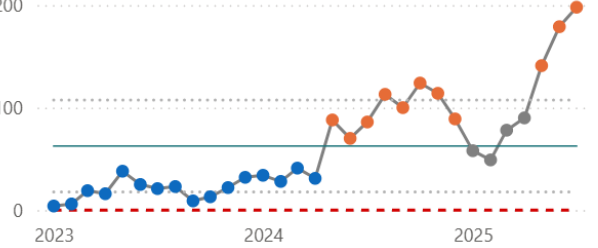
Number of patients waiting 14 weeks plus for Podiatry



Number of patients waiting 14 weeks plus for Occupational Therapy

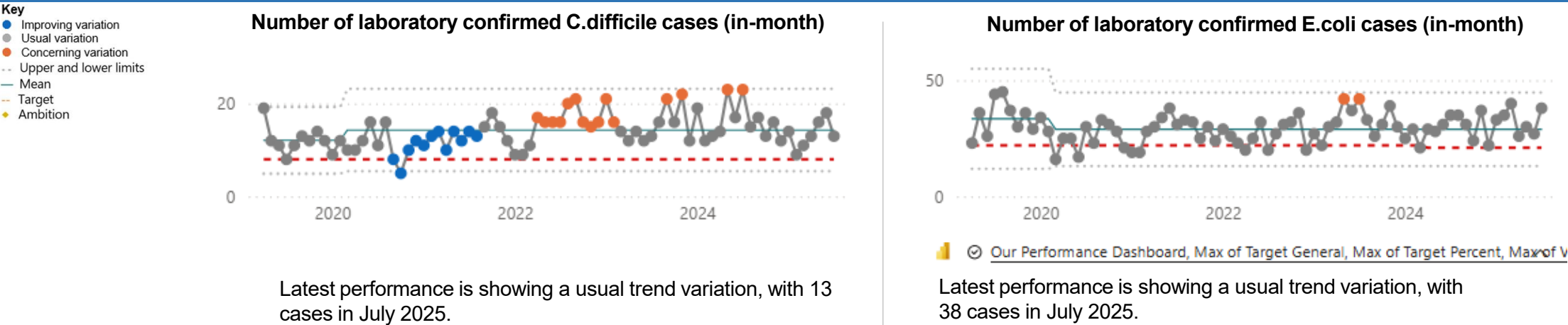


Dietetics: Number of patients waiting 14 weeks+ for Dietetics (excluding Weight Management)



Therapy	Latest period	Latest actual	Variation	Assurance	% children waiting < 14 weeks
All	July 2025	2,699	●	□	61.6%
Physiotherapy		1,173	●	□	99.2%
Podiatry		907	●	□	85.7%
OT		363	●	□	18.9%
Dietetics		198	●	□	47.2%
Art therapy		51	●	□	n/a
SALT		7	●	□	100%

Therapy waits over 14 weeks (continued) (Ministerial priority)		Therapies
Key challenges / issues	Key actions / initiatives	Due date
Physiotherapy 91% of breaches are within Musculoskeletal (MSK) Specialty. Demand is growing and is greater than capacity.	Physiotherapy - Development of a standard operating procedure for telephone triage initiative. Scope of project extended to include clinical risk stratification tool (Keele Start Back). - Secure 3 whole time equivalent (WTE) agency workers to cover service vacancies until January 2026. Action partially completed, with 2 WTE recruited. Due date extended whilst recruitment for 3rd post is underway. - Active recruitment to secure additional registrant workforce at Band 6 level to support bank work to cover vacancies. - Full MSK service review being undertaken in collaboration with National MSK Network.	31/08/25
		05/09/25
		01/09/25
		30/09/25
Podiatry - Increase in new referrals: from 9,000 to 14,500 annually over the past 5 years. - Growing backlog: Despite mitigation efforts, nearly 3,000 new referrals waiting. - Impact of vascular pathway changes: redirection plan contributed to rise in referrals. - Reduced overall patient contacts: from 60,000 to 45,000 annually due to increased patient complexity. - Stricter eligibility criteria: Lower-risk cases are now discharged to the private sector, narrowing the scope of patients seen. - Lower clinic throughput: Patients seen in clinics decreased from 18 to 10 per day, reflecting increased complexity and time per case.	Podiatry - Recruitment: Recruited 3 Whole Time Equivalent (WTE) Band 5 staff to replace leavers. - Skill mixing for efficiency: 6 admin staff (Bands 3 & 4) undergoing Agored training to become podiatry assistants, enabling task redistribution, backfilling with new admin recruits. - Consultant role development: Plans to establish a consultant podiatrist role to manage complex cases more efficiently. - Eligibility & discharge policy: Continued enforcement of strict criteria and robust discharge processes; Demand and capacity deep dive completed. - Innovative practice rollout: Ongoing implementation of phone triage, skill mixing, and pathway redesign to improve service efficiency.	01/09/25
		01/09/26
		01/03/26
		07/09/25
Occupational therapy - Paediatric Breaches: Most waiting time breaches are within the Paediatric Occupational Therapy service. - Backlog and Rising Demand: Existing backlog combined with increased demand is straining service capacity. - Reduced Clinical Leadership Capacity: Loss of Band 7 leadership due to one retirement and two staff on sick leave in July has impacted service delivery.	Occupational therapy - Band 7 Cover: A Band 6 staff member temporarily uplifted to fill leadership gaps. - Staff Return: A Band 7 returned to work following sickness absence, improving capacity. - External Support: Swansea Bay University Health Board Paediatric occupational therapy service providing remote clinical advice and support throughout August. - Safeguarding Support: Head of Paediatrics in Speech Language Therapy providing additional capacity for safeguarding concerns. - Recruitment to replace retired Band 7: start date 27/10/25 (currently on maternity leave).	01/09/26
Dietetics - All breaches in Paediatric Dietetic service. - Longstanding capacity issues: Demand has been escalating over several years, especially due to increased referrals for selective eating since COVID-19 pandemic. - Extended waiting times: The longest current wait is 52 weeks. - Process and documentation incidents creating increased workload for current staff, increasing waiting times. - Locum recruitment challenges: Fixed-term Band 8a locum post was approved, but the selected candidate withdrew, and no further interest has been received.	Dietetics - New leadership appointment: A service lead in paediatrics has been appointed. - Link with agency and adapt requests to gain further interest on agency roles. - Internal role adjustment: Internal recruitment into the Home Enteral Feeding (HEF) paediatric post will free up other team members to handle urgent referrals. - Short-term support option: Avoidant and Restrictive Food Intake Disorder (ARFID) dietitian to temporarily assist with selective eating cases until permanent/locum recruitment is successful.	
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Key challenges / issues

- C. difficile:**
- Increased incidence in specific wards with clusters being identified. Greater burden within hospital to community.
 - Start Smart and Then Focus (SSTF) audits for antibiotic prescribing not consistently completed.
 - Delays in recognition, isolation or diagnosis noted in some cases.
 - Environmental cleaning and deep cleaning challenges relating to staffing and surge capacity in ward areas.
 - Lapses in compliance to hand hygiene practices and bare below the elbow across all staff disciplines.
 - Level 2 mandatory compliance for Infection, Prevention and Control is at 75.56% as a Health Board below expected 85% target.

- E. coli:**
- Burden of infection remains community-onset; cases are linked to urinary tract infections and some catheter device related infections.
 - Lapses in compliance to hand hygiene practices and bare below the elbow across all staff disciplines.
 - Aseptic Non-Touch Technique (ANTT) compliance for the Health Board is at 82.58%

Key actions / initiatives

- C. difficile:**
- The SSTF audits have been scrutinised in terms of completion and prescribing, tazocin and cotrimoxazole most prescribed antibiotics. Around two thirds of C. difficile patients (67%) had a Proton Pump Inhibitor prescribed, quality improvement projects linked to C.difficile collaborative discussed at C. difficile Improvement Group.
 - Targeted staff training has been completed for areas where clusters have occurred.
 - Environmental audits and observational audits continue with oncology next to be completed
 - Healthcare-Associated Infection (HCAI) cases discussed monthly at the HCAI Assurance Group meeting for each site and learning disseminated through Clinical Care Groups (CCG). Review of areas with highest rates in CCG to be shared.
 - Hydrogen Peroxide Vapor (HPV) available on 3 acute sites currently, yet use is not consistent. Infection Prevention and Control team have presented at local Professional Nurse Forums.
- E. coli:**
- Health and Wellbeing Booklet for Hywel Dda University Health Board population in review status and to be published.
 - Healthcare Associated Infections (HCAI) cases discussed monthly at the HCAI Assurance Group meeting for each site and learning disseminated through Clinical Care Groups.
 - Hand Hygiene audits completed by Ward Managers, these are reviewed and monitored.

Due date

30/09/25

Complete
30/09/25
31/08/25

Complete

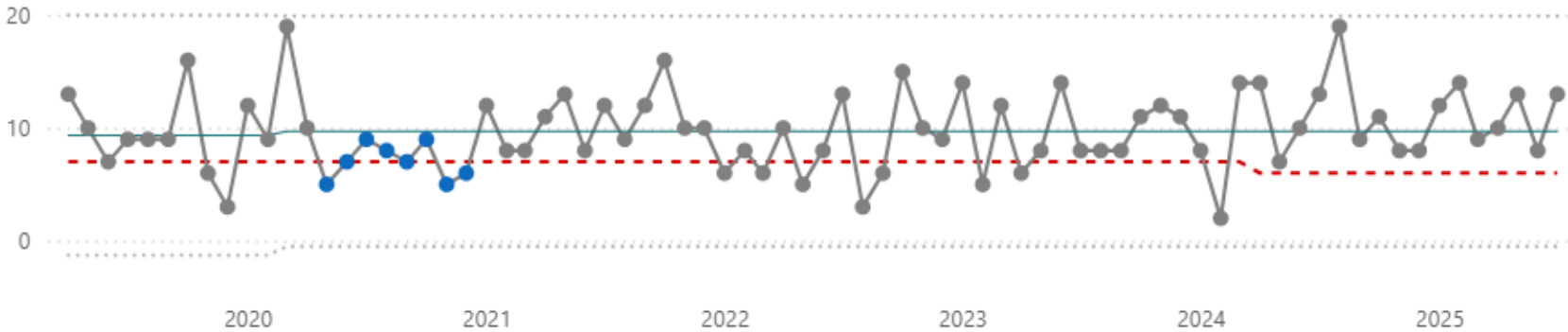
30/09/25

31/08/25

31/08/25

- Key
- Improving variation
 - Usual variation
 - Concerning variation
 - Upper and lower limits
 - Mean
 - Target
 - Ambition

Number of laboratory confirmed S.aureus cases (in-month)



Latest performance is showing a usual trend variation, with 13 cases in July 2025.

Key challenges / issues

- S. aureus:**
- Inconsistent compliance with aseptic non-touch technique (ANTT) or line care bundles.
 - Environmental or equipment contamination contributing to transmission, linked to challenges around environmental cleaning and surge.
 - Greater burden of infection remains to be in community, with wounds being the primary source of infection.
 - Lapses in compliance to hand hygiene practices and bare below the elbow across all staff disciplines.

Key actions / initiatives

- S. aureus:**
- ANTT compliance and competency assessments for clinical staff shared via Clinical Care Groups (CCG) H&S meetings .
 - Healthcare-Associated Infection (HCAI) cases discussed monthly at the HCAI Assurance Group meeting for each site and learning disseminated through CCGs . Review of areas with highest rates in CCG to be shared
 - Hand hygiene validation audits and observational audits in wards and departments as indicated from monthly senior nurse audits

Due date

31/08/25

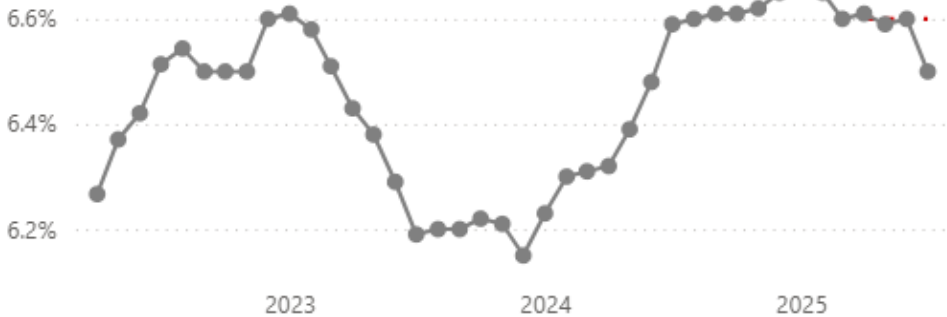
31/08/25

31/08/25

Key

- Improving variation
- Usual variation
- Concerning variation
- Upper and lower limits
- Mean
- Target
- Ambition

% staff sickness rate (12 months rolling)



In July 2025 12 month rolling sickness was 6.5%. In-month sickness was 6.3% (1.8% short term, 4.4% long term).

The sickness target has been revised to 6.6%, in-line with improvement against the 2024/2025 baseline.

Services with 60+ staff with the highest levels of in-month sickness rates in July 2025

Team	Staff	In-month %	R12m %
Glangwili Hotel Services	135 staff	(11.7%)	14.1%
Withybush Hotel Services	135 staff	(11.6%)	12.6%
Prince Philip Acute Response	64 staff	(11.1%)	11.3%
Prince Philip AMAU	74 staff	(8.6%)	10.9%

Key challenges / issues

Conditions impacting absence rates include:
The absence rates attributed to anxiety, stress and depression is increasing and continues to account for the highest reasons for absences across the Health Board.

Targeted support for sickness absence:
Estates and Facilities sickness rates continue to be the highest across the Health Board (10.01% rolling, 8.51% for July) with ongoing focused support from the Workforce Team.

Designated support continues to be utilised to help address concerns aligned to Employee Relations matters such as Respect and & Resolution, Raising Concerns etc. which are impacting on employee's wellbeing and attendance.

Key actions / initiatives

Temporary redeployment guidance:
The flow chart will be embedded in the policies portal to support the All-Wales Attendance At Work Policy. Trade Union input awaited.

Bite size training sessions:
9 sessions have been developed to date and the first session: 'How to conduct a Return-to-Work meeting' has been produced and animated and is now on the intranet for managers and staff to view. Work is progressing on the development of the session on the Occupational Health referrals process with Workforce liaising with colleagues in Swansea Bay to collaborate on this work.

Occupational Health referral how to guide
To assist managers a useful 'How to guide' is being developed to ensure managers can elicit the detail required from their Occupational Health referral in order to support individuals back to work in a timelier manner. Various examples of best practice referrals (reflecting the different job families) will be available for managers to use as a template to assist with more effective referrals.

Due date

31/07/25

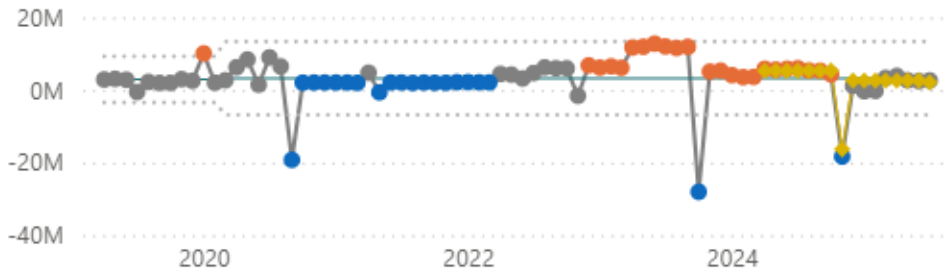
31/07/25
(First session)

31/07/25

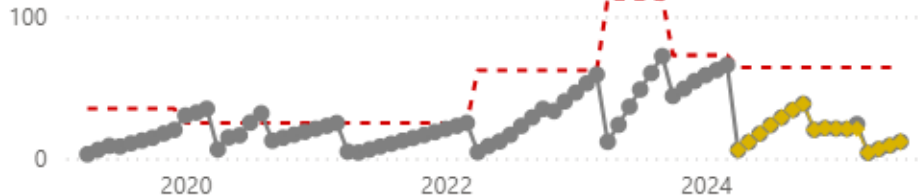
Key

- Improving variation
- Usual variation
- Concerning variation
- Upper and lower limits
- Mean
- Target
- Ambition

Financial in-month deficit



Financial deficit (£m) – year to date



Key challenges / issues

- Savings Delivery – There is a significant identification gap for savings schemes across Clinical Care Groups (CCG). Targeted intervention de-escalation and internal escalation for the Finance domain is likely due to risk associated with delivering the £30.0m revised annual plan equitably across services. There is a disconnect month on month with in-month delivery of savings and those forecast of future periods. This has been highlighted by Welsh Government as a credibility issue for the health board, and WG expect a comprehensive update.
- £30.0m to £24.0m further savings options - Timeline in place for Executive Directors to coordinate responses across their themes and portfolios, to generate quality impact assessment options to further improve the financial forecast to meet Welsh Governments expectations and revised TI de-escalation criteria.
- Medical Pay – Total medical pay expenditure is indicating a concerning trend, driven by both increased reliance on variable and agency use. Continued use of additional medical cover, including premium locum and agency in BGH, Planned Care and Mental Health.
- LTAs and Commissioning – Long Term Agreement increase in planned care (elective) activity in Swansea Bay Health Board £0.5m
- CCG Management – Over-establishment of management posts within new CCG structure with significant financial impact. Annual cost = £0.9m, 9.2 whole time equivalent (WTE).

Key actions / initiatives

- As agreed in May 2025 with Executives, continued underspends should be considered for savings schemes and not used to offset overspends. Overspends need to have mitigation plans to reduce their impact and not netted off masking their issue. The identification and delivery of robust recurrent and non-recurrent savings plans into future months is required urgently.
- The Health Board has submitted a revised annual financial plan to Welsh Government as part of the Month 4 reporting submission, having agreed it at the Public Board meeting on 31 July 2025. Whilst this demonstrates an improvement, Welsh Government have provided clarity of their expectations; the 2024/25 outturn. Welsh Government expect absolute confidence in the actions to deliver a deficit of £30.0m, and a robust understanding of the actions that could be taken to maintain the 2024/25 outturn position of a £24.1m deficit, all by 11 September 2025 as part of the Month 5 reporting submission
- Roster management, consistent rate card implementation and exit strategies for reliance on premium cover linked to sustainability service delivery plans.
- Review of uncoded contract activity to be undertaken to determine the demand growth
- Urgent review of supernumerary management costs and cost reduction strategies accelerated.

Due date

Overdue –
Qtr1 25/26

11/09/25

Overdue

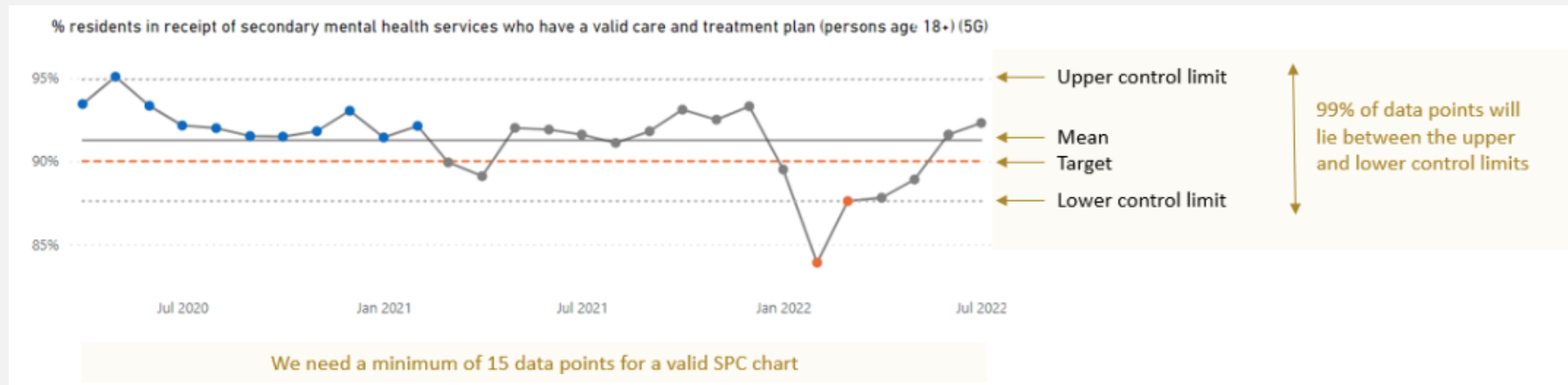
20/05/25

20/05/25

Why use SPC charts?

- Plotting data over time can inform better decision-making
- There are many factors that impact our performance and therefore month-on-month variation is to be expected
- RAG data in a table can hide what is happening
- SPC charts enable us to determine if changes are showing special cause variation (concerning or indeed improving) or if the changes are within our expected performance range. They also help us easily compare our performance against target.
- There is a strong evidence base to support the use of SPC charts to inform NHS improvement.
- We started using SPC charts for performance reporting to Board and Committee in March 2021. The feedback has been very positive, with SPC charts helping to change the conversation to focus on improvement.

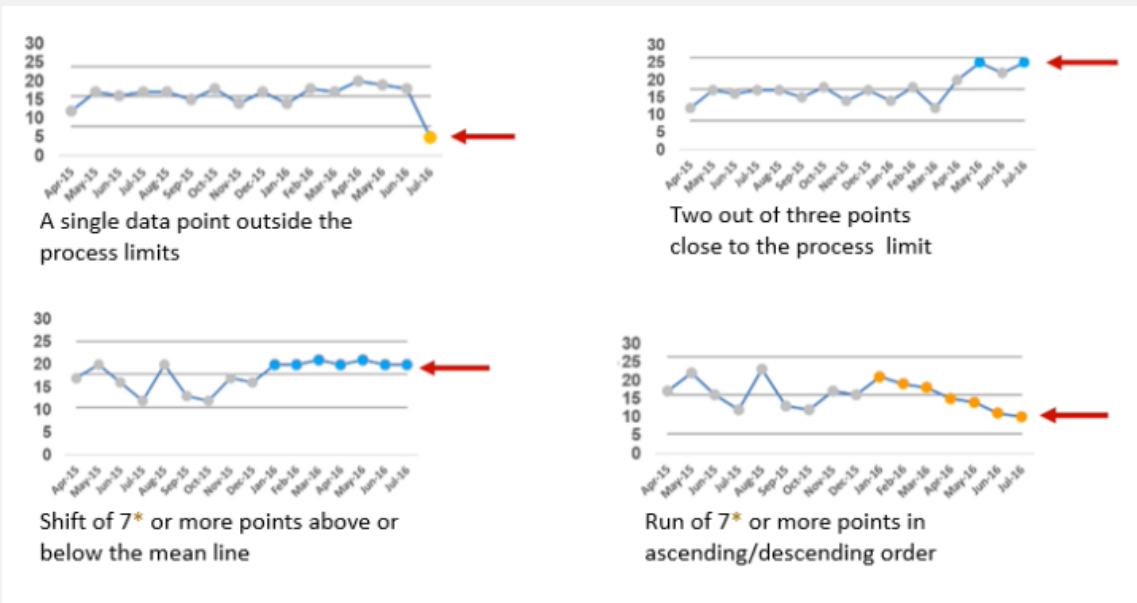
Anatomy of a SPC chart



Rules for special variation within SPC charts

Special variation is change that is unlikely to have happened by chance.

We are using the Making Data Count approach for SPC charts. There are 4 rules:



* A pattern of 7 has a 1 in 128 (0.8%) probability of occurring by chance.

Understanding the SPC icons

Each SPC chart produces 2 types of icons i.e.. one for variation and another for assurance.

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

Executive Improving Together Sessions (EITS)

Thematic Report

June and July 2025



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

Contents

1. Background
2. EITS meeting timetable
3. 3A assessment introduction
4. 3A assessment summary
5. Key issues identified by agenda item
6. Resulting actions and support from the EITS meetings
7. Key actions by function
8. Key achievements by function
9. Learning

Background

Improving Together is the health board's approach of embedding performance improvement through our governance to drive forward improvements for our patients and our staff.

Executive Improving Together Sessions (EITS) were introduced in January 2023 (originally called Directorate Improving Together Sessions). The EITS meetings give Executive Directors an opportunity to meet with leads from each function twice a year (June and November) to discuss key priorities and areas of concern.

This report summarises the EITS meetings held in June and July 2025. The meetings followed a standard agenda for all functions i.e. quality & safety, governance, workforce, finance, 2025/26 annual plan progress, fragile services, strategic refresh, performance, data quality and key achievements.

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

For further information on EITS meetings see:

[EITS – Ways of working 2025/2026](#)



EITS meeting timetable

Below is an overview of the schedule of EITS meetings that took place in June and July 2025.

Meeting date	Function			
05/06/2025	Medical	Finance & Digital	Workforce & OD	Public Health
09/06/2025	Nursing, Quality & Patient Experience	Governance & Communications	Primary Care, Community Strategy & Long-Term Care	Strategy & Planning
17/06/2025	Community & Integrated Medicine			
19/06/2025	Operational Allied Health & Health Sciences			
24/06/2025	Estates & Facilities			
30/06/2025	Mental Health & Learning Disabilities			
07/07/2025	Planned & Specialist Care			

The following functions did not have EITS meetings in June or July 2025:

- **Allied Health Professionals & Health Sciences** – stood down by lead Executive Director (excludes Estates and Facilities – see above)
- **Chief Operating Officer Management** – stood down by lead Executive Director

3A assessments summary

June & July 2025

Function	Quality	Governance	Workforce	Finance	2025/26 Annual Plan progress	Fragile Services	Strategic Refresh	Performance
Community & Integrated Medicine	Alert	Advise	Alert	Alert	Alert	Alert	Advise	Alert
Estates & Facilities	Assure	Alert	Advise	Alert	Advise	n/a	n/a	Advise
Finance & Digital	Advise	Advise	Assure	Assure	Assure	Assure	Advise	Assure
Governance & Communications	Assure	Assure	Advise	Assure	Assure	Assure	n/a	n/a
Medical	Assure	Assure	Assure	Assure	Assure	Assure	n/a	n/a
Mental Health & Learning Disabilities	Alert	Advise	Advise	Alert	Advise	Advise	Advise	Alert
Nursing, Quality & Pt. Experience	Assure	Advise	Advise	Assure	Assure	Advise	Advise	Advise
Operational Allied Health & Health Sciences	Advise	Advise	Alert	Alert	Advise	Advise	n/a	Alert
Planned & Specialist Care	Alert	Alert	Alert	Advise	Advise	Advise	Advise	Advise
Primary Care, Community Strategy & LTC	Advise	Assure	Alert	Advise	Advise	Advise	Advise	Advise
Public Health	Assure	Assure	Alert	Assure	Advise	Advise	Assure	Advise
Strategy & Planning	n/a	Advise	Assure	Advise	Assure	Assure	n/a	n/a
Workforce & OD	n/a	Assure	Assure	Advise	Assure	Assure	n/a	n/a

For further details see: [EITS Live Action Tracker - Bi-annual meetings.xlsx](#) (Hywel Dda staff only).

KEY

Assure - to note

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

Advise – to monitor

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

Alert – may require discussion

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

3A assessment summary (2)

Our most challenged functions

Community and Integrated Medicine

- Quality and safety - improvements needed in the management of incidents and complaints. Reduction needed in hospital acquired infections.
- Workforce – high levels of sickness and overdue pay progressions for staff.
- Finance – Reduction needed in premium costs for medical and dental staff. Further savings opportunities to be investigated.
- 2025/26 annual plan – progress has been made but further work needed to meet our annual plan commitments.
- Fragile services – further work needed to address over-reliance of agency nurses and medical locums in Bronglais Hospital, A&E medical staffing in Glangwili Hospital and respiratory services in Withybush Hospital.
- Performance – good work in progress but more needed as ambulance delays and delayed pathways of care remain very high.

Planned and Specialist Care

- Quality and safety - improvements needed in the management of incidents and complaints.
- Governance – concerns raised about the governance arrangements within the care group.
- Workforce – high levels of overdue pay progressions for staff to be addressed. Detail and complexity of cultural issues to be articulated to Executive Team.
- Fragile services – concerns over the fragility of theatre services in Glangwili Hospital. A plan is being developed to address.

Operational Allied Health and Health Sciences

- Workforce – high levels of overdue pay progressions for staff to be addressed.
- Finance - recognition that the care group is handling a lot of risk and needs support. However, overspend forecast for year and required savings have not been identified.
- Performance – high numbers of breaches for patients waiting for radiology diagnostics, physiotherapy and podiatry.

Mental Health and Learning Disabilities

- Quality and safety – trajectories and improvements needed in the management of incidents and complaints.
- Finance – clarity needed on proposed savings schemes.
- Performance – improvement trajectories needed for autism spectrum disorder (ASD) assessment waits for children and young people and psychological therapy waits.

Function with the highest levels of assurance

Medical directorate

Strong evidenced provided for the management of incidents, complaints, risks, audit & inspection recommendations, workforce, budget & savings, annual plan and support being provided for the Clinical Service Plan.

All corporate functions provided high levels of assurance across the range of improvement domains.

Key issues identified by agenda item

Quality and safety

Trajectories

- Functions need to produce clear trajectories as part of their action plans to meet targets/de-escalation criteria for the quality & safety domain.

Incidents and complaints

- Incorrectly assigned incidents and complaints need to be reported to the Quality Assurance and Safety Team (QAST) and the Performance Team by the function to which they are wrongly assigned as early as possible, so they can be reassigned to the correct function to ensure delays are not incurred.
- There has been focus to close incidents open over 120 days for over 2 years. However, the following functions still have very high numbers within this bracket: Community and Integrated Medicine (1,076), Planned & Specialist Care (228) and Mental Health & Learning Disabilities (196).

Patient experience data

- Clear communications needed to report the outcomes from the pilot scheme to capture patient feedback from 3 managed practices.

Welsh Language Commissioner's investigation

- Need to ensure the health board is integrating Welsh Language into the communications hub plan.

Health care acquired infections

- An investigation is needed into why hospital onset infections have been increasing
- Timelines for improvement plans are needed

Quality & safety outcomes for commissioning

- An assessment is needed for the data sources and information flows we could use to capture quality and safety metrics for our commissioned services e.g. incidents for Hywel Dda residents treated at non Hywel Dda hospitals. These metrics could be incorporated into our commissioning arrangements with mandated expectations similar to what is in place in NHS England.

Compliance maintenance

- There was recognition that many functions had worked hard to achieve compliance for the quality & safety domain. However, functions were advised to plan frequent review activities to prevent slippage and maintain compliance

Support from Executive Team

- Functions need to qualify exactly what help is needed from the wider organisation (skills/experience, time, task) to progress improvement plans.

Key issues identified by agenda item

Governance

Governance arrangements

- Several functions could not evidence that the governance arrangements agreed by Formal Executive Team had been established within the care group/directorate.

Compliance and maintenance

- All functions need to ensure robust processes are established so that compliance with the targets for risk management, audit recommendations, Welsh Health Circulars and control documentation and policies are achieved and maintained.

New Clinical Care Group (CCG) structure

- With the introduction of the CCGs in April 2025 and new CCG leads on-boarding, there has been a period of realignment and understanding which should all now be reconciled.

Audits and inspections evidence

- All evidence for progress towards audit and inspections recommendations needs to be added to the AMaT system in a timely manner. The Assurance & Risk Team can provide AMaT training, advice and support for functions if needed.

Time to complete risk actions

- Some risk actions have not been allocated adequate time to complete. These risks need to be reviewed by the function and going forward, all functions should ensure realistic timelines are assigned to risk actions.

Key issues identified by agenda item

Workforce

Making a difference training

- The uptake of the Making a difference training needs to be improved. Managers are asked to ensure opportunities are available for all staff to attend the face to face one day session.

Staff turnover

- It was agreed that appropriate levels of staff turnover can be an indicator of good career progression and development. Additionally, appropriate turnover rates will vary across functions due to the nature of the profession.
- More understanding is needed of what appropriate staff turnover looks like within the different health board functions.
- Exit interview data and workforce intelligence reports will provide additional insight into staff turnover reasons and identify any trends.

Overdue pay progressions

- More work needs to be done to ensure the current overdue pay progressions are resolved swiftly. Processes need to be strengthened to ensure pay progression timelines are monitored regularly so that all eligible staff receive their pay increment when it is due.

Workforce planning & implementation

- Strategic alignment, scenario planning and the use of integrated systems / tools are essential to enable modelling to inform the health board's planning process.

Key issues identified by agenda item

Finance

Managing within budget

It is an NHS requirement to manage within our given budget. However, some functions are forecasting an end of year overspend for 2025/26.

2025/26 savings

Functions have been allocated savings targets for this financial year that need to be met in the next financial year. There are still considerable gaps in savings opportunities from operational functions that need to be addressed.

Re-allocation of budgets

- The budget for key systems e.g. AMaT & DATIX should sit within and be managed by the Digital Team rather than individual functions. This may provide savings opportunities by combining contracts and improve consistency.

Medical rate card

- A unified approach is needed to resolve variable locum rates across the Health Board

Key issues identified by agenda item

2025/26 annual plan progress

Progress

- Recognition that a lot of good work has been done so far, and of the challenges with workforce and process issues. Further work needs to be done throughout operational functions for the health board to meet the 2025/2026 planning objectives.

Medical staffing

- Resource needs to be identified to enable the roll out of the activity manager rota system.
- Programme of training needed to increase knowledge of medical staffing terms and conditions.
- We need to develop opportunities to attract more medical staff to the health board.
- Recruitment from non-substantive roles into permanent posts needs to be progressed.

Finance

- Clear list of milestones needed to achieve the road map plan for financial balance.
- Movement of services from secondary care into primary care will need to be funded from the existing operational budget.

Organisational change process

- There are challenges to be met with the shift into community-based care. Clear planning arrangements and communication with staff and the public are essential

Digital Transformation

- A business review and plan for the future artificial intelligence (AI) utilisation is needed
- Requirement for senior leadership workshops to unblock the main challenges preventing progress.
- Digital innovation needed for transforming the patient communications hub and patient relationship management.

Modelling

- Modelling work needs to be undertaken for strategic improvement activities across the health board including:
 - Workforce planning
 - 45 minute ambulance handovers
 - Women’s Health Plan

Key issues identified by agenda item

Fragile services

Clinical Services Plan

The health board is currently engaging with the public to seek their views on options for our Clinical Services Plan (CSP). The CSP is working to address fragility for the following services:

- Critical Care
- Dermatology
- Emergency General Surgery
- Endoscopy
- Ophthalmology
- Orthopaedics
- Radiology
- Stroke
- Urology

Urgent and emergency care (UEC)

An urgent group has been established to develop a transformation plan to improve UEC services across Hywel Dda. The final plan will be presented to Board in September 2025.

Theatre

Theatre staffing within Glangwili Hospital is highly concerning and has the potential to impact our planned care performance commitments in the 2025/26 annual plan. An urgent plan is being developed and recruitment is underway.

Key issues identified by agenda item

Strategic refresh

A Healthier Mid and West Wales (AHMWW) strategy

The current strategy was approved before the COVID pandemic. Since that time and given that nearly 7 years have elapsed, there is a need to refresh the strategy to reflect any material changes to the key drivers of change and the potential strategic solutions.

A number of challenges will need to be addressed, for example:

- More scoping needed from CCGs on service changes needing to be reflected in the refresh.
- The challenges associated with completion of the engagement and the dovetailing with other health board processes.

Key issues identified by agenda item

Performance and outcomes

Urgent and emergency care

Despite efforts across our four acute sites and county teams, we are still not achieving the improvements across urgent and emergency care that we had hoped. Ambulance delays and pathway of care delay breaches remain unacceptably high. Patient flow within our acute hospitals is a key factor.

Radiology

- Breaches of patients waiting over 8 weeks for a radiology diagnostic test remain high. Scoping needed to determine what would be needed to eliminate all 8-week radiology breaches by 31st March 2026.

Diabetes

- Minimal improvement over the last 12 months for the 8 NICE recommended care processes and we are ranking last in Wales. An improvement plan and trajectories need to be developed.

Newborn hearing screening

- 1.3% of newborn babies are not receiving hearing screening. Investigations needed to determine if this cohort of babies are at risk.

Support from Executive Team

- Functions need to qualify exactly what help is needed from the wider organisation (skills/experience, time, task) to progress improvement plans.

Collaborative working

- Engagement across clinical care groups and corporate teams should be strengthened to provide insights, joined up working, clarity of processes and improvement opportunities

National targets and trajectories

- Some performance metrics are performing far below the national targets. Trajectories are needed to meet Targeted Intervention de-escalation criteria and performance improvement expectations.

Delivery plans

- Functions need to strengthen delivery/recovery plans. SMART actions must be devised to achieve trajectories and targets and to significantly improve performance within budget.

Cleaning standards

- New performance metrics need to be developed to track the quality of cleaning within our hospitals, as well as the number of cleaning audits undertaken.

Resulting actions and support from the EITS meetings

From the EITS meetings held June and July 2025:

Actions generated

Actions allocated Executive Director
and/or corporate team support

For details of all actions, please see:

[EITS Live Action Tracker - Bi-annual meetings.xlsx](#)
(Hywel Dda staff only).



Key resulting actions by function

Community and Integrated Medicine Clinical Care Group

- Carry out further investigation and root cause analysis on healthcare acquired infection (HCAI) cases to identify why numbers are increasing for hospital onset and provide timelines for HCAI improvement plans.
- Stroke service Welsh Health Circular (WHC) response needs to be completed as a matter of urgency
- Conduct a deep dive into staff burnout and sickness levels to enable a proper understanding of the situation within the CCG.
- Submit papers to Executive Team to vocalise OCP concerns/challenges
- Share indicative timeline for phase 2 of the OCP with relevant staff, clarifying the what, why and when.
- Review the current rate card costs/challenges across the organisation with a view to determining a unified approach. Executive Team to support in decision making.
- Scope out savings plans for Pembrokeshire and Carmarthenshire
- Value Based Health Care team to focus on UEC transformation.
- Discuss modelling 45-minute ambulance handover KPI and how that would impact the CCG.

Mental Health and Learning Disabilities Clinical Care Group

- Challenges in achieving annual plan in light of substantial workforce and estates challenges - provide an understanding of what transformational or configurational changes in MH&LD would get us to achieve the objectives in the Annual Plan.
- Provide an understanding of the objectives of the workforce plan for MH&LD, actions and dealing with fragility in workforce.
- Meet to resolve savings plans with more clarity on gap in savings identified.
- Discuss governance support for closure of 9 National Discharge Review recommendations in the new CCG management structure and trajectories to ensure closure within timescale.
- Review trajectories for closure of incidents and complaints and identify support needed to close and achieve trajectories.

Key resulting actions by function (2)

Planned and Specialist Care Clinical Care Group

- Urgent meeting to be arranged with the Director of Corporate Governance to give assurance that the governance arrangements agreed by the Formal Executive Team are being met.
- CCG to agree a process to ensure overdue pay progressions are investigated promptly and are done in a timelier manner moving forward. Assistant Director of People Planning to support where needed.
- Reduce variable pay in theatres and improve performance - the scale of this issue needs to be fully mapped out in the theatres business plan. Provide a paper to Executives outlining wider challenges within theatres and what needs to be done to overcome these challenges.
- Review saving plans and how to convert them to green over the next 6 months, including how many of these could convert to recurrent savings for next year's planning cycle. QIAs to be undertaken where needed.
- Provide a paper to Executives outlining details of maternity provisions at Bronglais Hospital.
- Women's Health Plan - Liaise with Public Health on support they can provide around health needs assessment, data and international models.
- Liaise with colleagues in MH&LD CCG to discuss priorities within the overall ASD and ADHD performance metric. Produce a recovery plan which can be taken to the Board which considers potential external capacity solutions for children and young people with ADHD.
- Digital Director to work with CCG to investigate why the outcome recorded on the Welsh Clinical Portal is not linking to WPAS.

Primary Care, Community Strategy and Long Term Care Clinical Care Group

- Patient feedback pilot in 3 managed practises - determine what needs to be done to take the pilot forward across other areas of the CCG.
- Staff turnover - higher levels noted for receptionists in managed practices. In addition to exit interview data, request a report from Workforce Intelligence to review the reason for leaving data.
- Conduct a deep dive into what support is needed for the new digital rostering system including how to resolve historic issues. Submit paper to Executive Team.
- Conduct a reasonable assessment to see how much of the potential full year underspend in Medicines Management could be converted into savings.
- Identify potential services to move from secondary care to primary/community care and how this could be funded from within the existing budget.
- Scale up and roll out of identified cluster projects
- Generate an improvement plan and trajectories for diabetes - 8 care processes.

Key resulting actions by function (3)

Operational Allied Health and Health Sciences Clinical Care Group

- Arrange a meeting with Medical for support around medical workforce stability.
- Plan needed to address month 2 £0.5m overspend to ensure a balanced position by year end. Mitigations needed within the next 2 months.
- Liaise with Director of Finance for support around articulating the risk of the CCG not meeting the 2025/2026 savings target.
- Contact VBHC to discuss/request methodology of how to quantify value within the health board through investment in Radiology diagnostics.
- Clinical Haematology plan to be submitted, detailing the fragility status and cost pressures associated.
- Radiology 8 weeks waits: Look at what it would take to reach the target of 0 breaches by March 2026 and send to Director of Operational Planning & Performance
- Clear remaining overdue pay progressions = 11 (8 of which are overdue by more than 3 months) .

Estates and Facilities

- Investigate themes & trends, to interrogate the reasons, identify root causes for staff turnover and discuss at the next CCG meeting. Consider what is good staff turnover for the CCG and what is bad.
- Conversation to be held to discuss training plans, recruitment and the CCG Workforce requirements going forwards.
- Review red & blue savings schemes at the next CCG meeting to determine which can be utilised to mitigate cost pressures. Include a projection total, if the CCG spend the monies for the Enhanced cleaning funding.
- Link in with Public Health regarding potential support to increase uptake of flu vaccinations for staff within the CCG.
- Communicate to all line managers the importance of timely sickness absence reporting on ESR and how delays can cause under reporting and the negative impact of poor data quality going into the system.
- New performance metrics need to be developed to track the quality of cleaning within our hospitals, as well as the number of cleaning audits undertaken.
- Discuss with Head of Culture & Workforce Experience how we can improve uptake of the Making a difference staff training within the CCG.
- Review longest open risks. Review approach to ensuring adequate time is allocated to achieve risk recommendations.

Key resulting actions by function (4)

Executive Director of Finance (includes Digital)

- Finalise plans to address risk relating to switchboard and the European working times directive.
- Enter negotiations with Royal Bank of Scotland to halt further charges until the Health board changes banking provider (Government Banking service).
- Conduct a quality impact assessment and submit a business case assessing the impact of moving letters from first to second class post has on patients.
- Review the use of digital in the proposed options for the clinical services plan of the health board.
- Clear identifiable list milestones needed to achieve the road map to balance plan.
- Organise a quarterly senior leadership workshop to unblock the main challenges preventing progress.
- Paper to developed on the patient communication hub, patient relationship management at front of house/reception and switchboard.
- Encourage all staff to attend the Making a difference training.

Executive Medical Director

- Work with colleagues in medical rostering and workforce teams to identify resource needed to accelerate the build and rollout of the activity manager rota system.
- Identify how many savings plans across all CCGs contain variable pay.
- Need a programme of training established to increase knowledge of medical staffing terms and conditions within the health board.
- Investigate centralising resources for key systems such as AMaT and DATIX, from existing budgets to Digital. Also, to understand the impact this will have on savings plans in other areas of the organisation.
- Urgent update needed on the status of the clinical variation and mortality dashboards, plus potential to pull together and make available to staff.
- Set up a working group to review the IPFR budget allocation and realign to a more appropriate area of the organisation. Investigate the use of PROMS for every approved request to provide assurance on quality of service.
- Work with Quality team to explore quality impacts, including patient stories, in relation to developments undertaken by Hywel Dda within the research and innovation space, which may help attract staff to the organisation.
- Investigate what is needed to reduce the time taken to complete a death registration from the current 12 days to 6 days. This could include 7-day week working or use of digital systems to reduce human error.
- Increase the number of medical staff that have attended Making a Difference training sessions.

Key resulting actions by function (5)

Executive Director of Nursing, Quality and Patient Experience

- Identify and profile numbers of posts to be filled by nursing students ongoing, incorporating retirements, leavers and potential impact on the safe staffing act. Findings to prompt a business executive planning discussion.
- Meet to discuss the reallocation of the Datix system budget to the Digital team.
- Develop a paper detailing the increasing demand and cost attributed to looked after children/out of area in preparation for the next planning cycle.
- Liaise with Digital Director to discuss potential widening of scope for single point of contact group, to incorporate NQPE stakeholders of the Communications Hub/front of house.
- Review the practicalities of permanently hiring staff into roles for ongoing generalised implementation work.
- Patient experience framework: capture data and impact evidence to aid in the decision making process at a future planning meeting.
- Work to resolve the incidents over 120 days that can be cleared and engage with necessary stakeholders in other functions to provide updates/close the remainder.
- Liaise with complaints/corporate team to ensure there is a robust process in place to prevent complains/incidents from being incorrectly assigned.

Executive Director of Public Health

- Strategic refresh: Inform Director of Finance and Senior Digital team of data analysis requirements.
- Health coaching: focus on piloting in the 2T cluster an investment of £250K, with the aim of investing to save by reducing ill health, to positively impact our acute sites and produce savings in 2026/27.
- Newborn screening - 1.3% of new-born babies are not screened for hearing: Develop engagement and visibility of this potential risk. Engage with Carmarthenshire Council regarding regional safeguarding database. Discuss appropriate governance process of highlighting this to Board.

Key resulting actions by function (6)

Executive Director of Strategy and Planning (includes Long Term Agreements (LTAs))

- Assess the data sources and information flows we could use to capture quality and safety metrics, e.g. incidents for Hywel Dda residents, into our commissioning arrangements for the basis of a Quality framework with mandated expectations similar to what is in place in NHS England. Take this to the commissioning group being established.
- Identify models of how the planning structure could align with the new clinical care group structure. This could be similar to the model Digital are working on for data analytics. Identify how the planning function could contribute specific skill sets across and support operational functions.
- Look into the additional activity in the Swansea Bay arrangement and spending this year on non-core activity. Could T&O be managed as a joint waiting list?
- Separate out LTAs and the core corporate planning team in future EITS meetings as the two areas have different issues.

Executive Director of Workforce and Organisational Development

- Alignment of 10-year workforce plan and financial/organisational recovery plan: As part of the work for submitting the organisation financial recovery plan, generate an economic assessment including what the projections are likely to be for workforce planning. Following Economic Assessment, arrange a session with Workforce, Finance & Planning to map a service and workforce planning as part of a costed 3 year plan leading to a 10 year strategy.
- Liaise with Deputy Chief Operating Officer to identify what the requirements are for a robust digital operational workforce planning modelling tool. Explore what a good integrated planning system would look like, which would provide people analytics and modelling for 10, 3 and 1 year plans.
- Determine what we would consider to be a healthy staff turnover rate by professional group to assess if the <6% target for staff turnover across our organisation is fit for purpose.
- Review, validate and finalise re-alignment of budget within the next 2 weeks. Executive Director of Workforce and OD to sign-off.

Governance and Communication

- Conversation to be held, to ensure the health board is addressing the Welsh Language Commissioner's requirement by integrating Welsh Language into the Communications Hub plan.
- Conversation to be held to address the obstacles preventing Targeted Intervention de-escalation to level 2.
- Complete outstanding PADRs by the end of the month

Key achievements

Below is a summary of some of the key achievements highlighted within the EITS meeting packs:

Community & Integrated Medicine

- The Bronglais Thrombosis Prevention Team has won a prestigious national award in recognition of work by teams across all departments in lowering the risk of thrombosis in patients under their care. The team picked up the 'Work in VTE Prevention' award at a special event at the House of Commons.
- Highly Commended under the Category of Partnership Working in the Social Care Wales Accolades for the Home First Hub together with Delta Connect
- Presented the West Wales Clinical Vision for Urgent & Intermediate Care to the Care Action Committee. Ministerial drive to deliver model across Wales and an impetus to develop a National Framework for TEC enabled IAA co-located with Home First Hubs & MDT working
- Pembrokeshire Diabetes Clinical Lead Nurses nominated for Diabetes Specialist Nurse Team of the year
- Cardigan Same Day Urgent Care Centre and Community Outreach identified by Welsh Government as a model for adoption across Wales
- Cardigan SDUC won Student Nurse Award for Best Practice Development Environment
- Clinical Lead Nurse Bianca Oakley nominated for Chief Nursing Officer award in the Nurse of the Year awards. (Ceredigion)
- Working in Partnership Award from West Wales Regional Partnership Board (Pembrokeshire)
- Team Y Bwa was Highly Commended in the Outstanding Contribution to Health and Social Care by the West Wales Regional Partnership Board (Ceredigion)
- Doccla remote monitoring launched for Hospital at Home (Pembrokeshire/Carmarthenshire)
- Securing funding to continue TWOC after the evaluation (Pembrokeshire/Carmarthenshire)
- Opening of Bronglais Hospital Chemotherapy Day Unit
- Clinically led Trusted Assessor pilot Mental Capacity (Pembrokeshire)
- SSDEC operational (Carmarthenshire)
- TTAC operational (Carmarthenshire)
- Repatriation database (Carmarthenshire led – across board)
- Reduction in Nurse agency – now 0 nurse vacancies (Carmarthenshire)
- Capital Plan for front door reconfiguration at Glangwili Hospital
- Prince Philip Hospital frailty model operational
- Charitable funding secured to provide bereavement support for children and young people (Ceredigion)

Key achievements (2)

Governance & Communications

Corporate Governance

- Positive all Wales Structured Assessment Report with 0 recommendations for corporate governance and assurance and risk
- National de-escalation of governance domain from Targeted Intervention (L4) to Enhanced Monitoring (L3)
- Implementation of new Board and Committee Structure
- Establishment of Regional Joint Committee
- Design of new operational governance arrangements (SOP, templates, SOD, etc) with significant support provided
- Completion of Board and Committee effectiveness programme for 2024/25 – including design of new Board Maturity Matrix
- Completion of Risk Maturity Matrix
- Seamless realignment of Datix Risk Module to new operational structure to enable reporting of risk and providing support to new CCGs with assurance and risk arrangements

Corporate Office

- Positive impact from CEO's evidence session at the UK Covid-19 Public Inquiry in November 2024
- Improved escalation process for CEO and Chair's correspondence has had a positive impact on responses
- Freedom of Information (FoI) compliance rate for 2024/25 is 98% with 100% achieved regularly

Communications, Engagement and Welsh Language

- Completion of internal staff audit on Communications – 3.6% of staff took part – this is now informing a programme of improvement work in our internal communications channels
- New web pages and video of Board's Annual Plan prepared for publication in June 2025
- Communications and videos created on Public Health Social Media Conference
- Produced patient stories to illustrate health board's direction towards our vision and strategy
- Supported openings, including Glangwili maternity and neonatal unit (February), Bronglais Hospital chemotherapy unit (May)
- Promoted and celebrated several staff awards (i.e. such as this for maternity services, which included a slot on BBC Radio Wales [Hywel Dda midwife team win prestigious national awards](#))
- Promoted communications on apprentices, produce key recruitment videos (Medical and Nursing Directors) and announced subsequent appointments
- Advising and supporting communication on reputational issues including FCP control group, access to mental health assessments north Ceredigion, Bronglais Hospital temporary change (and reinstatement) of elements of the paediatric service
- Launched communication and engagement plans on large consultations (inclusive of multiple materials and publicity as well as public and staff events and activities), Clinical Services Plan (May), Llanelli MIU (April)
- Maintained and delivered a robust translation service for the whole Health Board - continuing to ensure turnaround target remains at 95% and above

Key achievements (3)

Operational Allied Health & Health Sciences

Governance

- Clinical Care Group Integrated Governance meeting structure is in place, supporting timely 3A assessments reporting into bi-monthly IQFPDG.
- Established processes to get a grip on escalation issues:
 - Development of our business partner relationship with the Performance Team has resulted in the sharing of data sets to enable CCG leadership to agree improvement actions with service leads – Thank you!
 - Monthly Governance meetings have been successfully established with QAST business partner, resulting in positive engagement with service leads resulting in an improvement in closure of overdue incident investigations

Demand and Capacity

- A plan has been developed to implement demand and capacity work and service reviews across all 5 services within the CCG (phase 2 will look at testing this D&C tool with Radiology and Pathology)

Radiology Annual Plan 2025/26

- Funding was secured to stabilise cancer performance and the Radiology infrastructure.

Patient focus

- CCG ensure a patient-focus to Governance meetings by sharing patient stories. Speech and Language Therapy shared Gary's story which showed the impact to Gary and his family of accessing timely diagnostics in relation to his swallowing difficulties

Quality Improvement

- Podiatry shared their successful evaluation of a Podiatry and Arrhythmia Atrial Fibrillation Screening Project: 'Cutting out the middleman in Arrhythmia detection'. During a 16-week period, 36 patients were identified as requiring an ECG. Of those, 5 were found to have Atrial Fibrillation and another 2 were found to have Atrial Flutter. All 7 were asymptomatic. Those suffering with asymptomatic AF are known to have worse outcomes. Evidence base indicates their early detection, and subsequent treatment is vital for preventing Cardio-embolic strokes. This project involved the podiatrist for detection, the cardiac physiologist to interpret the ECG and pharmacy to administer treatment.

Key achievements (4)

Planned & Specialist Care

Nominations and awards

- Baby Lifeline award
- Promoting Collaboration and Teamworking
- Achieving Excellence Through Service Improvements
- Mariposa Saying Goodbye Awards, Midwife of the Year 2025, HDUHB
- Anwen Butten, Head and Neck Cancer Clinical Nurse Specialist, awarded a Member of the Order of the British Empire (MBE) in the 2025 King’s Birthday Honours.
- Positive Maternity HIW inspection
- HDUHB Maternity Fayre attended by over 250 service users March & June 2025
- Gynae 1-stop

Estates & Facilities

Domestic services

- Consideration for a new operating model to address the concerns across domestic services in Glangwili Hospital and Prince Philip Hospital in the first instance, followed by Withybush Hospital and Bronglais Hospital.
- The new operating model should include converting bank use to WTEs.

Governance Group

- Since May 2025, a Clinical Care Group has been established for Estates and Facilities. This includes the establishments of service groups for each service across the department that report directly to the Estates and Facilities Integrated Governance Group. The Group escalates matters to IQFPD utilising the 3A assessment reporting template, in line with the Clinical Care Group Governance structure.

Projects

- All current discretionary projects are on time including targeted Estates funding bids and ongoing RAAC work.

Key achievements (5)

Finance & Digital

Finance

- Completed OCP process, realising distinct Business Control and Business Partner functions and alignment to new operational management structure
- Stabilised former business partner function ahead of realising OCP structure and recruitment progress
- Financial Management Internal Audit concluded reasonable assurance and Cash Management Internal Audit concluded with substantial assurance
- School visits and lesson demonstrations to advertise numeracy roles within the NHS and the Finance Apprenticeship programme
- Reporting developments leading best practice nationally, namely Finance Performance Report and Pay Analysis ledger coding project
- Accommodation changes to Ty Gorwel to generate estate savings and embrace agile hot desk working in advance of the corporate headquarters in Picton Terrace
- Two members of the team won the HFMA Wales 2024 Rising Star award
- Organisational achievement - Delivered year end outturn 2024/25 ahead of WG Target Control; £24.1m outturn deficit
- Overhaul of corporate reporting arrangements linked to the implementation of the Clinical Care Group structure, and associated master data changes required across Finance systems, and held wider Corporate Function update sessions to ensure alignment across reporting offering

Digital

- Substantial assurance in the performance management internal audit report
- New Our Improving Together Framework approved by Board in March 2025.
- All performance outputs and processes revised to align to the new organisational structure.
- Published dashboard to help CITO project team monitor batch uploads and identify missing records and incorrectly linked patients
- Published 'Current Red Reasons' dashboard to support front line colleagues in monitoring reasons for delayed discharge and identify trends.
- Development of several operational tools utilising large language models (LLM) and AI.
- Introduction and migration of over 300 servers.
- Accelerating the implementation of an eOBS (Electronic Observations)
- Developed a robust benefits realisation process and approach.
- Accelerating the implementation of EPMA
- Replaced the Windows 10 devices planned, tested and instigated for 2025.
- Completed the movement from analogue to digital telecoms across our 4 acute sites.

Key achievements (6)

Medical Directorate	
• Not on my shift: Tackling unprofessional behaviours in the workplace film is complete. • Board approval of new Research and Innovation Strategy (2025-2030) • Effective Clinical Practice Roadshows have been successful, showcasing the good work across each of the hospital sites and community, winners from each of the roadshows will be presenting at the Health Board wide roadshow being held in October 2025.	• Following on from last year's success, the Trainer and Trainee of the Year Award's 2025 is now live and open for nominations. We have already received 15 nominations for Trainer of the Year and 11 for Trainee. • The 2025 Becoming a Doctor programme commenced in May with over 60 young adults from across the 3 counties signed up to attend. Those on placement in the hospitals will be provided with new distinct scrub tops, which will make them easily recognisable and will enhance their experience of the world of healthcare.
Mental Health & Learning disabilities	
• Recent confirmation that the Pembrokeshire CAMHS schools In-reach work has been shortlisted for a Nursing Times award in the Mental Health Nurse category.	Executive Team members flagged at the meeting the clinical care group had achieved a lot more than this and encouraged the team to vocalise their successes more moving forward.

Key achievements (7)

Nursing, Quality & Patient Experience	
• Substantive appointment of Executive Director of Nursing • Thrombosis UK first prize to Bronglais Hospital for systems to manage and prevent Hospital Acquired Thrombosis • Focussed approach with operational & workforce teams to create additional opportunities for students through streamlining, based on workforce planning intelligence, resulting in the number of posts offered exceeding student numbers • Establishment of nursing audit programme, including roll out with operational nursing teams • Implementation of 3Ps programme and associated development of the Waiting List Support Service	• Development of robust improved professional standards database capturing and monitoring progress on regulatory referrals to the NMC. Significant work has been undertaken with the NMC to cleanse the previous database, work through and conclude lengthy outstanding investigations. Framework being developed to ensure our staff feel supported during a professional standards investigatory process, or when called as a witness. This will then be considered in relation to legal processes such as coroners or crown court, as well as internal operational workforce investigations. • Completion of the investigation of harm for a large volume of patients (circa 4k notes).
Primary Care, Community Strategy & Long-Term Care	
• Long Term Specialist Nurse recently won the Chair's Commendation Award for collaboration • Lead Diabetes CNS won the BJN Diabetes Nurse of the year award • Continued progress with securing salaried GPs in Managed Practices with Tenby and Ash Grove not requiring locums on a regular basis	• Pharmacy Site Lead for Bronglais Hospital attended the Thrombosis UK Venous thromboembolism (VTE) Prevention Awards held in Westminster on the 13th May with other colleagues. The Bronglais team won the award for this category.

Key achievements (8)

Public Health

- Give Children and Young People the best start in life - RPB Children and Young People's Board re-established. Pilot programmes commenced in Infant Feeding, First 1000 Days: Food, Nutrition & Movement, starting well - Arts in Health/Peri Natal Mental Health initiative.
- Social Model for Health & Wellbeing (SMfHW) - Summit to celebrate and promote the system-wide adoption of equity and wellbeing principles of the regional Social Model for Health and Wellbeing. This initiative is supported by a regional steering group with national leadership. Launched 'Creating Change Together' across three counties, evolving into a dynamic community of practice aimed at driving local project- and partnership-based action, and fostering shared learning on health equity. SMfHW Maturity Matrix to be embedded in WBFG Maturity Matrix and Progress tracker to support embedding Social Model for Health and Wellbeing across Wales.
- Set up our HIV elimination steering group, a multiagency group brought together with the aim of eliminating transmission of HIV by 2030.
- Health Protection – Assertive Outreach work continued, in partnership with The Wallich, a homeless charity. Outreach days held across 'hot spot' areas in Llanelli, Carmarthen and Ammanford. 54 Contacts, 6 of whom only came forward due to receiving a blood transfusion prior to 1991 (Infected Blood Inquiry).
- Health Protection – Find & Treat Bus in partnership with Public Health Wales and University Hospital London a targeted TB and BBV screening service provided in Llanelli area for homeless, refugee/asylum seekers and at-risk population. 85 people attended the screening in the local community – good response.
- Delivery of Whole Systems Approach to Healthy Weight – 110+ stakeholders engaged across the region, leading to 'Access to Food' as a priority sub-system; 2 of 3 Public Service Boards adopted healthy weight as a strategic priority, with place-based asset mapping completed to guide local solutions.

Strategy & Planning

- Instrumental in the on-going Prince Philip Hospital MIU work/consultation; Clinical Services Plan (CSP); and the Strategic refresh. Establishment of a 'Knowledge Awareness Forum'
- The Health Pathways programme has published around 200 pathways, exceeding the target
- Successful completion and commissioning of the Leri Day Unit Scheme in Bronglais, approval of the BJC for SARC and funding to progress the scheme. Planning for the commissioning of Hydrotherapy Pool in Canolfan (Pentre Awel)
- Elective Orthopaedics at Swansea Bay (LTA vs Regional Monies) – adjustment to the LTA agreed.
- Velindre Cancer Centre (high-cost drugs (HCD)) – paying HCDs on utilisation
- DEXA – significant reduction around the waiting list
- Identification of inadvertent costs (either already in the system or potential cost proposals) primarily at Swansea and Cardiff - savings through SLA reviews, drug costs, locally provided services (Neurology)

Key achievements (9)

Workforce & Organisational Development

People Management Teams

- Recruitment – Hywel Dda continues to be the fastest recruiter in NHS Wales.
- 296 internationally educated nurses (IENs) appointed. Submitted our IEN Closure Report in January 2025. This programme has contributed to a reduction in Band 5 registered nurse vacancies from 280.67 WTE in December 2021 to 18.9 WTE in December 2024. Our retention rate remains high at 98.6%.
- First Medic (Haematology Specialist Grade) arrived in Withybush Hospital on 31 Mar 2025. This was the first Specialist Grade in Wales sourced via the NHS Wales programme. The first Allied Health Professional (AHP) campaign reached 85k+ applicants with 22 offers of employment made
- Headhunting directly from LinkedIn resulted in 6 appointments into hard to fill posts across nursing, medical & dental and admin & clerical.

Psychological Wellbeing and Occupational Health

- Our Recovery in Nature (RiN) programme is now in its fourth year. The programme offers single RiN days as well as 4-day Ecotherapy Retreats at different woodland sites and evaluation has shown its clinical effectiveness on measures of wellbeing and burnout while personal stories from participants demonstrate the powerful impact that recovery in nature is bringing to our workforce. The qualitative data gathered from staff attending has been deeply inspiring and heartwarming and hearing about the lasting impact of the work has been really satisfying for the team. Our RiN programmes for this year are already at more than 80%.
- Occupational Health achieved or exceeded the all Wales KPIs for all activity in the year.

Operational Workforce (including medical workforce and job evaluation (JE))

- We completed our 3-year employment policy review in March 2025 and removed 15 policies from our repository which were no longer required or subsumed into new policy frameworks. This has resulted in a 27% reduction in the number of employment policies held by the Health Board during that three-year period. We also pledged to reduce the number of pages in our policies to 5 or less (excluding corporate governance sections) over a 10-year period to enable their content to be streamlined. Over the first three years, we have seen 79% of our policies achieve this pledge.
- Invited to showcase work on the new internal JE governance process to All Wales colleagues – Hywel Dda is the only Health Board to have implemented these revised procedures. Also feeds into true social partnership working in terms of how we work with our TU JE lead.
- Working to validate all medical rotas to ensure compliance with the Fatigue & Facilities Charter etc and assessing any impact on service delivery. Also, some significant success in securing substantive employment of medical staff from agency & locum contracts to ensure significant savings are made. This work contributes to the activity on medical stabilisation.

Learning from the EITS process

What went well

- This was the first round of EITS for the new clinical care group structure. Good working relationships have been established between the Performance Team, corporate teams and the operational functions. This meant schedule changes were kept to a minimum, data was provided, and packs were returned within manageable timeframes. This resulted in smooth delivery of the 13 sessions over 4½ weeks.
- Functions were able to discuss issues and blockages with Executive Directors so that, where available, support could be allocated.

Where we need to improve

- It was agreed during the Strategy & Planning session that LTAs have different issues and focus to the rest of the function and would benefit from being considered separately moving forward.
- The information pre-gathered by the Performance Team for the data quality section was not as comprehensive as it needed to be.
- Lack of consistency in the meeting packs provided by the functions.

Resulting actions

- Performance Team to schedule separate EITS meetings in November for (1) Strategy & Planning and (2) LTAs.
- Performance Team to review the data quality self assessment responses and work with the Digital Director to develop an action plan.
- Performance Team to develop guidance for functions on completing meeting packs ahead of the November 2025 EITS. Guidance to cover:
 - Expectation from Executive Directors
 - Need to include SMART actions that will provide assurance
 - Improvement trajectories need to be derived and presented in the packs
 - Requests for help need to be specific in terms of skills/experience and capacity needed e.g. experienced project manager for 2 days a week for 6 months.
 - Supporting documents can also be linked from the pack to provide additional evidence of plans in place and progress being made.

5.2

12:35 PM, 0 Mins

5.2 - NWSSP PERFORMANCE REPORT QUARTER 1 2025/26

Andrew Spratt
(Hywel Dda UHB -
Deputy Director of
Finance)

| For assurance

Attachments

NWSSP Performance Report Q1 2025-26 FPC 26 August 2025.pdf

HDdUHB Summary Performance Report.pdf



**PWYLLGOR CYLLID A PHERFFORMIAD
FINANCE AND PERFORMANCE COMMITTEE**

DYDDIAD Y CYFARFOD: DATE OF MEETING:	26 August 2025
TEITL YR ADRODDIAD: TITLE OF REPORT:	NHS Wales Shared Services Partnership (NWSSP) Performance Report Quarter 1 2025/26
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Huw Thomas, Director of Finance
SWYDDOG ADRODD: REPORTING OFFICER:	Rhian Davies, Assistant Director of Finance

Pwrpas yr Adroddiad (dewiswch fel yn addas)

Purpose of the Report (select as appropriate)

Er Sicrwydd/For Assurance

**ADRODDIAD SCAA
SBAR REPORT**

Sefyllfa / Situation

The purpose of this report is to provide the Finance and Performance Committee with summary performance data in respect of the services provided by NHS Wales Shared Services Partnership (NWSSP) for the quarter ended 30 June 2025 (Quarter 1 2025/26).

The Finance and Performance Committee is requested to receive an assurance from the content of the NWSSP Performance Report for Quarter 1 2025/26.

Cefndir / Background

The NWSSP is hosted and governed by the Velindre NHS Trust Shared Services Regulations and the Shared Services Partnership Committee (SSPC). The SSPC is hosted by Velindre on behalf of the seven Health Boards, three Trusts and two Special Health Authorities within NHS Wales (the partners) and is responsible for monitoring governance and performance. The required standards for effective governance are outlined within the SSPC's Standing Orders, Values and Standards of Behaviours framework, and associated policies. The partners participate in the SSPC and take collective responsibility for the delivery of the services through a hosting agreement between the partners.

The purpose of the SSPC is to:

- Set the policy and strategy for NWSSP;
- Monitor the delivery of Shared Services, through the Managing Director of NWSSP;
- Seek to improve the approach to delivering Shared Services which are effective, efficient and provide value for money for partners;
- Ensure the efficient and effective leadership direction and control of NWSSP; and
- Ensure a strong focus on delivering savings that can be re-invested in direct patient care.

The Board has approved Standing Orders in relation to the establishment of joint committees. In line with these Standing Orders, Hywel Dda University Health Board (HDdUHB) has established a NWSSP Committee as a joint committee of the Board, the activities of which require reporting to the Board.

Asesiad / Assessment

As part of the approval of Year 1 of the SSPC Integrated Medium Term Plan (IMTP) for 2025-26, the SSPC reviewed its Key Performance Indicators. A number of Lead indicators were identified for each division. There are 21 Lead indicators in total.

Full details of the performance against all Wales agreed KPIs for services provided to HDdUHB are attached (**Appendix 1-3**) with comparison data for the rolling twelve-month period to 30 June 2025.

HDdUHB Specific Key Performance Indicators

In summary, of the 21 Lead indicators for Quarter 1 the performance is as follows:

	Green	Amber	Red	Not Applicable
Quarter 1 2025/26	17		1	3

By exception, the area where performance is not on target is highlighted below:

Accounts Payable – NHS Public Sector Prompt Payment (PSPP)¹

Performance driven by both HDdUHB and NWSSP shows the organisation missing the following KPI:

- **PSPP Compliance NHS: Target 95%**
- **Performance: 80.2%**

What is happening?

PSPP Compliance NHS missed the 95% target during Quarter 1 reporting 80.2%

What is NWSSP doing about it?

Accounts Payable continues to support NHS and non-NHS PSPP reporting by providing regular updates and invoice hold data to help address the performance.

The creation of a KPI for monitoring NHS PSPP performance by individual health organisation is new for 2025/26. The inclusion of the NHS PSPP measure this year was a recognition that this is also a joint measure between NWSSP and health organisations. The aim is to help

¹ Definition of the CBI Prompt Payment Code financial target for NHS bodies:

Payment of at least 95% of non-NHS invoices within 30 calendar days from the receipt of goods or a valid invoice (whichever is later) unless other payment terms have been agreed. NHS bodies must disclosure in their financial statements performance against the measure set out above and also performance on the same basis for NHS invoices (although the latter is not a financial target).

identify if there is something NWSSP need to act on or can support the organisation in any progress and improvement in this compliance.

The Finance Team within the Health Board work with NWSSP colleagues to improve performance in this area but it continues to be challenging as this is an area where more intervention is required as there are low numbers of Purchase Orders (POs) raised (as NHS organisations are on the PO exemption list) and authorised signatories frequently need a number of reminders before invoices are approved for payment.

The Health Board continues to meet the non NHS PSPP target which is the required financial target.

All Wales Key Performance Indicators

Performance is reported on an all Wales basis for KPIs that cannot be attributed to a specific health organisation, with comparative data for the rolling twelve-month period to 30 June 2025.

Summary Assessment by NWSSP

The Quarter 1 performance for the organisation was good with 17 out of 18 KPIs showing as green. The time to hire target was achieved in June and NWSSP continues to work with the organisation to cleanse any older records which can affect the overall time to hire performance.

Further action will continue to be taken forward to address the performance in areas of underperformance.

- 1 KPI did not achieve the targets:

This is a combination of NWSSP and Health Board responsibility. NWSSP continues to support the organisation in relation to accounts payable performance.

Appendix 4 shows the Outcome measures that NWSSP has been working on at the end of June 2025 to highlight and report the impact and importance of what it does.

Argymhelliad / Recommendation

The Finance and Performance Committee is asked to: -

- **RECEIVE ASSURANCE** from the content of the NWSSP Performance Report for Quarter 1 2025/26 that services provided are being delivered to expected standards; and
- **NOTE** the work being developed regarding outcome measures reporting.

Objectives: (must be completed)	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	3.1.11 Commission regular reviews of key contracts, suppliers and partners to ensure they continue to deliver value for money.
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)	Not Applicable
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	Not Applicable
Amcanion Strategol y BIP: UHB Strategic Objectives:	6. Sustainable use of resources
Amcanion Cynllunio Planning Objectives	Not Applicable
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022	10. Not Applicable

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Summary performance data in respect of the services provided by NHS Wales Shared Services Partnership (NWSSP) for the quarter ended 30 June 2025.
Rhestr Termiau: Glossary of Terms:	Explanation of terms is included within the report.
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Cyllid a Pherfformiad: Parties / Committees consulted prior to Finance and Performance Committee:	Shared Services Partnership Committee (SSPC)

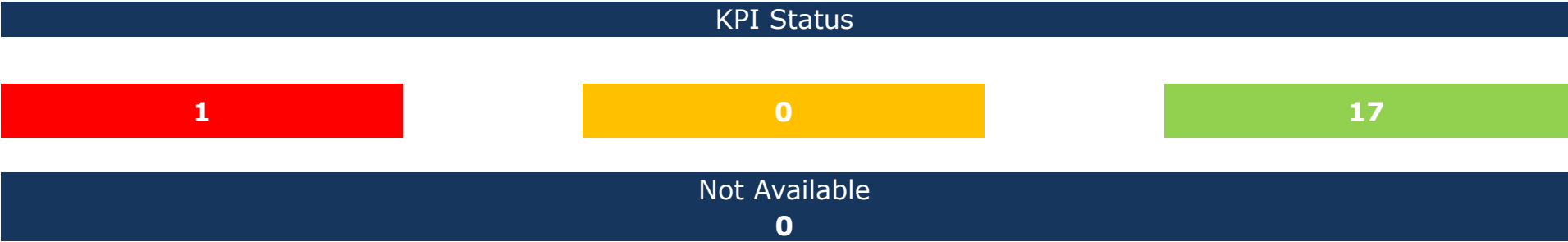
Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	NWSSP was established to improve the approach to delivering Shared Services, which are effective, efficient and provide value for money for Partners.

Ansawdd / Gofal Claf: Quality / Patient Care:	NWSSP has a remit to focus on delivering savings that can be re-invested in direct patient care.
Gweithlu: Workforce:	NWSSP is hosted by Velindre NHS Trust and any workforce implications are dealt with by the Trust.
Risg: Risk:	In line with its Standing Orders, the Health Board has established a NWSSP Joint Committee, the activities of which require reporting to the Board.
Cyfreithiol: Legal:	In line with its Standing Orders, the Health Board has established a NWSSP Joint Committee, the activities of which require reporting to the Board.
Enw Da: Reputational:	Not Applicable
Gyfrinachedd: Privacy:	Not Applicable
Cydraddoldeb: Equality:	Not Applicable

NWSSP SUMMARY PERFORMANCE REPORT

HYWEL DDA UNIVERSITY HEALTH BOARD

Period 1st April 2025– 30th June 2025



Points of Contact

Rebecca Nelson – Director of Planning, Performance & Informatics (Rebecca.Nelson2@wales.nhs.uk)
Richard Phillips – Assistant Director of Planning & Performance (Richard.phillips@wales.nhs.uk)

The purpose of this report is to provide summary performance data in respect of the services provided by NHS Wales Shared Services Partnership (NWSSP) for the quarter ended 30th June 2025.

As part of the approval of our Year 1 of our IMTP for 2025-26, the Shared Services Partnership Committee (the Committee) reviewed our Key Performance Indicators. We then identified a number of Lead indicators for each division. There are 21 Lead indicators in total.

The Quarter 1 performance for the organisation was good with 17 out of 18 KPIs showing as green.

The time to hire target was achieved in June and NWSSP continue to work with the organisation to cleanse any older records which can influence the overall time to hire performance.

Further action will continue to be taken forward to address the performance in areas of underperformance.

Of the 1 KPIs that did not achieve the targets:

- 1 is a combination of NWSSP and Health Board responsibility.

NWSSP continue to support the organisation in relation to accounts payable performance.

The main financial benefits accruing from NWSSP relate to professional influence benefits derived from NWSSP working in partnership with Health Boards and Trusts. These benefits relate to savings and cost avoidance.

- Legal Services – Settled Claims savings, damages and cost savings.
- Procurement Services – Cost reduction, catalogue management etc. (Heads of Procurement discuss with Director of Finance of Health Orgs)
- Specialist Estates Services – Property management/lease/rates negotiated reductions and Build for Wales framework savings.
- Counter Fraud Services – Financial Recoveries and prevention.
- Accounts Payable - statement reconciliation, priority supplier programme (PSP) and the prevention of duplicate payments.

The indicative financial benefits arising in the period April – June 2025 for the organisation is £2.2M with the breakdown in the following table.

Service	YTD Benefit £m
Specialist Estates Services	0.02
Procurement Services	1.98
Legal & Risk Services*	-
Accounts Payable	0.20
Oxygen Finance – PSP	0.01
Counter Fraud Services*	-
Total	2.2

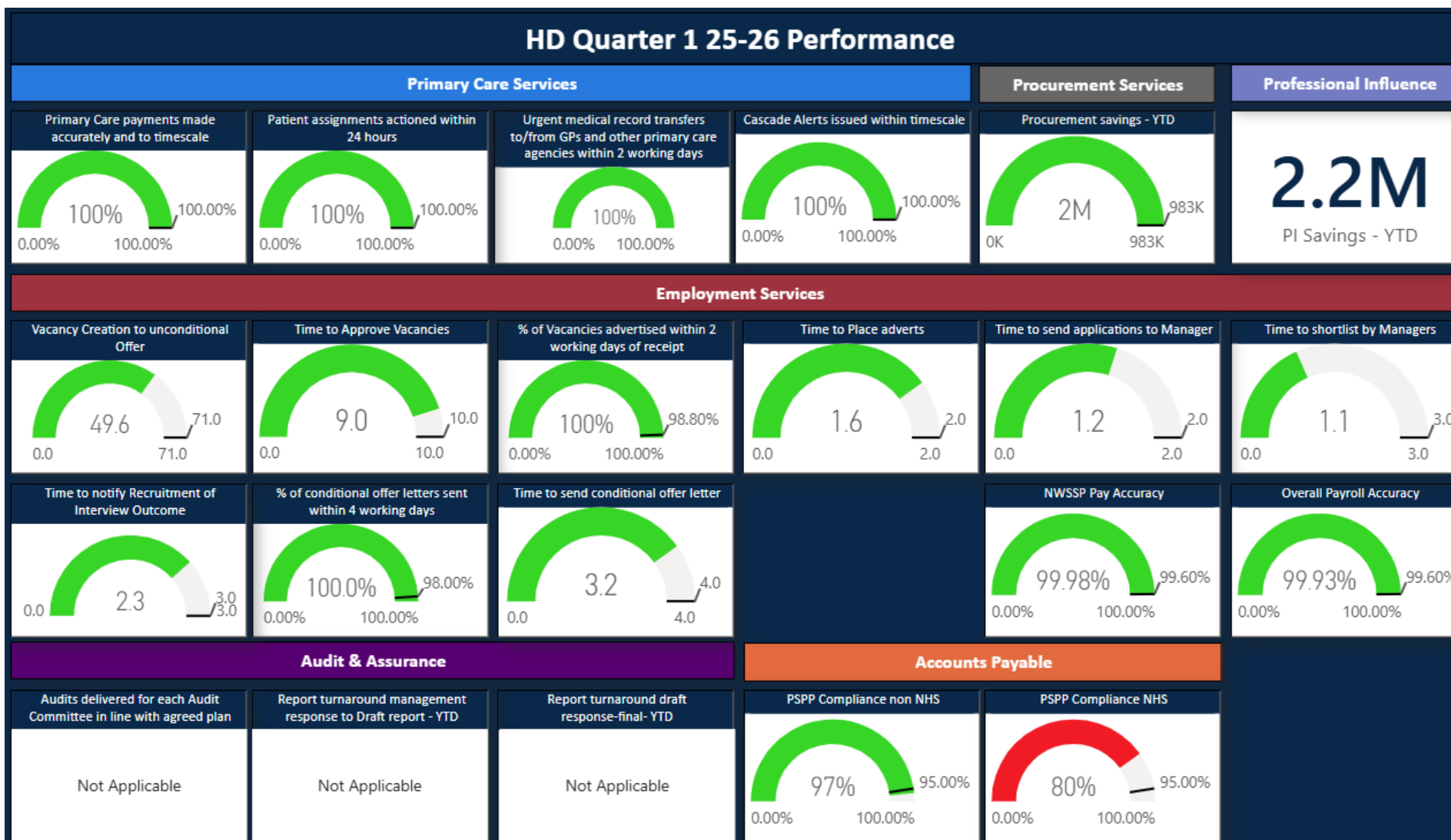
* Not available at the time of writing

Appendix 1 to this report provides the June performance for your health organisation against the Lead indicators with comparison data for the rolling twelve-month period to 30th June 2025.

Appendix 2 provides June performance against All Wales KPIs which cannot be attributed to a specific health organisation but report an All-Wales position with comparison data for the rolling twelve-month period to 30th June 2025.

Appendix 3 then highlights the position for all health organisations at the end of June 2025.

Appendix 4 highlights the Outcome measures reporting we have been working on at the end of June 2025.



Action Plan for Lead Indicators

There was one KPI showing as red for the in-month June position.

There were no KPIs showing as amber for the in-month June position.



HD High Level - KPIs June 2025	Target	30/09/2024	31/12/2024	31/03/2025	30/06/2025	Trend
Accounts Payable						
PSPP Compliance non NHS	95%	95.8%	97.8%	96.4%	96.8%	
PSPP Compliance NHS	95%				80.2%	

What is happening?

PSPP Compliance NHS missed the 95% target during Quarter 1 reporting 80.2%

What are we doing about it?

Accounts Payable continues to support NHS and non-NHS PSPP reporting by providing regular updates and invoice hold data to help address the performance.

Invoice on Hold

There are 485 invoices on hold older than 1st April 2020, some of these date back to 2015/16.

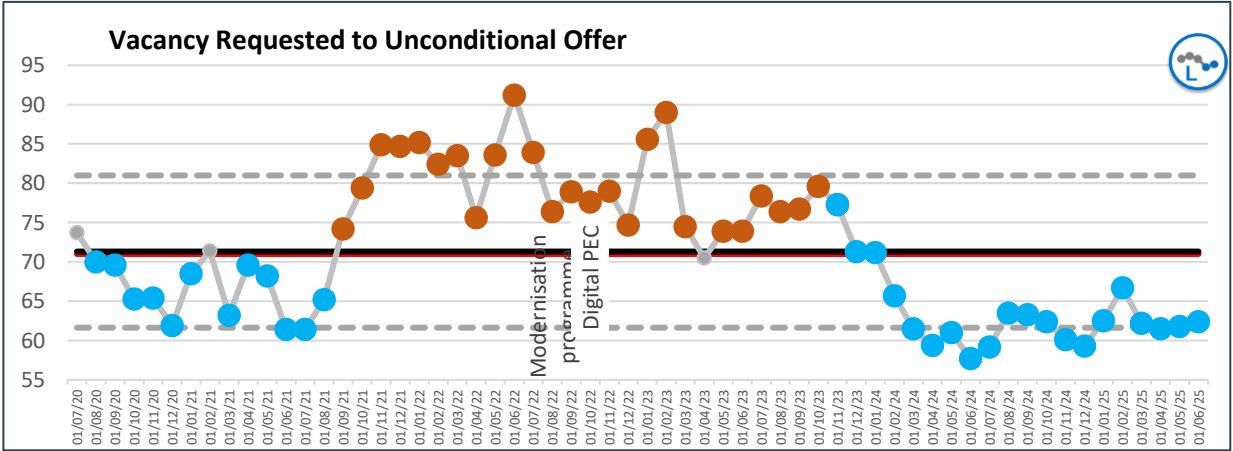
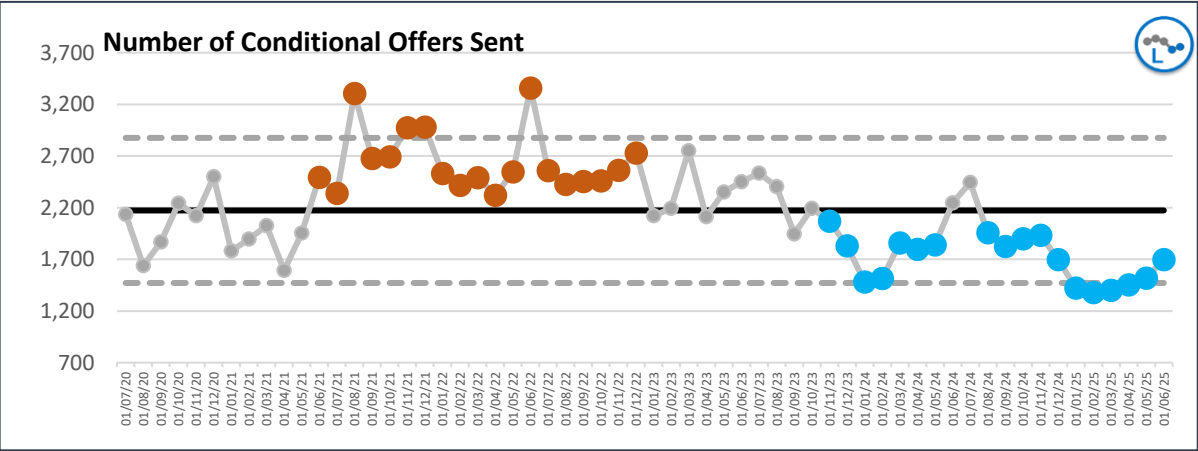
	All Invoices		Older than 30 days		Older than 1/4/25		Older than 1/4/24		Older than 1/4/23		Older than 1/4/22		Older than 1/4/21		Older than 1/4/20	
ORG	NUMBER	VALUE	NUMBER	VALUE	NUMBER	VALUE	NUMBER	VALUE	NUMBER	VALUE	NUMBER	VALUE	NUMBER	VALUE	NUMBER	VALUE
AB	6783	£16,474,745	4739	£6,689,017	3390	£3,839,613	1392	£1,642,522	719	£1,585,734	307	£381,512	156	£227,234	79	£95,420
BCU	9172	£23,841,182	6037	£9,863,034	3946	£4,703,112	1013	£916,586	403	£403,746	171	£158,822	66	£83,097	27	£41,446
CTM	7414	£17,272,350	4994	£7,680,511	3725	£4,864,495	1558	£1,950,215	607	£760,291	63	£24,006	7	£76		
CV	8547	£28,323,316	5594	£13,433,431	3596	£6,141,909	1105	£1,770,143	582	£755,597	412	£463,549	327	£435,460	253	£421,478
DHCW	151	£40,675,224	58	£611,547	40	£332,077	5	£304,146								
HD	3255	£12,317,706	2066	£5,140,500	1110	£1,208,195	228	£203,492	61	£71,707	10	£25,996				
HEIW	265	£4,155,736	95	£1,487,782	43	£530,229	1	£2,968								
PHW	1406	£5,840,802	926	£2,755,918	618	£1,046,513	187	£232,665	116	£126,680	48	£31,892	9	£4,592	3	£3,720
POWYS	849	£6,364,023	564	£5,768,492	355	£5,301,257	106	£41,285	49	£20,643	26	£9,385	23	£9,354	9	£11,765
SB	6130	£19,335,988	3823	£9,134,357	2609	£3,995,017	869	£1,432,001	442	£436,745	239	£162,167	154	£56,438	103	£42,764
VEL	2534	£11,340,202	1874	£4,686,149	1399	£2,596,996	242	£548,398	112	£57,892	55	£11,910	37	£10,033	11	£1,902
WAST	696	£4,218,988	344	£1,820,817	216	£1,456,994	41	£15,878	7	£5,269	3	£413				
Grand Total	47202	£190,160,263	31114	£69,071,554	21047	£36,016,409	6747	£9,060,299	3098	£4,224,305	1334	£1,269,653	779	£826,284	485	£618,497

There are 18k invoices across Wales on hold older than 30 days and not disputed, once paid this will negatively impact the future PSPP position.

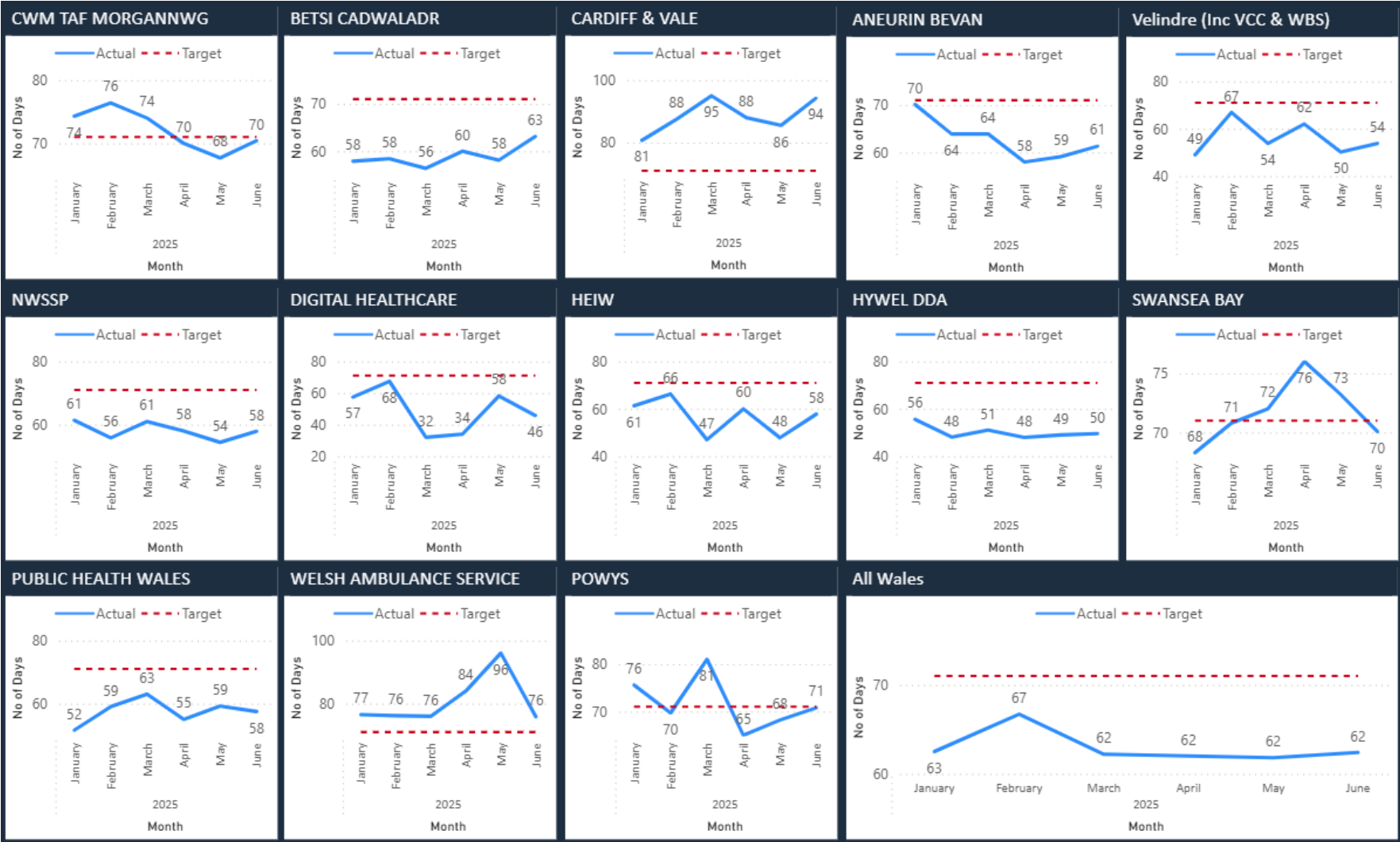
Invoices older than 30 days and NOT disputed	All Invoices	Not Disputed	%
AB	4,739	2,246	47%
BCU	6,037	3,781	63%
CV	5,594	3,884	69%
CTM	4,994	2,613	52%
HD	2,066	1,182	57%
HEIW	95	40	42%
DHCW	58	34	59%
PTHB	564	272	48%
PHW	926	585	63%
SBU	3,823	2,053	54%
VEL	1,874	789	42%
WAST	344	235	68%
All Wales	31,114	17,714	57%

Employment Services – Recruitment

Recruitment		Vacancy Creation to Unconditional Offer														
Org	Target	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Trend		
AB	71	72	67	69	67	76	68	70	64	64	58	59	61		↓	
BCU	71	69	71	66	66	61	57	58	58	56	60	58	63		↓	
CV	71	78	82	85	87	82	75	81	88	95	88	86	94		↓	
CTM	71	70	74	71	72	72	75	74	76	74	70	68	70		↓	
HD	71	51	52	55	52	55	50	56	48	51	48	49	50		↓	
HEIW	71	50	51	55	62	53	44	61	66	47	60	48	58		↓	
DHCW	71	45	34	43	46	39	45	57	53	32	34	58	46		↑	
NWSSP	71	56	62	63	60	49	50	61	56	61	58	54	58		↓	
PTHB	71	59	78	71	72	70	70	76	70	81	65	68	71		↓	
PHW	71	48	54	55	58	52	55	52	59	63	55	59	58		↑	
SBU	71	58	62	60	65	65	63	68	71	72	76	73	70		↑	
VEL	71	56	65	58	51	50	55	49	67	54	55	50	54		↓	
WAST	71	65	71	70	76	79	72	77	76	76	84	96	76		↑	
All Wales	71	59	64	63	62	60	59	63	67	62	62	62	62		↓	



The charts shows the Vacancy creation to unconditional offer performance for the individual organisations January – June 25.



Vacancy Creation to unconditional offer

Appendix 1 – Performance for the period to 30th June 2025



Partneriaeth
Cydwasaethau
Shared Services
Partnership

HD High Level - KPIs June 2025	Target	30/09/2024	31/12/2024	31/03/2025	30/06/2025	Trend
Financial Information						
Professional Influence Savings - YTD		£8.761 m	£16.173 m	£18.171 m	£2.217 m	
Employment Services						
Payroll Services						
NWSSP Pay Accuracy	99.6%	99.99%	99.95%	99.96%	99.98%	
Overall Pay Accuracy	99.6%	99.82%	99.86%	99.89%	99.93%	
Organisation KPIs Recruitment						
% of vacancy creation to unconditional offer within 71 days		81.2%	86.3%	80.0%	92.4%	
Vacancy creation to unconditional offer	71	54.6	50.0	50.8	49.6	
% of vacancies approved within 10 working		85.0%	80.2%	79.5%	81.5%	
Time to Approve Vacancies	10	6.1	8.0	7.4	9.0	
% of vacancies shortlisted within 3 working		82.8%	94.8%	92.5%	95.1%	
Time to Shortlist by Managers	3	2.5	3.3	1.2	1.1	
% of interview outcomes notified within 3 working		76.1%	85.8%	91.3%	80.9%	
Time to notify Recruitment of Interview Outcome	3	1.5	1.5	1.6	2.3	
NWSSP KPIs Recruitment						
% of Vacancies advertised within 2 working of receipt	95.00%	99.2%	98.9%	100.0%	100.0%	
Time to Place Adverts	2	1.7	1.6	1.8	1.6	
% of applications moved to shortlisting within 2 working of vacancy closing		100.0%	100.0%	100.0%	100.0%	
Time to Send Applications to Manager	2	1.0	1.0	1.1	1.2	
% of conditional offer letters sent within 4 working	95.00%	98.3%	94.5%	100.0%	100.0%	
Time to send Conditional Offer Letter	4	3.8	4.0	3.8	3.2	
Procurement Services						
Procurement savings - YTD		Target £2.622m Actual £2.928m	Target £2.751m Actual £4.676m	Target £3.012m Actual £4.784m	Target £0.983m Actual £1.983m	
Accounts Payable						
Invoices older than 30 days not disputed		1,033	1,326	638	1,182	
% Invoices on hold not disputed over 30 days		58%	59%	41%	57%	
PSPP Compliance non NHS	95%	95.8%	97.8%	96.4%	96.8%	
PSPP Compliance NHS	95%				80.2%	
Primary Care Services						
Primary Care payments made accurately and to timescale	100%	100%	100%	100%	100%	
Patient assignments actioned within 24 hours	100%	100%	100%	100%	100%	
Urgent medical record transfers to/from GPs and other Primary Care agencies within 2 working days	100%	100%	100%	100%	100%	
Cascade Alerts issued within timescale	100%	100%	100%	100%	100%	
Audit & Assurance						
Audits reported to agreed Audit Committee (Excluding External Factors)	80%		50%	74%	Not Applicable	
% of audit outputs in progress		28%	19%	13%	16%	
Report turnaround management response to Draft report - YTD	80%	80%	82%	81%	Not Applicable	
Report turnaround draft response-final- YTD	80%	100%	100%	100%	Not Applicable	

Appendix 2 – All Wales Performance for the period to 30th June 2025



GIG
CYMRU
NHS
WALES

Partneriaeth
Cydwasaethau
Shared Services
Partnership

ALL WALES KPIs		30/09/2024	31/12/2024	31/03/2025	30/06/2025	Trend
Primry Care Services						
Prescription - Payment Month keying Accuracy rates	99%	99.72%	99.77%	99.84%	99.69%	
Prescriptions processed (Apr)	7.28m	21.9m	43.2m	73.1m	7.03m	
Welsh Risk Pool						
Time from submission to consideration by the Learning Advisory Panel	95%	100%	100%	100%	100%	
Time from consideration by the Learning Advisory Panel to presentation to the Welsh Risk Pool Committee	100%	100%	100%	100%	100%	
Holding sufficient Learning Advisory Panel meetings	90%	100%	100%	100%	100%	
Legal and risk						
Advice acknowledgement- 24hrs	90%	100%	100%	100%	100%	
Advice response – within 3 days	90%	100%	100%	100%	100%	
Student Awards						
% of NHS Bursary Applications processed within 20 days	100%	100%	100%	100%	100%	
Student Awards % Calls Handled	95%	98.0%	97.7%	98.9%	98.9%	
CTeS						
P1 incidents raised with the Central Team Are responded to within 20 minutes	80%	100%	100%	100%	100%	
BACS Service Point tickets received before 14.00 will be processed the same working day	92%	100%	100%	100%	100%	
Digital Workforce						
DWS % Calls Handled	85%	98.0%	90.8%	96.5%	96.0%	
SMTL						
% of Monitoring reports completed within 14 days from receipt into the laboratory		100%	100%	100%	100%	
% of Monitoring reports completed within 40 days from receipt into the laboratory		100%	100%	100%	100%	
% delivery of Audited reports on time (Commercial)	87%	100%	100%	100%	100%	
% delivery of Audited reports on time (NHS)	87%	N/A	N/A	100%	100%	
Pharmacy Technical Services						
Service Errors	<0.5%	0	0	0	0	
Medical Examiner						
Deaths Scrutinised	60%	100%	100%	100%	100%	
All Wales Laundry						
Orders dispatched meeting customer standing orders	90%	88%	95%	94%	94%	
Microbiological contact failure points	85%	97%	100%	97%	97%	
Inappropriate items returned to the laundry including Clinical waste items	<5	0	1	0	0	

Appendix 3 – Health Org Performance comparison 30th June 2025

KPIs JUN 25	KFA	Target	SB	AB	BCU	C&V HEALTH ORG KPIs Financial Information	CTM	HD	PHW	PTHB	VEL	WAST	HEIW	DHCW
Professional Influence Savings- YTD	Our Value		£2.736 m	£4.329 m	£4.289 m	£4.228 m	£2.649 m	£2.217 m	£0.651 m	£0.366 m	£1.086 m	£0.147 m	£0.005 m	£0.154 m
Employment Services														
Payroll Services														
NWSSP Pay Accuracy	Our Services	99.6%	99.98%	99.96%	99.92%	99.94%	99.94%	99.98%	99.93%	99.93%	99.90%	100.00%	100.00%	100.00%
Overall Pay Accuracy	Our Services	99.6%	99.84%	99.87%	99.79%	99.87%	99.79%	99.93%	99.80%	99.87%	99.75%	99.66%	99.86%	99.96%
Calls Handling % Quarterly Average	Our Services	95%						98.8%						
Organisation KPIs Recruitment														
Vacancy creation to unconditional offer	Our Services	71 days	70.1	61.3	63.1	94.2	70.4	49.6	57.5	70.8	49.0	75.9	57.8	45.8
Time to Approve Vacancies	Our Services	10 days	9.4	7.3	5.9	33.3	14.6	9.0	3.4	12.5	0.8	5.5	7.7	0.4
Time to Shortlist by Managers	Our Services	3 days	7.1	5.7	5.9	7.5	5.7	1.1	11.1	5.6	13.3	2.3	5.6	10.4
Time to notify Recruitment of Interview Outcome	Our Services	3 days	2.6	2.6	2.3	1.1	3.1	2.3	6.4	2.0	6.6	2.3	1.4	1.1
NWSSP KPIs Recruitment														
Time to Place Adverts	Our Services	2 days	1.6	1.8	1.7	1.7	1.8	1.6	1.7	1.6	2.0	1.3	1.6	1.1
Time to Send Applications to Manager	Our Services	2 days	1.0	1.0	1.0	1.0	1.0	1.2	1.1	1.0	1.0	1.0	1.0	1.1
Time to send Conditional Offer Letter	Our Services	4 days	3.4	2.6	3.7	2.7	3.8	3.2	3.8	3.7	3.4	3.8	3.7	2.5
Calls Handling % Quarterly Average	Our Services	95%						99.3%						
Procurement Services														
Procurement Savings- YTD	Our Value		Target £1.153m Actual £1.804m	Target £2.736m Actual £3.807m	Target £1.588m Actual £3.270m	Target £2.776m Actual £3.542m	Target £1.247m Actual £1.997m	Target £0.983m Actual £1.983m	Target £0.412m Actual £0.536m	Target £0.104m Actual £0.360m	Target £0.032m Actual £0.898m	Target £0.003m Actual £0.051m	Target £0.001m Actual £0.000m	Target £0.000m Actual £0.000m
Accounts Payable														
Invoices older than 30 days not disputed	Our Services		2,053	2,246	3,781	3,884	2,613	1,182	585	272	789	235	40	34
% Invoices on hold not disputed over 30 days	Our Services		54%	47%	63%	69%	52%	57%	63%	48%	42%	68%	42%	59%
Call Handling % - Quarterly Average	Our Services	95%						97.9%						
PSPP Compliance non NHS	Our Services	95%	91.6%	97.2%	96.8%	95.8%	96.0%	96.8%	97.0%	91.6%	97.2%	98.7%	98.1%	97.6%
PSPP Compliance NHS	Our Services	95%	79.3%	90.4%	89.4%	81.2%	82.5%	80.2%	96.2%	79.3%	94.8%	96.4%	94.3%	98.9%
Audit & Assurance														
Audits reported to Agreed Audit Committee (Excluding External Factors)	Our Services	80%	100%	100%	Not Applicable	100%	100%	Not Applicable	100%	Not Applicable	100%	100%	100%	100%
% of Audit outputs in progress	Our Services		10%	14%	14%	14%	6%	16%	33%	8%	23%	25%	9%	23%
Report turnaround (15 days) management response to Draft report - YTD	Our Services	80%						Not Applicable						
Report turnaround (10 days) draft response-final- YTD	Our Services	80%						Not Applicable						
Primary Care Services														
Primary Care payments made accurately and to timescale	Our Services	100%	100%	100%	100%	100%	100%	100%	N/A	100%	N/A	N/A	N/A	N/A
Patient assignments actioned within 24 hours	Our Services	100%	100%	100%	100%	100%	100%	100%	N/A	100%	N/A	N/A	N/A	N/A
Urgent medical record transfers to/from GPs and other Primary Care Agencies within 2 working days	Our Services	100%	100%	100%	100%	100%	100%	100%	N/A	100%	N/A	N/A	N/A	N/A
Cascade Alerts Issued within timescale	Our Services	100%	100%	100%	100%	100%	100%	100%	N/A	100%	N/A	N/A	N/A	N/A

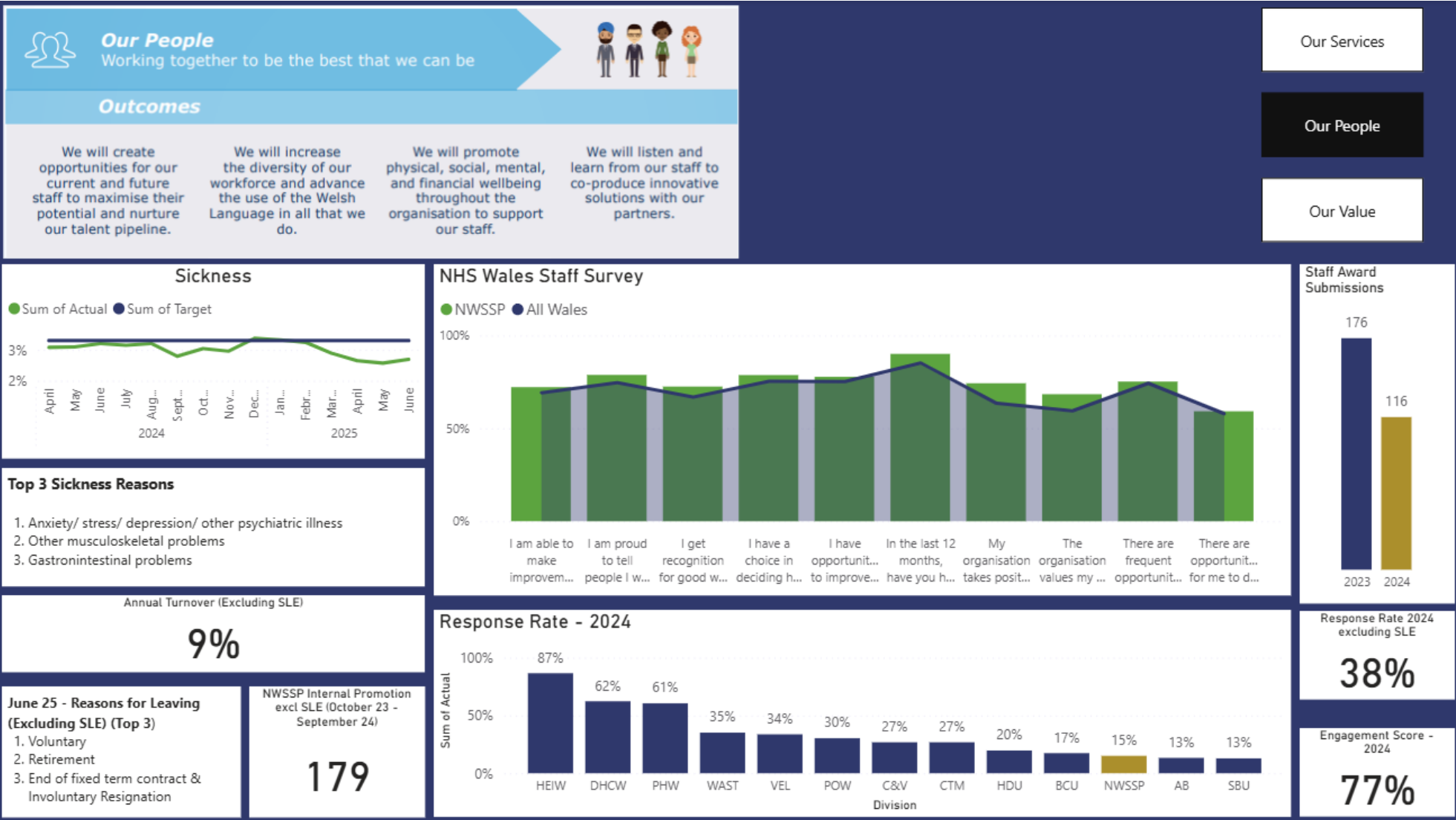
Appendix 4 – Outcome Reporting (Our Services)



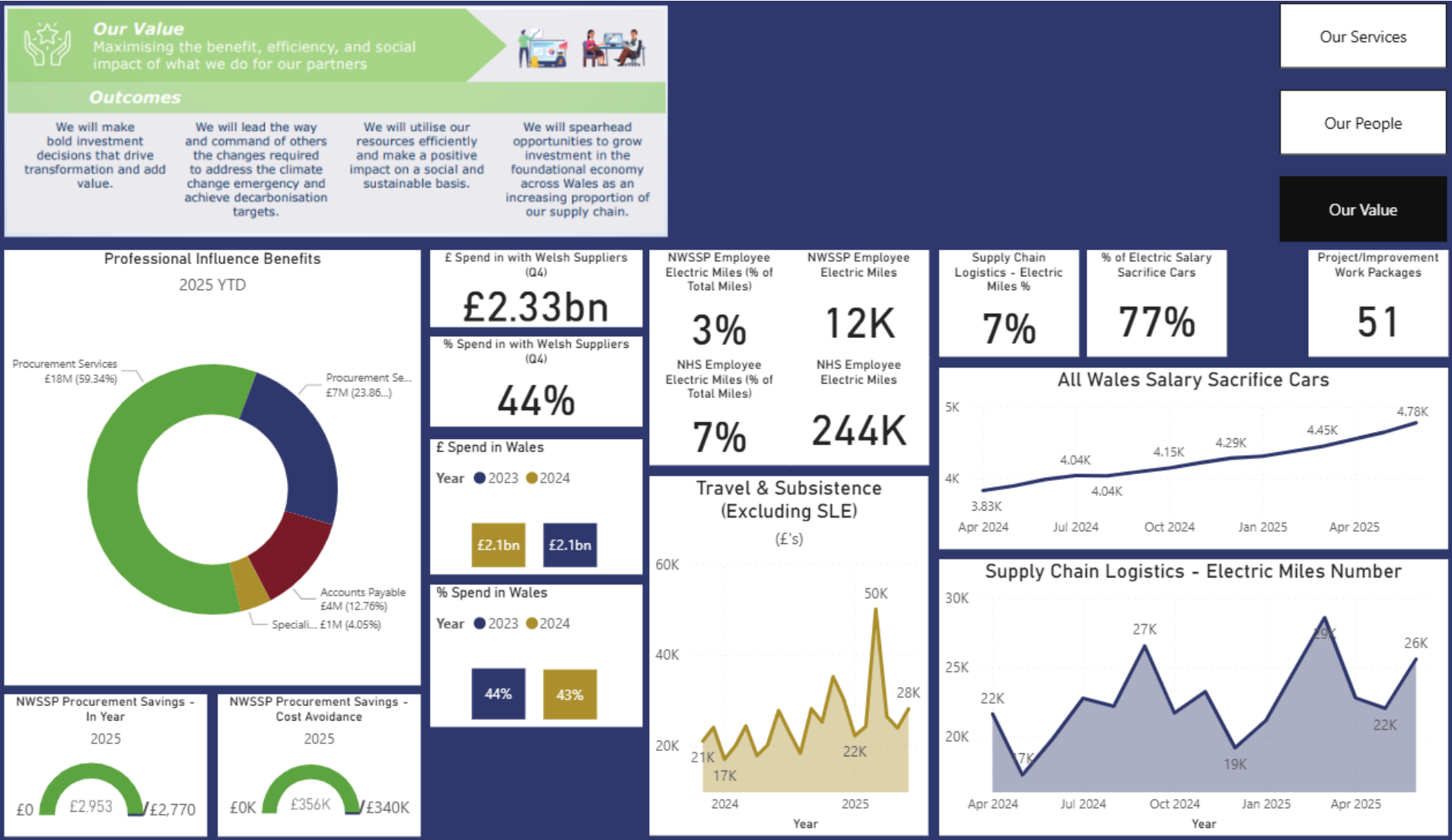
Heads of Internal Audit Annual Opinion (HOIA) - 24/25 Final Position

Client	Total Reviews Planned	Audits Reported (Draft/Final)	Audits in Progress	Report turnaround fieldwork to draft reporting [10 days]	Report turnaround management response to draft report [15 days]	Report turnaround draft response to final reporting [10 days]
Aneurin Bevan	28	100.00%	0.00%	96.00%	50.00%	100.00%
Betsi Cadwaladr	28	100.00%	0.00%	100.00%	85.00%	100.00%
Cardiff & Vale	30	97.00%	3.00%	100.00%	50.00%	100.00%
Cwm Taf Morgannwg	31	97.00%	3.00%	100.00%	56.00%	96.00%
DHCW	13	100.00%	0.00%	100.00%	63.60%	100.00%
HEIW	11	100.00%	0.00%	100.00%	67.00%	100.00%
Hywel Dda	31	100.00%	0.00%	96.70%	86.70%	100.00%
NWSSP	14	100.00%	0.00%	100.00%	85.00%	100.00%
PHW	10	100.00%	0.00%	100.00%	90.00%	90.00%
Powys THB	25	96.00%	4.00%	96.00%	86.00%	100.00%
Swansea Bay	27	100.00%	0.00%	74.00%	52.00%	91.00%
Velindre	21	100.00%	0.00%	95.00%	64.00%	100.00%
WAST	20	100.00%	0.00%	80.00%	73.70%	100.00%
Total	289	99.23%	0.77%	95.21%	69.92%	98.23%

Appendix 4 – Outcome Reporting (Our People)



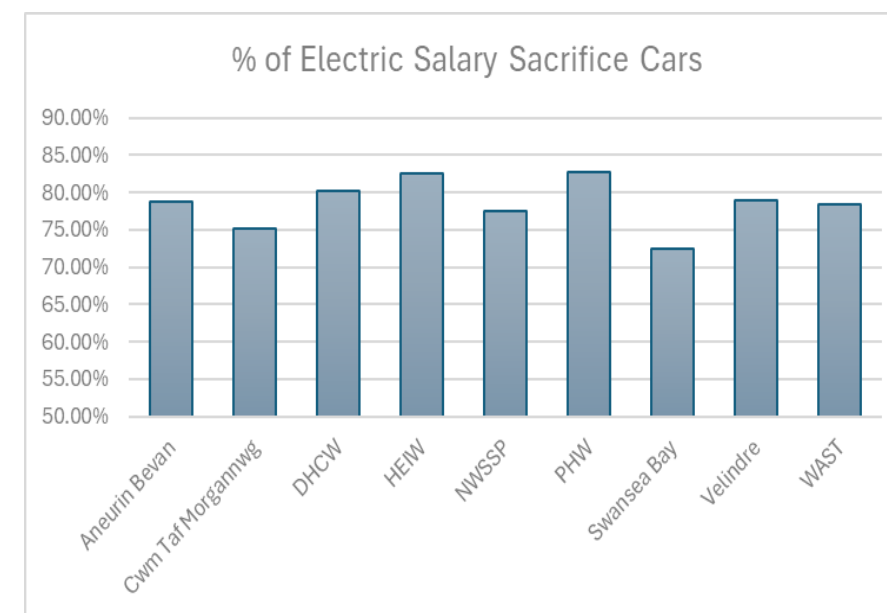
Appendix 4 – Outcome Reporting (Our Value)



Salary Sacrifice Cars

The table and chart below provide an overview of the total number of vehicles managed under the NWSSP scheme, along with the proportion that are electric.

Organisation	Total Cars	Live Electric	Live Hybrid	Live Petrol	% Electric
Aneurin Bevan	865	681	158	25	78.73%
Cwm Taf	813	611	163	38	75.15%
Morgannwg	146	117	25	4	80.14%
DHCW	69	57	11	1	82.61%
HEIW	288	223	63	2	77.43%
NWSSP	150	124	24	2	82.67%
PHW	889	644	192	52	72.44%
Swansea Bay	123	97	22	4	78.86%
Velindre	406	318	77	11	78.33%
WAST	4,778	3,658	929	188	76.55%



The table below provide an overview of the identified cash releasing procurement savings by procurement team for April – June 25.

TEAM DELIVERING SAVINGS	HDT	
	Target	Actual
HYWEL DDA PROCUREMENT TEAM	£117,656	£211,276
NATIONAL - CLINICAL	£94,995	£100,049
NATIONAL - COMMISSIONING	£0	£12,443
NATIONAL - ENERGY	£1,179	£625
NATIONAL - HOTEL SERVICES AND TEXTILES	£54,342	£45,285
NATIONAL - ICT & OFFICE EQUIPMENT	£61,383	£104,459
NATIONAL - MAINTENANCE	£9,134	£38,270
NATIONAL - MEDICAL	£228,889	£309,404
NATIONAL - PHARMACY	£378,090	£1,162,082
NATIONAL - PROVISIONS	£37,714	£1
	£983,383	£1,983,895



*Delivering
Value, Innovation and
Excellence through
Partnership*

6 - FOR APPROVAL

6.1 - BUSINESS CASE: URGENT AND
EMERGENCY CARE TRANSFORMATION

*Andrew Carruthers
(Hywel Dda UHB -
Chief Operating
Officer)*

- Deferred to Extraordinary Finance and Performance Committee Meeting, 12 September 2025

| For approval

6.2 - FINANCIAL PROCEDURES

Andrew Spratt
(Hywel Dda UHB -
Deputy Director of
Finance)

| For approval

Attachments

[Financial Procedures FPC 26 August 2025.pdf](#)

[FP084 Oracle E-Business Suite - System Access and Ledger Security.pdf](#)

[FP093 Disposal of Surplus and Obsolete Furniture.pdf](#)

[FP973 Cash Procedure.pdf](#)

[New FP Contract Management.pdf](#)



**PWYLLGOR CYLLID A PHERFFORMIAD
FINANCE AND PERFORMANCE COMMITTEE**

DYDDIAD Y CYFARFOD: DATE OF MEETING:	26 August 2025
TEITL YR ADRODDIAD: TITLE OF REPORT:	Financial Procedures
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Huw Thomas, Director of Finance
SWYDDOG ADRODD: REPORTING OFFICER:	Tim John, Head of Accounting and Statutory Reporting

Pwrpas yr Adroddiad (dewiswch fel yn addas)

Purpose of the Report (select as appropriate)

Ar Gyfer Penderfyniad/For Decision

**ADRODDIAD SCAA
SBAR REPORT**

Sefyllfa / Situation

Each year planned reviews are undertaken of the financial procedures operated by Hywel Dda University Health Board (HDdUHB). The procedures, which set out the main financial system controls, are reviewed in terms of:

- Relevance
- Best practice
- Audit recommendations
- System change
- Health Board policy

The Finance and Performance Committee can take assurance that there is a robust review process in place in respect of financial procedures.

Cefndir / Background

The following procedures have been reviewed and are presented to the Finance and Performance Committee for approval:

- **Financial Procedure 084** - Oracle E-Business Suite - System Access and Ledger Security Financial Procedure
- **Financial Procedure 093** - Disposal of Surplus and Obsolete Furniture, Equipment, Sale of Scrap and Other Waste Materials Procedure
- **Financial Procedure 973** - Cash Financial Procedure
- Contract Management Procedure (new procedure)

The purpose of these documents is to outline the key processes to be followed by Health Board staff in connection with the above-named financial procedures and to set out associated roles and responsibilities.

Asesiad / Assessment

- Financial Procedure 084 - Oracle E-Business Suite - System Access and Ledger Security Financial Procedure
- Financial Procedure 093 - Disposal of Surplus and Obsolete Furniture, Equipment, Sale of Scrap and Other Waste Materials Procedure
- Financial Procedure 973 - Cash Financial Procedure
- Contract Management Procedure (new procedure)

The financial procedures are covered by a specific Financial Procedures Equality Impact Assessment (EqIA) with no negative impact.

Argymhelliad / Recommendation

The Finance and Performance Committee is asked to **APPROVE** the following updated financial procedures:

- **Financial Procedure 084** - Oracle E-Business Suite - System Access and Ledger Security Financial Procedure
- **Financial Procedure 093** - Disposal of Surplus and Obsolete Furniture, Equipment, Sale of Scrap and Other Waste Materials Procedure
- **Financial Procedure 973** - Cash Financial Procedure
- Contract Management Procedure (new procedure)

Amcanion: (rhaid cwblhau)

Objectives: (must be completed)

Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	3.13 Review and approve financial procedures on behalf of the Health Board
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)	Not Applicable
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	Not Applicable
Amcanion Strategol y BIP: UHB Strategic Objectives:	All Strategic Objectives are applicable
Amcanion Cynllunio Planning Objectives	Not Applicable

Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022	10. Not Applicable

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Previous procedures, internal audit report recommendations, standing financial instructions.
Rhestr Termiau: Glossary of Terms:	Included within the body of the report.
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Adnoddau Cynaliadwy: Parties / Committees consulted prior to Sustainable Resources Committee:	HDdUHB Finance HDdUHB Local Counter Fraud Service HDdUHB Workforce & OD NHS Wales Shared Services Partnership (NWSSP)

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	Financial procedures are required to ensure sound financial control.
Ansawdd / Gofal Claf: Quality / Patient Care:	Not Applicable
Gweithlu: Workforce:	Not Applicable
Risg: Risk:	Financial procedures are required to ensure good governance and therefore minimise risk.
Cyfreithiol: Legal:	Not Applicable
Enw Da: Reputational:	Financial procedures are required to ensure good governance and sound financial control.

Gyfrinachedd: Privacy:	Not Applicable
Cydraddoldeb: Equality:	An Equality Impact Assessment has been undertaken with no negative impacts on those with protected characteristics.

Oracle E-Business Suite - System Access and Ledger Security

Procedure information

Procedure number: 084

Classification: Financial

Supersedes: 2.0

Version number: 3.0

Date of Equality Impact Assessment: 24/07/2025

Approval information

Approved by: Finance and Performance Committee

Date of approval: **Enter approval date**

Date made active: **Enter date made active (completion by policy team)**

Review date: **Enter review date (normally three years from approval date)**

Summary of document:

This Procedure highlights the processes in place both internal and external to the Organisation, which ensure that the Oracle E-Business Suite's security and integrity of data are maintained.

Scope:

Hywel Dda University Health Board wide.

To be read in conjunction with:

Standing Orders
Standing Financial Instructions
Other Financial Procedures
Information Security Policy
Disciplinary Policy

Patient information:

N/A

Owning group:

Financial Directorate
18/07/2025

Executive Director job title:

Director of Finance

Reviews and updates:

New Procedure - 24/09/2019
Reviewed – 22/08/2022
Reviewed - *Enter approval date*

Keywords

Oracle

Glossary of terms

COM - Common Operating Model
ADI - Application Desktop Integrator
NWSSP - NHS Wales Shared Services Partnership
TAG - Technical Accounting Group
CVT - Cardiff and Vale
OCI – Oracle Cloud Infrastructure
APEX – Standard Data Reporting System
OCR – Optical Character Recognition
RUEI – Real User Experience Insight
RMAN – Recovery Manager

FRAUD, BRIBERY AND CORRUPTION

All staff are required to comply with the Health Board's policies and procedures and apply best practice in order to prevent Fraud, Bribery and Corruption. Staff should be made aware of their own responsibilities in protecting the Health Board from these crimes.

All staff have a duty to notify the Local Counter Fraud Department of any suspected fraud or inappropriate actions and are protected by the [All Wales Procedure for NHS Staff to Raise Concerns Policy](#) (opens in a new tab). Anyone who suspects fraud or has any concerns reference Fraud Bribery and Corruption can make a referral by contacting the Counter Fraud Department by any of the following methods;

- Telephoning the office on 01267 266268,
- Emailing HDUHB.CounterFraudTeam.HDD@wales.nhs.uk,
- Making an online referral at <https://reportfraud.cfa.nhs.uk> or
- Making an anonymous referral by telephoning Crimestoppers on 0800 028 40 60.

Staff should refer to the [Counter Fraud, Bribery and Corruption Policy](#) (opens in a new tab) for further information.

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Scope

The Director of Finance will be responsible for ensuring that proper financial controls and segregation of duties exist for the integrity, validity and accuracy of the data fed into the general ledger and the resulting output.

The Deputy Director of Finance will hold delegated responsibility for the system administration function to ensure the integrity of the system is maintained and remains compliant with the Common Operating Model (COM). This includes the day to day management of the overall system, and maintenance of all standing data sets on the system.

Responsibility for accessing the system applies to all users of Oracle and is in accordance with the Information Security Policy. All Oracle user accounts are unique to each user and it is not permitted for an individual to use another person's user id or to log on to allow another individual to gain access to the system. Passwords must be kept confidential and never disclosed to others. Passwords are valid for 60 days only, at which point they need to be changed. Any security breaches will be taken seriously and dealt with in accordance with the [837 - All Wales Information Security Policy](#) (opens in a new tab) and may also include [201 - All Wales Disciplinary Policy and Procedure](#) (opens in a new tab).

This procedure applies to all permanent, temporary or contracted staff employed by the Health Board, and to students and volunteers and third party staff that use and access Hywel Dda University Health Board's Oracle E-Business Suite.

This also includes and relates to NHS Wales Shared Services Partnership (NWSSP) staff who require access to Hywel Dda's Oracle set of books to enable them to carry out their duties, and this access will be provided in accordance with agreed Oracle Consortium governance arrangements.

Aim

The aim of this document is to:

- Provide guidance on the access and security procedure for the Oracle E-Business Suite system within the Health Board. This is to assist the Health Board in maintaining financial probity and compliance with relevant legislation.

Objectives

The aim of this document will be achieved by the following objectives:

- Confirming the controls in place which manage access to the system and the controls for managing and ensuring the integrity, validity and accuracy of the data held on the system.
- Providing clear procedures of the actions to be followed.
- Identifying how further support can be obtained.

Roles and Responsibilities

Procedure	Responsible party
Access to the Oracle E-Business Suite	System Administrators
Security settings	System Administrators
General Ledger Maintenance	System Administrators
General Ledger Input Procedures	System Administrators, Core Accounting, Financial Accounting, Corporate Reporting
Month / Year End Procedures	Finance Department
General Ledger Reconciliation	Financial Accounting
Oracle E-Business Suite Back Up Procedures	Version 1 ¹ , Central Team ²
Oracle E-Business Suite Disaster Recovery	Version 1, Central Team, System Administrators

Access to the Oracle E-Business Suite

There will be nominated System Administrators who will be responsible for adding new users and their relevant responsibilities to the system and updating these records for authorised changes and end dating old users (users who have left, no longer use the system etc).

Levels of access to the financial and procurement (excluding iProcurement) elements of the system for each user will be determined and authorised by the user's line manager/Head of Dept, using the form in [Appendix A](#).

Access to the iProcurement (iProc) element of the system for ordering goods and services will be determined and authorised by the manager with responsibility for the relevant cost centre(s), using the form in [Appendix B](#).

Oracle usernames are unique to each user and access to the system is protected by password control. The system prompts users to reset their password every 60 days. Users have 3 attempts to login before being "locked" out of the system. Users must contact the NWSSP Helpdesk Department, or the System Administrators (contact details noted in section ['Further Information'](#)) to reset their password.

¹ Version 1 – is the Oracle System Supplier

² Central Team is part of NHS Shared Services Partnership

The System Administrators will under no circumstances use the system administration function to access databases of other Consortium members. Abuse of this may lead to disciplinary action.

General Ledger Maintenance

The Chart of Accounts structure consists of five elements:

- Entity (3 characters)
- Cost Centre (4 characters)
- Subjective (5 characters)
- Analysis (4 characters)
- Other Analysis (6 characters)

All these elements when linked together form a valid financial code. There are coding validation rules in place to ensure only allowable code combinations are used. The system does not allow invalid codes to be created or posted to in the general ledger or sub-modules, and it is the responsibility of the user to correct any invalid coding errors to allow posting to take place.

All requests for new/amendments to cost centres, analysis and other analysis codes are to be made using the form attached in [Appendix C](#). It is only System Administrators who have responsibility for creating/amending these data sets. The System Administrators will be responsible for maintaining records of all changes made to these data sets.

Requests for new/amendments to subjective codes will be made using the form attached in [Appendix D](#). The approver must be an appropriate senior finance officer. Completed forms are to be forwarded to the System Administrators who will forward them to the Oracle Central Team for action. The Central Team require the approval of all members of the Oracle Consortium, and this is facilitated through discussion and agreement via the Technical Accounting Group (TAG) prior to creating/amending any subjective code requests.

General Ledger Input Procedures

Journal Processing

Journals may be entered onto Oracle by manual journal entry direct to an Oracle form, by Application Desktop Integrator (ADI) via excel spreadsheet templates or imported for automated feeds. Internal Feeds from sub-modules will be automatically transferred to GL for posting, whereas external feeds such as Payroll or Pharmacy require processing through the Oracle Generic Interface to create journals that can be posted.

Appropriate control records for managing the import and uploading of feeds into the general ledger will be maintained by the System Administrators in combination with the Core Accounting Team to provide a clear audit trail of these processes, an example format of this record is noted in [Appendix E](#).

Journal Postings

The System Administrators post all balance type “Actuals” to the general ledger, including the feeders referred to above. This process is facilitated by an automated Posting procedure which runs on a variable periodic basis, in line with the month end closedown timetable. Other finance staff, notably, Financial Accounting, Core Accounting and Corporate Reporting have posting functionality and this is agreed by Finance Managers and controlled via system access controls.

Budget Journal Posting is controlled by the Corporate Reporting Team.

Each quarter the System Administrators will extract a list of all manual and ADI “Actuals” journals posted in the period and select a number at random for retrospective approval by the originator’s line manager.

Month End Procedures

A timetable will be produced for every period which will identify all monthly processing and reporting deadlines for the finance function to meet internal and external corporate requirements. The timetable will specify lead responsible officers for every identified task and deadlines for their completion.

Year End Procedures

The year end procedure will operate in the same way as the month end procedure noted in point [‘Month End Procedures’](#) above and will be supported by a separate timetable which will detail any other additional requirements and deadlines for annual accounting purposes.

General Ledger Reconciliation

The Assistant Director Finance for Statutory Reporting will be responsible for ensuring adequate and timely control account reconciliation processes are in place to provide assurance that the integrity of the ledger is maintained. These reconciliation processes are managed and facilitated through the use of Blackline software.

Oracle E-Business Suite Back Up Procedures

As part of the managed service provision for the Oracle Consortium, Version 1 performs regular backups of the NHS Wales Oracle E-Business Suite environments, databases and associated software.

Oracle EBS Databases are backed up using OCI automatic backup utility to Object Storage and are kept for 30 days. All other databases APEX, OCR and RUEI are backed up to disk using Oracle RMAN. All disks have the OCI gold policy applied. The gold policy includes:

- daily incremental backups, retained for seven days, along with weekly incremental backups, run on Sunday and retained for four weeks.
- monthly incremental backups, run on the first day of the month, retained for twelve months.
- an incremental backup, run yearly during the first part of January. This backup is retained for five years.

All production disks are replicated to the disaster recovery region UK West (Newport) providing disaster recovery capability. The production EBS database is replicated to UK West (Newport) using Oracle Data Guard.

Oracle E-Business Suite Disaster Recovery

Disaster recovery is the process of recovering the live Oracle system and all information held within the system should something go seriously wrong.

Disaster recovery is included in the Version 1 managed service provision, which states the recovery of Oracle should be tested on an annual basis.

This means that should something go wrong the system can be reinstated with data that will be accurate to within 24 hours of the collapse with no more than one day down time.

Each finance and procurement department of the Health Boards and organisations within the Oracle Consortium are responsible for the creation of local plans to manage any system down time.

The Disaster Recovery exercise will be facilitated and managed centrally by the Oracle Central Team in conjunction with Version 1.

Training

The System Administrators are responsible for ensuring staff in finance have detailed desk top instructions which support deployment of this procedure and that they are appropriately trained to use the system. NWSSP E-enablement team deliver training for iProcurement users on behalf of the Health Board.

Further Information

The System Administrators are based in Ty Gorwel, St. David's Park, Carmarthen. The main contact telephone number for the Dept is 01267 283017 and the helpdesk e mail at: Finance.SystemsTeam.HDD@wales.nhs.uk.

The System Administrations provide Oracle Helpdesk support on system administration set up queries and technical problems in using Oracle.

Shared Services provide iProcurement support and queries, training requests and invoice queries. The main contact telephone number is iProcurement: 02921 500800 and by e mail on: NWSSP.ProcurementServiceDesk@wales.nhs.uk

There is also a Sharepoint page where all user set up forms, contact information and other helpful information is noted.

[P2P End User Hub - Home](#) (opens in a new tab)

[eEnablement Procure-to-Pay \(P2P\)](#) (opens in a new tab)

Monitoring

The monitoring and review of this procedure is the responsibility of the finance directorate. Reviews will be undertaken in line with the Health Board's review policy, which is every 3 years, or when changes are identified prior to the required review date.

Appendix A – Oracle Financial System and Finance Shared Drive User Form

Details of User

Full Name:	
Job Title:	
Nadex (Cymru) No:	
Work Tel No:	
Work E mail:	
Date:	

Details of Oracle Responsibilities Required: Please ensure you maintain segregation of duties when selecting responsibilities for members of staff. Contact System Administrator for further details if required.

RESPONSIBILITY NAME	NEW USER/LEAVER/AMENDMENT TO EXISTING (N to add / R to remove / A to amend
HDT AP Enquiry	
HDT AP Manager	
HDT AP Payments	
HDT AP Superuser	
HDT AR Cashiers	
HDT AR Enquiry	
HDT AR Invoices	
HDT AR Manager	
HDT AR Superuser	
HDT Collections Administrator	
HDT Collections Agent	
HDT Collections Manager	
HDT CRM Resource Manager	
HDT Funds Disbursement Process Manager	
HDT GL ENQUIRY (AUDIT)	
HDT GL Enquiry (inc Payroll)	
HDT GL Financial Accounting Manager	
HDT GL Financials User	

HDT GL Management Accounts	
HDT GL Superuser	
HDT INV Superuser	
HDT Inventory Manager	
HDT iProc	
HDT iPROC VIEW ONLY	
HDT OM Manager	
HDT OM Superuser	
HDT PO Buyer	
HDT PO Enquiry	
HDT PO NWSSP E Enablement	
HDT PO NWSSP Service Desk	
HDT PO Superuser	
HDT Purchasing Manager	
HDT Receiver	
HDT Report Manager Super user	
HDT Report Manager User	
HDT Stock Manager	
HDT Stores Clerk	
HDT Tax Managers	
HDT Web ADI Superuser	
QlikSense	

Details of Finance Shared Drive Folders required – please allow up to 5 days for IT dept to complete set up

FOLDER DESCRIPTION	FOLDER IT NAME	ACCESS Y OR N
DOF (Protected)	hdd_findof	
ADF (Protected)	hdd_finadf	
DOF PA	hdd_findofpa	
Financial Accounting	hdd_finacc	
Management Accounting	hdd_finmgtacc	
Continuing Care_FNC_IPC (Protected)	hdd_finccfnicipc	
Service Modernisation	hdd_finsrvmod	
Financial Planning & Governance	hdd_finplan	
Patient Services Contracting & Performance (Protected)	hdd_finpatientserv	
Service & Cost Improvement	hdd_finsrvimp	

General	hdd_finance	
WAG	hdd_finwag	
Senior Finance Team (Protected)	hdd_sft	
Counter Fraud (Protected)	hdd_fincountfrd	
Joint Management Accs & Planning	hdd_jointmgtaccs&finplan	
Joint Management Accounting & Fin Accounting	hdd_jointmgtacc&finacc	
Procurement	hdd_Procurement	
WAO 1213 Audit	hdd_wao	
Corporate Reporting	Hdd_fincorrep	
Shared Services - Accounts Payable	hdd_nwsspap	
Shared Services - Accounts Payable	hdd_rr6_fin-toact	
Shared Services - Accounts Payable	hdd_rr6_fin-ooH	

Approval

Manager Name:	
Manager Signature:	
Date:	

To be completed by System Administrator

User Name:	
User informed of id/ password on date:	
Nadex (Cymru) No:	
System Administrator confirms segregation of duties is in place for Oracle:	
Actioned by (System Administrator Name:	
Date:	

PLEASE FORWARD COMPLETED FORMS BY E MAIL TO:

Finance.SystemsTeam.HDD@wales.nhs.uk

Appendix B – Request to Set Up Oracle Self Service Procurement (IPROC) User

Date	
User's Full Name (as detailed on user's payslip)	
Job Title	
Dept	
Work Base	
Full work telephone number	
Work e mail address	
Transfer Point number	
Cost Centre	
Level of Access Required	Requisitioner/Approver (please specify)
Authorised by (This request should be approved by an officer with responsibility for the cost centre specified above)	

Notes

1. Users are set up on Oracle in accordance with the Information Security Policy. Oracle user accounts are unique to each user and it is not permitted for an individual to use another person's user id or to log on to allow another individual to gain access to the system and passwords must be kept confidential and never disclosed or allowed to be used by others
2. The form should be emailed by the Authorising line manager to Finance.SystemsTeam.HDD@wales.nhs.uk

To be completed by the System Administrator

Oracle User Name	
Hierarchy Position Name	
Date user received iProc training	
Set up actioned by (name of System Administrator)	
Date completed	

Appendix C – Parent / Cost Centre / Analysis / Other Analysis Code Set Up / Amendment and End Date Request Form

Section A - New Code Request	All parts of Section A to be completed for new code request
Code Type	Cost centre/Analysis/Other Analysis /Parent (please specify)
Code Description	
Provide details of the immediate parent code & parent code description	
Provide details of purchasing hierarchy approvers: Level 1 budget holder Level 2 budget holder Level 3 budget holder Level 4 budget holder Level 5 budget holder	
Provide details of who should have access to QlikSense report	
Will the code generate pay costs – Y/N (please specify)	
Who will be the: Level 3 Budget Holder Level 4 Budget Holder Level 5 Budget Holder	
Who will be the Business Controller (Band 8a)	

Section B – Amendment to Existing Code Description	All parts of Section B to be completed for amendment to an existing code's description
Code Type	Cost centre/Analysis/Other Analysis (please specify)
Code	
Current code description	
New description	

Section C – Amendment to existing code's parent level	All parts of Section C to be completed for an amendment to an existing code's parent level
Code Type	Cost centre/Analysis/Other Analysis (please specify)
Provide details of code(s) being amended & code description(s), existing parent code & description and new parent code & description	
If purchasing hierarchy is to change provide details of new purchasing hierarchy approvers: Level 1 budget holder Level 2 budget holder Level 3 budget holder Level 4 budget holder Level 5 budget holder Note: Existing approvers will be deactivated	
Will the QlikSense report distribution change? If yes provide details of who should receive these reports Confirm if existing QlikSense user should be deleted (YES/NO)	
If the budget holders are changing please provide details of the new Level 3 Budget Holder Level 4 Budget Holder Level 5 Budget Holder	
If the Business Controller (Band 8a) is changing, please provide details of the new Business Controller (Band 8a)	

Section D – Code to be end dated	All parts of Section D to be completed for a code to be end dated (i.e. inactivated)
Code Type	Cost centre/Analysis/Other Analysis (please specify)
Provide details of code, code description and immediate parent level of code & parent code description to be end dated	
Is the code being replaced with an existing or new code? If yes provide details of replacement/new code & description	
System Administrators will check all data sets on Oracle for existence of the code to be closed & will confirm to the requester when this is complete Date System Administrators check complete The requester to confirm all ledger balances are zero and provide final date for closure	

Requestor			
Name of person making request in Sections A to D above		Date	
To be completed by System Administrators			
Request approved & actioned by			
Date			
Oracle Record Updated			
HR Informed re ESR			

Code Description for ESR Purposes e.g. 100 HDUHB Finance 0372	

Notes:

1. Large structural changes should be discussed with the System Administrators prior to submission to confirm timeframes for completion
2. Please submit completed forms to Finance.SystemsTeam.HDD@wales.nhs.uk

Appendix D – Subjective Code Request Form



SECTION A	TO BE COMPLETED BY ORGANISATION
Organisation	
Name of Requestor	
Date	
Code required	
Description	
Parent?	Yes/No
If Yes, which children to be attached?	
Includes	Parent Values/Child Values Only
Qualifiers Allow budgeting Allow posting Account type	Yes/No Yes/No Asset/Expense/Liability/Ownership/Revenue
Parent Code	
Level of code requested	Child/Parent
SECTION B	TO BE COMPLETED BY THE CENTRAL TEAM
Date	
Search carried out by	
Found	Yes/No
Subjective/category setup	Yes/No
Requestor informed	Yes/No

Service Point call number	
Other comments	

Appendix E – Posting Control Sheet

LEDGER MONTH:	YEAR:

WEEKLY	File Name/ Batch/ ID	Batch Value (Dr)	Date Received	Date Processed	Initial	Oracle Batch Name

Disposal of Surplus and Obsolete Furniture, Equipment, Sale of Scrap and other Waste Materials

Procedure information

Procedure number: 093

Classification: Financial

Supersedes: 4.0

Version number: 5.0

Date of Equality Impact Assessment: 24/07/2025

Approval information

Approved by: Finance and Performance Committee

Date of approval: *Enter approval date*

Date made active: *Enter date made active (completion by policy team)*

Review date: *Enter review date (normally three years from approval date)*

Summary of document:

Procedure to advise the process to follow when there is a need to dispose of surplus equipment.

Scope:

Hywel Dda University Health Board wide.

To be read in conjunction with:

[Standing Orders Hywel Dda University Local Health Board](#) (opens in a new tab)

[Standing Financial Instructions](#) (opens in a new tab)

[Counter Fraud, Bribery and Corruption Policy](#) (opens in a new tab)

[Financial Procedures](#) (opens in a new tab)

Patient information:

N/A

Owning group:

Finance Directorate

18/07/2025

Executive Director job title:

Director of Finance

Reviews and updates:

New Procedure – 01/10/2009

Full Review – 22/07/2019

Full Review – 02/07/2020

Full Review – 22/08/2022

Full Review - *Enter approval date*

Keywords

Disposal, Furniture, Equipment, Scrap, Waste, Materials

Glossary of terms

HUHB – Hywel Dda University Health Board

Key points:

The aim of this document is to explain:

- The process to follow when there is a need to dispose of surplus or obsolete equipment.

FRAUD, BRIBERY AND CORRUPTION

All staff are required to comply with the Health Board's policies and procedures and apply best practice in order to prevent Fraud, Bribery and Corruption. Staff should be made aware of their own responsibilities in protecting the Health Board from these crimes.

All staff have a duty to notify the Local Counter Fraud Department of any suspected fraud or inappropriate actions and are protected by the [All Wales Procedure for NHS Staff to Raise Concerns Policy](#) (opens in a new tab). Anyone who suspects fraud or has any concerns reference Fraud Bribery and Corruption can make a referral by contacting the Counter Fraud Department by any of the following methods;

- Telephoning the office on 01267 266268,
- Emailing HDUHB.CounterFraudTeam.HDD@wales.nhs.uk,
- Making an online referral at <https://reportfraud.cfa.nhs.uk> or
- Making an anonymous referral by telephoning Crimestoppers on 0800 028 40 60.

Staff should refer to the [Counter Fraud, Bribery and Corruption Policy](#) (opens in a new tab) for further information.

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Scope

This procedure is Hywel Dda University Health Board wide.

Aim

The aim of this document is to:

- Provide guidance in the event of a department needing to dispose of any surplus equipment or other items. This is to assist the Health Board in maintaining financial probity and compliance with relevant legislation

Objectives

The aim of this document will be achieved by the following objectives:

- Confirming roles and responsibilities to ensure clear accountability in the organisation.
- Providing clear procedures of the actions to be followed.
- Identifying how further support can be obtained.

Roles and Responsibilities

Procedure	Responsible party
Identification of surplus items to dispose of	Owning Department
Notification to Procurement of items to be disposed of	Owning Department
Contact made with Hilditch Group	Procurement
Sale of items	Hilditch Group

Procedure for Disposal of Surplus and Obsolete Equipment

When a department has identified that they have surplus equipment to dispose of the Procurement department should be advised at the earliest opportunity via their generic email address

NWSSP.HywelDda.Procurement@wales.nhs.uk

All sales of surplus items (except those with a minimal value below £20) are processed via the All Wales Contract with the Hilditch Group and will be co-ordinated by the Procurement team.

Disposal of Obsolete Equipment of Minimal Value

Where there is a need to dispose of equipment which is unlikely to be of use within the organisation and which is of very minimal intrinsic value, the responsibility for the disposal should lie with the appropriate General / Service manager rather than Procurement.

The appropriate senior manager will be responsible for ensuring that the equipment is not required internally within the Health Board before arranging disposal. The acceptance of offers for these items of very low value and arrangements for the collection of income will also be the responsibility of these managers. Items of equipment should only be removed from any location on production of an official receipt relating to these items, issued by one of the Health Board's General Offices.

It is recommended that this procedure for disposal only applies to items of very limited value, with individual items not exceeding £20 in value.

The advice of the Procurement team should be sought if there is any doubt as to the most appropriate method of disposal.

VAT

All sales of scrap, obsolete or surplus goods attract the standard rate of Value Added Tax.

Capital Charges

Pieces of equipment may be counted as assets for capital charging purposes. It is imperative that budget holders disposing of equipment contact the Finance Department to check its status. If it is on the register the Finance Department (Capital) will issue a form enabling the asset to be deleted.

Disposal of an Owned Vehicle

Managers seeking to dispose of a vehicle owned by HDUHB must ensure that the Central Transport Unit are notified of this once it has been suspended from active use. The Central Transport Unit will ensure that all necessary actions are taken to remove the vehicle from the Health Board's insurance register and that any fuel cards registered to the vehicle are cancelled. A notification should be sent to the following email address confirming the details of when the vehicle will be removed from active service:

ctu.hdd@wales.nhs.uk

Monitoring and Review

The monitoring and review of this procedure is the responsibility of the Finance Department. Reviews will be undertaken in line with the Health Board's review policy, which is every 3 years, or when changes are identified prior to the required review date.

Cash Procedure

Procedure information

Procedure number: 973

Classification:

Financial

Supersedes:

Previous Version

Local Safety Standard for Invasive Procedures (LOCSSIP) reference:

N/A

National Safety Standards for Invasive Procedures (NatSSIPs) standards:

N/A

Version number:

3.0

Date of Equality Impact Assessment:

Approval information

Approved by: Finance and Performance Committee

Date of approval:

Date made active:

Review date:

Summary of document:

This document provides a clear process to be followed with regards to banking arrangements, reconciliations, petty cash, unpresented out of date cheques and lost cheques.

Scope:

Hywel Dda University Health Board wide.

To be read in conjunction with:

[Standing Orders Hywel Dda University Local Health Board](#)

[Standing Financial Instructions](#)

[Counter Fraud, Bribery and Corruption Policy](#)

[Financial Procedures](#)

Patient information:

Include links to [Patient Information Library](#)

Owning group:

Finance Directorate

Executive Director job title:

Huw Thomas – Director of Finance

Reviews and updates:

1.0 – New Procedure – 26.01.2021

2.0 – Revised – 22.08.2022

3.0 – Revised -

Keywords

Cash

Glossary of terms

AW – All Wales

BACS - Bankers' Automated Clearing System

GBS - Government Banking Service

NHS – National Health Service

HMRC - His Majesty's Revenue and Customs

NWSSP - NHS Wales Shared Services Partnership

AP – Accounts Payable

CHAPS – Clearing House Automated Payment System

FIS – Financial Information System

Precision Pay – virtual payment solution to allow businesses to make secure and efficient payments to suppliers using virtual cards.

Fraud, Bribery and Corruption

All staff are required to comply with the Health Board's policies and procedures and apply best practice in order to prevent Fraud, Bribery and Corruption. Staff should be made aware of their own responsibilities in protecting the Health Board from these crimes.

All staff have a duty to notify the Local Counter Fraud Department of any suspected fraud or inappropriate actions and are protected by the [435 - All Wales NHS staff to Raise Concerns Procedure](#). Anyone who suspects fraud or has any concerns reference Fraud Bribery and Corruption can make a referral by contacting the Counter Fraud Department, details of which can be found [here](#).

Staff should refer to the [Counter Fraud, Bribery and Corruption Policy](#) for further information.

All losses or thefts should be dealt with in line with Health Board's Losses and Special Payments Procedure, which can be found  [here](#).

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Introduction

This procedure is an overarching cash procedure covering Banking Arrangements, Petty Cash, Loss of Cheques and Purchasing Cards

Scope

This procedure is Hywel Dda University Health Board wide.

Aim

The aim of this document is to:

- Provide a clear process to be followed with regards to banking arrangements, reconciliations, petty cash, unpresented out of date cheques and lost cheques and provide effective Financial and Budgetary Control within Hywel Dda Health Board

Objectives

The aim of this document will be achieved by the following objectives:

- Ensure financial probity and clarity of accountability in the organisation.

Roles and Responsibilities

	Procedure	Responsible party
1	Bank Accounts	Financial Accounting
2	General Ledger Reconciliations	Financial Accounting
3	Management of payment runs	Shared Services and Financial Accounting
4	Cash forecasting	Financial Accounting
5	Petty Cash Imprests	Financial Accounting
6	Security of cash	Relevant department holding cash
7	Loss of cheques	Financial Accounting
8	Use of Purchasing cards	Shared Services and the Finance team

Government Banking Service Accounts (GBS)

The Health Board maintains a Government Banking Service (GBS) Account into which all sums due from NHS bodies & Welsh Government are paid. The account is used for:

- a. The funding of the MAIN ACCOUNT.
- b. Making same day payments to other NHS bodies and Superannuation contributions.

All sums transferred from the GBS Account are authorised by senior finance staff via online authorisation. Dual authorisation is required for all values over £500,000. This list of authorised signatures is held in the Finance department and is reviewed at least 6 monthly for accuracy. The GBS Bank Account should never become overdrawn.

Main Account

All Health Board income excepting Charitable and NHS income is received into the MAIN ACCOUNT. The MAIN ACCOUNT is also funded by authorised transfers from the GBS Bank Account. The MAIN ACCOUNT is also used to transfer funding to the GENERAL ACCOUNT.

The MAIN and GENERAL accounts may be held either with a commercial bank or within the Government Banking Service and are operated on a group basis, with one account permitted to be overdrawn only to the extent of any net credit balance on the other account.

Internal bank transfers are actioned by those listed on the bank mandate that have online access to the system. The signatories are reviewed every 6 months for accuracy.

General Account

The GENERAL ACCOUNT is used for the payment of creditors (except same day payments to other NHS organisations and Welsh Government payments), salaries and wages, foreign payments and HMRC contributions.

GENERAL ACCOUNT cheques are prepared by the AP team (part of shared services) with a pre-printed signature in accordance with the bank mandate.

No income is paid into the GENERAL ACCOUNT, which is funded by transfer from the MAIN ACCOUNT.

Bank Account Signatories

A full list of authorised signatories and bank mandate signatories is available from the Finance Department. This is reviewed at least 6 monthly ensuring incoming signatories are added and outgoing signatories are removed in a timely fashion.

Online access for staff is administered by the Health Board. Two approvers must set up access in line with GBS guidelines, commercial guidelines and the Health Board's Bank Mandate to ensure segregation of duties is adhered to at all times. Any new staff or amendments to roles for current staff can only be authorised by the following Head of Accounting & Statutory Reporting, Deputy Head of

Financial Accounting and Assistant Head of Financial Accounting. All transactions processed for payment are input by an administrator and then authorised by an approver.

Where BACS payments need to be recalled, all requests to the bank must be sent by 1200 on the working day prior to credit being made into the payee's account. The payroll team will be responsible for contacting the bank for all salary recalls. A list of the authorised payroll team members who can recall the BACS is held within Finance. The cash book officer is responsible for contacting the bank for any payments processed by AP (AP must provide all the relevant information to ensure the recall can be requested via the bank).

Where foreign payments are requested, AP send a CHAPS request to the cashbook officer, together with the invoice. Approval is provided by the Deputy Head of Financial Accounting or Assistant Head of Financial Accounting prior to the CHAPS payment being processed by the cash book officer. Once the payment has been made, payment confirmation is sent to AP.

Signing Procedure for Cheques

The GBS Bank and commercial bank must be advised in writing of any changes in officer(s) and/or member(s) authorised to release money from and draw cheques on each account and be notified promptly of any cancellation of any such authorisation. This should be done before the authorisation is revoked or on the same day if this is not possible.

Charitable Funds Current Account

The CHARITABLE FUNDS ACCOUNT is used for paying in all donations and legacy income received by the Health Board.

Charitable Funds Deposit Account

The CHARITABLE FUNDS DEPOSIT ACCOUNT is used to generate bank interest.

Banking of Cash and other Negotiable Instruments

Banking must be carried out by a specifically designated officer or by the Health Board's designated security carrier.

Cash must be banked on a weekly basis where there is an arrangement with a security carrier to do so.

In all other areas banking must be done within 5 days of receiving the cash.

All cheques, postal orders, cash etc, must be banked within five days of receipt, to the credit of the Health Board's MAIN ACCOUNT.

A triplicate paying-in book, provided by the Finance Department must be used as follows:

- i. First copy retained by the bank; (when a security carrier is used, ensure that the copy is enclosed)
- ii. Second copy attached to a report sheet with a list of all receipts and forwarded to the Finance Department.
- iii. Third copy retained in the paying-in book.

The paying-in book is to be completed and checked by two members of staff. However, in exceptional circumstances where this is not possible due to staff absence one member of staff will be acceptable.

Bank Reconciliations

On a monthly basis the cash book officer must prepare a reconciliation for GBS account, main and general accounts which is authorised by the Assistant Head of Financial Accounting or Financial Analyst and reviewed by Deputy Head of Financial Accounting on a timely basis through the balance sheet reconciliation system.

Reporting of Concerns

Should any suspicion of fraudulent activity be identified then this information must be brought to the attention of the Local Counter Fraud Department, the Deputy Head of Financial Accounting and the bank concerned. Where foul play is suspected, the Deputy Head of Financial Accounting and the Local Counter Fraud Department should be notified.

Management of Payment Runs

Cheque and BACS runs are managed by the Accounts Payable team in NWSSP. Cheque runs are processed once a week with BACS runs processed daily. Approval to proceed with runs is given by one of the following personnel:

- Head of Accounting and Statutory Reporting
- Deputy Head of Financial Accounting
- Assistant Head of Financial Accounting
- Financial Analyst – Financial Accounting and Statutory Reporting
- Assistant Director of Finance
- Deputy Director of Finance
- Director of Finance

Cash Forecasting

A cash forecast is prepared for the Monthly Monitoring Return from month 2 onwards and completed in line with WG deadlines. In addition to this there is a requirement to submit a monthly request for cash (for receipt in the following month) on working day 5 of each month. This is done via email in the first instance, followed by submission of a FIS1 form.

Petty Cash Imprests

A list of all cash imprest accounts showing the following details must be maintained within the Finance Department by an officer not concerned with the issue of such imprests: -

- Location of the cash.
- The Designated Holder i.e. the officer nominated by the Chief Executive or Director of Finance to be responsible for the safe custody of the cash and the operation of the account.
- The Certifying Officer i.e. the officer responsible for checking and certifying claims for reimbursement submitted to the Director of Finance. There may be instances in General Offices where staff are collectively responsible.

- Amount held. The amount of the imprest held should be kept under constant scrutiny by the Certifying Officer.

Requests for new cash imprest accounts or to increase existing imprest accounts shall be made by the relevant manager via email to the Director of Finance (via the Deputy Head of Financial Accounting) who will decide if the request is to be granted and if so the amount of the imprest account. In each case, justification and budgetary authorisation should be provided to the satisfaction of the Director of Finance.

Banking Arrangements for Petty Cash Imprests

The Director of Finance will keep the Health Board's bankers informed of Cash Holders who require Open Credit Facilities, detailing an estimated amount (either per cheque, per day, per week or per month) of the current bank that will be used and specimen signatures.

At General Offices where a significant sum of petty cash is held the Health Board will employ the services of a security company to deliver petty cash directly to them. If staff at other locations are required to handle significant amounts of cash similar arrangements should be put into place.

Method of Issuing Petty Cash

When a request is made by a member of staff to the petty cash holder, for cash, the identity of the person making the request must be established. If they are not known to the petty cash holder, their identity badge shall be checked. The member of staff shall present a receipt, signed by an authorised approver, and with a financial code identified. The petty cash holder will then issue the cash and complete a petty cash voucher, which both they and the person requesting the cash will sign. The receipt is then attached to the voucher.

An advance may be given to a member of staff, on the written request of the manager, to make a purchase. This will only be in exceptional circumstances. The fact that an advance has been made will be recorded on a petty cash voucher. When the goods have been purchased, a receipt and any change will be promptly provided to the petty cash holder, who will complete the petty cash voucher with the actual details of the expenditure and attach to the relevant petty cash claim.

Any Charitable Fund expenditure, requiring to be reimbursed from petty cash, must be accompanied by an authorised Charitable Fund request form, which will be attached to the petty cash voucher. Staff Team Members' Personal Monies: Staff members are not permitted to use petty cash to purchase items for themselves and then replenish the petty cash float with their own money.

Patients Cash

Patients' cash will be issued, in line with the Patients' Property Financial Procedure [050 - Cash Imprest Accounts – Rehabilitation Monies Financial Procedure](#) using the patients' monies imprest account if there is a separate one, or the petty cash imprest up to a limit of £50. Patients are to be encouraged to have a cheque sent to their home address for large amounts.

Reimbursement of the Petty Cash Imprest

Petty cash imprest reimbursement sheets are used to request reimbursement of the expenditure up to the imprest amount. The main part of the sheet records details of the transaction cross-referenced to the petty cash voucher, the financial code, and amount.

The second section on the petty cash imprest reimbursement sheet identifies the Imprest amount, total value of expenditure, any outstanding claims for reimbursement, and the balance of cash. The amount of cash in hand plus the value of the claim and any outstanding claims will always equal the approved imprest amount.

The cash shall be counted to ensure it agrees to the balance on the form if there is a shortfall see section [‘Security of Cash and Regulation of Issuing Cash’](#).

For all Reimbursements via Cheque

The imprest Sheet is then signed by the certifying officer and sent to the Accounts payable Section for reimbursement. All the appropriate vouchers and receipts shall be attached to the Imprest Sheet. All Sheets shall be sent to the Accounts Payable Section at reasonable intervals, (at least once per month). Any incomplete Sheets will be returned which may result in delays in reimbursement. Under no circumstances can the occurrence of reimbursement without documentation be allowed. Upon receipt of the cheque, it should be kept under lock and key until arrangements are in place to cash the cheque.

For all Reimbursements via Security Company

The imprest sheet is then signed by the certifying officer. A cash request form must also be completed by the authorised staff in general office and patient welfare, with the required cash amount, and phoned through to the Security company cash centre. All the appropriate vouchers and receipts shall be attached to the imprest sheet. The Sheet should be sent to the financial accounting section.

Any incomplete forms will be returned. Under no circumstances can the occurrence of reimbursement without documentation be allowed.

All cheques issued by the Director of Finance to reimburse the cash must be cashed immediately.

The amount of the imprest held will be kept under constant scrutiny by the Director of Finance. A review will take place each year prior to year end. The Certifying Officer will ensure disbursements, any outstanding claims and cash in hand always agree to the authorised imprest amount.

General Ledger Reconciliation

The Director of Finance will nominate an officer from the Finance department, not concerned with the issue of such imprests, to ensure that all petty cash transactions are posted correctly to the General Ledger and reconciled to the imprest amount for each location. Any discrepancy should be investigated with the relevant site.

Year End

End of year certificates of cash held will be completed on 31 March for each imprest account in accordance with the relevant guidance, which is issued by the Finance Department.

Security of Cash and Regulation of Issuing Cash

The cash must be kept in a secure lockable cash box.

The cash box, when not in use, must be locked and stored in a safe or in a secure location if no safe available.

All disbursements from the cash must, wherever practicable, be supported by a Trader's receipt (authorised by a manager). An official petty cash voucher must be completed, together with a certification that the goods have been duly received.

Payments from the petty cash imprest must only be made in circumstances where alternative methods of payment are neither feasible nor practical and must not in any event exceed £25 for any individual payment, unless agreed with the Director of Finance. However, if it does exceed £25 an explanation and backing is required for this. It will be re-iterated that this is not standard practise and should not to be continued. Petty cash floats are only used where appropriate and must not be used to bypass the tendering/ordering procedures.

Staff expenses will not be reimbursed through petty cash.

Residential units within the Learning Disability Service are allowed to draw larger amounts, as agreed with the Director of Finance to purchase items for Housekeeping. This takes the form of an advance see section [‘Method of Issuing Petty Cash’](#).

Wards and other departments within the Mental Health Service are allowed a fixed weekly amount for Patient Rehabilitation/ Occupational Therapy. This is issued by the relevant Patients' Welfare Department, see [050 - Cash Imprest Accounts – Rehabilitation Monies Financial Procedure](#).

If postage stamps are purchased from petty cash, a duplicate record must be maintained showing details of postage incurred.

The designated petty cash holder is personally responsible for the safe custody and proper disbursement of the cash. Wherever possible a register will be maintained, recording hand over. When the holder goes on annual leave, the cash should be checked and signed for. The register can also record a running balance of cash held. Petty cash balances must be checked by two staff team members at the beginning of every shift, with the petty cash books being signed by both to indicate that the amount balances. If the amount does not balance, the two staff team members are to repeat the process, and if the amount still does not balance, take note of the discrepancy and report it to their direct line manager via telephone and email. Details are to be entered into Datix as an incident.

Where more than one member of staff issues cash, it is vital that a register is maintained which records transactions made by each member of staff to ensure the security of the cash.

Payment to patients who are entitled to claim their travelling expenses will be made from the Patients Travel Imprest (if there is one), or the Petty Cash Imprest, in accordance with the procedure [070 – Hospital Travel Cost Scheme Financial Procedure](#)

On no account must loans be made between imprest accounts e.g. from the petty cash imprest to patients' monies imprest.

The cash must be used for official purposes only. On no account should personal cheques be cashed or personal loans made from petty cash. No personal monies shall be kept in with the cash.

Ad hoc checking of the cash may be carried out by the Finance Department, Internal Audit or the Counter Fraud team. The cash holder will not have prior notice of the check and will not be left alone with the cash before counting. The cash will be counted in the presence of the cash holder and any anomalies investigated.

Any loss or shortfall of cash shall be reported immediately to the Head of Accounting and Statutory Reporting in the Finance Department and the Counter Fraud Team.

Loss of Cheques

The Cash Book Officer must be notified of all cheques reported missing, mislaid etc

The employee who raised notification of the loss of cheque must enter the full details on Datix and inform the cash book officer or a colleague deputising for them to enter it on the "Missing Cheque" register. It will be the responsibility of the Head of Accounting & Statutory Reporting to inform Counter Fraud if any fraud is suspected.

The Cash book officer must ensure from the bank statements held that the cheque has not been presented.

If the cheque has been cashed, the Local Counter Fraud Specialist must be informed of the facts of the occurrence.

If the cheque has not been cashed, the cash book officer must enter details of the cheque to be stopped into the Online Banking system. Once this process has been completed the cheque is stopped immediately. Prior to issuing a replacement cheque an indemnity form must be sent out to the recipient of the original cheque.

A replacement cheque can only be issued, after a signed indemnity form has been received from the recipient of the cheque – [See Appendix 1](#).

The replacement cheque must be drawn on the same account as the stopped cheque.

Cancellation of Cheques

The cash book officer is informed of any cancellation of cheques from accounts payable or in the mail due to incorrect payee or the payee returning the cheque. The cash book officer will inform accounts payable of any returned cheques via the mail which has not gone through accounts payable for them to void on Oracle and to re-issue.

The cash book officer will update the stop cheque register and take off the unpresented cheque list as well as cancelling on the bank website.

Expired Unpresented Cheques

Unpresented cheques that are six months or older from date of issue, must be cancelled by the cash book officer.

The cash book officer must enter details of the cheque to be stopped into the Online Banking system. Once this process has been completed the cheque is stopped immediately.

The cash book officer will send out an Indemnity letter only when requested ([See Appendix 2](#)), by the payee. Once the Indemnity letter has been received fully completed and signed, only then can a cheque or BACS payment be re-issued to the payee.

Once the procedure has been followed, the officer responsible will remove the stopped cheques from the unpresented spreadsheet and update the stopped cheque register.

The replacement cheque must be drawn on the same account as the stopped cheque.

Use of Purchasing Cards/Precision Pay

The Health Board has a contract with a commercial company for purchasing cards/precision pay. The administration process for the cards is managed by the Procurement team in Shared Services. Cards are to be used for agreed purchases only and must not be used to bypass the tendering/ordering procedures (details are included in the [1054 - Purchase to Pay Financial Procedure](#)). The total value of cash expenditure each month is debited from the Health Board's general account. This value is reconciled each month by the finance team.

Money Laundering

This is a process by which the proceeds of crime are converted into assets which appear to have a legitimate origin, so that they can be retained permanently or recycled into further criminal enterprises. Criminals will attempt to distance themselves from their crimes by finding safe havens for their profits where they can avoid confiscation orders, and where the proceeds can be made to appear legitimate.

Money Laundering Regulations 2017 apply to any high value dealer, i.e. any organisation that accepts cash transactions in excess of €10,000 (approximately £9,000). However, the Proceeds of Crime Act 2002 applies to all transactions and can include dealings with agents, third parties, property or equipment, cheques, cash or bank transfers.

Offences covered by the Proceeds of Crime Act 2002 and the Money Laundering Regulations 2017 will be considered in accordance with the Health Boards Fraud, Bribery and Corruption Policy and referred to NHS Counter Fraud Services Wales team for investigation where appropriate.

Monitoring

The monitoring and review of this procedure is the responsibility of the Deputy Head of Financial Accounting. Reviews will be undertaken in line with the Health Board's review policy, which is every 3 years, or when changes are identified prior to the required review date.

Appendix 1 – Form of Indemnity

Cheque No:

Amount: £

(Amount in words) -
.....

Date:

Payee:

Details of Payment:

I/We (Name)

Of (Address)
.....
.....

Hereby indemnify Hywel Dda University Health Board against any loss which may arise in the event of the above cheque being presented for payment.

Signed:

Date:

Witness: (Print name)
..... (Signature)

Address:
.....
.....

Appendix 2 – Expired Unpresented Cheque Letter of Indemnity

Our ref: - Unpresented Cheques
Please ask for: Carys Dufty
Telephone: 01267 283019
E-mail: Carys.duffy@wales.nhs.uk
Date:

Adran cyllid
Ty Gorwel,,Parc Dewi Sant,
Heol Ffynnon Jôb, Caerfyrddin
Sir Gaerfyrddin, SA31 3HB
Rhif Ffôn: 01267 283019

Finance Department
Ty Gorwel, St David's Park
Jobs Well Road, Carmarthen,
Carmarthenshire, SA31 3HB Tel:
01267 283019

Dear

Our records indicate that a payment Hywel Dda University Health Board issued to you more than 180 days ago, is still showing as unpresented. The details of this payment are below:

- [Payment Date]
- [Cheque Number]
- [Payment Amount]

Please note that our policy is to [void](#) outstanding checks after 180 days, as they can no longer be presented at the bank.

If the cheque has been lost or destroyed and you need a replacement, please verify the information below and return this letter to us as soon as possible.

If you would prefer the payment to be made via bacs please fill out the details below:

Account Name: Bank:

Account number Sort Code

Please issue a new cheque/Bacs for the payment referenced above. I have not attempted to negotiate this cheque and will not attempt to do so. If I find the cheque referenced above, I will return it to Hywel Dda University Health Board Finance Department immediately. I certify that I am entitled to the funds.
Signed,

[Payee Name] Print name and signature

Date: _____

Contract Management Procedure

Procedure number:

Classification: Corporate

Supersedes: New

Version number: V1

Date of Equality Impact Assessment:
30/07/2024

Approval information

Approved by: Finance and Performance Committee

Date of approval: *Enter approval date*

Date made active: *Enter date made active (completion by policy team)*

Review date: *Enter review date (normally three years from approval date)*

Summary of document:

This document provides guidance to be followed for contract management. A consistent approach to contract management is designed to ensure the organisation's awarded contracts via third party suppliers are managed appropriately, making the best use of resources, mitigating against known risks and demonstrating value for money. Achieving this will deliver organisational benefits and help achieve contract compliance. This procedure sets out the process contract managers should adhere to in order to meet the business, operational and policy objectives required from the contract.

Scope:

Hywel Dda University Health Board wide

To be read in conjunction with:

[Standing Orders and Standing Financial Instructions](#) 'opens in new tab'

[1054 - Purchase to Pay Financial Procedure \(sharepoint.com\)](#) 'opens in new tab'

Patient information: N/A

Owning group: Procurement Services

Executive Director job title: Director of Finance

Reviews and updates:

Reviews and updates	
Summary of Amendments:	Date Approved:
New Procedure	August 2025

Keywords

Contract management, value for money, risk management

FRAUD, BRIBERY AND CORRUPTION

All staff are required to comply with the Health Board's policies and procedures and apply best practice in order to prevent Fraud, Bribery and Corruption. Staff should be made aware of their own responsibilities in protecting the Health Board from these crimes.

All staff have a duty to notify the Local Counter Fraud Department of any suspected fraud or inappropriate actions and are protected by the [All Wales Procedure for NHS Staff to Raise Concerns Policy](#) (opens in a new tab). Anyone who suspects fraud or has any concerns reference Fraud Bribery and Corruption can make a referral by contacting the Counter Fraud Department by any of the following methods;

- Telephoning the office on 01267 266268,
- Emailing HDUHB.CounterFraudTeam.HDD@wales.nhs.uk,
- Making an online referral at <https://reportfraud.cfa.nhs.uk> or
- Making an anonymous referral by telephoning Crimestoppers on 0800 028 40 60.

Staff should refer to the [Counter Fraud, Bribery and Corruption Policy](#) (opens in a new tab) for further information.

Shared Services Partnership, Procurement Services [Contract Management Procedure](#) (opens in a new tab)

6.3

12:45 PM, 5 Mins

6.3 - POLICIES

Andrew Carruthers
(Hywel Dda UHB -
Chief Operating
Officer)

| For approval

Attachments

[Policy 534 Patient Access Elective Care Policy FPC 26 August 2025.pdf](#)

[Policy 534 Patient Access Elective Care Policy.pdf](#)

[Policy 534 Patient Access Elective Care Policy Equality Impact Assessment.pdf](#)



PWYLLGOR CYLLID A PHERFFORMIAD
FINANCE AND PERFORMANCE COMMITTEE

DYDDIAD Y CYFARFOD: DATE OF MEETING:	26 August 2025
TEITL YR ADRODDIAD: TITLE OF REPORT:	Policy 534: Patient Access – Elective Care Policy
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Andrew Carruthers, Chief Operating Officer
SWYDDOG ADRODD: REPORTING OFFICER:	Paula Goode, Service Director, Planned and Specialist Care, Lisa Humphreys, General Manager, Women and Children's Services

Pwrpas yr Adroddiad (dewiswch fel yn addas)

Purpose of the Report (select as appropriate)

Ar Gyfer Penderfyniad/For Decision

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

Welsh Government have updated the rules for Referral to Treatment (RTT) as of April 2025. These changes aim to improve patient care and recovery. Hywel Dda University Health Board (HDdUHB) representatives have participated in the development of these revised guidelines including providing feedback and attending relevant sub-groups.

This update has been finalised by Welsh Government and communicated to all CEOs on the 17 April 2025 by Nick Wood (Deputy Chief Executive, NHS Wales). A framework for the development of a patients travel policy is also attached for information.

Cefndir / Background

- The new rules focus on working closely with patients, managing their expectations, and ensuring they are fit for treatment.
- Key principles include the 3Ps Policy (Patient, Pathway, Prioritisation) and the Waiting Well Patient-Reported Outcome Measures (PROM) and Patient-Reported Experience Measures (PREM) to support shared decision-making.
- The updates reflect changes in planned care, including regional care models and outpatient services.

Asesiad / Assessment

- **New Rules:** Only patients who are fit for treatment should be listed. Better management of treatment offers and improved support for vulnerable groups.

- **Patient Information:** Resources to help patients understand their role and manage expectations, including leaflets and online resources.
- **Working with WPAS:** New methods for delivering services, managing patients on active monitoring, and better identification and support for vulnerable groups.

Argymhelliad / Recommendation

The Finance and Performance Committee is asked to **APPROVE** the following updated policy:

- Policy 534: Patient Access – Elective Care Policy

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	3.1.21 Review and approve financial procedures on behalf of the Health Board.
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)	Not Applicable
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	Not Applicable
Amcanion Strategol y BIP: UHB Strategic Objectives:	All Strategic Objectives are applicable
Amcanion Cynllunio Planning Objectives	Not Applicable
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022	10. Not Applicable

**Gwybodaeth Ychwanegol:
Further Information:**

Ar sail tystiolaeth: Evidence Base:	Previous procedures, internal audit report recommendations, standing financial instructions
Rhestr Termiau: Glossary of Terms:	Contained within the body of the report.
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Cyllid a Pherfformiad Parties / Committees consulted prior to Finance and Performance Committee:	None

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	No financial impact.
Ansawdd / Gofal Claf: Quality / Patient Care:	No adverse impact on quality or patient care.
Gweithlu: Workforce:	No adverse impact on existing or future staffing.
Risg: Risk:	No risks identified.
Cyfreithiol: Legal:	No likely legal impact or likelihood of legal challenge.
Enw Da: Reputational:	No potential for political or media interest or public opposition.

Gyfrinachedd: Privacy:	No potential impact on individual's privacy rights or confidentiality and/or the potential for an information security risk due to the way in which information is being used/shared.
Cydraddoldeb: Equality:	Equality Impact Assessment attached.

Patient Access – Elective Care Policy

(For Internal Management Use)

Policy information

Policy number: 534

Classification:
Corporate

Supersedes:
Previous version

Version number:
5

Date of Equality Impact Assessment: 04.06.2024

Approval information

Approved by: Strategic Development and Operational Delivery Committee SDODC

Date of approval: Enter approval date

Date made active: Enter date made active (completion by policy team)

Review date: Enter review date (normally three years from approval date)

Summary of document:

This policy is to ensure that the period patients wait for elective (planned) care are measured and reported in a consistent and fair manner.

Scope:

This policy applies to all patients who require to access elective care across Hywel Dda University Health Board and requires to be adhered to by all staff who are involved in the implementation of all aspects of this policy

To be read in conjunction with:

Patient information:

Include links to [Patient Information Library](#)

Owning group:

WatchTower Group

Date signed off by owning group

Executive Director job title:

Director of Operations

Reviews and updates:

1 – new policy 12.8.2021

2 – minor changes 18.12.2017

3 – review minor changes 26.6.2018

4 – three yearly review and COVID19 added 12.8.2021

5 – revised (three yearly review) No changes

Keywords

Patient access, elective surgery, elective care, referral to treatment times (RTT), waiting times

Glossary of terms

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Introduction

This document provides a detailed reference source of the waiting times management rules relating to the 26-week referral to treatment (RTT) target and related direct access diagnostic and therapies targets. For RTT, it is noted that some complex cases may take longer than this and a maximum of 36 weeks has been set to reflect this.

In March 2005, the First Minister and Minister for Health and Social Services announced that, by December 2009, patients in Wales should not wait more than 26 weeks from GP referral to treatment, including waiting times for any diagnostic tests or therapies required. *Designed for Life* (Welsh Government, 2005) subsequently set out a vision of a service designed around patients, with a 10-year programme to transform the system and create a world-class health and social care service for the people of Wales.

The guiding principles of the target were set in policy through a range of Welsh Health Circulars (WHC). These have been consolidated recently and re-released under WHC (2018)018.

The achievement of the 26-week RTT target is the responsibility of the Health Board (HB).

Within this waiting time period, both the patient and the NHS have their roles and responsibilities to achieve the target.

It is recognised a number of terms of a technical nature are included within the document. To support the reader, a glossary of terms can be found towards the back of this document.

Policy Statement

The underlying principle of the target is that patients should receive excellent care without delay. For other than complex clinical reasons, patients should receive commencement of their required treatment no later than 26 weeks from referral, with a maximum of 36 weeks to allow for clinically complex cases.

Scope

This policy applies to all patients who require access to elective care across Hywel Dda University Health Board and should be adhered to by all staff who are involved in the implementation of all aspects of this policy.

Aim

This policy is to ensure that the period patients wait for elective (planned) care are measured and reported in a consistent and fair manner.

Objective

The aim of the policy is achieved by:

- Setting out clearly and succinctly the rules to ensure that each patient's RTT period begins and ends fairly and consistently;
- Highlighting both the patient and NHS roles and responsibilities and the potential consequences if this mutual compact is not fully met.

Procedure

Guiding Principles

The guiding principles of the referral to treatment target clearly reflect the principles of prudent healthcare, these being to:

- minimise avoidable harm;
- carry out the minimum appropriate intervention;
- promote equity between the people who provide and use services.

There are a number of key principles which underpin the waiting times rules, and apply to all targets. These principles apply to all interactions with patients, and must be considered in the formation of all waiting times and access policies and procedures.

Do only what is needed and do no harm

All patients should wait the shortest possible time for treatment.

Care for those with the greatest health need first

The target should not distort clinical priorities. RTT targets are maximum acceptable waits, and urgent patients should be treated as their clinical need dictates.

Public and professionals are equal partners through co-production

The concept of an NHS/patient 'compact' around the delivery of waiting times is implicit and reflected in the definitions below. Both parties have rights and responsibilities within the arrangement. The NHS will be required to deliver high quality care within the target time, and to allow for patient choices within that time. Patients will be expected to make themselves available for treatment within reasonable timescales and at sites and times where the service is delivered, sometimes outside of the HB area. Their inability to do so may result in a longer waiting time.

It is important that the rights and responsibilities of the patient are explained to them at the time of referral, either directly through written resources, or being signposted to electronic resources (websites). This requires commitment from referrers and appropriate information resources for patients and healthcare staff. Patients have a duty to notify the NHS, hospital and their GP of any changes in circumstances while they are waiting to be seen, at any stage.

Within the information given to the public, it must give them adequate information on the expected timescales, the anticipated process and their responsibilities to assist the NHS to provide efficient and effective treatment of their condition. Patients will be empowered through this information to question and monitor their own progress against the target. Patients should be encouraged to become involved in all decisions relating to their care. This should include potential treatment options and administrative arrangements. All appointments within an RTT period must be arranged under the rules relating to reasonable offer, and therefore all practical steps must be undertaken to ensure appointments are

mutually agreed between the patient and the organisation. When a patient is removed from a pathway for reasons other than treatment, both the patient and referrer must be fully informed of the reasons behind this decision and any requirements for reinstatement.

Reduce inappropriate variation through evidenced based approaches

The rules have been written to be robust and clear. HBs will be expected to maintain appropriate governance structures to ensure that where there is flexibility within the rules, the spirit of the targets is achieved. All patient management methodologies should be transparent and guided by the principle that patients should wait the shortest time possible for treatment. There is provision for local variations to these rules where these are directly in the patient's best interest.

Scope of the Targets

The scope of the 26-week RTT target encompasses elective treatment for all Welsh residents, whether treated in Wales or elsewhere. The target covers patients who are referred by a healthcare professional to a consultant in secondary or tertiary care, including consultants who work in the community.

The 26 week RTT target does not replace the following waiting times targets:

- Cancer target (31 and 62 days) (see specific cancer document April 2017);
- Fitting of adult hearing aids (direct access) (14 week waiting time target);
- Diagnostic tests (non-RTT) (8 week waiting time operational target refer to section: [diagnostic test](#) for list);
- Therapy services (non-RTT) (14 week waiting time operational target refer to [section](#) for list);
- Consolidated Rules for Managing Cardiac Referral to Treatment Waiting Times.

Each of the above targets should be managed according to their own specific rules, where these exist. However, RTT principles can be applied in respect of DNA and CNA rules as long as local processes also follow the reasonable offer procedures.

The RTT period begins on the receipt of a referral in secondary or tertiary care and ends when treatment commences. Treatment will often continue beyond a first treatment and after a clock has stopped.

A referral received from a screening service will begin a new RTT period.

A self-referral or patient-initiated follow-up will not begin an RTT period unless it follows a period of unavailability*. If a new decision to treat or a change of management plan is subsequently initiated, a new RTT period will begin.

** This relates to patient unavailability ([section - adjustments](#)); when a patient has been unavailable and an agreement has been made that they can recommence when they are ready. The self-referral is when the clock is started for a continuation of the pathway. A new RTT pathway cannot start from a self-referral, only from a clinical referral.*

Some patients may be measured on more than one RTT period during the management of their condition in secondary or tertiary care. This will include patients who have a planned sequence* of treatments.

** This relates to any planned procedure following the initial treatment such as a second hip or knee or second cataract if the initial assessment deemed the patient needed bilateral procedures.*

Events other than treatment, which can end an RTT period, may include:

- A decision made not to treat a patient;
- Commencement of active monitoring ('watch and wait');
A consultant-to-consultant referral (other than from cardiology to cardiac intervention/surgery).

Further details of clock start and stop points are described later in this document.

Only specified diagnostic and therapy services are included in the 26-week RTT target. The following tables outline the diagnostic tests and therapy services that are included. An adjustment may be made for time spent waiting for excluded diagnostics or therapies where the requirement for such a test or service precludes treatment commencing.

Patients with a recurrence of cancer that is not covered by the 31 and 62-day targets will be covered by the 26-week RTT target, but their clinical priority should determine their appropriate clinical wait.

For orthodontics and restorative dentistry, the first outpatient appointment will be included in the RTT period. Any subsequent treatment will be outside the 26-week RTT target.

The table below provides guidance on special services, clinical conditions and patient groups, which are included within the scope of the 26-week RTT target.

To note: As at June 2018, guidance on CMAT services is still being reviewed by the planned care programme.

Included in the scope of the 26 week RTT target	
Special Services / Conditions / Patient Groups	Notes
Recurrence of cancer	Any recurrence not covered by the 31 and 62-day cancer targets.
Fertility treatment	Treatment at level 1 and level 2 only. Please refer to this guidance.  CP38 Specialist Fertility Services v9.1
Clinical genetics	New conditions identified because of a genetic test.
Military personnel	Included to the extent that HBs are responsible for their care. The target does not apply to MOD-commissioned care unless stated in agreements with HB. Waiting times for military personnel are subject to the provision in the letter from Director of Operations to Directors of Planning – July 2011

Prisoners	Prisoners should be treated within the same waiting time target as all other NHS patients. It is accepted that in some cases there will be circumstances unique to this population that may make achieving the 26 weeks RTT target particularly challenging. The detailed reasons why these patients exceeded the target time should be recorded in the breach analysis.
Private Patients	A patient cannot be both a private and a NHS patient for the treatment of one condition during a single visit to a NHS organisation. Any patient seen privately is entitled to subsequently change his or her status and seek treatment as a NHS patient. Any patient changing their status after having been provided with private services should not receive an unfair advantage over other patients. (Jump the queue) Patients referred for a NHS service following a private consultation or private treatment should join any NHS waiting list at the same point as if the prior consultation or treatment were a NHS service. Their priority on the waiting list should be determined by the same criteria applied to other referrals. The entry on to the appropriate stage commences a new 26-week clock start. If treatment has already commenced within the private sector, then a referral from private to NHS would not start a new RTT clock but be recorded as ongoing follow-up care. Only if there is a significant planned change in treatment would a new RTT clock commence.
Patients not normally resident in Wales.	Funding for treatment is based on permanent residence and patients should not be listed for elective treatment until prior approval is sought for residents from England, Scotland or Northern Ireland and non UK residents should be brought to the attention of the Overseas team so that funding can be arranged <u>prior</u> to treatment

26-week RTT target exclusions

The table below provides guidance on services and clinical conditions that are not included within the scope of the 26-week RTT target.

Excluded from the scope of the 26 week RTT target	
Special Services / Conditions	Notes

Emergency care episodes	Any emergency care episode. Further information on the management of referrals arising from an emergency care episode is available within this document.
Mental health services	All mental health services including Child and Adolescent Mental Health Services.
Palliative care	Including hospice care.
Cochlea implants	Where the treatment intervention is the specific provision of cochlea implants.
Screening services	A decision to refer from a screening service would begin a new RTT period.
Community paediatrics	A decision to refer from community paediatrics would begin a new RTT period.
Routine dialysis treatment	A decision to refer following a dialysis session would begin a new RTT period.
Obstetrics	A decision to refer from obstetrics for a non-obstetric condition would begin a new RTT period.
Fertility treatment	Specialist level 3 fertility treatment is subject to policy approved maintenance of a maximum 18-month waiting time.
Dental education	Dental patients receiving treatment in an undergraduate service are excluded.
Transplant and clinical trials	Once a treatment option is agreed for entry onto a Transplant list or clinical trial, the RTT clock will stop. The wait for these services are outside the RTT rules.

In the event of any questions regarding the application of RTT rules to individual services, conditions and/or patients, advice should be sought from the Scheduled Care RTT Watchtower group, which meet every Wednesday morning.

Clinical Responsibilities

Waiting times for patients are one of the key indicators of quality of service. Clinicians should make themselves aware of the current waiting times applying to their service, and work with HBs to instigate action when those waiting times are not meeting the expected level of quality of care.

Clinical staff must be aware of national requirements and organisational policies in respect of waiting times, and funding requirements as noted above for non- Welsh residents. As part of this awareness,

they should be actively aware of their own current waiting times and use this to discuss options and potential waits for their patients along their pathway.

Clinicians should ensure that their actions promote the principle of patients waiting the shortest possible time for treatment.

Clinicians should also ensure that patients are fit to proceed with the most appropriate treatment. If they are not fit, this should be discussed with the patient to understand their options.

Referrers must use prudent healthcare principles to ensure the most efficient and patient-centred approach to referral that reduces the steps needed to reach treatment.

Clinicians should make decisions in a timely manner, and that any onward referrals are completed promptly, according to local guidelines, and include adequate information to allow the receiving clinician to initiate appropriate interventions with the minimum of delay. Referrers must ensure that the patient is aware and agrees for a referral to be made.

Clinicians should cooperate with agreed local systems to enable the recording of the clinical outcome of all interactions with patients, whether face-to-face or by phone or letter.

Clinicians in secondary and tertiary care must ensure that all decisions relating to a patient's care or treatment are communicated to the patient and their primary care clinician in a timely manner, whether those decisions are made in the presence of the patient or not.

Clinicians must ensure that the intention of any intervention such as tests or treatment is clear, and whether it is just a stage of the agreed pathway or is considered start of definitive treatments and as such ends the pathway clock.

Referrals

The RTT period begins at referral by a GP or dentist to a consultant in secondary or tertiary care, and by any other healthcare professional where referral protocols exist. The clock will start on the date that the organisation receives a compliant referral.

Referrers must use the most efficient and patient-centred approach to referral that reduces the steps needed to reach treatment, based on prudent healthcare principles. As part of the referral information, referrers should include verified up to date patient contact details including mobile phone numbers and email addresses where available. Referrers should seek the consent of the patient to be contacted by the HB by such means as text, email or telephone and indicate if consent is given for this. Referrers should include this information in the referral. HBs must ensure that patients are seen by the most appropriate individual to meet the patient's clinical needs once the referral has been accepted.

HBs should provide up to date information to referrers relating to the patient pathway that will be followed, the likely waiting time and the locations the service will be delivered from, in order that this can be communicated clearly to the patient. Discussion should also be supported by written information for patients either provided during consultation or by signposting where they can get additional information. HBs should have systems in place to keep this information up to date and available to referrers. Within Hywel Dda these can be accessed at

<http://www.wales.nhs.uk/sitesplus/862/page/94029/> (opens in a new tab)

If a referral is made for a procedure that is not offered by the HB, it should be returned to the referrer with a full explanation and no clock will be started.

When a referral is made to a clinician or specialty that does not treat this condition, but is treated by the HB, the HB has the responsibility to direct the referral to the correct clinician / clinical team and the clock does not stop.

When the HB directs a referral in error to a clinician who does not treat this condition, an onward referral to the appropriate clinician will not stop the clock. The patient must be seen by the new consultant within the same RTT period.

When a referral does not comply with agreed referral guidelines the clock should not start until the referrer confirms full compliance and the appropriateness of the referral is confirmed. HBs should work with primary care to turn such referrals round within 48 hrs.

If the referral has insufficient information to enable a clinical decision to be made, it should be returned to the referrer for completion with guidance on what is required. The RTT period will continue whilst the information is obtained, as the delay is not related to a patient's breach of the shared compact

HBs need to work with primary care to ensure good quality information flows between the two areas to support effective patient care.

Booking and Reasonable Offer

Booking processes

All patient appointments should be booked using a patient-focused booking approach. The booking processes used by HBs needs to be clearly communicated to patients at referral to ensure patients are clear on their role in the local process. Wherever practical, appointments should be made with the involvement of the patient and their role to make any changes clear around how the appointment will be mutually agreed. This must be adhered to, even when the organisation does not hold complete contact details for the patient.

No organisation should be seeking periods of unavailability in order to meet targets. The focus of the booking interaction should be on achieving a mutually agreeable date.

Where fully automated booking systems are utilised and the HB sends the patient a confirmation letter, the HB should have a process in place to allow the patient to play an active role in changing the appointment if it is not mutually agreeable. Patients need to be clear about their role in agreeing dates in keeping with the principles of co-production. This process needs to be clearly explained to the patients when they are referred. Whenever possible, organisations should ensure that patients are treated in turn, allowing for considerations of clinical priority.

If a patient is to be seen within six weeks it is possible either a direct booking or partial booking system maybe be used. If the appointment is likely to be more than six weeks in the future, confirmation of the acceptance of the referral is needed either by letter, text or phone.

Each attempt to contact the patient under the booking processes must be recorded and available for subsequent audit.

Partial booking

Under the partial booking process, an acknowledgement must be sent to the patient when the referral is accepted. This should explain the booking process that will be used for their appointment. An invitation letter should then be sent to the patient six weeks before it is anticipated they will be seen asking them to phone and make an appointment within the next two weeks.

Patients, who do not respond to the invitation letter within two weeks (Day 14), will be removed from the waiting list seven days after. (Day 21).

If the local booking process is to send a proposed appointment date in the second letter (after the acknowledgement letter from referral), the patient should be clearly directed on their option and timeline (two weeks) to change this appointment. After this date, the appointment will be deemed as mutually agreed as long as the date was sent within three weeks of the date offered. An opportunity to actively confirm the date is encouraged via phone or text reminder process.

Direct booking

Whilst partial booking practice is the normal procedure to be used, on occasion and due to capacity & demand circumstances, direct booking may be utilised. This can take place in two ways. An appointment can either be booked in a face-to-face interaction with the patient or through a direct dialogue with the patient either via letter, telephone or, subject to patient communication preferences, email and / or text.

Under the direct booking process, if the appointment is being made by telephone, the HB should make at least two attempts to contact the patient. These telephone calls must take place on different days, and at least one must be outside normal working hours (Monday -Friday 9-5pm). If contact with the patient has not been achieved and if the local booking process is to send a proposed appointment date in a letter, the patient should be clearly directed on their option to change this appointment.

Reasonable offer

A reasonable offer to a patient is defined as any date mutually agreed between the patient and the organisation. Any subsequent application of waiting times rules based on this offer (e.g. Could Not Attend -CNA, Did Not Attend - DNA) may only be applied if the appointment date has been mutually agreed, and is therefore considered to be reasonable.

Organisations must ensure that, wherever practical, appointments are mutually agreeable, and that the patient has been offered a choice of dates within the agreed timeframes.

Patients should be offered a number of possible dates and/or times, at least two of which must be more than two weeks in the future. (Refer to the [next section](#) for the amount of offers).

Patients should be offered appointments at any location providing the required service, preferably at a venue that is nearest to their home. The offer of appointments at locations away from the patient's local area will be considered reasonable if this was explained to the patient when they were referred or in the receipt of referral acknowledgement.

All dates offered must be recorded and available for subsequent audit. If the required information is not recorded, it will be considered that no reasonable offer has occurred.

An adjustment or reset can be applied where it has not been possible to agree a suitable date within the originally planned booking period*.

** On making initial contact with the patient it is assumed as a staff member you are offering a range of available appointments that provide the patient with a reasonable offer. If the patient cannot attend these or they are not available, then an adjustment can be applied, but only at the booking stage.*

Refusal of a reasonable offer

A patient may only be deemed to have refused a reasonable offer when up to two appointments appropriately spaced apart and on alternative dates have been offered and it has not proved possible to agree an appointment. Two appointments may not be possible for some consultations such as agreeing treatment admission, diagnostics test dates or for clinics that run only monthly. Local discretion on reasonable offer on these occasions is appropriate and should be explained to the patient and noted in their records.

If the patient declares themselves as unavailable for the time period in which the offers are being made, the social unavailability rules will apply.

If the patient is available during the offer period, but refuses a reasonable offer, the clock will be reset (*adjusted for the time the patient is unavailable*). The new clock start will be the date that the patient refuses the offered appointments.

Could not attend (CNA)

A CNA occurs when the patient gives prior notice of their inability to attend a mutually agreed appointment. A patient may give notice up to and including the day but prior to the actual time of the appointment.

If a patient CNAs within any stage of the pathway, a new mutually agreed appointment must be made as soon as the patient is available, and their clock will be reset, but they remain on the pathway. This reset should be communicated to the patient when rebooking the appointment.

(Reset for the time lost from the date the appointment was originally booked to when you are informed the patient is unable to attend. The patient remains on the same stage and the clock continues with the adjustment made.)

On the second CNA within the same pathway, the patient should be categorised as a DNA as they will be deemed to have broken the “compact” to be reasonably available, and as such, they should be removed from the waiting list and responsibility for ongoing care should return to the referrer. Appropriate notification of removal must be given to the patient and the referrer.

Did not attend (DNA)

If the patient does not attend (DNA) an agreed appointment without giving notice, the patient should be removed from the waiting list and responsibility for ongoing care should return to the referrer. Appropriate notification of removal must be given to the patient and the referrer.

If the consultant responsible for the patient considers that they should not, for clinical reasons, be removed from the pathway following a DNA, they should remain on the pathway and their clock will be reset.

The DNA reset may be applied on a maximum of two occasions in any one RTT pathway. Confirmation of any reset must be communicated verbally and / or by letter to the patient and the referrer. If the patient DNAs for a third time or more, and the consultant responsible considers the patient should remain on the waiting list, the pathway clock should be stopped and the clinician should write to the referrer and patient seeking clarification that they need to continue on the pathway. Only if this is confirmed by the referrer, will the patient then be reinstated on the waiting list and the clock should be reset to the date of confirmation from the referrer and patient that they wish for the patient to remain on the pathway. They should restart at the most appropriate stage of the pathway based on their clinical need and their past pathway history.

Attendance outcomes

An outcome must be recorded within the information system for every patient interaction, whether the patient is present or not.

The outcome will fall into one of three categories: a clock continue, a clock stop, or a new clock start.

HBs need to ensure 100% compliance with outcome coding for any patient interaction, either face-to-face or virtual, to reduce the need for validation of un-coded activity.

Clock continue outcomes

A clock continue outcome is used to define decision points along the pathway where the current clock status will continue. Within an active RTT period, the clock continues to tick. When there is no current RTT period, the previous clock remains stopped.

There are various reasons for a clock stop, but once a clock stop has been reached, a new or continuous clock does not (re)commence unless there is a change in the clinical decision which originally led to the clock stop. For example, for patients who are being monitored under a 'watch and wait' regime, their clock is stopped and the patient remains a follow-up. If, after subsequent follow-up review, the consultant decides to change their treatment requirement, a new RTT clock should start. It would not continue from the previous clock.

If an appointment is cancelled by the organisation, the clock will continue, and a new appointment must be booked.

All referrals within an RTT period to diagnostic services, therapy assessments or anaesthetic assessment, will continue the clock. Where the referral is for an excluded diagnostic investigation, an

adjustment to the waiting time can be applied. (Refer to sections [Scope of targets](#) & [Clinical responsibilities](#), for tests and therapy services, which are included as, part of RTT pathway).

Note: A CMAT referral does not automatically start an RTT clock. However, if when reviewed and assessed the patient requires secondary care assessment, the referral into secondary care will start the clock. Note the National Planned Care Program Board (PCB), will issue formal CMAT guidance, one approved. Currently in June 2018, this is still subject to further review.

Where the patient has been informed of service options and the consequences of remaining on a named consultant waiting list (and/or hospital site that has a longer waiting time), the organisation can reset the clock to the date the patient informed the organisation about their decision. The patient should be informed of the consequences of their decision either verbally or in writing.

In these instances, it would be expected that patients should retain their place on the waiting list to acknowledge their previous wait and be treated appropriately when resources are available. Consequently, when a previously “reset” patient is then seen, it may appear the patient has been treated out of turn, (i.e. they have waited a shorter waiting time). This reset may only be applied once in any individual patient pathway. The patient must be informed verbally or in writing of the consequences of their decision in terms of their new expected waiting times at the point they make their decision.

When a patient’s RTT period takes place across more than one organisation, and the consultant responsible for the care of the patient does not change, the clock will continue when the patient is transferred between organisations. A referral to another consultant (except for a cardiac pathway) will stop the current RTT clock and commence a new RTT clock. HBs must ensure that communication protocols are utilised so that appropriate information is shared, and RTT periods are measured accurately.

When a patient is referred from an NHS organisation to an independent sector organisation as part of their NHS pathway, the clock will continue.

[Clock stop outcomes](#)

A clock stop outcome is used to define decision points along the pathway where a current RTT period will end.

Clock stop outcomes are used for events, which constitute a treatment, a decision that no treatment is required, or when the patient is unavailable for medical or social reasons longer than they agreed periods.

Treatment is defined as a clinical intervention intended at the time of the intervention to manage the patient’s condition.

When treatment is given in a non-admission setting, the clock will stop on the date the treatment commences.

When treatment is to be delivered following an admission, the clock will stop on the date of admission. If the treatment is not carried out during the admission, the clock stop must be retracted and the clock will continue.

When a decision is made not to treat at the present time, the clock will stop. This may be either a clinical decision not to treat, including active monitoring, or a patient decision to refuse or defer treatment. The clock will stop on the date the decision is communicated to or by the patient.

When a patient is transferred between consultants for reasons of clinical necessity that prevents the current pathway being completed, the clock will stop. This should be recorded for audit purpose. When this is simply a request for advice, this must be managed within the 26-week RTT period. The date on which it is explained to the patient that clinical responsibility for their care is being transferred to another consultant will be the clock stop date. The receipt of the referral by the second consultant will begin a new RTT period, however the organisation should take into account the time already waited by the patient in deciding treatment priority/timescales.

If a patient is enrolled on a clinical trial or added to a transplant list, the clock will stop on the date the decision is communicated to the patient.

If a patient elects to have the next stage(s) of their pathway delivered privately outside the NHS, the clock will stop when this intention is communicated to the organisation.

When a diagnostic procedure converts to a therapeutic intervention that meets the treatment definition, the clock will stop. The clock stop date will be the date of the intervention.

A referral for an excluded therapy treatment, where this is the intervention intended to manage the patient's condition (treatment) this is considered the start of definitive treatment which will constitute a stop clock. The clock stop date will be the date the referral is made. If the therapy referral however is only part of the pathway, it does not stop the clock but an adjustment for the wait can be made (see section under RTT excluded services, this excludes cardiac pathways).

If a patient is admitted as an emergency and receives an intervention for the condition for which they have an open RTT period, and the intervention meets the treatment definition, the clock will stop. The clock stop date will be the date of the intervention.

If a patient DNAs an appointment and is deemed clinically appropriate for removal, or has a second CNA during the pathway, or is unavailable for more than **eight weeks** in one period, the clock will stop. The clock stop date will be the date the organisation is made aware of the event

If, in the opinion of a suitably qualified healthcare professional, a patient has a medical condition that will not be resolved within 21 days, the patient should be returned to the referring clinician, or to another clinician who will treat the condition and the clock will stop. The clock stop date will be the date the patient is determined to be medically unavailable for this period.

If a patient is removed from the waiting list for reasons other than treatment, the patient and their referrer must be informed of the removal and the reasons for it. The information given must include the full reasons for removal and guidelines specifying the requirements for a return to the pathway. A full audit trail of this communication must be maintained.

If the patient being removed from the waiting list is under 18, consideration must be given to child protection implications and their risks from being removed need to be considered and documented. If the patient is younger than five years old, the health visitor should be informed of the removal.

[New clock start outcomes](#)

Following a clock stop, a patient should continue to be reviewed by the clinician only where this is clinically required. When a patient continues to be reviewed and a new decision to treat is made, a new RTT period will start. The clock start date will be the date the new decision to treat is made. When

there is a fundamental change in an ongoing treatment plan and the new treatment cannot be started at the point when the change is discussed with the patient, a new RTT period will begin. An example of this being as follows

- Pain relief is no longer considered effective and an operation is now considered the best treatment;
- A new clock would be started when this decision is made and continue until the patient is admitted for the operation;
- A full audit trail of this should be maintained. The clock start date will be the date the decision to change the treatment is communicated to the patient;
- An incremental change to ongoing treatment will not begin a new RTT period: an example being physiotherapy being offered to support ongoing pain relief.

When during an emergency admission or attendance a patient is placed on the waiting list for an elective procedure scheduled to take place after discharge from emergency care (A&E or an emergency admission), a new RTT period will begin. The clock start date will be the date of discharge from the emergency stay.

For clinical reasons, some patients will require a treatment at a later point in time. A new RTT period will begin for these planned treatments on the date that it becomes clinically appropriate to undertake the procedure.

When a patient has been removed from the waiting list for reasons other than treatment, (mainly non availability while trying to book appointments), organisations should allow the patient to self-refer back into the pathway rather than creating a new referral via the GP as long as the patient now commits to their availability and it is within 6 months of the original referral.) The patient should return to the pathway at the clinically most appropriate place, and a new RTT period will begin. The clock start date will be the date the referral is received by the HB.

If 6 months have elapsed since the original referral, a new referral should be created. However, the six-month maximum may be extended indefinitely in the case of 'expert patient' or See On Symptoms SOS clinics where guidelines are in place and agreed jointly by the clinician and patient to facilitate appropriate use of SOS for each patient.

Adjustments

Patient unavailability

When a patient is unavailable due to a short-term medical condition, such as a cold, an adjustment to the RTT period may be made. While this may be applied by receptionists, where required it should be supported by a suitably qualified healthcare professional, who agrees that a patient has a condition which will be resolved within 21 days. The patient should remain on the active waiting list and an adjustment of up to 21 days may be applied. If it is felt by a qualified medical professional not to be, a condition that should resolve in 21 days a clock stop should be applied.

The adjustment should start from the date of the decision that the patient is medically unfit and continue to the date that the patient is declared fit for the procedure. This period must not exceed 21 days in each stage of the pathway.

If a patient is reviewed after the expected recovery period and recovery has not been effective, or a further condition has developed, the patient should be returned to the referring clinician, or another clinician who will treat the condition, and the RTT period will end. A second 21-day period cannot be applied within the same stage of the pathway.

Social Reasons

When a patient is unavailable due to social reasons, an adjustment to the RTT period may be applied. (Maximum 8 weeks).

When the period of unavailability is less than two weeks, no adjustment may be made.

When the period of unavailability is between two and eight weeks, an adjustment may be made for the full period of time that the patient is unavailable.

When the period of unavailability is more than eight weeks the patient should be returned to the referrer but this should be discussed and agreed by their consultant.

RTT excluded services

If a patient is referred to a diagnostic or therapy service, which is excluded from the scope of the 26-week RTT target, an adjustment may be applied if it is a stage of their pathway. An adjustment may only be applied if the input is essential before the intended treatment can take place.

When the referral is for an excluded diagnostic test, the adjustment will apply from the date of the referral to the date that the test is undertaken.

When the referral is for an excluded therapy assessment or interim treatment, the adjustment will apply from the date of the referral to the date that the assessment or intervention is carried out.

Planned Care

Planned care relates to elective admissions planned to occur in the future where, for medical reasons, there must be delay before a particular intervention can be carried out. This will include the second part of a bilateral procedure, sequential treatments, interventions where a delay is necessary due to developmental maturity, and surveillance procedures.

When a patient clinically requires bilateral or sequential procedures, the RTT period for the first procedure will be managed routinely under the RTT rules. A new RTT period will begin when the patient is deemed fit and ready for the second or subsequent procedure/s. The clock will start on the date of the decision to admit and stop on the date of admission for the second or subsequent procedure/s.

When a required intervention must be delayed until a certain level of developmental maturity is reached, the patient will be actively monitored until ready to undergo the procedure. At the time of this decision, the current RTT period will end. A new RTT period will begin when the consultant decides

that the patient is ready and fit for the procedure, and a decision to admit is made. The clock will start on the date of the decision to admit and stop on the date of admission for the procedure.

When a planned intervention is part of a surveillance programme no RTT period will apply. When the decision is taken to commence a surveillance programme, the current RTT period will end. This may be because of an initial intervention or diagnostic test leading to the surveillance programme.

Emergency Care

RTT rules apply to elective pathways only and therefore admissions arising directly from emergency attendances will not begin an RTT period. However, a new elective or planned pathway initiated through an emergency event will begin a new RTT period.

If a patient is seen during an emergency attendance or admission by a consultant team and subsequent follow up is arranged under their care or at a specific emergency clinic, this will not begin a new RTT period. A later decision to treat would begin a new RTT period. The clock would start on the date the decision is made.

If a patient is seen during an emergency attendance or admission by a consultant team, and there is a decision to treat the patient on an elective or planned basis, a new RTT period would begin. The clock would start on the date of discharge from the emergency stay.

If a patient is referred during an emergency attendance or admission to another consultant to be seen outside of the emergency event, the referral will begin a new RTT period. The clock would start on the date the referral is received by the second consultant.

If a patient with a current RTT period is admitted as an emergency and is treated for that condition during their emergency stay, the RTT period will end. The clock will stop on the date the treatment is carried out.

If a patient with a current RTT period is admitted as an emergency, but is not treated for that condition during their admission, the clock will continue. In the event that the patient is deemed medically unfit to undergo the treatment for which they are waiting, the rules for patient unavailability should be applied.

Accountability

Recording and reporting

Reporting formats

All targets must be reported according to the requirements of the NHS Wales Data Dictionary. Organisations must consult the data dictionary for details of required formats, fields, timescales and routes of reporting.

The Health Board must ensure that appropriate systems are in place to capture the information necessary to meet the requirements for reporting.

Accountability for monitoring open pathways

The HB with current clinical responsibility for the patient is accountable for the monitoring of that patient's pathway (except cancer).

When the patient's RTT period involves more than one organisation or information system, HBs must ensure that communication protocols are utilised so that appropriate information is shared and RTT periods are measured accurately. (Particularly for cancer and cardiac pathways when the clock continues along the pathway from referral to intervention and/or surgery).

When NHS activity is commissioned from an independent sector provider (non-NHS), the HB commissioning the pathway is accountable for the monitoring of that patient's pathway. HBs must ensure that communication protocols are utilised so that appropriate information is shared, and RTT periods are measured accurately.

When a referral is made to an English NHS provider, the English NHS provider is accountable for the monitoring of that patient's pathway. English NHS providers must ensure that communication protocols are utilised so that appropriate information is shared, and RTT periods are measured accurately.

Accountability for performance

When the patient's RTT period is managed entirely within a single HB, the accountability for performance against the targets lies with that HB.

When the patient's RTT period involves more than one HB, the HB of patient's residence is accountable for performance against the RTT targets.

When NHS activity is commissioned from an independent sector provider, the accountability lies with the HB commissioning the activity.

Where NHS activity is commissioned from an English provider, the accountability for performance against the targets lies with the HB commissioning the activity.

Where the patient pathway is commissioned by Welsh Health Specialised Services Committee (WHSSC), the accountability for performance against the targets lies with WHSSC. HBs and WHSSC must jointly ensure that communication protocols are utilised so that appropriate information is shared, and RTT periods are measured accurately.

Accountability for reporting

The HB with clinical responsibility for the patient at the reporting census date is responsible for reporting performance against the open pathway waiting time target.

The HB with clinical responsibility for the patient at the time of treatment is responsible for reporting performance against the closed pathway waiting time target

When NHS activity is commissioned from an independent sector provider, the HB commissioning the pathway is responsible for reporting performance against the target. HBs must ensure that communication protocols are utilised so that appropriate information is shared, and RTT periods are reported accurately. When a referral is made to an English provider, that provider is responsible for

reporting performance against the target. HBs must ensure that requirements for reporting are contractually included in commissioning agreements.

Responsibilities

Chief Executive

The Chief Executive is overall responsible for ensuring the requirements within this policy are fulfilled.

Director of Operations

The Director of Operations is responsible for ensuring the requirements within this policy are fulfilled and that all operational responsibilities are in place.

Clinical Leads and Clinicians

Are responsible for ensuring that whilst considering patient care, all patients are managed in accordance with the agreed patient access policy and they are fully aware of the overarching principles.

General Managers

Are responsible for ensuring the patient access policy is disseminated, fully implemented and adhered to by all staff within their designated areas of managerial responsibility across the Health Board.

Service Delivery Managers (including support managers)

Are responsible for ensuring the patient access policy is disseminated, fully implemented and adhered to by all staff within their designated areas of managerial responsibility across the Health Board. They must also ensure all waiting lists under their managerial control are managed in accordance with the rules and regulations.

Administrative Support Services

Administrative support services such as Waiting List, Health Records, Validation, must ensure that patients are effectively communicated with; all staff are fully aware of the agreed policy, that they comply with agreed guidance and the patient pathway is managed in accordance with the principles.

Watchtower Group

The Watchtower Group has the responsibility for reviewing this policy and ensuring there is effective implementation and distribution across the necessary staff groups within the Health Board. The Watchtower Group is also responsible for monitoring and regularly reviewing compliance levels associated with the policy.

PPAC and Performance Review Committee

Will be responsible for receiving and reviewing regular update reports in regards to compliance with the patient access policy and national guidance.

COVID-19 National Guidance and supporting documentation

COVID-19 national guidance and supporting papers are included as appendices:

- Virtual approaches in the delivery of outpatient services

- Consistent approach on the management of patients on a waiting list with reluctance to engage with hospital treatment (face to face, OPA, diagnostics and or treatment)
- Risk stratification

Glossary

This glossary offers definitions of terms used within this document. Where possible, the NHS Wales Data Dictionary definition is used, and the latest version of the data dictionary should be consulted for up-to-date definitions when required.

These explanatory definitions should be considered only in relevance to this document.

26 week referral to treatment target	The Welsh Government waiting times target established December 2009, that no patient should wait more than 26 weeks from referral to treatment.
Active monitoring	A clinical intervention where the decision is made to monitor a patient's condition closely in secondary care, resulting in active steps being taken to ensure that the patient is regularly assessed and that any change in condition can be responded to.
Adjustment	A period of time for which the patient is either unavailable, for clinical or social reasons, or where the patient is referred to a service that is outside the scope of RTT.
Admission	The act of admitting a patient for a day case or inpatient procedure.
Cancer target	The Welsh Government waiting times target for cancer treatment: 62 days for an urgent suspected cancer (USC) and 31 days for a non-urgent suspected cancer (NUSC) referral.
Cardiac RTT target	The Welsh Government waiting times target for cardiac patients that no patient should wait more than 26 weeks from referral to treatment.
Cardiologist	A clinician who undertakes the majority of their clinical sessions in cardiology.
Clinic outcome	A record of the event of a clinical decision made by a clinician. This decision will not necessarily be made within a clinic environment.
Clock continue	Any events that occur along the patient pathway, but do not constitute a clock start or clock stop within the RTT rules.
Clock reset	An administrative process to change the start of the recorded RTT period to the date of the event causing the reset.
Clock start	An event that commences an RTT period within the RTT rules.
Clock stop	An event that ends an RTT period within the RTT rules.

Consultant:	A person contracted by a HB who has been appointed by an Advisory Appointment Committee. He or she must be a member of a Royal College or faculty. This includes GPs in cases where a GP is responsible for patient care and has an arrangement with a Local HB. For diagnostic departments, this includes a non-medical scientist of equivalent standing to a consultant.
Consultant office decision	Any decision that affects the clinical management of the patient and has been made when the patient is not present.
Consultant to consultant referral	Any patient referral made within a secondary/ tertiary care environment from one consultant to another.
Could not attend (CNA)	Any patient who contacts the organisation to notify that they will be unable to attend an agreed appointment is recorded as 'could not attend' (CNA).
Decision to treat	A record of the event that a clinical decision to admit a patient to a particular healthcare organisation has been made.
Decision not to treat	A clinical decision that, at the present time, no treatment is required for the condition for which the patient has been referred. This will normally result in the patient being discharged back to the referring doctor.
Diagnostic wait	The time waited from receipt of referral for a diagnostic investigation to the appointment for that investigation.
Did not attend (DNA)	Patients who have not kept an appointment at any stage along the pathway and have not notified the organisation in advance are identified as 'did not attend' (DNA).
Direct access	Patients who are referred directly rather than via a consultant-led clinic.
Direct booking	Booking methodology where an agreement of appointment is made through a direct communication between the organisation and patient.
Direct referral	A referral made by a clinician in primary care directly to a diagnostic or therapy service.
Emergency admission	Patients admitted to hospital when admission is unpredictable and at short notice because of clinical need.
Expert patient	Patients experiencing a long-term health condition who become 'experts' in their own care to improve their quality of life.
First definitive treatment	Any initial treatment that treats the patients cancer, stabilises their symptoms from cancer, or stabilises their health so cancer treatment can commence.
Fully automated model	A booking process whereby patients are sent appointment dates automatically without initial agreement with the patient.
Incremental change in treatment	A small change to a current treatment plan, e.g. adjustment of the dosage of a prescribed medication.
Inpatient/day case wait	The time waited from a decision to treat as an inpatient/day case to admission for the treatment.

Intended treatment	An intervention that, at that time, aims to manage the patient's condition.
Interim treatment	An intervention aiming to help the patient cope with their condition until the planned intended treatment can be delivered.
Health Board (HB)	The statutory NHS body.
Mutually agreed	Agreed by both the patient and the HB.
Non-admission event	Any event when the patient attends for an appointment but is not booked into a bed or trolley, e.g. an outpatient appointment.
Non-USC referral (NUSC)	Any patient diagnosed as having cancer that was not referred by their GP as a USC or upgraded by the specialist on analysis of the GP referral.
Organisation	The secondary care service, previously known as the Trust.
Out of hours contact	Between 6pm and 9pm on weekdays and between 9am and 9pm at weekends.
Partial booking	A system whereby appointments are agreed with the patient, following a written request from the LHB for the patient to telephone to make an appointment.
Pathway start date (PSD)	Used within the cardiac RTT target to denote the original clock start date caused by the receipt of a referral.
Patient pathway	The process of a patient's care for a particular condition across the whole of the NHS, from primary care onwards.
Planned care	Elective admissions planned to occur in the future, where, for medical reasons, there must be delay before a particular intervention can be carried out.
Pooled environment	A service design where all parties have been informed, at the time of referral or first outpatient visit, that a group of clinicians are working together to provide the service, and where patients may be seen by any of the clinicians in the pool, at any given stage of treatment.
Reasonable offer	Any offer of an appointment mutually agreed between the patient and the HB.
Receipt of referral by the HB	The referral is deemed to be received when it first arrives within the secondary or tertiary care.
Referral guidelines	Predetermined written criteria for referral that are formalised and agreed between the healthcare professionals making and receiving the referral.
Referral protocols	Agreements reached and documented locally to identify accepted sources for referrals to specific services.
Referral to treatment	The period between a referral being made for a particular condition and treatment being commenced for that condition.
RTT period	The waiting time will be monitored using the concept of a clock, which will start and stop according to the events and transactions that occur along the course of the patient pathway. The measured period of time between a clock start and a clock stop, under RTT rules, which is reported as the RTT waiting time.

Screening programme	A recognised national programme of screening for particular conditions e.g. Breast Cancer Screening Programme.
Secondary care	NHS care delivered as a result of a referral from primary care.
Self-referral	The process whereby a patient initiates an appointment with a secondary care service, without referral from either a primary or secondary care clinician.
Short-term medical condition	A medical condition precluding progression to the next stage of the pathway for less than 21 days.
Social Reasons	A period of unavailability for example due to a holiday or work commitments.
SOS clinics	Specialist direct access clinics that expert patients attend for urgent attention.
Stage of the pathway	A section of the RTT period. There are four stages: referral to first outpatient appointment; waiting for a diagnostic test; waiting for a subsequent outpatient appointment; waiting from decision to treat to the start of treatment. Stages of the pathway are contiguous, do not have to occur in this order, and any individual stage may occur more than once in any given pathway.
Step change in treatment	A substantial change to a current treatment plan, e.g. a change from oral to subcutaneous delivery of medication.
Suitably qualified healthcare professional	A healthcare professional approved by the consultant as competent to make a decision about the medical fitness of a patient to proceed to the next stage of the pathway.
Surveillance procedures	Procedures that are repeated at agreed intervals in order to monitor the patient's condition.
Suspension	A period during which the cancer or cardiac clock is paused due to the patient being unavailable or medically unfit due to a co-morbidity to proceed to the next stage of the pathway.
Tertiary care	Specialised NHS care in services designated to provide the service in a specialist centre, and delivered as a result of a referral from within secondary care.
Therapy services	NHS services providing treatment by Health Professions Council registered professions i.e. arts therapies, dietetics, occupational therapy, orthotics, orthotics and prosthetics, physiotherapy, podiatry, speech and language therapy.
Treat in turn	Management of the waiting list to ensure that patients are seen and treated in appropriate order, based on their clinical need and length of wait. Health Boards need to be able to explain and evidence any variance to treat in turn rates through their local policies as long as they reflect other WG strategic goals.
USC referral	A referral where a suspicion of cancer is stated by the GP and confirmed by the specialist. This is not restricted to designated USC-only referral methods e.g. fax lines.

Watchtower	Weekly meeting of the Secondary Care Team who review/monitor target compliance and other Scheduled care business matters.

References

Revised Rules for Managing Referral to Treatment Waiting Times for Phased Implementation April 2017: Welsh Government

Cancer specific additional guidance - To support revised RTT Guidance, Issued April 2017, Welsh Government

RTT - Patient perspective. What is it? What do I need to know? Issued April 2017, Welsh Government

Included Diagnostic Tests

- Barium enema;
- Computerized tomography (CT);
- Echocardiogram;
- Electromyography;
- Endoscopy -
 - Bronchoscopy
 - Colonoscopy
 - Sigmoidoscopy
 - Gastroscopy
 - Cystoscopy
- Exercise stress tests;
- Fluoroscopy;
- Magnetic resonance imaging (MRI);
- Nerve conduction studies;
- Non-obstetric ultrasound;
- Nuclear medicine;
- Pathology;
- Plain film x-rays;
- Urodynamic pressures and flows;
- Vascular investigations.

Included Therapy Services

- Adult hearing aids (at point of fitting);
- Dietetics;
- Occupational therapy;
- Physiotherapy;
- Podiatry;
- Speech and language therapy.

Policy Documents

- WHC (2004) 067 – Definitions to Support the Cancer Waiting Times SaFF Target.
- WHC (2005) 027 – Monthly data collection of cancer waiting times to start definitive treatment.
- WHC (2005) 090 – Implementation of a Guide to Good Practice.
- WHC (2006) 081 – Delivering a 26 Week Patient Pathway - An Implementation Framework.
- WHC (2007) 014 – Access 2009 - Referral to Treatment Time Measurement.
- WHC (2007) 051 – 2009 Access - Delivering a 26 Week Patient Pathway- Integrated Delivery and Implementation Plan.
- WHC (2007) 075 – 2009 Access Project – Supplementary Guidance for Implementing 26-Week Patient Pathways.
- Cancer waiting targets: A guide (Version 4) (Department of Health, 2005).
- A Guide to Good Practice: Elective Services (NLIAH, 2005).
- Cancer Waiting Times: a Guide for Urologists (NHS National Cancer Action Team, 2006).
- Cancer Waiting Times SaFF 05/06 and 06/07 query log.
- Single Source Guidance on the SaFF 2006-07 Cancer Waiting Times Target (WAG letter to service, 2006).
- WHC (2018)018 Consolidated Rules for Managing Cardiac referral to Treatment Waiting Times.

Patient Communication Letters

A list to standard template letters are provided below. Note these letters are regularly reviewed as the Health Board strive to improve services and incorporate patient feedback.

1. Acknowledgment of Referral letter
2. Invitation letter
3. Standard Confirmation letter
4. Cancellation letter
5. Non-Responder letter

Acknowledgement of Referral Letter

Dear Patient,

This letter **confirms receipt** of your referral to <dbtext>SPECIALTY_NAME/dbtext>.

If at any time you believe you no longer require this appointment, or if any of your contact details change, please contact us **immediately** on **0300 3039642**. Otherwise, **you do not need to contact us**.

You will receive another letter in due course, inviting you to book an outpatient appointment with the <dbtext>SPECIALTY_NAME/dbtext> team. **There is no need to contact us until you have received your invitation letter.**

You will be offered treatment at any one of our hospital sites, with any one of our suitable clinicians who work within the specialty suited to your case. This we would consider as a **reasonable offer**. If you are unable to accept this offer, **your waiting time may be affected**.

You can find more information about our current waiting times by visiting www.hywelddhb.wales.nhs.uk/waitingtimes. This information will also be made available to you at your GP Practice.

Yours sincerely

Hywel Dda University Health Board

Invitation Letter

Dear Patient

We are pleased to inform you that you may now arrange an appointment with:

The<dbtext>SPECIALTY_NAME/dbtext> Team

You may do this by contacting us on **0300 3039642**, Monday-Friday, 8am-5pm.

If you believe you no longer require this appointment, or if your contact details change, please contact us immediately on the above number. If we have received no contact within the next 2 weeks we will assume that you no longer require the appointment and you will therefore be removed from the waiting list.

You will be offered treatment at any one of our hospital sites, with any one of our suitable clinicians who work within the specialty suited to your case. This we would consider as **a reasonable offer**. If you are unable to accept this offer, your waiting time may be affected.

Yours sincerely

Hywel Dda University Health Board

Standard Confirmation Letter (small differences in some areas around bring x, y & z to the appointment)

Dear Patient

This letter confirms your appointment to attend the below clinic:

The <dbtext>SPECIALTY_NAME/dbtext> Team

<dbtext>DATONSYS</dbtext>

<dbtext>TIMONSYS</dbtext>

<dbtext>LOCONSUS</dbtext>

If possible, we would advise that you bring a list of all medications you are currently taking.

On arriving at your appointment location, please report to the outpatient department's reception desk, where a member of staff will direct you to your clinic location.

If you are unable to attend this appointment or feel as though you no longer require it, please contact us **immediately** on **0300 3039642**. If you do not do this, the consultant may decide to remove you from the waiting list.

You may find directions to your hospital location and outpatient department, as well as parking information by visiting **<http://www.wales.nhs.uk/sitesplus/862/page/42912>**.

Yours sincerely

Hywel Dda University Health Board

Cancellation Letter

This is a Cancellation Letter

Dear Patient

Unfortunately, we are writing to inform you that for reasons beyond our control, the Clinicians Outpatient Clinic below has been cancelled.

Clinician: <dbtext>ALL_NAME</dbtext>
Specialty: <dbtext>SPECIALTY_NAME</dbtext>
Date: <dbtext>TRT_DATE</dbtext>
Time: <dbtext displayformat='!90:00;0;
'APPOINTMENT_TIME </dbtext>
Department: <dbtext>LOCDESC</dbtext>
Location: <dbtext>BASE_DESC</dbtext>

.

We apologise for any inconvenience that this may cause you and would ask that you telephone our Contact Centre on <dbtext>CONF_TELEPHONE</dbtext> to agree another date and time that is convenient for you.

Yours sincerely

Hywel Dda University Health Board

Non-Responder letter

Dear Patient

Unfortunately we have not received a response to our letter requesting that you contact us to make an appointment for this clinic:

Clinician: ALL_NAME

Specialty: SPECIALTY_NAME

If you still require this appointment, can you please contact us on the following telephone number **HOSPITAL_TELEPHONE within the next 7 days.**

If we do not receive a response within this timescale you will be removed from the Waiting List.

Yours sincerely

Hywel Dda University Health Board

Appendix 1 - Virtual approaches in the delivery of Outpatient Services



**Virtual approaches in the
delivery of Outpatient
Services**

A toolkit for implementation

V3.0 12th November 2020

This version replaces V2.0 published on 22nd October 2020

Appendix 2 – COVID-19 guidance:

Consistent approach on the management of patients on a waiting list with reluctance to engage with hospital treatment (face-to-face OPA, diagnostics and or treatment).

APPENDIX 3 - Covid19 Guidance Risk Stratification



Llywodraeth Cymru
Welsh Government

INFORMATION STANDARDS ASSURANCE PROCESS

INFORMATION STANDARD DEVELOPMENT PROPOSAL FOR NEW OR CHANGED INFORMATION STANDARD

[Reprioritisation of patients on an RTT pathway]

[September 2020]

Equality Impact Assessment (EqIA) Screening Template

When to complete an EqIA Screening

An EqIA Screening Template must be completed when reviewing, changing and developing procedures/ proposals/ projects/ policies. This is a first step and is used to consider whether there are any negative impacts that may arise.

Purpose of an EqIA Screening Template

The purpose of this short exercise is to ensure that you have shown appropriate due regard when considering the impact for people with protected characteristics in your decision making. The screening process is designed to help you consider the circumstances and to inform evidence-based decisions.

If the proposal is of a significant nature and it is apparent from the outset that a full EqIA will be required, then it is not necessary to complete this Screening Template, you can proceed to complete the full [EqIA](#).

If no negative impacts are identified following completion of the EqIA screening then it is not necessary to undertake a full EqIA however, the decision and justification must be clearly recorded in this document.

On completion of the Screening Template:

- Ensure that all the white boxes within the screening are completed.
- Ensure that the Procedure/ Project/ Proposal/ Policy owner has signed and dated the Screening Template.
- Send a copy of the completed template along with the related policy or project proposal to Inclusion.hdd@wales.nhs.uk for the Diversity & Inclusion Team to review.
- Each Screening Template will be reviewed by the Diversity & Inclusion Team and feedback will be provided to the Procedure/ Project/ Proposal/ Policy owner. This may include recommendations for further action to inform robust decision-making.

Support

For further support please visit the [EqIA Sharepoint](#) or contact:

Email: Inclusion.hdd@wales.nhs.uk

Tel: 01554 899055

Director and DirectorateC	Paula Goode
Service Area	Scheduled Care

Title of Procedure, Project, Proposal, Policy being screened:	Access Policy

Description of the Procedure/ Project/ Proposal/ Policy being screened (including key aims and objectives)

This policy is to ensure that the period patients wait for elective (planned) care are measured and reported in a consistent and fair manner.

- Setting out clearly and succinctly the rules to ensure that each patient's RTT period begins and ends fairly and consistently;
- Highlighting both the patient and NHS roles and responsibilities and the potential consequences if this mutual compact is not fully met.

Evidence considered (including staff and population data, relevant research, expert and community knowledge etc.)

This policy applies to all patients who require to access elective care across Hywel Dda University Health Board and requires to be adhered to by all staff who are involved in the implementation of all aspects of this policy.

References that apply to the content of the policy which aligns with national rules, published as below.

Revised Guidance for Managing Referral to Treatment Waiting Times April 2025,
Revised Rules for Managing Referral to Treatment Waiting Times for Phased Implementation April 2017: Welsh Government Cancer specific additional guidance - To support revised RTT Guidance, Issued April 2017, Welsh Government RTT - Patient perspective. What is it? What do I need to know? Issued April 2017, Welsh Government

- WHC (2004) 067 – Definitions to Support the Cancer Waiting Times SaFF Target.
- WHC (2005) 027 – Monthly data collection of cancer waiting times to start definitive treatment.
- WHC (2005) 090 – Implementation of a Guide to Good Practice.
- WHC (2006) 081 – Delivering a 26 Week Patient Pathway - An Implementation Framework. Database No: 534 Page 31 of 39 Version 4.0 Patient Access – Elective Care Policy Please check that this is the most up to date version
- WHC (2007) 014 – Access 2009 - Referral to Treatment Time Measurement.
- WHC (2007) 051 – 2009 Access - Delivering a 26 Week Patient Pathway- Integrated Delivery and Implementation Plan.

- WHC (2007) 075 – 2009 Access Project – Supplementary Guidance for Implementing 26-Week Patient Pathways.
- Cancer waiting targets: A guide (Version 4) (Department of Health, 2005).
- A Guide to Good Practice: Elective Services (NLIAH, 2005).
- Cancer Waiting Times: a Guide for Urologists (NHS National Cancer Action Team, 2006).
- Cancer Waiting Times SaFF 05/06 and 06/07 query log.
- Single Source Guidance on the SaFF 2006-07 Cancer Waiting Times Target (WAG letter to service, 2006).
- WHC (2018)018 Consolidated Rules for Managing Cardiac referral to Treatment Waiting Times.

Assess which protected characteristics will potentially be affected by the proposal in the table below (please ✓ the relevant box to confirm positive, negative or no impact).

If at any point a negative impact has been identified (actual or potential), you do not need to proceed with the completion of this form, as a full EqlA must be undertaken: [Equality Impact Assessments \(EqlAs\) \(sharepoint.com\)](https://sharepoint.com)

Age					
Is it likely to affect older and younger people in different ways or affect one age group and not another?					
Positive Impact	✓	Negative Impact		No Impact	
Consideration of vulnerable groups within access policy to ensure clarity on access principles. See section 10 of the policy under the DNA section..In the context of the All-Wales Safeguarding Procedures, being ‘vulnerable’ is defined as in need of special care, support, or protection because of age, disability, risk of abuse or neglect. However, for the purpose of this RTT, vulnerability relates to an individual’s likelihood of experiencing disadvantage as a result of circumstances beyond their control. All children under the age of 18 should be considered/classed as “vulnerable” to risks and poor outcomes as a result of action or inaction by other people such as their carers/parents.					
Disability					
Is it likely to affect those with a physical disability, learning disability, sensory loss or impairment, mental health conditions, long-term medical conditions such as diabetes?					
Positive Impact	✓	Negative Impact		No Impact	
Consideration of vulnerable groups within access policy to ensure clarity on access principles. See above age category for detail.					
Gender Reassignment					
Is it likely to affect those who either:					
• Have undergone, intend to undergo or are currently undergoing gender reassignment. • Do not intend to undergo medical treatment but wish to live in a different gender from their gender at birth					
Positive Impact		Negative Impact		No Impact	✓

No difference in policy for this group. Everyone treated as equal.					
Marriage / Civil Partnership Under the Equality Act, the characteristic of Marriage and Civil Partnerships is only protected in the workplace/ employment. Is it likely to affect those who are married or in a Civil Partnership? This means someone who is legally married or in a civil partnership.					
Positive Impact		Negative Impact		No Impact	✓
This group is in relation to workplace and employment and is therefore not relevant for this policy					
Pregnancy and Maternity Is it likely to affect those who are pregnant or have recently had a baby? Maternity covers the period of 26 weeks after having a baby, whether or not they are on Maternity Leave.					
Positive Impact		Negative Impact		No Impact	✓
This policy does not have a differential impact on this group compared to others					
Race / Ethnicity Is it likely to affect people of a different race, nationality, colour, culture or ethnic origin including non-English / Welsh speakers, Gypsies/Travellers, asylum seekers and migrant workers?					
Positive Impact		Negative Impact		No Impact	✓
This policy does not have a differential impact on this group compared to others					
Religion or Belief Is it likely to affect people who have a religion or belief? The term 'religion' includes a religious or philosophical belief.					
Positive Impact		Negative Impact		No Impact	✓
This policy does not have a differential impact on this group compared to others					
Sex Is it likely to affect people who are mostly male or female. Where it applies to both equally does it affect one differently to the other?					
Positive Impact		Negative Impact		No Impact	✓
Justification of impact identified: This policy does not have a differential impact on this group compared to others					
Sexual Orientation Whether a person's sexual attraction is towards their own sex, the opposite sex or either.					
Positive Impact		Negative Impact		No Impact	✓

Justification of impact identified: This policy does not have a differential impact on this group compared to others					
Armed Forces Community Consider whether this impacts on members of the Armed Forces and their families, whose health needs may be impacted long after they have left the Armed Forces and returned to civilian life. Also consider their unique experiences when accessing and using day-to-day public and private services compared to the general population. It could be through 'unfamiliarity with civilian life, or frequent moves around the country and the subsequent difficulties in maintaining support networks, for example, members of the Armed Forces can find accessing such goods and services challenging.' For a comprehensive guide to the Armed Forces Covenant Duty and supporting resource please see: Armed-Forces-Covenant-duty-statutory-guidance					
Positive Impact	✓	Negative Impact		No Impact	
Consideration of vulnerable groups within access policy to ensure clarity on access principles. Positive for Armed forces community as required by law. See section 10 of the policy under booking process. 'All Armed Forces veterans are entitled to receive priority access to NHS care and treatment for any conditions (mental and physical) which are considered to be related to, or resulting, from their military service.'					
Socio Economic Duty Consider those on low income, economically inactive, unemployed or unable to work due to ill-health. Also consider people living in areas known to exhibit poor economic and/or health indicators and individuals who are unable to access services and facilities. Food / fuel poverty and personal or household debt should also be considered. For a comprehensive guide to the Socio-Economic Duty in Wales and supporting resources please see: more-equal-wales-socio-economic-duty					
Positive Impact		Negative Impact		No Impact	✓
This policy does not have a differential impact on this group compared to others					
Welsh Language Is it likely to impact on opportunities for people to use the Welsh language? The Welsh language should be treated no less favourably than the English language.					
Positive Impact		Negative Impact		No Impact	✓
The opportunity for a person to use their Welsh Language remains the same, all staff are aware of the translation services available.					

If a negative impact has been identified, you are not required to complete this form as a full EqlA must be undertaken. A full EqlA template and guidance can be found on the following link: [Equality Impact Assessments \(EqlAs\) \(sharepoint.com\)](#)

	Name	Jim Plunkett

Screening Completed by:	Title	Validation Manager
	Contact details	Jim.plunkett3@wales.nhs.uk
	Date	18/6/2025
Screening Authorised by: (Directorate level owner of the procedures/ proposals/ projects/ policy)	Name	Amorelle Jones
	Title	Service Delivery Manager
	Contact details	Amorelle.jones@wales.nhs.uk
	Date	18/6/2025
Guidance has been provided by Diversity & Inclusion Team:	Name	Kylie Daniels
	Title	Senior Diversity and Inclusion Officer
	Contact details	Kylie.daniels@wales.nhs.uk
	Date	17/07/25
Diversity and Inclusion Team additional Comments:		

Please note: The D&I team will save a copy of the completed form for reference. If any changes are made after the date of review, it is the directorate's responsibility to update the EqlA and inform the D&I team.

7 - FOR INFORMATION

7.1

12:50 PM, 5 Mins

7.1 - JCC PLANNING, PERFORMANCE AND FINANCE SUB-COMMITTEE REPORTS

*Andrew Spratt
(Hywel Dda UHB -
Deputy Director of
Finance)*

| For information

Attachments

JCC Planning, Performance and Finance Sub-Committee 15 July 2025 Highlight Report.pdf

Agenda Item

6.1.3

Joint Commissioning Committee

Planning, Performance & Finance Sub-Committee Highlight Report

Dyddiad y Cyfarfod / Date of Meeting	15/07/2025
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author	Maxine Evans, Interim Corporate Governance Officer
Cyflwynydd yr Adroddiad / Report Presenter	Paul Worthington, Lay Member
Noddwr yr Adroddiad / Report Sponsor	Jacqui Maunder-Evans, Committee Secretary

Pwrpas yr Adroddiad / Report Purpose	For Noting

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	Date	Outcome
	Click or tap to enter a date.	Choose an item.

1. SITUATION/BACKGROUND

This report had been prepared to provide Members of the Joint Commissioning Committee (JCC) with a summary of the key issues considered by the Planning, Performance and Finance sub-committee at its meeting on 10 June 2025.

Key highlights from the meeting are reported in Section 3.

1. PURPOSE

The Purpose and Role of the JCC and the sub-committees are set out in Paragraphs 2.18 and 2.20 of the JCC [Standing Orders](#).

2. HIGHLIGHT REPORT

(Links to reports highlighted [February 2025 – NHS Wales JCC PPF](#))

RAG Rating	Highlights
Alert / Escalate	There were no items to be deferred or escalated on this occasion.
Advise	- Risk 84 – Financial Break-Even 2025/26 was highlighted recognising the in-year risk of delivering the savings plan of £11.5m and its links with Risk 28 – Business Continuity and the reduced capacity within the JCC team to cover the breadth of work required to focus on delivering the foundation plan and driving the savings programme. - Conversations are ongoing with Cardiff and Vale UHB and other Providers to manage performance of the contracting arrangements in order to deliver within the financial envelope that is available to them whilst options are explored to have a more robust contracting arrangement going forward, including the conclusion of service reviews and new contract baselines. - Risk 61 – Obesity Waiting Times at Salford Royal Hospital was highlighted noting that the Trust had been in escalation for some time and the work required accelerating, in addition to the risk score being reviewed and any patient quality concerns being considered. - The Implementation Plan for the 2025/26 Foundation Plan now includes the profiling of delivery across the year mapped under eight strategic priority areas, the expected outcomes, deliverables that can be measured and the individual milestones which are broken down into quarterly timelines. The plan is phased, therefore some areas have yet to commence and the scope of each of these areas are in draft form to be agreed with the Collaborative Commissioning Leadership Group (CCLG) leads. - The timeline and key milestones for developing the IMTP, purposefully aligned to the development of the JCC Strategy, emphasising the need for continuous engagement with health boards to ensure that the JCC IMTP is also reflected clearly within health board IMTPs was shared. - The framework for the development of the JCC strategy, highlighting key components and strategic

	considerations such as capacity, collaboration, resources, care pathways, and evidence and value-based decision-making was shared. The engagement and timelines for the development of the strategy was noted. A first draft for socialising with the JCC would be available in December 2025, with the aim of final approval by the end of the financial year.
Assure	• Members received the risk register as of 30 April 2025, encompassing 14 risks scoring 15 and above, of which 7 have been assigned to the PPF sub-committee for monitoring and scrutiny. • The Month 1 Financial Performance Report was received noting a year-to-date overspend and the risks associated with delivering the savings plan as previously discussed under 2.1. JCC Risk Register. An in-depth discussion took place around what actions and decisions might need to be taken to alter the position if there remains no line of sight for delivery by the end of Qtr. 1 rather than allow the position to drift. It was agreed that a paper setting out manageable options to mitigate any non-delivery of the plan and to provide more visibility on the work that was being undertaken. • The Combined JCC Operational Performance Report highlighting key concerns such as workforce capacity issues and waiting times for specific services. Improvements in the presentation of the service performance scorecards was suggested and agreed to be taken forward. • Members were assured that a prioritised recruitment programme was in place and underway to appoint to key posts which will support the delivery of the foundation plan and drive the savings programme forward. In addition, support from health board Chief Executives, opportunities were being explored with CTM (host) and Health Education and Improvement Wales (HEIW) to secure additional short-term capacity through secondments and training/development placements. • Progress against the Plan and delivery confidence at the end of quarter 1 to year end was discussed and will be presented to the next Sub-Committee meeting (look forward view as well as tracking month on month).
Inform	• The Forward Plan of Business for the next twelve months was presented for information.

Appendices	None

3. ASSESSMENT

Objectives / Strategy	
Dolen i Amcan (au) Strategol CBC Link to JCC Strategic Objectives(s)	Maximise Value
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals 150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)	A Healthier Wales
Dolen i Hwyluswyr Ansawdd <i>(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /</i> Link to Enablers of Quality (Duty of Quality Statutory Guidance (gov.wales))	Leadership
	If more than one applies please list below:
Dolen i Feysydd Ansawdd <i>(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /</i> Link to Domains of Quality (Duty of Quality Statutory Guidance (gov.wales))	Effective
	If more than one applies please list below:
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	Yes - Refine
	If more than one applies please list below:

Impact Assessment		
Ansawdd <i>Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /</i> Quality <i>Have you undertaken a Quality Impact Assessment Screening?</i>	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below: N/A
Cydraddoldeb <i>Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb? /</i> Equality <i>Have you undertaken an Equality Impact Assessment Screening?</i>	Yes: ☒	No: ☒
	Outcome for Equality (delete as appropriate): POSITIVE/NEUTRAL/NEGATIVE Outcome for Welsh Language (delete as appropriate): POSITIVE/NEUTRAL/NEGATIVE	If no, please include rationale below: N/A
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw da / Reputational	There is no direct impact on the reputation of the Joint Committee as a result of the activity outlined in this report.	
Effaith Adnoddau <i>(Pobl / Ariannol) /</i> Resource Impact <i>(People / Financial)</i>	There is no direct impact on resources as a result of the activity outlined in this report.	
	Choose an item.	

4. RECOMMENDATIONS

The Joint Committee is asked to:

- **Note** the highlights outlined in Section 3 of this report.

7.2

12:55 PM, 5 Mins

7.2 - FINANCE AND PERFORMANCE COMMITTEE WORK PLAN 2025/26

***Michael Imperato
(Hywel Dda UHB -
Independent Board
Member)***

| For information

Attachments

FPC Work Programme 2025-26 Draft.doc.pdf

FINANCE AND PERFORMANCE COMMITTEE WORK PLAN APRIL 2025 – MARCH 2026

Currently, Finance and Performance Committee (FPC) meets bi-monthly. Based on this, the following table represents a proposal to incorporate the duties as outlined in the Committee's Terms of Reference into a basic work plan April 2025 – March 2026.

AGENDA ITEM/ ISSUE	LEAD	Responsible Officer	29 Apr 2025	26 Jun 2025	26 Aug 2025	21 Oct 2025	16 Dec 2025	24 Feb 2026	30 Apr 2026
GOVERNANCE									
Welcome and Apologies	Chair	All	✓	✓	✓	✓	✓	✓	✓
Declarations of Interests	Chair	CSO	✓	✓	✓	✓	✓	✓	✓
Minutes from previous meeting	Chair	CSO	✓	✓	✓	✓	✓	✓	✓
Matters Arising (not on agenda)	Chair	All	✓	✓	✓	✓	✓	✓	✓
Table of Actions (ToAs)	Chair	CSO	✓	✓	✓	✓	✓	✓	✓
FPC Terms of Reference (TORs) Review (12.1)	Chair	JW	✓						✓
SRC Annual Report 2024/25 (10.4.1)	Chair	HT	✓						
FPC Annual Report 2025/26 (10.4.1)	Chair	HT	✓						✓
Self-Assessment of Committee Effectiveness: Outcome Report (10.5)	Chair	JW						✓	
Self-Assessment of Committee Effectiveness: Six-Month Review (10.5)	Chair	JW			✓				
Corporate Risks Assigned to FPC (3.1.19)	HT	RW		✓					
Operational Risks Assigned to FPC (3.1.19)	HT	RW		✓					
Assurance and Governance Arrangements	CW	RW			✓	✓	✓	✓	✓
ESCALATION OVERVIEW									
Escalation Oversight and Highlight Report	SA	SA			✓	✓	✓	✓	✓
ESCALATION RESPONSE – RECOVERY ACTIONS PLANS AND IMPROVEMENT TRAJECTORIES									
Clinical Care Group Financial Savings	AC				✓				
Community and Integrated Medicine Performance and Productivity	AC				✓				

AGENDA ITEM/ ISSUE	LEAD	Responsible Officer	29 Apr 2025	26 Jun 2025	26 Aug 2025	21 Oct 2025	16 Dec 2025	24 Feb 2026	30 Apr 2026
Planned Care and Cancer Performance and Productivity	AC				✓				
Radiology Update	AC				✓				
FINANCE									
Finance Report (3.1.5) to include: - Deficit Drivers Annual Refresh (3.1.2) - Financial Outlook 2025/26 - Financial Recovery/In-Year Savings Programme - Risks on delivery of key financial targets key income sources & contractual safeguards (3.1.7) [From 26/08/2025: Financial Performance Assurance Report]	HT	AS	✓	✓	✓	✓	✓	✓	✓
Financial Plan and Strategy (3.1.4)	HT	AS	✓	✓					
Benefits Realisation Report	HT	SJ			✓	✓	✓	✓	✓
Financial Systems Assurance Report (3.1.6)	HT	AS							
Finance Targeted Intervention Actions (3.1.8)	HT	SA	✓	✓					
Procurement Plan (3.1.10)	HT	GD		D	✓				
Procurement Update (3.1.10 & 3.1.13) Review any investment/disinvestment	HT	GD	✓	✓	✓	✓	✓	✓	✓
Planning Objective Update Report (3.1.17)	HT	ALP	✓ Q4/Closure	✓ Q1	✓	✓ Q2		✓ Q3	
Contracts Assurance Report (3.1.11 & 12)	HT								
Balance Sheet Report	HT	AS		✓		✓		✓	
Monitoring Welsh Health Circulars (under the remit of FPC)	Relevant EDs	RW		✓	Incorporated within Assurance and Risk Report				
Ministerial Directions (as and when required)	Relevant EDs	RW	✓	✓	Incorporated within Assurance and Risk Report				

AGENDA ITEM/ ISSUE	LEAD	Responsible Officer	29 Apr 2025	26 Jun 2025	26 Aug 2025	21 Oct 2025	16 Dec 2025	24 Feb 2026	30 Apr 2026
FINANCE AND PERFORMANCE DEEP DIVES									
Thematic Reviews of Finance and Performance • UEC • Planned Care • Therapies • MHLD	AC	AC		✓					
Commissioned Care	JP	JP	✓						
Discharge to Assess	JP	JP		✓					
Ophthalmology performance: Getting It Right First Time (update on progress to address outstanding recommendations)	AC	SHi/VC		✓					
PERFORMANCE									
Integrated Performance Assurance Report (IPAR) (3.1.14)	HT	SH	✓	✓	✓	✓	✓	✓	✓
Performance Management Framework (3.1.14)	HT	HT							
NHS Wales Shared Services Partnership (NWSSP) Performance Report Quarter 2 2024/25 (quarterly) (3.1.16)	HT	RD		✓(Q4)	✓ (Q1)		✓(Q2)		
FOR APPROVAL									
Financial Procedures (3.1.21)	HT	TJ	✓	✓	✓	✓	✓	✓	✓
Policies (as required) (3.1.22)	All	All	✓	✓	✓	✓	✓	✓	✓
Business Cases (as and when required for scrutiny before onward ratification at Board) (3.1.9)	HT	HT	✓	✓	✓	✓	✓	✓	✓
FOR INFORMATION									
Capital Financial Management Update (3.5.3)	HT	RD	✓	✓	✓	✓	✓	✓	✓

AGENDA ITEM/ ISSUE	LEAD	Responsible Officer	29 Apr 2025	26 Jun 2025	26 Aug 2025	21 Oct 2025	16 Dec 2025	24 Feb 2026	30 Apr 2026
JCC Planning, Performance and Finance Sub-Committee Reports	HTy	JM	✓	✓	✓	✓	✓	✓	✓
ADMINISTRATION									
Agenda setting meeting with Chair & Exec Lead (at least 6 weeks before the meeting)	CSO	N/A	✓	✓	✓	✓	✓	✓	✓
Draft agenda to go to Executive Team	CSO	N/A	✓	✓	✓	✓	✓	✓	✓
Call for papers (at least 6 weeks before the meeting to receive papers at least 14 days before the meeting)	CSO	N/A	✓	✓	✓	✓	✓	✓	✓
Disseminate agenda/papers 7 days prior to meeting	CSO	N/A	✓	✓	✓	✓	✓	✓	✓
Issue a draft TOA within two days of the meeting	CSO	N/A	✓	✓	✓	✓	✓	✓	✓
Circulate minutes and TOA to the Lead Director within 7 days of meeting	CSO	N/A	✓	✓	✓	✓	✓	✓	✓
Issue minutes and TOA to Members (including the Committee Chair) following Lead Director review	CSO	N/A	✓	✓	✓	✓	✓	✓	✓

Chair: Michael Imperato **Vice Chair:** Anna Lewis **Lead Executive:** Huw Thomas

HT Huw Thomas	MH Mark Henwood	LD Lee Davies	JP Jill Paterson
JW Joanne Wilson	LG Lisa Gostling	SA Shaun Ayres	RD Rhian Davies
DW Daniel Warm	AS Andrew Spratt	GD Gemma Deverill	KJ Keith Jones
AJ Amorelle Jones	SHi Steph Hire	DB Debra Bennett	LC Liz Carroll
AL Angela Lodwick	HTy Helen Tyler (JCC)	SH Sally Havard	VC Vicky Coppack
TJ Timothy John	JM Jacqueline Maunder (JCC)	RW Rachel Williams	CSO Committee Services Officer
D Deferred	SJ Sian Jenkins		

8 - ANY OTHER BUSINESS

9 - DATE OF NEXT MEETING

- **Extraordinary Finance and Performance Committee** : Friday 12 September 2025; 14:00 - 15:00
- **Finance and Performance Committee**: Tuesday 21 October 2025; 09:30 - 13:00