CYFARFOD BWRDD PRIFYSGOL IECHYD
STRATEGIC DEVELOPMENT AND OPERATIONAL DELIVERY COMMITTEE

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	27 June 2024
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Strategic Development and Operational Delivery Committee (SDODC) Terms of Reference
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Maynard Davies, Chair SDODC
SWYDDOG ADRODD: **REPORTING OFFICER:**	Joanne Wilson, Director of Corporate Governance/Board Secretary

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 Strategic Development and Operational Delivery Committee has clear terms of reference which detail its purpose, boundaries, role, composition and operating arrangements.

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.

Cefndir / Background

The Committee last reviewed its terms of reference and operating arrangements in June 2023, and these were subsequently approved by the Board, as part of Standing Orders, on 27 July 2023.

Asesiad / Assessment

The Strategic Development and Operational Delivery Committee terms of reference and operating arrangements (Appendix 1) have been reviewed and some minor changes and amendments to terms have been made. These are clearly marked on Appendix 1 and relate to the following:

Section	What has changed?	Why?
2.1	Purpose - New section inserted	The areas relating to the strategy and planning, performance and outcomes and fragile services domains, and the required elements for de-escalation, outlined in the Targeted intervention Escalation Framework, have been included as the Committee is responsible for seeking assurance on the delivery of these on behalf of the Board.

2.2	Purpose - Section amended	Section amended to include 'aligned to the Committee' and added reference to appendix 2.
2.7	Purpose - Section amended	Section amended to remove reference to principal risks within the Board Assurance Framework (as these are reported direct to Board) and include reference to the Committee's responsibility to see assurance on the management of operational risks on Directorate Risk Registers.
2.10	Purpose – New section inserted	Section relating to reviewing contractual performance with significant commissioning partners been removed following previous discussions that this responsibility should be transferred to the Strategic Planning and Operational Delivery Committee from the Sustainable Resources Committee.
3.10	Key Responsibilities - Section amended	Section amended as follows, '***To revenue expenditure relating to capital and*** *provide assurance to the Board that arrangements for capital* ***expenditure and management*** *are robust'*.
App 1	Section added	Targeted Intervention areas relating to strategy and planning, performance and outcomes and fragile services intervention and focus and de-escalation criteria added.
App 2	Section added	Planning Objectives for 2024/25 aligned to the Committee have been added.

Argymhelliad / Recommendation

The Strategic Development and Operational Delivery Committee is asked to:

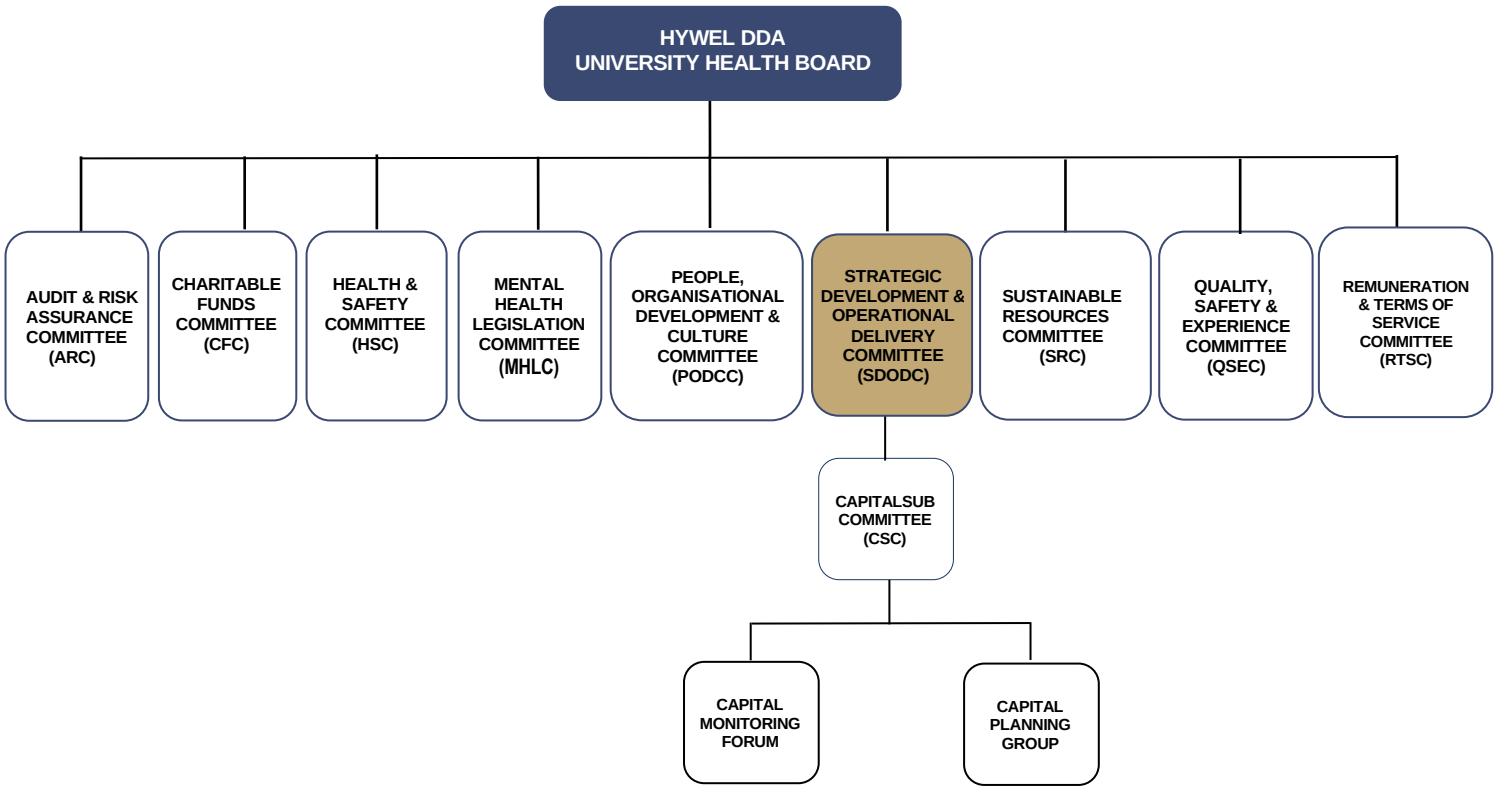
- **APPROVE** the Strategic Development and Operational Delivery Committee's Terms of Reference for onward ratification by the Board on 25 July 2024.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	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.
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	7. All apply
Galluogwyr Ansawdd:	6. All Apply

Enablers of Quality: Quality and Engagement Act (sharepoint.com)	
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:	Targeted Intervention Escalation Framework Annual Plan 2024/25
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:	SDODC Chair and Executive Lead Director of Corporate Governance/Board Secretary

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



STRATEGIC DEVELOPMENT & OPERATIONAL DELIVERY COMMITTEE

TERMS OF REFERENCE

Version	Issued To	Date	Comments
V1	Hywel Dda University Health Board	29.07.2021	Approved
V1	Strategic Development & Operational Delivery Committee	26.08.2021	Approved
V2	Strategic Development & Operational Delivery Committee	27.06.2022	Approved
V2	Hywel Dda University Health Board	28.07.2022	Approved
V3	Strategic Development & Operational Delivery Committee	26.06.2023	Approved
V3	Hywel Dda University Health Board	27.07.2023	Approved
V4	Strategic Development & Operational Delivery Committee	27.06.2024	For Approval

STRATEGIC DEVELOPMENT & OPERATIONAL DELIVERY COMMITTEE

1. Constitution

1.1 The Strategic Development & Operational Delivery Committee (the Committee) has been established as a Committee of the Hywel Dda University Health Board (HDdUHB) and constituted from 1 August 2021.

2. Purpose

The purpose of the Strategic Development & Operational Delivery Committee is:

2.1 Receive assurance on delivery against the areas of targeted intervention, and the required elements for de-escalation, related to strategy and planning, performance and outcomes, and fragile services (see Appendix 1 for additional detail):

Planning

i. Delivery of improved integrated planning
ii. Submission and delivery of an approvable plan
iii. Clinical strategy
iv. Regional planning

Performance and outcomes

i. Establish a baseline and agree improvement plans
ii. Implement improvement plans
iii. Work with national programmes and respond to external reviews such as Getting it Right First Time (GIRFT)
iv. Communications and engagement

Fragile services (stage 1)

i. Stroke
ii. Primary care
iii. Critical care
iv. Emergency general medicine
v. Ophthalmology

2.2 To receive an assurance on delivery against all relevant Planning Objectives aligned to the Committee, falling in the main under Strategic Objectives 4 (*The best health and wellbeing for our individuals, families and our communities*) and 5 (*Safe, sustainable, accessible and kind care*) (see Appendix 2), in accordance with the Board approved timescales, as set out in HDdUHB's Annual Plan.

2.3 Provide assurance to the Board that the planning cycle is being taken forward and implemented in accordance with University Health Board and Welsh Government requirements, guidance and timescales.

2.4 Provide assurance to the Board that, wherever possible, University Health Board plans are aligned with partnership plans developed with Local Authorities, Universities, Collaboratives, Alliances and other key partners, such as the Transformation Group who form part of A Regional Collaboration for Health (ARCH).

2.5 Provide support to the Board in its role of scrutinising performance and assurance on 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 in detail on specific issues where performance is showing deterioration or there are issues of concern.

2.6 Provide assurance to the Board that the data on which performance is assessed is reliable and of high quality and that any issues relating to data accuracy are addressed.

2.7 Seek assurance on the management of ~~principal~~ risks within the ~~Board Assurance Framework (BAF) and~~ Corporate Risk Register (CRR) and Directorate Risk Registers allocated to the Committee and provide assurance to the Board that risks are being managed effectively and report any areas of significant concern e.g. where risk tolerance is exceeded, lack of timely action.

2.8 Recommend acceptance of risks that cannot be brought within the Health Board's risk appetite/tolerance to the Board through the Committee Update Report.

2.9 Receive assurance through Sub-Committee Update 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).

2.10 Seek assurance on the commissioning element, including reviewing and making informed decisions on pathway changes, service planning, and strategic focuses for commissioning. ~~Regularly review contractual performance with significant commissioning partners (requiring Board approval as stated in the Scheme of Delegation).~~

3. Key Responsibilities

The Strategic Development and Operational Delivery Committee shall:

3.1 Seek assurance on delivery against all Planning Objectives aligned to the Committee (see Appendix 1), considering, and scrutinising the plans and programmes that are developed and implemented, supporting and endorsing these as appropriate.

3.2 Review business cases, prior to Board approval, including the development of the Programme Business Case for the new hospital and the Programme Business Case for the repurposing of the Glangwili and Withybush General Hospital sites, underpinned by a robust process for continuous engagement to support delivery.

3.3 Seek assurance on delivery of the Health Board's Annual Recovery Plan through the scrutiny of quarterly monitoring reports.

3.4 Seek assurance on the development of the Health Board's Integrated Medium Term Plan (IMTP), based on robust business intelligence and modelling, and assure the development of delivery plans within the scope of the Committee, their alignment to the Health Board's Plan/IMTP and the Health Board's strategy and priorities.

3.5 Seek assurances on all outstanding plans in relation to the National Networks and Joint Committees including commitments agreed with Swansea Bay UHB (SBUHB)/A Regional

Collaboration for Health (ARCH); Mid Wales Joint Committee; Sexual Assault Referral Centre (SARC); National Collaborative.

3.6 Seek assurances 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.

3.7 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

3.8 Consider the Health Board's approach to reducing health inequalities and the interventions aimed at addressing the causes.

3.9 Consider the new process that is established, involving all clinical service areas and individual clinical professionals, whereby the Health Board is assessed against local and national clinical effectiveness standards / NHS Delivery Framework requirements and fully contribute to all agreed national and local audits, including mortality audits.

3.10 To review revenue expenditure relating to capital and p~~P~~rovide assurance to the Board that arrangements for capital expenditure and management are robust.

3.11 Consider proposals from the Capital Sub Committee on the allocation of capital and agree these in line with HDdUHB's financial Scheme of Delegation (up to £0.5m, or up to £1m with the prior agreement of Executive Team), with any proposals over the £1m threshold to be recommended for approval to the Board.

3.12 Seek assurances on the delivery of the requirements arising from HDdUHB's regulators, WG and professional bodies.

3.13 Refer planning and performance matters which impact on quality and safety to the Quality, Safety & Experience Committee (QSEC), and vice versa.

3.14 Refer matters which impact on data quality and data accuracy to the Sustainable Resources Committee (SRC), and vice versa.

3.15 Any matters that impact on workforce, education or training should be referred to People Organisational Development and Culture Committee (PODCC).

3.16 Approve relevant corporate policies and plans within the scope of the Committee.

3.17 Review and approve the annual work plans for any Sub-Committee which has delegated responsibility from the Strategic Development & Operational Delivery Committee and oversee delivery.

3.18 Agree issues to be escalated to the Board with recommendations for action.

4. Membership

4.1 Formal membership of the Committee shall comprise of the following:

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

4.2 The following should attend Committee meetings:

In Attendance
Director of Strategy and Planning (Lead Executive)
Director of Finance
Director of Operations
Director of Primary, Community & Long-Term Care
Other Lead Executives to be invited to attend for their relevant Planning Objectives aligned to the Committee
Representative of the Department of Public Health
Llais Cymru/ Citizen Voice Body (not counted for quoracy purposes)

4.3 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 three of the membership and must include as a minimum the Chair or Vice Chair of the Committee, and two other Independent Member(s), together with half of the identified In Attendance members.

5.2 The membership of the Committee shall be determined by the Board, based on the recommendation of the UHB Chair, 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 UHB or 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 Chair of the UHB 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 Strategic Development & Operational Delivery Committee.

5.8 The Committee can arrange to meet with Internal Audit and External Audit (and, as appropriate, nominated representatives of Healthcare Inspectorate Wales), without the presence of officers, as required.

5.9 The Chair of the Strategic Development & Operational Delivery Committee shall have reasonable access to Executive Directors and other relevant senior staff.

5.10 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/or Vice Chair and the Lead Director (Director of Strategy and Planning), 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 all Committee members.

6.3 All papers must be approved by the Lead/relevant Director.

6.4 The agenda and papers 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 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** days. The Committee Secretary will then forward the final version to the Committee Chair for approval.

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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. Any 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, as set out within these terms of reference, the Board has delegated authority to the Committee for the exercise of certain functions, it retains overall responsibility and accountability 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 UHB'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 UHB'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/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 establish sub-committees or working/task and finish groups to carry out on its behalf specific aspects of Committee business. The Committee will receive an update following each sub-committee or working/task and finish group meeting detailing the business undertaken on its behalf. The Sub-Committee reporting to this Committee is:

10.3.1 Capital Sub-Committee.

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 end of the financial year.

10.4.2 Bring to the Board's specific attention any significant matters under consideration by the Committee.

10.4.3 Ensure appropriate escalation arrangements are in place to alert the UHB 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 UHB.

10.5 The Director of Board 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.

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 strategy and planning, performance and outcomes, and fragile services

The **strategy and planning 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. Delivery of improved integrated planning
   - Completion of the recommendations in the integrated planning review.
   - Board self-assessment against the integrated planning matrix and evidence assessment documentation with a view to achieving level 3/4 on the matrix.

2. Submission and delivery of an approvable plan
   - Deliver a credible annual plan as a stepping stone towards a full and financially balanced IMTP.
   - Make good progress in delivering the ministerial targets, accountability criteria and the targeted intervention requirements.

3. Clinical strategy
   - Develop the organisation's clinical services plan within an agreed timeline.
   - Demonstrate how the clinical strategy and plan are driving decision making across the organisation.

4. Regional planning
   - Review the learning from the orthopaedic intervention from Welsh Government and the NHS Executive, demonstrate effective partnership working to deliver a regional orthopaedic model that benefits the populations of each respective organisation.
   - Scope and develop regional opportunities for ophthalmology services with SBUHB and develop a regional delivery plan that reduces waste, harm and variation.

De-escalation criteria for strategy and planning

1. Submission of an acceptable annual plan in line with the current planning framework.

2. Evidence of integrated planning across the organisation which supports the development of a coherent and deliverable annual plan.

3. Board clarity on the strategic vision for the organisation.

4. Evidence of a clear roadmap and implementation of the health board's Clinical Services Plan.

5. Delivery of commitments set out within the annual plan, particularly in relation to the ministerial priorities.

6. Significant progress on a clinical services plan.

7. Sustained improvements in delivery of the plan throughout the year.

8. Welsh Government's confidence in delivery based on an assessment against the planning maturity matrix and planning quadrant.

9. Establishment of a Joint Committee with Swansea Bay UHB and demonstrate improved regional collaboration where required to ensure continued safety, quality and ongoing viability and sustainability of regional services; including orthopaedics and ophthalmology.

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

- 60% performance maintained for 3 months against the SCP target.
- 100% of open outpatient pathways to be waiting less than 52 weeks and maintained for 3 months.
- 100% of open pathways to be waiting less than 104 weeks and maintained for 3 months.
- 80% of open pathways to be waiting less than 52 weeks and maintained for 3 months.
- 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.)
- 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. 80% of patients waiting for a diagnostic test to be waiting less than 8 weeks and maintained for 3 months.
    - 80% of patients waiting for a diagnostic endoscopy to be waiting less than 8 weeks and maintained for 3 months.
    - 80% of patients waiting for a NOUS and non-cardiac MRI to be waiting less than 8 weeks and maintained for 3 months.
- 85% of patients waiting for therapies to be waiting less than 14 weeks and maintained for 3 months.
- Improving ratings from service user feedback experience responses and evidence of use of Datix and CIVICA data to inform quality improvement processes and the experience of patients and their families.

Urgent and Emergency Care

- 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).
- Continuous improvement towards no more than 7% of patients waiting over 12 hours at each individual site and across the health board.
- Median time from arrival at an emergency department to assessment by a clinical decision maker should not exceed 60 minutes.
- A continuous reduction in delayed pathways of care of 5% for three consecutive months and then maintained for three months (based on Oct-Dec 23 baseline).
- Improving ratings from service user feedback experience responses and evidence of use of Datix and CIVICA data to inform quality improvement processes and the experience of patients and their families.

CAMHS

- 80% of LPMHSS mental health assessments undertaken within 28 days from the date of receipt of referral.
- 65% of therapeutic interventions started within 28 days following an assessment by LPMHSS.

- 80% of Health Board residents in receipt of secondary mental health services who have a valid care and treatment plan.

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.

The **fragile services intervention and focus** whilst in targeted intervention will alter over time as it is likely that other services that may become fragile during the time frame of targeted intervention and if that is the case, then these concerns will be outlined clearly as below.

Initial analysis indicates that there are a number of fragile services across the health board. Stage one of the escalation framework will focus on the following:

- Stroke
- Primary care
- Critical care
- Emergency general surgery
- Ophthalmology

For each service, there will be a summary document setting out the issues of concern, expectations and de-escalation criteria.

De-escalation criteria for fragile services

1. Evidence that the health board has the appropriate mechanism to understand the drivers behind a fragile service through the triangulation of key data points, including staffing levels, staff and patient feedback, concerns, incidents, stakeholder feedback (HIW, AW, HMC, RC, Llais etc), mortality reviews, duty of quality/candour, infection protection control, performance, clinical and medical leadership.

2. Fragile services (including but not limited to stroke, primary care, orthopaedics and ophthalmology) are supported by strong clinical leadership, have an effective integrated improvement plan, project management structure and effective transformation support. Where appropriate key performance metrics will be agreed.

3. Evidence that all recommendations from the Royal Colleges, HIW and other reviews specific to Hywel Dda UHB are discharged and either verified or delivered or scheduled for delivery within the health board's longer-term improvement plan.

4. Evidence that the Board is sighted on fragile services and has a robust response to these issues that is being addressed by the health board.

Appendix 2 – Strategic Planning and Operational Delivery Committee Planning Objectives 2024/25

Planning Objective		**Lead**	**Class**
3	Transforming urgent and emergency care	Director of Operations	Ministerial priority
4	Planned care, diagnostics and cancer	Director of Operations	Ministerial priority
5	Mental health and CAHMS	Director of Operations	Ministerial priority
6	Clinical services plan	Director of Strategy & Planning	Service fragilities
7	Primary and community strategic plan	Director of Primary Care, Community and Long-Term Care	Ministerial priority Service fragilities
8	Estates plans	Director of Strategy & Planning	Estate fragilities
10	Population health	Director of Public Health	Long-term sustainability