

**PWYLLGOR STRATEGAETH A CHYNLLUNIO
STRATEGY AND PLANNING COMMITTEE**

DYDDIAD Y CYFARFOD: DATE OF MEETING:	18 December 2025
TEITL YR ADRODDIAD: TITLE OF REPORT:	Annual Plan
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Lee Davies, Executive Director of Strategy and Planning
SWYDDOG ADRODD: REPORTING OFFICER:	Shaun Ayres, Director of Delivery Daniel Warm, Head of 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

The Health Board approved the 2025/26 Annual Plan in March 2025, based on requirements specified in the NHS Wales Planning Framework 2025/28 and against the Escalation Framework. Since approval, Welsh Government(WG) has issued further communications that have modified financial targets, performance requirements and accountability conditions. This report provides the Committee with an update on progress against the Plan. Additionally, an update is also provided on the 2026/27 Planning Process.

Cefndir / Background

2025/26 Annual Plan

The Hywel Dda University Health Board (HDdUHB) Annual Plan 2025/26 was constructed through a structured process commencing in October 2024, involving comprehensive stakeholder engagement, demand and capacity modelling, and alignment with national directives available at the time. The Plan was developed in accordance with the NHS Wales Planning Framework 2025-28, issued by the Cabinet Secretary for Health and Social Care on 20 December 2024, which established five strategic priorities: Timely Access to Care, Population Health and Prevention, Building Community Capacity, Mental Health Access, and Women’s Health. The Planning Framework mandated delivery expectations and enabling actions on an “adopt or justify” basis, emphasising flexibility for local needs while integrating legislative requirements such as the Well-being of Future Generations (WBFG) (Wales) Act 2015.

Planning Cycle for the development of the 2026/27 Plan

As previously noted to the Committee, the implementation of the Planning Cycle for the development of the 2026/27 Plan has begun ahead of submission to WG at the end of March 2026, subject to Board approval.

Asesiad / Assessment

Progress against the 2025/26 Annual Plan

A full update on progress against the Annual Plan was provided to Board on 27 November 2025 highlighting a number of key updates, by exception, against both our Escalation requirements and the Annual Plan targets, including the challenging position regarding our finances; and the performance position with regards to Urgent and Emergency Care (UEC) (Ambulance Handovers and Emergency Department (ED) Waits); Delayed Pathways of Care (DPoC); R1 Ophthalmology; and 62-Day Cancer.

2026/27 Planning Cycle Development

An overview of the approach the Health Board is taking in the development of the 2026/27 Planning Cycle was presented to the Committee in August and October 2025. At its core, the approach is based on a risk stratification system to bring transparency and consistency to the challenge of managing competing priorities within constrained resources. The Planning Prioritisation Matrix captures all identified risks and systematically categorises them through a governance framework that clarifies which challenges can be managed within existing parameters versus those requiring system-level intervention.

Currently, there are 637 live risks, of which 168 are Extreme and 370 are High - around 84% of the register. These risks cluster around workforce sustainability and staff wellbeing, fragile and single-handed services, estates and infrastructure, digital and data resilience, and financial pressure. Those clusters align closely with our emerging Strategic Objectives of Thriving teams, Healthier communities, Great Care and Positive Futures.

Recognising the scale of challenge, the Health Board has deliberately shifted from aspirational planning to risk-informed, resource-constrained prioritisation. This is the central organising principle of the 2026/27 planning round. The key elements of the approach are:

- Plan from what we have, not what we want. There is no additional growth funding; transformation must be achieved through redeployment and re-sequencing of existing resource.
- Mandatory efficiency and savings delivery. Every reallocation must contribute towards the annual savings requirement, either through cash-releasing savings or demonstrable cost-reduction.
- Top three risks only per Clinical Care Group (CCG)/directorate. Each CCG and Executive Function has been asked to nominate its three highest priority risks for collective consideration; all others remain managed through existing governance but without expectation of resource reallocation in this cycle.
- Structured routing of risks. A three-route model directs operational risks either to local management (Route 1), reallocation decisions up to a threshold (Route 2), or system-wide strategic prioritisation where issues are cross-cutting, high-cost or transformational (Route 3).
- Funnel from long list to short list. Workshop 1 surfaced multiple risks. Workshop 2 will narrow three risks per CCG down into six to eight cross-system proposals for 2026/27, each with clear deliverables and early benefits (aiming for impact by April but no later than June 2026).

This evolving planning process is not simply technical. It is also a governance shift. It will require the Board to make explicit decisions about:

- Which risks to treat now, through resource reallocation or transformation;
- Which to manage as far as reasonably practicable within current resources; and
- Which to accept explicitly for a period, in line with the Board's risk appetite, while resources are focused on higher-impact areas.

Crucially, the planning method is now explicitly aligned to the Strategic Refresh. The eight planning goals – two under each chapter – act as the bridge between:

- The operational and corporate risk base (circa 637 risks),
- The annual plan for 2026/27,
- The three-year roadmap to financial balance, and
- The long-term mission of “Healthier lives, well lived”.

The Annual Plan process and the three-year financial roadmap are the mechanisms for converting a number of these risks into deliverable actions. By identifying six to eight cross-system priorities for 2026/27, aligning them with the planning goals, and applying the principles of radical openness, trust, and change to clearly articulate:

- Where we will reallocate resources and transform now;
- Where we will manage and improve within existing resource; and
- Where we will consciously accept and monitor risk over the next three years while we focus on the areas of greatest system impact.

Building on the initial workshop in October 2025, the follow-up workshop with the Core Delivery Groups (CDGs) was held in November 2025. Each CCG was required to present its three priority risks only, as set out in the refined planning principles and agreed following Workshop 1. For each of the three risks, they were asked to cover the following:

- What the risk is - taken directly from your operational risk register.
- Why it is one of your top three - the impact, scale and urgency.
- What you believe is required to address it - high-level only; this is not a business case.
- Whether it is realistically deliverable in 2026/27 - within the constraints described in the planning paper (e.g., no new growth funding, focus on reallocation, early impact required by April but June 2026 at the latest).
- How it aligns with the planning principles - particularly Principle 4 (Top 3 Risks Only), Principle 7 (Early Impact) and Principle 8 (Shift Left).

CCG priorities and themes from the planning workshop

The November 2025 planning workshop surfaced CCG priorities that cluster strongly around a limited number of themes. Community and Integrated Medicine emphasised the UEC “front door” - ED clinical streaming, Same day Emergency Care (SDEC) and acute medicine workforce, alongside whole-system flow and intermediate care. This would naturally include the Clinical Streaming Hub and Hospital at Home as core delivery vehicles for Home First and Discharge to Recover then Assess Model (D2RA). Planned and Specialist Care focused on theatres and peri-operative reliability, cancer 28-day diagnostics, dermatology (with strong links to skin cancer) and orthogeriatric modelling for trauma and frailty. Orthogeriatrics emerged as an area of strong cross-CCG consensus.

Allied Health and Health Sciences including Diagnostics highlighted structural ultrasound workforce deficits and broader imaging constraints, alongside Allied Health Professions (AHP) capacity in frailty, orthogeriatrics and weight management pathways. Population Health emphasised healthy weight and obesity (including GLP-1 pathways), falls and healthy ageing, cardiovascular risk and immunisation coverage. Across CCGs, theatres, UEC flow, diagnostics (especially Ultrasound Scans (USS), Computerised Tomography (CT) and Magnetic

Resonance Imaging (MRI)), cancer, dermatology and orthogeriatrics recur consistently, with community capacity and prevention as enabling themes.

Aligned System-Level Joint Priorities

On the basis of the Board Seminar, CCG submissions and the November 2025 workshop, five system-level joint priorities are proposed for the **2026/27 Annual Plan**, set within a three-year planning horizon to March 2028. Each draws together multiple CCG risks and programmes and is intended to provide a clear organising framework for workforce, finance, estates and performance planning rather than a long list of separate initiatives.

The priorities are:

1. UEC front door and whole-system flow (including Clinical Streaming Hub (CSH) and Hospital at Home).
2. Orthogeriatric and frailty model across trauma and medicine.
3. Theatres, anaesthetics and peri-operative system reliability.
4. Cancer and 28-day diagnostics (including dermatology).
5. Diagnostics capacity and resilience, with an early emphasis on ultrasound.

Prevention, digital/data, estates and workforce are treated as cross-cutting enablers that have to be built into each priority rather than as standalone programmes.

Priority 1 - UEC front door and whole-system flow

UEC remains structurally fragile: DPoC are well off trajectory, Audit Wales estimate around 55,000 delayed bed days and at times around a fifth of general and acute beds occupied by delayed patients. The four-site emergency model, ED and acute medicine workforce gaps, dependence on surge beds and an ageing estate all point to a system held together by short-term measures. Community capacity, social care, Continuing Healthcare (CHC) and mental health demand are integral to the problem.

Year one (2026/27) – what must change

- Establish a single UEC and flow programme, led by Community & Integrated Medicine with joint ownership across relevant CCGs and Local Authorities.
- Set realistic 2026/27 trajectories for DPoC, ambulance handovers and 12-hour waits, based on explicit assumptions about community, CHC, mental health and social care capacity.
- Standardise and scale core “home first” interventions (CSH, Hospital at Home, reablement), with quantified bed-day and DPoC impact, and agree minimum estates and staffing measures needed to keep four-site UEC safe.

Years two and three

- Use year-one data to inform decisions on hospital configuration, escalation capacity and the balance of hospital and community care.
- Embed consistently scaled home-based and discharge models across all counties, aligned with the longer-term Clinical Services and Estates Strategy.

Priority 2 - Orthogeriatric and frailty model across trauma and medicine

Orthogeriatrics and frailty were a strong area of consensus. There is a high volume of frail older people with fragility fractures; for example, around 400 fragility fractures a year at Glangwili Hospital (GGH). Clinicians described a consultant-led orthogeriatric model, supported by AHPs and community teams, that could reduce length of stay by 3–5 days and improve outcomes. Provision is currently variable and not consistently linked to falls prevention, bone health and rehabilitation.

Year one (2026/27) – what must change

- Agree a Health Board-wide design for orthogeriatric and frailty services, led jointly by Planned and Specialist Care and Community and Integrated Medicine.
- Produce a quantified case for change, showing expected bed-day, complication, readmission and CHC impact by site.
- Implement a demonstrator service on one site (most logically GGH) with defined orthogeriatric consultant time, Multi-Disciplinary Team (MDT) input and links to bone health and falls services.

Years two and three

- Extend the model systematically across other hospitals, using the demonstrator to refine workforce and bed assumptions.
- Fully integrate orthogeriatrics with falls prevention, fracture liaison and community rehabilitation within the wider healthy-ageing agenda.

Priority 3 - Theatres, anaesthetics and peri-operative system reliability

Theatres have the highest fragility score (37) and underpin Referral to Treatment (RTT) and cancer performance. At GGH there is a shortfall of around 30 theatre nurses, frequent cancellations of cancer and urgent lists and substantial reliance on temporary staff. Estates constraints (power resilience, ventilation, storage and an existing Health and Safety notification) mean some theatres are not used consistently within their intended clinical envelope. A theatres steering group exists but is not yet driving a single, coherent programme.

Year one (2026/27) – what must change

- Implement safer-staffing solutions in the most fragile locations, with business cases that offset costs against current temporary staffing, lost activity and outsourcing.
- Protect cancer and emergency theatre capacity on all sites through clear rules and escalation, reducing short-notice cancellations.
- Deliver targeted improvements in pre-operative assessment and scheduling, and agree essential estates and equipment works required in-year to maintain safety.

Years two and three

- Further develop a Getting It Right First Time (GIRFT) aligned theatre improvement programme covering case mix, productivity and post-operative flow.
- Shift appropriate diagnostic and low-acuity work into procedure rooms and community settings, and align theatre capacity explicitly with RTT, cancer and high-volume specialties such as ophthalmology.

Priority 4 - Cancer and 28-day diagnostics (including dermatology)

Cancer performance is constrained mainly by diagnostics rather than treatment. For tumour sites such as urology, lower gastrointestinal (GI) and gynaecology, CT, MRI and other tests often take six to eight weeks, making 62-day compliance difficult. Dermatology is critical to cancer performance (around a third of treated cancers are skin cancers) but the service is highly fragile: no substantive consultant or clear clinical lead, heavy reliance on insourcing and external teledermatology, and poor accommodation.

Year one (2026/27) – what must change

- Standardise understanding and application of the single cancer pathway and 28-day standard across clinical and operational teams.
- Implement practical pathway changes in key tumour sites (one-stop models, better sequencing of imaging and endoscopy) to shorten the diagnostic phase.
- Undertake a full dermatology service and risk review, secure interim clinical leadership, and progress an agreed solution for a dermatology hub or minor-procedure suite.

- Set explicit diagnostic capacity assumptions (CT, MRI, ultrasound, endoscopy) that underpin cancer trajectories and clarify how outsourcing will be governed and clinically led.

Years two and three

- Extend successful streamlined diagnostic models to other tumour sites and stabilise a substantive dermatology workforce and hub model.
- Embed cancer diagnostics within the wider imaging strategy, with more reliable 28-day performance and a reduced gap to the 62-day ambition.

Priority 5 - Diagnostics capacity and resilience (initial emphasis on ultrasound)

Diagnostics, especially imaging, are a structural constraint. An ultrasound SBAR describes a significant sonographer workforce deficit and escalating corporate risk, particularly at Withybush (WGH) and Bronglais (BGH) Hospitals. Ultrasound is first-line in many cancer, maternity and UEC pathways. Wider imaging capacity (CT, MRI) is not planned as a coherent system; outsourcing is fragmented and radiology does not always hold contractual and governance control.

Year one (2026/27) – what must change

- Develop a consolidated imaging view (demand, capacity and backlog by site and modality) to underpin cancer, UEC and ophthalmology trajectories.
- Stabilise ultrasound through a single programme bringing together workforce actions, demand management and more coherent use of outsourced capacity.
- Clarify governance and clinical leadership for outsourced imaging, ensuring radiology leads commission, quality and turnaround expectations.
- Begin using clinical validation and pathway redesign to reduce unnecessary imaging where safe.

Years two and three

- Move to a more sustainable imaging model with the right mix of substantive workforce and equipment and, where necessary, re-profiling or consolidation of capacity.
- Fully integrate imaging planning into UEC, cancer and planned-care programmes rather than treating diagnostics as a stand-alone technical function.

Next Steps

Before finalising the 2026/27 Plan, three areas of further quantification would materially strengthen the approach and support more precise prioritisation and phasing:

- A quantified orthogeriatric case for change, translating Length of Stay (LoS), complication and readmission reductions into explicit bed-day and financial trajectories by site.
- Consolidated diagnostics modelling, aligning CT, MRI, ultrasound and endoscopy demand and capacity with cancer, UEC and ophthalmology trajectories.
- A robust impact dataset for CSH, Hospital at Home, reablement and domiciliary care, including county-level variation, to evidence the bed-day and DPoC benefits of scaling the Home First model.

Subject to these refinements, the five proposed priorities provide a coherent organising framework for the 2026/27 Annual Plan and the associated three-year trajectories. They directly address the most material cross-cutting risks, use existing programmes such as CSH, Hospital at Home and the theatre steering group as delivery vehicles, and align with both Welsh Government priorities and the Board's Strategic Refresh.

Argymhelliad / Recommendation

The Committee is asked to:

- **NOTE** the update on the 2025/26 Annual Plan
- **SCRUTINISE and RECEIVE ASSURANCE** from the update on the progress against the Planning Cycle and risks for the production of the 2026/27 Plan.

Amcanion: (rhaid cwblhau)

Objectives: (must be completed)

Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	3.1.1 Receive assurance that the planning cycle is being taken forward and implemented in accordance with Health Board and Welsh Government requirements, guidance and timescales. 3.1.4. Receive assurance on delivery of the Health Board's Annual Plan through the scrutiny of regular monitoring reports.
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	6 Clinical services plan 7 Primary and community strategic plan 8 Estates plan 10 Population health
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 Board May, July, September and November 2025
Rhestr Termiau: Glossary of Terms:	Not applicable
Partion / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Strategaeth a Chynllunio	Board May, July, September and November 2025 Board Seminar October and November 2025

Parties / Committees consulted prior to Strategy and Planning Committee:	
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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

November Planning Workshop

Clinical Care Group (CCG) Issues, Interdependencies and 3-Year Planning Framework

Analysis and Recommendations for the Annual Plan 2026/27

Executive Summary

The November 2026 Planning Workshop brought together Clinical Care Groups (CCGs) and corporate directorates to identify the most significant risks facing Hywel Dda University Health Board (HDdUHB). Each area presented their top three priorities, revealing a picture of deeply interconnected challenges requiring collective action.

The Board has provided clear direction: the Annual Plan must address a small number of clearly articulated priorities rather than responding to dozens of disparate risks. This requires moving from separate conversations about finance, performance and quality to a single integrated story.

This analysis presents each CCG's identified issues, maps the interdependencies and cross-cutting requirements, and proposes a cause-and-effect framework to demonstrate impact across programmes. Critically, the analysis reveals that the majority of service pressures cannot be addressed through new funding but require strategic resource reallocation within existing constraints.

The analysis also considers two aligned papers, namely the Ultrasound Services (USS) SBAR (Risk 797) and the Clinical Streaming Hub (CSH) and 7 Day Same Day Emergency Care (SDEC) Business Case, which provides the detailed operational and financial analysis to support the resource reallocation decisions identified in this framework.

1. Issues Identified by CCG and Directorate

Each CCG and directorate presented their top three priority risks, aligned to their fragility assessments and risk registers. The following summarises these by area:

1.1 Planned & Specialist Care

Service Director: Paula Goode

Priority	Issue	Key Points
1	Theatre System <i>Fragility score: 37 (highest in CCG)</i>	30 WTE short at Glangwili Hospital (GGH); 8 lists cancelled/week (£2m lost); safer staffing resource reallocation £2m needed; estate issues (air handling, power, storage); Theatre 6 inappropriate use
2	Dermatology <i>Risk score: 16 (questioned accuracy)</i>	No substantive consultant or clinical lead; 38% of treated cancers; 22% year-on-year skin cancer increase; highest rate in Wales; entirely reliant on insourcing/outsourcing; clear transformation needed
3	28-Day Cancer Diagnosis <i>Single Cancer Pathway</i>	Diagnostic bottleneck is primary issue; CT/MRI 6-8 week waits; Lower Gastrointestinal (GI) CT colons 54 days; Urology, Lower GI, Gynaecology highest volumes; poor cancer outcomes

1.2 Allied Health Professions & Health Sciences

Service Director: Sara Quarrie

Priority	Issue	Key Points
1	Demand & Capacity Imbalance <i>Risk score: 25</i>	Ultrasound position affects cancer and paediatric pathways (further set out in USS SBAR); Dietetics (Avoidant Restrictive Food Intake Disorder (ARFID) - avoidant/restrictive eating); Adult weight management/Monjaro demand; First Contact Physio unsustainable
2	Radiology Deficit <i>Risk score: 25</i>	£1m Everlight out-of-hours reporting; Service 'extremely fragile'; Years of decision-making left deficit; Not at baseline; Impacts all CCG pathways
3	Orthotic Products <i>Supporting service</i>	Smaller quantum but affects multiple pathways; Costed for resolution; Part of CCG-wide demand/capacity issue

Note: Only issues scoring 25 were presented. Additional Welsh Government (WG) targets in Physio, Speech and Language Therapy (SLT) and Podiatry not currently being met and not included in this prioritisation.

1.3 Community & Integrated Medicine

Service Director: Peter Skitt

Priority	Issue	Key Points
1	Delayed Transfers of Care (DToC) <i>30+ linked risks</i>	£27-28m cost; Not solely Local Authority responsibility; Impacts flow across system; Requires partnership working; Community capacity gap
2	Emergency Department (ED) & Acute Medicine Staffing <i>Consultant and middle-grade</i>	Cannot staff rotas safely; Substantive numbers inadequate for current configuration; Organisation needs choice: fewer ED/takes OR more staff; Locum spend increasing yearly; CSH and 7 Day Same Day Emergency Care (SDEC) partly addresses this issue
3	Orthogeriatrics / Elderly Medicine <i>Including falls pathway</i>	>50% trauma ward patients need rehab not trauma care; 3-5 day – Length of Stay (LoS) reduction potential; Causing flow delays, corridor care, patient harm; Links to pre-op assessment

Key message: *"The answer is that we have to have less emergency medical takes*

1.4 Mental Health & Learning Disabilities (MH&LD)

Clinical Lead: Warren Lloyd / Matthew Richards

Priority	Issue	Key Points
1	Local Delivery Model <i>Flexible, Open Access, Person-Centred</i>	Aligned to Mental Health (MH) Strategy; 111 Option 2 strengthening; Lived experience workforce development; Recovery college model; Demonstrator site for psychological therapies
2	Patient Flow & Out-of-Area Beds <i>Including CHC spend</i>	Continuing Healthcare (CHC) within MH&LD budget (not separate); Placements back to 4-year-ago levels since July 2025; High-cost private sector transfers increasing; Quality of out-of-area provision variable; Patient outcomes affected by distance

Priority	Issue	Key Points
3	Neurodevelopmental Services <i>Political scrutiny area</i>	High national and political profile; Engaged with regional and national forums; Part of national strategic programme

Financial drivers: CHC spend, private sector hospital beds, and medical agency costs are symptoms of wider bed pressures, lack of community capacity, and increased acuity.

1.5 Public Health

Deputy Director: Bruce Bolam

Priority	Issue (Risk Reference)	Key Points
1	Health & Wellbeing Improvement <i>Risk 1192 + Risk 118 (partnerships)</i>	Embedding Social Model of Health and Wellbeing (SMoHW)/ 20four7; Partnership alignment critical; External partners must support keeping people out of unplanned care; 20four7 Framework implementation
2	Public Health Interventions Uptake <i>Risk 1194</i>	1/3 avoidable burden from lifestyle factors (SNAP); CVD/hypertension - significant untapped potential; Diabetes/healthy weight pathways; Falls prevention 'top tier priority'; 20% most disadvantaged areas need targeting
3	Immunisation Uptake & Equity <i>Risk 1194 (specific)</i>	Most powerful intervention to eliminate/reduce avoidable admissions; Rates not where needed; Equity of coverage requires improvement; Good latitude of control in primary care and immunisation services

1.6 Medical Directorate

Deputy Director: John Evans

The Medical Directorate took an enabling approach, seeking to support CCGs rather than competing for priority status:

1. **Workforce Resilience** - 'Our workforce is your workforce' - building resilience across the system
2. **Training Pathways** - Balancing professional standards with improving training places and medical education
3. **Effective Clinical Practice** - Ensuring clinical governance dovetails with CCG transformation

1.7 Estates & Facilities

Head of Operations: Simon Chiffi

Priority	Issue	Key Points
1	Backlog Maintenance <i>£107m - £140m range</i>	No backup power at Prince Philip Hospital (PPH) theatres (ventilators don't run on batteries); Air handling issues; 'Catastrophic incident potential'; Daily reactive challenges; 'Hand grenade' approach currently
2	Cleaning Standards Gap <i>Wales 2009 standards</i>	43 additional staff needed for current standards; Draft 2025 standards (unreleased) would require 2→3 cleans/day; 33% increase on facilities budget; Occupational Change Process (OCP) work bridging gap

Priority	Issue	Key Points
3	Security & Portering <i>Risks 1860 & 1861</i>	Increasing Violence and Aggression (V&A) incidents; Porters being used inappropriately as security; Not Security Industry Authority (SIA) licence trained; Professional boundaries being crossed

Key message: "I need to know what the organisation wants to go after clinically - only then can I dress up the estate to support it. We may be throwing money into areas that won't last."

1.8 Pharmacy & Medicines Management

Associate Clinical Director: Dilesh Khandhia

1. **Antimicrobial Stewardship** - No pharmacist support on some sites following unfunded posts and financial pressures; microbiology challenges
2. **Electronic Prescribing and Medicines Administration (EPMA) Clinical Engagement** - Electronic prescribing rollout requires clinical engagement; downstream issues likely without proper involvement
3. **Aseptic Services Fragility** - Estate below standards; demountable unit partially addressed; running at 130% capacity; workforce fragility; national outsourcing market at capacity

1.9 Primary Care

Assistant Director of Primary Care: Rhian Bond

Risk	Title / score	Rationale
1993	Risk of failure of Sidexis due to software being End of Life <i>Risk score: 16</i>	Sidexis is the system that manages digital imaging in the Community Dental Service. Whilst there is a workaround for short term system disruptions if the system was to fail (as no longer supported) there would be a risk to capturing and reporting on images. Procurement of a new system is the viable mitigation.
1451	Risk of increasing unsustainability of General Medical Services (GMS) Practices due to Independent Contractors serving notice on their Contracts <i>Risk score: 16</i>	Whilst there is a risk of contract terminations there is a statutory responsibility for the Health Board to deliver general medical services. The risk needs revising to cover sustainability of primary care services due to the impact of contractual changes on community pharmacy and dental services (Link to 1708)
1869 800 1823	<ul style="list-style-type: none"> • Risk of NHS Dental Services not achieving Patient Charge Revenue Income targets due to lower activity/income at practices • Health Board wide risk of a lack of General Anaesthesia service for Vulnerable Adults due to lack of consultant and theatre space • Risk to Sustainability of NHS Dental Services due to NHS Dental Contract 	All dental risks that link to financial stability of patient income to support commissioning of contracts, the ability to commission contracts and delivery of specialist services to vulnerable adults.

Risk	Title / score	Rationale
	Reform and handback of NHS contracts <i>Risk score: 12</i>	

2. Interdependencies and Cross-Cutting Requirements

A critical workshop finding was that risks are **multifaceted and interconnected**. A workforce issue drives poor quality, temporary staffing costs, and financial pressure simultaneously. The Board Chair emphasised the need for options that 'take into account all facets' rather than presenting separate finance, performance and quality conversations.

2.1 CCG-to-CCG Dependency Map

The following matrix shows where each CCG's priorities depend on or affect other CCGs:

CCG Priority	Planned Care	Comm & IM	AHPs & HS	MH & LD	Estates
Theatres	Owner	Emergency surgery capacity	Pre-op, anaesthetics support	Low	CRITICAL: Power, air handling
28-Day Cancer Diagnosis	Owner	Low	CRITICAL: CT/MRI capacity	Low	Imaging equipment
ED/AMU Staffing	Surgical take links	Owner	Front door AHPs	MH liaison at front door	CRITICAL: Site config
Orthogeriatrics	Transnasal Oesophagoscopy (TNO) beds, pre-op	Owner	CRITICAL: Frailty, Physio, OT	Low	Rehab space
DTOC	Surgical flow	Owner	Discharge support	MH DTOC component	Low
Radiology Deficit	CRITICAL: Cancer Dx	USC diagnostics	Owner	Low	Equipment, space

Key: Yellow = Owner CCG | Orange = Critical dependency | Grey = Low/No dependency

2.2 Cross-Cutting Enabling Requirements

Several requirements cut across **all** CCG priorities and must be addressed collectively:

Enabler	CCGs Affected	Implication if Not Addressed
Radiology Capacity	Planned Care (cancer); Community (USC); AHPs (all pathways)	Cancer performance unrecoverable; USC delays; continued £1m outsourcing
AHP Capacity	Community (orthogeriatrics); Planned Care (pre-op, rehab); MH&LD (pathways)	Flow improvement unrealisable; LoS gains not achieved; frailty pathway failure
Estate Infrastructure	Planned Care (theatres); Community (ED/AMU); All clinical areas	Catastrophic patient safety incident; service closure; regulatory intervention
Medical Workforce	Community (ED/AMU); MH&LD (psychiatry); All CCGs (on-call)	Continued agency spend; unsafe rotas; forced configuration change
Partnership Working	Community (DTOC); Public Health (prevention); MH&LD (community)	£27m+ DTOC costs continue; prevention agenda unfunded; shift left impossible

2.3 Natural Clusters of Interdependent Priorities

Analysis of the interdependencies reveals three natural clusters that should be addressed as integrated programmes rather than separate initiatives:

Cluster A: Flow & Frailty (Highest CCG Consensus)

- **Lead CCG:** Community and Integrated Medicine
- **Contributing CCGs:** AHPs (frailty team, physio, Occupational Therapy (OT)); Planned Care (TNO, pre-op); Public Health (falls prevention)
- **Scope:** Orthogeriatrics resource reallocation; DTOC reduction; falls pathway; discharge optimisation
- **Aligned Paper:** *CSH and 7 Day SDEC Business Case*
- **Estate enabler:** Rehabilitation space; SDEC expansion

Cluster B: Cancer Diagnostics & Capacity

- **Lead CCG:** Planned & Specialist Care
- **Contributing CCGs:** AHPs (radiology, ultrasound); Pharmacy (aseptics for chemotherapy)
- **Scope:** 28-day pathway redesign; CT/MRI capacity; dermatology stabilisation; one-stop cancer services
- **Aligned Paper:** *USS SBAR (Risk 797)*
- **Estate enabler:** Imaging equipment; minor ops hub

Cluster C: USC Configuration & Sustainability

- **Lead CCG:** Community and Integrated Medicine (with Medical Directorate)
- **Contributing CCGs:** Planned Care (surgical take); AHPs (front door services); MH&LD (liaison)
- **Scope:** ED/AMU workforce reality; site configuration options; emergency theatre provision
- **Estate enabler:** Power supply; critical infrastructure; potential estate rationalisation

3. Aligned Supporting Papers

Two papers currently in development provide detailed operational and financial analysis to support the resource reallocation decisions identified through the workshop. These papers are intrinsically linked to the annual plan priorities and should be considered as part of an integrated planning package.

3.1 USS SBAR (Risk 797) – Ultrasound Service Fragility

Link to Annual Plan Priorities (current POs, would be Great Care in 26/27)

This SBAR directly addresses:

- **Planning Objective 1:** Workforce Stabilisation
- **Planning Objective 3:** Transforming Urgent and Emergency Care
- **Planning Objective 4:** Planned Care, Diagnostics and Cancer Recovery
- **Cluster B:** Cancer Diagnostics and Capacity (AHPs as Contributing CCG)

Current Position

The USS is operating with insufficient numbers of qualified sonographers to deliver a full, timely, safe and effective diagnostic service. This risk has been present on the corporate risk register since 2023 and has now further deteriorated.

1. **From 1st January 2026:** Withybush Hospital (WGH) will be unable to sustain safe baseline capacity for routine and urgent non-obstetric imaging alongside obstetric scanning
2. **Structural deficit:** 6.4 WTE gap with demand (297,353 patients) significantly exceeding capacity (229,057)
3. **Annual shortfall:** 68,296 patients; 34,148 additional scanning hours needed
4. **National context:** Because the shortfall is national and systemic, insourcing is not a viable mitigation

Resource Reallocation Opportunity

The SBAR proposes resource reallocation through:

1. **Skill-mixing:** Create an 8a Clinical Validation post through internal skill-mix of current workforce (funded via vacancies)
2. **Pathway optimisation:** Work with National Imaging Programme to validate waiting lists and ensure pathways follow national guidance
3. **Workload redistribution:** Movement of workload to other professions (physiotherapy, podiatry, vascular scientists) following funding redistribution
4. **Obstetric capacity:** Procurement of obstetric ultrasound capacity funded via vacancies

Decision Required

Approval to escalate corporate risk 797 from 20 to 25 and endorse the resource reallocation strategy to stabilise the service.

3.2 CSH and 7 Day SDEC Business Case

Link to Annual Plan Priorities

This business case directly supports:

- **UEC Accelerated Transformation Programme:** 50% reduction in ED attendances; 75% of emergency activity delivered in a scheduled way
- **National Six Goals Programme:** Requirement for integrated 7-day services by end of September 2025
- **Targeted Intervention de-escalation:** Addresses UEC criteria for ambulance handover, ED waits and hospital length of stay
- **Cluster A:** Flow and Frailty (Community & Integrated Medicine as Lead CCG)

Proposed Model

Extension of CSH, SDEC, and Hospital@Home to 7-day operation:

- **Regional Clinical Streaming and Local Response Hubs:** Eastgate, Porth Preseli, and Cardigan with two-hour response capability
- **7-Day SDEC:** Optimal model strengthening current weekday services and providing weekend cover
- **7-Day Hospital@Home:** Currently limited to four days as patients must be discharged every weekend without CSH oversight
- **Integrated Falls Response:** Level 1, 2 and 3 falls response seven days a week

Resource Reallocation Opportunity

The model demonstrates clear resource reallocation pathways:

1. **Existing funding:** Can be delivered from current Six Goals budget for 2025/26 implementation
2. **Cost avoidance potential:** £3.9m – £9.9m annually through admission avoidance (16-17 bed saving equivalent)
3. **Variable pay reduction:** If surge spending (£1.38m) and pharmacy cost reductions (£0.62m) are realised, combined cash benefit (£2.0m) exceeds CSH service cost (£1.54m)
4. **Weekend pilot evidence:** 91% same-day discharge rate; SDEC absorbed 56% of all ED medical takes

Decision Required

Endorsement of 7-day model implementation from January 2026 with commitment to ongoing funding against cost avoidance realisation.

4. Three-Year Planning Framework with Year 1 Focus

The Board has challenged the organisation to build 'year-on-year pillars' toward strategic objectives, moving away from annual plans that are 'often devoid of strategy'. The following framework translates CCG priorities into a phased approach:

4.1 Year 1 (2026/27) – Foundation and Quick Wins

Focus on interventions that are deliverable within 12 months and create foundations for Years 2-3:

Priority	Year 1 Deliverables	CCG Requirements
Orthogeriatrics	Resource reallocation case approved; Model implemented at primary site; 3-day LoS reduction target	C&IM: Geriatrician posts; AHPs: Frailty team, physio, OT; Planned: TNO pathway
USS Mitigation <i>(Aligned Paper)</i>	SBAR recommendations implemented; 8a validation post in place; pathway optimisation with NIP	AHPs: Skill-mix; Planned: Cancer pathway input
CSH & 7 Day SDEC <i>(Aligned Paper)</i>	7-day model operational from Jan 2026; Hospital@Home extended; cost avoidance tracked	C&IM: Lead; AHPs: Frailty, therapy; Six Goals: Funding
Cancer Diagnostics	CT/MRI capacity solution (outsource or insource); 28-day pathway redesign for top three tumour sites	Planned: Pathway ownership; AHPs: Radiology capacity; Estates: Equipment
Theatre Staffing	Safer staffing resource reallocation (~£2m); Cancelled lists reduced by 50%; Pre-op pathway improvement	Planned: Workforce plan; AHPs: Pre-op, anaesthetics; Estates: Critical maintenance
USC Configuration	Workforce reality assessment complete; Options developed; Board-level choices presented	C&IM: Lead; Medical: Workforce data; Estates: Site options
Estate Risk Mitigation	Critical power supply addressed; Business continuity plans; Air handling prioritised	Estates: Lead; All CCGs: Clinical priority input

4.2 Years 2-3 Indicative Trajectory

Year 2 (2027/28): Consolidation and rollout – trainee sonographers qualifying; cost avoidance converted to cash-releasing savings; orthogeriatrics across sites; dermatology stabilisation; USC service model implementation; strategic maintenance programme

Year 3 (2028/29): Sustainable models – workforce substantively recruited; shift-left delivered; estate rationalisation aligned to configuration; prevention benefits realised

5. Demonstrating Cause and Effect

The Board requires that planning options present an **integrated story** across finance, workforce, quality and performance – 'not just a simple saving or performance improvement'. The following framework demonstrates cause-and-effect relationships:

5.1 Logic Model Template

Each programme should articulate its theory of change:

Element	Definition	Orthogeriatrics Example
Input	Resources reallocated	X WTE geriatricians; Y WTE AHPs; £Z resource reallocation
Activity	What we do differently	Daily ward rounds; early mobilisation; discharge planning from admission
Output	Direct deliverables	Patients reviewed/day; CGA completed; rehab sessions delivered
Outcome	Changes achieved	3-5 day LoS reduction; reduced readmission; improved patient experience
Impact	System-level effect	Bed release → flow → ED performance; DTOC reduction → £ savings

5.2 Cascade Effect: Orthogeriatrics Example

Demonstrating how a single intervention creates multi-domain impact:

- Quality:** Resource reallocation to geriatricians + AHPs → appropriate rehabilitation → reduced deconditioning → fewer falls → better outcomes → improved patient experience
- Performance:** 3- to 5-day LoS reduction → bed release → improved flow → reduced corridor care → ED 4-hour performance improvement
- Workforce:** Patients in appropriate setting → reduced staff stress → improved retention → reduced agency reliance → substantive recruitment
- Finance:** Shorter stays → bed day savings → DTOC cost reduction (of £27m) → offset resource reallocation → potential net benefit

5.3 Integrated Dashboard Approach

Each programme should report against all four domains monthly:

Domain	Example Metrics	Frequency
Quality	Harm events; patient experience; complaints; serious incidents	Monthly
Performance	LoS; 28-day cancer; ED 4hr; DTOC; theatre utilisation	Weekly/Monthly
Workforce	Vacancy rate; agency spend; sickness; roster compliance	Monthly

Domain	Example Metrics	Frequency
Finance	Run rate; savings delivery; resource reallocation profile; efficiency	Monthly

6. Implementation and Next Steps

6.1 Immediate Actions (Agreed at Workshop)

- Draft paper summarising priorities and assumptions for Executive Team review
- Socialise through Planning Coordination Group
- Individual CCGs continue development of workstreams within their control
- Performance framework alignment as guidance received
- Capacity planning and workforce assumptions development

6.2 Programme Governance Structure

Each priority cluster should have:

- **Executive Sponsor** – Board-level accountability
- **Clinical Lead** – Credible clinical voice
- **Programme Manager** – Dedicated delivery resource
- **Cross-CCG Working Group** – Representatives from dependent CCGs
- **Finance & Workforce Partner** – Real-time assumption validation

7. Conclusion

The November Planning Workshop has successfully surfaced and synthesised the most significant challenges facing each CCG. The analysis reveals that these are not independent problems but a system of interconnected risks requiring integrated responses through resource reallocation within existing constraints.

Two aligned papers the USS SBAR (Risk 797) and the CSH and 7 Day SDEC Business Case provide the detailed operational and financial analysis to support these decisions. The USS SBAR addresses diagnostic capacity and maternity safety through workforce skill-mixing and pathway optimisation. The CSH and 7 Day SDEC Business Case delivers UEC transformation through extending integrated services to seven-day operation, with admission avoidance pathways.

The three natural clusters Flow and Frailty, Cancer Diagnostics, and USC Configuration provide a framework for coordinated action. Each cluster has clear CCG interdependencies and requires enabling support from Estates, Medical Directorate, and corporate functions.

The Board's challenge is clear: demonstrate courage and realism; build year-on-year pillars toward strategic objectives; and present an integrated story across quality, performance, workforce and finance.

As noted in the workshop: 'How many of the things being presented today will happen by accident if we don't plan for them and do something about them – emergency change rather than planned change?'

The time for planned, integrated change is now.