APPROVED MINUTES OF THE STRATEGIC DEVELOPMENT & OPERATIONAL DELIVERY COMMITTEE MEETING/ COFNODION CYMERADWY CYFARFOD Y PWYLLGOR DATBLYGU STRATEGOL A CHYFLAWNI GWEITHREDOL

Date of Meeting: **09:30, Thursday 29 August 2024**

Venue: **Microsoft Teams Meeting/ Ystwyth Boardroom; Ystwyth Board Room Avocor (Hywel Dda UHB - Generic Account)**

Present:
Mr Maynard Davies, Chair
Mr Michael Imperato, Vice-Chair
Cllr Rhodri Evans, Independent Member
Mr Winston Weir, Independent Board Member
Mrs Eleanor Marks, HDUHB Vice Chair

In Attendance:
Mr Lee Davies, Director of Strategy and Planning
Mr Andrew Carruthers, Chief Operating Officer
Dr Ardiana Gjini, Director of Public Health
Mr Huw Thomas, Director of Finance
Ms Rhian Bond, Assistant Director of Primary Care for Ms Jill Paterson, Director of Primary Care, Community and Long Term Care
Mrs Joanne Wilson, Director of Corporate Governance/Board Secretary
Mrs Helen Mitchell, Committee Services Officer (Secretariat)
Ms Ruth Poynting, Committee Services Officer (Observing)

Item SDODC (24)88
Mr Craig Jones, Prevention & Population Health Improvement Manager
Ms Dawn Davies, Principal in Public Health
Ms Cath Einon, Service Development Manager

Items SDODC (24)89 and SDODC (24)100
Ms Bethan Lewis, Interim Assistant Director of Public Health

Item SDODC (24)90
Mr Keith Jones, Director, Secondary Care

Items SDODC (24)91 and SDODC (24)92
Ms Steph Hire, General Manager, Scheduled Care

Item SDODC (24)91
Ms Victoria Coppack, Service Delivery Ophthalmology & Neurology

Item SDODC (24)93
Mr Craig Toutt, Regional Orthopaedic Programme Manager

Items SDODC (24)96
Mr Shaun Ayres, Deputy Director of Operational Planning and Commissioning

Item SDODC (24)98
Ms Eldeg Rosser, Head of Capital Planning

Minutes Ref.	Item	Action

GOVERNANCE

SDODC (24)82 **Introductions and apologies**

Apologies were received from:

- Ms Jill Paterson, Director of Primary Care, Community and Long Term Care

SDODC (24)83 **Declarations of Interest**

There were no Declarations of Interest.

SDODC (24)84 **Minutes and Matters Arising from the Meeting held on 27 June 2024**

Decision:
RESOLVED - the minutes of the SDODC meeting held on 27 June 2024 were APPROVED as an accurate record of proceedings.

SDODC (24)85 **Table of Actions from Meeting Held on 27 June 2024**

There were no open actions from the meeting on 27 June 2024 and no related discussions.

SDODC (24)86 **Corporate Risks Related to SDODC**

Mr Maynard Davies indicated that all corporate risks would be discussed during the course of the meeting.

Mr Winston Weir referenced the minutes of the last meeting, noting that two risks were identified: the capacity of the Planning team and the capacity of the Public Health team. He expressed concern that these issues were not resolved and did not appear in the current risk reports; and enquired about the status of these risks. Mrs Jo Wilson indicated that these risks should be included in the Operational Risk Register.

Mr Weir acknowledged the response but emphasised the importance of these risks, particularly regarding the capacity of the Planning and Public Health teams. He noted that if these issues are not addressed, they could become strategic concerns, especially in relation to targeted intervention and necessary checks and balances.

Mrs Wilson outlined the process, indicating that the relevant Executive Leads, Dr Ardiana Gjini and Mr Lee Davies, had reviewed these risks. It was determined that these risks were being managed at Directorate level and did not need to be escalated to the Corporate Risk Register. Mitigation measures were in place, and the capacity issues were being addressed.

Dr Gjini reiterated that capacity issues remain, but mitigation processes are in place, and efforts are ongoing to recruit consultants.

Decision:
The Committee RECEIVED ASSURANCE that:

- All identified controls are in place and working effectively;
- All planned actions will be implemented within stated timescales and will reduce the risk further and/or mitigate the impact, if the risk materialises; and
- Challenge where assurances are inadequate.

This in turn will enable SDODC to provide the necessary assurance (or otherwise) to the Board through its Update Report, that Hywel Dda University Health Board (HDdUHB) is managing these risks effectively.

SDODC (24)87 **Cluster Integrated Medium Term Plan Monitoring Report**

Ms Rhian Bond presented the Cluster Integrated Medium Term Plan (IMTP) Monitoring report, highlighting the following:

- In October 2023, new regulations for the unified General Medical Services (GMS) contract were introduced, requiring the development of GP collaborative IMTPs alongside cluster IMTPs
- Due to the contractual changes, the team transitioned to a Plan on a Page summary document, replacing the former IMTPs. This new format provides a concise overview of population health data, priority projects, and expenditure for each cluster
- The team has implemented a robust process for monitoring and managing cluster projects using Quality improvement (QI) methodology. Projects are reviewed monthly at locality leads meetings and through additional meetings with Primary Care service managers and the business and risk manager

Mrs Eleanor Marks requested further detail regarding the monitoring arrangements and what actions could be taken when projects are not performing well, noting the importance of these projects.

Ms Bond explained that the monitoring process involves regular reviews and meetings to ensure projects are on track. If projects are not performing well, they are reviewed, and necessary actions are taken to address the issues. This includes discussions with the Primary Care services managers and the business and risk manager to ensure effective practice and compliance with monitoring requirements.

Mr Michael Imperato questioned the extent to which local clusters are responsible for their initiatives versus the potential for projects spanning multiple clusters. He emphasised the importance of projects that benefit all clusters, and the importance of encouraging innovation at the local level while ensuring alignment with the broader strategic goals. He raised a concern about balancing these aspects without making clusters feel they are merely following a corporate directive. In response, Ms Bond explained the balance between local and pan-cluster initiatives, highlighting the importance of both local innovation and alignment with the overall strategy. She outlined the significant investment in mental health projects and the

preference of some clusters to work with local providers over national ones. She also emphasised the importance of understanding the nuances between different providers and maximising the impact for patients while considering value for money.

Ms Bond highlighted the ongoing work around three specific projects and referenced the seven cluster public engagement events scheduled throughout September 2024. These events aim to showcase cluster projects to the public and gather valuable feedback.

Ms Bond noted that clusters sometimes proceed with projects without fully considering professional advice, and emphasised the need for detailed and challenging conversations to ensure the right qualifications and supervision arrangements are in place.

Mr Huw Thomas raised concerns about the perception of clusters as independent from the Health Board and the challenges this poses in ensuring value for public money. He highlighted the difficulty in managing cluster funding, which operates quasi-independently, while adhering to Health Board processes such as procurement.

Mr Thomas acknowledged the frustration this causes for colleagues in the independent sector who are accustomed to different practices. He emphasised the need to reflect on local innovative schemes and the process of mainstreaming these across the Health Board to avoid reinforcing inequity in provision.

Mr Thomas referenced two recent procurement items which aren't replicated across other clusters, leading to inequity. He proposed utilising the Value and Sustainability (V&A) group, Evergreen funding via Mr Simon Mansfield and value-based healthcare to scale successful projects from one cluster and prove their effectiveness at a Health Board level before mainstreaming them. Ms Bond agreed to approach Mr Mansfield to continue the discussion. She also provided an update on the Tywi/Taf Cluster Atrial Fibrillation project. She advised that the project, which had run successfully and was nearing its end, was now being regenerated and expanded to cover a wider geographical area. This expansion was being funded through the strategic Primary Care fund for the next two years. Ms Bond indicated that the goal of this expansion was to gather a broader evidence base of data to either prove the concept or determine that it does not provide the expected benefits. **RB**

Dr Gjini enquired whether ongoing programmes were integrated with those that have been discontinued or are still continuing, such as the Lifestyle Clinic which is linked with Ms Jo Dainton's and Mr Mansfield's work on lifestyle medicine. The Steering Group is rethinking this approach since it is neither purely a lifestyle choice nor strictly medicine. Dr Gjini indicated that there was a Health Board-wide programme with health coaches connected to Primary Care GP clusters, and that these links and transitions were being established.

Regarding the Singing for Lung Health initiative, Dr Gjini advised that uptake has been low. She highlighted national work on planning lung cancer screening, which will function as a lung health check, indicating that it would

be beneficial to involve any champions in this programme. Dr Gjini queried whether the Family Well-Being service and individuals linked to this service had awareness of key brief interventions, such as those related to obesity and mental health issues stemming from drugs and alcohol.

Ms Bond emphasised the importance of considering the wider Health Board's offerings and support during the initial stages of project development. This ensures that connections are established from the outset, rather than discovering midway through a programme that similar efforts are being made elsewhere without coordination. She stressed that this initial check and challenge was essential, and she would ensure that the correct connections with Public Health colleagues are made when initiating new projects.

Mrs Marks sought clarification on how health projects, including funding and cluster-based pilots, align with the Health Board's Strategic Plan and targeted intervention requirements. While these projects were engaging and tailored to specific clusters and geographic areas, she noted a lack of strong connection to the broader strategic goals. Although cluster meetings, as described by Ms Bond, may help, they seem more focused on mainstreaming projects rather than aligning with the Health Board's targeted intervention and population health objectives. Establishing this strategic link is challenging due to the independence of clusters and funding. She expressed uncertainty about the solution but identified a gap that should be addressed.

In response, Ms Bond noted that the cluster fund is relatively small, and the annual rollover of many schemes complicates these discussions. Although locality leads discuss the wider organisation's challenges, these discussions often do not translate into project initiatives that could benefit the broader system.

Dr Gjini indicated that Public Health colleagues were closely linked with and contributed to, the work of the cluster, particularly the bank clusters. However, the focus tends to be on the small but important funding directly related to clusters. Additionally, the Healthier Locality groups work on linking with population health needs, but not necessarily from the inception of projects. Parallel to this, the whole system tries to work with Public Service Boards (PSBs), presenting a significant opportunity to be more strategic about population needs with ongoing programmes. However, the fragmentation of funding and definitions often complicates this effort.

Mr Lee Davies indicated that consideration should be given to utilisation of revised structures. The A Healthier Mid and West Wales (AHMWW) group integrates various strands such as population health and digital services from a strategic perspective. Further discussion could focus on making connections at service level, especially since many of these projects overlap with Secondary Care services, such as Dermatology or Mental Health. Establishing an end-to-end pathway discussion would help determine the exit strategy for cluster funding, which is the ultimate goal. Ms Bond agreed to address this area in the next Primary Care and Community Strategic Plan update report. **RB**

In response to Mr Maynard Davies' enquiry regarding why the Domestic Violence and Abuse training was discontinued given its prominence in the headlines, Ms Bond indicated that the project was always intended to be time-limited, with an initial two-year commitment from the clusters. It was a pilot project, and several factors contributed to its conclusion. These included challenges in encouraging attendance at the training sessions; and the training not meeting the expectations set during commissioning. Consequently, when the project was reviewed, it was decided to end it. There has also been ongoing debate among Health Boards about where such funding should be allocated and how support should be provided.

Mr Maynard Davies also enquired about projects being limited by equipment due to stocking levels, specifically, with access to defibrillators. Ms Bond indicated that for cluster projects, an initial agreement is often made to purchase equipment and consumables, with the expectation that practices will cover the ongoing costs of consumables. This can cause issues when practices later forget this agreement. She agreed to follow up with the team to determine the exact problem. **RB**

Referencing the table on page 5 of the report outlining the 2023/24 Cluster Financial Position, Mr Maynard Davies enquired how funding was provided to the clusters. Ms Bond indicated that the budget is calculated on a per capita basis and is an indicative budget. Clusters can spend up to this cap on projects approved and signed off through the Panel cluster planning arrangements. If projects are not approved, the funds remain in the Health Board's budget. Over the past 12 months a cluster forecast to overspend reached an agreement with a neighbouring cluster to borrow money, which had to be repaid in the next financial year. Mr Thomas had helped to facilitate this with Finance colleagues. Most clusters manage their budgets well, but one has historically underspent due to difficulties in reaching a consensus on spending. A new team is now working in that cluster, and improvements in their ability to approve projects and utilise their budget effectively has been evidenced.

SDODC agreed that the Board should be advised of the Cluster Integrated Medium Term Plan (IMTP) Monitoring report.

Ms Bond left the meeting.

Decision:
The Committee:

- NOTED the former process for developing the Cluster IMTPs
- NOTED the new contractual requirement for the development of GP Collaborative IMTPs and the requirement to engage in the development of Cluster IMTPs
- NOTED the process being taken to ensure progress of Cluster projects through the monitoring and evaluation process

SDODC (24)88 **Public Health - Return on Investment**

Mr Craig Jones, Ms Dawn Davies, and Ms Cath Einon, joined the meeting.

Dr Gjini introduced the Return on Investment (ROI): Drugs and Alcohol and ROI: Smoking Cessation reports, indicating that following the in-depth

discussion on 27 June 2024 when the Committee approved the Health Improvement Strategic Plan, the Committee's request for an analysis of how key Public Health programmes and services directly benefit the Health Board had been prepared.

She indicated that there is ample evidence at national, UK, and international levels on return on investment for various Public Health services. For example, the King's Fund conducted a review in 2018 on drugs, alcohol, and tobacco. However, these studies typically focus on societal-level returns, considering social benefits and the broader health economy. For HDdUHB, colleagues examined published evidence on the financial benefits of two key services: Drug and Alcohol Services and Smoking Cessation Services. They focused specifically on the direct financial savings to the Health Board, rather than societal benefits. This is the first such analysis conducted in Wales and possibly one of the first within an Integrated Care System (ICS) in England.

Public Health colleagues plan to collaborate further with peers, key clinicians, and academics to expand this work.

ROI: Drugs and Alcohol
Mr Craig Jones highlighted the significant costs which drugs and alcohol impose on the NHS indicating that when he was the National Alcohol Lead for Public Health Wales, it was often emphasised that the annual cost of alcohol to the NHS was so high that it could fund the complete reconstruction of Singleton Hospital with state-of-the-art facilities, and still not cover all the expenses.

Importantly, alcohol and drug services provide a strong return on investment, as evidenced by numerous academic studies. A key study by Public Health England in 2019 showed that for every £1 invested in Drug services, there is a £4 return in the first year, rising to £21 over 10 years, provided evidence-based treatment structures are in place and adhered to. Similarly, for alcohol services, there is a £3 return per £1 invested in the first year, increasing to £26 over 10 years.

Mr Craig Jones indicated that investment in young people's services also shows a return of between £5 and £8 for every £1 invested, including prevention and harm reduction services. For example, the needle exchange programme, which costs £200 per patient annually, can yield returns of up to £41k per patient per year if a hepatitis case is prevented, or up to £40k if an HIV case is prevented.

Specific programmes across HDdUHB, such as the Alcohol Liaison Nurse Service, provide a £3.85 return for every £1 invested. Brief interventions, referenced above, offer a £27 return per patient per year for minimal investment. Programmes such as health coaches working across clusters can have a significant impact, especially when linked with other initiatives.

The Blue Light Project, targeting the most complex cases that heavily utilise resources, is still in its early stages but shows a promising £62 return on investment. This programme is particularly effective for individuals who typically do not engage with services.

17.3% of the Hywel Dda population reported drinking above the guidelines. If the Health Board can effectively reach these individuals through collaborative efforts, there is a potential annual saving of £1.75m for the Health Board. This is contingent on successfully targeting all those individuals.

Figure 3, Appendix 1 details actual figures from the 2023-2024 financial year. For example, there were 1005 individuals in alcohol treatment while 235 individuals received cannabis treatment. This table highlights not only the immediate safety benefits for those in treatment but also the long-term impact on the Health Board. By engaging individuals in treatment, making them safe, and helping them change their lives, future savings for the Health Board are ensured by reducing the need for ongoing care. Dr Gjini clarified that Figure 1, Appendix 1 illustrates the potential impact if HDdUHB reached the entire population that abuses or misuses drugs and alcohol. Figure 3 reflects the impact on those currently reached.

Mrs Marks noted that she was surprised by the above-average alcohol consumption rates in HDdUHB and was encouraged to see potential savings from interventions. She enquired whether there were adequate delivery mechanisms to reach the appropriate individuals in the necessary locations; and whether these potential savings were incorporated into the targeted intervention savings. She commended the academic rigor of this report and the collaboration with King's College for peer review.

Dr Gjini indicated that the first table on Page 3 of the report explores the potential RoI, considering that all population data is self-reported. This often leads to underreporting, particularly with drugs and alcohol and is likely to be underestimated. Most service delivery, harm reduction, and follow-up for Drug and Alcohol services come directly from the Area Planning Board, which focuses on substance misuse.

She also indicated that the budget is allocated specifically for the service, with the goal of achieving long-term savings in health service provision by preventing the development of illnesses.

Dr Gjini emphasised plans to work with academics, key clinicians, and other colleagues. This collaboration will assist other health decision-makers in reviewing the evidence.

Mr Thomas indicated that the report represents an economic assessment rather than a financial one, indicating an economic benefit without a corresponding financial evaluation; and emphasised that his team had not validated the data. It is imperative to independently support and validate these figures, akin to any business case or return on investment assessment within the Health Board. This would elucidate how to translate the economic assessment into a financial one applicable to the Health Board, clearly identifying which budgets would benefit.

He expressed concerns about relying on this for budget adjustments, indicating that assessment of savings should be viewed with caution regarding cash-releasing savings within the Health Board. While there is a definite economic saving and benefit, he advised against using this to reduce any specific budget at this stage.

Dr Gjini noted that Public Health and Finance colleagues had collaborated on the report and agreed that Mr Craig Jones would collaborate with Finance colleagues in future assessments to translate this into financial terms, thereby significantly strengthening the case. **CJ**

She indicated that economic assessments, rather than purely financial ones, have been conducted with both the Performance and Financial teams. These will not be included in the targeted intervention savings because they are not aimed at meeting the budget. Instead, these programmes are designed to prevent ill health and result in savings for the local health system.

The Joint Executive Team (JET) has started to examine this. Last winter Welsh Government sought to discuss prevention and evaluate HDdUHB's efforts and programmes as a Health Board.

Mr. Lee Davies emphasised the value of this intelligence and information in aiding strategic thinking about the organisation's needs. He questioned the public's willingness to access these services, asking whether the constraint was the capacity to provide the intervention or if only a certain proportion of the public wanted to engage.

Mr Craig Jones indicated that in recent years extensive work has been undertaken on HDdUHB's complex cases pilot, focusing on a cohort of Generation X individuals who had been using substances for many years. These individuals often know how to use their drugs and choose to do so, avoiding engagement with services due to dissatisfaction with the approach and concerns about police involvement. The approach with this pilot is to engage with individuals differently, asking what would work for them. They prefer discussions on harm reduction rather than abstinence. Providing them with resources like needle exchanges, advice, and support has had a significant impact, helping reach those who are harder to engage.

There has also been an increase in referrals from concerned others, ranging from grandparents to children, who refer their family members to services. This approach has broadened the reach to people who might not have considered Drug and Alcohol services before. Online provision helps reduce stigma, especially for professionals, and data analysis has been crucial. One major focus is on women of perimenopausal and menopausal age, as there is growing evidence of a return to addictive behaviours, particularly with heroin and alcohol. There have been several deaths in this age group, prompting a multi-agency effort to make services more aware and supportive of these women.

The pandemic has also led to increased alcohol consumption among professionals, particularly women, across Wales. The Health Board aims to address this by removing stigmas and encouraging open discussions about addiction, menopause, and the normalisation of alcohol consumption in Welsh culture. The goal is to break down barriers and engage individuals in meaningful ways.

RoI: Smoking

Ms Dawn Davies indicated that smoking prevalence has significantly decreased over the last 20 years, from 26% in the early 2000s to 12% in 2023. This reduction is due to a combination of approaches, including prevention in various settings and national policies at both UK and Welsh Government levels to reduce and restrict access to cigarettes. Work to increase smoke-free spaces in open areas continues; and tobacco control strategies in Wales have supported investment in smoking cessation services, which are effective in helping smokers quit. As a local Health Board, investment in these services has increased over the last 10 years.

As a result, HDdUHB is the first Health Board in Wales to achieve the Welsh Government's Tier 1 target. The annual budget for smoking cessation services, including Secondary and Community Care services, is £1.1m. In 2023/24, 2,547 smokers were treated, including 206 pregnant smokers.

Ms Cath Einon indicated that the data represents a year's referrals to the service, evidencing a year-on-year increase, with 1,600 more referrals last year compared to the previous year. This increase is largely due to the return to face-to-face support within hospital settings. While many acute sites are involved, referrals are not limited to inpatients. The graph on page 4 shows that inpatients are the largest source of referrals, but the team also engages with specialties impacted by smoking, such as Outpatients, Pre-op and Maternity. Practitioners work with midwives to identify smoking at the first booking appointment, with an opt-out referral system, resulting in 56% referrals from females, reflecting a 160% increase in inpatient referrals.

Inpatients are the largest source of referrals due to legislation preventing smoking on hospital grounds and the high representation of smokers in hospitals. Whether patients want to quit long-term or not, support is provided to manage withdrawal during their hospital stay. There was a significant increase in referrals across all counties, particularly in Pembrokeshire. Each hospital has a dedicated practitioner, including inpatient mental health wards, which have also become smoke-free for the first time, representing a major cultural shift.

Ms Einon highlighted the source of referrals known as Advise a Ward Round. This means that practitioners visit the wards regularly to identify smokers and offer support. This model is fragile because if the practitioner is unavailable, these referrals are not made, and smokers are not identified or supported.

Ms Dawn Davies, highlighting the potential cost savings from implementing smoking cessation services, indicated that the data presented had been calculated using the Ottawa model for smoking cessation. This model employs a Making Every Contact Count approach to identify, refer, and treat smokers in Secondary Care settings.

The implementation of this model resulted in an 11.7% reduction in re-admissions. The calculations in the tables were based on a smoking prevalence of 20% in this population, with the 11.7% reduction applied to re-admissions. Essentially, the tables show emergency admissions by hospital site, the estimated number of smokers based on a 20% smoking

prevalence, and the reduction in emergency admissions using the 11.7% reduction percentage, along with the potential cost savings.

The treatment costs were derived from the Royal College of Physicians report, with a 2.8% inflation increase applied annually since 2018/19. The tables are calculated using information from the Royal College of Physicians report on the harmful effects of smoking in the NHS, including the impact on admissions, treatment, and direct and indirect costs. This report highlights that not enough has been done in clinical settings to identify and treat smokers.

The report also provides smoking-attributable fractions for all conditions and the average episode costs, which were used to calculate the cost savings for key conditions. The age cohort is 35 to 89 years, as smoking-related conditions become more apparent in this group. The tables show the total episodes seen for each condition, the smoking-attributable episodes (with the fraction applied), the average cost per episode, and the smoking-attributable cost, with totals at the end of each column.

Mr Thomas indicated that, despite the positive nature of the report, none of the costings are based on HDdUHB internal data; they rely on Royal College costings, which are likely derived from national data for England, not England and Wales. These figures have been adjusted for inflation, whereas HDdUHB has its own costing methodology which could have been utilised.

Mr Thomas noted that he could not provide assurance to the Committee regarding their accuracy. He requested collaboration with Finance colleagues to provide specific information to enhance the robustness of these costings, thereby making this assessment more relevant. He expressed confidence in a payback which will depend on the scale and amounts involved. It is also important to note that this is an economic assessment, not a financial one, and achieving savings is inherently challenging.

Ms Dawn Davies agreed that this analysis is based on work conducted by the Royal College of Physicians. Certain elements were applicable to the Welsh context in terms of calculating savings. Additional work is planned, and collaborating with the Finance team will significantly enhance the robustness of this report. She indicated that Ms Dainton is leading further work with Aberystwyth University in the coming months to develop a more rigorous approach, making it more applicable to the HDdUHB context.

These interventions result in cost savings, particularly in Secondary Care settings and specific groups. Additionally, there are issues related to how medications are metabolised when individuals smoke, which affects recovery and length of stay. These factors should be considered in this analysis and discussion.

Mr Imperato agreed that this initiative is likely to make a significant impact; and that the report was valuable, providing an evidence base despite Mr Thomas’s comments. He questioned where a potential £100k allocated to anti-smoking efforts, would yield the greatest benefit.

Ms Einon indicated that she would recommend increasing the number of practitioners. Smokers are more challenging, often heavily addicted, with mental health conditions or substance issues, requiring more intensive support and being more prone to relapse. The focus is on engaging with patients, building rapport through a person-centred approach, and conducting outreach, including in mental health units, where referrals are generated and training is delivered. The team aims to reach every smoker and every medical professional who interacts with smokers, ensuring they view smoking as a comorbidity that complicates condition management. Increasing the number of Band 5 practitioners would yield significant benefits.

Dr Gjini indicated that this was the first discussion in a series on various returns on investments, and these topics would be further explored. The data is based on the Royal College of Physicians' findings, and more work is needed with the Finance team. The data has been sourced from reports and Mr Mark Bowling, but the cost-saving evidence per episode must come from peer-reviewed and published literature, such as the Royal College of Physicians' report. Public Health do not have, and likely will never have, their own peer-reviewed evidence. This published evidence is applied to HDdUHB figures and cases, and the financial savings need to be improved and made more robust with the Finance team's assistance.

Public Health has commissioned Aberystwyth University to bring academic rigor to various preventative services, as discussed by the Directors of Public Health at the national level. The team is also collaborating with other Clinical Directors, including those in medical, nursing, and therapies, to enhance awareness and robustness in assessing preventative services in the NHS. Bangor University will be commissioned to conduct a programme of budgeting and marginal analysis on key preventive services.

As a Health Board, HDdUHB is developing a Prevention Framework and an Equity Framework, which will be discussed with peer groups across the Health Board in the coming months. This will help integrate preventative services into clinical work. Regarding Mr Imperato's question about the allocation of £100k, Dr Gjini indicated that there are two elements: smoking cessation and tobacco prevention, which are slightly different. The economic health assessments become more challenging as prevalence decreases, making it more costly to reach those individuals.

Mrs Wilson indicated that the discrepancies in the financial information and data should have been reviewed by the Executive Team (ET) first to facilitate a thorough debate before being presented to this Committee. It is not equitable for the Committee to engage in this discussion without prior review. ET will address this for future reports to ensure clarity on finance and savings, thereby providing a more comprehensive picture.

Dr Gjini indicated that unforeseen circumstances had prevented presentation to ET and that she intended to address this matter.

SDODC agreed that the Public Health Return on Investment: Smoking and Drugs and Alcohol reports provided assurance regarding economic benefits to the Board.

Mr Craig Jones, Ms Dawn Davies and Ms Einon left the meeting.

Decision:
ROI Drugs & Alcohol:
The Committee NOTED the Return on Investment: Drugs and Alcohol report.

ROI Smoking:
The Committee:

- NOTED the information contained within the Smoking report
- CONSIDERED the benefits of continued investment in order to contribute to a reduction in overall disease and financial cost pressures within HDdUHB

SDODC (24)89 **PO10 - Population Health Quarter 1 Progress Update**

Ms Bethan Lewis joined the meeting.

Ms Bethan Lewis introduced the Planning Objective (PO) 10 – Population Health update report, indicating that the scope and aim of the objective had been clearly defined, and that key achievements had been identified against the seven deliverable actions for the first quarter. Most of these actions were progressing as planned, with a number already completed. She advised that there were no concerns regarding any actions falling behind schedule or failing to meet their targets within the designated timeframe. However, the Directorate currently faced a risk due to a shortage of Public Health consultants. Although a recruitment process is underway to mitigate this risk, it remained rated at a level of 20, which has implications for planning objectives. The situation was closely monitored, and the team was focussed on the necessary next steps.

Ms Lewis indicated that it was crucial to assess whether efforts within this planning objective were effectively improving population health; and to identify ways to enhance impact. Each deliverable action was supported by a comprehensive work plan, and colleagues were now considering measurable outcomes beyond the NHS Wales Performance Framework and the established Board Assurance Frameworks. Additional metrics to demonstrate the impact of actions were being explored to assist in identifying areas for improvement. Ms Lewis indicated that a workshop with the Performance team is scheduled for the week commencing 2 September 2024 to examine these measurable outcomes in greater detail, enabling more effective monitoring of progress.

Mr Maynard Davies commended the report for its clarity, noting that Ms Lewis had understood the Committee's needs and anticipated its questions; and that it was encouraging to see the progress being made.

SDODC agreed that the Board should be assured by the Planning Objective 10 – Population Health update report

Decision:
The Committee RECEIVED ASSURANCE on Quarter 1 progress and the focused commitment of the Directorate to further explore the impact these

objectives are having on population health and the actions required to demonstrate further improvement.

SDODC (24)90 **Deep Dive PO4 - Planned Care (Cancer, Diagnostics - Therapies Performance)**

Mr Keith Jones joined the meeting.

Planned Care

Mr Keith Jones introduced the PO 4 Planned Care, Diagnostics and Therapies update report, highlighting the positive development which followed the Health Board's progress in clearing and resolving all patients waiting four-years earlier this summer. He indicated the following:

- Provided all scheduled treatment plans for the remainder of the current week proceed as planned, HDdUHB was on track to achieve the objective of clearing all three-year plus waiting patients by 30 August 2024, in accordance with national expectations. This as a significant achievement, particularly in Orthopaedics.
- HDdUHB has stemmed the growth in the total treatment 104 weeks/ 2-year year wait target.
- Significant improvement in the outpatient 52-week position in July was observed, which had been increasing through Q1.
- Despite this progress and these improvements, current performance remained outside the initially forecast trajectory level indicated at the beginning of the year.
- Slide 9 provided a reference to the factors and issues affecting individual specialties outside the trajectory.
- Following the progress in clearing and resolving all patients waiting four-years earlier in the year, the three-year plus waiting list has reduced to 85 as of July 2024.
- Positive data regarding outpatient transformation, especially the application of See on Symptom (SOS) and Patient Initiated Follow-Up (PIFU) approaches, along with a stringent focus on triage of referrals as they entered the system. Clinical teams were managing referral demand judiciously, which supported recovery ambitions.
- Activity delivered in July 2024 was significantly improved on the same period last year. Notably, combined inpatient and day case activity volumes in July 2024 were 6% higher than the average levels in the pre-COVID year.
- Inpatient and day case volumes surpassed the 2019/2020 average, reflecting the ongoing improvement efforts focused on elective optimisation, productivity, and efficiency. This progress is evident despite the lower additional investment in Planned Care compared to pre-COVID years.

Mr Keith Jones advised that a request to update performance trajectories to the year-end by the end of this week had been received from Welsh Government.

He then highlighted challenges faced due to the financial control measures implemented which are beginning to impact performance trajectories. Specifically, issues in Ophthalmology, where a highly productive, high-cost locum was removed. This necessitated further adjustments to performance projections for the year-end.

Additionally, Mr Keith Jones highlighted emerging risks within the Radiology Diagnostic service. The financial control measures were beginning to limit activity rates, particularly affecting reporting. The position was currently being assessed to determine any significant threats to year-end performance targets.

Despite these challenges, HDdUHB's primary commitments for Planned Care delivery by March 2025 remain as previously reported. There have been encouraging improvements in Diagnostics, and a Therapies Recovery and Improvement Plan has been agreed. The trajectory in Therapies, which had been rising since Q1, is now stabilising, and further improvements are expected throughout the year.

In response to Mr Imperato's question regarding the most challenging issue, Mr Keith Jones advised that Orthopaedics do not expect to meet the 2-year total pathway target by the end of March 2024. Currently, a delivery risk affecting approximately 500 patients has been identified. This issue stems from a capacity and backlog demand imbalance within the specialty. He indicated that the data indicates that HDdUHB is nearing a balance between recurrent capacity and demand in Orthopaedics, suggesting positive long-term recovery prospects. However, the primary challenge remains the backlog and the speed at which it can be addressed. Orthopaedics represents the key specialty with significant risk but also notable potential for success.

Mr Keith Jones advised that regular positive feedback is received from Welsh Government, indicating that the focus on productivity and efficiency compares favourably with other Health Boards. This includes efforts across outpatient pathways and initiatives targeting high-volume, low-complexity treatments. HDdUHB's strong clinical focus on demand management has helped prevent the waiting list growth seen in other Health Boards, which is crucial for managing future demand without requiring substantial additional investment.

Cllr Rhodri Evans enquired whether, given the current and projected financial situation, SDODC could be assured that the targets outlined in the report were realistic. He expressed concern regarding the feasibility of these goals under the financial constraints and queried whether the plan was achievable.

Mr Keith Jones indicated that it was crucial to recognise that the Plan relies on an additional £2.8m investment for recovery measures. The Plan's feasibility is contingent upon this funding. Should this investment change, the projected trajectories for the upcoming year would need to be reassessed. He also indicated that emerging risks, particularly related to the financial control measures and their subsequent impact on activities have been identified in Radiology, which is concerning.

Additionally, while employment of the high-cost Ophthalmology locum being terminated will have a short-term impact due to the individual's productivity, the Health Board is exploring ways to mitigate this and bridge the gap through other means. The situation is still evolving and must be closely monitored as the year progresses. Should these risks escalate, it

is imperative that they are reported to the Committee to highlight issues where mitigating solutions cannot be found.

Mr Lee Davies drew the Committee's attention to a broader issue for HDdUHB, as highlighted on Slide 5: The comparison of current total waiters to pre-COVID-19 levels. While it is significant that there is no increase in the waiting list, which is a crucial first step, it is evident that this is a widespread issue across Wales.

Returning to the pre-COVID-19 position, which itself was not satisfactory in terms of the targets set, will require a substantial amount of time and improvement. It is important to acknowledge that there is a long journey ahead, with no clear path to achieving this soon. As an organisation, HDdUHB needs to rethink its approach to address this challenge effectively.

Mr Keith Jones indicated that HDdUHB will need supplementary capacity to mitigate the delivery risk, which is likely to involve external partners, particularly in the independent sector. The risk increases the longer the debate continues without resolution, delaying the availability of resources and heightening the delivery risk of securing and utilising that capacity in the second half of the year.

Cancer

Mr Keith Jones presented the PO4: Cancer update report, highlighting that the Health Board is now beginning to see anticipated improvements; and that for two consecutive months performance had improved. However, performance for July 2024 did not reach the 60% mark he had hoped for. This shortfall was primarily due to a backlog in the Dermatology skin pathway, which arose for various reasons.

HDdUHB successfully increased the activity and treatment response to address this backlog. However, the number of patients ultimately confirmed with a positive cancer diagnosis was lower than expected, which was an anomaly. Consequently, despite the increased activity, the impact on the performance target was less than anticipated.

Nevertheless, the prospects for improvement remain strong, and Mr Keith Jones expects this positive trend to continue until the end of August 2024. Reducing the backlog requires strengthening and expediting of the diagnostic phase of the Single Cancer pathway, ideally within a 28-day window. This will minimise the number of patients entering the backlog further along the pathway.

There are positive results in major tumour site pathways, particularly in Urology, Lower Gastrointestinal (GI) and Gynaecology. There remain risks, such as the Radiology risk which affects both Planned Care delivery and the Cancer pathway due to its reliance on diagnostic activity. Mr Keith Jones advised that HDdUHB must continue to closely monitor the situation and find ways to maintain the Cancer and urgent pathways diagnostic response. This is essential to ensure the necessary level of diagnostic activity for the steady progress of patients through their respective Cancer pathways. He indicated that the current metrics support the conclusion that these efforts are starting to have a beneficial impact.

Mrs Marks enquired what was causing prolonged diagnostic delays, expressing concern for individuals affected. Mr Keith Jones indicated that patients on a Cancer pathway experiencing a wait equivalent to two years (104 weeks) present a significant challenge. The primary reason for such extended waits is the complexity of their diagnostic pathways. There are clinically specific reasons why these patients remain undiagnosed at this stage of their cancer journey. HDdUHB is strongly focused on reviewing and monitoring each of these patients. Some may have multiple tumours or very complex tumours that require repeated and lengthy diagnostic processes. He offered assurance to the Committee that the capacity challenges within certain diagnostic pathways are less relevant to patients waiting two years. These challenges are more pertinent to patients progressing through their Cancer pathway within the 62-day window. For those experiencing longer waits, there are clinical reasons for the extended duration.

In response to Cllr Evans enquiry regarding collaborating with Swansea Bay (SB) UHB and whether departments are disadvantaged by the temporary relocation of breast services to Withybush Hospital (WGH) to increase capacity and reduce the backlog, Mr Keith Jones indicated that Breast pathways are largely self-contained and well-organised in terms of both diagnostics and treatment for patients. Therefore, focusing on the Breast pathway doesn't negatively impact other specialty areas. However, it heavily relies on the Radiology service for diagnostics. Due to capacity challenges at WGH, some activities have been temporarily transferred to Prince Philip Hospital (PPH). This puts pressure on the Radiology service, especially at PPH. Without these transfers, HDdUHB would have faced significant challenges in meeting patient needs in a timely manner. Historically and currently, the Breast pathway performs relatively well in terms of timely responses compared to other Health Boards.

SDODC agreed that the Board should be advised that the position continues to be monitored by the Committee.

Decision:
The Committee NOTED the PO4: Planned Care (Cancer, Diagnostics and Therapies Performance) Update reports.

SDODC (24)91 **Ophthalmology Performance - Getting It Right First Time (GIRFT)**

Ms Stephanie Hire and Ms Vicky Coppack joined the meeting.

Ms Stephanie Hire introduced the Ophthalmology Getting It Right First Time (GIRFT) report. Ms Vicky Coppack indicated that the comprehensive report detailed the Health Board's current status and outstanding recommendations, including the actions taken to advance them and next steps for those not yet closed. To date, 18 recommendations have been closed, with 39 still outstanding. Of these 39, 18 are almost complete, many of which are ongoing projects. These include the Wales General Ophthalmic Service (WGOS) delivery projects for glaucoma and diabetic retinopathy, as well as the ongoing work with One-Stop Cataract clinics, which became operational at the beginning of August 2024.

While these initiatives are progressing, several aspects of the recommendations still require finalisation. A practice development nurse post in Ophthalmology will be advertised soon, alongside three Speciality and Associate Specialist (SAS) doctors, one of whom is already in post. Additionally, a substantive consultant and a locum consultant, have been recruited.

HDdUHB is well positioned to complete the remaining 18 actions. A number of actions linked to the Clinical Services Plan (CSP) are being addressed as part of that broader project. This involves considerations on how to expand the service and integrate it with other services under the CSP.

Overall, significant progress on the 59 recommendations has been made, and the team is meeting weekly to advance these recommendations and close them where possible.

Ms Hire acknowledged that the team had been working closely with the Risk team on the recommendations. The transfer of these recommendations into the Audit Management and Tracking (AMAT) system had presented challenges, as it does not automatically update, requiring manual updates for each entry. Despite this, the Risk team had been highly supportive throughout the planning process, particularly given the volume of actions involving the documentation. They have dedicated considerable time to assisting the team, although Mrs Wilson indicated that the Risk team had not changed any target dates.

Mr Keith Jones advised that the service had been fragile for some time and remains one of the priority services under review through the CSP. This specialty is also prioritised for a deeper regional reflection, similar to upcoming discussions on Orthopaedics.

He indicated that it is important to remember that even with progress on the individual recommendations from the GIRFT review, this does not necessarily mean the service is no longer considered fragile. There remains a significant workforce challenge within the Ophthalmology service, which is a national issue. Therefore, while progress on these actions is crucial, it alone will not place the service on a fully sustainable pathway for the future. The Health Board must continue to consider the broader questions around a sustainable model for eye care as it moves forward.

Mr Maynard Davies noted that this report did not provide the full picture of Ophthalmology, as there is also the Clinical Service Plan element to consider.

Cllr Evans queried whether the recommendations currently being addressed, and the target dates indicated in the RAG status were realistic or optimistic. He indicated that Audit Risk and Assurance Committee (ARAC) monitors these dates closely, and as Chair, he requested assurance that the dates were achievable and not likely to be extended again. He also referenced the high cost of locums in Ophthalmology, which raised concerns about the progress being made; and noted his

concerns that even if HDdUHB meets the target dates and addresses certain points, the service will not be without risk.

Ms Coppack indicated that realistic target dates had been set; and that the 18 partially completed recommendations were progressing swiftly, particularly with the One-Stop Cataract Pre-assessment clinic, which addresses many of these recommendations. The process involved extensive documentation and coordination with the Working Control Documentation group, among other steps. This alignment is why these 18 recommendations have not yet been closed.

For the remaining 16 recommendations, which require more extensive work such as restructuring and alignment with the CSP, longer target dates were set. These are long-term goals. Ms Hire indicated that the team recognised that some of the initial dates set were unrealistic. Through the GIRFT review and other specialties, including Urology, they have worked with the Risk team to establish more realistic proposal dates. This approach ensures that HDdUHB is not rushing and compromising the quality of the service.

She agreed with Mr Keith Jones that stabilising and completing these actions alone would not fully resolve the issues in Ophthalmology. The service still faced significant challenges. This paper was prepared well in advance of the recent decision to exit the high-cost locum, which was made last week by the Financial Control Group. Any impact from that decision will be included in the next update.

Cllr Evans noted that there should be only eight open recommendations by Christmas 2024 and Ms Hire agreed to provide a further update to the Committee at that time. **SH**

In response to Mr Imperato's question regarding governance and oversight of GIRFT, Mr Keith Jones indicated that the operational team regularly monitors these reports and the GIRFT programme, which aimed to enhance productivity and efficiency in care delivery. This was the core objective of the GIRFT programme. From this perspective, SDODC oversight is appropriate. However, it is impossible to view services solely through the lens of efficiency and productivity without considering quality and impact. These reviews are the result of peer assessments conducted by a National Review team during their visits and evaluations.

Consequently, the recommendations will vary, with some fitting neatly within the Committee's remit and others less so. This presents a challenge and may prompt SDODC to reflect on how they determine the appropriate route for specific recommendations. If they pertain to quality and safety, they should be discussed within the relevant Committee. However, the recommendations often cover a broad spectrum and can be directed in various ways.

Mrs Wilson indicated that Mr Carruthers presented a proposal to Board on managing GIRFT recommendations. The proposal was clear in terms of preventing duplication across Committees. The only reason a recommendation would be called into ARAC is if it was six months past the original deadlines. This may explain why it had appeared on the ARAC

agenda, as the implementation dates have exceeded the agreed timeline by six months or more.

Any specific quality and safety issues not already addressed in the quality demand, would then be discussed in the Committee Chairs meeting to determine the appropriate Committee, thereby avoiding duplication. Mrs Wilson agreed to share the update presented to Board, as it was clear that quality issues had been tested and it no longer concerned budget delivery, but operational delivery. **JW**

Decision:
The Committee RECEIVED ASSURANCE from:

- The recommendations closed to date
- The recommendations being reviewed and progressed currently
- The future plans to address the outstanding recommendations

SDODC (24)92 **Extension to 534 - Patient Access Policy**

Ms Hire presented the Extension to the Review Dates of Strategic Development and Operational Delivery Committee - Access Policy Review, emphasising that in preparation for the renewal of the policy, the team had conducted all routine checks with the various Heads of Departments and requested comments, concluding that no changes were necessary. However, Welsh Government colleagues contacted HDdUHB to advise that the guidance was currently under review and requested the Health Board participated in this process. There was a regional WG meeting scheduled for the week commencing 2 September 2024, and the review is expected to take approximately three to four months.

Ms Hire is confident that HDdUHB is adhering to the current access policy and any previously issued guidance. However, significant changes are anticipated from Welsh Government, which will require a redraft of the Access policy. This has generated additional work, as the Health Board's response has been shared for comments within all services.

Ms Hire and Ms Coppack left the meeting.

Decision:
The Committee APPROVED the extension to the review dates of the Access policy until February 2025 when the new national guidelines are expected to be agreed.

SDODC (24)93 **Regional Orthopaedics Model**

Mr Craig Toutt joined the meeting.

Mr Craig Toutt presented the Regional Orthopaedic Model report, explaining that the Programme is a strategic initiative designed to transform orthopaedic healthcare delivery across Southwest Wales. The clinical model was approved by SBUHB's and HDdUHB's Executive Teams on 7 August 2024 and aligns with the Welsh Government's commitment to regional collaboration; and their expectations for its execution.

Mr Toutt indicated that the model functions across three locations, including Prince Philip (PPH), Neath Port Talbot (NPTH), and Morriston Hospitals. The services offered are tailored to meet the specific needs of patients. Therefore, PPH focuses on treating large numbers of patients with simple conditions, while Morriston Hospital caters to more complex cases with tertiary requirements. NPTH services are centred around patients with a high volume but less complex conditions.

The primary area of attention is on joint replacement surgeries, particularly hip and knee replacements, as these procedures represent a significant proportion of the waiting list. However, the regional approach also considers specialised areas, aiming to enhance efficiency and service quality. Efforts are underway to establish a Hand network and to segment Orthopaedic cases into subgroups for better efficiency and service improvement at a regional level. In the initial stages of this year, significant progress has been made, including the creation of a standardised procedure for joint replacement surgeries across the region, which has received approval and is currently being implemented. Additionally, there has been an increase in the number of patients from SBUHB traveling to PPH for surgery, indicating the success of these initiatives.

In response to Mr Maynard Davies' enquiry regarding waiting lists, Mr Toutt indicated that Medical Directors met on 27 June 2024 to explore how lists could initially be pooled on a subspecialty basis within each Health Board. Both teams are reviewing opportunities to share patient lists or merge waiting lists to ensure equitable service delivery, based on a regional approach. However, this approach is still in development and involves building alliances with clinicians to improve engagement and overcome operational challenges between the two Health Boards, who are identifying various processes and procedures needing to be addressed, ranging from digitalisation to establishing a centralised booking team in both Health Boards. Some of the differences in how these processes are currently managed, such as the pooling of patients, have been broken down into subspecialty levels, and pooling patients within each Health Board is now being investigated. The goal is to determine if pooling on a regional basis is feasible in the future.

Mr Imperato enquired when both Health Boards would be able to determine if this approach is effective and raised concerns that the host Health Board receives most of the benefits; and that there is an ongoing worry regarding the quality of patient treatment for those who are contracting in.

Mr Toutt advised that observing reciprocal activity across both Health Boards would indicate that the model is beginning to embed effectively. Increased activity corresponding with a reduction in waiting time disparities will suggest that the model is becoming successful, but this depends on resource investment and clinical engagement. Currently, the model is in the early stages, with SBUHB patients being treated at PPH. PPH patients now need to commence treatment at SBUHB. This is not a short-term solution but a long-term programme to achieve these benefits. Within the next six months, reciprocal activity should commence across both Health Boards.

Mr Toutt acknowledged that host organisations often benefit more, and he strives to remain as independent as possible and consider both Health Boards equally. The financial investment, aligned with the business case presented to the Welsh Government, and the resource requirements for staffing the three theatres in SBUHB were ongoing discussions.

Mr Carruthers indicated that from the perspective of Welsh Government, their measure of success would be a reduction in the number of patients waiting over 104 weeks, eventually moving towards 52 weeks. Their primary metric for success is predominantly waiting times. While reciprocal activity will be beneficial, it will not necessarily increase activity at present. A fundamental challenge across the region is the insufficient workforce to deliver the required and funded number of sessions, presenting a recruitment challenge the Health Boards are working to address. Early signs of success may be observed in the regional appointments now being made, with job plan sessions in both Health Boards. This will facilitate reciprocal activity. A move towards a more pooled waiting list, even for the long-waiting cohort, will see better use of capacity across the region, targeting the longest waiters first. Currently, HDdUHB would benefit from this approach as they have more patients waiting over 104 weeks than SBUHB.

In some sub-specialty areas, promising discussions are occurring regarding regional models, such as the plan for Hand services developed by clinicians. The significant challenge for HDdUHB, and for Mr Carruthers in his Senior Responsible Officer (SRO) role regionally, is addressing the Arthroplasty challenge, which is the primary driver of waiting times. This includes engaging arthroplasty surgeons, where there are notable engagement issues. This challenge was not unique to HDdUHB surgeons but was also present at SBUHB.

Mrs Marks, in emphasising the importance of regional working, queried clinician commitment to deliver the programme; and ensuring cultural change. In addition, she also enquired whether all HDdUHB and SBUHB sites would be included in the programme at a later stage.

Mr Carruthers indicated that the regional programme involves collaboration with SBUHB, focusing on the sites at NPTH, Morriston, and PPH. Currently, the roles of Bronglais (BGH) and Withybush Hospitals remain unchanged.

There is a necessary alignment with the CSP, particularly regarding the roles of these sites as they emerge from ongoing discussions. While this links to regional work, these two sites are largely unaffected in the context of the regional programme. However, there is a broader question about how BGH fits into the Mid and West Wales position on a larger scale, and whether further discussions with Betsi Cadwaladr UHB and Powys Teaching Health Board are needed.

Regarding workforce, HDdUHB has significant physical theatre space. Using Arthroplasty as a proxy, both organisations need 25 Arthroplasty lists per week to meet monthly demand. Although 25 sessions are available, staffing all sessions in both Health Boards is challenging. To

reduce waiting times to closer to 36 weeks, both organisations would need approximately 60 sessions per week over a 2–3-year timeframe. This regional conversation requires a different approach with clinical colleagues, emphasising the need for engagement. Currently, HDdUHB surgeons do not need to access theatre capacity elsewhere as they are utilising all available capacity. However, there is more incentive for SBUHB, as they have patients who can only be treated at PPH due to clinical guidelines and lack of theatre capacity at Morriston Hospital. These patients, often referred to as 'Morriston-Only,' have experienced long waits due to their non-urgent status.

There is a strong incentive for surgeons to travel to PPH for new sessions and bring their work there, as it allows them to treat a group of patients who would otherwise face long waits in SBUHB. Until the HDdUHB workforce and consultant numbers increase, neither Health Board will be in a position where surgeons are competing for sessions across the two sites. Additionally, it will be challenging to engage some local colleagues in this work, as there is no immediate clinical reason for them to participate.

Mr Mark Henwood and Mr Carruthers are addressing this challenge and plan to have an internal meeting with the HDdUHB Arthroplasty team in the coming weeks, involving Ms Christine Davis to foster a cultural conversation. HDdUHB will continue to work with the Medical Director at SBUHB, to bring the teams together and encourage them to work collaboratively. If the initial phase can be overcome, they may be able to consider the broader benefits of regional collaboration, such as developing a hub for complex revision surgery.

Mrs Marks enquired whether there Is there a shortage of consultants in this area across Wales and the UK, or whether attracting individuals to West Wales is challenging?

Mr Carruthers indicated that It is a very competitive market, with Orthopaedics traditionally being a challenging specialty in terms of capacity, demand management, and waiting times. Consequently, there is competition across the UK for orthopaedic capacity. This also applies to accessing external independent sector demand, with many trying to enter this space. Jointly across the region, Health Boards are exploring how to outsource or insource Orthopaedic services to maximise value for money.

In response to Cllr Evans question regarding staff engagement with the regional model, Mr Carruthers indicated that presently, interest is mixed. In some subspecialties, excluding Arthroplasty, there is a clear interest, and individuals are actively participating in discussions to determine how to implement the regional model. The most advanced in this regard is the Hand subspecialty. Recently, a shoulder surgeon was appointed to WGH, who was attracted by the regional model, which allows him to engage in complex work out of SBUHB and integrate into the broader framework. There are definite benefits to this approach. However, Arthroplasty presents a challenge due to its high volume and the difficulty in achieving engagement within this subspecialty. Engagement is not unanimous across all pathways, but there is participation in some areas.

Mr Toutt left the meeting.

Decision:
The Committee NOTED the progress the Regional Orthopaedic Programme has made to date.

SDODC (24)94 **Integrated Performance Assurance Report (IPAR)**

Mr Huw Thomas presented the Performance Update for Hywel Dda University Health Committee – Month 4 2023/2024 and highlighting the following:

- Workforce:
  - Sickness levels have increased for the seventh consecutive month
  - Impact on finances and performance is expected
- Staff Survey:
  - Increased pressure on staff
  - Performance is below the median across almost all measures
- Unscheduled Care:
  - Ambulance call rates have stabilised but remain below 50% within eight minutes
  - Ambulance handovers have improved over the last five to six months but remain concerning
  - 4- and 12-hour A&E wait times show concerning trends
- Child Neurodevelopmental Services:
  - Low performance, but Attention Deficit Hyperactivity Disorder (ADHD) assessments are improving
- C-difficile:
  - Deterioration in performance

In response to Mrs Marks enquiry regarding 12-hour waits, Mr Keith Jones indicated that the 12-hour wait challenge in Emergency Departments (EDs) primarily reflects the difficulties in transferring patients who require admission into designated hospital beds, but face delays due to pressures on available capacity to accommodate them.

In response to Mr Imperato's query regarding staff sickness, Mr Thomas conformed that the issue is regularly considered at People, Organisational Development & Culture Committee (PODCC).

SDODC agreed that the Board should be advised of staff sickness levels.

Decision:
The Committee NOTED the report from the IPAR – Month 4 2024/2025.

SDODC (24)95 **Targeted Intervention Update (SDODC Elements)**

Mr Shaun Ayres joined the meeting.

Mr Shaun Ayres presented the Targeted Intervention update (SDODC Elements) report, highlighting the following:

- Committee Alerts:

    - Of 14 alerts, nine relate directly to SDODC
    - These alerts are clearly identified and aligned with the Committee's focus
- 100-Day Programme Cycle:
    - Now exceeds 50-55 days
    - Attention is drawn to the delivery of the original intentions, particularly in medical variable pay and critical care
    - Other programmes are off track and unlikely to meet their original goals
- Mitigating Actions:
    - Addressed through the Targeted Intervention and Annual Plan Recovery Workshop
    - Outcome will be discussed in a Board Seminar
    - Options will focus on fragility and winter pressures
    - Choices will aim to meet the £64m target set in the Annual Plan
- Urgent Care and Cancer Performance:
    - Improvement in 1-hour ambulance handovers in Pembrokeshire and WGH
    - Significant challenges remain, both against TI escalation criteria and the Annual Plan
    - Awaiting latest cancer performance data
    - Target is 70% for TI, with an Annual Plan goal of 75% by March 2025
    - Concerns about meeting this target, despite ongoing good work

Cllr Evans enquired whether Mr Ayres was equally concerned about all alerts, or if there were any areas with potential for improvement. In response, Mr Ayres indicated that in some Planned Care areas, he was more confident, despite the challenges discussed in Ophthalmology. Balancing the focus on achieving the £64m target while ensuring that performance and quality remains central is crucial, given the 56 clear criteria of TI, many of which are outside finance. He also indicated that winter pressures and cost reduction expectations on the teams should be considered.

SDODC agreed that the Board should be advised of the targeted intervention position.

<u>Decision</u>:
The Committee:

- NOTED the actions being taken in response to Targeted Intervention, including the development of plans for the nine Alert criteria aligned to SDODC and the initiation of six key programmes for financial sustainability and service improvement
- DISCUSSED and sought further assurance on the improvements required in Urgent Care and Cancer performance to meet Welsh Government targets, including the 30% reduction in ambulance handovers over one hour and 70% of cancer patients starting treatment within 62 days by March 2025

SDODC (24)96 **Commissioning**

Mr Ayres presented the Commissioning Report August 2024, highlighting the following:

- Savings Achievement:
  - Total savings of £2.3m this year by the Commissioning and Contracting team
- Increased Pressures:
  - Rising run rates in areas such as Cardiology, both elective and non-elective
  - Increase in Intensive Therapy Unit (ITU) bed days linked to General Surgery and Cardiology
  - Complex areas where mitigating actions are difficult, such as Aortic Aneurysms
- Obstetric Pathway:
  - Efforts to repatriate more activity to benefit both Service Level Agreement (SLA) and Long Term Agreement (LTA)
- Plastic Surgery:
  - Slight increase in costs due to significant backlogs
- Computerised Tomography Simulator (CT SIM):
  - Additional cost of approximately £98k for a second CT SIM
  - Commissioned to 34.5% capacity, delivering 832 units of activity compared to the current 602 under CT1 temporary SIM, an increase of 230 units

Mr Maynard Davies indicated that because SDODC is now the lead Committee on Commissioning for all aspects, while the Sustainable Resources Committee (SRC) will only handle the financial implications, less frequent in-depth discussions were likely to be more beneficial than brief overviews at each meeting. Reports would therefore be presented on a bi-annual basis.

SDODC agreed that the Board should be advised that the position is being managed.

Mr Ayres left the meeting.

Decision:
The Committee:

- APPROVED the frequency of future commissioning reports bi-annually, based on the required level of detail and oversight
- AGREED the specific content of future reports, focusing on key commissioning activities, service delivery outcomes, and how these services align with strategic priorities and address capacity and demand pressures
- NOTED the significant scope and activity of commissioned services, with expenditure exceeding £185m
- CONSIDERED the strategic direction to ensure that these services effectively manage capacity and deliver on high-pressure areas
- NOTED that while financial performance is disaggregated through LTAs, future commissioning reports should also consider how financial resources align with service delivery to ensure sustainability and responsiveness to demand

SDODC (24)97 **A Healthier Mid and West Wales Update**

Mr Lee Davies presented the Implementing the A Healthier Mid and West Wales Strategy update report.

Decision:
The Committee:

- NOTED and CONSIDERED the update provided in this report relating to implementing the A Healthier Mid and West Wales Strategy, specifically:
    - The clarification to be sought by the Interim Chief Executive on the additional scenarios required to be appraised as part of the SOC
    - The further work underway to assess and agree the resource schedule and timeline for SOC completion
    - That the impact on cost and timeline is likely to be exacerbated if HDdUHB is required to explore additional scenarios
    - That the Health Board is seeking legal opinion on the potential implications of exploring new scenarios in the SOC
    - The clarification sought in relation to the endorsement of the PBC
    - The update on the AHMWW Community schemes and the associated capital and revenue affordability challenges.
- APPROVED the final version of the management response to the Nuffield Trust review (Appendix 1) and oversee the implementation of the actions in accordance with the agreed timescales

SDODC (24)98 **Capital Programme**

Ms Eldeg Rosser joined the meeting.

Ms Eldeg Rosser presented the Capital Programme for 2024/25 and Capital Governance Update Report, highlighting two key items in the report:

- The identification of VAT recovery funds amounting to £200k, which is proposed to reinvest into the capital programme. The Capital Planning Group suggests allocating these funds to spend-to-save projects, such as purchasing equipment currently being hired or leased, thereby alleviating pressure on revenue budgets.
- The proceeds from the disposal of the On Street Clinic and Penlan, which will contribute towards the capital costs of occupying Picton Terrace. Additionally, a proposal to allocate over £500k from the Discretionary Capital Programme (DCP) over the next five years to support this capital development. This would require a pre-commitment of £110k per annum from next year onwards against the DCP.

Ms Rosser left the meeting.

Decision:
The Committee:

- NOTED the update on the Capital Programme and CRL for 2024/25
- NOTED the updated digital allocation

- NOTED the amended equipment prioritisation
- ENDORSED the use of the VAT recoveries to create a spend to save allocation in 2024/25
- NOTED the capital schemes governance update
- NOTED the RAAC update
- ENDORSED use of the proceeds of disposal from Pond Street and Penlan and pre-commitment of the DCP at £110m phased over five years for the Picton Terrace project
- NOTED the update from Capital Sub Committee

SDODC (24)99 **SDODC Work Programme 2024/25**

The Strategic Development and Operational Delivery Committee NOTED the SDODC Annual Workplan.

SDODC (24)100 **ANY OTHER BUSINESS**

Winter Respiratory Vaccination Programme 2024_25

Mr Maynard Davies requested the Committee's approval for the Winter Respiratory Vaccination Programme 2024-25.

Decision:
The Committee:

- APPROVED the proposed delivery plan for the HDdUHB Winter Respiratory Programme
- NOTED the work underway to mitigate the risk to programme delivery of the proposed approach
- RECEIVED ASSURANCE from the control measures in place through recognition of the key enablers

SDODC (24)101 **MATTERS AND RISK FOR ESCALATION TO BOARD**

None were noted.

SDODC (24)102 **DATES OF FUTURE MEETINGS**

Thursday 31 October 2024 09.30 – 12.30
Venue: In-person (Ystwyth Boardroom) and MS Teams

Thursday 19 December 2024
Thursday 27 February 2025