MINUTES OF THE HDD STRATEGIC DEVELOPMENT & OPERATIONAL DELIVERY COMMITTEE MEETING

Date of Meeting: **09:30, Thursday 19 December 2024**
Venue: **Microsoft Teams Meeting;**

Present: Mr Maynard Davies, Independent Board Member (Chair)
Mr Michael Imperato Independent Board Member (Vice Chair)
Cllr Rhodri Evans, Independent Board Member
Mr Winston Weir, Independent Board Member
Ms Eleanor Marks, Hywel Dda University Health Board (HDdUHB) Vice Chair

In Attendance: Mr Lee Davies, Director of Strategy and Planning
Mr Andrew Carruthers, Chief Operating Officer
Mr Huw Thomas, Director of Finance
Miss Jill Paterson, Director of Primary Care, Community and Long Term Care
Mrs Joanne Wilson, Director of Corporate Governance/Board Secretary
Dr Ardiana Gjini, Director of Public Health
Ms Helen Mitchell, Committee Services Officer
Ms Marilize Preez, Improvement and Transformation Lead (Observing)

Item SDODC (24)129
Mr Shaun Ayres, Deputy Director of Operational Planning and Commissioning

Item SDODC (24)130
Ms Bethan Lewis, Interim Assistant Director of Public Health

Item SDODC (24)131
Ms Trina Nealson, Principal Public Health Practitioner

Item SDODC (24)132
Mr Keith Jones, Director of Operational Planning & Performance

Item SDODC (24)133
Ms Steph Hire, General Manager Scheduled Care Services
Ms Vicky Coppack, Service Delivery Ophthalmology & Neurology

Item SDODC (24)137
Ms Kim Neyland, Strategic Partnership Manager

Item SDODC (24)138
Ms Eldeg Rosser, Head of Capital Planning

Item SDODC (24)140
Mr Paul Williams, Head of Property Performance

Action

SDODC (24)124 Introductions and apologies

Mr Maynard Davies welcomed members to the virtual Strategic Development and Operational Delivery Committee (SDODC) meeting.

SDODC (24)125 Declarations of Interest

Cllr Rhodri Evans declared an interest in agenda item SDODC (24)138: Capital Programme 2024 - Plan for the Pentre Awel, Carmarthen Hwb and Cross Hands projects as a Local Authority Councillor.

Minutes and Matters Arising from the Meeting held on 31 October 2024

RESOLVED - the minutes of the SDODC meeting held on 31 October 2024 were **APPROVED** as an accurate record of proceedings.

SDODC (24)126 Table of Actions from Meeting Held on 31 October 2024

All actions were complete with no matters arising.

SDODC (24)127 Self-Assessment 6 Month Review (incl Self-Assessment Timelines)

Mrs Joanne Wilson presented the Self-Assessment 6 Month Review report, indicating that the team is currently working on both the new operational structure and the new corporate Committee structure simultaneously. It is hoped this will all be completed by 1 April 2025, aligning with the start of the new Committee cycle. Ms Wilson also indicated the documents, and other necessary materials are already prepared, with further work required to address impacts and outcomes elements.

Decision: The Committee RECEIVED ASSURANCE from the progress made against the actions being undertaken to improve its effectiveness.

SDODC (24)128 Corporate Risks Related to SDODC

Risk 1350: *Risk of not meeting the 75% Single Cancer Pathway (SCP) waiting times target for 2022 - 2026 due to diagnostics capacity and delays at tertiary centre*

Mr Andrew Carruthers explained that the reason for the risk increase was due to performance being behind the planned improvement trajectory over recent months.
A revised trajectory had been developed for the period to the end of March 2025.

While there is an anticipation of performance improvement in the upcoming months, the fragility of the position and the inability to meet the original Annual Plan targets led to the decision to increase the risk score for this month.

Mr Maynard Davies raised a query regarding the performance issues, specifically the backlog in Radiology reporting. Referencing the recent unsuccessful Welsh Government (WG) bid for extra funds to address this issue, Mr Davies enquired about

the potential impact of the additional funds, acknowledging it as a hypothetical question. Mr Carruthers explained that the Radiology performance issues were twofold: the scanning element and the reporting element in the Cancer pathway. The main challenge was with the reporting, and the issues had been managed at a relatively low cost over recent months and would continue to be managed within the current funding until the end of the year.

Mr Carruthers indicated that the lack of full funding has impacted routine and direct access wait times, which are now forecast to be between 2,000 and 3,000 by the end of the year, despite initial expectations to reduce them to zero. Advising that last year, the wait times were around 10,000 to 11,000 by the end of the year. Although there has been significant improvement, the original targets set in the Annual Plan will not be achieved due to these challenges and pressures.

Ms Eleanor Marks enquired about the actions in place to predict improvement from November 2024, expressing concern about potential optimism bias and sought assurance on the feasibility of achieving close to 75% performance. Mr Carruthers acknowledged the challenge in forecasting performance due to variability in Radiology reporting and backlog explaining that the performance figures were calculated based on validated data at the end of the month, which could be impacted by the backlog in Radiology reporting. The team was monitoring various milestones and metrics daily and weekly to track the pathway from referral to treatment. Indicating there was confidence in the November 2024 performance forecast due to higher performance at relative points compared to previous months. Reducing reporting delays and the overall backlog of patients waiting over 62 days should help to manage variability and improve performance. The goal is to reduce the backlog to around 200 patients to achieve close to 75% performance, with a more consistent performance over 60% as the first step. The team is currently tracking 2,000 to 3,000 patients on any given day, highlighting the volume of activity and efforts to navigate patients through the Cancer pathway as quickly as possible.

Regarding the risk of delivering against Ministerial Priorities, Mr Maynard Davies' enquired whether, if the Health Board had known of the additional funding , would the risk would have been reduced this month. Mr Carruthers explained that the cautious approach this month was due to the timing of activities commencing in January 2025. There was still a risk of 50 to 100 Orthopaedic patients due to the delivery timeframe of providers. The time lapse between funding allocation and providers starting the work had contributed to this risk. There was cautious optimism about clearing the 104-week backlog by the end of March 2025, but uncertainty remains.

Decision: SDODC 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.

SDODC (24)129 Targeted Intervention Update

Mr Shaun Ayres joined the meeting.

Mr Lee Davies introduced the Targeted Intervention (TI) Update report, indicating that there was a new approach to reporting TI progress, focusing on key areas relevant to each Committee. The TI report at the start of the agenda is used to frame key discussion points for Committee meetings. This approach aims to help Independent Members (IMs), focus on the most critical issues. Mr Lee Davies invited Committee members to provide reflections on the reports produced and suggest any amendments or developments. Emphasising the importance of feedback for improving the reports.

Mr Lee Davies then highlighted the significant item regarding the development of the Annual Plan for the next year. A significant amount l of work has been undertaken with the directorates on developing their Plans. The process is still early, with another set of submissions expected tomorrow. The team will work through these submissions to assess progress and identify further actions needed over January, February, and March 2025. This work is linked to discussions with the Board and other parallel discussions.

Mr Shaun Ayres provided an update on the planning cycle and TI, emphasising the difficulty in disaggregating the two and highlighted the process set out. Mr Ayres expressed several key concerns, including the £20m savings expectation for the year and the intrinsic link between performance and funding allocations, especially concerning Cancer diagnostics and Unscheduled Care performance. Highlighting the significant gap between demand and capacity, particularly in Diagnostics and Unscheduled Care, stressing the need for robust plans around Cancer and Unscheduled Care performance, linking it to finance allocations and de-escalation status.

Mr: Ayres indicated that the planning submission is an ongoing process and may require several more weeks to obtain clear performance answers, highlighting the importance of the second submission and upcoming escalation meetings. An Annual Plan workshop is scheduled for 9 January 2025, focusing on workforce assumptions. Targeted one-on-one conversations and virtual workshops with individual teams will be conducted to ensure plans triangulate as expected.

Ms Marks questioned the escalation process for issues lasting three to four months, urging the Executive Team (ET) to address this; and stressing the importance of coordination and linkage across all Committees.

Mr Lee Davies outlined the new escalation and Care Group arrangements, highlighting the need to define Care Group autonomy and actions if improvements are not seen. The Committee noted the escalation framework's upper limit of Level 3 and the need for further discussions on actions beyond this level.

Mr Davies acknowledged the lack of clear actions beyond the current escalation level and the complexity of performance management at both team and individual levels.

Ms Marks emphasised the importance of managing the performance of particular areas, stressing the need for clear communication and assurance that the ET is addressing these performance management issues.

Mr Huw Thomas referencing the ongoing transition into a new Care Group structure, emphasised the need to manage change over the next three to four months and the maturity required for the new structure; and raised the question of whether the escalation status of directorates will be inherited by the new Care Groups or whether there would be a period of latitude before retesting for escalation, highlighting the need for discussion and debate on this matter. Mr Thomas reflected on what escalation would look like in the new structure, noting that there will be fewer Care Groups and therefore fewer areas in escalation. Stressing the importance of having an effective escalation process with tangible outcomes, Mr Thomas highlighted the need to redesign the escalation status approach and seek the collective wisdom of the Board. The Committee noted that discussions with IMs will take place in the New Year to determine the new approach.

Mr Winston Weir enquired about the stage at which the demand and capacity graph would be merged to understand the gap across all services, including Secondary, Primary, and Community Care. Mr Weir also raised a question about integrating prevention mechanisms into an integrated plan, noting that the current timetable seems light on prevention and demand management schemes, as well as the impact and input from Public Health.

Dr Ardiana Gjini emphasised the importance of integrating more prevention throughout the Care Groups, indicating that work had already started with Clinical Leadership Groups and the Medical Leadership Group. The planning cycle for the next year would include mechanisms and tools to increase prevention activities, alongside the development of the Primary Care and Community Strategic plan.

Dr Gjini highlighted the need to integrate primary prevention activities with the services delivered by the Health Board and its partners. The process will involve planning through the development of the Primary and Community Strategic plan and the refresh of the overall Strategy.

In referencing the timescales set out for December 2024 and January, February, and March 2025, Mr Weir emphasised the importance of understanding how prevention mechanisms in Primary Care fit into these time scales and priorities: and prioritising them. Dr Gjini acknowledged the importance of articulating prevention mechanisms in a strengthened way; and stressed the need to ensure that all prevention activities were clearly integrated into the plan.

Mr Lee Davies provided an update on the demand and capacity analysis, indicating that there was already good analysis for Planned Care and Endoscopy, with further iterations to be discussed in January and February 2025. The Committee noted that while some areas had robust analysis, others, such as Radiology, were still being improved; and that Primary and Community Care would require further development over time.

Mr Carruthers referenced ongoing work with the NHS Executive on modelling and simulation for Urgent and Community Care (UEC) systems, focusing on Carmarthenshire, noting that outputs in the upcoming months would describe these systems in a new way. Mr Weir highlighted the opportunity to work with Swansea Bay Health Board (SBUHB) and other stakeholders on demand and capacity analysis.

Mr Michael Imperato requested clarification on the Stakeholder Reference Group's (SRG) composition and role. Mrs Wilson explained that the SRG is one of the mandated advisory groups to the Board, chaired by Mr Jeremy Hockridge, an Associate Member of the Board. The group represents the voice of the community and provides valuable input into the Board's activities. Mr Imperato questioned whether the group could be engaged earlier in the process for co-production purposes. Mrs Wilson indicated that the Health Board engages with the group as early as possible, depending on their meeting schedule, advising that the group had requested earlier engagement, and the current timeline was aligned with the plan being worked on by Mr Ayres and the team.

Mr Ayres reported that there were currently ten alert statuses out of the 27 criteria associated with the Committee, highlighting several key areas of concern:

- Ophthalmology Performance: Mr Ayres noted that the current level of performance in Ophthalmology was significantly below the expected level. The baseline was 45% at the start of Targeted Intervention, with a goal of 65%. However, performance dropped to 36% in September and 35% in October 2024. He emphasised the need to understand the gap between demand and capacity and the impact of existing resources.
- Cancer Performance: Mr Ayres highlighted the target of achieving 60% for three consecutive months. However, performance had been below 50% for the last three months, with 40% in September and 44.6% in October

2024. Mr Ayres stressed the importance of clear actions for both larger tumour sites such as Urology, Dermatology, Upper Gastrointestinal (UGI) and smaller ones such as Gynaecology.

- Unscheduled Care: Mr Ayres expressed concern regarding the deterioration in Unscheduled Care performance, similar to previous years, noting that ambulance handovers were starting to increase, which is a trend that needs to be addressed in the New Year.

Mr Ayres emphasised the need for strong plans for 2025-26 and clear oversight on the areas of concern for the remainder of the financial year.

Cllr Evans stressed the need for critical problem-solving, clear time scales, and specific targets. Mr Ayres agreed, emphasising granular breakdowns of plans, understanding the impact of actions, and ensuring clear oversight.

Mr Lee Davies stressed the importance of specifying dates and assessing the impact of ongoing actions, emphasising the need for the Committee to be assured or concerned based on progress. Mr Lee Davies also suggested future reports should clearly state dates and improvement expectations for each criterion. If information is unknown or unassured, it should be clearly stated to avoid ambiguity. Explaining there are two categories of alerts: those with some assurance of progress and those without, Mr Lee Davies indicated that this distinction should be clearer in future reports. **SA**

Cllr Evans emphasised the importance of having timescales and targets to track progress, noting that many of the issues have been ongoing for years and having specific dates to track against would be helpful. **SA**

Ms Marks enquired whether the ten alerts should be included in the Corporate Risk Register and expressed concern about the mismatch between communicated information and performance improvements, highlighting specific concerns regarding Neurodevelopmental (ND) waits, Cancer, and ambulance delays, stressing the reputational risk. Ms Marks then emphasised the importance of public transparency and suggested ensuring a "golden thread" of information across Committees to avoid duplication, recommending this for consideration by the Executive Team and Committee members.

Mr Huw Thomas emphasised the need to link alerts with de-escalation plans and ensure reporting is proportionate and relevant for the Committee, noting that this is a governance space, not operational, and the detail should reflect that.

Mr Lee Davies referenced the existing process of linking alerts to the Corporate Risk Register and suggested improving the connection between identifying, scoring, and mitigating risks in

next year's Plan. Mr Lee Davies highlighted Cancer, Unscheduled Care, and ND as main concerns, requiring robust operational plans, noting recent deteriorations, such as the ambulance handover position at Withybush Hospital (WGH), and stressing the need for strong plans to address these issues.

Ms Marks shared public criticism about the Health Board's performance, particularly ambulance wait times and A&E delays, emphasising the importance of addressing these issues and the challenges of high demand and fragile services during winter.

Mr Lee Davies agreed that performance in the identified areas was unacceptable, noting that both the Executive Team and Welsh Government share this view. Mr Lee Davies emphasised the seriousness with which these issues are being taken and acknowledged the substantial challenges that need to be addressed.

Ms Wilson confirmed that the risks are covered under wider risks and may not be in the sight of this Committee, advising that the UEC risk is a corporate risk discussed in detail at the Quality Safety and Experience Committee. Mrs Wilson agreed with the need to balance assurance with operational management.

Ms Wilson acknowledged that while changes had been made to the way reports were presented, there was still room for improvement, as the Triple-A report was not originally designed for its current use within the Health Board. While it has been helpful, it was not the initial intention when it was introduced from the Committee's perspective; and suggested working with the Chair, Mr Lee Davies and Mr Ayres to refine the report to better meet the Committee's needs.

Ms Wilson then proposed continuing to link with the Committee Chairs' meeting to help with alignment and avoid duplication, indicating that one Committee should own the issue, and the Audit & Risk Assurance Committee (ARAC) should oversee the assurance process across all Committees.

In response to Mr Imperato’s query, Mr Ayres emphasised the importance of quantifying the impact of actions, providing examples of running additional lists and clinics to reduce backlogs, highlighting the need for granular detail, oversight, and specific actions in plans. Mr Ayres stressed the importance of understanding the time required to achieve and maintain balance to prevent backlog spikes.

Mr Ayres also indicated that if balance couldn't be maintained, it could lead to financial risks, such as the need to insource, outsource, or incur additional costs; and emphasised the need for specific actions across all areas and being clear about the expected impact.

Mr Lee Davies highlighted the need for the Committee to be advised on whether there was a set of actions and an improvement trajectory that delivered the expected improvement, emphasising the importance of monitoring delivery against the improvement trajectory.

Mr Maynard Davies reiterated that the Committee's role was to ensure the delivery of actions, not necessarily the details of how they were being delivered.

Mr Ayres left the meeting.

Decision: The Committee RECEIVED ASSURANCE on the actions being undertaken to develop the 2025/26 Annual Plan

SDODC (24)130 Deep Dive PO10: Population Health

Ms Bethan Lewis joined the meeting.

Ms Bethan Lewis presented the Deep Dive Planning Objective 10: Population Health update report, indicating that despite capacity gaps at consultant level, good progress had been made against the process-oriented planning objectives set for 2024-2025. The focus had been on understanding the impact of these objectives on population health in West Wales. Additional actions had been identified to strengthen key deliverables for Quarters (Q) 3 and 4. An update was provided on indicators, including the following:

- The vaccine uptake for children reaching their fifth birthday improved to 86.1% in Q2, with significant improvement in the Measles, Mumps Rubella (MMR) Dose 2 vaccine.
- Improvement in vaccine uptake to 90.9% in Q2, despite a reduction in Pembrokeshire.
- Efforts to improve MMR vaccination uptake for staff, with support from Occupational Health colleagues and Primary Care teams.
- Continuous improvements in uptake areas, with discussions on improving the lowest uptake areas.

Ms Lewis indicated that the planning objective directly attributed to Risk 1884: *There is a risk that the Hywel Dda Public Health Team may struggle to support the Health Board's priorities for 2024-25 or fulfil statutory functions, including responding to acute outbreaks, due to limited capacity* had been reviewed, resulting in a reduced score of 12. The Deputy Director of Public Health had commenced their role, and consultants were gradually returning to work post-leave, which should further reduce the risk in Q3.
Mr Maynard Davies raised concerns about the drop in COVID-19 and influenza (flu) vaccinations among the adult and older population, questioning whether vaccine exhaustion or apathy may be contributing factors. Ms Lewis acknowledged the concern and noted that similar trends are being observed across Wales, referencing factors such as vaccine hesitancy, fatigue, and accessibility which were contributing to the lower uptake. Efforts are being made to improve accessibility through GP clusters and targeted approaches. In response to Mr Maynard Davies'

suggestion to increase efforts on social media to promote vaccinations Dr Gjini emphasised the importance of seasonal vaccinations for winter preparedness, highlighting the need to increase awareness of the benefits of vaccination and improve availability and access through Primary Care. Dr Gjini noted that the immunisation programmes covered almost 20 different areas; and highlighted the significant achievement of approaching 90% uptake for MMR Dose 2 for children, crediting Primary Care teams and Vaccination teams for their efforts, acknowledging the challenges ahead and the need for continued efforts to increase seasonal vaccination uptake.

Ms Lewis provided an update on a recent meeting with Welsh Government, advising that the message in England, using the NHS strapline, has been synonymous with flu and COVID vaccines, and has led to people disengaging. Efforts are being made to undo this by using trusted community leaders and voices.

Mr Weir enquired about the key achievements so far and how the impact was being measured, highlighting the importance of understanding the return on investment, not only financially but also in terms of health population benefits. Mr Weir also requested an update on the development of the Social Innovation Institute with Trinity Saint David's.

Dr Gjini explained that Public Health interventions, programmes, and services were generally adopted and implemented based on strong cost-effectiveness evidence, noting that there are no Public Health interventions in place with a lower evidence base. Social prescribing, for example, has been difficult to measure nationally due to its broad nature. Dr Gjini emphasised that Public Health interventions were introduced based on a cost-effectiveness threshold of £30k or less, as used by National Institute for Health and Care Excellence (NICE), highlighting that the directorate conducted a return on investment analysis on three key interventions, which showed very strong results. Dr Gjini stressed the importance of appreciating the benefits and impact of various prevention and Public Health programmes on the population; and advised against spending additional resources to prove the return on investment of Public Health programmes, suggesting instead a focus on applying and strengthening these interventions across the Health Board.

Dr Gjini provided an update on the development of the Social Innovation Institute with Trinity Saint David's. The academic institution has dedicated staff and resources to drive the initiative forward. An agreement has been received, and a meeting is scheduled in early January 2025 with the former Dean of Trinity Saint David's to finalise the agreements and discuss regional investments. The Institute will focus on raising funds and donations to prioritise research areas for social research.

Mr Weir emphasised that the return on investment did not have to be financial but could be outcome-based, highlighting the

importance of tracking areas such as immunisation, healthy weight, and reducing harm from alcohol, drugs, and tobacco. Mr Weir suggested establishing a baseline to measure changes over time and demonstrate the impact of interventions.

Dr Gjini acknowledged the importance of measuring outcomes and indicated that the return on investment for drugs, alcohol, immunisation, and tobacco had been estimated; and emphasised the need to strengthen the way outcomes are measured, both individually and at the population level. The Committee noted that this objective will continue to be a focus for the next year's planning.

In response to Ms Marks questions in the MS Teams Chat, Ms Lewis indicated that GP out of hours vaccination levels were lower due to the higher proportion of staff who are in the age group who previously would have assumed immunity (pre-1971). Many feel they are immune and wish the Health Board to explore antigen testing rather than simply accept a vaccine. Ms Lewis is working with the team to see how this can be overcome. The risk to service delivery is that contact without full immunisation will result in 21 days isolation.

Ms Lewis indicated that the absence of Prince Philip Hospital (PPH) Acute Medical Admissions Unit (AMAU) data is due to the complexity of data due to there being no dedicated AMAU team. The risk would be considered as Level 2 hierarchy because the Minor Injuries Unit (MIU) is more likely to have the initial contact. This is being explored this with the Occupational Health team.

Decision: The Strategic Development and Operational Delivery Committee RECEIVED ASURANCE on Quarter 2 progress and the Directorate's commitment to exploring the impact of objectives on population health and actions for further improvement.

SDODC (24)131 Principle of Social Model for Health and Well Being

Ms Trina Nealon joined the meeting.

Dr Gjini introduced the Embedding a Social Model for Health and Wellbeing report, indicating that the multi-agency Social Model for Health and Well Being Steering Group had agreed to develop principles to be adopted by all regional organisations and agencies, as well as the Well-being Future Generations Commissioner. The group was progressing with embedding these principles and developing a charter for the region's Social Model for Health and Well-being. The charter is expected to be launched at a summit in March 2025.

Ms Trina Nealon provided an update on the progress made in developing the Social Model for Health and Well-being. The steering group had agreed on six principles outlined in Appendix 1 of the report. The team plans to progress these principles to the next stage, including a framework, a charter, and a maturity

matrix. The embedding group will work on identifying the characteristics needed to achieve each principle and how to measure progress.

Ms Nealon emphasised that the framework was evolving and would involve organisations, communities, and partnership groups. The principles will be launched at a celebratory summit event on March 20, 2025, with keynote speakers including Michael Marmot and Cormac Russell.

Ms Lewis and Ms Nealon left the meeting.

Decision: The Strategic Development and Operational Delivery Committee RECEIVED ASSURANCE that the Health Board is taking forward as per annual plan 2024-25 the social model for health and wellbeing by supporting the definition and principles as outlined in Appendix 1, and subsequent actions outlined.

SDODC (24)132 Deep Dive PO4: Planned Care Update

Mr Keith Jones joined the meeting.

Planned Care
Mr Keith Jones provided an overview of Planned Care, highlighting the focus on Stage 1 Outpatient (OP) position and the means of removing patients from waiting lists for reasons other than treatment.

Mr Jones emphasised the greater focus on the clinical interface with patients, ensuring that patients are recommended for surgical or other interventions for the right reasons. Historically, patients may have been added to waiting lists as a "watch and wait" approach, but there is now a more focused approach in the demand management phase.

Acknowledging the importance of Health Board compliance and ensuring that patients receive the right form of treatment for their needs, Mr Jones indicated that some patients were previously listed for treatments they should not have been listed for. There is now a strong clinical and administrative focus on ensuring patients are waiting for the right intervention and treatment. Almost one-third of referrals received into the service do not progress to an OP appointment. This is due to a focused level of clinical triage at the front end of referral pathways. While this is positive in ensuring the right patients enter the system, it raises questions about avoiding the need for initial referrals.

Cllr Evans sought clarification to ensure that the figures were accurate. Mr Jones confirmed that the administrative approach is stringent and follows all procedures and rules in accordance with NHS Wales and Local Health Board access policy, indicating that audits undertaken in the recent past have evidenced the appropriateness of the team's approach.

Ms Marks requested further information to aid her understanding of the productivity improvement. Mr Thomas agreed to work with the directorate to provide more assurance regarding productivity. **HT**

Ms Marks enquired about the communication process with patients, particularly in relation to the removal from waiting lists, seeking assurance from Mr Jones that the communication process was properly handled. Mr Jones explained that any alternative treatment or clinical plan agreed for a patient is communicated to both the patient and the referring GP, indicating that the Health Board has a strong waiting list support service and was working to ensure consistent communication with patients. Acknowledging that there had been instances where the frequency of communication was not as expected, Mr Jones indicated that efforts were being made to address this. Any decisions regarding the appropriateness of a patient's position on the waiting list would be communicated through the principal channels.

Cancer

Mr Jones indicated that Cancer performance had been variable and below the desired level for the population. The main reason for the underperformance was related to capacity challenges in the diagnostic phase of the Cancer pathway, particularly in Radiology services. Other factors, such as capacity challenges within the Skin Cancer pathway, have also contributed to the drop in performance since the summer period. Mr Jones advised that, encouragingly, October 2024 saw an improvement in performance, largely in line with expectations. The work done to address delays in Radiology reporting and capacity challenges within the Skin Cancer pathway had a positive effect. The legacy impact of these issues is not expected to continue from November onwards, and a step improvement in performance is anticipated.

Mr Jones indicated a continuing reduction in the 62-day backlog of patients, which is crucial for improving future performance. Positive indications of reduced waits for various stages of the pathways, including first outpatient appointments and diagnostic and treatment phases, were being observed. Indicating that the Cancer trajectory performance has been revised to the mid-60% range (around 65%) to March 2025, Mr Jones advised that further improvement actions have been agreed upon, including additional CT imaging capacity within Radiology services and additional transparineal biopsy capacity within the Urology tumour pathway. These actions are expected to improve performance further.

Mr Jones noted that the performance improvement is contingent on the stability of the workforce in critical services such as Radiology and Skin Cancer. While there is hope for improvement, it was acknowledged that the current performance is unsatisfactory. Assurance can be taken from the actions being applied to drive improvement, but further assurance will depend on the outcomes of these actions.

In response to Mr Maynard Davies' question regarding sustainability of the actions being taken to improve performance, particularly in relation to reaching the 70% target by the end of March and the 75% target required for the TI target of three months at 60%, Mr Jones explained that the actions being taken were heavily supported by additional recovery resources that the Health Board had attracted. These resources are being prioritised and directed into this important pathway. However, some of these resources are non-recurrent in nature, meaning that while the actions are strong and sustainable, the resourcing of them is a non-recurrent solution.

Mr Jones highlighted that the performance target for the end of 2025-2026 increases to 80%, which presents an even greater challenge. The Committee acknowledged the importance of recognising the non-recurrent nature of some of the current resources and the need to plan for sustainable solutions to continue improving performance into the next year.

Mr Jones highlighted the significant focus on addressing large risk areas in the Cancer pathway, particularly the Radiology service, which is currently short of the required capacity; and emphasised the challenge of identifying sustainable actions to close the capacity gap and the need for additional support to achieve this in 2025-2026. More details will be discussed in the upcoming planning sessions.

SDODC agreed to maintain the alert status in view of the current unacceptable performance: and to request the Board to seek solutions to improve the position.

Decision: The Strategic Development and Operational Delivery Committee:
• RECEIVED ASSURANCE from progress achieved in reducing the volume of patients experiencing long planned care waiting times, and
• NOTED the additional measures being explored to mitigate potential delivery risks by March 2025
• RECEIVED ASSURANCE from the recovery actions being pursued to support recovery of Single Cancer Pathway performance and reduce delays for treatment

SDODC (24)133 Ophthalmology Performance (GIRFT)

Ms Steph Hire and Ms Vicky Coppack joined the meeting.

Ms Vicky Coppack presented the Ophthalmology Getting It Right First Time (GIRFT) indicating that initially, there were 59 recommendations, and weekly meetings were held with key team members, including consultants, clinicians, and management, to address these recommendations. To date, 37 recommendations have been closed, with 22 still outstanding and being actively progressed.

Ms Coppack indicated that eight of the outstanding recommendations were dependent on estates availability, which is being addressed through the clinical services plan (CSP). Interim workarounds were being implemented to streamline clinic operations and deliver these recommendations while awaiting the CSP outcome. Several recommendations were dependent on workforce planning, which is currently underway for 2025-2026. Training needs have been identified to develop existing staff and raise their profiles, as highlighted in the GIRFT recommendations. Ms Coppack also indicated that ongoing regional discussions included four subgroups, one of which focused on glaucoma. This would help progress the glaucoma-related recommendations.

Efforts to manage waiting lists are ongoing, with a focus on reducing 104-week and 52-week waits. The new Wales General Ophthalmic Services (WGOS) 4 initiative has started and is working well, with 144 new patients already sent to Primary Care and another 140 identified for management in Primary Care.

Cllr Evans enquired about the quality of care for patients who have been on long waiting lists and whether their conditions have worsened during the wait. Ms Coppack explained that all waiting lists have been clinically validated by highly trained optometrists. Patients with any doubts are referred to a consultant pathway. A safety netting pathway has been set up to ensure that long-wait patients are seen by highly trained optometrists who perform necessary tests. If any concerns arise, patients are re-referred to consultants through Consultant Connect and seen within days. This ensures that deteriorating patients are identified and brought into clinic urgently if necessary. Cllr Evans emphasised the importance of sustainability in managing the backlog and ensuring that the situation does not recur. Ms Coppack confirmed that the entire pathway is being managed with the WGOS 4 initiative preventing patients from needing to join the waiting list by directing them to highly trained optometrists in the community. Historic patients can now be managed and seen regularly by these optometrists, ensuring they receive regular appointments despite the backlog.

Ms Marks raised concerns regarding recommendations with an implementation date of January 31, 2027, questioning whether it is acceptable to delay these recommendations for over two years. Ms Coppack explained that the long target dates were set to provide realistic timelines, as they are tied to the CSP, which is a medium-term plan. Many of these recommendations are related to estates and require increased clinic and theatre delivery capacity. Interim plans are being implemented to increase cataract lists and grow clinics, but further estates are needed to continue meeting demand. Ms Coppack indicated that interim plans were in place to increase cataract lists by three per week and recruit fully trained doctors to commence operations immediately with full effectiveness. While there is some leeway to grow clinics and cataract delivery, a ceiling will be reached without additional estates. The 2027 date reflects the need for further estates to

continue growth. Mr Marks questioned what would expedite the implementation of these recommendations, given their seriousness and the long wait time.

Mr Carruthers explained that certain issues are particularly strategic and link to the CSP and the regional ophthalmology planning space with SBUHB, noting that from a clinician's perspective, a key part of the discussion was facilities and estates to optimise service delivery. Due to the strategic nature of these conversations, the dates were set to allow discussions to take place and deliver. However, there is a view that these could be completed sooner, and this will be reviewed in line with recent conversations regarding the CSP.

Mr Carruthers indicated that the Regional Ophthalmology Programme Board, which has only met once so far, will also influence the pace and approach across the region. The establishment of the Joint Committee with SBUHB in the New Year is expected to drive these initiatives at a different pace and in a different way.

Mr Lee Davies raised concerns about the long implementation dates extending to 2027, noting that such distant dates may be irrelevant from a Committee standpoint; and suggested involving IQFPD to review specific recommendations and actions to see what can be addressed within the current arrangements. Mr Lee Davies emphasised the need to explore how much of the recommendations could be addressed without wholesale configuration changes and estates investments, which would inevitably push the timeline into the medium term, noting that some recommendations were likely envisaged to prompt more immediate action. **AC**

SDODC agreed to alert the Board regarding the lack of estates capacity.

Decision: The Strategic Development and Operational Delivery Committee RECEIVED ASSURANCE from the progress made against the recommendations and the future plans in place to address the outstanding recommendations.

Mr Jones, Ms Hire and Ms Coppack left the meeting.

SDODC (24)134 Integrated Performance Assurance Report

Mr Huw Thomas presented the Performance Update for Hywel Dda University Health Committee – Month 8 2022/2023 (IPAR), highlighting those three themes that had not been picked up in the conversation about broad performance and challenges for the organisation:

- Therapies: This area had not been discussed in detail.
- Child ND waits: This was identified as an alert.
- Healthcare-Acquired Infections: This was another area of concern.

Mr Thomas referred to Section 7 on escalation, noting that three directorates had been highlighted: Mental Health, Facilities, and Planned Care. These directorates were predominantly escalated to Level 3 across all domains, with a low number of exceptions, indicating that the actions agreed upon within those directorate escalation meetings were noted in the summary.

Mr Lee Davies provided an update on a proposal from the Mental Health & Learning Disability (MH&LD) service to increase assessment capacity. This proposal was discussed at the last IQFPD meeting, and there is some national resource available to support this initiative, which is currently being progressed through the procurement process. Mr Lee Davies indicated that the discussion with the service questioned the value of adding an additional assessment into the process, given that 97% of patients referred to the service have their diagnosis confirmed. The meeting explored whether it would be more beneficial to utilise existing resources to increase support and treatment for individuals rather than reassessing something that had already been assessed. Mr Lee Davies advised that the challenge lay in adhering to guidelines and Welsh Government expectations around the assessment model. The service was asked to reconsider the approach and return to the IQFPD with a revised proposal, which may need further discussion with the Welsh Government.

SDODC agreed that the Board should be alerted regarding Cancer and Child ND waiting lists. The Board was requested to consider what further action the Health Board could take in response to the ND position and raise the matter with WG emphasising the need for national solutions.

Decision: The Strategic Development and Operational Delivery Committee:
• DISCUSSED the IPAR – Month 8 2024/2025 report
• RECEIVED ASSURANCE on the operational delivery of mitigating actions to improve performance in the areas that have been categorised as ‘alert’.

SDODC (24)135 DEFERRED: Review of Clinical Pharmacy Services at NHS Hospitals in Wales

SDODC (24)136 Deep Dive PO6: Clinical Services Plan

The Committee received a regular update as part of the work programme. Given the time constraints and the familiarity of the members with the position, it was suggested to move straight to any questions. The updates were noted as self-explanatory.

Decision: The Strategic Development and Operational Delivery Committee NOTED the Clinical Services Plan Update.

SDODC (24)137 Planning in Partnership: Regional Integration Fund Update

Ms Kim Neyland joined the meeting.

Mrs Jill Paterson introduced the West Wales Regional Partnership Board (RPB) Update report, indicating that the RPB had been undertaking self-assessment and review around its effectiveness and focus. The Committee noted that Cllr Evans is the Health Board Independent Member representative.

Ms Paterson highlighted that Welsh Government is increasingly passing funding through the RPB and expects central collation of responses across the region. Two examples provided were the Further, Faster Funding and the Regional Integration Fund (RIF) funding process. The tapering of RIF funding, which was deferred for two years, is expected to be implemented soon. Work is being undertaken to understand the legacy implications and identify projects that no longer meet refreshed criteria.

Ms Paterson advised that Further, Faster Funding was now combined with recent funding for the 50-Day Challenge, winter planning, and the Six Goals programme. The focus was on improving system flow, community capacity, and escalating areas where funding could improve the whole system response. Plans are currently being developed to address these areas.

Mr Maynard Davies enquired about the new ND improvement programme. Ms Kim Neyland explained that the programme has received £100k additional funding through the Welsh Government. This funding is not for the diagnostic side of the system, as there is already core funding for ND diagnostics. Instead, it is to put in place services to support individuals before they reach the diagnosis point in their journey. Two proposals have been approved, and two more are awaiting confirmation of approval. Positive sessions facilitated by the Welsh Government have supported the approach to addressing waiting lists through the funding provided by the RPB.

Mr Maynard Davies flagged an action regarding the end of RIF funding, noting the need to review funded projects and make decisions about which should continue to be financed. Mr Thomas emphasised the need for a clear business case if any projects are to be mainstreamed, outlining three options: mainstreaming with a business case, divesting from the service, or maintaining it within the residue of RIF funding. Mr Maynard Davies enquired about updates on this area of work being reported to one of the Committees. Ms Paterson confirmed that updates would be taken to the Executive Team meeting and relevant Committees for scrutiny and assurance. Ms Paterson explained that the initial RIF programme included existing programmes, which were intended to take a regional approach rather than a county approach; and noted challenges in defining programmes of work going forward and the potential rights gained by individuals in extended posts.

These issues will need to be addressed through business cases to maintain or stand down posts.

Cllr Evans acknowledged the work being done by Ms Paterson and emphasised the importance of moving forward with a unified strategy. highlighting the goal of Local Authorities and the Health Board working closer together, along with the RPB, to achieve common goals. Emphasising the importance of continued dialogue and collaboration, Cllr Evans noted that recent meetings of the RPB had been productive, with discussions focused on ensuring that all stakeholders are moving in the right direction.

SDODC agreed to advise the Board that the West Wales RPB RIF funding was coming to an end, necessitating a review of currently funded projects.

Decision: The Strategic Development and Operational Delivery Committee NOTED this update report.

SDODC (24)138 Capital Programme 2024 - Plan for 2025

Ms Eldeg Rosser joined the meeting.

Ms Eldeg Rosser presented the Capital Programme for 2024/25 and Capital Governance Update Report and the Capital Sub-Committee (CSC) 3As Board Update Report, providing an update on the capital planning activities since the preparation of the report as follows:

- Further slippage and dispensing in this year's discretionary programme.
- Reallocated £346k towards estate and infrastructure schemes, including upgrading fire alarms in WGH and updating building management systems in Bronglais Hospital (BH).
- Additionally, allocated £288k towards further replacements of medical equipment, prioritised by operational teams.
- HDdUHB received a further allocation of £480k towards digital replacements from Welsh Government.

Ms Rosser also provided an update on the governance elements of projects, specifically the Aseptics Project. The business justification case (BJC) for the project was delayed due to an extended tender return period to ensure sufficient responses. The tender process was closed, and two submissions had been evaluated. The outcome will be presented to the Executive Team meeting on 8 January 2025. The Aseptics BJC is then scheduled for consideration at a Chair's Action meeting on 10 January 2025. Subject to approval, the BJC will be presented to the Board for approval at the meeting on 30 January 2025, prior to submission to Welsh Government.

In response to the enquiry from Ms Marks regarding the Cross Hands project and whether the financial envelope provided will deliver all that is needed by the time it is built, Ms Rosser

explained that the original Outline Business Case (OBC) was for a development of around 5000 square metres. The current review indicates a size of around 3200-3500 square metres. Cost advisors are working to determine if this size is deliverable within the financial envelope. Efforts are being made to maintain integration and essential services, but some services may need to share rooms due to financial constraints. The General Medical Services (GMS) space remains largely unchanged, backed by benchmarks from shared services. Ms Marks expressed disappointment in the reduction of community and agile working spaces, emphasising their importance in the move towards community and integrated services and Public Health discussions. Ms Rosser acknowledged the disappointment and assured the Committee that efforts are being made to ensure flexible use spaces within the building to accommodate multiple services. The aim was to make treatment rooms versatile to serve more than one service.

Cllr Evans raised a question regarding the dependency on VAT recoveries mentioned in the paper, enquiring whether there were any issues with HMRC regarding VAT on capital projects and whether VAT was automatically recovered for such projects. Ms Rosser explained that VAT must be paid on capital projects, but it is recoverable for repair and maintenance type works. VAT advisors review capital schemes at the end of the year to recover the appropriate percentages.

Mr Thomas indicated that VAT recovery in the NHS is complicated and varies on a scheme-by-scheme basis, referencing an active claim with HMRC on the Bronglais Hospital front of house scheme and offered to discuss the details offline with Cllr Evans.

Ms Marks noted her pleasure at the additional funding provided for Pentre Awel, highlighting the significance of the development in Llanelli and the Board's approval of the extra funding. Ms Marks requested an update on the next steps for the Cylch Caron project, noting the lack of tender submissions and its importance. Ms Rosser reported a positive meeting with Welsh Government on 4 December 2024. The next steps include reviewing the schedule of accommodation, working up a resource schedule, and refreshing the OBC. Meetings with housing partners are scheduled for early January 2025 to determine whether to work up the scheme as a whole or split it into housing and health elements. A timeline for the completed business case will be developed following these meetings.

Ms Marks emphasised the importance of implementing decisions made by the Board and noted the challenges of future decisions if the other half of the equation cannot be implemented

Mr Lee Davies provided an update on the alert brought to the A Healthier Mid and West Wales Group, which reports to the Executive Team. The alert was a general one regarding plans for community facilities. Confirmed timelines and scales were

available for Pentre Awel and Carmarthen Hwb, while Cross Hands is advanced but still uncertain in terms of timeline and scope. Other projects, such as Fishguard and Llandovery, face broader challenges regarding capital availability. Mr Lee Davies highlighted the need for the Board to make decisions on the prioritisation and sequencing of community schemes, reflecting the available capital. The assessment of capital availability had changed, impacting the delivery of projects set out in the strategy.

Mr Maynard Davies noted that a concern was raised in the Sustainable Resources Committee (SRC) meeting on 17 December 2024 regarding the potential underspend on capital due to the diversion of funds into medical equipment and the extra funding for digital replacement. The question was whether the spend target is likely to be met. Ms Rosser indicated that the position should be better, but Welsh Government had asked for further bids for potential end-of-year capital in the upcoming weeks. The team was monitoring the situation and maintaining flexibility with contingencies to address any potential underspend that may arise.

SDODC agreed that the Board should receive an alert regarding HDdUHB's dependency on adequate community facilities being available. The progression of AHMWW infrastructure Strategic Outline Case (SOC) remains delayed due to the WG steer that the Health Board consider "the widest possible options" for the SOC.

Ms Rosser left the meeting.

Decision: The Strategic Development and Operational Delivery Committee:
• NOTED the update on the Capital Programme and CRL for 2024/25
• NOTED the capital schemes governance update
• NOTED the RAAC update
• NOTED the update from Capital Sub Committee
• APPROVED the amended terms of reference for the Capital Sub Committee

SDODC (24)139 A Healthier Mid and West Wales (AHMWW) Update (incl Nuffield Review Action Plan)

The Committee acknowledged that the item was discussed in detail at the last Board meeting and will be discussed again at the next Board meeting. Mr Lee Davies therefore gave a brief overview of the current position, advising that the community facilities was noted as already covered; and informing the Committee that arrangements were being made with the Welsh Government to attend the Infrastructure Investment Board (IIB) meeting in the New Year. The goal was to formally agree on the way forward in relation to the AHMWW business case process.

It was noted that any future SOC would need to consider a wider set of options than the original Programme Business Case (PBC)

and the draft SOC currently being worked on. This may require revisiting the original PBC, which is three years old and based on a narrower set of options. The Health Board is exploring with Welsh Government whether the PBC should focus solely on the final state (the new hospital and WGH) or cover both the final state and the interim period. This decision will impact the scope and complexity of the work. The aim is to agree on the approach with Welsh Government during the IIB meeting in the New Year. The Committee will be kept updated on the outcomes of this conversation.

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

Decision: The Strategic Development and Operational Delivery Committee:
• NOTED the key infrastructure and estates implications noted in this report as highlighted in the wider AHMWW update to Board on 28 November 2024
• NOTED the update on the AHMWW Community Schemes.

SDODC (24)140 Energy Performance Contract, Heat Network Efficiency Scheme and Solar Farm Projects Update

Mr Paul Williams joined the meeting.

Mr Paul Williams presented the Energy and Carbon Programmes of Work Update Decarbonisation report, highlighting the following:

- The current energy performance contract with Centrica (formerly British Gas) ends in March 2025. Preparations are underway to manage the transition to Health Board responsibility, with key risks regarding financial and operational delivery highlighted.
- A new energy performance contract is being developed, similar to the current one but with a structured framework and support. The key difference is the shift from capital funding to a spend-to-save model with loan repayment over ten years.
- HDdUHB was successful in gaining funds for optimisation studies on two sites and a bid for £1.3m for 50% match funding for optimisation work under the Engineering, Procurement, and Construction (EPC) projects.
- A four-stage approach to PPH includes transitioning to clean technology with heat pumps and removing gas Combined Heat and Power (CHP) and boilers. This will significantly improve carbon efficiency but has a substantial revenue impact.
- An opportunity to link to a nearby private wire solar farm, providing 1-2 megawatts of electricity, offering significant carbon and financial savings. Technical challenges and investment in decarbonisation are needed.
- The alignment project governance with internal governance changes within the Health Board.

Cllr Evans enquired about the private solar farm and how it fitted into procurement processes, raising concerns about the complexity, potential costs, and whether there is a worked pro forma from other Health Boards. Mr Williams explained that a power purchase agreement (PPA) would be established, with contractual terms ensuring a percentage reduction below National Grid rates. The goal was to negotiate the best deal with support from energy services and the Carbon Trust. Mr Williams indicated that the complexity lies in negotiating the best deal, but the expectation is to achieve better rates than the National Grid supply.

Cllr Evans noted the potential advantage due to the solar farm's need for a consistent user like the Health Board. Mr Williams confirmed that the solar farm developers were keen to collaborate with HDdUHB, given its 24-hour operation and significant energy usage. This strong position will be used to negotiate the best rates.

Mr Weir expressed support for the report, highlighting the Health Board's ability to make savings on traditional energy sources and use greener technology; and sought clarification on the interest-free loans and their repayment period. Mr Williams clarified that the loans have a maximum repayment period of 10 years. Welsh Government is encouraging all Health Boards to participate. Mr Weir suggested that future updates should include information on the timing of loan repayments and how savings will be realised, as this would help with budgeting and medium-term financial planning. Mr Williams noted that if the Energy Performance Contracts (EPC) fail to deliver, the contractor pays the difference; and mentioned that British Gas (Centrica) has previously lost money due to underperformance. **PW**

Ms Marks raised concerns about the infrastructure required to support the private wire solar farm electricity and whether the cost would fall on the Health Board; and also enquired if this would address existing risks around electricity failure at PPH. Mr Williams acknowledged the need to address work at PPH, indicating that the high voltage work would be completed by the National Grid and was designed to avoid conflicts with local risks. A cable will be brought into the site to link directly to the hospital. While full assurance could not be provided at this point, efforts were being made to align the infrastructure design with the developer.

Mr Williams emphasised that the Health Board would retain full resilience on site. The National Grid will provide full capacity alongside the solar farm, ensuring a reliable energy supply. The solar farm energy supply alone cannot be fully trusted, so maintaining the National Grid connection is essential.

Mr Williams left the meeting.

Decision: The Strategic Development and Operational Delivery Committee:
• RECEIVED ASSURANCE on the progress being made to deliver on the Energy Efficiency and sustainability projects with the aim to reduce energy costs and environmental impact.
• NOTED the content of the report.
• NOTED the progress being made on each project and risks and financial position set out in the paper.

SDODC (24)141 SDODC Work Programme 2024/25

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

SDODC (24)142 ANY OTHER BUSINESS

There was no other business reported.

SDODC (24)143 MATTERS AND RISK FOR ESCALATION TO BOARD

Social Model for Health and Wellbeing requires Board approval.

SDODC (24)144 DATES OF FUTURE MEETINGS

- Thursday 27 February 2025