Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

COFNODION Y CYFARFOD BWRDD IECHYD PRIFYSGOL
CYMERADWYO/ APPROVED
MINUTES OF THE UNIVERSITY HEALTH BOARD MEETING

Date of Meeting:	**09:00, Thursday 25 September 2025**
Venue:	**Y Stiwdio Fach, Canolfan S4C Yr Egin, College Road, Carmarthen SA31 3EQ**

Present:	Dr Neil Wooding, Chair, Hywel Dda University Health Board Mrs Eleanor Marks, Vice-Chair, Hywel Dda University Health Board Mr Maynard Davies, Independent Member (Information Technology) Cllr. Rhodri Evans, Independent Member (Local Authority) Mr Michael Imperato, Independent Member (Legal) (part) Ms Anna Lewis, Independent Member (Community) Ms Ann Murphy, Independent Member (Trade Union) Mrs Chantal Patel, Independent Member (University) Ms Sarah Harraway, Independent Member (Community) Mr Iwan Thomas, Independent Member (Third Sector) Mr Winston Weir, Independent Member (Finance) Professor Philip Kloer, Chief Executive Mrs Lisa Gostling, Deputy Chief Executive and Executive Director of Workforce and Organisational Development Mr Gareth Cottrell, Deputy Chief Operating Officer (deputising for Mr Andrew Carruthers, Chief Operating Officer) Ms Sharon Daniel, Executive Director of Nursing, Quality and Patient Experience Mr Lee Davies, Executive Director of Strategy and Planning Dr Ardiana Gjini, Executive Director of Public Health Mr Mark Henwood, Executive Medical Director Mr James Severs, Executive Director of Allied Health Professions and Health Science Mr Huw Thomas, Executive Director of Finance
In Attendance:	Ms Alwena Hughes Moakes, Communications and Engagement Director Ms Jill Paterson, Director of Primary Care, Community and Long-Term Care Mrs Joanne Wilson, Director of Corporate Governance/Board Secretary Mr Michael Gray, Director of Social Services and Housing, Pembrokeshire County Council Ms Donna Coleman, Llais West Wales (VC) Dr Jon Morris, Clinical Lead, Prince Philip Hospital Minor Injury Unit (part) Ms Sian Edwards, Lead Emergency Nurse Practitioner (part) Dr Daniel Warm, Head of Planning (part) Ms Nichola Couceiro, Head of Engagement (part) Ms Clare Moorcroft, Committee Services Officer (Minutes)

Minutes Ref.	Item	Action
PM(25)153	**Welcome and apologies**	
	Dr Neil Wooding, Health Board Chair, welcomed everyone to the Public Board meeting, which included a number of important items for discussion. He advised that additional attendees would be joining the meeting for the Prince Philip Hospital Minor Injury Unit	

item. There were no matters that Members felt were omitted from the agenda or reports. Dr Wooding reminded Members of the Board's five decision-making 'design principles':

1. Fair
2. Affordable/sustainable
3. Consistent with the Health Board's strategic approach
4. Does not create an unhelpful precedent
5. Safe

Apologies for absence were received from:

- Mr Andrew Carruthers, Chief Operating Officer
- Dr Jonathan Arthur, Health Professional Forum Chair
- Ms Mwape Burke, participant in the Aspiring Board Members Programme

PM(25)154 Declaration of Interests

Mr Iwan Thomas declared the following interests relating to item **PM(25)169** (Centre for Social Innovation): his role at PLANED and involvement in the Carmarthenshire Living Well Centre; and his membership of the Council of the University of Wales

PM(25)155 Minutes of the Public Meeting held on 26 June 2025

Decision: RESOLVED – that the minutes of the meeting held on 26 June 2025 be approved as a correct record.

PM(25)156 Minutes of the Public Meeting held on 31 July 2025

Decision: RESOLVED – that the minutes of the meeting held on 31 July 2025 be approved as a correct record.

PM(25)157 Matters Arising and Table of Actions from the Meetings held on 26 June and 31 July 2025

An update was provided on the Table of Actions from the Public Board meeting held on 31 July 2025. Confirmation was received that outstanding actions had been progressed. In terms of matters arising:

PM(25)120 – Dr Wooding advised that the date for attendance by the Peninsula Stakeholder Group may be revisited and changed to March 2026, to facilitate his attendance.

PM(25)158 Report of the Chair

Presenting his report on relevant matters undertaken since the previous Board meeting, Dr Wooding indicated that he had nothing further to add.

Cllr. Rhodri Evans wished Bronglais Hospital's Leri Cancer Unit the best of luck for the Picker Experience Network Awards on 2 October 2025.

Decision: The Board **SUPPORTED** the work engaged in by the Chair since the previous meeting and noted the topical areas of interest.

PM(25)159 Report of the Chief Executive

Professor Philip Kloer introduced his report on relevant matters undertaken since the previous Board meeting, drawing Members' attention to the request for an extension to the temporary service change in Ceredigion Community Mental Health Service. He also wished to highlight the significant work undertaken around ambulance handovers, which is demonstrating early signs of improvement in terms of handover times. The work has included both hospital and community-based involvement. Noting that this is an area of concern for the public and staff, the positive signs are welcomed. The challenge will be to ensure that the improvement in performance is sustained.

For additional context, Mr Gareth Cottrell advised that the work had begun approximately 4-5 months previously. It had emanated from a focus by the Chief Executive and Executive Team on poor patient experience in Urgent and Emergency Care (UEC) and a desire to improve this, together with patient outcomes. As indicated in the report, a System Reset Week had been held in early September 2025. Whilst such weeks had taken place previously, this version had proved more successful and focused. Learning from previous occasions had been incorporated, and this Reset Week had been system-wide, as opposed to more siloed. It had been clinically-led, with a focus on patients and their needs and interests. The result has been a step-change improvement in ambulance handover times. In addition to improved patient experience and outcomes, benefits include freeing up ambulances to respond to other calls and an uplift in staff experience and morale. One of the key elements has been empowering staff to work to the top of their licence. Mr Cottrell welcomed the support of the Executive Team, particularly the clinical executives, in sharing this message. As has been mentioned, however, the initiative is in its early stages and there must be a further focus on sustainability. It is vital to embed this work in order to achieve the national 45 minute ambulance handover target in October 2025, recognising that the Health Board is aiming to revert back to 15 minutes.

Whilst accepting that the situation is potentially fragile, Dr Wooding acknowledged and commended the work undertaken, which appears to have resulted in a genuine 'shift' in performance. He thanked all of those involved in what is an excellent example of the organisation coming together at a systemic level. Professor Kloer agreed, reiterating that previous initiatives had limited impact and this exercise has demonstrated the value of teams and disciplines working together. He wished to highlight that, whilst the incoming national handover target is 45 minutes, the Health Board is actively exploring how to achieve 15 minutes, which would lead to even better patient experience and outcomes.

Returning to the remainder of his report, Professor Kloer also drew Members' attention to the update regarding the 'A Healthier Mid and West Wales' (AHMWW) Strategy. Work in this area needs to be progressed at pace, with the appropriate public engagement. The Chief Executive's report also contains an update on work in relation to the Clinical Services Plan (CSP), which is beginning to produce results. The volume of responses to the public consultation has been significant, and has resulted in a large number of alternative options, which need to be given due consideration. The report requests Board approval for an extension to January 2026 for presentation of the consultation outputs to Public Board. However, subsequently, it has been determined that it would be more appropriate to hold a separate, Extraordinary Public Board meeting to discuss this item, on 19 February 2025. Finally, Members' attention was drawn to the request regarding the Collaboration Agreement in respect of the Hydrotherapy Pool at Pentre Awel.

Cllr. Evans requested assurance that the 45 minute target for ambulance handovers will not be achieved by increasing the number of patients waiting in Emergency Department (ED) corridors. He noted that neither the numbers of ED staff, nor the numbers of patients presenting are predicted to change. Mr Cottrell assured Members of a commitment to ensuring the problem or risk is not moved elsewhere. A clinically-led process has been crucial in this regard. Actions have included an increase in senior clinical decision-makers at the 'front door' to ensure the correct treatment route for patients. Also, changes to the way in which patients are managed on wards, including discharge processes. As an example, ensuring that patients ready for discharge are moved to Discharge Lounges earlier in the day, to free up beds. Mr Cottrell emphasised that quality and safety are at the forefront of changes and assured Members that this had not led to any increased risks in ED.

With regard to the request to approve the Ceredigion Community Mental Health temporary service change until November 2025, Mr Maynard Davies noted that a report on this topic is scheduled for the October 2025 Quality, Safety and Experience Committee (QSEC) meeting. He enquired whether it might be better to consider a longer extension, rather than potentially have to request a further extension following QSEC and Board discussion. Regarding the Hydrotherapy Pool at Pentre Awel and suggestion that additional accommodation be explored, Mr Maynard Davies recalled that the affordability of this scheme had been the subject of previous Board discussions, and queried whether additional expenditure was appropriate. Whilst commending Pentre Awel as a good example of collaborative working, Mr Winston Weir felt that the Board needs more information around timescales for the project. He also requested an indication of the likely timescale for completion of Phase 2 of the Operational Structure implementation. Finally, noting that the AHMWW Strategy Refresh has attracted feedback via the public engagement, whether the

Health Board has the capacity to respond to this in the correct manner and sufficiently.

In terms of the Mental Health Service, Mr Cottrell explained that, whilst there has been engagement with multiple stakeholders during the temporary service change period, it is clear that further dialogue is required. This includes additional engagement with colleagues in Primary Care. With regard to whether the requested extension is sufficient in length he felt that, by the November 2025 Board meeting, the service should be in a position to have taken into account stakeholder feedback, analysed the impact of the service change and identified a way forward. Ms Jill Paterson emphasised the importance of engagement with stakeholders, observing that the temporary arrangement relies heavily on GP support. If this is to be extended, it is imperative to ensure that the experience and views of GPs are taken into account. Members were assured that the Mental Health and Learning Disabilities (MHLD) team is committed to doing so. It was agreed that there would be an extension in the temporary service change to November 2025 in the first instance, with the position to be reevaluated at that point.

With regard to Pentre Awel, Mr Lee Davies recognised that there had been a great deal of discussion around this scheme, and that the original floor space allocation had been reduced. This position has not changed; neither has the caution to be applied in committing further funds. However, as there is additional space available, it is suggested that possibilities be explored. There are a number of options which could be pursued, which would reduce revenue costs. Naturally, any proposals would be presented to the Board for consideration and decision. In terms of responding to feedback around AHMWW, Mr Lee Davies advised that 627 responses on this topic had been received in addition to those on the CSP. An All Wales YouGov survey had attracted over 1,000 responses. Key themes had been drawn out and it is intended to maintain the Health Board's continuous engagement approach, seeking out all possible opportunities for dialogue with local communities, as opposed to a 'stand-alone' consultation or engagement process.

Returning to Mr Maynard Davies' concerns around Pentre Awel, Dr Wooding assured Members that any additional costs would need to be balanced by benefits or against other cost savings. In response to Mr Weir's query regarding the Operational Structure, Mrs Lisa Gostling advised that this topic is due to be considered at the next meeting of the People, Organisational Development and Culture Committee (PODCC) and discussions will then be reported to the November 2025 Board meeting.

Decision: The Board:

- **APPROVED** the extension of the temporary service change in Ceredigion Community Mental Health Service Medical and Nursing Position until November 2025 and asked that this

change is reviewed by the Quality, Safety and Experience Committee in October 2025.

- **APPROVED** the Clinical Services Plan (CSP) consultation outputs being presented to an Extraordinary Public Board meeting in February 2026
- **AGREED** to the Collaboration Agreement between the Health Board and Carmarthenshire County Council for the Hydrotherapy Pool at Pentre Awel, Llanelli being sealed when a final version of the Agreement, including schedules, is agreed between both parties
- **NOTED** the Strategic Refresh Strategy Outline
- **NOTED** the Corporate Risk Register (CRR) report and summary
- **ENDORSED** the Register of Sealings since the previous report on 31 July 2025
- **NOTED** the status report for Consultation Documents received/responded to
- **NOTED** Executive Team discussions

PM(25)160 **Annual Plan 2025/26**

Mr Lee Davies introduced the Annual Plan 2025/26 report, which – this being the mid-point of the year – reflects on progress to date. Members' attention was drawn to the increased savings expectation placed on the Health Board by Welsh Government, the various correspondence on this matter, and proposed revisions to the plan as a result. The Board was reminded of the extensive process undertaken in developing the original Annual Plan, and that any change in the balance of this requires careful consideration. As indicated, Welsh Government has clarified its expectations in terms of financial target. The timing and contents of the various communications are summarised within the report. Members were advised that the organisation has commenced work on developing next year's plan, which will be discussed at the next Board Seminar. Finally, Mr Lee Davies highlighted the proposed revised reporting approach for future Annual Plan, Financial and Integrated Performance Assurance Reports, and would welcome Members' feedback.

In response to the final point, Dr Wooding endorsed the proposed approach. Mrs Chantal Patel enquired whether there are specific timelines for delivery of the individual elements of the Annual Plan, in order to meet Welsh Government expectations. Mr Lee Davies indicated that timelines in relation to health board submission of plans are issued annually by Welsh Government. Deadlines have also been provided for submission of plans to meet the additional financial expectations. Locally, there also exists a three year roadmap to financial recovery. Mrs Eleanor Marks welcomed the summary and timeline of evolving Welsh Government expectations. Plans to achieve the revised financial target are ambitious and she was pleased that they are being embraced by the Health Board. Mrs Marks wished to offer her backing to the Executive Team and wider organisation in delivering these.

Dr Wooding felt that it was important to acknowledge that the Health Board had undertaken an extensive programme of work to develop a considered and balanced plan. This has since been subject to a series of external imperatives, introducing different requirements. The organisation needs to consider how it might build into future planning more flexibility, to adapt to such pressures. Welcoming the report, Mr Maynard Davies noted the following statement:

> '…when these requirements converge with an already stretching programme of financial recovery and performance improvement from challenged baselines, they collectively require careful sequencing and prioritisation of organisational capacity.'

This raises concerns, when viewed in conjunction with a potential restriction on recruitment outlined in the Financial Choices and Decisions agenda item. Consideration needs to be given to how the Health Board can balance the competing capacity demands involved in both accommodating change and delivery of savings.

Professor Kloer reminded Members that, whilst the original Target Control Total was £31.5m; the Health Board's financial outturn last year had been £24.1m. Additional Welsh Government funding had been allocated contingent on the organisation achieving financial balance within three years and demonstrating progress towards this. The revised Welsh Government position and expectation is, therefore, unsurprising. However, this must be balanced against ensuring that quality, safety, patient experience, staff wellbeing or wider performance are not compromised, which is, undoubtedly, challenging. Those areas where it is easier to save money are often the corporate teams which support operational teams in making progress and delivering improvements. It was recognised the corporate teams had no more left to give and the constant reduction was on corporate teams was impacting morale and the ability to support operational services. Members were assured that, in considering additional savings schemes, there has been a great deal of emphasis on Quality Impact Assessment (QIA); however, continued monitoring will be required.

Whilst recognising that meeting financial targets is a statutory responsibility, Dr Wooding agreed that extreme vigilance will be needed around the impact of any reductions in expenditure.

Decision: The Board:

- **RECEIVED** the update on the 2025/26 Annual Plan
- **CONSIDERED** the additional financial and performance expectations since the annual plan was submitted
- **AGREED** an aligned report moving forward, which triangulates the annual plan, escalation status and key highlights for Board to consider in the finance and performance report, to reduce duplication and improve overall reporting

PM(25)161 Financial Report

Presenting the Financial Report, Mr Huw Thomas reflected on the above discussion. He referenced an Audit Wales press release from earlier today, which had noted that all seven health boards breached their statutory duty to break even last year. This was also a common theme across the UK, providing important context to the Health Board's position. Mr Huw Thomas indicated that the challenge is two-fold: absolute and relative. The latter can be addressed via the three-year plan and roadmap for financial recovery. Members were reminded that the Health Board remains in dialogue with Welsh Government, whose position is that the organisation needs to 'own' its financial trajectory. The challenge going into next year will be linked to the separation of the year into two halves, due to the election. For the pre-election period, it has been made clear that the budget is a roll-over budget, with no more allocated than this year. The current funding envelope will be maintained until after the election period. Post May 2026, a new government will be in place, which will make its own decisions around budgets. This presents challenges in terms of the planning process, which will require careful consideration.

With regard to this year's position, Mr Huw Thomas wished to thank his team for their work in his absence. As has been discussed, Welsh Government is clear in its expectation of a £24.1m outturn. The report to accompany the next agenda item outlines that Welsh Government has mandated a response by 13 October 2025 to describe actions to deliver this position. In terms of delivery, there is relative assurance around delivery of £27.8m; however, there is no 'line of sight' to achieving £24.1m at present. Savings plans have been shared with functions and Clinical Care Groups (CCGs). It is potentially feasible that £24.1m could be delivered, if the entire organisation delivered all of the planned savings schemes. However, there are also material risks which are outside of the Health Board's control, such as that in relation to the Welsh Risk Pool risk share arrangements being invoked. The latter involves a potential financial liability for the Health Board of £4-5m. Such considerations also require management, in terms of at what point a potential risk is classified as a liability which needs to be accommodated in the financial forecast.

Building on this comment, Cllr. Evans enquired whether (if realised) the potential Welsh Risk Pool liability will need to be accommodated this year and, if so, whether this should be reflected in the recommendation to Board. In response, Mr Huw Thomas advised that the risk has not yet materialised. He and other Health Board Directors of Finance will be discussing this at their meeting tomorrow. If realised, he would envisage that the liability would need to be accommodated this year; however, clarity does not yet exist. Noting that it has not been possible to deliver all planned savings schemes, Mrs Patel requested clarification around the reasons for this and enquired how future plans can be made more robust. Mr Huw Thomas explained that the reasons will vary across the organisation. For instance, the

Community and Integrated Medicine CCG is managing changes which are required in Urgent and Emergency Care. These changes will, however, address certain core drivers of the financial position and offer financial benefits in the future. This is just one example. Dr Wooding indicated that a number of the challenges sit within the Community and Integrated Medicine area. These are often systemic issues, which cross disciplinary 'borders' and budgets. Costs may need to increase in the short-term, to address these systemic issues. In considering the recommendation, it was noted that delivery of recurrent savings is where the risk lies.

Decision: The Board:

- **APPROVED** the Health Board's revised forecast deficit as £27.8m, with a savings target of £46.4m, noting that the aspiration is to continue to improve beyond this in the coming months, in line with Welsh Government expectations.
- **TOOK ASSURANCE** on progress of savings actions to bridge the recurrent and non-recurrent savings gap from those Executive portfolios that have yet to identify their full target.
- **TOOK ASSURANCE** there are sufficiently robust plans in place to eliminate the use of all Healthcare Support Worker agency by the 30 September 2025 deadline set in the Ministerial Priorities.
- **NOTED** that a proposal for options around future run rate conversion has been discussed by the Executive Team, and the option to recognise 11 Amber schemes centrally referenced against each portfolio, with the risk adjusted extrapolation values – totalling £6.0m – has been included within the Month 5 position.
- **ACKNOWLEDGED** that an underlying deficit assessment has been undertaken and has identified that this will only be reduced via robust recurrent savings delivery improvements.

PM(25)162 **Financial Choices and Decisions Report 2025/26**

Professor Kloer introduced the Financial Choices and Decisions report, reiterating that the Health Board had developed a plan which would deliver a deficit of £31.5m. It has subsequently been requested to enact steps to achieve a position of £24.1m. The organisation's original plan had been a balanced and considered approach, intended to address quality, safety, experience, performance, finance, safeguarding the future and looking after staff. As already mentioned, Welsh Government has set the target of £24.1m given that, whilst it is the Health Board's statutory duty to achieve a balanced financial position, its original plan did not demonstrate progress towards this. Actions had been developed which would deliver a position of £27.8m, and the report describes potential actions to achieve £24.1m. There are also opportunities to go even further.

The options presented in the report had been categorised into Category 1 – most straightforward to implement; Category 2 – more challenging but should be considered; and Category 3 –

should not be pursued. Quality Impact Assessments had been completed for every option, which had identified that all have a level of adverse consequence. This is not altogether surprising, as should they not, they would have been included as savings schemes previously. Referencing correspondence with the Director General, Judit Paget, Members were advised that Professor Kloer and the Director General had met following the Extraordinary In-Committee Board meeting on 9 September 2025. During discussions, the expectation that the Health Board provide by 13 October 2025 a confirmed route to achieving £24.1m, together with delivery of all Green rated savings schemes, was restated. Professor Kloer had explained how challenging this would be, particularly delivery of all savings schemes, given that this would be an unprecedented achievement. From a positive perspective, Members were reminded that the organisation is only in Month 6, with half of the year still remaining. Professor Kloer emphasised that the Health Board needs to approach this challenge professionally and consider again the Category 2 options, their QIAs and any controls which would need to be implemented, with it noted that this would require the same level of scrutiny as for Category 1 schemes.

Reflecting further, Mr Huw Thomas reminded members that the 'genesis' for these options is their status as variable costs incurred as a Health Board. This is likely to mean that they will be the areas which be returned to for consideration in future years. He highlighted that addressing and mitigating the quality impact may be different in the short-term and long-term. In that, with more time for planning, it may be possible to reconsider options which are being classified as unfeasible currently based on their impact. Certain of these are already incorporated in plans to deliver £27.8m; the challenge is in going further.

Dr Wooding emphasised that he was not proposing the Board decide at this point which additional options are pursued. The request is for endorsement of the proposed approach. He recognised the need for the organisation to operate in a sustainable manner and 'live within its means'. The rationale is sound and undisputed. The challenge is achieving this position, and in the transition between making relatively small changes to reduce costs, and fundamentally restructuring service delivery, systems, ways of working and configuration of services, with the investment that this requires. Building on this comment, Mr Huw Thomas suggested that the Health Board's previous position as a relative outlier in terms of financial position has largely been addressed. This is the relative challenge he previously mentioned. The remaining challenge is an absolute one, of improving on the organisational bottom-line, to achieve a financially sustainable position. This necessitates 'organisational ownership' of the financial improvement trajectory referenced earlier.

Ms Anna Lewis supported the comments around short-term and long-term measures and the potential conflict between these. In terms of governance, she wished to highlight that an Extraordinary

Finance and Performance Committee (FPC) meeting had been convened to consider all Category 1 options, together with their impact and implications, with it recognised that not all schemes were supported, impacting on the financial quantum identified. Ms Lewis felt that it was important to provide assurance that this scrutiny had taken place prior to the Board meeting. The same process would be the expectation for Category 2 options also. In terms of sustainability, Mrs Marks emphasised that a key element will be to improve the Health Board's productivity, together with adopting the principles of the Social Model for Health. She reminded Members of the need to shape a Health Board which is 'fit for the future', and ensure that any actions taken now do not compromise the organisation's long-term ambitions.

Mr Iwan Thomas wished to recognise the work of colleagues in the Finance team. He enquired whether there had been any liaison with parties outside the healthcare sector, noting that several police forces are utilising Artificial Intelligence (AI) in supporting victims of crime, for example. This had been implemented as part of cost-savings and he suggested that there might be learning from elsewhere which may be useful. Dr Wooding agreed that other sources of knowledge should be sought. Mr Huw Thomas indicated that this could be incorporated into financial planning for next year, together with Mrs Marks' suggestions. The Health Board's digital partnership arrangement provides access to examples and information globally.

HT

Dr Ardiana Gjini highlighted the need to invest today for the future. In addition, feedback consistently suggests that the needs of the majority of patients presenting to ED could be met via other services or sources of support. Members' attention was drawn to the upcoming agenda item on the Centre for Social Innovation, and (with regard to the Social Model for Health) steps are being taken to learn from elsewhere and apply this learning to next year's planning. This will involve making different choices in terms of investment and resource.

Bringing the discussion to a close, Dr Wooding wished to thank Mr Andrew Spratt and Ms Sian Jenkins for their work and for their input to Board discussions. He highlighted that, if the Health Board delivers the intended cost savings by the end of the year, it will have delivered approximately £90m in savings during the past two years; a significant amount. This will have been achieved predominantly through efficiency planning, cost reduction, waste reduction, better use of resources and achieving better value for money. There is a need, however, to consider and discuss the broader financial strategy, which will involve a different model for healthcare; Social Model for Health principles; changes in service delivery and configuration; improved productivity; increased use of digitalisation and technology. This shift in emphasis is required as part of the financial planning process and needs to be a focus for the future.

Referencing an earlier comment by Ms Lewis, Mr Huw Thomas agreed to provide a report detailing the additional actions required to improve the financial position from £27.8m to £24.1m. This would subsequently be reported to the next Public Board meeting. **HT**

Noting the requirement to submit plans to Welsh Government by 13 October 2025, Professor Kloer committed to ensuring these clearly indicate that proposals are subject to Board ratification and detailed scrutiny by the Finance and Performance Committee. **PK**

Decision: The Board:

- **NOTED** the process that has been followed in considering the current financial position and scope to improve this, in response to the expectation from Welsh Government to match the 2024/25 outturn deficit of £24.1m.
- **DISCUSSED** and **CONSIDERED** the options framed in respect of further choices and impacts being proposed to achieve an additional improvement in the financial deficit trajectory beyond the planned £30.0m, following the latest feedback received from Welsh Government targeting £24.1m and building on latest scrutiny of QIA outputs.
- **APPROVED** the improvement of the Health Board deficit forecast to £27.8m and pursuit of opportunities presented within Category 1 schemes and further exploration of the Category 2 schemes, with a detailed review requested at the October 2025 Finance and Performance Committee meeting. In doing so, formally ratify the decisions made at the In-Committee Board meeting on 9 September 2025, as follows:
    - Approved the improvement of the Health Board deficit forecast to £27.8m and pursuit of opportunities presented within Category 1 schemes, recognising the caveats below and further exploration of the Category 2 schemes which will require further discussion at a future Public Board meeting
    - Endorsed the enactment of Category 1 schemes (subject to the provision and scrutiny of the schemes at an extraordinary Finance and Performance Committee, scheduled to be held on 15 September 2025, and reviewing in more detail quality and equality impact assessments, subject to formal ratification at the Public Board meeting on 25 September 2025)
    - In respect of the Category 1 schemes, the In-Committee Board DID NOT SUPPORT and requested amendments were made to the recommendation:
        - A blanket recruitment freeze for non-patient facing roles, recognising these needed to be reviewed on a role by role basis with enhanced financial controls to be put in place
        - Minor works being in Category 1 and requested this was moved into Category 2

        - The neurodiversity scheme, until this had been fully scrutinised at the extraordinary meeting of the Finance and Performance Committee
        - A blanket approach to virtual meetings and stopping all Continuing Professional Development (CPD)/training; however, requested prioritisation of virtual meetings and principles and a targeted approach to be put in place, which could still achieve the level of savings identified, recognising this should also impact on reducing travel expenditure
    - Agreed that Category 2 schemes would be subject to further development, evaluation and future consideration; however, requested work on contract agency to be progressed at pace
- **DISCUSSED** and **CONSIDERED** the latest feedback from Welsh Government and continued focus for the Health Board in declaring a £24.1m forecast outturn for 2025/26 and providing an assured plan to deliver in line with the 13 October 2025 timeline.

PM(25)163 Integrated Performance Assurance Report

Presenting the Integrated Performance Assurance Report (IPAR) for Month 5 of 2025/26, Mr Huw Thomas recognised that the position with regard to UEC described remained unacceptable. This position reflects performance in August 2025, which has since changed, with work in the area continuing. Members' attention was drawn to areas of concern, which include Therapies waits of over 14 weeks, with the highest number of breaches ever reported to Board. Podiatry, Dietetics and Physiotherapy present particular challenges. Performance in Psychological Therapies is also an area of concern, which had shown some improvement last year but has declined for the ninth consecutive month. The position around high-risk Eye Care patients has also declined; however, improvements are being seen, particularly as a result of regional working. Mr Huw Thomas was pleased to note the Health Board's improved position in Cancer Care, with performance maintained above 60%. In terms of the escalation process, Members heard that the two most challenged CCGs are Community and Integrated Medicine and Planned and Specialist Care. Whilst there is a great deal of work ongoing, these are areas of significant challenge and concern. Not only in terms of the number of domains in which these CCGs are escalated, but also the length of time they have been escalated in multiple domains. The way this is addressed, both for this year and next, requires consideration.

Ms Ann Murphy noted that long-term sickness rates have increased, and requested assurance that the reasons for this are being investigated and potential mitigations and support explored. She also highlighted that the Health Board is not meeting national or local targets and recommendations relating to Facilities. Noting that a new organisational structure is being introduced, she enquired whether this matter will be prioritised. Referencing the

number of C.difficile cases, Mrs Marks noted that this does not seem to reduce and enquired regarding the reasons. Mr Maynard Davies highlighted the excessive number of high and extreme risks. He queried whether this indicates a potential fragility within systems, which is in danger of being realised. Returning to the issue of escalation, Ms Lewis enquired regarding the measurement methodology utilised. As mentioned, a number of Directorates appear to be 'static' at Level 3. She queried whether this is because the methodology is not sufficiently sensitive to reflect progress, or whether there are issues beyond Directorates' short-term control. For those areas where it is reasonable to expect greater improvement, such as responses to complaints or regulatory inspections and recommendations, consideration should be given to how long the Board tolerate sustained sub-optimal performance.

With regard to the number of risks, Mr Huw Thomas advised that this is increasing and is reflective of the underlying issues being faced by the organisation. It also relates to the financial challenge, with restrictions in the ability to invest. The new operational structure also contributes, with new teams maturing and developing and identifying areas of risk, which had previously become 'normalised'. In response to Ms Lewis' query, Mr Huw Thomas indicated that the measurement methodology is a source of concern. Not so much in terms of 'measurement sensitivity', which is based on the level of assurance; more in terms of how findings are addressed. He tends to view the Quality, Governance and Workforce metrics as ones which require input or management actions for de-escalation; whilst the Finance, Strategy and Performance metrics tend to require leadership and/or systemic actions. The former group generally attracts lower tolerance levels. The issue of Directorates remaining at Level 3 for extended periods is a topic of discussion at Executive Team; consideration is being given to how this is addressed. It was suggested that the issue of tolerance of such a position should be discussed at a future Board Seminar. **HT**

With regard to concerns around Facilities, Mr James Severs advised that changes to the allocation of resources had been made to support staff in this area. New roles are also being recruited, which it is hoped will assist. An update will be provided at the next Board Seminar. **JS** In response to Ms Murphy's other query around staff sickness, Mrs Gostling indicated that work is taking place with Trade Unions to explore how staff unable to return to their original role might be supported to take up alternative roles. The team is also working with colleagues in Public Health to map the Health Board workforce with the demographics of local communities, to explore the impact of factors such as life expectancy and illness prevalence. Returning to the topic of tolerance around escalation, Mrs Gostling assured Members that this is reviewed from a Workforce perspective and various workstreams are ongoing to ensure that actions are implemented. Expectations in terms of tolerance are also being defined.

Responding to Mrs Marks' query, Ms Sharon Daniel indicated that a number of the C.difficile cases reflect in part hospital-onset infections resulting from recent Norovirus outbreaks. With C.difficile being one of the infections tested for, and the Health Board having a low threshold for sampling, more cases are detected and reported. Members were informed that a great deal of work is taking place around antibiotic prescribing. Certain antibiotics are high-risk for C.difficile, as are proton pump inhibitors, which are commonly prescribed to counteract the effects of NSAIDs (nonsteroidal anti-inflammatory drugs). The work described will contribute to the Health Board's overall strategy in reducing C.difficile cases.

With regard to the internal escalation process, and tolerance around those service areas consistently in Level 3, Dr Wooding queried whether this relates to an underlying issue of ineffective management. Whilst accepting that there are multiple factors involved and potential contingent reasons otherwise, it represents a fundamental contradiction and is not acceptable. Particularly when compared and contrasted with those services which are consistently delivering well. Board Members are right to question tolerance of such a position, and regardless of this, performance management is required.

Positive progress and improved performance in areas such as Ambulance Handovers, Planned Care, Cancer Care and Financial Management does not happen without effective leadership and operational oversight. There are other areas where patients are not having a positive experience, and these may be lacking this input. Professor Kloer suggested, however, that the reality is more nuanced, and that services which are in Level 3 also contain areas which are delivering improvements. He also highlighted that the Health Board is being compelled to take short-term decisions to meet financial constraints and reduce its corporate capability as a result, which will impact. Whilst accepting this viewpoint, Dr Wooding reiterated that tolerance of no assurance is not a position which can be sustained without challenge. In considering the report's recommendation, he suggested that this lack of assurance be reflected.

Decision: The Board **DISCUSSED** the IPAR – Month 5 2025/2026 report and **NOTED** but **WAS NOT ASSURED** on the operational delivery of mitigating actions to improve performance in the areas that have been categorised as 'alert'.

PM(25)164 **Management of Waiting Lists/DNAs/Appointments**

Dr Jon Morris, Ms Sian Edwards, Dr Daniel Warm and Ms Nichola Couceiro joined the Board meeting.

Introducing the report, Mr Cottrell indicated that he has reflected on the content and acknowledges that it is probably too process-oriented. It should also have considered the concerns of patients and the actions being taken to address these. Particularly the

mechanisms by which the Health Board communicates with patients, and the content, accuracy and timeliness of its communications with patients. Instead, the report focuses primarily on Welsh Government expectations and the process by which the Health Board complies with these. This topic has also been discussed at an Executive Team meeting, at which a differently focused report had been considered. Operational teams recognise that communication with patients is not as it should be, and that improvements are possible, even within the current infrastructure constraints. The level of work involved in addressing concerns is also acknowledged, and that the organisation is committed to undertaking this. He suggested that outputs from the work could be directed via QSEC.

Dr Wooding welcomed this context and reflection, noting that the view expressed was one shared by Board Members. He reiterated the rationale behind requesting this agenda item and report, which was concerns expressed by patients and members of the public around communication and correspondence. Members were seeking an explanation for these issues, which is not provided by the report in its current form. Whilst the complexities involved are acknowledged, there appears to be a lack of systematic approach or embracing of technological solutions. Thanking Mr Cottrell for his input, Mrs Marks indicated that she would welcome sight of the other report mentioned. She remained concerned by the number and variety of different systems being utilised. Also, when appointments are cancelled, the priority should not only be giving a reason for the cancellation; a replacement appointment should be offered at the same juncture.

GC

Ms Sarah Harraway noted the statement that a review had identified that 19% of appointment letters issued during the past 6 months were sent within 10 days or less of the appointment date; with 10 working days having been defined as a reasonable notice period. She highlighted that each ‘Did Not Attend’ (DNA) costs the Health Board £30-50. Ms Harraway also provided an example of extremely poor communication with a patient which had been conveyed to her. She emphasised the need to recognise the reality of the impact of such examples to individuals. Providing a separate example, Ms Murphy suggested that any review of processes also takes into account the location of appointments, versus patients’ home postcode. Mr Iwan Thomas also shared an example, emphasising that patients’ concerns are generally around the administration of appointments, rather than the clinical aspect. Reviews of and changes in process need to address the needs of service users.

Mr Michael Imperato joined the Board meeting.

Cllr. Evans noted reference to an external assurance review, with a report expected in December 2025 and requested clarification. In response, Mrs Joanne Wilson explained that this review specifically relates to Referral to Treatment (RTT), and will be reported to the Audit and Risk Assurance Committee (ARAC).

Whilst acknowledging this, Cllr. Evans suggested that its findings should inform the wider work and updates provided to QSEC and the Board, which was agreed. Mrs Wilson advised of a query received from Ms Donna Coleman, Llais, as follows:

> We appreciate that there is the CNA/DNA category but is there a mechanism for the Health Board to understand any linkages with transport. We heard in the CSP engagement event in Tenby that people using Non-Emergency Patient Transport Service (NEPTS) sometimes have to deal with last minute cancellations and cannot rearrange. Is there data on this that can be explored further.

Dr Wooding noted that this aligns with an earlier comment from Ms Murphy. He emphasised that the Health Board has a responsibility to assist patients in attending appointments. The examples of communication with patients provided by Members are unacceptable. Whilst most staff within the Health Board do their utmost to deliver good quality care, it is clear that there is a specific need in this area for services to take responsibility and engage with service users.

Welcoming discussion of this important issue at Board level, Ms Lewis suspected that most Members are able to provide examples of poor communication with patients. She thanked Mr Cottrell for his openness, which is in line with the organisational values. It is evident that matters such as the tone of letters require review. Ms Lewis wondered, however, whether this is reflective or symptomatic of the pressures being experienced by staff and the organisation in general to meet targets, etc. She sensed that there are fundamentally good intentions, which are being 'lost in translation'. Extreme pressures can lead to anyone losing sight of the individual at the other end of the communication. In view of the suggested role of QSEC, she offered her assistance to those in the operational team tasked with this process. Ms Lewis emphasised that she was not excusing poor communication or behaviour; rather attempting to understand the reasons for it and how it might be improved.

Mr Cottrell agreed that the examples of patient communication provided by Board Members were totally unacceptable. He offered his sincere apologies to all of those involved, along with any other patients similarly affected. This is clearly an area of deficit and in which there must be improvements. Mr Cottrell also welcomed Ms Lewis' offer of assistance in determining how these improvements might be made, and committed to providing a further update to a future Board meeting. The examples and patient stories shared were appreciated, and Mr Cottrell would be happy to provide support to any of the patients involved, should they wish to contact him personally. Mr Huw Thomas emphasised that this is also a collective responsibility, and that assistance can be offered to operational teams in terms of potential digital solutions. Agreeing, Ms Daniel highlighted the existing infrastructure, such as the Waiting List Support Service, where patients can access

AC/GC

additional advice. This issue requires a collective responsibility and an integrated approach.

Professor Kloer wished to add his apologies to any patients impacted by poor management of appointments. He confirmed that the topic had been discussed by the Executive Team. The need to align this area with the Health Board's stated values around customer service and experience was recognised. Consideration also needs to be given to potential reasons for these issues, as highlighted by Ms Lewis. Professor Kloer agreed that all members of the Executive Team need to support operational and clinical teams to address this matter.

In considering the report's recommendations, it was agreed that the Board cannot take assurance at this time, and that a much broader review of processes is required. An action plan must be derived from this review. The proposal that QSEC lead on this issue and scrutinise the review findings in the first instance was further agreed, with this to begin at the next meeting. **AC** **SD**

Decision: The Board:

- **NOTED** the content of the Management of Waiting Lists/DNAs/ Appointments report
- **WAS NOT ASSURED** by the reviews currently underway and the further actions planned to improve arrangements for timely communication with patients in respect of their care and treatment pathways
- **REQUESTED** that a broader review of processes be undertaken, the output of which should include an action plan
- **REQUESTED** that this issue be referred for detailed scrutiny to QSEC in the first instance, with an update to the Board in March 2026

PM(25)165 **Improving People and Community Experience Report**

Presenting the Improving People and Community Experience Report, Ms Daniel emphasised the importance of reflecting service user feedback. Whilst the report records some very positive feedback, other feedback is less so. The report format has been changed to reflect Board Members' comments, to facilitate a richer insight from the information; for example, demographic data is now considered. Within this, around 40% of respondents report experiencing some degree of limitation in their day-to-day activities due to health conditions or disabilities. Ms Daniel welcomed this insight, noting that services are taking steps to respond in various ways, to better meet patient needs. Issues in relation to UEC, ambulance handovers, waiting times and use of technology have all been discussed in earlier agenda items, and are consistent with feedback from service users. Ms Daniel ended by reiterating the Health Board's commitment to continue to listen to patients and service users and meet statutory requirements under the Duty of Quality.

Cllr. Evans noted reference in the report to the top 10 reasons for concerns and enquiries, with these including delays in diagnosis, incorrect interpretation of results, and medication management. He requested assurance that steps are being taken to analyse trends (particularly if feedback consistently identifies issues with specific individuals), apply learning and undertake additional checks. Echoing this, Mrs Patel expressed concern that, whilst this topic has been considered by the Listening and Learning Sub-Committee (LLSC), she was not sure that an adequate response had been provided. It would be beneficial to receive additional context. Also, to receive assurance that associated learning will feed into the Health Board's strategy around education and training.

In response, Ms Daniel reminded Members of professional governance processes, including regulation and revalidation, which allows tracking of outcomes for individual clinicians, and potential outliers in this regard. There is a Quality and Safety Intelligence Group, which reviews all of this data. Whilst issues with specific clinicians would not be discussed at a public forum, they would be addressed on a one-to-one basis with individuals and their managers. Regarding Mrs Patel's query, an assurance route is provided via the LLSC reporting process to QSEC. This forum includes Heads of Service, offering them an opportunity to hear feedback. The discussions have identified a need to provide additional training to individuals where appropriate; it may, however, be that this requires further strengthening.

Mr Mark Henwood confirmed that there is a formal revalidation and appraisal process for doctors, for which he is responsible. He noted that issues with clinical competence are very few; the more frequent issue is with behaviour. This sometimes requires formal intervention and management. In terms of the impact of LLSC in improving communication, for example, whilst all outputs are fed back, Mr Henwood acknowledged that there is not necessarily a process for ensuring systemic improvement. Dr Wooding suggested that this point echoes earlier comments around escalation, and the absence of evidence of consequences for negative performance. This disempowers any insightful conversation around improvement. He also requested that further consideration be given to the report format, emphasising that the Board are less concerned with the data itself; rather the analysis and outcomes of this. **SD**

<u>Decision</u>: The Board **RECEIVED** the Improving Patient Experience report, which highlights to patients and to the public the main themes arising from patient feedback across the Health Board.

PM(25)166 **Prince Philip Hospital Minor Injury Unit Options**

Before introducing the report, Mr Henwood welcomed colleagues attending for discussion of this item. He thanked them for their contribution, together with all of the staff involved in ensuring that this significant undertaking could be presented to the Board.

Members were reminded of the background and context to this item, with Mr Henwood thanking all stakeholders for their input to the process. He further reminded Members of the four options developed by the options appraisal group, as outlined within the report, along with the possibilities which were not within scope. The consultation process was described, with Mr Henwood emphasising that this is not intended to be a vote or referendum. Members heard that external assurance of the consultation process had been sought, with findings from the mid-point and closing reviews appended to the report. In addition, and also appended is a full evidence base from the consultation process.

The consultation had attracted more than 7,000 responses, with various engagement methods and output. Mr Henwood wished to thank stakeholders for their formal responses, noting that two petitions had also been produced. A period of conscientious consideration has taken place, with the final report shared with a number of groups and the Board. During the process, 26 additional options had been identified, which aligned with the original four options, as described in the report. These had been assessed via a hurdle criteria workshop, with six meeting the required hurdle criteria. Mr Henwood described these and their alignment to the original four options. The scoring is outlined in the report, and identifies that there is little difference between Options 1, 4, 4a and 4d. With regard to which of the options are deliverable:

In terms of workforce, Options 1, 2, 4 and 4a are considered deliverable. Options 2d and 4d would be less deliverable, as the hours involved would be less attractive to staff. Options 1a, 2a and 4b would require additional recruitment. Options involving the 111 element are considered difficult to deliver. Whilst the Health Board very much believes in the premise of being able to 'schedule' unscheduled care, delivering access via 111 within a timeframe of 6-12 months would be extremely difficult. Whilst Option 3 would be deliverable, in terms of the first two phases; it is unclear whether a return to a 24 hour model could, or should be achieved. The inability to staff a 24 hour model had been the genesis of this issue, and there is no evidence to suggest that the recruitment landscape locally has changed. Whilst the report sets out projected costs, these are not without a number of caveats, and it should be noted that there are various options which it is not possible to cost currently. Options 4 and 4a would require capital investment, which would require further consideration. Finally, Members' attention was drawn to the Quality and Equality Impact Assessments which had been conducted, and which are included.

Referencing page 15 of the report, and the section on costs, Mr Huw Thomas advised that historically, the unit has been operating broadly within the financial parameters of Option 3. Due to the issues in staffing, the spend was in the region of £3m of the £3.6m indicated. This year, the figure indicated in expenditure is around the level of Option 1, at £2.5m; a £0.5m implicit saving. Any of the other options would build on this figure, and the additional

resource required to deliver them would need to form part of the financial planning for next year. In response to a query around whether there has been any analysis of which options provide the best value for money, Mr Huw Thomas advised that the data is purely a cost base. Value for money would need to be considered subsequently. There is, however, a significant cost differential between operating for 12 hours and 14 hours.

With regard to the Quality Impact Assessment (QIA) process, Ms Daniel advised that the Panel had met to discuss the QIAs submitted for each option against the domains of quality. The latter are as follows: safe, timely, effective, efficient, equitable and person-centred care. There proved to be little difference between Options 1, 4 and 4a in terms of quality impact. Certain of the options were scoring significantly in the safe care domain. In the Panel's opinion, the most promising Options were 4 or 4a, as this had the broadest scope and most potential to alleviate pressure on EDs. Ms Murphy indicated that she had spoken with staff from the unit, who have clearly expressed that it would not be possible to deliver a 24 hour service safely. Their preference is to incorporate more of a Same Day Emergency Care (SDEC) model; 12 hours patient care with an additional 2 hours to ensure that patients are safely allocated. Staff have also expressed that they would very much like a decision to be made, so that they can make progress in delivering care.

Dr Jon Morris welcomed the comments thus far. He reminded Members of the decision made last year and the discussions around this, together with the concerns it had inevitably raised. Dr Morris felt that the MIU is now delivering safe and effective care to the patients who attend, confirming that the 12 hour model works effectively. Whilst there has been a recruitment drive which had recruited seven additional GPs, this was an insufficient level to facilitate a return to a 24/7 service. From his viewpoint, a 12 hour model is deliverable long-term and offers a safe, effective service which provides value for money. The prospect of an Urgent Care Centre model is exciting, and would better reflect the work of the unit. It would also offer a good service to those who attend the unit. Representing the Nurse Practitioners of the unit, Ms Sian Edwards confirmed that the current service model has enabled staff to deliver safe and effective care. Whilst there had been certain challenges around the redirection process on occasion, backup has been provided by GP colleagues. Ms Edwards wished to emphasise the need to ensure a sustainable future for the MIU, and – in view of the age demographic of current staff – ensure workforce succession planning.

Noting the suggestion that Option 4 potentially offers positive impacts elsewhere, Mr Michael Imperato requested clarification of the reasons for this. In response, Dr Morris explained that the current model restricts the type of service the unit can provide to patients. There is a group of patients which are redirected elsewhere – to Primary Care, Pharmacy or ED. An Urgent Care Centre model would address the needs of some of these patients,

reducing the number redirected elsewhere and alleviating pressure on those services. Members heard that this would be achieved by broadening the services offered and increasing clinical streaming. Mrs Wilson advised of a query received from Ms Coleman, Llais, as follows:

> To make the service change successful, there needs to be continuous education and engagement with the public about what fits within the remit of an MIU. Without this, there risks being a 'creep' in remit, which will create challenges for professionals and mixed messages for the public. Does the Health Board have a plan to achieve this?

Welcoming this query, Ms Alwena Hughes Moakes emphasised that the Health Board has sought, during this period of temporary service change, the support of its communities. Those concerned about their health have been encouraged to use the online symptom checker, and/or use the 111 service, or – for serious issues – contact 999. It is intended that this approach will be continued, as part of a planned programme of education to ensure that service users are signposted to the best source of support. Mr Imperato echoed Ms Coleman's comment, reiterating his own concerns around transport and emphasising the need to keep this under review. The Health Board should also consider how it might input to discussions and decisions around improving transport provision within the region.

In response to a query around whether transport will be devolved to Local Authorities in the future, Cllr. Evans explained that this depends on the route involved. Trunk roads will remain the responsibility of Welsh Government; smaller routes will fall under the remit of Local Authorities. This may offer more opportunities to influence decisions at a local level. The situation is, however, complex and evolving. Whilst recognising that transport is not the Health Board's responsibility, Dr Wooding emphasised that assisting patients to access transport is. On a more basic level, and linked to Ms Coleman's comments, Ms Murphy highlighted that the road signage around Prince Philip Hospital (PPH) still refers to an A&E. She suggested that, once a decision is made, this signage should be corrected by the Local Authority. **AC**

Mrs Marks wished to thank all of those involved with this work, and acknowledged the significant level of response to the consultation. Echoing an earlier comment, staff within the unit are extremely keen that a decision is made, and this will be key in terms of staff recruitment, retention and wellbeing. Whilst there has not been an A&E at PPH for quite some time, the people of Llanelli and the surrounding area need a quality service. The priority in providing this must be safety. An SDEC combined with Minor Injuries, as described, would differ from models elsewhere; however, it would appear to offer this quality service. Mrs Marks agreed that there needs to be more education of the public around the model and the services it would provide. In terms of operating hours, be this 12 or 14 hours, she suggested that the advice of

clinicians be prioritised. However, it must be recognised that this situation began because of an inability to safely staff the unit; any model must be both deliverable and safe. Taking into account the fact that it is the second most popular choice based on the responses, and clinically-advocated, Mrs Marks would support Option 4.

Focusing on the outcomes of the consultation and value for money considerations, Dr Gjini felt that it was important to contextualise the Health Board's duty to invest in the health of the population. Based on clinical outcomes, this has not worsened during the temporary service change. This is an opportunity to provide a better service for the needs of the local population. In terms of costs, providing a service model which does not improve outcomes for patients will not meet the needs of the population and will effectively 'divert' funding which might be better spent elsewhere. Dr Gjini agreed with others that more can be done to educate and engage with the public around how best to access the correct service for their needs.

Mr Lee Davies thanked Save Our Services Prince Philip Action Network (SOSPPAN) and Llais for their constructive input to the process. This had led directly to the development of Option 4, which had not been one of the original options. In terms of additional options involving 111, it is an ambition to reach a point at which appointments can be scheduled as far as possible. Mr Lee Davies acknowledged that there is confusion around how to access services and which services to access, which the Health Board will need to focus on addressing. Value for money will also require consideration. He wished to highlight that there has been no reduction in MIU activity, which is continuing to meet the needs of patients, in a more controlled manner. This had led to improved patient experience, improved performance, targets being met and improved staff experience.

One of the concerns which has not materialised is a detrimental impact on Glangwili or Morriston EDs. In terms of the financial implications of Option 4, whilst it would increase the Health Board's current run-rate, Mr Lee Davies emphasised that the long-term aim would be for 7 day SDEC provision across the entire Health Board. This aligns with the general 'direction of travel' and would serve to ensure that patients can access more timely care. It would also reduce unnecessary admissions, providing system efficiencies and value gains. With regard to opening hours, as part of the SDEC plans, it is envisaged that these would be aligned to demand patterns, 8am – 8pm. This may provide context in making the decision on the PPH model. Mr Severs advised that he has been working with the Medical Director and Director of Nursing to consider the sustainability of clinical workforce models. In support of Option 4, this absolutely aligns with principles of multi-professional clinical leadership and delivery, and was welcomed.

Focusing on Option 1 versus Option 4, Mr Maynard Davies noted that the staffing difference between these models was 14 WTE

posts. He enquired regarding the confidence in recruiting this additional workforce, the timescales in delivering the various options, and whether certain options are easier to deliver. In response, Mrs Gostling advised that the team involved believe that the staffing requirements can be fulfilled within 6-12 months, utilising a phased approach. Ms Edwards added that the workforce model would centre on merging the SDEC and MIU workforce and utilising some current staff. Dr Wooding emphasised the benefits of selecting an option which is consistent with staff preference in terms of working patterns.

Professor Kloer added his thanks to all parties for their input and engagement, and to the Health Board teams for managing a complex process. He reiterated the desire for a high quality and sustainable service model, and reminded Members of the decision-making principles outlined at the start of today's meeting. Professor Kloer felt that most of these had been considered during the foregoing discussions. He suggested that the Urgent Care Centre model offered by Option 4 feels like an enhancement over Option 1, whilst recognising that it does have cost implications. It does, however, appear to offer the potential for improved sustainability and quality for the public. The fact that it is being recommended by clinical staff also suggests that it will be easier to recruit to. Option 4, therefore, seems the best option. In terms of opening hours, Professor Kloer indicated that he would be cautious about the sustainability of the 14 hour model, suggesting that this might be considered at a later date. Professor Kloer wished to commend the process which had been followed.

Dr Wooding reminded Members of the context to this process, which reflected discomfort among clinicians around the quality and safety of the previous service model, together with staff wellbeing concerns. The previous model had been at risk of collapse due to unsustainability. The message had been powerful, only amplified by Healthcare Inspectorate Wales (HIW) findings around safety. The Board had made its decision to reduce opening hours based on both safety and sustainability. As a result, an effective service has been delivered, with relatively little negative impact and positive impacts on staff wellbeing. In addition to the decision-making principles, Dr Wooding emphasised the need to consider value for money and meeting the needs of future populations. An Urgent Care Centre model has the potential to align with the Health Board's wider and long-term strategy.

All of which appears to point towards Option 4 (and Option 4a, operating on a 12 hour basis specifically). This will involve planning for additional costs; however, there is a potential to add value. Dr Wooding was aware that any decision of this nature will not be universally popular. However, it must be based on what is best in all possible respects. He agreed that the Health Board should focus on communication and education, and consider the challenges around transport and how it might facilitate access to services. Mr Weir reiterated that Option 4a will require capital expenditure, requiring Welsh Government support. He

nevertheless felt that it was the correct option to choose. Mr Weir emphasised that the additional 14 WTE this option requires must be sourced via staffing establishment or bank, rather than agency.

Suggesting that there be an evaluation following implementation of the selected option/model (after 6 months), Professor Kloer proposed that this consider: **MH/LD/AHM**

- Patient experience and outcomes
- Staffing
- Transport
- Programme of work around communication
- Work with 111 to signpost the public to support
- Capital requirements and broader resource implications

Mr Lee Davies advised that there has been an initial scoping of works which might be required in redesigning the MIU to accommodate the changes required. This would be repeated and enhanced to allow consideration of the capital implications. Members were reminded by Mr Huw Thomas that choosing Option 4a will involve an investment over and above both current and historic levels, which needs to be recognised in terms of financial impact.

Decision: The Board:

- **CONSIDERED** the key findings from the consultation feedback report
- **CONSIDERED** the findings of the stakeholder review of the alternative options
- **CONSIDERED** the findings of the conscientious consideration process
- **AGREED** a preferred option for how the Health Board provides Minor Injury Unit (MIU) services at Prince Philip Hospital (PPH); this being Option 4a, operating on a 12 hour basis
- **NOTED** the requirement for the service to develop an implementation plan, setting out how the preferred option will be operationalised
- **REQUESTED** an evaluation 6 months post-implementation, to include the various elements indicated during discussion, to be brought back to Board

Dr Jon Morris, Ms Sian Edwards, Dr Daniel Warm and Ms Nichola Couceiro left the Board meeting.

PM(25)167 **Operational Delivery Network (ODN) South West Regional Pathology Arrangements**

Introducing the report, Mr Lee Davies reminded Members of the background to this item, which has involved an extended and ongoing programme of work. The original plan had been to develop a regional facility; however, Welsh Government had decided to cease support for this option. The service area most at risk is Cellular Pathology, and this is also an area identified as a

national priority by the Ministerial Advisory Group (MAG) process. As a result, Hywel Dda UHB and Swansea Bay UHB have been undertaking a programme of regional work, in which both Health Board Vice-Chairs have been involved. Their support and input is welcomed. Lifecycle Consulting was commissioned in May 2025 to provide external support and scrutiny, and their report has been included. The report's contents describe the 'What, Where and How?' (the various options available; the two potential locations; and the service model). Mr Lee Davies advised that a staff briefing had taken place on 22 September 2025, with both Health Boards committed to continued dialogue with staff. It is recognised in this that Pathology has been a long-standing issue of concern.

On this final point, Dr Wooding enquired regarding the staff response. He was advised that the regional proposals had been communicated and were widely known. The briefing had provided an opportunity to respond to staff questions, and the Health Board teams will continue to do so. Reiterating that this has been an extremely long-standing issue, Ms Lewis enquired how this proposal differs from previous ones in providing a potential solution. Mr Lee Davies explained that, whilst the original plan had begun with a specific scope, it had evolved into a very ambitious project, with significantly increased costs, of £135m+. Clearly, this was not realistic to fund or deliver. The revised proposal is significantly scaled down, to focus on the area presenting most risk – Cellular Pathology. This service area has been visited by Both Welsh Government and the MAG. Welsh Government is supportive of the steps proposed to address issues and it is hoped that this will enable the Health Boards to take the matter forward.

Thanking all of those involved, Dr Wooding welcomed the progress made and pragmatic approach taken in addressing what is currently an extremely poor working environment for staff. He suggested that it would be unconscionable not to support the proposals and recommended that they be progressed as quickly as possible. As such, he would welcome a detailed delivery plan and timescale. In considering the report's recommendations, regarding point 4, Dr Wooding was not of the opinion that significant energy should be expended on exploration of external partnership opportunities, as these are likely to be limited. Recommendation 6, around vacancies was viewed as a workforce and operational matter, which should be managed as such.

AC

<u>Decision</u>: The Board:

1. **ENDORSED** the aspiration to develop a fully integrated regional cellular pathology service (Option 5) in a single facility for South West Wales.
2. **ACKNOWLEDGED** that, based on early market assessment, it is unlikely that a full service provision/provider is interested in full development of capital and service for South Wales to progress development of a NHS developed and managed regional service.

3. **ENDORSED** the intention to develop a business case to support the conversion of one of the two preferred site options for the development of a regional cellular pathology and through the development of that business case confirm the preferred option.
4. **SUPPORTED** the continued limited exploration of external partnership opportunities (e.g. reporting service, managed service contract for specialist laboratory equipment).
5. **CONFIRMED** commitment to developing a single regional service pathology hosted by Swansea Bay as outlined in the Transitional Memorandum of Understanding re-endorsed in March 2025 Boards.
6. **AGREED** to review, at an operational level, any pathology leadership vacancies that emerge in either organisation whilst the capital solution is being developed for regional replacements or alternative interim arrangements/ consolidation.
7. **AGREED** to consider options to relieve pressure on Glangwili and implement a transitional plan to consolidate some services at Singleton (e.g. specialist services).

PM(25)168 **Equality, Diversity and Inclusion Taskforce Update**

Ms Lewis presented the Equality, Diversity and Inclusion Taskforce Update report, reminding Members of discussions at the most recent Board Seminar. Priority actions had been agreed, which are outlined on page 2 of the report, and these are being progressed. In the context of these first of these, evidencing Board allyship, Ms Lewis felt it was important to recognise the increasing divisiveness and toxicity in current public discourse, which is a major concern. It would not be possible for the Health Board to function as an NHS organisation without the contribution of some of those who are being targeted . Increasingly, and concerningly, this behaviour is becoming normalised. Ms Lewis suggested that it may be appropriate to consider what the Health Board could do to support staff who might be suffering the impact of this behaviour. Mrs Gostling indicated that she would discuss work in relation to equality during the Strategic Equality Plan (SEP) Annual Report agenda item.

Mr Weir advised that he had attended the group meeting, at which there had been good engagement. He emphasised that the Board should be uncomfortable with the disparity between staff evidenced by the SEP report mentioned above. Whilst there is some limited evidence of change, the organisation should be encouraging best practice and making clear that it will not tolerate behaviour which does not align with its values. There are resource implications, in terms of staff time; however, this is an area in which the Health Board needs to be making progress at pace. Mrs Patel, who was also a part of the group, advocated a focus also on the broader organisational culture, rather than compliance with legislation alone. This would serve to support staff feeling the effects of the negative and toxic atmosphere mentioned above.

Dr Wooding emphasised that the organisation is obliged to protect its staff, both outside and inside work. He remained concerned that there is too much complacency around this area, agreeing that the social pathology and divisiveness is becoming significantly more damaging.

<u>Decision</u>: The Board:

NOTED the items the Committee is advising them of
TOOK ASSURANCE on the items that the Committee is providing assurance on

PM(25)169 **Centre for Social Innovation**

Introducing the report, Dr Gjini explained that the Centre for Social Innovation is based on a partnership with the University of Wales Trinity St David (UWTSD) and informed by the Social Model for Health and Wellbeing (SMfHW). As indicated within the report, the Centre for Social Innovation (CfSI) has a focus on two main aims:

- Establish a physical and online presence for the CfSI, with a recognised brand and identity
- Carry out, support, and evaluate a minimum of 12 Social Innovation Change Projects in the Health Board region; 4 projects a year

A governance structure and business plan to support these aims has been developed, and consideration is being given to the workforce requirements. In collaboration with local communities, various key priorities have been identified, which Dr Gjini outlined for Members. Core areas for focus are cardiovascular disease; diabetes, obesity and weight; respiratory health; improving the health of children and young people, and healthy aging.

Mr Iwan Thomas welcomed the report. He declared two interests in this item, relating to the Carmarthenshire Living Well Centre, on which he is leading in his PLANED role; and his membership of the Council of the University of Wales. The CfSI is undertaking a full evaluation of the Living Well Centre; and the team have found their wider input and insight invaluable, and look forward to their continued involvement. Welcoming this initiative, Mr Imperato noted that the CfSI is described as an ‘arms-length body’ and enquired whether it was the responsibility of any one individual or organisation. In response, Dr Gjini advised that it was based on a collaborative agreement, with a Special Advisor who has worked with the Health Board for a number of years being one of the co-leads. The executive Oversight Group and operational Steering Group, which are part of the governance, are both collaborative.

Mrs Patel enquired whether the CfSI has defined outcomes it is seeking, or whether the aim is more ‘organic’. She explained that, given the financial investment involved, details of outcomes and evaluation of impact will be required. Dr Gjini indicated that the Centre’s ultimate aim is to improve the health of the local population. It is recognised, however, that the solutions involved

are far more complex and are long-term rather than short-term. The Centre will enable more innovative thinking and sharing of expertise, at 'arms-length'. The projects identified should, however, lead to improved outcomes in those areas. In terms of governance, Mr Weir enquired the reporting structure for the CfSI, noting that there was potential for relevance to various fora, including the Strategy and Planning Committee (SPC) and the Digital, Data and Innovation Committee (DDIC). He also enquired regarding the involvement of the Value Based Health Care (VBHC) team. Dr Gjini indicated that reporting will be via SPC, and confirmed that the VBHC team has been very much involved. Consideration will need to be given to whether PROMs (Patient-Reported Outcome Measures) and/or PREMs (Patient-Reported Experience Measures) are the most appropriate measures to use, or whether others should be explored.

Professor Kloer highlighted the apparent paradox that healthcare alone contributes to around 15% of population health and wellbeing, whilst the NHS accounts for 50% of the Welsh Government budget. This serves to emphasise that the current model is very much medicalised. There are many other contributory factors which the healthcare sector does not control. These are not necessarily controlled by other bodies either; some are entirely within the 'gift' of the general public and communities. As a result, retaining the SMfHW within a health board becomes inappropriate, which presents its own challenges. Professor Kloer wished to highlight that, whilst UWTSD is the formal partner in this arrangement, the other local universities are also actively involved. Collaboration is potentially more important than an actual staff presence. The advice and input of partners will be vital. In terms of outcomes, he suggested that these were less about healthcare and more concerning health promotion and prevention of ill health. It is envisaged that Board will receive some form of report, even if via another forum. Dr Gjini clarified that the concept is for the CfSI to attract funding, similarly to any other academic institution.

Dr Wooding welcomed this discussion, whilst emphasising the need to ensure that the CfSI and its work is not disregarded, with the organisation continuing to operate as it has always done. The Board needs to consider how it can actively support the Centre and ensure that its work permeates all areas of the Health Board. Defined actions are required. Dr Gjini emphasised that the organisation has committed to the principles of the SMfHW. Whilst these are reflected in Health Board workstreams, they are perhaps not as explicit as they might be, and could be strengthened. It was agreed that a further update, to include details of issues and challenges, would be presented to the Board in 6 months. **AG**

<u>Decision</u>: The Board:

- **NOTED** the progress of the establishment of the Centre for Social Innovation (CfSI) with the University of Wales Trinity St David (UWTSD)
- **TOOK ASSURANCE** that projects will contribute to the spread and adoption of the Social Model for Health and Wellbeing (SMfHW) within west Wales and requested a report to Board in 6 months' time

PM(25)170 Report of the Audit and Risk Assurance Committee

Cllr. Evans thanked Mr Weir for chairing this meeting in his absence. Mr Weir, ARAC Vice-Chair, presented the update report from the meeting held on 12 August 2025, suggesting that this covers the key discussions. As noted, concerns had been expressed regarding the sample sizes in relation to a couple of Internal Audits. Whilst these will be repeated, the issues identified therein and associated recommendations remain pertinent. Mrs Wilson clarified that the Limited Assurance ratings for these audits still stand.

Decision: The Board:

- **RATIFIED** the Risk Management Framework
- **RATIFIED** the Risk Management Strategy
- **NOTED** the items the Committee is advising it of
- **TOOK ASSURANCE** from the items that the Committee is providing assurance on

PM(25)171 Risk Management Framework and Risk Management Strategy

Members noted that these documents had been scrutinised by ARAC, following a process of consultation and feedback.

Decision: The Board:

- **APPROVED** the Risk Management Framework
- **APPROVED** the Risk Management Strategy

PM(25)172 Report of the Quality, Safety and Experience Committee

Ms Anna Lewis, QSEC Chair, presented the update report from the meeting held on 15 August 2025, advising that this is as presented. The 'Advise' item, around the sonography service in midwifery, relates to a risk which QSEC has been tracking for some time; the implications of workforce shortfalls for patients. The report on this matter was extremely helpful to the Committee. Whilst work is underway to mitigate the risk, addressing the core issue will require a more strategic workforce review. As indicated, it is intended that the service model redesign and workforce plan will be shared with the Executive Team and Board in March 2026. Ms Lewis suggested that the report reflects the broad range of topics discussed by the Committee. Members' attention was drawn to the establishment of a working group in Learning Disabilities and Epilepsy. QSEC was assured that this has a clear scope and is working at pace, and hopes to see evidence of significant results soon. Ms Lewis went on to advise that an

Extraordinary QSEC meeting had taken place on 15 September 2025. This had been to ensure that QSEC has sufficient oversight with regard to the CSP pathways and latest position. Three of the nine services had been considered: Critical Care, Emergency General Surgery and Stroke Services. A further three would be considered at the scheduled QSEC meeting in October and the final three at a further Extraordinary meeting in November. An issue relating to the Critical Care pathway was identified during the first meeting, which is being addressed by considering the application of the Standard Operating Procedure. Common themes included the 'critical mass' required to sustain services in a decentralised configuration, and challenges around rotas, recruitment, infrastructure and capital investment. All of these issues impact on the quality and safety of services. Ms Lewis suggested that the scrutiny provided by these discussions had demonstrated clearly that the current position is unsustainable. A written report from the Extraordinary meeting will be provided to the next Public Board meeting.

Dr Wooding emphasised that this information should be considered as part of the CSP process, with Mrs Wilson indicating that the meeting had been formally minuted. In the interests of clarity, Mrs Wilson advised that an agenda item on Section 136 Facilities was due to be considered by the Board today. However, additional work is required and had necessitated its deferral to the November 2025 Public Board meeting. **LD**

<u>Decision</u>: The Board:

NOTED the items the Committee is advising them of
TOOK ASSURANCE from the items that the Committee is providing assurance on

PM(25)173 Report of the Finance and Performance Committee

Mr Imperato, FPC Chair, presented the update report from the meeting on 26 August 2025. Several of the items therein had already been covered in earlier discussions, including the savings gap and concerns around performance. FPC had also held an Extraordinary meeting on 15 September 2025, which had focused on financial choices and decisions, another topic already considered by the Board.

Mr Weir observed that Ophthalmology is highlighted in both the QSEC and FPC reports. Whilst recognising that there is no simple solution to the issues in this service area, he expressed concern that it is appearing at more than one committee, and queried whether the Board should be considering further action. It was noted, however, that there were other services which are also raised as being of concern in multiple fora. Cllr. Evans enquired whether the Health Board is consistently advertising vacancies in this specialty, as informal feedback suggests not. In response, Mr Henwood assured Members that all possible steps to recruit staff are being taken, whilst emphasising that it does not send a positive message to constantly advertise vacancies in specific

service areas. Whilst acknowledging the challenges around the Ophthalmology workforce, Professor Kloer reminded Members that the Health Board is applying innovative solutions, including providing services via Optometrists. New ways of working such as this must be explored, as must regional solutions.

Decision: The Board:

- **APPROVED** the award of a Histopathology Managed Service Contract Renewal to Leica Microsystems UK Ltd
- **APPROVED** the award of an Outsourcing of Ophthalmology Services – Mobile Theatres (Stage 4 - Cataracts) contract to SpaMedica
- **APPROVED** the renewal of the National Care Homes Framework Agreement, should no further alternative be available (see item below)
- **RATIFIED** the revised Terms of Reference for the Finance and Performance Committee
- **RESPONDED TO** the items that the Committee is alerting them to
- **NOTED** the items that the Committee is advising them of
- **TOOK ASSURANCE** from the items that the Committee is providing assurance on

PM(25)174 **Procurement Report**

Mr Huw Thomas highlighted that Renewal of the National Care Homes Framework Agreement is the subject of discussions at a national level, with the position having changed since the report was produced. He requested that the Board approve renewal pending confirmation of national agreement, and committed to confirm this agreement in a future Procurement Report. **HT**

Decision: The Board:

- **APPROVED** the award of a Histopathology Managed Service Contract Renewal to the above provider for the period 1 December 2025 to 30 November 2029, with no option to extend. This contract will have onwards submission to Welsh Government for approval.
- **APPROVED** the award of an Outsourcing of Ophthalmology Services – Mobile Theatres (Stage 4 - Cataracts) contract to the above provider for the period 1 November 2025 to 31 March 2025, with the option to extend for a further one year. This contract will have onwards submission to Welsh Government for approval.
- **APPROVED** the Renewal of the National Care Homes Framework Agreement, subject to confirmation of national agreement. This Procurement will be undertaken by AW Commissioning to establish a framework agreement. Award of the framework agreement will have onwards submission to Velindre NHS Trust (as hosts of NHS Wales Shared Services Partnership), as well as to Welsh Government for approval, on completion of the procurement.

- **APPROVED** the Extension of the All-Wales Interventional Cardiology, Radiology, Endoscopy, and Surgical Urology Consumables Framework Agreement. This contract will have onwards submission to Velindre NHS Trust (as hosts of NHS Wales Shared Services Partnership).

PM(25)175 **Report of the Strategy and Planning Committee**

Mr Weir, SPC Chair, presented the update report from the meeting on 28 August 2025. He advised that he had met with the Chair of the Regional Partnership Board, in what had been a helpful meeting. An SPC Chair's Action meeting had taken place, reported under a separate agenda item, to discuss the Glangwili Hospital (GGH) Front Door Business Case. It had been pleasing to hear the enthusiasm of staff for the proposed change and the potential impact of this. Mr Weir reported that the Health Board has received additional capital funding from Welsh Government to support Radiology equipment and Ultrasound, which is very much welcomed. Finally, SPC had considered the Health Board's winter plans, which will include the Respiratory Vaccination Programme, also due for consideration under a separate agenda item.

Decision: The Board:

- **APPROVED** the Glangwili Hospital Front Door Business Case for onward submission to Welsh Government, subject to final cost confirmation and within the outlined governance framework
- **NOTED** the items the Committee is advising them of
- **TOOK ASSURANCE** from the items that the Committee is providing assurance on

PM(25)176 **Glangwili Hospital Front Door – Opportunities for Improved Patient Flow**

Presenting the report, Mr Lee Davies advised that this project has been ongoing for a number of months. Members will be aware of the challenges within GGH, together with the findings of the recent 'Getting It Right First Time' (GIRFT) report and MAG visit. Welsh Government officers had also visited to discuss potential routes to improvement, and operational and clinical teams had since been working on proposals which would deliver this. As indicated by Mr Weir, the resulting business case had been considered at a Chair's Action meeting and is commended for approval.

In considering the report's recommendations, it was agreed that the second of these would be subject to sign-off by the Chair and Chief Executive on behalf of the Board, if in excess of £1m. **AC/LD**

Decision: The Board:

- **APPROVED** the GGH Front Door Business Case for onward submission to Welsh Government, to request capital to deliver the project recognising that costs in excess of the funding that

may be awarded will be subject to UHB discretionary capital funding which could impact on capital programme of works.

- **APPROVED**, subject to sign-off by the Chair and Chief Executive on behalf of the Board, the award of the works contract to John Weaver, should the tendered costs be returned at over £1m, noting that this will be formally reported back to the Board, via the table of actions, in November 2025.

PM(25)177 **Winter Respiratory Vaccination Programmes Delivery Plan 2025/26**

Dr Gjini introduced the report, which outlines the planned delivery of winter respiratory vaccinations. The Health Board will support Primary Care in delivering Flu and COVID-19 vaccinations to core eligible groups. Vaccinations will also be delivered by the Health Board team, school nurses and pharmacists. Dr Gjini described the actions being taken to help in increasing vaccine uptake.

Professor Kloer advised that he had visited a local school where he had seen the school nursing team delivering vaccinations. They estimated that they will deliver 30-40,000 vaccinations. He had been extremely impressed with their work and with the engagement with schools. The region does have low vaccination rates, which has an impact on illness rates, demand for GP appointments, hospital admissions and staff sickness rates. He would encourage Health Board staff to take up vaccinations. Whilst acknowledging Professor Kloer's comments, Dr Gjini wished to highlight that HDdUHB has one of the highest rates for school-based vaccinations. Dr Wooding thanked all of those involved in delivering the vaccination programme.

Decision: The Board:

- **TOOK ASSURANCE** that there is a delivery plan for the HDdUHB COVID-19 and Flu Immunisation Programmes
- **NOTED** the work underway to mitigate the risk to programme delivery of proposed approach
- **TOOK ASSURANCE** from the control measures in place through recognition of the key enablers, and identified actions to improve uptake

PM(25)178 **Report of the People, Organisational Development and Culture Committee**

Mrs Marks, PODCC Chair, presented the update report from the meeting on 19 August 2025, highlighting concerns in relation to the time taken to implement the new Operational Structure. Discussions regarding the Strategic Equality Plan Annual Report and Pay Gap Report indicated that there is further work required. Mrs Marks also advised that PODCC had considered the Culture Overview Report and challenges around staff morale, resilience and tolerance, with a further update due in February 2026.

Decision: The Board:

APPROVED the Strategic Equality Plan Annual Report and Pay Gap Reports for publication
NOTED the items the Committee is advising them of
TOOK ASSURANCE from the items that the Committee is providing assurance on

PM(25)179 **Strategic Equality Plan Annual Report**

Introducing the item, Mrs Gostling advised that the Health Board produces a detailed Workforce Report and three Pay Gap Reports. All of these documents had been considered and discussed in detail at PODCC, with an Executive Summary provided for the Board. The full reports are available from the Health Board website. The Health Board recognises that not all staff have a positive experience; Members' attention was drawn to the 'Working for Us' page of Appendix 2, which is based on Staff Survey results. HDdUHB's position does not compare well with the rest of Wales. Whilst as indicated earlier in the meeting, there are 'green shoots' of improvement, there remains much to do in this area.

Dr Wooding expressed concern that the organisation is too passive and needs to take more proactive steps to drive improvement in this area. It is unacceptable for people to be treated differently or less favourably because of their ethnic group, gender or age. In response, Mrs Gostling assured Members that the Health Board is considering how to introduce pace and urgency and how to 'disrupt' the current position.

Decision: The Board:

APPROVED the Strategic Equality Plan Annual Report 2024-2025 for publication, noting that this is a consolidated report bringing together all reporting requirements established under the Equality Act 2010.

PM(25)180 **Report of the Health and Safety Committee**

Ms Murphy, Health and Safety Committee (HSC) Chair, presented the update report from the meeting on 9 September 2025, highlighting the single 'Advise' item.

Decision: The Board:

- **NOTED** the items the Committee is advising them of
- **TOOK ASSURANCE** from the items that the Committee is providing assurance on

PM(25)181 **Report of the Charitable Funds Committee**

Mr Iwan Thomas, Charitable Funds Committee (CFC) Chair, advised that, due to the Committee only meeting 9 days prior, a verbal report was necessary. The CFC had noted no issues with regard to the performance of Charitable Funds. It had considered three funding requests, in relation to the PPH Therapeutic Gardens project, the 'Heads Up' Initiative, an extremely insightful and emotive project, and the Arts Referral Programme. The first of

these is due for consideration at the Corporate Trustee session immediately following the Public Board meeting. Mr Iwan Thomas advised that the CFC has established, as a standing agenda item, evaluation of the impact of projects supported by Charitable Funds. This is serving to demonstrate the success and impact of projects, which is welcomed by the Committee. The meeting had also received a very insightful overview of investments. Members remain, however, concerned by the amounts held in accounts, and further detail has been requested in this regard.

Decision: The Board:

- **TOOK ASSURANCE** from the items that the Committee is providing assurance on.

PM(25)182 **Report of the Digital, Data and Innovation Committee**

Mr Maynard Davies, DDIC Chair, advised that the update report from the meeting on 22 July 2025 was as presented verbally at the previous Board meeting.

Decision: The Board:

- **APPROVED** the adoption of the LIMS2.0 programme deployment approach based on discipline, as this strategy will enable the earliest transition away from the current TCL system
- **RESPONDED TO** the items the Committee is alerting them to
- **NOTED** the items the Committee is advising them of
- **TOOK ASSURANCE** from the items that the Committee is providing assurance on

PM(25)183 **Report of the Regional Joint Committee**

Dr Wooding, Regional Joint Committee (RJC) Co-Chair, presented the update report from the meeting on 18 August 2025, which was as provided. The presentation received from CGI had been extremely interesting and valuable.

Decision: The Board:

- **CONSIDERED** the report of the RJC meeting held on 18 August 2025, recognising progress made in regional collaboration and 2025/26 work programme development.
- **RECEIVED** (identified separately on the September 2025 Public Boards' agenda) the paper articulating the set of final Cellular Pathology recommendations, for Board(s) approval.
- **RATIFIED** the approval and adoption of governance arrangements and endorse the direction of travel for all Regional Joint Committee Sub-Groups.

PM(25)184 **Committee Update Reports**

Introducing the Committee Update Reports, Mrs Wilson highlighted the reports included and indicated that the report stands as presented.

<u>Decision</u>: The Board:

- **RECEIVED** the update reports in respect of work undertaken on behalf of the Board at recent Committee meetings
- **RECEIVED** the update report in respect of the In-Committee Board meeting
- **RECEIVED** the update reports in respect of recent Advisory Group meetings
- **NOTED** the items that it is being advised of
- **TOOK ASSURANCE** from the items that it is being assured on
- **APPROVED** the Stakeholder Reference Group Terms of Reference

PM(25)185 **Joint Committees and Collaboratives**

Professor Kloer introduced the report, stating that this is as presented. In relation to the Joint Commissioning Committee (JCC), a financial risk to the Health Board of approximately £750k is emerging. This relates to the specialist (tertiary) end of the clinical treatment spectrum. Whilst it encompasses HDdUHB patients, it does involve expending additional Health Board resource within the specialist sector.

<u>Decision</u>: The Board:

- **RECEIVED** the updates in respect of recent Joint Commissioning Committee (JCC), NHS Wales Shared Services Partnership Committee (NWSSPC) and Mid Wales Joint Committee for Health and Care (MWJC) meetings
- **APPROVED** the adoption of the updated Scheme of Delegation and Reservation of Powers for the matters further delegated from the JCC to the Chief Commissioner (and other Officers as appropriate) as a schedule to the Hywel Dda University Health Board's Standing Orders

PM(25)186 **Statutory Partnerships Update**

Presenting the Statutory Partnership Update Report, Ms Paterson highlighted increasing alignment between topics considered by the Regional Partnership Board (RPB) and Public Services Boards (PSBs) and those being discussed by the Health Board. Members' attention was drawn to approval of Part 9 of the Statutory Partnership Regulations, relating to Terms of Reference for the RPB. Consideration will be given to Health Board representation on this forum, and Ms Paterson would agree with the Chief Executive and Director of Corporate Governance the most appropriate Board level Committee for discussion. **JP**

<u>Decision</u>: The Board **TOOK ASSURANCE** that the Health Board is working effectively with Statutory Partners in order to meet the required obligations as laid out by the Well-being of Future Generations (Wales) Act 2015 and the Social Services and Wellbeing (Wales) Act 2014.

PM(25)187 **Any Other Business**

There was no other business reported.

PM(25)188 **Board Annual Workplan**

The Board **NOTED** the Board Annual Workplan.

PM(25)189 **Date and Time of Next Meeting**

9:30am, Thursday, 27 November 2025