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

Date of Meeting: **09:30, Thursday 30 January 2025**
Venue: **Ceredigion County Council Chambers, Penmorfa, Aberaeron, Ceredigion SA46 0PA**

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)
Ms Anna Lewis, Independent Member (Community)
Ms Ann Murphy, Independent Member (Trade Union)
Mrs Chantal Patel, Independent Member (University)
Ms Delyth Raynsford, 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 Andrew Carruthers, Chief Operating Officer
Ms Sharon Daniel, Interim 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, Interim Medical Director
Dr Jonathan Arthur, Deputy Director of Health Sciences (deputising for 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 Sam Dentten, Deputy Regional Director, Llais West Wales
Ms Anne Beegan, Audit Manager, Audit Wales (part)
Ms Clare Moorcroft, Committee Services Officer (Minutes)

| Minutes Ref. | Item | Action |
|---|---|---|
| **PM(25)01** | **Welcome and apologies** | |

Dr Neil Wooding, Health Board Chair, welcomed everyone to the Public Board meeting, thanking them for their attendance. There were no matters that Members felt were omitted from the reports.

Dr Wooding reminded Members of the Board's five decision-making 'design principles' and the context behind these:

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 James Severs, Executive Director of Allied Health Professions and Health Science
- Mr Michael Gray, Director of Social Services and Housing, Pembrokeshire County Council

**PM(25)02 Declaration of Interests**

The following declarations of interest were made:

- Cllr. Rhodri Evans – discussions relating to Cylch Caron, due to his role for Ceredigion County Council
- Mr Iwan Thomas – discussions relating to community organisations, due to his PLANED role
- Ms Ann Murphy – discussions relating to the Clinical Services Plan, due to her Trade Union role
- Mr Michael Imperato – discussions relating to the Infected Blood Inquiry, due to his role as legal representative for a number of victims and for Haemophilia Wales; discussions regarding Emergency Medical Retrieval and Transfer Service (EMRTS) due to his firm's role in the Judicial Review

**PM(25)03 Minutes of the Public Meeting held on 28 November 2024**

**RESOLVED** – that the minutes of the meeting held on 28 November 2024 be approved as a correct record.

**PM(25)04 Matters Arising and Table of Actions from the Meeting held on 28 November 2024**

An update was provided on the Table of Actions from the Public Board meeting held on 28 November 2024. Confirmation was received that outstanding actions had been progressed, aside from two where the timescale for completion had been moved forward. There were no matters arising.

**PM(25)05 Report of the Chair**

Dr Wooding presented his report on relevant matters undertaken since the previous Board meeting, highlighting that the Board Seminar in December 2024 had focused on Equality, Diversity and Inclusion. It had been agreed that a Taskforce would be established. Dr Wooding welcomed the very helpful discussions, which had provided Board Members with an understanding of the scale of the issue and the actions required.

With regard to the Taskforce, Ms Anna Lewis advised that this has been established and that she anticipated being able to provide a

more detailed update at the next Board meeting. In response to a query around the impact of the changes to NHS Regulations, Mrs Joanne Wilson provided an overview of these changes and their impact.

Members heard that a number of Health Board representatives had been present at a well-attended community meeting in Aberystwyth regarding Stroke Services. Dr Wooding felt this had been an extremely positive and balanced meeting. He advised that this topic will be covered further during later discussions on the Clinical Services Plan and public engagement.

**Decision:** The Board:

- **RATIFIED** the Orthopaedic Independent Sector Contract Awards approved under the Chair's Action to the recommended provider Healthcare Business Solutions.
- **SUPPORTED** the work engaged in by the Chair since the previous meeting and noted the topical areas of interest.

**PM(25)06** **Report of the Chief Executive**

Professor Philip Kloer introduced his report on relevant matters undertaken since the previous Board meeting, highlighting that this contains a number of important items. He referenced in particular the update on the Prince Philip Hospital (PPH) Minor Injury Unit (MIU), where good progress is being made on this significant and complex area of work. The report contains an oversight of progress. Also included is an update on the 'A Healthier Mid and West Wales' (AHMWW) Strategy implementation, comprising a number of programmes of work.

Noting the Competitive Dialogue procurement exercise relating to Cylch Caron referenced on page 4 of the report, Mr Maynard Davies enquired regarding the duration of this process. Mr Lee Davies would confirm the position via the table of actions. Cllr. Rhodri Evans was able to confirm that the update mentioned was presented to Ceredigion County Council Cabinet on 21 January 2025. Noting the focus on communities within the AHMWW Strategy, Mr Iwan Thomas suggested that there is an opportunity for the Health Board to further engage with the local population. There are many examples of community projects which have had significant impact, and which could be used as 'blueprints' for similar elsewhere. He felt that the Health Board should look to support, promote and maintain such projects, which are often operated at a minimal cost. **LD**

Dr Wooding agreed that there were exemplar projects which should be utilised, and that engagement and co-production with communities should be promoted. The local population should be encouraged to lead initiatives rather than the Health Board. Agreeing, Professor Kloer emphasised that this aligns with ambitions around the Primary Care and Community Services

Strategic Plan. It is important for the health service to recognise that it is not the only component in and contributor to health and wellbeing. Ms Jill Paterson welcomed comments around engagement with local communities and projects and advised that she would be meeting with Mr Iwan Thomas on this matter. It was acknowledged that communities can achieve a great deal and build resilience at a local level. This will be key to the AHMWW Strategy and Ms Paterson looked forward to learning from projects already in existence. Dr Ardiana Gjini wished to emphasise that the Health and Wellbeing team is already working with community hubs and will continue to explore other opportunities.

Commending the pace and inclusivity of the work in relation to PPH MIU, Mr Michael Imperato enquired whether any consideration had been given to co-opting a transport expert. Also, whether a longlist of options has been developed. Mr Mark Henwood advised that the issue of travel and transport is being considered. He also confirmed that a longlist of options has been prepared. Members heard that a number of events in relation to the PPH MIU are planned during February 2025; these will include both 'in-person' and online events. There has been engagement with stakeholders, and the process is on track for presentation to the Public Board in March 2025. Mrs Eleanor Marks noted that members of the public are being sought via social media to join the various groups, and commended this approach.

Mrs Marks referenced that a number of capital schemes appear to be in the process of being curtailed or reduced, which is concerning. In view of the effectiveness and impact of projects such as the Cardigan Integrated Care Centre (CICC), it would be unfortunate to lose or downgrade similar schemes at Cross Hands or Fishguard. Noting that the Cabinet Secretary had recently visited CICC, Dr Wooding agreed, indicating that consideration needs to be given to how these schemes can be progressed.

**Decision:** The Board:

- **ENDORSED** the Register of Sealings since the previous report on 28 November 2024
- **NOTED** the status report for Consultation Documents received/responded to
- **NOTED** that the Health Board will be participating in the procurement process for Cylch Caron
- **NOTED** the change in end of lease date for the Clinical Engineering lease at Dura Park from 26 August 2028 to 26 January 2029
- **APPROVED** the Collaboration Agreement relating to the Flying Start and Families First Grant Programmes between the Health Board and Pembrokeshire County Council
- **APPROVED** the Virtual Pooled Fund Agreement for Adult Care Home Placements for the period 1 April 2025 – 31 March 2028

**PM(25)07** **Audit Wales Annual Audit Report/Audit Wales Structured Assessment**

Ms Anne Beegan from Audit Wales was welcomed to the meeting. Professor Kloer thanked Audit Wales for their reports and for their attendance at today's meeting. Members heard that these had been considered by the Chief Executive, Executive Director of Finance, Director of Corporate Governance and the ARAC Chair. Subsequently, by the Audit and Risk Assurance Committee (ARAC) and were considered to be an accurate reflection of the Health Board's position.

Ms Anne Beegan welcomed the opportunity to present the Annual Audit Report 2024 and Structured Assessment 2024 Report. The first of these draws together the findings of Audit Wales reports which have been presented to ARAC during the course of the year. In terms of the financial audit work, the Health Board's annual accounts had returned a qualified audit opinion. In terms of performance audit work, three reviews had been completed during the year, as follows:

Review of Operational Governance – this had considered both operational and corporate governance. Findings in relation to the latter indicated that arrangements were very clear. Governance arrangements for the operational directorates were in a less favourable position, although it is recognised that there has been ongoing work in this area, however further pace and clarity was required.

Review of Cost Savings Arrangements – the findings had reflected the financial challenges faced by the Health Board and reliance on non-recurrent savings. However, the Structured Assessment had noted the positive progress made more recently.

Structured Assessment – findings had recognised the continued positive work in relation to Board and Committee work, particularly recognising management of changes in Board membership. Also, the ongoing focus around transparency, good governance, continued improvement and listening to patients and staff. From a systems of assurance perspective, Audit Wales recognise the continued positive focus and robust arrangements. Two recommendations around enhancing the arrangements have been made. These relate to the performance management framework, and recognising the improving together framework alongside the internal escalation processes already in place; and a need for greater oversight of delivery of the quality improvement framework. One recommendation has been made in relation to planning and the Wellbeing Objectives, with a suggestion that these be reviewed and set alongside the Strategy refresh. As mentioned, there has been more positive progress in relation to finance; however, more work is required around sustainability of cost savings.

Finally, Ms Beegan wished to place on record her thanks for the continued support of the wider organisation and Board and, in particular, Mrs Joanne Wilson and Mr Huw Thomas.

Cllr. Evans thanked Audit Wales, in particular Ms Beegan and Ms Urvisha Perez, for their effective co-working and for their reports during the year. He assured Members that the ARAC Chair, Chief Executive, Director of Finance, and Director of Corporate Governance were provided with the opportunity to comment on the accuracy of the Structured Assessment report, and that the final report had been considered in detail at ARAC. Cllr. Evans felt that this was an accurate reflection of the Health Board's position. Whilst it is a positive report, it is recognised that there is more yet to do, particularly around operational governance. Members heard that the management response has been prepared and will be discussed at the February 2025 ARAC meeting, with the implementation of recommendations to be monitored by ARAC.

Mr Andrew Carruthers acknowledged that the observations around operational governance have been an issue of concern for some time. A great deal of work has been undertaken to address these, and the Health Board is in the process of making appointments to the new operational structure and supporting roles. These will aim to improve governance and accountability, and Mr Carruthers expressed thanks to Mrs Wilson and her team for their input. He was hopeful that the picture will be very different next year and that there will be a tangible improvement.

Welcoming the very balanced reports, Dr Wooding concurred with the recommendations and hoped that next year's reports would demonstrate an improvement. Mrs Wilson advised that an Internal Audit has been scheduled to ensure that the new operational governance arrangements are working as effectively as possible. She added her thanks to Ms Beegan and Ms Perez for their support during the year.

**Decision:** The Board:

- **SUPPORTED** the content of the Annual Audit Report 2024 and Structured Assessment 2024 Report, including the change to the Health Board's financial position since the report was issued
- **TOOK ASSURANCE** that the Structured Assessment report presents a fair and balanced view of the organisation, recognising both the positive aspects identified and those areas where further progress is required
- **REQUESTED** that a management response be developed and presented to the Audit and Risk Assurance Committee (ARAC) at its meeting scheduled to be held on 11 February 2025
- **DELEGATED** authority to ARAC to oversee implementation of the management response.

**PM(25)08** **Financial Report**

Presenting the Financial Report for Month 9 2024/25, Mr Huw Thomas advised that this is intended to update the Board on the organisation's financial position and progress in savings delivery. Members heard that the Health Board has received additional funding from Welsh Government, for which it is grateful. The funding, which is conditional, enabled the organisation to reduce its deficit from £64m to £31.55m, which has been set as the new Target Control Total. However, progress in delivering savings has allowed a further reduction to £28m. This reflects the efforts of staff across the organisation, in areas such as nurse agency use. The in-month deficit is £1.2m, a favourable variance of £1.4m and the fourth consecutive month where performance has been better than the forecast. However, the Health Board remains over-reliant on non-recurrent savings; an issue which needs to be addressed.

A number of Directorates are still overspending, as recorded in the report, and two have been escalated to Level 3 for the domain of Finance, Strategy and Planning. Conversely, the Health Board is at risk of underspending on its Capital allocation and is actively managing this situation. For an organisation which is challenged in terms of its estates and facilities, it is vital to maximise use of Capital funds. Mr Huw Thomas continues to converse with Welsh Government around strategic cash assistance, although he has not received a formal response to the Health Board's letter in this regard. Members were assured that there are continued and robust controls on recruitment and agency usage. However, as mentioned, further progress is required in terms of savings delivery. Mr Huw Thomas concluded by drawing Members' attention to the report's recommendations.

Mr Winston Weir felt that it was important to acknowledge that the Health Board will achieve the Target Control Total, which is what was requested by Welsh Government. It had also identified, albeit not yet delivered, all of the required savings. These achievements should be commended and recognised by the Board. Mr Weir requested, however, that there be further focus and updates on the Health Board's underlying deficit, the drivers for this and progress on reducing it, all of which are key to delivering an Integrated Medium Term Plan (IMTP). He also requested more information around the prescribing overspend, the underlying factors for this and whether spending is being appropriately targeted. Mr Imperato echoed the views of Mr Weir regarding the efforts of staff. He expressed concerns, however, regarding longer term performance, particularly around recurrent savings delivery. The terminology 'scrutinise' in the report's recommendations was queried, with Mr Imperato suggesting that a more proactive approach is required.

Noting that 9 Directorates are in Level 3 escalation, Ms Lewis enquired what percentage of the Health Board's operations this represents. Also, given that they have remained at this level for

five of the last six months, at what point is it recognised that interventions are not working and another approach is required. Building on this, Dr Wooding queried whether there is a correlation between those Directorates and their general performance (beyond budgetary management). Noting the statement that 'An urgent recovery plan is required from each…', and the time elapsed since the report was prepared, Mr Maynard Davies enquired whether there has been any progress on these plans.

Also on the topic of the Directorates in Level 3 escalation, Mrs Marks requested clarification around what escalation actually means for these Directorates, particularly given the length of time they have been escalated. Returning to an earlier comment around the overspend on prescribing, and highlighting Cancer drugs specifically, Mrs Marks enquired whether this reflects improved survival rates and higher numbers of patients treated, both of which could be viewed as positives. The major progress made on financial position was acknowledged, whilst recognising the challenges which will continue into next year. Finally, Mrs Marks enquired how HDdUHB's position compares with other Health Boards. Mrs Chantal Patel noted Audit Wales' assertion that the Health Board needs to improve how it manages and delivers savings, and a lack of capacity in this regard. Noting that this could be a reason for the lack of progress, Mrs Patel queried what steps are being taken to address this matter.

In response to Mr Weir's query regarding the underlying deficit, Mr Huw Thomas stated that this has improved, albeit largely due to the additional allocation of funding. In terms of prescribing costs, there are two drivers: a growth in activity and a growth in unit cost. Specifically in regard to Cancer, the Health Board is treating patients for longer and treating more patients. People with Cancer are living longer. There are also new and novel medications, which come at a cost. It is acknowledged that the financial forecasting for Cancer drug costs was incorrect. There are areas of underspend, for example on vaccines – including the Flu vaccination – which is of concern. Mr Huw Thomas felt that it would be beneficial to conduct a Deep Dive into prescribing expenditure. He would also welcome the opportunity for scrutiny into savings delivery, noting that the Health Board has a duty for transparency in spending. The objective around savings delivery by Christmas had not been met; however, it should be noted that the organisation is in the middle of a planning round and there have been further responses since, though not yet sufficient to meet the stated target.

**AC/JP HT**

In response to Ms Lewis' query around Directorates in Level 3 escalation, whilst Mr Huw Thomas did not know the percentage this represented, he estimated that 60-70% of the organisation's operations are in some form of escalation. There is a correlation across a number of Targeted Intervention domains. Whilst there has been an improvement in Workforce, Quality and Governance metrics, challenges remain in Performance, Productivity and Finance. The fact that Directorates are remaining in escalation for

a number of months demonstrates the scale of the challenges, suggesting, perhaps, that a more strategic approach is required. In response to Mrs Marks query, escalation is intended to be uncomfortable; however, it clearly has not had the impact on the 'bottom line' which the organisation would want. Mr Huw Thomas advised that he is reflecting on the escalation process and will meet with Chairs of Committees, etc, as part of this.

With regard to the underspend on vaccines, Dr Gjini emphasised that this reflects a low uptake. This is far from a local issue, with HDdUHB taking an ambitious approach to providing vaccine access. Returning to expenditure on Cancer, Dr Gjini highlighted that 1 in 2 people will be diagnosed with Cancer. Treating Cancer patients at current diagnosis points would consume the entire healthcare budget; the most significant improvement can be achieved by earlier intervention and diagnosis. She agreed that this merits a targeted Deep Dive.

Mr Carruthers indicated that there are a number of different aspects involved in savings delivery and performance. As an example, whilst there has been good progress around efficiency and productivity in Planned Care, more activity to reduce waiting times leads to increased costs. Achieving balance across the various conflicting demands can be challenging. He acknowledged, however, that there is an absence of recurrent savings plans. The most challenging areas financially probably correlate with performance challenges; for example, Pembrokeshire and Carmarthenshire in terms of Urgent and Emergency Care. This leads to issues in patient experience and costs, as part of the wider systems challenges around avoiding unnecessary admissions and discharging patients.

Whilst Mental Health and Learning Disabilities is performing relatively well in a number of areas (with the exception of Neurodevelopmental Assessments) it has also been unable to deliver recurrent savings. It is challenging and complex to balance service needs, risks and national requirements with regard to finances. Mr Carruthers suggested that there perhaps needs to be a discussion around whether Directorates have all the business skills required to deliver all these demands. Historically, in the operational environment, senior leadership roles have been unbalanced in terms of accountability and responsibility. The new operational models shifts some of this senior accountability more evenly across the organisation. It is hoped that this will also help to shift the culture, etc. Mr Carruthers felt that the internal escalation process has helped to change the messaging and focus within Directorates; however, the fundamental strategic challenges remain.

Dr Wooding agreed that there is a broader system issue, whilst emphasising that the organisation should try to eliminate the assumption that a lack of resources automatically leads to poor performance. There are many examples which serve to contradict this as a premise. He accepted that circumstances are not ideal,

and agreed that the Health Board should ensure that its managers possess the requisite business skills. Professor Kloer indicated that the work in relation to operational governance arrangements has been an involved and lengthy process. A great deal of effort has gone into the recruitment process, to ensure that the staff appointed have the correct skills. Also, to ensure that the new operational structure, together with its governance and organisational development, are in place for the next financial year. In addition, a programme for individuals, both managers and clinicians, is being developed. He was conscious that there is more to do in this area. In terms of accountability, the individuals appointed will expect to be held accountable. However, it needs to be ensured that they continue to hold the accountability and that this is not taken from them by the organisation or processes. In terms of finances and underspends, Professor Kloer noted that all of the underspends are in areas the Health Board would wish to prioritise, for example Primary Care and Organisational Development. This needs to be addressed.

Whilst welcoming the additional funding from Welsh Government, Cllr. Evans enquired regarding confidence around meeting the conditions associated with this, particularly Cancer performance. He queried the emphasis on this within the recommendations as stated. Dr Wooding agreed that the Board must ensure appropriate rigour in meeting these conditions. In response, Professor Kloer offered assurance around this, suggesting that all of the conditions are key priorities for the organisation. Mr Huw Thomas clarified that these relate to the in-year position, and will be revisited as part of the new Annual Plan and will be key to this.

Reminding Members of the request for strategic cash assistance which remains with Welsh Government, Dr Wooding reiterated that any funding provided will come from elsewhere in the 'public purse'. The Health Board has a responsibility to seek to minimise any such requests. The organisation should also not become content or complacent with its improved position, as there is still much more to do. In considering the recommendations, Dr Wooding suggested that future reports should offer a sense that plans are in place, rather than 'accepting the unacceptable'. He concluded discussions by thanking Mr Huw Thomas and the wider organisation for the progress made.

**Decision:** The Board:

- **RECOGNISED** that, following Welsh Government funding received, the Health Board's Deficit plan is now £31.55m, which is the new Target Control, and the reported financial position has improved to £28.0m in Month 9
- **ACKNOWLEDGED** that, with a year-to-date delivery of £21.3m against a planned deficit of £23.6m, the Health Board is now on a trajectory to achieve the revised financial position of £28.0m

- **NOTED** the five conditions attached to the £26.0m conditionally recurrent funding received in the letter on 2 December 2024
- **SCRUTINISED** the progress of savings actions to bridge the recurrent savings gap, with an Executive Team commitment to identify £20.0m of recurrent savings by the end of December 2024
- **SCRUTINISED** the Executive Delegated Officer portfolios which are overspending against their delegated budgets
- **ACKNOWLEDGED** that an underlying deficit assessment is ongoing as part of the 2025/26 planning cycle, and that it is likely to be significantly higher compared to the 2024/25 forecast outturn, due to the reliance in-year on non-recurrent actions and the lack of progress made in converting the same to recurrent improvements
- **TOOK ASSURANCE** for those directorates with a level 3 escalation for Finance, Strategy and Planning, that sufficient actions and milestones are in place to de-escalate (details provided within the IPAR report as well as key directorates listed under the alert section)
- **TOOK ASSURANCE** that:
    - Plans are translated from opportunities to delivery through the three-delivery functions Value and Sustainability Group, IQFPD Group and the Healthier Mid and West Wales Group
    - Mitigating actions are being developed to address areas of overspend
    - Appropriate mechanisms are in place to review and monitor the emerging Capital Resource Limit risk

**PM(25)09** **Annual Plan 2024/25 and Draft Annual Plan 2025/26**

Presenting the report, Mr Lee Davies advised that – since the previous Board meeting – Welsh Government had issued the Planning Framework. The Health Board had also met with Welsh Government representatives, as part of Joint Executive Team (JET) and Targeted Intervention (TI) meetings. As already mentioned, financial allocations have been issued to Health Boards, including additional funding. The latter is, as has been discussed, contingent on various elements; the most challenging of these probably being achieving financial balance across three years. When considering the content of the various letters, the Health Board's progress is recognised and Welsh Government's expectations are clearly summarised. The latter is very much being used as a guide for the development of the Annual Plan.

From a TI perspective, the report notes 14 Alerts – this has been revised down to 12, mainly due to the improved financial position. The main areas, however, remain as set out, and align well with Welsh Government expectations as stated. This should be viewed as positive, as it suggests Welsh Government and Health Board expectations and priorities are similar. Having said this, the organisation remains a consideration distance from achieving a

balanced IMTP; hence the proposed Annual Plan approach. It is recognised that this represents a breach of Statutory Duty; however, an alternative is not apparent. This requires the submission of an Accountable Officer letter, which the Board is requested to approve as part of the report's recommendations. Mr Lee Davies concluded by indicating that the organisation has tried to take a balanced approach to sustained improvement, with the intention of producing an IMTP from 2027/28 onwards.

Mr Weir enquired regarding the submission date for documents to Welsh Government. Recalling discussions at the previous Board meeting, where savings of 1.5% were mentioned, he further enquired whether there was any capacity for 'headroom' to facilitate innovation and investment. In response to the first query, Members heard that the deadline for submission of Annual Plans or IMTPs to Welsh Government is the end of March 2025. If not submitting an IMTP, Health Boards are required to tender an Accountable Officer letter by mid February 2025. Whilst acknowledging the challenging situation, Dr Wooding emphasised the need for an Annual Plan which aligns with the organisation's three year ambitions. It is not appropriate to keep operating on an annual basis; there needs to be a longer-term perspective, to recognise that it will not be possible to deliver certain objectives, ambitions or innovations within a year. In terms of creating 'headroom', Mr Huw Thomas agreed that there was a need to recognise a requirement in this regard. It was, however, challenging to do so in an organisation in deficit, due to the conflict of investing funds that could be used to reduce said deficit. This is a challenge faced by all Health Boards and by the system as a whole. It could be argued that prevention of ill health, promotion of health and wellbeing and digitalisation are all areas worthy of investment.

Mr Maynard Davies suggested that the progress being made in regional planning with Swansea Bay University Health Board (SBUHB) is not necessarily reflected within the report. Responding, Mr Lee Davies advised that the report does reference regional working being a key deliverable. In addition to SBUHB, the Health Board has established relationships with Betsi Cadwaladr UHB and Powys Teaching Health Board and is undertaking activity with various partners. Within the Regional Joint Committee space, there is a great deal of discussion around working together, both at a strategic level and on specific specialties (Orthopaedics and Ophthalmology, etc). There is an opportunity to work together more on strategic developments, for example a 'south west Wales strategic direction'.

*Ms Anne Beegan left the Board meeting.*

Ms Lewis sensed a tension between ministerial priorities and the organisational response to these, and the Health Board's wider ambition. The former tends to focus on the short-term, and keeps the organisation in a short-term place. The latter involves goals such as the 'shift left' (shift of resources into the community) and

requires a different mindset and approach. She suggested that the organisation needs to be careful about 'sanitising' or understating this tension, which inevitably involves constraints and conflicts, and shows in the decision-making required at Board. Ms Lewis felt that there should be openness about such conflicts. Acknowledging that the Health Board has not yet gripped the 'shift left', Dr Wooding agreed that this is testing when dealing with short-term operational delivery challenges. Mr Lee Davies noted that there is an inherent and natural tension involved in addressing the needs of the various groups the Health Board serves. These include the patients of today; local communities and the general public; the workforce; and future generations. The proposed approach is intended to be balanced, as far as is possible. He suggested that this topic be returned to during discussion of the Strategy Refresh.

**Decision:** The Board:

- **NOTED** the content and expectations within the 2025/26 NHS Wales Planning Framework and the JET and Financial Allocation Letters
- **DISCUSSED** the current 2024/25 alerts and the actions in place to mitigate the issues
- **ENDORSED** the development of an annual plan for 2025/26, set within a 3-year context, whilst acknowledging this is a breach of the Health Board's statutory responsibility
- **APPROVED** the submission of an accountable officer letter to Welsh Government
- **ENDORSED** the proposed approach and key deliverables for the 2025/26 annual plan

**PM(25)10 Integrated Performance Report**

Mr Thomas introduced the Integrated Performance Assurance Report (IPAR) for Month 9 of 2024/25, conscious that this contains a significant number of 'Alert' items. This will be of concern to the Board, as it is to the Executive Team and to patients and their families. Of particular note is staff sickness levels, which are increasing and are at their highest in over two years. Anxiety, stress and depression continues to account for the highest reasons for absence across the majority of Directorates. Members' attention was drawn to page 7 of the report, and the section on triangulation of data across systems. In terms of positives, the number of new complaints, the number of C. difficile cases and the level of agency spend should all be recognised. From the bottom of page 8 onwards, information is provided regarding the three Directorates with the highest levels of escalation (Mental Health and Learning Disabilities, Planned Care and Radiology). Mr Huw Thomas also highlighted inclusion as an appendix of the Directorate Improving Together Sessions (DITS) Thematic Report, which he hoped provided assurance around the actions being taken.

On the topic of A&E and MIU performance, Mr Sam Dentten advised that Llais had undertaken visits during October 2024, with mixed findings. Referencing the recent temporary (until April 2024) extension to CICC opening hours to include weekends, Mr Dentten enquired whether there are plans to evaluate this, with the potential for a longer-term arrangement. Mr Carruthers indicated that the impact of the Same Day Emergency Care (SDEC) model in Cardigan has been extremely valuable during January 2025. Over the course of the weekend, 80-100 patients are being seen, with a significant number of these stating that they would otherwise have presented to A&E. SDEC is one of the key design principles, and a component of the 50 Day Challenge response. The temporary extension of opening hours will be evaluated as part of the Urgent and Emergency Care Planning. Mr Carruthers explained that there is a radical vision for the future service model in this area, offering a real opportunity to 'schedule unscheduled care'. This will build on the experience of CICC, aiming to avoid unnecessary presentation to acute care and retain this for those patients who need it, whilst still meeting the needs of those needing to access unscheduled care. An example would be the ability to book timeslots for accessing SDEC, rather than attending 'ad hoc' and waiting.

Referencing Appendix B and specifically the Assessment Summary, Cllr. Evans noted the statement that 'Insufficient radiology reporting capacity is having a significant impact' on single cancer pathway performance. He enquired regarding actions being taken to address this issue. Mr Carruthers confirmed that significant challenges had been identified in this area. The organisation has put in place additional capacity, which will improve the position. He was not anticipating it to decline further in the January 2025 figures. However, there is a capacity gap, and steps need to be taken to ensure that there is no ongoing issue from the new financial year. The team is exploring the detail to ensure that the Cancer pathway experience is not impacted going forward. Cllr. Evans welcomed this assurance. Dr Wooding noted that this demonstrates the potential impact of just one element of a pathway not working optimally.

Expressing concern regarding increased staff sickness, Ms Delyth Raynsford queried whether there was any correlation between those Directorates with high staff sickness rates and those Directorates under increased scrutiny. Noting also the high levels of staff turnover, Ms Raynsford enquired how HDdUHB compares with other Health Boards. Whilst advising that the three Directorates with the highest escalation level do not have the highest staff sickness absence levels, Mrs Lisa Gostling noted that they are around 6.5%. There are plans to conduct a Deep Dive into sickness absence, looking at short-term sickness prevalence (coughs, colds, etc) and long-term sickness (particularly anxiety, stress). Findings will be presented to the People, Organisational Development and Culture Committee (PODCC).

In terms of staff turnover, HDdUHB has the lowest in Wales. Analysis of nursing staff turnover indicates it is 2% lower than the other Health Boards. December tends to be a 'peak' in turnover, as people tend to leave either at the end of the calendar year or financial year. Dr Wooding observed that 6.5% equates to 700-750 staff absent. This is a significant number of staff off work over the course of a month and needs to be better controlled. There needs to be a focus on sickness absence management, not just sickness. Mrs Gostling advised that the Health Board does conduct sickness audits. Higher numbers of long-term health issues leads to longer term sickness absence. It was recognised this needed to be owned in the operational space, through operational management, rather than through Workforce and Organisational Development.

Returning to performance in Mental Health and Learning Disabilities (MHLD), Mrs Marks express concern around the potential long-term impact of individuals not being able to access support and treatment due to the service being so pressured. She suggested that there is a possibility these individuals will present with worse issues in the future. Mrs Marks felt strongly that the Health Board should not wait for a national solution to this issue; rather should consider what might be done at a local level. Agreeing, Mr Carruthers reiterated that the specific issue around the Neurodevelopment Assessment target is recognised, together with the challenges in performance. He has requested that the Directorate itself determine what level of capacity would be required to meet the need and what the pathway would look like. Mr Carruthers anticipated a response from the Directorate in February 2025. There have been a number of discussions with potential digital providers who might be able to assist with access to assessments and diagnosis. He agreed that the Health Board should not wait for a national response. Ms Lewis echoed the comments of Mrs Marks, and welcomed the actions described. She felt that it was important to be cognisant of community need at a much broader level; this issue crosses the borders of healthcare into other sectors. It will be vital to involve partners and consider how they might provide support to Health Board operational teams.

In terms of Unscheduled Care, Professor Kloer recognised the need to reflect on the challenges for patients accessing services, and the demands on and experiences of staff. It is intended to focus on improving this area. There are systems elsewhere where A&Es are not overcrowded and there are fewer ambulance waits and ambulance handover issues. Such systems must be learned from. There will be different ways of working, for example with the ambulance service; more oversight and integration between hospital and community services; a 'phone first' approach to Unscheduled Care, to ensure patients are directed to the correct service. However, it will be necessary to instil in the public confidence that they will receive a good service. There will be further updates at future meetings.

Drawing discussion to a close, Dr Wooding noted the request within the recommendations for Board to take assurance that sufficient actions are in place to manage the 'Alert' items. Focusing on one of these in particular, he requested that a plan regarding Neurodevelopmental Assessments be considered at a future Quality, Safety and Experience Committee (QSEC) meeting. **SD**

**Decision:** The Board **DISCUSSED** the IPAR – Month 9 2024/2025 report and **TOOK ASSURANCE** on the operational delivery of mitigating actions to improve performance in the areas that have been categorised as 'Alert'.

**PM(25)11 Improving People and Community Experience Report**

Welcoming the opportunity to present the Improving People and Community Experience report, Ms Sharon Daniel advised that this represents a summary of patient feedback for October and November 2024. As discussed at the previous Board meeting, being open around feedback and receiving a report such as this in public demonstrates the organisation's accountability to the public, that it is listening to concerns, addressing issues and improving services. It also provides an opportunity to triangulate experience and service user voice with Board business, with examples discussed already today. For example, with regard to PPH MIU, patient feedback from April to October 2024 was showing a rating of 85% positive. In December 2024 this rose to 89%, and in January 2025 to 94%. Current ratings are showing 96% positive. This ability to 'plot' patient experience and present findings to the Board was welcomed.

Whilst there are high rates of satisfaction with the Health Board's services, there are still concerns around clinical care and treatment. It is vital to assure the public that the organisation is learning from the feedback they provide and is prioritising this. Ms Daniel wished to thank the patients who have contributed their experience in the form of patient stories. Two of these are from A&E, where the feedback rating is 80-85% positive, lower than other services. Ms Daniel suggested that actions aligned with the 6 Goals and 50 Day Challenge initiatives will provide a response to the significant pressures across the system, a focus on delays, improved clinical decision making and support earlier discharge into the community. This with the aim of improved patient experience and quality of care.

Members noted that the response rate to complaints has improved, as a consequence of altering the timeframe for early resolution. The Health Board is also responding to an increased number of complaints within 30 days. Recent information from the Ombudsman also shows a significant reduction in the percentage of upheld complaints, which suggests that the quality of the investigation responses is improving. In all, whilst there is evidence of improvement, further work is required. Ms Daniel

reminded Members of the decision to bring to the March 2025 Public Board meeting a report detailing plans to improve the impact of feedback received.

In response to a query from Ms Ann Murphy around the potential for low numbers of responses to give an unrepresentative effect and/or concern, Ms Daniel advised that it is intended to obtain more detailed feedback data, to ensure that it is more representative. Referencing Friends and Family Test (FFT) feedback, Mr Dentten noted that there are low response rates from MHLD. Whilst understanding that providing feedback may not be a priority for service users, it is acknowledged that this Directorate is one which is struggling with demand. Mr Dentten enquired whether there are any actions planned to improve response rates. Ms Daniel welcomed this comment, indicating that the current Civica system issues a request for feedback on discharge. She recognised the need to consider the timing of surveys and contact with service users, and whether the new system can facilitate more appropriate timing, when patients have had more time to reflect.

Referencing the Primary Care feedback, Ms Raynsford noted the overall negative rating and that 14 practices are mentioned. She enquired whether this rating was attributable to one or two Practices, or whether it represents more general dissatisfaction. Also, whether any are Managed Practices. Her second query was around the care and support provided for parents of children in hospital who are unable to leave them. In response, Ms Daniel advised that a QR code is currently used to obtain Primary Care feedback, which is not well utilised. It is intended to test use of the Civica system in Primary Care, which it is hoped will increase levels of feedback. Members heard that parents are provided with facilities on wards, and that feedback is obtained from parents as well as children. Going forward, the aim would be to bring these services into feedback discussions to a greater extent, to obtain responses directly from them.

Mr Iwan Thomas thanked Ms Daniel and her team for the report. He noted data on page 2 around complaints, with 503 complaints received and the extended timeframe for responding and resolving early resolution concerns from 2 to 5 working days. 150 were dealt with within 5 working days, currently 30% within a week. Noting the intention to effectively double the timeframe to 10 working days from 1 April 2025, in line with the national Putting Things Right (PTR) guidance, Mr Iwan Thomas queried why the Health Board is not maintaining the current timeframe locally. Ms Daniel explained that the original timeframe for response under local resolution was within 2 working days. Once this was missed, complaints automatically entered the PTR process, which potentially extended the timeframe to 30 working days. By extending the timeframe for local resolution to 5 days, more can be responded to under this classification, and in ‘real time’ as opposed to retrospectively. The PTR guidance which will be implemented in April 2025 extends this further to 10 days. The

logic being that the increased timescale for local resolution will allow Health Boards to respond more quickly to more complaints.

Ms Paterson emphasised the need to focus on obtaining feedback from Primary Care. Members were reminded of the Accessibility Standards, with which all Practices must comply as part of the General Medical Services (GMS) Quality Assurance and Improvement Framework. Practices are required to maintain a dashboard and participate in the national patient survey, which takes place in February. There is a requirement for a minimum of 25 completed patient questionnaires per 1,000 patients. The results from this are shared with Practices, who are then expected to produce a reflective report, which covers a variety of elements. Whilst Practices are not obliged to share this information with the Health Board, the reports are considered at Cluster level. The information suggests that, for Carmarthenshire, two Practices did not share their overall report rating; the six that did having satisfaction ratings of between 8.3 and 9.1. For Llanelli, all seven Practices shared their information, with satisfaction ratings of between 8.1 and 8.4. There are other more variable ratings within other Clusters, of between 6.1 and 8.1.

Whilst the Primary Care data in the Improving People and Community Experience Report may not be as balanced as it could be, it was noted that the most common theme is around access to appointments. Once patients do access the system, however, they are generally satisfied with their experience. Whilst Ms Paterson recognised that there are significant delays in access, she emphasised that Practices are obliged to act upon these and prepare action plans, which are individual to each Practice. Members were assured that plans are in place for collaboration between the Primary Care team and Patient Experience team to improve feedback collection in Primary Care. The Civica system is to be piloted in the Health Board's Managed Practices.

Concluding discussions, Dr Wooding requested that future reports are more analytical; with information on trends, patterns, commonality and themes. **SD**

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

**PM(25)12 Strategic Approach to Financial Recovery**

Dr Wooding outlined the background to this item, indicating that he had requested the Director of Finance to prepare a report. Presenting the report, Mr Huw Thomas emphasised that he does not yet possess the answers to financial recovery; however, the report attempts to present some of the likely challenges and actions required in this space. Returning to an earlier query around how HDdUHB compares with other Health Boards, Members heard that, even with the additional allocations from

Welsh Government, the position nationally remains challenging. Other public sector organisations are also in similar positions, as recent news stories will attest. Locally, this is of particular concern, given the constraints it places on the organisation. The Health Board's current financial position is unacceptable, and its current configuration is unsustainable. A financial roadmap to recovery is the end goal of strategic response. However, this is challenging to produce at this point, due to the length of time since the last Comprehensive Spending Review, the next of which is due in June 2025. Once this has been issued, it is hoped that the Health Board will have a better understanding of the likely expenditure on healthcare going forward.

Moving onto the presentation provided, Mr Huw Thomas focused on Slides 1.1 (UK context and key constraints). He explained that these outline the drivers behind expenditure, the ability of Governance to raise further tax income and historical spending and revenues since 2000/01. These present very real challenges. Slides 1.2 (Population changes in west Wales) provide more local data, with changes in demographics over the next 20 years being a significant challenge. This is not an issue which the Health Board can defer addressing. There will be a fundamental shift in the composition of the population, with a very much older population generally and a decline in the working age population. The region will need inward migration to provide services for this aging population.

Slide 1.3 outlines expected changes in chronic conditions, and Slides 1.4 economic conditions in west Wales. The latter shows that, pre-Brexit, west Wales was the poorest region in northern Europe. The position, if child poverty rates are used as an example, has deteriorated since. The second slide demonstrates that west Wales has lower than average earnings compared with the rest of Wales and the UK. there is also higher economic inactivity; this is not necessarily unemployment, but people who are unable to or choosing not to work for various reasons. Slide 1.5 (Health inequalities in west Wales) illustrates the gap of up to 12 years in life expectancy across the region. Healthy life expectancy shows an even larger gap of up to 15 years. Both gaps, together with the gap between them, need to be addressed.

Slide 2.1 (Funding outlook) outlines some of the challenges, and demonstrates the difficulty of creating the 'headroom' and investment opportunities mentioned earlier. Funding allocations purely meet current essential cost pressures. There will need to be a continued focus on robust cost control, productivity and efficiency measures, to align with Welsh Government expectations and mandates. The next few slides focus on various aspects of funding, including funding changes, planning guidance changes (and Cabinet Secretary priorities) and Welsh Government finance design principles, which will impact on service redesign. Section 3 of the presentation considers the Health Board's financial track record. Slide 3.2 (Expenditure trend) illustrates spending in hospital services, community care and Primary Care. More is

being spent proportionately in hospital services, especially on nursing capacity, medications and tertiary services. Slide 3.3 (Savings track record) shows that savings delivery is at its most significant level ever (£14.7m); however, more recurrent savings need to be delivered.

Section 4 of the presentation focuses on some of the questions for consideration. These include the need to consider reducing duplication of services across sites; and the need to recognise the change in demographics from a younger to older population and the need to shift associated resources and services to reflect this. Also, as mentioned earlier, to recognise that there are currently underspends in areas where there should be spending. Again, echoing earlier comments, there must be investment and 'headroom' creation to drive more efficient services.

Mr Huw Thomas remained of the view that these goals are achievable, in co-production with the public; however, there will need to be an acceptance that service delivery will need to change in order to do so.

Dr Wooding welcomed this useful presentation of circumstances, including those elements within the gift of the Health Board and those which are outside its control. He added that certain of the 'enablers' to resolving issues (prevention of ill health, 'shift left', digitalisation) are constrained by the tensions the organisation is having to manage (demands on services, population demands, new technology). The organisation needs to be intelligent in how it manages restricted finances to deliver the best outcomes and meet the needs of the population. Spending should be prioritised where it can deliver the best value and outcomes.

Mr Weir also commended the report, which links well with the AHMWW item which follows. He welcomed this consistency. Highlighting data on chronic conditions, Mr Weir suggested that it would be useful to have a more local perspective on these. The Health Board should be communicating with its population the steps they can take to prevent or avoid these conditions. On the topic of poverty, he suggested that there should be conversations with partners around housing, economic activity, etc. Dr Wooding agreed that there is an inherent value in investing in health promotion and the prevention of ill health. Dr Gjini reiterated that, in addition to an aging population, a key concern is a parallel decreasing population generally. This has implications in terms of how services are planned and delivered and the availability of people to care for the elderly. For chronic conditions, the actual position is worse than the projections shown in the presentation. However, 40% of Cancers are preventable, as is 80% of Diabetes due to obesity. As has been stated, there needs to be a 'shift left' and an investment in the lifestyle of the population, to encourage activity and healthy eating. In terms of deprivation and poverty, the gap between the poorest and richest is unacceptably high.

Mr Iwan Thomas suggested that there needs to be cognisance of the wider socio-economic landscape, due to the other factors at play. Households living in economic poverty are also living in health poverty. If good jobs are available, there is an associated uplift in terms of wellbeing. There are opportunities to increase engagement with potential local employers. Also, the demographic data can be utilised to target services to the areas where they are most needed. In terms of the wider impact of Health Board engagement with communities, there are now tools available to assess 'social value', which evaluate investments. Mr Iwan Thomas reiterated the importance of empowering community groups to work collaboratively with the Health Board.

In view of the fact that the region is very dependent on farming, Ms Lewis felt that it was important to consider the climate crisis and likely impact of this on the rural economy. She was also conscious of the privileged position of the Board, noting that members of the population will not have the same priorities and do not necessarily have the 'headspace' to consider longer-term issues.

Welcoming the discussion and helpful feedback, Mr Huw Thomas highlighted that more money is being spent on health in west Wales than ever before. The challenge is one of demand and redistributing resources, to ensure that services are delivered optimally. Despite its configuration, in Commonwealth Fund rankings (which compares outcomes in healthcare systems across 10 countries) the UK is third, well above other countries, including the USA. This suggests that the overall model is correct, the issue requiring consideration is how the model is discharged locally. On the topic of climate change, employment and the local economy, the Health Board needs to consider how it uses its 'economic advantage' to best effect. Initiatives such as 'Grow your Own' and supporting local suppliers, for example. It will be important to meet the needs of the current population without jeopardising the ability of future generations to meet their own needs. This should be built into the Health Board's Strategy and model for local delivery.

Dr Wooding drew discussions to a close, by emphasising that any proposals need to influence wider conversations with the general public. He requested that the approach be revisited at Executive Team, before presenting again to a future Board Seminar and Public Board meeting. **HT**

**Decision:** The Board:

- **CONSIDERED** the attached presentation and the challenges set out within, recognising the alignment with the Annual Plan paper.
- **CONSIDERED** the concluding questions, recognising these are strategic questions, each of which requires further work as part of the planning cycle.

- **ACKNOWLEDGED** the Welsh Government expectations set out within the criteria associated with the conditional funding and de-escalation criteria for targeted intervention.

**PM(25)13 Refreshing the 'A Healthier Mid and West Wales' Strategy**

Mr Lee Davies introduced the report, advising that – as suggested – it is intended to be considered in conjunction with the previous agenda item. It builds on discussions at the previous Board meeting, and includes the Clinical Services Plan as a sub-item. Discussions at the November 2024 Public Board had provided guidance on the scope of the Strategy Refresh, and there had since been more detailed discussions at a Board Seminar and Board Development session. Members were reminded that the Strategy acts as a 'bridge' between the Health Board's current and aspirational position in the long-term. The planning objectives and Annual Plan focus on the medium-term position. The organisation is keen to move forward with this workstream. The Board Development session had considered a refreshed purpose and strategic objectives, which are outlined in the report. These are not fixed, they will continue to be tested and developed; however, they will be used as a 'baseline' for the Annual Plan.

Whilst it is also expected that the purpose, values, vision and strategic objectives will be reviewed and revised; they are not likely to significantly deviate from what is outlined. The Strategic Refresh will, therefore, focus predominantly on how the organisation delivers the AHMWW vision within today's context. Input is also sought around any other areas that the Board might want the Refresh to explore. As has been mentioned, the organisation will need to think very differently about the services it provides. It will also need to encourage health promotion and prevention of ill health among its population. Whilst committed to the highest quality care, as close to home, in as timely way as possible, there are (as have been discussed) various tensions associated with this ambition. To give a topical example, Stroke is clearly a life-threatening condition, demanding the highest standards of care; however, is also preventable in many cases. Decisions regarding use of resources are highly consequential to both the patients of today, and the potential patients of tomorrow. It is important to frame consideration of this in a constructive way, exploring opportunities to impact positively on the lives and health of local communities. It will be important to engage the population and workforce in these fundamental decisions around service design. This will, in turn, impact on resource utilisation.

In response to a request for an update on the Welsh Government Infrastructure Investment Board (IIB) meeting, Professor Kloer reported that there had been a constructive discussion. It was recognised, however, that more conversations were required. A further meeting and visit to the Health Board is scheduled for March 2025. Professor Kloer emphasised that one of the challenges in this whole process is that 'staying still' is not an

option. Without a new hospital, all of the current challenges and drivers (including financial) around the Health Board's existing estate will remain.

Welcoming the helpful report, Mr Dentten highlighted that the recent community meeting in Aberystwyth had demonstrated the depth of feeling around clinical services. It will be challenging for the Health Board to get all of the elements involved in service configuration correct, and it will be challenging for people to understand the consequences of change. Llais would like to work with the Health Board to ensure that the consultation is optimal and look forward to being involved in the process. One issue of particular interest is travel and the impact of configuration changes on this.

Dr Wooding suggested that, in many consultations, the public is presented with scenarios which effectively feel like a 'fait accompli'. It will be unwise if the Health Board does not utilise the resources, knowledge and input of communities to develop solutions. This also has the benefit of creating a more positive feeling around the process, and one of co-production. He emphasised that the organisation needs to think differently about how it works with its communities. Mrs Marks echoed this, adding that the Health Board should be engaging with communities where the latter are 'comfortable'. Mrs Marks agreed with an earlier comment that there are tensions between short-term demands and long-term ambitions. She felt that the design principles as proposed remain as relevant as they ever did. The change in demographics, to her, points to a need to invest in communities and a need for increased regional working. The interface between Primary and Secondary Care is also crucial; with a need to prioritise hubs in the community to avoid unnecessary admissions to hospital and prolonged stays in hospital.

Returning to earlier discussion of performance, and statements around fragile services, Mr Weir suggested that the Health Board will be forced to live with these in the interim. There may be areas which can be worked on quickly to address fragilities; however, this needs to be within the wider long-term setting. Dr Wooding agreed that there are urgent priorities which need to be addressed without compromising the long-term strategy. An innovative and novel approach will be required. Mr Mark Henwood indicated that the Clinical Services Plan is the beginning of the process which will deliver the most significant ever change to service delivery in west Wales. He emphasised that it will improve the quality of care. There is, as has been mentioned, a list of fragile services. Whilst it would be wonderful to address the needs of all services concurrently, this is not possible. The Health Board's configuration will need to change, and Mr Henwood emphasised that there should be an open and honest discussion around which services each of the hospital sites will provide. As has been indicated, the organisation must seek opportunities to engage with its communities in multiple conversations around this topic.

Building on this point, Mr Iwan Thomas suggested that the Health Board needs to be more astute in its engagement with the public. It should be less confrontational, more humble and utilise existing community events and gatherings to converse with its population. **LD/ AHM**

Noting the proposed additional workstream to oversee the design and delivery of the Strategic Refresh, it was further suggested that Independent Members (IMs) should be involved, as several can offer specific expertise in this area. This may also lessen demands on Executive Directors. Dr Wooding agreed that including IMs in this group would add value. **LD**

Members were reminded that, whilst the Health Board is statutorily required to engage with its communities on services change, it needs to consider how it engages, to produce the optimal process and outcome. The Strategy will only be meaningful if it is produced in collaboration with communities. However, the Clinical Services Plan is very complex, and – if communities are to fully engage and understand these complexities – a different approach must be taken. Professor Kloer agreed, stating that he had found the meeting in Aberystwyth extremely useful and had learned a great deal. He agreed that the Health Board should meet with communities where communities want to meet. Whilst this may be an evolving process, Professor Kloer highlighted that the organisation does need to follow the established consultation guidance. He also wished to emphasise that a number of clinical services are extremely fragile. The more the process is prolonged, the more the risk of necessitating urgent service change. This will be another tension that needs to be managed.

Summarising, Dr Wooding advised that the foundation of the AHMWW Strategy remains as defined in 2018, and its design principles remain sound. The matter for debate is how this is now taken forward. In considering the recommendations, the Clinical Services Consultation Project Plan was endorsed; with the caveat that the Health Board must work with and listen to its communities, whilst recognising that services are fragile, some extremely so. The organisation must also be open to changing its approach to facilitate better engagement, and be flexible and open-minded around its processes.

**Decision:** The Board:

- **ENDORSED** the revised purpose statement and strategic objectives for inclusion in the 2025/26 Annual Plan and strategic refresh
- **DISCUSSED** and **CONSIDERED** the key areas it would wish the strategic refresh to explore
- **ENDORSED** the revised governance arrangements
- **NOTED** the Health Board's attendance at the Welsh Government Infrastructure Investment Board (IIB)
- **ENDORSED** the Consultation Project Plan provided as part of the Clinical Services Plan update

Regarding the Clinical Services Plan, the Board:

- **APPROVED** the Consultation Mandate, the matters on which the Health Board wish to make a decision upon
- **APPROVED** the Consultation Project Plan, including the consultation scope, timescales for delivery and resource requirements
- **APPROVED** the commencement of the detailed consultation planning (pre-consultation period)

Regarding the Urgent and Emergency Paediatrics Implementation Plan, the Board:

- **NOTED** the update on Urgent and Emergency Paediatrics Implementation Plan at Withybush Hospital

**PM(25)14 Corporate Risk Register**

Mrs Wilson introduced the Corporate Risk Register (CRR), reminding Members that since the previous report in September 2024, the risks have been discussed in detail by the Executive Risk Group and at Board level Committees. There have been significant discussions around certain areas of concern, for example at QSEC, and Deep Dives are conducted as necessary. There are 21 risks on the CRR, with Members noting that there are 2 new risks, 2 have been de-escalated/closed, 2 have increased in risk score, 3 have reduced in risk score and 14 show no change. Due to their confidential nature, 3 Corporate Risks involving physical and cyber security will be considered during the In-Committee Board session.

**Decision:** The Board **TOOK ASSURANCE** that corporate risks are being assessed, managed and reviewed appropriately/ effectively through the risk management arrangements in place, noting that these have been reviewed by Board level Committees.

**PM(25)15 Risk Appetite Statement**

Mrs Wilson presented the Risk Appetite Statement report, reminding Members that the Board had approved the previous iteration this time last year. The Risk Appetite Statement has been reviewed by the Executive Team, and (the minimal) changes are detailed within the report. This document will need to be realigned to the Strategy Refresh and new strategic objectives.

**Decision:** The Board **APPROVED** the Risk Appetite Statement.

**PM(25)16 Organ Donation Annual Report 2023/24**

Presenting the Organ Donation Annual Report 2023/24, Mr Carruthers suggested that this is relatively self-explanatory. The numbers within the Health Board are generally quite low; however, performance is good. Whilst this has continued, one referral was missed this year, which is disappointing. Mr Carruthers wished to

record his thanks to the team for their efforts during the year in training staff, raising awareness and undertaking discussions with families at an extremely challenging time. Members were assured that lessons have been learned from the missed referral, and that this had been discussed at the Organ Donation Committee, together with the Annual Report and action plan.

**Decision:** The Board **DISCUSSED** and **APPROVED** the Organ Donation Annual Report 2023/24 and **NOTED** the Health Board's performance against the priorities set for 2023/24 and action plan for 2024/25

**PM(25)17** **Revised Board Committee Governance**

Dr Wooding reminded Members that, during the latter part of last year, a decision was made to review the Health Board's committee structure. As a consequence, various changes are required to Terms of Reference, committee membership, etc. Mrs Wilson advised that the review had built on feedback from IMs and Executive Directors in their meetings with the Chair and on the findings of the Committee Self-Assessment exercise. Board approval is now being sought for several changes, including the establishment of a Finance and Performance Committee and associated disestablishment of the Sustainable Resources Committee (SRC). Also, the establishment of a Strategy and Planning Committee and disestablishment of the Strategic Development and Operational Delivery Committee (SDODC). In addition, it is proposed that a new Digital, Data and Innovation Committee be established. The Health Board is mandated to have an Information Governance Sub-Committee.

There has been an attempt to name committees to ensure that they better reflect their purpose. As a result of establishing the new committees, certain changes are required to the People, Organisational Development and Culture Committee (PODCC) and the Remuneration and Terms of Service Committee (RTSC), which are detailed within the report. Other amendments to the Membership, quoracy, and job titles in the Terms of Reference for other Board level committees are as indicated in the report. The names of these committees remain as they are currently. Legacy arrangements have been made. Thanks was expressed to committee Lead Executives and incoming and outgoing Chairs, for their input to this process. Mrs Wilson also thanked Miss Charlotte Wilmshurst for her work on this area.

Whilst Mr Weir fully supported the proposed changes, he suggested that reference to changing the Black, Asian and Minority Ethnic (BAME) Group be removed, with just a statement around establishment of a Hywel Dda Anti-Racism Group made. This is in response to feedback he has received from individuals in the organisation around this wording. **JW**

Members noted that the new arrangements will be reviewed and evaluated in due course, to ensure that they have achieved the intended impact.

**Decision:** The Board:

- **APPROVED** The establishment and Terms of Reference of the following new Committees from 1 April 2025:
  - Finance and Performance Committee
  - Strategy and Planning Committee
  - Digital, Data and Innovation Committee

- **APPROVED** The disestablishment of the following Committees on 31 March 2025:
  - Strategic Development and Operational Delivery Committee
  - Sustainable Resources Committee
  - Decarbonisation Task Force Group
  - Digital Oversight Group

- **APPROVED** The proposed revisions to the Terms of Reference for the People, Organisational Development and Culture Committee and Remuneration and Terms of Service Committee from 1 April 2025.

- **APPROVED** The proposed revisions to the Membership, quoracy, and job titles in the Terms of Reference for the following Committees from 1 April 2025:
  - Audit and Risk Assurance Committee
  - Charitable Funds Committee
  - Health and Safety Committee
  - Mental Health Legislation Committee
  - Quality, Safety and Experience Committee

**PM(25)18** **Joint Hywel Dda/Swansea Bay University Health Board Committee Update**

Members were reminded of the background to the establishment of the Regional Joint Committee (RJC), which had held its inaugural meeting on 15 January 2025. The Board is requested to agree the proposed RJC Terms of Reference and programme of work. Dr Wooding indicated that this forum will be instrumental in taking forward a number of areas and offers an opportunity to build on existing work. There is a great deal of energy and enthusiasm among those involved, and a number of emerging themes are evident. These include the potential for a regional approach to digital capability and capacity.

Ms Lewis enquired whether any consideration had been given to how the effectiveness of this forum will be evaluated. In response, Mrs Wilson confirmed that this has been discussed. In line with other Board level Committees, the RJC will be subject to Standing Order requirements around reviewing its effectiveness as a

committee. The exact process and format for this is yet to be agreed. Cllr. Evans queried whether the proposals have been considered by SBUHB yet and, if so, whether there is any feedback. Members were advised that a report mirroring this one is being considered by SBUHB's Board today. Amendments to the Terms of Reference were suggested following the inaugural meeting, all of which have been incorporated into the version presented today.

In response to a query around whether consideration has been given to co-opting university representation, Mrs Wilson advised that it has been agreed that the SBUHB IM (University) would be co-opted. However, it must be ensured that they represent the views of all the universities within the region. Professor Kloer indicated that he and the SBUHB Chief Executive are meeting with executive members of the RJC tomorrow, to follow up on actions agreed at the 15 January 2025 meeting and ensure that progress is being made. As noted, it is important to recognise that there are three universities within the region who should be consulted, along with other educational establishments such as local colleges. Dr Wooding advised that a helpful and compelling case for a regional approach to Public Health had been made. Also, a task for the Health Board Vice-Chairs to lead on has been identified, deriving from the Ministerial Advisory Group meeting last week. Dr Wooding concluded by suggesting that the RJC probably needs to be quite a dynamic forum and thinking needs to be more systemic, with a view to seamless services, wherever these are delivered.

Mrs Marks welcomed this positive update. In response to a number of queries she had received, however, she felt that it was important to formally record that this exercise is not about a merger of HDdUHB and SBUHB. Dr Wooding agreed, stating that it is absolutely not; its aim is to improve services for the population of the two Health Boards.

Ms Murphy noted that there is no mention in the Terms of Reference regarding co-opting Trade Union representatives for any discussions regarding workforce issues. Dr Wooding agreed that this should be considered. **JW**

**<u>Decision</u>:** The Board **APPROVED** the terms of reference for the Hywel Dda University Health Board and Swansea Bay University Health Board Regional Joint Committee.

**PM(25)19 Report of the Audit and Risk Assurance Committee**

Cllr. Evans, ARAC Chair, presented the update report from the meeting held on 10 December 2024. He drew Members' attention to the 'Alert' item in relation to the Discharge Management Follow-up Internal Audit, which had returned a second rating of Limited Assurance. It has been agreed that there will be a further internal

audit before the end of this financial year. ARAC is requesting a response from Board regarding the best course of action.

Regarding the latter, Dr Wooding expressed disappointment around the Limited Assurance rating, in such an intrinsically important area for the Health Board. He suggested that Board needs to understand the reason recommendations have not been met. Mr Carruthers shared this disappointment around the audit findings. He felt that the team had probably been overly-optimistic around timescales for completion of actions. These involve discharge pathways on multiple sites and with multiple partners. It has proved challenging to establish a consistent approach across the three counties. Mr Carruthers was, however, confident that the actions which have been taken will improve the position. These include initiatives around 6 Goals and Optimal Flow. There have been positive signs over the last 12 months with regard to reduced Length of Stay (LOS). In terms of next steps, the Discharge and Transfer of Care Adults Policy is due to be signed off via the formal process, and there will be more work around Optimal Flow. Dr Wooding hoped that the next follow-up audit would show an improved position.

Ms Murphy noted the statement that ‘the discharge process has become extremely complex for services’ and enquired whether the reference to complexity refers to the general discharge process or the Continuing Health Care process. In response, Mr Carruthers advised that this referred to discharge processes in their totality. Mr Weir agreed that the discharge process is extremely complex. He advised that he is involved with one of the Trusts in England, and that they had undertaken a similar exercise, with a similar outcome. This Trust had referred the issue to another committee, to seek a different approach. Dr Wooding said that he would like to think that this matter could be resolved without onward referral; however, should this be required, suggested that QSEC might consider the issue. Ms Lewis advised that QSEC has discussed discharge processes in detail before, whilst acknowledging that the latest Internal Audit report represents an updated position. This has been an ongoing topic of concern for some time, where progress should have been made. In view of this, Ms Lewis was willing to accept a mandate for referral to QSEC.

Ms Daniel noted that one of the findings from the most recent audit was in relation to utilisation of the Frontier system. She advised that the Quality, Safety and Improvement team is involved in addressing this high priority action. Members also heard that the Health Board uses its professional forums to ensure that discharge documentation is consistent across the organisation. there are areas where this approach is working, and others where it is not. This can form part of the QSEC report if required. Dr Wooding drew discussion to a close by requesting that the outstanding recommendations be resolved as soon as possible. If this is not achieved by the next audit, this matter would be referred to QSEC.

Returning to the report, Cllr. Evans drew Members' attention to the 'Advise' item on the Nursing Management Internal Audit report, which had also returned a Limited Assurance rating. Also, concerns in relation to the Clinical Audit Update, and the suggestion that services who do not participate in should be required to complete Quality Impact Assessments (QIAs). Finally, ARAC's continued concerns around outstanding external audit recommendations relating to Mental Health.

Referencing the Nursing Management audit, Dr Wooding felt that some of the findings seem quite serious. Ms Daniel advised that this is the first Internal Audit conducted since implementation of the Allocate system. A management response has been developed, and the team is working through the actions to meet the audit's recommendations. As indicated in the ARAC Update Report, there needs to be a focus on equipping nurse managers with management skills, which will be extremely important.

Professor Kloer emphasised the importance of Internal Audit as part of Health Board assurance mechanisms. Audits are directed towards areas of significance and concern. Limited Assurance Internal Audit reports are discussed at Executive Team. Professor Kloer is meeting tomorrow with Executive Directors to consider these and the approach going forward. Mrs Wilson advised that there will be a follow-up audit on Nursing Management in April 2025, with a widened scope.

**Decision:** The Board **RESPONDED** to the items the Committee is alerting them to, **NOTED** the items the Committee is advising them of and **TOOK ASSURANCE** from the items that the Committee is providing assurance on.

**PM(25)20 Report of the Quality, Safety and Experience Committee**

Ms Lewis, QSEC Chair, presented the update report from the meeting held on 5 December 2024. She drew Members' attention to the appended Chair's Briefing, which presents a progress report on various items of concern. Under the 'Advise' section, and as mentioned earlier, there had been a discussion of individual Corporate Risks, a number of which are long-standing. Ms Lewis expressed concern around the potential for these to become 'normalised' due to the length of time they have been in existence. She wished to assure members of the public that QSEC is not under any illusion about the impact of these on patients and that there is a route for action.

In response to a query around whether Ms Lewis had been assured by the additional information provided in the Chair's Brief; she confirmed that she was, following the additional report and subsequent discussion with colleagues. The next QSEC meeting is 13 February 2025, when further updates will be provided. Mrs Wilson apologised for the issues experienced around the December 2024 QSEC meeting regarding poor attendance and

deferral of papers without authorisation, assuring Members that changes have been put in place to prevent a recurrence.

**Decision:** The Board **NOTED** the items the Committee is advising them of and **TOOK ASSURANCE** from the items that the Committee is providing assurance on.

**PM(25)21 Report of the Sustainable Resources Committee**

Mr Weir, SRC Chair, presented the update report from the meeting on 17 December 2024, indicating that he had nothing further to add, as the items therein had already been discussed.

**Procurement Report**

Mr Huw Thomas introduced the Procurement Report, which differs in certain respects to the version considered by SRC. Items 3 and 4 have been considered by Executive Team and are presented for Board approval, Mr Weir having confirmed that he was content with this approach.

**Decision:** The Board **RESPONDED** to the items the Committee is alerting them to, **NOTED** the items the Committee is advising them of and **TOOK ASSURANCE** from the items that the Committee is providing assurance on.

Regarding the Procurement Report, the Board:

- **APPROVED** the award of the Bausch & Lomb Phacoemulsification and Vitrectomy Consumable Deal, 1 February 2025 to 31 January 2029, with no option to extend. This contract will have onwards submission to Velindre NHS Trust (as hosts of NHS Wales Shared Services Partnership).
- **NOTED FOR INFORMATION** the award (approved via Chair's Action and ratified in the Chair's report) of the Insourcing Orthopaedic Services, 1 January 2025 to 31 March 2026, with the option to extend for twelve (12) months to 31 March 2027. This contract will have onwards submission to Velindre NHS Trust (as hosts of NHS Wales Shared Services Partnership). As this will be awarded against a compliant NHS Wales framework, Welsh Government approval is not required.
- **APPROVED** to proceed to run a procurement exercise and enable award to a successful supplier of the Climate Adaptation Plan for a period of 8 weeks. The award will be presented to Financial Control Sub-Group (FCSG) prior to the award process.
- **APPROVED** to proceed to run a procurement exercise and enable award to a successful supplier of the Corporate Landlord Model for a period of 70 days. The award will be presented to Financial Control Sub-Group (FCSG) prior to the award process.
- **APPROVED** the award of the Outsourcing of Intravitreal (IVT) Injection, 1 February 2025 to 31 March 2025, with an option to

extend for an additional 12 months. This contract will have onwards submission to Velindre NHS Trust (as hosts of NHS Wales Shared Services Partnership). As this will be awarded against a compliant NHS Wales framework, Welsh Government approval is not required.

**PM(25)22** **Report of the Strategic Development and Operational Delivery Committee**

Mr Maynard Davies, SDODC Chair, presented the update report from the meeting held on 19 December 2024. Most of the 'Alert' items have already been discussed, with the exception of the Ophthalmology Getting It Right First Time (GIRFT) report recommendations. SDODC was extremely concerned by the proposed completion dates of 31 January 2027, due to the lack of estates capacity to expand clinics. The Committee has requested that the Integrated Quality, Financial Performance and Delivery (IQFPD) group investigates to ascertain whether these dates can be brought forward. The Board is requested to approve the Social Model for Health and Wellbeing proposals and Aseptic Project Business Justification Case, presented separately, both of which have been scrutinised by SDODC.

In regard to the Ophthalmology GIRFT report, Mr Carruthers advised that the team is in the process of reviewing a number of the recommendations. It is felt that aspects of certain of these could be seen to be complete. He would clarify further and provide a written update at the next meeting. **AC**

**Embedding a Social Model for Health and Wellbeing**

Dr Gjini presented the report, which sets out a proposed definition and principles of the Social Model for Health and Wellbeing. These have been discussed and shared previously, with Members' attention drawn to the summit planned for March 2025.

**Aseptic Project Business Justification Case (BJC)**

Ms Paterson introduced the Aseptic Project BJC, which represents an interim solution to address the fragility of the current service, until a regional provision is in place. Aseptic services are extremely important, and this is the only facility remaining in HDdUHB. The BJC has been well scrutinised at various fora.

**Decision:** The Board **RESPONDED** to the items the Committee is alerting them to, **NOTED** the items the Committee is advising them of and **TOOK ASSURANCE** from the items that the Committee is providing assurance on.

Regarding Embedding a Social Model for Health and Wellbeing, the Board **APPROVED** the definition and principles of the Social Model for Health and Wellbeing, and subsequent actions outlined in the report.

Regarding the Aseptic Project Business Justification Case (BJC), the Board **APPROVED** the BJC for onward submission to Welsh Government for further scrutiny and approval.

**PM(25)23** **Report of the People, Organisational Development and Culture Committee**

Mrs Patel, PODCC Chair, presented the update report from the meeting held on 16 December 2024. There was one 'Advise' item, which highlighted concerns around resuscitation/basic life support training compliance rates. An intervening update had been requested and this had presented a much improved position. It has been suggested that the issue is one of data capture and that changes are required, in order to provide the assurance required.

Returning to earlier discussions around staff sickness and low Flu vaccine uptake, Mrs Marks enquired whether PODCC had considered looking at this topic. Mrs Gostling advised that the Workforce team has been asked to examine this information, by department, to assess whether there is any correlation. She would encourage any staff who have not taken up the offer of a Flu vaccine to do so. The team is also examining staff sickness rates more generally, to assess whether there is any correlation with where staff live. Dr Gjini advised that the Flu season is ongoing and confirmed that vaccinations are still available to staff. There is proactive work being undertaken to analyse uptake in various professional groups, as certain of these are showing significantly lower rates of uptake. In response to Mrs Marks' query around correlation, Dr Gjini advised that this had been examined last year; however it is challenging to interpret.

Noting the statement around providing 'a holistic view of performance management and compliance rates across the Health Board', Dr Wooding enquired whether this is in relation to training and development. Mrs Gostling explained that this referred specifically to a Deep Dive into medical education. It has been identified that there are different mechanisms for recording training episodes. The Head of Education will be examining how all training records can be centralised onto the Electronic Staff Record (ESR) system, to facilitate accurate reporting.

**Decision:** The Board **NOTED** the items the Committee is advising them of and **TOOK ASSURANCE** from the items that the Committee is providing assurance on.

**PM(25)24** **Report of the Health and Safety Committee**

Ms Murphy, Health and Safety Committee (HSC) Chair, presented the update report from the meeting on 14 January 2025. There were no 'Alert' items. In terms of 'Advise' items, Ms Murphy reported that adequate assurance was not provided from the

Health and Safety Regulations Overview. This area will continue to be monitored by the Committee.

**Decision:** The Board **NOTED** the items the Committee is advising them of and **TOOK ASSURANCE** from the items that the Committee is providing assurance on.

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

Ms Raynsford, Charitable Funds Committee (CFC) Chair, presented the update report from the meeting held on 13 December 2024. There were four 'Advise' items, around: concerns pertaining to the level of fundraising expenditure in comparison to the donations and fundraising income received; learning in regard to the Therapeutic Gardens at PPH project; that an update will be presented to CFC to reflect the year's financial activity and return on investment provided; and a risk regarding stock market volatility.

**Decision:** The Board **NOTED** the items the Committee is advising them of and **TOOK ASSURANCE** from the items that the Committee is providing assurance on.

**PM(25)26 Committee Update Reports**

Mrs Wilson presented the Committee Update Reports, highlighting the reports included and noting that there were no 'Alert' or 'Advise' items being brought to the Board's attention. The Board is, however, requested to approve the Health Board Partnership Forum Terms of Reference.

**Decision:** 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
- **TOOK ASSURANCE** on the items that it is being assured on
- **APPROVED** the Health Board Partnership Forum Terms of Reference

**PM(25)27 Joint Committees and Collaboratives**

Introducing the Joint Committees and Collaboratives report, Professor Kloer advised that the Judicial Review on Emergency Medical Retrieval and Transfer Service (EMRTS) was heard at the Administrative Court in Cardiff 22 and 23 January 2025. Due to the length of the hearing, the case will continue to be heard on 7 February 2025.

Mrs Wilson highlighted the NHS Wales Joint Commissioning Committee (JCC) Sub-Committee Terms of Reference presented for approval. There is an inconsistency in these across Wales, with paragraph 4.6 proposing that a staff side partnership representative be in attendance. As this is a joint committee of all Boards, this would not be feasible in governance terms. There has, therefore, been a request to remove this from the Terms of Reference. Health Boards would liaise with their local Trade Union representatives should there be any areas of concern. It has also been requested that both JCC Sub-Committees provide reports to the Quality, Safety and Experience Committee and Finance and Performance Committee.

**Decision:** The Board:

- **RECEIVED** the updates in respect of recent JCC and NWSSPC meetings
- **APPROVED** the updated Terms of Reference for the JCC Quality, Safety and Outcomes Sub-Committee
- **APPROVED** the updated Terms of Reference for the JCC Planning, Performance and Finance Sub-Committee

**PM(25)28 Statutory Partnerships Update**

Ms Paterson presented the Statutory Partnerships Update report, advising that the Regional Partnership Board (RPB) is undertaking a review of its working practices. The Regional Integration Fund (RIF) allocation for this year has been received. Whilst the allocation remains the same, the criteria has changed. Beyond this year, there is an expectation that projects will be reviewed with Welsh Government and potentially mainstreamed. This will be a key part of considering how services are taken forward.

Aligned with earlier concerns around MHLD capacity, Mrs Marks highlighted that a large part of the funding for their services comes via the RIF. In view of Ms Paterson's final comment, this will need to be considered further. Dr Wooding noted the 10 'good practice' principles that each Region has been asked to assess against and provide a weekly update to the Cabinet Secretary, and enquired what is being measured. Ms Paterson advised that this relates to the 50 Day Challenge. There is a workbook which sets out the requirements for each principle. A performance framework is being developed. There has been some reporting; however, numbers are not yet sufficient to evaluate impact. The funding to support this initiative was received relatively late on and commissioning has only recently taken place. Professor Kloer and Dr Gjini drew Members' attention to the PSB updates also contained within the report.

**Decision:** 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
- **NOTED** the actions which have been completed to date

**PM(25)29 Any Other Business**

Professor Kloer provided an update on the Ministerial Advisory Group (MAG) visit to HDdUHB on 17 January 2025. This Group is visiting every Health Board in Wales. It comprises a number of experts across the system, who focus on key areas including Unscheduled Care, Planned Care, Cancer Care and Diagnostics. Professor Kloer indicated that the visit had been extremely constructive, with the Health Board's clinicians provided with an opportunity to present to the Group and facilitate visits to services. He felt that the Group had developed a good understanding of the challenges being faced by the organisation and he looked forward to their report. The Health Board's approach to its new operational structure was commended, together with its approach to and ambitions around Unscheduled Care and its approach to Planned Care.

Dr Wooding was reassured by this feedback and the fact that those areas in which the organisation is struggling are also common to other Health Boards. The visit had been collegiate and insightful. Professor Kloer agreed, noting that – whilst the Health Board had also shared information around its longer-term plans – the Group's priority was the key areas mentioned and driving performance in these. One piece of feedback was that the Health Board's staff demonstrate great kindness to both patients and to each other, despite being under significant pressure.

**Decision:** The Board **NOTED** the update on the Ministerial Advisory Group (MAG) visit.

**PM(25)30 Board Annual Workplan**

**Decision:** The Board **NOTED** the Board Annual Workplan, which would be updated to reflect discussions.

**PM(25)31 Date and Time of Next Meeting**

9:30am, Thursday, 27 March 2025