

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

Date of Meeting: **09:30, Thursday 31 July 2025**  
Venue: **Y Stiwdio Fach, Canolfan S4C Yr Egin, College Road, Carmarthen SA31 3EQ**

Present: Dr Neil Wooding, Chair, Hywel Dda University Health Board  
Mrs Eleanor Marks, Vice-Chair, Hywel Dda University Health Board  
Mr Maynard Davies, Independent Member (Information Technology)  
Cllr. Rhodri Evans, Independent Member (Local Authority)  
Mr Michael Imperato, Independent Member (Legal)  
Ms Anna Lewis, Independent Member (Community)  
Ms Ann Murphy, Independent Member (Trade Union)  
Mrs Chantal Patel, Independent Member (University)  
Ms Sarah Harraway, Independent Member (Community)  
Mr Iwan Thomas, Independent Member (Third Sector)  
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 Mandy Davies, Assistant Director of Quality Improvement and Assurance (deputising for Ms Sharon Daniel, Executive Director of Nursing, Quality and Patient Experience)  
Mr Lee Davies, Executive Director of Strategy and Planning  
Ms Bethan Lewis, Assistant Director of Public Health (deputising for Dr Ardiana Gjini, Executive Director of Public Health)  
Mr Mark Henwood, Executive Medical Director  
Mr James Severs, Executive Director of Allied Health Professions and Health Science  
Mr Huw Thomas, Executive Director of Finance

In Attendance: Ms Alwena Hughes Moakes, Communications and Engagement Director  
Ms Jill Paterson, Director of Primary Care, Community and Long-Term Care  
Mrs Joanne Wilson, Director of Corporate Governance/Board Secretary  
Ms Donna Coleman, Llais West Wales (VC)  
Dr Jonathan Arthur, Chair, Healthcare Professionals Forum  
Ms Mwape Burke, Aspiring Board Members Programme (observing)  
Dr Karen Brown, Associate Medical Director - Community and Integrated Medicine (part)  
Ms Clare Moorcroft, Committee Services Officer (Minutes)

| <b>Minutes Ref.</b> | <b>Item</b>   | <b>Action</b> |
|---------------------|---|---------------|
| <b>PM(25)116</b>    | <b>Welcome and apologies</b>  |               |
|                     | Dr Neil Wooding, Health Board Chair, welcomed everyone to the Public Board meeting, particularly Ms Mwape Burke and Dr Jon Arthur. Also, Audit Wales representatives, who were observing the meeting via the livestreaming facility. Members heard that there |               |

would be additional attendees joining the meeting for the Urgent and Emergency Care item.

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

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

Apologies for absence were received from:

- Mr Winston Weir, Independent Member (Finance)
- Ms Sharon Daniel, Executive Director of Nursing, Quality and Patient Experience
- Dr Ardiana Gjini, Executive Director of Public Health
- Mr Michael Gray, Director of Social Services and Housing, Pembrokeshire County Council

**PM(25)117 Declaration of Interests**

There were no declarations of interest made.

**PM(25)118 Minutes of the Public Meeting held on 29 May 2025**

**Decision: RESOLVED** – that the minutes of the meeting held on 29 May 2025 be approved as a correct record.

**PM(25)119 Matters Arising and Table of Actions from the Meeting held on 29 May 2025**

An update was provided on the Table of Actions from the Public Board meeting held on 29 May 2025. Confirmation was received that outstanding actions had been progressed.

**PM(25)120 Report of the Chair**

Dr Wooding presented his report on relevant matters undertaken since the previous Board meeting, highlighting in particular the Health Board's immersion in the Clinical Services Plan consultation, an extensive programme of engagement and consultation with the public. He had been able to attend several consultation events, which he had found insightful, valuable and humbling. Whilst certain of the stories communicated at these had been difficult to hear, others had been uplifting. The overwhelming message had been that what the organisation delivers impacts significantly on people's wellbeing and health. This consideration must be paramount in decision making. Dr Wooding expressed his gratitude to those who have attended events and shared their views by other mechanisms. These have offered tremendous learning opportunities regarding various topics and issues important to the local population.

Ms Jill Paterson noted Dr Wooding's attendance at the Pembrokeshire Peninsula Stakeholder Group and reminded Members of Board discussions regarding the St David's Practice a year ago. Also, that it had been agreed, at that point, to undertake further engagement six months after the opening of Meddygfa Penrhyn on 1 November 2024. In line with this, Members heard that stakeholder events had taken place on 24 and 26 June 2025. Ms Paterson suggested that it may be appropriate to bring to Board the findings from this exercise. In response, Dr Wooding recalled that an invitation to attend the January 2026 Public Board had been extended to the Peninsula Stakeholder Group, which would offer an appropriate opportunity. Whilst highlighting that the two matters were slightly different, Ms Paterson agreed that it might be appropriate to manage both as one agenda item at the January 2026 Board meeting.

JP

For accuracy, Mrs Eleanor Marks highlighted that the All-Wales Planning Event which she had attended on 4 July 2025 had been held in Carmarthen, rather than Lampeter.

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

PM(25)121

### **Report of the Chief Executive**

Professor Philip Kloer introduced his report on relevant matters undertaken since the previous Board meeting, drawing Members' attention to the positive announcement of further de-escalation from level three to level one for Child and Adolescent Mental Health Services (CAMHS) and level four to level three for Cancer services. This was small, but significant progress, which builds on the previous de-escalation in March 2025. Professor Kloer expressed his gratitude for and pride in the work of the Health Board's staff in achieving this position. In an update with regard to the Emergency Medical Retrieval and Transfer Service (EMRTS) Judicial Review, Members were informed that the permission to appeal has been refused on all grounds. The order was sealed on 1 July 2025, but was only served by the court on Tuesday 29 July 2025. This means that the time period for an application to the court of appeal has now passed. In essence, permission for Judicial Review on Ground 4 is refused; claim dismissed. Finally, Professor Kloer reported that there had been a Healthcare Inspectorate Wales (HIW) inspection of Bronglais Hospital (BGH) Emergency Department (ED) within the last few days, and initial feedback had been received. He requested that Mr Mark Henwood provide further detail.

Mr Mark Henwood confirmed that HIW had visited BGH ED on the evening of Tuesday 29 July 2025. He and Mr James Severs had attended a feedback session yesterday, and a full report would be provided in due course. Issues in relation to patient flow and staffing had been identified, together with immediate actions required, most of which can be addressed relatively quickly and easily. Mr Henwood wished to highlight in particular positive

feedback in relation to the ED staff, culture and attitude. Specific quotes from the feedback included 'unusual', 'doing a lot right' and 'positive patient feedback'. He felt that the staff should be recognised and thanked for their contribution to this positive outcome. Dr Wooding agreed that the Board's thanks to the staff of BGH ED should be registered and communicated.

**PK/MH**

Mr Iwan Thomas welcomed the proposed agreement of the Regional Integration Fund (RIF) Memorandum of Understanding (MOU). He advised, however, that there are concerns within a number of Third Sector organisations regarding the expectation for match funding. The Third Sector is experiencing various cost pressures, including the recent increase in employer National Insurance (NI) contributions. As a result, several projects are now very challenged in respect of the ability to continuing providing services. He communicated a suggestion from Third Sector organisations that they provide matched resources in the form of staff and/or time contribution, rather than financial. Dr Wooding agreed that the potential for such arrangements should be explored. Ms Paterson felt that it was important to recognise the opportunities offered by the RIF, together with the significant role of the Third Sector in projects. Members were reminded that funding will be in place until 2027; the Regional Partnership Board (RPB) has been requested to review RIF projects against the revised criteria, and is preparing to agree a process to undertake this review. Whilst still to be confirmed, the expectation is that statutory partners will take steps to either scale-up or mainstream appropriate projects. Essentially, while there will be a process, which will be transparent, and which will involve engagement with partner organisations; detail of the process is not yet confirmed or available. Mr Huw Thomas echoed Ms Paterson's comments, adding that non-recurrent funding streams present challenges to the organisation, including financial risk and challenges in relation to workforce, with staff employed in short-term, fixed-term contracts.

Whilst welcoming the de-escalation of CAMHS, Ms Anna Lewis requested clarification regarding the rationale behind this, and of the implications for children/young people and their families in terms of patient experience and service delivery. In response, whilst Professor Kloer was pleased that the service had been de-escalated, he equally recognised that there are a number of areas where levels of access are not at the level the Health Board would wish. These include Neurodevelopmental Assessment waiting times, where plans exist to improve access, but will not fully address the issues. Mrs Marks shared concerns regarding Mental Health services, where demand is continually outstripping capacity. These concerns extend to both the public and to staff. Mr Andrew Carruthers felt that it was important to clarify that the Health Board has been de-escalated against specific delivery targets and measures, achievement of which has been a challenge since the COVID-19 pandemic. The wider issues within Mental Health, including those around Neurodevelopmental waiting times, discussed a number of times by the Board, remain

a significant challenge. He assured Members, however, that these are very much a focus for the operational team. As indicated previously, Neurodevelopmental Assessment waiting times were originally included within the Escalation Framework; however, were removed by Welsh Government due to concerns that they were unachievable. Members heard that the Health Board has agreed revised Terms of Reference for a new project, which will consider service redesign to meet the demand being placed upon it. Dr Wooding took assurance from the planned work on the service model to identify a sustainable solution and looked forward to receiving further information on this in the future.

Noting the statement that current RIF projects will be reviewed, Mrs Chantal Patel trusted that this process will include consideration of the impact of projects and any evaluations undertaken. Ms Paterson confirmed that this would be the case, adding that regular reports are provided to both the RPB and to Welsh Government. She suggested that this information could be reported via the Strategy and Planning Committee if required. Returning to the issue of mental health, Mrs Patel felt that there should be consideration of why service demand is suddenly outstripping capacity, and whether this is due to gaps in service. In response, Mr Carruthers suggested that the 'catalyst' had been the COVID-19 pandemic and the impact of this (particularly lockdowns) on children and young people, together with increased awareness of mental health in general. These factors had led to an increase in people presenting with concerns regarding their mental health.

In addition, there are challenges within the service which are known, such as those mentioned earlier around waiting times for Neurodevelopmental Assessment. Health Boards are measured on performance in terms of the time between referral and assessment. However, as indicated during previous discussions on this topic, approximately 90% of referrals for assessments simply confirm the diagnosis suspected. There is then the issue of providing the appropriate intervention and treatment, which varies in scale, but can involve a number of treatment sessions. A pilot of a more multi-disciplinary approach had been undertaken; however, this had not necessarily provided the optimum balance, hence the re-evaluation. Consideration needs to be given to 'right-sizing' the approach, to ensure that patients are directed into the correct treatment pathway. Dr Wooding suggested that consideration also be given to anything the healthcare or other sectors might be able to do to positively influence the mental health of children and young people, to lessen demands on the service. Ms Bethan Lewis emphasised that mental health and wellbeing is one of the key Public Health pathways as part of the 24/7 framework.

**Decision:** The Board:

- **NOTED** the Escalation Status Update and letter

- **NOTED** the Corporate Risk Register (CRR) report and summary
- **APPROVED** the Deed of Variation: 25/035: APB and Barod Project Ltd
- **APPROVED** the signing of the Regional Integration Fund: Memorandum of Understanding
- **APPROVED** the re-signing of and application of the Health Board's seal to the Lease Agreements linked to the continued delivery of Renal Services at Glangwili and Withybush Hospitals (GGH and WGH)
- **ENDORSED** the Register of Sealings since the previous report on 29 May 2025
- **NOTED** the status report for Consultation Documents received/responded to
- **NOTED** Executive Team discussions

**PM(25)122**

### **Annual Plan 2025/26**

Presenting the report, Mr Lee Davies indicated that the Annual Plan contains a number of components which are addressed by other agenda items, and suggested that detailed discussion of any such items take place under those items. Following submission of the Health Board's Annual Plan, a series of letters has been exchanged between the Health Board and Welsh Government. Welsh Government has deemed the Health Board's Annual Plan unsupportable, primarily due to the financial forecast. Members were reminded that the Plan had been developed and constructed based on the Targeted Intervention (TI) de-escalation criteria. Whilst it fulfils the financial requirements of this (to meet the Target Control Total), it does not meet subsequent Welsh Government expectations around financial performance. The Health Board has also received its Accountability Conditions and attended its quarterly TI meeting with Welsh Government. In terms of performance, Cancer performance has improved, reflected in the de-escalation position mentioned earlier. Whilst certain other areas have also demonstrated improved performance, they are not yet at the levels required to meet de-escalation criteria. Other areas require further focus to facilitate sustained improvement; these include Emergency Departments (EDs), Follow-ups, Ophthalmology and Infection Prevention and Control (IPC). Members' attention was also drawn to specific challenges regarding workforce in Operating Theatres, in GGH particularly. The relevant Clinical Care Group (CCG) is monitoring this and developing an action plan.

Noting the statements regarding Ophthalmology performance, Cllr. Rhodri Evans queried the reduction in the risk score for Corporate Risk 1664 from 20 to 16, outlined within the earlier Chief Executive's Report. Mr Carruthers explained that this risk relates specifically to medical cover and on-call arrangements. There has been improved recruitment to the service, facilitating a reduction in the risk score. This does not, however, relate directly to the performance issues in Ophthalmology. Mrs Marks welcomed the report, and wished to raise a query around Did Not

Attend (DNA) figures. Relating feedback from members of public around appointment letters arriving too late, she enquired whether each department is responsible for booking appointments, and whether patients can book online or via text message. Fundamentally, whether there is anything further which could be done to maximise attendance.

Mr Carruthers advised that there are a number of factors involved; however, the way in which the Health Board communicates with patients is an important consideration and one which service user feedback frequently highlights. In terms of the issue of appointment letters specifically, whilst this has been reported in local media and raised by the Staff Partnership Forum, it is not something which has been specifically fed back by individuals. Without specific examples which can be investigated, it is therefore difficult to analyse and address. It is possible that there has been an impact from the change from First Class to Second Class postage. Mr Carruthers requested that any service users or staff make contact, with specific examples, to allow a more detailed understanding of the issue. The more granular the information available to the organisation, the better. Regarding the booking of appointments, services employ various processes; some of which are centrally managed, others by the services themselves.

In terms of feedback regarding the issue of late appointment letters, Mrs Marks knew personally of individuals affected. Their priority had generally been rearranging the appointment, rather than providing feedback regarding the process. She was concerned that certain services are keeping waiting lists for appointments on documents and spreadsheets, suggesting that a more systematic approach was required. Dr Wooding observed that there are significant numbers of patients waiting for appointments and that opportunities to see them should not be wasted. Whilst there are certain factors which are beyond the Health Board's control, any means to optimise the current process should be grasped. He also highlighted the excessive cost of sending letters, identified in a later agenda item relating to Outpatients, particularly in the current financial environment.

Mr Huw Thomas noted that this is a complex issue, around which the Health Board has a programme of work. This includes the hybrid print and post system, and managing appointments via the Welsh Patient Administration System (WPAS). He suggested that consideration may need to be given to moving to an 'opt out' process for text messaging, rather than 'opt in'. Also, to the potential for centres of excellence, consolidating patient access into a central facility. Ms Mandy Davies advised that there is a piece of work currently being undertaken, involving the central Communication Hubs and the Waiting List Support Service, which will consider how the Health Board responds to enquiries around waiting lists and appointments. This will be reported to the Quality, Safety and Experience Committee (QSEC) in due course. Mrs Patel suggested that the Digital Transformation team might, as a

priority, consider the practicalities of implementing a system which would make it easier for patients to access, make and reschedule appointments. She was aware of such systems being developed in other Health Boards.

Ms Anna Lewis referenced the information regarding Theatres capacity, and the shortfall in this of approximately 20%, due primarily to staffing issues. She requested clarification, however, regarding the statement around potential measures being restricted by 'policy limitations on additional hours or agency support'. In response, Mr Carruthers explained that this issue was mostly restricted to GGH, where there have been staff vacancies and sickness leading to challenges in service provision. Theatre time has been prioritised for dealing with urgent and emergency cases, which has impacted on routine surgery, particularly in Ear, Nose and Throat (ENT) and Ophthalmology. In terms of the specific statement referenced above, Mr Carruthers felt that this likely refers to the additional steps and checks put in place by the Health Board to limit variable pay costs. Services would often prefer to secure agency support at an earlier stage; one example of where the service and organisational perspectives diverge. To address this, there have been certain changes in the approval process for agency use, to provide balance and avoid a 'blanket' approach. There has also been some success in terms of overseas recruitment, and Mr Carruthers felt that an improvement should be seen in 3-6 months.

Ms Anna Lewis welcomed this additional context, and was pleased to hear that a 'blanket' approach is not being employed. It was noted, however, that this issue illustrates just one instance of where the Health Board is having to choose between reducing expenditure on temporary staff, and increasing service capacity in order to reduce waiting times and the resultant impact on people's lives and wellbeing. Ms Lewis felt that the Board and organisation must be open and transparent in such cases, on what actions are being taken and why. Dr Wooding agreed that such conflicts in priorities should be highlighted. Noting that the topic of productivity in Theatres is an extremely important issue, Mr Michael Imperato enquired whether any Board level Committee is considering this. Members heard that it is referenced within the People, Organisational Development and Culture Committee (PODCC) Update, in relation to staff sickness. The Vice-Chair noted that she had already requested an update at the next PODCC meeting; however, recognised that this may be a matter for QSEC, due to the quality and safety concerns .

**AC**

Professor Kloer emphasised that the Health Board is committed to addressing the targets in relation to 52 and 104 week waits. The expectation for Quarter 2 is for figures much closer to zero. The question is how to achieve the commitment within the Annual Plan in the most effective way possible. Waits of 104 weeks are still far too long and whilst achievement of the target is an aim, it should not necessarily be celebrated. There are numerous factors involved with Theatre productivity, a key part of the enabling

actions from Welsh Government in relation to Planned Care. As such, Professor Kloer would anticipate that the Finance and Performance Committee (FPC) would also consider this matter. With regard to 'blanket' approaches and the impact of prioritising savings, etc, Professor Kloer wished to highlight that, to achieve the financial target of £24m deficit set by Welsh Government will involve consequences in terms of service provision.

Ms Ann Murphy indicated that she has been involved in discussions with staff. Whilst she welcomed the positive news regarding recruitment, it was noted that staff joining the Health Board require training and induction, and she queried whether a timescale of 3-6 months for an improved position was somewhat optimistic. In response, Mr Carruthers advised that there are plans to stabilise the workforce position via insourcing by the end of the year, subject to later Board discussion. In addition, there has been international/overseas recruitment, and conversations regarding Nurse Staffing Levels Act requirements. There will be a plan in place to stabilise the workforce position within the next 3-6 months, following which, further work will take place to reach a more sustainable position.

**Decision:** The Board:

- **RECEIVED** the update on the 2025/26 Annual Plan
- **CONSIDERED** the response to Welsh Government's requirements for additional financial actions beyond £31.5m and review of £11.7m investments
- **DISCUSSED** the performance position against the de-escalation criteria
- **ENDORSED** the tracking of enabling actions across five themes (e.g., operational productivity, workforce efficiency) and the 'Plan on a Page' for each of the 10 Planning Objectives, with updates to relevant committees

**PM(25)123**

### **Financial Report**

Mr Huw Thomas introduced the Financial Report and focused in particular on the run-rate position. He reminded Members of the objective to de-risk the Plan by the end of Quarter 1. As indicated, an in-month financial position of a £2.5m deficit is being reported, against the planned deficit of £2.6m; a favourable deviation of £0.1m. The planned deficit would return a year-end deficit of £31.5m; it had been possible to reduce this further to £30m by removing two proposed investments, relating to the 24/7 model and certain maintenance costs.

Other measures are possible, which would further reduce the deficit to £28m; however, there is a gap in the Welsh Government funding to cover the impact of the increase to employer NI contributions, with a shortfall of £2m for the Health Board. As a result, the commitment to reduce the forecast deficit to £28m has been revised to a proposed £30m deficit. This is, as indicated earlier, insufficient to meet Welsh Government expectations for a £24m deficit. In terms of savings delivery, the priority must be

operationalising savings. Only half of the required savings target has been identified, with improvements in the financial position utilising areas of underspend month on month. The organisation needs to focus on better translating in-month assurance into assurance around the forecast position. Members' attention was drawn to Appendix 2, which summarises further potential areas of improvement which might facilitate achievement of the required Welsh Government financial target of £24m. Mr Huw Thomas emphasised that a simple test had been applied in drawing up the list: that the items therein were both significantly sufficient, and significantly variable, to enact by the end of the year. There has been no judgement of the potential adverse impact of these on service delivery, quality, safety or equity; Quality and Equality Impact Assessments (QIAs and EqlAs) would be required on any of the items listed. He further emphasised that a Board decision regarding enacting any of these is not being sought; rather, recognition that they represent areas which might be considered.

Ms Murphy advised that Trade Union colleagues were disappointed that Appendix 2 had not been subject to the usual process of consideration by a Board level committee. It is felt that Health Board staff have worked extremely hard over recent years, and that the manner of presentation of this information is unfair. Mr Maynard Davies shared this concern. Whilst welcoming the additional £5m of savings identified, he enquired regarding the status of these. Also, whether these are included in Appendix 2. Mr Davies highlighted that, despite Theatre usage being down by 20%, there has been an overspend on consumables. Which suggests that, should Theatre capacity be increased to more 'normal' levels, spending will increase significantly. This resonates with earlier comments around challenges in balancing finances with performance and delivery of the Plan. The second largest area of overspend is on Dental Contracts, which is concerning when significant numbers of local people cannot access dental services. Mr Davies noted, however, that there is a separate agenda item on dental services on the agenda.

Recognising that there are currently many 'moving parts', Mrs Marks nonetheless felt that the Health Board does have a vision of how it would like services to look in the future; care closer to home, etc. She would request, however, assurance regarding the strategy for moving towards this. Whilst there is clearly work being undertaken to address the financial position, Mrs Marks was less assured around future service model delivery. Mrs Patel enquired how and who assesses whether the financial measures being proposed or implemented are aspirational, or are feasible to sustain in the longer-term. Referencing the savings gap, Mr Imperato observed that the organisation is about to enter Quarter 2, and queried the level of progress possible by the end of August 2025. He emphasised that progress will be required by then and by the next Board meeting in September 2025.

Returning to earlier comments, Mrs Lisa Gostling advised that she has met with Trade Union representatives to discuss the contents

of Appendix 2. She had, at the meeting, emphasised that no decision has been made regarding any of the items on the list, and had acknowledged that it had not been subject to the usual governance process or practice. She had further committed to the document undergoing the proper process of consideration by the relevant forum. Dr Wooding agreed that the current status of this document, as merely a list of possibilities, needs to be emphasised and reinforced. Mr Huw Thomas recognised the need to work with staff-side colleagues. The document is presented simply to allow Board to be fully apprised of the scale and range of possible options, which are, by the very nature of meeting the requirements for inclusion, both significantly sufficient and variable. Whilst it is recognised that due process must be followed, it is also vital to be open and transparent in terms of the possibilities which might be considered.

Responding to Mr Maynard Davies' queries, Mr Thomas indicated that there is a certain element of duplication between savings, which steps will be taken to manage out. There has been an improvement between Month 2 and Month 3, and – it should be noted – a further improvement since the reported Month 3 position, from £22m to approximately £23.5m identified as Green and Amber savings schemes. Members were assured that the relevant operational team is sighted on the apparent 'disconnect' between Theatre usage and consumables cost; there are various complicating factors involved. In terms of the allocation for dental services, which is ring-fenced, it is vital to ensure that this is not underspent. There has not been any conscious decision to delay; these are naturally occurring delays resulting from contract handovers, etc. There is an option, described within Appendix 2, to delay; however, this would require discussion and decision by the Board following a full QIA and EqIA. Referencing Mrs Marks' query, Members heard that a 'roadmap' outlining a three-year recovery trajectory for the organisation has been presented to the Executive Team; however, this requires further finessing. It would require Board consideration as part of next year's Planning round and Mr Huw Thomas would anticipate this being presented to the November 2025 Board meeting.

HT

Members also heard that work is being undertaken with Swansea Bay UHB (SBUHB) to explore use of the STAR (Socio-Technical Allocation of Resources) approach, which will consider how to resource the organisation in a more strategic way. In response to Mrs Patel's and Mr Imperato's queries, Mr Huw Thomas explained that each member of the Executive Team has been tasked with evaluating in detail the options within their scope, including any Impact Assessments required. Findings will be reported to the Executive Team by 15 August 2025. Thereafter, to the FPC on 19 August 2025, for scrutiny and onward assurance to the Board in September 2025. This should provide an indication of the potential scale of opportunities, which will then form part of the Health Board's September 2025 submission to Welsh Government. In view of the final statement, and the relatively short timescale

involved, Cllr. Evans requested clarification of whether the intention is for a Board decision on options in September 2025.

Mr Huw Thomas reminded Members that the shortfall between the current forecast deficit and Welsh Government's stated expectation is £6m. The total value of the options contained within Appendix 2 is £22.5m. However, it should be recognised that options may well involve some level of detrimental impact, which will need to be balanced and considered during Board discussion. Ms Anna Lewis wished to record her support for Mr Thomas, observing that the list has been 'pitched' to the Board in such a way to reflect that it is purely an accounting exercise based only on the liquidity of these opportunities. She further noted that she has been part of many previous discussions, along with other Independent Board Members, when those in the Executive Team have been challenged to 'provide their workings' in respect of proposals being discussed. Appendix 2 does just that. Ms Davies confirmed that QIAs will be required for any options being considered. She also welcomed recognition of, and commitment to discuss, the professional issues which certain of the suggestions will involve.

Dr Wooding acknowledged that Health Board staff often feel that the focus is purely on saving money. Whilst it is vital to achieve sustainability as an organisation, there is a difference between that and 'just saving money'. Attempting to do the latter in isolation as an NHS organisation will result in risks to patient safety and care. Value-based Health Care involves the best possible use of resources; ensuring that clinicians and the wider workforce utilise resources in the optimum way. The Health Board needs to 'sophisticate' its approach to reducing costs. Whilst certain areas require investment; others could be decommissioned or reduced. The organisation needs staff to think intrinsically about how it can deliver services safely and sustainably, whilst also providing the best value for money.

Professor Kloer reminded Members of the need for cognisance of context. The organisation has been working on its Annual Plan since October 2024, and had identified that there are significant risks involved in meeting the Target Control Total of a £31.5m forecast deficit. It had agreed to spend the first Quarter of the year de-risking the Plan, and had achieved on this aim, resulting in the proposed amended forecast deficit of £30m. Without the recent increase in employers NI contributions, this figure would be £28m. However, last year's outturn was a £24m deficit, and the Cabinet Secretary has clearly stated (albeit only during Quarter 1) that achievement of this figure is Welsh Government's expectation. Professor Kloer emphasised that the organisation is under significant time pressure, with a response to Welsh Government required by 11 September 2025. Nevertheless, the Board recognises that a great deal is expected of Health Board staff, and is committed to working together to consider the impact of options on them and on their wellbeing. It is vital to ensure, in this

consideration, that nothing is enacted which will detrimentally affect the Health Board's future plans and sustainability.

Members heard that Dates for an additional Board meeting in early September 2025 are being sought, at which it is likely that options and decisions will be considered. In terms of savings, experience suggests that non-recurrent savings are generally from areas in which the organisation would wish to invest more heavily, such as dental services, public health, organisational development and mental health. As has been indicated, a three-year financial plan is being worked on, which will need to be considered later in the year. Professor Kloer also advised that Welsh Government has requested the Health Board to consider its savings profile for the rest of year, as this is higher at start of year compared with the end. Members were again assured that any options will be scrutinised fully in various fora, including Executive Team, FPC and the Board.

**Decision:** The Board:

- **APPROVED** the proposal to change the Health Board's financial plan deficit to £30m, with a revised savings target.
- **TOOK ASSURANCE** on progress of savings actions to bridge the recurrent and non-recurrent savings gap from those Executive portfolios that have yet to identify their full target.
- **TOOK ASSURANCE** there are sufficiently robust plans in place to eliminate the use of all off-contract agency, and reliance on Healthcare Support Worker agency by the deadlines set in the Ministerial Priorities.
- **DISCUSSED** and **CONSIDERED** the further choices and actions being proposed to achieve an additional improvement in the financial deficit trajectory beyond the proposed £30m, following the latest feedback received from Welsh Government, stating that the Health Board's Annual Plan is not supportable or acceptable.
- **ACKNOWLEDGED** that an underlying deficit assessment has been undertaken and that this will only be reduced via robust recurrent savings delivery improvements.

**PM(25)124**

### **Integrated Performance Assurance Report**

Presenting the Integrated Performance Assurance Report (IPAR) for Month 3 of 2025/26, Mr Huw Thomas drew Members' attention to page 3 and the '3As' assessment of the Health Board's position against key performance metrics. Urgent and Emergency Care remains the most challenged area, particularly Ambulance Handovers. These are impacting detrimentally on both patient experience and on performance. Patient flow is being impacted negatively by Pathway of Care Delays (PoCD) and discharge delays. Performance in treatment of eye patients is also below target, with the Health Board working on potential regional solutions and approaches. Whilst performance in Psychological Therapy waits had improved, this had not been maintained, and (as already discussed) waits for Neurodevelopment Assessments

continues to be an area of significant challenge. There has been an improvement against the Single Cancer Pathway performance metric. Mr Thomas highlighted that the Escalation Summary is included as an appendix to the report. The two CCGs with the most challenging position are Community and Integrated Medicine and Planned and Specialist Care, particularly Theatres and Critical Care for the latter.

Mr Maynard Davies noted reference in the most recent letter from the Cabinet Secretary to achieving targets regarding vaccination rates. He enquired how the Health Board is planning to address growing levels of 'vaccine hesitation', particularly in relation to the COVID-19 vaccine. He also highlighted that data around Dental metrics in the first table has a date of December 2021 and queried whether there is more recent data. Mr Davies also expressed concern around the significant numbers of high and extreme risks on the risk register. Mr Imperato indicated that FPC is taking steps to understand the actions being undertaken to address issues, and to seek assurance around the effectiveness of these. He did not feel that this aspect is fully captured within the report, and queried whether the intention is for a more detailed analysis to be provided to FPC. Mrs Marks requested clarification regarding the reasons for the recent increase in C.difficile cases. Whilst noting that performance against the target for staff sickness has slightly improved, Cllr. Evans requested an update on the position. Mr Iwan Thomas was aware that the report had been prepared prior to recent announcements of SBUHB's improvements in Ambulance Handover times and ED waiting times. These had also impacted significantly on staff welfare. Recognising that colleagues are working closely with SBUHB, he enquired whether specific work is being undertaken to learn lessons from their experience in this area. Dr Wooding stated that SBUHB should be congratulated on their achievement.

With regard to a query around the currency of dental data, Mr Huw Thomas explained that the information is within the public health domain and more up-to-date information is challenging to obtain. In response to the comment around vaccination targets, Ms Bethan Lewis acknowledged that there is a concerning decline in vaccine uptake. Previously, opportunities to 'catch-up' on vaccines had been offered, which had improved uptake; however, there is insufficient time during the spring to undertake such a process. There is, as indicated, a lack of interest in the COVID-19 vaccine, which is perhaps being translated to a reluctance around other vaccines also, although Ms Lewis was not sure that this was the case. She did feel that more needs to be done to improve access to vaccination opportunities and make it easier for individuals to attend, particularly families and parents. In response to Mr Imperato's query around the link between the scrutiny and assurance undertaken at FPC and the escalation process, Mr Huw Thomas suggested that there was an element of a mismatch in reporting cycles involved. He was also conscious of the need for focus within a report, which can make it challenging to include detail regarding progress on actions.

Returning to an earlier comment around staff sickness levels, Mrs Gostling advised that the Workforce team is undertaking work in relation to long-term sickness absence. Short-term sickness absence is less of an issue. There are a number of staff absent on long-term sick leave who cannot necessarily return to their substantive post, but who might be able to undertake an alternative role. The team is working on this with the relevant managers. In regard to Mrs Marks' query around C.difficile rates, Ms Davies was unable to add anything further to the information within the report; beyond suggesting that lapses in hand hygiene and compliance with 'bare below the elbow' may be contributing. She offered to explore this further following the meeting, if required. Mr James Severs noted that concerns in relation to IPC are also detailed within the QSEC Update Report, and suggested that he update also regarding Standards of Cleanliness at that point on the agenda. Professor Kloer assured Members that HDdUHB has been connecting with other Health Boards in this regard for some time. An update and presentation on the actions taken by SBUHB has been requested for the next meeting of the Regional Joint Committee (RJC).

Concluding discussions, Dr Wooding echoed an earlier comment around the achievement of targets and assurance regarding this. The Board does require assurance that there are, in place, impactful plans and architecture to address performance targets.

**Decision:** The Board **DISCUSSED** the IPAR – Month 3 2025/2026 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)125**

### **Improving People and Community Experience Report**

*Dr Karen Brown joined the Board meeting.*

Ms Davies introduced the Improving People and Community Experience Report, which covers April and May 2025 and provides an overall summary of the year 2024/25. Members heard that the new People's Experience Framework will provide data enabling a more analytical approach to be taken; however, this will take time to evolve. As noted within the report, 6354 people responded to the Friends and Family Survey, which represents a 15% response rate, a rate regarded as excellent nationally. The new Framework will allow additional analysis around patient demographic, which is already providing data around patient satisfaction among minority ethnic groups, and access issues for younger people and those with disabilities. This data will be triangulated with that from other sources, and in relation to national workstreams. The report provides further data around patient experience in Primary Care, with information from both Managed Practices and independent practices.

Themes in relation to complaints remain, unfortunately, consistent. This report contains additional analysis regarding one of these

themes: communication. The main issues are around engagement with patients and families in decision-making; communication with families and language choices; and multi-disciplinary working, particularly in relation to discharge planning, cancer diagnosis and end of life care. This topic will form the basis of a detailed discussion at the next Listening and Learning Sub-Committee (LLSC), with the findings reported to QSEC. Overall, there has been a steady increase in the number of enquiries, concerns and complaints. As already mentioned, the Waiting List Support Service (WLSS), Communication Hub and Patient Advice and Liaison Service (PALS) teams are undertaking a specific piece of work in relation to waiting list enquiries. This should feed into any future work around appointment processes, letters, etc. Work is also being undertaken with regard to the areas with the highest numbers of concerns; with early results confirming that these tend to be those areas seeing the greatest volume of patients and experiencing the most pressures. Further analysis of the data is, however, required. There has been a reduction in the 30 day response rate, as a result of the increased emphasis on early resolution, and for the reasons noted at the previous Board meeting.

Ms Sarah Harraway suggested that it would be helpful for the Board to receive more timely and recent data. She also felt that information around the impact of feedback, in terms of changes being made, was lacking. Building on this, Ms Patel reported that the LLSC has heard consistently that poor communication is an issue. There had been a commitment that this would be taken forward by the Education Department, to consider what actions might be put in place around staff skills and development. She enquired regarding progress in this regard. Mr Imperato echoed comments around the need for information and assurance on the impact of actions. Noting reference to data and work in relation to patient demographics, Mrs Gostling suggested that there be collaboration with the Equality, Diversity and Inclusion Taskforce.

**SD**

Ms Davies assured Members that patient experience data is utilised to inform Quality Improvement measures. She suggested that a detailed update on the actions being taken be requested for presentation to the Board as part of the next Improving People and Community Experience Report. Dr Wooding agreed that assurance that the process is not simply a data collection exercise is required. He also agreed regarding the timeliness of data, suggesting that this should be immediately available. Ms Davies advised that there is a month's delay in production of the relevant data. On the topic of data, Mrs Marks queried regarding the possibility of utilising technology or Artificial Intelligence (AI) in analysing and dissecting the data. The sense that she is getting during visits to services is that, whilst progress and de-escalation is being reported, which is positive, this is not necessarily being 'felt' by frontline staff. Mrs Marks questioned whether the pressures, stresses and demands on services and staff are impacting negatively on patient experience, reflecting in patient feedback. She suggested that specific information on those areas

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where there are more complaints would allow a more targeted approach rather than striving for more generalised improvements. In response to this, Mr Huw Thomas indicated that such analysis would be possible, whilst emphasising that to enact it would involve prioritisation over other investments. Dr Wooding suggested that the possibilities should be assessed and reported via an update on the Table of Actions.

HT

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

**PM(25)126**

### **Board Assurance Framework**

Mrs Joanne Wilson presented the Board Assurance Framework (BAF) report, advising that all Committees have reviewed their allocated Planning Objectives. In addition, the Principal Risks have been reviewed by the Executive Team and with risk owners. Most Planning Objectives are on track, with the exception of PO4 (Planned Care) and PO8 (Estate Plan), which continue to be reported as behind, and PO9 (Digital), which is now complete.

**Decision:** The Board **TOOK ASSURANCE** on areas giving rise to specific concerns.

**PM(25)127**

### **Refreshing the 'A Healthier Mid and West Wales' Strategy**

Introducing the report, Mr Lee Davies advised that this provides an update on the process to refresh the 'A Healthier Mid and West Wales' (AHMWW) Strategy. Key points include the drafting of design principles and an update on engagement work underway. 220 responses have been received to date. A session has taken place with SBUHB to explore how there might be alignment between organisational strategies, and the Health Board is planning to conduct similar exercises with Betsi Cadwaladr UHB and Powys THB. There have been ongoing discussions with Welsh Government, particularly around HDdUHB's aging estate; these have been both constructive and pragmatic. Members were reminded that, whilst the Health Board has an agreed Strategy, and submitted a Programme Business Case (PBC) based on this in 2022, there has been no formal response to or endorsement of this by Welsh Government.

It is now a key priority to establish whether a way forward can be agreed with Welsh Government. Whilst the Health Board remains committed to the fundamental elements of the Strategy, it is important for the Board to be aware that Welsh Government has indicated the likelihood of a phased development, as opposed to substantial capital projects/builds. This approach will bring with it significant challenges. As will the projected changes in demographics for the region and associated impact on population health, such as increased levels of diabetes and heart disease. The need for partnership working and shift towards public health, preventative and community-based care are recognised. Together

with the need to adopt digital enablers for delivery of service models and access to care, including the use of AI as a tool.

Noting reference to the work with SBUHB, Cllr. Evans enquired regarding the level of collaboration and whether this is proving successful or whether there are barriers to working together. In response, Mr Lee Davies indicated that the work is mainly in terms of how the two health boards can align their strategic thinking, to ensure it is compatible. Whilst strategic approach may align, certain practicalities present limitations, and it is recognised that separate strategies will be required in each health board. In terms of the wider work, whilst optimistic that alignment will be possible, it should be noted that each of the four health boards is at a different stage of strategy development. As Members will be aware, HDdUHB and SBUHB meet frequently to discuss service delivery more generally. Cllr. Evans welcomed the regional approach being applied, and this was echoed by Mrs Marks. With regard to community-based service provision, Mrs Marks emphasised that HDdUHB's Integrated Care Centres (ICCs) are good examples of delivery model, which should be recognised as such. Those which are planned will make a significant difference to the lives of the communities in which they sit, and should be supported. More generally, Mrs Marks commended the report and wished to endorse the strategic direction of travel outlined therein.

Mr Maynard Davies welcomed the section within the report on digital, and the commitment to digital inclusion, with the stated intention 'not to leave anyone behind'. It is important, however, to recognise that any proposed investment in this area is against a background of underinvestment across Wales in general. Whilst it has been pleasing to see, within recent digital business cases, information on financial benefits, an initial investment is still required. Hywel Dda also faces the additional challenge of connectivity, and Mr Davies suggested that consideration be given to working with commercial partners, to raise awareness of the Health Board's ambitions and explore how connectivity might be improved. In terms of AI, it is important to recognise the significant environmental impact; developments in this area would impact negatively on the organisation's objective around 'Net Zero'. Finally, Mr Davies wished to remind Members that even a phased approach to capital investment in the Health Board's infrastructure would involve an amount of over £300m.

Referencing the proposed design principles, Ms Anna Lewis suggested that some of these sound more like enablers. She emphasised that they need to be sufficiently robust to ensure that any decisions made based upon them will meet the STEEP criteria (Safety, Timely, Effective, Efficient, Equitable, Patient-Centred). It was suggested that the design principles be 'framed' around these, or consideration given at least to how they might align. Ms Lewis also noted that the terms 'transport' and 'travel' are sometimes used interchangeably; however, it is often the case that the consequences of travel are wider than transport alone. For example, patients with caring responsibilities, or commitments

which restrict the amount of time they can reasonably be away from home or work. This aspect can be much more significant than the means by which they physically move between locations.

Ms Anna Lewis also suggested that the Health Board has, effectively, been informed by Welsh Government with regard to the PBC, as they have indicated that it is 'no longer fit for purpose'. She queried whether this should be regarded as confirmation that Welsh Government recognise and support (as a consequence) that the capital requirements and system costs in the long-term will actually be higher than they would for a new hospital. Whilst acknowledging that the PBC has been described thus by Welsh Government, Professor Kloer emphasised that this should be demarcated from an assumption that the Health Board's entire approach and Strategy is 'no longer fit for purpose'. The PBC was developed based on a pre COVID-19 environment and it is, therefore, reasonable to regard it as no longer fully appropriate. In terms of the query in relation to costs, Professor Kloer felt that this is the point at which discussions with Welsh Government are currently. It is right to highlight that the Health Board has a £250m plus backlog maintenance deficit. There are both financial and clinical consequences in maintaining and upgrading the current estate which may, indeed, cost more than a new hospital. Discussions with Welsh Government will necessarily involve value for money considerations. The Health Board recognises that various options might need to be explored as part of this process, which will require discussion by the Board.

Mr Huw Thomas reiterated that the Health Board is well aware of the constraints on capital funding to which Welsh Government is subject. On the topic of value, it is also important to note that delaying any capital project increases costs due to inflation. As others have said, the organisation is and will need to continue to work with Welsh Government on this matter. In terms of digital, Mr Thomas first wished to thank Mr Maynard Davies for the work he undertakes on a regional basis around digital inclusion. As indicated, it must be recognised that the Health Board is starting this process with a significant digital deficit, and major constraints in this area, in common with those relating to capital projects. Specifically in relation to AI use, this covers a range of possibilities and would need appropriate 'guardrails' in place, together with a discussion of this topic by the Board. It should also be accepted that AI is not a solution to all issues. Dr Wooding agreed that, whilst AI use is inevitable, safeguards and caution are required.

On the topic of public health and prevention, Mr Lee Davies emphasised that this will present a significant dilemma in terms of the Strategy refresh. The data indicates that it will not be feasible to develop a strategy which simply sets out to treat all of the additional ill health which is expected. There will need to be a transition to a 'health service' as opposed to a 'healthcare service'. This will also involve moving resources from treating ill health to health promotion. With reference to the PBC, whilst it is true to say that the Health Board has not received a formal response from

Welsh Government, Mr Davies agreed that their statement can be seen as a response in this regard. It is likely that the PBC will need to be superseded by a more phased approach to capital development, and the Health Board will need to develop and test a broad range of alternative options for Welsh Government consideration, whilst remaining cognisant of the potential implications of any decisions. Dr Wooding emphasised that the Health Board's success will be based on how compelling it can be in its business cases. Whilst significant progress has already been made, this needs to be maintained. There also needs to be an acceptance that Welsh Government cannot provide the funding that the Health Board has requested in the form requested; therefore, alternatives, including health promotion, etc, need to be explored.

**Decision:** The Board:

- **DISCUSSED** the approach being adopted to refresh the AHMWW Strategy, including the associated work with Swansea Bay UHB
- **DISCUSSED** the challenges and opportunities relating to population health, partnership working and digital
- **DISCUSSED** the outcome of discussions of 3 July 2025 with WG colleagues relating to capital investment in support of the AHMWW Strategy

**PM(25)128**

**Integrated Urgent and Emergency Care Model**

Mr Carruthers presented the Integrated Urgent and Emergency Care (UEC) Model report, apologising for the late issue of this. It is acknowledged that the current performance in UEC is unacceptable, with waits which are too long and an environment which is challenging for staff to work in. He suggested that an opportunity to greatly improve this situation exists, which will reduce delays, and provide a better patient experience and improved support for staff. There are three timelines involved:

- The immediate pressures/challenges, such as those in Ambulance Handover times. The target is due to change from 1 October 2025, to 45 minutes maximum. Current Health Board performance is some way from this, averaging 60-120 minutes. There will need to be urgent changes in response, which may need to be temporary, due to sustainability issues. As has been indicated, HDdUHB needs to learn from others, including SBUHB and Cwm Taf Morgannwg UHB
- Changes required to manage winter pressures, which will put in place the foundations of the long-term 'direction of travel'
- The systemic redesign of the UEC service model, to include consideration of the demographic changes projected, and the health implications of these, as already mentioned

It is recognised that this process will be operationally challenging, and 'uncomfortable' both operationally and as a Board. UEC is an extremely complex system; taking a systemic approach will

require careful consideration of change management. The envisaged system changes will, however, provide significant benefits and should become a fundamental part of the wider strategic refresh.

In terms of the strategic vision, Dr Karen Brown indicated the desire for an enabling service, with the Health Board's citizens at its heart. The vision and model have been co-created with key stakeholders. In recognition of the system complexities, this process has been a clinically-led approach built over a number of years. The proposed model has been shared with Members at Board Seminar. The aim is to move from a reactive to a proactive and preventative approach, with people in control of their wellness; and to 'walk alongside' the Health Board's citizens. The process involves innovative thinking and external engagement, and builds on prioritising connected communities, and working with Third Sector partners. The focus is on high-quality care closer to home, more efficient patient flow and reducing duplication and waste. As part of this, Health Board data has been analysed, which suggests that the needs of 50% of those individuals presenting to its EDs could be better supported elsewhere. Approximately 28% could be managed via Integrated Care Centre (ICC)/Same Day Emergency Care (SDEC) provision, and around 13%, with more complex needs, could be supported by the wider intermediate care multidisciplinary team.

In order to stream crisis needs in the most efficient way, the plan is to focus on what matters to citizens, for staff to work to the top of their licence, facilitate value for all and build on strengths, for both current and future generations. With regard to the 'shift left', there will be a focus on health and wellbeing, prevention and the social model for health and wellbeing. This will involve four main constituent parts:

- Access to care when and where needed, walking with people in their healthcare journey which is efficient and removes waits
- Expertise at the 'front door' in terms of senior decision making
- Enabling processes and structures
- Taking care into the community (diagnostics, treatment, supporting healthy quality of life)

These will be underpinned by enablers including digital systems, etc. The shift left will require significant focus, as there are various elements involved. The next 3-6 months will see numerous discussions and decisions around how this is taken forward.

Dr Wooding emphasised the need to recognise just how incredibly complex and sizable the UEC system is, and not to understate this. The Health Board will also need to accept that it is working without all of the answers and detail of outcomes at present. A careful balance between the need for courage and robust governance is required. The value-based approach should lie at the heart of this process, which will consider how the organisation

empowers its clinicians and frontline staff in making the best decisions without a significant system of controls.

Expressing her support for the work, Ms Harraway recognised that proposals have developed since they were presented at Board Seminar. She welcomed the patient-centric, as opposed to academic, approach; emphasised that the enabling workstreams will be vital, and that the shift left will need to link with the Primary Care Strategic Plan. Ms Harraway queried the statement around 'high confidence in recruitment due to current local and national interest and reputation', given the other recruitment issues reported within the Health Board. Mrs Patel enquired whether consideration has been given to the potential barriers and risks there are to implementation. Mrs Marks queried how it is intended to continue and replicate this work, given the uncertainties involved and need to manage these. She reiterated the importance and value of the ICCs, which are patient-centric and have the potential both to reduce the numbers presenting to EDs, and save money.

In response to the query around recruitment, Dr Brown indicated that there is a great deal of interest in HDdUHB's plans; it is anticipated that this would generate significant recruitment interest. In terms of barriers, crises provide opportunities, and this model has been created by colleagues coming together to work systemically, to address a position which is unsustainable. Creating an infrastructure which enables those working within it, not only empowers those individuals; it will further network and extend beyond. Staff are the Health Board's largest resource, and should be recognised as such.

Referencing the need to 'shift left', to more community-based provision and a preventative approach, Dr Wooding emphasised that the delay in doing so is not due to a lack of commitment in this regard; it is due to the inherent complexities. Whilst the proposed model offers significant opportunities, it also involves significant risk. Whilst in the overall scheme of things, the associated investment is not significant, it is in the current financial environment. Professor Kloer suggested that the Board should take assurance, given the engagement Dr Brown and her colleagues have undertaken across the system, including with Primary Care. The Health Board has three horizons in relation to UEC, which do not fit the 'traditional' pattern of 1 year, 3 years, future. They are:

- 60 days
- Year end
- Future

Every individual engaged in this process needs to be engaged in every horizon. In addition, progress towards each horizon cannot be sequential; all must be worked on simultaneously. As mentioned earlier, a new Ambulance Handover time target is due to be implemented in 60 days. It is now necessary to translate

models from theory to practice – within the next 60 days. This will be crucial to HDdUHB's reputation, particularly compared to other health boards. With regard to next steps, Clinical Executive oversight is required, together with scrutiny in terms of clinical governance. In terms of finance, the proposals present a challenge, given that the Cabinet Secretary has clearly indicated their expectations financially, and considerations such as those contained within Appendix 2 of the Financial Report already involve challenging decisions. In addition, a further iteration of the UEC proposals will be required, to allow full consideration of the implications, including financial.

Ms Mwape Burke enquired whether there has been consideration of community involvement and their role in ownership of change. In response, Dr Brown indicated that the Health Board's communities have been inspirational in determining the proposals, and that these focus on what the public has asked for – more care closer to home and more control over their own health and wellbeing. Learning is key to the process, and change is being implemented in response to these requests. The Health Board has worked with Llais, carers and various community groups, as well as its staff. Also welcoming the proposals, Mr Imperato noted the need to work at pace, whilst undertaking the required governance. This will involve FPC, and potentially QSEC. He enquired whether consideration has been given to ensuring that work is not duplicated and that demands on staff and systems are not excessive or unnecessary. Returning to the issue of finances, Mr Huw Thomas highlighted that there is a dissonance between the need to make savings and the need to invest. Reallocation of resource between systems does increase financial risk until it becomes embedded. In addition, there is the question of where disinvestment is made, to enable the 'shift' or investment of resources.

Dr Brown emphasised the significance of the SDEC and clinical streaming hub, around which the organisation can layer and grow the UEC model. In the short-term, this can be 'overlaid' with process changes such as continuous flow modelling; placing senior clinical decision-makers at the front door. This will provide sufficient capacity to allow more medium-term measures to be embedded. The priority, however, is for a commitment to the 7 day service model in the medium-term, which does involve some resource and recruitment implications and provides the foundation for longer-term plans. Recognising the need for rapid decisions, and that certain of the short-term changes may not be sustainable. Drawing discussions to a close, Dr Gooding emphasised that, whilst the proposals are endorsed by the Board, there are caveats around governance and finances.

**Decision:** The Board:

- **NOTED** the Integrated Urgent and Emergency Care Model report and its proposals:

- Providing sustainable, resilient 7-day Same Day Emergency Care and Clinical Streaming services will improve urgent and emergency care experience for our population. Through providing quality care closer to home and reducing unnecessary demand on Emergency Departments and Hospitals we will continue to improve patient safety outcomes for those needing these critical services.
- This model is person centred and clinically led, building on established successful processes with a scalable and sustainable structure.
- Ready for phased implementation with strong established governance and workforce plan.
- Financially prudent operating model with evidenced cost efficiencies.
- The proposal supports national priorities and radical local transformation goals.
- **REQUESTED** that the UEC Business Case be presented for discussion at FPC on 26 August 2025, prior to further Board conversation on 25 September 2025

**PM(25)129**

### **Primary Care and Community Services Strategic Plan Update**

Ms Paterson introduced the Primary Care and Community Services Strategic Plan Update report, noting that this is inherently linked to the previous agenda item. She emphasised that this is a strategic plan, the Health Board's single Strategy being AHMWW. Whilst Primary and Community Care are part of an integrated system, it is important to recognise that 90% of healthcare activity is delivered by this sector independently. Appendix 1 of the report includes details of the role of Primary Care in first contact. As indicated, however, there is an important interface with UEC. This sector is very much subject to dynamic change, with major changes seen in the past few years and continuing into the present day. There has been significant engagement with the Primary and Community Care workforce during the previous few months, and it is anticipated that this engagement will be extended to the wider healthcare system at a later date. In addition, a number of national discussions are underway, which are expected to produce various documents relevant to Primary and Community Care. These include but are not limited to:

- A refreshed narrative around the Primary Care Model for Wales, which will focus on enabling and empowering citizens to live well
- 'Accelerating the Opportunities' which will set out opportunities to shift other clinical pathways, such as diagnostics, into Primary Care, and the actions required to facilitate this
- A focus on the development of Collaborative Directed Supplementary Services, which will build on opportunities with Primary Care Clusters to provide more formal arrangements. Intended to consider the changes required to respond to current challenges and population needs

It is recognised that detailed proposals will need to be presented to the Board, with the timescale for this being early next year.

Ms Harraway expressed concern that the report outlines two years of conversations and engagement, with further engagement being proposed. It does not, however, seem to detail the outcome of these discussions, or clearly articulate the vision for Primary and Community Care and questioned whether more pace could be applied. Dr Wooding wished to emphasise the merit of the report's contents, and that the process – as indicated by Ms Paterson – involves a period of dynamic and significant change within this sector. Ms Paterson further clarified that the timescale for the strategic plan was set by the Board, and involves working with both independent contractors and the public. There are numerous complexities, not least of which the Health Board's obligation to comply with contractual procedures at a national level. In addition, certain of the proposals being considered are quite radical. These include the potential to move certain Primary Care functions to SDEC, or defining a maximum and minimum list size for General Practices. Such proposals require due diligence, to ensure that they are not in conflict with national contract negotiations, for example. With regard to lack of clarity around the vision, Ms Paterson had not thought that this was the case; however, would reflect on how this narrative might be strengthened.

Whilst recognising the reasons for Ms Harraway's comment, Mr Iwan Thomas wished to record his thanks to Ms Paterson and her team for the level of engagement they have undertaken with the Third Sector. It should be acknowledged that this work does not involve Primary Care in isolation, it also encompasses communities, meaning that there is a need to ensure adequate interaction and access to community-based solutions. There are complexities involved, such as those already mentioned around short-term funding and projects. Despite this, there are existing local projects that support people to stay well, which can form part of a 'menu' of potential solutions. However, if there is insufficient future investment in such projects, those who would have been served by them will instead present to healthcare services. Mrs Patel requested further clarity around how Primary Care and Community Services align with the wider service model and Strategy.

**JP**

Mr Lee Davies reiterated that this is a large and complex system. It should also be noted that Ms Paterson and her team have been progressing the work in relation to the Primary Care and Community Services Strategic Plan in addition to their substantive roles. The Health Board is now undertaking the mid-point review of its public consultation on the Clinical Services Plan (CSP), which has provided an opportunity for reflection. There is a certain amount of overlap between the two processes and this requires further consideration, together with the potential resource implications, which may provide support for the Primary Care team. Professor Kloer added his endorsement, indicating that changes and transformation are being delivered in Primary and Community Care, such as those around Eye Care. Whilst the need for urgency and pace in this area is recognised; based on

the Health Board's experience, external support may be required to ensure sufficient engagement. This will need to be discussed by the Executive Team and Board, should this be consultancy.

Dr Wooding concluded by indicating that, whilst the Board was content to endorse the report's recommendation, further traction is required in this area, including the discussion mentioned above. The significant complexities in this regard are acknowledged, together with the need to consider the CSP consultation mid-point review findings.

**Decision:** The Board **SUPPORTED** the proposed next steps for development of the Primary Care and Community Services Strategic Plan, including the need to consider whether the scope needs revision following the CSP consultation mid-point review.

*Dr Karen Brown left the Board meeting.*

**PM(25)130**

### **Creating a Sustainable Dentistry Service**

Presenting the report, Ms Paterson welcomed the opportunity to bring this important issue to the Board's attention, recognising that it is an area of focus for the general public. Dental provision involves a comprehensive range of services, which are detailed within the report. Concerns regarding access to NHS dental services are acknowledged, as is the fact that performance in this area has declined. There has been a significant reduction in capacity within the region, which is a concern. Whilst Contract Reform has impacted, the principles behind this are sound. Reforms include the move from a six-monthly recall for routine check-ups to two years. Complexities around metrics and the number of General Dental Services (GDS) contracts reducing from 47 to 35 has also reduced access to NHS dental services. There are ongoing national contract negotiations, the outcome of which is not yet known. The number of training practices has also reduced. In terms of impact, data indicates that the oral health of 5 year olds in Wales has not changed, which is reassuring. However, there has been a noticeable change in the way in which patients access services, with more patients presenting with significant and urgent dental needs.

The increased level of investment in this area should be recognised; however, the matter now requiring consideration is how issues can be addressed, how progress can be made and how capacity can be increased. A report (attached as Appendix 1), suggesting how the current underspend might be utilised, had been considered by the Executive Team. This outlines various measures intended to improve access and increase capacity, including in specific locations. Whilst introduction of the Dental Access Portal (DAP) has facilitated some positive progress, it requires support to build administrative capacity. Proposals also include plans to improve education and training, and to enhance the 'Designed to Smile' programme. There needs to be consideration of gaps in service provision, together with maximisation of digital opportunities.

Ms Paterson felt that it was important to draw to the Board's attention the fact that a reduction in the number of individuals registered with an NHS dentist results in a significant reduction in the Patient Charge Revenue; a source of income for the Health Board. Whilst this impact has been covered off for the current year, the implications of it continuing in future years requires consideration and discussion with Welsh Government. Finally, the dental budget is ringfenced and intended for use solely for Primary Care dental services. However, in common with other health boards, HDdUHB has historically also utilised £2m of this budget to fund the other dental services outlined within the report, rather than drawing upon the hospital and community health services budget. Whilst this approach could be revisited, it would have implications and would require consideration by the Board. Currently, the underspend permits this; however, it is known that Welsh Government intends to raise the issue with health boards. Ms Paterson hoped that the report provides the Board with a sense of both the challenges involved with, and proposed approach to developing a sustainable dental service for the future.

Referencing earlier discussions of the organisation's financial position, specifically the run-rate, Mr Huw Thomas noted the need for Board to be cognisant that the proposals would increase this. Nevertheless, he would support the proposals and highlighted that the Dental team follows robust procurement and management control processes, from which the Board should take assurance. It is possible that there will be further contract terminations, which would reduce the amount indicated. Ms Anna Lewis enquired whether it would be possible to analyse dental data, particularly relating to children, and triangulate this with data regarding other services, to assess (for example) the impact of deprivation. It was agreed that the outcome should be presented to QSEC.

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Mr Imperato enquired whether the potential of community interest companies has been considered, noting that these exist in England. In response, Ms Paterson advised that, whilst consideration of these entities has not formed part of the process in terms of dental services, they do offer potential opportunities for Primary Care Clusters. They may also be part of the thinking around how the future relationship with dental contractors develops. Dr Wooding emphasised the need for openness to alternative models, adding that, whilst the report represents positive progress in terms of the next two years, there needs to be a focus beyond this. Agreeing, Ms Paterson advised that Welsh Government has recently conducted a public consultation on dental services, the findings of which will be taken into account.

**Decision:** The Board:

- **NOTED** the range of Dental services provided across HDdUHB for the local population
- **NOTED** the risks and challenges which have an impact on the delivery of services, both nationally, and locally

- **NOTED** the agreed 2-year investment plan to support delivery of a sustainable model of services and the associated benefit to direct patient care
- **TOOK ASSURANCE** from the steps being taken to improve the sustainability of NHS Dental Services across HDdUHB

**PM(25)131**

### **Fragile Services Framework Update Report**

Ms Davies introduced the report, explaining that this provides an update on development of a process to identify services at risk of becoming fragile; and the methodology to assess them, respond to their needs and support them. The Fragile Services Framework has been in development for 18 months and is intended to provide clear articulation of the risk via traditional methods, with the addition of specific fragility criteria, together producing an overall fragility score. The process has been further developed to offer services the ability to identify opportunities to reduce risks. Escalation thresholds and associated governance arrangements have also been agreed. The Framework has been presented at Board Seminar, and considered and approved by both QSEC and the Executive Team.

In terms of the fragility criteria, Dr Wooding enquired whether there is potential to consider whether staff culture and engagement impact on the fragility of services. It may be that this presents an opportunity to reconcile data on staff engagement with that on fragile services. Ms Anna Lewis suggested that the iteration presented differs from previous versions in exactly the way described, whilst accepting that it could be further finessed to incorporate additional workforce metrics. She explained that the intention of the Framework was to provide analysis which was focused not on service configuration; rather to provide support to services in areas such as leadership, etc. It adds in the component around leadership and culture, in an attempt to fully address the root cause of fragility in services.

**Decision:** The Board:

- **SUPPORTED** the work that has progressed in relation to fragile services, together with the revised methodology which represents an effective process to recognise and respond to services deemed at risk of being or becoming fragile.
- **RECOGNISED** the potential presented by the framework to influence organisational culture and learning systems and improve risk mitigation.

**PM(25)132**

### **Prince Philip Hospital Minor Injury Unit Update**

Presenting the Prince Philip Hospital (PPH) Minor Injury Unit (MIU) Update report, Mr Henwood reminded Members of the background to this item and issue. The following four options had been considered by the Board in March 2025, once it had been established that the previous service model could not be reinstated:

1. 12-hour doctor led unit
2. 14-hour doctor led unit
3. Phased option, doctor-led from 12-hours up to 24-hours
4. 14-hour urgent care treatment centre (Same Day Urgent Care type model)

A formal 12 week consultation process on these options had been deemed necessary. There was no preferred option, and any new/emerging options, within scope, would also be considered. The consultation period had closed on 22 July 2025. Ms Alwena Hughes Moakes assured Members that the Health Board has followed a comprehensive consultation process, involving a number of events, opportunities to engage and share views. Today's presentation represents a point in time in that process. She wished to thank representatives from Save Our Services Prince Philip Action Network (SOSPPAN) and Llais, along with Health Board colleagues, for their constructive involvement. Health Board partners, members of the Consultation and Engagement team and the general public were also thanked for their contributions.

Members heard that 730 completed questionnaires have been received, and that data from all consultation sources is now being analysed. An external company (HICO) had undertaken mid- and end-point reviews, and had provided assurance regarding the consultation process. In terms of next steps, Mr Henwood advised that this involves conscientious consideration, including any new options, within scope. He also drew Members' attention to the list of possibilities which are out of scope. The Steering Group and Project Group will oversee development of the final report. Finally, Mr Henwood added his thanks to all stakeholders involved in the consultation process. Dr Wooding enquired whether the September 2025 timescale for presentation of the final report to Board is realistic, given the need to analyse data. In response, Ms Hughes Moakes indicated that there is some concern regarding this, particularly with the need to consider alternative options. A number of meetings and discussions are planned for August 2025, so it is probably a little early to determine. Emphasising the Health Board's duty to explore alternative options, Dr Wooding stated that, if necessary, the timescale will need to be changed.

Mr Imperato agreed that consideration of alternatives will take time and effort. He welcomed in particular the involvement of SOSPPAN and Llais in the consultation process. Reiterating comments he has made previously, Mr Imperato queried the level to which the Health Board has interacted with providers of transport, including public transport. Ms Hughes Moakes acknowledged that transport and travel is a theme common to all public consultations. The Health Board has been considering data modelling around transport, and the Welsh Ambulance Services University NHS Trust (WAST) has been involved, including via attendance at public consultation events. Currently, however, the organisation is at the data analysis stage; the potential impact of transport will be studied further when options are considered in

detail. Dr Wooding shared Mr Imperato's concerns around the impact of travel and transport on patients, emphasising that steps must be taken to mitigate against disadvantaging them, particularly the most vulnerable.

**Decision:** The Board **TOOK ASSURANCE** on the process to deliver the consultation for the Minor Injury Unit (MIU) at Prince Philip Hospital (PPH) up to the mid-point, with particular reference to the assurance provided externally; and the next steps prior to the end of the consultation period, acknowledging that engagement is ongoing.

**PM(25)133**

### **National Outpatient Assessments Insource Project**

Mr Carruthers introduced the National Outpatient Assessments Insource Project report, explaining that this stems from the Cabinet Secretary's mandate that outpatient waiting list volumes across Wales be reduced by over 200,000 patients by March 2026. To meet this requirement, a two-part plan has been agreed, comprising national insourcing and local arrangements. The plan has involved national discussions and a national procurement process. One omission from the plan had been consideration of all the potential costs involved in delivery locally. Whilst a proportion of these costs had subsequently been funded by Welsh Government, this may not meet the entire amount required. As such, there is a potential financial risk involved in delivering the additional capacity, of up to £115,837. It is believed that the risk can be mitigated in-year; however, the Board needs to be aware of this, in considering the proposal.

Mr Maynard Davies enquired regarding the potential 'appetite' among staff for the overtime, etc, which would be required to deliver the additional capacity. In response, Mr Carruthers advised that, whilst the additional funding is intended to support this aspect, it is one which will require monitoring and management. Ms Murphy shared Mr Davies' concerns, noting that certain costs and impacts are not taken into account within the proposals, such as portering, cleaning and medical records management. Mr Carruthers indicated that costs such as these are those which the additional funding is intended to cover; the provider was also required to confirm that it could meet this capacity. Whilst there is certainty around the existence of suitable clinic space, the issue of staff capacity for additional hours is currently untested. Members were assured that induction will be the same as for agency staff, and that staff will be reimbursed appropriately.

Noting that the proposals focus on first Outpatient appointments, Ms Anna Lewis enquired around the modelling and whether it is known how many patients are discharged after just one appointment. Mr Carruthers advised that the conversion rate to further treatment is approximately 30%. If the proposals are enacted, it is recognised that these patients will start to enter the clinical pathway more quickly, requiring diagnostics, etc, in which the Health Board does not currently have sufficient capacity. Essentially, creating demand and backlog elsewhere in the

system. This matter is being discussed with Welsh Government. Ms Lewis emphasised that it is important to acknowledge and appreciate this issue, as addressing Outpatient waiting lists will effectively transfer the 'bottleneck' elsewhere. For example, the current backlog in diagnostics will further increase. Meaning that an improvement against one performance metric will result in a deterioration against another.

Whilst supportive of the proposals, Mr Huw Thomas indicated another issue of which the Board should be aware. There is a potential financial risk around the tax treatment of insourcing arrangements. Provision of healthcare is classed as VAT exempt; however, provision of staff is VAT chargeable. HMRC may require the Health Board to treat these as agency staff, with the associated requirement for checks on employment compliance. This risk is being actively managed; whilst this is a national procurement exercise, the Health Board as a sovereign body must satisfy itself with regard to the position. The Finance team will work with Operational and Procurement teams on this matter and will flag any issues to the Audit and Risk Assurance Committee. In regard to this issue, Mr Carruthers advised that the provider identified via the national procurement is one with which the Health Board has worked previously, which will assist.

Returning to an earlier comment, Professor Kloer emphasised that not all patients will progress beyond the first Outpatient appointment stage. The fact that this proposal will enable these individuals to move on with their lives should be viewed positively. Welsh Government has acknowledged the issue around diagnostic demand and has undertaken work in this area. The proportion of patients requiring diagnostic investigation varies between specialty, and local data around this has been analysed, with the results provided to Welsh Government. It should be recognised that the Health Board would be responsible for the clinical governance of this activity, which is undertaken on its sites. QSEC will likely wish to apply the appropriate scrutiny. Finally, in addition to the increased demand on diagnostics, there will be an impact on Health Board teams undertaking follow-ups subsequent to the first Outpatient appointments which these proposals cover. Mr Maynard Davies highlighted that there will also be responsibilities in terms of compliance with Information Governance and Caldicott requirements, which the Information Governance Sub-Committee (IGSC) should probably consider.

**SD**

**AC**

**Decision:** The Board:

- **NOTED** current progress in planning for local implementation of the national plan to reduce outpatient waiting list volumes across Wales by over 200,000 patients by March 2026
- **APPROVED** the award of a contract to deliver insourced first outpatient assessments to Healthcare Business Solutions (UK) Ltd

- **NOTED** the actions being pursued to mitigate the additional cost pressures and **AGREED** for these to be determined by the Executive Team

**PM(25)134**

### **Report of the Audit and Risk Assurance Committee**

Cllr. Evans, ARAC Chair, presented the update report from the meeting held on 24 June 2025, noting in particular ARAC's consideration of Audit Wales reviews of UEC and Planned Care and the associated management responses. The reports from both of these reviews had highlighted various issues and made a number of recommendations. In terms of the Standards of Cleanliness Internal Audit, whilst some progress has been made, several actions remain outstanding, which represents a disappointing position. A management response and action plan based on the SMART principles (Specific, Measurable, Achievable, Realistic/Relevant, Timely) are being developed. Members also heard that the Health Board's Escalation Status now includes a specific requirement around its response to Healthcare Inspectorate Wales (HIW) and Health Education and Improvement Wales (HEIW) inspections and reports. Finally, Cllr. Evans drew Members' attention to the recommendation that the Board approves ARAC's revised Terms of Reference, and (under the next agenda item) the revised Standing Financial Instructions.

Professor Kloer wished to provide context around the reference to a 'blame culture' in the Audit Wales UEC report. His understanding was that this referred to frustrations from both Primary and Secondary Care in developing UEC proposals. The Health Board is actively addressing this by means of the new operational structure.

**Decision:** The Board:

- **APPROVED** the revised ARAC Terms of Reference
- **APPROVED** the revised version of HDdUHB's Standing Financial Instructions
- **NOTED** the items the Committee is advising it of
- **TOOK ASSURANCE** from the items that the Committee is providing assurance on

**PM(25)135**

### **Review of Standing Financial Instructions**

**Decision:** The Board **APPROVED** the required amendments made to the HDdUHB's Standing Financial Instructions, in light of Welsh Government amendments to the Model Standing Financial Instructions as outlined in WHC/2025/012.

**PM(25)136**

### **Report of the Quality, Safety and Experience Committee**

Ms Anna Lewis, QSEC Chair, presented the update report from the meeting held on 10 June 2025, advising that this is as presented. There are two 'Alert' items, with the Board being very much aware of the first issue, in relation to EDs. The second item, around the condition of the Health Board estate and impact of this on IPC, has identified a need to consider how intelligence from

safety walkarounds is captured and how this feeds into capital investment discussions. Members heard that steps are being taken to address this matter.

Mr Severs advised that both QSEC and ARAC have requested updates on Standards of Cleanliness for their August 2025 meetings. He and Ms Sharon Daniel are reviewing processes to ensure the interface between IPC and cleaning standards. A further update will be available following the next round of committees.

**Decision:** The Board:

- **APPROVED** the QSEC Terms of Reference
- **RESPONDED** to the items that the Committee is alerting them to
- **NOTED** the items the Committee is advising them of
- **TOOK ASSURANCE** from the items that the Committee is providing assurance on

**PM(25)137**

### **Report of the Finance and Performance Committee**

Mr Imperato, FPC Chair, presented the update report from the meeting on 26 June 2025. Several of the 'Alert' items had already been covered in earlier discussions, which is reassuring. He wished to highlight that steps are being taken to streamline reports to the Committee and focus on key performance issues, to strengthen the tracking of progress against actions.

**Decision:** The Board:

- **APPROVED** the award of Fresh Non-Prepared and Prepared Fruit, Vegetables and Salad to the above providers for the period 1 January 2026 to 31 December 2028, with an option to extend for a further twelve months. This contract will have onwards submission to Velindre NHS Trust (as hosts of NHS Wales Shared Services Partnership)
- **APPROVED** the revised FPC Terms of Reference, as approved at the 29 April 2025 meeting
- **RESPONDED** to the items that the Committee is alerting them to
- **NOTED** the items that the Committee is advising them of
- **TOOK ASSURANCE** from the items that the Committee is providing assurance on

**PM(25)138**

### **Procurement Report**

Members' attention was drawn to the three items for which Board approval is sought, recognising that the third of these also appears as a separate agenda item.

**Decision:** The Board:

- **APPROVED** the award of Fresh Non-Prepared & Prepared Fruit, Vegetables and Salad to the above providers for the

period 1st January 2026 to 31st December 2027, with an option to extend for a further twelve (12) months. This contract will have onwards submission to Velindre NHS Trust (as hosts of NHS Wales Shared Services Partnership).

- **APPROVED** the award of Continence Products to the above provider for the period 1st June 2025 to 31st May 2026. This contract will have onwards submission to Velindre NHS Trust (as hosts of NHS Wales Shared Services Partnership).
- **APPROVED** the award of Principal Contractor for Construction Delivery of Phase 2 Fire Improvement Works at Withybush General Hospital to the above provider for the period of two years (start date to be confirmed as pending Welsh Government BJC approval). This contract will have onwards submission to Welsh Government and Velindre NHS Trust (as hosts of NHS Wales Shared Services Partnership).

**PM(25)139**

### **Report of the Strategy and Planning Committee**

Mr Maynard Davies, SPC Vice-Chair, presented the update report from the meeting on 1 July 2025, indicating that there were no 'Alert' items. The single 'Advise' item was as presented within the report.

**Decision:** The Board:

- **APPROVED** application of the seal for all schemes listed in Annex 1 of the report
- **APPROVED** the scoring of the Planning Maturity Matrix for the two-year review prior to its submission to Welsh Government
- **APPROVED** the submission of the Business Justification Case to Welsh Government, seeking approval to progress with the Withybush General Hospital Phase 2
- **NOTED** the items the Committee is advising them of
- **TOOK ASSURANCE** from the items that the Committee is providing assurance on

**PM(25)140**

### **Planning Maturity Matrix Update**

Introducing the Planning Maturity Matrix Update report, Mr Lee Davies explained that this had been discussed in detail by SPC.

Noting the decline in score for Domain 1, Strategy Development, Dr Wooding queried whether this self-assessment was perhaps somewhat harsh, given that the organisation does have a Strategy in place. Mr Davies indicated that this was the area which had prompted most debate. He agreed that the Health Board has a Strategy, which is being augmented via the CSP and Strategic Refresh. The assessment is probably overly self-critical. That said, there is a lack of clarity around the strategic direction of certain services within west Wales, and the score reflects the average of the multiple views expressed. Dr Wooding also highlighted that there has been feedback from certain partners and stakeholders that the Health Board's direction of travel is not sufficiently clearly communicated externally, suggesting that this needs to be addressed.

**Decision:** The Board **APPROVED** the scoring of the Planning Maturity Matrix for the two-year review, prior to its submission to Welsh Government.

PM(25)141

**Business Justification Case – Withybush Hospital, to support Phase 2 of Fire Enforcement Notices**

Mr Severs presented the report, indicating that it sets out the next stage in delivery of works to support compliance with Fire Enforcement Notices at WGH. The Business Justification Case had been considered by SPC, which had recommended it for Board approval.

**Decision:** The Board **SUPPORTED** and **APPROVED** the submission of the Business Justification Case to Welsh Government, seeking approval to progress with Withybush General Hospital Phase 2.

PM(25)142

**Report of the People, Organisational Development and Culture Committee**

Mrs Marks, PODCC Chair, presented the update report from the meeting on 27 May 2025, highlighting the 'Advise' item around Culture Progression, with a further update expected to the next meeting. This topic links with some of the earlier discussions today. Mrs Marks also wished to thank Mr Imperato for taking on the role of Forces Champion.

As a point of accuracy, Dr Wooding noted that the report refers to the 'Equality, Diversion and Inclusion (EDI) Taskforce', which should read 'Equality, Diversity and Inclusion (EDI) Taskforce'.

**Decision:** The Board:

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

PM(25)143

**Report of the Health and Safety Committee**

Ms Murphy, Health and Safety Committee (HSC) Chair, presented the update report from the meeting on 3 July 2025. She noted in particular the 'Advise' items in relation to compliance with Level 2 Fire Safety Training and delays in Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR) submission. Updates on both of these matters have been requested for the next HSC meeting. The Major Incident Plan is presented, under the next agenda item, for Board approval.

**Decision:** The Board:

- **APPROVED** the Major Incident Plan
- **NOTED** the items the Committee is advising them of

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

**PM(25)144**

### **Major Incident Plan**

**Decision:** The Board:

- **APPROVED** the Major Incident Plan
- **NOTED** the content of the Exercise Tendley report
- **NOTED** the content of the EPRR Annual Report, recognising that, due to sensitive information contained therein, this has not been issued publicly
- **TOOK ASSURANCE** regarding compliance with the Civil Contingencies Act 2004 and Welsh Government NHS Emergency Planning Core Guidance (2015)

**PM(25)145**

### **Report of the Charitable Funds Committee**

Mr Iwan Thomas, Charitable Funds Committee (CFC) Chair, presented the update report from the meeting on 17 June 2025. There was one 'Alert' item, in relation to the tender costs for the Development of Therapeutic Gardens at PPH, which had significantly increased. Further detail around this would be presented to the September 2025 meeting, and Mr Thomas thanked colleagues for the information being provided to the Committee to facilitate discussion. There was also one 'Advise' item, which is not included within the report. Currently there are, within charitable funds, reserves totalling £10.2m. The CFC had discussed whether this level of reserve should be retained or utilised. Further discussion will take place at the next meeting. Finally, Mr Thomas thanked colleagues across the Health Board for their engagement with the Committee.

With regard to the reserves issue, Dr Wooding suggested that most people donating to charity would prefer the funds raised to be expended, rather than remain in a bank account.

**Decision:** The Board:

- **APPROVED** the CFC Terms of Reference
- **RESPONDED** to the items that the Committee is alerting them to
- **TOOK ASSURANCE** from the items that the Committee is providing assurance on

**PM(25)146**

### **Report of the Digital, Data and Innovation Committee**

Due to the proximity of the meeting to the Board meeting, Mr Maynard Davies, Digital, Data and Innovation Committee (DDIC) Chair, presented a verbal report. A written report would be submitted to the September 2025 Board meeting. There was one 'Alert' item, in relation to the Laboratory Information Management System (LIMS) project, which has been revised. Implementation will now be undertaken on a discipline by discipline basis, resulting in an additional cost of £176k. An approach is being made to Welsh Government for the additional funding across

Wales to be met from any slippage in the 2025/26 Digital Priorities Investment Fund. The Board is asked to: approve the revised implementation approach; note that if funding is not available from Welsh Government, the Health Board will need to identify an additional £176k, either this financial year (2025/26) or next. There were no 'Advise' items. The Committee had taken assurance on:

- **Innovation**
  - The implementation plans for the Research and Development Strategic Plan
  - Progress on the TriTech Peer Review, confirming the governance for future business plans
  
- **Digital**
  - Planning Objective Update Report
  - The Digital Operational Plan
  - The Digital Strategic Update report
  - The Digital Inclusion report but concern was expressed about the amount of work being undertaken by a very small team.
  - Progress on the implementation of the Patient Flow and e-Obs system
  - Progress on the Radiology Informatics System Programme
  - The exploration of the potential application of Ambient AI and the ongoing pilot studies across Wales in the use of AI scribes
  
- **Data**
  - The IGSC update, approving the Mobile Working Policy
  - The report on the work on Data Quality

Two Corporate Risks were reviewed by the Committee: Risk 2079 (Loss of Pathology services due to delays in the delayed implementation of LIMS 2.0); Risk 1352 (Business disruption due to cyber attack).

Mr Huw Thomas explained that LIMS is a national programme of work. It is anticipated that the cost pressure (if it arises) will be next year rather than this; however, it will be covered this year if necessary. Recognising the importance in the Digital, Data and Innovation sphere of both governance and safeguarding the organisation; and of keeping pace with change and harnessing opportunities, Professor Kloer wished to confirm that these are both captured within the remit and Terms of Reference of this Committee. It was confirmed that they are.

**Decision:** The Board:

- **APPROVED** the revised implementation approach in relation to the Laboratory Information Management System (LIMS) project
- **NOTED** that if funding is not available from Welsh Government for the above, the Health Board will need to identify an additional £176k either this financial year (2025/26) or next.

PM(25)147

### Committee Update Reports

Mrs Wilson presented the Committee Update Reports, highlighting the reports included. Whilst there were no 'Alert' items, there were a number of 'Advise' items, which are summarised within the report. The Board is also requested to approve the revised Mental Health Legislation Committee (MHLC) Terms of Reference. Members heard that a decision had been made at MHLC which was outside the governance and remit of an assurance committee, which has been discussed and resolved. Dr Jon Arthur is attending today's Board in his capacity as incoming Chair of the Healthcare Professionals Forum (HPF), and will become an Associate Board Member following approval of his appointment by Welsh Government.

**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
- **NOTED** the items that it is being advised of
- **TOOK ASSURANCE** on the items that it is being assured on
- **APPROVED** the Mental Health Legislation Committee Terms of Reference

PM(25)148

### Joint Committees and Collaboratives

Introducing the report, Professor Kloer highlighted that this incorporates two updates, with the next Mid Wales Joint Committee for Health and Care (MWJC) update due in November 2025. He has taken over the lead Chief Executive role for the MWJC. Members also heard that the next meeting of the Regional Joint Committee (RJC) is scheduled for 18 August 2025.

**Decision:** The Board **RECEIVED** the updates in respect of recent Joint Commissioning Committee (JCC), NHS Wales Shared Services Partnership Committee (NWSSPC) and Mid Wales Joint Committee for Health and Care (MWJC) meetings.

PM(25)149

### Statutory Partnerships Update

Ms Paterson presented the report, suggesting that this provides a sense of the work being undertaken by the Public Services Boards (PSBs), particularly the local nature of discussions taking place around the Wellbeing Plans, which links to the population needs for each area. In terms of the Regional Partnership Board (RPB), the Part 9 statutory regulations have changed, which provides an opportunity to review RPB membership. It is likely that there will be a discussion at Executive Team and potentially Board around whether the Health Board should consider revising its role in the RPB and the Integrated Executive Group (IEG). Ms Bethan Lewis advised that conversations around joint working have commenced

between the three PSBs, and that they are developing an options paper on this topic.

With regard to Pembrokeshire PSB, Professor Kloer reported that Mr Marc Tierney has been elected as the new Chair, and Ms Jessica Bickerton has been elected as Vice-Chair. Dr Wooding offered, on behalf of the Board, congratulations to both.

**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.

**PM(25)150**

**Any Other Business**

No other business was recorded.

**PM(25)151**

**Board Annual Workplan**

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

**PM(25)152**

**Date and Time of Next Meeting**

9:30am, Thursday, 25 September 2025