COFNODION Y CYFARFOD BWRDD IECHYD PRIFYSGOL
HEB EU CYMERADWYO / UNAPPROVED
MINUTES OF THE UNIVERSITY HEALTH BOARD MEETING

Date of Meeting: **09:30, Thursday 27 March 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) (VC) (part)
Ms Delyth Raynsford, Independent Member (Community)
Mr Iwan Thomas, Independent Member (Third Sector) (part)
Professor Philip Kloer, Chief Executive (part)
Mrs Lisa Gostling, Deputy Chief Executive and Executive Director of Workforce and Organisational Development
Mr Andrew Carruthers, Chief Operating Officer
Ms Sharon Daniel, Interim Director of Nursing, Quality and Patient Experience
Mr Lee Davies, Executive Director of Strategy and Planning
Dr Ardiana Gjini, Executive Director of Public Health
Mr Mark Henwood, Interim Medical Director
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 (part)
Mr Michael Gray, Director of Social Services and Housing, Pembrokeshire County Council
Dr Warren Lloyd, Clinical Director, Mental Health and Learning Disabilities
Ms Angela Lodwick, Assistant Director, Mental Health and Learning Disabilities
Ms Becky Temple-Purcell, Assistant Director of Nursing, Mental Health and Learning Disabilities
Ms Cerian Llewellyn, Interim Head of Midwifery
Ms Dana Scott, Director of Midwifery and Professional Governance for Women and Children
Ms Nichola Couceiro, Head of Engagement
Ms Clare Moorcroft, Committee Services Officer (Minutes)

Minutes Ref.	Item	Action
PM(25)32	**Welcome and apologies**	
	Dr Neil Wooding, Health Board Chair, welcomed everyone to the Public Board meeting, thanking them for their attendance. There	

were no matters that Members felt were omitted from the 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)

PM(25)33 Declaration of Interests

No declarations of interest were made at this juncture.

PM(25)34 Minutes of the Public Meeting held on 30 January 2025

RESOLVED – that the minutes of the meeting held on 30 January 2025 be approved as a correct record.

PM(25)35 Matters Arising and Table of Actions from the Meeting held on 30 January 2025

An update was provided on the Table of Actions from the Public Board meeting held on 30 January 2025. Confirmation was received that outstanding actions had been progressed. In terms of matters arising:

PM(25)22 – Mr Andrew Carruthers advised that, as indicated, a report regarding the Ophthalmology Getting It Right First Time (GIRFT) recommendations had been presented to the Integrated Quality Financial Performance Delivery Group meeting yesterday. The recommendations had been subject to a review, following which it is apparent that there are opportunities to clarify and take further steps to progress and close actions. Mr Carruthers, Mrs Joanne Wilson and Mr Mark Henwood would be meeting with the service to revisit all open Ophthalmology audit recommendations prior to the next Board meeting. It therefore remains a work in progress at present. In response to a query around when assurance can be provided to Board, Mr Carruthers indicated the May 2025 Board meeting. **AC**

Dr Wooding noted that there were a number of actions relating to Patient Experience, most of which would be addressed during the relevant item later on the agenda.

PM(25)36 Minutes of the Corporate Trustee Meeting held on 30 January 2025

RESOLVED – that the minutes of the Corporate Trustee meeting held on 30 January 2025 be approved as a correct record.

PM(25)37 Report of the Chair

Dr Wooding presented his report on relevant matters undertaken since the previous Board meeting.

Ms Anna Lewis drew Members' attention to the section on page 1 in relation to establishment of an Equality, Diversity, and Inclusion Taskforce. She advised that a date has been set for the workshop in the next couple of weeks and an agenda agreed. Ms Lewis is committed to ensuring that the Taskforce reaches out into the organisation in determining its focus, rather than this being centrally-driven. It is hoped that a more extensive update will be available for the May 2025 Public Board meeting. Dr Wooding suggested that this work should also involve the Health Board's anti-racist strategy, with Mrs Lisa Gostling confirming this to be the case. Mr Michael Imperato stated that he had been pleased to attend, on behalf of the Health Board, the signing of the Charter for Families Bereaved through Public Tragedy on 18 March 2025. Hywel Dda University Health Board had been one of the first Health Boards to adopt this Charter, under the leadership of the previous Chair, Miss Maria Battle. It had been pleasing to see so many other organisations commit to doing so.

Dr Wooding wished to formally recognise that this was Ms Delyth Raynsford's final meeting as an Independent Board Member (IM), after eight years' tenure. He had enjoyed working with her and had appreciated her advice, humour and warmth. She would be very much missed. On the same topic, Mr Maynard Davies, who had joined the Health Board five years ago, praised Ms Raynsford for her welcoming, encouraging and insightful approach. Mrs Eleanor Marks also noted that Ms Raynsford had been one of the first to welcome her upon joining as Vice-Chair, and had been supportive and friendly. Echoing these comments, Cllr. Rhodri Evans thanked Ms Raynsford for her welcome when he joined and her friendship ever since. Mr Mark Henwood felt that Ms Raynsford's consistent 'voice' for Children and Young People should be recognised, and hoped that this would be her legacy. Professor Philip Kloer wished to record his thanks to Ms Raynsford for her contribution, indicating that he will miss her challenges, which are always delivered with warmth.

Ms Raynsford expressed that it has been a privilege to act as IM, coming from a nursing and rural background. She had seen the Health Board during challenging times, including the COVID-19 pandemic and Targeted Intervention. However, the strength of both its staff and communities had driven her on to try to improve services. She hoped to remain involved in some form, and ended by thanking everyone she has worked with, including those in the local communities.

Decision: The Board:

- **RATIFIED** the Bronglais Hospital (BGH) Lift Shaft Repairs approved under the Chair's Action
- **SUPPORTED** the work engaged in by the Chair since the previous meeting and note the topical areas of interest

- **NOTED** the formal signing of the Charter for Families Bereaved through Public Tragedy

PM(25)38 Report of the Chief Executive

Professor Kloer introduced his report on relevant matters undertaken since the previous Board meeting, drawing Members' attention to the Targeted Intervention (TI) Update and letter from Welsh Government outlining the reduction in escalation status for four areas. This is encouraging and recognises the progress made, and Professor Kloer wished to thank staff, including Board Members, for their help in achieving this position. However, there is no complacency around the Health Board's performance while patients are waiting too long for treatment and having sub-optimal experiences. There is much more still to be done, and the organisation remains in TI for a number of key areas.

Referencing the proposed new approach to Risk Tolerance, Cllr. Evans advised that this had been discussed at the Audit and Risk Assurance Committee (ARAC), which had endorsed the approach and would be revisiting it at a future meeting. Regarding the request to approve the use of the Common Seal for the Glangwili General Hospital Moulded Case Circuit Breaker Low Voltage Project, Mr Maynard Davies noted the allocation of £75k from Welsh Government. Given the date, he requested assurance that this funding can be utilised by year-end and that there will be no impact on the Health Board's Discretionary Capital funding. In response, Mr Lee Davies advised that the Health Board is liaising with Welsh Government and seeking to ensure that resource which spans two years is utilised flexibly. He assured Members that this process is being managed. Dr Wooding agreed that it can be challenging to manage allocations of funding late in the year.

Mrs Marks welcomed the update regarding plans for a Centre for Social Innovation and the Social Model for Health and Wellbeing (SMfHW). Dr Wooding suggested that this should form an agenda item at a future Board meeting, led by Dr Ardiana Gjini. It was agreed that it would be forward-planned for the September 2025 Public Board meeting. Mr Iwan Thomas wished to record his thanks to colleagues within the Health Board who had been involved in the recent Social Prescribing event, which had been extremely well attended. He thanked Ms Jill Paterson for her presentation, which he felt had communicated effectively the potential benefits that the Centre for Social Innovation will offer. Cllr. Evans, who had also attended, agreed that this had been an excellent event with an extremely positive ambiance, and added his thanks to those involved. **AG**

Dr Gjini advised that the event referenced was the Social Model for Health Summit, which had attracted both external and local keynote speakers. Dr Wooding indicated that he had also received positive reports from this event, whilst emphasising the need to embed the SMfHW into services and plans rather than focus on stand-alone events or initiatives. Agreeing, and confirming that this is the intended approach, Dr Gjini explained that the summit

had been a celebration and opportunity to mark the signing of the relevant Charter. Professor Kloer welcomed the progress in this important area, emphasising the need to establish robust relationships with a range of partners in recognition of the fact that this is a community initiative.

Returning to the TI Update, Dr Wooding suggested that progress made on de-escalation is as a result of mobilising the organisation to recognise a need for sustainability. Its fundamental delivery lies within the organisation, not at Board level. Whilst recognising the positive work achieved and thanking all of those who have contributed, he emphasised that the journey is a continuing one.

Decision: The Board:

- **NOTED** the letter from Welsh Government regarding Oversight and Escalation Arrangements
- **ENDORSED** the Register of Sealings since the previous report on 30 January 2025
- **NOTED** the status report for Consultation Documents received/responded to
- **APPROVED** Memorandum of Understanding for the procurement of carers' information, support and outreach services in Pembrokeshire
- **APPROVED** Virtual Pooled Fund Agreement for Adult Care Home Placements 2025/28
- **APPROVED** the use of the Common Seal for the Glangwili General Hospital (GGH) Moulded Case Circuit Breaker Low Voltage Project
- **NOTED** Executive Team discussions and **APPROVED** the new approach to risk tolerance.

PM(25)39 Annual Plan 2025/26

Presenting the report, Mr Lee Davies advised that the 2025/26 Annual Plan builds on the previous year's Plan and the Health Board's response to the TI domains, whilst also responding to the expectations of Welsh Government within the NHS Wales Planning Framework. These are the two key documents informing the organisation's approach. Mr Lee Davies wished to thank staff across the Health Board for their contribution, and particularly Mr Shaun Ayres and the Planning team for their work in coordinating and collating the Annual Plan. The Plan aims to describe a balanced and sustainable improvement journey, as the organisation seeks to progress quality, performance, service, workforce and financial sustainability. The Plan is a one year or Annual Plan, set within a three year context. Whilst the document is slightly longer than previous years, it hopefully provides a comprehensive summary of actions being taken in various areas. The overall ambition is to deliver on all key expectations of the organisation, and to respond to key clinical risks, including those around Urgent and Emergency Care (UEC). The Plan does not quite achieve the desired position, or meet the criteria for TI de-escalation; however, does deliver improvements.

In terms of progress towards balanced finances, the Plan does meet the Target Control Total, and improves on the underlying financial deficit, albeit predicated on significant savings and on underspends. However, it does not describe progress beyond the Target Control Total towards financial balance. Mr Lee Davies felt that it was important to raise these two matters to the Board. A scrutiny session with Welsh Government had taken place last week, which had been positive overall. Welsh Government had raised two areas of concern; those matters already flagged to the Board – Urgent and Emergency Care and progress towards balanced finances. In conclusion, Mr Lee Davies indicated that the Plan builds on progress made this year, particularly towards achieving TI de-escalation. Whilst this is positive position to start from, it also raises expectations.

Mr Huw Thomas advised that the financial component of the Annual Plan is an attempt to balance addressing the short-term cash challenges which the NHS is facing with the long-term productivity challenges. Further investment to improve productivity is proposed in Diagnostics, including radiology and endoscopy; and in Digital, which will support the organisation moving forward. The financial plan has been subjected to scrutiny by the Executive Team and the Board, at Board Seminar and by the Sustainable Resources Committee. As indicated, it does achieve the Target Control Total of £31.55m; however, the underlying financial deficit starting position is £51m. The financial plan includes savings totalling £43.5m; £19m recurrent and £25.4m non-recurrent. Mr Huw Thomas is working with individual Directors to explore the impact of these savings requirements on delivery of their objectives. There is a need to recognise the importance of efficiencies and to ensure that teams remain focused on savings delivery.

Whilst the expectation is achievement of the Target Control Total, the Plan does not deliver financial balance. The cash position is covered. However, the Health Board continues to spend more than its Welsh Government allocation and – as such – the Plan represents a novel and contentious action, requiring an Accountable Officer letter to be submitted to Welsh Government. Board approval is being sought for submission of the Plan to Welsh Government on the basis that it achieves the Target Control Total, as opposed to approval for the purpose of delegating budgets, which was the case last year. The report also requests Board approval of the Long Term Agreement (LTA), Continuing Healthcare (CHC) and Funded Nursing Care (FNC) financial values, as detailed therein.

Dr Wooding thanked Mr Huw Thomas, Mr Lee Davies and Mr Shaun Ayres for their work in producing a coherent and well composed document. Agreeing, Mrs Marks suggested that certain aspects of the Plan will be covered elsewhere on today's agenda. She would welcome, however, a more detailed description of how it is intended to achieve financial balance. The organisation has

not, to date, been in a position to deliver a balanced Integrated Medium Term Plan (IMTP) and continues to breach statutory requirements; it needs to have a routemap towards achieving an IMTP at some stage. On a separate point, Mrs Marks emphasised that the Health Board's Cellular Pathology laboratory facilities are extremely poor. Whilst a regional solution is the correct approach in the long-term, an interim solution is desperately needed. Dr Wooding noted and acknowledged this comment, suggesting that it be addressed during the later agenda item on Pathology.

Mrs Chantal Patel agreed with Mrs Marks regarding delivering an IMTP. Whilst appreciating the difficulties involved, there has been no discussion of a potential timeline and the Plan remains relatively 'silent' on this topic. Further consideration of this matter would be welcomed. Mr Michael Gray noted various references to 'rationalisation of continuing healthcare'. He highlighted that, within the CHC Framework, once eligibility criteria is met, CHC is an entitlement. Requirements for savings should not be used for the purposes of 'gatekeeping' to such entitlements, and he was concerned by the use of this language. Mr Gray requested assurance that there is no intention of making it more difficult for those who are entitled to receive CHC to obtain this funding.

Mr Maynard Davies felt that the earlier start to the planning process had resulted in a more considered Plan. With regard to the financial plan, Blue, Red, Amber and Green savings of £19m are identified. He noted that historically the Health Board has never achieved more than 50% savings delivery; should this be replicated, it would result in a shortfall financially. Members heard that the Kings Fund had conducted an analysis of increased funding to the NHS in England and its impact. This had suggested that an increase of 1-2% actually results in managed decline. The increase in the Health Board's funding is 1.77%.

Mr Maynard Davies described Digital as a crucial enabler and he welcomed the plans to invest in this area. However, the changes required to medical practice to benefit fully should not be underestimated. On the topic of non-recurrent savings being negotiated into recurrent from underspending against budgets, Ms Lewis noted that a number of the affected Directorates are crucial to delivering the SMfHW. She suggested that any reduction in funding to Primary Care and Public Health would be counterproductive. Agreeing, Dr Wooding also highlighted the inconsistency of doing so with the Health Board's Strategy.

Returning to comments around the need to achieve financial balance and an IMTP, Mr Huw Thomas acknowledged this as a reasonable concern. He should have reflected in his introduction on the additional funding received from Welsh Government and the criteria for this, one of which was to deliver a plan for achieving financial recovery/balance over three years. This would involve achieving balance in the year 2027/28; only at that point could the Health Board propose submitting an IMTP. To achieve this position any sooner would require the organisation to deliver a

financial surplus. In response to Mr Gray's concerns, Mr Huw Thomas assured Members that any individual entitled to CHC funding will receive this. The 'rationalisation' mentioned refers to the delivery arrangements around CHC.

With regard to savings plans, the financial plan is predicated on all of the £19m recurrent savings being delivered. Whilst accepting Mr Maynard Davies' comment regarding historical delivery, Members heard that there has been early engagement with Directorates, to ensure that they are given sufficient notice of requirements and plan accordingly. Mr Huw Thomas suggested that the days of expecting growth and funding into health are significantly reduced and the sector is likely entering a period of long-term financial challenge. The Health Board will need to look to Digital, Artificial Intelligence (AI) and staff development solutions to meet this challenge.

Conversion of non-recurrent savings is a conundrum which has been debated by the Executive Team. There are underspends in areas where the organisation would wish to see investment. Whilst there are certain opportunities for investment, these are limited and not at the scale desired. This is an area where a balanced approach is required, which will require close working with the Board. Members were assured that there will be transparency. Returning to the topic of CHC funding, Mr Carruthers advised that there is a Welsh Government run group, with one workstream being around CHC and spend. Comparative analysis suggests there are inconsistencies in spend per head of population across organisations and systems, which may offer opportunities for consideration and learning locally. This is what the statements around 'rationalisation' reflect.

In terms of underspends, there are other areas which also have underspends in their community budgets. As suggested, this does not intuitively align with the Strategic direction the Health Board is seeking to take. Mr Carruthers is hopeful, however, that the new operational structure will provide opportunities for conversations around how this might be addressed; for example, the benefits offered by models such as Tregaron. Evidence suggests that shifting resource from secondary care into the community allows three to four times as many patients to be cared for, for the same amount. For the time being, however, the spend needs to be held until there is a clear plan which delivers the benefit and outcome required. On the topic of CHC, Ms Jill Paterson advised that she is a member of the national group mentioned. She confirmed that there were a number of areas being explored in terms of potential improvements to the system. Ms Paterson also assured Members that individuals who meet the eligibility criteria for CHC will receive this funding. She has been working with Mr Gray to discuss how collaboration across organisations can be improved.

With regard to underspends, and declaring an interest, Ms Paterson emphasised that she supports and endorses the need to ensure that resources are utilised effectively. However, she felt

that clarification is required around the dental budget, which is often described as underspent, when it could be argued that the issue is one of robust contract management. The resource is often invested in contracts, however, a number have been handed back, which is challenging to manage within a single year. The Directorate has put forward a £1.7m dental investment plan, recognising that dental care is a priority. Hywel Dda has the lowest number of people registered with an NHS dentist, and had 17,000 people accessing urgent dental care this year, compared with 5,000 pre COVID-19. Only 20 of the Health Board's General Dental Practices are working within the new contract process, and a significant number of contracts are being handed back. This suggests the need to consider how dental services might be commissioned differently. Also declaring an interest, Dr Gjini acknowledged that Public Health has experienced an extremely challenging financial position. The underspend is mainly from the pay budget, together with the non-pay budget associated with the vaccination programme. Whilst recognising that direct clinical care processes need to prioritised in terms of resourcing, there is a need in the longer term to align with the Strategy and its tenets of prevention, health promotion and community based healthcare.

With regard to Diagnostics, Mr Carruthers indicated that the proposed investment will help to stabilise the service and address immediate operational pressures. There are, however, also real strategic opportunities offered by this stabilisation, in terms of earlier diagnosis and more timely intervention. Whilst the Plan does not necessarily meet the TI de-escalation criteria for UEC, it does describe a clear relationship between the actions and the anticipated impact these will have in mitigating the operational risks. Mr Carruthers acknowledged that the Health Board is not delivering the desired levels of service. He believed, however, that there are still opportunities which can be explored further, such as redesign of the UEC system, to be discussed at a meeting next week. Momentum must be maintained and progress in other areas, such as Social Prescribing, built on. Unless a radical approach is taken, solutions will only be short-term remedies.

Professor Kloer agreed that beginning the planning process earlier had assisted greatly in placing in front of the Board a coherent Plan with a balanced approach. He also recognised that the Health Board has strategic resource challenges, with underspends in areas where it would ideally be investing. It is proving difficult to do so; however, the organisation is trying to be tactical, in investing in those areas which will offer the best returns and most significant impacts. In respect of the £19m savings target, Professor Kloer agreed with comments around past conversion rates. It will, therefore, be crucial to identify further savings opportunities, in recognition of the fact that not all savings plans will be delivered. It is intended that risk-assessed savings plans will be taken through Board level Committees.

Dr Wooding welcomed the fact that the organisation appears to be in a better position in terms of planning, whilst emphasising the

need to drive work in relation to the Primary Care and Community Strategic Plan. Consideration should also be given to preventing future underspends and barriers to investment. Dr Wooding felt it was important to recognise that, whilst the financial plan as presented does deliver the Target Control Total, it does not achieve financial balance. The organisation must continue to address this, but must acknowledge the inherent risks and have the appetite for these risks. As has been suggested, it must develop a culture of growth without large scale investment, as resources simply will not be available. In considering the report's recommendations, and the LTAs specifically, Dr Wooding requested clarification around the Joint Commissioning Committee (JCC) financial variance to plan. Professor Kloer explained that the uplift in this area is higher than other commissioned services; however, it has been subject to significant scrutiny and is regarded as a realistic position. The risk equates to £400k, which it is hoped will be managed in-year.

Decision: The Board:

- **RECOGNISED** that the financial plan for 2025/26 meets the Welsh Government Target Control Total but does not deliver against our breakeven duty; and recognised that this will mean that the Health Board is in breach of its statutory duty and will consequently receive a qualified regularity opinion.
- **AUTHORISED** that the Accountable Officer writes to Welsh Government recognising that the Board's decision to approve a plan that does not meet the statutory requirements represents a novel or contentious action
- **APPROVED** the submission of the Annual Plan to Welsh Government, in line with the NHS Wales Act 2006, which mandates Health Boards to develop plans to improve the health of the population, improve the quality of healthcare services and integrate health and social care planning; whilst recognising that the financial deficit of the Health Board remains unacceptable as noted above.
- **APPROVED** the Long-Term Agreement (LTA) financial values for 2025/26 as detailed in the appendix of the Annual Plan:
  - Total LTA Commissioned Value: £199,227,388
  - Total LTA Provider Value: £23,997,525
  - Formally acknowledged a £400k JCC financial variance to plan
- **APPROVED** the Continuing Healthcare (CHC) and Funded Nursing Care (FNC) financial values for 2025/26 as detailed in the appendix of the Annual Plan, with a total uplift cost of £4,650,909.

PM(25)40 Financial Report

Presenting the Financial Report for Month 11 2024/25, Mr Huw Thomas advised that many aspects of this have already been discussed. He did, however, wish to recognise the work of colleagues across the organisation in helping to achieve the improved in-month position, contributing to the forecast year-end

deficit position of £24m, against the Target Control Total of £31.55m. Mr Huw Thomas suggested that the graphic on page 3, outlining Directorate internal escalation status is quite 'stark', whilst assuring Members that significant work is being undertaken. The Financial Control Sub-Group (FCSG) continues to meet on a weekly basis to scrutinise all requests for new posts and use of agency staff. Mr Huw Thomas thanked colleagues for their forbearance during the discussions which are required as part of this scrutiny.

Certain challenges remain, for example at Bronglais Hospital (BGH), which will largely be addressed by actions already in train; in Mental Health and Learning Disabilities (MHLD); and around Medical agency use. Members heard that the annual budget delegation accountability letters have been issued to budget holders. Finally, Mr Huw Thomas drew Members' attention to Appendix 3, which focuses on secondary care drug expenditure, thanking Ms Paterson and her team for their work on the document. It illustrates the significant challenges in this area and the actions being taken to address these.

Welcoming the report, Mr Imperato highlighted the statement on page 3 around assurances being required that 'the Operational transition to Clinical Care Group structure will not delay results to required actions'. Suggesting that the reorganisation should result in improvements, he enquired regarding the nature of the concerns and when assurance will be provided. Mr Huw Thomas explained that any significant change brings with a risk of distraction and takes time to embed. The issue is that plans have been developed under one operational structure, which are due to be delivered under another. He assured Members, however, that arrangements are being put in place.

Mr Carruthers indicated that the work being undertaken by corporate functions to enable the change in operational structure should not be underestimated. The transition, during March and April to the new structure, involves new personnel and new roles and responsibilities. It needs time to embed and settle in. Mr Carruthers accepted that the change is intended to enhance, emphasising that it must not, however, be viewed as a 'reset' or justification for losing traction. To this end, the organisation is continuing with its internal escalation process and meetings and is trying to ensure that the impact of the change does not become detrimental. Mrs Marks wished to emphasise that this change has the full support of the Board. She recognised, however, that it has been an extremely challenging year for staff and that the natural inclination might be to seek respite. In addition and as mentioned, the reorganisation will involve changes in personnel and roles, meaning that plans may be managed by people who did not develop them.

Whilst agreeing, Mr Carruthers suggested that inheriting and managing plans and workstreams is an integral part of taking over a role. Whilst it may be acceptable to review plans and potentially

disagree with them, the expectation in such an instance would be to present alternative solutions. Members heard that meetings with Clinical Care Group (CCG) triumvirates are planned for April 2025, to outline expectations. As has been indicated, the need for continued pace and momentum will be emphasised as part of these discussions. Whilst welcoming this additional context, Mrs Marks explained that the assurance being sought is around delivery itself, rather than the manner of delivery. Agreeing, Dr Wooding suggested that this matter be revisited and an update provided at the next Board meeting in May 2025. He would anticipate this including data on whether the risks have materialised and assurance that the changes enacted have not worsened the situation they were intended to improve. **AC**

Dr Wooding noted that a number of Directorates appear unable to manage their spending, and requested assurance that there is sufficient 'grip and control' in this regard. In response, Mr Huw Thomas suggested that the internal escalation process has changed the mindset and culture around this, and resulted in an improved level of grip and control. He recognised, however, that there are imperfections with the current system, necessitating change. Consideration is being given to aligning escalation processes with management accountability. Processes will need to mature quickly. As has been mentioned, discussions at FCSG can be challenging; however, meetings of this group have been maintained on a weekly basis for approximately a year. It is intended to request, in the future, that more senior leaders attend.

Observing that, recently, less business is being routed through FCSG, Mr Carruthers suggested that a continuation of this trend during April and May 2025 might be an early sign that implementation of the new structure has been successful. Mrs Marks agreed that this link will be useful in ensuring that the quality and impact aspects are not overlooked. Referencing the Directorate escalation status data on page 3, and the concerns that it raises, Cllr. Evans enquired whether the FCSG has clear timelines and milestones for improvement, to provide assurance. In response, Mr Huw Thomas explained that the role of the FCSG is to scrutinise requests for new posts and agency usage. It is not concerned with delivering savings, which is a management responsibility.

Concluding discussions, Dr Wooding emphasised that the challenges involved in delivering savings are not underestimated. However, the Health Board will not achieve its ambitions without embedding financial literacy and making it matter to staff. This is vital in ensuring the future sustainability of the organisation. He recognised the significant work which has taken place this year, particularly in exceeding the Target Control Total set by Welsh Government.

Decision: The Board:

- **RECOGNISED** that, following Welsh Government funding received, the Health Board's Deficit plan is now £31.55m, which is the new Target Control, and the reported financial position has improved to £24.0m as reported in Month 10.
- **TOOK ASSURANCE** that, with a year-to-date delivery of £20.8m against a planned deficit of £28.9m, the Health Board is now on a trajectory to achieve the revised financial position of £24.0m.
- **SCRUTINISED** the progress of savings actions to bridge the recurrent savings gap for those Executive portfolios who are yet to identify their full target.
- **SCRUTINISED** the Executive Delegated Officer portfolios which are overspending against their delegated budgets.
- **ACKNOWLEDGED** that an underlying deficit assessment has been undertaken and the brought forward balance going into the 2025/26 year will be £51.1m, significantly higher than the 2024/25 forecast outturn, due to the reliance in-year on non-recurrent actions and the lack of progress made in converting the same to recurrent improvements.
- **TOOK ASSURANCE** from those directorates with a Level 3 escalation for Finance, Strategy and Planning, that they have sufficient actions and milestones in place to de-escalate (full details provided within the IPAR report as well as directorates listed under the alert section for the finance domain).
- **TOOK ASSURANCE** that the Accountable Officer has delegated budgets to Executive Directors and Clinical Care Group / Executive Function Leads in advance of the new financial year commencing.
- **DISCUSSED** the main drivers of increased expenditure and mitigating actions from collaborative work between Pharmacy Services and Oncology Services contained within the Secondary Care Drugs report.

PM(25)41 **Data and Intelligence on Efficiency and Productivity**

Mr Huw Thomas introduced the report, drawing Members' attention to the three key functions by which intelligence supports the Board: Oversight; Insight; Foresight. It was the final of these where he suggested the greatest focus is required. There has been a great deal of work undertaken around the intelligence reported to the Board, particularly performance data. In developing these reports, there has been cognisance of the principles outlined in the 'Qualitative characteristics of accounting information'; recognising the two fundamental characteristics, Relevance and Faithful Representation and four enhancing characteristics, Verifiability, Timeliness, Understandability and Comparability.

The Health Board's Performance Dashboard is one of the most viewed across NHS Wales. A Safety Dashboard has also been developed, which is being actively used within the Nursing, Medical and Therapies/Health Science teams. Members heard that a presentation at yesterday's Executive Team meeting had outlined plans for an Activity Dashboard, which would incorporate

productivity, outcomes and population health, with the exact scope to be agreed. It is hoped that these dashboards will allow a comprehensive understanding across the organisation of the oversight and insight functions. As has been indicated, further work is required on the foresight function, to facilitate improved planning and specifically more intelligence-based planning.

Mr Henwood thanked Mr Huw Thomas and his team for their work in developing the dashboards described. Data from the Safety Dashboard (together with feedback from clinical staff) had recently suggested potential increased mortality in one of the Health Board's A&Es. This had prompted an immediate review, which had provided assurance that there was not, in fact, an issue. Members were informed that the data provided was being utilised on a daily basis. Mr Maynard Davies noted that two recent Internal Audit reports considered at ARAC had identified data quality and data management issues. There is also an issue around timeliness of data, with much of the Public Health information being historic rather than current, which limits foresight. Improved Primary Care data is also required. Finally, it was suggested that there is a place for presenting dashboards at an operational and frontline level, such as wards.

Dr Gjini agreed that there are challenges around Public Health data reporting, highlighting that organisations are currently reliant on nationally-collected data. There needs to be prioritisation of local collation of data, and it is hoped that a restructuring of the Directorate will provide this analytical resource. In parallel, there are plans to introduce additional Public Health service indicators into the Health Board's performance reporting. Ms Sharon Daniel emphasised the importance of having the ability to triangulate data from a number of dashboards. This provides important information when evaluating the impact of changes (for example, nurse workforce stabilisation actions) on quality and safety.

Whilst welcoming the positive progress described within the report, Dr Wooding agreed that the Health Board needs to reach the point of data providing foresight. The challenge of making data user-friendly and understandable is significant. He shared concerns around the quality and validity of data, which requires vigilance and discipline to address.

Decision: The Board **DISCUSSED** and commented on the proposed approach to providing intelligence to the Board and Committees, based on the plan presented.

PM(25)42 Integrated Performance Report

Presenting the Integrated Performance Assurance Report (IPAR) for Month 11 of 2024/25, Mr Huw Thomas indicated that he would not outline the contents in detail. This should not be taken as minimising, however, the impact of each and every performance metric on the individuals they affect. Members attention was drawn to Appendix B, which presents the new 'Our Improving Together Framework'. Pages 9-11 of the report detail the four

most challenged directorates (those with the highest levels of escalation): MHLD; Planned Care; GGH; Facilities and Estates. These have been flagged as being of particular concern to the Board for some time.

Ms Lewis noted that staff engagement appears under the 'Alert' category and shows special cause concerning variation, following a deterioration in performance, and requested clarification. She also noted that, under 'Triangulating our data' on page 8, there were reductions in various metrics, including the number of incidents causing moderate harm or above reported and patient falls. Ms Lewis was concerned that decreasing staff engagement might be contributing to lower incident reporting, and requested assurance that work is being undertaken to establish that this is not the case. Also referencing the 'Alert' section, Mr Imperato enquired whether forward trajectories are available to forecast the position for March, April and May. Noting the staff sickness figure of 6.65%, he requested clarification of how this benchmarks with other Health Boards.

Whilst acknowledging Mr Imperato's final query, Dr Wooding suggested that staff sickness is not necessarily a matter for the Board. A more appropriate forum for examining this in detail would be the People, Organisational Development and Culture Committee (PODCC). It is the Board's responsibility to receive assurance and solutions to mitigate risks. In terms of staff engagement, Mrs Gostling reminded Members that the Health Board conducts a monthly staff survey, which is issued to 1,000 different members of staff per month. Unfortunately, the response rate to this is relatively low, and alternatives are being considered. Findings from the NHS Wales Staff Survey have recently been received, with the Health Board's engagement rate being 71%. A report on this topic is scheduled for the May 2025 Board meeting. A great deal of work is being undertaken around leadership and management programmes, with encouraging early signs. More detailed discussion will take place at a future PODCC meeting.

With regard to staff sickness, the organisation supports managers in adhering to the sickness absence policy, and provides support to both staff and managers. At a recent meeting with Public Health colleagues, it was determined that HDdUHB will be a pilot site for a programme exploring population health and sickness absence correlation. This will recognise where people live in addition to where they work, and will utilise Public Health Wales health promotion materials. Members heard that PODCC had recently considered a Deep Dive report into sickness absences attributed to anxiety/depression/stress. Noting the statement regarding Ophthalmology, that 'February 2025 performance is expected to recover to 58%' Cllr. Evans enquired whether this had, in fact, been achieved. Mr Carruthers explained that the performance metrics were not yet finalised and committed to provide an update outside the meeting. **AC**

Returning to Ms Lewis' concerns around incident reporting, Ms Daniel advised that she has requested her team to explore the reduction in falls specifically. Members were assured that the Health Board has a low tolerance for reporting falls, tending (if anything) to over-report. In addition, its work in rehabilitation and managing deconditioning tends to result in higher numbers of falls. There has been a reduction in pressure damage. Ms Daniel agreed that steps must be taken to triangulate data and ensure that the figures do not provide false assurances. Whilst welcoming this commitment, Ms Lewis emphasised the need to recognise when staff begin to disengage and their behaviours change. Using only current and/or existing mechanisms may not be sufficient to do so. The special cause concerning variation suggests that something more may be happening, and this should be viewed as a prompt for further examination. Ms Lewis encouraged the organisation to be 'alert and curious' in this regard. Dr Wooding agreed, highlighting that staff who are engaged do their jobs well. In addition, many of the concerns received are in relation to staff behaviour and how patients feel that they were treated by staff. This suggests an area requiring focus. Referencing the response rate of 71% for the NHS Staff Survey, Dr Wooding commended this as extremely good.

Mr Maynard Davies expressed disappointment regarding the drop in Cancer care performance, noting that 60% for three or more consecutive months is one of the TI de-escalation criteria. He queried how sustained improvement will be achieved. Mr Carruthers shared the disappointment around this performance. The work already mentioned around securing additional capacity in Radiology is a key element of achieving consistent delivery against the Cancer pathway. Mr Carruthers was confident that performance in February, March and April 2025 will meet the 60% threshold. Once this is consistent for a three month period, improvement can be continued on a sustained basis. Reporting on discussions with the Chair of Digital Health and Care Wales, Dr Wooding advised that HDdUHB is an outlier in terms of Cancer diagnosis (not treatment). He felt that this is an area requiring focus, with sustained plans for delivery. Members heard that discussions are due to take place in April 2025, led by Mr Henwood, regarding the use of AI in Radiology to support diagnosis.

A number of the discussions today have suggested areas potentially worthy of insight, via Board level Committees, who can scrutinise the data in more detail. Finally, in terms of foresight, Members were assured that performance trajectories are in place and are available via the link to the dashboard on page 2 of the report.

Wishing to relate some of the challenges discussed to the Annual Plan presented earlier, Professor Kloer noted that the Health Board has, for example, chosen to invest preferentially in diagnostics which will assist in addressing Cancer performance. Conversely, due to the non-recurrent savings issues mentioned

earlier, it has not been possible to invest in certain other areas, including core workforce support. This illustrates the choices which are having to be made.

Decision: The Board **DISCUSSED** the IPAR – Month 11 2024/25 report and to **TOOK ASSURANCE** on the operational delivery of mitigating actions to improve performance in the areas that have been categorised as 'alert'.

PM(25)43 Measures to improve Children's Autistic Spectrum Disorder Service Performance

Dr Warren Lloyd and Ms Angela Lodwick joined the Board meeting.

Mr Carruthers introduced the report into Measures to improve Children's Autistic Spectrum Disorder Service Performance, recognising that this is an area in which the Health Board has struggled. However, it is not unique in this, with organisations across Wales and the UK also affected. As has been indicated previously, Welsh Government have themselves recognised that the target metric in this area is probably unachievable. The Health Board has undertaken work locally, to define a local target for performance. It has also redesigned the pathway to get children into treatment and intervention. Mr Carruthers has mentioned previously that the conversion rate from assessment to confirmed diagnosis is approximately 87%. There is an assessment backlog, and the conversion rate suggests that it would be appropriate to consider streamlining the process, which it is believed, would have a significant impact. To this end, a pilot is proposed.

Dr Warren Lloyd agreed that there is significant need in this area, and that the Health Board's performance is not at the desired level. He was hopeful that the proposed pilot will test whether changes to the pathway can address these issues, improve the legacy position and that for new referrals. Dr Lloyd assured Members that the impact of remaining on a waiting list for several years was recognised, particularly when children are unable to access certain interventions until they have a confirmed diagnosis. Nationally, there is consideration of moving to a needs-led service rather than a diagnostic-led service. This will enable needs to be met sooner. Dr Lloyd emphasised that the Health Board is not working in isolation, but collaboratively across Wales.

Dr Wooding sympathised with those children and young people waiting for diagnosis, and their families. Whilst welcoming the proposals, Ms Raynsford indicated that this has been an issue for a significant length of time. She enquired regarding the work being undertaken at a national level, and what this comprises. Whether consideration is being given to early intervention, pre-diagnosis and providing initial support to children and their families. Additionally, whilst appreciating that the pilot will begin in Carmarthenshire, Ms Raynsford emphasised the need for equity across all three counties of the Health Board. Finally, clarity was requested around communications with GP colleagues and

partners in education and Local Authorities. It was highlighted that this issue can impact greatly on education and life opportunities.

Noting the proposed investment in Digital innovation, Ms Ann Murphy queried whether this will include consideration of establishing a single integrated record or 'passport' for children, into which various data can be fed, including around education and health. Mr Iwan Thomas noted the focus on schools, and queried whether there will also be interaction with further education. This sector represents the 'bridge' into adulthood and is seeing significant issues involving mental health. He enquired regarding engagement with post-school education. Ms Lewis welcomed the proposals and fully supported the team in implementing these. She emphasised, however, that the Board's responsibility to consider the hostile environment which neurodivergent children and adults face, remains. Board Members are strategic leaders within their communities. They should consider the contacts they may have who might be in a position to assist in taking this forward. It should be recognised that medicine has very few answers in this area, and the main issues will not be solved by healthcare interventions.

Mrs Marks enquired around the length of the pilot and how it will be evaluated. She agreed with Ms Lewis, that this exceeds the bounds of the Health Board, and involves economy, rural poverty, communities and links with the SMfHW. It will, as suggested, require collaboration with other parties in order to secure the required strategic approach. Declaring an interest as a member of the Regional Partnership Board (RPB), Cllr. Evans enquired whether a shorter assessment period potentially risks shifting the backlog to treatment and intervention. Dr Wooding suggested that the latter will be both medical and non-medical. Welcoming the proposed pilot, Dr Gjini highlighted that diagnosis links to many follow-on issues, for example additional educational funding. She agreed that there is a potential for an over-medicalised approach, suggesting that there needs to be a more sustainable solution to managing the social and behavioural aspects of neurodivergence. There needs to be more national leadership and an alternative approach. Dr Gjini also felt that there need to be improved links with the healthier schools programme. She advised Members that one of the Centre for Social Innovation workstreams is around the mental resilience of children and young people.

Welcoming these comments, particularly around the strategic approach, Mr Carruthers acknowledged that there is a broad range of issues affecting children and young people, not all of which relate to health. Certain conditions mean that there is overlap between sectors, and between healthcare services – such as the potential impact of mental health on dietetics due to eating disorders. He agreed that a collaborative approach is required. Dr Lloyd also thanked Members for their comments and welcomed the suggested 'whole system' approach. He recognised that there is work to be done to meet this challenge. The Board's recognition of how this area interfaces with other agencies, and nationally,

was welcomed. Dr Lloyd explained that the Neurodevelopmental team consists of 11 WTE staff. There is a need to be pragmatic regarding what can be delivered. Whilst the team is extremely dedicated and enthusiastic, their wellbeing also needs to be safeguarded. Dr Lloyd agreed that greater traction in collaboration with colleagues in Local Authorities and education is required.

Returning to an earlier comment and concern, Ms Angela Lodwick emphasised that the intention is for a Health Board wide approach in the pilot, not one limited to Carmarthenshire. Collaboration with colleagues in Paediatrics and Health Visiting will enable early referrals without the need for intensive assessment. The aim is to begin in mid-April 2025, with outcomes anticipated in Quarter 1. It is intended to involve parents and carers. In terms of collaboration with GPs and education, Ms Lodwick assured Members that this is in place. The focus is on early intervention, with signposting to sources of support. A Health Board ASD webpage, which will also incorporate Attention Deficit Hyperactivity Disorder (ADHD), will be launched imminently. In terms of Digital opportunities, these represent a significant potential cost; however, the team is working on scoping and is grateful for the support provided. Welsh Government is exploring a potential pilot which may offer opportunities in this regard. Ms Lodwick welcomed the comment around further education, which is extremely important. A number of individuals enter further education without a diagnosis; the regional forum reporting into the RPB has recognised this issue.

Dr Wooding and Professor Kloer thanked the team for their report. Professor Kloer agreed that this is very much a 'whole system' issue and contemplated how the relevant parties might be brought together to facilitate the conversation required. He suggested that those involved in the Centre for Social Innovation could consider this matter and convene a workshop. Members of the Board with particular interest and expertise might also be co-opted. An update will be brought back to the Board in September 2025. **AG/AC/ PK**

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

- **RECEIVED** the update in respect of the current waiting list position and associated challenges within the Children's Neuro-developmental Autistic Spectrum Disorder (ASD) Service
- **SUPPORTED** the plans outlined to:
  - Pilot a rapid assessment to diagnosis pathway
  - Develop digital options to improve effectiveness
  - Work with partners to develop further actions to enable needs led approaches

Mrs Chantal Patel, Dr Warren Lloyd and Ms Angela Lodwick left the Board meeting.

PM(25)44 Improving People and Community Experience Report

Ms Cerian Llewellyn and Ms Dana Scott joined the Board meeting.

Ms Daniel introduced the Improving People and Community Experience Report, covering December 2024 and January 2025. She advised that the team is continually considering new mechanisms to capture service user feedback, in an effort to improve quality, safety and experience. Ms Daniel wished to record her thanks to those who have contributed to the report. There has been a 12% reduction in complaints, and improvements in both early resolution of concerns, and those resolved within 30 days. Work is underway to increase levels of feedback from Primary Care, with a pilot to be conducted in the Health Board's Managed Practices. Ms Daniel outlined upcoming changes, with introduction of the new People's Experience Framework and alterations to the Civica system. The Health Board will, as an organisation, be required to undertake a self-assessment against the new Framework, which requires teams to indicate local priorities.

Ms Daniel introduced colleagues from the Maternity service, who have recently received a national award recognising their team culture and team-working. Ms Dana Scott and Ms Cerian Llewellyn presented to the Board their work in relation to patient and staff experience. Ms Scott explained that the team stopped the usual 'workplace cycle' to enable a proper evaluation of patient needs. There has been engagement with the workforce and consideration of whether and how examples of mistakes and poor patient experience can be learned from. It was emphasised that staff are keen to learn and share good practice. Whilst this may only be a start, it will contribute to 'making a difference'. The evidence suggests that the presence of an empathetic witness can greatly reduce the impact of a traumatic experience.

Ms Cerian Llewellyn advised that, in Maternity, a number of indicators have historically been utilised when assessing quality; however, clinical outcomes were generally prioritised. Very few considered service user experience, when ultimately, the service 'belongs' to the women and babies who use it. Evidence suggests that poor clinical experience and service has adverse outcomes for women and children for years to come. As a result, the team had recognised the need to listen to its service users. These are generally engaged young women, who sought different mechanisms to feed back on their experience. These included 'softer' measures, such as social media and post-birth 'clinics'. Whilst it is important to learn from clinical outcomes, the service user voice is also required, to ensure a holistic understanding.

Turning to the section of the report on baby loss, Members heard that this affects 4 out of every 1,000 births in the UK. Whilst there has been a reduction in the stillbirth rate within HDdUHB, it is a harrowing experience for those affected. Such a case is outlined within the report, whereby a couple on holiday in the region sadly lost their baby. Their story, however, suggests that staff had provided them with something that they did not think possible and, in recognition, they had nominated the midwife involved for a Midwife of the Year Award, which she had won. Members heard

that the Perinatal Mortality Review Tool has been in place for some time; however, the service user voice was missing from this, and is required. Baby loss should be regarded as more than 'a case to learn from', as it represents a baby and a life.

It is important to build a rapport with families and their feedback is fundamental in recognising the 'lived experience'. When individuals have had a poor experience, it is crucial to learn from this and ask them what they would change and improve. It is also important to consider those who are seldomly heard and/or marginalised. Services need to commit to recognise when they have delivered less than optimal service and utilise tools such as the 'You Said, We Did' approach. Members heard that the Maternity service had received an action plan from Llais, which included feedback that women were feeling isolated during the birth experience. They had since implemented a pathway to address this issue. Scale and spread should also be a consideration, including the sharing of good practice. An example is the Maternity Passport, which recognises the needs of mothers with autism or conditions which might affect their communication. There is very little data around maternity care for this group. This document has been embedded nationally.

Dr Wooding thanked Ms Llewellyn and Ms Scott for their presentation, indicating that – whilst challenging to read – he had taken great assurance from the patient story therein. Mr James Severs also thanked the team and agreed that the actions being taken felt very sincere. He commended the team's ability to create a culture of 'recalibration' and focus on the true business of the Health Board, and questioned how this can be learned from and embedded elsewhere. Mr Iwan Thomas did not feel, however, that there was much reference to partners who experience baby loss, given that they will also be dealing with the impact going forward. He enquired whether there is any 'wrap-around' support for them.

Ms Donna Coleman welcomed this agenda item, and praised in particular the 'debrief session' for mothers. As has been indicated, it is important for these service users to be listened to; GPs and Health Visitors may not have time, or their focus may be the baby rather than the mother. For some mothers, it may be their only birth experience. Ms Scott reiterated the service's commitment to learning, and Dr Wooding thanked them on behalf of the Board.

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, and specifically in relation to Maternity services.

Ms Cerian Llewellyn and Ms Dana Scott left the Board meeting.

PM(25)45 Board Assurance Framework

Mrs Joanne Wilson introduced the Board Assurance Framework (BAF), reminding Members that this will need to be aligned with the revised Strategic Objectives. All Committees have reviewed

their allocated Planning Objectives, and the Population Health outcome measures have also been considered. In addition, the Principal Risks have been reviewed by the Executive Team and with risk owners. All Planning Objectives are on track, with the exceptions of PO9 (Digital) which is now complete, PO4 (Planned Care, Diagnostics and Cancer) and PO8 (Estate Plan) which are currently reported as behind.

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

PM(25)46 Refreshing the 'A Healthier Mid and West Wales' Strategy

Presenting the report, Mr Lee Davies indicated that this was the third in a series on the 'A Healthier Mid and West Wales' (AHMWW) Strategy Refresh. This report focuses on the Health Board's estate and capital availability. It is being presented at a time when the Health Board is undertaking further discussions with Welsh Government, including at its Infrastructure Investment Board (IIB). The Health Board is clear that its current service model is unsustainable, both in terms of the clinical model, configuration and service delivery; and in terms of the condition of its estate. Whilst there are examples of excellent facilities, such as the Integrated Care Centres, the estate is generally aging. Hence, large sums of money are spent on extending the life of buildings, which constrains ability to transform service delivery.

The AHMWW Strategy is predicated on capital funding, which is highly unlikely to be available to the timescale required. As such, the Health Board needs to realign its estates and service plans to likely capital availability. Key considerations will be the programme for Community Hubs and long-term plans for Glangwili and Withybush Hospitals (GGH and WGH). There is a need to ensure both value for money and longevity. Mr Lee Davies emphasised that the report does not seek to provide answers, but outlines the challenges involved. Plans will need to be agreed jointly with Welsh Government, who have accepted that the current clinical model is unsustainable and that GGH and WGH will require either substantial refurbishment or replacement in the next 10 to 15 years. A phased approach to capital plans is proposed, recognising that the cost may ultimately be the same as previously suggested. The Health Board committed to consider these issues ahead of a further follow-up meeting with Welsh Government in three months' time.

Whilst noting the ongoing discussions with Welsh Government, Mr Imperato suggested that it is challenging to develop detailed plans without an indication of the likely capital support. Acknowledging this comment, Mr Lee Davies explained that one of the constraints is that Welsh Government do not have a mechanism for substantial capital investment beyond the allocated money available to them. They are, however, committed to working through the impact of this and the pros and cons of major short-term investment, versus extended investment over a longer term.

Mrs Marks felt sets out the challenges well. Some of the areas in which patients are treated are in extremely poor condition, including estate in Mental Health. Mrs Marks emphasised the need to consider this issue from the patient perspective, and that of the staff required to work in these conditions. If a significant capital investment from Welsh Government is not anticipated, she enquired whether the Health Board is considering collaboration with the private sector, partner organisations and other more creative options. Also, whether there is any consideration being given to regional approaches. With regard to the Integrated Care Centres, Mrs Marks agreed that these are effective and valuable facilities. As such, proposals to reduce in scale plans for the Cross Hands scheme conflict with the AHMWW design principles.

Professor Kloer suggested that public and staff need a clear sense of the Health Board's strategic direction, and emphasised the need to make progress. He agreed that discussions with Welsh Government had been positive and felt that Mr Imperato's concerns will probably be addressed by the Health Board working closely with Welsh Government to ensure that they understand the organisation's priorities. It should be noted, however, that these priorities are multitudinal. He agreed that many locations would benefit from facilities like the Integrated Care Centres, and that the Health Board will need to be creative in considering its options. In terms of a regional approach, this will benefit from the establishment of the Regional Joint Committee with Swansea Bay University Health Board (SBUHB), and the Health Board also recognises the need to consider mid Wales. It will be important to ensure that capital requirements are not over-duplicated within the wider region.

Noting that the position is becoming more and more complex, Dr Wooding emphasised the need to set clear goals. He suggested that consideration be given to modelling and determining the number of beds required and the classification of these. It is crucial for the organisation to have a sense of its future ambitions, model and aspirations, via a 'simulation' process. Agreeing, Mr Lee Davies added that the order in which steps are taken also becomes important, as one element impacts on another. These different elements cannot be considered independently of each other. The organisation is committed to giving due consideration to these aspects going forward. In view of the need for more Board discussion around this, it was suggested that it be a topic for a future Board Seminar. **LD**

Decision: The Board:

- **DISCUSSED** and **CONSIDERED** the key matters pertaining to estate and infrastructure as part of the AHMWW strategic refresh
- **NOTED** the outcome from the Health Board's attendance at the Welsh Government Infrastructure Investment Board (IIB)

PM(25)47 Conversations with our Community

Ms Nichola Couceiro joined the Board meeting.

Ms Alwena Hughes Moakes introduced the report, welcoming the opportunity to discuss this matter at Board, and thanking those who have contributed in advance. She introduced Ms Nichola Couceiro, recently appointed as Head of Engagement and already having a positive impact. Members were reminded that the Health Board has undertaken a great deal of engagement work already in the recent and distant past, both via the Communications and Engagement teams and via the wider organisation. The Hywel Dda CHC and Hywel Dda University Health Board Joint Framework for Continuous Engagement and Consultation is included as an appendix to the report. This document requires updating, not least to reflect the change from Community Health Councils to Llais. The team would value the views of Members on how engagement can be enhanced and suggestions of further opportunities.

Mr Iwan Thomas emphasised that engagement with communities is a vital component of the Health Board's 'journey' as an organisation. It is especially important to consider those who do not engage regularly with the Health Board. He thanked the Engagement team for taking the time to meet with him and take on board his ideas, noting that he has been vocal around past engagement and why it may not represent the optimal approach. In order to meet the needs of stakeholders, public and staff, there is a need for a diverse approach to consultation and engagement. Welcoming the report, Ms Lewis highlighted numerous references to the SMfHW during today's discussions. This requires the Health Board as an organisation to completely rethink its position and relationship with those using its services and in its communities. Whilst this shift in relationship is being considered to some extent at a clinical level, there is more work required at an organisational level. One area of focus must be in building trust. There are many interactions and, therefore, indirect opportunities to build trust with communities which need to be explored.

Mr Maynard Davies welcomed the report and its commitment to engagement with the local population. Noting that this needs to encompass all generations, Members were reminded that 25% of elderly people do not have access to the internet and some are living in rural and isolated communities. Those in this group are, however, probably the main users of secondary care services. Consideration should be given to meeting their needs in terms of facilitating engagement. Dr Wooding emphasised that, if a community identifies something which it cares about, it can be incredibly powerful. The Health Board needs to ask its communities to focus on what is important to it as an organisation, as well as what is important to them. Observing that there is much on this topic worthy of a more detailed discussion, Cllr. Evans suggested that it form the basis of a Board Seminar session. **AHM**

Suggesting that one of the key messages is around listening to rather than talking to communities, Ms Raynsford felt that the focus of conversations needs changing to reflect this. It is also important to recognise that engagement is not the responsibility of the Communications and Engagement team solely. The whole organisation is responsible for engaging with stakeholders. Mrs Marks suggested that the Health Board has always been quite traditional in its approach to engagement. She welcomed recent changes such as increased use of social media and the different tone used therein.

Ms Nichola Couceiro embraced the feedback from Members and would welcome any ongoing conversations and suggestions. She agreed that a 'blended' approach to engagement is required, adding that it is not simply a case of meeting communities where they want, but also when they want. Engagement with the local population tends to take place when services are being changed; however, it needs to be a continuous process, in order to build trust. Dr Gjini highlighted that involvement with individuals and communities is a central objective of the SMfHW and needs to be embedded going forward.

Concluding discussions, Dr Wooding noted the connect between this item and the Strategy discussions, recognising the importance of not compartmentalising the various workstreams.

Decision: The Board **DISCUSSED** and **CONSIDERED** the report, sharing views on how the Health Board could approach its continuous engagement activity, to increase the number of individuals and groups actively participating in decision-making and build stronger relationships with our communities.

Mr Iwan Thomas, Ms Donna Coleman and Ms Nichola Couceiro left the Board meeting.

PM(25)48 Prince Philip Hospital Minor Injury Unit Options

Dr Warren Lloyd and Ms Becky Temple-Purcell joined the Board meeting.

Mr Mark Henwood introduced the Prince Philip Hospital (PPH) Minor Injury Unit (MIU) Options report, reminding Members of the temporary service change enacted in September 2024 and the reasons for this. The change had been for a period of six months, during which Board had requested that options be developed for presentation at the March 2025 meeting. Mr Henwood thanked those involved, both Health Board teams and stakeholders, for their contribution to this significant piece of work. Members heard that two groups had been established, a Steering Group and a Project Group. A continuous engagement process involving various stakeholders had been undertaken. Stakeholders included partner organisations, patient and community representatives, members of Save Our Services Prince Philip Action Network (SOSPPAN), Llais and members of staff. Mr Henwood thanked all

of those who have engaged so positively and constructively with the process.

Mitigating actions had been put in place to ensure access to the Acute Medical Assessment Unit (AMAU) by working with the GP Out Of Hours (OOH) and 111 service. During the four months to date, demand in November and December 2024 has been at similar levels to that seen in November and December 2023. Attendance at MIU has reduced, as would be expected with the overnight closure, and attendance at the AMAU has remained consistent. The number of 'majors' patients attending the MIU has decreased, along with waiting times. There has been no increase in those patients from Llanelli attending GGH A&E. 4 hour and 12 hour breaches in MIUs have decreased. 111 data has shown a slight increase in total calls being transferred to 999 or referred to A&E, which reflects the 'majors' patients. There has been no increased attendance in patients from Llanelli to Morriston A&E.

In terms of the options development process, an initial longlist of options had been developed on the basis of Safe, Sustainable, Accessible and Kind care. Workshops had taken place to consider these options, which included a return to the previous overnight model. Four options passed the hurdle criteria and were scored at a workshop on 3 March 2025 to produce a shortlist of options. The four options, described in detail in the report, are as follows:

- 12-hour Doctor led unit (option C)
- 16-hour Doctor led unit (option B)
- Doctor led phased option from 12 hours up to 24 hours (option L)
- 'Urgent' care/treatment centre 16 hour (SDUC type model) (option I)

These four options were appraised using a series of evaluation criteria aligned to themes within Quality Impact Assessments, namely: Safe, Timely, Effective, Efficient, Equitable and Person Centred (STEEEP). The two options scoring most highly were Option C (12-hour Doctor led unit) and Option I '(Urgent' care/treatment centre 14-hour SDUC type model). However, due to the closeness of scores, it is recommended that all four options be considered, should the Board agree to public consultation.

Members heard that, throughout the period since this change was made, the Health Board has undertaken continuous engagement, providing regular updates, engagement events and stakeholder sessions. Consistent themes from these were concerns around access to care, transport and a sense that services are being withdrawn from PPH. In terms of next steps, the current temporary model has seen improved safety and patient experience, and a reduction in complaints. Whilst there has been some success in recruiting to posts, this is insufficient to support a return to the previous overnight model, and the Health Board is not currently in a position to return to the 24/7 model. It is recommended that a public consultation on the four shortlisted options be commenced.

Mr Maynard Davies noted that among the longlist of options was a nurse-led model, which was deemed not clinically sustainable, and requested clarification around the rationale for this decision. In response, Mr Henwood explained that one of the hurdle criteria related to ability to implement in 6-12 months, and a nurse-led model unfortunately could not be implemented in this timeframe. Ms Daniel confirmed that this was the case, with the rationale being based on failure to meet the hurdle criteria, rather than the model itself. Members were assured, however, that – over the longer term – the role of nurses within the unit will develop.

Noting that there is a lack of understanding around the differences between an MIU and A&E, Mr Maynard Davies suggested that (whatever the future model) there must be clarity around where people should seek help. Mr Henwood agreed, indicating that the Health Board needs to better describe the services provided by MIU. Mr Imperato was assured by the report, which clearly represents a great deal of work. He welcomed the evident involvement of both Llais and SOSPPAN. Emphasising the need for momentum, he warned against letting timescales for resolving issues slip. This view was shared by Dr Wooding. Ms Hughes Moakes indicated that, whilst the proposed timescales are challenging, teams are working at pace to ensure they can be met.

Mrs Marks suggested that this topic links with the previous agenda item. She requested additional clarification around the scoring system, which Mr Henwood provided, adding that this was described in detail in the appendices. In response to a query around whether he was confident these represent the four best options, Mr Henwood confirmed this to be the case. He explained that they have been developed by the stakeholder group, taking into account the various views. He had shared Mr Maynard Davies' perspective around a nurse-led model, whilst recognising that it did not meet the hurdle criteria for implementation. This can, as indicated, be explored further in the future. In addition, it should be noted that taking these four options out for consultation does not preclude new options being identified for Board consideration, subject to their meeting the hurdle criteria.

On Ms Coleman's behalf, Mr Lee Davies followed up on an earlier comment, around the naming and perception of the unit, which has been regarded as 'MIU+'. Whatever scope is determined to be the correct one for the unit, the naming requires consideration. Secondly, he had attended the most recent scoring session, and had been struck by the positive engagement of staff and stakeholders. He felt that this reflects well on the community and suggests that the process will be constructive going forward. Ms Hughes Moakes felt that it was important to recognise that staff had proposed eight options and four had come from the local community. Of the latter, two were going forward as shortlisted options. Cllr. Evans noted the suggestion to rename the options for improved clarity and welcomed this approach.

Noting that one of the options is for an SDUC type model, Dr Wooding observed that the Cardigan Integrated Care Centre SDUC is nurse-led. Commending that unit, he questioned whether this might become a possibility for Llanelli. Ms Daniel confirmed that it was a possibility for the future, agreeing that the Cardigan model is an extremely good example, which could be replicated elsewhere in the Health Board. Mr Henwood did wish to clarify that the model at PPH would be slightly different, due to that location having an AMAU. Whilst recognising this, Dr Wooding suggested that it is not necessary to get overly-exercised if there are different models for different communities. It is consistency in standards of care which is important.

Bring discussions to a close, Dr Wooding reiterated the need to maintain pace and suggested that this item be scheduled for a future Board meeting. After consideration, it was agreed that there would be an interim update to the July 2025 Board meeting, with more extensive discussion at the September 2025 meeting. **MH**

Decision: The Board:

- **NOTED** the output reports and engagement review
- **CONSIDERED** the options developed and appraised by the stakeholder group to determine which option(s) should be taken forward for further consideration
- **APPROVED** the continuation of the temporary 12/7 model until a long-term option can be implemented
- **APPROVED** the recommendation to formally consult on the four shortlisted options and retitle these options to ensure they are consistent and reflect the opening hours to the public

PM(25)49 **Mental Health Service Provision: Ceredigion - Temporary Change to the GP Referral Pathway for Mental Health Assessments within Ceredigion**

Presenting the report, Mr Carruthers explained that this is a service which has been fragile for some significant time. There have been concerted efforts to stabilise it, including the development of medical staff; however, the two individuals who had achieved consultant status with the service had since taken up posts elsewhere. There have also been efforts to recruit to consultant posts, with an offer made recently. However, the successful candidate had subsequently been offered and had accepted a post with their current employer. As such, the Health Board has been unable to secure the required medical workforce on a permanent basis. Whilst locums have been employed, this is unsustainable in the long-term. There are also challenges with the non-medical workforce, where a number of vacancies exist.

As a result, and following escalation to the Executive Team on 19 February 2025, the decision was made to alter the referral pathway for GPs, in order to address the access needs of the population and address patient safety concerns. The urgent temporary service change was enacted a week later. Colleagues

from MHLD will explain how this will work in practice and how it will mitigate risks. Due to the cost issues involved in employing high-cost locums, together with the employment market generally in this specialty, there are concerns that it may not be possible to fully address this challenge. There will need to be consideration, therefore, of how long this change may need to be maintained, while an alternative, sustainable position is sought. In the meantime, the Board is requested to ratify the urgent temporary service change described.

Dr Lloyd indicated the temporary service change has been implemented in order to address concerns around patient need and safety. Ms Becky Temple-Purcell advised that the proposed change is not just concerned with stabilisation, it is also intended to test a different way of working, which will meet patient needs, support the team and target resource to where it is most needed, ensuring that those with the greatest need are prioritised. The service has been working with GPs to divert routine referrals to 111 option 2, rather than to the Community Mental Health Team (CMHT). Currently, individuals referred in this way can wait up to 28 days or longer to be seen, following referral, and data suggests that less than 5% require ongoing support from Secondary Care Mental Health. The 111 option 2 service will meet the needs of the majority of these referrals. GPs will also be able to contact 111 option 2 on behalf of patients. Ms Temple-Purcell emphasised that there is no change to the urgent pathway, with crisis teams continuing to receive urgent referrals.

There has been engagement with GPs and various stakeholders, to which the service has been working with Ms Hughes Moakes' team. It is intended to collect feedback from various parties and evaluate the impact of the temporary service change. At the end of the six month period, the service would wish to assess whether there is potential to build on and upscale this approach. A number of monitoring mechanisms and quality metrics are in place to support oversight of this change, including around clinical outcomes and 111 service performance. Also, around compliance with the Mental Health Measure for Wales, which requires that treatment plans are in place for those accessing Secondary Care Mental Health services. It will be vital to ensure the team within Ceredigion are supported. Actions planned include high visibility within the area as a senior team and regular discussions with the team. There is also a commitment to meeting governance requirements, both within the MHLD Directorate, and in terms of reporting to the relevant Health Board Committees. The Mental Health Legislation Committee (MHLC) will have a particular oversight in this regard.

Cllr. Evans appreciated the risks outlined and the need to develop a sustainable solution. He enquired, however, whether the intention is to continue medical recruitment campaigns during the six month period. Dr Lloyd confirmed that the service is actively trying to recruit both substantive and locum consultants, engaging with all possible routes to do so. It is also collaborating with

international psychiatry recruitment initiatives. Ms Lewis advised that she had undertaken discussions with the relevant parties as Chair of the Quality, Safety and Experience Committee (QSEC). It should be recognised that proposals such as this would normally first be considered at a Board level Committee, before presentation to Board. However, operational services must be able to make urgent decisions on the grounds of patient safety. Members heard that a Deep Dive into Mental Health services is scheduled for the next QSEC meeting, and this topic will be part of the discussion. **AC**

Ms Lewis wished to make clear that, even if the Health Board was able to secure two consultants immediately; with the rurality of this location and service fragilities involved, a more sustainable service model must be sought going forward. Dr Wooding shared this view, whilst expressing concern that the risks around this service had not been visible to the Board. He was content for QSEC to be the body scrutinising and monitoring this area on behalf of Board. Referencing an earlier statement, Dr Wooding suggested that it cannot be beneficial for patients requiring Mental Health support to wait 28 days or more following referral. The service as it existed was clearly sub-optimal, though not through the fault of anyone working there. Professor Kloer emphasised that QSEC would need to consider both Equality and Quality Impact Assessments relating to the temporary service change. **AC**

Dr Lloyd and Ms Temple-Purcell were thanked for their attendance and commitment.

Decision: The Board:

- **ACKNOWLEDGED** the operational decision to make the urgent temporary change to the GP Referral Pathway for Mental Health Assessments within Ceredigion for six months from 3 March 2025, due to the service risks outlined in the report
- **APPROVED** the next steps highlighted
- **AGREED** to receive a further update in May 2025 on the accompanying engagement plan to support the development of a sustainable solution at the end of the six months

Dr Warren Lloyd and Ms Becky Temple-Purcell left the Board meeting.

PM(25)50 Hywel Dda Eye Health Needs Assessment

Ms Paterson introduced the report, noting that the last 18 months has seen the most significant reform of eye care services within Primary Care across Wales. 20 October 2023 saw establishment of the Wales General Ophthalmic Services (WGOS) levels 1–5, as detailed within the report. WGOS 1 and 2 have been in place for some years; the most significant development is in relation to WGOS level 4. This has seen a number of new pathways created on glaucoma, cataract and medical retina in particular, to divert service provision from Secondary Care into the community. Welsh

Government placed a duty on Health Boards to conduct an Eye Health Needs Assessment (EHNA) every three years. This document needs to identify the provision of services currently available, and identify gaps in service which may require further consideration. The EHNA is prepared in accordance with a Welsh Government template and should consider service provision, prevalence of eye disease, demographical risks and needs on a community and population basis. The latter is addressed via a Cluster-based approach.

Vision impairment can significantly impact on an individual's quality of life, and presents a substantial socio-economic burden. With an aging population, a significant increase in the prevalence of eye care disease is expected. Optometry contract reform has attempted to respond, and the EHNA sets this out at a Cluster level. Ms Paterson recognised that the existence of Domiciliary Care service provision needs to be added to the document. **JP**
Subject to this, Board approval is sought for the EHNA, together with the proposed next steps, to inform service delivery going forward. The deadline for publishing the EHNA is 31 March 2025, and this process will be repeated on a three-yearly basis.

Decision: The Board **TOOK ASSURANCE** that the Health Board has fulfilled its statutory duties by completing an Eye Health Needs Assessment in line with the Legislative Direction, which will support the review of service provision and enable any gaps in provision to be identified and remedied within available resources and in line with the appropriate governance and contractual arrangements which may be required.

Professor Philip Kloer left the Board meeting.

PM(25)51 Regional Pathology Operational Delivery Network Update

Mr Carruthers introduced the Regional Pathology Operational Delivery Network (ODN) Update report, noting that this was also being considered at the SBUHB Board, reflecting the regional nature of this programme. Members were reminded of the development of the ODN, and advised of Welsh Government's subsequent position of not providing capital support for a regional centre of excellence and refurbishment of facilities. Mr Carruthers expressed disappointment around the lack of progress, the reasons for which were multiple. Not least, the loss of capital support, after which a number of individuals involved had sought employment elsewhere. There has been some progress – for example the joint mortuary service, which has provided improved resilience. Board approval is sought for extension of the Memorandum of Understanding (MOU). Notwithstanding the need to improve facilities, service fragilities in this area are sufficient reason to do so.

Mrs Marks suggested that 12 months to reach an MOU is too long. As mentioned earlier, the condition of the Pathology estate, its impact on staff and the ability to deliver an effective service is unacceptable. Mrs Marks again felt that options in terms of

innovative or creative funding sources should be explored. Also, that an interim solution may well be required, prior to a longer term regional solution. In the absence of this, she was unsure how long the goodwill of staff can be relied upon, and was concerned about the impact on recruitment and retention. Mrs Marks agreed that the mortuary service is well-run, and that there were other positive aspects to the programme; whilst emphasising that this is an area requiring impetus. She requested that consideration be given to developing an interim solution with partners and Welsh Government; that pace be applied; and that the ODN be finalised in under 12 months.

Dr Wooding agreed, expressing concern at the lack of a coherent approach and the need for physical changes to the service environment in which people are working. Turning to the report's recommendations, he requested that Board receive in September 2025 the options rather than an update on the options. This will ensure that progress is being made. Members were advised that the Vice-Chairs at HDdUHB and SBUHB have been tasked with providing oversight in this area. Whilst emphasising that the Board is fully supportive, Dr Wooding reiterated the need for improvement and momentum. Highlighting a governance issue, Mrs Wilson noted that the transitional MOU had not been signed and sealed, which will need addressing by both Health Boards. **AC** **AC**

Decision: The Board:

- **CONSIDERED** the implications of the delayed development of the Regional Pathology Operational Delivery Network (ODN) and decision by Welsh Government to not support the further development of the Outline Business Case to develop the Hub Pathology Centre of Excellence
- **APPROVED** the extension of the Transitional Memorandum of Understanding to recommit the Health Boards to develop an alternative Pathology solution at pace
- **APPROVED** the continued development of the Regional Pathology ODN via the leadership of the Regional Pathology Transition Group
- **ACCEPTED** the need to review the resource to support delivery of the regional pathology programme
- **AGREED** to receive details of the options to provide fit for purpose cellular pathology services in the region at its September 2025 Board meeting

PM(25)52 Report of the Audit and Risk Assurance Committee

Cllr. Evans, ARAC Chair, presented the update report from the meeting held on 11 February 2025. He drew Members' attention to the 'Advise' items in relation to the Revised Operational Governance Arrangements; Limited Assurance Internal Audit reports on Management of Bed Capacity, Mortuary Services, Health and Safety and Data Quality; and breaches of Standing Financial Instructions, with mitigating actions for the latter noted. Mrs Wilson advised Members that all Limited Assurance Internal

Audits are being followed-up in-year, to inform this year's Head of Internal Audit Opinion.

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

PM(25)53 Report of the Quality, Safety and Experience Committee

Ms Lewis, QSEC Chair, presented the update report from the meeting held on 13 February 2025, indicating that there were no 'Alert' items. Ms Lewis wished to pay tribute to Ms Raynsford in her capacity as Vice-Chair of QSEC, noting her supportive and consistent presence. She was a compassionate and kind individual, with an exceptional talent for 'cutting through to the heart of the matter'; a role model for nurses and for women in leadership roles.

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

PM(25)54 Report of the Sustainable Resources Committee

Mr Maynard Davies, Sustainable Resources Committee (SRC) Vice-Chair, presented the update report from the meeting on 25 February 2025. He noted that this had been the final meeting of SRC and thanked all of those who had contributed to the Committee during its existence. The two 'Alert' items, on the recurrent savings gap and Directorates escalated to Level 3 had already been discussed. The only remaining issues for Board consideration were the two contract awards within the Procurement Report and the Digital Maternity Cymru Business Case, presented as separate agenda items.

Decision: The Board:

- **RESPONDED** to the items the Committee is alerting them to, **NOTED** the items the Committee is advising them of and **TOOK ASSURANCE** from the items that the Committee is providing assurance on.
- **APPROVED** the award of the All-Wales Pulp Medical Products contract to Vernacare International Ltd., for the period 1 March 2025 to 28 February 2029, 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) and Welsh Government for approval.
- **APPROVED** the award of the external Maintenance Contract for 2 x Combined Heat & Power Units (CHP), one located at PPH, Llanelli and one located at WGH, Haverfordwest, for the period 1 April 2025 to 31 March 2033, 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) and Welsh Government for approval.

- **APPROVED** the Digital Maternity Cymru Business Case and support the funding gap in Year 1 of £48,359 in capital funding and £80,487 in revenue funding.

PM(25)55 Procurement Report

Decision: The Board:

- **APPROVED** the award of the All-Wales Pulp Medical Products contract to Vernacare International Ltd., for the period 1 March 2025 to 28 February 2029, with an option to extend for a further 12 months. This contract will have onwards submission to Velindre NHS Trust (as hosts of NHS Wales Shared Services Partnership).
- **APPROVED** the award of the external Maintenance Contract for 2 x Combined Heat & Power Units (CHP), one located at PPH, Llanelli and one located at WGH, Haverfordwest, for the period 1 April 2025 to 31 March 2033, with an option to extend for a further 12 months. This contract will have onwards submission to Velindre NHS Trust (as hosts of NHS Wales Shared Services Partnership) and Welsh Government for approval.

PM(25)56 Digital Maternity Cymru Business Case

Decision: The Board:

- **APPROVED** the Digital Maternity Cymru System Business Case and **ACCEPTED** that the minor cost pressure for 2025/26 will be absorbed within the digital plan for 2025/2026.
- **AGREED** that, following Board approval of the Business Case, the project team will be appointed to execute the Digital Maternity Cymru System Programme for the 2025/2026 period.
- **TOOK ASSURANCE** that regional discussions with Swansea Bay University Health Board are ongoing to ensure the seamless transition of patients between the organisations, by procuring a regional single instance.

PM(25)57 Report of the Strategic Development and Operational Delivery Committee

Mr Maynard Davies, Strategic Development and Operational Delivery Committee (SDODC) Chair, presented the update report from the meeting on 27 February 2025. As with SRC, this was the final meeting of SDODC, and those who had contributed to the Committee were thanked. The single 'Alert' item, regarding Child Neurodevelopmental waiting lists, had already been discussed as a substantive agenda item. Matters recommended to Board for approval are presented as separate agenda items.

Decision: The Board:

- **APPROVED** the proposed allocation of the Discretionary Capital Programme (DCP) for 2025/26

- **APPROVED** the Programme Business Case (PBC) for Letters of Fire Safety Matters (LoFSM) at Bronglais Hospital (BGH) prior to submission to Welsh Government
- **RESPONDED** to the items the Committee is alerting them to, **NOTED** the items the Committee is advising them of and **TOOK ASSURANCE** from the items that the Committee is providing assurance on

PM(25)58 Discretionary Capital Programme 2025/26

Decision: The Board **APPROVED** the proposed allocation of the Discretionary Capital Programme (DCP) for 2025/26

PM(25)59 Programme Business Case for Letter of Fire Safety Matters at Bronglais Hospital

Decision: The Board:

- **NOTED** the position of this Programme Business Case within the overall HDdUHB Fire Investment Programme
- **SUPPORTED** the submission of the attached Programme Business Case to Welsh Government for Endorsement
- **NOTED** that further reports will be provided to the relevant Committee as this Fire Programme progresses

PM(25)60 Report of the People, Organisational Development and Culture Committee

Ms Lewis, PODCC Vice-Chair, presented the update report from the meeting held on 18 February 2025. There were no 'Alert' or 'Advise' items. Members heard that there had been a verbal report on the findings from the NHS Staff Survey, which would be presented as a written report to the next meeting. Mr Maynard Davies noted that oversight of Research and Innovation will be moving to the new Digital, Data and Innovation Committee, and will also need to be considered by the Regional Joint Committee.

Decision: The Board:

- **APPROVED** the Research and Innovation Strategy 2025-2030
- **TOOK ASSURANCE** from the items that the Committee is providing assurance on

PM(25)61 Research and Innovation Strategic Plan

Mr Henwood presented the Research and Innovation Strategic Plan, suggesting that the Board recognise the work undertaken and progress seen in this area, which he felt it was important to celebrate. In the past four years, the number of staff working in research and innovation has doubled; it has a higher profile, with research facilities in all three counties; there are more clinical researchers than ever before; the TriTech Institute has been established and developed; there are mature partnerships with local universities; research is being undertaken in women's health, respiratory disease, orthopaedics, stroke, cardiovascular disease and ophthalmology. A very considered and significant exercise

has been undertaken to develop a new Strategic Plan, the process around which is described in the report. This has been supported by the Research and Innovation Sub-Committee, Executive Team and PODCC, all of whose feedback has been incorporated into the version presented today. The visions and aims are outlined within the Plan; to deliver high quality and impactful research and innovation, which improves services and health outcomes for communities, patients, and staff. The Plan is intended to be dynamic as opposed to prescriptive. A communications and engagement plan will be developed with Ms Hughes Moakes and her team. Mr Henwood wished to thank in particular Professor Leighton Phillips and the Research and Innovation team for their work, indicating that the influence and impact of a strong Research and Innovation Directorate should not be underestimated.

Mrs Marks agreed that the report and the achievements it describes should be celebrated. Dr Gjini welcomed the opportunity to embed Public Health workstreams into the Plan. Commending the report, Dr Wooding requested that consideration be given to how the Board might hear more about this important area. **JW**

Decision: The Board **APPROVED** the Research and Innovation Strategic Plan 2025-2030.

PM(25)62 Report of the Health and Safety Committee

Ms Murphy, Health and Safety Committee (HSC) Chair, presented the update report from the meeting on 4 March 2025, advising that there were no 'Alert' items and three 'Advise' items. Board approval of the Committee's revised Terms of Reference was sought. Cllr. Evans thanked the HSC Chair for taking forward the actions highlighted in the Health and Safety Internal Audit.

Decision: The Board:

- **APPROVED** the HSC 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)63 Report of the Charitable Funds Committee

Ms Raynsford, Charitable Funds Committee (CFC) Chair, gave a verbal update from the meeting held on 18 March 2024. There was only one 'Advise' item, which is the challenging external financial environment, as raised by the Charities' investment partners. This is being monitored carefully and scrutinised by the CFC and will be reported further to the May 2025 Public Board meeting. There are requests due for consideration at the Corporate Trustee session which follows today's Public Board meeting. Ms Raynsford wished to take this opportunity to thank the fundraisers and public who have contributed to the Hywel Dda Health Charities, the Hywel Dda Health Charities team and Ms Daniel as Executive Lead of CFC.

PM(25)64 Regional Joint Committee Update

Introducing the Regional Joint Committee (RJC) Update report, Dr Wooding explained that this aims to provide Board with assurance around the governance arrangements for this Committee. Members heard that the report also includes an update from the inaugural meeting on 15 January 2025. Consideration is being given to a programme of work, which is likely to include population health and the health economy of the region. He would wish that this assurance Committee is a space for innovative thinking.

Decision: Swansea Bay UHB and Hywel Dda UHB Public Boards **ACKNOWLEDGED** the report of the establishment and inaugural meeting of the Regional Joint Committee held on 15 January 2025, recognising that the respective Sovereign Boards **APPROVED** the terms of reference for the Regional Joint Committee at their meetings held on 30 January 2025.

Decision: The Board **TOOK ASSURANCE** from the governance arrangements to be implemented to establish the Hywel Dda and Swansea Bay University Health Boards Regional Joint Committee from 7 May 2025.

PM(25)65 Committee Update Reports

Mrs Wilson presented the Committee Update Reports, highlighting the reports included and noting that the 'Advise' item raised by MHLC has already been discussed under a substantive agenda item. The Board is requested to approve the Ethics Panel and Clinical Reference Group Terms of Reference.

Decision: The Board:

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

PM(25)66 Joint Committees and Collaboratives

Decision: The Board **RECEIVED** the updates in respect of recent JCC and NWSSPC meetings.

PM(25)67 Statutory Partnerships Update

Ms Paterson advised that the RPB continues to examine its working to ensure effectiveness, with discussions taking place with the Chairs and Chief Executives of all partner organisations. Work also continues, via the Public Services Boards (PSBs), on the local wellbeing plans.

Decision: The Board:

- **TOOK ASSURANCE** that the Health Board is working effectively with Statutory Partners in order to meet the required obligations as laid out by the Well-being of Future Generations (Wales) Act 2015 and the Social Services and Wellbeing (Wales) Act 2014
- **NOTED** the actions which have been completed to date

PM(25)68 Any Other Business

No other business was reported.

PM(25)69 Board Annual Workplan

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

PM(25)70 Date and Time of Next Meeting

9:30am, Thursday, 29 May 2025