GIG CYMRU NHS WALES | Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

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

Date of Meeting:	**09:30, Thursday 26 March 2026**
Venue:	**Ceredigion County Council Chambers, Penmorfa, Aberaeron, Ceredigion SA46 0PA**

Present:	Dr Neil Wooding, Chair, Hywel Dda University Health Board Mrs Eleanor Marks, Vice-Chair, Hywel Dda University Health Board (VC) Mr Maynard Davies, Independent Member (Information Technology) Cllr. Rhodri Evans, Independent Member (Local Authority) Ms Sarah Harraway, Independent Member (Community) Mr Michael Imperato, Independent Member (Legal) Ms Ann Murphy, Independent Member (Trade Union) Mrs Chantal Patel, Independent Member (University) (part) Mr Neil Prior, Independent Member (Community) Mr Winston Weir, Independent Member (Finance) (VC) Professor Philip Kloer, Chief Executive Mrs Lisa Gostling, Deputy Chief Executive and Executive Director of Workforce and Organisational Development Mr Andrew Carruthers, Chief Operating Officer Ms Sharon Daniel, Executive Director of Nursing, Quality and Patient Experience Mr Lee Davies, Executive Director of Strategy and Planning Dr Ardiana Gjini, Executive Director of Public Health Mr Mark Henwood, Executive Medical Director Mr James Severs, Executive Director of Allied Health Professions and Health Science Mr Huw Thomas, Executive Director of Finance
In Attendance:	Ms Alwena Hughes Moakes, Communications and Engagement Director Mrs Joanne Wilson, Director of Corporate Governance/Board Secretary Mr Michael Gray, Director of Social Services and Housing, Pembrokeshire County Council Ms Mwape Burke, Aspiring Board Member (VC) Dr Warren Lloyd, Associate Medical Director, MHLD (VC) (part) Mr Richard Williams, Senior Nurse MHLD (VC) (part) Dr Bruce Bolam, Deputy Director of Public Health (part) Professor Sue Denman, Peninsula Working Group (part) Mr Richard Hayward, Peninsula Working Group (part) Ms Sarah Foster, City Councillor, St Davids City Council (part) Professor Chris Hopkins, Head, TriTech Institute (VC) (part) Ms Clare Moorcroft, Committee Services Officer (Minutes)

Minutes Ref.	Item	Action
PM(26)53	**Welcome and Apologies**	
	Dr Neil Wooding, Chair of Hywel Dda University Health Board, welcomed everyone to the Public Board meeting.	

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', intended to ensure that Board decision-making is consistent and robust:

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 Iwan Thomas, Independent Member (Third Sector)
- Dr Jonathan Arthur, Health Professionals Forum Chair
- Mr Tegryn Jones, Stakeholder Reference Group Chair
- Ms Donna Coleman, Llais West Wales

PM(26)54 Declaration of Interests

Noting that there are a number of references to Ceredigion County Council, Cllr. Rhodri Evans declared an interest, given his role with this organisation. Similarly, Mr Neil Prior declared an interest, given his role with Pembrokeshire County Council. He also declared a specific interest in item PM(26)67, due to his involvement in the Peninsula Working Group (including previously as Chair). He has since stood down from the Group. Whilst he would appreciate the opportunity to contribute to discussions, he would not take part in decision-making for this item. Mrs Chantal Patel declared as an interest her employment with Swansea University; both generally, and more specifically in relation to item PM(26)66.

PM(26)55 Minutes of the Public Meeting held on 29 January 2026

<u>**Decision**</u>**: RESOLVED** – that the minutes of the meeting held on 29 January 2026 be approved as a correct record.

PM(26)56 Matters Arising/Table of Actions from Meeting held on 29 January 2026

An update was provided on the Table of Actions from the Public Board meeting held on 29 January 2026. Confirmation was received that outstanding actions had been progressed. There were no matters arising.

PM(26)57 Minutes of the Corporate Trustee Meeting held on 29 January 2026

<u>**Decision**</u>**: RESOLVED** – that the minutes of the Corporate Trustee meeting held on 29 January 2026 be approved as a correct record.

PM(26)58 Report of the Chair

Presenting his report on relevant matters undertaken since the previous Board meeting, Dr Wooding highlighted the inclusion (as an appendix) of a copy of his objectives as agreed with the

Cabinet Secretary for Health and Social Care. He felt that the new process for evaluating performance will provide a more balanced appraisal and noted that the 360° feedback approach will be incorporated into the Independent Members' appraisal process.

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

PM(26)59 **Report of the Chief Executive**

Professor Philip Kloer introduced his report on relevant matters undertaken since the previous Board meeting, noting that this includes various important matters and a number of agreements requiring approval. He drew Members' attention to the sections providing updates on the Clinical Services Plan (CSP), which had been discussed extensively during the extraordinary Board meeting in February 2026, and on the 'A Healthier Mid and West Wales' (AHMWW) Strategy, discussed at the January 2026 Board meeting. There have been minor amendments to the latter, which are detailed in the report. Professor Kloer highlighted the Welsh Government scrutiny session on the Health Board's Annual Plan. He also noted positive news around the decision to de-escalate the organisation for Cancer performance in relation to the Single Cancer Pathway (SCP) from Level 3 to Level 1, and paid tribute to the teams involved in achieving this important milestone. Performance in this area had improved from a position of mid 40% to 63%+. It was noted that the national target performance is 75%, indicating that there is more work to be undertaken.

Professor Kloer reported that Welsh Government has issued new guidance around accountability arrangements; which will be shared with Members and progressed through the governance structure via the Audit and Risk Assurance Committee. This will result in changes to the way in which Welsh Government operates with health boards. Members heard that the Board Assurance Framework will be presented to the Board in July 2026, following approval of the refreshed AHMWW Strategy. The update in regard to the Centre for Social Innovation and Social Model for Health and Wellbeing links to the later agenda item Local Community Action for Health and Wellbeing. HDdUHB has been selected as a pilot site for the new Electronic Staff Record (ESR) ESR2 system. this will involve a significant workstream led by Mrs Lisa Gostling in collaboration with Mr Huw Thomas. The existing ESR system is scheduled to be phased out by 2030. Changes to the Direct Payment arrangements will have a significant impact, for which preparation work needs to be undertaken. These have been, until now, processed via Local Authorities rather than health boards. Finally, the report details various collaborative agreements and a Memorandum of Understanding all requiring approval, which emphasise the importance of partnership working.

Noting the need for Board oversight of information around CSP implementation, Mr Michael Imperato enquired regarding the planned timescale for this. Mr Lee Davies acknowledged and

recognised this requirement. He indicated that there are two aspects involved: planning for implementation in the eight services where options were agreed; and, for Stroke, undertaking work required to progress a new, merged option. He advised that the Options Development Group had been reconvened to provide the scrutiny required for the latter. It is intended to bring together all the relevant information and documentation in anticipation of engagement processes during June 2026. An update, with further detail around Stroke services, will be provided at the May 2026 Public Board meeting. Dr Wooding requested that this also include a general, 'line of sight' progress update on the CSP. **LD**

Referencing Cancer performance, Dr Wooding enquired regarding the overall trend and trajectory. Mr Andrew Carruthers advised that, as discussed previously, the organisation has taken steps to reduce the backlog and improve diagnostic processes. In January 2026, as predicted, this had impacted negatively on SCP performance resulting in a drop to 61%. He would, however, anticipate that performance will return to the mid 60% level by the next Board meeting. Members were assured that the actions taken to strengthen processes are resulting in quicker diagnosis, with Urology being one of the highest volume diagnostic pathways, as discussed in relation to CSP in February 2026.

Noting the Public Health Wales Test and Post Incident, Mrs Chantal Patel requested assurance that the affected individuals have been identified. She enquired particularly around any children affected, and any individuals who were children at the time of testing and were now adults. Assurance was also requested around whether all possible measures have been put in place to avoid a recurrence of this incident, and that there has been adequate communication with the general public. Members were informed that the operational and confidential aspects of this topic would be discussed during the In-Committee session. Dr Ardiana Gjini emphasised that this is a service provided by Public Health Wales (PHW). Following identification of the incident, PHW issued public communications on 24 February 2025 around those elements which do not meet the required standards of service provision. The incident has affected individuals across Wales, including in HDdUHB.

Health boards have been informed of the first cohort of affected individuals, those who are still minors (under 18). This confidential information is being managed via the PHW Incident Management Group. Health boards are validating those processes with which PHW has requested assistance. Mrs Joanne Wilson clarified that, whilst detailed discussion is restricted to In-Committee at this stage, as PHW and health boards are still working through the issue; it is recognised that this topic will need to be discussed in the public domain at the earliest opportunity. Dr Wooding suggested that the outcome of this incident must include learning, and how the service quality can be improved. He requested that the report to Public Board include consideration of this aspect. **AG**
Whilst acknowledging this comment, Dr Gjini emphasised that the

incident is being managed by PHW, and that health boards are not members of the Incident Management Group.

Cllr. Rhodri Evans enquired whether the Health Board is ready operationally for the changes to Direct Payments which will need to be in place from 1 April 2026. In response, Mr Carruthers indicated that one of the challenges is that the relevant guidance has not yet been issued, meaning that health boards are having to make preparations in its absence. However, HDdUHB has been exploring the implications for a number of months with its Local Authority partners. Whilst there had been consideration of possible partnership working, other solutions are now looking more likely. These may involve external providers, given that there are already companies providing this service. It is anticipated that numbers will be relatively low to begin with. Whilst there are 68 eligible HDdUHB patients, the number from 1 April is probably in the region of five. Processes will be evaluated and reviewed on an ongoing basis.

Mr Imperato noted that the Consultation Report references new Welsh Government strategies in relation to Dementia and Speech, Language and Communication. Observing that these will no doubt overlap with the organisation's Annual Plan, he enquired whether any actions are required in response. Professor Kloer indicated that the relevant consultations remain open until April 2026, and that the financial position is, as yet, unconfirmed. These are clearly services which are key to the Health Board and, as such, the consultation findings are likely to impact on its Plan. However, he did not envisage that the organisation's priorities will differ significantly from the likely outcome of these consultations. In more general terms, Professor Kloer emphasised that – this being an election year – the organisation will need to be adaptable and flexible, in order to respond to potential changes. Mr James Severs indicated that he is also the Senior Responsible Officer for the West Wales Regional Partnership Board Dementia Strategy. This Strategy has been issued widely for consultation, including to health boards. He confirmed that it has been factored into HDdUHB's planning in relation to Dementia. The consultation in respect of Speech and Language is being considered through the Clinical Care Group (CCG) structure currently.

With regard to the Welsh Government scrutiny session, Mr Winston Weir enquired whether anything was raised of which the Board should be aware. Also, whilst recognising the importance of the ESR system, whether the Health Board has the capacity and capability to take on the role of a pilot site, and whether Welsh Government will be providing any support. Professor Kloer felt that the scrutiny session had been very constructive, whilst recognising that the review undertaken represented 'a point in time' and that further work had taken place since. Welsh Government had emphasised the Health Board's statutory duty to produce a plan to achieve financial breakeven. Also, that health boards should not be forecasting a deterioration in financial or performance position, as this would be unsupportable. There had,

however, been a recognition of the challenging environment in which HDdUHB is operating, of the progress it has made during the past two years and its improved understanding of its position. Dr Wooding noted that this matter will also be discussed in more detail as part of the next agenda item.

In response to the query around ESR2, Mrs Lisa Gostling advised that two posts have been awarded as part of the project, to support implementation/roll-out. The Digital Director is undertaking an assessment of resource requirements. In terms of technical expertise, this will be provided via the Workforce team, and there will also be a team recruited to NHS Wales Shared Services Partnership (NWSSP). Members were assured that the skills required to deliver this pilot will be mapped to ensure coverage.

Decision: The Board:

- **APPROVED** the Collaboration Agreement between Ceredigion County Council and Hywel Dda University Local Health Board for Speech and Language Flying Start services for the period 1 April 2024 to 31 March 2027
- **APPROVED** the Collaboration Agreement between Ceredigion County Council and Hywel Dda University Local Health Board for Health Visiting Flying Start services for the period 1 April 2024 to 31 March 2027
- **APPROVED** the Collaboration Agreement between Pembrokeshire County Council and Hywel Dda University Local Health Board for Flying Start services for the initial period of 1 April 2025 to 31 March 2026
- **APPROVED** the Memorandum of Understanding between Ceredigion County Council and Hywel Dda University Local Health Board setting out their roles for the Carers Information, Support and Outreach
- **ENDORSED** the Register of Sealings since the previous report on 29 January 2026
- **NOTED** the status report for Consultation Documents received/responded to
- **NOTED** Executive Team discussions

PM(26)60 **Annual Plan 2026/27**

Presenting the report, Mr Lee Davies explained that he would provide an overview, with Mr Huw Thomas to cover the financial aspect. Members would be familiar with the requirement for health boards to submit an Integrated Medium Term Plan (IMTP). HDdUHB had submitted an Accountable Officer letter earlier in March, indicating its intention to submit instead an Annual Plan. This matter has been discussed on a number of occasions, as this is a breach of both the Health Board’s statutory duties relating to planning and finance. The Plan itself has been discussed at the February 2026 Board Seminar. In preparing IMTPs or Annual Plans, health boards are required to respond to a number of expectations, including around performance and finances. The report provides an overview of the key aspects of the Plan.

Whilst the Plan for 2025/26 was recognised as extremely challenging, and was deemed unacceptable by Welsh Government, it was aimed at providing balanced improvement across all the domains against which the Health Board is judged, and specifically against all the Targeted Intervention deescalation criteria. Mr Lee Davies would suggest that it had been successful in this aim. The Plan for 2026/27 is even more challenging, involving a number of significant risks. Specific objectives include the shift towards a value based system, with a particular focus on productivity and efficiency, an aspiration to make progress in the AHMWW Strategy and consolidate progress made during the past two years. In performance, the Health Board intends to prioritise the Urgent and Emergency Care (UEC) system, as discussed at the January 2026 Board meeting. It is not assuming any additional funding from Welsh Government in this regard. However, progressing this work is likely to lead to deterioration against certain key performance measures, for example Referral to Treatment (RTT). The intention following this meeting is to submit the Plan to Welsh Government, subject to any minor amendments required. In doing so, it is anticipated that the Plan will be deemed unacceptable and unapprovable by Welsh Government; however, the Health Board hopes that it can be seen was an honest, credible and thorough representation. Mr Lee Davies wished to end by thanking those involved in its preparation, particularly Mr Shaun Ayres.

Providing financial context, Mr Huw Thomas referenced a recent report by the Institute for Fiscal Studies, on the economic and fiscal outlook in Wales for the foreseeable future. It is important to be aware that public bodies will be facing, in the medium-term, the tightest real-terms settlement in devolved history. This means that the trajectory for NHS spending growth is below what is required to maintain services and improve access gaps. Clearly, this constrains the Health Board's ambitions, and it is recognised that the financial position proposed in the Annual Plan will be unacceptable to both Welsh Government and to the Board. Even if the forecast position is delivered, the financial deficit by the end of the year would be £41m. The deterioration from this year's outturn of £22.1m is due to two key elements. Firstly, this year the Health Board had a central accounting gain, amounting to £6m. This was a one-off gain, which will not be repeated. The second financial pressure impacting on the forecast is the Welsh Risk Pool liability of approximately £13m. The latter is a volatile liability, which is not unique to HDdUHB, or to Wales; it relates to the increasing number of clinical negligence cases being settled.

The Plan sets out the recurrent savings challenge, which is even more significant than previous years. The organisation is not yet in the same position in terms of savings plans as it was last year. At this point in time, there is a £30m gap, meaning that the Health Board's outturn next year could be a £50m deficit or, in the worst case, £90m. Mr Huw Thomas felt that the likely position was in the £60m's, recognising that this will require a Board response.

Members will note in the Plan, as has been alluded to, a shift towards being a value-led organisation and value-managed system. At the heart of this change is a move to measuring patient outcomes, by means of increased use of Patient Reported Outcome Measures (PROMs), in which the Health Board is rapidly advancing. 50,000 patients have been 'onboarded' onto the PROMs capture system, with approximately 200,000 PROMs measures collected. This will provide data of extremely high value. The organisation is also embarking on a social and technical allocation of resources process, to examine clinical pathways in order to determine best value. The immediate task, however, is to demonstrate that the Health Board can close the financial gap and deliver a credible three-year trajectory of delivery. The assurance around this is not yet in place. It would be doing a disservice to the Board to present a savings-only Plan, without recognising the need to also discuss and determine the type of health system the organisation wants to build for the future. The challenge comes when attempting to balance short-term choices with the long-term needs, to ensure that the former does not conflict with the latter.

Dr Wooding suggested that one of the challenges in not being able to deliver an IMTP, is that the organisation is not able to plan the future consequences of the current year. Whilst this can be done informally, it is not within the structure of an IMTP, as would be optimal. This presents a real issue for the Health Board in terms of effective planning. He wished to emphasise, however, that this is a 'system issue', rather than a 'people issue'.

Mrs Marks thanked all of those involved in preparing the Plan for their work. The progress made and hard work to achieve this should be recognised. She suggested, however, that the gap between the stated achievements and the service received by the public is significant. No matter what is stated in the Plan, the Health Board will be judged on the service that people receive and their personal experience. Mrs Marks wished to enquire specifically who takes overall accountability for delivery against all the stated aims in the Plan, and where this risk is managed. Also, where in the Plan is the shift towards prevention, Community by Design (CbD) and the Social Model for Health and Wellbeing (SMfHW). Whilst recognising that the organisation receives a great deal of funding, and that this must be prioritised on those areas delivering best value; financial constraints severely impact on its ability to take forward the plans it would wish to. Whilst adding his thanks, and welcoming the level of detail provided, Mr Weir queried in particular capacity. This relates firstly to the physical capacity required to cope with patient demand for services, and how the Hospital@Home initiative will be expanded to reduce Pathway of Care Delays. Secondly, to theatre capacity and whether consideration has been given to increasing this via outsourcing.

Professor Kloer commended the team for bringing together this year's Plan, the development of which has been extremely

challenging. He explained that it seeks to provide balance in addressing all of the Health Board's Strategic Objectives, and has involved the entire Executive Team and wider organisation. Responding to Mrs Marks' queries, he indicated that he, as Chief Executive, takes overall accountability for delivery. However, there is clearly a need for a connection and ownership across the organisation. Members heard that changes are being made to streamline Executive arrangements, and other structural and governance changes are being instituted around the CCGs. These changes should provide improvements in the connection he has referenced. In terms of the shift to community-based delivery, Professor Kloer would maintain that the Plan refers in several places to CbD. He emphasised that this must not be viewed as a separate entity; it is a major part of the overall Health Board Strategy, as is work in relation to the SMfHW and 20four7.

Turning to Mr Weir's queries, Professor Kloer suggested that there are various elements involved including the capacity to undertake and drive forward the ambitions outlined in the Plan. The Executive Team has expressed concerns around this, and is considering the programme management implications. There are also, as Mr Weir notes, implications in terms of capacity in hospital and community settings. As has been discussed previously, the Health Board is seeking to make progress in and prioritise actions around streaming hubs and seven-day working, as a route to improving the UEC system. The Plan also contains information around how the organisation intends to improve theatre capacity and productivity. Mr Carruthers highlighted that, historically, the Health Board has been heavily reliant on Welsh Government funding external activity to increase theatre capacity. There have been long-standing issues around theatre staffing fragilities. Whilst the organisation has plans to recruit and stabilise its own workforce, there would still be a sizeable capacity gap. This only serves to emphasise the importance of progressing measures to improve efficiency, productivity and address Getting It Right First Time (GIRFT) recommendations.

With regard to CbD and investment in the community, Mr Huw Thomas suggested that Welsh Government has effectively made this shift on the Health Board's behalf, by awarding an uplift on the allocation into Primary Care of 5.8%. This, compared with the 1.1% (plus pay inflation) uplift being applied elsewhere. However, it is recognised that the organisation must seek to maximise this financial benefit. There also needs to be due consideration of how the Health Board maintains its performance trajectories in Planned Care and urgent Cancer care. In the short-term, there appear to be few opportunities for allocating funds differently; with the possible exception of considering alternatives to the variable pay spend, which currently sits at approximately £5m per month. Dr Gjini highlighted that the Health Board's second Strategic Objective 2 'Healthier Communities' focuses on prevention and the SMfHW. A later agenda item will cover this in more detail. The 'STAR' approach (social and technical allocation of resources) will be applied in various ways, including alignment with the 20four7

model. Whilst all of this is referenced in the Plan, more detailed information will follow during its implementation.

Dr Wooding suspected that the shift into community-based service delivery will not be made until and unless there is a shift in resource. He also suspected that the Primary Care Clusters will be key in taking this forward. He requested that a detailed overview and update on Clusters be prepared for the next Board meeting in May 2026. Mr Carruthers agreed that an update on Clusters should be provided to the Board; this should both reflect on their achievements and their future role, particularly in the value-based work. In terms of resources, he suggested that there should be a focus on better utilisation of the basic funding allocation, rather than on additional funding allocations. **AC**

Whilst somewhat reassured regarding his main concern, which was around productivity, Mr Imperato requested confirmation that this will remain a 'golden thread' across both the Plan and the forthcoming year. Professor Kloer confirmed this, whilst indicating that the challenge will be in achieving and monitoring. He suggested that it would be helpful if Independent Members (IMs) could prioritise this in their scrutiny. Cllr. Evans welcomed what is an extremely honest and transparent Plan. In terms of Planned Care, for example, it identifies a residual capacity gap across several specialties, with patients waiting over 104 weeks. It is important to raise and recognise this, for patient awareness. Returning to theatre capacity, he noted the following statement on page 22:

> The Glangwili theatre estate remains a significant operational constraint, with the fire evacuation lift programme scheduled for 2027 and a minimum eighteen-month period of reduced capacity.

Cllr. Evans felt that this was too 'open-ended' and suggested that the maximum period should be indicated.

Whilst welcoming references to Digital throughout the Plan, Mr Maynard Davies emphasised that implementing change, including initiatives involving Digital, requires investment. The significant challenges around finance have already been mentioned. He expressed concern around the Health Board's ability to improve services for its patients against this financial backdrop. Moving on to organisational maturity, Mr Maynard Davies noted that the CCG structure has now been in place for a year; however, Phase 2 of the Organisational Change Process (OCP) has not yet concluded. He enquired regarding the level of confidence that CCGs will be in a position to deliver on the Plan.

In regard to theatre capacity, it was also noted that there were instances of day surgery units being closed, which was indicative of the Health Board's aging estate. Given this, Mr Maynard Davies requested assurance that delivery of increased capacity will be possible. Finally, he was aware that funding to support Diagnostic

stabilisation is due to end, and requested clarification around the implications of this. Dr Wooding suggested that issues around theatre capacity sit more within the operational risk management space, noting that the Plan involves a considerable number of risks, some of which are unpredictable.

Mr Prior recognised that there is much still to do. Echoing the comments of others, he noted numerous references to the SMfHW, whilst suggesting that these feel somewhat retrospective and are not being substantiated by delivery. He also felt that there is a need for focus on communications and engagement, to ensure that there is adequate control of the narrative and messaging. Finally, it was suggested that the Health Board look beyond the traditional routes of partnership working, and consider those which can genuinely add value. Dr Wooding was of the opinion that the SMfHW is still in the conceptual space to some extent, recognising the challenges involved in taking forward its delivery.

Whilst pleased to see mention of evaluation, Ms Sarah Harraway queried whether what is suggested is, in fact, a measure of metrics rather than actual evaluation. She suggested that, in order to truly achieve and deliver a system shift, a supporting evaluation plan is required. Echoing an earlier comment, Mr Weir noted that the loss of £1.6m funding to support Radiology (diagnostics) creates a dilemma for the Health Board. A decision is required around whether core funding is diverted to cover this shortfall, which would allow the organisation to maintain its performance in early diagnosis of Cancer. Not doing so would result in a deterioration in performance and lead to delays in diagnosis. He requested clarification around the Health Board's plans in this regard. Dr Wooding agreed that this is a fundamental issue; productivity will decline following a loss of funding. A decision is required on the steps needed to maintain performance.

Mr Huw Thomas wished to clarify that the Plan does commit to recurrent funding in Radiology, albeit to offset current growth, rather than future activity. He noted a number of tensions identified within Members' comments and queries. In terms of investment, the Plan does not include any in relation to Digital. Any innovation in this area would require additional funding. There may be alternative routes, solutions or partnerships to achieving this; however, these would need to involve cash or productivity returns. Achieving system change whilst still operating is clearly challenging. The organisation will need to consider how it supports operational teams in managing change. Finally, in regard to evaluation, Mr Huw Thomas suggested that the Health Board needs to explore how it can garner the valuable learning and benefits from its successful Enabling Quality Improvement in Practice (EQIiP) programme.

With reference to Members' queries around operating theatres, Radiology and CCGs, Mr Carruthers advised that theatres are referenced later, in regard to capital schemes. The organisation is

considering the options which provide the optimal solution and ensure best use of theatre space. In terms of Radiology, the national funding allocation was utilised mainly to reduce routine waits. Core Radiology capacity is generally prioritised for urgent, emergency and Cancer cases. He confirmed that the performance position would deteriorate, whilst assuring Members that potential opportunities are being explored. With regard to CCGs, Mr Carruthers urged caution in correlating delivery of the Plan with CCG maturity. He emphasised that there is a definite maturity and enthusiasm within CCGs for greater ownership and accountability. They have some concerns around the command and control processes; however, they understand why these need to be in place. Whilst agreeing that consideration needs to be given to how resources are used differently, Mr Carruthers highlighted that there are a many demands placed on the CCGs, and the organisation needs to consider how best to support them.

Dr Wooding would not disagree with these assertions, and recognised the tensions between command and control processes and having ownership. He suggested that the Health Board needs to create an environment of purposeful empowerment, generating tangible benefits to the organisation. Returning to the potential deficit figures mentioned earlier, Mrs Marks highlighted that a £54m or £90m outturn would put the organisation back by two years. She enquired regarding the best approach to managing the Health Board's relationship with Welsh Government, given that both parties want what is best for the population they serve. In response to an earlier comment around communications, Ms Alwena Hughes Moakes suggested that there are multiple opportunities to communicate and engage with the public, particularly around the Strategy. She agreed, however, with Mrs Marks that public perception of services is shaped by their own individual experience.

With regard to the tension between delivery and resource, Dr Gjini highlighted that the NHS Constitution requires delivery of a comprehensive service. Prevention of ill health is both central to achieving this, and provides a financial return and benefit, as evidenced by experience elsewhere, such as Singapore. Welsh Government has made a commitment to reflecting this in legislation. Mr Lee Davies wished to remind Members that the specifics within the Plan, and scrutiny of their delivery, is assigned to specific Board level Committees. In response to Mrs Marks query around the relationship with Welsh Government, Mr Huw Thomas identified that there is a clear issue around cash affordability. Whilst Welsh Government may, theoretically, cover the cash consequences of the Health Board's financial outturn; the organisation must take steps to consider its cash management and cash strategy.

Dr Wooding agreed that a contingency plan must be developed, adding that it would be challenging to achieve even the best forecast outturn. Whilst he felt that the Health Board's Plan is well balanced, it still requires Welsh Government to approve a position

where they will have to cover a shortfall. He requested that the Executive Team consider those areas over which the organisation has control, and develop an action plan to reduce the forecast deficit of £41m to match this year's outturn of £22.1m. **PK**

Professor Kloer reiterated the Board's thanks to those involved in preparing the Annual Plan, which has been a significant and challenging task. This is a Plan which describes both delivering care in the 'here and now' and a focus on the future. Without the two cost drivers mentioned by Mr Huw Thomas, financially, it would have been a 'standstill' Plan. Professor Kloer wished to recognise that HDdUHB has delivered one of the most extensive savings plans in Wales this year. Next year's Plan requires a similar commitment. He emphasised that, in addition to the scrutiny session, the Health Board has worked closely with Welsh Government colleagues during development of the Plan. The Plan sets out actions to change and prioritise Cancer Care and Urgent and Emergency Care.

Whilst there is still more to do, Professor Kloer suggested that the organisation is in a better position in terms of data clarity; which will facilitate flexibility in responding to potential changes in political priorities, given that this is an election year. The Health Board has also made significant progress in work relating to productivity and value, and will need to continue to do so. However, this alone would not be sufficient to meet the challenge set by Dr Wooding. Value-based, productivity and efficiency savings will not close the financial gap. He would, nevertheless, explore the possibilities with the Executive Team. Noting that Ms Harraway's query around evaluation had not been entirely addressed, Professor Kloer suggested that this be considered further outside the meeting. He suggested that it may require specialist input and advice from university partners, and requested that Mr Lee Davies bring this back to the next meeting. **LD**

Dr Wooding agreed that the Plan was well-constructed, and that the focus should not be solely on delivery, but also on ambition. He reiterated, however, that it fundamentally requests additional resource, and reminded Members that HDdUHB is not the only public body requiring funding. The Health Board needs to improve its management of this, and consider opportunities such as the variable pay spend mentioned earlier. All of this, however, should take nothing away from the quality of the Plan produced, of which the organisation should be proud.

Decision: The Board:

- **RECOGNISED** that the financial plan for 2026/27 presents a planned deficit of £41.0m, or £27.9m excluding the additional impact of Welsh Risk Pool, which does not meet the financial trajectory expectations set out in the Welsh Government's February 2026 Escalation Framework, nor does it deliver against the Health Board's statutory breakeven duty; and that this will consequently result in a qualified regularity opinion.

- **AUTHORISED** that the Accountable Officer writes to Welsh Government 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 onward delegation and allocation of 2026/27 financial budgets based on Year 1 of the financial plan, inclusive of Long Term Agreements (LTAs) – Commissioning £207,719,882 (Excludes PHW) and for Income £25,064,098 (Excludes PHW)
- **NOTED** the recent dialogue from Welsh Government that the financial deficit is unlikely to be accountable or supportable.
- **REQUESTED** that the evaluation framework, together with further supporting plan and information be presented to the next Public Board meeting.

PM(26)61 **Financial Report**

Introducing the Financial Report, Mr Huw Thomas indicated that the forecast deficit is, as already stated, £22.1m. This represents an improvement on last year's outturn, and meets the revised target control total set by Welsh Government. Whilst this position remains achievable, Mr Huw Thomas felt that there are a number of important issues requiring further reflection. These include the financial implications of: medical pay; rostering; variable pay, oncology drug price increases and increased Joint Commissioning Committee (JCC) activity. Members heard that the report includes an additional section and appendix relating to RTT patient numbers and estimated costs, which will be incorporated into financial reporting going forward.

Mr Imperato requested clarification around the non-recurrent savings review, and whether this is intended as a way of tracking finances. In response, Members heard that there were a number of reasons behind this proposal, including underspends and accountancy gains. Whilst these are not new issues, it is felt that there should be consideration of how they are reflected going forward. Cllr. Evans noted that the conflict in the Middle East will result in significant cost pressures, which should be publicly-recognised. He enquired whether there is yet a sense of the level of exposure in this regard. Mr Huw Thomas advised that the most significant impact is on energy prices; however, the majority of the Health Board's energy is purchased on the forward markets, limiting this exposure. The amount remaining would probably involve a financial liability of £200-300k. A more pressing response is required in relation to ensuring Health Board vehicles are fuelled. Helium supply is also an important consideration, given its use in MRI (Magnetic Resonance Imaging) scanners.

The latter is more likely to be a price issue than a supply issue, as the healthcare sector will probably be prioritised. All of these will contribute to a general inflationary uplift, in terms of non-pay inflation, given that everything is delivered to the Health Board in some way.

Welcoming the report's clarity, Mr Weir wished to focus firstly on the non-recurrent savings delivery. He noted mention of 'rebuttable proposal presumption', and assumed this referred to removal of items not spent and treating them as savings. Whilst arguably correct from a strategic perspective, he wondered whether, operationally and tactically, CCGs might have a different view. Also, whether taking this approach transfers the risk to CCGs and how it is proposed to manage and mitigate this. Secondly, Mr Weir referenced a risk identified in the later Strategy and Planning Committee (SPC) Update Report around capital expenditure and potential underspend against the Capital Resource Limit. He enquired whether there is a sense of the likely trajectory and outcome. Finally, with regard to information around RTT and the cost of significantly reducing waiting lists, Mr Weir queried whether other health boards have undertaken similar analyses. If so, how HDdUHB compares, or whether costs are dependent on the type of specialty involved; given that a significant proportion relates to Orthopaedic waiting lists.

With regard to the first query, Mr Huw Thomas advised that the process had begun with the presumption that savings would transpire and repeat again next year. However, this is a presumption which is rebuttable on the part of budget managers. The element which has not been rebutted is approximately £9m, split half-and-half between recurrent and non-recurrent. However, this position is not ideal in terms of planning, which Mr Huw Thomas is keen to remediate. This is expected to be one of the most challenging years in terms of capital since the COVID-19 pandemic. The organisation does not yet have a sense of the likely position at year-end. In respect of the final query, Mr Huw Thomas was not aware of any other health boards analysing the costs involved in addressing RTT. He is keen to test this locally in the first instance, and may seek comparisons at a later point.

In terms of those areas which have over-identified savings, Mr Weir noted that the highest burden is on Corporate teams as opposed to CCGs. He enquired whether there is a risk of restricting future strategic capacity in Corporate functions limiting the amount of support that can be provided to CCGs and their ability to continue to deliver all expectations placed on corporate teams with an ever decreasing resource. Both Professor Kloer and Mr Huw Thomas acknowledged that Corporate savings are disproportionately represented in the totality. It was recognised that this does result in these teams being stretched, which could impact on the support they are able to provide to operational teams. It also makes allocating resources to strategic priorities, such as CbD, Organisational Development and Mental Health

more challenging. However, the Health Board has tried to apply a balanced approach.

Bringing discussions to a close, Dr Wooding acknowledged the significant work undertaken to reach this point, suggesting that this discipline needs to be maintained.

Decision: The Board:

- **RECOGNISED** that the Health Board's forecast deficit is on track to deliver the revised target control total set by Welsh Government of £22.1m.
- **SCRUTINISED** the top priority alerts for urgent remedial action plans in Month 11.
- **ACKNOWLEDGED** that the in-year savings delivery target has been over-achieved.
- **NOTED** the work undertaken to review non recurrent savings to recurrent schemes.
- **ACKNOWLEDGED** that an underlying deficit assessment has been undertaken and that this will only be reduced via robust recurrent savings delivery improvements, in particular those Executive portfolios that have yet to identify their full target.
- **NOTED** the information shared around the Referral to Treatment analysis.
- **NOTED** that the Financial Risk 2086 has been downgraded, recognising that Welsh Government have formally agreed to support the Health Board's strategic cash request.

PM(26)62 **Integrated Performance Assurance Report**

Mr Huw Thomas presented the Integrated Performance Assurance Report (IPAR) for Month 11 of 2025/26, recognising that behind each figure and statistic are patients and service users. The report presents a mixed picture across UEC, with delayed discharges increasing to 241 in February 2026; contrasted with the lowest number of patients waiting over 12 hours in A&E or Minor Injury Units since February 2023. Ambulance Handover performance has also improved. A sharp decline has, however, been seen in performance around adult Mental Health assessments within 28 days. The target in relation to this has been missed for the first time since June 2023. Neurodevelopmental Services, particularly for children and young people, has seen another decline, with the ADHD pathway showing a decline in performance for the sixth consecutive month.

Patient experience feedback also showed a downturn in February, which is not a surprise, given the above and pressures throughout the system. A new Radiology system was implemented at the end of 2025, which resulted in a pause in some reporting activity and an associated increase in breaches. An improvement has been seen since that time, with priority being given to Cancer and urgent activity. There has also been a focus on reducing numbers of high-risk eye care patients. Challenges have been seen in

Orthopaedics, resulting from a global bone cement shortage and a cyber attack impacting one of the key Orthopaedic suppliers.

Turning to the Health Board's internal escalation processes, Mr Huw Thomas advised that scoring for the Planning, Strategy and Fragile Services domain has not been assessed in last month, due to challenges in concluding work on the Annual Plan. Executive Recovery meetings had also been stood down at the request of the COO due to operational pressures. The Community and Integrated Medicine CCG remains the most challenged, and will be a key focus. However, Mr Huw Thomas was pleased to report that Primary Care has been de-escalated to Level 1 in two domains.

Ms Harraway queried whether the improvement in A&E waiting time performance is masking poor patient experience in A&E. She noted that significant numbers of A&E patients are spending multiple days being treated in reclining or standard chairs. Ms Harraway was concerned whether the organisation is actually improving this and making a difference. She also requested clarification around the impact of the Winter Resilience Incident Management Group. Mr Imperato wished to highlight that the Finance and Performance Committee (FPC) will be conducting a Deep Dive into delayed discharges at its next meeting.

Whilst agreeing that patients are not having the best experience, Mrs Marks emphasised that this is a systemic issue, which involves partners and parties other than the Health Board. Prompt discharge and admission avoidance is not simply a healthcare issue; it requires a collaborative approach. Mr Michael Gray agreed that it is a complex and whole-system issue. His Local Authority has benefited from Welsh Government funding, which has allowed investment into additional reablement staff. They have deliberately developed a reablement in-reach model, to facilitate identification of patients ready for discharge.

He acknowledged, however, that there is more to be done to build relationships with and confidence among healthcare colleagues, so to make best use of this reablement resource. It should also be recognised that some patients refuse to leave hospital when fit for discharge; this requires a careful and considered response. Mr Gray also raised the issue of the potential impact on risk threshold when hospitals are escalated. There have been some examples of patients being discharged without sufficient support which can lead to readmissions. A number of positive improvements are being seen, however, such as the increased investment in Social Worker resource, which will facilitate multidisciplinary working.

Dr Wooding emphasised the need to take a different approach in solving this issue, agreeing that collaboration with partners is required. Mr Carruthers acknowledged that it is not acceptable for patients to be treated in chairs for extended periods, and that the Health Board should not be tolerating this as an organisation. He reminded Members, however, that poor ambulance handover

performance has previously resulted in equally unacceptable waits for ambulances in the community. Actions taken to improve ambulance handover times has resulted in A&Es having to absorb this pressure. Mr Carruthers emphasised that the Winter Resilience Incident Management Group had had an impact, whilst recognising that it had not achieved every objective. It had been helpful in certain aspects; however, there is significantly more to be done.

Members were reminded that the Board had, at its previous meeting, supported the UEC Business Case. This will contribute to how demand is managed differently, and is a key area of priority. Ms Sharon Daniel stated this is not the standard of service the Health Board would wish to be providing. She wished, however, to acknowledge the resilience and effort of staff working in A&E departments. She highlighted that the EQIiP Programme event held earlier this week had included a team from the A&E at Glangwili Hospital. Their submission had reported a 26% reduction in concerns and complaints by interventions undertaken in the A&E waiting room. It is important to recognise, therefore that the workforce possess the skills and knowledge to address these issues; they must be enabled and empowered to do so. Dr Wooding emphasised that no criticism is aimed at the staff, the issue is a systemic one. It requires focus, which should include provision of support for staff.

Decision: The Board **DISCUSSED** the IPAR – Month 11 2025/2026 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(26)63 **Public Services Ombudsman Wales Public Interest Report**

Ms Daniel explained that the Public Services Ombudsman Wales had issued a Public Interest Report following a complaint regarding the Health Board's management of a cataract. The events involved and the Ombudsman's findings were outlined in the report. Firstly, Ms Daniel wished to say that the Health Board is deeply sorry for this patient's experience and that of her family. The life-changing impact of this is recognised, as is the distress and harm caused. A formal apology has been issued. All of the Ombudsman's recommendations are accepted, and actions to address all of them are in progress. However, this is not viewed as the end of the process. An action plan is being presented to the Listening and Learning Sub-Committee today, and this issue will be considered by the Quality, Safety and Experience Committee (QSEC) at a future meeting. It will be important to ensure that other patients do not experience harm in the same way.

Dr Wooding took assurance from the proposal to delegate oversight to QSEC. He was concerned, however, that others may have had similar experiences, and emphasised that action must be taken to address this.

Decision: The Board:

- **REVIEWED** the findings and **TOOK ASSURANCE** that appropriate arrangements are in place to support compliance with the associated recommendations.
- **DELEGATED** responsibility for ongoing compliance oversight to the Quality, Safety and Experience Committee.

PM(26)64 **Mental Health Service Provision: Ceredigion**

Dr Warren Lloyd and Mr Richard Williams joined the Board meeting.

Mr Carruthers reminded Members of the background to this item, and described the changes made to the routine GP referral pathway into the adult Community Mental Health Team in Ceredigion. It is now proposed that these arrangements are formalised, developed and rolled-out across the wider Health Board. An engagement process has been undertaken, in conjunction with the Communications and Engagement teams. This has generated a great deal of rich information and feedback, upon which the organisation needs to reflect more generally. Welcoming this context, Dr Warren Lloyd agreed that the engagement had been extremely informative in understanding the impact of the changes, together with the patient and service user experience. He wished to thank the Engagement and Outreach teams for their valuable contribution.

Whilst noting that the underlying rationale appears to be delivering an improved service, Mr Maynard Davies noted both an apparent reluctance to engage among GPs, and mixed experience among patients. Whilst this change seems to be an important step forward and sensible use of resources, he felt that consideration should be given to how to build confidence in the new process. Dr Lloyd acknowledged that these were themes heard during the engagement and raised important issues. He highlighted, however, that the engagement report – whilst valuable – does not necessarily reflect the constructive discussions which have taken place, and the solutions and adjustments developed. It is also important to bear in mind that this process is new to a number of GP colleagues, especially those outside Ceredigion.

Dr Lloyd felt that, generally, the consensus has shifted from one of concern to seeing the value of the new referral process. He recognised, however, the need to involve stakeholders, patients and service users in service development. In addition, steps will be taken to ensure that the 111 Option 2 service is sufficiently robust and to enable a broader discussion around Mental Health services. Dr Lloyd emphasised that this will be an ongoing process. Agreeing that feedback had been mixed, Ms Hughes Moakes suggested that there are opportunities to build trust in and awareness of the new process. She also highlighted that, whilst the 111 service is well-known, there is generally less awareness of 111 Option 2. The fact that this does connect people with a local Mental Health specialist needs to be better communicated.

Ms Hughes Moakes wished to thank those individuals who had shared their experience, together with West Wales Action on Mental Health and Llais.

Dr Wooding felt that there has been a positive case presented for taking the proposed change forward. Whilst this was prompted by necessity, it appears to have generated a good opportunity for service change. Mrs Marks commended Dr Lloyd and his team for responding to a need in the community and the learning which has resulted. This will potentially enable more people across Hywel Dda to be helped. A number of practical issues around facilitating engagement with the service will require further consideration; however, the response should be recognised. Mr Richard Williams welcomed the opportunity to engage with stakeholders, emphasising that the dialogue generated had been vital in building trust. The change made in Ceredigion has enabled a greater control over the flow of work and allowed patient safety concerns to be addressed. He wished to thank the team locally for their work and engagement with the service change.

Dr Wooding requested that this change be monitored via QSEC, with a report on its progress relatively soon. This should include steps taken to build trust among patients, service users and other stakeholders. Mrs Marks, Chair of QSEC, committed to schedule such a report in a few months' time. **AC**

Decision: The Board:

- **ACKNOWLEDGED** the outcomes of the temporary urgent referral pathway change implemented in Ceredigion, including assurance on patient safety, service quality, and improved prioritisation of clinical capacity.
- **NOTED** the Health Board wide engagement that has been undertaken, including in Pembrokeshire and Carmarthenshire, to understand the potential impacts of the pathway change, capture stakeholder views, and inform consideration of wider implementation.
- **ACKNOWLEDGED** the feedback received through engagement with GPs, patients, third sector partners, and wider stakeholders, the key themes identified and proposed next steps with mitigations to address impacts.
- **APPROVED** the proposal to make the temporary urgent referral pathway change in Ceredigion permanent.
- **SUPPORTED** the phased roll-out of the pathway across Pembrokeshire and Carmarthenshire, subject to ongoing monitoring of impact, workforce capacity and service demand, to ensure a safe, equitable, and sustainable model across the Hywel Dda footprint.

Dr Warren Lloyd and Mr Richard Williams left the Board meeting.

PM(26)65 **Prince Philip Hospital Urgent Care Centre Implementation Update**

Mr Carruthers presented the Prince Philip Hospital (PPH) Urgent Care Centre Implementation Update report. He reminded Members of the Board decision in September 2025 regarding development of the Minor Injuries Unit (MIU): to proceed with Option 4a – a 12-hour urgent care treatment model. Following this, an Implementation Group had been established, with clinical model and care pathways agreed. The workforce plan is close to finalisation, and estates implications are being examined. In terms of timescale, it is anticipated that the Urgent Care Centre will be fully operational from November 2026. Mr Carruthers expressed gratitude for SOSPPAN's (Save Our Services Prince Philip Action Network) input to the process, which he emphasised will continue.

Ms Harraway requested confirmation that a benefits realisation plan exists for this development. Dr Wooding reminded Members that the benefits had been articulated at the time of decision-making. In addition, Mr Carruthers confirmed that there will be a benefits realisation plan, advising that the future model is very much aligned to national policy direction. Mr Prior noted and welcomed the fact that SOSPPAN are referred to as key stakeholders. He enquired whether they are to be involved in operationalisation of the new service model. Mr Carruthers advised that an invitation to be involved in implementation has been extended and accepted.

Decision: The Board:

- **ACKNOWLEDGED** the progress made to date on the implementation of an Urgent Care Centre at Prince Philip Hospital
- **RECOGNISED** the indicative timeline
- **NOTED** that further assurance updates will be provided, as required

PM(26)66 **Property Leases**

Introducing the Property Leases report, Mr Lee Davies suggested that this is relatively self-explanatory. Board approval of such arrangements is required in order to comply with Standing Orders.

Decision: The Board:

- **NOTED** the approval status to proceed with each arrangement
- **APPROVED** the progression of the legal arrangements subject to final agreement to arrangements and lease contract terms:
  - **Unit 4, Stradey Business Park, Llangennech** - lease end / Unit 2A Heol Cropin, Dafen approval is sought to complete on the following:
    - New lease arrangement for Unit 2A Dafen, subject to finalised due diligence checks, planning change of use and legal contract.

        - New lease arrangement for Unit 3 Dafen to extend the lease term to align to Unit 2A Dafen.
        - Endorse the termination of the Unit 4 Llangennech lease.
    - **Canolfan Rheidol Building, LA lease for Therapies Services** - approval is sought to complete the lease following agreement of the legal documentation.
    - **Omnicell Lease with the Welsh Ambulance Services NHS Trust** –approval is sought to complete the leases following agreement of the legal documentation.
    - **Pentre Awel Project – Swansea University Sub-Lease** - approval is sought to complete the leases following agreement of the legal documentation.

Following Board approval, the Common Seal will be applied to those documents which are required to be signed under seal (in accordance with Standing Orders).

PM(26)67 **Local Community Action for Health and Wellbeing**

Dr Bruce Bolam, Professor Sue Denman, Mr Richard Hayward and Ms Sarah Foster joined the Board meeting.

Those attending for this item were welcomed, as was their contribution in terms of presentation and input to the Peninsula Working Group. Dr Gjini explained that the item is intended to provide an update on work to embed the SMfHW principles and shift of focus into the community. Members heard that a summit had been held a year ago, to launch the SMfHW principles, which had led to development of a regional delivery plan. Progress has been made in various areas, including securing additional resource in Arts in Health and in building a community of practice, which includes the Peninsula Working Group. A large part is based on voluntary effort, not least among carers; the long-term aim is an organised network, facilitating engagement with all relevant parties.

Introducing the presentation, Mr Richard Hayward drew Members' attention to the background, highlighting establishment of the Peninsula Working Group, transition of Solva to a Health Board Managed Practice and formation of Meddygfa Penrhyn. Professor Sue Denman outlined key recommendations from the Working Group, which were as follows:

- Adopt St Davids Peninsula as a test bed for implementing the Social Model
- Integrate primary care, social model, and community action using 20four7
- Asset-based approach, innovation, and real-time evaluation
- Shifting Toward Prevention

The case for support and funding was outlined, which included the area's rural challenges, transport barriers, inequalities and strong social capital. It was highlighted that additional potential funding sources exist. The various and numerous deliverables, as

indicated within the presentation, were also outlined in detail. In summary, the Working Group felt that the proposal, given ongoing support of the Health Board, offers a unique opportunity to implement the SMfHW. Ms Sarah Foster advised that her involvement with the St David's community had confirmed that there exists a group of very committed volunteers. In order to succeed, they need the opportunity to regroup and conduct a pilot, which could potentially be replicated elsewhere in the region.

Mr Prior, as mentioned earlier, had chaired the Peninsula Working Group. He thanked colleagues attending for this item, volunteers and staff from the Health Board for their contribution. He drew Members' attention to Appendix C, which represented the output from a Workshop on 13 February 2026. It is recognised that the needs of communities and their perspectives will differ across the region. However, Mr Prior was of the opinion that there is broad alignment. He emphasised that there is a significant level of 'social capital' available to the Health Board. It will be necessary to consider the future focus, and how institutions and statutory bodies can contribute without taking over. The process should be one of co-production. Whilst there is a need for resources, first and foremost, the request is for a commitment to the principle. Mr Prior felt that this offers an opportunity to be a real exemplar. As indicated, however, he would not take part in any decision-making with regard to this item.

Dr Wooding thanked representatives for attending and for sharing their views. He emphasised that the SMfHW is, at this stage, a construct and concept, and that the organisation is still working through how it can be embedded. Whilst welcoming the inspiring and uplifting presentation, and confirming his support for the principle, Mr Weir emphasised that 'one size does not fit all'. Different localities have different needs and profiles, and will require different models. He enquired also whether there are opportunities in terms of Digital innovation. Mr Weir highlighted that any investment would need to be justified, requiring measurable outcomes, deliverables and impact. He suggested that some of these, such as improved wellbeing and life expectancy may be challenging to measure.

Ms Harraway expressed that a key outcome would be understanding 'spread', whether this model is replicable, and has dependent factors and enablers. This is key learning which would be required. Whilst an admirable model, she queried how it would be spread and scaled. Agreeing, Dr Wooding suggested that the core drivers would be from the SMfHW. Ms Ann Murphy enquired whether children and young people had been involved, highlighting that any model is also for their future and requires their input. She suggested that schools and sports clubs would offer a good starting point. Mr Imperato echoed this, adding that Local Authority partners, other public bodies and the Third Sector should also be involved, to ensure sustainability.

Welcoming the item and presentation, Mr Huw Thomas commended the Group's advocacy for their proposal. He noted that, whilst there had not been an explicit request for resource, this had been implied. Health Board resource is also being utilised and requested through staff and management contribution. The Board discussed, as an earlier agenda item, next year's financial plan, and his comment was made in this context. The 'bar' for investment is high and will become even higher; especially given that the Health Board is already prioritising the 20four7 model. Whilst there is an ambition and commitment to becoming a value-managed organisation, investment in this proposal would necessitate disinvestment elsewhere and would, therefore, require detailed consideration and would need to ensure this was in accordance with the Board's permitted abilities in terms of funding. Dr Wooding explained that the Health Board is juggling many demands, and much of the focus in terms of performance targets is on acute services. In an ideal world, there would be greater investment in communities and prevention, etc; however, this is not necessarily straightforward.

Mrs Marks thanked the Group for their presentation. She felt that it was important to acknowledge and support a community which is clearly taking initiative and responsibility, and seeking to engage with the Health Board. The Group, however, is being held together by the involvement of key individuals, and Mrs Marks wondered whether this would be the case in their absence. Also, whether it can reliably be replicated elsewhere, given the differences between locations. Finally, she queried whether this point would have been reached, had the local surgery not closed, and how the work would be evaluated. Thanking the Group for attending, Mr Carruthers wished to reflect on discussions from the morning's session and on the issue of replicability. He was also cognisant of the fact that the Peninsula Group's work had arisen from a particular set of circumstances. Any developments need to be considered in the context of the CbD Strategic Plan, the future role of Primary Care Clusters, and designing and planning services based on local population need. The fact that Clusters may perform a very different role in the future may offer opportunities such as addressing a lack of availability of enablers, for example. There is potential for a Health Board role in providing support of this type. Consideration would need to be given to the resources and support Clusters would require, and the learning which could be obtained and applied elsewhere.

Mr Gray advised that, whilst he had been invited to join meetings of the Working Group, he had found it difficult to attend due to the locations selected. The one he had attended had evidenced the difficulties in manifesting the SMfHW. He emphasised that this is no criticism of anyone involved, it simply reflects the inherent challenges. The work is commendable, with principles having been established, a commitment to lived experience and asset mapping undertaken. Mr Gray did query, however, whether the Group has the correct resources and skillset to move into the next 'test and learn' phase, particularly as it is not clear what the Group

wants to test. He stressed that he is interested, keen to be involved and has made alternative suggestions. The key outcome, however, would need to be a difference 'on the ground'. Whilst welcoming this feedback, Mr Prior suggested that the SMfHW is a Health Board and Public Health strategy, which the community want to help implement. They have taken steps to develop principles and identify next steps; however, they do not possess the necessary resources to move forward. He felt that statutory partners need to be involved and contribute.

Professor Kloer thanked the Group for attending and for their work. In considering the rationale for placing the SMfHW at the heart of the Health Board's Strategy, he referred Members to the first paragraph of Standing Orders:

> 1.0.1 The LHB's principal role is to ensure the effective planning and delivery of the local NHS system, within a robust governance framework, to achieve the highest standards of patient safety and public service delivery, improve health and reduce inequalities and achieve the best possible outcomes for its citizens, and in a manner that promotes human rights.

This places improving health on an equal footing with delivering care. Professor Kloer highlighted that the majority of health and wellbeing does not directly result from Health Board delivered services in isolation; healthcare forms part of a much wider wellbeing environment. Most wellbeing is created within communities. Whilst communities have certain requirements of health organisations, it is also incumbent on those organisations to work with communities. The approach made in this instance should be treated with humility, especially given that it is intended as a 'test bed' for other communities in the region. He was not sure at this stage how its implementation or success would be measured; however, agreed that consideration should be given to how learning can be harnessed.

Professor Denman welcomed Members' comments and queries, sensing that there are positive answers to these. She suggested that there are ways to measure change, highlighting for example that Solva Care has evidenced a reduction in hospital admissions. In response to a couple of specific queries, Professor Denman advised that local schools have expressed an interest in being involved. She was not of the opinion that the work would have taken place without the surgery having closed, and felt that this could be viewed as a positive outcome. Ms Foster stated that the journey ahead is long, and requires both a strategic approach, and courage. She agreed that the involvement of children and young people is crucial.

Dr Gjini was delighted that the Board have spent time discussing the SMfHW. She emphasised that the Health Board has made a commitment to the Charter in this regard; this commitment needs to be matched by a shift to the preventative agenda. A key driver should be the reduction in inequalities in health. It is recognised

that some locations will not have the benefits available to the Pembrokeshire Peninsula. There needs to be surety that such areas are equally enabled and not left behind. There needs to be an active shift in resources to those areas of most need. It had been intended to present perspective from other locations in the region; however, this had not been possible for logistical reasons. The challenges around replication are fully acknowledged. There are opportunities in terms of both the 20four7 model and the STAR approach mentioned earlier. Finally, Dr Gjini assured Members that potential measures for benefits, outcomes and impacts are being explored.

Concluding discussions, Dr Wooding suggested that it is refreshing for Board to hear and discuss community ambition. He agreed that the Health Board needs to be part of this work and have a clearer understanding of how it can support the Group. However, the Group also needs a clearer sense of what it hopes to achieve and test. Dr Wooding suggested that asset and impact mapping should perhaps be the first step in this respect.

Decision: The Board:

- **NOTED** regional progress on the Social Model for Health and Wellbeing
- **DISCUSSED** the Pembrokeshire Peninsula Working Group presentation, reports, and delivery plan, considering:
  - Work undertaken by Pembrokeshire Peninsula as the geography for a 'test bed' of an evidence-based approach to implementing the SMfHW in the setting of communities of place.
  - Shifting towards and embedding prevention and early intervention in our work.
  - Developing the role of PPWG as an effective, multi-sectoral partnership, embedded in local, regional and national policies, that can be spread and scaled elsewhere within and beyond the region as part of local partnership and primary care cluster development.

Dr Bruce Bolam, Professor Sue Denman, Mr Richard Hayward and Ms Sarah Foster left the Board meeting.

PM(26)68 **Report of the Audit and Risk Assurance Committee**

Cllr. Evans, Audit and Risk Assurance Committee (ARAC) Chair, introduced the update report from the meeting held on 10 February 2026, indicating that there are three 'Advise' items. In addition, ARAC is recommending Board approval of the Scheme of Delegation, under the next agenda item.

In response to a request for assurance that actions are being taken with regard to the audit findings in relation to Managed Practices, Members received confirmation that this was the case.

Decision: The Board:

- **APPROVED** the Scheme of Delegation
- **NOTED** the items the Committee is advising it of
- **TOOK ASSURANCE** from the items that the Committee is providing assurance on

PM(26)69 **Scheme of Delegation**

Mrs Wilson highlighted that further amendments will be required to reflect changes in relation to responsibility for Estates and Facilities. Ms Murphy wished to recognise the significant work involved in preparing the Scheme of Delegation for Board consideration, and thanked Mrs Wilson and her team.

Decision: The Board **APPROVED** the revised Scheme of Delegation

PM(26)70 **Report of the Quality, Safety and Experience Committee**

Mrs Marks, QSEC Chair, introduced the update report from the meeting held on 12 February 2026, drawing Members' attention to the three 'Advise' items. The revised QSEC Terms of Reference are presented for approval, which seek to provide greater clarity around the role and purpose of the Committee.

In relation to the Operational Risks, Dr Wooding noted discussion of the likelihood of further deterioration as a result of ongoing financial pressures. He enquired whether this suggests an assumption that more money decreases risk. Mrs Marks indicated that, whilst less money increases risks, the converse is not necessarily the case. This is the intended purpose of the Deep Dives.

Decision: The Board:

- **APPROVED** the QSEC Terms of Reference
- **APPROVED** the Health Equity Assessment Toolkit
- **NOTED** the items the Committee is advising them of
- **TOOK ASSURANCE** from the items that the Committee is providing assurance on

PM(26)71 **Report of the Finance and Performance Committee**

Mr Imperato, FPC Chair, presented the update report from the meeting on 24 February 2026, noting that the 'Alert' items have already been referenced. The 'Advise' item highlights concerns around data quality.

With regard to the latter, Members were advised that FPC has recorded this concern and requested that actions be taken. Mr Huw Thomas indicated that the challenge related to data from different sources, and that he had committed to examine this issue in more detail.

Decision: The Board:

- **APPROVED** the award of Principal Contractor for Construction Delivery – Glangwili Hospital Phase 2 Fire Improvement Works to T Richard Jones Ltd. This contract will have onwards submission to HDUHB Board, Velindre NHS Trust (as hosts of NHS Wales Shared Services Partnership) and Welsh Government for approval.
- **APPROVED** the award of Principal Contractor for Constructor Delivery – Glangwili Hospital Phase 2 Fire Improvement External Civils Works to T Richard Jones Ltd. This contract will have onwards submission to HDUHB Board, Velindre NHS Trust (as hosts of NHS Wales Shared Services Partnership) and Welsh Government for approval.
- **APPROVED** the award of Outsourcing of IVT Procedures to SpaMedica Ltd. This contract will have onwards submission to HDdUHB Board and Velindre University NHS Trust (as hosts of NHS Wales Shared Services Partnership).
- **RESPONDED** to the items that the Committee is alerting them to
- **NOTED** the items that the Committee is advising them of
- **TOOK ASSURANCE** from the items that the Committee is providing assurance on

PM(26)72 **Procurement Report**

Mrs Chantal Patel left the Board meeting.

Mr Huw Thomas introduced the Procurement Report, which was as presented. Members heard that there had been a request for he and Mrs Wilson to examine the issue of contracts being awarded to the same contractors on a regular basis. The approach is based on use of a regional framework. This issue would be taken forward as part of wider contract management considerations. Dr Wooding welcomed this, emphasising the need to ensure that there is sufficient scrutiny.

Decision: The Board is requested to:

- **APPROVE** the award of Principal Contractor for Construction Delivery - Glangwili Hospital Phase 2 Fire Improvement Works to T Richard Jones Ltd for a period of two years from May 2026, subject to Welsh Government Approval. This contract will have onwards submission to Velindre NHS Trust (as hosts of NHS Wales Shared Services Partnership) and Welsh Government for approval.
- **APPROVE** the award of Principal Contractor for Constructor Delivery - Glangwili Hospital Phase 2 Fire Improvement External Civils Works to T Richard Jones Ltd for a period of two years from September 2026, subject to Welsh Government Approval. This contract will have onwards submission to Velindre NHS Trust (as hosts of NHS Wales Shared Services Partnership) and Welsh Government for approval.
- **APPROVE** the award of Outsourcing of IVT Procedures to SpaMedica Ltd for the period of 1 April 2026 to 31 March 2027.

This contract will have onwards submission to Velindre NHS Trust (as hosts of NHS Wales Shared Services Partnership).

- **APPROVE** the award of a Contract Change to the Electronic Patient Flow Management System (eFlow) and Electronic Patient Observation System (eObs) contract to Alcidion UK Limited from 1 April 2026 to 6 February 2030, with an option to extend to 6 February 2032. This contract will have onwards submission to Velindre NHS Trust (as hosts of NHS Wales Shared Services Partnership).
- **APPROVE** the award of the Microsoft Enterprise Agreement contract to Trustmarque Solutions Limited via DHCW from 1 July 2026 to 30 June 2031 with no option to extend. This contract will have onwards submission to Velindre NHS Trust (as hosts of NHS Wales Shared Services Partnership).

PM(26)73 **Report of the Strategy and Planning Committee**

Mr Weir, SPC Chair, presented the update report from the meeting on 26 February 2026, noting that the single 'Advise' item had already been discussed. The report details various items for approval, most of which are presented as separate agenda items.

Decision: The Board:

- **APPROVED** the Well-being Objectives Review
- **APPROVED** the Glangwili Fire Phase 2 Business Justification Case
- **APPROVED** the Climate Adaptation Plan
- **APPROVED** the proposed allocation of the DCP for 2026/27
- **APPROVED** application of the seal for all schemes listed in Annex 1
- **NOTED** the items the Committee is advising them of
- **TOOK ASSURANCE** from the items that the Committee is providing assurance on

PM(26)74 **Climate Adaptation Plan**

Members heard that the Climate Adaptation Plan is a first, across Wales. Whilst pleased to see this work presented, Professor Kloer emphasised that any additional resource required for delivery would need to be considered as part of budgetary prioritisation discussions. Acknowledging this, Dr Gjini explained that at the time of initial planning, more resource had been available. The allocation had since changed. Implementation is mandated; the Health Board will need to consider how delivery is achieved. Professor Kloer suggested this be discussed by SPC. **AG**

Decision: The Board:

- **TOOK ASSURANCE** that HDdUHB has developed a structured and evidence-based Climate Adaptation Plan, in line with Welsh Government expectations, and **ENDORSED** the content, noting the need to consider how delivery is achieved without additional resource.

- **NOTED** the direction of travel to embed climate adaptation within clinical, operational and strategic planning processes.
- **NOTED** the ongoing resource, capacity and infrastructure risks associated with delivering long-term climate resilience.

PM(26)75 **Discretionary Capital Programme 2026/27**

Mr Lee Davies presented the report, noting that there has been an increase in allocation, albeit against the backdrop of a substantial backlog. Board support is sought for allocation of the Discretionary Capital Programme, as is the usual and annual process.

Decision: The Board:

- **NOTED** the Health Board Discretionary Capital Programme (DCP) allocation for 2026/27
- **NOTED** the underlying capital risks and demand for capital resource
- **NOTED** the current pre-commitments and ringfenced allocations against the DCP for 2026/27
- **APPROVED** the proposed allocation of the Discretionary Capital Programme for 2026/27
- **APPROVED** the provisional allocation of the Discretionary Capital Programme for 2027/28, so that early planning can commence

PM(26)76 **Wellbeing Objectives Review**

Dr Gjini advised that the Health Board's Wellbeing Objectives have been reviewed with operational teams and Trade Unions. They have also been considered by SPC, which has commended them to Board for approval. Members noted that the Regional Partnership Board (RPB) will be refreshing its Population Needs Assessment and Public Services Boards (PSBs) will be undertaking a review of Wellbeing Needs Assessments and priorities. As a result, and to ensure consistency, the Wellbeing Objectives may need to be revisited again.

Decision: The Board **APPROVED** the updated HDdUHB Well-being Objectives.

PM(26)77 **Glangwili Hospital Fire Phase 2 Business Justification Case**

In considering the Business Case, Dr Wooding expressed concern around additional costs resulting from the need to relocate the Moducel unit, which houses critical IT components. Mr Lee Davies advised that there had been extensive discussions around this issue. He recognised, however, that it warrants further review and consideration. Members were informed it has been agreed with Welsh Government that the Health Board will proceed to submission as planned, to enable progress to be made.

Decision: The Board **APPROVED** submission of the Business Justification Case to Welsh Government, to commence the formal scrutiny process, noting that alternatives to moving the Moducel unit would be explored.

PM(26)78 **Report of the Health and Safety Committee**

Ms Murphy, Health and Safety Committee (HSC) Chair, presented the update report from the meeting on 10 March 2026, highlighting the three 'Advise' items. These related to risks and the need for risk profiling, and fire safety governance.

Decision: The Board:

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

PM(26)79 **Report of the People, Organisational Development and Culture Committee**

Mrs Marks presented the update report from the meeting on 17 February 2026, noting that this was her final report as Chair of the People, Organisational Development and Culture Committee (PODCC). There was one 'Advise' item, relating to Phase 2 of the CCG Organisational Restructure. Members were assured that lessons will be learned from Phase 1, and that Phase 2 will be revisited by the Committee. It is important to ensure that pace is maintained. Mrs Marks wished to record her thanks to Mrs Gostling for the support offered by her as Executive Lead for PODCC. In return, Mrs Gostling thanked Mrs Marks for chairing the Committee, and looked forward to working with Mr Prior in this role.

Decision: The Board:

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

PM(26)80 **Report of the Charitable Funds Committee**

Due to the proximity of the Charitable Funds Committee (CFC) meeting to the Board meeting, a verbal report was provided by Ms Harraway, CFC Vice-Chair. Whilst there are no 'Alert' items, there are two 'Advise' items. The first is an emergent risk around decreasing donation levels, believed to result from Cost of Living pressures and potentially the consequences of the CSP, particularly in relation to Bronglais Hospital. Secondly, the need for a more proactive utilisation of Charitable Funds, with strengthened local CCG ownership of plans to ensure funds are allocated effectively. 'Assure' items were as follows:

- The positive impact of charitable funds, evidenced by several projects. Discussions did, however, identify a need for a more robust evaluation framework. This is currently being developed in collaboration with TriTech, and will be brought back to the next meeting.
- Rationalisation of the Charitable Funds structure continues, to support grant applications.

- An update was received from CCLA regarding the medium risk ethical long term growth investments held with them, currently valued at £13.2m.
- The Charitable Funds financial and governance procedures are being reviewed and strengthened.
- 37 applications, totalling in excess of £400k, had been received to the second phase of the 'Making a Difference' fund. Those for the lowest amounts will be fast-tracked via the Sub-Committee.
- The Committee considered and recommends approval of the proposed governance, support and fundraising budget for 2026/27, with this to be considered during the Corporate Trustee session following conclusion of the Public Board meeting.

Decision: The Board:

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

PM(26)81 Report of the Digital, Data and Innovation Committee

Mr Maynard Davies, Digital, Data and Innovation Committee (DDIC) Chair, presented the update report from the meeting on 15 January 2026, noting that this had been reported verbally at the previous meeting. Concerns outlined at that time regarding the Laboratory Information Management System (LIMS) programme are increasing. He wished to formally thank the Digital team for their contribution to implementation of the Patient Flow System. DDIC had recommended Board approval of the TriTech Business Plan, which forms the next agenda item.

With regard to the LIMS programme 'Advise' item, Mr Huw Thomas indicated that this involves a financial risk, which has been included in the Annual Plan. The bigger risk, however, is around the migration in system. This is being actively managed, and further reports will be made to the Executive Team in the first instance.

Decision: The Board:

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

PM(26)82 TriTech Business Plan

Professor Chris Hopkins joined the Board meeting.

Mr Henwood introduced the TriTech Business Plan, which represents the ambitious approach to be taken over the next five years. Professor Chris Hopkins confirmed this, adding that it builds on the progress made during the past five years. It has

been subject to external review and internal governance processes, including via the Executive Team and DDIC. The previous Plan has supported 114 projects, generated over £4.6m income for the Health Board and built national and international partnerships. This refreshed Plan emphasises a role in turning innovation into measurable impact and outlines a much closer alignment with HDdUHB Planning Objectives. It highlights four main areas:

- Digital and Artificial Intelligence (AI)
- Prevention and pathway optimisation
- Supporting services in making value-based decisions
- Collaborative Research and Development

The Plan:

- Positions TriTech as a regional and national enabler
- Supports the move to Pentre Awel, where TriTech will be co-located with academic and industry partners
- Strengthens HDdUHB's ability to tackle some of its biggest priorities
- Provides clarity, ambition and a structured approach, to ensure TriTech continues to deliver real value for patients, the Health Board and wider partners

Mrs Wilson wished to clarify that certain of the aspects of the Plan are being considered In-Committee, due to their commercial sensitivities. Recalling the start of TriTech, Ms Murphy suggested that its work is extremely impressive and has elevated the Health Board's reputation. She thanked everyone involved. Mr Huw Thomas identified that one of the challenges is around how innovations are adopted into services. TriTech offers opportunities in this regard. It has been a major success, which needs to be built upon as the Health Board moves to becoming a value-managed organisation. Dr Wooding commended the mature and comprehensive Business Plan, which Professor Kloer suggested was a credit to the team. He emphasised that TriTech is based on a 'cost recovery' model, meaning that it is required to cover its own costs, which does impact on risk appetite. If further growth is required, this will need to be via a careful and considered business case process.

Decision: The Board **APPROVED** the TriTech Business Plan

Professor Chris Hopkins left the Board meeting.

PM(26)83 **Report of the Regional Joint Committee**

Decision: The Board:

- **CONSIDERED** the report of the RJC meeting held on 22 January 2026, recognising the progress made in regional collaboration and work programme development.

- **CONSIDERED** the report of the RJC meeting held on 16 February 2026, noting the progress made in advancing the Regional Cellular Pathology Programme, including the updated Transitional MoU and the endorsement of a preferred laboratory site.

PM(26)84 **Committee Update Reports**

Mrs Wilson presented the Committee Update Reports item, explaining that this covers various Committees and Groups. It highlights a number of 'Advise' items. The second of these, around delays in relocating the Section 136 Place of Safety facility, is subject to ongoing legal discussions. Members were assured that the Health Board is seeking to progress the situation as quickly as possible. The Board is also requested to approve the revised Remuneration and Terms of Service Committee (RTSC) Terms of Reference.

Decision: The Board:

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

PM(26)85 **Joint Committees and Collaboratives**

Professor Kloer introduced this item, highlighting the reports from the Joint Commissioning Committee (JCC) and NHS Wales Shared Services Partnership Committee (NWSSPC). Mrs Gostling had attended a meeting of the JCC on 23 March 2026 to consider the JCC IMTP. Concerns had been expressed around the financial gap identified amounting to £16.2m, of which the risk to HDdUHB comprises £1.6m. Health Boards were being asked to approve the IMTP, subject to the requirement for the JCC to work collaboratively with Local Health Boards to urgently develop the 2026/27 priorities to maximise cost improvement efficiencies and savings, with a view to improving the additional financial requirement of £16.2m in year. He highlighted that this would represent an uplift for specialist services in excess of the 1.1% applied elsewhere, meaning less for other services. In considering this request, Professor Kloer's preference would have been 'with a view to eliminating the additional financial requirement of £16.2m in year.' That being said, he understood that financial risk had been included in this year's Annual Plan. Dr Wooding shared this view, suggesting that JCC should be requested to work on reducing and eliminating this deficit in-year and requested this be incorporated into the correspondence issued to the JCC from the CEO.

Decision: The Board:

- **RECEIVED** the updates in respect of recent Joint Commissioning Committee (JCC), NHS Wales Shared Services Partnership Committee (NWSSPC) and Mid Wales Joint Committee for Health and Care (MWJC) meetings.
- Agreed to **APPROVE** the 2026/27 JCC Annual Plan, subject to the requirement for the JCC to work collaboratively with Local Health Boards to urgently develop the 2026/27 priorities to maximise cost improvement efficiencies and savings, with a view to improving the additional financial requirement of £16.2m in year.

PM(26)86 **Statutory Partnerships Update**

Presenting the Statutory Partnership Update Report, Dr Gjini highlighted various areas of work being undertaken by the RPB and PSBs. Members heard that a workshop had taken place last month to consider the review of RPB governance structures. Within this, it had been agreed that the RPB would move to a 'life stage' approach. Ceredigion and Carmarthenshire PSBs had agreed to merge from September 2026. Whilst Pembrokeshire PSB will continue to operate as one, it will align its priorities and work with the new joint PSB.

Noting that the report outlines RPB and PSB activity, Mr Prior observed, however, that it does not identify the value these provide to the Health Board. Dr Wooding suspected that this will be evaluated soon; and if not, it can be revisited.

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

PM(26)87 **Any Other Business**

No other business was reported.

PM(26)88 **Board Annual Workplan**

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

PM(26)89 **Date and Time of Next Meeting**

9:30am, Thursday, 28 May 2026