

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

Date of Meeting: **09:30, Thursday 29 January 2026**
 Venue: **Ceredigion County Council Chambers, Penmorfa, Aberaeron,
Ceredigion SA46 0PA**

Present: Mrs Eleanor Marks, Vice-Chair, Hywel Dda University Health Board
 Mr Maynard Davies, Independent Member (Information Technology)
 Cllr. Rhodri Evans, Independent Member (Local Authority)
 Mr Michael Imperato, Independent Member (Legal)
 Ms Ann Murphy, Independent Member (Trade Union)
 Mrs Chantal Patel, Independent Member (University)
 Mr Neil Prior, Independent Member (Community)
 Mr Iwan Thomas, Independent Member (Third Sector)
 Mr Winston Weir, Independent Member (Finance)
 Professor Philip Kloer, Chief Executive
 Mrs Lisa Gostling, Deputy Chief Executive and Executive Director of Workforce
 and Organisational Development
 Mr Andrew Carruthers, Chief Operating Officer (VC) (part)
 Mr Peter Skitt, Care Group Director, Community and Integrated Medicine,
 deputising for Mr Andrew Carruthers, Chief Operating Officer (part)
 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
 Ms Leanda Wynn, Engagement Officer, Llais (VC) (part)
 Ms Mwape Burke, Aspiring Board Member (VC)
 Ms Anne Beegan, Audit Wales (part)
 Mr Alex Martin, Principal Programme Manager (part)
 Ms Eldeg Rosser, Head of Capital Planning (VC) (part)
 Ms Clare Emanuel, Senior Capital Programme Manager – Planning (VC) (part)
 Ms Emma Talla, Consultant, SHP (VC) (part)
 Mr Nick Durham, Consultant, BDP (VC) (part)
 Dr Will Mackintosh, Clinical Lead Primary and Community Care (part)
 Dr Sion James, Deputy Medical Director (part)
 Ms Rhian Bond, Assistant Director of Primary Care (VC) (part)
 Ms Anna Henchie, Principal Programme Manager (part)
 Dr Karen Brown, Associate Medical Director, Community and Integrated
 Medicine (part)
 Ms Clare Moorcroft, Committee Services Officer (Minutes)

Minutes Ref.	Item	Action
PM(26)01	<p>Welcome and apologies</p> <p>Mrs Eleanor Marks, Vice-Chair of Hywel Dda University Health Board, welcomed everyone to the Public Board meeting. She advised that additional attendees would be joining for various agenda items. Mr Neil Prior, Independent Member (Community), was welcomed to his first Public Board meeting.</p> <p>There were no matters that Members felt were omitted from the agenda or reports. Mrs Marks reminded Members of the Board's five decision-making 'design principles':</p> <ol style="list-style-type: none"> 1. Fair 2. Affordable/sustainable 3. Consistent with the Health Board's strategic approach 4. Does not create an unhelpful precedent 5. Safe <p>Apologies for absence were received from:</p> <ul style="list-style-type: none"> • Dr Neil Wooding, Chair, Hywel Dda University Health Board • Ms Sarah Harraway, Independent Member (Community) • Dr Jonathan Arthur, Health Professionals Forum Chair • Mr Michael Gray, Director of Social Services and Housing, Pembrokeshire County Council • Ms Donna Coleman, Llais West Wales 	
PM(26)02	<p>Declaration of Interests</p> <p>No declarations of interest were made.</p>	
PM(26)03	<p>Minutes of the Public Meeting held on 27 November 2025</p> <p>Decision: RESOLVED – that the minutes of the meeting held on 27 November 2025 be approved as a correct record.</p>	
PM(26)04	<p>Matters Arising/Table of Actions from Meeting held on 27 November 2025</p> <p>An update was provided on the Table of Actions from the Public Board meeting held on 27 November 2025. Confirmation was received that outstanding actions had been progressed. There were no matters arising.</p>	
PM(26)05	<p>Report of the Chair / Adroddiad y Cadeirydd</p> <p>Mrs Marks presented the Report of the Chair, highlighting in particular the Public Accountability Meeting with Welsh Government held on 11 December 2025. She thanked all of those involved in preparing for and contributing to this meeting. With regard to the key meetings listed, Members noted that the Long Service Awards event mentioned had been postponed and will be rescheduled. Finally, Mrs Marks wished to commend all of those who had received the awards recorded in the report.</p>	

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

PM(26)06

Report of the Chief Executive

Professor Philip Kloer introduced his report on relevant matters undertaken since the previous Board meeting, drawing Members' attention to the section on Business Continuity Incident (BCI) arrangements. He explained that the Health Board's systems have been under significant pressure during the first weeks of January. Whilst this is often the case, the situation seems to become increasingly challenging every year. Professor Kloer recognised that both staff and public are feeling the effects of this pressure very intensively. Staff are working extremely hard to provide the best possible patient outcomes and experience, and he wished to thank all of them for their efforts under difficult circumstances. There are instances of additional patients on wards, and some of these patients are not being accommodated in normal conditions. These measures are to ensure that ambulance handover times are met and to release ambulances to respond to patient need in the community. Professor Kloer recognised the challenges involved and suggested that the Urgent and Emergency Care (UEC) Business Case item later on the agenda will be an important discussion item. He added that the Health Board has established a Winter Resilience Incident Management Group, which it is hoped will be time limited. This is intended to provide additional focus and facilitate prioritisation.

Professor Kloer welcomed the positive news around the Health Board's escalation status, with Leadership and Governance having been de-escalated from Level 3 to Level 1. He thanked everyone involved in achieving this, whilst cognisant that the organisation remains escalated in other key areas. A letter from the Director General of NHS Wales providing further feedback in relation to the Health Board's escalation status is appended to the report. Members noted the update regarding the Pathology Transitional Memorandum of Understanding (MOU). In addition, Professor Kloer provided a verbal update regarding the Site Selection Process for a South-West Wales Cellular Pathology Laboratory, as follows:

A Regional workshop has been scheduled for 2 February 2026 to determine a preferred site for a South-West Wales Cellular Pathology Laboratory. Three sites are being considered, which have met the required hurdle criteria, previously outlined in the Board Paper received at both the Hywel Dda and Swansea Bay Public Health Board meetings in September 2025. This work is being progressed by the Regional Cellular Pathology Capital Working Group, chaired by the Executive Director of Strategy and Planning in Hywel Dda University Health Board, which sits within the agreed Regional Cellular Pathology Programme governance structure.

A South-West Wales Cellular Pathology Laboratory Options Appraisal paper will be prepared following the workshop, outlining the preferred regional option. It has been agreed with Welsh Government that this will be submitted by Friday 20 February 2026, to precede pre-election decision making embargos on new requests for Capital monies.

The process and timeline to approve this paper prior to Welsh Government submission has been defined as:

- Regional Joint Committee for review and endorsement at a single issue meeting, which has been scheduled virtually on 16 February 2026.
- Swansea Bay UHB for approval at a Special Board meeting, which has been scheduled virtually on 17 February 2026.
- Hywel Dda UHB for approval at an Extraordinary Board meeting, which is scheduled for Thursday 19 February 2026.

Professor Kloer committed to share the above information with Members in written form. He concluded by drawing Members' attention to the proposed changes to the organisation's Risk Appetite Statement, and the update regarding the Corporate Risk Register (CRR). The latter includes a great deal of information around the significant risks which the Health Board is carrying as an organisation.

PK

Before opening the floor to questions, Mrs Marks wished to apologise to those viewing on the livestream for the absence of sound in the early part of the meeting; due to technical issues.

Referencing the CRR update, Cllr. Rhodri Evans noted Risk 1552 - Risk of insufficient mortuary capacity due to current and anticipated future demand - and requested additional clarification. Also, whether the situation has been impacted by the new Medical Examiners process. Mr James Severs advised that this risk had been recorded on local risk registers previously. Discussions had been undertaken with the Human Tissue Authority (HTA) regarding additional capacity, and temporary arrangements had been put in place. However, these temporary arrangements had since become more substantive, which is not necessarily appropriate and is an unsustainable position. As a result, the threshold of concern had been raised. Members heard that work is underway with Swansea Bay UHB (SBUHB) to consider the potential actions which might be taken; this work is being monitored via the Strategy and Planning Committee (SPC). Mr Severs assured Members that regular discussions are taking place with the HTA, adding that this is an issue affecting all of Wales. Mr Mark Henwood recognised that the introduction of the new Medical Examiners rules had resulted in issues which slowed the process. He advised, however, that HDdUHB is 'mid pack' in Wales in this area and assured Members that the Health Board is continuing to engage with all the relevant parties.

With regard to the BCI arrangements, Mrs Chantal Patel enquired whether the pressures being experienced are exceptional, and in excess of the planning operational teams undertake around winter resilience. Also, whether – in response to the mortuary capacity risk – consideration has been given to alternative methods for dealing with the deceased, citing approaches taken in other countries. In response to the first query, Mr Andrew Carruthers reminded Members that there is an All Wales escalation framework, with BCI being a level of escalation within this. This winter, however, organisations across Wales are finding themselves increasingly in Level 5. There are several factors involved in determining the level of escalation. Locally, the position has been at a higher level for longer than would be wished; as a result, additional responses and support have been put in place. In response to Mrs Patel's first query, Mr Severs assured Members that options are being considered and that all possible measures are being taken to support families and carers in respect of their loved ones.

Referencing the list of activities on page 4 of the report, Mr Maynard Davies recognised that Digital was predominantly an enabling activity. However, as its usage is increased, he queried whether Digital Innovation should be considered as a potential risk category. Agreeing, Mr Huw Thomas suggested that this be taken forward for consideration by the Digital, Data and Innovation Committee (DDIC). In Appendix 6, Executive Team Discussions, Mr Maynard Davies noted the update on the Operational Structure Update. He enquired regarding the reason for and anticipated duration of the pause in Phase 2 of the Organisational Change Process (OCP) for the Community and Integrated Medicine Clinical Care Group (CIM CCG). Also, how soon the new Medical Rate Card will be implemented, and the timescale for establishing the Prince Philip Hospital (PPH) Urgent Care Treatment Centre.

HT

Mr Carruthers advised that Phase 2 of the Operational Structure OCP had been paused since the autumn of 2025. This had been to realign the management portfolio for Primary Care, Community Care and Medicines Management. Meetings are planned for the coming week to consider this further, and it is intended to take Phase 2 of the OCP to the People, Organisational Development and Culture Committee (PODCC) in February 2026. With regard to PPH, an implementation group has been established, although there have been issues resulting from the operational pressures already mentioned. A high-level timeline and plan is in place, and a detailed implementation plan is being developed. The intention being for full implementation of the clinical model by November 2026, with certain aspects of this being implemented by July 2026. Progress will be reported to Executive Team, and can be communicated to Committees and the Board as required. Professor Kloer welcomed the update, emphasising the need to ensure that this is reported via the Committee structure and thence to the Board.

AC

In response to the query around the Medical Rate Card, Mr Henwood indicated that the Health Board has been working with the Local Negotiating Committee to develop a new rate card. The current version dated from 2017, so clearly required updating. The BMA has its own version; however, has been very supportive and helpful in providing advice. A way forward has now being agreed, and it is hoped to launch the new Medical Rate Card in early to mid February 2026.

Decision: The Board:

- **NOTED** the letter from Welsh Government in relation to the Health Board's escalation status
- **NOTED** the timelines to review and refresh the Health Board's Board Assurance Framework
- **APPROVED** the revised Health Board's Risk Appetite Statement
- **NOTED** the Corporate Risk Register (CRR) report and summary
- **ENDORSED** the Register of Sealings since the previous report on 27 November 2025
- **NOTED** the status report for Consultation Documents received/responded to
- **NOTED** Executive Team discussions

PM(26)07

Audit Wales Annual Audit Report and Structured Assessment

Ms Anne Beegan, representing Audit Wales was welcomed to the meeting. introducing the Annual Audit Report 2025 and Structured Assessment 2025 Report, Ms Anne Beegan advised that the first of these draws together the findings of Audit Wales reports which have been presented to the Audit and Risk Assurance Committee (ARAC) during the course of the year. The second provides the findings of Audit Wales annual governance review. Focusing on the Annual Audit Report, in terms of the financial audit work, Audit Wales had issued an unqualified 'true and fair' opinion on the Health Board's annual accounts, and a qualified regulatory opinion. The latter is due to the Health Board's inability to achieve financial balance over the three year period and a balanced three-year Integrated Medium Term Plan. Drawing Members' attention to page 6 of the report, Ms Beegan noted that this presents an overall conclusion in relation to the performance audit work.

In relation to Audit Wales' governance work, they continue to see evidence of strong Board and corporate governance arrangements. There is good risk performance and oversight, and the work being undertaken by the Health Board in relation to the Strategy Refresh is recognised. There are only two minor recommendations, regarding the Board Assurance Framework and '3As' reports. Efforts to reduce long waits are noted, although there is still further work required, including around inefficiencies. Whilst improvements are being seen in Urgent and Emergency Care, there remain significant pressures, many of which are caused by delayed discharge. Finally, Audit Wales had examined

capital allocation and had identified effective capital prioritisation arrangements, with only one minor recommendation. Members were reminded that all of Audit Wales' recommendations are tracked via the Health Board Audit Tracker and ARAC.

Cllr. Evans welcomed the report, which he felt represented an accurate reflection of the Health Board's position. He wished to thank the Director of Corporate Governance and Executive Director of Finance for all their work, which had contributed to the fact that only two minor recommendations had been identified. He also expressed his thanks to Ms Beegan and the wider Audit Wales team for their work. Mrs Joanne Wilson added her thanks, noting that the regular meetings held with Audit Wales are extremely useful. Whilst welcoming the fact that the two recommendations can be addressed fairly easily, she recognised that the organisation as a whole has more still to do.

Mr Maynard Davies thanked Audit Wales for their reports, which were very clear. He noted that on page 13 of Appendix 1, five areas of performance audit work remain outstanding. He enquired regarding the likelihood of these being completed this year. In response, Ms Beegan advised that Audit Wales are working to clear outstanding performance audit work by the end of March 2026. The Cancer Services review is expected to be delivered by July 2025, and all work should be complete by the summer.

Mrs Marks thanked Audit Wales for working with the Health Board, and for the positive relationship. Whilst the reports' findings are positive, the work still required of the Health Board is recognised. Professor Kloer echoed this sentiment, and welcomed the finding of only two minor recommendations, whilst emphasising the need to maintain momentum. He noted that the performance audit work still being undertaken is in areas where the organisation is keen to make progress and requiring additional focus.

Decision: The Board:

- **SUPPORTED** the content of the Annual Audit Report 2025 and Structured Assessment 2025 Report, including the change to the Health Board's financial position since the report was issued
- **TOOK ASSURANCE** that the Structured Assessment report presents a fair and balanced view of the organisation, recognising both the positive aspects identified and those areas where further progress is required.

PM(26)08

Annual Plan

Presenting the report, Mr Lee Davies explained that it provides an update on development of the 2026/27 Annual Plan. Since the previous Board meeting, the Health Board has received the NHS Wales Planning Framework, along with the funding allocations. The Performance Framework is, however, yet to be issued. Members were reminded of the decision to apply a risk-based approach to the planning process, with more than 600 risks

identified, the vast majority of which are rated 'high' or 'extreme'. Mr Lee Davies wished to highlight the following:

- The planning process had been commenced earlier; however, operational teams are (as has been noted) under significant pressure, which is impacting on their ability to participate. The Executive Team has considered and agreed various mitigations
- It is anticipated that there will be a requirement to submit an Accountable Officer letter to Welsh Government, due to an inability to submit a balanced Integrated Medium Term Plan (IMTP)

In the context of major risks, the funding allocation for 2026/27 is particularly challenging, with Welsh Government identifying that it represents a 'no investment' year. This will present challenges in terms of the organisation's ability to develop a plan which is acceptable to and supportable by both the Board and Welsh Government. The Health Board remains in Targeted Intervention for both Planning and Finance. This continues the challenging situation experienced in the current year, and is important for the Board to be aware of during the planning process.

Mr Michael Imperato noted reference in the report to a planning workshop on 8 January 2026, and enquired regarding the outcome. Mr Lee Davies advised that there had been difficulties securing full attendance due to current operational pressures. It is a significant commitment for CCGs to develop their local plans, and there has been a range of responses. The team is discussing how this is managed, recognising the operational demands being experienced at this time. Mr Maynard Davies commended the report. He highlighted, however, that there are various requirements placed upon health boards which do not feature in the Planning Guidance, such as the need to meet Ministerial Priorities. In addition, the issuing of the Guidance by Welsh Government is not especially timely, which adds to the pressures involved.

Professor Kloer agreed that the scale of the challenge is significant. He reminded Members, however, of the Health Board's statutory duty to break-even, and that it has been allocated a sum of recurrent funding on the condition of achieving this. There is significant demand on the organisation's resources, and current savings plans are insufficient to deliver the required position. Work is underway with CCGs, recognising the multiple and competing demands on staff time. The situation will mean that it is necessary to de-prioritise certain workstreams. It is highly unlikely that the Health Board will be in a position to submit an acceptable plan, and it will need to issue an Accountable Officer letter. The organisation will continue to work with Welsh Government regarding its intentions. Whilst welcoming the openness and transparency around this situation, Mrs Marks was conscious that staff are working extremely hard, and that many are being pushed to their limits. She felt that this needs to be recognised.

Decision: The Board:

- **DISCUSSED** the emerging planning architecture and the structured approach to developing the 2026/27 Annual Plan
- **TOOK ASSURANCE** from the deliberate sequencing of planning activities and the convergence of risk-based prioritisation, national Framework requirements, and local planning methodology into one connected planning system
- **ENDORSED** and **APPROVED** the planning format and principles as the basis for an Annual Plan 2026/27 set in a 3-year context, ahead of the Board meeting in March 2026
- **NOTED** the key submission milestones, including the Accountable Officer letter requirement by 13 February 2026
- **NOTED** the risks to delivery of an acceptable Plan for 2026/27

PM(26)09

Financial Report

Presenting the Financial Report, and at the risk of repeating the messaging of the previous agenda item, Mr Huw Thomas highlighted that there remains an extremely challenging financial position. Progress has, however, been made, particularly in terms of increased grip and control over previous years. At the end of Month 9, the Health Board is forecasting a year-end deficit of £22.1m. This is an improvement since the previous meeting, and results from the settlement of certain funding issues. The £22.1m figure is, however, a challenging forecast. The pressures seen during Month 9 are expected to continue for the rest of the year. The forecast represents an improvement on the original Annual Plan, which was £30m. Rather than the end point, however, the key issue is probably the trajectory required to achieve this, which is an in-month deficit of £2.4m. This is currently not achievable and is at risk, the drivers being: Primary Care prescribing costs; additional Planned Care capacity to reduce waiting lists; medical and nursing agency usage; Pathology and clinical supplies. By the end of Month 9, the Health Board has identified £49.8m in savings against a target of £46.4m. Expected delivery is £49.5m; however, this is heavily reliant on non-recurrent savings. Mr Huw Thomas was particularly grateful to a number of the Corporate teams, who have over-delivered on savings against requirements. The underlying deficit going into next year is substantial, anticipated at this stage to be £59.3m. The significance of this figure is in terms of scale of requirement for the next two years, if the organisation is to meet its obligation to achieve financial balance and retain the conditionally recurrent funding mentioned earlier. The risk in relation to this is especially acute, particularly in view of the constrained funding envelope for next year, along with limited ability to engage with operational teams for the reasons already outlined.

Grip and control in various areas has been strengthened in terms of: revised escalation arrangements; tighter controls over recruitment, agency, training and procurement; strengthened Financial Control Steering Group (FCSG); improved visibility and

assurance to reporting and dashboards. Whilst these are beginning to show effect, they need to be maintained. The Board's retrospective approval of the revised letter submitted to Welsh Government for Strategic Cash Support is requested. A medium level risk around capital remains, largely due to the profile of expenditure being 'back-ended', with allocations received later in the year.

Mr Imperato commended the report, agreeing that financial grip and control has improved. In terms of the drivers of the month to month position, he enquired whether agency spending is driven by staff sickness rates, in addition to other factors. Noting that recurrent savings is a recurring concern, he queried whether there are actions which are potentially being overlooked. In response, Mr Huw Thomas indicated that staff sickness is a contributory factor in agency usage, with the recent increase to 7.1% a significant one. Reducing the staff sickness rate to approximately 5.5% would result in an impact of £2.2m. However, current operational demand and pressures are also a driver of agency expenditure. Patients are being cared for in ways which result in pressures on the medical and nursing workforce. The Health Board as an organisation is under significant demand pressures; these need to be addressed before it can request services to make additional savings. Mr Imperato highlighted that staff resilience will also impact on performance.

Mrs Lisa Gostling indicated that the principle reason for long-term staff sickness is stress. There are, at this time of year, also seasonal reasons for short-term sickness, such as coughs and colds. However, nurse agency usage in December 2025 was lower than in November. It is also important to recognise the impact of patient acuity. Agreeing with this, Ms Sharon Daniel added that surge capacity also influences nurse agency usage. Members heard from Mr Henwood that medical agency usage is increasing, which is a major concern. There are, within the Health Board, areas which are chronically challenging to recruit to. Acute Medicine is the greatest concern, as it contributes to 'front door' care. The situation makes a number of rotas unattractive to potential applicants. The organisation also has a duty to provide training to its employees, with recent Health Education and Improvement Wales (HEIW) reports raising concerns in this regard. Whilst work is ongoing in terms of a medical workforce stabilisation programme, the Health Board's challenging position is very much driven by its current configuration and structure.

Mrs Patel expressed concerns around whether the measures planned are realistic, particularly given the pressures under which the workforce is operating currently. Also, whether the organisation has the capacity and capability to achieve its aims. Adding to this, Mr Maynard Davies highlighted that the Welsh Risk Pool (WRP) risk remains significant, with a potential additional cost of £1.1m. There is also a risk in relation to savings plans and the achievement of the £22.1m target. Given that a request for cash support is already being proposed, the potential impact of

these requires clarification. Mr Huw Thomas acknowledged that there is a challenge in terms of how realistic the 'change challenge' is. It should be recognised, however, that the Health Board's funding allocation is finite, and it is incumbent upon the organisation to address the choices it may have to face in a timely manner. Such measures will be discussed at the Finance and Performance Committee (FPC). Members noted that there is always a risk in relation to the WRP towards the end of the financial year, associated with the timing of the potential financial impact. The Health Board is in ongoing discussions with Welsh Government in this regard. Overall, there are options available, with Mr Huw Thomas reminding Members that the organisation has a strategy in relation to cash management.

Professor Kloer echoed that it will not be possible to resource all of the Health Board's ambitions, and that there will be 'trade-offs'. There are areas in which investment will not be forthcoming, and the organisation will need to be creative and innovative. It should be recognised that the Health Board does receive a significant financial allocation. Agreeing, Mrs Marks emphasised that the financial envelope is fixed, and this will mean that difficult decisions will be required.

Referencing the run-rate in December 2025, Mr Winston Weir noted that January 2026 is also likely to be challenging again. He queried whether the inflationary growth rate is insufficient. Mr Weir also reiterated comments made at previous Board meetings around the need to shift resources into Primary and Community Care, both financial and other. In terms of the run-rate, Mr Huw Thomas suggested that the challenge will be how quickly it will be possible to recover from winter pressures. The impact involved is likely to be +/- £2-3m. The inflationary growth rate, 1.1%, does not include the financial impact of pay awards, as this risk is absorbed by Welsh Government. The rate is set by others rather than the Health Board, whose responsibility is to make choices and decisions based on it. In terms of moving forward, Professor Kloer suggested that much information will be presented under later agenda items around the Strategic Refresh and Community by Design. The UEC Business Case focuses significantly on investment in the community; it is important to retain Board oversight in this area. Also to note, included in the allocation from Welsh Government is an additional allocation for Primary Care. It will be necessary to assess the impact; clarity around this does not yet exist.

In reference to staff sickness rates, Cllr. Evans felt that it is also important to both recognise and thank staff for their efforts under significant demands. The associated Ministerial Priority and the expectation around this involves a major pressure. Whilst acknowledging this as a priority, he suggested that the realities being managed at present also need to be recognised. Agreeing, Mrs Gostling emphasised that staff in all areas are experiencing the pressures, with support staff expressing concerns around the demands on them, as well as frontline staff. She reminded

Members that the Health Board's staff are also its public. The exercise being conducted to examine illness prevalence based on population has evidenced a correlation with sickness rates.

Returning to the issue of inflationary growth rate, Mr Weir acknowledged the assumptions around the application of 1.1%. His concern related rather to whether the organisation has an understanding of and scenarios for managing the impact of this growth rate, and whether there is clarity around the 'gap' it creates. If not, whether there is a clear timescale for identifying and defining these. To preface all of this, Mr Weir felt that achieving £22.1m after the challenges at the beginning of the year should be recognised as a significant achievement. In response, Mr Huw Thomas advised that the Health Board is undertaking a piece of work with Aberystwyth University around disease prevalence rates and their impact on the organisation's systems should it continue to provide services in the same way. On this basis, over the next three years, the projected financial impact is £12.4m. The organisation is being asked to deliver a level of savings of approximately 2%, just to keep the position static. On this basis, Mr Huw Thomas would estimate an actual cost pressure or inflation rate of just over 3%, with funding of 1.1% allocated. With regard to the work Mrs Gostling had referenced earlier, Dr Ardiana Gjini confirmed that there is a close correlation between staff sickness rates and population illness prevalence and levels of deprivation. A key factor in addressing this will be the 20four7 model, which it is hoped will be taken forward locally, subject to Board discussion later on the agenda.

Decision: The Board:

- **RECOGNISED** that the Health Board's forecast deficit has improved to £22.1m, the revised target control total, following funding allocation confirmation from Welsh Government.
- **SCRUTINISED** the top priority alerts for urgent remedial action plans, especially given the worsening run rate trajectory evidenced in Month 9.
- **ACKNOWLEDGED** that the in-year savings delivery target has been over-achieved.
- **NOTED** that the Amber savings scheme judgement around future run rate conversion totalling £1.5m has now been converted to a Green scheme within the Month 9 position, as evidenced by past performance.
- **ACKNOWLEDGED** that an underlying deficit assessment has been undertaken and that will only be reduced via robust recurrent savings delivery improvements, in particular those Executive portfolios that have yet to identify their full target.
- **RETROSPECTIVELY APPROVED** the revised letter submitted to Welsh Government on 9 January 2026 for Strategic Cash Support.
- **NOTED** the Finance Performance report now includes additional outputs to provide more insightful and relevant reporting to the Committee.

- **NOTED** the Welsh Government allocation update and delivery expectations.

PM(26)10

Integrated Performance Assurance Report

Mr Huw Thomas introduced the Integrated Performance Assurance Report (IPAR) for Month 9 of 2025/26, indicating that this presents a mixed picture. There are areas of improvement, areas of fragility and a number which continue to require Executive and Board attention. Certain encouraging trends are being seen around quality and safety. Since July 2025, there has been a sustained reduction in incidents causing moderate harm or greater. This, alongside a reduction in patient falls and medication errors. Complaints have also reduced significantly since September 2025. This is, however, balanced by continuing concerns around Infection Prevention and Control (IPC), with increasing rates of Healthcare Acquired Infections (HCAIs). Issues such as this reinforce the challenges being seen currently across systems and services.

UEC remains an area of significant challenges. There have been improvements against the 45 minute Ambulance Handover performance target, and the stabilisation programme is beginning to show results. Whole system flow is key to this area. Whilst Planned Care is also seeing some improvements, there are certain 'trade-offs', with increases in delayed follow-up waits. The target trajectory for the Single Cancer Pathway (SCP) has not been met. There are pressures in specific areas in this regard, with arrangements to address these in place. There are also issues around waits for diagnostics, with action plans in place, albeit more in relation to the mid-term than short-term. Some improvements are being seen in relation to Mental Health performance measures; however, other areas remain challenging. Workforce has already been mentioned and, whilst Mr Huw Thomas would not revisit these discussions, he shared the views of Cllr. Evans.

Mr Imperato felt that it is important not to lose sight of the organisation's achievements during the year. During discussions at FPC around the performance trajectories in relation to Cancer and Ophthalmology, whilst the Committee took assurance overall, there was concern that these were, perhaps, overly optimistic. Whether there is an over-reliance on the trajectories themselves, and whether these are not sufficiently realistic. Mr Carruthers welcomed this feedback. He highlighted the challenges of balancing trajectories with managing service fragilities and workforce issues. Members were assured that the Health Board does all it can to protect Cancer pathways in taking any performance improvement actions. Whilst improvements are starting to be seen, and the treatment element of the pathway is less of an issue, there is more which could be done.

Mr Carruthers felt that the organisation should consider how it can better use the expertise and knowledge it has available, and share this on a regional basis. Agreeing, Mr Huw Thomas highlighted

that there are two components involved with Cancer performance: the 62 day target for the SCP, and addressing the backlog. As has been noted before, addressing the second inadvertently impacts deleteriously on the first. However, recently, both have deteriorated, and the reasons for this need to be examined. It may be necessary to employ a risk scenario-based approach in addressing this area.

Whilst welcoming the reduction in complaints, Cllr. Evans enquired regarding the reasons for the increase in HCAs. In response, Ms Daniel explained that the Health Board has seen an increase in respiratory and norovirus infections. There is a high risk of transmission with both, and IPC precautions have been increased accordingly. The organisation continues to monitor and seek to drive improvements in this area. With regard to complaints, it will be necessary to review and analyse past and current performance. Members were reminded that systems have been changed, and it may be that there are other reasons impacting on the apparently dramatic improvement.

Referencing the Escalation Summary, Mr Maynard Davies welcomed the overall reduction in those RAG rated as Red. He noted that there is one area which remains significantly Red, but understood that steps are being taken to address this. The domain which does appear to require focus is Population Health, and he suggested that doing so would potentially reduce pressure on other areas. Welcoming this feedback, Mr Huw Thomas explained that escalation in Population Health is relatively limited at this stage, being around resilience and business control recovery plans and flu vaccinations. In addition, and more generally, discussions are taking place in the Executive Team around how the escalation processes might be refined. Dr Gjini added that the Population Health domain will be extended, and that next phases will take forward various areas of work. In response to a query around how the impact of the Clinical Streaming Hub is being monitored, Professor Kloer suggested that this be addressed during the UEC Business Case item.

Decision: The Board **DISCUSSED** the IPAR – Month 9 2025/26 report and **TOOK ASSURANCE** on the operational delivery of mitigating actions to improve performance in the areas that have been categorised as ‘alert’.

PM(26)11

Refreshing the ‘A Healthier Mid and West Wales’ Strategy

Ms Anne Beegan left the Board meeting. Mr Alex Martin, Dr Will Mackintosh, Dr Sion James, Mr Peter Skitt and Ms Anna Henchie joined the Board meeting.

Mr Lee Davies began by welcoming the additional attendees, particularly Mr Alex Martin, who had contributed significantly to the development of the Strategy Refresh workstream and report. It is important to recognise that the Health Board has only one Strategy – ‘A Healthier Mid and West Wales’ (AHMWW) – first agreed in 2018. The work of Professor Kloer and other colleagues

in developing this was acknowledged. The Strategy Refresh being discussed today builds on AHMWW but neither stops nor changes the direction of travel outlined within that. It recognises the scale of the challenge and the need to go further. This requires the Health Board to be bolder and be open with its public and partners. Working with neighbouring health boards, partners and communities will be vital. Whilst the Strategy sets out Strategic Objectives, it is recognised that robust delivery plans will be required for these, some of which are being considered today. Others have already been considered previously by Board, and the remaining ones will be progressed during 2026. Subject to Board approval of the refreshed Strategy, the Board Assurance Framework will also be updated. The Strategy will be a 'live' document, and further refreshes may be required in the future. However, there is a commitment to retain its key principles.

Acknowledging that there had been a significant clinical presence at the Board meeting in 2018 when the Strategy was originally agreed, Mr Alex Martin reiterated that the principles in the clinical strategy remain unchanged. It should also be noted that the approach to the Strategy Refresh has been tested with clinical colleagues, and that the Engagement team has undertaken a great deal of engagement work with staff. A series of recommendations had been made in 2018 by the Community Health Council (the forerunner to Llais), which have also been addressed. Mr Martin hoped that this provides assurance around engagement. With regard to engagement with the public, the team had considered how this might be undertaken differently, which had been of great benefit during the process. Rather than running separate engagement events, an approach of utilising existing opportunities, including 'Making Every Contact Count' had been applied. This approach has produced a real breadth of feedback, not limited to the Strategy refresh scope. The feedback received, however, has been 'woven' into the refresh.

Mrs Marks thanked the team for their work, commending the report and the approach used for engagement. Mr Maynard Davies advised that he had already commented on the proposals when they had been presented at SPC. He also commended the document, suggesting that it maintains the correct direction of travel. Mr Maynard Davies emphasised, however, that Digital needs to become a key mechanism for delivering the Strategy. The lines and demarcation between sectors need to be 'blurred', in order to deliver improved patient access to care. Cllr. Evans agreed that the document is helpful and easy to read. He noted, however, that it contains 23 references to 'radical' and queried whether, in view of this, the organisation realistically has the capacity to deliver. Mr Iwan Thomas welcomed the document, noting that the partnership and co-production element to proposals is clear. The challenge will be in articulating how this is achieved, particularly with regard to prevention of ill health. He emphasised that the associated fiscal challenge involved cannot be passed on to other sectors. There will also need to be

consideration of how communities are involved and engaged with the proposals.

Mr Weir advised that the proposals had been well received when presented to SPC. Achieving the balance between aspiration and detail is difficult; however, the document has done so and is well written. He found the focus on healthier communities, 20four7, acting in partnership with communities and preventing ill health particularly inspiring, along with the aspiration to address poverty and inequalities. Mr Weir would welcome information around how life expectancy varies across the three Hywel Dda counties, and how these differences might be addressed. The section on Positive Futures was especially inspiring, and Mr Weir thanked all of those involved in preparing the document and the wider work. Whilst echoing his colleagues' positive comments, Mr Imperato reiterated previous concerns around the need to consider the issue of transport, which is a common theme within Equality Impact Assessments. Whilst assured that this is being considered, he queried whether a specific Committee and/or the Board need to take more oversight on this area particularly. Mrs Patel enquired whether there are plans to revise the Health Board's educational approach to support delivery of the refreshed Strategy.

With regard to Population Health and reduction of inequalities, Dr Gjini assured Members that this is an area the organisation is committed to strengthening. The development and implementation of the 20four7 model will be key. The intention for community-led prevention of ill health is described, albeit at high-level. This will be achieved via co-production with communities and community-based services. The Health Board will be working with people embedded in communities, to enable individuals and communities to stay healthier for longer. Members were assured that partnership working is already taking place, and were reminded of mechanisms in place via the Public Services Boards (PSBs) and the Regional Partnership Board (RPB), all of which have committed to the principles involved. Disparities in life expectancy are a priority, and the data Mr Weir mentioned was shared at a recent Board Seminar. There is a stark difference between the region's least and most deprived communities. Whilst there is a moral aspect to this, it also impacts significantly on healthcare services and demand.

Ms Ann Murphy commended the work, whilst noting that it feels somewhat like a 'wish list' and aspirational. She reminded Members that, in 2018, the fragility of Emergency Departments was identified as a risk; in 2026, that risk has been realised. Ms Murphy emphasised and reiterated that to deliver the Strategy will require a major investment and shift of resources into Primary and Community Care. Indicating his involvement in this work in his previous role, Mr Neil Prior observed that the NHS and other public services face a challenge, and need to accept that they 'cannot do it all'. This mirrors earlier discussions around the various competing priorities, and the need to consider the

workstreams which are stopped and/or de-prioritised. There needs to be an accompanying societal shift in recognition of this change.

Mr Prior welcomed the Strategy as a reflection of the Health Board's direction of travel, noting that it contains a number of strong principles around working with communities. There are opportunities to maximise certain partnerships, which should be explored. Whilst welcoming the proposals around adoption of the Social Model for Health and Wellbeing (SMfHW), he suggested that this will be challenging to achieve. For long-term sustainability, the key will be investing in prevention of ill health. Overall, the organisation faces a huge challenge, but Mr Prior looked forward to supporting it in this. He suggested that the Board's focus should be on those areas requiring de-prioritisation in order to implement the Strategy, and how the Health Board as an organisation takes ownership of the Strategy. Mrs Marks emphasised that the case for change had been made in 2018. There is also an holistic perspective: the proposals are not simply concerned with shifting care; they are to do with how people look after themselves more effectively. She welcomed the inclusion of values and behaviours, suggesting that it is vital to underpin the Strategy with these.

Welcoming the comments and feedback, Mr Lee Davies observed that all of these reflect the challenges being faced by the Health Board. In terms of key messages in the Strategy refresh, he would highlight:

- The Health Board is fundamentally a health organisation, rather than a healthcare organisation
- The projected demographic changes impact on healthcare, meaning that:
 - It is unsustainable to continue as at present
 - There is an inherent case for change
- It is challenging to change course, even slightly. This is further magnified by the current challenges and pressures being faced in the healthcare sector
- The refresh is not intended to be unconditionally positive. Stark choices will be required

He suggested that there are two significant opportunities for the Health Board: Digital and a shift into the prevention of ill health; Primary Care and community-based services. There are challenges involved, and it will be vital to progress plans in co-production with communities. Whilst it is not possible to address the issue of poverty in isolation, the Health Board is a major employer within the region, and can contribute by way of this role. Mr Lee Davies agreed that transport is significant, and would suggest that more discussion on this topic takes place at a future Board Seminar. It will also be important to recognise that the future workforce will require a different set of skills, for example in Artificial Intelligence (AI). Finally, Mr Lee Davies acknowledged the need to substantiate ambitions and aspirations with actions.

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On the topic of transport and the challenges involved, Mr Martin noted that this had been a common theme raised during public engagement. He further noted that the public view the development of Digital solutions as a potential mechanism for addressing this issue, whilst recognising that more enabling work would be required for certain parts of the community. Whilst the public is committed to holding the Health Board to account for changes, it is evident that they also want to support it to improve services. Ms Alwena Hughes Moakes explained that the Strategy is a 'live' document, and that it must be accessible to the public and staff. To this end, various versions will be developed. The version presented today should be viewed as a starting point, rather than the 'finished article'.

Professor Kloer wished to place on record his thanks to the team involved in this work, noting that development of the original Strategy in 2018 had been a significant exercise. The process and approach employed to the Strategy refresh has been extremely impressive. He felt that the Strategy is grounded in reality and is an expression of what the organisation has both heard and experienced during the past seven years. The refresh is the correct course of action at this time. The associated Strategic Objectives will be key, and if time and resources are invested in these, progress will be made. Reassuringly, the next few agenda items reflect a commitment to do so. Finally, Professor Kloer emphasised that the Board sets the culture for the organisation. If Members believe and agree that this is the correct direction of travel, there must be a commitment to take this forward and to test ourselves against it.

Decision: The Board:

- **DISCUSSED** the content of the 'A Healthier Mid and West Wales' Strategy and **CONSIDERED** whether it meets the long-term aims of the organisation.
- **APPROVED** the Strategy refresh and attachments, in order that the final versions can be created for circulation to public, staff and partners.

PM(26)12

'A Healthier Mid and West Wales' Programme Business Case Addendum

Ms Eldeg Rosser, Ms Clare Emanuel, Ms Emma Talla and Mr Nick Durham joined the Board meeting.

Presenting the report, Mr Lee Davies thanked those joining the meeting for their work on the Programme Business Case (PBC) Addendum. Where the Strategy Refresh sets out the Strategic Objectives, fit-for-purpose facilities are one element of delivering these. Members were reminded of Welsh Government's challenge to the Health Board around the AHMWW PBC and Strategic Outline Case (SOC). As part of the constructive dialogue on this matter, the Health Board was asked to develop an addendum to the PBC. This had a specific scope: the new hospital, Glangwili Hospital (GGH) and Withybush Hospital (WGH), not Bronglais

Hospital (BGH), PPH and the community sites included in the original PBC. The process undertaken considered a number of potential scenarios or options. Following testing, certain of these had been deemed unsuitable. The document has now been completed, with the revised set of options included. Mr Lee Davies emphasised that the proposals are at an early stage, and will require a considerable amount of additional work. However, Board support for submission of the PBC Addendum is sought.

Mr Weir advised that the proposals had been considered (and supported) at an Extraordinary meeting of SPC on 16 January 2026. As a Health Board, the ambition is for a new hospital; however, Welsh Government has not endorsed this approach. The PBC Addendum represents a compromise, which does acknowledge the long-standing estates issues faced at GGH and WGH. SPC had recognised the challenges involved in refreshing the Strategy; acknowledging the need to invest more in estates; actioning feedback from services and taking forward the Clinical Services Plan, all at the same time. Given the additional expenditure involved, SPC had suggested that wider consideration of the proposals by the Board is required. However, Members had been assured by the process undertaken and by the positive engagement with Welsh Government.

Looking to the future, Mr Maynard Davies noted that, should proposals reach the Outline Business Case stage, the design for a new hospital would be significantly different to that which was envisaged in 2018. Mr Lee Davies highlighted that it is not necessarily possible to predict, at this stage, the potential impact of Digital on the configuration or design of new clinical estate. Mr Nick Durham agreed that Digital innovation will probably be the greatest influence on hospital design. Careful consideration will need to be given to the potential benefits which might be offered. This is a rapidly evolving area and, as such, it is unwise to make too many assumptions.

Professor Kloer welcomed the helpful suite of documents produced by the Planning team, which represent a significant achievement. These were especially helpful when viewed in conjunction with the next two agenda items. He recognised that some of the estates and facilities within the Health Board are extremely poor, and that these present significant challenges for staff in delivering services. A great deal of resource is 'locked into' the current estate model. The organisation is participating in a constructive dialogue with Welsh Government, which is at an important stage. With regard to Digital, Mr Huw Thomas emphasised that, globally, this is accelerating faster than in the UK. It will be vital to learn lessons from elsewhere. Agreeing, Professor Kloer indicated that clinical space will need to be flexible and adaptable in nature.

Decision: The Board:

- **NOTED** that the 2022 'A Healthier Mid and West Wales Strategy' Programme Business Case (PBC) remains unendorsed and that, as stated in previous updates to Board, Welsh Government has advised that the options need to be "as wide as practicable"
- **NOTED** the work undertaken to test alternative scenarios
- **AGREED** and **APPROVED** the PBC Addendum for submission to Welsh Government

Ms Eldeg Rosser, Ms Clare Emanuel, Ms Emma Talla and Mr Nick Durham left the Board meeting.

PM(26)13

Community by Design Strategic Plan

Ms Rhian Bond joined the Board meeting.

Mr Lee Davies welcomed additional attendees for this item. He wished to formally acknowledge the work undertaken by Miss Jill Paterson in developing the Community by Design Strategic Plan to this stage. Whilst the proposals represent 'a point in time', they also define the intended direction of travel. There are four key aspects involved:

- Through the engagement work undertaken, it has been possible to articulate the six priority areas
- Hurdle criteria have been developed to progress these
- It has been possible to begin to describe the clinical model. The Primary Care Cluster configuration is integral to progressing this
- Consideration needs to be given to the next steps and support required

Focusing on the clinical model, Dr Will Mackintosh explained that this emphasises the importance of Primary Care Clusters. The model has been under development for a number of months, and is an emerging whole-system model. It reflects the importance of connecting with other parts of the organisation; colleagues in UEC and Public Health have been key in contributing to the design phase. Also of import are the 4Cs of Primary Care: Contact, Coordination, Comprehensive, Continuity. The machinery of these is central to the model, as it takes care beyond prevention; reflecting Primary Care's generalist responsibility in providing holistic, person-focused care, rather than disease-focused care. The model is truly multiprofessional, and it is hoped that this will influence not just the practice of clinical care, but the clinical culture within the Health Board. Referencing earlier discussions, Dr Mackintosh emphasised the importance of ensuring that the core values of patient treatment are digitally-enabled, rather than digitally-driven.

Members will note that the representation of where Clusters sit in the clinical model crosses boundaries. This underscores the intention to work together, reflects the key role of Primary and Community services in being the closest part of the system to

engage on a day-to-day basis with the population, an understanding of the inequalities that some communities face, and the poor outcomes driven by these. The model also offers opportunities to be more closely integrated with specialist care colleagues. Collaboration with Public Health is vital, with the 20four7 principles inherent to the overall clinical model. Concluding, Dr Mackintosh emphasised the opportunities for ambition offered by the Community by Design Strategic Plan, and suggested that, within the organisation, the clinical leaders exist to enable establishment of a centre of excellence in Primary and Community Care.

Mr Weir advised that this topic had been the focus of a useful discussion at SPC. Whilst noting that the diagram describing the clinical model is extremely powerful, he queried whether there should be different models for each county, to ensure their relevance to different locations. Endorsing the proposals, Mr Prior indicated that feedback suggests that the Health Board's relationship with communities is too 'transactional', and needs to become stronger in other ways. Building on Mr Weir's comment, he stated that communities just a few miles apart can have vastly different needs.

In response to a query around Cluster configuration, Mr Lee Davies explained that the Clusters have provided an important function in bringing together clinical leadership in Primary Care within a particular geographical footprint. They have generally been involved in delivering projects based on supporting the needs of their specific populations. Whilst positive, the feedback from clinical leaders in Primary Care is that they are keen to make more of an impact on system design. There are multiple opportunities for working with others in the Health Board and local communities to 'shift' care, not restricted to healthcare provision. In order to do this, there will need to be consideration of how additional resources are provided. Welcoming this context, Mrs Marks emphasised that Clusters know their areas very well. She also recognised the value and impact of the 4Cs.

Mr Carruthers agreed that the proposals represent an exciting opportunity. The Health Board is in a strong position in terms of Primary Care clinical leadership. He shared the view that increased integration of Clusters into the operational structure should be explored. Implementation of the proposals will be challenging and will require changes to ways of working; however, they offer real opportunities and benefits. Dr Gjini wished to highlight that future iterations will focus more on the inequalities element. She suggested that it would be preferable to utilise terminology used in the SMfHW. Mr Iwan Thomas thanked all of those involved in developing the Strategic Plan. He suggested that it is important, in discussions with communities, to ensure engagement with the 'silent majority' not just the 'vocal minority'. There should also be consideration of how projects which already exist within communities might be expanded to meet needs. Acknowledging the significance of the proposals, Mr Severs

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confirmed that members of the Allied Health Professions (AHP) and Health Science have contributed. There has been a tendency until now for this group to be focused on Planned Care provision; it will be necessary to consider how their skills and expertise can be utilised in community-based settings going forward.

Professor Kloer thanked and congratulated the team on their work, recognising the clinical leadership and the work of Ms Rhian Bond and her team. He was keen to explore how Primary and Community Care can facilitate the organisation to achieve its strategic goals more quickly. Also, how best to engage and utilise the entrepreneurial spirit of Primary Care practitioners. As suggested to him by a member of its staff, Primary Care needs to be viewed as 'the solution not the problem'. He agreed that the Health Board needs to listen to and engage with communities and be driven by their needs.

Decision: The Board:

- **AGREED** that the strategic plan is further developed in line with the six priorities of:
 - Prevention
 - Partnership Working
 - Access
 - Digital
 - Estates and Infrastructure
 - Workforce and Sustainability
- **AGREED** the hurdle criteria as the tools for assessing the ideas and options and investments generated to date
- **ENDORSED** the work to date on the draft Clinical Model for Primary and Community Care based on the 4Cs: Contact, Coordination, Comprehensive, Continuity
- **CONSIDERED** the ideas from 'Insights and Ideas', to be appraised through the hurdle criteria
- **ENDORSED** the plan to review cluster arrangements and the establishment of a Transformation Group
- **AGREED** the next steps identified:
 - Establish Hywel Dda Transformation Programme arrangements that mirror the governance, assurance, and delivery approach of the Community by Design National Programme.
 - Arrange and deliver workshops on a cluster footprint basis to review current arrangements and explore the potential future design of Cluster Planning Groups and Clusters to ensure they are well placed to drive forward the Community by Design Strategic Plan and, beyond that, the vehicles for system change in the Health Board.
 - Continue to meet with professional collaboratives and the 6 Goals Programme and 20four7 Programme to further engage clinicians and develop the Clinical Model, ensuring alignment with national clinical direction and Whole System approach (January 2026).

- Develop the 2026/27 annual plan setting out the key deliverables for Community by Design through next year and the broader ambition for the next three years.
- Establish a structured engagement campaign involving clinicians from Primary and Secondary Care and partners to explore current insights and challenges, generate ideas, and develop a range of options under priority headings.
- Create structured appraisal sessions to take all ideas and emerging options through an agreed hurdle criteria process, enabling consistent assessment and identification transformational solutions that benefit patients and whole systems operations.
- Build on engagement with external partners across social care and the third sector to communicate strategic priorities, update them on progress to date, and actively seek their views on opportunities to strengthen integration, collaboration and joint service delivery.

Ms Rhian Bond left the Board meeting.

PM(26)14

Digital Strategic Plan

Whilst noting that there has been limited reference to Regional Joint Committee (RJC) discussions, Mr Huw Thomas was cognisant that these feed into the Health Board's approach to various topics, not least Digital. The proposals are not in relation to technology in its 'narrowest' sense, rather around how Digital enables better care outcomes. They do not represent a solution in isolation, and need to be both ambitious and pragmatic. There needs to be consideration of capability need in the first instance. The report outlines the four pillars which are the 'cornerstone' of the digital transformation approach:

- Citizen engagement
- Health and care co-ordination and collaboration
- Digital operations and control centre
- Regional data fabric

As would be expected, the team has dedicated a great deal of time and effort to examining core clinical systems. Governance arrangements are aligned to national requirements, with oversight provided by DDIC. Mr Huw Thomas concluded by emphasising that the development of Digital capability to support service delivery is not optional; it is fundamental.

Mrs Marks welcomed and commended the report. Mr Maynard Davies confirmed that there had been a positive discussion at the RJC regarding the strategic direction. This report 'signals' the work that needs to be delivered during the next five months to develop a plan which supports delivery of the Strategy. Mr Neil Prior was reassured by the statement that this is not a strategy. He highlighted that even those people who say that they are not digital users are, in their everyday lives. There is, however, a danger of assuming that digital technology is the solution to everything. Whilst it is important to consider large-scale changes,

there also needs to be consideration of how small-scale innovation might be supported, to facilitate positive change and a cultural shift.

Decision: The Board:

- **NOTED** and **CONSIDERED** the proposed approach to the Digital Strategic Plan
- **NOTED** that a full Digital Strategic Plan will be developed over the next five months, with thorough engagement across staff and the public, to ensure the next version reflects a comprehensive range of perspectives.

Mr Alex Martin, Dr Will Mackintosh and Ms Anna Henchie left the Board meeting.

PM(26)15

Urgent and Emergency Care Business Case

Dr Karen Brown joined the Board meeting.

Mr Andrew Carruthers introduced the Urgent and Emergency Care Business Case, noting that the Board has discussed, during the past 12 months, various elements of UEC and the strategic approach for addressing the associated challenges involved. The Board had received, at its previous meeting, a powerful presentation from clinical colleagues on the impact of current service delivery on both staff and patients. This had emphasised again a theme common to other discussions: without a system-wide transformation of the service delivery model, it will never be possible to deliver a service which is high quality, safe, timely and sustainable. The first stage in this transformation is represented by the Business Case. The Business Case is consistent with national policy, adopts international best practice, and aligns fully with the Health Board Strategy, particularly the ambition to provide more care in the community and closer to home. It facilitates a move towards a seven-day delivery model for the Clinical Streaming Hub, Hospital@Home services and Same Day Emergency Care (SDEC) services, all of which are key in appropriately managing demand away from acute sites and protecting the acute capacity for the most unwell and vulnerable patients.

Mrs Marks opened comments by acknowledging that the Business Case requires a significant financial investment. Whilst extremely supportive of the improvements it would facilitate, she suggested that consideration be given to whether this would be the chosen approach, if the organisation were to 'start from scratch'. Mr Huw Thomas felt that it was important to recognise that what this Business Case is facilitating is not in itself an investment, but is recognising the demand the Health Board is likely to see in its UEC system. It represents a new method of addressing both the demand which already exists and is being seen and experienced, and the anticipated demand during the next financial year. As mentioned earlier, disease prevalence and demand is likely to increase by approximately £12m a year for the next three years.

There are a number of ways in which organisations might respond; Mr Huw Thomas understood from clinical colleagues that these proposals represent the best way to immediately address this demand, and took assurance from the scrutiny process undertaken to reach this point.

Addressing Mrs Mark's query, Dr Karen Brown suggested that creating seven day resilience and core infrastructure in the UEC service should be regarded as a 'fulcrum' to enable the paradigm shift left. It also enables a focus on the whole system. So her response would be, yes, what is proposed would be the chosen route if starting again. Ms Daniel indicated that, from her perspective, the case for improved safety, reduction in harm, better patient experience is made by the proposals. This is backed and supported by strong clinical leadership. The proposals offer opportunities to reduce overcrowding, waits and potential harm within Emergency Departments (EDs) in particular. Also to improve frailty management, continuity of care between acute and community settings, and patient flow system-wide. Adding his support for the proposals, Mr Henwood suggested that they represent a significant first step. The multiprofessional aspect is extremely important, and clinicians feel that the proposals would deliver the model they would wish to have in place. It is not sustainable to continue as present; the Health Board needs to provide care in a more efficient and effective way.

Mr Maynard Davies recalled that, at the previous Board meeting, various healthcare professionals had imparted their experience. The Business Case represents a practical way forward to address the challenges described. Whilst supportive of the proposals, he assumed that they do not necessarily release expenditure and, as such, queried the impact on the organisation's projected trajectory to achieving financial balance. Mr Huw Thomas explained that, should the Board approve this Business Case, it would be regarded as the first demand on spending from the Health Board's budget. It is asserted that the proposals represent the best value means of addressing the issues involved. However, it should not be viewed as the end point; the organisation will need to understand the opportunities it offers. Whilst emphasising Ms Sarah Harraway's support for the proposals, Mrs Wilson outlined two concerns raised: A suggestion that the evaluation framework requires strengthening in order to provide meaningful assurance to the Board, particularly given the level of funding involved; and whether the plan provides sufficient operational detail to describe how and when delivery will occur, especially given the mobilisation challenges and pace required. Also, how the Board will receive assurance around progress.

Noting that there are various key metrics and measures involved, Mr Carruthers recognised that there will be a need to understand how attendances and admissions, for example, are impacted. In responding to the immediate demand challenges, a mechanism to not only monitor, but to forecast system performance is close to being available. The ability and capability, from a data science

perspective is, therefore, about to increase significantly. In terms of evaluation, Dr Brown added that the focus should be on what matters to citizens. This includes reducing risks in the system and increasing efficiency. The proposals address these by providing seven day system resilience, reduction in surges and weekend delays, and increasing care closer to home. They also align with the 20four7 model. As such, there are many anticipated benefits, together with an anticipated improvement against targets in various performance metrics. Admission avoidance offers comprehensive benefits across the system.

Whilst supportive of the need for change, Cllr. Evans noted current challenges with diagnostics and requested assurance that the proposed model will assist with this, rather than cause further issues. Also, whether there is confidence around the ability to recruit to posts. In response, Dr Brown noted that the proposals will not create new demand, they are to address demand which already exists. There should, therefore, be no new diagnostics activity. In addition, consideration will be given to 'upscaling' community-based diagnostics (for example by utilising portable diagnostic equipment) to increase capacity. In terms of staffing, whilst there have already been expressions of interest based on the proposals, the limited workforce pool is recognised. Other measures include 'Grow Your Own', succession planning and empowering staff to work at the top of their licence.

With regard to recruitment, Ms Daniel indicated that the Business Case mentions reliance on Advanced Clinical Practitioner development. There are various strategies already employed within the Health Board around 'Grow Your Own' and Agenda for Change Annex 21 which will offer opportunities. The proposals are transformative and innovative, which should generate interest and make posts attractive to potential staff. Mr Severs stated that work has been undertaken with clinical leaders in the CIM CCG in particular. If posts cannot be recruited to, there are national frameworks around enhanced advanced consultant practice across a number of different professions. The outcome should be the focus, and there are a number of different ways to achieve this. He was fully supportive of the proposals. Mrs Gostling added her support for the Business Case, highlighting that the proposed phased approach will assist in recruitment.

Whilst noting that workforce is clearly of concern, Mr Imperato stated that he was assured by the responses received. Mr Weir emphasised the need for the UEC model to interface with the Community by Design model discussed earlier. He was also concerned that the Business Case represents investment in Secondary, rather than Primary Care, where the focus should be. Mr Carruthers suggested that it is important to recognise that the Business Case proposes development of a model which is outside the 'front door' of hospitals, based in the community. It is the direction of travel which the organisation should be taking, as part of its investment in Primary and Community Care services. Agreeing, Dr Brown emphasised that the original UEC model was

very different to that presented today. The Business Case recognises that this is the start of the shift left, and hence is focused on those areas which need to change and creating the infrastructure required. There are many more elements to the model, with the ultimate aim that Community by Design and Public Health are represented throughout.

Dr Gjini confirmed that the Business Case absolutely fits with Community by Design and the preventative model, and that the SMfHW is intertwined. It is intended that members of the population are enabled to stay well, which is the focus of the 20four7 model. Primary Care and Public Health will be leading on this area. By training staff in prevention, the Health Board will have increased capacity to reduce ill health and demand. Dr Gjini reiterated that the proposals are to address already existing demand; to do so will require the 'wraparound provision' described in the SMfHW and 20four7 models. Ms Murphy advised that staff at WGH are extremely keen to implement and take forward the changes. They are enthusiastic about the proposals and are awaiting Board approval.

Professor Kloer recognised that this represents a significant moment and step forward for the organisation. It also involves a considerable level of financial resource, which will limit that available for other priorities. The Health Board only has a finite amount of funding, and approving this proposal will reduce the amount available for other choices by over £4m. However, it is clearly unanimously supported, and is a major priority for the organisation. The proposed changes will assist in tackling some of the most significant challenges. There are, however, concerns around evaluation and implementation, which will require the oversight of SPC to provide assurance. It was suggested that, due to the significant resource involved, the team reflect on the evaluation. This should be presented again to SPC for the purposes of agreeing the evaluation criteria. Otherwise, Professor Kloer very much supported the proposals and felt that they offer an excellent opportunity for the Health Board.

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Decision: The Board:

- **APPROVED** total resourcing of £8.2m, to enable the implementation of Option B, which will establish 7-day clinical streaming, Hospital@Home and optimal 7 day Same Day Emergency Care (SDEC) services across the Health Board, supporting the following phased approach:
 1. **APPROVED** resourcing in 2026/27 equivalent to £4.4m recurrently to support:
 - The implementation of clinical streaming and Hospital@Home services to cover 7 days per week at a cost of £1.9m across the Health Board;
 - The implementation of the optimal 7 day SDEC service at Withybush at a cost of £2.5m;

2. **APPROVED** additional resourcing in 2027/28 equivalent to £1m recurrently to enable the implementation of the optimal 7 day SDEC service at Bronlais Hospital;
 3. **APPROVED** additional resourcing in 2028/29 equivalent to £2.8m to enable the implementation of the optimal 7 Day SDEC service at Glangwili Hospital.
- **REQUESTED** that SPC oversees implementation and evaluation of the proposals, including agreeing the evaluation criteria.

Dr Karen Brown left the Board meeting.

PM(26)16

Patient Service Centre

Introducing the report, Mr Huw Thomas explained that the Patient Service Centre system is designed to transform and modernise the way in which frontline administrative support is provided to patients. There is currently a significant amount of waste in the system, and the proposals present a mechanism to improve this position. These inefficiencies were acknowledged during DDIC's scrutiny of these proposals. Members were advised that what is presented is an Outline Business Case (OBC) rather than a Full Business Case (FBC), with permission being sought to go out to market. Following this, and in due course, a FBC will be brought back to the Board for consideration. DDIC had discussed both scope and scale; the Business Case's focus is on ensuring that no one is excluded. Whilst it does not currently incorporate Primary Care, recognising the independence of contractors, it is possible to expand the scope. Next steps will be monitored via DDIC and updates presented to the Board as necessary. Members noted that consideration will be given to the possibility of deferring certain of the costs until cost benefits are delivered.

Clarifying the request being made of Board, Professor Kloer requested assurance that approval is on the basis of there being no commitment to additional resource at this stage, whilst recognising that this is an area requiring significant future investment. Mr Huw Thomas confirmed that approval is on this basis.

Decision: The Board:

- **TOOK ASSURANCE** from the proposed approach to the Patient Services Centre and Patient Relationship Management Tool.
- On the basis of there being no commitment to additional resource at this stage, **APPROVED** the Patient Service Centre and 360° View Outline Business Case, noting that this will enable market engagement.
- **NOTED** that a Final Business Case will be brought back to Board, including market tested costs and further detail on benefits, prior to approving and committing any expenditure and approving any contracts

Meddygfa'r Sarn

Ms Rhian Bond and Ms Leanda Wynn joined the Board meeting.

Deputising for Mr Carruthers, Mr Peter Skitt introduced this item. He described the Meddygfa'r Sarn practice and the population it serves. Members noted that it had been a Health Board Managed Practice since 2017 and had experienced significant workforce challenges. The premises are extremely small and it is progressively becoming more challenging to provide the services required. The report outlines the issues being faced, resulting in a position which is not where the Health Board would wish to be. Ms Rhian Bond advised that, in line with the prescribed process, the Vacant Practice Panel (VPP) had considered the various options available, which were as outlined in the report. Ms Bond noted that there have been certain inaccurate and inappropriate communications to staff, which have been corrected. However, the concern caused was recognised.

In terms of options, Members were advised that there is not sufficient interest to facilitate a GMS contract, and the other issues and challenges would remain. Taking all of these considerations into account, the VPP had recommended Option 3: managed list dispersal. This would be subject to a period of public engagement. It is recognised that there is a degree of risk and impact for the practice's patients. However, there is confidence that they can be absorbed into neighbouring practices' patient lists. Staff would be transferred under TUPE arrangements (Transfer of Undertakings (Protection of Employment) Regulations 2006).

Members heard that Llais have received various expressions of concern around this proposal. Ms Hughes Moakes outlined the contents of a letter received by the Health Board which detailed these, which centred on: Expectations around the nature of public engagement; a lack of discussion with public or community representatives around the challenges being faced in the running of Meddygfa Sarn; a lack of direct communication from the Health Board about the findings of the Vacant Practice Panel; and a failure to take on board Llais suggestions around the need for public engagement. In light of this, Llais felt that a decision by the Board as proposed would be premature and inconsistent with duties and responsibilities as set out in the Guidance for Engagement and Consultation on changes to Health Services (2022). The letter would be shared with Board Members and published on the Health Board website.

JW

Mrs Marks welcomed the input from Llais, indicating that she had discussed the issue with Ms Donna Coleman yesterday. Mrs Marks understood the passion of the community around this issue, emphasising that the Health Board is committed to listening, and to being fair, sustainable and transparent. She also recognised how the VPP had reached its opinion on the way forward, based on the information available to it. Mrs Marks suggested that an eight week period of public engagement be undertaken, with the

outcome presented to the May 2026 Public Board meeting. No decision should be made prior to this. Whilst agreeing that the VPP was entitled to form a view, Mr Imperato emphasised the need to also hear from the community. He suggested that the findings of the VPP be noted at this stage, with proposals to be reconsidered following a period of public engagement.

Ms Hughes Moakes indicated that her team would be happy to support an engagement exercise which seeks to understand the impact of proposals on communities. The proposed eight week period would fit with the requirement to restrict Health Board activities during the pre-election period. In addition, it was suggested that an apology is due to the community for the way in which they had learned about the proposals. Mr Henwood wished to highlight that the driver for the proposed change is quality and safety of care. He emphasised that the almost 10 years of staffing by locum doctors is not consistent with providing these. Dr Sion James thanked the practice team for their efforts in providing valued GP services under the challenging circumstances described. He agreed, however, with Mr Henwood that, long-term, locum provision does not offer the best approach. Supporting the proposed (revised) approach, Mr Prior advised that he has experienced a similar process as a member of the community. He recognised that it is emotive and challenging, whilst also acknowledging that the Health Board is itself faced with difficult decisions. Mr Prior agreed, however, that there is a need to engage effectively with communities.

Professor Kloer agreed with colleagues and added his apologies for the concern caused. He thanked members of the local community for travelling to the Board today. In view of the concerns expressed, it was agreed that the revised approach outlined above would be adopted.

**AC/RB/
AHM**

Decision: The Board:

- **NOTED** the recommendation from the Vacant Practice Panel on 31 October 2025 that a managed dispersal of the Meddygfa'r Sarn patient list take place.
- **AGREED** that an 8 week period of public engagement would be undertaken, with the outcome presented to the May 2026 Public Board meeting.

Ms Rhian Bond and Ms Leanda Wynn left the Board meeting.

PM(26)18

Organ Donation Annual Report

Mr Skitt presented the Organ Donation Annual Report, indicating that this is as provided. He wished to thank and congratulate the Organ Donation team for their efforts, together with the Organ Donation Committee, chaired by Mrs Patel. HDdUHB performs relatively well in this area, and the report's findings, which include the Health Board's achievements, are encouraging. The region is a large geographical area, with just two staff in the main who coordinate organ donation.

Mrs Patel assured Members that the Organ Donation Committee does discuss all of the issues around how organ donation occurs and referrals are made. She was confident in the effectiveness of the Organ Donation team. Recognising that the team continues to deliver positive performance, Ms Daniel emphasised that this is based on safe, compassionate and effective care, with strong leadership at its core. She also wished to congratulate the team.

Decision: The Board **DISCUSSED** and **APPROVED** the Annual Report and **NOTED** the Health Board's performance against the priorities set for 2024/2025 and action plan for 2025/2026.

PM(26)19

Report of the Audit and Risk Assurance Committee

Cllr. Evans, ARAC Chair, introduced the update report from the meeting held on 9 December 2025, indicating that this is as presented. With regard to the 'Advise' items, concerns had been raised around responses to audits, which need to be timely, honest and open. This issue had been raised with the Chief Executive. An Audit Wales review into UEC had highlighted significant and ongoing challenges in patient flow. The Senior Operational team had confirmed that all the issues raised are recognised by the Health Board, with Cllr. Evans noting the link between this and the UEC Business Case considered earlier.

Decision: The Board:

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

PM(26)20

Report of the Quality, Safety and Experience Committee

Ms Daniel, QSEC Lead Executive, presented the update report from the meeting held on 4 December 2025, noting that there were no 'Alert' items. In terms of 'Advise' items, there was concern around Sonography services (Risk 797). This will be monitored and there are actions planned, including development of an integrated midwifery sonography service and the strengthening of radiography leadership. Also of concern were Autism Spectrum Disorder (ASD) diagnostic waiting times, which has been escalated to the Executive Team and will be scheduled for a future Board discussion. Waiting List Management is an item on the March 2026 Public Board agenda.

Referencing discussions on UEC at the previous Board meeting, and specifically 'care in the corridor', Mrs Patel enquired whether this issue is being considered by QSEC. In response, Ms Daniel advised that there is an item on UEC scheduled for the February 2026 QSEC meeting. Discussions will be reported to the Board in March 2026. Welcoming this query and the concerns behind it, Professor Kloer indicated that he has seen this issue first-hand during visits to hospital sites. Caring for patients in corridors has impacts both in terms of dignity and ability to treat effectively, and

the description does not necessarily reflect the risks involved. It is a factor which drives the opinion and ambition around the UEC Business Case. Mr Severs advised that this issue had also been raised at the Health and Safety Committee (HSC), with input to be provided to both QSEC's discussions and to PODCC's discussions around the impact on staff.

Mr Weir noted QSEC's concerns around a recent Clinical Health Knowledge System (CHKS) report which has identified that GGH has almost twice as many mortality rates as BGH and WGH for post operative trauma patients. He enquired regarding the time period involved, whether this was recent, and whether the review mentioned has commenced. In response, Mr Henwood advised that the Health Board had been made aware of this issue in October 2025 and had instigated a review. The Mortality Review Group has met with CHKS and is in the process of triangulating the relevant data, to ensure that this is correct. A response to these findings will then be developed. It is recognised that there are issues in relation to Orthopaedic trauma care at GGH, which have been the subject of work by the CCGs for some time. Once the full report has been received, it will be considered and discussed further.

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)21

Report of the Finance and Performance Committee

Mr Imperato, FPC Chair, presented the update report from the meeting on 16 December 2025, noting that a number of the issues raised have already been considered. These include concerns around recurrent savings and neurodevelopmental services. There had been a constructive discussion around the medical workforce stabilisation programme, with certain aspects of this dependent on the changes already discussed today.

Decision: The Board:

- **APPROVED** the award of Citrix Hardware Replacement to Softcat Plc. for the period 1 March 2026 to 31 October 2030, with an option to extend to 31 October 2031. This contract will have onwards submission to Velindre NHS Trust (as hosts of NHS Wales Shared Services Partnership)
- **APPROVED** the award of Insourcing of Theatre Scrub Team to ID Medical Group Ltd for the period 1 February 2026 to 31 March 2027 with no option to extend. This contract will have onwards submission to Velindre NHS Trust (as hosts of NHS Wales Shared Services Partnership) and Welsh Government for approval
- **APPROVED** the award of Car Park Management to CP Plus Ltd for the period 1 April 2026 to 31 March 2029 with the

option to extend to 31 March 2031. This contract will have onwards submission to Velindre NHS Trust (as hosts of NHS Wales Shared Services Partnership) and Welsh Government for approval

- **RATIFIED** the revised Terms of Reference for the Finance and Performance Committee
- **RESPONDED** to the items that the Committee is alerting them to
- **NOTED** the items that the Committee is advising them of
- **TOOK ASSURANCE** from the items that the Committee is providing assurance on

PM(26)22

Procurement Report

Mr Huw Thomas introduced the Procurement Report, advising that all have been subject to the appropriate procurement process. He requested that the final item, in relation to ad hoc Attention Deficit Hyperactivity Disorder (ADHD) and Autism Spectrum Diagnostic (ASD) Assessments, be deferred to a future Board meeting for approval. It had been hoped that the evaluation outcome for this would have been available in time for today's meeting; however, it is ongoing. Mr Huw Thomas suggested that this funding request be carried over to the March 2026 Board meeting.

Decision: The Board:

- **APPROVED** the award of Citrix Hardware Replacement to Softcat Plc for the period of 1 March 2026 to 31 October 2030, with an option to extend to 31 October 2031. This contract will have onwards submission to Velindre NHS Trust (as hosts of NHS Wales Shared Services Partnership).
- **APPROVED** the award of Insourcing of Theatre Scrub Team to ID Medical Group Ltd for the period of 1 February 2026 to 31 March 2027. This contract will have onwards submission to Velindre NHS Trust (as hosts of NHS Wales Shared Services Partnership) and Welsh Government for approval.
- **APPROVED** the award of Car Park Management to CP Plus Ltd for the period of 1 April 2026 to 31 March 2029, with the option to extend to 31 March 2031 in 12 month increments. This contract will have onwards submission to Velindre NHS Trust (as hosts of NHS Wales Shared Services Partnership) and Welsh Government for approval.
- **APPROVED** the award of Rental of APCOA Car park in Carmarthen to APCOA Parking UK Ltd for the period of 1 April 2026 to 31 March 2041, with a break option at four, five, and/or six years. This contract will have onwards submission to Velindre NHS Trust (as hosts of NHS Wales Shared Services Partnership) and Welsh Government for approval.
- **DEFERRED CONSIDERATION** of the award of Ad Hoc Attention Deficit Hyperactivity Disorder (ADHD) and Autism Spectrum Diagnostic (ASD) Assessments until the March 2026 Public Board meeting.

Report of the Strategy and Planning Committee

Mr Weir, SPC Chair, presented update reports from the meetings on 18 December 2025 and 16 January 2026. There was one 'Advise' item, relating to capital and infrastructure challenges, particularly at WGH and GGH. The report makes various requests for approval, including the revised SPC Terms of Reference and publication of the Well-being of Future Generations Annual Report.

Decision: The Board:

- **APPROVED** the revised SPC Terms of Reference
- **APPROVED** publication of the Well-being of Future Generations Annual Report 2024-2025
- **APPROVED** application of the seal for all schemes listed
- **RATIFIED** the Targeted Estates Fund (TEF) Projects: Provision of Second Generators at Glangwili and Withybush Hospitals
- **ENDORSED** progression of the Clinical Services Plan when it is presented to the Board at its Extraordinary Board Meeting in Public on 18 and 19 February 2026.
- **APPROVED** the refreshed A Healthier Mid and West Wales Strategy (already considered under item PM(26)11)
- **APPROVED** the A Healthier Mid and West Wales Programme Business Case Addendum (already considered under item PM(26)12)
- **APPROVED** the Community by Design Strategic Plan (already considered under item PM(26)13)
- **NOTED** the items the Committee is advising them of
- **TOOK ASSURANCE** from the items that the Committee is providing assurance on

Wellbeing Objectives Annual Report

Dr Gjini introduced the report, which centres on the Health Board's duty to deliver on the Wellbeing of Future Generations (WBFG) Act and Wellbeing Objectives. The latter were set in 2019 and are aligned to the long-term strategy and the wellbeing objectives of the three PSBs. The report illustrates some of the work being undertaken across the Health Board which enables delivery. As noted above, the report has been considered at the SPC. The examples in the report are just that, and do not necessarily reflect the full scale of the work undertaken. A number, however, align with earlier discussions on various topics.

Ms Murphy wished to emphasise that Trade Unions and other stakeholders have worked with the team in preparing the report, and their input has been taken on board. The report very much, therefore, represents a collaborative effort. Whilst recognising that the WBFG Act is a noble piece of legislation, Mr Prior suggested that its application can sometimes feel like a 'tick-box' exercise. He commended HDdUHB's wellbeing objectives; however, highlighted that they only become genuinely meaningful when embedded. Mrs Marks advised that there had been a presentation

on the WCFG Act at the recent RJC. She had not been aware that waste and food are not included in the Act under sustainability. However, these are areas being considered by the Health Board. Whilst acknowledging Mr Prior's comment, Mrs Marks felt that the report was well-written and did not feel like a 'tick-box' exercise.

Decision: The Board:

- **RECEIVED ASSURANCE** that the Health Board is meeting the statutory obligations of the Well-being of Future Generations (Wales) Act, 2015, in the publication of its Annual Report.
- **APPROVED** for publication Hywel Dda University Health Board's Well-being of Future Generations Annual Report for the period 1 April 2024 – 31 March 2025.

PM(26)25

Targeted Estates Fund Projects

Presenting the report, Mr Severs advised that SPC had considered and ratified the Targeted Estates Fund (TEF) projects in relation to provision of second generators at GGH and WGH. The projects, however, require Board approval due to the monetary value of the contracts being in excess of £1m.

Decision: The Board **APPROVED** award of the contracts at £1,115,292.09 (exc. VAT) for Glangwili General Hospital and £1,197,845.51 (exc.VAT) for Withybush General Hospital to 'T. Richard Jones (Betws) Ltd', with call-off agreement to be prepared and executed by the Health Board.

PM(26)26

Report of the Health and Safety Committee

Ms Murphy, Health and Safety Committee (HSC) Chair, presented the update report from the meeting on 13 January 2026, highlighting the three 'Advise' items, around outstanding audit recommendations; processes to review, monitor, and enhance health and safety regulatory compliance; and progress against the actions outlined in the site visit report.

Decision: The Board:

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

PM(26)27

Report of the Charitable Funds Committee

Mr Iwan Thomas, Charitable Funds Committee (CFC) Chair, presented the update report from the meeting on 8 December 2025. As always, he wished to thank the Hywel Dda Charities team for supporting the Committee's work. There were no 'Alert' items; the single 'Advise' item brought to the Board's attention that two applications for expenditure had not been approved, due to concerns expressed during their scrutiny. One application was approved, which requires consideration and approval by the Board

in its role of Corporate Trustee, during the separate session which follows Public Board.

Noting references to the Hydrotherapy Pool, Mr Maynard Davies advised Members that this facility is due to be officially opened on 16 February 2026.

Decision: The Board:

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

PM(26)28

Report of the Digital, Data and Innovation Committee

Mr Maynard Davies, DDIC Chair, presented a brief verbal update from the meeting on 15 January 2026, indicating that the full written version will be presented to the March 2026 Board meeting. There are no 'Alert' items. There is an 'Advise' item, relating to implementation of the new Laboratory Information Management System (LIMS). This is a high-risk project, which is incurring delays. There is a potential cost to the NHS in Wales of £3m due to the delays, of which the impact to HDdUHB would be £300-400k. Negotiations are ongoing. In terms of 'Assure' items, the Health Board has approved a number of pilots of the use of Ambient AI; and the Tritech Business Plan will be presented to the Board in March 2026 for approval.

With regard to the Ambient AI pilots, Mr Huw Thomas explained that this is a piece of technology which would sit alongside the Health Board's clinicians and transcribe their discussions with patients. It should assist with productivity; however Members were assured that there will be testing and due consideration of Information Governance compliance.

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)29

Committee Update Reports

Introducing the Committee Update Reports, Mrs Wilson highlighted that, subject to various approval processes, a new Chair of the Stakeholder Reference Group has been appointed, who would become an Associate Member of the Board.

Decision: The Board:

- **RECEIVED** the update reports in respect of work undertaken on behalf of the Board at recent Committee meetings
- **RECEIVED** the update report in respect of the IC 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)30

Joint Committees and Collaboratives

Professor Kloer introduced this item, highlighting the two reports from the Joint Commissioning Committee (JCC), and one NHS Wales Shared Services Partnership Committee (NWSSPC) report. With regard to the JCC, a financial risk for this year has been flagged as an 'Alert' item and is not completely mitigated. The risk for next year's plan is also significant. Mr Huw Thomas advised that these risks are translated into the Health Board's financial forecast when confirmed. He shared Professor Kloer's concerns around this issue. Members noted that the JCC is concerned with specialist services, and the amount involved is significantly in excess of the 1.1% inflationary uplift. There is a risk that investment will be required to support the financial allocation to specialist services, rather than to support the Health Board's local priorities. However, it is recognised that the population of Hywel Dda themselves require access to specialist services.

Separate from this item, Members received a brief verbal update from the RJC meeting on 22 January 2026. Professor Kloer advised that there had been constructive discussion on a range of matters, with Welsh Government also attending the meeting. Regional conversations are focused on clinical services, with several examples of cross-region working. In one such example, Mrs Wilson advised that the topic of Regional Cellular Pathology will be considered at the Extraordinary Public Board in February. It was agreed that the RJC is a valuable and useful forum. However, whilst HDdUHB's relationship with SBUHB is a positive one, the different needs of the two populations must be recognised.

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

PM(26)31

Statutory Partnerships Update

Presenting the Statutory Partnership Update Report, Dr Gjini highlighted various areas of work being undertaken by the RPB and PSBs. Mr Prior, who previously chaired a PSB, emphasised the importance of the Health Board identifying partners who will be of value to both the organisation and local communities. It was suggested that a great deal more can be undertaken within the partnership sphere, and Mr Prior indicated that he would appreciate consideration being given to how this can be developed further through the committee structure. Dr Gjini agreed that there is a 'busy landscape' in this regard, whilst assuring Members that steps are being taken to align efforts in partnership working.

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)32

Any Other Business

For governance and accountability, Mrs Marks advised that the letter from Llais in relation to Meddygfa'r Sarn has been published on the Health Board website. Secondly, she thanked Mrs Gostling for sharing with Members the Equality, Diversity and Inclusion Group Newsletter, which evidences the excellent work being undertaken in this area.

PM(26)33

Board Annual Workplan

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

PM(26)34

Date and Time of Next Meeting

9:00am, Wednesday 18 February 2026 (Extraordinary Meeting)

9:30am, Thursday 19 February 2026 (Extraordinary Meeting)

9:30am, Thursday, 26 March 2026