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

Date of Meeting: **09:30, Thursday 28 May 2026**
Venue: **Y Stiwdio Fach, Canolfan S4C Yr Egin, College Road, Carmarthen SA31 3EQ**

Present:
Dr Neil Wooding, Chair, Hywel Dda University Health Board
Mrs Eleanor Marks, Vice-Chair, Hywel Dda University Health Board
Mr Maynard Davies, Independent Member (Information Technology)
Cllr. Rhodri Evans, Independent Member (Local Authority)
Ms Sarah Harraway, Independent Member (Community)
Mr Michael Imperato, Independent Member (Legal)
Ms Ann Murphy, Independent Member (Trade Union)
Mrs Chantal Patel, Independent Member (University)
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
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
Dr Jonathan Arthur, Healthcare Professionals Forum Chair
Ms Donna Coleman, Llais West Wales (part)
Mr Tegryn Jones, Stakeholder Reference Group Chair
Ms Mwape Burke, Aspiring Board Member (VC) (part)
Dr Helen Wang, South Pembrokeshire Cluster Lead (part)
Dr Iwan Griffiths, North Pembrokeshire Cluster Lead (part)
Dr Ahmed Ellaban, North Ceredigion Cluster Lead (part)
Mr Gareth Harlow, Amman Gwendraeth Cluster Lead (part)
Ms Rhian Bond, Assistant Director of Primary Care (part)
Ms Sarah Bolton, Head of Primary Care Transformation (part)
Ms Clare Moorcroft, Committee Services Officer (Minutes)

| Minutes Ref. | Item | Action |
|---|---|---|
| **PM(26)90** | **Welcome and Apologies**<br><br>Dr Neil Wooding, Chair of Hywel Dda University Health Board, welcomed everyone to the Public Board meeting, particularly Mr Tegryn Jones, Stakeholder Reference Group Chair, who was attending his first meeting. Members noted that a number of | |

individuals would be attending for later agenda items, and that members of the public would be joining at the break for the Meddygfa'r Sarn item.

There were no matters that Members felt were omitted from the agenda or reports. Dr Wooding reminded Members of the Board's five decision-making 'design principles', intended to ensure that Board decision-making is consistent and robust:

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

Apologies for absence were received from:

- Mr Michael Gray, Director of Social Services and Housing, Pembrokeshire County Council

**PM(26)91** **Declaration of Interests**

Given his membership of the Pembrokeshire Public Services Board, Mr Tegryn Jones declared an interest in item PM(26)125.

**PM(26)92** **Minutes of the Public Meeting held on 18/19 February 2026**

**Decision: RESOLVED** – that the minutes of the meeting held on 18 and 19 February 2026 be approved as a correct record.

**PM(26)93** **Minutes of the Public Meeting held on 26 March 2026**

**Decision: RESOLVED** – that the minutes of the meeting held on 26 March 2026 be approved as a correct record.

**PM(26)94** **Matters Arising and Table of Actions from the Meeting held on 26 March 2026**

An update was provided on the Table of Actions from the Public Board meeting held on 26 March 2026. Confirmation was received that outstanding actions had been progressed. In terms of matters arising:

**PM(26)74** – Mr Maynard Davies noted the statement that the Climate Adaptation Plan will require further discussion at the Executive Team and enquired whether there is a timescale for this. Mrs Joanne Wilson advised that it will be considered by the Formal Executive Team within the next month and would provide an exact date via the Table of Actions. **JW**

**PM(26)95** **Minutes of the Corporate Trustee Meeting held on 26 March 2026**

**Decision: RESOLVED** – that the minutes of the Corporate Trustee meeting held on 26 March 2026 be approved as a correct record.

**PM(26)96** **Matters Arising and Table of Actions from the Corporate Trustee Meeting held on 26 March 2026**

An update was provided on the Table of Actions from the Public Board meeting held on 26 March 2026. Ms Sharon Daniel advised that, whilst updates have been provided, the Charitable Funds Committee (CFC) has not yet met. She assured Members that the actions noted will be taken forward.

**PM(26)97** **Report of the Chair**

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

In relation to Board Seminar discussions on 23 April 2026 and the Fragility of Withybush Hospital (WGH) A&E section, Mr Winston Weir suggested that this sets out the risks around Urgent and Emergency Care (UEC). Given that it is clear that short-term mitigations are not sustainable, he enquired whether the Board should consider next steps. Mr Andrew Carruthers indicated that, whilst the immediate risk discussed at Board Seminar had been mitigated in the short-term by various actions, the underlying workforce position in A&E and Acute Medicine at WGH remains fragile. This needs, however, to be viewed in the context of the wider UEC system across the Health Board. Members will be aware that there is ongoing work on reshaping the UEC system. He hoped that this, in combination with work in relation to patient flow, will respond to concerns raised at the Board Seminar. Whilst noting that specific actions had been enacted in the short-term to address issues at WGH, Dr Wooding emphasised that a solution on a wider scale is required.

Again in relation to Board Seminar discussions, Cllr. Rhodri Evans noted discussions around transport, travel and the region's rurality. He enquired whether there has been any wider discussion of, or progress on, this issue. In response, Mr Lee Davies advised that a Working Group has been established and is linking with Local Authorities and other parties. It is intended that an update be presented to the Strategy and Planning Committee (SPC) in August and Board in September 2026. Mr Neil Prior confirmed that the discussion at Board Seminar had been a useful one. To provide an example of the type of issues being faced, at a recent Walkabout at Glangwili Hospital (GGH) he and Mr Carruthers had met a couple from St Nicholas in Pembrokeshire. They had indicated that attending their appointment at GGH would, in total, involve a 10 hour commitment, including lifts, train and taxis.

Welcoming this example, Dr Wooding emphasised the importance of lived experience. The Health Board's 'business' is health rather than transport; however, the two are very much intertwined, and need to be considered as such. Mr Michael Imperato suggested that these comments demonstrate how exercised Independent Board Members are by this issue. Whilst somewhat reassured by the response, he would request that the report for SPC is of a practical nature, with tangible measures to address the challenges

involved. Mr Lee Davies indicated that the report will provide this to some extent; however, it must be recognised that certain transport aspects and solutions are outside the Health Board's control and remit. Closing the item, Dr Wooding noted the need to keep in mind other potential solutions such as use of digital and telemedicine. He reiterated, however, that the Health Board does need to support its population to access its services.

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

**PM(26)98 Report of the Chief Executive**

Professor Philip Kloer introduced his report on relevant matters undertaken since the previous Board meeting, highlighting the inclusion of Corporate Risk Register information. Members also heard that the Board Assurance Framework (BAF) will be an agenda item at the July 2026 Public Board meeting. The report also includes an update on the new Health Board operating model and ways of working. Welsh Government has introduced new escalation arrangements, and the first meeting of the Escalation Board for Hywel Dda will take place next week. This will be an important forum, which will meet on a regular basis. Finally, a novation agreement and deed of cancellation relating to the Cross Hands Community Hub project is appended, for Board approval.

Cllr. Evans noted Risk 2204 and the expected date to achieve the Target Risk Score, and enquired whether this had, in fact, been achieved. Mrs Wilson confirmed that it had, hence the reduction in risk score to 1. Members were advised that there will be a new risk in relation to this year's Capital Resource Limit. With regard to the Cross Hands Community Hub documents, Mrs Eleanor Marks wished to reiterate both the importance of this project to the population local to that area, and the importance of community hub development in general.

In response to a request for further information around the new ways of working, Professor Kloer reminded Members that the Health Board as a whole was escalated to Targeted Intervention (TI) in January 2024. At that time, a 'Command and Control' approach was instituted. Whilst this has delivered certain benefits, the best-performing organisations do not retain such operating models long-term. The Health Board is now transitioning to a structure whereby accountability is delegated, rather than being held at the Executive level. This also better fits with the Clinical Care Group structure and expectation. As this transitional stage has the potential to be challenging, the organisation is putting in place measures to provide support. These include additional guidance to budget holders, for example. Professor Kloer emphasised that this is not a step back in leadership; it is a different kind of leadership. He recognised the need to ensure, for Committees' assurance, that scrutiny is at the correct level. Dr Wooding felt it important to acknowledge that this is the culture the

Health Board is trying to develop – a culture of trust. Trusting staff to do their jobs and fostering trust in leadership.

**Decision:** The Board:

- **NOTED** the timelines to review and refresh the Health Board's Board Assurance Framework
- **NOTED** the Corporate Risk Register (CRR) report and summary
- **NOTED** correspondence around changes to Welsh Government Oversight and Escalation Arrangements and Terms of Reference for the new HDdUHB Escalation Board
- **APPROVED** the Novation Agreement for the Cross Hands Community Hub and Glangwili Fire Precaution Works, that will be signed by the Executive Director of Strategy and Planning, following Board approval
- **AGREED** to the Deed of Cancellation and Termination of Parent Company Guarantee that applies to the Cross Hands Community Hub only being sealed
- **ENDORSED** the Register of Sealings since the previous report on 26 March 2026
- **NOTED** the status report for Consultation Documents received/responded to
- **NOTED** Executive Team discussions

**PM(26)99 Annual Plan 2025/26 Closure Report**

Introducing the report, Mr Lee Davies suggested that it provides an opportunity to reflect on the past year and on the progress made. Members heard that updates on the Planning Objectives have also been provided to Board level Committees. They were reminded that the Health Board had set itself an ambitious Plan, which aimed to achieve balanced improvements across all priority areas and Targeted Intervention domains, and to progress the longer-term Strategy. Broadly speaking, these aims have been achieved and delivered. However, there are a number of areas in which the desired level of progress has not been made, together with questions around the sustainability of improved performance. The organisation had met the financial Target Control Total set by Welsh Government and performed better than the Plan.

In performance metrics, an improvement against baseline is seen in all but two areas, both of which are in UEC, reinforcing earlier comments. There is also some variability in terms of the Infection Prevention and Control performance. Whilst the organisation has been de-escalated in a number of areas during the past 12 months, a number of challenges remain in these areas. The Health Board has made significant progress in relation to the Clinical Services Plan and Community by Design Strategic Plan. It has refreshed its 'A Healthier Mid and West Wales' (AHMWW) Strategy and developed an addendum to the Programme Business Case supporting this Strategy. It has rolled-out a number of digital tools and has delivered various improvements to its estate, including the Chemotherapy Day Unit at Bronglais

Hospital, Sexual Assault Referral Centre at Aberystwyth, Same Day Emergency Care Unit at GGH and Hydrotherapy Pool at Pentre Awel. A further 'pipeline' of other projects are due to be delivered this year. All of these have contributed to an extremely demanding 12 months, which has both challenged and stretched the organisation. Mr Lee Davies wished to thank all of those who have contributed.

Mr Maynard Davies commended and welcomed the report, and the opportunity it offers to celebrate the Health Board's achievements. He had two queries: firstly, noting that the figures in relation to Cancer performance are now below 60% again, he enquired regarding the risk of the organisation being re-escalated in this criteria. Secondly, to what extent issues with the Health Board's aging estate are contributing to its inability to improve Operating Theatre utilisation. Mrs Marks added her thanks to Health Board staff in what has been a challenging year. Whilst she agreed that it has also been a successful year, she highlighted the dissonance between this and the public perception and experience of Health Board services. Mrs Marks reminded Members that the organisation's purpose is to serve its public and patients, and that there is much still to do.

In relation to the Enabling Actions set by the Cabinet Secretary, a particular concern for Mrs Marks was Continuing Health Care (CHC), in which progress is changing from Green to Red. There are issues in relation to this which require consideration, including affordability. The correct approach is vital, given the importance of CHC, and its influence in hospital admission avoidance and expediting discharge. Particularly in view of the region's demographics, aging population and associated complex health needs. Mrs Marks would welcome greater clarity around how CHC impacts on the Health Board drugs expenditure and how costs are allocated between the relevant contributors. She suggested that this information is required to provide the Board with assurance regarding grip and control. Finally, Mrs Marks wished to recognise the difference made by the Arts Therapy work being undertaken in the organisation. The positive impact this is having on patients should be recognised.

Dr Wooding agreed that the Board needs a line of sight with regard to CHC, including information on the current model and risks, and requested that a report be prepared for the next Public Board meeting. **HT/AC**

Ms Sarah Harraway also thanked staff for their efforts. She noted that, whilst partial improvements have been achieved across the Targeted Intervention domains, the Health Board is struggling to maintain its three month performance. Ms Harraway highlighted the importance of sustained improvement in attaining a solid foundation for next year and future years. The organisation is yet to achieve a strong base performance level of this nature. Mr Iwan Thomas felt it was important, however, to consider the report in the context of the new Corporate Risk 2305 outlined in the Chief

Executive's Report – Risk to staff wellness due to pace and breadth of organisational change – which has a target risk score of 12 and a current risk score of 20. He suggested that the operational staff cohort in particular is suffering from fatigue and uncertainty around future employment, etc. Mr Iwan Thomas emphasised the need for cognisance of this risk.

Mr Lee Davies agreed with and shared the concerns expressed by Members. Whilst the organisation has made significant progress, this has only been made possible through external support and the exceptional efforts of staff. Steps are needed to ensure that improved performance can be sustained. He reminded Members that the organisation had started from a low baseline and, as a result, a phased improvement approach is required. Feedback from staff in all parts of the organisation is that they are feeling extremely stretched. They are committed to delivering high quality care; however, conditions are challenging. It is vital that support systems are put in place.

Countering this, Dr Wooding highlighted that, whilst there has been an increase in the workforce since COVID-19, productivity has decreased. There are also higher levels of staff sickness absence and stress-related absence. He queried how this should be addressed. In response, Mrs Lisa Gostling advised that there has been a detailed discussion of the risk mentioned by Mr Iwan Thomas at the most recent People, Organisational Development and Culture Committee (PODCC) meeting. The conversation had considered whether change is happening too quickly or, in some cases, too slowly. It was noted that the Clinical Services Plan is creating uncertainty; in that, whilst there is awareness it will result in change, the nature and timing of this change is currently unknown. Further work will be undertaken, to consider how the various elements contributing to the risk might be addressed.

In terms of the more general feeling among staff, Members heard that the Staff Survey results will be presented to the Public Board meeting in July 2026. Responding to the comment around productivity, Mrs Gostling felt that it was important to recognise that the Health Board has expanded into various new areas, mostly community-based, with an associated increase in workforce. It is possible that hospital-based staff are not, however, seeing a change in demand and pressure. Dr Wooding welcomed PODCC's consideration of this topic and would encourage it to undertake further discussion. Board's leadership role in relation to the risk mentioned above also requires further consideration. **LG**

Returning to the query in relation to Cancer performance, Mr Carruthers advised that the most recent measure demonstrates a recovery to just above 60%. He reminded Members that, as explained at previous meetings, addressing the treatment backlog negatively impacts on the Single Cancer Pathway performance. The Health Board's approach has been discussed and agreed with Welsh Government. Mr Carruthers agreed, however, that a sustained performance improvement is required, and assured

Members that this will continue to be monitored closely. In terms of Operating Theatres, whilst there is further work required around job planning, progress has been made in recruitment. Mr Carruthers suggested that he has probably taken a slightly more negative view than the service, recognising that there is more yet to do. He assured Members that there is a focus on this area, and that he expects to see progress. He would welcome detailed discussion of this topic at the Board level Committee deemed to be most appropriate. Mr Carruthers agreed that the 'sustainability test' is crucial. He felt that this reflects issues in terms of workforce resilience which require addressing. Dr Wooding highlighted that this resilience is fragile, with certain services reliant on individual staff members. The solution will be multi-factorial, and the Board needs to be assured that actions are being taken in this regard.

In relation to the issue of organisation fatigue, Mrs Chantal Patel enquired whether the new operational structure and ways of working are likely to have a positive or detrimental effect. Professor Kloer emphasised that there are a multitude of elements which contribute to workforce wellbeing. Whilst the new ways of working will not solve all the issues, he felt that they should assist, by provided more autonomy and clearer accountability. This should help to clarify what is being asked of people, uncertainty about which can lead to stress. Professor Kloer acknowledged that the organisation places significant demands on its staff, whilst noting that this can often lead to the most creative and innovative solutions. Mr Prior welcomed discussions around productivity and confirmed that there had been a constructive discussion at PODCC. He emphasised how challenging it can be to change organisational culture. In terms of a reflection on the 2025/26 Annual Plan, he highlighted the topic of Population Health. Mr Prior suggested that there is a great deal more which the Health Board could and should be doing in this area, and that it is one requiring a significant focus and shift.

Concluding the discussion, Dr Wooding wished to recognise the Health Board's achievements during the year. He commended the organisation on the efforts involved in delivering these, adding that a similar level of effort will be required once again this year.

**Decision:** The Board **TOOK ASSURANCE** on the delivery of the 2025/26 Annual Plan including the current escalation status; Ministerial Priorities; Planning Objectives; and enabling actions, noting that the 2026/27 Annual Plan builds upon these.

**PM(26)100 Annual Plan 2026/27**

Mr Lee Davies presented the report, reminding Members that this year's Annual Plan had been discussed in March 2026. During that discussion, the Board had explicitly recognised that the Plan is both challenging in nature, and unacceptable in terms of financial outturn and risk. As a result, the Board had requested that consideration be given to the following:

- De-risk, during Quarter 1, delivery of the Plan to a financial deficit position of £41m
- What might be required to improve further on that figure and ultimately reach a break-even position

This request had been further reinforced by the letter from the Director General dated 22 April 2026, which is appended to the report. Members heard that extensive work, described in the report, has taken place to address this challenging request. The work is not yet complete; therefore, the Executive Team is not yet in a position to assure the Board around delivery. However, a summary of the current position is provided and further discussion on specifics will take place during the In-Committee session. Mr Lee Davies explained that a great deal of work is still required to deliver sufficient savings, and the Plan would still require Welsh Government support. He suggested that the recommendations as presented probably do not capture the response required as a Board, and may need further refinement.

Mr Huw Thomas confirmed that this year's Plan represents an extremely challenging position. The forecast deficit of £41m has, as anticipated, been deemed unacceptable by Welsh Government. However, he suggested that delivery of the Plan is a test of the Health Board's credibility. Given this, the current in-month deficit trajectory of £5.5m, which would result in a year-end position of £64m, clearly requires addressing. Closing the gap between £64m and £41m necessitates a significant change and reduction in the organisation's spending profile. The main cost drivers currently are variable pay, in particular medical and dental variable pay, approximately £7m per year; and CHC costs of approximately £5.7m per year. Mr Huw Thomas noted that any discussion on financial recovery needs to either begin with the causes and work towards the effects, or begin with the effects and work back to the causes.

Welcoming the report, Mrs Marks indicated that her reading of it had identified a number of themes: variable pay, non-recurrent benefits and Clinical Care Groups (CCGs). She reiterated that the Health Board has committed to achieving a balanced budget by 2027/28. Mrs Marks suggested that the Board should focus on what the organisation spends on, rather than where it can make savings. It should consider how to shift care delivery into the communities, which is both a better and more cost-efficient place to treat people. Also, what more can be done in the preventative space, which will result in savings in the longer-term. The message she is receiving consistently from staff is that they are feeling worn-down by constant requests for savings and have already exhausted most options. Mrs Marks felt that the request of staff in relation to this should be rephrased, to emphasise improved patient experience and outcomes. Whilst it is crucial to maintain financial grip and control, the message to the Health Board's staff needs to be 'reframed'.

Cllr. Evans noted that a response to the Director General's letter is required by 29 May 2026, and enquired whether this has been prepared. If so, whether the Health Board has sufficiently articulated how it intends to address the points made in the letter. He highlighted in particular comments around the impact of regional planning and delivery and the regional committee on performance, and the Plan's length and lack of clarity. With regard to the latter, he enquired whether other health boards' Plans have been consulted as suggested. Dr Wooding added to these, the need to consider whether the Health Board's Plan works towards target metrics.

Ms Ann Murphy expressed concern around the statement on page 4 of the report in relation to Community and Integrated Medicine: 'The current savings schedule includes… delayed investment and pay reviews.' She advised that there is a national programme under which all Band 5 posts will be reviewed in terms of skills. In addition to the Health Board considering its ways of working and student recruitment, it will also need to take this review process into account, if services are to utilise staff at the correct skill level and pay rate. Ms Murphy recognised that the issue may simply be the wording used in this statement; however, wished to highlight her concerns. Dr Wooding agreed that this is one of the core elements of the productivity discussion; ensuring that staff are working at the top of their licence.

Dr Ardiana Gjini welcomed earlier comments around Population Health and the need to shift towards prevention of ill health. She acknowledged that CCGs and variable pay do contribute to financial challenges whilst recognising that, once a patient is admitted to hospital, they must be given safe and high quality care in that environment. Enabling a shift 'left' into community care and prevention of ill health will require resources to be released and re-allocated. Whilst the 20four7 model should facilitate this, the Health Board's Plan is necessarily based on the allocation it has, and is focused on achievement of Ministerial Priorities and delivery of the AHMWW Strategy. Dr Gjini assured Members that the organisation is working on various initiatives in relation to Population Health; however a number of these would require additional investment and resource. Dr Wooding highlighted that the Health Board is not developing a Plan based on the resource it has when it is proposing a £41m deficit; it is basing its Plan on an overspend beyond its allocation.

Agreeing that staff must be empowered to work at the top of their licence, Mrs Gostling highlighted that, in future workforce models to support care closer to home, this will bring more autonomy. The organisation also needs to focus on digital delivery of care, rather than adding to the workforce. Especially in view of census data which evidences a reducing pool of working age people, and an increase in numbers of young people not working due to health conditions. Finally, Mrs Gostling advised that the Health Board has submitted its numbers for graduate nurse recruits, which it is hoped will serve to reduce nurse agency use further.

Mr Prior agreed that the Health Board needs to work towards planning on the basis of its allocation rather than a deficit position. This will require consideration of those services and areas which can be removed or changed. He felt that the recommendations as they stand are too passive, and enquired who is owning the challenge of making savings. The organisation continues to describe a number of savings plans, perhaps without sufficiently articulating the impact of these. Mr Prior queried whether the Health Board is truly doing all it can, suggesting that the level of savings required should be achievable, given the percentage that this represents of the total budget (approximately 2.5%).

Given the comments around Population Health, Mr Imperato emphasised the importance of the upcoming agenda item on Community By Design (CbD). He also noted that accountability is highlighted as a specific concern in the report and suggested that the importance of accountability should be amplified, particularly in relation to reducing the financial deficit. Echoing an earlier comment, Mrs Patel felt that the Plan should be more explicit around the impact of potential choices and trade-offs, and articulate more clearly the reality of its financial situation. Whilst Ms Harraway noted that the Plan highlights several opportunities around long-term transformation, she felt that there is a gap between aspiration and delivery. She enquired what is needed to convert these opportunities, and whether they will be sufficient to improve the financial run-rate to the required level.

Mr Maynard Davies noted the statement that the report asserts that there is a route to a balanced budget. However, this is likely to involve changes to the configuration of sites and services, and the Board will need to understand what these changes are. He recognised, however, that there is due to be discussion during the In-Committee session. In addition to Cllr. Evans' queries, he noted that the letter also includes a request to improve the forecast deficit and to address deterioration in performance. With regard to the latter, Mr Maynard Davies highlighted in particular the statement in relation to 104-week waits, with the submitted plan projecting 5,507 breaches, against a target of zero.

To provide context around medical variable pay costs, and whilst recognising that there are job planning issues which contribute, Mr Mark Henwood explained that this expenditure is a direct consequence of the current Health Board configuration, which necessitates multiple rotas. These rotas make recruitment challenging, as they are less attractive to applicants. Whilst changes could be made, these would have significant impacts on performance and would cause harm to patients. In addition to this, there are other issues which impact on medical pay expenditure in its entirety, at a basic level. The only long-term solution would be to reduce the number of EDs and Acute Medicine rotas. Anaesthetics is also delivered across multiple sites and poses significant challenges in terms of recruitment.

Mr Henwood indicated, however, that the Health Board is developing a new Value Based Health Care (VBHC) plan, which is due to be considered by the Board in the summer. He suggested that the organisation needs to focus on patient outcomes in determining where investment should be prioritised. Dr Wooding emphasised that the clinical body appears to be committed to engaging and to the VBHC and whole-system approach, and agreed that there is a need to think differently. He was extremely concerned by the level of expenditure on variable pay which feels, to some degree, exploitative.

In responding to Members' queries around performance, Mr Carruthers highlighted the challenges involved in balancing the various demands around quality, safety, experience, finances, workforce and performance. These challenges are all central to discussions he is conducting with his operational teams. In terms of Planned Care, he is confident that the Health Board will meet the trajectory outlined in the Plan, and potentially improve upon this. He assured Members that consideration is being given to regional and national approaches to the various issues. This also includes Unscheduled Care, where the national lead is joining Health Board discussions around the UEC system. A number of initiatives will be piloted from next month.

Alongside this, however, he acknowledged that there is urgent work required to evaluate the Health Board's own systems and standards in terms of responses, to ensure that these are optimal and maximised. He anticipates being able to provide an updated position at the end of next month. In terms of accountability, feedback from operational teams suggests that they feel their ownership and recognition of accountability for the financial position has not been sufficiently acknowledged. They are very much committed to ownership of this, and have indicate that they are considering it on a daily basis. Their responses to requests for savings schemes are evidence of this commitment. Dr Wooding emphasised that the challenge with regard to finances is not a consequence of staff failing to focus on this. He was confident that functions and CCGs are doing so, and is grateful for their work. The issue is that this commitment needs to be translated into an improved financial position.

Mr James Severs indicated that discussions at and following the Executive Team meeting yesterday had reflected on the importance of being able to release cash and need for value and productivity. Additionally, the need for cognisance around the environment in which healthcare services are operating. Whilst the Quality Impact Assessment (QIA) process being used is rigorous, the output from this is often negative, due to impacts on the quality of services. This introduces another consideration, regarding the organisation's risk threshold and tolerance around the level of change being contemplated. This will factor in future deliberations as an Executive Team. In terms of specifics in relation to the report, there is no denying that the aging infrastructure and estate impacts. It will be important to recognise those issues within and

beyond the Health Board's control and articulate this clearly, along with their impacts, going forward. In regard to Mr Severs' first comment, whilst accepting that it is challenging, Dr Wooding emphasised that this is the space in which the Executive Team should be operating. Balancing all the various and, at times, competing demands, elements and risks to reach the required outcome.

Reflecting on some of the comments and queries, Mr Lee Davies wished to highlight that teams are, in addition to the potential opportunities for savings, contending with a number of other cost pressures and making quite significant changes in order to offset these. He felt it was important to recognise that savings opportunities are not the totality of what has been achieved. In response to Cllr. Evans' query around regional planning, Mr Lee Davies considered the comment in the letter to be fair. There are aspects of the regional work which will generate tangible examples of deliverables, including Cellular Pathology and Cancer. Others are less so and this requires further reflection.

Members were assured that the Health Board has looked at other plans and will continue to do so. It also has regular meetings with the planning team at Welsh Government and has discussed this matter in detail with them. Mr Lee Davies recognised that this year's Annual Plan is both lengthy and focuses on risks; however, there is a valid reason for this. The Plan this year is unlike last year, which aimed to deliver improvements across multiple areas. This year's Plan does not seek to do so, and the organisation therefore wished to be clear about both what it is, and is not, aiming to achieve. Members heard that the Health Board's response to the letter has been drafted and will be finalised following today's Board meeting.

Mr Lee Davies suggested that the tone of discussions reflects the scale of the task ahead, and the fact that the organisation does not yet have a line of sight for every element of the Plan, which outlines a demanding set of deliverables. He suggested the following in terms of next steps:

- Finalise and issue response to letter from Director General
- Undertake discussion at Regional Joint Committee (RJC) regarding examples of tangible deliverables
- Work with NHS Performance and Improvement team around opportunities and strategic solutions to improve performance
- Schedule Board Seminar discussion around savings schemes, choices and trade-offs, resulting in a paper to the Finance and Performance Committee (FPC)
- Discuss with Welsh Government:
    - The route to and requirements for de-escalation from TI
    - The route to and choices required to achieve a break-even financial position

To provide context to the figures, Mr Huw Thomas indicated that, based on Month 1 expenditure, the Health Board will be spending over the course of the year:

- £7m+ on medical and dental agency premium
- £18m+ on additional hours for medical and dental staff
- £6m+ on Agenda for Change agency staff
- £16m on Bank staff
- £8m on overtime

These are the only areas of expenditure which are at sufficient scale and sufficiently variable to offer opportunities over the course of the year. Whatever schemes are presented to FPC and the Board will, ultimately, need to address the consequences of the above expenditure.

Mr Huw Thomas suggested that the Health Board's challenge is less about identifying high-value interventions in which to address; it has already proved itself to be good at doing so. The challenge is in identifying the low-value interventions which it should discontinue and disinvest. Mrs Marks added to this the challenge involved in those interventions where it is difficult to assess the impact at an early stage, making decisions on their value challenging. In terms of the challenges associated with Quality and Equality Impact Assessments, Mr Huw Thomas agreed that assessment of savings schemes purely on the basis of these will often lead to them being rejected, due to negative impacts. The issue is less about the Impact Assessment processes themselves, which are robust, rather the need to ensure that negative impacts are adequately mitigated, to avoid costs being reduced at the expense of quality and equality.

In response to Mr Prior's comment regarding the level of savings required being 2.5%, this was accepted. It is widely recognised that there is low-value activity within the health system in general, and HDdUHB will be no exception. Mr Huw Thomas wished to emphasise, however, that this is not as a result of people delivering low-value activity; it is due to the system not supporting the elimination of low-value activity. Members were reminded that the Health Board's funding allocation is based on population. However, its resources are allocated based on its unique configuration of multiple sites. The organisation will always struggle as a result, unless it changes its configuration. Clearly the Plan as it stands, is not sufficient; the financial challenge is real and needs to be addressed. Whilst there are other opportunities for savings, variable pay is at the heart of the issue.

Ms Daniel accepted that the QIA needs to evolve and mature. Whilst it had served the organisation well in its current form, the financial aspect also needs to be recognised. She suggested that, in the future, the organisation should be considering an integrated impact assessment to support decision-making, incorporating quality and safety, health needs and finance and workforce impacts. This would align well with the new ways of working and

address comments around leadership and accountability, by enabling the Executive Team and Board to consider the risk threshold and make informed decisions. Agreeing with the need for maturity and, whilst acknowledging earlier comments, Dr Wooding emphasised that it is not feasible to adopt a Plan which is unsustainable.

Professor Kloer welcomed the important and constructive Board discussion. It has been made clear that the proposed deficit position of £41m is not acceptable to Welsh Government or the Board, no matter how challenging it would be to achieve this, not to mention even further improvement. Significant progress is, therefore, required. However, the savings schemes already suggested, in addition to those which will be considered during the In-Committee session, would deliver a potentially substantial figure. It should be noted that there will be duplication between the two lists, and there will be schemes which it is not possible to take forward. These will need to be discussed in detail, categorised and considered by the Board; firstly, at Board Seminar, then at FPC and finally at Public Board. Consideration also needs to be given to the support teams will need in order to deliver these savings, and the support needed to achieve de-escalation. It is vital that savings and choices are subject to full impact assessments; it would be surprising if the results are not negative. However, the organisation will need to face the implications and take steps to mitigate them where possible. Finally, Professor Kloer agreed that the report's recommendations are too passive and require review.

Dr Wooding reminded Members that the Health Board has two statutory financial responsibilities: to deliver healthcare to the population of west Wales in a sustainable affordable way and to have an action plan which delivers against that. The organisation is currently in breach of these statutory duties. He reiterated that it is unreasonable to accept a position of unsustainability, no matter how challenging the change process may be. Whilst recognising that staff are working exceptionally hard, the organisation needs to face this challenge. It is not acceptable to recommend a Plan to Welsh Government which does not deliver and which is unsustainable. A route to sustainability is required.

Achieving a deficit of £41m appears questionable at this point; however, the Health Board needs to focus on delivering this, and improving upon it. Dr Wooding reminded Members that the funding being discussed is managed by Welsh Government on behalf of all public services. Reallocating additional funding to health has consequences for other public services, and the Health Board cannot 'isolate' and prioritise itself at their cost. All of these public services – education, transport infrastructure, etc – have the potential to impact themselves positively or negatively on healthcare. The Health Board needs to build an organisational culture and system architecture of financial literacy. Dr Wooding suggested that the recommendations be amended as indicated below. Mrs Wilson clarified that the appendix mentioned in the

report is not being shared publicly, due to its sensitivity. She confirmed that it meets the criteria for discussion during an In-Committee session. Its contents will, however, form part of Public Board documentation in the future.

Closing the item, Dr Wooding thanked Mr Lee Davies and his team for the significant effort involved in producing the Plan presented today.

**Decision:** The Board:

- **APPROVED** the Care Group and Function action plans set out in Appendix A (which, due to its sensitive nature, is being considered during the In-Committee section of the Board) on the basis of the named SRO, decision date and Q1 to Q4 conversion profile against each scheme.
- **AGREED** the 2026/27 in-year target of £41m as the deliverable position, and **NOTED** that the route to breakeven for 2027/28 will be brought back in a separate paper to the July 2026 Board following discussion and engagement with Welsh Government.
- **REQUIRED** that a paper is taken to the June Finance and Performance Committee with a fully owned and dated plan closing the residual delivery gap to £41m and a clear articulation of what would be required to de-risk each scheme. **HT**
- **AGREED** that the configuration premium as set out in Appendix B, are considered with Welsh Government as part of the configuration position underpinning the Three-Year Financial Plan.
- **NOTED** that the annual plan financial deficit of £41.0m will be revised down only when blue and red-rated schemes have been converted, assuming cost pressures are managed within budget.

**PM(26)101 Financial Report - Month 12 2025/26 and Month 1 2026/27**

Introducing this item, Mr Huw Thomas explained that it involves three reports. He began with the Financial Report for Month 12 of 2025/26, which describes a year-end financial outturn of £22.1m, meeting the Target Control Total set by Welsh Government. The Health Board had also spent within its Capital Resource Limit. These contributed to a positive position, which will be revisited in more detail when the Annual Accounts are considered at the June 2026 Public Board meeting. Mr Huw Thomas recognised, however, that the position is somewhat skewed by a one-off £7m accountancy gain, previously discussed at Board, which forms part of the savings over-delivery. The core in-month position for Month 12 was a £1.4m overspend against plan, contributing to a worsening trajectory as the year closed. Members were reminded that there is an underlying deficit of £53.7m, with the gap represented by non-recurrent actions taken. It should also be acknowledged that savings delivery was not shared evenly between functions, with Executive functions and Public Health over-delivering on savings, and CCGs under-delivering. The

Community and Integrated Medicine CCG, in particular, was £4m short of its target. This will only serve to add to challenges in the current year.

With regard to Month 1, Mr Huw Thomas noted that the challenges involved in delivering a forecast deficit of £41m and savings schemes have already been rehearsed. In respect of the latter, the organisation has, to date, identified schemes totalling £7.2m against the £42.8m savings target. What has not been discussed yet today is the cash consequences of the forecast financial position. Whilst this will not impact immediately, it will become challenging from February 2027 onwards. Mr Huw Thomas concluded by emphasising the need for clarity around accountability as the new operating structure and ways of working are implemented.

Referencing the 'Alert' section of the Month 1 report, and 'Conscious decisions potentially compounding delivery of Annual Plan', Ms Harraway noted that a Patient Flow Unit had been established without business case approval. She requested clarification around this statement. In response, Mr Huw Thomas explained that the unit had been configured and staffed by individuals already in the Health Board's employ, so involved no additional net cost at this stage. If and when the unit moves to operating 7 days a week, this would involve a cost, and a Business Case would be required. A Patient Flow Unit generates clear benefits, which can be fully articulated. There is now a patient flow system in place, which the Health Board needs to optimise. A Patient Flow Unit managing this will provide a command structure and drive patient flow implementation and improvements. He acknowledged, however, that substantiating a 7 day model would require discussion at the relevant fora. Dr Wooding advised that he and Mr Maynard Davies had met with the Patient Flow Unit team and the staff have a significant amount of knowledge and expertise.

Noting that the report indicates that a number of budget delegation accountability letters are outstanding, Mr Weir requested the latest position. He was advised that whilst a number remain outstanding, he did not anticipate this would be an issue and would update at FPC in June 2026. Returning to the new ways of working and governance arrangements, Mr Imperato requested assurance that financial grip and control will remain effective. Mr Huw Thomas indicated that he was not necessarily in a position to provide assurance at this point. As has been reported, the organisation is currently transitioning from a command and control system to one of management accountability, and the new structure is being embedded.

Thanking all staff for their efforts in delivering savings, Mrs Marks enquired whether the Health Board is utilising Artificial Intelligence (AI) to identify potential financial trends. She was advised that it is not currently, and there are clearly opportunities in this regard. Whilst AI is being utilised in certain areas, it is under-used. The

organisation is undertaking an AI readiness assessment, which it will use to identify requirements and provide the support needed. Cllr. Evans enquired whether Welsh Government has committed to covering the financial liability associated with the Welsh Risk Pool. Mr Huw Thomas explained that the scale of this issue had become apparent last year. Given its novel nature, Welsh Government had covered this cost, to the tune of £12m. They were not in a position to do so again this year, and the potential impact for the Health Board is approximately £13m. Members heard that the reason for this cost is that the growth in medical negligence claims has been so significant that costs have increased beyond the Welsh Risk Pool cap. The excess has to be shared between health boards, hence the additional liability for HDdUHB.

Referencing the 'Actionable Insights – Top Priority Alerts', Mr Maynard Davies noted that no financial value is assigned to 'Conscious decisions potentially compounding delivery of Annual Plan'. He enquired whether there is any sense of the total value of these items. Mr Huw Thomas committed to provide an update via either the Table of Actions or at FPC. Dr Wooding agreed that the Board needs a line of sight on this issue. In considering the report's recommendations, and the recommendation relating to CHC specifically, Members were reminded that CHC will be an agenda item at the July 2026 Public Board meeting. **HT**

**Decision:** With regard to Month 12 2025/26, the Board:

- **NOTED** that the Health Board's unaudited year-end financial position is £22.1m, slightly exceeding (without roundings) the Target Control Total set by Welsh Government of £22.1m.
- **NOTED** that the Health Board has spent within its Capital Resource Limit (CRL) and achieved the statutory target.
- **ACKNOWLEDGED** that an underlying deficit assessment has been undertaken, and that the brought forward deficit into the 2026/27 financial year is £53.8m, significantly higher than the 2025/26 outturn of £22.1m, due to the reliance in-year on non-recurrent actions, reduced by £4.7m with the rebuttal exercise undertaken in March 2026.

**Decision:** With regard to Month 1 2026/27 the Board:

- **NOTED** that the Health Board's reported plan and outturn is £41.0m, which is both unacceptable and unsupportable by Welsh Government.
- **NOTED** that the Health Board has a significant savings delivery gap of £35.6m, with urgent action plans required.
- **SCRUTINISED** the top priority alerts for urgent remedial action plans, as they pose a significant risk to the organisation in delivering the plan and outturn of £41.0m.
- **ACKNOWLEDGED** that an underlying deficit assessment has been undertaken and the brought forward deficit into the 2026/27 financial year is £53.8m, based on £42.8m recurrent savings schemes.

- **TOOK ASSURANCE** that accountability letters for the delegation of budgets for the 2026/27 financial year will be signed by those areas that have not yet done so.
- **APPROVED** the uplift of Continuing Health Care (CHC) rates to providers.

**PM(26)102 Integrated Performance Assurance Report - Month 12 2025/26 and Month 1 2026/27**

As with the previous agenda item, Members noted that there are two reports, for Month 12 and Month 1. With regard to the former, Mr Huw Thomas noted that there are clearly areas of both success and challenge. The Health Board's Planned Care performance had recovered and improved throughout the year; with 52 week waits for first Outpatient appointments reduced to zero, and 104+ week waits for Referral to Treatment (RTT) down to 3. The 3 breaches were caused by non-availability of bone cement for Orthopaedic procedures, rather than the Health Board's capacity. These should be recognised as significant achievements. In other areas, quality and workforce signals had stabilised, with incidents causing moderate harm or above and C difficile rates at their lowest in Month 12, and complaints and staff turnover rates reduced. These were, perhaps measures which suggest that the organisation's operational base is steadying, which should also be viewed as a success.

However, the trajectory in those areas dependent on the Health Board's own capacity, where it cannot outsource sufficiently, did not necessarily improve to the required level. These include Cancer performance, which has already been discussed, and where Urology is a key challenge. Also, Neurodevelopmental Assessment waits and Psychological Therapy waits. The Annual Report will examine the Health Board's performance across the year and will be presented to the Public Board meeting in June 2026. Mr Huw Thomas was acutely aware that, at the end of each of these statistics, were individuals.

In Month 1, certain positive signals are continued, including staff turnover and incidents causing moderate harm or above reducing even further. The new metric for waits of more than 26 weeks for a new outpatient appointment remains on an improving trajectory. These suggest clear areas of momentum. RTT numbers, however, are beginning to increase again. Improvements in these rely on outsourcing measures being carried forward, and removal from waiting lists for reasons other than treatment. There are also deteriorations in other measures, including 52 week waits for first Outpatient appointments and Radiology breaches against the metric in relation to Diagnostic waits. The latter may reflect the significant activity around Outpatient appointments in Quarter 4 of last year having generated additional diagnostic demand. The recent announcement of funding from Welsh Government to support Planned Care activity is welcomed. However, the Health Board continues to face a number of entrenched challenges, and there are already signs that it may not be able to sustain performance improvements without additional funding.

Referencing the Internal Escalation Update, Ms Murphy enquired whether and how it is intended to hold to account those areas which have been rated as Level 3 for some time. In response, Mr Huw Thomas indicated that there are various routes by which these might be escalated. There are discussions taking place around processes to escalate from Level 3 to Level 4, and the Health Board is working with external experts from NHS Wales Performance and Improvement on this matter. Cllr. Evans noted that, the performance tables showing that the staff sickness rate is described as 'Hitting target', whilst the variation is rated as 'Concerning'. He enquired whether it is, therefore meeting the target. Members were advised that, from a strictly statistical view, this assessment was correct.

Mrs Gostling described a number of programmes of work which are being undertaken around this, including collaborations with Public Health to examine population health and epidemiology correlation between workforce domicile and sickness absence. The Public Health team is also undertaking work to aid staff in understanding and improving their own health. Attendance Management staff have also been appointed to the Workforce team, and Mrs Gostling personally examines and discusses all long-term sickness cases. An audit of all CCGs and functions is being undertaken to ensure that they are following sickness absence management processes correctly.

Mrs Marks wished to raise a number of points. Firstly, the reason for the worsening position in relation to Adult Psychotherapy waits in excess of 26 weeks and the steps being taken to address this. Secondly, the reason for the low percentage rate of children up to date with scheduled vaccinations and details of programmes in this area. Finally, with regard to bottlenecks in Diagnostics, Mrs Marks indicated that she had recently met three medical secretaries in Cancer services. They had informed her that they cancel 5-6 appointments every week due to diagnostic reports not having been received. They were not able to specify the impact of these cancellations was on the patients in question. Mrs Marks enquired regarding mitigating actions being taken.

In response to the third query, Mr Carruthers highlighted that the Health Board is prioritising the backlog in urgent and emergency Cancer care, which, regrettably, negatively impacts on routine Cancer diagnostics and treatment. He assured Members that discussions are taking place at a national level around the issues and challenges in Diagnostics and how performance might be improved. Radiology is not yet at the optimal capacity to deliver the required or desired level of Cancer performance. Whilst acknowledging this, Mrs Marks suggested that the apparent lack of clarity around the impact on patients and their wellbeing, goes beyond concerns around performance. Mr Carruthers advised that the pathway of every Cancer patient is tracked individually and committed to examine how this information is communicated to medical secretaries and other key contact points. **AC**

In terms of the Psychological Therapies query, similar to Cancer, in addressing the backlog of patients waiting, the overall performance is impacted negatively. The backlog has reduced by 33% over the course of the year. Some of the improvement this year has been delayed, due to an operational decision to use the streamlining process rather than recruit new staff to increase capacity. He would, however, anticipate a continued reduction in the backlog and improvement in the metrics. Mr Carruthers has requested that Patient-Reported Outcome Measures (PROMs) and Patient-Reported Experience Measures (PREMs) data be initiated for this service, as informal feedback suggests strong patient satisfaction in terms of outcomes. Finally, in terms of capacity, the position is being reached whereby more patients are being discharged than are entering the referral pathway, which should result in further performance improvements.

Responding to Mrs Marks second query, Dr Gjini noted that the region has, historically, seen lower childhood vaccination rates than both would be desired and the target. Whilst the latest data will demonstrate a rate of 90%, this is still under the target of 95%. Vaccination uptake has deteriorated generally, with reasons being multifactorial. These include vaccine hesitation and reduced trust in vaccinations. The Health Board is taking steps to increase public knowledge, enhance vaccine education and improve access. Vaccine delivery in schools has been impacted negatively by both vaccine hesitation, and issues around parent/guardian consent not having been confirmed. Whilst an improvement is anticipated, there is further work required.

Returning to the issue of sickness absence, Dr Wooding suggested that the Health Board seeks to draw on experiences and good practice from elsewhere, including outside Wales. He noted that issues in Radiology are a recurrent theme, and wondered whether there are other potential digital solutions. He emphasised the need to accelerate performance improvements in this area and ensure that the organisation becomes more sustainable. Otherwise, delays will continue to impact on patients and performance. The Board will continue to monitor this area.

**Decision:** The Board **DISCUSSED** the IPAR – Month 12 final position 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’.

**Decision:** The Board **DISCUSSED** the IPAR – Month 1 2026/27 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)103 Improving People Experience Report**

Introducing the report, Ms Daniel explained that this has a new format, and thanked both the Patient Experience and Performance teams for their work in producing it. Compassionate care remains

a clear and consistent strength across the organisation, with over 90% feedback positive evidenced in the report. There has also been an increase in compliments. This should be acknowledged, given the pressures that services are working under. It is also evident that patient experience is increasingly shaped by system pressures. In particular waiting times, access and communication. Therefore, dissatisfaction is not always related to clinical care itself, more how care is experienced, coordinated and communicated. Complaints intelligence is now providing clearer signals on risk, with common themes being delays in diagnosis, escalation and continuity of care. This serves to highlight that patient experience is closely linked to quality and safety, not separate from it.

The major shift in the new report is a move away from describing patient experience activity to providing insights and towards clearer, more triangulated understanding of system drivers and patient experience of risk. This is intended to demonstrate how the organisation is attempting to translate learning into practice. The direction of travel is from insight to impact, with an increased focus on strengthening communication, improving the timeliness of responses, complaints handling, etc. since April 2026, the 'Listening to People' regulations have been introduced, and are already shifting towards a more timely frontline resolution of concerns. This is impacting on the number of concerns which are escalated to complaint level. Teams are also transitioning from the previous, retrospective model, to the response in real-time model. It is hoped that this will translate into further improvements by the next report. Finally, Ms Daniel wished to draw Members' attention to the Arts and Health Annual Report, thanking Mrs Marks for her input and leadership in this area. The experiences outlined in this report only serve to affirm that health begins at home and is very much founded in personal wellbeing.

Dr Wooding commended the report, which was much improved. Whilst there are a number of areas showing positive results, he emphasised that the organisation must not become complacent. Noting the common themes of communication failures and lengthy waits, Mrs Patel enquired how it is intended to address and reduce these. Members recognised that waits, in particular – and not only those involved in waiting lists – only serve to increase patients' stress and frustration. Cllr. Evans commended the Arts and Health Annual Report as excellent. Speaking as the Board's Welsh Language Champion, he requested assurance regarding priority and access for patients and families who wish to communicate in Welsh. Finally, staff attitude and empathy is highlighted a number of times within feedback. Noting the link with a Planning Objective referenced in an earlier report around creating a positive workforce culture, Cllr. Evans requested assurance that issues with staff attitude and empathy will not become a recurring theme.

Ms Murphy agreed that the new report format is much improved. She shared the views of others around frustrations caused by

waiting times and delays, and would add to this the challenges of parking on Health Board sites. Ms Murphy also wished to commend and thank the Arts and Health team for their support, particularly from a staff wellbeing perspective. Agreeing with both of these comments, Mrs Marks highlighted that the Arts and Health team is extremely small, yet achieves a great deal. She would encourage engagement with their activities. Adding her praise, Ms Harraway noted that the team has a 'gold standard' approach to evaluation, with robust evidencing of impact, and that others could learn from their approach. In terms of the main Improving People Experience report, Ms Harraway remained unconvinced that non-response from Children and Young People suggested satisfaction with their experience. It may be that there is a lack of appropriate engagement or access to feedback mechanisms. She further suggested that the organisation consider a 'Shadow Board' for Children and Young People.

Whilst noting that much is beyond the Health Board's gift, Ms Harraway emphasised that communication with patients is within its control. Waits for treatment are frustrating and unacceptable; however, waits which are explained are more palatable, and can be facilitated by the organisation. Mr Prior echoed the comments of others, welcoming the learning described in the report and emphasising the need for system-level change. Adding his approval for the new format, Mr Imperato welcomed in particular the analysis of feedback by site and service. Returning to the Arts and Health service, Mr Iwan Thomas noted that this is funded in its entirety externally, via Charitable Funds and the Arts Council of Wales. Additional funding sources are required.

Ms Daniel confirmed that a significant amount of work is being undertaken around communication. The organisation needs to focus on communication with people in real time, on the mechanisms used, and the nature of the information communicated. Responding to one of Ms Harraway's comments, she emphasised that the feedback data relating to Children and Young People is a summary only. She assured Members that there are separate surveys for this group. Dr Gjini confirmed that the service recognises that the feedback is not comprehensive and cannot, therefore, provide full insight. However, the suggestion that this 'skews' the feedback positively would not mirror the evidence from other feedback, where those dissatisfied with their experience tend to participate more. Dr Gjini emphasised that the service is utilising wider patient feedback mechanisms, including the 'You Ask, We Do' format, and is continuing to implement learning from these. With regard to the Shadow Board suggestion, whilst this is being considered, it may not be possible to take it forward at the current time due to capacity issues.

Responding to Cllr. Evans query, Ms Alwena Hughes Moakes confirmed that the Health Board has a statutory duty to provide an 'active offer' of communication via the medium of Welsh. Whilst not every member of staff speaks Welsh, they should all be aware

of access routes to enable patients and families to communicate in Welsh. The Welsh Language team is working with clinical teams to raise awareness and is able to provide stickers and door hangers which can assist in identifying patients whose first language and communication preference is Welsh. Should anyone be in doubt about the impact of this, Ms Hughes Moakes suggested that they read the poem recently published by Tudur Hallam about his experience of being treated for cancer at Prince Philip Hospital (PPH). She would be happy to provide copies or translations of the poem on request.

Dr Wooding drew discussions to a close by endorsing, on behalf of the Board, the new report format and requesting that the Board's thanks be passed on to the Patient Experience team. He also requested that the Board's commendation of the Arts and Health Annual Report be communicated to that team, together with gratitude for their work.

**Decision:** The Board:

- **TOOK ASSURANCE** from the Improving People Experience Annual Report
- **NOTED** the Arts and Health Annual Report

**PM(26)104 Meddygfa'r Sarn**

*Ms Rhian Bond joined the Board meeting.*

Mr Carruthers introduced the item, reminding Members of discussions around the Vacant Practice Panel recommendation at the January 2026 Public Board meeting. This had recommended dispersal of the Meddygfa'r Sarn patient list. However, it had been resolved at the meeting that there was a need for engagement with and input from patients and the community before a final decision was made. The report brings together the outcomes of the public engagement undertaken. Mr Carruthers wished to record his thanks to Ms Hughes Moakes, the Communications and Engagement teams, and to the Primary Care team, led by Ms Rhian Bond, who is in attendance today.

There had been strong and active engagement from patients and stakeholders, reflecting the strength of feeling on this topic, and the Health Board is grateful for their input. Most responses were not supportive of the dispersal of the list, with a number of concerns expressed around the impact of this course of action. These included health inequality and access considerations and highlighted the rurality of the population served. During the engagement process, the Health Board had received a small number of informal expressions of interest in the General Medical Services (GMS) Contract for Meddygfa'r Sarn. These may offer an alternative route for consideration, however, do not diminish the long-term issues which led to the original Vacant Practice Panel discussion and recommendation.

All of the evidence and feedback obtained during the engagement has been taken into account in proposing the new course of action, which recommends a procurement process to test the market and request formal expressions of interest.

Mrs Marks thanked all of those members of the community attending for this item. She emphasised that reading and hearing the views of those potentially impacted is extremely important, and recognised the strength of feeling on this matter. Also thanking the public for their feedback, Mr Imperato suggested that Meddygfa'r Sarn's status as a Health Board Managed Practice may offer opportunities as opposed to being an issue. referencing the later agenda item on CbD: Integrated Neighbourhoods, he felt that this might be an example of such a model. Noting that there are various concerns and options, Cllr. Evans queried the intention to consider a way forward at a future Board meeting. He enquired whether a timescale has been defined for this.

With regard to the final query, Mr Carruthers advised that a new procurement process has been introduced and that it will take time to consider the requirements. The timescale involved before an outcome to Board may be up to six months. Ms Rhian Bond confirmed that this may be the first contract let under the new Provider Selection Regime (PSR) Wales framework. Under normal circumstances, the Health Board would look to award a new contract from either the start of a financial year, in April, or a mid-point of October. The latter would be too soon, given the need to run an open and transparent process, which is likely to take six months. In the interim, Meddygfa'r Sarn would continue to operate as a Managed Practice.

Ms Murphy noted reference in the report to 'alternative locations' and the possibility of 'repurposing existing underused buildings'. She enquired whether this would be considered concurrently with the procurement process. In response, Ms Bond explained that any new premises would need to be subject to the procurement exercise. In the interim, the practice would continue operating from the existing premises. It would be for any party expressing an interest in the contract to identify alternative suitable premises. As part of the process, the geographical area would be defined. This may involve the existing premises, or an alternative location within Pontyates, where the service is to be provided. Dr Wooding suggested that, should a new facility be proposed, consideration be given to the possibility of a multi-purpose space.

Whilst welcoming the informal expressions of interest, Mr Maynard Davies highlighted recent media reports regarding issues with Primary Care providers experienced by other health boards. Mr Carruthers advised that these are very different circumstances to the process HDdUHB would be undertaking. The expressions of interest are from local potential providers rather than national companies. Members were reminded that it is not possible to provide further detail in a public forum, due to the commercial sensitivity of this information.

Dr Wooding suggested that the Board's 'in principle' position would be a desire to see the service maintained. However, he echoed the need to address the issues which had led to the original VPP and their recommendation. It is important to ensure that the process is the correct one, and not compromised by excessive urgency. He would suggest that the Board endorse the report's recommendation. In the meantime, Ms Donna Coleman requested assurance that there is a communication plan in place, to ensure that the community is kept informed. Dr Wooding agreed, emphasising the need to maintain contact with and work alongside the community to develop the service required. It was agreed that this would be added as a recommendation. Mr Carruthers did wish to stress that the process was the one which has been signed off as a Board, and was correctly applied and followed. However, there has been reflection on the process and it should also be noted that a national review of the VPP process is being undertaken. It is likely that both of these will be reflected in the future within a different process, in which engagement is central from the outset.

**Decision:** The Board:

- **NOTED** the feedback from the public engagement period
- **NOTED** the informal expressions of interest received during the engagement period into the procurement of the GMS/ APMS Contract for the Practice
- **AGREED** that a procurement process should be undertaken to test the feasibility for an independent contractor to take a GMS or APMS contract for Meddygfa'r Sarn, with VPP constituted to consider the outcome and make a recommendation to a future Board meeting on the way forward
- **AGREED** that a communication plan should be put in place, to ensure that the community is kept informed and a commitment made to work alongside the community to develop the service

*Ms Rhian Bond left the Board meeting.*

**PM(26)105 Public Health Wales Test and Post Incident**

Dr Gjini presented the Public Health Wales Test and Post Incident report, reminding Members of the background to this item. The incident spans four key areas of concern:

- Safeguarding, where statutory processes for children, young people, and adults at risk were not consistently met.
- Patient safety, particularly relating to incorrect or delayed communication of test results.
- Information governance, including weaknesses arising from complex and manual data-handling processes.
- Hepatitis C (HCV) testing within a specific blood testing pathway used by people living with HIV, where testing had not been included in a way that aligned with service user expectation.

Members were reminded that, in relation to this incident, Public Health Wales (PHW) is the accountable organisation. It has established an internal Incident Management Group (IMG) and have commissioned an independent external review. PHW has concluded that continuing the service with mitigations is safer than suspending the service, a conclusion with which Dr Gjini agrees. The safeguarding concerns relate to statutory processes not being followed fully, in relation to both under 18s and older individuals. Patient safety concerns involve the handling and communication of results. Information Governance concerns relate to data handling and incorrect results. Hepatitis C testing concerns are around tests not being conducted and incorrect results. PHW has taken immediate and substantive action across all four areas. These include strengthening safeguarding checks and referrals, auditing and redesigning processes, improving data governance and reporting to the Information Commissioner's Office. With regard to the HCV testing pathway, a 'lookback' exercise has been undertaken, with no significant concerns identified to date.

The incident is being managed under the Duty of Candour requirements and independent advice is being taken around ethics, openness and transparency. Whilst the Health Board is working closely with PHW, it is not part of the Incident Management investigations or response. HDdUHB has completed the safeguarding reviews referred to it by PHW and has not identified any unmet safeguarding actions to date. It has tested its HCV pathway and offered all individuals HCV testing. It has also ensured that its sexual health and blood-borne virus (BBV) services are available to support as required. In terms of risk and assurance, whilst the incident has clearly raised a number of areas of concern, these are being addressed. Patients are being communicated with, and mitigating actions are being implemented and offered.

Mrs Patel enquired whether there is still an issue around identifying all of those who might have been affected, or whether this is no longer the case. In response, Dr Gjini highlighted that there have been public announcements and publicity on this incident, which provides an opportunity for anyone with concerns to make contact. In all cases where it has been possible to establish contact details, attempts have been made. There is a small group of individuals it has not been possible to contact. Likewise, PHW has indicated that there is a small number of individuals affected by the HCV issue not followed-up. In response to a request for clarification around Phase 1 and Phase 2 cohorts, Dr Gjini explained that Phase 1 refers to those individuals under 18 at the point they accessed the service and still under 18, and Phase 2 is those individuals under 18 at the point they accessed the service and now over 18.

**Decision:** The Board:

- **NOTED** the consolidated position regarding the PHW Sexual Health Service incident.
- **TOOK ASSURANCE** from the actions undertaken by PHW to address the four identified areas of concern, and Health Board system actions in relation to safeguarding review, BBV testing access, and shared learning.

**PM(26)106** **'A Healthier Mid and West Wales' Strategy**

Introducing the report, Mr Lee Davies reminded Members that the Health Board's AHMWW Strategy had been refreshed earlier in the year. The organisation has been taking steps to raise awareness, and will undertake engagement with its population and partners over the coming months. He reiterated that the Health Board is currently operating an unsustainable model, a reality which needs to be faced head-on. As has been mentioned, a fundamental shift is required to deliver the Strategy, and teams will need to consider how they can contribute to its delivery.

Mr Prior noted use of the term 'radical trust' in the report and queried how it is intended to make the Strategy the topic of an ongoing conversation within the organisation, given the need for every member of staff to take ownership and contribute. Recognising that a number of groups have already shared their views on the Strategy, Ms Hughes Moakes advised that steps will first be taken to close the loop with these parties. Various versions and formats of the Strategy documents will be produced. She reminded Members that the Strategy has a timeframe extending until 2040; therefore, the process of taking it forward will be phased. Whilst agreeing, Mr Lee Davies highlighted that progressing the Strategy is not enabled by production of documents alone. There needs to be an honest reflection on where change is required, which will be challenging. This process will involve developing trust both inside and outside the Health Board. He drew Members' attention to the four Strategic Objectives and eight Planning Goals, which apply to every part of the organisation. It will take time to embed these.

Mr Tegryn Jones indicated that he has been a member of the Stakeholder Reference Group for some time. He observed that one area where progress is lacking is in social prescribing and the Social Model for Health. He emphasised that there are hundreds of organisations across the region who would be interested in helping the Health Board to improve people's health. It seemed to him that the organisation can be perceived as somewhat 'impenetrable' to these external bodies. Whilst not necessarily agreeing that this was the case, Dr Wooding and Professor Kloer felt it was important to register this perception. Professor Kloer reminded Members that the Health Board's recognition of the need for change was the driving force behind the original 2018 Strategy. It is clear that there will be even more changes and challenges in the near- and long-term future. The organisation needs to develop alternative ways of working to address these. He agreed that there are valuable resources in the community who want to assist and engage with the Health Board.

Dr Gjini confirmed that the Health Board recognises the importance of progressing the Social Model for Health, with almost all of the public services in the region having signed up to this. The principles are regularly restated at the Public Services Boards (PSBs); however, there is more which could be done. Looking at how to enable capacity to develop social prescribing; a model utilising community health and wellbeing workers would be one option. Making Every Contact Count also provides opportunities; however, there is a need to strengthen community interventions. It may also be possible to explore other options, including training public service staff and volunteers. Approaches from external bodies would be welcomed.

Dr Wooding suggested that the Health Board should seek to project itself to the point at which the Strategy is delivering its aims, and reverse-engineer the enablers required for success. He agreed that the support and engagement of staff is crucial to this, adding that the organisation also needs to facilitate other stakeholders and communities to contribute. The Strategy pivots on a number of key elements, and is a topic which the Board will need to revisit regularly.

**Decision:** The Board:

- **NOTED** the work which has been carried out to date to create the final version of the strategy and alternative formats.
- **TOOK ASSURANCE** from the work carried out to engage with our staff on the strategy and future planning for public and stakeholder engagement.
- **TOOK ASSURANCE** that work is being undertaken to bring the strategy into operational delivery through the development of strategic delivery plans and the alignment of key monitoring and reporting structures, with these to be reported to relevant Committee meetings in June 2026.

**PM(26)107 Clinical Services Plan**

Mr Henwood presented the Clinical Services Plan (CSP) report, which is intended to provide assurance regarding the steps taken to progress decisions on the CSP made by the Board in February 2026. He reminded Members that decisions were made on eight of the services in the CSP, with it determined that further consultation should take place around Stroke. The report describes the steps being taken in Phase 4, divided into 4 parts together with an indicative timeline. The organisation will be refreshing the communications and engagement plan. The report includes as an appendix summary report from the hurdle and scoring appraisal session on the proposed Stroke option. Dr Wooding reminded Members that this report is intended to demonstrate that the Health Board is delivering on the agreement and commitment made as part of the CSP discussions. He further advised that there will be a more detailed discussion around the Stroke consultation under the next agenda item.

Mr Maynard Davies highlighted the need for staff engagement and enquired regarding progress in engaging with staff in those services who are affected. He also enquired regarding engagement with Welsh Government, given that certain of the proposed options require investment in both capital and human resources. In respect of the first query, Mr Henwood advised that the communications and engagement plan is being refreshed; however, there is less formal engagement on an ongoing basis. The Health Board is also engaging with Welsh Government. Whilst it is not currently in a position to develop or submit business cases for additional resource, there will, therefore, be an awareness of plans. Mr Lee Davies advised that Task and Finish Groups have been established for each service, which all include staff-side representatives. As indicated, Welsh Government is being kept appraised of the CSP work and its potential capital implications. The Board should be aware, however, of the challenge involved in dovetailing the capital plans relating to CSP services with other wider plans such as for any new hospital, etc. This challenge will necessitate an ongoing dialogue with Welsh Government, to ensure the correct balance is struck.

**Decision:** The Board **TOOK ASSURANCE** that work is progressing to develop a detailed implementation plan for the eight Clinical Services Plan services upon which final decisions were made at the February 2026 Public Board meeting.

*Ms Donna Coleman left the Board meeting.*

**PM(26)108 Stroke Consultation**

*Dr Helen Wang, Dr Iwan Griffiths, Dr Ahmed Ellaban, Mr Gareth Harlow, Ms Rhian Bond and Ms Sarah Bolton joined the Board meeting.*

Introducing the report, Mr Henwood reminded Members of the decision made in regard to Stroke at the February 2026 Public Board meeting. It had been agreed that the proposed merged option for this service required full appraisal and additional consultation with the public. An appraisal and scoring session had taken place in April 2026; with the merged option passing the hurdle criteria and scoring more favourably than other options considered previously. Materials have been developed for engagement with the public, it having been determined that a second phase of public consultation is required. It is requested that Board discuss this matter and agree a way forward. Dr Wooding reminded Members of the discussions and decision reached in February 2026. The consideration today is around assurance that the consultation process being proposed meets Board expectations based on those discissions and decision.

Cllr. Evans wished to make clear that the process is one of consultation, rather than engagement, noting that the two have different legal definitions. He recognised that the concerns raised in relation to the future of Stroke services have been acknowledged. Further, that the consultation will also ask whether

people believe that one of the other four options previously considered by Board better addresses the issues highlighted. He enquired whether those who had responded previously need to respond again to this phase of the consultation, or whether their previous comments will be included when it comes to consideration of feedback. Ms Hughes Moakes stated that the Health Board is extremely grateful to those who completed the questionnaire previously. Their feedback and comments will be taken into account when it comes to analysing responses. In this phase of the consultation, the Health Board is seeking views on the merged option and – should people feel that one of the other options better addresses issues – which one. She would actively encourage people to engage, whilst emphasising that the Health Board is not seeking new options or suggestions.

Mr Iwan Thomas enquired whether the Equality Impact Assessment (EqIA) tool is bespoke to this particular exercise, or whether it could be used for other purposes. In response, Dr Gjini advised that the EqIA tool was tested during phase one of the CSP consultation. It is bespoke to the Health Board, although it has been shared with other health boards. As outlined earlier, it is intended in the future to design an integrated impact assessment, which would include equality considerations. This EqIA specifically had identified that the merged Stroke option has the capacity to improve outcomes, whilst also potentially impacting negatively on certain aspects. It will be important to ensure due diligence to mitigate such impacts.

In relation to Cllr. Evans' comments, Professor Kloer indicated that he would encourage engagement from anyone wishing to express their opinion. He emphasised, however, that the Health Board should take into account previous feedback, as various important points had already been made within that. Whilst agreeing, Dr Wooding reiterated that new options and ideas are not being sought in this phase of the consultation. Ms Hughes Moakes reminded Members that the merged option had stemmed from two options suggested by members of the public. This round of consultation will ask people to consider whether this option, or one of the others previously proposed, is their preferred choice. She confirmed that analysis will take account of what was heard previously, including comments around transport and travel, and the Welsh language.

Mr Prior felt that efforts should be made to more clearly articulate for the public and stakeholders what the merged option would mean for patients and service delivery, with particular reference to local rehabilitation. Dr Wooding noted the tension, identified within the EqIA, between the option's capacity to improve Stroke care to the highest possible quality, and potential impacts on equality caused by travel, for example. Whilst acknowledging this, Mr Henwood reminded the Board of the need for cognisance that Stroke is a specialist service. If national guidance was to be applied, there would be only four or five Stroke units in Wales, none of which would be in Hywel Dda.

Mrs Patel enquired whether the reality of the transport implications involved in the treat and transfer model has been articulated. Concerns around ambulance response times are a legitimate concern for members of the public. Mr Lee Davies advised that the Health Board is working with the Welsh Ambulance Services University NHS Trust (WAST) and others on this issue, for all services within the CSP. There is some clarity regarding the other eight services, and this will evolve with regards to Stroke, once a final option is determined. This should lead to greater clarity around the potential requirements and impact associated with transfer of patients. He indicated that adding to the demand on the emergency ambulance service is not proposed; the intention would be to create a bespoke transfer service.

Emphasising that Stroke is highly preventable, Dr Gjini expressed the need to strengthen the pathway end to end, including prevention. Mr Henwood and Dr Wooding agreed, noting that the consultation will offer opportunities to highlight and discuss this aspect of Stroke care. Dr Wooding requested that Executive Directors and Independent Members make every effort to attend as many consultation events as possible.

**Decision:** The Board:

- **TOOK ASSURANCE** from the stroke output report, shared as part of the Clinical Services Plan implementation progress report, that the preferred option has been developed to the same level of detail as other options previously discussed in February 2026 Public Board.
- **ENDORSED** the format of engagement for the second phase of the Clinical Services Plan consultation for stroke services.
- **APPROVED** the scope of the phase 2 consultation, including the matters excluded from the consultation.
- **TOOK ASSURANCE** from the consultation project plan that there are appropriate resources in place to manage a consultation, including the analysis and evaluation of consultations, and that this continues to be quality assured by HICO.
- **APPROVED** the second phase of the Clinical Services Plan consultation for stroke services to run from 28 May 2026 until 26 July 2026.

**PM(26)109 Community By Design: Integrated Neighbourhoods**

Reminding Members that this was an item requested at the previous Board meeting, Dr Wooding suggested that Primary Care Clusters are the ‘fulcrum’ in delivering the AHMWW Strategy. Mr Carruthers welcomed those attending the meeting for this item and their commitment to this area. He agreed that consideration of Clusters is extremely important, especially in the context of strategy discussions. The report presented deliberately focuses on ‘what’ rather than ‘how’ at this stage, reflecting the need to ensure consensus before further work is undertaken. Proposals are

intended to signal a ‘gravitational shift’ and recognise the need to empower local communities. Members’ feedback on these would be welcomed.

Ms Bond advised that the report highlights the successes of Clusters to date and notes that, with the introduction of the national CbD programme, now is the time for the ‘shift left’ to support prevention and improved patient outcomes. The new model of Integrated Neighbourhoods facilitates this and ensures that community-based services are at the forefront of service planning and delivery, on a greater scale than Clusters were previously. Ms Sarah Bolton asked Members to consider the last time they needed care and faced challenges in this, and the reasons for these challenges. The tension between systems and people is the rationale behind today’s item. For decades, the healthcare sector has a system which is effective at responding to illness, but far less effective in supporting people to live well.

The system is organised around services, contracts, professions and buildings, rather than people, families and communities. The results are familiar – pressure in hospitals, fragmented care, limited capacity to scale, a workforce constantly under strain. She asked, if we were designing the system again, knowing what we know about inequalities, long-term conditions and aging populations, whether we would build the current system, or closer to what the AHMWW Strategy describes. The direction has been clear for some time – the need for a ‘shift left’, earlier prevention, better integration and care delivered closer to home. What has been missing, is not the ambition, but delivery at pace with accountability. This is the gap which needs to be closed.

Primary Care Clusters have given the organisation something valuable – relationships, collaboration, innovation. However, they are too often project-focused, time limited and disconnected from real decision-making power. The result is stretched community services, prevention discussed but not delivered, hospital flow dominating, innovation struggling to scale. Critically, there is no single place where systems truly come together to take responsibility for population health. The question of who is accountable for the health of a neighbourhood leads to Integrated Neighbourhoods. These are not simply rebranding Clusters; they represent a fundamental shift in power, leadership and accountability are organised.

Integrated Neighbourhoods are place-based delivery units, with shared accountability, collective decision-making, leadership across health, social care, local government and the Third Sector. No single organisation will dominate or can opt out. This is partnership, not coordination. Ms Bolton asked Members to imagine a different experience of care – one clear way in, navigation happening with you, not to you, professionals working as one team around your needs; working together, with shared data, shared priorities, shared accountability. This level of change needs good leadership. Each Integrated Neighbourhood would

have a designated Cluster Director with real authority, accountability and parity with secondary care leaders. If care closer to home is the real ‘centre of gravity’, leadership needs to sit there too. These leaders will work alongside professional collaboratives, to ensure decisions are grounded in clinical reality.

Integrated Neighbourhoods will move from projects to outcomes, using 4Cs (Contact, Comprehensive, Continuity, Coordination). They will oversee access, pathways and interface with hospitals, and proactive population health management. Every contact will count and every decision will consider prevention. This change will not be easy, given that it is cultural and relational. It will also not happen quickly. Integrated Neighbourhoods will also develop at different speeds. What is crucial is establishing clear guardrails, shared expectations, robust data and maturity frameworks, so that innovation is not at the cost of equity.

This brings us to the choices presented today, with a request that Board supports a shift of power to communities, a rebalancing of leadership and resource, a placing of trust in integrated teams and a true commitment to care closer to home. If the Health Board truly believes in prevention, integration, improved outcomes and avoiding hospital admission, Integrated Neighbourhoods are needed, to transform not just how the organisation works but the lives of the people it serves. Integrated Neighbourhoods are not the destination, but the vehicle. The vehicle which moves us from pressure to purpose, from fragmentation to connection, from managing demand to improving lives across Hywel Dda. The team then introduced a film which illustrated the Integrated Neighbourhoods model, available on the meeting recording via the Health Board’s website.

Dr Helen Wang thanked the Board for the invitation to attend and discuss potential opportunities. Whilst the report describes the barriers to progress, it should also be recognised that Clusters have made a significant difference to communities. They are leaning into partnerships and other stakeholders; however, to expand would require support from the Board, to facilitate a true shift bringing care closer to home. Part of the challenge is centred on the fact that decision-makers are external to the Health Board. The organisation is, however, gifted with an extremely committed team who want to take this area forward. Dr Wang emphasised the need to engage with communities where they already are: in schools, community centres and at existing events.

Dr Ahmed Ellaban indicated that the need to shift left and provide more care in the community is well-recognised. Whilst certain changes are required, these will facilitate and deliver a great deal more. Dr Iwan Griffiths suggested that Integrated Neighbourhoods offer a real opportunity for radical change, with Clusters already having evidenced the possibilities. He hoped this focus can be developed further, adding that Cluster teams understand their localities and their individual needs. Mr Gareth Harlow emphasised that, if the shift left is to work effectively, it will require

true integration between healthcare professions, the Third Sector, partner organisations and others.

Dr Wooding suggested that this item echoes comments made during earlier discussions, around the need to develop a culture of trust. Whilst indicating that the proposals have his full support, Mr Prior noted that the report requests the Board's endorsement, without necessarily describing a process for achieving the model. He emphasised that this is an extremely important constituent of decision-making. Whilst absolutely commending the 'theory' presented, it is important for the Board to also have the detail and process involved in achieving this. In addition, the reality of partnerships is that they can test organisational boundaries, power, resources and control. As a result, they require effective and engaging leaders. With funding in the public sector being so stretched, a convincing case will be required to make such radical change. Mr Prior felt that the resources within communities, such as 'grass-roots' community groups, was somewhat absent, from the report in particular. Finally, whilst the report suggests this is not a structural reconfiguration, that is the impression given.

Mr Imperato also supported the proposals, which begin to address the challenges experienced by Clusters around empowerment. He agreed, however, that more detail around the model and timeline to achieving it would be required. Whilst the report itself had been light on Third Sector and Local Authority involvement, the film had included more information in this regard. Mr Imperato suggested that the sooner further detail can be provided on how the model would be achieved, the better. He noted, however, that there is a time and financial cost involved simply in doing this; a commitment which would need to be agreed.

Whilst agreeing that Integrated Neighbourhoods appear to be the next logical step, Mr Iwan Thomas felt that it does not adequately recognise integrated community initiatives which already exist. He highlighted the example of the Carmarthenshire Living Well Centre, which integrates 34 services in one location, and provides these services to the community free of charge. He also highlighted that the local Cluster already contributes to these services. This centre provides services to 900+ people per month. Mr Iwan Thomas suggested that examples of existing community initiatives such as this should be considered as part of any development of proposals.

Ms Harraway agreed that Integrated Neighbourhoods offer a compelling vision of the future; however, the report fails to offer an understanding of the gap between where the organisation is now and where it needs to be. Whilst the passion, vision and aspiration are evident, what is not clear is the steps required and whether these are feasible within the timescale. Agreeing, Ms Daniel noted that the rationale for change is recognised and acknowledged; the mechanism for achieving this is now required, and needs to consider:

- What the clinically credible and safe model looks like
- What the workforce looks like
- What the transitional risks are

Mr Huw Thomas recognised that there is a planning element and a delivery element involved. With regard to the former, it is important to understand and see the activity rates for Primary Care patients, costs at both a GP and Cluster level, and the target allocation. He committed to work with Cluster teams on these matters. Further, a shift left implies a shift away from elsewhere, ie low-value interventions. In terms of the delivery element, the patient management system being developed should address a number of the issues described around integration and data-sharing, for example, by providing 'one view' of an individual. He would also work with Cluster teams in this regard. **HT** **HT**

Ms Murphy wished to highlight the award won by the South Pembrokeshire Cluster for their respiratory project with local schools. The feedback from children, parents and teachers on this project was very positive, and this offers a perfect example of a potential high-impact service with significant benefits. In addition to the offers made above, Mr Henwood wished to make a commitment on behalf of the Clinical Executives to assist Clusters in developing the clinical leadership required to take these proposals forward. Whilst agreeing that the model needs to be progressed, Cllr. Evans shared Mr Iwan Thomas' view that care is required, to avoid duplication of initiatives already in place. He noted that the recommendations have major implications around procurement, finances and accountability; particularly the latter. Dr Wooding emphasised that far more detail would be required before any procurement could be embarked upon. **MH/SD/ JS**

Related to this, Mr Lee Davies noted the concepts of power, authority and control. Whilst he is a Board Member, his ability to enact change is limited, given that most of the Health Board's resources are used to employ staff who will still be required. He highlighted, however, the importance of the 'centre of gravity' phrase within the recommendations, suggesting that this does identify an area of imbalance. The current organisational structure is based on CCGs and services, most of which are Secondary Care. Yet the Clusters are being challenged to change service delivery, without resource, control or influence. The Health Board needs to support them to make the shift in a systematic way. He highlighted that it is not appropriate for them to enter into detailed planning, without first securing organisational support to take this forward, and recognition of the fact that most of the control and resources sit within Secondary Care. Dr Wooding noted the need to acknowledge the tensions and barriers which have prevented change before now.

Mrs Patel felt that it is important to identify exactly the issue which change is intended to address. She has seen, during her time with the NHS, similar initiatives before, which have failed to deliver significant change. Further clarity is required around the problem

which is being solved. Noting that any change will require investment, and that the source of this would need to be identified, Mrs Patel also shared Cllr. Evans' concerns around procurement, accountability and finances. She added to this the need to identify specific impacts, and the benefits and returns on any investment.

Mr Severs wished to commend the team's proposals and presentation. He confirmed that the Clinical Leads had been represented in the discussions, he having attended a meeting himself. During his week as on-call Executive Director, he had considered the number of individuals who try to access emergency services via 999 and abandon the call, who then self-present to A&Es. The reason for this is often that they cannot access healthcare more locally. The proposals would give them this access. Mr Severs suggested that 'shift left' is too nebulous, what is being proposed is moving resource from secondary care to primary and community functions. It is about enabling the people closest to local communities to take more support, control and navigation on behalf of those people. Whilst some of the proposals, particularly in terms of enabling leadership, are very radical, they actually have the potential to create capacity in secondary care. The proposals present a vivid picture of the end point; however, Mr Severs agreed that the mechanism for achieving this requires definition.

Mr Weir welcomed the proposals, and the team's contribution to the meeting. He agreed with Mr Severs that it is undoubtedly the correct route and praised the radical nature of the proposals. However, he highlighted that unexpected issues can arise and queried whether the proposals and Integrated Neighbourhoods are 'right-sized'. He also enquired how co-terminus these bodies will be with officials who represent communities, given that these have and will change. There may be implications in terms of political interface for Cluster Directors, which they will need to accept and manage. As has been identified, the Health Board currently has significant financial challenges. It is possible, though Mr Weir hoped this would not be the case, that devolution of resources could include devolution of a financial deficit. In order for Integrated Neighbourhoods to be successful, they need budgets, authority and responsibility. The organisation would also need to ensure that they have a 'safety net', to try initiatives and projects which may not work and learn from these jointly, without blame. Finally, consideration needs to be given to the timescales involved and ensuring proposals progress at the correct pace.

Mrs Marks welcomed the aspiration of working more closely with communities and putting the patient at the heart of the system. She suggested that, whilst healthcare professionals understand the system, others may not. In this respect, the presentation and film provided better context and explanation than the report. The latter had given the impression of Super Clusters being the proposal. It is clear that those within Clusters have a greater knowledge of their local communities and are approaching the topic from a different perspective than the wider Health Board or

Board. However, their shared aims are a healthier population, better treatment, better access and equity of treatment.

Mrs Marks suggested that integrated communities is far more important than Super Clusters. She felt that it was less about a change in power, and more about effective sharing of information, to improve services and experience. Patients access Primary Care just as often as Secondary Care, with one often the route to the other, however, they currently work in silos. Mrs Marks welcomed the multidisciplinary way of working proposed, whilst emphasising that every part of the system has a contribution to make. It is often the case in healthcare that the complex has to be made more complex, until it becomes more straightforward. As such, these proposals need to be driven by strong strategic leaders. The Cluster Leads will be part of this, together with the Executive Directors. Whilst the proposals have her 'in principle' support, the detail already requested by others is needed.

Also offering her support and endorsement, Dr Gjini highlighted that Integrated Neighbourhoods are the vehicle enabling delivery of the 20four7 model. She suggested, however, that the principle of Integrated Neighbourhoods is the person being at the heart, not the patient. One of the aims should be to work with people to prevent ill health occurring. This is central to the Social Model for Health and Wellbeing. Dr Gjini agreed with others that care needs to be taken to ensure that work already being undertaken is not duplicated, such as that being progressed by PSBs.

Dr Wang thanked Members for their comments. She wished to clarify that a shift in resource does not solely concern finances, it would also involve staff, and how they work. Integrated Neighbourhoods would change a patient's journey. It should be noted that data and evidence in relation to prevention of ill health is challenging to secure, given that population health data takes years to reflect the impacts of interventions. A longitudinal approach is required; however, whilst the impact at an individual level can be significant, it can also be difficult to evidence. Members were assured that a great deal of work has been undertaken with partners, including Local Authorities. There are gaps, however, which need to be addressed, together with avoidance of duplication. Mapping of services across Primary Care, Secondary Care and the Third Sector is required. The region's aging population is significant, and there are deprived areas embedded in every community. In addition, the region is very rural in nature. These issues impact on health and on the service needed. However, they are not necessarily reflected sufficiently in the funding formula.

Dr Wooding suggested that a more developmental conversation is required. This would offer an opportunity to address more of the issues and concerns raised, greater engagement and more consideration of the consequences of the proposals. He felt that transformation, as opposed to transaction is required to achieve the paradigm shift required. Any significant adaptive change

requires recognition that the organisation is part of the system, problem and solution and will need, itself, to change. It is clear that a focus on the mechanics of and process for change is required, and Dr Wooding suggested that a Board Seminar would offer this opportunity. **JW**

Professor Kloer thanked the team for attending, noting that the group includes a number of influential individuals. He agreed that the discussion should be viewed as a start, whilst highlighting that there have been more comments from Board Members on this item than any other today. Professor Kloer felt that the film had aligned a great deal with both the AHMWW Strategy and the national direction of travel. He agreed that a Board Seminar conversation on the mechanics of change would be useful, and suggested that this also include input from others. Concluding discussions, Dr Wooding thanked the team for attending and their contribution.

**Decision:** The Board **NOTED** the recommendations within the report; however, these were not approved or agreed at this juncture, with the Board requesting that conversations be progressed via a future Board Seminar.

*Dr Helen Wang, Dr Iwan Griffiths, Dr Ahmed Ellaban, Mr Gareth Harlow, Ms Rhian Bond, Ms Sarah Bolton and Ms Mwape Burke left the Board meeting.*

**PM(26)110 Nurse Staffing Levels (Wales) Act Annual Report 2025/26**

Presenting the report, Ms Daniel advised that it provides assurance to Board that the Health Board continues to meet its statutory duties under the Nurse Staffing Levels (Wales) Act 2016. Ms Daniel wished to highlight the following:

- The organisation remains fully compliant with the Act; with robust governance, bi-annual reviews and strengthened use of data to support oversight and assurance
- Whilst there continue to be challenges in consistently maintaining planned rosters in adult wards, there is evidence of an improve reporting culture, improved escalation, greater use of professional judgement and active risk mitigation. Paediatric services continue to demo consist high levels of appropriate staffing. The report identifies significant improvements associated with workforce stabilisation, and a reduction in agency use over the past couple of years
- Impact on patient care remains low, with very few incidents of moderate harm or above where staffing levels were a contributory factor. This highlights that risks have been identified and managed effectively

Overall, the report provides the required assurance and evidence of improvements, with further work planned around data quality.

Dr Wooding enquired whether there is any evidence to suggest a correlation between patient falls and harm and staffing levels. In

response, Ms Daniel advised that for the purposes of the Act, the criteria are incidents of moderate harm or above. There were three such incidents relating to falls during this period. Ms Harraway requested clarification regarding the phrase ‘reasonable steps’. Ms Daniel explained that these are defined within the Act, and include the use of bank staff, use of agency staff, postponing of Study Leave, etc. She assured Members that the Health Board ensures all are taken in order to maintain compliance.

**Decision:** The Board **RECEIVED** the 2025/26 Annual Assurance Report and **TOOK ASSURANCE** that Hywel Dda UHB remains compliant with its duties under the Nurse Staffing Levels (Wales) Act 2016.

**PM(26)111 Report of the Audit and Risk Assurance Committee**

Cllr. Evans, Audit and Risk Assurance Committee (ARAC) Chair, introduced the update report from the meeting held on 14 April 2026. There are two ‘Alert’ items, around the Limited Assurance ratings and findings of the Operational Governance Arrangements and Internal Escalation: Level 3 and 4 Functions Internal Audit reports. Progress updates in relation to both audits have been requested from Health Board management. With regard to the ‘Advise’ item relating to the Head of Internal Audit Opinion, the Health Board had since received confirmation that this will be one of Limited Assurance. Whilst the opinion had been finely balanced, the total number of Limited Assurance reports had eventually determined this rating. ARAC is also recommending Board approval of the revised version of HDdUHB’s Standing Orders and Standing Financial Instructions, under the next agenda item.

With regard to the ‘Alert’ items, Mrs Wilson advised that progress reports have been requested for a future meeting. She would support Mr Carruthers, if required, in relation to the Operational Governance audit, and Mr Huw Thomas has already advised on work underway in relation to Level 3 and 4 Escalation. Both audits will be followed-up during the coming year. Dr Wooding expressed concern regarding the Operational Governance findings, indicating that this demonstrates a lack of maturity as an organisation and needs to improve. The Board will continue to monitor this area.

Professor Kloer indicated that, whilst disappointing, the Limited Assurance Head of Internal Audit Opinion is understandable. The root causes for this will need to be addressed by the Executive Team. Cllr. Evans advised that there has been a meeting to discuss the Opinion and Internal Audit in general. There is a protocol, which the organisation will be seeking to implement and enforce. He reminded Members that the Internal Audit programme is developed on a risk-based approach, with the Health Board selecting those areas where it is aware of challenges. The experience this year in particular, however, has also highlighted other issues, including timely follow-up of recommendations.

Cllr. Evans presented the update report from the meeting held on 7 May 2026, noting that there are two 'Advise' items, in relation to the Sickness Management Follow-up (Review) and Major Infrastructure Investment Programme (Reasonable Assurance) Internal Audit reports.

**Decision:** The Board:

- **APPROVED** the revised version of HDdUHB's Standing Orders and Standing Financial Instructions
- **RESPONDED** to the items the Committee is alerting it to
- **NOTED** the items the Committee is advising it of
- **TOOK ASSURANCE** from the items that the Committee is providing assurance on

**PM(26)112 Standing Orders/Standing Financial Instructions**

Dr Wooding noted that paragraph 1.1.1 makes reference to 'the Minister for Health and Social Services'. Mrs Wilson indicated that the document had been revised prior to the Senedd election and committed to amend this to 'Cabinet Minister for Health and Care'. **JW**

**Decision:** Subject to the above amendment, the Board:

- **APPROVED** the revised version of the HDdUHB's Standing Orders
- **APPROVED** the revised version of the Standing Financial Instructions

**PM(26)113 Report of the Quality, Safety and Experience Committee**

Mrs Marks, Quality, Safety and Experience Committee (QSEC) Chair, introduced the update report from the meeting held on 9 April 2026. There were no 'Alert' items and the three 'Advise' items, around which there had been comprehensive discussion. A Deep Dive on Ophthalmology is planned for the October 2026 QSEC meeting.

**Decision:** The Board:

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

**PM(26)114 Draft Quality Improvement Strategic Framework 2026-29**

Ms Daniel presented the updated Quality Improvement Strategic Framework, which sets out the planned approach during the next three years and seeks to underpin how the organisation delivers safe, more effective, equitable care. There are six system-level priorities, all of which align to the Health Board's Strategic Objectives. The Framework is concerned with maturity and a focus on outcomes and evidence-based practice.

Mr Maynard Davies welcomed the Framework, whilst noting that Research and Innovation sits with the Digital, Data and Innovation Committee (DDIC), rather than QSEC. There is an emphasis on the importance of data, and he suggested that there should be joint consideration of this between DDIC and QSEC. Mr Maynard Davies also wished to highlight the Enabling Quality Improvement in Practice (EQIiP) programme, and the need to ensure good practice is shared.

**Decision:** The Board **APPROVED** the Quality Improvement Strategic Framework 2026-29

**PM(26)115 Report of the Finance and Performance Committee**

Mr Imperato, FPC Chair, presented the update report from the meeting on 30 April 2026, noting that much of its contents have already been discussed. The single 'Alert' item relates to the Health Board's capacity to deliver the required level of savings. There are a number of 'Advise' items, focusing on overdue audit recommendations, hospital flow, Planned Care trajectories and the interplay between savings and performance.

**Decision:** The Board:

- **APPROVED** the extension of the Hybrid Print and Post contract with PSL Print Management Limited from the 1 June 2026 to the 31 May 2028 at a value of £612,000.00 ex VAT taking the total contract value to £1,343,214.70 ex VAT. This contract will have onwards submission to Velindre NHS Trust (as hosts of NHS Wales Shared Services Partnership) and Welsh Government for approval.
- **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)116 Procurement Report**

Introducing the report, Mr Huw Thomas indicated that this requests an extension of the Hybrid Print and Post contract. Whilst this involves a significant cost, it has facilitated the containment of expenditure on postage. Members heard that this service had been a runner-up at the Health Service Journal awards.

**Decision:** The Board **APPROVED** the extension of the Hybrid Print and Post contract with PSL Print Management Limited from 1 June 2026 to 31 May 2028 at a value of £612,000.00 ex VAT, taking the total contract value to £1,343,214.70 ex VAT. This contract will have onwards submission to Velindre NHS Trust (as hosts of NHS Wales Shared Services Partnership).

**PM(26)117 Report of the Strategy and Planning Committee**

Mr Weir, SPC Chair, presented the update report from the meeting on 22 April 2026, noting that there are no 'Alert' or

'Advise' items. The report requests Board approval of the application of the seal for those schemes listed.

**Decision:** The Board:

- **APPROVED** application of the seal for all schemes listed
- **APPROVED** award of the contract at £1,197,665.00 (exc. VAT) for Prince Philip Hospital to 'T. Richard Jones (Betws) Ltd', with call-off agreement to be prepared and executed by the Health Board.
- **NOTED** the items the Committee is advising them of
- **TOOK ASSURANCE** from the items that the Committee is providing assurance on

**PM(26)118 Targeted Estates Fund Project**

**Decision:** The Board **APPROVED** award of the contract at £1,197,665.00 (exc. VAT) for the provision of a Second Generator and associated infrastructure works to 'T. Richard Jones (Betws) Ltd', with call-off agreement to be prepared and executed by the Health Board

**PM(26)119 Report of the Health and Safety Committee**

Ms Murphy, Health and Safety Committee (HSC) Chair, presented the update report from the meeting on 5 May 2026, highlighting the two 'Advise' items. These related to audits, inspections and regulatory reports and progress against the Fire Risk Assessment Improvement Plan. Ms Murphy highlighted the need for more constructive responses from CCGs and functions in recognising the importance of Health and Safety. She hoped that this situation will improve. Two items are presented for the Board's approval.

**Decision:** The Board:

- **APPROVED** the Health and Safety Committee Terms of Reference
- **APPROVED** the Pandemic Response Framework
- **NOTED** the items the Committee is advising them of
- **TOOK ASSURANCE** from the items that the Committee is providing assurance on

**PM(26)120 Report of the Charitable Funds Committee**

Mr Iwan Thomas, CFC Chair, introduced the update report from the meeting on 17 March 2026. He wished to thank Ms Nicola Llewellyn and her team for their work. Whilst there were no 'Alert' items, there were two 'Advise' items; an emerging risk relating to declining donation levels and the need for a more proactive utilisation of Charitable Funds.

**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)121** **Report of the Digital, Data and Innovation Committee**

Mrs Patel, DDIC Vice-Chair, presented the update report from the meeting on 21 April 2026, indicating that there were no 'Alert' or 'Advise' items. There was one item for Board approval.

**Decision:** The Board:

- **APPROVED** the Digital, Data and Innovation Committee Terms of Reference
- **TOOK ASSURANCE** from the items that the Committee is providing assurance on

**PM(26)122** **Report of the Regional Joint Committee**

Dr Wooding introduced the update report from the Regional Joint Committee meeting held on 16 April 2026. He suggested that the presentation on poverty had been very thought-provoking and that the Health Board should consider this further.

**Decision:** The Board:

- **RECEIVED** the report and note that the assurance provided is underpinned by the RJC's formal self-assessment and associated improvement actions, providing an evidence-based narrative of both progress and continuous improvement.
- **APPROVED** the updated South West Wales Regional Joint Committee Terms of Reference, noting that these reflect learning from the RJC Annual Self-Assessment and strengthen clarity around the Committee's role, objectives, system-level governance, assurance responsibilities and reporting relationships.

**PM(26)123** **Committee Update Reports**

Mrs Wilson presented the report, indicating that the only forum reporting during this period was the In-Committee Board. Members were reminded that the single item for approval had already been considered and granted at the Extraordinary Public Board in February 2026.

**Decision:** The Board:

- **APPROVED** the submission of the Regional Cellular Pathology Programme – Preferred Laboratory Site paper identifying the preferred site to Welsh Government, including the above recommendations (approved at Public Board meeting on 19 February 2026)
- **RECEIVED** the update report in respect of the In-Committee Board meetings
- **TOOK ASSURANCE** from the items that it is being assured on

**PM(26)124** **Joint Committees and Collaboratives**

Professor Kloer presented the report, advising that the Board is requested to approve changes to the Joint Commissioning

Committee (JCC) Standing Orders, which are largely administrative in nature. Also to approve the updated guidance and Terms of Reference listed. Members were assured that these have been considered at JCC and the relevant Executive Directors involved. They have also been reviewed from a governance perspective.

**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.
- **NOTED** the proposed amendments to the JCC Standing Orders, which are largely administrative in nature and seek to either re-format or re-define the content of each document, or update sections to reflect operational reality. The changes to the Standing Financial Instructions are also mainly administrative, with the more substantial updates relating to Section 11 which has been replaced for the updated Procurement Regulations (including Schedule 1) and updated references for NWJCC/JCCT, together with the addition of a debt recovery paragraph in section 9 to reflect current processes.
- **APPROVED**:
    - The updated Standing Orders for the JCC for inclusion at Schedule 4 of Hywel Dda University Health Board Standing Orders, subject to formal approval by the NWJCC at the JCC meeting on 26 May 2026.
    - The updated Standing Financial Instructions (SFIs) for the JCC subject to formal approval by the NWJCC at the JCC meeting on 26 May 2026.
    - The updated Guidance on the Handling of Interests.
    - The updated Terms of Reference for the JCC Quality, Safety and Outcomes Sub-Committee; and
    - The updated Terms of Reference for the JCC Planning, Performance & Finance Sub-Committee.

**PM(26)125 Statutory Partnerships Update**

Presenting the Statutory Partnership Update Report, Dr Gjini highlighted in particular that the Regional Partnership Board (RPB) Chair's tenure has been extended. Also, the update in relation to the Future Funding Process (FFP) gateway progress. Discussions around the Integrated Executive Group (IEG) and governance are ongoing. PSBs continue their work, with Members reminded that Ceredigion and Carmarthenshire have agreed to merge and Pembrokeshire remaining a single PSB.

Cllr. Evans enquired regarding the reason Pembrokeshire PSB's decision. In response, Dr Gjini indicated that they are content with being a single entity, whilst Ceredigion and Carmarthenshire have identified more areas of commonality. Professor Kloer suggested that they had some concerns around the potential loss of local identity and focus. Mr Jones, declaring an interest in this item,

emphasised that there is no objection to partnership working, with all parties committed to this continuing. Mr Prior reiterated his comments at the previous meeting around a lack of evidence of the value for the Health Board of participating in these meetings. He felt that the purpose requires definition and true partnership working created.

Whilst acknowledging this comment, Dr Gjini was of the opinion that these are effective partnerships. They bring senior leaders in several statutory organisations together, to focus on some of the most impactful and current issues. However, none of these bodies has any allocated funding. Health Board teams also do not receive any resource for their time and work; however, still contribute and commit. The reports represent bi-monthly updates. Dr Gjini accepted that they could, perhaps, contain more information on impacts, whilst reiterating that the team has little resource to undertake this work.

**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)126 Any Other Business**

There was no other business reported.

**PM(26)127 Board Annual Workplan**

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

**PM(26)128 Date and Time of Next Meeting**

2:00pm, Thursday, 25 June 2026 (extraordinary meeting)
9:30am, Thursday, 30 July 2026