Swansea Bay University Health Board (SBUHB)
Minutes of the Board Meeting held on
26 March 2026 at 10:15am

Present		
Jan Williams	(JW)	Chair
Stephen Spill	(SS)	Vice Chair
Abigail Harris	(AH)	Chief Executive Officer
Jean Church	(JC)	Independent Member
Marie Davies	(MD)	Executive Director of Planning and Partnerships
Anne-Louise Ferguson	(ALF)	Independent Member
Andrew Griffiths	(AG)	Independent Member
Claire Osmundsen-Little	(COL)	Interim Executive Director of Finance and Performance
Martin Lloyd	(ML)	Independent Member
Nicola Matthews	(NM)	Independent Member
Reena Owen	(RO)	Independent Member
Patricia Price	(PP)	Independent Member
Charlotte Rees	(CR)	Independent Member
Gill Richardson	(GR)	Interim Executive Director of Public Health
Liz Rix	(LR)	Executive Director of Nursing and Patient Experience
Nuria Zolle	(NZ)	Independent Member

In Attendance		
Helen Annandale,	(HA)	Associate Board Member
Denise Chaffer	(DC)	External Reviewer (for Item 4.6)
Alison Clarke	(AC)	Deputy Director of Therapies and Health Science
Pat Dunmore	(PD)	Stakeholder Reference Group Chair
Matthew John	(MJ)	Director of Digital
Raj Krishnan	(RK)	Deputy Executive Medical Director
Alun Llewelyn	(AL)	Associate Board Member (Up until item 3.4)
Hazel Lloyd	(HL)	Director of Corporate Governance
Ian MacDonald	(IM)	Assistant Director of Finance
Theresa Ogbekhiulu	(TO)	WG Development Programme
Sharron Price	(SP)	Group Nurse Director (for item 2.1)
Carys Richards	(CER)	Senior Corporate Governance Manager
Jayde Summer	(JS)	Ward Leader (for item 2.1)

Richard Thomas	(RT)	Director of Insight, Communications and Engagement
Sonya Velichkova	(SV)	Ward Leader (for item 2.1)
Sharon Vickery	(SVi)	Assistant Director of Workforce and OD
Craige Wilson	(CW)	Deputy Chief Operating Officer

Apologies		
Richard Evans	(RE)	Executive Medical Director & Deputy Chief Executive
Deb Lewis	(DL)	Chief Operating Officer/ Interim Executive Director of Primary Care & Community and Mental Health & Learning Disabilities
Tina Ricketts	(TR)	Executive Director of Workforce & OD
Heather Richards	(HR)	Chair of the Health Board Partnership Forum

Acronyms	
AC	Audit Committee
BJC	Business Justification Case
CAMHS	Child and Adolescent Mental Health Services
CCH	Cefn Coed hospital
CSP	Clinical Services Plan
CTMUHB	Cwm Taf Morgannwg University Health Board
D2RA	Discharge to Recover then Assess
DAP	Dental Access Portal
DDRIC	Digital, Data, Research and Innovation Committee
DPOC	Delayed pathways of care
ED	Emergency Department
HEIW	Health Education and Improvement Wales
HIE	Hypoxic ischaemic encephalopathy
HIW	Healthcare Inspectorate Wales
HPF	Health Professionals Forum
IMTP	Integrated Medium-Term Plan
ITU	Intensive Therapy Unit
JCC	Joint Commissioning Committee
JCVI	Joint Committee on Vaccination and Immunisation
JET	Joint Executive Team
LIMS	Laboratory Information management System
LTA	Long-Term Agreement(s)

MBRRACE	Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries
MIU	Minor Injuries Unit
NHSPI	NHS Performance and Improvement
NoF	Fractured Neck of Femur
NPT	Neath Port Talbot
OD	Organisational Development
PADR	Personal Appraisal Development Review
PFC	Performance and Finance Committee
PFI	Private Finance Initiative
PHC	Population Health Committee
PID	Project Initiation Document
PSB	Public Service Board(s)
Q1	Quarter 1
QSC	Quality and Safety Committee
RPB	Regional Partnership Board
SRG	Stakeholder Reference Group
SBUHB	Swansea Bay University Health Board
UC	Unscheduled Care
UEC	Urgent and emergency care
UK	United Kingdom
UKHSA	UK Health Security Agency
ULD	Upper Limb Disorders
WAST	Welsh Ambulance Service Trust
WG	Welsh Government
WODC	Workforce and OD Committee
WTE	whole time equivalent
YTD	year to date

The meeting began at 10:36.

Minute Ref:	Agenda Item
PART 1. PRELIMINARY MATTERS	
1.1 Welcome and Introductory Remarks	
033/26	JW welcomed everyone to the meeting, extending a warm welcome to those observing online. As the Governing Body of the organisation, the Board constituted the highest level of decision making, with stewardship of £1.8bn of public money, the employment of 14,500 whole time equivalent (WTE) staff, and the provision of services for approximately 400,000 people across Swansea and Neath Port Talbot. This made SBUHB one of the largest public bodies in the UK. JW outlined the role of the Board as a strategic population health body, with a statutory duty to promote and protect public health and to prevent disease The agenda for the meeting covered the breadth of the Board's responsibilities; open government was important, and the meeting provided the Board with a platform to hold itself accountable to the public and to explain the rationale for decisions taken covering the three time horizons in which the Board worked: long, medium and short term. JW then mapped the key agenda items against the Board's responsibilities for: strategic direction setting; setting the risk appetite and overseeing strategic risks; building and sustaining strategic partnerships; oversight of delivery against the in-year plan; practising good governance; and setting the tone and culture of the organisation. The Board wanted staff to come to work and be their best authentic selves and to know that they could speak up safely in respect of any concerns. JW highlighted the scale of the challenges and the significant change agenda facing the organisation. The decisions taken by the Board at the meeting would have far reaching consequences, particularly in respect of the 2026/27 Annual Plan.

1.2 Apologies for Absence	
034/26	The following Board members had tendered their apologies: Richard Evans, represented by Raj Krishnan Deb Lewis, represented by Craige Wilson Tina Ricketts, represented by Sharon Vickery Chris Morrell, represented by Alison Clarke JW welcomed HA and PD to the meeting, along with Theresa Ogbekhiulu, attending as part of the Welsh Government (WG) Aspiring Board Members programme.
1.3 Declaration of Interests	
035/26	There were no declarations of interest outside those already on the Declarations of Interest Register.
1.4 Chief Executive's Report	
036/26	Introducing the Chief Executive's report, AH drew attention to: • The pending 2025/26 year-end; this was important both from a delivery perspective and the 2026/27 Annual Plan commitments; focus throughout the year on planned care had resulted in a good position at the year-end; partial reliance on external capacity would be a factor for 2026/27, and AH indicated that she would refer to that later in the meeting. • The considerable pressures on the Unscheduled Care (UC) system, leading to a crowded Emergency Department (ED), increased pressure on staff, crowded clinical environments, and a level of care below the standard expected. The commitment, as part of the recovery and sustainability actions, to reduce surge capacity had also impacted adversely on the response to the increased demand. The organisation was currently at Business Continuity status; this triggered a series of additional responses and actions across the organisation. AH reflected on the Staff Story early in 2025 that had so vividly described the UC challenges; considerable improvements made in the summer of 2025 had proved unsustainable in the face of increased demand. Delayed pathways of care (DPOC) numbers were also affecting

	bed availability and flow; AH confirmed work ongoing both internally and with local authority and third sector partners to secure a resolution. • On mental health, the Transformation Board continued to oversee and drive improvements; a forthcoming Board development session would provide the Board with an in-depth analysis of the key issues and of progress across the range of workstreams led by Executive director colleagues. The digital system was now live, replacing a range of hard copy data sources, with positive feedback. • On *Organising for Success,* a Top 100 Leaders Day in April 2026 would focus on leading a complex organisation with many challenges whilst also reflecting the organisation's values, along with providing the leaders with tools and techniques to deliver change and support delivery of the refreshed Clinical Services Plan (CSP). • The implementation of *Listening to People,* a national policy requirement reflecting people's experiences of SBUHB services, both positive and negative. The Board **CONSIDERED** the Report and **TOOK ASSURANCE** from its contents and the verbal update.
PART 2. PATIENT/STAFF EXPERIENCE	
2.1 Staff Story • **Managing Ward Absence**	
037/26	LR welcomed Sharron Price, (SP), the Singleton and Neath Port Talbot Service Group Nurse Director, Jayde Summer (JS) Ward Manager of Ward E, Neath Port Talbot Hospital and Sonya Velichkova (SV), Ward Manager of Ward 12, Singleton Hospital. SP welcomed the opportunity to provide the Board with a presentation on how JS and SV's inspirational leadership had helped to significantly reduce sickness absence levels. In line with the *People Strategy*, they had also focused on making the workplace somewhere where staff wanted to be. She provided a summary of the impact their leadership had in reducing sickness absence:

	• For Ward 12, a year ago sickness absence stood at 8.2% (long term and 3.5% short term). This had now reduced to 6.4% long term and 1.5% short term. • For Ward E, a year ago sickness absence was at 22% long term and 6% short term; this had now reduced to 2% long term and 4% short term. Each Ward Manager outlined their approach to leadership and to reducing sickness absence by providing a supportive and enthusiastic workplace. SV invested time and effort in listening to her team, understanding what motivated them and what they found challenging. She welcomed the diversity of her team and the different perspective everybody brought to the table. Over time, staff on sickness absence actually wanted to return to work and be part of such a vibrant team. The benefits exceeded expectations, with more positive patient feedback and a significant reduction in concerns and complaints. JS had taken a transformational leadership approach that had reduced sickness on her ward to much lower levels including, at times, 0%. She worked with the ward team to develop shared goals and strove for excellence; communication and listening to staff were essential. The management of sickness absence itself had taken some time and effort to ensure appropriate action in line with the policy; this involved regular meetings with HR. Effective communication had surfaced issues such as childcare which could be a barrier to attendance. A dedicated 'therapy space' had given staff the chance to take time for themselves. JW thanked SV and JS for their presentation and their clear and innovative leadership; she then invited questions. JC praised their instinctive leadership skills and compassion, whilst also recognising their firm application of the attendance at work policy. NM thanked both for their presentations and felt fortunate to have them both working for SBUHB; she asked about sharing their success and rolling out some of their style and enthusiasm across the wider organisation. Both advised that the key driver had involved listening to staff and supporting them; sickness reductions followed on from this.

	LR referred to the leadership programme in place for ward managers, recognising their key role in delivering high quality care. This provided an opportunity to share the compassionate approach adopted with others. NZ was enthused and inspired by the presentation; she reflected on the fact that they had not focused on targets or indicators but instead had listened to their staff. She asked both to describe their main enabler and whether there was a support system around them that had enabled that. Both responded that the key lay in the focus on a team approach. PP welcomed the energy and enthusiasm that both SV and JS demonstrated, with a focus on compassionate leadership, building and supporting teams. RO reflected that, as Chair of the Workforce and Organisational Development Committee (WODC), it was a pleasure to hear such a positive staff story. She asked two questions: (i) whether peer pressure within the team assisted their work, and (ii) about the practicalities of maintaining contact with all staff on a 24/7 basis. JS advised that positivity tended to spread across the team and having shared goals helped. SV added the need to ensure that the ward could operate in the same way when she was not on duty; part of this was developing more junior nurses to take on leadership roles. JW concluded by thanking SP, JS and SV for their presentation and for their inspirational leadership styles that had made such a difference to their ward areas. The Board **RECEIVED** and **TOOK ASSURANCE** from the Staff Story.
PART 3. SETTING STRATEGIC DIRECTION	
3.1 Population Health Committee Key Issues Report	
038/26	SS took the report as self-explanatory and drew particular attention to the Public Health Annual Report, referencing it as being of key importance. He also comments on Meningitis outbreak in Kent which had occurred after the last PHC meeting; he invited GR to provide an update on this.

	GR referred to the outbreak as being of great concern and drew attention to the following points: • The continuing investigations to understand why so many young people became unwell so quickly. • Immunization of young people at school against Meningitis A, C, I and W, but not against Meningitis B. • Vaccination of infants against Meningitis B; this was currently under review in terms of national immunization policy. • The lack of any connection between the Swansea area and the Kent outbreak; plans were in place for counter measures, including the rapid cascade of antibiotics, should an outbreak happen in the SBUHB area. • Whilst Wales had the highest rates of teenage vaccination against Meningitis, some people would always fall through the net, these individuals could still have the vaccine, along with other groups, including overseas students. GR assured the Board that she had confidence that SBUHB was well placed to respond to any similar outbreak. AH added that, as the Easter holidays approached, Universities and other higher education establishments had written to students providing information. JC drew attention to media coverage around vaccination costs; she sought information on any impact of this and on any roll-out plans. GR indicated that Welsh Government (WG) took its advice from the UK Health Security Agency (UKHSA); the Joint Committee on Vaccination and Immunisation (JCVI) met regularly to decide which vaccines to recommend for which population age group, the cost was not factored into their recommendations. The lead in time following a vaccination decision included the need to order sufficient vaccine doses. Any change in childhood Meningitis B vaccination eligibility would require a co-ordinated and planned approach. JW asked SS and PHC to follow up on any further actions resulting from the Kent outbreak. **Action: SS/HvW** The Board **RECEIVED** and **TOOK ASSURANCE** from the Key Issues Report.

3.2 Population Health Annual Report	
039/26	Inviting GR to provide a summary of her report, JW advised the Board that this would be GR's last meeting, prior to her retirement in April 2026. GR had held a number of prominent public health roles throughout her career, with a well-deserved reputation for subject matter expertise across the domains of public health and health protection. On behalf of the Board, JW thanked GR for her distinguished service and wished her well for the future. GR thanked JW for her kind remarks and drew the Board's attention to the following: • The underpinning data in the report; this demonstrated a population adversely affected by population level inequities and led to challenges such as higher rates of cardiovascular disease; diabetes; and cancers. • The aim of the report to provide a stock take and to increase awareness of: high-level population health and equity factors; the role of the public health team; the specialist aspects of public health work; and responsibilities in working together with partners. • The close working with both planning functions and with local authority partners on Public Service Boards (PSBs). • The recommendations: these reflected the direction of travel and the need to further embed public health support for the local population health analysis. • The importance of producing a State of the Population report focused on mental health, and a similar report focused on children and young people. These would also be of benefit, along with a partnership approach to ensuring a healthy start in life. • The key need to progress preventative work, for example in areas such as hypertension, the main risk factor for cardiovascular disease; this was one of a suite of evidence-based interventions that would be of benefit. • The fragility of smoking and weight management services, given the review of grant funding cycles; they had to be more embedded and resilient in the face of any cuts.

	• Targeted work with clusters on screening services, along with a pilot on asymptomatic individuals with positive faecal occult blood tests who declined the offer of colonoscopy. • Immunisation rates, these generally also needed improvement, including influenza vaccinations for infants as well as adults. • The importance of a comprehensive approach to women's health. JW thanked GR for her expert advice and invited questions: NZ praised GR's leadership role in public health and reflected on the need to shift resources towards population health, referring to the £14 return for every £1 invested. She asked how SBUHB could focus on deprived communities, using its allocation differently. MD referred to the State of the Population report as a foundation stone to support the strategic planning process and identify the optimum resource distribution. AH valued the report as the basis for strategic planning; it would act as a cornerstone for *Community by Design*. The challenge centred on abjuring proportionate resource distribution. PP emphasised the role of partnership working in supporting and developing deprived communities; she asked about the strengths of local partnership working and measurement of the impacts. Responding, GR recognised the difficulty in capturing the impacts; each PSB was engaged, with more work to do on a suite of joint partnership indicators that measured collective success. The joint data hub was one example of major progress; joint working to support Neath Port Talbot (NPT) residents following the Tata Steel closure announcement was another example. GR was pleased to confirm the choice of NPT as one of two Marmot regions in Wales; this provided £150k via the Institute for Health Equity to support improved health and wellbeing outcomes. She also referenced the Home Office grant awarded in Swansea; this would focus on substance misuse and addressing county lines in the Dyfatty area. ALF asked about the rationale behind the decision to reduce funding for the Diabetes Prevention Programme; a reduction in preventative spending risked building higher levels of demand for future services. GR

	agreed that national grants were often short term in nature; this grant would taper off over a two-year period with SBUHB expected to then pick up funding on an ongoing basis, but without any additional resource. The long-term health and resource benefits from preventative services were clear. MD confirmed that the Diabetes Prevention Programme, funded through two different sources, would reduce then cease, the rationale being that benefits should offset the loss of grant funding. Work between clinical teams and health economists on a regional basis had produced a methodology to support preventative services. This would not negate the need for difficult decisions on resource allocation but would inform such decisions. RO welcomed the report, recognising the major life expectancy gap that applied across much of the SBUHB area; she regretted the limited traction to date in addressing health inequalities. Closing the discussion, AH welcomed the report as a key component of the strategic refresh underway. She extended her thanks to GR for her leadership over the past year and for raising key public health issues at Board level. The Board: • **RECEIVED** the report. • **THANKED** GR for her leadership throughout 2025/26. • **ACKNOWLEDGED** the sobering inequities that the Report highlighted and the intention to use the State of the Population Report to frame decisions in the forthcoming Clinical Services Plan and subsequent board decision making.
3.3 Annual Plan 2026-27	
040/26	Introducing the Annual Plan ('the Plan') MD welcomed the input and support received during its development from Board members, partners and stakeholders. It was anchored firmly in the SBUHB strategic objectives, providing strategic alignment and a detailed route map for delivery over the coming year. MD acknowledged the impact of the financial deficit on the planning timeline.

	MD also accepted that, as currently presented, WG would not support the Plan, deeming it to be unaffordable. Work was underway to reduce financial exposure and to design sustainable service models; the Plan also centred on recovery, sustainability and transformation to deliver against the strategic objectives, with more detailed delivery plans supplementing the core programmes. At this stage, the Plan described a route towards financial sustainability rather than to a break-even position. JW invited CO-L to add detail on the financial context. From an annual planning perspective, CO-L drew attention to: • The £57.8m deficit carried forward from 2025/26, along with £32.2m non recurrent savings. • The in-year cost pressures, partially offset by WG funding. • The deficit and additional pressures; these were reflected in the Plan through the £65.5m savings target, worked through with Deloitte and the Recovery and Sustainability Board; this still left a deficit of £76.6m. • The range of both strategic and structural opportunities and choices for Year 2 and Year 3. AH welcomed the work undertaken to produce the Plan, recognising that it captured the position at a point in time; a public facing summary document would be of value in sharing the position with the wider public. AH acknowledged the fact that WG would not accept the Plan, given the scale of the financial deficit; in her view the Plan was as robust as possible but with significant associated risks, given the level of savings required and the scale and pace of essential organisational change. Whilst financial sustainability was essential, she emphasised the need to ensure safe and effective care and services. AH went on to comment on the good progress in 2025/26 against planned care. She sought the Board's support in continuing negotiations with WG colleagues on the possible inclusion of additional activity in Q1 2026/27, to avoid losing the gains achieved in year.

	AH thanked all those involved in producing the Plan, JW added the Board's thanks and invited PP to comment on behalf of PFC. PP viewed the Plan as being honest and evidence based, with recognition of the significant scale of the challenge and the complex range of actions required. The evidence-based trajectory would help the organisation to stabilise over the next three years; the major challenge would be the level of savings required over the three-year period; this exceeded £180m. PP also referred to inflation and other cost pressures that may materialise that could add to the challenge. The need to maintain grip and control was critical; this would require transformation across strategic, service and financial aspects. Some actions in the Plan lacked detail on accountabilities, timescales and financial implications. PFC had asked for regular updates to seek assurance that savings plans were mature and deliverable; there were concerns that the scale of the challenge and the capacity and capability to address that would impact adversely on achievability. The Delivery Unit would be fundamental to driving change and its establishment was required urgently. MD recognised the scale of the challenges facing the Board; from a financial delivery perspective more detailed granular level information and data was required, as any under delivery in Q1 and Q2 would build up additional delivery challenges. CO-L confirmed that new budgetary processes would necessitate senior leaders delivering against their budget holder responsibilities; this would drive the grip and control required, overseen by PFC. JC referenced the broad timelines identified in parts of the Plan and the need to tighten up on these. SS referred to the inefficiencies and service challenges of operating services across multiple sites; he recognised that rationalisation formed part of the Plan and that opportunities could exist to make the best use of the HBs estate by exploring alternative funding options. SS sought an estates strategy to complement the Clinical Services Plan and MD agreed with this point.

	AH proposed to keep the ten-year capital priority list under review and to assess this against the Clinical Services Plan. On PPs point about the scale of change required, AH referred to the role of *Organised for Success* and the development of central capacity and capability to drive continuous improvement at the level of transformational change. Supporting and developing leaders across the organisation was a priority for the Executive Team. JW referred to the three Board Advisory Groups, two of which were represented at the meeting; Board members would engage with the Partnership Forum following the meeting. JW invited HA to comment on behalf of the Health Professionals Forum (HPF). HA welcomed the opportunity to comment and recognised the scale of the challenge facing the organisation. HPF welcomed the emphasis on preventative measures and early intervention to accelerate *Community by Design*, as did the opportunities offered by the Clinical Services Plan. On behalf of the HPF HA drew attention to: • Workforce capacity and sustainability; successful delivery would depend on realistic assumptions related to capacity, skill mix, productivity, early engagement and staff wellbeing. • The pace of transformation across multiple programmes and delivery risks; the scale of transformation activity combined with the savings requirements meant that prioritisation, sequencing and strong governance were essential. • Health inequalities and equitable access; HPF supported the focus on preventative actions along with continued service redesign to actively address inequity, accessibility, and inclusive communications across the range of services provided. HA concluded by confirming that HPF members supported the Plan. JW extended her thanks to the HPF for its insightful and supportive comments; MD confirmed that close engagement would continue. AH referenced a recent meeting with Partnership Forum representatives and the clear message to the Board around more engagement and involvement. The Board would meet again with the Partnership Forum on 30 April and was committed to building a constructive working

	relationship. The Board valued all staff engagement and looked forward to building the organisational culture around this in 2026/27. For the Stakeholder Reference Group (SRG) PD welcomed the proposal to present the Plan to the next SRG meeting, and the intention to provide a public facing commentary. **Action: MD/RT** AL welcomed the opportunities to participate in development sessions and to receive feedback from the Deloitte team; this had helped him to understand the complex challenges the Board faced. He also welcomed the constructive discussions taking place between SBUHB and both partner local authorities. The Board: • **RECEIVED** the SBUHB Annual Plan 2026/27. • **ACKNOWLEDGED** the strengthened governance, clearer accountability arrangements and improved analytical understanding underpinning the 2026/27 Plan. • **ACKNOWLEDGED** the scale of operational, performance and financial challenges and the actions set out to address these. • **ACKNOWLEDGED** that the Plan did not deliver a financially approvable position but provided a credible and evidence-based trajectory for stabilisation. • **ACCEPTED** that WG would not approve the Plan, given the ongoing financial deficit. • **AGREED** to submit the Annual Plan 2026/27 **FOR SCRUTINY** to Welsh Government by 31 March 2026.
3.4 Planning and Partnerships Report • **Annual Plan Progress (Qtr. 3)** • **Business Case - Suite**	
041/26	MD provided an update on work underway to underpin the Clinical Services Plan (CSP); the State of the Population Report, horizon scanning actions, and the development of baseline principles would now underpin work with clinical reference groups, adjusted to reflect to Senedd 2026 elections.

	A high-level principles-based document would set out service models and assumptions to deliver long term sustainability, with subsequent service specific infrastructure plans. The Board was asked to approve the outline approach and completion by the end of 2026. The Annual Plan provided an overview of WG planning framework and expectations, and the SBUHB response, as discussed earlier in the meeting. The Regional Partnership Board (RPB) had delegated authority for delivery of specific parts. The Board was asked to consider the work underway to strengthen strategic partnership arrangements. NZ sought assurance on two points: (i) that the Climate Action Plan had been subject to prior Committee oversight, and (ii) oversight at Committee level of the Future Generations Commissioner's Recommendations. JW reminded members that the full Board discharged the oversight role on the Planning and Partnerships work programme. MD confirmed the process used to test compliance against the Future Generations Commissioner's Recommendations and proposed a Board Development Session to provide further detail. JW suggested the inclusion of briefings on different aspects of the Planning and Partnerships work programme in the Independent Members (IMs) catch-up meetings. She also asked HL and MD to meet with NZ on the latter's specific queries around oversight and scrutiny. **Action: NZ/MD/HL** JC expressed an interest in seeing the outcome of the series of joint finance and performance workshops underway to identify funding gaps and redesign pathways in respect of PODC and Discharge to Recover then Assess (D2RA) processes. **Action: CO-L** JC then asked about (i) the timeline for improvement, given the current performance on psychological therapies of 40% against a target of 80%, and (ii) how the non-clinical service model under the Western Bay Drug and Alcohol Alliance would align with secondary care services.

	On the first question, MD advised that the RPB had made limited investment; the Mental Health Transformation Programme Board would include the priority for additional investment in its deliberations. On the second question, MD indicated that this contract related to a multi-agency, community-based project, with no in reach into secondary services. She agreed to provide JC with further details. **Action: MD** RT referred to cross cutting agendas resulting from the Future Generations Act and population health and health inequities; detailed Integrated Impact Assessments would support Board level decision making and help mitigate disadvantage. He advised that decisions likely to have a major impact on either the organisation or the population would benefit from an Integrated Impact Assessment; this would help to consider and mitigate issues and support decision making. AG welcomed the strategic approach taken; he referred to the complexity of some commissioning arrangement and asked about possible means of simplifying the process. MD outlined various commissioning strands and indicated that she and CO-L would be reviewing Long-Term Agreements (LTAs), both between internal service groups and with external partners, together with reviewing other commissioning mechanisms. This work would prioritise and sequence actions in a structured way. AH referred to the Joint Commissioning Committee (JCC) and its ambition to become a centre of excellence for commissioning; this was evident for some national work. She also referred to the 2026/27 JCC Plan that could impact adversely on the SBUHB Annual Plan, as it had a financial gap. JW and AH agreed to invite the JCC Chair and Interim Chief Commissioner to a future Board meeting. **Action: HL** JW then welcomed IM and invited him to present the Business Justification Case (BJC) for developments at Caswell Clinic. IM outlined the background to the BJC and the urgent clinical need for additional high dependency units. PFC had considered and supported

	the BJC at a capital cost of £5.733m, with no ongoing revenue costs, for delivery over the next two financial years. Subject to WG approval, work would start on site in June 2026, in three phases over the two-year period. IM expected the WG decision in mid-June 2026, given the Senedd 2026 election. PP confirmed the PFC was content to recommend Board approval of the BJC as it referred to a specific and complex service and the possibility of repatriating some patients cared for elsewhere. The Board: • **CONSIDERED** and **AGREED** the items as requested throughout the report. • **APPROVED** changing the CSP completion date from March 2026 to November 2026 and extending the current CSP to that date. • **APPROVED** the Capital Business Case of £5.733m for the provision of two additional high dependency units at Caswell Clinic, for submission to WG.
3.5 Digital, Data, Research and Innovation Committee Key Issues Report **i. January 2026** **ii. March 2026**	
042/26	JW invited AG to provide an update on the Digital, Data, Research and Innovation Committee (DDRIC). AG drew attention to two alerts in the March 2026 report: • The large number of March delivery milestones in the Digital Strategy Plan; a small number of these had slipped for prioritization purposes. • The Plan for Emergency and Unscheduled Care. This included a number of unknowns at this stage and needed clarity to make progress. JW and AG had agreed a 'refresh' of DDRIC, in line with the programme of reviewing Committees' Terms of Reference and work programmes. In the meantime, AG confirmed that the Committee would focus on benefits, delivering products, and digital transformation.

	JW thanked AG and invited MJ to comment. MJ provided the Board with an update on the significant digital work underway, including: • The mental health system going live recently; this would transform the way in which staff would work. • An update to the radiology system to provide easier access to images. • The pending go live date for the maternity system, using a phased approach and starting with new antenatal referrals. • Thirteen more services going live with hybrid mail. • The pending replacement of the NPT wireless network. • Blood sciences and transfusion service system changes, these would be live in July, with transfusion services following in September 2026. The Board **RECEIVED** and **TOOK ASSURANCE** from the Key Issues Report.
PART 4. IN YEAR DELIVERY: QUALITY, SAFETY, PERFORMANCE AND RESOURCES	
4.1 Performance and Finance Committee Key Issues Report **i. January 2026** **ii. February 2026**	
043/26	JW invited PP to take the Board through the performance elements of PFC scrutiny. PP drew attention to: • Stroke performance, particularly the lack of a 24/7 stroke consultant rota, and earlier alerts to the Board on this. • The concerning level of clinically optimised patients and the adverse impacts on urgent and emergency care. • Concerns identified in January 2026 on a dental contract hand back and the risk of 6000 patients losing dental access cover; the Dental Access Portal (DAP) had helped to mitigate this. On stroke performance, MD advised that only two hospitals in Wales currently provided 24/7 stroke consultant cover: the Grange and University Hospital of Wales. Such a service at the Morriston hospital site would require additional resources and a reconfiguration of acute

	stroke services across the Western Bay footprint. Mitigations in place included physicians with an interest in stroke. Other indicators in the stroke pathway did not require 24/7 consultant stroke cover to deliver, including door to needle time and admission to scan time. The Clinical Services Plan would include stroke services. NZ sought assurance that clinical need drove door to needle time and not target driven. Responding, MD confirmed that speedy access to thrombolysis, where appropriate, led to better outcomes for patients; this provided the evidence base to underpin response times. RK set out the impacts on brain function of a delay in treatment, the aim being to thrombolyse within the first four hours. In addition to improved outcomes for patients, this reduced reliance on longer term care and support services. He assured the Board that clinicians at the front door were trained to provide thrombolysis; this mitigated the risk to some extent. JW asked QSC to review the issue, with AH suggesting the use of anonymised patient case studies, as part of a joint exercise with the Welsh Ambulance Service Trust (WAST). JC recognised the role of bed management in ensuring smooth flow into the most appropriate location for stroke treatment; given the removal of surge capacity, she asked about ring-fenced beds, and suggested the inclusion of access to beds in the review. ALF supported this, remembering a presentation that emphasised ring fenced capacity as a means of rapid access to therapy services. JW asked JC and LR to scope the basis of a review format making use of anonymised patient case studies and engaging with WAST counterparts to conduct a joint learning exercise. **Action: JC/LR/RK** The Board: • **RECEIVED** and **TOOK ASSURANCE** from the Key Issues Report. • **SUPPORTED** the conduct of a joint learning exercise with WAST on the stroke services pathway.
The Board took Agenda item 4.3 Finance Report at this point before returning to the Integrated Performance Report.	

4.2 Integrated Performance Report	
044/26	Using a slide presentation, MD drew attention to Section 2 of the Integrated Performance Report; this focused on performance against strategic objectives and included both national and local targets. She invited Executive colleagues to provide an update: <u>Immunisation and Vaccinations</u> GR reported on: • The increase in the percentage of children up to date with childhood vaccinations; however, this was still below the target of 95%. • The uptake rate of HPV vaccinations at the age of 15 years. • The 3.5% of adult smokers who made a quit attempt, below the 5% target. The target would possibly increase to 10% and this would be a challenge. • Improvement in bowel screening uptake at 64.2%, against a target uptake of 60% (a low target in itself). • Influenza vaccinations for adults aged 65 years and over; these were below target and needed to improve, with the position on the COVID vaccination needing even greater focus. • The increase in staff vaccinations from 32.9% to 43.1%, an increase of over 10%; GR extended her thanks to peer vaccinators and to RT and the communications team. • The increased uptake of 'flu vaccinations in pregnancy, with a demonstrable increase in the more deprived communities. <u>Emergency and Unscheduled Care</u> MD drew attention to: • Deteriorating positions on both 4 hour and 12 hour waits, a factor since Christmas which was disappointing. She outlined a range of actions in place. • A deteriorating position on urgent and emergency care (UEC) measures, with continued increased demand. • Continued difficulties throughout February and March; Executives would be meeting with Morriston Service Group colleagues on 27 March to consider any additional urgent actions to provide support across the whole system. These would include primary care actions, bed management actions to improve flow, and flow into community settings.

	• The impact of demand pressures on ambulance handovers; close ongoing work with WAST focused on mitigating the impacts of this. • The ongoing work to strengthen and improve stroke pathways of care. <u>Planned Care</u> • Maintenance of the improvement trajectory would ensure that SBUHB would meet its targets in reducing outpatient rates and eliminating over 104 week waits; 5 waits in excess of 104 weeks in February resulted from an orthopaedic surgery cement supply issue, with resolution expected by the year end. • Improvement in performance and a reduction in over eight week waits for diagnostics as a result of operationalising the Endoscopy Unit. • The elimination of waits for patients waiting over 14 weeks for therapies as of February 2026, with a small reduction in follow up rates, subject to ongoing validation. • The gap for psychological therapies; this continued to be an issue nationally and work was ongoing with WG to explore national solutions whilst also exploring local opportunities. • The recovering trajectory of the number of therapeutic assessments in 28 days in Child and Adolescent Mental Health Services (CAMHS); WG had recently made additional funding available to access additional capacity and reduce some waits. • Theatre efficiency had remained below requirements and would be the subject of a programme of work in 2026/27. The team was assisting in developing a model. • Fractured Neck of Femur (NoF) performance was impacted by a lack of ring-fenced capacity; time to theatre was also a factor for improvement. • The number of primary care practices in escalation had remained steady throughout the winter, with an increase in patients accessing the Common Ailments Scheme. <u>Quality and Safety</u> RK advised on: • A 24% drop in C.diff rates compared with 2024/25 data; this was not enough to trigger de-escalation. The high incidence management group would continue. • Good progress in staph aureus and klebsiella management.

	• Quality improvement work underway to address an increase in E.coli. • The conduct of a hospital acquired pneumonia audit and the consolidation of this audit process. <u>Patient experience</u> LR drew attention to: • The overall positive feedback, 93%, of patients said that they had received a good or very good experience, against a national target of 85%. • Complaint response times; these were improving with more work needed to reach the 30-day target consistently. • The redirection of resources to address some outstanding complaints. • Actions underway to ensure readiness for the implementation of *Listening to Patients* from 1 April. • The increase in pressure ulcer rates over recent months; QSC would scrutinize the reasons for this increase. • Falls; these continued to be below the national average, with SBUHB being the lowest reporter per 1000 bed days. Falls admissions to the Minor Injuries Unit (MIU) had increased by 20% and ED attendance for falls by 7%. • Four nationally reportable incidents related to falls in the last 12 months, compared with 12 in the previous 12 months. • The care home project; this was now live across 15 care homes in Swansea, with plans for further work aimed at reducing ambulance callouts and hospital attendance. In response to a question from MD, LR confirmed that the falls prevention work aligned with the RPB programme. <u>Mortality</u> RK had no specific issues to raise; he went on to advise about the increase in ED deaths in the winter months. <u>Maternity and Neonates</u> LR advised that she would cover this as part of the Perinatal Committee report later in the meeting. <u>Digital</u> MJ confirmed:

	• Work still to do to improve discharge information, including the electronic discharge letter sent to GPs. The backlog for some outpatient clinic letters would be a key focus for 2026/27. • Use of the Patient Portal had increased month on month; this would become the default process to interact with patients. • That the new radiology system had improved pathology test requesting. • That the estimated date of discharge completion stood at 42%. • An increase in the number of staff completing digital intelligence courses; this would be a key aspect of the Delivery Unit work in 2026/27. • The current red score for the Laboratory Information management System (LIMS); a local business case was under development to determine the best way to address LIMS related issues. <u>Workforce</u> SV drew attention to: • PADR: this stood at 75.79% against a target of 80% and work continued to improve the position. • Statutory and mandatory training compliance, at 88.54% against a target of 85% • A slight reduction in sickness absence rates, with a current rate of 7.2%, significant work was underway across the organization to address sickness absence management. The main reasons for sickness absence were stress, anxiety and depression. Long term sickness was at 4.39% and short term at 2.81%. <u>Service Specific Targets: Cancer</u> On cancer, CW indicated that the target was 75%, with a 60% target for three consecutive months set by WG for de-escalation purposes. An 80% target was aspirational on the part of SBUHB and did not form part of the escalation requirements. PP reported that PFC had identified poor performance in a number of service areas this month, consistently so over a long time period. She commented specifically on the internal cancer services target of 80% by March 2026, due to performance concerns at the growing backlog.

	CW advised that cancer performance data would vary over time and that specific issues, including access to specialists or trials underway, would have an impact. RK updated the Board on a recent workshop with clinicians to explore a systems wide approach to cancer, from prevention through to treatment. This had identified system priorities, with a 90-day plan underway, focused on improved delivery. PP then highlighted the impact of losing additional funding to support waiting times delivery. Q1 could see a deterioration without that funding. AH agreed and asked PFC to look back at 2025/26 and identify performance against core funding, without additionally; it would help to review four specialties. **Action: PP/DL/CW** JW asked CW to assure the Board that all clinically optimised patients who required NHS interventions were not experiencing a delay. CW advised that daily ward rounds identified any ongoing diagnostic or clinical issues, supplemented by random bed audits to capture and investigate any outstanding action. He was confident that SBUHB was not contributing to delays. JC and LR confirmed the intention to conduct a 'deep dive' at the next QSC meeting; LR proposed the use of case studies to inform the exercise. Members supported this approach. **Action: JC/LR/CW** AH provided detail on the all-Wales Dashboard; this supplemented local dashboards and included all the metrics that WG tracked, albeit that the data was not live. She agreed to place this in the Reading Room. **Action: HL** PP suggested a Board Development Session on data and data sources. Members supported this. **Action: HL** AH also reported that WG had refreshed the Performance and Accountability Framework; this described escalation, different approaches to Joint Executive Team (JET) meetings, escalation meetings.

	The Board: • **CONSIDERED** the monthly update in respect of performance against escalation measures and de-escalation criteria. • **ACKNOWLEDGED** and **DISCUSSED** performance against key measures and targets. • **SUPPORTED** ongoing discussing with WG on possible actions to avoid loss of momentum against waiting times reductions in Q1, 2026/27
4.3 Finance Report	
045/26	CO-L introduced herself and drew attention to: • The statutory obligations to submit an Integrated Medium-Term Plan (IMTP) to secure compliance with break-even over a rolling three-year period. Given the current financial position. SBUHB would fail to meet this obligation. • The Month 11 position and the delivery of a surplus revenue position of £93k; this brought the cumulative deficit position to £57.25m against an annual deficit plan of £58.7m. • The improving trend in monthly deficit positions. • Capital spend of £446k; this was behind plan, but with a projected break-even position at year-end. • The public sector pay policy; this stood at 96, against a target of 95. • The September 2025 Annual Plan submission; this indicated an out turn deficit position of £58.7m after the £55.4m recurrent savings. • Improved performance in month of £5.9m, offset by a shortfall of £0.9m in savings. This was as a result of LTA income from Cwm Taf Morgannwg University Health Board (CTMUHB) of £2.2m, a primary care prescribing reduction of £620k and a digital phasing net benefit of £392k. • Savings to date; these totaled £45m against a target of £55.4m; she referred to the breakdown in Tables 2A and 2B in the finance report. • Further interventions agreed by the Board and executive controls applied to non-pay had delivered £327k. • The £9.8m opportunities set out in Table 3. • Additional cash support of £85m.

	• Two key risks: revenue risks including non-recurrent savings challenges and the opening position for 2026/27, which stood at £32.2m, and a capital risk of £12m. • The work undertaken with Deloitte partners, at Section 7; the Recovery and Sustainability Board reviewed each deliverable. The table provided set out the actions and position against all nine deliverables, aimed at supporting delivery of a sustainable financial balance. • The IMTP refinement process; this would include the 'how' and 'when' against each Deloitte recommendation in respect of the 'what'. JW thanked CO-L and invited PP as chair of the PFC to comment. PP advised that: • On the Month 11 position, PFC acknowledged the underspend of £0.1m as the best position to date; it left the year to date (YTD) position at £57.2m, a result of non-recurrent gains, rather than increased controls. • Confidence in the ability to land the £58.7m deficit in 2025/26 was increasing but there was still over-reliance on non-recurrent opportunities to deliver that position • There were actions to improve financial grip and control, but there was still work to do, with variable pay still running at £4.4m in February 2026, despite all the work to date; it would be critical to strengthen grip on this into the next financial year. Greater control and enhanced management of sickness absence was a clear requirement in the management and reduction of variable pay. • The lack of significant delivery of the September and December 2025 savings plan; this had resulted in a £32.2m shortfall in 2026/27. JW thanked PP and invited other PFC members to comment. RO reflected on the need to ensure that 2026/27 actions were ready to implement from April; given the non-recurrent nature of most of the savings, the Board faced increased challenges moving into 2026/27 and RO asked about grip and control. CO-T acknowledged this issue and summarised two key actions in Q1 of 2026/27: (i) the continuity of pay and non-pay actions, supported by the Executive Scrutiny Committee that shared weekly tracker data with the Executive team and (ii) the implementation of the new budget

	setting process to re-baseline budgets and incorporate an allocation of the deficit, together with the relevant share of the £65m. This would increase transparency around non-delivery and ensure earlier action. CO-T also drew attention to the weekly maturity tracker on completion of 2026/27 savings PIDs. The Delivery Unit would focus on this. SS was clear that the combined savings requirements had to apply immediately on 1 April to deliver on the full year benefits; any delay in finalising PIDs would lead to a fall behind in run rates. CO-L agreed and referred to the maturity tracker as a means of overseeing progress. AH acknowledged the work of both Deloitte and the finance team in ensuring that the budget setting approach was sound and that savings requirements were clear. RT recognised the impact of the extra controls on staff; continuing to set out the context and explain the need for action was important. Staff would appreciate acknowledgement of the challenges that the controls presented for their working environment. JW acknowledged this and AH confirmed that the Executive Team would highlight this in ongoing discussions. The Board would also do so at its meeting with the Partnership Forum on 30 April 2026. Moving on to the recommendations, JW drew particular attention to the Deloitte deliverables; these clearly identified 'what' needed to happen; the Board and Executive had to identify 'how' and 'when' for each recommendation. given the challenging operating context. The Board: • **ACKNOWLEDGED** the 2025/26 Financial Plan, and that neither the Health Board nor Welsh Government could approve it, given the planned deficit of £58.7m. • **CONSIDERED** and commented upon the Health Board's financial performance for Month 11 2025/26, including cash, capital and balance sheet. • **SUPPORTED** the implementation of the actions to address the savings gap and assessed position to reach the £58.7m plan. • **CONSIDERED** the actioning of non-recurrent opportunities to support the delivery of £58.7m plan and the impact of this on 2026/27.

	• **ACCEPTED** that the Deloitte team had set out 'what' needed to happen to secure a return to financial balance and sustainability. The 'how' and 'when' were matters for the Board, for assessment against the operating context in which SBUHB found itself, as part of NHS Wales. Actions included in the 'strategic' and 'structural' categories of the ULD would also require Welsh Government support. • **DISCUSSED** the risks to the position at Month 11.
The Board took Agenda item 4.6 at this point, before moving back to consider the Mental Health Update.	
4.4 Mental Health Update • **Update on Transformation Programme**	
046/26	AH introduced the report by referring to the five workstreams operating under the Mental Health Transformation Board: the service model; quality and safety; the workforce; digital enablement; and the estate. Concerns about the inpatient environment at Cefn Coed hospital (CCH) continued. AH provided an update on urgent work, with a tender process that focused on refurbishment whilst the ward was still operational; this required closing a bed at a time which added time to the process. The Service Group and current patients were positive about the improvements underway. In late 2025, the Board had considered interim options, with the preferred option being the consolidation of older people's wards at Neath Port Talbot hospital, and the older people's accommodation at CCH utilised to centralise all adult acute mental health services on the CCH site. The longer-term option would need to reflect the most appropriate model, recognising that the previous outline business case may no longer be appropriate, given service realignment and the financial position. AH confirmed that she and Executive colleagues had met with WG policy, performance and capital colleagues to discuss options. Whilst the WG acknowledged the inherent risks, WG officials did not support the

	interim solution because of (i) the capital requirements and whether this represented a good investment and (ii) the fact that other health boards were also seeking capital for similarly challenged environments. WG preferred to proceed with an accelerated permanent solution, rather than invest capital on an interim basis. WG also wanted to take stock and consider the potential for regional solutions for acute inpatient mental health services. This work was at its very early stages and the NHS Wales Leadership Board would discuss it further in May 2026. WG had asked for a plan to stabilise existing services at the CCH site; the HB estates and capital teams had now scoped that work with a broad cost estimate of £20m, substantially less than the interim solution. This would not address the service challenges related to limited space for therapeutic interventions, for family interactions, or lack of any appropriate outside space to support wellbeing. Neither did it mitigate the ongoing risks associated with isolated single ward service configuration. Managing the risk would incur costs and the Transformation Board had considered this at its recent meeting. Stabilisation work, including urgent works, would continue in a phased approach, as would the Section 136 suite and the Ligature Risk Assessment work; there were also additional challenges to negotiate related to the PFI contract. This added to the complexity. The long-term solution still needed work, and would have to involve neighbouring health boards, albeit that they had aligned service models in place. The Transition Board would continue to develop the proposals as required; seeking the help of the Mental Health Special Advisor, MW. One older people's mental health ward at CCH was currently not in use and could form part of the stabilisation work, alongside actions to address the derelict parts of the estate. JW thanked AH for the update; she referred to the WG Mental Health Strategy issued in 2025 and asked MD whether it included reference to a regional approach for adult mental health services. MD confirmed that it did not.

	MD advised that the Managing Director of NHS Performance and Improvement (NHSPI) had recognised the significant risk that SBUHB was carrying; this would be set out clearly in the position statement that WG had requested. JW thanked AH for her detailed update and invited questions: JC welcomed the comprehensive update but expressed concern at the level of risk that the Board was tolerating, with no resolution in sight; her recent visit to CCH had highlighted the poor estate and the extremely challenging environment for both patients and staff. She also expressed concern at the resources required to maintain and stabilise the current environment rather than to resource improvement. From her perspective, the Board could no longer tolerate this risk alone. SS reflected on the fact that the Board had raised concerns about the state of the estate with WG for a decade; the expectation that the current infrastructure could continue with some improvements for a further extended period was not acceptable. Resources should focus on improving the infrastructure. NZ also expressed concern at the level of risk that WG expected the Board to tolerate and also the delay agreeing a course of action, with the focus on cosmetic improvements. Healthcare Inspectorate Wales (HIW) had commented positively on the care and compassion shown by staff and NZ emphasised the need to consider the staffing establishment. AH confirmed that the Business Case would include this. RO echoed the concerns already expressed at the length of time the Board had carried this level of risk. There was little sense of progress, linked to a lack of clarity or capital support from WG; she proposed escalating the concern. Responding, AH was of the view that WG did recognise the risk that the Board was tolerating and was focused on seeking the best solution to address the risks on a long term, sustainable basis, within the context of constrained resources and similar issues in other parts of Wales. She advised that WG was challenging the clinical model, with its over reliance on inpatient beds dispersed across a number of sites and a lack

	of admission alternatives. This did not constitute a modern, contemporary model of mental health service provision. SS recognised the need to ensure that the service model was appropriate; the deficit calculation did not include the significant costs of placing patients out of area; this was an added cost pressure moving into 2026/27. The prominent level of variable pay mapped across to the poor working environment and clinical conditions, making recruitment and retention more of a challenge. It would be important to engage staff in the redesign now required. JC acknowledged the need to revisit the plans and ML echoed this. He referred to similar estate issues for learning disability services. JW assured ML that the Transformation programme would include learning disability services. JW then summarised the position: JW proposed that she, along with AH, write as a matter of urgency, to the Cabinet Secretary and to Jacqueline Totterdell, setting out the position that the Board found itself in and proposing a risk share approach to resolving the matter. JW also indicated the need for the Board to allocate specific time on the agenda at each Board meeting to oversee the next steps and agreed actions. AH acknowledged the issues outlined by JW; she supported the need for correspondence with WG on risk sharing and advised that she would, in the meantime, continue with the actions proposed by WG. AH suggested that, in addition to receiving a report at each meeting, to include an update from the Mental Health Transformation Board, the Board should hold a specific development session in the coming months, to review the whole agenda. This could include the Service Group and MW could provide a further report on progress against the issues that she identified when first alerting the Board in February 2025. JW reminded the Board that the interim solution proposed in November 2025 was far from ideal and that the service model remained too secondary care focused, with insufficient focus on community services and admission alternatives. The Board was responsible for the safety of its services and facilities and, when it found itself unable to resolve issues without external support, had to work in partnership with others,

	most notably WG. The Board had to escalate the risk to WG, and seek a 'risk share' approach, given that the solution had both strategic and structural elements that were outside the Board's control. The Board: • **REVIEWED** the current risk position and mitigating actions underway; Board members **CONCLUDED** that the Board could no longer tolerate the scale of risk in its own, given that it could not deliver a sustainable solution without WG support. • **ENDORSED** the continued escalation of the risk to WG, to include reference to a risk sharing approach, given that the sustainable solution involved strategic and structural decisions that were outside the Board's control. • **ENDORSED** the acceleration of work to design and develop the long term, sustainable model of care. • **ACKNOWLEDGED** and **SUPPORTED** the stabilisation approach as a necessary interim measure, within current resources. • **AGREED** to hold a specific Board Development Session in the coming months, together with including a formal agenda item at each meeting for 2026/27.
4.5 Quality and Safety Committee Key Issues Report	
047/26	JC drew attention to two issues: • The alert on *Your Next Patient*; the April 2026 QSC meeting would include a deep dive exercise on clinically optimised patients. • The plans to ensure that the Committee could track the implementation of recommendations resulting from all reviews and investigations. The Board **RECEIVED** and **TOOK ASSURANCE** from the Key Issues Report
4.6 Perinatal Services • **Perinatal Committee Report** • **Oversight Panel Report**	
048/26	**Perinatal Committee Report** Introducing the Perinatal Committee Report, LR recognised that every woman and their family deserved high quality compassionate care; this

	was the case for most families. There were times when things did not happen as they should; when that happened the impacts on the woman and the whole family were profound. LR reiterated her commitment to listening, learning and improving so every family received the care they deserved. The Perinatal Committee meeting members remained passionate about improving and getting things right. She drew attention to: • 257 births in January, with 261 babies born. • The gradual rise in caesarean sections, in line with the position across the UK. • Recent improvements in infection rates, with training provided for community midwives on wound care and work with GPs to recognise the early detection signs of infection; this included specific work with black ethnic minority women to recognise signs of infection. • In the sad event of any baby death, SBUHB applied the Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries (MBRRACE) process. There were no stillbirths in January 2026; SBUHB rates remained in line with those for other health boards and there was a detailed review of each case. • A thematic review of 2025 cases had helped to strengthen growth surveillance, with follow up for non-attendance. The review had led to a change in the process to a three-stage approach, including a letter and follow up in person. • Hypoxic ischaemic encephalopathy (HIE) instances were rare but had devastating impacts. The rolling 12 month moderate to severe HIE rate had fallen from 3.32 in 2024 to 1.24 per thousand births currently. • In January 2026, over 500 women were triaged; 93% of these within 15 minutes. There were no adverse incidents reported for the 7% where triage took longer. • Perinatal tears and post-partum haemorrhage rates; these mirrored national benchmarking levels. • The monitoring of Intensive Therapy Unit (ITU) admissions, with daily processes in place to review any pregnant woman receiving care outside the main maternity unit. There had been one birth in the ED in February 2026, this had been well managed. • Substantial progress in closing incidents and complaints, with low numbers still remaining, improving compliance with Duty of Candour requirements.

	• Listening to families and their experiences was hugely important, with waiting times at antenatal clinics identified as an issue. The pathway was subject to redesign as a result of the engagement. • The re-modelling of staffing on postnatal wards to reflect the higher cesarean section rate and the impacts of this on staffing. • The significant difference made by the patient experience midwife in engaging with hard to reach communities; specific work was underway on the recognition of father and partner experiences. • The challenges around neonatal medical staffing, managed by the team to avoid any impact on the service. • Good mandatory training compliance, with targeted intervention aimed at areas where compliance had dropped. • No negative outlier positions against national comparators for SBUHB; constant scrutiny and oversight was in place. • The Improvement programme; this was proceeding well, overseen by QSC and then to the Board. JW thanked LR for the comprehensive update and for the progress made. She invited questions: RO asked how the Birthing Centre was developing and the percentage of births that took place there. LR advised that in the first year of opening the Birthing Centre had 197 births and supported 75 home births. Year two to date had seen 85 births with 35 home births supported. AH advised that the Dashboard provided this information; she sought assurance over the maintenance of staff skills, given that, for most weeks, the number of weekly births was in single digits, running at approximately 14 per month. Numbers had never reached the level expected when the Board approved the reintroduction of the service. LR confirmed that she would commission a report for the Perinatal Committee and then to QSC. **Action: LR** MJ responded to JCs earlier query regarding cardiotachography; he confirmed that a work around was in place to address the loss of connectivity. TO asked about caesarean sections and the underlying reasons for this; she also asked about the availability of demographic data. LR confirmed that she would provide the data. GR commented on the risk factors associated with decisions to request a caesarean birth; dashboard and weight management data would assist in this.

	JC wanted to put on record her thanks to RK and LR for their work on maternity services and in briefing QSC. Reflecting on earlier comments, she asked about the learning and themes emerging about the women's experiences forum that met monthly. LR confirmed this was available; she would provide a report to QSC on a quarterly basis. **Action: LR**
	
	The Board:
	
	• **WAS ADVISED** that:
	  ○ The Perinatal Improvement Plan Executive Programme Board was well established and would continue to monitor the Improvement Plan, in response to the Independent Review, all-Wales Self-Assessment, and other improvement actions.
	  ○ The Perinatal Committee would continue to meet monthly and review all key metrics.
	• **WAS ASSURED THAT:**
	  ○ The Perinatal Service had no elements of care that would flag as a Negative Outlier.
	  ○ Any stillbirths or neonatal deaths were reported sensitively through the MBRRACE process, to support learning and improve future care.
	• **WAS ALERTED TO:**
	  ○ The strong steer nationally that an All-Wales maternity triage service would follow, as a recommendation from the All-Wales Perinatal Assessment. The Perinatal Improvement Plan Executive Programme Board had agreed to pause development of a standalone SBUHB model pending publication of the Assessment (due end of Jan 2026).
	  ○ The achievement of mitigating action to provide a single point of contact triage on 3 March 2026. Calls were directed to a single telephone entry point, with women then directed to the appropriate department based on their needs. This process would deliver one central call centre for maternity triage.
	
	Oversight Panel ('the Panel') **Report**
	
	DC referred to the paper provided, and highlighted:
	
	• The Panel consideration of the latest version of the Improvement Plan and commentary on the Perinatal Committee Report.

	• The Panel's view that there was some more work to do on the Improvement Plan; this would also provide an opportunity to incorporate the outputs of the all-Wales Maternity Assessment Review. • The need for more work on (i) the strategic framing of family involvement and experiences, (ii) the overall increase in the Caesarean section rate, happening across Wales and also England, and (iii) more detail on two-site working. The Panel recognised the significant work already undertaken on obstetric admissions to the intensive care unit; the challenges of multi-site working needed a little more work. DC commented on the one case of a woman giving birth in the ED, and the opportunities to learn from that for those giving birth on a site without access to obstetric services. • The Panel's overall view was that the reports had significantly improved, providing the Board with information on actions and progress with the Improvement Plan; DC also recognised that the Improvement Plan would by its nature be an iterative report. • The Panel's decision to follow on from the Conference held in November 2025 by holding another full day event for frontline staff. This was scheduled for 18 June 2026 and would also include a clinical visit. • The Panel would also share an assurance framework, against which SBUHB could track progress, once the Panel stepped down. JW thanked DC for her helpful update and asked about the timeline for finalising the Improvement Plan. Responding, DC suggested that the Panel could supply further detail in time for the Board to approve the Improvement Plan in final form at its May 2026 meeting. The Plan would evolve further, using the outcomes of the all-Wales Assessment as an example of the need to continually update it in line with developments. DC suggested a separate progress report as a means of tracking progress and supplying the up to date position. LR extended her thanks to DC and the Panel for their advice and guidance. She outlined the different ways in which the Executive team, the QSC, and the Board would receive updates. JC welcomed the focus on partners and fathers, together with the opportunity to further develop the engagement theme. She asked about the implementation of computerised cardiotachography in February

	2026. LR confirmed that the system was operational with no issues identified over recent weeks; she would check the position and confirm this. **Action: LR** JW asked DC to expand on the Panel's intention to stand down in the autumn. DC confirmed this and advised that the Panel was very positive about the management and oversight infrastructure that the Board had instituted; this provided the Panel with confidence that they could stand down as soon as an assurance framework was in place to track ongoing progress. JW extended the Board's thanks to DC and the Panel for their expert advice and guidance; she also thanked JC and QSC members for their rigorous oversight. The Board: • **RECEIVED** and **ACCEPTED** the update from the Chair of the Independent Review of Maternity and Neonatal Services Oversight Panel. • **AGREED** to receive the final Improvement Plan at the May 2026 Board meeting, alongside the assurance framework to track ongoing progress.
PART 5. PEOPLE	
5.1 Workforce and OD Committee Key Issues Report	
049/26	RO drew attention to two alerts: • A delay in implementing the Managing Vexatious and High-Risk Complainants policy, causing staff to raise safety concerns. RO had referred the matter to QSC. • Ongoing issues regarding sickness within primary, community and therapy services. RO also confirmed that *Organised for Success* work was progressing, with the Committee receiving regular updates. SS asked for clarity about those staff groups for which sickness levels were of concern. RO advised this related to was primarily community staff.

	The Board **RECEIVED** and **TOOK ASSURANCE** from the Key Issues Report for.
5.2 Education Commissioning Process for 2027-28	
050/26	SV advised that SBUHB submitted figures annually to Health Education and Improvement Wales (HEIW), forecasting the required number of university training places to train the future workforce; nursing tended to be the biggest category, although the forecast had reduced from 350 to 240. Therapy and pharmacy numbers had also reduced. HEIW required the submission by 31 March; WODC had considered and supported the proposed numbers. JW thanked SV and invited LR to comment. LR confirmed the reduction in forecast numbers for adult nurses qualifying in four years time. SBUHB currently had an over-establishment of adult nurses, with an attrition rate of 2% for registrants, so a reduction in forecast numbers was inevitable. The Board **APPROVED** the commissioning numbers as set out in appendix 1 of the report.
PART 6. GOVERNANCE	
6.1 Audit Committee Key Issues Report	
051/26	NZ advised that the March Audit Committee (AC) meeting had focused on strengthening assurance and performance across several areas. This included improving consistency in scoring strategic risks and embedding escalation points across service groups. NZ highlighted a risk related to Parkway Dental Service, accepting discussions on this earlier in the meeting. NZ went on to reference the reasonable assurance rating, following an Internal Audit review on Committee systems. The Committee had also reviewed the proposed changes to Standing Orders, and the resulting strengthened governance. Finally, NZ commented on the need for full engagement of Executives in delivering against audit findings.

	NZ went on to reference the reasonable assurance rating, following an Internal Audit review on Committee systems. The Committee had also reviewed the proposed changes to Standing Orders, and the resulting strengthened governance. Finally, NZ commented on the need for full engagement of Executives in delivering against audit findings. The Board **RECEIVED** and **TOOK ASSURANCE** from the Key Issues Report.
6.2 Mental Health Legislation Committee Key Issues Report	
052/26	ALF advised that the last Committee meeting had not identified any alerts, she confirmed that SBUHB was compliant with mental health legislation. The Board **RECEIVED** and **TOOK ASSURANCE** from the Key Issues Report.
6.3 Charitable Funds Committee Key Issues Report	
053/26	NM drew attention to: • The significant amount of work undertaken by the charity team during the last quarter, an itinerary of future events would be shared, Board members were encouraged to attend. • The job description being developed for the Head of Charity post JW asked HL to include the itinerary dates into the forward look for the Board. **Action: NM/HL** The Board **RECEIVED** and **TOOK ASSURANCE** from the Key Issues Report.
6.4 Regional Joint Committee Key Issues Report **i. 22 January 2026** **ii. 16 February 2026 (Special)**	
054/26	HL had no specific issues to draw to the Board's attention. She referred to a special meeting held to endorse and support the regional cellular pathology arrangements.

	The Board **RECEIVED** and **TOOK ASSURANCE** from the Key Issues Reports.
6.5 Corporate Governance Report • **Standing Orders** • **Board Site Visits 2026-27 Protocol**	
055/26	HL drew attention to the main changes to the Terms of Reference underpinning the Board Site Visit Protocol; this would now provide for 144 visits over the year. The Board: • **RECEIVED** for **ASSURANCE** The Matters considered In-Committee at the Board meeting; o Welsh Health Circulars; o The Common Seal Register; o Board Work Programme; o Board Site Visits Protocol 2026-27. • **APPROVED** the Standing Orders and Standing Financial Instructions.
6.6 Public Affairs Strategy	
056/26	JW introduced this new agenda item, advising that a Public Affairs Strategy ('the Strategy') would support the Board in preparing for the outcome of the forthcoming Senedd elections in May 2026. She invited RT to provide a summary. RT drew attention to some of the key points, based on the design of the Strategy as an enabler, supporting the *Healthier Swansea Bay strategy* and the Clinical Service Plan. It would complement work already underway to promote openness and transparency. RT confirmed that he would deploy existing resources to implement the Strategy, making adjustments as required. JW invited questions: NZ thanked RT and welcomed the Strategy as being a timely action; she asked about the measures proposed to assess the impact.

	Responding, RT referred to the range of outputs already available to assess the impact of his Directorate's work. Impact measurement of the Strategy would follow this format, together with assessing the impact on relationships and engagement; the strengths of relationships over time could be one indicator, and RT agreed to consider further indicators. JC suggested that the provisions of the People Strategy should align with this public affairs approach. **Action: RT** The Board: • **APPROVED** The Public Affairs Strategy. • **TOOK ASSURANCE** from the alignment with the Organisational Strategy and its key role as an enabler of the long term 'Transforming for the Future' Clinical Strategic Services Plan. • **TOOK COGNISANCE** of the use of existing Directorate resources, adjusted as necessary.
6.7 Minutes of Previous SBUHB Board Meetings **i. 29 January 2026** **ii. 17 February 2026 (Special)** **iii. 26 February 2026 (Special)**	
057/26	The Board **APPROVED** the three sets of minutes as a true and accurate record of the meetings.
6.8 Action Log	
058/26	HL provided an update on the Action Log and the position against each action and agreed to circulate an update post meeting. **Action: HL**.
PART 7. ITEMS FOR NOTING	
7.1 Board Advisory Groups Report **i. Health Board Partnership Forum** **ii. Health Professionals Forum** **iii. Stakeholder Resource Group**	

059/26	The Board **RECEIVED** the discussions of the i. Health Board Partnership Forum held on 22 January 2026. ii. Health Professionals Forum held on the 12 February 2026. iii. Stakeholder Reference Group held on 19 March 2026.
7.2 Chair's Report	
060/26	JW referenced her attendance at the recent uplifting Healthcare Support Worker Conference. The Board **TOOK COGNISANCE OF** the Chair's report.
PART 8. ITEMS FOR DISCUSSION	
8.1 Any Other Business	
061/26	There was no other business.
8.2 Review of Meeting Effectiveness	
062/26	This would issue under separate cover for comment.
Next SBUHB Board Meeting: Thursday 28 May 2026	

The meeting concluded at 16:32.