Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

Agenda Item	

Unapproved Minutes of the Board

Date and Time of Meeting	Thursday 25th September 2025 09:00
Venue	In Person, The Hub, Royal Glamorgan Hospital, Llantrisant

Members Present	Jonathan Morgan	Board Chair
	Kath Palmer	Board Vice Chair
	Dilys Jouvenat	Independent Member – Third Sector
	Carolyn Donoghue	Independent Member – University
	Hayley Proctor	Independent Member – Trade Union
	Patsy Roseblade	Independent Member – Finance/Audit
	Neil Mesher	Independent Member – Commercial Business
	Kathy Mason	Independent Member – IT & Information Governance (in part)
	Paul Mears	Chief Executive Officer
	Greg Dix	Executive Director of Nursing, Midwifery and Patient Care/Deputy CEO
	Dom Hurford	Executive Medical Director
	Gethin Hughes	Chief Operating Officer
	Hywel Daniel	Executive Director of People
	Lauren Edwards	Executive Director for AHPs and Health Science
	Philip Daniels	Executive Director of Public Health
	Claire Thompson	Executive Director of Strategy & Transformation
	Lisa Curtis Jones	Associate Board Member (Virtually – In part)
	Alex Brown	Associate Board Member (Virtually)
	Paul Deenik	Associate Board Member
In Attendance	Gareth Watts	Director of Corporate Governance/Board Secretary
	Stuart Morris	Director of Digital (In part)

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	Richard Hughes	Deputy Director of Nursing
	Alex Harden	Head of Communications and Media
	Atif Ali	Acute Clinical Services Plan Programme Director (In part)
	Andrew Jones	Assistant Director of Finance
	Daniel Price	Regional Director, Llais Cymru (Virtually)
	Emma Walters	Head of Corporate Governance & Board Business
	Rhian Mannings	Member of the public
	Becky Gammon	Assistant Director of Nursing
Meeting Observers	Rhiannon Dubberley	Corporate Governance Officer (Virtually)
	Hannah Jones	Audit Wales
	Tajwar Md Naqib Farhan	Aspiring Board Member Programme
	Emma Samways	Deputy Head of Internal Audit NWSSP (Virtually)
	Cally Hamblyn	Assistant Director of Governance and Risk (Virtually)
	Kathrine Davies	Corporate Governance Manager (Virtually)
	Victoria Oxley	Deputy Director of Strategy and Partnerships

Agenda Item	Meeting Business
1.	**PRELIMINARY MATTERS**
1.1	**Welcome and Introductions**
	The Chair welcomed everyone to the meeting, particularly those joining for the first time and guests and colleagues joining for specific agenda items. The format of the proceedings was also noted by the Chair.
1.2	**Apologies for Absence**
	Apologies for absence were received from: • Helen Lentle, Independent Member - Legal • Rachel Rowlands, Independent Member – Community • Sally May, Executive Director of Finance • Simon Blackburn, Director of Communications, Engagement and Fundraising
1.3	**Declarations of Interest**
	There were no interests declared.
2.	**CONSENT AGENDA BUSINESS**

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2.1	The Chair asked members if there were any items from the consent agenda that Board Members wished to bring forward to the main agenda for discussion. There were none.

3.	**STAFF AND USER EXPERIENCE**
3.1	**Shared Listening and Learning Story – End of Life Care**
	R Mannings shared a Listening & Learning Story which related to her families experience of the care provided to her late father within the Health Board. In sharing the story, the following key matters were highlighted: • Whilst there were examples of good care, the family witnessed multiple instances of unkindness, lack of compassion and poor communication from staff, which left her father feeling reluctant to return to hospital; • The family witnessed staff behaving inappropriately near bereaved families, with nurses being dismissive or rude and repeated discussions being held in relation to Do Not Resuscitate. There was also lack of basic comfort provided to her elderly mother who was staying at the hospital overnight and poor communication about her father's treatment and prognosis; • The family believed there was a missed diagnosis of a large tumour in her father's throat during his six-week hospital stay; • During her father's readmission, the family observed staff making derogatory comments about patients, failing to communicate basic procedures and neglecting basic care needed such as cleaning equipment and responding to call bells. R Mannings extended her thanks to specific doctors who showed compassion and care and emphasised that her father was fortunate to have family to advocate for him and stressed that kindness and compassion were fundamental in healthcare and not optional. R Mannings advised that following her father passing away at home, whilst the family received excellent community care, her mother received no follow-up, condolences, or support from the hospital, which highlighted a gap in bereavement care. R Mannings challenged the board and staff to ensure compassion is at the heart of care, both for patients and for families after a death. Following the presentation of the story, B Gammon acknowledged the experiences and outlined the following actions that were being taken to address the issues raised: • **Visiting Policy & Carers Passport**: The health board is reviewing its visiting policy and rolling out a carers passport to support families and patients, capturing their wishes and needs, including meal preferences.

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	• **Volunteer Involvement**: Plans are in place to increase the visibility and role of volunteers on wards, including helping with activities like providing newspapers and supporting patients. • **Patient Advisory Liaison Service (PALS)**: The PALS team was being made more visible and accessible on wards to support patients and families. • **Multi-Faith Chaplaincy**: The chaplaincy service had been expanded to include multi-faith support. • **Nursing Reflection & Leadership**: Nurses would reflect on the story shared, and senior/lead nurses were being encouraged to demonstrate visible leadership and role modelling on wards. • **Training Initiatives**: Over 40 training sessions for high-performing teams had been conducted, focusing on care, compassion, and respect. Clinical leadership and professional standards training were being rolled out. • **Patient Story Toolkit**: Work was underway to provide more platforms for patients and relatives to share their stories. • **Bereavement Support**: Strategic work was ongoing to improve bereavement support frameworks for both children and adults, and to enhance end-of-life care. P Mears expressed deep regret regarding the family's experience, stating it was unacceptable and not the standard expected from any staff member, regardless of their role or how busy they were and emphasised that everyone's primary job was to ensure people were well cared for and looked after, acknowledging that the organisation had failed the family on multiple occasions. P Mears advised this this would be taken seriously by the board and stressed the need to reset expectations with staff in relation to certain core behaviours which were non-negotiable. P Mears highlighted the importance of respect and civility in every interaction with patients and families, noting that even a single negative interaction could have a lasting impact and committed to using this story as an opportunity for organisational learning and improvement, with the story to be shared with staff so that they could reflect on whether they would want the same experience for their own loved ones. P Mears concluded by thanking R Mannings for sharing her story and confirmed that the organisation would take action to address the issues raised. D Hurford advised that he found the story incredibly hard to listen to and acknowledged that whilst an apology could not change the experiences of the patient and their family, he emphasised the need to ensure others do not have the same experience and highlighted the importance of values, behaviours, respect, and compassion. D Hurford added that it would be helpful if R Mannings would be willing to record her story so that this could be shared at other forums to help staff understand the impact of such experiences and extended his thanks to R Mannings for sharing the story and for her willingness to help drive change. L Curtis-Jones advised that she found the story heartbreaking and stated that no one enters the care field expecting someone to be treated that way and

	queried if learning stories like this were included in training for nurses and doctors, emphasising the importance of such stories in professional education. L Curtis-Jones also shared a positive story of an experience following a visit made by her mother to Royal Glamorgan Hospital and added that her mother wanted to compliment the nursing staff for their care, which had been fed back to the Executive Director of Nursing. L Curtis-Jones concluded by highlighting the value of hearing both challenging and positive experiences. P Roseblade sought clarity as to how the actions being put in place would be checked for effectiveness and specifically inquired about the feedback loop and how the board would know if the actions being taken were working. B Gammon explained that effectiveness would be checked through several methods, including monitoring volunteer recruitment and presence on wards, patient experience surveys, audits of the carers' passport and related frameworks, and visible leadership by nurses on the wards. B Gammon emphasised the importance of leaders being present and available during visiting times to ensure visibility and direct feedback. P Mears commented that while audits and checks were important, ward leadership was also crucial, emphasising that Ward Managers were supernumerary and should be available to speak to relatives or patients if there were concerns. P Mears added that ward managers had a core responsibility to ensure good quality care and be accessible for immediate resolution of issues and proposed further work to engage ward managers in this role. C Donoghue reflected on the importance of ensuring the Quality, Safety & Experience Committee had an equal focus on patient experience, noting that hearing such a powerful and heartbreaking story highlighted the need to incorporate these experiences into Committee discussions and visits. C Donoghue suggested that more could be done to personally engage with patients and relatives during visits to better understand and impact patient experience. G Dix apologised for the experience and stated it was not the standard expected from nurses. G Dix highlighted the importance of relatives or family members presenting their stories directly to the ward staff, as it is powerful for staff to hear stories firsthand and added that the health board sometimes plays patient or relative stories to staff to remind them of the impact of compassionate care and the consequences when things go wrong. G Dix provided assurance that such stories would be integrated into wider patient experience work and that his successors would continue this approach when he leaves the organisation. G Hughes advised that ‘Alan's experience’ should be used as a reference point for ongoing improvement, with suggestions to refer to "Alan's experience" in future discussions to ensure lessons were not forgotten. R Mannings stated that every one of her presentations now ends with "Alan's legacy," emphasizing that her father's legacy is kindness and compassion and added that she uses this

	message to encourage others to focus on what can be done better, highlighting the importance of compassion in care. The Chair advised that he was disappointed to hear of the experience of the patient and family and emphasised that while the NHS was a pressurised environment, this should never excuse poor behaviour or falling standards. The Chair stated the board's responsibility was to set the right culture and expectations, support staff, but also recognise and address poor behaviour when it occurred. The Chair committed that the board would learn from the story, incorporate it into future work, and ensure actions were taken to do things differently. The Chair extended his thank to R Mannings for sharing the story and to B Gammon for outlining improvement efforts.
Resolution:	The Listening & Learning story was **NOTED**.
4.	**SETTING THE SCENE**
4.1	**Chair's Report**
	The Chair presented the report and highlighted the key matters for Members attention. The Chair noted that this would be the last Board meeting for G Dix and extended his thanks to him on behalf of the board for his leadership and support, highlighting his energy, compassion, passion for nursing, exceptional leadership, visibility in the hospitals, and engagement with Board Members and executives. The Chair highlighted that the organisation would be celebrating staff achievements that evening through a staff annual celebration event, which brings together various staff awards and categories. The Chair emphasised the importance of recognising the amazing work staff do across the organization and noted the success of the Seren of the month awards. The Chair informed the board that a Public Accountability Meeting with the Cabinet Secretary had been provisionally set for 23 October 2025 and explained that this session was required to review the board's performance data, organisational progress, and future ambitions, emphasising the statutory responsibility of the Cabinet Secretary to ensure the Board and Chair were fulfilling their duties. The Chair advised that more information would be shared with board members once available.
Resolution:	The Board resolved to: • **NOTE** the report. • **RATIFY** the Affixing of the Common Seal
4.2	**Chief Executive's Report**
	P Mears presented his report and highlighted the key matters for Members attention. The following key updates were noted: • There had been no change in the Health Board's Escalation Status; • There had been significant improvement in Ambulance Handover Performance, particularly at Cwm Taf Morgannwg hospitals, with CTM leading the way in Wales, which had been positively noted by Welsh Government;

	• Good progress had been made in Elective Care Performance, particularly with orthopaedic services relocated to Princess of Wales and cataract services performing above plan; • Work is underway to establish women's hubs in line with Welsh Government priorities, aiming for community-based, integrated services by March 2026; • The formal consultation on shift patterns had closed, with over 1,100 responses. Discussions with trade unions were ongoing to adapt proposals, especially regarding Continuing Professional Development (CPD) time and shift structure. H Daniel stated that national elements were being incorporated into the shift pattern design and added that ongoing conversations with trade union colleagues had led to additional suggestions which were in the process of being worked through. A further update would be presented to the Board in November. • The Human Tissue Authority recently gave a very positive inspection report, highlighting national best practices in mortuary services. Previous challenges from 2019 had been addressed, and the team were commended for the work undertaken to address the challenges; • An all-Wales assurance review of maternity and neonatal services had commenced, led by an independent chair, with feedback expected in early 2026. P Mears also acknowledged and thanked G Dix for his significant contributions, especially in transforming maternity services and stakeholder confidence.
Resolution:	The report was **NOTED.**
5.	**ESTABLISHMENT OF THE SOUTH EAST WALES REGIONAL JOINT COMMITTEE**
5.1	**Establishment of the South East Wales Regional Joint Committee - Context and Terms of Reference**
	C Thompson presented the report and advised that this Committee marked a significant step for regional collaboration among three health boards and aimed to improve service delivery for 1.5 million people in South East Wales. Members noted that the Committee provided a governance framework for delegating decision-making powers from individual boards to the joint committee, reducing duplication and enabling collective leadership. C Thompson advised that success depended on building trust and a shared purpose, with a focus on new ways of working rather than structural changes and added that the Committee would start with a shared purpose, considering the spectrum of collaboration and emphasising that change happens at the pace of trust. G Watts added the committee does not replace the statutory responsibilities of individual health boards or Accountable Officers and was designed to enhance regional working. P Roseblade expressed concerns that the new committee should not replicate issues seen with previous joint committees, for example the Welsh Health Specialised Services Committee, where health boards retained too much separate responsibility which limited effectiveness.

Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board

	P Roseblade questioned the use of the word "may" in the terms of reference regarding whether health boards were bound by majority decisions, and queried how this affected the committee's authority and the effectiveness of the dispute resolution processes. In response, G Watts explained that whilst the intention was to achieve consensus among the three health boards, the terms of reference included provisions for scenarios where there was disagreement. G Watts clarified that the dispute resolution process outlined escalation steps to reach a conclusion, added that the Regional Joint Committee does not replace the statutory responsibilities of individual health boards and emphasised that the RJC's authority was limited by the need to respect each board's statutory duties, which is why the word "may" is used. C Thompson added that the process was about building trust and committing to a new way of working and not repeating past approaches and emphasised that starting from a position of organisational compromise before relationships were developed could set the wrong tone, and that all parties needed to move forward together. C Thompson highlighted the importance of not appearing as if any one party was acting independently and reinforced the need for collective action. H Proctor sought clarity as to where decisions made by the Regional Joint Committee would be reported. C Thompson clarified that made by the RJC would be reported functionally similarly to other committees and then brought back to the board as appropriate. The Chair stated that this new arrangement presented a opportunity for the three health boards to think more ambitiously about the types of services they could deliver together, given their combined financial resources and the defined geographical area of South-East Wales. The Chair noted that the region's transportation links, and population dynamics support collaborative service delivery, and that people often live, work, and socialise across different health board areas, making joint service planning logical. The Chair suggested that this collaborative approach could help determine the location, style, and size of services to better serve the population. G Hughes expressed strong support for the establishment of the Regional Joint Committee, highlighting that the health board was already working more collaboratively with Aneurin Bevan and Cardiff and Vale health boards across various areas, and emphasised that having a formal governance arrangement around this collaboration was welcome and necessary. G Hughes noted the importance of building on successful collaborative areas, such as the single cataract delivery model, and stressed that the underlying organisational development (OD) principles and trust between organisations were crucial for the committee's success. G Hughes also pointed out the opportunity to use resources differently and expand services for the benefit of the population, while acknowledging potential pitfalls and the need to build the committee properly. D Jouvenat agreed that the Regional Joint Committee is important for the health board and added that she acknowledged the significant work put into the

	supporting papers to ensure proper arrangements. D Jouvenat advised that whilst she recognised the rationale, she felt concerned regarding the governance support for the committee, specifically questioning whether rotating governance support annually among the health boards would work effectively, given that this could disrupt relationship and process continuity. The Chair acknowledged the concern raised as a valuable point and explained that, as the process starts, the appointed chair of the regional joint committee would likely chair for the first 18 months to provide continuity and stated that as the committee progresses, a reassessment could be undertaken of how governance support is resourced and whether changes were required, noting that initially, current teams would support the process. The Chair emphasised that while the additional responsibilities were significant, the work is valuable, and the approach could be adjusted as the committee develops. N Mesher suggested thinking more holistically about the benefits and opportunities of the Regional Joint Committee, beyond just the Llantrisant Health Park (LHP) and orthopaedics and highlighted that Wales was underperforming in research and suggested that the committee could represent a population of 1.5 million to facilitate research opportunities. N Mesher added that there were other areas, such as sustainability, where collaborative work could be beneficial. H Daniel echoed the comments made by N Mesher and stated that whilst Organisational Development (OD) was often seen as a solution to everything, this needed to be reframed as a leadership challenge, noting that OD enables leadership, which was essential for success across the three organisations. Members noted that a positive first meeting of regional partners had already taken place to begin designing what leadership work should look like. D Hurford expressed his support for the regional collaboration and emphasised the need to balance working separately and together, and specifically highlighted the importance of research, noting that national efforts had not progressed and suggested a more flexible regional approach. D Hurford added that individual health boards were not large enough to handle certain issues alone, hence the need for regional structures, particularly for clinical challenges like vascular services, but stressed the need for clear governance structures to support such work. C Donoghue advised that whilst she was supportive of the establishment of the Regional Joint Committee, she cautioned against duplicating efforts regionally if national solutions were not working, advocating for stopping ineffective national work rather than running parallel regional initiatives. The Chair agreed that sometimes when things were not working well enough locally, there was a tendency to look for a regional solution, as seen with the regional partnership boards and also cautioned that just because something wasn't working individually does not necessarily mean a collective regional response will solve the problem. The Chair emphasised the need to be cautious

	and to distinguish between issues that genuinely require a larger footprint and those that simply need more local effort to resolve. P Mears stated that having the Regional Joint Committee in place would have provided greater clarity and direction and more streamlined and effective decision-making in regard to projects such as the Llantrisant Health Park and suggested that the absence of such a structure highlighted the need for more formal governance arrangements to support regional working, given that informal arrangements had their limitations. P Mears acknowledged that while there were many areas that would benefit from regional collaboration, the main challenge would be having the capacity to deliver this work and emphasised that the real test would be how conflicts and difficult positions were handled between the organisations. The Chair advised that similar collaborative structures had already been working in local government for several years, including the Cardiff Capital Region, and suggested this demonstrated that public bodies could work together effectively. The Chair extended his thanks to C Thompson and G Watts for the work they have undertaken on this matter.
Resolution:	The board resolved to: • **APPROVE** the establishment of the South-East Wales Regional Joint Committee (RJC) and its associated terms of reference and operating arrangements as attached; • **NOTE** the RJC will appoint a Chair from its membership followed by a rotating period of appointment. Governance support will be provided by the Health Board of the Chair appointed as RJC Chair; • **DETERMINE** membership from each respective health board to join the RJC, in-line with the membership requirements; • **NOTE** the wider determinants for the RJCs long term sustainable success and; • **APPROVE** the development of a regional OD programme for the RJC and its partners.
6.	**BOARD GOVERNANCE ARRANGEMENTS**
6.1	**Action Log**
	The Chair presented the action log.
Resolution:	The Action Log was **NOTED.**
6.2	**Matters Arising not Contained within the Action Log**
	There were no matters arising
6.3	**Board Assurance Framework**
	G Watts presented the report and advised that since the July meeting, a key change was the update and escalation of strategic risk 9, which related to the failure to plan and manage revenue resources within the limits set by Welsh Government. Members noted there were no other substantive changes to new risks or the scoring of strategic risks and were reminded that the framework was

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	underpinned by the organisational risk register, which is scrutinised by the Committees of the Board. P Roseblade commented that whilst she found the addition of strategic risk 9 appropriate, she queried that since the Board had already agreed the plan, the issue was not a failure to plan but rather the implementation or delivery of that plan and suggested the risk wording should be adapted to reflect this focus on delivery. Following discussion, G Watts agreed to work with Board members to find a suitable form of words to describe this risk, for example, Failure to Deliver the plan.
Resolution:	The Board resolved to: • **APPROVE** the escalation of Strategic Risk 9 subject to amendment of wording of this risk • **APPROVE** amendments made to the existing risks and **CONFIRM** that the updates provide adequate assurance and reflect recent discussions.
Action:	Review to be undertaken of the wording of Strategic Risk 9 so that it better reflects the focus on delivery.
6.4	**Board Committee and Advisory Group Highlight Reports**
6.4.1	**Quality, Safety & Experience Committee Highlight Report 22 July 2025**
	Prior to presenting the report, C Donoghue reflected on the need to focus more on patient experience within the Committee's agenda, noting that while it was addressed, there may be room for greater emphasis. C Donoghue also praised the improved quality and succinctness of papers and reports being presented to the Committee, which had helped with effective management of the agenda. In presenting the report, the following key matters were highlighted: • The Committee noted significant progress on the paediatric general dental anaesthetic list, with reinstatement of the theatre list and improved service delivery; • The Committee acknowledged the Welsh Government assessment of maternity services and the Committee's ongoing involvement with its implications; • The continuing oversight of stroke services, with the Committee recognising that while some metrics remain poor, substantial work and progress had been made to improve services, which would continue to be closely monitored; • The Research and Development Strategy and the Annual Duty of Quality report were endorsed for Board approval. In relation to the current waiting list position for paediatric general anaesthetic dental lists, G Hughes confirmed that this will be reduced to 26 weeks by Christmas, and by the end of March 2026, it was expected to return to a two to three-week window for surgery for patients.
Resolution:	The report was **NOTED.**
6.4.2	**Operational Delivery Committee Highlight Report 29 May 2025**
	In presenting the report, P Roseblade highlighted the positive escalation in ambulance handover performance, noting that improvements had continued

	through the summer with no reported negative impact on the emergency department. P Roseblade also drew attention to financial performance, specifically that forecast savings were significantly below target. R Hughes provided assurance to the Board that enhanced monitoring was in place to ensure that improved ambulance handover performance did not create unintended consequences within the Emergency Department or wards and added that collaboration with local authorities was helping to improve patient discharge processes. The Chair advised that during his recent accountability meeting with the Cabinet Secretary, he was asked about plans to sustain the improved ambulance handover performance and advised that he discussed the team's ongoing internal monitoring to ensure sustained performance and to check for any unintended consequences within the emergency department and wards. The Chair also highlighted the importance of system-wide effectiveness, mentioning close collaboration with local authority partners to support timely patient discharge, especially for those with social care needs. G Dix provided an update on boarding of patients, stating that boarding was still occurring at Prince Charles Hospital, with triple boarding also being experienced in some areas. Members noted that whilst the wards were large and patients did not feel as cramped as in other sites, this was still not a pleasant experience for patients and noted that, despite boarding, no safety issues had been reported through the governance system.
Resolution:	The report was **NOTED.**
6.4.3	**Mental Health Act Monitoring Committee 20 August 2025**
	K Palmer presented the report which highlighted the ongoing staffing vacancies, particularly the fragility around clinical medical cover and highlighted a positive unannounced Healthcare Inspectorate Wales visit to Ward 7 at Ysbyty Cwm Cynon Hospital. G Dix advised members that A Llewellyn, Care Group Nurse Director, would be retiring in November and expressed his thanks for her leadership over the Health Board over last few years. Members noted that a discussion had recently been held in relation to Mental Health Services at an Executive Team meeting where the ongoing national and UK wide shortage of Consultant Psychiatrists and the impact this was having on medical staffing within Mental Health was acknowledged. D Hurford advised that an interim appointment had now been made into the Medical Director post within Mental Health whilst recruitment was being undertaken for the substantive post. Members noted that the Mental Health Team were in the process of developing a Mental Health Strategy which focussed on moving to an operating model that uses the available workforce more effectively and prioritises care delivery and noted that this transformative work would be presented to the Board in due course.

	H Daniel advised that the Health Board had recently secured funding from Welsh Government to recruit two Specialty Doctors and one Consultant Psychiatrist, which should help to improve the staffing position and added that work was being undertaken to broaden recruitment strategies, which included improved creativity regarding branding in order to attract candidates. P Daniels advised that Welsh Government had recently published the Mental Health & Wellbeing Strategy and the Suicide and Self Harm Strategy and added that the Public Health Team were concluding a healthcare needs assessment for mental health and wellbeing, following which a work plan would be developed. Members noted the aim of this piece of work was to ensure people have appropriate access to mental health and wellbeing support.
Resolution:	The report was **NOTED.**
7.	**DELIVERING OUR PLAN**
7.1	**Strategic Clinical Services Plan**
	C Thompson introduced the item and explained that the update responds to a request from Board for the timelines around the Strategic Clinical Services Plan and provided an opportunity to discuss the foundational work needed for significant strategic change across several areas, including primary and community care, integration of health and social care, and mental health transformation. C Thompson emphasised the importance of ensuring the right foundations were in place for these interlinked transformation programmes and added that a more detailed update would be presented to the Strategic Development Committee in October. C Thompson also highlighted the need to link this work with the Regional Joint Committee, referencing ongoing collaboration with colleagues. Following the introduction, A Ali shared the presentation with members. P Roseblade advised that whilst she appreciated the presentation, which was exactly what would be expected in planning documentation in terms of graphics and terminology, she felt concerned that the plan could be generic and might apply to any context, rather than being specifically politically led or tailored to the organisation's unique needs, which she felt to have been the case since the plan's conception. C Thompson responded by emphasising the importance of having foundational evidence before moving to a more dynamic stage of planning and made reference to discussions held with the Executive Medical Director about how to engage clinical leadership around the future ambition. C Thompson also referenced ongoing work in primary care as an example of how clinical leadership was being manifested in that stream of work and highlighted the need to bring together the portfolio of transformation programs and the necessity of transforming community services alongside clinical services, stressing the importance of having a basis for clinical staff to engage with these changes.

	A Ali clarified that the current stage was foundational, and added once workstreams were set up, they would be led by clinical leads and involve clinical staff, given they were best positioned to design services. A Ali emphasised that clinicians would be provided with the necessary tools, such as health assessments and information on challenges and new models, to help develop several options for public consultation. C Donoghue made reference to the delivery timeline, noting that the presentation stated that the Health Board was currently in phase 0, scoping and preparation, and added that it felt like the organisation had been in this phase for some time, given the previous work undertaken on the Acute Clinical Services Plan. C Donoghue advised that it would be helpful if clarity could be provided in relation to clear start and end points for phases which would help in setting the expectations for the Board and its stakeholders as to when tangible changes would occur. P Mears advised that some consolidation and moves of services had already taken place, some of which had been driven by clinical teams and others by necessity, enabling rapid clinical changes that had been difficult to implement previously, and suggested it would be useful to describe these existing changes within the plan to highlight the progress already made. P Mears advised that the consultation process would be affected by upcoming electoral events, noting that with elections approaching, public focus on health services would increase and make consultations more challenging and suggested that timelines should reflect that the Health Board may not be able to proceed with consultations until after the next election. D Hurford advised that clinicians often have fantastic ideas and were eager to drive change, highlighted the challenges around harnessing that enthusiasm and noted that there was sometimes a lack of consideration for the broader impact of changes on other service areas, which needed to be considered in the next phase of developing the new framework. K Palmer noted the distinction between public consultation and ongoing engagement, stressing that engagement can continue even when formal consultation is not possible and expressed interest in seeing the case for change. K Palmer also agreed on the need to be realistic about what is achievable given current capacity, referencing the significant effort required for engagement and the challenges of making changes in the local context. Members noted that even one small change in one community hospital had required a significant amount of external engagement with stakeholders and noted that the time and effort required to manage changes could not be underestimated. In response to a query raised by A Brown as to whether the clinical services plan was a framework for every clinical service to run their IMTP through or if it was focused on a smaller set of areas or pathways, C Thompson advised that the clinical services plan was intended to deliver the overall strategy of the Health Board, which would result in every element of every service needing to change

	over time to keep pace. C Thomspon added that alongside this transformation, the Health Board must continue to run its IMTP and business on a daily basis. In response to queries raised by N Mesher as to whether the plan was about improving the next 12 months or reshaping over five years, C Thompson advised that she acknowledged the importance of having a clear vision and foundational elements to support the long-term strategy and added that she would be presenting the foundational products to the Strategic Development Committee in October, prior to updates being presented back to Board. P Mears highlighted the need to consider digital and data approaches, in addition to technology, within the foundation piece of work and noted the challenges in relation to predicting what technology would look like given its rapid pace of change. P Mears expressed the importance of using opportunities, such as the Llantrisant Health Park, to act as a test bed for new systems, applications and infrastructure. S Morris agreed with the comments made and advised that recent engagement had been held with Clinicians in relation to the Llantrisant Health Park where discussions were held in regard to foundational principles as well as digital systems. The Chair suggested that over the next 12 months, the organisation should engage with staff to identify which services may require the most immediate attention, referencing the organisational risk profile to prioritise areas most challenged. The Chair suggested that it would be beneficial to return to this subject in future board updates or briefing/development sessions, to ensure the Board remains engaged as the thinking around the topic is refined. The Chair reiterated the need to articulate what the next five years would look like for the Health Board, focusing on describing the future estate and referenced the ambition for the organisation to be a provider of community-based healthcare services, not just hospital-based care. A Ali reinforced the approach of rethinking service delivery by focusing on what care can be provided safely at home, at a cluster or health centre level, and emphasised not being constrained by traditional hospital-based models, citing global examples of successful community-based care. The Chair concluded the item by advising that consideration would now be given as to how the Board could be updated on progress over the next 12 months.
Resolution:	The report was **NOTED.**
Action:	Consideration to be given be given as to how the Board could be updated on progress over the next 12 months.
7.2	**Community Based Healthcare Plan - Presentation**
	G Hughes shared a presentation and highlighted the key matters. K Palmer expressed how impressed she was by the Primary Care Transformation Board meeting she recently attended and highlighted the strong engagement and progress made and the value of hearing the GP voice directly. Members noted the involvement of the three GP cluster leads and the intention to do

	further engagement with all GPs across CTM and noted the importance of aligning the local work with the national programme to ensure integration between the clinical services strategic plan and community engagement, which would be picked up by the Strategic Development Committee. Members also noted the need to bring together physical services and mental health services within community health, which would be a key focus moving forward. The Chair echoed the comments made by K Palmer and agreed with the positive feedback shared about GPs engaging in shaping and designing the future model. P Mears highlighted that GPs were independent contractors, with no single way of working and each practice working differently, and the challenges that would be faced moving forwards to move towards a standardised way of working which would require a different approach compared to acute service. P Mears emphasised the need for peer support leaders within the GP community to help drive change and referenced the importance of building trust, especially by addressing day-to-day issues that affect GPs. The Board noted the national shift in focus toward primary and community care, noting the Chief Medical Officer and Cabinet Secretary's support for this agenda and the expectation for health boards to demonstrate resource allocation toward these priorities. Members noted that getting primary and community care right was fundamental to the success of the broader clinical services strategy, including hospital service redesign. S Morris emphasised the need to clearly distinguish between having a single system and having a single record, especially in the context of integrating mental health services and cautioned that focusing solely on a single system could be prohibitive, highlighting the importance of data sharing between primary and secondary care. N Mesher referred to the potential role of community pharmacy, particularly in managing long-term conditions and monitoring patients, and referenced opportunities for community pharmacy to contribute to diagnostic testing and integrating diagnostic data into medical records for ongoing patient management. Members noted that the Health Board already had a good relationship with community pharmacists and were working with them on several service provisions. Members recognised the need to address paper documentation and the challenge of integrating this data into electronic records and also noted that patient-held data and wearable technology would become increasingly important, with consideration being given to how these developments could be used in future service design. G Hughes advised that work was progressing at pace on delivery plans, with 'plans on a page' being reviewed at the next Transformation Board meeting for each focus area. Members noted these plans would clarify the delivery of immediate actions as well as medium and longer-term objectives.

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	In response to a query raised by the Chair as to how the vision and ambition for the next five years could be articulated externally, P Mears highlighted the need to translate this ambition into an easy-to-understand description for the public, making it clear how services will be reoriented and what that will mean for patients. Members noted that engaging and having conversations with the public about this vision was essential, given that the cultural shift required would be significant and overwhelming. K Mason highlighted the importance of having a shared record that was understandable to all stakeholders, including patients and stated she would like to see something much more upfront and explicit in relation to shared information management in the plans that were being developed. H Proctor raised concerns about the socio-economic profile of patients, noting that many people do not have access to digital resources to enable them to receive information via text or email, and questioned how accessibility would be ensured for everyone. P Mears acknowledged the concerns raised and referenced solutions used in maternity services, such as providing SIM cards to those without access to digital devices. P Mears emphasised the need to design solutions that fit the majority who can use digital, while also ensuring alternative options for those without digital access. P Daniels commented that regional working needs to be recognised, especially regarding the flow of information and noted that whilst a national solution may be on the horizon, interim solutions would be necessary to meet ambitions and timelines. The Chair emphasised that it was the statutory duty of the Health Board to drive forward the interim solutions. D Hurford stated that other sectors, such as local authorities and libraries, had addressed digital access by providing computers for public use and suggested that this could be a possible approach that could be taken by community pharmacies for remote consultations for example. Following a query raised by the Chair, members noted that the next steps included taking the overall five-year plan through the Strategic Development Committee and presenting the deliverables through the Operational Delivery Committee. Members noted that updates would also be provided through board briefings, and actions for the upcoming year's planning and ambitions would be incorporated into the Integrated Medium Term Plan ambitions for next year.
Resolution:	The presentation was **NOTED.**
7.3	**Integrated Performance Report (Quality, People & Operational Performance)**
	C Thompson introduced the report and highlighted the key matters for members attention in terms of the key performance metrics, before handing over to Executive leads to provide updates against their performance areas.

	In relation to the staff survey, the Chair encouraged board members to support the staff survey by being present on sites over the next couple of weeks to help publicise and promote the initiative. P Roseblade referred to Ophthalmology which had consistently been at the bottom of the Follow-Up Not Booked metrics during the last five years, despite seeing many plans and processes to address the issue and queried when the situation would improve. G Hughes advised that whilst the numbers of patients waiting had stabilised, he would seek an update on timelines for further improvement outside the meeting and agreed to share with Members once obtained. In response to a query raised by P Roseblade as to the approach being taken this year by the Health Board in relation to staff vaccines, H Daniel advised that a combination of methods would be used which included clinics for booking or walk-ins, peer vaccinators in clinical settings and roaming vaccinators to reach staff within their areas of work. P Daniels added that there was also an option for staff to visit community vaccination centres and added that staff incentives were also being offered to encourage staff uptake. H Proctor welcomed the process taken this year which she found to be much easier and accessible. K Palmer queried whether there were other metrics, such as weight management, that were particularly important for CTM that should be included within the performance dashboard and queried when the Board would begin to consider or introduce new or draft metrics related to primary and community care. C Thompson responded to advise that this formed part of the strategy deployment item that would be discussed at the Strategic Development Committee and advised that there was an intention to ensure the metrics reflect the Health Board's priorities. D Jouvenat queried how much of the increase in staff sickness, particularly stress, was related to changes in working patterns due to the incident at the Princess of Wales Hospital and ongoing consultation about shift patterns and queried whether the data is analysed in enough detail to link stress increases to specific areas or changes. H Daniel explained that while detailed local analysis was done within care groups, at the broader level it was not clear if there is a direct link. Members noted that the well-being and OD teams use a heat mapping process to identify and target areas of concern and noted that spikes in sickness had been observed following service changes, such as in maternity, and that there was ongoing work to reframe conversations about sickness and expectations post-COVID. H Proctor highlighted to Board Members that Allied Health Professionals would be celebrating AHP month on the 14 October. The Chair welcomed the improvement in Emergency Department handover times, noting the significant work undertaken and highlighted that while handover targets were being met, the Health Board was still relatively low

Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board

	compared to other health boards in red, amber, and purple ambulance call response times, and suggested ongoing monitoring and possible further discussions with the Welsh Ambulance Services Trust if data does not improve. The Chair also mentioned the importance of considering the geography of the Health Board region and ambulance positioning, cautioning that improved handover times do not necessarily mean ambulances were reaching patients faster. G Dix shared that staff at Prince Charles Hospital (PCH) questioned the impact of improved 45-minute ambulance handover times, noting that while the target was nearly achieved, staff still feel crowded in the Emergency Department and wards, and expressed they would like to see tangible benefits from these changes. G Hughes advised that he had met with the Welsh Ambulance Service NHS Trust to discuss the possibility of them presenting the impact of these changes on WAST performance within CTM.
Resolution:	The Board **NOTED** the Integrated Performance Dashboard.
Action:	Update on timelines for further improvement in relation to Ophthalmology Follow-Up Not Booked metrics to be shared with Members outside the meeting
7.4	**Month 5 Financial Performance Report**
	A Jones presented the update and highlighted the following key matters for members attention: • The month 5 financial position had improved, with a small deficit reported and the year-to-date deficit remaining stable. • New savings had been identified, but there was still a gap compared to the planned savings target. • Additional funds had been released from reserves and accounting policies to help offset shortfalls. • The break-even forecast was still achievable, but there are risks from lower-than-expected government allocations and unresolved national pay issues. • The capital programme was progressing well, and no major cash flow risks are anticipated. The Chair sought clarity in relation to the difference in understanding between the health board's required pay settlement for 2024/25 and what Welsh Government saw as their obligation, specifically referencing the Band 2 and 3 pay issue. A Jones explained that Welsh Government received insufficient funding for National Insurance across the public sector and, although they added some local funding, the recurrent position was worse than the in-year position. Members noted that the interim settlement for the current year was non-recurrent and that the shortfall would continue into next year unless resolved. Members also noted that Welsh Government did not recognise variable and non-contractual pay (like agency and bank staff) in the pay settlement, which were real costs for the health board which would increase with inflation. In response to the query raised by the Chair regarding the Band 2 and Band 3 issues, H Daniel explained that the Band 2 and 3 issue stemmed from changes

	made in 2021 to Healthcare Support Worker job profiles set by the Workforce Staff Council at UK level, moving some duties from Band 2 to Band 3. Members noted that there was a campaign, led by one union, to up-band healthcare assistants from Band 2 to Band 3, with Swansea Bay as the initial pilot site. H Daniel advised that whilst a national framework exists to manage this process, Welsh Government had not yet clarified how this would be funded. Members noted that the health board had received its first grievance related to this issue, and noted the potential financial risk could be around £8 million, which made funding confirmation from Welsh Government crucial. P Roseblade congratulated the organisation and finance team for reducing the monthly deficit, which she felt was a significant achievement for such a large organisation. P Roseblade advised she presumed that the funding for 2024/25 was non-recurrent meaning that the shortfall experienced this year would continue into the recurring position. A Jones confirmed this to be the case and advised that this had been factored into the current assessment. In relation to the National Insurance position, members noted this would deteriorate recurrently given that only a non-recurrent allocation had been given to support the national programme and had also been incorporated into the recurring deficit. P Roseblade expressed her disappointment with the Audit Wales media release stating all seven health boards failed to meet their targets. P Mears clarified that technically the Health Board had failed to meet their targets in the context of the three-year financial rule that had been set by Welsh Government. P Mears emphasised that whilst the current financial position was a significant achievement, he highlighted the need to maintain close oversight over the next six months due to ongoing internal and external risks, especially given the challenging environment for Welsh Government funding. Members noted that that Welsh Government expected all boards to deliver their plans, given there was no additional funding available. K Palmer acknowledged the improved monthly deficit, recognised the risks outlined in the finance update and queried about the ability to invest in key service areas this year and at what point those investments could be made. P Mears explained that whilst investment was already being made in some key areas, the profile of spend may differ from initial expectations and advised that some areas were behind schedule. A Jones confirmed that the discrete investment was still in the plan, with funding available, and that some investments were already being incurred, some of which were happening at a slower rate, with some yet to commence. Members noted that whilst the £1.7 million released was related to anticipated cost pressures that had not materialised as expected, allowing some funds to be reallocated, this had not stopped planned investments. Members agreed that it would be helpful if future reports could include information on discretionary spend and progress against the original plan which

	would provide the board with confidence that resources were being released for key priorities. The Chair extended his thanks to A Jones for presenting the report.
Resolution:	The report was **NOTED.**
Action:	Future reports to include information on discretionary spend and progress against the original plan to provide the board with confidence that resources were being released for key priorities.
8.	**STRATEGIC PLANNING**
8.1	**Outline Business Case - Llantrisant Health Park**
	G Hughes and R Cavill presented the report and highlighted the key matters for Members attention. The Chair expressed strong appreciation for the work undertaken by R Cavill and her team, highlighting the significant amount of detailed analysis and the significance of delivering the first regional diagnostic and treatment centre in Wales. The Chair also recognised the support and energy from Rhondda Cynon Taff Local Authority, specifically mentioning Councillor Andrew Morgan and colleagues for their enthusiasm and help in expediting planning approval. The Chair emphasised the project's importance as a fantastic resource for South East Wales. In response to a question raised by P Roseblade as to whether there had been a good level of response to the managed service contract procurement, P Mears advised that there had been a lot of interest from suppliers and that the procurement process was nearly complete. Members noted that the supplier selection process involved all three health boards in the South East Wales region. In response to a question raised by P Roseblade whether there had been any informal feedback on the technical aspects of the Outline Business Case (OBC), R Cavill advised that the technical aspects of the OBC had already been reviewed twice by specialist estate services, with feedback incorporated, and added that whilst no written feedback had been received to date, a face-to-face meeting was scheduled to finalise any outstanding issues. In response to a query raised by N Mesher as to whether the managed service provider could bring forward and invest in the additional (future) capacity themselves, possibly for private patients or other business at risk, and whether the contract would allow for this, R Cavill advised that this possibility would require contractual negotiation with the preferred provider and would also need to consider Welsh Government's position, given that they were funding the building. G Hughes added that various options were being evaluated, including examples from England, and that further discussions could take place once the supplier was identified. A Jones added that whilst most suppliers had asked about this option, the priority was delivering the core service specification first.

	K Palmer noted that regional engagement was listed as a top risk for the programme and queried whether this would be addressed by the South East Wales regional forum as a top priority. P Mears stated that regional support for the programme had improved significantly, with recent regional calls showing strong endorsement from partners, and added he anticipated that the risk score for regional engagement would decrease. In response to a query raised by K Palmer as to how the risks of this programme would feed into the organisational risk register, P Mears suggested adopting a similar approach to risk management as was used with the Prince Charles Hospital ground and first floor project, where programme risks were managed at the project level and any significantly escalated risks being treated accordingly. Members noted that whilst this proposal was being presented to this Board for approval, the proposal had also been presented to Aneurin Bevan and Cardiff & Vale Health Boards for endorsement, given that this was a regional solution.
Resolution:	The board **DISCUSSED** and **NOTED** the LHP OBC and **APPROVED** the submission of the OBC to the Welsh Government.
9.	**CONSENT AGENDA**
9.1	**FOR APPROVAL**
9.1.1	**Unconfirmed Minutes of the meeting held on 31 July 2025**
Resolution:	The minutes were **APPROVED.**
9.1.2	**Board Committee Annual Reports**
Resolution:	The Committee Annual Reports were **APPROVED.**
9.1.3	**Putting Things Right Annual Report**
Resolution:	The report was **APPROVED.**
9.1.4	**Interim Amendments to the Model Standing Financial Instructions Chapter 11 for Local Health Boards/Annual Review of Standing Orders**
Resolution:	The board **APPROVED** the amendments to Chapter 11 of the Health Board's SFIs.
9.1.5	**Annual Duty of Quality Report**
Resolution:	The report was **APPROVED.**
9.2	**FOR NOTING**
9.2.1	**Non-Routine Board Business (Forward Plan)**
Resolution:	The Non-Routine Board Business (Forward Plan) was **NOTED.**
9.2.2	**Annual Cycle of Business**
Resolution:	The Annual Cycle of Business was **NOTED.**
9.2.3	**Board Committee and Advisory Group Highlight Reports**
Resolution:	The report was **NOTED.**
9.2.4	**Annual Unpaid Carer's Report**
Resolution:	The report was **NOTED.**
9.2.5	**Infection Prevention & Control Annual Report**
Resolution:	The report was **NOTED.**
9.2.6	**Confirmed Minutes of the NHS Wales Joint Commissioning Committee Meeting held in public on Tuesday 15 July 2025**
Resolution:	The minutes were **NOTED.**

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10.	CLOSE OUT BUSINESS
10.1	**Any Other Business**
	There was no other business to report.
10.2	**Meeting Feedback**
	The Chair requested feedback on this meeting within the next two weeks.
11.	**Private/In Committee Session**
	Members noted that the following items would be received in the In Committee session: • Full Business Case - PCH Ground & First Floor Phase 3 • South East Wales Regional Orthopaedic Plan • Joint Controller Agreement Verbal Update • Mental Health Electronic Patient Record Business Case Verbal Update • Unconfirmed Minutes of the In Committee Board held on 31 July 2025
12.	**DATE AND TIME OF NEXT MEETING** The next meeting will be held on Thursday 27 November 2025 at 10:00am
13.	**Close of Meeting**

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