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

Date of Meeting:	**10.00AM, WEDNESDAY 26TH SEPTEMBER 2018**
Venue:	**CARMARTHENSHIRE COUNTY COUNCIL, COUNTY HALL, CARMARTHEN, SA31 1JP**

Present:	Mrs Bernardine Rees, Chair, Hywel Dda University Health Board Mrs Judith Hardisty, Vice Chair, Hywel Dda University Health Board Mr Owen Burt, Independent Member Professor John Gammon, Independent Member Cllr. Simon Hancock, Independent Member Ms Anna Lewis, Independent Member Mr Mike Lewis, Independent Member Mr Adam Morgan, Independent Member Mr Paul Newman, Independent Member Mr David Powell, Independent Member Ms Delyth Raynsford, Independent Member Mr Steve Moore, Chief Executive Mr Joe Teape, Deputy Chief Executive & Director of Operations Mrs Lisa Gostling, Director of Workforce & Organisational Development Mrs Ros Jervis, Director of Public Health Dr Philip Kloer, Medical Director & Director of Clinical Strategy Mrs Karen Miles, Director of Planning, Performance & Commissioning Mrs Mandy Rayani, Director of Nursing, Quality & Patient Experience Ms Alison Shakeshaft, Director of Therapies & Health Science Mr Huw Thomas, Interim Director of Finance
In Attendance:	Mrs Joanne Wilson, Board Secretary Ms Jill Paterson, Director of Primary Care, Community & Long Term Care Ms Sarah Jennings, Director of Partnerships and Corporate Services Mrs Libby Ryan-Davies, Transformation Director Mr Andrew Carruthers, Turnaround Director Dr Kerry Donovan, Chair, Healthcare Professionals Forum Dr John Morgan, Chair, Hywel Dda Community Health Council Mr Sam Dentten, Chief Officer, Hywel Dda Community Health Council Dr Owen Cox, Chair, Local Medical Committee Ms Hilary Jones, Chair, Stakeholder Reference Group Mr Andrew Burns, Consultant Surgeon/Withybush Hospital Director Dr Eiry Edmunds, Cardiology Consultant/ Glangwili Hospital Director Dr Robin Ghosal, Respiratory Consultant/Prince Philip Hospital Director Dr Sion James, GP/Clinical Director for Primary Care, Ceredigion Dr Warren Lloyd, Clinical Director of Mental Health/Consultant Psychiatrist Dr Alan Williams, GP/Locality Lead, Llanelli Mr Jeremy Williams, Consultant/Clinical Director Unscheduled Care Ms Helen Annandale, Head of Physiotherapy/Carmarthenshire Therapy Lead Ms Paula Evans, Directorate Nurse Paediatrics Ms Jina Hawkes, General Manager for Community Primary Care, Ceredigion Ms Julie Jenkins, Head of Midwifery Ms Bethan Lewis, Hospital Head of Nursing, Glangwili General Hospital Ms Elaine Lorton, County Director, Pembrokeshire

	Ms Zoe Paul-Gough, Head of Nutrition & Dietetics Service/Pembrokeshire Therapy Lead Ms Delyth Simons, Head of Pharmacy Mr Rob Jeffrey, Ambulance Operations Manager, Welsh Ambulance Service NHS Trust Mr Jonathan Lee, Managing Director, Opinion Research Services Ms Kelly Lock, Head of Qualitative Research, Opinion Research Services Ms Clare Moorcroft, Committee Services Officer (Minutes)

PM(18)157	**INTRODUCTIONS & APOLOGIES FOR ABSENCE**	
	The Chair, Mrs Bernardine Rees, welcomed everyone to this extraordinary meeting of the Board, and thanked Carmarthenshire County Council for accommodating the meeting at short notice. Members were reminded that a regular Public Board meeting would take place on 27th September 2018 and that today's meeting was focused solely on Transforming Clinical Services (TCS). Mrs Rees stated that a great deal of work has taken place both recently and over the last two years to develop the TCS proposals, and that the University Health Board (UHB) has worked with stakeholders and the public in regard to these. Members were reminded of the significance of today's meeting, for both the Board and for local communities. Mrs Rees thanked all of those who had taken the time to contribute to and engage with the Public Consultation, and welcomed members of the public attending today's meeting, which was also being webcast. Mrs Rees apologised if anxiety had been caused by the consultation exercise and emphasised that this had not been the UHB's intention, which was to focus on long term healthcare provision. Members were informed that clinical staff would deliver the majority of today's presentation, following which, the Board would be requested to make a decision on the appropriate 'direction of travel' for clinical services. Apologies for absence were received from: • Mr Michael Hearty, Associate Member • Mr Jonathan Griffiths, Pembrokeshire County Council Director of Social Services, Local Authority Representative	

PM(18)158	**DECLARATION OF INTERESTS**	
	No declarations of interest were made.	

PM(18)159	**TRANSFORMING CLINICAL SERVICES**	
	Dr Philip Kloer emphasised that today's meeting represents the culmination of 2-3 years' work with HDdUHB staff and public, and thanked both for their contribution. Dr Kloer suggested that, when designing the NHS, neither Bevan nor Beveridge could have ever predicted the changes in healthcare which have taken place in a relatively short time. There is an increasing aging population, and treatments have advanced significantly; however the health service has not necessarily adapted at the same pace. HDdUHB has the opportunity to set a strategic direction and to support people to live healthier lives. Also, to provide clinical excellence, sustainable health services which are of high quality and safety, and to attract staff to our region.	

Mrs Libby Ryan-Davies the presentation 'Transforming Clinical Services – Consultation Closing Report'. Mrs Ryan-Davies outlined the topics to be covered, which included: Our responsibilities, the Guidance on Engagement & Consultation, and the Quality Assurance process; Our Big NHS Change – Consultation and findings; Our approach to Conscientious Consideration; Restating the Case for Change; Clinical Recommendations. Detailing the Health Board's responsibilities (Slide 3), Ms Sarah Jennings explained that debate and discussion of the clinical recommendations is required, in order for informed decisions to be made. Slide 4 outlined the Welsh Government guidance on engagement and consultation, with which the University Health Board must comply; however Ms Jennings emphasised that, beyond this, the Board believe that consultation and engagement is the correct approach to take. Members were reminded that, in order to obtain external quality assurance of the consultation process, the Consultation Institute (CI) had been engaged. The CI had applied a tried and tested method for the quality assurance of public consultations including the testing and review of the project plan, documentation, mid-point review, closing date and final closing report. To achieve a good practice consultation, the consultation must achieve six key gateways throughout the process, which were detailed in Slide 5. The consultation had reached the sixth of these, in the closing report, today.

Mrs Ryan-Davies introduced Slide 6, which provided a reminder of the background to the establishment of TCS, including the three-phased approach of 'Discover, Design and Deliver' and the timings for these. Also, the four guiding principles which underpin all TCS work: 'Safe, Sustainable, Accessible and Kind'. In Slide 7, Members were reminded of the remit and timeline for Phase 1: Discover; and that this had been clinically-led, focused on the long-term future, on prevention and keeping people healthy, and on care closer to home. Ms Helen Annandale presented Slide 8, which detailed our challenges as a University Health Board and examined the case for change. There are long-term strategic issues which need addressing, around clinical and financial sustainability. Development of the guiding principles Safe, Sustainable, Accessible and Kind had resulted from examining the case for change with the clinicians. These centred around challenges such as increasing demand, people living longer with longer-term conditions, recruitment and retention of workforce, advancing medicine and treatment and technology and concerns around facilities and estates, amongst others. Members were reminded in Slide 9 that, at the 22nd June 2017 Public Board meeting, we launched our 12 week listening and engagement exercise 'The Big Conversation'. The case for change engagement document developed was circulated to over 4000 stakeholders and we held over 80 different events during this time across a wide range of staff, public and stakeholders; utilising 50+ different forums to ensure a broad spectrum of views. Introducing Slides 10 and 11, Ms Zoe Paul-Gough stated that a number of common themes had been heard from our public, staff and stakeholders. As outlined on the slides, there had also been a focus around quality of care; where to receive healthcare; travel and access; resources and the need for joined up services, with themes including a need for effective

communication and timeliness of care; more community-based services; concern that a number of hospital sites are not fit for purpose, and the importance of informal carers. Feedback had also included concerns around inequalities and variation in care, with a 10 year healthy life expectancy gap between the most and least affluent areas; recruitment and retention challenges; recognition of improvement in some areas of performance, whilst noting that many remain a challenge, such as Unscheduled Care; variation in facilities and fragilities in delivery of services in remote and rural settings.

Ms Jina Hawkes presented Slide 12, on emerging models of care. Members noted that the work of Phase 1 TCS was developed through three clinically-led programme sub-groups: Community Care, Chaired by Dr Sion James; Urgent and Emergency Care, Chaired by Mr Jeremy Williams and Planned Care, Chaired by Mr Mark Henwood. These groups were informed by various information, including what was heard in the Big Conversation listening and engagement exercise, what can be learned from good practice from around the world, what must be undertaken to comply with legislation, the University Health Board's current challenges, what is known about current services and performance and our clinicians' vision for the future. As detailed on the slide, groups had examined numerous models from around the world, including Canterbury, New Zealand, Primary Care Home and Healthy Prestatyn and had, from all of these models, noted a number of common themes. Mrs Ryan-Davies introduced Slide 13, which outlined the remit and timeline for Phase 2: Design. Slide 14, Developing our proposals, summarised the various stages through which the 27 options considered were taken. The rigorous process had involved various stakeholders, and included a Strengths, Weaknesses, Opportunities and Threats (SWOT) analysis. A multi-agency group, not involved with the options, had developed the Options Criteria, and the Options Scoring process had included a wide range of stakeholders. The process had ultimately resulted in confirmation of three proposals on which to consult.

Members were reminded by Ms Jennings, in Slide 15, of the importance of acknowledging the University Health Board's responsibilities in terms of conducting an Equalities Impact Assessment. There had been a concerted focus during the consultation process on reaching disadvantaged and vulnerable people and the groups representing them. The University Health Board had arranged 45 events with a range of seldom-heard groups, who had provided a great deal of rich feedback during dynamic discussions. Further information regarding these events was provided in the appendices. The feedback obtained suggested that none of the proposals resulted in anything which specifically discriminated against any of the groups consulted; however, they made similar comments and shared similar concerns regarding the proposals as the general public. Ms Bethan Lewis presented Slide 16, Teulu Jones – Our Family, and reminded Members that Teulu Jones were developed to overcome a potential over-focus on buildings and existing facilities, and to refocus on what matters to, and the experience of, our patients. They were first used at a staff and stakeholder workshop to test and challenge our emerging options, however have featured in our Design

work ever since. The family are broadly representative of the population in terms of health and social issues, to reflect our demographics, and live in locations that would help test the emerging models. The TCS team worked with our Public Health Director to look at prevalence data to inform the family design, giving them conditions and health/care challenges that are more common in our area. Our clinical leads used their experience to develop scenarios for our family members to test the options. They will develop their lives and needs to show a journey through as changes as they happen.

Introducing Slide 17, Mrs Ryan-Davies summarised the aim of the Public Consultation process, which had been to: inform and provide opportunities for people to share their views about how the proposals have been developed; describe and explain the consultation proposals and what is and is not in scope; seek people's views on the proposals; ensure that a diverse range of voices is heard which reflect the communities involved; understand the responses made in reply to the proposals and take them into account in decision-making; ensure that the consultation process maximises community engagement and complies with legal requirements and duties; ensure that the consultation effectively captures views and feedback from our local communities, particularly individuals and groups potentially affected by changes proposed and representatives of groups with protected characteristics. Consultation methodologies were designed to be as accessible as possible and in a range of different formats. A particular emphasis was placed on engaging with staff and seldom-heard patient and population voices, and meeting people where they felt most comfortable. To support the consultation, a wide range of materials were developed for use on multiple platforms.

Dr Alan Williams presented Slide 18, A new model for community care, emphasising that the proposed community model is the foundation of the whole system model. This is based on provision of enhanced community and primary care available 24/7, delivered through integrated networks of care which include social care and third sector provision. It represents a change of focus from reactive treatment and intervention to prevention, early intervention and supporting people to manage their own health and wellbeing. Staff will be working in the local community providing care as close to home as possible. This represents a social model for health – not just health and care, also education, housing, leisure, etc. The model is asset based community-driven development (ABCD). All proposals for our hospitals would be supported by the community model previously outlined, and were detailed on Slide 19, presented by Mr Jeremy Williams. Each of the three proposals consulted on was described individually as follows:

Proposal A included:

- A District General Hospital at Bronglais General Hospital
- Glangwili, Withybush and Prince Philip Hospitals becoming Community Hospitals
- New build Urgent and Planned Care Hospital being located somewhere between Narberth and St Clears

Proposal B included:

- A District General Hospital at Bronglais General Hospital
- Glangwili and Withybush Hospital becoming Community Hospitals
- New build Urgent and Planned Care Hospital being located somewhere between Narberth and St Clears
- Prince Philip being retained as a Local General Hospital

Proposal C included:

- A District General Hospital at Bronglais General Hospital
- Withybush Hospital becoming a Community Hospital
- A new build Urgent Care Hospital somewhere between Narberth and St Clears
- Glangwili Hospital repurposed as a Planned Care Hospital
- Prince Philip Hospital being retained as a Local General Hospital

Slide 20, introduced by Mrs Ryan-Davies, focused on technical information with Members reminded that, as part of the consultation and to aid in decision making, a number of technical documents were developed in key areas namely: Population Health; Demand and Capacity modelling; Transport; IT and Digital; Finances; Workforce and Estates. These technical documents were developed as background to the main consultation document and to answer common questions that may have arisen. The documents were developed in conjunction with Enabling Groups; these groups being formed as part of the development process to sense-check all the proposals during the development phase. The Consultation Scope was reiterated in Slides 21 and 22.

At this point, Mrs Ryan-Davies introduced Mr Jonathan Lee and Ms Kelly Lock from Opinion Research Services (ORS), who had been commissioned as an external organisation to undertake an independent analysis of the consultation feedback on behalf of the University Health Board. Mr Lee introduced a presentation of their findings, first providing in Slide 25 background on ORS in terms of their history and experience. Members were reminded in Slides 26 and 27 of the information provided on community and hospital service proposals. Slide 28 detailed the purpose of consultation, with Mr Lee noting that this is a statutory responsibility when making changes to services. Organisations must listen and take concerns into account, and potentially reconsider proposals in the light of feedback. It was emphasised that consultation is not a referendum, not a 'numbers game' and not a popularity contest. It is for Health Boards to make decisions on the basis of all the evidence, of which consultation is only one element. The University Health Board's role was further outlined on Slide 29: to undertake consultation in a number of different ways, with it recognised that fundamentally different methods will mean that outcomes cannot be combined for a single answer. Different parts of the University Health Board's population will have different perspectives, and that these cannot necessarily be reconciled to provide a 'best overall' outcome. The ORS report does not and is not intended to provide an answer; it is intended to present 'what was said' and a range of other information to aid decision-making.

Slides 30 and 31 provided details of the feedback obtained during the consultation, including questionnaires, workshops, social media posts

and petitions. It was noted that questionnaire responses are not necessarily representative of the view of the population as a whole. Those who are perhaps more relaxed or unconcerned about the proposals also need to be heard, which is why survey workshops had been arranged, with participants selected at random. Staff workshops had also taken place. The UHB had arranged in excess of 140 meetings, with notes taken at all of these and provided to ORS. The 275 written submissions had been wide ranging in both form and source. All social media posts had also been fed into the consultation process. Five petitions had been received, with more than 50,000 signatures. Whilst Members were reminded that the consultation is not 'a numbers game', it is important to recognise that 50,000 people had signed petitions relating to the proposals. Slides 32, 33 and 34 considered and analysed the demographics of respondents, and responses by geographical area. In regards to the latter, responses had been highest in Pembrokeshire and around Llanelli, Aberystwyth and Lampeter. Again, numbers are not a determining factor in decision making; however this does demonstrate the strength of opinion in these areas. Moving on to Core Consultation Questions, Slide 37 revisited the need for change and examined support for this aspect of the proposals. There was widespread support for change, although certain individuals were dissatisfied about specific issues. Members noted that there was almost universal support for change across staff groups.

Moving on to consideration of Community Services, Slide 39 detailed the split in opinion in respect of proposed locations and services. It was noted, however, that the consultation asked about a number of proposals and locations, and that anyone disagreeing with any element would be classed as disagreeing overall. Mr Lee felt that it was important to recognise that 35% of the NHS employees who responded disagreed with proposals around locations, and suggested that this needs to be further considered. Slide 40 analysed agreement/disagreement levels by geographical area, which broadly repeated the pattern seen previously, suggesting that the proposals are clearly a cause for concern in those locations. Suggestions received during the consultation in terms of community services were detailed on Slide 41, with requests for additional community hubs, concerns regarding loss of community beds and recommendation of early trialling/piloting of hubs. Analysis around Planned and Urgent Care was introduced in Slide 43, with the majority of respondents agreeing that these should be separated. However, most suggested that they should be separated on the same site. Slide 44 provided in graphical form data on the split in opinion around the principle of a new urgent/emergency care hospital in the south of the region. Slide 45 provided data in the same format around the proposed location of a new urgent/emergency care hospital, demonstrating the highest levels of disagreement with any proposal. A number of Planned and Urgent Care Considerations were detailed in Slide 46; Mr Lee suggested that, whilst these will likely be taken into account, there were specific concerns which need to be acknowledged. These included access to the proposed location; potential migration of patients to Abertawe Bro Morgannwg University Health Board (ABMUHB); impact on recruitment; funding concerns,

particularly in the interim/transitional period; potential impact on Bronglais General Hospital. There were also competing arguments around the proposed location, suggesting that it could be both further east and further west.

In relation to the three proposals, and consideration of a preferred proposal, Slide 48 explained that support varied across the different consultation elements, and presented this in more detail. Support for the proposals also varied notably by area. There was, therefore, no clear strongest option. Slide 49 analysed feedback in terms of preferred option, from the open questionnaire, by area. Reflecting on the three proposals in turn, Slides 50, 51 and 52 presented feedback on the potential pros and cons of each and whether they had been supported by any groups in particular. It was noted that Proposal C had limited support and was not considered viable either financially or in terms of staffing. Slide 53 focused on the topic of alternatives, with more than half of residents in many areas supporting 'another alternative', particularly the retention of existing services. Others suggested an amalgamation of HDdUHB and ABMUHB, which was outside the scope of the consultation. Conclusions around support for the three proposals were detailed in Slide 54, with it noted that both Proposal A and B command support and that the University Health Board could reasonably pursue either of these two options, providing its final decision is informed by the full range of information available. Mrs Ryan-Davies thanked ORS for their contribution, and welcomed Mr Sam Dentten, Chief Officer, Hywel Dda Community Health Council (CHC).

Mr Dentten introduced a presentation entitled 'CHC Conclusions from "Our Big NHS Change"'. Slide 58 outlined the role of the Community Health Councils in terms of NHS planning and service change, which is set out in Welsh Government regulations/guidance. The participation and contribution of Hywel Dda CHC during the consultation was detailed in Slide 59, with Mr Dentten emphasising that the CHC will continue to listen to patients and service users. The CHC's views on the consultation were expressed on Slide 60; it was suggested that the consultation had begun a helpful conversation with the public, although it might be viewed as difficult for them and a great deal to ask due to the complexity and uncertainty involved. However, the public had taken part in the consultation process and their concerns must be recognised and respected by the University Health Board. Slides 61, 62, 63 and 64 outlined the CHC's views as the Board considers its next steps. It was suggested that this should be regarded as the start of a long journey rather than the end of a consultation period, with principles rather than detail having been provided at the early stages. Whilst the case for change is strong, people have concerns around accessing services and changes must lead to better care, not worse. More detail is required, particularly on those issues which have created the greatest concern; and the CHC is reserving its right to Ministerial Referral. There is a need for certain foundations to be in place, particularly effective and safe Primary Care and community services, transport, workforce planning and integration with Mental Health. Management capacity and risks also need to be considered, together with opportunities for innovation. There

is a need for the University Health Board to demonstrate how it will drive change while keeping on top of the day-to-day delivery of current healthcare services. Slide 65 provides a weblink to the full CHC commentary document.

Introducing the section on Conscientious Consideration, Mrs Ryan-Davies explained that this will briefly detail the process undertaken to give conscientious consideration to a range of factors informing future models of health and care within Hywel Dda UHB, which includes the consultation feedback received, and highlights the output from those sessions. The definition of and process applied to Conscientious Consideration was detailed on Slide 67; Members were informed that the UHB had undertaken a series of Conscientious Consideration Sessions between 14th August and 17th September 2018, with clinicians and wider staff and stakeholders. The outcomes of these sessions had fed into the final consultation Closing Report, and informed the recommendations. Conscientious Consideration sessions were outlined on Slide 68, including sessions with clinicians, staff and stakeholders (involving 120+ participants) and Equalities Groups. Discussions also took place with neighbouring Health Boards, Welsh Ambulance Services NHS Trust (WAST) and Local Authority partners. At each session, attendees were asked to read the findings thoroughly and to conscientiously consider everything they had heard in order to robustly test and challenge the initial proposals (and underpinning modelling assumptions, for clinical sessions). This involved considering everything 'in the round' from Phase 1 into Phase 2. The process then explored what impact the findings had on the proposals and the recommendations going forward. Attendees were reminded not to give any particular weighting to any individual aspect of the analysis. The output of each session was captured into a template or via written notes, which were collated and shared with the clinical conscientious consideration group members. Outputs from all sessions were discussed in detail at the second Clinical Conscientious Consideration session, on 6th September 2018. In order to inform the development of the final clinical recommendations to Board, the clinicians were asked to shape the recommendations on the basis of all the conscientious consideration, and reach a collective view on the emerging recommendations. On 10th September 2018, a Clinical Recommendations Group was convened to agree the final Clinical Recommendations to be taken forward for discussion at today's Board meeting.

On Slide 69, Members noted that as part of conscientious consideration, due regard needed to be given to consultee responses which contain innovative and credible suggestions or arguments not advanced by others. A key element is consideration of any alternative proposals or suggestions put forward as part of the public consultation. Mrs Ryan-Davies outlined the process for managing alternative proposals and suggestions which had been applied by the UHB. A number of alternatives were proposed, ranging from suggesting a small change to one of the proposals consulted on, to a suggestion for a completely different proposal. All alternative proposals or suggestions were

reviewed and categorised; the categorisation and proposed actions were reviewed and approved by Hywel Dda UHB's Executive Team on 29th August 2018. Mrs Ryan-Davies then outlined the process by which twelve alternative proposals had been considered, as detailed on the slide. This review highlighted that that there was only one alternative proposal that had previously been considered, and that was to maintain the status quo. The status quo had been ruled out at an early stage of the options development process and so no further action was taken. For the remaining alternative proposals and modifications, the same process that was used in the options development phase was followed, with modelling of options (including consideration of Travel; Flow/Beds; Zone for site of proposed new build; Affordability; Workforce) and scoring, following the same methodology employed during the options development phase. Any alternatives with a score greater than or equal to that scored by any of the three original proposals would progress to the next stage. Eleven alternative proposals or modifications were considered using this process. They were all reviewed by members of the ODAG, who each undertook a SWOT analysis. Whilst many useful suggestions were received, all of which were considered as part of the conscientious consideration, none of the alternative proposals or modifications to the proposals consulted on were assessed as being viable, although they have had a key role in informing the recommendations.

Dr Sion James introduced Slide 70, which summarised general reflections on the outputs from Conscientious Consideration. There is a consensus that the ORS analysis report reflected what was heard during the consultation, and what was heard during Phase 1, particularly support for more care closer to home; the separation of planned and urgent care; the need for more joined up services; the impact of travel and access, whilst noting that people are willing to travel to access specialist planned care. There is also recognition of the need for further detail in the next phase of work and concerns around language and terminology, with a particular issue being the 'hub' terminology. The high level of responses from Pembrokeshire in comparison with Ceredigion and large parts of Carmarthenshire is acknowledged, together with the petition in Pembrokeshire and the strength of feeling this indicates. There is also recognition of the importance of transport and anxiety around distance to access emergency care. Outputs suggest that there is a tendency of respondents to over-focus on the hospitals and buildings rather than development of the community model. Focusing particularly on the community model and outputs around this, as presented on Slides 71 and 72, Members heard that key feedback included the need for clarity around the types of service and locations of hubs; a perceived lack of detail in the proposals; and confusion around what services a 'hub' or a 'community hospital' would include. Also, the need to move away from buildings and 'hubs' to networks of care within a social model for health and wellbeing, focusing on prevention and self-care; the need to shift the focus away from community beds in buildings to supporting people in their own bed and embracing the alternatives to community beds. Provision of integrated and seamless care in the community, working alongside Local Authority and third sector partners

to deliver a whole system change; and the need to build upon and upscale existing successful locality driven initiatives, models and areas of good practice, and ensure consistency of approach where relevant. Outputs also noted the current fragility of community services, and the lack of permanent arrangements in both funding and staffing. There were suggestions that it is necessary to see the community model working in practice first, through exemplars and early implementer sites; also, that there is a need to demonstrate the concept of a network of care. Public perception of Community Hospitals is largely based on traditional models as opposed to the intended ambition for those sites, therefore this needs to be better articulated. There is a need to continuously engage and commit to co-designing the community model. Commitment to an enhanced community model, prioritised and progressed at pace, will provide real alternatives to traditional hospital based services. If co-designed and communicated effectively with the public, this will help to provide confidence; mitigate the impact of where buildings are located and help allay concerns expressed by consultees around access to care and support.

Conscientious Consideration Outputs relating to the Hospital Model were outlined in Slides 73 and 74, presented by Dr Robin Ghosal. Key messages included: widespread agreement that there was not enough support for Proposal C as a viable option and that it should therefore be discounted; Mixed support for Proposals A and B, with no clear preferred proposal and agreement that either could be progressed. There are two key differences between Proposals A and B: the provision of acute medicine at Prince Philip Hospital and the relevance to patient flows to Morriston Hospital; the number of acute hospitals and the impact this has on investment released for developing the community model. Elements of both proposals supported through the consultation were the separation of planned and urgent care, but on a single site; and a new hospital for the south of the Health Board area; the need for development of approaches and models to provide enhanced support to communities furthest from the main hospital services, which should mitigate the impact of where the centre was located. Strong messages were received during consultation against the removal of community hospital beds, with a particular focus on Amman Valley Hospital. There was a recognition that there may be increased patient flow to Morriston Hospital/ABMUHB in paediatrics and obstetrics due to the impact of the proposed location of the new build urgent and planned care hospital. The strength of feeling was evident in Pembrokeshire; including a large petition, associated predominantly with the proposed removal of A&E from Withybush. Feedback was also received around the ambition for, and sustainability of, Bronglais Hospital; consideration centred around the need to fully understand the impact of the location of a new hospital upon patient flows, and on clinical pathways, including Bronglais Hospital. There is a need for an ongoing assessment of the impact on demand and patient flows, and the impact of investment in the community model; and an agreement that an effectively functioning community model, focusing on health promotion and prevention, would reduce the reliance on hospitals and make the location of buildings less significant.

Dr Ghosal introduced Slide 75, which presented outputs around Other Considerations and Equalities Considerations. The following areas were identified as requiring further development and clarification:

- Transport and Infrastructure: the impact that transport and infrastructure has on travel and access to hospital and community services within any proposed model which, whilst universal, is intensified for the most vulnerable in society. Therefore there is a need to design and deliver travel and transport solutions as a key enabler to the proposed changes. It is also necessary to design and develop, through ongoing engagement with local communities, the additional provision required to support access for those communities with the longest travel times. Particular focus was given to public perceptions around emergency transport and concerns about distances from the proposed location of hospital services;
- Communication: the need for clear communication, using Teulu Jones, in ways that the public can understand, of the proposals for change and how they are described;
- Transition Planning: the anxieties caused from a perception that changes were going to happen immediately, and the impact this would have on service sustainability, and the need for clearly defined transition plans which demonstrate how changes will be phased to maintain business continuity. This will provide reassurance to the public that change will happen incrementally;
- Continuous Engagement: the need for a firm commitment to continuous engagement and co-design so that staff, the public and partners are involved with the final design and decisions. This will need to involve targeted engagement at a local level, and associated with specific pathways of care;
- Workforce and Resourcing: the need to address a number of key questions and areas for further consideration (such as successful recruitment and retention of adequate numbers of roles across community and hospitals, building a comprehensive skill mix working across organisations and regionally, and addressing potential de-stabilisation) through an extensive workforce re-modelling, planning and transformation plan, which should commence immediately.
- Alignment with Transforming Mental Health: the need to ensure full alignment across both TCS and TMH programmes.
- Equalities: There was overall agreement that the analysis report reflected what was said during the consultation. Participants emphasised certain key areas, which included: transport and access; the need for further information about what services will be delivered from community hubs and hospitals, and where they will be located; recruitment and workforce planning; and a recognition of the challenges surrounding Withybush Hospital.

Members were assured that Hywel Dda UHB will continue to work with key stakeholders, partner organisations and the people most affected, in order to work towards eliminating or reducing any potential disadvantage at any stage and explore opportunities to advance equality.

Presenting Slide 76 – Restating the Case for Change – Mrs Ros Jervis reminded Members that the Parliamentary Review of Health and Social Care Report, published in January 2018, makes it clear that the combined effects of an ageing population, a growing demand for complex and more specialised services and increasing workforce pressures mean that there is an urgent need to think innovatively about what the health and care system in Wales will look like in future. This is alongside all of the many challenges we have in delivering health care in Hywel Dda. The Board has, today, an opportunity to make decisions which could lay the foundations for healthcare going forward. Mrs Jervis advised that the next few slides would restate the evidence underpinning our Case for Change. Slide 77 focused on Population Health, with Members noting that the population of Hywel Dda is projected to experience significant growth, from an estimated 390,000 residents in 2016 to approximately 410,000 in 2036 – a projected growth of 7.3%. Much of this population growth will be accounted for by a growth in the proportion of older people, and oldest age groups in particular. In terms of population ageing, Hywel Dda has a higher proportion of people aged 75 years and older (10.3%) compared with Wales (8.9%) and marginally longer life expectancy at birth for both males and females. There is a projected marked rise in the number of people in oldest age groups, who are often economically dependent and in some cases care-dependent. Projections suggest that population ageing will continue at least until 2039, with the largest increase in our oldest population group (aged 75 years and over) which is projected to increase by approximately 30,000 people over the years 2014-2039. No other age group is projected to increase in count at such an accelerated rate.

Members were reminded that an older population is likely to cause a rise in chronic conditions, such as circulatory and respiratory diseases and cancers, which will impact on demand for our care services. Currently, demand for hospital and community services by those aged 75 and over is in general more than three times that from those aged between 30 and 40 (West Wales Population Assessment, 2017). The number of people living with chronic conditions is increasing and is projected to continue to increase in the future, with people living longer and developing more than one chronic condition. Data on chronic condition prevalence from GP Population Profiles on Public Health Wales Observatory, as at April/May 2016, show that Hywel Dda has higher than Wales prevalence of diabetes (HDdUHB 7.3%, Wales 7.0%), hypertension (HDdUHB 16.3%, Wales 15.5%) and coronary heart disease (HDdUHB 4.2%, Wales 3.8%). In terms of life expectancy, in Hywel Dda, life expectancy at birth for both males (78.9 years) and females (82.7 years) is longer than it is in Wales overall (78.1 years and 82.2 years respectively). That our population is living longer is undoubtedly something to celebrate. However, healthy life expectancy and disability-free life expectancy are rising more slowly than life expectancy in Hywel Dda. This means that life expectancy has improved more than the quality of life and health, suggesting an increased need for care and support over time. That people are living longer but not necessarily with improved quality of life suggests an increased need for care and support over time, particularly from age-related conditions such

as dementia. Rates of dementia in older people are set to rise. By 2021, it is predicted that there will be a 31% increase in dementia (Annual Report of the Director of Public Health 2016/17). There is a link between life expectancy and healthy life expectancy according to area based deprivation. Trends show that people in more deprived areas tend to have shorter life expectancy and healthy life expectancy than those in less deprived areas.

Dr Sion James summarised current challenges around our primary and community services, as detailed in Slide 78. It was emphasised that Primary Care is the foundation of health services; within Hywel Dda University Health Board (HDdUHB) it delivers in excess of 6 million episodes of care for our population every year. When it works well, it is often taken for granted; when it struggles and changes, it generates high levels of public and political anxiety. When it fails, it has a profound systemic impact, with the capacity to undermine and destabilise the rest of the healthcare system. Primary care is impacted by sustainable funding challenges. As Independent Contractors, Primary Care providers have had to manage the rising demand of service delivery, staff cost of living increases and the rising costs of consumables, utilities and locum cover, within a largely flat cash environment. Costs have increased in recent years due to the need to employ high cost locums in order to deliver a safe service. The University Health Board also now directly manages 5 GP Practices. Members were reminded that there are also pressures on social care, not least the insufficient number of carers in the community to provide social care for our ageing population. In addition, the limited number of care packages mean delayed discharges from hospital beds, which can cause considerable distress and unnecessarily long stays in hospital for patients. We rely heavily on the unpaid caring duties of our population, and they are vital to those they care for and to the foundation of the health and social care system. Figures from the West Wales Population Assessment suggest that around 1 in 8 people in West Wales, many of them young people, are providing unpaid care with a significant proportion providing between 20 to 50+ hours of unpaid care per week. Based on a national calculation conducted by Carers UK and Sheffield University in 2015 (Carers UK, 2015), the cost of replacing unpaid care in West Wales, can be estimated at £924m. This exceeds the NHS annual budget for the region which is almost £727m (Hywel Dda University Health Board 2016). The provision of unpaid care is becoming increasingly common due to our older population, and it is expected that the demand for unpaid care provided by spouses and adult children will increase as our population continues to age.

Presenting Slide 79, Mr Jeremy Williams emphasised that, whilst the majority of patients attending HDdUHB hospitals receive excellent care, there are challenges facing our hospitals. It should be noted that the statistics presented are representative of a point in time. A significant amount of work is ongoing to try and address our many challenges and some improvements are being made; however our current model hinders transformational progress. Specific aspects of performance in Secondary care were considered as follows: A&E waits: New A&E

attendances dropped from 14,684 in July 2018 to 13,987 in August 2018. However, performance for patients seen in Accident and Emergency and Minor Injury Unit (MIU) within four hours remained static at 82.9% (Integrated Performance Assurance Report (IPAR), August 2018). Length of stay (LOS): Average length of stay for medical emergency inpatients is 8.4 days (Performance Dashboard, USC dashboard August 2018). This does not compare favourably with the rest of Wales. Complex discharges and increasing numbers of medically optimised patients across the University Health Board is resulting in an increasing LOS. Protracted assessment periods also contribute to longer LOS; there is increasing evidence that frail elderly people are at significant risk of developing dependencies which occur as a consequence of hospitalisation as well as losing independence because of delays associated with interventions that support and enable them to maintain the skills they have. Breaches: The number of patients waiting 14 weeks or more for therapies has seen a decline in performance with 307 breaches in August 2018 compared to 287 in July 2018 (IPAR, August 2018). Referral to Treatment (RTT): RTT times vary, with the longest waits in orthopaedics at 97-100 weeks (Performance Dashboard, RTT, August 2018). The number of 36+ week breaches in August 2018 was 2,080. The University Health Board is currently on target with the delivery profile for 2018/19. The percentage of patients waiting less than 26 weeks from referral to treatment was 84.8% in August 2018. Both metrics have shown improvement during the past 12 months and August 2018 performance compares favourably to 3,394 reported breaches in the same month last year. Postponed procedures: In July 2018 the number of Hospital Initiated Cancellations (HIC) on the day and the day before was 166 which is higher than the 137 reported in June 2018 (IPAR, August 2018). In summary, Mr Williams stated that current performance levels are not acceptable, and that it is hoped this would be addressed and improved by a new model of care.

The case for change in relation to Workforce was presented in Slide 80 by Ms Bethan Lewis and Mr Andrew Burns. Members were reminded that the UHB has fragile rotas across 4 main hospital sites and a reliance on locum and agency staff in key posts. In the last year, despite innovative recruitment campaigns which involved running recruitment open days, overseas recruitment, and online recruitment campaigns, we are still left vulnerable in some areas and continue to use locum and agency staff in key posts, resulting in quality and financial risks. There are around 350-500 vacancies at any one time (350 live vacancies and an average 500 when including vacancies to be financially approved or on-boarding). Our present vacancy rate is just over 4% across all professional groups, with specific problematic areas including medical staff (8.9% vacancy) and nursing (5.2% vacancy). Certain areas are also high risk, with vacancies across a number of sites, for example Withybush, Bronglais, Glangwili General Hospitals. In addition, a number of community hospitals are supported by single handed consultants or have low numbers of support staff. There are also high risk areas within primary care, with GP vacancies, especially in more rural practices. There are a number of single handed GPs and a significant retirement profile. Most recent figures show 53 Full Time

Equivalent medical and dental locums (data from Hywel Dda UHB Workforce Intelligence) and a headcount of 95 GP locums (data from Hywel Dda UHB Shared Services). Of our current workforce, around 34% are currently over 51 years old, although our average retirement age is rising (from 61 in 2015/16, to 62 last year). 33% of our total workforce are between the ages of 46 & 55, with the latter end of that age profile able to consider retirement in certain circumstances in the next 5 years i.e. during the change. Changes to the pension scheme will mean, however, that the early retirement at 55 for some staff groups will cease in 2022. This older age profile presents both risks and opportunities as we reconfigure services; more people may choose to leave than to stay on beyond retirement age. This reduces our collective business intelligence, experience and peer support for new employees; critical during a period of change. It is believed that 80% of our future workforce already work with us; it is our job to support and enable them to fulfil their current roles and prepare them for future roles and to meet career aspirations. We need to ensure they are supported with flexibility, assurance frameworks and access to education and training, remembering that the health and well-being of our staff is paramount. We must ensure we have a flexible and adaptable workforce that is competent, confident and engaged. They will need different skills and competences to deliver care using new models, focusing on increased proactive care and supported by technology, allowing them to work differently. We also need to attract a new generation of workforce; a workforce that uses digital technology to enable them to optimise their day and improve the wellbeing of their patients and clients.

Ms Paula Evans and Ms Delyth Simons introduced Slide 81, which outlined the case for change in terms of facilities, estates and infrastructure. Members were reminded that HDdUHB estates range from 19th Century to modern day buildings, in varying degrees of functionality, condition and performance. Parts of the main hospitals are old, with some areas built over 60 years ago. Over 51% of our current estate is over 32 years old. This presents considerable challenges in terms of running costs, repairs and maintenance, meaning that it costs us more to keep our hospitals open and up to date. Furthermore it is essential to have facilities to support the provision of modern health care and know that some of our current facilities do fall short, in areas such as space and a lack of facilities such as en-suite bathrooms and space in general ward areas. Whilst this rarely impacts on the safety of patients or the quality of care received, it can often affect patient experience. Our total backlog maintenance stands at circa £61 million (2016/17) this is spilt into: High Risk Backlog (£2.9m) and Significant Risk Backlog £39.4m). Despite a considerable investment of around £136.5 million in our estate since 2008/09, there has not been a significant reduction in the backlog. This is mainly due to the ageing nature of large parts of the estate and because backlog reduction investments have been targeted on critical service improvements according to the priorities of the University Health Board. The opportunity to develop and modernise some of our existing sites is also very limited by a range of constraints, in particular the ability to build or extend any further and the infrastructure required to benefit from digital and technological

advances. There is a large backlog of investment required to bring our facilities and networks up to the required standard to support 24/7 services which are digital-first and paper-light. Our sites are often situated within remote areas, which means that staff members have to be flexible and able to access certain documents and meetings everywhere. There remain challenges with the understanding, uptake and utilisation of digital systems by both health professionals and the public due to multiple factors including lack of knowledge, training, system problems and perceived and real resilience challenges. For example, in our hospitals, patient observations data (temperature, blood pressure, etc.) is collected on paper and stored at the end of beds on wards. Historically the majority of Informatics investment was focused on the acute sector and, as a result, community staff are poorly served by Informatics technologies, which challenges any remote working. In addition, the technical challenges of making our clinical applications work on a mobile platform and suitable mobile coverage has limited the functionality and practicality. In a complex service delivery environment with annual numbers of contacts in the millions, reliance on manual processes and information flows, and the duality of paper and electronic systems creates the potential for significant errors and inefficiencies. However, a significant proportion of medical errors are due to the inadequate availability of patient information and account for considerable cost to the NHS each year.

Members were reminded by Ms Elaine Lorton, in Slide 82, of the organisation's financial challenges, with the challenges that the University Health Board faces being set against an increasingly testing financial backdrop. Overspend is growing year on year as we try to manage rising demand for healthcare services and increasing costs to provide healthcare to our population. It is recognised by the Board that, whilst we have made good progress in stabilising and improving the performance of the organisation in most other respects, financial performance has become the key factor in our continuing Targeted Intervention status and needs to be significantly improved in 2018/19. In the Annual Plan for 2018/19 a £62.550m deficit in-year was projected. However, following allocation of Zero Based Review funding totalling £27m by Welsh Government, the forecast deficit for 2018/19 is £35.5m. The figure of £27m is to address our issues of population, scale and rurality. Therefore the remaining £35m must be achieved through savings. The financial position remains an expression of the service challenges we face with ongoing and new cost pressures and the requirement to deliver savings targets. The financial position at the end of August 2018 is £15.7m deficit, £0.9m in excess of plan.

Dr Eiry Edmunds introduced, in Slides 83 and 84, the Clinical Recommendations to Board, emphasising that these represent the collective view of our clinicians, and that they reflect:

- A recognition of the need to respond to the case for change;
- A response to what we have heard in the public engagement and consultation;
- The views expressed by clinicians, staff and stakeholders in

conscientious consideration of the consultation feedback sessions;
- The outcome of a debate in a session with clinicians on 6th September 2018, and finalised and agreed in a follow-up session on 10th September 2018.

Each of the Clinical Recommendations was then presented in turn, as follows:

Recommendation 1 (Slides 85 and 86), emphasising the commitment to early co-design of the model in Pembrokeshire to address concerns expressed by the population there.

Recommendation 2 (Slides 87 and 88), with it noted that there is no decision on community hospital beds at this stage and that significant work with the local community will take place.

Recommendation 3 (Slide 89), requesting approval of the suggestion that Proposal C be discounted.

Recommendation 4 (Slides 90 and 91), noting the need to recognise the importance of neighbouring Health Boards, particularly ABMUHB. Also, to commit to work around clinical pathways in Maternity and Child Health which will ensure that consultant-led obstetrics, midwifery led care, acute paediatrics and neonatal care are maintained across Hywel Dda. To align TCS with the requirements of the Transforming Mental Health programme. Also, to commit to realising the ambition of the Mid Wales Joint Health & Social Care Committee, recognising the significance of Bronglais General Hospital.

Recommendation 5 (Slides 92 and 93), highlighting the intention to conduct a formal feasibility study and options appraisal of location options. Also, a commitment to work with those communities furthest from main urgent care and hospital services and to develop robust pathways for time-sensitive emergency conditions.

Recommendation 6 (Slide 94), with it noted that working with local people and partners will be key to ensuring we develop and deliver a plan for seamless care and support at these hospitals. Mr Andrew Burns advised that Withybush General Hospital had experienced a significant increase in demand during the previous week and had needed to work with local partners to resolve the resulting issues. The TCS proposals will offer similar and enhanced opportunities to work with partners.

Recommendation 7 (Slides 95 and 96), with Members reminded that access and transport had been a significant concern heard during consultation. It was noted that, whilst ambulance services have undergone significant changes, further movement away from the conventional model is required. During the consultation, alternative locations for the proposed new hospital had been suggested, as follows: Carmarthen Show Ground, Llanelli, Cross Hands, Newcastle Emlyn, Canaston Bridge, Haverfordwest. The UHB undertook modelling at a more granular level than previously, looking particularly at the longest

drive times to access Accident and Emergency care for each location, including our current configuration and three points within our proposed 'zone' (Narberth, St Clears, Whitland) for comparison. The outcome of this exercise was that none of the suggested alternative site locations proved to be a better option that the proposed zone. We also noted that the more granular modelling showed that the outputs of our previous modelling had been overly pessimistic, and that 100% of our population are within 1 hour (average drive time) of Narberth, Whitland or St Clears, Bronglais or Morriston Hospitals.

Recommendation 8 (Slides 97 and 98), noting that technology is a major enabler of the new model, improving access and efficiency and supporting people to manage their own health and wellbeing. As such, a great deal of work is required in this regard, with it being vital that staff have access to up to date patient information.

Recommendation 9 (Slides 99 and 100), highlighting that our new model will require a new staffing model including joint roles that span services, regions and organisations. We need to develop Advanced Practitioner roles and utilise the workforce in different ways. Planning with education and training providers must start now to take account of lead-in times, although there has been engagement with University and education partners throughout the course of the programme. We must address the potential impact on recruitment and retention of staff, to ensure sustainability both in the short and long term. We must involve our staff in co-design of the future workforce needed to deliver the proposed model. Our Organisational Development strategy must focus on supporting the organisation and individuals through transition to the future model.

Recommendation 10 (Slide 101), with it emphasised that continuous engagement with the public, our staff and our partners and co-design of our new model will be fundamental to our joint success.

Recommendation 11 (Slide 102), requesting approval of the further development of all recommendations into the draft Health Strategy for consideration at the Public Board meeting on 29th November 2018.

In his closing remarks, Dr Kloer thanked all of those involved in the presentation, noting the powerful messages received from staff on the frontline of clinical services. Members were reminded of the significance of decisions for both current and future generations of local people, and of the need for a clear strategic direction for the UHB. It is hoped that the proposed changes will attract new staff to the area, assisting with the recruitment challenges experienced for some time. However, the key driver must be to ensure improved services for the public, with safer and better care. Dr Kloer also thanked ORS and the CHC for their contribution, acknowledging that a great deal more detail is required. This process offers opportunities for staff, the public and stakeholders including the CHC, to help the University Health Board to design local healthcare services. Members were assured that the UHB will work with its partners to consider infrastructure and training needs, among others.

Dr Kloer concluded by reminding Members of our responsibilities as a Health Board, detailed in Slide 3 of the presentation. Mrs Rees thanked Dr Kloer and everyone who had presented to the meeting, and opened the floor for questions.

Ms Delyth Raynsford requested assurance with regard to the involvement of children and young people in the consultation process; suggesting that there is a lack of evidence of their involvement. Members were reminded that this group represents both current and future service users, and potentially the UHB's future workforce. Ms Jennings advised that the consultation process had taught the organisation a great deal about how to reach new audiences. A video aimed at young people had suggested, by the number of 'shares' and 'likes' on social media platforms, that the UHB had reached groups it had not previously accessed. It was acknowledged, however, that opportunities exist for applying the knowledge gained to take this further, for example by work with local partners, schools and youth groups, police and the probation service. Ms Jennings noted that younger people tend to use different social media platforms from those utilised during the consultation process. It had been clear, however, from the feedback received from children and young people, that they have specific opinions, queries and concerns, which need to be listened to and addressed. Cllr. Simon Hancock assured Members that the UHB's aspiration to create a new community care model is shared by the three Local Authorities, and welcomed their identification as key partners on a number of occasions during the presentation. Cllr. Hancock noted that good work is already taking place within the region, and encouraged the organisation to prioritise developing links with Local Authorities in this regard. Vital improvements to infrastructure will release healthcare professionals to provide care.

Mr David Powell drew attention to one particular area of feedback, detailed on page 16 of the SBAR, relating to 'meeting the challenges'. Mr Powell expressed concern that there were low levels of agreement that any of the proposals would successfully meet the challenges and suggested that Members require assurance that they will. Also, this feedback suggests that the organisation needs to address public perception in this regard. Mr Steve Moore acknowledged this as an important point, noting that consistent concerns had been expressed during the consultation regarding whether the proposals were the correct approach. It was emphasised, however, that delivery of the current model of care is becoming increasingly untenable. Whilst it is difficult to provide guarantees that a new model of care will address challenges, the proposals put forward offered the best chance of improving services, which must be the priority. Mr Moore recognised the need to work with clinicians and partners, particularly in regards to workforce planning. Ms Jill Paterson emphasised the importance of the relationship between the public and Primary care services. Whilst there are significant fragilities in this sector, Ms Paterson was encouraged by recent engagement of all parties, including the public, in considering the strategic direction going forward. The proposals offer vital opportunities to invest in, develop and build on existing examples of good practice in community services.

Professor John Gammon noted that workforce, education, recruitment and training have been key recurrent themes. Nationally, it is recognised that the current NHS is not fit for purpose in terms of training its future workforce. With particular reference to rural healthcare, current training is too secondary care focused and too focused on urban areas. Professor Gammon requested clarification regarding how either option will support the training of healthcare workers for rural communities. Mrs Lisa Gostling acknowledged the need to ensure that the organisation has a workforce fit for the future, and the need to work with education providers to this end. Members were assured that the UHB will continue to develop its 'Grow your Own' career strategy, and will look to develop new innovative roles. It will work with education providers to ensure that rural health experience and experience in an urban setting are given equal regard. Discussions with Health Education and Improvement Wales (HEIW) are ongoing, and consideration will also be given to alternative routes to training and local delivery of training. Members were reminded that 80% of today's workforce will be the future workforce, and the need to engage with current staff. Mrs Rees emphasised that the organisation must ensure that the service model is correct, in order to effectively recruit staff. Professor Gammon, referencing quality and safety of care, recognised the anxieties and need for assurance among the local population; emphasising the need to ensure that services during the transitional period and beyond will be safe, sustainable and of sufficient quality. Mrs Mandy Rayani reminded Members that the Quality Improvement Framework, approved by Board, sets out 5 key priorities, as follows: No avoidable deaths; Protect patients from avoidable harm from care; Reduce duplication and eliminate waste; Reduce unwarranted variation and increase reliability; Focus on what matters to patients, service users, their families and carers, and our staff. Members noted that the Quality Dashboard is being developed, which will assist in this regard. Mrs Rayani recognised the need to utilise feedback from patients and services users, including children and young people. Mr Moore emphasised that the workforce will be a key enabler for delivery and, as such, must be at the centre of plans. Defining a clear future strategy as an organisation will allow more effective workforce planning. Examples from across the world had been examined; however none have or are undertaking anything at a similar scale, and Mr Moore would encourage any interested parties to join the organisation at this exciting point, to help shape and design future services. As stated, quality and safety must be at the core of the health strategy, and Members noted that there are likely to be challenges to face, particularly during the transitional period.

Mrs Judith Hardisty requested assurance that, as suggested in Recommendation 1, the community model will be developed at pace. Also, that workforce plans will include the Primary Care workforce, particularly as staff in this sector are not generally employed by the UHB. Finally, that there is engagement with carers throughout the process to ensure that their views are reflected. Responding to the first query, Dr Kloer confirmed the intention to maintain momentum and pace; explaining that planning and approval of the new hospital will take

time and that changes to the primary and community care model will need to be put in place. Members were assured that changes are already being made, with a move away from the traditional approach to Primary care. Development and uptake of digital technology will be key, although this will require investment. There is also a need to 'scale up' successful projects, whereby community services can support people in crisis to remain at home under certain circumstances, rather than default automatically to A&E attendance. In terms of workforce, Dr Kloer advised that steps are being taken already, with medical students undertaking training placements in rural GP practices. Referencing Mrs Hardisty's comment regarding carer involvement, Dr Kloer acknowledged that in the 7 localities, carers will be as important as doctors. Ms Jennings confirmed the intention to integrate health and social care, with approval of the clinical recommendations providing a mandate to accelerate the pace of change in joint commissioning of services. Integration must be regarded as a fundamental element to the whole process. Mr Adam Morgan reiterated that staff will be key to the delivery of TCS proposals and emphasised the need to empower staff to change services and thereby build trust, or risk potential disengagement. Mr Morgan also highlighted the need to 'future-proof' plans and build in the flexibility for staff to deliver healthcare requirements as they change further in the future. Acknowledging that the Board is required to consider all available evidence, Dr Kerry Donovan assured Members that a range of professionals had been involved and engaged in the process. Senior clinicians and managers have worked hard to maintain fragile rotas, and Dr Donovan felt confident that this work will continue. Finally, Dr Donovan emphasised the need to support the UHB's workforce through the TCS changes, recognising the impact of uncertainty; and encouraged the organisation to think more radically in terms of roles, with the associated workforce planning in advance.

Noting the organisation's ambition for services to be 'safe, sustainable, accessible and kind', Ms Anna Lewis queried whether these four elements are compatible, or whether there is potentially a need for 'trade-offs'/compromises. Secondly, there is a suggestion that clinical outcomes will improve; Ms Lewis enquired what form of system will be employed to evaluate this, and about opportunities for the local population to be involved. Dr Kloer acknowledged that 'safe, sustainable, accessible and kind' services is a high bar to set, and that everyone will have an individual view on what, for example, constitutes 'safe'. There is no perfect measure by which to judge each element. In response to Ms Lewis' second query, Dr Kloer advised that there is a range of indicators around quality and safety which are monitored. It was acknowledged, however, that all healthcare services struggle in terms of a suitable suite of outcome measures. Dr Kloer reminded Members that the UHB is working with Swansea University on establishing Value Based Healthcare outcome measures, which will contribute significantly in this regard. In terms of community involvement, Mrs Jervis noted that, whilst it is possible to measure outcomes quantitatively, qualitative measurement is also important. Mrs Jervis suggested that the UHB needs to work with the community to develop its understanding of patient stories and the patient experience. Referencing the four

principles, Mr Moore acknowledged that of these, accessibility is probably of most concern to most people. However, the organisation should be confident of its ability to improve on all four, providing the correct community model is in place.

Noting that the presentation had recognised a variation in provision and health inequalities, for example the 10 year gap in life expectancy between different areas; Mr Owen Burt queried how the UHB can ensure that those most likely to be affected by health inequalities (not only those with protected characteristics) will be involved in the change process. Whilst Mr Burt was impressed by the consultation and engagement process, he noted the need for ongoing engagement which brings with it a risk of 'consultation fatigue'. Ms Jennings highlighted the work which has taken place with various vulnerable groups beyond those with protected characteristics, and suggested that plans around how the UHB engages with these groups and individuals be presented to a future Board meeting. In response to concerns about 'consultation fatigue', Ms Jennings explained that it will not be necessary to consult with the whole population about every aspect again; there will be a focus on specific areas. A work plan will be developed, followed by engagement with the relevant groups. Mrs Rees suggested that focused engagement at an operational level in each of the 7 localities would be a sensible approach. Mrs Jervis noted that those experiencing health inequalities often do not see themselves as disadvantaged and that the UHB needs to ensure that it does not 'label' them as such. Mr Paul Newman enquired when Members are likely to be provided with more detail in terms of financial modelling, in order to be assured that proposed services are sustainable from this perspective. Mr Huw Thomas advised that this will form part of the strategy being presented to Board in November 2018, although it will be at a high level in the first instance, with capital and revenue costs to be brought forward as part of the business case.

Reporting discussions at the Stakeholder Reference Group, Mrs Hilary Jones advised that, whilst there was a general consensus to move forward with proposals, it was felt that the differing views of communities and the challenges made by specific communities should be acknowledged. There had also been a suggestion that a 'show home/ show hub' be established, to demonstrate how this concept will work in practice. Whilst Mrs Rees noted this suggestion, she was concerned that, with variances between communities, it may not be that 'one size fits all'. The concerns expressed, particularly by communities in Pembrokeshire, were however acknowledged by Mrs Rees. Dr Owen Cox emphasised that enhanced integration of community care and health and social care will be crucial to the success of TCS. It was suggested that any development would require cuts in services elsewhere. Noting that the UHB has consistently returned a financial deficit, and that plans would require 'pump-priming', Dr Cox expressed concern that financial constraints will prevent the development of community services necessary for delivery. Mr Moore stated that, whilst there is currently no easy or straightforward response to this concern, a change is required and more detail will be provided in November 2018.

Opportunities for funding do exist, such as the national Transformation Fund, and increased integration may result in a larger pool of resources. Mr Moore looked forward to working with all services, including Primary Care and community services. Mrs Rees added that the UHB will need to discuss the potential for transitional funding with Welsh Government; recognising that whilst there is a certain amount the organisation can achieve internally, there will be an element of 'double-running' during the transitional period.

Prior to consideration of the clinical recommendations, it was agreed that the CHC's position and recommendations would be formally supported and adopted. In considering each of the clinical recommendations individually, the following additional comments were made:

Recommendation 1 – It was suggested that the wording around working with Local Authority partners and wider partners to integrate health and social care be strengthened. It was further suggested that the recommendation be made more specific in terms of safety.

Recommendation 2 – It was emphasised that there is no decision on closure of community hospital beds and that the UHB will be working with local communities in the design and development of plans.

Recommendation 3 – No additional comments.

Recommendation 4 – It was emphasised that repurposing Glangwili and Withybush General Hospitals does not mean closing these sites. There is a need to work with neighbouring Health Boards, particularly ABMUHB. Also, to commit to work around clinical pathways in Maternity and Child Health, and to realising the ambition of the Mid Wales Joint Health & Social Care Committee.

Recommendation 5 – It was emphasised that there will be no 'short cuts' and that there will be further engagement and consultation around the proposed new Planned and Urgent Care hospital.

Recommendation 6 – No additional comments.

Recommendation 7 – It was emphasised that there will be continuing and ongoing engagement. In terms of transport, it was suggested that it would be sensible to work with Welsh Government around the need for improvements to the A40, and to work with Local Authority partners in this regard. It was recognised that WAST is also crucial to any new service model. It was suggested that the UHB needs to formally state the case on behalf of its population for provision of 24/7 Emergency Medical Retrieval and Transfer Service (EMRTS), Cymru inter-Hospital Acute Neonatal Transfer Service (CHANTS) and continuation of 24/7 responsive Wales and West Acute Transport for Children (WATCh) services. Emergency transport, non-emergency transport and road/rail transport all need further consideration.

	Recommendation 8 – It was noted that maximising the use of technology and developing the required IT infrastructure is not necessarily entirely within the gift of the organisation. There is, however, work in this field taking place on an All Wales basis, and the Welsh Government document 'A Healthier Wales: our Plan for Health and Social Care' signals the direction of travel/policy direction. Recommendation 9 – It was recognised that Welsh is the first language for a significant proportion of the population, and that it is also important to offer opportunities for staff to train and work using the Welsh language. The ambition to provide care in Welsh should be reflected in the recommendation. Recommendation 10 – No further comments. Recommendation 11 – No further comments. In response to a query from Mrs Rees regarding what the Board can expect to see in November 2018, Dr Kloer emphasised that there is only a relatively short period of time between now and then to put together the health strategy. Whilst it is recognised that more detail is required in November 2018, the full process will take a number of years. Dr Kloer acknowledged that there is a need to bring together health and well-being work. Mrs Rees thanked all of those involved in today's meeting, including Board Members and presenters. Whilst it is recognised that not all parties will be fully supportive of the outcome, Mrs Rees emphasised the organisation's commitment to continued engagement with staff and the local population.	
	The Board **APPROVED** completion of Stage 2 of the consultation process (public consultation) and, reflecting the amendments suggested above, **APPROVED** the clinical recommendations as follows: **<u>Recommendation 1</u>** The Board **APPROVED** the integration of health and social care to deliver an integrated community model, based on an integrated social model for health and well-being (the model), at pace. Working with social care and other partners, this will be a long term commitment focused on prevention, well-being, early intervention and help build resilience to enable people to live well within their own communities. In addition, the Board **COMMITTED** to: • stabilising and investing in the model, to build on and scale up local and cluster led initiatives and services which are already provided; • identify and develop opportunities for local people to be able to see the model working in practice, with specific consideration to the geographical areas highlighted in the consultation response as gaps in current provision; • demonstrate real commitment to the model by resolving current uncertainty caused by temporary funding and short / fixed term contracts, which stifle development of and confidence in this model;	

- work with local people to design together how the model will work in their area, to ensure that it is fit for future generations and beyond. This will include clearly describing what is meant by integrated networks, moving away from the term “Hub”; enabling help and support to be accessed in a variety of ways including both face to face and virtually;
- concentrating on early co-design of the model in Pembrokeshire, in response to the strength of feeling expressed throughout the consultation in terms of a loss of services, with particular focus on an enhanced 24/7 community response;
- a whole system approach to the model where social, primary and secondary care are not seen in isolation but work together to provide seamless care for local people.

Recommendation 2

The Board **APPROVED** the development of a plan for the existing Community Hospitals, working with local communities. This plan will be focussed on the provision of ambulatory care including out-patient services, diagnostics, treatment, observation, rehabilitation and end of life care. In addition the Board **COMMITTED** to:

- address the concerns regarding the removal of community hospital beds, working with local people to explore the potential for a range of different types of beds within the local community, whether in hospital, at home or another setting, built around the needs of the person;
- develop a transition plan where any change in the provision of community hospital beds takes place in a phased way and takes into account the development and impact of the proposed model;
- support the development of a robust commissioning model, including independent and third sector provision, based on local need and demand.

Recommendation 3

The Board **AGREED** that proposal C should be discounted, as the separation of planned and urgent care on different sites was not supported.

Recommendation 4

The Board **APPROVED** a modification of the remaining proposals for delivering hospital services, to include:

- a new urgent and planned care hospital in the South of the Health Board area;
- acute hospital services retained and developed in Bronglais General Hospital;
- acute medicine retained at Prince Philip General Hospital;
- a repurposed Glangwili General Hospital and Withybush General Hospital offering a range of services to support a social model for health and well-being, designed with local people to meet their needs.

In addition, the Board **COMMITTED** to:

- develop a long term plan that enables the delivery of acute medicine

over time to be tested and challenged, and to be responsive to demand and patient flows associated with the proposed changes;
- develop a transition plan to transfer emergency and urgent services from existing General Hospitals in a safe and sustainable phased way, dependent on the development and impact of the model and the new Urgent and Planned Care Hospital;
- ensure continued close working with ABMUHB in order to align the developing Health Strategy with ABMUHB's developing Clinical Strategy, ensuring a focus on maximising opportunities for effective regional pathways;
- a focussed piece of work on clinical pathways to model the impacts and opportunities of the new hospital configuration and community model for Maternity and Child Health. This will examine a range of options which will ensure consultant-led obstetrics, midwifery led care, acute paediatrics and neonatal care are maintained across Hywel Dda;
- guarantee complete alignment with the requirements of the Transforming Mental Health Programme to ensure mental health and learning disability assessment and treatment units are provided at the new urgent and planned care hospital, with fully integrated mental health and well-being services in the community;
- realising the ambition of the Mid Wales Joint Health & Social Care Committee, recognising the strategic importance of Bronglais Hospital in the sustainable delivery of services for the populations of Ceredigion, Powys and South Gwynedd.

Recommendation 5

The Board **APPROVED** the progression of a proposed new Planned and Urgent Care hospital on a single site through the business case process (Five Case Model). In addition, the Board **COMMITTED** to:

- progress consideration of location options within the defined new hospital zone, between Narberth and St. Clears, through a formal feasibility study and options appraisal to robustly consider all potential impacts;
- work with local people to develop models to provide enhanced support to those communities furthest from main urgent care and hospital services;
- consider the impact and opportunities a new hospital in the south of the Health Board area would provide to Bronglais General Hospital and the population of mid-Wales;
- develop a plan for the approach to managing emergency conditions which are time-sensitive.

Recommendation 6

The Board **APPROVED** development of a plan to redesign the remaining main hospital sites, working with local people, to maximise the range of services and support available aligned to the proposed model, and a new Urgent and Planned Care Hospital. In addition, the Board **COMMITTED** to:

- working closely with Local Authorities, Third Sector partners, and other agencies to develop and deliver a plan for provision of seamless care and support at these hospitals.

Recommendation 7

The Board **APPROVED** the development of a detailed plan to address the significant concern heard during the consultation regarding access, travel, transport and infrastructure, ensuring a focus on exploring innovative approaches to accessing care and support. In addition, the Board **COMMITTED** to:

- engage with the Regional Transport Group to contribute to the development of the Strategic Transport Plan to consider the opportunities which developments in road and rail infrastructure could provide for both staff and public travelling to or visiting our future health and care services;
- develop a plan to commission community access solutions, building on and scaling up existing successful models;
- engage specifically with local equality groups to ensure consideration is given to the particular access needs of people with protected characteristics and those most vulnerable in our population;
- work closely with WAST to commission Ambulance Services that are not exclusively based on the conventional vehicle based model, which better support the delivery of services within the community, and focus on accessibility for our whole population;
- formally state the Health Board's support for provision of 24/7 Emergency Medical Retrieval and Transfer Service (EMRTS), Cymru inter-Hospital Acute Neonatal Transfer Service (CHANTS) and continuation of 24/7 responsive Wales and West Acute Transport for Children (WATCh) services.

Recommendation 8

The Board **APPROVED** the development of a plan to maximise the use of technology as a key enabler to the delivery of the proposed model underpinned by secure IT infrastructure with sufficient back-ups, so that patient data is safe, timely and secure. In addition, the Board **COMMITTED** to:

- ensuring that digital technology drives improvement and efficiency, and changes the way people can access and engage with services and manage their own health and wellbeing;
- working with national and regional partners, under a revitalised 'Once for Wales' approach which sets standards and expectations aligned to common platforms where there are clear benefits of working in this way;
- support the development of a fully integrated information system which joins up community health care and social care records, so that all staff working in community settings can appropriately share information, with the aim of people no longer needing to repeatedly explain their individual circumstances and medical history on numerous occasions;
- within this fully integrated information system, maximize the use of innovative technology enabled care, which meets the individual patient's needs in their own homes, promoting greater self-care and wellbeing through the use of self-help apps, information apps and 24/7 medical status recording devices;
- invest in modern technology to provide on-line clinics, on-line

	appointment bookings and telehealth to use our resource more wisely. **Recommendation 9** The Board **APPROVED** the development of a workforce redesign and transformation plan – starting now and forward planning – to enable delivery and sustainability of the future model. In addition, the Board **COMMITTED** to: • explore innovative new roles including joint roles that span services, regions and organisations; • work closely with education and training providers to confirm the training requirements to deliver the new model along with clear educational lead in times; • develop a recruitment strategy which addresses the potential impact on recruitment and retention of staff, to ensure sustainability both in the short and long term; • a process whereby staff co-design the future workforce needed to deliver the proposed model; • providing opportunities for the workforce to train, work and live through the Welsh language; • develop an Organisational Development strategy to support the organisation and individuals through transition to the future model. **Recommendation 10** The Board **REAFFIRMED** its commitment to continuously engage in innovative ways, and support co-production between staff, and local people, partner organisations and other interested parties with a particular focus on engagement and co-design with those most vulnerable in our population, and those with Protected Characteristics, as set out in the Equalities Act (2010). This includes the co-design of integrated local care and support, clinical pathways and innovative ways of working together. **Recommendation 11** The Board **APPROVED** the further development of all recommendations into a Health Strategy for consideration at the Public Board meeting on 29th November 2018.	

PM(18)160	**DATE AND TIME OF NEXT MEETING**	
	9.30am, Thursday 27th September 2018, Ceredigion County Council Chambers, Penmorfa, Aberaeron, Ceredigion SA46 0PA	