Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

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

Date of Meeting:	**9.30AM, THURSDAY 30 NOVEMBER 2023**
Venue:	**BLOOMFIELD HOUSE COMMUNITY CENTRE, REDSTONE ROAD, NARBERTH, PEMBROKESHIRE**

Present:	Mrs Judith Hardisty, Interim Chair, Hywel Dda University Health Board Mr Maynard Davies, Independent Member (Information Technology) Cllr. Rhodri Evans, Independent Member (Local Authority) Mr Michael Imperato, Independent Member (Legal) Ms Anna Lewis, Independent Member (Community) Ms Ann Murphy, Independent Member (Trade Union) Mr Winston Weir, Independent Member (Finance) Mrs Chantal Patel, Independent Member (University) (part) Ms Delyth Raynsford, Independent Member (Community) Mr Iwan Thomas, Independent Member (Third Sector) Mr Steve Moore, Chief Executive Professor Philip Kloer, Executive Medical Director and Deputy Chief Executive Mr Andrew Carruthers, Executive Director of Operations Mr Lee Davies, Executive Director of Strategy and Planning Dr Ardiana Gjini, Executive Director of Public Health Mrs Lisa Gostling, Executive Director of Workforce and Organisational Development Mrs Mandy Rayani, Executive Director of Nursing, Quality and Patient Experience Ms Sharon Daniel, Deputy Director of Nursing, Quality and Patient Experience Mr James Severs, Executive Director of Therapies and Health Science Mr Huw Thomas, Executive Director of Finance
In Attendance:	Ms Jill Paterson, Director of Primary Care, Community and Long-Term Care Mrs Joanne Wilson, Director of Corporate Governance/Board Secretary Ms Alwena Hughes-Moakes, Communications and Engagement Director (VC) Ms Helen Williams, Deputy Regional Director, Llais (deputising for Ms Donna Coleman, Regional Director, Llais) (part) Dr Marcus Andrews, Paediatric Consultant (part) Dr Kathryn Lewis, Paediatric Consultant (part) Mr Nick Williams Davies, Service Delivery Manager, Acute Paediatric and Neonatal Service (part) Ms Yvette Pellegrotti, Principle Programme Manager (part) Mr Kester Holmes, Head of Research Projects, ORS (part) Ms Angharad Davies, Senior Researcher, ORS (part) Ms Clare Moorcroft, Committee Services Officer (Minutes)

Agenda Item	Item	Action
PM(23)201	**INTRODUCTIONS & APOLOGIES FOR ABSENCE**	
	The Interim Chair, Mrs Judith Hardisty, welcomed everyone to the meeting, including Ms Sharon Daniel. Apologies for absence were received from: • Donna Coleman, Regional Director, Llais	

PM(23)202	**DECLARATION OF INTERESTS**	
	The following declarations of interest were made: • Mrs Chantal Patel – discussions relating to Welsh Health Specialised Services Committee (WHSSC) • Ms Ann Murphy – discussions relating to Industrial Action • Mrs Judith Hardisty – discussions relating to the West Wales Regional Partnership Board (RPB)	

PM(23)203	**MINUTES OF THE EXTRAORDINARY PUBLIC MEETING HELD ON 14 SEPTEMBER 2023**	
	RESOLVED – that the minutes of the meeting held on 14 September 2023 be approved as a correct record.	

PM(23)204	**MINUTES OF THE PUBLIC MEETING HELD ON 28 SEPTEMBER 2023**	
	RESOLVED – that the minutes of the meeting held on 28 September 2023 be approved as a correct record.	

PM(23)205	**MINUTES OF THE ANNUAL GENERAL MEETING HELD ON 28 SEPTEMBER 2023**	
	RESOLVED – that the minutes of the Annual General Meeting held on 28 September 2023 be approved as a correct record.	

PM(23)206	**MATTERS ARISING & TABLE OF ACTIONS FROM THE MEETINGS HELD ON 14 SEPTEMBER AND 28 SEPTEMBER 2023**	
	An update was provided on the table of actions from the Public Board meetings held on 14 September and 28 September 2023, and confirmation received that all outstanding actions had been progressed. In terms of matters arising: **PM(23)173 (PM(23)124)** – Mrs Hardisty enquired whether a date has yet been determined for resolution of issues in relation to the Regional Partnership Board (RPB) Memorandum of Understanding (MOU). Acknowledging that this matter has been pending for some time, Mr Huw Thomas responded that, unfortunately, it remained unresolved. It has been escalated via the RPB Integrated Executive Group (IEG) and responses from Local Authority partners were awaited. **PM(23)181** – on the topic of food and drink provision for patients waiting in A&E, Mrs Mandy Rayani advised that vending machines are due to arrive this week, and she would be checking that this is the case. Noting the separate update around the Children and Young People's (CYP) Group, indicating that outputs are reported to the relevant assurance Committee of the Board. Mr Maynard Davies requested clarification regarding the Committee involved. In response, Mr Andrew Carruthers explained that this would depend on the nature of the topic. For example, a number of issues have been reported to the Quality, Safety and Experience Committee (QSEC). For assurance, Ms Delyth Raynsford, Children and Young People's Champion, advised that she	**MR**

	sits on the CYP Group and makes recommendations regarding referral of issues to the relevant Committee.	

PM(23)207	**REPORT OF THE CHAIR**	
	Mrs Hardisty presented her report on relevant matters undertaken by the Chair since the previous Board meeting, noting that the report covers the period of Miss Maria Battle's tenure ending and Mrs Hardisty taking on the role of interim Chair. The Board's condolences were expressed to the families, friends and colleagues of the two members of staff noted in the report who had died in service. Mrs Hardisty wished to highlight the staff and teams recognised in the 'Celebrating Success/Awards' section on pages 3-6 and congratulated all of those involved. Focusing on the update on page 6, Mrs Hardisty paid tribute Miss Maria Battle on her retirement from the Health Board. Members heard that Mrs Eleanor Marks has been appointed Vice-Chair of the Health Board, and will take up this post in February 2024. Until then, Mrs Hardisty was pleased to record that Cllr. Rhodri Evans has agreed to act as Interim Vice-Chair. There is no further update at present in terms of the appointment of a substantive Chair. Members were reminded that this is Mrs Mandy Rayani's final Board meeting, as she is retiring from her role as Director of Nursing, Quality and Patient Experience in December 2023. Mrs Hardisty stated that Mrs Rayani has made a remarkable contribution to the Health Board and will be much missed. On the topic of awards, Ms Raynsford wished to formally congratulate the Health Board's Maternity services teams on their achievements. These illustrate and demonstrate good practice, which is especially pleasing with the current focus on maternity services nationally.	
	The Board **SUPPORTED** the work engaged in by the Chair since the previous meeting and **NOTED** the topical areas of interest.	

PM(23)208	**REPORT OF THE CHIEF EXECUTIVE**	
	Mr Moore also wished to recognise Mrs Rayani's contribution and record his sincere thanks to her, both personally and on behalf of the Board. Mrs Rayani had put quality and safety at the heart of all Health Board activities and had changed the organisation's culture. The improvement culture she had introduced and promoted would be her legacy. Mr Moore said that it had been a joy working with Mrs Rayani and that she would be greatly missed. Members were advised that this was Mr James Severs' first Board meeting since taking up his role as Director of Therapies and Health Science. Mr Severs has already made a significant impression in his short time with the Health Board, and Mr Moore looked forward to working with him. Introducing his report updating on relevant matters undertaken since the Board meeting held on 28 September 2023, Mr Moore highlighted updates from the most recent Targeted Intervention and Joint Executive Team meetings with Welsh Government. A further update will be provided via the usual report to the Audit and Risk Assurance Committee (ARAC). The tone expressed by Welsh Government had been more positive. With regard to the financial position, it was noted that the Board is aware of the scale of the issue and steps being taken; in respect of the Clinical Services Plan, the Health Board must consider how it maintains services between the current time and implementation of its Strategy; in terms of regional	

	working, the Health Board should ensure it is working together with its partners and neighbouring Health Boards to address the waiting time challenges. Mr Moore drew Members' attention to information within the report around the South Wales Sexual Assault Referral Centres (SARC) Regionalisation Programme. Following a number of years of work, this matter is progressing further. The funding requested is within planned expenditure. On this topic, Mr Maynard Davies noted the request for approval of an in year funding uplift of £347k, and requested further clarification regarding the Health Board's financial commitment. Mr Moore explained that £347k is the regional figure; the Health Board's contribution is £139k.	
	The Board: • **ENDORSED** the Register of Sealings since the previous report on 28 September 2023 • **NOTED** the status report for Consultation Documents received/ responded to • **AGREED** to the updated governance structure of the UHB's Joint Escalation and Intervention status and the updated Terms of Reference for the Escalation Steering Group; the standing down of the Enhanced Monitoring Working Group and the Targeted Intervention Working Group, with the Escalation Steering Group continuing • In relation to the South Wales Sexual Assault Referral Centres Regionalisation Programme: o **CONSIDERED and APPROVED** the updated South Wales Sexual Assault Referral Centres (SARC) Regionalisation Programme model o **APPROVED** the request of the NHS Wales Chief Executives that the WHSSC Joint Committee undertake the reporting function for the Programme o **APPROVED** an in year funding uplift of £347k, and a recurrent full year funding of up to £506k (the Health Board's contribution is £139k) by 2025/26 for Phase 1 of the Programme o **APPROVED** the continuation of funding for Phase 2 of the Regionalisation Programme at the current level. • **NOTED** the progress and recommendations from the Ministerial Review of national commissioning functions and the establishment of the new national commissioning joint committee to be known as the NHS Wales Joint Commissioning Committee/Cyd-bwyllgor Comisiynu GIG Cymru	

PM(23)209	**REPORT OF THE AUDIT & RISK ASSURANCE COMMITTEE**	
	Cllr. Rhodri Evans, ARAC Chair, presented the ARAC update report from its meeting held on 17 October 2023, highlighting the key items discussed, key risks, issues and matters of concern. Members were assured that reports and topics are considered and scrutinised fully, with follow-ups requested where necessary, as evidenced by the matters of concern section. Matters requiring Board level consideration or approval were revisions to the Model Standing Orders and Standing Financial Instructions and amendments to the Scheme of Delegation. These are covered within the report and are the subject of separate agenda items, for approval.	

	Ms Anna Lewis requested further information around the actions being taken to address the findings of the Quality and Safety Governance Bronglais Hospital (BGH) Internal Audit. In response, Mrs Rayani advised that this review had been undertaken at her request and that there have been additional conversations and clarification around the standard reporting processes, which have now been deployed. Ms Sharon Daniel, Deputy Director of Nursing, Quality and Patient Experience, has visited BGH to make clear the expectations around quality and safety governance. Mrs Rayani was anticipating an improvement by the time of the follow-up audit, which the Internal Audit team has indicated will come to the February 2024 ARAC meeting; however, it should be noted that an interim update will be provided to ARAC at its December 2023 meeting. Mrs Joanne Wilson reported that Internal Audit has already followed-up the actions listed in the management response with an imminent implementation date, and confirmed that an update will be provided to the December 2023 ARAC meeting, with the BGH management team due to attend. To ensure that recommendations are fully embedded, there will be a formal follow-up audit, reporting to ARAC in February 2024. Noting that the Deprivation of Liberty Safeguards Internal Audit report would be re-presented to the next meeting, Mrs Chantal Patel requested clarification around the issues necessitating this. Ms Jill Paterson advised that the same wording had been used by Internal Audit for each of the recommendations, which was not necessarily appropriate for one. A meeting had taken place with Internal Audit, the relevant wording had been amended and the revised report would be presented to the December 2023 meeting. Mrs Wilson added that the sign-off process for Internal Audit reports had been reviewed following this incident, as it had placed the Committee in a difficult position. Cllr. Evans was, however, unapologetic for the scrutiny applied in this case, which was required.	
	The Board **NOTED** the ARAC update report and **ACKNOWLEDGED** the key risks, issues and matters of concern, together with actions being taken to address these.	

PM(23)210	**REVISED MODEL STANDING ORDERS (SOS) AND STANDING FINANCIAL INSTRUCTIONS (SFIS)**	
	The Board **APPROVED** the revised HDdUHB Standing Orders and Standing Financial Instructions.	

PM(23)211	**REVISED SCHEME OF DELEGATION**	
	The Board **APPROVED** the changes to the Scheme of Delegation.	

PM(23)212	**REPORT OF THE QUALITY, SAFETY & EXPERIENCE COMMITTEE**	
	Ms Lewis, QSEC Chair, also wished to add her recognition of Mrs Rayani's significant contribution to quality and safety on the occasion of her final Board meeting. QSEC as a committee is in a very different position now as a result of Mrs Rayani's efforts, and Ms Lewis was extremely grateful for her support, which will be greatly missed. Presenting the QSEC update report from 5 October 2023, Ms Lewis highlighted in particular that the Committee self-assessment workshop	

has now taken place. The output from this will be considered in terms of potential for ongoing improvement. Members heard that the Patient Story presented to the October 2023 meeting had been extremely powerful. A number of next steps had been identified, and Ms Lewis has requested that the family involved is kept informed regarding progress. The Committee was grateful for the patients and families who continue to share their stories. Board Members heard that one set of metrics is examined in detail at each meeting, with the focus in October 2023 having been on Pressure Damage and Falls. It had been agreed that it would be beneficial to try to analyse the data further to establish whether and how improvements can be made. In terms of Operational Governance, a specific issue reported to the Committee had been low attendance at meetings of the Operational Quality, Safety and Experience Sub-Committee (OQSESC). There is a need to consider the robustness of governance arrangements in order to inspire improved confidence in this area.

Ms Helen Williams noted reference to a meeting with the Health Minister and the need for public conversations, and enquired whether these public conversations have begun. Mrs Rayani explained that this was specifically in relation to the financial position, to share the challenges that are being faced by the organisation and ensuring the quality and safety of services remain as high as possible given these challenges. It is important to recognise the impact for both providers and service users. Members were assured that the Health Board takes every opportunity possible to engage with members of the public around services and strategic direction; the Paediatrics consultation being one such example. Whilst there is more which could be done, this engagement is part of the organisation's regular programme of work.

Referencing the matters of concern identified within the report, Mrs Patel enquired regarding actions being taken to address these. In response, Mrs Rayani advised that it had been her who had commissioned the Internal Audit into quality and safety governance at BGH, due to concerns in this regard, which had proved to be founded. It was emphasised, however, that teams are taking their responsibilities around quality and safety seriously. There is a specific issue around attendance at OQSESC, and ensuring that concerns are escalated into that forum appropriately. This has been reinforced. The corporate Quality Assurance team is working closely with services, and the role and contribution of the triumvirate teams has been made clear. In terms of Pressure Damage and Falls, steps are being taken to understand the level of harm and impact which can be expected as a result. The majority are within the community environment, and not known to acute services. Work is, therefore, required within the community including around capturing data. For Falls, the Health Board is considering extending its exercise around managing falls, to encompass the community. Strategic work is also required. In terms of inpatient/hospital Falls, there are regular discussions with senior ward staff to scrutinise all incidents associated with nursing care, including Falls, Pressure Damage and Medication Errors. This is an area of considerable scrutiny.

	Ms Raynsford expressed concern around an average figure of 32% for hand hygiene compliance across all inpatient areas and requested assurance around steps being taken to improve this. Mrs Rayani advised that there is significant progress in terms of actions around Infection Prevention and Control (IPC), with hand hygiene measures and 'bare below elbow' being key elements. It was emphasised that the figure of 32% is not consistent across the organisation. Whilst there are pockets of high compliance, where 90%+ is consistently achieved, there are other areas where there are consistent issues with compliance, in some cases due to resistance to measures and disagreement with the evidence base for these. Mrs Rayani stressed, however, that these are Health Board policies and standards, requiring compliance. In terms of steps to address this issue, the organisation is considering reinvigorating a number of campaigns around hand hygiene and IPC; it is likely that these will need to be consistently reinforced. Professor Philip Kloer agreed that there are a number of areas where significant improvements have been seen. The areas of resistance and reluctance are being addressed. In response to a query around whether consideration has been given to implementing objectives around IPC as part of the Performance Appraisal and Development Review (PADR), Mrs Rayani advised that a process has been implemented to address non-compliance; the first stage being a conversation, the second a reminder conversation and the third formal escalation. Mrs Lisa Gostling explained that this is not an appropriate objective for a PADR or appraisal process; it should be an expected behaviour. Members heard that there have been discussions involving Health Education and Improvement Wales (HEIW) where it had been suggested that more might be done at an educational level to reinforce this topic. Mrs Patel confirmed that IPC is included in all medical education and suggested that the issue may lie in how it is presented/'socialised' in the clinical setting.	
	The Board **NOTED** the QSEC update report and **ACKNOWLEDGED** the key risks, issues and matters of concern, together with actions being taken to address these.	

PM(23)213	**PAEDIATRIC SERVICES CONSULTATION**	
	Introducing the Paediatric Services Consultation report, Mrs Hardisty highlighted that this was a key element of the next stage of the Clinical Services Plan. Professor Kloer and Mr Lee Davies would introduce clinical colleagues at the relevant points, together with input from Opinion Research Services (ORS). Once the presentation had concluded and a discussion had taken place, a break would occur, after which the recommendations would be considered, and a decision made. Professor Kloer recognised that the report and accompanying appendices comprise a significant amount of information, whilst emphasising that they represent the culmination of two years of work and include the findings of the public consultation. Members were assured that the Health Board is striving to implement the safest service for children. This has been a matter of discussion and consideration for almost ten years, and the significant public interest in this matter was acknowledged. Professor Kloer welcomed members of Consultant Paediatric staff, the Service Delivery Manager for Paediatrics and colleagues from ORS. Llais were thanked for their support.	

Mr Lee Davies introduced a presentation entitled 'Consideration of the Public Consultation on Urgent and Emergency Children and Young People's Services (Paediatrics) at Withybush and Glangwili Hospitals: 30 November 2023'. The Board is receiving the independent report from ORS summarising the consultation process and findings. Members are requested to consider the findings of and feedback from the consultation and stakeholders, and the three options presented. The Health Board has undertaken a comprehensive and detailed process, reflected in the information presented. Mr Lee Davies thanked Dr Marcus Andrews, Dr Kathryn Lewis, Mr Nick Williams Davies and the Paediatrics team for their contribution. Also, Ms Yvette Pellegrotti, Mr Conrad Hancock and members of the Transformation Programme Office team, together with Ms Alwena Hughes-Moakes and the Engagement team. Finally, the public and other stakeholders were thanked for their input. Members were reminded that the consultation was not a 'voting process'; it seeks views to feed into decision-making. Mr Lee Davies drew Members' attention to Slide 3 of the presentation, which details the previous service changes, dating back to 2014, and the reasons for these. The service model going forward has been a key concern for the Health Board for some considerable time.

Dr Marcus Andrews, Clinical Lead for Paediatrics and Consultation Lead, indicated that he had been interviewed for his Health Board position in 2014 and had taken up the post in 2015. Members were assured that the three options presented have been agreed upon following a comprehensive process of listening to stakeholders and their desires for what services could be provided on the Withybush Hospital (WGH) site, together with much reflection and discussion with clinicians and managers. Two working groups had been established, involving paediatricians, managers, nurses, parents, and representatives from primary care and the ambulance service. These groups had met regularly to consider the various options, after which the options had been appraised by a wider audience of stakeholders. Following this process, the three options presented today had been decided upon. The desire is to enhance the current services provided, in light of the needs of the childhood population and those of their parents, carers and families. Dr Andrews emphasised that it is not possible to return to the model in place in 2014. All three options reflect the wish among primary care and the public to maintain access to paediatric secondary care on an urgent basis. This is currently provided by a Rapid Access Clinic, which there is a desire to develop further, with children seen by a Consultant Paediatrician within 72 hours of referral. Slide 4 presents the three options, with Option 1 being the most similar to current service provision, no Paediatric Ambulatory Care Unit (PACU); Option 2 including a return to a limited PACU service; and Option 3 including a limited PACU service, together with additional services. Dr Andrews introduced Mr Nick Williams Davies, to explain how the three options were scored.

Mr Nick Williams Davies, Service Delivery Manager, advised that the consideration of future Urgent and Emergency Paediatrics service provision was a significant piece of work, whilst emphasising that the

service is extremely keen to achieve a stabilised position. A major element is to ensure that children can access safe care as close to home as possible. However, the Health Board needs to be cognisant of the risks seen in previous iterations of service models, which are outlined within the report. The three options had been subject to an options appraisal process, involving 25 stakeholders, including patients and their guardians, Llais, and staff – doctors, nurses and administrative staff. Every participant was able to score options against each criteria, using a scale of 1-10, 1 being lowest and 10 highest. The outcome is detailed on Slide 5. As indicated on the slide, Option 1 has the highest score, although it has the lowest scores for Accessibility and Impact on people. This is because, in all of the models, the emergency pathways are retained at Glangwili Hospital (GGH), meaning that if admission at the point of contact is required, this will be via GGH. This arrangement will be retained, as it has been made more safe and more sustainable, with a full consultant rota in place. The Health Board is providing more care for children than has been seen previously and transferring fewer into critical care pathways than in previous years.

Options 2 and 3 have similar total scores; however, Workforce viability and Safe inter-hospital transport system scored lowest in both. In all options, workforce challenges have been recognised and risk assessed; there is a need for cognisance around the challenges involved in maintaining any service model. Options 2 and 3 deliver more services and, therefore, require more staff. Safe inter-hospital transport system scores relate to the difficulties involved with moving children who may become critically ill, particularly with compromised airways. For the most severe cases, the Health Board is reliant on the dedicated transfer service based in Bristol, with a 2 hour response time. The Dedicated Ambulance Vehicle (DAV) and other transfer services would find it challenging to move children with compromised airways. Ongoing discussions with the relevant teams, including Paediatrics, Anaesthetics and A&E are required. Concluding, Mr Williams Davies hoped that this had presented a robust analysis of the options scoring.

Mr Kester Holmes introduced himself and Ms Angharad Davies, who work for ORS which runs consultation and engagement processes across the UK for the NHS and other public sector organisations. Presenting the key consultation findings, Members heard that a comprehensive exercise had been conducted, with a full report available providing additional detail. Mr Holmes highlighted the following:

- A consultation questionnaire had been available, in both paper and online formats and in both English and Welsh versions. 342 responses had been received
- There had been considerable staff engagement
- Engagement events had taken place, along with stakeholder meetings
- There had been public drop-in events and discussions with community groups
- Questionnaire responses had been received from across the area, although most were from Pembrokeshire, which was to be expected

being the location most affected – a breakdown by geography was provided
- Views on the options were also presented graphically, including responses from on the child-friendly questionnaire (response rate for the latter was fairly low)
- The majority of respondents favoured Option 3

Ms Angharad Davies presented more detailed feedback around each of the options, as follows:

Option 1

Positive	*Negative*
More care close to home	No return of PACU
Cheapest/least complex	Limited support for CYP with long term/complex medical needs
Least confusing for service users	Concern around ability to staff services
More OP provision through Rapid Access Clinics	
Easiest to staff	
Enhances current situation	
Better than now	

Option 2

Positive	*Negative*
Return of PACU	Insufficient services at WGH
Better/more timely access	Limited PACU hours
Less travelling time	Limited OP and Rapid Access Clinics
Takes pressure off GGH and local GPs	Concern around confusion caused by different models at different times
	Concerns around staffing and sustainability
	Specialist treatment and doctor cover may be fragile if split between GGH and WGH

Option 1

Positive	*Negative*
As for Option 2, above, plus	As for Option 2, above
Return of services to WGH	
Provision of staff training and upskilling	
Improved retention of staff	
Reduced waiting times	
Dedicated waiting area for CYP (A&E at GGH not appropriate)	
'Least worst option'	

There was confusion among questionnaire respondents as to why Options 2 and 3 would mean less Outpatient/Rapid Access Clinic activity. This will require further explanation. Feedback common to all three options was:

- The introduction of more services at WGH was welcomed
- Clarification required around arrangements in relation to Rapid Access Clinics
- Concern around the continued need for difficult and lengthy journeys
- Concerns around staffing (Options 2 and 3 particularly)
- Difficulties around accessing GP appointments, potentially resulting in children being taken to A&E 'as a default'
- Signposting – potential for confusion. Option 1 provides the most clarity in this respect. Clear signposting/signage would be required for Option 2 or 3
- The DAV is an important and positive resource but there are concerns/questions around its availability, which need clarification

Whichever option is chosen:

- GGH needs improvements, ideally a separate CYP waiting area
- The PACU environment needs improvement
- Staff training needs to be prioritised

Common comments/feedback were:

- Restore full paediatric services to WGH
- Amend proposed hours for services at WGH (evenings/weekends)
- More telemedicine/use of digital options (eg video triage between GGH and WGH)

In terms of equalities and health inequalities impacts, there were concerns around ongoing impacts on CYP in Pembrokeshire and some parts of Ceredigion, especially those requiring inpatient admission and with complex needs/requiring ongoing care. There were also specific concerns for families with disabled/neurodivergent children; disabled parents; parents with other children/caring responsibilities; single parent families and potential for disproportionate impacts on low income families. A number of positive impacts were also identified in relation to the three options.

Mr Lee Davies concluded by advising Members that feedback had been received from various groups and analysed by ORS. A Conscientious Consideration process had taken place, reported in Appendix 5, with various key themes identified. There had been a review of alternative suggestions, reported in Appendix 4, and the Board should consider the following alternative suggestions: why additional 'extras' offered under Option 3 cannot also be offered under Option 1; An enhanced service and additional training for paediatric (PACU) staff at GGH and WGH. A Consultation Institute best practice award for Quality Assurance is recorded at Appendix 7. The Equality Impact Assessments (EqIAs) at Appendix 6 are dynamic documents and once a preferred option is identified the EqIA for that option will be developed into an Equality and Health Impact Assessment (EHIA).

Drawing Members' attention to the summary slides, Mr Lee Davies reiterated that the Board is asked to consider the best option for the

provision of Urgent and Emergency Children and Young People's Services (Paediatrics) at Withybush and Glangwili Hospitals.

Ms Williams expressed gratitude to the Health Board for including Llais in the engagement process from its beginning. It was emphasised that, whichever option is selected, clear communication from services, including Primary Care, is required. Ms Raynsford highlighted the rurality and transport/access issues inherent in considering this matter. Also, there are significant numbers of lower income families within Pembrokeshire. Ms Raynsford enquired how the Health Board is engaging with the population to identify how it might help in such circumstances. Mr Williams Davies advised that activity across the three counties had been analysed, with it highlighted that 80% of acute conveyances to GGH are not admitted and go home the same day. The Health Board is proposing that this be further influenced by enhancing the Rapid Access Clinic service; however, it is recognised that urgent cases will still require ambulance conveyance. Members were reminded that the DAV is 'ringfenced' for use by Women and Children's services. Conveyance is accessed via various mechanisms, including 999 and direct referral. Mr Williams Davies assured Members that the Health Board is seeking to return patients to Pembrokeshire in the highest numbers possible.

In response to a request for clarification around proposals in relation to the Rapid Access Clinics, Mr Williams Davies explained that these already exist; however, the options propose their enhancement. Dr Kathryn Lewis confirmed that the clinics have been established for some considerable time and are operating extremely effectively. The issue around delivering them consistently relates to staffing. Even Option 1 would involve an expansion of the current service. They are currently delivered by three Paediatricians, who work either on a part-time basis or split between WGH and GGH. This means that there would be at least one day per week which could not (with current resources) be covered. It is not possible to remove staff from the GGH rota, as this would be destabilising.

Mr Michael Imperato noted the statements around transport/access being discussed during the implementation process and queried the level of opportunity available for refinement. In response, Mr Williams Davies advised that facilities already exist to transport children home, etc. However, the requests to access such services are limited. It was noted that the DAV is due for a commissioning review and consideration should be given to how its existence and availability is communicated. Taxis probably provide the most effective repatriation method. Overnight discharge, whilst possible, is not generally considered optimal. Mr Imperato noted that the Impact Assessment discusses a policy for accessing transport for families without this facility, and suggested that – if such a policy exists – this should be made more clear, and publicised more widely. Members were informed that the document in question (noting that the word 'policy' is used in the EqIA) is the Hospital Travel Cost Scheme Procedure, which is cross-organisational. It is recognised that further conversations are required with clinical colleagues around anything further which might be required in this regard.

Professor Kloer recognised that there is significant feedback around transport and access. There has been a great deal of work already undertaken and this matter has been considered at length. As has been mentioned, a policy is in existence and use; however, given the gap between feedback on this topic and the number of people taking up transport, it should be evaluated further. It is likely that the concern will perpetuate whatever decision is made with regard to the options. Mr Moore agreed that transport and access is a key concern; not only for those accessing paediatric services, but also more generally. The Health Board's Strategy sees a move further west for the proposed new hospital. The need to work with families to establish the level of knowledge of the relevant policy, and whether more could be done in this respect was acknowledge.

Noting reference during the consultation to suggestions around increased use of telemedicine and digital support services, Mr Maynard Davies felt that this was not necessarily reflected to any great extent in the proposals. An example might be increased use of digital for GP to Consultant discussions. Dr Andrews agreed that technology should be embraced and confirmed that models of communication have been discussed with GP colleagues. It had been suggested that a suitable compromise might be a telephone call at a specific time. Discussions with regard to the use of telemedicine and digital consultations had raised concerns among clinicians around this not providing the same experience and clinical cues as 'being in the same room'. It was emphasised that clinical decisions need to be made by 'the person with the child in front of them'. Dr Lewis added that consideration needs to be given to how WGH will be staffed in future models. Rotas may involve only one Consultant, and their most 'beneficial' activity should be determined, whether this be liaising with GPs, delivering a PACU service or delivering Rapid Access Clinics. It may be that one is delivered to the detriment of another. Mr Maynard Davies agreed wholeheartedly that the Health Board needs to be cognisant of this issue around balance. He suggested that the ORCHA Apps offer potential assistance in terms of supporting parents or in terms of prevention.

Cllr. Evans noted on page 17 of the SBAR the intention to develop 'an implementation plan… which will be presented to Board in January 2024' and highlighted the short timescale, querying the ability to adequately scrutinise such a plan. Mr Lee Davies explained that the short timeline reflects the desire for pace, recognising the uncertainty that current arrangements present for the public. A prompt conclusion is advantageous. The implementation plan referenced will be a project plan setting out the key elements which need to be progressed and the likely timescale for this. Mr Lee Davies felt that this could be achieved by January 2024, whilst recognising the need for scrutiny. It was agreed that this matter would be discussed outside the meeting. Dr Ardiana Gjini wished to highlight that the EqIAs take direct account of need, with equity being key. Whilst access is a major consideration, the service also needs to be sustainable and resilient. It would be undesirable to implement an inferior service due to an excessive focus on access. Returning to the issue of digital, Mr Huw Thomas recognised the need to

LD/JW

consider this matter more broadly, including how the Health Board's various sites are connected. A 'light' approach must be taken, however, to ensure that digital supports and enables change, rather than driving it. It must support and facilitate clinical decision-making, not introduce other potential risks.

Mr Huw Thomas wished to highlight the financial implications of the various options, emphasising that all would represent a net investment and involve consequential trade-offs. This, within a resource-constrained environment. The most significant financial implications are associated with Options 2 and 3.

Mr Iwan Thomas welcomed the consultation findings and in particular the number of responses, with feedback from both questionnaires and stakeholder events. He requested, however, additional context around this, in terms of representation. As the consultation is focused on services relating to children and young people including vulnerable families, Mr Iwan Thomas enquired whether there is any data around the proportion of feedback from families, parents and carers (those individuals actually utilising or likely to utilise the services in question) as opposed to those who are simply 'expressing an opinion'. Mr Holmes advised that there is data in the full report around this issue. He confirmed that a reasonable proportion of participants were parents. Ms Davies added that participants in the focus groups were screened, and all were parents of children under 18 or grandparents with regular caring responsibilities. Whilst not criticising the consultation process undertaken, Mr Iwan Thomas was disappointed in the numbers involved, noting that there are 52 or 53 Primary Schools within Pembrokeshire, each with around 160 children on the school roll. If this is multiplied by the potential number of parents, it represents a figure of between 6-8,000 people. Mr Iwan Thomas felt that, to ensure the correct decisions are made, the Board needs assurance that feedback is representative of the relevant audience for the topic in question, not just the 'loudest voices'.

Mr Williams Davies advised that he had attended all of the 50+ public events. Members also heard that, prior to the engagement process, meetings had taken place with children, a number of whom access the services involved, and many of the themes incorporated into the proposals came from them. The general feedback from engagement was that it was refreshing that services were being reintroduced to WGH and Mr Williams Davies felt that this had impacted on the responses received. Nearly all of those who attended the public events were families. Whilst a few other local groups had attended, they were also generally supportive. Mr Williams Davies was of the opinion that the level of response was not disproportionate. Mr Holmes confirmed that this was the case, stating that numbers were proportionate given the population and topic. It should be noted that engagement is not wholly to do with the level of response; it is also about the efforts made to engage and the cross-section of stakeholders involved. Ms Yvette Pellegrotti highlighted that the Health Board has received a Certificate of Best Practice from the Consultation Institute in respect of this engagement process.

Whilst noting the clear case for change, and the need for operational sustainability, Ms Lewis requested assurance that locally-based services within Pembrokeshire would provide sufficient case volume and 'critical mass' to ensure that clinicians are able to maintain their skills, etc. Mr Williams Davies confirmed that this was the case, advising that current facilities are used to their maximum. Planned Care forms the vast majority of clinical contacts. 4-6 children per day on average come to GGH from Pembrokeshire. A clinic usually consists of 6-8 patients, which provides sufficient critical mass for a Pembrokeshire based service. Participation in the acute rota at GGH allows clinical colleagues to maintain skills and practice. The complexity associated with PACU, however, introduces a risk which the Health Board would need to ensure it can manage in terms of sustainable provision, without introducing risks to the care of children. Members heard that there has been a change in how children with respiratory presentations are cared for, with earlier clinical intervention. As has been mentioned earlier, the acutely unwell child will still need to be managed at GGH, for a variety of reasons. This consultation and discussion focuses on Urgent and Emergency Care; however, there is a Planned Care aspect and service, also to be considered. This includes children with complex and long-term conditions, for example, who can be managed locally.

Professor Kloer highlighted that one concern might be the potential for the instatement of a WGH PACU to impact negatively on the GGH critical mass. Given that the numbers involved are reasonably small, however, he did not feel that this would be an issue. In terms of Ms Lewis' query, there is sufficient critical mass to operate a PACU at WGH due to clinical staff working across sites and undertaking other clinical activities. There are many different activities in which Consultant Paediatricians can participate. Ms Lewis welcomed this clarification, suggesting that the configuration across the three options is clearly important in maintaining the quality and safety of care for children and their families across the entire Health Board 'footprint'. Whilst there are other considerations around access, etc, these are practical and sit behind the main issue – how services are configured across a rural population in as safe, effective and high quality way as possible. It is clear that this is not achievable by treating each county in isolation.

Dr Lewis confirmed that, as the changes to Paediatric services have evolved, clinical staff have been increasingly incorporated onto the Carmarthenshire rota. She felt that her skills had been enhanced as a result and that her training and skill base was on a par with GGH clinicians. This had translated into her clinical practice and Dr Lewis assured Members that quality and safety was being maintained. On a related note, Ms Ann Murphy enquired regarding other staff groups and whether there are sufficient staff to open and maintain a PACU at WGH. Mr Williams Davies advised that consideration of this issue would form part of the implementation plan. Workforce planning will be key to implementing any of the options; the staffing requirements will depend on the option selected. Members heard that HDdUHB does have one of only two Physicians Associates within Paediatrics in Wales. It also has 4 Advanced Practitioners at different points within their training. This

provides for a different workforce model opportunity than previously. However, colleagues need to understand how this will impact on delivery of care locally and more work needs to be undertaken in this regard. Nursing has seen reasonably strong recruitment recently. As the options increase in terms of services offered, the risks around workforce also become higher.

Dr Lewis advised that – at this point – there are not sufficient staff to deliver any of the options and that a great deal of work is required in this area, which could delay implementation. Children and young people, their families and staff all require robustness and stability in service model, as this will help to address many of the issues currently being experienced. Mrs Hardisty and Professor Kloer both agreed that certainty will assist in this regard. Professor Kloer emphasised that this whole process, including staffing considerations, is centred upon improving patient safety. There are clear differences between the options. Members' attention was drawn to the table outlining costs on page 7 of the SBAR, with the estimated ongoing revenue increase, much of which will involve staffing costs. There is, as can be seen, a significant difference in cost between Option 1 and Options 2 and 3. The 'achievability' of staffing models also requires consideration. In terms of cost, Mrs Patel enquired whether this is ringfenced or whether funding would need to be secured. Mr Huw Thomas advised that it is the latter.

Thanking Dr Andrews, Dr Lewis, Mr Williams Davies, ORS colleagues and the Planning team, Mr Carruthers indicated that much of what he wished to say had already been covered. He did, however, want to reiterate the importance of certainty, robustness and availability of services, and the need to avoid unplanned closures. As has been indicated, the increasing levels of workforce required with the stepped options results in the risk associated with being able to fulfil each also increasing exponentially. It is crucial to recognise the risks and challenges around delivery of each of the options, together with the potential for ongoing confusion around services among the general public. Professor Kloer wished to highlight certain issues, one being the importance of acknowledging concerns around transport and the need to establish a workstream to consider this in more detail and engage with service users. Secondly, the need for clarity of service model and concerns around implementing a model which has the potential for unplanned closures.

Mr Moore added his thanks to all of the teams involved, and the Board, for both today's and previous discussions on this important topic. When Mr Moore had joined the Health Board in 2015, the service change recently implemented had still been extremely 'raw'. The organisation is now hopefully at a point when it can take the next step in developing a substantive service model. The significance of this is not underestimated and the responsibility is one which Members take seriously. In considering the options presented, Mr Moore reminded Members of the Option Scoring table presented earlier and emphasised the need to balance sustainability, reliability and robustness. It is vital to ensure that the Health Board's precious clinical resource is utilised to its best effect for the local population. Certainty of option is important, as is an option

which offers certainty. On this basis, Mr Moore noted that the option which reflected the discussion was Option 1. Therefore, Option 1 was recommended to the Board for consideration, to place the service on a sound footing. Whilst it is acknowledged that this is probably the least popular with the general public, it has been recognised as an improvement on the current service provision. The clinical 'voice' is key in considering the options, to ensure that there is certainty, reliability, and operational robustness. Mr Moore agreed that there is a need to consider in more detail the issues of accessibility and transport, as these represent particular needs for this group of patients.

The Board took a scheduled break at this point. Mr Kester Holmes and Ms Angharad Davies left the Board meeting.

Mrs Hardisty welcomed Members back, indicating that each of the report's recommendations would be considered individually. Thanks were again recorded to staff from the Paediatrics team, Ms Pellegrotti and representatives of ORS. In considering the recommendations, Mrs Hardisty offered other supplementary comments, in terms of the cognisance given to the manner in which the engagement and consultation was managed, and the fact that the key findings and queries around these have been discussed thoroughly. Key themes raised as part of this discussion include:

- An apparent lack of knowledge in relation to the DAV and the need to promote awareness
- The need for improved signposting around the referral process into PACU
- Concerns around the suitability of the A&E environment at GGH for children and young people
- General concerns around travel, transport and access
- The need for a sustainable service, in terms of staffing, financially and operationally
- Reinforced Autoclaved Aerated Concrete (RAAC) at WGH – whilst not discussed in detail today, this has been discussed extensively at previous meetings

In considering the recommendation to agree a preferred option from those presented, Members had reflected upon the case for change and how services should be configured in as safe, effective and sustainable way as possible, together with the need for certainty for both staff and public. Following these deliberations, it was proposed that Option 1 be adopted, with this agreed by the Board.

It was noted that a plan around implementation would be developed, potentially for consideration at the January 2024 Public Board meeting. This would take into account the following:

- Workforce requirements
- Accessibility/transport
- Digital agenda
- Primary Care involvement, particularly GPs
- Issues raised within GGH

	• Communications plan (around both the options decision and future implementation) Mrs Hardisty drew discussions to a close, thanking all participants. *Dr Marcus Andrews, Dr Kathryn Lewis, Mr Nick Williams Davies and Ms Yvette Pellegrotti left the Board meeting.*	
	The Board: • **NOTED** the 'Best Practice' Quality Assurance certification achieved from the Consultation Institute • **CONSIDERED** the summary of the changes that have occurred within the service since 2014, and the challenges that led to the requirement for these changes • **CONSIDERED** how the options were scored as part of the options development process • **CONSIDERED** the key findings from the Urgent and Emergency Children and Young People's Services (Paediatrics) at Withybush and Glangwili Hospitals consultation feedback report • **CONSIDERED** the findings of the stakeholder review of the alternative options • **CONSIDERED** the findings of the conscientious consideration process • **AGREED** a preferred option for how the Health Board provides urgent and emergency children and young people's (paediatric) services at Withybush and Glangwili Hospitals, this being Option 1 • **NOTED** the development of an Equality and Health Impact Assessment (EHIA) for the preferred option • **NOTED** the requirement for the service to develop an implementation plan, setting out how the preferred option will be operationalised	

PM(23)214	**UPDATE ON ANNUAL PLAN 2023/24**	
	Presenting the update on the Annual Plan 2023/24, Mr Lee Davies suggested that the report is relatively self-explanatory. The Health Board is more than half-way through the current year's Plan and is already giving consideration to next year's. The report provides an update on delivery of Planning Objectives, with most either complete or on track for completion. The impetus behind the Core Delivery Group (CDG) has delivered on various fronts, although there is still much to do. As mentioned above, work is commencing on the Annual Plan 2024/25 and a new Planning Steering Group is proposed, which will work alongside the CDG. Welcoming the report, Mr Maynard Davies noted that certain Planning Objectives are behind schedule and enquired around confidence in terms of delivery of the Plan by year end. Also, whether for next year's Plan, wider involvement is being sought from all levels of the organisation. In response to the first query, Mr Lee Davies was confident that those indicated as on track will be delivered. Certain of the Planning Objectives have been paused, as previously discussed. The report summarises progress and anticipated progress as identified by the Health Board. In terms of the second query, there is more connectivity with the higher tiers of the organisation, particularly following the work	

	undertaken during the summer around financial savings. Mr Lee Davies was content that there will be constructive engagement with more senior staff; other, wider engagement remains a work in progress. Noting the focus on savings, Mr Winston Weir enquired regarding the expectation regards recurrent, as opposed to non-recurrent savings. Also, the expectation of departments in delivering longer-term savings. Mr Huw Thomas explained that there is a savings delivery gap of £10m, together with a deterioration in the underlying financial deficit. Savings opportunities are not necessarily consistently delivered across the organisation; there are areas, for example, which continue to exhibit high agency usage. This topic will be explored in more detail at the Board Seminar in December 2023. Mr Weir felt that the Health Board should consider how savings expectations are translated and communicated to staff at all levels. Today's agenda includes two business cases requesting funding, at a time when there are significant cost pressures. It was agreed that the above issue would be considered at the Board Seminar. Referencing the paused Planning Objectives, Ms Lewis noted that several of these are around staff wellbeing and satisfaction and enquired whether the potential consequences and risks associated with pausing these had been considered. Mrs Gostling advised that certain of these are now embedded into normal practice; however, the pausing of Planning Objectives is a direct consequence of the financial constraints being experienced. The organisation will continue to focus on its crucial objectives; the desirable but non-essential ones will need to be delayed for the time being. Whilst recognising the rationale, Ms Lewis enquired whether the risk of not recruiting to vacancies has been considered in relation to the impact on experience of current staff. Mrs Gostling confirmed that this is being taken into account, via the Risk Register. Members were assured that staff in the Workforce and Organisation Development (OD) teams continue to make every effort to focus on supporting the workforce. Mrs Gostling was confident that the route taken was the appropriate one. Ms Jill Paterson wished to add that there should not be a reliance on the Workforce and OD teams to for staff support. Managers should be checking with their teams, be available and manage any concerns as promptly and effectively as possible. Agreeing, Mrs Hardisty emphasised the need to develop managers to provide this support rather than the OD team.	**HT**
	The Board: • **NOTED** the continued work of the Core Delivery Group • **APPROVED** the changes to the milestones and timelines in the delivery of the Planning Objectives • **NOTED** the approach for the production of the 2024/25 Plan	

PM(23)215	**FINANCIAL REPORT**	
	Mr Huw Thomas introduced the Financial Report for Month 7 2023/24, indicating his intention to present the financial position to the Board. Since the previous meeting, the Health Board has sent an Accountable Officer letter to Welsh Government. On the same day, Welsh Government allocated the Health Board additional funding, which is conditionally recurrent, subject to achievement of a Control Total. Welsh Government has also indicated its intention to recover from Health	

	Boards any underspend on COVID-19. The Health Board is grateful for both the additional funding and clarity from Welsh Government. Members' attention was drawn to pages 3 and 4 of Appendix 1, which include details of the Control Total versus the forecast deficit, and the £27.9m gap between the two. Achievement of the Control Total will require a significant improvement in run rate. Mr Huw Thomas reported that there has been an improvement of £4.4m, with drivers outlined within the report. These include Pathology, Oncology, Unscheduled Care and Planned Care drugs, Continuing Health Care (CHC) and Primary Care. However, there has been savings scheme slippage in Mental Health and Learning Disabilities (MHLD) and CHC. In terms of position against the original plan versus the Control Total, whilst the additional allocation has improved the Health Board's cash position, a shortfall remains. The organisation is in ongoing dialogue with Welsh Government around this. Mr Huw Thomas highlighted the figure of £18.9m savings identification on page 7, which indicates a shortfall of £0.6m; this has since been identified. Members were informed that further analysis around recurrent savings, as requested earlier, will be undertaken. Delivery challenges, and the drivers behind these, are outlined within the report. Members heard that fill rates are improving which, in turn, improves service quality. Page 15 contains a summary financial performance forecast by portfolio, with expenditure dominated by the Carmarthenshire and Ceredigion systems. Financial performance in Women and Children's and the Pembrokeshire system services show significant improvement; consideration needs to be given to how the other two counties' performance is managed. The Whole Time Equivalent (WTE) worked position is at the highest level ever, with nurse recruitment in particular showing a significant improvement and nurse agency usage reducing to a level not seen since 2021. Medical locum usage, however, remains on an upward trajectory, with the Health Board spending almost £1m per month more on this. A concerted focus is required on workforce and how the use of agency is stabilised. Page 19 highlights the work and impact of CDG, with Mr Huw Thomas thanking Mrs Gostling for Chairing this Group. In summary, the Health Board faces an extremely challenging financial position. Whilst actions are being taken, risks remain high. Members were assured that the cash implications in particular are being actively monitored. Mr Weir welcomed the report, commending as particularly helpful the information on page 19. Whilst the 'green shoots' of improvement are evident to some extent, Mr Weir suggested that it would be useful to have more in the way of timescales. Mr Huw Thomas indicated that he could provide this information to the Sustainable Resources Committee (SRC) meeting in December 2023. Mrs Gostling added, for assurance, that detailed timelines do exist for the delivery of schemes between now and January 2024; these can be shared with Members. Mr Carruthers emphasised the need for clarity on those actions which can be taken which will materially impact on the financial position and understanding the balance between the various aspects. As has been stated, clear timelines have been obtained via CDG, which all services attend to provide progress updates. Additional information can, however, as	**HT**

	suggested, be presented to SRC. Mr Weir felt that this was a matter more suited for Board consideration, having as it does different priorities than SRC, including for example, quality and safety. On a separate matter, Mr Weir emphasised the need to ensure sufficient support for delivery, in view of the scale of the 'ask'. Mr Carruthers confirmed that this is being considered and that individuals have been identified to lead on various workstreams. Further discussions and decisions are, however, required. In response to a query around communications relating to the challenges being faced, Ms Alwena Hughes-Moakes advised that various opportunities are being explored to highlight the efforts of staff teams. Videos are also being produced to outline how staff can help to make a difference and contribute to savings. Various campaigns in this regard are being planned. In terms of wider communications, it is intended to build on those already issued by Welsh Government around accessing services appropriately. Mr Moore assured Members that communications have been incorporated into planning from the start and that quality impact assessments and equality impact assessments are routinely undertaken. Mr Maynard Davies noted on page 19 of the report the performance improvement within Pembrokeshire contributed to by the 39 bed reduction, partly prompted by RAAC and partly as a result of previous positive work. He enquired how this reduction will be maintained in view of likely impending winter pressures and how similar models can be rolled-out elsewhere. Mr Carruthers confirmed that it has been stated by those managing the system in Pembrokeshire that they do not wish to reinstate these beds and that the current model is optimum. There is a risk, which will need to be monitored; however, the clinical consensus and commitment to the model is clear. Discussions around this have been ongoing for a year and there has been a very engaged clinical response to the specific challenges faced. To 'lift and impose' the model elsewhere would not be straightforward. Staff from the other county systems have visited Pembrokeshire and are developing their own plans/models, with different focuses according to their individual challenges. It is anticipated that there will be information on the steps required by Christmas or New Year. Whilst taking assurance from this, Mrs Hardisty queried why the other counties were not already in the same position as Pembrokeshire. In response, Mr Carruthers explained that it was not that they had just begun this work, they had been considering their challenges through a different lens. RAAC had presented a specific and focusing issue requiring immediate action. Carmarthenshire, for example, does not have the community capacity which South Pembrokeshire Hospital provides. Ms Lewis noted that it is possible to 'normalise' negative issues such as financial challenges. She felt that it was important to both recognise successes and examine those predictions which do not materialise and enquired whether any retrospective analysis is undertaken. Mr Moore conceded that the Health Board probably spends more time looking forwards than back. This reflects the complexity and scale of the challenges being faced, but is also a tendency of organisations, particularly NHS ones. There have been discussions in the past around HDdUHB becoming a learning organisation and this should probably be	**HT/LG**

	revisited. There are undoubtedly lessons to be learned, including from the COVID-19 Pandemic. Mrs Gostling assured Members that there is a focus on learning at the CDG. For example, discussions around the nurse stabilisation programme had considered its impact, including unforeseen, retrospectively. Mr Carruthers and his team examine any planned initiatives and ensure that submissions contain all of the required information before they are presented to CDG. There have been a number of examples where plans and proposals have been examined, and the rigour of the process has identified instances which need to be learned from and examples of learning having taken place. A further example is the Medical Locum situation which is due to be discussed by CDG next week. Mr Lee Davies agreed that the process and methodology which has been developed includes evaluation of schemes. He suggested, however, that in those cases where plans or proposals are not taken forward or are unsuccessful, this learning should also be captured. Mr Huw Thomas indicated that the Health Board is trying to be more 'forward-looking', whilst emphasising that it does also revisit previous forecasts and performance against these. What is possibly missing is formal documentation of this. Ms Lewis welcomed this clarification, whilst highlighting that when each report differs in performance from the previous one, it does potentially introduce questions around the organisation's ability to effectively predict and forecast. Mrs Rayani agreed that formalisation of process is required, together with increased integration with other mechanisms and processes. These actions should be supplemented with corrective action when learning is identified. CDG, Directorate Improving Together sessions (DITs) and QSEC all form part of this structure. It will, however, also require a cultural change. Ms Raynsford also felt that the organisation should establish a mechanism for capturing learning from Quality Improvement projects; this would also serve to enthuse staff and share good practice. Mrs Patel enquired regarding the process for disseminating learning. In response, Mrs Rayani suggested that a variety of mechanisms is required, due to the variety of different staff groups. It should also be easy to understand and suitable for public consumption. The organisation should, however, consider how to publicise learning and change.	
	The Board **NOTED** and **DISCUSSED** the financial position as at Month 7.	

PM(23)216	**IMPLEMENTING THE 'A HEALTHIER MID AND WEST WALES' STRATEGY**	
	Mr Lee Davies provided an update on the Implementing the 'A Healthier Mid and West Wales' (AHMWW) Strategy, highlighting the following five key points of note: • The Clinical Model Review by the Nuffield Trust • Feedback from the Welsh Government Infrastructure Investment Board Meeting • The Programme Business Case (PBC) was submitted to Welsh Government in February 2022 and is awaiting Ministerial Endorsement • The Strategic Outline Case has been drafted as far as possible	

	• The Programme Gateway Review was completed in October 2023, with an amber rating awarded Mr Maynard Davies expressed concern and disappointment that the Health Board is no further forward than when the PBC was submitted and has received no timescale for approval. The Health Board has also been required to undertake additional work as part of its submission. Mr Lee Davies indicated that the level of additional work is not yet known; clarity around this is awaited. It will, however, undoubtedly impact on the definitive timescale. In response to a request for an update on the Community Hubs, Members heard that the Cross Hands Full Business Case (FBC) is expected to be completed in March 2024. The Board has received a previous update on Cylch Caron. There has been less progress with Llandovery due to competing pressures with regard to RAAC. Noting that Welsh Government are due to publish their 2024/25 budgets imminently, Mr Iwan Thomas enquired whether there is any indication of whether these will be helpful to the Health Board's case. In response, Members heard that Welsh Government is significantly constrained in terms of capital. The capital budget available would be substantially depleted if it was the source for funding for the new hospital. It should be noted and reiterated, however, that HDdUHB's estate is significantly aging, with two hospitals of 50 and 70 years old. The issue of 'affordability' and need for capital therefore remains, with or without the new hospital. In response to a query around whether the Health Board can publish the Nuffield Trust Review report, Members noted that this is a Welsh Government-commissioned review, and their permission would, therefore, be required. Mr Lee Davies emphasised, however, that the Health Board's intention to publish the report had been stated from the beginning of the review process.	
	The Board: • **NOTED** the status of the current programme of work in relation to the Programme Business Case and Strategic Outline Case. • **NOTED** the receipt of correspondence from the Deputy Chief Executive NHS Wales and the work underway to clarify the likely resource and timeline implications for key programme activities. • **NOTED** the receipt of the draft Nuffield Trust Review of the Health Board's Clinical Model and that clarification is being sought in relation to the finalisation of this report. • **NOTED** the completion of the Programme Assessment Review (PAR) and the Amber status achieved. • **NOTED** that there may be implications for the Principal Risk 1196, which will be subject to further review.	

PM(23)217	**IMPROVING PATIENT/SERVICE USER EXPERIENCE**	
	Mrs Rayani introduced the Improving Patient/Service User Experience report, stating that it has been a privilege to present this to every Public Board meeting. Not all Health Boards receive a dedicated report on this topic. Mrs Rayani welcomed the importance placed on listening to feedback from the population which the Health Board serves, demonstrating a commitment to put patients at the heart of everything it does. The report presented covers the period of August and September	

2023. Members were advised that the Patient Charter is due to be updated and presented to the January 2024 Public Board meeting, with much work taking place to facilitate this. Mrs Rayani expressed her gratitude to those who take the time to respond to questionnaires, with 6,450 responses received to the 41,000 Friends and Family Test (FFT) questionnaire alone. Despite the well-publicised issues being faced by the NHS, 92% of respondents had rated their experience as 'good' or 'very good'. The report also, however, details areas which offer opportunities for improvement and information on complaints and concerns. 58% of the cases received were responded to within 30 working days, which is a disappointing reduction in average response time. One of the key and recurring themes is communication. Members heard that there will be a detailed discussion on this area at the December 2023 QSEC meeting, which Mrs Rayani hoped would provide a good opportunity to scrutinise this issue further. Referencing page 21, Mrs Rayani thanked Seren and her father for sharing their story, which is timely with this being Sensory Awareness Week. Members were advised that all services are now being covered in terms of feedback, with expansion of coverage having taken place, to include services such as Primary Care and MHLD. The Arts in Health has made its usual positive impact with limited resources.

Mrs Hardisty wished to acknowledge the significant development and evolution of this report under Mrs Rayani's leadership. Ms Raynsford also recognised the efforts of Mrs Rayani and her teams. It was disappointing, however, to note the complaints around dignity and respect, behaviour and attitude of staff. Ms Raynsford queried the reasons behind this trend and whether there was any potential link with the use of locum medical staff. In response, Members heard that of the complaints in this area, 5 related to nursing staff, 14 medical staff and 4 reception staff. There was not a clear correlation in terms of locum staff. Whilst not excusing these examples of poor experience, Mrs Rayani felt that the pressures and environment staff are working under and in should be recognised. Mrs Rayani suggested that there needs to be an exercise across all staff groups to reinforce how words and the way in which they are said can impact on patients and families.

Whilst welcoming the report, which provides a great deal of assurance, Mr Imperato noted the increase of 73 in the number of complaints, and enquired regarding the overall trajectory. In response, Mrs Rayani explained that there is no formal trajectory recorded. The number of complaints is extremely variable; 446 had been received during the period this report covers, this figure fluctuates by 20-30 each month. Whilst there is no specific commonality, complaints relating to A&E and Outpatient experience are frequent. Building on this topic, Mr Imperato enquired whether there are 'complaints about complaints' and (if so) whether this is captured and/or monitored. Noting the response that this is assisted by the work of the Ombudsman, Mr Imperato clarified that his query was more in relation to local processes. Mrs Rayani explained that the common theme in terms of complaints handling is timeliness. One of the most significant challenges is securing clinical engagement to facilitate timely responses to complainants. Members were assured that this matter is monitored.

	Mr James Severs welcomed the opportunity provided by the report for an oversight of patient and service user experience. He enquired how opportunities to learn from other professions are identified. Also, whether FFT is somewhat 'restrictive' in this regard. In response to the latter, Mrs Rayani informed Members that bespoke feedback mechanisms are available and utilised. There is not a specific focus on particular groups, other professions are considered. Services can download and review their feedback from Civica and can (and do) publicise how they have addressed this – for example via 'You Said, We Did' posters in clinical areas.	
	The Board **RECEIVED** the Improving Patient Experience report, which highlights to patients and to the public the main themes arising from patient feedback.	

PM(23)218	**ANNUAL PRESENTATION OF NURSE STAFFING LEVELS FOR WARDS COVERED UNDER SECTION 25B OF THE NURSE STAFFING LEVELS (WALES) ACT**	
	Ms Sharon Daniel introduced the annual presentation of nurse staffing levels for wards covered under Section 25B of the Nurse Staffing Levels (Wales) Act (NSLWA). Members were well-sighted on the methodology used for these calculations. Ms Daniel assured Members that the Nurse Staffing Programme Lead regularly networks with colleagues across Wales and participates in the national group concerned with NSLWA; this allows input into the process. The 'uplift' identified in Table 1 within the report is primarily as a result of the acuity and activity on these wards, based on the complexity of cases. The Board is asked to note that the Nurse Staffing Levels have been presented to and discussed with Mrs Rayani, as the Health Board's Designated Person. *Ms Helen Williams left the Board meeting.*	
	The Board **TOOK ASSURANCE** that: • Hywel Dda University Health Board (HDdUHB) is meeting its statutory 'duty to calculate' responsibility in respect of the nurse staffing level in all wards that fall under the inclusion criteria of Section 25B of the Nurse Staffing Levels (Wales) Act 2016 • HDdUHB is meeting its statutory duty to provide an annual presentation to the Board of the detail of the nurse staffing levels • The actions identified within the attached templates will be progressed and monitored through the Quality, Safety and Experience Committee (QSEC).	

PM(23)219	**INTEGRATED PERFORMANCE ASSURANCE REPORT**	
	Mr Huw Thomas presented the Integrated Performance Assurance Report (IPAR) for Month of 7 2023/24, noting that this is of the standard format, and describes the achievements and challenges in performance which the Health Board is facing. Referencing page 4 of the report, and 'Key initiatives and improvements impacting our performance', Mr Maynard Davies noted the outsourcing of 379 diagnostic assessments for autism spectrum disorder (ASD), with 212 referrals made to date. He enquired whether this outsourced capacity will be fully utilised. In response, Mr Carruthers confirmed that	

	the level of referrals was on track to maximise the capacity usage. In response to a query around the planned use of Ty Bryn for Neurodevelopmental Services and whether capital has been identified for refurbishment, Mr Carruthers advised that the service is working with the Estates team; a potential Welsh Government funding source has been identified. Mr Maynard Davies requested clarification if available around the reasons for removal of patients as part of the waiting list validation exercise; whether and how many were due to improvement in condition or patients opting for private treatment. Mr Carruthers advised that there are multiple reasons for removal and committed to provide further detail.	**AC**
	Noting on page 5 the issues around therapies agency staff, with other organisations willing to pay above framework rates, which is at variance with other agency staff, Mr Maynard Davies enquired whether this had been escalated to Welsh Government. In response, Mr Carruthers stated that it has not yet been escalated through the operational route. Different Health Boards do, in fact, pay different rates, which creates significant challenges. Mrs Gostling advised that there is an All Wales group focusing on Agency Staff and suggested that this matter will be picked up there. Mr Severs felt that there needs to be a focus on the reasons behind agency staff usage. A report on this topic had been scheduled for presentation to QSEC's December 2023 meeting; he had, however, requested deferral to seek further clarification around what staffing is required to deliver services. Referencing the table on page 3 of the report, Cllr. Evans noted a number of 'n/a' entries in the Trajectory column, where he would expect there to be information, for example 'Ambulance handovers over 4 hours'. It was agreed that the reason for this would be explored.	**HT/AC**
	Ms Paterson drew Members' attention to the introduction of a new metric, at Welsh Government's behest, Delayed Pathways of Care (DPOC), which replaces Delayed Transfer of Care (DTOC). This will allow improved tracking going forward. Noting the figure of 192 individuals in hospital ready to leave, Ms Raynsford enquired regarding actions being taken in conjunction with Local Authority partners to address this issue. Mr Carruthers reminded Members that this figure has been in excess of 300 at times, so does represent an improvement. There have been a number of actions taken, with a particular focus on the 'window of opportunity' within 72 hours of admission. The number of patients with a Length of Stay (LOS) of more than 21 days is reducing. The second part of the pathway is around speeding up discharge processes. Members were reminded of work in relation to the Trusted Assessor role, which has seen a framework agreed across the Hywel Dda region. Partnership working has focused on the three Local Authorities co-terminus with the Health Board area.	
	Ms Paterson advised that there are issues around capacity for assessment, and that the Health Board has been working with local Care Homes. It should be remembered that Care Homes are independent businesses, who are at liberty to decline to take individuals. Members heard that a workshop with Care Home representatives had recently taken place, to share information and challenges. This had also	

	included representation from Primary Care. There is occasionally a lack of understanding around the challenges faced by Care Homes, and it is important for the Health Board to support them. Equally, it is important to understand that the Trusted Assessor role is not 'a panacea' and is intended for low-level assessment. Considerable work in relation to Domiciliary Care has already taken place; further work around the above will be progressed through the IEG. Mrs Patel enquired with regard to individuals who have been in hospital care for a significant length of time, with no identified date for discharge. Ms Paterson recognised that there are individuals with complex care needs who may be with the Health Board for long periods. Members were assured that their cases are continuously assessed; however, it can be challenging to source packages of care which offer sufficiently safe discharge. For example, it can be difficult to secure medical support for these individuals in their homes or in a Care Home. Various options need to be considered in such cases. Mrs Hardisty suggested that this matter should be addressed as part of the Primary Care Strategy or via discussions at the Strategic Development and Operational Delivery Committee (SDODC). In considering the Recommendation, it was suggested that it would be more appropriate to record that the Board notes the data within the IPAR, rather than takes assurance from the performance outlined therein.	**JP**
	The Board **NOTED** the data within the IPAR - Month 7 2023/2024.	

PM(23)220	**OPERATIONAL UPDATE**	
	Introducing the Operational Update report, Mr Carruthers highlighted the following: **RAAC at WGH** – work has been undertaken to repair and reinstate two wards. The temporary replacement kitchen should be available the week commencing 4 or 11 December 2023. One further ward should be reinstated in early January 2024, with others to follow. It is likely that the Health Board will be able to consider de-escalation from an internal Major Incident during December 2023. **Emergency General Surgery Rota WGH** – Members were reminded of the change made in May 2023. The substantive service model has been reinstated since the beginning of November 2023. This is in part due to the successful appointment of a locum consultant and partly to concerns around the sustainability of the alternative model. The temporary service change has, therefore ceased. The Health Board had been optimistic that it had successfully appointed an NHS locum; however, they have since withdrawn. The other candidates will be revisited to establish whether any are suitable and/or available. **Focus on Regional Working** – Welsh Government has a significant focus around this area, particularly in respect of improved access and reduced waiting times. The first regional clinical workshop in Orthopaedics took place on 29 November 2023. Welsh Government has allocated programme support and Swansea Bay UHB (SBUHB) has advertised for a Programme Manager. There is an intended focus on maximising capacity to reduce waiting lists.	

	Winter Planning – data provided for information. The Health Board is facing a challenging winter period, with no capacity for surge beds due to financial restrictions. Actions implemented as part of the Transforming Urgent and Emergency Care (TUEC) programme are, however, helping. **Planned Care** – Members were reminded of Ministerial Priorities in this regard. Whilst the Health Board is currently on track to deliver the 52 week target, achievement of the 104 week and 156 week targets is looking more challenging. The position is being reviewed and monitored; however, is dependent on activity. **Cancer Care** – the 'headline' performance remains too low at 46%, however, there is confidence around an improvement in the backlog. The national team are cautiously optimistic that the Health Board will recover its performance to 60+%. Mrs Hardisty enquired around the findings of the 'Getting It Right First Time' (GIRFT) review on Theatre Utilisation. In response, Mr Carruthers advised that Health Boards have only recently received the data pack. There are significant (and shared) concerns around the comparability of data across Health Boards, which have been expressed. In response to a query around the Cross Hands and Tumble Medical Practice and potential use of the Cross Hands Health and Wellbeing Centre, Ms Paterson indicated that it would not be appropriate to prejudge the outcome of the current process. However, should the Board decision be to go out to tender, and should this be successful, the Health Board would want to invite parties to consider this as an option. It would not, however, be an option if the decision is to disperse the patient list. Mr Moore clarified that any decision to de-escalate the internal Major Incident relating to RAAC would need to be considered by the Gold Command Group and approved by the Board. Mrs Hardisty advised that Independent Board Members had recently received an update around vaccination rates, and that further information would be included either in the Operational Update or as a stand-alone agenda item at the January 2024 Public Board meeting.	**CM**
	The Board **RECEIVED** the Operational Update and Progress Report.	

PM(23)221	**CLINICAL SERVICES PLAN UPDATE**	
	Mr Lee Davies provided an update on the Clinical Services Plan. Members' attention was drawn in particular to the targeted early engagement survey, which had attracted in excess of 6,000 responses from service users. The potential amendment to the timeline flagged as a risk at the previous Board meeting has materialised, meaning that, subject to Board approval, the programme issues paper will need to be presented to the March 2024 Public Board meeting. This does provide the advantage of allowing additional discussion at the February 2024 Board Seminar.	
	The Board: • **TOOK ASSURANCE** that the Clinical Services Plan programme is progressing in line with the Board agreed plan.	

	• **APPROVED** the proposed timeline adjustment for the production of the programme issues paper. Now to be presented to Public Board in March 2024, with a summary view for discussion at Board Seminar in February 2024. • **NOTED** that, at the Public Board meeting in March 2024, the programme will seek a decision on the scope of the next phases of the programme for each service, including understanding which services require a deliberative conversation and options appraisal phase.	

PM(23)222	**BOARD ASSURANCE FRAMEWORK**	
	Mrs Wilson introduced the Board Assurance Framework, reminding Members that progress reports on all Planning Objectives are presented to the relevant Board level Committees. Outcome measures are also reviewed by the Executive Team. All are on track, with the exception of 3A (Transforming Urgent and Emergency Care); 5A (Estates Strategy) and 8A (Decarbonisation and Sustainability). *Mrs Chantal Patel left the Board meeting.*	
	The Board **TOOK ASSURANCE** on areas giving rise to specific concerns.	

PM(23)223	**DIGITALLY ENABLED TRANSFORMATION PLAN**	
	Mr Huw Thomas presented the Digitally Enabled Transformation Plan, recognising that this has been a significant time in development. Members were assured, however, that its development has involved input from a number of stakeholders. The challenges being faced by the Health Board are well known. Digital transformation is needed at scale to assist in addressing these challenges. Mr Huw Thomas highlighted that the report covers the Strategic and Management case for change only; the economic, financial, and commercial case will be developed if and when agreed by the Board. There have been unprecedented changes to and adoption of digital solutions. The Health Board has and continues to build relationships in this regard with Welsh Government, Digital Health and Care Wales (DHCW) and others. In developing this Plan, the organisation has considered the needs and barriers across the healthcare system. Mr Huw Thomas was particularly pleased with the work to develop personas, based on Teulu Jones used in the AHMWW Strategy, which help to assimilate the needs of patients and service users. It is important to put as much as possible in the hands of patients and their families. It should be noted, however, that there is no electronic patient management system currently in Wales. There is a need to develop remote monitoring systems, building on the strong work already undertaken, together with programme charters. Whilst Mr Huw Thomas was confident that investment would bring productivity benefits, he could not guarantee that it would produce cash benefits. Staff requirements would also need to be considered. Members were assured, however, that individual cases would be presented for Board approval and no commitment would be entered into without Board agreement. The governance arrangements have been reviewed and a Digital Oversight Group established.	

	Ms Raynsford noted that the Hywel Dda region is notorious for poor connectivity, and enquired whether any steps are being taken to address this by the relevant parties. Mr Huw Thomas responded that Openreach and a number of other telecoms providers are working with Health Boards; however, this challenge will remain in certain communities. It may be that satellite technology needs to be considered. Referencing the Recommendations, Cllr. Evans noted the importance of benefits realisation, and suggested that the relevant recommendation should be amended to agree, rather than note. Whilst agreeing that this Plan has been a long time in preparation, Mr Moore suggested that it will likely be one of the most important, sitting as it does very much within the productivity agenda. The process should be to set out the needs and aims. HDdUHB is leading the way in this area, with Welsh Government and DHCW monitoring progress. Referencing the strategic case, and the single shared patient record specifically, Mr Weir enquired whether this is being explored by Welsh Government, or whether it would be feasible for HDdUHB to implement this out with Welsh Government. Mr Huw Thomas clarified that there is a demographic record, but no shared patient record. There are organisations implementing a single electronic patient record, although these are generally Secondary Care focused. Whilst Welsh Government is currently not developing a shared patient record, they are interested in the work being undertaken. Mr Imperato noted that, against Equality in the Impact section of the report, there is an entry of 'Not applicable', which he suggested was inaccurate. Mr Huw Thomas accepted this comment as valid and committed to correct this in any future reports or business cases.	**HT**

	The Board
	• **AGREED** that, before any investment decisions are made on specific programmes, individual business cases will be developed which will:
	  ○ Identify a source of funding, either internal or external
	  ○ Be scrutinised by the Digital Oversight Group and Sustainable Resources Committee, for Board approval, following the 5-case approach
	  ○ Include a full benefits realisation methodology
	• **NOTED** that this transformation plan is moving the current operating model within digital to be more fully aligned with the clinical/operational models proposed in AHMWW
	• **NOTED** the alignment with the regional and national strategies for planned care recovery and transforming urgent and emergency care.
	• **AGREED** to proceed to a Full Programme Business Case, with the identification of a preferred supplier for a Digital Strategic Partner
	• **AGREED** that no commitment to a specific supplier will be made until a further review has taken place to confirm that the recommended investment decision is appropriate and Board APPROVED; before the contract is placed with a supplier or partner	

PM(23)224	**ELECTRONIC PRESCRIBING MEDICINES ADMINISTRATION (EPMA) SYSTEM**	
	Mr Huw Thomas presented the Electronic Prescribing Medicines Administration (EPMA) System report, explaining that this relates only to the Secondary Care element, as Primary Care is being progressed by	

	DHCW. Members were informed that the costs involved are significant; £10.6m over 7 years, with HDdUHB's commitment being approximately £5.5m. The request of Board is to proceed to Full Business Case (FBC), which would be presented for Board approval. Whilst the implementation period is relatively lengthy, there is significant potential to improve patient experience and safety. Mrs Hardisty suggested that it would be worthwhile to present an update on the Primary Care element to SDODC. Mrs Rayani suggested that this case represents an urgent priority, as the benefits cannot be realised without its progression. Whilst agreeing, Mr Weir emphasised the need to clearly outline the quantified benefits within the FBC.	**JP** **HT**
	The Board: • **NOTED** the Outline Business Case, and the requirement to complete the Financial Case once the tender has been returned. • **AGREED** to proceed to a Full Business Case, with the identification of a preferred supplier. • **AGREED** that no commitment to a specific supplier will be made until a further review to confirm that the recommended investment decision is appropriate is conducted; before the contract is placed with a supplier or partner and **AGREED** due to the financial investment required this will need to be brought back to the Board for final approval.	

PM(23)225	**WELLBEING OBJECTIVES ANNUAL REPORT**	
	Ms Ardiana Gjini introduced the Wellbeing Objectives Annual Report, which has been considered and discussed by SDODC, and which had recommended to Board approval for publication. The report was commended by Mrs Hardisty.	
	The Board: • **APPROVED** for publication HDdUHB's Well-being Objectives Annual Report for the period 1 April 2022 – 31 March 2023 • **APPROVED** the existing eight well-being objectives as continuing to be relevant to the Health Board for the next five-year period, aligning with the PSB Well-being Plan cycle	

PM(23)226	**REPORT OF THE SUSTAINABLE RESOURCES COMMITTEE**	
	Mr Weir, SRC Chair, presented the SRC Update Report from the meeting held on 24 October 2023, which had approved the Financial Procedures and noted the changes to digital governance, with the Agile Digital Business Group being replaced by the Digital Oversight Group. As has been mentioned, an additional allocation has been received from Welsh Government, recurrent conditional on delivery of the defined Control Total. This brings with it potentially significant ongoing impacts. The Committee also discussed risks in relation to winter pressures and the potential need for surge capacity. Also, concerns around regional funding arrangements regarding healthcare commissioning and contracting and the risk of inequity for HDdUHB patients.	
	The Board **NOTED** the SRC update report and **ACKNOWLEDGED** the key risks, issues and matters of concern, together with actions being taken to address these.	

PM(23)227	**REPORT OF THE STRATEGIC DEVELOPMENT & OPERATIONAL DELIVERY COMMITTEE**	
	Mr Maynard Davies, SDODC Chair, presented the SDODC Update Report from the meeting held on 26 October 2023.	
	The Board **NOTED** the SDODC update report and **ACKNOWLEDGED** the key risks, issues and matters of concern, together with actions being taken to address these.	

PM(23)228	**REPORT OF THE PEOPLE, ORGANISATIONAL DEVELOPMENT & CULTURE COMMITTEE**	
	Ms Lewis, PODCC Vice-Chair, presented the PODCC Update Report from the meeting held on 10 October 2023.	
	The Board: • **NOTED** the PODCC update report and **ACKNOWLEDGED** the key risks, issues and matters of concern, together with actions being taken to address these. • **NOTED** the progress on the Strategic Equality Plan Annual Report.	

PM(23)229	**REPORT OF THE HEALTH & SAFETY COMMITTEE**	
	Ms Murphy, Health and Safety Committee (HSC) Chair, presented the HSC Update Report from the meeting held on 13 November 2023, highlighting that the updated CCTV camera installation has been completed in two hospitals, with the entire installation programme due for completion by the end of December 2023. There is a planned campaign on violence and aggression. The Committee recommended that Board Members receive updated training around CONTEST and PREVENT, with Mrs Wilson advising that this has been added to the Board Seminar workplan.	
	The Board **NOTED** the HSC update report and **ACKNOWLEDGED** the key risks, issues and matters of concern, together with actions being taken to address these.	

PM(23)230	**COMMITTEE UPDATE REPORTS**	
	Mrs Wilson presented the Committee Update Reports, highlighting the request for Board to ratify the change to the Health Board's financial position and approve new Healthcare Professionals Forum members. Referencing the Staff Partnership Forum update report, Mr Maynard Davies noted the pay offer to consultant staff in England and enquired regarding the potential industrial action in Wales. Mrs Gostling advised that there is no change to the position in Wales, with BMA members being balloted on taking industrial action.	
	The Board: • **ENDORSED** the updates, recognising any matters requiring Board level consideration or approval and the key risks and issues/matters of concern identified, in respect of work undertaken on behalf of the Board at recent Committee meetings, noting that a Corporate Trustee session will be held directly after the Public Board meeting to consider the charitable funds items outlined above • **RECEIVED** the update report in respect of the In-Committee Board meeting	

	○ **RATIFIED** the change to the Health Board's financial position • **RECEIVED** the update reports in respect of recent Advisory Group meetings ○ **APPROVED** new members to the Healthcare Professionals Forum	

PM(23)231	**HDdUHB JOINT COMMITTEES & COLLABORATIVES**	
	The Board **RECEIVED** the minutes and updates in respect of recent WHSSC, EASC, NWSSP and MWJC meetings.	

PM(23)232	**STATUTORY PARTNERSHIPS UPDATE**	
	The Board **NOTED** the update on recent activity of the PSBs and RPB.	

PM(23)233	**BOARD ANNUAL WORKPLAN**	
	The Board **NOTED** the Board Annual Workplan, which would be updated in line with foregoing discussions.	

PM(23)234	**ANY OTHER BUSINESS**	
	There was no other business reported.	

PM(23)235	**DATE AND TIMES OF NEXT MEETINGS**	
	9.00am, Thursday 14 December 2023 (Extraordinary Meeting) 9.30am, Thursday 25 January 2024	