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

| | |
|---|---|
| Date of Meeting: | **09:30, Thursday 26 September 2024** |
| Venue: | **Y Stiwdio Fach, Canolfan S4C Yr Egin, College Road, Carmarthen SA31 3EQ** |

| | |
|---|---|
| Present: | Dr Neil Wooding, Chair, Hywel Dda University Health Board<br>Mr Maynard Davies, Independent Member (Information Technology)<br>Cllr. Rhodri Evans, Independent Member (Local Authority)<br>Mr Michael Imperato, Independent Member (Legal)<br>Ms Anna Lewis, Independent Member (Community)<br>Ms Ann Murphy, Independent Member (Trade Union)<br>Mrs Chantal Patel, Independent Member (University)<br>Ms Delyth Raynsford, Independent Member (Community)<br>Mr Iwan Thomas, Independent Member (Third Sector)<br>Mr Winston Weir, Independent Member (Finance)<br>Professor Philip Kloer, Interim Chief Executive<br>Mr Andrew Carruthers, Chief Operating Officer<br>Ms Sharon Daniel, Interim Director of Nursing, Quality and Patient Experience<br>Mr Lee Davies, Executive Director of Strategy and Planning<br>Dr Ardiana Gjini, Executive Director of Public Health<br>Mrs Lisa Gostling, Interim Deputy Chief Executive and Executive Director of Workforce and Organisational Development<br>Mr Mark Henwood, Interim Medical Director<br>Mr James Severs, Executive Director of Allied Health Professions and Health Science<br>Mr Huw Thomas, Executive Director of Finance |
| In Attendance: | Ms Alwena Hughes Moakes, Communications and Engagement Director<br>Ms Jill Paterson, Director of Primary Care, Community and Long-Term Care<br>Mrs Joanne Wilson, Director of Corporate Governance/Board Secretary<br>Mr Sam Dentten, Deputy Regional Director, Llais West Wales (part)<br>Dr Eiry Edmunds, Interim Deputy Medical Director; Cardiac Consultant (part)<br>Mr Peter Skitt, County Director, Ceredigion (part)<br>Ms Tracey Evans, Head of Community Nursing, Ceredigion (part)<br>Dr Jon Morris, Clinical Lead, Minor Injuries Unit (part)<br>Dr Robin Ghosal, Hospital Director, Prince Philip and Glangwili General Hospitals; Respiratory Consultant (part)<br>Ms Sarah Perry, General Manager, Prince Philip and Glangwili General Hospitals; Acting County Director, Carmarthenshire (part)<br>Dr Prem Kumar Pitchaikani, Clinical Director, Women and Child Health; Consultant Paediatrician (part)<br>Ms Lisa Humphrey, General Manager, Women and Children's Directorate<br>Mr Nick Williams-Davies, Service Delivery Manager, Acute Paediatric and Neonatal Services (part)<br>Mr Anthony Tracey, Digital Director (part)<br>Ms Clare Moorcroft, Committee Services Officer (Minutes) |

| Minutes Ref. | Item | Action |
|---|---|---|

**PM(24)162 Welcome and apologies**

Dr Neil Wooding, Health Board Chair, welcomed everyone to the Public Board meeting, thanking them for their attendance. Dr Wooding reminded Members of the five decision-making 'design principles' proposed at the previous Board meeting:

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

He emphasised in particular the final of these, requesting that Members especially keep in mind quality and safety aspects when making decisions.

Apologies for absence were received from:

- Mrs Eleanor Marks, Vice-Chair, Hywel Dda University Health Board
- Mr Michael Gray, Director of Social Services, Pembrokeshire County Council and Associate Board Member

**PM(24)163 Declaration of Interests**

The following declarations of interest were made:

- Mrs Chantal Patel – role at Swansea University, with particular reference to item PM(24)183 (Pentre Awel)
- Cllr. Rhodri Evans – role on Ceredigion County Council, and specifically items PM(24)173 (Accelerating the Cylch Caron Model of Care) and PM(24)175 (Paediatric Inpatient Provision at Bronglais Hospital)
- Mr Michael Imperato – discussions regarding Emergency Medical Retrieval and Transfer Service (EMRTS)

Mrs Joanne Wilson highlighted that Cllr. Rhodri Evans, the Health Board's Local Authority Independent Member, has declared an interest in item PM(24)173, advising that this matter has been considered in detail. Cllr. Evans is not representing Ceredigion County Council; he brings to the Board a Local Authority perspective. However, due to involvement in the Cylch Caron project, and Cllr. Evan's Council ward being the neighbouring ward to Tregaron Community Hospital, it is felt that there is a personal and professional conflict of interest. Cllr. Evans would, therefore, withdraw from the discussion for this item.

**PM(24)164 Minutes of the Public Meeting held on 11 July 2024**

**RESOLVED** – that the minutes of the meeting held on 11 July 2024 be approved as a correct record.

**PM(24)165** **Minutes of the Public Meeting held on 25 July 2024**

**RESOLVED** – that the minutes of the meeting held on 25 July 2024 be approved as a correct record.

**PM(24)166** **Matters Arising and Table of Actions**

An update was provided on the Table of Actions from the Public Board meeting held on 25 July 2024 and confirmation received that outstanding actions had been progressed. There were no matters arising.

**PM(24)167** **Report of the Chair**

Dr Wooding presented his report on relevant matters undertaken since the previous Board meeting. Referencing page 1, Dr Wooding advised that his first NHS Chair Quarterly Review had taken place with Jeremy Miles, Cabinet Secretary for Health and Social Care, rather than Mark Drakeford. Dr Wooding felt that he had been able to engage more with services since his previous report, having visited Cancer and Neonatal services at Singleton Hospital and Glangwili Hospital (GGH).

Professor Philip Kloer wished to note the sad passing of Dr George Eltom, who was a well-loved and highly respected doctor. Dr Eltom had been a significant member of the medical registrar rota and had made a major contribution to the Same Day Emergency Care (SDEC) centre at GGH. He will be greatly missed.

**Decision:** The Board:

- **RATIFIED** the actions undertaken by the Chair on behalf of the Board.
- **SUPPORTED** the work engaged in by the Chair since the previous meeting and note the topical areas of interest.

**PM(24)168** **Report of the Chief Executive**

Introducing his report on relevant matters undertaken since the previous Board meeting, Professor Kloer highlighted in particular the update on St David's Surgery. Since the decision at the previous Public Board meeting to progress with managed dispersal of the patient list and explore locations to establish a Branch Surgery, the Health Board has received a great deal of correspondence from the general public. Members were assured that the concerns expressed therein are acknowledged, and the Health Board is progressing work in relation to the Branch Surgery as quickly as possible.

Ms Jill Paterson welcomed the opportunity to update on this important issue, and thanked the local community for their patience. Members were reminded that there is a relatively short space of time in which to ensure services are in place. As indicated by Professor Kloer, the significant concerns and levels of correspondence around this matter were recognised, and the Health Board had this week received a letter from the St David's City Council. Ms Paterson reminded Members of the decision to delegate consideration of the Practice name change to the community working group, and advised that the group had proposed that this be the Peninsula Practice/Meddygfa Penrhyn.

Whilst recognising that work in relation to the changes agreed at the previous Board meeting may not appear evident, Ms Paterson explained that legal discussions have been taking place and the landowner in question has been out of the country. However, plans are in place and the appointed contractor is ready to commence work. The Practice building in Solva will be making changes to where staff operate from and converting rooms for new uses. Concerns in relation to parking at and travel to the Practice are acknowledged; Ms Paterson advised that there will be 18 dedicated patient parking spaces available. Whilst recognising that travel may be challenging, it is hoped that this the requirement to do so will not be significant, with the commitment to provide services via a Branch Surgery in St David's. The Health Board is working with the Pembrokeshire Association of Community Transport Organisations (PACTO) to explore options which will respond to patient need. It is also hoped that the Practice will accommodate appointments at times which best match with travel arrangements.

In response to concerns raised regarding the need to travel affecting particular groups, which were also highlighted within the Equality Impact Assessment, the Board did agree to establish a Branch Surgery. Again, concerns have been expressed that no updates on progress have been issued. Ms Paterson explained that this was due to sensitive legal conversations which needed to take place. The Health Board has undertaken a great deal of scoping of suitable premises and Ms Paterson was pleased to advise that the owners of the premises identified as the location of the Branch Surgery have agreed that this could be announced at today's Public Board meeting. Shalom House in St David's will provide two rooms which can be utilised as a Branch Surgery, with services largely provided by the multi-disciplinary team. Members heard that the Health Board is also working with local pharmacies and are trying to ensure that services are delivered locally wherever possible, to avoid unnecessary travel to Solva.

The Peninsula Practice/Meddygfa Penrhyn will have three permanent GPs and a range of locum GP staff; the nursing team will double in size and the administrative team will combine staff from both practices. Ms Paterson wished to thank the staff for embracing this change in such a positive manner. Members were advised that a formal review will be undertaken in six months.

There have been suggestions that the decision-making process has been unnecessarily rushed. Ms Paterson assured Members that this was not the case, drawing their attention to data within the Chief Executive's Report, and reminding them of the comprehensive information presented at the previous Board meeting, the engagement process undertaken and the involvement of Llais. This had been, as required, an evidence-based decision.

There have also been queries around the deadline for implementing change, and whether this could have been postponed. Ms Paterson explained that the Health Board, contractually, has only six months to respond when advised of an Independent Contractor relinquishing their GMS contract. Members were reminded that the Health Board is retaining services within St David's via provision of a Branch Surgery. All patients will receive a fourth letter this week which will be a 'welcome letter' reiterating details of their new surgery and including information regarding PACTO. Ms Paterson ended by emphasising that all parties are working hard to meet the deadline of 1 November 2024. Dr Wooding enquired whether the Branch Surgery in Shalom House is accessible. He was advised that it is, being in St David's. In response to a query around measures to continually monitor the situation, Ms Paterson suggested that in similar situations previously, Health Board Primary Care team staff are present pretty much daily to ensure support and monitoring. There will be appropriate measures to respond to patient/ community concerns and the Health Board will also continue to work with Llais. There are also plans to audit a random selection of clinical records and for liaison with the clinical team. The Health Board will engage again with the local population at the end of the initial six month period.

Mr Michael Imperato reminded Members that the Health Board has a duty to continuously engage, noting that the planned six month review will offer an opportunity to do so. He reflected on the productive and constructive discussions at the previous Board regarding the Health Board's response to the St David's GP relinquishing their contract, including the decision to establish a Branch Surgery. He was somewhat disappointed, therefore, by media headlines following the meeting, and wondered whether this can be addressed by an alternative approach to communications. Ms Alwena Hughes Moakes explained that, whilst Health Board communications have emphasised the establishment of a Branch Surgery, this is not necessarily what has been reported. The Health Board will now be able to share the location of this facility. Ms Hughes Moakes also highlighted that much of the Health Board's communication has been directly with patients.

Mr Iwan Thomas welcomed the update provided, whilst cognisant of the timescale involved, with only six weeks until 1 November 2024. He enquired whether the remedial and construction works will be completed in sufficient time, so as to ensure a seamless

transition. In response, Ms Paterson advised that – for the reasons described above – building works have been delayed. Teams are assessing the building and, whilst the contractor will do as much work as possible prior to 1 November, it is likely that this will still be ongoing beyond that date. Ms Paterson apologised for any disruption this may cause. She ended by expressing a genuine desire to continue working with the St David's community.

Concluding discussion around this matter, Dr Wooding recognised the community's concerns and emphasised that this has not been an easy decision. It is, however, one which is well-founded and evidence-based. The Board should be cognisant that concerns are likely to remain and continue. He thanked Ms Paterson and her team for their ongoing work.

Cllr. Rhodri Evans noted planned works in relation to Reinforced Autoclaved Aerated Concrete (RAAC) due to commence in Bronglais Hospital from December 2024. Whilst pleased that they are not anticipated to impact on service access, he enquired regarding the duration. Mr Andrew Carruthers understood that the work would take between three and six months.

Referencing page 2, and the A Healthier Mid and West Wales (AHMWW) Strategy Update, Ms Anna Lewis requested clarification around the statement regarding 'additional scenarios' in the Strategic Outline Case (SOC). Professor Kloer reminded Members that the AHMWW Strategy had been agreed in 2018, six years ago. The intervening COVID-19 pandemic had inevitably impacted on progress. Both Welsh Government and the Health Board need to reflect on learning from the interim, particularly from COVID-19. The basic principles of the Strategy remain sound; however, it will be important to reassess in light of this learning, with a 'refresh' process extending into next year.

A key piece of feedback from Welsh Government was that, when considering a business case, there needs to be a range of options; the Health Board therefore needs to broaden the SOC to meet this requirement. Mr Lee Davies reminded Members that the Programme Business Case (PBC) was submitted in 2022, and remains unendorsed by Welsh Government. Welsh Government has since requested the Health Board to develop an SOC and commissioned the Nuffield Trust Review of the Health Board Clinical Models. As indicated, Welsh Government have now requested that the Health Board present a broader range of options, and clarification around this is being sought. Once provided, a Board discussion will be required. All of this will result in a further delay to the planned timescales. Dr Wooding highlighted that most strategies operate within a five year window, suggesting that it is only right and 'healthy' to refresh and review at this point.

Professor Kloer drew Members' attention to the NHS Wales Joint Commissioning Committee (JCC) documentation for approval, which has been subject to the necessary scrutiny.

**Decision:** The Board:

- **ENDORSED** the Register of Sealings since the previous report on 25 July 2024
- **NOTED** the status report for Consultation Documents received/responded to
- **APPROVED** the following documentation, which form part of the NHS Wales Joint Commissioning Committee (JCC) governance framework:
  - Memorandum of Agreement
  - Hosting Agreement
  - The proposed sub-committee structure, including the accompanying terms of reference for the JCC Quality, Safety and Outcomes Sub-Committee and the JCC Planning, Performance and Finance Sub-Committee
  - The continuation of the transitional reporting arrangements for the All Wales Individual Patient Funding Request (IPFR) Panel, Welsh Kidney Network (WKN) and Specialised Services Management Group pending the establishment of a new Collaborative Commissioning Leadership Group (CCLG)
- **NOTED** the terms of reference (ToR) for the CTMUHB Audit and Risk Committee (ARC) for hosted bodies are contained within the CTMUHB ARC ToR which are under review and will be presented to the CTMUHB board meeting on 26 September 2024 for approval

**PM(24)169 Financial Report**

Presenting the Financial Report for Month 5 2024/25, Mr Huw Thomas reminded Members that, whilst the Plan had been approved, it is regarded as unacceptable by both Welsh Government and the Board. The past month had, however, been more positive in terms of achieving the forecast deficit, being £0.1m adrift of target. This was largely as a result of reductions in agency usage and delivery of savings. Mr Huw Thomas was conscious of the need to maintain this trajectory. Progress has been made in reducing the savings 'gap' and further progress is anticipated. The forecast deficit is also improved; £68m with a £4m option for improvement. Members were advised, however, that the Health Board is overly-reliant on non-recurrent measures and there is a need to convert these opportunities to recurrent. Challenges include growth in drugs costs and medical staff costs, with too much variable pay usage. Mr Huw Thomas emphasised the importance of planning conversations around next year, which need to take place earlier than has been the case previously. It was recognised that even an improved forecast deficit of £64m is not the Welsh Government target Control Total of £44.8m, and that the organisation needs to maintain momentum and pace.

Dr Wooding reminded Members that the Health Board has committed to achieve the Control Total deficit of £44.8m by the

end of March 2026. He reiterated his previous comments that – should HDdUHB be unable to achieve a sustainable position – Welsh Government will need to divert resource from elsewhere, depriving other public services of funding. The Health Board as an organisation has a responsibility to recognise this. Welcoming the report and its identification of positive progress, Mr Weir enquired whether the organisation's underlying deficit is showing improvement and whether further improvement is anticipated. In response, Mr Huw Thomas suggested that the progress made is a testament to work around agency nursing expenditure in particular. In May 2023, the monthly expenditure had been £3m; in August 2024, this was £1m, with a trajectory to reduce further. This improvement is recurrent in nature. It is intended to review non-recurrent measures and how these might be converted to recurrent, in order to enhance grip and control.

Dr Wooding was grateful for the work of the Executive Team and across the wider organisation. He advised that he had assured the Cabinet Secretary for Health and Social Care that the Health Board would be working towards achieving the Control Total by end of March 2026. Dr Wooding had emphasised, however, that there are significant risks associated with doing so, and that certain of these are outside the organisation's control – for example, surge demand and estates issues. The Health Board does not have sufficient resources to address unforeseen risks such as these.

Mrs Chantal Patel expressed concern around whether additional measures to achieve the Welsh Government Control Total by March 2026 have the potential to place further pressure on services which are already fragile and managing risks. Referencing the upward trajectory in Primary Care medicines prescribing, Ms Delyth Raynsford queried whether HDdUHB is an outlier in this respect, or whether all Health Boards are experiencing this issue. If the latter, whether there should be a national view taken, for example around use of generics. Ms Lewis highlighted the discrepancy between the forecast deficit of £64m and the Control Total figure of £44.8m; suggesting that this presents Board with a scenario of 'accepting the unacceptable'. She wished to establish what principles or assumptions would have to be applied, or changes made to achieve a financial position of sub-£64m, and the level of confidence around achieving the Control Total by March 2026.

In response to Mr Weir's query, it was suggested that there has been a fundamental change, with consideration of value to the taxpayer in addition to duty to the local population. There has also been a recognition of the need to begin the planning process at an earlier stage. Mr Huw Thomas acknowledged that there are other areas which will require consideration, including preventative healthcare; limiting demand for services; use of digital; value-based healthcare and wider implementation of electronic rostering system. There are practical opportunities which need to be developed, and it was suggested that a report outlining planning

challenges and opportunities could be presented to a future Board meeting. **HT**

Regarding Ms Raynsford's query around medicines prescribing, Members heard that comparators do exist. In terms of Primary Care expenditure, HDdUHB compares well with other Health Boards. It has a positive history of exploring options at an early point in terms of use of generics and biosimilars. Mr Huw Thomas suggested that this is, in fact, an international concern, with healthcare bodies seeing the impact of global supply chain issues. There is potentially more which can be done, in terms of addressing variability and maximising rebates and commercial arrangements with suppliers.

Building on statements around the potential for diversion of funding from other public services, Mr Iwan Thomas observed that the Third Sector is seeing a huge upturn in terms of demand. This illustrates the 'ripple effect' of impact within communities and, in turn, the Third Sector. Dr Wooding agreed that decisions made by the Health Board will impact on communities and the Third Sector in a demonstrable manner and that the organisation must be cognisant of this.

**Decision:** The Board:

- **RECOGNISED** that the Health Board's opening budget deficit of £64.0m is not an acceptable position for the Board, or Welsh Government. This position is not backed by cash support from Welsh Government at this stage, as it is in excess of the Target Control Total of £44.8m, which represents a key corporate risk for the Health Board
- **RECOGNISED** that, whilst the underlying deficit has reduced from the opening plan value of £96.4m, due to the level of non-recurrent savings delivery in 2024/25, it remains higher than the forecast deficit at £79.2m
- **ENDORSED** the savings delivery and actions undertaken to date
- **CONSIDERED** that the current expenditure trajectory is in excess of the £64.0m, with further recovery actions presented to the Extraordinary Board Seminar on 11 September 2024 to close the £4.0m gap to achieve £64.0m
- **SCRUTINISED** the deliverability of options put forward in the Board Seminar and articulated within the Annual Plan report
- **SCRUTINISED** the Executive Delegated Officer portfolios which are forecasting an end of year overspend against their delegated budgets
- **TOOK ASSURANCE** that the Escalation Framework which has been put in place, with directorates assessed across six domains, of which one domain is Finance and Planning (details reported within the IPAR) is addressing any financial overspends or savings shortfalls
- **TOOK ASSURANCE** that:

- Plans are translated from opportunities to delivery through the three delivery functions: Value and Sustainability Group, Integrated Quality, Finance and Performance Delivery (IQFPD) Group and the Healthier Mid and West Wales Group
- Mitigating actions are being presented via the Escalation meetings to address areas of overspending
- Recurrent savings plans are being progressed at pace in those Executive Delegated Office Portfolios that have yet to achieve their savings aspirations

**PM(24)170 Update on Annual Plan and Financial Recovery Actions**

Mr Lee Davies presented the Update on Annual Plan and Financial Recovery Actions report, noting that Members will be familiar with the position. As has just been described, the Health Board's forecast financial position is unacceptable and necessitates savings of £32m, the achievement of which involves significant anticipated risk. The Board was tasked with 'de-risking' the Plan and embarked upon a series of workshops. Following this process, a gap of £4m (down from £10.7m) remains. As a result, a further set of controls has been instigated, which were discussed at an Extraordinary Board Seminar on 11 September 2024. Even with these, the Health Board remains a significant distance away from achieving the Welsh Government Control Total, and work is required to secure a routemap towards this for March 2026. The next phase of work is critical.

Dr Wooding enquired around steps being taken to address those areas where cost savings aspirations are not being met. In response, Mr Huw Thomas explained that information regarding escalation status of Directorates is contained within the Integrated Performance Assurance Report (IPAR). Those Directorates with an escalation status of Level 3 (the highest level) are met with on a monthly basis. He felt that it has taken two to three months to achieve an understanding of the issues and consider potential solutions, the latter including workforce and digital enablers. The most recent round of meetings was extremely positive and – whilst not sufficient to de-escalate Directorates – had produced positive responses. Support is being offered as required, and it is hoped that the organisation will be in a position to de-escalate certain Directorates during the autumn.

Mr Weir expressed concern regarding variable pay. Whilst there have been major steps forward in reducing nursing variable pay expenditure, the same cannot be said regarding medical variable pay. Mr Weir noted the statement around no exit plans due to quality and safety concerns, which may be acceptable in the short-term, however, should not be regarded as such longer-term. Mrs Lisa Gostling advised that there has been a significant improvement in medical agency staff numbers, which will have been reduced to single figures by November 2024. As mentioned earlier, there has – until now – been no electronic rostering

system in place; however, Allocate will provide this and is being piloted within the organisation. A rate card is also being introduced, which will address the issue of variation in pay rates within professional groups across Wales (versus Agenda for Change pay, which is standardised). Mrs Gostling assured Members that the Workforce team will be focusing on medical variable pay. Options such as overseas recruitment will be explored.

Mr Mark Henwood agreed that there are changes within the Health Board's gift and suggested that grip and control in this area is increasing. He hoped that improvements would be evident soon. It was noted, however, that there are issues outside the organisation's control, for example national recruitment challenges, site configuration and multiple rotas. The way in which services are structured is key. The Health Board's Clinical Services Plan is concerned with fragile services which is, in turn, linked to medical workforce issues. Referencing statements within the report around regional working which appear less positive, Cllr. Evans requested assurance regarding progress. Mr Carruthers confirmed that this continues to be an area where activity is increasing. The Health Board is participating in discussions with Swansea Bay University Health Board (SBUHB) regarding Orthopaedics and Pathology. It is also seeking to establish a more formal arrangement around Ophthalmology, with Mr Carruthers anticipating a clinical workshop in the next couple of months. Members were reminded that a joint Board meeting between HDdUHB and SBUHB would be taking place in October 2024.

**Decision:** The Board **DISCUSSED** the delivery of the actions within the annual plan and how they respond to the accountability criteria set by Welsh Government and the TI de-escalation criteria.

The Board **TOOK ASSURANCE** on the actions undertaken to de-risk the 2024/25 financial plan.

**PM(24)171 Integrated Performance Report**

Mr Huw Thomas introduced the Integrated Performance Assurance Report (IPAR) for Month 3 of 2024/25, which he suggested was relatively self-explanatory. He hoped that the new format, utilising the 'Alert', 'Advise' and 'Assure' categorisation was helpful, emphasising that the seriousness of issues identified was not underestimated. Triangulation of data on page 5 was quantitative rather than qualitative, with some positive improvements evident. The escalation status of Directorates mentioned earlier is summarised on page 6. Mr Huw Thomas suggested that the metrics for the six domains could be split into two categories, with Quality, Governance and Workforce being more process-based measures, and Finance, Strategy and Planning, Fragile Services and Performance and Outcomes being

more contextual and outcome-based measures. The latter is inherently more challenging than the former.

Dr Wooding suggested that the analysis demonstrates a pattern, with areas of underperformance often showing challenges in various elements when one is highlighted. It is often a combination of these elements which leads to non-optimal delivery.

Highlighting one of the 'Alert' items, staff sickness, Mrs Patel noted in particular the increase in numbers of staff absent due to anxiety/stress/depression/other psychiatric illnesses. She requested assurance that they are being signposted to sources of support, such as the Staff Wellbeing Service. Ms Lewis requested additional detail around the tolerance levels within the internal escalation process. She had been surprised that three key clinical pathways (Women and Children; Mental Health and Learning Disabilities; Planned Care) are in Level 3 escalation for all or most of the domains. Women and Children and Mental Health and Learning Disabilities (MHLD) in particular are high profile services, and Ms Lewis was concerned that they had been allowed to reach this position without prior intervention. She also queried whether monthly meetings were a sufficiently proportional response to Directorates in Level 3 escalation.

Ms Raynsford echoed concerns around the escalation levels of these three Directorates. She wished to highlight the positive progress made around ambulance handover times, whilst enquiring around mitigations for the winter period when demand will increase. Mrs Raynsford expressed concern regarding child neurodevelopmental waits, noting that only 16.3% of children had an Autism Spectrum Disorder (ASD) neurodevelopmental assessment within 26 weeks, and again requested assurance around actions and mitigations.

In response to Mrs Patel's query, Mrs Gostling advised that support for staff suffering from stress or anxiety-related sickness absence focuses both on treatment, and on 'upstream' work to ensure that individuals remain well. Members were reminded that the Health Board has an online Staff Wellbeing portal which signposts staff to support. There are toolkits for staff and guides for managers, together with a Stress Risk Assessment. The Health Board runs Wellbeing and Psychological Wellbeing Programmes and there is a series of interventions available. The long-term sickness absence process includes conversations (as part of the sickness review) around return to work, including potential return to a different role or workplace

With regard to queries and concerns around the escalation status of Directorates, Mr Huw Thomas reminded Members that the internal escalation framework is relatively new and has, therefore, involved a steep learning curve. There is a process by which issues have been escalated and highlighted for consideration in a measured way. Each domain has a professional lead, who has the responsibility to determine the escalation status of Directorates.

This does not contradict the process already in place. Mr Huw Thomas agreed that the assessment of the Women and Children and MHLD Directorates is high, and felt that this is rightly so, with the organisation 'setting a high bar'. These Directorates are facing structural, operational and recruitment challenges, reflected across a number of the escalation domains. A meeting had been held with operational colleagues on 25 September 2024 to reflect on learning from the previous six months, including the 'soft intelligence' gleaned during implementation of the escalation process. The findings will be incorporated into the process, as it continues to mature.

In terms of response to escalation, Mr Huw Thomas felt that there was a balance required between the regularity and impact of meetings; suggesting that anything more than monthly would potentially impede Directorates' ability to implement change on a sustainable basis. Dr Wooding reiterated that there was a need for assurance around both appropriate scrutiny and sufficient traction. Mr Huw Thomas committed to reflect to a greater extent on progress in future reports. Whilst accepting the comment around learning, Ms Lewis emphasised that it was crucial to ensure that this position does not recur. She was not suggesting that the frequency of executive scrutiny be increased; however, was concerned as to whether the organisation has the capacity and capability to turn around the situation. Whilst accepting that the metrics are numerical, it was highlighted that they must, nevertheless, be indicative and reflective of the operational activities within services. As indicated above by the Chair, a pattern such as this is likely to be indicative of other issues. Finally, whilst Ms Lewis recognised that the process is evolving, the Health Board needs to ensure that its internal governance processes and committee structure are sufficient day-to-day to identify and scrutinise such serious issues. Whilst agreeing that the implications and impact of the data are alarming, Dr Wooding suggested it may be that it is being presented pictorially in a manner not seen before. **HT**

Mr Carruthers was pleased that the improved performance in ambulance handovers had been highlighted; this being a significant improvement driven by major enhancements across Pembrokeshire including Withybush Hospital (WGH). It has been led by senior clinicians at WGH, with positive collaboration between acute, community and Primary Care services and the Local Authority. The progress shown is extremely encouraging, with clinically-led pathway redesign having helped to avoid admission and treat and discharge patients promptly. The Acute Frailty Unit has also proved to be key. As the Health Board enters the winter period, pressures become ever more present, and the Six Goals Programme is central to improving performance, patient experience and quality of care. It will be crucial to ensure that learning from Pembrokeshire is rolled out regionally; to continue to build on models of community care; to continue to develop streaming hubs to provide increased levels of care at home; and to continue to work with Local Authority partners to facilitate

effective discharge processes. Mr Carruthers highlighted that there has also been a reduction in Pathway of Care Delays (POCD) and that the data suggests that there will be further improvements to come. This will mean that the Health Board will have achieved the Targeted Intervention (TI) targets in respect of both POCD and ambulance handovers.

Members were reminded that Neurodevelopmental Assessments has been an area of concern for some considerable time. Mr Carruthers advised that, within the last three months, Welsh Government has removed the target in relation to this from the TI discussions, recognising that no Health Board is able to achieve it due to the way in which the clinical pathway is structured. It is felt that a more strategic discussion is required at a national level. However, in the interim, Mr Carruthers has asked the service to consider and identify an appropriate local measure to provide assurance to the Board. A national meeting with Mental Health Network Directors had recorded that 85% of individuals referred for an assessment receive a confirmed diagnosis of a neurodevelopmental condition. The issue is identifying the 35% of this cohort who require specialist care, as opposed to support to manage their condition. Mr Carruthers suggested that this is an area offering opportunities to test new models of care, which will be discussed with colleagues nationally next week.

Mr Lee Davies and Mrs Gostling offered to provide additional context in response to Ms Lewis' queries outside the meeting. **LD/LG**

Returning to the issue of sickness absence, Cllr. Evans enquired regarding the percentage absence level at any one time and the level provided for in forecasts, including financial. Also, whether there is any specific correlation or pattern with regard to Directorates. Cllr. Evans also referenced the 'Alert' item with regard to Ophthalmology and the statement that 'Performance … is now lower than any time since February 2020.' He noted that a number of target completion dates have passed and requested an update on progress and/or mitigations being applied. In response to the first query, Mrs Gostling advised that the 'rolling' sickness absence level, calculated over a 12 month period, is 6.6%. The in-month sickness absence level, based on the Health Board's 'headcount' for August 2024 had been 6.13%. The sickness absence level allowed for, ie the 'headroom' figure, was 5.2%; anything above this involved additional cost.

With regard to Cllr. Evans' second query, Mr Carruthers advised that Ophthalmology as a service is trying to balance and address the challenge of how it best allocates its workforce to meet the demands in various areas. There has been recent success in recruiting Specialty and Associate Specialist (SAS) doctors, and the Health Board is fortunate to have an extremely engaged Optometry sector, into which service provision will increasingly be rolled out. A 'one-stop' Cataract pathway has now been established, which will free up capacity. In addition, one substantive and one NHS Locum Consultant have been recruited.

Mr Carruthers acknowledged, however, that there is work still required. Dr Wooding emphasised the need for plans to mature and accelerated discussions with SBUHB. Whilst he felt that the Board can take assurance from the reporting and monitoring structure, there is a need to see change, traction and impact.

**Decision:** The Board **DISCUSSED** the IPAR – Month 5 2024/2025 report and **TOOK ASSURANCE** on the operational delivery of mitigating actions to improve performance in the areas that have been categorised as 'alert'.

**PM(24)172 Corporate Risk Register**

Mrs Wilson introduced the Corporate Risk Register (CRR), reminding Members that since the previous report in May 2024, the risks have been discussed in detail by the Executive Risk Group and at Board level Committees, and reported via the Committee Update Reports. Where areas of concern are identified, additional assurance is requested. There are 21 risks on the CRR, with Members noting that there are 3 new risks, 5 have been de-escalated/closed, 2 have increased in risk score, 1 has reduced in risk score and 15 show no change. Due to their confidential nature, 3 Corporate Risks involving physical and cyber security will be considered during the In-Committee Board session. Following the review process described above, 5 risks are undergoing evaluation by the Executive Risk Owners. Members were reminded that there are a significant number of risks at Directorate level which sit below the Corporate Risks, and Mrs Wilson highlighted that a number of these are at extreme level, meaning that the Health Board is carrying a significant amount of risk as an organisation.

Dr Wooding underlined the final comment, highlighting probability and impact. He indicated that the Health Board is running above tolerance, emphasising the need for vigilance and reduction and mitigation of risk wherever possible.

**Decision:** The Board **TOOK ASSURANCE** that corporate risks are being assessed, managed and reviewed appropriately/ effectively through the risk management arrangements in place, noting that these have been reviewed by Board level Committees.

**PM(24)173 Accelerating the Cylch Caron Model of Care**

*Dr Eiry Edmunds, Mr Peter Skitt and Ms Tracey Evans joined the Board meeting.*

Dr Wooding noted that the next three agenda items relate to proposed service change, reminding Members of the five 'design principles' to be utilised in decision-making. Whilst the Board must make the best decision possible, it needs to be cognisant of the potential impact on patients and service users. The first item,

around the Cylch Caron model of care, requires Members to consider a potential reduction in beds at Tregaron Hospital.

Mr Carruthers welcomed Mr Peter Skitt and Ms Tracey Evans. He reminded Members of discussions at the previous Board meeting and the decision to undertake a four week period of engagement around plans to accelerate the service model at the heart of the Cylch Caron project. The report presented shares the key issues raised during this engagement and service responses to these. During the engagement, 210 responses had been received via the various mechanisms available. It is clear from these responses that there is understandably a significant level of affection for Tregaron Hospital within the local community, with the majority of responses reflecting on the quality of care provided. The staff involved can be credited with continuing to offer this level of care and Mr Carruthers wished to thank them for their efforts.

The Health Board agreed, in 2018, the AHMWW Strategy, which included at its centre provision of care closer to home, enhanced community care and reduced reliance on inpatient hospital beds. Key drivers behind the Strategy were increasing workforce fragility and deteriorating estate, both in relation to inpatient service provision. The Strategy made it clear that the Health Board would need to change its models of care to meet these challenges and maintain the safety of services. Unfortunately, Tregaron Hospital has now reached a point at which it is unable to recruit effectively into qualified nursing posts, making it increasingly difficult to staff beds safely. The building is also now unsuitable for providing inpatient care; however, it could provide a valuable hub for community based nursing teams and outpatient clinics, as part of a new service model.

Mr Carruthers indicated that the proposed model has already been tested to a certain extent in the south of Ceredigion, with the Cardigan Integrated Care Centre, the community outreach team and the SDEC there. The proposed change would enable consistency of service provision across Ceredigion, and would treat four times as many patients within the local community. It would reduce hospital admissions, speed up discharge, support Bronglais Hospital (BGH) and mitigate some of the emergency pressures. As winter approaches, steps need to be taken to address service fragilities and support the overall resilience of the health system in Ceredigion. Mr Carruthers recognised that change of this nature is challenging; however, there is good evidence that accelerating the Cylch Caron model of care would provide better quality of care, closer to home, and improved patient outcomes.

Focusing on the fragilities mentioned above, Mr Peter Skitt wished to commend the staff in their efforts. The demands and pressures on staff to work additional shifts to respond to these fragilities should not be underestimated. As has been described, a similar model of care already exists in south Ceredigion; Cylch Caron would provide equality of service. Whilst it is challenging to

embark upon this process of change, it is important to recognise the fragility of service provision, together with the threats and opportunities involved. Ms Tracey Evans echoed Mr Skitt's comments, adding that the staffing fragilities have also impacted on the wider Community Nursing service, with staff brought in to provide cover at Tregaron Hospital. There have been occasions when this has meant there is no overnight Community Nursing service, which can impact on patients such as those receiving Palliative or End of Life Care and those with blocked catheters. Instances which can lead to unnecessary conveyance to hospital. Dr Eiry Edmunds echoed all of these comments, particularly around the impact on the Community Nursing service.

Dr Wooding recognised the affection in which Tregaron Hospital is held, and that this is a significant issue locally. Ms Sharon Daniel wished to assure Members that a Quality Impact Assessment had been undertaken and considered and approved by a panel. This had identified that the risk scores in relation to the current service are significant, and that the proposed change and mitigation would reduce these considerably. A full Equality Impact Assessment had also been conducted, which had returned a positive rating on the proposed change, with a caveat around the need for continued staff engagement. Ms Daniel reiterated that staff provide the best service they can; however, to continue to do so is becoming increasingly challenging. Concerns have been expressed around staff working double shifts to ensure cover, and – as has been described – the diversion of Community Nursing resource.

Ms Raynsford felt that the report presented to Board had not necessarily adequately reflected the additional context provided today. She noted that the proposed change is dependent on progressing the Clych Caron model and requested an update on the tender process for the project build. Ms Raynsford observed that working in a ward environment is very different to working in the community and enquired regarding the support which would be offered to staff in this respect. Finally, she requested clarification regarding the process by which it would be ensured that those patients currently in Tregaron Hospital would be safely discharged.

Mr Weir enquired around the financial impact of this proposed change. Whilst it is helpful to have information on the current position, the new model will involve development of various elements, including a GP surgery, community pharmacy and nursing provision. In order for the Board to make an informed decision, it needs to receive data on potential costs/investment as well as savings. The existing building will require ongoing maintenance, which will incur expenditure. Whilst it may not be possible to provide this information today, it will potentially strengthen the case with regard to safety of both patients and staff. Mrs Patel noted that during the period from April 2023 to June 2024, 21 patients had received End of Life Care in Tregaron Hospital, and enquired where these patients would receive care should this option be removed.

In response to Ms Raynsford's first query, regarding the Cylch Caron tender, Mr Skitt advised that this is in process and is in the closing phases. There will be an evaluation; however, there is no change of direction and the Cylch Caron project remains a Board approved priority. Mr Skitt is the Project Director for both the Health Board and the Local Authority, and will work with the successful tender partner once awarded. The Cylch Caron model does represent an investment, and has been supported via a Welsh Government funding grant until now. Development work around the project design, etc, has been underway for a number of years. Members may be aware that a partner had previously been identified; however, had since withdrawn, hence the need for a new tendering process.

In terms of the backlog maintenance, Members heard that tens of thousands of pounds have been spent every year repairing the roof, driveway and fire safety system of Tregaron Hospital; more than £100k within the last two to three years. This expenditure will continue. The proposed model shifts clinical staff resource and budget into the community. Whilst this does not provide savings, there are efficiency gains in terms of avoiding hospital admission and improved patient flow, especially with regard to BGH. There are no additional costs at present; the Cylch Caron model will require consideration of a business case at Board in due course. Dr Wooding emphasised the importance, for the confidence of the local community, of maintaining pace and impetus towards the Clych Caron model.

In terms of nursing staff transition from acute to community, Ms Evans advised that training materials, including workbooks, have been developed for staff to record achievement of competencies. Staff will be placed in supernumerary roles within the District Nursing team, with the associated support and supervision, for as long as required. A Practice Professional Development Nurse works across the county to provide a training, competency and support network for staff from Band 3 upwards. There is a robust mechanism, which has been developed out of necessity to support staff who are working independently and making clinical decisions. Strong governance has been implemented, to ensure safe practice within community care.

With regard to End of Life and Palliative Care, it was recognised that previously, Tregaron Hospital was one of the places patients would choose to receive this. However, over the last six months, due to the issues with nurse staffing, it has not been possible to offer this care. Ms Evans advised that there is a robust Palliative Care team and all Community Nurses are trained to provide End of Life and Palliative Care. Whilst the majority of patients wish to remain at home, there are some who do not, or for whom it is not appropriate to do so. Beds within local Care Homes have also, therefore, been commissioned. These beds are overseen by senior Community Nurses from the Health Board, who manage them on a daily basis. In response to the final query, around the

process for discharging existing inpatients, Ms Evans advised that this is ongoing and that there are multidisciplinary plans for each individual patient. Whilst these cannot be discussed due to patient confidentiality, she emphasised that any discharge must meet the accepted requirements in terms of safety, etc. No change will be made to this obligation, and timescales will be dependent on patient needs and how these can be accommodated. Health Board staff will work with Local Authority colleagues to facilitate the discharge process.

Mr Sam Dentten, on behalf of Llais, recalled discussions at the previous Board meeting regarding the engagement process. Whilst Llais was of the opinion that the timescale and duration for this was not ideal, the pressures involved were recognised. It was felt that the public had been given the opportunity to express their views. However, Llais would not wish this approach of undertaking the minimum period of engagement to become routine in cases of proposed service change. In terms of outcome, the Llais response was somewhat nuanced. It was not opposing the proposals, as managed changed was considered preferable to maintaining a failing and fragile service. However, Llais has suggested that the Board needs to seek assurance that the proposed model delivers safe and good quality care, with rigorous collection of patient and service user experience data. Also, that there be an effective description for the general public of the new pathway of care and how this is accessed. It may be appropriate to utilise the Teulu Jones device used previously and/or an engagement event.

Dr Wooding agreed that the optimum, rather than the minimum period should be adopted for engagement; and that there needs to be ongoing evaluation of any new model. Also, that the public needs to be adequately informed of any change..  Mr Imperato suggested that the report presented to Board gives the impression that the proposals are dependent on establishment of the Integrated Care Centre, which is not the case. His concerns around the operational aspect have been somewhat allayed by the additional information and context provided today. The engagement documentation should be commended for its focus on inpatient beds at Tregaron Hospital and the clarity of its statement that the new model will facilitate provision of care for 40 patients within the community. Mr Imperato felt that this shift of healthcare into the community is absolutely the correct direction of travel. He requested, however, assurance that the above assertion was correct and is not dependent on the Integrated Care Centre. Mr Carruthers confirmed that this was the case.

Indicating her role as Independent Board Member (Trade Union), Ms Ann Murphy wished to place on record feedback from Trade Unions who have been involved with staff at Tregaron Hospital regarding the proposals. Senior staff have expressed concerns around compromised safety as a result of staffing issues and the inability to provide a safe and stable service. All efforts to recruit nursing staff have been exhausted, without success. Bank staff are being utilised; however, it is challenging to source staff beyond

the local area due to Tregaron Hospital's location and the distances involved. As a result of all of these issues, the Health Board's duty of care to both patients and staff is not being met.

Summing up, Dr Wooding indicated that the proposals are consistent with the Health Board's strategic approach and with the design principles for decision-making. They are also an exemplar of the direction of travel in healthcare. He accepted, however, that they are not without inherent concerns and disappointment. Whilst the recommendations were supported and approved, these concerns were recognised, together with the obligations and commitments outlined above.

**Decision:** The Board **SUPPORTED** the acceleration of the Cylch Caron Model and **APPROVED** the decommissioning of the nine beds in Tregaron Hospital, which will enable a greater number of patients to be cared for in the Ceredigion community.

*Mr Peter Skitt and Ms Tracey Evans left the Board meeting.*

**PM(24)174 Proposed Overnight Closure Prince Philip Hospital Minor Injury Unit**

*Dr Jon Morris, Dr Robin Ghosal and Ms Sarah Perry joined the Board meeting.*

Mr Carruthers presented, as an urgent interim service change, the proposed overnight closure of the Prince Philip Hospital (PPH) Minor Injury Unit (MIU) from 1 November 2024 for a period of six months. The proposals are a direct response to clinical concerns raised by staff within the service and expressed to the Executive Team, the Board and Healthcare Inspectorate Wales (HIW). At their core was the safety of patients accessing the service, particularly overnight, and the impact of delivering this service on the welfare of staff. The concerns focus on the increased challenge of securing medical cover overnight, and the clinical risk this leaves nursing staff to manage, in the absence of GP staff. The MIU was never intended to provide a Majors service; however, 35% of the cases presenting overnight have this additional clinical need. These cases should be presenting to the Emergency Department at GGH. The presence of a GP has helped to mitigate this risk until now. Whilst incredibly skilled, Emergency Nurse Practitioners who staff the MIU are not trained to either assess or treat patients with these more serious conditions. It is unacceptable to continue to expose these nurses to the critical risk involved in staffing the MIU without the presence of a doctor.

The number of minors cases attending the MIU overnight are relatively small – an average of less than 9/10 per night. Despite the best efforts of the Health Board, there has been no success in recruiting substantive medical staff. There are currently two GPs who each cover seven nights per month. The service, therefore,

relies heavily on ad hoc shifts provided by other GPs and locums. However, it is not attractive to staff, particularly for overnight shifts. The number of shifts without medical cover has doubled over the last 12 months. Mr Carruthers was grateful for Dr Jon Morris' efforts to attract GPs to the MIU. Whilst these staff have added resilience to the daytime cover; as indicated above, they are reluctant to take up overnight shifts due to other commitments. Three further GPs have left the service, the most recent in August 2024. It is vital that the Health Board has a safe clinical model as it enters the winter period, to deal with increased levels of activity. Failure to do so will lead to further staff losses, potentially putting the daytime service at risk.

On the advice of clinical staff, it is, therefore, proposed that the PPH MIU be closed from 8pm to 8am, initially for a period of six months. The Health Board will continue its efforts to recruit, and identify staff to support the service. The six month period will allow discussions with the local population, stakeholders and staff on a future model. There are opportunities to improve access, quality of care and outcomes. Mr Carruthers emphasised that the safety of both patients and staff is the priority, and is at the centre of this proposed urgent change.

Dr Jon Morris advised that he has been part of the MIU team since 2016 and the Clinical Lead since 2022. He confirmed that the MIU is managing much more complex patients on a regular basis; these include unwell children, surgical emergencies and problems relating to pregnancy. As has been stated, the MIU nursing staff are not adequately experienced or trained to clinically manage these patients. Over the last 12 months, it has become increasingly difficult to secure cover particularly overnight, despite various recruitment initiatives. The reports of concerns and risks from nursing staff have increased in this time. The current situation presents a risk to patient safety.

Dr Robin Ghosal reiterated that the MIU is not a safe environment for acute cases such as those described by Dr Morris. Even with GPs present, staff are not sufficiently skilled to address the needs of acutely unwell patients; the optimal clinical environment for these patients is A&E at GGH or Morriston. Despite concerted public communications to this effect, these patients continue to attend. Since the inception of the MIU in 2016, a highly successful system has been established, by which acutely unwell adults (with conditions such as heart attacks, strokes, respiratory issues) can be seen within the Acute Medical Assessment Unit (AMAU). This provides better and faster care, and improved clinical outcomes. Unfortunately, a sub-group of these patients continue to self-present to MIU, compromising their care. In response to a request for clarification regarding the referral route, Members noted that patients presenting to MIU largely self-refer, whilst those presenting to the AMAU are generally referred by GP or conveyed by ambulance.

Dr Ghosal suggested that the proposal presents an opportunity to further enhance the model, noting that the AMAU has evolved since 2016 into a highly skilled and efficient unit. The ambition is to ensure that adult patients with more urgent clinical needs are still able to access this resource, whilst not in a manner which will overload the system; via ambulance, GP or 111. Among the clinicians, there is cognisance that this provision needs to be in place before the overnight closure can be enacted. It was emphasised that MIU is, as the name suggests, intended for minor conditions, which could wait for treatment until the next day. Overnight closure should not and must not have an adverse effect on GGH or Morriston A&E departments. However, patients with acute conditions, including children, should be attending GGH, as that is where they can be most appropriately treated. The model being evolved should, in fact, be an improvement rather than a loss of service. Any changes implemented in terms of ambulance conveyance and 111 referral of acute patients should also apply to the daytime service, which will lessen pressure on this also.

Echoing all of the comments already made, Ms Sarah Perry added that the absence of a specialist team on site to manage acute paediatric and surgical patients presents a real risk and has been cited as a major concern by the Emergency Nurse Practitioners. These staff feel extremely vulnerable in professional terms. In response to a query, Ms Murphy advised that, whilst there has not been formal Trade Union feedback from PPH, she had discussed this matter with the staff concerned and their position was very much ‘when, not if’ the change should be made, from a safety perspective. Ms Murphy enquired how many times the MIU had been closed on an ad hoc basis, due to lack of cover. Dr Morris advised that, whilst the MIU had not closed, it had been a nurse-led facility overnight, with no doctors on a number of occasions during the previous six months.

Ms Daniel wished to reiterate and emphasise that the Emergency Nurse Practitioners are extremely skilled; however, within a specified scope of practice. They are not permitted to work outside this, and their nursing registration is at risk should they do so, hence their professional concerns. Members heard that a Quality Impact Assessment had been undertaken and approved on 12 August 2024. A full Equality Impact Assessment had also been conducted. In response to a query around whether the latter had identified any detrimental effects of closing the MIU overnight, Ms Daniel advised that the impact of additional travel had been considered. However, if the true definition of an MIU is applied, patients with Minor conditions can be seen the following day; therefore, overnight provision is not required.

Mrs Patel enquired regarding the location of MIU and was advised that it is next to the SDEC and close to the AMAU. Recognising that the community, patients and their families view PPH as ‘their’ local hospital and the source of assistance in times of need, Ms Raynsford enquired regarding a communications strategy. It was suggested that there needs to be clarity around the definition of an

MIU and the conditions treated there. Mr Imperato was persuaded that permanent closure is not inevitable, he requested assurance that during the six month period, all options will be considered and that there will not be slippage, extending the temporary overnight closure to 12 or 18 months.

Ms Lewis highlighted that the proposals seek to solve a problem – patients who are too unwell for the skill mix of available staff, which would be the case even with GPs present – by temporarily closing and removing access to the MIU overnight. She wished to understand the mechanisms in place to ensure that patients are streamed correctly, including those with minor conditions who could be managed by nursing staff. Linked to this, whether there is any precedent for a nurse-led MIU elsewhere. Mr Dentten advised that Llais shared the local population's disappointment with the proposal to close the MIU overnight, which is viewed as a loss of service provision. Llais could not, however, contradict a clinical opinion that the service in its current form is unsafe. If, however, the eighth most populous town in Wales is not able to sustain A&E or 24 hour MIU provision, there does need to be a discussion regarding the future of urgent care in this location. He looked forward to discussions with the Health Board and public, and echoed comments around the need for effective communications to ensure that patients know how to access services.

In response to one of Ms Lewis' queries, Mr Carruthers advised that there are examples of nurse-led units, including in Wales. The challenge is managing the way in which an MIU service is utilised and accessed, which has led locally to additional risk being placed on staff. He agreed with Mr Imperato that the proposals were in response to an immediate operational risk and how this can best be mitigated in the short-term. Mr Carruthers shared the view that there is an opportunity to provide a different point of access within a new model, for example scheduled appointments. In terms of concerns around slippage in timescales, Mr Carruthers would wish to establish a stakeholder group as soon as possible, ideally commensurate with the closure, to develop a sustainable model. It is the intention to outline the proposed process in more detail at the November 2024 Public Board. Emphasising that this is an operationally-driven temporary change for six months, Mr Lee Davies stressed that no options are 'off the table' and the Health Board does not have a fixed view of any future model.

Dr Ghosal advised that the nurse-led MIU in Neath Port Talbot closes overnight. He wished to reiterate that the proposal is not a full closure, but to close overnight. This will make the MIU more robust during its daytime hours. The intention is not to remove this service, rather to improve it and make it more sustainable. PPH has different strengths from the other Health Board sites, which has allowed it to attract staff in other specialties. The position with regard to people attending MIU with very sick children, however, has not changed. These patients should be attending A&E at GGH or Morriston. An overnight closure of the MIU will allow optimisation of patient care. In terms of serving the local

population, Dr Morris indicated that he had grown up in the area and worked there since 2007. PPH's clinical staff are committed to providing care and this has not been an easy decision. Whilst they do not want to let down the local population, they do want a service which is safe and which meets patient needs.

In response to a query around whether there will be additional pressure on Morriston, necessitating discussion with SBUHB, and mitigation of any impact; Dr Ghosal suggested that the mitigation is that patients who should be managed at PPH are. He emphasised that what the Health Board set out to deliver in 2016 has not changed. GGH and Morriston should not be receiving any more patients than clinical need stipulates. It is a case of ensuring that patients are managed in the right place at the right time. Welcoming the additional context provided, Cllr. Evans requested clarity around the intended timescale for an options paper, and whether this would come to the November 2024 Board meeting. In response, Members heard that details of the planned approach would be presented in November 2024, with an options paper to follow at a later date.

Ms Raynsford reiterated her comment around communications with the public being key, suggesting that the Health Board needs to actively undertake messaging to the public, including and particularly around the definition of Minor Injuries. Ms Hughes Moakes confirmed that the team is working on a comprehensive programme of communications; aware of the timings involved. However, it was highlighted that – even with the best of communications – patients or service users may not follow these in times of urgent need, when they will gravitate to what they view as a place of safety and help. Ms Hughes Moakes agreed that the Health Board needs to work with the local community and stakeholders and will ensure that there is input from service users.

Dr Wooding drew discussions to a close and reminded Members that the proposal is for a temporary overnight closure. Should this be agreed, he suggested the following provisos:

- Discussions with SBUHB regarding the potential implications for their service
- No slippage in timescales; however, a long-term sustainable solution is sought
- Any new model and the process surrounding it must be robust and involve a clear way forward
- Full engagement with the community must be at the heart of the process
- The Health Board needs to work with the local community to signpost them to alternative pathways of care and points of access

It was emphasised that the proposals are driven by concerns around safety, with staff unable to safely manage the cases presenting to the MIU overnight. Dr Wooding recognised that this

was another challenging decision and one which would generate disappointment.

Highlighting the intended implementation date of 1 November 2024, Ms Lewis enquired why the risk of remaining open overnight was more tolerable than a sooner closure date. In response, it was suggested that the Health Board has a duty to the public to communicate the change and give notice. Dr Ghosal indicated that clinical staff also need time to finalise and communicate pathways into AMAU. Whilst conversations are advanced, the intervening time until 1 November 2024 is required.

**Decision:** The Board **SUPPORTED** the proposal for the short-term closure of the Minor Injury Unit (MIU) in Prince Phillip Hospital (PPH) overnight (8pm to 8am) for a period of six-months from 1 November 2024, as proposed by the Carmarthenshire Unscheduled Care Management team; due to a significant and continued lack of medical cover, leading to clinical concerns in relation to patient safety and the impact on staff welfare. This temporary six-month change, due to operational pressures, will involve a period of information-sharing with residents regarding how they can access the services they need during the proposed overnight closure. The Health Board will engage with service users and the broader community as it develops options for future service provision at the MIU in PPH.

*Dr Jon Morris, Dr Robin Ghosal and Ms Sarah Perry left the Board meeting.*

**PM(24)175 Paediatric Inpatient Provision at Bronglais Hospital**

*Dr Prem Kumar Pitchaikani, Ms Lisa Humphrey and Mr Nick Williams-Davies joined the Board meeting.*

Mr Carruthers presented a further request for an urgent interim service change to the provision of Paediatric inpatient beds at BGH for a period of six months from 1 November 2024. Since early 2024, the service sustainability risks on Angharad Ward, BGH have increased significantly due to challenges in recruiting specialist paediatric nurses. These have increased further due to two senior staff commencing maternity leave. Their absence will compromise both clinical leadership and quality of care on the Ward. The service has rotated staff from GGH to BGH; however, there will be, from October 2024, a shortfall in GGH staff which will preclude this arrangement continuing. For clarity, Mr Carruthers described the current structure of Angharad Ward: a four bed Paediatric Ambulatory Care Unit (PACU), six inpatient ward beds and one Paediatric High Dependency stabilisation space. The proposal is to close the six inpatient beds and transfer patients requiring a stay of longer than 24 hours to Cilgerran Ward, GGH.

In reality, as medical staff will still be available, together with PACU provision, it is likely that children requiring treatment for up

to 36 hours will remain at BGH. It is anticipated that only the most unwell children will need to be transferred, an estimated four per month. Members were assured that the service will remain 24/7, and the point of access will not change. Mr Carruthers was grateful for the leadership of Dr Prem Kumar as Clinical Director, the clinical team and the Directorate team in developing a model which is safe and retains as much care at BGH as possible. The Health Board will, it should be emphasised, look to restore the service prior to the six months ending, should it be able to fill staffing gaps at BGH. Mr Carruthers was conscious that proposals which involve Paediatric care raise concerns among both the public and staff; however, the option presented today is the optimum operational model to mitigate the risk involved.

Dr Prem Kumar advised that his first UK consultant post was at BGH, so the hospital is close to his heart. Whilst the ideal would be to retain the six inpatient beds, this is no longer possible or safe. There has, therefore, been engagement with the wider clinical team to develop a model which provides both safe and high quality clinical care. As has been suggested, the proposed change can be reviewed should circumstances improve with regard to staffing. Members heard that, based on data from even the busiest of periods, most children return home within 36 hours. Those requiring more support come to GGH anyway, due to the availability of specialist staff. This is, therefore, not a significant change to practice, rather one which will provide a more planned approach. Dr Kumar emphasised that the proposals represent the view and consensus of the entire team.

Ms Lisa Humphrey reported that this situation has been ‘live’ since January 2024, with the team having worked tirelessly to manage it. There had been a predicted 40 unplanned overnight closures, which bring with them inherent risks. The team had managed to put in place mitigations to reduce this to nine closures. However, the situation has deteriorated significantly, and from October 2024 there would be unplanned, ad hoc closures. Members heard that the local team is passionate about maintaining a 24/7 service. In developing the proposed model, clinical data, including on acuity and demand, has been analysed. Under the proposals, the care for the majority of children at BGH will remain unchanged. It is only a very small number of children who will be affected and only for a short time.

Such is the dynamic nature of the situation, there have been (in the last week) applications from nurses and several overseas nurses have also been appointed. Once appropriately trained and inducted, these additional staff will potentially allow this temporary change to end earlier. Ms Humphrey wished to emphasise the key message that nothing changes for children accessing emergency care and the majority of children staying for 24 hours. Even within the proposed model, there will be further flexibility. The local team are now working on operationalising the proposed model and ensuring that it is safe, by ensuring there are robust clinical pathways in place. In addition, there will be daily oversight from a

clinical and leadership perspective, to ensure that children are receiving care in the appropriate place.

Mr Nick Williams-Davies wished to highlight the issue of system pressures. A number of the nine unplanned closures mentioned above had coincided with times when BGH was in escalation and the A&E department was particularly pressured. With the additional impacts on the ambulance service, they have indicated that they would rather work within a planned process than an ad hoc closure. Members were assured, with regard to the specialist transfer services, that all of the doctors and medics involved are extensively trained in the transfer of children. As indicated by Ms Humphrey, there have been developments in terms of recruitment since the report was submitted, and Mr Williams-Davies was quietly confident that the proposed change could be ended prior to the six month period suggested. The Board was advised that there have been consistent discussions with Llais. Finally, Mr Williams-Davies expressed gratitude to the wider BGH team for their support in mitigating risks and retaining a 24 hour model.

In response to a query around the potential impact on Powys and Gwynedd, areas which access HDdUHB services, Mr Williams-Davies confirmed that conversations with service managers in these areas had taken place. Anything less than a 24 hour service would cause significant impact and disruption. Communications will be maintained. Members were also informed that Health Boards in these areas had been approached regarding support; however, they are facing similar challenges.

Mr Dentten praised Health Board colleagues for their active dialogue with Llais. He suggested that the proposed model is preferable to the potential alternative. Llais was hopeful that this would be a temporary change and can return to the previous service model as soon as possible. The importance of targeted communications for those children/families who attend regularly was emphasised. Mr Imperato noted that this was, again, an operationally-driven change, and reiterated the request that all options are considered and for full engagement with stakeholders. Returning to an earlier comment, Dr Wooding shared concerns around the potential for slippage in the six month timeframe, noting that this can sometimes be viewed as ‘breathing space’ rather than a defined period. He was, however, somewhat assured by discussions today.

Ms Raynsford wished to raise the wider issue around Paediatric trained nurses, who have a specific and different skill set. She felt that this needs to be highlighted on a national level, especially with Health Education and Improvement Wales (HEIW). Members were also reminded of the Health Board’s partnership with Aberystwyth University in terms of nursing training. Ms Daniel confirmed that there is a pre-registration programme with Aberystwyth University for Adult and Mental Health Nursing, though not currently Paediatrics. Discussions are ongoing with HEIW. Potential opportunities in terms of recruitment, including

overseas nurses and ‘grow your own’, need to be explored. It was agreed that succession planning is vital and required, and that the Health Board needs to be more proactive in this respect. Mrs Patel highlighted that Swansea University runs a nursing programme, suggesting that there could be discussions around increasing the number of places.

In considering the recommendation, Dr Wooding suggested that this be endorsed with the caveat that the previous service model be reinstated earlier than six months, should staffing levels permit.

Reflecting from a governance perspective on the three agenda items relating to service change, Mrs Wilson advised that all appear on Directorate Risk Registers at extreme levels of risk. It would have been usual for these to have first been considered by the Quality, Safety and Experience Committee (QSEC) and there should be an evaluation of why this had not happened. Mrs Wilson suggested that QSEC should be asked to have oversight of these three issues. Echoing this, Dr Wooding observed that the Board has considered three challenging issues. Whilst pleased that there had been open discussion in this forum, he expressed concern that the approach was reactive rather than strategic. The organisation needs to become more strategic, to avoid being presented with a ‘fait accompli’. This would ensure improved interaction with communities and improved optics. For any similar situations in the future, he requested a more strategic approach with discussion at QSEC prior to Board. Mr Carruthers agreed and welcomed these comments. He felt that the items considered today have served to highlight the levels of complexity, fragility and risk which operational teams are managing on a daily basis. The solution to this is a robust framework and strategy which can be appreciated and supported by the local community. **SD**

**Decision:** The Board:

- **ACKNOWLEDGED** the fragile service position within the Paediatric Inpatient Provision at Bronglais Hospital (BGH)
- **APPROVED** an urgent interim operational service change via the introduction of Model 2 for a period of six months commencing on 1 November 2024, with the previous service model to be reinstated earlier than six months, should staffing levels permit

*Mr Sam Dentten, Dr Eiry Edmunds, Dr Prem Kumar Pitchaikani, Ms Lisa Humphrey and Mr Nick Williams-Davies left the Board meeting.*

**PM(24)176 Property Leases**

Introducing the Property Leases report, which is presented in line with the Health Board’s Standing Orders, Mr Lee Davies suggested that this is relatively self-explanatory. It relates to four leases: Cylch Caron, Glien House, Dura Park and Solva Surgery.

Mr Maynard Davies noted that the deadline for deferral of the current lease break option for Glien House is 29 September 2024. In response, Mrs Wilson advised that (subject to Board approval) the relevant documentation will be signed, sealed and couriered to Cardiff this afternoon.

**Decision:** The Board:

- **NOTED** the Executive Team approval status to proceed with a Deed of Variation for the Glien House lease and new lease arrangements for Dura Park and Solva Surgery sites.
- **APPROVED** the proposed amendments to lease arrangements subject to final agreement to the contract terms:
  - Cylch Caron project - approval to complete on the amended Collaboration Agreement variation (between Ceredigion County Council and Health Board only), as agreed between parties.
  - Glien House lease - approval to arrange the Deed of Variation agreement, a deferral of the current lease break option date by 12 months, subject to the legal document drafting and agreement between parties.
  - Dura Park leases - approval to arrange two new leases, to replace the existing single lease agreement, this is subject to legal contract drafting and agreement between parties.
  - Solva Surgery lease - approval to arrange the lease, subject to legal contract drafting and agreement between parties.
- **NOTED** that, following Board approval, the Common Seal will be applied to those documents which are required to be signed under seal (in accordance with Standing Orders)

**PM(24)177 Report of the Audit and Risk Assurance Committee**

Cllr. Evans, Audit and Risk Assurance Committee (ARAC) Chair, presented the ARAC update report from the meeting held on 13 August 2024. He drew Members' attention to the 'Advise' items, around the Health Board's escalation status, the Audit Wales Review of Cost Savings Arrangements Report findings, nurse staffing levels, Transforming Urgent and Emergency Care and discharge management. There were also several 'Assure' items for the Board to note. In terms of learning: the need to be cognisant of the potential financial implications of service and staffing changes; the need to identify realistic timescales for actions and sharing of learning from capital projects across the Health Board.

**Decision:** The Board **NOTED** the items the Committee is advising them of and **TOOK ASSURANCE** from the items that the Committee is providing assurance on.

**PM(24)178 Report of the Quality, Safety and Experience Committee**

Ms Lewis, Quality, Safety and Experience Committee (QSEC) Chair, presented the QSEC update report from the meeting held on 15 August 2024. She highlighted the 'Alert' item around concerns regarding the progress and pace of national transformational change for ASD diagnostic services and its impact upon local service improvement. This has already been mentioned; however, it is an important area which has been discussed on a number of occasions. Local progress is linked to progress at an All Wales level, which has been limited. QSEC feels that an appropriate route for discussion at a national level needs to be identified. There can be adverse life outcomes for people with ASD, which will become evident for many years to come, in multiple environments.

Dr Wooding agreed that a national discussion should be facilitated. Noting that the Regional Partnership Board (RPB) has a children's forum and involves Local Authority partners, Ms Raynsford suggested that this might provide an appropriate platform. Professor Kloer endorsed the comment made by Ms Lewis around the potential future impact of ASD and agreed that this has been a long-standing issue. It has been the subject of discussions with Welsh Government; however, the Health Board could consider writing formally to Welsh Government outlining its concerns and the reasons for these. Dr Wooding agreed, suggesting that an All Wales discussion and solution is required. Dr Ardiana Gjini indicated that the Children and Young People's Board is prioritising issues for discussion, and this is one of the top priorities. She agreed that it could be fed through the RPB. It was agreed that the RPB would be approached regarding the best mechanism for escalating to Welsh Government. Mr Carruthers advised that there is a meeting next week with the national Directors for MHLD, which Ms Liz Carroll attends; he would ask her to raise this issue. **AG** **AC**

**Decision:** The Board:

- **RESPONDED** to the 'alert' item
- **NOTED** the 'advise' items
- **TOOK ASSURANCE** on the 'assure' items
- **NOTED** QSEC's recommendation to approve the Duty of Quality and Candour Report 2023/24

**PM(24)179** **Duty of Quality and Duty of Candour**

Ms Daniel presented the Duty of Quality and Duty of Candour report, outlining the Quality and Engagement Act, its purpose, and the duties that Health Boards must meet as a result. The report demonstrates the Health Board's commitment to improving the quality of services to meet its Duty of Quality, which involves a system-wide way of working. It also details how the Health Board is meeting its Duty of Candour. Ms Daniel thanked all of the services who have provided input to the report, emphasising that it contains only examples, not a comprehensive list of actions.

**Decision:** The Board **APPROVED** for publication the Health and Social Care (Quality and Engagement) (Wales) Act Annual Report: How we met the Duty of Quality and the Duty of Candour for 2023 to 2024

**PM(24)180 Report of the Sustainable Resources Committee**

Mr Weir, Sustainable Resources Committee (SRC) Chair, presented the SRC update report from its meeting held on 27 August 2024, highlighting the 'Alert' items with regard to concerns around the financial run rate, the finance Targeted Intervention actions and the financial commitment necessary to progress the Pentre Awel Development. Whilst noting that the financial position has slightly improved, there remains concerns around the potential cash management risk.

With regard to the revised Terms of Reference, Dr Wooding queried the deletion of paragraph 2.5 and was advised that this task had been transferred to the Strategic Development and Operational Delivery Committee (SDODC).

**Decision:** The Board:

- **NOTED** the report
- **NOTED** SRC's recommendation that the Welsh Government Building, Picton Terrace, lease should be signed under seal by the Chair and the Chief Executive
- **NOTED** SRC's recommendation to award the tender for the Provision of Dental Services for South Pembrokeshire and Carmarthen, and to provide services from 1 January 2025 to 31 December 2030 with extension option to 31 December 2035 for onward approval to WG and to ratify the award of the All-Wales Provision of Outsourced Radiology Reporting Services, 1 November 2024 – 31 October 2027 for onward submission to Velindre NHS Trust and WG for approval
- **NOTED** SRC's recommendation for approval of the Patient Flow and Electronic Observations Full Business Case, pending the successful resolution of a funding model to address the investment requirement in initial years until the savings begin to be realised through bridging funding
- **APPROVED** the SRC Terms of Reference

**PM(24)181 Procurement Report**

Mr Huw Thomas introduced the Procurement report, which seeks approval of four items and is self-explanatory.

**Decision:** The Board:

- **APPROVED** to proceed to award the tender for the Provision of Dental Services for South Pembrokeshire, Carmarthen, and

South Ceredigion/North Pembrokeshire Border to provide services from 1 January 2025 to 31 December 2030 with extension option to 31 December 2035

- **APPROVED** the award of the All-Wales Provision of Outsourced Radiology Reporting Services, 1 November 2024 to 31 October 2027. This contract will have onwards submission to Velindre NHS Trust (as hosts of NHS Wales Shared Services Partnership) and Welsh Government for approval, noting that there is no requirement for Welsh Government approval, as this is a pre-approved All Wales Framework
- **PRE-APPROVED** to proceed to award the tender for the Provision of General Medical Services (GMS) or Alternative Provider Medical Services (APMS) Contract at Neyland and Johnston Surgery to provide services from 1 January 2025 to 31 December 2029 with extension option to 31 December 2034
- **APPROVED** to proceed to award the tender for the Data Centre Storage, Computing and Hypervisor Environment Replacement – Glangwili General Hospital and Withybush General Hospital to provide services from 1 November 2024 to 31 October 2029, including an extension of 12 months to 31 October 2030

**PM(24)182** **Patient Flow and eObservations Full Business Case**

*Dr Robin Ghosal, Mr Peter Skitt and Mr Anthony Tracey joined the Board meeting.*

Presenting the Patient Flow and eObservations Full Business Case (FBC) report, Mr Huw Thomas advised that this has been subject to the usual approval processes for digital projects. Should Board approval be forthcoming, it will offer significant opportunities to embrace digital change. The FBC does, however, present challenges in terms of affordability in the first couple of years; there are various options which can be considered in this regard. Mr Anthony Tracey advised that the business case has been two years in development and that there has been liaison with both operational and clinical teams. This represents the first occasion when the starting point has been business need (in this case patient flow) and how a digital solution might be provided, rather than vice versa. A number of the issues are well documented; these include paper-based systems; silo working; poor communications. The solution presented offers a fully integrated system, covering all care bases. Discussions have taken place with Digital Health and Care Wales (DHCW) and the Health Board's existing systems are able to interface with this one. The benefits are outlined from page 35 of the FBC.

Reminding Members of earlier discussions around the need for a strategic approach, Mr Skitt confirmed that in the process applied here, this had certainly been the case. To align with the Health Board's strategic direction for increased care in the community,

there needs to be a seamless, integrated solution such as this. Beginning the introduction of this system in the community will meet this need. It will also enable the ambition for an overarching Command and Control Centre which will provide a picture of services across both community and acute sectors. Mr Skitt had experience of similar systems, and they offer great benefits in terms of improving patient flow and in clinical practice and referral.

Dr Ghosal highlighted the fragmented nature of the acute and Primary Care sectors, resulting in a highly inefficient system. This affects patient care and results in inappropriate use of resource. The COVID-19 pandemic had emphasised the potential value of technology. Speaking from his own specialty perspective, the local lung cancer service has transferred entirely to a digital approach, from Primary Care across all four hospital sites. It is vital to move forward in this sphere to ensure that patient care is optimised. A system such as this will offer improved monitoring and improved patient flow. Much of the system in England is digitalised, and an absence of this is deterring potential staff from moving to HDdUHB. Digital and technology are the future of healthcare and the Health Board has a choice to be leaders in this; it represents an exciting opportunity.

Mr Maynard Davies advised that he has seen various iterations of this business case. When he had joined the health service, its biggest problem had been identified to him as patient flow. A system such as the one described begins to address this issue, using a digital solution to transform the delivery of integrated care across the whole system; therefore, he would fully support approval. Mr Carruthers suggested that the operational benefits have been articulated well. One of the issues he has considered in the past has been around comparison with other, better performing organisations and what they are doing differently. Most of the top performing organisations will have had systems like this for some time, at least for their acute services. If the Health Board is to realise ambitions operationally, this system appears to be an intrinsic contributor.

Mr Weir indicated that one of the biggest issues for staff was around the amount of paperwork and duplication involved in inputting data onto IT systems. They had expressed a desire for a single patient care record. Mr Weir emphasised, however, that the effort involved in implementing this system should not be underestimated. Whilst the benefits realisation was not the greatest in the first few years, overall, it did offer significant benefits, and he would also support its approval. Ms Paterson highlighted the need to ensure any system is fully embraced within Primary Care and community services. This represents an important part of the ongoing integration and delivery of services.

Professor Kloer advised that he had been lobbied by many clinicians across the Health Board to progress a system of this type. Whilst it may not address all of the organisation’s digital issues, it is an important contributor to the solution. The funding

issue is challenging and the Health Board will need to ensure that benefits are realised. Cllr. Evans enquired regarding return on investment and whether this was a conservative estimate. Also, in view of the ambitions for regional working, whether the system is compatible with other Health Boards. Whilst highly supportive, Dr Wooding wished to clarify whether the system is tried and tested; whether it is a 'vanilla' product (as is); whether there are any potential negative consequences; and whether it is future-proofed.

In terms of realising benefits, Mr Huw Thomas recognised that there will be a significant change management process. The system is a potential enabler for significant transformation and integration of systems. He was not sure that this aspect has been tried and tested, as the system is being used 'in pockets' elsewhere. As regards a positive bias, this is probably the first digital business case where the margins are so significant as to diminish any bias which might exist. The only potential negative is the short-term affordability. Mr Tracey confirmed that the system is a 'vanilla'/as is product. In terms of whether it is tried and tested, as indicated, it is being used elsewhere in Wales in limited applications. However, it is being used in upwards of 50 NHS Trusts in England and is used extensively in Australia. The provider is working closely with the suppliers of the Electronic Prescribing Medicines Administration (EPMA) and GP IT systems to ensure compatibility.

Adoption of any system will always present the biggest obstacle. However, the Health Board's clinicians have had to opportunity to test this system and were of the opinion that it should be relatively easy to use. Beginning with the clinical viewpoint has been key. The issue of future-proofing does require consideration. Dr Ghosal indicated that, from a patient perspective, the system will provide better care, with improved communication between services and equitable service and access. It will never be possible for clinicians to truly work in one integrated system without the support of digital solutions. Whilst the cost may be significant, the benefits outweigh this in real terms. With regard to costs, Dr Wooding felt that this is where the challenge lies. Whilst there can be an approach to Welsh Government, he was not sure that they will be in a position to support this. It is, however, a relatively small amount for a high impact outcome. Mr Huw Thomas emphasised that approval in principle is being sought. Potential funding sources can then be explored. These might include funding from Welsh Government, spreading the cost as part of an arrangement with the business partner, or as part of the business planning cycle, albeit in competition with other projects. Should it not be possible to resolve this satisfactorily, the issue will come back to Board for further discussion.

**Decision:** The Board:

- **APPROVED** the award of the contract to the preferred supplier, SUBJECT TO the successful resolution of a funding

model to address the investment requirement in initial years, until the savings begin to be realised through bridging funding
- **DELEGATED** authority to the Chair and Chief Executive Officer to authorise approval of the contract, following the resolution of the funding model as described above

*Dr Robin Ghosal, Mr Peter Skitt and Mr Anthony Tracey left the Board meeting.*

**PM(24)183 Pentre Awel**

Mr Lee Davies introduced the Pentre Awel report, which centres on a complex project. The Health Board has been working with Carmarthenshire County Council since 2016 on this multi-million pound development. It has ambitions in terms of jobs, economic benefits and improvements to the health of the local population and to services. The Health Board would be leasing a Clinical Decision Unit in the development. To reduce costs, the extent of this has been reduced from four to two floors. There will also be a Hydrotherapy Pool, upon which it is not anticipated rent will be payable. There are revenue consequences associated with this project, which the Health Board has sought to mitigate, by reducing leases and staffing costs. Against an original net £714k cost, the mitigations applied would reduce this to £429k. These are only directly quantifiable costs; no account has been taken of potential benefits resulting from improvements to population health, etc. Additional capital was requested, as part of a bid to Welsh Government's Integration and Rebalancing Capital Fund (ICRF). Since the report was prepared, Welsh Government has advised that the bid does not meet ICRF criteria. Board approval for the lease to be signed is being sought, subject to the resolution of the capital issues and requirements.

Mrs Patel recalled a suggestion that the costs will increase year on year and enquired whether this had been taken into account. She was advised that the rental cost is not expected to rise. Utility costs may increase; however, this is not possible to predict. Whilst commending the project and recognising that it has been long-awaited, Dr Wooding felt that there should be further work around the potential benefits. Ms Raynsford wished to bring to the Board's attention that the funding for the Hydrotherapy Pool is from a legacy and fundraising by the local population. The former specifically bequeathed the funding to 'enhance the health and wellbeing of the population of Llanelli'. Should the project not go ahead, there would be a legal challenge and this funding would need to be returned to both sources. Mrs Wilson and Mr Huw Thomas confirmed that this would represent a significant issue to the Board in its role as Corporate Trustee.

Recognising that the revenue implications involved in this project are challenging, particularly in view of the current financial position, Mr Huw Thomas emphasised that it does offer opportunities in terms of a strategic asset in an area where

investment is needed. A commitment has been made in good faith, and the efforts made to minimise the costs to the Health Board were commended. There is now a need to take the project forward. Professor Kloer recognised that the donation for the Hydrotherapy Pool was extremely generous. Also, that partnership working with the Local Authority on this project over a number of years has been good; however, there may be learning from the process which can be extracted. He also suggested that the detailed business case which exists should be shared with Board Members. **LD**

**Decision:** The Board:

- **NOTED** the cost information provided, the work already done and the work which is ongoing to mitigate the additional revenue costs associated with the project
- **NOTED** that the Health Board will be required to engage with the two charitable donors if there are any changes to the proposed hydrotherapy service
- **ENDORSED** and **APPROVED** the lease to be signed under seal by Chair and Chief Executive

**PM(24)184** **Welsh Government Building, Picton Terrace**

Introducing the Welsh Government Building, Picton Terrace report, Mr Lee Davies explained that this building was key to the Health Board's estate rationalisation plans. Welsh Government has requested a contribution towards the fit-out costs, with an agreement of a 50:50 split. This will result in a contribution from the Discretionary Capital Programme (DCP) of the proceeds of the disposal of two buildings, plus the sum of £110k per year for a period of five years.

**Decision:** The Board:

- **ENDORSED** SRC's approval of Welsh Government's proposal letter setting out the agreed repayment terms for the 50% fit out costs to be repaid over 5 years commencing 2025/26
- **APPROVED** the lease signing under seal by Chair and Chief Executive

**PM(24)185** **Report of the Strategic Development and Operational Delivery Committee**

Mr Maynard Davies, Strategic Development and Operational Delivery Committee (SDODC) Chair, presented the SDODC update report from its meeting held on 29 August 2024. He indicated that the single 'Alert' item, around the 100-day planning and delivery cycle, had already been mentioned. Board is requested to approve the Winter Respiratory Vaccination Programme Delivery Plan.

**Decision:** The Board:

- **NOTED** the report
- **NOTED** SDODC's recommendation to approve the Winter Respiratory Vaccination Programme: Delivery Plan 2024/25

**PM(24)186** **Winter Respiratory Vaccination Programme**

Dr Gjini presented the Winter Respiratory Vaccination Programme Delivery Plan, advising that this had been approved by SDODC as indicated above. Dr Gjini wished to highlight a significant change regarding eligibility for the COVID-19 vaccination, in that the Joint Committee on Vaccination and Immunisation (JCVI) has not recommended the inclusion of frontline Health and Social Care workers. Health Board staff will not, therefore be invited for COVID-19 vaccinations; however, arrangements will be made for them to receive these, should they wish. Staff vaccination rates will not be monitored by Welsh Government. Members heard that there will be increased access to Flu vaccines for 2/3 year olds.

**Decision:** The Board:

- **APPROVED** the proposed delivery plan for the HDdUHB Winter Respiratory Vaccination Programme, recognising that this has been reviewed in detail by SDODC
- **NOTED** the work underway to mitigate the risk to programme delivery of the proposed approach
- **RECEIVED ASSURANCE** from the control measures in place through recognition of the key enablers

**PM(24)187** **Report of the People, Organisational Development and Culture Committee**

Mrs Patel, People, Organisational Development and Culture Committee (PODCC) Chair, presented the PODCC update report from its meeting held on 20 August 2024. In terms of 'Alert' items, Members' attention was drawn to the request to identify which areas of inequality highlighted in the Strategic Equality Plan (SEP) Annual Report it wishes to include in its list of priorities.

**Decision:** The Board:

- **NOTED** the item that they are being alerted to, agreeing that this required further detailed discussion
- **NOTED** the items the Committee is advising them of
- **TOOK ASSURANCE** on the items that the Committee is providing assurance on
- **APPROVED** the PODCC Terms of Reference

**PM(24)188** **Strategic Equality Plan Annual Report 2023/24**

Mrs Gostling presented the Strategic Equality Plan Annual Report 2023/24, which highlights a number of areas where progress has been made. However, there are also areas of concern and disproportionality which warrant further work. These include numbers of Black, Asian and Minority Ethnic (BAME) applicants versus appointees and low numbers of international nurses achieving promotions versus newly qualified nurses. Also, the gender imbalance at more senior Agenda for Change bands. The Workforce and OD teams will be working on the issue of unconscious bias during the recruitment process, and numbers of staff accessing training and leadership development. Also, the low percentage of disabled people recruited to the Health Board.

Thanking the team for the report, Dr Wooding expressed serious concerns regarding the data within the report and its implications, suggesting that it justifies more detailed discussion at a Board Seminar session. **JW**

**Decision:** The Board:

- **AGREED** the SEP Annual Report 2023-2024 for publication, noting that this is a consolidated report bringing together all reporting requirements established under the Equality Act 2010
- **REQUESTED** that the findings be discussed at a Board Seminar, to allow agreement on the areas of action the Board would like to see progressed and monitored during the first two years of the next SEP reporting period (2024-2026)

**PM(24)189 Report of the Health and Safety Committee**

Ms Murphy, Health and Safety Committee (HSC) Chair, presented the HSC update report from its meeting held on 10 September 2024, thanking Ms Daniel for acting as Executive Lead and welcoming Mr James Severs as her replacement in this role. Outlining the 'Advise' and 'Assure' items, Ms Murphy reported that there have been improvements in a number of areas previously presented to the Committee. It was noted that two new risks, around management of violence and aggression and security management, have replaced the previous single risk relating to these issues. Due to the sensitive nature of these risks, they were discussed during an In-Committee session.

**Decision:** The Board:

- **NOTED** the items the Committee is advising them of
- **TOOK ASSURANCE** on the items that the Committee is providing assurance on

**PM(24)190 Committee Update Reports**

Mrs Wilson presented the Committee Update Reports, highlighting the reports included and noting the issue being brought to the Board's attention by the Charitable Funds Committee.

**Decision:** The Board:

- **RECEIVED** the update reports 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 expenditure outlined
- **RECEIVED** the update report in respect of the In-Committee Board meeting
- **RECEIVED** the update reports in respect of recent Advisory Group meetings
- **RESPONDED** to the items that it is being alerted to
- **NOTED** the items that it is being advised of
- **TOOK ASSURANCE** on the items that it is being assured on

**PM(24)191 Joint Committees and Collaboratives**

Introducing the Joint Committees and Collaboratives report, Professor Kloer advised that there had been a further meeting of the Joint Commissioning Committee on 17 September 2024. This meeting had received an update on the Emergency Medical Retrieval and Transfer Service (EMRTS) and specifically the work responding to Recommendation 4, the potential for a land-based service in the mid Wales area.

**Decision:** The Board **RECEIVED** the minutes and updates in respect of recent NHS Wales Joint Commissioning Committee (JCC) and NHS Wales Shared Services Partnership (NWSSP) meetings.

**PM(24)192 Statutory Partnerships Update**

Ms Paterson presented the Statutory Partnerships Update report, advising that the RPB is undertaking a review of its purpose and governance, assisted by an external consultant. Ms Paterson suggested that this was timely and would hopefully inform partnership working going forward.

**Decision:** The Board:

- **TOOK ASSURANCE** that the Health Board is working effectively with Statutory Partners in order to meet the required obligations as laid out by the Well-being of Future Generations (Wales) Act 2015 and the Social Services and Wellbeing (Wales) Act 2014
- **NOTED** the actions which have been completed to date

**PM(24)193** **Any Other Business**

There was no other business reported.

**PM(24)194** **Board Annual Workplan**

The Board **NOTED** the Board Annual Workplan, which would be updated to reflect discussions.

**PM(24)195** **Date and Time of Next Meeting**

9.30am, Thursday 28 November 2024