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Ymddiriedolaeth Brifysgol GIG
Gwasanaethau Ambiwylans Cymru
Welsh Ambulance Services
University NHS Trust

**CONFIRMED MINUTES OF THE OPEN MEETING OF THE WELSH AMBULANCE SERVICES UNIVERSITY NHS TRUST BOARD, HELD on THURSDAY 25 JULY 2024
MEETING HELD IN THE CARDIFF MAKE READY DEPOT AND VIA ZOOM**

Meeting started at 09:30

PRESENT:

Colin Dennis	Non-Executive Director and Chair of the Board
Jason Killens	Chief Executive
Lee Brooks	Executive Director of Operations
Peter Curran	Non-Executive Director
Professor Kevin Davies	Non-Executive Director
Bethan Evans	Non-Executive Director
Estelle Hitchon	Director of Partnerships and Engagement
Angela Lewis	Director of People and Culture
Rachel Marsh	Executive Director of Strategy, Planning and Performance
Trish Mills	Director of Corporate Governance/Board Secretary
Hugh Parry	Trade Union Partner
Hannah Rowan	Non-Executive Director
Jonny Sammut	Director of Digital Services
Joga Singh	Non-Executive Director
Andy Swinburn	Executive Director of Paramedicine
Chris Turley	Executive Director of Finance and Corporate Resources
Damon Turner	Trade Union Partner
Liam Williams	Executive Director of Quality and Nursing

Attendees:

Steve Owen	
Alex Payne	Corporate Governance Officer (Virtual) Corporate Governance Manager

BSL Interpreters:

Hayley Brown
Hannah Wilson

Apologies:

Ceri Jackson

Non-Executive Director and Vice Chair of the Board

61/24 WELCOME AND APOLOGIES FOR ABSENCE

Welcome and apologies.

The Chair welcomed all to the meeting and noted that apologies were received from Ceri Jackson.

Declarations of interest.

The Board noted that all declarations of interest were formally recorded on the Trust's Register of Interests.

RESOLVED: That the declarations of interest on the register were formally recorded and the apologies as described were noted

62/24 PROCEDURAL MATTERS

The Chair reiterated that the Board meeting was part of the overall scrutiny and assurance process with much of the detailed work undertaken in the Committees, that met prior to the Trust Board, and that Committee AAA highlight reports, which featured later in the agenda, together with committee minutes, all added to the overall assurance and scrutiny process. He added that all Committee meetings had been quorate and well attended.

Minutes:

The Minutes of the Board meeting held on 30 May 2024 were presented and confirmed as a correct record.

Action Log:

The Board received the action log:

Action 43/24: Angela from the Stroke Association raised a concern about the number of ambulance cancellations and unavailability, specifically relating to patients with suspected strokes. The query relates to data found in the board papers for April 2024, highlighting nearly 8000 patients who cancelled their ambulance and 117 callers who did not receive an ambulance due to high escalation levels. The question is how many ambulances were cancelled from callers where there was a suspected stroke and how many of the 117 that were unable to receive an ambulance were patients with a suspected stroke if any. While immediate data on the specific numbers is not available, it was agreed that Andy Swinburn would take steps to analyse and provide a comprehensive response. A comprehensive response in the form of a letter had been sent to Angela. The letter was attached as an annex to the action log. Action Closed.

Action 44/24: *Following on from the Staff Story it was agreed that Estelle Hitchon would put Emma Worrall in touch with Lois Hough to explore potential improvements to the "Work With Us, Not Against Us" campaign, by incorporating feedback and insights from our people that resonate more effectively with the public.* The Head of Communications Lois Hough met with Emma Worrall on 4 June 2024 to discuss her experience of verbal abuse, and Emma agreed to support the next phase of the Trust's With Us, Not Against Us anti-violence campaign. Estelle Hitchon added there had been recent media coverage highlighting the abuse faced by call handlers, specifically mentioning individuals named Emma and another colleague. This type of coverage was crucial for raising awareness about the challenges and mistreatment that call handlers often experience. Estelle Hitchon further added that that the story has gained traction in both mainstream and social media, as this can help to inform the public about the reality of these roles and the importance of supporting the staff who handle difficult situations

RESOLVED: That

- (1) The Minutes of the meeting held on 30 May 2024 were confirmed as a correct record.**
- (2) The update on the action log was noted.**

63/24 CHAIR'S REPORT AND UPDATE

The Chair presented the report as read adding that a new Non-Executive Director had been appointed as the Chair of the Finance and Performance Committee, Jayne Beeslee, following the departure of Joga Singh who is due to leave in September. The Chair thanked Joga Singh for his time and dedication during his tenure as a NED for the past several years with the Trust.

The Chair added that during the past two months he had taken the opportunity to visit various Trust sites and colleagues, and these included visiting colleagues in the Clinical Contact Centre and Palliative Care Teams at Vantage Point House. He formally commended the work by the Team and thanked them for their continuing work.

RESOLVED: The update was noted.

64/24 CHIEF EXECUTIVE'S UPDATE

In presenting his report, Jason Killens drew the Board's attention to the following:

The Trust was aiming to enhance operational efficiency by addressing key areas such as mobilisation times, time spent on scene, clinician travelling unavailability, and multiple auto-allocations. The focus of the work was to emphasise the need for a system-focused approach and the implementation of a live dashboard for dynamic efficiency management. The plan included identifying stakeholders, discussing strategies, and documenting an action plan, along with the development of new measures specific to the key areas of the job cycle time

that require improvement. Additionally, new management processes will be established to ensure continuous monitoring and adjustment. The plan will be delivered with benefit realisation through PowerBI dashboard development. The goal was to optimise resource utilisation and improve service capacity.

The capital programme was on track with projects and programmes progressing well, given it was still the early part of the financial year, most schemes were in their planning stages, however many orders have been placed for the vehicles replacement programme in order to ensure delivery in time for conversion in this financial year.

Steve Magee, Consultant Paramedic, continued to be central to the excellent improvements within maternity care, some of which included the development of an all-Wales maternity transport document, the delivery of multi-profession training to student Midwives and Paramedics, as well as designing a new maternity equipment bag that is intended to support staff in highly stressful situations. In collaboration with the College of Paramedics and a consultant Midwife from London, he was currently organising a national pre-hospital Maternity conference. Aimed at pre-hospital staff across the UK, this event would be the first of its kind and was planned to host an impressive programme of speakers who are experts in their fields.

Andy Swinburn, Executive Director of Paramedicine, chaired the inaugural Chief Paramedic Group (CPG) which was held on 1 July. The group consisted of Chief Paramedics and Directors of Paramedicine from the UK Trusts. The Terms of Reference were currently in development and will be put forward to the Association of Ambulance Chief Executives for approval in the coming weeks.

The recent programme of work to implement the new patient management and clinical decision support system into the NHS 111 Wales service included a large and complex staff training plan. The training included Call Prioritisation and Streaming System (CPSS), Emergency Communication Nurse System (ECNS) and the patient management system C3/MIS. The Education, Professional and Clinical Practice (EPCP) Team were supported by the International Academies for Emergency Dispatch (IAED) for initial CPSS and ECNS training but had to quickly become 'the experts' to effectively deliver this training to the whole workforce. Creating the Management Information System (MIS) training from scratch, the EPCP Team adapted the content daily (sometimes more than once a day) to reflect the refinements to the system right up to the go-live day).

Following the introduction of the Health & Social Care (Quality and Engagement) (Wales) Act 2020 on 1 April 2023, the Quality, Safety and Patient Experience Directorate have been working hard to embed the principles of Citizen Voice, Duty of Quality and Duty of Candour across the organisation. As part of the communication plan for both this activity and the Quality & Performance Management Framework (QPMF), the first Trust Quality Event (WASTQ) was held in the Metropole Hotel in Llandrindod Wells on Tuesday 2 July 2024.

Comments:

The recent media coverage on platforms like Sky News regarding inappropriate behaviour toward female staff, particularly in England, can have significant impacts on the organisation involved. The impact of such media coverage can be profound, influencing both internal operations and public perception. The Board were keen to hear how the Trust had responded to maintain trust and support from both the public and its employees.

Jason Killens acknowledged the longstanding issues of inappropriate behaviour experienced by staff members within the Trust. He highlighted a recognition of past and ongoing challenges and expressed a commitment to creating a safer and more inclusive work environment going forward.

Angela Lewis added that the Trust was reaching out to students entering paramedicine degrees, which was an important initiative for the Trust. It addresses both recruitment and the organisational culture, with a focus on supporting new entrants to the field. The initiative recognises that potential new recruits may be apprehensive about joining an organisation that has been associated with inappropriate behaviour, even if the issues were limited to small pockets.

The Board were pleased to see that the inaugural WAST Quality Event appeared to have been a success, and queried if there was potential in continuing these events a regular fixture. Liam Williams explained there was good engagement at the event advising it would be held again next year.

Members noted there had been a cyber-attack on two of the Trust's suppliers recently and asked for an update and if the Trust had been affected by the recent Global IT outage. Jonny Sammut commented on the importance of technological resilience and preparedness in ensuring the Trust's operations could withstand disruptions, whether from cyber-attacks or other causes, such as global IT outages. The Trust stood up well during the global IT outage on 19 July 2024 which indicated that the existing technology infrastructure and protocols were effective. This resilience was crucial for maintaining continuity of services, especially in critical sectors like healthcare. It was important to clarify that the incident was not a cyber-attack but rather a technical failure or outage. This distinction helped in understanding the nature of the risks involved and the types of defences that need to be prioritised.

RESOLVED: That the update was noted.

65/24 QUESTIONS FROM MEMBERS OF THE PUBLIC

Estelle Hitchon confirmed there were no questions and reminded viewers that the Board welcomed questions from members of the public.

RESOLVED: The Board noted there were no questions.

66/24 PATIENT STORY

Liam Williams introduced the story which was shared by Mr. Maxwell and his son who had lost their wife and mother, respectively. It brought to light the human impact of healthcare, emphasising the emotional and psychological aspects that extend beyond clinical treatment. The experience shared by Mr Maxwell and his son emphasises the profound emotional and psychological impacts that healthcare experiences can have, not just on the immediate outcomes but on the long-term well-being of those involved. This story serves as a poignant reminder of the real-life consequences of healthcare experiences.

Members were shown a video of the tragic account in which Mr Maxwell's son highlighted a series of critical issues in the emergency response process that unfortunately resulted in the death of his mother. This narrative not only underscored the emotional and psychological toll on the family but also points to systemic failures that need to be addressed.

The six-hour delay for the ambulance to arrive was a central concern. In cases where time was of the essence, such as suspected sepsis, delays can lead to severe deterioration and, as in this tragic case, death. This underlined the critical need for timely emergency medical services (EMS).

The need for multiple calls and the repetition of the same information indicated potential issues in the communication processes and protocols within the EMS system. Efficient triage and information handling were vital to ensure that the severity of a situation was recognised and responded to appropriately.

The description of his mother's symptoms, including the presence of brown fluid indicating severe illness, should have been immediately flagged as a critical emergency. This, as Mr Maxwell pointed out, suggested a possible gap in the assessment or prioritisation process. The son's experience of witnessing his mother's deterioration, attempting CPR, and ultimately her passing, highlighted the profound emotional trauma faced by families in such situations. It emphasises the need for adequate support for both patients and their families during emergencies.

Mr. Maxwell's son poignantly illustrated the devastating aftermath of an unexpected death, particularly when it involved a medical emergency that was not anticipated to end tragically. The involvement of the police and the coroner added a layer of legal and procedural steps that families must navigate. This process, while necessary for a thorough investigation, can be overwhelming for grieving families, adding to their emotional burden.

Mr. Maxwell's account revealed a deeply distressing and profoundly challenging experience regarding the handling of his wife's body after her death. The inability to pay final respects and the circumstances described, where the body was not in a condition suitable for viewing added a layer of emotional and psychological trauma to an already devastating situation.

Subsequently, Mr. Maxwell's son initiated the complaints process with the Trust highlighting several key issues and ongoing concerns related to the handling of the complaint and subsequent improvements. The significant delay in ambulance response, which led to the complaint, underscores a serious concern about emergency response times. This was a critical issue that triggered the complaint process. The family's frustration with the inability to get definitive answers about responsibility and the effectiveness of promised changes was a critical issue.

While the pressures of COVID-19 and staff shortages were cited as reasons, it was the view of the family that these explanations had not satisfactorily addressed the family's concerns or led to visible improvements. Mr Maxwell's son continued that he was still experiencing a challenging and emotional situation regarding the memory of his mother. Although he had received apologies and explanations, he still felt as though the situation was still unresolved and wanted assurance that similar incidents would not happen to others in the future.

Comments:

Liam Williams acknowledged the significance of the story and expressed gratitude towards Mr. Maxwell and his son for sharing their story. This story has underscored the vital importance of maintaining an ongoing duty of care, not just in providing medical treatment but also in listening to families, valuing their experiences, and ensuring comprehensive support both during their immediate time of need, and afterwards.

Members commented that as an organisation, it was crucial there was continuous dialogue for fostering a culture of empathy and improvement. It was important that the impact this and other stories were shared beyond individual interactions and extended to broader systemic changes. Members inquired whether the insights and learnings from this experience had been communicated with the Health Boards, ensuring that the lessons learned have a wider influence and contributed to overall healthcare improvements. Liam Williams explained that this story along with others, were shared with Health Boards. He mentioned that this story has been shared with National Health Board representatives across Wales and was presented at the Duty of Quality conference. This acknowledgment and dissemination were significant steps toward systemic improvement and reflected a commitment to learning from these experiences.

The Board were keen to understand how the call was initially categorised and notwithstanding the significant handover pressures, questioned whether the Trust asked for an Immediate Release Directive (IRD) from the local Health Board concerned.

Liam Williams advised that the call was initially categorised as an Amber 2 and then progresses to an Amber 1. He also agreed, as the information was not immediately available, to confirm whether an IRD was issued and would advise the Board accordingly.

Jason Killens added his thanks to the Maxwells for sharing their story and highlighted the importance of considering the ongoing psychological impact and harm caused by the response delay on those left behind. This acknowledgment was crucial as it emphasised the broader implications of such incidents on the mental health and well-being of affected families.

Estelle Hitchon emphasised the importance of acknowledging the point raised by Mr. Maxwell's son concerning public confidence in the Trust.

Hannah Rowan noted that Mr Maxwell had not been allowed to say goodbye to his wife following advice given after the postmortem. She wanted to understand if that was standard policy, and if so, how it might impact how Paramedics support people at the point they realised there was going to be an unexplained death investigation. Hannah Rowan suggested that perhaps Paramedics could be encouraged to allow close relatives a few minutes with the deceased at the scene before they were taken away.

Jason Killens explained that in situations where there was an unexplained death and the patient had not seen a medical practitioner for a period of time, it was standard practice to conduct a postmortem. Typically, after a postmortem, access to close relatives was granted. In this case, it seemed unusual that this protocol was not followed. However, this matter fell under the jurisdiction of the Coroner's Office, not the Trust. Liam Williams explained that from a clinical practice perspective, it was anticipated and expected that the process would allow for someone to say their farewells under normal circumstances.

Liam Williams explained that this story emerged through the efforts of the Putting Things Right Team and the Patient Experience Community Involvement Team. These teams identified families who might wish to share their experiences. Both teams ensured that families were comfortable sharing their stories and followed up afterwards to make sure they felt supported.

RESOLVED: The patient story was noted.

67/24 ACTIONS TO MITIGATE AVOIDABLE PATIENT HARM IN THE CONTEXT OF EXTREME AND SUSTAINED PRESSURE ACROSS URGENT AND EMERGENCY CARE

Prior to the update, Jason Killens reminded the Board that the report has been in its current format for two years. He added that the purpose and content of this report will be reviewed following this Trust Board meeting, given that position. Jason Killens presented the Report and highlighted the following for the Board's attention:

Good progress continued to be made on actions that the Trust can control, both from a tactical and more strategic perspective; however, the Trust does not control the biggest variable that was affecting patient safety, namely, the levels of handover lost hours with handover lost hours in June 2024 at 22,229 hours (20% higher than June 2023).

At the end of June 2024, there was a 20% increase in hours lost to handover compared to June 2023, totalling just over 22,200 hours. It was important to note that the roster production was based on an expectation of no more than 6,000 hours being lost per month.

Long response times coupled with extended lengths of time in ambulances waiting for handover have led to avoidable patient harm. For the 3-month period April 2024 to June 2024.

- 1,697 patients could have come to severe harm as a result of being held on an ambulance for longer than an hour outside an Emergency Department (ED);
- 28,683 patients will not have received a response due to the operation of the Clinical Safety Plan or through the patient cancelling the ambulance; and
- There were 23 severe cases of avoidable harm, including death, referred to health boards under the Joint Investigation Framework.

Sickness absence to 6% by March 2024: whilst missing the target and being RAG rated red, the Trust achieved 7.55% in May 2024 which demonstrates a significant shift in the right direction over the last 12 months.

Eradication of handover waits of greater than 4 hours: the main Welsh Government target was now the no waits over one hour with a 30% reduction by December 2024. There had previously been a focus on four hour waits.

The Trust's 2024-27 IMTP set out a range of actions designed to evolve the clinical model at pace to try and address the impact of handover and these were listed in detail the report.
Comments:

The Board expressed their grave concern with the Handover delays acknowledging the impact this had both on patients and staff.

Rachel Marsh expressed confidence that the revised clinical model will have a positive impact. Furthermore, a session with the new Joint Commissioning Committee was scheduled, which will provide a valuable opportunity to present the issues, discuss potential mitigations, and address challenges across the system.

Andy Swinburn commented that while taking these actions might help with some of the challenges, it was important to acknowledge that patients may still come to harm and that risks cannot be eliminated.

Kevin Davies expressed his frustration with the Same Day Emergency Care (SDEC) pathway, noting that it still was not available for the Trust. He emphasised that if the current approach was not working, the Trust would need to consider alternative solutions. Jason Killens added that the Trust had consistently raised the issue of SDEC referral capabilities with colleagues across the system. The Trust's modelling suggested that approximately 4% of activity could be diverted through SDEC if these pathways were available consistently.

While the SDEC pathway issue remained a challenge, there has been notable progress with Health Board colleagues on exploring alternative routes for high-volume patient cohorts, particularly those with chest pain, respiratory problems, and falls.

Peter Curran inquired about sickness absence figures, specifically whether long-term sickness has decreased and when the Trust can expect the rates to improve and reach the target level of 6%.

Angela Lewis confirmed that long-term sickness rates had improved. However, short-term sickness remained a challenge and the Trust was focusing on areas with anomalies to understand the underlying issues. Achieving the 6% target remained a commitment and required ongoing effort each month. Addressing cultural issues, as well as recognising the impact of stress, mental health, and anxiety, was also a priority. While reaching the target was not a short-term issue, the Trust was on the right trajectory.

The Chair noted with interest that handover delays were worse in June 2024 compared to June 2023, highlighting that the pressures appeared to be consistent year on year. The Chair added that a refreshed version of the report going forward would be welcomed.

RESOLVED: The Trust Board noted the continued level of avoidable patient harm.

68/24 MONTHLY INTEGRATED QUALITY PERFORMANCE REPORT

Rachel Marsh drew attention to the following areas:

Data quality issues have been identified in 111 particularly relating to the 111 contribution towards the overall Consult and Close rate. These were currently being addressed. 111 call handling performance has stabilised post-delivery of the new 111 CAS, but the abandonment rate was higher than the 5% target. This was due to several factors including: increased demand levels during the first half of the year, a lower level of staff in post caused by training capacity having to be diverted to the implementation of the new system, sickness absence and also a 4% commissioned reduction in call handlers in 2024/25. The Trust anticipated that staff in post will be restored to establishment levels by September 2024.

In June 2024 complaint response times improved to 88%, a strong improvement on the 50% recorded in May 2024, and achieving the 75% target; however, cases remained complex. Reviews of lower graded concerns was being undertaken to ensure proportionate investigations were undertaken. The Trust has recruited to a new structure for the Putting Things Right (PTR) Team, which was a key enabler in the improved performance.

The consult & close rate was 12% in May 2024, a reduction from the previous month due to the system changes within the 111 CAS system, which has affected reporting capabilities i.e. the 111 contribution to consult & close was not currently included in the 12% above. The IMTP

ambition (and Welsh Government target) remained at 17%. The Trust has a recovery plan in place, with further work continuing during 2024/25.

The Executive Director Strategy, Planning & Performance had undertaken a review of the MIQPR metrics together with Executive colleagues and a presentation was given at July 2024 Finance & Performance Committee on the outputs from this review. The review identified that the MIQPR was comprehensive, covered all the key metrics that the Trust was held to account on by Welsh Government and commissioners. A new metric, 'length of lie,' for fallers was identified as a proxy for outcome and would be included in the MIQPR going forward. While no additional changes were recommended at this time, the review indicated that further adjustments might be anticipated as the Trust evolved its clinical model, continued to address the Duty of Quality, and explored opportunities arising from data linking work.

Comments:

Joga Singh informed the Board that the Finance and Performance Committee had scrutinised the report and reviewed and endorsed the proposed change to the MIQPR – with the inclusion of the 'length of lie' metric for Board approval.

RESOLVED: The Trust Board considered the May/June 2024 Integrated Quality & Performance Report and actions being taken and determined that it provided sufficient assurance and formally approved the change to the metrics.

69/24 RISK MANAGEMENT AND BOARD ASSURANCE FRAMEWORK (BAF)

Trish Mills presented the report and explained that due to the Trust's Board and Committee meeting cycle, the second quarterly Risk Management and Board Assurance Report was sitting slightly outside of normal reporting cycles for the principal risks due to the mid-year placement of Board and Committee meeting dates. Therefore, agreement was sought from the Chair of the Board and Chair of Audit, Risk and Assurance Committee to provide a short report that included several key highlights as there was nothing new to report at this time.

The Board took assurance that each of the principal risks have been reviewed in line with the agreed reporting schedule throughout the latter part of May, June and early July, and the risks are navigating Trust governance processes in readiness for the next reporting cycle.

Given the nature of the Trust's two highest scoring risks, and to support the Avoidable Harm report on the Board Agenda, the Board Assurance Framework extract described the full risk detail of **Risks 223** (*the Trust's inability to reach patients in the community causing patient harm and death*) and **Risk 224** (*Significant handover of care delays outside accident and emergency departments impacts on access to definitive care being delayed and affects the Trust's ability to provide a safe & effective service for patients*) Both risks scored 25, and remained unchanged because of sustained and extreme pressure across the Welsh NHS urgent and

emergency care system which was negatively impacting on patient flow leading to avoidable patient harm and death.

RESOLVED: The Board received assurance that each of the Trust's principal risks have been reviewed in line with agreed review schedules and full details will be reported in the next cycle of meetings.

70/24 FINANCIAL POSITION FOR MONTH 3, 2023/24

Chris Turley advised the Board that the report had been reviewed at the last Finance and Performance Committee (FPC) meeting on 16 July 2024.

Key highlights from the report included:

The Trust was reporting a small revenue surplus (£29k) for month 3 2024/25.

In line with the balanced financial plan approved as part of the submitted 2023-26 IMTP, the Trust was currently forecasting to breakeven for the 2024/25 financial year.

Capital expenditure plans were being finalised with plans to fully achieve in year.

In line with the financial plans that supported the IMTP, gross savings of £1.967m had been achieved in month 3 against a target of £1.704m.

Public Sector Payment Policy was on track with performance, against a target of 95%, of 97.5% for the number, and 98.2% of the value of non NHS invoices paid within 30 days.

Reported Income against the initial budget set to Month 3 shows an overachievement of £0.009m.

Whilst there was a small surplus reported at Month 3 there were some small variances between Directorates in terms of financial performance.

At Month 3, the Trust's approved Capital Expenditure Limit (CEL) set by and agreed with WG for 2024/25 was £19.622m. This included £14.167m of All Wales Approved schemes and £5.455m for Discretionary schemes. By the next Board meeting there will be a more detailed update on the Capital and Discretionary capital with details on some the schemes.

Understandably this early in the financial year, the risks reported were still being fully assessed, however in reporting through to WG it was considered that there were currently no individual high likelihood risks but over the next few months the Trust will continue to review the risks to ensure that the level of likelihood was assessed along with the financial value

Comments:

Peter Curan sought an update in terms of the implications of not being able to replace vehicles in accordance with the strict replacement schedule and of any associated risks

Chris Turley explained that fleet maintenance presented a variance and would result in an overspend due to insufficient funding. Although it was a revenue cost that can currently be managed based on projections, it was expected to be a cost pressure in next year's financial plan.

RESOLVED: The Board

- (1) Noted and gained assurance in relation to the Month 3 revenue financial position and performance of the Trust as at 30 June 2024.**
- (2) Noted the delivery of the 2024/25 savings plan, and the context of this within the overall financial position of the Trust.**
- (3) Noted the capital programme for 2024/25, and**
- (4) Noted the Month 2 and Month 3 Welsh Government monitoring return submission included within the report at Appendices 1 – 4 (as required by WG).**

71/24 INTEGRATED MEDIUM TERM PLAN (IMTP) 24/25 DELIVERY & ASSURANCE APPROACH AND Q1 DELIVERY & ASSURANCE UPDATE

Rachel Marsh presented the report was read advising the Board the report had been discussed in detail at the Finance and Performance Committee (FPC) meeting on 16 July 2024.

Rachel Marsh highlighted the fact that there had been substantial effort in reviewing and revising all assurance mechanisms, including the transformation programme structures and extended her thanks to the team involved in this work.

Comments:

Trish Mills explained that the governance structure, initially quite complex, has been simplified and streamlined. It has been integrated with the existing Trust structures, aligning with the direction to avoid duplication while utilising those structures.

The Chair asked for an update on any pressures affecting staff in producing the next iteration of the IMTP. Rachel Marsh explained that the team was focused on ensuring that work was not being duplicated and that team members were complementing each other's efforts. She noted that planning for next year's iteration would begin in earnest in

September, which involved a considerable amount of work.

Rachel Marsh added that the Ministerial priorities were also linked to the report, noting that it is important for Ministers to see a consistent approach in Integrated Medium Term Plans (IMTPs) across all organisations.

RESOLVED: The Board

- (1) Noted the revised arrangements for IMTP delivery and assurance.**
- (2) Noted the IMTP 2024-27 Q1 position; and**
- (3) Noted the progress against Ministerial Priorities in Q1.**

72/24 DIGITAL PLAN REFRESH: 2024-2029

Jonny Sammut explained that the purpose of the report was to present the Refreshed Digital Plan to Trust Board for approval and implementation. He highlighted some key areas for the Board's attention:

The digital landscape within the healthcare sector has undergone rapid evolution over the past few years, driven by technological advancements, shifting patient expectations, and the increasing necessity for efficient healthcare delivery.

Following a comprehensive review of digital demand and global sector benchmarking, the plan was produced using a VMOST (Vision, Mission, Objectives, Strategies, Tactics) framework. This meant that the refreshed Digital Plan maintains strategic alignment across all levels.

The renewed digital plan focuses on three main areas: regulatory compliance, patient outcome enhancement, and resource optimisation. Aligning with governmental and NHS directives ensures that the Trust's digital initiatives continue to build public trust and adapt to the evolving regulatory landscape.

The Digital Plan outlines the purpose behind each of the Trust's digital pillars and was designed to support the overarching vision. This plan was designed to be agile and dynamic in nature, with actions for years 2-5 to evolve as the Trust progressed, with the year 1 projects outlined in the plan document as part of the commencement of this digital journey.

A "rich picture" has also been developed, with the aim of bringing to life the digital vision and how this will look and feel for the Trust. This picture was currently in final stages of design and would supplement the plan as it is published. Pending approval by the Trust Board, the plan would be officially launched in August 2024.

Comments:

Joga Singh explained that the Plan had received a comprehensive discussion at the FPC meeting on 16 July 2024. It was also fully supported by the Digital Lead for the Board, Ceri Jackson.

Chris Turley commented that the Trust had previously identified digital as an area for investment within the overarching financial plan. He added that the strategy had been built around this focus, and the Trust was committed to addressing the financial impacts for the upcoming and following year.

Hannah Rowan added that this Plan was well thought through in relation to the priorities and how they were embedded, which was important. She highlighted the potential of data information and insights to dovetail with ongoing research and innovation work. The ability to use the data in new ways was seen as a particular strength of the Welsh system, given the theoretical access to data for the whole of Wales. Furthermore, it presented significant potential for research studies.

Peter Curran emphasised the importance of maximizing technology to enhance all aspects of the Trust's operations. He mentioned the future potential of drone technology, which could be massively effective for the Trust. He stressed the need to balance forward-looking initiatives with maintaining the current operational picture, and highlighted technology as a major component of the Trust's mission to achieve its goals.

Angela Lewis commented that it was powerful to see the alignment with the People and Culture Plan. The rich picture will be particularly beneficial for staff, as the Trust has committed to improving digital literacy, which will make a significant difference for them.

Following a query regarding the digital threat and the implications of Artificial Intelligence (AI), Jonny Sammut explained that AI was a very broad topic. A plan was in place to define what AI meant for the Trust. Additionally, the Trust will develop an educational initiative to clarify the differences between automation, machine learning, and AI. The Trust will begin later in the year by setting its ambitions, considering different ideas, and then prioritising them. As more AI was developed, new routes for cyber-attacks were also created, so there needs to be a balance between AI and security. It was crucial to ensure that this balance was appropriately managed.

RESOLVED: The Board approved the Digital Plan 2024-2029 for implementation and received the Equality Impact Assessment.

73/24 GOVERNANCE REPORT

Trish Mills presented the report which set out the Chair's Action's taken since the last

Board meeting and ratifications required, and decisions made in private session.

There has been one decision made by Chair's Action made since 30 May 2024. This related to approval of the Trust's Microsoft Enterprise Agreement and will be ratified in the private session of the Board on the 25 July 2024 and reported in the September Governance Report in full.

At the closed Trust Board meeting on the 30 May 2024 the Board received a request to approve the new Grange University Hospital Transfer Service, Service Level Agreement (SLA).

RESOLVED: The Trust Board

- (1) Noted the decision made by Chair's Action, and**
- (2) Noted the decisions made in private which have been reported in open session.**

74/24 SCHEME OF RESERVATION AND DELEGATION OF POWERS - CONTRACT AWARDS BY BOARD

Trish Mills presented the report which proposed amendments to the Scheme of Reservation and Delegations of Powers (SoRD). The SoRD was set out in two parts. The first part was the Schedule of Matters Reserved to the Board which was prescribed by Welsh Government; the second part was the Scheme of Delegation to Executive Directors, Directors and Officers. This second part contains Table A – delegated matters, and Table B – delegated financial limits.

The amendments provided clarifications regarding issues raised in a recent internal audit, as well as the logistical processes resulting from these changes. Several material changes were made to Table A and Table B, which detail the delegations from the Chief Executive to Directors. These changes included clarifications on delegated authorities for tenders, quotations, and awards.

There was also further clarity provided on procedures for single tender waiver approvals. Additionally, it was noted that the delegations to the Director of People and Culture would transfer to the Director of People once that position was filled. The amendments were reviewed and endorsed by the Audit, Risk, and Assurance Committee on 10 July.

RESOLVED: The Board approved the amendments to the Scheme of Reservation and Delegation of Powers.

75/24 BOARD COMMITTEE REPORTS

The following Committee highlight reports were received noting that updates had been provided earlier in the agenda.

Audit, Risk and Assurance Committee (ARAC)

Peter Curran, as Chair of the ARAC added that the Committee had endorsed the 2023-24 Annual Accounts and Annual Report, as well as the Letter of Representation, and the Duty of Quality Annual Report 2023-24.

Finance and Performance Committee

Joga Singh commented that all the points had already been raised previously during the meeting.

Academic Partnership Committee

Hannah Rowan commented that owing to the timing of the Committee meeting a written AA had not been produced. A verbal update was given. Hannah noted that a new campaign has commenced to appoint a new academic Non-Executive Director and that the process would continue over the coming weeks.

As the Trust Board Research Champion, Hannah advised Members that she met with Research Champions from other Health Boards several times a year and was informed about an upcoming funding opportunity in Wales. This funding was part of the Voluntary Scheme for Branded Medicines Pricing and Access, with the UK government approving a £400 million investment over five years to drive innovation, sustainability, and growth.

Of this, £22.1 million has been allocated to Wales, which was a significant amount relative to its population size. The focus will be on enhancing the NHS's capacity to deliver commercial clinical research, with investment primarily in the first half of the funding period. This funding was intended to kickstart projects that could lead to further commercial opportunities. While the exact allocation process was not yet clear, it was important for the Trust to monitor this development, as there were significant potential benefits for the Trust.

The Committee had been very pleased that the Trust had achieved University Trust Status and had discussed how the Trust could maximise and realise the benefits associated with this formal status. The Committee had a productive discussion about the anticipated advantages of this status. To realise these benefits, the Trust needs to be highly focused and strategic in prioritising its actions and ensuring accountability. What began as a broad discussion will be refined, with the goal of presenting a more detailed plan at a future Board development session. This will help the Trust use its new status as a launchpad for further initiatives.

RESOLVED: The Board received the above Committee Highlight Reports and

received assurance that each of the Committees had fulfilled their Terms of Reference, and that matters of concern had been escalated in line with the Alert, Advise, and Assure process.

76/24 MINUTES OF BOARD COMMITTEES AND NHS WALES JOINT COMMITTEE UPDATE REPORTS

The minutes of the following Board Committees were received.

Academic Partnerships Committee - 16 January and 23 April 2024

Audit, Risk and Assurance Committee: 30 April 2024

Finance and Performance Committee: 14 May 2024

NHS Wales Joint Committee Update Reports.

Joint Commissioning Committee meeting – 21 May 2024

RESOLVED: That

- (1) The minutes of the Academic Partnerships Committee dated 16 January and 23 April 2024, the Audit, Risk and Assurance Committee dated 30 April 2024 and the Finance and Performance Committee dated 14 May 2024 were received.**
- (2) The Joint Commissioning Committee meeting dated 21 May 2024 was received.**

77/24 ANY OTHER BUSINESS

None.

78/24 EXCLUSION OF THE PRESS AND MEMBERS OF THE PUBLIC – 25 JULY 2024

Members of the Press and Public were invited to leave the meeting because of the confidential nature of the business about to be transacted (pursuant to Section 1(2) of the Public Bodies (Admission to Meetings) Act 1960).

RESOLVED: The Board would meet in private on 25 July 2024.

Date of next Open meeting: 26 September 2024.

Meeting closed at 11:15