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Powys Teaching
Health Board

BOARD

CONFIRMED MINUTES OF THE MEETING HELD ON 16 SEPTEMBER 2026 AT 13:00 HELD VIA MICROSOFT TEAMS

MEMBERS		
Carl Cooper	CC	Chair
Pete Hopgood	PH	Acting Chief Executive Officer
Rhiannon Beaumont-Wood	RBW	Vice Chair
Mererid Bowley	MB	Executive Director of Public Health
Steve Elliot	SE	Independent Member (Finance)
Mick Giannasi	MG	Independent Member (General)
Nicola Johnson	NJ	Executive Director of Planning, Performance and Commissioning
Rhobert Lewis	RL	Independent Member (General)
Jennifer Owen Adams	JOA	Independent Member (Third Sector)
Cathie Poynton	CP	Independent Member (Trade Union)
Hywel Pullen	HP	Acting Executive Director of Finance
Ian Thomas	IT	Independent Member (General) - until 10:25
Chris Walsh	CW	Independent Member (Local Authority)
Debra Wood-Lawson	DWL	Executive Director People, Culture and Transformation
Kate Wright	KW	Acting Deputy Chief Executive / Executive Medical Director
Simon Wright	SW	Independent Member (University)
IN ATTENDANCE		
Katie Blackburn	KB	Regional Director, Llais
Helen Bushell	HB	Director of Corporate Governance / Board Secretary
Lucie Cornish	LC	Director of Improvement and Transformation
Nina Davies	ND	Associate Member (Director of Social Services, Powys County Council)
Adrian Osborne	AO	Deputy Director Communication, Engagement and Corporate Governance
Liz Patterson	LP	Head of Corporate Governance (Meeting Support)
APOLOGIES FOR ABSENCE:		
Ronnie Alexander	RA	Independent Member (General)
Paul Hooton	PHo	Executive Director of Nursing, Quality, Women and Family Health
Elaine Lorton	EL	Executive Director of Primary Care, Community and Mental Health
Claire Madsen	CM	Executive Director of Allied Health Professions, Health Science and Digital
Hayley Thomas	HT	Chief Executive Officer

1. PRELIMINARY MATTERS
1.1 WELCOME AND APOLOGIES FOR ABSENCE (PTHB/26/062)
The Chair (CC) welcomed everyone to the meeting. Apologies for absence were received as recorded above.
1.2 DECLARATIONS OF INTEREST (PTHB/26/063)
No interests were declared in addition to those already declared within the published register.
1.3 CORRESPONDENCE FROM THE PUBLIC (PTHB/26/064)
CC advised that there had been no specific correspondence received under the arrangements for questions to the Board. However, Board Members had received a number of letters and emails, and CC had personally received 14 items of correspondence, seven of which related to specifically to the future of services in Llanidloes. All correspondence has been responded to.
This morning a petition had been received organised by Liberal Democrat representatives.
CC noted that feedback and comment is welcomed, and the Board will seek to ensure that the areas of interest, enquiry and concern within the feedback are explored as the Business Case is scrutinised regarding its readiness for public consultation.
2. ITEMS FOR APPROVAL/DECISION
3.1 BETTER TOGETHER: PHASE ONE – COMMUNITY AND MENTAL HEALTH SERVICES (PTHB/26/065)
PH introduced the item, and together with KW, DWL and LC gave a presentation on the Pre-Consultation Business Case which set out the rationale for change and the evidence supporting progression to public consultation. The primary driver for change is the need to improve quality, safety and outcomes for the population of Powys. Whilst recognising the commitment of staff and the quality of care currently delivered, the evidence demonstrated increasing pressures associated with an ageing population, rising levels of frailty and complexity, workforce fragility, delayed discharge, prolonged hospital stays, fragmented care pathways and estate limitations that do not consistently support modern standards of care. Maintaining the current model was not considered a risk-free option and could result in increasing challenges to service sustainability, quality and patient experience.
The case for change was centred on delivering better outcomes for patients rather than reducing services, beds or buildings. Evidence showed that avoidable hospital admissions and unnecessarily prolonged hospital stays can contribute to loss of independence, reduced mobility, deconditioning, poorer mental wellbeing and delayed recovery, particularly amongst older people and those living with frailty. The possible future model seeks to ensure people receive the right care, in the right place and at the right time, with greater emphasis on prevention, early intervention, rehabilitation, Hospital at Home, urgent community response services and improved support. This will enable people to remain independent in their own homes wherever clinically appropriate.

The Better Together programme is the mechanism through which existing strategic ambitions would be delivered, including those set out within the Powys Health and Care Strategy, Population Health Strategic Framework and Strategic Commissioning Framework. The proposed direction supports a shift towards prevention, integrated care, improved community-based services, enhanced mental health support and care closer to home, whilst recognising Powys' rural geography and ongoing reliance on neighbouring district general hospitals for specialist services.

The options have been developed through a robust, transparent and evidence-based process in accordance with NHS Wales Service Change guidance and Enhanced Consultation Framework requirements. Extensive engagement has been undertaken with patients, the public, staff, clinicians, partners and stakeholders, supported by clinical review, demand and capacity modelling, workforce and financial analysis, travel assessments, integrated impact assessments and independent challenge and assurance. A long list of 81 potential options has been systematically assessed against agreed criteria, resulting in five credible consultation options comprising of two physical health options, two urgent care and diagnostics options and one mental health option.

All options share a common commitment to strengthening community services and integrated pathways across physical health, mental health and urgent care. The proposed future model seeks to provide earlier intervention, improve continuity of care, reduce avoidable harm, strengthen community and crisis response services, support timely discharge and create more resilient inpatient services where admission is required. If the programme progressed to implementation, this would be phased and dependent upon demonstrable readiness, including sufficient workforce capacity, community services, clinical governance, digital capability, estate development and partnership arrangements.

PH concluded the presentation noting that no final decisions had been made. Approval was being sought to proceed to formal public consultation rather than to implement any preferred option. The purpose of consultation would be to test the evidence, assumptions, benefits, risks, equality impacts, travel implications and alternative proposals before any future decision is taken. The Board was therefore asked to take assurance from the evidence presented, the options development process and the supporting business case, and to consider whether the proposals were sufficiently developed and evidenced to proceed to public consultation.

KB (Regional Director of Llais, the Citizens Voice Body) offered the following reflections:

- Llais has an independent statutory role and, whilst Llais had engaged throughout the programme, it had not participated in the selection of options or decision-making and would remain an independent voice for patients, service users and communities during any formal consultation.
- Transparency and clarity are important during the consultation process, ensuring that people understand how the proposed options were developed, the evidence informing them, alternative approaches considered and how previous engagement has influenced the proposals.

- Better Together represents a whole-system model of care encompassing urgent care, diagnostics, mental health, community and primary care services, rather than being solely focused on hospital provision.
- Accessibility is a key concern for Powys residents. There are concerns around travel times, transport availability, repeated journeys for families and carers and the practical implications of service changes for people living in rural communities.
- Feedback received from residents included concerns regarding access to local services, minor injury units, diagnostics, visiting arrangements, family support, and the importance of Welsh language provision, dignity and maintaining links with local communities.
- Partnership working across organisational boundaries is important and the success of any future model will depend upon effective collaboration between health, social care, transport, community services and wider partners.
- Supporting infrastructure will need to be in place before any service changes are implemented, including appropriate community services, care packages, equipment, adaptations and workforce capacity.
- It is important to engage with seldom-heard groups, including individuals facing barriers related to disability, language, caring responsibilities, transport or digital access, to ensure all communities can participate.
- People will expect clear evidence of how consultation responses are considered including how feedback, themes and alternative suggestions contribute to subsequent decision making.
- Llais commits to listen independently throughout the consultation period and will represent the views and concerns of communities, identify gaps in engagement, and raise emerging themes with the Health Board.
- Llais welcomes the inclusion of a midpoint review during the consultation period to assess levels of engagement, identify groups requiring further involvement, and highlight areas where additional information or clarification may be required.
- The ultimate test of any preferred model should be whether it delivers improved health and wellbeing outcomes for the people of Powys, and Llais encourages residents to engage actively in the consultation process to ensure their views inform future decisions.

Independent Members asked the following questions for assurance:

What are the implications of the proposed Minor Injury Unit (MIU) changes for residents in areas at the extreme end of the county (e.g. Ystradgynlais) in terms of access to minor injury and enhanced care services?

KW advised the proposed model seeks to enhance the current urgent care offer available across Powys. While existing Minor Injury Units provide an important service, their scope is limited to treating relatively minor conditions and, in some cases, they do not benefit from onsite diagnostic facilities such as X-ray services. The proposed model would enable a broader range of conditions to be treated within the county, reducing the need for patients to travel outside Powys for care. A key feature of the proposals is the expansion of community-based and home-based urgent care services, ensuring that more care can be delivered closer to where people live and, where appropriate, in their own homes.

However, the proposed future model may not replicate the current service configuration at every existing site. Therefore, there would need to be careful

engagement with local communities to understand the potential impact of any changes and to consider any mitigating measures required to maintain appropriate access to local services.

How confident are we that increasing demand, GP pressures, delayed transfers of care and other system bottlenecks will not compromise delivery of the strengthened community care model? How sensitive are the proposals to these pressures?

KW and LC recognised that system pressures and bottlenecks already exist, but extensive modelling work has improved understanding of where improvements can be made. The proposals are based on greater integration and partnership working, with the aim of reducing delays, handovers and duplication. Successful delivery depends on continued collaboration with health and care partners. The proposed direction is evidence-based, aligned with wider system developments, and supported by partners who are committed to addressing system constraints to improve patient experience and service effectiveness.

Will there be a detailed workforce plan to support the preferred models, including the skills, competencies and workforce transition required to deliver the proposed changes?

DWL confirmed that an extensive workforce plan will be developed. This will include understanding both the skills currently available within the workforce and any additional skills required to support future models of care. The plan will consider staff development needs, the time required to build new competencies, support arrangements for staff, recruitment pipelines, and any gaps between current and future workforce requirements. This detailed work has not yet been undertaken because the programme remains at the staff engagement stage, but a comprehensive workforce plan and readiness assessment would be developed to inform implementation and phasing.

KW added that the Health Board is already investing in a clinical oversight model to strengthen senior clinical support, training and workforce development. Encouraging signs had been seen in recruitment to key posts, which provides optimism that the workforce can be supported to develop the skills needed should the proposals proceed.

If the Board agrees to proceed to consultation, what guardrails or mechanisms will be put in place to ensure that any future changes are tested safely and do not place patients at risk of avoidable harm?

KW explained that during the consultation period there will be no changes to service provision. The focus will be on gathering, monitoring and evaluating feedback and evidence. Any important information emerging through the consultation process will be acted upon promptly, and the planned midway review point will provide an opportunity to pause and evaluate progress.

NJ emphasised that the Board's decision at this stage is only whether to proceed to consultation and not whether to implement any service changes. Should implementation be considered in the future, clear readiness assessments and ongoing quality and patient safety assessments would form part of implementation planning. Quality and safety considerations have been integral to the programme to date, with the STEEP quality domains from the Welsh

Government Quality and Safety Framework being used throughout the options appraisal process. Patient safety, quality and stakeholder feedback would continue to be central to any future decision-making.

Given the two-site physical health model was initially not considered to have met the hurdle criteria, can assurance be provided that the two-site physical health option received further clinical assessment and sign-off following the development of the enhanced community model?

LC advised that the two-site option was assessed alongside the strengthened community model, as the two-site configuration would not be feasible without the enhanced community offer. Further modelling and information relating to the community-based provision were considered through the options development process. All options were reviewed through the Options Development Group, which included senior clinical and operational leaders, and were subsequently considered through the programme board, portfolio board and Better Together governance arrangements. These governance processes provided senior clinical and operational oversight and support for the recommendation to take the option forward.

Why was Option 002B (retaining beds on six sites with medical and mental health integration) not shortlisted for public consultation?

LC explained that Option 002B did not sufficiently address the Case for Change because it would not deliver the level of service transformation required to shift care into community settings. While the option was recognised as representing movement in the right direction and could potentially act as a transitional or bridging arrangement, it was not considered to go far enough to achieve the sustainable model of care required for the future. Consequently, it was not recommended as a consultation option.

How would the Health Board secure the capital funding required to implement any preferred option, given the significant investment likely to be required?

HP advised that an assessment of the capital implications for each option had been undertaken and was reflected within the Pre-Consultation Business Case. Following consultation and any subsequent decision-making, the Health Board would use the outcomes to inform discussions with Welsh Government regarding future capital requirements. Any agreed service model would therefore form part of ongoing engagement with Welsh Government concerning investment in the Health Board's estate and infrastructure.

How would the Health Board manage the significant transitional revenue costs associated with implementation, particularly in the context of the current financial position?

HP acknowledged that implementation of the proposed options would require upfront investment in community services and would result in a period of double-running costs while services transitioned to any new model. These costs would need to be reflected in future financial plans and would be subject to approval processes with Welsh Government. The Health Board would seek Welsh Government support to meet transitional implementation costs should a decision be taken to proceed with service change.

What assurances can be given to the people of Powys that, if the Board decides to proceed to consultation, there will be comprehensive opportunities for their views to be heard?

AO advised that a detailed consultation plan had been included within the Board papers. A previous version of the consultation plan had been approved, without prejudice, by Board in July 2026. Subject to any Board decision to proceed, the proposed approach would include a major public drop-in event in each of Powys' 13 localities, targeted engagement with a broad range of community groups, and proactive efforts to reach people with protected characteristics and those experiencing socio-economic disadvantage.

The plan would also include a county-wide leaflet drop to households across Powys, providing information on consultation events, online engagement opportunities, and how to access consultation materials. Information would be made available in a variety of formats, including Easy Read, Welsh and English versions, and British Sign Language (BSL). The Health Board's website would support accessibility needs through screen readers and other assistive technologies.

In addition, an online survey would be available, and the intention would be to exceed the minimum statutory consultation period by running the consultation from 05 October 2026 to 10 January 2027 acknowledging the Christmas period fell within this timescale. The aim would be to maximise opportunities for people to hear about the proposals, access information, attend events where possible, and provide feedback to inform future Board decisions.

What does the 'conscientious consideration period' mean? How will the process take place, who will be involved, and how will it be reported back to the Board?

AO explained that a key part of the conscientious consideration process is the independent analysis of all consultation feedback by ORS, an external organisation appointed to undertake this work. Feedback will be collected from a range of sources, including online and paper questionnaires, easy-read questionnaires, and comments gathered through public engagement events.

Once the consultation period closes, all feedback will be brought together and independently analysed by ORS, which will produce a report setting out what has been heard. The subsequent process will be informed by the issues raised during consultation and will be designed to respond to the themes emerging from that feedback.

As part of conscientious consideration, the Health Board will consider whether:

- The issues identified in the case for change have been fully explored.
- The appropriate factors have been considered when assessing and verifying options.
- The right range of options has been examined.
- Any additional options raised through consultation require further assessment.

The findings will then inform the development of a Post-Consultation Decision Case, enabling the Board to see how consultation feedback has been considered and reflected in future decision-making. Where consultation identifies new or

revised options requiring further exploration, additional engagement or consultation may be undertaken. For example, in Hywel Dda's clinical services consultation, feedback had led to a second phase of consultation on revised options.

The ORS reports will be published and available in the public domain. As part of the conscientious consideration process, stakeholders will also be asked to test whether the reports accurately reflect the range and strength of views expressed during consultation. Consultation is not a referendum, but rather an opportunity to robustly test options, scrutinise evidence, identify gaps and opportunities, and inform future Board decisions.

Section 6.8 of the PCBC, which explains how community pathways and modelling assumptions lead to future bed projections, was difficult to follow and should a decision be made to go out to consultation, could this be made more accessible for the public during consultation?

PH confirmed that, if the programme moved into public consultation, the team would review how best to explain this section in a simpler and more accessible way, potentially through improved narrative and supporting materials.

Can further assurance be provided that the Better Together proposals are realistically deliverable, even though detailed implementation plans are not yet required?

PH confirmed that the key dependencies and complexities around workforce, infrastructure, partnerships, estates, digital services, transport and community capacity are recognised and that preparatory work is underway. More detailed implementation plans would be required before any future implementation decisions.

How will the Board ensure that community services are fully established before any reduction in hospital beds takes place, and what assurances will be required before progressing through future phases of the programme?

PH confirmed that, subject to consultation outcomes and any subsequent decisions, implementation would need to be carefully staged and phased to ensure that services are maintained appropriately throughout the process.

The Independent Member (Trade Union) advised that staff members have been central to shaping and driving the ongoing organisational change programme. Through extensive engagement and involvement throughout the process, staff have recognised the need for change and have contributed their views and experiences to its development. Whilst not all staff will agree with every aspect of the programme, the majority understand the reasons for change and remain committed to supporting its delivery. Staff recognise change as a long-term process and are, in the main, looking forward to continuing to work with services, directorates and departments to help shape the future direction of the Health Board.

The Associate Member made a statement and asked the following questions for assurance.

ND confirmed this was not a formal Local Authority response to the consultation, but she was acting as a critical friend and recognised the strength of the case for

change and ambition to transform services through stronger, community-based care and had the following questions regarding assumptions and risk underpinning the options proposed for consultation.

Is it appropriate to consult on only a single mental health option, and should a more centrally located single-site option have been considered?

KW and LC explained that independent advice had been obtained and the Health Board had been assured that consulting on a single preferred option was appropriate, provided the rationale was clearly set out within the pre-consultation business case. An extensive options appraisal process had been undertaken, including consideration of alternative single-site models such as Llandrindod Wells. However, those alternatives had been discounted because of significant estate and workforce feasibility challenges. Should consultation proceed, stakeholders would have the opportunity to comment on the preferred option and propose alternatives for consideration.

How will travel and transport concerns be mitigated, particularly if mental health inpatient services are concentrated at Bronllys?

LC advised that travel and transport impacts had been examined through the Integrated Impact Assessment process and through detailed travel-time analysis using both private and public transport data. Travel remained a key concern and one that would continue to be tested during consultation. However, access to services was not solely about access to a hospital site, as the proposed model included significant strengthening of community mental health provision and sanctuary services. In addition, the current model already results in many Powys residents travelling considerable distances out of county for care. Whilst some residents may experience increased travel to Bronllys, the proposed model could reduce the need for out-of-county placements and improve access to services within Powys overall.

What assurance can be provided that the workforce and resources required for the future community model can be funded, recruited and retained?

DWL explained that all proposed options had undergone both workforce and financial challenge and review processes before reaching the consultation stage. Workforce requirements had been modelled alongside proposed service configurations, enabling the organisation to understand the numbers, skill mix and service developments that would be required. Implementation would not depend solely on recruiting new staff, but on retaining and developing the existing workforce, expanding advanced and enhanced clinical roles, and continuing to invest in training opportunities. The Health Board's clinical oversight model is a key enabler of future workforce transformation and the Executive team had sufficient assurance that credible workforce solutions existed to support progression to consultation.

What assumptions have been used to model future demand for Urgent Care Centres and Minor Injury Units?

KW and LC explained that extensive modelling work had been undertaken to understand future patient demand, activity flows and service capacity. The modelling considered not only activity volumes but also workforce capacity, specialist skills and the ability of services to provide a wider range of care closer to home. The proposed model would not be implemented as a sudden or

immediate change but would be phased over time as workforce capability and service capacity developed. The intention would be to increase the amount of care delivered within Powys and reduce the need for residents to travel elsewhere for treatment.

How has the potential for residents to continue accessing services outside Powys been reflected in the modelling, and would the proposed centres remain viable if expected demand is not achieved?

LC advised that the modelling had assumed people would generally attend the nearest appropriate service. However, it also reflected the expectation that improving the capability of services within Powys would enable significant quantities of activity that currently take place outside the county to be repatriated. This increased activity would support both the viability of the proposed facilities and the maintenance of specialist clinical skills. Modelling assumptions would need to be tested through consultation and implementation, but the work undertaken indicated the proposed centres would be sustainable if the anticipated activity returns to Powys were achieved.

Have the cumulative impacts on vulnerable groups, people living in poverty, people with disabilities and Welsh-speaking communities been adequately identified and assessed?

LC explained that the Integrated Impact Assessment process had evolved from Level 1 assessments during the development of long-list options into more detailed Level 2 assessments supporting the current proposals. These assessments had been clinically and operationally led, supported by external scrutiny and overseen by dedicated quality and equality panels. The assessments considered both quality and equality impacts, including Welsh language considerations, and that the organisation's Welsh language lead had participated in the equality assessment process. The assessments would remain live documents throughout the consultation period, allowing feedback received during consultation to be incorporated into future decision-making and mitigation planning.

CC noted that an important and comprehensive discussion had taken place and read out the recommendation. CC invited Board Members to indicate if they wished to comment on the recommendations or any part of it, or if they wished to indicate their dissent from supporting the recommendations.

There being no comments, the Board unanimously:

1. **ACCEPTED** the Case for Change.
2. Took **ASSURANCE** that the proposed options for future service models align with national policy and priorities, the Health and Care Strategy for Powys, the Population Health Strategic Framework and the Strategic Commissioning Framework.
3. Took **ASSURANCE** that the proposed options for consultation have been developed through a structured, clinically led and evidence-based process, informed by engagement with patients, the public, staff, clinicians, partners and wider stakeholders.

4. **NOTED** that, subject to the outcome of consultation, further work will be required to develop a Post Consultation Business Case and Implementation Plan.
5. **CONFIRMED** that no decision on a preferred option will be made until the period of public consultation is concluded, and that the Board will give full and conscientious consideration to the consultation feedback, updated impact assessments, further technical analysis and any revised options before determining the way forward.
6. **APPROVED** the Pre-Consultation Business Case and the five recommended options for consultation as the basis for progressing to formal public consultation. Those five options being:

For physical health:

 1. PH005b - Fewer Community Inpatient Beds reduced to 3 sites, with enhanced community model and better join up with mental health
 2. PH008 - Even fewer Community Inpatient beds reduced to 2 sites, with enhanced community model and better join up with mental health

For urgent care and diagnostics:

 3. UC013 - Local Urgent Care Centres at 2 sites and Minor Illness and Injury Unit at 1 site
 4. UC013ii - Local Urgent Care Centres at 2 sites

For mental health:

 5. MH006a - All functional and organic inpatient beds at 1 site with enhanced care and strengthened community model
7. **APPROVED** the updated consultation plan (Appendix Z4) **NOTING** that consultation will begin week commencing 05 October 2026.

CC thanked staff, partners and stakeholders for their continued hard work and dedication in progressing the Better Together transformation programme, recognising the significant effort involved. He emphasised that the Board's decision was not to approve a preferred option for implementation, but to approve a range of potential options for further public consultation. He encouraged widespread participation in the consultation process, inviting people to challenge assumptions, scrutinise the evidence, and contribute alternative ideas. CC reiterated the Board's commitment to working in partnership with communities and assured attendees that the Board would remain focused on securing safe, sustainable healthcare services for the people of Powys.

3. OTHER MATTERS

3.1 ANY OTHER URGENT BUSINESS (PTHB/26/066)

No other business was raised.

3.2 DATE OF NEXT MEETING (PTHB/26/067)

30 September 2026.

Meeting closed at 16:14