24 June, 2025

LLANELLI RURAL COUNCIL

Minute Nos: 65 – 69

At a **SPECIAL COUNCIL** Meeting of the Llanelli Rural Council hosted at the Council Chamber, Vauxhall Buildings, Vauxhall, Llanelli, and via remote attendance on Tuesday, 24 June, 2025, at 6.00 p.m.

Present: Cllr. S. N. Lewis (Chairman)

Cllrs.

S. R. Bowen	R. E. Evans
D. M. Cundy	J. Lovell
M. V. Davies	A. G. Morgan
S. L. Davies	K. Morgan
A. Evans	J. S. Phillips
E. M. Evans	A. Rogers
N. Evans	W. E. Skinner
A. G. Stephens	

Absent: S. M. T. Ford, J. P. Hart, S. K. Nurse and O. Williams

65. APOLOGIES FOR ABSENCE

An apology for absence was received from Cllr. T. M. Donoghue.

66. MEMBERS' DECLARATIONS OF INTEREST

No declarations of interest were made.

67. PUBLIC PARTICIPATION

There was no public participation in the proceedings.

68. 1. ANNUAL REVIEW ON COUNCIL ACTIVITIES
2. STATEMENTS OF ACCOUNTS 2024/25
2.1 ADMINISTRATION AND BURIAL SERVICES
2.2 TRAINING
2.3 CONSOLIDATED

Members considered the annual review on council activities and were then guided through the statements of accounts during which the Finance Manager stated that the accounts had been prepared in accordance with proper accounting practices, and it was

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RESOLVED that the following be received, accepted and approved:
1. Annual review on council activities for the financial year 2024/25.
2. Statements of Accounts for Administration, Burial Services, Training and consolidated for the financial year 2024/25.

It was

FURTHER RESOLVED that the earmarked reserves as at 31 March, 2025, be noted as follows:-

	Balance at 01/04/2024 £	Contribution to reserve £	Contribution from reserve £	Balance at 31/3/2025 £
Llanelli Joint Burial Advisory Committee (Llanelli Rural Council share)				
General Fund	136,339	254,562	(255,363)	135,538
Redevelopment	117,772	4,831	(2,965)	119,638
Infrastructure	15,130			15,130
Monument Repairs	1,854			1,854
Training/Consultancy	20,215		(9,190)	11,025
Share due to LTC	(145,655)	133,759	(129,696)	(141,592)
	145,655	393,152	(397,214)	141,593
Other Earmarked Reserves				
Swiss Valley Hall Funds	0	57,083	(3,362)	53,721
Community Halls	0			0
Committed Grants	5,776		(3,976)	1,800
Capital Schemes	1,950		(1,950)	0
Dafen Pitch R & R	9,932	6,005		15,937
Parks & Play Areas	204,550	50,455	(202,830)	52,175
Vauxhall Buildings	15,680	800	(9,780)	6,700
Resources	0			0
Global	109,309	1,647	(97,758)	13,198
Council Earmarked Reserves	347,197	115,990	(319,656)	143,531
Training Department Earmarked Reserves	18,050		(1,850)	16,200
	365,247	115,990	(321,506)	159,731
TOTAL EARMARKED RESERVES (Consolidated)	510,902	509,142	(718,720)	301,324

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69. HYWEL DDA UNIVERSITY HEALTH BOARD CLINICAL SERVICES PLAN – CONSULTATION

Members considered Hywel Dda University Health Boards's (HDUHB) consultation documentation regarding its clinical services plan which was about nine key health services delivered in its hospitals and how future changes in the services might impact upon how they were organised at the HDUHB's four main hospitals and in some of its community facilities.

The service areas subject to change were:

- Critical care.
- Dermatology.
- Emergency general surgery.
- Endoscopy.
- Ophthalmology.
- Orthopaedics.
- Radiology.
- Stoke; and
- Urology.

The Clerk then proceeded to guide members through the consultation bundle, highlighting the reasons presented by the HDUHB for carrying out the consultation review. The HDUHB stated some of its hospitals were fragile, mainly because clinical staff and teams were spread across lots of sites, and sometimes they relied on individual staff. Furthermore, the impacts of the Covid-19 pandemic continued to affect service delivery with it leaving the HDUHB with long waiting lists, gaps in staffing made worse by shortages nationally for some healthcare staff, social care pressures and more demand for health services. Some services had not been able to return to pre-pandemic activity levels. This meant patients were waiting longer than the HDUHB would like for some treatment and care. Given the challenges, the HDUHB had developed a clinical services plan, setting out options to change the above services, which conceivably could take up to four years to change from when decisions were agreed about them along with what further change could be made beyond this time frame.

The HDUHB asserted there were several reasons why the nine services needed change and support:

- There were fragilities in delivering critical care and emergency general surgery services.
- The need to improve access and reduce patient waiting times in planned care (dermatology, ophthalmology, orthopaedics, and urology) and diagnostics (endoscopy and radiology).
- The need to improve standards and respond to service fragility in stroke services.

Members were informed that changes made to the nine clinical service areas after the results of consultation, would impact upon how the services would be organised and delivered at the HDUHB's four main hospitals depending on which option was selected from the mix of options set out for each service area. In total there were 26 service options spread across the nine service areas. Therefore, the future roles of the main hospitals could be re-purposed as follows:

- Bronglais Hospital – providing services as it currently did, though some specialities might be provided from different Hywel Dda sites.
- Glangwili Hospital – providing more acute and emergency care, with some planned care moved to other sites, either by service or health condition.
- Prince Philip Hospital – providing more planned care, particularly across a wider region where services were delivered in partnership with Swansea Bay University Health Board.
- Withybush Hospital – providing more planned care, particularly within the Hywel Dda area, with initial access to acute care remaining on site, but transfers to Glangwili Hospital for patients with the highest needs.

In all the options, there were no changes to how people accessed emergency care at any of the sites.

Members then generally discussed the options set out for Prince Philip Hospital (PPH) choosing to focus on some of the headline points presented under the options for each service area, the Stroke service being a case in point. To varying degrees all the options would have a knock-on effect on the general operation of the other three main hospital sites. Members questioned the feasibility of effectively delivering proposals and then having the necessary resources and infrastructure in place at PPH to accommodate the possible changes and enhancements for planned care activities particularly physical space requirements, especially if the decision was taken to provide PPH with a stroke unit, with specialist cover 24 hours a day.

In response to points raised about the provision of critical care and the potential impact on PPH's intensive care service, Minor Injury Unit (MIU) and Acute Medical Assessment Unit (AMAU) services; the Clerk commented that the services within the clinical services plan did not impact Prince Philip Hospital's Minor Injuries Unit consultation which was currently running in parallel to the clinical services plan consultation. To this end the Clerk read out an email communication from Hywel Dda's Head of Engagement confirming this. However, the issue of whether the changes outlined for critical care, specifically options to repackage PPH's intensive care unit by possibly reconfiguring it as an enhanced care unit might detrimentally impact the hospital's Acute Medical Assessment Unit (AMAU) was less clear. This was a concern and something to raise with the HDUHB because the consultation document made no reference to this under the option appraisal and it was important to establish whether there was any negative correlation impacting upon the AMAU, if ultimately patients at PPH needing critical care would be transferred to Glangwili Hospital intensive care unit under the enhanced care unit option.

Members opined the options set out in the consultation were tantamount to a postcode lottery. It was human nature to expect and want key services to be retained and enhanced as close to home as possible, keeping services local and accessible. The way the option permutations were presented regrettably either advantaged or disadvantaged certain cohorts of patients living within the hospital catchment areas covered by Prince Philip or Withybush Hospitals, including some community hospital care facilities. There would be winners and losers and it was unfair to expect communities to battle against one another to fight to retain and safeguard services for fear of them being lost to other hospital sites much further away. This was far from ideal and undermined the principles of equality and fairness in how patients might access services in the future. Linked to this was the issue of transport including meeting the needs of the disabled, members asserted the clinical services plan would be heavily reliant on

significant improvements being made to regional transport arrangements as patients would be required to attend hospital appointments further away from home. The issue of putting in place more effective and affordable patient transport measures for those that did not have access to a private vehicle was a longstanding contentious issue given the geographic size and rurality of the HDUHB area.

Thereupon, the Clerk drew members' attention to the frequently asked questions document contained in the consultation bundle and which highlighted whether the HDUHB had considered the travel and transport impacts associated with the options. The Clerk read out the HDUHB's official stance which acknowledged that some of the options in the consultation might have an impact on patient or visitor travel, whereby:

- Some patients and their visitors might be negatively impacted by travel times and travel expenses as they might need to travel further to receive their care.
- Some patients would be transported to a different site by the Health Board, however for return journeys home, or for visitors, there might be longer journeys and additional cost either by car or public transport.
- Some staff may be required to travel further to work at alternative sites bringing with it potential additional travel costs and childcare needs.
- Given services might be focused on fewer sites, waiting areas at those sites might get busier, which some people might find unsettling.

To mitigate this the HDUHB contended that it continued to consider the balance between the positive impact change could bring, as well as the negative. For example, services provided across fewer sites would bring different professionals together to work, which was a better use of resources and would improve service quality and continuity of care for patients. Furthermore, bringing services together would also allow for multiple appointments to take place on the same day at the same location, which would reduce the number of visits for patients. Moreover, the HDUHB would continue to consider ways to reduce risks or negative impacts on people. These were ideas currently and were not guaranteed. However, there was a desire to explore these further by seeking the publics' views, in the consultation questionnaire. For example, the HDUHB could explore:

- Improved transport links between hospital sites, exploring public/private partnerships, shuttle buses between sites etc.
- Partnering with local transport companies to offer discount or travel vouchers for set journeys or time periods, as well as review supported travel / taxi costs.
- Non-emergency Patient Transport services were already available for those that met the eligibility criteria.
- Community and voluntary transport services were available for patients that did not meet the eligibility criteria to enable them to receive non-emergency patient transport.

As debate continued, it was observed that most of the options were dependent on securing staff support and increasing staffing resources in most service areas. The concern was should the HDUHB continue to encounter recruitment difficulties with it failing to recruit additional staff that this would undermine the general delivery of the clinical services plan. What would happen to services then?

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In drawing an end to discussion members commented upon the timing of this important consultation exercise. They remarked it was unhelpful to stage this fresh consultation at the same time as the Minor Injuries Unit consultation at PPH. That consultation exercise was still ongoing and there was a danger that the two separate exercises would be conflated, with members of the public not realising they were distinct from one another and so they might not engage in this significant wider debate about the reconfiguration of clinical services. Not only this but there was a general feeling there was an element of consultation fatigue currently, so the public might be less inclined to positively engage with the HDUHB. Adding to this was the volume of information set out in the consultation bundle. There was a lot of information to digest, and most people would find this off-putting and difficult to follow given the potential options affecting all four hospital sites. There were still lots of questions to answer before the public could make an informed choice and most people including local stakeholders lacked the clinical knowledge and experience to effectively scrutinise what was being presented. Therefore, it was unrealistic to expect the public to suggest new options or different ideas when having to strictly adhere to the HDUHB's hurdle criteria, which required new options and ideas to be:

- Clinically sustainable – did the option allow for progress towards delivering quality standards, did it consider any co-dependencies, would the workforce be able to deliver it?
- Deliverable – was the option clinically and operationally deliverable with the timeframe of two to four years and were there capital or building requirements that could be secured and delivered in the timeframe?
- Accessible – did the option provide access for people within an appropriate timeframe, did the option support a reduction in waiting times for patients, was there equity in access?
- Strategically aligned – did the option support the direction set out in the "A Healthier Mid and West Wales" strategy, or at least not contradict it, and did the option support joint work on prevention to improve population health, or at least not contradict it?
- Financially sustainable - did the option support effective use of HDUHB finances?

Given the extent of the above criteria, some members felt the HDUHB had already decided upon a preferred direction of travel, and it would have been helpful if this had been highlighted publicly in the documentation. Furthermore, without members of the public having access to the same datasets as the HDUHB and to then subsequently find the time to study and research this data while comparing it against the current set of options during the consultation timeframe which concluded on 31 August 2025; it was nigh-on impossible to come up with alternative proposals. Therefore, the suggestion of entertaining further options in place of the current range of options was fanciful, and it was

RESOLVED that the Clerk composes a letter to the Health Board setting out member's views and observations addressing the timing and substance of the consultation process also highlighting the key issues identified during the meeting discussion, associated with the realisation or otherwise of the various delivery options outlined for the nine service areas.

Cllrs A. Evans and E. M. Evans both left the meeting during the debate.

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The Meeting concluded at 7.00 p.m.

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The afore-mentioned Minutes were declared to be a true record of the proceedings and signed by the Chairman presiding thereat and were, on 8 July, 2025 adopted by the Council.