



**CYFARFOD BWRDD PRIFYSGOL IECHYD  
STRATEGIC DEVELOPMENT AND OPERATIONAL DELIVERY COMMITTEE**

<b>DYDDIAD Y CYFARFOD: DATE OF MEETING:</b>	31 October 2024
<b>TEITL YR ADRODDIAD: TITLE OF REPORT:</b>	Targeted Intervention update including update on the 2024/25 Planning Objectives
<b>CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:</b>	Lee Davies, Director of Strategic Development and Operational Planning
<b>SWYDDOG ADRODD: REPORTING OFFICER:</b>	Shaun Ayres, Deputy Director of Operational Planning and Commissioning / Programme Director for Targeted Intervention  Daniel Warm, Head of Planning

**Pwrpas yr Adroddiad (dewiswch fel yn addas)**

**Purpose of the Report (select as appropriate)**

Er Sicrwydd/For Assurance

**ADRODDIAD SCAA  
SBAR REPORT**

**Sefyllfa / Situation**

The Annual Plan for 2024/25 has been built around two key elements, our 10 Planning Objectives (which in themselves are aligned to Ministerial and Local Priorities) and the de-escalation of our Targeted Intervention (TI) status (across six critical domains: Finance, Strategy and Planning; Performance and Outcomes; Fragile Services; Governance; Leadership, Capability and Culture; and Quality of Care).

A revised set of 10 Planning Objectives (PO) has now been incorporated into Hywel Dda University Health Board's (HDdUHB) plan for 2024/25. The POs set out the aims of the organisation, ie the horizon that HDdUHB is driving towards over the long term, as well as a set of specific, measurable actions, which move the organisation towards that horizon over the next year.

For 2024/25, seven Planning Objectives are aligned to the Strategic Development and Operational Delivery Committee (SDODC), namely:

- PO3: Transforming urgent and emergency care
- PO4: Planned care, diagnostics and cancer
- PO5: Mental health and Child and Adolescent Mental Health Services (CAMHS)
- PO6: Clinical services plan (CSP)
- PO7: Primary and community strategic plan
- PO8: Estates plans
- PO10: Population health

As in previous years it is the expectation that SDODC will receive an update on the progress made in the development (delivery) of the Planning Objectives for onward assurance to the Board through the Board Assurance Framework (BAF).

The Health Board has made substantial progress towards in year financial delivery, moving closer to achieving the planned deficit of £64m for this year. This reflects a significant effort to

improve cost control and financial discipline, particularly in the areas of reducing agency spend and managing variable pay more effectively. The progress observed in reducing reliance on agency staff and optimising internal workforce utilisation is an important milestone, contributing positively to the overall financial position and enhancing workforce stability.

Further, a reduction in in-month expenditure was noted in Month (M) 5, alongside improvements in the end-of-year forecast. To date, assured savings of £29.1m have been achieved (improved in M6), with further savings identified to close the gap to the £64m deficit target (currently £200k short based on the M6 forecast). This progress demonstrates a strong commitment to achieving the Annual Plan deficit, with continued confidence that this target will be met. Furthermore, the international recruitment plans have also contributed to reducing agency nursing costs, providing a more sustainable approach to workforce management.

In addition to financial progress, several operational improvements have been realised, such as improved ambulance handover times at Withybush General Hospital (WGH), a reduction in hospital bed reliance, and early signs of cultural change through the new governance and escalation arrangements. These initiatives are starting to bear fruit, positioning the Health Board well for future progress.

While there remain a number of key areas that require focused action, particularly in cancer performance, urgent and emergency care, and healthcare-acquired infections, the current trajectory is a promising first step towards achieving de-escalation. The Welsh Government's feedback underlines both the positive steps taken and the areas where continued attention is required (set out in the assessment section). This assessment identifies the specific areas requiring targeted intervention over the next three months to align with escalation criteria and achieve the objectives set out in the Welsh Government's response letter dated 3 October 2024 (Appendix 1).

## **Cefndir / Background**

The Planning Objectives are the bedrock of our Annual Plan for 2024/25 and their delivery fundamental to meeting the de-escalation criteria. This element of the report (Appendix 2) is presented as an update to demonstrate where progress has been made in delivering the Planning Objectives aligned to the SDODC.

### ***Revised Action Plan Embedded Across Organisation***

- The original action plan, introduced when the Health Board was placed into Targeted Intervention (TI) for finance and planning, was overhauled in April 2024. The new governance framework ensures that TI is woven into every aspect of the organisation's operations, not treated as a separate process.

### ***56 de-escalation Criteria as the Core Accountability Mechanism***

- These criteria, monitored weekly, serve as the backbone of the Health Board's action plan, covering six critical domains: finance, planning, fragile services, governance, leadership capability and culture, and quality of care.
- The de-escalation criteria are integrated into daily operations, creating a continuous feedback loop between performance, governance, and planning processes.

### ***Streamlined Governance Structure Ensures Organisational Alignment***

- Three core reporting groups—Value and Sustainability, Integrated Quality, Finance and Performance Delivery, and A Healthier Mid and West Wales - align the Health Board’s strategic and planning objectives with operational actions.
- This governance structure supports real-time accountability, ensuring that any action not on track is swiftly escalated and addressed.

### ***Directorate Improving Together Framework***

- Mirroring the TI domains, this framework (Appendix 3) cascades responsibility down to individual directorates and operational teams. Each team is directly accountable for delivering on the objectives tied to TI and planning, ensuring alignment across all levels of the organisation.

## **Asesiad / Assessment**

### **Planning Objectives**

The overarching status of the seven POs aligned to SDODC are as per the table below:

Planning Objective	Executive Lead	Current Status
PO3: Transforming urgent and emergency care	Chief Operating Officer	On-track
PO4: Planned care, diagnostics and cancer	Chief Operating Officer	Behind
PO5: Mental health and CAMHS	Chief Operating Officer	On-track
PO6: Clinical services plan	Director of Strategic Development and Operational Planning	On-track
PO7: Primary and community strategic plan	Director of Primary Care, Community and Long-Term Care	On-track
PO8: Estates plan	Director of Strategic Development and Operational Planning	Behind
PO10: Population health	Director of Public Health	On-track

All POs have separate reports on this Committee agenda, with the exception of PO6; PO8; and PO10, and these have highlight reports included in Appendix 1.

### **Targeted Intervention**

The Health Board has made notable progress in several key areas, particularly with improvements in governance, workforce utilisation, financial savings, and healthcare quality. However, significant challenges remain that require clear and strategic next steps to ensure sustainable progress. The Targeted Intervention (TI) framework includes a comprehensive set of escalation criteria including key indicators (56) and 14 specific alerts that are essential to support the Health Board in achieving de-escalation.

However, whilst these alerts continue to be important and form the foundation of our strategic objectives to achieve de-escalation, in order to deliver the necessary changes and maintain a clear focus over the next three months, it is essential to prioritise the eight specific areas requiring immediate attention set out below. These areas act as milestones or anchor points towards achieving the broader, more strategic TI objectives set out in the escalation framework.

Therefore, this isn't a change in direction, but rather a three-month focused approach based on the priorities raised during the Welsh Government escalation meeting which are essential building blocks to the 56 de-escalation criteria set out in the TI Framework.

It should be noted that it is anticipated that Staff Morale and Leadership Development (Point 5) and Fragile Services (Point 8) already have clear plans and actions in place. Therefore, the focus here is primarily on providing the evidence to demonstrate progress rather than addressing significant concerns. For Fragile Services, it is expected that we will be able to clearly demonstrate that Quality Impact Assessments (QIAs) are already in place and the emphasis will be on continuing to review our approach to QIAs to ensure robustness. Similarly, for Staff Morale and Leadership Development, the necessary evidence exists to demonstrate progress, making this more about presenting that evidence and ongoing monitoring rather than significant corrective action. Both areas are well-positioned for closure, subject to effective documentation; however, they have been included for completeness.

## **Key Areas for Immediate Action and Next Steps**

### **1. Financial Sustainability and Control**

- Next Steps: Develop and present a clear financial roadmap to achieve the control target of £44.8m by March 2026. This includes finalising a timeline by November 2024 to ensure Board scrutiny and Welsh Government oversight in January 2025. Strengthen financial governance by embedding the newly introduced measures for tighter control over variable spend, including prioritising internal staffing over agency usage and reinforcing strict authorisation protocols from 1 November 2024.

### **2. Urgent and Emergency Care**

- Next Steps: Replicate the learning and successes from Withybush Hospital and Glangwili Hospital to improve ambulance handovers and reduce waiting times. Develop and implement a detailed operational plan to address delays in emergency care pathways, particularly for patients waiting over 12 hours. Monthly reporting will be necessary to track progress, allowing for ongoing adjustments based on data insights.

### **3. Cancer Performance Improvement**

- Next Steps: Review and revise as necessary the action plan to meet cancer performance targets, with a bi-weekly review to ensure interventions are effective. Continuous collaboration with Welsh Government will be required, providing transparent updates through the Integrated Quality and Performance Delivery (IQPD) reports. A focus on targeted interventions and adapting operational demands swiftly will be critical.

### **4. Healthcare-Acquired Infections (HCAI) Management**

- Next Steps: Strengthen infection control measures, specifically focusing on reducing Clostridium difficile (C. Diff/ CDI) infections. Establish the CDI Improvement group, led by the Director of [Nursing, Quality & Patient Experience](#) and ensure that monthly monitoring and bi-monthly progress updates to the Quality, Safety, and Experience Committee (QSEC) are maintained. This will be complemented by a review of infection prevention and control (IPC) priorities.

### **5. Staff Morale and Leadership Development**

- Next Steps: Implement the Leadership Development programme, focusing on actioning the insights from staff survey results. Monitor staff morale improvements and ensure quarterly updates on survey outcomes are used to adjust the Leadership strategy where necessary. Workshops aimed at enhancing leadership skills will be rolled out, with a specific emphasis on ensuring leaders are well-equipped to address emerging challenges in a supportive and proactive manner.

## **6. Addressing Complaints and Service User Feedback**

- Next Steps: Focus on improving complaint closure rates by implementing targeted workshops aimed at key stakeholders, with a target to meet 70% closure within 30 working days. A structured plan for better complaints handling will ensure that concerns are addressed efficiently, reducing the current high rate of complaints per thousand population. This will involve consistent monitoring and bi-monthly progress reviews to gauge improvements.

## **7. Strategic Planning and Integration**

- Next Steps: Ensure alignment of the Clinical Services Plan (CSP) with the overall organisational strategy for A Healthier Mid and West Wales. Phase 2 of the CSP will be submitted to the Board on 28 November 2024, with stakeholder engagement commencing immediately thereafter.

## **8. Fragile Services, Critical Care, and Service Configuration**

- Next Steps: Conduct Quality Impact Assessments and Equality Impact Assessments (EQIAs) to ensure all service configuration decisions are robust and sustainable. Monitor fragile services, including critical care and emergency general surgery, with clear action plans developed and reported to the appropriate committees. The emphasis will be on maintaining service continuity and safety while addressing any critical issues identified during monthly Directorate Escalation Meetings.

## **9. Revised Alerts System and Key Priorities**

- Next Steps: Maintain focus on the six revised core alerts to ensure actionable and timely interventions. This includes setting clear milestones, designating ownership for each alert, and conducting regular reviews to track progress. Key areas such as emergency care, fragile services, and healthcare-associated infections will be continuously assessed, with regular feedback provided to Welsh Government to demonstrate progress towards de-escalation.

## **Conclusion and Immediate Actions**

The path forward demands sustained attention to financial sustainability, improved healthcare outcomes, and strengthened staff morale. Immediate actions include developing a clear financial roadmap, replicating successful interventions in urgent care, and the on-going fostering to continuously improve leadership engagement. Ensuring that these next steps are executed with rigour will be essential for addressing the Welsh Government's expectations and progressing towards de-escalation in the Targeted Intervention framework. Continued focus, with frequent reviews and transparent updates, will help drive meaningful progress and instil confidence both within the Health Board and externally.

## **Specific Oversight for SDODC Committee**

Specifically, for SDODC, the areas that require focused oversight are: Urgent and Emergency Care (Point 2), Cancer Performance Improvement (Point 3), Strategic Planning and Integration (Point 7), and in conjunction with QSEC Fragile Services (Point 8).

**Argymhelliad / Recommendation**

The Strategic Development and Operational Delivery Committee is asked to:

- **RECEIVE ASSURANCE** on the current position in regard to the progress of the Planning aligned to the Strategic Development and Operational Planning Committee, in order to assure the Board that the Planning Objectives are progressing and are on target, and to raise any concerns where a Planning Objective is identified as behind in its status and/or not achieving against its key deliverables.
- **ENDORSE** the revised actions based on Welsh Government feedback from the TI meeting.
- **ACCEPT** the specific oversight responsibilities for the areas set out in the assessment.

**Amcanion: (rhaid cwblhau)**

**Objectives: (must be completed)**

Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	<p>2.1 Receive assurance on delivery against the areas of targeted intervention, and the required elements for de-escalation, related to strategy and planning, performance and outcomes, and fragile services (see Appendix 1 for additional detail):</p> <p style="padding-left: 40px;">Planning</p> <p>i. Delivery of improved integrated planning</p> <p>ii. Submission and delivery of an approvable plan</p> <p>iii. Clinical strategy</p> <p>iv. Regional planning</p> <p>Performance and outcomes</p> <p>i. Establish a baseline and agree improvement plans</p> <p>ii. Implement improvement plans</p> <p>iii. Work with national programmes and respond to external reviews such as Getting it Right First Time (GIRFT)</p> <p>iv. Communications and engagement</p> <p>Fragile services (stage 1)</p> <p>i. Stroke</p> <p>ii. Primary care</p> <p>iii. Critical care</p> <p>iv. Emergency general surgery</p> <p>v. Ophthalmology</p>
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Not applicable
Parthau Ansawdd:	7. All apply

Domains of Quality <a href="#">Quality and Engagement Act (sharepoint.com)</a>	
Galluogwyr Ansawdd: Enablers of Quality: <a href="#">Quality and Engagement Act (sharepoint.com)</a>	6. All Apply
Amcanion Strategol y BIP: UHB Strategic Objectives:	3. Striving to deliver and develop excellent services 4. The best health and wellbeing for our individuals, families and communities 5. Safe sustainable, accessible and kind care
Amcanion Cynllunio Planning Objectives	3 Transforming Urgent and Emergency Care programme 6 Clinical services plan 8 Estates plans 10 Population health
Amcanion Llesiant BIP: UHB Well-being Objectives: <a href="#">Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022</a>	9. All HDdUHB Well-being Objectives apply

<b>Gwybodaeth Ychwanegol: Further Information:</b>	
Ar sail tystiolaeth: Evidence Base:	3 Year Plan and Annual Plan Decisions made by the Board since 2017-18 Recent <i>Discover</i> report, published in July 2020 Gold Command requirements for COVID-19 Input from the Executive Team Report presented to Public Board in September 2020
Rhestr Termiau: Glossary of Terms:	Explanation of terms is included within the report
Partion / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	Public Board - March 2024 (acceptance of 2024/25 Planning Objectives as part of the 2024/25 Annual Plan)

<b>Effaith: (rhaid cwblhau) Impact: (must be completed)</b>	
<b>Ariannol / Gwerth am Arian: Financial / Service:</b>	Any financial impacts and considerations are identified in the report
<b>Ansawdd / Gofal Claf: Quality / Patient Care:</b>	Any issues are identified in the report
<b>Gweithlu: Workforce:</b>	Any issues are identified in the report
<b>Risg: Risk:</b>	Consideration and focus on risk is inherent within the report. A sound system of internal control helps to ensure any risks are identified, assessed and managed.
<b>Cyfreithiol: Legal:</b>	Any issues are identified in the report

<b>Enw Da: Reputational:</b>	Any issues are identified in the report
<b>Gyfrinachedd: Privacy:</b>	Not applicable
<b>Cydraddoldeb: Equality:</b>	Not applicable



**Cyfarwyddwr Cyffredinol Grŵp Iechyd, Gofal Cymdeithasol a'r  
Blynyddoedd Cynnar / Prif Weithredwr GIG Cymru**

**Director General Health, Social Care & Early Years Group / NHS  
Wales Chief Executive**



**Llywodraeth Cymru  
Welsh Government**

Dr Philip Kloer  
Interim Chief Executive  
Hywel Dda University Health Board  
Corporate Offices  
Ystwyth Building  
Hafan Derwen,  
St Davids Park  
Jobswell Road  
Carmarthen  
SA31 3BB

Our Ref: JP/GE/SB

3 October 2024

Dear Phil

### **Targeted Intervention meeting**

This is the second targeted intervention meeting since the health board was escalated earlier this year. Thank you for the slide pack that forms an important part of the record. Apologies were noted from Sue Tranka, Jeremy Griffith and Hywel Jones.

#### Update on targeted intervention oversight and governance

You explained the new governance and working arrangements that have been established for the executive team including your internal performance and escalation framework. The new way of working was bedding in and starting to bear fruit from a cultural perspective. A reduction on reliance on agency staff, and the reliance on hospital beds was noted.

#### Finance

You confirmed that you are committed to achieving the control target of £44.8 million by March 2026. Your assurances to reach or better on the deficit of £64 million this year was covered in your annual plan. You are confident this will be achieved.

You advised month five had seen some improvement, with a reduction in in-month expenditure and improvements to the end of year forecast position. To date, you have assured savings of £28million with a further £4million required to achieve the £64million

planned deficit. You were increasingly confident around the delivery of this year's annual plan but highlighted the challenges on securing those savings on a recurrent basis. I would like to receive the timeline in place to achieve the target control timeline.

You highlighted the improvement made on agency nursing spend through the international recruitment plans.

You mentioned a number of potential service changes around critical care bed optimisation, optimisation of day surgery unit at Withybush Hospital, closure of surge capacity beds, MIU opening hours at Prince Philip Hospital and the paediatric service at Bronglais Hospital that are being discussed. These are likely to be highly controversial. I would urge you to keep me updated on any developments, to ensure that service standards and patient care will not be compromised, and that the necessary quality impact assessments are undertaken before any decision is made.

### Planning

You have developed detailed action plans following the independent planning reviews carried out last year. The revised governance framework ensures that targeted intervention is embedded into every aspect of the organisation's operations. The de-escalation criteria are monitored weekly and reported through to the appropriate committees.

Phase two of the clinical services has been concluded, and a paper would be submitted to the public board in November 2024. This will progress to engagement and consultation on some of the clinical changes. I welcome wider discussions between yourselves and Welsh Government colleagues around the strategic direction and other consultation requirements.

### Quality and Safety

Some progress has been made in some aspects of the healthcare acquired infections though not in all areas and your intention is to achieve the set trajectories. The developments and improvements made around the quality management system was noted along with the QIA process due to the scale of the potential service changes.

C Diff continues to be challenging for the health board and I note the progress with your improvement plan, including the establishment of a CDI improvement group to focus on higher-level management strategies with the Medical Director taking the lead on antimicrobial stewardship.

On complaints, the health board has the most complaints per thousand population in Wales. You have arranged some workshops during the autumn where colleagues from the Welsh Risk Pool, Ombudsman and medical examiners would be attending to discuss how to improve your complaints handling within the organisation and achieve the 70% target of closing complaints within 30-working days by quarter four. Welsh Government colleagues would forward the complaints data to the health board as part of the performance pack shared with all organisations.

The health board agreed to share a copy of their national reported incidents with Welsh Government colleagues outlining the closure rate and times to closure.

## Performance and Outcomes

I note the progress being made against the 104-week RTT, diagnostics and mental health targets. Cancer performance however needs to improve. Unfortunately, urgent and emergency care continues to be one of your biggest challenges and an even bigger risk going into the winter period. The improvements seen in ambulance handover performance at the end of August at Wthybush General hospital is a positive step forward. This must be maintained and learning applied to Glangwili General hospital.

Discussions with Swansea Bay health board colleagues were ongoing for a regional solution for cataracts and the Regional Orthopaedics Programme Board meeting had recently met to develop an agreement on a regional solution.

## Fragile Services

A discussion was held on emergency general services surrounding the clinical services plan, critical care issues and the temporary model in place at Prince Philip General hospital, and the single handed and managed GP practices.

## Governance and Leadership

You highlighted a series of workshops had been held for each of the committees to support continuous learning and effective leadership. The newly appointed Chair is focused on developing leadership skills. I note the health board is actively trying to recruit to the Chief Executive as well as other senior posts.

We discussed your staff survey findings which were concerning as they highlighted poor levels of morale amongst staff. A workshop with your trade union to discuss the findings and develop an action plan has happened.

In relation to your WRES action plan, 55 of the overseas nurses who qualified in the UK have been promoted during the last two years, echoing concerns that this is lower than expected and you will continue to develop this area.

## Summary

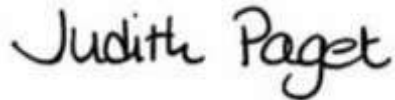
My overall reflection is one of some progress being made. This had been a helpful discussion around the processes and systems in place to support targeted intervention within the health board. I do expect to see performance improved for cancer, planned care, urgent and emergency care and healthcare acquired infections.

Your financial position is not supportable, and the health board will need to reduce its forecast deficit both in-year and on a recurrent basis. I expect you to have a clear route map to financial balance which reverses the deteriorating trajectory of the financial position. We agreed the following actions:

- Health board to forward a copy of the timeline towards achieving the target control timeline.
- Welsh Government colleagues to forward the complaints data as part of the performance pack shared with all organisations to the health board.
- The health board to share a copy of their national reported incidents with Welsh Government colleagues outlining the closure rate and time to closure.

Please thank your team for the discussion and information provided. I look forward to seeing progress at the next meeting.

Yours sincerely



**Judith Paget CBE**

**Attendance**

<b>List of attendees and noted apologies</b>	
<b>Health Board</b>	<b>Welsh Government</b>
Dr Philip Kloer	Judith Paget - Chair
Andrew Carruthers	Pushpinder Mangat
Joanne Wilson	Helen Arthur
James Severs	Olivia Shorrocks
Huw Thomas	Samia Edmonds
Lee Davies	Richard Desir
Lisa Gostling	Gaynor Evans - Secretariat
Sharon Daniel	
Helen Mitchell	Claire Green – NHS Executive
Jill Paterson	
Alwena Hughes	
Ardiana Gjini	
<b>Apologies</b>	
	Hywel Jones
	Jeremy Griffith
	Sue Tranka

Planning Objective: 6 – Clinical Services Plan

Executive Lead: Lee Davies/ Mark Henwood

Reporting Period: 22 June 2024 – 31 October 2024

Overall status: On-track

Rationale for overall status: Four shortlisted options have been developed and appraised. Activity is now focused on closing report for Board on 28 November 2024.

**Progress against planned outcomes / trajectories / milestones:**

Since the last update in June 2024, the Clinical Services Plan has taken the four shortlisted options and worked up the detail to allow them to meet a series of evaluation criteria which they could be appraised against.

Alongside Quality Impact Assessments and Equality Impact Screening, work has been undertaken by workforce and finance to understand what the change would be from current service delivery to assess the change in workforce and finance to deliver the options. Where capital changes are required these have also been captured, along with any additional equipment costs, for inclusion into the costing envelope.

The outcome of this work will be a report to Board on the options, their appraisal and feedback which the Options Development Group felt was important when making decisions on next steps.

**Activities completed in previous reporting period**

- Refinement of options to meet the evaluation criteria
- Development of a Strengths, Weaknesses, Opportunities and Threats assessment against the criteria
- Development of Equality Impact Assessments, Quality Impact Assessments and Health Impact Assessments for each service configuration in the options
- Development of simplified options wording for presentation
- Weighting of the evaluation criteria and scoring of options

**Activities planned for next milestone and reporting period**

- Presentation of Phase 2 Closing Report to Board on 28 November 2024
- Procurement activity for consultation/ engagement support should Board wish to progress to Phase 3 of the Clinical Services Plan.

**Any other Comments**

**Matters for information:** Included as part of this update are the output reports for 5 and 6 September 2024. These form the final output reports for each stage of Phase 3 and will be referenced in the closing report.

**Any other comments:** Work to support Phase 3 has not yet been planned as it will be dependent on the outcome of the Board decision in November. Should there be a decision to engage or consult on options, a project plan will be developed detailing the timescales and resources to deliver this activity.

**Planning Objective: PO8 Estates Plan**

**Executive Lead: Lee Davies**

**Reporting Period: Quarter 2 – July, August, September 2024**

**Overall status: Complete / Ahead / On-track / **Behind****

**Rationale for overall status (please provide a brief summary of current progress indicating any key highlights or potential barriers to delivery).** Whilst the Health Board has delivered against some of the outcomes contained in Planning Objective (PO) 8 we remain behind on the timeline for the completion and submission of a Board approved A Healthier Mid and West Wales (AHMWW) Strategic Outline Case (SOC). Discussions with Welsh Government (WG) to clarify the next steps for the SOC development have commenced and further discussions will be required to reach agreement on next steps.

**Progress against planned outcomes / trajectories / milestones (please provide SPC/data charts and an explanation of any variances):**

- |   |  |
|---|--|
| <ol style="list-style-type: none"> <li>1. Response to the Nuffield Trust Review to be presented to Infrastructure Investment Board (IIB)</li> <li>2. Secure Ministerial endorsement to AHMWW Programme Business Case (PBC)</li> <li>3. Completion and submission of Board approved SOC</li> <li>4. Review and refresh 10 year Regional Capital Plan</li> <li>5. Submission of Full Business Case (FBC) Cross Hands</li> <li>6. Submission of FBC for Pentre Awel</li> </ol> | <ol style="list-style-type: none"> <li>7. Submission of Business Justification Case (BJC) for Carmarthen Hwb</li> <li>8. Appointment of Supply Chain Partner Fishguard SOC/ Outline Business Case (OBC)</li> <li>9. Implementation of Property Asset Strategic Plan as a consequence of the limited response to the market testing exercise to inform the scheme target price</li> <li>10. Scoping agreed for Aberystwyth Integrated Care Centre (ICC)</li> <li>11. BJC's for major infrastructure</li> <li>12. Continued implementation of Hywel Dda University Health Board (HDdUHB) Decarbonisation Plan</li> </ol> |
|---|--|

**Activities completed in previous reporting period**

1. Action plan of the recommendations contained in the Nuffield Trust review to be developed for Strategic Development and Operational Delivery Committee (SDODC)
2. Board approval of Carmarthen Hwb Lease
3. Completion of Pentre Awel FBC for Integrated Regional Capital Fund (IRCF) funding
4. Review of Cross Hands schedule of accommodation following WG discussion on initial capital costs
5. Meeting held HDdUHB and WG 12 September 2024 to discuss the SOC, implications of timeline scenarios and how to reach agreement on the way forward

**Activities planned for next milestone and reporting period**

1. Finalisation of Picton Terrace capital funding and approval of lease
2. Review of Cross Hands timeline and capital costs for refreshed FBC
3. Follow up on 12 September 2024 discussion with WG and agree next steps for the PBC/SOC
4. Internal review of options for Fishguard Health and Wellbeing Centre
5. Participate in the refresh of the 10 year Regional Capital Plan
6. Development of bids for Decarbonisation scheme through WG Invest to Save funding route
7. Approval of Pentre Awel lease and finalisation of the Pentre Awel capital funding

**Any other Comments**

**Matters for information:** All other matters reported via SDODC SBAR updates

**Risks to delivery: The programme is in delay.** There is a risk that the programme might be further delayed or stopped. This is because of the risk of insufficient capital ( or potentially revenue for innovative finance solutions) to support the development and implementation of the programme infrastructure requirements. The impact would be the highly significant risk to current service provision, location of services, equity of access and the need for unplanned service changes in response to potentially unsustainable service scenarios. There will also be a need for significant interim investment in the current estate .

**Any other comments:** N/A

**Planning Objective: 10 – Population Health**

**Executive Lead: Dr Ardiana Gjini, Executive Director of Public Health**

**Reporting Period: Quarter 2 – July – September 2024**

**Overall status: Complete / Ahead / On-track / Behind**

**Rationale for overall status (please provide a brief summary of current progress indicating any key highlights or potential barriers to delivery)**

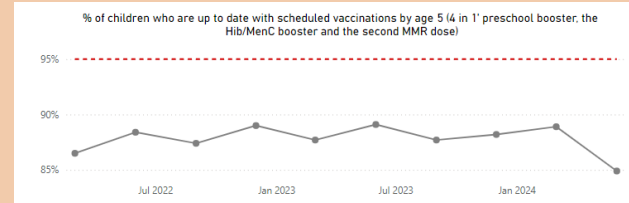
Key deliverable actions for reporting period, including those reported in Quarter 1, are on track. It has been noted these actions are predominantly process driven with clear output which enables the reporting period to indicate as on track. The Directorate is committed to further explore the impact our deliverable actions within the objective are having on population health and actions required to demonstrated further improvement.

**Progress against planned outcomes / trajectories / milestones (please provide SPC/data charts and an explanation of any variances):**



The latest data is showing improvement. However, improvement actions need to be identified and successfully embedded for the target to be consistently met.

Expected performance is between 0.8% and 1.7%



Latest data showing no improvement but within usual variation.

September 2024 – 84.9% uptake

**Activities completed in previous reporting period:**

- **10.1 Develop a strategic approach to improving health equity** – Immunisation Equity Strategic Plan 2024-27 approved at Board, annual action plan developed and driven by steering group
- **10.3 Deliver on National Immunisation Framework with a focus on increasing uptake of Measles, Mumps, Rubella (MMR) and seasonal immunisations** – targeted approach to offer of MMR to school aged children, summer clinics offered for all childhood immunisations. Planning complete for WRVP and RSV programmes
- **10.6 (Re)establish regional Children and Young people’s governance forum under Regional Programme Board (RPB)** – regional forum re-established
- **10.7 Progress the development of the Social Model for Health and Wellbeing (SMFHW)** – framework for action for SMFHW developed
- **10.8 Alcohol and drug use** – tender specification finalised through key forums
- **10.9 Equity in Clinical Service Planning** – frameworks for equity and prevention developing
- **10.10 Produce a Form of Return on Investment to health services for a few key public health services** – Return on investment reports on smoking and drugs & alcohol developed and discussed at SDODC

**Activities planned for next milestone and reporting period:**

- **10.3 Deliver on National Immunisation Framework with a focus on increasing uptake of MMR and seasonal immunisations** – delivery of seasonal flu and autumn Covid-19 booster programme, targeted focus on offer of preschool booster and MMR second dose to low uptake areas
- **10.5 Deliver a Whole System Approach to Healthy Weight** - develop sub-system areas of focus and agree priority areas for future two years of programme
- **10.7 Progress the development of the Social Model for Health and Wellbeing** – initiate development of social innovation with partners
- **10.8 Alcohol and drug use** – tender process to formally commence from October 2024
- **10.9 Equity in Clinical Service Planning** – to finalise report on equity and prevention frameworks

**Any other Comments**

**Matters for information:** Ambition for immunisation improvement this year identified as 5% improvement of last year’s baseline – our local ambition therefore would be to achieve 82% uptake in planned outcome measure for % of children who are up to date with their scheduled immunisations by age 5 years.

**Risks to delivery: 1884** - Risk of not being able to provide a timely and effective Public Health service due to limited Public Health Consultant capacity. Risk decreased to 16 due to recent recruitment campaigns. Anticipate risk will reduce further with plans in place. No impact on delivery to date but likely impact to pace at which further exploration of impact of actions has on population health.



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**Escalation  
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# Hywel Dda University Health Board Targeted Intervention Progress Report October 2024

# Contents



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# Targeted Intervention (TI) Feedback From Welsh Government



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## Key Areas of Progress

- New governance and working arrangements established for Executive team
- Reduction in reliance on agency staff and hospital beds
- Improvements in financial position and savings assurance
- Development of detailed action plans following independent planning reviews
- Progress in some aspects of healthcare acquired infections
- Improvements in Referral to Treatment (RTT), diagnostics, and mental health targets
- Positive steps in ambulance handover performance at Withybush Hospital (WGH)

## Areas of Concern

- Financial position remains unsupportable
- Cancer performance needs improvement
- Urgent and emergency care (UEC) continues to be a significant challenge
- Staff survey findings indicate poor levels of morale
- Complaints rate highest per thousand population in Wales
- C. Diff infections remain challenging
- Lower than expected promotion rate for overseas nurses who qualified in UK



## Key Actions and Expectations

1. Health Board to provide timeline for achieving target control
2. Welsh Government to forward complaints data as part of performance pack
3. Health Board to share national reported incidents data
4. Expectation to see improved performance in cancer, planned care, urgent and emergency care, and healthcare acquired infections
5. Clear route map to financial balance required
6. Quality impact assessments to be undertaken before any service changes

## Notable Discussions

- Potential controversial service changes being considered
- Progress on clinical services plan and consultation requirements
- Ongoing recruitment for Chief Executive and other senior posts
- Developments in regional solutions for cataracts and orthopaedics
- Establishment of C.Diff (CDI) Improvement group with Medical Director leading antimicrobial stewardship
- Workshops planned to improve complaints handling process
- Fragile services discussion, including emergency general services and GP practices



## Financial Targets

- Committed to achieving control target of £44.8m by March 2026
- Current year's planned deficit: £64m
- Assured savings to date: £28m
- Additional savings required: £4m

## Overall Assessment

Some progress noted, but significant challenges remain in financial position, performance improvements, and staff morale. Continued focus on targeted intervention areas is crucial. The Health Board needs to balance necessary service changes with maintaining service standards and patient care.

# Annual Plan 2025/26 - Workshop Outputs and Process



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## Engagement and Collaboration

- Approximately 35 senior leaders from Operational and Corporate Teams participated
- Strong emphasis on co-production, ensuring the Plan is an organisational product

## Key Discussions

- Financial Roadmap - Greater clarity needed on significant financial changes and smaller-scale efficiencies
- Performance Impact - Strategies to ensure performance remains unaffected
- Building on Current Year - Continuity of initiatives, allowing sufficient time for workforce planning and Quality Impact Assessments (QIAs)
- Strategic Alignment - Ensuring planning aligns with the overall organisational strategy
- Support Services Inclusion - Need to formally include services such as Health Records and Medical Secretaries to avoid unintended impacts
- Regional Collaboration - Continued focus on collaboration between Health Boards and regional partnerships

## Priority Areas Identified

- Teams broke into groups to identify priorities, focusing on how they support performance, TI de-escalation, and financial objectives
- Thematic analysis of these outputs is currently underway

## Next Steps

- A follow-up meeting on 15 October 2024 to review outcomes
- Outputs from the workshop will feed into the next full workshop on 11 November 2024



## Overview of Planning Approach

### Introduction of Planning Coordination Group

- A newly formed, action-oriented Planning Coordination Group to ensure effective coordination across strategic areas
- Representation from key directorates - Operations, Planning, Finance, Workforce, Quality and Safety, Governance, Medical, and Performance
- Group size limited to 10-12 members (ideally) for efficiency and effectiveness (this is a co-ordination group)
- Responsible for ensuring each component of the plan is accounted for and addressing any gaps

## Key Functions

- Executive Focus- Business Executive meetings will conduct fortnightly deep-dives into strategic areas, setting the overall planning goals and agreeing on deliverables
- Workshops and Planning Sessions - Monthly workshops to foster cross-team collaboration, with direct Executive oversight for strategic alignment
- Focused Plan Development - Methodical approach to develop the plan, ensuring all components are integrated with a focus on outcomes, deliverables, and trajectories



## Effective Planning Principles and Roles

### Roles and Responsibilities

- Planning Coordination Group - Supports operational aspects, oversees plan development, and cascades information to respective teams
- Business Executive Meetings - Equivalent to Board seminars, setting key planning objectives, specific, measurable, attainable, realistic, and time-bound (SMART) deliverables, and resource needs
- Executive Team Seminars - Sessions led by relevant executives to produce visually appealing, outcomes-focused information that reduces duplication

### Core Benefits

- Strategic Alignment - Ensures cohesion between executive vision and operational planning
- Timely Delivery - Regular touchpoints and small focused teams facilitate timely action and problem-solving
- Stakeholder Engagement: Representation from each major directorate (clinical and managerial) ensures co-production and integration of perspectives

### Next Steps

- Priority Setting and Coordination - Members are tasked with identifying priority areas, ensuring alignment with overall strategic and operational goals, including, addressing information gaps through direct cross-team collaboration
- Workshops and Feedback Loop - Continue monthly workshops, follow-up meeting on 15 October 2024 (small group) and next full workshop on 11 November 2024 to refine and finalise planning components



## Update on Additional Measures to Control Variable Spend from 1 November 2024

As part of our ongoing efforts to control variable spend, the following measures will be implemented across all directorates and professional areas starting from the 1 November 2024:

- 1. Prioritisation of Internal Staff Over Agency** - From 1 November 2024, we will be prioritising the use of bank staff and additional hours for substantive employees. Overtime will only be authorised when absolutely necessary, and agency staff will be a last resort, requiring higher-level approval. This approach will help ensure that we are maximising our existing workforce and controlling costs effectively.
- 2. Discontinuation of Health Care Support Worker (HCSW) Agency Usage** - In line with our cost-saving measures, the use of agency Health Care Support Workers will no longer be supported after 1 November 2024. All staffing gaps will be covered by internal staff, with additional hours and overtime being used where required.
- 3. Strengthened Authorisation Process** - The booking of additional hours, overtime, and agency shifts will follow a strict escalation process. Senior nurse managers or heads of service will need to sign off on all agency requests, ensuring that internal options have been fully explored before committing to external solutions. This will provide more robust control over workforce spend.
- 4. Risk-Assessed Enhanced Patient Support** - Any requests for enhanced patient support staffing must go through a thorough risk assessment, ensuring that internal staff rotations are considered first. Additional staffing will only be authorised if the need is critical, and regular monitoring will help ensure that we are deploying resources appropriately.
- 5. Ongoing Monitoring and Documentation** - We will be conducting regular spot audits and reviewing staffing plans to ensure that the process remains effective. All requests for additional staffing must be documented, and decisions will be reviewed periodically to ensure alignment with our financial objectives.

These measures will significantly help us reduce reliance on agency workers and better manage variable spend while maintaining patient safety and staff wellbeing. We will continue to review these measures with our trade union colleagues to ensure they remain effective.



The revised structure for the Targeted Intervention pack focuses on achieving a more streamlined and impactful approach to managing the alerts that are critical for driving progress towards de-escalation. Currently, the TI pack contains a large number of alerts and actions, which has diluted focus on key areas where more imminent action is required. This new approach aims to shift towards a systemic review of the key priorities, particularly those flagged by Welsh Government, to ensure we are better positioned to meet their expectations and demonstrate progress.

## Focus on Six Core Alerts

The revised alerts system will focus on six key alerts that have been identified as priority areas where more immediate action is necessary. These alerts have been selected based on feedback from Welsh Government, as well as their alignment with our strategic objectives for de-escalation. The logic behind this refined focus is to ensure:

1. **Clarity and Confidence** - We have a clear understanding and assurance around the actions that need to be taken, allowing us to build confidence internally and externally.
2. **Actionable Focus** - We are concentrating efforts on delivering tangible outcomes in the short term, particularly on areas that will drive de-escalation when we next meet Welsh Government in January 2025.
3. **Reduced Complexity** - By reducing the number of competing alerts, we avoid the risk of losing focus in the wider complexities of the full TI pack, allowing us to concentrate on the areas that will have the biggest impact.

## Rationale Behind the Focus

The rationale for narrowing the focus to these six alerts is that the broader TI framework is aimed at supporting de-escalation. While we recognise the systemic challenges and complexities that exist, these six areas are critical 'big-ticket' items that require urgent and coordinated action. Importantly, we are not disagreeing with the broader set of actions required, but rather ensuring that our focus remains aligned with Welsh Government's priorities.



Our approach is designed to be collaborative and proactive. We are not aiming to create a hierarchical relationship between us and Welsh Government but instead to ensure that we are presenting clear, actionable steps that demonstrate meaningful progress. This will give Welsh Government the confidence that we are working towards de-escalation in a structured and measurable way.

## Ensuring Assurance and Focus

In this revised structure, each of the six core alerts will be reviewed systemically to ensure we are confident in the complexity of the actions required. The focus will be on ensuring:

1. Ownership and Accountability - Each alert will have a designated lead and clear action points to ensure accountability. Progress will be reviewed regularly, and issues escalated where necessary.
2. Clear Milestones - We will set specific milestones for each alert to ensure progress is being made, with regular updates to provide assurance that actions are on track.
3. Integration with broader TI Framework - While the focus is on these six alerts, we will continue to monitor and address the wider TI framework to ensure that longer-term and systemic issues are still captured, without allowing them to overshadow the immediate priorities.

## Systemic Review and Delivery Focus

The revised alert system will drive a more systemic review of progress on the key areas, ensuring that we are continuously aligning our actions with the goal of de-escalation. By focusing on these six alerts and providing clear, detailed updates on progress, we will be well-positioned to demonstrate our commitment to delivering on Welsh Government's feedback.

Ultimately, this approach will give us the clarity and confidence needed to drive towards delivery in a coordinated and focused way. The next few months leading up to the January 2025 meeting with Welsh Government will be critical in ensuring that we maintain momentum, avoid distraction from broader complexities, and achieve meaningful progress towards de-escalation.

# Alerts and Advise aligned to Welsh Government Feedback



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Number	Concern	Action	Reporting Group	Committee	Status	Lead	Actions to be Taken	Action Completion Date
1	Urgent and Emergency Care (UEC)	Apply learning from Withybush Hospital (WGH) to improve Glangwili Hospital's (GGH's) ambulance handovers and UEC performance	Integrated Quality, Financial Performance and Delivery Group (IQFPD)	SDODC	Alert	Chief Operating Officer	1. Develop a plan to replicate WGH model.	
							2. Track UEC performance.	
							3. Monthly reporting to TI pack.	
2	Fragile Services (Critical Care and Service Configuration)	Conduct Quality Impact Assessment (QIA) and develop action plans for critical care optimisation and service configuration decisions	IQFPD/ A Healthier Mid and West Wales (AHMWW)	SDODC	Alert	Director of Strategic Development and Operational Planning	1. Complete QIA/ Equality Impact Assessment (EQIA) for all service changes.	
							2. Continue to highlight and report on fragile services to the Board.	
							3. Monitor monthly through Directorate Escalation Meetings - through agreed baselines and metrics.	
3	Cancer Performance	Develop and implement a revised detailed action plan to improve cancer performance	IQFPD	SDODC	Alert	Chief Operating Officer	1. Review and amended as appropriate the current interventions to meet cancer targets.	
							2. Review performance bi-weekly.	
							3. Update Welsh Government on the progress via Integrated Quality, Financial Performance and Delivery Group (IQFPD) and Targeted Intervention	

# Alerts and Advise aligned to Welsh Government Feedback



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Number	Concern	Action	Reporting Group	Committee	Status	Lead	Actions to be Taken	Action Completion Date
4	Financial Roadmap	Submit a clear timeline for achieving the £44.8m control target	Value and Sustainability	Sustainable Resources Committee (SRC)	Alert	Director of Finance	1. Develop financial roadmap, as part of the Annual Planning Process for 2025/26.	
							2. Present timeline to Board on 28 November 2024.	
							3. Provide final update to Welsh Government in January 2025.	
5	Complaints Handling	Implement workshops and meet 70% closure rate target for complaints	IQFPD	Quality, Safety and Experience Committee (QSEC)	Alert	Director of Nursing, Quality & Patient Experience	1. Schedule workshops with key stakeholders.	
							2. Track complaints closure progress.	
							3. Report bi-monthly.	
6	Healthcare-Acquired Infections (HCAIs)	Improve CDI rates and implement CDI improvement strategies	IQFPD	QSEC	Alert	Director of Nursing, Quality & Patient Experience	1. A review of the IPC priorities is underway and recommendations will feed into the CDI group.	
							2. Monitor CDI rates monthly.	
							3. Submit bi-monthly progress reports to QSEC.	

# Alerts and Advise aligned to Welsh Government Feedback



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Number	Concern	Action	Reporting Group	Committee	Status	Lead	Actions to be Taken	Action Completion Date
7	Staff Morale and Leadership	Implement action plan based on staff survey and leadership development	Value and Sustainability	People, Organisational Development & Culture Committee (PODCC)	Advise	Deputy Chief Executive and Director of Workforce & Organisational Development	1. Implement leadership development programme.	
							2. Monitor staff morale improvement.	
							3. Report quarterly on staff survey outcomes.	
8	Clinical Services Plan Phase 2	Submit clinical services plan and engage stakeholders for Phase 2	AHMWW	SDODC	Advise	Director of Strategic Development and Operational Planning	1. Submit Phase 2 plan to Board on 28 November 2024.	
							2. Begin stakeholder engagement.	
							3. Provide updates through the Healthier Mid and West Wales strategy.	



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## Approach to TI and revised arrangements

# Definitions



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Assurance Level	
Assurance Level: High = Assure	<ul style="list-style-type: none"><li>• There is strong evidence that the criteria are being met or exceeded.</li><li>• Actions are robust and effectively addressing the issue.</li><li>• No significant concerns exist, and performance is consistently on target.</li></ul>
Assurance Level: Moderate = Advise	<ul style="list-style-type: none"><li>• There is partial evidence that the criteria are being met.</li><li>• Actions are in place but require close monitoring and additional efforts.</li></ul>
Assurance Level: Low = Alert	<ul style="list-style-type: none"><li>• There is little or no evidence that the criteria are being met.</li><li>• Actions are insufficient or not effectively addressing the issue.</li><li>• Significant concerns exist, and there is a high risk of not meeting targets.</li></ul>

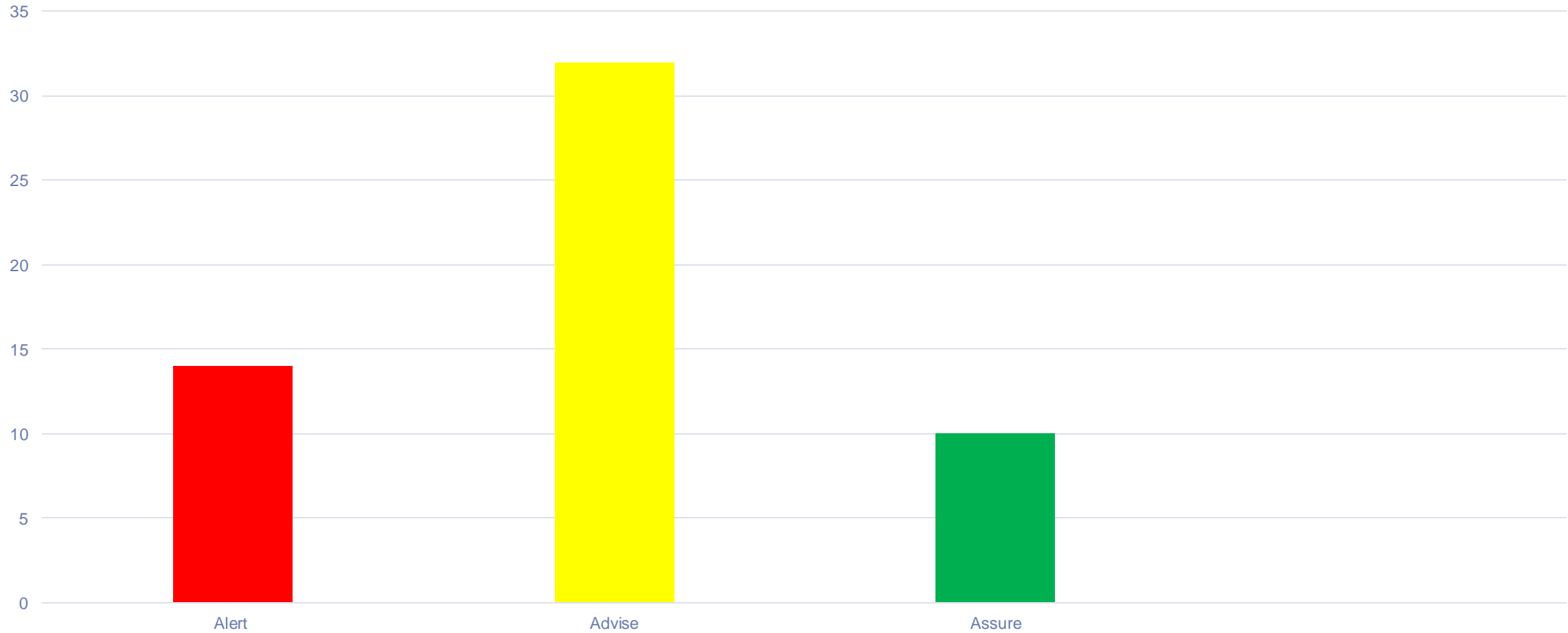
# TI progress July 2024



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Current Status of the 56 De-escalation Criteria



# TI responsibilities



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Action	Lead	Committee	RAG Status	Comments
1 Appoint a Senior Responsible Officer(s) (SRO) for the overall escalation and each domain if considered necessary and appropriate project leads.	CEO	Audit, Risk and Assurance Committee (ARAC)	Assure	Complete - Director of Strategic Development and Operational Planning appointed as SRO.
2 Have Board ownership and oversight with a clear governance structure, ensure that the Board is appraised of the escalation plan and evidence regular progress updates to the Board on progress against de-escalation criteria.	SRO	ARAC	Assure	The de-escalation criteria is clearly set out and aligned to leads and committees. All current alerts have clear actions and/or plans.
3 Agree the Targeted Intervention plan(s) and commit sufficient resources to ensure that the plan deliverables are achieved.	CEO	ARAC	Advise	Some resources have yet to be identified.
4 Provide monthly progress reports and evidence against the escalation plan to Welsh Government/NHS Wales Executive as required.	SRO	ARAC	Assure	This TI Framework is a live document and is updated daily/weekly/monthly and then shared as required.
5 Strengthen the formal review mechanisms to support urgency in delivering confidence and improvement to the overall position.	Director of Finance (DOF)	ARAC	Assure	



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## Domain 1: Finance, strategy and planning

# Domain 1: Finance, Planning and Strategy



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Criteria	Reporting Group	Committee	Status	Comments
1 The Health Board must demonstrate that robust financial governance and robust financial control environment are in place with risks minimised.	Value and Sustainability	SRC	Advise	Additional measures introduced.
2 Substantial progress to be made in delivering the targeted intervention action plan including actions to improve the organisation's understanding of the existing deficit and key drivers and development and realisation of opportunities.	Value and Sustainability	SRC	Advise	Further work undertaken on the opportunities to underpin the financial route map but continues to be raised as a concern by WG.
3 Annual Plan developed with Board approval demonstrating a substantial financial improvement trajectory to deliver as a minimum the target control total.	Value and Sustainability	SRC	Alert	Annual Plan does not deliver the control total.
4 Submission of an acceptable Annual Plan in line with the current planning framework.	TI Coordination group	SDODC	Alert	Annual Plan remains unacceptable.
5 Evidence of integrated planning across the organisation which supports the development of a coherent and deliverable Annual Plan.	TI Coordination group	SDODC	Advise	This remains on-going and through the Annual Plan and TI workshop, the integrated planning process will be enhanced.
6 Board clarity on the strategic vision for the organisation.	AHMWW	SDODC	Advise	Agreed strategy in place, AHMWW, however Programme Business Case (PBC) not yet endorsed by WG and therefore Strategic Plan remains uncertain.

# Domain 1: Finance, Planning and Strategy

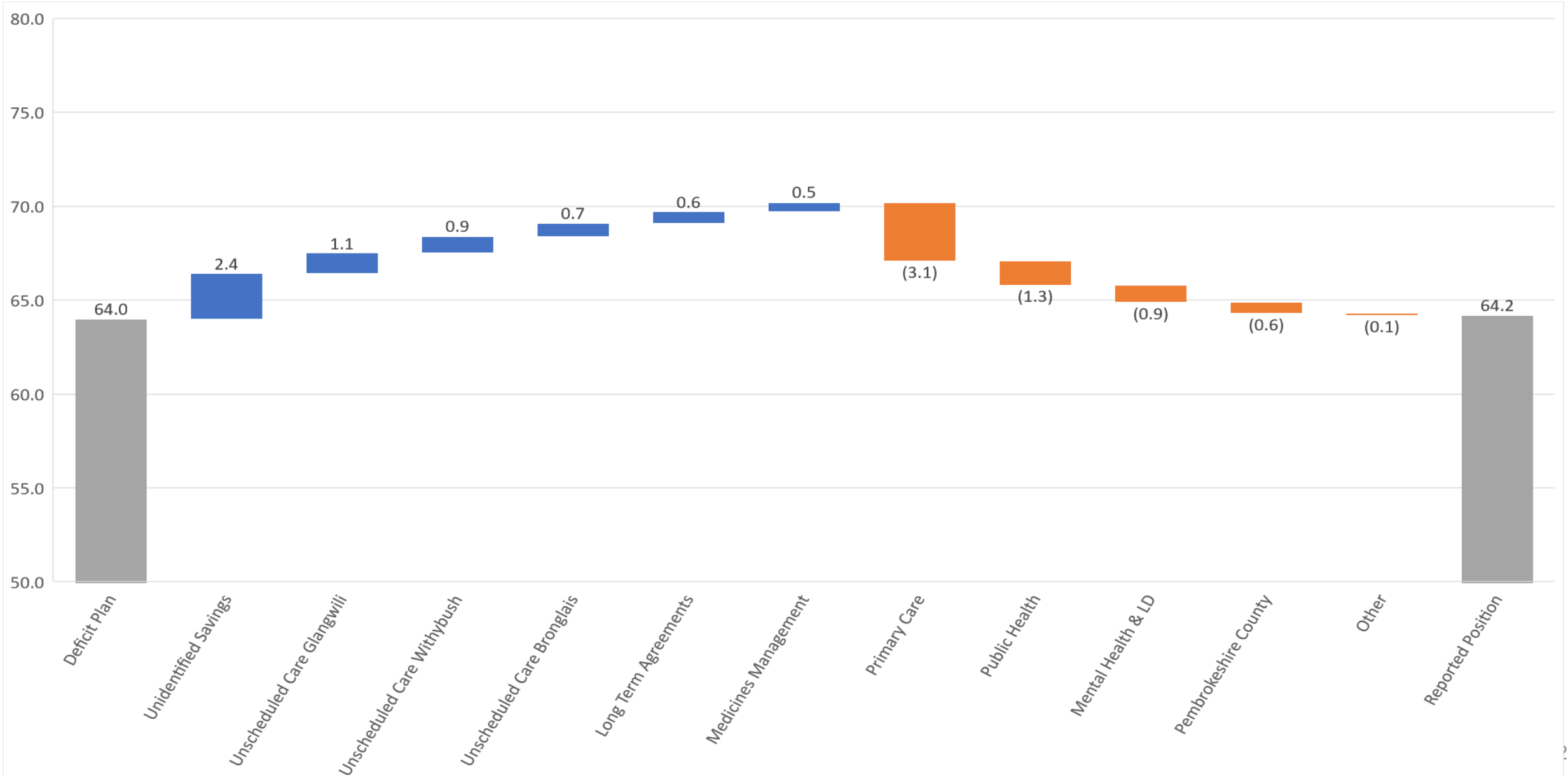


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Criteria	Reporting Group	Committee	Status	Comments
7 Evidence of a clear roadmap and implementation of the Health Board's Clinical Services Plan (CSP).	AHMWW	SDODC	Advise	Work on the CSP is progressing but remains in development phase.
8 Delivery of commitments set out within the Annual Plan, particularly in relation to the Ministerial Priorities.	IQFPD	SDODC	Alert	Currently significant challenges in Urgent and Emergency Care, Cancer and Diagnostics. Orthopaedics remains an outlier to achieving stage 104 week waits.
9 Significant progress on CSP.	AHMWW	SDODC	Advise	Work on the CSP is progressing but remains in development phase.
10 Sustained improvements in delivery of the Plan throughout the year.	IQFPD	SDODC	Advise	There are several improvements, however the status may need to be reviewed in September 2024.
11 Welsh Government's confidence in delivery based on an assessment against the Planning Maturity Matrix and planning quadrant.	TI Coordination group	SDODC	Advise	Our position has shown improvement; however, this is finely poised and may require revision in September 2024
12 Establishment of a Joint Committee with Swansea Bay (SB) UHB and demonstrate improved regional collaboration where required to ensure continued safety, quality and ongoing viability and sustainability of regional services; including orthopaedics and ophthalmology.	Executive team	Board	Advise	The joint committee is currently being established with the relevant executives meeting to discuss both the sustainability and prioritisation of services.

# End of Year: Key Directorates (£m)



# Savings Plans and Delivery Performance



**Annual Plan Requirement**  
**£32.4m**



**In-Year Delivery**  
**£29.1m**



**In-Year Shortfall**  
**£3.3m**

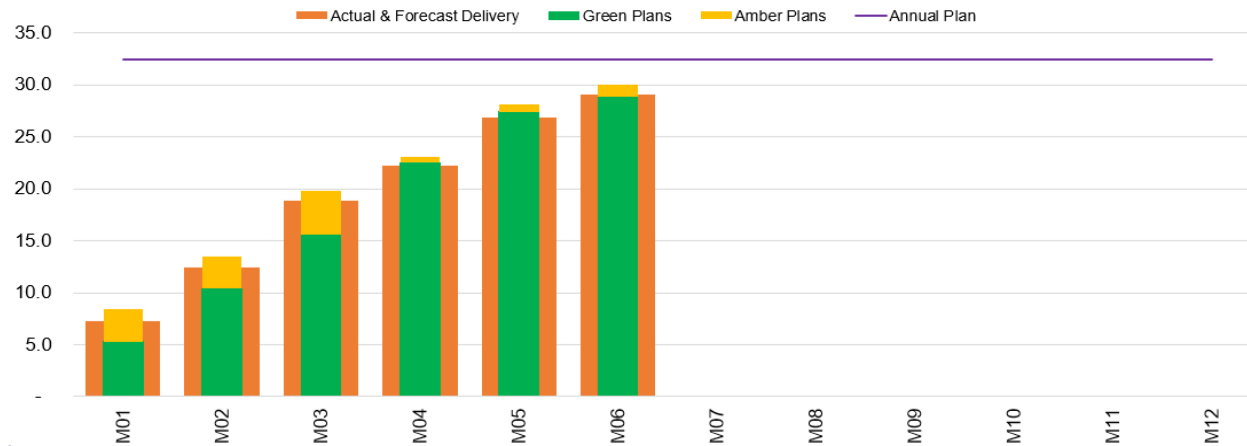


**Recurrent Delivery**  
**£19.0m**

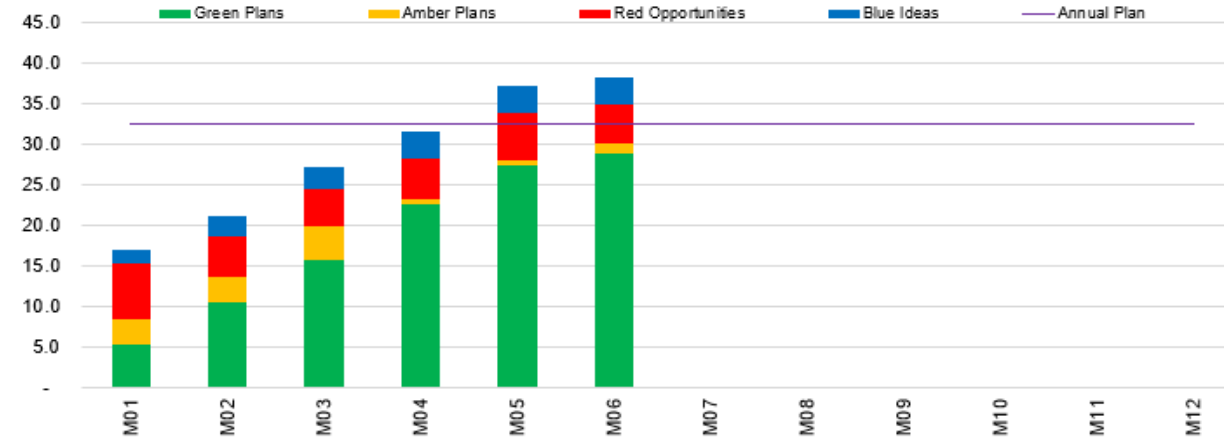


**Recurrent Shortfall**  
**£13.4m**

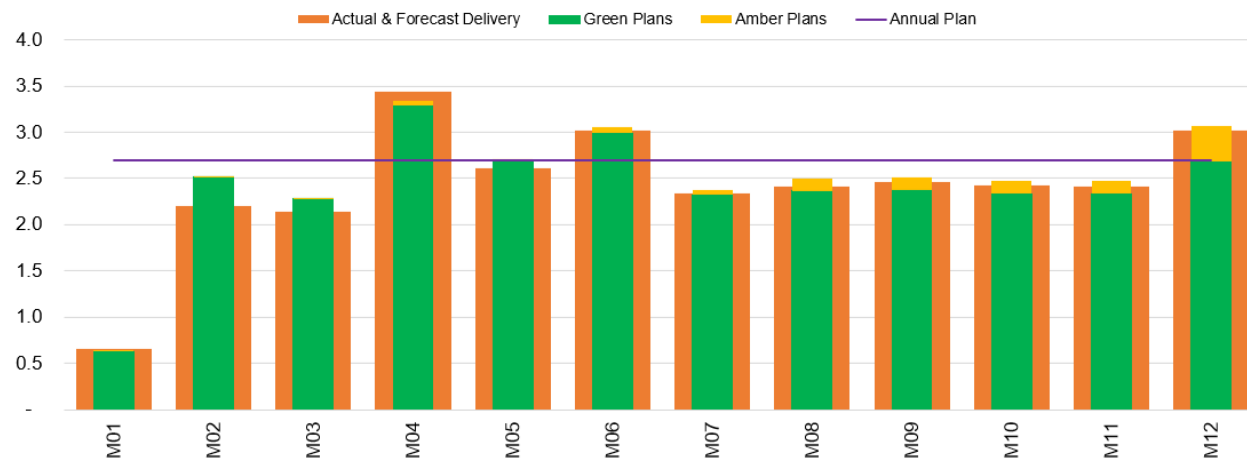
**Monthly Trend of Annual In-Year Risk-Assessed Savings Delivery (£'m)**



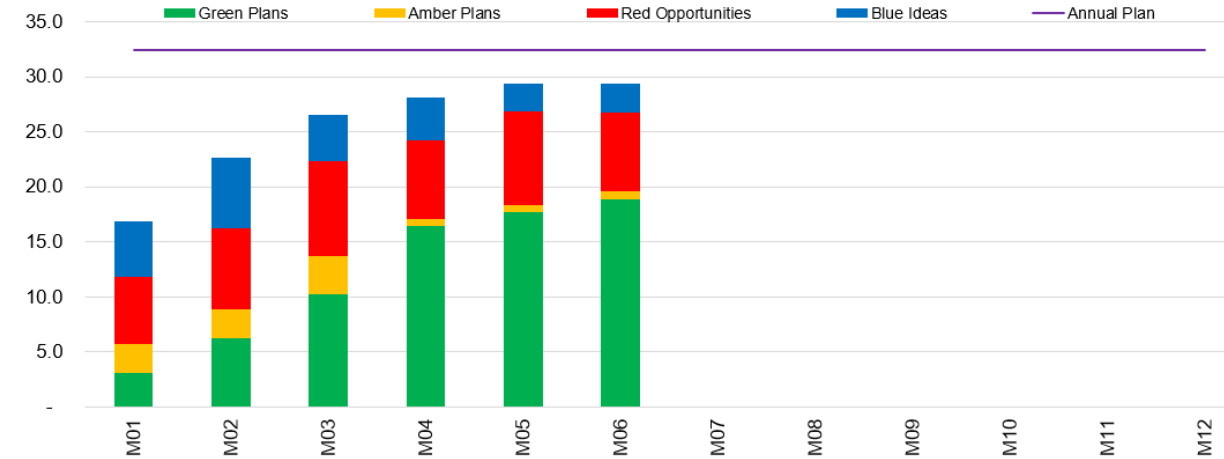
**Monthly Trend of Annual In-Year Opportunity, Pipeline & Savings Plans (£'m)**



**Monthly Profiled Risk-Assessed Savings Delivery (£'m)**



**Monthly Trend of Annual Recurrent Opportunity, Pipeline & Savings Plans (£'m)**



# End of Year: Savings Identification and Delivery Summary

Saving Identification	£m	Comments
<b>Savings Target</b>	<b>32.4</b>	<b>As per Annual Plan</b>
Underspend conversions	0.0	None converted in Month 6
Newly identified schemes	1.7	11 new schemes identified in Month 6, five schemes as recurring £0.9m, six schemes as non-recurring £0.8m
Red and Blue conversions	0.2	Three Red recurrent schemes converted to Amber/Green
<b>New Identified Savings</b>	<b>1.9</b>	<b>Added since the prior months end of year forecast</b>
Previously Identified Planned Schemes	28.1	Identified within the prior months end of year forecast
<b>Total Savings Plans Identified</b>	<b>30.0</b>	<b>Identified plans (not necessarily the actual delivery)</b>
<b>Unidentified Savings Gap to Annual Plan</b>	<b>2.4</b>	
Under / (Over) Delivery of Planned Schemes	0.9	Shown within directorate financial performance
<b>Savings Delivery Gap</b>	<b>3.3</b>	

# Welsh Government Finance Themes

- Welsh Government Finance Themes are:
  - System affordability in the short term (cash releasing efficiency opportunities)
  - System sustainability in the longer term (productivity and prevention opportunities)
  - Impact of expenditure (performance, outcomes and broader impact on economy, environment, and culture of our communities)
- Our design principles need to ensure that the tensions and trade-offs between these themes are managed.



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## Domain 2: Performance and outcomes

# TI - September Performance



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	Measure	De-escalation criteria	Baseline	Goal	Latest position																
					Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24
Planned Care and Cancer	% single cancer pathway patients starting treatment within 62 days	60% for 3 consecutive months	50%	60%	51%	42%	46%	49%	51%	46%	50%	41%	56%	49%	47%	60%	43%	53%	54%	54%	n/a
	% patients waiting less than 52 weeks for new outpatient appointment	100% for 3 consecutive months	94%	100%	93.6%	94.2%	95.6%	94.8%	94.3%	94.6%	94.0%	93.4%	92.7%	92.8%	93.1%	93.8%	92.5%	91.5%	91.3%	92.9%	93.4%
	% patients waiting less than 104 weeks from referral to treatment	100% for 3 consecutive months	97%	100%	96.5%	96.7%	97.1%	97.1%	97.1%	97.1%	97.2%	97.2%	97.4%	97.6%	97.9%	98.5%	98.4%	98.3%	98.2%	98.2%	98.1%
	% patients waiting less than 52 weeks from referral to treatment	80% for 3 consecutive months	85%	80%	85.8%	86.1%	87.1%	86.5%	85.7%	85.6%	85.2%	84.7%	84.2%	84.5%	84.9%	85.1%	84.3%	83.7%	83.4%	83.7%	83.7%
	Number of patients delayed by 100% for their follow up appointment	15% reduction 3 consecutive months, maintained for 3 months	15,419	9,469	16,181	15,867	15,526	15,377	15,399	15,957	15,571	15,419	15,668	16,310	15,478	15,829	16,028	16,201	16,062	15,714	16,015
	% R1 ophthalmology patients waiting no longer than 25% of target date	65% for 3 consecutive months	45%	65%	49.1%	49.7%	50.4%	49.6%	47.5%	46.6%	45.2%	44.0%	42.1%	40.5%	40.1%	40.0%	40.1%	38.1%	37.7%	36.6%	n/a
	% patients waiting less than 8 weeks for a diagnostic endoscopy	80% for 3 consecutive months	28%	80%	26.8%	27.6%	28.5%	28.9%	24.7%	24.8%	27.8%	26.9%	25.3%	27.0%	31.9%	37.0%	35.8%	34.4%	34.5%	44.0%	36.1%
	% patients waiting less than 8 weeks for a Non-obstetric ultrasound (NOUS)	80% for 3 consecutive months	73%	80%	75.8%	70.2%	72.7%	74.1%	67.5%	67.8%	73.3%	68.4%	63.1%	60.6%	70.3%	79.0%	77.5%	81.8%	84.7%	85.9%	77.0%
	% patients waiting less than 8 weeks for a non-cardiac MRI	80% for 3 consecutive months	75%	80%	55.1%	63.1%	78.7%	84.3%	70.7%	67.6%	74.6%	69.5%	61.5%	54.4%	65.2%	78.5%	71.7%	66.0%	63.6%	65.2%	57.1%
	% patients waiting less than 14 weeks for a specific therapy (excluding Audiology and Weight Management Service)	85% for 3 consecutive months	75%	85%	83.7%	83.3%	85.4%	86.6%	85.3%	84.1%	86.1%	87.4%	86.2%	86.8%	87.8%	86.9%	81.8%	78.9%	78.3%	77.6%	74.6%
UFC	Ambulance handovers taking over 1 hour	11% reduction 3 consecutive months, maintained for 3 months	964	680	901	993	863	944	980	854	1,019	915	959	1,245	1,124	1,192	1,103	970	1078	959	721
	Median time from arrival at ED to assessment by a clinical decision maker (mins) *	60	58	60	57	57	58	71	71	70	65	58	67	64	64	67	65	73	75	74	73
	% patients waiting over 12 hours in an emergency department	Continuous improvement towards no more than 7%	9%	7%	8.6%	8.6%	8.2%	8.9%	10.9%	9.2%	9.2%	9.0%	9.7%	11.7%	10.8%	11.3%	10.3%	10.6%	10.7%	10.1%	9.4%
	Number of delayed pathways of care	5% reduction 3 consecutive months, maintained for 3 months	203	174	278	230	247	256	238	222	192	227	190	207	212	220	237	249	253	203	194
CAMHS	% 0-17 year olds LPMHSS assessments undertaken <28 days	80%	92%	80%	88.2%	86.6%	93.5%	88.5%	76.5%	91.9%	93.8%	86.9%	89.6%	81.3%	92.0%	98.2%	92.2%	95.7%	85.7%	97.0%	n/a
	% 0-17 year olds therapeutic interventions started <28 days	65%	59%	65%	45.2%	72.9%	72.2%	48.9%	58.5%	58.5%	65.5%	81.3%	80.0%	78.0%	96.2%	95.8%	91.5%	95.3%	85.1%	81.0%	n/a
	% 0-17 year olds having secondary mental health services with valid care treatment plan	80%	95%	80%	100%	100%	100%	97.0%	95.2%	95.5%	93.2%	92.7%	92.9%	91.1%	92.1%	88.4%	93.5%	90.9%	95.0%	91.6%	n/a
Infections	Number of hospital onset C.difficile infections	25% reduction, maintained for 3 months	8	6	7	6	3	9	8	5	8	10	6	10	7	7	6	8	11	7	4
	Number of hospital onset Staph aureus infections	33% reduction, maintained for 3 months	3	2	3	3	3	3	2	2	4	3	2	4	1	5	7	1	4	3	5
	Number of hospital onset E.coli infections	25% reduction, maintained for 3 months	7	5	3	9	5	8	3	3	5	12	3	2	5	4	4	4	4	3	7

# Domain 2: Performance and outcomes

## Planned care and cancer



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Criteria	Reporting Group	Committee	Status	Comments
13 60% performance maintained for three months against the Single Cancer Pathway (SCP) target.	IQFPD	SDODC	Advise	Agreed improvement trajectory delivers this criteria.
14 100% of open outpatient pathways to be waiting less than 52 weeks and maintained for three months.	IQPFD	SDODC	Advise	Agreed improvement trajectory delivers this criteria.
15 100% of open pathways to be waiting less than 104 weeks and maintained for three months.	IQFPD	SDODC	Alert	Current plan delivers 104 weeks for all services except Orthopaedics.
16 80% of open pathways to be waiting less than 52 weeks and maintained for three months.	IQFPD	SDODC	Assure	Criteria being achieved.
17 15% reduction in the number of patients delayed by 100% for their follow up appointment in three consecutive months and maintained for three months (Based on the November 2023 baseline.)	IQFPD	SDODC	Alert	Actions and Plans set out within the Alerts
18 65% R1 Ophthalmology patient pathways to be waiting within or no longer than 25% of their target date for an outpatient appointment and maintained for three months.	IQFPD	SDODC	Alert	Actions and Plans set out within the Alerts

# Domain 2: Performance and outcomes

## Planned care and cancer



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Criteria	Reporting Group	Committee	Status	Comments
19 80% of patients waiting for a diagnostic test to be waiting less than eight weeks and maintained for three months.	IQFPD	SDODC	Advise	Agreed improvement trajectory delivers this criteria.
20 80% of patients waiting for a diagnostic endoscopy to be waiting less than eight weeks and maintained for three months.	IQFPD	SDODC	Advise	Agreed improvement trajectory delivers this criteria.
21 80% of patients waiting for a Non-Obstetric Ultrasound (NOUS) and non-cardiac MRI to be waiting less than eight weeks and maintained for three months.	IQFPD	SDODC	Advise	Agreed improvement trajectory delivers this criteria.
22 85% of patients waiting for therapies to be waiting less than 14 weeks and maintained for three months.	IQFPD	SDODC	Advise	Agreed improvement trajectory delivers this criteria.
23 Improving ratings from service user feedback experience responses and evidence of use of Datix and CIVICA data to inform quality improvement processes and the experience of patients and their families.	IQFPD	QSEC	Advise	Do we have trajectories and plans for this?

# Domain 2: Performance and outcomes

## Urgent and emergency care



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Criteria	Reporting Group	Committee	Status	Comments
24 A continuous reduction of ambulance handovers over an hour of at least 11% in three consecutive months and maintained for three months (Based on the October - December 2023 baseline).	IQFPD	SDODC	Alert	Current actual performance is a significant concern and is negatively deviating from the set trajectories.
25 Continuous improvement towards no more than 7% of patients waiting over 12 hours at each individual site and across the Health Board.	IQPFD	SDODC	Alert	Remains a significant challenge. Whilst improvement actions identified, this has not to date translated in a clear operational plan.
26 Median time from arrival at an emergency department to assessment by a clinical decision maker should not exceed 60 minutes.	IQFPD	SDODC	Alert	No current operational plan in place.
27 A continuous reduction in delayed pathways of care of 5% for three consecutive months and then maintained for three months (based on October - December 2023 baseline).	IQFPD	SDODC	Alert	Remains significantly above plan with no operational plans in place.
28 Improving ratings from service user feedback experience responses and evidence of use of Datix and CIVICA data to inform quality improvement processes and the experience of patients and their families.	IQFPD	SDODC		

# Domain 2: Performance and outcomes

## Mental health



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Criteria	Reporting Group	Committee	Status	Comments
29 80% of Local Primary Mental Health Support Service (LPMHSS) mental health assessments undertaken within 28 days from the date of receipt of referral.	IQFPD	SDODC	Assure	Welsh Government have de-escalated the Health Board for Part 1 of assessments.
30 65% of therapeutic interventions started within 28 days following an assessment by LPMHSS.	IQPFD	SDODC	Assure	Criteria being achieved.
31 80% of HDdUHB residents in receipt of secondary mental health services who have a valid care and treatment plan.	IQFPD	SDODC	Assure	Criteria being achieved.



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outcomes

6. Quality of  
care

**Escalation  
Domains**

3. Fragile  
services

5.  
Leadership,  
capability  
and culture

4.  
Governance

## Domain 3: Fragile services

# Domain 3: Fragile services



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Criteria	Reporting Group	Committee	Status	Comments
32 Evidence that the Health Board has the appropriate mechanism to understand the drivers behind a fragile service through the triangulation of key data points, including staffing levels, staff and patient feedback, concerns, incidents, stakeholder feedback (Healthcare Inspectorate Wales (HIW), Audit Wales (AW), Royal College (RC), Llais etc), mortality reviews, duty of quality/candour, infection protection control, performance, clinical and medical leadership.	IQFPD	QSEC	Advise	Update on fragile services framework presented at QSEC in April.
33 Fragile services (including but not limited to stroke, primary care, orthopaedics and ophthalmology) are supported by strong clinical leadership, have an effective integrated improvement plan, project management structure and effective transformation support. Where appropriate key performance metrics will be agreed.	IQFPD	QSEC	Advise	Stroke, orthopaedics, ophthalmology and primary care are supported through Clinical Services Plan and Primary and Community strategy programmes. Support for other services to be established as part of framework above.
34 Evidence that all recommendations from the Royal Colleges, HIW and other reviews specific to HDdUHB are discharged and either verified or delivered or scheduled for delivery within the Health Board's longer-term improvement plan.	IQFPD	QSEC	Alert	Further work required to establish the position against recommendations.
35 Evidence that the Board is sighted on fragile services and has a robust response to these issues that is being addressed by the Health Board	IQFPD	QSEC	Advise	Clinical Services Plan presented regularly at Public Board. Work on the fragile services framework to be presented at

# Fragile services register



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## Domain 4: Governance



Criteria	Reporting Group	Committee	Status	Comments
36 Effective oversight and scrutiny of current service provision consistently being provided by the Board and the appropriate Committee as demonstrated by Committee and Board papers.	TI Coordination group	ARAC	Assure	<ul style="list-style-type: none"> <li>Refreshed approach to Committee self-assessment feeding into the Board Development Programme.</li> <li>Independent Member (IM) reflective sessions following every meeting.</li> <li>Operational risks are reviewed by Committees every alternate meeting.</li> <li>Ministerial Priorities are aligned to Committee.</li> </ul>
37 Evidence of Board considering the Duty of Quality to inform their decision making and evaluating their compliance with the Duty.	TI Coordination group	ARAC	Advise	<ul style="list-style-type: none"> <li>QIA process approved by QSEC and is being implemented with QIA Panels taking place.</li> </ul>
38 Effective programme and performance management structure is in place, which defines objectives of the improvement work, has plans which show how the work is delivered and what barriers could impact on delivery of outcomes; structures have effective, open and transparent reporting, with effective Board oversight and a clear performance and delivery framework that drives improvement.	TI Coordination group	ARAC	Advise	



Criteria	Reporting Group	Committee	Status	Comments
39 Risk management arrangements are in place for identifying, recording, managing risks across the organisation. Board is sighted on key risks and areas of concern on a regular basis and is able to offer constructive scrutiny on performance and effective oversight and scrutiny of fragile services provided by QSEC and Board.	TI Coordination group	ARAC	Advise	<ul style="list-style-type: none"> <li>Defined process in place for reporting risks to Board and Committees.</li> </ul>
40 Clear governance and assurance systems in place with performance (quality, resource, activity/outcomes) issues escalated appropriately through clear structures and processes.	TI Coordination group	ARAC	Advise	<ul style="list-style-type: none"> <li>New Executive Team governance arrangements in place.</li> <li>New Internal Escalation Framework in place.</li> <li>Further work required on strengthening operational governance arrangements linked to new operational directorate structure.</li> </ul>
41 Self-assessment against an agreed governance maturity matrix with evidence the agreed level.	TI Coordination group	ARAC	Advise	<ul style="list-style-type: none"> <li>Board Effectiveness Self-Assessment undertaken in April 2024, feeding into the Board Development Programme, reporting to ARAC and Board in May and July 2024.</li> <li>Following feed-back a more detailed maturity matrix to be developed reflecting the six domains of TI and core roles of Board</li> </ul>



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and  
outcomes

6. Quality of  
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Domains**

3. Fragile  
services

5.  
Leadership,  
capability  
and culture

4.  
Governance

## Domain 5: Leadership, capability and culture

# Leadership, capability and culture



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Criteria	Reporting Group	Committee	Status	Comments
<p>42 A full and substantive Executive Director Team, with a clear organisational structure in place with robust succession and development plans in place to ensure adequate capacity and capability in all areas of the organisation to deliver high quality, sustainable care.</p>	TI Coordination group	PODCC	Advise	<ul style="list-style-type: none"> <li>Board succession is being addressed thorough Board development session with both Independent Members (IMs) and Executive Directors with recent time out sessions held.</li> <li>Robust performance management framework being introduced for Executive Directors with objectives set for 2024/2025 and personal development plans identified.</li> </ul>
<p>43 Effective leadership programmes are in place to support the ongoing development of leadership and management skills at all levels / professions to strengthen management maturity. Evaluation of the impact of these programmes including decision making, use of equality impact assessment, safeguarding and participant feedback.</p>	TI Coordination group	PODCC	Assure	<ul style="list-style-type: none"> <li>Four cohorts of LEAP leadership programme in train with second cohort graduating recently.</li> <li>Second new consultant cohort has commenced on the programme.</li> </ul>
<p>44 Positive staff engagement in NHS Wales surveys.</p>	TI Coordination group	PODCC	Assure	<ul style="list-style-type: none"> <li>Staff survey results have been considered in partnership with staff side.</li> <li>Local implementation plans being developed for consideration at the next Staff Partnership Forum.</li> <li>Cultural progression report for the last 12 months approved at PODCC in April 2024.</li> </ul>

# Leadership, capability and culture



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Criteria	Reporting Group	Committee	Status	Comments
45 Plans are in place to develop a sustainable workforce resulting in improved staff retention and staff well-being; a reduction in the number of vacancies; and the number of interim and agency staff. Workforce plans and clinician job plans are reviewed annually to ensure that the organisation can deliver the requirements of the Annual Plan.	Value and Sustainability	PODCC	Alert	<ul style="list-style-type: none"> <li>Workforce plan compiled as part of the Annual Plan and retention plans are in place for nursing and medical staff with AHP retention group being established from June 2024.</li> <li>Plan in place regarding job plans – monitored by ARAC.</li> </ul>
46 Whether the people who use services, the public, staff and external partners are engaged and involved to support high quality sustainable services, demonstrated by local surveys showing increasing confidence in the leadership and awareness of strategies.	TI Coordination group	SDODC	Assure	<ul style="list-style-type: none"> <li>Full details in the culture progression report.</li> <li>38% of leavers have an exit interview.</li> <li>76% engagement rate with Board outcome survey (February 2024).</li> </ul>
47 Clinical change is led and driven forward by clinical leaders at all levels of the organisation.	TI Coordination group	PODCC	Advise	<ul style="list-style-type: none"> <li>Interim Medical Director held a medical leadership forum (April 2024) to discuss challenging organisational agenda and expectation of clinical leaders in organisation change.</li> </ul>

# Leadership, capability and culture



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Criteria	Reporting Group	Committee	Status	Comments
48 A culture of listening, learning, and improving is embedded throughout the organisation based on early and rapid triangulation and resolution of issues from a variety of sources, including quality, mortality, staffing levels, patient outcomes, user and staff feedback.	TI Coordination group	QSEAC	Advise	<ul style="list-style-type: none"> <li>Development of a quality surveillance group led by Clinical Executives is being established to further embed triangulation of data and information.</li> </ul>
49 Effective use of data to help demonstrate improvements in leadership.	TI Coordination group	PODC	ASSURE	<ul style="list-style-type: none"> <li>Full details in the culture progression report.</li> </ul>



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## Domain 6: Quality of care



Criteria	Reporting Group	Committee	Status	Comments
<p>50</p> <p>Stabilisation of the increased trajectory of cases of Health Care Acquired Infections (HCAI) and evidence of continuous improvement accompanied by a strong quality improvement approach and plan that has oversight and monitoring by QSEC and Board. The Health Board to have a clear improvement plan based on a root cause analysis to address the issue of hospital onset HCAs.</p> <ul style="list-style-type: none"> <li>• C-Diff: reduce the number of hospital onset infections by 25% and maintain for three months (from a baseline of the average number of cases in Quarter 3 of eight cases to no more than six per month)</li> <li>• Staph aureus: reduce the number of hospital onset infections by 33% and maintain for three months (from a baseline of the average number of cases in Quarter 3 of three cases to no more than two per month)</li> <li>• E-coli: reduce the number of hospital onset infections by 25% and maintain for three months (from a baseline of the average number of cases in Quarter 3 of seven cases to no more than five per month)</li> </ul>	IQFPD	QSEC	Advise	
<p>51</p> <p>70% of complaints that had final reply (Reg 24) / interim reply (Reg 26) to be closed less than 30 working days of concern received.</p>	IQFPD	QSEC	Alert	The actions and plans are set out in the Alerts section.

# Quality of care



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Criteria	Reporting Group	Committee	Status	Comments
52 Effective response from the Health Board to external reports and reviews including those from Audit Wales, the Ombudsman, Royal Colleges and HIW resulting in sustainable improvements.	IQFPD	QSEC	Alert	The actions and plans are set out in the Alerts section
53 Demonstrate how service user and staff experience/involvement is being used to improve quality processes and inform service development across the organisation.	IQFPD	QSEC	Advise	
54 Demonstrate the progress made against implementing the requirements of the Duty of Candour and Duty of Quality including the embedding of the Care and Quality Standards through the organisation from Board to service area delivery.	IQFPD	QSEC	Advise	
55 Oversight of safeguarding arrangements to ensure the Board have sufficient, meaningful assurance that organisation is delivering against its safeguarding statutory responsibilities.	IQFPD	QSEC	Assure	

# Quality of care



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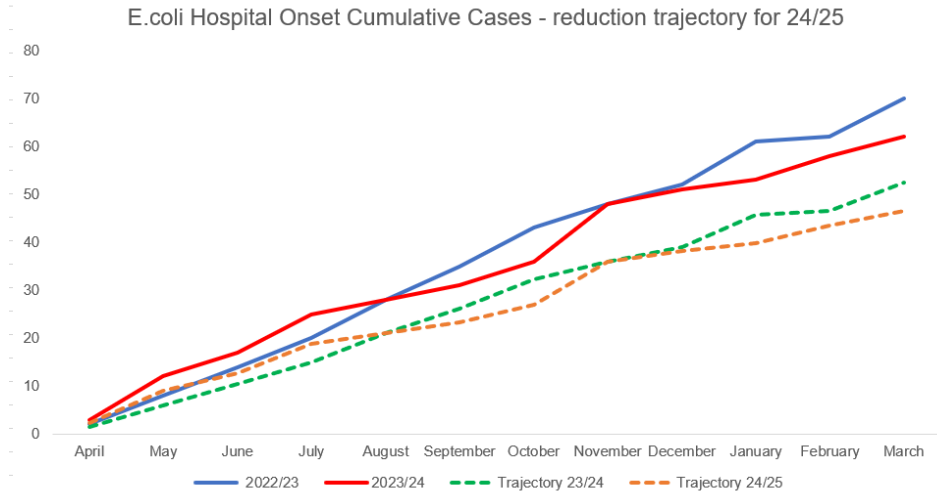
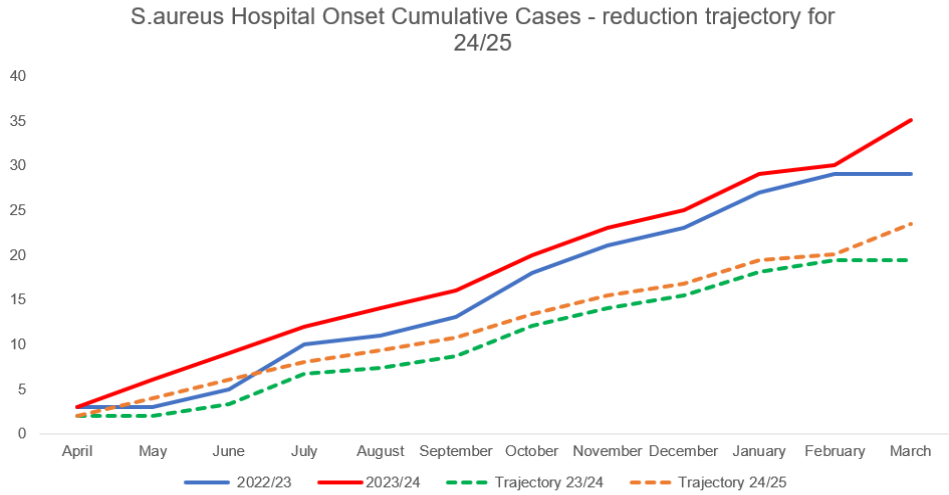
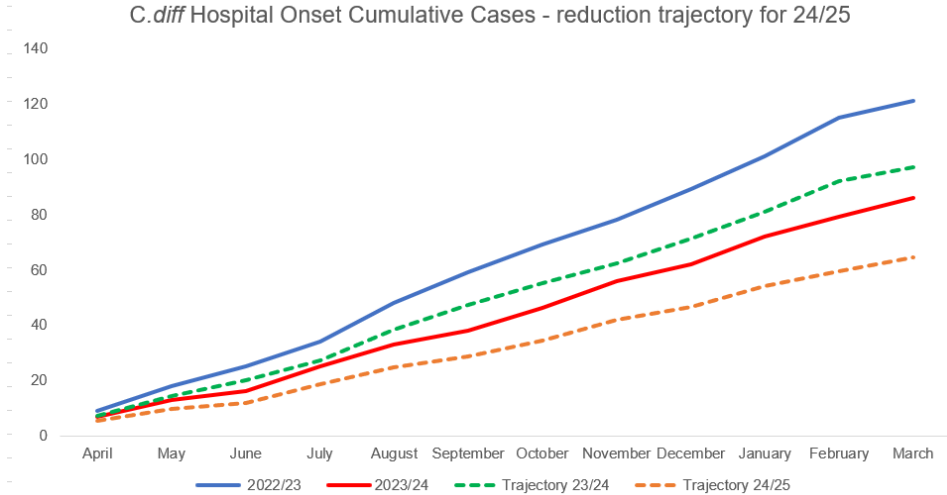
Criteria	Reporting Group	Committee	Status	Comments
56 Use of National Clinical Audit and Outcome Review Programme and Value in Health dashboards to support quality improvement and address unwarranted variation in care (including the use of patient and staff feedback to influence service design).	IQFPD	QSEC	Advise	

# HCAI trajectories 2024/25



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# Escalation exception report

October 2024 (as at 7 October 2024)

# Escalation status overview



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## Escalation status levels overview as of 30 September 2024

1 Reasonable assurance    2 Limited assurance    3 No assurance

	Directorate	Quality	Governance	Workforce	Finance, Strategy and Planning	Fragile Services	Performance and Outcomes
Director of Operations	Director of Operations	1	2	2	3	1	1
	Facilities	3	2	3	2	1	3
	Mental Health & Learning Disabilities	3	3	3	3	2	3
	Cancer & Oncology	1	2	2	2	1	3
	Pathology	1	2	2	3	2	1
	Radiology	3	2	2	2	1	3
	Planned Care (incl. Audiology and Endoscopy)	3	3	2	3	2	3
	Bronglais Hospital	3	1	2	2	2	3
	Glangwili Hospital	3	1	2	3	3	3
	Prince Philip Hospital	3	1	2	3	2	3
	Withybush Hospital	3	1	2	3	2	3
	Women & Children	3	3	2	3	2	3
Director of Primary, Community and LTC	Carmarthenshire County	2	1	2	3	1	3
	Ceredigion County	2	1	2	3	2	2
	Pembrokeshire County	2	1	2	3	1	3
	Primary Care	1	1	2	2	2	1
	Primary Care Management	1	1	2	2	1	1
	Medicines Management	1	1	2	3	2	1
Other	Director of Therapies and Health Sciences	2	1	2	3	1	3
	Director of Finance	1	2	1	1	2	1
	Director of Nursing	1	2	2	3	1	3
	Director of Public Health	1	1	2	1	1	2
	Director of Strategy and Planning	1	1	2	3	1	1
	Director of Workforce & OD	1	1	1	1	1	1
	Medical Directorate	1	2	1	1	1	1
Corporate Services	1	1	2	1	1	1	

- Directorates with the most concerning levels of escalation:

Directorate	Domains in level 3 escalation
Mental Health & Learning Disabilities	5
Glangwili Hospital	4
Planned Care	4
Women and Children	4

However, the Women and Children's directorate have reduced from 6x level 3 escalation (de-escalated to level 2 for workforce and fragile services) and Planned Care have been de-escalated this month for Workforce.

- Widespread issues within the following domains:
  - Finance: 15 directorates level 3
  - Performance: 14 directorates level 3
  - Quality: 9 directorates level 3

Details of escalation status trends, escalation reasons and de-escalation criteria can be accessed via the [Our Performance dashboard](#).

# Directorate changes

Following the Executive Team leads escalation level reviews in October 2024



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Changes in escalation status from 31 August to 30 September 2024:

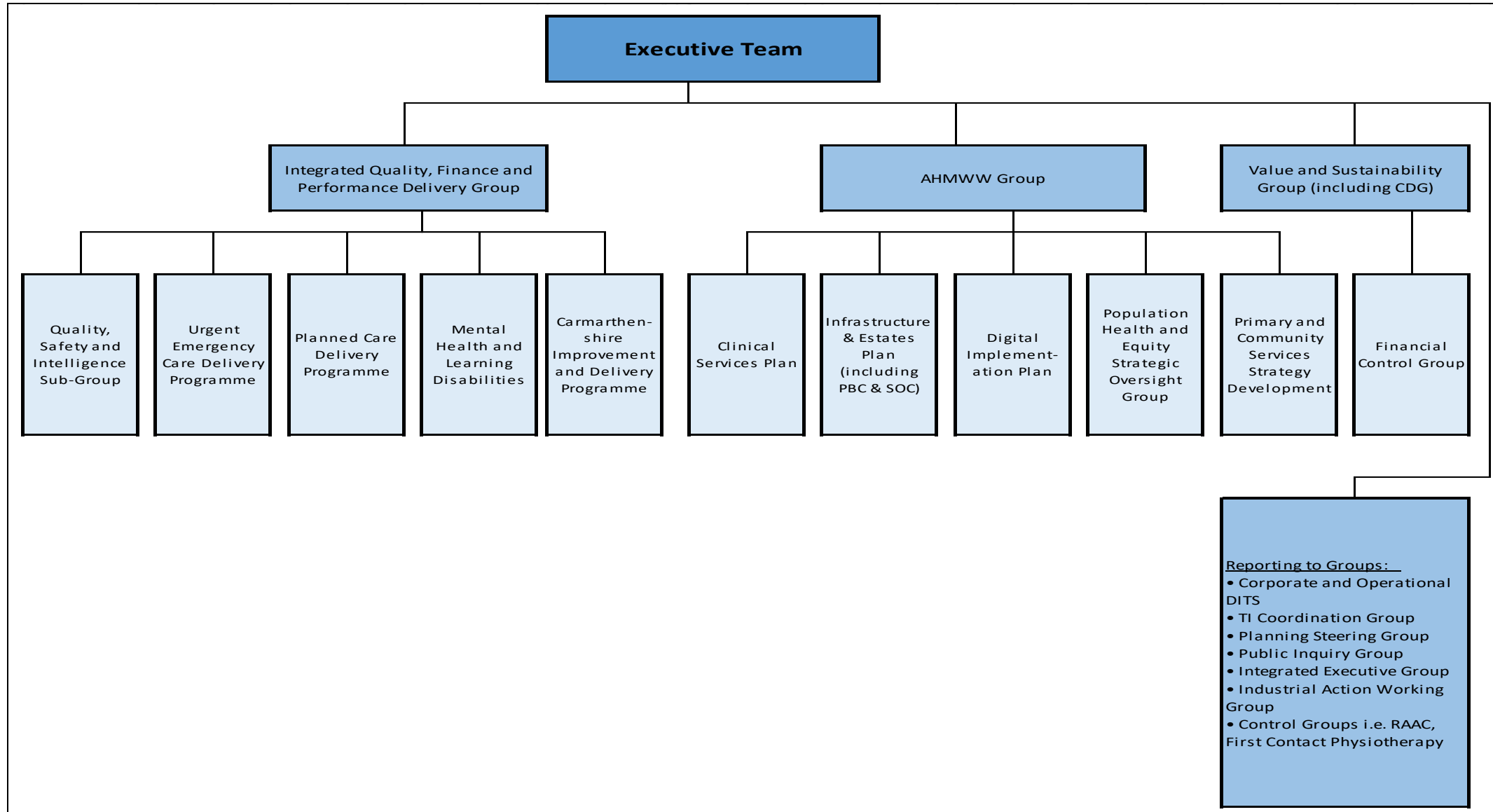
Domain	Escalated up <span style="color: red;">↑</span>	De-escalated <span style="color: green;">↓</span>
Quality	-	-
Governance	Medical Directorate Pathology Radiology	Director of Operations (Central Ops)
Workforce	Corporate Services Medicines Management	Planned Care Women and Children
Finance, Strategy and Planning	Ceredigion County Director of Nursing Director of Strategy and Planning Withybush Hospital	Cancer and Oncology Facilities Radiology
Fragile Services	-	Prince Philip Hospital Women and Children
Performance & Outcomes	-	Ceredigion County

# New Executive Team Governance Arrangements



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# New Executive Team Governance Arrangements



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- **Executive Team:** Provides strategic oversight and decision-making for the TI process
- **TI Coordination Group:** Coordinates and manages the Health Board's response to the TI Framework

## Reporting Groups:

- **Value and Sustainability:** Focuses on financial improvement and sustainability initiatives (Planning Objectives 1 and 2)
- **Integrated Quality, Finance and Performance Delivery:** Oversees performance management and delivery of the Annual Plan/ Integrated Medium Term Plan (IMTP) (Planning Objectives 3, 4 and 5)
- **A Healthier Mid and West Wales:** Ensures delivery of the Health Board's strategy and associated programmes (Planning Objectives 6, 7, 8, 9 and 10)

# Mapping of TI domains to the new arrangements



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Domain	Reporting group	Programme (PO)	Committee
Overall	Executive Team	All POs	ARAC
B1: Finance intervention	Value and sustainability	PO 1, PO 2	SRC
B1: Planning intervention	TI Coordination group	All	SDOD
B1: Strategy intervention	AHMWW	PO 6, 7 & 8	SDOD
B1: Regional planning	IQPFD	PO 4	SDOD
B2: Performance and outcomes	IQPFD	PO 3, 4 & 5	SDOD
B3: Fragile services	AHMWW	PO 6, 7	SDOD
B4: Governance	TI Coordination group	N/A	ARAC
B5: Leadership, capability and culture	TI Coordination group	N/A	PODCC
B6: Quality of care	IQPFD	All	QSEC

# TI Coordination Group - outputs and outcomes



GIG  
CYMRU  
NHS  
WALES

Bwrdd Iechyd Prifysgol  
Hywel Dda  
University Health Board

## Objectives:

Coordinate and oversee all Targeted Intervention actions across the Health Board

- Establish strong governance mechanisms and ensure accountability in all domains
- Align interventions strategically and manage them effectively with clear responsibility and accountability

## Outcomes:

Ensure consistent and robust oversight by the Board and its Committees through:

- Continuous updates and communications to the Executive Team and Welsh Government
- Reinforce governance structure, ensure strategic directives are followed, and address performance issues

## Domains:

- Governance (D5): Embed robust governance structures, refresh risk management framework, and conduct governance maturity assessments

## Maturity Matrix Alignment:

- Systems and Processes for Performance, Accountability, and Improvement (D7): Develop systems to enhance performance management and accountability, align the organisation, and embed sustainable change



## Objectives:

- Establish a sustainable financial framework supporting long-term goals
- Create a financial roadmap addressing challenges and aligning with strategy
- Integrate financial strategies with clinical and operational needs

## Outcomes:

- Create and maintain a Board-approved financial roadmap
- Implement targeted saving schemes and cost control measures
- Stabilise workforce costs through programmes such as nurse stabilisation programmes
- Enhance financial oversight through the Finance Control Group

## Domains:

- Financial management and sustainability (D1): Develop financial approaches ensuring long-term viability
- Workforce development (D6): Integrate workforce planning with financial strategies

## Maturity Matrix Alignment:

- Realistic and Deliverable (D6): Ensure plans are realistic and achievable
- Systems and Processes for Performance, Accountability, and Improvement (D7): Develop financial governance systems enhancing accountability



## Objectives:

- Ensure high-quality, financially sustainable clinical services
- Align services with A Healthier Mid and West Wales strategic directives
- Provide strategic oversight of the Clinical Services Plan
- Integrate clinical needs, financial planning, and infrastructure
- Future-proof services to adapt to health demands within budget

## Outcomes:

- Regular updates of Clinical Services Plan to align with needs and goals
- Integration of service delivery with sustainable financial strategies
- Development of estate and infrastructure plans for efficient operations
- Implementation of strategic improvements to enhance outcomes and sustainability

## Domains:

- Clinical strategy and oversight (D2, D4, D7): Craft a cohesive, feasible, and effective clinical strategy

## Maturity Matrix Alignment:

- Strategy Development (D1): Ensure comprehensive and sustainable Clinical Services Plan
- Dynamic and Engaged Planning (D3): Foster dynamic planning aligned with needs and goals
- Operational Planning (D4): Align strategies with operational and financial plans for efficient delivery

## Objectives:

- Achieve in-year delivery of Annual Plan targets
- Integrate Ministerial Priorities and Planning Objectives into operations
- Ensure adoption of best practices, quality management, and resource allocation

## Outcomes:

- Consistently achieve performance and financial targets
- Implement quality improvement initiatives improving patient outcomes
- Establish effective governance and accountability mechanisms
- Strategically adopt best practices enhancing service quality and efficiency

## Domains:

- Quality management (D7), operational performance (D3), strategic planning and governance (D2, D5)

## Maturity Matrix Alignment:

- Dynamic and Engaged Planning (D3): Adaptable and responsive planning
- Operational Planning (D4): Align operations with financial planning and resources
- Best Practice Approach to Improvement (D5): Integrate best practices into operations
- Realistic and Deliverable (D6): Create achievable plans aligned with priorities and goals
- Systems and Processes for Performance, Accountability, and Improvement (D7): Enhance performance management and governance systems

# Internal Escalation Framework



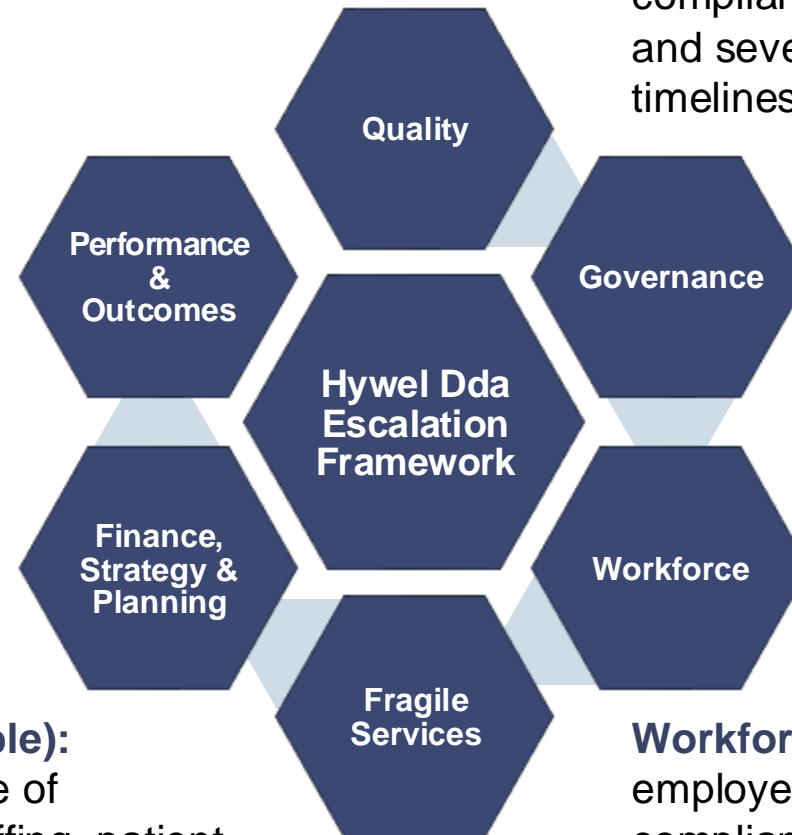
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**Performance & Outcomes:** Evaluates performance against key targets and agreed improvement trajectories. Escalation levels are determined by the extent of underperformance and the effectiveness of recovery plans.

**Finance, Strategy & Planning:** Focuses on financial performance, including overspend, budget management, and the credibility of recovery plans. Escalation levels are determined by the extent of overspend, the robustness of financial plans, and the effectiveness of savings initiatives.

**Fragile Services (Timely, Safe, Equitable):** Assesses the sustainability and resilience of services, considering factors such as staffing, patient safety, and service continuity. Escalation levels are based on the level of risk to service delivery and the effectiveness of mitigating actions.



**Quality:** Focuses on patient safety incidents, complaints, medical examiner issues, and Duty of Candour compliance. Escalation levels are based on the number and severity of incidents, open complaints, and the timeliness of Duty of Candour processes.

**Governance:** Assesses the effectiveness of quality governance meetings, risk management, audit and inspection compliance, and decision-making processes. Escalation levels are determined by the regularity and quoracy of meetings, outstanding actions, and the timeliness of policy updates.

**Workforce:** Evaluates sickness absence rates, employee relations cases, mandatory training compliance, and adherence to the career framework. Escalation levels are based on the number of unresolved cases, sickness absence rates, and compliance with training and career development requirements.



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## **CLINICAL SERVICES PLAN (CSP)**

### **Shortlist Options Development**

(5 September 2024)

## **SUMMARY REPORT**

**9 September 2024**

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## Introduction

Hywel Dda University Health Board's Clinical Services Plan seeks to deliver services in the medium term in line with Hywel Dda's longer term vision contained in the "A Healthier Mid and West Wales" strategy.

The Clinical Services Plan (CSP) programme has an opportunity to look at how and where the Health Board provides services, in line with the strategy's goal to deliver care closer to home, while also seeking to make specialist services more sustainable.

A clinically led process representing the nine clinical service areas has been implemented to develop options which would meet the aim and objectives of the programme:

### **Aim**

- Develop a series of options for delivery of the Clinical Services Plan programme in response to service fragilities or unsustainability based on the principles of care that is safe, sustainable, accessible, and kind. The development of a Clinical Services Plan is also an action within the Targeted Intervention requirements of Welsh Government.

### **Objectives**

- Respond to Critical Care service fragility.
- Respond to Emergency General Surgery service fragility.
- Sustainably improve access and reduce waiting times for patients for Planned Care (Ophthalmology, Dermatology, Urology and Orthopaedics) and Diagnostics (Endoscopy and Radiology).
- Improve standards and respond to service fragility within the Stroke service.

An in-person session was convened on 5<sup>th</sup> September 2024. It had five objectives:

- Recap on the work developed and shared since the last session on 9<sup>th</sup> July, which was held online.
- Receive additional information developed but not shared before the session; this included outputs from Allied Health Professions and Health Sciences, Finance and Estates.
- Agree the simple option wording to describe each of the four options.
- Finalise the Strengths, Weaknesses, Opportunities and Threats (SWOT) assessment for each of the four options.
- Develop a presentation to be shared with the room on 6<sup>th</sup> September using the simple option wording and the SWOT assessment as the basis of the information.

The in-person session was attended by clinicians and operational leads of the nine specific clinical services, and staff members and stakeholders representing interdependent services:

- 42 staff members, including service, interdependent services, and support services representatives

- 2 Health Board Executives, including the Interim Chief Executive Officer
- 1 Welsh Ambulance Service Trust (WAST) representative
- 2 Welsh Government representatives
- 2 Trade Union representatives
- 9 Transformation Programme Office team members who provided facilitation and scribing for the day

## Methodology

The in-person session commenced with Professor Philip Kloer, Interim Chief Executive Officer of Hywel Dda University Health Board, welcoming attendees and reminding them of their progress to date regarding the Clinical Services Plan (CSP) programme.

Ben Rogers, Principal Programme Manager, presented feedback on the task and finish group progress, noting that this had been previously covered in greater detail on 3<sup>rd</sup> September in an online drop-in session, with facilitators able to share this information throughout the day. Participants were invited to ask questions, but none were received.

John Davies, Head of Physiotherapy Service and Jon Adams, Interim Head of Occupational Therapy, presented the summary findings and key messages of the Allied Health Professions and Health Sciences SWOT assessment workshop which took place on 2<sup>nd</sup> September. The purpose of the workshop was to appraise the four options from this clinical perspective, with a series of questions posed to the Options Development Group for consideration.

Following the presentation, participants were invited to ask questions; below are the captured questions and answers:

- Has workforce modelling across community and acute sites been considered to provide emergency assessments in A&E / Intermediate Care?
  - Need to know the details, sighted on the proposals regarding preventing admissions, essential to be sighted on risk if workforce moved around the system and fragility.
- What is the strategy for recruitment – there are vacancies at present, it is not easy to move staff around the system from their current base due to family and other commitments. What is the feasibility on how this can be done?
  - There are clear challenges due to lifestyle choices – how to match this, workforce strategy – training and age profile and creating centres of excellence to attract workforce into the area, need a medium-term strategy on how to attract people.
  - Need to look at baseline of staff and their skills and need to communicate this to services.
- Have you looked at prehabilitation services in hospitals and in the patient's home?
  - We have looked at this; there is prehabilitation in Orthopaedics at present and it has benefits to patients in the pathway.

Rhian Davies, Assistant Director of Finance, and Julian Wheeler-Jones, Discretionary Capital Projects Manager, presented their SWOT assessments from a revenue costings and capital costings perspective. The SWOTs were carried out on a programme basis, as the findings related to all four options, with the difference between them being the costs. Prior to sharing the costing detail, assumptions and information considered to develop the costings were shared with the room followed by the capital costs for each option, and the breakdown of revenue costs by service in each option.

Following the presentation, participants were invited to ask questions; below are the captured questions and answers:

- If this programme is looking at the medium term until the proposed new hospital is in place, is this level of spend wise? 'Is it spend to save or spend to spend?'
  - (Answered by the Interim Chief Executive Officer) When the Health Board developed its strategy, we were already concerned about the fragility of clinical services at that point. If Welsh Government does support our business cases to build a new hospital, there will be up to ten years until that is operational. This piece of work is therefore important – we cannot just wait for the new hospital to be built to address the fragility of our services – we must tackle the fragility of our services now, and this piece of work does that.
- Now that we have seen the costs for the options, why can't we put together the cheapest option based on the costings for each service in the options?
  - If the Board decide to go out to engagement or consultation about the options, it can invite views about any other ideas for options. At that point, it would be possible to consider what works well or less well in the options (including cost) and suggest another option. The detailed work undertaken to develop the options for the Clinical Services Plan will be presented to the Board in November and will support the Board to make their decisions.
- Why can't we remove beds from the system if we are already using more than other health boards?
  - There could be opportunities that have not been considered or modelled yet, for example, the opportunity to remove beds as a result of an option. The task and finish groups will consider opportunities to remove / offset costs within the options over the next few weeks. The costs presented at the workshop are indicative costs only.
- The process went into fewer options early, without the opportunity to consider more options at an early point before shortlisting which could have had more financial benefits.
  - The programme was working towards a specific deadline for reporting the final options to Board. All the Options Development Group workshops were planned to work through the required process in order to achieve this deadline. At a certain point during the process (after the options were shortlisted), it was not possible to make any further changes to the options. If the Board decides to engage or consult about the options, however, further options can be proposed.
- It has been hard working on the options to see them at this stage as being potentially financially unviable, especially as we have done the work to make them clinically viable and sustainable.
  - There could be opportunities that have not been considered or modelled yet – for example, the opportunity to remove beds as a result of an option. The task and finish groups will consider opportunities to remove / offset costs within the options over the next few weeks. The costs presented at the

workshop are indicative costs only. The work undertaken so far is all valuable as it will present the Board with information to help it deliberate and make decisions.

As the financial assessment of the options provided new information that had not been shared previously, a plenary session was held to test the indicative cost estimates and provide feedback. The following responses were received:

- Critical Care – Still need additional consultants in Prince Philip Hospital to provide support to Enhanced Care Units, but there are potential opportunities in the future to change the workforce model, but this will not be understood until looking into how the pathway works.
- Critical Care – Option Three and Option Four have considerably fewer transfers as care will continue to be delivered in the same place, so the transport costs would be expected to be lower than the costs in Option One and Option Two.
- Critical Care – Any option with Enhanced Care Units needs to consider the acuity of patients and how they arrive and access care in hospitals, i.e. Withybush Hospital has an Accident and Emergency department, Prince Philip Hospital does not.
- Emergency General Surgery – The cost for all four options is the same, why is there no variation in the cost when there are two different models?
  - There are two surgical SDECs in each option
- Therapies – Has work been captured on beds that could be closed when services move?
  - There could be opportunities that have not been considered or modelled yet – for example, the opportunity to remove beds as a result of an option. The task and finish groups will consider opportunities to remove / offset costs within the options over the next few weeks.
- General – Are these costings current costs or additional costs as some of these areas are already established, such as at Withybush Hospital which already has a surgical SDEC in place.
  - The indicative costs of the options have only become available over the past week. The task and finish groups will be asked to check the accuracy of these costs over the coming weeks.

Alex Martin, Principal Programme Manager, introduced the group tasks that the option development groups would spend the remainder of the session working on. The three tasks were to refine the simple option wording for their option, finalise the SWOT assessment for their option, and develop an option presentation.

Participants were reminded that the simplification of the option wording and finalising the SWOT assessment was not an opportunity to reconfigure the options, but to make the options easier to understand, with the work that has been completed to date sitting underneath to provide the detail.

## Outputs

The four option development groups spent the remainder of the session working through each of the three tasks at their own pace, calling on service colleagues and support services in the room to support them as necessary.

The SWOT assessments which informed the option presentations were not used on 6th September but can be found within this report as an appendix (Appendix A).

The simple option definitions and presentations were added into the presentation pack for 6<sup>th</sup> September, ready to be presented during the shortlist scoring session.

## Next Steps

- 6<sup>th</sup> September 2024
  - Weighting the evaluation criteria
  - Presentation of the four options
  - Scoring of the four options

The process is underpinned by continuous engagement including, but not limited to, check and challenge sessions with wider colleagues and service users.

## Appendix A – Strengths, Weaknesses, Opportunities and Threats Assessments

### Option 1

	Criteria	Strengths	Weaknesses	Opportunities	Threats
Safe	Number of patients likely to need transport between sites when unwell	No transfer between sites for Dermatology or Endoscopy with little to no impact for Ophthalmology and Urology.	<p>Increase in Stroke and Critical Care patients requiring transfer.</p> <p>There may be increased numbers and delays in transporting Emergency General Surgery patients from Withybush Hospital to Glangwili Hospital - this could cause delays in patients who need to go to theatre.</p> <p>Potential increase in radiology patients requiring transfer to Glangwili Hospital for Emergency Intervention</p>		
	Compliance/ attainment of standards	<p>Anticipated improvement in standards for most services.</p> <p>Greatest positive impact for Critical Care compared to the other options.</p>	<p>No change in standard compliance for Radiology, with negative impacts identified for Emergency General Surgery.</p> <p>Stroke patients attending Bronglais are unlikely to be admitted into a Stroke unit within 4 hours due to transfer times.</p>		Radiology provision will allow Urology to meet basic requirements.

<p><b>Impact on internal services (e.g. Accident &amp; Emergency, Theatres, Paediatrics, Respiratory)</b></p>	<p>Stroke and Orthopaedics to use existing spaces, as well as swapping Urology theatre lists between sites to not overload theatre capacity.</p> <p>Radiology would be able to provide more services on acute sites, and emergency radiology in Glangwili can be delivered faster.</p> <p>No estate changes required at Bronglais, Withybush or Glangwili hospitals for Endoscopy.</p>	<p>Additional space and capital investment required on sites to manage increased demand of centralisation.</p> <p>Concerns around the impact on Withybush Hospital Emergency Department with the removal of Critical Care and Emergency General Surgery, services outside of CSP scope being displaced and impact on theatre lists.</p> <p>Increased pressure on Withybush Hospital Emergency Department having to care for intensive care patient prior to transfer.</p> <p>If beds are not closed when services move from sites, this will result in an increase in demand for therapies across the hospital network</p>	<p>Opportunities to use space left behind on sites for new purposes.</p> <p>Introduction of new clinical models, procedure rooms and roles can reduce the impact on services and theatres.</p> <p>Ability to co-locate services and phase implementation to reduce or mitigate need to displace other services or teams.</p> <p>Attainment of standards will improve staff retention and recruitment.</p> <p>Attainment of standards could lead to potential research funding.</p> <p>Attainment of standards should result in a reduction if complaints and incidents.</p> <p>Potential to explore rehabilitation ward area in sites where services are removed.</p>	<p>Capital funding is not secured for estate change or equipment and services outside of the scope of CSP may be resistant to change if there are no perceived benefits for them.</p> <p>Space requirements to bring Ophthalmology together on an acute site are limited within existing footprints and would require other services to move.</p> <p>Workforce investment required to support Endoscopy in HSDU and Pathology.</p> <p>Ability to recruit and retain into Withybush ED, anaesthetics and surgical services.</p> <p>There is a risk to the viability of Withybush ED.</p>
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	<p><b>Impact on external services (e.g. Health boards, Welsh Ambulance Service Trust, Acute Critical Care Transfer Service)</b></p>	<p>Ophthalmology regional working will not be affected.</p> <p>Increased Radiology capability to support North and Mid Wales patients, providing care closer to home.</p>	<p>WAST resources currently not available to deliver this option.</p> <p>Impacts identified on NEPTS for transfer and due to changes in Radiology, Ophthalmology, Orthopaedics and Urology.</p> <p>Patients will require secondary transfers for Critical Care and Stroke, and if ACCTS are unavailable then an intensivist would need to accompany Critical Care patients.</p>	<p>Time for planning with WAST to identify and plan capacity to support model, including Dedicated Ambulance Vehicles.</p> <p>Care closer to home through outreach clinics maybe best for patients but may impact treat in turn models.</p> <p>Opportunities to support Swansea Bay and absorb Mid Wales patient activity currently being sent to Aneurin Bevan.</p>	<p>Potential increased contractual cost to scaling WAST service and delays in transfers and repatriations may create additional Delayed Pathways Of Care.</p> <p>Potential loss of SLA income with BCUHB and PTHB if the services are no longer available in Bronglais Hospital.</p>
<p><b>Sustainable</b></p>	<p><b>Clinically sustainable – Patient demand to require service</b></p>	<p>Centralisation of service will provide more efficient use of beds and theatre lists for Critical Care, Dermatology, EGS, Ophthalmology and Urology.</p> <p>Population and demand growth estimations indicate that Endoscopy will be able to run required level of activity.</p> <p>Repatriation and use of Early Supported Discharge Teams will enable bed flow to stop sites becoming overloaded for Stroke and EGS without needing additional beds.</p>	<p>Requires beds to be in Glangwili hospital with transport in place for transferring EGS patients.</p> <p>For Orthopaedics, Ophthalmology and Urology the model is expected to reduce waiting lists but may not mitigate against demand growth over the longer term if waiting list is not cleared.</p> <p>There is not enough demand in the EGS model to accommodate the increased rota, which could result in fewer opportunities for consultants to undertake surgery - running contrary to GIRFT recommendations of repeating types of surgery. Operating sessions per consultant will be reduced.</p> <p>Additional Radiology capacity at other sites required to take the planned</p>	<p>Centralisation of Ophthalmology services will benefit patients as there will be more clinical support available and increased patient throughput.</p> <p>Could look at reduction of Length of Stay and same day discharge of Arthroplasty in Orthopaedics.</p> <p>Opportunity to optimise allocated Endoscopy sessions.</p>	<p>Dependent on capital availability for procedure rooms, theatres and equipment purchasing or relocation.</p> <p>Dependent on dedicated ringfenced beds to protect service flows and transport to transfer patients.</p> <p>Potential development of Radiology backlog without extension of hours at other sites.</p> <p>Additional funding will be required to support Endoscopy demand, particularly in HSDU and Pathology.</p>

			diagnostic activity transferred away from Glangwili.		
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<p><b>Workforce sustainability – Substantive workforce available to meet solution in 2-4 years</b></p>	<p>Centralisation of services will provide improved recruitment with opportunities to focus on speciality and rotate between sites.</p> <p>Consolidation of rotas in EGS make the consultant roles more appealing for recruitment.</p> <p>Improved training with centralised senior staff able to offer more time to trainees.</p> <p>Along with option 3 requires lower numbers of additional staff.</p>	<p>Existing staff approaching retirement age may leave before model is implemented creating issues with the model.</p> <p>Overnight accommodation may be needed where staff need to be able to attend site within 30 minutes when on call, especially if they are not living locally.</p> <p>Dermatology and EGS would need to recruit staff in order to make the option work, currently holding vacancies.</p> <p>Additional recruitment required across medical, nursing and therapies.</p> <p>Therapies are attached to sites rather than services, movement of services will result in lack of capacity to meet cohort demand.</p>	<p>Creating a Urology hub will help attract specialist nurses and consultants. This will help develop a larger, skilled workforce over the medium to long term.</p> <p>Greater opportunities for 'Grow your own' recruitment and training.</p> <p>Opportunities to develop new Nurse Consultant roles in Dermatology in the longer term to mitigate national shortage of consultants.</p> <p>Potential to use natural turnover and recruitment in therapies and pharmacy to move resources between sites to match patient cohorts.</p> <p>Creating acute stroke units will help attract Advanced Clinical Practitioner or Nurse Consultant roles</p>	<p>There are national shortages at consultant level for Dermatology.</p> <p>Risk that staff may be unwilling or unable to relocate, impacting service change implementation.</p> <p>Staff outside the 30 minute radius for EGS on call may be unwilling to join the rota, even if accommodation is made available.</p> <p>May take 2-4 years to train Endoscopy staff to deliver the model.</p> <p>Therapies staff are not ringfenced for services, will need alignment with services to support attainment of standards and deliver activity.</p> <p>Additional Theatre and Outpatient staff may be required to meet demand of centralised services.</p>
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	<p><b>Financial sustainability – Cost difference between current delivery and option</b></p>	<p>Along with option 3 requires lower levels of revenue investment.</p>	<p>Funding for additional posts required, as well as funding for transportation/transfer services to manage change in delivery.</p> <p>Savings identified will be dependent on Capital funding being provided to allow service change to be delivered.</p> <p>Increased activity is likely to increase costs on non-pay and consumable items.</p>	<p>Potential to save on funding for medical costs</p> <p>Opportunity to look at a reduced 1:10 EGS rota to increase surgical sessions per consultant while remaining attractive to new recruits, or consider taking work to boost surgical sessions per consultant. This could be a long-term saving or income generation stream.</p> <p>Potential longer-term savings through reduced travel costs.</p> <p>Reduction in requirements of agency usage and Additional Duty Hours through recruitment to substantive posts.</p> <p>Opportunity to generate income from Bowel Screening Wales services.</p> <p>Centralisation may increase likelihood of additional research funding</p>	<p>Interdependencies between service moves and estate refurbishment mean that some business cases will need to be approved as part of a phased package to allow option to be delivered.</p> <p>Ophthalmology use of Bronglais Hospital is dependent on services vacating theatre sessions, but finances remain.</p>
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	<p><b>Reduction in waiting lists across diagnostics, treatments, and surgery</b></p>	<p>Reductions in waiting times and length of stays will support overall reductions in waiting lists.</p> <p>Centralised rotas reduce the risk of cancellations with multiple staff on a single site.</p>		<p>Opportunities to increase patient flow, enabling Critical Care patients to move to ward faster and facilitate discharge planning.</p> <p>Ringfencing of centralised staff can create more Dermatology consultant sessions and opportunity for EGS consultants to undertake more elective work.</p> <p>Centralisation of Ophthalmology equipment reduces cancellations due to equipment faults, and utilising treatment rooms frees up theatre capacity on sites.</p> <p>Opportunity to work regionally with Swansea Bay.</p>	<p>Increased demand for Urology services exceeds capacity gained through centralising services, resulting in static waiting lists in the longer term.</p> <p>Following the centralisation of Critical Care, there is a threat that there could be an increased demand on patient flow for the wider service at Glangwili Hospital.</p>
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Accessible	Patient travel time to sites	<p>Reduction in travel time and/ or visits for those needing elective Radiology or Ophthalmology.</p> <p>No change for Orthopaedics patients as that is how service is currently being delivered, and EGS and Stroke patients will still attend local hospital for initial treatment.</p> <p>Minimal impact on those accessing Critical Care, Dermatology or Urology services in Carmarthenshire.</p>	<p>Reduction in number of community sites will result in some patients needing to travel further in some cases for Ophthalmology and Radiology, with longer transfers to Glangwili for emergency interventional Radiology.</p> <p>Increased travel time for Stroke and Critical Care visitors if patients are transferred onwards.</p> <p>Increased travel time expected for Dermatology, Ophthalmology, Orthopaedics and Urology patients travelling from Pembrokeshire and Ceredigion.</p> <p>Centralisation of Endoscopy specialities will require patients to travel further.</p> <p>Car Parking for staff, patients and visitors on centralised sites is likely to become busier, compounding existing issues.</p>	<p>Opportunities to carry out patient reviews to reduce the numbers of transfers for Critical Care and EGS.</p> <p>Centralisation of Urology services will mean that multiple activities can be carried out for patients in a single attendance, reducing the need for multiple visits.</p> <p>Opportunity to deliver some Dermatology work in the community to reduce travelling to Prince Philip Hospital.</p> <p>Opportunity to develop digital services to support consultations.</p>	<p>NEPTS service provided by WAST is unable to meet the demand following centralisation of service.</p>
	Transfer travel time impact on options	<p>Crews would be conveying Stroke patients locally and treat and transfer model ensures TIAs and mimics are identified locally.</p>	<p>Will be a lesser increase than option 2 in transferring Stroke and EGS patients between sites, with patients requiring secondary transfers to other sites.</p> <p>More frequent need for WAST need to transfer Critical Care patients between sites if ACCTS are unavailable, they will need to be accompanied by an intensivist impacting the service provision on site.</p>	<p>Dedicated Transfer Vehicles would provide transport for the service to reduce transfer delays.</p>	<p>Resources not currently available to deliver this option.</p> <p>Resources will be lost for considerable periods of time through secondary transfers, as well as increased patient waiting time for a transfer vehicle.</p> <p>Will require dedicated bed availability to allow bed to bed transfer and reduce transfer delays.</p>

Kind	Impact on local communities/ infrastructure when developing community sites	<p>Urology to provide more Trial Without Catheter activity from community locations, reducing pressure on acute sites.</p> <p>Urology moving to Prince Philip Hospital will be counterbalanced by Ophthalmology moving to Glangwili Hospital, mitigating impacts on parking.</p> <p>Estates at Prince Philip allow for a better patient experience due to site layout.</p>	<p>Reduced community sites will mean Llandoverly's Radiology and Ophthalmology's Diabetic Eye Screening Wales patients will need to travel further to access services.</p> <p>Increased flow at Withybush Hospital site due to increased Stroke patients transferring in and out of site, with increased flow at Prince Philip Hospital due to increased activity through centralisation of Dermatology and Urology services.</p>	<p>Dermatology patients and visitors attending a centralised site should free some parking capacity across other sites.</p>	<p>Overall staff and patient/ visitor parking could be overwhelmed following centralisation of sites.</p>
	Impact on staff and patients needing to travel to access regional care pathways	<p>No change to regional care pathways above those already being delivered for Urology and Orthopaedics.</p>	<p>Dermatology referrals for regional pathways may increase with increased capacity to see more patients.</p> <p>Current regional working arrangements for Orthopaedics are not addressing Hywel Dda patient needs.</p> <p>There is a deficiency in the number of appropriately skilled staff to accompany patients needing intensive care during transfer.</p>	<p>Regional job planning can support local recruitment and service delivery.</p>	<p>Regional recruitment may result in staff being unwilling to travel to Hywel Dda or choosing not to apply for roles.</p>
	Amount of activity taking place in a community setting	<p>Increase in Urology activity delivered in the community.</p> <p>X-Ray services remaining in community sites will alleviate pressure on acute sites</p>	<p>Reduction in number of community sites providing Ophthalmology services</p>	<p>Opportunity to develop community Dermatology services as spokes from the acute site hub.</p> <p>Centralisation of Ophthalmology onto fewer community sites reduces risk of cancellation due to staff absence or equipment failure and maximises equipment usage.</p> <p>Opportunity to expand x-ray services at Cardigan Integrated Care Centre and Tenby Hospital</p>	

	<p><b>Impact on population health outcomes</b></p>	<p>Health Impact Assessment identifies that the option optimises interventions, considers partnership working, engagement, transparency and leadership and avoids widening inequalities.</p>	<p>Health Impact Assessment identifies consideration of impacts on deprived communities, protected characteristics, vulnerable groups, and geographic communities which may face difficulties through increased travel times and associated costs, explored more fully within the Equality Impact Assessments.</p>	<p>Data systems in place or due to be implemented will provide close monitoring in health impacts during and following implementation.</p> <p>Auditing systems, research projects and external monitoring (such as the Armed Forces Covenant and Welsh Government reporting) will further support monitoring of impact.</p>	
	<p><b>Addressing barriers to care (telemedicine, transport enablers, patient support)</b></p>	<p>Use of virtual platforms by Stroke will mitigate increased travel time and care further from home.</p> <p>Dermatology will provide clinics and services from the community, reducing barriers to care.</p> <p>Orthopaedics to include more virtual consultations, already running upper limb and hand virtual consultations.</p>		<p>Opportunity to develop community Dermatology services as spokes from the acute site hub, improving equity of care across acute and community sites.</p> <p>Opportunity to make the Ophthalmology pathways less complex, with fewer repeat visits for patients following changes.</p> <p>Moving or retaining care in the community will reduce demand on car parking for people needing to travel to centralised acute sites.</p>	

	<p><b>Addressing barriers to equality</b></p>	<p>While there may be some decrease in equity of access for Critical Care and EGS, equity of care will be increased through the stabilisation and standardisation of care delivered from Glangwili Hospital which will also support person centred delivery.</p> <p>Orthopaedics and Urology will be able to prioritise patient needs through centralised lists rather than by waiting time, ensuring those most in need are treated sooner.</p> <p>Centralised Ophthalmology waiting list for all counties inclusive of Powys will ensure equity of care following change.</p> <p>Trial Without Catheter services for Urology will take place in community/ closer to home reducing travel time impact. A specialised unit for Urology will also improve privacy and dignity in consultations for people with gender reassignment.</p> <p>A centralised Urology unit and complex orthopaedic services in Prince Philip will be better than Glangwili due to:</p> <ul style="list-style-type: none"> <li>- Access to the hospital is improved</li> <li>- Access within the hospital is easier than at Glangwili</li> <li>- Disabled parking access is improved in Prince Philip than Glangwili</li> <li>- Llanelli is a generally more deprived area than Carmarthen, so having a centralised site in Llanelli will be easier for the local population</li> </ul>	<p>Negative impact for Critical Care, Radiology, Dermatology, Stroke, EGS, Ophthalmology, Orthopaedics and Urology due to centralisation of services impacting equity to access around staff and patient travel (Geographic equality) and cost of travel and time spent attending appointments (socio-economic).</p> <p>Families of stroke patients from Ceredigion, Powys and Gwynedd are likely to face barriers to supporting inpatients and being part of person-centred care.</p>		
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## Option 2

	Criteria	Strengths	Weaknesses	Opportunities	Threats
Safe	Number of patients likely to need transport between sites when unwell	No transfer between sites for Dermatology or Endoscopy with little to no impact for Ophthalmology and Urology.	<p>Increase in Stroke and Critical Care patients requiring transfer.</p> <p>There may be an increase and delays in transporting Emergency General Surgery patients between Withybush Hospital and Glangwili Hospital - this could cause delays in patients who need to go to theatre.</p> <p>Potential increase in radiology patients requiring transfer to Glangwili Hospital for Emergency Intervention.</p> <p>This option is likely to have the greatest numbers of patient transfers.</p>		
	Compliance/ attainment of standards	<p>Anticipated improvement in standards for all services.</p> <p>Greatest overall improvement in attainment of standards.</p>	<p>Negative impacts identified for Emergency General Surgery and performs less well than Option 1 for Critical Care and Option 4 for Endoscopy.</p> <p>Option doesn't allow to meet standards for GPICS from a therapies perspective,</p>	Increased Radiology staff would allow training in ultrasound to ease DVT123 pressure. Additional staff would allow backfill to positions vacant from upskilling.	Radiology provision will allow Urology to deliver care at a higher standard.

	<p><b>Impact on internal services (e.g. Accident &amp; Emergency, Theatres, Paediatrics, Respiratory)</b></p>	<p>Radiology to provide more timely services across acute sites.</p> <p>Additional theatre session requirements in Prince Philip Hospital offset by additional sessions released in Glangwili.</p> <p>No estate changes required at Bronglais, Withybush or Glangwili hospitals for Endoscopy.</p>	<p>Additional space and capital investment required on sites to manage increased demand of centralisation.</p> <p>Concerns around the impact on Glangwili Hospital with increased patient transfers for EGS and Critical Care, increased emergency intensive Radiology requirements and increased demand on theatres.</p> <p>Potential that site will be overloaded.</p> <p>If beds are not closed when services move from sites, this will result in an increase in demand for therapies across the hospital network.</p>	<p>Opportunities to use space left behind on sites for new purposes.</p> <p>Introduction of new clinical models, procedure rooms and roles can reduce the impact on services and theatres.</p> <p>Ability to collocate Dermatology services in Primary Care to reduce or mitigate need to displace other services or teams.</p> <p>Potential to explore rehabilitation ward area in sites where services are removed.</p> <p>Opportunity to remove planned elements of Radiology services into diagnostics hub.</p>	<p>Capital funding is not secured for estate change or equipment and services outside of the scope of CSP may be resistant to change if there are no perceived benefits for them.</p> <p>Space requirements to bring Ophthalmology together on an acute site are limited within existing footprints and would require other services to move.</p> <p>Workforce investment required to support Endoscopy in HSDU and Pathology.</p>
	<p><b>Impact on external services (e.g. Health boards, Welsh Ambulance Service Trust, Acute Critical Care Transfer Service)</b></p>	<p>Ophthalmology regional working will not be affected.</p> <p>Increased Radiology capability to support North and Mid Wales patients, providing care closer to home.</p>	<p>WAST resources currently not available to deliver this option.</p> <p>Impacts identified on NEPTS for transfer and due to changes in Radiology, Ophthalmology, Orthopaedics and Urology.</p> <p>Patients will require secondary transfers to Prince Philip for Stroke, and if ACCTS are unavailable then an intensivist would need to accompany Critical Care patients.</p> <p>Option has the greatest impact on WAST and ACCTS.</p>	<p>Time for planning with WAST to identify and plan capacity to support model, including Dedicated Ambulance Vehicles.</p> <p>Care closer to home through outreach clinics maybe best for patients but may impact treat in turn models.</p> <p>Opportunities to support Swansea Bay and absorb Mid Wales patient activity currently being sent to Aneurin Bevan.</p>	<p>Potential increased contractual cost to scaling WAST service and delays in transfers and repatriations may create additional Delayed Pathways Of Care.</p> <p>Potential loss of SLA income with BCUHB and PTHB if the services are no longer available in Bronglais Hospital.</p>

Sustainable	Clinically sustainable – Patient demand to require service	<p>Centralisation of service will provide more efficient use of beds and theatre lists for Dermatology, EGS, Ophthalmology and Urology, as well as better Radiology pathways for cancer diagnostics.</p> <p>Population and demand growth estimations indicate that Endoscopy will be able to run required level of activity.</p> <p>Repatriation and use of Early Supported Discharge Teams will enable bed flow to stop sites becoming overloaded for Stroke and EGS without needing additional beds.</p>	<p>Requires beds to be in Glangwili hospital with transport in place for transferring EGS patients.</p> <p>For Orthopaedics, Ophthalmology and Urology the model is expected to reduce waiting lists but may not mitigate against demand growth over the longer term if waiting list is not cleared.</p> <p>There is not enough demand in the EGS model to accommodate the increased rota, which could result in fewer opportunities for consultants to undertake surgery - running contrary to GIRFT recommendations of repeating types of surgery. Operating sessions per consultant will be reduced.</p> <p>Unknown if capacity will be able to be met for Ophthalmology on call, unless linking with Swansea Bay UHB.</p> <p>EGS hybrid model - there would be no consultant cover in Glangwili on alternating weeks for Paediatric emergencies.</p> <p>No 7-day therapy service to support increase in Orthopaedic service</p>	<p>Opportunity around national Stroke programme - this option could support that model.</p> <p>Opportunity for Critical Care to develop a Medical Intensive Care Unit service within Hywel Dda UHB. ACCTS/EMRTS Southwest Wales hub is an option.</p> <p>Opportunity to optimise allocated Endoscopy sessions.</p>	<p>Dependent on capital availability for procedure rooms, theatres and equipment purchasing or relocation.</p> <p>Dependent on dedicated ringfenced beds to protect service flows and transport to transfer patients.</p> <p>Workforce model for therapies support of ESD, for this option, has not been completed.</p>

<p><b>Workforce sustainability – Substantive workforce available to meet solution in 2-4 years</b></p>	<p>Centralisation of services will provide improved recruitment with opportunities to focus on speciality and rotate between sites.</p> <p>Improved options for regional recruitment in Ophthalmology and Orthopaedics with shared posts with Swansea Bay UHB.</p> <p>Consolidation of rotas in EGS make the consultant roles more appealing for recruitment.</p> <p>Improved training with centralised senior staff able to offer more time to trainees.</p>	<p>Existing staff approaching retirement age may leave before model is implemented creating issues with the model.</p> <p>Overnight accommodation may be needed where staff need to be able to attend site within 30 minutes when on call, especially if they are not living locally.</p> <p>Dermatology and EGS would need to recruit staff in order to make the option work, currently holding vacancies.</p> <p>Additional recruitment required across medical, nursing and therapies.</p> <p>Therapies staff are attached to sites rather than services, movement of services will result in lack of capacity to meet cohort demand.</p>	<p>Creating a Urology hub will help attract specialist nurses and consultants. This will help develop a larger, skilled workforce over the medium to long term.</p> <p>Greater opportunities for 'Grow your own' recruitment and training.</p> <p>Opportunities for EGS staff to work closer to home with alternating service provision between Withybush and Glangwili hospitals.</p> <p>Potential to use natural turnover and recruitment in therapies to move resources between sites to match patient cohorts.</p>	<p>There are national shortages at consultant level for Dermatology.</p> <p>Risk that staff may be unwilling or unable to relocate, impacting service change implementation.</p> <p>Staff outside the 30 minute radius for EGS on call may be unwilling to join the rota, even if accommodation is made available.</p> <p>May take 2-4 years to train Endoscopy staff to deliver the model.</p> <p>Therapies staff are not ringfenced for services, will need alignment with services to support attainment of standards and deliver activity.</p> <p>Additional Theatre and Outpatient staff may be required to meet demand of centralised services.</p> <p>Staffing element for hub is unknown as hub functionality has not yet been defined.</p>
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	<p><b>Financial sustainability – Cost difference between current delivery and option</b></p>		<p>Funding for additional posts required, as well as funding for transportation/transfer services to manage change in delivery.</p> <p>Savings identified will be dependent on Capital funding being provided to allow service change to be delivered.</p> <p>Increased activity is likely to increase costs on non-pay and consumable items.</p> <p>Has the greatest level of Capital investment required.</p>	<p>Potential to save on funding for medical and nursing costs on the reduction of EGS beds.</p> <p>Opportunity to look at a reduced 1:10 EGS rota to increase surgical sessions per consultant while remaining attractive to new recruits, or consider taking work to boost surgical sessions per consultant. This could be a long-term saving or income generation stream.</p> <p>Potential longer term savings through reduced travel costs.</p> <p>Reduction in requirements of agency usage and Additional Duty Hours through recruitment to substantive posts and recruitment to joint Hywel Dda and Swansea Bay roles for Ophthalmology.</p> <p>Opportunity to generate income from Bowel Screening Wales services.</p> <p>Opportunity to consider acute site for diagnostic hub rather than site outside of these (following capital cost estimate) or a mobile hub vehicle for planned Radiology</p> <p>Centralisation of Ophthalmology could release Blue Suite in Outpatients</p>	<p>Interdependencies between service moves and estate refurbishment mean that some business cases will need to be approved as part of a phased package to allow option to be delivered.</p> <p>Ophthalmology use of Bronglais Hospital is dependent on services vacating theatre sessions, but finances remain.</p>
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<p><b>Reduction in waiting lists across diagnostics, treatments, and surgery</b></p>	<p>Reductions in waiting times and length of stays will support overall reductions in waiting lists.</p> <p>Centralised rotas reduce the risk of cancellations with multiple staff on a single site.</p> <p>Regional working may improve Ophthalmology access to emergency care Out Of Hours</p>	<p>Stroke patients attending Bronglais are unlikely to be admitted into a Stroke unit within 4 hours due to transfer times.</p>	<p>Transport opportunity to feed model if demand versus capacity mapping is achieved and capacity can be met.</p> <p>Centralisation of Critical Care improves access to diagnostics</p> <p>Reduction in the Dermatology waiting lists gives potential to re-introduce the 'see and treat' aspect for USC patients. Potential in reduction in Paediatric Dermatology wait due to nurse led clinics being able to be re-established. Some opportunities for patients to receive minor ops via Primary Care (minor BCC skin cancers)</p> <p>EGS patients could be repatriated to Withybush Hospital from Glangwili Hospital, beds not used for Emergency General Surgery could be used for repatriation of patients / those requiring non-complex surgery.</p>	<p>Increased demand for Urology services exceeds capacity gained through centralising services, resulting in static waiting lists in the longer term.</p> <p>Model relies on transferring the largest number of Critical Care patients between the 4 options and the risks of transferring patients.</p>
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Accessible	Patient travel time to sites	<p>Reduction in travel time and/ or visits for those needing elective Radiology or Ophthalmology.</p> <p>No change for Orthopaedics patients as that is how service is currently being delivered, and EGS and Stroke patients will still attend local hospital for initial treatment.</p> <p>Minimal impact on those accessing Critical Care, Dermatology or Urology services in Carmarthenshire.</p>	<p>Reduction in number of community sites will result in some patients needing to travel further in some cases for Ophthalmology and Radiology, with longer transfers to Glangwili for emergency interventional Radiology.</p> <p>Increased travel time for Stroke and Critical Care visitors if patients are transferred onwards. Don't know how model will impact patients from Powys/Gwynedd etc, also in terms of supporting families, etc.</p> <p>Need to ensure we have infrastructure to transfer patients, need to have a dedicated transfer system to manage this, and take pressure off/support WAST</p> <p>Increased travel time expected for Dermatology, Ophthalmology, Orthopaedics and Urology patients travelling from Pembrokeshire and Ceredigion.</p> <p>Centralisation of Endoscopy specialities will require patients to travel further.</p> <p>Car Parking for staff, patients and visitors on centralised sites is likely to become busier, compounding existing issues.</p>	<p>Patients being transferred onwards by the Stroke service will see benefits from enhanced care, but need to ensure correct patients go there.</p> <p>Centralisation of Urology services will mean that multiple activities can be carried out for patients in a single attendance, reducing the need for multiple visits.</p> <p>Opportunity to deliver some Dermatology work in the community to reduce travelling to Prince Philip Hospital.</p>	<p>NEPTS service provided by WAST is unable to meet the demand following centralisation of service.</p> <p>Placement of Radiology hub may also impact some patient travel times/ NEPTS demand based on location.</p> <p>May be an impact for Mid Wales Stroke patients as we don't know what neighbouring health boards are doing - how will this impacts the patients and their families, this will be more challenging for northerly patients.</p>

	<b>Transfer travel time impact on options</b>	Crews would be conveying Stroke patients locally and treat and transfer model ensures TIAs and mimics are identified locally.	Has the greatest travel time impact in transferring Stroke and EGS patients between sites, with patients requiring secondary transfers to other sites.  If WAST need to transfer Critical Care patients between sites if ACCTS are unavailable, they will need to be accompanied by an intensivist impacting the service provision on site.	Dedicated Transfer Vehicles would provide transport for the service to reduce transfer delays.	Resources not currently available to deliver this option.  Resources will be lost for considerable periods of time through secondary transfers, as well as increased patient waiting time for a transfer vehicle.  Will require dedicated bed availability to allow bed to bed transfer and reduce transfer delays.
	<b>Impact on local communities/ infrastructure when developing community sites</b>	Urology to provide more Trial Without Catheter activity from community locations, reducing pressure on acute sites.  Urology moving to Prince Philip Hospital will be counterbalanced by Ophthalmology moving to Glangwili Hospital, mitigating impacts on parking.  Estates at Prince Philip allow for a better patient experience due to site layout.	Reduced community sites will mean Llandoverly's Radiology and Ophthalmology's Diabetic Eye Screening Wales patients will need to travel further to access services.  Increased flow at Wityhush Hospital site due to increased Stroke patients transferring in and out of site, with increased flow at Prince Philip Hospital due to increased activity through centralisation of Dermatology and Urology services.  All Prince Philip Hospital Critical Care staff groups will need to travel to Glangwili Hospital, impacting on staff parking.	Dermatology patients and visitors attending a centralised site should free some parking capacity across other sites.	Overall staff and patient/ visitor parking could be overwhelmed following centralisation of sites.
	<b>Impact on staff and patients needing to travel to access regional care pathways</b>	No change to regional care pathways above those already being delivered for Urology and Orthopaedics.	Dermatology referrals for regional pathways may increase with increased capacity to see more patients.  Current regional working arrangements for Orthopaedics are not addressing Hywel Dda patient needs.  Stroke patients unable to travel far following TIA, etc. unable to drive	Regional job planning can support local recruitment and service delivery.	Regional recruitment may result in staff being unwilling to travel to Hywel Dda or choosing not to apply for roles.

			therefore local clinics would be beneficial.		
Kind	Amount of activity taking place in a community setting	<p>Increase in Urology activity delivered in the community.</p> <p>Regional Diagnostics Centre for Radiology will allow for more activity to be delivered in the community.</p>	Reduction in number of community sites providing Radiology services and Ophthalmology services.	<p>Opportunity to develop community Dermatology services as spokes from the acute site hub.</p> <p>Centralisation of Ophthalmology onto fewer community sites reduces risk of cancellation due to staff absence or equipment failure and maximises equipment usage.</p>	Regional Diagnostics Centre for Radiology will need significant capital investment.
	Impact on population health outcomes	Health Impact Assessment identifies that the option optimises interventions, considers partnership working, engagement, transparency and leadership and avoids widening inequalities.	Health Impact Assessment identifies consideration of impacts on deprived communities, protected characteristics, vulnerable groups, and geographic communities which may face difficulties through increased travel times and associated costs, explored more fully within the Equality Impact Assessments.	<p>Data systems in place or due to be implemented will provide close monitoring in health impacts during and following implementation.</p> <p>Auditing systems, research projects and external monitoring (such as the Armed Forces Covenant and Welsh Government reporting) will further support monitoring of impact.</p>	

	<p><b>Addressing barriers to care (telemedicine, transport enablers, patient support)</b></p>	<p>Use of virtual platforms by Stroke will mitigate increased travel time and care further from home.</p> <p>Dermatology will provide clinics and services from the community, reducing barriers to care.</p> <p>Orthopaedics to include more virtual consultations, already running upper limb and hand virtual consultations.</p>		<p>Opportunity to develop community Dermatology services as spokes from the acute site hub, improving equity of care across acute and community sites.</p> <p>Opportunity to make the Ophthalmology pathways less complex, with fewer repeat visits for patients following changes.</p> <p>Moving or retaining care in the community will reduce demand on car parking for people needing to travel to centralised acute sites.</p>	
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	<p><b>Addressing barriers to equality</b></p>	<p>While there may be some decrease in equity of access for Critical Care and EGS, equity of care will be increased through the stabilisation and standardisation of care delivered from Glangwili Hospital which will also support person centred delivery.</p> <p>Orthopaedics and Urology will be able to prioritise patient needs through centralised lists rather than by waiting time, ensuring those most in need are treated sooner.</p> <p>Centralised Ophthalmology waiting list for all counties inclusive of Powys will ensure equity of care following change.</p> <p>Trial Without Catheter services for Urology will take place in community/ closer to home reducing travel time impact. A specialised unit for Urology will also improve privacy and dignity in consultations for people with gender reassignment.</p>	<p>Negative impact for Radiology, Dermatology, Stroke, EGS, Ophthalmology, Orthopaedics and Urology due to centralisation of services impacting equity to access around staff and patient travel (Geographic equality) and cost of travel and time spent attending appointments (socio-economic).</p> <p>Families of stroke patients from Ceredigion, Powys and Gwynedd are likely to face barriers to supporting inpatients and being part of person-centred care.</p>	<p>A centralised Urology unit in Prince Philip will be better than Glangwili due to:</p> <p>Access to the hospital is improved</p> <p>Access within the hospital is easier than at Glangwili</p> <p>Disabled parking access is improved in Prince Philip than Glangwili</p> <p>Llanelli is a generally more deprived area than Carmarthen, so having a centralised site in Llanelli will be easier for the local population</p>	
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### Option 3

	Criteria	Strengths	Weaknesses	Opportunities	Threats
Safe	Number of patients likely to need transport between sites when unwell	<p>Option transfers the fewest patients overall, however there will still be patient transfers for Stroke, Critical Care and EGS at the same level as Option 4.</p> <p>No transfer between sites for Dermatology or Endoscopy with little to no impact for Ophthalmology and Urology.</p>	<p>Increase in Stroke and Critical Care patients requiring transfer.</p> <p>There may be delays in transporting Emergency General Surgery patients from Withybush Hospital to Glangwili Hospital - this could cause delays in patients who need to go to theatre.</p>		<p>Would need to carefully consider management of any new Endoscopy emergencies at community site &amp; transfer to acute hospital site.</p>
	Compliance/ attainment of standards	<p>Anticipated improvement in standards for all services, but at lower levels than Options 2 and 4.</p>	<p>No changes to MRI capabilities or DVT123 ultrasound training in Radiology, and negative impacts identified for Emergency General Surgery.</p>	<p>Potential to improve compliance with Stroke standards.</p> <p>Urology - potential for compliance with the GIRFT recommendations.</p> <p>Reducing reliance on agency staff will provide better continuity of care/compliance with HB standards.</p>	<p>Radiology provision will allow Urology to meet basic requirements.</p>

<p><b>Impact on internal services (e.g. Accident &amp; Emergency, Theatres, Paediatrics, Respiratory)</b></p>	<p>Radiology to provide more timely services across acute sites.</p> <p>Minimal capital investment required for Stroke, equipment needed can be transferred from other sites.</p> <p>Less Critical Care impact due to levels of care remaining largely as they are at each site and delivered within current footprint.</p> <p>Additional theatre session requirements in Prince Philip Hospital offset by additional sessions released in Glangwili.</p> <p>No estate changes required at Bronglais, Withybush or Glangwili hospitals for Endoscopy.</p>	<p>Additional space and capital investment required on sites to manage increased demand of centralisation.</p> <p>Concerns around the impact on Glangwili Hospital with increased patient transfers for EGS and Critical Care, increased emergency intensive Radiology requirements and increased demand on theatres.</p> <p>Potential that site will be overloaded.</p> <p>No community sites have been identified for Endoscopy.</p> <p>If beds are not closed when services move from sites, this will result in an increase in demand for therapies across the hospital network.</p>	<p>Opportunities to use space left behind on sites for new purposes.</p> <p>Introduction of new clinical models, procedure rooms and roles can reduce the impact on services and theatres.</p> <p>Ability to collocate Dermatology services in Primary Care to reduce or mitigate need to displace other services or teams.</p> <p>Potential to explore rehabilitation ward area in sites where services are removed.</p>	<p>Capital funding is not secured for estate change or equipment and services outside of the scope of CSP may be resistant to change if there are no perceived benefits for them.</p> <p>Space requirements to bring Ophthalmology and Urology services together on an acute site are limited within existing footprints and would require other services to move.</p> <p>Workforce investment required to support Endoscopy in HSDU and Pathology, as well as identification of community sites.</p> <p>Impact on ED from downgrade of general surgical services at Withybush. Surgical pts attending ED OOH. Risk of confusion in Primary Care re. advising patients of where to go.</p>
<p><b>Impact on external services (e.g. Health boards, Welsh Ambulance Service Trust, Acute Critical Care Transfer Service)</b></p>	<p>Increased Radiology capability to support North and Mid Wales patients, providing care closer to home.</p> <p>Stronger regional partnership working potential with Swansea Bay UHB in Dermatology and Ophthalmology.</p> <p>Least impact on WAST and ACCTS transport and transfer services.</p>	<p>WAST resources currently not available to deliver this option.</p> <p>Impacts identified on NEPTS for transfer and due to changes in Radiology, Ophthalmology, Orthopaedics and Urology.</p> <p>Patients will require secondary transfers to Prince Philip for Stroke, and if ACCTS are unavailable then an intensivist would need to accompany Critical Care patients.</p>	<p>Time for planning with WAST to identify and plan capacity to support model, including Dedicated Ambulance Vehicles.</p> <p>Requires the least WAST/ ACCTS resource to implement for Critical Care and shares the same model as option 4.</p> <p>Care closer to home through outreach clinics maybe best for patients but may impact treat in turn models.</p> <p>Opportunities to support Swansea Bay and absorb Mid Wales patient activity currently being sent to Aneurin Bevan.</p>	<p>Potential increased contractual cost to scaling WAST service and delays in transfers and repatriations may create additional Delayed Pathways Of Care.</p> <p>Potential loss of SLA income with BCUHB and PTHB if the services are no longer available in Bronglais Hospital.</p>

Sustainable	<p><b>Clinically sustainable – Patient demand to require service</b></p>	<p>Centralisation of service will provide more efficient use of beds and theatre lists for Dermatology, EGS and Ophthalmology.</p> <p>Endoscopy, Urology and Critical Care should be able to support growth in demand in future years.</p> <p>Repatriation and use of Early Supported Discharge Teams will enable bed flow to stop sites becoming overloaded for Stroke and EGS without needing additional beds.</p>	<p>Requires beds to be in Glangwili hospital with transport in place for transferring EGS patients.</p> <p>For Ophthalmology <del>Orthopaedics and Urology</del> the model is expected to reduce waiting lists but may not mitigate against demand growth over the longer term if waiting list is not cleared.</p> <p>There is not enough demand in the EGS model to accommodate the increased rota, which could result in fewer opportunities for consultants to undertake surgery - running contrary to GIRFT recommendations of repeating types of surgery. Operating sessions per consultant will be reduced.</p> <p>Radiology staff may be deskilled and lost with the moving of specific procedures to sites.</p>	<p>New medicines in Ophthalmology can reduce number of follow up injections.</p> <p>Opportunity to optimise allocated Endoscopy sessions.</p> <p>Opportunity for Withybush to develop day surgery arthroplasty service.</p>	<p>Dependent on capital availability for procedure rooms, theatres and equipment purchasing or relocation.</p> <p>Dependent on dedicated ringfenced beds to protect service flows and transport to transfer patients.</p> <p>Some Radiology patients travelling further to site would need to come in overnight.</p> <p>There is a risk of harm to the patient presenting at WGH with undifferentiated abdominal pain due to Gynae. not on-site OOH and limited availability of senior surgical opinion on site.</p> <p>There is a risk that Stroke patients attending Bronglais might not be admitted into a Stroke unit within 4 hours due to transfer times, as per Stroke guidelines.</p> <p>There is a risk of delayed transfer from WGH to GGH and potential harm to patients requiring Emergency General Surgery</p>
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<p><b>Workforce sustainability – Substantive workforce available to meet solution in 2-4 years</b></p>	<p>Centralisation of services will provide improved recruitment with opportunities to focus on speciality and rotate between sites.</p> <p>Consolidation of rotas in EGS make the consultant roles more appealing for recruitment.</p> <p>Improved training with centralised senior staff able to offer more time to trainees.</p> <p>Along with option 1 requires lower levels of staff additionality.</p>	<p>Existing staff approaching retirement age may leave before model is implemented creating issues with the model.</p> <p>Overnight accommodation may be needed where staff need to be able to attend site within 30 minutes when on call, especially if they are not living locally.</p> <p>Dermatology and EGS would need to recruit staff in order to make the option work, currently holding vacancies.</p> <p>Additional recruitment required across medical, nursing and therapies.</p> <p>Therapies staff are attached to sites rather than services, movement of services will result in lack of capacity to meet cohort demand.</p>	<p>Creating a Urology hub will help attract specialist nurses and consultants. This will help develop a larger, skilled workforce over the medium to long term.</p> <p>Greater opportunities for 'Grow your own' recruitment and training.</p> <p>Opportunities to develop Therapy Assistant roles in Stroke and digital technology in Critical Care to support delivery of services.</p> <p>Potential to use natural turnover and recruitment in therapies to move resources between sites to match patient cohorts.</p> <p>A centralised Ophthalmology service would attract medical trainees and other specialist workforce.</p> <p>A centralised Dermatology service be more attractive, improve staff retention etc.</p> <p>Opportunity to potentially develop a Stroke consultant rota across the HB</p> <p>Optimising the existing estate by investment in new substantive staff.</p> <p>Opportunity to recruit specialist interventional radiologists if interventional procedures are focused at two sites only.</p>	<p>There are national shortages at consultant level for Dermatology.</p> <p>Risk that staff may be unwilling or unable to relocate, impacting service change implementation. Critical Care staff may be resistant to using digital technology as part of the care pathway.</p> <p>Staff outside the 30 minute radius for EGS on call may be unwilling to join the rota, even if accommodation is made available.</p> <p>May take 2-4 years to train Endoscopy staff to deliver the model.</p> <p>Therapies staff are not ringfenced for services, will need alignment with services to support attainment of standards and deliver activity.</p> <p>Additional Theatre and Outpatient staff may be required to meet demand of centralised services.</p> <p>By moving services across acute sites, there is a risk that highly skilled staff may not follow the service, therefore there is a loss of experience in the team</p> <p>Retention of middle grade doctors may be affected if no senior support is on site (EGS)</p>
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<p><b>Financial sustainability – Cost difference between current delivery and option</b></p>	<p>Along with option 1 requires lower levels of revenue investment.</p>	<p>Funding for additional posts required, as well as funding for transportation/transfer services to manage change in delivery.</p> <p>Savings identified will be dependent on Capital funding being provided to allow service change to be delivered.</p> <p>Increased activity is likely to increase costs on non-pay and consumable items.</p>	<p>Potential to save on funding for medical and nursing costs on the reduction of EGS beds.</p> <p>Opportunity to look at a reduced 1:10 EGS rota to increase surgical sessions per consultant while remaining attractive to new recruits, or consider taking work to boost surgical sessions per consultant. This could be a long-term saving or income generation stream.</p> <p>Potential longer-term savings through reduced travel costs.</p> <p>Reduction in requirements of agency usage and Additional Duty Hours through recruitment to substantive posts. Opportunity to decrease reliance on variable pay and optimising the substantive staff in post.</p> <p>Opportunity to generate income from Bowel Screening Wales services (Endoscopy), and Swansea Bay University Health Board (Dermatology).</p> <p>Need to understand Orthopaedics regional model.</p>	<p>Interdependencies between service moves and estate refurbishment mean that some business cases will need to be approved as part of a phased package to allow option to be delivered.</p> <p>Opportunity to relocate existing equipment rather than purchase new equipment (Ophthalmology)</p> <p>Orthopaedics use of Bronglais Hospital is dependent on Ophthalmology services vacating theatre sessions, but finances remain at Bronglais.</p>
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	<p><b>Reduction in waiting lists across diagnostics, treatments, and surgery</b></p>	<p>Reductions in waiting times and length of stays will support overall reductions in waiting lists.</p> <p>Centralised rotas reduce the risk of cancellations with multiple staff on a single site.</p> <p>Reduced Critical Care transfer requirements mean patients get treatment faster.</p>	<p>Continuing with the current model at PPH of planned inpatient orthopaedic surgery only taking place in PPH is unlikely to address the waiting list and any future increased demand on the service.</p>	<p>Opportunities to increase patient flow, enabling Critical Care patients to move to ward faster and facilitate discharge planning.</p> <p>Ringfencing of centralised staff can create more Dermatology consultant sessions and opportunity for EGS consultants to undertake more elective work.</p> <p>Centralisation of Ophthalmology equipment reduces cancellations due to equipment faults, and utilising treatment rooms frees up theatre capacity on sites.</p> <p>Opportunity to work regionally with Swansea Bay.</p> <p>Appropriate elective care capacity to meet future demand</p> <p>Potential to re-introduce Dermatology 'See and Treat' sessions thus reducing patient wait for minor ops and need to return to hospital</p>	<p>Increased demand for Urology services exceeds capacity gained through centralising services, resulting in static waiting lists in the longer term.</p> <p>Radiology waiting times may increase with additional patients going to Bronlais Hospital.</p>
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Accessible	Patient travel time to sites	<p>Reduction in travel time and/ or visits for those needing elective Radiology or Ophthalmology. Good public transport links to Glangwili Hospital from Ceredigion and Llanelli.</p> <p>No change for Orthopaedics patients as that is how service is currently being delivered, and EGS and Stroke patients will still attend local hospital for initial treatment.</p> <p>Minimal impact on those accessing Critical Care, Dermatology or Urology services in Carmarthenshire.</p>	<p>Reduction in number of community sites will result in some patients needing to travel further in some cases for Ophthalmology and Radiology, with longer transfers to Glangwili for emergency interventional Radiology.</p> <p>Increased travel time for Stroke and Critical Care visitors if patients are transferred onwards.</p> <p>Increased travel time expected for Dermatology, Ophthalmology, Orthopaedics and Urology patients travelling from Pembrokeshire and Ceredigion. Centralisation of Endoscopy specialities will require patients to travel further.</p> <p>Previous Ophthalmology patient feedback has been that Prince Philip Hospital patients are less willing to travel to Glangwili Hospital than Bronglais Hospital patients.</p> <p>Car Parking for staff, patients and visitors on centralised sites is likely to become busier, compounding existing issues.</p>	<p>Centralisation of Urology services will mean that multiple activities can be carried out for patients in a single attendance, reducing the need for multiple visits.</p> <p>Opportunity to deliver some Dermatology work in the community to reduce travelling to Prince Philip Hospital.</p> <p>Existing transport links from Ceredigion and Llanelli to Glangwili Hospital to support Ophthalmology patient access compared to Ceredigion to Prince Philip Hospital.</p>	<p>NEPTS service provided by WAST is unable to meet the demand following centralisation of service.</p>
	Transfer travel time impact on options	<p>Crews would be conveying Stroke patients locally and treat and transfer model ensures TIAs and mimics are identified locally.</p> <p>Shares the least travel time impact with option 4 in transferring Stroke and EGS patients between sites, with patients</p>	<p>If WAST need to transfer Critical Care patients between sites if ACCTS are unavailable, they will need to be accompanied by an intensivist impacting the service provision on site.</p>	<p>Dedicated Transfer Vehicles would provide transport for the service to reduce transfer delays.</p>	<p>Resources not currently available to deliver this option.</p> <p>Resources will be lost for considerable periods of time through secondary transfers, as well as increased patient waiting time for a transfer vehicle.</p> <p>Will require dedicated bed availability to</p>

		requiring secondary transfers to other sites.			allow bed to bed transfer and reduce transfer delays.
	<b>Impact on local communities/ infrastructure when developing community sites</b>	<p>Urology to provide more Trial Without Catheter activity from community locations, reducing pressure on acute sites.</p> <p>Urology moving to Prince Philip Hospital will be counterbalanced by Ophthalmology moving to Glangwili Hospital, mitigating impacts on parking.</p> <p>Estates at Prince Philip allow for a better patient experience due to site layout.</p>	<p>Reduced community sites will mean Llandovery's Radiology and Ophthalmology's Diabetic Eye Screening Wales patients will need to travel further to access services</p> <p>Increased flow at Withybush Hospital site due to increased Stroke patients transferring in and out of site, with increased flow at Prince Philip Hospital due to increased activity through centralisation of Dermatology and Urology services.</p>	Dermatology patients and visitors attending a centralised site should free some parking capacity across other sites.	Overall staff and patient/ visitor parking could be overwhelmed following centralisation of sites.
	<b>Impact on staff and patients needing to travel to access regional care pathways</b>	No change to regional care pathways above those already being delivered for Urology and Orthopaedics.	<p>Dermatology referrals for regional pathways may increase with increased capacity to see more patients.</p> <p>Current regional working arrangements for Orthopaedics are not addressing Hywel Dda patient needs.</p>	Regional job planning can support local recruitment and service delivery.	Regional recruitment may result in staff being unwilling to travel to Hywel Dda or choosing not to apply for roles.
<b>Kind</b>	<b>Amount of activity taking place in a community setting</b>	Increase in Urology activity delivered in the community (TWOC)	Reduction in number of community sites providing Radiology services and Ophthalmology services	<p>Opportunity to develop community Dermatology services as spokes from the acute site hub.</p> <p>Centralisation of Ophthalmology onto fewer community sites reduces risk of cancellation due to staff absence or</p>	Need to ensure there is adequate funding to meet demand for TWOC in the community. Need to ascertain 'ownership' of removal of catheters in the community.

				equipment failure and maximises equipment usage.	
	<b>Impact on population health outcomes</b>	Health Impact Assessment identifies that the option optimises interventions, considers partnership working, engagement, transparency and leadership and avoids widening inequalities.	Health Impact Assessment identifies consideration of impacts on deprived communities, protected characteristics, vulnerable groups, and geographic communities which may face difficulties through increased travel times and associated costs, explored more fully within the Equality Impact Assessments.	Data systems in place or due to be implemented will provide close monitoring in health impacts during and following implementation.  Auditing systems, research projects and external monitoring (such as the Armed Forces Covenant and Welsh Government reporting) will further support monitoring of impact.	
	<b>Addressing barriers to care (telemedicine, transport enablers, patient support)</b>	Use of virtual platforms by Stroke will mitigate increased travel time and care further from home.  Dermatology will provide clinics and services from the community, reducing barriers to care.  Orthopaedics to include more virtual consultations, already running upper limb and hand virtual consultations.		Opportunity to develop community Dermatology services as spokes from the acute site hub, improving equity of care across acute and community sites.  Opportunity to make the Ophthalmology pathways less complex, with fewer repeat visits for patients following changes.  Moving or retaining care in the community will reduce demand on car parking for people needing to travel to centralised acute sites.  Opportunity to consider virtual consultations from distant sites with the surgical team at Glangwili	

	<p><b>Addressing barriers to equality</b></p>	<p>While there may be some decrease in equity of access for Critical Care and EGS, equity of care will be increased through the stabilisation and standardisation of care delivered from Glangwili Hospital which will also support person centred delivery.</p> <p>Orthopaedics and Urology will be able to prioritise patient needs through centralised lists rather than by waiting time, ensuring those most in need are treated sooner.</p> <p>Centralised Ophthalmology waiting list for all counties inclusive of Powys will ensure equity of care following change.</p> <p>Trial Without Catheter services for Urology will take place in community/ closer to home reducing travel time impact. A specialised unit for Urology will also improve privacy and dignity in consultations for people with gender reassignment.</p>	<p>Negative impact for Radiology, Dermatology, Stroke, EGS, Ophthalmology, Orthopaedics and Urology due to centralisation of services impacting equity to access around staff and patient travel (Geographic equality) and cost of travel and time spent attending appointments (socio-economic) and accommodation for relatives/visitors when patients are admitted out of their local area.</p> <p>Families of stroke patients from Ceredigion, Powys and Gwynedd are likely to face barriers to supporting inpatients and being part of person centred care.</p> <p>Impact on equity of access as a result of Radiology services withdrawing from Llandovery and South Pembrokeshire Hospital.</p>	<p>A centralised Urology unit in Prince Philip will be better than Glangwili due to:</p> <p>Access to the hospital is improved</p> <p>Access within the hospital is easier than at Glangwili</p> <p>Disabled parking access is improved in Prince Philip than Glangwili</p> <p>Llanelli is a generally more deprived area than Carmarthen, so having a centralised site in Llanelli will be easier for the local population</p>	
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## Option 4

	Criteria	Strengths	Weaknesses	Opportunities	Threats
Safe	Number of patients likely to need transport between sites when unwell	<p>Along with Option 3 out of all the options, inter hospital transfers the fewest patients for Stroke, Critical Care and EGS.</p> <p>No transfer between sites for Dermatology or Endoscopy with little to no impact for Ophthalmology and Urology.</p> <p>Repatriation of patients</p>	<p>There may be delays in transporting Emergency General Surgery patients from Withybush Hospital to Glangwili Hospital - this could cause delays in patients who need to go to theatre.</p> <p>There may be delays in transporting Emergency General Surgery, stroke and critical care patients Increase in Stroke patients requiring transfer</p> <p>There may be delays in transferring critical patient patients resulting in patient not receiving consultant care at site.</p>	Develop inter hospital transfer team	<p>recruitment of staff and cost to providing this service</p> <p>Timely repatriation of patients to improve flow- reduce DTOCs and LOS</p>
	Compliance/ attainment of standards	<p>limited improvement in standards for some services.</p> <p>Radiology provision will allow Urology to deliver care at a higher standard.</p>	<p>Inability to meet SNAP 4 hour targets</p> <p>GPICS standards for medical cover not met at PPH</p> <p>Current EGS, CC, stroke and therapies does not meet standards currently and this option will not improve these standards</p> <p>Radiology - does not comply with standards for Spinal Network</p>	Increased Radiology staff would allow training in ultrasound to ease DVT123 pressure. Additional staff would allow backfill to positions vacant from upskilling.	<p>Loss of Critical care consultant cover at PPH due to cross cover from Glangwili cover if made permanent</p> <p>Critical Care and EGS compliance against the standards could deteriorate in this option.</p> <p>Therapies - unless we have a workforce plan to address to meet the clinical standards, these will not be met</p>

	<p><b>Impact on internal services (e.g. Accident &amp; Emergency, Theatres, Paediatrics, Respiratory)</b></p>	<p>Radiology to provide more timely services across acute sites.</p> <p>Minimal capital investment required for Stroke, equipment needed can be transferred from other sites.</p> <p>Less Critical Care impact due to levels of care remaining largely as they are at each site and delivered within current footprint.</p> <p>No estate changes required at Bronglais, Withybush or Glangwili hospitals for Endoscopy and utilising fallow sessions.</p>	<p>Additional space and capital investment required on sites to manage increased demand of centralisation.</p> <p>Concerns around the impact on Glangwili Hospital with increased patient transfers for EGS.</p> <p>There may be delays in transporting Emergency General Surgery, stroke and critical care patients from Potential that site will be overloaded.</p> <p>If beds are not closed when services move from sites, this will result in an increase in demand for therapies across the hospital network.</p>	<p>Opportunities to use space left behind on sites for new purposes.</p> <p>Introduction of new clinical models, procedure rooms and roles can reduce the impact on services and theatres.</p> <p>Potential to explore rehabilitation ward area in sites where services are removed.</p> <p>Additional theatre session requirements in Prince Philip Hospital offset by additional sessions released in Glangwili (ophthalmology) take out?</p>	<p>Capital funding is not secured for estate change or equipment and services outside of the scope of CSP may be resistant to change if there are no perceived benefits for them.</p> <p>Space requirements to bring Ophthalmology and Urology services together on an acute site are limited within existing footprints and would require other services to move.</p> <p>Workforce investment required to support Endoscopy in HSDU and Pathology.</p>
	<p><b>Impact on external services (e.g. Health boards, Welsh Ambulance Service Trust, Acute Critical Care Transfer Service)</b></p>	<p>Increased Radiology capability to support North and Mid Wales patients, providing care closer to home.</p> <p>Stronger regional partnership working potential with Swansea Bay UHB in Dermatology and Ophthalmology.</p> <p>Least impact on WAST and ACCTS transport and transfer services.</p>	<p>WAST resources currently not available to deliver this option.</p> <p>Impacts identified on NEPTS for transfer and due to changes in Radiology, Ophthalmology, Orthopaedics and Urology.</p> <p>Patients will require secondary transfers to Prince Philip for Stroke, and if ACCTS are unavailable then an intensivist would need to accompany Critical Care patients.</p>	<p>Time for planning with WAST to identify and plan capacity to support model, including Dedicated Ambulance Vehicles.</p> <p>Requires the least WAST/ ACCTS resource to implement for Critical Care and shares the same model as option 3.</p> <p>Care closer to home through outreach clinics maybe best for patients but may impact treat in turn models.</p> <p>Opportunities to support Swansea Bay and absorb Mid Wales patient activity currently being sent to Aneurin Bevan.</p>	<p>Potential increased contractual cost to scaling WAST service and delays in transfers and repatriation may create additional Delayed Pathways Of Care.</p> <p>Potential loss of SLA income with BCUHB and PTHB if the services are no longer available in Bronglais Hospital.</p>

Sustainable	Clinically sustainable – Patient demand to require service	<p>Centralisation of service will provide more efficient use of beds and theatre lists for Dermatology, EGS and Ophthalmology.</p> <p>Endoscopy, Urology and Critical Care should be able to support growth in demand in future years.</p> <p>Repatriation and use of Early Supported Discharge Teams will enable bed flow to stop sites becoming overloaded for Stroke and EGS without needing additional beds.</p>	<p>Requires beds to be in Glangwili hospital with transport in place for transferring EGS patients.</p> <p>For Orthopaedics and Urology the model is expected to reduce waiting lists but may not mitigate against demand growth over the longer term if waiting list is not cleared.</p> <p>There is not enough demand in the EGS model to accommodate the increased rota, which could result in fewer opportunities for consultants to undertake surgery - running contrary to GIRFT recommendations of repeating types of surgery. Operating sessions per consultant will be reduced.</p>	<p>Centralisation of Ophthalmology should provide a more robust service, however this is contingent on the right estate being provided.</p>	<p>Dependent on capital availability for procedure rooms, theatres and equipment purchasing or relocation.</p> <p>Dependent on dedicated ringfenced beds to protect service flows and transport to transfer patients.</p>
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<p><b>Workforce sustainability – Substantive workforce available to meet solution in 2-4 years</b></p>	<p>Centralisation of services will provide improved recruitment with opportunities to focus on speciality and rotate between sites.</p> <p>Consolidation of rotas in EGS make the consultant roles more appealing for recruitment.</p> <p>Improved training with centralised senior staff able to offer more time to trainees.</p>	<p>Existing staff approaching retirement age may leave before model is implemented creating issues with the model.</p> <p>Overnight accommodation may be needed where staff need to be able to attend site within 30 minutes when on call, especially if they are not living locally.</p> <p>Dermatology and EGS would need to recruit staff in order to make the option work, currently holding vacancies.</p> <p>Additional recruitment required across medical, nursing and therapies.</p> <p>Therapies staff are attached to sites rather than services, movement of services will result in lack of capacity to meet cohorted demand.</p> <p>Has the greatest requirement for staff additionality.</p>	<p>Creating a Urology hub will help attract specialist nurses and consultants. This will help develop a larger, skilled workforce over the medium to long term.</p> <p>Greater opportunities for 'Grow your own' recruitment and training.</p> <p>Opportunities to develop digital technology in Critical Care to support delivery of services.</p> <p>Potential to use natural turnover and recruitment in therapies to move resources between sites to match patient cohorts.</p> <p>Creating acute stroke units will help attract advanced clinical practitioner roles and support creating pharmacist or nurse consultant roles</p>	<p>There are national shortages at consultant level for Dermatology.</p> <p>Risk that staff may be unwilling or unable to relocate, impacting service change implementation. Critical Care staff may be resistant to using digital technology as part of the care pathway.</p> <p>Staff outside the 30 minute radius for on call may be unwilling to join the rota, even if accommodation is made available.</p> <p>May take 2-4 years to train Endoscopy staff to deliver the model.</p> <p>Therapies staff are not ringfenced for services, will need alignment with services to support attainment of standards and deliver activity.</p> <p>Additional Theatre and Outpatient staff may be required to meet demand of centralised services.</p>
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<p><b>Financial sustainability – Cost difference between current delivery and option</b></p>	<p>Has the lowest level of capital investment required.</p>	<p>Funding for additional posts required, as well as funding for transportation/ transfer services to manage change in delivery.</p> <p>Savings identified will be dependent on Capital funding being provided to allow service change to be delivered.</p> <p>Increased activity is likely to increase costs on non-pay and consumable items.</p> <p>Has the greatest requirement for revenue additionality.</p>	<p>Potential to save on funding for medical and nursing costs on the reduction of EGS beds.</p> <p>Opportunity to look at a reduced 1:10 EGS rota to increase surgical sessions per consultant while remaining attractive to new recruits, or consider taking work to boost surgical sessions per consultant. This could be a long term saving or income generation stream.</p> <p>Potential longer term savings through reduced travel costs.</p> <p>Potential income generation from Bowel Screening Wales lists delivered by Endoscopy.</p> <p>Reduction in requirements of agency usage and Additional Duty Hours through recruitment to substantive posts.</p> <p>Opportunity to generate income from Bowel Screening Wales services.</p>	<p>Interdependencies between service moves and estate refurbishment mean that some business cases will need to be approved as part of a phased package to allow option to be delivered.</p> <p>Ophthalmology use of Bronglais Hospital is dependent on services vacating theatre sessions but finances remain.</p>
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	<p><b>Reduction in waiting lists across diagnostics, treatments, and surgery</b></p>	<p>Reductions in waiting times and length of stays will support overall reductions in waiting lists.</p> <p>Centralised rotas reduce the risk of cancellations with multiple staff on a single site.</p> <p>Reduced Critical Care transfer requirements mean patients get treatment faster and Radiology would be able to meet waiting list and waiting time targets.</p>	<p>Stroke patients attending Bronglais are unlikely to be admitted into a Stroke unit within 4 hours due to transfer times.</p>	<p>Opportunities to increase patient flow, enabling Critical Care patients to move to ward faster and facilitate discharge planning.</p> <p>Ringfencing of centralised staff can create more Dermatology consultant sessions and opportunity for EGS consultants to undertake more elective work.</p> <p>Centralisation of Ophthalmology equipment reduces cancellations due to equipment faults, and utilising treatment rooms frees up theatre capacity on sites.</p> <p>Opportunity to work regionally with Swansea Bay.</p>	<p>Increased demand for Urology services exceeds capacity gained through centralising services, resulting in static waiting lists in the longer term.</p>
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Accessible	Patient travel time to sites	<p>Reduction in travel time and/ or visits for those needing elective Radiology or Ophthalmology. Good public transport links to Glangwili Hospital from Ceredigion and Llanelli.</p> <p>No change for Orthopaedics patients as that is how service is currently being delivered, and EGS and Stroke patients will still attend local hospital for initial treatment.</p> <p>Minimal impact on those accessing Critical Care, Dermatology or Urology services in Carmarthenshire.</p>	<p>Reduction in number of community sites will result in some patients needing to travel further in some cases for Ophthalmology and Radiology, with longer transfers to Glangwili for emergency interventional Radiology.</p> <p>Increased travel time for Stroke and Critical Care visitors if patients are transferred onwards.</p> <p>Increased travel time expected for Dermatology, Ophthalmology, Orthopaedics and Urology patients travelling from Pembrokeshire and Ceredigion.</p> <p>Previous Ophthalmology patient feedback has been that Prince Philip Hospital patients are less willing to travel to Glangwili Hospital than Bronglais Hospital patients.</p> <p>Centralisation of Endoscopy specialities will require patients to travel further.</p> <p>Car Parking for staff, patients and visitors on centralised sites is likely to become busier, compounding existing issues.</p>	<p>Centralisation of Urology services will mean that multiple activities can be carried out for patients in a single attendance, reducing the need for multiple visits.</p> <p>Opportunity to deliver some Dermatology work in the community to reduce travelling to Prince Philip Hospital.</p> <p>Existing transport links from Ceredigion and Llanelli to Glangwili Hospital to support Ophthalmology patient access compared to Ceredigion to Prince Philip Hospital.</p>	<p>NEPTS service provided by WAST is unable to meet the demand following centralisation of service.</p>
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	<b>Transfer travel time impact on options</b>	<p>Crews would be conveying Stroke patients locally and treat and transfer model ensures TIAs and mimics are identified locally.</p> <p>Shares the least travel time impact with option 3 in transferring Stroke and EGS patients between sites, with patients requiring secondary transfers to other sites.</p>	<p>If WAST need to transfer Critical Care patients between sites if ACCTS are unavailable, they will need to be accompanied by an intensivist impacting the service provision on site.</p>	<p>Dedicated Transfer Vehicles would provide transport for the service to reduce transfer delays.</p>	<p>Resources not currently available to deliver this options.</p> <p>Resources will be lost for considerable periods of time through secondary transfers, as well as increased patient waiting time for a transfer vehicle.</p> <p>Will require dedicated bed availability to allow bed to bed transfer and reduce transfer delays.</p>
	<b>Impact on local communities/ infrastructure when developing community sites</b>	<p>Urology to provide more Trial Without Catheter activity from community locations, reducing pressure on acute sites.</p> <p>Urology moving to Prince Philip Hospital will be counterbalanced by Ophthalmology moving to Glangwili Hospital, mitigating impacts on parking.</p> <p>Estates at Prince Philip allow for a better patient experience due to site layout.</p>	<p>Reduced community sites will mean Llandovery's Radiology and Ophthalmology's Diabetic Eye Screening Wales patients will need to travel further to access services.</p> <p>Increased flow at Withybush Hospital site due to increased Stroke patients transferring in and out of site, with increased flow at Prince Philip Hospital due to increased activity through centralisation of Dermatology and Urology services.</p>	<p>Dermatology patients and visitors attending a centralised site should free some parking capacity across other sites.</p>	<p>Overall staff and patient/ visitor parking could be overwhelmed following centralisation of sites.</p>
	<b>Impact on staff and patients needing to travel to access regional care pathways</b>	<p>No change to regional care pathways above those already being delivered for Urology and Orthopaedics.</p>	<p>Dermatology referrals for regional pathways may increase with increased capacity to see more patients.</p> <p>Current regional working arrangements for Orthopaedics are not addressing Hywel Dda patient needs.</p>	<p>Regional job planning can support local recruitment and service delivery.</p>	<p>Regional recruitment may result in staff being unwilling to travel to Hywel Dda or choosing not to apply for roles.</p>
<b>Kind</b>	<b>Amount of activity taking place in a community setting</b>	<p>Increase in Urology activity delivered in the community.</p>	<p>Reduction in number of community sites providing Radiology services and Ophthalmology services</p>	<p>Opportunity to develop community Dermatology services as spokes from the acute site hub.</p> <p>Centralisation of Ophthalmology onto fewer community sites reduces risk of cancellation due to staff absence or</p>	

				equipment failure and maximises equipment usage.	
	<b>Impact on population health outcomes</b>	Health Impact Assessment identifies that the option optimises interventions, considers partnership working, engagement, transparency and leadership and avoids widening inequalities.	Health Impact Assessment identifies consideration of impacts on deprived communities, protected characteristics, vulnerable groups and geographic communities which may face difficulties through increased travel times and associated costs, explored more fully within the Equality Impact Assessments.	Data systems in place or due to be implemented will provide close monitoring in health impacts during and following implementation.  Auditing systems, research projects and external monitoring (such as the Armed Forces Covenant and Welsh Government reporting) will further support monitoring of impact.	
	<b>Addressing barriers to care (telemedicine, transport enablers, patient support)</b>	Use of virtual platforms by Stroke will mitigate increased travel time and care further from home.  Dermatology will provide clinics and services from the community, reducing barriers to care.  Orthopaedics to include more virtual consultations, already running upper limb and hand virtual consultations.		Opportunity to develop community Dermatology services as spokes from the acute site hub, improving equity of care across acute and community sites.  Opportunity to make the Ophthalmology pathways less complex, with fewer repeat visits for patients following changes.  Moving or retaining care in the community will reduce demand on car parking for people needing to travel to centralised acute sites.	

	<p><b>Addressing barriers to equality</b></p>	<p>While there maybe some decrease in equity of access for Critical Care and EGS, equity of care will be increased through the stabilisation and standardisation of care delivered from Glangwili Hospital which will also support person centred delivery.</p> <p>Orthopaedics and Urology will be able to prioritise patient needs through centralised lists rather than by waiting time, ensuring those most in need are treated sooner.</p> <p>Centralised Ophthalmology waiting list for all counties inclusive of Powys will ensure equity of care following change.</p> <p>Trial Without Catheter services for Urology will take place in community/ closer to home reducing travel time impact. A specialised unit for Urology will also improve privacy and dignity in consultations for people with gender reassignment.</p>	<p>Negative impact for Radiology, Dermatology, Stroke, EGS, Ophthalmology, Orthopaedics and Urology due to centralisation of services impacting equity to access around staff and patient travel (Geographic equality) and cost of travel and time spent attending appointments (socio-economic).</p> <p>Families of stroke patients from Ceredigion, Powys and Gwynedd are likely to face barriers to supporting inpatients and being part of person centred care.</p>	<p>A centralised Urology unit in Prince Philip will be better than Glangwili due to:</p> <p>Access to the hospital is improved</p> <p>Access within the hospital is easier that at Glangwili</p> <p>Disabled parking access is improved in Prince Philip than Glangwili</p> <p>Llanelli is a generally more deprived area than Carmarthen, so having a centralised site in Llanelli will be easier for the local population</p>	
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## **CLINICAL SERVICES PLAN (CSP)**

### **Shortlist Options Scoring**

(6 September 2024)

## **SUMMARY REPORT**

**9 September 2024**

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## Introduction

Hywel Dda University Health Board's Clinical Services Plan seeks to deliver services in the medium term in line with Hywel Dda's longer term vision contained in the "A Healthier Mid and West Wales" strategy.

The Clinical Services Plan (CSP) programme has an opportunity to look at how and where the Health Board provides services, in line with the strategy's goal to deliver care closer to home, while also seeking to make specialist services more sustainable.

A clinically led process representing the nine clinical service areas has been implemented to develop options which would meet the aim and objectives of the programme:

### **Aim**

- Develop a series of options for delivery of the Clinical Services Plan programme in response to service fragilities or unsustainability based on the principles of care that is safe, sustainable, accessible, and kind. The development of a Clinical Services Plan is also an action within the Targeted Intervention requirements of Welsh Government.

### **Objectives**

- Respond to Critical Care service fragility.
- Respond to Emergency General Surgery service fragility.
- Sustainably improve access and reduce waiting times for patients for Planned Care (Ophthalmology, Dermatology, Urology and Orthopaedics) and Diagnostics (Endoscopy and Radiology).
- Improve standards and respond to service fragility within the Stroke service.

An in-person session was convened on 6<sup>th</sup> September 2024. It had two objectives:

- To weight the evaluation criteria that would be used to appraise each of the four options.
- To score the four options against each of the evaluation criteria.

The in-person session was attended by clinicians and operational leads of the nine specific clinical services, and staff members and stakeholders representing interdependent services:

- 38 staff members, including service, interdependent services, and support services representatives
- 1 Health Board Executive (Interim Chief Executive Officer)
- 2 Patient representatives
- 1 Welsh Ambulance Service Trust (WAST) representative
- 1 Welsh Government representative
- 2 Trade Union representatives
- 10 Transformation Programme Office/Communications team members who provided facilitation and scribing for the day

## Methodology

The in-person session commenced with Helen Morgan-Howard, Head of Engagement and Transformation Programme Office, welcoming attendees, and reminding them of the purpose of the day.

Bethan Andrews, Interim General Manager, provided the room with a recap on progress to date within the Clinical Services Plan (CSP) programme, covering activities within the Options Development Group, the wider Check and Challenge group, and the task and finish groups to generate the information to support each of the options.

A comment was received during the question and answer period following the recap, noting that Trade Union representatives had attended the Options Development Group and Check and Challenge group sessions throughout the process, but that they did not attend any of the task and finish group sessions.

Alex Martin, Principal Programme Manager, who was facilitating the session, invited participants in the room to ask questions throughout the day, reflecting that the information that would be shared during the session was the highest-level summary of the work done to date and, as such, attendees should feel empowered to ask questions if they were unsure of any detail.

A question was asked: 'Why are we here?' Reflecting on the objectives and aim of Phase 2 of the programme, there is a need to address fragility and sustainability within the nine services while also improving activity and standards. The long term aim to build a new hospital is still the goal but we need to look at how we manage services between now and then, recognising that this is a challenging task which is why we have such wide representation in the room.

Alex Martin, Principal Programme Manager, presented the evaluation criteria that would be used throughout the day, detailing the process of how the criteria had been developed and selected and the rationale for aligning the criteria under the headings of 'safe', 'sustainable', 'accessible' and 'kind', finishing with the detail used to assess the impact against the Strengths, Weaknesses, Opportunities and Threats (SWOT) assessment that would be presented later.

The room was opened for questions again and the following questions were raised:

- How do individuals provide a service specific appraisal of the options if they are contained within a broader programme option?
  - It was noted that to manage the process the options are considered as a whole, so people are required to appraise the whole option and not service by service, however, once the options have been scored there would be an opportunity for participants to document any justifications of qualifications to their scores that they believe are important for Board to be made aware of when making their deliberations on next steps.
- Options that require transferring patients will have a cost impact, how has that been captured and considered?

- It was noted that meetings have taken place outside of the option development groups with Welsh Ambulance Service Trust (WAST), Adult Critical Care Transfer Service (ACCTS), and with NHS Wales Transport Commissioning colleagues who provided some detailed feedback on what is deliverable and how this would mobilise. They advised that they would require more information once a decision has been made on the next steps. An indicative cost was provided to support the SWOT appraisal and financial criteria.

Professor Philip Kloer, Interim Chief Executive Officer, presented further on why the session was taking place and the direction of travel for the day. He also noted the importance of the room input and the value of the session to support Board's decision making in November.

Alex Martin, Principal Programme Manager, explained the task for the morning: the weighting of the evaluation criteria and how this would be achieved. Participants in the room were required to allocate 160 points in total between the 16 evaluation criteria, allocating a greater number of points to the criteria which were more important to them, and fewer points to the criteria of lesser importance to them.

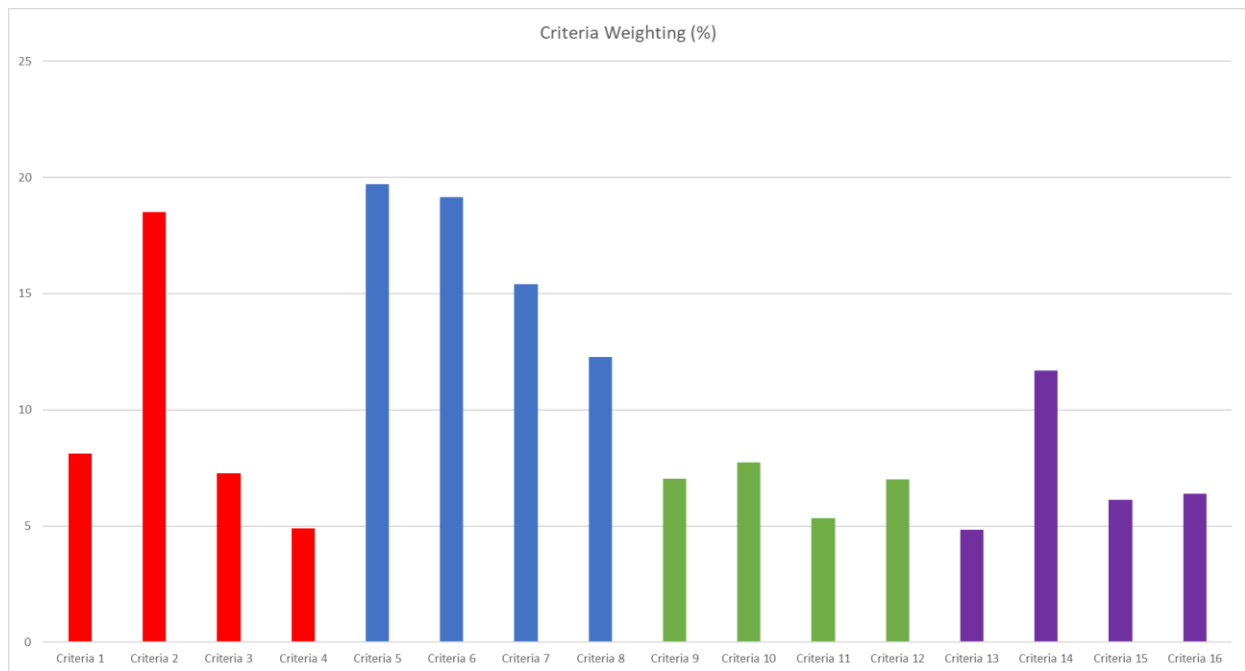
Each participant was provided with a test sheet to determine their weightings before inputting them into an online survey form which gathered responses anonymously. They were instructed that they could give as few as 0 points for a criterion if they wished or score a single criterion with 160 points, but the total number of points allocated across the 16 criteria must add up to 160 points. As a guide, the participants were advised that if they began with a starting position of all criteria being equal they would have 10 points each, and then they could add or remove points as required, depending on how they felt about each criterion.

Before beginning the task, the room was opened for questions.

- Feedback was shared that weighting service by service may provide different results than option by option as the weightings might be influenced by how each service operates.
  - Participants were reminded that they would be able to share their justifications for weighting and scoring in the feedback survey at the end of the day.
- Participants asked whether they should score from an option perspective or a service perspective.
  - Participants were reminded that they were attending as experts of either delivering or supporting services, or as experts of experience as patient representatives or supporting organisations, and should use that knowledge to inform their weighting.
- Feedback was also shared that the process seemed difficult to complete and it may be hard to see it working fairly.

Following the evaluation criteria weighting exercise, the results were presented to the room and feedback on the weighting results was gathered through a plenary session. Criteria 2 (Compliance / attainment of standards), Criteria 5 (Clinical Sustainability), Criteria 6

(Workforce Sustainability), Criteria 7 (Financial Sustainability), Criteria 8 (Reduction in waiting lists and treatment times), and Criteria 14 (Impact on population health outcomes) were noted as receiving the highest weighting.



The 16 evaluation criteria above are as follows:

1. Number of patients requiring transfers
2. Compliance/ attainment of standards
3. Impact on internal services
4. Impact on external services
5. Clinically sustainable
6. Workforce sustainability
7. Financial sustainability
8. Reduction in waiting lists and treatment times
9. Patient travel time to sites
10. Transfer travel time
11. Impact on local communities
12. Impact on staff and patients needing to travel regionally for care and treatment
13. Amount of activity taking place in the community
14. Impact on population health outcomes
15. Addressing barriers to care
16. Addressing barriers to equality

Plenary discussion topics:

- Patients may reflect differently with the weighting scoring.
  - This would be addressed when the options reach public engagement as members of the public would be able to provide their own appraisal for Board to consider.

- Overall weighting scoring did not reflect individual weighting scoring.
  - It was noted that the overall weighting of a criterion is based on the average of all scores received for that criterion. An individual's weighting score may differ from the room average if the majority felt that the criterion was more or less important.
- Concerns that limited representation from interdependent services would impact the overall weighting scoring.
  - It was reflected that it would not be possible to get everyone into a room to properly reflect the weighting scores of the wider interdependent services, however, the room should be representative of the wider organisation. Further engagement on the options would allow for those views to be sought. In the meantime, the survey at the end of the day could be used to capture this feedback.
- It was noted that the weighting scores did reflect the aim and objectives of the programme to become more sustainable and meet standards in some services.
- A question was asked about how many of the proposed options would go to a public consultation.
  - It was felt that some level of engagement or consultation would be needed to implement changes of this scale, and if this was the case it would also provide an opportunity to seek the wider views of clinicians not in the room.

Full detail on the evaluation criteria weighting scores can be found within the appendices (Appendix A).

Alex Martin, Principal Programme Manager, introduced the option presentation component of the session with an overview of how the presentations would be provided to support in the later scoring exercise.

Presentations would be given using a simple option wording (with printed copies available on the tables) followed by a colour coded assessment (also available on the tables). The content of the presentation would be informed by the SWOT assessment carried out by the option development group for their option.

The colour coding showed how each option met the different evaluation criteria in comparison with the other options. Red (with stripes) identified where an option provided the least positive impact of the options against the criteria, green (with dots) identified where an option provided the greatest positive impact against the criteria, and amber (solid) identified where an option had no differentiation or provided neither the least nor greatest positive impact against the criteria.

The room was opened to questions before the first presentation, with one question received:

- How do we score an option if it relies on an interdependency, but we have limited confidence that it will be deliverable?
  - The room was advised that they could reflect this in their option scoring by indicating a low confidence with a low score and a high confidence with a

high score, when considering criteria such as 'impact on external services'. In addition, this could be further reflected when responding to the online survey following the scoring exercise (which captured additional information / views).

The four options were then presented by the Clinical Editors or their deputies for each option, with an opportunity for questions to be asked after each presentation. Option One was presented by Bethan Andrews, Interim General Manager; Option Two was presented by David Lewis, Service Manager for General Surgery and Associated Services deputising on behalf of Annette Snell, Hospital Director; Option Three was presented by Michaela Duskova, Locum Consultant General Anaesthetist; and Option Four was presented by Eiry Edmunds, Interim Deputy Medical Director on behalf of Robin Ghosal, Hospital Director. The summary wording and the colour blocks for each option can be found within the appendices (Appendix B).

### **Option One questions and answers**

- For scoring can we get guidance on why this option scored better / worse on certain areas (red elements)?
  - Red is against 'clinical sustainability', based on service level SWOT assessments and the detail sitting behind them.
- If acute surgical patients are moved from Withybush Hospital to Glangwili Hospital, who will deal with those admitted at Withybush Hospital?
  - There will still be a surgical team based at Withybush Hospital.
- Regarding the focus on transfer of patients – if there are three or four patients in Withybush Hospital, we need to ensure there is sufficient staff cover there, including out of hours. There is lots of focus on transfer, which is important, but it is also important not to lose focus on inpatients.

### **Option Two questions and answers**

- Will the Hyper-acute Stroke Unit (HASU) offer thrombectomy or will patients continue to be transferred to Bristol / Cardiff?
  - Patients will continue to be transferred.
- With rotation of the on-call EGS rota, this option does not seem workable due to support required for Paediatrics on each site.
  - Paediatrics has been identified within the SWOT assessment and issues would need to be worked out.
- Radiology hub – Are the financial implications, which are significant, being factored in, and issues with staff retention and transportation?
  - The hub was a big discussion point yesterday (05/09 session) following capital costs. If Option Two goes further, then the hub itself needs to be further defined. Details have been added to the SWOT assessment to call out that the hub could potentially be located on an existing acute site to reduce capital costs.

- Orthopaedics – it was noted that the table notes for Option Two were incorrect, but the information presented on the screen and PowerPoint slides (within Appendix B) were accurate.

### Option Three questions and answers

- Is it correct that the only surgical presence at Withybush Hospital would be at the SDEC, and if so, is it 24/7? Otherwise, does anyone that needs referring to surgeons go to Glangwili Hospital?
  - There was no consensus on the table on how it would be. As the option is, there would be no surgical support overnight as it is a surgical day unit so anyone needing this out of hours would need to be transferred. This is the main concern of this option – the removal of EGS from Withybush Hospital.
  - Follow-up response: The SDEC will run Monday to Friday with consultant cover between 9am-7pm. Surgical SAS to cover 9am-5pm at weekends who will refer if needed. There will be senior presence every day at Withybush Hospital. For overnight, expectation is that day patients will be admitted at Withybush Hospital under speciality doctor.
- Challenge for Critical Care SWOT – not sure how standards are listed as being ‘met’ in the SWOT assessment, as the option reflects the current configuration and the service does not currently meet standards.
  - Plan is for Withybush and Bronglais hospitals to be Rural Critical Care units so there is a difference to current setup.
- Follow up question on above: GPICS standards concession states overnight can be covered by non-Intensivist but during the day there should be cover provided by an Intensivist. Ability to recruit into that moving forward would be difficult.
- Stroke having two units, travel for those from Bronglais Hospital – how long will patients stay four hours away from home at another site?
  - Length of stay times vary and would depend on the patient, 1/3 often go home on the same day. Early Supported Discharge will be used to help get other patients closer to home more quickly.
- Follow up question on above: There are staffing issues with Early Supported Discharge – Therapies, etc.
  - Length of stay answer is difficult because every patient is different. By centralising the service, the specialist team is all together so time to discharge should be quicker. Early Supported Discharge team are already in Ceredigion. The options aim to get these patients home more quickly.
- Radiology – interventional to be provided as emergency across all sites?
  - No, two sites only, at Bronglais and Glangwili hospitals. CT scanning will remain as it is currently.
- Follow up question on above: What will happen to existing nurses in Cardiac Catheter and patients requiring interventional services, will they need to be transferred?
  - This is a pathway discussion, and not in scope at this time, but would be considered during option implementation.

## Option Four questions and answers

- Endoscopy - How should we score the option as the Endoscopy element has two potentials (one extra room, versus evening/weekend service)?
  - At the point of passing the hurdle criteria, the fundamental option detail needs to remain. Option Four at hurdle criteria stage included an extra room. Since then, the option development group have further developed the option and thought it would be better to extend service hours. However, we cannot remove the extra room from the option, so it must stay in. Participants should score the option as it is with both elements and call out anything else in the feedback survey following scoring. This feedback will be included in the closing report for Board in November.
- Transport – the group picked up on the issues. All four options have issues with patient transport, so these are not specific to Option Four. There was concern about volume of transfer needed.
  - An indicative figure of £2 million was listed in the finance appraisal. Feedback from Welsh Government was that an internal service would cost a lot more, rather than in partnership with, for example, Swansea Bay University Health Board. Specifics need to be worked out in more detail with WAST etc. from a commissioning perspective.
- Transport – patient repatriation will be needed for many of the proposed options. This is when the conversation around an internal transport service was had within the option.
  - Patient repatriation demand has been added to the SWOT assessment. There will be an opportunity to scope and consider the correct end to end pathways that will be developed further down the line. WAST feedback was that there needs to be a protected bed available at the site on arrival and not blocked up, this would allow optimisation of the transport service to implement patient repatriation. The WAST representative at the session confirmed that this is a current issue for their service.

With the presentation of each of the options concluded the session moved into the final task of the day which was scoring the four options.

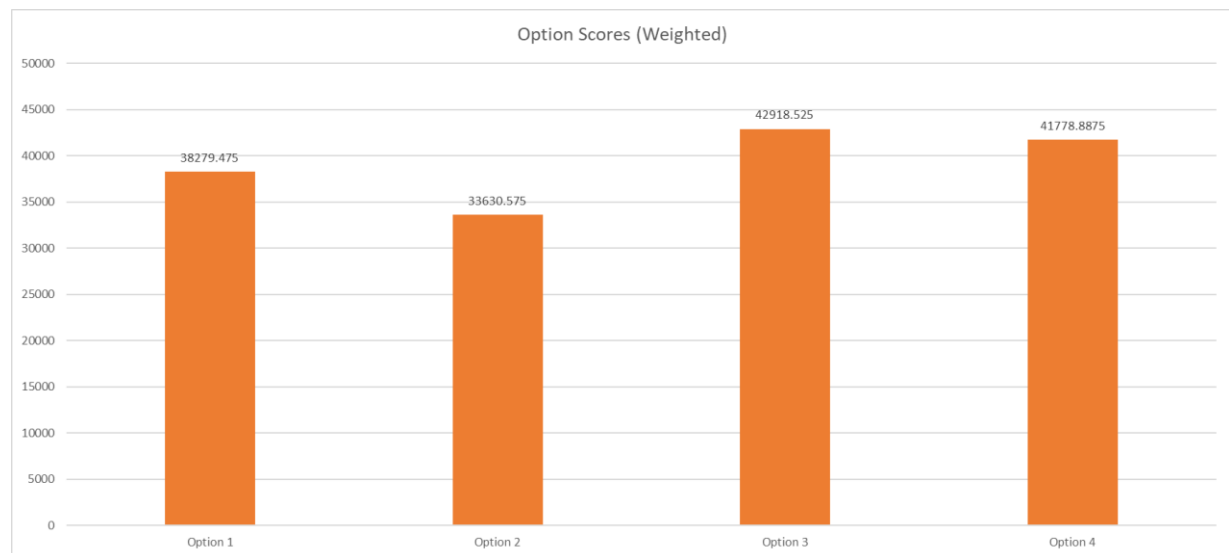
## Outputs

Alex Martin, Principal Programme Manager, began the option scoring task by providing the room with the methodology that would be used. Each evaluation criterion would be scored from 1 to 10, with '1' indicating that the option fails to meet the criterion and '10' indicating that the option fully satisfies the criterion.

Participants in the room were urged to fully consider the options and their merits when providing their scores. They were informed that there would be no alteration of voting scores as a result of 'extreme' voting (for example, where an individual scores 10 for all criteria in one option and 0 for all criteria in other options) as this could be a valid opinion.

Participants were also advised that there would be no weighting applied to the scores – every scoring participant would have the same weight as the others in the room as a balanced room was not being sought.

Participants were given an opportunity to practice their scores on a test sheet before entering them into an online survey form which would gather the responses anonymously. Once all the scores were entered and everyone confirmed they were finished, the scores with the evaluation criteria weighting applied were presented on screen.



Of the four options, Option Three scored highest followed by Option Four and Option One, with Option Two scoring the lowest. Following presentation of the results the participants were invited to share their reflections on the scores and whether they felt that they reflected the view of the room.

- The room agreed that the scores were representative of the options.
- Questions were asked about how this information would be used, and the next steps.
  - It was noted that this depends on the decision from Board in November, though should further engagement be required, this would take time to plan and implement.
  - The Options Development Group were advised that they, and others, would be kept up to date on the programme via the Health Board’s Intranet and Internet Clinical Services Plan webpages.

Further breakdown of the option scoring results can be found within the appendices (Appendix C).

The participants were invited to complete the reflective survey online, which provided them with an opportunity to share feedback and justifications regarding their scoring, as well as any additional information that they felt would be useful to the Board in their decision making. They were informed that their responses would be anonymous unless they identified themselves in their answers, such as by providing their job title, etc.

The information from the final survey will be included within the Phase 2 Closing Report presented to Board on 28<sup>th</sup> November 2024.

The session was brought to a close by Helen Morgan-Howard, Head of Engagement and Transformation Programme Office.

## Next Steps

- 28<sup>th</sup> November 2024
  - Presentation of option scoring to Board for decision on next steps.

The process is underpinned by continuous engagement including, but not limited to, check and challenge sessions with wider colleagues and service users.

## Appendix A – Criteria weighting results

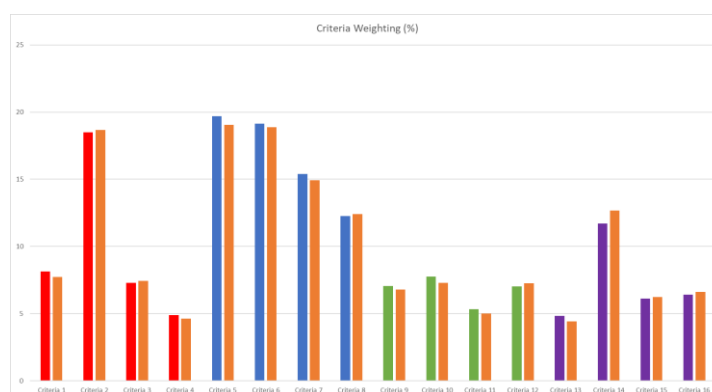
Below is a breakdown of the weighting applied to each evaluation criterion.

Criteria	Weighting
Number of patients requiring transfers	8.1
Compliance/ attainment of standards	18.5
Impact on internal services	7.3
Impact on external services	4.9
Clinically sustainable	19.7
Workforce sustainability	19.2
Financial sustainability	15.4
Reduction in waiting lists and treatment times	12.3
Patient travel time to sites	7.0
Transfer travel time	7.8
Impact on local communities	5.3
Impact on staff and patients needing to travel regionally for care and treatment	7.0
Amount of activity taking place in the community	4.8
Impact on population health outcomes	11.7
Addressing barriers to care	6.1
Addressing barriers to equality	6.4
<b>Total</b>	<b>161.5</b>

While participants were asked to provide weightings that added up to 160, after the session it was noted that some individuals had provided weightings which totalled greater than or less than 160.

In total eight participants out of 40 provided inaccurate weightings ranging from 155 to 200. On reviewing the weightings these do not appear to have affected the overall weighting of the evaluation criteria as the weights are in line with the other weights applied and have not impacted the overall results.

Below, an alternative graph shows in orange what the weightings would be if the incorrect scores were removed. Due to the lack of impact, it is proposed that they remain as they are.



## Appendix B – Option Presentation for Options One, Two, Three and Four

The following slides are the presentations and SWOT summaries presented for each option

### Option One - Presentation Bethan Andrews, Interim General Manager



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In Critical Care, the service will remain the same at Glangwili Hospital, with the addition of also providing care for very ill patients transferred from both Prince Philip and Withybush hospitals. Prince Philip and Withybush hospitals will have Enhanced Care Units (who would provide intermediate level of treatment for patients), instead of Intensive Care Units (who look after the most critically ill patients). Enhanced Care Units will offer an increased level of care (compared to inpatient wards) If patients need intensive care, they can be stabilised in an Enhanced Care Unit and then transferred to Glangwili Hospital for ongoing intensive care treatment. Bronglais Hospital will continue with its current service.

In Dermatology, services will be centralised to run from Prince Philip Hospital. There will be no clinics at Bronglais, Glangwili, or Withybush hospitals. In the community, Cardigan Integrated Care Centre and Amman Valley Hospital will provide some nurse led clinics.

In Emergency General Surgery, patients who arrive at Withybush Hospital and need admission for an operation under Emergency General Surgery (not planned surgery) will be transferred to Glangwili Hospital for their treatment. If they do not need an emergency operation, their care will remain under Withybush Hospital. In the north of the Hywel Dda area, Bronglais Hospital will continue to deliver emergency general surgery, as it does now.

In Endoscopy, Gastrointestinal services will continue to be provided from Bronglais, Glangwili and Withybush hospital. At Prince Philip Hospital, the Unit will continue to provide and be expanded (from two rooms to three). Urology and Respiratory endoscopy services will be centralised at Prince Philip Hospital. No changes to the current service provided for Bowel Screening Wales.

In Ophthalmology, Cataract services at Bronglais Hospital and outpatient ophthalmology services at Prince Philip Hospital will be moved to Glangwili Hospital, where the majority of main hospital based services will be centralised. Withybush Hospital and North Road Eye Clinic, Aberystwyth, will continue to carry out regular eye injections. Outpatient services will continue at Cardigan Integrated Care Centre and North Road Eye Clinic. Aberaeron Integrated Care Centre and South Pembrokeshire Hospital will no longer provide a service.

In Radiology, Bronglais, Glangwili, Prince Philip and Withybush hospitals will continue to provide Emergency Diagnostic Radiology. Bronglais, Prince Philip and Withybush hospitals will also provide Planned Diagnostic Radiology and Interventional services, which are treatments that include a surgical element, but Glangwili Hospital will not. Withybush Hospital will also continue to provide Nuclear Medicine, which is a medical specialty involving the application of radioactive substances in the diagnosis and treatment of disease. In the community, Cardigan Integrated Care Centre and Tenby Hospital will continue to provide X-Ray services.

In Stroke, Glangwili and Bronglais hospitals will be Treat and Transfer hospitals. A Treat and Transfer hospital is where stroke patients would be assessed and given initial treatment before transport to another hospital to meet their needs. Initial treatment in a Treat and Transfer hospital could include thrombolysis (clot busting drugs). Prince Philip and Withybush hospitals will have Acute Stroke Units. An Acute Stroke Unit will provide the initial assessment and treatment, such as at a Treat and Transfer hospital, but also specialised care. The Acute Stroke Units will also provide hospital-based rehabilitation for stroke survivors from Monday to Friday 9am-5pm, and access to consultants out-of-hours when required. Both the Acute Stroke Unit and the Treat and Transfer hospitals would be able to transfer to specialist thrombectomy (clot removal) centres, such as at Bristol, when necessary for patients who need more specialist care, as happens now.

In Urology, Prince Philip Hospital will become the Urology Centre for the health board. This centre will deliver all diagnostics, which is the process of identifying a particular illness, planned care and cancer services. Glangwili Hospital will provide emergency urology care only. Bronglais and Withybush hospitals will continue with day case and outpatient services only. Trial Without Catheter Services, where a catheter is removed for a trial period of time to see if you are able to pass urine as before, will be carried out in community settings by primary care services.

In Orthopaedics, Bronglais Hospital will provide emergency (trauma) orthopaedic services, as well as planned inpatient and day case services. Dedicated ward, theatre and staffing will be allocated to meet relevant national standards. Prince Philip Hospital will provide planned, overnight hospital care and more complex planned care, such as arthroplasty, which is the reforming of joints. Withybush Hospital will provide emergency (trauma) orthopaedic services, outpatient services and day case serves within the Day Surgery Unit. Cardigan Integrated Care Centre and Tenby Hospital will provide outpatient clinics in the community, as they do now. To support regional work, Prince Philip Hospital will work in partnership with Swansea Bay University Health Board to reduce the number of patients waiting for treatment across West Wales. Tywyn Hospital (based in Betsi Cadwaladr University Health Board) will continue to provide outpatient clinics for their patients.

# Option One - Presentation




Bethan Andrews, Interim General Manager



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		Option 1			
Safe		Yellow	Yellow	Accessible	
		Yellow	Yellow		
		Yellow	Yellow		
		Yellow	Green		
Sustainable		Red	Yellow	Kind	
		Green	Yellow		
		Green	Green		
		Yellow	Yellow		

-  The least positive impact out of the 4 options against the criteria
-  No difference in positive impact between the options
-  The greatest positive impact out of the 4 options against the criteria

## Option Two - Presentation

### David Lewis, Service Manager for General Surgery & Associated Services



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Hywel Dda  
University Health Board

In Critical Care, the services at Bronglais and Withybush hospitals, will become Rural Critical Care Centres. The service will remain the same at Glangwili Hospital, with the addition of also providing care for very ill patients transferred from Prince Philip Hospital. Prince Philip Hospital will become Enhanced Care Unit, instead of Intensive Care Unit. The Enhanced Care Unit will offer an increased level of care (from inpatient wards). If patients need intensive care, they can be stabilised in an Enhanced Care Unit and then transferred to Glangwili Hospital for ongoing intensive care treatment.

In Dermatology, services will be centralised to run from Prince Philip Hospital. There will be no clinics at Bronglais, Glangwili, or Withybush hospitals. In the community, South Pembrokeshire Hospital will provide some nurse led clinics. Across the Health Board, GPs with an Extended Role in Dermatology (these are GPs that have undertaken specialist training in the diagnosis of skin lesions) will remove some minor skin cancers at GP practices.

In Emergency General Surgery, in the south of the Hywel Dda area, emergency general surgery will alternate weekly between Withybush and Glangwili hospitals. Patients who arrive at Withybush or Glangwili hospitals and do not need to stay overnight in hospital for surgery, will remain under the care of that hospital. Patients that need to stay overnight in hospital for surgery will be transferred to whichever hospital is undertaking surgery during that week. In the north of the Hywel Dda area, Bronglais Hospital will continue to deliver emergency general surgery, as it does now, every week.

In Endoscopy, Units will continue to be provided from Bronglais, Glangwili and Withybush hospital. At Prince Philip Hospital, the Unit will continue to provide and be expanded from two rooms to three. Urology, respiratory and gastrointestinal services, will be centralised at Prince Philip Hospital for Carmarthenshire. No changes to the current service provided for Bowel Screening Wales.

In Ophthalmology all adult eye services, including emergencies, will move from Glangwili Hospital to Prince Philip Hospital. Bronglais and Withybush hospitals to maintain existing services. North Road Eye Clinic will maintain non-emergency care and Cardigan Integrated Care Centre will remain unchanged. All other existing community activity will be moved to single sites in Pembrokeshire and Carmarthenshire, locations of which need to be determined.

In Radiology, Bronglais, Prince Philip, Withybush and Glangwili hospitals will continue to provide Emergency Diagnostic Radiology. Glangwili will provide Emergency Interventional Services. Bronglais, Prince Philip and Withybush hospitals will continue to provide Planned Diagnostic Radiology and Interventional services, which are treatments that include a surgical element. Planned Diagnostics will be extended to a seven day service, and Interventional services extended to a five day service (Monday-Friday). Prince Philip and Withybush hospitals will provide Cancer focused services. In the community, services will be centralised within a Regional Diagnostics Centre and X-Ray services will also be provided from Cardigan Integrated Care Centre and Tenby Hospital.

In Stroke, Prince Philip Hospital will have a Hyper Acute Stroke Unit. Bronglais, Glangwili and Withybush hospitals will be Treat and Transfer hospitals. A Treat and Transfer hospital is where stroke patients would be assessed and given initial treatment before transport to another hospital to meet their needs. Initial treatment in a Treat and Transfer hospital could include thrombolysis. Add definition of Hyper Acute Stroke Unit and Acute Stroke Unit in glossary.

In Urology, Prince Philip Hospital will become the Urology Centre for the health board. This centre will deliver all diagnostics and outpatients services, which is the process of identifying a particular illness, planned care and cancer services. Glangwili Hospital will provide emergency urology care only. Bronglais and Withybush hospitals will continue with day case and outpatient services only. Trial Without Catheter Services, where a catheter is removed for a trial period of time to see if you are able to pass urine as before, will be carried out in community settings by primary care services.

In Orthopaedics, Bronglais Hospital will provide emergency (trauma) orthopaedic services, as well as inpatient and day case services and all Orthopaedic theatre facilities will be fully allocated to this service so that the health board can meet the relevant standards. Glangwili Hospital will provide emergency (trauma) orthopaedic services, and planned outpatient clinics. Planned overnight hospital care or surgery will be provided at Bronglais and Prince Philip hospitals. Prince Philip Hospital will provide planned, overnight hospital care, and more complex planned care, such as arthroplasty, which is the re-forming of joints. Withybush Hospital will provide emergency (trauma) orthopaedic services, outpatient services, and day case services within the Day Surgery Unit, which means that patients will not stay in hospital overnight. Cardigan Integrated Care Centre and Tenby Hospital will provide outpatient clinics in the community, as they do now. To support regional work, Prince Philip Hospital will work in partnership with Swansea Bay University Health Board to reduce the number of patients waiting for treatment across West Wales. Tywyn Hospital (based in Betsi Cadwaladr University Health Board) will continue to provide outpatient clinics for their patients.




**Option Two - Presentation**  
**David Lewis, Service Manager for General Surgery &**  
**Associated Services**



**GIG**  
**CYMRU**  
**NHS**  
**WALES**

Bwrdd Iechyd Prifysgol  
 Hywel Dda  
 University Health Board



-  The least positive impact out of the 4 options against the criteria
-  No difference in positive impact between the options
-  The greatest positive impact out of the 4 options against the criteria

## Option Three - Presentation

### Michaela Duskova, Locum Consultant General Anaesthetist



GIG  
CYMRU  
NHS  
WALES

Bwrdd Iechyd Prifysgol  
Hywel Dda  
University Health Board

In Critical Care, the service will remain the same at Bronglais and Withybush hospitals, which will become Rural Critical Care Centres. The service will remain the same at Glangwili Hospital, with the addition of also providing care for very ill patients transferred from Prince Philip Hospital. A current temporary change at Prince Philip Hospital, which sees very ill patients stabilised and transferred to Glangwili Hospital, will become a permanent change.

In Dermatology, services will be centralised to run from Prince Philip Hospital. There will be no clinics at Bronglais, Glangwili, or Withybush hospitals. In the community, South Pembrokeshire Hospital and Cardigan Integrated Care Centre will provide some nurse led clinics, and Cross Hands Health Centre will provide some paediatric clinics. From some GP practices across the Health Board, GPs with an Extended Role in Dermatology (these are GPs that have undertaken training in the speciality) will remove minor skin lesions.

In Emergency General Surgery, patients who arrive at Withybush Hospital will be assessed at the surgical SDEC and those that need admission and Inpatient treatment will require transfer to Glangwili Hospital. If they do not need surgical admission, they will be treated at Withybush Hospital. In the north of the Hywel Dda area, Bronglais Hospital will continue to deliver Emergency General Surgery, as it does now.

In Endoscopy, All bowel screening to be transferred to a newly developed community site dedicated for the bowel screening service. All other Gastrointestinal Services being delivered at Bronglais, Glangwili, Prince Philip and Withybush to remain within the same configuration, as they are currently. There will be an opportunity to reconfigure Gastrointestinal, Urology, and Respiratory services utilising the vacant sessions previously used to deliver bowel screening.

In Ophthalmology, Bronglais Hospital will continue current services. Move outpatient services from Prince Philip and Withybush hospitals to centralise to Glangwili Hospital. Withybush Hospital to maintain regular eye injection services only. North Road Eye Clinic will continue to deliver outpatient activity. Cardigan Integrated Care Centre will remain as a diagnostic centre. Amman Valley Hospital will continue with regular eye injection services only, as cataract surgery will be moved to Glangwili Hospital. Services from Aberaeron Integrated Care Centre and South Pembrokeshire Hospital will be relocated to other sites.

In Radiology, Bronglais, Prince Philip, Withybush and Glangwili hospital will continue to provide Emergency Diagnostic Radiology. Bronglais, Prince Philip and Withybush hospitals will continue to provide Planned Diagnostic Radiology. Bronglais and Glangwili hospitals will provide Interventional services, which are treatments that include a surgical element. In the community, Cardigan Integrated Care Centre and Tenby Hospital will continue to provide X-Ray services.

In Stroke, Glangwili and Bronglais hospitals will be Treat and Transfer hospitals. A Treat and Transfer hospital is where stroke patients would be assessed and given initial treatment before transport to another hospital to meet their needs. Initial treatment at a Treat and Transfer hospital could include thrombolysis. Prince Philip and Withybush hospitals will have Acute Stroke Units. An Acute Stroke Unit will provide the initial assessment and treatment, such as at a Treat and Transfer hospital, but also specialised care. The Acute Stroke Units will also provide hospital-based rehabilitation for stroke survivors, from a specialist stroke multi disciplinary team which includes therapy, nursing and medical staff. Both the Acute Stroke Unit and the Treat and Transfer hospitals would be able to transfer to specialist thrombectomy centres, such as at Bristol, when necessary for patients who need more specialist care, as happens now. Patients being discharged will have access to ongoing rehab in the community if needed provided by a community Stroke rehab team or early supported discharge team.

In Urology, Prince Philip Hospital will become the Urology Centre for the health board. This centre will deliver diagnostic services, which is the process of identifying a particular illness, planned care and cancer services. Glangwili Hospital will provide emergency urology care only. There will be a possibility of utilising endoscopy vacant sessions previously used for bowel screening. Bronglais and Withybush hospitals will continue with day case and outpatient services only. Trial Without Catheter Services, where a catheter is removed for a trial period of time to see if you are able to pass urine as before, will be carried out in the community.

In Orthopaedics, Bronglais Hospital will provide emergency (trauma) orthopaedic services, as well as inpatient and day case services, which is the current configuration. Dedicated theatre, ward, and staffing would be required so that the health board can meet the relevant standards. Glangwili Hospital will provide emergency (trauma) orthopaedic services, and planned outpatient clinics, as per current configuration. Prince Philip Hospital will provide planned, overnight hospital care, and more complex planned care, such as arthroplasty, which is the re-forming of joints, as per the current configuration. Withybush Hospital will provide emergency (trauma) orthopaedic services, outpatient services, and day case services within the Day Surgery Unit. This makes permanent the temporary change currently in place, meaning that no Inpatient planned procedures will take place at this site. Cardigan Integrated Care Centre and Tenby Hospital will provide outpatient clinics in the community, as per the current configuration. To support regional work, Prince Philip Hospital will work in partnership with Swansea Bay University Health Board to reduce the number of patients waiting for treatment across West Wales. Tywyn Hospital (based in Betsi Cadwaladr University Health Board) will continue to provide outpatient clinics for their patients.

**Option Three - Presentation**  
**Michaela Duskova, Locum Consultant General Anaesthetist**



**GIG**  
**CYMRU**  
**NHS**  
**WALES**

Bwrdd Iechyd Prifysgol  
 Hywel Dda  
 University Health Board

		Option 3			
Safe		Green	Yellow	Accessible	
		Yellow	Green		
		Yellow	Yellow		
		Green	Green		
Sustainable		Yellow	Yellow	Kind	
		Green	Yellow		
		Green	Green		
		Green	Yellow		

	The least positive impact out of the 4 options against the criteria
	No difference in positive impact between the options
	The greatest positive impact out of the 4 options against the criteria

## Option Four - Presentation Eiry Edmunds, Interim Deputy Medical Director



GIG  
CYMRU  
NHS  
WALES

Bwrdd Iechyd Prifysgol  
Hywel Dda  
University Health Board

The service will remain at Bronglais and Withybush hospitals as Rural Critical Care Centres. The service will remain at Glangwili Hospital, continuing to provide care for very ill patients transferred from Prince Philip Hospital, making the current amended changes permanent.

The Dermatology service will be centralised to run from Prince Philip Hospital. There will be no clinics at Bronglais, Glangwili, or Withybush hospitals. In the community, South Pembrokeshire Hospital and Cardigan Integrated Care Centre will provide some nurse led clinics with Cross Hands Health Centre will provide nurse led Paediatric clinics.

Emergency General Surgery Patients who arrive at Withybush Hospital will be assessed and be given a treatment plan, if they do not need surgical admission, their care will remain under Withybush Hospital. For those patients needing an admission will be transferred to Glangwili Hospital for their treatment. Bronglais Hospital will continue to deliver emergency general surgery, as it does now. Prince Phillip Hospital patients will continue to be treated at Glangwili Hospital as it does now.

Endoscopy Units will continue to be provided at Bronglais, Glangwili and Withybush hospitals. At Prince Philip Hospital, the Unit will have an extra room to provide additional capacity. No changes to the current service provided for Bowel Screening Wales. In addition to this the option considers the use of out of hours sessions in the evenings and weekend working to provide additional capacity without the development of an additional room.

The majority of the service including Cataract services at Bronglais Hospital and outpatient services at Prince Philip Hospital will be centralised and will be moved to Glangwili Hospital. Withybush Hospital will maintain regular eye injection services only. North Road Eye Clinic will remain unchanged. Cardigan Integrated Care Centre will remain as a diagnostic centre. Services will be relocated from Aberaeron Integrated Care Centre and South Pembrokeshire Hospital with their care will be provided elsewhere. All emergency care will remain unchanged.




Bronglais, Glangwili, Prince Philip and Withybush hospitals will continue to provide Emergency Diagnostics Radiology, Planned Diagnostics Radiology and Interventional services, which are procedures that include a surgical element. Planned Diagnostics will be extended to a 7 day service with Interventional services extended to a 5 day service (Monday to Friday). In the community, X-ray services will only be provided in Cardigan Integrated Care Centre and Tenby Hospital. There will be no X-Rays services in Llandovery and South Pembrokeshire hospitals.

In Stroke, All hospitals will have an initial assessment and treatment provision 24 hours a day. Glangwili and Bronglais hospitals will be Treat and Transfer hospitals, where stroke patients will be assessed and given an initial treatment before transport to another hospital to meet their needs. Prince Philip and Withybush hospitals will have Acute Stroke Units. An Acute Stroke Unit will provide an initial assessment and treatment and ongoing specialist care. The Acute Stroke units will also provide a base rehabilitation service Monday to Friday 9am to 5pm and access to a consultation out of hours when required.

Prince Philip Hospital will become the Urology Centre for the health board. This centre will deliver the majority diagnostics (which is the process of identifying a particular illness, planned care and cancer services. Glangwili Hospital will provide emergency urology care only). Bronglais and Withybush hospitals will continue with day case and outpatient services only. Trial Without Catheter Services, where a catheter is removed for a trial period of time to see if you are able to pass urine as before, will be carried out in community settings by primary care services.

Bronglais Hospital will provide emergency (trauma) orthopaedic services, as well as inpatient and day case services. Glangwili Hospital will provide emergency (trauma) orthopaedic services, and planned outpatient clinics. Prince Philip Hospital will expand the provision of inpatient and day case complex planned services to six days from the current five day service, which will include Arthroplasty, which is the re-forming of joints. Withybush Hospital will provide emergency (trauma) orthopaedic services, increased low complex planned day case services within the Day Surgery Unit and outpatient services. The hospital will also provide outpatient services. The current temporary change of treating day cases only will be made permanent. Cardigan Integrated Care Centre and Tenby Hospital will provide outpatient clinics in the community, as they do now. To support regional work, Prince Philip Hospital will work in partnership with Swansea Bay University Health Board to reduce the number of patients waiting for treatment across West Wales. Tywyn Hospital (based in Betsi Cadwaladr University Health Board) will continue to provide outpatient clinics for their patients.



-  The least positive impact out of the 4 options against the criteria
-  No difference in positive impact between the options
-  The greatest positive impact out of the 4 options against the criteria

## Appendix C – Option scoring results

The table below shows the scoring of each option against each of the evaluation criteria.

Criteria	Option 1 score		Option 2 score		Option 3 score		Option 4 score	
	Unweighted	Weighted	Unweighted	Weighted	Unweighted	Weighted	Unweighted	Weighted
Number of patients requiring transfers	204	1658	136	1105	273	2218	272	2210
Compliance/ attainment of standards	262	4847	244	4514	266	4921	279	5162
Impact on internal services	205	1491	171	1244	239	1739	249	1811
Impact on external services	189	926	156	764	249	1220	243	1191
Clinically sustainable	233	4590	222	4373	285	5615	273	5378
Workforce sustainability	279	5343	222	4251	282	5400	243	4653
Financial sustainability	266	4096	168	2587	272	4189	228	3511
Reduction in waiting lists and treatment times	244	2995	246	3020	293	3597	297	3646
Patient travel time to sites	208	1464	171	1203	241	1696	250	1759
Transfer travel time	199	1542	162	1256	256	1984	260	2015
Impact on local communities	213	1137	197	1051	242	1292	246	1313
Impact on staff and patients needing to travel regionally for care and treatment	217	1522	203	1424	255	1788	253	1774
Amount of activity taking place in the community	212	1026	241	1166	248	1200	246	1190
Impact on population health outcomes	236	2761	240	2808	254	2972	256	2995
Addressing barriers to care	250	1531	245	1501	264	1617	272	1666
Addressing barriers to equality	211	1350	213	1363	230	1472	235	1504
<b>Total</b>	<b>3628</b>	<b>38279</b>	<b>3237</b>	<b>33631</b>	<b>4149</b>	<b>42919</b>	<b>4102</b>	<b>41779</b>

The table presents the unweighted score (the scores of 1 to 10 provided by the participants added together) and the weighted score (the unweighted score multiplied by the criteria weighting). Weighted scoring totals for each criterion may not add up to the weighted scoring total for each option due to rounding.

It should be noted that while Option Three scored the highest of the options, there were criteria where Option Four scored higher on a weighted and unweighted basis. These are:

- Compliance / attainment of standards
- Impact on internal services
- Reduction in waiting lists and treatment times
- Patient travel time to sites
- Transfer travel time
- Impact on local communities
- Impact on population health outcomes
- Addressing barriers to care
- Addressing barriers to equality

While Option One did not score higher than Option Three on any of the criteria, Option One did score higher than Option Four on two of the criteria. These are:

- Workforce sustainability
- Financial sustainability

While Option Two did not score higher than Option Three or Option Four on any of the criteria, Option Two did score higher than Option One on three of the criteria. These are:

- Reduction in waiting lists and treatment times
- Amount of activity taking place in the community
- Impact on population health outcomes