

Phase 2 public engagement for strategy refresh

19th December 2025

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Executive summary

Aim of Phase 2 public engagement

Phase 2 engagement was designed to ensure the Health Board's refreshed long-term strategy, *A Healthier Mid and West Wales*, is shaped by the lived experiences and priorities of its population. Building on Phase 1, Phase 2 tested and refined strategic objectives through 11 structured questions across four themes: A Social Model for Health and Well-being, digital healthcare support, balancing hospital and community care, and clinical services and hospital redevelopment. The process aimed to raise awareness, listen to people's ideas and concerns, address misinformation, and ensure seldom-heard voices were included.

Engagement approach

Between September and November 2025, a robust, multi-method approach was used. Activities included targeted group meetings, hospital walkarounds, community outreach, and multilingual online and paper questionnaires. Stakeholder mapping ensured broad representation, with a focus on under-represented groups. Over 2,000 individuals participated, including 287 responses using the health board's 'Have Your Say' website. Feedback was also gathered via email and written submissions. The approach prioritised inclusivity, accessibility (e.g., British Sign Language (BSL) interpretation, large print), and ongoing dialogue rather than a one-off consultation.

Key themes

Barriers to access:

Transport, rurality, GP and dental appointment bottlenecks, digital exclusion, and estate limitations (e.g., parking and toilets) were consistently stated as being barriers to equitable care, especially for rural, disabled, and digitally excluded groups.

Community assets and prevention:

There was strong support for a Social Model of Health and Well-being with community hubs, local groups, and third-sector partnerships seen as vital for prevention, well-being, and reducing demand on acute services.

Digital transformation – inclusion by design:

While digital tools (e.g., NHS Wales App) were welcomed by some, concerns about digital exclusion, accessibility, and the need for human contact were prominent. Participants called for digital to be an option, not a default, with robust support for those less confident or able to use technology.

Communication and navigation:

Clear, compassionate, and accessible communication, across all channels and formats, was a recurring theme. Participants highlighted the need for plain-language, bilingual materials, reliable information on service changes, and visible feedback loops ("You said, we did").

Equity and rurality:

Rural transport, travel times, and service centralisation were seen as major drivers of inequity. There was a strong preference for care “closer to home” and for practical mitigations (e.g., park-and-ride, volunteer drivers, satellite clinics) during the transition to any new hospital network.

Workforce and service fragility:

Workforce shortages, especially in primary care and fragile specialties, were linked to access delays and service instability. Staff well-being, recruitment, and retention were highlighted as priorities for sustainable transformation.

Equality impacts

Equality impacts were evident throughout. Rurality, disability, age, digital poverty, and language barriers shaped experiences of access and care. The risk of digital exclusion, transport inequity, and the need for accessible estates and communications were particularly salient for disabled, older, and minority groups. The engagement process itself was designed to mitigate these risks through targeted outreach, accessible formats, and partnership with community organisations.

Key recommendations

The most frequently mentioned recommendations included requests to:

- Improve transport and local access (community transport, volunteer drivers, park-and-ride, local hubs).
- Strengthen community hubs and prevention programmes.
- Ensure digital inclusion by design (maintain non-digital access, provide digital skills support, accessible digital tools).
- Invest in accessible estates and facilities (parking, toilets, signage).
- Enhance communication and feedback (plain-language, bilingual, “You said, we did”).
- Support workforce resilience (recruitment, retention, multidisciplinary teams).
- Advance equity and inclusion (monitor and address disparities, embed equality impact assessments).

Strengths and limitations

Strengths: Breadth and inclusivity of engagement, systematic thematic analysis (supported by AI), and strong alignment with strategic priorities.

Limitations: Potential bias in AI-supported coding, incomplete data from some groups, limited human verification, and under-representation of some feedback channels.

Strategy refresh alignment

Findings from Phase 2 engagement strongly align with the objectives of *A Healthier Mid and West Wales*: shifting to prevention of ill health, strengthening community-based delivery, ensuring

equitable access, and modernising acute care. Persistent barriers, especially transport, digital exclusion, and estate fragility, are recognised as priorities for immediate and medium-term action.

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1. Introduction

In November 2024, work started to refresh the Health Board's existing long-term strategy, "A Healthier Mid and West Wales" (AHMWW).

Since then, work has been carried out to understand which elements of the strategy are still valid and can remain as they are, which elements are still valid but need revising to reflect, for example, demographic changes, and which elements may need refreshing because they are fundamentally different from how they were envisioned when the strategy was approved in 2018.

As part of the strategy refresh process, the Health Board has engaged with the public to ensure that the refreshed strategy meets the needs of communities and reflects the "public voice."

Public engagement activity for the strategy refresh process has been split into two distinct phases: Phase 1 and Phase 2.

Phase 1 public engagement

Phase 1 public engagement activity for the strategy refresh process started in July 2025. It took place alongside other consultation events and engagement activity by asking people the broad question: "What is important for you to live a healthy life?"

The question was asked in various ways, including via the Health Board's online engagement platform Have your say/Dweud eich Dweud, YouGov polling, and postcards with the question were also handed out at Health Board consultation activities and events. Events such as the Royal Welsh Agricultural Show and Pembrokeshire Agricultural Show invited visitors to share their views on a large message board also.

A six-step systematic thematic analysis of the "Have your say" responses and YouGov responses was carried out with the support of Copilot. The themes identified in the two data sets were then synthesised. The five common themes in the two data sets were:

1. Equitable Access to Health and Support Services

Includes proximity, affordability, digital access, and joined-up care.

2. Holistic Prevention and Lifestyle Support

Encompasses diet, exercise, screening, and proactive health behaviours.

3. Mental and Emotional Well-being

Covers stress, sleep, purpose, and psychological resilience.

4. Social Connection and Community Belonging

Emphasises relationships, peer support and community infrastructure.

5. Empowering Environments and Autonomy

Includes clean air, green spaces, mobility, independence, and self-care.

Phase 1 engagement activity highlighted the diversity of the building blocks of health and well-being. Factors such as diet, community infrastructure, equitable access to healthcare services and

access to green spaces, among others, were all reported to influence and impact people's health and well-being.

Phase 2 public engagement

Themes identified in Phase 1 were used to inform the development of 11 questions across 4 broad themes (sections) for Phase 2 engagement. The 11 questions and 4 themes were:

Section 1 Social Model for Health and Well-being

1. What helps you stay healthy day-to-day, beyond seeing a doctor, nurse, or healthcare professional?
2. Who outside the NHS do you think could be part of keeping people well?
3. Are there people or groups in your local area who could play a big role in helping others live healthier lives?
4. What kind of support would make it easier for you to live a healthier life?

Section 2 Digital Healthcare Support

5. How do you feel about using the internet or apps to look after your health or share health information?
6. If digital healthcare worked well for you, what would it look like?
7. What would help you to feel confident using online tools or services to get healthcare?

Section 3 Balancing Hospital Care and Community Support

8. If you could get help quickly to stay well in your community, how would that change how you feel about going to hospital?
9. What kind of care or support would you like to have nearby so you don't need to go to hospital?
10. If you had to travel further for specialist care, what could we do to make that journey worthwhile and less stressful?

Section 4 Clinical Services and Hospital Redevelopment

11. If we secure funding to improve healthcare buildings and facilities, especially at sites most in need of repair – what would you like us to prioritise and what concerns should we work through together as those changes take place?

The purpose of Phase 2 engagement was to:

- Publicise the strategy refresh process and raise awareness across communities.
- Provide opportunities for communities to share their views and respond to the strategy questions and inform the strategic direction of the Health Board moving forward.
- Identify appropriate engagement and communication tools and methods, to reach more of our communities and engage them in the conversation.
- Seek to manage public expectations and provide reassurance about service provision.
- Reactively address any widely spread misinformation.

The engagement approach was positioned as an on-going conversation with communities rather than a formal public consultation framework. The engagement focus was to go to communities

where they meet and have a two-way dialogue to understand in more detail their views on the 11 questions. This approach reflected the fact that the Health Board had recently completed two back-to-back public consultations and wanted to avoid community engagement fatigue.

2. Engagement approach

2.1 Introduction to engagement approach

The purpose of the engagement period was to promote and raise awareness of the strategic refresh process. We also wanted to provide opportunities for our communities to share their views and respond to the strategy questions to inform the strategic direction of the Health Board moving forward.

A detailed stakeholder map was developed to identify a wide range of stakeholders across in the Hywel Dda University Health Board (UHB) area with an interest in health and well-being and enable them to participate in the process.

Engagement was tailored to suit their differences, circumstances, and requirements. There was also an emphasis on targeted face-to-face group engagement in their community settings or specific group meetings to engage them in the conversation on key issues identified from Phase 1 of the strategic refresh.

We worked with local community and voluntary sector groups and networks, alongside the Community Development Outreach Team to ensure that under-represented groups had the opportunity to have their say and respond to the strategy questions.

The following activities were undertaken, and participants were given the opportunity to give their feedback in the following ways:

- Public engagement through targeted group meetings where there was an opportunity to share information, have facilitated conversations and handwritten feedback notes were taken.
- Hospital visits and walkarounds to speak with staff and patients in outpatients' departments.
- Community Development Outreach Team sessions and meetings where information was shared.
- Third sector and partner organisations network events where the Health Board had a stand to share information, promote the engagement, and encourage participation.
- Online questionnaire, available in English, Welsh, Arabic and Polish, on the Health Board's Have Your Say/Dweud eich Dweud website.
- Information circulated to key stakeholders via email and post.

In addition, participants were invited to share their feedback via:

- Hard copy questionnaire in large postcard format and other written feedback posted to FREEPOST HYWEL DDA HEALTH BOARD

- Telephone, directed to the Communications Hub 0300 303 8322
- Email to Hyweldda.Engagement@wales.nhs.uk
- Via feedback to Llais West Wales which would be shared with the Health Board (anonymised)
- Visibility campaign internally and in health care settings through poster distribution and display (QR code and phone number as a call to action)

Groups Sessions / Events

During the 9-week long engagement period, there were 121 meetings, events, and activities. These sessions meant we were able to speak with 2021 people.

Walkarounds were arranged at our hospital and integrated care centre sites to raise awareness of the strategy refresh activities among Health Board staff. During the walkarounds we also shared information on how staff could share their views. There was also the opportunity for us to speak with patients in some of the outpatients' departments.

Date	Hospital Site	County	Numbers Engaged/Informed
15th October 2025	Withybush Hospital	Pembrokeshire	90
16th October 2025	South Pembrokeshire Hospital	Pembrokeshire	25
16th October 2025	Tenby Cottage Hospital	Pembrokeshire	15
20th October 2025	Prince Philip Hospital	Carmarthenshire	160
22nd October 2025	Glangwili Hospital	Carmarthenshire	175
23rd October 2025	Amman Valley Hospital	Carmarthenshire	12
23rd October 2025	Llandovery Hospital	Carmarthenshire	14
27th October 2025	Cardigan Integrated Care Centre	Ceredigion	19
27th October 2025	Aberaeron Integrated Care Centre	Ceredigion	15
28th October 2025	Bronglais Hospital	Ceredigion	95

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A wide variety of group meetings, community activities and third sector networking events identified during the stakeholder mapping exercise were attended by the Health Board's Engagement Team and the Community Development Outreach Team.

As a targeted approach to engagement was identified, the teams were able to respond to the requirements of specific groups appropriately. For example, BSL interpretation was booked for a Llanelli Deaf Club meeting, and large print versions of the questions were taken to meetings for people with visual disabilities.

The meetings took the form of facilitated conversations framed around the 11 questions. Feedback from the following sessions was captured by notetakers:

ID	Name of group / session	Primary stakeholder group	Number of participants /people
1	Caffi no.5 - supported employment for people with disabilities	People with learning disabilities	6
3	HOPE MS Charity	People with physical disabilities	2
5	Tenby Friendship Group	Older people	40
6	Llanelli Deaf Club	People with sensory disabilities	12
7	Caredig 10 Year Anniversary Event	Older people	2
8	Sign and Share	People with sensory disabilities	9
9	Pembrokeshire Bereavement Forum	Partner organisations	4
10	Llanybydder Family Centre	Mothers/Parents	8
11	Pembrokeshire 50+ Forum	Older people	17
12	Coffee morning with parents of disabled children	Pan-disability	7
13	CWTCH	People with mental health conditions	7
14	Area 43 panel of young people meeting	Young people	6
15	Cylch ti a fi Hwlfordd / Haverfordwest	Mothers/Parents	17
16	Young People Speak Up Llanelli	Young people	7
17	Nacro Connect Drop in Event, Llandovery	General public	8
18	Pembrokeshire Carers Group	Carers	5
19	Milford Haven Macular Group	People with sensory disabilities	13
20	Lampeter Food Project	Older people	12
21	Women's Health and Wellbeing Network	Women	10
22	Aberystwyth & District Visually Impaired Club	People with sensory disabilities	15
23	Aber Dads	Fathers/Parents	15
24	Carers Rights Day (Ceredigion)	Carers	15
25	Amroth Craft Group	Women	10
26	Carmarthen Town Council General Purpose Committee	Partner organisations	7
27	Carmarthenshire People First	People with learning disabilities	14
28	Cosheston Local Community Group	General public	7
29	Macular Group, Carmarthenshire	People with sensory disabilities	9
30	Pembrokeshire Coast National Park Accessible Walk Group	People with physical disabilities	7
31	People Speak Up over 50's, Llanelli	Older people	16
32	Pembrokeshire Carers Rights Day	Carers	36
33	Pembrokeshire Youth Assembly	Young people	20
34	Stakeholder Reference Group	Partner organisations	11
35	Pride in Age Friendship Group	LGBTQ+ communities	5

36	Age Cymru Dyfed – Building Stronger Futures for Older Veterans	General public	2
37	Older Adult Art for Health and Wellbeing, Borth Community Hub	Older people	10
38	Forget me Knot Dementia Group – Ray Ceredigion, Aberaeron	Older people	22
39	Dream Team and Pembrokeshire People First meeting	People with learning disabilities	8
40	Cylch Ti a Fi Llanddewi Brefi	Mothers/Parents	4
41	West Wales Amputee Social Group	People with physical disabilities	11
42	Ceredigion Disability Forum – targeted session	Pan-disability	3
43	Ceredigion Youth Council	Young people	37

The following table lists other events and activities attended by the Engagement Team and Community Development Outreach Team:

Event	Type of stakeholder(s)	No of people informed / engaged
Teams Meeting with Age Friendly Ceredigion	Partner Organisation/Older people	1
Meeting with Health and Wellbeing Officer, PCNPA	General public	1
Rachel's Organics	Migrant workers	20
World Mental Health open day	Mental health	25
Fishguard Food Festival	General public	15
Cardigan Foodbank	General public	2
Pen y Bryn and Gypsy Lane	Gypsy/Traveller	15
Rachel's Organics	Migrant workers	10
The Health Care & Wellbeing Alliance (PAVS)	General public	20
CAVS Health & Wellbeing Forum	General public/Third sector organisation	12
Salvation Army	Homeless/vulnerably housed	2
Links Tumble Veterans Coffee Morning	Veterans	4
St Annes Church, Aberystwyth	General public	3
CAMFAN	Mental health	13
ESOL, Aberystwyth	Refugees	7
St Annes Church, Aberystwyth	General public	14
Llanelli Food Bank	Socially disadvantaged	6
Capel Y Morfa, Aberystwyth	Socially disadvantaged/Homeless	13
Wallich Coffee Morning	Migrant workers/Socially disadvantaged	18
CAVO Green Spaces Information Event	General public/Third sector organisations	15

Living Well Food Strategy Event	General public	20
Monkton Dezza's cabin, Gypsy Woman's Group	Gypsy/Traveller	19
Aberaid Coffee and Chat	Refugees	10
Volunteering and Jobs Fair	General public/Third sector organisation	10
Primavera	LGBTQ+	6
Scolton Manor Craft Fayre	General public, people with learning disabilities, young families/ parents	44
NACRO Drop-in	General public	8
Pembrokeshire Peninsula working group	Partner Organisations	6
Community Cafe Tenby	Socially disadvantaged	9
Lampeter Food Project	Socially disadvantaged	25
Dunbia Abattoir, Llanybydder	Migrant workers	20
Liver Health Check Event	General Public/HB Staff	30
PAVS Community Connector Speed Network	Local Authority and Third sector organisations	33
Cardished	Third sector organisation	13
Money Matters	Socially disadvantaged	2
VC Gallery	Veterans	Not reported
St Dogmaels Jig-So Parent and Toddler	Mothers/parents	20
Ammanford Foodbank	Socially disadvantaged	8
Llanelli Foodbank	Socially disadvantaged	4
Haverfordwest Mosque	Religious community	70
Ceredigion Employability Support	Partner organisations	1
Aberaeron Friendship Group	Older people	35
Pembrokeshire Older's people Network	Older people	11
VC Gallery, Pennar	Veterans/Homeless/Vulnerably housed	20
VC Gallery Young people's cooking course	Young people	5
Carmarthen Foodbank	Socially disadvantaged	3
Veterans Day	Veterans, Partner organisations	20
PAVS Funding Fair	General public/Third sector organisation	47
Over 50s Group (Railway Goods Shed)	Older people	7
Waterloo Gypsy Site	Gypsy/Travellers	Not reported
Gilead, Cardigan	General public	15
Dubia, Cross Hands	Migrant workers	30

Carers Rights Day	Carers	30
Carers Rights Day event (Aberaeron ICC)	General public	10
Pembrokeshire Learning Disabilities Board	People with learning disabilities	Not reported
Llanddewi Brefi Community Centre Cafe	General public	20
Aberystwyth University	Young people	20
Tenby Town Council	General public	5
Macular Degeneration	People with sensory disability	6
Lampeter ESOL	Refugees	2
The Well, Aberystwyth	Socially disadvantaged	15
Carmarthen Foodbank	Socially disadvantaged	1

2.2 Social media approach

The 'strategy refresh' social media campaign ran for 9 weeks with primary objectives of raising awareness of the engagement exercise and driving increased survey completions.

The campaign ran across Instagram and Facebook with both organic and paid boosts. Paid boosts ran for 7 days each across each of the three official health board accounts;

<https://www.facebook.com/HywelDdaHealthBoard/>,

<https://www.facebook.com/bwrddiechydyhweldda/> and <https://www.instagram.com/hywelddauhb/>.

The metrics recorded included views, reach, shares, comments, engagements, profile visits, landing page views and link clicks.

The primary objectives were focussed on:

- raising awareness of the engagement activities,
- driving people to view to the 'Have your Say' strategy refresh webpage, and
- driving engagement with the 'Have your Say' strategy survey.

The schedule of posts spanned nine weeks with questions from the survey being shared in social media posts according to the schedule. The campaign was closed out with further social media posts reminding people of the closing date for completing the survey. The social media pages were monitored between the hours of 9am and 5pm, Monday to Friday and comments in response to posts were recorded, with person-identifying details redacted, in a social media comment log.

3. Data analysis methods

3.1 Introduction to data analysis

Different methods were used to analyse data collected via the various data collection methods. This section of the report describes the different methods used for data analysis.

3.2 Summary of qualitative data, thematic analysis, and systematic thematic analysis

Most of the data collected through the engagement activity were qualitative data. Qualitative data are data that are non-numerical. In other words, qualitative data cannot be represented by numbers. Examples of qualitative data include notes from focus groups, transcripts from interviews, responses to open-ended questions in surveys, videos, photographs, diary entries or field notes.

One of the most common ways to analyse qualitative data is thematic analysis.

“Thematic analysis (TA) is one of the most widely used methods for analysing qualitative data. It offers a structured yet flexible framework for identifying, analysing and interpreting patterns of meaning within datasets.”

Using thematic analysis in qualitative research - ScienceDirect
(Accessed 5th September 2025)

Thematic analysis is a useful research method that can be used to understand people’s views, opinions, knowledge, experiences, or values from qualitative data.

Thematic Analysis: A Step-by-Step Guide
(Accessed 3rd December 2025)

One commonly used framework to carry out thematic analysis of qualitative data is Braun and Clarke’s (2006) six-phase framework. A summary of Braun and Clarke’s six-phase framework for thematic analysis is presented in Appendix 1. Braun and Clarke’s framework is often praised for its accessibility, clarity and easy to follow step-by-step process.

Braun and Clarke: An Approach to Thematic Analysis
(Accessed 5th September 2025)
(PDF) *Using thematic analysis in psychology*
(Accessed 5th September 2025)

In 2023, Naeem et al. modified Braun and Clarke’s six phase framework to create the “systematic thematic analysis process”. The modified process also has six steps. A summary of Naeem et al.’s six-step systematic thematic analysis framework is shown in Appendix 2. As Naeem et al. (2023) report:

“The thematic analysis process is called “systematic” because it follows a structured, sequential approach to interpreting research data. Each stage builds on the previous one, which results in a comprehensive understanding of the data. This organized method enhances the consistency and replicability of the findings, and it enables clear connections between the data, interpretation, and final conclusions. This systematic structured approach ensures thoroughness and limits potential bias.”

*A Step-by-Step Process of Thematic Analysis to Develop a Conceptual Model in Qualitative Research - Muhammad Naeem, Wilson Ozuem, Kerry Howell, Silvia Ranfagni, 2023
(Accessed 5th September 2025)*

There is an increasing focus on the potential of using Artificial Intelligence (AI), such as Copilot (or ChatGPT), to carry out or support thematic analysis of qualitative data. For example, it is reported that:

“The public availability and popularity of AI tools such as ChatGPT1 marks a transformative step in handling text data and raises questions about its potential use in qualitative research. This technology presents a compelling alternative to more traditional Natural Language Processing (NLP) approaches, which often require extensive programming knowledge and complex coding procedures. Instead, ChatGPT offers an intuitive, conversational interface that simplifies the analytical process, potentially enhancing the quality and efficiency of research outcomes.”

Turobov, A. et. al. (2024). Using ChatGPT for thematic analysis- working paper. University of Cambridge. Available at Using-ChatGPT-for-analytics-WP.pdf (accessed 14th November 2025)

Despite potential benefits, there are reported limitations of using AI to support or carry out thematic analysis, as summarised in Appendix 3. To address the potential limitations of using AI, such as Copilot, for systematic thematic analysis, Naeem et. al developed a toolkit about using AI for systematic thematic analysis. The toolkit provides clear guidelines and outlines a rigorous approach to develop prompts for AI systems, such as Copilot.

*Thematic Analysis and Artificial Intelligence: A Step-by-Step Process for Using ChatGPT in Thematic Analysis - Muhammad Naeem, Tracy Smith, Lorna Thomas, 2025
(Accessed 5th September 2025)*

Thematic analysis and the six-step systematic thematic analysis approach were used to analyse data collected through engagement activity.

3.3 Systematic thematic analysis of Have Your Say responses and feedback from group sessions and events

Of all the data collection methods, only the Have Your Say questionnaire and some of the group sessions and events collected data specifically for the 11 engagement questions. To identify themes for each of the 11 engagement questions, the Have Your Say question-level responses were combined with (manually identified and recorded) question-level comments and feedback from the group sessions and events. This combining of the two data sets was carried out for each of the 11 questions.

It was decided that Copilot would be used to support the systematic thematic analysis of the collated question-level data using the six-step systematic thematic approach.

A draft prompt was developed for Copilot to carry out the six-step systematic thematic analysis.

The “prompt coach” agent, incorporated in Copilot, was used to refine and improve the draft prompt. The refined prompt was reported to be clearer and easier for Copilot to understand.

Following the six-step approach, the prompt included, for example, some contextual information and a summary of the analysis and outputs required for each of the six steps in the process.

The Copilot prompt used for the analysis is shown in Appendix 4.

3.4 Analysis of email responses and responses in writing

Feedback received via email and the response received in writing was combined into one data set.

It was decided that the six-step systematic thematic analysis approach, used to analyse Have Your Say responses and feedback from the group sessions and events, would not be used to analyse email responses and the response received in writing. This is because there was limited data in the combined data set. It was considered that it would not be appropriate or feasible to analyse the limited data using the six-step approach. Instead, it was decided that Copilot would be used to support a high-level thematic analysis of the feedback.

A draft prompt was developed for Copilot to carry out a thematic analysis. The “prompt coach” agent, incorporated in Copilot, was used to refine and improve the draft prompt. The refined prompt was reported to be clearer and easier for Copilot to understand.

The Copilot prompt used for the analysis is shown in Appendix 4.

3.5 Analysis of feedback from individual stakeholder groups

It was vitally important for the Health Board to engage with seldom heard groups and communities as part of the engagement process for the strategy refresh. Seldom heard refers to under-represented groups, who may face barriers, such as communication barriers, to having their voices heard.

The Health Board engaged with the following 25 under-represented groups and communities to seek and obtain their feedback:

- Carers
- Faith communities/People of faith
- General public
- Gypsy and traveller communities
- Health Board staff
- LGBTQ+ communities

- Men
- Migrant workers
- Mothers / Parents
- Older people
- Pan-disability
- Partner organisations
- Patients
- People affected by substance misuse
- People experiencing homelessness
- People experiencing social disadvantage
- People with learning disabilities
- People with mental health conditions
- People with physical disabilities
- People with sensory disabilities
- Refugees and asylum seekers
- Roma
- Veterans
- Women
- Young people

Various events and sessions took place with stakeholder groups. In brief, some of the events and sessions were used to draw out feedback about the 11 engagement questions; others were used to raise awareness about and signpost people to, for example, the online questionnaire that people could use to give feedback.

Each event or session was attributed to just one stakeholder group, e.g., carers. However, this meant that feedback from some stakeholder groups was not specifically captured or analysed. For example, if an event was set up primarily for people with physical disabilities, it was attributed as an event only for people with physical disabilities. If, for example, carers attended the event, their feedback was included in the group feedback and it was analysed with the whole group feedback, i.e. included in feedback from people with physical disabilities; it was not filtered out and analysed separately. One reason for this was that it was not possible to identify individuals in the notes from the events and sessions. This meant that it was not possible to attribute feedback from individuals to the stakeholder group that they represented.

Although feedback from some stakeholder groups was not specifically recorded or analysed (for the reasons above), it is expected that people from all 25 stakeholder groups did, in fact, participate in the engagement process, e.g., by submitting an online response or attending an event. It is known that many of the group sessions and events were attended by people, who aligned with multiple stakeholder groups (e.g., older people and physical disabilities). However, as noted, only the primary stakeholder group for each group session or event was recorded.

The notes from events and sessions were grouped according to the primary stakeholder group that the event or session was for. For example, feedback from all the events and sessions primarily for older people were grouped together for analysis.

It was decided that an analysis of the feedback from stakeholder groups would be carried out.

Copilot was not used to support a six-step systematic thematic analysis of the feedback from stakeholder groups. Instead, it was used to support a high-level analysis of the feedback to identify the main themes from stakeholder groups. This alternative analytical approach was used partly because the six-step systematic thematic approach was not appropriate or feasible for the limited data available for some of the stakeholder groups.

The prompt for Copilot to carry out a high-level analysis is shown in Appendix 4.

3.6 Analysis of feedback via social media

The health board collated all the comments made on its official Instagram and Facebook pages during the engagement period. All comments were recorded and reviewed by the communications team. Thematic analysis was undertaken.

4. Results

4.1 Introduction to results

This section of the report presents the results of the various analyses carried out.

Copilot was used to support the various analyses and produce the findings. However, it is acknowledged that Copilot can occasionally make mistakes. For example, it can generate outputs, content or findings that are factually incorrect, incomplete, or inappropriate. The Copilot-produced findings have been reviewed by members of the Strategic Refresh team to try to mitigate against this and ensure that the results are as accurate and as relevant as possible.

All quotes and comments are reported verbatim.

Quantitative data, such as the number of questionnaire responses, were analysed in Excel and are also reported.

4.2 Have Your Say, group sessions and events

This section of the report presents the results of the Have Your Say responses and feedback from the group sessions and events.

4.2.1 Summary of Have Your Say responses

In total, there were 287 Have Your Say responses.

The table below shows a breakdown of how the 287 responses were submitted:

	Number (n)	% of total responses
English online	253	88.2%
Welsh online	6	2.1%
Paper versions	28*	9.8%
Total	287	100.1%**

**Included 1 response in Polish*

*** Does not equal 100.0% because of rounding*

The table below shows the response rate for the questions on Have Your Say:

Question number	Number of responses (n)	Response rate (%) *
1	276	96.2%
2	273	95.1%
3	255	88.9%
4	262	91.3%
5	278	96.9%
6	272	94.8%
7	264	92.0%
8	264	92.0%
9	258	89.9%
10	265	92.3%
11	255	88.9%
Equality impact	113	39.4%

**Based on total 287 respondents*

4.2.2 Summary of group sessions and events

Of the total 25 stakeholder groups, feedback notes were produced for 14 of them and feedback notes were not produced for 11 of them. The table below shows the stakeholder groups that feedback notes were and were not produced for:

Feedback notes produced for	Feedback notes not produced for
Carers	Faith communities/People of faith
General public	Gypsy and Traveller communities
Health Board staff	Men
LGBTQ+ communities	Migrant workers
Mothers / Parents	Patients
Older people	People affected by substance misuse
Pan-disability	People experiencing homelessness
Partner organisations	People experiencing social disadvantage
People with learning disabilities	Roma
People with mental health conditions	Refugees and asylum seekers
People with physical disabilities	Veterans
People with sensory disabilities	
Women	
Young people	

In total, feedback notes from 43 group sessions and events (spanning the 14 stakeholder groups above) were produced.

Of the total 43 group sessions and events that feedback notes were produced for, the number of participants was recorded for 40 of them. Overall, 815 people participated in the 40 group sessions and events.

The table below shows the number of events for each stakeholder group that feedback notes were produced for, and the total number of people at those events:

Stakeholder group	Number of events	Number of participants	Comments
Carers	3	100	
General public	3	17	
Health Board staff	2	335	
LGBTQ+ communities	1	5	
Mothers/Parents	4	44	
Older people	7	102	Number of participants not recorded for 1 event
Pan-disability	2	10	
Partner organisations	3	22	
People with learning disabilities	3	28	
People with mental health conditions	1	7	
People with physical disabilities	3	20	
People with sensory disabilities	5	36	Number of participants not recorded for 2 events
Women	2	20	
Young people	4	69	
Total	43	815	

The group sessions and events with the least number of people were HOPE MS Charity, Caredig 10 Year Anniversary Event and Age Cymru Dyfed – Building Stronger Futures for Older Veterans (2 people at each). The group session and event with the highest number of people was the Glangwili Hospital Site Visit / Walkaround (175 people).

The mean number of people at the 40 group sessions and events that feedback notes were produced for was 20.4.

Various engagement questions were discussed and covered during individual group sessions and events.

The table below shows the number of group sessions or events that each of the 11 engagement questions, the 4 section-level questions, and 'other comments' question were discussed and covered at:

Question	Number of events that covered the question	% of total number of events*
1	31	72.1%
2	27	62.8%
3	30	69.8%
4	29	67.4%
5	32	74.4%
6	27	62.8%
7	24	55.8%
8	28	65.1%
9	31	72.1%
10	31	72.1%
11	30	69.8%
Section 1 comments	20	46.5%
Section 2 comments	20	46.5%
Section 3 comments	21	48.8%
Section 4 comments	8	18.6%
Other comments	34	79.1%

**The total number of events was 43.*

The results show that 'other comments' were discussed or covered at more group sessions and events than any of the other questions. Of the total 43 group sessions and events, 34 (79.1%) discussed or covered 'other comments'. Question 5 (How do you feel about using the internet or apps to look after your health or share health information?) was the next most discussed or covered question. Of the total 43 group sessions and events, 32 (72.4%) discussed or covered the question. Of the 11 engagement questions, Question 7 (What would help you to feel confident using online tools or services to get healthcare?) was least discussed or covered question. Of the total 43 group sessions and events, 24 (55.8%) discussed or covered it.

4.2.3 Themes for 11 engagement questions (Have Your Say responses, group sessions and events combined)

This section of the report presents the results (themes) of the six-step systematic thematic analysis of the Have Your Say, group sessions, and events for the 11 engagement questions. In line with the six-step approach, keywords, codes, and conceptual models are also reported.

4.2.3.1 Themes for Section 1: Social Model for Health and Well-being (questions 1,2,3 and 4)

1. What helps you stay healthy day-to-day, beyond seeing a doctor, nurse or healthcare professional?

Step 1 — Familiarisation

The full dataset for Question 1 (free text responses on what helps people stay healthy day-to-day, beyond clinical care) was reviewed. The information provided is rich, varied, and highly repetitive around several topics (e.g., exercise, walking, diet/healthy food, social contact, access/affordability, nature/outdoors, sleep, transport, community groups, carers' needs, disability access). A small subset references experiences with primary care access, test results, and deaf awareness — although the prompt asked about non-clinical supports, these items signal communication and inclusion barriers linked to well-being. Data quality issues noted include duplication, inconsistent punctuation/capitalisation, named individuals/places (removed/redacted below), and opinion statements (e.g., anti-vaccination or supplementation positions) that require cautious interpretation in a public health strategy context.

Step 2 — Keyword Selection (using the “6 Rs”: Relevance, Recurrence, Richness, Resonance, Representativeness, Rigour)

Programmatic frequency analysis was used to bring out from the dataset recurring terms and bigrams (two consecutive words that have a distinctive meaning when used together). This was then filtered with the 6 Rs to retain substantive, widely represented, and strategically relevant signals. Bigrams are two consecutive words that have a distinctive meaning when used together. https://topic-modeling.pythonhumanities.com/01_03_bigrams_and_trigrams.html (Accessed 8th December 2025)

Frequency counts reflect stems as they appear in the text (lowercased).

Keyword	Frequency	Rationale
exercise	96	High recurrence; central to staying healthy; appears with classes, gym, daily routines (Relevance, Recurrence, Richness).
healthy	77	Used with diet/food/eating; broad resonance across age groups; anchors prevention narrative (Relevance, Resonance).
Eating	69	Often collocated with “healthy,” “home-cooked,” “affordable”; food environment signal (Richness, Representativeness).
walking	56	Accessible physical activity in rural/urban settings; links to transport, safety, nature (Relevance, Reach).

Keyword	Frequency	Rationale
access	50	Repeated in relation to parks, transport, services, affordability, disability; barrier/enabler term (Rigour, Representativeness).
Diet	48	Nutritional choices, UPFs, plant-based, affordability; policy levers on food environment (Richness, Resonance).
Food	44	Reinforces diet/affordability; references food banks, organic shops; social determinants (Relevance, Representativeness).
friends	39	Social support, isolation-breaking groups; community cohesion signal (Resonance, Reach).
social	34	Socialising, clubs, groups, choir; mental health protection (Richness, Relevance).
active	34	Physical and social activation; behavioural pattern signal (Recurrence, Resonance).
family	32	Carers, multi-generational support; protective factor (Representativeness, Richness).
mental	22	“Mental health,” “mindfulness,” “stress,” sleep; well-being pillar (Relevance, Resonance).
community	20	Hubs, groups, volunteering; strategy aligned to community-based care (Relevance, Rigour).
sleep	14	Repeated as a daily health foundation; relates to work–life balance (Richness, Resonance).
outdoors	14	Nature/green-blue spaces; environmental determinants (Representativeness, Richness).
cycling	12	Active travel; link to infrastructure (Relevance, Representativeness).
support	15	Peer support, PAs, social services; system navigation theme (Rigour, Richness).
affordability	—	Expressed through references to cost, expensive, money; economic barrier (Resonance, Representativeness).
transport	—	“Bus,” “train,” “driving,” cancellations (e.g., Bwcabus); access barrier (Relevance, Rigour).

Note: Frequencies derived via programmatic token counts; compound signals (e.g., “affordability,” “transport”) surfaced through phrases and context review rather than single token frequency alone.

Step 3 — Coding (codes ≤ 3 words)

Using the 6 Rs and the selected keywords, interpretable, inductive codes were generated and were each linked to an anonymised data extract (identifiers and named individuals/places removed or generalised).

Code	Anonymised Quote
Daily exercise	“I exercise every morning; walking groups locally help.”
Walking outdoors	“Getting out in fresh air, walking the dog, beach on the doorstep.”
Healthy eating	“Cooking from scratch; balanced diet; limit UPFs.”

Code	Anonymised Quote
Food affordability	"Healthy food is expensive; need access to affordable meals."
Social connection	"Choir, craft groups, coffee and chat—breaks isolation."
Nature & greenspace	"Access to parks, cycle paths, countryside helps me stay well."
Sleep & rest	"Enough sleep and time to exercise; naps help."
Work–life balance	"Work later in life; balance work and health; regular breaks."
Access barriers	"Classes at work times; poor public transport; cancellations isolate me."
Disability access	"Need accessible parks, toilets, parking, equipment (e-bikes)."
Deaf awareness	"Clinicians look at interpreter not patient; disrespectful; poor empathy."
Carer strain	"Caring responsibilities limit my ability to exercise or socialise."
Peer support	"Groups share information; accessible wellbeing walks help."
Digital & info	"Use apps/step counters; online recipes; need accurate information."
Cost of living	"Can't afford transport; heating; gym; impacts health."
Scheduling fit	"Classes during working day exclude working people."
Mental health care	"Mindfulness, meditation, breathing; social groups protect mental health."
Active travel	"Build cycling and walking into daily journeys; safer routes needed."
Test results comms	"Without help, would not know test results; need clearer communication."
Young families	"Busy parent; need pram-friendly classes; realistic feeding."

Step 4 — Theme Development (using the “4 Rs”)

Codes were clustered into higher order themes assessed against the “4 Rs” (Relatedness/coherence, Robustness/grounding across extracts, Reach/coverage across groups, and Resonance/strategic salience), per Naeem’s systematic approach.

Theme	Related Codes
Physical Activity & Active Living	Daily exercise; Walking outdoors; Active travel; Scheduling fit; Nature & greenspace.
Food Environment & Nutrition	Healthy eating; Food affordability; Cost of living; Young families.
Social Connection & Community Assets	Social connection; Peer support; Carer strain; Community groups.
Access & Inclusion	Access barriers; Transport; Disability access; Deaf awareness; Test results comms.
Mental Health, Sleep & Self-care	Mental health care; Sleep & rest; Work–life balance.
Digital, Information & Literacy	Digital & info; Accurate health information; Apps/trackers.

Step 5 — Conceptualisation (linking to strategic priorities)

1. Community anchored prevention — Prioritise keeping people well through accessible community hubs, integrated networks, and social prescribing that connect physical activity,

nutrition, and peer support close to home. Aligns to the strategy's shift from treatment to prevention and delivery in community settings.

2. Inclusive access & equity — Address transport, scheduling, disability access, deaf awareness, and communication barriers to ensure equitable reach of prevention and wellbeing offers. Supports resilient communities and integrated community networks.
3. Healthy food environment — Improve affordability and availability of healthy foods support skills for cooking and practical family nutrition. Aligns to population health goals.
4. Green/blue infrastructure for well-being — Leverage nature (parks, paths, coast) to embed daily active living and social connection; invest in safe routes and amenities. Fits the community model and place-based delivery.
5. Digital & information enablement — Provide trusted, accessible information (easy read, multilingual, BSL-friendly), digital tools, and literacy support to self-manage health; integrate virtual consultations and telehealth where appropriate (e.g., hubs).
6. Carers & life-stage support — Tailor offers for carers, disabled residents, young families, older adults (e.g., pram-friendly classes, subsidised sessions, respite linked activity). Aligns with supporting informal carers and resilient communities.
7. Place-based flagship (Canolfan Pentre Awel) — Use Canolfan Pentre Awel as a regional exemplar hub integrating leisure, therapy, digital innovation, and research to scale prevention, rehabilitation, and inclusion.

Step 6 — Conceptual Model (textual description)

Model overview:

A three-layer, systems model linking Enablers → Behaviours → Outcomes, anchored in community infrastructure.

- **Enablers (outer layer):** Access & inclusion (transport, scheduling, disability/deaf aware design, clear test result communication), Food environment (affordability/availability), Green/blue infrastructure, Digital & information enablement, and Carer/life-stage tailoring. (Community hubs such as Pentre Awel act as integrated nodes.)
- **Behaviours (middle layer):** Physical activity (walking, classes, active travel), Healthy eating (home-cooked, balanced diets), Social connection (groups, volunteering), Sleep & self-care (rest, stress management).
- **Outcomes (core):** Improved mental and physical wellbeing, reduced isolation, greater self-management, and lower demand on crisis care—directly supporting the strategy's prevention vision and community-based delivery.

Feedback loops run from Outcomes back to Enablers (e.g., growing participation strengthens community assets), while governance and evaluation ensure robustness and reach across localities.

2. Who outside the NHS do you think could be part of keeping people well?

Step 1 — Familiarisation

The dataset is rich, multisource, and highly specific to West Wales community assets (e.g., leisure centres, walking groups, pharmacies, schools, councils, third sector, faith groups, alternative/holistic providers). Initial observations: strong emphasis on community-based supports

and selfcare, repeated references to cost/affordability, transport and rural access, digital inclusion/exclusion (esp. visually impaired), and food environment/healthy eating. Data quality issues include duplicated/very short entries (“Everyone”, “No idea”), typos, mixed granularity (from named venues to generic categories), and occasional personal identifiers (individual names) which were excluded from quoted extracts below to preserve anonymity.

Step 2 — Keyword Selection (AI-assisted using Naeem’s “6 Rs”: Relevance, Recurrence, Richness, Resonance, Representativeness, Rigour)

Computational frequency counts were generated programmatically from the dataset; rationale combines frequency with qualitative salience (6 Rs).

Keyword	Frequency	Rationale
Friends & Family	83	Highly recurrent and resonant references to informal networks; central to representativeness of community support.
Schools/Education	75	Frequent calls for health education, cooking classes, PE/outdoor play; relevant across life course priorities.
Local councils/Authority	51	Emphasis on planning, parks, paths, day centres, funding; richness of actionable levers.
Community groups	47	Core community assets (walking/talking groups, arts, hubs); broad representativeness.
Charities/Third sector	42	Named charities (Age Cymru, MIND, VC Gallery, foodbanks) and funding fragility; rigour via multiple examples.
Affordability/Cost	38	“Free sessions”, “reduced rates”, funding concerns; strong resonance with access barriers.
Nutrition/Food environment	36	Calls for healthy food, UPF/sugar tax, supermarkets; policy and behavioural levers (richness).
Leisure centres	35	Repeated as accessible physical activity hubs; recurrence across towns.
Parks/Outdoors/Nature	35	National Park walks, outdoor gyms, benches/bins; representative of rural context.
Gyms	24	Structured exercise; barriers include cost and timing; relevance to prevention.
Transport/Paths	24	Cycle paths, footpaths, Trunk Road Agent, rural routes; rigour via consistent access barrier.
Digital/Apps/Online	23	Apps, online classes, AI; mixed resonance (benefits vs accessibility issues for visually impaired).
Pharmacies/Pharmacists	20	Community pharmacy as accessible support; relevance to minor ailments/self-care.
Alternative/Holistic	16	Homeopathy, acupuncture, yoga, breathwork; richness in non-NHS supports; affordability caveat.
Accessibility/Disabled	16	Low vision aids, accessible walks/parking; representative equity lens.

Step 3 — Coding (inductive; codes ≤ 3 words; anonymised quotes; rationales via 6 Rs)

Code	Anonymised Quote
Informal networks	"Family and friends."
School health	"Schools...proper meals and cooking classes."
Council enablers	"Local councils...information hubs...community events."
Leisure access	"Free sessions at local leisure centre."
Walking outdoors	"National Park walks...walking groups."
Pharmacy first	"Local pharmacy...pharmacist."
Third sector hubs	"Community groups...signpost people to different things."
Cost barrier	"Gyms that aren't extortionate...reduced rates for low incomes."
Active travel	"Cycle paths...footpaths kept clear."
Digital support	"Online communities...apps and wellbeing platforms."
Digital exclusion	"Online sites are inaccessible for visually impaired."
Accessible spaces	"Outdoor areas...boardwalk options...disabled parking."
Food environment	"Supermarkets...stop price gouging...promote healthy foods."
UPF controls	"Treat big UPF food companies like tobacco."
Community cafés	"Local café/restaurants...healthy choices."
Social connection	"They keep us sane...we meet people who understand."
Carer support	"We offer support to carers...[day centres] never re-opened."
Workplace health	"Employers should encourage staff to exercise...not sit for hours."
Holistic options	"Alternative therapists...yoga...aromatherapy."
Library as hub	"Libraries...wellness hubs...chair exercises."
Social prescribing	"Volunteers, social prescribing, carers."
Rural equity	"Highway authorities...safe to cycle between villages."

Step 4 — Theme Development (grouped using the "4 Rs": Recurrence, Relevance, Resonance, Rigour per Naeem's systematic approach)

Theme	Related Codes
Community Assets & Social Connection	Informal networks; Community cafés; Social connection; Third sector hubs; Library as hub; Social prescribing
Physical Activity Infrastructure	Leisure access; Walking outdoors; Active travel; Rural equity
Primary/Community Care & Pharmacy	Pharmacy first; Carer support
Food Environment & Healthy Living	Food environment; UPF controls; School health
Digital Health & Inclusion	Digital support; Digital exclusion

Theme	Related Codes
Accessibility & Inclusive Design	Accessible spaces; Rural equity
Workplace, Schools & Life-course Settings	Workplace health; School health
Alternative/Holistic Supports	Holistic options
Affordability & Funding Enablers	Cost barrier; Leisure access (free/reduced); Third sector hubs (funding)

Step 5 — Conceptualisation (definitions and alignment with Hywel Dda strategic priorities)

1. Whole-Community Wellness Ecosystem — Keeping people well depends on a network of community assets, informal supports, and place-based services that complement the NHS. Aligns with Hywel Dda’s shift to prevention, resilient communities and care closer to home.
2. Active Places, Everyday Movement — Leisure centres, parks, paths, and safe active travel create normalised physical activity across ages. Supports strategy’s community model and integrated networks.
3. Pharmacy Enabled Self-care — Community pharmacies act as accessible front doors for advice, minor ailments, and signposting to social support. Reinforces early help and care closer to home.
4. Healthy Food Environments — Affordability and availability of healthy options (supermarkets, cafés, UPF regulation) underpin behaviour change. Aligns with prevention and population health aims.
5. Digital with Inclusion — Apps/online communities/AI can scale support, but accessibility (e.g., low vision users) must be designed in. Aligns to digital healthcare support in the strategy refresh.
6. Inclusive Design for Disability & Rurality — Accessible outdoor spaces, transport links and infrastructure reduce inequities, especially in rural areas. Supports equitable access across the Health Board footprint.
7. Workplace & School Settings — Employers and schools can embed healthy routines (movement, cooking skills, oral health) at scale. Aligns to life course priorities and community-based prevention.
8. Pluralistic Support Mix — Alternative/holistic options coexist with statutory/community offers; choice with quality/affordability safeguards enhances engagement. Fits the strategy’s person-centred ethos.
9. Sustainable Affordability — Free/reduced cost offers, stable funding for third sector, and targeted subsidies address cost barriers to engagement—critical during the strategy refresh period.

Step 6 — Conceptual Model (text description for diagram conversion)

A layered “Community Wellness Constellation” model:

- **Core:** *Person & informal network* (family, friends, neighbours) supported by selfcare and pharmacy enabled advice.
- **Inner ring:** *Community assets* (leisure centres, walking groups, arts/faith groups, libraries/hubs, third sector connectors).

- **Outer ring:** *Enabling environments* (council planning for parks/paths/benches/bins; healthy food retail; workplace and school settings; transport safety and rural connectivity).
- **Crosscutting enablers:** *Digital & accessibility* (inclusive design for low vision users; affordable offers; social prescribing pathways).
- **Feedback loops:** Clinical services ↔ social prescribing ↔ community groups; schools/workplaces ↔ local councils ↔ leisure/transport infrastructure.

Strategic relevance: The model operationalises Hywel Dda’s prevention first, community-based system by showing how non-NHS actors and place-based infrastructure keep people well upstream of hospital care; it provides practical levers for the ongoing strategy refresh.

3. Are there people or groups in your local area who could play a big role in helping others live healthier lives?

Step 1: Familiarisation

Initial Observations:

- Responses are highly varied, ranging from specific named groups (e.g., "HOPE charity", "Walking groups") to general statements ("Everyone could step up").
- Common mentions include community centres, leisure facilities, volunteer groups, churches, sports clubs, and mental health support groups.
- Recurring issues: transport barriers, funding challenges, digital access gaps, and volunteer shortages.
- Data quality: Mostly clear, but some responses are very short ("Yes", "No", "Don't know"), which limits richness for those entries.

Step 2: Keyword Selection (6 Rs)

Recurring keywords were extracted based on Relevance, Recurrence, Richness, Resonance, Representativeness, Rigour:

Keyword	Frequency	Rationale
Community centre	42	Central hubs for social and health activities
Leisure centre	38	Frequently cited as a health-promoting space
Walking group	33	Popular low-cost physical activity
Volunteer	29	Highlights dependency and sustainability issues
Transport	21	Barrier to access, especially rural
Mental health	18	Strong resonance with wellbeing priorities
Funding	16	Represents sustainability challenge
Digital access	14	Gap in online engagement and information
Food bank	12	Indicates socioeconomic determinants
Schools	11	Role in education and prevention

Step 3: Coding

Codes are short (max 3 words) and linked to anonymised quotes.

Code	Anonymised Quote	Rationale
Community hub	"Our village has a community hall – excellent but no organisations for exercise."	Indicates central role of hubs
Leisure access	"Leisure centres organising events both dry side and in the pool."	Access to structured activities
Walking activity	"Yes a walking group and a community hub in our local chapel."	Physical activity promotion
Volunteer shortage	"These groups are dependent on volunteers, and it is getting harder to find new volunteers."	Sustainability concern
Transport barrier	"Without a rural bus system you cannot connect at appropriate times."	Access challenge
Mental health support	"Craft groups for mental health."	Emotional wellbeing
Funding gap	"Short term funding is the biggest issue."	Resource sustainability
Digital gap	"We don't do as much online as we should."	Digital inclusion
Food insecurity	"Food Hubs – Excess food supplied by companies such as M&S."	Social determinants
School engagement	"Schools, school nurses who can monitor excessive weight."	Prevention role

Step 4: Theme Development (4 Rs)

Six themes, grouped by related codes, have been identified:

Theme	Related Codes
Access	Transport barrier, Leisure access, Walking activity
Community Capacity	Community hub, Volunteer shortage, Funding gap
Mental Health & Wellbeing	Mental health support, Craft groups
Digital Inclusion	Digital gap
Food & Socioeconomic Support	Food insecurity
Education & Prevention	School engagement

Step 5: Conceptualisation

Emerging concepts aligned with strategic priorities:

1. Accessible Community Infrastructure

Definition: Physical and digital spaces that enable inclusive health-promoting activities.

Link: Aligns with "Care Closer to Home" and "Prevention".

2. Sustainable Volunteer Ecosystem

Definition: Strategies to recruit, retain, and support volunteers for community health initiatives.

Link: Supports “Community Resilience”.

3. Integrated Mental Health Support

Definition: Embedding mental health activities within community settings.

Link: Aligns with “Wellbeing and Mental Health”.

4. Digital Health Equity

Definition: Bridging digital gaps for information and engagement.

Link: Supports “Digital First” priority.

5. Food Security and Healthy Living

Definition: Community-led initiatives to address nutrition and affordability.

Link: Aligns with “Reducing Health Inequalities”.

6. Preventive Education

Definition: Schools and youth clubs as hubs for health literacy and early intervention.

Link: Supports “Prevention and Early Help”.

Step 6: Conceptual Model

The model positions Community Infrastructure at the centre, supported by Volunteer Ecosystem and Funding Stability. Surrounding layers include Mental Health Integration, Digital Inclusion, and Food Security, all feeding into Education and Prevention. Arrows indicate bidirectional relationships: e.g., digital inclusion enhances access; volunteer sustainability underpins mental health programs. Strategic priorities (Care Closer to Home, Prevention, Digital First) frame the outer layer.

4. What kind of support would make it easier for you to live a healthier life?

Step 1. Familiarisation

Initial observations: (a) high recurrence of issues around *access* (services, transport, affordability), *primary care appointments*, *dental availability*, *cost of healthy living*, and *information /communication*; (b) richness and specificity on operational barriers (e.g., “8 am phone bottlenecks”, “letters arriving after appointments”, “two hour gaps between buses”, “lack of local groups or evening classes”); (c) data quality issues include typographical errors, duplicated phrases, inconsistent punctuation/capitalisation, occasional references to named individuals and precise locations (removed/avoided in quotes below), and some empty table cells.

Step 2. Keyword Selection (6 Rs)

Using Naeem’s 6 Rs (Relevance, Recurrence, Richness, Resonance, Representativeness, Rigour), recurring terms and phrase clusters have been identified. Frequencies below are counts from the uploaded dataset (single word terms plus prominent bigrams [two related keywords]), used only to *triangulate* salience; they are not inferential statistics.

Note: Counts are derived directly from the Question 4 dataset.

Keyword / Phrase	Frequency*	Rationale (6 Rs)
Access	91	Central to many responses (service, information, transport, affordability) → high Recurrence/Resonance, broad Representativeness.
Transport	35	Significant barrier, esp. rurality and evening travel; mentions of buses/minibus partnerships.
GP (Primary Care)	37	Access, booking, 8 am queues, home visits; strong Relevance and Richness.
Appointments / Letters	23 / 19	Reliability/timeliness across services; delays/missed letters; high Resonance.
Cost / Affordability	18	Gym/leisure fees, healthy food costs, parking; clear barrier to uptake.
Leisure centres / Gym	14 / 17	Desire for cheaper/free access, age specific offers, starter classes.
Information	19	Need for a central hub, accurate websites, surgery notice boards.
Public transport (bigram)	9	Specific to bus/train frequency and connectivity.
Mental health	7	Mid-point support between primary and secondary care, counselling.
Dentist / NHS dentist	7 / 3	Access crisis; proposals incl. subsidy or expanded provision.
Nutrition / Diet	8 / 10	Dietary advice, weight loss support, UPF reduction; strong Richness.
Community groups	4	Social connection reduces isolation; group-based well-being.
Walking paths / Pavements	7 / 2	Safer routes, maintenance, lighting; outdoor activity facilitation.
Parking	7	Cost and accessibility (incl. digital only meters as barrier).
Digital access / Website	4 / 4	Better portals, email/chat, NHS app; info accuracy.
B12	5	Specific condition related access/understanding requests.
Home visits	4	Flu jabs and GP home visiting for those housebound.
Screening / Prevention	3 / 3	Well man/woman checks, mobile units, early diagnosis.
Childcare	3	Linked to ability to exercise; suggestions for creche/parent linked sessions.

*Frequencies approximate the count of explicit lexical items/phrases in the dataset.

Step 3. Coding (max 3 words)

Codes were inductively generated from the keywords applying the 6 Rs to ensure analytic rigour. Quotes are anonymised (no personal identifiers) and lightly edited for clarity. All quotes come from the uploaded dataset.

Code	Anonymised Quote
Access-Barrier	"It's access — not being able to get places as there are no buses."
GP-Booking	"Remove the 8 am rush to phone the local surgery."
Appointment-Delays	"Appointment letters arriving after the appointment; delays are appalling."
Dental-Access	"There are no NHS dentists; toothache for months."
Leisure-Cost	"Cheaper leisure centre/gym membership — especially in winter."
Info-Hub	"Information is scattered; a central hub would be great."
Starter-Confidence	"People are afraid to go to the gym — starter classes needed."
Rural-Transport	"Two and three-quarter hours between buses."
Home-Visits	"Easier access to flu injections — e.g., home visits."
Mental-Midpoint	"Not ill enough for secondary care, but need a mid-point."
Diet-Advice	"Dietary and nutrition advice — specific to conditions."
Volunteer-Support	"1:1 volunteering would help; recognise time on a CV."
Walking-Routes	"Better maintained paths; lighting so older people can walk at night."
Digital-Access	"Email/chat with clinicians; website not fit for purpose."
Parking-Barrier	"Reduced parking charges to access places of exercise."

Step 4. Theme Development (4 Rs)

Themes were formed by grouping related codes, ensuring Relevance to the question and strategy, Recurrence across the dataset, Relationships among codes, and Rigour in linkage back to data.

Theme	Related Codes
Access & Transport	Access-Barrier; Rural-Transport; Parking-Barrier; Walking-Routes.
Primary Care Access & Reliability	GP-Booking; Appointment-Delays; Home-Visits.
Oral Health Access	Dental-Access.
Cost & Affordability of Healthy Living	Leisure-Cost; Parking-Barrier; Healthy-Food-Cost (implicit in quotes on affordability).
Information, Communication & Digital	Info-Hub; Digital-Access; Starter-Confidence (signposting, onboarding materials).
Condition Specific Support & Prevention	Diet-Advice; B12-Understanding (from dataset); Screening-Prevention; Home-Visits.
Mental Health Continuum	Mental-Midpoint; Community Groups (social connection to reduce isolation).

Theme	Related Codes
Community Capacity & Volunteering	Volunteer-Support; Community Groups; Creche/Childcare link to activity.

Step 5. Conceptualisation (link to strategic priorities)

Derived concepts integrate the themes and align to Hywel Dda's strategy—shifting from illness treatment to prevention, community-based joined-up support, better access close to home, and digital enablement.

1. Place-based Access Equity

Definition: Reducing geographic, transport and environmental barriers so people can reach services, groups, and natural spaces locally.

Strategic link: *Our future community model; resilient communities; integrated community networks (care closer to home).*

2. Reliable, Person-centred Primary Care

Definition: Consistent, timely booking and communication (letters, reminders, home visits) that match need and reduce anxiety.

Strategic link: *Preventing ill-health, timely help early on; quality standards and safety.*

3. Affordable Healthy Living

Definition: Financial enablers (reduced fees, discounts, low-cost food access/recipes) to remove cost as a barrier to wellbeing.

Strategic link: *Keeping people well; community assets enabling healthier choices.*

4. Trusted Information & Digital Navigation

Definition: A single, reliable “what’s on” hub and improved digital channels (email/chat/app) for access, booking and advice.

Strategic link: *Joined up support; working across the whole system; digital channels for access.*

5. Preventive & Condition-specific Support

Definition: Proactive checks (well man/woman, mobile units) and tailored advice (nutrition, B12, weight management).

Strategic link: *Prevention, early intervention, health, and wellbeing centres.*

6. Mental Health “Mid-point” Provision

Definition: Accessible, non-stigmatising support between primary and specialist MH care, with strong community connectors.

Strategic link: *Working together in communities; integrated support early on.*

7. Community Capacity & Volunteering Pathways

Definition: Structured 1:1 volunteering, youth involvement, and recognition (e.g., CV credit) to augment local support.

Strategic link: *Supporting informal carers; resilient communities; partnership working.*

Step 6. Conceptual Model (textual)

Inputs/Enablers (Transport & Place; Affordability; Information/Digital) → Access Gateways (Primary care booking/reliability; Dental access; Community group signposting) → Support Modalities (Preventive checks; Condition-specific advice; Mental health midpoint; Home visits; Volunteering) → Participation & Behaviour (Starter confidence; outdoor activity via safe routes; group-based engagement) → Outcomes (Reduced stress/isolation; improved fitness/nutrition; faster, appropriate care) → System Alignment (Joined-up communication, records and scheduling).

This model operationalises the Strategy's *community-first, prevention-led* vision by showing how place, cost, and communication constraints, once addressed, unlock participation and timely care, leading to better health and reduced pressure on urgent services.

4.2.3.2 Themes for Section 2: Digital Healthcare Support (questions 5,6 and 7)

5. How do you feel about using the internet or apps to look after your health or share health information?

Step 1: Familiarisation

The dataset comprises a large volume of anonymised qualitative responses from a diverse cross-section of the public, reflecting a wide range of digital literacy, attitudes, and experiences regarding digital health tools. The responses are rich and varied, with some brief or ambiguous entries (“No”, “Fine”, “Ok”) and others providing detailed accounts of barriers, enablers, and personal stories. There are no apparent data quality issues, but the brevity of some responses may limit depth for certain perspectives.

Step 2: Keyword Selection

Using the “6 Rs” (Relevance, Recurrence, Richness, Resonance, Representativeness, Rigour), the following keywords were identified:

Keyword	Frequency	Rationale
Access	High	Recurring references to digital access, broadband, devices, and rural connectivity issues.
App(s)	High	Frequent mention of NHS app, GP apps, usability, and functionality.
Confidence	Medium	Many respondents discuss confidence or lack thereof in using digital tools.
Security	High	Concerns about data privacy, hacking, and trust in digital systems.
Face-to-face	High	Strong resonance around the need for in-person options and human contact.
Simplicity	Medium	Calls for user-friendly, simple systems and frustration with complexity.
Support	Medium	Need for training, help from family/friends, and community support.
Exclusion	Medium	Digital exclusion, especially for elderly, disabled, or those with low digital literacy.
Communication	Medium	Importance of clear, reliable communication and information sharing.
Misinformation	Medium	Concerns about unreliable or confusing online health information.
Choice	Medium	Desire for options between digital and traditional methods.
Anxiety	Medium	Digital tools causing stress, anxiety, or frustration.
Integration	Medium	Desire for joined-up systems and integrated digital health records.
Appointment(s)	High	Booking, reminders, and barriers to accessing appointments digitally.
Accessibility	Medium	Barriers for visually impaired, dyslexic, or those with physical limitations.

Step 3: Coding

Code	Anonymised Quote	Rationale
Digital Access	“Reception in rural areas is poor. With landlines going digital and smartphones being the only internet access people have, access to the internet is poor.”	Highlights infrastructural barriers to digital health.
App Usability	“Aber surgery – my surgery app is a nightmare. Horrendous app. It used to have a link to prescription which worked really well, but they did an update and the app is now it worse and this feature has gone.”	Illustrates frustration with app design and updates.
Security Concerns	“Given the rate of hacking these days, not very confident that my data would be safe.”	Reflects widespread anxiety about data

Code	Anonymised Quote	Rationale
		privacy and cyber security.
Human Contact	"I use the internet but apps and AI should not take the place of real people, real communication and real support."	Emphasises the value placed on face-to-face interaction.
Simplicity Needed	"If it was simple to use, then I would be ok with it."	Simplicity is a key enabler for digital adoption.
Need for Support	"You need people to help you (friends and family)."	Support networks are crucial for digital inclusion.
Digital Exclusion	"Older people are anxious."	Digital exclusion is a recurring theme, especially among older adults.
Communication Gaps	"Unfortunately, there is already communication issues between services now."	Points to the need for better information sharing and communication.
Misinformation Risk	"There is so much misinformation. I use books or take different courses, like on mental health, or public health."	Concerns about reliability of online health information.
Choice Required	"You need to provide options for face to face or digital. It really depends on what's needed and what suits best."	Highlights the importance of offering multiple access routes.
Digital Anxiety	"It is not conducive to well-being. I want to use it but it gets so complicated it needs to be simple."	Digital tools can cause stress and anxiety.
Integration Needed	"What we really need to start developing are Health and Social care AI agents... centrally aligned Public Health Strategy."	Desire for integrated, joined-up digital health systems.
Appointment Barriers	"I use the nhs app to get repeat prescriptions. However the system doesn't allow us to book appointments."	Digital systems not meeting user needs for appointments.
Accessibility Issues	"Screen readers are often incompatible, so would need many to visit different sites."	Accessibility for disabled users is a significant barrier.

Step 4: Theme Development

Theme	Related Codes
Access	Digital Access, Digital Exclusion, Accessibility Issues, Appointment Barriers
Digital Tools	App Usability, Integration Needed, Simplicity Needed, Appointment Barriers
Security & Trust	Security Concerns, Misinformation Risk, Digital Anxiety
Human Contact	Human Contact, Choice Required, Communication Gaps
Support & Inclusion	Need for Support, Digital Exclusion, Accessibility Issues

Step 5: Conceptualisation

1. Equitable Digital Access

Ensuring all individuals, regardless of geography, age, or ability, can access digital health services.

Linked to strategic priorities: Reducing health inequalities, improving rural health access.

2. User-Centred Digital Tools

Designing apps and systems that are intuitive, reliable, and meet real user needs, including appointment management and accessibility.

Linked to: Digital transformation, patient experience, service efficiency.

3. Trust and Security in Digital Health

Building confidence in digital health through robust security, clear communication, and combating misinformation.

Linked to: Data protection, public trust, safe digital innovation.

4. Preserving Human Connection

Maintaining options for face-to-face care and ensuring digital does not replace essential human interaction.

Linked to: Person-centred care, mental health, community cohesion.

5. Inclusive Support Structures

Providing training, support, and alternative options for those less confident or able to use digital tools.

Linked to: Digital inclusion, community support, workforce development.

Step 6: Conceptual Model (Textual Description)

The conceptual model positions “Equitable Digital Health” at the centre, supported by five interlinked pillars: Access, User-Centred Tools, Trust & Security, Human Connection, and Inclusive Support. Each pillar interacts dynamically; effective digital access relies on user-friendly tools, which in turn require trust and security. Human connection and inclusive support ensure that digital transformation does not exacerbate inequalities or erode personal care. The model aligns with strategic priorities by promoting a balanced, inclusive, and resilient digital health ecosystem for Hywel Dda UHB.

6. If digital healthcare worked well for you, what would it look like?

Step 1 — Familiarisation

The dataset is rich and diverse: it ranges from short, emphatic statements (“It wouldn’t”; “Rubbish”) to detailed, actionable suggestions (e.g., single NHS app, joined-up records, BSL video support, virtual queues, clearer websites, data visualisations of results over time). Recurring issues include difficulty booking GP appointments, inconsistent features across services/apps, accessibility barriers (BSL, visual impairment, low digital confidence), and variable connectivity in rural areas. Data quality is generally good; some entries are incomplete (“”), and a minority are off-topic or highly brief, which were treated as negative sentiment indicators rather than substantive content.

Step 2 — Keyword Selection (6 Rs)

Using Naeem’s **6 Rs** (Relevance, Recurrence, Richness, Resonance, Representativeness, Rigour), recurring terms/phrases indicative of patterned meaning were selected. Frequencies are approximate counts of distinct mentions.

Keyword	Frequency	Rationale
GP appointments / booking	60+	Highly recurrent: telephone queues, desire to book online, bypass reception, advance booking; representative of access pain-point; strong resonance.
Single NHS app	40+	Calls for a one-stop platform consolidating records, booking, prescriptions; richness in detailed feature lists; relevance to strategy’s digital enablers.
Records access (joined-up)	50+	Desire for all-Wales shared records across GP/secondary care; comparisons with England/MyChart; representative crosscutting need.
Results visibility & trends	25+	View bloods, thyroid, diabetes over time; graphs; richness in analytic needs; resonance with self-management.
Prescriptions (repeat/order)	30+	Digital reordering, visibility of meds; recent changes causing confusion for visually impaired; recurrence and rigour (specific examples).
Accessibility (BSL/large text/audio)	30+	Need for BSL videos, better lighting for video, large text/audio options; relevance to inclusive design; representativeness across groups.
Connectivity (Wi-Fi/signal)	20+	Rural / in-clinic connectivity problems causing interpreter freeze and poor video; resonance with rural strategy context.
Human contact options	40+	Persistent preference for face-to-face or human fallback; distrust of bots; desire for live chat with clinicians; richness in examples.
Notifications/reminders	20+	Text reminders; virtual queues; appointment notifications; relevance to operational UX; recurrence.
Platform consistency (all services)	25+	“Not every department uses the same app”; fragmentation theme; representativeness across sites/services.
Self-management tools / wearables	20+	Sleep/activity apps, watches, AI coach concepts; richness for prevention and lifestyle support.

Keyword	Frequency	Rationale
Trust, privacy & security	15+	"Unhackable", misinformation controls; resonance with digital trust; rigour via specific cautions.

Step 3 — Coding (max 3 words)

Codes are derived inductively from keywords, applying the **6 Rs** for coding and using anonymised verbatim extracts (no personal identifiers).

Code	Anonymised Quote	Rationale
Online GP booking	"I would be able to book a GP appointment online without having to queue on the phone."	High recurrence; central barrier to access.
One-stop app	"A single NHS app where I could book all services... like Transport for Wales."	Richness and representativeness of consolidation requests.
Joined-up records	"Need All Wales access to records between GPs, hospitals..."	Cross-system interoperability repeated across entries.
Results over time	"Graphs showing readings over time... see if what you are doing makes a difference."	Richness for self-management & insight.
Repeat Rx digital	"Order repeat prescriptions... not having to phone."	Recurrence and operational efficiency.
BSL support	"You need BSL videos... a right to information in a language we understand."	Strong resonance; inclusion rigour.
Accessible UI	"Accessible—large text option and audio."	Inclusive design relevance.
Rural connectivity	"Better wifi in GP surgeries and hospitals... poor signal in rural areas."	Context-specific representativeness (Hywel Dda rurality).
Human fallback	"Easy access & have a person of contact if required—not a bot."	Persistent preference; safety/assurance.
Live clinician chat	"Speaking on a chat line to a doctor/nurse... advise whether face-to-face needed."	Richness in triage pathway.
Virtual queue	"Virtual queue—know you still have one hour... return nearer the time."	Resonance with waiting experience.
Consistent platforms	"Not every department uses 'Patient Knows Best'... one way across Wales would be handy."	Rigour on fragmentation.
Wearable integration	"Watch that measures sleep and workouts... see trends."	Prevention & monitoring richness.
Trust & security	"Private and unhackable."	Digital trust essential to adoption.
Clear content	"Simple language... information is freely given... trusted sites updated regularly."	Rigour in information quality & literacy.
Notifications & reminders	"Reminder text for appointments... app notifications."	Recurrence in comms needs.

Code	Anonymised Quote	Rationale
Human-first care	“Digital should not replace person-to-person... more face to face.”	Ethical/practical resonance.
Inclusive training	“Training for apps or online systems.”	Adoption representativeness across confidence levels.
Specialist access	“Ability to message consultants when things change.”	Continuity and responsiveness richness.

Step 4 — Theme Development (4 Rs)

Using Naeem’s **4 Rs** (Relationships, Relevance, Rigour, Resonance), related codes were grouped into higher order themes.

Theme	Related Codes
Access & Booking	Online GP booking; Virtual queue; Inclusive training; Human fallback; Live clinician chat; Ability to book in advance; Bypass reception.
Integrated Records & Results	Joined-up records; Results over time; Specialist access; Access to documents/letters; View past/future appointments.
Usability & Inclusion	One-stop app; Accessible UI; Clear content; Notifications & reminders; Consistent platforms; Simple navigation.
Connectivity & Infrastructure	Rural connectivity; Good Wi-Fi; Multi-platform availability; Reliability of video/lighting.
Trust, Safety & Governance	Trust & security; Misinformation controls; Privacy; Human-first care boundaries.
Prevention & Self-Management	Wearable integration; Self-management apps; Tailored advice (e.g., PCOS/asthma); Lifestyle nudges/coaches.

Step 5 — Conceptualisation (aligned to strategic priorities)

1. **Frictionless Access Pathways** — Seamless digital routes to book, triage, and consult with clinicians, augmented by human fallback where needed, reducing phone queues and enabling timely care. Strategic link: shifting care closer to home; “working across the whole system” access improvements.
2. **Unified Longitudinal Health Record** — All Wales, joined-up record spanning primary, community, and secondary care, with patient-facing views of results and trends to support self-management. Strategic link: integrated community networks; information continuity.
3. **Inclusive, Human Centred Digital** — One-stop app with BSL, large text/audio, clear content, and training. Digital augments—not replaces—person-to-person care. Strategic link: people and communities at the heart; equity of access.
4. **Reliable Rural Connectivity** — Investment in Wi-Fi and signal quality across clinics and communities to ensure interpreters/video clinics function reliably. Strategic link: addressing rural fragilities and estate constraints; interim measures in Clinical Services Plan.

5. **Trust by Design** — Robust privacy/security, control of misinformation, transparent governance, and consent-based sharing, building confidence in digital tools. Strategic link: safe, quality, sustainable care; refreshed strategy emphasis on enablers.
6. **Personalised Prevention Ecosystem** — Integration of wearables, nudges, tailored advice, and virtual coaching for lifestyle and condition management, escalating to human care as needed. Strategic link: vision to keep people well and prevent ill health; community-based support.

Step 6 — Conceptual Model (textual description)

Model overview:

At the core sits the person, surrounded by two concentric layers:

- Inner layer (Digital Services): *Frictionless Access* (booking/triage/consult), *Unified Record* (longitudinal data, results), and *Inclusive UX* (one-stop app with accessibility features). These are bound by Trust by Design (privacy, security, misinformation controls).
- Outer layer (Enablers & Ecosystem): *Connectivity & Infrastructure* (Wi-Fi/signal, reliability), and *Prevention & Self-Management* (wearables, tailored advice, reminders), with Human Fallback touchpoints bridging digital to in-person care.

Relationships:

- Access depends on both Unified Record (to pre-populate data and enable safe triage) and Connectivity (to function reliably).
- Inclusive UX and Trust by Design moderate the Person's willingness to adopt and persist.
- Prevention feeds data into the Unified Record, generating insights and alerts that trigger Access pathways when thresholds are crossed.
- Human Fallback remains available at every node, enforcing the strategic principle of "digital where appropriate, face-to-face when necessary." This aligns with Hywel Dda's refreshed strategy aim to deliver safe, quality, sustainable care while leveraging digital enablers in a rural context.

7. What would help you to feel confident using online tools or services to get healthcare?

Step 1 — Familiarisation

The dataset is rich, with broad viewpoints ranging from high digital confidence to strong resistance to online healthcare. Initial observations: (1) high recurrence of training/support, security/trust, ease of use/UX, and system reliability; (2) persistent concerns about exclusion, language and accessibility, and assurance of non-digital alternatives; (3) operational pain points around GP telephony, feedback/acknowledgement, and inconsistent services across sites. Data quality: multiple duplicates of short entries ("easy access", "I am confident"), occasional empty cells, and some typography/grammar noise; however, signal is strong, and patterns are clear.

Step 2 — Keyword Selection (the "6 Rs")

Keyword	Frequency*	Rationale
Training / Classes / Workshops	40+	Recurr across age groups; rich detail (1to1 help, community groups); representative of confidence-building needs; rigorous links to digital literacy.
Security / Privacy / Data safety	35+	High resonance; detailed concerns about hacking, data selling, ownership; critical for trust.
Ease of use / Simple / User-friendly	50+	Most frequent usability motif; maps to design quality and accessibility standards.
Reliability / "If they worked" / Consistency	30+	Recurrent frustration with outages, non-responses, broken journeys; strong resonance.
Human contact / Face-to-face / Live person	30+	Desire for hybrid care and escalation to people; prevents exclusion/anxiety.
GP telephony / Access / Response	20+	Operational barrier (queues, call-backs); users prefer online if phones fail.
Feedback / Acknowledgement / Confirmation	15+	Need for "message received / appointment booked" signals; reduces uncertainty.
Accessibility (vision/hearing, language, screen readers)	20+	Rich, specific needs (screen readers, Braille, Welsh/other languages).
Integration / One national system / Joined-up	20+	Calls for all Wales consistency; fewer portals; single sign-on.
Trust in motives / Minimal AI / Not replacing services	15+	Concerns about AI "robotic" replies and erosion of face-to-face.
Device/connectivity / Coverage / Cost	15+	Equity concerns about devices, broadband, mobile signal; affordability.
Guidance / Tutorials / Help pages	25+	Demand for step-by-step guides, videos, helpline; complements training.

*Approximate counts derived from visible repetitions and near-synonyms within the dataset.

Step 3 — Coding (max 3 words per code)

Code	Anonymised Quote	Rationale
One-to-one training	"You need someone 1-2-1 that's in your corner and listens to your needs."	Specifies personalised coaching as confidence driver.
Community classes	"Council set up sessions as training sessions... Friday café helps to learn."	Community-based literacy support recurs.
Simple design	"It being plain and simple to follow."	Emphasises simplicity/clarity in UI.
Easy access	"Easy access to trusted apps... QR codes on every GP website."	Reduces friction; familiar entry points.
Confirmation receipts	"A link that says it has been received and your appointment booked."	Need for acknowledgement reduces anxiety.
Reliable systems	"If they worked and I had confidence to know they worked."	Reliability as prerequisite to adoption.

Code	Anonymised Quote	Rationale
Joined up systems	"One national system rather than too many."	Consistency/integration across HB and Wales.
Security assurance	"Knowing that my data was secure and protected."	Data protection central to trust.
Two factor login	"Secure access 2-step etc as with banks."	Concrete security control requested.
Minimal passwords	"Not too many passwords... keeps redirecting."	Password burden harms usability.
Human fallback	"Being able to talk to a relevant person when you have exhausted all digital avenues."	Hybrid care model expectation.
Keep telephone	"Older people... really need to keep the telephone."	Retain non-digital channels for equity.
Language options	"First of all the app in my native language."	Language accessibility and inclusion.
Screen reader support	"Don't know about screen readers and how to use them."	Accessibility capability and literacy.
Visual impairment aids	"Computers and Braille... very difficult due to eye problems."	Specific accessibility adjustments.
GP online booking	"Online appointment booking system."	Clear, high value use case.
Telephony barriers	"Waiting for a phone to answer... telephony is a barrier."	Push to digital when phones fail.
Feedback delays	"Promise of a response is not forthcoming."	Reliability of communications loop.
Real person review	"Knowing a real person is linked... not just an algorithm."	Human oversight in digital pathways.
Not replacing F2F	"Face to face healthcare cannot be replaced by online tools."	Safeguard against substitution anxiety.
Device access	"What about people who can't afford... tablets or computers?"	Digital poverty concerns.
Connectivity	"A decent phone signal... better access to the web."	Infrastructure limits uptake.
Help pages	"Better help pages... simple instructions, helpline."	Self-service guidance.
Tutorials/videos	"YouTube tutorials... teaching material – written and video."	Multi-format learning preference.
National consistency	"All Wales systems rather than ad-hoc."	Policy-level standardisation.
Feedback on design	"Systems tested against accessibility standards before launch."	Co-design and robust testing ask.
Trust motives	"Trusting the motive... not phasing out face to face."	Institutional trust and intent.

Code	Anonymised Quote	Rationale
Low AI use	"Minimal use of AI and a secure network."	Cautious AI stance.
Scam risk	"I worry about the risk of scammers online."	Cyber safety literacy need.

Step 4 — Theme Development (the “4 Rs”: Relatedness, Recurrence, Resonance, Rigour)

Theme	Related Codes
Usability & Design	Simple design; Easy access; Minimal passwords; Help pages; Tutorials/videos; GP online booking
Reliability & Performance	Reliable systems; Confirmation receipts; Feedback delays
Security, Privacy & Trust	Security assurance; Two factor login; Scam risk; Trust motives; Low AI use; Real person review
Access & Inclusion (Digital Equity)	Device access; Connectivity; Keep telephone; Human fallback; Not replacing F2F
Accessibility (Needs & Adjustments)	Language options; Screen reader support; Visual impairment aids
Integration & Consistency	Joined-up systems; National consistency; Feedback on design (standards/testing)
Operational Access (GP/Pathways)	Telephony barriers; GP online booking; Human fallback (escalation)

Step 5 — Conceptualisation (aligned to strategic priorities)

1. Trust Anchored Digital Care

Definition: Digital services underpinned by visible, bank-grade security, transparent data use, and human oversight.

Strategic link: Builds Public Confidence & Digital Trust, essential for adoption across Mid & West Wales.

2. Inclusive, Hybrid Access

Definition: Always available digital routes complemented by safeguarded nondigital alternatives (telephone, in-person) and clear escalation to people.

Strategic link: Supports Equity of Access and avoids a two-tier system.

3. Universal Usability

Definition: Consistently simple, intuitive, low friction designs with step-by-step journeys and auto acknowledgement.

Strategic link: Advances Patient Experience & Safety through error reducing UX.

4. Assured Reliability & Responsiveness

Definition: Services that work first time, provide rapid confirmations, and meet service level

expectations for responses.

Strategic link: Delivers Operational Excellence and reduces avoidable demand on urgent care.

5. Accessible by Design

Definition: Compliance with accessibility standards, multilanguage support (including Welsh and community languages), and assistive tech readiness.

Strategic link: Embeds Inclusion & Legal Compliance (e.g., WCAG).

6. Integrated All-Wales Platform

Definition: Joined-up, single front door digital health with common sign-in, shared components, and interoperable records.

Strategic link: Enables System Cohesion & Efficiency across primary /secondary/community care.

7. Community Capability & Confidence

Definition: Sustained digital literacy programmes (1to1 coaching, community classes, helplines) co-delivered with local partners.

Strategic link: Builds Community Resilience & Self-care, reducing inequalities.

Step 6 — Conceptual Model (text description for diagram)

Core premise: *Confidence* in online healthcare emerges where Trust, Usability, and Reliability intersect, moderated by Inclusion/Accessibility and enabled by Integration and Community Capability.

- **Inputs/Enablers:**

(A) Integrated All Wales Platform (single sign in, shared services) →

(B) Accessible by Design (language, assistive tech, WCAG) →

(C) Community Capability & Confidence (training, helplines).

- **Primary Drivers:**

(1) Trust Anchored Digital Care (security, transparency, human oversight) +

(2) Universal Usability (simple journeys, minimal friction) +

(3) Assured Reliability & Responsiveness (working services, confirmations).

- **Moderators / Safeguards:**

Inclusive, Hybrid Access ensures non-digital alternatives and escalation to humans, preventing exclusion and anxiety.

- **Outcomes:**

Higher adoption, reduced avoidable demand on telephone/urgent care, and improved patient experience, feeding back data for continuous improvement and co-design.

4.2.3.3 Themes for Section 3: Balancing Hospital Care and Community Support (questions 8,9 and 10)

8. If you could get help quickly to stay well in your community, how would that change how you feel about going to hospital?

Step 1 — Familiarisation

Initial observations: responses are rich, varied and predominantly *experience based*, with frequent mentions of access barriers (GP appointments, waiting times, transport/parking), preference for community based care (pharmacy, MIU/SDUC, community hubs), concerns about discharge and home support, and information/signposting gaps. Data quality issues include occasional blank entries, one word answers (“Better”, “Fine”), typos, and inconsistent formatting where tabular HTML fragments were present; none affected the core meaning. Place and service references are common (e.g., MIU, Cardigan centre), but no personal identifiers need to be retained in quotations.

Step 2 — Keyword Selection (6 Rs)

Using Naeem’s **6 Rs** criteria (Relevance, Recurrence, Richness, Resonance, Representativeness, Rigour), automated counts were combined with domain informed screening. Frequencies are from programmatic parsing of the uploaded file (unigrams and clustered forms).

Keyword	Frequency*	Rationale
Hospital	30	Central concept; emotionally charged; recurrent across sentiments (avoidance vs. necessity).
Community (care)	21	Strong preference for local services/hubs; rich in practical suggestions.
GP access/appointments	30	Primary access barrier; drives ED/MIU substitution and frustration.
Waiting times	9	Salient deterrent for ED/hospital use; affects trust/experience.
Pharmacy	8	First point of contact; valued for advice and minor ailment management.
MIU/SDUC (urgent care)	5	Perceived as effective alternative to ED; reduces pressure.
Transport & travel	7	Rurality and limited public transport constrain access; equity implication.
Parking & access	7	Practical barrier/stressor; affects hospital willingness and experience.
Discharge/home support	21	Continuity/safety concerns; desire for reablement and reliable aftercare.

Keyword	Frequency*	Rationale
Nurses/district/liaison	5	Workforce availability and liaison roles (e.g. LD) key to confidence.
Diagnostics & tests (community)	4	Preference to move bloods/diagnostics locally; reduces travel burden.
111/triage	3	Mixed experience; navigation difficulty noted; desire for human contact.
Information/signposting	8	Need for clarity on “where to go” (ED vs. MIU vs. GP vs. pharmacy).
Digital/virtual care	1	Acceptability for some (video/online) to avoid hospital; low recurrence but high strategic relevance.
Mental health crisis environment	2	Environment deters attendance; proposal for dedicated calm spaces.

* Frequencies combine token and phrase clusters derived from automated counts on

Step 3 — Coding (max 3 words)

Codes were inductively generated from high value keywords and appraised against the **6 Rs** (fit to data, recurrence, richness, representativeness, resonance, rigour). Quotes are anonymised to avoid personal identifiers e.g., ages, family roles).

Code	Anonymised Quote	Rationale
Hospital last resort	“I don’t want to go to hospital unless it’s very serious.”	Strong preference to avoid hospital for non-urgent needs; recurring.
Community first	“Much happier being seen in the community where available.”	Desire for local accessible services; high resonance.
Pharmacy pathways	“The pharmacist can advise you and keep you out of A&E.”	Pharmacy valued as safe diversion from ED.
GP access barrier	“It’s really difficult to see and speak to a GP... everything is over the phone.”	Access/format constraints drive ED attendance; high recurrence.
Waiting-time deterrent	“I was in A&E twice, each time a 12-hour wait.”	Long waits reduce confidence; emotional impact.
Transport burden	“Without ready transport it wouldn’t [help].”	Rural transport limits equitable access to care.
Parking stressor	“Parking is a nightmare... it’s all added stress.”	Practical barrier that shapes hospital sentiment.
Community diagnostics	“Blood tests should be done in surgery, not hospital.”	Move routine tests locally; reduces hospital trips.
Home-first care	“Would prefer to stay at home and get better at home.”	Strong home-care preference; aligns with strategy.
Discharge gaps	“Sent home at night without support.”	Need for reliable reablement and follow-up.
LD liaison needed	“Would feel less nervous if there was a learning disability nurse at the hospital.”	Specific liaison roles increase access and confidence.

Code	Anonymised Quote	Rationale
MIU/SDUC alternative	“Cardigan urgent care centre is fantastic.”	Positive appraisal of same-day urgent care.
111 navigation issue	“111 is good, but the time can take too long.”	Friction in tele-triage; user experience concern.
Signposting clarity	“Clearer messaging: A&E is for... MIU is for...”	Explicit pathways reduce inappropriate ED use.
Mental health setting	“Waiting in A&E for mental health support is a deterrent... need a welcoming room.”	Environment modifications can improve access.
Digital acceptability	“I would happily have an online consultation over a video call.”	Conditional acceptance; low frequency but meaningful.
White-coat anxiety	“White coat syndrome is still huge.”	Psycho-social factors shape hospital avoidance.
Optics data-sharing	“Opticians could do more but info from hospital isn’t available to them.”	Interoperability gap; continuity of care issue.
Rehab confidence	“Confidence to go if there’s a clear pathway to get home and rehabilitate.”	Assurance about discharge/rehab changes hospital sentiment.

Step 4 — Theme Development (4 Rs)

Codes were clustered into higher order **themes** using Naeem’s **4 Rs** for theming (Relatedness, Recurrence, Relevance, Resonance).

Theme	Related Codes
Access	GP access barrier; Pharmacy pathways; MIU/SDUC alternative; Community diagnostics; Transport burden; Parking stressor
Communication	Signposting clarity; Optics data-sharing; 111 navigation issue
Digital	Digital acceptability; 111 navigation issue (technology UX)
Community Services & Hubs	Community first; Home-first care; Community diagnostics; MIU/SDUC alternative
Discharge, Reablement & Continuity	Discharge gaps; Rehab confidence; LD liaison needed
Patient Experience & Trust	Hospital last resort; Waiting time deterrent; Whitecoat anxiety; Mental health setting

Step 5 — Conceptualisation (aligned to strategic priorities)

From these themes, the following concepts emerge, each aligned to the Board’s strategic direction in A Healthier Mid and West Wales (community model; integrated networks; health & well-being centres; unscheduled care in the community; timely discharge; digital enablement).

1. Home and Community-First Pathways

Definition: Organise routine care (minor ailments, diagnostics, therapies) in community settings

(pharmacies, MIU/SDUC, hubs) so hospitals act as assets of last resort. Priority link: *Our future community model; health & well-being centres; unscheduled care in the community.*

2. Access Equity in Rural Systems

Definition: Address practical barriers (transport, parking, travel time) to ensure timely access and reduce avoidable ED attendance. Priority link: *Resilient communities; integrated community networks; estates planning.*

3. Assured Transitions and Reablement

Definition: Guaranteed post discharge support (reablement, liaison roles, clear pathways) to build confidence and shorten hospital stays. Priority link: *Ensuring timely discharge from hospital; integrated networks; supporting carers.*

4. Clear Navigation and Signposting

Definition: Single front door information and explicit, simple rules: “A&E is for... MIU is for... GP is for... Pharmacy is for...”, delivered consistently across channels. Priority link: *Working across the whole system; community access points.*

5. Digital Enabled Access (with Human Backup)

Definition: Offer video/online consultations and remote advice where acceptable but retain human triage options to reduce anxiety and digital exclusion. Priority link: *Using technology; prevention and early support.*

6. Environment-Sensitive Urgent Care

Definition: Adapt ED environments (quiet/comfort spaces for mental health crisis; sensory-aware settings) to lower deterrents and improve dignity. Priority link: *People at the heart; improving urgent care experience.*

Step 6 — Conceptual Model (textual)

Model summary:

A community first system distributes routine and subacute care across pharmacies, MIU/SDUC, and integrated care hubs, underpinned by clear signposting and digital enabled access. Hospitals are reserved for complex/emergency care. Confidence in hospital use increases when transitions are assured (liaison roles, reablement at home) and practical barriers (transport/parking) are mitigated. Patient experience (waiting times, environment) acts as a moderator: improvements in ED experience reduce avoidance, while robust community options reduce demand and shorten stays. This aligns with the Health Board’s community model and integrated networks and supports the aim of wellness and prevention in Mid and West Wales.

9. What kind of care or support would you like to have nearby so you don’t need to go to hospital?

Step 1 — Familiarisation

The material is rich, varied, and highly granular; it spans service access (GPs, nurses, diagnostics), community hubs, transport, out-of-hours provision, digital/remote support, social care, and condition specific needs (e.g., mental health, palliative, paediatrics, learning disability). Data quality observations: duplication (“as above”), occasional ellipses/blank cells, spelling/typos (“manor”, “NzhS”), mixed specificity, and some entries expressing frustration without explicit service ask. These were retained and coded inductively; personal identifiers were not present in quotes.

Step 2 — Keyword Selection (using the “6 Rs”: Relevance, Recurrence, Richness, Resonance, Representativeness, Rigour)

(Frequencies are derived via programmatic parsing of the uploaded document; sample shown for the most salient items.)

Keyword	Frequency	Rationale
Access	65	Recurrs across GP, pharmacy, diagnostics; high resonance with barriers and timeliness.
Care	93	Central to the prompt; spans clinical and social support; high representativeness.
Health	66	Broad anchor term linking to hubs, centres, checks; conceptually rich.
Hospital	59	Contrast point (avoid hospital); signals proximity and diversion goals.
Services	59	Encompasses multiple modalities (clinics, MIU, diagnostics).
Community	8	Dominant setting preference (hubs, cottage hospitals, village halls).
Nurse(s)	50	Strong ask for nurse-led clinics, district nurses, specialist nurses.
Home	47	Desire for home visits, monitoring, social support; high recurrence.
Centre / Hub	67	“Health centre”, “community hub”, “ICC”; one-stop models perform strongly.
Appointment(s)	43	Timeliness/booking barriers (8am rush); demand for same day slots.
Clinic(s)	43	Nurse led, minor injuries, wellness, specialist (e.g., diabetes).
GP	16	Gatekeeping, continuity, face-to-face; consistent resonance.
Diagnostics/Tests	16–20	Bloods, X-ray, ultrasound, community radiology/mobile units.
Mental health	n-gram (top)	Recurrent triage/support requests; ‘human to talk to’.
Minor injuries	n-gram (top)	Desire for local MIU, 7-day opening; strong recurrence.
Transport	Narrative	Barriers (no direct buses); need for arranged transport.
Palliative/Hospice	Narrative	More beds and home-based support requested.

Keyword	Frequency	Rationale
Learning disability	tri-gram	Dedicated nurses; accessible GP pathways.
Paediatrics	Narrative	Paediatrician access/preventive escalation.

Step 3 — Coding (max 3 words), with anonymised quotes and rationale (6 Rs)

Code	Anonymised Quote	Rationale
GP access	“Easier access to GP... the 8am rush every day.”	High recurrence; strong resonance on timeliness and gatekeeping; representative across locales.
Nurse-led clinics	“Nurse led clinics locally would help... sit in and wait.”	Rich, practical modality; broad representativeness (district/specialist nurses).
Community hubs	“Integrated care centre... one place, one time, be seen and treated.”	Relevance to one-stop models (ICC/Cardigan); high recurrence and resonance.
Diagnostics-nearby	“Blood tests close by... X-rays would be excellent.”	Clear asks for local tests; rigour via multiple specific modalities (phlebotomy, imaging).
Minor injuries	“Walk-in urgent care clinics... minor injuries 7 days a week.”	Frequent; actionable; reduces ED demand; representative across counties.
Mental health support	“A human to talk to... far better mental health care.”	High resonance; qualitative richness; cross theme links (trust/communication).
Home visits	“District nurses... visit home, save hospital trips.”	Recurr across nursing and social care; strong representativeness for frail/disabled.
Social care help	“Care packages... home carers with 24/7.”	Richness around carer support, costs, respite; high relevance to prevention.
Transport support	“No direct bus... arranged transport if needed.”	Common barrier; representative geography; strong resonance with rural context.
Continuity of care	“Same GP who knows my needs.”	Recurrence across complaints; rigour via continuity links to outcomes.
Pharmacy first	“Raise awareness of what pharmacies can offer.”	Richness/representativeness; improved triage; ties to prescribing pharmacists.
Learning disability nurses	“Boards should employ learning disability nurses.”	Specific equity ask; recurrence in cluster; strong resonance.
Paediatric access	“See a paediatrician... prevent crisis.”	Condition-specific; high relevance for family pathways; preventive framing.
Digital/remote care	“Option for face-to-face or remote... 24hour access.”	Richness in modality mix; representative; aligns with strategy’s community focus.
Aftercare/coordination	“Central point who kept communication between everyone.”	Resonance with navigation; rigour via multiple pathway examples.

Note: Quotes are anonymised and truncated to remove any personal identifiers; each is exemplary of many similar statements.

Step 4 — Theme Development (using the “4 Rs”: Recurrence, Relevance, Resonance, Rigour)

Theme	Related Codes
Access & Timeliness	GP access; Minor injuries; Diagnostics nearby; Paediatric access; Pharmacy first; 24/7/out-of-hours
Community-Delivered Care	Community hubs; Nurse led clinics; Home visits; Digital/remote care
Care Coordination & Continuity	Continuity of care; Aftercare/coordination; Navigation; Specialist advice lines
Social Care & Carers	Social care help; Carer support/respite; Home support packages
Transport & Rural Equity	Transport support; Cross border access; Weekend opening; Geographic equity
Mental Health & Wellbeing	Mental health support; Wellness clinics; Social prescribing; Peer groups
Condition Specific Provision	Learning disability nurses; Palliative/hospice; Paediatric; Chronic disease clinics (e.g., diabetes, asthma)

Themes are coherent clusters with strong recurrence and resonance in the corpus and align with Hywel Dda’s strategic intent to shift care into community settings, reduce avoidable hospital attendance, and strengthen prevention.

Step 5 — Conceptualisation (linking concepts to strategic priorities)

1. One Stop Community Access — Local Integrated Care Centres (ICCs) and hubs offering same day triage, diagnostics (bloods, Xray/ultrasound), and minor injuries; reduces ED attendances and travel burden. *Strategic link:* Community model; health & wellbeing centres; unscheduled care in the community.
2. Nurse Led First Contact — District/specialist nurses, prescribing pharmacists, and advanced practitioners delivering front door clinical capacity with escalation protocols. *Strategic link:* Integrated community networks; workforce resilience.
3. Continuity & Coordination — Named clinician/team and pathway navigators for complex needs; integrated records; proactive aftercare. *Strategic link:* Working across the whole system; timely discharge; partnership working.
4. Digital Enabled Access — Blended face-to-face/remote models, 24/7 advice lines, remote monitoring; equitable digital inclusion support. *Strategic link:* Prevention and early help; innovation; access at home/community.
5. Social Care & Carer Support — Care packages, respite, home help, transport facilitation; carer mental health support. *Strategic link:* Supporting informal carers; resilient communities; discharge and reablement.

6. Equity for Rural & Specific Populations — Transport solutions, weekend opening, cross border pragmatism; tailored roles (learning disability nurses, paediatrics, palliative).
Strategic link: Community hospitals/beds; equitable access across geography.

Step 6 — Conceptual Model (textual description)

Model title: *Community-First Access and Continuity (CFAC) Model for Avoiding Unnecessary Hospital Use*

Description:

At the entry point, residents access a One Stop Community Hub (ICC) via walk-in, booked, or remote channels. A Nurse Led Front Door provides triage, same day care (minor injuries, common ailments), and onsite diagnostics (bloods, basic imaging), with clear escalation (letters/protocols) to ED when clinically necessary. Digital/phone advice lines operate 24/7, integrated with GP continuity and named navigators for complex pathways (paediatrics, palliative, learning disability). Social care and carer support (packages, respite, transport) wrap around clinical care to stabilise needs at home. Equity mechanisms (transport schemes, weekend opening, cross border access) ensure geographic fairness. Data flows support feedback and “You Said, We Did” cycles, reinforcing trust and communication and enabling iterative improvement aligned with the refreshed strategy.

10. If you had to travel further for specialist care, what could we do to make that journey worthwhile and less stressful?

Step 1 — Familiarisation

Long-form qualitative responses across varied stakeholders and localities; many entries reference specific Hywel Dda sites such as GGH, PPH, BGH, Withybush and travel to Swansea, Cardiff, Liverpool, Leicester. The data is rich, repetitive, and highly contextual to rurality. Initial observations & data quality notes: (i) high volume of near duplicate concerns around *transport reliability/cancellations* and *parking*; (ii) orthographic variation (e.g., “Glangwilli/Glangwili”; typos such as “nothrntally”); (iii) some entries include location names and site abbreviations; (iv) multiple blank cells near the end of the tabular section; (v) a small number of entries embed political or system level commentary beyond the question’s scope. These do not affect thematic extraction but were treated neutrally.

Step 2 — Keyword Selection (6Rs)

Using the **6Rs** (Relevance, Recurrence, Richness, Resonance, Representativeness, Rigour), recurring terms and phrases were identified. Frequencies below are indicative counts from computational parsing of the dataset, then checked manually for context.

Keyword	Frequency	Rationale
transport (incl. hospital transport)	90+	<i>Recurrence</i> and <i>Resonance</i> : dominant barrier across rural areas; reliability and eligibility repeatedly raised.

Keyword	Frequency	Rationale
parking (incl. free parking)	60+	<i>Richness</i> : evokes stress, access for disabled, and arrival logistics; strong <i>Recurrence</i> at GGH and other sites.
appointment time / timing	50+	<i>Relevance</i> : early morning slots vs. long-distance travel; fairness for those >1 hr away.
cancellations / reliability	40+	<i>Resonance</i> : missed/cancelled transport and clinics; emotional/financial impact.
bus / buses	35+	<i>Representativeness</i> : bus frequency/connectivity gaps in rural communities.
taxi / vouchers	25+	<i>Richness</i> : affordability; calls for voucher schemes and reimbursement.
community transport / Country Cars / volunteers	30+	<i>Relevance</i> : local schemes; volunteer shortages and incentive needs.
one-stop clinics / combine tests	40+	<i>Recurrence</i> : making travel <i>worthwhile</i> via consolidated diagnostics.
digital / video / online	25+	<i>Rigour</i> : appropriateness of remote consultations to avoid travel; supported hubs cited.
directions / signage / maps	20+	<i>Richness</i> : wayfinding, especially for visually impaired; high contrast signage requested.
carer / escort	20+	<i>Resonance</i> : allow escorts on transport; support for elderly or anxious patients.
continuity / same specialist	20+	<i>Relevance</i> : avoid repeating history; share records across boards/sites.
satellite centres	15+	<i>Representativeness</i> : limb centre / ophthalmology examples; closer “satellite” options.
rural / long distances	45+	<i>Recurrence</i> : structural geography challenge across Mid & West Wales.

Note: Counts are conservative and used for relative weighting; manual cross-checking ensured Rigour per Naeem et al. (2023).

Step 3 — Coding (max 3 words; 6Rs-informed)

Code	Anonymised Quote	Rationale
Transport access	“Provide transport; hospital transport unreliable; cancellations.”	High Recurrence and Resonance; core barrier to specialist access.

Code	Anonymised Quote	Rationale
Transport reliability	“Hospital transport is very unreliable; cancellations result in empty appointments.”	Reliability standard repeatedly mentioned; needs service level remedy.
Transport equity	“Affordable, accessible transport for those who don’t drive; include carers.”	Equity/eligibility clarity sought; Relevance to vulnerable groups.
Volunteer drivers	“Community Cars do a great job but are short of volunteers—need incentives.”	Representativeness of community schemes; capacity constraint.
Bus services	“Main bus is only twice a day—arrive 10 mins late; no one talks to each other.”	Richness in network coordination gap; reliability and timing.
Taxi support	“Taxi is ~£60 one way; vouchers or reimbursement needed.”	Cost barrier with Resonance; proposal emerges frequently.
Parking access	“Free parking; more disabled spaces; GGH parking is stressful.”	Arrival logistics central to stress; Recurrence across sites.
Accessible signage	“Signage is appalling; yellow works best for visually impaired.”	Richness and Rigour (specific accessibility standard).
Wayfinding support	“Clear directions and maps before the visit—hospitals are like a maze.”	Pre-visit information reduces cognitive load; Relevance.
Appointment timing	“Don’t book 9 am in Cardiff for people from Pembrokeshire.”	Recurrence on early slots; fairness for long-distance travellers.
Reduce waits	“Being seen on time—long overrun is most frustrating.”	Resonance and Richness on punctuality.
Avoid cancellations	“Ensure appts not cancelled last minute; notify promptly.”	Recurrence; communications and reliability intertwined.
One-stop clinics	“Fit as much as possible into one appointment—tests and consults same day.”	Makes travel <i>worthwhile</i> , strong Relevance.
Joint clinics	“Joint clinics to lessen time and travel.”	Recurrence; multidisciplinary efficiency.
Virtual care	“Video call for quick check-ups—avoid unnecessary travel.”	Rigour: clinically appropriate remote visits cited often.
Chaperone support	“Allow escorts/chaperones; some can’t navigate an unfamiliar hospital alone.”	Resonance for safety/trust; eligibility clarity needed.
Specialist continuity	“See the same specialist; don’t re-tell history; share records across boards.”	Richness on continuity and information flow.
Satellite clinics	“Satellite limb/eye centres closer to home where feasible.”	Representativeness; conditional local provision.
Facilities when travelling	“Park & ride hubs with toilets; step-free buses.”	Rigour: practical enablers reduce travel stress.

(All quotations stripped of any personal identifiers per instruction.)

Step 4 — Theme Development (4Rs: Recurrence, Relevance, Resonance, Rigour)

Theme	Related Codes
Access & Transport	Transport access; Transport reliability; Transport equity; Volunteer drivers; Bus services; Taxi support; Facilities when travelling; Chaperone support
Scheduling & Flow	Appointment timing; Reduce waits; Avoid cancellations; One-stop clinics; Joint clinics
Wayfinding & Environment	Parking access; Accessible signage; Wayfinding support
Digital & Remote Care	Virtual care
Continuity & Information	Specialist continuity; Satellite clinics

These five themes explain the drivers of journey stress and “worthwhile” factors: reliable/affordable access, fair scheduling, efficient care models, navigable sites, and continuity of care.

Step 5 — Conceptualisation (aligned with strategic priorities)

1. **Transport Equity** — Ensure affordable, reliable, accessible transport—including carers/escorts—and integrate with local schemes; aligns with *community-based, equitable access* in the Hywel Dda strategy.
2. **One-Stop Pathways** — Consolidate diagnostics/consults per visit (MDT/joint clinics) to minimise repeat travel; aligns with *better outcomes and patient experience*.
3. **Flexible Scheduling** — Avoid early slots for long-distance travellers; prioritise midday; protect punctuality; aligns with *person-centred care*.
4. **Inclusive Wayfinding** — High contrast signage, clear maps/directions, volunteers for navigation; aligns with *accessibility and dignity*.
5. **Virtual-First Triage** — Use video/phone where clinically appropriate, supported by local digital hubs; aligns with *preventative and digital enabled services*.
6. **Continuity & Record Sharing** — See the same specialist; interoperable records across sites/boards; aligns with *safer, integrated care*.

Step 6 — Conceptual Model (textual description for diagram conversion)

Flow: *Public Feedback on Travel Stressors* → *Design Enablers* (Transport Equity; Flexible Scheduling; One-Stop Pathways; Virtual First Triage; Inclusive Wayfinding; Continuity & Record Sharing) → *Implementation* (service standards, eligibility clarity, booking systems, signage upgrades, MDT scheduling, digital pathways) → *Outputs* (reduced travel burden, fewer cancellations, shorter waits, improved navigation) → *Outcomes* (better access, equity, trust, satisfaction; alignment with *A Healthier Mid and West Wales* trajectory).

4.2.3.4 Themes for Section 4: Clinical Services and Hospital Redevelopment (question 11)

11. If we secure funding to improve healthcare buildings and facilities, especially at sites most in need of repair – what would you like us to prioritise and what concerns should we work through together as those changes take place?

Step 1 — Familiarisation

Approx. 300+ bullet/paragraph entries) to understand breadth, depth, and variability. The dataset covers estates fabric and safety, car parking/transport, A&E experience, accessibility (BSL, Changing Places, neurodivergence), wayfinding and communication, community hubs/MIU, cleanliness and maintenance, equipment and Wi-Fi, staffing vs. buildings, and site-specific views (notably Withybush, Glangwili, Bronglais, Prince Philip). Data quality is rich, diverse in tone (from constructive to highly frustrated), and includes multiple duplicates around parking, toilets, and cleanliness—useful for recurrence analysis. No personal identifiers appear; several quotes reference specific sites, which are retained as context while anonymising speakers.

Initial observations: Recurrent pain points are *parking, toilets/Changing Places, A&E conditions and comfort, cleanliness/maintenance, accessibility and wayfinding*, and the *tension between investing in existing hospitals (esp. Withybush/Glangwili) versus a new build*. There is consistent support for community-based care hubs and stepdown/convalescent beds to relieve acute pressure.

Step 2 — Keyword Selection (using Naeem’s “6 Rs”)

Criteria applied: Relevance, Recurrence, Richness, Resonance, Representativeness, Rigour (per Naeem 2023/2025).

Keyword	Frequency*	Rationale
Parking	Very high	Highly recurrent across sites (GGH, PPH, BGH), includes staff ticketing, stress at A&E drop-off, calls for multistorey/park-and-ride → strong Relevance/Recurrence/Resonance.
Toilets / Changing Places	High	“TOILETS”, Changing Places absent at PPH/GGH; links to dignity, disability access → Richness/Resonance.
Cleanliness / Maintenance	High	Dirty/derelict spaces, broken showers, air vents filthy → Relevance/Rigour (safety and IPC).
Accessibility (BSL, disabled access)	High	BSL interpreters, Sign Live/Sign Wow blocked by Wi-Fi, doors/ramps → Representativeness across disability groups.

Keyword	Frequency*	Rationale
Wayfinding / Signage	Medium-High	Colour coding praised (WGH/BGH) but inconsistent; letters need maps/large print → Resonance with anxious users.
A&E environment / overcrowding	High	Chairs for hours, overnight discomfort, segregation needs, dignity/privacy → Richness/Relevance.
Community hubs / MIU	High	One-stop hubs, local MIU (Cardigan/Aberaeron), stepdown beds → Strategic fit with HDUHB vision.
Equipment (MRI/CT/diagnostics)	Medium	Call for modern kit and proximity (e.g., MRI), lab upgrades → Rigour/Quality.
Digital / Wi-Fi	Medium	Wi-Fi limiting interpreter apps; call for connectivity in hubs → Relevance to AI-adapted framework.
Staffing vs. buildings	High	“Buildings matter less without staff”; burnout; deploy auxiliaries/admin → Richness/Resonance.
New hospital vs. upgrade existing	High	Polarised views; Withybush and Glangwili upgrades vs. new site; timeline concern mirrors strategy refresh narrative → Representativeness.
Transport (bus/park-and-ride)	Medium	Links to rurality, BGH hill, Bronglais top deck blue badge → Relevance to access.

*Approximate, based on manual counts and repeated phrasing clusters in

Step 3 — Coding (max three words per code)

Codes were derived inductively from the keywords and assessed with the **6 Rs** (Naeem 2023/2025). Quotes are **anonymised** and truncated to protect identity and avoid personal data.

Code	Anonymised Quote	Rationale
Parking crisis	“Car parking is a nightmare at all the main hospitals”	High recurrence; cross site burden; stress in emergencies.
Multi-storey ask	“All the main hospital sites need multi-storey car parks”	Concrete solution demand; capital implication.
Park-and-ride	“A park and ride in Aberystwyth for Bronglais hospital”	Demand management lever tied to rurality.
Toilets priority	“We desperately need TOILETS, TOILETS, TOILETS”	Dignity/safety; high emotional resonance.
Changing Places gap	“Changing Places—there are none in PPH and GGH”	Compliance gap for complex disability needs.

Code	Anonymised Quote	Rationale
Cleanliness failings	"The CT room was filthy... air vents so dirty"	IPC risk; urgent estates/soft FM attention.
Wayfinding weak	"Colour code areas so you can find where you're going"	Navigability affects anxiety and flow.
Large-print info	"Eye clinic leaflets... font you can't read"	Accessible communication compliance.
BSL provision	"We need qualified BSL interpreters based in hospitals"	Language access; equality duty.
Wi-Fi for access	"Can't access Sign Live... invest in decent Wi-Fi"	Digital inclusion as an enabler of access.
A&E comfort	"Spending a whole night sitting in a chair... it's purgatory"	Dignity, mental health, experience.
Segregated waiting	"Separate A&E areas—children, adults, MH, LD"	Safety, trauma reduction, safeguarding.
Community hubs	"One-stop hubs... clinics there so people don't travel"	Aligns with strategy shift to community. https://hduhb.nhs.wales/about-us/healthier-mid-and-west-wales/healthier-mid-and-west-wales-folder/documents/a-healthier-mid-and-west-wales-strategy/
Step-down beds	"Convalescent beds in local communities"	Patient flow; discharge; capacity.
Local MIU	"If they can do it in Cardigan, why not in Aberaeron?"	Demand for minor injury access closer to home.
Diagnostics nearer	"MRI and other equipment being available"	Diagnostic access reduces delays and travel.
Lab upgrade	"Laboratory at GGH needs updating"	Quality and turnaround; service resilience.
Staffing first	"It's the staff... not the buildings"	Persistent message on workforce constraints.
Role redesign	"Use clerks and auxiliaries for checks"	Efficiency through appropriate skill-mix.
Upgrade existing	"Upgrade Withybush... Glangwili needs serious work"	Capital prioritisation toward legacy estate.
New build support	"Personally I would like a new purpose-built hospital"	Counter position; modernity, futureproof.

Code	Anonymised Quote	Rationale
Rural transport	“Better connectivity between hospitals and bus services”	Social gradient of access in rurality.
Comfort spaces	“Make patient/visitor areas more comfortable”	Experience of care and anxiety reduction.
Green spaces	“Green spaces for respite make you feel cared for”	Emotional well-being, healing design.

Step 4 — Theme Development (using the “4 Rs”: Relationship, Relevance, Reach, Rigour)

Codes were clustered into coherent themes that demonstrate internal homogeneity and external heterogeneity (Naeem 2023/2025).

Theme	Related Codes
Access & Transport	Parking crisis: Multi-storey ask; Park-and-ride; Rural transport; Local MIU; Diagnostics nearer.
Dignity, Safety & IPC (Estates Fabric)	Toilets priority: Changing Places gap; Cleanliness failings; Comfort spaces; Green spaces.
Inclusive Communication & Wayfinding	Wayfinding weak; Large-print info; Clear maps in letters; Colour coding.
Disability & Neurodiversity Readiness	BSL provision; Wi-Fi for access; Disabled access/doors; Sensory-friendly areas; Private/soundproof rooms.
Urgent & Emergency Care Experience	A&E comfort; Segregated waiting; Overcrowding relief; Basic needs (food/water/seating).
Community Hubs & Step-down Capacity	Community hubs; Stepdown beds; Convalescence/restorative care; One-stop clinics.
Workforce–Infrastructure Fit	Staffing first; Role redesign; Cleanliness staffing/QA; Volunteers/navigation support.
Capital Direction & Site Strategy	Upgrade existing; New build support; Site-specific priorities (WGH, GGH, BGH, PPH); Lab upgrade.
Digital Foundations for Access	Wi-Fi for access; Digital letters/maps; Assistive tech enablement in clinics.

Step 5 — Conceptualisation (linking to strategic priorities)

Drawing on Naeem’s guidance, the themes have been integrated into higher-level **concepts** that align with *A Healthier Mid and West Wales* (community first, prevention, sustainable hospital care, rural access).

1. Right Care, Right Place — Reconfigure front door demand by strengthening community hubs, MIU access, and stepdown beds, thereby reducing acute pressure and travel for rural populations. (*Links to community model, integrated community networks*).

2. Accessible Estate, Inclusive by Design — Treat parking, transport, signage, accessible information, and Changing Places as essential access infrastructure, not amenities. (*Links to equitable access, reducing health inequalities*).
3. Safe, Clean, Dignified Environments — Prioritise IPC critical maintenance, toilets, A&E comfort and segregation, and sensory-friendly/quiet spaces to improve outcomes, experience, and flow. (*Links to quality and safety commitments*).
4. Workforce–Place Synergy — Align capital with workforce: skill mix, cleaning/portering QA, and administrative load shifting so clinical time is protected. (*Links to sustainable services; staff wellbeing and recruitment*).
5. Digital as an Enabler of Inclusion — Invest in reliable Wi-Fi, assistive tech (e.g., BSL platforms), and digital wayfinding/maps to remove barriers and support remote/satellite clinics. (*Links to digital/innovation enablers*).
6. Pragmatic Capital Sequencing — In the context of the refreshed strategy and uncertain timelines for a new hospital, targeted upgrades to existing acute sites (e.g. Glangwili Withybush hospitals) plus modular/rapid builds for critical functions (labs/diagnostics/parking) provide near-term risk reduction and service resilience. (*Links to: Clinical Services Plan and strategy refresh statements*).

Step 6 — Conceptual Model (textual description for diagram)

Inputs (Public Voice & Strategy Context): Public priorities- HDUHB strategic intent to shift care closer to home and stabilise fragile services while major capital remains long-term.

Core Mechanisms:

- Access Enablers (parking, transport, signage, accessible info, Wi-Fi) → lower barriers to timely care.
- Environment & IPC (toilets/Changing Places, cleanliness, A&E comfort/segregation) → safer, more dignified care and improved flow.
- Community Capacity (hubs, MIU, step-down beds) → decompress acute sites and reduce travel.
- Workforce–Place Alignment (skill mix, admin/auxiliary roles, volunteer navigation) → optimise clinical time and experience.
- Capital Sequencing (targeted upgrades + modular builds) → risk based, staged improvements compatible with the longer timeline for any new hospital.

Outcomes: Improved patient access and experience, equity for disabled and neurodivergent users, reduced acute congestion, safer environments, better staff well-being, and strategic consistency with the *Healthier Mid and West Wales* model.

4.2.4 Overall themes for sections 1, 2, 3 and 4 (group sessions and events only)

General feedback about the 4 broad sections of the questionnaire* was only provided at the group sessions and events. This section of the report presents the themes for each of the 4 sections in turn:

**The 4 sections were:*

- Section 1 Social Model for Health and Well-being*
- Section 2 Digital Healthcare Support*
- Section 3 Balancing Hospital Care and Community Support*
- Section 4 Clinical Services and Hospital Redevelopment*

4.2.4.1 Overall themes for Section 1: Social Model for Health and Well-being

(questions 1,2,3 and 4)

Step 1: Familiarisation

Rich, first-hand accounts across access, communication, transport, workforce, funding, social care integration, and digital processes. The data includes multi-issue narratives typical of rural health systems, with repeated mentions of waiting times, difficulties accessing primary/ophthalmic/dental care, transport barriers, and the need for better integration with social care and the third sector. Minor data quality considerations include mixed formatting (bulleted items, headings interspersed) and references to specific place names/services that require anonymisation when quoted.

Step 2: Keyword Selection (the “6 Rs”)

Keyword	Frequency	Rationale
Access	18	Recurr across care settings (GP, dentistry, ophthalmology), strong Relevance to strategy, high Resonance for rural communities.
Waiting / Wait	12	Persistent delays for appointments and procedures; Recurrence and Representativeness of system pressure.
Transport	16	Repeated references to buses, taxis, NEPTS; critical Relevance in rural areas; Richness in examples.
Communication	14	Concerns about clarity, tone, accessibility of letters; Rigour need for accessible information.
Integration	10	Health–social care alignment repeatedly raised, Resonance with strategic aims.
Digital	9	Mixed views on digital scans, letters, scheduling, AI; Representativeness across multiple threads.
Workforce	11	Recruitment/retention, newly qualified staff; significant Relevance and Recurrence.
Funding	8	Affordability of travel, third-sector sustainability; Richness in detailed accounts.
Preventative	7	Desire for health checks, rehab, wellbeing; aligns with strategy’s prevention focus (Resonance).
Ophthalmology	7	Specific pathway and private/NHS interface concerns; Relevance, Rigour implications.
Dentistry	6	Access problems and out-of-pocket payments; Recurrence in primary care access.
Rural	6	Rurality as structural determinant of access/transport; Representativeness of region.

Note: Frequency counts are approximate tallies from the dataset to support prioritisation rather than statistical inference.

Step 3: Coding (max 3 words; anonymised quotes; “6 Rs” applied)

Code	Anonymised Quote	Rationale
Appointment delay	“Had to wait three weeks for basic tests.”	Recurrence of delays; Relevance to service timeliness.
Preventive checks	“Annual health MOTs no longer offered.”	Resonance with prevention; supports strategic shift.
Dental access	“Finding an NHS dentist is a problem.”	Representativeness of primary care gaps.
Disability access	“Local facilities lack wheelchair access.”	Rigour need for inclusive infrastructure.
Community venues	“No accessible community centre available.”	Richness: place-based barriers.
Aging population	“Older residents need support to avoid hospital.”	Resonance with demographic reality.
Info awareness	“Does the health board know about our group?”	Relevance to engagement pathways.
Clinical tone	“Told ‘nothing more can be done’—distressing.”	Rigour: compassionate communication standards.
Explanation clarity	“Condition not explained; had to seek answers elsewhere.”	Recurrence of comprehension issues.
Out-of-pocket	“Charged for a diagnostic scan despite referral.”	Richness: affordability concern.
Data sharing	“Community providers cannot access hospital scans.”	Relevance to interoperability.
Pathway interface	“Unclear feedback loops between private clinic and NHS.”	Rigour: governance of mixed models.
Travel burden	“Long journeys for short hospital procedures.”	Representativeness of rural travel strain.
Workforce gaps	“Recruitment and retention problems persist.”	Recurrence and strategic priority.
Newly qualified	“New clinicians struggle to find local posts.”	Relevance to pipeline planning.
Board confidence	“Rumours of closures affect willingness to work locally.”	Resonance: organisational stability.
Accessible letters	“Appointment letters are hard to read.”	Rigour: accessible formats duty.
Mental health gaps	“Poor continuity for mental health support.”	Recurrence across accounts.
Third-sector strain	“Groups are asked to deliver without funding.”	Richness: sustainability risk.
NEPTS scheduling	“Shared transport causes long waits between appointments.”	Relevance: logistics optimisation.

Code	Anonymised Quote	Rationale
Local knowledge	“Centralised services miss rural nuances.”	Representativeness in rural context.
Care home capacity	“Insufficient step-up/step-down beds nearby.”	Relevance: intermediate care.
Home adaptations	“Discharge delayed by lack of basic home ramps.”	Rigour: discharge planning.
Physio continuity	“Brief instructions then discharged; paid privately.”	Recurrence: pathway quality.
Emergency response	“Ambulance delays led to self-transport for urgent care.”	Richness: patient safety risk.
Service hours	“Local centres close evenings/weekends.”	Relevance to access equity.
Carers’ burden	“Relatives expected to provide complex care.”	Resonance with community model.
Dementia pathway	“Slow assessment; whole-person view needed.”	Rigour: pathway redesign.
Digital fit	“Digital options help but cannot replace social contact.”	Representativeness: blended model.
AI scheduling	“Suggested AI could optimise transport bookings.”	Relevance to digital enablers.

Step 4: Theme Development (grouping via the “4 Rs”: Relevance, Rigour, Resonance, Representativeness)

Theme	Related Codes
Access & Equity	Appointment delay; Preventive checks; Dental access; Service hours; Rural; Aging population; Travel burden; Care home capacity; Home adaptations.
Communication & Experience	Clinical tone; Explanation clarity; Accessible letters; Info awareness; Carers’ burden; Dementia pathway.
Transport & Logistics	Transport; NEPTS scheduling; Local knowledge; AI scheduling; Travel burden.
Workforce & Organisational Confidence	Workforce gaps; Newly qualified; Board confidence.
Integration & Pathways	Integration; Pathway interface; Data sharing; Physio continuity; Mental health gaps; Preventive checks.
Funding & Sustainability	Funding; Third-sector strain; Out-of-pocket.
Digital & Accessibility	Digital fit; AI scheduling; Accessible letters; Data sharing.

Step 5: Conceptualisation (aligned with strategic priorities)

1. Community-First Access Hubs

Definition: Place-based, accessible venues offering preventive checks, evening/weekend services, and integrated discharge support (e.g., home adaptations).

Strategic link: Embeds the strategy's community model and prevention ambitions in A Healthier Mid and West Wales; addresses fragile services pending hospital reconfiguration.

2. Compassionate, Accessible Communication

Definition: Standardised, plain-language, assured-tone communications with accessible formats (large print, audio, digital alternatives), plus proactive signposting to third-sector support.

Strategic link: Improves patient experience and outcomes, aligning with the Board's commitment to safe, quality, sustainable care.

3. Smart Rural Mobility for Health

Definition: Integrated health transport scheduling combining NEPTS, local volunteer drivers, and public routes, augmented by rules-based/AI optimisation with local knowledge safeguards.

Strategic link: Reduces missed appointments and inequity for rural populations; supports continuity of care.

4. Workforce Pipeline & Confidence

Definition: Targeted programmes to attract/retain clinicians (including newly qualified), stabilise services, and communicate organisational plans transparently to reinforce place-based confidence.

Strategic link: Addresses fragility and recruitment challenges highlighted in the refresh narrative.

5. Integrated Care Pathways & Data Interoperability

Definition: Clear, end-to-end pathways across NHS, independent providers, and community services with interoperable diagnostics and shared feedback loops.

Strategic link: Enables "whole system" working central to the strategy and Clinical Services Plan.

6. Sustainable Partnerships with the Third Sector

Definition: Commissioned roles and micro-grants for community groups delivering preventive and social support, reducing isolation and long-term system costs.

Strategic link: Realises resilient communities and integrated networks envisaged in the strategy.

7. Blended Digital Care with Human Connection

Definition: Digital options (booking, information, remote support) complemented by in-person community activities; accessibility-by-design across channels.

Strategic link: Advances modernisation while guarding against loneliness and exclusion; consistent with digital accessibility commitments.

Step 6: Conceptual Model (textual description)

Model Overview:

At the **core**, *Community-First Access Hubs* anchor services locally. **Inputs** flow from *Workforce Pipeline & Confidence* and *Sustainable Partnerships with the Third Sector*, ensuring capacity and place-based support. **Enablers** are *Smart Rural Mobility for Health* and *Blended Digital Care*, which improve reach and convenience. **Processes** are governed by *Integrated Care Pathways & Data Interoperability*, ensuring seamless movement between primary care, hospital services, and community provision. **Experience Layer** is *Compassionate, Accessible Communication*, which strengthens trust and understanding at every touchpoint. **Outcomes**: reduced waits and travel burden, equitable access for rural and disabled residents, improved continuity and preventive care, and stronger organisational confidence—collectively advancing the refreshed strategy’s goals amid longer timelines for estate changes.

4.2.4.2 Overall themes for Section 2: Digital Healthcare Support (questions 5,6 and 7)

Step 1: Familiarisation

The data set comprised free text public feedback about access, communication, digital tools, and service navigation. The data are rich and detailed, with recurring issues around digital exclusion, accessible formats (BSL, large print, audio), rural connectivity, interoperability of health systems, and appointment booking barriers. Minor data quality notes: (a) mixed punctuation and typographical errors, (b) occasional duplicated ideas, and (c) references to local services/events without dates. None of these issues impeded thematic analysis.

Step 2: Keyword Selection (6 Rs)

Using *Relevance, Recurrence, Richness, Resonance, Representativeness, Rigour*, the recurring terms were identified and tallied at the level of explicit mentions and strong paraphrases.

Keyword	Frequency	Rationale
Digital / Apps	28	Highly recurrent concerns about reliance on apps and digital processes; strong resonance with exclusion risks and older adults.
Letters / Paper	19	Frequent preference for letters as reliable memory aid and inclusive alternative; representative of non-digital groups.
Telephone / Speak to someone	22	Emphasised need for human contact, reassurance, and alternative to text-only systems.
BSL / Deaf access	13	Specific accessibility gaps (BSL videos, identification flags); rich, actionable detail.
Large print / Audio	8	Accessibility format requirements and claims of discrimination when not provided.
Broadband / Signal / Wi-Fi	17	Rural connectivity barriers; recurring mentions of poor signal, storm outages, and affordability.
Interoperability / Records	11	Systems “not talking to each other”; cross-border record access issues (England/Wales).
Appointment booking (8am, text reminders)	20	Barriers due to phone queues, one-way SMS, web confirmation requirements; high recurrence and resonance.
iPads / Assistive tech	7	Requests for devices on wards and in GP settings to support communication.
Face-to-face	12	Preference for in person interactions, especially among older adults; rich, emotive content.
Bilingual messaging clarity	6	Difficulties understanding long Welsh only texts; need for clear bilingual pathways.
AI (uses / reliability)	3	Curiosity and caution about AI roles; rigour needed in communicating scope and contingencies.

Note: Frequencies are approximate, based on explicit mentions and near synonyms to satisfy Representativeness and Rigour in Naeem’s approach.

Step 3: Coding (max 3 words; 6 Rs)

Codes derive from keywords and apply the 6 Rs criteria to ensure relevance, recurrence, and richness. Quotes are anonymised.

Code	Anonymised Quote	Rationale
Digital overload	“I don’t think digital is for everyone... older people feel neglected.”	Recurrent exclusion linked to heavy digital reliance; resonates strongly with older adults.
Paper preference	“It’s a memo if you have difficulty with memory (having a letter).”	Rich detail on paper aiding recall; representative of non-digital populations.
Human reassurance	“You need a human voice—to speak to someone and explain.”	Reassurance via conversation recurs; high resonance and practical relevance.
BSL provision	“Where is the BSL version?... weeks of nagging for a BSL video.”	Accessibility gap; recurrent and actionable.
Accessible formats	“We need large print or audio versions... not producing them is discrimination.”	Strong, rich claims supporting inclusive formats.
Rural connectivity	“Appalling signal in rural areas... broadband needs to be improved.”	Recurrence of poor signal and outages; representative of rural contexts.
System interoperability	“You need systems that talk to each other—Hospitals, Health Boards, GPs.”	Persistent barrier; high strategic importance.
SMS limitations	“Appointment reminder... wouldn’t allow me to reply back. One way.”	Recurrent issue with one-way messaging; actionable.
8am bottleneck	“You have to call GP Practice by 8am... appointments gone.”	Recurrence and resonance; clear bottleneck in access.
Assistive devices	“Wards should have iPads/laptops for us to use.”	Specific, practical enabler; supports communication access.
Face-to-face valued	“In person is much better... feel more comfortable.”	Recurrent preference; informs service design balance.
Bilingual clarity	“Long message all in Welsh... couldn’t find the date.”	Salient readability issue; aligns with communication quality.
Outage contingency	“If your systems go down you are sunk!”	Strong resonance about resilience; urgent operational risk.
No-show charges	“There should be a charge for no shows.”	Minority but notable suggestion; signals accountability theme.
Vaccination comms	“Texts for jabs... not helpful if you don’t have a phone.”	Preventive care impacted by digital only messaging; recurrent.

Step 4: Theme Development (4 Rs)

Codes grouped using *Recurrence, Relevance, Resonance, Rigour*.

Theme	Related Codes
Access Pathways	8am bottleneck; SMS limitations; Face-to-face valued; Paper preference; Vaccination comms; Human reassurance.
Digital Inclusion & Choice	Digital overload; Assistive devices; Accessible formats; BSL provision; Bilingual clarity.
Connectivity & Resilience	Rural connectivity; Outage contingency; Wi-Fi quality.
Interoperability & Records	System interoperability; Cross border access (England/Wales); Repetition of story across sites.
Accountability & Engagement	No-show charges; Timeliness of BSL content; Transparency in public posts.

Step 5: Conceptualisation (aligned to strategic priorities)

1. Multi-channel Access Assurance

Definition: Guarantee parallel access routes (face-to-face, telephone, paper, digital), with real-time human support for complex needs.

Strategic link: Community first, prevention-oriented access model in AHMWW, emphasising care “as close to home as possible” and inclusive pathways.

2. Inclusive Digital by Design

Definition: Embed accessibility (BSL, large print, audio, reply enabled SMS), user choice, and assistive tech (ward iPads) within all digital services.

Strategic link: Strengthening the digital enabler and social model of health in the refreshed strategy.

3. Rural Connectivity Stewardship

Definition: Joint initiatives with partners to improve broadband/signal, hospital Wi-Fi, and contingency for outages, prioritising rural communities.

Strategic link: Resilient infrastructure and equitable access in a rural setting (core AHMWW context).

4. Interoperable Care Records

Definition: Seamless data sharing across GPs, hospitals, and cross border services to stop repetitive histories and missed information.

Strategic link: “Working across the whole system” and “joined up support” commitments in AHMWW; accelerated in the refresh.

5. Accessible Public Communications

Definition: Proactive, bilingual, accessible content with timely BSL videos; plain English letters aligned to average reading age; two-way channels.

Strategic link: Engagement and community partnership principles; communications enabling prevention and adherence.

Step 6: Conceptual Model (textual description)

Core outcome: *Equitable Access to Care*

Inputs/Enablers:

- (a) **Inclusive Digital by Design** and **Rural Connectivity Stewardship** provide *capable channels*;
- (b) **Interoperable Care Records** delivers *joined up information*.
- (c) **Accessible Public Communications** ensures *comprehension and engagement*.

Process: The **Multichannel Access Assurance** layer orchestrates channels (paper/letter, telephone with human support, face-to-face, digital with assistive tech), selecting the optimal route per person/context.

Feedback loops: Data from access failures (missed appointments, unread texts, BSL delays) feed continuous improvements in accessibility standards, connectivity investments, and system interoperability.

Strategic relevance: The model operationalises AHMWW's vision—shifting from reactive illness care to proactive, community-based, inclusive health—while addressing rurality, workforce/digital fragilities, and infrastructure constraints noted in the strategy refresh materials.

4.2.4.3 Overall themes for Section 3: Balancing Hospital Care and Community Support (questions 8,9 and 10)

Step 1 — Familiarisation

The dataset is rich, with detailed experiences across access, transport, audiology, ophthalmology/dermatology, staffing, and organisational issues. Initial observations: (i) high recurrence of hospital/transport/care terminology; (ii) consistent accounts of access inequity north–south; (iii) cross boundary issues between health and social care; (iv) variable signposting/communication; (v) emotional burden (waiting, anxiety); (vi) scattered mentions of digital/communication and Common Ailment Scheme awareness gaps. Data quality is adequate, though some statements are narrative heavy with merged topics; this is typical for public engagement and handled in coding.

Step 2 — Keyword Selection (using Naeem’s “6 Rs”: Relevance, Recurrence, Richness, Resonance, Representativeness, Rigour)

Frequency indicates occurrences in the file; rationale applies the 6 Rs criteria. (Counts computed programmatically for transparency.)

Keyword	Frequency	Rationale
Hospital	18	Recurrent anchor of experiences; representative of acute and community interfaces; conceptually rich (care locations).
Care	19	Central construct spanning clinical and social care; high recurrence; resonates across stories.
Transport	12	Strong recurrence; strategic relevance to rural access; rich detail (eligibility, cancellations).
Ambulance	7	Recurrent for urgent access and criteria; emotionally resonant incidents; safety implications.
Community	7	Reflects preventative/community model in strategy, representative of desired shift.
Access	4	Explicitly named issue; links to inequity north–south; rigorously evidenced via multiple cases.
Audiology	3	Specific service pathway concerns; signposting gaps; resonance for deaf children/families.
Ophthalmology	2	Cross-service coordination; transport eligibility; representative of “fragile services” focus.
Dermatology	2	Illustrates “care closer to home” opportunities and coordination issues.
Staff	7	Workforce pressures (ratios, stress); resonates with sustainability goals.

Keyword	Frequency	Rationale
Carers	6	Social care funding/value; interface challenges with health; representative of community reality.
A&E	4	Urgent/emergency experiences; waiting; safety narratives; high resonance.
Signposting	1	Low frequency but high richness/strategic relevance; repeated implicitly (awareness gaps).
Messaging	2	Perception/communication strategy; resonance for public confidence and utilisation.
Prevention/Preventative	3	Aligns with strategic emphasis on prevention/community, representative of desired shift.
Inequity	1	Low frequency term, but concept richly evidenced (north–south access), high strategic relevance.

Framework sources: systematic six step model and AI support guidance.

Step 3 — Coding (max 3 words; inductive; guided by 6 Rs)

Code	Anonymised Quote	Rationale
Transport unreliability	“Hospital transport... can be cancelled at short notice... difficult to find a replacement.”	Recurrent; safety, anxiety; representative for rural logistics.
Ambulance criteria confusion	“Eligibility... different criteria... staff say you’re not eligible, call later and you can get transport.”	Resonance; rigour via multiple mentions; equity implications.
North–south inequity	“Lots of provision in the south... not so much in the north.”	Clear inequity theme; strategic relevance to geography.
GP access barriers	“Phone at 8:30am, all appointments gone.”	Recurrence across testimonies; gateway to care.
Dental access failure	“Paid all my life and can’t get dental treatment.”	Richness (frustration); preventative impacts.
A&E waits risk	“Waited 3 hours in A&E... three weeks later this person died.”	High resonance; safety and timeliness concerns.
Audiology signposting gap	“Leave appointments without knowing next steps... need clear signposting.”	Richness; continuity of care for deaf children.
Deaf communication barriers	“90% of deaf people don’t have a voice... barrier at pharmacies.”	Accessibility; equalities; service design.
Eligibility to re-attend	“Can’t go back to HOPE until clearance from GP/physio... why is that?”	Cross-boundary protocol friction; anxiety.
Staffing strain	“Three nurses to 29 patients... criminal.”	Workforce pressure; safety; resource allocation.

Code	Anonymised Quote	Rationale
Community preference	“Rather be treated in the community than in hospital.”	Aligns with strategy’s community care model.
System not joined up	“Big problem with social and health care – it is not joined up.”	Integration theme; persistent barrier.
Bureaucracy perception	“Top heavy with bureaucracy... needs slimming down.”	Organisational trust/accountability; resonance.
Positive messaging asks	“Change the messaging – ‘we do this really well’.”	Communication/confidence; utilisation.
Common Ailment unawareness	“Group did not know... not signed well at pharmacies.”	Preventative scheme awareness gap.
Care workforce value	“Care sector poorly paid... society doesn’t value care.”	Social care sustainability; equality.
Pathway duplication	“GP sends you to hospital... hospital sends you back to GP.”	Inefficient pathways; navigation burden.
Service coordination gaps	“Dermatology could have been done locally by GP.”	Care closer to home; triage optimisation.
Anxiety non-attendance	“Members... don’t attend [appointments] because of anxiety.”	Psychological access barrier; support need.
Reception coverage	“Front reception... frequently unmanned.”	First-contact quality; patient experience.

Step 4 — Theme Development (using Naem’s “4 Rs”: Relationship, Resonance, Representation, Rigour)

Theme	Related Codes
Access & Equity (Geography)	North–south inequity; Transport unreliability; Ambulance criteria confusion; A&E waits risk; GP access barriers; Dental access failure.
Integration & Pathways	System not joined up; Pathway duplication; Service coordination gaps; Eligibility to reattend.
Workforce & Capacity	Staffing strain; Care workforce value; Reception coverage.
Community & Prevention	Community preference; Common Ailment unawareness; Prevention/Preventative (implied across text).
Communication & Signposting	Audiology signposting gap; Positive messaging ask; Deaf communication barriers.
Patient Experience & Anxiety	Anxiety non-attendance; A&E waits risk; Transport unreliability (anxiety effects).
Governance & Accountability	Bureaucracy perception; Plan ahead (strategy horizon); Resources directed “where needed”.

Step 5 — Conceptualisation (definitions aligned to strategic priorities)

1. **Place based Access Equity** — Ensuring timely, reliable access across rural geographies (north–south parity) through transport, eligibility clarity, and localised care models. *Links to* community-based care; resilient communities; integrated networks in the strategy.
2. **Integrated Care Pathways** — Seamless protocols between primary, community, hospital, and social care to reduce duplication and improve continuity (e.g., reattendance clearances, dermatology triage to GP). *Links to*: “working across the whole system,” integrated community networks.
3. **Workforce Sustainability & Value** — Adequate staffing ratios, supportive environments, and valuing the social care workforce to safeguard safety and quality. *Links to* improving nurse staffing levels and sustainable workforce aims noted in the refresh communications.
4. **Community first Prevention** — Strengthening awareness and utilisation of prevention schemes (e.g., Common Ailment), social prescribing, and community hubs to reduce acute demand. *Links to*: prevention focus and community hubs progress.
5. **Accessible Communication & Signposting** — Universal design for information (BSL aware, pharmacy signage, next step guidance), positive messaging to build confidence and appropriate utilisation. *Links to* person-centred care, “Our people and communities at the heart.”
6. **Patient Experience & Psychological Safety** — Reducing anxiety-related nonattendance via assurance, transport reliability, and waiting time transparency. *Links to* unscheduled care in the community; timely discharge; quality standards.
7. **Lean Governance & Accountability** — Transparent, outcome focused stewardship, reducing perceived bureaucracy, planning over a 5–10year horizon consistent with strategy refresh timelines. *Links to*: Board refresh statements; interim Clinical Services Plan enabling fragile services support.

Step 6 — Conceptual Model (textual description suitable for diagramming)

Core proposition: *Equitable access in a rural system depends on integrated pathways, sustainable workforce, and community anchored prevention, all enabled by accessible communication and lean governance.*

The model positions **Place-based Access Equity** at the centre. Five enabling subsystems feed into it:

- **Integration & Pathways** (protocols, eligibility clarity, GP–hospital handshakes)
- **Workforce Sustainability** (capacity, competencies, value of social care)
- **Community-first Prevention** (schemes, hubs, social prescribing)
- **Accessible Communication** (signposting, inclusive formats, positive messaging)
- **Lean Governance** (planning, accountability, resource focus)

Outcomes: reduced waiting/anxiety, fewer duplications, improved utilisation of local care, and strengthened trust. **Feedback loops:** better patient experience increases confidence and uptake of prevention, which lowers acute demand, easing workforce strain and creating capacity for

integration improvements. This aligns with the strategy's shift to community care while addressing interim fragilities highlighted in the refresh.

4.2.4.4 Overall themes for Section 4: Clinical Services and Hospital Redevelopment (question 11)

Step 1 — Familiarisation

The data include short, free text statements on maternity care experiences (notably at Glangwili, Bronglais, and Withybush), access and travel burden (e.g., emergency sections, c-sections not provided locally), engagement process complexity (difficulty with documents/questionnaires), health board collaboration queries, and community health/fitness infrastructure (gyms, wheelchairs, corridors). Quality is high for salience and clarity, though statements are terse and sometimes fragmented (e.g., ellipses), requiring careful interpretation. No personal identifiers appear; site names and service references are retained as contextual descriptors, not identifiers.

Step 2 — Keyword Selection (6Rs: Relevance, Recurrence, Richness, Resonance, Representativeness, Rigour)

Note: Frequencies reflect explicit mentions or strongly synonymous phrasing in the dataset; given the short corpus, counts are indicative rather than inferential.

Keyword	Frequency	Rationale
Maternity	8	Central to many comments (care quality, facilities, emergency sections), high <i>relevance/recurrence</i> and <i>resonance</i> for strategy.
Withybush	4	Repeated reference to service fragility/cuts and facilities; anchors <i>representativeness</i> of rural access concerns.
Travel/Distance	4	“Travel further... long way to go” indicates access burden and equity issues, high <i>resonance</i> .
Facilities	4	New/improved (maternity, special care flat) vs. lack (Withybush), informs estates and patient experience.
Support	3	Perceived staff support (inclusion of partners, midwives) aligns with patient-centred care.
Wheelchairs	2	Concrete accessibility gap (availability in Bronglais; long corridors), high <i>richness</i> .
Consultation/Questionnaire	2	Engagement process seen as complex; critical for strategy refresh legitimacy and <i>rigour</i> .
Collaboration (Health Boards)	2	Stakeholder integration question; strategic enabler.
Gym/Exercise	6	Community fitness access, cost, and health referrals; prevention agenda alignment.
Paediatrics	1	Waiting and access concerns; signals wider children’s services fragility.

Methodological note: Keywording follows Naeem’s systematic approach to early familiarisation and salience assessment, adapted for AI-supported extraction.

Step 3 — Coding (inductive; codes ≤3 words; 6Rs-guided)

Code	Anonymised Quote	Rationale
Maternity excellence	“Maternity ward is all new – it’s incredible...”	Highlights exemplary experience and modernised facilities; positive deviance to learn from.
Partner inclusion	“More support for Dad... included my husband more.”	Relates to family-centred care and inclusive practices.
Staff confidence	“Doctors said midwives know what they are doing.”	Trust in workforce competence; workforce sustainability signal.
Facility inequity	“Withybush... very few facilities.”	Perceived inequity across sites; estates planning priority.
Service fragility	“Services being cut at Withybush.”	Reflects fragility themes known in strategy updates.
Centralisation impact	“Had to have c-section in GGH... don’t do it in WGH.”	Centralisation creates travel burden and identity issues (registration locale).
Emergency travel risk	“For emergency sections you need to go to Carmarthen.”	Urgent care/time critical travel challenge in rurality.
Access burden	“To have to travel further for care is insane.”	Strongly emotive access/ inequity statement; prioritises proximity.
Engagement complexity	“Need a degree... make it simple to engage.”	Process barrier to inclusive engagement and representativeness.
Feedback loop	“Will you come back and feedback?”	Expectation for demonstrable accountability in engagement.
Inter-board working	“What about collaboration between different health boards?”	Cross boundary commissioning/operational collaboration.
Community fitness gap	“Need for fitness facilities... each town.”	Prevention and local access to physical activity infrastructure.
Cost barrier	“Pay gym membership...”	Socio-economic barrier to health improvement.
Clinical referral gym	“Many... are going for health referrals.”	Links clinical pathways to community assets; social prescribing.
Mobility constraints	“Can’t do exercise as can’t walk.”	Need for inclusive/adaptive activity options.
Equipment availability	“Need more wheelchairs in Bronglais... long corridors.”	Immediate, tangible accessibility fix in hospital settings.

Coding approach mirrors Naeem’s six step process (initial codes anchored in salient keywords and judged against 6Rs for richness and representativeness).

Step 4 — Theme Development (grouping via Naeem’s “4Rs”: Relationship, Relevance, Rigour, Replicability)

Theme	Related Codes
Access & Equity of Care	Facility inequity; Service fragility; Centralisation impact; Emergency travel risk; Access burden; Equipment availability
Quality & Experience (Maternity)	Maternity excellence; Partner inclusion; Staff confidence
Engagement & Accountability	Engagement complexity; Feedback loop
Prevention & Community Health	Community fitness gap; Cost barrier; Clinical referral gym; Mobility constraints
System Integration	Inter-board working

Themes were iteratively reviewed for internal coherence and external distinction, consistent with Naeem’s theming and review steps.

Step 5 — Conceptualisation (linking themes to strategic priorities)

1. **Proximity-Safe Care** — Define: Deliver time-critical and planned services within safe travel times for rural populations by balancing centralisation with mitigations (e.g., urgent transfer pathways, outreach clinics). **Links to strategy:** addresses rurality, fragile services, interim models before any new hospital network; aligns with Clinical Services Plan focus on medium term sustainability.
2. **Family-Centred Maternity Excellence** — Define: Standardise inclusive maternity practices (partner involvement, supportive environments) across sites while reducing inequities in procedures availability. **Links:** “people and communities at the heart,” quality and safety aims in the long-term strategy.
3. **Accessible Engagement** — Define: Simplify consultation materials and close the loop with visible feedback to participants. **Links:** governance and transparency commitments in strategy refresh communications.
4. **Community Prevention Infrastructure** — Define: Expand affordable, accessible fitness options (including referral based and adaptive activity) in towns, integrating with clinical pathways. **Links:** prevention, community hubs, integrated community networks in the strategy.
5. **Cross Boundary Collaboration** — Define: Formalise collaboration mechanisms with neighbouring health boards for shared capacity and pathway resilience. **Links:** “working together in partnership” within the strategy and ongoing refresh.

Method note: Conceptualisation follows Naeem’s guidance to move from themes to higher order concepts and align with organisational priorities, using AI to trace linkages transparently.

Step 6 — Conceptual Model (text description for diagramming)

Core dynamic: *Population needs in rural contexts* drive two concurrent imperatives:

*(A) reliable access to safe, timely care and
(B) upstream prevention capacity.*

The model positions **Access & Equity of Care** and **Prevention & Community Health** as twin pillars. **Quality & Experience (Maternity)** sits as an exemplar microsystem demonstrating what “good” looks like when estates, workforce, and inclusive practices align. **Engagement & Accountability** encircles the pillars as a governance loop (simplify → participate → feedback → iterate). **System Integration** acts as a lateral enabler, connecting pillars across organisational boundaries to smooth capacity and reduce duplication. Strategic levers (clinical service planning, estates actions, community asset development) moderate flows between pillars and outcomes (safety, satisfaction, equity). This layout is congruent with the Board’s shift to community-first, partnership-enabled delivery while addressing fragile services now.

4.2.5 Themes for other comments (group sessions and events only)

This section of the report presents themes from other comments (that did not align with any of the other questions) made at the group sessions and events.

Step 1 — Familiarisation

The dataset is rich, multi-voice, and covers access barriers, communication needs (especially deaf community and sensory impairment), digital inclusion/exclusion, transport, primary care access, waiting times, patient experience, policy/legal expectations (BSL Act, Equality Act), and service configuration (Clinical Services Plan). Data quality is high (ample detail, specific situations); minor issues include duplication of points (e.g., repeated references to feedback/BSL video) and long, narrative entries that required careful anonymisation and compression into codes.

Step 2 — Keyword Selection (using the “6 Rs”: Relevance, Recurrence, Richness, Resonance, Representativeness, Rigour)

Keyword	Frequency*	Rationale
GP appointments / booking	40+	Highly recurrent barrier to access, central to primary care experience; rich detail on queues, phone-only triage, walk-ins, and prioritisation.
Deaf / BSL / interpreter	50+	Strong resonance and richness across communication, training, and legal compliance; representative of sensory access needs.
Phone barriers	30+	Recurrence across Deaf and non-Deaf groups; reflects systemic communication modality mismatch.
Email / text / WhatsApp	15–20	Alternative channels requested, practical solutions with high relevance to digital support and access.
Waiting times (A&E, clinics)	30+	Core system pressure theme; rich accounts of cancellations, long waits, anxiety.
Transport (patient & public)	40+	Recurrence and resonance, especially rurality; impacts equity and utilisation.
Dental access	25+	Representative of preventive and primary services fragility; cross-border issues.
Accessibility / reasonable adjustments	20+	Richness in real-world barriers (clear masks, calling names, signage, facilities).
Digital exclusion / choice	20+	Resonance around “not wanting” digital, skills gaps, trust; aligns with strategy’s digital ambitions.
Feedback / consultation fatigue	15+	Representative of engagement process risks; affects trust and participation.
Policy & legal (BSL Act, Equality Act)	10–15	Rigour/representativeness for statutory duties; timing relevant to Jan 2026.
Veterans identification/recording	10+	Specific group access needs: duty to identify and record; links to equity.

*Approximate counts derived from repeated mentions and clustered references within

Step 3 — Coding (max 3 words; anonymised quotes)

Code	Anonymised Quote	Rationale
Phone barrier	“We can’t use the phone... the surgery hangs up.”	Recurring mismatch between telephony and user needs; systemic access gap.
Email access	“Have been offered emails... really useful.”	Alternative channel that improves engagement; simple, actionable.
Text booking	“Work mobile for Deaf patients to book.”	Practical exemplar to scale across practices; low-cost, high impact.
BSL at Board	“Consider live BSL interpretation at Board meetings.”	Governance-level accessibility; signals organisational commitment.
Interpreter booking	“Told it was our responsibility to book an interpreter.”	Highlights non-compliance risks and inconsistency in reasonable adjustments.
Clear masks	“Refused to wear clear masks... I didn’t know what was happening.”	Infection control vs. communication trade-off; need policy guidance.
Reception barrier	“Receptionists tell us to phone... how can we if we’re Deaf?”	Front-door gatekeeping affecting equity and dignity.
Queue overload	“39 in the queue at 8 am... appointments gone by 8:05.”	Demand/capacity imbalance; need access redesign.
A&E calling	“They call your name but need to come over to you.”	Simple adjustment improves accessibility in busy settings.
Transport cancelled	“Hospital transport cancelled at short notice.”	Reliability and contingency gaps; health inequity amplified in rurality.
Dental scarcity	“No NHS dentist... long waits... private fees rising.”	Preventive care access fragility; affordability challenges.
Digital choice	“Not everybody wants digital... even with free tablet.”	Respect for preference and capacity; multi-channel imperative.
Consultation fatigue	“Don’t keep asking the same questions and ignore the answers.”	Trust/engagement risk; need visible change and feedback loops.
Veterans recording	“Identify, record and assist veterans across services.”	Statutory/ethical duty; structured pathways needed.
Policy compliance	“BSL Act in force Jan 2026—cost should not be a barrier.”	Temporal urgency; compliance and risk management.

Step 4 — Theme Development (using “4 Rs”: Relevance, Relationship, Robustness, Resonance)

Theme	Related Codes
Access to Care (Primary & Urgent)	Phone barrier; Reception barrier; Queue overload; A&E calling; Transport cancelled; Dental scarcity

Theme	Related Codes
Communication & Sensory Inclusion	Email access; Text booking; BSL at Board; Interpreter booking; Clear masks
Digital Inclusion & Choice	Digital choice; Email access; Text booking
Trust, Engagement & Feedback	Consultation fatigue; Policy compliance (BSL Act); Veterans recording
Rurality & Transport Equity	Transport cancelled; A&E calling; Access adjustments in rural settings
Service Configuration & Pathways	Reception barrier; Queue overload; Dental scarcity; Veterans recording; Interpreter booking

(Themes were grouped by conceptual relatedness and reinforced by recurrence and cross-cutting resonance across entries in the feedback).

Step 5 — Conceptualisation (definitions & alignment to strategic priorities)

1. Accessible First Contact — Redesign the *front door* to care (GP, A&E, clinics) with multi-channel booking and sensory-aware processes; aligns with community-based access and preventative model in “A Healthier Mid and West Wales”.
2. Communication Equity — Embed BSL, interpreters, clear-masks policy, and plain-language standards across settings; supports equity, dignity, and legal compliance ahead of Jan 2026 (BSL Act; Equality Act).
3. Digital-by-Choice (not default) — Provide digital options and non-digital parity (email/SMS/face-to-face), respecting capability and preference; aligns with digital healthcare support in the strategy refresh page.
4. Rural Transport Assurance — Stabilise patient transport and integrate contingency routes; ties to place-based equity and community support networks envisioned in the strategy.
5. Responsive Pathways & Duty to Record — Standardise identification (e.g., veterans), interpreter pathways, and cross-border information flow; aligns with joined-up care and clinical service robustness (interim CSP).
6. Trustworthy Engagement — Close the loop: feedback-visible changes, accessible updates (including BSL video), and measurable commitments; aligns with ongoing engagement and Board reporting Jan 2026.

Step 6 — Conceptual Model (textual description for diagram)

Model overview:

At the centre sits Equitable Access & Communication, fed by four enabling pillars:

Multi-Channel First Contact
Sensory Inclusive Practice
Digital by Choice
Rural Transport Assurance.

These pillars are operationalised through Standardised Pathways & Duty to Record (e.g., interpreters, veterans, cross-board information), governed by Trustworthy Engagement & Feedback Loops (e.g., Board level BSL interpretation, visible actions).

The model aligns to the Hywel Dda strategy's community-first, prevention-focused, digitally enabled vision while recognising CSP interim constraints; arrows from each pillar connect to Access Outcomes (shorter waits, successful bookings, reduced cancellations) and Experience Outcomes (dignity, comprehension, confidence), with a compliance timeline marker for Jan 2026 BSL Act.

4.2.6 Themes about equality impact (Have Your Say only)

One of the questions on Have Your Say was:

Is there anything about what is being discussed or proposed that you feel could either positively or negatively affect you or particular people in society more than others? If yes, please explain.

This section of the report presents the results of the systematic thematic analysis of the responses to that question.

Step 1: Familiarisation

The dataset is rich, emotive, and diverse, with recurrent references to access, transport, digital inclusion/exclusion, staffing/capacity, and acute service configuration (e.g. Bronglais, Withybush). Data quality is strong; however, there are occasional typos, emphasis by capitalization, and a small number of statements containing strong language or potentially discriminatory sentiments. These have been handled sensitively and anonymised, per the instruction to avoid personal identifiers in quotes.

Step 2: Keyword Selection (6 Rs)

Using Naeem et al.'s **6 Rs** (Relevance, Recurrence, Richness, Resonance, Representativeness, Rigour), recurring terms have been identified and validated by simple frequency scanning to support inductive selection.

Note: Frequencies are indicative from the dataset; selection blends count with conceptual salience (6Rs).

Keyword	Frequency*	Rationale
Access	20	Central to barriers and equity; widely referenced across contexts (transport, digital, clinical).
Transport	14	Strong recurrence; resonates with rurality and independence loss.
Community	18	Richness in prevention, hubs, social model; strategic alignment.
Digital	—	Frequently noted via “digital services,” “online,” “technology,” indicating inclusion/exclusion tension.
Hospital	19	Acute reconfiguration salience (Bronglais/Withybush); safety and proximity concerns.
Bronglais	10	Specific site; stroke services, continuity of care, travel time.
Withybush	—	Perceived downgrading and calls for standard care retention.
Ambulance/Waiting	—	Urgency and emergency access delays; safety risks.
Staffing	—	Capacity constraints, primary care access, continuity.
Prevention/Education	—	Health literacy, schools, lifestyle support; social model emphasis.

Keyword	Frequency*	Rationale
Vulnerable groups	—	Elderly, disabled, rural, carers, mental health; representativeness across responses.
Communication	—	Inter-department coordination, plain language, bilingual navigation.

*Frequency values shown where straightforward lexical counts were observed; for compound notions (“Digital”/ “Staffing”), frequency is inferred across variants; inclusion is driven by **6Rs**, not counts alone. (Analytic support from a simple frequency pass.)

Step 3: Coding (max 3 words)

Codes are inductively derived using the **6 Rs** criteria. Quotes are anonymised and trimmed for clarity (no identifiers).

Code	Anonymised Quote	Rationale
Rural transport	“People living in rural areas with poor public transport routes are at risk of exclusion from NHS services.”	High recurrence and resonance; access inequity tied to geography.
Golden hour risk	“If A&E is further, people will die... the disabled and poor will not have as much access to transport.”	Richness in safety timing and equity; representative of acute concerns.
Bronglais stroke	“It is imperative to have stroke services in Bronglais hospital.”	Recurrent, site-specific patient safety and outcomes.
Withybush standard care	“Standard treatment should be kept at Withybush... maintaining full A&E & ITU.”	Resonant theme on local acute provision stability.
Digital exclusion	“Providing more services via the internet can disadvantage people; not everyone can use computers.”	Richness and recurrence; vulnerable groups at risk.
Plain-language comms	“It is essential that any digital communication is plain and simple to use.”	Rigour in clarity; accessibility and adoption.
Bilingual navigation	“Make it easier to find the English version of your posts.”	Representativeness for language access in Welsh context.
Primary care access	“Ability to get a GP appointment without ringing at 8am... actually seeing a doctor.”	Recurrent barrier; continuity and gatekeeping.
Staffing capacity	“Shorter waiting times... really it means increasing numbers of medical and nursing staff.”	Recurrence: capacity constraint drives delays.
Carer respite	“Please open day centres back up... a few hours can be life changing.”	Richness; preventative and wellbeing impact.
Community hubs	“Community hubs are essential to rebuild communities... prevention is better than cure.”	Resonance with social model; strategic fit.

Code	Anonymised Quote	Rationale
Prevention education	“Health education for the general population, especially children, should be a high priority.”	Richness and long-term impact; strategic alignment.
Mental health access	“We need better access for mental health support; there doesn’t appear to be anything.”	Representativeness; access gap for vulnerable groups.
Inter-team coordination	“Communication... departments need to talk to each other; experience is appalling when they don’t.”	Rigour in internal processes; patient experience.
Engagement trust	“Consultations have happened previously... you have not listened to the community.”	Resonant; legitimacy and accountability in engagement.

Step 4: Theme Development (4 Rs)

Grouped codes using the **4 Rs** (Relationships, Relevance, Rigour, Resonance).

Theme	Related Codes
Access & Equity	Rural transport; Golden hour risk; Bronglais stroke; Withybush standard care; Primary care access; Mental health access.
Digital Inclusion & Communication	Digital exclusion; Plain-language comms; Bilingual navigation; Inter-team coordination.
Community Prevention & Support	Community hubs; Carer respite; Prevention education.
Capacity & Workforce	Staffing capacity; Primary care access (gatekeeping/continuity).
Engagement & Trust	Engagement trust; Bilingual navigation (as part of inclusive engagement).

Step 5: Conceptualisation (aligned to strategic priorities)

Drawing on Hywel Dda’s strategy—shift to prevention/community, joined-up care close to home, safe specialist care, and the ongoing refresh focus on digital, social model, community vs hospital balance, estates—the following are conceptualised:

1. Proximity-Safe Access

Ensuring timely, equitable access to urgent and planned care for rural and vulnerable populations; balances local access with safe specialist pathways (golden hour, stroke). (*Priorities: Unscheduled care safety; equitable access*).

2. Inclusive Digital-by-Design

Digital offers efficiency and self-service, but must be opt-in, accessible, plain-language, bilingual, and always with non-digital alternatives. (*Priorities: Digital healthcare support; accessibility*).

3. Community-First Prevention

Invest in community hubs, carer support, and health education to reduce demand, improve wellbeing, and support self-management. (*Priorities: Social model for health and well-being; resilient communities*).

4. Integrated Communication & Coordination

Strengthen inter-departmental and cross-sector communication, improving continuity, navigation, and patient experience. (*Priorities: Whole-system integration; patient experience*).

5. Capacity Stabilisation

Workforce and primary care access improvements to reduce waiting, enhance continuity, and support appropriate service use. (*Priorities: Medium-term clinical service fragilities; workforce resilience*).

6. Trustworthy Engagement

Visible listening and feedback loops (closing the loop, accessible bilingual content) to rebuild confidence. (*Priorities: Ongoing engagement; transparency*).

Step 6: Conceptual Model (textual description)

Model overview:

At the centre is Population Equity, surrounded by five interlocking capability rings:

Proximity-Safe Access
Inclusive Digital-by-Design
Community-First Prevention
Integrated Communication & Coordination
Capacity Stabilisation

A permeating outer layer—Trustworthy Engagement—ensures continuous feedback informing each ring.

Relationships:

- Proximity-Safe Access depends on Capacity Stabilisation (staffing) and Integrated Communication (routing, escalation) to meet urgent timelines.
- Inclusive Digital-by-Design interfaces with Community-First Prevention to support self-management; both must be adaptable with non-digital options to prevent exclusion.
- Integrated Communication is the connective tissue across rings, enabling joined-up care close to home while maintaining safe specialist routes.
- Trustworthy Engagement feeds intelligence into all rings, improving design, clarity (plain language, bilingual) and accountability.

Strategic relevance: This model operationalises the Board's ambition to shift from treating illness to keeping people well, while safeguarding acute safety and reducing inequities linked to rurality and digital access.

Notes on Framework Application

- Steps and outputs follow Naeem et al. (2023) six-step process (familiarisation → keyword selection → coding → themes → conceptualisation → conceptual model) with AI-supported adaptations (2025) for keyword surfacing and structured coding while retaining human oversight for rigour and ethical safeguards.

Annex (Analytic Support)

A lightweight lexical scan of the dataset reinforces high-salience terms (e.g., access, transport, community, hospital, Bronglais) and validates inductive keyword selection; counts are indicative and were balanced with conceptual significance under the 6Rs.

4.3 Phone call feedback, email responses, responses in writing and responses via Llais

This section of the report presents the results of phone call feedback, email responses, responses in writing and responses submitted via Llais.

4.3.1 Number of phone calls

In total, 0 phone calls took place.

4.3.2 Number of email responses

In total, 2 emails were received.

4.3.3 Number of responses in writing

In total, there was 1 response in writing.

4.3.4 Number of responses via Llais

In total, there were 0 responses submitted via Llais.

4.3.5 Themes from email responses and responses in writing

This section of the report presents the results (themes) of the high-level thematic analysis of email responses and the response submitted in writing.

Section 1: Summary of Themes (with representative quotes)

1) Access to Care (Orthopaedics, GP, Diagnostics, Community Beds)

Summary: Stakeholders emphasise difficulty accessing timely specialist and GP care, with Orthopaedics repeatedly cited as fragile. Community hospitals and outreach clinics are viewed as essential pressure relief and closer-to-home provision.

Representative quotes:

- *“...unable to gain access to Orthopaedic services or consultation... there are no Orthopaedic service in the area... waiting list... far too long.”*
- *“Community Hospitals are vital to alleviate pressure within district General Hospitals.”*

Concerns & opportunities: Long waits (especially Orthopaedics), travel burden for rural residents, need for local X-ray/haematology/ear care and community beds; opportunity to stabilise fragile services and expand outreach clinics. This aligns with the Clinical Services Plan focus on Orthopaedics and other fragile services.

2) Prevention & Rehabilitation (Social Model for Health, Physio-supported activity)

Summary: People want supported self-management and rehabilitation options (e.g., *free swimming* as physio), seeing these as cost saving and well-being enhancing.

Representative quotes:

- *“...if there were Physio services... such as free swimming... this would... relieve patients... and ease the financial burden on the NHS...”*
- *“Healthy living/exercise advice... build on current facilities ideally in one complex.”*

Concerns & opportunities: Current community rehab offer is inconsistent; opportunity to invest in prevention consistent with A Healthier Mid and West Wales vision for a wellness service and social model for health.

3) Integration with Social Care & Reduced Bureaucracy

Summary: Strong calls for integrated health–social care, with frustration about bureaucracy undermining patient-centred care.

Representative quotes:

- *“Social Care must be allowed to work alongside ALL services.”*
- *“Care is needed NOT meeting targets which appear to have taken over providing basic vital care.”*

Concerns & opportunities: Interface delays and perceived ‘target driven’ culture; opportunity to formalise integrated discharge pathways and joint outcomes with local authorities.

4) Digital Inclusion & Service Access

Summary: While supportive of digital tools, stakeholders caution that not everyone can participate due to connectivity, access needs or digital confidence.

Representative quotes:

- *“While moving forward using digital tools it must be considered that not all patients will be able to partake.”*

Concerns & opportunities: Risk of digital exclusion; opportunity to expand assisted digital, multi-channel access, and leverage the NHS Wales App while addressing connectivity and accessibility needs noted in engagement updates.

5) Transport, Travel & Estates (Parking, Park-and-ride)

Summary: Practical barriers—parking and transport—are recurring issues, with concrete suggestions such as reinstating Bronglais Hospital park-and-ride.

Representative quotes:

- *“Bring back the bronglais hospital park and ride to make the parking problem less of an issue.”*

Concerns & opportunities: Estates constraints and rural transport challenge; opportunity for low-cost estate/transport mitigations aligned with the strategy refresh emphasis on making existing hospital network work better in the next decade.

6) Community-based Care & Hubs

Summary: The public favours expanded community clinics/hubs (e.g. diagnostics, ear wax micro suction, healthy living advice) and colocation with social care.

Representative quotes:

- *“Community based clinics also help: X-ray... Haematology... ear wax microsection clinics... Further out-reach clinics... in one complex.”*

Concerns & opportunities: Need to scale successful local models and formalise hub functions, consistent with the strategy’s Integrated community networks and Health and well-being centres.

7) Workforce Sustainability (GP retention)

Summary: Workforce shortages—especially GPs—affect access; bureaucracy is seen as a factor in retention.

Representative quotes:

- *“More initiatives are needed to keep GPs in post... current high level of unnecessary bureaucracy prevent this.”*

Concerns & opportunities: Recruitment/retention and role redesign; opportunity for productivity-focused changes and expanded multidisciplinary teams, echoing strategic refresh goals.

Section 2: Key Trends & Insights

1. High salience of access fragilities, especially Orthopaedics

Feedback repeatedly flags Orthopaedics as inaccessible and slow, matching the Health Board’s identification of Orthopaedics among nine fragile services (with planned decisions Feb 2026).

2. Preference for ‘closer to home’ care via community hospitals and hubs

Stakeholders frame community beds and diagnostics as essential for flow and dignity, aligning

with the long-term vision to strengthen **community models** while the new hospital is a decade away.

3. **Preventative, rehabilitative offers seen as cost saving and well-being enhancing**

Calls for physio supported activity (e.g. free swimming) mirror the strategy's wellness and social model ambitions, indicating appetite for tangible community level interventions.

4. **Digital optimism tempered by inclusion concerns**

Public messages support consolidated digital access (e.g. NHS Wales App) but insist on multichannel pathways for those with poor connectivity or access needs—highlighted across press and radio summaries of engagement.

5. **Practical enablers—transport & estates—matter to perceived access**

Specific ask to reinstate **Bronglais** park-and-ride and broader calls to address parking point to practical quick wins with meaningful impact on patient experience during an extended transition period.

6. **Integration & bureaucracy: desire for joined-up care over target chasing**

Strong sentiment for better health—social care integration and less bureaucracy, implying that success metrics should reflect outcomes valued by communities.

4.4 Feedback from individual stakeholder groups

This section of the report presents the results of feedback from the 14 individual stakeholder groups that feedback notes (from group events and sessions) were produced for.

4.4.1 Carers

Section 1: Summary of Themes (with quotes)

1) Access to Services & Care Pathways (Primary, Community, and Hospital)

Summary: Carers consistently report difficulty accessing GP and dental services, fragmented pathways between health and social care, and inconsistent experiences across urgent and emergency care. Delays, unclear requirements for service re-entry (e.g. proof of “fitness” to resume community rehab), and site changes (e.g. services moving away from Withybush) amplify anxiety—especially in rural areas.

Representative quotes:

- *“Access to GP and dentist – we hear that all the time from carers.”*
- *“Mum... spent 7 hours in an ambulance... communication was poor, and people are afraid to ask.”*

Concerns: Long waits (GP/dentistry), last minute cancellations (patient transport), and disjointed processes between hospital and community services (e.g., HOPE centre readmission rules).

Opportunities: Define and publish clearer pathway handovers; standardise documentation to avoid unnecessary rereferrals; create local ‘step down/step up’ touchpoints in rural communities.

Suggested actions: Introduce a unified discharge-to-community protocol; implement a single ‘clearance’ template recognised by HOPE/ therapy and GPs; publish local service directories.

2) Carer Support, Respite, and Wellbeing

Summary: Carers value community assets (halls, theatres, groups) that sustain wellbeing but struggle to find practical, local respite and mental-health support—especially in remote areas. The emotional and physical toll of caring (sleep deprivation, isolation) is a prominent thread.

Representative quotes:

- *“As a carer... I have never found anyone to help out locally... Dale Peninsula could do with a hub.”*

- *“The most important thing to me is that my wife, who is my carer, gets support... She needs some mental health and respite support.”*

Concerns: Sparse respite options close to home; inconsistent follow-up from OT; uncertainty about what happens when a carer “can no longer cope.”

Opportunities: Expand hyperlocal respite/microbreaks; formalise rapid response carer backup; partner with community venues to host carer wellbeing activities.

Suggested actions: Commission carer “relief hours” in rural micro-hubs; publish a clear “if I can’t cope today” pathway; improve OT follow-up standards and SLAs.

3) Digital Inclusion & Choice

Summary: Views on digital care are mixed. Some carers use NHS online services comfortably and see value in data access and longitudinal views; others feel digital is being “imposed,” excludes older/ non-ID populations, and cannot replace face-to-face care. Confidence, ID verification barriers, and accessibility issues (hearing/vision) are recurring pain points.

Representative quotes:

- *“You are forcing people to use digital, and they can’t handle it... Older people feel neglected.”*
- *“You should be able to register [for the NHS app] with another format like a letter from a GP.”*

Concerns: Digital first pathways limiting F2F; ID requirements excluding those without passports/driving licences; low confidence with video consultations.

Opportunities: Alternative identity verification; carer proxy functionality; “digital & analogue” by design; targeted skills support through community partners.

Suggested actions: Adopt flexible ID routes; implement proxy access; preserve F2F defaults for specific cohorts; commission community-based digital coaching.

4) Communication, Transparency & Patient Experience

Summary: Participants report difficulty getting through on phones, inconsistent information across staff, and limited proactive updates during long waits. There are calls for transparent waiting time information and more dignified experiences in A&E, especially for children and people living with dementia.

Representative quotes:

- *“Can’t get people to answer the phone... one person answers and next person doesn’t know.”*
- *“It’s not right for a 10-year-old child to be sitting in A&E next to drunk men.”*

Concerns: Poor call handling; lack of real time updates; physical environment issues (e.g. inaccessible information boards); perceived lack of dignity in mixed waiting areas.

Opportunities: Centralised telephony/ management; standardised “what to expect today” scripts; environment audits for accessibility/dignity.

Suggested actions: Deploy callback/virtual queueing; publish honest queue times and pathways; redesign A&E information/wayfinding with accessibility standards.

5) Travel, Transport & Rurality

Summary: Distance to services (e.g. Carmarthen from St Davids/Fishguard; loss or reduction of services at Withybush) and unreliable nonemergency transport create significant burden for carers and patients. Last minute patient transport cancellations undermine confidence and attendance.

Representative quotes:

- *“People who live in Fishguard or St Davids have a very long way to travel to Carmarthen. The hub should be at Withybush.”*
- *“Non-emergency ambulance transport has been cancelled... This is a big issue especially the last-minute dropouts.”*

Concerns: Travel time, cost, and uncertainty for specialist care and routine follow-ups; reduced local provision.

Opportunities: Stabilise patient transport; coordinate volunteer/community transport; expand “closer to home” diagnostics/outpatients.

Suggested actions: Introduce transport reliability KPIs; contingency vouchers for lastminute cancellations; outreach clinics in high travel time localities.

6) Children & Young People’s (CYP) Experience and Paediatrics

Summary: Strong concerns about paediatric provision and dignity in emergency settings. Requests for paediatric services to be available at Withybush and for child-appropriate waiting areas.

Representative quotes:

- *“Paediatrics should come back to WGH... there has to be some dignity especially around children.”*

Concerns: Long waits and inappropriate mixed waiting areas for children; perceived downgrading/moves of local paediatric services.

Opportunities: Dedicated paediatric triage/waiting spaces; enhanced children’s streaming; family-centred communication.

Suggested actions: Implement paediatric priority flow with separate space; publish a clear plan on paediatric access at WGH and alternatives.

7) Estate Condition & Environment of Care

Summary: Estate issues (e.g. WGH roof, noisy/undignified assessment areas, wheelchair inaccessible information boards) directly affect perceived quality and safety. Carers want investment prioritised where repairs are most urgent and where changes improve the lived experience.

Representative quotes:

- “You need to start with WGH roof.”
- “The information board in A&E is not accessible by wheelchair users.”

Concerns: Poor environments for people with dementia; noise; lack of privacy; accessibility barriers.

Opportunities: Targeted capital maintenance; accessibility and dementia-friendly design adjustments that can be implemented quickly.

Suggested actions: Fasttrack critical roof/plant works; accessibility audit and fixes; create quiet spaces in A&E and assessment units.

Section 2: Key Trends & Insights

1. **High salience of access barriers across the pathway:** Recurrent mentions of difficulties with GP/dentistry access, hospital–community transitions (e.g. HOPE re-entry paperwork), and phone responsiveness suggest systemic friction points at “front doors” and “handoffs.”
2. **Rural disadvantage compounds burden:** Distance, service centralisation, and unreliable nonemergency transport disproportionately affect coastal and remote communities (e.g. Dale Peninsula, St Davids/Fishguard). This shapes perceptions of fairness and feasibility of the model of care.
3. **Digital is valued by some but must remain optional and inclusive:** While a subset sees benefits (record access, online booking), many carers perceive digital first as exclusionary—especially where ID verification blocks proxy/carers use. The clear preference is for “digital alongside strong F2F.”
4. **Carers’ resilience is supported by community assets yet hampered by thin formal support:** Carers cite local venues, clubs, and leisure as protective factors, but need readily available respite, mental-health support, and practical home adaptations with reliable follow-up.
5. **Experience of care and communication drive trust:** long waits without updates, inaccessible information (e.g. wheelchair users), and undignified environments (especially for CYP and people with dementia) erode confidence more than distance alone.
6. **Paediatric provision is a flashpoint:** Strong, emotive feedback about paediatrics at Withybush and children’s dignity in A&E indicates a priority perception gap that could become reputationally significant if not addressed visibly.

4.4.2 General public

Section 1: Summary of Themes (with quotes)

1) Access to Primary & Community Care

Summary: Participants value timely, local access to GP, physiotherapy, and pharmacy services. Concerns focus on appointment booking (“8am rush”), inconsistent access routes (“front door”), and variable pharmacy / common ailments provision. There is strong support for more use of existing community assets (e.g. South Pembrokeshire Hospital, Tenby Hospital) and hub models.

Representative quotes:

- *“There is a problem with GP appointments and the 8am rush every day to try secure an appointment.”*
- *“South Pembrokeshire Hospital should be used more. There is a lack of information on what Tenby Walk in Centre can be used for.”*

Concern: Booking systems and reception interfaces act as barriers (physiotherapy telephone tree; inability to leave messages).

Opportunity: Introduce single point of access/triage and extended hours (physio, wellness clinics).

Suggested actions: Standardise online and phone booking across services; clarify walk-in centre scope; strengthen use of community hospitals and hubs (in line with strategy’s community model).

2) Communication & Information Clarity

Summary: People need clearer, consistent information on service eligibility (e.g., common ailments scheme age limits) and what specific local services provide (e.g. Tenby Hospital). Poor telephone systems and reception experiences deter access.

Representative quotes:

- *“There is a lack of information on what Tenby Walk in Centre can be used for.”*
- *“The receptionists are a real barrier. They were very rude and abrupt.”*

Concern: Non-standard pharmacy criteria cause inequity and additional travel.

Opportunity: Clear front-door communication and service directory aligned to the refresh engagement materials.

Suggested actions: Publish a localised, bilingual “Where to go and when” guide; standardise call handling scripts and escalation routes; set minimum customer service standards at reception.

3) Digital Inclusion, Reliability & Consistency

Summary: While reminders via email / SMS are welcomed, stakeholders worry digital pathways can miss important clinical assessment and exclude groups with sensory needs or low digital confidence. Calls for consistent use of digital tools across services, with fallback face-to-face options.

Representative quotes:

- *“One of the downfalls of digital is that you can’t properly assess a problem.*
- *“Concerned about the deaf community and how it would work for them.”*
- *“Some services use emails and text reminders... this doesn’t seem to happen with all services, and it should.”*

Concern: Inconsistent digital reminder use; accessibility for sensory impairments.

Opportunity: Build on interest in NHS Wales app as an integrated front door; provide digital support and alternatives for those lacking confidence/connectivity.

Suggested actions: Mandate standardised digital reminders across services; accessibility audits; invest in assisted digital/telephone options.

4) Transport, Travel & Parking

Summary: Travel and parking are persistent barriers, particularly for rural patients and those requiring hospital visits. Suggestions include park-and-ride and increased disabled parking capacity.

Representative quotes:

- *“Parking is a nightmare! Could you operate a park and ride service?”*
- *“Disabled parking is sometimes limited.”*

Concern: Stress associated with travel/parking deters attendance.

Opportunity: Expand volunteer transport support and consider park-and-ride where estates constraints exist.

Suggested actions: Site-level parking reviews; feasibility of shuttle services; integrated travel information in booking communications.

5) Social Care Interface & Prevention

Summary: Stakeholders emphasise prevention and the critical importance of social care capacity (carer pay, bed flow). Some feel the Health Board should “stick to medical work,” yet most acknowledge the value of strong community/home-based support consistent with the social model.

Representative quotes:

- *“Prevention is better than a cure.”*
- *“Carers are not paid enough. The social care system is broken. Bed blocking has an impact on availability of ambulances.”*

Concern: Delayed discharges and emergency care pressures linked to community capacity.

Opportunity: Joint planning with local authorities and third sector to strengthen prevention and home-based services (aligned with strategy).

Suggested actions: Integrated discharge pathways; carer support packages; targeted prevention clinics.

6) Service Quality & Experience

Summary: Despite access hurdles, perceived care quality is strong once patients reach clinicians. However, negative experiences at reception and call handling are recurring barriers.

Representative quotes:

- *“Once you get in to see someone in the NHS, the care is exceptional.”*
- *“The receptionists are a real barrier.”*

Concern: Front-end experience undermines trust and access.

Opportunity: Customer service training and experience standards; integrate patient feedback loops into the refresh.

7) Veterans Identification & Support

Summary: Stakeholders from Age Cymru Dyfed highlight the need to consistently identify and record veteran status across primary and secondary care, improve signposting, and leverage third sector partnerships to reduce repeat attendance and improve outcomes.

Representative quotes:

- *“Identify, record, and assist older veterans... Most services have a legal duty to work alongside veteran communities.”*
- *“Lancashire... saved ¼ million pounds in 6 months—putting [veterans] in touch with the right organisations.”*

Concern: Inconsistent recording at GP/hospital reception.

Opportunity: Standardise a veterans’ identification prompt and referral workflow; partner with local / UK programmes and e-learning to build staff awareness.

8) Appointments Management & DNAs (Did Not Attend)

Summary: DNAs frustrate both staff and patients; there is support for consistent digital reminders and discussion of charging for no-shows (noting policy/ethics implications).

Representative quotes:

- *“Some services use emails and text reminders... this doesn’t happen with all services.”*
- *“There should be a charge for no shows to appointments.”*

Concern: Inconsistent reminder systems and limited re-booking flexibility.

Opportunity: Standardise cross-service reminder protocols and enable proactive rebooking /self-serve options.

9) Clinical Estate & Redevelopment Priorities

Summary: Estates issues (parking, disabled spaces) affect perceived accessibility and stress. While buildings are not the sole determinant of care quality, site improvements should support

better patient flow and experience pending longer-term hospital decisions.

Representative quotes:

- *“Disabled parking is sometimes limited at some sites.”*

Concern: Current estate limitations hinder access during interim period before any major redevelopment.

Opportunity: Quick win estates upgrades (parking layout, signage, waiting areas) consistent with the Clinical Services Plan’s medium-term stabilisation.

10) Handling Exceptional / Outlier Concerns

Summary: One submission raises “electrical sensitivity / radiation poisoning” attributed to a 5G mast and an asserted lack of NHS support. This is outside mainstream clinical guidance but underscores the need for respectful signposting, psychological support, and clear communication about evidence-based care.

Representative quotes:

- *“This destroyed my health... I will not go near health now... There is no help for people with this condition.”*

Concern: Distress and disengagement from services.

Opportunity: Trauma informed, compassionate response pathways; referral to appropriate services e.g., mental health, environmental health information, advocacy).

Section 2: Key Trends & Insights

1. **Strong appetite for local, timely access—especially GP/physio—via clearer front doors and community hubs.** Cardigan ICC style models and better use of South Pembrokeshire Hospital are viewed positively, echoing the strategy’s community-based care ambition.
2. **Digital is a means, not an end.** Participants favour consistent, accessible digital reminders and booking, but insist on preserving face-to-face options and accommodating sensory impairments and low confidence. This aligns with public engagement summaries referencing interest in using the NHS Wales app—alongside support for those struggling digitally.
3. **Reception / telephony experience is pivotal.** Negative interactions and non-navigable call trees materially reduce access and trust; improvements here may yield disproportionate benefits to perceived quality and equity.
4. **Transport and parking remain practical barriers.** Park-and-ride and expanded disabled bays are commonly proposed; rural transport solutions (including volunteers) feature in wider engagement narratives.
5. **Integration with social care and prevention is seen as essential to flow and sustainability.** Feedback highlights carer support, bed blocking impacts, and prevention

clinics as priorities—consistent with the strategy’s social model and whole-system approach.

6. **Veterans’ identification is underexploited.** Standard prompts and linkage to third sector agencies can improve outcomes and reduce unnecessary use of NHS services, with precedent cases cited.
7. **DNAs and rigid re-booking rules waste capacity.** Stakeholders support robust reminder systems and easier re-booking; charging for DNAs is raised but would need policy consideration and equality impact review.
8. **Estates quick wins are expected while major decisions are pending.** The refresh acknowledges that new hospital timelines are long; interim improvements should focus on access, safety, and experience.

4.4.3 Health Board staff

Section 1: Summary of Themes (with quotes)

1) Access & Capacity (Primary, Community, and Hospital)

Summary: Stakeholders emphasise difficulty accessing timely primary care (especially GP appointments and phlebotomy) and call for more care to be delivered locally (minor procedures, blood tests, x-ray). Concerns are strongest in rural areas, where travel to hospital sites is challenging and perceived service reductions (e.g. local diagnostics) heighten anxiety.

Representative quotes:

- *“By the time you phone at 8.30am all appointments have gone. No wonder people are turning up to A&E.”*
- *“You are making people travel further for their care... It’s just too far for people to travel especially elderly.”*

Concerns: GP access bottlenecks; loss of local minor ops; relocation/availability of diagnostics; rural travel burden.

Opportunities: Extend community phlebotomy; reinstate/minimise travel for minor procedures; optimise community diagnostics; align with the strategy’s community model.

Actions: Pilot same day GP access reforms; expand integrated community networks with local diagnostics/minor surgery sessions; publish travel mitigation plans.

2) Transport & Travel (Rural Equity)

Summary: Travel distance and transport options are recurring barriers to care, particularly for older people and those in isolated communities. Stakeholders request practical support that makes unavoidable journeys “worthwhile and less stressful.”

Representative quotes:

- *“Travelling will be a problem / challenge for some people.”*
- *“We need our hospital to stay open. It is a vital resource to the community.”*

Concerns: Longer journeys for specialist care; limited public transport; perceived erosion of local services.

Opportunities: Volunteer driver expansion; scheduled shuttle links; coordinated appointment times to reduce multiple trips.

Actions: Develop a rural transport support package and publish service-specific travel plans (including booking support and escorts where appropriate).

3) Digital Inclusion & Confidence

Summary: Appetite exists for digital support (e.g. NHS Wales App), but confidence and capability vary widely; older cohorts highlight limited familiarity with apps. Stakeholders stress the need to retain face to face options and provide training and accessibility features.

Representative quotes:

- *“My era are dying out fast. They are not good with technology.”*

Concerns: Digital confidence gap; connectivity issues; need for bilingual / accessibility-compliant tools; trust and data security.

Opportunities: On-site digital coaching; simple, bilingual workflows; assisted digital routes in community hubs; leverage NHS Wales App integrations.

Actions: Roll out “Digital Health Coaches” and assisted digital kiosks; publish a digital inclusion plan aligned to the engagement’s four themes.

4) Estates, Infrastructure & Site Experience (Parking, Toilets, Environment)

Summary: Car parking is a prominent issue at PPH and GGH, impacting both patients and staff (including ticketing pressures). Stakeholders also call for improvements to basic facilities—particularly toilets—and ward environmental conditions.

Representative quotes:

- *“Car parking is a problem here... Staff are being ticket[ed] due to lack of parking spaces.”*
- *“GGH need investments in public and staff toilets... We desperately need TOILETS, TOILETS, TOILETS.”*

Concerns: Insufficient parking capacity; patient access frictions; poor toilet provision; ward environment (e.g. AMAU air/ventilation).

Opportunities: Build on recent parking partnerships (e.g. Gwili Railway spaces for staff, reserving patient areas); targeted estates upgrades for high-impact amenities.

Actions: Estate level toilet refurbishment programme; codify parking allocation (patients first); investigate ventilation/comfort fixes (e.g. AMAU).

5) Financial Sustainability & Service Model Choices

Summary: A minority view questions the viability of maintaining numerous small (“cottage”) hospitals and hints at willingness to consider co-payment for certain treatments (noting unpopularity). This intersects with the Health Board’s need to manage fragile services ahead of any new hospital build.

Representative quotes:

- *“You can’t run all these cottage hospitals. It’s expensive and costly to the NHS.”*
- *“We need to contribute to some treatment (ringfenced). This may be very unpopular.”*

Concerns: Cost pressures; long lead time for new hospital; fragility across services; public acceptability of changes.

Opportunities: Transparent options appraisal through the Clinical Services Plan; communicate medium-term service resilience measures; engage on trade-offs.

Actions: Publish clear criteria for site/service changes; link estates and service consolidation decisions to quality and equity outcomes.

Section 2: Key Trends & Insights

1. **High salience of access pressures across the pathway:** Recurrent references to GP access, local diagnostics, and minor procedures point to system congestion and a desire to “decompress” hospital demand by strengthening community services. This aligns with the Strategy’s long-term shift to integrated community networks and early intervention.
2. **Rurality shaping equity concerns:** Travel and transport burdens are core themes—older and isolated populations feel changes disproportionately. Practical transport solutions (volunteer drivers, shuttles, better scheduling) are viewed favourably and are consistent with recent engagement coverage.
3. **Digital is welcomed but must be inclusive:** Stakeholders want convenient digital access but emphasise confidence, simplicity, bilingual access, and the continued availability of non-digital routes. This mirrors Phase 2 engagement framing on “Digital Healthcare Support.”
4. **Immediate estates fixes would improve experience:** Parking capacity and toilet availability are repeatedly cited, with recent partnership action at GGH indicating progress to build on. Targeted, visible estates improvements can quickly lift patient and staff experience.
5. **Strategic realism about timelines and fragility:** Stakeholders’ comments on small hospitals and funding echo Board communications: the new hospital is likely a decade away; interim consolidation and resilience measures are necessary via the Clinical Services Plan. Managing expectations transparently will be critical.

4.4.4 LGBTQ+ communities

Section 1: Summary of Themes (with quotes)

1) Access & Continuity of Care (Primary and Community Services)

Summary: Participants report significant barriers to timely, consistent access—especially GP appointments, continuity of information across borders (England ↔ Wales), and reliable community support in rural areas. There is a perceived erosion of “community hospital” functions and walk-in accessibility.

Quotes:

- *“Since computerised system came in (GPs) – by time you get to speak to someone, it’s fully booked.”*
- *“If in a couple and something happened to one person – how would you manage – here, there is no care in community.”*

Concerns: Booking systems saturate quickly; fragmented cross-border prescribing information; closure/reduction of local cottage hospitals; ambulance delays.

Opportunities: Strengthen social prescribing; reinstate or reimagine local “community health hubs”/walk-in centres; enhance care navigation and continuity across GP practices and pharmacies.

Suggested actions: Expand same day access pathways; create rural outreach clinics; formalise cross border records transfer protocols; surge capacity for urgent transport.

2) Digital Healthcare Support (Inclusion, Usability & Hybrid Models)

Summary: Digital is welcomed when simple and supportive, but usability, navigation, and trust are variable. The group endorses proactive messaging (e.g. SMS) and hybrid care; caution against overreliance on video for conditions requiring examination.

Quotes:

- *“I’m digitally wise but can be frustrating to find what you need to find.”*
- *“Can’t rely on video call for everything, GP will need to see people face to face for certain things.”*

Concerns: Poor discoverability / usability; risk of misdiagnosis from images; digital triage becoming a barrier.

Opportunities: Use SMS / push notifications to signpost mobile clinics; co-production to design journeys; peer support to build confidence; integrate advice/booking via NHS Wales app as a single front door.

Suggested actions: Usability testing with LGBTQ+ older adults; bilingual, accessible content; guarantee face-to-face fallback; digital literacy sessions via community partners.

3) Travel & Rurality (Balancing Hospital Care and Community Support)

Summary: Rural travel is a critical pain point—ambulance delays and long journeys to specialist care heighten stress; participants value treatment “somewhere I know” and want more local

options for routine care, medications, and urgent assessment.

Quotes:

- “Broken tibia and fibula – couldn’t get Ambulance and had to get taxi.”
- “Community Care – not having to travel for medication – Walk in health centre.”

Concerns: Limited transport; consolidation of specialist services away from rural communities; episodic uncertainty when being redirected between sites.

Opportunities: Volunteer driver schemes; scheduled mobile services; clearer pathway communication; local dispensing and outreach.

Suggested actions: Map transport gaps; commission rural transport support; expand community pharmacy services and mobile clinics; provide pre-travel information packs.

4) Clinical Services & Estate Redevelopment (Safety, Capacity, Familiarity)

Summary: Strong perceptions that existing facilities (e.g. Bronglais General Hospital) no longer meet contemporary demand; calls for investment, including a new hospital in Ceredigion, while retaining familiarity and community trust.

Quotes:

- *“Need new hospital in Ceredigion.”*
- *“BGH not built for capacity of today.”*

Concerns: Estate condition and capacity; long timescales for major reconfiguration; interim fragilities.

Opportunities: Interim upgrades; redistribute services to relieve pressure; link estate works to improved patient flows and staff experience.

Suggested actions: Publish a transparent prioritisation matrix for site upgrades; interim works at high-pressure sites; configure “hub and spoke” community assets to offset hospital demand.

5) Equity, Inclusion & Cultural Safety (LGBTQ+ affirming Care)

Summary: The group reports instances of discomfort, perceived stigma, and uneven LGBTQ+ specific support—particularly around staff attitudes, and meaningful use of “rainbow” identifiers without training assurances.

Quotes:

- *“Atmosphere changes when mention partner is male.”*
- *“Rainbow Lanyard – want to have confidence that staff have had training – want to be confident to approach staff wearing them.”*

Concerns: Variable staff cultural competence; disrupted access during COVID (e.g. hormone therapy); lack of clear LGBTQ+ community support pathways; historic trauma references (e.g. Section 28) affecting trust.

Opportunities: Mandatory LGBTQ+ cultural safety training; named contacts / advocates; formal community partnerships.

Suggested actions: Standardise visible allyship with training verification; create an LGBTQ+ navigation line; codesign gender affirming care journeys; publish inclusive language guidelines.

6) Information Sharing, Prescribing & Pharmacy Reliability (Cross-border & Local Access)

Summary: Participants experience delays and mismatches in repeat prescribing (England vs Wales), pharmacy closures/instability, and lack of proactive results communication (e.g. blood tests).

Quotes:

- “Surgery in Wales couldn’t access prescription – information had not come through – have to courier information from England to Wales.”
- “Jhoots Pharmacy... not open for months... locums stopped coming out.”

Concerns: Inconsistent medicines management; dependency on fragile local pharmacy provision; patients chasing results without systematic follow-up.

Opportunities: Cross-border data exchange protocols; pharmacy resilience plans; automatic results notifications and callbacks.

Suggested actions: Implement electronic transfer standards with English practices; create a pharmacy continuity framework; mandate SMS/portal result alerts with timebound GP review.

7) Communication Quality & Patient Experience (Respect, Proactivity, Feedback)

Summary: Reports of dismissive interactions (“do you expect me to read your notes?”), paid letters, and lack of proactive result communication undermine trust and patient experience.

Quotes:

- *“Called into GP and they asked what am I here for – you called me in!”*
- *“Went for blood tests... you don’t hear back – ring up and you want to know the results.”*

Concerns: Professionalism and empathy; inconsistent follow up protocols; administrative charges.

Opportunities: Realtime communication standards; patient held appointment context summaries; staff coaching on compassionate communication.

Suggested actions: Introduce “always events” (e.g. clinician has read key notes); standardise results callback SLAs; review non clinical letter charging policies.

Section 2: Key Trends & Insights

1. **Strong preference for hybrid care with reliable human touchpoints.** Even digitally confident older LGBTQ+ members want assured face-to-face options, especially for conditions requiring examination; digital should enhance—not replace—access. This aligns with the Health Board’s strategy to shift care closer to home while ensuring safe specialist support.
2. **Rural access and transport are decisive determinants of experience.** Ambulance delays and travel for specialist services shape perceptions of safety and equity; participants

favour local hubs and walk-in centres to avoid long journeys for routine care. Public engagement coverage confirms transport as a recurrent theme regionwide.

3. **Fragile services and estate capacity require interim solutions.** Stakeholders recognise long lead times for major hospital developments and call for immediate, pragmatic improvements to existing sites and community care pathways. This reflects the Board's stated need to act ahead of any new hospital.
4. **Cultural safety and inclusion need to be operationalised—not symbolic.** Rainbow identifiers without verified training reduce trust; LGBTQ+ affirming pathways, respectful communication, and continuity in gender-related care are essential for engagement.
5. **Information continuity and pharmacy resilience are critical system enablers.** Cross-border transfers (England ↔ Wales), pharmacy closures, and manual chasing of results erode confidence; participants want automatic alerts and easier medicine access locally.
6. **Proactive, clear communication is a low-cost, high-impact fix.** SMS signposting to mobile services, clear pretravel information, and “always events” (e.g. clinician has reviewed notes) can materially improve experience without major capital investment. Engagement materials emphasise communication clarity as part of inclusive digital support.

4.4.5 Mothers / parents

Section 1: Summary of Themes (with quotes)

1) Access & Urgent Care (including Rurality, Transport, and Waiting Times)

Summary: Across groups, access barriers dominate: long waits for ambulances and GP appointments; instructions to attend A&E for issues that could be managed closer to home; stressful travel with infants; and limited public transport options—particularly acute in rural communities. Stakeholders value local minor injuries and outpatient capacity (e.g., Cardigan, Tregaron) and ask for better scheduling and smoother pathways.

Representative quotes:

- *“Someone I know fell and broke a hip... waited 6 hours on the floor for an ambulance.”*
- *“If appointment is at 2pm, then it should be at 2pm... People who travel further should have appropriate appointment times.”*

Concerns: Prolonged ambulance waits; GP triage delays; reliance on A&E; car-parking stress at hospitals; limited buses for families.

Opportunities: Expand community-based minor injuries/outpatients; optimize appointment sequencing; volunteer/transport support schemes; park-and-ride; service continuity closer to home.

Suggested actions: Increase local minor injuries slots (e.g., Aberaeron), targeted access improvements for rural areas, transport scheduling aligned to clinic times, expand community diagnostics.

2) Primary Care & Continuity (GP Access, Health Visiting, Holistic Care)

Summary: Parents and carers report difficulty securing timely GP appointments and inconsistent health visitor continuity. Desire for drop-in clinics; more health visitors; holistic, family-centred consultations; and local presence (e.g., at Family Centres).

Representative quotes:

- *“If you phone GP at 8 o’clock all the appointments are gone... triage list can be 5 hours to respond.”*
- *“There aren’t enough Health Visitors... I’ve seen four different Health Visitors with my baby.”*

Concerns: Variable GP access; HV unreliability/shortage; fragmented follow-up for infants and postnatal support; clinic times not compatible with working parents.

Opportunities: Health visitor drop-ins in community hubs; GP and HV co-located sessions; flexible clinic hours; local breastfeeding expertise.

Suggested actions: Embed HVs at Family Centres (e.g., Tregaron, Llanybydder); create regular GP/HV drop-ins and telephone slots; invest in breastfeeding specialist outreach; pilot holistic GP reviews.

3) Community Well-being & Prevention (Social Model)

Summary: Stakeholders strongly value local social assets—Family Centres, Cylch Ti a Fi, leisure centres, parks, charities—supporting physical activity, peer connection, early advice, and low-cost wellbeing. They seek affordable childcare, creche-enabled exercise, and local wellbeing hubs (Lampeter highlighted).

Representative quotes:

- *“Cylch ti a fi... it’s a massive help... good for kids and mums.”*
- *“Llanybydder Family Centre... early intervention... healthy eating on a budget, CPR, baby massage, mindfulness.”*

Concerns: Childcare cost/availability (including Welsh-medium childminders); limited daytime classes compatible with parenting; need for local wellbeing hubs.

Opportunities: Build formal partnerships with community groups; creche-supported physical activity; low/no-cost family programmes; integrate HV/pharmacy advice in hubs.

Suggested actions: Commission community wellbeing programmes via Integrated Community Networks; co-fund creche-enabled exercise; microgrants to local groups for preventive offers; formalize signposting from GP to Family Centres.

4) Digital Health & Information Sharing

Summary: Attitudes to digital are mixed: many already use GP apps and welcome a unified NHS Wales solution for bookings, results, letters; others worry about reliability, response times, consistency across departments and cross-border record access (England/Wales). Desire for simple, bilingual, trusted, and no overloading platforms with face-to-face retained.

Representative quotes:

- *“Personal accounts so letters can be uploaded... access to documents anytime.”*
- *“GP here can’t access my records from England... Public think of NHS as one thing not separate health boards.”*

Concerns: Inconsistent digital features across services; nonresponses to messages; interoperability and cross-border data sharing; digital exclusion for older relatives.

Opportunities: Enhance NHS Wales App capability; “one-stop” portal across pathways; digital literacy support; in hospital assisted video appointments with clinical support present.

Suggested actions: Deliver a unified digital front door; enable document upload and appointment coordination; implement cross-border information sharing protocols; staff supported video clinics in local hospitals.

5) Maternity, Paediatrics & Family Support

Summary: Strong desire to maintain maternity and paediatrics close to home (notably WGH), with concerns about safety of home birth recommendations when local capacity is constrained. Positive experiences reported for upgraded maternity environments at Glangwili and Bronglais; yet breastfeeding support gaps and inter-site pathway issues cause stress.

Representative quotes:

- *“Keep WGH... most important thing in this county... stop the plans [for a new hospital], put money here.”*
- *“Maternity... all new... it’s incredible in Bronglais... Staff are great.”*

Concerns: Travel for C-section / paediatrics; pathway friction (Out of hours paediatrics referral); limited breastfeeding specialist outreach; parking stress during acute episodes.

Opportunities: Stabilise local paediatric / maternity access; streamline referral/transfer processes; expand breastfeeding specialist home/outreach; align appointment times to family logistics.

Suggested actions: Maintain safe local maternity / paediatrics footprints; standardise out of hours paediatrics referral; mobile breastfeeding clinics; family-friendly scheduling.

6) Dental Access

Summary: Dental access is a persistent pain-point: long waits (six years on portal), travel out of area, high private costs, and misalignment of dental pathways with broader NHS processes. Stakeholders request mobile units and integrated booking options.

Representative quotes:

- *“On the dental portal the waiting list is six years for a dentist.”*
- *“We go to Ammanford... 45 minutes... The whole dental system needs changing.”*

Concerns: Long waits; travel burden; lack of unified digital access; emergency 111 call-backs slower than direct local calling.

Opportunities: Reinstate mobile dental vans; integrate dental into digital front door; targeted contracting to increase NHS capacity.

Suggested actions: Commission mobile/community dental sessions; unify dental bookings in NHS Wales App; procure additional orthodontic/paediatric dental capacity.

7) Estate, Facilities & Parking

Summary: Estates issues (GP practice equipment / rooms; hospital supplies; A&E space; parking scarcity) compound stress, especially for lone parents or urgent visits. Park-and-ride and targeted refurbishments are requested.

Representative quotes:

- *“GP practice in Tregaron needs an update... exam bed fell back when pregnant.”*
- *“In Glangwili there is never enough parking... high stress situations already.”*

Concerns: Physical environment safety; supplies access; carparking; stress of drop-offs.

Opportunities: Prioritise essential refurbishments at high use estate; local park and ride; storage optimisation; outpatient expansion at community sites.

Suggested actions: Targeted GP estate upgrades (e.g. Tregaron); park-and-ride for Bronglais; A&E space and flow improvements; local outpatient capacity.

Section 2: Key Trends & Insights

1. **Rural Access & Travel Burden is Systemic:** Repeated accounts of long ambulance waits, reliance on neighbours, and complex journeys with children point to a structural rural

access gap. Stakeholders strongly favour shifting appropriate care into community settings and better transport alignment.

2. **Demand for Reliable, Local Primary Care and Health Visiting:** Difficulty getting GP appointments and desire for consistent HV relationships are recurrent. Community-based drop-ins and colocation in Family Centres are perceived as high value, low barrier solutions.
3. **Community Assets are Central to the Social Model:** Family Centres, Cylch Ti a Fi, leisure facilities, and local charities are trusted anchors for prevention, early help, and mental health support. There is appetite for creche-enabled physical activity and practical, low-cost programmes.
4. **Digital Front Door Needs to be Unified and Responsive:** Many already use apps but want a single, reliable portal for multidepartment bookings, results, and documents, with cross-border interoperability (England/ Wales). Reliability and responses are as important as features.
5. **Family Centred Care & Maternity:** Significant emphasis on keeping maternity/ paediatrics accessible locally (e.g. WGH) while recognising and praising high quality environments elsewhere. Pathway smoothness, breastfeeding expertise, and family friendly scheduling are priorities.
6. **Dental is a Standout Pressure Point:** Six year waits and long-distance travel indicate severe capacity and access issues; stakeholders suggest mobile provision and integration into digital tools.
7. **Estates & Parking Affect Experience and Safety:** Practical constraints (parking, equipment, space) materially impact stress and perceived quality; targeted improvements are requested.

Strategic alignment note: These themes are consistent with the Health Board's long-term vision to shift care towards prevention and community settings while addressing fragile services and ageing estates; the 2024–2025 refresh acknowledges new hospital timelines and the need for interim changes within existing sites.

4.4.6 Older people

Section 1: Summary of Themes (with quotes)

1) Access to Care (Primary, Community & Specialist)

Summary: Across groups, people report difficulty getting GP appointments (“8am rush”), limited home visits, and long waits for testing and operations. Many want more nearby services delivered through community hubs and walk-in clinics, and enhanced use of cottage/integrated care hospitals to avoid hospital attendance.

Representative quotes:

- *“Remove the 8am rush to phone local GP surgery.”*
- *“By the time you see someone you have deteriorated. Everything then becomes an emergency.”*

Concerns & opportunities: Inequity of provision between north/south of counties; desire for annual health checks and accessible dentistry; clear support for multi-service community hubs (bloods/BP, advice, social care).

Suggested actions: Restore/expand routine checks; extend hub model; increase nurse prescribers and district nursing capacity; targeted outreach for rural areas.

2) Transport & Travel (including NEPTS)

Summary: Transport is a dominant barrier, especially in rural areas—limited public transport, eligibility confusion, cancellations and long, stressful journeys. People ask for clearer criteria, more reliable NEPTS, volunteer/community schemes and aligning appointment times with local transport.

Representative quotes:

- *“Hospital transport booked in advance can be cancelled... it’s not reliable.”*
- *“Why don’t these computers pick up when they have a patient... and they give them 9am appointment and there’s no buses before that?”*

Concerns & opportunities: Digital scheduling could integrate transport constraints; local “fleet manager”/coordinator concept; expand Country Cars style volunteer services; publish eligibility pathways for ophthalmology and other specialties.

Suggested actions: Clarify NEPTS criteria; codesign appointment scheduling with transport data; invest in community transport partnerships; pilot travel coordinators.

3) Digital Inclusion & Choice

Summary: Views on digital are mixed. Many older adults feel excluded or anxious about apps, prefer “a human voice,” and need simple, bilingual tools with training and reliable connectivity. Consistent call to maintain paper/letter and face-to-face options to avoid penalising those who are offline.

Representative quotes:

- *“You need alternatives to apps... option 1 paper, option 2 text, option 3 digital.”*
- *“We want to maintain our independence... that might be taken away if everything is made digital.”*

Concerns & opportunities: Missed appointments due to text only invites; Welsh/English language barriers; device/internet poverty; appetite for supported digital clinics in hubs and simple online GP booking when done well.

Suggested actions: “Digital by default but not digital only,” expand assisted digital sessions, align messaging channels, ensure bilingual accessibility, and audit connectivity blackspots.

4) Communication, Coordination & Joined-up Pathways

Summary: People report repeating information between sites, unclear pathways (especially dementia, ophthalmology, physio), and weak links between primary, community and hospital services. There is appetite for clearer directories, proactive signposting, and shared records.

Representative quotes:

- *“There needs to be better communication between clinicians and different sites.”*
- *“There is a lack of linked up systems – for example Ophthalmology not linked with local optician.”*

Concerns & opportunities: Dementia pathway awareness in primary care; early diagnosis messaging in GP surgeries; simple “who to contact” and service directories; extend pharmacist prescribing and integrated care centre signposting.

Suggested actions: Create unified pathway guides; standardise discharge communications; improve cross-site information sharing; promote ICC services strongly.

5) Acute Care Experience, Capacity & Waits

Summary: A&E experiences at GGH/other sites are described as crowded, stressful with trolley waits and perceived staff shortages; strong sympathy for staff. People prioritise reducing waiting lists and ensuring post discharge physio/rehab.

Representative quotes:

- *“A&E in GGH is shocking... I was on a trolley for a while. The consultants were really good.”*
- *“Sat in... A&E for 13 hours... not very impressed.”*

Concerns & opportunities: Rehabilitation gaps, falls prevention access, step-up/stepdown capacity; community-based physio and exercise referral can relieve pressure.

Suggested actions: Focused improvement plans for ED flow; invest in community rehab; create falls clinics and homebased physio options; public reporting on wait reduction programmes.

6) Estate, Wayfinding & Amenities

Summary: Car parking is consistently problematic at main sites; signage and site comfort matter. People want multi-storey parking, better wayfinding, accessible toilets, comfortable seating, and use of community sites for more services.

Representative quotes:

- *“Car parking is a nightmare at all the main hospitals!”*
- *“Finding your way around GGH. Better signage. I really struggle with this.”*

Concerns & opportunities: Amenities in ED (refreshments), colour-coding effective at BGH, improved accessibility features at all sites.

Suggested actions: Prioritise parking and wayfinding upgrades; adopt consistent signage standards; ensure amenities and accessible toilets; expand services at Tenby Hospital/ South Pembrokeshire Hospital/ Town hubs.

7) Social Model & Community Assets

Summary: Strong endorsement of community groups (Friendship Groups, People Speak Up, Ray Ceredigion, Warm Hubs, libraries, churches, leisure centres) for social connection, activity, and mental wellbeing. Sustainability of 3rd-sector funding and transport to access groups are recurring issues.

Representative quotes:

- *“Community groups are essential to signpost people to different things... huge wealth of volunteer community to support people.”*
- *“Social things are important – talk about similar problems and feel less alone.”*

Concerns & opportunities: Risk to hubs from unstable funding; requests for minibus/transport support; desire for local “health and wellbeing days” at existing groups.

Suggested actions: Commission community connectors; co-fund transport; create a maintained directory of groups/services; regular “pop-up” clinics at groups.

8) Dementia & Carer Support

Summary: Participants highlight gaps in primary care dementia pathways, need for early diagnosis messaging, and practical support for carers. Integrated Care Centres and hospices are valued as local support.

Representative quotes:

- *“Poor primary care support for dementia patients – need to improve the pathways.”*

- *“I have been a great advocate of early diagnosis... without Primary Care’s involvement to refer early, the ability to live a full and independent life is limited.”*

Concerns & opportunities: Promote dementia awareness at surgeries; strengthen carer support and direct payments; better signposting to Age Cymru/ Admiral Nurses/ ICC.

Suggested actions: Primary care dementia prompts; carer navigation support; local dementia clinics within hubs.

9) Dental Access

Summary: Access to NHS dentistry is consistently poor, driving private costs and undermining prevention. Participants want emergency access clarity and more local NHS capacity.

Representative quotes:

- *“More dentists!”*
- *“It’s a hell of a gap in this area... spending a fortune just to get basic examination.”*

Concerns & opportunities: Oral health’s link to wider health motivates investment; pharmacy triage and mobile/community dental sessions may help.

Suggested actions: Strengthen NHS dental commissioning in rural areas; clear emergency dental pathways; explore mobile clinics.

Section 2: Key Trends & Insights

1. **Transport is the cross-cutting constraint.** Barriers to attending appointments, accessing hubs, and visiting hospitals dominate feedback; reliability and eligibility of NEPTS and lack of public transport are central frustrations. Aligning appointment times with transport is a specific, practical ask.
2. **Strong preference for local, integrated community services.** People want more “done in one visit” at community hubs (bloods/BP, social support, signposting), avoiding long trips to GGH/other hospitals and reducing deterioration while waiting.
3. **Digital must be inclusive, bilingual, and optional.** Many older adults fear being penalised if services go digital only; missed appointments due to text only invites and Welsh only messages are notable; there is openness to simple tools with training when supported.
4. **Communication and pathway clarity need improvement.** Repetition of information, unclear referral routes (dementia, ophthalmology, physio), and under publicised ICC offerings undermine confidence. People want directories and consistent, proactive signposting.
5. **Acute pressures and rehab gaps are visible to the public.** ED crowding, long waits and limited post discharge physio/falls prevention are repeatedly cited; there is empathy for staff and appetite for community-based rehab and exercise referral.

6. **Estate basics matter.** Parking, wayfinding, and amenities (toilets, seating, refreshments) significantly shape experience; colour-coded wayfinding is noticed as positive; multistorey parking is a common suggestion.
7. **Third sector is a cornerstone—but funding and transport threaten sustainability.** Community groups deliver connection and prevention but rely on unstable funding and cannot bridge transport gaps alone. People welcome health board outreach to existing groups.
8. **Equity concerns (rurality & north–south variation).** Perceived inequity in service location and travel burden—especially in Ceredigion and north Pembrokeshire—underscores the need for targeted access solutions.

4.4.7 Pan-disability

Section 1: Summary of Themes (with quotes)

1) Access & Inclusion (Physical Environment and Facilities)

Summary: Stakeholders consistently report barriers to physical access across hospitals, community facilities and public spaces—especially for disabled children and adults. Priority gaps include Changing Places toilets, accessible parking, and purpose-built spaces (e.g. sensory rooms). These deficits materially limit participation and dignified care.

Representative quotes:

- *“Changing Places – there are none in PPH and GGH... Actual bed changing room. Not having to put a child on the floor to change. We need this desperately.”*
- *“More blue badge parking at Bronglais on the top level of the multi storey so people don’t have to walk up the hill... Definitely need more wheelchairs in Bronglais – there are such long corridors.”*

Concerns: Lack of compliant assisted or accessible toilets; constrained disabled parking; limited accessible play/leisure facilities (e.g. parks, pools).

Opportunities: Integrate Changing Places standards into capital and refurbishment programmes; designate and enforce proximity blue badge bays at key entrances; co-design sensory/quiet rooms in new sites (e.g. Pentre Awel).

Suggested actions: Prioritise Changing Places compliance (BS 83002 aligned) at Glangwili (GGH), Prince Philip (PPH) and Bronglais; publish site-specific accessibility maps and parking policies; improve wheelchair availability at Bronglais.

2) Primary & Community Care Access (Appointments, Continuity, Empathy)

Summary: Parents and carers emphasise difficulty obtaining timely GP appointments, the need for longer slots for complex needs, and consistent clinician continuity (especially paediatrics). Empathy and flexible contact routes (e.g. avoiding 8am telephone bottlenecks) are repeatedly requested.

Representative quotes:

- *“Timely GP appointments... Longer GP appointments... Greater empathy from GP receptionists. We just can’t pick up a phone at 8am but can do at 9am.”*
- *“See a paediatrician that knows their stuff... To see someone reliable and the same paediatrician not a locum... They don’t have time to read the notes.”*

Concerns: Gatekeeping and rigid booking windows; locum churn undermining continuity; reluctance to see complex children; slow dementia assessments and fragmented health–social care pathways.

Opportunities: Expand advanced GP access models; embed **continuity of care** clinics for paediatrics and geriatrics; joint clinics to reduce travel and repetition.

Suggested actions: Pilot flexible telephone windows and online callback queues; commission GP led minor procedure capacity (e.g. dermatology) to avoid unnecessary hospital trips; strengthen liaison with local authorities for step-up/step down community support.

3) Digital Healthcare (Choice, Usability, Records Interoperability)

Summary: Views are mixed: digital helps with convenience, but face-to-face remains essential for complex or behavioural needs. Barriers include limited device confidence, accessibility needs (sensory, hearing), and lack of a unified, **All Wales record** view for cross-organisational care.

Representative quotes:

- *“Sometimes remote access does not work. Face to face is better... You need to provide options for face to face or digital.”*
- *“Need All Wales access to records between GPs, hospitals etc... I have to take a lever arch file of records wherever I go.”*

Concerns: Usability for disabled users and older adults; impersonal/robotic telephony; distrust of AI; rural connectivity.

Opportunities: Promote inclusive design (bilingual, screen reader, sensory friendly), retain phone lines with minimal IVR, and accelerate patient record sharing consistent with the strategy’s integrated model.

Suggested actions: Define clear **digital triage criteria** for when remote is appropriate; advance NHS Wales App capabilities for appointments/results (while keeping human options); deliver hands-on digital confidence support via community hubs.

4) Travel & Transport (Rurality, one-Stop Clinics)

Summary: Significant travel burdens affect access, with long bus journeys, limited hospital transport, and costly taxis. Stakeholders ask for one-stop pathways (joint clinics, multiple tests per visit) to make travel worthwhile.

Representative quotes:

- *“It’s a commute from here to Cardigan – it’s 2 hours on the bus now... Members of our community have had to spend £300 on a taxi.”*
- *“When people have to travel 4 hours for an appointment – why can’t it be dealt with in a one stop shop?”*

Concerns: Inconsistent transport services; referrals to distant sites when local GP procedures are possible.

Opportunities: Scheduled **joint clinics** (e.g. paediatrics and therapies), mobile/outreach clinics, and better referral guidance to keep procedures local where clinically appropriate.

Suggested actions: Map specialty outreach to rural locations; expand volunteer driver schemes with formal signposting via the Health Board's patient information pages; publish "one-stop" clinic calendars.

5) Community Wellbeing & Social Model (Respite, Carer Support, Local Infrastructure)

Summary: While stakeholders support the social model, they describe **insufficient infrastructure** (respite, longer daycentre hours, inclusive leisure) and strained volunteer capacity. Families self-fund/support groups to fill gaps, and request recognition and investment.

Representative quotes:

- *"There are a lot of activities for carers but not for carers for children with complex needs... There is a big gap in the provision."*
- *"It is currently not a wellbeing/prevention model – it is a crisis model... This idea needs to be halted until people are more affluent."*

Concerns: Limited community inclusivity (accessible parks/play), short daycentre hours, reliance on under resourced charities/volunteers.

Opportunities: Co-produce with county councils and third sector to expand inclusive facilities (parks, leisure, food hubs) and targeted respite; align with strategy commitment to resilient communities.

Suggested actions: Commission "complex needs carer" respite programmes; small grant schemes for peer groups; accessibility audits of council leisure assets (e.g. Pentre Awel pool changing).

6) Clinical Services & Estate Redevelopment (Clarity, Continuity, Meaningful Refurbishment)

Summary: Stakeholders ask for clarity and consistency during estate changes, emphasising continuity of services, **meaningful** refurbishment (not cosmetic), and developing centres of excellence (e.g. Bronglais) with adequate equipment and pharmacy capacity.

Representative quotes:

- *"Any refurbishment needs to be meaningful – not just paint a wall... Make building exciting... New equipment to work with."*
- *"Shortage of pharmacies in Aberystwyth... You have to queue... There is a shortage of medicines also."*

Concerns: Perceived frequent changes (Cardigan), uncertainty around community hospitals (e.g. Tregaron, Llandovery), pharmacy access pressures.

Opportunities: Tie estate projects to clear service models from the Clinical Services Plan and the refreshed strategy—publish timelines, one-stop clinic designs, and parking/access solutions.

Suggested actions: Transparent programme updates (site-specific FAQs), maintain services during transitions (popup clinics), expand community pharmacy capacity/extended hours where feasible.

7) Mental Health & Long-term Conditions (Capacity, Early Intervention)

Summary: Feedback indicates long waits, limited therapy sessions, and site accessibility issues (e.g. Gorwelion upper floor). Early intervention for anxiety/depression and clearer pathways for ME/CFS and Long COVID were requested.

Representative quotes:

- *“Mental health services not good, there is a long wait... When you get a therapist after waiting months, you only get a couple of session and then go to a charity.”*
- *“What is happening with services for Chronic Fatigue... You’re letting people down... You really need to up your game.”*

Concerns: Physical accessibility of mental health settings; inconsistent provision for ME/CFS/Long COVID; GP diagnostic bias concerns (e.g. women’s health).

Opportunities: Expand psychological therapies capacity; relocate clinics to accessible floors/sites; publish updated ME/CFS pathway; embed women’s health quality checks in primary care.

Section 2: Key Trends & Insights

1. Strong Preference for Choice in Care Modalities

Across groups, people want **face-to-face retained** and **digital offered as an option** when appropriate. Digital is valued for convenience, but not suitable for complex behavioural assessments; usability and accessibility standards are critical. This aligns with strategy aims to create inclusive, joined-up models that “keep people well” while improving access.

2. Continuity and Time with Clinicians Matter

Repeated calls for continuity (e.g. same paediatrician) and longer GP slots for complex needs indicate that **relationship based care** is central to experience, outcomes, and efficiency (less repetition, fewer crises).

3. Physical Accessibility is Foundational, Not Peripheral

From Changing Places provision to blue badge bays and wheelchairs in long corridors, physical infrastructure shapes dignity, stress, and throughput. The refresh should embed **mandatory accessibility baselines** in estates plans and operational policies.

4. Rural Transport Burdens Drive Inequity

Long journeys, poor connections, and high costs are recurrent. “**One-stop**” clinics and local GP procedures can offset travel stress and reduce wasted capacity.

5. **Social Model Ambition vs. Current Reality**

Stakeholders support prevention and community resilience but describe a **crisis led** reality with under-resourced respite, volunteers, and inclusive leisure. Community assets (food hubs, free fruit, family centres) are positive, but scale and accessibility remain uneven.

6. **Need for Clear, Transparent Programme Communication**

Change fatigue is evident. People ask for **clear timelines, reasons, and continuity plans** during estate/service changes, consistent with Board commitments to engagement and reporting (e.g. Strategy Refresh to Public Board Jan 2026).

4.4.8 Partner organisations

Section 1: Summary of Themes (with quotes)

1) Social Model for Health & Wellbeing (Community, Prevention, Partnerships)

Summary: Stakeholders strongly endorse the social model and see local authorities and third sector partners as central to wellbeing. There is an emphasis on aligning funding/governance, mapping existing community assets, and ensuring prevention is visible and coordinated.

Representative quotes:

- *“It is integral as Community Councillors and Town Councillors that we support Health and Wellbeing across our population.”*
- *“The community role is vital to help with accessibility of services, innovation in services/support and use of community venues.”*

Concerns: Fragmentation across organisations; need to align funding streams and governance; risk that prevention budgets are constrained.

Opportunities: Microenterprises/sole trade carers; local voluntary councils (PAVS/CAVS/CAVO); Warm Hub grants; social prescribers and community hubs already active.

Actions: Undertake a mini-audit/asset map of groups (“who, what, when, where, how”); formalise multiagency governance to deliver prevention at scale.

2) Digital Healthcare Support (Inclusion, Skills, Connectivity, Trust)

Summary: Digital is welcomed where it is simple, bilingual, secure, and complemented by face-to-face options. Training via community organisations is valued. Connectivity gaps (rural broadband) and interoperability issues across frontline systems are recurring barriers.

Representative quotes:

- *“Training for elderly people to be able to access these services. How are you going to make sure that some of these people are not going to be left behind?”*
- *“Front line staff have limited access to systems...you have to repeat your story several times over.”*

Concerns: Digital exclusion (low but present); rural broadband quality; BT digital landline switch and 999 resilience; clarity on NHS Wales App rollout.

Opportunities: Community-based digital literacy (Age Cymru Dyfed, PLANED); leveraging the NHS Wales App as the “digital front door” with inclusive identity verification.

Actions: Commission local digital skills programmes; work with Welsh Government/DHCW to maximise app functionality (waiting list tracking, appointments, messaging), ensure bilingual support, and strengthen interoperability.

3) Access & Transport (Rurality, Travel Burden, Navigation)

Summary: Travel to hospital and between sites is challenging for rural communities; transport solutions and clearer navigation of community services are needed. Stakeholders want community prevention and rapid support closer to home but recognise specialist travel will still be required.

Representative quotes:

- *“It’s getting people from one place to another. People will have to travel... very challenging for rural areas.”*
- *“Are the community aware of all of this? It’s a lot for people to navigate.”*

Concerns: Limited public transport; long rural journeys; complexity of service landscape for citizens.

Opportunities: Enhance volunteer driver schemes; publish clear local service directories and “ways to access help” guides; expand wellbeing hubs and rapid community support.

Actions: Coordinate transport support with local authorities/third sector; introduce single front door navigation (digital & phone & in-person) to reduce confusion.

4) Communication & Engagement (Inclusive Formats, Reach, Feedback Loop)

Summary: Stakeholders request accessible materials (Easy Read) and wider dissemination beyond established groups (PPF/CPF), fearing a “missing middle” of high functioning but low support individuals. Clear feedback loops on “what happens next” are also requested.

Representative quotes:

- *“Is there an Easy Read version?...It’s a real missed opportunity [not having one].”*
- *“Can you please share a copy of the presentation... What are you going to do with these answers gathered?”*

Concerns: Over-reliance on already engaged groups; accessibility gaps; transparency on how feedback informs decisions.

Opportunities: Publish Easy Read and multilingual materials; share presentations and findings; expand outreach to groups like Stackpole Gardens and Clynyfw.

Actions: Implement an engagement accessibility standard; publicly track “you said, we did”; widen channels (community visits, libraries, schools, workplaces)

5) Clinical Services & Hospital Redevelopment (Interim Fragilities, Timelines, Alignment)

Summary: Questions focus on how the Clinical Services Plan links to the strategy refresh and whether timelines/decisions are coordinated—given fragilities and the longer horizon for any new hospital. Stakeholders want clarity on sequencing and resourcing.

Representative quotes:

- *“Does the Clinical Strategy link in with this consultation?... Are both consultations on the same timeline?”*

Concerns: Medium-term fragility across services; ageing estate; workforce constraints; decade plus horizon for a new hospital.

Opportunities: Use the Clinical Services Plan to stabilise priority services (e.g. critical care, stroke, surgery) ahead of estate changes; maintain public transparency on milestones (consultation report Jan 2026, decisions Feb 2026).

Actions: Publish an integrated roadmap linking strategy refresh, clinical decisions, and capital planning; set out interim estate upgrades and service consolidation where necessary.

Section 2: Key Trends & Insights

1. Strong validation of the social model

Local authority and council representatives are “already converted” to wellbeing approaches and want practical alignment of funding, governance, and delivery with the Health Board. This indicates readiness for joint commissioning and integrated community networks.

2. Digital appetite with caution

Participants welcome the NHS Wales App vision but emphasise inclusion: training for older adults, bilingual support, proxy access, and assurance on emergency provisions during telecom changes (BT digital switch). Interoperability pain (repeating histories) is salient.

3. Rural transport remains a critical barrier

Travel burden persists; stakeholders suggest practical transport support and better local access to rapid community care. Navigation of services is confusing citizens need clear, simple pathways.

4. Engagement quality & inclusivity

Requests for Easy Read and broader outreach suggest current processes risk excluding “high functioning, low support” groups who still need voice. A “you said, we did” cycle is expected.

5. Clarity on clinical changes and timelines

Stakeholders seek explicit alignment between the strategy refresh and the Clinical Services Plan, acknowledging fragilities and long estate timelines; transparent milestones and decision points will build trust.

4.4.9 People with learning disabilities

Section 1: Summary of Themes (with quotes)

1) Access to Primary & Community Care

Summary. Across groups, the most salient issue is difficulty accessing GP appointments (long waits, phone queues, single-issue appointments) and limited domiciliary/community options (home phlebotomy, community nurses). Stakeholders want earlier, local help to avoid hospital use.

Representative quotes.

- *“There is 3 week wait for an appointment... You are always in a queue.”*
- *“Outside of hospital setting – hubs and clinics like podiatry, breast, bone, bowel... More screening / tests in the community setting.”*

Concerns. Long waits; telephone barriers; lack of home visits; inconsistent community testing.

Opportunities. Expand community nurses/home bloods; preventive clinics in primary care; clear pharmacy offers.

Suggested actions. Prioritised access pathways for people with disabilities/communication needs; increase community diagnostics and nurse led clinics.

2) Transport, Travel & Rurality

Summary. Transport is a consistent barrier—limited buses, anxiety about parking, long distances, and timing (school runs, early appointments). People are more accepting of travel if support (transport, navigation, liaison) is provided and the care is clearly “worth the journey.”

Representative quotes.

- *“There are no buses to get me up to GGH... If you have to travel there is no one there to help you.”*
- *“Don’t give us appointments in Cardiff for 8am... If they’re coming from Pembrokeshire, don’t give them an appointment before 10am.”*

Concerns. Lack of public transport; parking stress; appointment times misaligned to travel realities; unclear eligibility for patient transport/expenses.

Opportunities. Pooled/accessible minibus services; travel information in letters; clearer patient transport criteria; synchronised appointment scheduling.

Suggested actions. Co-design transport pilots (accessible shuttles); revise scheduling templates; include maps, parking, and travel guidance with appointments.

3) Digital Inclusion, Choice & Trust

Summary. Views on digital care are mixed: some value apps, video, and text reminders; many prefer face-to-face and dislike automated systems. Confidence depends on simplicity, training, security, and the guarantee of nondigital options.

Representative quotes.

- *“I don’t do apps – just phone and talk... I like to see people face to face.”*
- *“Make more of the NHS app – more services on it, it would be brilliant.”*

Concerns. Digital anxiety; scams; complex/surveys too long; dislike of AI/voicemail; reliance on family to navigate systems.

Opportunities. One-to-one coaching; short, accessible (Yes/No) forms; bilingual, easy read content; SMS reminders.

Suggested actions. “Digital with a human” model: default human backstop, assisted digital at hubs, and optout for automated triage.

4) Communication & Wayfinding

Summary. People want clear, accessible, and respectful communication: simpler letters, maps, colour-coding, and visible staff identification. Experiences of not being listened to—especially for people with learning disabilities—were highlighted.

Representative quotes.

- *“Colour code areas so you can find where you’re going... include a map... There’s too much writing; people don’t understand.”*
- *“When I speak... they find it hard to understand me... I need to see them face to face.”*

Concerns. Dense appointment letters; poor phone experiences; anxiety about not knowing what to expect at procedures (e.g. MRI mask).

Opportunities. Pre-visit familiarisation (videos, photos of staff), Easy Read letters, signage upgrades.

Suggested actions. Standardise accessible communications pack (maps, parking, timing, what to expect), extend colour coded wayfinding.

5) Support for People with Learning Disabilities (LD) & Wider Accessibility

Summary. Repeated calls for LD liaison support at GPs and hospitals; help to book and attend; environmental/access adjustments (quiet spaces, visual aids). Annual health checks valued for prevention.

Representative quotes.

- *“Health boards should be looking at employing learning disability nurses.”*
- *“This happens a lot; people with learning disabilities are not listened to.”*

Concerns. Limited LD nurse capacity; anxiety leads to DNAs; inaccessible forms; need for face-to-face booking help.

Opportunities. LD liaison in acute settings; “disability line” or priority pathway; carer/PA support to book.

Suggested actions. Commission LD liaison posts; embed reasonable adjustments policy; expand annual LD health checks uptake.

6) Pharmacy & Dentistry (Primary Care Alternatives)

Summary. Pharmacy is seen as underused due to variable awareness and certification (e.g. dental antibiotics). Access to NHS dentistry is a major pain-point, driving costly travel and private care.

Representative quotes.

- *“Common Ailment Scheme... most pharmacies cannot help... Not all have this certification.”*
- *“I don’t have an NHS dentist... Have been unable to register at an NHS Dentist.”*

Concerns. Inconsistent pharmacy services; dental deregistration after 12 months; cross-border travel for dentistry.

Opportunities. Increase public awareness of pharmacy services; targeted commissioning for dental access.

Suggested actions. Publish a local “who can help” directory; align pharmacy certifications; dental access improvement plan with travel support for urgent cases.

7) Community Assets, Prevention & Social Model

Summary. People actively use community assets—leisure centres, clubs, People First groups, MIND, social and creative activities—to stay well. They want support to keep participating (including transport and PA/carer support). This aligns with the strategy’s prevention and community-based care model.

Representative quotes.

- *“Walk and Talk activities... Boccia Club... Slimming World... We also have a cooking group.”*
- *“Leisure centre – they have all sorts of groups... Gym, socialising, going to work. The NHS can only advise.”*

Concerns. Transport limits participation; need tailored lifestyle/dietetic advice.

Opportunities. Wellbeing hubs with assisted access; social prescribing scale-up; community dietetics.

Suggested actions. Commission community navigation and PA support; embed social prescribing in PCNs aligned to the strategy.

8) Hospital Estate, Service Configuration & Confidence

Summary. Stakeholders want clarity and reassurance about hospital changes (e.g. Withybush, South Pembrokeshire Hospital), plus visible improvements—mobile diagnostics, staffing, and responsiveness. Wayfinding and accessibility improvements are priority asks.

Representative quotes.

- *“South Pembs Hospital and Withybush – I would like still to be there in future.”*
- *“Get Withybush Hospital back on track so we don’t have to travel... Colour code areas so you can find where you’re going.”*

Concerns. Fear of service loss; fragility of services; reporting and follow-through.

Opportunities. Mobile screening (cancer, bone density); transparent updates linked to the Strategy Refresh and Clinical Services Plan.

Suggested actions. Publish near-term estate and service access improvements; communicate timelines and decisions via Board papers.

Section 2: Key Trends & Insights

1. **Access barriers dominate sentiment.** High frequency of comments on GP access (queues, waits, single-issue appointments) and a desire for local, earlier support. This strongly echoes the strategy's shift to community-based, preventative care.
2. **Transport is pivotal in rural care acceptability.** People accept travel for specialist care if appointments are reasonably timed, navigation is easy, and transport support is explicit. Anxiety rises with early appointments, parking stress, and unclear transport eligibility.
3. **Digital must be optional, assisted, and simple.** A split between digitally confident users (keen on apps/SMS/video) and those preferring human, face-to-face interaction. Assisted digital and short, accessible forms increase uptake without excluding anyone.
4. **Stronger LD-inclusive pathways are needed.** Recurrent calls for LD liaison nurses, pre-visit familiarisation, and accessible booking reflect a systemic gap. Annual LD health checks are valued and prevent problems.
5. **Pharmacy and dental access are inconsistent.** Awareness and certification variability limit pharmacy's role; NHS dental access problems drive private/cross-border use and additional costs for families.
6. **Community assets already carry significant preventive load.** People actively engage in local groups that support mental and physical wellbeing; this is a strength to invest in, consistent with the Board's strategic intent.
7. **Confidence in the estate depends on visible improvements and clear communication.** Mobile diagnostics, staffing visibility, and accessible wayfinding increase trust during the strategy refresh and interim Clinical Services Plan changes.

4.4.10 People with mental health conditions

Section 1: Summary of Themes (with quotes)

1) Community & Social Model for Health

Summary: Stakeholders emphasised the importance of local social networks, clubs, and informal community assets (e.g. WI, Women's Shed, CWTCH, gardening/Tai Chi) in preventing isolation and supporting day to day wellbeing. Physical community infrastructure (accessible venues and transport) is seen as essential enablers of the social model.

Representative quotes:

- *“Community Groups... help people to socialise and break isolation... People need to be more proactive to find out what's going on in their community.”*
- *“There is no community centre in Pwll... Meeting here is not fully accessible... Desperately need funding for a stair lift.”*

Concerns: Loss of local facilities; accessibility barriers; limited information flow for older residents.

Opportunities: Invest in community hubs and accessible spaces (e.g. Canolfan Pentre Awel as a multi-disciplinary hub), and strengthen community connectors.

Suggested actions: Map local assets; small grants scheme to sustain clubs; accessibility improvements to village venues; targeted communications to older adults.

2) Digital Inclusion & Choice

Summary: Participants expressed mixed confidence with digital health tools; many require training and still prefer or need non-digital options (letters, telephone). Systems integration across NHS providers is a major ask to improve continuity and reduce duplication.

Representative quotes:

- *“I wouldn't know how to put a computer on... You need people to help you.”*
- *“There needs to be other ways of communication... Elderly people need other forms of communication, letters, and telephone. You cannot discriminate.”*

Concerns: Digital exclusion due to skills, affordability, devices/connectivity; single access routes (e.g., 8am GP phone lines) disadvantaging some residents; interoperability gaps across GP/hospital systems.

Opportunities: Bilingual training, supported access pathways, and consistent multi-channel communication; leverage regional TEC/telecare (Delta Wellbeing) to support digital skills and independence.

Suggested actions: Expand digital skills training; maintain parity of non-digital options; accelerate information sharing and system integration across HB and GP practices.

3) Access to Primary & Community Care

Summary: Difficulty accessing GP appointments (phone queues, limited home visits) is a dominant theme. Stakeholders want responsive, local services (care packages, rehab, hospice, convalescence) to reduce hospital reliance.

Representative quotes:

- *“It’s really difficult to see and speak to a GP... Everything is over the phone.”*
- *“Convalescent homes... They say care in the community—there is no care.”*

Concerns: Insufficient homebased GP provision; limited capacity in hospice and care homes; affordability of private care; perceived gaps in community care continuity.

Opportunities: Scale community based multidisciplinary models/hubs (e.g. Canolfan Pentre Awel), enhance step-up/step down provision and carer support, utilise TEC and community responder models to keep people well at home.

Suggested actions: Increase same day primary care access routes; expand hospice beds; commission convalescence/rehab capacity; strengthen 24/7 homecare packages and rapid community response.

4) Transport, Travel & Site Access

Summary: Travel for specialist care is stressful and often costly; poor road links and limited public transport increase inequity—especially for those without cars. Hospital parking is a significant barrier.

Representative quotes:

- *“Why have I got to travel far?... I had a problem with my eyes had to go to Liverpool. It was costly.”*
- *“Parking in hospital sites is horrendous... GGH is the worst... over an hour to park.”*

Concerns: Transport availability; travel time; parking stress; fragmented clinic locations.

Opportunities: Transport support schemes; clearer travel information; scheduling coordination; onsite parking expansion and bus connectivity; consolidation of ambulatory clinics in community hubs closer to home.

Suggested actions: Travel assistance offers; multistorey parking at constrained sites (e.g. GGH); integrated bus timetables; promote virtual consults where clinically appropriate.

5) Communication & Engagement

Summary: Participants want simpler public documents and easier ways to speak directly with staff (e.g. ward sister) without formal appointments. They perceive complexity as a barrier to participation and care navigation.

Representative quotes:

- *“Make it simple for people to engage with you... People are turned off by the complexity.”*
- *“I had to make an appointment to discuss anything... Can’t we just speak to the sister?”*

Concerns: Overly complex consultation materials; gatekeeping of communication channels; lack of proactive updates on waits.

Opportunities: Plain language, bilingual materials; direct ward contact processes; proactive status updates; multichannel engagement aligned to Strategy Refresh.

Suggested actions: Redesign patient and public communications; publish expected wait milestones and updates; implement ward “open hour” phone slots for families/carers.

6) Capacity, Waiting Times & Equity

Summary: Long waits (e.g. ophthalmology injections) drive people to seek private care when they can afford it, creating perceived inequity. Stakeholders voiced frustration about limited information during waits. These concerns align with Hywel Dda’s identified fragilities in several clinical services (e.g. Ophthalmology, Orthopaedics).

Representative quotes:

- *“3 years wait... I had to make a nuisance of myself... You are not kept up to date of what’s happening.”*
- *“Friends have had to go private because of waiting times... They wanted quality of life.”*

Concerns: Prolonged waits; lack of transparency; affordability divides.

Opportunities: Medium term Clinical Services Plan actions to stabilise fragile services; community delivery (e.g. therapies at Pentre Awel) to relieve hospital pressure; improved waitlist communication.

Suggested actions: Targeted capacity increases in high wait specialties; ringfenced community clinic sessions; proactive patient communication and escalation protocols for deteriorating conditions.

Section 2: Key Trends & Insights

1. **Strong reliance on community assets with infrastructure gaps.** The social model is welcomed and already lived through local groups; however, the loss or inaccessibility of community venues (e.g. Pwll) undermines participation, especially for older adults. This supports the strategy’s vision of care closer to home but requires tangible investment in local spaces.
2. **Digital-by-default risks exclusion without parity of options.** Confidence in apps/online is variable; stakeholders emphasise continued access via phone and letter, plus supported training. Interoperability across GP/hospital systems is repeatedly called out—consistent with the Health Board’s emphasis on modernised, joined-up care.
3. **Primary care access is the pressure point.** Difficulty getting GP appointments and limited home visiting are key drivers of dissatisfaction; residents want multi-disciplinary services locally and timely responses to avoid hospital attendance.
4. **Transport and parking significantly shape perceived access and stress.** Travel to distant specialist centres is a burden; parking at GGH is a notable friction point, reinforcing the case for local hubs and improved site access planning.

5. **Communication needs simplification and proactivity.** Complexity of engagement materials and barriers to speaking with ward staff deter involvement and reduce trust; clearer, more human communication is repeatedly requested.
6. **Waiting time frustration links to equity concerns.** Extended waits, particularly in ophthalmology, align with the Health Board's own identification of fragile services and drive some to private care. Transparent updates and targeted capacity are critical.

4.4.11 People with physical disabilities

Section 1: Summary of Themes (with quotes)

1) Access & Transport (including Rurality and Physical Accessibility)

Summary: Stakeholders strongly prefer local, convenient services and raise recurring concerns about transport availability, journey length, and physical accessibility of facilities (parking, toilets, ramps). There is consistent emphasis on reliable transport, closer satellite provision (especially for limb services), and accessible infrastructure.

Representative quotes:

- *“Prefer to access services locally as transport limited or not available/accessible.”*
- *“We would like Satellite centre for limbs... it's a long way [to Swansea ALAC].”*
- *“Need plenty of disabled parking... Need toilet with handrails... Small things – make things better.”*

Concerns: Long travel times to specialist centres (e.g. ALAC Swansea); infrequent public transport; inaccessible toilets; insufficient disabled parking; closures or limited hours (e.g. ICC).

Opportunities: Satellite or sessional outreach clinics; transport coordination/volunteer driver schemes; accessibility audits; integration with local hubs.

Suggested actions: Develop satellite limb services in Hywel Dda; publish a transport offer (routes, eligibility, escorts); implement minimum accessibility standards and audits across sites; co-design improvements with disabled users.

2) Community & Third Sector Partnership (Social Model for Health)

Summary: Community groups and charities (e.g. HOPE MS; National Park accessible walks; local cafés and warm spaces) are vital for day-to-day wellbeing, offering therapies, peer support, and social connection. Stakeholders want recognition and practical support for carers and existing local organisations.

Representative quotes:

- *“We are trying to raise people's spirits... it's mental and physical wellbeing.”*
- *“Support for organisations already in existence that provide care and support. More support and recognition for people who care for friends and family.”*

Concerns: Funding insecurity for third sector initiatives; perceived lack of formal recognition; missed opportunities to commission community-based services; variable collaboration across condition specific charities.

Opportunities: Commissioning or SLAs with proven community providers; co-located services within community venues; carer-focused support pathways.

Suggested actions: Establish flexible micro-commissioning/SLA frameworks; create a “Community Wellbeing Partner List” and referral pathways; invest in carer support (training, respite, financial advice).

3) Digital Inclusion & Confidence

Summary: Mixed attitudes to digital care—valued for convenience (video clinics, reminders) but concerns persist around digital exclusion, usability, trust, and reliability (connectivity, power cuts). People want simple, bilingual, accessible tools with alternative non-digital routes preserved.

Representative quotes:

- *“There are people who don’t/can’t use the internet... People are afraid of AI.”*
- *“It was a video appointment – it was brilliant... didn’t have to travel.”*
- *“Simple to use. Easy to navigate. Access to support... large text option and audio.”*

Concerns: Confidence gaps; poor rural connectivity; lack of accessible design; telephony barriers; inadequate coaching to use IT.

Opportunities: Digital coaching via community partners; hybrid models; accessible UI features; proactive family/carer support while respecting independence.

Suggested actions: Deliver “Digital Health Coach” sessions locally; set minimum accessibility standards; maintain letters/phone lines; expand video clinics where clinically appropriate; improve practice telephony and online triage usability.

4) Primary Care, Pharmacy & Local Preventive Support

Summary: Pharmacies and GPs are seen as key for advice, triage, and keeping people out of hospital. Stakeholders welcome expanded pharmacy services, mobile units, and routine checks delivered closer to home.

Representative quotes:

- *“Going to pharmacy for small things is great... The more they can deliver, the better.”*
- *“Mobile units, pharmacy – vaccines, testing, bloods... Full health checks.”*

Concerns: Long waits at A&E; 111 perceived as difficult; stress when appointments unavailable.

Opportunities: Community diagnostics (phlebotomy, ECG, BP, spirometry), mobile clinics, pharmacy led minor ailments and independent prescribing, structured reassurance/communication.

Suggested actions: Scale pharmacy services; pilot community diagnostics/mobile units; improve 111 navigation support; include “reassurance and status updates” in access protocols.

5) Rehabilitation, Case Coordination & Holistic Pathways (Amputee Focus)

Summary: Amputees report fragmented pathways, limited holistic rehabilitation, and heavy travel burdens for prosthetics. Strong desire for dedicated case coordination, timely prosthetic adjustments, and closer provision for routine issues.

Representative quotes:

- *“Need a holistic approach... could have done with a case manager to oversee whole journey.”*
- *“Because of how far we live, don’t get a leg that fits as well as it should... keep having to go back to Swansea.”*

Concerns: Repeated recasting delays; limited local repair/adjustment options; cost and stress of travel; inconsistent information; insufficient local physio expertise.

Opportunities: Create a satellite clinic model; virtual triage for minor adjustments; community gym/exercise access tailored to amputees; specialist case coordinators bridging services.

Suggested actions: Commission parttime ALAC satellite in Hywel Dda; fund rapid response adjustment sessions; introduce amputee case coordinators; partner with local gyms for adapted programmes.

6) Estates, Cleanliness & Redevelopment Priorities

Summary: Stakeholders call for investment in existing sites (e.g., Withybush), improved cleanliness and wayfinding, and accessible layouts. There’s low appetite here for a brand new hospital versus upgrading current facilities and strengthening community hubs.

Representative quotes:

- *“Don’t build a new hospital, invest in and improve Withybush.”*
- *“GGH – poor state of cleanliness... derelict looking... CT room was filthy.”*

Concerns: Perceived cleanliness issues; adjacency/access to imaging; student accommodation quality; awareness of facilities (e.g. South Pembrokeshire Hospital).

Opportunities: Focused refurbishment (cleanliness, imaging proximity, accommodation); transparency on RAAC remediation and phased upgrades; better public information on available facilities.

Suggested actions: Publish estates improvement plan and cleanliness standards; complete RAAC works and communicate milestones; improve signage/communications for under-used sites; co-design accessible toilets/parking.

7) Communication & Experience (Culture, Respect, Information)

Summary: People value being talked **with** not **over**, timely updates, and “joined-up” communication across services. Some experiences (discharge, letters, telephony) feel impersonal or confusing; clear, respectful communication improves trust and reduces anxiety.

Representative quotes:

- *“Clinical letters can come over cold... fund doctors to communicate with normal people... don't talk about you as if not there.”*
- *“Reassurance; if you can't get an appointment, you get stressed.”*

Concerns: Disjointed information; stressful access; perceived lack of empathy; limited coaching on digital/telephony systems.

Opportunities: “One front door” case coordination; communication standards; patient-friendly letters; proactive status updates; staff training on disability-aware communication.

Section 2: Key Trends & Insights

1. Localism Strongly Preferred; Travel Is a Material Barrier

Across groups, local services (including pharmacy and community venues) are favoured; transport limitations are a major determinant of access, with amputees particularly impacted by distance to Swansea ALAC.

2. Third Sector Capacity Exists but Needs Formal Support

Charities and community groups already reduce demand on hospital services and improve wellbeing; stakeholders seek funding, SLAs, and recognition to scale impact.

3. Digital Is Promising but Must Remain Optional, Simple, and Accessible

Positive experiences with video clinics coexist with rural connectivity and inclusion challenges; multichannel access and accessible design are non-negotiables.

4. Rehabilitation & Case Coordination Are Central to Patient Experience

Calls for holistic, coordinated pathways (especially for amputees) indicate gaps in continuity, timely adjustments, and local rehabilitation options.

5. Estate Investment Should Prioritise Usability, Cleanliness, and Accessibility

Stakeholders emphasise upgrades to existing hospitals and community hubs; this aligns with the Health Board's ongoing RAAC works and wider strategy refresh timelines.

6. Communication Quality Drives Trust and Reduces Anxiety

Plain-English, respectful communication and proactive updates (appointments, transport, delays) are repeatedly requested; letters and telephony systems require improvement.

Strategic context alignment: Hywel Dda's strategy aims to shift care closer to home and invest in sustainable hospital services—now under a “refresh” with Board consideration in January 2026; any large hospital newbuild is long dated, strengthening the rationale to focus on community hubs, digital inclusion, and targeted estate upgrades in the interim.

4.4.12 People with sensory disabilities

Section 1: Summary of Themes (with quotes)

1) Access & Transport (Rurality, Patient Transport, Locality of Care)

Summary: Participants consistently describe transport as the single biggest barrier to engaging with care and community health—covering the cost, availability, eligibility rules, reliability, and the anxiety of travel when visually impaired or deaf. Rural distances and poor public transport disproportionately affect timely access and follow-up, especially for injections and outpatient reviews.

Representative quotes:

- *“Transport is our biggest issue... It cost me £11 to get to the group today... It would cost me £27 one way to get to Llandybie.”*
- *“Appointment times do not work for people travelling long distance... Country Cars aren't always there... Hospital transport won't take an escort.”*

Concerns: Inconsistent non-emergency patient transport criteria; limited volunteer/community drivers; clinics sited away from hospital (ineligible for transport).

Opportunities: Local follow up (e.g., dressings, suture removal) in community; taxi voucher or mileage reimbursement streamlined; scheduled transfer services; align appointment slots with transport availability.

Actions suggested by groups: GP led transport schemes; expand community transport; ensure escorts/PA eligibility; better signage and parking at GGH.

2) Communication, Accessible Information & Sensory Awareness

Summary: Accessible formats, plain language, and reliable two-way communication are recurring needs. Visually impaired participants ask for large print/audio; Deaf participants ask for BSL, interpreters on site, text/email channels, and functioning visual call screens. Both groups report dignity impacts when needs are not recognised or flagged in systems.

Representative quotes:

- *“Why does the Health Board produce everything in small print?... By not producing... in audio or large print it's discrimination.”*
- *“We need qualified BSL interpreters based in hospitals... Invest in decent Wi-Fi so Sign Live/Sign Wow works.”*

Concerns: Letters late or unreadable; one-way SMS; lack of BSL across channels; reliance on family mediators; screens not working; staff call names verbally.

Opportunities: Implement accessibility policy and flagging at point of booking/arrival; standardise visual call systems; publish BSL videos with Board/urgent updates; invest in site-wide Wi-Fi to enable VRI (video remote interpreting).

Actions suggested by groups: Mandatory Deaf/sensory awareness training; provide iPads on wards for interpreting; create a central accessible-communications team; simplify letters (“plain English”).

3) Digital Inclusion & Confidence

Summary: Digital tools are welcomed only when they are accessible, optional, and supported. Many visually impaired participants cannot use current portals/forms; Deaf participants value apps (e.g. Sign Live/Sign Wow) but face local funding, connectivity, and usability barriers. Face-to-face and non-digital routes must remain.

Representative quotes:

- *“It’s a big NO from our group... You can’t see data on the phone or computer.”*
- *“We like the apps, Sign Live and Sign Wow, but there’s no funding in Pembrokeshire or Carmarthenshire... Better Wi-Fi in GP surgeries and hospitals.”*

Concerns: Inaccessible forms; screen reader incompatibilities; poor rural signal; NHS app proxy access for carers not working well.

Opportunities: Accessibility audits; alternative formats; kiosk/assisted digital options; local training with councils/third sector.

Actions suggested by groups: Invest in site Wi-Fi; enable email/text two-way with GP; publish BSL videos for all key updates; fund interpreter apps.

4) Timely Access to Clinical Care (Ophthalmology & Across Pathways)

Summary: Backlogs and late/lost appointments are reported, particularly for macular injections and glaucoma follow-up, with perceived consequences for sight loss. Groups propose nurse injectors, use of community sites, and tighter appointment/letter systems.

Representative quotes:

- *“Regular eye injections. On time! Delays severely impact eyesight.”*
- *“There is a massive backlog... 19 weeks delays... You need the injections every 4 weeks.”*

Concerns: Staffing constraints; centralised booking issues; poor coordination between hospital and optometry; limited feedback loops with independent sector providers (e.g., Spa Medica).

Opportunities: Scale nurse-injector model; community injection clinics; optometry enabled follow-up; digital reminders plus phone/text; transparent escalation for overdue appointments.

5) Community Support, Prevention & Third Sector Partnerships

Summary: Clubs (macular, Deaf, TORCH, U3A) and local charities significantly reduce isolation and maintain wellbeing but rely on fragile funding and volunteers. Participants call for recognition, micro-grants, and coordinated signposting.

Representative quotes:

- *“If it wasn’t for these clubs our lives would be very much isolated... We live in a different world to those who are sighted.”*
- *“These groups are dependent on volunteers, and it is getting harder to find new volunteers.”*

Concerns: Short-term grants; rising venue/transport costs; diminishing volunteer base; gaps in RNIB/Macular Society local presence.

Opportunities: Social model micro fund; reduced venue rates; brokerage for volunteers (youth/colleges); systematic signposting from clinics to groups/ECLOs.

6) Hospital Estate, Wayfinding & Environment

Summary: Participants emphasise making existing hospitals safer and easier to navigate now—good lighting, contrasting signage, tactile routes, drop-off/parking—while expressing anxiety about potential service changes that lengthen travel. GGH/Withybush environments and wayfinding are frequently cited.

Representative quotes:

- *“GGH require a lot of improvements... Need to future proof the hospital.”*
- *“Improving buildings is signage, floor textured pathways, ramps/lifts, and training of front-of-house staff.”*

Concerns: Confusing layouts; lift controls; brushed metal signage; reception left unmanned; fear that estate plans could worsen access.

Opportunities: Rapid low-cost accessibility upgrades; sensory aware design standards in any redevelopment; visible reception/navigation support; consistent visual calling systems in outpatients.

7) Trust, Engagement & Feedback Loops

Summary: Some groups report repeated engagements without visible change, eroding trust. Requests include defined actions, timeframes, updates (including BSL), and coproduction with sensory impaired people.

Representative quotes:

- *“Nothing changes... We bang on about the same things all the time.”*
- *“Tell people what’s available in the community. I had to find out.”*

Concerns: Perception of “lip service,” inaccessible board communications, and inconsistent signposting.

Opportunities: Publish an “You said/We did” tracker; regular accessible updates; BSL interpreted Board meetings; appoint sensory impairment champions in each Clinical Care Group.

Section 2: Key Trends & Insights

1. **Transport is the dominant access constraint across all sessions** Across VI and Deaf groups, travel cost, eligibility, escort policies, timing and reliability of services are persistent barriers to appointments and social model activities. This risk interacts with rurality and limited public transport, reinforcing isolation and inequity.

2. **Accessibility is multi-dimensional—format, environment, and human behaviour**
Large print/audio, BSL across channels, visual calling screens, and staff who understand sensory needs (mask removal, facing the patient, lighting on wards) are as critical as ramps and lifts. Failure to meet these needs undermines safety, experience, and outcomes.
3. **Digital must be optional and genuinely accessible**
Participants want dependable Wi-Fi and accessible apps—but only alongside non-digital routes. Proxy access problems and inaccessible forms are current blockers; investment in Wi-Fi and interpreter apps is a prerequisite, not a luxury.
4. **Ophthalmology is a pressure point with safety implications**
Backlogs for injections and follow-up create anxiety about irreversible sight loss. Groups endorse scaling nurse-injector models and community delivery to protect vision and reduce travel.
5. **The social model lives in community groups—but funding and volunteers are brittle**
Clubs materially improve well-being yet depend on self funding and volunteer goodwill. Strategic micro investment and systematised signposting could yield outsized prevention benefits aligned to the Board’s social model vision.
6. **Rapid “fix the basics” estate improvements would be highly valued**
Before major redevelopment, low-cost improvements (contrasting signage, visual call boards, staffed receptions, clearer wayfinding at GGH/WGH/PPH) would deliver immediate benefits and rebuild trust.
7. **Trust depends on visible follow-through**
Participants explicitly request timelines, feedback, and co-production (including BSL-interpreted Board sessions and accessible online updates), consistent with the publicly stated Strategy Refresh process and upcoming Board reporting in January 2026.

Strategic fit note: These insights align with the Health Board’s emphasis on a **social model**, **community based care**, and **accessible estate** within *A Healthier Mid and West Wales*, and with the 2025/26 Annual Plan focus on urgent care, planned care, diagnostics, and workforce. A transparent refresh that prioritises near-term accessibility wins, and community enablement is consistent with the Board’s published direction and timelines.

4.4.13 Women

Section 1: Summary of Themes (with quotes)

1) Access to Primary & Community Care

Summary: Participants consistently emphasised difficulties accessing GP and NHS dental services, continuity of care, and overload in A&E when GP appointments are scarce. They want more specialist nurses and better organisation of appointments to reduce repeat travel and duplication.

Representative quotes:

- *“Access to GP services – remove the 8am rush on phonenumber... more specialist nurses, continuity of care... better communication from surgery.”*
- *“It’s down to the basics of not being able to get a GP appointment... so much preventable stuff could be dealt with before it gets too far down the line.”*

Concerns: Phone-line bottlenecks; fragmented appointments; long waits (e.g. ENT, cataracts, orthopaedics); poor NHS dental access; perceived inequities when private options are available.

Opportunities: Expand pharmacy-based services; optimise GP workflows; increase community clinics (e.g. flu clinics in community centres); leverage specialist nursing roles.

Suggested actions: Trial call-back/triage models; standardise continuity-of-care protocols; commission additional capacity for dentistry; extend community outreach (flu/vaccination).

2) Transport & Travel (including affordability)

Summary: Transport is a major barrier, especially for rural patients and families needing to reach Glangwili or other sites; cancellations of hospital transport and high taxi costs create distress. Parking limitations across sites are a recurring grievance.

Representative quotes:

- *“I have families in Milford... children need to get to Glangwili... They have no transport... taxis costing £300.”*
- *“Parking at all the main hospitals is terrible and needs sorting.”*

Concerns: Reliability of hospital transport; weekend gaps; emergency trips; parking constraints and cost; digital engagement plans perceived to gloss over real-world transport gaps.

Opportunities: Enhancing volunteer transport schemes; clearer signposting and booking; consolidating care “more done in one appointment” to reduce repeat travel.

Suggested actions: Transport coordination hub; guaranteed transport for oncology and paediatrics; parking improvement programme; appointment bundling to minimise journeys.

3) Digital Healthcare Inclusion & Choice

Summary: While some participants value the NHS App for prescriptions and routine bookings, many (especially older adults) are anxious, wary of scams, or simply **do not want** digital healthcare. Strong emphasis that face-to-face pathways must remain.

Representative quotes:

- *“Older people are anxious... Scammers make people wary... NHS App is good for prescriptions.”*
- *“You’ve missed the glaringly obvious... They might not want to. ...It needs to be noted that not everybody wants it.”*

Concerns: Trust; usability; reliability (e.g., app failures); digital exclusion and preference for non-digital options.

Opportunities: Community hubs for digital support; on-site demonstrations by HDUHB; bilingual/simple interfaces; robust alternatives maintained.

Suggested actions: “Digital + face-to-face by default” policy; training with local partners; resilience testing of the NHS app; targeted outreach to older adults.

4) Communication, Engagement & Trust

Summary: There is noticeable scepticism and “consultation fatigue.” Participants questioned influence, follow-through, and whether past consultations led to tangible improvements; desire for transparency on “what happens next.”

Representative quotes:

- *“I am very sceptical... keep asking... and then nothing changes.”*
- *“What influence do you actually have and what happens at the end of this consultation?”*

Concerns: Perception of pre-determined decisions; lack of feedback loops; variability across local authorities undermining joined-up delivery (e.g. leisure centre closures).

Opportunities: Publish clear timelines and decision thresholds; report using “you said, we did” format; integrate with local authority partners; regular progress updates. (The Have Your Say page signposts a January 2026 Board report—useful for setting expectations.)

Suggested actions: Transparent decision criteria; engagement dashboards; targeted comms on interdependencies with councils; “close-the-loop” reporting.

5) Hospital Estate & Site Condition

Summary: Concerns about the physical condition of Glangwili and parking constraints across hospitals; interest in maximising community sites; questions about ophthalmology cover.

Representative quotes:

- *“Glangwili Hospital – really poor state overall and needs investment.”*
- *“Is there Consultant Ophthalmologist cover at GGH?”*

Concerns: Estate modernisation lagging; parking infrastructure; clarity on specialist cover.

Opportunities: Prioritise high-need sites; near-term refurbishments within Clinical Services Plan while longer-term hospital programme progresses; optimise community facilities. (Board documents recognise fragilities and the longer timeline to any new hospital.)

Suggested actions: Publish an estate improvement schedule; near-term upgrades at Glangwili; hospital-wide parking strategy; service coverage communications (e.g. ophthalmology at GGH).

6) Care Pathways, Aftercare & Coordination

Summary: Mixed experiences—good cardiac aftercare contrasted with poorer stroke aftercare; desire for linked records and fewer repeat journeys; reduce medicine waste via smarter repeat prescribing.

Representative quotes:

- *“Consistent after-care... positive experience for cardiac... poor experience for stroke patient.”*
- *“Reduce repeat prescriptions to reduce wastage.”*

Concerns: Variability across pathways; fragmentation of appointments and records; cancelled procedures causing emotional distress, especially for neurodiverse patients.

Opportunities: Integrated records; pathway “bundling”; improved discharge and social care coordination; personalised support for neurodiverse patients. (The Strategy emphasises integrated community networks and timely discharge.)

Suggested actions: Pathway reviews (stroke, ENT, ophthalmology); implement “one-stop” models where feasible; medication optimisation programmes.

7) Inequalities & Variation across Counties

Summary: Stakeholders noted differences in access and facilities between Carmarthenshire, Ceredigion, and Pembrokeshire, including closures (e.g. Cardigan swimming pool) and variable leisure provision impacting prevention.

Representative quotes:

- *“It can be very different for people... in terms of access to services.”*
- *“Cardigan Swimming pool has been closed down... surely that should be part of the strategy in keeping people well.”*

Concerns: Uneven preventative infrastructure; travel burden concentrated in certain areas; variable local authority policies.

Opportunities: Cross-sector planning with councils; community wellness hubs; targeted investment to address geographic inequity (consistent with the Strategy’s community model).

Suggested actions: Joint planning board with LAs; publish an inequalities impact and mitigation plan linked to investment choices.

Section 2: Key Trends & Insights

1. High salience of Access & Capacity constraints

Both groups return repeatedly to difficulties with GP and dental access, specialist waits (ENT/orthopaedics/ophthalmology), and fragmented appointments—driving avoidable A&E

attendance. This aligns with the Health Board's stated fragilities and the need for medium-term service stabilisation through the Clinical Services Plan.

2. **Transport as a systemic barrier, compounding inequities**

Transport unreliability, cost, and parking deficits are not incidental—they shape whether people can access planned or urgent care, with heightened impact on families, older adults, and those unable to drive. Media coverage of the engagement also highlighted transport concerns as a common theme.

3. **Digital healthcare: support welcomed, but strong preference for choice**

There is a clear cohort who value the NHS Wales app for routine tasks, but equally clear insistence that digital should **not** become mandatory. Trust, reliability, and plain-language support are paramount, alongside in-person alternatives.

4. **Engagement fatigue & trust deficit**

The tone indicates scepticism regarding consultation efficacy and transparency around influence and decision-making. To sustain legitimacy, the refresh should evidence tangible “you said, we did” outcomes, consistent with the Have Your Say timeline to a January 2026 Board report.

5. **Estate condition and near-term improvement needs**

Glangwili Hospital's condition and parking across major hospitals emerge as priority estate issues. Given the decade-plus horizon for a new hospital (subject to funding), near-term investment and clear communication on what will improve **now** are crucial.

6. **Pathway consistency & joined-up care**

Variation in aftercare (cardiac vs stroke), appointment bundling, and repeat prescribing/medicine waste signal the need for more integrated workflows and data-sharing, aligned to the Strategy's integrated community networks.

7. **Geographical variation and cross-sector interdependencies**

Differences across counties (e.g. leisure facilities) point to the importance of whole-system planning (health + local authority + community) to deliver the social model for health and wellbeing.

4.4.14 Young people

Section 1: Summary of Themes (with quotes)

1) Access to Care & Local Provision (Primary, Community, and Urgent Care)

Summary: Young people emphasise difficulties accessing GP appointments, long waits in ED/A&E, and limited awareness of alternatives such as MIUs and community/pharmacy support. They value timely local options (blood tests, monitoring, youth-friendly services) that reduce hospital reliance.

Representative quotes:

- *“You struggle to get GP appointments... My father waited 6 hours in A&E... More beds are needed in hospitals.”*
- *“Not many [are] aware there is an urgent care unit... people go to the same place... need better signposting to MIU.”*

Concerns: Long waits; limited GP access; poor awareness of urgent care alternatives; transport barriers for specialist care.

Opportunities: Expand community testing and monitoring; strengthen pharmacy/111 pathways; improve MIU visibility; targeted youth service design.

Suggested actions: Clear “right place, first time” signposting; weekend community access; physical “111” navigation points; local community check-in schemes for elderly.

2) Communication, Navigation & Signposting

Summary: Navigation across services (and between Wales/ England digital resources) is confusing. Young people ask for clearer messaging on what ED/ MIU/ GP/ pharmacy do, real-time directions, and transparency on waiting lists.

Representative quotes:

- *“More information / better communication on what you can do in the community... A&E is for... MIU is for... Clearer messaging.”*
- *“In Wales things need to be really well signposted... sometimes you end up... on NHS England service... Need to do better.”*

Concerns: Confusing pathways; inconsistent information (web/app); lack of transport and location guidance for appointments.

Opportunities: Unified, youth-friendly communications; live wait-time info; journey planning support.

Suggested actions: Launch a bilingual “Start Here” guide; integrate MIU/ED guidance into digital tools; provide appointment wayfinding/transport details.

3) Digital Healthcare: Trust, Inclusion & Usability

Summary: Views on digital are mixed. Young people value prescription apps and virtual options but worry about security, identity theft, poor UX, patchy connectivity, and over-reliance on

phone/AI. They want simple, trusted, bilingual tools with face-to-face alternatives and support to build confidence.

Representative quotes:

- *“Really like the NHS app... prescriptions... notifications... makes the process easy.” / “My surgery app is a nightmare... it’s gone backwards.”*
- *“I wouldn’t trust digital as much as going to see a doctor... Security risk online.”*

Concerns: Digital trust; privacy; usability; digital divide (skills, Wi-Fi/signal); need for basic skills training and simple modes for older people.

Opportunities: Build on NHS Wales app; provide training and “how to” support via GPs/schools; virtual appointments with video support; transparent waitlist status.

Suggested actions: Co-design youth-friendly UX; roll out digital inclusion workshops; publish real-time queue/appointment updates; maintain telephone/in-person routes.

4) Social Model for Health & Youth Wellbeing

Summary: Non-medical factors—family support, schools, youth clubs, arts/sports, affordable healthy food—are central to health. Closures and cost barriers reduce opportunities; young people call for more youth clubs, activities, and practical education (healthy living, confidence to use gyms).

Representative quotes:

- *“Hobbies are very important... good for mental health... Need access to healthy and affordable food... I’ve not seen a vegetable for four years in school.”*
- *“Youth subscription at the Leisure centre is £24 – it’s very expensive... Starter classes for young people.”*

Concerns: Affordability; rural access; loss of youth clubs; food quality in schools; confidence barriers for gym/exercise.

Opportunities: Partnerships with schools/leisure centres; subsidised youth access; mobile/outreach (e.g. “Feelz on wheels”); school wellbeing hubs.

Suggested actions: Expand youth hubs/afterschool clubs; co-fund leisure discounts; healthy school meals initiatives; targeted rural outreach.

5) Estates, Environment & Neurodiversity-Friendly Design

Summary: Estate condition and environments matter. Priorities include general maintenance, better signage/wayfinding, neurodiversity-friendly spaces, improved A&E waiting areas (including play spaces), overnight parent facilities, accessible buildings, green spaces, and ventilation.

Representative quotes:

- *“Make hospitals Neurodiverse friendly... Better waiting room at the A&E GGH... bed settee for parents staying overnight.”*
- *“Building in Aberystwyth looks run down... Green spaces are so important... would make you feel cared for.”*

Concerns: Ageing/daunting buildings; poor signage; inadequate accessibility; limited family facilities; ventilation/infection control.

Opportunities: Quick wins in maintenance/signage; youth-informed design standards; outdoor/green areas; inclusive wayfinding; refurbishments aligned to clinical priorities.

Suggested actions: Implement ND-friendly design guidelines; A&E waiting area upgrades (youth/child spaces); accessibility audits; parent overnight accommodation standards.

6) Transport, Travel Reliability & Cross-Board Collaboration

Summary: Transport reliability is a significant stressor—missed/cancelled hospital transport, complex routes, and limited public transport to hospitals. Young people request medical-centred transport, clear directions, and reliable logistics; they also raise the need for collaboration across Health Boards.

Representative quotes:

- *“Hospital transport is very unreliable; cancellations result in empty appointments... Reliability is a big thing.”*
- *“More medical centred transportation... buses all day... give clear directions to where [the service] is.”*

Concerns: Unreliable hospital transport; lack of journey support; stress around appointments.

Opportunities: Enhanced nonemergency transport; volunteer schemes; digital journey planners integrated with appointments; regional coordination.

Suggested actions: Set transport reliability KPIs; publish cancellations/rebooking protocols; integrate travel guidance into appointment letters/apps; explore cross-HB transport solutions.

Section 2: Key Trends & Insights

1. Preference for Local, Early Support & Clear Alternatives to ED

Young stakeholders consistently prefer accessible community options (pharmacy, MIU, blood tests locally, school wellbeing hubs). Awareness and signposting are as important as capacity.

2. Communication Gaps Undermine Confidence

Confusion about pathways (ED vs MIU vs GP vs 111) and insufficient, inconsistent information (web/app) lead to inappropriate service use and frustration. A structured, bilingual navigation offer is needed.

3. Digital: Useful but Not Sufficient; Trust Must Be Earned

Positive experiences (NHS app for prescriptions) coexist with distrust (privacy/security), poor UX, and connectivity barriers. Youth want blended models: simple digital tools + human support + face-to-face options.

4. Social Determinants Are Central

Health is strongly linked to family support, schools, youth clubs, sports, arts, and affordable healthy food. Cost and rural access are recurrent barriers; practical life skills/health education are requested.

5. **Environments Influence Experience**

Estate quality, signage, neurodiversity friendly spaces, child/youth waiting areas, parent overnight facilities, and green spaces are seen as high-impact improvements—aligned with strategy commitments to modern, supportive environments.

6. **Transport Reliability is a System Enabler**

Reliable, accessible transport (and clear directions) is fundamental to equitable access—particularly in rural areas and for young/older patients.

Strategic Alignment Note: These trends align with the Board's refreshed strategic intent to strengthen community care, invest in digital as an enabler (while ensuring inclusion), and improve estates within current constraints as the new hospital timescale extends (~10 years).

Public communications reaffirm the Phase 2 engagement (11 questions) and the plan to present findings to the Board in **January 2026**. The underlying 2018 strategy emphasises prevention, community delivery, and modernised acute care—providing continuity with the refresh.

4.5 Feedback from social media

This section of the report presents the results of feedback from social media. 212 comments were received across the three official health board social media pages.

The main themes from social media feedback are presented in the following table:

Theme	Frequency
Frustration with hospital experience	23
Travel times	23
Frustration with existing services	18
Mistrust in Health Board	17
Frustration with GP services	15
Education and individual responsibility for health	13
Lack of local service provision	10
Waiting times	8
Mistrust in digital technology	8
Mistrust in/Frustration with Welsh Government	5
Mistrust in/Frustration with NHS Wales	4
Existing local service provision	3
Poor communication from Health Board	3
Transport provision	3
Early diagnosis	2

Social media discussion is an important part of any engagement activity. It provides a way for the health board to respond to enquiries and helps us to direct people to resources that can help them learn more and get involved. Although comments on social media are not considered formal submissions, and it is often unclear whether they represent someone's final views or simply evolving thoughts as part of an online discussion, they still offer valuable insight. Because of this it should be noted that these comments can serve as a useful benchmark for identifying concerns, gauging sentiment, and highlighting issues that matter to people.

5. Conclusion

Phase 2 of Hywel Dda University Health Board's strategy refresh engagement was carried out to ensure that the evolving long-term vision for *A Healthier Mid and West Wales* is firmly rooted in the lived experiences and aspirations of the Health Board's population.

Building on the broad thematic insights from Phase 1 engagement, Phase 2 employed a robust, multi-method approach to collect feedback about 11 engagement questions spanning 4 broad areas. Phase 2 engagement combined targeted group sessions, hospital walkarounds, community outreach and multilingual online and paper questionnaires—to gather feedback from over 2,000 individuals. The engagement prioritised inclusivity, with particular efforts to reach under-represented communities, and used systematic thematic analysis, supported by Copilot, to synthesise qualitative and quantitative data.

Quantitative findings highlight strong participation, including 287 Have Your Say responses (with high question completion rates).

Key themes emerging across the 4 broad engagement areas include persistent barriers to access (notably transport, GP and dental appointments, and digital exclusion), the centrality of community assets and prevention, the need for equitable digital transformation, and the importance of clear, compassionate communication. Equality impacts were evident, with rurality, disability, and digital poverty shaping experiences of care and access. The most frequent recommendations—though frequency data is sometimes unclear—emphasise improving transport and local access, strengthening community hubs, ensuring digital inclusion by design, and investing in accessible estates and workforce resilience.

The engagement's strengths lie in its breadth, inclusivity, and the innovative use of AI to support systematic analysis; its limitations include potential bias in AI-supported coding and incomplete data from some groups. Crucially, the findings demonstrate strong alignment between public priorities and the strategy's objectives of prevention, community-based care, and equitable access.

As the Health Board considers these insights, a forward-looking question remains: How will the Health Board continue to adapt its strategic direction to ensure that the voices of seldom-heard communities shape both immediate improvements and long-term transformation?

6. Strengths and limitations of using Copilot to support analysis

Strengths

Use of Copilot to support thematic analysis

- Copilot was successfully used to support the analysis, including a systematic thematic analysis, of the Phase 2 public engagement qualitative data.
- The Copilot “prompt coach” was used to help refine and improve initial draft prompts.
- Copilot was used to identify recommendations from the feedback received.

Limitations

Use of Copilot to support thematic analysis

- There was limited human verification of themes identified through the Copilot systematic thematic analysis. This was mainly because of lack of capacity and time.
- There was potentially inherent bias in the analysis, interpretation, outputs, and results. This was because of the nature of generative AI, such as Copilot.
- Copilot is not as effective as humans in identifying nuance or emotional tone in data. Therefore, the results may not accurately reflect subtle nuances or sentiment in the data.
- People involved in engagement activity were not informed that Copilot would be used to support the analysis of the data.
- Consent to use Copilot to analyse the data was not sought or obtained from people involved in engagement activity.
- Although there was a carbon impact every time Copilot was used, the carbon impact was not estimated, calculated, or reported.
- Considerable manual manipulation (e.g., copy and paste) of data was needed to create data sets for analysis. This had a human resource impact. In addition, there was a risk of human error when the data were manually manipulated.
- Up to three files can be uploaded for analysis in each Copilot conversation. However, for some of the stakeholder groups, more than three files (with data) needed to be included in the analysis. To overcome the three-file limit, files needed for the analysis were uploaded to SharePoint. The links to the files in SharePoint were then added to the Copilot prompts. Initially, Copilot was unable to access the files on SharePoint because of the access / sharing settings of the links. It was only when the links to the files were changed to “People in NHS Wales can edit” that Copilot was able to access the files and the data in them. However, there may be a risk in changing the link status of files to “People in NHS Wales can edit”, especially if the files contain personal or sensitive data.

7. Suggested recommendations

This section of the report presents suggested recommendations produced as part of the Copilot analyses.

7.1 Recommendations from 11 engagement questions (Have Your Say and group sessions and events combined)

This section of the report presents the suggested recommendations from the 11 engagement questions. The suggested recommendations are presented by the 4 broad sections that the 11 engagement questions were in.

7.1.1 Recommendations for Section 1: Social Model for Health and Well-being

(questions 1,2,3 and 4)

1. What helps you stay healthy day-to-day, beyond seeing a doctor, nurse or healthcare professional?

Access & Inclusion

- Codesign inclusive schedules: Offer evening/weekend and pram-friendly sessions; ensure BSL aware facilitation; provide quiet/low-sensory options.
- Transport solutions: Partner on community transport and active travel improvements; review the impact of service changes/cancellations (e.g., local bus services) on isolation and access.
- Accessible infrastructure: Increase park accessibility (toilets, benches, disabled parking, inclusive equipment), and safe walking/cycling routes (lighting, crossings).
- Healthcare communication: Strengthen test result communications, deaf-aware practice (clinician training to address the patient directly), and accessible formats.

Communication

- Deaf awareness & dignity: Mandatory clinical and front-of-house training; clear protocols to address patients directly when interpreters are present; audit respectful practice.
- Information clarity: Provide easy-read, multilingual, and BSL video materials; standardise messaging across hubs, GP receptions, leisure centres, and schools.

Digital

- Digital literacy & tools: Offer short tutorials on apps/step counters, diet trackers; integrate virtual consultations and telehealth rooms within hubs; curate trusted online resources.
- Data enabled social prescribing: Use hub systems to refer to community activities and track participation/outcomes (privacy compliant).

Physical Activity & Active Living

- Low-cost community activity: Expand free/low-cost walking groups, tai chi, chair yoga; promote parkrun and inclusive sessions; restore funding where small grants catalyse participation.
- Active travel embedment: Link daily journeys to walking/cycling; provide secure bike storage at hubs; wayfinding for safe routes.

Food Environment & Nutrition

- Affordable healthy options: Pilot subsidised healthy meals/snacks at hubs; partner with local producers/markets; skills-based cooking classes for families.
- Practical family nutrition: Support batch cooking, realistic feeding practices, and school canteen improvements (tasty healthy options).

Social Connection & Community Assets

- Scale peer support groups: Support warm hubs, craft/choir/social clubs; embed volunteering pathways; promote accessible wellbeing walks.
- Carer friendly offers: Provide respite linked activity slots; mutual aid circles; tailored information for carers.

Mental Health, Sleep & Self-care

- Everyday mental health: Integrate mindfulness/breathwork sessions; sleep hygiene workshops; promote stress-management resources.
- Life-stage tailoring: Adjust offers for older adults (chair based sessions), parents, and people with long-term conditions.

Place-based Flagship (Pentre Awel)

- Use Pentre Awel to demonstrate the integrated model (therapy, leisure, digital/telehealth rooms, social prescribing desk, inclusive scheduling). Harms reduced by co-produced design and constant evaluation.

2. Who outside the NHS do you think could be part of keeping people well?

Access & Place

- Expand free/reduced cost activity offers (e.g. *back friendly classes*, daytime sessions) in leisure centres and village halls; prioritise low-income groups.
- Invest in parks and paths (boardwalks, benches, bins; maintenance of footpaths; nature rich, traffic free multiuse routes). Coordinate with National Park and local councils.
- Strengthen rural active travel safety (cycling/walking on trunk/busy roads between villages). Collaborate with Local Highway Authorities/Trunk Road Agent. [
- Re-establish/modernise day-centre functions as community hubs with accessible transport, protecting carer respite and inclusion.

Communication & Community Hubs

- Develop multiuse wellness hubs (libraries, community centres) offering signposting, chair based exercises, peer groups and arts activities; ensure consistent information flow.
- Scale social prescribing & connectors to link clinical pathways to community assets; monitor uptake and outcomes.
- Create local information hubs (online and physical) that map community groups, timetables, costs, and accessibility features.

Digital

- Inclusive digital design (WCAG aligned) for apps, booking systems and websites; codesign with low vision users; offer offline/assisted signup routes.
- Leverage digital communities (moderated peer support, habit trackers, online yoga) with clear data/privacy guidance and digital literacy support.

Food & Nutrition

- Healthy retail partnerships with supermarkets/cafés to promote affordable healthy options and reduce UPF marketing; consider local subsidy schemes and community cooking classes (schools, hubs).
- Advocate policy levers (e.g. sugar taxes, planning constraints on fast food saturation) with councils and Welsh Government.

Primary/Community Care

- Pharmacy enabled selfcare: expand advice services and minor ailments support; integrate with signposting to local groups.
- Joint outreach: GP practices and community connectors co-run “Keep Well” events, with targeted sessions (e.g. chair-based activity, oral health, vision support).

Schools & Youth

- Embed health skills (cooking, oral health, daily movement, outdoor learning) through curriculum and extra-curricular clubs; use children as advocates for intergenerational health.
- Inclusive activity offers (walk and talk clubs, park runs) with low/no cost access for families.

Workplace Health

- Employer partnerships to normalise movement breaks, active commuting, and flexible time for community exercise; include wellbeing training for managers.

Accessibility & Inclusion

- Audit and upgrade accessibility (parking, gradients, surfaces, signage) at outdoor and indoor venues; involve disability groups (e.g. low vision services).
- Provide assisted transport for those excluded by current public transport to reach hubs/activities.

Alternative/Holistic

- Pluralistic offer with safeguards: enable access to yoga/meditation/holistic classes through community hubs, with quality standards and affordability considerations.

Funding & Sustainability

- Stabilise third sector funding (multiyear grants; community investment funds) to reduce closure risk (e.g. local charities/ hubs). Track impact via shared outcomes.

3. Are there people or groups in your local area who could play a big role in helping others live healthier lives?

Access

- Expand rural transport solutions (community buses, volunteer drivers).
- Improve accessibility in leisure centres (inclusive design, affordable pricing).

Community Capacity

- Develop volunteer recruitment campaigns and retention incentives.
- Secure multi-year funding for community health initiatives.

Mental Health & Wellbeing

- Embed mental health activities (craft, mindfulness) in community hubs.
- Train community leaders in mental health first aid.

Digital Inclusion

- Create local digital champions and provide training.
- Develop a centralised online directory of health-promoting groups.

Food & Socioeconomic Support

- Scale up food hubs and community fridges.
- Partner with retailers for healthy food incentives.

Education & Prevention

- Integrate health literacy into school curricula.
- Support intergenerational activities to reduce isolation and promote wellbeing.

4. What kind of support would make it easier for you to live a healthier life?

Access & Transport

- Pilot a rural “health & wellbeing minibus” in partnership with local authorities (shared funding model), synchronised with leisure centre and community group timetables.
- Reintroduce/extend key bus routes and evening services where clinical and community demand is evidenced; coordinate transfers for hospital appointments.
- Maintain and signpost safe walking routes (lighting, path maintenance, accessible pavements) to enable outdoor activity, esp. for older adults.
- Review parking policies (reduced/low-income tariffs near parks/leisure sites) to remove cost barriers to physical activity.

Primary Care Access & Reliability

- Fix the 8 am bottleneck: implement call-back queues, multi-channel booking (phone, web, email, app), and triage that allows multiple related issues when clinically appropriate.
- Improve appointment communications: SMS/email reminders; reaudit postal timelines; temporary cover for key booking/admin posts; message leaving facility on central lines.
- Expand home visiting for preventive tasks (e.g. flu jabs, brief checks) for housebound or mobility limited people.

Oral Health Access

- Commission targeted NHS dental capacity (e.g. sessional contracts, mobile dental clinics) and explore interim subsidy mechanisms for urgent private care where NHS access is not available.

Cost & Affordability of Healthy Living

- Introduce “Healthy Living Passes” (discounted/free off-peak access) for low-income groups, OAPs, and young people; include starter classes to build confidence.
- Community food affordability measures: budget friendly recipe packs, batch cooking groups, and engagement with local retailers to increase healthy, low-cost options.

Information, Communication & Digital

- Create a single “What’s On” hub aggregating council, voluntary, and private wellbeing offers; ensure practice notice boards advertise local groups and transport options.
- Enable asynchronous advice channels (secure email/chat) for non-urgent clinical queries; optimise practice websites for findability and currency; promote use of the NHS app for health information.

Preventive & Condition-specific Support

- Reestablish well man/woman clinics and expand mobile screening units (e.g. liver checks, BP, diabetes risk) at community venues.
- Provide tailored nutrition/diet programmes (incl. condition specific advice) and improve access to weight management services (address long waits, eligibility clarity).
- Clinical education on specific conditions (e.g. B12 deficiency) to harmonise protocols and communication.

Mental Health Continuum

- Develop a “midpoint” MH offer (group based talking therapies, peer support, brief interventions) for those not meeting secondary care thresholds but needing support.
- Strengthen community connectors (youth clubs, carers’ groups, evening classes) to reduce isolation and enhance social wellbeing.

Community Capacity & Volunteering

- Structured 1:1 volunteering schemes (including sixth form participation), with formal recognition for CVs and flexible micro volunteering roles (transport support, activity buddies).

7.1.2 Recommendations for Section 2: Digital Healthcare Support

(questions 5,6 and 7)

5. How do you feel about using the internet or apps to look after your health or share health information?

Access

- Invest in rural broadband and infrastructure to reduce digital exclusion.
- Ensure all digital health services are accessible to people with disabilities (e.g., compatible with screen readers)
- Provide alternative access routes (phone, face-to-face) for those unable or unwilling to use digital tools.

Digital Tools

- Co-design apps with users to ensure simplicity, reliability, and accessibility.
- Expand the functionality of the NHS app (e.g. appointment booking, access to full medical records).
- Regularly review and update digital systems to address usability issues and feedback.

Security & Trust

- Strengthen data protection and communicate security measures clearly to users.
- Provide guidance on identifying trustworthy health information online.

- Address concerns about data sharing and commercial use transparently.

Human Contact

- Maintain and promote face-to-face and telephone options alongside digital services.
- Recognise the importance of human interaction for mental health and complex care needs.
- Avoid making digital the only route for essential services.

Support & Inclusion

- Offer digital skills training and community support, especially for older adults and those with additional needs.
- Involve family, carers, and community organisations in supporting digital health adoption.
- Develop clear, accessible guidance and support for using digital health tools.

6. If digital healthcare worked well for you, what would it look like?

Access

- Implement online GP booking with advance scheduling and virtual queue features; enable direct asynchronous messaging with clinicians for low acuity queries.
- Introduce live clinician chat for rapid triage, with protocolled escalation to video or face-to-face.
- Standardise human fallback routes (option to speak to a person) across all digital entry points.

Integrated Records

- Prioritise an All Wales shared, longitudinal record, patient viewable across GP, community, and hospital, including letters, referrals, results, and appointment history.
- Provide results dashboards with trend graphs (e.g., thyroid, diabetes), and plain language explanations.

Communication & Inclusion

- Make the single NHS app the primary front door, with consistent features across departments and health boards.
- Embed BSL video content and interpreting support; improve lighting/video quality standards in clinics; add large text/audio modes by default.
- Issue timely reminders/notifications for appointments, referrals, and test results; ensure plain language and trusted, up-to-date content.

Digital & Data

- Integrate wearables and home devices to support self-management, with configurable nudges and personalised advice (condition specific modules).

- Build misinformation safeguards (curated links, verified content, update cadence) and privacy/security features transparent to users.

Infrastructure

- Invest in Wi-Fi and mobile signal improvements in GP surgeries/hospitals and rural communities; mandate minimum connectivity standards for video interpretation and telehealth.

People & Capability

- Provide digital skills training for staff and public, focusing on accessibility needs (visual impairment, BSL users, low confidence).
- Establish digital hubs with on hand support (“digital operators”) for appointments, forms, and video consults.

7. What would help you to feel confident using online tools or services to get healthcare?

Access & Inclusion

- Maintain guaranteed nondigital channels (telephone, face-to-face) with clear, publicised escalation paths to humans.
- Provide callback/queue save features and set telephony SLAs to reduce avoidance of primary care due to phone barriers.
- Offer device loan schemes, Wi-Fi hotspots in health buildings, and signpost social tariffs to mitigate digital poverty.
- Publish a Channel Choice Policy: digital as *an option*, never the sole route to care.

Communication & Engagement

- Send instant confirmations (“received”, “triaged”, “appointment booked”) with expected response times.
- Use plain language notifications and status trackers for referrals/tests.
- Explain how data is used/stored and the role/limits of AI, in lay terms.

Digital (Usability & Design)

- Adopt a design system for consistent patterns (navigation, forms, error handling, confirmations).
- Minimise password friction (NHS login with 2FA, biometric options); avoid unnecessary redirects.
- Provide task first journeys (e.g. “Book GP appointment”, “View test result”) with no dead ends.
- Embed real time service status and graceful fallbacks (e.g. switch to phone when online triage unavailable).

Reliability & Performance

- Define and publish service level targets for uptime and response; monitor and report “it just works” metrics publicly.
- Implement automated acknowledgements and triage timers to prevent limbo after submissions.
- Use synthetic monitoring and patient beta programmes before go-live.

Security, Privacy & Trust

- Implement bank grade security (2FA, encryption), transparency dashboards (who accessed my data), and data sharing registers.
- Offer security assurances in writing (plain English data promises), plus privacy “quick wins” (device checks, phishing education).
- Provide a “speak to a clinician/human” flag within digital flows where risk or distress is detected.

Accessibility (Needs & Adjustments)

- Meet WCAG 2.2 AA; test with users who have vision/hearing/cognitive/mobility needs.
- Provide Welsh and community language options; include read aloud, high contrast, and font scaling features.
- Publish accessible help (screen reader guides; BSL/Welsh video explainers; Easy Read).

Integration & Consistency

- Prioritise an All-Wales single front door with shared components (appointments, messaging, results).
- Align GP, hospital, pharmacy pathways; reduce local variation; ensure one medical record view for patients.
- Introduce API-based confirmations so every booking generates consistent, trusted receipts.

Capability & Support

- Fund community delivered training (1to1 coaching, drop ins) with partners (e.g. third sector, libraries, councils).
- Provide a multichannel helpdesk (chat, phone, email) with warm handover to clinical teams when appropriate.
- Create micro-learning: 2-minute task videos, printable crib sheets, and YouTube playlists.

7.1.3 Recommendations for Section 3: Balancing Hospital Care and Community Support

(questions 8,9 and 10)

8. If you could get help quickly to stay well in your community, how would that change how you feel about going to hospital?

Access

- Expand “pharmacy first” services (independent prescribing, minor ailments, structured advice) and promote them as default for nonurgent issues.
- Increase GP appointment flexibility (open access sessions, extended hours, mixed modalities) to reduce ED substitution.
- Scale MIU/SDUC capacity and hours in line with local demand patterns; use Cardigan’s model as an operational exemplar.

Communication

- Publish a simple access map (“A&E is for... MIU is for... GP is for... Pharmacy is for...”) across web, print, and reception triage scripts; test comprehension with seldom heard groups.
- Improve 111 user experience (shorter queues, clearer questions, option to speak to a person sooner).
- Enable cross professional information sharing (e.g. community optometry and hospital clinics) to avoid duplication and missed local management.

Digital

- Offer video/online consultations by default for appropriate cases, with clear guidance and easy fallback to phone/in-person to safeguard inclusion.
- Integrate MIU/SDUC booking and triage into digital front doors, tied to local hub capacity dashboards.

Community Services & Hubs

- Move routine diagnostics (bloods, spirometry, micro-suction) to community sites; publish reliable local schedules to reduce hospital trips.
- Strengthen integrated care centres (e.g., Cardigan; Aberaeron) as multiservice hubs with clear signage and directions.

Discharge, Reablement & Continuity

- Guarantee post discharge support windows (e.g., 48–72 h reablement check ins; targeted liaison) to reduce readmission anxiety.
- Fund and deploy liaison roles (e.g. Learning Disability Liaison, visual impairment awareness) across acute sites; mandate staff training.
- Formalise “home-first” pathways with IV therapy at home and advanced care planning to avoid unnecessary admissions.

Patient Experience & Trust

- Reduce ED waiting time variance via SDUC diversion, robust streaming, and real-time wait communications.
- Create calm rooms for mental health crisis within ED; co-design with local groups.
- Sensory aware environments (lighting, noise, smells) in wards/ED to support visually impaired and ME affected individuals.

Transport & Estates

- Address transport gaps (community vehicles; flexible taxi vouchers; volunteer escorts) for rural and mobility restricted populations.
- Review parking policies and capacity (blue badge enforcement consistency; overflow solutions; clear drop-off points).

Workforce & Capacity

- Increase community nursing presence (district nurse prescribers; targeted visit schedules) and formalise PA/carer support pathways to sustain home-based recovery.

9. What kind of care or support would you like to have nearby so you don't need to go to hospital?

Access

- Establish same day access pathways in hubs for minor illnesses/injuries, staffed by ANPs/prescribing pharmacists; publish local escalation protocols to ED.
- Implement open phlebotomy clinics and extend community diagnostics (portable ultrasound/X-ray pilots), including mobile units across rural towns.
- Replace the "8am rush" with blended online/phone booking, priority routing for frail/complex cases, and weekend opening where demand supports it.

Communication & Coordination

- Deploy pathway navigators for complex cohorts (oncology, paediatrics, learning disability) with a single point of contact and integrated records.
- Institute a "You Said, We Did" quarterly report cycle showing actions taken, linked to Board updates during the strategy refresh.

Digital

- Offer 24/7 advice lines (nurse/clinician led) and remote monitoring for selected conditions; provide digital inclusion support (devices/connectivity) for rural residents.
- Pilot AI assisted triage/selfcare information with strict clinical governance and equitable access measures.

Community Hubs / ICC

- Scale the Cardigan ICC model to other towns (e.g. Aberaeron, Lampeter) with co-located GP, nurse led clinics, diagnostics, pharmacy, and social prescribers.
- Ensure 7-day MIU coverage where feasible, aligning opening times to local demand and transport patterns.

Social Care & Carers

- Expand home support (care packages, district nurse visits), and commission respite services with carer mental health support.

- Integrate rapid reablement and falls prevention services into hubs, with equipment access and practical home safety support.

Transport & Rural Equity

- Introduce arranged community transport (minibus/taxi vouchers, volunteer mileage) to hubs and diagnostics; publish cross-border access guidance for urgent care.
- Coordinate weekend opening and satellite clinics in village halls to reduce long travel times and avoid ambulance default.

Mental Health & Wellbeing

- Provide “human to talk to” capability via walk-in wellbeing clinics, peer groups, and third sector partnerships; ensure crisis team reliability and clear hours.

Condition-Specific

- Commission learning disability nurses for primary/community settings; strengthen paediatric access to prevent escalation.
- Expand palliative/hospice capacity and homebased end-of-life support; publicise eligibility and referral routes.

10. If you had to travel further for specialist care, what could we do to make that journey worthwhile and less stressful?

Access

- Establish a funded patient transport offer with clear eligibility, simple booking, and guaranteed inclusion of carers/escorts where needed.
- Expand community transport partnerships (e.g. Country Cars, Dolen Teifi) with volunteer incentives and service level agreements.
- Introduce park-and-ride hubs with accessible toilets and step free shuttle buses to major sites.
- Pilot taxi voucher schemes and prompt travel reimbursement, with equity based eligibility.

Communication

- Provide clear pre-visit information: maps, entrance locations, parking guidance, and public transport connections, in accessible formats (large print/high contrast).
- Implement real-time notification of clinic/transport changes (SMS/app/phone), with standards on minimum notice.
- Offer onsite navigation volunteers / meet-and-greet, especially for visually impaired and anxious patients.

Digital

- Default to virtual consultations when clinically appropriate (Pre-assessment, quick reviews); create supported digital hubs at community sites for those without devices/connectivity.
- Integrate virtual-first triage with same-day diagnostics scheduling (hybrid model) to reduce repeated travel.

Scheduling

- Prioritise mid-day slots for long-distance travellers; avoid 8 am appointments for commuters travelling more than 1 hour; embed a fair-travel scheduling rule in booking systems.
- Create one-stop clinics and joint clinics where feasible to consolidate multiple tests/consults into a single visit.
- Track and publish punctuality metrics (clinic start, wait times), with improvement actions.

Infrastructure

- Increase disabled parking capacity, reserve slots for those traveling long distances, and implement accessible signage (including high-contrast “yellow” standard).
- Set service standards for hospital transport reliability (on-time pickups, escort inclusion, route knowledge) with escalation pathways for failures.

Continuity & Information

- Prioritise seeing the same specialist/team where possible; avoid recounting medical history; ensure interoperable record sharing across sites/boards and private provider partnerships (e.g., Spa medica).
- Deploy pre-visit orientation options (short videos, photos, step-by-step route guides) for anxiety reduction and familiarity.

7.1.4 Recommendations for Section 4: Clinical Services and Hospital Redevelopment

(question 11)

11. If we secure funding to improve healthcare buildings and facilities, especially at sites most in need of repair – what would you like us to prioritise and what concerns should we work through together as those changes take place?

Access

- Deliver multistorey or decked parking at main acute sites (prioritise GGH, evaluate PPH/BGH/WGH), coupled with time limited priority bays near entrances for breathless/frail patients. Consider park and ride pilots (e.g. Aberystwyth/Bronglais) and staff satellite parking with shuttle (Gwili example).
- Establish/expand MIU capacity in Aberaeron/Cardigan-style community locations with clear hour guarantees to divert minor injuries from A&E.
- Include a site map in appointment letters and launch a digital wayfinding app with indoor colour-coded routes across all hospitals.

Dignity, Safety & IPC (Estates Fabric)

- Immediate toilet investment programme, including Changing Places at PPH and GGH and ambulant toilets across sites; publish an accessibility map per site.

- Targeted IPC rectification: deep clean programmes (vents, clinical rooms); broken showers/equipment backlog clearance with public KPIs.
- Create comfort upgrades: soft seating, temperature control, green/quiet spaces, and family rooms near paediatrics.

Inclusive Communication & Wayfinding

- Standardise colour-coding (learning from Withybush/Bronglais) and refresh signage (including lifts and tactile/contrast standards).
- Accessible information overhaul: large-print leaflets; high contrast design; maps in letters; plain language A&E guidance.

Disability & Neurodiversity

- On-site BSL interpreters and/or on-demand video BSL supported by robust Wi-Fi; staff training for deaf awareness and sight impairment.
- Neurodivergent-friendly zones in A&E and outpatients (low stimulus lighting, quiet rooms, soundproofed consultation spaces).

Urgent & Emergency Care Experience

- Re-zoning of A&E waiting with separate areas for children/mental health/LD alongside a mixed option; provide blankets, water, vending, volunteers as standard.
- Rapid seating upgrades and overspill modular lounges to avoid prolonged chair only waits overnight.

Community Hubs & Step-Down Capacity

- Scale “one stop” community hubs (e.g. Cardigan model) with nurse led chronic care clinics, diagnostics (plain film, phlebotomy), and co-located social prescribing/benefits advice.
- Reintroduce stepdown/ “convalescent” beds in community hospitals (e.g. Llandovery/Tregaron type capacity) to accelerate discharge and patient flow.

Workforce–Infrastructure Fit

- Protect clinical time by expanding admin/clerical functions in clinics and using HCAs for vitals; introduce volunteer navigators in front-of-house.
- Cleaning and portering QA with visible audit boards on wards and outpatient areas (“Matron’s board” style).

Capital Direction & Site Strategy

- Prioritise remedial and modernisation works at Glangwili (outpatients, toilets, front door experience, labs) and Withybush (RAAC/safety, environment, diagnostics), reflecting strong public voice and strategy refresh reality that major new build is >10 years away. Consider modular/rapid build solutions to maintain capacity during works.,
- Publish a risk based capital pipeline (safety → IPC → access → experience), with quarterly public reporting to rebuild trust.

Digital Foundations

- Upgrade Wi-Fi across estates to support BSL video, tele-consult pods in community hubs, and digital wayfinding; adopt accessible design standards for all digital comms.

7.2 Overall recommendations from sections 1,2,3 and 4 and other comments

This section of the report presents the suggested overall recommendations from sections 1,2,3, 4 and other comments.

7.2.1 Overall recommendations from Section 1: Social Model for Health and Well-being (questions 1,2,3 and 4)

Access & Equity

- Establish evening/weekend clinic sessions in local hubs, prioritising preventive checks (flu, health MOTs) and rapid follow-ups.
- Create a discharge adaptation fast-track with same-week ramp/aid installations to prevent delayed returns home.
- Develop ophthalmology and dentistry access programmes, including pooled triage lists and community outreach sessions.

Communication & Experience

- Implement plain-language, accessible letters (large print/audio/digital) and prohibit discouraging phrases; embed a “teach-back” protocol for complex diagnoses.
- Introduce proactive signposting from clinics to local support groups and carers’ networks via standard templates.

Transport & Logistics

- Pilot an NEPTS Optimisation Cell using local dispatchers with AI-assisted scheduling to batch appointments by route/time; publish guaranteed maximum waiting windows.
- Co-fund community minibus microgrants with local authorities/charities to restore transport to health activities.

Workforce & Organisational Confidence

- Launch a “Rural Fellowships” programme for newly qualified clinicians with rotational posts across hubs and incentives (housing/travel support).
- Provide transparent service stability updates to counter rumours and improve local recruitment sentiment.

Integration & Pathways

- Formalise NHS-independent provider feedback loops (e.g., cataract pathways) with shared dashboards and turnarounds.
- Standardise interoperable diagnostics access (optometry/ophthalmology imaging) across settings, reducing duplicate scans and costs.

- Redesign physiotherapy pathways for structured follow-up and escalation, minimising private-pay reliance.

Funding & Sustainability

- Establish a Third-Sector Preventive Commissioning Fund and per-session stipends for community groups hosting health outreach.
- Introduce travel support subsidies (means-tested vouchers) for high-cost journeys to hospital.

Digital & Accessibility

- Roll out multichannel booking and reminders integrated with transport scheduling; ensure WCAG-compliant formats by default.
- Design digital–in-person hybrids (virtual triage + local group sessions) to preserve social contact and reduce isolation.

7.2.2 Overall recommendations from Section 2: Digital Healthcare Support (questions 5,6 and 7)

Access Pathways

- Introduce parallel booking routes: retain telephone lines beyond 8 am; offer callback queuing; enable walk-in/face-to-face triage at set times; maintain paper letter confirmations.
- Make SMS two-way: allow text replies to confirm/change/cancel; auto switch to letter for non-responders.
- Human support hubs: create community-based “access navigators” who assist with appointments and communication preferences.

Communication (Accessibility & Bilingual)

- BSL service standard: publish service-level timelines for BSL video availability on public posts; embed BSL interpreters into key announcements.
- Accessible letters: default large-print, plain English options; audio alternatives; design letters to meet the UK average reading age.
- Bilingual clarity: ensure all Welsh language messages include a clear English access path; avoid long text chains without dates/times.

Digital Inclusion & Choice

- Assistive devices on wards: maintain iPads/laptops for communication, translation, and remote interpreting; provide staff training.
- Preference registry: record BSL/large-print/audio needs and communication channel preferences in EHR; auto apply across services.
- Community digital support: regular “digital surgeries” for those wanting help, without forcing digital adoption.

Connectivity & Resilience

- Rural network partnership: work with local authorities/providers on broadband/signal upgrades; map “not-spots” to prioritise clinics and outreach.
- Hospital Wi-Fi upgrade: minimum bandwidth/availability standards; public reporting of uptime.
- Outage contingency: printed fall-back processes, manual appointment lists, and analogue communication plans (esp. during storms).

Interoperability & Records

- Cross-border data access: implement interoperable solutions (national summary care, consented sharing) to avoid repeating stories across sites/borders.
- One record view: consolidate GP/hospital records where feasible; track preference flags (BSL/format/communication channel).

Accountability & Engagement

- Transparent posting protocols: publish accessibility checks for Facebook/website content, including BSL status and timelines.
- Fair no-show policy: codesign with public, paired with inclusive comms (letters + 2way SMS) and hardship exemptions.

7.2.3 Overall recommendations from Section 3: Balancing Hospital Care and Community Support (questions 8,9 and 10)

Access & Equity

- Publish a unified nonemergency transport eligibility standard (plain language, consistent staff training; SMS/online checker), and introduce reliability SLAs with contingency (community transport/third sector) for late cancellations.
- Place-based clinics for ophthalmology/dermatology triage (GP led minor procedures, teleophthalmology hubs in north/west) to reduce long-distance travel.
- Rural access commitments: targeted capacity for GP/dental access in underserved localities; publish north–south parity metrics in Board papers.

Integration & Pathways

- Single “return to community” clearance protocol (HOPE/physio/GP) with interoperable documentation so patients don’t miss sessions.
- Right place first triage: shared pathways where hospital specialties can redirect to GP provided procedures (dermatology examples), with agreed thresholds.

Workforce & Capacity

- Safe staffing action plans (ward level ratios, escalation rules) and well-being supports for high strain areas; publish monthly staffing safety dashboards.
- Value social care workforce: advocate for fair pay and stability; build micro-carer partnerships (Pembrokeshire model) into integrated networks.

Community & Prevention

- Relaunch Common Ailment Scheme awareness with pharmacy cobranding, local signage, and community demonstrations; include BSL ready resources.
- Expand community hubs/social prescribing visibility (Park Dewi Sant, clusters) via “what’s available near me” finder integrated with NHS site.

Communication & Signposting

- After appointment next steps scripts (e.g., audiology) and inclusive communication standards (visual displays, backup when screens fail; BSL/video relay).
- Positive performance messaging (“we do this really well”) balanced with practical “how to access” guides to influence utilisation behaviours.

Patient Experience & Anxiety

- Transparent wait time communication (A&E and clinics), proactive anxiety support (text prompts, quiet spaces), and transport assurance messaging to reduce no-shows.

Governance & Accountability

- Lean programme governance focused on outcomes (access equity, integration metrics, staffing safety), visible in public Board packs; align with interim Clinical Services Plan for fragile services.

7.2.4 Overall recommendations from Section 4: Clinical Services and Hospital Redevelopment (question 11)

Access & Equity of Care

- Publish and implement a rural “time to care” standard for time critical maternity/paediatrics, with explicit triggers for transfer and escalation; monitor variance across sites.
- Mitigate centralisation impacts by expanding outreach clinics and enhanced transport/escort support for those needing to travel for procedures (e.g., planned c-sections).
- Address immediate accessibility gaps by increasing wheelchair availability and wayfinding aids in long corridor sites (e.g. Bronglais), tracked through estates KPIs.
- Site level facilities review for Withybush, prioritising essential patient facing facilities to reduce perceived inequity and support dignity.

Quality & Experience (Maternity)

- Scale partner inclusion practices (e.g., presence policies, comfort amenities) and capture positive deviance from Glangwili/Bronglais to inform a standard maternity experience bundle.
- Codify midwifery autonomy and confidence within clinical governance narratives and patient information to build trust.

Engagement & Accountability

- Simplify consultation materials: plain language summaries, tiered “read more” layers, and short visual explainers; ensure questionnaires are brief, mobile friendly, and avoid technical jargon.
- Close the loop with a “You said, we did” tracker per locality/service, published after each engagement cycle.

Prevention & Community Health

- Develop low/no cost fitness access in each town (e.g., time limited free referral passes; off-peak concessions for older or clinically referred people).
- Expand adaptive activity offers (seated exercise, supervised circuits, outdoors walking support) to accommodate mobility limitations.
- Embed social prescribing pathways from primary/secondary care into community gyms and clubs, with feedback loops to clinicians.

System Integration

- Formalise inter-board collaboration compacts for specific pathways (maternity emergencies, paediatrics), including mutual aid triggers and shared communication protocols for patients.

7.2.5 Recommendations from other comments (group sessions and events only)

Access to Care

- Implement Multi Channel Booking across all GP practices (phone, email, SMS, web forms, reception), with same day urgent slots and priority routes for disabled patients. Pilot scaling of the “work mobile for Deaf booking” model across practices.
- Reception Standards & Triage Training to remove gatekeeping behaviours; introduce scripts for non-phone access and visual queuing aids.
- A&E Accessibility Protocols: announce arrivals visually/audibly, approach patients (not shout names), and provide clear wayfinding.

Communication & Sensory Inclusion

- Board Level Accessibility: provide live BSL interpretation at Public Board meetings and publish BSL video summaries of engagement outcomes and decisions.

- Interpreter Pathway Policy: Health Board funded interpreters (WITs) by default where needed; remove expectation on patients to book; audit compliance quarterly.
- Plain Language & Clear Masks: adopt plain English (and Welsh) templates; approve clear masks policy where safe; staff guidance on lipread facilitation.

Digital Inclusion & Choice

- Digital by Choice Standard: guarantee *equivalent nondigital routes* for all transactions; expand SMS/email two-way for results, prescriptions, and appointment changes.
- Assisted Digital in Community: partner with third sector to offer supported sessions (repeat, hands-on), recognising older adults' retention challenges; measure uptake vs. preference.

Rurality & Transport Equity

- Transport Reliability Charter: publish service standards (notice periods, contingency, weekend coverage), with escalation routes and voluntary sector coordination; track cancellations and mitigations.
- Pre-visit Information Packs: include transport options, parking, accessibility features (e.g., toilets), and contact points for adjustments.

Service Configuration & Pathways

- Veterans: Identify Record Assist: standardised prompts in GP and hospital reception/EMR; link to third sector support; audit recording rates.
- Dental Access Action Plan: transparent waiting lists, cross provider options (optometry and pharmacy for preventative interfaces), and communications on entitlements/fees.
- Cross Border Records Flow: improve interoperability and clear guidance when moving between England/Wales systems.

Trust, Engagement & Feedback

- Publish "You Said—We Did" (including BSL and Easy Read) with timelines and owners; avoid repeated questioning without visible change; report to Board Jan 2026.,
- Mandatory Sensory & Deaf Awareness Training (baseline modules; device basics like hearing aid batteries; ward posters; champions in each site).

7.3 Recommendations from responses via email and response submitted in writing

This section of the report presents the suggested recommendations arising from the analysis of the responses via email and the response submitted in writing.

Access to Care

- Stabilise Orthopaedics now: Implement interim access plan (e.g., additional lists/sessional capacity, shared care pathways, regional mutual aid) pending Clinical Services Plan decisions; publish wait-time recovery trajectory and quarterly public updates.
- Community diagnostics & clinics: Scale X-ray/haematology/ENT micro suction sessions across community sites on a hub and spoke model, with standardised referral criteria and bookable slots.
- Flow through community beds: Define capacity bands and admission/discharge criteria for community hospitals to relieve acute sites; monitor LOS and readmissions as quality indicators.

Prevention & Rehabilitation

- Physio supported 'Active Recovery' offer: Commission low/no cost community activity schemes (e.g., pool-based programmes with means tested/free access) codesigned with physio leads; embed outcome tracking (pain/function scores, PROMs).
- Healthy living hubs: Co-locate exercise advice, smoking cessation, weight management, and social prescribing within community hubs; integrate with the Social Model for Health programmes.

Integration with Social Care

- Integrated discharge collaboratives: Joint daily 'home first' huddles across hospital/community/social care; shared KPIs (time to package of care, reablement uptake) and public dashboards.

- Reduce administrative load: Pilot 'paperwork lite' pathways and task shifting to admin support for GPs/clinicians; align targets to patient centred outcomes rather than process proxies.

Digital Inclusion & Access

- Assisted digital & multichannel booking: Expand telephone/face-to-face booking alongside NHS Wales App; deploy digital navigators and accessibility features for sensory impairments.
- Connectivity contingencies: Identify rural hot spots; provide community Wi-Fi kiosks or partner venues (libraries, hubs) for telehealth; publish inclusive digital standards.

Transport, Travel & Estates

- Reinstate park-and-ride at Bronglais (pilot): Conduct 6month trial with utilisation and patient experience metrics; evaluate for replication at other pressured sites.
- Volunteer transport enhancement: Partner with third sector to scale driver schemes for frail patients; integrate referral triggers into discharge planning.
- Wayfinding & parking optimisation: Low-cost estates changes (signage, appointment staggering, discharge lounges) to ease flow and A&E backlog, consistent with public suggestions to free up beds.

Community-based Care & Hubs

- Define hub functions & coverage: Standardise what a 'community hub' provides (diagnostics, rehab, healthy living, social care presence) with equitable geographic coverage; publish service maps.
- Coproduction with communities: Use local assets (e.g., repurposed school buildings) for co-located services; adopt community involvement charters and advisory panels.

Workforce Sustainability

- Retention & role redesign: Expand multidisciplinary teams (ANPs, ACPs, first-contact physios, pharmacists) to protect GP time; introduce admin support pools to cut bureaucracy.
- Transparent staffing plans: Publish annual workforce pipeline and stabilisation measures for fragile services, consistent with the strategic refresh narrative.

7.4 Recommendations from individual stakeholder groups

This section of the report presents the suggested recommendations arising from the analysis of feedback from individual stakeholder groups.

7.4.1 Carers

A) Access to Services & Care Pathways

- **Publish a unified “Discharge to Community” standard** covering documentation accepted by community providers (e.g., HOPE), eliminating the need for new GP/physio “clearance” when clinically unnecessary.
- **Introduce a single “Transfer of Care Summary – Community Rehab” template** cosigned by hospital therapy to standardise re-entry to community programmes.
- **Create locality service directories (“What’s on, near me”)** co-produced with community connectors and kept current; host in print, phone, and web formats.
- **Primary/Dental access plan for carers:** identify practices with capacity; trial protected carer appointment slots and proactive recall for carers at risk.

B) Carer Support, Respite & Wellbeing

- **Commission rural micro-respite** (hourly relief) through accredited local providers / volunteers, prioritising remote areas (e.g., Dale Peninsula).
- **Define an urgent “If I can’t cope today” pathway** with a single number, same day triage, and short stay options to prevent crisis admissions.
- **OT and adaptations SLA:** agree response and follow-up times; provide status updates via SMS/calls and a named contact.
- **Leverage community venues** (halls, theatres, leisure centres) for carer wellbeing sessions and discounted access; formalise partnerships (e.g., Torch Theatre, Meads).

C) Digital Inclusion & Choice

- **Adopt alternative ID verification routes** for NHS app/portals (e.g., clinician letter, in-person verification) and enable **carer proxy access** with consent.
- **Codify “Analogue Always Available”:** ensure phone and F2F options remain first-line for specified cohorts (older adults, sensory impairments, dementia).

- **Community digital coaching:** commission partners to deliver 1:1 coaching and device support; provide clear “how to” guides for video/phone consultations.
- **Design longitudinal record views** (e.g., trend graphs for thyroid/diabetes) to make digital tools meaningfully useful to motivated users.

D) Communication, Transparency & Patient Experience

- **Implement call handling improvements** (virtual queue, callback, knowledge base, first-call resolution) across hospital departments; measure time to answer and abandonment.
- **Publish real-time and honest wait information** online and onsite; standardise “what to expect today” scripts in A&E/assessment areas.
- **Environment & accessibility fixes:** wheelchair height digital/physical information boards; quiet spaces; privacy screens, especially in ACUDU and waiting areas.
- **Staff briefing on carer inclusive communication** (frequent updates; encouraging questions; named point of contact during long waits).

E) Travel, Transport & Rurality

- **Stabilise nonemergency patient transport:** set on time reliability KPIs; escalate and investigate cancellations; offer **contingency travel vouchers** when cancellations occur within 24 hours.
- **Community transport partnerships:** coordinate volunteer driver schemes and accessible vehicle hire; advertise through local directories.
- **Bring care closer** where safe: rotate outreach clinics/diagnostics in high travel time localities (Fishguard, St Davids, Dale Peninsula).

F) Children & Young People (CYP) and Paediatrics

- **Create dedicated paediatric triage and waiting areas** within A&E/urgent care to ensure dignity and safeguarding; review streaming to minimise CYP exposure to distressing environments.
- **Clarify paediatric service model for Pembrokeshire** (what is/will be available at WGH; clear pathways for emergencies/electives), with public facing FAQs.

G) Estate Condition & Environment of Care

- **Prioritise critical fabric issues** (e.g., WGH roof) within capital maintenance plans and communicate timelines publicly.
- **Dementia-friendly design adjustments** (lighting, noise control, signage, zoning) in A&E/assessment areas; codesign with carers.
- **Accessibility audits** for information boards, seating, and wayfinding; implement low-cost fixes rapidly and track completion.

7.4.2 General public

A) Access

- **Establish a Single Point of Access (SPA)** for GP-led and community services, with clear triage and pathways (including walk-in centre scope).
- **Extend operating hours** for high demand community services (e.g., physiotherapy, wellness clinics) to smooth demand and reduce pressure on urgent care.
- **Optimise use of community hospitals/hubs** (e.g., South Pembrokeshire Hospital; ICC-type models) with defined service menus and capacity plans.

B) Communication

- **Publish a bilingual, local service directory** (“Where to go and when”), clarifying eligibility (e.g., common ailments scheme) and access routes to reduce unnecessary travel.
- **Standardise reception and call handling protocols**, including escalation steps and behaviour standards; monitor through experience reporting.
- **Proactive public information on walk-in centres** (e.g., Tenby) and community services, using multiple channels (web, SMS, posters, primary care).

C) Digital

- **Mandate cross service digital reminders (SMS/email)** with optout and language preference; audit compliance quarterly.
- **Embed accessibility by design** (sensory impairments, low digital confidence) and ensure **assisted digital/telephone alternatives** are always available.
- **Leverage the NHS Wales app** as the integrated front door for information, booking and results, with phased roll-out and local support.

D) Transport & Parking

- **Conduct site-level parking audits** to expand disabled bays, improve signage, and test **park-and-ride pilots** where feasible.
- **Expand/coordinate volunteer driver schemes** and publish travel support information within appointment communications.

E) Social Care & Prevention

- **Joint discharge and community support planning** with local authorities/third sector to reduce bed blocking (carer support, rapid reablement).
- **Commission targeted prevention clinics** (e.g., falls, MSK) in hubs with extended hours to pre-empt escalation to hospital care.

F) Service Quality & Experience

- **Frontend experience standards** for reception/telephony; incorporate training, mystery shopping and real-time feedback loops within the **Integrated Experience Reporting** approach.
- **Rapid re-booking pathways** after missed appointments to minimise lost capacity and frustration.

G) Veterans

- **Introduce a standard veterans' prompt** at GP and hospital reception (“Have you served?”) and **record status** consistently in clinical systems.
- **Create a referral workflow to third sector partners** and promote e-learning for staff (e.g., Age Cymru Dyfed resources) to improve awareness and outcomes.

H) Appointments & DNAs

- **Implement a unified DNA reduction framework** (multichannel reminders, easy self-service rebooking, communication of consequences).
- **Undertake an equality impact assessment** before considering any **charging for DNAs**, to avoid unintended harm to vulnerable groups.

I) Estates (Interim)

- **Prioritise quick win estates improvements** that reduce stress and improve flow (parking, waiting areas, signage) while longer-term decisions progress via the Clinical Services Plan.

7.4.3 Health Board staff

A) Access & Capacity

- **Expand community diagnostics and procedures:** Reinstate minor skin procedures in GP/community settings; extend community phlebotomy (incl. GP surgeries and hubs); establish targeted x-ray/ultrasound sessions in rural community sites where feasible.
- **Primary care access improvement package:** Pilot same day/urgent access models (phone, online, walk-in triage) with clear KPIs; publish weekly appointment availability dashboards to increase transparency.
- **Integrated Community Networks (ICNs):** Accelerate ICN rollout focusing on early intervention, frailty pathways, and rapid support to avoid hospital admission.

B) Transport & Travel (Rural Equity)

- **Rural transport support scheme:** Scale volunteer driver programmes; commission scheduled shuttle services linking key towns to hospital sites; coordinate appointment clustering to minimise trips.
- **Travel assurance for specialist care:** Publish route maps, parking options, and on-site wayfinding; offer travel booking support (including escorts for vulnerable patients) for designated specialties.
- **Locality impact statements:** For any service changes, provide plain language travel/impact summaries with mitigations before decisions are implemented.

C) Digital Inclusion & Confidence

- **Assisted digital and coaching:** Deploy “Digital Health Coaches” in hospitals and community hubs; provide drop-in tuition on the NHS Wales App and local services (bilingual, accessible).
- **Maintain choice:** Guarantee equivalently easy nondigital access (phone, in-person) for all key transactions; monitor uptake and satisfaction by age/disability group.
- **Usability standards:** Implement a design checklist (simplicity, bilingual content, accessibility for sensory impairments), with periodic user testing in rural communities.

D) Estates, Infrastructure & Site Experience

- **Parking optimisation:** Extend staff parking partnerships (build on Gwili Railway model); ringfence closest car parks for patients; review enforcement and ticketing policy during peak pressure periods.
- **Toilet and comfort upgrades:** Launch a rapid refurbishment programme for public/staff toilets at GGH and PPH with clear timelines; address ventilation/thermal comfort issues (e.g., MAU window/air-conditioning review).
- **Wayfinding and access:** Improve signage, drop-off points, and accessible routes; publish site maps (print and digital) in Welsh and English.

E) Financial Sustainability & Service Model Choices

- **Transparent options appraisal:** Link any consolidation or service re-location to quality, safety, and equity outcomes; publish criteria and evidence, aligned to the Clinical Services Plan.
- **Medium-term resilience actions:** Prioritise fragile specialties for interim redesign (e.g., dermatology, orthopaedics, radiology) ahead of the new hospital timeline; communicate clearly why changes are needed now.
- **Public dialogue on trade-offs:** Continue structured engagement explaining costs, benefits, and mitigations—reiterate that core NHS services remain free at point of use and clarify positions on any suggestions of copayment.

7.4.4 LGBTQ+ communities

A) Access & Continuity of Care

- **Establish Rural Community Health Hubs** with same day access (nurse/GP/paramedic practitioners), minor illness/injury, and social prescribing, co-located with pharmacy/dispensing where feasible.
- **Create a Cross-Practice Care Navigation Standard** (scripts + staff training) to reduce callback cycles and ensure continuity for complex/older LGBTQ+ patients.
- **Introduce “Rapid Review Slots”** reserved for results/medication issues to prevent backlog and patient chasing.

B) Digital Healthcare Support

- **Adopt a “Hybrid by Default” Model:** Digital first when suitable, with guaranteed face-to-face fallback; publish clear criteria (e.g., dermatology lesion assessments requiring in-person).

- **Implement Proactive SMS/Push Notifications** for mobile clinic locations and appointment prompts; align with NHS Wales app as single sign on/front door.
- **Run Coproduction Usability Sprints** with LGBTQ+ older adults to simplify journeys (find/book/results), including bilingual accessibility and sensory friendly formats.

C) Travel & Rurality

- **Commission a Volunteer Driver Network Expansion** (cost recovery mileage, safeguarding, LGBTQ+ sensitive training) to support isolated patients attending appointments.
- **Deploy Scheduled Mobile Health Services** (phlebotomy, vaccination, medications collection) to priority rural areas based on travel gap analysis.
- **Provide Pre-Travel Information Packs** (maps, timing, site contact, what to expect) for redirected specialist care.

D) Clinical Services & Estate Redevelopment

- **Publish an Interim Estate Upgrade Plan** for capacity/safety at high-pressure sites (e.g. Bronglais), with metrics on patient flow, waiting areas, accessibility, and staff facilities.
- **Implement a “Hub-and-Spoke” Model** linking hubs to specialist centres to manage demand and maintain familiarity for routine care; monitor impact via KPIs (ED attendances, ambulance waits, travel time).
- **Transparent Prioritisation Matrix** for capital decisions reflecting rurality, fragility, and patient experience.

E) Equity, Inclusion & Cultural Safety

- **Mandate LGBTQ+ Cultural Safety Training** for staff using rainbow identifiers; verify completion (badge/QR code linking to training status).
- **Appoint Named LGBTQ+ Care Navigators** (per locality) to support gender affirming care continuity, and advocacy during transitions/disruptions.
- **Co-design Inclusive Communication Standards** (respectful language, partner recognition, privacy) and embed in staff appraisal and patient feedback loops.

F) Information Sharing, Prescribing & Pharmacy Reliability

- **Implement Cross Border Electronic Transfer Protocols** for repeat prescriptions and care summaries (England ↔ Wales), with timebound acceptance SLAs.
- **Develop a Pharmacy Resilience Framework** (locum pool, continuity contracts, escalation triggers) and publish real-time status/opening information via app/SMS.
- **Automate Results Communication** (SMS/portal alerts) with “no surprises” callbacks for abnormal results within defined timeframes; audit compliance.

G) Communication Quality & Patient Experience

- **Introduce “Always Events” in Consultations:** clinician reviews key notes; confirms reason for appointment; agrees next steps and timelines; provides contact route for queries.
- **Standardise Courtesy & Professionalism Micro skills** (empathy scripts, reflective listening) via regular coaching and patient stories (including LGBTQ+ experiences).

- **Review Administrative Charge Policies** (e.g., letters) and publish a fair use schedule to avoid inequitable barriers.

7.4.5 Mothers / Parents

A) Access & Urgent Care

- **Expand Community Minor Injury/Outpatient Capacity:** Increase bookable slots at Cardigan style centres and pilot additional capacity in Aberaeron/ Lampeter catchments to reduce A&E demand.
- **Appointment Flow Optimization for Travellers:** Implement “sequenced pathways” (pre-visit diagnostics, tight time windows) for patients traveling long distances to minimize dwell time.
- **Transport Alignment & Support:** Coordinate clinic schedules with public transport timetables; explore volunteer driver expansion and targeted travel support for families with infants.
- **Ambulance/OOH Escalation Protocols:** Strengthen community escalation routes to avoid prolonged waits for non-life-threatening injuries, with pharmacy and GP urgent care pathways.

B) Primary Care & Health Visiting

- **Co-located GP/HV Drop-ins in Family Centres:** Regular, predictable sessions (including telephone/video slots) embedded in sites like Tregaron and Llanybydder to improve continuity and access.
- **HV Continuity & Reliability Standards:** Assign named HVs for perinatal families and set service reliability KPIs (e.g., attendance at scheduled walks/clinics).
- **Holistic GP Reviews:** Pilot integrated, multi-issue consultations for complex family cases, reducing “single condition” fragmentation.
- **Working Parent Timetabling:** Offer early/late clinic slots and rapid callbacks to accommodate employment constraints.

C) Community Well-being & Prevention

- **Fund Creche Enabled Exercise & Parenting Programmes:** Commission low/no cost offers through Integrated Community Networks and trusted providers (Family Centres, Cylch Ti a Fi).
- **Microgrants to Local Groups:** Support volunteer led initiatives (e.g., popup cafés, mental health peer support, outdoor activity clubs) that build resilience and reduce isolation.
- **Structured Signposting from Primary Care:** Formalize GP/pharmacy referral pathways to community programmes and track uptake/outcomes.
- **Childcare Access (incl. Welsh medium):** Work with local partners to grow childminder capacity as a mental health enabling factor for parents returning to work.

D) Digital Health & Information Sharing

- **Unified “Digital Front Door”:** Accelerate NHS Wales App enhancements to include multi-department bookings, document upload, and messaging with response SLAs—kept simple and bilingual.
- **Cross Border Interoperability:** Implement data sharing protocols to access English records for new arrivals; reduce “one NHS” confusion at point of care.
- **Assisted Video Clinics:** Provide in hospital/ICC video suites with a nurse present for sensitive consultations (e.g., cancer discussions) to ensure support and comprehension.
- **Digital Inclusion:** Offer basic digital confidence training and alternative nondigital routes for older adults and low connectivity areas.
- **Maintain Local Safe Footprints:** Stabilize key maternity/ paediatric services where travel burdens are greatest (e.g., WGH), within clinical safety constraints, aligning with interim Clinical Services Plan.
- **Streamline out of hours Paediatric Referral Pathways:** Standardize and communicate transfer processes to avoid unnecessary A&E waits.
- **Breastfeeding Specialist Outreach:** Prioritize home/outreach services for complex cases (e.g., premature twins; post-C-section), reducing the need for clinic attendance when exhausted.
- **Family-Friendly Scheduling & Parking Support:** Align appointment times to nap/school runs; consider short stay priority parking near paediatrics/ maternity entrances.

F) Dental Access

- **Mobile Dental Provision:** Reinstate/expand dental vans in rural communities to address backlog and travel burdens.
- **Digital Integration:** Incorporate dental bookings/status into the NHS Wales App; reduce reliance on separate portals/111 call-backs.
- **Targeted Commissioning:** Procure additional NHS capacity (including paediatric/orthodontic sessions) in high-pressure localities.

G) Estate, Facilities & Parking

- **Targeted Primary Care Estate Upgrades:** Prioritize safety critical refurbishments (e.g., Tregaron GP equipment/rooms) and supply chain/storage improvements in hospitals.
- **Parking & Flow:** Implement park-and-ride (e.g. Bronglais), expand short stay bays for urgent drop-offs, and redesign A&E flow to reduce crowding.
- **Community Outpatient Expansion:** Increase capacity at community hospitals (e.g., Tregaron) to reduce travel and parking stress at main sites.

7.4.6 Older people

A) Access to Care

- **Reinstate/standardise proactive “annual health checks” (MOTs)** in primary care for older adults and those with long-term conditions, with clear eligibility and invite process.
- **Expand community hub capacity** (e.g., Integrated Care Centres, Tenby Hospital, South Pembrokeshire Hospital) to deliver “one stop” visits (bloods/BP, basic tests, social prescribing, signposting).

- **Increase community nursing and nurse prescriber access** within GP practices; establish more home visits for housebound or rural patients.
- **Publish local service maps/directories** (physical and online) to help residents find groups and services (Warm Hubs, exercise referral, Age Cymru, etc.).

B) Transport & Travel

- **Clarify NEPTS eligibility and processes** for specific specialties (e.g., ophthalmology), publish consistent criteria, and provide a single point of contact for patient transport queries.
- **Introduce “Travel aware Scheduling”**: align appointment slots with local transport timetables; flag and avoid 9am slots where no buses operate; pilot a local “travel coordinator/fleet manager” role.
- **Co-fund and expand community transport schemes** (Country Cars model) with volunteer incentives; communicate availability widely via GP, pharmacy, and hub networks.
- **Offer bundled appointments** (multiple tests in one visit) for those travelling long distances to reduce repeat journeys.

C) Digital Inclusion & Choice

- **Adopt a formal “Digital by Default but Not Digital Only” policy**: always retain phone/letter and face-to-face routes; avoid penalising nondigital users.
- **Improve bilingual, accessible communications**: ensure invites/reminders are available in both Welsh and English; provide alternative formats where needed.
- **Scale assisted digital support in hubs** (regular drop-ins with Age Cymru/partners); provide simple, supported pathways for GP online booking where desired.
- **Audit connectivity gaps** and explore device/connection support for those in “not spots,” signposting to libraries/hubs as interim access points.

D) Communication, Coordination & Pathways

- **Create unified pathway guides** (dementia, physio, ophthalmology, dental emergency) for patients and staff; circulate via surgeries, pharmacies, and hubs.
- **Strengthen cross site information sharing** to reduce repetition and improve continuity, including optometry–ophthalmology links.
- **GP surgery awareness campaigns**: display dementia prompts and early diagnosis messages prominently; support clinicians to initiate sensitive conversations opportunistically.
- **Proactively promote ICC services** (e.g., Cardigan) with better signage, directions, and local marketing.

E) Acute Care Experience, Capacity & Rehab

- **ED flow improvement programme** focusing on queue management, observation spaces and communication; share progress publicly to build confidence.
- **Invest in community rehabilitation**: expand physio access post discharge (homebased and hub classes), create falls clinics including Tai Chi/balance training.
- **Enable “exercise referral” locally** (e.g., Tenby) with concessions for older adults, reducing costs cited as barriers.

F) Estate, Wayfinding & Amenities

- **Prioritise parking solutions** (including multistorey where feasible) at main hospitals; introduce concessions for long treatments; review blue badge compliance and enforcement sensitivity.
- **Improve wayfinding** (consistent, colour-coded standards, clearer internal/external signage) and site maps, highlighting accessible routes and drop-off points.
- **Upgrade amenities**: ensure accessible toilets, comfortable seating in waiting areas, and refreshments (e.g., vending in ED).
- **Extend services at community sites** (Tenby Cottage Hospital, South Pembrokeshire Hospital) to reduce travel burden.

G) Social Model & Community Assets

- **Commission and fund community connectors and group outreach**, including regular “health & wellbeing days” at existing groups (Friendship Groups, Ray Ceredigion, People Speak Up).
- **Co-fund local transport for group access** (e.g., minibus support) to tackle isolation and enable prevention activities.
- **Maintain a living directory** of community groups and third sector services, managed with partners, available in print and online.

H) Dementia & Carer Support

- **Introduce community-based dementia clinics within hubs**, integrating Admiral Nurses/Age Cymru advice and carer navigation (including direct payments guidance).
- **Primary care prompts & training** to support earlier referral and open conversations about cognitive concerns.
- **Improve discharge planning and carer communication**, including simple tools like patient diaries for families of those with complex needs.

I) Dental Access

- **Strengthen NHS dental commissioning** in underserved rural areas; explore mobile/community dental sessions and clearer urgent care routes.
- **Promote oral health prevention** via hubs and pharmacies, linking dental access to broader cardiovascular health messaging.

7.4.7 Pan-disability

A) Access & Inclusion (Physical Environment and Facilities)

- **Install and certify Changing Places toilets** at GGH, PPH and ensure provision at Bronglais; integrate BS 8300-2 design and publish site maps showing locations and equipment.
- **Reconfigure disabled parking**: increase, re-site and enforce proximity blue badge bays; publish parking guidance and eligibility for reimbursements where applicable.
- **Ensure mobility support availability**: increase wheelchair stock and wayfinding for long corridors (Bronglais); audit entrances, lifts and waiting areas for barrier free routes.

- **Design sensory/quiet rooms** in new and refurbished sites (e.g., Pentre Awel) for children with complex needs; coproduce operating policies with parent forums.

B) Primary & Community Care Access

- **Flexible access windows:** replace single 8am phone bottlenecks with call-back queues and staggered booking times; maintain human agents with minimal IVR scripting.
- **Continuity clinics:** create named clinician lists for paediatrics and complex multimorbidity; reduce locum reliance via pooled sessions and structured handover templates.
- **Longer appointments for complexity:** commission extended GP slots for neuro-developmental/ complex paediatrics and dementia assessments; monitor outcomes via QI cycles.
- **Community based minor procedures:** accredit additional GPs for dermatology procedures to avoid distant referrals when clinically appropriate.

C) Digital Healthcare (Inclusive by Design, Interoperability, Choice)

- **Define digital appropriateness criteria** (e.g., stable conditions; no requirement for behavioural observation) and embed **choice** for face-to-face. Communicate through patient letters/SMS.
- **Advance records interoperability** to deliver an “**All Wales**” view for clinicians across settings; reduce the need for families to carry paper records, aligned to the integrated model in the strategy.
- **Accessibility first:** bilingual interfaces, large-print/audio options, captions, and simplified IVR; publish digital confidence sessions via community hubs.

D) Travel & Transport

- **One stop clinics:** schedule combined specialties (e.g., paediatrics + therapies + diagnostics) and consolidate multiple tests per visit to justify long travel.
- **Outreach/mobile services:** extend specialty outreach to rural hubs (e.g., Cardigan, Tregaron) on set days; coordinate with patient transport to these clinics.
- **Transport support signposting:** enhance web and appointment letters with clear guidance to hospital transport, volunteer driver schemes, and reimbursement routes.

E) Community Wellbeing & Social Model

- **Commission respite for complex needs carers** (children and adults); extend daycentre hours beyond 3–4pm to support working families and crisis prevention.
- **Microgrant programme:** fund peer-led groups (e.g., coffee mornings, autism centres) with simple application processes; track participation and wellbeing outcomes.
- **Inclusive leisure and parks:** partner with local authorities to audit and upgrade accessible play/leisure (ramps, swings, hoists) and publish accessibility information.

F) Clinical Services & Estate Redevelopment

- **Transparent service change plans:** publish site-specific FAQs, clear timelines, and continuity measures for Cardigan, Tregaron, Llandovery, and other community sites; link to Clinical Services Plan communications.

- **Meaningful refurbishment:** prioritise functional upgrades (equipment, clinic layouts, access routes) over cosmetic changes; set and report on accessibility KPIs for each project.
- **Pharmacy capacity:** review Aberystwyth pharmacy access, queue times and stock issues; explore extended hours and collaboration with community pharmacy networks.

G) Mental Health & Long-term Conditions

- **Expand psychological therapy capacity** and session length; publish waiting time dashboards and early intervention offers (guided self-help, digital CBT options with human support available).
- **Improve physical accessibility** of mental health sites (e.g., relocate clinics from upper floors where egress is a safety concern; add safe evacuation planning for lift users).
- **Update and publish ME/CFS & Long COVID pathways**, including referral criteria, service locations, and self-management resources; involve patient groups in pathway design.
- **Primary care quality focus for women's health** (diagnostic vigilance for GI/gynaecological malignancy red flags), with audit/learning loops.

7.4.8 Partner organisations

A) Social Model & Prevention

- **Map community assets systematically:** Deliver a **mini audit/asset register** (who/what/when/where/how) across Carmarthenshire, Ceredigion, Pembrokeshire, starting with known partners (PAVS, CAVS, CAVO; Warm Hubs; micro-care enterprises).
- **Formalise joint governance:** Establish a cross-sector **Prevention & Wellbeing Board** to align funding streams, outcomes, and accountability; adopt shared measures that reflect the strategy's resilient communities vision.
- **Scale social prescribing & community hubs:** Expand connectors, hubs (e.g., Park Dewi Sant), and cluster-based prevention programmes with clear public navigation and referral routes.

B) Digital Healthcare Support

- **Community led digital inclusion:** Commission **local training** through Age Cymru Dyfed, PLANED and libraries; embed "digital buddies" in hubs; provide device loan schemes and connectivity advice.
- **Maximise NHS Wales App rollout:** Partner with Welsh Government/DHCW to accelerate **waiting list tracking, appointment viewing, secure messaging, proxy access**, and bilingual UX; publicise **Welsh Identity Verification Service** for non-ID users.
- **Improve interoperability:** Prioritise frontline access to records across sites and sectors; reduce "tell your story repeatedly" via integration workstreams and shared care records.
- **Assure on safety & emergencies:** Publish a **999/BT digital switch** contingency note for patients/carers; maintain nondigital channels (phone/in-person).

C) Access & Transport

- **Transport support package:** Codesign with councils/third sector an **enhanced volunteer driver scheme**, appointment aligned bus links, and travel bursaries for eligible patients.
- **Local rapid support:** Expand **same day community access** (urgent care pathways, home visiting, remote monitoring) to reduce avoidable hospital trips.
- **Simplify navigation:** Launch a **single front door** (digital/phone/in-person) with clear directories of services and “how to get help” guides per locality.

D) Communication & Engagement

- **Accessible materials at scale:** Produce and proactively distribute **Easy Read**, Welsh/English, and other language versions; share slide decks publicly after events.
- **Broaden reach beyond usual forums:** Target outreach to **Stackpole Gardens, Clynfyw** and workplaces/schools; use pop-ups in town centres and community venues.
- **Transparent feedback loop:** Publish a “**You said, we did**” tracker and timelines; explain how responses inform Board decisions (Jan 2026 report).

E) Clinical Services & Estate Redevelopment

- **Integrated roadmap:** Publish a **consolidated timeline** showing strategy refresh → consultation report (Jan 2026) → decisions (Feb 2026) and how medium-term **Clinical Services Plan** stabilisation dovetails with longer-term estate changes.
- **Interim estate & workforce actions:** Identify priority site upgrades to address safety/condition; set out workforce resilience plans aligned to service consolidation where required.
- **Public clarity on interdependencies:** Communicate clearly how clinical fragilities, service redesign, and capital timelines interact, acknowledging the decade-plus horizon for any new hospital and the need to act now.

7.4.9 People with learning disabilities

A. Access to Primary & Community Care

- **Create Priority Access Pathways for Disabled and Communication Support Needs.** Pilot a dedicated “disability line/slot” and reasonable adjustments flag in GP systems; enable face-to-face booking at community venues. Track DNAs and experience metrics by adjustment type.
- **Expand Community Nursing & Domiciliary Phlebotomy.** Commission home blood tests for anxious or housebound patients; set response SLAs for community nurse visits.
- **Scale Community Diagnostics & Nurse Led Clinics.** Add spirometry, phlebotomy, wound care, diabetic foot checks, and women’s health procedures to PCN hubs to reduce outpatient demand.
- **Primary Care Improvement Package.** Address “single question” consultations by offering extended slots for complex needs; publish access standards and practice level performance dashboards.

B. Transport, Travel & Rurality

- **Accessible Shuttle Pilots.** Trial scheduled, wheelchair accessible minibuses from rural pickup points to hospitals on high-volume clinic days (e.g., dermatology, imaging). Evaluate load factor and patient stress scores.
- **Appointment Time Protocols.** Default out-of-area appointments to post10:00 for long-distance travellers; add school run sensitivity flags. Embed in PAS templates.
- **Travel Information Pack.** With every appointment: map, parking info, walking time, public transport options, shuttle eligibility, and expense/PTS criteria.

C. Digital Inclusion & Choice

- **“Digital with a Human” Standard.** Offer SMS reminders and video consults but guarantee a human route at all steps (no AI/IVR lock in). Publish a service charter covering digital choice.
- **Assisted Digital Coaching.** Fund one-to-one support at libraries/leisure centres/People First venues; produce short, bilingual, easy read guides; limit online forms to concise, Yes/No pathways.
- **NHS App Enablement.** Prioritise high value features (appointments, results, advice) and promote trusted source browsing heuristics (e.g., "use NHS first").

D. Communication & Wayfinding

- **Accessible Letter Standard.** Shorten letters; include visual summaries (“what to bring/expect”), maps, QR code to a 2-minute video, and contact photo board for clinics.
- **Wayfinding Upgrades.** Extend colour coded routes; improve signage consistency across sites; align with accessibility audit insights (e.g., with Llais partners).
- **Respectful Communication Training.** Target reception and call handling teams to reduce reports of rudeness and improve understanding for speech/communication difficulties.

E. Learning Disability (LD) & Accessibility

- **LD Liaison Nurse Coverage.** Commission LD liaison presence in acute sites and primary care networks; publish coverage and referral criteria; co-produce reasonable adjustments policy.
- **Pre-Visit Familiarisation.** Offer optional virtual tours and in-person walkthroughs for high-anxiety procedures (MRI), with preparatory visuals (mask, sounds). Track uptake and DNA reduction.
- **Boost Annual LD Health Checks.** Proactive recall with accessible communications; link to social prescribing offers for ongoing support.

F. Pharmacy & Dentistry

- **Pharmacy Services Directory & Certification Alignment.** Publish an easy read directory of what each pharmacy can do (e.g., Common Ailment Scheme, dental PGD availability). Work with contractors to standardise offer and hours.
- **Dental Access Plan.** Map NHS capacity gaps; commission targeted sessions; provide travel support for complex/safeguarding cases until local access improves; communicate re-registration rules.

G. Community Assets & Prevention

- **Invest in Wellbeing Hubs & Social Prescribing.** Formalise referral pathways to clubs, leisure centres, arts, and People First activities; add community dietetics and group education (weight management, cooking).
- **Personal Assistant/Carer Enablement.** Small-grants or brokerage to help people plan and attend activities (transport costs, PA hours).

H. Hospital Estate, Configuration & Confidence

- **Mobile Diagnostics & Outreach.** Expand mobile units (cancer screening, bone density) at accessible locations; publish schedules well in advance.
- **Transparent, Time lined Updates.** Link site changes (e.g., Withybush and South Pembrokeshire hospitals service profiles) to the Strategy Refresh and Clinical Services Plan milestones in Board papers and web updates.
- **Strengthen Staff Voice & Follow Through.** Create rapid resolution loops for staff-raised issues so “small things” don’t escalate; publish monthly “you said, we did” logs.

7.4.10 People with mental health conditions

A) Community & Social Model

- **Establish/strengthen local community hubs** with multidisciplinary clinics and wellbeing activities, prioritising accessibility upgrades (e.g., stair lift funding) for venues in villages lacking centres (e.g. Pwll).
- **Create a micro-grants programme** to sustain small clubs (gardening, Tai Chi, sewing, WI/Women’s Shed) that reduce isolation and promote healthy living.
- **Expand community connector roles** and targeted information campaigns for older adults to improve awareness and uptake of local activities. [

B) Digital Inclusion & Choice

- **Maintain multichannel access parity** (letters, telephone, face-to-face) alongside digital options to avoid excluding those without devices, skills, or connectivity.
- **Commission bilingual digital skills training and supported access**, delivered via community hubs and partners (e.g., Delta Wellbeing TEC support) including device loan schemes and assisted app setup.
- **Accelerate interoperability** across GP–hospital–HB systems to enable seamless records access and reduce duplication for patients and staff.

C) Access to Primary & Community Care

- **Increase same day/urgent access routes** (e.g., care navigation, eConsult/phone triage parity, extended hours) and **review 8am call bottlenecks** to improve fairness.
- **Scale home-visiting capacity** (GP and multidisciplinary community teams) for frail/housebound patients, supported by TEC remote monitoring.
- **Expand step-up/stepdown and hospice capacity**, including convalescence beds and Ty Bryngwyn hospice beds, to relieve acute hospitals and improve end-of-life support.

- **Embed community rehabilitation** (e.g., at facilities like Pilipala/Mynydd Mawr) with clear referral pathways and wraparound carer support.

D) Transport, Travel & Site Access

- **Introduce/scale transport assistance schemes** (subsidised travel, volunteer driver networks, clearer travel info) for those attending distant specialist services.
- **Improve parking capacity and flow** at constrained sites—consider **multistorey parking at GGH**—and align bus connectivity with clinic schedules.
- **Consolidate ambulatory clinics in local hubs** (e.g., Pentre Awel) and increase use of virtual consultations where clinically appropriate to reduce travel burden.

E) Communication & Engagement

- **Redesign public materials** into plain language, bilingual summaries with visuals; create “quick read” versions of consultations and surveys to broaden participation.
- **Establish ward communication standards** (e.g., daily “open hour” phone slots) to enable families to speak to the ward sister or designated lead without formal appointments.
- **Provide proactive waitlist updates** (SMS/email/letters) showing current position, expected timeframes, and escalation routes for deterioration.

F) Capacity, Waiting Times & Equity

- **Target capacity uplifts** in fragile, high wait specialties (e.g., Ophthalmology) through protected community clinic sessions, extended hours, and productivity support (e.g., pooling lists, consistent triage).
- **Deploy community settings like Pentre Awel** to host therapy and diagnostics closer to home, reducing acute pressures and travel.
- **Publish transparent performance dashboards** (by specialty/site) to build trust and inform choices, aligned to the Strategy Refresh timeline to Board (Jan 2026).
- **Implement equity impact checks** on access changes (digital shifts, booking rules) to avoid disadvantaging older and lower income residents.

7.4.11 People with physical disabilities

A) Access & Transport

- **Establish satellite limb services (ALAC) within Hywel Dda** (e.g., sessional clinics in Carmarthenshire/Ceredigion), prioritising routine adjustments and repairs locally; retain escalation to Swansea for complex cases.
- **Publish a consolidated transport offer:** routes, eligibility, escort policies, and booking timelines; strengthen volunteer driver and non-emergency transport coordination with clear SLAs to reduce cancellations and long road times.
- **Implement accessibility standards and audits** across all patient facing sites (parking bay width, ramp gradients, door widths, signage, toilets with appropriate handrails and space for prosthetic removal). Report compliance and timelines publicly.
- **Extend hours of key community facilities (e.g., ICCs)** where feasible, and communicate opening times clearly to reduce unnecessary A&E attendances.

B) Community & Third Sector Partnership (Social Model)

- **Introduce micro-commissioning/SLA frameworks** for high-impact community organisations (e.g., HOPE MS, accessible walking groups), with outcome measures (reduced hospital attendances, wellbeing scores).
- **Create a “Community Wellbeing Partner List”** integrated into primary care referral systems, enabling clinicians to signpost to local activities, warm spaces, carers’ support, and condition specific groups.
- **Fund carer support packages** (training, respite, benefits advice) and recognise carers explicitly within care plans.

C) Digital Inclusion & Confidence

- **Deliver local “Digital Health Coach” sessions** through libraries/third-sector venues, covering video appointments, NHS app functions, data privacy, and accessibility features; include bilingual materials and large-print/audio options.
- **Maintain multichannel access** (letters, phone, in-person) alongside digital; improve practice telephony (callback queues, staff prompts to assess digital confidence).
- **Prioritise clinically appropriate video clinics** (e.g., follow-ups where examination is limited), while clearly excluding services needing in-person gait assessment or prosthetic fitting.
- **Advocate for rural connectivity improvements** with local partners; publish contingency plans for power or connectivity failures during digital appointments.

D) Primary Care, Pharmacy & Community Diagnostics

- **Scale pharmacy independent prescribing and minor ailments pathways**, promote local examples (Clunderwen/Neyland), and publish the scope of services in patient friendly formats.
- **Pilot community diagnostics/mobile units** (bloods, vaccines, simple imaging where feasible) in rural locations on set timetables and evaluate impact on A&E and travel.
- **Improve 111 usability and navigation support**, including scripts that recognise digital limitations and offer human assistance early in the pathway.

E) Rehabilitation, Case Coordination & Holistic Pathways

- **Introduce condition specific case coordinators** (starting with amputees) to provide a single point of contact across hospitals, prosthetics, physio, mental health, and transport.
- **Commission rapid adjustment prosthetic sessions** locally (popup/sessional) to reduce repeat travel and prevent mobility loss; track turnaround times and avoid multiweek delays.
- **Partner with local gyms and leisure centres** to create adapted exercise programmes (wheelchair basketball, archery, indoor bowls, adapted cycling), with referral criteria and concessions for disability and low income.
- **Strengthen multidisciplinary rehab in community settings** (physio, OT, speech & language, dietetics), linked to carers’ support and mental health.

F) Estates, Cleanliness & Redevelopment

- **Prioritise refurbishment and cleanliness standards** at existing sites (e.g., Withybush, Glangwili), with public dashboards on RAAC remediation progress, cleanliness audits, and imaging adjacency improvements.
- **Co-design accessible facilities** (parking, toilets) with disabled users and publish accessibility assessments for each site; include student accommodation upgrades where relevant.
- **Increase public awareness of underused facilities** (e.g., South Pembrokeshire Hospital) via clear communications and referral pathways.

G) Communication & Experience

- **Adopt a Hywel Dda “Communication Charter”** (patient friendly letters, plain English/Welsh, speak to the person—not about them, respectful disability aware practice).
- **Proactive status updates:** appointments, delays, transport changes; standardise reassurance messaging within access protocols to reduce anxiety.
- **Train front-of-house and clinical staff** in disability aware communication and digital coaching; embed prompts to assess digital confidence and offer alternatives.

7.4.12 People with sensory disabilities

A) Access & Transport

- **Create a Sensory-Inclusive Transport Offer:**
Update nonemergency patient transport criteria and processes to **permit escorts/PAs** as standard for sensory-impaired people; publish clear eligibility and a simple booking route.
- **Synchronise Appointments with Transport Availability:**
Offer **later morning/early afternoon slots** for long-distance patients; automated text/email options to retime around community transport schedules.
- **Pilot Travel Support Schemes:**
Taxi voucher/mileage reimbursement pilots for priority pathways (ophthalmology, post-op dressings); evaluate impact on DNAs and outcomes.
- **Map & Broker Community Transport:**
Partner with local authorities/volunteer schemes to **revive “Country Cars”** capacity; recruit and train volunteers (accepting guide dogs), including sixth form/university placements.
- **Wayfinding & Parking Enhancements at GGH (and all sites):**
Immediate improvements to **contrasting signage, lift controls, drop-off bays**, and staffed wayfinding posts during peak clinics.

B) Communication, Accessible Information & Sensory Awareness

- **Adopt a Board-wide Accessible Communications Standard:**
All patient letters available by **default in large print/audio**; standard **plain language** templates; add patient preferred format flag to PAS/EPR visible at all contact points.

- **Two-way Digital & Non-Digital Channels:**
Enable **replies** for **SMS** and **practice email** for Deaf patients; ensure **visual call screens** in outpatients; contingency if screen fails (runner to waiting areas).
- **Onsite and On-demand Interpreting:**
Provide **BSL interpreters** in hospitals (rota or on-demand VRI) with **sitewide Wi-Fi** and **ward iPads**; publish a simple “How to access BSL/VRI” poster.
- **Mandatory Sensory Awareness Training:**
Introduce **annual e-learning + in-situ drills** for reception, HCSWs, nurses and clinicians: facing the patient, lighting, removing masks when safe to facilitate lipreading, handling hearing-aid batteries, and respectful interpreter use.
- **Accessible Public Communications:**
Ensure **BSL-interpreted** Board meetings and publish **BSL videos** (and large-print/audio equivalents) for key updates (e.g., MIU changes), responding to criticism about delays.

C) Digital Inclusion & Confidence

- **Accessibility-First Redesign:**
Commission an **accessibility audit** (WCAG + screen reader testing) of patient-facing systems (NHS app workflows, repeat prescriptions, web forms) with VI and Deaf users involved; fix **proxy access** issues for carers.
- **Connectivity as Core Infrastructure:**
Upgrade **Wi-Fi coverage** in GP/hospital sites to support BSL video platforms and telehealth; monitor uptime and performance publicly.
- **Assisted Digital Offers:**
Provide **kiosks/assisted check-in**, and partner with councils/third sector for **local digital training** tailored to VI/Deaf users (screen readers, voice assistants like Alexa/Siri).
- **Choice Preservation:**
Guarantee **nondigital alternatives** (telephone with interpreter, in person) are equal priority pathways, not second-class routes.

D) Timely Clinical Access (with Ophthalmology Focus)

- **Scale Nurse Injector Capacity & Community Delivery:**
Accelerate training and deployment of **nurse injectors**; **pilot community macular injection sessions** at suitable local facilities (e.g., Barlow House/eye clinic rooms), reducing travel and backlog risk.
- **Strengthen Booking & Reminder Systems:**
Fix central booking failure points; **multichannel reminders** (text/email/phone/large-print letters) with easy cancel/rebook. Track missed letters and late deliveries.
- **Integrate with Optometry & Independent Sector:**
Implement a **data sharing protocol** so optometrists can view relevant imaging/reports; require **timely feedback loops** with independent providers (e.g., Spa Medica).
- **Backlog Transparency:**
Publish **wait time dashboards** for ophthalmology (including macular) and set recovery milestones; offer **clinical harm reviews** where follow-up extends beyond safe windows.

E) Community Support, Prevention & Third Sector

- **Microgrants & Venue Subsidy Scheme:**
Establish a **small-grants fund** and **venue-fee reduction** programme for sensory impairment clubs (transport/room hire), recognising prevention value and social connectedness.
- **Systematic Signposting:**
Ensure all relevant clinics (ophthalmology, audiology) **routinely signpost to ECLOs and local groups**, with take-home accessible information.
- **Volunteer Brokerage:**
Partner with colleges/6th forms to **recruit volunteers** (including 1:1 befrienders/ “sighted guides”), recognising hours for CV/awards.

F) Estate, Wayfinding & Environment

- **Rapid “Fix the Basics” Package (next 6–9 months):**
High-contrast wayfinding (avoid brushed steel; use **yellow/black** contrasts), tactile routes, improved lighting on wards, staffed reception during clinics, and **universal visual call boards**.
- **Sensory-Aware Design Standards:**
Embed standards in all refurbishments/redevelopment: contrast, acoustics, lighting controls, quiet spaces, and accessible lift controls. Publish the standard.
- **Patient Navigation Support:**
Introduce **volunteer “navigators”** at complex sites (e.g., GGH) during peak times to accompany patients to departments.

G) Trust, Engagement & Governance

- **“You Said / We Did” Tracker:**
Publicly track commitments from this refresh, with **deadlines, owners, and status**, and publish in **BSL/large print/audio**.
- **Sensory-Impairment Champions:**
Nominate champions in each **Clinical Care Group** (as introduced in the 2025/26 plan) to embed changes and report quarterly to Board.
- **Coproduction Panels:**
Establish VI and Deaf **coproduction panels** to test letters, signage, and digital changes **before go-live**; compensate for time/expertise.

7.4.13 Women

A) Access to Primary & Community Care

- **Expand and standardise GP access models:** Implement call-back/queue-bypass for clinically prioritised cases; broaden same-day urgent triage; embed continuity-of-care tracking in primary care systems.
- **Scale specialist nursing capacity in community settings:** Prioritise high-need pathways (e.g., stroke, ophthalmology, orthopaedics) to reduce specialist bottlenecks.
- **Commission targeted NHS dentistry capacity:** Use flexible commissioning and incentives to address long waits and geographic gaps.

- **Strengthen pharmacy-first and community clinics:** Extend vaccination/flu clinics in community venues; promote minor ailment schemes and structured pharmacist consultations (with clear non-fee routes).

B) Transport & Travel

- **Create a dedicated Health Transport Coordination Hub:** Single number/app + phone alternative to book, track, and confirm transport; protected capacity for oncology, paediatrics, and learning disability pathways.
- **Introduce ‘One-Trip’ appointment bundling:** Redesign outpatient scheduling to consolidate diagnostics/consults where clinically appropriate; track “number of trips per episode” KPI.
- **Hospital Parking Improvement Programme:** Short, medium, long-term actions—reflow design, digital guidance to spaces, concession schemes for frequent attenders, and capital projects at constrained sites.

C) Digital Healthcare Inclusion & Choice

- **Adopt a ‘Digital + Face-to-Face by Default’ access standard:** Explicitly guarantee non-digital routes for booking, results, and queries; publicise this commitment to build trust.
- **Community digital support pathway:** Partner with hubs/WIs/libraries to run drop-ins; HDUHB demos of NHS Wales app; bilingual, plain-language materials; scam-awareness.
- **Reliability and resilience testing:** Work with digital partners to harden app workflows (prescriptions, bookings) and publish uptime/incident metrics. (Supports digital ambitions in Strategy and current transformation programmes.)

D) Communication, Engagement & Trust

- **Publish clear decision criteria & timelines:** Map how Phase 2 feedback flows into the January 2026 Board report; set thresholds and rationale for changes; provide case studies of changes implemented.
- **‘You Said, We Did’ reporting cycle:** Quarterly public updates summarising top themes and actions; track completion; share via website and partner channels.
- **Strengthen cross-sector messaging:** Joint statements with local authorities on preventive assets (e.g., leisure facilities), clarifying roles and plans to sustain community wellness hubs.

E) Hospital Estate & Site Condition

- **Near-term Estate Improvement Plan (GGH priority):** Identify immediate safety/quality enhancements (e.g., wards, outpatient areas, wayfinding); publish timelines and progress.
- **Parking infrastructure strategy across main sites:** Integrated approach (layout upgrades, demand management, concessions for frequent attenders/carers).
- **Transparent updates on hospital programme:** Regular communications on the new urgent & planned care hospital timeline and interim investments under the Clinical Services Plan.

F) Care Pathways, Aftercare & Coordination

- **Pathway audits & standardisation:** Prioritise stroke aftercare to match best-performing pathways (e.g., cardiac); ENT/ophthalmology backlog plans; publish pathway SLAs.
- **Integrated records & navigation:** Accelerate linked records to reduce duplication; appoint pathway navigators for complex needs; ensure specific accommodations for neurodiverse patients (minimise cancellations, provide predictable scheduling).
- **Medicines optimisation & repeat prescribing:** Review policies to curb waste; pharmacist-led reviews; patient education.

G) Inequalities & Variation across Counties

- **Geographic equity plan:** Identify differential access (services, transport, prevention assets) by locality; set targeted mitigations and investment priorities.
- **Joint planning board with local authorities:** Formalise cross-sector governance for the social model (active travel, leisure, housing, fuel/food security), aligned to Integrated Community Networks.

7.4.14 Young people

A) Access to Care & Local Provision

- **Establish community diagnostics & monitoring pods** (BP, simple tests) in schools, youth centres, and pharmacies, with clear referral pathways to reduce ED visits.
- **Expand pharmacist-led minor illness and weekend services** and publicise them to youth audiences; include clear thresholds for ED vs MIU vs GP.
- **Youth-friendly service redesign** for Children & Young People services (e.g., adolescent-appropriate spaces at GGH children's ward; refurbish the Children's Centre).
- **MIU awareness campaign**, co-designed with youth, focusing on conditions treated and how to access without ED triage (BGH/PPH).

B) Communication, Navigation & Signposting

- **“Right Care, Right Place” bilingual toolkit:** simple infographics/videos distinguishing ED/MIU/GP/pharmacy/111; embed in school curricula and social media.
- **Appointment letters & SMS with journey info:** building entrances, parking, bus routes, walking time, and live map links; reduce pre-visit anxiety for unfamiliar sites.
- **Unified Wales-specific web navigation:** ensure pages/apps clearly distinguish NHS Wales vs NHS England services; audit and fix misleading links.

C) Digital Healthcare: Trust, Inclusion & Usability

- **NHS Wales app optimisation for youth:** co-design improvements (waitlist/queue visualisation, simple mode, bilingual UX, privacy-by-design messaging).
- **Digital inclusion pathway:** short, practical training delivered via GPs/schools/youth centres (how to book, share data safely, use video consults), with phone/in-person alternatives maintained.
- **Service status transparency:** push notifications for prescriptions, appointments, and waitlist position to build trust and reduce phone queues.

D) Social Model for Health & Youth Wellbeing

- **Reinvest in youth clubs & outreach** (e.g., mobile “Feelz on wheels”) targeting rural communities; integrate mental health support and healthy living education.
- **Leisure access scheme**: subsidised youth memberships, starter-confidence classes, and coach-led sessions to reduce cost and confidence barriers.
- **Healthy schools initiative**: co-develop with local authorities improvements to canteen offerings and practical lessons on affordable healthy meals.

E) Estates, Environment & Neurodiversity-Friendly Design

- **Quick-win programme**: signage/wayfinding upgrades; ND-friendly design standards (lighting, colour, quiet zones, sensory considerations); A&E waiting area improvements (play/youth spaces) at GGH.
- **Parent overnight accommodation standards**: introduce bed-settees or family rest facilities in paediatrics; prioritise refurbishment where experience gaps are largest (e.g., Children's Centre GGH).
- **Create/restore green spaces** at hospital sites to support respite and reduce “daunting” perceptions; include ventilation upgrades in refurbishment plans.

F) Transport, Travel Reliability & Cross-Board Collaboration

- **Nonemergency transport reliability charter**: KPIs, cancellation thresholds, rebooking guarantees, live status updates, and escalation lines for day-of-appointment issues.
- **Travel support module** in digital/letters: integrated door-to-door journey planning, parking info, and bus timetables; link to volunteer driver schemes.
- **Explore regional collaboration** across Health Boards for shared transport solutions and specialist referrals to minimise missed appointments.

7.5 Recommendations about equality / equality impact

This section of the report presents the suggested recommendations arising from responses to the equality / equality impact question on Have Your Say.

Access & Equity

- Maintain/strengthen local stroke and emergency access in Bronglais/Withybush using clear clinical criteria and time-to-treatment metrics; publish travel-time and outcome dashboards.
- Rural transport solutions: expand demand-responsive transport, volunteer driver schemes, and integrated booking aligned to appointments (including carers).
- Primary care access redesign: flexible booking (beyond 08:00 calls), continuity options, triage that reduces unnecessary gatekeeping.

Digital Inclusion & Communication

- Dual-channel default: every digital pathway must have an equivalent non-digital route (phone/face-to-face).
- Plain-language, bilingual content with simplified navigation and visible language toggle; co-design with older adults and disabled people.
- Digital literacy support: community-based training, device access, and privacy-safe options for those in sensitive situations (e.g., domestic abuse).
- Inter-team handovers: standardise communication protocols and shared care plans to prevent fragmentation.

Community Prevention & Support

- Fund community hubs focused on health literacy, cooking/nutrition, movement, with carer respite embedded.
- Make Every Contact Count (MECC): consistent lifestyle support, early intervention, and condition-specific education (e.g., B12 awareness) via community channels.
- Signposting partnerships: leverage voluntary sector and charities to reach hard-to-reach groups and reduce hospital pressures.

Capacity & Workforce

- Targeted recruitment/retention and skill-mix optimisation (advanced practitioners, digital triage). Align medium-term actions to the Clinical Services Plan fragilities.
- Continuity in primary/specialist care: named clinician/team models; reduce bureaucracy that blocks local specialist follow-up.

Engagement & Trust

- Close the loop: publish “You said/We did” updates for each locality and theme; show changes and constraints transparently.
- Inclusive engagement: targeted outreach to rural, elderly, disabled, and carers; better advertisement of events; accessible venues and materials.
- Monitor sentiment and equity: regular reporting on access disparities (transport, digital, language), and corrective action plans.

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9. Appendices

Appendix 1:

Braun and Clarke's six-phase framework for thematic analysis

The six phases in Braun and Clarke's framework are:

Thematic analysis steps	Practical application for researchers
1. Familiarization with the data	Researchers immerse themselves in the raw data (e.g., transcripts, notes) by reading and rereading. They actively engage with the material, noting initial ideas and potential patterns. Transcription by the researcher can enhance familiarity, and reflective memos can support early insights.
2. Generating initial codes	Systematically work through the data to identify meaningful features. Codes summarise data segments and can be semantic or latent. Researchers may use software like NVivo, but manual coding is also valid. The aim is comprehensive and inclusive coding.
3. Searching for themes	Researchers begin grouping codes into broader patterns or themes. A theme reflects meaningful data patterns related to the research question. Tools like mind maps or thematic maps assist in organizing themes. This stage involves interpretive thinking.

Thematic analysis steps	Practical application for researchers
4. Reviewing themes	Candidate themes are reviewed for coherence within and distinction between themes. Researchers return to the data to ensure accurate representation. This recursive process may lead to merging, splitting, or discarding themes.
5. Defining and naming themes	Researchers refine the essence of each theme and describe how it relates to the research question. Effective naming should be concise and reflective. Supporting quotations and detailed descriptions are developed to enhance clarity.
6. Writing the report	Researchers present findings through a coherent narrative. The report includes a detailed account of themes, data extracts, and analytic commentary. The write-up should interpret the data meaningfully and link findings to the literature, ensuring methodological transparency.

*Using thematic analysis in qualitative research - ScienceDirect
(Accessed 5th September 2025)*

Appendix 2:

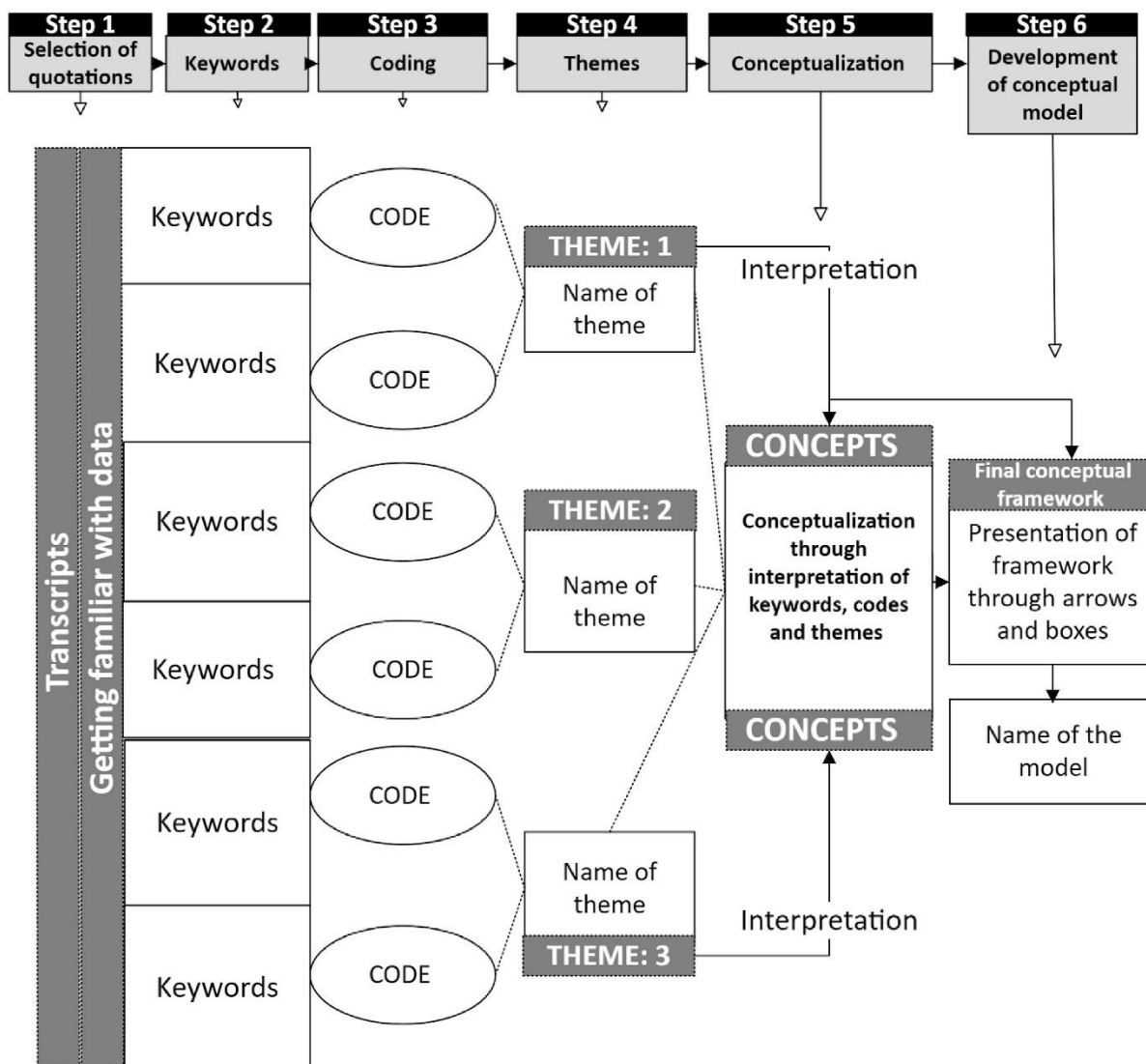
Naeem et al six-step systematic thematic analysis framework

Naeem et al. (2025) explain that:

“(The process)....allows researchers to create themes based on identified quotations and keywords, grouping them into different categories known as codes (Naeem et al., 2023). These codes are based on relevant quotations and keywords. Subsequently, these codes are grouped according to research questions and objectives, forming what is called a theme. Thus, through systematic thematic analysis, themes are derived from the data based on research gaps, theoretical underpinnings, philosophical underpinnings, and research questions, whereas in traditional thematic analysis, themes are based on commonalities in the data.”

*Thematic Analysis and Artificial Intelligence: A Step-by-Step Process for Using ChatGPT in Thematic Analysis - Muhammad Naeem, Tracy Smith, Lorna Thomas, 2025
(Accessed 5th September 2025)*

The six steps in the process developed by Naeem et al. are presented in the following diagram:



Naeem et. al “Systematic thematic analysis process” (2023)

Appendix 3:

Reported limitations of using AI to support or carry out thematic analysis

It has been reported that, in some thematic analyses, human-generated codes (considered to be sub-themes) have been more reliable than AI-generated codes. There could be several reasons for this, such as:

1. The studies did not follow all six steps of Braun and Clarke’s (2006) approach to thematic analysis.
2. The studies did not provide the AI system with contextual information about the research, such as the aim and the research questions.
3. The AI system was not informed about the researchers’ methodological considerations for each step of thematic analysis.

Thematic Analysis and Artificial Intelligence: A Step-by-Step Process for Using ChatGPT in Thematic Analysis - Muhammad Naeem, Tracy Smith, Lorna Thomas, 2025

(Accessed 5th September 2025)

Appendix 4: Copilot prompts used for six-step systematic thematic analysis and thematic analysis

Copilot prompt for systematic thematic analysis of Have Your Say responses and feedback from group sessions and events

Prompt Title: Thematic Analysis of Public Engagement Responses for Strategy Refresh

Role: Act as an academic expert in thematic analysis of qualitative data, specialising in public engagement, health, and strategy development.

Goal: Perform an inductive, systematic thematic analysis of qualitative data using the six-step framework by Naeem et al. (2023), adapted for AI-supported analysis (Naeem et al., 2025). Identify recommendations and group them by theme (e.g., Access, Communication, Digital).

Context: Hywel Dda University Health Board is refreshing its long-term strategy, "*A Healthier Mid and West Wales*". Public engagement was conducted across four thematic areas using 11

questions. Your analysis will inform the refreshed strategy and will be presented at the Public Board meeting in January 2026.

Source Material:

- Strategy document: hduhb.nhs.wales/about-us/healthier-mid-and-west-wales/healthier-mid-and-west-wales-folder/documents/a-healthier-mid-and-west-wales-strategy/
- Six-step framework: Naeem et al. (2023)
- AI adaptation: Naeem et al. (2025)
- Data: Word document containing responses to one engagement question (assume full text provided).

Instructions:

Complete all six steps sequentially. Use a formal tone and prioritise relevance, accuracy, objectivity, and depth. Do not include personal identifiers in quotes.

Step 1: Familiarisation

- Review context and data.
- **Output:** Short paragraph confirming familiarisation and noting initial observations or data quality issues.

Step 2: Keyword Selection

- Identify recurring terms using the “6 Rs” (Relevance, Recurrence, Richness, Resonance, Representativeness, Rigour).
- **Output:** Markdown table with columns: Keyword | Frequency | Rationale.

Step 3: Coding

- Assign codes (max 3 words) using keywords and “6 Rs”.
- **Output:** Markdown table with columns: Code | Anonymised Quote | Rationale.

Step 4: Theme Development

- Group codes into themes using “4 Rs”.
- **Output:** Markdown table with columns: Theme | Related Codes.

Step 5: Conceptualisation

- Define concepts emerging from themes and align with strategic priorities.
- **Output:** Numbered list of concepts with short definitions and links to priorities.

Step 6: Conceptual Model

- Provide a textual description of a conceptual model (suitable for diagram conversion).
- **Output:** Short description explaining relationships and strategic relevance.

Recommendations:

- Identify recommendations from the analysis.
- **Output:** Bullet points grouped under theme headings (e.g., Access, Communication, Digital).

Copilot prompt for analysis of email responses and responses in writing

Title: Thematic Analysis & Recommendations Report – Hywel Dda UHB Strategy Refresh

Role: Act as a qualitative research expert specialising in thematic analysis, public engagement, and strategic health planning.

Goal: Produce a structured thematic analysis of stakeholder feedback to inform the refresh of

Hywel Dda University Health Board's long-term strategy (*A Healthier Mid and West Wales*). Identify actionable recommendations grouped by theme (e.g., Access, Communication, Digital).

Context: Hywel Dda UHB is updating its strategic plan following public engagement across four thematic areas using 11 structured questions. Feedback was collected from diverse stakeholder groups, including veterans and individuals experiencing homelessness. Your analysis will directly inform the final report for the Public Board meeting in January 2026, shaping strategic priorities.

Source Material:

- Strategy document: hduhb.nhs.wales/about-us/healthier-mid-and-west-wales/healthier-mid-and-west-wales-folder/documents/a-healthier-mid-and-west-wales-strategy/
- Feedback documents: Word file containing qualitative responses received by email and in writing.

Instructions:

1. Review all feedback documents thoroughly and disregard irrelevant content.
2. Identify and categorise key themes, recurring ideas, and underlying patterns.
3. For each theme:
 - Provide a concise summary (2–3 sentences).
 - Include 1–2 representative quotes.
 - Highlight concerns, opportunities, and suggested actions.
4. Identify trends based on frequency, tone, or context.
5. Compile actionable recommendations grouped by theme in bullet points.
6. Maintain a formal, evidence-based tone suitable for inclusion in a strategic report.
7. If any information is unclear or missing, flag it for clarification.

Output Format:

- Section 1: Summary of Themes (with quotes)
- Section 2: Key Trends & Insights
- Section 3: Recommendations grouped by theme (bullet points)

Copilot prompt for analysis of feedback from individual stakeholder groups

Title: Thematic Analysis & Recommendations Report – Hywel Dda UHB Strategy Refresh

Role: Act as a qualitative research expert specialising in thematic analysis, public engagement, and strategic health planning.

Goal: Produce a structured thematic analysis of stakeholder feedback to inform the refresh of Hywel Dda University Health Board's long-term strategy (*A Healthier Mid and West Wales*). Identify actionable recommendations grouped by theme (e.g., Access, Communication, Digital).

Context: Hywel Dda UHB is updating its strategic plan following public engagement across four

thematic areas using 11 structured questions. Feedback was collected from diverse stakeholder groups, including veterans and individuals experiencing homelessness. Your analysis will directly inform the final report for the Public Board meeting in January 2026, shaping strategic priorities.

Source Material:

- Strategy document: hduhb.nhs.wales/about-us/healthier-mid-and-west-wales/healthier-mid-and-west-wales-folder/documents/a-healthier-mid-and-west-wales-strategy/
- Feedback documents: Word files containing qualitative responses from stakeholder groups. The links to the Word documents are: *(Add links to each Word document)*

Instructions:

1. Review all feedback documents thoroughly and disregard irrelevant content.
2. Identify and categorise key themes, recurring ideas, and underlying patterns.
3. For each theme:
 - Provide a concise summary (2–3 sentences).
 - Include 1–2 representative quotes.
 - Highlight concerns, opportunities, and suggested actions.
4. Identify trends based on frequency, tone, or context.
5. Compile actionable recommendations grouped by theme in bullet points.
6. Maintain a formal, evidence-based tone suitable for inclusion in a strategic report.
7. If any information is unclear or missing, flag it for clarification.

Output Format:

- Section 1: Summary of Themes (with quotes)
- Section 2: Key Trends & Insights
- Section 3: Recommendations grouped by theme (bullet points)



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Hywel Dda
University Health Board

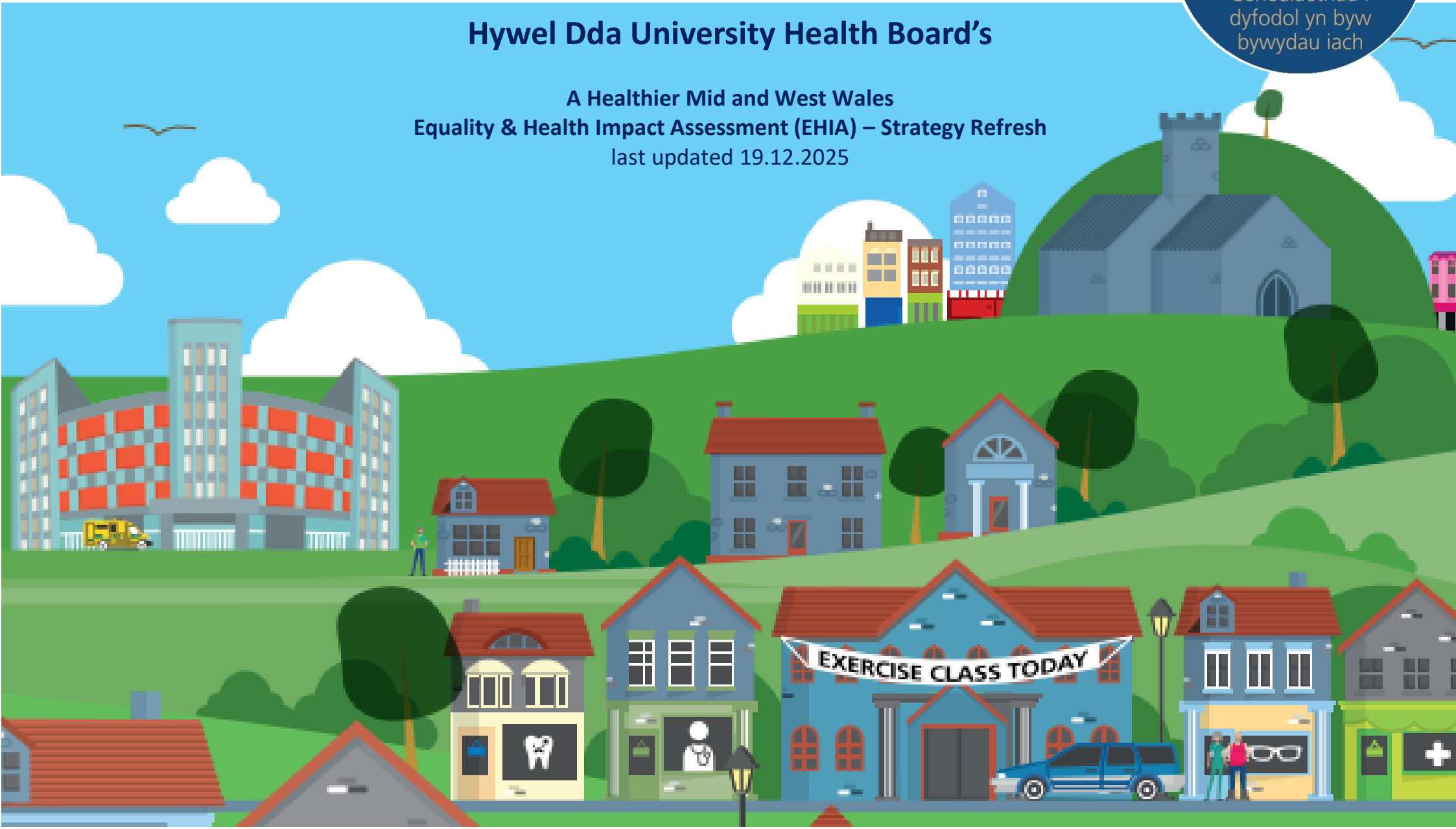
Canolbarth
a Gorllewin
Iachach

Cenedlaethau'r
dyfodol yn byw
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LIVE DOCUMENT SUBJECT TO CHANGE

Hywel Dda University Health Board's

A Healthier Mid and West Wales
Equality & Health Impact Assessment (EHIA) – Strategy Refresh
last updated 19.12.2025



VERSION CONTROL

Version	Date	Author	Comments
Final Draft for inclusion with PBC Annex	19.01.22	C Hale	Live document subject to change.
Final Draft for inclusion with papers for Board Meeting 04.08.22	26.07.22	C Hale & K Cobley	Live document subject to change
Final Draft with updated action plan for Consultation	16.02.23	K Cobley & E Harries	Live document subject to change
Updated draft including Census data 2023	29.06.23	E Harries	Live document subject to change
Updated Draft with updates following the New Hospital Site Consultation feedback report	24.08.23	E Harries	Live document subject to change
Updated for Strategy Refresh	19.12.2025	A Winter	Live document subject to change
Incorporating Strategy Refresh engagement findings	22.12.2025	A Martin	Live document subject to change

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DRAFT

Purpose of document

This document forms the ongoing Equality and Health Impact Assessment (EHIA) that is being undertaken in support of 'A Healthier Mid and West Wales: Our Future Generations Living Well' Programme.

The Equality and Health Impact Assessment was presented as part of the supporting documents in submission of our Programme Business Case which was endorsed by Board in January, 2022 for submission to Welsh Government. The UHB is at a key milestone point in the process of selection of a site for the new urgent and planned care hospital. This will remain a live document for identification of impact, mitigation and action for the duration of the programme.

The Equality and Health Impact Assessment was also submitted as part of the land consultation documents during the August 2022 board meeting.

The scope of the document is to provide an overview of how the Programme might have positive and/or negative impacts on different groups of people with 'protected characteristics'. It uses information from a variety of sources, including public and staff engagement, general background research and from surveys of people living in Wales and in the Hywel Dda region. If you would like further detailed information, this can be obtained by contacting hyweldda.engagement@wales.nhs.uk.

Introduction

Anyone can experience health issues at any given time and we all may need to access healthcare services at some point in our lives. Evidence suggests that people with a protected characteristic are more likely to suffer from ill-health. Protected characteristics are defined by the Equality Act 2010 and include: Age, Disability, Sex, Gender Reassignment, Marriage and Civil Partnership, Pregnancy and Maternity, Race, Religion and Belief and Sexual Orientation. [Further information on the Equality Act 2010 and the protected characteristics can be found here.](#)

The Equality Act 2010 means that health boards have a legal duty to protect people from discrimination in the workplace and the wider society. This means that we must consider the needs of people from different groups in our communities who might be affected by the decisions we make on how we deliver healthcare services across the Hywel Dda region.

The Public Sector Equality Duty in Wales forms part of the Equality Act 2010. The Duty means that policies and service plans developed by the health board must be designed to contribute to a fairer society. They must attempt to:

- Eliminate unlawful discrimination, harassment and victimisation and other conduct that is prohibited by the act.
- Advance equality of opportunity between people who share a relevant protected characteristic and those who do not; and
- Foster good relations between people who share a protected characteristic and those who do not.

[Further information on the Public Sector Equality Duty in Wales can be found here.](#)

This means that, wherever possible, the health board must take reasonable steps to identify both the positive impacts and negative impacts that our policies and services may have upon people with a protected characteristic. Once identified, the health board must try to mitigate and eliminate any negative impacts by whatever means possible to avoid putting people with a protected characteristic at a further disadvantage.

The Human Rights Act 1998 places a duty upon health boards to promote and protect human rights for all. This means that health boards must treat everyone equally, with fairness, dignity and respect. [Further information on the Human Rights Act 1998 can be found here.](#)

In Wales, health boards also have a responsibility to comply with the Welsh Language (Wales) Measure 2011 and must implement a set of Welsh Language Standards. This means that health boards have a duty to meet the needs of Welsh speakers and offer healthcare services bilingually. When developing policies and service plans, Health Boards must assess the impact they may upon Welsh speakers and ensure that they do not treat the Welsh language any less favourably than English. [Further information on the Hywel Dda UHB's Welsh Language Standards can be found here.](#)

Assessing impact across a broad range of characteristics (not just those required by law), helps organisations to embed equality and human rights in the delivery of their services. For this reason, we are also concerned about other groups who might be affected. These include unpaid carers (people who care for someone with a disability, but who often may face barriers to accessing services themselves) and people who experience socio-economic disadvantage (for example, people who lack access to their own or public transport, people who are homeless, people who live in remote areas or people who live in areas of deprivation). Evidence suggests that people from protected groups are more at risk of experiencing socio-economic disadvantage and as a result may face additional barriers to accessing services. Evidence also suggests that many people in society face disadvantages associated with multiple protected characteristics.

Throughout this document the term 'protected characteristics' should be taken to include all the nine protected characteristics, as well as human rights, the Welsh language and socio-economic considerations.

Equality and Health Impact Assessments (EHIA) is a process which enables an organisation to consider the effects of its decisions, policies or services on different communities, individuals or groups, particularly in relation to those most vulnerable in society. Assessing the impact on the equality of proposed changes is also a positive opportunity for health boards to ensure that better decisions are made which are based on robust evidence. EHIA draws on existing research, monitoring information and the feedback from engagement and consultation to systematically assess the potential equality impacts of an activity or policy. This involves anticipating the consequences of activities for groups of people with protected characteristics and making sure that, as far as possible, any negative consequences are eliminated or minimised and opportunities for promoting equality are maximised. It is a constantly evolving process ensuring that the needs of protected groups are considered at every stage of planning, development and delivery.

Annex 3 in particular provides feedback from a recent engagement exercise in Hywel Dda ('Building a healthier future after COVID-19') during May – June 21. This was an opportunity to check in with its staff, patients and their families, and the wider public to find out how their lives had been impacted by the global pandemic.

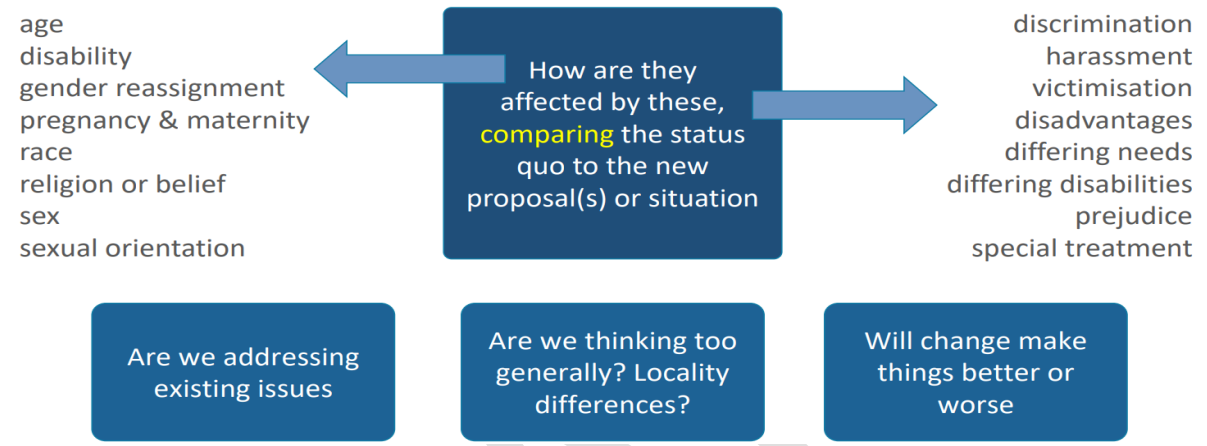
The Health Board wanted to learn more about how the pandemic has affected the people's health and care, and their access to it, as well as the implications of these experiences for its long-term health and care strategy, 'A Healthier Mid and West Wales: Our Future Generations Living Well'.

As the Health Board plans to develop a new hospital in the south of the area, somewhere between and including the towns of St Clears (Carmarthenshire) and Narberth (Pembrokeshire), people were also invited to nominate possible sites for the new build. In addition, people were asked for their top priorities when considering the location of the hospital.

The Health Board is committed to continuous engagement. This means the Health Board will continue to talk with staff, patients, their families and the wider public and consider their experiences and views, whether they are positive or negative, when planning services, which will be used to further inform this EHIA.

The Health Board also recognises the need to confirm whether there are existing issues in relation to the 'status quo'. We will ensure that an impact question is asked as part of all future engagement and consultation stages and analysed so that we are fully aware of existing issues and what we need to put right, as outlined in the diagram below:

 **The shape of analysis and impact assessment**



The EHIA remains a live document and has taken into consideration the recently published Local Well-being Assessments from each of the Local Authorities which were published in May, 2022.

Part 1 – The Proposal

Sponsored by:	Name	Paul Williams
	Title	Assistant Director, Strategic Planning
	Contact details	Paul.Williams19@wales.nhs.uk

Policy or project title:	A Healthier Mid and West Wales: Our Future Generations Living Well Programme
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Brief outline of what is being proposed:

Following extensive engagement and consultation, in late 2018 the Health Board published our Health & Care Strategy – ‘A Healthier Mid and West Wales: Our Future Generations Living Well’.

Our Strategy articulates our vision for services fit for current and future generations, and invests in primary and community services that create a shift from the existing and predominant medical model:

“Our shared vision is a Mid and West Wales where individuals, communities and the environments they live, play and work in are adaptive, connected and mutually supportive. This means people are resilient and resourceful and enabled to live joyful, healthy and purposeful lives with a strong sense of belonging.”

Realising our vision means implementing an ambitious and innovative programme of whole system change to realise our population health ambitions, which signals a fundamental shift from our current emphasis on hospitals to a focus on working in partnership with people and communities to keep people well in, or close to, their own homes.

It means the development and implementation of an enhanced community model, based on an integrated social model for health and wellbeing, and its implementation at pace as a long-term commitment focused on prevention, wellbeing and early intervention to help build resilience and enable people to live well within their own communities.

The Programme includes responding to the need to achieve a sustainable workforce model with fewer emergency rotas and reduced use of agency staff. Key to the Programme is a new Urgent and Planned Care Hospital located in the south of our region, which will operate as our main site for all specialist children and adult acute services, supported by a network of hospitals which will provide more locality-based care, including Bronglais General Hospital in Aberystwyth, Glangwili Hospital in Carmarthen, Prince Philip Hospital in Llanelli and Withybush Hospital in Haverfordwest.

The service model is as follows:

Facilities	Description
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	<p>Three main hospitals</p>	<p>A major new urgent and planned care hospital centrally located somewhere between Narberth and St Clears, with all planned and specialist care centralised on a single site</p> <p>Bronglais District General Hospital will continue to provide acute hospital services for mid Wales</p> <p>A general hospital on the existing site at Prince Philip Hospital, Llanelli, with acute medicine retained</p>			
<p>Who will be affected by the strategy / policy / plan / procedure / service? (Consider staff as well as the population that the project / change may affect to different degrees)</p>	<p>Two repurposed hospitals</p>	<table border="1"> <tr> <td data-bbox="1077 707 1565 815">Glangwili in Carmarthen</td> <td data-bbox="1576 707 2134 1082" rowspan="2">These will be repurposed to offer a range of services to support the social model for health and well-being</td> </tr> <tr> <td data-bbox="1077 815 1565 924">Withybush in Haverfordwest</td> </tr> </table> <p>Community hubs</p> <p>Integrated locality networks</p>	Glangwili in Carmarthen	These will be repurposed to offer a range of services to support the social model for health and well-being	Withybush in Haverfordwest
Glangwili in Carmarthen	These will be repurposed to offer a range of services to support the social model for health and well-being				
Withybush in Haverfordwest					
<p>Evidence and Background Information / Data Sets considered</p>		<p>The public as well as those accessing Health and Care services specifically: Families, carers and friends. Staff delivering health and care services. Partner organisations including the three constituent local authorities and the public, private sector and voluntary sectors. Other neighbouring health boards Community groups. Welsh Ambulance Service NHS Trust (WAST). Emergency Medical Retrieval and Transfer Service (EMRTS).</p> <p>The following information has been used to inform health board planning and long-term health and care strategy and the subsequent EHIA:</p> <p>Population Needs Assessment Report June 2022 population-needs-assessment-revision-v2-final-v3-accessible-final.pdf</p> <p>West Wales Area Plan 2023 Area Plan – West Wales Regional Partnership Board</p>			

Pharmaceutical Needs Assessment

<https://hduhb.nhs.wales/about-us/your-health-board/board-meetings-2021/board-agenda-and-papers-30th-september-2021/agenda-and-papers-30th-september-2021/item-6-2-1-pharmaceutical-needs-assessment/>

Wellbeing Plan – Pembrokeshire 2023-2028

[Pembrokeshire Well-being Plan 2023-28 E \(1\).pdf](#)

Wellbeing Plan – Ceredigion 2023-2028

[ceredigion-local-well-being-plan-2023-28.pdf](#)

Wellbeing Plan – Carmarthenshire 2023-2028

[psb-well-being-plan.pdf](#)

Public Health Wales Observatory

<https://phw.nhs.wales/services-and-teams/observatory/>

HUHB Strategic Discovery Report (July, 2020)

<https://hduhb.nhs.wales/about-us/your-health-board/board-meetings-2020/board-agenda-and-papers-30th-july-2020/board-30th-july-2020-documents/item-3-3-strategic-discover-report/>

Strategic Equality Plan 2024-2028

hduhb.nhs.wales/about-us/governance-arrangements/equality-diversity-and-inclusion/equality-diversity-and-inclusion-documents/strategic-equality-plan-2024-2028/

COVID-19 Research, The Influence of the COVID-19 pandemic on mental wellbeing and psychological distress: impact on a single country (October 2021)

[All Wales COVID 19 Survey 1.pdf](#)

HUHB Cluster Development Plans

Building a healthier future after COVID-19 (Feedback report on the public engagement around the pandemic, our strategy, our Programme Business Case, and equalities 10 May to 21 June, 2021)

<https://www.haveyoursay.hduhb.wales.nhs.uk/7617/widgets/39505/documents/21675>

The health and care strategy was based on the 2018 public consultation and this EHIA also draws upon the positive and negative feedback from that time.

[How the population changed in Carmarthenshire, Census 2021 - ONS](#)

[How the population changed in Pembrokeshire, Census 2021 - ONS](#)

[How the population changed in Ceredigion, Census 2021 - ONS](#)

[Carmarthenshire Assessment of Local Wellbeing - May 2022.pdf](#)

[Ceredigion Assessment of Local Well-being 2022](#)

[Pembrokeshire Well-being Assessment May 2022 .pdf](#)

Discussion Forum with the public 14.06.22

Findings of public questionnaire 'help us to understand how the location of the new urgent and planned care hospital may affect you' June 2022

New Hospital Site Consultation - feedback report August 2023

StatsWales -

Breastfeeding, quarterly rates by age and LHB

Singleton live births with low birth weight by area

Population Health profile 2025

Strategy Refresh - Phase 1 and Phase 2 engagement, Summer and Autumn 2025

Part 2- Equality, Human Rights and Welsh language

How will the strategy, policy, plan, procedure and / or service impact on people? Questions in this section relate to the impact on people on the basis of their 'protected characteristics'.

Age - Is it likely to affect older and younger people in different ways or affect one age group and not another?

Age - Evidence - Population Data

As evidenced in the data obtained from StatsWales, Hywel Dda has a higher proportion of people aged 75 years and older compared with the rest of Wales, and life expectancy for both males and females is longer than it is in Wales overall. Residents over retirement age were highlighted as a growing demographic who may be disproportionately affected by the proposals as they are more likely to develop more health issues and require more healthcare intervention as they age and accessing healthcare services may become more difficult.

Projections suggest that population ageing will continue at least until 2036, with the largest increase in our oldest population group (aged 75 years and over) which is estimated to increase by approximately 30,000 people over the years 2014-2039 (PHWO 2016)¹. No other age group is projected to increase at such an accelerated rate.

Children and young people make up approximately 22.2% of the population in the West Wales region (0-19 - West Wales Area Plan, 2023). The number of young people is expected to stay relatively stable over the next 15 years (Health Needs Assessment 2022).

We know from the TCS listening and engagement exercise (summer 2017) that people would like to see more support for children's health and wellbeing, including more community-based children's services and school-based lifestyle education. The findings from our engagement work reported in September 18 found that the **majority of issues raised in relation to equalities impacts related to travel and transport issues** for specific groups which mainly include the frail, **the elderly**; those with disabilities; expectant parents; **families with children** and **children themselves**.

Early 2021 census data released on the 28th June, 2022 confirms the predictions above with data showing the below increases and decreases in population by age:

Carmarthenshire shows an increase of 18.9% of people 65 years and older. Decrease of 2.5% of people aged 15-64 and a decrease of 0.8% of people aged under 15.

Pembrokeshire 20.6% increase in 65 and over. Decrease 4.9% 15-64 years and a decrease of 5.5% in children under 15 years.

Ceredigion shows an increase of 17.2% in 65 years and older. Decrease of 12.2% age 15-64 and a decrease of 10.1% in children under 15.

Age – Workforce Information (extracted from the Strategic Equality Plan Annual Report 2024/25 and Annual Workforce Equality Report 2024/25)

This section outlines comparisons between workforce data published as at 31 March 2025 against data published at 31 March 2024. The majority of the workforce as at 31 March 2025 were aged between 31–60 years which accounted for approximately 71% of staff. Compared to 2024, workforce information data on 31 March 2025 showed:

- The percentage of staff identifying within the Age Profile for the ages of 55 and below has decreased by 0.01%.
- Age Profiles for the ages of 55 and above have shown a percentage increase of 0.29%. This means that the health board has a slightly increasing workforce over the age of 55. This will need to be considered in the long-term plans for healthcare delivery to ensure that plans are in place to attract and recruit new staff in line with the projected retirement plans of our workforce aged 55 and above.

¹ – These estimates are based on assumptions about births, deaths and migration

Impact identified - Age	Positive	Negative	No Impact	Opportunities for improvement / mitigation If not complete by the time the project / decision/ strategy / policy or plan goes live, these should also be included within the action plan.
With services expanded within the community model, it supports the older demographic in reducing isolation and loneliness agenda, with services likely to be co-located in community hub settings. <ul style="list-style-type: none"> • more healthcare provided away from hospitals and nearer to people’s homes, delivering outcomes that are important to the patient. • Accessible local primary and community care services delivered from fit for purpose facilities. • fit for purpose facilities meeting best practice standards on accessibility. • facilities designed to support patient, visitor and staff wellbeing. • integrated services with social care • Use of technology should support more care delivered in the home, with potentially less need to travel to UHB sites 	✓			Continue to review as the programme is developed through using patient experience feedback and data. The community model will support elderly people with ongoing care needs on prolonged waiting list. Continue to improve community response to meet needs and maintain independence within their own community

<p>There is an increase in the number of women choosing to give birth at an older age. Pregnancies of women aged 40 or more are allocated into consultant led care criteria because of their age and the increased risks of developing pregnancy-related diabetes, hypertension, poor outcomes for mothers and babies.</p> <p>They may need to travel further for their care in the new urgent and planned care hospital, or they may decide to have their babies in and adjacent Health Board area e.g., Swansea Bay.</p> <p>Update 11.07.22 The Clinical land appraisal July 22 highlighted that there is a potential negative impact on women who choose to give birth at an older age. This is due to the need to access consultant led birthing, potentially travelling further to the new Urgent and Planned Care Hospital, or choosing to have their births in another health board. This was echoed in the Discussion Forum with the public on 14.06.22.</p> <p>Secondly, that for stroke patients who are generally an older cohort, they normally have older family and relatives who visit as part of the rehabilitation process, and their access should be considered also.</p>	✓	<p>Providing safe and quality consultant-led midwifery care 24/7 can only be achieved by creating a singular consultant-led unit at a one location within Hywel Dda UHB. Pooling specialist consultancy led midwifery care in the new hospital with the most up-to-date facilities will ensure the best possible care and treatment for pregnant women who are at a higher risk of pregnancy-related complications. Provision of Midwifery Led Units at Withybush, Glangwili and Prince Philip hospitals and in some of the other community hubs across the region could mitigate against negative impacts of increased travel for women with low-risk pregnancies.</p> <p>We will seek advice from other Health Board's and trusts that have undertaken similar changes to services to better understand the impact it has had to ensure shared learning.</p> <p>We will seek advice from our own clinical advisory group.</p> <p>Update 11.07.22 Women needing specialist care and transport was discussed as part of the clinical led appraisal workshops and as part of follow up discussions where the mitigation would be a hospital site in the East area of the zone to enable the best access to tertiary services and specialist transport services provided along the M4 corridor. This area would also likely provide the best opportunities to recruit and retain a workforce to support more complex births.</p> <p>Access to the hospital for older people was raised in workshops which provided additional impacts to consider when mitigating. Firstly, that transport routes main mostly East to West, but need to consider North to South for patients who may be travelling from</p>
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<p>A new impact was identified during the clinical land appraisal workshops around support for children and young people as a result of being unable to support birthing options.</p>			<p>North East Carmarthenshire, North Pembrokeshire and South Ceredigion.</p> <p>Should Paediatric services be unable to sustain clinical skills and competencies due to fewer birth numbers and more children and young people attending other health boards, then more paediatric services might need to be commissioned from other health boards. The mitigation for this relates to the decision which will be taken in relation to the siting of the proposed new urgent and planned care hospital.</p> <p>No further age impacts or mitigations were identified</p>
<p>The location of a new urgent and planned care hospital in the west of the region might be perceived as disadvantaging certain age groups due to lack of access to transport, including our older population.</p> <p>Our engagement exercise during 10 May to 21 June 21 identified a concern about the inability for older people to drive or long travel times and that older people do not own private transport or are unable to use it</p>		✓	<p>The zone between Narberth and St Clears was determined through our consultation in 2018, which resulted in the development of our long-term strategy A Healthier Mid and West Wales: Our future generations living well. You can read it here Healthier mid and west Wales - Hywel Dda University Health Board (nhs.wales)</p> <p>Update 1/12/2025: The requirements for changes to public transport networks will be fully considered by the Transport workstream, working in partnership with key stakeholders. This will include the scoping of new and repurposed routes servicing the new hospital and community networks. Transport for Wales and regional transport planning around the South West Wales Metro development support these requirements.</p> <p>Community transport opportunities will be explored, and we will learn lessons from successes in existing rural schemes and Welsh Government pilot initiatives.</p>

			<p>The opportunities available to maximise the offer of digital remote consultations will provide additional routes to access our services for our older population in their own home and/or their own community.</p> <p>The design of the new build will include ensuring that drop off and waiting areas for public transport are warm, comfortable and meet the needs of this protected characteristic group.</p> <p>We will seek advice from other health boards and Trusts.</p> <p>This location is the most central for most of the population in the south of the Hywel Dda area</p>
<p>People of all ages living east of the region (e.g., Llanelli, Ammanford) may choose to travel to Morriston Hospital (Swansea Bay UHB) to access A&E provision as Withybush and, Glangwili hospitals will be re-purposed as community hubs and will not have the A&E departments that they have currently. This may result in patients not being able to access NEPTS to return home after urgent or unscheduled care if required.</p>		✓	<p>The Transport Group will consider how patients can be supported to arrange transport to return home after urgent or unscheduled care at the urgent and planned care hospital to mitigate against the need to travel a greater distance.</p> <p>We will undertake discussions with neighboring health boards to discuss potential impact.</p>
<p>Concerns raised about time needed for children to attend specialist appointments at the new hospital and the possible impact on education and loss of working hours to parents / guardians accompanying them to appointments.</p>		✓	<p>Further focused work would be needed to verify which services will only be accessible at the new hospital and the impact.</p> <p>Plans to move more services to the Community Hubs/ closer to home may mitigate the additional travel time for some parents/children. Digital remote consultation will also mean more follow-up appointments can be arranged from home.</p> <p>We will take consideration to these issues when pathways are re-designed, e.g., access in local community to manage time off school/work, etc.</p>

<p>Concerns raised about people being able to access digital technology particularly for some of our older generations.</p> <p>Update 22.12.25 Engagement on strategy refresh identified impacts of aging on digital skills and confidence. As people age they may lose confidence, skill or ability to access digital services, despite previously having experience of using digital health services.</p>		✓	<p>The Health Board will promote available support services to support those who experience challenges when accessing digital appointments / remote consultations, e.g., working with local authority partners to support the use of digital community hubs, using digital champions in the community, work with third sector and volunteers to promote available support.</p> <p>Following promotion of remote consultations, ensure that there are alternative options available e.g., face-to-face appointments, and ability to update patient communication preferences over time.</p>
<p>With an ageing workforce there may be an impact from a lack of appetite for travelling further if required to work within the new urgent and planned care hospital.</p>		✓	<p>These issues will need to be explored with the workforce workstream of the programme along with how we ensure we have specialist skills in the workforce that we need, in replacing ageing workforce as they retire over next 5-10 years.</p> <p>OD Relationship Managers have been appointed to support change management.</p> <p>We will engage with staff throughout process seeking their views.</p>
<p>Update 11.07.22 The workforce land appraisal output report July 22 identified that a potential negative impact upon groups of staff closer to retirement in lower salary pay bands</p>		✓	<p>This should be mitigated through workforce planning and a collaborative approach utilizing the UHB agreed workforce policies.</p>
<p>Update 31.07.23 Themes generated from the Residence Focus groups during the land consultation highlighted that older people were thought to be less likely to have a support network and oftentimes more isolated. It was also said that many older people have existing disabilities, frailty, and/or mobility issues, so having to travel to either Whitland or St Clears could cause real issues with transport for the purpose of visiting or attending planned appointments.</p>		✓	<p>Opportunities for improvement / mitigation regarding this theme are highlighted under both the Age and Disability section of the EHIA.</p> <p>Update December 2025: Transport for all groups will be updated in the below Action Plan.</p> <p>Maximising care close to people's homes remains the UHB strategy.</p>

<p>Update 22.12.25 Engagement on strategy refresh identified impacts on children either as patients, dependents of patients or young carers, when visiting hospital or community sites being unable to access child friendly environments outside of paediatric areas, such as accident and emergency departments, etc.</p> <p>Other considerations such as spaces to play are also not often considered, while coffee shops or hospital shops are often considered for adults and older people.</p>		✓	<p>Opportunities for improvement / mitigation regarding this theme can be met at a design stage when considering the layout and use of spaces as part of site designs.</p> <p>Development of a Children and Young Peoples' Board will be able to support the development, testing and design of these spaces.</p>
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Disability

Those with physical impairments, learning disability, sensory loss or impairment, mental health conditions, long-term medical conditions such as diabetes

Evidence - Population Data

Recent data highlights a significant and continuing rise in dementia prevalence across the Hywel Dda region (Carmarthenshire, Pembrokeshire, Ceredigion), consistent with national trends.

Current Prevalence (2022)

- **West Wales total:** 6,884 people aged 65+
 - Carmarthenshire: 3,204
 - Pembrokeshire: 2,358
 - Ceredigion: 1,322

Dementia prevalence in Hywel Dda is expected to rise by over **58% between 2022 and 2035**, creating significant demand for:

- Health and social care services
- Workforce planning
- Community support and dementia-friendly initiatives

References:

- West Wales Regional Partnership Board, *Population Assessment (2022)*
- Welsh Government, *Dementia Action Plan*
- Alzheimer's Society UK projections

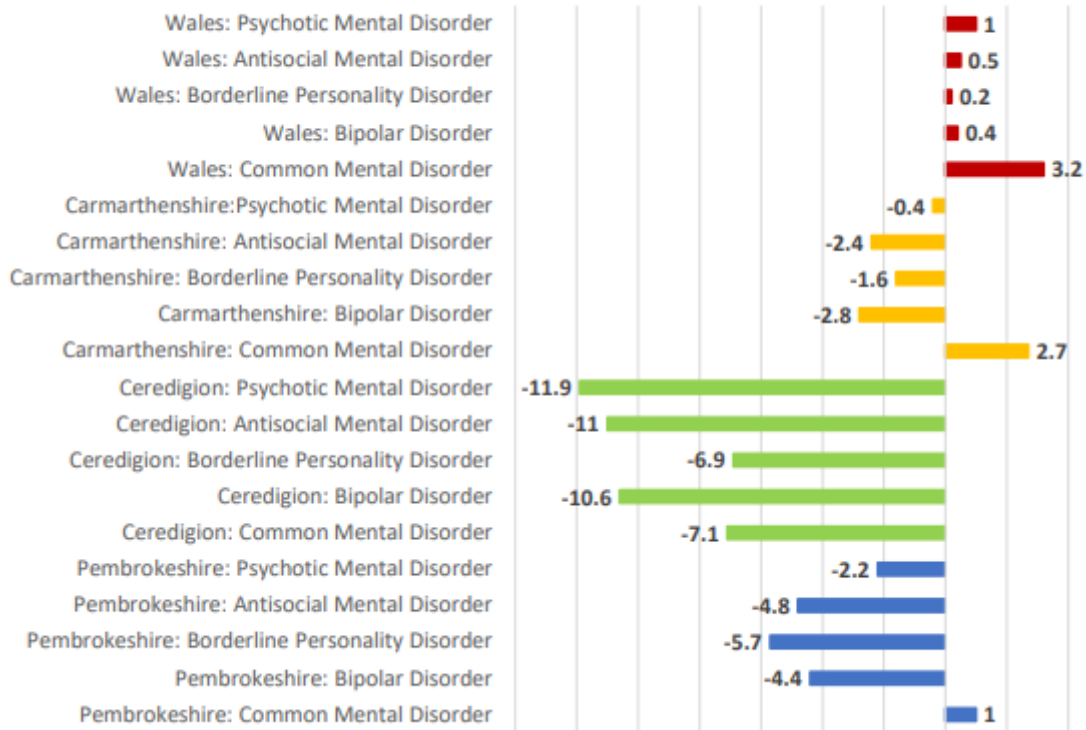
Data from the West Wales Area Plan (2023) reveal that in West Wales:

- Neurological conditions are the most common cause of serious disability and have a major, but often unrecognised, impact on people's lives and care and support services.
- There are an estimated 1,483 people over age 18 with a moderate or severe learning disability (2015 figures), representing just under 0.5% of the total adult population and comparable with other parts of Wales.
- The number of people over age 18 with a moderate or severe learning disability is expected to rise over the next two decades, but in proportion with overall population growth.
- A more significant rise of 33% in people over 75 with a moderate or severe learning disability is predicted over the same period.

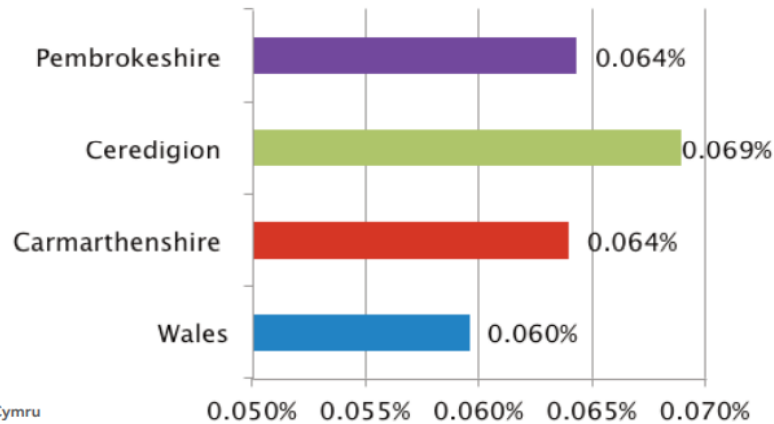
Around 75% of people with a mental health issue have a common mental disorder (which include depression, anxiety disorder, panic disorder, obsessive-compulsive disorder and post-traumatic stress disorder). The following chart shows the predicted percentage change

between 2020 and 2043 of people with a mental health disorder in each of the counties. In West Wales the overall percentage of people with mental health disorders is generally predicted to decrease between 2020 and 2043. Although it is predicted that there will be an increase common mental disorders in Carmarthenshire and Pembrokeshire. Overall, the total number of people in Ceredigion suffering from a mental disorder is predicted to decrease the most out of the three local authorities.

16+ with a mental disorder: % change 2020-2043

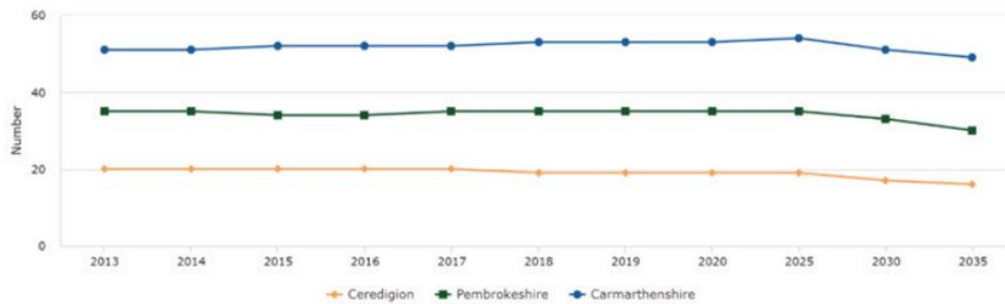


Dementia in people aged less than 65 is described as early onset dementia, young onset dementia or working age dementia. It is estimated that 1 in 1000 people in Wales have early onset dementia. This figure is slightly higher in Carmarthenshire and Pembrokeshire, and slightly higher still Ceredigion



Source: Daffodil Cymru

The Alzheimer's Society predict a small decrease in the numbers of people aged 30-64 with early onset dementia by 2035 (Alzheimer's Society). The following graph shows how this trend will affect the population in West Wales.



Source: Welsh Government

In 2015 there were an estimated 1,483 people over the age of 18 with a moderate or severe learning disability in the West Wales region. This represents just under 0.5% of the total adult population, which is comparable with the picture across Wales. The breakdown across the constituent parts of the region is as follows: Carmarthenshire: 713 Ceredigion: 305 Pembrokeshire: 465 The rate of incidence within the adult population stands at approximately 0.5% in each of the county areas, in line with the regional average. This regional total is predicted to rise to 1,571 by 2030, although as a percentage of the total population the position is expected to remain largely the same.

An increase of 35 in the total number of adults with a moderate or severe learning disability in Carmarthenshire is predicted over the same period, whilst in Pembrokeshire and Ceredigion numbers are expected to remain the same. This means the proportion of adults with a learning disability will decline slightly in those 2 areas (although the change will be negligible), whilst in Carmarthenshire it will remain about the same. Of note is the expected significant rise in the numbers of people aged 75 and over with a moderate or severe learning disability, estimated to increase by 33% by 2030. Current numbers and projections for each part of the region are as follows:

	2015	2030
Carmarthenshire	38	57
Ceredigion	16	23
Pembrokeshire	27	40
Region	81	122

Source: Daffodil Cymru

We know from the TCS listening and engagement exercise (summer 2017) that people want facilities that take account of ‘hidden disabilities’ such as learning disabilities, particularly in our A&E departments. The findings report for HDUHB published in September 2018 found that the majority of issues raised in relation to equalities impacts related to **travel and transport issues** for specific groups, which mainly include the frail, the elderly; **those with disabilities**; expectant parents; families with children and children themselves.

The COVID-19 pandemic and the necessity for many healthcare staff to wear face masks has made communication more difficult, especially for those Deaf or Hard of Hearing patients who use lip-reading to assist with communication. Some patients will use British Sign Language (BSL) and others who have become deafened and are hard of hearing may be fluent in English but do not use BSL. While some will be using technology such as hearing aids, many will not be using any assistive technology.

Workforce Information (extracted from the Strategic Equality Plan Annual Report 2024/25 and Annual Workforce Equality Report 2024/25)

At 31 March 2025, the Health Board employed 718 staff who identified as Disabled, which accounted for 5.37% of our workforce. (10.95% of staff had not recorded their response to this characteristic). The health board has measures in place to support those with a disability in the workplace and will continue to implement plans to increase support to ensure that current and future employees are not placed at any further disadvantage and to ensure that inclusivity is promoted across the health board.

Update 11.07.22

The local wellbeing assessments for each of three local authority areas published in May, 2022 have been reviewed and confirm the findings above and below.

The feedback from the Discussion Forum 14.06.22 with the public and the analysis of public questionnaire 'help us to understand how the location of the new urgent and planned care hospital may affect you', did not identify any new impacts upon persons with a disability. The findings in fact echoed those noted below

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Issue identified - Disability	Positive	Negative	No Impact	Opportunities for improvement / mitigation If not complete by the time the project / decision/ strategy / policy or plan goes live, these should also be included within the action plan.
The new urgent and planned care hospital and repurposed sites will be accessible for patients with a disability and sensory loss	✓			<p>The Programme includes new build and refurbished sites which provides opportunities to improve accessibility and patient experience for disabled people via facilities that are built to be physically accessible and disability and sensory loss-friendly e.g., loop systems, accessible signage, easy read, accessible drop off points and car park facilities</p> <p>We will ensure that our Health Board approach to continuous engagement and co-production of services facilitates the involvement of disabled people in the design of new and renovated site facilities.</p> <p>We will consider making Sensory Loss e-learning mandatory training for all new employees.</p> <ul style="list-style-type: none"> - Continue to offer specialised training to staff on how they can improve service delivery and support persons with a disability (including mental health and learning disabilities) and sensory loss when accessing services. - Managers to continue monitoring staff mandatory training records to ensure that staff have completed basic 'Treat me Fairly' e-learning. - Improved facilities on wards for those with dementia

<p>The new urgent and planned care hospital may be more difficult to access for people with disabilities because of its location and additional travel time.</p> <p>Disabled people living east of the region (e.g., Llanelli, Ammanford) may choose to travel to Morriston Hospital (Swansea UHB) which may impact upon their ability to access NEPTS transport</p>		✓	<p>The proposed community-based service delivery model has the potential to positively impact access and equity of service for people with a disability. By providing care closer to home could minimise travel, providing it is supported by adequate transport provision.</p> <p>Welsh Government have provided funding to establish a 6-month conveyance scheme to support service user flow to and from inpatient settings. The service has been operational since 1st May 2021 and is being provided by St. Johns Cymru. The service provides 1 full time vehicle with crew and operates from 10.00am – 10.00pm 7 days per week. Outside of these hours (10.00pm – 10.00am) there is an on-call system in place. The Health Board is currently working with Welsh Government to agree a sustainable funding model for service continuation post 2021/22.</p> <p>For those needing acute care consideration of transport and accessibility will need to be part of the Programme.</p> <p>Ensure that our Health Board approach to continuous engagement and co-production of services facilitates the involvement of disabled people in the design of new and renovated site facilities. From mental health perspective this will include West Wales Action for Mental Health and for learning disabilities it will be the RILP</p> <p>As part of regional transport planning and wider initiatives such as the South West Wales Metro, accessibility will form a key component of the public transport requirements, such as disabled friendly vehicles, infrastructure etc. These wider initiatives will consider this business case within their planning, reinforced by the work of the transport</p>
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			<p>workstream to ensure that all accessibility opportunities are taken forward.</p> <p>The Programme will explore the impact of service re-locations on patients, carers and families where accessing public transport is an issue. Discussions with Swansea Bay UHB re urgent care service provision to those who choose to travel to Morriston Hospital</p> <p>We will use digital technology to support access to specialist care & self-management.</p>
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<p>Disabled people are more likely to have high risk pregnancies and need to have care by a consultant obstetrician. This means they would need to attend the urgent and planned care hospital for the majority of their care which may mean a greater distance of travel than to existing maternity services</p> <p>Update 11.07.22 This was discussed at the clinical land appraisal workshops.</p>		✓	<p>Providing safe and quality consultant-led midwifery care 24/7 can only be achieved by creating a singular consultant-led unit at a one location within Hywel Dda UHB. Pooling specialist consultancy led midwifery care in the new hospital with the most up-to-date facilities will ensure that the best possible care and treatment for pregnant women who are at a higher risk of pregnancy-related complications. Provision of Midwifery Led Units at Withybush, Glangwili and Prince Philip hospitals and in some of the other community hubs across the region could mitigate against negative impacts of increased travel for women with low-risk pregnancies.</p> <p>We will seek advice from other Health Board's and trusts that have undertaken similar changes to services to better understand the impact it has had to ensure shared learning</p> <p>We will work with clinicians, specialists and professional recommendations from bodies.</p> <p>Update 11.07.22 As noted in the above section for women who choose to give birth at an older age. The mitigation from the perspective of participating clinicians would be a hospital site in the east area of the zone to enable the best access to tertiary services and specialist transport services provided along the M4 corridor. This area was also thought likely to provide the best opportunities to recruit and retain a workforce to support more complex births.</p>
<p>People's abilities to access services independently are likely to be affected by the level of their disability. Also, people with certain 'hidden' disabilities (e.g. autism spectrum disorder) might find it difficult to understand the</p>		✓	<p>The health board will continue to implement its communication strategy to inform the public at every opportunity of the progress made against our long-term plans. Communication will be promoted via a number of channels to ensure that the public know about any changes</p>

<p>changes being proposed and to adapt to changed facilities.</p>			<p>to healthcare services. This will include producing easy read versions and holding regular engagement sessions with the public and protected groups. Information will also be provided in alternative formats for those who need it.</p> <p>Our proposals are underpinned by a community model which will support people to stay well and live independently in their communities, enabled by joint working between health and social care services and the third sector. Community-based staff will be able to help support people with disabilities to adapt to the changes we are making and explain the benefits this will have for individuals.</p> <p>The health board will continue to implement its diversity and inclusion plans which includes raising awareness amongst staff and delivering training programmes to help staff who work with people who have autism and learning disabilities to enhance communication and effectiveness of care delivery.</p> <p>The Improving Care, Improving Lives report published in February 2020 has set out a number of recommendations regarding the provision of long-term hospital care for people with Learning Disabilities and we are developing an action plan which will set out how we will look to step people down and move closer to home. In the Hywel Dda area there are relatively small numbers with just 12 people placed in these care settings outside of the region. To date good progress has been made in moving individuals on from the Health Board long term care units with patients from Tudor and Ty Bryn now re-settled, with a further 2</p>
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			<p>patients due to move on from Bro Myrddin in September 2021</p> <p>We have recently established a Learning Disabilities Service Improvement Programme whereby we are undertaking a review of community and inpatient specialist LD Services. The work includes reviewing the role and function of the Teams, caseloads and capacity, demand and unmet need, with the view of informing a re-structure of services to meet our future needs. In scope of the review are Ty Bryn, Residential/Continuing Care Units in Pembrokeshire and the Community Learning Disability Teams</p>
<p>Update 31.07.23 Themes generated from the Residence Focus groups during the land consultation highlighted concerns about the impact of changes on patients and visitors with disabilities, who might already find travelling to hospital challenging and expensive.</p> <p>Themes generated from Interviews with Staff Members also highlighted that Service users with learning difficulties can struggle to adapt to change and may thus disengage with services unless their needs are taken into consideration in the design process. It was also considered especially important that as much care is</p>		<p>✓</p> <p>✓</p>	<p>Opportunities for improvement / mitigation regarding this theme are highlighted earlier on in the Disability section of the EHIA; with the proposed community-based service delivery model having the potential to positively impact access and equity of service for people with a disability.</p> <p>Update December 2025: Transport for all groups will be updated in the below Action Plan.</p> <p>A Learning Disability Service Improvement Programme has been established to oversee the redesign and restructure of LD Services. A number of workstreams were established with a range of multi-agency stakeholders including people with lived experience, their carers/families to review existing LD Services and develop a new model of service delivery in line with WG recommendations and local need. We are undertaking a comprehensive coproduction process in 2023 to facilitate the development of robust</p>

<p>provided in the community as possible for this patient cohort.</p> <p>The Public drop in events also raised a theme in regard to the D/deaf community and concerns as to how they would access clinical care at the new hospital site.</p>	<p>✓</p>		<p>operational processes and procedures in line with the proposed service delivery model.</p> <p>The Interpretation and Translation Access Guide for staff includes provision of BSL support. We can provide training to staff on how to access BSL and other interpretation and translation support services.</p> <p>Suggestions shared with Estates department which explains what good looks like for a facility for people with sensory loss. These suggestions could also be utilised for design considerations.</p> <p>Informatics team are commissioning a hybrid appointment system where patients, D/deaf and other vulnerable groups can manage their preferred language including BSL.</p>
<p>Attendees at the Community events expressed concerns over access to and within the new hospital for vulnerable residents and those living with disabilities. These issues could, it was said, be overcome by involving and engaging with a wide range of service users throughout the development process.</p>	<p>✓</p>		<p>The MH&LD Directorate will engage with those with lived experience, their carers and families on any proposed changes to services including location of services. Any proposed service changes will be fully coproduced and take into consideration the needs and wishes of those accessing services.</p> <p>The health board will continue to implement its diversity and inclusion plans which includes raising awareness amongst staff and delivering training programmes to help staff who work with vulnerable residents and those living with disabilities.</p> <p>The health board will also continue to implement its communication strategy to inform the public at every opportunity of developments regarding the new planned</p>

				and emergency care hospital. Communication will be promoted via a number of channels to ensure that the public know about any changes to healthcare services.
<p>Update 22.12.25 Engagement on strategy refresh identified impacts for people with sensory loss when accessing digital or virtual services.</p> <p>People with hearing loss shared that telephone consultations, or systems which required patients to call to arrange appointments or cancellations, or services available by phone were not accessible.</p> <p>People with sight loss shared that most websites or applications were inaccessible as they were not suitable for screen reading software.</p>		✓		<p>Opportunities for improvement / mitigation regarding hearing loss included increased use of text services which were more accessible for both groups as font size can be increased on devices.</p> <p>For people with hearing loss in particular, increasing the use of BSL translations and ensuring that virtual appointments have the ability to 'call in' interpreters was raised.</p> <p>For people with sight loss in particular, providing more materials in audio format for websites, as well as alternative forms of communication such as phone services are important steps to mitigate inaccessibility of websites and digital apps.</p>
<p>Update 22.12.25 Engagement on strategy refresh identified impacts for people with disabilities, particularly accessing their personal data through biometric security methods.</p> <p>Examples include people who experience a stroke and facial recognition no longer recognises the individual or inability to use fingerprint scanners on phones.</p>		✓		<p>Opportunities for improvement / mitigation regarding this theme will be around ensuring that any apps or websites that contain personal information are secure, but remain accessible for people with physical disabilities or changes as a result of a condition.</p>

Gender Re-assignment

Consider the potential impact on individuals who either: Have undergone, intend to undergo or are currently undergoing gender reassignment.

Do not intend to undergo medical treatment but wish to live permanently in a different gender from their gender at birth.

Evidence - Population Data

Gender Reassignment –

Research used to inform Welsh Government's Transgender Action Plan suggests the following:

- Many trans people consider transitioning or do transition in middle to later life.
- Age at disclosure of transgender identity is getting younger; and
- Transgender people report facing a number of possible barriers to using public transport, in particular: fears of harassment, abuse, or mis-gendering.

The survey results from a UK-Wide Trans Mental Health and Emotional Wellbeing Study conducted in 2012 also suggest the following:

- 1% of pupils should expect to be gender variant to some degree.
- 12% had been refused or ended care because of being trans or a trans history;
- 24% had experienced hurtful or insulting language about trans people;
- 29% had received a refusal to discuss or address a particular trans-related health concern;
- 54% had been told by the health professional they didn't know enough about a particular type of trans-related care to provide it. This has lowered to 45% according to Stonewall's 2023 data; and
- 61% had been asked questions about transgender people which made them feel they were educating the health professional.

Workforce Information (Ref: Strategic Equality Plan Annual Report 2024/25)

Statistics on gender reassignment are not currently collected on the Health Board's Electronic Staff Record system, however, probability tells us that we are likely to have a small percentage of staff who are gender variant to some degree.

Information on all Health Board on referrals to Gender Reassignment services can be found via Welsh Health Specialised Services Committee (WHSSC)

According to the Census 2021, 91-93% of the population across our three counties identify as being the same sex registered at birth.

County	Non Binary	Trans Man	Trans Woman	Different to registered at birth (not specified)
Ceredigion	0.22%	0.06%	0.12%	0.14%
Carmarthenshire	0.04%	0.06%	0.06%	0.12%
Pembrokeshire	0.04%	0.06%	0.06%	0.12%

*An average of 7% did not answer the question on Gender Identity. Source: Office for National Statistics, Census 2021

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Impact identified - Gender Re assignment	Positive	Negative	No Impact	Opportunities for improvement / mitigation If not complete by the time the project / decision/ strategy / policy or plan goes live, these should also be included within the action plan.
Positive impacts are anticipated for people who are transgender or are undergoing gender reassignment, including having care closer to home via MIUs and community hubs.	✓			Care closer to home via MIUs and community hubs. Community-based care services will continue to undergo EIA to ensure that gender reassignment will be considered as part of our service delivery plans. Therapy for people who are transgender and who are undergoing gender reassignment will be delivered locally, and this has been considered under the Transforming Mental Health programme
The capital programme will enable the design of the new hospital and renovated sites to provide gender neutral facilities that will improve patient experience	✓			Our transgender population should expect to see improved mental health and wellbeing supported in the community with early intervention, advice and support delivered locally with improved access to experts
Transgender mothers are more likely to have high-risk pregnancies and need to have care by a consultant obstetrician; this means they would need to attend the new hospital for the majority of their care, which may impact on distance of travel and how able they are able to get to the new unit.		✓		Taxis can be provided to support access to these services. These mothers are likely to require ongoing inter professional support by other agencies and support by the mental health services which is currently in place. Discussions on access to services closer to home from neighboring health boards Patient Experience Midwife will work alongside the consultant midwife who supports bespoke birth plans for transgender parents. Staff education and training

Sex

Consider whether those affected are mostly male or female and where it applies to both equally does it affect one differently to the other?

Population data from Stats Wales tells us that there are almost equal numbers of males and females across all three counties within the Hywel Dda region. Women in the Hywel Dda region have a longer life expectancy of 82.7 years compared to 78.9 years for men. Men are more likely to:

- Die of diseases that are attributable to smoking, including all cancers, all circulatory disease, all respiratory disease, and all diseases of the digestive system.
- Have Types 1 and 2 diabetes: and
- Report drinking alcohol above guidelines.

The percentage of adults reporting to be overweight or obese is higher in men than women for each age group.

Women are more likely to report, consult for and be diagnosed with depression and anxiety. However, it is possible that depression and anxiety are under-diagnosed in men. Suicide is more common in men, as are all forms of substance abuse.

Workforce Information

On 31 March 2025, the Health Board employed 13,361 staff of which 79.13% identified as female and 20.87% identified as male.

Issue identified - Sex	Positive	Negative	No Impact	Opportunities for improvement / mitigation If not complete by the time the project / decision/ strategy / policy or plan goes live, these should also be included within the action plan.
<p>Some patients prefer to be supported by someone of the same sex, e.g., some women may request not to be supported by 'male' staff, which may be difficult to fulfil if services are stretched across another site.</p>		✓		<p>Where possible, the health board will respect patient choice and aim to provide health and care in line with personal preferences by reviewing staffing rotas and sourcing available staff. Increased support will also be available via new roles such as Family liaison officer who can support patients and help staff to understand their needs.</p>
<p>Update 11.07.22 A new impact and mitigation has been identified as part of the clinical land appraisal workshops June 22 which particularly impacts on women.</p> <p>Due to the co-location of Obstetrics and Gynaecology with Paediatrics services and the clinical risks identified due to a reduction in birthing numbers, women are likely to experience a greater impact than men as they provide a broader range of clinical support outside of births.</p>		✓		<p>The impact would be mitigated by a hospital sited in the eastern area of the zone to enable the greatest number of births to reduce impacts on obstetrics and gynaecology services to support women in Hywel Dda.</p> <p>Mitigations will be explored as part of pathway activity.</p> <p>No further sex impacts or mitigations were identified</p>
<p>Update 31.07.23 Feedback gathered during Community events highlighted a number of other suggestions to accommodate individual needs, such as providing a creche and childcare; offering a "multi faith room in the new hospital"; offering translation and interpretation services; and providing quiet spaces for those who need them.</p>	✓			<p>There is the potential for the new hospital and re-furbished sites to better meet the needs of families and patients through the provision of creche and childcare services.</p>

Marriage and Civil Partnership

Under the Equality Act, the characteristic of Marriage and Civil Partnerships is only protected in the workplace/ employment. This also covers those who are not married or in a civil partnership.

Data from the population health profile 2025;

Never married/ civil partnership – 30.6%

Married / civil partnership – 51.9%

The proposal will have no impact upon service users because of their marital status. Having analysed the available data in our Workforce Equality Report for 2024/2025, the proposal will also have no impact upon staff who are married or in a civil partnership.

Impact identified - Marriage and Civil Partnership	Positive	Negative	No Impact	Opportunities for improvement / mitigation If not complete by the time the project / decision/ strategy / policy or plan goes live, these should also be included within the action plan.
Improved facilities for patients and partners in palliative care	✓			The programme will enable the facilities that are offered for patients and partners in palliative care, to meet the values of patient voice and choice.

Pregnancy and Maternity

Maternity covers the period when the mother books with maternity services between 9 and 11 weeks in pregnancy to 26 weeks after having a baby whether they are on maternity leave or not.

Hywel Dda has a lower birth rate than the Wales average, with 56.8 live births per 1,000 women aged 15-44 years (Wales has 59.1 live births per 1,000 women aged 15-44 years). In Wales and England, the average age of mothers continues to rise (ONS 2015). This is important because there is an increased risk of developing gestational diabetes (diabetes in pregnancy) in older mothers, which in turn, raises the risk of women subsequently developing type 2 diabetes. Older women are also more likely to have pregnancy complications such as high blood pressure, placenta praevia, pre-eclampsia, premature birth, and stillbirth and to have babies with genetic or chromosomal defects.

Birth weight is an important consideration when determining the future health and well-being of children. Maternal smoking and nutrition are important risk factors associated with low birth weight (less than 2500g). Low birth weight babies are not only at a greater risk of problems occurring during and after birth but there is also an association with poor health and increased risk of chronic diseases in adulthood. The percentage of low-birth-weight babies in Hywel Dda (5.7%) is similar to Wales (5.8%), and at a county level are highest in Carmarthenshire (6.5%) and lowest in Ceredigion (4.6%) (Pembrokeshire 6.2%) (StatsWales). Breastfed babies are less likely to have to go to hospital with infections and are more likely to grow up with a healthy weight and without allergies. The percentage of babies breastfed at birth is higher in Hywel Dda (71.8%) than it is in Wales overall (63.5%), We're seeking the updated numbers per county (StatsWales 2022).

Pregnancy is a powerful motivator for change as it represents a time when women and partners are more susceptible to new information and are more likely to make positive lifestyle changes to provide optimal conditions to ensure the health and wellbeing of the unborn baby. The periods before, during and after pregnancy also provide opportunities to give women practical, consistent advice to help them manage their weight and stop smoking to avoid associated complications. The health benefits of breastfeeding are far reaching for both infants and mothers. These benefits are often not being realised, with only 1% of children in the UK being breastfed up to 12 months. In addition to the health impact, it is estimated that not breastfeeding results in a loss of around £200 billion in economic growth globally every year. Breastfeeding reduces health inequalities and has environmental benefits. National Infant Feeding Surveys have shown that over 90% of women who stop breastfeeding in the first 6 weeks would have liked to breastfeed for longer. Success in breastfeeding is not solely the responsibility of mothers, but a collective responsibility of society through the wide adoption of breastfeeding friendly initiatives and policies.¹

We know from the TCS listening and engagement exercise (summer 2017) that travel and transport and access to healthcare services were particularly problematic for expectant women and new mothers. Our Big NHS Change, findings report in Sept 18 found that the **majority of issues raised in relation to equalities impacts related to travel and transport issues** for specific groups, chiefly: the elderly; those with disabilities; **expectant parents**; families with children and children themselves. There were comments about other specific equality groups which could be affected by the proposals e.g. **'I am concerned about expectant mothers from the extreme west and north of Pembrokeshire should an emergency arise.**

Data from the population health profile 2025 there were 3,037 births.

Workforce Information (Ref: Annual Workforce Equality Report 2024/25)

Conclusions following the analysis of data:

The number of employees recorded as taking maternity and adoption leave is 614, which is 4.6% of the workforce. This is an increase of 0.01% on the data reported on 31 March 2024.

There were no employees on maternity or adoption leave involved in grievance or disciplinary procedures during the reporting period.

¹ HDUHB: Pharmaceutical Needs Assessment Oct 2021

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Impact identified - Pregnancy and Maternity	Positive	Negative	No Impact	Opportunities for improvement / mitigation If not complete by the time the project / decision/ strategy / policy or plan goes live, these should also be included within the action plan.
<p>Women may be negatively impacted by having to travel further to the new urgent and planned care hospital for services including: Antenatal, labour and postnatal follow up care.</p>		✓		<p>The programme / new model has potential to increase number of home births.</p> <p>Safer care and quality of services</p> <p>Mothers to continue to have a thorough risk assessment during pregnancy to ensure they have their babies in the right area according to risk.</p> <p>Collate patient experience information from PALS from social media and from maternity experience midwives' coming into post to develop mitigations.</p> <p>To ensure we use PREMS to monitor our outcomes. Monitor clinical risks using DATIX system</p>
<p>The transfer time for women from GGH midwifery led unit, to the new obstetric unit in an event of an emergency would take longer. This will have impact on WAST and their timely availability in the event of an emergency transfer being required.</p>		✓		<p>Early recognition of complications, the development of clear clinical pathways, early communication with WAST and obstetric unit in new build.</p>
<p>Very clinically high-risk mothers who are assessed to be not suitable to give birth in BGH, and babies born in poor condition requiring SCBU care would need to come to the new hospital (BGH does not have a SCBU facility).</p>		✓		<p>All community midwives have laptops and remote access to access results so that mothers are given timely support after attending hospital to mitigate the risk of them returning</p>

<p>There is a risk it might take longer with the new hospital to transfer emergency patients from Bronglais Hospital without appropriate transport infrastructure in place. For high-risk mothers not suitable to give birth in BGH, this would mean the majority of their antenatal care might be conducted by consultant led obstetricians in the new unit.</p>	✓	<p>The location of the New Urgent and Planned Care Hospital is not yet determined. Travel times for services will be part of the consideration of suitable alternative sites.</p> <p>BGH will continue to provide support to parents during their pregnancies and up until the baby is born. BGH is a bespoke obstetric unit with 450 births a year where care is supported by obstetric consultants for medium risk mothers. Strict pathways and protocols will continue to determine the most appropriate treatment site.</p> <p>There are and will continue to be Maternity Infant Feeding coordinators who provide support in WGH, GGH and BGH. These roles provide individualised breast feeding / infant feeding support. Virtual access has also been supported.</p> <p>7 community midwifery teams that work across the health board that provide and will continue to provide antenatal, postnatal and care during labour for mothers and provide public health advice in line with All Wales Maternity Vision. They will also continue to work alongside GPs and visitors to provide postnatal care in line with national guidance (NICE)</p> <p>Opportunities to provide areas for staff within new hospital and repurposed sites areas for breast-feeding.</p> <p>Continued engagement as business case develops further detail, cognisant of concerns raised for maternity services.</p> <p>Community based support groups, midwifery / health visiting services will be subject to the same benefits in local transport network requirements</p>
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<p>For mothers living to the East of the Health Board (Ammanford, Llanelli, Burry Port, Trimsaran), there is a possibility that they would want to have their pregnancy care in Singleton Hospital , Swansea Bay University Hospital as this will be closer to their home This would have an impact on the continuing skill set of the obstetric and neonatal staff in the new hospital due to the reduced number of births, babies requiring SCBU care and exposure to high risk cases</p>		✓	<p>On booking with Hywel Dda Maternity Services Community midwives would ensure that place of birth is discussed and give the 'place of birth' decision booklet to mothers to ensure that they have an informed choice where to give birth and the facilities available in the new hospital including reference to transport times in the event that mother has a home birth or requires transfer from midwifery led unit.</p> <p>The UHB will put in place any requirements including working with our neighboring UHB's to ensure a sustainable and suitably skilled workforce.</p>
<p>From a staffing perspective, there is a risk that staff living to the east of the health Board area might look for jobs closer to home rather than travel further to the new hospital. This might also be a factor for recruitment into the maternity and neonatal departments.</p>		✓	<p>The location of the new hospital is not yet determined and therefore the potential impact not yet known. The UHB would seek to ensure very attractive jobs in a new hospital would be attractive to new and existing staff.</p> <p>Midwives currently work a 12-hour shift pattern in Glangwili and Bronglais in order to mitigate the risk of daily travel to work.</p> <p>Community Midwives work a 9-5 shift pattern with community on calls. These shift patterns are in place to ensure that care remains close to home and there is optimum continuity of carer to ensure the safety and quality of the service.</p> <p>Discussion with Swansea Bay about cross site working / cross site training to ensure that the skills set of our obstetricians and midwives is relevant for DGH services.</p>

<p>Currently 300 mothers go to Swansea Bay consequently there is an increased chance that this will increase which would impact on the number of births in the health board and the level of the Special Care Baby Unit which is currently level 1-2. This would have an impact on the increased number of births required in Singleton Hospital on Swansea Bay.</p>		✓	<p>The location of the new hospital is not yet known and this issue will be one of the factors used to determine the most appropriate location.</p> <p>The UHB is also already in discussion with Swansea Bay University Health Board to discuss the potential impact of any activity flow changes and this will be an important part of the planning of services between the Health Boards</p>
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Race or Ethnicity

People of a different race, nationality, colour, culture or ethnic origin including non-English / Welsh speakers, gypsies/travellers, asylum seekers and migrant workers

Data has been collated to inform this section from a variety of sources, all of which are listed in the introduction section.

The Black Asian and Minority Ethnic population in the Hywel Dda region is made up of less than 3% of the overall population (compared to 5.6% in Wales).

Most of the current healthcare research data for Black Asian and Minority Ethnic populations focuses on the impact of COVID and the fact that people from a Black Asian and Minority Ethnic background experience greater risk of COVID and are more likely to suffer serious health complications from the disease.

Since 2011 there has been inward migration of people from other parts of the EU and of refugees and asylum seekers from other parts of the world. Hywel Dda contains communities of Eastern Europeans, with a concentration – particularly of Polish people – in and around Llanelli (an urban town in Carmarthenshire). Our three counties have been involved in re-locating Syrian refugees and we also have a proportion of Black Asian and Minority Ethnic staff among our workforce.

The numbers of White Gypsy Roma Travellers or Irish Travellers vary by county with 7 caravans in Ceredigion, 174 caravans in Pembrokeshire and 68 caravans in Carmarthenshire. The Gypsy Roma Traveller population faces poorer health outcomes when compared to the general population.

Certain groups such as Gypsy Roma Traveller groups, refugees and asylum-seekers are less likely to be registered with general practices.

Black Asian and Minority Ethnic groups generally have worse health than the overall population, although some groups fare much worse than others, and patterns vary from one health condition to the next. Surveys commonly show that Pakistani, Bangladeshi and Black-Caribbean people report the poorest health. South Asian and Caribbean-descended populations have a substantially higher risk of diabetes; Bangladeshi-descended populations are more likely to avoid alcohol but to smoke, and sickle cell anaemia is an inherited blood disorder, which mainly affects people of African or Caribbean origin.

UK research, including that of Public Health Wales suggests that:

- Ethnic differences in health are most marked in the areas of mental wellbeing, cancer, heart disease, human immunodeficiency virus (HIV), tuberculosis and diabetes. Black Asian and Minority Ethnic persons tend to have higher rates of cardio-vascular disease than White, British people, but lower rates of many cancers.

- Elderly Black Asian and Minority Ethnic persons are also more likely to be disproportionately affected by health conditions. This means that an increase in the number of older black and minority ethnic people is likely to lead to a greater need for provision of culturally sensitive social care and palliative care.
- There are worse rates of ill-health among Black Asian and Minority Ethnic persons born in the UK than in first generation migrants).

The same UK research also highlights differences in the way that Black Asian and Minority Ethnic persons use healthcare services, these include:

- Most Black Asian and Minority Ethnic groups are likely to access primary care services in the same way as White groups but are less likely to access secondary care services;
- Rates of smoking cessation have been lower in Black Asian and Minority Ethnic groups than in White groups;
- Rates of dissatisfaction with NHS services are higher among some Black Asian and Minority Ethnic groups than their White British counterparts.

Public Health Wales has found that Black Asian and Minority Ethnic persons are more likely to come from low-income families, suffering poorer living conditions and gain lower levels of educational qualifications. In Hywel Dda, Black Asian and Minority Ethnic groups are less likely to own a car or van. Lack of access to their own transport would impact on individuals within these groups who would be reliant on public transport to access services in any capacity. Black Asian and Minority Ethnic groups also may face discrimination and harassment and may be possible targets for hate crime.

It is important to note that Black Asian and Minority Ethnic groups are diverse in terms of migration history, culture, language and religion. The health board must consider this diversity in its service planning and aim to meet the needs of individuals.

At 31 March 2025 the Health Board employed 1,249 staff who identified their ethnic group as Asian or Asian British, Black or Black British, Mixed, or any other ethnic group. This accounted for 9.34% of our workforce and an increase of 219 staff compared with 2024 data. 687 employees (5.14%) have chosen not to record their ethnicity on ESR which makes data analysis and comparisons less accurate.

Impact identified - Race and Ethnicity	Positive	Negative	No Impact	Opportunities for improvement / mitigation If not complete by the time the project / decision/ strategy / policy or plan goes live, these should also be included within the action plan.
There are some ethnic minority populations that have a history of greater health problems than the overall population.	✓			<p>The focus of the community model on prevention and early intervention will be particularly relevant to some ethnic minority populations who may have greater health problems than the overall population.</p> <p>The Health Board has invested in a Community Development Outreach team to engage to provide further insight into the needs of our need to reach communities, including some ethnic minority populations, Gypsy Roma Travellers, migrants, asylum seekers and refugees and any other vulnerable groups. Feedback obtained from the engagement work can be used to inform service development to ensure that any health risks and disadvantage relating to ethnic minority population and service users is minimised.</p>
Some groups such as the Gypsy Roma Travelling community have been identified as tending to be more reluctant to access health care and possibly may not engage in attending for consultation in a new hospital.		✓		<p>A number of positive impacts are anticipated, including having care closer to home via MIUs and community hubs. Specific engagement with ethnic minority populations and GRT communities can be facilitated via the Community Development Outreach Team.</p> <p>We will provide information in other languages as requested to ensure that ethnic minority populations understand the changes we are making and are encouraged to engage with the health board on an ongoing basis.</p> <p>We will pay due consideration to barriers to access that impact the travelling community.</p>

<p>Issues that have been highlighted for both migrants and asylum seekers include the need for more advocacy and floating support for migrants, lack of a strategic approach to information and service provision for new migrants and lack of coordination between services for migrants, asylum seekers and refugees.</p>	<p>✓</p>			<p>Determining the language and suitability of format (e.g., written, audio, face to face, telephone) and support available, such as advocacy and interpretation are critical elements to ensure effective communication. Training and Education of the workforce resulting in improved communication.</p> <p>The health board will liaise with the Resettlement Managers in the local authorities to ensure that appropriate support and information is provided to migrants and asylum seekers around accessing healthcare services.</p>

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Religion or Belief (or non-Belief)

The term 'religion' includes a religious or philosophical belief.

According to the 2021 Census, around 46-48% of our counties' population are Christian, around 43-44% have no religion and 6-7% would prefer not to say.

Evidence suggests that certain religious groups (e.g., Muslims) report worse health than average.

Religion and belief within a healthcare environment could impact on:

- Gender and choice of staff.
- Disclosure of sensitive information.
- Attitudes towards illness and health practices.
- The ways in which health promotion messages are received and acted upon, for example, some religious practices (such as not drinking alcohol) may have positive links to health; others may affect whether or not certain medications can be taken due to animal/alcohol by-products.

The health board will need to consider the above and what it could mean for service delivery and the impact it could have upon the wellbeing of our service users and staff.

Workforce Information (Ref: Annual Workforce Equality Report 24/25)

The percentage of staff identifying a specific religion or belief has risen by 1.76% compared to data reported on 31 March 2024. The workforce profile of Hywel Dda highlights that 42.62% are Christian, 13.76% are of other religion, 17.39% reported as atheists and 18.45% preferred not to say. 7.78% of the workforce are not recorded on ESR which makes drawing a conclusion on the data more difficult.

Issue identified - Religion or Belief	Positive	Negative	No Impact	Opportunities for improvement / mitigation If not complete by the time the project / decision/ strategy / policy or plan goes live, these should also be included within the action plan.
Lack of education amongst staff of the religious requirements of service users and colleagues. Staff might be unaware of the religious and spiritual needs of patients. For example, patients are not offered running water to wash their hands in particularly before meals, patient's dietary requirements are not met.		✓		<p>Increase staff training around religion and belief and how they can meet the needs of service users and support staff within the workplace.</p> <p>Facilitate and enable conversations about 'patients' faith' and how they want to connect.</p> <p>Raise awareness about the available facilities within our hospitals and ensure that staff and patients are able to access them.</p> <p>Assess our community hubs to ensure that people are empowered to have quiet and prayer time within their own space.</p> <p>Review admission procedures to ensure that religious and spiritual needs are identified at the earliest opportunity.</p> <p>Encourage people to do what they want to do within their 'given space' e.g., by the hospital bedside, providing it is appropriate and safe to do so.</p> <p>Every person needs to be given the opportunity to deal with their lifestyle in their own way.</p>
Lack of facilities that are sensitive to the needs of religious people; for example, spaces for prayer and observance of religious festivals, and facilities that protect dignity, modesty and privacy.	✓			Assess opportunities to develop space in new hospital and re furnished sites for prayer or quiet spaces. Include places of worship which are suitable for everyone, quiet safe spaces / belief and non-belief.

			<p>Consideration of prayer needs for both patients and staff (e.g., direction of prayer room). Consideration of mortuary services and their experiences of supporting bereavement.</p> <p>Open spaces and being outdoors are important to people. The health board will consider creating corridor outside the urgent and planned care hospital for people to reflect. There are opportunities to incorporate faith symbols in a corridor, people may want to meditate, electric candles burning, etc.</p> <p>Discussions with Aneurin Bevan Health board to share learning on their facilities.</p>
Staff may be prevented from providing care and treatment due to religious requirements e.g., patients who are unable to receive medication with animal / alcohol ingredients. Patients are unwilling to receive blood transfusion.		✓	<p>Increased staff training to help raise awareness and enable conversations with service users and their families to discuss the best course of health and care treatment which will not conflict with their religious beliefs</p>
<p>Update 31.07.23</p> <p>Feedback gathered during Community events highlighted a number of other suggestions to accommodate individual needs, such as providing a creche and childcare; offering a “multi faith room in the new hospital”; offering translation and interpretation services; and providing quiet spaces for those who need them.</p>		✓	<p>This theme has been captured earlier on in the EHIA but did lead to additional opportunities for improvement/mitigation. Recent communications with staff across the health board has identified a need for an ablutions room as part of the faith centre/quiet spaces; this would be particularly relevant for the Islamic community.</p> <p>It has also been noted that the faith centre/quiet space be large enough to allow multiple faiths to be present at the same time, therefore ensuring the space is as effective as possible. The need for a screen to divide the room (when needed) was also highlighted.</p>

				<p>It was also recommended that the faith area/quiet space contain a reflective space for those of no faith and that there is connection to the internet. There have been examples where inpatients have used existing faith areas/quiet rooms for a webcast to connect to a funeral of a friend or relative and that away space is important for their meditation.</p>
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Sexual Orientation

Whether a person's sexual attraction is towards their own sex, the opposite sex or to both sexes.

Data provided by Stonewall Cymru reports that approximately 7% of people living within the Hywel Dda region would be Lesbian, Gay or Bisexual. A survey conducted by the Equality and Human Rights Commission in 2012 suggested that employees who are LGBTQ+ are more likely to have poorer physical and mental health outcomes than heterosexual people.

Research suggests that the following barriers exist for LGBTQ+ persons when accessing health care services:

- Some health care professionals lack knowledge of LGBTQ+ persons' health care needs or have negative attitudes towards LGBTQ+ people;
- LGBTQ+ persons may delay or avoid seeking services because of their experiences of past discrimination or perceived homophobia within the health care system;
- Some LGBTQ+ persons are reluctant to disclose their sexual orientation, which may mean they do not receive appropriate care;
- Access may be affected by LGBTQ+ persons' ethnicity, education and income level, geographic isolation, immigration status, knowledge and cultural beliefs.

The public health white paper 'Healthy Lives, Healthy People' identified poor mental health, sexually transmitted infections, problematic drug and alcohol use and smoking as the top public health issues facing the UK. All of these disproportionately affect Lesbian Gay Bisexual Transgender (LGBTQ+) populations:

- Illicit drug use amongst LGBTQ+ people is at least 8 times higher than in the general population.
- Around 25% of LGBTQ+ people indicate a level of alcohol dependency.
- Nearly half of LGBTQ+ individuals smoke, compared with a quarter of their heterosexual peers.
- LGBTQ+ people are at higher risk of mental disorder, suicidal ideation, substance misuse and deliberate self-harm.
- 41% of transgender people reported attempting suicide compared to 1.6% of the general population.

Workforce Information

At 31 March 2025 Health Board data showed that 2.61% of staff had recorded their sexual orientation as Lesbian, Gay or Bisexual, which is an increase of 0.19% from 31 March 2024.

A survey conducted by the Equality and Human Rights Commission in 2012 suggested that employees who are LGBTQ+ are twice as likely to be bullied and discriminated against in comparison to heterosexual employees.

Based on the data above, I would suggest that there are potential negative impacts:

Negative Impact - Lack of awareness amongst staff about the individual needs of LGBTQ+ service users which may require sensitivity and encouragement when accessing services.

Mitigating Action – The health board’s Business, Partnerships and Inclusion Team will continue to promote diversity and inclusion and raise awareness amongst staff of the individual needs of LGBTQ+ service users. This will be achieved via staff training, communication and promotion. The health board will continue to engage with LGBTQ+ communities to ensure that their health concerns are considered in our service delivery and policy development.

Positive Impact – LGBTQ+ staff members feel included and supported in the workplace due to the commitment of the health board to implement LGBTQ+ initiatives, for example participating in LGBTQ+ events, facilitating an LGBTQ+ staff network.

Action – continue to engage with LGBTQ+ staff and encourage inclusive attitudes amongst the workforce.

Issue identified - Sexual orientation	Positive	Negative	No Impact	Opportunities for improvement / mitigation <small>If not complete by the time the project / decision/ strategy / policy or plan goes live, these should also be included within the action plan.</small>
It is not foreseen at this stage that any of the changes proposed will disproportionately disadvantage people based on their sexual orientation.				
				<p>There is the opportunity to deliver services that are inclusive of LGB persons, and to target health promotion messages to LGB persons that better suit their unique health needs.</p> <p>The programme will engage with the Enfys network.</p>

Welsh Language

Please note opportunities for persons to use the Welsh language and treating the Welsh language no less favourably than the English language.

The Hywel Dda region has a high percentage of Welsh speakers. 47% of the Hywel Dda Population are Welsh speaking. Recent increases in Welsh speakers are largely among younger age groups; that is, school-age children attending Welsh medium schools.

It is vital that healthcare services are available in the Welsh language for people within the community for whom Welsh is the language of choice or need. Although most Welsh speakers are bilingual, in situations of stress and vulnerability many feel more comfortable and confident communicating in Welsh with healthcare professionals and are more able to express their thoughts and feelings through the medium of Welsh. Moreover, even those who are fluent in English may temporarily lose their command of English and revert completely to Welsh when they are tired, ill, or under stress.

The TCS programme was informed by the findings of the West Wales Population Assessment, which was required to consider how care and support services will be provided through the medium of Welsh. It will respond to the recommendation arising from the population assessment that 'Services should be available in Welsh for all who need them'.

Our Big NHS Change, findings report for HDUHB in Sept 18 identified specific suggestions around ensuring future healthcare facilities and services are fully inclusive and designed to cater for the needs of all protected characteristics. These included: translation services for those whose first language is not English or Welsh.

Workforce Data

The Health Board is setting its own target to ensure 50% of its workforce have a skill level which is at foundation level or above within the next 10 years. This target is aligned to the National Population Survey 2022 published by the Welsh Government, around 48% of the Hywel Dda population are able to speak Welsh. As at March 2025, 35.0% of the workforce have Welsh language skills at foundational level or higher, whilst it shows a slight decrease of 0.03% there is an increase in headcount of an additional 106 employees at foundation level and above. Those staff whose Welsh Language Skills are not recorded on ESR is 2.6% (312 employees). This has increased when compared to the headcount reported in 2024/25.

Issue identified - Welsh language	Positive	Negative	No Impact	Opportunities for improvement / mitigation If not complete by the time the project / decision/ strategy / policy or plan goes live, these should also be included within the action plan.
<p>Lack of Welsh speaking staff to provide services bilingually to those who prefer to be dealt with in Welsh. This may be more of a risk for elderly patients and very young children who are only able to communicate effectively in Welsh.</p> <p>The centralization of consultant led maternity services also means there is a risk that a lack of Welsh speaking staff in maternity services will prevent families from receiving care in their preferred language.</p>		✓		<p>Consolidating urgent and planned care on one hospital site could provide a wider pool of Welsh speaking staff to further integrate the Welsh language in healthcare delivery.</p> <p>There will be a proactive drive to ensure patient information leaflets, signposting, maternity services health board page are bilingual in line with the Welsh Language Act</p> <p>The health board will continue to implement monitor progress against the actions within its bilingual skills strategy, the Welsh Language Standards and the 'More than Just Words' Strategic Framework. Progress will be detailed in the annual monitoring procedures.</p> <p>They health board will continue to contribute to the wider implementation of 'Cymraeg 2050: Welsh Language Strategy', which is Welsh Government's vision for reaching a million Welsh speakers in Wales by 2050. The health boards will take action to promote and increase the use of Welsh in the workplace and across different service areas which should have a positive impact on both our service users and our staff.</p> <p>There is an opportunity to improve the quality of our signage as well as to rebrand and embed local culture and the Welsh language into our new site and planned refurbishments. All signage external and internal will be bilingual.</p>

			<p>The health board will continue to increase training opportunities for staff to improve Welsh language skills and will expand the current practice for staff to display the 'iaith gwaith' logo to identify themselves as Welsh speakers.</p> <p>Welsh Language Champions will continue to promote bilingualism and Welsh language initiatives across the organisations.</p>
<p>Update 31.07.23 Elderly patients and those dependent on public transport will be particularly badly affected by the move to a more rural location as the new site is poorly connected to public transport and many will need to travel long distances to access urgent and planned care. Moreover, the likely displacement of patients and services such as maternity and obstetrics to Swansea will undermine access to Welsh Language based healthcare given the lower levels of Welsh spoken outside Carmarthenshire. This is likely to produce further dislocation and disadvantage for Welsh speaking Carmarthenshire and Ceredigion residents.</p>		✓	<p>Opportunities for improvement / mitigation regarding the transport element of this theme are highlighted in both the Age and Disability section. Mitigations are also captured within Part 4 – Health Wider determinant for consideration: Access and quality of services of the EHIA.</p> <p>Update December 2025: Transport for all groups will be updated in the below Action Plan.</p> <p>All Health boards are subject to the same Welsh language standards as Hywel Dda.</p>

Intersectionality

It may be important to break the analysis down by more than one protected characteristic. This is often referred to as 'intersectionality'.

Intersectional disadvantage (a phrase used to describe the relationship between overlapping social identities and protected characteristics) and at-risk groups, such as homeless people and carers. The Health Board recognises that increasingly, it is understood that inequality is intersectional. People's characteristics interact in a complex way to give a unique experience of inequality. For example, the experience of a Muslim woman cannot separate 'female' and her experience as a Muslim. It will differ from that of a Muslim man and of a non-Muslim woman. Another example, while an EIA may identify impacts for Muslim people, it will be important to recognise that impacts could be very different for a Muslim woman compared to a Muslim man.

As the EHIA continues to develop we endeavour to capture and suggest mitigating actions with consideration for intersectional disadvantage.

Part 3 – Human Rights

Human Rights: The Human Rights Act contains 15 Articles (or rights), all of which NHS organisations have a duty to act compatibly with and to respect, protect and fulfil. The 6 rights that are particularly relevant to healthcare are listed below. For a fuller explanation of these rights and other rights in the Human Rights Act please refer to Appendix A: The Legislative Framework.

Depending on the Policy you are considering, you may find the examples below helpful in relation to the Articles.

Consider, is the Policy relevant to:	Yes	No
<p>Article 2: The right to life</p> <p>Example: The protection and promotion of the safety and welfare of patients and staff; issues of patient restraint and control</p>	✓	
<p>Article 3: The right not be tortured or treated in an inhuman or degrading way</p> <p>Example: Issues of dignity and privacy; the protection and promotion of the safety and welfare of patients and staff; the treatment of vulnerable groups or groups that may experience social exclusion, for example, gypsies and travellers; Issues of patient restraint and control</p>	✓	
<p>Article 5: The right to liberty</p> <p>Example: Issues of patient choice, control, empowerment and independence; issues of patient restraint and control</p>	✓	
<p>Article 6: The right to a fair trial</p> <p>Example: issues of patient choice, control, empowerment and independence</p>	✓	
<p>Article 8: The right to respect for private and family life, home and correspondence; Issues of patient restraint and control</p> <p>Example: Issues of dignity and privacy; the protection and promotion of the safety and welfare of patients and staff; the treatment of vulnerable groups or groups that may experience social exclusion, for example, gypsies and travellers; the right of a patient or employee to enjoy their family and/or private life</p>	✓	
<p>Article 11: The right to freedom of thought, conscience and religion</p> <p>Example: The protection and promotion of the safety and welfare of patients and staff; the treatment of vulnerable groups or groups that may experience social exclusion, for example, gypsies and travellers</p>	✓	

Part 4 – Health

Questions in this section relate to the impact on the health and wellbeing outcomes of the population and specific population groups (sometimes referred to as communities of interest or communities of place) who could be more impacted than others by a policy / project / proposal.

The part of the assessment identifies;

- Which specific groups in the population could be impacted more (inequalities)
- Potential gaps, opportunities to maximise positive health and wellbeing outcomes.
- Recommendations / mitigation to be considered by the decision makers.

Identification of specific population groups

The groups listed below have been identified as more susceptible to poorer health and wellbeing outcomes (health inequalities) and therefore it is important to consider them in EHIA Screening and Appraisal. In an EHIA, the groups identified as more sensitive to potential impacts will depend on the characteristics of the local population, the context, and the nature of the proposal itself. The lists provided are therefore just a guide and are not exhaustive. It may be appropriate to focus on groups that have multiple disadvantages.

Complete the wider determinants framework table below providing rational / evidence where appropriate:

1. Consider how the proposal could impact on the population and specific population groups identified above (positive / negative) for each of the wider determinants (the bullets under each determinant are there as a guide).
2. Record any unintended consequences (negative impacts) and / or gaps identified. Please remember to include evidence to support this view along with details of any engagement which has taken place with any group(s)
3. Record any positive impacts or missed opportunities to maximise positive health and wellbeing outcomes.
4. identify and record mitigation / recommendations where appropriate.

Please note you may find that not all determinants are relevant to the project / plan.

Wider determinant for consideration Lifestyles (Diet / nutrition / breastfeeding, Physical activity, use of alcohol, cigarettes, e-cigarettes, Use of substances, non-prescribed drugs, abuse of prescription medication, Risk-taking activity i.e. gambling, addictive behaviour)

Evidence:

Hywel Dda University Health Board has recently completed an extensive Health Needs Assessment, to inform the Pharmaceutical Needs Assessment, we provide a link to this as it complements the document for information to clearly describe the health needs of the population. The Health Needs Assessment is described in chapters 2, 3 and 4 of the Pharmaceutical Needs Assessment. see [Link](#)

Citizens living in our three counties generally have healthier lifestyles than is typical across Wales, however this varies across different localities, with pockets of deprivation and poverty across both urban and rural areas. For example, there is a slightly higher rate of adults reporting alcohol consumption above guidelines in Ceredigion; and obesity rates are higher than the Welsh average in Pembrokeshire and Carmarthenshire. And while smoking prevalence has improved across Hywel Dda, there are higher rates in Carmarthenshire and in areas of deprivation, including Llanelli and Pembroke Dock. This demonstrates that Hywel Dda has a higher proportion of “most deprived” and “next most deprived” areas than Wales as a whole.

The Hywel Dda University Health Board Health Pharmaceutical Needs Assessment identified that:

- Hywel Dda UHB sees 44 **young people** per 100,000 head of population admitted to hospital annually directly due to alcohol. This is slightly above the all-Wales average (43 per 100,000 population) and Hywel Dda UHB is one of the top 4 Health Boards in Wales in terms of adolescent alcohol related admissions.
- In Hywel Dda UHB **25.6% of children, aged 4-5 years are overweight** or obese. There are also differences in children aged 4-5 years with obesity and levels in children living in the least deprived quintile compared to children living in the most deprived quintile in Wales and there is evidence that this gap is growing. Evidence shows that 80% of children who are obese at age 4-5 years remain obese into adulthood. In children aged 11-16 years within Hywel Dda UHB, 20% are classed as overweight or obese. This is above all Wales average of 18%. Generally, within Hywel Dda UHB as nationally more boys (26%) are overweight and obese than girls (14 %).
- In adults' **prevalence of overweight and obesity in Wales is higher in men than women** but for obesity prevalence alone, it is slightly higher in women and in terms of age, prevalence is highest in the 45-64 age group.
- Studies have also demonstrated a relationship between adverse childhood experiences (ACE) and adult obesity.
- As with children higher incidences of overweight and obesity are also found in adults who live in more deprived areas.
- In Hywel Dda UHB, 5% of all hospital admissions for males and 3% of all hospital admissions for females are attributable to smoking. For respiratory diseases, 22.7% of male admissions and 22.0% of female admissions are attributable to smoking.

- Type 2 diabetes is more common in socio-economically deprived communities and in Black and Asian people

Update 11.07.22 the following were reviewed and confirm similar themes to below:

[Carmarthenshire Assessment of Local Wellbeing - May 2022.pdf](#)

[Ceredigion Local Wellbeing Assessment - May 2022.pdf](#)

[Pembrokeshire Assessment of Local Wellbeing - May 2022.pdf](#)

Positive impacts or additional opportunities Please include evidence to support your view.	Negative impacts, unintended consequences or gaps Please include evidence to support your view	Population groups affected Please include evidence to support your view	Mitigation / recommendations
<p>Our health and wellbeing centres will provide a range of support and services, e.g. - Social Prescribers. Building upon the Social Model for Health and Wellbeing. Wellbeing centres will support prevention and early intervention services to help keep people well, not just tackle poor health. This will bring a number of people and services together in one place and also provide virtual links between the population and the community network. The model of service is built on the idea of empowering people to look after themselves. The multidisciplinary and multi-agency approach in our health and well-being centres will be of particular</p>	<p>The development of a new hospital and the renovation of other sites, and the attendant change in service model may negatively impact staff due to the cost of living (rental and purchase) in and around the proposed site.</p> <p>The pandemic has exacerbated the poverty gap. There is a direct link between poverty and poor health outcomes.</p> <p>Our workforce will require sustainable and consistent access to online platforms as well as the equipment to enable the access. Without it, there is a risk that</p>	<p>Young people (alcohol) Children (obesity) Boys (obesity) 45-64 age range (obesity) Black and Asian community (diet/obesity) Staff Patients Visitors Those with a disability i.e. sensory impairment Mother & Children BAME Domestic violence victims Gypsy Roma Traveler Community</p>	<p>The move to a community-based, social model for health and wellbeing will require a fundamental shift in resources and service delivery. The pace of change needs to match the development of the new hospital and renovated sites, to ensure there is no service gaps and negative outcomes for the population.</p> <p>The adoption of a social model for health and wellbeing is built on a</p>

<p>benefit for our frail and older population and those with complex needs.</p> <p>We will use community facilities such as community halls to deliver some of our services and activities, either face to face or virtually.</p> <p>We will continuously engage to personalise and tailor our health and care services to the needs and preferences of both individuals and localities, with a focus on supporting people to manage their own care and outcomes.</p> <p>We will use technology and innovative transport solutions to provide more choice and better access to care where it is needed</p> <p>Integrated community networks will be the main interface of patient and health services</p> <p>Presence of wider support services provided by LA within the model i.e., drug & alcohol services, welfare, employability etc.</p> <p>More opportunities for active travel to attend appointments.</p>	<p>training and development will not keep pace with demand.</p>	<p>Homeless and roofless people</p>	<p>foundation of asset-based development, community-based services and a focus on prevention and early intervention. The integration of services, partnership working - particularly social care and health working more closely with the third sector and ensuring local hubs reflect local expertise and resources in one place has the potential to improve the lifestyle and wellbeing of the population.</p> <p>The programme offers the opportunity to build on the learning from the pandemic of the role communities have played in improving community resilience.</p> <p>-The Wellbeing hub model can support local groups and formalize better links with community services, and realise the resource shift required from acute to community services.</p> <p>There are opportunities to:</p>
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<p>Opportunity to invest in electronic cycling infrastructure</p> <p>Services will be aligned to need based on local issues</p>			<ul style="list-style-type: none"> • Request active travel infrastructure on new acute site • Developing a sustainable travel plan for new hospital and community sites. • Promotion of routes, infrastructure development • Local Authority liaison – working together to consider active travel opportunities
	<p>Update 31.07.2023.</p> <p>Themes generated from the Residence Focus groups during land consultation highlighted that prospective homeowners wishing to live close to the chosen site may experience an increase in house prices making it difficult for them to purchase houses near the hospital site.</p> <p>Themes generated from the Public drop in events highlighted that many people were primarily concerned about how the need to travel to the new site could affect older people, disabled people, and the economically disadvantaged.</p>	<p>See Link to Pharmaceutical Needs Assessment, chapters 2, 3 and 4</p> <p>Staff and patients. All population groups</p>	<p>See Mitigation / recommendations in this section of the EHIA.</p> <p>The health board will continue to implement its communication strategy to inform the public at every opportunity of the community model, which will support people to stay well and live independently in their communities, enabled by joint working between health and social care services and the third</p>

		<p>sector. There may then not be the necessity to travel frequently to the new site, which is for planned care emergency care, as other services will be available closer to home.</p> <p>Community-based staff will be able to help support people with disabilities to adapt to the changes we are making and explain the benefits this will have for individuals.</p>
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Social and community influences on health (Adverse childhood experiences, Citizen power and influence, Community resilience, Domestic violence, Family relationships, Language, cultural and spirituality, Social exclusion i.e. homelessness, Parenting and infant attachment, Peer pressure, Racism, Social isolation/loneliness, Social capital/support/network)

Evidence:

Hywel Dda University Health Board has recently completed an extensive Health Needs Assessment, to inform the Pharmaceutical Needs Assessment, we provide a link to this as it complements the document for information to clearly describe the health needs of the population. The Health Needs Assessment is described in chapters 2, 3 and 4 of the Pharmaceutical Needs Assessment. see [Link](#)

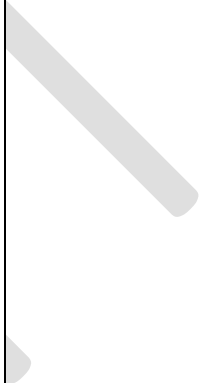
Update 11.07.22 the following were reviewed and confirm similar themes to below:

[Carmarthenshire Assessment of Local Wellbeing - May 2022.pdf](#)

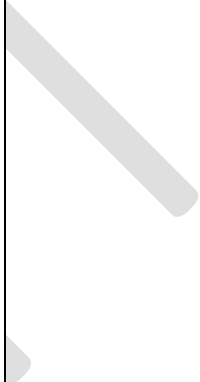
[Ceredigion Local Wellbeing Assessment - May 2022.pdf](#)

[Pembrokeshire Assessment of Local Wellbeing - May 2022.pdf](#)

<p>Positive impacts or additional opportunities Please include evidence to support your view.</p>	<p>Negative impacts, unintended consequences or gaps Please include evidence to support your view</p>	<p>Population groups affected Please include evidence to support your view</p>	<p>Mitigation / recommendations</p>
<p>HDUHB has made a clear commitment to deliver a social model of health and wellbeing with a focus on prevention and early intervention. The model provides the focus to tackle challenges like loneliness and other social impacts, that can be treated better and more swiftly using non-medical interventions. The long-term impact on dealing with such issues can and will have a profound impact on our population health.</p>	<p>The medical model of service provision has engendered an over reliance on NHS services. This will be a difficult culture to break and will require time and effort. The shift to a social model of health and wellbeing, in tandem with the development of the new hospital and renovated sites could leave some people without a service they feel they need due to a lack of engagement and/or buy in to the transformation.</p>	<p>See Link to Pharmaceutical Needs Assessment, chapters 2, 3 and 4</p>	<p>There has been a growth in mental health issues due to the pandemic. In addition, there has been an increase in domestic violence and safeguarding referrals due to the prolonged lockdown. This growth in need will need to be factored into the service model redesign.</p>

<p>Adopting a whole system approach will enable our people and our communities to care for themselves, prevent ill health, improve wellbeing, promote independence and interconnectedness, and access specialist care and support when required.</p> <p>There will be integrated care and support, enabled by digital technology with communication of information between health and social care partners.</p> <p>A single point of access to health and care, linking all areas that contribute to the healthier lives of our people and communities. As single point of access approach offers real opportunities for Cross skilling staff, developing integrated roles that meet the social model of health and wellbeing service model as well as increasing the learning opportunities for all people working within the health and wellbeing field.</p> <p>Integrated localities will tackle inequalities by working in partnership with local people to co design solutions and services</p> <p>Community focussed family and children's services, with a strong wellness ethos. This will help support an increase in midwife led pregnancies and births.</p>	<p>WG have a commitment to a town centre first focus – the programme needs to consider implications of taking footfall out of town centres.</p>		<p>A move to a community-based prevention and early intervention, model of service provision has the potential to increase personal and community resilience, and tackle health issues before they escalate to require medical intervention.</p> <p>A truly integrated model of partnership working has the potential to combine services and amplify the positive impact of each other to the benefit of our population.</p> <p>The adoption of the social model for health and wellbeing embeds the idea of patient voice and choice, as well as the awareness of expert experience. Co-producing and co designing services to meet the local needs of particular populations increases the impact of non-health solutions on health outcomes, with the potential to make health resources stretch further.</p>
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<p>Integrated community networks will provide information, advice, assistance and treatment through integrated community networks. Our aim is that these integrated community networks will provide the majority of health and care services, some of which have traditionally been provided in the acute hospital setting.</p> <p>Each integrated community network is supported by one or more health and wellbeing centres. This will bring a number of people and services together in one place and also bring virtual links between the population and the community network. Multidisciplinary teams and the wider networks will wrap around individuals and families. This approach will be of particular benefit for our frail and older population and those with complex needs. The MDT approach to service provision increases the impact of the 'Making Every Contact Count' approach, due to the close and speedy linkages between agencies (statutory and 3rd Sector).</p> <p>UHB have appointed community development outreach workers reaching out to ethnic minority people living in Carmarthenshire, Ceredigion and Pembrokeshire in response to recommendations in a Welsh Government</p>			<p>The UHB will source funding to retain HDUHB Community Development Outreach Workers and Family Liaison Officer roles</p> <p>Other mitigation measures include:</p> <ul style="list-style-type: none"> • Early intervention and support • Preventative services • Health and well being centres • 24/7 mental health centres • Collaborative working with partners • Transport infrastructure • Regional Carers Strategy, increased support to unpaid Carers. • Armed Forces Covenant • Continuous engagement
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<p>report on tackling health inequalities experienced by black, Asian and minority ethnic communities. The community development outreach workers will develop close links with local authorities, third sector organisations and community groups to raise awareness and understanding of the Test Trace Protect (TTP) process and the COVID-19 vaccination roll-out programme. The team will ensure wider health messages are culturally accessible and support minority ethnic communities to have a greater understanding of their rights and access to health care.</p> <p>7 community midwifery teams support all women, provide assessments in first 6 months of pregnancy regarding any issues at home, safeguarding issues, etc. They also work in tandem with health visiting and the public health team and specialized nurses in the team that specialize in motivational behavioural change.</p> <p>Effect of loneliness – community midwives have laptops and phones to facilitate face-to face assessment and support and are available 24/7 supported by the maternity teams in the Obstetric Units in GGH and BGH.</p>			
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Health Wider determinant for consideration: Mental Wellbeing

(Does this proposal support sense of control? Does it enable participation in community and economic life? Does it impact on emotional wellbeing and resilience?)

Evidence:

Hywel Dda University Health Board has recently completed an extensive Health Needs Assessment, to inform the Pharmaceutical Needs Assessment, we provide a link to this as it complements the document for information to clearly describe the health needs of the population. The Health Needs Assessment is described in chapters 2, 3 and 4 of the Pharmaceutical Needs Assessment. see [Link](#)

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Positive impacts or additional opportunities Please include evidence to support your view.	Negative impacts, unintended consequences or gaps Please include evidence to support your view	Population groups affected Please include evidence to support your view	Mitigation / recommendations
Our health care strategy adopts a whole-system collaborative approach to improve well-being, promote independence, prevent ill-health and access specialist care as and when required. The future whole-system approach aims to: Deliver integrated care and support, enabled by digital technology with communication of information between health and social care partners across	Change is hard and often a source of anxiety. This can be the case for the population as well as staff and partner organisations. The programme is sizeable and extensive, therefore the potential for anxiety and depression is high and prolonged. There is already a long wait for services. This has been exacerbated by COVID as well as the impact of loneliness and	<ul style="list-style-type: none"> • Women & Children • Adolescents • Older adults – i.e. frail, dementia • People with disabilities • Army veterans • Patients with eating disorders - i.e. not enough bed numbers • Staff 	The social model for health and wellbeing is based on patient voice and choice, prevention and early intervention and individual and community resilience. The adoption of this service model alongside the capital programme has the potential to empower patients to manage their

<p>traditional community and hospital boundaries and allows people to access more information about their health and care, and enable more colocation of staff and services, for the benefit of patients and staff.</p> <p>Views mental health and care equally with physical health and care, ensuring that those with mental health problems receive equitable access to the most effective and safest care available.</p> <p>Our urgent and planned care hospital will have 24/7 access to specialties including mental health assessment and treatment.</p> <p>There will also be numerous locations providing Mental Health and Learning Disabilities Services</p> <p>The health board is reviewing the Transforming Mental Health Programme Business Case and delivery of Transforming Mental Health against the positive outcomes delivered in the last 12 months as a response to COVID. Improvements have been delivered in line with the TMH programme ambitions, this will be an opportunity to learn and deliver in line with population changes.</p>	<p>isolation due to lock down, the additional of a programme of change, on staff time and resource has the potential to impact negatively.</p> <p>Anxieties when required to attend acute site – many factors outside your control (or what would've been experienced previously)</p> <p>Disruption of work/life balance from additional commuting requirements</p> <p>Availability of public transport affecting anxieties – struggling to access general services.</p> <p>Impacts on visitors – volume of attendances to visit family.</p> <p>Many patients feeling that the front door is inaccessible currently (anecdotal), need reassurance that services in the community from remodeling are accessible.</p>	<p>See Chapters 2, 3 and 4 of the Pharmaceutical Needs Assessment. see Link</p>	<p>own symptoms, as well as meet the mental wellbeing challenges present in the population, as a much earlier stage. An example of such an opportunity could be the upskilling of parents to meet the needs of their children with ADHD.</p> <p>From, a prudent healthcare perspective, this model has the potential to free up acute services for the most unwell, as well as prevent more people suffering from more severe mental health crises.</p> <p>The new hospital and renovated sites have the potential to review and revise the specialist unit provision in the health board and the integrated hub model will allow staff to be collocated with other partners, increasing the cross pollination of learning and the service offer.</p>
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<p>New buildings and renovated sites have the potential to maximise the health benefits of green spaces and be designed to enhance people's wellbeing.</p> <p>Will support community cohesion and a sense of wellbeing if transport needs are lessened to an extent.</p> <p>Staff – less anxiety, not requiring finding a parking space. Adequate car parking on site within scope</p> <p>General positivity from services seen as being boosted / bolstered in their community.</p> <p>7 community midwifery teams support all women, provide assessments in first 6 months of pregnancy regarding any issues at home, safeguarding issues, etc. They also work in tandem with health visiting and the public health team and specialized nurses in the team that specialize in motivational behavioural change.</p> <p>Improving loneliness - midwives will link in remotely via laptops and phones to be available 24/7 supported by the maternity teams in the Obstetric Units in GGH and BGH.</p>			
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Part 4 – Health Wider determinant for consideration: Living / environmental conditions affecting health

(Attractiveness / access / availability / quality of area, green and blue space, natural space, Health & safety, community, individual, public / private space, Housing, quality / tenure / indoor environment, Light / noise / odours, pollution, Quality & safety of play areas (formal/informal), Road safety, Urban/rural built & natural environment, Waste and recycling, Water quality)

Evidence:

Hywel Dda University Health Board has recently completed an extensive Health Needs Assessment, to inform the Pharmaceutical Needs Assessment, we provide a link to this as it complements the document for information to clearly describe the health needs of the population. The Health Needs Assessment is described in chapters 2, 3 and 4 of the Pharmaceutical Needs Assessment. see [Link](#)

Update 11.07.22 the following were reviewed and confirm similar themes to below:

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Positive impacts or additional opportunities Please include evidence to support your view.	Negative impacts, unintended consequences or gaps Please include evidence to support your view	Population groups affected Please include evidence to support your view	Mitigation / recommendations
Use of green spaces in our hospitals and premises Biophilic design of our estates Working in collaboration with local authority partners	The new hospital and renovation - Programme may require the destruction of the green spaces, and thus require remedial work. Any new building and-or renovation has the potential to increase or change traffic flow, both impacting negative on the carbon footprint of the population and workforce alike. The model of care in the home or close to home may necessitate more home visits.	See Link to Pharmaceutical Needs Assessment, chapters 2, 3 and 4	There is real potential to make a positive and sustainable impact on the built environment, through good, energy efficient, accessible design, both for the new hospital and the renovated sites.

<p>Establishment of Green Health initiatives across the Health Board estate building on the work currently underway</p> <p>Development of strategic partnerships with a wide range of organisations and funders and deliver effective programmes that improve people’s quality of lives. E.g. development of social enterprise cafés, encompassing a range of available support across the themes of communities, health and wellbeing, and employment, skills and enterprise. Activities focus on welfare benefits, housing, debt and legal advice, training opportunities and careers advice, art and horticulture, healthy lifestyles and more, tackling social isolation while increasing personal wellbeing.</p> <p>We will design our Programme to meet the long-term needs of our population, so we will consider how we can procure our construction, equipment and facilities management contracts to enable ongoing refinement as digital and environmental technologies evolve; we will also consider how we will maximise the long-term socio-economic impacts of the Programme as a whole and the individual projects within it.</p> <p>Prevention: the framework encourages us to design our Programme so that it supports the breaking of negative cycles</p>	<p>In a rural and dispersed area such as Hywel Dda, there is the potential staff safety to be negatively impacted.</p> <p>Local community will lose some of their green space, which will impact on their sense of place (a large hospital on green space with large areas of car parking).</p> <p>Health board will need to look at how they can mitigate the impact e.g. how the health board can offset the development and contribute to wider green landscape for the benefit of the community.</p> <p>Increasing volumes of traffic and clean air issues along A40 will impact on the local community. The UHB will need to look at what can be done to offset this, e.g. planting of additional trees and plants.</p> <p>Travelling to and from the new urgent and planned care hospital site may be challenging for some mothers and their families. Mitigation would be community midwives delivering some risk assessed individualized patient reviews virtually.</p>		<p>Working with transport partners, the new hospital could increase the public transport offer and therefore uptake for patients, their families and carers, as well as the workforce.</p> <p>The new and renovated sites can add value to the patient and staff experience through good design and the provision of green and blue spaces.</p> <p>There is the potential for the new hospital to better meet the needs of families and patients through the provision of family accommodation, for long term/ acutely ill patients.</p> <p>The development of integrated with statutory and non-statutory services being co-located, has the potential to build on the Making Every Contact Count approach in a very meaningful way. The development of integrated</p>
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<p>and/or inter-generational challenges such as poverty, poor health, environmental damage and loss of biodiversity; breaking cycles of poverty and poor health are the point of the Social Model of Health we want to implement, which envisages health and care facilities and services as integral and accessible parts of a community's social fabric; avoiding environmental damage and contributing where we can to the biodiversity of the communities where our facilities are placed are elements of our Environmental Strategy</p> <p>Biodiversity / decarbonisation agenda may support staff recruitment / retention.</p> <p>Active transport / travel also a positive</p> <p>H & WB centre scopes supporting these considerations.</p> <p>Clean air quality in Carmarthen, Haverfordwest > congestion alleviated.</p> <p>EV infrastructure & vehicles within model offsetting carbon emissions</p> <p>Car parking pressures / inappropriate parking in WGH, BGH & GGH alleviated with change in model.</p>			<p>services based on a social model for health and wellbeing has the potential to transform patient pathways to reflect prevention and early intervention and community asset-led solutions for their health and wellbeing.</p>
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Noise pollution – emergency vehicles transporting to a new location			
	<p>Update 31.07.2023 Themes generated from the interviews with staff members during land consultation highlighted that People living near the chosen site would be negatively affected by the “construction and also the increased traffic that the patients and staff will bring to the area.</p>	<p>See Link to Pharmaceutical Needs Assessment, chapters 2, 3 and 4</p>	<p>See Mitigation / recommendations actions at the start of this section.</p>

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Part 4 – Health Wider determinant for consideration: Economic conditions affecting health

(People on low income, economically inactive, unemployed / workless, People who are unable to work due to ill-health, People living in areas known to exhibit poor economic and/or health indicators, People unable to access services and facilities, Food / fuel poverty, Personal or household debt.

Socio Economic Duty in Wales <https://gov.wales/more-equal-wales-socio-economic-duty>)

Evidence: Hywel Dda University Health Board has recently completed an extensive Health Needs Assessment, to inform the Pharmaceutical Needs Assessment, we provide a link to this as it complements the document for information to clearly describe the health needs of the population. The Health Needs Assessment is described in chapters 2, 3 and 4 of the Pharmaceutical Needs Assessment. see [Link](#)

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Positive impacts or additional opportunities Please include evidence to support your view.	Negative impacts, unintended consequences or gaps Please include evidence to support your view	Population groups affected Please include evidence to support your view	Mitigation / recommendations
Opportunities for local colleges and apprenticeship programmes to upskill a workforce for careers in construction, design, maintenance and sectors that are shown to have significant job creation for a green and just recovery. With the support of the Future Generations Commissioner, we aim to work with Welsh Government to	The centralisation of services at a new hospital will require some patients and staff to travel further. The cost of travel, as well as access to travel options and the additional time it will take, poses negative impacts.	See Link to Pharmaceutical Needs Assessment, chapters 2, 3 and 4	The move to a community based service model allows us to explore the community assets already in place, and potentially use them as service delivery options. This increases community

<p>benefit the local economy as much as possible.</p> <p>We have developed a strategy for improving our approach to social value. We will bring this ongoing work into our procurement strategies and engage regularly with Welsh Government and SVP to ensure that we are maximising opportunities to achieve our socio-economic duty through our procurements and contracts. In addition to the work underway on improving social value as noted above, we are also giving consideration to what impacts the Health Board can have on improving the performance of the 'foundational economy'.</p> <p>Community based services as well as a move to an agile workforce, may provide greater opportunities to attract a more diverse workforce, as well as provide a more sustainable model for a rural and dispersed Health Board such as Hywel Dda.</p>	<p>For the workforce who currently walk to work, a move to a centralised site may reduce the appeal of working for the Health Board and exacerbate the staffing challenge already being faced.</p> <p>Demographics of the population shows high areas of deprivation to the east and to the west of the Health Board and to the west of the health board linked to rural poverty. These are likely to suffer from fuel poverty which again will provide challenging in arranging transport to the urgent and planned care hospital.</p>		<p>resilience due to the investment being made by health, as well as provide care close to home and</p>
	<p>Update 11.07.22 The impact of the cost of living crisis could potentially have a negative impact on patients and staff who may not be able to afford the additional costs of living impacting on travel, food, heating and lighting, etc.</p>	<p>Staff and patients. All population groups</p>	<p>Multiple teams across the UHB including patient experience and OD team to look at how to reduce the impact of the current cost of living crisis.</p>

	<p>Update 22.12.25 The strategy refresh engagement identified concerns that deprivation and poverty across west Wales could result in widening of health inequalities if people are unable to access the same level of leisure and healthy lifestyle opportunities as those who are not experiencing poverty or deprivation.</p>	<p>Staff and patients. All population groups</p>	<p>Working with PSBs to look at health needs in communities to identify ways to prevent widening inequity and make best use of community resources as part of a Social Model for Health and Wellbeing.</p>
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Part 4 – Health Wider determinant for consideration: Access and quality of services

(Careers advice, Education and training, Information technology, internet access, digital services, Leisure services, Medical and health service, Other caring services i.e. social care; Third Sector, youth services, child care, Public amenities i.e. village halls, libraries, community hub, Shops and commercial services, Transport including parking, public transport, active travel)

Evidence:

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Positive impacts or additional opportunities Please include evidence to support your view.	Negative impacts, unintended consequences or gaps Please include evidence to support your view	Population groups affected Please include evidence to support your view	Mitigation / recommendations
<p>The programme will enable:</p> <ul style="list-style-type: none"> • Social model for health working with partners including leisure services. • Working closer with third sector, use of community assets use of public halls, etc • Support the foundation economy. <p>We anticipate that the opportunities presented through newly built facilities, new innovative or advanced roles, and modernised services will encourage people to join Hywel Dda’s workforce now and in the future.</p> <p>In terms of existing staff, we actively lead and support a number of programmes and initiatives that focus on retaining staff and developing future skills by creating opportunities for existing staff, delivering an attractive and alternative career pathway for our local population, attracting medical and other clinical staff to the area with innovative career opportunities, and meeting our corporate social responsibility by investing in local population and building our future workforce.</p>	<p>Themes from recent engagement May 21</p> <p>We heard mixed feedback about virtual care.</p> <p>Positives were:</p> <ul style="list-style-type: none"> • Virtual care and triage worked well for some people – quicker access and more convenient (however for others it did not work) • Worked well for non-frontline staff and some specialties. • Mixed feedback about virtual consultations • Mixed feedback about GP triage in its various forms (phone, photo, online, video etc.) • Not equitable - some people don’t have the skills, access to equipment, others don’t have signal. • Challenges for people with sensory impairments such as hearing issues as well as people who have difficulty using the phone. • Need to give patients ‘autonomy’ in the healthcare system. 	<p>Specifically - Older adults, people who need physio, people with sensory impairments See Link to Pharmaceutical Needs Assessment, chapters 2, 3 and 4</p>	<p>Requirements of changes to public transport networks to be fully considered by the transport workstream including scoping of new and repurposed routes servicing the new hospital and community networks.</p> <p>More local public transport will be developed to reflect services delivered in community</p> <p>SB&WW Metro liaising to ensure the acute sites are part of this programme.</p> <p>Community transport opportunities to be explored and lessons learnt from existing rural schemes and WG pilots</p>

<p>Fundamental to our health and care system transformation, will be the delivery of high quality, cost effective Digital Services. Our vision is to have secure, resilient, accurate and timely information at the point of patient care. This will be delivered through an integrated All Wales application suite, combining clinical and line of business applications, underpinned by a robust and cost-effective information infrastructure which will increasingly become cloud based. Our key focus areas will be:</p> <ul style="list-style-type: none"> - Integration with the partners to take forward the digital programmes and related population health initiatives. - Unlocking the power of information to improve decision making at the point of care. Keeping patient and service user's information safe, secure and up to date, and only used with appropriate governance and controls. - Improving organisational digital maturity and user digital literacy to maximise the benefits of digital technologies. - Delivering digital services which will be paper-free at the point-of-care by 2022. 	<ul style="list-style-type: none"> • Virtual risks potential discrimination against older people • Some concerns raised about need to see older people in person. • Limitations for staff in not seeing people in person e.g. physiotherapy <p>Transport (in relation to proposal for new hospital):</p> <ul style="list-style-type: none"> • Need to improve public transport links (bus and train) – suggestions for new stations; cost / expense of transport. • Concern about good road networks (beware of traffic and congestion) • Concerns about emergency transport - air ambulance; EMERTs, needs a helipad. • Wider transport concerns community transport: access for people living in rural areas, transport out of hours; cycle shelters. • Concerns about distance to hospital and how people would get there in a timely way; access to public transport. • Fears about potential risk to lives, including some concerns 		
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<ul style="list-style-type: none"> - We will collaborate with our partners to deliver the best solutions for our communities. We will learn from each other and share our experiences so that we can all improve digital technology for the benefit of our patients wherever they are treated. • In addition, Hywel Dda has already deployed the Welsh Clinical Portal which means the GP record is already viewable in secondary care locations for appropriate authorised staff. In addition, GP's have access to secondary care information through integration with the Welsh Clinical Portal and using services such as GP Links and the Welsh Clinical Communications Gateway. • Hywel Dda are also deploying the Welsh Clinical Community Information System (WCCIS) so are moving rapidly towards an integrated record for community teams in Ceredigion (where the local authority has already deployed WCCIS). • We are working closely with Carmarthenshire and Pembrokeshire local authorities on opportunities to work more closely together. 	<p>expressed about the 'The golden hour'.</p> <ul style="list-style-type: none"> • Worries about the rurality of location - needs to be central and local and provide access for people living in rural areas. • Queries about the suitability of site (within zone), ensuring there is room for expansion and digital connectivity. • Pleas for free parking and plenty of it • Requests for plenty of accessible parking • Allow sufficient space for staff parking. • Concerns about public transport links (bus and train) to proposed site / zone, suggestions for new stations. • Worries about the costs of transport. • Identification of issues of access for people living in rural areas, the distance and challenges for older people, families etc. • Concerns about the availability of transport out of hours • Major concerns about the suitability of the road network • Worries about the traffic and congestion, particularly in the peak season summer months. 		
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<ul style="list-style-type: none"> • The Health Board is also investing in Telehealth technologies, which will see many patients benefitting from monitoring their health from the comfort of their home, and when the need arises, the ability to link via video to their supporting healthcare professionals. <p>Car parking demands will switch – less demand for oversubscribed car parks.</p> <p>Active travel opportunities greater in community sites</p> <p>Improved front of house arrangements will improve accessibility for public transport.</p> <p>Designated bays – alleviating issues, more adequate provision for disabled parking, NEPTs etc.</p> <p>Themes from recent engagement May 21: There is a need for more:</p> <ul style="list-style-type: none"> • Classes in the community around health and wellbeing • Social prescribing groups • Community groups <p>We also heard mixed feedback about virtual care: Positives were:</p> <ul style="list-style-type: none"> • Virtual care and triage worked well for some people – quicker access 	<ul style="list-style-type: none"> • Acknowledgement the hospital needs to be close to the main road. <p>Access – other issues raised in engagement:</p> <ul style="list-style-type: none"> • Concerns about addressing accessibility for wheelchair users. • Worries about access around and to the hospital site. • Fears about access to services • Concerns about access to the hospital for people from the east, west, south and north boundaries of the Health Board • Community Connectors • Local colleges and apprenticeships web skill that we can pre opportunities for careers in construction and sectors • Work life balance • Easy systems to use to find what you need. <p>Public transport to the acute site will be less developed than the existing model of public transport.</p> <p>Active travel less of a possibility</p> <p>Lack of taxi supply may be scenario.</p>		
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<p>and more convenient Worked well for non-frontline staff and some specialties.</p>			
	<p>Update 31.07.2023 Themes generated from the Residence Focus groups during land consultation highlighted that the proposed locations were also said to put people from rural areas and small villages at a disadvantage, in particular those who are reliant on public transport, or isolated individuals without a support network of family and friends who are able and willing to drive them to appointments, and to visit them whilst in hospital.</p> <p>Themes generated from the Residence Focus groups during land consultation highlighted that individuals living in areas with poor internet connections who would be unable to access telemedicine and other digital healthcare opportunities.</p> <p>Themes generated from interviews with staff members highlighted the proposed locations (for the new hospital) were also said to put people from rural areas and small villages at a disadvantage, in particular those who are reliant on public transport.</p>	<p>See Link to Pharmaceutical Needs Assessment, chapters 2, 3 and 4</p> <p>Staff and patients.</p>	<p>See Mitigation / recommendations actions at the start of this section.</p> <p>The Regional Digital Inclusion Group is in the process of conducting a Digital Divide Research Project that will help identify pockets in West Wales with poor internet connections.</p> <p>A key part of our A Healthier Mid and West Wales strategy is to bring care closer to home and reduce travel for unnecessary hospital admissions or long lengths of stay.</p>

The impact of having to travel further on patients and visitors without private transport was also frequently raised during the Public drop in events at land consultation.

Our Programme Business Case includes significant investment in community facilities close to where you live. This will ensure that you can continue to receive your care mostly in your own home and communities, or from more local hospitals. You would also come back to these local facilities and services or your own home, more quickly after a stay in hospital. Our aim is for people to need only a short stay in our Urgent and Planned Care Hospital (72 hours).

Our proposals are underpinned by a community model which will support people to stay well and live independently in their communities, enabled by joint working between health and social care services and the third sector.

Part 5 – Action Plan

The Action Plan below will be developed as the Programme progresses. The UHB has not yet decided on the location of the new urgent and planned care hospital and the actions below will be developed in parallel of projects and outline business cases.

Actions (required to address any potential negative impact identified or any gaps in data)	Assigned to	Target Review Date	Completion Date	Comments
Implementation of communications strategy and promotion of information in alternative formats for those who need it.	Communication & Engagement Workstream	Reviewed quarterly	Completed 16.02.23 for consultation. Action will remain open for future programme activities	Versions of consultation provided in alternative formats as below: Welsh version, Youth Version, Easy Read Version, animation, BSL, Audio Only version, and Summary versions in Polish,

				Russian, Arabic & Ukrainian.
Ensure that an impact question is asked as part of all future engagement and consultation stages and analysed so that we are fully aware of existing issues and what we need to put right	Communication & Engagement Workstream	Reviewed quarterly	Completed 16.02.23 for consultation. Action will remain open for future programme activities	The Consultation Institute has been engaged to carry out this function. Impact question included in the new hospital site consultation questionnaire
Work closely with the Patient Experience Team on how we can talk with people going through hospital services about the status quo to ascertain if there was anything related to equality/inequality issues that should be addressed in the new hospital	Transformation Team – service design and pathways Diversity & Inclusion Team	Reviewed quarterly	Ongoing Ongoing	Progress report to be discussed at next Programme Team meeting March 23 D&I team will be attending public engagement events during the consultation period. D&I team have representation on Patient Experience Group.
To set up a continuous mechanism for people to tell us about anything that they felt we should hear related to equality/inequalities – e.g. online forum using Engagement HQ as an option.	Communication & Engagement Workstream	Reviewed quarterly	Ongoing	Ensuring the public is provided with a range of ways of using their voice and getting involved in their NHS here in Hywel Dda so that they can shape, own and improve it, is of paramount importance. One such

				mechanism is Engagement HQ's Guestbook Tool which offers a simple, streamlined, and moderated space for our community to upload comments in relation to equality and inequalities.
Transport Workstream to develop a transport specific EqIA to identify possible transport related barriers and to suggest improvements/mitigating actions to combat those barriers.	Transport workstream	Reviewed quarterly	Ongoing Update December 2025	Discussions have taken place to highlight the role of the EHIA as well as to highlight a specific need for a transport EqIA. Further development of the Transport & Accessibility Plan and related transport stream EqIA is currently on hold until the AHMWW business plan progresses to outline business case.
Age				
Continue to review the programme to ensure it meets the needs of the older demographic in reducing isolation and loneliness e.g. through the use of technology and ongoing care needs / prolonged waiting lists.	Digital Workstream Transformation Team – service design and pathways	Reviewed quarterly	Ongoing	Digital Strategy will provide an opportunity to help transform our services and ensure improved access. This will support isolation and loneliness. The social

	Diversity & Inclusion Team		Completed	<p>model for health includes working with partners to maximise community inclusion. These issues will be further developed as part of the pathway development work and service design and implementation.</p> <p>D&I members attended digital inclusion workshop in February 2023 & have linked in with the digital inclusion manager.</p> <p>D&I team are currently conducting an analysis of 2021 Census data which will allow for a better understanding of our aging population.</p> <p>2021 Census data collated and has been included in all full EqIA forms</p>
Seek advice from other health boards and trusts that have undertaken similar changes to services to understand the impact to ensure shared learning	Programme Manager	February, 2023	December 2022	Lessons learnt documentation received following meetings with staff responsible for service changes at the

			Ongoing	<p>Grange Hospital, a recent and similar example.</p> <p>We will continue to engage with other health boards to learn lessons for the successful implementation of our strategy</p>
<p>Requirements of changes to public transport networks to be fully considered by the transport workstream including scoping of new and repurposed routes servicing the new hospital and community networks.</p>	<p>Transport Workstream</p>	<p>Reviewed quarterly</p>	<p>Ongoing Update December 2025</p>	<p>HDUHB's Central Transport Unit has been involved in the development of the current RTPs and provided a detailed response to the public consultation process. Further engagement with the CJsCs and local authorities during the implementation and future planning phases of these plans will be key to ensuring health board sites are well served by public transport.</p> <p>In 2024 HDUHB introduced a free bus trial for staff supported</p>

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and funded by Transport for Wales. Health board staff were able to travel for free on the T1 TrawsCymru bus service operating between Aberystwyth and Carmarthen, serving both Bronglais and Glangwili hospitals. During the 4-month trial the free travel offer was utilised over 3,000 times by staff. Following the trial, TfW introduced a discounted fare scheme for health board staff offering a one third discount on fares. A similar trial is planned for the T5 service in 2026 serving Withybush Hospital and Cardigan Integrated Care Centre.

HDUHB has and will continue to engage with TfW and the local authorities during the planning and implementation stages of the new bus network for the region. HDUHB

				has also provided detailed feedback and copies of recent patient and staff travel surveys to help inform the bus network development process being undertaken by TfW.
Community transport opportunities to be explored and lessons learnt from existing rural schemes and WG pilots.	Transport Workstream	Reviewed quarterly	Ongoing Update December 2025	Representatives from HDUHB's Central Transport Team sit on Carmarthenshire County Council's Community Transport Project Board. The board was set up in 2024, and its first task was to develop a community transport strategy for the county in partnership with key stakeholders. The group is currently considering how demand responsive transport services could be introduced in rural areas. HDUHB's Central Transport Team Working worked in partnership with Dolen Teifi to set up a new community transport in

				<p>2024. Serving rural North Pembrokeshire and Ceredigion, the service relies on volunteer drivers and provides a transport service for patients attending the Cardigan Integrated Care Centre. HDUHB's Central Transport Unit is currently working in partnership with Dolen Teifi on introducing a dedicated telephone and transport booking service for patients across Carmarthenshire, Ceredigion and Pembrokeshire who are struggling to access health appointments due to transport barriers. Funding for the initiative is currently being sought.</p>
<p>Maximise offer of digital remote consultations to provide additional routes to access for our older population in their own homes / community</p>	<p>Digital Workstream</p> <p>Transformation Team – service</p>	<p>Reviewed quarterly</p>	<p>Ongoing operational service development</p>	<p>Significant progress has been made in relation to remote consultations and this will be built upon as the programme progresses.</p>

	design and pathways County Directors – for community model	Reviewed quarterly	Ongoing operational service development	Significant progress has been made in relation to remote consultations, and this will be built upon as the programme progresses.
As a result of the clinical land appraisal undertaken in July 22, further pathway work will be undertaken to ascertain mitigations for women who choose to give birth at an older age and those who need consultant led care. This group may be at risk due to distance to new urgent and planned care hospital.	Transformation Team – pathways	Reviewed quarterly	Outline Business Case Stage	This will form part of the pathway development work for obstetric services
As a result of the clinical land appraisal undertaken in July 22, further work is needed to understand the potential mitigations for older people and stroke patients who may be negatively impacted due to distance to new urgent and planned care hospital.	Service lead supported by TPO	Reviewed quarterly	Outline Business Case Stage	This will form part of the pathway development work for older people and stroke services
Updated 15.07.22 Continue to monitor age profile of the workforce to ensure any adverse impact on ageing workforce and impact on retirement for those in lower pay bands	Workforce Workstream	Reviewed quarterly	Ongoing	Subject of analysis and actions as part of workforce strategy submitted as an annex to the Programme Business Case (PBC)
Updated 25.07.22 Look into potential increase in travel times on our ageing workforce	Workforce Workstream	Reviewed quarterly	Ongoing	Subject of analysis and actions as part of workforce strategy submitted as an annex to the Programme Business Case (PBC)
Disability				

<p>Ensure HB approach to continuous engagement facilitates involvement of disabled people in the design of new and renovated sites</p>	<p>Engagement Team</p>	<p>Reviewed quarterly</p>	<p>Ongoing</p>	<p>Continuous Engagement Framework in place to support this, along with a Continuous Engagement Plan. In addition to the Continuous Engagement Plan, and as part of our commitment to Continuous Engagement, a new Engagement & Experience Group (EEG) has been established to ensure that the voices of staff, stakeholders, patients, carers and citizens are listened to when designing, developing, reviewing or changing services, whilst informing the work of the Hywel Dda University Health Board (HDdUHB) at all times. The EEG, in respect of its provision of assurance/advice to the Listening and Learning Sub Committee,</p>
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				<p>ensures that engagement activities taking place across the HDdUHB are shared to allow for aligning of messages wherever possible, sharing resources and avoiding duplication.</p> <p>The involvement of disabled people in the design of new and renovated sites will be considered as part of the group's ongoing commitment to ensuring the voices of all are heard within our local communities.</p>
Sensory loss e learning training for all employees	<p>Diversity & Inclusion Team</p> <p>L&D</p>	Reviewed quarterly	Ongoing	<p>Sensory loss e-learning module available to staff on ESR</p> <p>As at 19/12/2025 – 273 staff had completed</p>
Offer specialist training to staff on how they can improve service delivery and support persons with a disability and sensory loss when accessing services	<p>Diversity & Inclusion Team</p> <p>L&D</p>	Reviewed quarterly	Ongoing	<p>D&I team have promoted the following specialist training to staff over the last 12 months:</p> <p>Introduction to BSL Level 1 & DDBA training.</p>

				<p>Understanding Charles Bonnet Syndrome. Epilepsy Awareness Training. Introduction to Autism Sensory loss e-learning module available to staff on ESR Future action Source further training & promote to staff</p>
Managers to continue monitoring staff mandatory training records to ensure that all staff have completed basic treat me fairly e learning	L&D	Reviewed quarterly	Ongoing	<p>Part of the Health Board policy is that staff complete their mandatory training. This is monitored and reported as part of the performance management framework for the organisation</p> <p>Update as at 19 December 2025</p> <p>Paul Ridd learning disability Awareness – 93.53% or 11642 staff have completed. Dementia Awareness – 95.99% or 11948 staff have completed. Treat me Fairly – 89.26% or 11110 staff have completed.</p>
Discussions with Swansea Bay UHB re urgent care service provision to those who choose to travel to Morriston hospital.	Programme Manager	Reviewed quarterly	Ongoing	Discussions have been taking place at an

				<p>executive director level and is likely to be considered as part of the strategy review. Further work will be carried out when exploring pathways once more detail about patient cohorts and service delivery options become available.</p>
<p>Continuation of diversity and inclusion implementation plans which includes raising awareness amongst staff and delivering training programmes to help staff who work with people who have autism and learning disabilities to enhance communication and effectiveness of care delivery.</p>	<p>Diversity & Inclusion Team L&D</p>	<p>Reviewed quarterly</p>	<p>Ongoing</p>	<p>D&I team have promoted the following specialist training to staff over the last 12 months: D&I team have promoted the following specialist training to staff over the last 12 months: Introduction to Neurodiversity and Autism training sessions delivered via Teams. Understanding Autism e-learning module available to staff on ESR (As at 19/12/2025 – 93.35% or 11619 staff have completed)</p>

				Respectability staff network facilitated by D&I team. D&I team to continue sourcing available training on disability awareness.
Sex				
Update 11.07.22 As a result of the clinical land appraisal undertaken in July 22, further work is needed to understand the potential mitigations for women requiring obstetrics and gynaecology services who may be negatively impacted due to distance to new urgent and planned care hospital.	Service lead supported by TPO	Reviewed quarterly	Ongoing	This will form part of the pathway development work for obstetrics and gynaecology services
Pregnancy and Maternity				
Collation of patient experience information from PALS from social media and from maternity experience midwives coming into post to develop mitigations	Head of Midwifery and Patient Experience Team	Reviewed quarterly	Ongoing	To be developed as part of the process described above.
Discussions with Swansea Bay about cross site working / cross site training to ensure that the skills set of our obstetricians is relevant for DGH	Programme Manager	Reviewed quarterly	Ongoing	Discussions have been held at an executive director and service level and is likely to be considered as part of the strategy review. Further work will be carried out when exploring pathways once more detail about patient cohorts and service delivery options become available.

Race and Ethnicity				
Engagement through community development outreach team	<p>Community Development Outreach Team</p> <p>Engagement Team</p> <p>Community Development Outreach Team</p>	Reviewed quarterly	<p>May 2023</p> <p>Complete</p> <p>Ongoing</p>	<p>Community Development Outreach Team able to support engagement team during consultation.</p> <p>Stakeholder mapping undertaken for new hospital site consultation.</p> <p>Community outreach team identified to support with reaching some stakeholders including homeless, Syrian refugees, Ukrainian refugees, veterans and other vulnerable groups.</p>
Provide information in other languages	<p>Community Development Outreach Team</p> <p>Communication & Engagement Workstream</p>	Reviewed quarterly	<p>January 2023</p> <p>Complete</p>	<p>Community Development Outreach Team able to support engagement team during consultation.</p> <p>Versions of consultation provided in alternative formats as below: Welsh version, Youth Version, Easy Read Version, animation,</p>

				BSL, Audio Only version, and Summary versions in Polish, Russian, Arabic & Ukrainian.
Liaison with resettlement managers in the LA to ensure appropriate support	Community Development Outreach Team	Reviewed quarterly	January 2023	Community Development Outreach Team in regular contact with LA resettlement managers.
Engagement with Black Asian Minority Ethnic Network	Engagement Team	Reviewed quarterly	May 2023	Engagement as part of consultation.
	Diversity and Inclusion Team	Reviewed quarterly	May 2023	Diversity & Inclusion Team able to promote consultation documents & questionnaire via Black Asian Minority Ethnic staff network.
Religion or Belief				
Increase staff training around religion and belief	D&I Team L&D	Reviewed quarterly	Ongoing	D&I team to promote any training opportunities around religion and belief
Raise awareness of the available facilities within our hospitals	Chaplaincy Services	Reviewed quarterly	Ongoing	This process to be discussed and agreed with the Chaplaincy Services Team
Assess community hubs to ensure that people are empowered to have quiet and prayer time	Chaplaincy Services	Reviewed quarterly	Ongoing	This is an ongoing operational access issue and will also form part of the design

				development discussions for new community facilities as part of the programme
Assess opportunities to develop space in new hospital and re purposed sites for prayer or quiet spaces	Chaplaincy Services	Reviewed quarterly	Ongoing	This will form part of the design development discussions for new hospital and re purposed sites
Consideration of open spaces and corridors outside the hospital for people to reflect.	Chaplaincy Services Capital Planning Estates	Reviewed quarterly	Ongoing	Open spaces and well-being spaces are being considered as part of the biophilic design workstream of the programme
Discussion with Aneurin Bevan to share learning on their facilities	Chaplaincy Services Programme Manager	Reviewed quarterly	December 2022	Lessons learnt documentation received following meetings with staff responsible for service changes at the Grange Hospital, a recent and similar example. Unknown if an update has been gathered regarding chaplaincy services.
Sexual Orientation				
Delivery of services inclusive of LGB persons and target of health promotion messages that better suit unique needs.	Communication and Engagement Workstream	Reviewed quarterly	Ongoing	The Engagement Team will continue to work closely with the Communications and

	D&I Team		Ongoing	<p>Diversity and Inclusion Teams to ensure information is tailored and targeted appropriately for the needs of LGBTQ persons. The Engagement Team will also undertake a gap analysis with other relevant teams during the mid-point review to ensure the views of LGBTQ persons have been taken into account.</p> <p>D&I team have linked in with Engagement team to formulate a list of key LGBT+ groups to target health promotion messages. These include: Heart of Wales network Carmarthenshire LGBTQ+ community Pembrokeshire Pride.</p>
Engagement with Enfys (LGBTQ+ Staff) Network	D&I Team	Reviewed quarterly	Ongoing	D&I team able to promote consultation documents & questionnaire via ENFYS staff network.
Welsh Language				

Proactive drive to ensure patient information leaflets, signposting etc are bilingual in line with Welsh Language Act.	Patient Experience Communication and Engagement Corporate Services	Reviewed quarterly	February 2023	All consultation documents and marketing materials are available in Welsh, the website for land consultation is also provided in Welsh.
Continue to monitor progress against actions within its bilingual skills strategy, more than just words, strategic framework.	Welsh language team	Reviewed quarterly	Ongoing	These recommendations have been noted and will be addressed as part of programme / scheme development.
Improvements to quality of our signage to re brand and embed local culture and Welsh language into our new site and planned refurbishments.	Estates Capital Planning	Reviewed quarterly	Ongoing	These recommendations have been noted and will be addressed as part of programme / scheme development.
Health Impact Assessment				
See Recommendations Section of EHIA		Reviewed quarterly	Ongoing	These recommendations have been noted and will be addressed as part of programme / scheme development.
Further work on Health Impact Assessment with Public Health Wales		Reviewed quarterly	Ongoing	These recommendations have been noted and will be addressed as part of

				programme / scheme development.
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EHIA Completed by:	Name	Eiddan Harries
	Title	Senior Diversity and Inclusion Officer
	Department	Strategic Partnerships
	Contact details	Eiddan.Harries@wales.nhs.uk
	Date	Updated 18.08.2023
	2025 Review	
	Name	Alan Winter
Title	Senior Diversity & Inclusion Officer	
Date	19/12/2025	
EHIA Authorised by:	Name	Paul Williams
	Title	Assistant Director of Strategic Planning
	Department	Capital Planning
	Contact details	Paul.williams19@wales.nhs.uk
	Date	24.08.2023
	2025 Review	
	Name	Paul Williams
	Title	Assistant Director of Strategic Planning
Date		

Annex 1

Pharmaceutical Needs Assessment – see link

<https://hduhb.nhs.wales/about-us/your-health-board/board-meetings-2021/board-agenda-and-papers-30th-september-2021/agenda-and-papers-30th-september-2021/item-6-2-1-pharmaceutical-needs-assessment/>

Annex 2

Record of engagement with protected characteristics – Programme Business Case

A Healthier Mid and West Wales – Programme Business Case Protected Characteristics Engagement Log		
Protected Characteristic	Activity Completed or Scheduled	Additional Actions/Notes
Age	<ul style="list-style-type: none"> 10/05/21 - PBC Main Document/Questionnaire and Easy Read Document - Distribution to the following groups and organisations: Carmarthenshire Youth Council, Ceredigion Youth Council, Pembrokeshire Youth Assembly, Dyfed-Powys Police Youth Forum, Youth Clubs, Area 43 Youth Project, Future Minds CAMHS User Group, Mudiad Meithrin, Cylch Ti a Fi, Nurseries, Parent and Toddler Playgroups, Family Centres, Plant Dewi, Carmarthenshire, Ceredigion and Pembrokeshire Federation of Young Farmers, Guides and Brownies, Scouts, Carmarthenshire, Ceredigion and Pembrokeshire Youth Services, Youth Carers Services, Urdd Cymru, Action for Children, Carmarthenshire Youth Cares Service , Crossroads Young Adult and Young Carers Service, Echo (Voices from Care), LGBTQ at Dr.M'z ,Coleg Ceredigion, Coleg Sir Gar, Pembrokeshire College, University of Wales 	

	<p>Trinity St David, University of Wales Trinity St Davids Student Unions, Children’s Commissioner for Wales, Older Persons Commissioner for Wales, Red Roses Luncheon Club, Saron Cuppa Club, 50+ Carmarthenshire, Ceredigion and Pembrokeshire, Age Cymru Ceredigion, Pembrokeshire and Sir Gar</p> <p>Representatives from Hywel Dda University Health Board attended meetings with the following groups:</p> <ul style="list-style-type: none"> • 15/05/21 – PBC Engagement – Young People Speak Up Llanelli • 02/06/21 – PBC Engagement – Carmarthenshire Youth Council • 07/06/21 – Future Minds CAMHS User Group • 09/06/21 – PBC Engagement – Pembrokeshire Youth Assembly – facilitated own meeting and provided feedback • 11/06/21 – PBC Engagement – Ceredigion Youth Council 	
Disability	<ul style="list-style-type: none"> • 10/05/21 - PBC Main Document/Questionnaire and Easy Read Document- Distribution to the following groups and organisations: Wales Council for the Deaf, Action for Hearing Loss, RNIB Cymru Aberystwyth District Visually Impaired Club, Llanelli Blind Society, Sign and Share Club, Narberth Deaf Club, Carmarthen and Ceredigion Hard of Hearing Groups, Deaf Blind Cymru, Gwendraeth Amman Blind Social Group, Carmarthenshire Disability Coalition for Action, Ceredigion MS Group, Cymru Verses Arthritis, Arthritis Care in Wales, Disabled People Together Forum, Learning Disability Wales, Pembrokeshire Access Group, Ataxia South Wales, Disabled People 	

	<p>Together Forum, Disability Wales, Stroke Recovery Service, MS Support Group, Scope Cymru, MENCAP, Carmarthenshire and Pembrokeshire People First, Branching Out, Clynyfw Care Farm, , Noddfa, HUTS Workshop, VC Gallery, Arts Care, Links, Llanelli Veterans Association, Hywel Dda UHB Veterans Service, Carmarthenshire and Pembrokeshire Counselling Service, Create Me Happy, Get the Boys A Lift, Hafal, MIND, Spirituality and Mental Health Network, West Wales Action for Mental Health</p> <p>Representatives from Hywel Dda University Health Board attended meetings with the following groups:</p> <ul style="list-style-type: none"> • 07/06/21 – Future Minds CAMHS User Group • 09/06/21 – PBC Engagement – Cymru Versus Arthritis • 05/07/21 – PBC Engagement – Carmarthenshire Disability Partnership • 28/7/21 – SPD&I - Carmarthenshire Disability Partnership – specific questions from the PBC EHIA 	
Gender Reassignment	<ul style="list-style-type: none"> • 10/05/21 - PBC Main Document/Questionnaire and Easy Read Document- Distribution to the following groups and organisations: Stonewall Cymru, Trans GIST Interaction • 3/8/21 - SPD&I – ENFYS County Lead & Carmarthenshire LGBTQ+ Forum – specific questions from the PBC EHIA 	
Pregnancy and Maternity	<ul style="list-style-type: none"> • 10/05/21 - PBC Main Document/Questionnaire and Easy Read Document – Distribution to the following groups: Carmarthen Breast Feeding Club and Tumble Breast Feeding Club 	

Race	<ul style="list-style-type: none"> 10/05/21 - PBC Main Document/Questionnaire and Easy Read Document- Distribution to the following groups and organisations: Bawso, Diverse Cymru, EYST, Syria Sir Gar, Syrian Refugee Resettlement Programme, Llanelli Multicultural Network, Polish Welsh Association, Gypsy and Traveller Trust 	
Religion or Belief	<ul style="list-style-type: none"> 10/05/21 - PBC Main Document/Questionnaire and Easy Read Document- Distribution to the following groups and organisations: Swansea Mosque, West Wales Islamic Cultural Education Centre 29/7/21 - SPD&I – Senior Chaplain – specific questions from the PBC EHIA. Teams meeting followed to discuss and follow up email with outcome sent to PBC 	
Sex	<ul style="list-style-type: none"> 10/05/21 - PBC Main Document/Questionnaire and Easy Read Document- Distribution to the following groups and organisations: Men’s Sheds, Merched y Wawr, Federation of Women’s Institute, Rugby Clubs (Men and Women’s), Football Clubs, Cricket Clubs, Cylch Ti a Fi, Parent and Toddler Playgroups, Family Centres, Plant Dewi 	
Sexual Orientation	<ul style="list-style-type: none"> 10/05/21 - PBC Main Document/Questionnaire and Easy Read Document- Distribution to the following groups and organisations: Carmarthenshire LGBTQ+ Group, LGBTQ Youth Group Pembrokeshire, LGBTQ+ Pembrokeshire, LGBTQ at Dr.M’z, Aber Staff LGBT Network, Aberpride, Snowdrops, Enfys Staff Network, West Wales LGBT Group, Dyfed Diners 3/8/21 - SPD&I – Enfys County Lead & Carmarthenshire LGBTQ+ Forum – specific questions from the PBC EHIA 	

Annex 3

Summary of Engagement Exercise (Building a Healthier Future after COVID-19 around the pandemic our strategy, our programme business case, and equalities. 10 May to 21 June 2021)

What did the engagement cover?

The Health Board engaged about the following areas:

- The impact of the pandemic on the population: people's perceptions about the impact on health and wellbeing, access to services, personal experiences of using services
- The strategy: what people feel needs to be considered since the strategy was approved in 2018
- People's understanding of the Social Model of Health and Wellbeing, and the wider determinants of health
- Nominations for potential sites for the new hospital and key priorities when considering its location
- Understanding impacts:
 - a) Suitable and accessible services for all without disadvantage or discrimination
 - b) The effects of poverty or reduced income on wellbeing or access to services

How did the engagement take place?

Engagement methods included:

- an online questionnaire on the Health Board's engagement platforms 'Have Your Say' and 'Dweud Eich Dweud'
- paper questionnaires
- inviting feedback by email, letter and telephone

- A mail-out of the discussion document and questionnaire to stakeholders on the Engagement Team’s database and the Siarad Iechyd/ Talking Health network, including 1700 by email and 1520 by post

How was the engagement promoted?

Media releases promoting the engagement exercise were issued to local and regional press and we broadcast information about the engagement across Radio Pembrokeshire, Radio Carmarthenshire and Radio Ceredigion, with an estimated audience reach of 101,000 adults.

We posted regular messages on the Health Board’s corporate Twitter account and Facebook pages, and paid social media advertising on Facebook to promote our posts about the engagement exercise to local people who may not ‘follow’ our pages. Each English boosted post reached an average of 8475 people, and each Welsh boosted post reached an average of 7824 people.

Internally, messages were posted to the closed staff Facebook page (5.8k members), and in the Global email and Team Brief, both of which are distributed to all Hywel Dda staff (circa 13k).

We facilitated 24 meetings with groups including Health Board staff bodies, an open-to-all-staff online event, local authority chief executives and leaders, a disability organisation, and young people’s groups.

How many people responded to the engagement, and who were they?

Our reach on our online engagement platform, ‘Have your Say’ was as follows:

- 2,396 visits to the English language site, and 42 to the Welsh language site
- 1,590 people accessed the English language information, and 19 people access the Welsh
- 227 people shared their views (completed the survey online)

We also received 44 paper questionnaires, 34 email responses, 8 telephone calls, and 5 letters.

In addition to the general public, respondents included our staff, County councillors, organisations, town and community councillors, politicians and Hywel Dda Community Health Council.

How did we analyse the responses?

The questions in the survey were free text, and therefore generated detailed responses.

For the majority of questions, the Engagement team used a simplified version of Braun and Clarke's 6-step Framework for Thematic Analysis to analyse responses.

The responses to some questions have been analysed and reported in greater detail – for example, questions around nomination of land (Programme Business Case), and equalities.

How successful was the engagement exercise?

One measure of the success of this engagement is that **of the 271 respondents** (including online and paper questionnaire responses), **209 asked to be kept informed** as the work progresses.

Another measure of success is people's willingness to share their views with the Health Board. Although many respondents offered negative views about the zone for the location of the new Hospital, they offered their detailed views nevertheless about their priorities and considerations in relation to the site of the hospital. This suggests that respondents believe they have an opportunity to influence the next steps in the process.

A final measure of success is that the feedback from completed surveys, the meetings with groups, and on our social media platforms, all present very similar themes. This suggests that we have probably captured the key priorities and considerations from our communities in relation to the Programme Business Case, and that we can use their feedback to influence the next steps of the work, for example the land nomination process, with some confidence.

What did we learn about people's views in relation to the Programme Business Case for a new Hospital?

A detailed report provides the full thematic analysis of feedback relevant to the Programme Business Case. For example, here is a summary of some of the feedback about the strategy:

- Concerns about travel and transport and access to services
- A request for more integrated services, health and social care and closer working with the third sector
- The importance of local hubs

- The impact of the pandemic on mental health and wellbeing
- The need to build more resilient communities
- Frustration about the lack of detail in the strategy – e.g., what services will be delivered in each of the hospitals, including the new hospital?
- The need for more staff engagement at ground / frontline level

Here is a summary of people's priorities and key considerations for the location / site of the new hospital:

- Concerns about distance to hospital and how people would get there in a timely way
- Access to public transport to proposed site
- Road infrastructure for proposed site – concerns about suitability of road network, and traffic and congestion, especially during summer months
- Concerns about costs of transport
- Plenty of free, accessible parking for patients and staff
- Consider impact on local community and population
- Environmental considerations: avoid greenfield sites, consider carbon footprint and impact on wildlife, include green spaces around the hospital for patients and staff
- Accessibility for wheelchair users
- Attracting and retaining staff: importance of affordable staff housing near the hospital site, easy access for staff, and affordable transport for staff
- Future proofing: consider the need for expansion in future, and sustainability of the design, build and future development of services

Engagement Key Findings

Stated or perceived impacts on individuals with protected characteristics

The effects on individuals in accordance with age, sex, race and other protected characteristics and how the impacts may differ between different groups have been gathered in recurring themes throughout the report.

The questionnaires were neither tailored nor targeted to gathering equalities information. Many of the statements were observations made by others who do not share a protected characteristic; they may have witnessed inequality or believe that there is potential inequality.

This section highlights the potential groups adversely affected under each of the themes, using the feedback to identify potential groups affected, however further focused work would be needed to verify whether this information is accurate, and to what extent the impact would affect them.

Distance / travelling times

- Age – Inability for older people to drive or long travel times
- Age – Increased distance/ travelling times for children's services impacting school education
- Pregnancy and maternity – Increased distance/ travelling to access maternity services
- Gender – Increased distance/ travelling times for Women's services
- Carers – Increased distance/ travelling times impacting on Carers lives

Access to technology

- Age – Inability for older people to use digital technology
- Disability – Inability for people with disabilities to use digital technology

Transport

- Age – Older people do not own private transport or are unable to use it
- Disability – Disabilities make public transport difficult to use
- Pregnancy and maternity – Lack of affordable public transportation options

Mental Health

- Age – Children are unable to access services
- Disabilities – People experiencing mental ill health unable to use virtual appointments, etc.
- Disabilities – Lack of dementia and learning disabilities training on hospital wards making services less accessible
- Carers – Carers of those with dementia were negatively impacted during the pandemic

Flexible Service Provision

- Pregnancy and maternity – Single mothers who are pregnant have difficulties attending appointments with other dependants or during school collection times, etc.
- Age – Working age adults have difficulty accessing services when appointments are within working hours
- Age – Children miss longer school hours when appointments are made during school time to account for travelling
- Carers – Carers have difficulty supporting people to attend early appointment times as travel time is not always factored into the appointment time

Summary report also available on this link

<https://www.haveyoursay.hduhb.wales.nhs.uk/7617/widgets/39505/documents/21675>

Duty of Quality

Quality-driven decision-making tool



Part 1 - Quality Impact Assessment Toolkit

Overview & Guidance

This initial assessment should be completed to quantify potential impacts on quality or safety aspects (positive and negative), from any strategic decisions e.g. policy decisions, business cases, service improvements and changes, or efficiency savings projects that will affect operational services.

When completing the assessment consider the impact that the change will bring about in the long term. Also consider any impacts that might occur whilst the change is being implemented. For example, the project may be to introduce a new clinical pathway into an existing team, this will reduce waiting times for patients and result in smaller caseloads which are both long-term positive impacts. However, to introduce the new pathway staff working arrangement will need to change which may increase staff turnover resulting in patient waiting times for treatment increasing both are short term negative impacts. The QIA should reflect both the short-term and long-term impacts.

For the approval process and to ensure you are using the current version of the tool, please visit the QIA SharePoint page https://nhs.wales365.sharepoint.com/sites/HDD_Nursing-assurance-and-safety/SitePages/Quality-Impact-Assessment.aspx

The tool once approved by the Clinical Care Group Trumvirate e.g. Service Director, Assistant Director of Quality, Safety and Patient Experience and Associate Medical Director, should be submitted to patient.safety@wales.nhs.uk for consideration at the QIA Panel

Strategic Decision / Organisational Activity / Project Title:	Strategy Refresh - A Healthier Mid and West Wales
Name and role of lead:	Alex Martin - Principal Programme Manager
Clinical Care Group/ Function:	Strategy and Planning Directorate

Description of Strategic Decision / Project:	
Broadly outline what is being proposed and the decision that needs to be made	<p>In 2018 Hywel Dda University Health Board approved a strategy called <i>A Healthier Mid and West Wales</i> which set out how it would provide care in the future. This focused on moving from a treatment focus to prevention, developing a social model for health and wellbeing and providing more care closer to home.</p> <p>Since that time a number of significant events have happened which requires the strategy to be reviewed, and the strategy refresh will set out how we will seek to deliver the strategy between now and 2040, taking into account what we have achieved, what we still seek to deliver, and what has changed that we need to consider moving forward.</p>
Why is the proposal / decision needed	The strategy is needed to help us set out how we as an organisation will seek to deliver services over the next decade and beyond. This will inform future IMTP planning processes and help set organisational priorities, to meet national, regional and our own local priorities.
What are the drivers and influencing factors around the decision to be made? (e.g. legislation, national policy, professional body guidance, cost savings, ministerial priorities, quality standards, incidents etc)	The drivers which initiated the 2018 strategy are still in place. Fragilities and workforce pressures predicted are being realised, and shifts in population health are needed to balance future demand on services. National strategy (<i>A Healthier Wales</i>) still remains and our strategy is still aligned to this. By refreshing our strategy, it will become a key enabler to help us move towards improved professional body guidance, reduce cost pressures and improve quality standards and experience across our services.
Who is directly affected by this proposal / decision? Please also consider people who may be indirectly affected	<p>The strategy refresh will impact everyone in west Wales as well as people in our surrounding areas.</p> <p>Patients will be directly impacted through the shifting care model. There will be increased travel time for some who may need to travel further for specialist care, but there will be increased care closer to home or from the home with digital innovation and technology. Moving to a population health model should mean that patients live healthier lives in their communities.</p> <p>Staff will be directly impacted through the shifting care model. There could be changes to roles if locations of where some specialist services are provided, and as more services move into the community which could lead to more travel. It is expected that developments of hospital and community sites will improve staff wellbeing and provide better opportunities for career development, supporting recruitment and retention and reducing issues for staff.</p> <p>Stakeholders and partners will be directly impacted as the strategy requires partnership working to address issues with transport, supporting a social model of health and wellbeing through leisure and education services, and working with communities to develop resilience and connectivity.</p>
How have you engaged with the people affected? If you have not yet engaged, what are your plans?	Engagement has taken place in 2 parts. The first phase during the summer asked people "What is important to live a healthy life?" while the second phase during the autumn focused on 11 questions looking at how we can keep people healthy in their community, the balance between community and hospital care, the use of digital and technology in people's healthcare and how we can improve our estates.
How does the proposal / decision impact on delivery of the organisation's strategic objectives or ministerial priorities?	Detail of this engagement has been reported throughout the refresh process and will be included as part of the decision making process in January 2026.
Is the proposal / decision planned to be temporary or permanent?	This strategy will set out our strategic objectives, aligning them to our organisational vision and supporting our 3 year planning process.
	Permanent.

Has this Quality Impact Assessment been completed in collaboration with the clinical team(s) that the project will affect?	No
	While the Clinical Reference Group have been kept updated with the changes happening with the strategy refresh, the strategy is organisational wide and so has not been worked on by individual teams. Where additional engagement may be required in the future, clinical teams identified as dependencies will have the opportunity to feed into this document as a revised version.

Considered and supported by (in line with Scheme of Delegation):	Name
Clinical Service Group	
General Manager	
Head of Nursing	
Clinical Lead	
Clinical Care Group	
Service Director	
Assistant Director of Quality, Safety and Patient Experience	
Associate Medical Director	
Other Executive Function	
Director	

QIA Panel Use Only

Considered and supported by:	Name	Supported	Comments	Date
Deputy Director of Health Science	Jon Arthur			
Head of Strategic Partnerships (or nominated deputy)	Anna Bird / Helen Sullivan			
Associate Medical Director for Quality and Safety	Subhamay Ghosh			
Interim Assistant Director of Nursing, Assurance & Safeguarding	Cathie Steele			
Consultant in Public Health Medicine	Michael Thomas			

Considered and approved by Clinical Executive:	Name	Supported	Comments (if applicable)	Date
Director of Nursing, Quality and Patient Experience	Sharon Daniel			
Medical Director	Mark Henwood			
Director of Allied Health and Health Science	James Severs			

Date presented to panel	
Chair of Panel	
Notes of panel discussion	
If supported by QIA panel, what is the recommended frequency for review	Note: QIA must be reviewed if there is a trigger for escalation is met Date for review recommended by QIA panel:

IMPACT MATRIX

LIKELIHOOD		
1	Rare	Not expected to occur for years. Will occur in exceptional circumstances.
2	Unlikely	Expected to occur at least annually. Unlikely to occur
3	Possible	Expected to occur at least monthly. Reasonable chance of occurring.
4	Likely	Expected to occur at least weekly. Likely to occur.
5	Almost Certain	Expected to occur at least daily. More than likely to occur.

LIKELIHOOD	OPPORTUNITY						IMPACT				
	5	4	3	2	1	0	-1	-2	-3	-4	-5
5	25	20	15	10	5	0	-5	-10	-15	-20	-25
4	20	16	12	8	4	0	-4	-8	-12	-16	-20
3	15	12	9	6	3	0	-3	-6	-9	-12	-15
2	10	8	6	4	2	0	-2	-4	-6	-8	-10
1	5	4	3	2	1	0	-1	-2	-3	-4	-5

CATEGORY		
Excellent opportunity	Extreme risk	
Good opportunity	High risk	
Moderate opportunity	Moderate risk	
Minor opportunity	Low risk	

OPPORTUNITY AND IMPACT		
IMPACT	SCORE	The proposed change is anticipated to lead to the following level of opportunity and/or impact:
Positive	5	Excellence Multiple enhanced benefits including excellent improvement in access, experience and/or outcomes. Outstanding reduction in health inequalities by narrowing the gap in access, experience and/or outcomes between people with protected characteristic(s) and the general population. Leading to consistently improved standards of experience and an enhancement of public confidence. Significant improvements to <u>service delivery, performance, financial and workforce sustainability</u> .
	4	Major Major benefit leading to long term improvements and access, experience and /or outcomes. Major reduction in health inequalities by narrowing the gap in access, experience and /or outcomes between people with protected characteristic(s) and the general population. Benefits include improvements in management of patients with long term effects and compliance with national standards. Substantial <u>improvements to service delivery, performance, financial and workforce sustainability</u> .
	3	Moderate Moderate benefits requiring professional intervention with moderate improvement in access, experience and /or outcomes. Moderate reduction in health inequalities by narrowing the gap in access, experience and /or outcomes between people with protected characteristic(s) and the general population. Moderate improvements to service delivery, performance, financial and workforce sustainability.
	2	Minor Minor improvement in access, experience and /or outcomes for people. Minor reduction in health inequalities by narrowing the gap in access, experience and /or outcomes between people with protected characteristic(s) and the general population. Minor improvements to <u>service delivery, performance, financial and workforce sustainability</u> .
	1	Negligible Negligible improvement in access, experience and /or outcomes for people with this protected characteristic. Negligible reduction in health inequalities by narrowing the gap in access, experience and /or outcomes between people with protected characteristic(s) and the general population. <u>Negligible improvements to service delivery, performance, financial and workforce sustainability</u> .
Neutral	0	Neutral No effect either positive or negative
Negative	-1	Negligible Negligible negative impact on access, experience and /or outcomes for people. Negligible increase in health inequalities by widening the gap in access, experience and /or outcomes between people with protected characteristic(s) and the general population. Potential to result in minimal injury requiring no/minimal intervention or treatment, peripheral element of treatment suboptimal and/or informal <u>complaint/inquiry. Negligible negative impacts to service delivery, performance, financial and workforce sustainability</u> .
	-2	Minor Minor negative impact on access, experience and /or outcomes for people. Minor increase in health inequalities by widening the gap in access, experience and /or outcomes between people with thi protected characteristic(s) and the general population. Potential to result in minor injury or illness requiring minor intervention, formal complaint and overall treatment suboptimal. Minor negative impacts to <u>service delivery, performance, financial and workforce sustainability</u> .
	-3	Moderate Moderate negative impact on access, experience and /or outcomes for people. Moderate increase in health inequalities by widening the gap in access, experience and /or outcomes between people with protected characteristic(s) and the general population. Potential to result in moderate injury requiring professional intervention, formal complaint and failure to meet internal standards. Moderate negative impacts to <u>service delivery, performance, financial and workforce sustainability</u> .
	-4	Major Major negative impact on access, experience and /or outcomes for people. Major increase in health inequalities by widening the gap in access, experience and /or outcomes between people with protected characteristic(s) and the general population. Potential to lead to major injury leading to long-term incapacity/disability, multiple complaints/independent review and critical report. Major negative impacts to <u>service delivery, performance, financial and workforce sustainability</u> .
	-5	Catastrophic Catastrophic negative impact on access, experience and /or outcomes for people with this protected characteristic. Catastrophic increase in health inequalities by widening the gap in access, experience and /or outcomes between people with protected characteristic(s) and the general population. Potential to result in incident leading to death, multiple permanent injuries or irreversible health effects, an event which impacts on a large number of patients, totally unacceptable level or effectiveness of treatment, gross failure of safety and does not meet required standards. Significant negative impacts to service delivery, performance, financial and workforce sustainability.

