



GIG  
CYMRU  
NHS  
WALES

Bwrdd Iechyd Prifysgol  
Hywel Dda  
University Health Board

Date **16/01/2026**  
Time **15:00 - 17:00**  
Location **Microsoft Teams Meeting**

# Confirmed: Virtual Extraordinary Strategy and Planning Committee Meeting

HDD\_Strategy and Planning Committee

NHS Wales

# Agenda - 16 January 2026

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## 1 Governance and Risk

15:00, 0 min

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### 1.1 Welcome and Apologies

15:00, 0 min

*Winston Weir (Hywel Dda UHB - Independent Board Member)*

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### 1.2 Declarations of Interests

15:00, 0 min

*All*

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## 2 Strategy, Planning and Partnerships

15:00, 0 min

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### 2.1 Clinical Services Plan

15:00, 30 min

*Lee Davies (Hywel Dda UHB - Executive Director of Strategy and Planning), Yvette Pellegrotti (Hywel Dda UHB - Principal Programme Manager), Alexander Martin (Hywel Dda UHB - Principal Programme Manager)*

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### 2.2 Strategy Refresh

15:30, 1 hr

*Lee Davies (Hywel Dda UHB - Executive Director of Strategy and Planning), Nathan Davies (Hywel Dda UHB - Senior Project Manager), Alexander Martin (Hywel Dda UHB - Principal Programme Manager), Rhian Bond (Hywel Dda UHB - Assistant Director of Primary Care), Sarah Bolton (Hywel Dda UHB - Head of Primary Care Transformation), Anna Henchie (Hywel Dda UHB - Principal Programme Manager), William Mackintosh (Hywel Dda UHB - Clinical Lead - Primary and Community Services Academy)*

Including: Community by Design Strategic Plan

Due to the size of the file please use the following link for access:

[Appendix 5 Clinical Mondel Primary Care and Community](#)

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### 2.3 AHMWW Business Case Addendum

16:30, 30 min

*Lee Davies (Hywel Dda UHB - Executive Director of Strategy and Planning), Andrew Carruthers (Hywel Dda UHB - Chief Operating Officer), Huw Thomas (Hywel Dda UHB - Director of Finance), Paul Williams (Hywel Dda UHB - Assistant Director Of Strategic Planning), Eldeg Rosser (Head of Capital Planning), Clare Emanuel (Hywel Dda UHB - Senior Capital Programme Manager - Planning)*

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**3**

**Date and Time of Next Meeting**

17:00, 0 min

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**3.1**

**26 February 2026, 09:30 - 12:30, MS Teams**

17:00, 0 min

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1 - Governance and Risk

1.1

15:00, 0 Mins

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1.1 - Welcome and Apologies

*Winston Weir (Hywel  
Dda UHB -  
Independent Board  
Member)*

1.2

15:00, 0 Mins

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1.2 - Declarations of Interests

*All*

## 2 - Strategy, Planning and Partnerships

2.1

15:00, 30 Mins

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2.1 - Clinical Services Plan

*Lee Davies (Hywel Dda UHB - Executive Director of Strategy and Planning), Yvette Pellegrotti (Hywel Dda UHB - Principal Programme Manager), Alexander Martin (Hywel Dda UHB - Principal Programme Manager)*

| For approval

**Attachments**

[2.1 Strategy and Planning committee SBAR Jan 2026 incl links.pdf](#)

**PWYLLGOR STRATEGAETH A CHYNLLUNIO  
STRATEGY AND PLANNING COMMITTEE**

<b>DYDDIAD Y CYFARFOD: DATE OF MEETING:</b>	16 January 2026
<b>TEITL YR ADRODDIAD: TITLE OF REPORT:</b>	Clinical Services Plan
<b>CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:</b>	Lee Davies, Executive Director of Strategy and Planning
<b>SWYDDOG ADRODD: REPORTING OFFICER:</b>	Yvette Pellegrotti, Alex Martin, Ben Rogers, Principal Programme Managers, Transformation Programme Office

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

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

Ar Gyfer Penderfyniad/For Decision

**ADRODDIAD SCAA**

**SBAR REPORT**

**Sefyllfa / Situation**

The Clinical Services Plan (CSP) programme was established to develop plans for the provision of key services over the medium term. This report aims to provide assurance on the work undertaken following the 13.5 week consultation period (29 May – 31 August 2025) to support the Board in its decision-making at the extra-ordinary Board meeting in February 2026.

Committee members are asked to review and take assurance on the following programme materials to inform decision-making in February 2026:

1. CSP Overview Programme Assessments
2. Capital Assessment Summary and Development Assessment Forms (DAF)
3. CSP Programme Workforce and Finance Estimates
4. Programme Impact Assessments – Equality Impact (including Welsh Language) (EqIAs)
5. Informing Plan and supporting appendices, including the draft CSP consultation report, to enable conscientious consideration
6. Conscientious Consideration presentation – sets out a summary of the Informing Plan, and the draft decision-making process.

The purpose of sharing these papers is to provide assurance to the Committee that a robust process is being followed to support Board Members in their decision-making in February 2026.

**Cefndir / Background**

The long-term plans for services remain as set out in our strategy; however, there is a need to consider service provision over the medium term, particularly with the delays in the 'A Healthier Mid and West Wales' programme business case timelines as originally envisaged. Prior to the pandemic, and in our strategy, it was recognised that many of our services are fragile, predominantly because our clinical teams are spread across multiple sites and, therefore, there

is an over-reliance on a small number of individuals. This remains the case and in certain areas that risk has materialised. Similarly, there are services that have not returned to pre-pandemic activity levels, which is limiting access for patients, e.g. for those patients awaiting elective surgery.

At the Board meeting held in [March 2023](#), it was agreed that the following services required focused support and would form a programme of work to deliver a Clinical Services Plan (CSP); the table has been revised to indicate services in scope and changes of roles:

Table 1: Drivers for pathways within scope of the CSP programme updated to reflect services in scope and changes in roles:

<b>Service</b>	<b>Driver</b>	<b>Executive Lead</b>
Critical Care	Response to service fragility, in particular at Prince Philip Hospital (PPH)	Chief Operating Officer
Planned Care (Dermatology, Elective Orthopaedics, Ophthalmology, and Urology)	To support the return to pre-COVID activity levels (as a minimum), as part of improving access and reducing waiting times for patients	Chief Operating Officer
Emergency General Surgery	To respond to service fragility, particularly at Worthybush Hospital (WGH), as referenced in the March 2023 operational update	Chief Operating Officer
Stroke	To meet standards and respond to service fragility	Executive Director of Allied Health Professions and Health Science
Diagnostics (Endoscopy and Radiology)	To support the return to pre-COVID activity levels (as a minimum), as part of improving access and reducing waiting times for patients	Chief Operating Officer

The Board update in [November 2024](#) approved the recommendation to develop a project plan to undertake a public consultation. In addition, this update included the closing report for Phase 2 of the CSP programme in the development of a shortlist of options.

The Board update in [January 2025](#) approved the consultation project plan, and within this the consultation mandate, including the aims and objectives of 'Phase 3 – Public Consultation'. The public consultation will enable the Board to make a formal decision on the nine services in scope, as well as the potential roles of the acute hospital sites, until the full implementation of the 'A Healthier Mid and West Wales' strategy.

The Board update in [May 2025](#) endorsed the formal launch of the CSP public consultation and received assurance from the Quality Assurance process undertaken by Hugh Irwin & Co. (HICO).

The Board update in [September 2025](#) requested an extension to the consultation reporting timeline due to the number of responses received and the time required to evaluate and appraise alternative options and ideas received during the consultation. During the meeting this was verbally updated to be February 2026, as the paper initially stated January 2026.

The Board update in [November 2025](#) set out the key outcomes to date following public consultation, confirming that the programme remains aligned to the adjusted timeline, with an Extraordinary Board meeting scheduled for 19 February 2026.

### **Asesiad / Assessment**

The following products have been developed to support the Board in its decision-making. Each is provided as an appendix for reference:

1. [CSP Overview Programme Assessments – Programme-level workforce, capital, and finance assessments.](#)
2. [Capital Assessment Summary & Development Assessment Forms \(DAF\) – Preliminary estimates of capital requirements for all options in line with NHS specifications, including summary documents and detailed DAF forms. Stage 1 capital assessments will follow post-decision.](#)
3. [CSP Programme Workforce and Finance Estimates – Indicative assessments of workforce requirements and financial needs, including phased delivery timelines. Developed with Finance and Workforce colleagues via the Service Task and Finish Groups. Detailed assessments will be completed after a decision is made.](#)
4. [Programme Impact Assessments – Equality Impact Assessments \(including Welsh Language\) completed for each option, considering equality, diversity, and Welsh language impacts. These are live documents and will be updated following decisions.](#)
5. [Informing Plan – Sets out what has changed since the issues paper was published, including the draft CSP consultation report, stakeholder reflections, and review of alternative options.](#)
6. [Conscientious Consideration presentation – sets out a summary of the Informing Plan, and the draft decision-making process.](#)

The Committee should also note the following documents and products, which are currently in progress however will be included in the Board Pack for the Extraordinary Board meeting in February:

- CSP SBAR
- CSP Board Presentations – to support decision-making
- Phase 3 Closing Report – Provides a comprehensive overview of the activities and milestones achieved during Phase 3 of the CSP Programme. This will also include the output of conscientious consideration undertaken with Board members on 13 January 2026, where the Informing Plan (including the draft CSP Consultation Report) was considered.
- Programme Impact Assessments – Health Impact Assessments (HIAs), Quality Impact Assessments (QIAs), Regional Impact Assessments (RIA) and Environmental and Sustainability Impact Assessments (ESIAs).
- Final CSP consultation report – the final version of the full findings from the 13.5-week consultation process, produced by Opinion Research Services (ORS).

### **Argymhelliad / Recommendation**

**The Committee is asked to:**

- **TAKE ASSURANCE** from the suite of products developed to support Board with its decision-making; and
- **ENDORSE** progressing the Clinical Services Plan (CSP) to the Board for decision-making at the February meeting.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	<ul style="list-style-type: none"> <li>➤ 3.1.21. Seek assurance on delivery against all Planning Objectives aligned to the Committee, in accordance with the Board approved timescales, as set out in the Health Board's Annual Plan, considering and scrutinising the plans and programmes that are developed and implemented, supporting and endorsing these as appropriate.</li> </ul>
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	<ul style="list-style-type: none"> <li>➤ 1363 - (Critical Care) Inability to safely support Level 3 Critical Care provision across PPH and GGH (current score 20)</li> <li>➤ 1082 – (T&amp;O) Lack of Major Trauma Weekend Theatre Sessions GGH (current score 20)</li> <li>➤ 1383 (Endoscopy) Nursing Staffing Issues/recruitment (current score 8)</li> <li>➤ 1254 - (Endoscopy) Prince Philip Reconfiguration (current score 8)</li> <li>➤ 1531 - (General Surgery) Inability to safely support on call rota at WGH and GGH (current score 10)</li> <li>➤ 1084 - (General Surgery) Surgical Rota at PPH (current score 9)</li> <li>➤ 1235 - (Urology) Urology Urgent Suspected Cancer (USC) and PCNL (PERCUTANEOUS NEPHROLITHOTOMY) Treatment Delays (current score 16)</li> <li>➤ 1407 - (Corporate Level Risk) Risk to delivery of Annual Recovery Plan &amp; achievement of WG Ministerial Priorities or the reduction in elective waiting times</li> <li>➤ 1488 - (Endoscopy) Decontamination BGH (current score 12)</li> <li>➤ 1092 - (OPD) Progress against F/UP OPD Targets (current score 12)</li> <li>➤ 1255/56 - (T&amp;O) Lack of Orthogeriatric Consultants and ANP Support (current score 20)</li> <li>➤ 747 - (Dermatology) Delivery of sustainable Dermatology Service (current score 8)</li> <li>➤ 1428 - (Rheumatology) Unable to meet Service requirements (current score 4)</li> <li>➤ 632 - (Ophthalmology) Ability to fully implement WAG Measures (current score 16)</li> <li>➤ 1066 – (Ophthalmology) Inability to provide nursing staff to cover required level of activity within Ophthalmology across HB (current score 9)</li> <li>➤ 1234 - (OPD) Inadequate ventilation GGH/WGH (current score 12)</li> </ul>

Parthau Ansawdd: Domains of Quality <a href="#">Quality and Engagement Act (sharepoint.com)</a>	7. All apply Choose an item. Choose an item. Choose an item.
Galluogwyr Ansawdd: Enablers of Quality: <a href="#">Quality and Engagement Act (sharepoint.com)</a>	6. All Apply Choose an item. Choose an item. Choose an item.
Amcanion Strategol y BIP: UHB Strategic Objectives:	All Strategic Objectives are applicable Choose an item. Choose an item. Choose an item.
Amcanion Cynllunio Planning Objectives	6 Clinical services plan Choose an item. Choose an item. Choose an item.
Amcanion Llesiant BIP: UHB Well-being Objectives: <a href="#">Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022</a>	2. Develop a skilled and flexible workforce to meet the changing needs of the modern NHS Choose an item. Choose an item. Choose an item.

### Gwybodaeth Ychwanegol: Further Information:

Ar sail tystiolaeth: Evidence Base:	The Clinical Services Plan followed the advice and direction provided by the Consultation Institute (tCI) for Phase 1 and most of Phase 2. For Phase 3 this advice is being provided by HICO under the CfC.
Rhestr Termiau: Glossary of Terms:	
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Strategaeth a Chynllunio Parties / Committees consulted prior to Strategy and Planning Committee:	<a href="#">Board (March 2023 for approval to deliver the Clinical Services Plan Programme)</a> <a href="#">Board (May 2023 for an update on progress of the Clinical Services Plan)</a> <a href="#">Board (July 2023 for an update on progress of the Clinical Services Plan)</a> <a href="#">Board (September 2023 for an update on progress of the Clinical Services Plan)</a> <a href="#">Board (September 2023 Project Plan to develop a Primary Care and Community Strategy)</a> <a href="#">Board (November 2023 for an update on progress of the Clinical Services Plan)</a> <a href="#">Board Seminar (December 2023 for the agenda including items related to Primary Care and Community)</a> <a href="#">Board (January 2024 for an update on progress of the Clinical Services Plan)</a> <a href="#">Board (March 2024 for an update on progress of the Clinical Services Plan)</a>

	<p><a href="#">Board (May 2024 for an update on progress of the Clinical Services Plan)</a></p> <p><a href="#">Board (July 2024 for an update on progress of the Clinical Services Plan)</a></p> <p><a href="#">Board (September 2024 for an update on progress of the Clinical Services Plan) Page 3, Chief Executives Report</a></p> <p><a href="#">Board (November 2024 for an update on progress of the Clinical Services Plan)</a></p> <p><a href="#">Board (January 2025 for an update on the progress of the Clinical Services Plan).</a></p> <p><a href="#">Board (May 2025 for an update on the progress of the Clinical Services Plan)</a></p> <p><a href="#">Board November 2025 for an update on the progress of the Clinical Services Plan)</a></p>
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<b>Effaith: (rhaid cwblhau)</b> <b>Impact: (must be completed)</b>	
<b>Ariannol / Gwerth am Arian:</b> <b>Financial / Service:</b>	An indicative financial estimate has been included within the programme and is contained within the supporting documents directory for public consultation.
<b>Ansawdd / Gofal Claf:</b> <b>Quality / Patient Care:</b>	The CSP is intended to improve Quality and Patient Care. Quality Impact Assessment screenings have been completed and have been considered at the Quality Impact Assessment Panel. These were included with submissions to the Board in November 2024.
<b>Gweithlu:</b> <b>Workforce:</b>	Indicative programme workforce assessments have been completed and are contained within the supporting documents directory for public consultation.
<b>Risg:</b> <b>Risk:</b>	As outlined above.
<b>Cyfreithiol:</b> <b>Legal:</b>	The consultation project plan as shared in the Board update in January 2025 highlights the relevant legal considerations for public consultation.
<b>Enw Da:</b> <b>Reputational:</b>	It is anticipated that there may be political and media interest in the development of these plans. A Communications and Engagement plan has been developed as part of the programme.

<b>Gyfrinachedd: Privacy:</b>	<p>Relevant privacy statements are linked and described within the consultation documents.</p> <p>A Data Protection Impact Assessment (DPIA) has been completed for the programme.</p>
<b>Cydraddoldeb: Equality:</b>	<p>The CSP is intended to improve equality, and this will be further assessed as service plans are developed. Baseline Equality Impact Assessments have been undertaken based on current service provision. In addition to this Equality Impact Screening templates have been completed to consider the impacts within each of the proposed options. These were submitted with Board papers in November 2024.</p>

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## 2.2 - Strategy Refresh

**Lee Davies (Hywel Dda UHB - Executive Director of Strategy and Planning), Nathan Davies (Hywel Dda UHB - Senior Project Manager), Alexander Martin (Hywel Dda UHB - Principal Programme Manager), Rhian Bond (Hywel Dda UHB - Assistant Director of Primary Care), Sarah Bolton (Hywel Dda UHB - Head of Primary Care Transformation), Anna Henchie (Hywel Dda UHB - Principal Programme Manager), William Mackintosh (Hywel Dda UHB - Clinical Lead - Primary and Community Services Academy)**

Including: Community by Design Strategic Plan  
Due to the size of the file please use the following link for access:  
[Appendix 5 Clinical Mondel Primary Care and Community](#)

| For approval

### Attachments

[2.2.1 SPC SBAR - Strategy Refresh.pdf](#)

[2.2.2 Appendix 1 - First draft Strategy Refresh.pdf](#)

[2.2.3 Appendix 2 - Strategy Refresh Engagement Report v1.pdf](#)

[2.2.4 SPC SBAR Primary Care and Community Strategic Plan Jan 26.pdf](#)

[2.2.5 Appendix 1 Community By Design Strategic Plan Enabling A Healthier Mid and West ~.pdf](#)

[2.2.6 Appendix 2 Primary Care Systems V8.pdf](#)

[2.2.7 Appendix 3 CbD Transformation Programme Delivery Plan \(004\).pdf](#)

[2.2.8 Appendix 4 Insights and Ideas.pdf](#)

**PWYLLGOR STRATEGAETH A CHYNLLUNIO  
STRATEGY AND PLANNING COMMITTEE**

<b>DYDDIAD Y CYFARFOD: DATE OF MEETING:</b>	16 January 2026
<b>TEITL YR ADRODDIAD: TITLE OF REPORT:</b>	Strategy Refresh
<b>CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:</b>	Lee Davies, Executive Director of Strategy and Planning
<b>SWYDDOG ADRODD: REPORTING OFFICER:</b>	Paul Williams, Assistant Director of Strategic Planning

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

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

Er Sicrwydd/For Assurance

**ADRODDIAD SCAA**

**SBAR REPORT**

Sefyllfa / Situation

The purpose of this report is to provide the Strategy and Planning Committee (SPC) with the analysis of the engagement to date and present the content of the draft strategy refresh ahead of sharing with Board.

Cefndir / Background

In November 2024, work was initiated to refresh the existing *A Healthier Mid and West Wales* (AHMWW) strategy. 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 need refreshing because they are fundamentally different to how they were envisioned when AHMWW was ratified in 2018.

Engagement has been an integral part of the strategy refresh process, which has been split into two distinct phases:

Phase 1 engagement 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?". A thematic analysis of the responses was carried out and the results were presented to the SPC Committee in October 2025.

Phase 2 engagement started at the end of September 2025. It lasted for 9 weeks and finished at the end of November 2025. Phase 2 engagement activity sought to gather feedback from our communities on 11 questions across 4 broad categories, focusing on the Social Model for Health and Wellbeing, digital healthcare support, balancing hospital care and community support and clinical services and hospital redevelopment.

Asesiad / Assessment

As noted in the earlier stages of the work to refresh the strategy, the key principles and the broad direction remain unchanged.

The work since November 2024 has focused on realigning our vision, mission and values with the strategic objectives that we will need to deliver if we want to move away from a treatment model.

Where the 2018 strategy envisaged care closer to home, the strategy refresh explores care from the home with the use of virtual and digital healthcare alongside community services in community centres to help people remain well and healthy.

We still want to develop a social model for health and wellbeing, and the strategy looks at not only developing this further as a key objective, but how we can use a 20Four7 approach to population health to support community wellness.

To do this we will need to reprioritise where we deliver the majority of our care, while making sure that when people do need hospital services they are treated in modern, fit for purpose facilities in a safe, timely way with staff delivering a high-quality service.

Throughout the strategy, and included as appendices, we have woven in what we have heard throughout the engagement from our public, staff and partner organisations. We have listened to where they have said we have done well, where they think we could make improvements, and what changes we can make to create a more accessible and equitable health care service for all.

The strategy itself is not intended to be an exhaustive document instead sets out the direction of travel we seek to take. Within the strategy we describe how the goals outline our ambitions, strategic delivery plans will oversee key pieces of work, and our three-year planning process will track the annual delivery of these key pieces of work.

As well as the strategy and engagement feedback, we have also updated the Equality and Health Impact Assessment, which is being shared as a draft ahead of the Board meeting on 29 January 2026, with additional feedback shared during the engagement, as well as completing a Quality Impact Assessment, both support the refreshing of our strategy and our overall mission, while providing ways that we can support patients to overcome barriers to accessing health care services.

It should be noted that while the strategy has been developed by Hywel Dda University Health Board, its delivery is dependent on working in partnership with our public, staff and partners. The intention is that once the content of the strategy has been approved, we will work to create a more public friendly document which will support us to share our refreshed strategy with others who will be essential to help us deliver the changes we wish to seek.

### Argymhelliad / Recommendation

The Committee is asked to:

- **DISCUSS** the content of the draft strategy and consider whether it meets the long-term aims of the organisation.
- **Take ASSURANCE** from the draft report and attachments that the strategy has been refreshed, considering the views of public, staff and partner organisations.

<b>Amcanion: (rhaid cwblhau)</b> <b>Objectives: (must be completed)</b>	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	3.1.11. Seek assurance on the development of the Estates Strategy and Infrastructure Investment Enabling Plan aligned to the A Healthier Mid and West Wales Strategy, and review documents prior to Board approval.
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Risk 1196 - Insufficient investment in facilities/equipment/digital infrastructure (risk score 16)
Parthau Ansawdd: Domains of Quality <a href="#">Quality and Engagement Act (sharepoint.com)</a>	7. All apply
Galluogwyr Ansawdd: Enablers of Quality: <a href="#">Quality and Engagement Act (sharepoint.com)</a>	6. All Apply
Amcanion Strategol y BIP: UHB Strategic Objectives:	All Strategic Objectives are applicable
Amcanion Cynllunio Planning Objectives	All Planning Objectives Apply
Amcanion Llesiant BIP: UHB Well-being Objectives: <a href="#">Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022</a>	9. All HDdUHB Well-being Objectives apply

<b>Gwybodaeth Ychwanegol:</b> <b>Further Information:</b>	
Ar sail tystiolaeth: Evidence Base:	Contained within the body of the report
Rhestr Termiau: Glossary of Terms:	Contained within the body of the report
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Strategaeth a Chynllunio Parties / Committees consulted prior to Strategy and Planning Committee:	Board Seminar Clinical Reference Group

<b>Effaith: (rhaid cwblhau)</b> <b>Impact: (must be completed)</b>	
<b>Ariannol / Gwerth am Arian:</b> <b>Financial / Service:</b>	The Programme Business Case (PBC) and Strategic Outline Case (SOC) sets out both the revenue and capital funding assumptions for the programme.
<b>Ansawdd / Gofal Claf:</b> <b>Quality / Patient Care:</b>	Implicit within the PBC and SOC. This is an integral part of the PBC and SOC case for change.
<b>Gweithlu:</b> <b>Workforce:</b>	Implicit within the PBC and SOC. This is an integral part of the PBC and SOC case for change.
<b>Risg:</b> <b>Risk:</b>	Risk 1196 Insufficient investment in facilities/equipment/ digital infrastructure.
<b>Cyfreithiol:</b> <b>Legal:</b>	Implicit within the PBC.
<b>Enw Da:</b>	Implicit within the PBC.

<b>Reputational:</b>	
<b>Gyfrinachedd: Privacy:</b>	Implicit within the PBC.
<b>Cydraddoldeb: Equality:</b>	There is an Equality and Health Impact Assessment which will remain 'live' through the duration of the programme.

*Insert image*

# **A Healthier Mid and West Wales**

**A refresh of the strategy of Hywel Dda University Health Board strategy**

**January 2026**

## **Executive Summary**

### **01 Healthier lives, well lived**

**Our mission:** *Healthier lives, well lived*

**Our strategic objectives**

**Our values and behaviours**

### **02 Thriving teams**

**Goal 1:** Healthy, thriving teams

**Goal 2:** Customer service excellence

### **03 Healthier communities**

**Goal 3:** '20-4-7' population health

**Goal 4:** Primary and community by design

### **04 Great care**

**Goal 5:** Digital first

**Goal 6a:** Timely, high-quality care

**Goal 6b:** Safe, high quality care

### **05 Positive futures**

**Goal 7:** Future orientated

**Goal 8:** Fit for purpose, modern facilities and services

### **06 Delivering the change**

### **Concluding remarks**

# Executive Summary

Our 'A Healthier Mid and West Wales' strategy, first set out in 2018, described a future where we would provide care closer to home, supporting people to develop, live and age well in their communities.

To do this, we would move from an organisation that treats illness to supporting people to stay well and health through prevention in the community. We recognised that people would still need to use hospitals for those rare life events, but we wanted to create a service which could provide as much care as possible from community hospitals and integrated care centres.

Since the strategy has been published there have been many changes, such as the Covid-19 pandemic which impacted our services, our buildings have become older and in greater need of repair, and the issues we predicted could take place without change have started to appear, with services becoming more fragile as staff age and retire. There have also been more encouraging developments, with the progression of Pentre Awel, moving services into the community and an accelerated digital transformation which has gained more momentum as a result of the need to create digital ways of working.

The strategy refresh has been a process of looking at what we said we wanted to achieve, what we have managed to accomplish and what we still set out to do. We have also engaged with our public to understand what is important to help them live a healthy life, as well as understand what some of those changes could mean to our wider communities. The engagement, as well as the review of the strategy, has helped identify new areas that we want to explore between now and 2040.

Throughout our strategy, we have used what staff, patients and partner organisations have told us during the engagement to help shape our goals, whether that is the development of care closer to home, improvement in our buildings, or considering how people access and get to their care.

While we may need to be more radical in our delivery, we will need to ensure that we are retaining quality within our decision making and our refreshed strategy considers our duty of quality in each of our strategic objectives.

As our strategy will set out the direction of how we provide services in the future, our strategy has looked at goals which support our staff to work in services which are Safe, Timely, Efficient, Equitable and Person Centred Care. We have also considered what we can do to support them ensuring that the enablers of quality are in place.

In summary many of the things that we said in our original strategy still remain, but we may need to do things differently to achieve our goals and recognise that it is the public and our partners who need to play a greater role in our transformation.

# 01 Healthier lives, well lived

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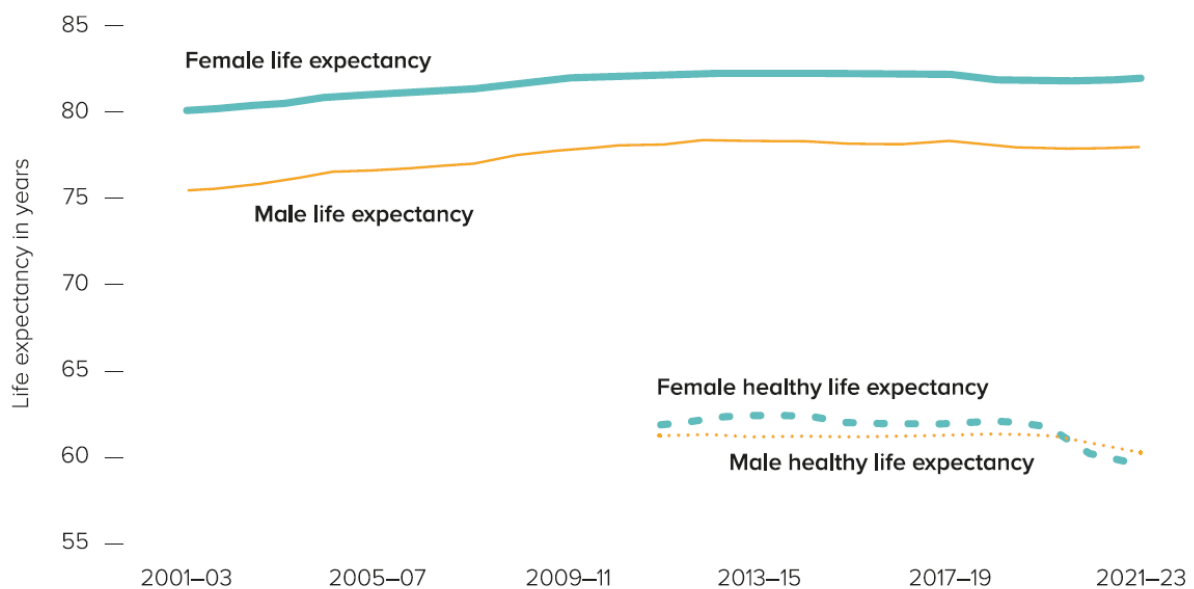
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## The NHS today

In 2018 we launched our A Healthier Mid and West Wales strategy which looked to fundamentally change the health of our population and the way health care was delivered. The aim of the strategy was to address future challenges, which we predicted would occur if nothing was done, and deliver healthcare in a system which promoted prevention and more care in communities.

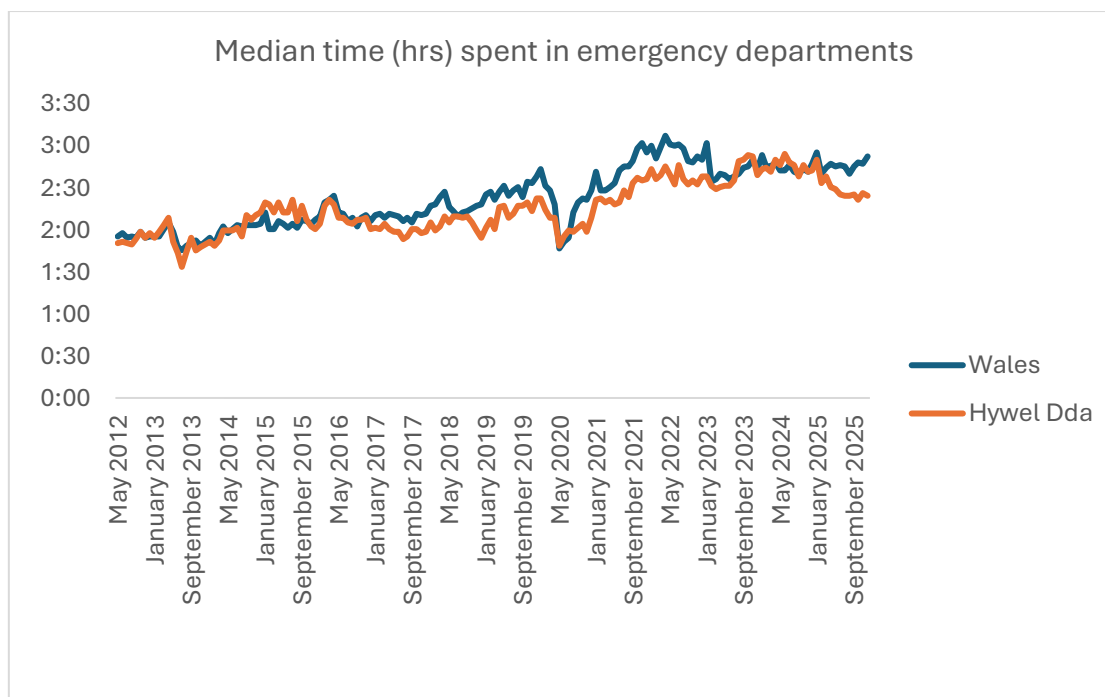
Moving forward to 2025 and the health and care system is under considerable strain. It is no exaggeration to say that, like other parts of the UK (*reference: 10 year plan*), the NHS in Wales is currently facing an existential threat. The factors behind this are numerous and complex.

The long-term trend, since the second world war, of improvements in life expectancy, healthy life expectancy and mortality have all stalled (CMOs Annual Report, 2025) and many indicators are pointing to a less healthy population.



Inflation and economic pressures, including the effects of Brexit, have meant that, despite the NHS consuming a growing proportion of the overall Welsh Government budget (in 2026/27 it will be 55%), Health Boards in Wales are facing substantial financial pressures.

Ambulances do not get to patients as quickly as they previously did and patients spend nearly 50% longer in Emergency Departments than they did a decade ago.



Hospital waiting lists, whilst gradually improving are, post-Covid, at their longest for a generation, with over 1 in 6 of us waiting on a referral to treatment pathway (StatsWales). At current trends it would take NHS Wales 50 years to return to pre-pandemic waiting list sizes. Despite the challenges in hospital care, access to primary care is actually the UK public’s top priority for the NHS (The Health Foundation, 2025).

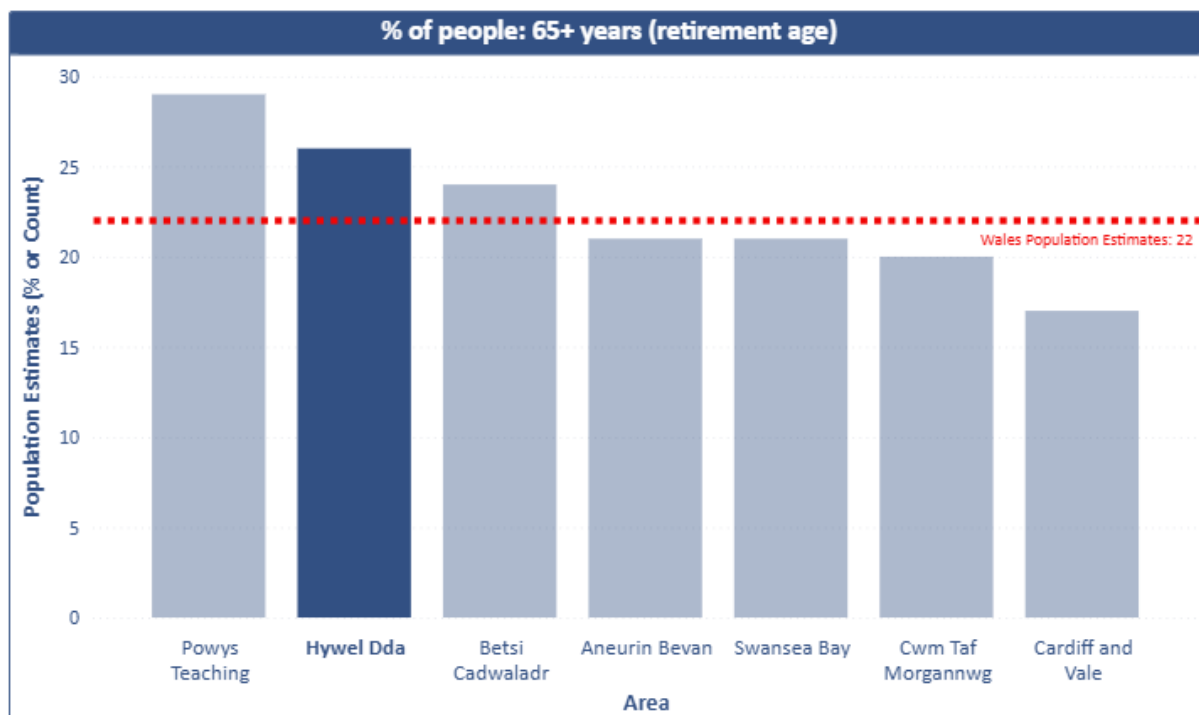
Faced with these challenges it is clear the NHS will need to be bold and deliver significant change yet, at the same time, trust in public institutions is declining and often people do not believe their voices are being heard in decision-making (Future Generations Report, 2025).

## The NHS in 2040

Looking forward to 2040, the overall population of Wales is expected to grow, but only by 3.0% (StatsWales), and the population of Hywel Dda by 1.6%. The number of residents in Carmarthenshire is projected to increase by 2.7% by 2040 and 2.0% for Pembrokeshire. However, the population in Ceredigion is falling and is projected to decrease by 2.4%.

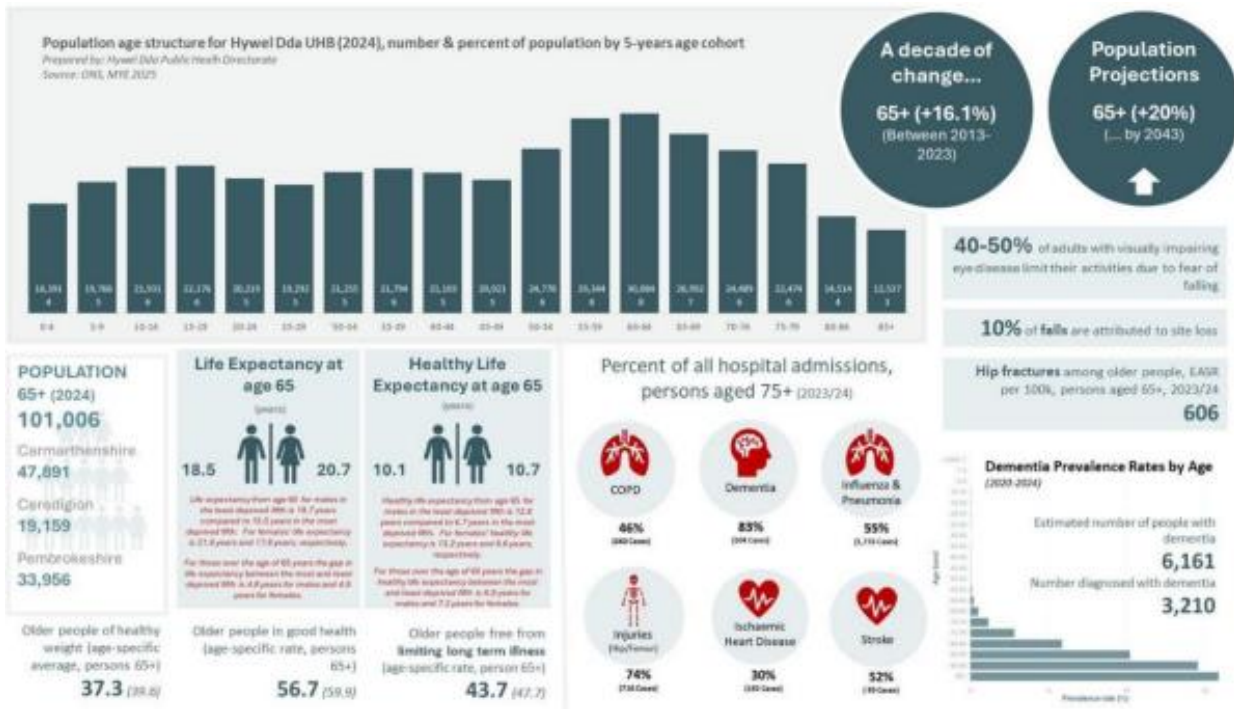
The more significant change is the make-up of our population. We can expect a significant increase in older age groups as the ‘baby boomer’ generation will all be 65 and above from 2029. Simultaneously, parts of Wales, will see a fall in the working age population, shrinking the potential workforce for health and care services and restricting the country’s tax base. The recruitment of internationally trained staff has been vital for the NHS over many years, tighter controls on immigration may further compound these challenges.

It is well documented that the population of Wales is ageing and this is anticipated to add significant demand to the NHS. The proportion of Wales aged over 65 is expected to increase from 22% today to around 26% in 2040. However, the ageing of the population has already happened in Hywel Dda, currently 27% of our residents are over the age 65 and this is expected to increase further to nearly 32% in 2040, with Pembrokeshire reaching 34%. Proportionally, this trend accelerates for older age groups. For example, between 2018 and 2040 the number of people aged over 90 is predicted to increase by 85%, equivalent to over 3800 additional nonagenarians.



Meanwhile the working age population is shrinking across all three counties. By 2040 it is projected that the population aged 16-64 will have reduced by 15,300 with the most significant fall in Ceredigion (15.1%). This combination of more older people and fewer of working age is a trend seen for Wales as a whole, but is particularly pronounced in rural areas – West Wales, Powys and North Wales. The working age population is actually expected to continue to grow for the rest of South Wales, driven by proximity to the three cities of Cardiff, Swansea and Newport. This ‘hollowing out’ of the rural population presents a significant risk to our communities and the delivery of public services.

The prevalence of conditions such as diabetes and dementia are expected to grow significantly. It is estimated that 79,700 people will be living with dementia in 2040, a 70% increase from 2019, and 260,000 with diabetes if current trends continue.



It is also *highly likely* that there will be an increase in multimorbidity (patients with 2 or more LTCs) bringing added complexity and pressure on health services, with the majority (two-thirds) including a mental health condition (SEA, 2023). The number of people diagnosed with cancer each year is expected to rise from 19,800 in 2017-19 to 24,800 in 2040.

**Compared to Wales**

Wales  
 Significantly better  
 Similar  
 Significantly worse

	Wales	Hywel Dda UHB	Ceredigion	Pembrokeshire	Carmarthenshire
Healthy life expectancy at birth (females), 2015 to 2017 (Years)	62.0	62.0	65.8	62.7	59.7
Healthy life expectancy at birth (males), 2015 to 2017 (Years)	61.4	62.5	67.4	62.5	60.4
Life expectancy at birth (females), 2015 to 2017 (Years)	82.3	82.9	84.2	83.3	82.2
Life expectancy at birth (males), 2015 to 2017 (Years)	78.3	78.6	79.5	78.9	78.0

If we continue without change, the 2040 predictions for our population are stark:

- The life expectancy gap between the most and least deprived communities will continue to grow, people will die younger
- People will age with more chronic conditions, requiring more support from health and social care services
- There will be shortages of workers, more people will become economically inactive due to poor health

- Services will no longer be able to meet demand, the competition nationally for staff and local workforce will not be here

Put simply deaths will occur which could be prevented, and they can.

## The Financial Outlook

Of course, this is not the first time that NHS Wales has faced such stark warnings.

In 2000, the Chancellor announced that a long-term assessment of the trends affecting expenditure on health services would be commissioned. This resulted in the publication of *Securing our Future Health: Taking a Long-Term View*, known as the “Wanless Report” on 17<sup>th</sup> April 2002. The report, produced by Derek Wanless, set out projections of how much it would cost to deliver high quality services throughout the NHS over the next 20 years. It used scenarios of public engagement with their own health – *fully engaged*, *steady progress* and *slow uptake* – to model demand for health care services and project a range of spend. The Wanless Report concluded that, “*Over the next 20 years, the UK will need to devote a substantially larger share of national income to health care.*” The Wanless Report recommended that the percentage of total health spending would need to rise over time from 7.7% of GDP in 2002-03 to between 9.4% and 9.5% in 2007-08, between 10.3% and 11% in 2012-13, between 10.6% and 11.9% in 2017-18 and between 10.6% and 12.5% in 2022-23.

The recent Darzi review of the NHS in England concluded that we are much closer to the ‘slow uptake’ scenario than the ‘fully engaged’ scenario. As health expenditure in the UK was 10.9% in 2023 (ONS, 2024), and therefore towards the lower end of Wanless’ projections, it perhaps is not such a surprise that the NHS in the UK is struggling today to the extent that it is, particularly given that a pandemic would not have been within the Wanless projections.

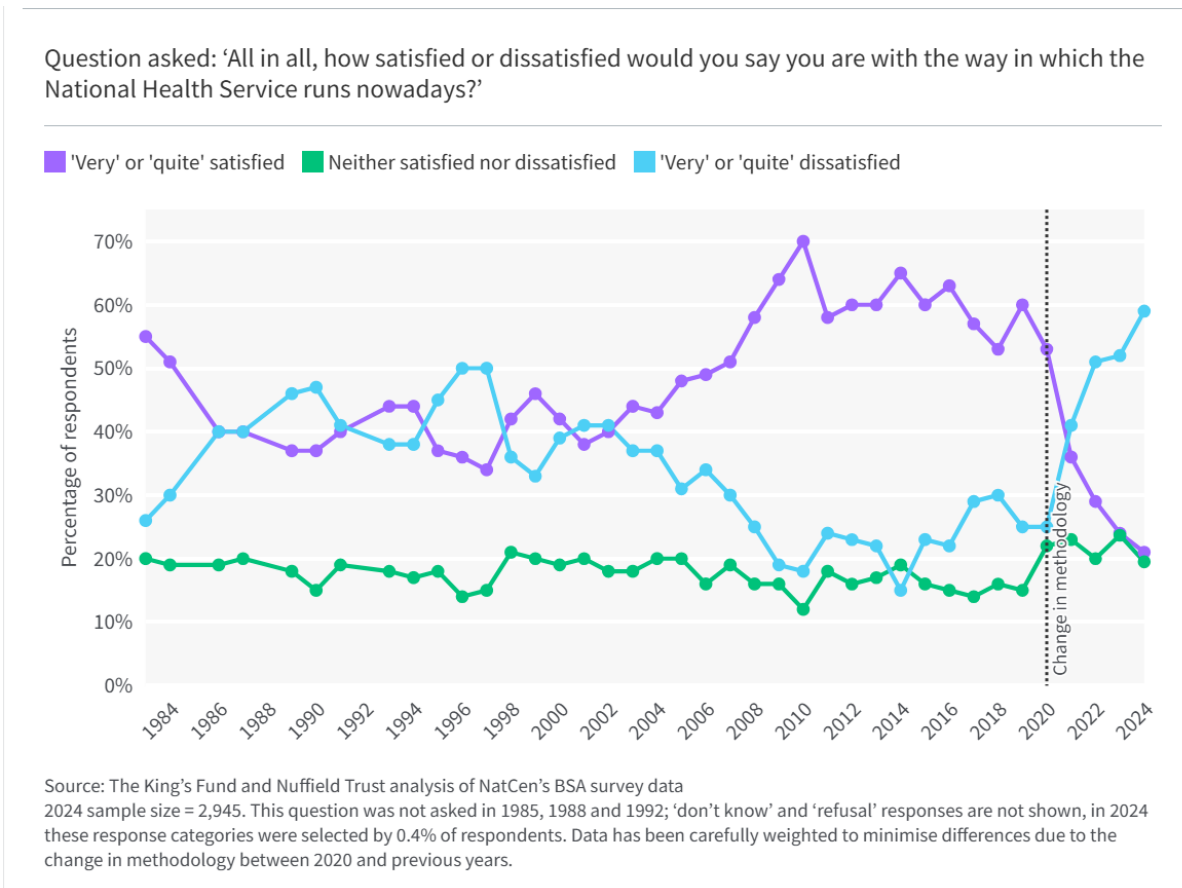
The 2002 Wanless report focused on the NHS across the UK. However Derek Wanless was invited to advise the project team which had been set up specifically to review health and social care in Wales: *The Review of Health and Social Care in Wales - The Report of the Project Team advised by Derek Wanless (June 2003)*.

The foreword of the review about health and social care in Wales stated that:

*Generally, the current position in Wales is worse than in the UK as a whole, reflecting trends evident over decades. Wales does not get as much out of its spending as it should; in health, for example, it now places unsustainable pressure on its acute sector.*

In the aftermath of the Wanless Report the NHS received an unprecedented 5-year funding settlement, with real terms increases of 7.4% (Health Foundation, 2021).

The funding increases led to substantial staffing increases and improvements in waiting times and outcomes. The proportion of the British public satisfied with the NHS rose to a high of over 70% in 2010.



That seems a long time ago now. In the 15 years since, the UK has gone through a period of significant political, social and economic disruption, with austerity following the 2008 financial crisis and economic recession, the vote to leave the European Union, six Prime Ministers in 8 years, the cost of living crisis and the fifth deadliest pandemic in human history.

Unsurprisingly these factors have combined, along with the anticipated ageing of the population and insufficient progress with prevention and improved health, to place considerable strain on the NHS. Correspondingly, public satisfaction with the NHS has plummeted with the highest proportion of people now stating they are 'very' or 'quite' dissatisfied with the NHS since the survey began over 40 years ago.

The experience of the early 2000s does demonstrate that a combination of sustained investment and reform can result in substantial improvements to the NHS, enabling it to match up with the best health systems in the World (King's Fund 2010).

However that formula looks like it is unlikely to be repeated. Earlier this year the work done on [financial recovery](#) was presented to our Public Board and it is clear from that analysis that public finances within the UK are likely to be significantly constrained for many years to come. Key points include: UK Government has not delivered a surplus

since 2001; Government debt is now over 100% of GDP; the higher debt combined with increased interest rates has meant the costs of borrowing have exceeded £100b a year; Public sector investment has been below peer groups since the financial crash of 2008; private sector investment has been below peer groups since Brexit; growth in GDP has been low and there is a risk of no growth. In other words, the sustained investment that was seen on previous occasions when the NHS has faced significant pressures is unlikely to be a route available over the next 15 years.

The position the NHS finds itself in 2025, combined with the anticipated health, workforce and economic pressures over the next 15 years, and the development of new treatments and technologies, means there is a real question about the feasibility of maintaining a *national* health service in Wales, or at least one which is universal, comprehensive and free at the point of delivery. As loved as the NHS is by the Welsh population, it cannot be assumed (and nor should it) that citizens will indefinitely tolerate a health service that the majority are dissatisfied with and does not match up to the best in the World.

The task therefore is a formidable one. Whilst this may appear daunting, it equally offers the opportunity for positive change. Often, when services are 'just good enough', it can limit ambition for truly great care. It is clear that the current situation, combined with the projections for the next 15 years, means anything less than a transformation of our NHS will not be enough. Where our 2018 strategy was innovative, we must now embrace what may be seen as radical ways in delivering our services. This is a strong message in the recently published NHS England 10 year plan and is equally true for NHS Wales. For Hywel Dda we choose to grasp this opportunity and radically transform our health and care system, not just for the NHS to survive but to thrive.

## **Our mission: Healthier Lives, Well Lived**

Health Boards in Wales were established with two purposes:

- i) the planning and delivery of health services, and
- ii) improving population health and reducing inequalities.

This is reflected in the Model Standing Orders - Reservation and Delegation of Powers for Local Health Boards, which are issued by Welsh Ministers to Local Health Boards. Local Health Boards (LHBs) in Wales must agree Standing Orders (SOs) for the regulation of their proceedings and business.

Standing Order 1.0.1 is:

*The LHB's principal role is to ensure the effective planning and delivery of the local NHS system, within a robust governance framework, to achieve the highest standards of patient safety and public service delivery, improve health and reduce inequalities and achieve the best possible outcomes for its citizens, and in a manner that promotes human rights.*

Of course, there is a relationship between these two functions, and both are ultimately a means of improving the nation's health and wellbeing, which is the fundamental purpose of the NHS. Whilst within the statute these two aspects are of equal importance, it is fair to say the former (provision of health care services) has tended to dominate the latter (improving population health and reducing inequalities), both in terms of perception and the allocation of resources.

The scale of the challenge facing the NHS means the balance needs to shift significantly. It is not credible that the NHS can simply treat the anticipated growth in demand resulting from the demographic and disease prevalence projections.

It is generally accepted that the social determinants of health and wellbeing (or building blocks of health and wellbeing) outweigh the influence of healthcare services on the health of citizens. Estimates vary but one study reports that approximately 20% of health outcomes are attributable to clinical care (Carlyn et al, 2016).

The same study reports that about 40% of health outcomes are due to social and economic factors, 30% due to health behaviours and 10% due to physical environmental factors.

Similarly, the Australian Institute of Health and Welfare report that:

*"According to the WHO, social determinants of health account for between 30–55% of health outcomes."*

<https://www.aihw.gov.au/reports/australias-health/social-determinants-of-health>

(Accessed 30<sup>th</sup> September 2025)

In other words if our mission is to improve the health of our population then we should be equally concerned about other factors such as education, housing, social care and income; and the more resource that is directed to the NHS the less is available for other important public services.

We therefore have to find another way. The good news is there is significant opportunity to improve the health of our population, which in turn can reduce the demand for health care services. Shifting our emphasis towards promoting good health and wellbeing offers a win-win opportunity, moderating demand for health care services whilst enabling our population to enjoy better health and wellbeing.

Furthermore, in Hywel Dda we aspire to more than treating patients when they are ill. We are passionate about the communities we serve and we want to contribute to making Mid and West Wales a great place to live, characterised by healthier citizens and strong communities. It is for this reason we describe our mission as **Healthier Lives, Well Lived**. It underlines the wider role we play in society and that we are a *health* service, not just a 'health care' service.

This is a bold ambition and it is clear that we cannot fulfil this mission in isolation. It will require us to work in partnership with individuals, carers, volunteers, families, community groups, the third sector, the rest of the public sector and the private sector to realise our shared goals. In other words, we need your help.

Much of Mid and West Wales is made up of small towns and villages, sparsely populated over a large geographical area, often with poor transport networks and limited access to services and facilities. Our approach cannot be a 'one size fits all' and will require us to work with communities to develop bespoke solutions, capitalising on the assets available.

Through our public engagement we consistently hear a key concern about accessing services and travelling for care. Anyone who has spent time in West Wales would understand this. It is not simply an inconvenience, the time and costs associated with travel presents genuine issues for patients and their families and can even impact on treatment choices. This presents a stark dilemma - we in West Wales accept lower quality, fragile services or we consolidate and add to our travel burden, potentially worsening inequalities. Unfortunately we cannot avoid this reality or solve the transport deficiencies. However what we can do is relentlessly pursue a strategy that aims to reduce the frequency that this travel is necessary.

The vision set out in A Healthier Mid and West Wales, continued in this refresh, was for a health service which promoted good health and wellbeing, maximised prevention, optimised primary care and community services and developed digital solutions to maintain independence and treat people in their own homes. It is through delivering this vision that we will best be able to support our citizens with these transport and travel challenges, whilst at the same time delivering great hospital care when that is required.

This approach is of course not unique to Hywel Dda - they are the basis of most health policies and strategies - but they do carry more significance for us in West Wales given the distances involved and poor transport infrastructure.

## **Our values and behaviours**

To deliver on our mission we need to create the right environment for our staff, public and partners. This includes developing safe working cultures, supporting open and honest leadership, developing trust within the organisation and with others outside. Our values is where this begins.

We all value different things in life: family, health, freedom, personal fulfilment. Our values are ideas that guide our thinking and actions.

While different backgrounds, experiences, knowledge and skills are needed to create a successful organisation, having shared values creates unity and lets people know what is important to each of us.

As an organisation, it is important that we have our own values which help our staff, partners and our patients to understand what is important to us, what makes us stand out from other organisations and underpins everything that we do. These are:

- Belonging – Putting people at the heart of everything we do
- Growth – Striving to deliver and develop excellent services
- Together – Working together to be the best we can be

Our values are more than words, and when we bring them to life through the things we say and do, we create a positive and vibrant organisation for our staff, patients and partner organisations. Our daily actions and behaviours shape the culture that we work in and will support future generations of staff and patients, as well as our long term vision for health and wellbeing in West Wales.

Within Hywel Dda, the behaviours which underpin these values were developed by our staff for our staff and form the nine things which are most important to us, these are:

- Dignity, Respect and Fairness
- Integrity, Honesty and Openness
- Caring, Kindness, Compassion

## **Our strategic objectives: *thriving teams, healthier communities, great care and positive futures***

In order to deliver our mission we have identified four key areas where we will need to make progress if we are to move towards our aspiration of ***Healthier Lives, Well Lived***. We have termed these our strategic objectives and are the foundation of our strategy.

We believe that any strategy begins with *thriving teams*, particularly in a people-centred business like health care. These teams should be orientated towards supporting *healthier communities* emphasising a social model for health and wellbeing and enhancing primary and community provision. When required patients deserve to receive *great care*, with timely access, improved health outcomes and high quality services. Finally we should be building *positive futures* where people are born healthy, live and age well, and die with dignity; and the NHS maximises its contribution to building a strong and sustainable society.

Hywel Dda has established Well-being Objectives that reflect the seven well-being goals and five ways of working outlined in the Well-being of Future Generations (Wales) Act 2015.

These objectives not only support the Health Board's implementation of the Act but also foster integrated and collaborative approaches that improve population health and sustainability, aligning with the long-term priorities set out in the revised strategy.

We recognise that we are a part of a wider NHS in Wales, and that our strategy cannot be in isolation. While we have a duty to care for our population, we do this by working with our partners in neighbouring health boards to either seek specialist care for our patients, or provide care for their patients on their behalf. Our aspirations for ***Healthier Lives, Well Lived***, will mean that our strategy will need to consider how services are also planned and delivered regionally and nationally, so that we meet the NHS Wales vision of '*A Healthier Wales*'.

The following chapters set out in more detail what we seek to achieve in each of our strategic objectives and are summarised here:

### **Thriving teams**

Health and health care is fundamentally a people business. The majority of NHS expenditure is on its workforce, professionals are motivated to enter the service to care for others and of course there is nothing more important to people than their own health and that of their friends and family.

West Wales, even more so than other parts of Wales, has traditionally struggled to recruit sufficient staff, particularly in medical and nursing disciplines. This has undermined the development of high performing, resilient teams and contributed to higher costs and greater service fragility. These challenges have often been

compounded by unsustainable service models which have made it harder to recruit and retain key posts.

Substantial progress has been made in recent years in stabilising the nursing workforce, this has allowed us to virtually eradicate the use of nurse agency, improving the quality of care, stabilising teams and reducing costs. Medical staffing is a more complex area to resolve but some progress has been using the learning from the nurse stabilisation programme.

Beyond the workforce numbers it will be important that teams are supported to grow, become more empowered and there is greater equality and diversity across the workforce. The NHS has a tendency to be overly hierarchical, bureaucratic and risk-averse potentially stifling teams in the pursuit of control.

There are good reasons for this, not least the potential consequences for patients and the need for appropriate stewardship of public funds. Nonetheless, the delivery of our vision will require more devolved decision-making and, in particular, an increase in clinical leadership. The recent establishment of Clinical Care Groups is the first step in enabling this change.

The final component of ‘thriving teams’ is an enhanced focus on customer service. Having well-staffed and well-functioning teams is of limited benefit if those teams are not driven to improve the patient experience, constantly seeking feedback and improving systems in order to simplify and streamline.

Time and again the feedback we receive from patients and families is they struggle to navigate an overly complex system, are frequently redirected from one department to another and are unable to get basic information or easily make appointments. In our view a significant weakness of the NHS, across the UK, has been the inadequate attention given to serving the ‘customer’.

In delivering this strategy we will aim to substantially overhaul the interface with patients, making it simpler, more accessible and designed around what works for the service user rather than what is easiest for the service.

## **Healthier Communities**

In West Wales, we believe health starts with ourselves and in our homes, schools, workplaces, and communities — not just in clinics or hospitals. A strong social model means working together with local councils, charities, sports clubs, private sector partners and community groups to support wellbeing. Health is a part of everyday life, shaped by the people who live it.

People like community connectors, volunteers, and carers are already making a difference, with great examples of initiatives which have been generated in individual communities. We want to build on that by listening to what matters most to you —

whether it's help with transport, access to green spaces, or support with food and heating.

By bringing together learning from these communities, we can help others develop the skills and experience, with support from partner organisations, to develop local responses which meet their needs across a patchwork of connected communities.

### **Great care**

We also want to move healthcare directly to people's homes. Whether that is through telemedicine and virtual wards with patients interacting in their own homes virtually with clinicians or enabling people to manage their own healthcare with digital support through apps which they can use any time of the day or equipment to monitor health remotely. Digital healthcare can make things easier — from booking appointments to checking results or getting advice. But we know not everyone has the same access or confidence and we will need to work with individuals, communities and other agencies to help all have the same opportunities.

For some, it's about having the right device or internet connection; for others, it's about trust and knowing your information is safe. We want digital services to feel simple, secure, and supportive — not a barrier. That means offering training, making services bilingual, and always keeping face-to-face options for those who need them. Everyone should feel included.

To support this, we're working to shift more care into communities — so people can get help earlier, closer to home. That might mean more nurses, therapists, or wellbeing hubs in your town or village. If we get that right, hospitals can focus on the most serious cases. We believe that in the future there will be fewer working age people so we cannot rely on just building up our primary care and community teams, we will need to bring those services that are currently provided in hospitals out into local neighbourhoods and shift their focus from treatment to prevention. We've already seen positive examples where fracture and heart failure services have developed preventative services which not only keep people well in their community, but when they do need hospital care, their stays are shorter and they return home faster.

We also know travel matters — especially in rural areas. If you do need to go further, we want to make it easier: more transport options, clearer communication, and making sure the care you get is truly worth the journey. It's about balancing what's safe, sustainable and fair.

### **Positive futures**

As a public body, we are reliant on funding from Welsh Government to deliver our services. With health funding devolved to Wales from the UK Government, any

adjustment in UK health spend does not automatically equate to additional spend for NHS Wales. We recognise that every £1 of additional NHS spend is at the expense of other day to day public spending such as social care, education, leisure services, refuse collection, as well as funding in support of business or for broader services such as Natural Resources Wales.

As an organisation we have grappled with operating within our allocated funding since the formation of Health Boards. There are a range of factors that have contributed to this but the most significant have been our reliance on agency or locum workforce to maintain services where we have been unable to recruit or retain staff, escalating continuing health care costs, unavoidable cost increases associated with providing medications to a population with increasing needs and expanding treatment options and the duplication of services across our acute sites.

We are determined not to hand this on to the next generation and are in a position where we are seeing that overspend reduce. We know we will need to continue to make changes to how we deliver services, to ensure that services are sustainable and affordable for the long-term.

We also want to ensure that changes that we put in place now are suitable for the next generation, which is why we want to develop a Children and Young People's Board to further strengthen how we listen and incorporate the voice of future generations. We already have a Voice of the Child group which has started to inform decision making, but we want to support young people, with development support, to help us shape our planning processes going forward.

Alongside being more efficient, we need to ensure that we are providing the most value to our patients. The principles of Values Based Health Care help us to deliver the best outcomes for patients at the greatest value. Using clinically developed tools to measure the health and wellbeing of patients, as well as conversations with the patients on what their needs are, results in reaching care plans which best meet the patient needs while reducing waste in the system. This support will help us to ensure that going forward we are able to make balanced financial decisions where we are able to invest in our longer-term service provision.

In 2018 our strategy set out an ambitious case for capital investment in west Wales for improvements in our existing estate and development of new infrastructure. The development of our estates would enable more care to be delivered closer to home, as well as address our ageing hospital network. Developing our estates would allow us to consider biophilic design (bringing nature into our environment), as well as ensure that our buildings would be resilient to climate change as well as enabling them to function in an emerging digital landscape.

We believe that the majority of the areas highlighted within the Programme Business Case remain unchanged. Bronlais and Prince Philip hospitals will require ongoing maintenance to support the lifespan of the estates, with adaptations for climate and

future requirements. We also believe that the future role of Withybush Hospital will remain as described in the strategy, with a range of day case, outpatients and diagnostics services with urgent care on site to meet local needs.

As a consequence, we foresee that we will need to broaden our Clinical Services Plan to consider a greater range of services to understand what this would mean across our sites and ensure that we are able to provide safe and sustainable care in the interim. Given the extent of capital investment required, it would be likely that the complete delivery of this investment would occur around 2040, which means we cannot wait for the estates to make changes to our services.

Alongside the strategy delivery we will also need to consider what a revised Programme Business Case would look like, including the location of an urgent and planned care hospital, whether it is a new site or repurposed site, and how our hospital network supports and operates within a wider regional network across mid Wales and south west Wales.

Beyond this is a need to develop resilient communities which are able to adapt and overcome climate change. The impact of climate change has already been recognised and is expected to intensify over the coming years. By developing resilience communities will be protected and able to thrive in their local environment.

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# 02 Thriving Teams

Thriving Teams is about developing a strong and sustainable workforce, where our staff are happy and healthy, and able to provide customer focused person centred care.

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## Goal 1 – Healthy, thriving teams

### *Current position*

We are dedicated to putting people at the heart of everything we do. This means treating our staff fairly and with respect, regardless of their background or beliefs, and creating an inclusive environment for all.

We achieved a response rate of 20% for the 2024 NHS Wales staff survey, and a 21.9% response rate in 2025, a 9.9% increase on the first survey which took place in 2023, and shows that we are moving in the right direction and that more of us are choosing to share our experiences. We are improving our Speak Up culture to ensure staff feel safe to voice their concerns by improving accessibility, visibility, and trust in the process. We have also incorporated psychological safety into leadership development programmes, to ensure leaders are equipped to create environments where staff feel able to speak up.

We have developed our approach to workforce planning, working closely with Health Education Improvement Wales (HEIW). We have over 70 operational people plans to support services with their workforce challenges.

We continue to showcase and celebrate our outstanding staff through various awards. This includes the Chair's Commendation Awards, which has received 238 nominations since it began and our Hywel's Applause Staff Awards which have been well-received, with many staff feeling appreciated.

We support research and innovation to improve patient care and services. 2024/25 was the final year of our current Research and Innovation Strategic Plan (2021–2024) and following significant engagement, we have developed a new Strategic Plan (2025-2030) to continue its success.

### *What we have achieved (since 2018)*

We have focused on strengthening our staff retention. For example, we have significantly reduced nurse agency use (down from 324 full-time equivalents in June 2023 to 93 in February 2025) and participated in international recruitment programmes. We have recruited 296 Internationally Educated Nurses and 10 Doctors since 2022.

We have continued to work with young people and engaged with 8,567 pupils, including 2,855 through the medium of Welsh, covering all secondary schools in Hywel Dda. Our programmes supported 1,527 students with health masterclasses, 337 work experience opportunities and 36 virtual taster sessions. 67 students also started the 'Becoming a doctor' programme. Simulation activities have increased interest in Health Board careers from 35% to 63%.

Alongside internal awards recognising the achievements of individuals and teams, we continue to win regional and national awards, recognising the organisations commitment to deliver the best services possible. Examples include:

- Nuclear Medicine Team’s ‘Walter the Penguin’ video to reassure children in their care.
- The PROSTAD joint initiative to tackle the delay in prostate cancer.
- Becoming the first health board in Wales to achieve ‘Autism Understanding’ status.
- Our Health Visiting Service maintained its UNICEF ‘Baby Friendly’ accreditation.
- For the fourth year running, our Nutrition and Dietetics Service has retained its top nutritional screeners award
- Our programme to recycle absorbent hygiene products, to lower carbon emissions and improve recycling rate, won a Medi Wales award and was highlighted in Climate Action Wales and Life Stories magazine as an example of good practice in health and life sciences.

We have seen several research and innovation achievements during the past year including:

- Opening a new research office at Withybush Hospital, meaning each of our acute sites have a dedicated and visible research presence.
- Furthering plans to locate research and innovation functions at the new Pentre Awel scheme.
- Consistent improvement in Health and Care Research Wales indicators around women’s health, respiratory, metabolic disorders, orthopaedics and primary care.
- Conclusion of one of the first orthopaedic robot research studies and opening one of our first commercial studies at Bronlais Hospital.
- Working in partnership to deliver prostate cancer diagnosis services, harm reduction services, and prevention service initiatives to support elderly and families with young children when facing fuel poverty to stay healthy during colder weather.

*What we want to achieve*

- *Sustainable workforce in hospitals and communities*
- *Shape organisational culture*
- *To celebrate success and promote innovation*

*How we expect to deliver this*

- *Creating a positive workforce culture*
- *Delivery of workforce stabilisation programme*
- *Implementing the Research and Innovation Strategic Plan (2025 – 2030)*

### *What this might mean for you*

We heard during the engagement that people want to see a sustainable workforce that can provide care for future generations, and one that supports innovation while reducing barriers to accessing future care.

People want to see our staff working more closely together both within our hospitals and wider community. People expect to see our workforce coming together to provide a service for everyone, by working with others who are involved in that person's care such as family, carers or volunteer agencies, to provide a single person-centred response.

People also want to see more joined up care taking place, with the ability for their care and information to follow them as they receive their care, from the community to the hospital and home. People don't want to fall between the gaps of pathways and want to know that someone is with them throughout the entirety of their care who they can talk to and understand what is happening to them.

People are keen to see innovation take place, especially in the community, but do not want others to be left behind who may have barriers to accessing that care. They want to see a workforce that can embrace and promote innovation, but bring patients along with them, either by supporting them to learn and use new skills or providing alternatives.

We believe that we will need to provide more care from the home and support future care, while ensuring that we can still provide safe, quality care for those who need it from our hospitals.

### *What support we will need*

We have agreements in place already to work with our local universities to support and promote research and innovation, and our workforce development plans look at the skill mixes within our services to create a balance to support patient needs and make the best use of everyone's skills.

We will need to explore further how we integrate our partners as part of our workforce reviews to create an integrated person-centred approach, as well as support leaders within our organisation to develop workforce cultures that support future care delivery in our hospitals and in patients' homes and communities.

We already work with Health Education and Improvement Wales to plan our training requirements for current and future staff. We will continue to do this, but will need to explore what future training may be needed to support our staff to work differently to provide a preventative and social model of health and wellbeing.

## Goal 2 – Customer Service Excellence

### *Current position*

Modern healthcare has changed over time, with new innovations and treatments for conditions, and new ways of how we can deliver those closer to home. We also know that the right treatment may not always be the best treatment, while we may be the experts in healthcare, we need to learn from the experts in experience to find the right solution for everyone.

When we talk about customer service excellence, we are describing how we can empower people to find out about their healthcare, get the right information for them to make decisions, and most importantly hear from them when things don't go right so we can learn and improve.

### *What we have achieved (since 2018)*

As part of the 2018 strategy, we have been looking at how people can gain access to information from one place, a single point of contact, which has a team of staff who are able to answer a wide range of questions and follow up further where needed.

The Communication Hub was in place during the Covid-19 pandemic to help people manage vaccination and testing appointments and has since evolved to support a wider range of services such as dental services and the Waiting List Support Service.

We have also reduced barriers to access to support patients to manage their own care, either through allowing patients to make their own referrals into services to reduce the need for initial appointments and delays for referral, to allowing patients to book test or even access care at a time that suits them through open access radiology.

### *What we want to achieve*

- *To promote a culture of speaking up safely*
- *Promote equality, diversity and inclusion*
- *Provide excellent bilingual services*

### *How we expect to deliver this*

- *Compassionate experiences*
- *Customer service excellence*
- *Community connectedness*

### *What this might mean for you*

We heard during the engagement that people want to see an improvement in how customer service is provided at their first point of contact so that it is consistent no matter how or where they access healthcare services.

People want our staff to feel confident in having compassionate conversations, not just for when things go well, but also for when they don't. Our staff are often present at some of the most significant moments in people's lives, and our public want to be able to have an informed but compassionate conversation about what happens next, and to know where they can get support if needed and not left behind for the next patient.

It is important for people to feel that they have been listened too and understood so that they can trust the information they receive and feel empowered to act on it. Staff should be supported with training and scripts to enable them to provide information that not only meets their needs but is also developed by feedback and experience of previous users, meeting the same quality standard across the organisation.

People told us that materials need to be more than plain language and bilingual, but that the same active offer should be broadened out to support British Sign Language (BSL), audio and easy read formats to support everyone to access information about healthcare fairly.

People have also shared that this needs to go beyond our hospitals and community centres, but into community health services as well so that people can receive the same experience and information wherever they go, ensuring that they are able to access information to make local choices with confidence.

We believe that the feedback around how we communicate and the formats we use will be crucial as we move forward with the increasing use of digital technology in healthcare. We want to constantly improve our customer services, which will require partnership working and support for commissioned services, as well as improving the skills that our staff have to support sensitive conversations and reflect learning when they need revising based on what is shared with us.

#### *What support we will need*

Alongside ongoing support to access Welsh Language training for our staff to provide a bilingual active offer across our services, we will need to support our staff to access broader training to support customer service skills.

We will also need to work in partnership with commissioned health services to create a consistent experience across all of our communities so that people can receive the same trusted information from anywhere within the Hywel Dda and nearby area when accessing our services.

# 03 Healthier Communities

*Healthier Communities focuses on addressing and tackling the barriers to health inequalities, strengthening and embedding the principles of the Social Model for Health and Wellbeing with primary and community services by design, and developing resilient communities which are connected.*

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## Goal 3 - '20-4-7' population health

### *Current position*

Our future generations will be both our workforce and our patients, as well as supporting previous generations. While there are steps that people can take to improve their health, it is important that we start to make changes so that future generations live healthier lives.

In order to support a preventative and social model for health and wellbeing, we will need to ensure that we have a consistent approach to support population health, this is our '20-4-7' approach.

By focusing support for those in the lowest 20% of the Welsh Index of Multiple Deprivation to tackle 4 key risk factors (Smoking, Nutrition, Alcohol, Physical Activity), we can have the greatest impact on preventing the top 7 disease areas (Cardiovascular, Cancer, Diabetes, Respiratory, Mental Health, Child and Maternity, Frailty).

### *What we have achieved (since 2018)*

The social model for health principles were a key component of the 2018 strategy, and in March 2025 a summit was held which launched the charter and principles which have been adopted by key partners to move the model forward.

### *What we want to achieve*

- *To reflect population health priorities that build in equality of opportunity and human rights, together with plans to reduce health inequalities*

### *How we expect to deliver this*

- *Strengthen prevention services*
- *Advance population health programmes*
- *Monitor performance*

### *What this might mean for you*

We heard during the engagement that there was support for improving prevention and wellbeing services to reduce demand on acute services.

People told us that they are willing to do more to remain fit and healthy but asked that universal services such as leisure facilities were more accessible both physically and financially.

People felt that work should be done to understand what is already working well and not try and build services where they are not needed. Local communities can respond to local needs, however what is needed is support for those existing community groups rather than a new service brought in.

People were worried that services were also not always inclusive, particularly for carers and parents who may have dependents with them, as they are not able to make the most of prevention services.

There was also concern that this would increase the divide for those who experience poverty who may be less able to access the same services that more affluent people can afford.

We believe that while it is positive to hear that there is a willingness to embrace prevention and wellbeing, we will need to work in partnership and rebalance resources to ensure that there are no gaps in provision. While we do not need to provide the same service for every community, we will need to ensure that we are providing equitable support for each community to help them develop the resources they need, while not undermining what already exists and works.

#### *What support we will need*

Within Hywel Dda we will need to move our resource from hospitals to communities to create the support closer to home, while maintaining a balance that still allows us to treat people when unwell in hospitals. This will take time and will be supported through our planning processes.

We will also need to work with partner organisations, recognising that a lot of the factors that contribute to health and wellbeing are supported by a wide range of organisations. Whether this is access to education, leisure, transport, or healthy eating.

Lastly, we will need the support of communities to shape what is needed to help them live healthy lives. This will require co-production to ensure that it is locally relevant and meets the needs of the community.

## Goal 4 - Primary and community by design

### *Current position*

Hywel Dda has begun work on developing its Primary Care and Community Services Strategic Plan, this will look to incorporate changes such as the Primary Care Model for Wales, which introduces a place-based care model, seeking to increase resources and resilience in local communities.

To support the implementation, a shift in how we plan and deliver services will need to take place where we start with primary and community care, determining how much we can provide as close as home as possible, before we start to consider which parts of healthcare need to be delivered in a hospital. This is what we mean by primary and community by design.

### *What we have achieved (since 2018)*

In 2023, work began on developing an Issues Paper which was presented to Board in March 2024. The Issues Paper also covered services in the Clinical Services Plan, as the same methodology was applied, but had dedicated chapters to explore the issues around primary care services, including workforce, finance, activity as well as what works well.

Following the publication of the Issues Paper, work was done to expand the content to include wider community services, and focused engagement took place with public and key stakeholders around primary care and community services to help shape and develop a strategic plan.

A Mid Point review took place in the autumn of 2025 to reflect on the work to date, what has been shared and carried out, and focus on the next steps to deliver a strategic plan to shape forward service design and implementation.

### *What we want to achieve*

- *To ensure that HDdUHB has a clear vision and strategic direction that secures the long-term sustainability of the organisation, both at local community and wider system levels*

### *How we expect to deliver this*

- *Develop and deliver a primary and community strategic plan*

### *What this might mean for you*

We heard during the engagement that primary care and community services are valued and relied upon by our communities, but that access to them isn't always equitable and that people are concerned about their sustainability.

People told us that they rely on their local services and see them as important for helping them to stay healthy. When they can't access their local services, they are more likely to use hospital services instead. While they know this may not be the best service, it is the only one that can be available to them at times and believe that better community services would reduce pressure on hospitals.

People also said that the greatest barrier to accessing GP services was the "8am queue", where people ring in the morning for appointments and if they are not successful may not get an appointment that day. They would like better arrangements put in place to help them manage booking appointments that are more accessible as phone services do not support everyone, particularly those who are deaf or have hearing loss.

People were worried about the sustainability of primary care and community services, in particular GP and dental services. Changes to the number of providers and their location has meant that people have less access to services without travel or transport or need to fund care privately which can be unaffordable.

We believe that the primary care and community services strategic plan will seek to address these issues, alongside the development of digital services, to make services more accessible and sustainable to keep people healthier in their communities.

#### *What support we will need*

While Hywel Dda runs some GP practices (these are called managed practices) and provides some community services, a lot of what happens in the community is done by private providers who we ask to provide on our behalf.

While there are some changes that we can make, we will need to work in partnership with all of our providers to develop primary care and community services, and the work of the strategic delivery plan will help us to do this.

# 04 Great Care

*Great care focuses on improving the timeliness and safety of care that we are able to provide, by providing evidence based, standard led care. We will support this by improving the visibility of our performance and removing variation in how we provide care, and place more control and information in the patients hands through the use of an emerging and growing digital and AI landscape.*

*As part of a wider NHS Wales, we work with other health boards and trusts to deliver the 'A Healthier Wales' strategy, which means that we will need to work with our partners to deliver the services which our public expect. Our Goals, while setting out what we expect to deliver locally, are part of a wider regional and national planning and delivery process.*

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## Goal 5 – Digital first

### *Current position*

The technological environment is rapidly changing, it is becoming more available, and people are finding innovative ways to support them in their daily lives which may not have been thought possible almost a decade ago.

Health technology is no different, with people using wearable technology to monitor health and fitness and even maintain personal safety with location sharing and fall alerts.

Healthcare has an opportunity to use digital advances too, automating processes, bringing information together and making information more accessible in a timely way for staff and patients.

### *What we have achieved (since 2018)*

Within our 2018 strategy we identified that Digital would be a key enabler in delivering timely, high quality and safe care, recognising that we would need to make considerable changes in how we use Digital to provide a seamless service irrespective of where someone accesses their care.

While COVID-19 had a considerable impact on many of our services, it also provided a catalyst for our Digital transformation, bringing forward many of the elements that we recognised would be needed to deliver more care from the home, such as virtual wards and virtual consultations.

Our original Digital strategy focused on the first 10 years following the launch of the strategy, exploring and testing elements that we would need to deliver our strategy. This has been recently accelerated with a refresh of the Digital strategy, noting the achievements that have been made in many key areas, and the appointment of a strategic partner to provide advice and support to help us make these changes.

### *What we want to achieve*

- *To bring the benefits of digitisation and technological advances into healthcare*
- *Create digital pathways between hospital, community and home*
- *Support our staff with digital tools to deliver safe, effective, quality care*

### *How we expect to deliver this*

- *Delivery of Digital Strategic Plan*
- *Progress digital, tech and AI adoption*

### *What this might mean for you*

We heard during the engagement that while people recognised the value that digital could bring to healthcare, people were concerned about how it would be introduced to avoid people becoming excluded.

People told us that they believe that digital and AI developments could support them to live healthier lives, sharing information faster and easier through trusted apps to manage their information in a single place, regardless of where they access care.

People also felt that if more services were digitally integrated, being able to book appointments or tests online, or receive notifications for upcoming events would support not only them to be able to access care more easily but could also reduce missed appointments or needing to repeat information every time they access a different part of the healthcare system due to different records.

People raised concerns about what a digital healthcare system may look like, especially if it was a digital first approach. People were concerned that older people may not be able to currently access digital services in the same way or become less confident as they age and miss important information.

People were also worried about those who have physical barriers to accessing digital services, such as blind or partially sighted people or those with a language barrier if the systems did not support their language needs. As security of health information is important, people want to feel assured that they will be able to access information if something physically changes, i.e. if someone has a stroke and it alters their facial appearance.

We recognise the concerns that people have raised and we will need to ensure that not only are digital systems accessible to reduce barriers to care, but that we maintain a person centred approach and ensure that there are alternatives where they are needed.

### *What support we will need*

We will need the ongoing support of our strategic partner to support in our digital transformation as well as support from clinical leads, to make sure that systems we introduce are clinically safe, and our public to ensure that the systems we introduce are able to meet their needs also.

To support the changes, investment will also be needed to support the development and introduction of systems. This will be managed through the Digital Strategic Plan as part of Hywel Dda's annual planning process.

We will also need to ensure that there is a digital culture both within Hywel Dda and with our public and partners. We need to provide more than support to use a piece of software or technology, but create a culture where people are happy and feel safe using digital services.

## Goal 6a – Timely, high quality care

### *Current position*

In our 2018 strategy we identified fragilities that existed within our Urgent Emergency Care services and adult Mental Health services. In that time the impact of the Covid-19 pandemic meant there were changes in how people accessed Primary Care and people waiting for elective surgery were asked to wait longer.

2025 saw a review take place into our Emergency Departments, which called out a number of areas that will need to be addressed if we wish to ensure we are providing timely, high quality care. These have been considered as part of an Urgent and Emergency Care redesign programme, incorporating the national 6 Goals programme, as well as responding to emerging priorities, such as reducing ambulance handover delays.

Since 2018, we have made efforts to reduce the length of time people wait, and the numbers of people waiting for planned care. We have also explored through our Clinical Services Plan how we can meet demand going forward in a sustainable way. For both adult Mental Health and Primary Care, national strategies have been developed which are being brought forward so that we can implement and deliver those in Hywel Dda.

For Primary Care we will seek to deliver the Primary Care model for Wales through the Primary Care and Community Services Strategic Plan, while adopting the national Mental Health strategy to deliver a Flexible, Open Access Mental Health Model alongside changes to learning disabilities provision.

### *What we have achieved (since 2018)*

In March 2025, the Health Board was de-escalated for Child and Adolescent Mental Health Services, Planned Care, Governance and Leadership, with these all moved from targeted intervention to enhanced monitoring status (level 4 to level 3). This highlights the impact of our collective efforts, though we remain focused on addressing the areas still requiring improvement and further building on our successes to date.

In 2025 we also explored what could be done to support our Urgent and Emergency Care services across Hywel Dda. Taking into account learning from Cardigan Integrated Care Centre and the wider 6 Goals programme, a blueprint was put together which explored how we could treat people with urgent care needs, but not needing Emergency Care, closer to home. This would mean moving services closer to home where the majority of patients could be safely treated, while supporting our Emergency Care services to help the sickest patients.

### *What we want to achieve*

- Safe and sustainable planned care and community services
- Improved experiences and outcomes for those using our urgent and emergency care services
- Implementation of national Mental Health and Women's Health strategies in Hywel Dda that meet local needs

### *How we expect to deliver this*

- Deliver the programme commitments made as part of the Clinical Services Plan and Primary and Community Services strategic delivery plan
- Develop and deliver an Urgent and Emergency Care strategic delivery plan which may include consideration of reconfiguration
- Develop and deliver a Flexible, Open Access Mental Health Model in Hywel Dda
- Develop and deliver the Women's Health Plan for Wales in Hywel Dda
- Implement Hywel Dda's Learning Disability Transformation Programme

### *What this might mean for you*

We heard during the engagement that people are not happy with their current experience of services. While the actions of staff providing care were praised, people felt that the service that they were offered, the time to wait for the service and the environments in which they received care in were of poor quality.

People find the way to access services confusing, with not enough clear language about what each service can offer or signposting to community alternatives that can support them. This often leads people to access the services which they know are open, or advised by other health professionals, which may not be the best place for them to go.

People also told us that the environments that they attend are not always suitable, either physically due to the age and condition of our estates, or due to their emotional distress at the time. In particular people with mental health shared their experiences of waiting in busy, crowded environments such as A&E departments while in crises because other community support wasn't available.

We recognise that this isn't the healthcare that we would want to provide or people to expect. While we have made changes to services such as 111 press 2 for mental health to support people at home and away from A&E departments, it is clear that there is more that needs to be done to support messaging about alternatives and the best place to go when unwell both with staff and partner organisations and the public.

We believe that by making these changes we can improve the timeliness and quality of care, as well as find ways to deliver it closer to home to avoid the need to travel where it may not be required.

### *What support we will need*

To make the changes that would make a difference we would need to explore across the whole health system, as looking at things by individual services may move problems from one place to another. To do this we are going to need to support our services through larger programmes of work similar to the Clinical Services Plan to explore the issues and solutions, as well as engaging with the public on what those changes could mean.

We have already received support from national teams to support us with the local implementation of strategies, but we are likely to also need to use expertise to help us with other areas of work, either directly to help support emerging ideas, or indirectly by helping us find examples where other organisations have faced similar challenges and overcome them.

Our public will also be key in helping us to deliver the changes we make. By using continuing to use services responsibly and accessing care at the right time from the right place, it will mean that changes we make to services will be more effective and will improve patient experience. We will also listen to people who tell us when things haven't gone right so that we can make changes that can improve services for the next person.

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## Goal 6b – Safe, high quality care

### *Current position*

Our safety dashboard has continued to develop over 2024/25 to help identify potential patient safety issues. Operational leaders and managers continue to use it to identify safety hotspots needing further investigation/action, triangulate data at an operational level, facilitate further discussion or escalation, support deep dives, benchmark against our services to help identify outliers and inform report and papers. The dashboard has been used to inform discussions at our QSEC meetings, executive team meetings and the Improving Together sessions.

During 2024/25, we introduced a new process to ensure we can demonstrate consideration of quality when making strategic decisions. A quality impact assessment was developed and a wrap-around governance process. The quality impact assessment uses the healthcare quality standards, and each domain is considered through a risk and mitigation lens. The quality impact assessment panel, which is comprised of the Executive Director of Nursing, Quality and Patient Experience, the Executive Director of Allied Health Professions and Health Science, the Executive Medical Director, with other clinicians and experts, receive each quality impact assessment before the proposed strategic change is considered by the Board for approval.

### *What we have achieved (since 2018)*

During 2025, more than 40 quality impact assessments were presented to the panel for consideration. The assessments ranged from recruitment decisions to decisions relating to the Clinical Service Plan and changes to service delivery. This new process ensures that we consider each strategic decision and change through a quality lens.

In 2025, we are produced our Annual Quality Report, our Duty of Candour Annual Report and our Putting Things Right Annual Report, all of which can be found on our website: <https://hduhb.nhs.wales/quality-and-engagement-act/>. These reports detail the improvements we have made to ensure our services are safe, timely, effective, efficient, evidence-based and person-centred, in line with the Duty of Quality: <https://hduhb.nhs.wales/duty-of-quality/>

### *What we want to achieve*

- *Ensure patient safety is a priority*
- *Promote high ethical standards*
- *To act as a catalyst for change, providing independent and objective perspectives. This includes having the courage to speak up about any concerns*

### *How we expect to deliver this*

- *Improve patient pathways, embed safety dashboard & remove clinical variation*
- *To promote a way of working that is open, transparent and accountable*

### *What this might mean for you*

We heard during the engagement that people are concerned that people may receive different care based on where they live and access care, and that information about them recorded on different systems isn't always considered when making decisions about their care due to access barriers.

People told us that they were concerned that the care they receive from their local hospital could be different to the care provided from other sites. While they thought that they might be able to access better care at another site, travel and transport barriers prevent them from doing so.

People also said that they believe that the information that might be recorded about them by different parts of the healthcare system may not always be seen or read by the person treating them. They felt this could mean that important information is missed which could affect them and believe that the information should be accessible by all those involved in their care.

We recognise that while patient needs and treatments may vary when delivered in a person centred way, there shouldn't be differences between how that care is delivered and the outcomes received based on where people live. As we look towards regional working in the future, we want patients to have confidence that the standard, timeliness and quality of care is consistent no matter where it is provided.

### *What support we will need*

Alongside the work of the Digital strategic delivery plan to bring together patient information, we will need support from our Value Based Health Care and Quality Improvement teams to support services recognise variation and support changes in pathways to remove these.

We will also need to work with partner organisations and using national benchmarking to identify where there are variations that occur between Hywel Dda and other NHS organisations which could be reduced or avoided to further improve the quality of our care.

# 05 Positive Futures

*Our strategy needs to consider the future needs of our population as well as our current demands. The children in our communities today will form our workforce in the future as well as potentially being future users of our services. To realise positive futures we need to bring in those voices, to help us shape our future clinical services plans and ensure that we are providing services that provide the best outcomes for our patients, allowing Hywel Dda to provide services sustainably in the future.*

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## Goal 7 - Future Orientated

### *Current position*

Health inequalities continue to exist, alongside climate and nature emergencies. To improve public health and well-being, we need to work together to tackle issues like poverty, environmental problems, poor housing, and social isolation.

As an organisation we are committed to environmental sustainability and reducing carbon emissions, complying with the Environment (Wales) Act 2016 and The Climate Change (Wales) Regulations 2021. We continue to make positive progress towards net zero targets and climate adaptation planning, aligning to the NHS Wales Decarbonisation Strategic Plan and the Climate Adaptation Strategy for Wales.

To support this our Decarbonisation Delivery Plan includes 46 initiatives to meet Welsh Government's net zero targets.

We also want to establish a Children and Young Persons Board that will provide meaningful advice on how to engage with younger generations and address the health and well-being challenges they face. This will be supported by a bespoke leadership programme, supporting their development, influence and leadership capability to address the future public health challenges and climate crises.

### *What we have achieved (since 2018)*

We are driving a shift towards a Social Model for Health and Well-being focusing on actions to reduce health inequalities and enable people and communities to achieve and maintain the best possible health.

We have agreed on six principles to reinforce our commitment and help partners and organisations adopt this model. These principles are outlined in a charter that connects to our well-being objectives.

In 2024/2025, Public Service Boards (PSBs) achieved several key milestones:

- Carmarthenshire implemented the 'Making Every Contact Count' approach, focusing on improving practices, training, and exploring joint web presence and data sharing.
- Ceredigion formed a 'Fair Work' group to create a charter and developed a toolkit to address poverty stigma.
- Pembrokeshire held a Poverty Summit with contributions from various organisations, including The Bevan Foundation and National Energy Action, to discuss the lived experiences of poverty.

Within Hywel Dda we have developed a Voices of Children and Young People group. The purpose of the group is to bring forward working professionals, including HB apprentices to move forward the Children's Charter and ensure that the rights and priorities of children are considered when planning and delivering services.

### *What we want to achieve*

- *Connected and resilient communities*
- *Establish a children & young persons' Board*

### *How we expect to deliver this*

- *Embed the Principles of Social Model for Health & Wellbeing*
- *Delivering our Decarbonisation Delivery Plan*
- *Encourage collaboration with others*

### *What this might mean for you*

We heard during the engagement that there was strong support for a Social Model of Health and Wellbeing, support for developing services which support the needs of children beyond paediatrics, and the advocacy role that they can play in moving forward the social model for health.

While decarbonisation and climate change were not specifically mentioned during the engagement, people asked us to make more use of the environment and green spaces in how we deliver care.

The Social Model for Health and Wellbeing was not something that people recognised as a term, but throughout the engagement feedback showed recognition of what it sets out to achieve and the component parts, suggesting more work may be needed if it is expected that people recognise this.

Some people shared concern that the Social Model for Health and Wellbeing may be introduced too soon, with hospital services needing to be stabilised first before making changes in community services. Some people felt that moving staff into delivering care this way will reduce the staff available in hospitals and could cause harm.

People told us their concerns about accessibility for children to access services, but also the need to ensure that children are involved in decisions about service change and redesign so that children, either in need of health care or visiting with others, can be in a safe environment that is suitable for children.

We recognise that green spaces are important not just for our patients but also our staff in providing care and supporting their own wellbeing. While it is positive that recognition is growing around what Social Model for Health and Wellbeing means in its parts, we will be taking care to ensure that this is introduced in a way that does not impact how we provide our care.

We believe that the Children and Young Persons Board will support us not only in delivering the Social Model for Health and Wellbeing but will also support the wider organisation make changes to services for current and future generations.

### *What support we will need*

Much of the support needed for the Social Model for Health and Wellbeing has already been covered within Goal 3 – 20-4-7 for population health. We will need to work with partners and the public to shape a new model for prevention and wellbeing.

As we already have a Voices of Children and Young People group, we are starting with good foundations to build a Children and Young People's Board, with the ability to bring in support from our wider organisation to help with leadership and development.

For decarbonization, we are likely to need resources to support, both deliver against the many areas which contribute to our carbon footprint, as well as working with other organisations to look at reducing carbon in transport footprints for patients and staff and improve public transport, as well as capital support to ensure that our buildings do not waste energy. These will be managed through the decarbonization plan and support our annual planning processes.

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## Goal 8 - Fit for purpose, modern facilities and services

### *Current position*

In 2018 we recognised that we have some of the oldest hospital infrastructure in Wales, and while we would need to make changes to our services to improve our workforce and quality of services, we also recognised that we would need to invest in our community and acute hospitals to ensure that they were fit for purpose and able to meet the needs of future service delivery.

Our Clinical Services Plan set out what this could mean for our hospitals in the medium term as well as go some way to informing what the short term investment may be needed to maintain our services.

Our Programme Business Case for wider estates development will continue to set out our ambitions to deliver our longer term vision of a network of fit for purpose community facilities supported by our hospitals. In late 2025 we were asked to consider additional options alongside those already submitted, called an addendum, to explore additional ways in which this could be delivered.

### *What we have achieved (since 2018)*

In early 2022 we submitted our Programme Business Case to Welsh Government to develop our community and acute hospital estates. This was guided by our clinical strategy to inform the estates we would need to support a Social Model for Health and Wellbeing and care closer to home.

In 2024 a review of our clinical strategy by Nuffield Trust was commissioned by Welsh Government to appraise the assumptions on which the Programme Business Case is based. While it recognised that some of the assumptions may need revision since the Programme Business Case was developed, the strategy was correct and should be implemented.

In 2023 we looked at some of the most fragile services in the organisation which we recognised as part of our initial strategy would likely be unsustainable in the future. Due to the delay in the endorsement of the Programme Business Case, a programme of work called the Clinical Services Plan, was put together.

The Clinical Services Plan explored the issues that these services face and were reported on in 2024, we then put together options for how we could deliver these differently until we could deliver the Programme Business Case and then consulted on these with the public in 2025, asking for alternative ideas that could help us address these challenges.

### *What we want to achieve*

- Develop & engage on a supportable Clinical Services Plan
- Deliver our Programme Business Case to have fit for purpose, modern facilities

### *How we expect to deliver this*

- Provide an addendum to our Programme Business Case to allow us to proceed with the development of community and hospital schemes
- Develop the Clinical Services Plan to make changes to services, and consider other services which may need support, to allow us to provide safe and sustainable services for the future.

### *What this might mean for you*

We heard during the engagement that there are mixed views on a new hospital being developed, but the development of services in the community was supported, along with the types of services that they can provide. There were also recommendations on things that can be done now that can immediately provide better experiences for those using our services.

While people want to see improvement in our estates and services, people are concerned about the need to bring services together further away from where they currently access services and the travel impacts as a result. This is similar to feedback that was received during the Clinical Services Plan consultation where people shared their concerns about how they will access timely care.

People believe the development of community sites would be positive, this would mitigate some of the concerns that people had around digital exclusion, while allowing them to access care locally. People also felt that these community schemes should consider a step up/ step down care model so that people could receive rehabilitation care in the community closer to home, which they believe would help relieve pressure on the hospitals.

During the engagement we asked people where we should focus any investment into our buildings should funding become available. Recommendations ranged from improving and supporting the cleaning and maintenance around hospital sites to make them feel more comfortable and support patient experience, improving toilet and changing facilities at our hospitals, creating dedicated spaces for children and young people to make safer environments for them in mixed waiting areas, and improving signage through our buildings to help people navigate them more easily.

We recognise that travel and transport is extremely important to patients and their visitors, as well as our staff, and we will need to ensure that changes to where we provide services does not prevent people from accessing them. We acknowledge that there are changes that we can make to improve our buildings which will improve people's experience and look to build these into our estate plans.

### *What support we will need*

To deliver the long term changes to our community and hospital sites, we will need the support and investment of Welsh Government to allow us to gain the external support and capital funding to develop our estates.

We will also need to seek additional support in the short term to help us maintain our buildings until then, either with essential maintenance or to support changes identified as part of the Clinical Services Plan.

We will need to work with our clinical leaders to deliver as much of our services as possible outside of hospitals as possible, either directly into people's homes using digital or community services, or through community hospitals and centres.

We will need to work with our partners to ensure that public transport works to allow people to attend or visit those in hospital or community centres. While we can explore ways to support people to attend hospital through appointment booking and open access, we will need to work with transport providers and local authorities to ensure that staff and patients can access public transport when it is needed.

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# 06 Delivering the change

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## Radical Change

Lastly, we will need radical change to deliver what we set out. Despite the impacts of the COVID-19 pandemic in 2020, as well as other factors which led to us revising our Strategy, there were many areas of our Strategy where we could have gone further. Simply refreshing the strategy will not be enough - we must fundamentally change how we approach change and transformation to deliver what we set out to do.

We will need to consider ways of working which may not have been explored before in Hywel Dda, looking at new ideas, and learning from other places in Wales, the UK and worldwide which provide services to rural populations, but maintaining service quality. We will need to be prepared to work differently if we want to bring our strategy to life.

Interestingly, there are differing views on the degree of change seen in Hywel Dda over the last decade. Some argue that the Board has been reluctant to confront its most fundamental configuration challenges, opting instead to keep services going until they reach the point of collapse, whereas others perceive significant loss in local service provision. In truth there are elements of both. It is correct that, outside of the Grange development, in no other part of Wales, despite the South Wales Plan, there has been a change in the number of Emergency Departments or Obstetric units or Inpatient Paediatric services over the past 10 years – Hywel Dda has had all three. Nonetheless the degree of duplication that remains is greater than other health boards in Wales where we provide the same services across multiple sites, with smaller and fragile rotas.

## Moving from strategy to action

Throughout the goals we mention things such as strategic delivery plans and annual planning cycles. These are ways that we can move forward from our strategy, which sets out our long term vision and ambitions, to steps we will take and tangible actions.

To help understand how all these fit together, as well as how people can monitor our progress against these goals, we have produced a diagram to show how our strategy, strategic delivery plans and our 3 year planning process works together.



We have a duty as an organisation to plan for how we will provide services over the next 3 years through an Integrated Medium Term Plan (IMTP). This is refreshed every year to allow us to focus on where we need to provide support across the organisation to help us make manageable changes.

A strategic delivery plan is a specific plan for a programme or piece of work which will take time, resource and support to deliver and is likely to last over 3 years. Examples could include the Digital strategy or Primary Care and Community services work.

This sets out what we will seek to do across a number of years and provides that constant steer throughout multiple versions of the 3 year planning process documents.

Our plans will need to dovetail with regional and national planning to ensure that we are working in partnership to provide the best services for our residents and the wider population of Wales. This could mean regional and national working to develop and deliver services for the benefit of a wider group of people with the same specialist resources. Examples of this include the national trauma pathways and cardiology, but in the future is likely to include more planned care such as orthopaedics and ophthalmology and acute services such as stroke services.

We couldn't have known the things that would take place when the strategy was originally published, and there may be other challenges that arise between now and 2040, so this strategy will need to be a living document that retains the principles at its heart, while being able to respond to new goals as our organisation, staff and population needs change so we can best respond to the challenges of the future.

### Engaging with our communities

To make any changes happen we are going to need to continue to engage with our public, staff and partners. This is so all our communities are not only informed of what we are doing but can help shape and support, in the design and delivery of our services.

Since 2018 we have run several formal consultations on changes we have had to make to services, and we know it can be difficult for some of our communities to engage, particularly when the consultations are talking about complex services, or a large number of changes.

As part of the strategy refresh we prioritised a continuous engagement approach. We sought to break down the questions and headed to where people wanted to talk to us about them. This approach to engagement has allowed people to share their views in spaces that are more comfortable for them and talk to us about the things that matter most. This has given us rich and detailed feedback which has informed this refreshed strategy.

Alongside the continued use of the Teulu Jones family, a fictitious family which reflects the population and community of Hywel Dda, we plan to take a continuous engagement approach as we move forward, whenever possible. We hope this will lead to more

people being involved in our planning and service design and ensure that we develop high quality services, that also meet the needs of the communities we are here to support.

## **Resourcing the strategy**

The Health Board has, since its inception in 2009, failed to deliver a balanced financial position and at the time of writing the Health Board remains at level 4, targeted intervention, for finance and planning within the Welsh Government escalation framework.

The anticipated growth in demand for health services, associated with the ageing of the population, will additionally challenge the affordability of the NHS in west Wales. In addition, the recent planning round has further surfaced the broader deficits. The Health Board has over 600 risks, the majority of which are categorised as extreme or high, and most are attributed in some way to workforce, funding or infrastructure. In reality this means the 'hidden' financial deficit far exceeds that of the visible deficit and manifests as risks to quality and safety, service fragility or access and delays.

It is easy to miss or underplay the significance of these issues but these are the areas that impact on the experience of patients and staff on a daily basis. The gap between what is available in west Wales versus other parts of Wales and the UK is often stark and will not easily be resolved – costs associated with mitigating the 600+ risks are estimated to run to the hundreds of millions of pounds. As an example, Emergency Departments in larger centres such as University Hospital Wales, Morriston Hospital and the Grange Hospital typically have over 20 consultants working within them. Hywel Dda, with a similar population to Swansea Bay, has 9.8 wte, spread across three units. This underlines that there are configuration challenges compounding these issues but, even if the configuration was fully addressed, the gap between what Hywel Dda is able to provide and best practice standards, including what exists in other parts of Wales, would still be very significant for some services.

The strategy is written in the context of three realities which will influence how and if the aspirations within this vision can be realised.

Firstly, the strategy is written with the assumption that NHS Wales remains funded through general taxation. Hywel Dda receives the vast majority of funding directly from Welsh Government and has minimal opportunities to generate other sources of income.

This means that decisions about the overall resourcing of the health service are predominantly political, weighing up the societal benefits of the NHS versus other highly important public services such as education, housing and social care. As noted earlier, it is well documented that the NHS itself actually contributes only a proportion (estimated as 15-20%) to the overall health of the population.

Other factors such as the economy, employment rates and other public services, alongside genetics and wider environmental factors, contribute the remainder.

Therefore, even if health is the number one priority, it is not necessarily the case that NHS funding should take precedence over all other Government priorities. We are very aware that NHS Wales now consumes over 50% of the overall Welsh Government budget and, with the economic outlook remaining challenging, it is inevitable that the funding of the NHS will continue to be constrained.

On this basis we can assume the Health Board will need to deliver substantial savings annually alongside the resourcing of this strategy. Whilst the Health Board typically has little influence over the overall funding it receives it does largely have discretion over how that resource is allocated and utilised. The extent to which the Health Board can deliver the strategy will be determined by how effective we are in delivering efficiency and productivity gains, whilst re-directing resources to the highest impact, highest value activities.

Whilst this may appear an uncontroversial statement – everyone supports the principle of not wasting public money – the pursuit of ever increasing efficiency and value will lead us to difficult questions about the role of the NHS and the way services are delivered.

It may be necessary to have discussions with government and our population about how core NHS funding could be supplemented through other sources of funding in order to enhance the offering.

Secondly, international evidence shows that ultimately it is the overall resourcing of a health system that determines the outcomes at a population level rather than the way in which it is organised - with the US being the most significant exception. Debates about whether the NHS should move to an insurance or other model are important, and may well be necessary over the duration of this strategy, but are unlikely to alter the fundamental point that, in health care, you largely get what you pay for. Over time health inflation typically exceeds general inflation and as a result countries are allocating ever-increasing proportions of their overall wealth (their Gross Domestic Product, GDP) on health care.

Consequently, a drive for greater productivity and efficiency will likely only take us so far. The position of the NHS today (as exemplified by the Health Board's risks, see above), the anticipated growth in demand and the expected constraints to growing the resource of the NHS, will likely require us to confront some uncomfortable choices about what the NHS can and cannot provide. Within this there will be difficult decisions for the Health Board about the scope of service provision. To date the Health Board, alongside the rest of NHS Wales, has attempted to maintain a near comprehensive health service. As technology and treatment options expand and the population ages, if funding cannot keep pace, there will increasingly be the need to have an open debate about what the NHS is able to provide and the point at which it becomes preferable to deliver a reduced range of services at a higher quality.

When we undertake public engagement events a very common perception is that, as people have contributed to the funding of the NHS over their lifetime, the NHS should now be in a position to resource all of their health requirements as they age. This is a perfectly reasonable and understandable challenge and points to the implicit social compact – i.e. the population will give its support for the NHS through general taxation and in return the NHS will support the population “from cradle to grave”. Unfortunately, the reality is the contributions made by the public have not been retained as a fund for future use. The funding of today’s services comes from today’s tax returns. It may therefore become necessary to have an open discussion about what can be afforded in West Wales through the NHS model and what aspects may not, and what other arrangements members of the public may need to consider.

Thirdly, how the NHS allocates resources and delivers services will be fundamental to the delivery of this strategy. It is well recognised that, despite the aspirations of our strategy and national policy, there has been insufficient progress with re-balancing the system to a health and wellness service, with greater emphasis on prevention, early intervention and community provision. The reasons behind this are multi-faceted but a significant factor is the challenge of moving resources from expensive but necessary treatment services, typically in hospital settings, towards services that will benefit population health and wellbeing for the longer-term.

Most people agree that it will be necessary for us to deliver this shift if the NHS is to be sustainable and realise the aspirations within this strategy. Nonetheless the practical implications of this, present more of a challenge. In the absence of additional resources to grow primary, community and preventative services this shift can only be achieved through moving resources from one part of the system to another. In the long term the evidence suggests this should provide a better, more effective health service alongside a healthier population. However in the short-term there will likely be trade-offs, meaning an acceptance that hospital services may be impacted as resources are re-directed to out of hospital, upstream activities. This will require a degree of long-term thinking and belief in preventative services that has not been evident to date. Consequently, delivery of the strategy will require recognition that this trade-off exists and the NHS will need to give greater priority to prevention and primary care.

## **Value based health care and sustainable shift of resources**

### *Current position*

To make a shift from a treatment to a prevention service, we will need to move our staff from our acute sites, into our communities and remotely into homes, while also maintaining a balance to provide care for people in hospital when it is needed. It will not be possible to develop preventative services without reducing work we do elsewhere.

To enable this we will need to review the value of the care we provide to ensure that we are providing care only where it is providing value to patients lives. This will help us ensure that we are not doing things which are not needed or wanted, allowing us to support people with what matters most to stay healthy.

We will also need to look at our pathways of care so that we can support people at the earliest opportunity so that they can prevent becoming unwell and remain in their communities for longer. This will be supported through our planning processes and a gradual move of staff and procedures from inpatients, to outpatients, to community and home.

#### *What we have achieved (since 2018)*

Our Value Based Health Care team was established in 2019 to support delivering value and reducing variation across our services.

The team has supported work around moving Heart Failure services from an acute service into a community prevention service, as well as supporting other services with the use of grant funding to test alternative ways of working.

Working alongside Enabling Quality Improvement in Practice (EQiP) and the Organisational Development Team, the team acts as a critical and trusted friend to services to make improvements to services.

#### *What we want to achieve*

- *Develop a Financial Strategy for Sustainability*
- *To ensure the integrity, timeliness and relevance of financial, clinical and other information systems*

#### *How we expect to deliver this*

- *Improve resource allocation*
- *Ensure robust oversight and accountability mechanisms are in place*
- *Deliver within cost and programme, the primary and community facilities being funded through IRCF*

#### *What this might mean for you*

We heard during the engagement that people are concerned about how we use our limited resources and how we can do things more efficiently, as well as differences in the care that they may receive based on where they live, both of which can have impact on patient experience if improved.

People told us that they believe that waiting times could be improved if changes were made to our booking systems. By improving how appointments are booked, or even letting patients have involvement in booking, they believe that the number of cancellations that take place could be reduced making services more efficient and reducing waiting times.

Patients were also concerned about how medicines are prescribed, sharing how they are often prescribed more medicines than they believe are needed, without reviews taking place to check what they are given when they speak to different parts of the health system. Again they felt by reviewing the amount of medicine prescribed, there could be money saved which could be invested into staff and services.

We also heard that people felt that their care and aftercare could vary based on which hospital service that they accessed, and where they lived could affect the aftercare they received when they go home following treatment. People want to feel confident that no matter where they live or access care, they are receiving the same quality service as everyone else.

During the Clinical Services Plan consultation, we also heard that people were concerned about the number of administrative and clerical staff, particularly those in management roles, in the organisation and whether this was diverting resources away from clinical roles.

We recognise that many of the issues raised during the engagement are problems that we need to address now, and we are actively working on those issues now. While digital may help reduce the need for additional administrative and clerical staff, as well as support patients to make and edit their bookings, we will need to support our services to make changes either through quality improvement, or larger transformation such as our Clinical Services Plan.

#### *What support we will need*

Much of the support that we will need is already in place, we have ways to capture patient outcomes and experience to gather data, and we have a digital strategy to enable us to gather and share data insights with services to make meaningful changes to reduce waste and variation.

#### **Hywel Dda in 2040**

Even with all of the challenges highlighted throughout this Strategy Refresh we believe firmly that, by taking a long-term view, the NHS in west Wales cannot only survive but thrive.

By 2040 we will have seen a significant improvement in the health of our population in west Wales, with a sharp reduction in obesity rates, reduced alcohol intake, healthier eating and a continuation in the decline of smoking. People will be more active in monitoring their own health, using wearables, smart devices and AI to track trends and identify where to make lifestyle changes. Health inequalities will have narrowed as a result of community action, supported by the Health Board and partner organisations, particularly in our most deprived areas. An expanded primary and community care will proactively work with families and community groups to promote good health and wellbeing and provide early intervention.

Clusters will be highly influential in the design of services and the allocation of our resources, facilitating a shift from hospital based care to care in communities. We will have a stable, right-sized workforce and teams will be well connected with their communities, radically improving the customer service and building trust across the public, staff and partners. Primary and secondary care leaders will work closely together, developing seamless and high value pathways, moving services into communities as clinically appropriate. Teams and services will be trusted to work more autonomously, empowered to make decisions on the design of services and resource allocation, underpinned by better measurement and benchmarking.

Whilst primary and community care has expanded, hospital services have shrunk, as a result of the reduced reliance on acute care and the shift to community. Patients will only access specialist care when it is required and for the shortest possible period of time. The number of patients accessing Emergency Departments, for example, will have fallen by 75% as more appropriate alternatives are developed and whilst the number of hospital beds are approximately the same (reflecting the additional demand from an ageing population), the number of patients with very long hospital stays has reduced significantly due to the increased community and social care provision. The quality of hospital care will be considered the priority and as such services will be consolidated to raise standards and improve outcomes.

The Health Board's estate will be modernised with a network of community hubs supporting the shift to a community model, improvements to Bronglais and Prince Philip sites, a repurposing of Withybush and a new central hospital for the south of Hywel Dda. The adoption of digital technologies will transform the way citizens access their own health information and interact with health services, and AI will be commonly used to support patients and professionals. Patient records will be integrated across all functions and sectors of the health service, with advanced analytics widely utilised to forecast demand and understand service utilisation and efficiency.

## Concluding remarks

Our existing strategy remains the solid foundation on which we can provide the best services possible. Since 2018 we have made improvements in how we support our staff and develop the culture we need to make these changes, as well as create the support networks to deliver this through our digital transformation and value based health care teams.

Our strategy has been a living document, and while the principles of the 2018 strategy have remained the same, our goals have been refreshed to show how we will deliver our strategy in light of what has changed around us. We will maintain this approach so that we are able to plan and deliver services that meet our communities needs as things change, with further refreshes likely needed between now and 2040.

We do need to go further, we will need to be more radical in our approach to ensure that we can overcome the barriers we are expected to face in the future, but we are already seeing those changes through partnership working and the social model for health and wellbeing, as well as through our staff culture and responses to staff surveys.

Significant opportunities exist for improvement in the way we work which can support the radical transformation required. We believe the path to realising our vision of a Healthier Mid and West Wales will require us to become world leading in the following areas:

1. Connection to communities – partnering with our communities to facilitate improved health and wellbeing, and listening to what is important to live healthier lives through continuous engagement
2. Integration across primary and secondary care – maximising the opportunities offered by an integrated model to bring primary and secondary care together to improve patient pathways and support the shift to a community model
3. Customer service – transform the way in which the public and patients access information and our services
4. Adoption of digital – acceleration in the utilisation of digital tools and new technologies including Artificial Intelligence, as well as fostering a culture which embraces and thrives in a digital environment
5. Radical leadership and connection - working together to be the best we can be.

By becoming leaders in these areas we can support both our patients and staff, through working locally and in partnership with others on a regional and national basis, to live healthier lives for longer with an NHS service there for those who need it.



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Hywel Dda  
University Health Board

# Refreshing our A Healthier Mid and West Wales Strategy

Strategy Refresh Engagement Report  
January 2026



## About this document

This document summarises community feedback from the engagement activity undertaken to help inform Hywel Dda University Health Board's (Hywel Dda or Health Board) refreshed strategy.

This document has been produced to support the Health Board to understand the feedback shared by staff, members of the community, partners, and key stakeholders. In addition to this summarised version of the output of our engagement activity, a full detailed Strategy Refresh Engagement Report has also been produced.

The main part of the document provides a summary of the feedback heard during phase 1 and phase 2 of the engagement. With further information available for the phase 2, nine-week engagement period, in the full strategy refresh engagement report, including source data.

### Version control:

Version	Issued to	Date	Comments
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# 1. Executive Summary

## 1.1 Background and context

The health system in west Wales has for many years faced serious challenges across workforce, finance, estate and service sustainability. This stems from a combination of factors, present across the whole of the NHS, but particularly evident in Hywel Dda. This includes outdated ways of delivering care across hospitals, an over-reliance on acute hospital beds, challenges in attracting staff to west Wales, an under-investment in the Health Board's estate and digital infrastructure and challenges with providing services to a population spread over a large, mainly rural, area.

Our strategy has built on more than 20 years of work to address these key issues, with a significant milestone reached in 2018 through the agreement of the first strategic plan for this part of Wales, 'A Healthier Mid and West Wales'. Our strategy aims to deliver safe, sustainable, accessible and kind services. As part of the strategy development, the Health Board explicitly referenced that services were unsustainable, and this unsustainability could not be addressed without fundamental change.

In the seven years since the strategy was agreed further change has occurred, including:

- Inpatient paediatric services have been brought together for the south of the Health Board at Glangwili Hospital
- Some inpatient elective services have moved during COVID, with protected urology and colorectal surgery in Prince Philip Hospital and Orthopaedic inpatient surgery also brought together Prince Philip Hospital
- Nurse staffing has improved substantially, with international recruitment supporting a successful workforce stabilisation plan
- The opening of Integrated Care Centres in Aberaeron and Cardigan, and plans in progress for other community facilities such as Carmarthen Hwb, Pentre Awel (Llanelli), Cross Hands and Fishguard
- The number of very long stay patients (over 50 days and over 100 days) has steadily reduced, particularly at Witybush Hospital, supporting more patients in the community and a change in the acute bed base
- Significant capital investment to respond to fire safety and prevention work, Reinforced Autoclaved Aerated Concrete (RAAC) etc.

These changes have brought some improvements to services but are not to the level needed to address the fundamental sustainability risks across the Health Board, as set out in 2018.

For example:

- Despite the significant capital investment in response to fire safety and RAAC, it has only allowed current services to continue and has not increased capacity, enhanced patient care or transformed service models. Backlog maintenance has continued to increase over the same time.
- The stabilisation of nurse staffing has not yet been matched by an equivalent improvement in the medical staffing position. Some services remain overly reliant on

locums, agency, and additional sessions. This includes critical services such as A&E, stroke, critical care and general surgery.

- Many services continue to operate over multiple sites and, whilst the Clinical Services Plan programme has developed a range of options to improve standards and respond to sustainability risks, there are no plans, ahead of the new hospital, for the complete bringing together of Withybush Hospital and Glangwili Hospital as envisaged in the strategy. This is particularly important for A&E, medicine, and trauma, which currently sit outside of the scope of the Clinical Services Plan.

## 1.2 Developing a refreshed strategy

The Health Board's strategy refresh is about adapting to the changing health needs of our population, demographic changes, and long-term workforce projections. The need for change remains clear, and our refreshed strategy will need to focus on the 'who' will deliver, starting with the people who live in our communities.

To support people living with chronic diseases and improve prevention and early intervention, our strategy up to 2040 aims to help people live longer, healthier lives. The existing strategy has eight main chapter headings, which have formed the basis for the refresh. The eight headings are:

1. Working together in partnership
2. Working together every step of the way
3. Our vision and goals to improve health and well being
4. Working across the whole system
5. Our future community model
6. Some of the things we will do first
7. Our future hospitals model
8. Transforming our future

It is believed that many of these are still key areas that we would want our strategy to address and will need to be considered going forward. However, the structure of the strategy document will be different, bringing these areas together under new headings and paying more attention to what we want to change and how we will deliver this.

### 1.2.1 Discover phase methodology

To understand what might need to change within our current strategy, as part of a refreshed strategy, chapters in the document were reviewed using the following process of:

- Review: Test the current content to see what has been said already
- Confirm: Agree what still exists and what isn't subject to change and out of scope of refresh
- Query: Identify elements which are no longer current or correct and need refreshing and add into scope
- Identify: Establish whether there are existing workstreams for those areas or if new working groups are needed to meet the refreshed strategy needs



- Revise: Check to see how the strategy works once those new parts are added. This is likely to be supported with engagement with our communities.

The existing strategy, published in 2018, was envisioned as a 20-year strategy. Within this, it contained a section on some of the things that the Health Board would do first, as well as its longer term aims and change programmes.

It was agreed by the Board, that we retain this approach through the refresh of the strategy and to develop it in three phases.

1. Discover - which was undertaken between May 2025 and January 2026
2. Design - development of Strategic Delivery Plans during 2026/2027 along with alignment to year 1 of the three-year planning cycle
3. Deliver - the delivery of the Strategic Delivery Plans through our three-year planning cycles

This will mean that the refreshed strategy will now take us to 2040.

The result of this process will be a refreshed version of the strategy that will be ready for presentation to Board by January 2026, as well as supporting the 2026/2027 planning cycle that will be presented to Board in March 2026.

### 1.2.2 Design Principles

To support the refresh, a set of Board-approved design principles were developed to help ensure that the strategy can talk about all parts of the organisation in a way that people understand. The design principles were also created to ensure the refreshed strategy is understandable to our staff, our public, and stakeholders, so they can help co-design how we shape our services.

The strategy should be seen as forming our long-term plan, delivered initially through our planning processes that are refreshed annually, and tied to strategic delivery plans to help deliver what we set out in the strategy. Performance is assessed against planning objectives, based on those strategic delivery plans. These are brought together and reported through the Strategic Objectives and Board Assurance Framework. These were refreshed for the 2025/2026 annual plan but have been reassessed as part of the strategic refresh to ensure they are aligned to the direction of travel we want to take.

The Strategic Objectives themselves are aligned to our values and vision, which underpin the strategy. Our organisational values are:

- Belonging – Putting people at the heart of everything we do
- Growth – Striving to deliver and develop excellent services
- Together – Working together to be the best we can be

These are supported by our behaviours, which were developed by our staff:

- Dignity, Respect and Fairness
- Integrity, Honesty and Openness
- Caring, Kindness, Compassion

By assessing our performance against our Strategic Objectives, which are aligned to our organisational values we will have indicators on how well we are delivering our strategy.

Additionally, the Community Health Council (now Llais West Wales) provided a series of recommendations as part of their response to the existing 2018 strategy. Of these 18 recommendations, 17 are still reflective of how we would want to plan and deliver services. While one of these, which referenced previous programmes, may no longer be relevant. The key message from the recommendations was to ensure that whole Health Board engagement and clinical leadership is present throughout our strategic approach, which still remains.

While some areas of the strategy may not be fully addressed by the refresh, they will be included in a series of Strategic Delivery Plans aligned with our Integrated Medium-Term Plan. These plans will detail the 'how' we will deliver changes, while the strategy will outline the 'what' we need to do, which remains broadly consistent with the existing strategy.

The Health Board will play a key role in delivering change, but it is equally important for individuals and communities to support the 'who' will deliver and realise the strategy.

If we continue without change, the 2040 predictions for our population are stark:

- The life expectancy gap between the most and least deprived communities will continue to grow, people will die younger
- People will age with more chronic conditions, requiring more support from health and social care services
- There will be shortages of workers, more people will become economically inactive due to poor health
- Services will no longer be able to meet demand, the competition nationally for staff and local workforce will not be here.

The 'A Healthier Mid and West Wales' strategy in 2018 set out how we would move from treating illness to preventing people becoming unwell:

- A Social Model for Health and Well-being would be needed, supporting people and communities to manage their wellness
- More care would be provided closer to home, services which don't need to be in a hospital would be in the community
- Staff roles would change, people would need to work differently and in new ways to support prevention
- Digital would be an enabler to deliver this change, we would have to link systems to ensure information was where it's needed.

The strategic refresh is not a new strategy but a continuation, reflecting our changing environment, going further to deliver the strategy:

- A Social Model for Health and Well-being - supported with investment in prevention, digital services and AI to help people take ownership of their care
- Care from the home - using telemedicine to support virtual wards and virtual outpatient consultations, reducing travel

- Safe and sustainable services - not just clinically sustainable, but climate change resilient and further decarbonising our services to net zero

### 1.3 Engagement scope

Due to the planned public consultations for both the Minor Injury Unit at Prince Philip Hospital and the Clinical Services Plan, we adopted a continuous engagement approach to our conversations with our communities about our strategy refresh.

Our engagement activity sought to take a blended approach to help foster meaningful conversations with our communities, tailored to the specific topics identified for further discussion. This included both listening to people's experiences and sharing stories that illustrate the impact of changes in our strategic approach.

Alongside these face-to-face conversations, we also used our online engagement website - Have your Say/Dweud eich Dweud. This platform allowed people to contribute to their views online during both phases of the engagement.

After the end of the engagement period, we reviewed the feedback, tested it against the draft refreshed strategy and incorporated the key themes of what we've heard. We have included a section within each of the goals, which focuses on what our strategy means for people who have engaged with us. There is also a separate appendix that contains more detailed analysis of everything our communities told us, including how we analysed the feedback.

### 1.4 Engagement questions

In July 2025, the Health Board launched Phase 1 of its strategy refresh engagement, by asking its population one simple question:

**'What is important for you to live a healthy life?'**

Phase 2 of the engagement launched at the end of September 2025 and sought to gather feedback from our communities across four key themes that came out of the first phase of engagement. There were 11 questions in total that we wanted to hear views on:

#### 1.4.1 Social Model for Health and Well-being

We believe health starts in our homes, schools, workplaces, and communities, not just in clinics or hospitals. A strong social model means working together with local organisations and partners, charities, clubs and groups to support well-being. People like community connectors, volunteers, and carers are already making a difference. We want to build on that by listening to what matters most to you - whether it's help with transport, access to green spaces, or support with food and heating. Health should be part of everyday life, shaped by the people who live it.

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?

### 1.4.2 Digital Healthcare Support

Digital healthcare can make things easier, from booking appointments to checking test results or getting advice. But we know not everyone has the same access or confidence. For some, it's about having the right device or internet connection; for others, it's about trust and knowing your information is safe. We want digital services to feel simple, secure, and supportive - not a barrier. That means offering training, making services bilingual, and always keeping face-to-face options for those who prefer them. Everyone should feel included.

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?

### 1.4.3 Balancing Hospital Care and Community Support

We're working to shift more care into communities, so people can get help earlier, closer to home. That might mean more healthcare staff, or well-being hubs in your town or village. If we get that right, hospitals can focus on the most seriously ill. But we also know travel matters - especially in rural areas. If you do need to travel further, we want to make it easier: better transport, clearer communication, and making sure the care you get is truly worth the journey. It's about balancing what's safe, sustainable and fair.

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?

### 1.4.4 Clinical Services and Hospital Redevelopment

Across our communities we understand that the quality of healthcare isn't just about buildings, it's about the care delivered within them. That said, we know that the condition of our sites can affect how safe, accessible and welcoming services feel. Any investment in our health estate should reflect what matters most to you: timely care, supportive environments, modern equipment, and facilities that help staff do their best work. As we plan for future re-developments, we need to make changes at sites most in need of repair. We're committed to listening, being transparent, and working with communities to make sure improvements support better care for everyone.

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?

## 1.5 Engagement approach

The purpose of the engagement periods was to promote and raise awareness of the strategic refresh process and provide opportunities for our communities to share their views. Public engagement promotes accountability and helps with decision making; public bodies give an account of their plans or proposals and listen to feedback from the communities they serve. Engagement has been described as a dialogue, based on a genuine and purposeful exchange of views.

However, it should be noted that engagement and consultations are not referenda or 'votes' in which the loudest voices or the greatest numbers automatically determine the outcome. The feedback received often reflects widely varied and sometimes polarised views, and it is important to report these concerns and contrary views robustly, for decision-makers, in this case the Health Board, to be able to conscientiously consider the issues raised.

As part of the engagement planning a detailed stakeholder map was developed to identify a wide range of stakeholders in the Hywel Dda area and inform where focussed engagement should be targeted. This was supported by Communications and Engagement Plan.

### 1.5.1 Phase 1

The eight-week long public engagement began at the start of July and ran until 31 August 2025.

At that time, the Health Board was undertaking a wide range of engagement activity, including two public consultations on the Clinical Services Plan and the Minor Injury Unit at Prince Philip Hospital. Therefore, Phase 1 focused on using existing engagement events to encourage the public to 'join the conversation'.

To enable members of the public to more easily share their views during face-to-face events, printed postcards were shared. Two formats were designed, which could either be handed in during events or taken away and posted back to us, using the pre-filled freepost address.

This was supported by the online engagement on Have your Say/Dweud eich Dweud where members of the community could either respond the single question directly – 'What is important for you to live a healthy life' or could contribute ideas through the online ideas tool.

### 1.5.2 Phase 2

The nine-week public engagement period began on 29 September and ran until 28 November 2025.

During this time members of the public, service users, Health Board staff, partner organisations, and other stakeholders were invited to give feedback on the four key areas outlined in 1.4 above. Engagement was tailored to suit their differences, circumstances and requirements, with an emphasis on targeted face to face group engagement in their community settings or specific group meetings to engage in conversations on key issues identified from Phase 1.

Throughout the engagement, stakeholders were provided with paper documentation and/or signposted by direct email or communication activities, such as press releases and social media advertising, to the dedicated page Have your Say/Dweud eich Dweud.

Views, opinions and feedback were sought through a wide range of methods including:

- paper-based questionnaires
- online questionnaires
- targeted / focused group meetings facilitated by the Engagement Team and Community Development Outreach Team, with a particular focus on seldom heard groups
- hospital visits and walkarounds to speak with staff and patients in outpatients' departments
- Third sector and partner organisations network events public events
- social media responses

## 1.6 Communications and social media approach

Our communications approach was designed to reach as many people as possible in accessible ways, with branding aligned to 'A Healthier Mid and West Wales' and our Teulu Jones family.

We provided a summary on the Health Board website, signposting directly to the engagement platform, with dedicated pages on Have your Say/Dweud eich Dweud, offering background information and the engagement questions/questionnaire.

Targeted social media adverts and organic content ran across our social media channels during both phases of the engagement. This was supported by a campaign in healthcare settings (including pharmacies and GP surgeries) through distribution of posters and digital screen displays, including QR codes and phone numbers inviting communities to share their views.

Digital information was primarily provided on the Have your Say/Dweud eich Dweud website, with direct links from the main Health Board website. During Phase 1 of the engagement we captured views at source through postcards and interactive materials, and ensured information was circulated to key stakeholders and shared with the media to encourage participation. Phase 1 also included a broad social media advert that invited people to answer a single question on the Have Your Say/Dweud Eich Dweud website with responses recorded.

During Phase 2 the social media campaign ran for nine weeks with the primary objective of raising awareness of the engagement and driving increased survey responses. The campaign ran across Instagram and Facebook with both organic and paid boosts. Paid boosts ran for seven days each across each of the three official health board accounts:

- <https://www.facebook.com/HywelDdaHealthBoard>
- <https://www.facebook.com/bwrddiechydhyweldda>
- <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 focused on:

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

The schedule of posts spanned nine weeks with the focus shifting across the 11 questions throughout the campaign period. The campaign was closed out with further social media posts reminding people of the closing date for completing the survey and sharing their views.

### 1.7 Summary of engagement activity - Phase 1

Feedback to the question was gathered across the eight-week engagement period:

#### “What is important for you to live a healthy life?”

This was captured in the following ways:

- online at Have your Say/Dweud eich Dweud
- captured via responses to social media ads and posts
- Minor Injury Unit, Prince Philip Hospital consultation events
- Clinical Services Plan consultation events
- public events – Royal Welsh Show and Pembrokeshire County Show
- focus group engagement with seldom heard groups through our Community Development Outreach Team sessions

There were 627 responses to the question on the Have your Say/Dweud eich Dweud platform. There were an additional 125 responses to the question administered by YouGov by people with a Carmarthenshire, Ceredigion or Pembrokeshire postcode (excluding “Don’t know” responses). YouGov are an organisation who will independently ask members of the public a series of questions to get responses from different people than those who may usually respond.

### 1.8. Summary of engagement activity - Phase 2

During the nine-week long engagement period, there were 121 meetings, events, and activities. These sessions meant we were able to speak with 2024 people.

#### 1.8.1 Staff engagement

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.

Staff walkaround			
Location	Date 2025	County	Numbers Engaged/Informed
Withybush Hospital	15 October	Pembrokeshire	90
South Pembrokeshire Hospital	16 October	Pembrokeshire	25

<b>Tenby Cottage Hospital</b>	16 October	Pembrokeshire	15
<b>Prince Philip Hospital</b>	20 October	Carmarthenshire	160
<b>Glangwili Hospital</b>	22 October	Carmarthenshire	175
<b>Amman Valley Hospital</b>	23 October	Carmarthenshire	12
<b>Llandovery Hospital</b>	23 October	Carmarthenshire	14
<b>Cardigan Integrated Care Centre</b>	27 October	Ceredigion	19
<b>Aberaeron Integrated Care Centre</b>	27 October	Ceredigion	15
<b>Bronglais Hospital</b>	28 October	Ceredigion	95
<b>Total</b>			<b>620</b>

### 1.8.2 Public engagement

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 and Community Development Outreach teams.

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 booked for a Llanelli Deaf Club meeting, and large print versions of the 11 questions, were made available at 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 and have fed into the analysis:

<b>Stakeholder Group engagement sessions</b>			
<b>Name of group / session</b>	<b>Date 2025</b>	<b>County</b>	<b>Numbers Engaged / Informed</b>
<b>Ceredigion Youth Council</b>	17 October	Ceredigion	37
<b>Llanybydder Family Centre</b>	22 October	Carmarthenshire	8
<b>Aberystwyth &amp; District Visually Impaired Club</b>	3 November	Ceredigion	15
<b>Ceredigion Disability Forum – targeted session</b>	3 November	Ceredigion	3
<b>Coffee morning with parents of disabled children</b>	4 November	Carmarthenshire	7
<b>Llanelli Deaf Club</b>	4 November	Carmarthenshire	12
<b>Lampeter Food Project</b>	4 November	Ceredigion	25
<b>Tenby Friendship Group</b>	5 November	Pembrokeshire	40

<b>Caredig 10 Year Anniversary Event</b>	6 November	Carmarthenshire	2
<b>Pembrokeshire 50+ Forum</b>	6 November	Pembrokeshire	17
<b>Caffi no.5 - supported employment for people with disabilities</b>	7 November	Pembrokeshire	6
<b>West Wales Amputee Social Group</b>	7 November	Health Board-wide	11
<b>Cylch Ti a Fi Llanddewi Brefi</b>	7 November	Ceredigion	4
<b>Cosheston Local Community Group</b>	8 November	Pembrokeshire	7
<b>HOPE MS Charity</b>	10 November	Pembrokeshire	2
<b>Area 43 panel of young people meeting</b>	10 November	Ceredigion	6
<b>Pride in Age Friendship Group</b>	11 November	Ceredigion	5
<b>CWTCH</b>	12 November	Carmarthenshire	7
<b>Young People Speak Up Llanelli</b>	12 November	Carmarthenshire	7
<b>Age Cymru Dyfed – Building Stronger Futures for Older Veterans</b>	12 November	Ceredigion	2
<b>Macular Group</b>	13 November	Carmarthenshire	9
<b>Pembrokeshire Coast National Park Accessible Walk Group</b>	13 November	Pembrokeshire	7
<b>Milford Haven Macular Group</b>	14 November	Pembrokeshire	13
<b>Sign and Share</b>	15 November	Pembrokeshire	9
<b>Aber Dads</b>	15 November	Ceredigion	15
<b>Older Adult Art for Health and Well-being, Borth Community Hub</b>	17 November	Ceredigion	10
<b>Pembrokeshire Bereavement Forum</b>	17 November	Pembrokeshire	4
<b>Nacro Connecting Carmarthenshire Drop-in - Llandovery</b>	17 November	Carmarthenshire	8
<b>Carers Rights Day (Ceredigion)</b>	18 November	Ceredigion	15
<b>Carmarthenshire People First</b>	18 November	Carmarthenshire	14

<b>Women's Health and Wellbeing Network</b>	19 November	Pembrokeshire	10
<b>Pembrokeshire Carers group</b>	20 November	Pembrokeshire	5
<b>People Speak Up over 50's, Llanelli</b>	24 November	Carmarthenshire	16
<b>Stakeholder Reference Group</b>	24 November	Health Board wide	11
<b>Pembrokeshire Carers Rights Day</b>	25 November	Pembrokeshire	36
<b>Amroth Craft Group</b>	25 November	Pembrokeshire	10
<b>Pembrokeshire Youth Assembly</b>	26 November	Pembrokeshire	20
<b>Carmarthen Town Council General Purpose Committee</b>	26 November	Carmarthenshire	7
<b>Forget me Knot Dementia Group – Ray Ceredigion, Aberaeron</b>	28 November	Ceredigion	22
<b>Dream Team and Pembrokeshire People First meeting</b>	28 November	Pembrokeshire	8

In addition, 62 further events and activities were attended by the Engagement Team including multi-agency networking events, food fairs and other seasonal activities which provided opportunities to share information with our communities and encourage participants to complete the survey.

## 2. Key engagement findings

### 2.1 Findings from Phase 1 engagement

Below are the five key themes that came from this engagement with our communities:

- Getting healthcare close to home and making sure everyone has fair access
- Helping people stay healthy and looking after all aspects of health
- Supporting people to make healthy choices in daily life
- Building strong social connections and supporting emotional well-being
- Improving how services work together and making the system easier to use

In addition to this, we also funded a YouGov poll, asking individuals across Wales the same question. Responses from this engagement approach identified five distinct areas that they mentioned were important to living a healthy life:

- Having the support and confidence to make choices about your own health and well-being
- Being part of a community where people help and support each other
- Making it easy for everyone to get the care and services they need
- Looking after our surroundings so they stay healthy for everyone

- Encouraging simple, everyday habits that help people stay healthy

## 2.2 Findings from Phase 2 engagement

### 2.2.1 Social Model for Health and Well-being

There were four questions under this key theme and they were:

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?

This is what you told us in your responses:

- Many respondents mentioned the importance of exercise in helping them to stay healthy day to day; walking, running, gym, yoga, pilates, swimming, cycling, and group fitness classes were all activities mentioned.
- Being outdoors and in nature, parks, or green spaces was also frequently mentioned as both a motivator and a benefit for physical and mental health for our communities.
- Eating a healthy, balanced diet is a top priority, with references to cooking from scratch, eating fruits and vegetables, and limiting processed foods. Access to affordable, quality food was highlighted as both a facilitator and a barrier to staying healthy day to day.
- Social interaction with friends, family and community groups were seen as vital for both physical and mental health by many people. As well as participation in clubs, choirs, volunteering, and group activities being valued for motivation, support, and a sense of belonging.
- Support networks were mentioned as being especially important for those with chronic conditions or caring responsibilities.
- Mental health practices such as meditation, mindfulness, and maintaining a positive outlook were also frequently mentioned. Although some groups mentioned that mental health services were lacking, with no continuity and virtually no local support in some communities.
- Some groups mentioned that they rely heavily on volunteers for social and health support, but while some celebrate their contribution, others warn that recruitment and sustainability are becoming major challenges and this could impact how they can help in future.
- There was strong support for the Health Board to be working together with third sector (charities), local groups and community hubs to support prevention and wellbeing, reducing the need to use hospital services.
- There were concerns around how poverty and transport barriers would be addressed to ensure that everyone can access care equitably in their local communities.

- The need to work with partners (other organisations) was also raised as important, to support healthy eating, accessing green spaces and leisure services, to ensure they are accessible to all.
- Many expressed a sense of personal responsibility for their health, emphasising self-care, self-education, and proactive management of conditions. Although some felt there could be more on social side of health in local GP surgeries, especially for LGBTQ+ communities.

### 2.2.2 Digital Healthcare Support

There were three questions under this key theme and they were:

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

This is what you told us in your responses:

- Many respondents told us they feel comfortable or even enthusiastic about using digital tools for health, stating ‘I’m confident in my ability to use the internet or apps’ and ‘very confident and I feel they are the future.’
- Some see digital health as inevitable and positive, especially for routine tasks like booking appointments or accessing information.
- The use of digital technology was also seen as a positive way to overcome barriers to travel and transport, particularly for short appointments where patients don’t need to be face-to-face.
- Some respondents from rural communities mentioned that poor rural connectivity, lack of mobile signal and power cuts hinder digital access, leaving some completely cut off.
- A significant number of responses raised worries about data safety, privacy and the risk of hacking; ‘not so confident on how safe that data would be’ with another response mentioning ‘I’m concerned about privacy/data security. The hackers have the upper hand.’ There was some broader distrust in digital health systems, especially for sensitive information.
- Many respondents value face-to-face or phone contact for complex or sensitive issues, stating that Apps and AI should not take the place of interacting with real people.
- People were concerned that those who may face barriers to digital services, physical or sensory disability, or people with low skill or confidence, may get left behind if a digital first approach is taken. People also asked for digital to be an option, not the default, and felt the Health Board should be providing support for those who want to use it but need more help.
- Offers of tutorials, helplines, and in-person support for those less comfortable with technology were also suggested as potential mitigations for those facing barriers to accessing digital services.
- The ability to join up information across health systems, so people don’t need to repeat their information or say what is wrong with them was seen as really helpful.

- There was interest in Apps that provide tailored advice, reminders, and support for specific conditions or needs. Some responses mentioned the value of AI-driven features, such as health coaches or remote monitoring. Taking a more holistic approach to care was also raised, with services being more joined up and appointments happening in one meeting, resulting in more accountability across services and reducing waiting times.
- Many respondents highlighted the importance of systems that worked as promised with assurance that personal health information would be secure and transparency about how personal data would be used and who can access it.

### 2.2.3 Balancing Hospital Care and Community Support

There were three questions under this key theme and they were:

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

This is what you told us in your responses:

- People overwhelmingly want to stay well and receive care in their own community, only using hospital as a last resort or for emergencies.
- There is a strong desire for more local and timely access to GPs, nurse-led clinics, minor injuries units, urgent care, physiotherapy, diagnostics like blood tests and scans, as well as specialist nurse services.
- Multiple groups mentioned concerns about poor discharge planning and a lack of rehabilitation support.
- Integrated 'health hubs' or community centres that combine pharmacy, dental, therapy, opticians, mental health and social care were also highly valued by respondents.
- Home-based care (district nurses, home visits, palliative care, specialist nurses) was highlighted as especially important for those with chronic conditions, disabilities, or limited mobility.
- People also told us they feel more comfortable, reassured, and confident when they can access care locally or at home. With some mentioning that community-based care feels more personal, less disruptive and better for people's mental and physical wellbeing.
- People also told us that they sometimes use hospital services because of bottlenecks in the community, and hospital services always being available.
- People were concerned about the fragility of our services from a staffing perspective and want to see Hywel Dda being an employer that can retain and support its staff.
- From an equity and inclusion perspective there was concern that those without cars, those living in rural areas, or those with disabilities are disadvantaged by current systems, with calls for fair access to care, transport and support, regardless of location or personal circumstances.

- Some raised that getting all necessary tests and treatments done efficiently and not repeating journeys for minor issues was an important factor.
- Others mentioned that they are willing to travel further for high-quality, specialist care if it means better health outcomes.
- Continuity and good communication between local and specialist services were also raised as important for patient confidence and care.

## 2.2.4 Clinical Services and Hospital Redevelopment

There was one question under this key theme, and it was:

1. 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?

This is what you told us in your responses:

- People told us that they want to see improvement in our estates and services. People are concerned about the need to bring services together further away from where they currently access services and the travel impacts as a result. This is similar to feedback that was received during the Clinical Services Plan consultation where people shared their concerns about how they will access timely care.
- People believe the development of community sites would be positive, as this would mitigate some of the concerns that people had around digital exclusion, while allowing them to access care locally. People also felt that these community schemes should consider a step up/ step down care model so that people could receive rehabilitation care in the community closer to home, which they believe would help relieve pressure on the hospitals.
- During the engagement we asked people where we should focus any investment into our buildings should funding become available. Recommendations ranged from improving and supporting the cleaning and maintenance around hospital sites to make them feel more comfortable and support patient experience, improving toilet and changing facilities at our hospitals, creating dedicated spaces for children and young people to make safer environments for them in mixed waiting areas, and improving signage through our buildings to help people navigate them more easily.
- Specifically, people consistently emphasised the need to make buildings safe, waterproof, warm, and structurally sound before investing in new features or services. There is a strong call to prioritise urgent repairs, address leaks, and ensure cleanliness and infection control throughout all facilities.
- Improving disabled access, wheelchair access, and the availability of affordable, convenient parking (including users with disability and their families) is a major concern. People also want clearer signage, floor textured pathways and easier navigation within and around hospital sites.
- Respondents want investment in modern equipment, technology, and digital infrastructure to support efficient, high-quality care. There is a desire for facilities to be adaptable and future-proofed to keep pace with clinical and technological advances.
- There is strong support for maintaining and upgrading local hospitals (e.g., Withybush, Bronglais, Prince Philip) to reduce the need for long-distance travel,

especially for older people, people with disabilities and those with young children. People want services to remain accessible in rural areas and not be overly centralised.

- Many responses highlight the importance of addressing staff shortages, burnout, and morale. People want staff (both clinical and non-clinical) to be involved in decisions about building priorities and design, and for staff facilities and rest areas to be improved.
- Training of reception, portering and health care staff in awareness of sight impairment and the additional support that sight impairment patients require, was also raised.
- People are concerned about minimising disruption to clinical services during building works. They suggest phased construction, temporary buildings, and careful planning to ensure continuity of care, especially for vulnerable groups.
- There is a call for spaces that are welcoming, safe, and accessible for all, including those with neurodivergence, mental health needs, or sensory sensitivities. Suggestions include private consultation spaces, family rooms, and areas for relatives.
- Reliable, affordable, and accessible transport is a recurring theme in response to this question. People calling for better and more hospital transport, volunteer drivers, and improved public transport links, especially in rural areas.
- Investment in community hubs, minor injuries units, and preventative care facilities is seen as a way to reduce pressure on acute hospitals and keep care closer to home.
- People want to see action, not just more surveys or bureaucracy and for funding to be used for patient care rather than administrative overheads. There is also concern about centralisation, loss of local services, and the impact on rural and vulnerable populations.

### **2.3 Findings from Phase 2 social media activity**

Overall, feedback from across our social media tells us that people want better care, easier access, shorter waits, and clear, honest updates.

The social media activity achieved a total reach of 246,286, generating 408,507 views and 15,476 clicks. Strong engagement was reflected in posts being shared 129 times, 1,737 reactions (likes etc.), and 231 comments.

- Many social media comments show that people are unhappy with their time in hospital and with how far and how long they have to travel.
- People also feel current services and GP appointments are not working well.
- A number of comments tell us that people do not trust the Health Board.
- People also talked about long waits, there not being enough local services, and experiencing problems with transport.
- Some stated that they want clear information about how to stay healthy and what people can do for themselves.
- Some commenters do not trust digital or online services.
- A smaller number mention poor communication from the Health Board and worry about the Welsh Government and NHS Wales.

- A few commenters point to good local services that already exist, and some ask for quicker checks so problems are found early.

### **3. Equalities issues and considerations**

#### **3.1 Introduction**

As part of the engagement analysis, we listened for areas that people feel may bring benefits or impacts to them or other groups of people. We also asked about and listened to suggestions about ways that we can reduce any negative impacts.

As part of our wider *A Healthier Mid and West Wales* programme, we have been developing and maintaining an Equalities and Health Impact Assessment (EHIA), which has been updated whenever we have engaged on our strategy or parts of the strategy delivery. Our EHIA is a live document and we will continue to update it as new information is provided to us.

#### **3.2 Existing themes emerging from strategy refresh engagement**

There were some themes that were raised that have already been shared and captured within our EHIA. These were mainly based around transport for patients and their visitors, availability of public transport and car parking at our sites. We also heard concerns around the impact of travelling further for specialist care and what this means for patients, and those who may be supporting them, to attend appointments.

We also heard concerns about digital exclusion, particularly those who are elderly and may not have the skills or access to use digital systems such as apps or video calling. These had previously been noted within the EHIA along with the recommendation that face-to-face options remain for those who have a digital access barrier.

#### **3.3 New themes emerging from strategy refresh engagement**

There were six new themes identified during the analysis of the engagement activity, which have been included within the EHIA document, for consideration when delivering the strategy. These related to people's age, whether they have a disability, whether they care for others with disabilities, and financial barriers that people face when trying to live a healthy life.

Concerns were raised about people's ability to continue using digital technology as they age, with skills potentially being lost if they grow less confident.

People raised concerns about the lack of spaces for children and young people in our hospital and community sites to wait safely, either as a patient or a child or grandchild of a patient. We were also asked to consider how we can provide a safe environment for young carers, who may be supporting patients. This would help them to also have a positive experience when spending time in our sites.

People raised concerns about accessibility of digital services for those with sensory loss or disability, and how they could make sure that their information is kept safe, but accessible when they need it.

Lastly, people raised concerns that children in poverty and households with low incomes could face more barriers to living a healthy life if they don't have the same access to community support as those with more money. They were worried that this would lead to some people living longer healthier lives, while those with less money would experience poorer health.



## PWYLLGOR STRATEGAETH A CHYNLLUNIO STRATEGY AND PLANNING COMMITTEE

<b>DYDDIAD Y CYFARFOD: DATE OF MEETING:</b>	16 January 2026
<b>TEITL YR ADRODDIAD: TITLE OF REPORT:</b>	Community by Design Strategic Plan
<b>CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:</b>	Lee Davies, Executive Director of Strategy and Planning
<b>SWYDDOG ADRODD: REPORTING OFFICER:</b>	Rhian Bond, Assistant Director of Primary Care

<b>Pwrpas yr Adroddiad (dewiswch fel yn addas) Purpose of the Report (select as appropriate)</b>
Er Sicrwydd/For Assurance

### ADRODDIAD SCAA SBAR REPORT

<p><u>Sefyllfa / Situation</u></p> <p>The purpose of the report is to present to Board the progress with the Community by Design Strategic Plan (formerly known as the Primary Care and Community Services Strategic Plan), which aims to transform the future model of service delivery and support the delivery of A Healthier Mid and West Wales (AHMWW).</p> <p>The attached document (Appendix 1) is the first draft for Board consideration, setting out the work undertaken to date, the emerging direction of travel and the framework for progressing the Strategic Plan. The Strategic Plan, as a key component of A Healthier Mid and West Wales, is designed to support the transformation of our health system to one that is orientated towards prevention, early intervention and care in communities. As such this needs to be at the heart of our activities and decision-making on a daily basis, rather than a one-off event. Consequently, the Strategic Plan is intended to be a living document and will be updated as the work progresses.</p> <p>The next key date will be the finalisation of the Annual Plan for 2026/27 and this will include the key deliverables for next year and the three-year context.</p>
<p><u>Cefndir / Background</u></p> <p>Primary Care and Community Services are the front door to the NHS, delivering the majority of patient contacts and shaping people's experience of care; and is the driver of the majority of patient outcomes.</p> <p>Hywel Dda University Health Board (HDdUHB) serves an ageing and rural population with demand for services rising faster than workforce capacity. National policy, including Community by Design and the Primary Care Model for Wales reinforces the need to provide more care in communities and strengthen prevention, integration and early intervention.</p>

The development of the draft Strategic Plan has been shaped by engagement with patients, staff and partners, aligns with national policy and is a key component of the 'A Healthier Mid and West Wales' strategy. It will require continued engagement in 2026 to build on these foundations.

When developing the plan feedback was gathered from GPs, practice managers, optometrists, community pharmacists, community dental services, allied health professionals, mental health, and health science teams. Key themes from engagement have included: sustainability, funding, digital innovation, joined up working and long-term support.

Insights from the 'Insights and Ideas' (Appendix 2) document highlight that stakeholders want fair, well-planned changes, improved access for rural patients, adequate and long-term funding, better training, improved buildings and easier information sharing. They also support technology use (including AI) and innovation to improve care and efficiency.

### Asesiad / Assessment

The draft Plan articulates that services are at risk of becoming unsustainable without significant transformation whilst summarising the issues highlighted within the primary care issues paper<sup>1</sup>, the community services issues paper<sup>2</sup> and engagement feedback.

The plan sets out a vision for integrated, place-based care, with a focus on prevention, partnership, digital innovation, and workforce development. It introduces a draft clinical model based on international and national evidence that shows that strong primary and community care systems improve population health, reduce inequalities, and deliver better value for money with a focus on the '4Cs' framework.

Detailed in the draft plan, includes the current configuration of Clusters and a proposal to review Cluster arrangements that will assist in the delivery of the Community by Design Programme.

In the summer 2025 the project team engaged with clinicians through the professional collaboratives for GP Practices, Community Pharmacies and Optometric Practices. The feedback and ideas (detailed in the Insights and Ideas appendix) helped us identify six priorities for the Strategic Plan. At this time the project team were unable to meet with the Nursing collaborative, however a date has been confirmed for January 2026 where the team will seek to hear their views and ideas.

### **Six Priorities**

As a result of the engagement, six priorities have been identified:

- Priority 1: **Prevention** - build a culture that empowers both our patients and teams to lead on prevention and early intervention, promoting healthier lives and more sustainable services
- Priority 2: **Partnership Working** - fully commit to strategic and operational collaboration to deliver a comprehensive and holistic, integrated health and care system across the region

<sup>1</sup> [hduhb.nhs.wales/about-us/your-health-board/board-meetings-2024/board-agenda-and-papers-28-march-2024/board-agenda-and-papers-28-march-2024/item-4-3-clinical-services-plan-issues-paper-pdf/](https://hduhb.nhs.wales/about-us/your-health-board/board-meetings-2024/board-agenda-and-papers-28-march-2024/board-agenda-and-papers-28-march-2024/item-4-3-clinical-services-plan-issues-paper-pdf/)

<sup>2</sup> [hduhb.nhs.wales/about-us/your-health-board/board-meetings-2024/board-agenda-and-papers-28-november-2024/board-agenda-and-papers-28-november-2024/3-7-update-on-a-healthier-mid-and-west-wales-strategy-pdf/](https://hduhb.nhs.wales/about-us/your-health-board/board-meetings-2024/board-agenda-and-papers-28-november-2024/board-agenda-and-papers-28-november-2024/3-7-update-on-a-healthier-mid-and-west-wales-strategy-pdf/)

- Priority 3: **Access** - make health, care and wellbeing information and services as accessible as possible for our patients, our partners and our workforce
- Priority 4: **Digital** – make our Digital offer for our patients, our partners and our workforce seamless, holistic and accessible; to enable all teams to share information, trust information and deliver the best patient care
- Priority 5: **Estates and Infrastructure** - shape the region’s estate and infrastructure to maximise the delivery of sustainable, prevention-focussed holistic health and care in the community
- Priority 6: **Workforce and Sustainability** – develop our workforce to deliver a sustainable, multi-disciplinary service that will support the shift to a community-based model of care and maximise prevention focussed patient outcomes

### Hurdle criteria

The next step to delivering a strategic plan that is fit for purpose now and for the future, relies on the emerging ideas and actions to be tested to see if they are deliverable from a statutory, strategic, perspective and that they are viable, sustainable and measurable. The four areas that are the focus of the hurdles are:

1. Improved quality (Safe, Timely, Effective, Equitable and Person-centred (STEEP))
2. Whole system
3. Strategic alignment
4. Deliverable and affordable

The following hurdle criteria provides the Health Board with a universal approach to assessing service change that can be applied across the organisation.

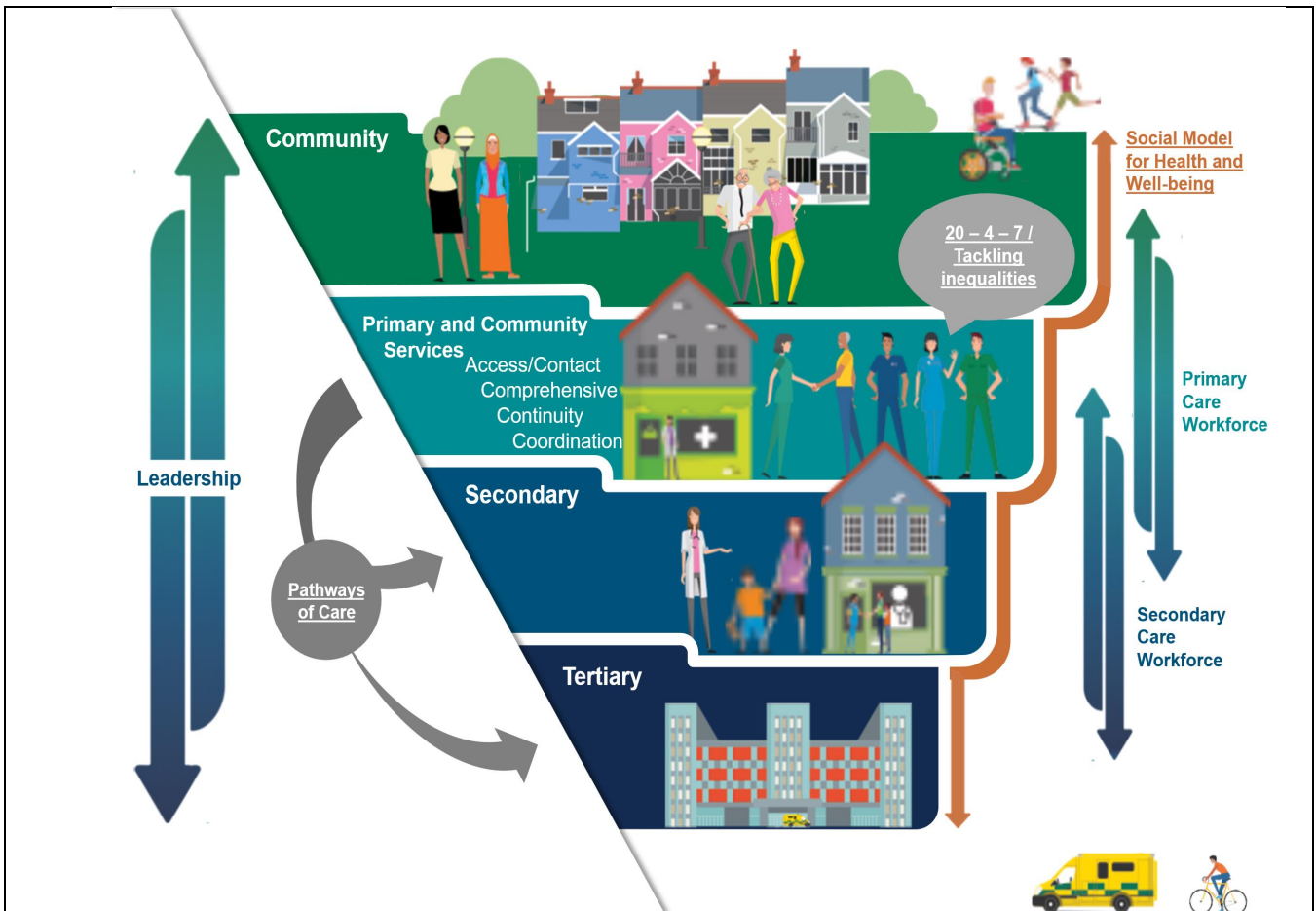
Hurdle Criteria	As an example (Community by Design) To achieve this, proposals should...
Improve quality (STEEP)	<ul style="list-style-type: none"> <li>• Be assessed against the STEEP framework - safe, timely, effective, equitable and person-centred</li> <li>• Utilise the Health Board’s health equity checklist to impact on reducing health inequalities and improving outcomes for disadvantaged groups</li> <li>• Support continuous learning and quality improvement</li> <li>• Promote holistic person focused and preventative care</li> <li>• Enhance (or not disrupt) the 4Cs of primary care</li> </ul>
Whole system	<ul style="list-style-type: none"> <li>• Demonstrate integrated, whole system response that reflects the principles of our Social Model for Health and Wellbeing – addressing wider determinants of health such as housing, transport, education, employment or the environment</li> <li>• Reinforce the aim of local, place (cluster)-based planning</li> <li>• Consider all contractor professions and third sector partnerships along with directly employed staff</li> </ul>

	<ul style="list-style-type: none"> <li>• Interface with all other aspects of Health Board planning e.g. acute and planned care services</li> <li>• Have involved staff, trade unions and the public in the design at the earliest opportunity</li> </ul>
Strategically aligned	<ul style="list-style-type: none"> <li>• Progress the aspirations of A Healthier Mid and West Wales and the national programmes of Community by Design and Primary Care Model for Wales</li> <li>• Align with principles of primary and community clinical model</li> <li>• Reflect the 20four7 model, prioritising primary and secondary prevention/early intervention, and building capacity to care in disadvantaged communities</li> <li>• Be future-orientated, long-term and not setting any unhelpful precedents</li> </ul>
Deliverable and affordable	<ul style="list-style-type: none"> <li>• Be clinically and operationally deliverable within a medium-term (3-5 years) timeframe, to include workforce, estate and capital requirements</li> <li>• Have a realistic possibility, based on evidence, of being affordable over the medium term using existing resources, including the reallocation of current Health Board resources</li> <li>• Accommodate contractual changes including directed supplementary services</li> <li>• Reflected value-based healthcare principles, including wider system and societal benefits and costs for partners, the public, and the regional health economy</li> <li>• Consider process and outcome evaluation of any novel service</li> </ul>

### Clinical Model

Work has progressed to develop a draft clinical model, ensuring this complements and aligns with the Urgent and Emergency Care (UEC) system model, 20-four-7 Health Pathway Framework and planned care pathways. The clinical model is based on the 4Cs:

- Access/Contact
- Comprehensive
- Continuity
- Co-ordination



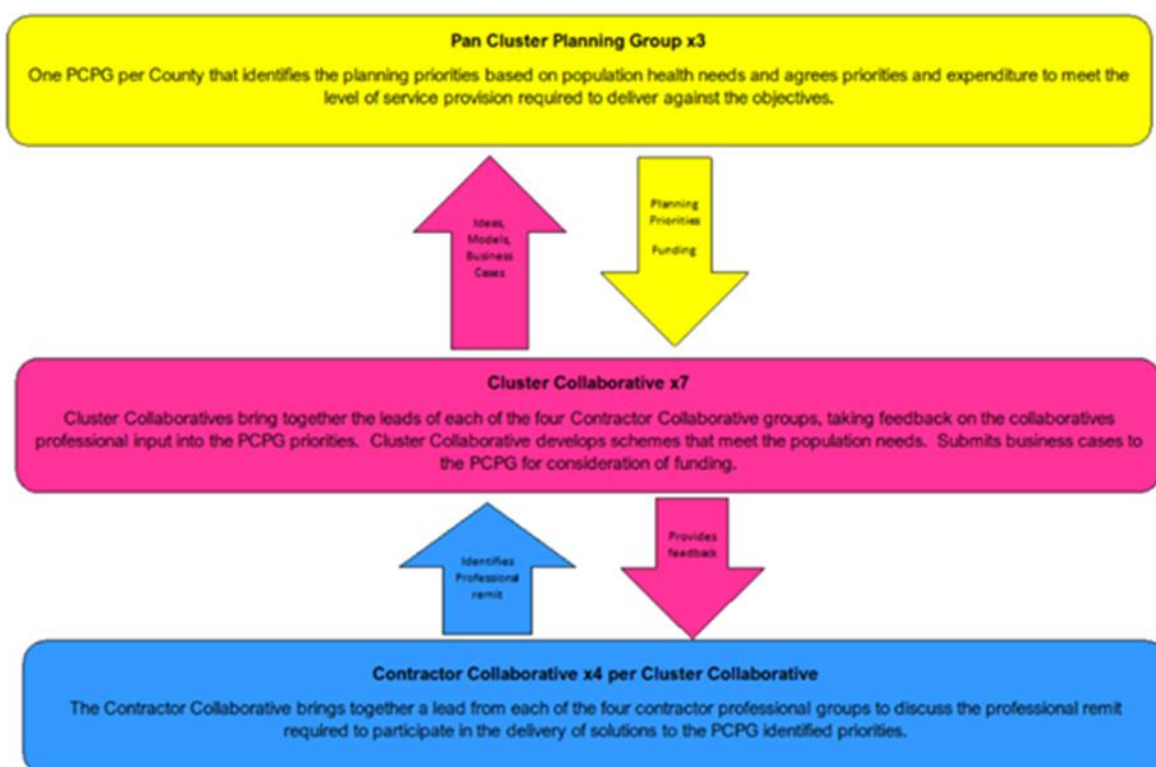
To test and gather feedback on the clinical model, engagement sessions have been scheduled throughout January 2026.

When	Who
Tuesday 13 January 19:00 - 20:00	Community Pharmacy (Ceredigion)
Wednesday 14 January 13:00 - 14:30	GP (Pembrokeshire)
Thursday 15 January 14:00 - 15:00	Nursing Collaborative
Thursday 15 January 19:00 - 20:00	Community Pharmacy (Carmarthenshire)
Tuesday 20 January 13:00 - 14:30	GP (Carmarthenshire)
Tuesday 20 January 19:00 - 20:00	Community Pharmacy (Pembrokeshire)
Thursday 22 January 13:00 - 14:30	GP (Ceredigion)
Tuesday 27 January 19:00 - 20:00	Optometry (all 3 Counties)
Wednesday 28 January 13:00 - 14:00	Allied Health Professionals (AHP) & Health Sciences
Thursday 29 January 13:00 - 14:00	Community Dental Services

## Next Steps

1. **Establish Hywel Dda Transformation Programme arrangements** that mirror the governance, assurance, and delivery approach of the Community by Design (CbD) National Programme.
2. **Arrange and deliver workshops on a cluster footprint basis** to review current arrangements and explore the potential future design of Cluster Planning Groups (CPGs) and Clusters to ensure they are well placed to drive forward the CbD Strategic Plan and, beyond that, the vehicles for system change in the Health Board.

## Current Configuration



3. **Meet with professional collaboratives and the Six Goals Programme and 20-four-7 Programme** to further engage clinicians and develop the Clinical Model, ensuring alignment with national clinical direction and Whole System approach (*January 2026*).
4. **Develop the 2026/27 Annual Plan** setting out the key deliverables for Community by Design through next year and the broader ambition for the next three years.
5. **Establish a structured engagement campaign** involving clinicians from Primary and Secondary Care and partners to explore current insights and challenges, generate ideas, and develop a range of options under priority headings.
6. **Create structured appraisal sessions** to take all ideas and emerging options through an agreed hurdle criteria process, enabling consistent assessment and identification transformational solutions that benefit patients and whole systems operations.
7. **Build on engagement with external partners across social care and the third sector** to communicate strategic priorities, update them on progress to date, and

actively seek their views on opportunities to strengthen integration, collaboration and joint service delivery.

### Argymhelliad / Recommendation

The SPC Committee is asked to support this submission to Board to:

1. **AGREEMENT** that the Strategic Plan is further developed in line with the six priorities of:
  - Prevention
  - Partnership Working
  - Access
  - Digital
  - Estates and Infrastructure
  - Workforce and Sustainability
2. **APPROVE** the hurdle criteria as the tools for assessing the ideas and options and investments generated to date
3. **ENDORSE** the work to date on the draft Clinical Model for Primary and Community Care based on the 4Cs: Contact, Coordination, Comprehensive, Continuity
4. **CONSIDER** the ideas from 'Insights and Ideas', to be appraised through the hurdle criteria
5. **ENDORSE** the plan to review cluster arrangements and the establishment of a Transformation Group.

### Amcanion: (rhaid cwblhau)

### Objectives: (must be completed)

Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	Primary Care and Community Strategic Plan Group
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	<p>1937 – Risk of Enforcement Notice being served by Mid and West Wales Fire and Rescue Authority due to non-compliance (8)</p> <ul style="list-style-type: none"> <li>➤ 1869 – Risk of NHS Dental Services not achieving Patient Charge. Revenue income targets due to lower activity/income at practices (6)</li> <li>➤ 572 – Risks of patients deconditioning due to fragile domiciliary care provision (8)</li> <li>➤ 576 – Fragile EMI and General Nursing Home availability due to degeneration of residential homes affecting Ceredigion County (6)</li> <li>➤ 1171 – Risk of avoidable medication related patient harm due to no e-prescribing and electronic medication administration system (6)</li> <li>➤ 1231 – Risk to patient flow due to demands and pressures on the community health and social care system (6)</li> <li>➤ 1451 – Risk of increasing unsustainability of GMS Practices due to Independents Contractors service notice on their Contracts (6)</li> <li>➤ 1708 – Risk of increasing fragility in primary care contractor services due to recruitment challenges (6)</li> <li>➤ 1823 – Risk of sustainability of NHS Dental Services (6)</li> <li>➤ 1951 – Risk of overspend against Specialist</li> </ul>

Palliative Care budget due to potential withdrawal of funding of permanent posts (6)

➤ 695 – Risk to sustainability of Care Home Sector due to financial, operational and service-level issues (6)

➤ 1437 – Risk to patient safety due to insufficient administrative resource to cover Specialist Palliative Care service (6)

➤ 1570 – Risk to timely assessments/interventions due to Community Nursing Pressures (6)

➤ 1898 – Risk to management of patient information due to lack of single electronic patient file (6)

➤ 1900 – Risk of patient harm due to increased waiting times to access specialist care from Heart Failure CNS Team (6)

➤ Risk of not achieving savings targets due to continued expenditure without mitigating savings plans (6)

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➤ 1109 – Risk of no Doctor days in Managed Practices due to challenges in securing GP cover (6)

➤ 1427 – Risk of community patient – held records being mislaid due to a lack of appropriate electronic systems (8)

➤ 1852 - Partial compliance with national premises guidance in Managed Practiced (6)

➤ 1517 – Risk of poor patient and harm experience due to escalating routine Physiotherapy waiting times (8)

➤ 1820 – Risk of patient harm due to the withdrawal of funding for the Diabetes Remission Service (8)

➤ 1894 – Risk of stroke patients not receiving the therapy rehabilitation then need due to lack of staffing (6)

➤ 1877- Risk of financial impact on service deliver due to lack of reoccurring funding for Prevention and Early Years from Welsh Government (8)

➤ 1316- Risk to harm to patients who require rehabilitation due to inadequate therapy capacity (6)

➤ 1631 – Risk of failure to achieve financial management objectives due to staff shortages and fragility of agency provision (6)

➤ 1738 – Risk of a lack of accommodation for Smoking Cessation team at Bronglais Hospital due to local changes by management team (6)

➤ 1319 – Risk of patient harm due to inability to access and manage digital health documentation systems (8)

➤ 1513 – Risk of harm to patients and staff due to

	unsuitable environment and working conditions of current clinical accommodation (6)
Parthau Ansawdd: Domains of Quality <a href="#">Quality and Engagement Act (sharepoint.com)</a>	7. All apply
Galluogwyr Ansawdd: Enablers of Quality: <a href="#">Quality and Engagement Act (sharepoint.com)</a>	Not Applicable
Amcanion Strategol y BIP: UHB Strategic Objectives:	All strategic objectives are applicable
Amcanion Cynllunio Planning Objectives	7 Primary Care and Community Strategic Plan
Amcanion Llesiant BIP: UHB Well-being Objectives: <a href="#">Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022</a>	All strategic objectives

<b>Gwybodaeth Ychwanegol: Further Information:</b>	
Ar sail tystiolaeth: Evidence Base:	Ideas and insights Primary Care issues Paper Community Services Issues Paper Primary Care and Community Clinical Model
Rhestr Termiau: Glossary of Terms:	Contained in report
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Strategaeth a Chynllunio Parties / Committees consulted prior to Strategy and Planning Committee:	

<b>Effaith: (rhaid cwblhau) Impact: (must be completed)</b>	
<b>Ariannol / Gwerth am Arian: Financial / Service:</b>	Linked to Strategic Refresh
<b>Ansawdd / Gofal Claf: Quality / Patient Care:</b>	Improved quality of service and access

<b>Gweithlu: Workforce:</b>	Improved quality of workforce and sustainability
<b>Risg: Risk:</b>	Financial
<b>Cyfreithiol: Legal:</b>	Subject to contractual obligations
<b>Enw Da: Reputational:</b>	Links to the strategic refresh AHMWW
<b>Gyfrinachedd: Privacy:</b>	Not applicable
<b>Cydraddoldeb: Equality:</b>	Options generated will be subject to EQIAs

Hywel Dda University Health Board

Community by Design Strategic Plan

Enabling *A Healthier Mid and West Wales*

January 2026

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## Introduction

Primary and community care sits at the heart of the health and care system in Hywel Dda University Health Board. They are the places and services people turn to every day, accessing GP practices, community pharmacies, dental services, optometry, district nursing teams, mental health support, and countless other services in their communities. These services shape how people experience healthcare because they are close to home, accessible, personal, and focused on keeping people well for as long as possible.

Primary care has always been considered as the front door to the NHS. For generations it has provided trusted first-contact care, built on long standing relationships with patients, families and the communities they serve. We know that this front door is under unprecedented pressure, with rising demand, workforce constraints and increasing complexity meaning many services are struggling to provide the responsive, personalised care that has defined primary care for decades. While transformation may feel challenging under these circumstances, change is essential as the struggle in primary care impacts directly on the health of our population and demand on the wider system, e.g. Secondary Care services.

We are excited to share with you the work undertaken to date to develop a Community by Design Strategic Plan. We are committed to the development of a plan that is clinically led and continues to be shaped by our workforce, partners and patients and part of a wider system view.

The Strategic Plan's scope was agreed in May 2024, to focus on: **Primary and Community services which provide safe, sustainable and accessible services to patients, as close to the patients home as possible.**

### **We will do this by:**

- Using the principles of a social model for health and wellbeing
- Using the evidence, based on world class Primary and Community services
- Supporting patients to access timely and appropriate health and social care when needed
- Ensuring that every contact counts and that Value Based Health and Care principles are at the core of what we do
- Designing Primary care and Community Services that are sustainable and able to deliver modern health care in appropriate environments.

### **In scope:**

- Primary care contracted services (General Medical Service, Optometry, Community Pharmacy and General Dental Services)
- Out of Hours services, 24/7 and Urgent Primary care
- Community Dental Services
- Health Board Managed Practices
- Community Nursing services
- Community provision including social prescribing, multi-disciplinary working, Community Resource Teams, outreach service provision e.g. leg ulcer clinics etc

- Health Board wide framework for the design and development of services at Pan Cluster Planning Groups at County level (Integrated Locality Planning)

## What is Primary Care & Community Care?

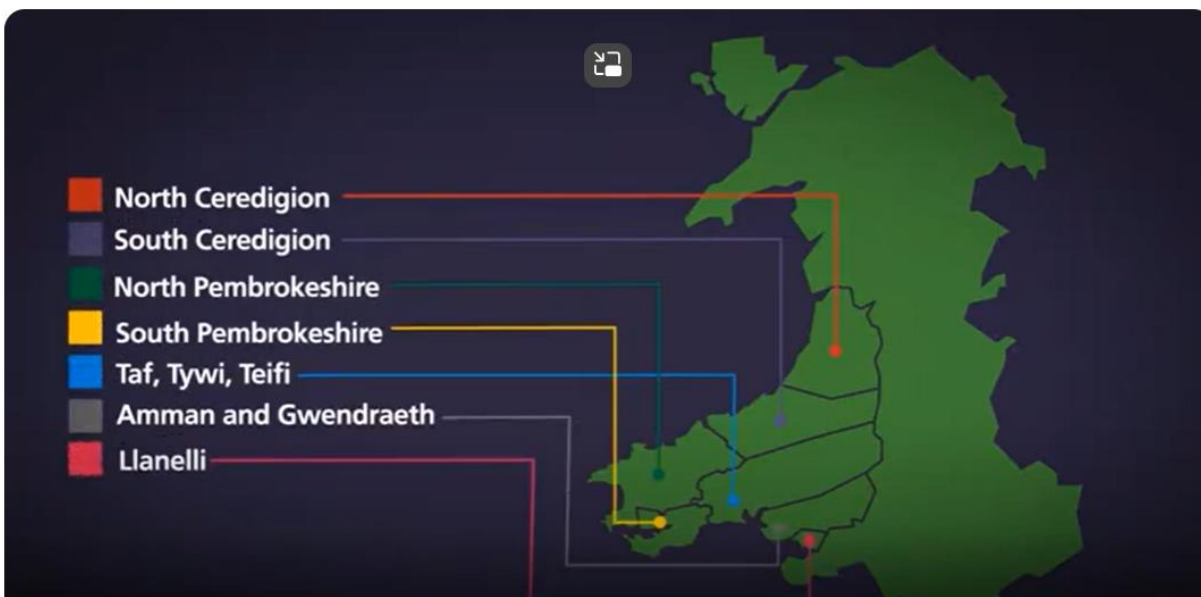
The Primary care Model for Wales defines primary care as a shorthand term to refer to health and wellbeing services delivered at home or in the community. Whilst often funded and delivered by the NHS, it can also be delivered in partnership with Local Authorities, Third and Independent Sector and our communities themselves.

For the purposes of establishing a baseline, primary and community care could be defined as:

- Primary care: Services within the community that are typically contracted and provide the first point of contact for individuals within the healthcare system. This includes general practice, community pharmacy, dental, and optometry services.
- Community Care: Services delivered in community settings that support ongoing health and wellbeing, often for people with long-term conditions, complex needs, or requiring rehabilitation. This may include community nursing, community hospitals, therapies (such as physiotherapy, occupational therapy, speech and language therapy), and other locally commissioned services that are not hospital-based.

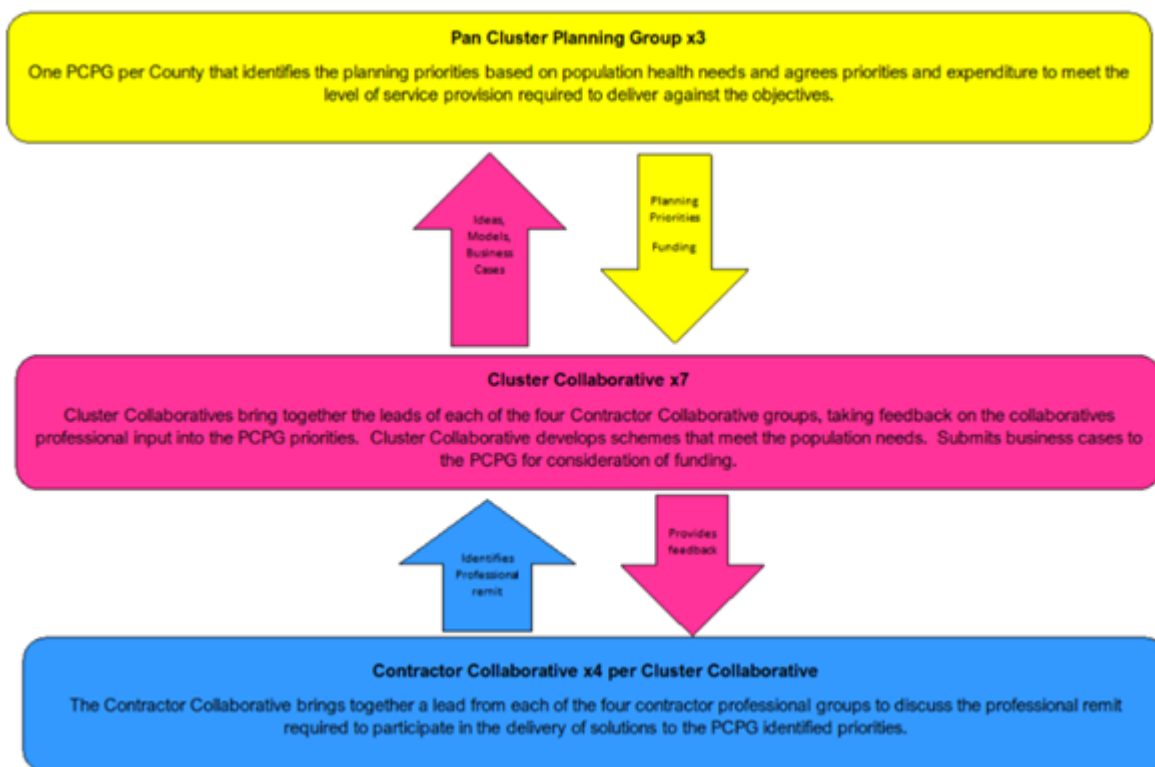
## Clusters

Currently Hywel Dda has seven Primary Care Clusters that are multi professional groups that consider local needs, seek opportunities to work together more effectively and plan new approaches. The seven Clusters currently work under three Pan Cluster Planning Groups and come together to collaborate with representatives of health board, local authority, public health experts to consider which services are planned at county, health board/regional level.



The seven primary care Clusters and three Pan Cluster Planning Groups are aligned to the model of working that was set out as part of the Accelerated Cluster Development (ACD) programme by the National Strategic Programme for Primary Care. The role of the Pan Cluster Planning Groups is to set the strategic direction based on the population health needs for their geographical area with the members of the Primary Care Clusters working with the Professional Collaborative leads (contractually required for GP Practices, Optometry and Community Pharmacy) including Community Nursing and Allied Health Professions and Health Scientists.

The current configuration is set out below:



Through our engagement clinicians strongly support clusters becoming the core delivery unit for prevention, early intervention, long-term condition management, and multidisciplinary working. Feedback calls for:

- a meaningful shift of resources and activity from acute to community settings,
- strengthened local leadership through a Cluster Programme Board,
- enhanced MDT roles and evidence-based pathways,
- closer alignment of community services with cluster footprints.

In considering Clusters as the future delivery vehicle for driving system-wide change across key priority areas, a review of the Cluster configuration will be required to ensure it is fit for purpose and aligned to the Community by Design (CbD) programme<sup>1</sup>.

<sup>1</sup> [1 - Community By Design 0.7 - English.docx](#)

## Primary care contracting

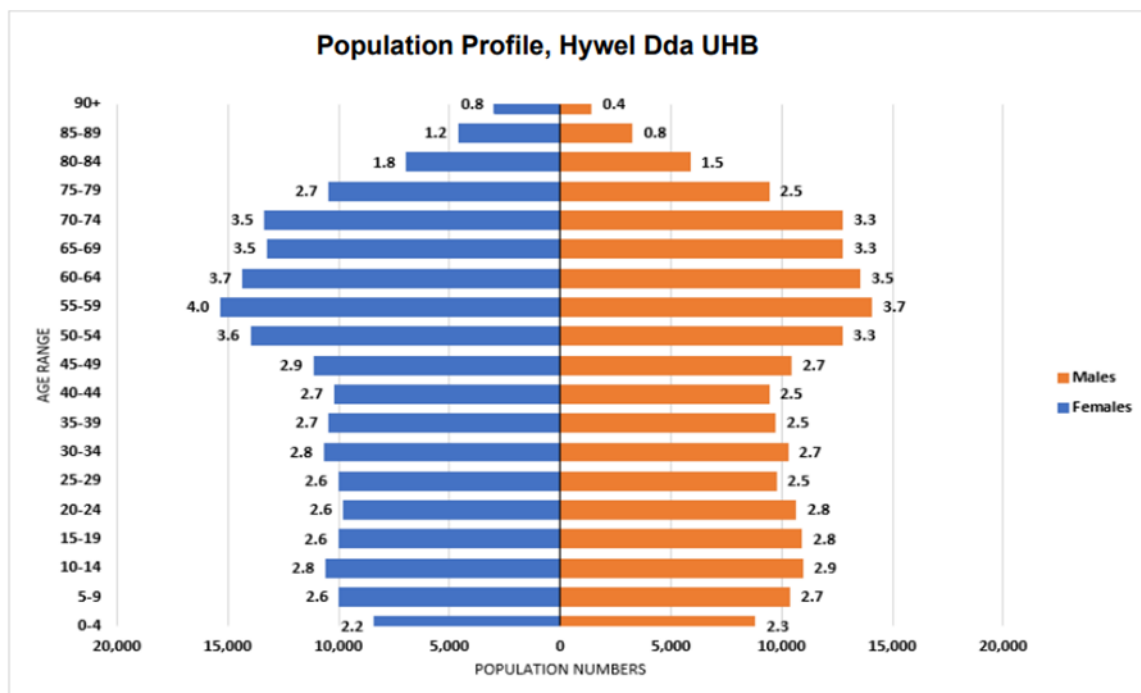
We know that Primary care is a fundamental part of the health and care system. However, it has a unique relationship within the health system due to how it is organised and paid for. This has an impact on how changes and challenges in primary care can be addressed, both in terms of decision making and time scales for transformation.

Primary care service provision is delivered through the four contractor services. The shape and scope of the service on offer is based on this contractual relationship and the All-Wales negotiated Contracts and payment regime. The common factor in all four services is the tripartite nature of the Contract negotiations; the negotiations that are held to review and renegotiate terms, payments, and service level reporting.

At the time of writing, negotiations for General Medical Services (GMS), more commonly called general practice (GPs), have concluded and whilst a formal announcement has been made the detail around the level of work required to ensure successful implementation has not yet been shared. optometry and community pharmacy negotiations have concluded and been announced. The consultation on the dental contract has been completed; however further detail is required before implementation can proceed. The new contractual arrangements are due to be in place from 1 April 2026. This dynamic national landscape reinforces the need for an adaptable and responsive strategic approach within Hywel Dda's Primary and Community Care planning.

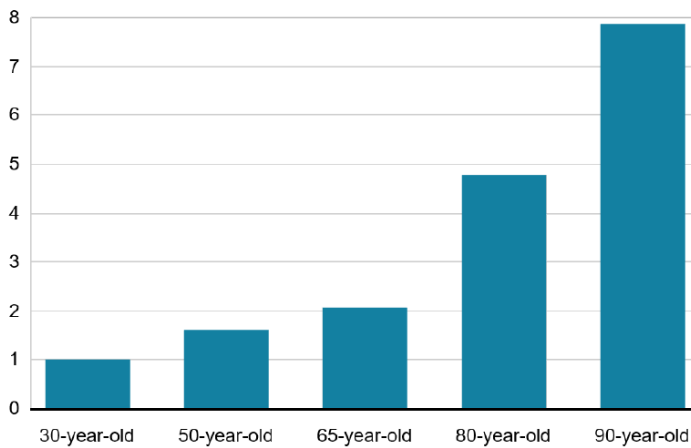
## Our Population

As of the latest estimates (StatsWales, 2018-based projections), Hywel Dda University Health Board serves a population of 388,682. 49.1% live in Carmarthenshire, 32.7% in Pembrokeshire and 18.2% in Ceredigion. The populations of Carmarthenshire and Pembrokeshire are growing whilst the population of Ceredigion is reducing. Projections suggest that the total population will rise to approximately 396,000 by 2043.



Source: ONS 2022

Relative cost in £

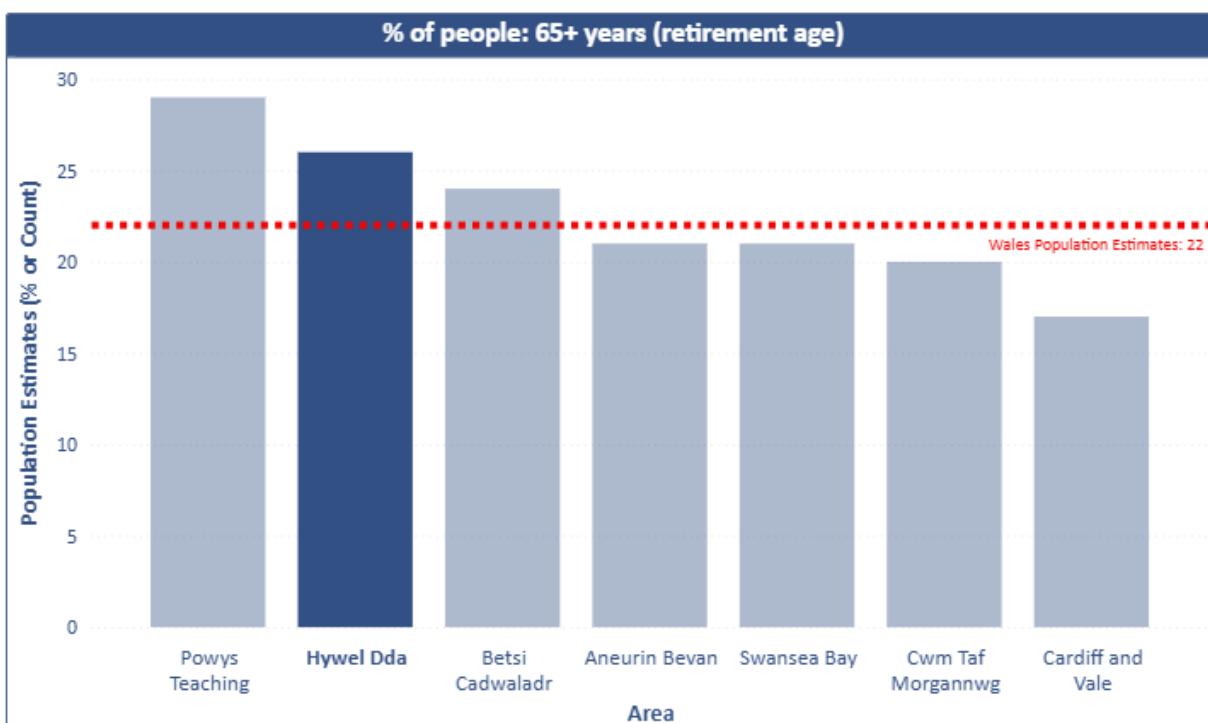


The Chart on the left illustrates the financial impact of average healthcare usage by adult age bracket. This shows the significance of an increasing average population age.

Source: Institute for Fiscal Studies, as reported on BBC News (05/11/2019) “11 charts on why the NHS matters in this election”

The proportion of Wales aged over 65 is expected to increase from 22% today to around 26% in 2043. The ageing of the population has however already happened in Hywel Dda, 27% of our residents are over the age 65 and this is expected to increase further to 31% in 2043, with Pembrokeshire reaching 34%. Proportionally, this trend accelerates for older age groups. For example, between 2018 and 2043 the number of people aged over 90 is predicted to increase by 93%, equivalent to over 4200 additional nonagenarians in West Wales.

Meanwhile the working age population is shrinking across all three counties. By 2043 it is projected that the population aged 16-64 will have reduced by 14,500 with the most significant fall in Ceredigion (15.6%). This combination of more older people and fewer of working age is a trend seen for Wales as a whole but is particularly pronounced in rural areas – West Wales, Powys and North Wales. The working age population is expected to continue to grow for the rest of South Wales, driven by proximity to the three cities of Cardiff, Swansea and Newport.



Gains in life expectancy have stalled, and inequalities between the least and most deprived populations have widened. The life expectancy gap between the least and most deprived increased from 3.8 to 4.7 years for men, and from 3.3 to 4.5 years for women between 2011–13 and 2020–21. The disparity in healthy life expectancy is now 12.5 years for men and 9.3 years for

Around one in five deaths are now preventable. All-cause mortality rates for people under 75 years of age rose from 324 to 365 per 100,000 between 2014 and 2023.

## Why are we producing a Strategic Plan?

Across the world, strong primary and community care systems are recognised as integral to healthier populations. They prevent illness, help people manage long-term conditions, and reduce the pressure on hospitals by solving problems early. This holds true in Wales. A King's Fund report in 2024<sup>2</sup> highlighted that around 90% of NHS activity takes place in primary or community settings - a reminder that these services are not just important; they are indispensable.

The paper *Primary Care Systems* sets out the case for strengthening primary care and community services (APPENDIX 1). The resilience of primary care and Community services is critical. A fragile and unstable primary care system poses significant risks, with the potential for devastating consequences for people across Wales. Strong international evidence shows that poor-quality or inaccessible primary care leads to worse health outcomes, increased h

Health inequalities, higher demand on acute services, and greater overall system costs. Conversely, high-quality primary care is a cornerstone of population health, supporting wellbeing while also delivering significant social and economic value

Across Wales, annual investment in primary care exceeds £1 billion, supporting General Practice, General Dentistry, Community Pharmacy, and Optometry services for a population of around 3.2 million people.

The central role played by primary care and community services in the whole health system means that the success of the strategic plan relies on being a joint enterprise across all the wider health and care system and beyond. This includes education and employment. Therefore, whilst the strategic plan is concentrating on primary care and Community Services, it is really a whole system action plan.

Our work to date has identified six priority areas – Prevention, Partnership working, Access, Digital Offer, Estate and Infrastructure and Workforce and Sustainability. These priorities are shaped by, and should conversely shape, the strategic and operational plans of all Health Board services and functions. Most notably the Digital Response, the Future Workforce plan and the 20four7 population health model. A mapping exercise (APPENDIX 2) has been undertaken to highlight potential areas of alignment and / or duplication, in the attempt to highlight the jigsaw of ambitions and ideas that the whole system can commit to deliver.

In line with the aspirations of *A Healthier Mid and West Wales*<sup>3</sup>, in primary care and community services our ambition is to shift from a service that simply treats illness to one that keeps people well, prevents ill-health or deterioration, and provides help early, long before conditions become crises. This requires widening the lens of health services to recognise that most of what shapes health often happens outside of health care itself. This provides the opportunity to focus on preventative holistic healthcare.

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<sup>2</sup> <https://www.kingsfund.org.uk/insight-and-analysis/data-and-charts/NHS-activity-nutshell>

<sup>3</sup> [hduhb.nhs.wales/about-us/healthier-mid-and-west-wales/healthier-mid-and-west-wales-folder/documents/a-healthier-mid-and-west-wales-strategy/](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/)

The Social Model for Health and Wellbeing (SMfHW) highlights that wellbeing is shaped by income, education, housing, employment, environment, trauma, and inclusion. These social determinants account for around 80% of health outcomes, far outweighing the impact of healthcare alone. Yet the gap in healthy life expectancy has not improved since 2011, and our most disadvantaged communities continue to experience the worst outcomes.

The burden of ill health disproportionately falls on the 20% most deprived people in our communities, whose health is more heavily influenced by socioeconomic pressures and by the four major behavioural risks (smoking, nutrition, alcohol, physical activity). This is why prevention cannot be limited to clinical advice; it must extend into the conditions of daily life.

However, no single organisation can improve health and wellbeing alone. The move to deliver services through a social model, rather than a medical model focusses on bringing together health, local government, the third sector, communities, and people themselves to strengthen resilience and reduce avoidable harm.

There are many key drivers within the Health Board that are influencing and shaping the strategic direction noting the following:

## A Healthier Mid and West Wales Strategy Refresh

In November 2024 work began to revisit and refresh the *A Healthier Mid and West Wales Strategy* that was ratified in 2018. The refresh was aimed at reviewing whether the strategic aims and objectives are still valid and can remain as they are, what elements are still valid but require revising to reflect, for example, demographic changes and which elements need refreshing because the current situation is fundamentally different from that which the Health Board was facing in 2018. We know that there are some key differences, most notably around the use of digital systems and AI.

The refresh has put forward four strategic objectives with eight attendant planning goals, one of which is primary care and the Community by Design and anchors the production of the strategic plan as a key driver in the delivery of *A Healthier Mid and West Wales Strategy*.

## The 20four7 Population Health Framework

The Health Board has committed to becoming a population health-focussed organisation, delivered through its *20four7 Population Health Framework*<sup>4</sup>. This framework aims to reduce avoidable ill health and improve long-term outcomes and provides a clear direction of travel for the strategic plan by outlining the areas of focus for prevention and early intervention and providing clarity on the Health Board's plan to tackle inequity. The framework informs the strategic plan by focussing on the following areas:

- The 20% of the population that is most socioeconomically deprived and directing its attention and resources towards those most affected by avoidable ill health

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<sup>4</sup> [hduhb.nhs.wales/about-us/your-health-board/board-meetings-2025/board-agenda-and-papers-27-november-2025/board-agenda-and-papers-27-november-2025/22-director-of-public-health-annual-report-pdf/](https://hduhb.nhs.wales/about-us/your-health-board/board-meetings-2025/board-agenda-and-papers-27-november-2025/board-agenda-and-papers-27-november-2025/22-director-of-public-health-annual-report-pdf/)

- The four major modifiable behavioural risk factors make up much of the preventable illness, early death, and health inequality in our population. They are smoking, poor nutrition, alcohol, and physical inactivity
- The seven prevention priority areas where early intervention can show the greatest impact on improving outcomes, reducing system pressures, and supporting healthier lives. They are children and young people, older people and frailty, cancer, cardiovascular disease, mental health, respiratory conditions, and diabetes.

## Community by Design

The *Community by Design* model aims to improve health outcomes by taking a whole system approach to delivering health and care services closer to home for the people of Wales, with services designed around and integrated to meet the needs of individuals and communities. Following a summit in October 2025, Health Boards have been issued a national action plan (APPENDIX 3). A national Transformation Board has been established to oversee delivery, with an expectation that each Health Board will mirror this governance structure locally. The Community by Design Transformation Board is led by the Chief Medical Officer and therefore a proportion of the direction of travel for service shift will be nationally agreed and directed. The first meeting of the national Transformation Board took place on the 10 December 2025.

The national action plan focuses on three pillars:

- a. Provision of urgent and unscheduled care in the community,
- b. Primary prevention and population health management,
- c. Management of long-term conditions in the community and secondary prevention

Health Boards will be required to accelerate progress across these domains.

Together, these initiatives are intended to support a more coordinated, accessible and efficient model of community-based care, enabling the system-wide shift required to deliver the *Community by Design* vision.

## Primary Care Model for Wales

Alongside the challenges of access to appointments, there is a need to ensure that the workforce can respond to patient need. The Primary care Model for Wales (PCMW) was developed in 2017 to provide a clear route-map for the delivery of care to support the ambitions of '*A Healthier Wales*'<sup>5</sup>.

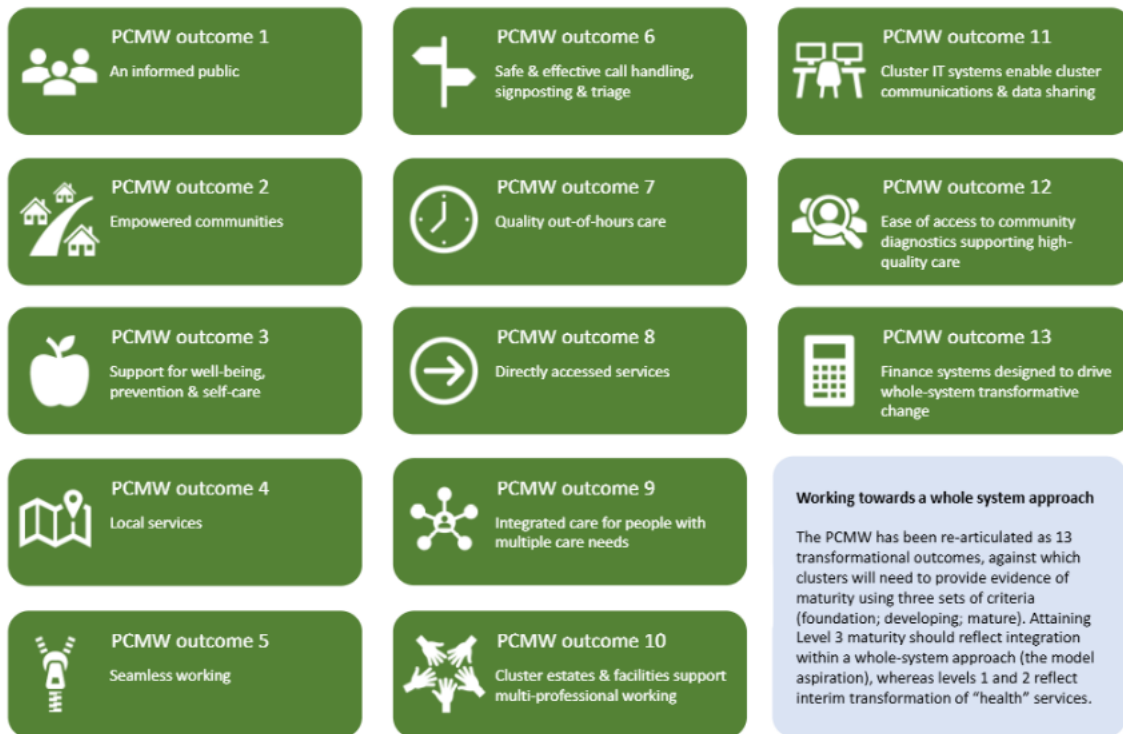
In 2024, the Strategic Programme for Primary Care undertook a review of the Primary Care Model for Wales (PCMW). It was reviewed through a series of national working groups who considered that the model remained valid in supporting the delivery of sustainable and accessible local health and wellbeing care. The refreshed model focuses on place-based care, care closer to home, and multi-professional working and aligning to the vision of a Healthier Wales. Work to develop the Primary care and Community Strategic plan has been based in part on the 13 outcomes that support the implementation of the PCMW<sup>6</sup>.

<sup>5</sup> <https://primarycareone.nhs.wales/primary-care-model-for-wales/>

<sup>6</sup> <https://primarycareone.nhs.wales/files/strategic-programme/13-outcomes-pdf/>

## PCMW | PRIMARY CARE MODEL FOR WALES

Describes how care will be delivered locally, now & in the future, as part of a whole system approach to deliver *A Healthier Wales*



This document is available in Welsh / Mae'r ddogfen hon ar gael yn Gymraeg

## Phase 1: Issues Papers

In 2023, the Board recognised the need for a dedicated Primary care Strategic Plan based on the continual service fragility of some GP contractors. By early 2024, scope of the programme to deliver a Primary care Strategic Plan was expanded to include Community Services. This change recognised the fact that the two systems are fundamentally interdependent of one another.

Two Issues Papers were produced to help understand the challenges facing Primary care and Community Services. The Primary care issues paper<sup>7</sup> formed part of phase 1 of the Clinical Service Plan (CSP) and followed the same methodology used for the nine CSP pathways; although there was some variation due to the structural difference between Health Board delivered services and contractor-led services.

The Community Services Issues Paper<sup>8</sup> focussed on the key findings in the Primary care issues paper and followed – where possible – the same methodology, in both the Primary Care and the Community Services Issues Papers similar issues were identified that can be grouped under the following key areas of challenge.

This outcome of the issues papers confirmed that incremental improvements would not be enough. Transformation was needed.

### Workforce and workforce data

There is very little workforce information available for most of the four contractor professions that make up Primary care Services. This is due to the limited data mandated through the optometry, community pharmacy, and general dental services contract requirements. Whilst there is potentially more available for general medical services (GMS), the data is not fully reliable. This lack of information and where available, fully reliable data, has a direct negative impact on the ability to:

- Understand the current workforce pressures facing Primary care contractors in a timely way to support service providers and proactively address challenges prior to potential service disruption
- Map the current staffing structures, future trends and potential gaps and opportunities facing Primary care contractors
- Impacts on the Health Board's ability to set a baseline to support future education, training and development plans.
- Impacts on the Health Board's ability to plan for future service commissioning arrangements

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<sup>7</sup> [hduhb.nhs.wales/about-us/your-health-board/board-meetings-2024/board-agenda-and-papers-28-march-2024/board-agenda-and-papers-28-march-2024/item-4-3-clinical-services-plan-issues-paper-pdf/](https://hduhb.nhs.wales/about-us/your-health-board/board-meetings-2024/board-agenda-and-papers-28-march-2024/board-agenda-and-papers-28-march-2024/item-4-3-clinical-services-plan-issues-paper-pdf/)

<sup>8</sup> [hduhb.nhs.wales/about-us/your-health-board/board-meetings-2024/board-agenda-and-papers-28-november-2024/board-agenda-and-papers-28-november-2024/3-7-update-on-a-healthier-mid-and-west-wales-strategy-pdf/](https://hduhb.nhs.wales/about-us/your-health-board/board-meetings-2024/board-agenda-and-papers-28-november-2024/board-agenda-and-papers-28-november-2024/3-7-update-on-a-healthier-mid-and-west-wales-strategy-pdf/)

There is a significant impact in the near future on the community services workforce due to retirement projections. This is an additional pressure that compounds the recruitment challenge facing community services.

## Outcomes, data and quality

There is a system wide gap in patient outcomes data. There is no system wide patient pathway data to enable the Health Board and that results in there being no reliable way to understand the impact that Primary care services have on patients and the wider health system. This is due to the lack of a shared digital record system that enables patient information to be shared with all clinical and professional partners.

The activity data that is available does not provide a baseline of activity which means that there is a limited understanding of how Primary care Contractor services perform locally and in comparison, to the rest of Wales. This means that the Health Board does not know if services meet the needs of the specific areas that they serve.

There is a lack of consistency and in some instances no contractual obligation to report incidents to the Health Board. This poses a challenge for the Health Board in understanding the service quality being experienced by patients using Primary care Contractor Services

The data that is available shows that demand for GP Practice appointments is rising as well as the number of patients accessing to services across Community Pharmacy and Optometry are also rising. Due to a lack of an integrated system wide patient database we cannot know if the same patients are having multiple contacts for the same health condition across a number of contractors or if demand in general has increased.

The lack of General Dental appointments for routine and urgent dental care impacts on other service areas due to patients seeking treatment from GPs, Pharmacists, Minor Injuries Unit or Accident and Emergency In relation to general dental service the increased demand for urgent dental care is impacting on the ability to provide routine preventative care for patients who have access to dentist appointments

## The impact of working within a contractual framework

The Health Board must commission and deliver Primary care services in line with national legislation set out in Regulations or Directions. This means that there are boundaries to the opportunities to change the way in which services are commissioned and delivered

Primary care Contractor contract values are calculated on a nationally agreed formula set by Welsh Government. An example of this mechanism can be seen in the decision about how much each GP Practice will receive. Between the four Primary care contractor services there are significant contractual disparities. The four Contractor services do not receive the same level of financial business support within their Contracts mainly due to the private and/or commercial elements for General Dentistry, Community Pharmacy and Optometry. This funding difference impacts significantly on the ability for each service to be able to develop their services and estate.

## Estates and infrastructure

The estate used by Contractors and Health Board Community Services is, in general, insufficient, and/or not suitable, for current services or to provide a wider range of modern Primary care services.

Whilst there is a desire to transform service delivery to meet new opportunities with Primary care services, poor conditions stifle the ability to deliver. The current GP Practice estate is not fit for purpose or for the development of modern services or to accommodate the changing workforce. Premise constraints could impact on the scope and range of services to be delivered.

In addition, Community Pharmacy, Optometry and General Dental Services are delivered in commercial premises. Any service changes that require additional space and new estate developments must be commercially viable for Contractors. The Community Pharmacy, Optometry and General Dental Services contract does not provide ongoing business support or capital investment to fund new premises. This is outside of the control of the Health Board.

In relation to community services provided by the Health Board the impact of servicing a relatively small population, spread across a large and rural landmass is a challenge needs to be acknowledged the desire to provide care closer to home must factor in the travel costs for the workforce and the accessibility challenges of a deeply rural population.

There is varying reliance on acute and Community Hospital sites dependent on the current Health Board stock. Any changes to acute settings will have an impact on Community Services and needs to be understood in any acute setting re-configuration

## Financial sustainability

Cost pressures impact on the delivery of Primary care services in the same way that they are for the rest of the Health Board. Some costs are outside the control of the Health Board by virtue of inflationary pressure as well as being controlled by the All-Wales Contracts. Therefore, the majority of the spend in Primary care – for the four contractor services - is fixed.

Drugs, clinical supplies and service-related expenses, including community staff travel mileage expenses, are directly correlated to the acuity of patients in need of care and the length of time people are cared for in their own home or in a placement. The 'shift left' to care closer to home and instead of care within an acute setting will challenge the budgets accordingly.

The rising cost of drugs and the increase in prescribing them is an issue for the Primary care financial position. Statutory services such as Continuing Health Care (CHC) is a cost pressure now and in the future due to meeting service demand in a market driven sector that is facing inflationary pressures.

The loss of NHS dental contracts reduces the amount of income the Health Board receives from patient charges and has had a direct impact on the level of income that the Health Board receives from the Patient Charge Revenue.

For Community Services there is a clear split in spend between pay and non-pay related costs. Whilst there is an increase in recruitment overall, but there remains a challenge to

recruit sufficient staff to the services and as such there has been underspend in the budget allocation.

In contrast non-pay related spend has been consistently overspent according to the budget allocation. The areas in question are most impacted by inflationary pressures and market forces. In the Health Board's managed practices locum GP costs continue to be the main cost pressure for and the Out of Hours service

## Insights and Ideas

During the development of the Strategic Plan innovative projects in primary care and community settings have already delivered measurable outcomes, achieved the priorities and supporting a reduction in hospital stays.

### Listening to communities and workforce

An extensive engagement campaign (My Health, My Choice) was launched across all clusters in September 2024. Patients, staff, and partners took part through in-person events across each Cluster and via online platforms<sup>9</sup>.

People shared:

- what mattered to them
- their experiences of accessing care
- the challenges they face navigating the system
- ideas for improving services
- their hopes for healthcare in the future

This engagement and feedback became the foundation for developing and informing strategic ideas.

The next stage of engagement one of clarity and ambition: What kind of system do we want to build between now and 2035?

As we move deeper into the development of our Strategic Plan, we recognise that transformation requires more than ambition, it requires a clear set of options that can be tested, shaped and owned that aligns with the wider programmes of the Health Board and places prevention and early intervention at the heart of everything we do.

Between July and September 2025, we held a series of focus group discussions with different professional groups. These sessions gave the project team, a chance to share what work had been done so far. We also shared ideas that had already been included in Board reports and listened carefully to views of our Clinicians.

We met with:

- General Medical Services Collaboratives & Practice Managers
- Community Dental Collaborative
- Optometry Collaborative
- Community Pharmacy Collaborative
- Mental Health, Allied Health Professions and Health Science

We were told that Clinicians and colleagues valued this chance to be involved. Some people raised concerns about the process for developing the plan so far. There were

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<sup>9</sup> [hduhb.nhs.wales/about-us/your-health-board/board-meetings-2024/board-agenda-and-papers-28-november-2024/board-agenda-and-papers-28-november-2024/3-7-update-on-a-healthier-mid-and-west-wales-strategy-pdf/](https://hduhb.nhs.wales/about-us/your-health-board/board-meetings-2024/board-agenda-and-papers-28-november-2024/board-agenda-and-papers-28-november-2024/3-7-update-on-a-healthier-mid-and-west-wales-strategy-pdf/)

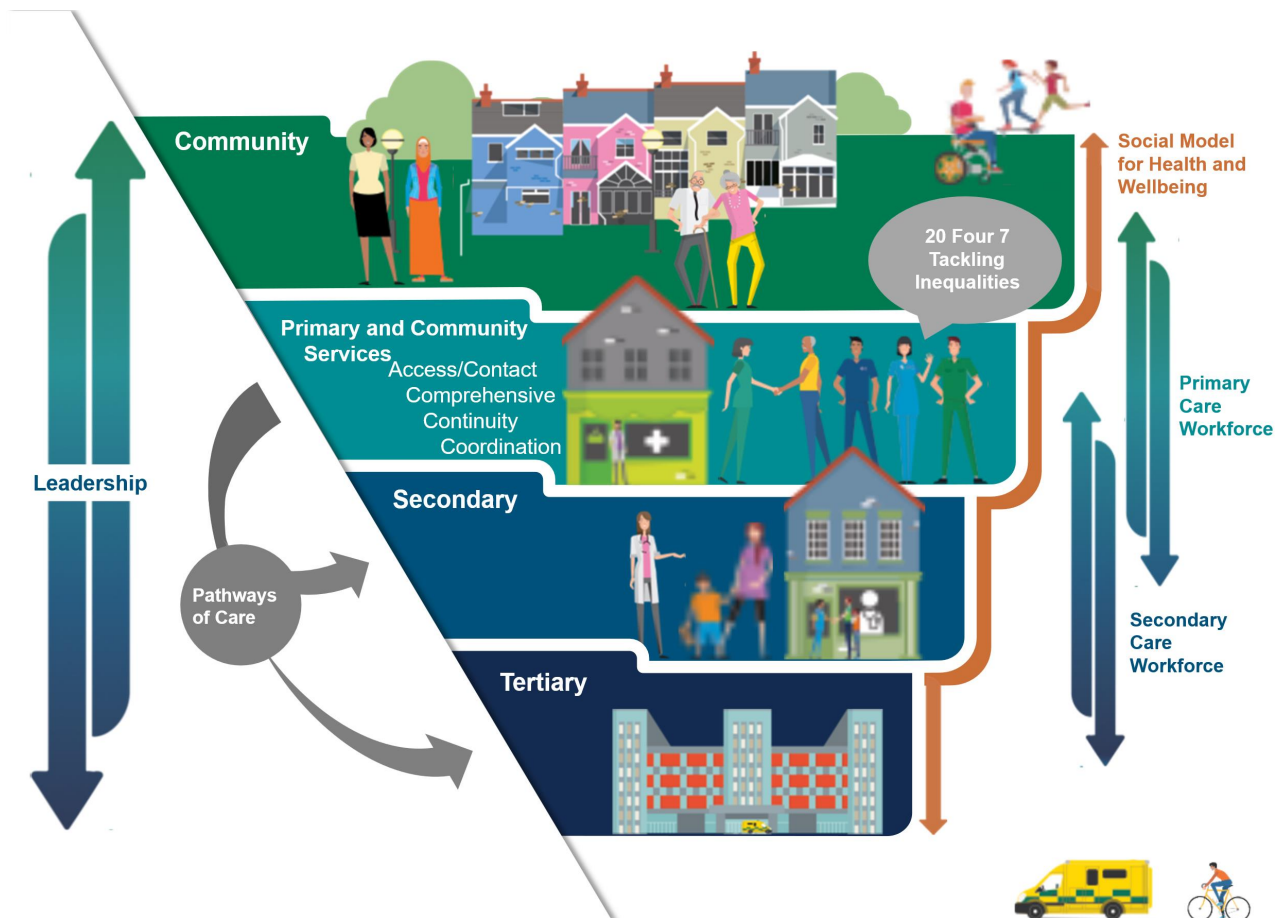
worries about limited clinical involvement, and some questioned whether the ideas in the Board reports were supported clinically.

# Proposed Clinical model for Primary Care and Community Services

The national policy for Primary care and Community services supports our ambition to realise the 'left shift' of services that will benefit our patients, by improving accessibility to care and health outcomes. While contractual and other priorities may also support these changes, we have an opportunity communicate a clinical model that maps out how clinicians and professionals throughout the health and care system work together to realise a left shift in service and operational delivery, and how it works with our communities and our partners. Ultimately, we should continue to create a clinical vision which allows us to realise our system as a centre for excellence in Primary care delivery.

The core of the model is based on internationally accepted evidence for primary care systems summarised by the '4Cs'<sup>10</sup>:

- Contact (accessible services in the community)
- Coordination (care is holistic and integrated across services)
- Comprehensive (principles of prudent and value-based health care apply)
- Continuity (all services prioritise both informational and relational continuity of care)



Proposed Clinical Model for Primary Care and Community Services

<sup>10</sup> [Revisiting the four core functions \(4Cs\) of primary care: operational definitions and complexities](#)

Our model for primary care and community services (APPENDIX 5) demonstrates the Primary and Secondary care interface and the opportunity to improve working in this area. It also describes the wide-ranging benefits of left shift as described in the international evidence base. The model is intended to support the delivery of national priorities, incorporate contractual boundaries and set out a vision for primary care which could provide an innovative baseline for quality of care and benchmarking for international comparisons.

Overall, the model sets out a vision which may form the basis for not only stability of services but a foundation for an internationally renowned primary and community care system. Throughout January 2026 the clinical model will be presented to the primary care collaboratives for engagement and feedback.

## Priorities

Insights and ideas (APPENDIX 4) gathered through engagement have been systematically reviewed and have directly shaped the identification of strategic priorities that complement the wider vision of the organisation and other programmes of work. The priorities represent the areas of greatest opportunity, impact and alignment with our long-term goals for population health and sustainable care. We are asking the Board to endorse these emerging priorities so that:

- We can focus our resources on developing the most promising and feasible options.
- We provide clarity and direction for staff, partners and communities
- We are ready to move confidently into the next stages of engagement
- Our Strategic Plan is built on Board approved foundations

Priority 1: **Prevention** - build a culture that empowers both our patients and teams to lead on prevention and early intervention, promoting healthier lives and more sustainable services

Priority 2: **Partnership Working** - fully commit to strategic and operational collaboration to deliver a comprehensive and holistic, integrated health and care system across the region

Priority 3: **Access** - make health, care and wellbeing information and services as accessible as possible for our patients, our partners and our workforce

Priority 4: **Digital** – make our Digital offer for our patients, our partners and our workforce seamless, holistic and accessible; to enable all teams to share information, trust information and deliver the best patient care

Priority 5: **Estates and Infrastructure** - shape the region's estate and infrastructure to maximise the delivery of sustainable, prevention-focussed holistic health and care in the community

Priority 6: **Workforce and Sustainability** – develop our workforce to deliver a sustainable, multi-disciplinary service that will support the shift to a community-based model of care and maximise prevention focussed patient outcomes

# What do we need to agree to deliver the next steps of the Strategic Plan?

The next step to delivering a strategic plan that is fit for purpose now and for the future, relies on the emerging ideas and actions to be tested to see if they are deliverable from a statutory and strategic perspective and that they are viable, sustainable and measurable.

The four areas that are the focus of the hurdles are:

1. Improved quality (STEEP)
2. Whole system
3. Strategic alignment
4. Deliverable and affordable

## Hurdle Criteria

The following hurdle criteria provides the health board with a universal approach to assessing service change that can be applied to all projects, programmes and service innovation.

Hurdle Criteria	Applied to Community by Design): To achieve this, proposals should...
Improve quality (STEEP)	<ul style="list-style-type: none"> <li>• be assessed against the STEEP framework - safe, timely, effective, equitable and person-centred</li> <li>• utilise the Health Board's Health equity checklist to impact on reducing health inequalities and improving outcomes for disadvantaged groups</li> <li>• support continuous learning and quality improvement</li> <li>• promote holistic person focused and preventative care</li> <li>• enhance (or not disrupt) the 4Cs of primary care</li> </ul>
Whole system	<ul style="list-style-type: none"> <li>• demonstrate integrated, whole system response that reflects the principles of our Social Model for Health and Wellbeing – addressing wider determinants of health such as housing, transport, education, employment or the environment</li> <li>• reinforce the aim of local, place(cluster)-based planning</li> <li>• consider all contractor professions and third sector partnerships along with directly employed staff</li> <li>• interface with all other aspects of health board planning e.g. acute and planned care services</li> <li>• have involved staff, trade unions and the public in the design at the earliest opportunity</li> </ul>
Strategically aligned	<ul style="list-style-type: none"> <li>• progress the aspirations of A Healthier Mid and West Wales and the national programmes of Community by Design and Primary care Model for Wales</li> </ul>

	<ul style="list-style-type: none"> <li>• align with principles of primary and community clinical model</li> <li>• reflect the 20four7 model, prioritising primary and secondary prevention/early intervention, and building capacity to care in disadvantaged communities</li> <li>• be future-orientated, long-term and not setting any unhelpful precedents</li> </ul>
<p>Deliverable and affordable</p>	<ul style="list-style-type: none"> <li>• be clinically and operationally deliverable within a medium-term (3-5 years) timeframe, to include workforce, estate and capital requirements</li> <li>• have a realistic possibility, based on evidence, of being affordable over the medium term using existing resources, including the reallocation of current Health Board resources</li> <li>• accommodate contractual changes including directed supplementary services</li> <li>• reflected value-based healthcare principles, including wider system and societal benefits and costs for partners, the public, and the regional health economy</li> <li>• consider process and outcome evaluation of any novel service</li> </ul>

# What are the next operational steps to deliver the Strategic Plan?

## Next Steps

1. **Establish Hywel Dda Transformation Programme arrangements** that mirror the governance, assurance, and delivery approach of the CbD National Programme.
2. **Arrange and deliver workshops on a cluster footprint basis** to review current arrangements and explore the potential future design of Cluster Planning Groups and Clusters to ensure they are well placed to drive forward the CbD Strategic Plan and, beyond that, the vehicles for system change in the Health Board.
3. **Meet with professional collaboratives and the 6 Goals Programme and 20-four-7 Programme** to further engage clinicians and develop the Clinical Model, ensuring alignment with national clinical direction and Whole System approach (*January 2026*).
4. **Develop the 2026/27 annual plan** setting out the key deliverables for CbD through next year and the broader ambition for the next three years.
5. **Establish a structured engagement campaign** involving clinicians from Primary and Secondary Care and partners to explore current insights and challenges, generate ideas, and develop a range of options under priority headings.
6. **Create structured appraisal sessions** to take all ideas and emerging options through an agreed hurdle criteria process, enabling consistent assessment and identification transformational solutions that benefit patients and whole systems operations.

## Appendices

1. Primary Care Systems v.8
2. Primary Care and Community Strategy Evidence Synthesis v.3
3. CbD Transformation Programme Delivery Plan
4. Insights and Ideas
5. Clinical Model for Primary Care and Community Jan 2026



## Primary Care Systems: A review Contents

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## Introduction

The current draft of this paper is mainly focussed on General Medical Services. It is acknowledged that a Primary Care Model will need to reflect a broader picture of service provision, including the three additional contractor services.

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Additional best practice information and input from Community Pharmacy, Dental and Optometry services is being sought for addition, and to shape the final Model.

This paper is intended to explore some of the basic principles of primary care systems, complexity theory and the primary and secondary care interface. This is supported by summary examples of primary care systems from the UK and internationally. It is a submission from the Hywel Dda University Health Board's (HDdUHB) Primary Care strategic plan. This paper does not provide an exhaustive list, but highlights some examples which offer learning for HDdUHB and has been produced collaboratively within the task and finish group membership prior to staff and patient engagement. This paper focuses on the delivery of primary medical care and is not intended to provide a review of our other contractor professions. However, the principles described in the model provide a basis for us to explore an interface and integration with all other aspects of health and community care.

## Defining Primary Care

In the UK, definitions of primary care are inextricably linked to definitions of general practice. UK general practice has deep historical roots but remains grounded in the 'independent contractor model' devised at the advent of the NHS. This model for primary care services is not clearly defined in terms of clinical provision and organised because of historical precedent rather than evidence.

International research can, however, give us a clear definition of the core functions of primary care including how they relate to a host of positive patient outcomes and cost reduction. This evidence can in turn provide a benchmark for the current independent contractor system in the UK along with emerging models. The key research which underpins the definition of general practice was conducted in the 1990s by American academic Barbara Starfield<sup>1</sup> and comprised the **4cs** of primary care.

- **First Contact (access):** Primary care services as the main entry point and interface between the population and health system. People go to primary care first for each new need or problem.
- **Continuity:** Primary care emphasizes the relationship over time between a patient and provider. This can be viewed through the domains of relational continuity, informational continuity, management continuity and possibly team based continuity<sup>2</sup>. In recent times extensive evidence has been produced in the UK demonstrating the importance of continuity of care to health outcomes<sup>3</sup>.
- **Comprehensiveness:** Primary care offers a comprehensive range of services, with capacity to manage common health conditions at all stages of a person's life.

- **Coordination:** Primary care brings together different elements of the health system for the care of a patient. It coordinates with secondary and tertiary care clinicians, as well as community and social services.

Over subsequent years, Starfield and colleagues were able to establish and replicate research which confirmed that primary care systems with these characteristics, were associated with a wide variety of improved health outcomes including all-cause mortality and reduced cost of healthcare<sup>4</sup>. These key elements of primary care function have remained the benchmark for international organisations such as the World Health Organisation and OECD<sup>5,6</sup>. Strong primary care systems reduce overall health costs and numerous examples of this follow in this paper.

While the independent contractor model has dominated provision of services it is not the exclusive provider and there are both historical and recent examples of integrated or commissioned services which are not considered in detail here. Examples include, out of hours services and more recently urgent care hubs and walk in centres.

Who provides primary care services is also a question of much debate and discussion in recent times as a result of the well documented crisis in recruitment and retention. While this paper is not intended to provide comprehensive analysis of non-medical service provision it does include some examples from the UK and elsewhere which demonstrate the diversity primary care provision delivered by a wide range of team members both clinical and non-clinical. The proportion of non-medical staff delivering clinical care in the UK is rising and the effect on service provision and quality of care is a subject of active debate<sup>7</sup>. Despite this rise, a cross sectional study of general practice in England published this year demonstrated a reduction in the number of GPs, access to appointments and continuity of care all of which are associated with lower life expectancy<sup>8</sup>.

In response to the changing landscape of UK general practice the Royal College of General Practitioners (RCGP) currently offer the following definition of a GP:

- ▶ *“A GP is a doctor who is a consultant in general practice. GPs have distinct expertise and experience in providing whole person medical care whilst managing the complexity, uncertainty and risk associated with the continuous care they provide. GPs work at the heart of their communities, striving to provide comprehensive and equitable care for everyone, taking into account their health care needs, stage of life and background. GPs work in, connect with and lead multidisciplinary teams that care for people and their families, respecting the context in which they live, aiming to ensure all of their physical and mental health needs are met.” RCGP UK Council 2023*

A recent review of the independent contractor model in England found that the current independent contractor system of primary care provision provides close theoretical alignment to the Starfield 4C framework. It also concludes that<sup>9</sup>:

*‘Underlying causes of current challenges in general practice in England appear more closely linked to under-resourcing than the fundamental design of the system’.*

**Analysis**

The HDdUHB primary care strategy should consider the evidence base for a strong primary care system and use these criteria to benchmark service planning and delivery going forward. Alignment of these principles with A Healthier Wales strategy allows for a clearer definition of primary care and form the basis for engagement with public and staff. In turn the evidence base for primary care systems provides a vision for person centred care that may both support or challenge the planning of services via disease pathways in the clinical services plan. Crucially, a strong primary care system reduces overall spending on healthcare and should be considered a core component of a move towards financial sustainability.

**Complexity in Primary Care**

*“What happens between a patient and a general practitioner within a single consultation is also infinitesimal but nonetheless infinitely important. The tragedy is how poorly this is understood...”*

From the foreword to Complexity in Primary Care, Iona Heath 2006

Much attention has been paid to the management of complex patients in primary care. There is extensive interest in how clinicians can use the principles of the emerging complexity science in the management of patients, but this is outside the scope of this paper. Instead, we have referenced some of the available research and ideas to be applied to workforce planning for complex patients in practice teams and some high level principles of complexity theory in primary care systems.

**Workforce Planning for Complex Patients**

Significant attention has been paid in recent years to the concept of complexity in general practice as the number of our patients with multiple conditions rises. In the Welsh context this has related to the concept of ‘working at the top of your licence’ in healthcare<sup>10</sup>. This idea was first developed in the US hospital sector to reduce costs<sup>11</sup>. The primary focus here was to increase productivity by ensuring that highly skilled (and highly paid) practitioners focused only on the tasks that they could perform. In general practice, this has led to initiatives to free GPs to focus on more complex cases. Indeed, the need to face complexity is referenced in the RCGP’s definition of a GP above. However, research suggests that this can increase the risk of burnout in primary care doctors<sup>12</sup>.

Our existing descriptors for high quality primary care suggest a role for practitioners to deal with complexity under the guise of co-ordinated or comprehensive care. However, it is possible that both access to care and continuity could be disrupted if we ask primary care clinicians (particularly GPs) to focus on complexity (or simplicity) alone. Anecdotally many GPs would observe that their ability to deal with complexity comes from spending time with the same group of patients being accessible and providing continuity for several years.

We may suppose, therefore, that newly qualified GPs and those new to our region may require more support to manage complexity. Furthermore, our current training pathways for MDT colleagues, particularly those in nursing, can, anecdotally, lead to disease focused specialisation in career progression. High level initiatives that seek to free up practice time and direct patients to a service designed around a specific disease pathway (such as UTIs or ear syringing) often exclude complex patients. This, in turn, risks the provision of continuity of care and denies clinicians the opportunity to build meaningful relationships in non-complex cases. As recent research on remote working has shown, the adoption of new technologies also risks the disruption of the functioning of general practice teams unless they have the capacity and autonomy to implement those systems themselves<sup>13</sup>. All these factors may result in fragmentation of care for complex patients and significant inefficiency in primary care delivery.

Considering these factors alongside our ambition to care for complex patients closer to home requires significant clinical leadership using the principles of primary care.

#### **Summary analysis**

- GPs should be freed to focus on team leadership (alongside other senior clinicians) not only to manage complex patients on their own.
- Disease focused workforce planning, training programmes and service delivery can undermine the core values of primary care.

## **Complex Primary Care Systems**

The new science of complexity theory challenges not only our traditional notions of basic scientific processes but can positively influence our understanding of how health care systems work<sup>14</sup>. The following 'Stacey diagram' has been used to demonstrate complexity in primary care along with multiple other applications<sup>15</sup>. Many of the concepts described will be familiar to clinicians and healthcare leaders. Best practice and 'complicated' (pathway type) planning of systems have dominated planning within the system in recent years<sup>16</sup>. For primary care in Wales, the locality cluster leads will be familiar with working on innovation, dialogue and trial and error, and the framework has given them scope to work in this realm of healthcare delivery. Although, concerns remain around rolling out cluster projects at scale.

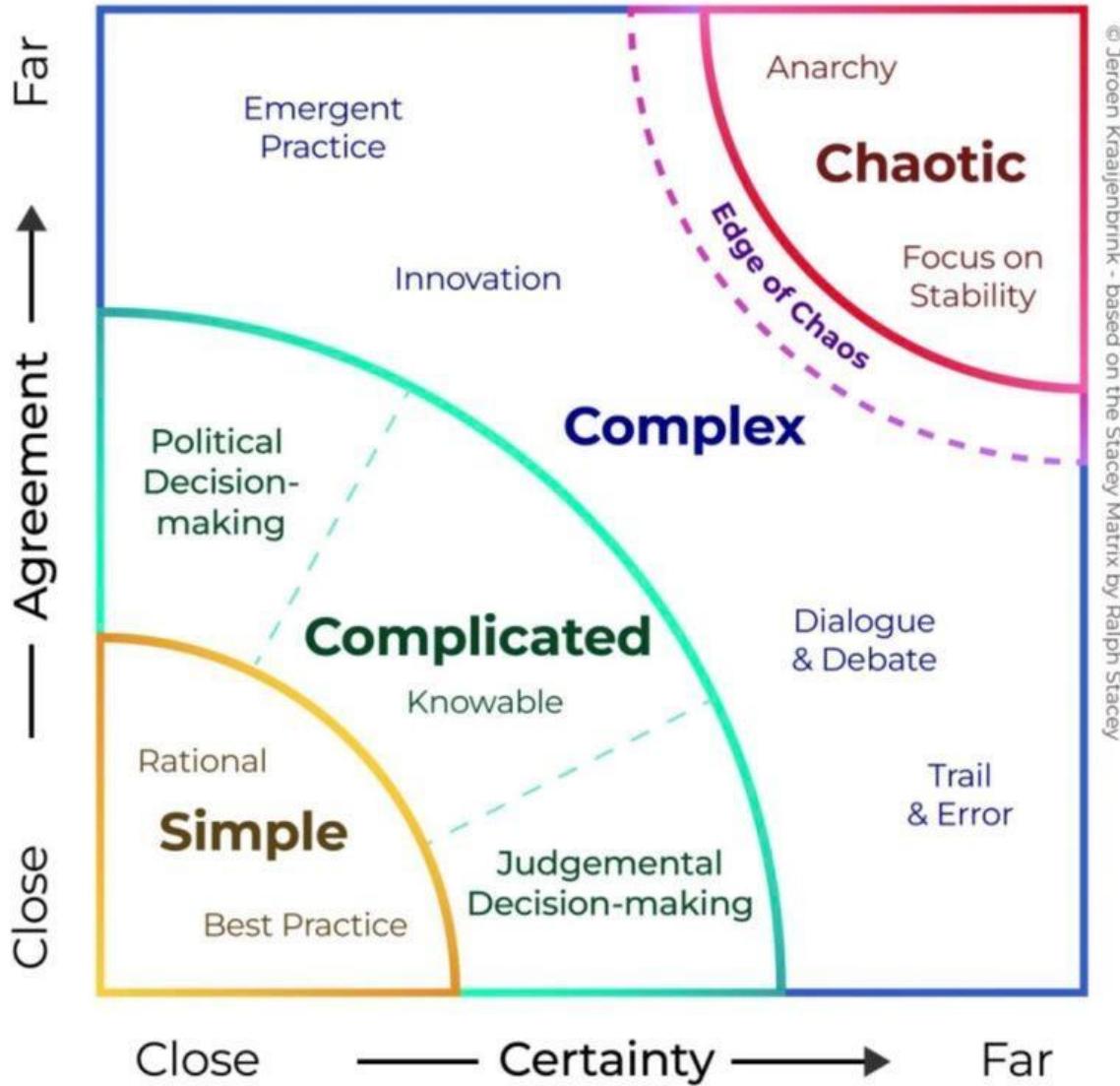
Less commonly discussed, and therefore the focus of this section, is on the theory of 'emergence'. Emergent phenomena have been extensively measured in science for many years and challenge our received theories of reductionism and mechanics<sup>17</sup>. They may also allow us permission, in planning healthcare delivery, to trust local teams to run their services. In very simple terms an emergent phenomena (or practice) is a measurable output from a system which is not explained by the parts of the system. These effects can be positive or negative. It may be supposed that continuity of care could be considered a positive emergent practice of the traditional GP delivered primary care system. In a similar sense GP burnout could be an emergent element of asking them to focus on complex care only.

Given the shifts we have seen in healthcare pressure and modes of delivery in recent years, it is important for us to understand this principle for two reasons. Firstly that our attempts to reduce primary care delivery to small components may disrupt existing emergent phenomena. Secondly that primary care teams, particularly GP practices, should be trusted to respond to local need by being asked to follow the basic principles of primary care. In doing so we are more likely to see those positive emergent phenomena retained and we should, as healthcare leaders, put in place systems to monitor for new emergent practices.

**Summary analysis**

- Complexity theory can help us better understand and plan our current system.
- Emergent practice should be considered alongside pathway design and cluster working.
- Local teams should be trusted to care for their patients around a few simple principles.
- High level monitoring for emergent practice should be put in place.

# The Stacey Matrix



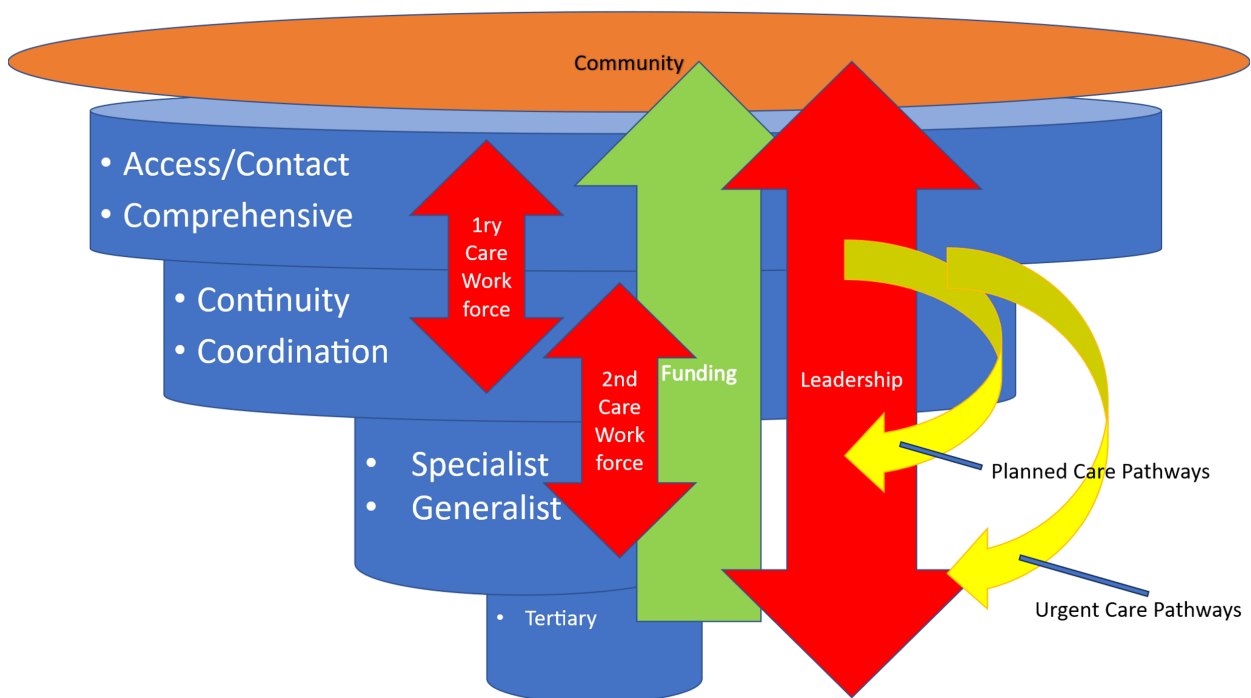
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## Primary and Secondary Care Interface

The primary and secondary care interface is often cited as an important focus for improvement in health systems. The most notable UK example of improvement project in this area is in Merseyside, where they have focused on improving the communications between primary and secondary care through a variety of methods<sup>18</sup>. Much of this work focuses on good communication between hospital and community teams and continues to focus on patient pathways.

An understanding of primary care evidence base and complexity theory can help us better understand the interface. The use of disease pathways in a secondary care setting where disease processes are more clearly defined; efficiency can be found in division of labour, scale and process management leading to reduced variation.

Person centred practice in the community is more efficient when it focuses on the whole person. In some cases this involves prudent avoidance of patient pathways in the interest of holistic care. As a result, sole reliance on pathway design could undermine the primary care model, stretches the available workforce and increase costs when deployed in community settings. The following graphic demonstrates the point at which disease pathways requiring specialist input emerge from the system and could be better integrated with a robust primary care model.



## International Models

By setting the context for the current UK system of primary care provision, we can explore primary care landscape in other nations against the criteria set out by Starfield. Despite the presence of high-quality evidence to inform policy and

governance the World Health Organisation estimates that around half the world's population lack the essential health care they require<sup>19</sup>

## **The United States of America**

Page | 9 In a national consensus report published in 2021, the National Academies of Sciences, Engineering and Medicine produced a highly comprehensive review of primary care systems in the USA<sup>20</sup>. They produced a helpful definition of primary care as follows:

*High quality primary care is the provision of whole person, integrated, accessible, and equitable healthcare, by multi professional teams that are accountable for addressing the majority of an individual's health and wellness needs across settings and through sustained relationships with patients, families and communities.*

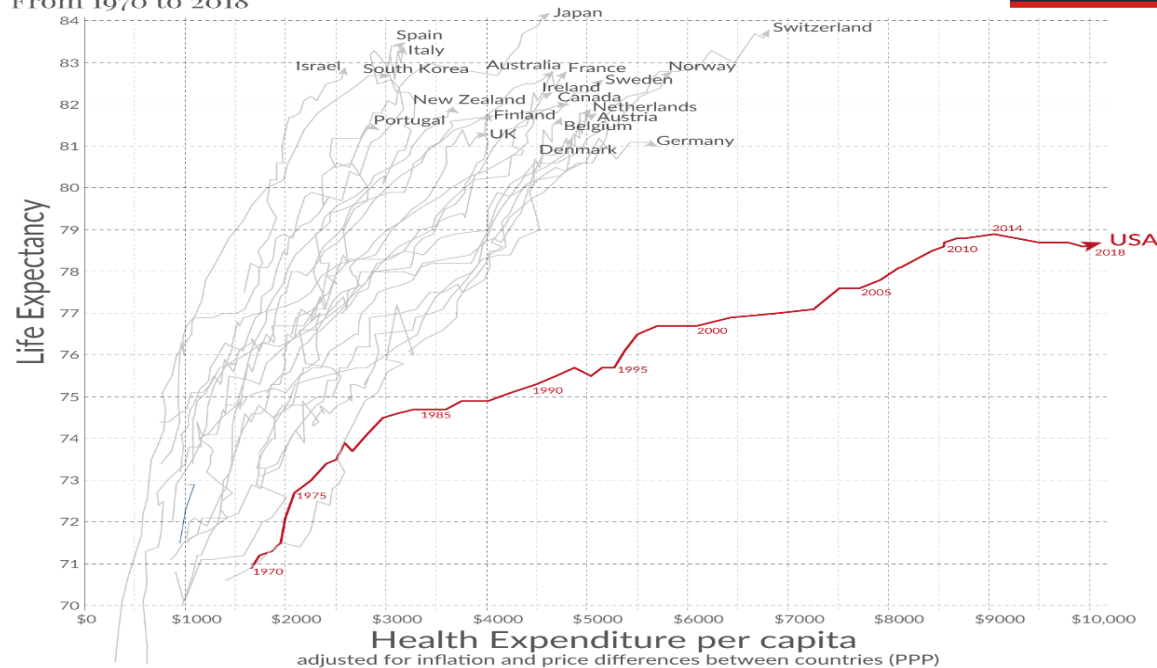
They also highlight primary care as *'the essential element for improving the health of the US population... Yet in large part due to chronic underinvestment, primary care in the United States is slowly dying'*.

Unlike the UK, the USA does not have universal access to primary healthcare. Poor health outcomes are primarily driven by wider social inequalities. However, the lack of primary care provision compounds this problem and leads to excessive use of healthcare resources in specialist settings lacking in person focused care. The following graph demonstrates how increasing use of health care resources does not lead to improved health outcomes in the US system.

# Life expectancy vs. health expenditure

Our World in Data

From 1970 to 2018



Data source: OECD — Note: Health spending measures the consumption of health care goods and services, including personal health care (curative care, rehabilitative care, long-term care, ancillary services, and medical goods) and collective services (prevention and public health services as well as health administration), but excluding spending on investments. Shown is total health expenditure (financed by public and private sources). Licensed under CC-BY by the author Max Roser. OurWorldinData.org – Research and data to make progress against the world's largest problems.

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The size and diversity of the USA mean that while their overall outcomes are poor there are pockets of good practice which align with the Starfield principles. The most notable of these is the **Patient Centred Medical Home (PCMH)** which are accredited by several providers in the USA and was initially devised in the 1960s to improve the care of children with special needs. There are a wide variety of providers under this model though core characteristics include interdisciplinary working, care coordination by a named individual and person/family focused care. Some studies have found that this model is associated with reduced levels of staff burnout and improved patient outcomes<sup>21, 22</sup>.

## Analysis

In HDdUHB we can learn much from the US system about how not to deliver a primary care strategy. The limited success of the Patient Centred Medical Home (PCMH) model provides a basis for positive engagement with staff and patients about the organisation of multi-disciplinary teams.

## Norway

In contrast to the USA (which often ranks worst in the world for healthcare provision), Norway has previously been regarded as the best healthcare system in the world and continues to be ranked as the highest in Europe.<sup>23</sup> Like the UK, Norway has an independent contractor model for provision of primary care which remains staffed primarily by doctors and nurses. There is a closer and more flexible relationship between the 'municipality' (overarching health provider) and the individual contractors. In some cases, GPs are obliged to do 7.5 hours of work per week directly for the municipality including locally organised provision of out of hours care. Contracts incentivise preventive care and continuity of care particularly for the elderly and those with chronic disease. There is a recognition of the need to expand MDT

working in order for GPs to focus on continuity of care<sup>24</sup>. Norway has a relatively low level of hospitalisations compared to other European countries.

One of the most important recent studies demonstrating the benefits of continuity of care (including reduced hospitalisation and mortality) was conducted in Norway in 2022<sup>25</sup>.

### **Analysis**

The similarities between the UK system and Norway are striking but incentives to focus on continuity and coordination of care appear to be associated with better patient outcomes and reduced costs. In particular, the provision of a 'Named GP' (which is mandated in Norway) may be an important engagement question for staff and patients as part of the primary care strategy.

## **The Netherlands**

Primary care provision in the Netherlands is similar to that of the UK, but along with Norway has drawn attention in recent years because of the high level of happiness experienced by GPs working in that system compared to other European nations<sup>26</sup>. The Netherlands has an insurance-based system, but every Dutch citizen is required to register with a GP who acts as gatekeeper and coordinator of their care. GPs are expected, by insurers, to control costs by reducing specialist referrals. 72% of the population visit their GP every year and 82% have a high level of confidence in their GP according to the Dutch association of GPs<sup>27</sup>.

There are likely to be several subtle factors that enhance the Dutch system of primary care compared to the UK. The notable features include the Dutch College of GPs' patient education website, which has become the most popular website about health and disease in The Netherlands. Unification of primary care records and data sharing allow Dutch GPs to do research. This is enhanced by longer and more flexible speciality training in general practice and, as a result, GP training schemes are oversubscribed and there are a large number of primary care academics in the country.

Practice list size in the Netherlands is relatively small with 40% of practices having one or two partners. Smaller practices are incentivised by the government. In data from 2018, 19% of Dutch citizens failed to get a same day appointment compared with 41% in the UK<sup>28</sup>.

### **Analysis**

There may be strategic lessons for HDdUHB which could inform staff and patient engagement from the Dutch system. These include the potential benefits of scaling up the 'Pocket Medic project' which could form the basis for dynamic ongoing engagement with primary care teams in health literacy. There may also be diverse benefits in the health board considering an enhanced offer for GPs to become involved in research. Our analysis of GP fellowships may support an expansion of this model. In HDdUHB in recent years we have associated small list size of practice with unsustainability. The Dutch system of primary care encourages

smaller practice size and data from the UK suggests patient satisfaction is lower with larger practice list size<sup>29</sup> Further learning in HDdUHB may be available from the consultation with patients and staff on this question.

## Israel

Israel is one of the most progressive and successful healthcare systems in the world. It spends 7.2% of GDP on health care (OECD average of 9.2%) and yet achieves a wide range of positive outcomes including relatively high life expectancy, low levels of infant mortality and good outcomes from chronic disease. Israel's success is underpinned by a progressive primary care system and focus on public health rather than hospital-based care<sup>30</sup>. Nationally mandated insurance schemes are delivered by four 'non-profit' providers across the country known as health maintenance organisations (HMOs).

The largest of the four HMOs is the Clalit organisation which runs 1,400 primary care clinics and just eight hospitals. They also run an extensive network of dental services and laboratories. This organisation has invested intensively in technology including remote consulting and shared records. It also co-locates specialists and generalists in the community. The strength of their primary care focused model has allowed them to conduct successful centrally directed initiatives, to tackle health inequalities in a very diverse population. This has included agreeing a measurable outcome disparity reduction strategy and delegating responsibility for delivery to local teams<sup>31</sup>.

Israel has 1 full-time equivalent GP to 1600 patients<sup>32</sup> compared to 1 to 2290 in the UK.<sup>33</sup>

### **Analysis**

Israel's health system can provide inspiration for a primary care strategy for HDdUHB. It demonstrates the outcomes that can be achieved from a primary care focused system by a non-profit provider. In contrast to the UK model of independent contractor delivery, the model is run centrally and crucial to its success is the use of technology, shared records, co-locating clinicians in the community and delegating responsibility to GP-led local teams. The latter view is supported by a recent King's Fund paper on care closer to home<sup>34</sup>.

## Singapore

Singapore consistently ranks highly in the World Health Organisation rankings of healthcare systems<sup>35</sup>. For a population of 5.5 million people, Singapore has 1,800 GP clinics which provide universal healthcare to the population through a mandatory insurance system. Singapore spends just 4.6% of its GDP on health. It has 16 acute and community hospitals.

During the early 2010s, the Singaporean system contended with increased stress on its hospital system due to rises in non-communicable disease and an ageing

population. A plan in 2012 to expand the number of hospital beds and increase investment into primary care was considered insufficient and, in 2016, the Health Ministry developed (and is implementing) a strategy called the three Bs<sup>36</sup>.

- Beyond health care to health.
- Beyond hospital to community.
- Beyond quality to value.

### **Analysis**

Singapore's system demonstrates the importance of socioeconomic factors in the health of the population and the success of the healthcare system it provides. It invests heavily in the provision of universal primary care and has a high ratio of community services compared to hospitals in comparison to both HDdUHB and Wales.

The Singaporean strategy of the three Bs provides a helpful example of public messaging which mirrors the strategy adopted by HDdUHB and may provide inspiration on how to expand the 'care closer to home' message.

### **Alaska - Nuka**

While we have already covered the USA above, the Nuka model of healthcare delivery deserves closer scrutiny because it is an important example of multi-professional primary care delivery which builds on the primary care home model<sup>37</sup>. The Nuka model was co-created with the local population of 60,000 Alaska Native and American Indian people. The redesign focused on the population becoming 'owners' of their services rather than recipients. The unique feature of their multidisciplinary teams is the inclusion of psychologists in their practice MDTs who support both patients and staff development. There is a strong focus on the wider determinants of health including collaborative working to tackle issues like domestic abuse.

The Nuka model has achieved a number of positive results including:

- Improved access to primary care services.
- A reduction in a variety of hospital activity metrics.
- Very high levels of patient satisfaction.

### **Analysis**

The Nuka model was included in an evidence submission as part of the first phase of HDdUHB's launch of transforming clinical services. It demonstrates how radical redesign of services, with a primary care focus, can improve outcomes. It also highlights that a strong primary care system can play an enhanced collaborative role in tackling issues affecting wider determinants of health.

The focus on psychological support for teams also appears to be a key aspect of their success and may form the basis for engaging on this question with staff.

## Estonia

What is notable about the primary care system in Estonia is that they have been successfully reforming their healthcare system over the last two decades around an independent contractor model for general medical practice which improved recruitment and retention of staff<sup>38</sup>. The core of their GP contract contains job descriptions for their GPs which reference the core principles of primary care and offers autonomy to doctors in practice. Improvements in their primary care system have also been built on simple consistent targets, a focus on improving quality and digitization. They have also successfully used financial incentives to achieve their goals.

### Analysis

A detailed understanding of Estonia's use of financial incentives and standardised job descriptions may be useful points of engagement with primary care teams in Hywel Dda. Their recent implementation of an independent contractor model demonstrates the potential for our own to be maintained and strengthened.

## Denmark

Denmark has a successful health system and the approach they take to urgent and emergency care has influenced HDdUHB's approach to UEC transformation. What is most striking in primary care is the great similarity between the GMS contract and the system of delivery in Denmark. There are a couple of notable differences which are that their system allows for a more flexible payment by results and for emergency work<sup>39</sup>. The second is that they have about one full time equivalent GP to approximately one thousand five hundred patients (1:1500), compared to the UK average of approximately 1:2300. The ratio of specialists to generalist is about 1:1 where in the UK this is closer to 1:2 with twice the number of specialists to generalists.

### Analysis

The Danish system of primary care highlights the importance of the number of GPs present in the community. It is likely from the evidence base presented in this paper that a move to reduce the ratio of GPs to population is likely to be associated with a significant number of emergent system benefits including reduce patient mortality and reduced costs. A more dynamic and accurate process for measuring workforce numbers, skills and location per cluster would assist in this regard.

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## Primary Care Systems in the UK

Despite the primarily uniform model that exists for provision of primary care services in the UK, there are some notable examples of targeted improvement to systems which can provide helpful information for the health board to consider:

### Deep End GP

In 2009 the RCGP helped fund a project which targeted the 100 most deprived practices in Scotland. The work was inspired by the pioneering GP Julian Tudor-Hart and was focused in the first instance to listen and respond to the views of the GPs running the practices in the 'deep end'<sup>40</sup>.

The group began to work together to develop reports and publications and has grown into a group with firm academic connections. A variety of projects have been developed as part of the collaborative which include a link worker programme, integration of health and social services in Glasgow, financial advice programme and alcohol nursing projects. The project has also secured funding for additional doctors to work in some practices ranging from more GP locums to academic fellows<sup>41</sup>. Deep End GP has projects set up in Greater Manchester, Yorkshire, Ireland and in Wales.

The Deep End projects are likely to be the most notable examples in the UK of a sustained effort to target improvements in care to the most vulnerable in society. The academic work of Michael Marmot supports this approach and can be summarised in two ways. Firstly, there is an obligation on those of us providing healthcare to question why we should treat patients only to return them to the conditions that made them sick. Secondly, unequal health care systems bring down outcomes for even those in the most affluent 5%. A fairer system improves outcomes for the whole population.

A summary of the work of Michael Marmot can be found by following this link: [Health Inequalities](#)

#### **Analysis**

An understanding of the social determinants of health and primary care's key role in collaboration with other community services in addressing them are central elements in developing a primary care strategy. This is a key opportunity for us to integrate with the 'social model for health' initiative and contribute to 'Marmott@' status of the health board. A specific consideration for staff and public engagement could be to explore the potential benefits of targeted projects in areas of deprivation.

### Cuckoo Lane Surgery – Nurse Led Primary Care Leadership

Following the retirement of GP partners, Cuckoo Lane surgery in Ealing, West London was transformed in 2005 into a nurse led social enterprise<sup>42</sup>. The leaders of the social enterprise are a practice nurse, advanced nurse practitioner and practice

manager. The practice serves 5,000 patients and employs 3 salaried GPs along with other team members. The practice was rated as outstanding by the Care Quality Commission (CQC) in 2015.

### **Analysis**

This example of general practice provision demonstrates the possibility of services delivered outside of a GMS model being facilitated by clinical leaders who are not necessarily GPs. However, the practice is not run without GPs which is also an important consideration. This may inform enhanced work to identify and train a wide range of clinical leaders in primary care organising local services in the community.

## **Additional Roles Reimbursement Scheme (ARRS)**

The ARRS began in 2019 in primary care networks in England and was introduced in order to improve access to general practice by reimbursing practice costs for recruiting 'additional roles' into patient facing care.

The scheme has been subject to much controversy and debate which has centred around workforce planning and concerns around clinical supervision of the new roles<sup>43</sup>. The ARRS scheme has been subject to very little empirical research however one study found that the scheme could possibly improve access to general practice for patients but expressed concerns about appropriate funding, estates and management of staff<sup>44</sup>. There is currently a lack of clarity around ongoing provision of the scheme beyond 2024.

Further qualitative data from Scotland has demonstrated that their more modest plans to enhance MDT working (similar to those in the ARRS plan) had not yet led to a reduction in workload and the care of complex patients. These difficulties were particularly highlighted in rural or deprived areas<sup>45</sup>.

### **Analysis**

The ARRS scheme can provide interesting insights for primary care providers outside of England including HDdUHB. At the time of writing there is anecdotal evidence of significant and complex workforce planning implications of the scheme which has created job shortages for GPs in some parts of England. In addition, it demonstrates (by its absence) the key importance of a shared vision for primary care within organisations supported by strong clinical leadership in local teams.

Services should not be planned around tackling specific diseases but around whole person care. This insight may inform questions to our staff and patients about who should be delivering care.

## Northumberland Primary Care

Northumberland Primary Care (NPC) is an important example of primary care delivery at large scale while retaining the GMS contract. They have an expanding group practice of up to one hundred thousand patients covering a diverse geography not dissimilar to HDdUHB. The practices retain autonomy over clinical delivery around a 'salaried partner' model. They all have a consistent approach to access via a 'digital front door' which is similar across England. While workload and clinical pressure remain significant, the model allows for scale of back office functions, including complaints handling and reduced risk and workload for senior GPs in employing staff and finances<sup>46</sup>.

### **Analysis**

GMS 'at scale' models are possible and have strengths and weaknesses that should continue to be monitored. In this model there are significant benefits which may form helpful consultation points with primary care teams.

***NB: At the time of writing an RCGP paper is to be published shortly summarising UK partnership models in more detail'***

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## Radical solutions

While the analysis sections of this document provide insights which may inform the strategic plan process and engagement with staff, the nature of the challenge facing our health board in transformation calls for a radical grass roots change. In the course of this work on international models there are several high-level radical changes the health board could consider which could enable system transformation in its engagement with primary care staff:

- Include the basic principles of primary care into core values of the organisation.
- To establish the first centre of excellence for multi professional primary care training in the UK
  - Promote, teach and evaluate clinical leadership in primary care
  - Develop primary care staff to lead at the operational interface of primary care
  - Develop unique quality metrics for services based on our primary care model
  - Create the environment for clinicians to work together in clearly defined interface space
- At scale, integration of contractor services under a unified contract including a standard contract for all staff embedding primary care system and social model for health standards
- Realise the emergent benefits to the system by reducing FTE GP to patient population through setting up new and smaller practices along with disinvestment in specialist services
- Develop a clinically led contractor professions forum to integrate services around the basic principles of primary care systems rather than disease areas

## Conclusion

This summary paper has covered the evidence-based characteristics of high quality primary care systems including complexity theory in PC. It also provides summary examples and analysis from selected examples of PC systems from around the UK and the world. It concludes some radical solutions for the health board to consider from the evidence provided.

*The lead author and the HDdUHB Primary Care Academy Team along with the PC Strategic Plan team welcome further discussion or correspondence from stakeholder in our region and beyond. We also wish to acknowledge the contributions of the whole primary care team in particular the task and finish group for workforce and sustainability.*

**Dr Will Mackintosh FRCGP**

**Clinical Lead - Primary Care and Community Services Academy, HDdUHB**

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## Summary of analysis – International and UK models

Section	Analysis
<p><a href="#"><u>Defining Primary Care</u></a></p>	<p>The HDdUHB primary care strategy should consider the evidence base for a strong primary care system and use these criteria to benchmark service planning and delivery going forward. Alignment of these principles with A Healthier Wales strategy allows for a clearer definition of primary care and form the basis for engagement with public and staff.</p> <p>In turn the evidence base for primary care systems provides a vision for person centred care that may both support or challenge the planning of services via disease pathways in the clinical services plan.</p> <p>Crucially, a strong primary care system reduces overall spending on healthcare and should be considered a core component of a move towards financial sustainability.</p>
<p><a href="#"><u>International models – USA</u></a></p>	<p>In HDdUHB we can learn much from the US system about how not to deliver primary care strategy. The limited success of primary care home models provides a basis for positive engagement with staff and patients about the organisation of multi-disciplinary teams.</p>
<p><a href="#"><u>International models – Norway</u></a></p>	<p>The similarities between the UK system and Norway are striking but incentives to focus on continuity and coordination of care appear to be associated with better patient outcomes and reduced costs. In particular, the provision of a ‘Named GP’ (which is mandated in Norway) may be an important engagement question for staff and patients as part of the primary care strategy.</p>
<p><a href="#"><u>International models – The Netherlands</u></a></p>	<p>There may be strategic lessons for HDdUHB which could inform staff and patient engagement from the Dutch system. These include the potential benefits of scaling up the ‘Pocket Medic project’ which could form the basis for dynamic ongoing engagement with primary care teams in health literacy. There may also be diverse benefits in the health board considering an enhanced offer for GPs to become involved in research. Our analysis of GP fellowships may support an expansion of this model.</p>

	<p>In HDdUHB in recent years we have associated small list size of practice with unsustainability. The Dutch system of primary care encourages smaller practice size and data from the UK suggests patient satisfaction is lower with larger practice list size. Further learning in HDdUHB may be available from the engagement with patients and staff on this question.</p>
<p><a href="#"><u>International models – Israel</u></a></p>	<p>Israel’s health system can provide inspiration for a primary care strategy for HDdUHB. It demonstrates the outcomes that can be achieved from a primary care focused system by a non-profit provider. In contrast to the UK model of independent contractor delivery, the model is run centrally and crucial to its success is the use of technology, shared records, co-locating clinicians in the community and delegating responsibility to GP-led local teams. The latter view is supported by a recent King’s Fund paper on care closer to home.</p>
<p><a href="#"><u>International models – Singapore</u></a></p>	<p>Singapore’s system demonstrates the importance of socioeconomic factors in the health of the population and the success of the healthcare system it provides. It invests heavily in the provision of universal primary care and has a high ratio of community services compared to hospitals in comparison to both HDdUHB and Wales.</p> <p>The Singaporean strategy of the three Bs provides a helpful example of public messaging which mirrors the strategy adopted by HDdUHB and may provide inspiration on how to expand the ‘care closer to home’ message.</p>
<p><a href="#"><u>International models - Nuka, Alaska</u></a></p>	<p>The Nuka model was included in an evidence submission as part of the first phase of HDdUHB’s launch of transforming clinical services. It demonstrates how radical redesign of services, with a primary care focus can improve outcomes. It also highlights that a strong primary care system can play an enhanced collaborative role in tackling issues affecting wider determinants of health. The focus on psychological support for teams also appears to be a key aspect of their success and may form the basis for consulting on this question with staff.</p>

<p><a href="#"><u>International models – Estonia</u></a></p>	<p>A detailed understanding of Estonia’s use of financial incentives and standardised job descriptions may be useful points of engagement with primary care teams in Hywel Dda. Their recent implementation of an independent contractor model demonstrates the potential for our own to be maintained and strengthened.</p>
<p><a href="#"><u>International models – Denmark</u></a></p>	<p>The Danish system of primary care highlights the importance of the number of GPs present in the community. It is likely from the evidence base presented in this paper that a move to reduce the ratio of GPs to population is likely to be associated with a significant number of emergent system benefits including reduce patient mortality and reduced costs. A more dynamic and accurate process for measuring workforce numbers, skills and location per cluster would assist in this regard.</p>
<p><a href="#"><u>UK models – Deep End GP</u></a></p>	<p>An understanding of the social determinants of health and primary care’s key role in collaboration with other community services in addressing them are central elements in developing a primary care strategy. A specific consideration for staff and public engagement could be to explore the potential benefits of targeted projects in areas of deprivation.</p>
<p><a href="#"><u>UK models - Cuckoo Lane Surgery</u></a></p>	<p>This example of general practice provision demonstrates the possibility of services delivered outside of a GMS model being facilitated by clinical leaders who are not necessarily GPs. However, the practice is not run without GPs which is also an important consideration. This may inform enhanced work to identify and train a wide range of clinical leaders in primary care organising local services in the community.</p>
<p><a href="#"><u>UK models - Additional Roles Reimbursement Scheme (ARRS)</u></a></p>	<p>The ARRS scheme can provide interesting insights for primary care providers outside of England, including HDdUHB. At the time of writing there is anecdotal evidence of significant and complex workforce planning implications of the scheme which has create job shortages for GPs in some parts of England. In addition, it demonstrates (by its absence) the key importance of a shared vision for primary care within organisations supported by strong clinical leadership in local teams. Services should not be planned around tackling specific</p>

	<p>diseases but around whole person care. This insight may inform questions to our staff and patients about who should be delivering care.</p>
<p><a href="#"><u>UK models - Northumberland Primary Care</u></a></p>	<p>GMS 'at scale' models are possible and have strengths and weaknesses that should continue to be monitored. In this model there are significant benefits which may form helpful consultation points with primary care teams.</p>

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## Community by Design Transformation Programme: DRAFT DELIVERY PLAN

This delivery plan has been developed through consolidation and alignment of existing documentation, as well as a range of engagement sessions with stakeholders across the system, notably a Ministerial Summit held on 14 October 2025 with 130 attendees. The delivery plan is intended to be a dynamic document that represents current agreed system priorities and activities and should not be seen as an exhaustive list of actions to be taken.

**Aim:** *A Healthier Wales* achieved through an integrated, sustainable, population-focused system delivering care closer to home, with prevention and wellbeing at its core where:

- Access and availability of services in the community is improved, and people and staff can navigate care pathways easily.
- Appointments are timely and appropriate to need, in the right setting (the right care at the right time and place).
- Staff well-being is enhanced through better flow, role clarity, and multidisciplinary support.
- Population health approach and prevention are business-as-usual, systematically embedded into every contact.

Design principles:

- Prevention as Core Business
- Equity and Welsh Language
- Embedding continuity of care between community providers
- Multidisciplinary community teams anchored in community care settings, integrating diagnostics, rehabilitation, and social care
- Digital-First (But Not Digital-Only)
- Reducing health inequalities and improving outcomes for communities.
- Clarity of Functions Before Structures
- Phased, Systematic Change
- Clinical Leadership and Co-Production

A phased approach will be adopted to first establish a strong and consistent foundation within the NHS. This initial phase focuses on ensuring there is a unified vision, clearly defined outcomes, deliverables and robust mechanisms for delivery and agreement across the Welsh Government and NHS Wales. By prioritising internal alignment and consistency, the NHS can strengthen its internal structures and processes, creating the necessary conditions for successful integration. Once this foundation is in place, wider partners can be engaged more effectively, ensuring that integrated services are delivered in a coordinated and sustainable manner.

In Phase I of the Community by Design programme the focus will be:

- build confidence through delivery of immediate enabling actions and quick wins e.g., community diabetes model, 0.5% population, Information Governance conclave, programme arrangements (please see included tables below).

Phase II will move to a delivery plan that reflects the transformational ambition of delivering integrated services in Wales.

## LEADERSHIP & GOVERNANCE

<b>AIM</b>	To improve health outcomes through an integrated, sustainable, population-focused system delivering care closer to home, with prevention and wellbeing at its core ensuring sustainable, high quality and innovative primary and community care services for the population.		
<b>OUTCOME</b>	A Programme of Transformation wholly aligned to <i>A Healthier Wales</i> delivery. Progress towards an agreed set of national health outcomes and provision of community services in line with national expectations.		
<b>DELIVERABLE A</b>	Ensuring clear local and national leadership and accountability for the delivery of integrated services in the community working closely with key stakeholders		
<b>ACTIONS</b>	<b>DESCRIPTOR</b>	<b>LEAD</b>	<b>WHEN</b>
<b>0-3 months</b>	Each Health Board and NHS delivery organisation to identify an Executive Director as the Responsible Officer for ensuring delivery of this agenda who will be a member of the National Programme Board	HBs	Dec 25
	Establish the Community by Design Programme and convene the Programme Board	WG/P&I	Dec 25
	Develop and agree the delivery plan	PB	Jan 26
	Health Boards to establish their own Transformation Programme arrangements that mirror that of the National Programme to ensure effective delivery	HBs	Feb 26
	Set objectives for Chairs and Chief Executives of HBs and other NHS organisations on advancing the delivery of integrated services in the community with clear accountability for delivery of the integrated care model in their area	WG	Apr 26
<b>3-6 months</b>	Implement local networks bringing together primary care clinicians with hospital clinicians to agree standardised pathways in line with national expectations and best practice	HBs	Mar 26
	Define national and local operational delivery mechanisms, specifically Cluster footprints and the governance arrangements for clusters	WG/HBs	Mar 26
	Clarify local 'commissioning' approach for Community by Design priorities	HBs	Apr 26
	Agree and publish Community by Design priority areas for 2026 / 2027	WG	Apr 26
<b>DELIVERABLE B</b>	<b>NHS Planning and Financial Framework that enables and supports the delivery of integrated services in the community</b>		
<b>3-6 months</b>	Ensure the planning and performance frameworks and remit letters include the expectation that Health Boards will develop integrated primary and community care services supported with a clear plan for the shift and workforce redesign.	HBs	Dec 25
<b>&gt;6 months</b>	Implementation of Breathlessness, Diabetes and Mental Health CbD pathways to be included in Planning Framework	WG	Apr 26
<b>&gt;6 months</b>	Develop a financial framework to support appropriate resourcing of integrated pathways	WG	Apr 26

<b>DELIVERABLE C</b>	<b>An agreed Shared Vision for how the ambition to deliver integrated services in the community will be realised and agreed Health Outcomes to be delivered by the system, described in a common language that is recognised by our society, public sector partners and the third sector</b>		
<b>0-3 months</b>	Develop and implement a communications and engagement plan for the CbD programme that covers the public, partners and NHS organisations	WG/P&I	Dec 25
	Communication events (six monthly) to share progress and good practice	PB	Mar 26
<b>&gt;6 months</b>	Communications for wider public notably with a focus on 'what matters to them' e.g., access.	TBC	TBC
<b>DELIVERABLE D</b>	<b>A National Quality, Improvement and Performance Monitoring framework for the Community by Design Programme to monitor progress and provide assurance that the aims of the programme are being met.</b>		
<b>0-3 months</b>	Develop a set of supporting indicators and metrics aligned to the National Health Outcomes Framework	PB	TBC
<b>0-3 months</b>	Develop arrangements for monitoring performance in relation to implementation of the delivery plan and agreed health outcomes.	PB	Feb 26

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## SERVICE TRANSFORMATION: PREVENTION, CHRONIC CONDITIONS & URGENT SAME DAY CARE

<b>AIM</b>	<b>To deliver care closer to home when it is evidenced that is more effective and efficient to do so.</b>		
<b>DELIVERABLE A</b>	<b>Develop and implement model for the management of long-term conditions in the community in line with the aims of the Cbd programme, rooted in population need and value-based care</b>		
<b>ACTIONS</b>	<b>DESCRIPTOR</b>	<b>LEAD</b>	<b>WHEN</b>
<b>0-3 months</b>	Define a standard model (functions, outcomes, pathways) for high-burden chronic conditions (e.g. CVD, diabetes, COPD, MSK, mental health), using a community by design approach	PB	Mar 26
	Work up plans to implement the model in a phased manner as required	HBs	Mar 26
<b>3-6 months</b>	Commence plans to implement the immediate, quick win areas identified in the Planning Framework: respiratory, breathlessness pathway, diabetes, mental health	HBs	Apr 26
<b>3-6 months</b>	Consider how community diagnostic hubs can best be developed to meet both the needs of urgent care and chronic condition management ensuring with rapid access, integrated booking/results, and co-location with urgent/community services where feasible.	TBC	TBC
<b>3-6 months</b>	Health Boards to consider appropriate models for multiprofessional working and to develop a plan to map existing resources into these models.	HBs	Mar 26
<b>3-6 months</b>	Agree and publish priority Community by Design areas for 2026 / 2027	PB	Mar 26
<b>DELIVERABLE B</b>	<b>Urgent and Same Day Care: Timely access to appropriate services, reducing complexity, supporting effective navigation to the right services and making effective and efficient use of existing capacity</b>		
<b>0-3mths</b>	Develop the Community by Design model for urgent and same day care that defines the national ambition, expectations and roadmap for the transformation to increase access and availability of integrated, sustainable urgent and same day services in the community which people and staff can navigate easily.	PB	Mar 26
	Conclude QS&I audit re urgent care demand in cohort of managed practices and latest data for 111, OOHs, Clinical Support Hubs and SDEC.	NHS P&I	Feb 26
	Define & develop minimum viable specification (product) for Minor Injury Units / Minor Illness Units / Community Pharmacy Minor Ailment Schemes / Role of pharmacist within urgent care.	NHS P&I	Mar 26
	Clarify national vs local responsibilities – define which elements of the programme are nationally specified and which are for local adaptation especially regarding MIU and UPCC.	WG/ NHS P&I	Mar 26
<b>3-6 months</b>	Monitor implementation of and assess impact from 0.5% high risk cohort Ministerial Priority	WG/ P&I	Apr 26
	Explore national opportunities for digital consultation that meet urgent primary care demand on GP practices and OOHs to ensure greater consistency 24/7 (to be informed by outcome of QS&I audit), noting the contract renewal for OOHs before Dec 2026.	NHS P&I	Mar 26
	Pilot and audit demand data – conduct rapid audits in selected practices to quantify the volume and type of urgent demand, understand how it is being dealt with an whether there are alternative options for	NHS P&I	Apr 26

	delivery either in practice or other services, informing future planning and prioritisation (shaping strategy for the next 5 years)		
	Develop primary and community care KPIs and dashboard development	NHS P&I	Apr 26
	Map and consolidate community services – Each Health Board to map existing urgent and community care services to support integration with SPOA, 111, and winter planning and ensure information is fully updated on the Directory of Services.	HBs	Mar 26
	Review and define 7/7 requirements for effective urgent care/same day response to escalating needs to mitigate avoidable demand at national, regional and local level NB particularly in relation to adults with complex needs (acute frailty and falls, end of life)	WG/NHS P&I	Mar 26
	Benchmark current 7/7 provision against agreed definition and ensure awareness across 111 / WAST / Directory of Service	WG/NHS P&I	TBC
<b>&gt;6 months</b>	Consolidate Directories of Service (across NHS, Local Authorities and Third Sector) into 'Once for Wales' approach that effectively provides 111/SPOA with information to signpost patients to right service/right time/right place	NHS P&I/WG	TBC
	Undertake piece of discovery that explores opportunities and interventions that increase uptake of pharmacy enhanced services	WG	Apr 26
<b>DELIVERABLE C</b>	<b>Implement a preventive approach to support people to remain well in the community and apply population health management approaches, adopting Proactive Care Management of 'Rising Risk' and 'High Risk' Population Groups</b>		
<b>0-3 months</b>	Develop the Community by Design model for primary and secondary prevention that enables people remain well in the community.	PB	Mar 26
	Identification and management (0.5%) this winter outlined in Winter Toolkit and evaluate its effectiveness	HBs	Mar 26
	Design a Population Health Management approach for Wales. A commitment to develop a 'roadmap to delivery' by April 2026 is part of the workplan of the existing Population Health Management Task and Finish Group.	PB	Apr 26
	Identify priority preventative interventions (e.g. vaccination, blood pressure/AF detection, smoking cessation, weight management) and embed them in the models for chronic conditions (deliverable A) and urgent care contacts (deliverable B) and commission these at a cluster/locality level.	PB / HBs	TBC
<b>3-6 months</b>	Implement population health management to identify and proactively support vulnerable cohorts, integrating self-management and personalised care planning. This will include the need for consensus about a national approach to a population health management for proactive management of the most vulnerable populations and actions to reduce inequalities such as outreach to underserved groups.	TBC	TBC
	As part of the model for primary and secondary prevention, incorporate prevention approaches as an integral part to the development of patient-centred, equitable, and effective holistic care. Develop and deliver training and resources to support preventive approaches including "Making Every Contact Count".	TBC	TBC

## DATA & DIGITAL

<b>AIM</b>	<b>System-wide intelligence capability: data &amp; digital architecture, information governance &amp; legislative framework Digital System enablers that support integrated data driven approaches to delivering integrated care</b>		
<b>OUTCOME &amp; MEASURES</b>	<b>Information Governance that supports integrated working Inter-operability of systems that connect services to deliver integrated care</b>		
<b>DELIVERABLE - A</b>	<b>Information Governance that supports integrated working</b>		
<b>ACTIONS</b>	<b>DESCRIPTOR</b>	<b>LEAD</b>	<b>WHEN</b>
<b>0-3mths</b>	IG conclave - collective agreement on the 'art of the possible' with regards information governance	DHCW	Feb 26
	Clear road map to address information governance / data controller issues	WG	TBC
<b>DELIVERABLE - B</b>	<b>Inter-operability of systems that connect services to deliver integrated care</b>		
<b>0-3mths</b>	Identify a rapid solution for cluster working whilst the roadmap for a digital record across primary care and community services is developed. Agree test areas– by February 2026 e.g. <ul style="list-style-type: none"> <li>• Pathways e.g. Breathlessness, Diabetes</li> <li>• Cluster pilots</li> <li>• Women's Health Hub</li> <li>• Unscheduled care navigation hub /SPOAs</li> </ul>	DHCW	Feb 26
	<b>3-6 months</b>	Develop a roadmap including: <ul style="list-style-type: none"> <li>• an integrated digital patient record in primary &amp; community care</li> <li>• a digital solution to facilitate community working at scale 24 /7</li> <li>• consensus and a national digital infrastructure to support local implementation of Population Health Management approaches.</li> </ul>	DHCW
<b>&gt;6 months</b>	<ul style="list-style-type: none"> <li>• Create working groups focused on care navigation/digital triage and AVT/AI Scribes, with the aim to develop a plan - by Q2 2026</li> </ul>	WG	Apr 26
<b>DELIVERABLE - C</b>	<b>Develop enhanced functionality of the NHS App</b>		
<b>3-6 months</b>	Develop a design or prototype for the potential future NHS Wales App experience for an improved 24/7 experience	DHCW	Jun 26
	Scope an approach for bringing self-care apps into the NHS Wales App experience (24/7)	DHCW	Jun 26

## WORKFORCE & ESTATE

<b>AIM</b>	<b>Build the organisational and system foundations for integrated working; <i>includes our Commissioning Approach, Workforce Development &amp; Preparedness</i></b>		
<b>OUTCOME</b>	<b>Workforce readiness for integrated working</b>		
<b>DELIVERABLE A</b>	<b>Workforce readiness for integrated working</b>		
<b>ACTIONS</b>	<b>DESCRIPTOR</b>	<b>LEAD</b>	<b>WHEN</b>
<b>0-3 months</b>	Consider how to support clinical and care coordination skills for current workforce to provide the enhanced frailty service using Primary Care academy and HEIW multi professional unit	HEIW	Feb 26
	General Practitioners <ul style="list-style-type: none"> <li>- Consideration of the immediate actions on training numbers</li> <li>- Position (policy/funding) on employment of General Practitioners</li> </ul>	WG	Mar 26
<b>3-6 months</b>	Develop workforce planning scenarios for the future General Practice workforce as part of the future multi professional workforce model to inform future training numbers	HEIW	Sept 26
	Local OD work to bring primary and community care services, understand roles and agree priorities, together with support nationally where required.	HBs / HEIW	May 26
<b>&gt;6 months</b>	Developing a longer-term workforce model to support integrated health services in the community. This would include: <ul style="list-style-type: none"> <li>- mapping current developments</li> <li>- inform a national set of design principles or model to be developed locally</li> <li>- establish clear baseline – what roles and skills have we got now so that these can be mapped against the future model to inform workforce planning and supply.</li> </ul>	HEIW	TBC
<b>DELIVERABLE B</b>	<b>Placed based planning, commissioning and associated governance and resourcing arrangements</b>		
<b>0-3mths</b>	Review estate utilisation (hub-and-spoke model) across HB agreed geographical delivery mechanism (e.g., 'Cluster')	Shared Services	Mar 26
<b>3-6 months</b>	Explore the potential of a Collaborative Directed Supplementary Service particularly with reference to the identified priorities for Community by Design	WG	Feb 26
<b>DELIVERABLE C</b>	<b>Data-informed decision making is enabled (based on segmentation and stratification)</b>		
<b>0-3 months</b>	Map existing population health management approaches, monitor, evaluate	NHS P&I	Feb 26
	Establish Community of Practice to support national spread and scale while national data / digital architecture is developed	NHS P&I	Feb 26
<b>3-6 months</b>	Assess and develop plan to enhance workforce skills and competencies in PHM, planning and commissioning at national and local level to enable Intelligence to Innovation (Clusters, Planners / Commissioners)	HBs	Apr 26
<b>&gt;6 months</b>	Implement population health management across all health boards supported by a single health tool for Wales if needed.	Directors of PH	TBC

DRAFT

# Stakeholder Insights and Feedback

This document outlines the feedback gathered during engagement sessions with the following groups:

- General Practice Collaboratives & Practice Managers
- Community Dental Service
- Optometry Collaborative
- Community Pharmacy Collaborative
- Mental Health, Allied Health Professions and Health Science

While the document reflects feedback on any specific ideas that have been reported, it also captures wider views and emerging proposals aimed at supporting the delivery of intended priorities. These insights highlight potential approaches to ensure the transformation of primary care and community services.

General Medical Services – GPs and Practice Managers
<b>1.</b> Moving to a minimum and maximum practice list size to ensure future sustainability of general medical service provision
<b>What was suggested:</b>  The Health Board sets a minimum and maximum number of patients for each GP practice to help make sure services are sustainable.
<b>What people said:</b> GPs and Practice Managers wanted to know what the exact numbers would be and how they would work. <ul style="list-style-type: none"><li>• Some worry that small practices might have to close or join with others, which could make it harder for some patients to get care, especially in rural areas.</li><li>• There are concerns about whether just counting patients is the best way to measure if a practice is working well.</li><li>• GPs and Practice Managers said that funding and staff numbers are also important measurements, not just patient numbers.</li></ul>
<b>Risks:</b> <ul style="list-style-type: none"><li>• Some patients might have to travel further if their local practice closes.</li><li>• Rural areas could lose services.</li><li>• There might not be enough money or staff to support bigger practices.</li><li>• The current contract does not provide regulations that would support these changes.</li></ul>
<b>Overall:</b> Most GPs did not support this idea.

## General Medical Services – GPs and Practice Managers

2. Seek an external provider to contract with for the delivery of Managed Practices and Out of Hours services. Managed Practices are GP practices that are run by the Health Board, rather than run by an independent contractor.

What was suggested:

Seek an external provider to contract with for the delivery of Managed Practices and Out of Hours

What people said:

- Many worry this could make things worse for patients and staff.
- Local GPs might leave, and patients could lose their regular doctor.
- It could cost more money and not improve care.
- There is not enough evidence that this would work better.

Risks:

- GPs might leave or not want to join.
- Rural areas might not get the care they need.
- Patients could lose the close relationship with their GP.
- It could be more expensive and harder to manage.

Overall:

Most GPs did not support this idea.

### General Medical Services – GPs and Practice Managers

3. Making all future GP Practices run by the Health Board

What was suggested:

Agreeing that all future GP contract terminations become a salaried service via Health Board Managed Practice

What people said:

- This could cost a lot more money.
- GPs might not want to work as salaried staff.
- Patients might not get the same level of care or continuity.
- It could be hard for the Health Board to manage many practices.

Risks:

- Higher costs.
- GPs might not feel as committed.
- Patients might not see the same doctor.
- Too much work for the Health Board.

Overall:

GPs and Practice Managers think support should be given to practices that are struggling, but not all should be run by the Health Board.

### General Medical Services – GPs and Practice Managers

4. Pump priming small GP practices (Netherlands model)

What was suggested:

Give extra support, including funding to small GP practices, like in the Netherlands model of pump priming small providers. Pump priming means to provide additional resources, most often financial support to help support and grow a project, organisation or idea.

What people said:

- Most people support the idea of helping small or single-handed practices, especially in rural areas.
- There are questions about what counts as a “small” practice and how to make it fair for all.
- Larger practices also need support, as size is not the only factor in fragile service provision

Risks:

- Larger practices may not feel equity in outcome.
- It could be hard to decide who gets help, as the parameters are not clear
- The support could generate additional administration work and could slow things down.

Overall:

GPs and Practice Managers want more information about how this would work and want it to be fair for everyone

## General Medical Services – GPs and Practice Managers

5. Health Board lease holding for all GP Practices with an investment programme into the estate (match funding of Improvement Grants). Work with GP sector to improve GP practice estate in line with stock conditions survey

What was suggested:

The Health Board would take over the leases for all GP practice buildings and invest in improvements.

What people said:

- Many like the idea of improving buildings.
- There are worries about costs and if this was possible and affordable
- Many questioned who would be responsible for the building
- Many questioned if this would mean that GPs would lose control of their business

Risks:

- High costs for the Health Board.
- GPs might not want to join if they don't own the building.
- More paperwork and slower repairs.

Overall:

GPs and Practice Managers want clear rules and fair access to improvements for all practices, rather than one way of dealing with improving the GP estate.

## General Medical Services – GPs and Practice Managers

6. Move to delivering urgent, on the day care through a salaried GMS / alternative commissioned model.

What was suggested:

Move urgent, same-day GP care to a salaried or specially commissioned service.

What people said:

- People want to know what counts as “urgent” care.
- There are worries about breaking up care and making it harder for patients to see the same doctor.
- People had concerns about costs.
- People had concerns about staff burnout.
- People had concerns about rural access.

Risks:

- Confusion about what is urgent.
- Patients might not get continuous care.
- Staff could be overworked.
- Rural areas might lose out.

Overall:

GPs and Practice Managers want more details and careful planning before making changes.

### General Medical Services – GPs and Practice Managers

7. Develop a GP fundholding approach to commissioning of secondary care services for certain specialities. Fund holding would mean that GPs are in charge of commissioning some services for their patients.

What was suggested:

Enable GPs to manage / provide some hospital services, like dermatology or rheumatology.

What people said:

- This could help tailor services to local needs and save money.
- GPs worry about having too much extra work and not enough support.
- There needs to be clear rules and enough resources.

Risks:

- GPs could be overworked.
- Not enough support staff.
- Services could become fragmented.

Overall:

GPs and Practice Managers support trying this with clear plans and support

Conclusion:

The feedback from GPs and Practice Managers shows that people want changes to be fair, clear, and well-planned. They want to make sure that all patients, especially those in rural areas, can get good care. Any changes should be carefully thought out, with enough funding, support, and clear rules to help everyone.

### Optometry, Community Pharmacy and Community Dental Services

The following feedback was provided following on from group discussions on some specific ideas that had been suggested as well as the feedback from general discussions on new ideas that the group members put forward.

### Optometry

### Main ideas and feedback

1. Enabling optometrists to diagnose Glaucoma. - Enable optometrists (eye care specialists) confirm if someone has glaucoma, a serious eye condition.

- People said that, according to current rules (NICE guidelines), only consultant eye doctors can confirm this diagnosis.
- Some thought that optometrists could help more if they had extra training and if consultants could check their work remotely.
- There are not enough highly trained optometrists right now, so more training would be needed.

2. Optometry-Led Yttrium Aluminium Garnet (YA) Laser Clinics - Enable optometrists to run clinics for a special laser treatment after cataract surgery.

- People liked this idea and said it is already starting to be rolled out.
- They suggested adding more types of laser treatments to these clinics.

### Additional group suggestions

Members of the Optometrist Collaborative suggested the following additional ideas:

- Make it easier for patients to know when to see an optometrist instead of going to A&E or the pharmacy, through a communication and signposting plan.
- Join up digital patient records to allow optometrists to see patient records to give better care.
- Improve the NHS app so patients can see all their medical history and test results.
- Include optometry practices in building improvement grants, like GPs and dentists.

## Community Pharmacy

1. Expanding Community Pharmacy Services with more Patient Group Directions (PGDs) – to let pharmacists give certain medicines without extra training.

- Pharmacy Collaborative members said using PGDs is a quick way to offer more services to patients.
- It would help patients get treatments faster
- It would reduce demand on GPs

2. All Community Pharmacists Become Independent Prescribers (IPs)

- Pharmacy Collaborative members highlighted a number of challenges to becoming an IP, including:
  - cost for the course
  - Finding and funding replacement staff to cover business needs,
  - finding a university
  - getting mentors with the experience and time.
- Pharmacy Collaborative members said that more support and funding are needed to help pharmacists become IPs.

3. Increase the number of dispensing machines

- Some pharmacies use machines to give out medicines when the pharmacy is closed.
- These machines can be helpful but can have problems, like technical issues and high costs for maintenance.
- Staff need to check the machines every day to make sure they work properly.

4. Community Pharmacy to managing Long-Term (Chronic) Diseases.

- Pharmacy Collaborative members said this could work, but pharmacies would need:
  - more money,
  - More staff,

- Additional room/s
- clear rules for referring patients to other health services.
- Shared patient records

#### 5. Additional Group Suggestions

- Invest more in community pharmacy training.
- Make it easier for pharmacies to get funding for new services and building improvements.
- Improve digital systems so community pharmacies and GPs can share information easily.

## Community Dental Services

### Recruitment Challenges

- Community Dental Services staff said that it is hard to hire enough dental staff quickly and this is a barrier to service provision.
- The process for hiring new people takes a long time and can slow down improvements.

### Community Dental Services Ideas

1. Commissioning Dental Services - Enable community dental teams provide more routine dental care.

- To make this work Community Dental Services staff said this would need:

- more staff,
- better equipment
- allocated space.

- The Health Board would need to invest money to make this happen.

2. Develop a Dental Training Unit (DTU) – Create a special training centre for dentists.

- This would help train more staff and enable more treatments to be done locally.
- The DTU would need new buildings and equipment.

3. Extended Hours in Carmarthen Hub

- There is a plan to offer dental services for longer hours in Carmarthen.
- This would need more staff and changes to job roles.

4. Social Enterprise Model - To work with a social enterprise (a business that helps the community) to provide dental services.

- This could help with hiring staff and running services more smoothly.
- There are examples of this model that we could learn from
- This would mean that the health board would need to build a partnership with another organisation.

## Conclusion – themes from the Optometry, Community Pharmacy and Community Dental Services engagement

The feedback from optometry, community pharmacy, and dental teams shows that people want to improve services for patients, but there are challenges. These include:

- needing more staff
- better training
- improved buildings
- easier ways to share information.

Everyone agrees that changes should be fair, well-planned, and make it easier for patients to get the care they need.

## Mental Health, Allied Health Professionals, and Health Science

### Mental Health Services Feedback

1. Local Primary Mental Health Support Service (LPMHSS)
  - The law for mental health services in Wales has not changed recently.
  - The main jobs of the service are to assess people's mental health, give treatment, refer people to other helpful services, and provide advice to patients and their carers.
  - The Health Board has updated its agreement with local councils to make sure everyone knows their roles.
2. Working Together
  - Future meetings will include more people, like those from neurodevelopmental services, to make sure all voices are heard.

## Allied Health Professionals (AHPs) and Health Science

### Allied Health Professionals (AHPs) and Health Science

The draft priorities were presented to the AHP and HS teams. People were asked their opinion on the draft priorities and for their ideas of how to deliver the priorities for their services. The following ideas were provided by the teams.

#### Occupational Therapy (OT)

##### 1. Integration in Primary Care

- Occupational Therapists (Ots) are already working more closely with GP surgeries to help patients earlier.
- There are pilot projects where OTs work part-time with GP clusters, and these are being extended.
- Pembrokeshire has a model where OTs are available in all GP surgeries, helping build strong relationships.

##### 2. Open Access and Referrals

- Patients can be referred to OTs by GPs or other health teams, and sometimes directly.
- OTs have concerns about having enough resources if more people start using OT services through GPs

##### 3. Barriers and Education

- There is evidence that some people – public and other professionals - don't fully understand what OTs do and think they only provide equipment.
- Better communication and education about what OTs can do is needed so OTs can help more people

##### 4. Digital Systems

- OTs use digital systems to share patient information, but there are big challenges in the system.
- Whilst there are some projects to improve how data is shared and used; there needs to be more integrated and accessible patient information

##### 5. Using Technology and AI

- AI (artificial intelligence) can help find patients who need help early, preventing hospital stays.
- Some clusters are testing ways to use data to spot patients at risk. This should be scaled up

#### 6. Fit Notes and Vocational Rehabilitation

- OTs want to help with fit notes (documents for work) as part of their therapy work. This would meet the Social Model for Health and Wellbeing Principles that have been agreed by the Health Board as well as freeing up GP appointments.
- There is a need for clear rules and training for this.

#### 7. Funding and Service Expansion

- Funding for OT services is often short-term, making it hard to plan for the future.
- People want the Health Board to provide more stable funding

#### 8. Facilities and Group Programmes

- There are challenges finding space for group sessions and community programmes, and the budget to use community spaces for patient sessions.
- Partnerships with local organisations could help, but funding and planning are needed.

#### 9. Involvement in Continuing Healthcare (CHC) Teams

- OTs want to play a bigger role in teams that help people with complex health needs.
- Right now, these teams are mostly led by nurses.

### Multi-Model Rehabilitation

#### Main Priorities:

1. Empowering Communities: Help people manage their own health through support groups and early help.
2. Holistic Care: Work together across services to provide complete care, including long-term conditions and mental health.
3. Simplifying Access: Make it easier for people to get the help they need, especially urgent care.
4. Improving Digital and IT: Use technology to help patients and staff, making information easy to find and share.
5. Reviewing Estate Needs: Make sure there are enough spaces and facilities for services to work well.

### Audiology (Hearing Services)

#### 1. Advanced Practice Audiologists

- There is a plan to have expert audiologists in community settings to help people with hearing, balance, or tinnitus problems.
- This would mean people don't always need to see a GP first.
- The service needs investment in buildings and staff.

### Community Psychology Services

#### 1. Empowering Communities

- People need better IT support is needed to help people find psychological advice and self-help online.

## 2. Holistic Care

- Psychology services help people with both mental and physical health problems.
- Pilots have shown that early help can reduce hospital visits and improve health.

## 3. Simplifying Access

- Waiting lists for psychological help are long, which affects patient health.
- Digital resources and support are needed to help more people.

## 4. Improving Digital and IT

- Many psychology services are delivered remotely, which works well for patients.
- IT experts help make data easier to understand and use.

## 5. Estate Needs

- There is not enough office space for staff, and some leases are ending soon.
- Remote appointments are popular, but staff need confidential spaces to work.

## Podiatry

### 1. Provide Holistic Care

- Podiatrists want to review how and who does diabetic foot checks, which are sometimes repeated because GPs lack training or equipment.
- Better training and communication with GPs could help.

### 2. Simplifying Access

- New pathways have reduced waiting times for surgery, but there are now more referrals, creating new challenges.
- Education for GPs could help make sure only the right cases are referred.

### 3. Group Education

- Group sessions for patients help prevent serious foot problems.
- Keeping good records is important for patient safety and legal reasons.

## Speech and Language Therapy

### 1. Holistic Care

- The team find it hard to arrange meetings with GPs for patients' best interests.
- Most referrals are for swallowing problems, especially in care homes.
- Staff shortages mean long waits for help, which can lead to greater health problems for patients.

### 2. Simplifying Access

- Providing outside organisations with training and education could help staff spot problems earlier.
- Putting in place and working with dementia coaches could improve care and service demand

### 3. Improving Digital and IT

- Services still use paper records, which makes things harder. IT records and links are required right now.

## Physiotherapy

### 1. Funding and service models

- Many services are funded short-term, which is not sustainable.
- More data is needed to plan for the future and keep people healthy.

## 2. Scope of NHS Services

- Physiotherapists can help people of all ages and with many conditions.
- Clear decisions are needed about what the NHS should provide and what could be done by other organisations.

## Dietetics

### 1. Food systems and community support

- The team have clear ideas to help tackle food poverty, like community kitchens and gardens.
- Programmes and apps are already helping people learn about healthy eating and cooking. These can be scaled.

Conclusion – themes from mental health allied health professionals and health science engagement

The feedback from mental health, allied health, and health science teams shows that people want:

- services to be joined up and better understood in terms of what each are capable of doing for patients.
- Services must be easier to access
- Services must be well-funded, including long term/ permanent funding
- Teams want to use technology including AI to help patients and staff
- Enough spaces and resources.

## Current projects and future operational action plan

During the development of the Strategic Plan innovative projects in Primary Care and Community settings have already started to work towards the achievement of the identified priorities and supporting a reduction in hospital stays. [Hywel Dda Community and Primary Care Briefing 2.pdf](#).

The following operational and strategic actions have been identified by Primary Care senior leaders to be taken forward in 2026- 2027.

Priority	• Actions
Priority 1 - Prevention	<ul style="list-style-type: none"> <li>• Map the current Social Prescribing commitment across the Primary Care Clusters and ensuring that signposting information is readily available for patients</li> </ul>

	<ul style="list-style-type: none"> <li>• Explore commissioning Health Coaching at Cluster level across the Primary Care professions to ensure that consistent and appropriate messages are given to patients</li> <li>• Consider the use of group consultations for relevant patient groups to ensure that health literacy is improved and patients are confident in articulating their needs which leads to co-produced care plans, taking account of best practice.</li> <li>• Review falls prevention, linking to polypharmacy and Low Vision Services as well as Third Sector agencies; patient identification via a risk stratification tool linking to and expanding on the Directed Supplementary Service for Frailty based on the top 0.5% of the population</li> <li>• Explore Commissioning Local Supplementary Services for patients with Heart Failure and Atrial Fibrillation, both of which have been tested as Cluster initiatives that have identified a benefit both in terms of patient outcomes and the health system.</li> <li>• Progress with the Women's Health Local Supplementary Service specification for commissioning</li> <li>• Optometrist led YAG laser clinics with PROMS data to measure patient outcomes</li> </ul>
<p>Priority 2 – Partnership Working</p>	<ul style="list-style-type: none"> <li>• Agree a number of appointment slots based on Practice list size at both ends of the working day to allow for the pre-booking of patients into in hours GMS or Out of Hours services for patients who present early or late in either service that need to be seen on the day but not urgently. This will stop patients being redirected back through 111 and will ensure that patients are booked in to see the most appropriate clinician. If clinical systems allow (Odyssey Patient), this could be expanded to booking into a Community Pharmacy or Optometrists.</li> <li>• Implement Optometrist led YAG laser clinics delivered in acute sites but improving the timeliness of care to patients</li> <li>• Seek to commission services at Cluster level across a range of professional groups to ensure that every opportunity to engage with patients is taken e.g. a weight management service might be led by a GP Practice but a Community Pharmacy could have a role in identifying patients who are seeking Over The Counter (OTC) weight management products, NHS Dentists will undertake a risk assessment of patients using the ACORN tool which allows them to educate the patients on their diet and Optometrists will see patients who are part of the Diabetic pathway and could take the opportunity to provide signposting and advice.</li> </ul>

	<ul style="list-style-type: none"> <li>• Review key Cluster projects where a new approach to delivering care on a multi-agency basis to patients meets Value Based Healthcare principles e.g. the Amman Gwendraeth Cluster MDT approach to pain management. Opioid prescribing continues to be a risk for the Health Board.</li> <li>• Community Pharmacies can deliver chronic disease management services. The model is supported by the OECD Patient Reported Indicator Surveys (PaRIS) Does Healthcare Deliver (February 2025)<sup>1</sup>. Scope whether this model could be commissioned across Community Pharmacies to improve patient outcomes and compliance with medication.</li> </ul>
Priority 3 - Access	<ul style="list-style-type: none"> <li>• Further explore providing chronic disease management based on the patients' needs rather than being disease specific. Pilots in both Ash Grove and Tenby Surgeries for pharmacist-led chronic disease management has seen patients with multiple chronic conditions have single reviews where all necessary tests were requested in advance, allowing for medicine optimisation and considering polypharmacy.</li> <li>• Develop a Women's Health Supplementary Service that can be provided across Community Pharmacy and GP Practices that improves the scope and range of services that can be delivered within Primary Care including more specialist menopause and osteoporosis care at Cluster level.</li> <li>• Consider the investment to support the purchase of automated dispensing machines at Community Pharmacies to improve accessibility to prescribed medication outside of normal working hours.</li> <li>• Review the potential to shift some Outpatient services into Primary Care as part of a Local Supplementary Services agreement.</li> <li>• Move to the four C's approach for continuity of care should provide patients with improved clinical management and outcomes reducing the need for multiple attendances and improving overall service accessibility</li> <li>• Share the learning from the Pharmacist led chronic disease management in Managed Practices with recommendations on the future model of care</li> </ul>
Priority 4 – Digital Offer	<ul style="list-style-type: none"> <li>• Commission Odyssey Patient for use in Out of Hours / In Hours Primary Care as a system that enables remote triage and booking of patients and can be used across Accident</li> </ul>

<sup>1</sup> [Full Report: Does Healthcare Deliver? | OECD](#)

	<p>and Emergency Departments, the Out of Hours Service and in hours Primary Care e.g. Community Pharmacy. The system will assist with patient flow and provide an assurance that care is being managed in a timely way.</p> <ul style="list-style-type: none"> <li>• Consider the purchase of EMIS Community, in line with any national procurement programmes to ensure consistent recording of patient information across GP Practices and Community Services; this could include Intermediate Care Services and Cluster projects where access to clinical records is needed</li> <li>• Review the use of digital triage tools in General Practice that support the appropriate signposting of patients and enabling the provision of more timely care</li> <li>• Support the improved use of the NHS App supporting the booking of GP Practice appointments and ordering repeat prescriptions.</li> <li>• Maximise the benefits of having one single GP clinical system alongside the introduction of electronic prescribing considering the impact that both of these have on patient care and the wider system</li> <li>• Progress with the development of the GP Practice dashboard bringing together available data across GP Practices and Secondary Care which will bring greater insight into demand and capacity management as well as clinical management of patients.</li> <li>• Trial the In Hours / Out of Hours cross booking system, with the aim of securing the agreement to move forward with system procurement</li> <li>• Trialling the GP Practice dashboard with the six Health Board Managed Practices and those IC Practices that have expressed an interest in being part of the trial.</li> </ul>
<p>Priority 5 – Estates and Infrastructure</p>	<ul style="list-style-type: none"> <li>• The Welsh Government Improvement Grant (IG) fund for GMS has been suspended for a number of years whilst the Premises Cost Directions have been reviewed subject to changes in England. Historically, the better organised Practices have been successful at securing funding to develop their own premises, whilst those which we might consider to be in greater need do not come forward. Further incentivising the scheme either to support 100% rather than 66% reimbursement or match funding the scheme to allow for greater levels of development to be undertaken could support future sustainable service delivery without major redevelopment of the estate.</li> <li>• During the last two years Welsh Government has supported a Community Pharmacy Improvement Grant programme to</li> </ul>

	<p>support the expansion and development of existing premises, enabling contractors to support the shift from dispensing items to wider service delivery. This is a programme that again could be match funded on a Health Board basis with consideration given to supporting the purchase of automated dispensing machines to allow for ease of access to patients who have not been able to access the Pharmacy during normal working hours.</p>
<p>Priority 6 – Workforce and Sustainability</p>	<ul style="list-style-type: none"> <li>• Look at different GP Practice operating models (e.g. micro teams) to better manage patient demand and ensure that care is provided to the patient and not condition specific. This would see multi-professional teams working together in joint consultations</li> <li>• Whilst the Health Board has a GMS Practice Merger package in place it has not been used for several years. Whilst workforce issues appear to have resolved for many Practices, mentorship for newly qualified clinicians to ensure that they are supported to undertake their due diligence when joining a Partnership has proved to be a useful tool to support the continuation of the partnership model. Alternative solutions to sustainability measures across the professional groups needs to be considered.</li> <li>• Consider the use of group consultations for relevant patient groups to ensure that health literacy is improved and patients are able to co-produce their care plans and take responsibility for their own health and wellbeing</li> <li>• Primary Care workforce planning that includes operational services (Managed Practices, Community Dental Services, Out of Hours) to ensure future workforce plans articulate the future service delivery model. Through the Primary and Community Services Academy training, education and development plans are produced that support multi professional education and learning</li> </ul>

2.3

16:30, 30 Mins

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2.3 - AHMWW Business Case Addendum

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| For approval

**Attachments**

[2.3 PBC Addendum Presentation to S\\_PC v0.3.pdf](#)



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# **A Healthier Mid and West Wales (AHMWW) Programme Business Case Addendum (Draft subject to finalisation)**

Strategy and Planning Committee, 16 January 2026



## Section 1 - Key points from Programme Business Case (PBC) Addendum

- Scope of the PBC Addendum
- Capital costs
- Implementation timelines
- Travel time analysis
- Communication and Engagement/Impact Assessments
- Next steps

## Section 2 - Background

- An overview of chronology
- Information shared at Board meetings (November 2025 Board)

## Section 3 - Discussions with Welsh Government 2024/2025

- Range of additional scenarios to be considered
- Next steps agreed
- The assessment of the phased redevelopment of Withybush Hospital (WGH)
- The assessment of the phased redevelopment of Glangwili Hospital (GGH)
- Summary feasibility findings / agreed way forward
- WG meeting 4 November 2025 and delivery expectations PBC Addendum



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## Section 1 - Key points from the PBC Addendum



## Do nothing

Agreed to be not applicable at meeting with Welsh Government (WG) and Shared Service Partnership (SSP) on 27 November 2025.

Option does not eliminate any risks – unsustainable from service and infrastructure perspectives

## Do minimum

Following meetings and discussions with Welsh Government on 27 November and 11 December 2025 consideration was given to:

- Full Reinforced Autoclaved Aerated Concrete (RAAC) replacement: this would necessitate the rebuilding of WGH, which does not align with a 'Do minimum' scenario
- RAAC replaced through the construction of a smaller hospital: essentially the same as outlined in our AHMWW strategy
- Scope of Do Minimum agreed to be a high-level assessment of capital requirements to sustain site infrastructure over 60-year period:
  - Uplift the Major Infrastructure Business Case to current costs
  - Appraise over a 60-year period for consistency with Do medium and Do maximum
  - Assume estate brought up to condition B
  - No change in service models
  - Service configuration therefore as per current – i.e. no major transformation as per AHMWW

# Scope of PBC Addendum



## Do medium

Revision to PBC – scenario as agreed at meeting with WG on 4 November 2025.

Scope: Likely efficiency scenario – no change to PBC for activity or approach to revenue modelling assumptions. Only the Urgent and Planned Care Hospital (UPCH), WGH and GGH elements – Prince Philip (PPH) and Bronglais hospitals (BGH) to be Phase Two and separate business case processes

Solution: Capital investment to support implementation of:

- Single phase new build UPCH incorporating acute service and GGH community service assumptions
- Repurposing of WGH to a community hospital, as per AHMWW strategy
- Functional content assumptions reviewed in line with discussions at meeting 4 November to drive Gross Internal Floor Area (GIFA) efficiencies (currently assessed as circa 11%).

## Do maximum

As per the PBC: Scope: Likely efficiency scenario – no change to PBC for activity or revenue modelling assumptions. Only the UPCH, WGH and GGH elements – PPH and BGH to be Phase Two and separate business case processes

Solution: Capital investment to support implementation of Proposal B+

- Single phase new build UPCH
- New build of WGH - community hospital
- New build of GGH - community hospital
- Capital costs to be uplifted from PBC base to reflect indices as of January 2026 (agreed at WG meeting 27 November 2025).
- No change to service model assumptions configurations – i.e. as PBC.

# Capital costs - do minimum



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	Glangwili	Withybush	Total
<b>Gross Floor Area</b>	30,895 m <sup>2</sup> *	54,477 m <sup>2</sup> *	85,372 m <sup>2</sup>
	£	£	£
<b>Departmental cost</b>	144,888,407	316,825,980	461,714,387
<b>On-costs</b>	0	0	0
<b>Location Adjustment</b>	0	0	0
<b>Fees</b>	27,528,024	58,612,806	86,140,830
<b>Non-Works costs</b>	15,159,677	38,019,118	53,178,795
<b>Equipment costs</b>	0	22,177,819	22,177,819
<b>Contingency</b>	28,136,089	43,563,572	71,699,661
<b>VAT</b>	43,142,440	95,839,859	138,982,299
<b>VAT reclaim</b>	(5,505,343)	(20,728,400)	(26,233,743)
<b>Project Out-turn cost</b>	253,349,294	554,310,754*	807,660,048

Cost Index: 1Q 2026 PUBSEC 325  
Date: 2 January 2026

# Capital costs - do medium



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	Urgent and Planned Care (1bb)	Withybush (3dd)	Glangwili (4dd)	Total
<b>Gross Floor Area</b>	90,305 m <sup>2*</sup>	16,764 m <sup>2*</sup>	0 m <sup>2</sup>	107,069 m <sup>2</sup>
	£	£	£	£
<b>Departmental cost</b>	585,919,626	96,807,338	0	682,726,964
<b>On-costs</b>	65,918,888	11,524,336	0	77,443,224
<b>Location Adjustment</b>	0	0	0	0
<b>Fees</b>	120,590,125	20,041,360	0	140,631,485
<b>Non-Works costs</b>	71,420,006	12,501,209	0	83,921,215
<b>Equipment costs</b>	58,156,085	7,680,868	0	65,836,953
<b>Contingency</b>	90,200,473	14,855,511	0	105,055,984
<b>VAT</b>	198,441,040	32,682,124	0	231,123,164
<b>VAT reclaim</b>	(25,034,845)	(4,008,272)	0	(29,043,117)
<b>Project Out-turn Cost</b>	1,165,611,398	192,084,472**	0	1,357,695,870**

# Capital costs - do maximum



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	Urgent and Planned Care (1b)	Withybush (3d)	Glangwili (4d)	Total
<b>Gross Floor Area</b>	91,080 m <sup>2</sup> *	13,793 m <sup>2</sup>	15,548 m <sup>2</sup>	120,421 m <sup>2</sup>
	£	£	£	£
<b>Departmental cost</b>	578,494,735	84,308,333	95,035,595	757,838,663
<b>On-costs</b>	65,083,550	10,118,135	11,425,506	86,627,191
<b>Location Adjustment</b>	0	0	0	0
<b>Fees</b>	119,061,983	17,468,897	19,695,304	156,226,184
<b>Non-Works costs</b>	70,493,816	12,288,347	11,064,931	93,847,094
<b>Equipment costs</b>	57,142,214	6,744,667	7,602,848	71,489,729
<b>Contingency</b>	89,027,630	13,092,838	14,482,418	116,602,886
<b>VAT</b>	195,860,786	28,804,243	31,861,321	256,526,350
<b>VAT reclaim</b>	(24,729,216)	(3,493,779)	(3,939,061)	(32,162,056)
<b>Project Out-turn Cost</b>	1,150,435,497**	169,331,681	187,228,863**	1,506,996,041**

Cost Index: 1Q 2026 PUBSEC 325

Date: 23 December 2025

\* Includes campus accommodation/residences

\*\* Rounding error £1

# Capital Costs - summary



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	Do Minimum (£m)	Do Medium (£m)	Do Maximum (£m)
<b>Departmental cost</b>	461,714,387	682,726,964	757,838,663
<b>On-costs</b>	0	77,443,224	86,627,191
<b>Location Adjustment</b>	0	0	0
<b>Fees</b>	86,140,830	140,631,485	156,226,184
<b>Non-Works costs</b>	53,178,795	83,921,215	93,847,094
<b>Equipment costs</b>	22,177,819	65,836,953	71,489,729
<b>Contingency</b>	71,699,661	105,055,984	116,602,886
<b>VAT</b>	138,982,299	231,123,164	256,526,350
<b>VAT reclaim</b>	(26,233,743)	(29,043,117)	(32,162,056)
<b>TOTAL</b>	807,660,048	1,357,695,870	1,506,996,041
<b>m<sup>2</sup></b>	85,372 m <sup>2</sup>	107,069 m <sup>2</sup>	120,421 m <sup>2</sup>

# Potential timelines - do medium



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Do medium	UPCH	WGH	GGH
<b>PBC Addendum completion</b>	January 2026		
<b>Submission to WG</b>	February 2026		
<b>WG Endorsement</b>	March - June 2026		
<b>Procurement of OBC team(s)</b>	July - September 2026		
<b>OBC development</b>	September 2026 - September 2028	September 2026 - September 2028	N/A
<b>Land selection process</b>	July 2026 - September 2027	N/A	
<b>FBC development</b>	October 2028 - September 2030	October 2028 - March 2030	
<b>Construction</b>	October 2030 - January 2034	April 2030 - September 2032	
<b>Hospital commissioning</b>	January - September 2034	July - September 2032	
<b>Hospital operational</b>	July 2034	October 2032	
<b>Clinical services retained in existing estate until UPCH available</b>	N/A	September 2032 - July 2034	
<b>Once services are in situ, decommissioning / demolition / disposal</b>		July 2034 - July 2035	July 2034 - July 2035

# Potential timelines - do maximum



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Do maximum	UPCH	WGH	GGH
<b>PBC Addendum completion</b>	January 2026		
<b>Submission to WG</b>	February 2026		
<b>WG Endorsement</b>	March - June 2026		
<b>Procurement of OBC team(s)</b>	July - September 2026		
<b>OBC development</b>	October 2026 - September 2028	October 2026 - September 2028	October 2026 - September 2028
<b>Land selection process</b>	July - December 2026	N/A	N/A
<b>FBC development</b>	October 2028 - September 2030	October 2028 - March 2030	October 2028 - March 2030
<b>Construction</b>	October 2030 - September 2033	April 2030 - March 2032	April 2030 - March 2032
<b>Hospital commissioning</b>	October 2033 - March 2034	April - June 2023	April - June 2032
<b>Hospital operational</b>	April 2034	July 2032	July 2032
<b>Clinical services retained in existing estate until UPCH available</b>	N/A	October 2032 - March 2034	October 2032 - March 2032
<b>Once services are in situ, decommissioning / demolition / disposal</b>		April 2034 - March 2035	April 2034 - March 2035

## Background:

- In May 2022, a report was created for WAST and Hywel Dda showing conveyance travel times from incidents in Lower Super Output Areas (LSOAs) to the nearest hospital with an Emergency Department (ED).
- Various combinations of hospitals were used:
  - Current ED hospital configuration
  - New ED hospital configurations replacing certain current ED hospitals with a new ED hospital in a new location. 3 possible locations for the new hospital were used.
- Now, in December 2025, new scenarios are being analysed.

## Objective:

- Repeat the previous 2022 analysis using the new scenarios
- To show the differences between travel times to the nearest hospital using the new configuration of ED hospitals and compare to previous new hospital outputs
  - Analysis 1: Travel Time Analysis within 1 hour of hospital EDs
  - Analysis 2: Travel Time Analysis to the closest hospital ED from LSOAs

# Analysis 2a – Travel Time from LSOAs to closest ED (Baseline v Scenario)



## Summary (Excluding Prince Philip)

What % of Hywel Dda population is affected in a positive / negative way of Travel Time?

### Population Weighted Average:

Shows the average travel time change from Baseline per person for each scenario

E.g. The average person has a travel time of 4.9 minutes slower in the Whitland scenario than in the baseline.

Scenario:	Scenario 2a (Exc PP)		
New Hosp:	Whitland	St Clears	Carmarthen
20+ mins Quicker	0%	0%	0%
10-20 mins Quicker	1%	1%	0%
1-10 mins Quicker	5%	5%	9%
1 min either side of 0	20%	20%	20%
1-10 mins slower	57%	63%	60%
10-20 mins Slower	16%	4%	3%
20+ mins Slower	0%	7%	9%
<b>Total</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>
<b>Pop. Weighted Avg</b>	<b>+4.9</b>	<b>+4.9</b>	<b>+6.0</b>



As an example: This says that 0% of the Hywel Dda population are in an LSOA that has an average travel time to hospital 10-20 mins quicker in the Carmarthen Scenario than in the baseline.

# Analysis 2b – Travel Time from LSOAs to closest ED (Baseline v Scenario)



## Summary (Including Prince Philip)

What % of Hywel Dda population is affected in a positive / negative way of Travel Time?

### Population Weighted Average:

Shows the average travel time change from Baseline per person for each scenario

E.g. The average person has a travel time of 4.5 minutes slower in the Whitland scenario than in the baseline.

Scenario:	Scenario 2b (Inc PP)		
	New Hosp:	Whitland	St Clears
20+ mins Quicker	0%	0%	0%
10-20 mins Quicker	1%	1%	0%
1-10 mins Quicker	6%	5%	5%
1 min either side of 0	22%	22%	23%
1-10 mins slower	56%	62%	59%
10-20 mins Slower	15%	3%	3%
20+ mins Slower	0%	7%	9%
<b>Total</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>
<b>Pop. Weighted Avg</b>	<b>+4.5</b>	<b>+4.7</b>	<b>+6.1</b>

This says that 0% of the Hywel Dda population are in an LSOA that has an average travel time to hospital 10-20 mins quicker in the Carmarthen Scenario than in the baseline.



The programme Business Case submission was made through a quality lens, using the domains with the Health and Care Quality Standard: Safe, Timely, Effective, Efficient, Equitable, Person-centred with a submission of an Integrated Impact Assessment. This theme has continued whilst developing the PBC Addendum. QIA will be a continuous process as we receive feedback on the outcome of the PBC Addendum

**The Equality and Health Impact Assessment** has been updated with:

- Refreshed data for staff and the general public.
- Feedback from the engagement that took place in the summer and autumn of 2025 for the strategy refresh

## **Communication and Engagement**

Through public consultation, the Health Board identified a zone between Narberth and St Clears as the optimum location for the new UPCH. The new scenario will require this zone to be reconsidered to support the widened catchment. It is acknowledged that full land searches have not been undertaken and this option would be subject to public engagement and consultation. The Health Board also recognise that a relocation of the proposed hospital site may result in more people needing to travel further to access acute services. Whilst this is not anticipated to be significant it is important that this is tested through the next stage business case.

Updates on the progress of the PBC are shared with the A Healthier Mid and West Wales Group that includes representative of trade unions, the Infrastructure and Estates Group, Capital Sub Committee, Strategy and Planning Committee and Board. Engagement also undertaken with the Clinical Reference Group on the functional content review involving them in considering any proposed changes to what was submitted in the PBC. Additional communication will be developed in the lead up and post 29 January 2026 Public Board to inform staff and public of PBC progress.



The following appendices have been updated to reflect changes since the PBC was developed and are specific to this addendum:

- Appendix 5** - Equality and Health Impact Assessment
- Appendix 8c** - Functional Content
- Appendix 8d** - Schedule of Accommodation
- Appendix 9** - Estates
- Appendix 10** - Revenue Cost Assumptions
- Appendix 11** - Digital Strategy
- Appendix 13** - Transport
- Appendix 19** - Mandatory Business Case Checklist
- Appendix 21** - Integrated Assurance and Approval Plan (IAAP)
- Appendix 22** - Risk Potential Form (RPA)

New appendices:

- Appendix 24** - Nuffield Review of UHB Clinical Models
- Appendix 25** - HDUHB Decarbonisation Delivery Plan

# Next steps



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- 29 January 2026 - consideration of PBC Addendum at Public Board meeting
- Submission of PBC Addendum to Welsh Government following Public Board
- February 2026 - Welsh Government scrutiny
- 13 March 2026 (target) - Welsh Government Infrastructure Investment Board



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## Section 2 - Background



- A Healthier Mid and West Wales strategy was agreed by Public Board in 2018 following extensive public and staff engagement and consultation
- PBC developed in line with strategy, scope agreed with Welsh Government, final version agreed by Public Board and submitted to Welsh Government in February 2022. Since 2022, the Health Board has met with WG on a regular basis to seek endorsement for PBC. (See next slide for scope of PBC)
- Following attendance at Infrastructure Investment Board (IIB) the Health Board was asked to develop a Strategic Outline Case and WG would commission an independent review of the clinical strategy
- Scope for SOC agreed with WG as: New Hospital, GGH and WGH; same options as PBC
- Land appraisal process completed, including public consultation, leading to shortlist of 2 sites agreed by Public Board for the new hospital in the agreed zone between Narberth & St Clears
- WG-commissioned Nuffield Trust review of the Clinical Models - final report received in April 2024 - was broadly supportive of the strategy; this has been reported to Public Board and the actions are subject to Committee and Board monitoring
- Correspondence received advising that WG wish the options for the SOC to be “as wide as practicable”
- Meeting held with WG officers to further explore what these options may be in April 2024
- Infrastructure Investment Board January 2025
- To progress the PBC, the Health Board has met with WG officers on an ongoing basis since 2022. Last meeting held 4 November 2025 asked the HB to consider additional scenarios.



- The development of a **plan for the existing Community Hospitals**, working with local communities
- This plan will be focused on the provision of ambulatory care including out-patient services, diagnostics, treatment, observation, rehabilitation and end of life care
- **A new urgent and planned care hospital in the south of the Health Board area**; between Narberth and St Clears
- Acute medicine and low risk day case surgery continues at **Prince Philip Hospital**
- **A repurposed Glangwili General Hospital and Withybush General Hospital** offering a range of community hospital services to support a social model for health and well-being, designed with local people to meet their needs
- **Bronglais General Hospital** services to continue the range of DGH services. Bronglais strategy subsequently agreed to ensure longer term sustainability



At our Public Board meeting in November 2024, we shared that our existing strategy - A Healthier Mid and West Wales was...

- Developed following extensive staff and public engagement and consultation in 2018
- The first ever agreed strategy for west Wales
- Set out a shift from an illness service to a wellness service - with a focus on a social model for health, primary and community services, use of digital etc
- In addition, it described the consolidation of acute services to enhance resilience and improve standards

Since the strategy was developed...

- Six years elapsed
- COVID pandemic
- Macro-economic factors
- Escalated to Targeted Intervention
- Technology and treatment advances

It was agreed that there was a need to refresh the 2018 A Healthier Mid and West Wales strategy to take account of the changes since 2018. It was also agreed that the timeline for the delivery of the new Urgent and Planned Care Hospital, as outlined in AHMWW was now highly unlikely.



## Implications for the delivery of our programme Business Case (PBC)

- Programme timescales
- Timing and sequence of delivery will need to change
- Interim plans will need to change
- Progressing the PBC Addendum could mean that the proposed location of a new Urgent and Planned Care Hospital may need to be reviewed
- Programme costs are likely to increase but the programme may become more affordable
- In light of ongoing discussions with WG, the Board agreed to progress with the next steps needed to submit an addendum for the PBC, with the intention of presenting back to Public Board in January 2026.

# What might this mean for the PBC?



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The timing and sequence of delivery will need to change

- Given the limited progress with the AHMWW business case (PBC), the impact and disruption caused by Covid and the broader economic challenges facing the country, it appears inevitable now that the pace of transformation envisaged when the strategy (2018) was conceived is no longer achievable.
- In the PBC (2022) the intention was to deliver the programme over the shortest possible period including all the major estates schemes being completed by the end of 2029 (developing the community hubs, refurbishing Prince Philip and Bronglais, repurposing Glangwili and Withybush and constructing the new Urgent and Planned Care hospital).
- Whilst it was always known that that timeline was highly optimistic, it was nevertheless the ambition of the Health Board to deliver change as quickly as possible in recognition of the significant service and estate fragilities.
- The Health Board will likely need to prioritise and sequence the capital schemes and adjust the wider plans to reflect this.

# What might this mean for the strategy?



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## The broad direction of travel

We anticipate the overall direction of the strategy remains valid, i.e.:

- a wellness service rather than an illness service
- developing a social model for health
- supporting citizens through technology and other means to stay healthy, independent and in their own homes
- capital investment to address the ageing estate
- the consolidation of acute services, where needed, to enhance resilience, improve standards and ensure sustainability

These core principles continue to have a lot of support within the Health Board and beyond, have recently been supported by the Nuffield Trust's review of the strategy and align with Welsh Government policy and strategy including 'A Healthier Wales'

# What might this mean for the strategy?



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## The interim plan will need to change

- When AHMWW was agreed it was anticipated that the service models, whilst recognised as unsustainable over the longer-term, would be broadly maintained up to the point of the new hospital. This of course was predicated on the assumption that delivery of the strategy would progress at pace.
- Through the Clinical Services Plan (CSP), the organisation has effectively already acknowledged that this is no longer a viable planning assumption, at least for the nine services identified. The CSP process, alongside the work on workforce stabilisation, has further underlined the prevalence and extent of service fragilities across the Health Board and the disparity that exists between services in Hywel Dda and some other parts of Wales.
- In accepting that a new hospital will not be operational until the mid to late 2030s, it follows that the key service changes unlocked through a new hospital will now need to be considered ahead of a new facility.

# What might this mean for the strategy?



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Some aspects of the strategy have been reviewed

- Whilst AHMWW was a radical long-term plan, it was also pragmatic, aiming to address the most significant service and estate risks. It did not attempt to address every potential service risk the Health Board has.
- Over the past six years further service fragilities have been exposed and, with the programme timeline now extending to the mid 2030s or beyond, it further raises the question of the sustainability of some services.
- The work on the CSP, for example, is focused on the interim period but, in response to fragilities, is also generating options for services such as stroke and critical care, which potentially go beyond the strategy.
- In agreeing the strategy, the Health Board set out a 'zone' between Narberth and St Clears where the new hospital would be located, based upon detailed analysis of journey times for the population. The draft refreshed strategy contains a section that summarises the need to further refine our PBC, to deliver the infrastructure estate needed to provide safe, kind and timely care.

# What might this mean for our estate?



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Likely more capital investment overall but phased over a longer period

- Part of the rationale for progressing AHMWW with urgency was the costs and risks associated with the current estate, particularly at WGH and GGH, and the risk of incurring costs twice.
- Inevitably a longer timeline means more investment will be required to maintain existing sites. Over £50m has already been spent on WGH and GGH over the past two years purely to maintain service provision (it has not materially improved the environment of care, supported transformation or expanded capacity). Very significant investment is anticipated in existing estate to address major infrastructure backlog risk such as fire, RAAC, engineering infrastructure and buildings fabric and condition.
- Furthermore, inflation has driven up the capital costs of delivering the strategy a longer timeline will therefore add to the affordability challenge unless the all-Wales capital budget increases in line with inflation or other funding mechanisms are used.
- Significant investment is also anticipated in existing estate to bridge the gap and/or to phase estate modernisation to support service imperatives (e.g. Clinical Services Plan). For example, if more consolidation of emergency pathways is required that will likely necessitate significant interim capital investment, particularly given the condition of the existing estate. (This is excluded from the costs in the PBC Addendum).



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## Section 3 - Discussions with Welsh Government 2024/2025



- The Health Board has met with WG on a regular basis since 2022 to seek endorsement of the Programme Business Case
- The Health Board had, with agreement from WG, commenced the drafting of a Strategic Outline Case, pending PBC endorsement.
- WG correspondence required that a wider range of scenarios needed to be explored before the business case process could develop further.
- A series of meetings have taken place with WG officers and with the Deputy Chief Executive - NHS Wales, which have included the Hywel Dda CEO and Director of Strategy and Planning. This commenced with a meeting between UHB and WG Officers April 2024.

# Range of additional scenarios to be considered



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- Meeting: 24 April 2024 in WG Offices, Penllergaer with WG and Shared Services representatives
- Purpose: To explore and summarise the range of potential additional scenarios. Originally it was thought this would inform the development of a Strategic Outline Case, which had been drafted by the Health Board following completion of the PBC.
- Wider range of scenarios agreed in meeting and confirmed for further exploration.
  - Scenario 1** – Realistic Do Minimum
  - Scenario 2** – Centralise emergency and selected inpatient elective surgery at Glangwili, retaining a community hub at Withybush
  - Scenario 3** – Build a new hospital in the proximity of Carmarthen and retain a community hub in Withybush
  - Scenario 4** – Build a new hospital in the identified zone plus new community hubs in GGH and WGH sites
  - Scenario 5** – Build a new hospital in the identified zone plus refurbished community hubs in GGH and WGH sites
  - Scenario 6** – Centralise emergency and selected inpatient elective surgery in a new hospital in the zone, leaving other services in current locations

Scenarios in **Black text** were part of the PBC

Scenarios in **Blue text** are new scenarios as a result of the Penllergaer meeting



- Through subsequent discussions, it was agreed that Scenario 6 would not be explored further as it would require the development of a new hospital and the retention and duplication of secondary care services at Withybush Hospital and Glangwili Hospital requiring the investment in that provision and the further maintenance of the estate.
- Subsequently, WG also requested the Health Board consider the phased redevelopment of Withybush Hospital in response to the pressing need to consider mitigations for the RAAC risks evident in the hospital fabric.
- It was therefore agreed with the Deputy Chief Executive – NHS Wales that further exploratory work should be undertaken on the feasibility of the following:
  - The phased redevelopment of Withybush Hospital, to be assessed as a fast-track solution.
  - **Scenario 2** – Centralise emergency and selected inpatient elective surgery at Glangwili, retaining a community hub at Withybush



The following three slides summarise the assessment of the redevelopment of Withybush Hospital as a fast-track solution responding to the RAAC infrastructure risks.

This scenario was discounted at the meeting with Welsh Government on 4 November 2025. The phasing of development in any of the three identified development zones takes too long to achieve and would in any case require the development of the new hospital in support of the AHMWW strategy or would require the need to redevelop the full site at c60000m<sup>2</sup>.

# Withybush General Hospital: Constraints

Existing building area circa 40,000sqm  
Built between 1973 and 1978 (50+ yrs)

- Significant backlog maintenance risks
- RAAC
- Fire compartmentation
- Façade degradation
- Engineering systems outdated

Funding constraints may require a phased delivery with individual phases of circa £50m. Consequential impact on costs such as inflation and extended prelims

Clinical connection between new build & existing will require diversion of loop road

Strategic FM services located in areas affected by backlog risk

Areas not affected by RAAC are isolated



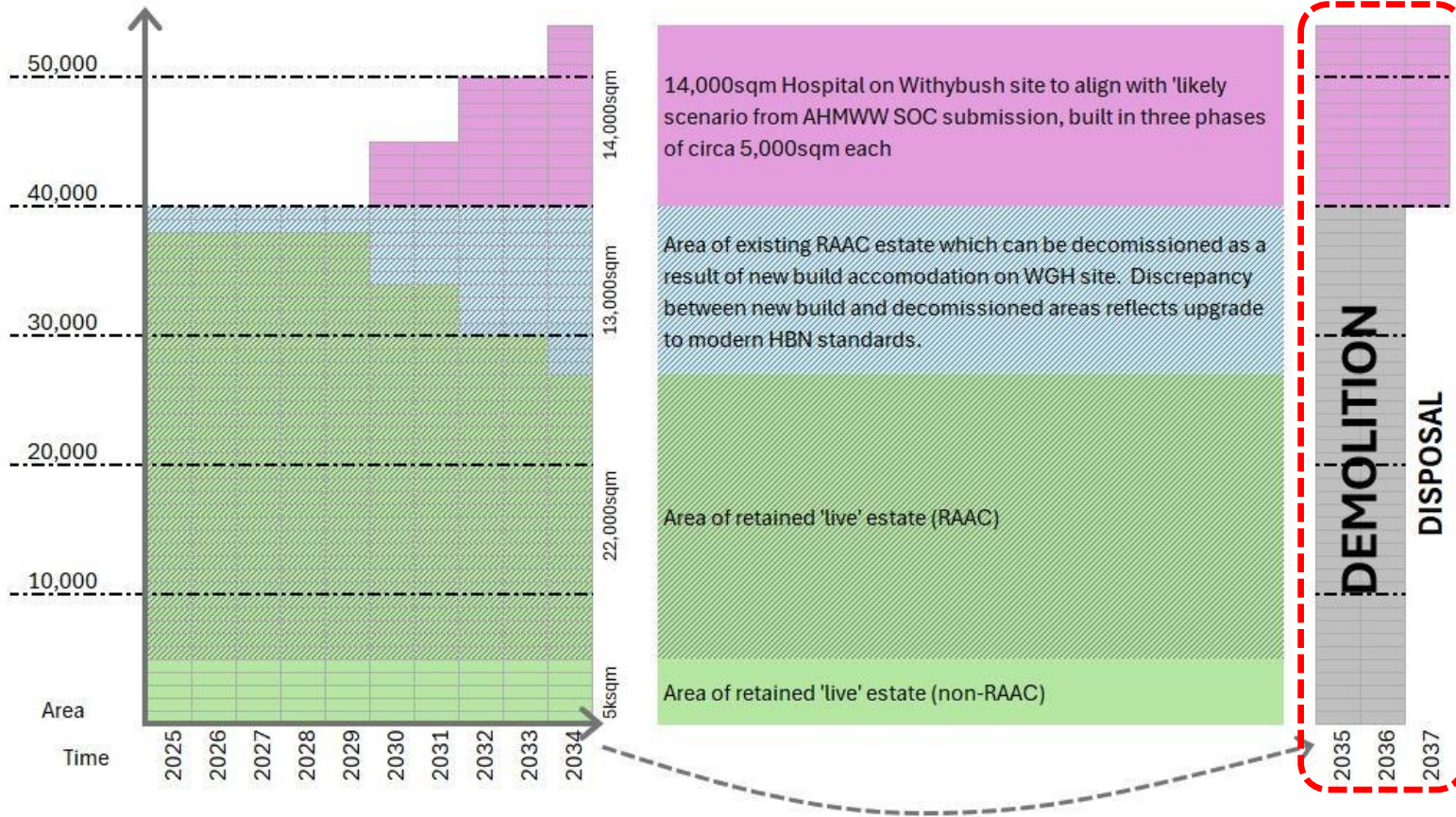
# Withybush General Hospital: opportunities

Address critical backlog maintenance / mitigate estate risks through

- decommissioning and demolition of areas affected by RAAC
- Move towards a zero-carbon site
- Improve access to clinical services
- Respond to AHMWW clinical transformation strategy
- Compliance with best practice
- Minimise impact on live clinical services during construction
- Retention of non-RAAC buildings to be explored further
- Explore alternative development sites within the current ownership boundary and consider option to purchase adjacent land
- Site disposal



# Withybush General Hospital: development plan

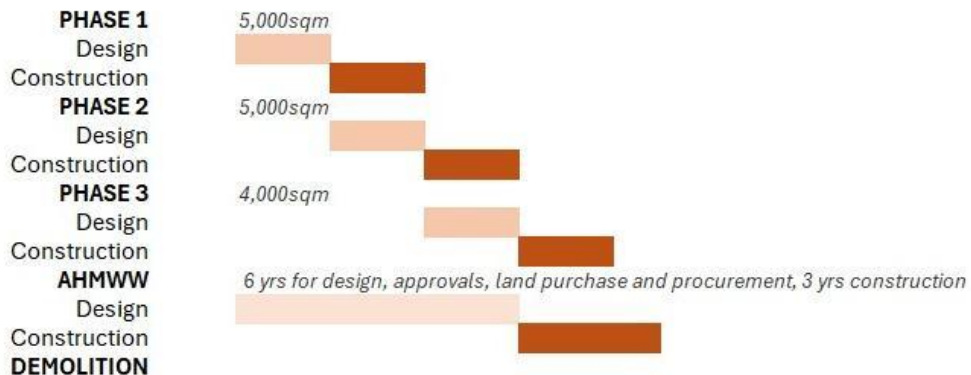


Full decommissioning of RAAC affected areas at WGH is reliant on delivery of the wider AHMWW strategy

SOC indicates a 9-year programme for delivery of AHMWW which aligns with phased delivery programme for WGH redevelopment

Assuming delivery of AHMWW the earliest full decommissioning and demolition of areas affected by RAAC is 2035 with associated site disposal by 2037

*Alternative scenario which allows the new Withybush Hospital to be delivered independently of the AHMWW transformation strategy will require 60,000sqm of new build to fully replace clinical functions at WGH*



tbc

This work could not be considered in isolation to the delivery of the AHMWW Strategy, the development of a new hospital and future of the GGH site

## AHMWW developments: Understanding the challenge

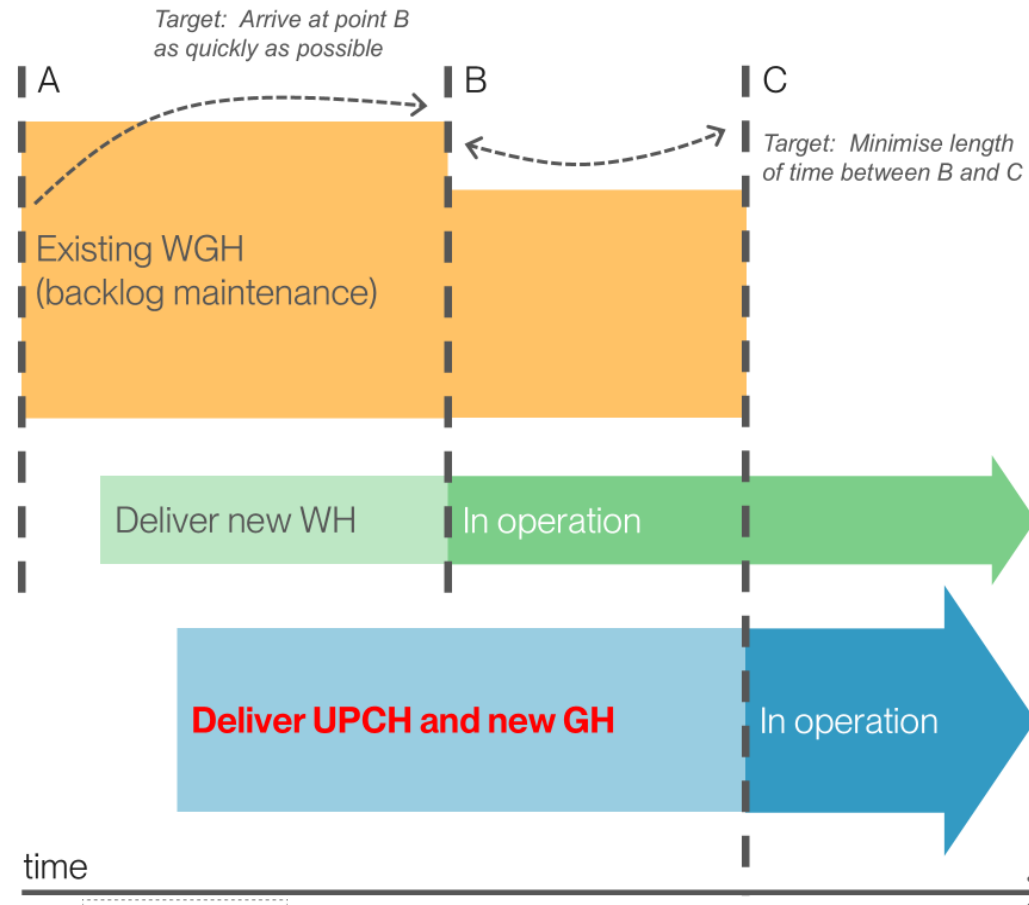
Current position (A) shows significant backlog maintenance risk at WGH

Completion of the new Withybush Hospital (B) reduces backlog maintenance risk by decommissioning areas of existing estate

Only following delivery of the wider AHMWW strategy (C) can the existing buildings at WGH be fully decommissioned and backlog maintenance risk eliminated

Between points B and C the UHB will be operating and maintaining an increased estate area at WGH (+14,000sqm)

Longer time between points B and C leads to increased cost to the Health Board in terms of backlog maintenance and increased revenue costs



# The Assessment of the phased redevelopment of GGH Hospital



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The following four slides summarise the assessment of the redevelopment of Glangwili Hospital as the new Urgent and Planned Care Hospital and to include the Glangwili Community Hospital functions.

This option was discounted at the meeting with Welsh Government on 4 November 2025. The phasing of development would take too long to achieve, would be hugely complex and costly developing on the operational site over many years and would be likely to face significant planning challenges.

## Glangwili Hospital site:

Develop the site for both the new UPCH and Community Hospital functions

Explore potential to deliver some campus functions off site (mental health, staff residences and admin)

Minimum 35 acres required for UPCH (hurdle criteria for PBC)

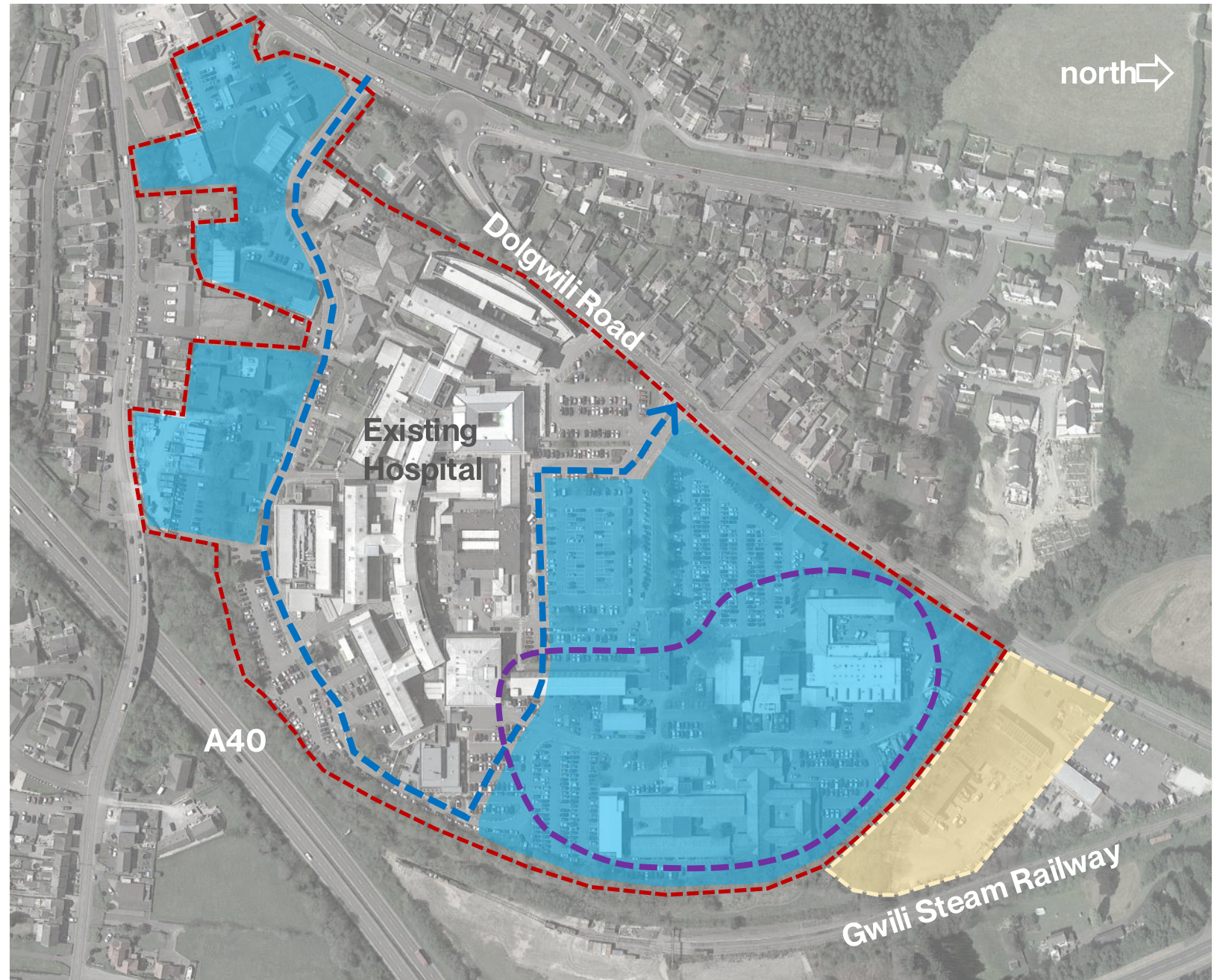
Current site area is 28 acres. Potential to increase to 30 acres with land purchase

Potential for 11-acre development zone

Significant enabling works to relocate parking, energy centre, FM, hub, staff residences, admin, therapies and mental health services.

Planning risks (height, BNG, SABS)

Post completion of UPCH and demolition of existing buildings the remaining site could be adapted for parking and other campus developments



# Glangwili General Hospital: Development scenario

UPCH and community functions combined on Glangwili site

Significant enabling works to relocate energy centre, FM hub, clinical services and most staff and visitor parking off site

Live hospital site during construction

Purchase of adjacent land required to support enabling works strategy

Potential for other campus related developments as on-site enabling projects (MHU, staff residences & admin)

Clean and safe development zone with potential for dedicated construction access from Dolgwili Road - minimising impact on live hospital operations

Tight development site which may increase construction costs & risk

Potential to phase the build to optimise cashflow – but will extend programme



# Glangwili General Hospital: Development option

New build area based on AHMWW 'Likely Way Forward' for combined UPCH and community development of circa 90,000sqm

Existing estate decommissioned and demolished following completion of the wider AHMWW strategy

New parking and landscaped areas  
Retained site access from Dolgwili Road

Segregated blue light / FM flows from visitor traffic

Key risks:

- Planning approval (6-storey +)
- Operational site (disruption)
- Cost & programme
- Land purchase
- Limited expansion potential



# Glangwili Hospital site: Development Scenario

Existing GGH estate area 51,000sqm  
 AHMWW 'Likely Way Forward' includes

- Glangwili Hospital: 14,515sqm
- UPCH: 91,079sqm\*

*\*includes campus developments: staff residences, administration, research and mental health unit*

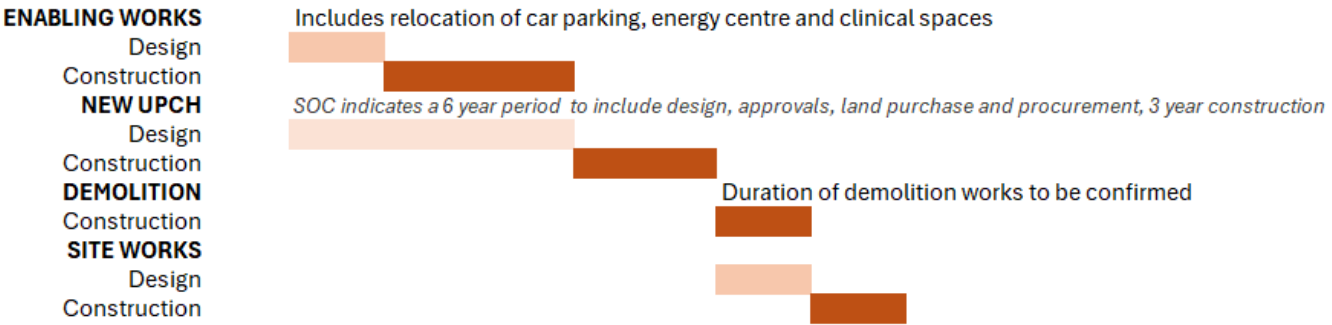
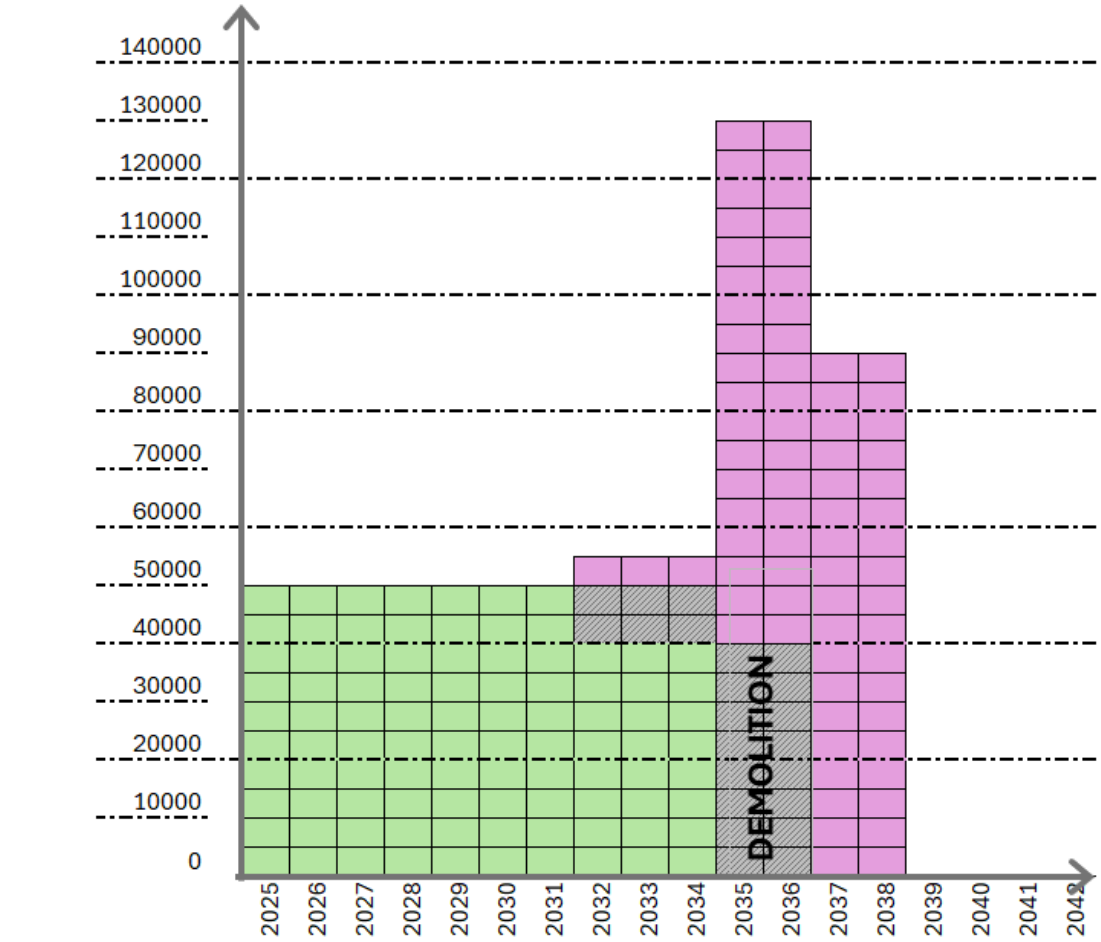
SHP schedule of areas dated 06/10/21

Assumed single delivery phase to mitigate programme risk

Option to deliver some campus developments off-site

SOC indicates a 9-year programme for delivery of AHMWW

Assuming delivery of AHMWW the earliest full decommissioning and demolition of existing estate on GGH and WGH is 2035 with associated demolition and site works completed by 2038



# Summary Feasibility Findings – Agreed way forward

## Meeting with WG 4 November 2025



GIG  
CYMRU  
NHS  
WALES

Bwrdd Iechyd Prifysgol  
Hywel Dda  
University Health Board

Therefore, it was agreed with WG that the UHB would produce a PBC Addendum exploring in more detail the retained additional business case scenario

**Scenario 3** – Build a new hospital in the proximity of Carmarthen and retain a community hub in Withybush



The results of this work presented at the meeting 4 November 2025 at which it was agreed that the phased development of WGH and the phased development of GGH would take too long, be too complex and be too costly

**Ask from WG that the PBC is updated to include an addendum** to be submitted in January/February 2026 with the objective it might be endorsed by the Minister. The update will be in the form of a PBC Addendum and will need to include:

## **Strategic fit and objectives**

- The essence of the AHMWW strategy remains extant, although evolved through the strategic refresh engagement. Also, that there have been changes and challenges that impact on the operational delivery of the strategy and consequently the capital solutions.

## **Delivery and scope of addendum, in response to WG request:**

- We will **define the delivery scope and timeline for the Urgent & Planned Care Hospital (U&PCH)** to be delivered on a site within the geographic boundaries of Carmarthen.
- The service scope will negate the need for a separate Carmarthen Community Hospital.
- The **scope and timeline for the redevelopment of Withybush Hospital** will remain consistent with the AHMWW clinical model.
- These will be phased to take account of operational programme delivery challenges. Other UHB issues included in the original PBC such as the modernisation of PPH and Bronglais Hospitals will be future phases, timelines to be agreed at a future date.



During the meeting with WG on 4 November 2025, it was outlined that the PBC Addendum will need to:

- Clearly **define the scope of services at each site** and take on board the challenge that we clearly reflect modern medicine and digital/technological opportunities to right size developments for our population.
- **Retain the activity modelling assumptions produced for the PBC** with the undertaking these will be revisited at the OBC stage and reflect advice received as part of the Nuffield Trust's review of our clinical model.
- Provide an **updated options analysis** that reflects the discussions and conclusions reached through our series of meetings. The VFM analysis will predominantly be a reassessment of the capital costs at price indices to be agreed with Shared Services colleagues.
- Include **refreshed financial, commercial and management information**. The commercial will reference the likelihood that the new U&PCH development is likely to be based on a MIM type solution. In this timeframe there will not be a full revenue reassessment however we will project the revenue impact /benefit we would expect to gain in headline terms (This needs to be agreed)
- Set out the **high-level delivery plans for both sites**
- Reference the potential for **wider economic benefit** particularly through working with local authorities on health & care campus opportunities and also in relation to transport infrastructure for which the new hospital could be a catalyst.
- Clarify the cost consequence to delivering the PBC addendum given the range of external commissions required. If these could be capitalised that would be helpful.

It is important to note that no decisions have been made. The Health Board has been asked to explore scenarios and options at this stage. Through public consultation in 2021, the Health Board identified a zone between Narberth and St Clears as the optimum location for the new UPCH. The new scenario will require this zone to be reconsidered to support the widened catchment. Any additional option would be subject to public consultation and consultation.



The Strategy and Planning Committee is asked to:

- **DISCUSS** the PBC Addendum and **SUPPORT** onward consideration by the Board



**DIOGEL | CYNALIADWY | HYGYRCH | CAREDIG**  
**SAFE | SUSTAINABLE | ACCESSIBLE | KIND**

### 3 - Date and Time of Next Meeting

3.1

17:00, 0 Mins

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3.1 - 26 February 2026, 09:30 - 12:30, MS  
Teams