Submitted By: Ben Rogers and Alex Martin, Principal Programme Managers

GIG CYMRU NHS WALES | Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Date Submitted: 4 November 2025

Planning Objective: 6 – Clinical Services Plan (CSP) | **Executive Lead: Lee Davies/ Mark Henwood**

Reporting Period: 1 October 2025 – 31 December 2025 Quarter (Q) 2 2025-26

Overall status: On track
Rationale for overall status: higher than planned response rate from public consultation resulting in an Extraordinary Board meeting now scheduled on 19 February 2026.

Progress against planned outcomes / trajectories / milestones:
Q3 2025-26 - To Support (Parts 7 and 8 below)

- Alternative Options Process – On track
  - Hurdle session – Complete
  - Scoring session – Complete
  - Presentation of options to Board – On track: Detail for impact assessments initially captured in Strengths, Weaknesses, Opportunities, and Threat (SWOTs framework, phasing of options to be carried out in revised workforce and financial considerations document.

Q4 2025-26

- Phase 3 – Part 6 Feedback Report – On track: Output reports from scoring to be shared via Strategy and Planning Committee (SPC) as part of process and support final feedback reporting
- Phase 3 – Part 7 Conscientious Consideration – On track: The high level of engagement during the consultation period has extended the time required to report consultation feedback. To ensure stakeholders have adequate opportunity to reflect on the consultation findings and provide input into the Informing Plan, the Board's conscientious consideration session has been rescheduled to 13 January 2026.

Activities planned for next milestone and reporting period

Q4 2025-26

- Phase 3 – Part 8 Final Report – On track: Report is due to be available on time for Board decision making. Reporting on consultation findings to be carried out by internal staff to allow programme to remain within budget, but with quality assurance provided by Hugh Irwin Company (HICO) within existing quality assurance arrangements.

Other items

- CSP review of the Lessons Learned and development of framework– Delayed previously reported as at Q3 2025-26 – Following demand of CSP Alternative options this will be pushed back Q4.
- CSP 2 – On track: Phase 0 preinitiation planning to commence Q4 2025-26
- Paediatrics Implementation Plan – In collaboration with the Withybush Hospital (WGH) site team, there is work underway to utilise the former Samed Day Emergency Care (SDEC) area in WGH to facilitate the return of the Paediatric Service in place of the Puffin Ward area; to reduce the need for a large capital investment; and allow the service to return to the site earlier in Q 4 2025/26 as there will be less capital work required to make it fit for purpose.

Matters for information: More than 4,000 survey responses were received during public consultation, alongside engagement and written responses, increasing reporting timelines for consultation timelines and conscientious consideration.

Submitted By: Ben Rogers and Alex Martin, Principal Programme Managers

Date Submitted: 04NOV2025

GIG CYMRU NHS WALES | Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Planning Objective: 6 – Clinical Services Plan | **Executive Lead: Lee Davies/ Mark Henwood**

Additional papers:

We have added 4 papers along with this update which are related to the CSP Process. These are:

- Output report from the Hurdle Appraisal Session
- Output report from the Scoring session
- Revised Patient Insight and Transport document
- Revised data science information

The purpose of sharing the output reports is to provide assurance to the Committee that a process has been followed to consider alternative ideas that have come to light during the consultation. As the options have been appraised against the hurdle criteria, these will now all be presented to the Board when it meets in February 2026.

The additional documents have been refreshed as part of the alternative options activity to allow Board Members to have information for all options which will be considered in February 2026 and again provides assurance that options have been treated fairly.

Submitted By: Ben Rogers and Alex Martin, Principal Programme Managers

Date Submitted: 04NOV2025

Planning Objective: 6 – Clinical Services Plan	**Executive Lead: Lee Davies/ Mark Henwood**

Recommendations:

The Committee is asked to:

- **NOTE** the progress being made within the Clinical Services Plan
- **RECEIVE ASSURANCE** from the output reports that the alternative options are being treated in a fair and transparent manner.

CLINICAL SERVICES PLAN (CSP)
Alternative Options Hurdle Appraisal Session

(9 October 2025)

SUMMARY REPORT
14 October 2025

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1 Executive Summary

1.1 Introduction

Hywel Dda University Health Board (HDdUHB) is advancing its Clinical Services Plan (CSP) to align with its vision of "A Healthier Mid and West Wales" (AHMWW). The plan aims to enhance local care and sustain specialist services.

The aim and objective of the alternative options hurdle assessment session was to assess alternative options generated during the consultation, along with additional information to date, against the Hurdle Criteria to move from a long list to a short list.

The session was attended by clinicians, operational leads, staff members and stakeholders representing interdependent services and the services within the CSP. The invitees were broadly the same as Sprint 2 from Phase 2 of the programme, with additional people invited to reflect organisational changes to operational structures.

1.2 Methodology

The session involved assessing options against the Hurdle Criteria to shortlist viable options, with each option requiring a two-thirds room and two-thirds service representation majority approval. The session concluded with the results being shared back to the room with a reminder of the passed options detail, and a recap of the next steps and activity to take place before the 19 November 2025 shortlist scoring session.

The methodology mirrored that of Phase 2, requiring a two-thirds majority from both room and service representatives for approval. Due to the high volume of alternative ideas from public consultation, these suggestions were first reviewed by task and finish groups, then appraised by service representatives for the 9 October 2025 session to determine which met the hurdle criteria.

On 9 October 2025, the session was split into two parts. In the morning, the Options Development Group (ODG) considered ideas not meeting criteria, with feedback from stakeholders, the CSP Clinical Reference Group, the CSP Project Group, and CSP Project Support Group shared. It was decided that any upheld or uncontested challenges would allow options to progress from the morning to the afternoon ODG hurdle appraisal.

1.3 Summary of Discussions

The room recognised thematic challenges which affected all options, as well as service specific concerns throughout the day.

The more thematic challenges were around the underlying issues within the long-term delivery of services, while balancing the rurality of our populations and how these can be delivered sustainably. Challenges were raised during the day on access for different parts of the community, as well as the potential impacts these options could have on Primary Care and community services.

From a strategic perspective, it was difficult to assess the long-term alignment of options if there are going to be changes to the acuity of care provided at hospital sites, and recognised that any regional solutions would need more detailed

discussions with regional partners, particularly Swansea Bay University Health Board (SBUHB).

There were questions about whether the balance between hospital and community services was appropriate, and if reliance on outsourcing could be reduced. Primary Care recognised opportunities to support Dermatology, Urology, and Ophthalmology, but noted that the programme currently focuses more on Secondary Care functions.

It was noted that the alternative options would need to match the interdependencies of services on site to ensure that we were using resources effectively. Notably endoscopy respiratory procedures, as there are not respiratory physicians on all sites.

For Critical Care, concerns were raised around the consistent use of language when talking about services, and that an Intensive Care Unit (ICU) needs to be on site where there is an Emergency Department, and that transfers should not be required for any site with an ICU.

1.4 Next Steps

Work will be undertaken to develop the detail around the shortlisted options to understand the clinical, workforce, finance and accessibility impacts and benefits of the options, in line with the evaluation criteria, to allow the Options Development Group to score the options against the criteria on 19 November 2025.

2 Introduction

HDdUHB's CSP seeks to deliver services in the medium term in line with the Health Board's longer term vision contained in the AHMWW strategy.
The CSP programme has an opportunity to look at how and where the Health Board provides services, in line with the Strategy's goal to deliver care closer to home, while also seeking to make specialist services more sustainable.
A clinically led process representing the nine clinical service areas has been implemented to develop options which would meet the aim and objectives of the programme:

Aim:

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

Objectives:

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

The alternative options hurdle appraisal session was a one-day event held on 9 October 2025 with the purpose of producing a short list of options.

The session was attended by clinicians, operational leads, staff members and stakeholders representing interdependent services and the services within the CSP.

Thursday 9 October 2025:

- 60 staff members joined the event including service, interdependent services and support services representatives
- Two Welsh Ambulance Service Trust (WAST) representatives
- A representative from SBUHB
- A representative from Llais, West Wales
- A representative from Public Health Wales
- A representative from Welsh Government
- Two Trade Union Representatives
- Two Health Board Executives
- 11 Transformation Programme Office/Engagement team members
-

3 Methodology

The session opened at 9:21am with Lee Davies, Executive Director of Strategy and Planning welcoming attendees.

The objective of the session was to:

- Assess the alternative options against the Hurdle Criteria to move from a long list of options to a short list.

Ben Rogers, member of the Transformation Programme Office, ran though housekeeping and the rules of engagement for the day, reminding people that they would need electronic devices for the appraising element, and that a park it board would be available for capturing conversations out of scope to allow time to be kept to discuss all 190 options.

A reminder was shared back with the room about the original drivers for the services as part of the CSP programme, along with the process to date and the origins of the options being discussed during the session.

A brief reminder of the hurdle criteria was given back to the room before Lee Davies gave an update on the AHMWW strategy, and how this should be considered when applying the strategically aligned criteria when considering alternative options.

Ben Rogers then facilitated the morning part of the session up until lunch, reminding people of the process by which options needed to pass hurdle (two thirds service majority and two thirds room majority). The morning session would focus on the options that the service felt did not meet the hurdle criteria, the feedback that had been gathered through check and challenge, and the room would be able to challenge the service as to whether an option still did not meet hurdle criteria, or whether it should be considered in the afternoon. If the service did not change their opinion of their hurdle assessment, then the option did not have the two thirds service majority to progress.

Ben Rogers spoke to the options for each service, read aloud the check and challenge feedback and noted its source and then facilitated plenary discussion in the room. People were asked to note which options they were discussing so the feedback could be captured specifically, or where thematic and applicable to all options. At the end of each discussion the service were asked if they felt the discussion and information altered their assessments, and whether the option should be considered by the room in the afternoon.

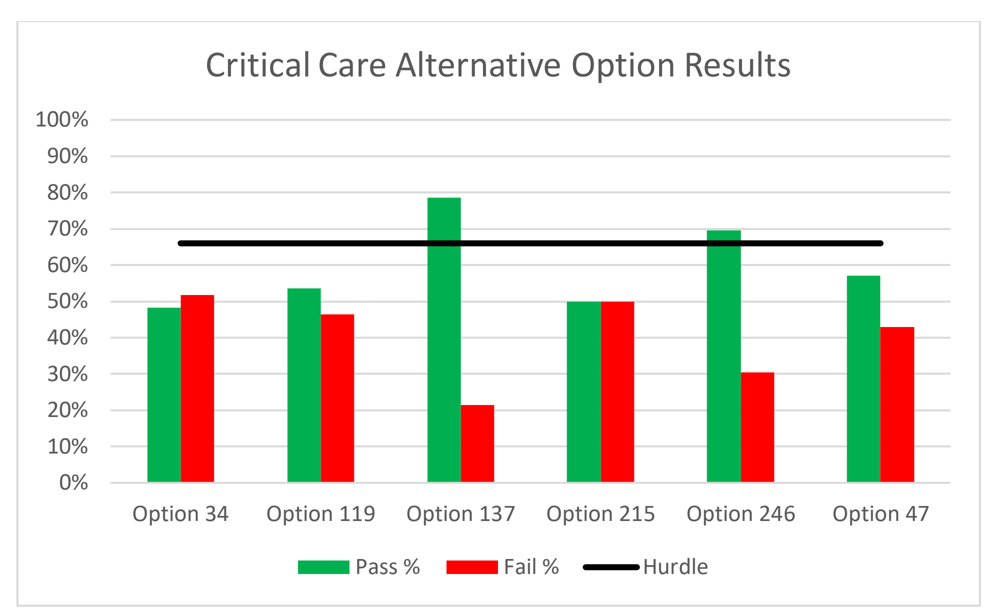
As there was no service representation from Orthopaedics available, the option which received challenge from the Clinical Reference Group (CRG) was automatically taken forward into the afternoon session for the room to appraise, however no challenge was made in the room for other options that the service believed to have not met criteria and so failed to meet two thirds service majority to progress.

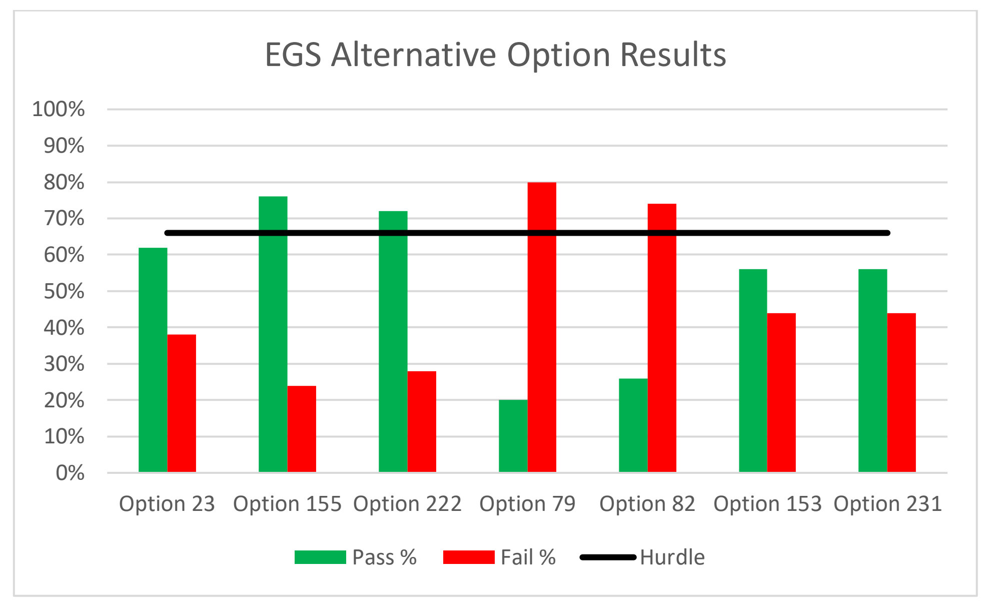
After the lunch break Alex Martin, member of the Transformation Programme Office, facilitated the afternoon session. The process followed was similar to the morning session, except representatives from the services presented the alternative options provided via the consultation process and answered questions related to the detail of how the options could work. This was followed by Alex Martin sharing the feedback from the different sources back to the room and allowing the room the opportunity to hurdle assess each of the options. Where a clinical/service lead was not available from the service, Sarah Isaac, the clinical lead within the Transformation Programme Office, presented the options on the service's behalf.

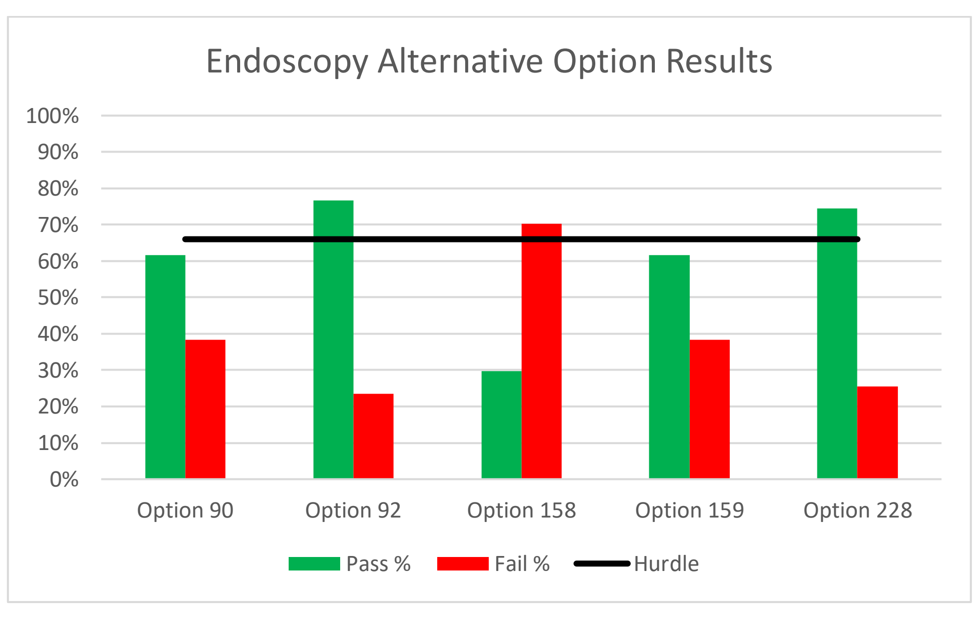
As all the options had been initially appraised as either Green (meets criteria) or Amber (may meet criteria), they had the two thirds service majority to proceed, and the room would now assess whether they met the two thirds room majority for an option to be shortlisted.

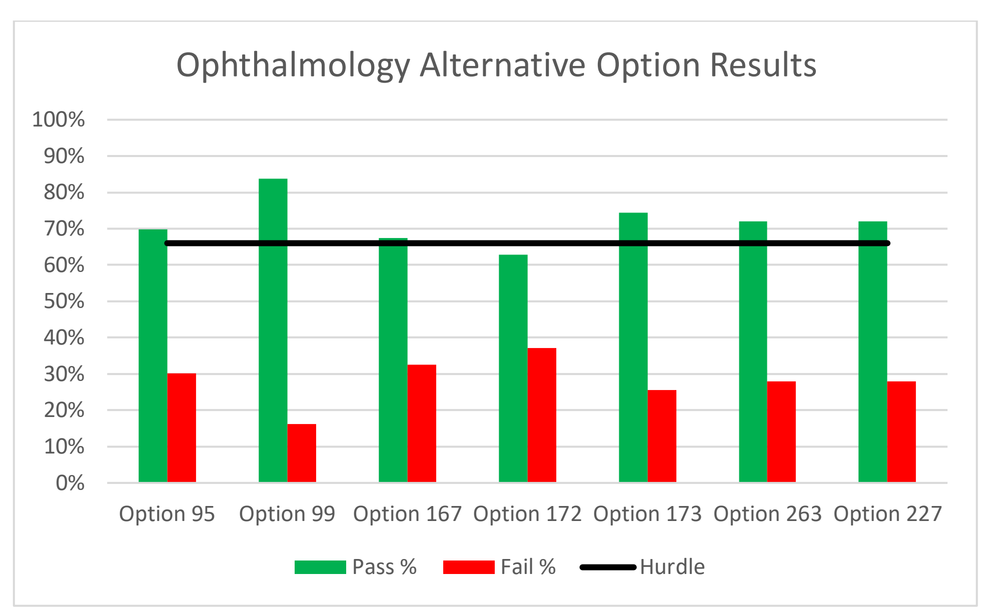
None of the Dermatology options were challenged in the morning, so there were no alternative options to hurdle appraise for this service in the afternoon.

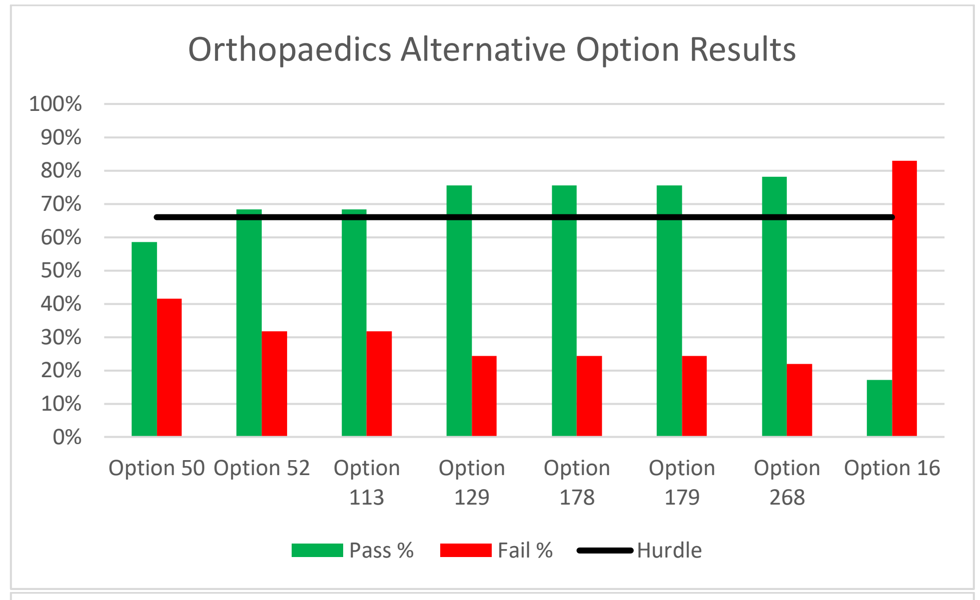
By 3:30pm the room had completed their hurdle appraisals of the options, and the results were shared with the room. The options graphs below were presented, with the room reminded of the detail of that option.

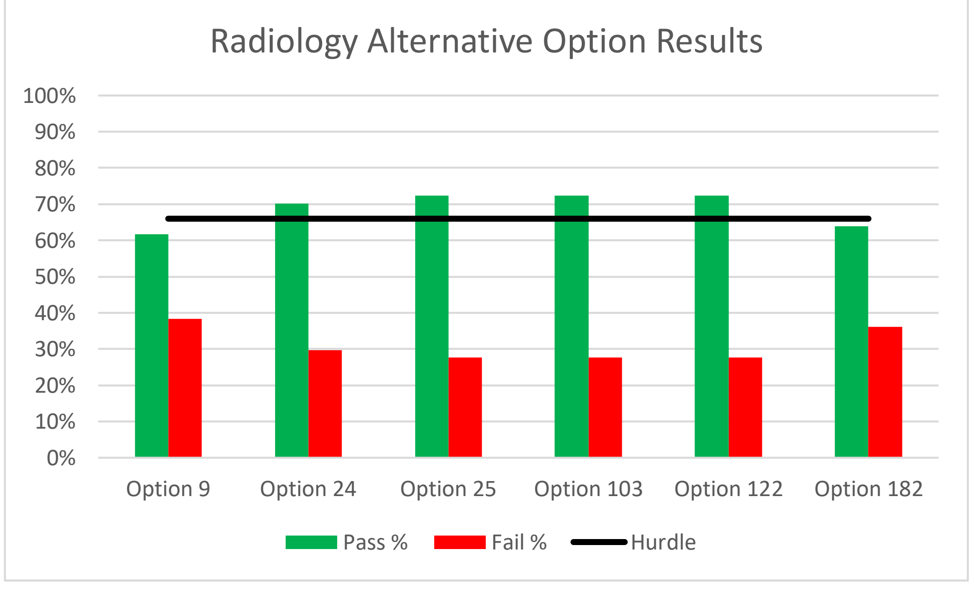

Critical Care Alternative Option Results
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Option 34
Option 119
Option 137
Option 215
Option 246
Option 47
Pass %
Fail %
Hurdle

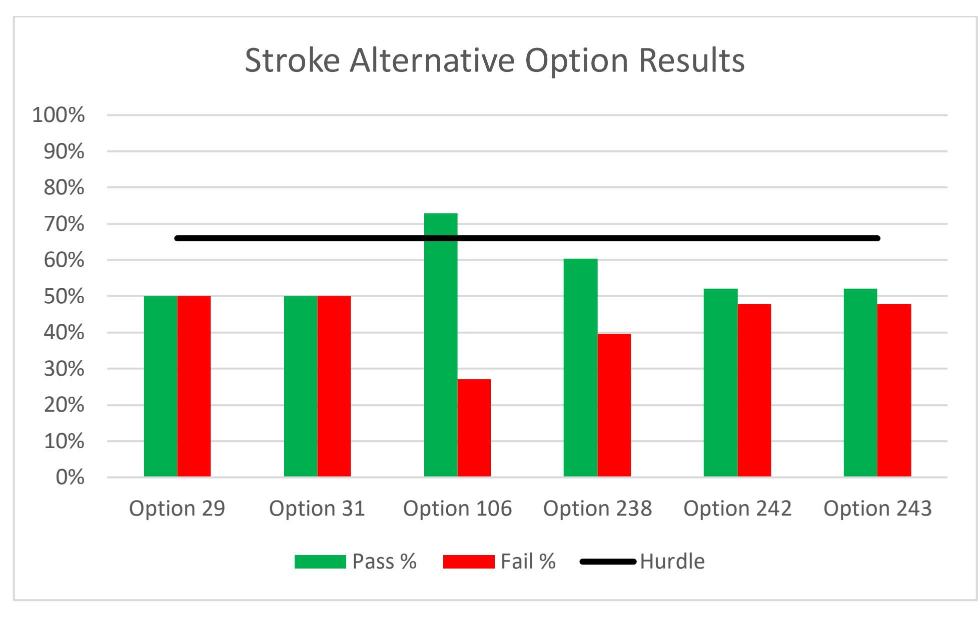

EGS Alternative Option Results
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Option 23
Option 155
Option 222
Option 79
Option 82
Option 153
Option 231
Pass %
Fail %
Hurdle

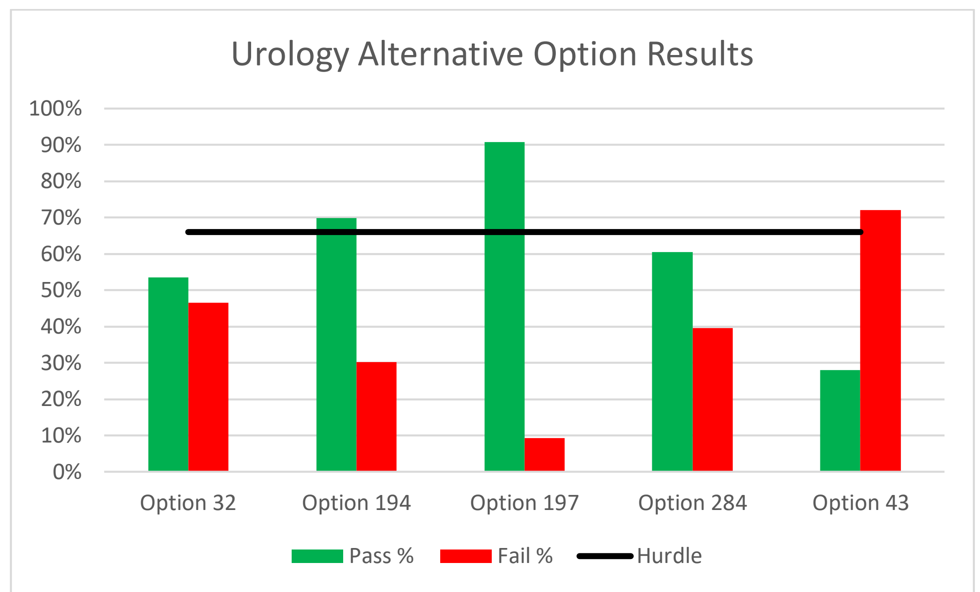

Endoscopy Alternative Option Results
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Option 90
Option 92
Option 158
Option 159
Option 228
Pass %
Fail %
Hurdle


Ophthalmology Alternative Option Results
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Option 95
Option 99
Option 167
Option 172
Option 173
Option 263
Option 227
Pass %
Fail %
Hurdle


Orthopaedics Alternative Option Results
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Option 50
Option 52
Option 113
Option 129
Option 178
Option 179
Option 268
Option 16
Pass %
Fail %
Hurdle


Radiology Alternative Option Results
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Option 9
Option 24
Option 25
Option 103
Option 122
Option 182
Pass %
Fail %
Hurdle





Andrew Carruthers, Chief Operating Officer, provided closing remarks for the session, thanking the attendees for their work to date and their continued support, and reminding the room of the work that would need to take place ahead of the shortlist scoring session.

The session was brought to a close at 3:45pm.

4 Key for options assessment

Service Assessments – EXAMPLE

- The table below demonstrates how alternative options will be presented today.
- RED (R) indicates 'does not meet', AMBER (A) suggests 'may meet', and GREEN (G) signifies 'does meet'. An 'S' within any coloured box represents a SPLIT DECISION.
- In the CHALLENGE column, amber denotes a check or challenge; blue indicates it has been reviewed, and white shows it has not been reviewed or commented on by the CSP Clinical Reference Group, Project Group, or Project Support Group. However, the rationale from similar options should be applied here.

Reference	Alternative Ideas - Option A's, B's and New ideas	Clinical	Deliverable	Accessible	Strategic	Financial	Challenge?
1	Option A – but with something else.	A	S	A	R	A	
2	Option B – but with the addition of this service	R	A	S	A	A	
3	New idea – new option – which is not always similar as what went to public consultation	A	A	R	A	S	

5 Critical Care Options (Do not meet hurdle criteria)

Critical Care - Do Not Meet Slide							
Reference	Alternative Ideas - Option A's	Clinical	Deliverable	Accessible	Strategic	Financial	Challenge?
20	Option A - with an Intensive Care Unit at Bronglais and Withybush. Enhanced Care Units at Glangwili and Prince Philip	A	A	A	R	A	
133	Option A - with Intensive Care Unit at Bronglais, Glangwili and reciprocal arrangements at Prince Philip.	R	A	A	A	A	
139	Option A - with Intensive Care Unit at Prince Philip & Glangwili, Enhanced Care Unit at Withybush and Bronglais	A	A	R	A	A	
140	Option A - with Prince Philip, Bronglais and Glangwili Hospitals would remain as they are described in Option A. Withybush Hospital it is a level 2 unit with transfers for sickest patients to Glangwili Hospital, and in the longer term (4+ years) it becomes an Enhanced Care Unit	R	A	A	A	A	
212	Option A - with Bronglais High Dependency Unit, Glangwili with an Intensive Care Unit, Withybush and Prince Philip Enhanced Care Unit	A	A	R	R	A	
214	Option A - with Intensive Care Unit and Enhanced Care Unit at Glangwili, Intensive Care Unit at Bronglais/ Prince Philip, Enhanced Care Unit at Withybush	A	A	R	R	R	
218	Option A – with centralisation of services to Glangwili	R	A	A	A	A	

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Critical Care - Do Not Meet Slide

Reference	Alternative Ideas Option B and Cs	Clinical	Deliverable	Accessible	Strategic	Financial	Challenge?
45	Option B - a Post Anaesthetic Care Unit (PACU) at Prince Philip with Medical Enhanced Care Unit. Intensive Care Units at Bronglais, Glangwili and Withybush	R	A	A	A	R	
217	Option B with Intensive Care Unit at Glangwili/ Bronglais/ Prince Philip, High Dependency Unit at Withybush with transfer of patients to Glangwili.	A	A	R	R	R	
1	Option C - Options Development Group Sprint 1 - An Intensive Care Unit at all sites but transfer of sickest patients at Prince Philip and Withybush	R	G	G	A	G	
132	Option C - is the most appropriate choice if supported by proper investment in staffing and workforce planning. Maintaining intensive care units on all four main sites Bronglais, Glangwili, Withybush, and Prince Philip	R	R	G	A	R	
134	Option C - with Intensive Care Units on all sites with additional Enhanced Care Unit in Bronglais and Glangwili.	R	A	R	A	R	

Critical Care - Do Not Meet Slide

Reference	Alternative Ideas – New ideas	Clinical	Deliverable	Accessible	Strategic	Financial	Challenge?
3	New idea - Sprint 1 - Option 4a - A High Dependency Unit on Bronglais, Prince Philip and Withybush with an Intensive Care Unit at Glangwili.	R	A	A	A	A	
4	New idea - Sprint 1 - Option 4b - Enhanced Care Unit at Bronglais, Prince Philip and Withybush with Intensive Care Unit at Glangwili.	R	A	A	A	A	
47	New idea - Transfer patients to Morriston Intensive Care Unit from Prince Philip. With a Intensive Care Unit at Bronglais, Glangwili and Withybush.	R	A	A	A	A	
135	New idea - Enhanced Care Unit in all hospitals in addition to Intensive Care Unit	R	R	G	A	R	
138	New option - Intensive Care Unit on all sites, with one hospital (unspecified) to hold longer term/stable patients	R	A	A	A	A	
213	New Option - Morriston Intensive Care Unit, Bronglais/ Glangwili High Dependency units, Prince Philip/ Withybush Enhanced Care Unit	A	A	R	R	A	
216	New Option - Intensive Care Unit at Morriston/ Bronglais / Withybush, Enhanced Care Unit at Glangwili/ Prince Philip	R	A	A	A	R	

Critical Care Check & Challenge Feedback

Reference	Check & Challenge feedback 'Do Not Meet' the hurdle criteria	Challenge?
3, 4, 133, 139, 212, 213, 214, 218	Strategic alignment appraisal may need to be reviewed for consistency with option A, that went as part of the consultation, as far as passing/failing an option based on not using a specific site is concerned, following recent conversation on guidance on assessing against this criteria. Strategic alignment appraisal may need to be reviewed for consistency with option B, that went as part of the consultation, as the detail of this option considered the site being managed in line with rural critical care unit.	
47	Morriston considered easier to access for Llanelli residents than Glangwili, this option would be more accessible than those consulted on. (Stakeholders)	
General	Due to the highly rural and sparsely populated nature of Powys, our residents are critically dependent on acute hospital services in neighbouring health boards in Wales and neighbouring NHS Trusts in England. In this context, the strategic importance of Bronglais General Hospital fornorth west Powys communities is well recognised, including in Professor Marcus Longley's "Mid Wales Healthcare Study" (2014) which concluded that Bronglais General Hospital should remain a key centre for secondary care for the foreseeable future, and which recognised that significant changes may be required to ways of working. (PTHB)	

5.1 Critical Care Plenary Discussion – Does not meet hurdle criteria

The following individual feedback was provided by some members of the Options Development Group and is not a representation of the Options Development Group as a collective. This feedback has been shared in its raw form as captured during the session, and should be considered with this in mind.

- **Option 20:**
  Lack of perceived staffing, strategic alignment, strategically have Emergency Department (ED) on site, didn't consider the Strategy assumed. Sustainability – unsustainable to have ED on all four sites. There are some alternative options that are similar and did pass the hurdle criteria. Option A is very similar. Ruled out High Dependency Unit (HDU). Challenge on whether Withybush Hospital (WGH) would become a community hospital within 10 to 15 years.

  There is significant concern over WGH becoming a community hospital. Was the strategy in 2018 considered during conversations?

- **Option 45:**
  Using Guidelines for the Provision of Intensive Care Services (GPIC) standards, this is similar to Option B but this mentions Post Anaesthetic Care Unit (PACU), do not recognise the language.

  If there is an ED on site then there should be an ITU on site.

  Unsustainable to have an ITU on all four sites.

  Some options that are being discussed this morning that have slight amendments to be green this afternoon.

  Quite difficult not knowing the afternoon options to know what to challenge.

  With the strategic alignment regarding WGH becoming a community hospital.

  Should four ITU sites be considered moving forward?

  Enhanced Care Unit would require a full range medical team and would therefore be an interdependency.

How did Option 45 fail on financial when it's similar to Option B?

- **Option 47:**
  Transfer of Llanelli patients to Morriston – were the Morriston team involved? Task and Finish Group outside of their remit to answer this. Feel that we can't exclude this option without speaking to SBUHB. Morriston is closer than Glangwili Hospital (GGH) for ICU, so need to have a service conversation with them. See option 246 that has passed the hurdle criteria.

  There is no reason why Llanelli patients cannot be sent to Morriston or those discussions could happen.

  If it said Enhanced Care Unit (ECU) with transferring the sickest patients it would have been considered differently.

  Don't think we can exclude this if we have not had the conversation with SBUHB.

  Option 47 taken through to the afternoon hurdle criteria appraisal session.

- **Options 3 & 4:**
  Service didn't feel that ECU in place of ICU is safe in Bronglais Hospital (BGH).

  Surprised they passed the accessibility? – 'amber' so unknown

  Should Option 4 at the moment still be considered, if we are looking at the 10-15 years? There is an interdependency where ECU are staffed by a medical team. There are interdependencies about the shape of the model.

- **Option 213:**
  Failed on strategic direction.

- **Option 1:**
  Should we reconsider Option 1 due to strategic direction, if you have an ITU why would you need to transfer patients?

- **Option 216:**
  Were the Morriston team consulted regarding this option? Also it had four ITU's which is not sustainable?

- **Options 212, 214:**
  There is significant concern over WGH becoming a community hospital. Was the strategy in 2018 considered during conversations?

- **Options 133, 140, 218:**
  Are clinical ‘rejections’ because of concern over lack of staffing?

6 Dermatology Options (Does not meet hurdle criteria)

Dermatology - Do Not Meet

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Reference	Alternative Ideas Option A, B's and C's	Clinical	Deliverable	Accessible	Strategic	Financial	Challenge?
74	Option A - with AVH used with consultant	R	A	A	R	R	
146	Option A - but consolidate at Withybush not Prince Philip, and remove from South Pembrokeshire. (due to proximity). Opportunities to provide paediatrics, dermatology. from Withybush too.	R	R	A	A	R	
149	Option A - but with consultant clinics at Bronglais too	R	R	A	A	R	
71	Option B - but consolidate in Withybush	R	R	A	R	R	
219	Option B - but with nurse led clinics to allow greater accessibility for public transport	R	R	G	A	R	
64	Option C - but Consolidate in Glangwili	R	A	A	A	R	
69	Option C - with Outpatients at Withybush	R	R	A	A	R	
76	Option C - but rotate across health centres/community sites	R	R	A	R	R	

Dermatology - Do Not Meet

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Reference	Alternative Ideas – New ideas	Clinical	Deliverable	Accessible	Strategic	Financial	Challenge?
70	Services at Withybush	R	R	A	A	R	
57	New option - Service on all sites	R	R	G	G	R	
58	New idea - Use of virtual assessments, consolidate in community setting	R	R	R	R	R	
59	New Option - Service at more than one acute site and use of GPs	R	R	G	G	R	
61	New Option - Rotating clinics across GPs	R	R	R	A	R	
62	New Option - Mobile clinics/unit	A	A	G	G	R	
63	New Option - Keep service as it is at Glangwili	A	A	G	A	R	
66	New idea - Service at Bronglais	A	R	A	R	R	
67	New idea - Merge devices across Pembrokeshire and Bronglais- use of GPs	R	R	A	R	R	
75	New idea - Use of local health centres - Aberaeron	R	R	A	R	A	
104	New idea - Everything brought into Prince Philip to ensure it's a centre of excellence	A	A	R	R	A	
144	New idea - Nurse led clinics in Llandovery	R	A	A	R	R	
147	New idea - Clinic at least once a month in Bronglais and Glangwili	R	R	A	A	R	
220	New Option - Regional solution with SBUHB supporting Carmarthenshire, with Outpatients and MOPs in Bronglais and Withybush	R	R	A	R	R	
221	New Option - As Alt Op 57, but clinics are rotational and not continuously at each site.	R	R	G	A	R	
249	New Option - 3 counties all with community provision, Re-introduction of tele-derm for minor ops providers may encourage more GP participation	R	R	A	R	R	

Check & Challenge Feedback

Reference	Check & Challenge feedback Dermatology – 'Do Not Meet' the hurdle criteria	Challenge?
58, 59, 61, 62 & 67	Query raised around why options which contain partnership with primary care were red as it is something the service is doing now	
149	Believed to improve access to consultant dermatology. (Stakeholders)	
71, 146	Believed to be as inaccessible as the consultation options from a Ceredigion perspective. (Stakeholders)	

6.1 Dermatology Plenary Discussion – Does not meet hurdle criteria

The following individual feedback was provided by some members of the Options Development Group and is not a representation of the Options Development Group as a collective. This feedback has been shared in its raw form as captured during the session, and should be considered with this in mind.

- **Option 249:**
  Shouldn't consider hospital services as services start at Primary Care / Why does a dermatologist need to be based on an acute site?

  Currently the service offering teledermoscopy service from Newport consultants, very expensive service.

  We would like to train our own consultants to do own procedures. Must have Secondary Care sessions to deal with GP services. Not sustainable or value for money.

  Narrow view of Dermatology, introduction of tele-dermatology would be revolutionary.

  No trained dermatologists in South West Wales, currently using Newport to review lesions.

  Hywel Dda would like to train their own dermatologists, we haven't had a dermatologist since 2016.

  Tele-dermatology is important and a solution, however not beneficial with the current service.

  Why does a dermatologist have to be based on an acute site? The only way that the Health Board can recruit and retain dermatologists is for them to work in Secondary Care.

  Skin cancer is not practical to be based in Primary Care, not sustainable and no connection to a central hub or Multi-Disciplinary Team (MDT).

- **Option 62:**
  Challenge – can we deliver within financial envelope – phased implementation?
  Why did this fail on financial grounds?

Is this an option for a mobile unit?

Currently using consultants from other Health Boards and this would not be something that they would consider practical.

7 Emergency General Surgery Options (Does not meet criteria)

Emergency General Surgery - Do Not Meet							
Reference	Alternative Ideas – Option A's and B's	Clinical	Deliverable	Accessible	Strategic	Financial	Challenge?
78	Option A - with full emergency general surgery at Withybush Hospital	R	R	R	R	R	
77	Option A - but only keep surgeries in one location	R	R	A	A	A	
152	Option A - with hybrid model could be explored: Maintain permanent consultant presence at Bronglais and Glangwili Hospitals, as in Option A at Withybush Hospital, consider a scheduled daytime emergency surgery service for lower-risk, common conditions (e.g., appendicitis), supported by visiting surgical teams Use a "hub and spoke" system, where Glangwili is the hub for complex or high-risk surgery, but simpler cases are treated locally where possible This model would retain sustainability, but reduce the number of patients who need to be transferred from Pembrokeshire while still protecting Bronglais vital role in Mid Wales.	G	A	A	G	R	
223	Option A - but no SDEC at Withybush Hospital, unlike 153 no suggestion of phasing	R	R	S	S	S	
81	Option B - with Same Day Emergency Care in Prince Philip	R	R	R	S	R	
83	Option B - with Bronglais and Glangwili Hopitals alternating weeks	S	S	R	S	R	

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Emergency General Surgery - Do Not Meet

Reference	Alternative Ideas – New ideas	Clinical	Deliverable	Accessible	Strategic	Financial	Challenge?
80	New idea - EGS at Prince Philip and Glangwili Hospitals	R	R	S	S	S	
84	New idea - operations in Swansea	R	R	R	R	S	
230	New option - strengthen day care services.	R	R	S	S	S	
233	New option - move whole general surgery service to Glangwili Hospital	R	R	R	R	R	
234	New option - Withdraw services from Glangwili Hospital and locate to Withybush and Prince Philip Hospitals	R	R	S	S	S	
235	New option - EGS in Prince Philip and Bronglais Hospitals	R	R	S	S	S	

EGS Check & Challenge Feedback

Reference	Check & Challenge feedback 'Do Not Meet' the hurdle criteria	Challenge?
77	Option considered inaccessible to have only a single site providing EGS. (Stakeholders)	
223	Option considered less accessible than option A by Pembrokeshire reps.(Stakeholders)	
81	Felt this option would be accessible if there was a surgical SDEC in Llanelli. Challenge RAG rating (Stakeholders)	
80	Option considered inaccessible as service would be too far for those in the North and West of Hywel Dda. (Stakeholders)	
General	Due to the highly rural and sparsely populated nature of Powys, our residents are critically dependent on acute hospital services in neighbouring health boards in Wales and neighbouring NHS Trusts in England. In this context, the strategic importance of Bronglais General Hospital for north west Powys communities is well recognised, including in Professor Marcus Longley's "Mid Wales Healthcare Study" (2014) which concluded that Bronglais General Hospital should remain a ke centre for secondary care for the foreseeable future, and which recognised that significant changes may be required to ways of working. (PTHB)	

7.1 Emergency General Surgery Plenary Discussion – Does not meet hurdle criteria

The following individual feedback was provided by some members of the Options Development Group and is not a representation of the Options Development Group as a collective. This feedback has been shared in its raw form as captured during the session, and should be considered with this in mind.

- No challenges or questions received.

8 Endoscopy Options (Does not meet hurdle criteria)

Endoscopy – Does Not Meet								GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Hywel Dda University Health Board
Reference	Alternative Ideas – Option A's, B's and C's	Clinical	Deliverable	Accessible	Strategic	Financial	Challenge?	
156	Option A - with respiratory and urology only at Glangwili, bowel and gastro at all other sites	R	A	R	R	R		
86	Option B - with Service use at South Pembrokeshire & Tenby	A	R	A	A	A		
87	Option B - with Service (new bowel screening site) at South Pembrokeshire	A	R	A	A	A		
162	Option B - with Bronglais doing all the bowel screening	R	R	R	R	R		
157	Option C - plus develop a nurse led Endoscopy service with consultant supervision	R	R	R	R	R		
160	Option C - with respiratory and Urology remaining at Glangwili. Bowel screening could be moved to Glangwili or Withybush	R	R	R	R	R		
247	Option C - with out of hours option to Withybush	R	R	R	R	R		
256	Option C - with respiratory and urology at Withybush also	R	R	R	R	R		
257	Option C - with respiratory and urology at Glangwili also	R	R	R	R	R		
258	Option C - with respiratory and urology at Bronglais also	R	R	R	R	R		

Endoscopy – Does Not Meet

Reference	Alternative Ideas – New ideas	Clinical	Deliverable	Accessible	Strategic	Financial	Challenge?
13	New option - Hurdle session - Option 5 - Regional Diagnostic Hub for scheduled, 2 emergency sites (one to be Glangwili)	R	R	R	R	R	
88	New option - services at Bronglais and one other in South	R	R	R	R	R	
89	New option - mobile service, which would travel to each of the hospitals	R	R	A	R	R	
91	New option - Specialility centre of excellence at Glangwili	R	R	R	R	R	
161	New option - bowel screening, gastrointestinal, respiratory and urology all to be at Withybush	R	R	R	R	R	
248	New option - full services should be retained at Bronglais as at present - downgrading Llanelli services and diverting patients to Swansea	R	R	R	R	R	
250	New idea - respiratory at all sites	R	R	R	R	R	

Endoscopy Check & Challenge Feedback

Reference	Check & Challenge feedback 'Do Not Meet' the hurdle criteria	Challenge?
13	Why has regional model not progressed when it is something that exists elsewhere (within the options)	
90	Would want to see more detail about workforce assessments and impacts for this. (CRG)	
90	Workforce requirement likely to be medium term 5+ years, community sites unknown at present, do we have the estates to be able to deliver this in our current format, if not this is likely to be strategy delivery rather than CSP. IF extended hours, what are the additional workforce requirements to assess financial sustainability? (PSG)	
158	Is Llandovery viable for Endoscopy? Likely to be financially unsustainable. Lack of support services around to support. (CRG)	
158	Would community site be able to meet required standards for service. Need to consider all required criteria a site needs to meet and consider what happens if something were to go wrong. (PG)	
158	Estates in Llandovery unlikely to be viable for endoscopy, workforce provision for Llandovery doesn't currently exist, medium term solution 5+ years due to workforce modelling required and workforce pipeline alignment. (PSG)	
159, 162, 228, 256,257, 258	Concerns raised about travel times from the South to the North to access bowel screening, or inequity of access if certain hospitals retain services over others. (Stakeholders)	
250	While it was understood why Urology services might be brought together, it was unclear why other services needed to be also. Having those services across all sites would be more accessible. Likely RAG Green. (Stakeholders)	

8.1 Endoscopy Plenary Discussion – Does not meet hurdle criteria

The following individual feedback was provided by some members of the Options Development Group and is not a representation of the Options Development Group as a collective. This feedback has been shared in its raw form as captured during the session, and should be considered with this in mind.

- **Option 250:**
  We don’t have respiratory physicians on all sites

- **Option 158:**
  Option progressed to afternoon hurdle appraisal as ‘amber’.

- **Option 228:**
  Option progressed to afternoon hurdle appraisal as ‘amber’.

9 Ophthalmology Options (Does not meet hurdle criteria)

Ophthalmology – Does Not Meet							
Reference	Alternative Ideas – Option A's	Clinical	Deliverable	Accessible	Strategic	Financial	Challenge?
126	Option A - with cataracts every three months in Aberystwyth	R	R	R	R	R	
166	Option A - Glangwili-for tertiary needs, Prince Phillip for out patient needs, Amman valley- for cataract services and IVT (eye injections) , Cardigan Integrated Care Centre and North Road Eye Clinic- for IVT services. Some basic outpatient work in Withybush Hospital for those that cannot travel	S	A	R	S	S	
226	Option A - but cataracts carried out at Prince Philip Hospital Day Surgery Unit	A	A	G	G	R	

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Ophthalmology – Does Not Meet

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Reference	Alternative Ideas – Option B's	Clinical	Deliverable	Accessible	Strategic	Financial	Challenge?
98	Option B - with no North Road Eye Clinic, patients seen at Bronglais Hospital	G	A	R	A	G	
170	Option B - Emergency Eye care pathway should be regional with a regional on call rota supporting this. this should align to the national clinical networks. As such there should be no emergency eye care in HDd. Ophthalmology services should focus on elective and planned treatments, with no service at Glangwili, Withybush, and Bronglais. Prince Philip will consolidate services, utilizing Attend Anywhere for initial triage assessments before formal assessments for complex needs. Community services will consolidate at North Road Eye Care Clinic and Cardigan Integrated Care Centre. Tenby should offer clinics in underutilized space for patients within a one -hour commute, accessible by bus, rail, and car. CICC and Tenby would share the Outpatients clinic lists from Withybush site with Cardigan focusing on the North Pembrokeshire cluster. Amman Valley should have no service for this service as its so inaccessible for eye care treatments and Prince Philip is betters placed to be a regional centre. The service needs to transition to an EPR to allow sensible appointment allocations, offering patients the choice of a local clinic even if it means a longer wait versus a longer trip sooner.	R	R	R	R	S	
224	Option B - with Cataract lists delivered from Withybush	A	A	G	G	R	

Ophthalmology – Does Not Meet

Reference	Alternative Ideas – Option C's	Clinical	Deliverable	Accessible	Strategic	Financial	Challenge?
163	Option C - full services should be provided from Aberystwyth and Withybush Hospital	R	R	G	G	R	
165	Option C - centralise to Glangwili and Bronglais Hospitals	R	R	S	S	S	
174	Option C - with Cardigan Integrated Care Centre carrying our 24/7 emergency eye services	R	R	R	R	R	
225	Option C - but Llanelli residents are able to receive care from Morriston Hospital instead of Glangwili Hospital	A	R	G	A	R	
260	Option C - Bronglais and Glangwili Hospitals are hubs doing emergency and day case work. Community sites and opticians carrying out Out-patients and day case.	R	R	G	A	A	
261	Option C - Glangwili Hospital is for emergencies, Llanelli patients to Swansea Bay University Health Board. Withybush Hospital doing Out-patients and day case	S	R	A	S	R	
262	Option C - plus emergency eye care at Bronglais, Withybush and Glangwili hospitals	R	R	G	A	S	
265	Option C - but with mobile eye clinics based at GP surgeries	R	R	S	S	S	
267	Option C - with Emergency eye care at Withybush Hospital	R	R	G	R	R	
280	Option C - with Llandovery Community Hospital providing Outpatients and Diagnostics	R	R	R	R	R	

Ophthalmology – Does Not Meet

Reference	Alternative Ideas – New ideas	Clinical	Deliverable	Accessible	Strategic	Financial	Challenge?
94	New idea - hybrid model with enhanced outreach clinics. Emergency eye care in Glangwili Hospital. Amman Valley Hospital and Bronglais Hospital day case and outpatients, mobile/outreach clinics in Carmarthenshire and Pembrokeshire.	R	R	G	A	R	
97	New idea - Clinicians to rotate across sites	R	R	G	R	R	
15	Hurdle session - Option 5 - With Prince Philip Hospital as the specialist hub. Emergencies in Swansea Bay University Hospital between 8am-10pm and Withybush Hospital delivering diagnostics and injections. Amman Valley Hospital continues with Injections and potential cataracts. **NO SERVICE PROVISION IN CEREDIGION – FAILS ACCESSIBLE**	A	A	R	R	A	

Ophthalmology Check & Challenge Feedback

Reference	Check & Challenge feedback 'Do Not Meet' the hurdle criteria	Challenge?
226	Cataracts in the DSU could be feasible, especially if there are fallow sessions. Could this be explored? Query as to whether Community have been involved in some of this.	
170	It is believed that this option is feasible, even if it may not be a preferred or desirable option and should be considered, however not sure this option would work without a trauma centre in GGH. Concern that there would be bias as it doesn't consider all counties.	
163, 165, 260, 267, 280	While accessible for patients in the north, it was felt that this would be inaccessible for patients in east Carmarthenshire. (Stakeholders)	
262, 97	Concerns raised about accessibility for staff to be able to travel to all the sites, which might make them unwilling to remain in the role. (Stakeholders)	
General	Due to the highly rural and sparsely populated nature of Powys, our residents are critically dependent on acute hospital services in neighbouring health boards in Wales and neighbouring NHS Trusts in England. In this context, the strategic importance of Bronglais General Hospital fornorth west Powys communities is well recognised, including in Professor Marcus Longley's "Mid Wales Healthcare Study" (2014) which concluded that Bronglais General Hospital should remain a key centre for secondary care for the foreseeable future, and which recognised that significant changes may be required to ways of working. (PTHB)	

9.1 Ophthalmology Plenary Discussion – Does not meet hurdle criteria

The following individual feedback was provided by some members of the Options Development Group and is not a representation of the Options Development Group as a collective. This feedback has been shared in its raw form as captured during the session, and should be considered with this in mind.

- **Option 15:**
  Moved to afternoon hurdle appraisal session. Counter challenge from the service as no Ceredigion locations for service.

10 Orthopaedics Options (Does not meet hurdle criteria)

Orthopaedics – Does Not Meet

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Reference	Alternative Ideas	Clinical	Deliverable	Accessible	Strategic	Financial	Challenge?
51	Option A - with inpatient services could be provided on alternate weeks in Withybush	R	R	A	R	R	
180	Option B - with inpatient services at Glangwili	R	R	R	R	R	
229	Option B - but weekend working at Bronglais, Prince Philip and Withybush	R	R	G	A		
56	New idea - query procedure basket at Withybush	R	R	R	R	R	
105	New option - create an absolute 24 hour, 7 days a week planned care specialist orthopaedic unit at Glangwili	R	R	A	R	R	
269	New idea - Need to consider discontinuing elective hip & knee replacement patients at BGH as there are less patients having joint replacement surgery there & they can travel to PPH.	R	A	R	A	A	
270	New idea - Centralise the service at WGH	R	R	R	R	R	
271	New idea - Why can't regional cases be transferred to BGH?	R	R	R	S	S	

Orthopaedics Check & Challenge Feedback

Reference	Check & Challenge feedback 'Do Not Meet' the hurdle criteria	Challenge?
51	Challenge about whether patients would have to travel further if the service alternated between sites, causing people to travel further based on week offered (Stakeholders)	
180	Weekend working would be a benefit to patients, provided transport was provided. GGH is also most accessible site for all 3 counties. (Stakeholders)	
General	More complex pathways would need to be established in community provision if changes introduce greater distances of travel to acute care, particularly for stroke, but potentially applicable in other service areas. This will require targeted resource for expedited discharge, recovery and rehabilitation closer to home. (PTHB)	

10.1 Orthopaedics Plenary Discussion – Does not meet hurdle criteria

The following individual feedback was provided by some members of the Options Development Group and is not a representation of the Options Development Group as a collective. This feedback has been shared in its raw form as captured during the session, and should be considered with this in mind.

- **Option 16:**
  Moved to afternoon hurdle appraisal session.

11 Radiology Options (Does not meet hurdle criteria)

Radiology – Does Not Meet								Bwrdd Iechyd Prifysgol Hywel Dda University Health Board
Reference	Alternative Ideas – Option A's, B's, C and New ideas	Clinical	Deliverable	Accessible	Strategic	Financial	Challenge?	
185	Option A - with cancer focus (Prince Philip and Withybush)	R	G	A	G	G		
281	Option A - with planned diagnostics in GGH also	R	G	A	A	A		
254	Option B - 2 site option with Radiology hub	R	R	R	R	R		
259	Option B - with 7 day Interventional at GGH	R	A	G	A	A		
253	Option B - without the hub to reduce waiting lists, then revert to option D.	R	A	A	A	A		
251	Option D - with Inpatient interventional services also in Withybush	R	A	A	A	A		
184	New idea - Llandovery open 5 days a week	R	R	A	G	R		
186	New idea - Interventional 24/7 across all sites	R	R	G	R	R		
252	New option - Llandovery Hospital Radiology service reduced rather than removed from options	R	G	A	A	R		

Radiology Check & Challenge Feedback

Reference	Check & Challenge feedback 'Do Not Meet' the hurdle criteria	Challenge?
185, 259	May be accessible, however barrier will be public transport or private transport costs for those needing Cancer focus services especially from the North. (Stakeholder)	
252	Already a 2 day a week service, reducing the hours of the service would make it more inaccessible rather than remain accessible. (Stakeholder)	

11.1 Radiology Plenary Discussion – Does not meet hurdle criteria

The following individual feedback was provided by some members of the Options Development Group and is not a representation of the Options Development Group as a collective. This feedback has been shared in its raw form as captured during the session, and should be considered with this in mind.

- No challenges or questions received.

12 Stroke Options (Does not meet hurdle criteria)

Stroke – Does Not Meet								Bwrdd Iechyd Prifysgol Hywel Dda University Health Board
Reference	Alternative Ideas – Option A's and B's	Clinical	Deliverable	Accessible	Strategic	Financial	Challenge?	
203	Options A - with two Stroke units - in Bronglais and Withybush	R	R	A	S	S		
204	Options A - 2 Stroke units - Bronglais and Prince Philip	R	S	S	S	S		
236	Option A - but with Glangwili as a third unit	R	R	S	R	R		
37	Option B - with Bronglais instead of Withybush	R	S	S	S	R		
117	Option B - with Glangwili instead of Prince Philip..	R	R	A	A	R		
202	Option B - 24h stroke units at Prince Phillip and Withybush	R	R	S	S	R		
210	Option B - In this option Bronglais would take the place of Withybush providing a 12 hour specialist unit, while Glangwili would take the place of Prince Philip for the 24 hour specialist unit. In the longer term (4+ years) Glangwili site would merge with staff from Swansea Bay to provide a regional stroke unit, with Bronglais remaining as a local stroke unit. At this point Bronglais would no longer provide treat and transfer to Glangwili would be a self sufficient stroke unit with patients given the opportunity to be transferred to the regional stroke unit.	R	S	S	A	S		
239	Option B - but with Glangwili as the Main site and Prince Philip and Bronglais and Withybush as the stroke unit	R	R	S	R	R		
275	Option B - Bronglais and one hospital in the south (GGH) with 24/7 cover	R	R	A	R	R		

Stroke – Does Not Meet

Reference	Alternative Ideas	Clinical	Deliverable	Accessible	Strategic	Financial	Challenge?
6	New idea - Sprint 1 - Option 3 - Acute Stroke service delivered at three sites for Hywel Dda. (Carmarthenshire, Pembrokeshire & Ceredigion) - ref 6 and 29 cover options for Carmarthenshire unit at each site. For this example a Stroke Unit with Rehabilitation in Bronglais, Glangwili and Withybush. With a transfer service in Prince Philip.	R	R	S	S	R	
7	New Idea - Sprint 1 - Option 4 - A Morriston Comprehensive Regional Stroke Centre with Stroke Units and Rehabilitation on all sites	R	R	S	G	R	
12	New option - Hurdle session - Option 2 - Withybush with a 24/7 Stroke Unit. 12/7 Stroke unit at Bronglais, Glangwili and Prince Philip. With rehabilitation on all sites	R	R	A	S	R	
18	New option - Centralise to single unit or **Morriston (option ref 7)**. If centralising the service due to staffing fragilities it would make more sense to have a single unit for Hywel Dda, or possible Morriston in line with National Stroke development.	R	R	A	S	R	
33	Ne option - Comprehensive Regional Stroke Centre at Bronglais with Stroke Units and Rehabilitation at Glangwili, Prince Philip and Withybush.	R	R	R	R	R	
111	New option - Glangwili with a Stroke Unit, Rehabilitation in Prince Philip. Stroke Units with Rehabilitation in Bronglais and Withybush	R	R	S	R	R	

Stroke – Does Not Meet

Reference	Alternative Ideas	Clinical	Deliverable	Accessible	Strategic	Financial	Challenge?
118	New Option - Stroke Unit at Glangwili with Consultant Therapist Rehabilitation led units at Bronglais, Prince Philip and Withybush.	R	R	S	S	S	
206	New Option - 24/7 hour service at all sites	R	R	S	S	R	
211	New option - keep stroke unit 24 hour specialist care in Glangwili, stroke unit 12 hour specialist care in Prince Philip, Bronglais and Withybush. Give the hospital an acute stroke ward and rehab stroke ward in Glangwili with how it used to be.	R	R	R	R	R	
240	New Option - Glangwili as CRSC with Prince Philip as therapy unit consultant therapist led.	A	A	R	A	A	
241	New Option - Morriston as CRSC with Prince Philip as therapy unit consultant therapist led.	A	A	R	G	A	
274	New Option - Bronglais, Withybush, Glangwili. Increased MRI at Bronglais. Rotational clinicians across sites during absence and increase use of Consultant Nursing and Therapies	R	R	G	R	R	
277	New option for 24/7 at PPH and 12/7 at GGH,WGH &BGH	R	R	G	R	R	
286	New option Bronglais and one hospital in the south (WGH) with 24/7 cover	R	R	A	R	R	
287	New option Bronglais and one hospital in the south with 24/7 (PPH) cover	R	R	A	R	R	

Stroke Check & Challenge Feedback

Reference	Check & Challenge feedback 'Do Not Meet' the hurdle criteria	Challenge?
37	Felt this is deliverable as the take would split between BGH and PPH.	
210	Unsure why this option fails, as it meets the longer -term aim. Perhaps it can be worded differently to meet short term and long term.	
118	This service configuration is aligned with the strategy. Unclear on why this couldn't be delivered. Consultant therapists may be an affordable alternative. Felt workforce could be available to deliver this.	
204, 275, 6, 274, 286, 287	While recognised as more accessible from a North/ South perspective, it would impact East/West access. Likely Amber. (Stakeholders)	
236	Considered inaccessible as 3rd unit in the South doesn't address the access requirements of those in the North. (Stakeholders)	
37,117, 202, 239, 7, 12, 18, 33, 111, 118	Options believed to be inaccessible due to travel time and distance to PPH for initial stroke care, or location of units for whole population. (Stakeholders)	
210	Concerns about the distance to travel to a regional stroke centre, and transport links from communities to Swansea. (Stakeholders)	
206	This would be the most accessible option as patients would be able to receive total care from local acute site. RAG likely to be Green. (Stakeholders)	
211, 277	Believed to be accessible, however would create inequity between sites. (Stakeholders)	
General	More complex pathways would need to be established in community provision if changes introduce greater distances of travel to acute care, particularly for stroke, but potentially applicable in other service areas. This will require targeted resource for expedited discharge, recovery and rehabilitation closer to home. We would be happy to consider the options of stroke centre in Bronglais or a single centre for Mid Wales more carefully if those get through the hurdle criteria stage, as we know that they would be attractive to our population, although also understand there may be feasibility issues. (PTHB)	

12.1 Stroke Plenary Discussion – Does not meet hurdle criteria

The following individual feedback was provided by some members of the Options Development Group and is not a representation of the Options Development Group as a collective. This feedback has been shared in its raw form as captured during the session, and should be considered with this in mind.

- **Option 210:**
  Check and challenge - Unsure why this option fails, as it meets the longer-term aim. Perhaps it can be worded differently to meet short term and long term.

  There was a question on whether Betsi Cadwaladr University Health Board (BCUHB) had responded to these alternative options; they had not yet responded, only Powys Teaching Health Board (PTHB).

- **Option 118:**
  No change from service.

- **Option 204:**
  Staff provision in BGH is the main issue which stops this happening.

- **General:**
  In any option referring to 24/7 BGH cover, there is not the expertise there to deliver this. To expect this to change dramatically in the future is unrealistic.

  This is a process question… There are a lot of interdependencies. Are you linking with other departments to address these?

  Single Stroke physician in both BGH and GGH and therefore fragile.

  'Red' options are realistic and therefore agree with Task and Finish Group's decision.

  Are you linking with Radiology?

  Powys have provided feedback, have Betsi and Gwynedd provided feedback?

13 Urology Options (Does not meet hurdle criteria)

Urology – Does Not Meet

GIG CYMRU NHS WALES | Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Reference	Alternative Ideas	Clinical	Deliverable	Accessible	Strategic	Financial	Challenge?
38	Option A - with consultation option but services brought together at Bronglais Hospital	R	R	S	S	R	
39	Option A - with consultation option with urgent suspected cancer also remaining at Bronglais Hospital	S	S	S	R	S	
189	Option A - With full diagnostics and treatment at Bronglais and Withybush Hospitals	S	S	S	A	R	
11	New Option - Emergency, outpatients, day cases and inpatients at GGH & PPH with diagnostic hub in PPH. No service at other sites	R	S	R	R	S	
40	New option - Consultation option with urgent suspected cancer also remaining at Withybush Hospital	R	R	G	A	R	
43	New option - Urology outreach clinics: Even with a central hub, occasional consultant-led outreach days at Bronglais, Glangwili or Withybush Hospitals could serve high-demand local areas. Mobile diagnostics for rural patients: A mobile scanning unit for basic urology diagnostics (e.g. bladder scanning, PSA monitoring) could help patients in more remote communities.	S	S	G	S	R	
195	New option - develop robust community-based urology clinics staffed by nurse specialists and consultants visiting regularly to provide diagnostic and follow-up care closer to patients homes, reducing the need for hospital visits	S	S	G	S	R	
198	New option - emergency Urology at Withybush and Bronglais Hospitals	R	S	S	S	R	
199	New option - emergency Urology at Withybush Hospitals	R	S	G	A	R	
255	New option - Urology services delivered from Glangwili/ Bronglais Hospitals	R	R	S	R	R	

Urology Check & Challenge Feedback

Reference	Check & Challenge feedback Do Not Meet' the hurdle criteria	Challenge?
195	Should be looked at further, especially putting more in the community. Unable to see why this would fail if phased, and review of skill mix took place to understand what could be done by district nursing, for example.	
38	Felt that the option would not be any more accessible than the options which went out to consultation, citing difficulties for those in remote areas to travel to any extremity of the Health Board. (Stakeholders)	
189	Felt that having Urology diagnostic units in the extremities of the HB area would be very accessible and easier to get to, although it was noted that the resourcing to deliver this may not be available (Stakeholders)	
40	Believed to be inaccessible for those living in the North, challenge to RAG would likely be amber. (Stakeholders)	
255	No service in WGH or PPH believed to be inaccessible. (Stakeholders)	

13.1 Urology Plenary Discussion – Does not meet hurdle criteria

The following individual feedback was provided by some members of the Options Development Group and is not a representation of the Options Development Group as a collective. This feedback has been shared in its raw form as captured during the session, and should be considered with this in mind.

- **Option 43:**
  Challenge – do in the longer term? Service doesn't see the value in using a mobile service. Option moved to the afternoon session for hurdle appraisal.

  Central hub and spokes seem like a reasonable patient centred approach. Why would that fail on financial grounds?

  If Option 43 cannot be delivered in the financial envelope, why should it move forward?

  What can logistically be delivered in a mobile unit; some procedures would not be able to be delivered on a mobile unit.

- **Option 189:**
  Challenge is equipment and staffing.

  Option moved to the afternoon session for hurdle appraisal.

- **General:**
  Unsure what Primary Care were doing in [some of the] other services.

14 Critical Care Options (Meets/ may meet hurdle criteria)

Critical Care Does Meet/ May Meet Slide

GIG CYMRU NHS WALES | Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Reference	Alternative Ideas	Clinical	Deliverable	Accessible	Strategic	Financial	Challenge?
34	Option C - but with Centralised Consultant Intensivist Rota supporting Critical Care beds on existing sites (This could include peripatetic staff and / or a flexible rota approach)	A	A	A	A	A	
119	Option B - with Prince Philip service led by senior anaesthetics combined with medical consultants (as option B with more detail on requirements believed to be needed) (See letter received from Prince Philip Consultant Group)	A	A	A	G	A	
137	Option B - with Intensive Care Unit in 3 hospitals and High Dependency Unit in Prince Philip	G	G	G	A	A	
215	Option A - with Intensive Care Unit and Enhanced Care Unit at Glangwili/ Bronglais/ Withybush, Enhanced Care Unit at Prince Philip	A	A	A	A	A	
246	New idea - regional model	A	A	A	A	A	

Brought forward from morning.

Reference	Alternative Ideas	Clinical	Deliverable	Accessible	Strategic	Financial	Challenge?
47	New idea - Transfer patients to Morriston Intensive Care Unit from Prince Philip. With a Intensive Care Unit at Bronglais, Glangwili and Withybush.	R	A	A	A	A	

Critical Care Check & Challenge Feedback

Ref	Check & Challenge feedback 'Do Not Meet' the hurdle criteria	Challenge
34	Who was involved in this? What is the detail behind this model? Would this be sustainable, address issues? Not strategically aligned to future model of WGH. (CRG)	
34	OCP required to undertake change, with possible significant impact on employment contract and bases of staff. Not financially viable due to the amount of sites required for the cover, also significant risk in hiring consultant levels workforce, challenges exist in work force pipelines, pipeline likely to take over 5+ years - Strategy rather than CSP option? (PSG)	
119	Concern about the level of additional staff required to run the ECU, especially therapies. Not strategically aligned to future model of WGH. (CRG)	
119	Additional workforce required in Gen Med Consultant group, significant workforce gaps already exist, and possibility to de-stabilise other gen medical rota's. This option would unlikely be financially viable over the medium term, possibly leading to a more strategic implementation of 5+ years (PSG)	
137	Not strategically aligned to future model of WGH. (CRG)	
137, 215	Workforce model unsustainable over medium term 3 -5 years. Therapies workforce unstable in the medium term option would be unsustainable. Additional staffing for PPH unknown currently but additional workforce and finance resources required unlikely to be available in medium term. The level of additional workforce requirements is needed to assess financial sustainability. (PSG)	
215	Workforce model for regional solution unknown, likely to be high cost in short -medium term along with resource alignment. (PSG)	
34	Although it would be accessible for patients and families, concern about staff travel and whether this would support retention. (Stakeholders)	
General	Due to the highly rural and sparsely populated nature of Powys, our residents are critically dependent on acute hospital services in neighbouring health boards in Wales and neighbouring NHS Trusts in England. In this context, the strategic importance of Bronglais General Hospital for north west Powys communities is well recognised, including in Professor Marcus Longley's "Mid Wales Healthcare Study" (2014) which concluded that Bronglais General Hospital should remain a key centre for secondary care for the foreseeable future, and which recognised that significant changes may be required to ways of working. (PTHB)	
47	Morriston considered easier to access for Llanelli residents than Glangwili, this option would be more accessible than those consulted on. (Stakeholders)	

14.1 Critical Care Plenary Discussion – Meets/ may meet hurdle criteria

The following individual feedback was provided by some members of the Options Development Group and is not a representation of the Options Development Group as a collective. This feedback has been shared in its raw form as captured during the session, and should be considered with this in mind.

- **Option 47:**
  Need to be clear on the exact language.

  Is it ITU at all sites?

- **Option 34:**
  Meets the strategic direction. Needs some additional work on how to support staff and infrastructure.

  Lots of people management required bringing people together for one rota.

  Are some of these options going to make HDdUHB an unattractive place to come and work?

15 Dermatology Options (Meets/ may meet hurdle criteria)

There were no alternative options believed to meet the hurdle criteria for Dermatology, and none were brought forward from the morning session, so no discussion took place for this service.

16 Emergency General Surgery Options (Meets/ may meet hurdle criteria)

EGS Does Meet/ May Meet Slide

GIG CYMRU NHS WALES | Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Reference	Alternative Ideas	Clinical	Deliverable	Accessible	Strategic	Financial	Challenge?
23	New idea - EGS hybrid model, surgical Same Day Emergency Care at Bronglais, Withybush and Glangwili Hospitals for day case procedures. On Call and high-risk procedures centralised at Glangwili Hospital	A	A	A	A	A	
155	Option A, but an additional Surgical Same Day Emergency Care at Bronglais Hospital.	S	S	S	S	A	
222	New option - EGS centralised in Glangwili and Bronglais Hospitals. Surgical patients repatriated to Prince Philip and Withybush Hospitals for recovery	S	S	S	S	A	

The options below have been considered green even though there is a split decision on delivery from a service lens:

Reference	Alternative Ideas	Clinical	Deliverable	Accessible	Strategic	Financial	Challenge?
79	New idea - Centralise to Glangwili Hospital	S	S	S	S	S	
82	New idea - EGS service at each hospital (row 145)	S	S	G	S	S	
153	Option A - but with longer term plan to withdraw from Withybush Hospital into Glangwil Hospital	S	G	S	S	G	
231	Option A - with dedicated recovery in Withybush Hospital. Is this too similar to Opt A?	S	S	S	S	S	

EGS Check & Challenge Feedback

Reference	**Check & Challenge feedback** **'Do Not Meet' the hurdle criteria**	Challenge?
23	Procurement of non-urgent transport needed from WAST, extra impact on GGH for high-risk procedures unknown, how many beds would be required for GGH for urgent patient movements' workforce requirement noted, unable to provide workforce assessment or financial sustainability implications.	
155	Medical and Nursing workforce currently fragile in Ceredigion, medium term solutions not in place from a workforce pipeline perspective, likely to take 5+ years due to the need to change education pipelines. With an additional SDEC what are the additional workforce requirements to assess financial sustainability?	
222	Additional nursing workforce along with therapies unlikely to be sourced in the medium-term 5+years, additional bed base would require additional staffing requirements along with estates usage, a planned estates strategy would need to aligned to facilitate this.	
231	Having patients return to WGH for rehabilitation would be better for Pembrokeshire residents if they can't have their surgery in county. More accessible than no service in county. (Stakeholders)	
23	Concerns raised around accessibility and timely access to Emergency Surgery if only 1 site in the HB for high risk patients. Challenge to RAG rating. (Stakeholders)	
General	Due to the highly rural and sparsely populated nature of Powys, our residents are critically dependent on acute hospital services in neighbouring health boards in Wales and neighbouring NHS Trusts in England. In this context, the strategic importance of Bronglais General Hospital for north west Powys communities is well recognised, including in Professor Marcus Longley's "Mid Wales Healthcare Study" (2014) which concluded that Bronglais General Hospital should remain a key centre for secondary care for the foreseeable future, and which recognised that significant changes may be required to ways of working. (PTHB)	

16.1 Emergency General Surgery Plenary Discussion – Meets/ may meet hurdle criteria

The following individual feedback was provided by some members of the Options Development Group and is not a representation of the Options Development Group as a collective. This feedback has been shared in its raw form as captured during the session, and should be considered with this in mind.

- **Option 23**
  What are the high-risk procedures?

17 Endoscopy Options (Meets/ may meet hurdle criteria)

Endoscopy Does Meet/ May Meet Slide

GIG CYMRU NHS WALES | Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Reference	Alternative Ideas	Clinical	Deliverable	Accessible	Strategic	Financial	Challenge?
90	Option B - with the units open for longer. Extend opening times .	A	A	A	A	A	
92	Option C - with extended hours at Prince Philip. Weekend clinics	G	G	G	G	G	
158	Option B - with the use Llandovery Hospital for community services	A	A	A	A	A	
159	Option B - with the addition of bowel screening at Bronglais	A	A	A	A	A	
228	Option B - with Withybush also providing the bowel screening	A	A	A	A	A	

Endoscopy Check & Challenge Feedback

Reference	Check & Challenge feedback 'Do Not Meet' the hurdle criteria	Challenge?
90, 92	Would want to see more detail about workforce assessments and impacts for this. (CRG)	
90, 92	Workforce requirement likely to be medium term 5+ years, community sites unknown at present, do we have the estates to be able to deliver this in our current format, if not this is likely to be strategy delivery rather than CSP. IF extended hours, what are the additional workforce requirements to assess financial sustainability? (PSG)	
158	Is Llandovery viable for Endoscopy? Likely to be financially unsustainable. Lack of support services around to support. (CRG)	
158	Would community site be able to meet required standards for service. Need to consider all required criteria a site needs to meet and consider what happens if something were to go wrong. (PG)	
158	Estates in Llandovery unlikely to be viable for endoscopy, workforce provision for Llandovery doesn't currently exist, medium term solution 5+ years due to workforce modelling required and workforce pipeline alignment. (PSG)	
90	While recognising the Llandovery as a site would be accessible that community, the facilities available on site would mean that it may not support patients' dignity so the site makes this less accessible.	

17.1 Endoscopy Plenary Discussion – Meets/ may meet hurdle criteria

The following individual feedback was provided by some members of the Options Development Group and is not a representation of the Options Development Group as a collective. This feedback has been shared in its raw form as captured during the session, and should be considered with this in mind.

- **General**
  Clarity on what [aspect of respiratory] service, it was confirmed that it is elective respiratory.

- **Option 92:**
  Would that be an additional cost, all endoscopy options will require additional funding, including options A to C.

  Cost of weekend working more expensive?

18 Ophthalmology Options (Meets/ may meet hurdle criteria)

Ophthalmology Does Meet/ May Meet Slide

GIG CYMRU NHS WALES | Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Reference	Alternative Ideas	Clinical	Deliverable	Accessible	Strategic	Financial	Challenge?
95	Option A - but centralise to Glangwili Hospital, centre of excellence. 12 hours / 7 days a week.	A	A	G	G	G	
99	Option A - but in the Community section it would read Amman Valley Hospital day cases (cataract) and Outpatients (eye injections). Diagnostics and outpatient services in Cardigan Integrated Care Centre and North Road Eye Clinic.	G	G	G	G	G	
167	New option - Aberaeron Integrated Care Centre becomes an optometry hub. This would allow for the service to meet its sustainability aims, as well as make best use of estates assets across the health board.	G	G	G	G	A	
172	Option A - plus community diagnostics in Llanelli	S	S	G	G	A	
173	Option C - with Aberaeron Integrated Care Centre doing diagnostics	G	S	G	G	A	
263	Option B - with extended working	S	A	A	A	A	

The option below have been considered green even though there is a split decision on delivery from a service lens:

Reference	Alternative Ideas	Clinical	Deliverable	Accessible	Strategic	Financial	Challenge?
227	Option A - But increased working hours at Withybush Hospital for eye injections	S	S	G	G	S	

Ophthalmology Check & Challenge Feedback

Reference	Check & Challenge feedback 'Do Not Meet' the hurdle criteria	Challenge?
95	Due to extended work hours impact on sickness might be seen, additional WTE needed to facilitate the change unknown at present. 2 criteria are amber therefore is this green overall. Does this require additional whole time equivalent (WTE) and if so, is it financially sustainable?	
99	Workforce assessment needed for Amman Valley Hospital due to additional diagnostics. What are the additional workforce requirements to assess financial sustainability?	
172	Might be possible, but not whole of service. Need to understand primary care workforce impact in community services. Hub at Llanelli would require estates plan, if this was the main delivery area workforce need wouldn't change but OCP would be required for existing staff due to base change, if Llanelli was in addition to current community plan workforce assessment needed and unlikely delivery in medium term 5+ years. If additional workforce is required it will need assessment as to financial sustainability	
173	Need to understand primary care workforce impact in community services. Workforce assessment needed, current workforce pipelines would need to be updated to understand delivery, impact on estates in primary care and ability to deliver.	
95	Considered to be inaccessible for communities, noting in particular lack of direct public transport to AVH as a community site, and lack of car parking on GGH site. RAG likely to be Amber or Red. (Stakeholders)	
99, 167, 172	Challenge to RAG status due to travel distance for North Ceredigion and neighbouring areas needing to travel south for cataracts in either AVH or acute hospital. Concerns raised around lack of facilities in AVH to support families if making long journeys. (Stakeholders)	
227	Due to availability of public transport, and people being unwilling to drive in the dark, concerns that extended hours will not be more accessible and just create more people not attending. Challenge to RAG likely Amber (Stakeholders)	
263	Option considered to be more accessible than appraised, would likely be Green for access, although stakeholders did note that they believed this might not be affordable or deliverable. (Stakeholders)	
173	Challenge to RAG status for accessible due to no service in PPH and accessibility issues to other sites in HB. (Stakeholders)	
General	Due to the highly rural and sparsely populated nature of Powys, our residents are critically dependent on acute hospital services in neighbouring health boards in Wales and neighbouring NHS Trusts in England. In this context, the strategic importance of Bronglais General Hospital for north west Powys communities is well recognised, including in Professor Marcus Longley's "Mid Wales Healthcare Study" (2014) which concluded that Bronglais General Hospital should remain a key centre for secondary care for the foreseeable future, and which recognised that significant changes may be required to ways of working. (PTHB)	

18.1 Ophthalmology Plenary Discussion – Meets/ may meet hurdle criteria

The following individual feedback was provided by some members of the Options Development Group and is not a representation of the Options Development Group as a collective. This feedback has been shared in its raw form as captured during the session, and should be considered with this in mind.

- **Option 127:**
  Does only noting Aberaeron does this only mean the service will be delivered here?

  Workforce is already working at increased capacity, is therefore the extra work going to be deliverable?

19 Orthopaedics Options (Meets/ may meet hurdle criteria)

Orthopaedics Does Meet/ May Meet Slide

GIG CYMRU NHS WALES | Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Reference	Alternative Ideas	Clinical	Deliverable	Accessible	Strategic	Financial	Challenge?
50	New option - Inpatients at Withybush	A	A	A	A	A	
52	New option - Query hip/knee procedure basket at Withybush	A	A	G	G	A	
113	Option C - Arthroplasty at Withybush - this would mean INPT work in Withybush.	A	A	A	A	A	
129	Options A,B,C,D - Combination of options: - Increased inpatients and day cases at Bronglais (Option D) But cannot comment on prioritisation of one service over another (understand orthopaedic can only increase if ophthalmology activity comes out?) - Extend hours at Withybush if it extends capacity (option B) - Additional beds and investment outlined at PP (Option C) – but as part of a regional working approach (Option A, B and D) - Increase capacity at Neath Port Talbot (Swansea Bay UHB) for regional working across South West Wales. - A regional / local hybrid surgical hubs network with Neath Port Talbot (A, B and D).	A	A	A	A	A	

Orthopaedics Does Meet/ May Meet Slide

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Reference	Alternative Ideas	Clinical	Deliverable	Accessible	Strategic	Financial	Challenge?
178	Option B - only with the extended hours at Prince Philip rather than Withybush	A	A	G	G	A	
179	Option D - plus: Elective Orthopaedics should increase activity at Bronglais to address regional pressures in Powys, reducing patient transfers to NHSE Trusts and supporting the mid Wales community. Glangwili should not have elective procedures, while Prince Philip should focus on regional pathways with SBUHB, supported by a Medical ECU and increased ward availability. Orthopaedic inpatient care should be retained but aligned with Neath Port Talbot, and a single regional patient tracking list should be developed. Withybush should become an optimized day surgery site, shifting more procedures from Prince Philip and reallocating EGS theatre sessions. Workforce plans include reviewing job plans for optimal procedure flow and developing a regional orthopaedic rota. Orthopaedics should reduce face -to-face Outpatients sessions, delivering more virtual assessments and utilizing community X -ray to keep services local. dependency - the flow and increased activity on Prince Philip will require additional Beds.	A	A	A	A	A	
268	Option D - but with the additional beds and investment of C but as a regional / local surgical hub model. Option D with some of the ideas of Option C, therefore, is perhaps most likely to achieve results.	A	A	G	A	A	

Orthopaedics Does Meet/ May Meet Slide

Brought forward from morning.

Reference	Alternative Ideas	Clinical	Deliverable	Accessible	Strategic	Financial	Challenge?
16	Hurdle session - Option 5 - Bronglais focusing on Day Case, Glangwili on Out Patients, Prince Philip on Day Case and Withybush doing Inpatients and more complex cases.	R	R	R	R	R	

Orthopaedics Check & Challenge Feedback

Reference	Check & Challenge feedback 'Do Not Meet' the hurdle criteria	Challenge?
50,52, 113	Not aligned to the regional strategy for Orthopaedics (PG) Considered inaccessible for Ceredigion residents (113), as wider residents who may be able to access GGH as a more central location (50/52). (Stakeholders)	
50	If this is a new inpatient facility at Withybush, workforce requirements required to assess if it is financially sustainable? (PSG)	
52	If this is increasing facilities at Withybush, would it increase workforce requirements and if so is it financially sustainable? (PSG)	
113	If this is increasing inpatient care at Withybush, what are the workforce requirements to assess financial sustainability? (PSG)	
179	Considered to be more accessible than current appraisal due to regional inpatients and local outpatients and diagnostics. (Stakeholders)	
129	Supported as comprehensive and more accessible than current appraisal, balancing need to travel further for operations, and locally for outpatients/ diagnostics. (Stakeholders)	
16	Not sure why this has failed? Is it because there isn't a ward? Could this be done in the future as part of wider site changes?	
General	More complex pathways would need to be established in community provision if changes introduce greater distances of travel to acute care, particularly for stroke, but potentially applicable in other service areas. This will require targeted resource for expedited discharge, recovery and rehabilitation closer to home. (PTHB)	

19.1 Orthopaedics Plenary Discussion – Meets/ may meet hurdle criteria

The following individual feedback was provided by some members of the Options Development Group and is not a representation of the Options Development Group as a collective. This feedback has been shared in its raw form as captured during the session, and should be considered with this in mind.

No challenges or questions received.

20 Radiology Options (Meets/ may meet hurdle criteria)

Radiology Does Meet/ May Meet Slide

GIG CYMRU NHS WALES | Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Reference	Alternative Ideas	Clinical	Deliverable	Accessible	Strategic	Financial	Challenge?
9	Sprint 1 - Option 2 - centralised Outpatients – use of mobile	A	G	A	A	A	
24	Option B - but excluding the Radiology Hub	A	G	A	A	G	
25	Option B - but with a smaller Radiology Hub	G	G	G	G	G	
103	Option A and B mix	A	G	G	G	A	
122	New idea - extend hours of Xray services at CICC to match opening hours (as current elsewhere)	A	G	A	G	A	
182	New idea - extended hours at Tenby	A	G	A	G	A	

Radiology Check & Challenge Feedback

Reference	Check & Challenge feedback 'Do Not Meet' the hurdle criteria	Challenge?
9, 24, 25, 103,122, 182	Challenge on Financial Sustainability (PG)	
9	Procurement of vehicle and staffing requirement noted by the service as possibly taking over 4 years to achieve. No Workforce requirement noted, unable to provide workforce assessment. Staffing profile due to current education pipelines would take at least 2 years, change of contract for staff needed to ensure travel along with correct driving licence requirement and insurance to cover the vehicle and equipment. (PSG)	
24,25,122,182	Workforce Assessment needed, service changing to 7 days a week will require a significant workforce uplift, unlikely to be deliverable due to current staffing issues in .radiology in the medium term 5+ years. Once workforce assessment known will be able to assess financial sustainability (PSG)	
182	Extended hours at CICC make sense, but unsure on the level of demand to provide those services at other sites. (CRG)	
24, 25, 103	May be accessible, however barrier will be public transport or private transport costs for those needing Cancer focus services especially from the North. (Stakeholder)	
9	Felt to be a very accessible option, especially with the ability to be more local in communities (Stakeholder)	

20.1 Radiology Plenary Discussion – Meets/ may meet hurdle criteria

The following individual feedback was provided by some members of the Options Development Group and is not a representation of the Options Development Group as a collective. This feedback has been shared in its raw form as captured during the session, and should be considered with this in mind.

- **General**
  Is the hub just radiology or will it include wider services?

21 Stroke Options (Meets/ may meet hurdle criteria)

Stroke Does Meet/ May Meet Slide

GIG CYMRU NHS WALES | Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Reference	Alternative Ideas	Clinical	Deliverable	Accessible	Strategic	Financial	Challenge?
29	Sprint 1 - Option 3 - Acute Stroke service delivered at three sites for Hywel Dda (Carmarthenshire, Pembrokeshire & Ceredigion) - ref 6 and 29 cover options for Carmarthenshire unit at each site	A	A	G	A	A	
31	Option A - But with Stroke in 2 sites at Bronglais and Glangwili	A	A	S	A	A	
106	Options A - with an acute stroke rehabilitation unit at Bronglais gives a robust option for a Treat and Transfer option	A	A	G	S	A	
238	Option B - but with Bronglais as a stroke therapy rehab unit	A	A	G	A	A	
242	Option A - but Bronglais is supported as a third site via telemedicine	A	A	S	A	S	
243	Option B - but Bronglais is supported as a second 12 hour stroke unit via telemedicine	A	A	G	A	A	

Stroke Check & Challenge Feedback

Reference	Check & Challenge feedback 'Do Not Meet' the hurdle criteria	Challenge?
37	Felt this is deliverable as the take would split between BGH and PPH.	
210	Unsure why this option fails, as it meets the longer -term aim. Perhaps it can be worded differently to meet short term and long term.	
118	This service configuration is aligned with the strategy. Unclear on why this couldn't be delivered. Consultant therapists may be an affordable alternative. Felt workforce could be available to deliver this.	
204, 275, 6, 274, 286, 287	While recognised as more accessible from a North/ South perspective, it would impact East/West access. Likely Amber. (Stakeholders)	
236	Considered inaccessible as 3rd unit in the South doesn't address the access requirements of those in the North. (Stakeholders)	
37,117, 202, 239, 7, 12, 18, 33, 111, 118	Options believed to be inaccessible due to travel time and distance to PPH for initial stroke care, or location of units for whole population. (Stakeholders)	
210	Concerns about the distance to travel to a regional stroke centre, and transport links from communities to Swansea. (Stakeholders)	
206	This would be the most accessible option as patients would be able to receive total care from local acute site. RAG likely to be Green. (Stakeholders)	
211, 277	Believed to be accessible, however would create inequity between sites. (Stakeholders)	
General	More complex pathways would need to be established in community provision if changes introduce greater distances of travel to acute care, particularly for stroke, but potentially applicable in other service areas. This will require targeted resource for expedited discharge, recovery and rehabilitation closer to home. We would be happy to consider the options of stroke centre in Bronglais or a single centre for Mid Wales more carefully if those get through the hurdle criteria stage, as we know that they would be attractive to our population, although also understand there may be feasibility issues. (PTHB)	

21.1 Stroke Plenary Discussion – Meets/ may meet hurdle criteria
The following individual feedback was provided by some members of the Options Development Group and is not a representation of the Options Development Group as a collective. This feedback has been shared in its raw form as captured during the session, and should be considered with this in mind.

- **Option 106**
  Need to be careful with the wording on the rehabilitation element. Requirement for the patients to be medically optimised before being transferred.

- **General**
  Options costs would allow the Health Board to meet the standards required, query over finance being shown as 'amber' but shouldn't they been shown as 'red' as with other services as they will cost additional funding.

  Finance – are some of the costs going to be incurred even without these options as we have to meet the standards – 7 day consultant working, daily ward rounds.

  Not really discussed these additional costs with PTHB or BCUHB.

  Do need something in BGH for patients in the North.

  If all options will cost more, how are they financially viable if they all require workforce uplifts.

  If all the options cost more, will they enable HDdUHB to meet the standards?

  Is there cost charging to BCUHB and PTHB for their patients?

  Will some of the costs be incurred anyway outside of the CSP, and if so, those costs shouldn't be considered as part of this process.

  Does the workforce uplift meet the requirement for the standards and if so should that be considered as part of the CSP process?

Mid Wales discussions, have BCUHB or PTHB considered that they will need to financially contribute to BGH to support their patients.

45-50% of patients go home after three days of having a stroke.

Has the letter been considered for the regional options?

22 Urology Options (Meets/ may meet hurdle criteria)

Urology Does Meet/ May Meet Slide

GIG CYMRU NHS WALES | Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Reference	Alternative Ideas	Clinical	Deliverable	Accessible	Strategic	Financial	Challenge?
32	Option A - centralise service to Glangwili Hospital - allocate ward split between beds and procedure area	G	G	G	S	G	
194	New option - retain some minor diagnostics or pre-op assessments in Glangwili Hospital to minimise unnecessary travel	G	G	G	S	G	
197	New option - Outpatient services to remain in Glangwili Hospital	G	G	G	G	G	
284	New option - use renal unit to support service in Withybush Hospital	A	A	S	S	S	

Brought forward from morning.

Reference	Alternative Ideas	Clinical	Deliverable	Accessible	Strategic	Financial	Challenge?
43	New option - Urology outreach clinics: Even with a central hub, occasional consultant-led outreach days at Bronglais, Glangwili or Withybush Hospitals could serve high-demand local areas. Mobile diagnostics for rural patients: A mobile scanning unit for basic urology diagnostics (e.g. bladder scanning, PSA monitoring) could help patients in more remote communities.	S	S	G	S	R	

22.1 Urology Plenary Discussion – Meets/ may meet hurdle criteria

The following individual feedback was provided by some members of the Options Development Group and is not a representation of the Options Development Group as a collective. This feedback has been shared in its raw form as captured during the session, and should be considered with this in mind.

No challenges or questions received.

23 Next Steps

The Task and Finish Groups will now need to complete the detail for the shortlisted options to allow for scoring to take place. This will follow the same process as the options that went to consultation and will include:

1. **Standardized Direct Observation Tools (SDOTs)** - shortlisted options will move to evaluation phase. Within this, Task and Finish groups will update the existing 'Service Development Options Templates' which informs Capital, Estates and Workforce needs
2. **SWOT** - shortlisted Options will be assessed against the 16 evaluation criteria and a Strengths, Weaknesses, Opportunities and Threats analysis completed
3. **Programme Estimates -** indicative Workforce, Finance, Capital and Estates estimates will be generated by support services
4. **Impact Assessments -** including Equality Impact Assessment (EqIA), Health Impact Assessment (HIA), Quality Impact Assessment (QIA) and Environmental will be initiated for each shortlisted option.

This information will be brought back to the Options Development Group on 19 November 2026 to allow them to score the options against the evaluation criteria.

The process is underpinned by continuous engagement via check and challenge sessions with wider colleagues and service users, and will also feed into the session on 19 November 2026.

CLINICAL SERVICES PLAN (CSP)
Shortlist Options Scoring

(19 November 2025)

SUMMARY REPORT

24 November 2025

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Introduction

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

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

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

Aim

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

Objectives

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

An in-person session was convened on 19 November 2025. It had two objectives:

1. **Hurdle re-appraisal of Stroke options 210 and 118**
2. **Scoring all of the programme options against each of the 16 Evaluation criteria**

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

- 34 staff members, including service, interdependent services, and support services representatives
- One Health Board Executive
- Two Trade Union representatives
- One Public Health Wales (PHW) representative
- One Regional Joint Committee (RJC) representative
- One Llais West Wales representative
- One Swansea Bay University Health Board (SBUHB) representative
- One Local Medical Committee representative
- One Local Negotiating Committee representative

- One Stroke Association representative
- 11 Transformation Programme Office/Engagement team members

Objectives of the session

The in-person session commenced at 9:09am with Lee Davies, Executive Director of Strategy and Planning, welcoming attendees, and reminding them of the purpose of the day.

Lee Davies reminded the room of the purpose of the programme and progress to date and the aims and objectives of the day. Lee Davies also provided a brief synopsis of the Executive Team check and challenge feedback which resulted in two options being retained within the longlist, while other similar options would be brought together.

The purpose of the day would be the hurdle appraisal of options retained in the longlist following the previous session and scoring of shortlisted options.

Hurdle appraisal of remaining longlist option

Lee Davies ran through the housekeeping for the day and how the room would engage with each other before providing a recap on the three phases of the CSP to date.

Lee Davies then provided more detailed feedback from the Executive Team's Formal meeting check and challenge process, which was carried out to review the Alternative Options appraisal results following the Hurdle Appraisal session. Lee Davies also provided an update from the Strategy Refresh report that would be presented to Board on 27 November 2025 (Appendix A).

The reason for sharing this information was because the Executive Team felt that with this information, they came to a different conclusion around two of the Stroke options (118/210) and that they should be reconsidered using this information.

Lee Davies then opened the floor for questions; there was one question:

Question: If Stroke units need to be on sites with Emergency Departments (EDs), is this an issue for some sites, however Bronglais Hospital (BGH) must have an ED due to its strategic position in Wales

Response: The national standards appear to imply that it is expected that stroke units are co-located with EDs. This is something we are seeking clarity on. However, it is not out of the question that stroke units can be provided on sites without an ED, as we already have an example of that [Prince Philip Hospital (PPH) has an Acute Medical Assessment Unit instead of an ED and a Stroke Unit].

Lee Davies then handed over to Ben Rogers, Principal Programme Manager, to support the Options Development Group through the hurdle appraisal process. Ben Rogers ran through the two Stroke options (118/210) and the process taken to manage them in the longlist.

Ben Rogers then invited Dr Senthil Kumar, Clinical Lead for Stroke, and Bethan Andrews, Assistant General Manager Glangwili Hospital, to share any additional comments. Dr Kumar

explained why option 118 may not be deliverable, and option 210 could be deliverable, but with significant risk to workforce.

Bethan Andrews added that HDdUHB does not have a framework to run four units on a therapy basis as described in option 118 and reinforced the view of Dr Kumar that option 210 could be workable, but with challenges.

Ben Rogers then opened the floor for questions; there was one comment:

Comment: Recruitment remains a challenge at BGH, as advertising has not previously taken place there. If recruitment does go ahead, it is essential that adverts include the full story about the programme of work and future plans. This will help provide candidates with reassurance that the service will continue, reducing concerns about fragility and encouraging applications.

Ben Rogers shared the additional check and challenge feedback related to the options which was previously shared, along with any new feedback since received. A QR code was shared, and the room was then able to appraise the option.

37 people appraised the two options, option 118 failed to meet hurdle criteria and did not progress further. Option 210 met the hurdle criteria and would be scored in the session later in the day.

Shortlist scoring methodology

Alex Martin, Principal Programme Manager, provided the room with a reminder of how the evaluation criteria would be applied, what the criteria were, how they correspond with various data sets, and the weighting that the Options Development Group previously applied to the criteria, meaning they would not need to review the weightings.

Alex Martin reminded the room that scoring for each criteria would be on a 1-10 basis, and that while extreme scores would not be removed (scoring 10 for a preferred option and scoring 1 for other options), the room was asked to be consistent with their scores, particularly where they felt there was no difference in criteria impact between options.

The room was opened for questions again, but none were raised.

Alex Martin then handed back over to Ben Rogers who supported the options presentation part of the session. Ben Rogers showed the room how the options would be presented against the evaluation criteria, while the Strengths, Weaknesses, Opportunities and Threats (SWOT) would be shared by representatives from the service.

Ben Rogers also reminded the room about the packs available on the tables, with information about the options printed in packs for participants to read alongside the presentation, as well as how they could access information generated throughout the process.

Additional programme activity: alternative options

Ben Rogers outlined the additional programme activity that had taken place since the Hurdle Appraisal session on 9 October 2026, which produced the shortlist of alternative options. During this period, views on interdependencies, potential impacts, and wider system considerations were gathered through the following engagement activities:

- Options Development Group (via survey)
- Staff team briefing – 16 October 2025
- Key stakeholders, including partner organisations and health campaign groups – 21 October 2025
- Formal Executive Team – 15 October 2025
- Clinical Reference Group (CRG) – 21 October 2025
- Board Seminar – 23 October 2025
- Planned Care and Specialist Care Clinical Care Group (CCG) Business Meeting – 29 October 2025

Ben Rogers explained that feedback from these sessions, where relevant, had been incorporated into the Task and Finish Group's SWOT assessments for consideration.

Ben Rogers then provided more detailed feedback on additional information received for consideration today, which had not been incorporated into the SWOT assessments due to time constraints. This included feedback from Board Advisory Groups, the Staff Partnership Forum (SPF), which met on 18 November 2025, and the Formal Executive Team (FET) feedback shared earlier by Lee Davies. Full details of this additional programme activity can be found in Appendix A.

Ben Rogers also noted that further comments on the shortlisted alternative options would be sought from:

- Ceredigion County Council
- Carmarthenshire County Council
- Pembrokeshire County Council
- Public Services Boards (PSBs) (Carmarthenshire, Ceredigion, Pembrokeshire)
- Board Advisory Groups - Healthcare Professionals Forum, Stakeholder Reference Group

These contributions will be reflected in the Informing Plan, which the Board will consider as part of its conscientious consideration and decision-making process. Ben Rogers then opened the floor for questions.

There was one question received:

Question: Should Powys and Gwynedd County Councils be included as stakeholders who reviewed the Alternative Options?

Response: Yes. They were invited to the session held on 21st October 2025, which included partner organisations and health campaign groups.

Options presentations

Before handing over for the first presentation, Ben Rogers reminded the room that the Strengths, Weaknesses, Opportunities and Threats for each option would not be read verbatim, but that full detail could be found on the tables, with presenters only calling out key points for each option.

Ben Rogers facilitated the options presentations, with each service managed in the same way.

The QR code to access the survey was shared for each service on the screen and on the table, ahead of the presentation. Service representatives then called out key themes from their SWOT assessment, and then Ben Rogers shared feedback from the check and challenge before opening to the room for any questions and then scoring. The option packs for each service can be found in Appendix C.

Dr Anthony Smith, Clinical Lead for Critical Care, was invited to present the options for the service, and invited nursing leads present to add any additional information, but they felt it was already presented.

Ben Rogers opened the floor to questions, and one was received:

Question: Should the Critical Care options be reconsidered in light of the additional information about the medical take at Withybush Hospital (WGH), as was done for Stroke?

Response: There is already an option that aligns with this scenario for Critical Care - Option A.

During the scoring for Critical Care several questions were asked around scoring. The room was advised that 10 is positive, 1 is negative. The decision of how to apply the criteria was at their discretion using their knowledge and experience, but that they should be consistent.

One participant noted that they had submitted their score incorrectly, after validating the result was their score, it was removed so they could resubmit it.

Ben Rogers checked that the room had completed scoring and then handed over to Ceri Wisdom, Service Delivery Manager, to present the options for Dermatology. No questions were raised.

When the room had completed scoring, Ben Rogers invited Caroline Lewis, Service Delivery Manager, to present the Emergency General Surgery options. Before the room moved to scoring one question was raised:

Question: Many aspects of the options are positive, but they are not all contained within a single option. Everyone agrees that Same Day Emergency Care (SDEC) is essential for centralised acute services. Frailty services and repatriation are also needed. It would be easier to score if this was clearly stated as the strategic direction of the Health Board. Do we accept this is what should happen?

Response 1: All options are totally reliant on Welsh Ambulance Services Trust (WAST), which is an important consideration to keep in mind.

Response 2: Two thirds of patients are seen and assessed on the same day in Glangwili Hospital (GGH), but this would not happen in Withybush Hospital (WGH).

When the room had completed scoring, Ben Rogers invited Sara Jones, Service Delivery Manager, to present the Endoscopy options. Before the room moved to scoring one question was raised:

Question: Have you modelled the cost of the new unit and have the costs been modelled considering access from neighbouring Health Board patients?

Response: Yes, costs have been modelled, and consideration has been given to patients coming from external Health Boards such as Powys and Gwynedd.

Question: With reference to Option A, would this option be viewed more favourably due to reduced costs?

Response: All options have similar cost profiles; each requires investment, whether in capital or staffing.

When the room had completed scoring, Ben Rogers invited Victoria Coppack, Service Delivery Manager, to present the options for Ophthalmology. Before the room moved to scoring, one question was raised:

Question: What is the position regarding North Road Clinic?

Response: The status of North Road Clinic remains unchanged across all options.

Ben Rogers then informed the room that they could break for lunch and return for 1pm, but would need to score the options for Ophthalmology within this time.

At 12:58pm Ben Rogers called the session back together to begin at 1pm and invited Lianne Gregory, Service Delivery Manager, to present the Orthopaedics options, with additional comments from Mr Owain Ennis, Clinical Lead for Orthopaedics. Before the room moved to scoring, two questions were raised:

Question: With reference to Option 179, will there still be regional working with Powys Training Health Board (PTHB), given that Powys patients currently go to the Robert Jones & Agnes Hunt Orthopaedic Hospital in Oswestry?

Response: Yes, regional working would continue. PTHB patients currently flow across multiple providers, as there are no orthopaedic medics in PTHB, although a clinical lead has been appointed. HDdUHB will continue to support PTHB, but PTHB may also maintain a stronger support network through access to English hospitals.

Question: Is Ward 9 an option for a dedicated ward at WGH?

Response: Staff have suggested this could be an option, but it would need to be fully costed to determine value for money, including the number of sessions required. Previously, Ward 9 was costed as a high throughput site at WGH but was not considered to be taken forward by the Health Board. Currently, WGH is only utilised for three and a half days per week, so economies of scale and value for money must be considered. Additional costs for pharmacy, therapies, and junior doctors would also need to be factored in.

Ben Rogers then invited Sarah Procter, Deputy Head of Radiology to present the options for Radiology with additional feedback from Dr Liaquat Khan, Clinical Lead for Radiology. No additional questions were raised.

Ben Rogers then invited Bethan Andrews, Assistant General Manager GGH to present the Stroke options with additional feedback from Dr Senthil Kumar, Clinical Lead for Stroke, including option 210 which had passed the hurdle criteria in the morning. No additional questions were raised.

Ben Rogers then invited Neil Griffiths, Service Delivery Manager, to present the options for Urology. No additional questions were raised.

Scoring outputs

Once people had been given enough time to score the Urology options, Alex Martin presented the results, service by service, back to the room.

The results were shared back to the room showing just the overall score of each option; within the appendix this is shown on the left-hand side.

Following the session, it was noticed that an error within the formulae meant that the overall scores had been consistently overinflated. While the options ranking as presented to the room remained the same, the total score for each option was lower than shared with the room. Within the appendix these are shown on the right-hand side.

The breakdown of the criteria scores is based on the revised and correct scorings and can be found within the appendices (Appendix D).

Once this was completed Alex Martin invited the room to complete the ‘Reflections’ survey, which provided participants with an opportunity to share feedback and justifications regarding their scoring, as well as any additional information that they felt would be useful to the Board in their decision making. They were informed that their responses would be anonymous unless they identified themselves in their answers, such as by providing their job title, etc.

The room was also able to share comments or any information that they may want Board to know around their scoring, if they did not wish to include it in the survey, as there were scribes in the room.

Three questions were asked:

Question: Now that the scoring has been completed, how will the jigsaw come back together to present to the Board?

Response: The scoring of the options will enable services to engage in further discussions to explore interdependencies and how they can work together effectively. In addition, we are developing an Informing Plan for the Board to consider as part of its conscientious consideration. This plan will include all outputs from the consultation and subsequent alternative options work, as well as capturing changes since the publication of the Issues Paper. This process is designed to ensure that the proposals presented to the Board support informed decision making on 19 February 2026.

Question: When the report is written up, what happens if the Board is not satisfied with an option?

Response: This has been a significant piece of work, bringing together both the consultation options and the alternative options. During the consultation, we gathered views from communities and partner organisations, including feedback on staffing. The Board will need to consider each option alongside the strategic direction, consultation feedback, and supporting data to make an informed decision.

Question: What happens given the uncertainty around staffing between now and the Board’s decision?

Response: There is recognition of this uncertainty, and the Board will need to consider what mitigations should be put in place to ensure that services remain accessible.

Here are the key insights from the aggregated survey responses:

- The majority of respondents (16 out of 18) felt that the scores reflected the discussion in the room, while a small minority (2 out of 18) disagreed. This suggests a strong alignment between the scoring process and group discussions.
- Most participants did not find anything in the results that surprised them (16 out of 18 answered 'No'), indicating that the outcomes were largely expected. Only 1 respondent expressed surprise, and 1 was unsure.

- Narrative responses highlighted recurring themes such as the need for more discussion on closely scored options, concerns about the number of clinicians involved in decision-making, and the importance of aligning the process with strategic goals. Some comments also pointed to challenges in scoring similar options and the influence of service leads on the scoring outcomes.

The information from the final survey can be found within the appendices (Appendix E).

The session was brought to a close by Ben Rogers at 15:22pm.

Next Steps

- Finalisation of Impact Assessments
- Phased assessment of Finance and Workforce
- Development of Informing Plan to support Board in decision making
- Presentation of options and materials to support Board to make decisions on 19 February 2026.

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

Appendix A – Hurdle appraisal of remaining longlist options

Formal Executive Team Feedback
Lee Davies, Executive Director Strategy & Planning

Stroke Review and Evaluation

- After the Hurdle Appraisal session on October 9, 2025, and a review of the Alternative Options appraisal results, the Formal Executive Team discussed the findings and made a request to further assess Stroke options 210 and 118.
- Due to the complexity of the stroke service and the variety of perspectives both inside and outside the organisation, executives have requested that two alternative options, 210 and 118, be examined further.
- The next slide addresses the rationale behind why the Options Development Group may have applied the Hurdle Criteria differently at that point in time.
- In addition to this challenge, advice was given to merge several options as on further assessment they did not vary from existing options within the programme.

Formal Executive Team Rationale
Lee Davies, Executive Director Strategy & Planning

- Firstly, there are draft standards out for stroke for NHS Wales which we need to consider. The stroke team has seen these but the wider ODG may not have. There is nothing entirely unexpected in these but the standards are silent on treat and transfer as a model and refer to patients being taken to Emergency Departments etc, the inference being that all stroke units will be on sites with EDs. We have sought a meeting with the national team to obtain further clarity on these points but the meeting was cancelled due to the national clinical lead having to take unplanned leave
- Secondly, the Exec team recently received an SBAR on the challenges with regard Emergency Departments and a recommendation from the clinical leads, which in effect would mean that we progress with delivering the model set out in the strategy, ahead of a new hospital. This is understood to mean the HB cannot sustain two EDs in the south for the medium to long-term. Depending on the view, see point 1, this may impact on the sites and number of sites that a stroke unit could be based on
- Thirdly, in relation to strategic estate planning, at our last meeting with WG we were asked to "provide a high-level cost plan and programme for the phased delivery of the Withybush site redevelopment proposals". The implication being that, due to RAAC and other estate issues, WG may wish to support a phased redevelopment of the WGH site in line with the original vision (i.e. repurposing to a community hospital). If this was to proceed with pace it could occur over a 10 year period. Whilst this is obviously beyond the 2-4 year window it would potentially mean the existing stroke options, if supported by Board, would need to be revised, possibly even before they are implemented.

Strategy Refresh - Update
Extract from SBAR going to Board, November 2025

The strategy refresh will also reflect the fact the UHB has had further constructive discussions with WG on the infrastructure challenges facing the Health Board, in particular at the Withybush and Glangwili sites.

WG has recently requested the UHB produce, by early in the New Year, an addendum to the PBC submitted in February 2022. This is a significant piece of work, which is currently being scoped, but at this stage the intention is to present this to Public Board in January. Over the last 18 months the Health Board has been working with WG to consider the feasibility of options and to establish a 'short list range of options' that could be considered through the business case process.

Previously the Deputy Chief Executive, NHS Wales advised through the Infrastructure Investment Board (IIB), Welsh Government, that the Health Board's identification of a preferred way forward was reached too early in the process. The view being that options considered to deliver the Health Board's clinical strategy needed to be as wide as practicable and set out in a business case for consideration. WG have challenged the feasibility and affordability of a new urgent and planned care hospital alongside the retention of all other existing estate, set against a challenging WG capital budget.

The Health Board has therefore been asked to develop a range of options setting out how best to deliver services within the existing estate alongside the development of a new facility to address current infrastructure challenges. The Welsh Government strategy 'A Healthier Wales' is focussed on delivery of more services within the community and closer to home and as such all options need to align to that strategic intent. The UHB is aware that any such changes to community provision would be subject to public consultation should changes be identified within a future business case.

Our understanding of the position is WG expects the PBC addendum to set out the scope and indicative timelines for a phased approach to the delivery of a programme, aligned to the AHMWW strategy. This will include the scope of services to be based on each site, reflecting the modernisation of service delivery and best-practice options, making best use of technological advancements. The addendum will also need to include a high-level delivery plan that is realistic and achievable but looks to deliver at pace so that the offered benefits are realised, and the ongoing financial, clinical and operational risks are mitigated.

Hurdle Re-appraisal
Stroke alternative options –

Reference	Alternative Ideas	Clinical	Deliverable	Accessible	Strategic	Financial	Challenge?
118	New Option - Stroke Unit at Glangwili with Consultant Therapist Rehabilitation led units at Bronglais, Prince Philip and Withybush.	R	R	S	S	S	
210	Option B - In this option Bronglais would take the place of Withybush providing a 12 hour specialist unit, while Glangwili would take the place of Prince Philip for the 24 hour specialist unit. In the longer term (4+ years) Glangwili site would merge with staff from Swansea Bay to provide a regional stroke unit, with Bronglais remaining as a local stroke unit. At this point Bronglais would no longer provide treat and transfer to Glangwili would be a self sufficient stroke unit with patients given the opportunity to be transferred to the regional stroke unit.	A	A	A	A	A	

To Note:

- **118 – The service hurdle appraisal remains unchanged.**
- **210 – The Service ODG Representatives Hurdle Appraisal has updated the 'Clinical' criteria from RED to AMBER (May meet) after further discussion. It is understood that key components are achievable, though some elements may present more difficulty. These difficulties specifically pertain to the acute medical cover required to deliver a specialist stroke service in BGH.**

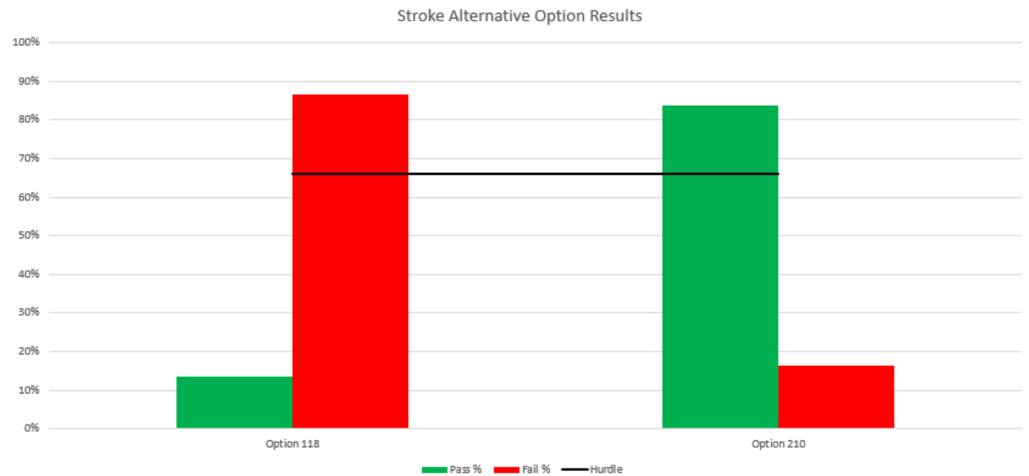
Key

- RED (R) indicates 'does not meet', AMBER (A) means 'may meet', and GREEN (G) signifies 'does meet'. An 'S' stands for SPLIT DECISION.
- In the CHALLENGE column, amber highlights a check or a challenge comment found on the following slide.

Stroke Check & Challenge Feedback

Reference	Check & Challenge feedback 'Do Not Meet' the hurdle criteria	Challenge?
210	Unsure why this option fails, as it meets the longer-term aim. Perhaps it can be worded differently to meet short term and long term.	
118	This service configuration is aligned with the strategy. Unclear on why this couldn't be delivered. Consultant therapists may be an affordable alternative. Felt workforce could be available to deliver this.	
210	Concerns about the distance to travel to a regional stroke centre, and transport links from communities to Swansea. (Stakeholders)	
General	More complex pathways would need to be established in community provision if changes introduce greater distances of travel to acute care, particularly for stroke, but potentially applicable in other service areas. This will require targeted resource for expedited discharge, recovery and rehabilitation closer to home. We would be happy to consider the options of stroke centre in Bronglais or a single centre for Mid Wales more carefully if those get through the hurdle criteria stage, as we know that they would be attractive to our population, although also understand there may be feasibility issues. (PTHB)	
RJC	The regional Stroke programme advocates alignment with regional/national stroke models and standards. The draft national standards set out ambitions and expectations for stroke services. Final standards should be available shortly (current expectations are December 2025). The CSP highlights sustainability issues with the current four-unit setup, stresses need for pragmatic treat-and-transfer solutions, and expectations that a consistent level and quality of service is available. The regional programme's ambitions would be that Hywel Dda sets out a model of care that would lay the foundation a future regional model. Our review of the options presented in the Hywel Dda CSP suggest that: • Option 210 would seem most in line with ambitions for regional working and future national models, showing strong alignment with SBUHB's ambitions for a Comprehensive Regional Stroke Centre in Morriston. • All other options to a varying extent would need greater or lesser levels of future adjustment to accommodate regional working	

Hurdle Re-appraisal
Stroke alternative options



Appendix B – Criteria weighting results

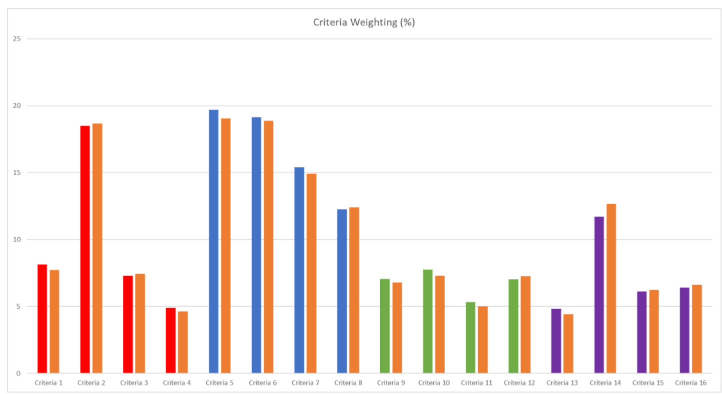
Below is a breakdown of the weighting applied to each evaluation criterion. These weightings were originally developed by the Options Development Group in September 2024 and have been previously reported on in the Phase 2 shortlist scoring. They are repeated here for information.

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

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

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

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


Criteria Weighting (%)
25
20
15
10
5
0
Criteria 1
Criteria 2
Criteria 3
Criteria 4
Criteria 5
Criteria 6
Criteria 7
Criteria 8
Criteria 9
Criteria 10
Criteria 11
Criteria 12
Criteria 13
Criteria 14
Criteria 15
Criteria 16

Appendix C – Option Presentations

Critical Care
Dr Anthony Smith, Clinical Lead (TBC)

R	Negative impact on service
A	Unknown (opportunity/threat) on service
G	Positive impact on service

Ref	Option Overview	Safe				Sustainable				Accessible				Kind			
A	In Option A GGH and BGH would maintain ICUs. ECUs would be provided at PPH and WGH to support stabilisation and transfer of assessed patients to GGH ICU. GGH would also have an ECU so that its ICU can focus on patients with the highest clinical need.	A	G	R	R	A	G	A	A	R	A	A	R	A	A	A	R
B	In Option B, BGH, GGH and WGH would maintain ICUs. PPH would have an ECU and would support stabilisation and transfer of assessed patients to GGH ICU.	A	G	A	A	G	G	A*	A	G	A*	A	A	A	G	A	G
C	Maintain an ICU on all sites. However, at PPH, the current temporary arrangement of transferring patients with the highest needs to GGH ICU would continue. Some level two patients, could continue to be cared for at PPH with remote (telemedicine) access to critical care consultants at other hospital sites.	R	R	A	A	R	R	A*	A	A	A	A	A	A*	R	A	R
246	New idea - regional model. Option B with Opportunity for increased virtual model (within HDdUHB) 1-3 years Facilitate cross site working. Working closer with neighbouring Health Boards - longer term, standardisation of policies and protocols (HDdUHB)	A	G	A	A	G	G	A*	A	G	A	A	A	G	G	G	A

Critical Care – additional feedback
(Slide is a summary of feedback that may not have been considered by Task and Finish Group)

Response From	Evaluation Criteria	Summary of feedback
Programme team for RJC	1.4	**General Feedback from Meeting held on 6 November'25:** • Changes in critical care provision at Prince Philip have reduced the complexity of patients that can be treated there, impacting the regional orthopaedics programme. • The regional model has adapted to these changes, but if higher acuity care were available, the regional approach might differ.
Facilities	1.3	All options. Once a decision has been made, essential facilities and estates will be reviewed and consulted for impacts on workforce and service model change. These consequential impacts must be considered ahead of any implemented and agreed changes to ensure critical cleaning, portering, catering, maintenance & engineering and contractual amendments are fully considered, understood and accepted and resourced accordingly. If the service change increases activity it is vital full consideration is given to all areas of this key enabling service, including but not limited to linen, fire and H&S compliance, statutory engineering and infrastructure concerns, risk, patient cleaning, portering, security, catering and pest control.
Stakeholders	3.4	**Positive (Option 246):** Works for Llanelli, but further clarity needed on implications for ITU at Withybush and patient pathways if the stroke unit moves to Prince Philip. **Negative (Option 137):** Not seen as beneficial for Llanelli. **Negative:** Concerns about patient safety during transfers, especially for stroke and critical cases; need for clear escalation pathways and understanding of impact on Withybush's ITU.
Staff Briefing	3.4	**Critical Enablers:** Transport, parking, staffing, and clear mileage policies must be resolved to ensure safe, practical, and sustainable care delivery. **Patient & Service Impact:** Long travel times, poor public transport, limited family contact, unsafe transfers, and stretched therapy and radiology services risk patient outcomes and feasibility of proposed models.

Dermatology
Ceri Wisdom, Service Delivery Manager

All Options propose that the temporary change of having dermatology hospital services centralised at PPH is made permanent.

Ref	Option Overview	Safe				Sustainable				Accessible				Kind			
A	Keeps the current community, nurse-led, provision at CICC, but not at SPH. In addition, some nurse led clinics would take place at AVH.	G	G	A	A	A	G	A	A	A	G	A	G	A	G	G	A
B	Keeps the current community, nurse-led, provision at SPH, but not at CICC. Across the Health Board, some minor operations could take place in participating GP practices.	G	G	A	A	A	G	A	A	A	G	A	G	A	G	G	A
C	Keeps the current community, nurse-led, provision at CICC and SPH. In addition, some nurse-led paediatric clinics would take place at CHHC. Across the Health Board, some minor operations could take place in participating GP practices.	G	G	A	A	G	G	A	G	G	G	A	G	G	G	G	G
D	Keeps the current community, nurse-led, provision at CICC and SPH. In addition, some nurse-led paediatric clinics would take place at CHHC.	G	G	A	A	A	G	A	G	G	G	A	G	G	G	G	G

Dermatology – additional feedback
(Slide is a summary of feedback that may not have been considered by Task and Finish Group)

Response From	Evaluation Criteria	Summary of feedback
Facilities	1.3	All options. Once a decision has been made, essential facilities and estates will be reviewed and consulted for impacts on workforce and service model change. These consequential impacts must be considered ahead of any implemented and agreed changes to ensure critical cleaning, portering, catering, maintenance & engineering and contractual amendments are fully considered, understood and accepted and resourced accordingly. If the service change increases activity it is vital full consideration is given to all areas of this key enabling service, including but not limited to linen, fire and H&S compliance, statutory engineering and infrastructure concerns, risk, patient cleaning, portering, security, catering and pest control.
Staff Briefing	3.4	**Critical Enablers:** Transport, parking, staffing, and clear mileage policies must be resolved to ensure safe, practical, and sustainable care delivery. **Patient & Service Impact:** Long travel times, poor public transport, limited family contact, unsafe transfers, and stretched therapy and radiology services risk patient outcomes and feasibility of proposed models. Staff Briefing

Emergency General Surgery
Caroline Lewis, Service Delivery Manager

Ref	Option Overview	Safe				Sustainable				Accessible				Kind			
A	Emergency surgical operations are performed at GGH and not at WGH. Patients who arrive at Withybush and need an emergency surgical operation, will be transferred to Glangwili. Strengthened SDECs at WGH and GGH	R	A	A	R	A	A	A	G	A	A	A*	A*	A	A	A	A
B	Emergency surgical operations will alternate weekly between GGH and WGH. Patients who arrive at either hospital on a week that emergency surgical operations are not performed, would be transferred to the alternative hospital if they need an emergency surgical operation. Strengthened SDECs at WGH and GGH	R	A	R	R	A	A	A	G	A	A	A*	G	A	A	A	A
155	As option A, but an additional Surgical SDEC at Bronglais.	R	G	A	R	A	G	A	G	A	A	A*	A*	A	A	A	A
222	New Option - EGS centralised in Glangwili and Bronglais. Surgical patients repatriated to Prince Philip/ Withybush for recovery	R	R	R	R	R	R	A	A	R	R	A*	A*	A	A	A	A

Emergency General Surgery – additional feedback
(Slide is a summary of feedback that may not have been considered by Task and Finish Group)

Response From	Evaluation Criteria	Summary of feedback
Facilities	1.3	All options. Once a decision has been made, essential facilities and estates will be reviewed and consulted for impacts on workforce and service model change. These consequential impacts must be considered ahead of any implemented and agreed changes to ensure critical cleaning, portering, catering, maintenance & engineering and contractual amendments are fully considered, understood and accepted and resourced accordingly. If the service change increases activity it is vital full consideration is given to all areas of this key enabling service, including but not limited to linen, fire and H&S compliance, statutory engineering and infrastructure concerns, risk, patient cleaning, portering, security, catering and pest control.
Stakeholders	3.4	**Positive (Option 222):** Seen as positive for Prince Philip Hospital (PPH) if a rehab unit is included, potentially reducing pressure elsewhere. **Negative (Option 155):** Would require strengthening community services in Powys to support patient flow from SDEC. **Negative:** General concerns about increased travel for patients and families, loss of services at Withybush. Questions raised about monitoring impact and whether previous service reductions could be reversed.

Endoscopy
Sara Jones, Service Delivery Manager

Ref	Option Overview	Safe				Sustainable				Accessible				Kind			
A	Capacity increased by expansion of procedure rooms from two to three at PPH. This would allow all urology and respiratory endoscopy procedures to be provided at PPH. Bowel screening services and gastrointestinal endoscopy services continue at all four main hospitals.	G	G	G	A	G	G	G	G	G	G	G	G	G	G	G	G
B	Capacity increased by a new community site (location not yet identified) to replace hospital provision of bowel screening services. Other endoscopy procedures continue at the four main hospitals as they do now with a slight increase in the number of appointments available with the movement of bowel screening services to the community	A	G	A	A	G	G	A	G	G	G	G	G	G	G	G	G
C	Capacity increased by extended working hours (later into the evenings Monday-Friday, and on weekends) at PPH. This would allow all urology and respiratory endoscopy procedures to be provided at PPH. Bowel screening services and gastrointestinal endoscopy procedures continue at the four main hospitals as they do now. Glangwili would be able to see more gastrointestinal patients than currently.	G	G	G	A	G	G	G	G	G	G	G	G	G	G	G	G
228	Option B with Withybush also providing the bowel screening	A	A	A	A	G	A	A	G	G	G	G	G	G	G	G	A

Endoscopy – additional feedback
(Slide is a summary of feedback that may not have been considered by Task and Finish Group)

Response From	Evaluation Criteria	Summary of feedback
Facilities	1.3	All options. Once a decision has been made, essential facilities and estates will be reviewed and consulted for impacts on workforce and service model change. These consequential impacts must be considered ahead of any implemented and agreed changes to ensure critical cleaning, portering, catering, maintenance & engineering and contractual amendments are fully considered, understood and accepted and resourced accordingly. If the service change increases activity it is vital full consideration is given to all areas of this key enabling service, including but not limited to linen, fire and H&S compliance, statutory engineering and infrastructure concerns, risk, patient cleaning, portering, security, catering and pest control.
Stakeholders	3.4	**Negative (Option 228):** If bowel screening is removed from Bronglais, Withybush would be the only site, raising major accessibility concerns for northern patients, especially after bowel prep. Issues with patient transport reliability and dignity during travel. **Negative:** Long travel distances post-procedure, lack of community recovery spaces, and diminishing public toilet availability. Accessibility for frail and elderly patients is a significant concern.
Programme team for RJC	1.4	The general direction of travel of the regional discussions would support both option 92 and option 228, which advocate for either a community screening site for Bowel Screening Wales (BSW), single site for BSW or an extended service provision over 7 days a week in Prince Phillip which would support BSW. If bowel screening was transitioned in the future to being delivered regionally these options would support the service transformation on a regional footprint. **General Feedback from Meeting held on 6 November'25:** • Endoscopy and radiology are part of the regional diagnostics programme, but current resource allocation is limited. • Regional diagnostic hub options are supported in principle, but short-term focus is on optimizing existing equipment and systems.

Endoscopy – additional feedback
(Slide is a summary of feedback that may not have been considered by Task and Finish Group)

Response From	Evaluation Criteria	Summary of feedback
Staff Briefing	3.4	**Critical Enablers:** Transport, parking, staffing, and clear mileage policies must be resolved to ensure safe, practical, and sustainable care delivery. **Patient & Service Impact:** Long travel times, poor public transport, limited family contact, unsafe transfers, and stretched therapy and radiology services risk patient outcomes and feasibility of proposed models. Staff Briefing

Ophthalmology
Victoria Coppack, Service Delivery Manager

Ref	Option Overview	Safe				Sustainable				Accessible				Kind			
A	Main hospital services, including emergency eye care, would be brought together at GGH. BGH and PPH would no longer provide services. AVH would provide day-cases (for cataracts) but not outpatients (for eye injections). WGH with outpatients and diagnostics.	A*	G	A	A	A	G	G	G	A	A*	A	A	A	A	A	A
B	Main hospital service, including emergency eye care, would be brought together at PPH. GGH would no longer provide services. Current services would remain at BGH. AVH keeps outpatient services (for eye injections) but not day cases (for cataracts). Outpatients would be provided at a community site in Pembrokeshire (site to be confirmed) WGH with outpatients and diagnostics.	A*	G	R	R	R	G	G	G	R	R	A	G	A	A	A	A
C	Main hospital services, including emergency eye care, brought together at GGH. PPH would no longer provide services. Current services would remain at BGH. AVH keeps outpatient services (for eye injections) but not day cases (for cataracts) WGH with outpatients and diagnostics.	A*	G	A	A	A	G	A*	G	A	A*	A	G	A	A	A	A

Ophthalmology
Victoria Coppack, Service Delivery Manager

Ref	Option Overview	Safe				Sustainable				Accessible				Kind			
95	Option A - But centralise to Glangwili, centre of excellence. 12 hours / 7 days a week.	A*	G	A	A	A	R	R	G	A	A	A	G	A	A	R	A
99	Option A but in the Community section it would read AVH day cases (cataract) and Outpatients (eye injections). Diagnostics and outpatient services in CICC and NREC	A*	G	A	A	G	G	A	G	A	A	A	G	A	A	A	A
167	Option A - Aberaeron Integrated Care Centre becomes an optometry hub. This would allow for the service to meet its sustainability aims, as well as make best use of estates assets across the health board.	A*	G	R	R	A	R	R	G	A	A*	A	A	A	R	A	A
173	Option C with AICC doing diagnostics	A*	G	G	A	A	G	R	A	A	A*	A	G	A	A	A	A
227	Option A - But increased working hours at Withybush for eye injections	A*	G	A	A	A	R	R	G	A	A*	A	G	A	A	R	A
263	Option B - with extended working	R	G	R	A	R	G	G	G	R	R	A	G	A	A	R	A

Ophthalmology – additional feedback

(Slide is a summary of feedback that may not have been considered by Task and Finish Group)

Response From	Evaluation Criteria	Summary of feedback
Facilities	1.3	All options. Once a decision has been made, essential facilities and estates will be reviewed and consulted for impacts on workforce and service model change. These consequential impacts must be considered ahead of any implemented and agreed changes to ensure critical cleaning, portering, catering, maintenance & engineering and contractual amendments are fully considered, understood and accepted and resourced accordingly. If the service change increases activity it is vital full consideration is given to all areas of this key enabling service, including but not limited to linen, fire and H&S compliance, statutory engineering and infrastructure concerns, risk, patient cleaning, portering, security, catering and pest control.
Stakeholders	3.4	**Negative (Options 95 & 99):** Lack of service at Prince Philip and Bronglais is unacceptable; current transport and appointment systems are inadequate. **Positive (Option 167):** Outpatient services at Prince Philip are positive, but diagnostics are needed. Enhanced facilities in Aberaeron seen as a reasonable compromise. **Negative (Options 173 & 227):** No service at Bronglais or Glangwili is strongly opposed; emergency eye care must be retained locally. **Negative (Option 263):** No service at Glangwili is also opposed. **Negative:** Difficulty accessing appointments, especially for serious conditions; poor infrastructure at North Road Eye Clinic; need for local services to avoid long, difficult journeys.

Ophthalmology – additional feedback

(Slide is a summary of feedback that may not have been considered by Task and Finish Group)

Response From	Evaluation Criteria	Summary of feedback
Programme team for RJC	1.4	Following discussion with the SDM in Hywel Dda for Ophthalmology, there is clear support for Option 99, which proposes maintaining capacity in Amman Valley Hospital and centralising services in Glangwili General Hospital. This option is considered positive and preferred, as it strengthens regional service integration and enables more sustainable resource deployment across the region. In contrast, alternative options that reduce or fragment capacity are not supported by the service (options 95, 167, 173, 227, 263). Maintaining Amman Valley Hospital capacity while centralising in Glangwili General Hospital is therefore viewed as the most effective approach to improving both patient access and clinical resilience across the region **General Feedback from Meeting held on 6 November'25:** • RJC emphasized the fragility of the eye care service and the need to optimize activity at Amman Valley and Prince Philip to meet high-risk patient targets (R1 cohort). • Reducing activity at these sites would negatively impact both internal service sustainability and regional planning. • There is ongoing investment and recruitment to improve the R1 position, with recent funding being recurrent.
Staff Briefing	3.4	**Critical Enablers:** Transport, parking, staffing, and clear mileage policies must be resolved to ensure safe, practical, and sustainable care delivery. **Patient & Service Impact:** Long travel times, poor public transport, limited family contact, unsafe transfers, and stretched therapy and radiology services risk patient outcomes and feasibility of proposed models. Staff Briefing

Orthopaedics
Lianne Gregory, Service Delivery Manager

Ref	Option Overview	Safe				Sustainable				Accessible				Kind			
A	PPH would carry out more complex planned care for local and regional patients. More day-case activity would be delivered at WGH (as well as usual day case activity at BGH and PPH).	G	G	A	A	A	G	A	G	A	R	A	A	A	G	G	A
B	PPH would carry out more complex planned care, for local and regional patients. More day cases would be carried out at Withybush Hospital (achieved by focusing on less-complex cases) and longer working hours.	G	G	A	A	A	G	A	A	A	R	A	A	A	G	G	A
C	PPH would carry out more complex planned care, prioritising higher need Hywel Dda, rather than regional, patients. More day-case activity would be delivered at WGH (achieved by focusing on less-complex cases). Subject to funding, this option would increase orthopaedic activity by providing additional beds at PPH.	G	G	A	A	A	G	A	G	A	R	A	A	A	G	G	A
D	PPH would carry out more complex planned care, for local and regional patients. More day cases would be delivered at WGH (achieved by focusing on less-complex cases). An increased service would be delivered at Bronglais Hospital, to provide surgery to more patients.	G	G	A	A	A	G	A	G	A	R	A	A	A	G	G	A

Orthopaedics
Lianne Gregory, Service Delivery Manager

Ref	Option Overview	Safe				Sustainable				Accessible				Kind			
52/ 113	52 - Query hip/knee procedure basket at Withybush 113 - Option C - Arthroplasty at Withybush - this would mean INPT work in Withybush.	G	G	A	A	A	G	A	G	A	A	A	G	A	G	G	G
129	Options A,B,C,D - Combination of options: - Increased inpatients and day cases at Bronglais (Option D) But cannot comment on prioritisation of one service over another (understand orthopaedic can only increase if ophthalmology activity comes out?) - Extend hours at Withybush if it extends capacity (option B) - Additional beds and investment outlined at PP (Option C) – but as part of a regional working approach (Option A, B and D) - Increase capacity at Neath Port Talbot (Swansea Bay UHB) for regional working across South West Wales. - A regional / local hybrid surgical hubs network with Neath Port Talbot (A, B and D).	G	G	A	A	A	G	A	G	A	A	A	A	A	G	G	A
178	Option B, only with the extended hours at Prince Philip rather than Withybush	G	G	A	A	A	G	A	G	A	A	A	A	A	G	G	A

Orthopaedics
Lianne Gregory, Service Delivery Manager

GIG CYMRU NHS WALES | Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Ref	Option Overview	Safe				Sustainable				Accessible				Kind			
179	Option D plus: Elective Orthopaedics should increase activity at Bronglais to address regional pressures in Powys, reducing patient transfers to NHSE Trusts and supporting the mid Wales community. Glangwili should not have elective procedures, while Prince Philip should focus on regional pathways with SBUHB, supported by a Medical ECU and increased ward availability. Orthopaedic inpatient care should be retained but aligned with Neath Port Talbot, and a single regional patient tracking list should be developed. Withybush should become an optimized day surgery site, shifting more procedures from Prince Philip and reallocating EGS theatre sessions. Workforce plans include reviewing job plans for optimal procedure flow and developing a regional orthopaedic rota. Orthopaedics should reduce face-to-face Outpatients sessions, delivering more virtual assessments and utilizing community X-ray to keep services local. dependency - the flow and increased activity on Prince Philip will require additional Beds.	A	R	R	R	R	R	R	R	A	A	A	A	A	R	A	R
268	Preference of the option D, but with the additional beds and investment of C but as a regional / local surgical hub model. Option D with some of the ideas of Option C, therefore, is perhaps most likely to achieve results.	G	G	A	A	A	G	A	G	A	A	A	A	A	G	G	A

Orthopaedics – additional feedback

(Slide is a summary of feedback that may not have been considered by Task and Finish Group)

Response From	Evaluation Criteria	Summary of feedback
Facilities	1.3	All options. Once a decision has been made, essential facilities and estates will be reviewed and consulted for impacts on workforce and service model change. These consequential impacts must be considered ahead of any implemented and agreed changes to ensure critical cleaning, portering, catering, maintenance & engineering and contractual amendments are fully considered, understood and accepted and resourced accordingly. If the service change increases activity it is vital full consideration is given to all areas of this key enabling service, including but not limited to linen, fire and H&S compliance, statutory engineering and infrastructure concerns, risk, patient cleaning, portering, security, catering and pest control.
Stakeholders	3.4	**Mixed (Option 52):** Mixed views; seen as downgrading by some, but others note it benefits Withybush. Travel difficulties for elderly and frail patients highlighted. **Positive (Options 129 & 268):** Considered "liveable with" from a PPH perspective. **Positive (Option 179):** Attractive for Powys due to population health needs and geography, but commissioning implications need consideration. **Negative:** Concerns about balancing increased orthopaedic activity with loss of ophthalmology theatre space at Bronglais; need to avoid trade-offs between essential services.

Orthopaedics – additional feedback

(Slide is a summary of feedback that may not have been considered by Task and Finish Group)

Response From	Evaluation Criteria	Summary of feedback
Programme team for RJC	1.4	From a regional perspective the previous Clinical Service Plan options included regional Orthopaedic working centred at Prince Philip Hospital. The alternative options 129, 268, 178, and 179 continue to support regional collaboration, which is aligned with the regional strategy and are therefore supported. While options 52 and 113 do not explicitly reference regional working, Regional Inpatient and Day Case activity could still be accommodated if appropriately developed. **General Feedback from Meeting held on 6 November'25:** • The clinical services plan options for orthopaedics generally support regional working and make permanent the post-COVID changes. • RJC noted that increased bed capacity and reliance on Neath Port Talbot and Prince Philip are important for meeting demand, especially for reducing long wait times. • No significant concerns were raised about the options from a regional perspective, but options that support increased activity are seen as more favourable.
Staff Briefing	3.4	**Critical Enablers:** Transport, parking, staffing, and clear mileage policies must be resolved to ensure safe, practical, and sustainable care delivery. **Patient & Service Impact:** Long travel times, poor public transport, limited family contact, unsafe transfers, and stretched therapy and radiology services risk patient outcomes and feasibility of proposed models. Staff Briefing

Radiology
Sarah Procter, Deputy Head of Radiology

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Ref	Option Overview	Safe				Sustainable				Accessible				Kind			
A	Planned diagnostic radiology (Monday-Friday, daytime), and day case interventional radiology (Monday-Friday, daytime) from BGH, PPH and WGH. GGH would provide all inpatient interventional radiology (Monday-Friday, daytime), so patients needing this at other hospital sites would be transferred by ambulance to GGH.	A	A*	G	G	G	A	R	G	A	A	R	A	R	A	A	A
B	Planned diagnostic radiology (extended from five days to seven days a week, daytime), interventional inpatient and day case radiology (Monday-Friday, daytime) would be provided from BGH, GGH, PPH and WGH. Planned diagnostic radiology would also be provided from a new regional radiology diagnostic hub (site to be confirmed), in a community setting. This new hub and the extended working hours for planned diagnostic radiology would mean PPH and WGH could provide a dedicated cancer focus (multiple tests on the same day in the same location instead of several days on different sites).	A	G	G	G	G	A	R	G	A	A	A	A	R	G	A	A
C	Planned diagnostic radiology (Monday Friday, daytime) at BGH, GGH, PPH and WGH. Inpatient and day case interventional radiology (Monday-Friday, daytime) would be brought together at BGH and GGH	A	A*	G	G	G	A	R	G	A	A	R	A	R	A	A	A
D	Planned diagnostic radiology (extended from five days to seven days a week, daytime) at BGH, GGH, PPH and WGH. Inpatient interventional radiology would be brought together at GGH and extended to 24/7. Day case interventional (Monday-Friday, daytime) would be provided at BGH, PPH and WGH	A	G	G	G	G	A	R	G	A	A	A	A	R	G	A	A

Radiology
Sarah Procter, Deputy Head of Radiology

Ref	Option Overview	Safe				Sustainable				Accessible				Kind			
24	Option B - But excluding the Radiology Hub	A	G	G	G	G	A	R	G	A	A	A	A	R	G	A	A
25	Option B - But with a smaller Radiology Hub	A	G	G	G	G	A	R	G	A	A	A	A	R	G	A	A
103	Option A and B mix	A	G	G	G	G	A	R	G	A	A	A	A	R	G	A	A
122	Extend hours of Xray services at CICC to match opening hours (as current elsewhere)	A	R	A	A	A	A	A	R	R	A	A	A	G	A	A	A

Radiology – additional feedback

(Slide is a summary of feedback that may not have been considered by Task and Finish Group)

Response From	Evaluation Criteria	Summary of feedback
Facilities	1.3	All options. Once a decision has been made, essential facilities and estates will be reviewed and consulted for impacts on workforce and service model change. These consequential impacts must be considered ahead of any implemented and agreed changes to ensure critical cleaning, portering, catering, maintenance & engineering and contractual amendments are fully considered, understood and accepted and resourced accordingly. If the service change increases activity it is vital full consideration is given to all areas of this key enabling service, including but not limited to linen, fire and H&S compliance, statutory engineering and infrastructure concerns, risk, patient cleaning, portering, security, catering and pest control.
Stakeholders	3.4	**Positive (Option 122):** Positive feedback for Llandovery Hospital; new chest clinic and increased X-ray use. **Negative:** Loss of X-ray services would undermine new clinics and local access.
Programme team for RJC	1.4	The proposed 7 days working for Radiology at all 4 acute sites is in line with discussion held at a regional forum (option 24). The Regional Diagnostic programme is aware that a regional hub proposal is part of option 103, and supports the intention to explore options for strategic long term delivery of diagnostic provision in 'hubs' or 'centres' for a range of diagnostic modalities, and supports option 103. **General Feedback from Meeting held on 6 November'25:** • Endoscopy and radiology are part of the regional diagnostics programme, but current resource allocation is limited. • Regional diagnostic hub options are supported in principle, but short-term focus is on optimizing existing equipment and systems.

Radiology – additional feedback

(Slide is a summary of feedback that may not have been considered by Task and Finish Group)

Response From	Evaluation Criteria	Summary of feedback
Staff Briefing	3.4	**Critical Enablers:** Transport, parking, staffing, and clear mileage policies must be resolved to ensure safe, practical, and sustainable care delivery. **Patient & Service Impact:** Long travel times, poor public transport, limited family contact, unsafe transfers, and stretched therapy and radiology services risk patient outcomes and feasibility of proposed models. Staff Briefing

Stroke
Dr Senthil Kumar, Clinical Lead Stroke
Bethan Andrews, Asst General Manager Glangwili

Ref	Option Overview	Safe				Sustainable				Accessible				Kind			
A	In Option A, PPH and WGH would have stroke units, with specialist cover 12-hours a day. This means, stroke patients from the Treat and Transfer hospitals at BGH and GGH would be transferred to PPH or WGH for their inpatient stroke care (unless they need care from a specialist centre elsewhere, as now).	A	G	A	R	G	A	A	G	R	A	A	R	A	G	G	A
B	In Option B, PPH would have a stroke unit, with specialist cover 24-hours a day. This means, stroke patients from the treat and transfer hospitals (BGH and GGH) and from WGH treat and transfer and stroke unit would be transferred to PPH typically for 72-hours of inpatient care. Following this, patients' ongoing inpatient care would be provided either within PPH, or at the stroke unit at WGH.	A	G	A	R	G	R	A	G	R	A	A	R	A	G	G	A

Stroke
Dr Senthil Kumar, Clinical Lead Stroke
Bethan Andrews, Asst General Manager Glangwili

Ref	Option Overview	Safe				Sustainable				Accessible				Kind			
106	Options A - with a stroke rehabilitation unit at Bronglais gives a robust option for a Treat and Transfer option	A	A	A	A	A	A	A	G	A	A	A	A	A	A	A	A
210	Option B - In this option Bronglais would take the place of Withybush providing a 12 hour specialist unit, while Glangwili would take the place of Prince Philip for the 24 hour specialist unit. In the longer term (4+ years) Glangwili site would merge with staff from Swansea Bay to provide a regional stroke unit, with Bronglais remaining as a local stroke unit. At this point Bronglais would no longer provide treat and transfer to Glangwili would be a self sufficient stroke unit with patients given the opportunity to be transferred to the regional stroke unit.	A	R	A	A	A	R		G	A	A	A	R	A	A	G	A

Stroke – additional feedback

(Slide is a summary of feedback that may not have been considered by Task and Finish Group)

Response From	Evaluation Criteria	Summary of feedback
Facilities	1.3	All options. Once a decision has been made, essential facilities and estates will be reviewed and consulted for impacts on workforce and service model change. These consequential impacts must be considered ahead of any implemented and agreed changes to ensure critical cleaning, portering, catering, maintenance & engineering and contractual amendments are fully considered, understood and accepted and resourced accordingly. If the service change increases activity it is vital full consideration is given to all areas of this key enabling service, including but not limited to linen, fire and H&S compliance, statutory engineering and infrastructure concerns, risk, patient cleaning, portering, security, catering and pest control.
Stakeholders	3.4	**Positive (Option 106):** Support for a stroke rehab unit in Bronglais. **Negative (Option 106):** concerns about "treat and transfer" models—safety of long ambulance journeys post-thrombolysis, family travel burdens. **Negative (Options 118 & 210):** "Treat and transfer" not sufficient for Withybush. **Negative:** Need for local, high-quality rehab in line with NICE and Welsh Government guidelines; concerns about equity of access, rurality, and travel times. Calls for integrated, survivor-led rehab and better transport planning

Stroke – additional feedback

(Slide is a summary of feedback that may not have been considered by Task and Finish Group)

Response From	Evaluation Criteria	Summary of feedback
Staff Briefing	3.4	**Critical Enablers:** Transport, parking, staffing, and clear mileage policies must be resolved to ensure safe, practical, and sustainable care delivery. **Patient & Service Impact:** Long travel times, poor public transport, limited family contact, unsafe transfers, and stretched therapy and radiology services risk patient outcomes and feasibility of proposed models. Staff Briefing
Programme team for RJC	1.4	**Regional alignment:** Stroke programme aims to align with national standards (final expected Dec 2025) and ensure consistent, sustainable services across the region. **Preferred option:** Option 210 best supports regional ambitions and future national models, aligning strongly with SBUHB's plan for a Comprehensive Regional Stroke Centre at Morriston. **Other options:** Would require varying levels of adjustment to fit regional working and future standards. **General Feedback from Meeting held on 6 November'25:** • Multiple options for stroke services were discussed, including option 106A (acute stroke rehab in Bronglais, 24-hour unit in PPH, 12-hour unit in Withybush). Cheryl supported this option for its regional benefits but noted concerns about CT scan capacity. • raised the issue of tension between regional and organisational planning, highlighting the need for alignment and clear communication. • There is uncertainty and lack of clarity regarding the national stroke programme, with participants noting limited engagement and unclear timelines from the national team. This complicates local and regional planning. • It was agreed that the RJC would provide a general statement for stroke, emphasizing the need for alignment with evolving national and regional programmes, rather than specific comments on each option.

Urology
Neil Griffiths, Service Delivery Manager

Ref	Option Overview	Safe				Sustainable				Accessible				Kind			
Proposed	Bring together all urology inpatients at PPH (rather than at both GGH and PPH as currently) Develop a urology diagnostics hub at PPH to bring together all diagnostic services for Carmarthenshire, and diagnostic urology urgent suspected cancer services for the whole Health Board area (outpatients, day cases and other diagnostics would remain at BGH and WGH) GGH would care for emergency cases that come through the emergency department only.	A	G	A	A	A	G	G	G	A	A*	G	G	A	A	A	A
194/197	194 - Retain some minor diagnostics or pre-op assessments in Glangwili to minimise unnecessary travel 197 - New option, OP services to remain in Glangwili	A	A	A	A	A	A	G	A	G	A*	A	G	G	A	A	A

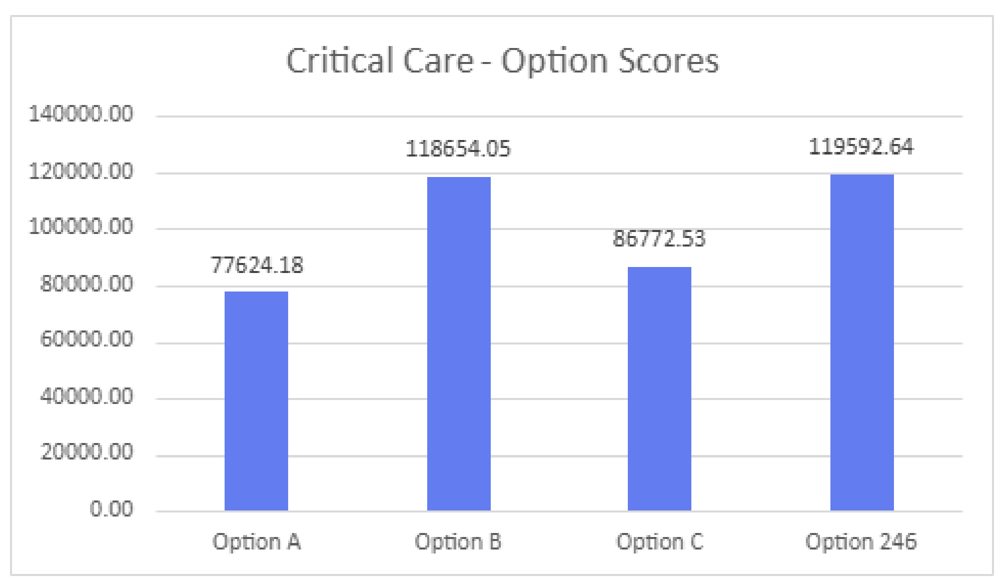
Urology – additional feedback
(Slide is a summary of feedback that may not have been considered by Task and Finish Group)

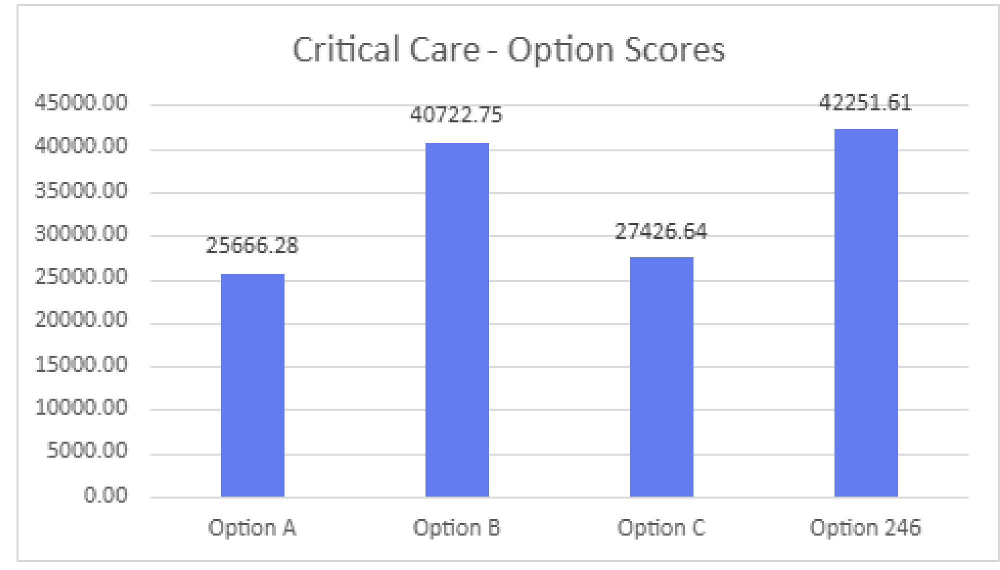
Response From	Evaluation Criteria	Option reference	Summary of feedback
Facilities	1.3	All options. Once a decision has been made, essential facilities and estates will be reviewed and consulted for impacts on workforce and service model change. These consequential impacts must be considered ahead of any implemented and agreed changes to ensure critical cleaning, portering, catering, maintenance & engineering and contractual amendments are fully considered, understood and accepted and resourced accordingly. If the service change increases activity it is vital full consideration is given to all areas of this key enabling service, including but not limited to linen, fire and H&S compliance, statutory engineering and infrastructure concerns, risk, patient cleaning, portering, security, catering and pest control.	
Staff Briefing	3.4	**Critical Enablers:** Transport, parking, staffing, and clear mileage policies must be resolved to ensure safe, practical, and sustainable care delivery. **Patient & Service Impact:** Long travel times, poor public transport, limited family contact, unsafe transfers, and stretched therapy and radiology services risk patient outcomes and feasibility of proposed models. Staff Briefing Staff Briefing	

Appendix D – Option scoring results

The following displays the weighted scoring results from the session.

Graph to the left outlines results as shown to the Options Development Group following scoring on the day.
Graph to the right outlines revised scoring following full results analysis.



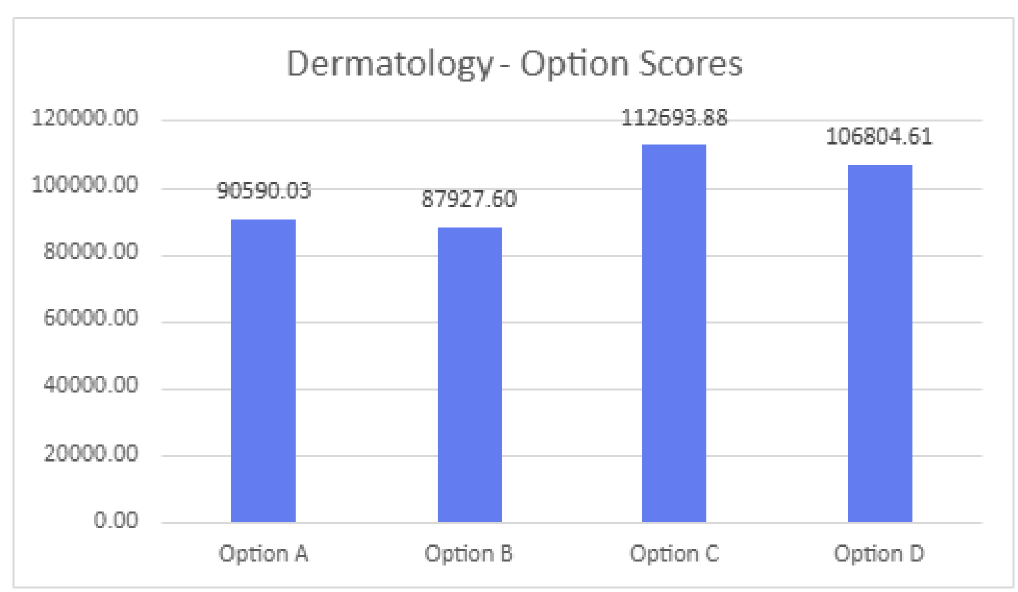


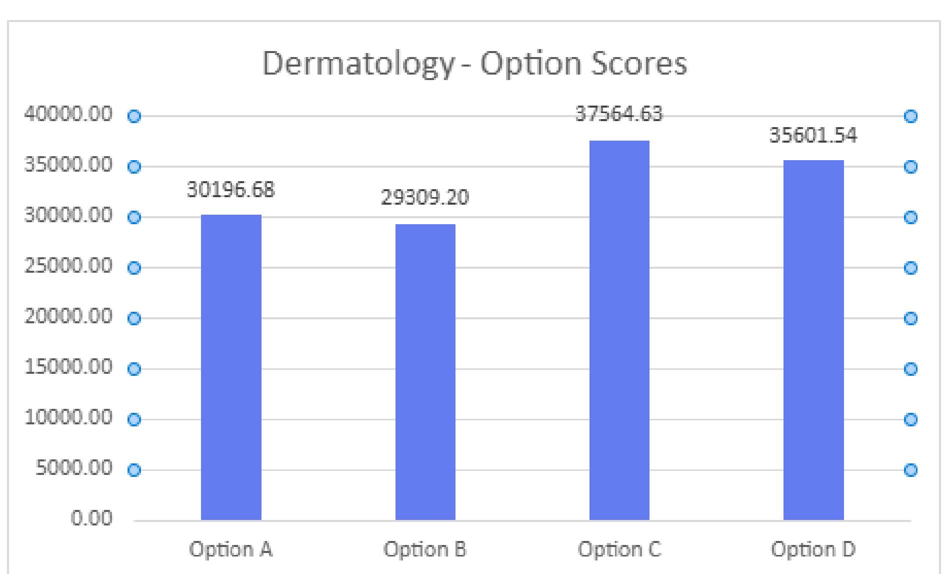
Data tables include full option scoring and breakdown of scores per evaluation criterion/ criteria

	Safe	Sustainable	Accessible	Kind
Critical Care Option A	6007	11152	4208	4299
Critical Care Option B	9717	16883	6745	7378
Critical Care Option C	6879	10149	5288	5110
Critical Care Option 246	10311	17444	6745	7751

	Safe				**Sustainable**				**Accessible**				**Kind**			
	1	**2**	**3**	**4**	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Critical Care Option A	1146	3201	989	671	3054	3428	2633	2038	1091	1248	769	1101	668	1849	919	864
Critical Care Option B	1950	4921	1724	1122	5240	5056	3727	2860	1935	1876	1286	1648	1137	3136	1397	1709
Critical Care Option C	1479	2942	1499	960	2857	2604	2295	2394	1450	1519	966	1353	905	2012	1047	1146
Critical Care Option 246	1991	5328	1768	1225	5477	5362	3758	2848	1858	1976	1270	1641	1263	3147	1709	1632

Graph to the left outlines results as shown to the Options Development Group following scoring on the day.
Graph to the right outlines revised scoring following full results analysis.



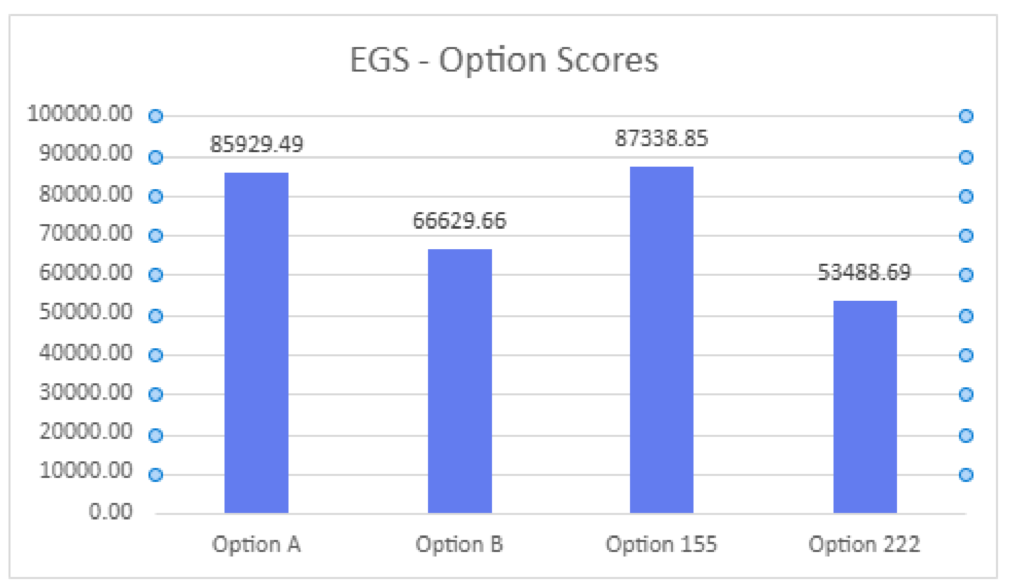


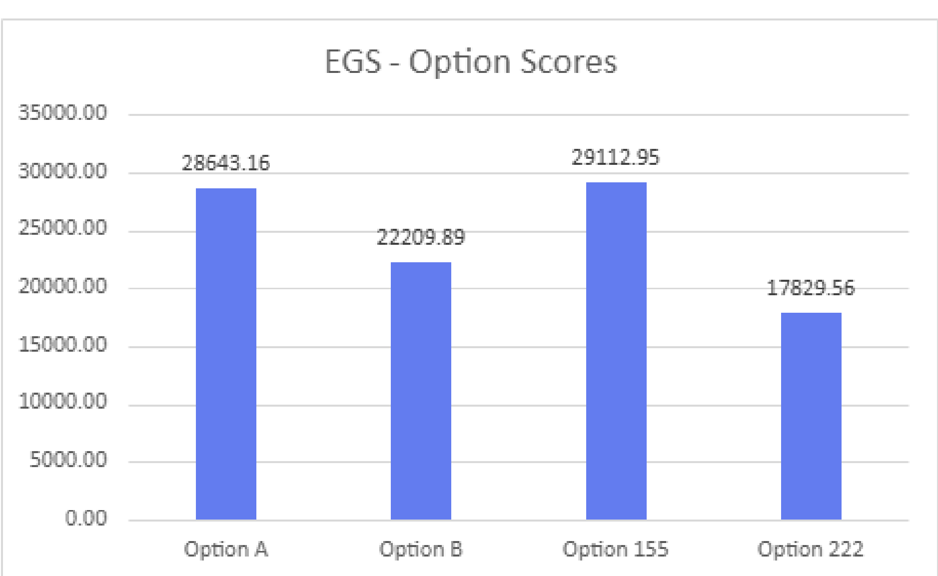
Data tables include full option scoring and breakdown of scores per evaluation criterion/ criteria

	Safe	Sustainable	Accessible	Kind
Dermatology Option A	7695	12430	4734	5338
Dermatology Option B	7314	12204	4551	5241
Dermatology Option C	8764	15548	6190	7063
Dermatology Option D	8307	14842	5879	6574

	Safe				**Sustainable**				**Accessible**				**Kind**			
	1	**2**	**3**	**4**	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Dermatology Option A	1609	4163	1135	789	3467	3945	2772	2246	1175	1364	918	1276	827	2246	1176	1088
Dermatology Option B	1503	3848	1193	769	3448	3677	2834	2246	1147	1349	870	1185	827	2200	1152	1062
Dermatology Option C	1853	4496	1440	975	4728	4634	3142	3044	1675	1806	1110	1599	1200	2820	1482	1562
Dermatology Option D	1796	4274	1346	892	4275	4424	3234	2909	1506	1674	1121	1578	1122	2621	1372	1459

Graph to the left outlines results as shown to the Options Development Group following scoring on the day.
Graph to the right outlines revised scoring following full results analysis.



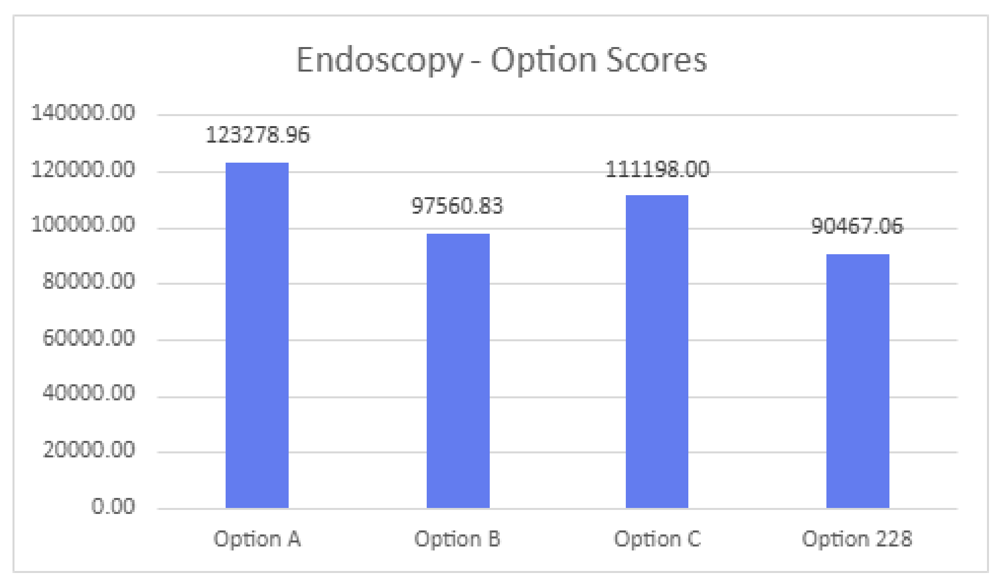


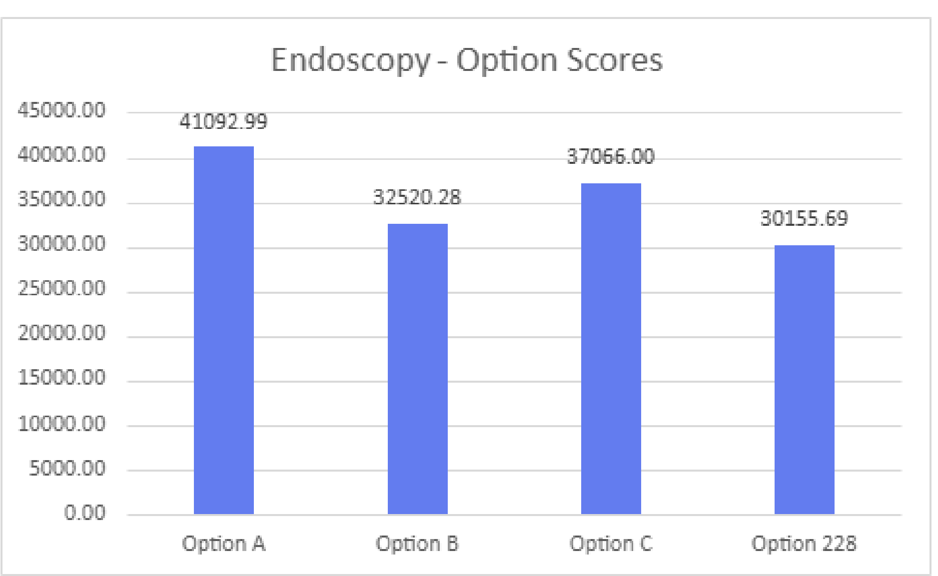
Data tables include full option scoring and breakdown of scores per evaluation criterion/ criteria

	Safe	Sustainable	Accessible	Kind
EGS Option A	6538	12814	4245	5046
EGS Option B	4783	9488	3787	4153
EGS Option 155	7139	12433	4503	5038
EGS Option 222	4084	7225	2940	3581

	Safe				**Sustainable**				**Accessible**				**Kind**			
	1	**2**	**3**	**4**	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
EGS Option A	1113	3571	1193	662	3605	3696	2972	2541	1084	1186	833	1143	764	2153	1060	1069
EGS Option B	886	2553	815	529	2502	2777	2171	2038	943	1039	683	1122	624	1732	882	915
EGS Option 155	1235	3811	1353	740	3585	3830	2526	2492	1239	1310	833	1122	755	2129	1060	1094
EGS Option 222	821	1924	800	539	1891	1896	1879	1559	676	767	614	884	561	1509	717	794

Graph to the left outlines results as shown to the Options Development Group following scoring on the day.
Graph to the right outlines revised scoring following full results analysis.



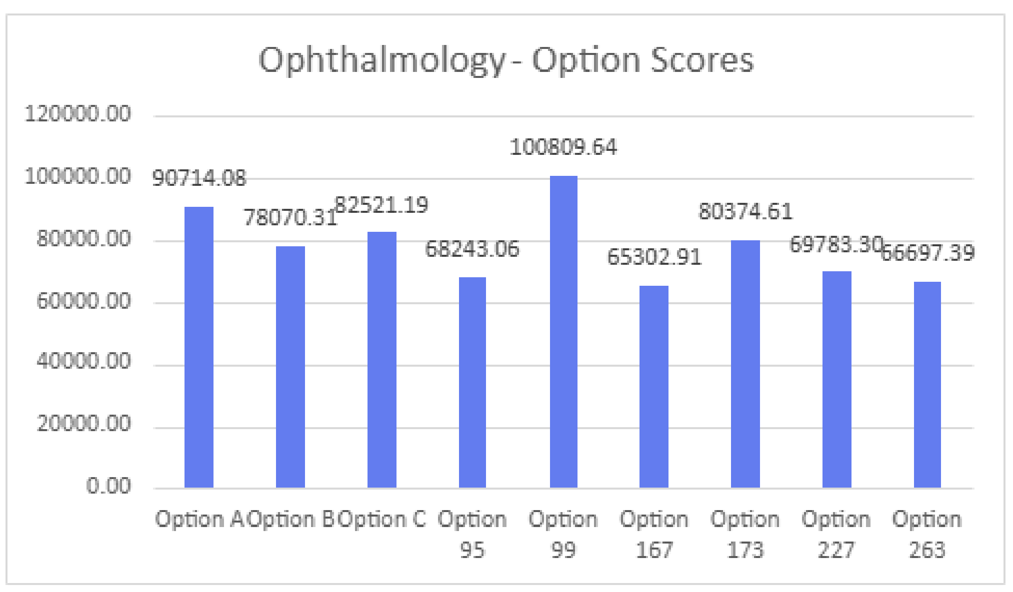


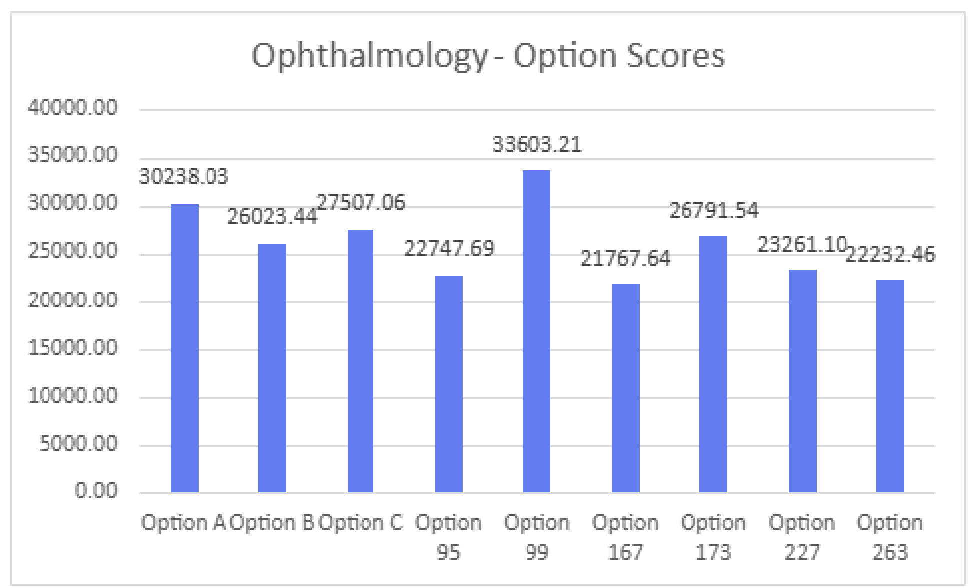
Data tables include full option scoring and breakdown of scores per evaluation criterion/ criteria

	Safe	Sustainable	Accessible	Kind
Endoscopy Option A	10231	17345	6513	7005
Endoscopy Option B	7567	13311	5391	6251
Endoscopy Option C	8799	15490	6125	6652
Endoscopy Option 228	6871	12445	5171	5668

	Safe				**Sustainable**				**Accessible**				**Kind**			
	1	**2**	**3**	**4**	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Endoscopy Option A	2064	5217	1848	1103	5358	5056	3727	3204	1703	1860	1260	1690	1074	2867	1458	1606
Endoscopy Option B	1398	4107	1244	818	4255	4079	2387	2590	1422	1566	1100	1304	1045	2539	1311	1357
Endoscopy Option C	1934	4107	1739	1019	4728	4213	3480	3069	1640	1744	1185	1557	1021	2668	1415	1549
Endoscopy Option 228	1414	3312	1273	872	4078	3160	2556	2651	1386	1426	1019	1339	958	2363	1176	1171

Graph to the left outlines results as shown to the Options Development Group following scoring on the day.
Graph to the right outlines revised scoring following full results analysis.





Data tables include full option scoring and breakdown of scores per evaluation criterion/ criteria

	Safe	Sustainable	Accessible	Kind
Ophthalmology Option A	7220	13509	4446	5063
Ophthalmology Option B	6136	11510	3928	4449
Ophthalmology Option C	6908	11714	4315	4571
Ophthalmology Option 95	6236	8928	3751	3832
Ophthalmology Option 99	7926	14605	5304	5769
Ophthalmology Option 167	5630	8336	3717	4084
Ophthalmology Option 173	6820	10922	4283	4766
Ophthalmology Option 227	6244	9003	3857	4156
Ophthalmology Option 263	5477	9252	3407	4097

	Safe				**Sustainable**				**Accessible**				**Kind**			
	1	**2**	**3**	**4**	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Ophthalmology Option A	1300	4033	1128	760	3782	4060	3003	2664	1140	1240	859	1206	818	2235	962	1050
Ophthalmology Option B	1105	3441	968	622	2955	3313	2787	2455	957	961	769	1241	735	1872	882	960
Ophthalmology Option C	1243	3756	1149	760	3487	3504	2587	2136	1119	1232	827	1136	730	1884	900	1056
Ophthalmology Option 95	1024	3515	1011	686	2778	2241	1786	2124	971	1008	721	1052	600	1615	741	877
Ophthalmology Option 99	1446	4274	1353	853	4472	4251	2972	2909	1365	1480	993	1466	987	2363	1145	1274
Ophthalmology Option 167	1008	3164	851	608	2463	2164	1648	2062	929	1054	753	982	735	1556	839	954
Ophthalmology Option 173	1219	3552	1280	769	3369	3504	1987	2062	1112	1139	833	1199	842	1919	943	1062
Ophthalmology Option 227	1154	3367	1077	647	2975	2355	1648	2025	964	1046	774	1073	759	1697	760	941
Ophthalmology Option 263	845	3127	844	662	2305	2643	2156	2148	830	876	705	996	701	1615	809	973

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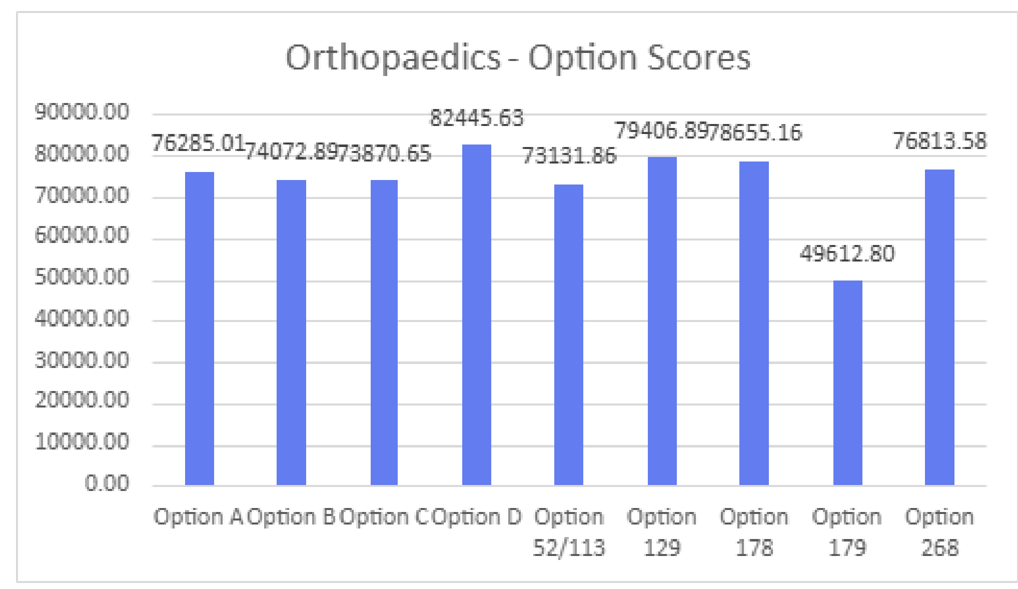
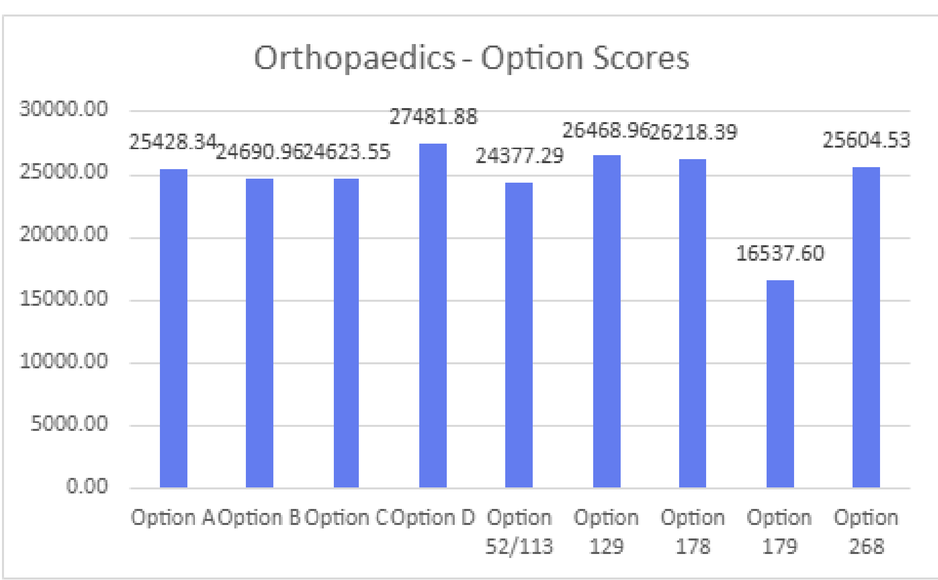
Graph to the right outlines revised scoring following full results analysis.





Data tables include full option scoring and breakdown of scores per evaluation criterion/ criteria

	Safe	Sustainable	Accessible	Kind
Orthopaedics Option A	6388	10728	3654	4658
Orthopaedics Option B	6305	10079	3590	4717
Orthopaedics Option C	6140	10304	3628	4551
Orthopaedics Option D	6879	11510	4023	5070
Orthopaedics Option 52/113	5836	9735	3964	4843
Orthopaedics Option 129	6660	10749	4101	4959
Orthopaedics Option 178	6572	10806	3974	4866
Orthopaedics Option 179	4001	6130	3100	3306
Orthopaedics Option 268	6528	10653	3821	4602

	Safe				**Sustainable**				**Accessible**				**Kind**			
	1	**2**	**3**	**4**	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Orthopaedics Option A	1300	3330	1062	696	3014	3275	2279	2160	964	946	721	1024	663	2012	1023	960
Orthopaedics Option B	1292	3275	1048	691	2975	3160	2141	1804	985	930	721	954	706	1977	1035	998
Orthopaedics Option C	1243	3256	989	652	3034	3160	2048	2062	985	915	705	1024	658	1942	1017	934
Orthopaedics Option D	1422	3571	1157	730	3290	3581	2295	2345	1070	1070	790	1094	764	2153	1096	1056
Orthopaedics Option 52/113	1300	2905	960	671	2600	2987	1987	2160	1027	1085	715	1136	682	2024	1023	1114
Orthopaedics Option 129	1357	3404	1149	750	3073	3236	2156	2283	1042	1132	806	1122	726	2106	1078	1050
Orthopaedics Option 178	1389	3423	1055	706	3152	3236	2171	2246	1063	1108	758	1045	663	2083	1084	1037
Orthopaedics Option 179	926	1850	735	490	1872	1685	1309	1264	788	891	657	764	581	1287	741	698
Orthopaedics Option 268	1324	3404	1069	730	3093	3179	2233	2148	1027	1077	742	975	677	1954	998	973

Graph to the left outlines results as shown to the Options Development Group following scoring on the day.
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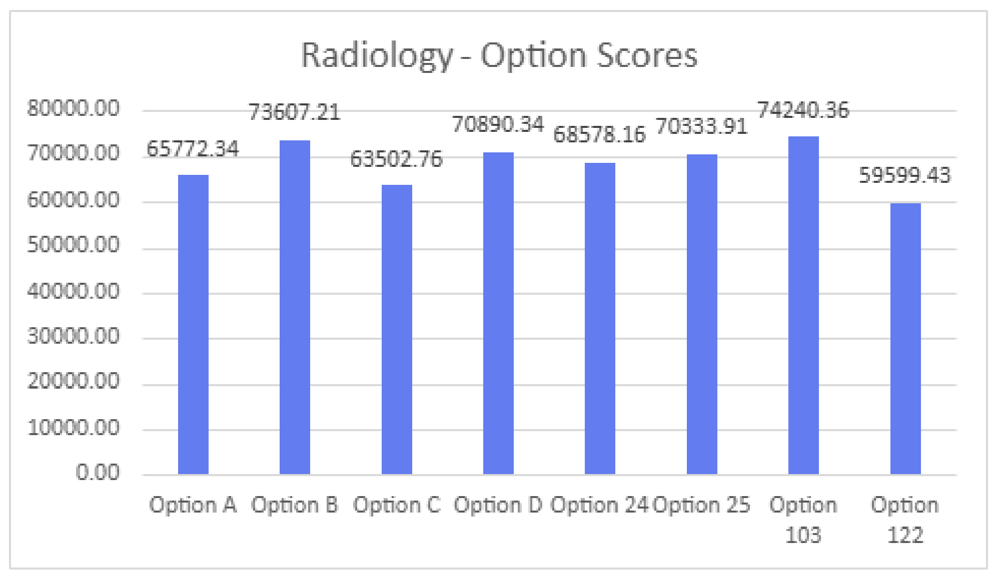
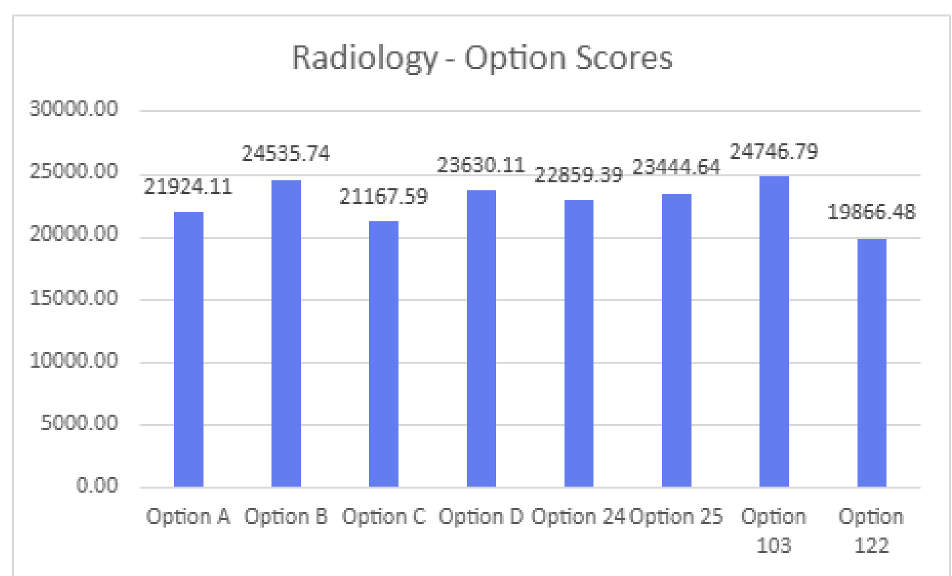


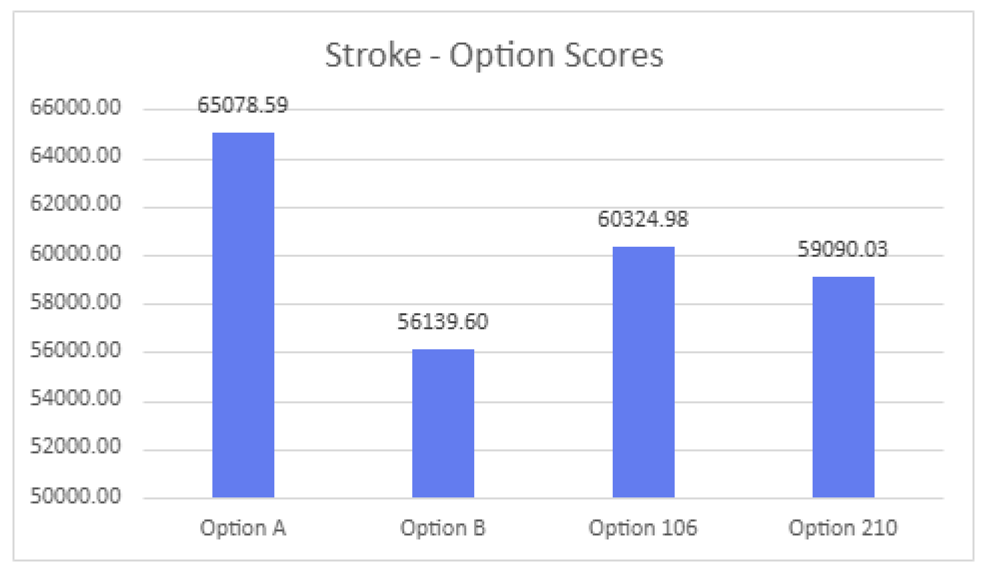


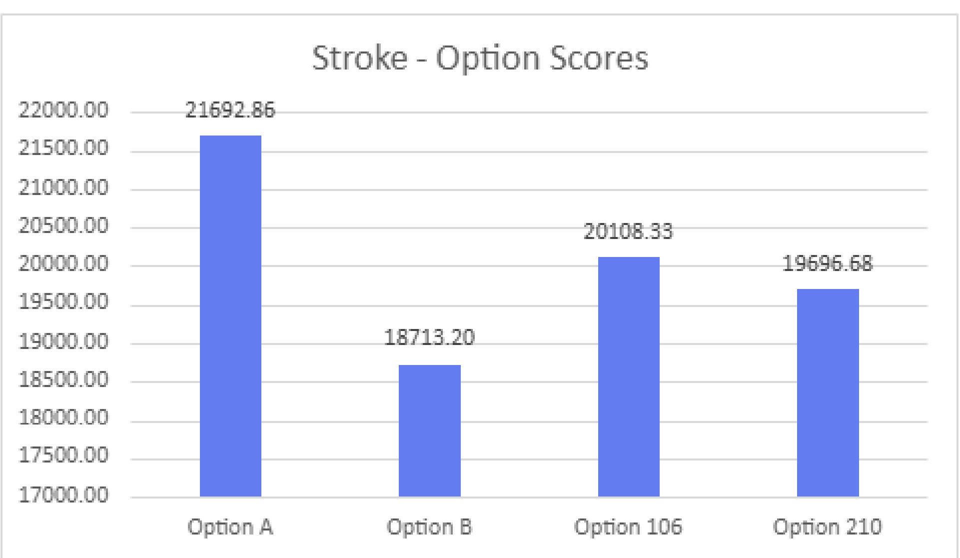
Data tables include full option scoring and breakdown of scores per evaluation criterion/ criteria

	Safe	Sustainable	Accessible	Kind
Radiology Option A	5575	9269	3264	3815
Radiology Option B	6154	10276	3740	4366
Radiology Option C	5358	8887	3162	3761
Radiology Option D	6066	10006	3500	4058
Radiology Option 24	5916	9192	3594	4157
Radiology Option 25	6111	9481	3649	4204
Radiology Option 103	6266	10210	3847	4423
Radiology Option 122	4490	8030	3375	3972

	Safe				**Sustainable**				**Accessible**				**Kind**			
	1	**2**	**3**	**4**	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Radiology Option A	1048	2794	1033	701	3014	2566	1786	1903	887	930	571	877	537	1568	821	890
Radiology Option B	1073	3182	1135	764	3428	2815	1786	2246	985	1077	731	947	614	1884	876	992
Radiology Option C	959	2590	1099	711	3014	2375	1571	1927	845	922	560	834	527	1580	778	877
Radiology Option D	1089	3164	1099	715	3329	2738	1925	2013	915	1008	694	884	537	1767	833	922
Radiology Option 24	1008	3090	1084	735	3132	2451	1632	1976	901	992	747	954	566	1825	858	909
Radiology Option 25	1048	3164	1135	764	3172	2547	1725	2038	950	1039	721	940	585	1802	876	941
Radiology Option 103	1121	3182	1179	784	3369	2796	1971	2074	1006	1054	763	1024	663	1919	888	954
Radiology Option 122	1008	1924	931	627	2463	2298	1956	1313	746	984	726	919	701	1580	821	870

Graph to the left outlines results as shown to the Options Development Group following scoring on the day.
Graph to the right outlines revised scoring following full results analysis.



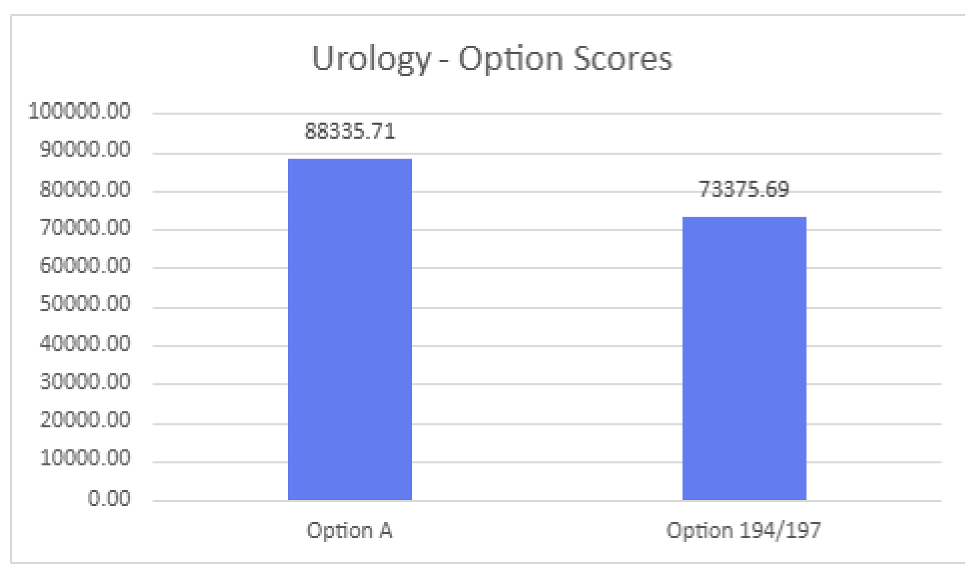


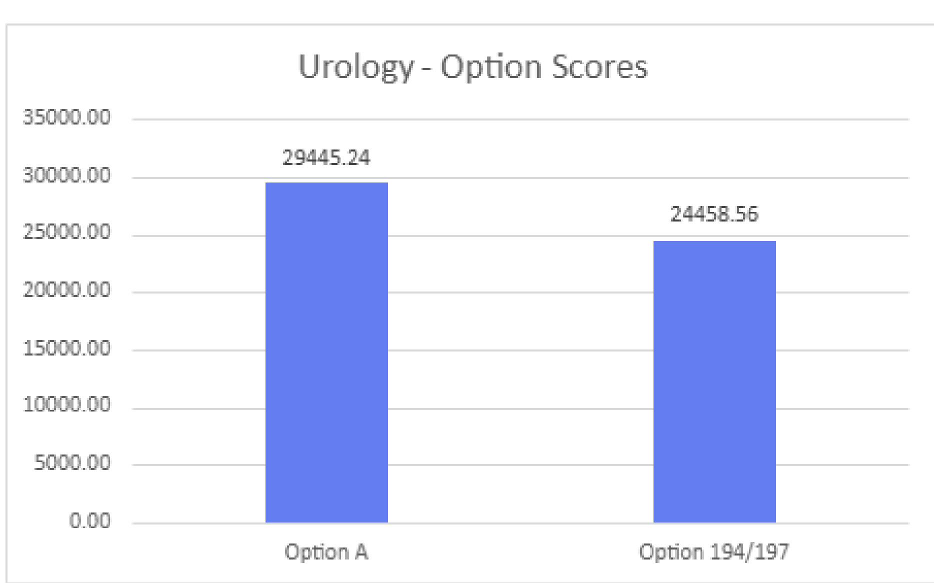
Data tables include full option scoring and breakdown of scores per evaluation criterion/ criteria

	Safe	Sustainable	Accessible	Kind
Stroke Option A	5474	9020	3038	4161
Stroke Option B	4973	7655	2630	3455
Stroke Option 106	5045	8169	3339	3555
Stroke Option 210	4714	7917	3298	3767

	Safe				**Sustainable**				**Accessible**				**Kind**			
	1	**2**	**3**	**4**	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Stroke Option A	1056	2868	1011	539	2955	2317	2017	1731	711	961	630	736	595	1790	937	838
Stroke Option B	926	2757	815	475	2600	1762	1709	1583	662	798	539	631	479	1451	802	723
Stroke Option 106	1105	2350	938	652	2344	2221	1910	1694	880	969	635	856	561	1404	790	800
Stroke Option 210	1008	2146	924	637	2403	1877	1894	1743	901	1000	641	757	581	1486	907	794

Graph to the left outlines results as shown to the Options Development Group following scoring on the day.
Graph to the right outlines revised scoring following full results analysis.





Data tables include full option scoring and breakdown of scores per evaluation criterion/ criteria

	Safe	Sustainable	Accessible	Kind
Urology Option A	6902	12888	4587	5068
Urology Option 194/197	5688	10313	4130	4328

	Safe				**Sustainable**				**Accessible**				**Kind**			
	1	**2**	**3**	**4**	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Urology Option A	1284	3608	1222	789	3664	3830	3049	2345	1175	1256	929	1227	789	2094	1072	1114
Urology Option 194/197	1129	2794	1055	711	2955	2911	2556	1890	1154	1108	753	1115	759	1720	882	966

Appendix E – Reflective Survey Responses

These responses are as they were provided in the survey without any correction or amendment.

Is there anything in the results that surprises you?	What is your reason for the answer above?	Do you think that the scores reflect the discussion in the room?	What is your reason for the answer above?	Is there anything further that you think the Board should consider when reviewing the option scores in November?
No	Not Applicable	Yes	It seems that the services were aligned with the options that scored higher	
No	When there's little variability within the options the scores are similar.	Yes		
No	The options that were expressed that best suited the service scored highest.	Yes		
No	I think people who did not have a great deal of understanding of individual services just scored in line with the service leads RAG rated document.	Yes		
No		Yes		
No	I think it was very difficult to score many options. For example radiology. This is demonstrated in the scores being very equal.	Yes		N/A
No	Criterion selection quite similar	Yes	Experienced group	

No	I think on the whole the results matched the room opinion.	Yes		I think it was difficult due to the number of options and some being similar to be able to score each individual option.
Yes		No		
No	Most of the results matched the opinions of the services	Yes	Yes	More discussion would be needed with services that have many options and where options scored closely. For example, radiology. Options that had clear results should move to the next stage with no additional options brought back to be evaluated
No	The last few options all had comparable results which I think represents voting fatigue.	Yes		I think there are not enough clinicians on this room to be voting on these decisions. The process does not seem to be aligned with the strategic direction of the Health Board.
No	Most of the preferred options as assessed by the teams were the strongest options.	Yes	The discussions influenced my voting.	How is local infrastructure such as roads, public transport going to be improved to support increased inter-hospital transfers?
Don't know/ unsure	Can't remember enough about the different areas.	Yes	Seemed approximately OK.	Score weighting should be mapped to each area in the CSP better. Too generic. Make sure none of the highest scoring options are clinically unworkable.
No	The results are what I expected for each service. The service leads gave an overview as to what option they felt would be most feasible for their service, and as the panel scoring, we were led by their expertise.	Yes	Yes, the scores reflect what was discussed in the room and again scores were likely to be influenced by the service leads who gave narrative re the feasibility of the option.	
No	Been involved in ongoing discussions so was aware of general direction.	Yes		Re Stroke. While we understand the urgent need to streamline, we are still concerned that the proposed options won’t deliver a ‘gold standard’ of stroke care. When final options are agreed, we want to see clear rehabilitation and community plans, good governance of robust safety measures and alignment with national

				stroke work, particularly stroke standards and plans to improve thrombectomy access.
No	The better options for the service scored more highly.	Yes	The options called out as suiting the services better were scored more highly.	Yes, the services should be involved in the process of how the services would fit together e.g. if we have several services needing GGH as their main site, how do we all fit together. We need to evaluate the options together as services mapping what would go where and how this would work ready to present to board
No	With stroke- group seems to reflect initial rationale. Not sure more transparency of WGH ED/ medical take situation will help.	Yes	Yes	Clear direction and transparency on where WGH is with regards to ED and medical take. This will play a major influence on stroke options. If option 210 is then considered (based on the above) to be the futuristic option, will a public consultation take place as this was not part of public consultation before?
No	None of the options really address the system constraints. The preliminary presentation of results is so generic without the RAG rating that so far, the results are meaningless	No	The results so far are not discriminatory.	In the current contexts of emergency pressures and planned care delays with such long waits for care the CSP has highlighted once again the unsustainable nature of our delivery models as historically structured- with externally enforced dependence on sustaining so many sites with insufficient overall resource to make any of them truly viable. It is folly to attempt to separate planned from unplanned where the same workforce has to deliver both. It is folly to consider services separate from all their interdependencies - especially where some acute services are so fragile they have actually already fallen over - for instance, our A&E functions and the interdependencies of all with WAST emergency services. What the CSP processes to date provide is robust evidence that even the best resourced and tech enabled logical driven processes are unable to even scratch the surface of the complexities here

				within. Complexity powered processes are imperative from the start.

Patient and Travel Insights

Executive Summary

The Patient and Travel Insights document gives an overview of the information used in the Clinical Services Plan (CSP) programme. It helps readers understand key details about patient access and movement. This document should be read with the Main Consultation document and other detailed technical information. It is not meant to stand alone but to provide insight into the considerations made during Phase 1 – The Issues Paper and Phase 2 – The Options Development process.

The document includes data from Phase 1 and Phase 2, which was used to evaluate options through a Strengths, Weaknesses, Opportunities, and Threats (SWOT) analysis. The document also considered impact assessments such as the Equality Impact Assessment (EqIA), Quality Impact Assessment (QIA), Health Impact Assessment (HIA) screening and Regional Impact Assessments. These assessments help ensure that the options developed are practical and beneficial for patient care. By integrating these analyses, the CSP programme ensures well-informed and balanced decision-making.

An appendix has been added to this version to document alternative options considered in response to feedback from the Phase 3 public consultation.

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Introduction

The **Patient and Travel Insights** document provides an overview of the information used within the CSP programme, offering readers an understanding and summary of key details related to patient access and potential patient movement. This document should be read in conjunction with the Main Consultation document and the additional detailed technical information referenced throughout. It is not intended to stand alone but aims to provide insight into the considerations made during the development of Phase 1 – The Issues Paper and Phase 2 – The Options Development process.

Readers with a specialist interest in data and the information within this document may wish to conduct further analysis of the supporting documents within the CSP programme, which contain significantly more technical detail than this brief summary overview.

The information in this overview was utilised during Phase 1 – The Issues Paper and Phase 2 – The Options Development process. It aligns with the needs described in the methodology for Phase 2, particularly aspects of the Evaluation Criteria. These criteria were fundamental to the SWOT analysis for Phase 2, which was used to evaluate each option. Where relevant, this information may have also been considered within impact assessments in the programme, such as the EqIA, QIA, and HIA screening.

Phase 3 – Gateway: Post Public Consultation and Alternative Options Update (November 2025)

In this version of the document, an additional appendix has been included to address the consideration of alternative ideas submitted during the public consultation phase. These alternatives have been reviewed following the hurdle appraisal session held in October 2025. Notably, this review excludes two specific stroke-related options, referred to as options 118 and 210. These two options, following a challenge, have undergone further development and will be reappraised (November 2025) against the hurdle criteria due to the receipt of new information after the Hurdle appraisal workshop in October 2025.

The appendix presents data analysis, where available, regarding the configuration of each alternative option. This analysis focuses on potential patient movement associated with each configuration and is based on the same information utilised during Phase 2 of the CSP programme.

Methodology

The table below highlights where information related to patient activity and travel insights was considered during Phase 2 – The Options Development process. This information was subsequently analysed in detail using the SWOT analysis framework.

The items identified in the table are integral to this document, providing an overview of how patient activity and travel considerations were incorporated into the development and evaluation of various options. By examining these insights, stakeholders can better understand the potential impacts on patient access and movement, ensuring that the options developed are both practical and beneficial for patient care.

This detailed analysis aims to offer a clear understanding of the considerations made during the options development process, highlighting the importance of patient activity and travel insights in shaping the options.

Graphic 1: Evaluation Criteria

Sustainable
·Clinically sustainable – Patient demand to require service

Safe
·Number of patients likely to need transport between sites when unwell
·Impact on external services (e.g. Health boards, Welsh Ambulance Service Trust (WAST), Adult Critical Care Transfer Service)

Accessible
·Patient travel time to sites
·Transfer travel time impact on options
·Impact on local communities / infrastructure when developing community sites

Kind
·Addressing barriers to care (telemedicine, transport enablers, patient support)
·Addressing barriers to equality

Clinically sustainable: Patient demand to require service

This section covers each of the nine services and the delivered activity taking place at each site. For clarity and understanding, several tables are provided for each service:

Service Table 1: Patient activity data

- **Description**: This table illustrates the information shared within the programme to-date, covering the date range from 2018 to 31 March 2024. In some cases, the date range includes part financial years or completed financial years. By 'financial years' for the purposes of this document we mean 1 April to 31 March the following year or part thereof.
- **Data Representation**: The data may be represented as a group or broken down into specific areas such as outpatients, day cases, inpatients, or procedure types. This detail helps in understanding the historical activity and trends for each service.

Service Table 2: Activity estimate by current configuration and Options

- **Description**: This table considers the current activity and provides an indicative estimate of the end-state option. Each service area may have specific aspects that need to be considered.
- **Purpose**: The information in this table serves as an indicative estimate to gauge how an option may look within our Health Board. It helps in visualising the potential future state of each service based on historical data.

Service Table 3: Patient movement activity estimate by Option

- **Description**: This table specifically examines known patient movement from one site (Amber) to a receiving site (Purple). A Yellow colour indicates where further planning may be conducted at implementation.

Colour	Meaning
(Amber)	Amber denotes transferring site
(Purple)	Purple denotes receiving site
(Yellow)	Numbers to be defined during implementation

- **Purpose**: Its purpose is to show how many people, based on the analysed data, would have been impacted for that particular year. This analysis is crucial for understanding the implications of patient transfers and movements between sites.

Additional Considerations:

- **Data Refresh and Updates**: Within each table, it is possible that the information may be refreshed or have additional options added following the Public Consultation phase, where alternative options are considered.

By providing these tables, the document aims to offer an overview of the activity and patient movement for each service, helping stakeholders make informed decisions based on factual data.

Critical Care

Below are the tables for Critical Care.

Critical Care Table 1: Patient activity data

Critical Care admissions activity (1 August 2018 to 31 March 2024)					
Reporting period	**Bronglais**	**Glangwili**	**Prince Philip**	**Withybush**	**Total**
2018-19 (1 Aug – 31 Mar)	**147**	**342**	**63**	**225**	**777**
2019-20	**249**	**478**	**107**	**271**	**1105**
2020-21	**220**	**488**	**200**	**370**	**1278**
2021-22	**233**	**501**	**236**	**398**	**1368**
2022-23	**236**	**463**	**278**	**377**	**1354**
2023-24 (refreshed)	**248**	**437**	**236**	**271**	**1192**
Total	**1333**	**2709**	**1120**	**1912**	**7074**
Total as % of overall activity	**19%**	**38%**	**16%**	**27%**	**100%**

(Source: www.hduhb.nhs.wales/clinical-services-consultation)

Between August 2018 and March 2024, four hospitals had a total of 7,074 critical care admissions. GGH had the most with 2,709 admissions, making up 38% of the total. WGH had 1,912 admissions (27%), BGH had 1,333 admissions (19%), and PPH had the least with 1,120 admissions (16%). This shows how many patients each hospital cared for during this time.

Critical Care Table 2: Activity by Current configuration and Option

It should be noted that this is an estimate based on analysis of the date range stated in the table. Therefore, these figures should be considered indicative at this stage.

01APR23-31MAR24	Bronglais	Glangwili	Prince Philip	Withybush	Community	TOTAL
Current	248	437	236	271	0	1192
Option A	248	878	47	19	0	1192
Option B	248	626	47	271	0	1192
Option C	248	437	236	271	0	1192
Data includes patient numbers for Level 0,1,2 & 3.						

The table shows patient numbers for critical care at different hospitals from April 2023 to March 2024. Currently, there are 1,192 patients spread across Bronglais, Glangwili, Prince Philip, and Withybush hospitals. Option A suggests moving most patients to GGH, while Option B proposes a mix between BGH, GGH and WGH. Option C keeps the

current distribution. All options maintain the total number of patients at 1,192. The data includes patients at various levels of care (Level 0, 1, 2, and 3).

Critical Care Table 3: Patient Movement Activity Estimate by Option

It should be noted that this is an estimate based on analysis of the date range stated in the table. Therefore, these figures should be considered indicative at this stage.

01APR23-31MAR24	Bronglais	Glangwili	Prince Philip	Withybush	Community	TOTAL
Current	0	49	49	0	0	49
Option A	0	441	189	252	0	441
Option B	0	189	189	0	0	189
Option C	0	49	49	0	0	49
Option A - Levels 2 and 3 moving from PPH and WGH to GGH as part of change from ICU to ECU						
Option B/C - Levels 2 and 3 moving from PPH to GGH as part of change from ICU to ECU						

There are different numbers of patients moving amongst the four hospitals within each option. Currently, it is estimated that there are 49 patient movements to GGH from PPH under the temporary service change as described within the Main Consultation Document and the Issues Paper.

- **Option A**: 441 patients would move to GGH, with all patients from PPH and WGH moving to GGH.
- **Option B**: 189 patients would move to GGH.
- **Option C**: Patient numbers would stay the same as they are now – 49 patients would move to GGH.

Option A involves moving higher-level care patients from PPH and WGH to GGH. Option B and C moves higher needs patients from PPH only.

Within the following section 'Safe – patient transfers when unwell', this analysis considers the current arrangement in place at PPH and how this could look if modelled at other sites.

Dermatology

Below are the tables for Dermatology. It should be noted that a large proportion of Dermatology outpatient data reflects appointments that have been delivered virtually. Within the electronic patient record system this is recorded as the location from which the staff member attended the virtual appointment.

Dermatology Table 1: Patient activity data

Dermatology activity (1 August 2018 to 31 July 2023)					
Reporting period	**Glangwili**	**Prince Philip**	**Withybush**	**Cardigan (ICC)**	**South Pembrokeshire**
2018-19 (1 Aug – 31 Mar	**3753**	**3983**	**675**	**0**	**219**
2019-20	**6830**	**7484**	**1007**	**0**	**221**

2020-21	595	6817	569	0	3
2021-22	916	11626	1149	0	353
2022-23	1747	8809	1087	95	664
2023-24 (1 April – 31 July	506	3249	31	59	21
Total	14347	41968	4518	154	1481

(Source: www.hduhb.nhs.wales/clinical-services-consultation)

Between August 2018 and July 2023, dermatology activity varied across different locations. PPH had the most cases with 41,968. GGH followed with 14,347 cases. WGH had 4,518 cases, and South Pembrokeshire Hospital had 1,481 cases. Cardigan ICC had the fewest cases, totalling 154. This shows that PPH had the highest activity, while Cardigan ICC had the least.

Dermatology Table 2: Activity by Current configuration and Option

It should be noted that this is an estimate based on analysis of the date range stated in the table. Therefore, these figures should be considered indicative at this stage.

2022-23	Bronglais	Glangwili	Prince Philip	Withybush	Community	TOTAL
Current	0	1747	8809	1087	759	12402
Options A, B, C, D	0	0	11643	0	759	12402

In 2022-23, patient activity data was collected from different locations. Under the current service, PPH had the most activity with 8,809, followed by GGH with 1,747. WGH had 1,087, and the community had 759.

For options A, B, C, and D, only PPH and the community would have patient activity. PPH would have 11,643 activities, and the community would have 759.

Dermatology Table 3: Patient Movement Activity Estimate by Option

It should be noted that this is an estimate based on analysis of the date range stated in the table. Therefore, these figures should be considered indicative at this stage.

2022-23	Bronglais	Glangwili	Prince Philip	Withybush	Community	TOTAL
Current	0	1747	8809	1087	759	12402
Options A, B, C, D	0	1747	2834	1087	759	2834

Options A, B, C, D - GGH, WGH move to PPH
Option A - no service at South Pembrokeshire Hospital (664)
Option B - no service at Cardigan ICC (95)
Options A, B, C, D - provision added to the community but details to be further refined at implementation phase

From 2022-23, there were 12,402 activities provided across all locations.

- **Options A, B, C, and D**, services at GGH and WGH move to PPH. A total of 2,834 activities would move. It should be noted that a proportion of this activity is virtual and not all are face to face, in person appointments.
- In **Option A** there is no service at South Pembrokeshire Hospital, affecting 664 activities, while
- **Option B** means no service at Cardigan ICC, affecting 95 activities.

Emergency General Surgery

Below are the tables for Emergency General Surgery (EGS).

Emergency General Surgery Table 1: Patient procedures data

Emergency General Surgery procedures (1 August 2018 – 31 July 2023)				
Reporting period	**Bronglais**	**Glangwili**	**Withybush**	**Total**
2018-19 (1 Aug – 31 Mar	368	1033	847	2248
2019-20	187	510	300	997
2020-21	72	250	267	589
2021-22	116	341	230	687
2023-24 (1 April – 31 July	145	359	319	823
Emergency General Surgery procedures (1 April 2023 to 31 March 2024)				
2023-24	308	593	418	1319
Total	**1196**	**3086**	**2381**	**6663**

(www.hduhb.nhs.wales/clinical-services-consultation)

Between August 2018 and March 2024 there were 6,663 emergency general surgery procedures carried out at BGH, GGH, and WGH. GGH had the most with 3,086 procedures. WGH had 2,381 procedures, and BGH had 1,196. The number of procedures changed each year, but GGH generally had the most. From April 1, 2023, to March 31, 2024, there were 1,319 procedures across BGH, GGH, and WGH.

Emergency General Surgery Table 2: Activity by Current configuration and Option

It should be noted that this is an estimate based on analysis of the date range stated in the table. Therefore, these figures should be considered indicative at this stage.

01 Apr 23 - 31 Mar 24	Bronglais	Glangwili	Prince Philip	Withybush	Community	TOTAL
Current	308	593	0	418	0	1319
Option A	308	1011	0	0	0	1319
Option B	308	506	0	506	0	1319

Between April 2023 and March 2024, a total of 1,319 procedures were carried out across different locations. Under the Current service, GGH had 593 procedures, WGH

had 418, and BGH had 308. PPH and the community had no procedures as the service does not operate from these locations.

- **For Option A**, GGH would have 1,011 procedures, and BGH would have 308. There would be no procedures at WGH, PPH, or in the community.
- **For Option B**, GGH and WGH would each have 506 procedures, and BGH would have 308. PPH and the community would have no procedures.

Option A increases the number of procedures at GGH significantly compared to the Current option, while Option B distributes procedures more evenly between GGH and WGH. BGH remains constant across both options, and PPH and community have no procedures in either option.

Emergency General Surgery Table 3: Patient Movement Activity Estimate by Option

It should be noted that this is an estimate based on analysis of the date range stated in the table. Therefore, these figures should be considered indicative at this stage.

01 Apr 23- 31 Mar 24	Bronglais	Glangwili	Prince Philip	Withybush	Community	TOTAL
Current	308	593	0	418	0	1319
Option A	0	418	0	418	0	418
Option B	0	297	0	209	0	506
Option A - WGH EGS procedures transferred to GGH						
Option B - EGS procedures alternate weekly between GGH/WGH - a literal split of activity has been taken to represent weekly split. Any variance has not been accounted for.						

Currently, there are 1,319 procedures provided across all locations.

- **Option A**, services at BGH are unchanged, and patients needing a procedure at WGH are transferred to GGH, resulting in a total of 418 procedures being transferred.
- **Option B**, services at BGH are also unchanged, but services alternate weekly between GGH and WGH, resulting in a total of 506 procedures being transferred between the two sites.

Option A involves transferring WGH's Emergency General Surgery (EGS) procedures to GGH, while Option B involves alternating EGS procedures weekly between GGH and WGH. To present the options there has been a literal split of activity. Any variance in this split has not been accounted for.

Endoscopy

Below are the tables for Endoscopy. Within table 1 below, the first part of the table considers the gastrointestinal activity at the sites for the period. Within the lower part of the table and during the options development process further activity was considered with reference to endoscopy unit activity for urology and respiratory endoscopic related activity.

Endoscopy Table 1: Patient activity data

Endoscopy service activity (1 August 2018 – 31 July 2023)				
Reporting period	**Bronglais**	**Glangwili**	**Prince Philip**	**Withybush**
2018/19 (1 Aug – 31 Mar)	2371	4852	3135	5211
2019/20	4006	7891	5679	8108
2020/21	1953	3697	1582	2996
2021/22	3058	5795	3233	5021
2022/23	3285	6092	3701	5415
2023/24 (1 April – 31 July)	1315	2083	1341	2266
Elective Respiratory and Urology activity logged against Endoscopy units 1 April 2023 to 31 March 2024				
Respiratory Medicine	-	187	457	-
Urology	166	1274	951	376

(Source: www.hduhb.nhs.wales/clinical-services-consultation)

Overall, the number of activities went up and down over the years. The identified dips in the activity were likely due to COVID-19.

Endoscopy Table 2: Activity by Current configuration and Option

It should be noted that this is an estimate based on analysis of the date range stated in the table. Therefore, these figures should be considered indicative at this stage.

2022-23	**Bronglais**	**Glangwili**	**Prince Philip**	**Withybush**	**Community**	**TOTAL**
Current	3285	6092	3701	5415	0	18493
Options A, B, C	3285	6092	3701	5415	0	18493

For the year 2022-23, BGH had 3,285 procedures, GGH had 6,092, PPH had 3,701, and WGH had 5,415, making a total of 18,493 procedures. There were no procedures listed under the community category.

In the options, assessments of the totals will be further defined upon the detailed understanding of any procedure changes at the sites. The activity is expected to increase at PPH in Option A and Option C. In Option B, there would be an increase in community activity, as Bowel Screening Wales lists would be delivered from there, and no longer from the acute sites.

Endoscopy Table 3: Patient Movement Activity Estimate by Option

It should be noted that this is an estimate based on analysis of the date range stated in the table. Therefore, these figures should be considered indicative at this stage.

2022-23	Bronglais	Glangwili	Prince Philip	Withybush	Community	TOTAL
Current	3285	6092	3701	5415	0	18493
Options A, B, C	0	0	0	0	0	0
Options A, B, C – increased activity at PPH (additional sessions) - therefore unknown impact on patient movements at this stage.						
Option B – some movement to community sites, to be defined at implementation phase (for 2023-2024 this was assessed to be 834 related activities)						

Within the options there are suggested changes to endoscopy related procedures for Urology, Respiratory and Bowel Screening Wales. Due to the nature of the varying elements of each of these procedures further analysis will need to be made at implementation phase to understand the detail behind movements of specific groups of patients. Table 1 highlights some of the activity which gives an indicative position on this activity.

Ophthalmology

Below are the tables for Ophthalmology.

Ophthalmology Table 1: Patient activity data

Ophthalmology activity (1 August 2018 to 31 July 2023)							
Site	**2018-19** (1 Aug – 31 Mar)	**2019-20**	**2020-21**	**2021-22**	**2022-23**	**2023-24** (1 Apr – 31 Jul)	**Total**
Aberaeron Integrated Care Centre	338	509	1854	804	1021	393	4919
Amman Valley Hospital	4130	6681	7064	7173	6229	2248	33525
Bronglais	650	2225	0	526	529	154	4084
Cardigan Integrated Care Centre	26	82	204	1509	1817	512	4150
Glangwili	13480	20225	5905	12487	15243	5682	73022
Prince Philip	4253	6037	2464	3520	5844	2126	24244
North Road Aberystwyth	5162	7983	2275	5079	5564	2064	28127
South Pembrokeshire	251	294	0	0	91	62	698
Withybush	5103	6710	3080	4960	5855	2085	27793
Werndale	0	0	2403	0	0	0	2403

Total	33393	50746	25249	36058	42193	15326	202965

(Source: www.hduhb.nhs.wales/clinical-services-consultation)

Between August 2018 and July 2023 there were 202,965 ophthalmology procedures across different sites. GGH had the most with 73,022 procedures. Amman Valley Hospital had 33,525 procedures, North Road (Aberystwyth) had 28,127 procedures, WGH had 27,793 procedures, and PPH had 24,244 procedures. Other sites such as Aberaeron ICC, Cardigan ICC, BGH, South Pembrokeshire Hospital, and Werndale had fewer procedures, ranging from 698 to 4,919. This shows that the activity varied a lot across different locations.

Ophthalmology Table 2: Activity by Current configuration and Option

It should be noted that this is an estimate based on analysis of the date range stated in the table. Therefore, these figures should be considered indicative at this stage.

2022-23	Bronglais	Glangwili	Prince Philip	Withybush	Community	TOTAL
Current	529	15243	5844	5855	14722	42193
Option A	0	21616	0	5855	14722	42193
Option B	529	0	21087	5855	14722	42193
Option C	529	21087	0	5855	14722	42193

In 2022-23, a total of 42,193 procedures were carried out across different locations. Under the Current service, GGH had 15,243 procedures, PPH had 5,844, WGH had 5,855, BGH had 529, and the community sites had 14,722.

For Option A, GGH would have 21,616 procedures, WGH would have 5,855, and the community would have 14,722. BGH and PPH would have no procedures.

For Option B, PPH would have 21,087 procedures, WGH would have 5,855, BGH would have 529, and the community would have 14,722. GGH would have no procedures.

For Option C, GGH would have 21,087 procedures, WGH would have 5,855, BGH would have 529, and the community would have 14,722. PPH would have no procedures.

Option A increases the number of procedures at GGH significantly compared to the Current service, while Option B shifts the procedures to PPH. Option C also increases procedures at GGH and eliminates them at PPH. WGH and the community remain constant across all options, and BGH has the same number of procedures in all options except Option A.

Ophthalmology Table 3: Patient Movement Activity Estimate by Option

It should be noted that this is an estimate based on analysis of the date range stated in the table. Therefore, these figures should be considered indicative at this stage.

2022-23	Bronglais	Glangwili	Prince Philip	Withybush	Community	TOTAL
Current	529	15243	5844	5855	14722	42193

Option A	529	6373	5844	0	0	6373
Option B	0	15243	15243	0	0	15243
Option C	0	5844	5844	0	0	5844
Option A - move to GGH *Option B - move to PPH* *Option C - move to GGH*						
Option A, B, C - move from Aberystwyth ICC to Cardigan/North Road. (AICC current to move - 393)						

For the year 2022-23, BGH had 529 procedures, GGHhad 15,243, PPH had 5,844, WGH had 5,855, and the community had 14,722, making a total of 42,193 procedures.

- **Option A**, BGH and PPH procedures move to GGH with BGH moving 529 procedures and PPH moving 5,844, totalling 6,373 procedures centralised to GGH.
- **Option B**, services are moved to PPH, totalling 15,243 procedures.
- **Option C**, PPH has 5,844 procedures moved to GGH.

Additionally, Options A, B, and C involve moving 393 services from Aberaeron ICC to Cardigan/North Road.

Orthopaedics

Below are the tables for Orthopaedics.

Orthopaedics Table 1: Patient activity data

Orthopaedics activity (1 August 2018 to 31 July 2023)						
Reporting Period	**Bronglais**	**Glangwili**	**Prince Philip**	**Withybush**	**Community**	**Total**
2018-19 (1 Aug – 31 Mar	3434	3975	8949	6011	1007	23376
2019-20	5204	5636	11635	10246	1336	34057
2020-21	2302	3190	1671	3653	500	11316
2021-22	3008	4276	4868	6420	958	19530
2022-23	3695	4501	5661	7449	832	22138
2023-24 (1 Apr - 31 Jul	1344	1645	2382	2841	180	8392
Total	**18987**	**23223**	**35166**	**36620**	**4813**	**118809**

(Source: www.hduhb.nhs.wales/clinical-services-consultation)

From August 2018 to July 2023, there were 118,809 orthopaedics activities across five locations. The busiest year was 2019-20 with 34,057 activities, while the quietest year was 2020-21 with 11,316 activities. Activity levels changed a lot over the years, with a

peak in 2019-20 and a big drop in 2020-21likely due to COVID-19. The data for 2023-24 is for a partial year, showing 8,392 activities to 31 July 2023.

Orthopaedics Table 2: Activity by Current configuration and Option

It should be noted that this is an estimate based on analysis of the date range stated in the table. Therefore, these figures should be considered indicative at this stage.

2022-23	Bronglais	Glangwili	Prince Philip	Withybush	Community	TOTAL
Current	3695	2753	5661	7449	2580	22138
Options A, B, C, D	3695	2753	5661	7449	2580	22138

In 2022-23, there were 22,138 orthopaedics activities across five locations. Both the 'Current' and 'Options A, B, C, D' categories show the same numbers. This means the options would not change the total, or the distribution of activities. However, movements may be impacted by regional working, which will be further refined at implementation phase. There would be an impact on activity numbers across all options as the options look to increase capacity. This is to be further refined at implementation phase.

Orthopaedics Table 3: Patient Movement Activity Estimate by Option

It should be noted that this is an estimate based on analysis of the date range stated in the table. Therefore, these figures should be considered indicative at this stage.

2022-23	Bronglais	Glangwili	Prince Philip	Withybush	Community	TOTAL
Current	3695	2753	5661	7449	2580	22138
Options A, B, C, D	0	0	0	0	0	0
All options - no impact on patient movements as options look to do more rather than move						
Options A, B, D - regional working may have an impact on activity, to be refined at implementation phase						
Option D - more activity at BGH to be refined at implementation phase						

For the year 2022-23, BGH had 3,695 activities, GGH had 2,753, PPH had 5,661, WGH had 7,449, and the community had 2,580, making a total of 22,138 activities.

- **Options A, B, C, and D**, there is no movement of orthopaedic services at any location.

All options aim to increase activity, so there is no known impact on patient movements.

Options A, B, and D suggest that regional working may affect activity, with details to be decided at implementation phase. Option D also indicates that more activity would be added at BGH, with specifics to be determined during the implementation phase.

Radiology

Below are the tables for Radiology.

Radiology Table 1: Patient activity data

Radiology service activity (1 May 2019 – 31 July 2023)							
Site	**2019** (1 May – 31 Dec)	**2020**	**2021**	**2022**	**2023** (1 Jan – 31 Jul)	**Total**	**% of Total**
Withybush	53872	74447	98346	116060	75907	**418632**	**28%**
Glangwili	55062	73359	100560	108765	71728	**409474**	**27%**
Prince Philip	53270	69157	95140	102349	70266	**390182**	**26%**
Bronglais	30515	39045	54444	60421	39373	**223798**	**15%**
Cardigan Integrated Care Centre / Cardigan and District Memorial Hospital	1313	3709	5675	9859	6238	**26794**	**2%**
Tenby Hospital	3055	3421	5181	6385	6147	**24189**	**2%**
Llandovery Hospital	552	390	1190	1397	671	**4200**	**<1%**
South Pembrokeshire Hospital	314	165	146	2	0	**627**	**<1%**

(Source: www.hduhb.nhs.wales/clinical-services-consultation)

From May 2019 to July 2023 there were 1,493,896 radiology activities across several sites. WGH had the most with 418,632 activities (28% of the total). GGH followed with 409,474 activities (27%), and PPH had 390,182 activities (26%). BGH recorded 223,798 activities (15%). Smaller sites such as Cardigan ICC, Tenby Hospital, Llandovery Hospital, and South Pembrokeshire Hospital had fewer activities, making up 2% or less of the total.

Radiology Table 2: Activity by Current configuration and Option

It should be noted that this is an estimate based on analysis of the date range stated in the table. Therefore, these figures should be considered indicative at this stage.

2022-23	Bronglais	Glangwili	Prince Philip	Withybush	Cardigan ICC	Tenby	Llandovery	South Pembs	TOTAL
Current	60421	108765	102349	116060	9859	6385	1397	2	405238
Options A, B, C, D	60421	108765	103746	116062	9859	6385	0	0	405238

In 2022-23, there were 405,238 radiology activities across different sites. Both the ‘Current’ and ‘Options A, B, C, D’ categories show the same total but have small differences in where the activities take place. The ‘Current’ category includes 60,421 activities at BGH, 108,765 at GGH, 102,349 at PPH, 116,060 at WGH, 9,859 at Cardigan ICC, 6,385 at Tenby, 1,397 at Llandovery, and 2 at South Pembrokeshire hospitals. The ‘Options A, B, C, D’ category has similar numbers but shows 103,746 activities at PPH,

116,062 at WGH, and zero activities at Llandovery and South Pembrokeshire hospitals. The main differences are in the activities for pph, Llandovery, and South Pembrokeshire hospitals.

Within the options, interventional radiology is split from diagnostic radiology which will impact activity across sites. This is to be further refined at implementation phase.

Radiology Table 3: Patient Movement Activity Estimate by Option

It should be noted that this is an estimate based on analysis of the date range stated in the table. Therefore, these figures should be considered indicative at this stage.

For the year 2022-23, the service shows BGH had 60,421 activities, GGH had 108,765, PPH had 102,349, Withybush had 116,060, Cardigan ICC had 9,859, Tenby had 6,385, Llandovery had 1,397, and South Pembrokeshire had 2, making a total of 405,238 activities.

- **Options A, B, C, and D**, there are no activity movements at BGH, GGH, Cardigan ICC or Tenby. Prince Philip receives activity from Llandovery, totalling 1,397 activities, and South Pembrokeshire has 2 activities move to WGH.

2022-23	Bronglais	Glangwili	Prince Philip	Withybush	Cardigan ICC	Tenby	Llandovery	South Pembs.	TOTAL
Current	60421	108765	102349	116060	9859	6385	1397	2	405238
Option A, B, C, D	0	0	1397	2	0	0	1397	2	1399
Option A, B, C, D - South Pembrokeshire and Llandovery patients moving to WGH and PPH (assumed moving to closest acute site)									
Interventional activity split has not been included, to be further refined at implementation phase									

Options involve moving patients from South Pembrokeshire and Llandovery hospitals to WGH and PPH, assuming they move to the closest acute site. The details of the interventional split within the activities data will be decided at implementation phase.

Stroke

Below are the tables for Stroke.

Stroke Table 1: Patient admissions data

Stroke admissions activity (1 August 2018 to 31 March 2023)					
Reporting period	**Bronglais**	**Glangwili**	**Prince Philip**	**Withybush**	**Total**
2018-19 (1 Aug – 31 Mar)	26	47	56	54	183
2019-20	145	205	186	231	767
2020-21	121	211	165	196	693
2021-22	132	210	172	210	724
2022-23	137	227	129	224	717
Stroke admissions activity (1 April 2023 to 31 March 2024)					

2023-24	166	246	171	209	792
Total	**727**	**1146**	**879**	**1124**	**3876**
Total as % of overall activity	**19%**	**30%**	**23%**	**29%**	**100%**

(Source: www.hduhb.nhs.wales/clinical-services-consultation)

Between August 2018 and March 2023, the number of people admitted for strokes at BGH, GGH, PPH, and WGH varied. In 2018-19 (partial year), there were 183 admissions. This number jumped to 767 in 2019-20. The following year, it dropped to 693, then went up again to 724 in 2021-22. In 2022-23, it decreased slightly to 717, and in 2023-24, it increased to 792.

Over the whole period, BGH had 727 admissions, GGH had 1146, PPH had 879, and WGH had 1124, making a total of 3876 stroke admissions across all hospitals.

Stroke Table 2: Activity by Current configuration and Option

It should be noted that this is an estimate based on analysis of the date range stated in the table. Therefore, these figures should be considered indicative at this stage.

2023-24	Bronglais	Glangwili	Prince Philip	Withybush	Community	TOTAL
Current	166	246	171	209	0	792
Option A	0	0	390	357	0	747
Option B	0	0	724	0	0	724
Estimates from NICE guidelines data have been used to represent that 10.9% of patients who present with a suspected Stroke are known to be well within between 12 hours and 24 hours. We have based our figures on the remaining 89.1% of patients that would require transfer. *Option B - 357 patients are estimated to be transferred to the Withybush Stroke Unit following initial admission at PPH.*						

In 2023-24, the number of stroke admissions at BGH, GGH, PPH, and WGH was 792. BGH had 166 admissions, GGH had 246, PPH had 171, and WGH had 209.

In Option A, PPH would have 390 admissions, and WGH would have 357, totalling 747 admissions.

In Option B, PPH would have 724 admissions initially with an estimated 357 patients that would be transferred to receive ongoing care at WGH following their initial care at PPH.

Stroke Table 3: Patient Movement Activity Estimate by Option

It should be noted that this is an estimate based on analysis of the date range stated in the table. Therefore, these figures should be considered indicative at this stage.

2023-24	Bronglais	Glangwili	Prince Philip	Withybush	Community	TOTAL
Current	166	246	171	209	0	792

Option A	166	246	246	166	0	412
Option B	166	246	412	166	0	412
Option A - BGH move to WGH, GGH move to PPH *Option B - BGH/GGH move to PPH first 72hrs then BGH move to WGH - different hours to Option A. Assumes patients move to PPH then WGH*						

In 2023-24, there were 792 stroke admissions, with BGH having 166, GGH 246, PPH 171 and WGH 209.

- **Option A** involves moving patients from BGH to WGH and from GGH to PPH. BGH moves 166 admissions and GGH moves 246.
- **Option B** involves moving patients from BGH and GGH to PPH for the first 72 hours, then moving BGH patients to WGH, offering different hours compared to Option A.

Urology

Below are the tables for Urology.

Urology Table 1: Patient activity data

Urology activity (1 August 2018 to 31 July 2023)						
Reporting Period	**Bronglais**	**Glangwili**	**Prince Philip**	**Withybush**	**Werndale**	**Total**
2018-19 (1 Aug – 31 Mar)	2226	10530	6848	4937	0	24541
2019-20	1911	10967	6520	5431	0	24829
2020-21	620	6383	3168	2287	911	13369
2021-22	651	9842	3544	2944	0	16981
2022-23	1264	12741	4651	3230	0	21886
2023-24 (1 Apr – 31 Jul)	328	3285	713	750	0	5076
Total	**7000**	**53748**	**25444**	**19579**	**911**	**106682**

(Source: www.hduhb.nhs.wales/clinical-services-consultation)

From August 2018 to July 2023, urology activity at BGH, GGH, PPH, WGH, and Werndale hospital varied. The total number of activities was 106,682. GGH had the most with 53,748. BGH had 7,000 activities, PPH had 25,444, and WGH had 19,579. The yearly totals changed, with the highest being 24,829 in 2019-20 and the lowest being 13,369 in 2020-21, likely due to COVID-19. For 2023-24 (up to 31 July 2023) there were 5,076 activities.

Urology Table 2: Activity by Current configuration and Option

It should be noted that this is an estimate based on analysis of the date range stated in the table. Therefore, these figures should be considered indicative at this stage.

2022-23	Bronglais	Glangwili	Prince Philip	Withybush	Community	TOTAL
Current	1264	12741	4651	3230	0	21886
Proposed option	1264	3534	13858	3230	0	21886

For the year 2022-23, there were 21,886 urology activities across BGH, GGH, PPH, WGH, and community sites. In the 'Current' service, BGH had 1,264 activities, GGH had 12,741, PPH had 4,651, WGH had 3,230, and community sites had zero.

In the proposed option, GGH's activities would drop to 3,534 while PPH's would increase to include a proportion of activity from GGH and the Urgent Suspected Cancer procedures at BGH and WGH. Both the 'Current' service and the proposed option have the same total of 21,886 activities, but the distribution between sites is different.

Urology Table 3: Patient Movement Activity Estimate by Option

It should be noted that this is an estimate based on analysis of the date range stated in the table. Therefore, these figures should be considered indicative at this stage.

2022-23	Bronglais	Glangwili	Prince Philip	Withybush	Community	TOTAL
Current	1264	12741	4651	3230	0	21886
Proposed option	0	9207	9207	0	0	9207
Proposed option - Emergency only in GGH. Other activity (9207) moved - emergency/planned split within the inpatient/day case data to be refined at implementation phase (within this Urgent Suspected Cancer patient numbers at BGH and WGH may be affected)						

For the year 2022-23, the service shows BGH had 1,264 activities, GGH had 12,741, PPH had 4,651, and WGH had 3,230, making a total of 21,886 activities.

- **Proposed option** GGH would have 9,207 outpatient activities moved to PPH. The proposed option also considers a small number of patient moves for the bringing together of the Urgent Suspected Cancer diagnostic pathway to the PPH site, which could see (based on 2023-24 data) 125 activities moved from BGH and 154 activities moved from WGH.

Safe: Number of patients likely to need transfer when unwell and potential external service impacted.

In our evaluation criteria, we considered several factors to ensure the standards of patient care and safety. One of the key aspects we focused on was the estimated number of patient transfers that may be required for an unwell patient. Understanding the potential transfer requirements for each service is essential for optimising patient outcomes and resource allocation.

The table below describes the estimated patient transfers by option for each of the acute services, including EGS, critical care, and stroke. It is important to note that the analysis in the table below may differ from the insights above, as a different methodology was applied for assessing what transfers may be required by each service. These nuances are highlighted below:

- **Critical Care**: The learning from the temporary arrangement in place and actual data for PPH patients was applied. 55.5% of Level 3 admissions required a transfer, and 11.5% of Level 2 admissions required a transfer.
- **Stroke**: Stroke mimics were considered at the national audit level (52.8% of all suspected strokes may be mimics, meaning patients may present with stroke symptoms but are not having a stroke). National Institute for Health and Care Excellence (NICE) guideline data was applied, where 89.1% of strokes require an admission.
- **Emergency General Surgery**: Conversion to surgery data was used to assess the number of likely transfers between sites. For the patient group analysed, 22% of admissions required a theatre procedure.

Table 1: Transfer impact estimate on EGS, Critical Care and Stroke

Transfer Impact Estimate

	Assumption				Transfer Estimate Per Week		
	NEPTS	WAST	ACCTS	EST %	Option A	Option B	Option C
Emergency General Surgery		•		22.5%****	8	10	
Critical Care			•	Variable	8	4	1
Stroke		•		90%**	17	25	
Estimated total Acute Transfer Requests Per week*					**33**	**39**	**1**

(Source: www.hduhb.nhs.wales/clinical-services-consultation)

Deductions were made regarding which organisation may facilitate the transfer, but this has not yet been decided and would require further detailed planning. For EGS, this could be the Welsh Ambulance Service Trust (WAST) or the Adult Critical Care Transfer

Service (ACCTS). For Critical Care, transfers would need to be facilitated by ACCTS, as a doctor is sometimes required to support the transfer of sickest patients. Both of these services currently support Hywel Dda University Health Board (HDdUHB) and may need to be scaled for any of these options.

Representatives from WAST and ACCTS also supported conversations throughout the options development process. The information above is crucial as it has informed our thinking on the likely number of inter-hospital transfers required. It will be key in supporting planning conversations with external partners such as ACCTS and WAST in implementing a potential service change.

Safe: Impact on external services

The information in each of the graphics and tables in this section reflects how WAST, ACCTS and Non-Emergency Patient Transport Service (NEPTS) supported our Phase 2 – Options Development process. This support included, but was not limited to, advice on inter-hospital travel times, feedback on current pressures in the healthcare transport system, and considerations for assessing the options.

The feedback and advice provided by these three services was captured and incorporated into the SWOT analysis. For example, one piece of advice received was that there is a lead time of up to 18 months for scaling up new inter-hospital transfer demand, which includes the staffing and resources needed to implement a planned change and that some of this work is essential in implementing potential changes.

Adult Critical Care Transfer Service

The first table below relates to ACCTS and is a heat map table which describes a green zone within 60 minutes and escalates to amber and red for longer inter-hospital travel times. The ACCTS service is part of the Emergency Medical Retrieval and Transfer Service (EMRTS) which includes the Wales Air Ambulance Charity and currently operates within the HDdUHB area as clinically required to do so. A unique aspect of ACCTS is that the inter-hospital transfers are supported by doctors.

This information is important as it helps the Health Board understand how our sickest patients can be supported when being moved between sites.

Table 2: Acute Critical Care Transfer Services (ACCTS) travel time grid

South Team Travel Times

ACCTS South Response Times	Cardiff Heliport	Bronglais	Withybush	Glangwili	Prince Phillip	Singleton	Morriston	Neath and Port Talbot	Pricess of Wales	Royal Glamorgan	Llandough	UHW	Royal Gwent	The Grange	Nevil Hall	Prince Charles	London St Thomas	Birmingham QE	Bristol Southmead	Gloucester The Dean
Cardiff Heliport	N/A	2 Hours 30 Min	2 Hours	1 Hour 20 Min	1 Hour	1 Hour 15 Min	50 Minutes	45 Minutes	1 Hour	30 Minutes	10 Minutes	15 Minutes	25 Minutes	30 Minutes	50 Minutes	50 Minutes	3 Hours	2 Hours	1 Hour	1 Hour 15 Min
Bronglais	2 Hours 30 Min	N/A	1 Hour 40 Min	1 Hour 15 Min	1 Hour 45 Min	2 Hours	1 Hour 45 Min	2 Hours	2 Hours 10 Min	2 Hours 25 Min	2 Hours 30 Min	2 Hours 30 Min	2 Hours 30 Min	2 Hours 20 Min	2 Hours	2 Hours	5 Hours	2 Hours 50 Min	3 Hours	2 Hours 40 Min
Withybush	2 Hours	1 Hour 40 Min	N/A	45 Minutes	1 Hour 10 Min	1 Hour 20 Min	1 Hour 10 Min	1 Hour 20 Min	1 Hour 30 Min	1 Hour 45 Min	1 Hour 55 Min	1 Hour 55 Min	2 Hours	2 Hours 5 Min	2 Hours	1 Hour 45 Min	4 Hours 35 Min	3 Hours 40 Min	2 Hours 30 Min	2 Hours 50 Min
Glangwili	1 Hour 20 Min	1 Hour 15 Min	45 Minutes	N/A	30 Min	45 Min	30 Min	45 Min	1 Hour	1 Hour 10 Min	1 Hour 20 Min	1 Hour 20 Min	1 Hour 25 Min	1 Hour 30 Min	2 Hours	1 Hour 10 Min	4 Hours	3 Hours 5 Min	2 Hours	2 Hours 15 Min
Prince Phillip	1 Hour	1 Hour 45 Min	1 Hour 10 Min	30 Min	N/A	30 Min	20 Min	30 Min	45 Min	1 Hour	1 Hour 5 Min	1 Hour 5 Min	1 Hour 10 Min	1 Hour 20 Min	1 Hour 15 Min	1 Hour	3 Hours 45 Min	2 Hours 50 Min	1 Hour 40 Min	2 Hours
Singleton	1 Hour 15 Min	2 Hours	1 Hour 20 Min	45 Min	30 Min	N/A	25 Min	30 Min	45 Min	1 Hour	1 Hour	1 Hour	1 Hour 10 Min	1 Hour 15 Min	1 Hour 20 Min	1 Hour	3 Hours 45 Min	3 Hours	1 Hour 40 Min	2 Hours
Morriston	50 Minutes	1 Hour 45 Min	1 Hour 10 Min	30 Min	20 Min	25 Min	N/A	20 Min	30 Min	45 Min	50 Min	50 Min	1 Hour	1 Hour 5 Min	1 Hour 5 Min	45 Min	3 Hours 35 Min	2 Hours 40 Min	1 Hour 30 Min	1 Hour 50 Min
Neath and Port Talbot	45 Minutes	2 Hours	1 Hour 20 Min	45 Min	30 Min	30 Min	20 Min	N/A	25 Min	35 Min	40 Min	40 Min	50 Min	55 Min	1 Hour 5 Min	45 Min	3 Hours 45 Min	3 Hours	1 Hour 20 Min	1 Hour 40 Min
Princess of Wales	1 Hour	2 Hours 10 Min	1 Hour 30 Min	1 Hour	45 Min	45 Min	30 Min	25 Min	N/A	25 Min	45 Min	30 Min	40 Min	45 Min	1 Hour 5 Min	50 Min	3 Hours 15 Min	2 Hours 20 Min	1 Hour 10 Min	1 Hour 30 Min
Royal Glamorgan	30 Minutes	2 Hours 25 Min	1 Hour 45 Min	1 Hour 10 Min	1 Hour	1 Hour	45 Min	35 Min	25 Min	N/A	25 Min	25 Min	30 Min	35 Min	55 Min	40 Min	3 Hours 5 Min	2 Hours 10 Min	1 Hour	1 Hour 20 Min
Llandough	10 Minutes	2 Hours 30 Min	1 Hour 55 Min	1 Hour 20 Min	1 Hour 5 Min	1 Hour	50 Min	40 Min	45 Min	25 Min	N/A	20 Min	30 Min	40 Min	1 Hour	45 Min	3 Hours 5 Min	2 Hours 10 Min	1 Hour	1 Hour 20 Min
UHW	15 Minutes	2 Hours 30 Min	1 Hour 55 Min	1 Hour 20 Min	1 Hour 5 Min	1 Hour	50 Min	40 Min	30 Min	25 Min	20 Min	N/A	20 Min	30 Min	50 Min	40 Min	3 Hours	2 Hours	50 Min	1 Hour 10 Min
Royal Gwent	25 Minutes	2 Hours 30 Min	2 Hours	1 Hour 25 Min	1 Hour 10 Min	1 Hour 10 Min	1 Hour	50 Min	40 Min	30 Min	30 Min	20 Min	N/A	15 Min	35 Min	50 Min	2 Hours 45 Min	1 Hour 50 Min	40 Min	1 Hour
The Grange	30 Minutes	2 Hours 20 Min	2 Hours 5 Min	1 Hour 30 Min	1 Hour 20 Min	1 Hour 15 Min	1 Hour 5 Min	55 Min	45 Min	35 Min	40 Min	30 Min	15 Min	N/A	25 Min	45 Min	2 Hours 45 Min	1 Hour 50 Min	40 Min	1 Hour
Nevil Hall	50 Minutes	2 Hours	2 Hours	2 Hours	1 Hour 15 Min	1 Hour 20 Min	1 Hour 5 Min	1 Hour 5 Min	1 Hour 5 Min	55 Min	1 Hour	50 Min	35 Min	25 Min	N/A	30 Min	3 Hours	1 Hour 40 Min	55 Min	1 Hour
Prince Charles	50 Minutes	2 Hours	1 Hour 45 Min	1 Hour 10 Min	1 Hour	1 Hour	45 Min	45 Min	50 Min	40 Min	45 Min	40 Min	50 Min	45 Min	30 Min	N/A	3 Hours 20 Min	2 Hours	1 Hour 15 Min	1 Hour 20 Min
London St Thomas	3 Hours	5 Hours	4 Hours 35 Min	4 Hours	3 Hours 45 Min	3 Hours 45 Min	3 Hours 35 Min	3 Hours 45 Min	3 Hours 15 Min	3 Hours 5 Min	3 Hours 5 Min	3 Hours	2 Hours 45 Min	2 Hours 45 Min	3 Hours	3 Hours 20 Min	N/A	2 Hours 30 Min	2 Hours 25 Min	2 Hours 30 Min
Birmingham QE	2 Hours	2 Hours 50 Min	3 Hours 40 Min	3 Hours 5 Min	2 Hours 50 Min	3 Hours	2 Hours 40 Min	3 Hours	2 Hours 20 Min	2 Hours 10 Min	2 Hours 10 Min	2 Hours	1 Hour 50 Min	1 Hour 50 Min	1 Hour 40 Min	2 Hours	2 Hours 30 Min	N/A	1 Hour 35 Min	1 Hour
Bristol Southmead	1 Hour	3 Hours	2 Hours 30 Min	2 Hours	1 Hour 40 Min	1 Hour 40 Min	1 Hour 30 Min	1 Hour 20 Min	1 Hour 10 Min	1 Hour	1 Hour	50 Min	40 Min	40 Min	55 Min	1 Hour 15 Min	2 Hours 25 Min	1 Hour 35 Min	N/A	45 Min
Gloucester The Dean	1 Hour 15 Min	2 Hours 40 Min	2 Hours 50 Min	2 Hours 15 Min	2 Hours	2 Hours	1 Hour 50 Min	1 Hour 40 Min	1 Hour 30 Min	1 Hour 20 Min	1 Hour 20 Min	1 Hour 10 Min	1 Hour	1 Hour	1 Hour	1 Hour 20 Min	2 Hours 30 Min	1 Hour	45 Min	N/A

0 - 29 Min	30 - 59 Min	1 - 1.5 Hours	1.5 - 2 Hours	2 - 2.5 Hours	2.5 - 3 Hours	3 - 3.5 Hours	3.5 Hours Plus

The table below, supplied by WAST, supports the analysis of non-urgent and urgent (lights and sirens) travel times between HDdUHB's main hospital sites and those within and beyond the Health Board.

On a typical Monday at 09:00 in 2023, non-urgent transfers between hospitals range from 18 minutes (PPH to Morriston Hospital (MH)) to 2 hours, 17 minutes (BGH to Princess Royal, Telford). Emergency transfers with lights and sirens are faster, ranging from 14 minutes (PPH to MH) to 1 hour 53 minutes (BGH to Ysbyty Gwynedd). These times highlight the varying travel durations for patient transfers between key hospitals, depending on urgency.

This information is crucial as it provides an indication of the likely inter-hospital travel times using the WAST service and will inform implementation planning for any potential service changes.

Table 3: WAST non-urgent/urgent transfer times

2023 Monday 09:00					
Hospitals		Non-urgent		Lights and sirens	
From	To	Hours	Minutes	Hours	Minutes
Bronglais	Glangwili	1	25	1	4
Bronglais	Withybush	1	51	1	25
Bronglais	Prince Philip	1	50	1	29
Bronglais	Royal Shrewsbury	1	55	1	32

Bronglais	Princess Royal	2	17	1	52
Bronglais	Ysbyty Gwynedd	2	12	1	53
Bronglais	Morriston (MH)	1	49	1	30
Glangwili	Morriston	0	34	0	28
Glangwili	Prince Philip	0	34	0	27
Glangwili	Withybush	0	42	0	38
Prince Philip	Morriston	0	18	0	14
Prince Philip	Withybush	1	7	0	58
Withybush	Morriston	1	6	0	59

(Source: www.hduhb.nhs.wales/clinical-services-consultation)

Non-Emergency Patient Transfer Service (NEPTS)

The data used within the Clinical Services Plan (CSP) follows the application of findings from the HDdUHB patient and visitor transport survey (www.hduhb.nhs.wales/clinical-services-consultation). The table estimates the potential patients requesting transport support based on any site location, indicating that 2% of patients requiring a service will request assistance for transportation.

It is important to note that NEPTS has specific eligibility criteria to support patient transfer requests. For example, priority is given to patients requiring cancer treatment over routine appointment requests.

This information is crucial as it provides an indication of the likely number of requests for support in accessing routine appointments. Understanding these estimates helps in planning and resource allocation, informing transport reviews and workstreams that look to improve ways in which patients can be supported where needed to access services.

NEPTS feedback, included within the SWOT analysis (see: www.hduhb.nhs.wales/clinical-services-consultation), emphasises the need to consider the impact on NEPTS when bringing services together. For instance, if patients' average journey times increase, it may necessitate additional resources to support transport requests. This consideration is vital for optimising transport services and ensuring timely and efficient patient transfers.

Table 4: Indicative routine requests estimate based on 12 months 2023-2024 data at 2% of activity

Service	Transport request estimate
Urology	490
Trauma and Orthopaedics	953
Ophthalmology	855
Dermatology	295
Endoscopy	195

(Source: www.hduhb.nhs.wales/clinical-services-consultation)

Patients Insights | Powys and Gwynedd

The tables below illustrate information received from the HDdUHB data set regarding Long Term Agreements (LTAs) for patients accessing services within the Health Board who reside in either a Gwynedd or Powys postcode. The services illustrated are those within the scope of the CSP.

Each table describes the Elective (planned/routine) or Non-Elective (urgent/emergency) figures for the 2023/2024 financial year reporting period.

Table 5: Patients from Gwynedd (Betsi Cadwaladr University Health Board (BCUHB)) accessing CSP services. Data from APR2023-MAR2024

Betsi Cadwaladr University Health Board patients accessing Hywel Dda CSP services		
Service	Routine care	Urgent care
Dermatology	8	-
Emergency General Surgery	-	82
Endoscopy	285	3
Ophthalmology	928	-
Stroke	69	30*
Urology	382	14

(Source: www.hduhb.nhs.wales/clinical-services-consultation)

The table above indicates the number of patient activities recorded in the Hywel Dda electronic system, known as Welsh Patient Administration System (WPAS), for the 2023/2024 period. It should be noted that not all activities related to the services identified above are delivered from the BGH site. The data pertains to the delivery of services for this cohort of patients within the HDdUHB system.

*Note: Stroke data shown here is extracted from the WPAS system and not the Sentinel Stroke National Audit Programme (SSNAP) system used elsewhere within the programme. Therefore, it may differ from other analyses related to stroke services.

Table 6: Patients accessing HDdUHB services from Powys (Powys Teaching Health Board). Data from APR2023-MAR2024

Powys Teaching Health Board patients accessing Hywel Dda CSP services		
Service	Routine care	Urgent care
Critical Care	-	43
Dermatology	11	-
Emergency General Surgery	-	117
Endoscopy	487	7
Ophthalmology	772	29
Orthopaedics	646	-

Stroke	54	61
Urology	220	22

(Source: www.hduhb.nhs.wales/clinical-services-consultation)

The table above indicates the number of activities related to patients accessing HDdUHB services from the Powys Teaching Health Board (PTHB) area. It should be noted that patient activity is delivered throughout the HDdUHB system.

The information above regarding BCUHB and PTHB patients is important to the CSP programme as it allows those involved or supporting alternative options to understand the number of people that could be affected beyond the HDdUHB area.

Accessible: Patient travel times to sites

To further understand patient and travel insights, we considered various factors including travel times for each service, Lower Super Output Area (LSOA) averages, conveyance times by WAST and ACCTS, and travel times for non-urgent cases in heavy traffic. Each of these elements was incorporated into our evaluation criteria for accessibility. This information was considered and fed into the SWOT analysis, ensuring an assessment of accessibility and transport-related impacts. (www.hduhb.nhs.wales/clinical-services-consultation)

Table 7: Drive time analysis in minutes by Lower Super Output Area averages

Drive Time Analysis (average in minutes) from locality to a specific site.						
Locality	Average of BGH Travel Heavy	Average of GGH Travel Heavy	Average of PPH Travel Heavy	Average of WGH Travel Heavy	Average of SH Travel Heavy	Average of MH Travel Heavy
Carmarthenshire	100	30	32	68	46	35
Ceredigion	38	64	97	94	109	91
Pembrokeshire	116	51	78	29	89	72
Grand Total	**93**	**43**	**59**	**61**	**72**	**58**

(Source: www.hduhb.nhs.wales/clinical-services-consultation)

(Key: BGH – Bronglais, GGH – Glangwili, PPH – Prince Philip, WGH – Withybush, SH – Singleton Hospital, MH - Morriston Hospital)

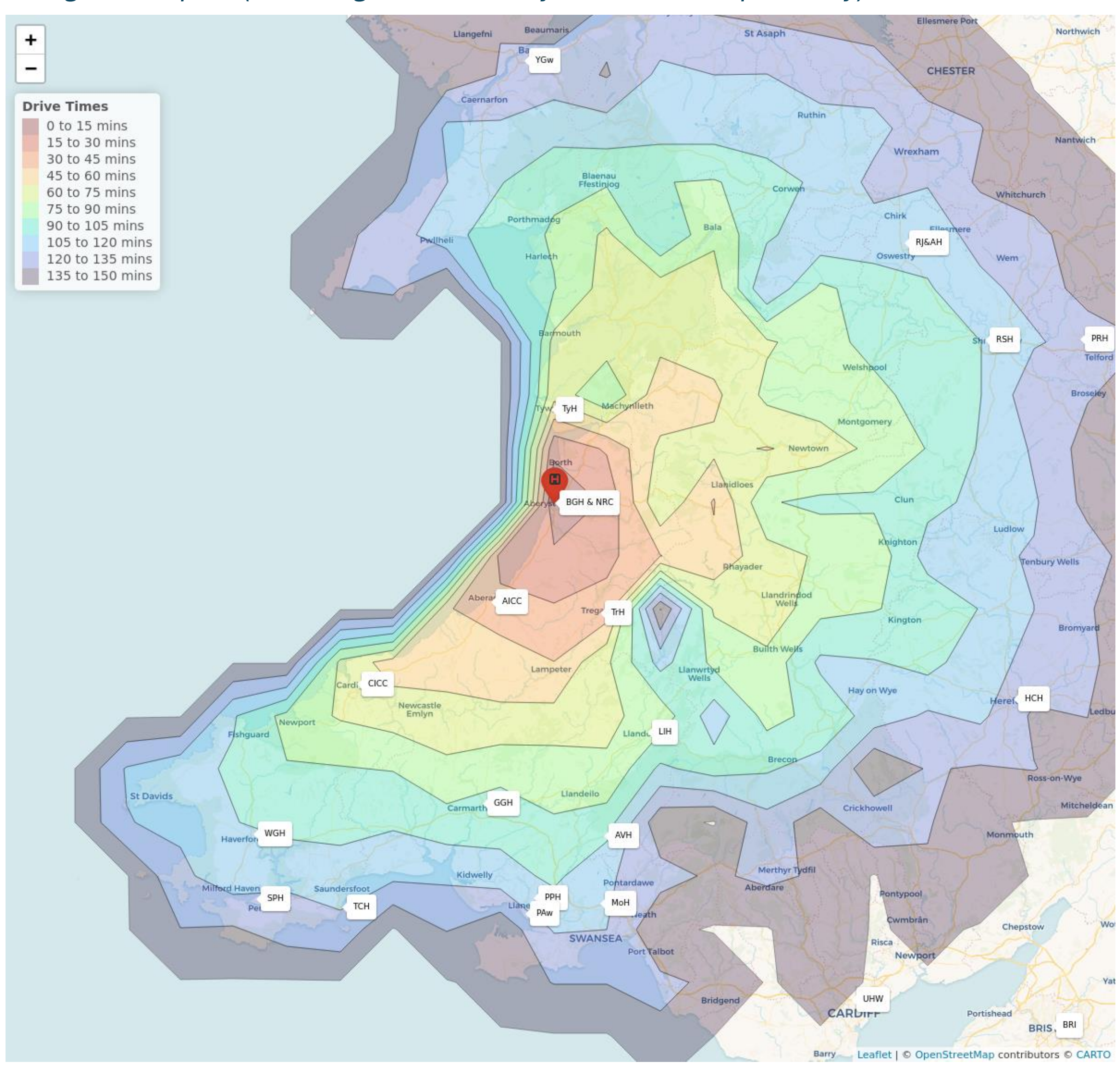
Isochrone mapping

Using detailed information from the LSOA data set, we have produced Isochrone maps for readers who prefer visual illustrations over data-centric tables. These maps have been developed for each individual site within HDdUHB (BGH and North Road Eye Clinic, Aberystwyth are in the same isochrone due to their close proximity to each other, including both main hospital sites and community hospital sites).

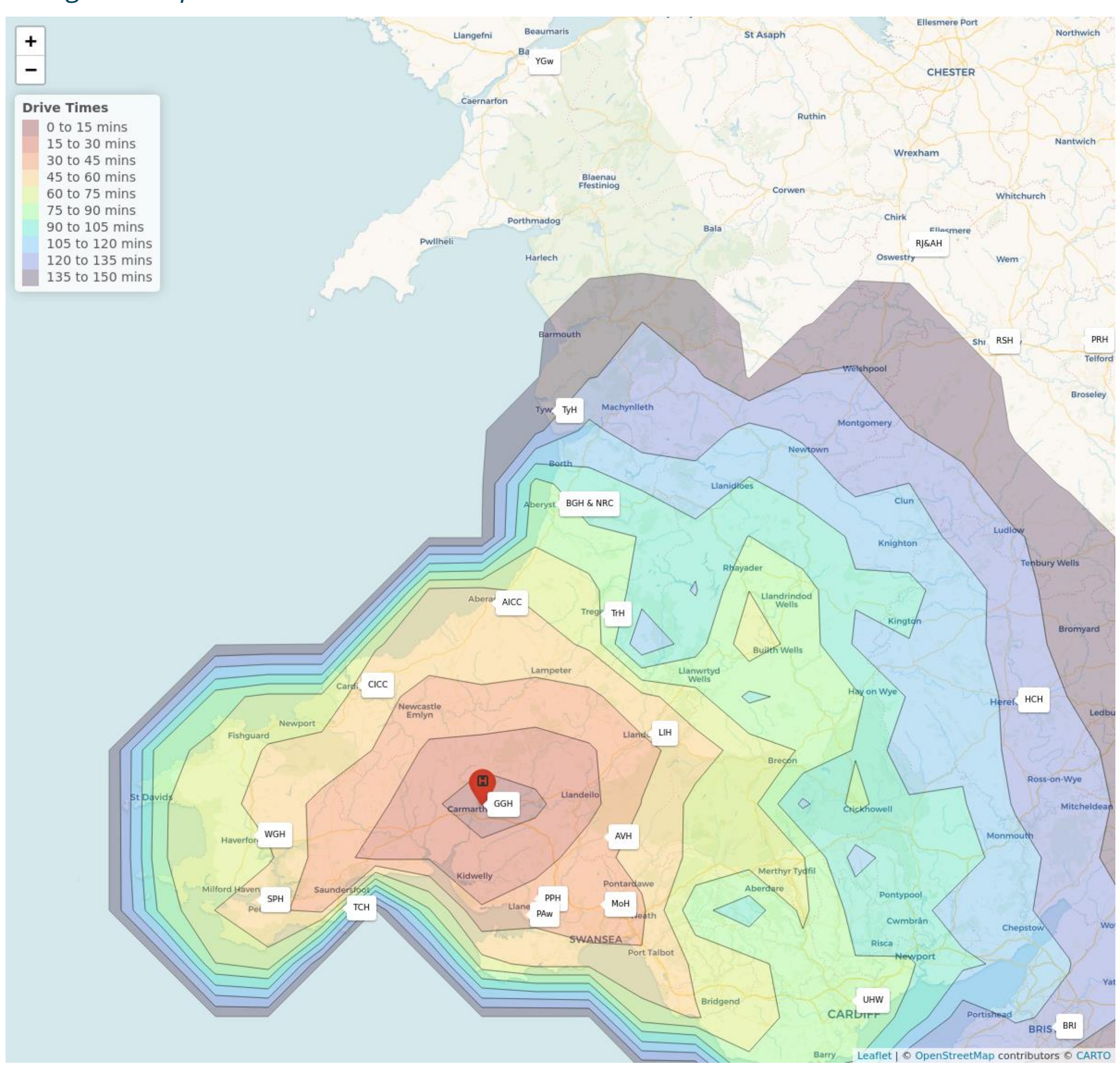
Readers can visually deduce travel times from their current location to a specific site and use these illustrations to consider journey and travel times between different options. This approach provides a clear and intuitive way to understand accessibility and travel implications

Main sites:

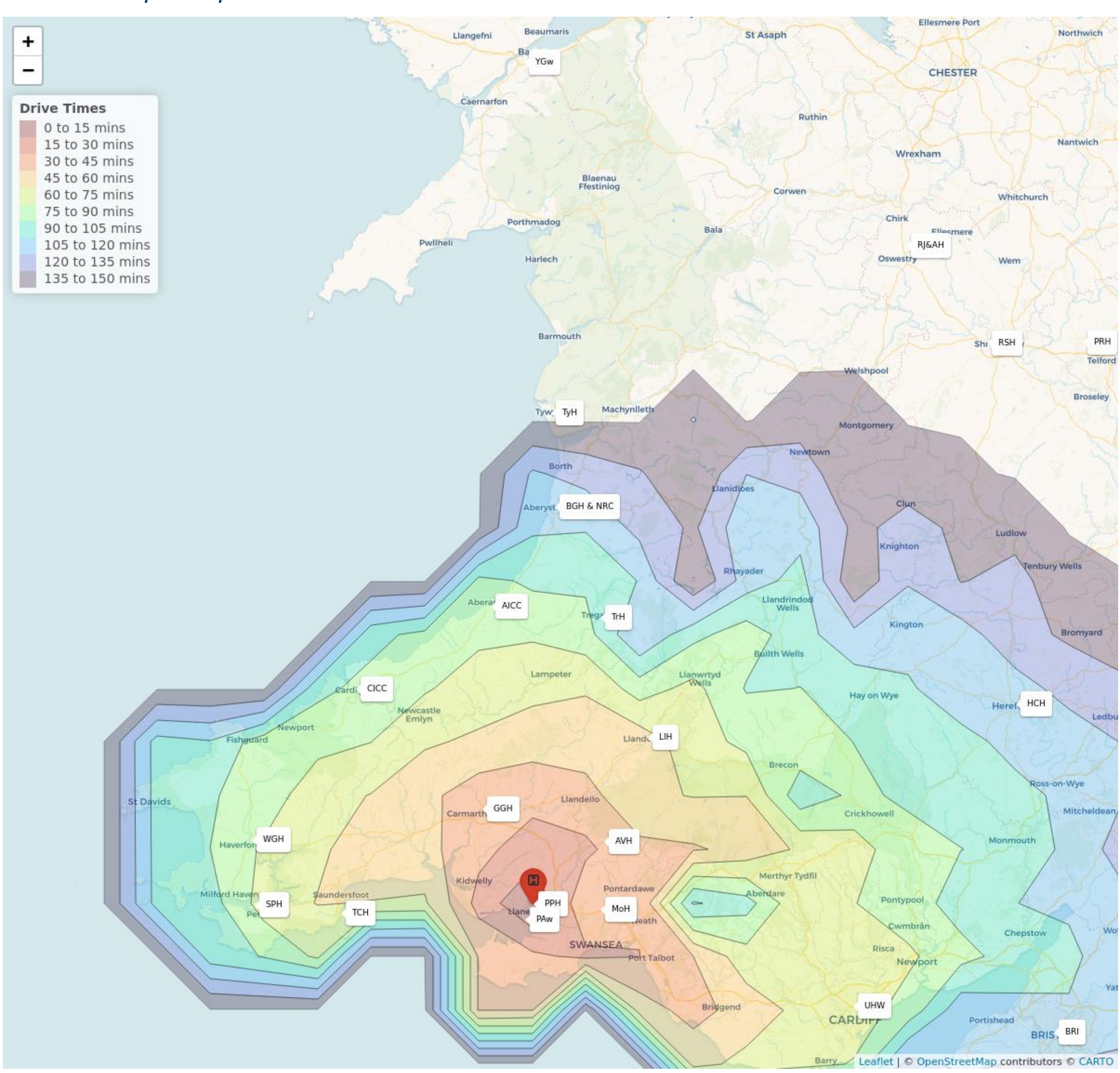
Bronglais Hospital (including North Road Eye Clinic due to proximity)



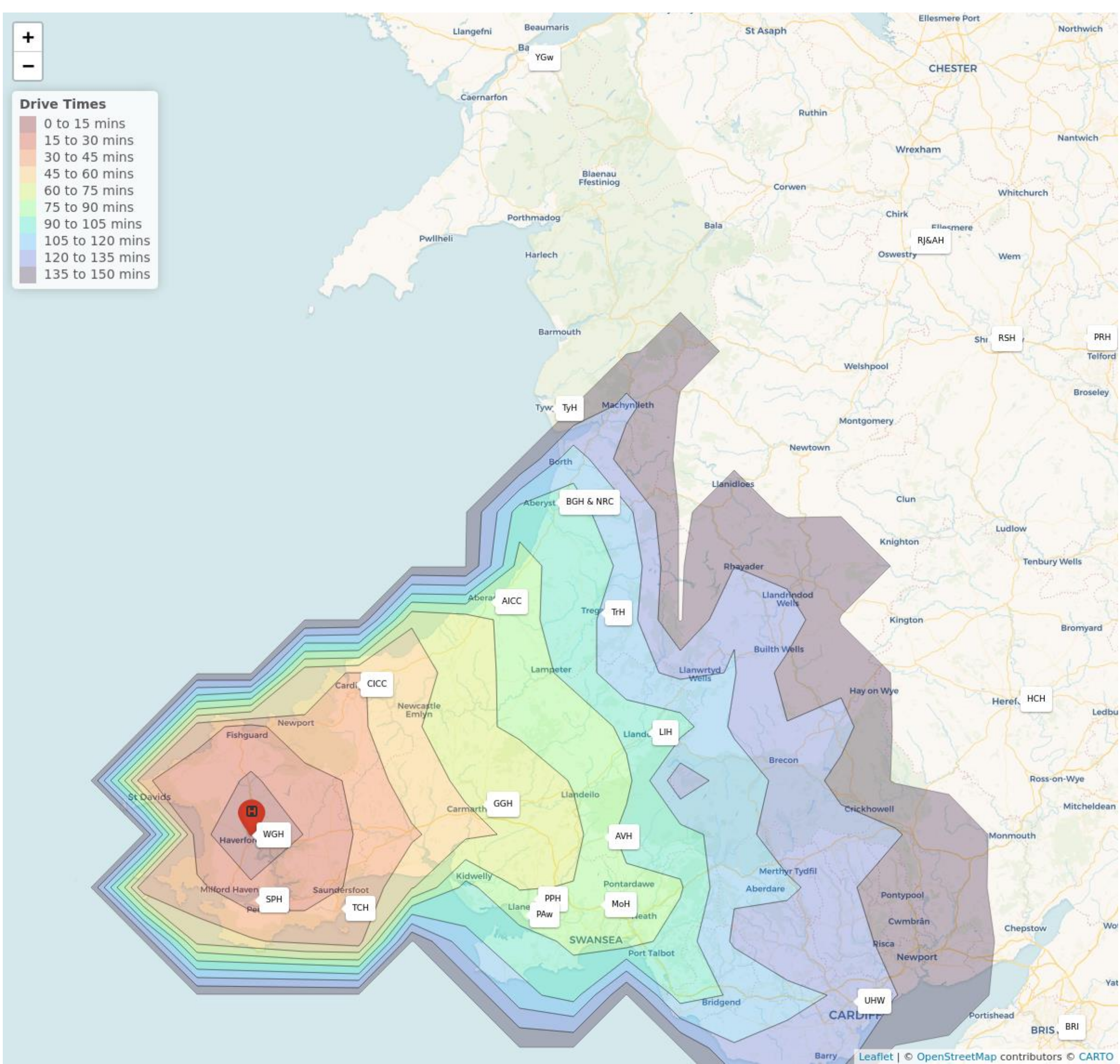
Glangwili Hospital



Prince Philip Hospital

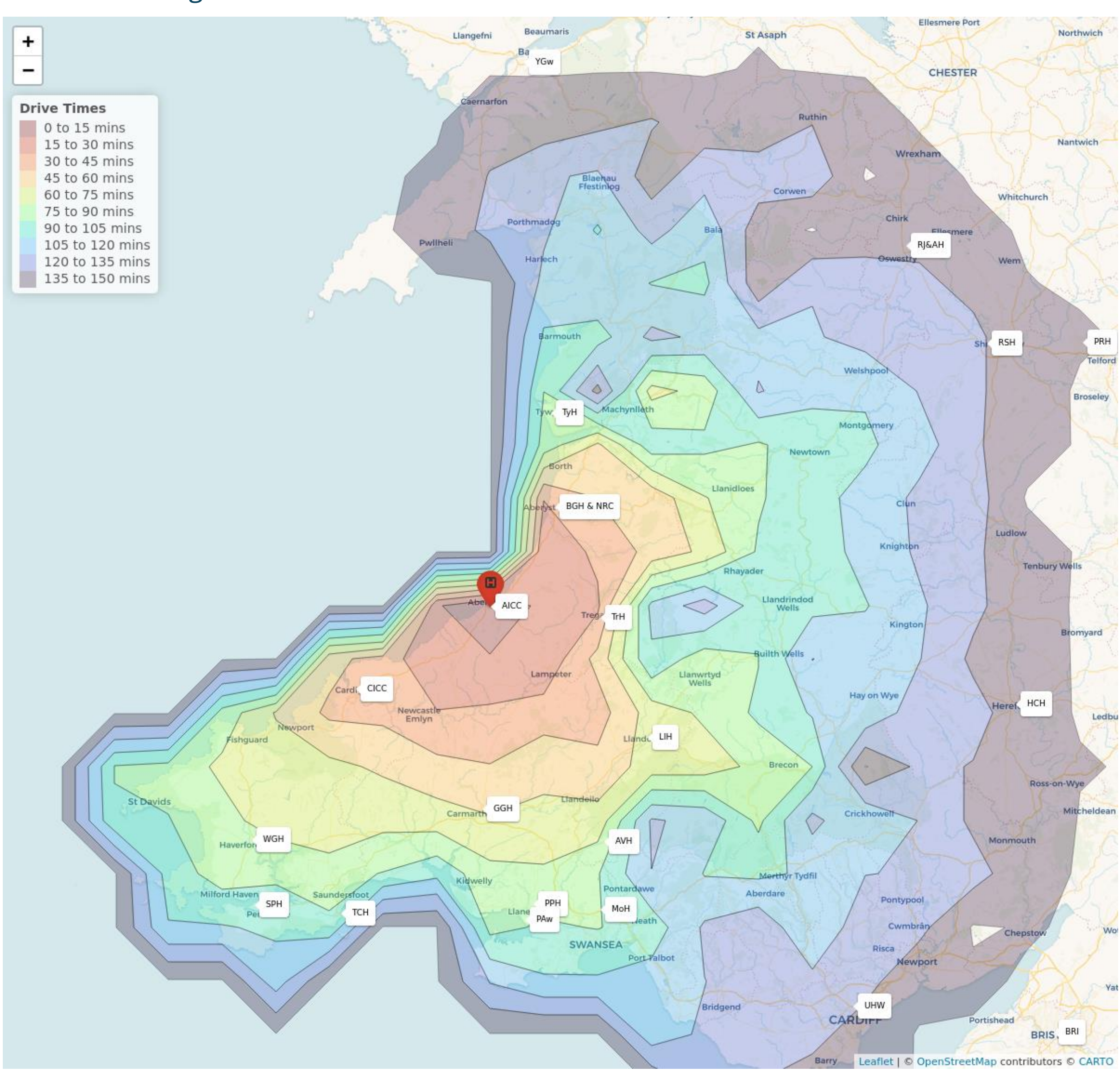


Withybush Hospital

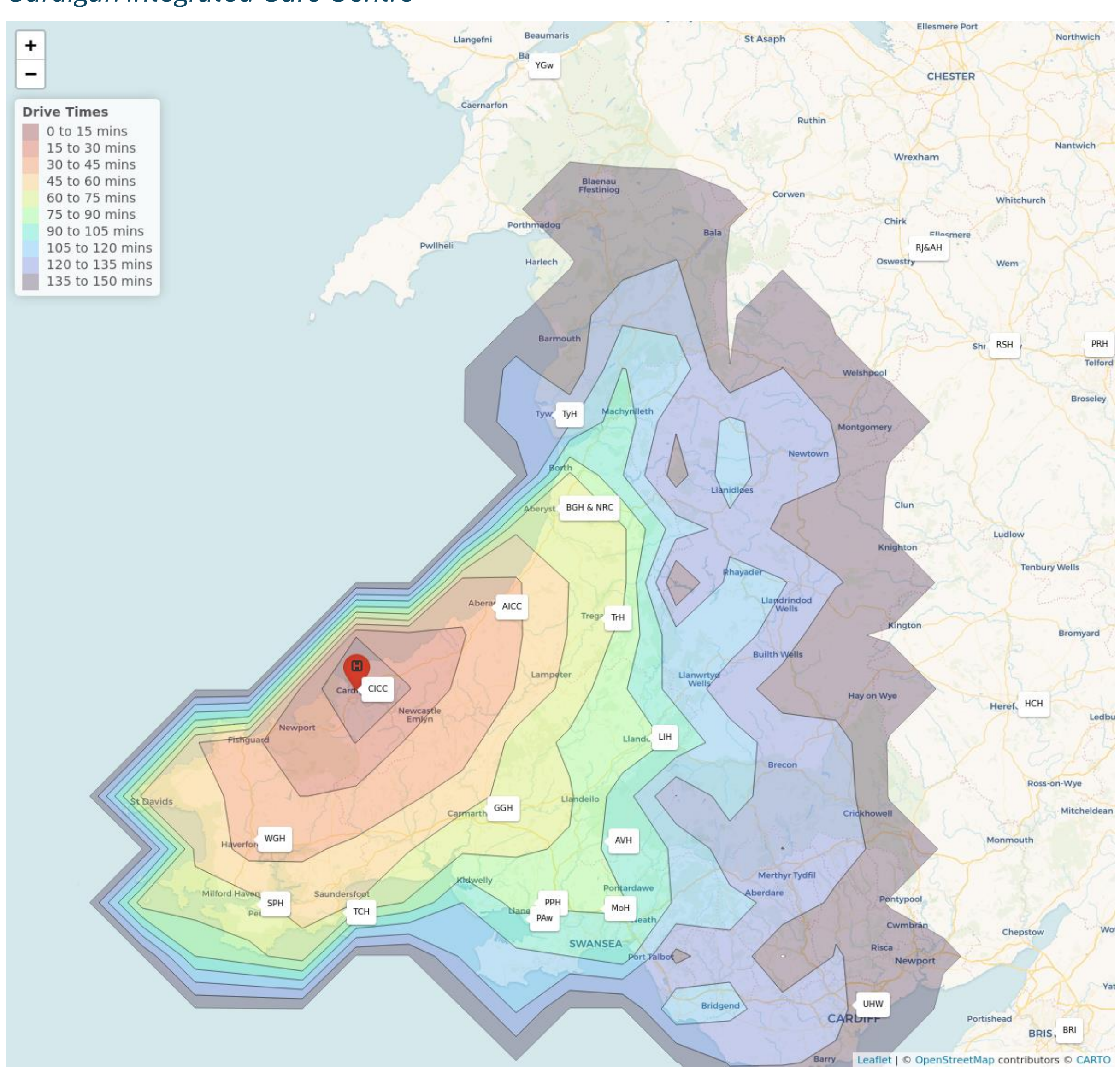


Community sites:

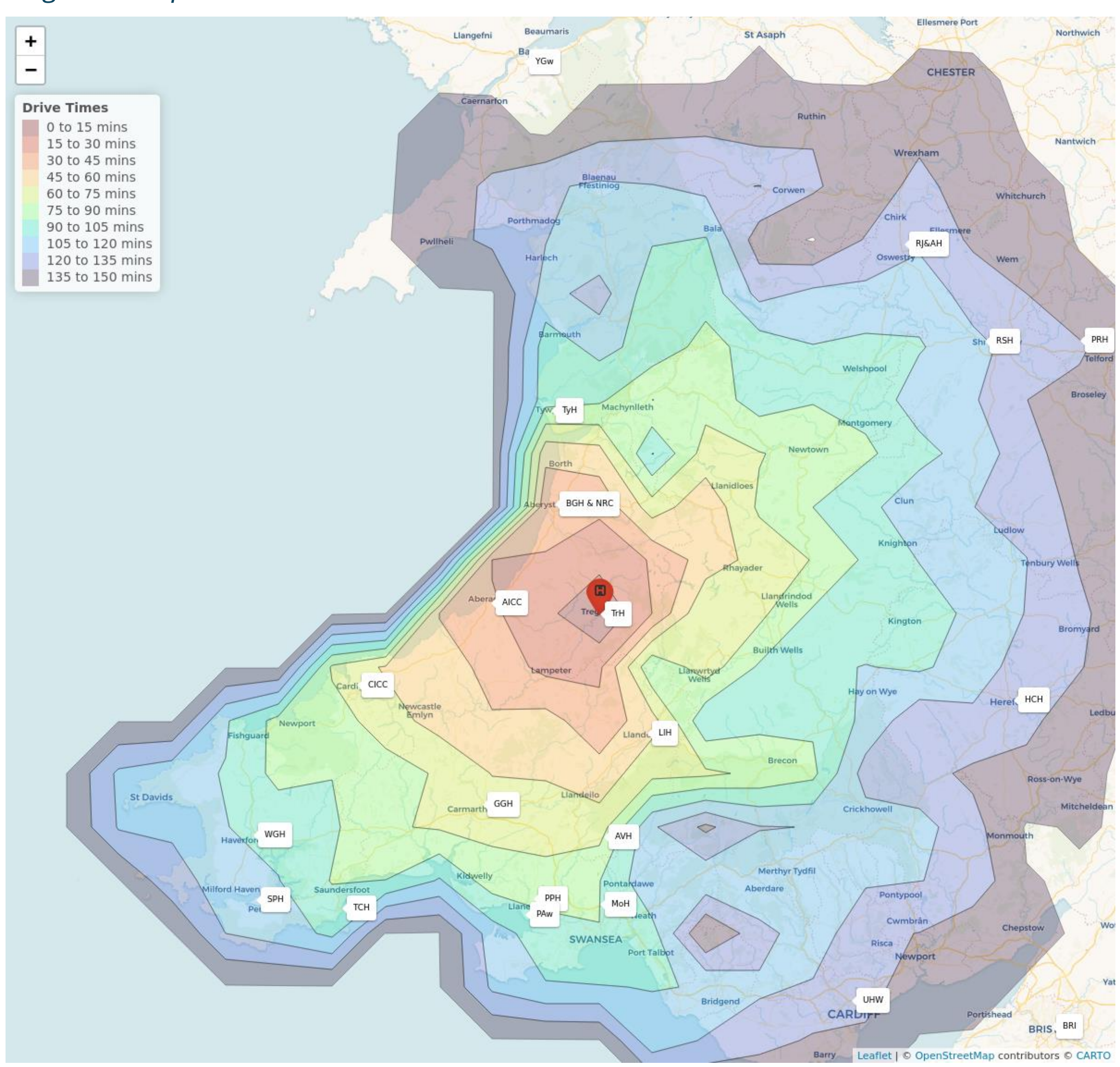
Aberaeron Integrated Care Centre



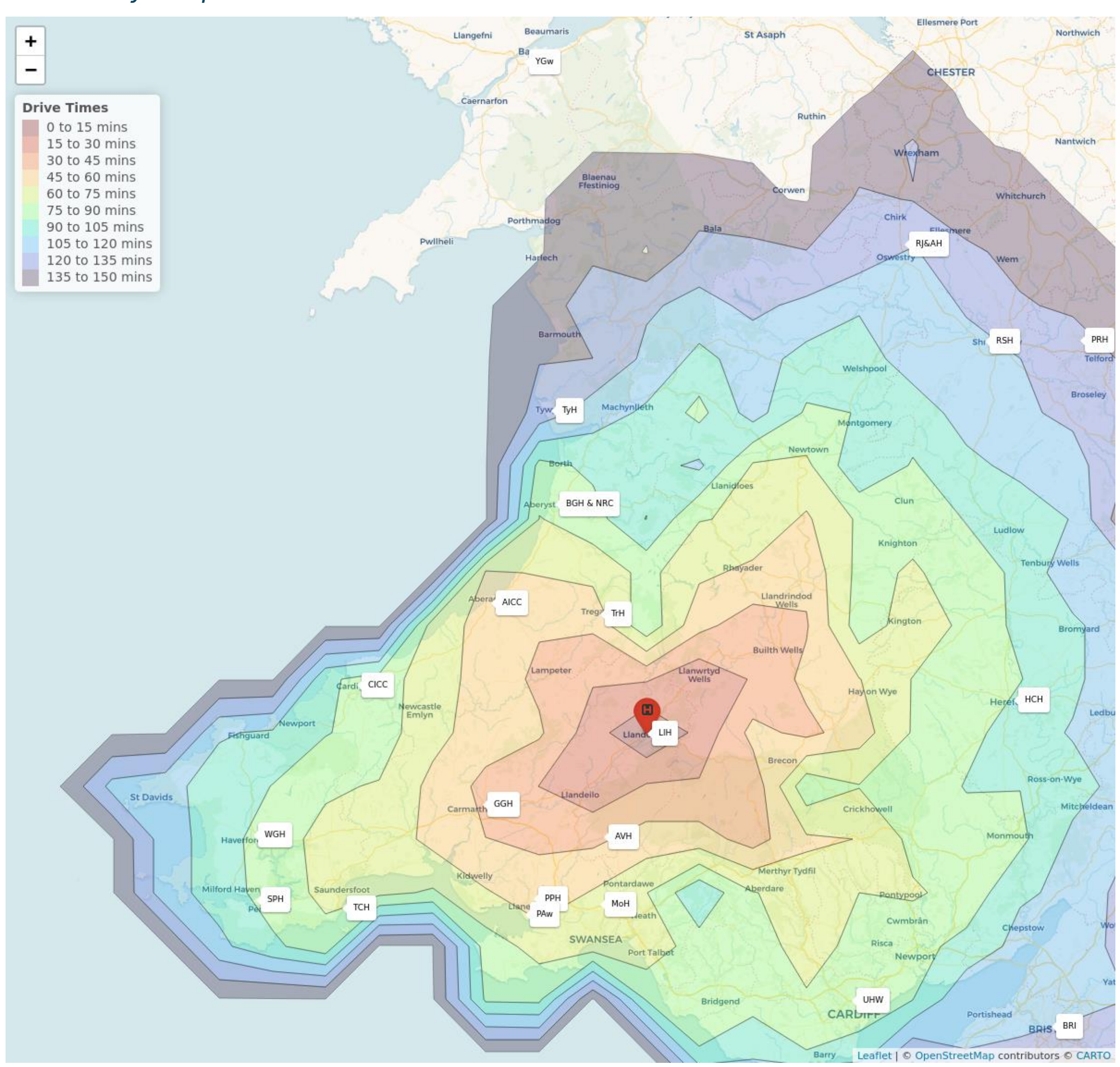
Cardigan Integrated Care Centre



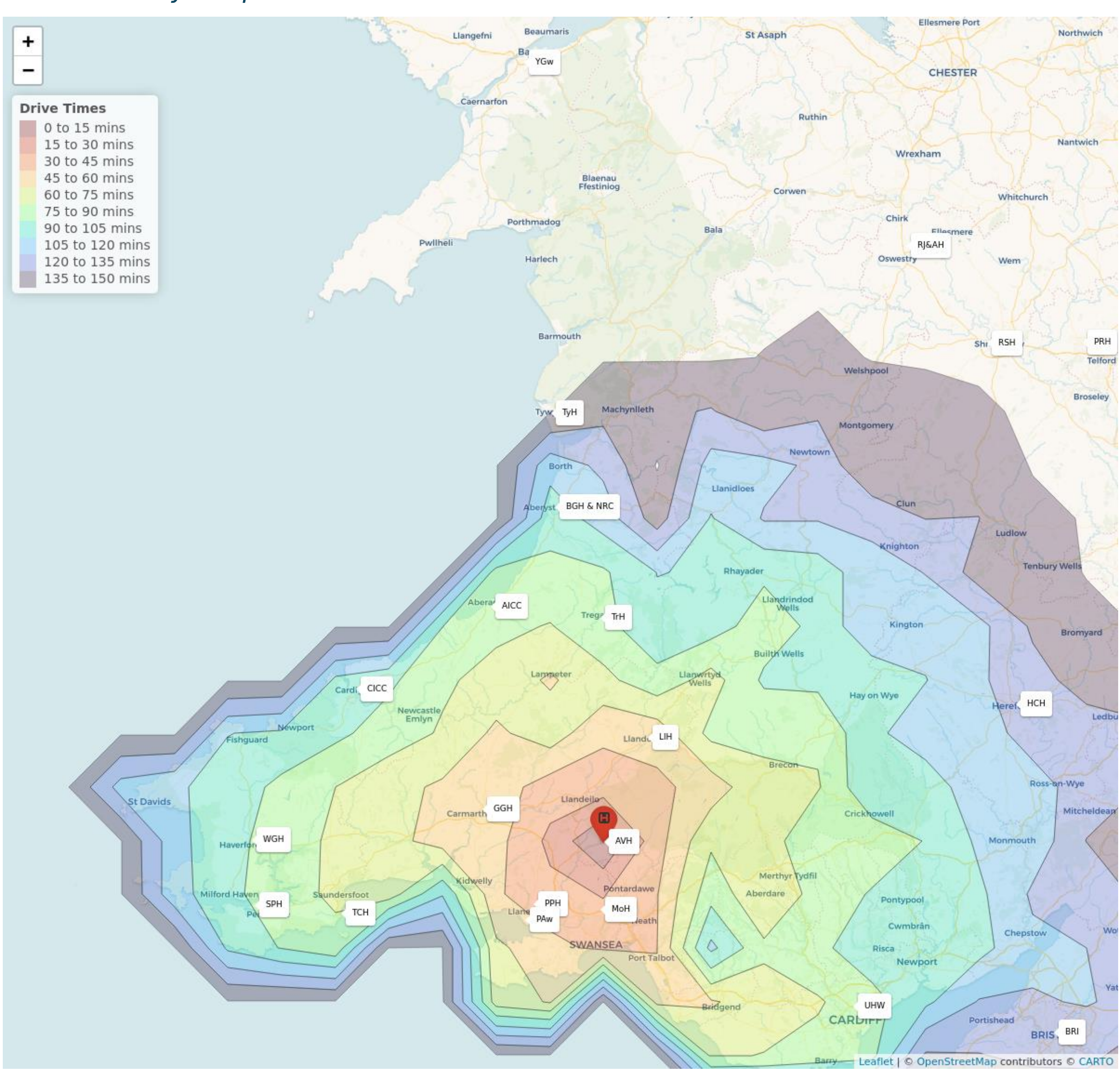
Tregaron Hospital



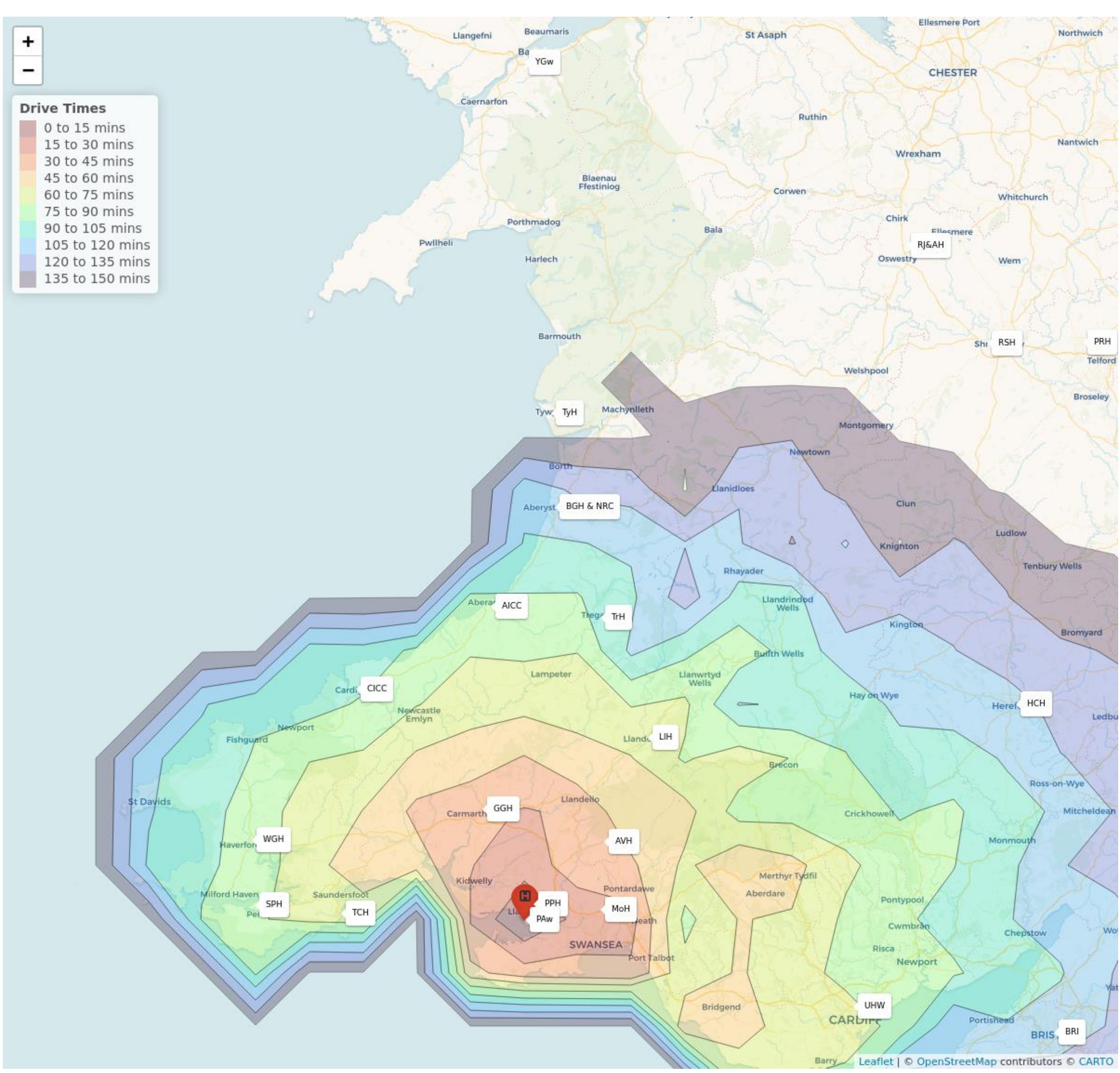
Llandovery Hospital



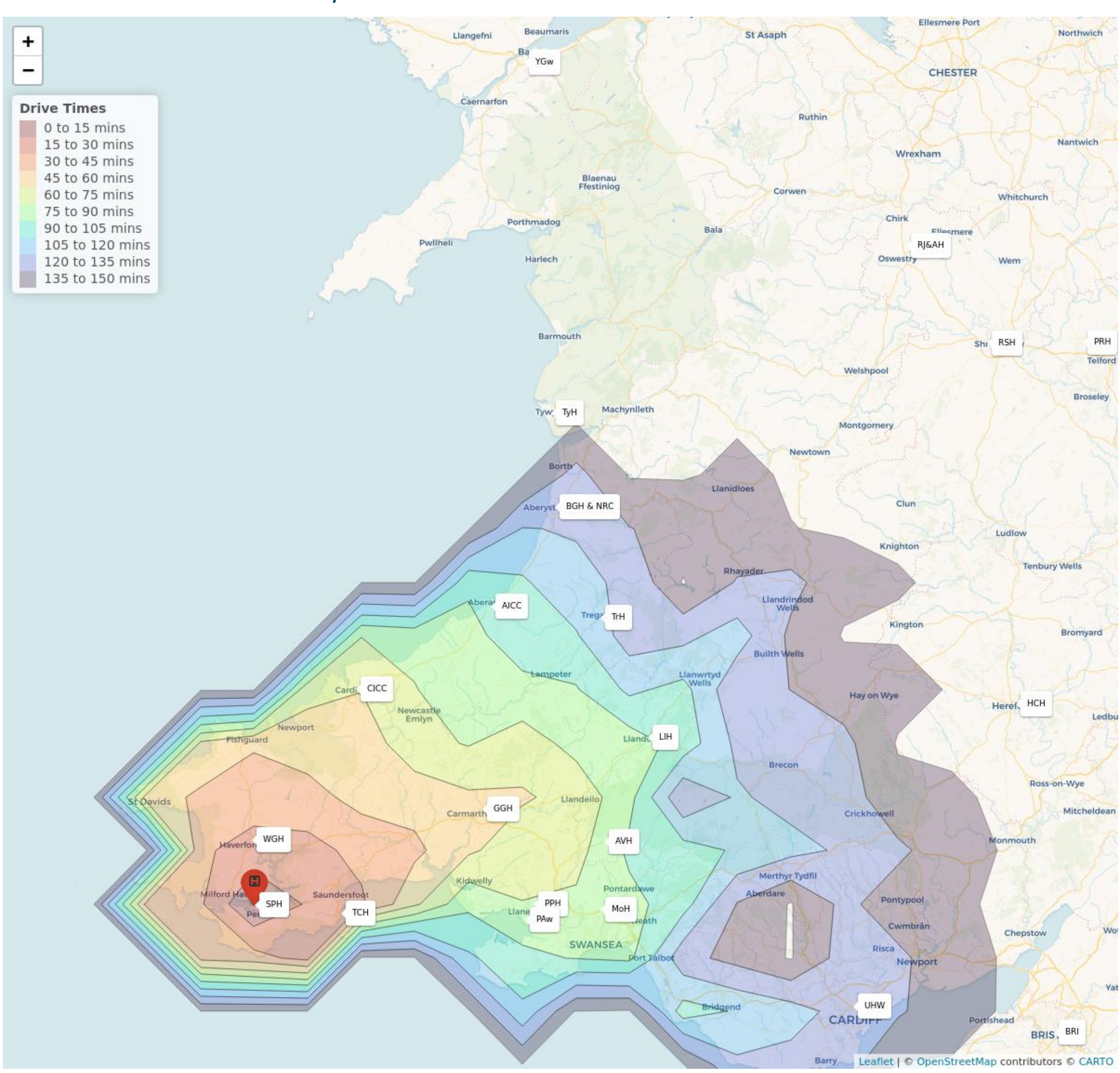
Amman Valley Hospital



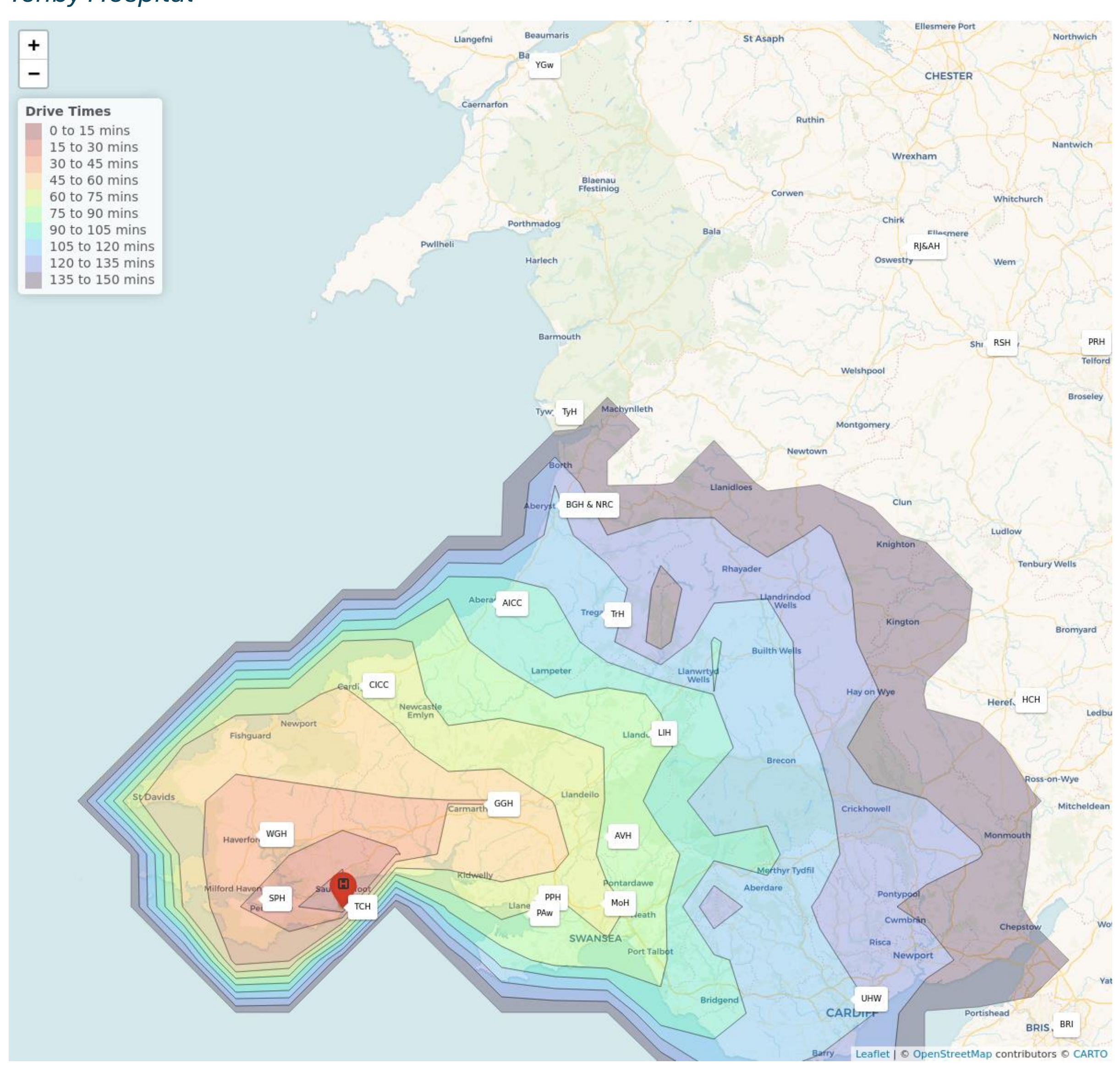
Pentre Awel



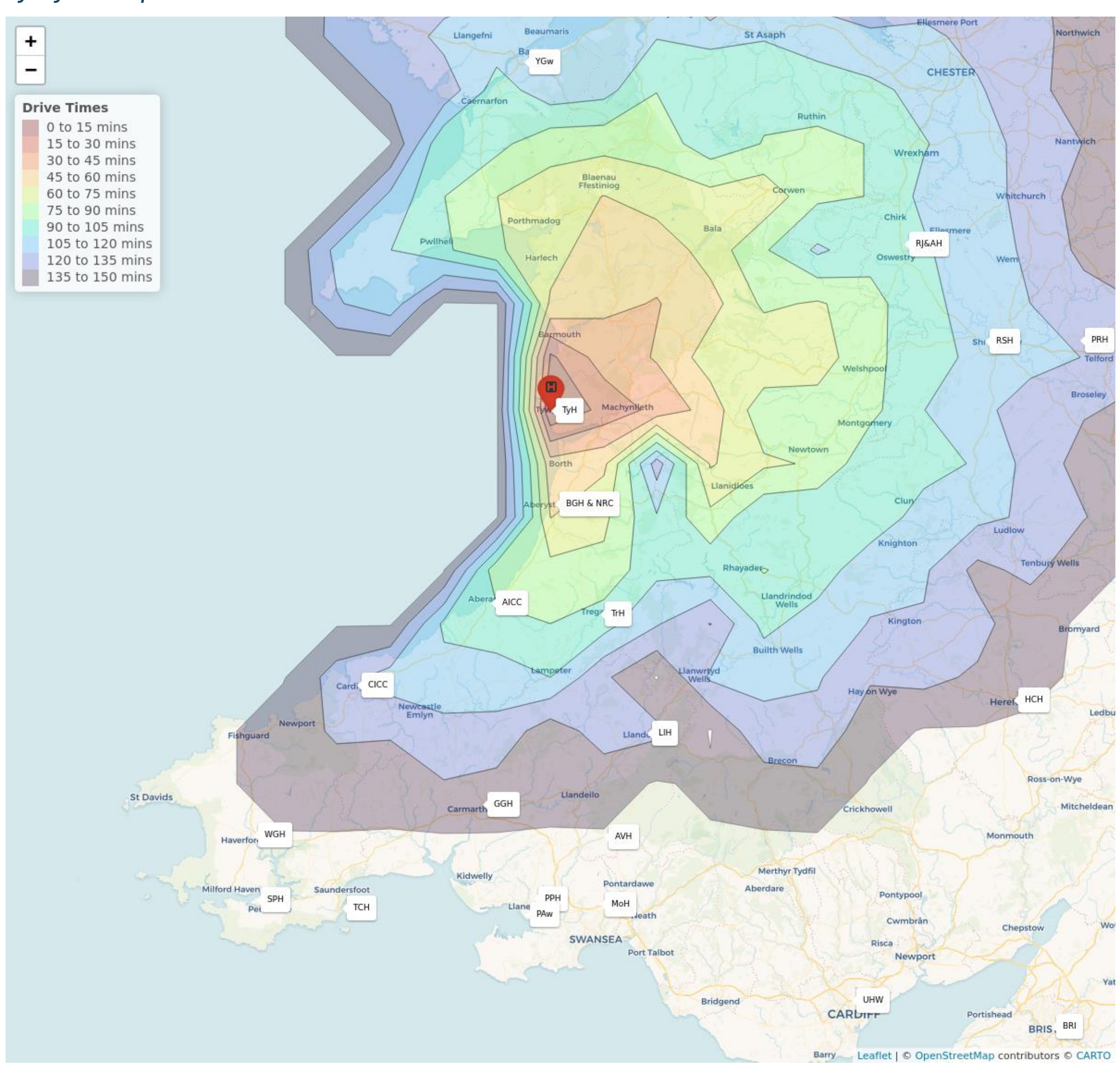
South Pembrokeshire Hospital



Tenby Hospital



Tywyn Hospital



Kind: Addressing barriers to care and equality

The information and data gathered during the Issues Paper and Options Development process was evaluated against the criteria through a SWOT analysis. Various impact assessments and screening tools were used to assess potential impacts on patients, including QIAs, EqIA screening, and HIA screening.

QIAs focus on maintaining and improving the quality of health services in Wales, as emphasised by the Health and Social Care (Quality and Engagement) (Wales) Act 2020. The QIA process evaluates the impact of business cases, service changes, and major consultations on healthcare quality and safety, informing strategic decision-making and identifying necessary mitigations. HIA screenings are used at the start of work programmes to assess potential impacts and analyse health equity. EqIA screenings ensure that due regard is given to the impact on people with protected characteristics during decision-making, helping to inform evidence-based decisions.

These live documents can be viewed below. Readers should note that these are live documents and may further be updated during the course of the CSP programme. It is therefore expected that newer versions may be available and accessible during the public consultation process and can be found at www.hduhb.nhs.wales/clinical-services-consultation :

- For the CSP, the QIAs considered by the panel can be seen here: 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/#page=85
- HIA screening templates can be found here: 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/#page=197
- Updated EqIA screening templates can be found here: 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/#page=233

Summary:

- **Data Utilisation**: The information within this document provides summary supporting data that underpinned the Issues Paper and the Options Development Group's deliberations within this programme to date. Presented in both summary and visual formats, this data enables readers to grasp the key considerations related to patient activity and potential travel insights within the CSP's programme.
- **Informed Decision-Making**: The data and information from both the Issues Paper and the Options Development process was used in informing the SWOT analysis within the programme. This analysis was a component of scoring the options during Phase 2 – The Options Development process, ensuring that each option was evaluated objectively.
- **Impact Assessments**: Further assessment of the impacts of these options is detailed in the EqIA and the QIA documentation. These assessments were important in identifying and addressing barriers to care and equality, ensuring that the programme's options consider inclusivity and equity. The impact assessments provide an evaluation of how different patient groups might be affected, guiding the development of approaches to mitigate negative impacts and enhance positive outcomes.

By integrating these detailed analyses and impact assessments, the CSP programme ensures that potential implications are carefully considered, leading to informed and balanced decision-making.

Appendix – Clinically sustainable: Patient demand to require service - Alternative Options

This section covers each of the nine services and the delivered activity taking place at each site. Alongside Service Table 1 from the "Clinically sustainable: Patient demand to require service" section within the main document, Tables 2 and 3 have been updated to reflect Alternative Options within the process.

For clarity and understanding, several tables are provided for each service:

Service Table 2: Activity estimate by current configuration and Options

- **Description**: This table considers the current activity and provides an indicative estimate of the end-state option. Each service area may have specific aspects that need to be considered.
- **Purpose**: The information in this table serves as an indicative estimate to gauge how an option may look within our Health Board. It helps in visualising the potential future state of each service based on historical data.

Service Table 3: Patient movement activity estimate by Option

- **Description**: This table specifically examines known patient movement from one site (Amber) to a receiving site (Purple). A Yellow colour indicates where further planning may be conducted at implementation.

Colour	Meaning
(Amber)	Amber denotes transferring site
(Purple)	Purple denotes receiving site
(Yellow)	Numbers to be defined during implementation

- **Purpose**: Its purpose is to show how many people, based on the analysed data, would have been impacted for that particular year. This analysis is crucial for understanding the implications of patient transfers and movements between sites.

By providing these tables, the document aims to offer an overview of the activity and patient movement for each service, helping stakeholders make informed decisions based on factual data.

Critical Care

Table 2: Patient insight by option

01 Apr 23 - 31 Mar 24	Bronglais	Glangwili	Prince Philip	Withybush	Community	TOTAL
Current	248	437	236	271	0	1192
Option A	248	878	47	19	0	1192
Option B	248	626	47	271	0	1192

Option C	248	437	236	271	0	1192
Option 246	248	626	47	271	0	1192

Data includes patient numbers for Level 0,1,2 & 3.

Table 3: Patient activity movement insight estimate

01 Apr 23 - 31 Mar 24	Bronglais	Glangwili	Prince Philip	Withybush	Community	TOTAL
Current	0	49	49	0	0	49
Option A	0	441	189	252	0	441
Option B	0	189	189	0	0	189
Option C	0	49	49	0	0	49
Option 246	0	189	189	0	0	189

Option A - Levels 2 and 3 moving from PPH and WGH to GGH as part of change from ICU to ECU
Option B/C - Levels 2 and 3 moving from PPH to GGH as part of change from ICU to ECU

Emergency General Surgery

Table 2: Patient insight by option

01 Apr 23 - 31 Mar 24	Bronglais	Glangwili	Prince Philip	Withybush	Community	TOTAL
Current	308	593	0	418	0	1319
Option A	308	1011	0	0	0	1319
Option B	308	506	0	506	0	1319
Option 155 (A1)	308	1011	0	0	0	1319
Option 222	308	1011	0	0	0	1319

Table 3: Patient activity movement insight estimate

01 Apr 23- 31 Mar 24	Bronglais	Glangwili	Prince Philip	Withybush	Community	TOTAL
Current	308	593	0	418	0	1319
Option A	0	418	0	418	0	418
Option B	0	297	0	209	0	506
Option 155 (A1)	0	418	0	418	0	418
Option 222	0	418	0	418	0	418

Option A - WGH EGS operations transferred to GGH

Option B - EGS operations alternate weekly between GGH/WGH - a literal split of activity has been taken to represent weekly split. Any variance has not been accounted for.

Option 155 (A1) creates an additional SDEC at BGH

Option 222 - has no EGS service at WGH - therefore the figure not only assumes the conversion rates but the total presentations also. Due to there being no EGS pathway at WGH, the additional presentation of 1886 admissions needs to be considered (2023/24 data set)

Endoscopy

Table 2: Patient insight by option						
2022-23	Bronglais	Glangwili	Prince Philip	Withybush	Community	TOTAL
Current	3285	6092	3701	5415	0	18493
Option A, B, C	3285	6092	3701	5415	0	18493
Option 228 (B1)	3285	6092	3701	5415	0	18493

Table 3: Patient activity movement insight estimate						
2022-23	Bronglais	Glangwili	Prince Philip	Withybush	Community	TOTAL
Current	3285	6092	3701	5415	0	18493
Option A, B, C	0	0	0	0	0	0
Option 228 (B1)	0	0	0	0	0	0

Option A, B, C - more activity at PPH - therefore no impact on patient movements.

Option B - movement would take place to community sites, to be defined at implementation phase
Option 228 - Bowel screening activity yet to be defined

Opthalmology

Table 2: Patient insight by option						
2022-23	Bronglais	Glangwili	Prince Philip	Withybush	Community	TOTAL
Current	529	15243	5844	5855	14722	42193
Option A	0	21616	0	5855	14722	42193
Option B	529	0	21087	5855	14722	42193
Option C	529	21087	0	5855	14722	42193
Option 95 (A1)	0	21616	0	5855	14722	42193
Option 99 (A1)	0	21616	0	5855	14722	42193
Option 167	0	21616	0	5855	14722	42193
Option 173 (C1)	529	21616	0	5855	14722	42722
Option 227 (A3)	0	22145	0	5855	14722	42722
Option 263 (B1)	529	0	21616	5855	14722	42722

Table 3: Patient activity movement insight estimate						
2022-23	Bronglais	Glangwili	Prince Philip	Withybush	Community	TOTAL
Current	529	15243	5844	5855	14722	42193
Option A	529	6373	5844	0	0	6373
Option B	0	15243	15243	0	0	15243

Option C	0	5844	5844	0	0	5844
Option 95 (A1)	529	5844	5844	0	0	5844
Option 99 (A1)	529	6373	5844	0	0	5844
Option 167	529	6373	5844	0	0	5844
Option 173 (C1)	0	5844	5844	0	0	5844
Option 227 (A3)	529	5844	5844	0	0	5844
Option 263 (B1)	0	5844	5844	0	0	5844

Option A - centralise to GGH

Option B - move to PPH

Option C - move to GGH

Option A, B, C - move from AICC to Cardigan/North Road. (AICC current to move - 393)
Option 95, 227, 264 - extra hours activity yet to be defined
Option 99, 167,173 - procedure activity yet to be defined

Orthopaedics

Table 2: Patient insight by option

2022-23	Bronglais	Glangwili	Prince Philip	Withybush	Community	TOTAL
Current	3695	2753	5661	7449	2580	22138
Option A, B, C, D	3695	2753	5661	7449	2580	22138
Option 52/113 (C)	3695	2753	5661	7449	2580	22138
Option 129 (A,B,C,D)	3695	2753	5661	7449	2580	22138
Option 178 (B)	3695	2753	5661	7449	2580	22138
Option 179 (D)						0
Option 268 (D,C)	3695	2753	5661	7449	2580	22138

Table 3: Patient activity movement insight estimate

2022-23	Bronglais	Glangwili	Prince Philip	Withybush	Community	TOTAL
Current	3695	2753	5661	7449	2580	22138
Option A, B, C, D	0	0	0	0	0	0
Option 52/113 (C)	0	0	0	0	0	0
Option 129 (A,B,C,D)	0	0	0	0	0	0
Option 178 (B)	0	0	0	0	0	0
Option 179 (D)	0	2753	2753	0	0	2753
Option 268 (D,C)	0	0	0	0	0	0

All options - no impact on patient movements as options look to do more rather than move

Options A, B, D - regional working may have an impact on activity, to be refined at implementation phase

Option D - more activity at BGHto be refined at implementation phase
Alternative options - options including increased activity will need to be further defined at implementation

Radiology

Table 2: Patient insight by option

2022-23	Bronglais	Glangwili	Prince Philip	Withybush	Cardigan ICC	Tenby	Llandovery	South Pembrokeshire	TOTAL
Current	60421	108765	102349	116060	9859	6385	1397	2	405238
Option A, B, C, D	60421	108765	103746	116062	9859	6385	0	0	405238
Option 24 (B1)	60421	108765	103746	116062	9859	6385	0	0	405238
Option 25 (B2)	60421	108765	103746	116062	9859	6385	0	0	405238
Option 103	60421	108765	103746	116062	9859	6385	0	0	405238
Option 122	60421	108765	102349	116060	9859	6385	1397	2	405238

Table 3: Patient activity movement insight estimate

2022-23	Bronglais	Glangwili	Prince Philip	Withybush	Cardigan ICC	Tenby	Llandovery	South Pembrokeshire	TOTAL
Current	60421	108765	102349	116060	9859	6385	1397	2	405238
Option A, B, C, D	0	0	1397	2	0	0	1397	2	1399
Option 24 (B1)	0	0	1397	2	0	0	1397	2	1399
Option 25 (B2)	0	0	1397	2	0	0	1397	2	1399
Option 103	0	0	1397	2	0	0	1397	2	1399
Option 122	60421	108765	102349	116060	9859	6385	1397	2	0

Option A, B, C,D - South Pembrokeshire and Llandovery patients moving to WGH and PPH (assumed moving to closest acute site)

Option 122 - to be defined what additional activity is allocated to Cardigan ICC

Interventional activity split has not been included, to be further refined at implementation phase

Stroke

Table 2: Patient insight by option

2023-24	Bronglais	Glangwili	Prince Philip	Withybush	Community	TOTAL
Current	166	246	171	209	0	792
Option A	0	0	390	357	0	747
Option B	0	0	724	0	0	724
Option 106 (A1)	0	0	390	357	0	747
Option 118	0	792	0	0	0	792
Option 210	166	626	0	0	0	792

Estimates from NICE guidelines data has been used to represent that 10.9% of patients who present with a stroke are known to be well within between 12 hours and 24 hours. We have based our figures on the remaining 89.1% who would require transfer.

Option B - 357 patients are estimated to be repatriated to the WGH Stroke Unit

Table 3: Patient activity movement insight estimate

2023-24	Bronglais	Glangwili	Prince Philip	Withybush	Community	TOTAL
Current	166	246	171	209	0	792
Option A	166	246	246	166	0	412
Option B	166	246	412	166	0	412
Option 106 (A1)	166	246	246	166	0	412
Option 118	166	546	171	209	0	546

Option 210	0	380	171	209		380
Option A - BGH move to WGH, GGH move to PPH						
Option B - BGH/GGH move to PPH first 72hrs then BGH move to WGH - different hours to Option A. Assumes patients move to PPH then WGH						

Urology

Table 2: Patient insight by option						
2022-23	**Bronglais**	**Glangwili**	**Prince Philip**	**Withybush**	**Community**	**TOTAL**
Current	1264	12741	4651	3230	0	21886
Option	1264	3534	13858	3230	0	21886
Option 194/197	1264	3534	13858	3230	0	21886

Table 3: Patient activity movement insight estimate						
2022-23	**Bronglais**	**Glangwili**	**Prince Philip**	**Withybush**	**Community**	**TOTAL**
Current	1264	12741	4651	3230	0	21886
Option	0	9207	9207	0	0	9207
Option 194/197	0	9207	9207	0	0	
Option - Emergency only in GGH. Only Outpatient activity (9207) moved - emergency/planned split within the inpatient/day case data to be refined at implementation phase *Option 194/197 - Emergency only in GGH. Only Outpatient activity (9207) moved - emergency/planned split within the inpatient/day case data to be refined at implementation phase*						

Glossary

ACCTS – Adult Critical Care Transport Service

AICC – Aberaeron Integrated Care Centre

AVH – Amman Valley Hospital

BGH – Bronglais Hospital

CICC – Cardigan Integrated Care Centre

GGH – Glangwili Hospital

LH – Llandovery Hospital

NEPTS – Non-Emergency Patient Transport Services

PPH – Prince Philip Hospital

SPH – South Pembrokeshire Hospital

SSNAP – Sentinel Stroke National Audit Programme

TH - Tenby Hospital

TrH – Tregaron Hospital

WAST – Welsh Ambulance Service Trust

WGH – Withybush Hospital

References

Reference to further detail on the sections above can be found within the supporting documents section of www.hduhb.nhs.wales/clinical-services-consultation, this includes but is not limited to:

1. Evaluation Criteria
2. Safe – Patients Requiring transport when unwell – service impacted
3. ACCTS Transfer Times
4. WAST Transfer Times & Heat Map
5. NEPTS estimate not considering threshold criteria
6. Patient and Visitor transport Survey
7. Staff transport survey
8. Patients accessing Hywel Dda from Gwynedd
9. Patients accessing Hywel Dda from Powys
10. SWOT analysis
11. Equality Impact Assessments
12. Quality Impact Assessments

Hywel Dda University Health Board

Fact Sheet

Using the following Datasets:

SSNAP Data - provided by Hywel Dda Information Services

Data filtered as follows:

Sites:	All
Specialties Included:	Stroke
Age:	All
Dates:	1st April 2023 to 31st March 2024

Other Considerations:

Only activity that has a discharge date has been included

Of the 808 patients in the SSNAP data for 2023/24, 693 had a discharge date, 115 (14%) had no discharge date

The absence of a discharge date may indicate that the episode was a "mimic" and therefore not to be included in the data, but this would need to be confirmed.

Includes all patients with a LoS of between zero and one, if the patient was in a bed at midnight

Assumptions made to provide the staging groups:

- HASU <= 72 hours grouping is less than 4 days to allow for small delays in transfer
- ASU <= 7 days grouping is less than 8 days to allow for small delays in transfer
- Rehabilitation > 7 days

Data was uploaded into R to wrangle back into daily data

Midnight count has been used to calculate bed occupancy

Concerns

Including only discharged patients may result in slightly lower numbers of patients through the whole year

Abbreviations and definitions:

BGH - Bronglais General Hospital
GGH - Glangwili General Hospital
PPH - Prince Philip Hospital
WGH - Withybush General Hospital
ASU - Acute Stroke Unit
HASU - Hyper-Acute Stroke Unit

Worksheets

ALoS - Admitted Patients, Dischrged Patients, ALoS by Admission and ALoS by Discharged, all by Month
Hospital_Splits - four acute sites
GGH_PPH - GGH and PPH combined
BGH_GGH_PPH - BGH, GGH and PPH combined
Alt Op 118 - Alternative option 118 which assumes all HASU and ASU go to GGH, Rehab to four individual sites
Alt Op 210 - Alternative option 210 which assumes combined numbers for GGH, PPH and WGH
Pivots
Data
Unique_patients

Hywel Dda University Health Board

Patients Admitted with a Discharge Date Accessing Stroke from 1st Arpil 2023 to 31st March 2024

Number of Patients													
Site	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Grand Total**
Bronglais General Hospital	13	14	11	16	8	15	13	14	11	11	9	11	146
Glangwili General Hospital	13	22	16	19	19	16	24	26	13	21	14	15	218
Prince Philip Hospital	9	19	12	18	14	8	10	15	9	10	8	7	139
Withybush General Hospital	8	11	17	25	12	15	14	15	14	18	24	17	190
Grand Total	**43**	**66**	**56**	**78**	**53**	**54**	**61**	**70**	**47**	**60**	**55**	**50**	**693**

Average Length of Stay (Days), for Discharged Patients, by Admission Month from 1st Arpil 2023 to 31st March 2024

Average of LoS_Days													
Site	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Grand Total**
Bronglais General Hospital	26	16	23	20	29	12	30	19	10	38	19	20	21
Glangwili General Hospital	43	25	24	34	18	26	22	27	24	25	23	26	26
Prince Philip Hospital	50	23	19	23	40	28	34	56	44	64	21	25	35
Withybush General Hospital	21	32	24	33	21	27	31	14	29	15	16	22	24
Grand Total	**35**	**24**	**23**	**28**	**26**	**23**	**28**	**29**	**26**	**31**	**19**	**23**	**26**

Patients Discharged from Stroke Services from 1st Arpil 2023 to 31st March 2024

Number of Patients													
Site	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Grand Total**
Bronglais General Hospital	14	11	13	16	11	14	13	16	10	9	10	13	150
Glangwili General Hospital	17	21	18	17	22	18	21	23	16	20	14	16	223
Prince Philip Hospital	8	14	15	16	18	13	10	8	11	10	10	10	143
Withybush General Hospital	8	16	13	16	16	15	16	22	8	19	21	15	185
Grand Total	**47**	**62**	**59**	**65**	**67**	**60**	**60**	**69**	**45**	**58**	**55**	**54**	**701**

Average Length of Stay (Days), for Discharged Patients, by Discharge Month from 1st Arpil 2023 to 31st March 2024

Average of LoS_Days													
Site	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Grand Total**
Bronglais General Hospital	28	15	22	18	64	14	20	24	11	25	20	34	24
Glangwili General Hospital	35	23	25	41	19	40	20	31	18	18	38	22	27
Prince Philip Hospital	41	16	21	44	50	46	28	45	43	36	51	38	38
Withybush General Hospital	17	39	19	13	20	36	35	36	8	18	7	12	23
Grand Total	**31**	**24**	**22**	**29**	**35**	**34**	**25**	**33**	**21**	**23**	**25**	**25**	**28**

Hywel Dda University Health Board

All Sites as Singular Sites

Total Number of HASU Days for 1st April 2023 - 31 March 2024

	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Total
BGH	48	45	36	33	27	47	44	46	32	36	28	45	**467**
GGH	45	72	61	66	62	57	80	86	45	60	45	55	**734**
PPH	34	59	33	72	40	30	39	58	34	28	28	26	**481**
WGH	25	42	54	80	42	50	46	46	47	47	59	55	**593**
All sites	**152**	**218**	**184**	**251**	**171**	**184**	**209**	**236**	**158**	**171**	**160**	**181**	**2,275**

HASU Maximum Midnight Count in Month

	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Max Midnight Count in Year: No Patients	Occurrences
BGH	5	3	3	3	4	6	3	4	3	4	3	3	6	1
GGH	4	5	5	5	5	4	9	6	5	6	3	3	9	1
PPH	3	4	3	5	4	3	4	5	3	2	2	3	5	4
WGH	3	4	3	6	4	4	5	3	4	4	4	5	6	3
All sites	9	12	10	15	12	12	13	13	9	11	11	11	15	1

Total Number of ASU Days for 1st April 2023 - 31 March 2024

	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Total
BGH	34	31	23	22	10	51	34	29	22	28	13	34	**331**
GGH	43	48	48	53	43	37	51	52	40	45	26	32	**518**
PPH	30	44	18	49	33	30	17	52	17	32	21	15	**358**
WGH	20	38	29	54	40	44	43	15	34	32	33	41	**423**
All sites	**127**	**161**	**118**	**178**	**126**	**162**	**145**	**148**	**113**	**137**	**93**	**122**	**1,630**

ASU Maximum Midnight Count in Month

	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Max Midnight Count in Year: No Patients	Occurrences
BGH	5	3	3	2	2	5	3	4	2	4	2	3	5	2
GGH	4	4	4	5	3	3	5	4	4	5	3	3	5	3
PPH	3	3	3	4	3	3	2	3	3	2	2	2	4	2
WGH	2	3	3	4	4	3	5	2	3	4	2	5	5	2
All sites	9	9	8	13	11	11	12	10	7	8	5	10	13	2

Total Number of Rehabilitation Days for 1st April 2023 - 31 March 2024

	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Total
BGH	235	273	248	223	185	194	213	184	178	204	200	174	**2,511**
GGH	442	419	470	431	403	361	379	380	381	413	430	437	**4,946**
PPH	397	440	460	442	383	288	250	375	459	440	375	303	**4,612**
WGH	251	224	187	313	397	407	438	254	153	263	223	284	**3,394**
All sites	**1,325**	**1,356**	**1,365**	**1,409**	**1,368**	**1,250**	**1,280**	**1,193**	**1,171**	**1,320**	**1,228**	**1,198**	**15,463**

Rehab Maximum Midnight Count in Month

	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Max Midnight Count in Year: No Patients	Occurrences
BGH	10	12	12	9	9	9	9	9	7	9	9	8	12	3
GGH	20	16	18	16	15	14	15	15	14	16	17	17	20	1
PPH	15	17	18	17	15	12	9	17	17	16	14	10	18	6
WGH	9	9	9	13	16	16	17	11	7	11	9	12	17	4
All sites	49	50	49	50	53	47	45	44	42	48	46	43	53	2

Total Number of Days for 1st April 2023 - 31 March 2024

	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Total
BGH	317	349	307	278	222	292	291	259	232	268	241	253	**3,309**
GGH	530	539	579	550	508	455	510	518	466	518	501	524	**6,198**
PPH	461	543	511	563	456	348	306	485	510	500	424	344	**5,451**
WGH	296	304	270	447	479	501	527	315	234	342	315	380	**4,410**
All sites	**1,604**	**1,735**	**1,667**	**1,838**	**1,665**	**1,596**	**1,634**	**1,577**	**1,442**	**1,628**	**1,481**	**1,501**	**19,368**

All Stages Maximum Midnight Count in Month

	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Max Midnight Count in Year: No Patients	Occurrences
BGH	12	14	14	12	11	12	12	10	9	10	10	10	14	6
GGH	22	22	22	20	20	18	20	20	20	21	19	19	22	9
PPH	17	21	20	20	17	14	13	20	20	18	16	14	21	1
WGH	11	13	12	18	18	19	20	13	11	14	13	15	20	1
All sites	59	67	62	67	62	57	59	58	52	58	56	53	67	2

Hywel Dda

Glangwili (GGH) a

Total Number of Hyper-Acute Stroke Unit (HASU)						
	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23
BGH	48	45	36	33	27	47
GGH & PPH	79	131	94	138	102	87
WGH	25	42	54	80	42	50
All sites	**152**	**218**	**184**	**251**	**171**	**184**

HASU Maximum Midnight						
	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23
BGH	5	3	3	3	4	6
GGH & PPH	6	9	5	9	7	7
WGH	3	4	3	6	4	4
All Sites	9	12	10	15	12	12

Total Number of ASU Days for 1st A						
	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23
BGH	34	31	23	22	10	51
GGH & PPH	73	92	66	102	76	67
WGH	20	38	29	54	40	44
All sites	**127**	**161**	**118**	**178**	**126**	**162**

ASU Maximum Midnight (						
	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23
BGH	5	3	3	2	2	5
GGH & PPH	5	6	4	9	5	6
WGH	2	3	3	4	4	3
All Sites	9	9	8	13	11	11

Total Number of Rehabilitation Days for						
	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23
BGH	235	273	248	223	185	194
GGH & PPH	839	859	930	873	786	649
WGH	251	224	187	313	397	407
All sites	**1,325**	**1,356**	**1,365**	**1,409**	**1,368**	**1,250**

Rehab Maximum Midnight						
	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23
BGH	10	12	12	9	9	9
GGH & PPH	32	33	33	33	29	25
WGH	9	9	9	13	16	16
All Sites	49	50	49	50	53	47

Total Number of Days for 1st Apr						
	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23
BGH	317	349	307	278	222	292
GGH & PPH	991	1,082	1,090	1,113	964	803
WGH	296	304	270	447	479	501
All sites	**1,604**	**1,735**	**1,667**	**1,838**	**1,665**	**1,596**

All Stages Maximum Midnig						
	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23
BGH	12	14	14	12	11	12
GGH & PPH	38	43	39	40	35	31
WGH	11	13	12	18	18	19
All Sites	59	67	62	67	62	57

University Health Board

nd Prince Philip Hospitals (PPH) Combined

Days for 1st April 2023 - 31 March 2024						
Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Total
44	46	32	36	28	45	**467**
119	144	79	88	73	81	**1,215**
46	46	47	47	59	55	**593**
209	**236**	**158**	**171**	**160**	**181**	**2,275**

Count in Month					
Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
3	4	3	4	3	3
9	8	6	8	5	5
5	3	4	4	4	5
13	13	9	11	11	11

pril 2023 - 31 March 2024						
Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Total
34	29	22	28	13	34	**331**
68	104	57	77	47	47	**876**
43	15	34	32	33	41	**423**
145	**148**	**113**	**137**	**93**	**122**	**1,630**

Count in Month					
Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
3	4	2	4	2	3
6	6	4	7	4	4
5	2	3	4	2	5
12	10	7	8	5	10

1st April 2023 - 31 March 2024						
Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Total
213	184	178	204	200	174	**2,511**
629	755	840	853	805	740	**9,558**
438	254	153	263	223	284	**3,394**
1,280	**1,193**	**1,171**	**1,320**	**1,228**	**1,198**	**15,463**

Count in Month					
Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
9	9	7	9	9	8
23	31	31	31	30	26
17	11	7	11	9	12
45	44	42	48	46	43

il 2023 - 31 March 2024						
Oct-23	**Nov-23**	**Dec-23**	**Jan-24**	**Feb-24**	**Mar-24**	**Total**
291	259	232	268	241	253	**3,309**
816	1,003	976	1,018	925	868	**11,649**
527	315	234	342	315	380	**4,410**
1,634	**1,577**	**1,442**	**1,628**	**1,481**	**1,501**	**19,368**

ht Count in Month					
Oct-23	**Nov-23**	**Dec-23**	**Jan-24**	**Feb-24**	**Mar-24**
12	10	9	10	10	10
32	38	38	37	35	32
20	13	11	14	13	15
59	58	52	58	56	53

Max Midnight Count in Year	
No Patients	Occurrences
6	1
9	4
6	3
15	1

Max Midnight Count in Year	
No Patients	Occurrences
5	2
9	1
5	2
13	2

Max Midnight Count in Year	
No Patients	Occurrences
12	3
33	11
17	4
53	2

Max Midnight Count in Year	
No Patients	**Occurrences**
14	6
43	1
20	1
67	2

Hywel Dda University Health Board

Glangwili (GGH), Prince Philip (PPH) and Withybush (WGH) Hospitals Combined (Alternative Option 210)

Total Number of Hyper-Acute Stroke Unit (HASU)Days for 1st April 2023 - 31 March 2024													
	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Total
BGH	48	45	36	33	27	47	44	46	32	36	28	45	**467**
GGH, PPH & WGH	104	173	148	218	144	137	165	190	126	135	132	136	**1,808**
All sites	**152**	**218**	**184**	**251**	**171**	**184**	**209**	**236**	**158**	**171**	**160**	**181**	**2,275**

HASU Maximum Midnight Count in Month												
	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
BGH	5	3	3	3	4	6	3	4	3	4	3	3
GGH, PPH & WGH	7	10	8	13	8	9	11	9	7	10	9	9
All sites	9	12	10	15	12	12	13	13	9	11	11	11

Max Midnight Count in Year	
No Patients	Occurrences
6	1
13	1
15	1

Total Number of ASU Days for 1st April 2023 - 31 March 2024													
	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Total
BGH	34	31	23	22	10	51	34	29	22	28	13	34	**331**
GGH, PPH & WGH	93	130	95	156	116	111	111	119	91	109	80	88	**1,299**
All sites	**127**	**161**	**118**	**178**	**126**	**162**	**145**	**148**	**113**	**137**	**93**	**122**	**1,630**

ASU Maximum Midnight Count in Month												
	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
BGH	5	3	3	2	2	5	3	4	2	4	2	3
GGH, PPH & WGH	7	7	6	12	9	7	11	7	5	7	5	9
All sites	9	9	8	13	11	11	12	10	7	8	5	10

Max Midnight Count in Year	
No Patients	Occurrences
5	2
12	2
13	2

Total Number of Rehabilitation Days for 1st April 2023 - 31 March 2024													
	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Total
BGH	235	273	248	223	185	194	213	184	178	204	200	174	**2,511**
GGH, PPH & WGH	1,090	1,083	1,117	1,186	1,183	1,056	1,067	1,009	993	1,116	1,028	1,024	**12,952**
All sites	**1,325**	**1,356**	**1,365**	**1,409**	**1,368**	**1,250**	**1,280**	**1,193**	**1,171**	**1,320**	**1,228**	**1,198**	**15,463**

Rehab Maximum Midnight Count in Month												
	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
BGH	10	12	12	9	9	9	9	9	7	9	9	8
GGH, PPH & WGH	40	39	40	43	45	39	39	38	35	39	38	37
All sites	49	50	49	50	53	47	45	44	42	48	46	43

Max Midnight Count in Year	
No Patients	Occurrences
12	3
45	2
53	2

Total Number of Days for 1st April 2023 - 31 March 2024													
	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Total
BGH	317	349	307	278	222	292	291	259	232	268	241	253	**3,309**
GGH, PPH & WGH	1,287	1,386	1,360	1,560	1,443	1,304	1,343	1,318	1,210	1,360	1,240	1,248	**16,059**
All sites	**1,604**	**1,735**	**1,667**	**1,838**	**1,665**	**1,596**	**1,634**	**1,577**	**1,442**	**1,628**	**1,481**	**1,501**	**19,368**

All Stages Maximum Midnight Count in Month												
	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
BGH	12	14	14	12	11	12	12	10	9	10	10	10
GGH, PPH & WGH	48	53	51	56	51	49	50	49	43	49	46	44
All sites	59	67	62	67	62	57	59	58	52	58	56	53

Max Midnight Count in Year	
No Patients	Occurrences
14	6
56	2
67	2

Hywel Dda University Health Board

Bronglais (BGH), Glangwili (GGH) and Prince Philip Hospitals (PPH) Combined

Total Number of Hyper-Acute Stroke Unit (HASU) Days for 1 April 2023 - 31 March 2024

	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Total
BGH, GGH & PPH	127	176	130	171	129	134	163	190	111	124	101	126	**1,682**
WGH	25	42	54	80	42	50	46	46	47	47	59	55	**593**
All sites	**152**	**218**	**184**	**251**	**171**	**184**	**209**	**236**	**158**	**171**	**160**	**181**	**2,275**

HASU Maximum Midnight Count in Month

	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
BGH, GGH & PPH	8	11	7	12	10	10	11	11	8	9	7	7
WGH	3	4	3	6	4	4	5	3	4	4	4	5
All sites	9	12	10	15	12	12	13	13	9	11	11	11

Max Midnight Count in Year	No Patients	Occurrences
BGH, GGH & PPH	12	1
WGH	6	3
All sites	15	1

Total Number of ASU Days for 1 April 2023 - 31 March 2024

	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Total
BGH, GGH & PPH	107	123	89	124	86	118	102	133	79	105	60	81	**1,207**
WGH	20	38	29	54	40	44	43	15	34	32	33	41	**423**
All sites	**127**	**161**	**118**	**178**	**126**	**162**	**145**	**148**	**113**	**137**	**93**	**122**	**1,630**

ASU Maximum Midnight Count in Month

	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
BGH, GGH & PPH	8	8	7	10	7	9	7	10	6	7	4	6
WGH	2	3	3	4	4	3	5	2	3	4	2	5
All sites	9	9	8	13	11	11	12	10	7	8	5	10

Max Midnight Count in Year	No Patients	Occurrences
BGH, GGH & PPH	10	2
WGH	5	2
All sites	13	2

Total Number of Rehabilitation Days for 1 April 2023 - 31 March 2024

	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Total
BGH, GGH & PPH	1,074	1,132	1,178	1,096	971	843	842	939	1,018	1,057	1,005	914	**12,069**
WGH	251	224	187	313	397	407	438	254	153	263	223	284	**3,394**
All sites	**1,325**	**1,356**	**1,365**	**1,409**	**1,368**	**1,250**	**1,280**	**1,193**	**1,171**	**1,320**	**1,228**	**1,198**	**15,463**

Rehab Maximum Midnight Count in Month

	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
BGH, GGH & PPH	41	45	44	40	37	33	30	36	36	40	39	32
WGH	9	9	9	13	16	16	17	11	7	11	9	12
All sites	49	50	49	50	53	47	45	44	42	48	46	43

Max Midnight Count in Year	No Patients	Occurrences
BGH, GGH & PPH	45	2
WGH	17	4
All sites	53	2

Total Number of Days for 1 April 2023 - 31 March 2024

	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Total
BGH, GGH & PPH	1,308	1,431	1,397	1,391	1,186	1,095	1,107	1,262	1,208	1,286	1,166	1,121	**14,958**
WGH	296	304	270	447	479	501	527	315	234	342	315	380	**4,410**
All sites	**1,604**	**1,735**	**1,667**	**1,838**	**1,665**	**1,596**	**1,634**	**1,577**	**1,442**	**1,628**	**1,481**	**1,501**	**19,368**

All Stages Maximum Midnight Count in Month												
	Apr-23	**May-23**	**Jun-23**	**Jul-23**	**Aug-23**	**Sep-23**	**Oct-23**	**Nov-23**	**Dec-23**	**Jan-24**	**Feb-24**	**Mar-24**
BGH, GGH & PPH	49	57	52	51	44	39	40	47	47	47	45	41
WGH	11	13	12	18	18	19	20	13	11	14	13	15
All sites	59	67	62	67	62	57	59	58	52	58	56	53

Max Midnight Count in Year	
No Patients	**Occurrences**
57	1
20	1
67	2

Hywel Dda University Health Board

All HASU and ASU at GGH, Rehab at all sites (Alternative Option 118)

Total Number of HASU Days for 1 April 2023 - 31 March 2024

	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Total
Glangwili Hospital (GGH) (4 sites combined)	**152**	**218**	**184**	**251**	**171**	**184**	**209**	**236**	**158**	**171**	**160**	**181**	**2,275**

HASU Maximum Midnight Count in Month

	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Total	Max Midnight Count in Year: No Patients	Max Midnight Count in Year: Occurrences
GGH (4 sites combined)	9	12	10	15	12	12	13	13	9	11	11	11		15	1

Total Number of ASU Days for 1 April 2023 - 31 March 2024

	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Total
GGH (4 sites combined)	**127**	**161**	**118**	**178**	**126**	**162**	**145**	**148**	**113**	**137**	**93**	**122**	**1,630**

ASU Maximum Midnight Count in Month

	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Total	Max Midnight Count in Year: No Patients	Max Midnight Count in Year: Occurrences
GGH (4 sites combined)	9	9	8	13	11	11	12	10	7	8	5	10		13	2

Total Number of Rehabilitation Days for 1 April 2023 - 31 March 2024

	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Total
Bronglais Hospital (BGH)	235	273	248	223	185	194	213	184	178	204	200	174	**2,511**
GGH	442	419	470	431	403	361	379	380	381	413	430	437	**4,946**
Prince Philip Hospital (PPH)	397	440	460	442	383	288	250	375	459	440	375	303	**4,612**
Withybush Hospital (WGH)	251	224	187	313	397	407	438	254	153	263	223	284	**3,394**
All sites	**1,325**	**1,356**	**1,365**	**1,409**	**1,368**	**1,250**	**1,280**	**1,193**	**1,171**	**1,320**	**1,228**	**1,198**	**15,463**

Rehab Maximum Midnight Count in Month

	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Max Midnight Count in Year: No Patients	Max Midnight Count in Year: Occurrences
BGH	10	12	12	9	9	9	9	9	7	9	9	8	12	3
GGH	20	16	18	16	15	14	15	15	14	16	17	17	20	1
PPH	15	17	18	17	15	12	9	17	17	16	14	10	18	6
WGH	9	9	9	13	16	16	17	11	7	11	9	12	17	4
All sites	49	50	49	50	53	47	45	44	42	48	46	43	53	2

Total Number of Days for 1 April 2023 - 31 March 2024

	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Total
BGH (Rehab only)	235	273	248	223	185	194	213	184	178	204	200	174	**2,511**
GGH (All sites Hyper-Acute Stroke Unit (HASU) and	721	798	772	860	700	707	733	764	652	721	683	740	**8,851**
PPH (Rehab only)	397	440	460	442	383	288	250	375	459	440	375	303	**4,612**
WGH (Rehab only)	251	224	187	313	397	407	438	254	153	263	223	284	**3,394**
All sites	**1,604**	**1,735**	**1,667**	**1,838**	**1,665**	**1,596**	**1,634**	**1,577**	**1,442**	**1,628**	**1,481**	**1,501**	**19,368**

All Stages Maximum Midnight Count in Month

	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Max Midnight Count in Year: No Patients	Max Midnight Count in Year: Occurrences
BGH (Rehab only)	10	12	12	9	9	9	9	9	7	9	9	8	12	3
GGH (All sites HASU and ASU and GGH Rehab)	30	34	32	35	29	32	30	30	27	27	28	30	35	1
PPH (Rehab only)	15	17	18	17	15	12	9	17	17	16	14	10	18	6
WGH (Rehab only)	9	9	9	13	16	16	17	11	7	11	9	12	17	4

All sites	59	67	62	67	62	57	59	58	52	58	56	53	67	2