Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

Date	**18/12/2025**
Time	**09:30 - 12:30**
Location	**Microsoft Teams Meeting**

Virtual Strategy and Planning Committee

HDD_Strategy and Planning Committee

NHS Wales

Agenda - 18 December 2025

1 Governance and Risk

09:30, 0 min

1.1 Welcome and Apologies

09:30, 0 min
Winston Weir (Hywel Dda UHB - Independent Board Member)

1.2 Declarations of Interests

09:30, 0 min
All

1.3 Minutes from the Strategy and Planning Committee meeting on 30 October 2025

09:30, 0 min
Winston Weir (Hywel Dda UHB - Independent Board Member)

1.4 Table of Actions the Strategy and Planning Committee meeting on 30 October 2025

09:30, 5 min
Winston Weir (Hywel Dda UHB - Independent Board Member)

1.5 Matters Arising

09:35, 0 min
Winston Weir (Hywel Dda UHB - Independent Board Member)

1.6 Assurance and Risk Report

09:35, 10 min
Joanne Wilson (Hywel Dda UHB - Director of Corporate Governance/Board Secretary)

Including:

Corporate Risks; Operational Risks; Audits and Inspections; Welsh Health Circulars; Ministerial Directions

1.7 SPC Terms of Reference

09:45, 5 min
Joanne Wilson (Hywel Dda UHB - Director of Corporate Governance/Board Secretary)

1.8 Targeted Intervention Update

09:50, 10 min
Lee Davies (Hywel Dda UHB - Executive Director of Strategy and Planning), Shaun Ayres (Hywel Dda UHB - Director of Delivery)

2 Strategy, Planning and Partnerships

10:00, 0 min

2.1 Strategy Refresh

10:00, 15 min
Lee Davies (Hywel Dda UHB - Executive Director of Strategy and Planning), Paul Williams (Hywel Dda UHB - Assistant Director Of Strategic Planning), Nathan Davies (Hywel Dda UHB - Senior Project Manager), Alexander Martin (Hywel Dda UHB - Principal Programme Manager)

2.2 Annual Plan Progress

10:15, 10 min
Lee Davies (Hywel Dda UHB - Executive Director of Strategy and Planning), Shaun Ayres (Hywel Dda UHB - Director of Delivery)

2.3 Planning Objective 6: Clinical Services Plan

10:25, 20 min
Lee Davies (Hywel Dda UHB - Executive Director of Strategy and Planning), Helen Morgan-Howard (Hywel Dda UHB - Head of Transformation Programme Office), Alexander Martin (Hywel Dda UHB - Principal Programme Manager)

2.4 Value Based Healthcare Update

10:45, 10 min
Mark Henwood (Hywel Dda UHB - Executive Medical Director), Leighton Phillips (Hywel Dda UHB - Director Research, Innovation and Value)

2.5 Planning in Partnership: Regional Integration Fund Update

10:55, 10 min
Andrew Carruthers (Hywel Dda UHB - Chief Operating Officer), Linda Jones

3 BREAK

11:05, 10 min

4 Population Health, Primary and Community

11:15, 0 min

4.1 **Planning Objective 10: Population Health**

11:15, 20 min
Ardiana Gjini (Hywel Dda UHB - Executive Director of Public Health), Trina Nealon (Hywel Dda UHB - Head of Population Health + Wellbeing / Principal Public Health Officer)

Including:
Social Model for Health and Wellbeing
Population Health Needs Assessment
Health Inequalities

4.2 **Well-being of Future Generations (Wales) Act 2015**

11:35, 10 min
Ardiana Gjini (Hywel Dda UHB - Executive Director of Public Health), Trina Nealon (Hywel Dda UHB - Head of Population Health + Wellbeing / Principal Public Health Officer)

Including:
Wellbeing Objectives Annual Report

4.3 **DEFERRED to 26 February 2026: Progress Report for 2023/24 DPH Annual Report: Their Health, Our Future: Advancing the Agenda for CYP in Hywel Dda**

11:45, 0 min

5 **Capital and Estates**

11:45, 0 min

5.1 **Capital Programme for 2025-26 and Capital Governance**

11:45, 10 min
Lee Davies (Hywel Dda UHB - Executive Director of Strategy and Planning), Eldeg Rosser (Head of Capital Planning)

Including:
Annual Review CSC ToR
Capital Planning Equipment Replacement Programme

5.2 **Targeted Estates Fund (TEF) Projects**

11:55, 10 min
Lee Davies (Hywel Dda UHB - Executive Director of Strategy and Planning), Darrel Barnes (Hywel Dda UHB - Design Manager)

Provision of Second Generators at Glangwili & Withybush Hospitals

6 **For Information**

12:05, 0 min

6.1 **Joint Commissioning Committee Planning, Performance and Finance Sub-Committee Reports**

12:05, 0 min
Winston Weir (Hywel Dda UHB - Independent Board Member)

6.2 **Strategy & Planning Committee Workplan 2025-26**

12:05, 0 min
Winston Weir (Hywel Dda UHB - Independent Board Member)

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7 **Any Other Business**

12:05, 0 min
Winston Weir (Hywel Dda UHB - Independent Board Member)

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8 **Date and Time of Next Meeting**

12:05, 0 min

8.1 **16 January 2026, 15:30 - 17:00, MS Teams**

12:05, 0 min

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

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9 **Issues for Board/Committees**

12:05, 5 min
Winston Weir (Hywel Dda UHB - Independent Board Member)

Table of contents

18/12/2025 09:30 - 12:30

1

09:30, 0 Mins

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1 - Governance and Risk

1.1 **09:30, 0 Mins**

1.1 - Welcome and Apologies

Winston Weir (Hywel Dda UHB - Independent Board Member)

1.2 **09:30, 0 Mins**

1.2 - Declarations of Interests ***All***

1.3

09:30, 0 Mins

1.3 - Minutes from the Strategy and Planning Committee meeting on 30 October 2025

Winston Weir (Hywel Dda UHB - Independent Board Member)

For approval

Attachments

1.3 2025-10-30 - SPC - Minutes DRAFT.pdf

MINUTES OF THE HDd STRATEGY AND PLANNING COMMITTEE MEETING

Date of Meeting: **09:30, Thursday 30 October 2025**
Venue: **Microsoft Teams**

Present:
Mr Winston Weir, Independent Board Member, Chair
Mr Michael Imperato, Independent Member
Ms Chantal Patel, Independent Member
Ms Eleanor Marks, Independent Member

In Attendance:
Mr Lee Davies, Executive Director of Strategy and Planning
Ms Alwena Hughes Moakes, Communications and Engagement Director
Dr Ardiana Gjini, Executive Director of Public Health
Mr Huw Thomas, Director of Finance
Mrs Joanne Wilson, Director of Corporate Governance/Board Secretary
Mr Keith Jones, Director of Operational Planning & Performance, deputising for Mr Andrew Carruthers, Chief Operating Officer
Mrs Helen Mitchell, Committee Services Officer

Items SPC(25) 72 and **SPC(25) 77**
Mr Shaun Ayres, Director of Delivery
Ms Katrina Davies, Project Support Officer
(Mr Dan Warm, Head of Planning)

Item SPC(25) 74 and **SPC(25) 76**
Mrs Eldeg Rosser, Head of Capital Planning

Items SPC(25) 73 and **SPC(25) 75**
Mr Paul Williams, Head of Property Performance

Item SPC(25) 78
Mr Nathan Davies, Senior Project Manager

Item SPC(25) 79
Ms Trina Nealon, Principal Public Health Officer

Item SPC(25) 81
Mr Owain Williams, Clinical Director of Pharmacy and Medicines Management
Ms Elizabeth Williams, Lead Pharmacist Clinical Services

Items SPC(25) 81, SPC(25) 82 and **SPC(25) 83**
Ms Rhian Bond, Assistant Director of Primary Care

Minutes Ref.		Action
SPC(25) 64	**Welcome and Apologies** Mr Winston Weir welcomed members to the third Strategy and Planning Committee (SPC) meeting.	

The following apologies for absence were noted:

- Mr Maynard Davies, Independent Board Member, Vice Chair
- Mr Andrew Carruthers, Chief Operating Officer

SPC(25) 65 Declarations of Interests

There were no declarations of interest.

SPC(25) 66 Minutes from the Strategy and Planning Committee Meeting on 28 August 2025

RESOLVED - the minutes of the Strategy and Planning Committee (SPC) meeting held on 28 August 2025 were APPROVED as an accurate record of proceedings.

SPC(25) 67 Table of Actions the Strategy and Planning Committee meeting on 28 August 2025

All actions were listed as complete.

SPC(25) 68 Minutes from the Chair's Action Meeting on 15 September 2025

The Committee **NOTED** the Chair's action in relation to the Glangwili Hospital (GGH) Front Door project. Mr Keith Jones confirmed that the proposal had been approved by the Board and subsequently supported by Welsh Government (WG).

Construction is scheduled to commence on 17 November 2025.

SPC(25) 69 Matters Arising

No matters arising were raised.

SPC(25) 70 Ratification of Chairs Actions - Glangwili Front Door - Opportunities for Improved Patient Flow

The Committee **NOTED** the ratification of the Chair's Action and **RECEIVED ASSURANCE** on the project's progress and implementation timeline.

SPC(25) 71 Assurance and Risk Report

Mr Lee Davies, Dr Ardiana Gjini, and Mr Jones presented the Assurance and Risk report, highlighting the following:

- Risk 1197: *Implementing models of care that do not deliver our strategy:* Concerns regarding the implementation of care models not aligned with strategic direction due to uncertainty around estates planning.
- Risk 1185: *Consistent and meaningful engagement:* Ms Alwena Hughes Moakes reported progress towards continuous engagement and invited members to participate in ongoing activities. Mr Weir indicated that he wished to be involved and Mrs Hughes Moakes agreed to liaise with him regarding his contribution. **AHM**
- Risk 1844: *Risk of not being able to provide a timely and effective Public Health service due to limited public health*

Consultant capacity: Dr Gjini confirmed improvements due to staff returning from long-term absence.

Decision:
The Committee, in relation to the areas presented in this paper:

Risk Management

- **RECEIVED ASSURANCE** that identified controls are in place and working effectively.
- **RECEIVED ASSURANCE** that all planned actions are credible and deliverable, and in line with agreed plans, and will be implemented within stated timescales and will reduce risks further and/or mitigate the impact should risks materialise; and

Welsh Health Circulars (WHCs)

- **RECEIVED ASSURANCE** from the lead Executive Director on the management of WHCs within their area of responsibility, particularly in respect of understanding when the WHC will be delivered, any barriers to delivery, impacts of non/late delivery and assurance that the risks associated with these are being managed effectively.

SPC(25) 72 Targeted Intervention Update: SPC De-escalation Criteria Assessment

Mr Shaun Ayres and Ms Katrina Davies joined the meeting.

Mr Lee Davies and Mr Shaun Ayres presented the Targeted Intervention: De-escalation Assessment report, highlighting the following:

- The Health Board remains at Alert status in respect of the requirement to develop a credible Annual Plan.
- The 2025/26 Annual Plan initially met the £31.5m control total but WG later revised the expectation to £24.1m.
- HDdUHB intially responded with a revised forecast of £30.0m (including addressing a £2.0m National Insurance (NI) shortfall), with Month 6 now reporting a £27.8m deficit.
- £22.5m in cost reduction options were identified, with robust Quality Impact Assessment (QIA) processes in place.
- Despite the improvements made, the Health Board has not yet secured WG approval for the revised plan, emphasising HDdUHB's financial uncertainty and the need for a sustainable trajectory in order to break even.

Mr Ayres advised that the 2026/27 planning process has been formally adopted with 605 risks logged and categorised. Clinical Care Groups (CCGs) are now leading integrated planning efforts whilst strategic and operational planning is being developed as a single process. A shift toward a three-year planning horizon is underway, but full integration is still developing.

Mrs Alwena Hughes Moakes indicated that the Clinical Services Plan (CSP) Consultation closed in August 2025 with nearly 4,000 responses and over 100 alternative options. Final decisions are expected in February 2026 (delayed from November 2025). The Committee noted that the CSP is well-governed, with external assurance and a transparent process for evaluating public input, although the delay introduces planning uncertainty for 2026/27.

Regarding the Planning Maturity Matrix, Mr Lee Davies advised that the Health Board has adopted a more rigorous, evidence-based self-assessment process; and that WG has acknowledged the improved methodology and inclusive engagement.

Mr Lee Davies also advised that the Regional Joint Committee (RJC) and sub-groups are operational, with progress in orthopaedics, ophthalmology, Urgent and Emergency Care (UEC), and pathology. Resource constraints and variability across services remain challenging, while governance structures are maturing, and a regional Digital Strategy is in development.

Mr Michael Imperato queried whether any critical issues required further scrutiny. Mr Ayres confirmed that all key areas were being addressed and would be revisited in subsequent agenda items.

Mr Weir noted that HDdUHB has made significant progress in strategic planning maturity; and that the CSP is a standout area of strength. The Annual Plan remains a concern due to evolving WG financial expectations, not planning deficiencies. Continued Executive focus and Committee oversight are essential to sustain progress and meet WG expectations.

The Committee agreed to Advise the Board regarding the deficit shortfall.

Decision:
The Committee:

- **NOTED** the SPC De-escalation Criteria Assessment October 2025 Report.
- **RECEIVED ASSURANCE** as indicated in the body of the report.

SPC(25) 73 Prince Philip Solar Project

Mr Paul Williams presented the Prince Philip Hospital (PPH) Private Wire Solar Farm Connection Update report, indicating that although the project initially appeared promising offering potential carbon savings, financial benefits, and improved electrical resilience, it was ultimately deemed not viable for either the developer or the Health Board. The key reasons included:

- The cost of connecting the solar farm to the hospital's substation was prohibitively high due to the hospital's electrical capacity needs.

- The developer's financial offer was equivalent to current grid electricity costs, meaning there was no financial advantage for the Health Board. Additionally, future inflation would apply to this baseline, increasing long-term risk.
- HDdUHB could not commit to future electrical capacity requirements under the terms proposed.

Mr Paul Williams noted that although the private developer will continue with the broader solar scheme, the PPH element will not proceed. However, the Health Board remains engaged with the developer in the event that circumstances change.

In response to Ms Chantal Patel's enquiry, Mr Paul Williams confirmed that HDdUHB intends to reallocate the £600k Targeted Estates Funding (TEF) to other carbon-reduction projects, subject to WG approval.

Decision:
The Committee:

- **NOTED** the position on the PPH Private Wire Solar Farm Connection Project.

SPC(25) 74 Capital Programme for 2025-26 and Capital Governance

Ms Eldeg Rosser joined the meeting.

Ms Eldeg Rosser presented the Capital Programme for 2025/26 and Capital Governance Update Report, highlighting that VAT recovery on Withybush Hospital (WGH) works was returned to WG. The Committee noted that the total Capital Resource Limit (CRL) for the year was confirmed at £35.081m, comprising £27.950m from the All Wales Capital Programme (AWCP), £6.850m from the Discretionary Capital Programme (DCP), and £0.281m under International Financial Reporting Standard (IFRS) 16 Leases.

It was noted that the DCP allocation had increased to £10m for 2025/26, representing a 35% increase from the previous year. Despite this, the Health Board continues to face significant challenges in addressing a combined capital backlog of approximately £300m, including £266m in estates, £26.6m in medical devices, and £15m –18m in digital infrastructure.

The Committee was informed of several amendments to the CRL since the previous report, including both funding returns to WG due to underspends and new allocations for targeted schemes. Notable allocations included funding for mental health estate improvements, diagnostic equipment upgrades, and infrastructure works.

Ms Rosser highlighted a risk of overspend against the CRL, primarily due to the uncertainty surrounding the funding of urgent remedial works to the concrete cladding at WGH. The DCP has been overcommitted by £0.845m in anticipation of this funding,

and the outcome of the funding request is not expected until at least November 2025. Ms Rosser agreed to record a new risk regarding capital volatility. **ER**

Mr Weir reviewed the expenditure profile, which indicated that actual spend as of September 2025 was significantly below forecast, with only 15.6% of the allocated budget spent and 31.3% committed. This raised concerns regarding the timely delivery of the capital programme.

The Committee was also updated on the status of key capital projects:

- The Cross Hands Health and Wellbeing Centre remains red RAG-rated and was reported as being at Alert status due to ongoing scoping work and discussions with WG regarding a revised footprint and potential joint funding.
- HDdUHB's contract documentation for the lease of the Carmarthen Hwb project, led by Carmarthenshire County Council, was approved under seal by the Board on 25 July 2024. Construction is progressing well, and the expected completion date is early 2026.
- The hydrotherapy pool element of the development at Pentre Awel, (also led by Carmarthenshire County Council) is complete and currently being commissioned by the Health Board. Contractors for the Clinical Delivery Unit (CDU) are on site, and this phase is expected to be completed in early 2026/27.
- A tender process for partners to work on the Cylch Caron scheme, led by Ceredigion County Council, closed with no returns. WG requested a report outlining next steps for refreshing the Outline Business Case (OBC) and reviewing the resource schedule. A housing consultant has been commissioned to explore options for Ceredigion County Council's elements of the scheme. HDdUHB expects to respond to WG with an update in Autumn 2025.

The Committee was advised of the need to seal certain contracts associated with capital schemes, in line with governance requirements. A schedule of such contracts was provided for reference.

The Capital Sub-Committee (CSC) update from its meeting on 18 September 2025 was also received. No items were escalated for alert, seven items were noted for advice, and four items were confirmed for assurance.

The Committee agreed to Advise the Board of the emerging capital risk and the need for a new operational risk entry.

Decision:

The Committee:

- **RECEIVED ASSURANCE** from the update on the Capital Programme and CRL for 2025/26 and discussed the potential overspend.
- **NOTED** the allocation of the DCP for 2025/26 and the changes since Board ratification.
- **RECEIVED ASSURANCE** and **WILL UPDATE THE BOARD,** that the seal can be applied for all schemes listed in Annex 1.
- **RECEIVED ASSURANCE** from the capital schemes governance update and discussed the status of the Cross Hands scheme.
- **RECEIVED ASSURANCE** from the Capital Sub Committee update in Annex 2.

SPC(25) 75 Estate Condition and Performance Update

Mr Paul Williams presented the Estate Condition and Performance Update, indicating that HDdUHB is planning to update its estate condition and performance data, referencing two key documents:

- The NHS England Estatecode Guidance which is undergoing consultation and is expected to be adopted in Wales. It reflects challenges similar to those faced by NHS Wales, including:
  - Ageing estate
  - Financial constraints
  - Compliance and risk management
- The Backlog Maintenance Report which outlined the scale of the Health Board's maintenance backlog raised numerous concerns. Mr Paul Williams emphasised the urgency of strategic investment and the need for improved visibility of estate risks.

The Committee noted that HDdUHB intends to develop a new Estate Strategy aligned with the CSP and future infrastructure needs; undertake updated 6-facet surveys to assess estate condition, compliance, and functionality; and use digital tools and technologies, such as asset registers and lifecycle analysis, to improve data quality and support investment decisions.

Mr Paul Williams indicated that the Health Board is exploring digital transformation, sustainability, and productive delivery models as part of its estate planning and is engaging with other NHS organisations (e.g. Cardiff and Vale University Health Board (CVUHB)) and WG to ensure alignment.

Mr Lee Davies indicated that HDdUHB aims to develop a new Estate Strategy for the short, medium, and long term, aligned with the CSP and future service models. He emphasised the importance of updating the 6-facet surveys to provide granular detail on estate condition and performance, which would inform investment decisions over the next decade.

In response to the Committee's query regarding timelines, Mr Lee Davies noted that the timing of the Estate Strategy development would depend on the alignment with the CSP. He suggested that the Health Board could begin developing the Strategy in early 2026, but did not commit to a specific completion date, acknowledging that it was still uncertain.

Decision:
The Committee

- **NOTED** the position on the Estate Condition and Performance Project and the next steps.

SPC(25) 76 Strategy Refresh

Mr Lee Davies presented the Strategy Refresh report, confirming that it builds on the 2018 A Healthier Mid and West Wales (AHMWW) strategy, and emphasising that the Refresh is not a radical overhaul but a refinement based on updated public and staff engagement. Mr Lee Davies highlighted that the engagement is focused on understanding what matters most to people in terms of health and wellbeing, rather than specific service changes; and in response to Ms Eleanor Marks' question, confirmed that the Strategy is being developed in alignment with the CSP and will be presented at the Board meeting on 29 January 2026.

Ms Hughes Moakes provided a detailed update on Phase 2 engagement, which includes:

- Hospital walkarounds
- Staff and outpatient conversations
- Attendance at community events
- Digital engagement via "Have your say" and social media

Ms Hughes Moakes reported over 672 face-to-face engagements, 159 online responses, and six freepost submissions. She encouraged Independent Members (IMs) and Executives to participate in engagement sessions, stressing the importance of continuous engagement rather than one-off consultations, especially following recent formal consultations.

Mr Nathan Davies outlined the use of Copilot AI to analyse qualitative data from Phase 1 engagement, describing a six-step thematic analysis process applied to responses from both the Health Board's platform and YouGov. He identified five key themes:

- Equitable Access to Health and Support Services
- Holistic Prevention and Lifestyle Support
- Mental and Emotional Wellbeing
- Social Connection and Community Belonging
- Empowering Environments and Autonomy

Mr Nathan Davies proposed replicating the same analytical process for Phase 2 data.

Mr. Weir welcomed the approach, commended the use of AI for thematic analysis, and encouraged greater involvement of third-sector organisations and schools, noting that young people provide distinct perspectives on digital technology compared to older generations. Ms. Hughes Moakes agreed to review the extent of school participation in the consultation so far. Mr. Weir also supported the continuous engagement model and highlighted the importance of anticipating future population needs. **AHM**

Ms Patel raised a question regarding safeguards and oversight when using AI tools such as Copilot and emphasised the need for consistency and transparency in how questions are asked, and data is analysed.

Mr Lee Davies noted that HDdUHB would probably not have had the capacity to analyse the public feedback without use of Copilot, particularly given that CSP and Prince Philip Hospital (PPH) Minor Injuries Unit (MIU) consultations were running in parallel.

Mr Thomas supported the approach adopted by Mr Nathan Davies, describing the method as a robust, transparent and rich way of using generative AI for public engagement analysis, and suggested that the Health Board should consider publishing the process as a learning tool for other organisations. He provided assurance that Copilot has the Information Governance (IG) clearance necessary to include HDdUHB documents within it. Mr Thomas also indicated that he had been asked by the Chief Executive to lead a project through the Digital Data and Innovation Committee (DDIC) to develop protocols for the use of generative AI, including safeguards and governance. This work would build on existing protocols for machine learning already in place. Mr Weir agreed to update Mr Maynard Davies (Chair, DDIC) on the expected report. **HT/ND** **WW**

The Committee was supportive of the Strategy Refresh process, endorsing the engagement approach and the themes emerging from public feedback. There was a shared recognition of the importance of aligning the Strategy with the CSP, digital transformation, and population health priorities.

Decision:
The Committee:

- **NOTED** the information regarding the process used for the Strategy Refresh.
- **NOTED** the information about the progress made on the Strategy Refresh process.
- **NOTED** the intention to present the results of Phase 2 engagement activity at the Public Board meeting on 29 January 2026.

SPC(25) 77 Annual Plan Progress: Including Planning Objectives Update

Mr Dan Warm joined the meeting.

Mr Lee Davies introduced the Update on 2025/26 Annual Plan and the 2026/27 planning cycle, highlighting HDdUHB's risk-based planning approach, particularly the categorisation of risks into Route 1 (manageable within current resources), Route 2 (requiring resource reallocation), and Route 3 (strategic/system-wide issues). He acknowledged the importance of aligning planning with strategic transformation, including the shift-left agenda and the CSP. Mr Lee Davies also emphasised the need for Executive ownership and early oversight of savings plans, especially in light of the audit findings from the 2025/26 planning round, which had revealed over-reliance on high-risk or "pipeline" savings schemes.

Mr Ayres emphasised the importance of deliverability in the planning process, noting that the Health Board must be realistic about what can be achieved within available resources. Mr Ayres clarified that Route 2 risks do not imply new funding, but rather resource reallocation. He also indicated that HDdUHB would narrow down the 600+ risks to approximately three core risks per Clinical Care Group (CCG) to focus planning efforts, highlighting the need for an iterative planning process, and acknowledging that not all risks can be resolved immediately, but that prioritisation and transparency are key.

Mr Ayres highlighted the following:

- The risk stratification approach (Routes 1 - 3) to prioritise planning decisions.
- The need for Executive validation of proposals, especially those requiring resource reallocation.
- The importance of early oversight to avoid over-reliance on uncertain savings schemes.
- Recognition of the pressure on staff and the need for clear communication about difficult decisions.

Mr Dan Warm provided a detailed update on the status of the 2025/26 Annual Plan, confirming that all four Planning Objectives (POs) aligned to SPC (PO6, PO7, PO8, PO10) were currently on track. He indicated that none of the 38 enabling actions had been completed yet, but 27 were on track, seven delayed but achievable, and four would not be achieved in-year.

Addressing the 2026/27 planning cycle, including the use of a Planning Prioritisation Matrix to categorise the 605 risks, Mr Warm referenced the three risk routes and the process for identifying which risks could be managed internally and which required escalation. These would be the highest scoring and most critical risks, with others managed through governance or tolerated where necessary. He confirmed that the October 2025 workshop had

helped refine priorities and that further workshops in November and December 2025 would finalise decisions.

In response to Mr Weir's request for clarification on what "on track" means in relation to the four Planning Objectives aligned to SPC, specifically, he enquired whether "on track" referred to processes or outcomes, Mr Warm responded that "on track" refers to progress against the defined processes and measures set out in the planning objectives. These were previously assured through the Committee and are being monitored via Plans on a Page and quarterly updates.

Mr Warm confirmed that the CCGs were responsible for providing updates and RAG ratings for the enabling actions. These were signed off by the relevant Executive Directors and aligned with WG's planning framework.

Mr Weir raised a concern about residual risks and how the Health Board would manage those that cannot be mitigated due to resource constraints. He also asked how this would be balanced with the duty of candour for clinical staff, and Mr Ayres, acknowledging the challenge, stated that the planning process would include transparent decisions about which risks would be tolerated. These would be actively monitored, and triggers for escalation would be defined. He emphasised that prioritisation would be based on deliverability, not only risk severity. Mr Ayres confirmed that the risks included both corporate and operational risks, and that strategic risks were being considered, especially those aligned with transformation goals such as the 24/7 model and shift-left agenda.

Mr Ayres, Ms Katrina Davies and Mr Warm left the meeting.

Decision:
The Committee:

- **RECEIVED ASSURANCE** from the update on the 2025/26 Annual Plan.
- **NOTED** the current status of the four Planning Objectives aligned to the Plan.
- **NOTED** the update on progress against the Planning Cycle and the associated risks for developing the 2026/27 Plan.

SPC(25) 78 Planning Objective 8: Estates Plan

Ms Rosser presented the Planning Objective (PO) 8: Estates Plan report, indicating that PO8 is now considered on track, following a rebasing of the programme for 2025/26. This reflects ongoing WG discussions regarding strategic capital support. She noted that WG had asked the Health Board to explore a phased redevelopment of WGH. A follow-up meeting was scheduled for 4 November 2025 to discuss potential scenarios and capital implications.

Ms Rosser confirmed that an interim Estate Strategy would be developed in 2026 to align with the CSP and the refreshed AHMWW strategy, highlighting the updated estate backlog figure of approximately £265.8m, up from £255.5m the previous year.

As previously outlined by Mr Williams, Estatecode 6-facet surveys will be conducted to assess estate condition, functionality, compliance, and environmental performance.

The following updates were provided on Community Schemes:

- Carmarthen Hwb construction is progressing well, with expected completion in early 2026.
- The Pentre Awel hydrotherapy pool is complete; the Clinical Delivery Unit (CDU) is currently expected to finish in early 2026/27.
- The Cylch Caron tender process failed and Ceredigion County Council are reviewing the way forward.
- The Fishguard Health and Wellbeing Centre site selection workshop is delayed to November 2025.
- WG are currently exploring collaborative development options for Aberystwyth Integrated Care Centre (ICC).

In response to Ms Marks' question, Ms Rosser indicated that her greatest concern was the uncertainty around the long-term future of the GGH site which affects capital planning decisions, specifically to ensure that the highest-risk estate issues are being addressed through the major infrastructure programme, which has WG support. These include critical risks such as leaking roofs and fire compliance. A prioritised list of the top 10 risks has been agreed, and procurement plans are underway to address them over the next four to five years. Mr Lee Davies shared the Capital Programme for 2024/25, 2025/26 and Capital Governance Update Report (https://hduhb.nhs.wales/about-us/governance-arrangements/board-committees/strategy-and-planning-committee-spc/strategy-and-planning-committee-24-april-2025/5-1-capital-programme-for-2025-26-and-capital-governance/) which was presented to SPC on 24 April 2025 categorising the risks and outlining the prioritisation process.

Mr Lee Davies added that while the Health Board is actively managing the most critical risks, many others are being tolerated longer than ideal due to resource constraints.

Decision:
The Committee **RECEIVED ASSURANCE**:

- From the progress of discussions with WG in relation to progressing the AHMWW Programme. This includes WG support to progress the ten highest risk estate backlog schemes and the support to refresh HDdUHB's major infrastructure Programme Business Case (PBC).

- From the consideration being given to the 6-facet surveys to provide a comprehensive property appraisal methodology to assess a number of key areas.
- From the aim to develop an interim Estate Strategy in 2026 to align to the outputs of the CSP and AHMWW refreshed strategy.
- From the progress of Community Schemes.

SPC(25) 79 Partnership Governance Assurance Report

Ms Trina Nealon joined the meeting.

Dr Gjini introduced the Partnership Governance Assurance Report, as a means to provide assurance to SPC regarding the governance arrangements of the Health Board's statutory partnerships. These include:

- The West Wales Regional Partnership Board (RPB)
- The three Public Services Boards (PSBs): Carmarthenshire, Ceredigion, and Pembrokeshire

Outlining how these partnerships are structured and governed, and how they align with the Health Board's strategic priorities, particularly in relation to population health and prevention, Dr Gjini indicated that the RPB guidance from WG had recently been updated, clarifying the role of the Responsible Officer (now the Chief Executive, Prof Phil Kloer). There is ongoing work to streamline subgroups under the RPB, such as the Prevention Board and the Children and Young People's Board, to improve alignment and effectiveness.

Ms Trina Nealon outlined the structure of the RPB, highlighting the complexity and number of subgroups, and indicating that some subgroups are active and meet regularly, while others have not met for some time. The structure is currently under review to improve alignment and effectiveness. The Executive leads for the partnerships are:

- Mr Joe Patterson for the RPB
- Dr Gjini for the PSBs

Ms Nealon outlined four options currently under consideration by the three PSBs for future collaboration:

- Maintain current arrangements
- Merge into a single regional PSB
- Form a formal collaborative (with or without a strategic coordinating group)
- Merge two of the three PSBs

The Committee noted that Ceredigion PSB had scheduled a workshop in November 2025 to discuss the options, while similar discussions were expected in Pembrokeshire and

Carmarthenshire. The outcomes of these discussions would inform future governance and strategic alignment.

Asked about the timeline for when the three PSBs would reach a decision on the collaboration options presented in the report, Dr Gjini indicated that all three PSBs had received the options paper. She confirmed that Pembrokeshire PSB had voted in favour of a merger, while Carmarthenshire and Ceredigion were still considering their positions. She expected that a formal alignment or decision would be reached in the next quarter (early 2026).

At Mr Weir's request, Dr Gjini agreed that the next time the item returns to the Committee, it would include an update on the Population Needs Assessment, to facilitate better understanding of the needs of the population and how planning will respond. Dr Gjini emphasised that the Population Needs Assessments conducted by the PSBs in 2022–2023 showed similar priorities across the three counties - poverty, climate change/sustainability, and prevention, supporting the case for greater regional alignment. **AG/TN**

In response to Mr Imperato's enquiry regarding an exemplar PSB which was delivering outstanding results, and whether there were any PSBs that were underperforming, Dr Gjini referenced the recently published Well-being of Future Generations Commissioner's 10-year report, which highlighted good practice. She noted that Gwent, where six Local Authorities had merged into a single PSB, was often cited as a positive example of regional collaboration. She also mentioned that other organisations like Natural Resources Wales (NRW) face similar challenges in working across multiple PSBs, and that HDdUHB has aligned well with such partners.

Dr Gjini referenced the Area Planning Board (APB) for Substance Use Services and agreed to present an update on its governance and delivery to a future SPC meeting. **AG/TN**

In response to Ms Marks' questions regarding whether there were any metrics to measure the effectiveness of PSB interventions on health outcomes; and how much time the Health Board spends managing partnerships versus the actual impact delivered, Dr Gjini indicated that effectiveness is measured through Population Needs Assessments, which are refreshed every three years. She acknowledged that some PSBs are more strategic than operational. Ms Marks' concern about the complexity and fragmentation of partnership working was acknowledged as valid and shared by others.

Decision:
The Committee:

- **RECEIVED ASSURANCE** regarding the governance arrangements of strategic partnerships with West Wales RPB; the sub-groups of the Preventions Board; the CYP

Board; and the PSBs of Ceredigion, Carmarthenshire and Pembrokeshire.

SPC(25) 80 Wellbeing Objectives Annual Report

DEFERRED until SPC on 18 December 2025, ahead of submission to Board for approval on 29 January 2026.

SPC(25) 81 Review of Clinical Pharmacy Services at NHS Hospitals in Wales

Ms Rhian Bond, Mr Owain Williams and Ms Elizabeth Williams joined the meeting.

Mr Owain Williams presented the Welsh Government's Independent Review of Clinical Pharmacy Services at NHS Hospitals in Wales, indicating that the review was commissioned by WG and conducted by the Royal Pharmaceutical Society (RPS). It identified 60 actions across four key themes:

- Enabling pharmacy professionals to practise where they add most value
- Developing hospital pharmacy teams to deliver outstanding clinical care
- Strengthening quality, leadership, and governance
- Realising the potential of digital, automation, and technology

In terms of progress to date, Mr Owain Williams indicated that 21 of the 60 actions (35%) have been completed and incorporated into practice. The remaining 39 actions are either in progress or require external support from bodies such as Health Education and Improvement Wales (HEIW), WG, or the Directors of Pharmacy Peer Group. Five Delivery Assurance Groups have been established nationally to support implementation, and HDdUHB pharmacy staff are actively involved in these.

Mr Owain Williams confirmed the following key achievements and initiatives:

- Clinical Prioritisation
  13 Pharmacy Technicians trained to identify patients needing pharmacist intervention.
  Enabling Quality Improvement in Practice (EQIiP) projects which demonstrated the value of early pharmacy involvement in emergency care to reduce medication errors.
- Urgent and Emergency Care (UEC)
  Pharmacy services are provided during core hours in UEC settings.
  Expansion is limited by workforce constraints.
  Proposals for Clinical Streaming Hubs include pharmacy roles, but recruitment is challenged by short-term funding.
- Prehabilitation and Preadmissions
  A part-time Prehabilitation Pharmacist is in post until 2026.

More data is needed to assess the impact of pharmacy involvement in preadmission services.

- Multidisciplinary Team (MDT) Working
  Pharmacists are embedded across specialties including mental health, cancer, stroke, and gastroenterology.
  Prescribing pharmacists are managing patient cohorts directly.
- Education and Workforce Development
  74% of secondary care pharmacists are active prescribers.
  Pharmacy students graduating from 2026 will be “prescriber-ready.”
  HDdUHB hosted 126 undergraduate placements in 2025/26.
  The first Consultant Pharmacist in Wales was appointed in HDdUHB Primary Care.
  The first accredited Technical Officer was appointed in HDdUHB.
- Digital Transformation
  Electronic Prescribing and Medicines Administration (EPMA) rollout planned for Q1 2026.
  Digital literacy training underway for pharmacy staff.

Mr Owain Williams indicated that workforce pressures and recruitment challenges may delay full implementation, and that sustaining core pharmacy services while expanding clinical roles is a balancing act. Effective workforce planning and service redesign are essential to meet future NHS demands.

In response to Ms Marks’ enquiry regarding the relationship between pharmacists and GPs, particularly in the context of independent providers and community pharmacy and how this relationship supports the population and whether it is being fully utilised, Mr Williams indicated that the relationship is evolving, especially with the expansion of independent prescribing in community pharmacies. There is a need for governance and mentorship to support pharmacists working independently, and HDdUHB is working to improve data sharing and digital integration so that GPs and pharmacists can see each other's prescribing activity. He acknowledged that while progress is being made, more work is needed to ensure joined-up care across primary and secondary sectors.

Mr Weir enquired what the priorities for planning should be in relation to the review and how HDdUHB compares to other Health Boards in Wales. Mr Owain Williams advised that HDdUHB is not behind other Health Boards and has areas of excellence, such as in mental health and cancer services. The priority is to embed pharmacists in MDTs and expand their roles in areas such as emergency care and chronic disease management. He emphasised the importance of electronic prescribing and digital transformation as enablers of future service improvement.

In response to Ms Patel’s question regarding clinical prioritisation and whether data is being collected to demonstrate its impact and cost-effectiveness, Mr Owain Williams responded that HDdUHB is

working on Value-Based Healthcare (VBHC) and Patient Reported Outcome Measures (PROMs)/ Patient Reported Experience Measures (PREMs). The EQIiP project has already shown the value of pharmacy interventions in emergency care, although Mr Owain Williams acknowledged that more work is needed to systematically collect and analyse data to demonstrate the impact of clinical prioritisation.

Ms Rhian Bond, indicating that the Health Board is working on supplementary service specifications to better integrate services between GPs and community pharmacies, reinforced Mr Owain William's response, highlighting that:

- Access to GP appointments is decreasing, while community pharmacy activity is increasing.
- There is a need for better data systems to track patient journeys and outcomes across services.

Mr Owain Williams concluded that while significant progress has been made, continued innovation, digital transformation, and workforce development are critical to delivering the review's recommendations. He emphasised the need for sustainable models and permanent roles to support clinical pharmacy's evolving contribution to patient care.

Decision:
The Committee:

- **NOTED** the content of the Welsh Government's Independent Review of Clinical Pharmacy Services at NHS Hospitals in Wales Report and the achievements to date across the actions recommended within the WG Review.
- **NOTED** the ongoing work and development within HDdUHB and in collaboration with external organisations to support and achieve recommendation within the Review.
- **SUPPORTED** the recommendation to update actions, completion dates and deadlines within the recommendations on AMAT, where actions have now been updated or identified for external national development. Details of the changes to be agreed through the CCG governance structure.

SPC(25) 82 **Deep Dive PO7: Primary Care and Community Strategic Plan Update**

Ms Bond presented the Primary Care and Community Strategic Plan Update, highlighting the following:

- The plan supports the "shift left" agenda, moving care closer to home and strengthening community-based services.
- Approximately 90% of patient contacts occur in primary and community services, making them central to the health system.

- The service has evolved from being considered fragile (especially General Practice) to one with strong clinical engagement and strategic momentum.
- Over the summer, engagement with Professional Collaboratives and seven Clusters helped shape the plan, identifying key themes:

    - Continuity of care
    - Access and quality
    - Coordination between primary and secondary care
    - Innovation in service models

Ms Bond indicated that a mapping exercise is underway to align cluster-level suggestions with clinical feedback, revealing consistent priorities; and will be presented at the Board meeting on 29 January 2026, including:

- Strategic vision
- Clinical model
- Stakeholder engagement summary
- Risks of maintaining the status quo
- Implementation considerations

Ms Bond also indicated that national contract negotiations (General Medical Services (GMS), pharmacy, optometry, dental) are ongoing and the plan must remain flexible to accommodate national developments.

In response to Ms Marks' question regarding the timeline and assurance for delivering a robust strategic plan, Ms Bond confirming that the full Strategic Plan would not be complete by January 2026, but the vision, priorities, and strategic direction would be presented, emphasised that the January 2026 report would include the foundational elements and next steps for implementation. She acknowledged the need to align with national contract negotiations and the CSP.

Ms Marks, emphasising the importance of aligning the Plan with the Social Model for Health and Well-being (SMfHW), the CSP and long-term transformation goals, encouraged Executive-level discussions to ensure strategic coherence.

Dr Gjini supported Ms Bond's approach and confirmed that the SMfHW and population health principles were being embedded in the Strategy.

Ms Marks also emphasised the importance of having a clear and timely Primary Care Strategy, noting that the Health Board had been without one for too long.

Decision:
The Committee:

- **RECEIVED ASSURANCE** regarding the progress made in developing the Primary and Community Services Strategic Plan.

SPC(25) 83 Pharmaceutical Needs Assessment

Ms Bond presented the Pharmaceutical Needs Assessment (PNA), highlighting that the PNA is a statutory requirement under Section 82A of the NHS (Wales) Act 2006 and the NHS (Pharmaceutical Services) (Wales) Regulations 2020. HDdUHB published its last PNA on 1 October 2021. Since then, two supplementary statements have been issued:

- June 2023: Following the closure of the dispensary at Solva Surgery.
- February 2024: Following the closure of Superdrug in Llanelli.

A revised PNA is now being developed ahead of the five-year deadline, with a Steering Group and Working Group established to oversee the process. Ms Bond indicated that the revised PNA will include updated cluster-level information, with input from Community Pharmacy Wales, Public Health, and Llais. A detailed timeline was shared, showing key milestones from October 2025 through to publication in October 2026, including a 60-day public consultation from May to June 2026.

Mr Weir enquired whether the Health Board was confident that the timeline for revising the PNA was achievable and whether the necessary engagement and governance were in place. Ms Bond, confirming that the timeline was realistic and achievable, with clear governance structures in place, emphasised that the Steering Group includes key stakeholders and that the process is aligned with national guidance. The Committee noted that the consultation period would follow the same format as the original PNA, as advised by WG.

The Committee expressed support for the structured and collaborative approach being taken, recognising the importance of the PNA in informing pharmacy service planning, particularly in light of recent service changes and closures. The Committee appreciated the transparency and forward planning demonstrated in the timeline and governance arrangements.

Decision:
The Committee:

- **NOTED** the process set out to review and update the Pharmaceutical Needs assessment for HDdUHB and the associated timeline.

SPC(25) 84 Joint Commissioning Committee Planning, Performance and Finance Sub-Committee Reports

The Committee **NOTED** the Joint Commissioning Committee Planning, Performance and Finance Sub-Committee Reports

SPC(25) 85 **Regional Joint Committee 3As Update Report to Hywel Dda and Swansea Bay University Health Boards (September 2025)**

The Committee **NOTED** the Regional Joint Committee 3As Update Report to Hywel Dda and Swansea Bay University Health Boards.

SPC(25) 86 **Strategy & Planning Committee Workplan 2025-26**

The Committee **NOTED** the Strategy & Planning Committee Workplan 2025-26

SPC(25) 87 **Date of Next Meeting**

18 December 2025, 09:30 - 12:30, MS Teams

26 February 2026

1.4

09:30, 5 Mins

1.4 - Table of Actions the Strategy and Planning Committee meeting on 30 October 2025

Winston Weir (Hywel Dda UHB - Independent Board Member)

For discussion

Attachments

1.4 SPC Table of Actions - 30 October 2025.pdf

PWYLLGOR STRATEGAETH A CHYNLLUNIO / STRATEGY AND PLANNING COMMITTEE

TABL GWEITHREDOEDD / TABLE OF ACTIONS

DYDDIAD / DATE: 30 OCTOBER 2025

MINUTE REF	ACTION	LEAD	TIME SCALE	PROGRESS
SPC(25) 71	**Assurance and Risk Report** Risk 1185: *Consistent and meaningful engagement:* To liaise with Mr Winston Weir regarding his contribution to continuous engagement.	**AHM**	**18 December 2025**	**Complete** Opportunities for involvement in engagement have been shared with the Committee Chair.
SPC(25) 74	**Capital Programme for 2025-26 and Capital Governance** To record a new risk regarding overcommitment of Discretionary Capital Programme (DCP) by £0.845m and capital volatility.	**ER**	**18 December 2025**	**Complete** Risk 2204 now added to the Risk Register.
SPC(25) 76	**Strategy Refresh** To review the extent of school participation in the consultation to date.	**AHM**	**18 December 2025**	**Complete** To date, participation from schools in the consultation has mainly occurred through youth-focused engagement activities such as youth council meetings, young people's panels, as well as parent and child sessions. These engagements have provided opportunities for children and young people, as well as parents and carers, to share their views and contribute to questions raised as part of Phase 2 of the Strategy Refresh. Due to the nature of the engagement and the timeframe of the activity, this approach has been favoured over direct outreach in

				schools. This method has enabled broad and inclusive input from young people and families, while remaining flexible to the engagement timescales.
SPC(25) 76	**Strategy Refresh** To consider publishing the public engagement analysis process as a case study as a learning tool for other organisations.	**HT/ND**	**18 December 2025**	**Complete** Shared with SPC members on 4 November 2025.
SPC(25) 76	**Strategy Refresh** To update Mr Maynard Davies (Chair, Digital Data and Innovation Committee (DDIC)) on Mr Huw Thomas' expected report regarding development of protocols for the use of generative AI, including safeguards and governance, which will be presented to a future DDIC meeting.	**WW**	**18 December 2025**	**Complete** The relevant extract of the minutes of SPC were highlighted to Mr Maynard Davies on 25 November 2025. In addition, an executive action was noted to Mr Huw Thomas to brief Mr Maynard Davies on the reporting protocols in this area.
SPC(25) 79	**Partnership Governance Assurance Report** To include an update on the Population Needs Assessment at the next meeting, to facilitate better understanding of the needs of the population and how planning will respond.	**AG/TN**	**18 December 2025**	**Complete** Forward planned for 18 December 2025 (to be included within Planning Objective 10: Population Health).
SPC(25) 79	**Partnership Governance Assurance Report** To present an update on the Area Planning Board (APB) for Substance Use Services and its governance and delivery to a future SPC meeting.	**AG/TN**	**18 December 2025**	**Complete** Forward planned for 26 February 2026.

AHM: Alwena Hughes Moakes	ER: Eldeg Rosser	HT: Huw Thomas	ND: Nathan Davies	WW: Winston Weir
AG: Ardiana Gjini	TN: Trina Nealon			

1.5 **09:35, 0 Mins**

1.5 - Matters Arising

Winston Weir (Hywel Dda UHB - Independent Board Member)

For information

1.6 **09:35, 10 Mins**

1.6 - Assurance and Risk Report

Joanne Wilson (Hywel Dda UHB - Director of Corporate Governance/Board Secretary)

Including:
Corporate Risks; Operational Risks; Audits and Inspections; Welsh Health Circulars; Ministerial Directions

For assurance

Attachments

1.6.1 SPC CRR Assurance and Risk Report Nov 25 FINAL 271125.pdf

1.6.2 Appendix 1 - SPC CRR 26Nov25.pdf

1.6.3 Appendix 2 SPC - Audit Inspections Nov 25.pdf

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Hywel Dda
University Health Board

Assurance and Risk Report

Strategy & Planning Committee – 18 December 2025

Situation

This report provides the Strategy and Planning Committee (SPC) with the status of the corporate risks, audit and inspections recommendations and Ministerial Directions (MDs).

The Committee is asked to seek assurance from the Lead Executive Directors that risks are being managed effectively and that recommendations from audit and inspections, and MDs, are being implemented by the Health Board.

Principal risks, operational risks, and Welsh Health Circulars (WHCs) are reported at alternate meetings, and due to be presented to SPC at its next meeting in February 2026.

Corporate Risks:	Audits & Inspection Reports	Ministerial Directions
1	10	0

Risk Management - Overview

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Effective risk management requires a 'monitoring and review' structure to be in place to ensure that risks are effectively identified and assessed, and that appropriate controls and responses are in place.

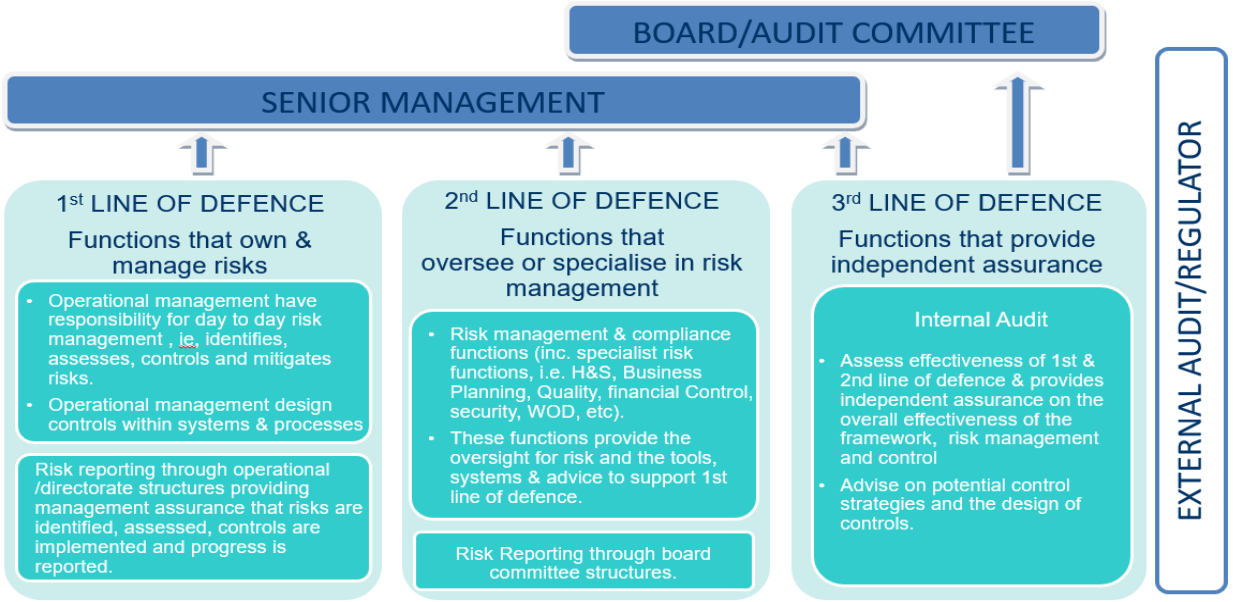
The Health Board's risk management process is recorded via the Datix Risk Register module, and enables risks to be recorded at either Principal, Corporate or Operational level. An escalation process is in place to ensure that risks which require escalation or de-escalation are done via appropriate approval processes and governance arrangements.

The Health Board operates within the widely accepted "Three Lines of Defence" model to ensure the appropriate responsibility is allocated for the management, reporting and escalation of risk.

Risks are aligned to an appropriate Clinical Care Group (CCG) or Executive Function (hereto referred to as "Functions"), and each has a designated risk lead responsible for reviewing in a timely and comprehensive manner.

The Board's Committees are responsible for the monitoring and scrutiny of corporate and operational risks within their remit, providing assurance to the Board that risks are being managed effectively; and reporting areas of significant concern (eg where the risk appetite is exceeded, or there is a lack of action).

Committees are also responsible for reviewing risks over tolerance and where appropriate, recommend the 'acceptance' of risks that cannot be brought within risk appetite.



Corporate risks assigned to SPC

Hywel Dda Risk Heat Map					
	LIKELIHOOD →				
IMPACT ↓	Rare 1	Unlikely 2	Possible 3	Likely 4	Almost Certain 5
Catastrophic 5					
Major 4					
Moderate 3				**2212** (NEW)	
Minor 2					
Negligible 1					

Each risk on the Corporate Risk Register (CRR) has been mapped to a Board level Committee to ensure that risks on the CRR are being managed appropriately, taking into account gaps in controls, planned actions and agreed tolerances, and to provide assurance to the Board through their update report on the management of these risks.

These risks have been identified by individual Directors via a top down and bottom-up approach and are either:

- Associated with the delivery of the Health Board objectives; or
- Significant escalated operational risks that are of significant concern and require corporate oversight and management.

There is one new risk currently aligned to SPC (out of the 23 that are currently on the CRR).

The following slide provides a summary of the reportable corporate risk aligned to SPC. The Corporate Risk Register attached at **Appendix 1**, provides full detail of the risk, including control measures in place, a risk action plan to further manage and mitigate the risk, and sources of assurance.

Corporate Risks assigned to SPC

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Risk Reference & Title	Lead Director	Current Risk Score	Target Risk Score (TRS)	Expected Date to Achieve TRS
2212 - There is a risk that the Health Board will not have an approvable Integrated Medium-Term Plan (IMTP) by March 2028.	Director of Strategy and Planning	**12** (NEW)	**4**	31/03/2028

Rationale for Current Risk Score

The Health Board does not have an approvable IMTP in place due to the inability to demonstrate a financially balanced position, and as a consequence is in breach of its statutory duty under Section 175(2A) of the National Health Service (Wales) Act 2006. This has led to the Health Board being placed into Targeted Intervention (TI). The current risk score of 12 after controls acknowledges that while the Health Board is strengthening its planning processes (setting it in a 3-year context as a form of mitigation), the fundamental challenges remain. The likelihood reduces slightly to "likely" (4) rather than "certain" (5) as improved planning might achieve "consideration" even if not approval. However, until operational risks reduce and assurance provided on the ability of services across the Health Board to deliver on their savings targets, full mitigation remains impossible.

Rationale for Target Risk Score (TRS)

The achievement of a financially balanced and an approvable plan would be a key driver for the Health Board to be de-escalated from Targeted Intervention by Welsh Government. (WG) The financial roadmap to achieve this by 2027/28 is critical to this.

TRS and expected date to achieve have been agreed by Formal Executive Team in November 2025

Audits and Inspections - Overview

The Health Board remains in TI (Level 4) status with WG as a result of challenges relating to financial sustainability, strategy and planning, service delivery and organisational performance. Whilst the Health Board has been de-escalated for 'Governance' from TI (Level 4) to Enhanced Monitoring (Level 3), the Health Board must meet the revised set criteria:

- Evidence that all recommendations from the Royal Colleges / Health Inspectorate Wales (HIW) and other reviews specific to Hywel Dda University Health Board (HDdUHB) are discharged and either verified, delivered or scheduled for delivery within the Health Board's longer-term improvement plan; and
- Demonstrate a prompt response to any HIW inspections, concerns, incidents, never-events, coroners requests and regulation 28s– *which has replaced the previous criteria of 'Effective response from the Health Board to external reports and reviews including those from Audit Wales, the Ombudsman, Royal Colleges and HIW resulting in sustainable improvements.'*
- The Board acts on, and addresses appropriately, concerns raised through NHS regulators such as HIW.

All reports from audits, inspections and reviews undertaken across the Health Board are logged and tracked via the **AMaT (Audit Management and Tracking)** system, with progress updated by relevant service leads against each recommendation and evidence required to be uploaded to demonstrate implementation.

AMaT enables services to directly update progress against all recommendations via one central system, promoting a consistent approach to processes and reporting, improvement in transparency and accountability, supporting services with their governance arrangements, and improvement in information flow. Progress is monitored using a categorisation system based on performance against original completion dates, with several new categories introduced since the previous meeting (shown on the next slide).

Recommendations that have exceeded original timescales, along with the management responses, completion dates and barriers to implementation as provided by the lead officer on AMAT are included in **Appendix 2**.

Audit & Inspections – New tracker statuses

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

There are 10 open reports aligned to SPC to enable it to undertake the following responsibility set out in its Terms of Reference:

3.1.22. Seek assurance on the delivery of the requirements arising from Health Board's regulators, WG and professional bodies.

Each recommendation raised within audit and inspection reports is assigned a status category. Since the previous report to SPC, three new status categories have been introduced to provide enhanced analysis on the progress being made in implementing recommendations. Definitions for these new categories are included in the table below:

Status Category	Definition	Number of recommendations
Overdue	The recommendation is behind schedule to the timescale provided by the lead officer.	8
Unable to Complete (NEW)	The recommendation cannot be implemented due to existing barriers and/or it is no longer relevant/appropriate for the Health Board. Formal sign-off by the CCG/Function Lead is required prior to escalation to the Executive Team for formal approval via operational governance structures.	1
Pending Decision (NEW)	The recommendation is pending a decision in order to implement e.g. outcomes of annual planning process, approval of funding requests, outcome of a Quality Impact Assessment (QIA) panel. Committee updates will detail whether the recommendation is overdue or not whilst decision is pending.	0
In Progress	The recommendation is currently in progress, and within the agreed original timeframe for implementation.	14
Reliant on External Factors	The recommendation is considered to be outside the gift of the Health Board to currently implement, e.g. reliant on an external organisation to implement.	6
Complete Pending Formal Approval (NEW)	The Service / Function have completed the recommendation and is currently awaiting formal approval to close.	5
Complete	The recommendations has been confirmed as completed by the CCG / Function Lead and formal approval to close has been received.	26

Audits and Inspection Reports assigned to SPC (1 of 2)

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

The following reports have been assigned to SPC to enable them to undertake the following responsibility set out in their Terms of Reference: -

Report issued by	Report Title	Clinical Care Group / Executive Function	Lead Director	Original Completion Date	Revised Completion Date	Total number of Recs	Overdue	In Progress	Complete	Complete Pending Formal Approval	Reliant on External Factors	Unable to Complete	Any Barriers to Completion Noted?
Audit Wales	Structured Assessment 2022 **(issued Dec 22)**	Corporate Services	Director of Corporate Governance	Mar-24	N/K	6	0	0	6	0	0	0	None
Welsh Govern-ment	Independent Review of Clinical Pharmacy Services at NHS Hospitals in Wales **(issued Sep 23)**	Primary Care, Community Strategy & Long-Term Care	Chief Operating Officer	Apr-31	Apr-31	16	1	8	0	2	4	1	Lack of space within Health Board to support medicine hub.
Audit Wales	Structured Assessment 2023 **(issued Nov 23)**	Corporate Services	Director of Corporate Governance	Jul-24	N/K	5	0	0	5	0	0	0	None
Audit Wales	Primary Care Follow-up Review **(issued Nov 23)**	Primary Care, Community Strategy & Long-Term Care	Chief Operating Officer	Mar-25	N/K	2	1	0	0	0	1	0	Success will be achieved when CIVICA is available for use across Primary Care contractors
Internal Audit	Capital Systems Final Internal Audit Report 2024/25 **(issued Nov 24)**	Director of Strategy and Planning	Director of Strategy and Planning	Dec-24	N/K	4	0	0	3	0	1	0	Awaiting WG publication of revised version.
Audit Wales	Structured Assessment 2024 **(issued Nov 24)**	Corporate Services	Director of Corporate Governance	Mar-26	Mar-26	3	0	1	2	0	0	0	None noted.
Internal Audit	Energy Management Final Internal Audit Report 2024/25 **(issued Nov 24)**	Estates & Facilities	Director of Allied Health Professions and Health Sciences	Mar-26	Mar-26	8	1	0	5	2	0	0	None noted.
Audit Wales	Review of Capital Investment Prioritisation **(issued May 25)**	Director of Strategy and Planning	Director of Strategy and Planning	Nov-25	Nov-25	1	0	1	0	0	0	0	None noted.

Audits and Inspection Reports assigned to SPC (2 of 2)

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Report issued by	Report Title	Clinical Care Group / Executive Function	Lead Director	Original Completion Date	Revised Completion Date	Total number of Recs	Overdue	In Progress	Complete	Complete Pending Formal Approval	Reliant on External Factors	Unable to Complete	Any Barriers to Completion Noted?
Audit Wales	Urgent and Emergency Care: Arrangements for Managing Demand – **(issued May 25)**	Community & Integrated Medicine	Chief Operating Officer	Dec-25	Dec-25	14	5	3	5	1	0	0	None noted.
Internal Audit	Commissioning – Long Term Agreements Final Internal Audit Report 2025/26 **(issued Sep 25)**	Director of Strategy and Planning	Director of Strategy and Planning	Apr-26	Apr-26	1	0	1	0	0	0	0	None noted.

Implementation of Ministerial Directions (MDs)

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Ministerial Directives (MDs) are legislative in character as they alter legal rights and duties. MDs are issued by Welsh Ministers and include codes of practice and guidance. In complying with the requirements of various governance codes and the Annual Governance Statement requirements, HDdUHB has a duty to provide assurance of compliance with MDs.

The table below shows the number of MDs assigned to SPC per category as at November 2025. To provide a more accurate reflection of MD's progress, three new status categories have been introduced since the last Committee report to mirror those used on the Audit & Inspection tracker. Definitions for these new categories are included in the table below, and shows the number of MDs assigned to SPC per category as at November 2025.

Status Category	Definition	Number of MDs
Overdue	The MD is behind schedule to the timescale provided by the lead officer.	0
Unable to Complete (NEW)	The MD cannot be implemented due to existing barriers and/or it is no longer relevant/appropriate for the Health Board. Formal sign-off by the CCG/Function Lead is required prior to escalation to the Executive Team for formal approval via operational governance structures.	0
Pending Decision (NEW)	The MD is pending a decision in order to implement e.g. outcomes of annual planning process, approval of funding requests, outcome of a QIA panel. Committee updates will detail whether the recommendation is overdue or not whilst decision is pending.	0
In Progress	The MD is currently in progress, and within the agreed original timeframe for implementation.	0
Reliant on External Factors	The MD is considered to be outside the gift of the Health Board to currently implement, e.g. reliant on an external organisation to implement.	0
Complete Pending Formal Approval (NEW)	The Service / Function has completed the MD and is currently awaiting formal approval to close.	0
Complete	The MD has been confirmed as completed by the CCG / Function Lead and formal approval to close has been received.	0

MDs aligned to SPC based on the following criteria:

3.1.22. Seek assurance on the delivery of the requirements arising from Health Board's regulators, WG and professional bodies

Progress updates relating to the implementation of MDs are extracted from the A[illegible] **There are currently no MDs assigned to SPC.**

Recommendations

The Committee is requested, in relation to the areas presented in this report, to:

Risk Management

- **RECEIVE ASSURANCE** that identified controls are in place and working effectively;
- **RECEIVE ASSURANCE** that all planned actions are credible and deliverable, and in line with agreed plans, and will be implemented within stated timescales and will reduce risks further and/or mitigate the impact should risks materialise; and

Audits, Inspections and Regulatory Reports

- **RECEIVE ASSURANCE** from the lead Executive Director or Supporting Officer on the management of recommendations raised in audit, inspection and regulatory reports within their area of responsibility, particularly in respect of confirming the full implementation of recommendations with any barriers to delivery noted.

Ministerial Directions

- **RECEIVE ASSURANCE** that the Health Board is compliant with the Ministerial Directions issued by Welsh Government.

DIOGEL | CYNALIADWY | HYGYRCH | CAREDIG

SAFE | SUSTAINABLE | ACCESSIBLE | KIND

GIG CYMRU NHS WALES

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Hywel Dda
University Health Board

CORPORATE RISK REGISTER SUMMARY NOVEMBER 2025

Risk Ref	Risk (for more detail see individual risk entries)	Executive Director	Domain	Previous Risk Score	Risk Score Nov-25	Trend	Target Risk Score (tolerable score)	Expected Date of achieving Target Risk Score
2212	Risk the Health Board will not have an approvable Integrated Medium-Term Plan (IMTP) by March 2028.	Davies, Lee	Statutory duty/inspections	NA	**4×3=12**	New risk	**1×4=4**	31/03/2028

RISK SCORING MATRIX

Likelihood x Impact = Risk Score					
Likelihood	**1**	**2**	**3**	**4**	**5**
Descriptor	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost Certain**
Frequency - How often might it/does it happen? (how many times will the adverse consequence being assessed actually be realised?)	**This will probably never happen/recur (except in very exceptional circumstances).**	**Do not expect it to happen/recur but it is possible that it may do so.**	**It might happen or recur occasionally.**	**It might happen or recur occasionally.**	**It will undoubtedly happen/recur, possibly frequently.**
	Not expected to occur for years.*	Expected to occur at least annually.*	Expected to occur at least monthly.*	Expected to occur at least weekly.*	Expected to occur at least daily.*
	* time-framed descriptors of frequency				
Probability - Will it happen or not? (what is the chance the adverse consequence will occur in a given reference period?)	**(0-5%*)**	**(5-25%*)**	**(25-75%*)**	**(75-95%*)**	**(>95%*)**
	*used to assign a probability score for risks related to time-limited or one off projects or business objectives.				
Risk Impact Domains	**Negligible - 1**	**Minor - 2**	**Moderate - 3**	**Major - 4**	**Catastrophic - 5**
Safety of Patients, Staff or Public	**Minimal injury requiring no/minimal intervention or treatment.**	**Minor injury or illness, requiring minor intervention.**	**Moderate injury requiring professional intervention.**	**Major injury leading to long-term incapacity/disability.**	**Incident leading to death.**
	No time off work.	**Requiring time off work for >3 days**	**Requiring time off work for 4-14 days.**	**Requiring time off work for >14 days.**	**Multiple permanent injuries or irreversible health effects.**
		Increase in length of hospital stay by 1-3 days.	**Increase in length of hospital stay by 4-15 days.**	**Increase in length of hospital stay by >15 days.**	**An event which impacts on a large number of patients.**
			Agency reportable incident.	**Mismanagement of patient care with long-term effects.**	
			An event which impacts on a small number of patients.		
Quality, Complaints or Audit	**Peripheral element of treatment or service suboptimal.**	**Overall treatment or service suboptimal.**	**Treatment or service has significantly reduced effectiveness.**	**Non-compliance with national standards with significant risk to patients if unresolved.**	**Totally unacceptable level or quality of treatment/service.**
	Informal complaint/inquiry.	**Formal complaint.**	**Formal complaint -**	**Multiple complaints/ independent review.**	**Gross failure of patient safety if findings not acted on.**
		Local resolution.	**Escalation.**	**Low achievement of performance/delivery requirements.**	**Inquest/ombudsman inquiry.**
		Single failure to meet internal standards.	**Repeated failure to meet internal standards.**	**Critical report.**	**Gross failure to meet national standards/performance requirements.**
		Minor implications for patient safety if unresolved.	**Major patient safety implications if findings are not acted on.**		
		Reduced performance if unresolved.			

Workforce & OD	Short-term low staffing level that temporarily reduces service quality (< 1 day).	Low staffing level that reduces the service quality.	Late delivery of key objective/ service due to lack of staff.	Uncertain delivery of key objective/service due to lack of staff.	Non-delivery of key objective/service due to lack of staff.
			Unsafe staffing level or competence (>1 day).	Unsafe staffing level or competence (>5 days).	Ongoing unsafe staffing levels or competence.
			Low staff morale.	Loss of key staff.	Loss of several key staff.
			Poor staff attendance for mandatory/key training.	Very low staff morale. No staff attending mandatory/ key training.	No staff attending mandatory training /key training on an ongoing basis.
Statutory Duty or Inspections	No or minimal impact or breach of guidance/ statutory duty.	Breach of statutory legislation.	Single breach in statutory duty.	Enforcement action	Multiple breaches in statutory duty.
		Reduced performance levels if unresolved.	Challenging external recommendations/ improvement notice.	Multiple breaches in statutory duty.	Prosecution.
				Improvement notices.	Complete systems change required.
				Low achievement of performance/delivery requirements.	Low achievement of performance/delivery requirements.
				Critical report.	Severely critical report.
Adverse Publicity or Reputation	Rumours.	Local media coverage – short-term reduction in public confidence. Elements of public expectation not being met.	Local media coverage – long-term reduction in public confidence.	National media coverage with <3 days service well below reasonable public expectation.	National media coverage with >3 days service well below reasonable public expectation. AMs concerned (questions in the Assembly).
	Potential for public concern.				Total loss of public confidence.
Business Objectives or Projects	Insignificant cost increase/ schedule slippage.	<5 per cent over project budget. Schedule slippage.	5–10 per cent over project budget. Schedule slippage.	Non-compliance with national 10–25 per cent over project budget. Schedule slippage. Key objectives not met.	Incident leading >25 per cent over project budget. Schedule slippage. Key objectives not met.
Finance including Claims	Small loss.	Loss of 0.1–0.25 per cent of budget.	Loss of 0.25–0.5 per cent of budget.	Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget.	Non-delivery of key objective/ Loss of >1 per cent of budget.
	Risk of claim remote.	Claim less than £10,000.	Claim(s) between £10,000 and £100,000.	Claim(s) between £100,000 and £1 million.	Failure to meet specification/ slippage
					Claim(s) >£1 million.
Service or Business interruption or disruption	Loss/interruption of >1 hour. Minor disruption.	Loss/interruption of >8 hours.	Loss/interruption of >1 day.	Loss/interruption of >1 week.	Permanent loss of service or facility.
		Some disruption manageable by altered operational routine.	Disruption to a number of operational areas within a location and possible flow onto other locations.	All operational areas of a location compromised. Other locations may be affected.	Total shutdown of operations.
Environmental	Minimal or no impact on the environment.	Minor impact on environment.	Moderate impact on environment.	Major impact on environment.	Catastrophic/critical impact on environment.
Health Equity	Minimal or no impact on our attempts to improve health equity	Minor impact on our attempts to improve health equity or low level of certainty on the impact we are having on health equity	Moderate impact on our attempts to improve health equity or a lack of sufficient information that would demonstrate this. Indications that we are not having a positive impact on health improvement or health equity	Major impact on our attempts to improve health equity. Validated data suggesting that we are not improving the health of the most disadvantaged in our population whilst clearly supporting the least disadvantaged. Validated data suggesting we are having no impact on health improvement or health equity.	Validated data clearly demonstrating a disproportionate widening of health inequalities or a negative impact on health improvement and/or health equity.

RISK MATRIX

IMPACT ↓	LIKELIHOOD →				
	RARE	UNLIKELY	POSSIBLE	LIKELY	ALMOST CERTAIN
	1	2	3	4	5
CATASTROPHIC 5	5	10	15	20	25
MAJOR 4	4	8	12	16	20
MODERATE 3	3	6	9	12	15
MINOR 2	2	4	6	8	10
NEGLIGIBLE 1	1	2	3	4	5

RISK ASSESSMENT - FREQUENCY OF REVIEW

RISK SCORED	DEFINITION	ACTION REQUIRED (GUIDE ONLY)	MINIMUM REVIEW FREQUENCY
15-25	Extreme	Unacceptable. Immediate action must be taken to manage the risk. Control measures should be put into place which will have an effect of reducing the impact of an event or the likelihood of an event occurring. A number of control measures may be required.	This type of risk is considered extreme and should be reviewed and progress on actions updated, at least monthly.
8-12	High	Very unlikely to be acceptable. Significant resources may have to be allocated to reduce the risk. Urgent action should be taken. A number of control measures may be required.	This type of risk is considered high and should be reviewed and progress on actions updated at least bi-monthly.
4-6	Moderate	Not normally acceptable. Efforts should be made to reduce risk, providing this is not disproportionate. Establish more precisely the likelihood & harm as a basis for determining the need for improved measures.	This type of risk is considered moderate and should be reviewed and progress on actions updated at least every six months.
1-3	Low	Risks at this level may be acceptable. If not acceptable, existing controls should be monitored & reviewed. No further action or additional controls are required.	This type of risk is considered low risk and should be reviewed and progress on actions updated at least annually.

Assurance Key:

3 Lines of Defence (Assurance)		
1st Line	Business Management	Tends to be detailed assurance but lack independence
2nd Line	Corporate Oversight	Less detailed but slightly more independent
3rd Line	Independent Assurance	Often less detail but truly independent

Key - Assurance Required	
	Detailed review of relevant information
	Medium level review
	Cursory or narrow scope of review

NB Assurance Map will tell you if you have sufficient sources of assurance not what those sources are telling you

Key - Control RAG rating	
LOW	Significant concerns over the adequacy/effectiveness of the controls in place in proportion to the risks
MEDIUM	Some areas of concern over the adequacy/effectiveness of the controls in place in proportion to the risks
HIGH	Controls in place assessed as adequate/effective and in proportion to the risk
INSUFFICIENT	Insufficient information at present to judge the adequacy/effectiveness of the controls

Date Risk Identified:	Sep-25
Strategic Objective:	3. Great Care

Executive Director Owner:	Davies, Lee	**Date of Review:**	Nov-25
Lead Committee:	Strategy and Planning Committee	**Date of Next Review:**	Dec-25

Risk ID:	**2212**	**Corporate Risk Description:**	There is a risk that the Health Board will not have an approvable Integrated Medium-Term Plan (IMTP) by March 2028. This is caused by the Health Board not maintaining the 2024/25 outturn position of £24.1m as an absolute minimum at end of 2025/26, with a clear trajectory toward breakeven by 2027/28 as specified in our escalation framework. This could lead to an impact/affect on the Health Board meeting its statutory duty to breakeven, increased escalation and loss of public and stakeholder confidence.
Does this risk link to any Directorate (operational) risks?	2086		

Risk Rating:(Likelihood x Impact)		**No trend information available.**
Domain:	Statutory duty/inspections	
Inherent Risk Score (L x I):	5×4=20	
Current Risk Score (L x I):	4×3=12	
Target Risk Score (L x I):	1×4=4	
Expected Date To Achieve TRS:	31/03/2028	
Trend:	*New risk*	

Rationale for CURRENT Risk Score:
The Health Board does not have an approvable IMTP in place due to the inability to demonstrate a financially balanced position, and as a consequence is in breach of its statutory duty under Section 175(2A) of the National Health Service (Wales) Act 2006. This has led to the Health Board being placed into Targeted Intervention. The current risk score of 12 after controls acknowledges that while the Health Board is strengthening its planning processes (setting it in a 3 year context as a form of mitigation), the fundamental challenges remain. The likelihood reduces slightly to "likely" (4) rather than "certain" (5) as improved planning might achieve "consideration" even if not approval. However, until operational risks reduce and assurances on the ability of services across the Health Board to deliver on their savings targets, full mitigation remains impossible.

Rationale for TARGET Risk Score:
The achievement of a financially balanced and an approvable plan would be a key driver for the Health Board to be de-escalated from Targeted Intervention by Welsh Government. The financial roadmap to achieve this by 2027/28 is critical to this.

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	**Gaps in CONTROLS**				
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
1. A Healthier Mid and West Wales Strategy agreed by Board in 2018 forms the basis of the Health Board's Annual Plan 2. Financial roadmap has been developed and periodically updated to align to the planning cycle 3. Clear annual planning process led by the Planning Team in place - set out in Annual Plan Report to Board 25/09/25 4. Regional working partnerships in place 5. Planning Co-ordination Group in place with membership from corporate and operational/CCG representation 6. Continued dialogue with Welsh Government 7. Annual WG Planning Framework 8. Engagement with Stakeholder Reference Group on Annual Plan for 2026/27 - planned for November 2027 9. Commissioning team is a member of the Specialist Services Commissioning Group (SSCG) which meets bi-monthly, and reports to the JCC. 10. Commissioning and Contracting Oversight Group established, which meets quarterly 11. Regional Clinical Service Planning Subgroup in place 12. Operational management structures in place including Clinical Care Groups; Value and Sustainability Group; A Healthier Mid and West Wales Group; Integrated Quality, Performance and Finance Delivery Group.	1. Implications of the strategy refresh of AHMWW and the development of the Clinical Services Plan on the annual planning for 2026/27 and 2027/28 are currently not known or understood 2. Health Board's Financial Roadmap does not yet align to WG expectations with assured recurrent savings schemes to achieve breakeven in 2027/28 3. Feedback from WG includes the need for clearer delivery plans within the Annual Plan going forward 4. Closer working with the NHS Wales Joint Commissioning Committee (JCC) in regard to all-Wales commissioning decisions 5. Stronger regional planning and delivery actions through the Regional Joint Committee with Swansea Bay UHB on priority areas 6. Operational risks create compound effects that make planning assumptions unachievable 7. There is a gap in the organisations ability to deliver change	The Annual Plan 2026/27 will be written in the context of a 3 year plan cycle, the implications of the strategy refresh and CSP will be factored into year 2 (2027/28).	Davies, Lee	31/03/2026	The planning cycle will be continually reviewed throughout 2026/27 in the wider context of the delivery of an approvable IMTP. Operational risk registers have been fundamental in the approach to developing the annual plan for 2026/27. of Year 1 will focus on addressing the implications of the strategy refresh and CSP, which are due to be presented to Board in Q4 of 2025/26.
		Sufficient and assured recurrent savings schemes are planned across Clinical Care Groups	Carruthers, Andrew	31/03/2026	Progress update to be provided at next risk review
		Share WG feedback of last year's Annual Plan at the scheduled Planning Workshops throughout Autumn 2025 (Oct, Nov and Dec) with clear expectations of input and output, with support from the Planning Team.	Davies, Lee	31/12/2025	Series of workshops held during Autumn 2025, with feedback from Welsh Government to date shared. The Health Board are still awaiting the Planning Framework to be published by Welsh Government, expected by the end of first week of December 2025 in order to fully address this action, which will also define the regional approach.

ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed Further action necessary to address the gaps	By Who	By When	Progress
	Planning Co-ordination Group	1st								
	Regular updates on development of annual Plan discussed at Business Executive Team	2nd								
	Strategy and Planning Committee receive assurance on the development of the Annual Plan	2nd								
	Finance & Performance Committee to review and approve financial roadmap and financial plan	2nd								
	PODCC and FPC provide guidance on people and finance elements of Annual Plan	2nd								
	Planning Maturity Matrix is annually reviewed and presented to Board and WG	2nd								
	Regular oversight by WG of our Annual Plan through JET, TI, IQPD and informal touchpoint meetings with WG Planning Team	3rd								

IA Annual Planning - May25 (Reasonable)	3rd								
Addressing feedback from WG on Annual Plan 2025/26 to incorporate into planning process and product	3rd								

Inspection Title	Recommendation	Action	Clinical Care Group/Executive Function	Original Due Date	Current Due Date	Barriers
Audit Wales Primary Care Follow-up Review – Hywel Dda University Health Board	Through the planned development of its Integrated Primary and Community Services Strategy, the Health Board should: 1. Ensure engagement with key stakeholders as to how services set out in the strategy will be provided 2. Ensure that the strategy encompasses a detailed workforce plan and is fully costed 3. Use the 2023-24 budgetary information as a baseline position of the cost of primary and community care to enable the shift of resources to be reported on an annual basis. 4. Once the strategy is approved, ensure periodic update reports are provided to the relevant committee demonstrating progress on delivery of the strategy.	The development of the strategy will follow the Clinical Services Plan methodology and will include all of the recommended areas. Engagement has been proposed to happen at Cluster and Pan Cluster level to ensure appropriate levels of engagement with key stakeholders and members of the public.	Primary Care, Community Strategy & Long Term Care	31/03/2025	31/03/2025	Engagement in September 2024 both professionally and public was limited in the responses provided
Audit Wales Primary Care Follow-up Review – Hywel Dda University Health Board	Through the planned development of its Integrated Primary and Community Services Strategy, the Health Board should: 1. Ensure engagement with key stakeholders as to how services set out in the strategy will be provided 2. Ensure that the strategy encompasses a detailed workforce plan and is fully costed 3. Use the 2023-24 budgetary information as a baseline position of the cost of primary and community care to enable the shift of resources to be reported on an annual basis. 4. Once the strategy is approved, ensure periodic update reports are provided to the relevant committee demonstrating progress on delivery of the strategy.	Workforce data is currently only available for GP Practices and has been identified as an area of concern in the issues paper. Community nursing workforce information is available and included in the issues paper.	Primary Care, Community Strategy & Long Term Care	30/11/2023	31/03/2025	Independent contractor GP Practices unwilling to participate in workforce planning

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Audit Wales Primary Care Follow-up Review – Hywel Dda University Health Board	Through the planned development of its Integrated Primary and Community Services Strategy, the Health Board should: 1. Ensure engagement with key stakeholders as to how services set out in the strategy will be provided 2. Ensure that the strategy encompasses a detailed workforce plan and is fully costed 3. Use the 2023-24 budgetary information as a baseline position of the cost of primary and community care to enable the shift of resources to be reported on an annual basis. 4. Once the strategy is approved, ensure periodic update reports are provided to the relevant committee demonstrating progress on delivery of the strategy.	An implementation plan to support the development of key themes coming out of the strategy development which will be overseen by the project group and reported through the relevant Board level committee.	Primary Care, Community Strategy & Long Term Care	30/11/2023	31/03/2025	
Audit Wales Primary Care Follow-up Review – Hywel Dda University Health Board	The Health Board should improve oversight at Board and committee level of performance within primary care by: 1. Increasing the coverage of primary care performance within its Integrated Performance Assurance Report 2. Increasing the focus on outcomes and experience.	Currently available data is reported through the IPAR and as part of the reporting on the Ministerial Milestones on access to Primary Care services. As more data becomes available on contract management and performance information will be reported to the appropriate Board level committee (SDODC) and will be considered for inclusion in the IPAR.	Primary Care, Community Strategy & Long Term Care	30/11/2023	30/04/2024	

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Audit Wales Primary Care Follow-up Review – Hywel Dda University Health Board	The Health Board should improve oversight at Board and committee level of performance within primary care by: 1. Increasing the coverage of primary care performance within its Integrated Performance Assurance Report 2. Increasing the focus on outcomes and experience.	(EXTERNAL) Further work needs to be done data on outcomes and experience as currently that is limited to information held by GP Practices only. Some work has started to look at the use of PROMS and PREMS in the Community Dental Service. PROMS and PREMS will be introduced as part of the service manuals for Optometry WGOS and will form part of a national framework. Public engagement to be a key part of the strategy development with a strong focus on quality outcomes.	Primary Care, Community Strategy & Long Term Care	31/03/2025	31/03/2025	Independent GP practices currently only have to participate in patient engagement once a year in line with the contractual requirements. Patient response rates in the pilot are low, potentially due to the contractual engagement period concluding in March 2025.
Audit Wales Primary Care Follow-up Review – Hywel Dda University Health Board	The Health Board should improve oversight at Board and committee level of performance within primary care by: 1. Increasing the coverage of primary care performance within its Integrated Performance Assurance Report 2. Increasing the focus on outcomes and experience.	Assurance & Risk Officer to ensure all actions are complete and evidence uploaded prior to closure of report	Primary Care, Community Strategy & Long Term Care	03/04/2026	03/04/2026	
Audit Wales- Review of Capital Investment Prioritisation – Hywel Dda University Health Board - May 2025	R1. The Health Board should ensure all clinical care groups are aware of the procedure for purchasing medical and nonmedical equipment and ensuring that when appropriate they engage with the clinical engineering team, so the medical equipment inventory is kept up to date to prevent information gaps (see paragraph 10).	The UHB will ensure that Senior Leadership at the Clinical Care Groups are all made aware of the procedure for purchasing medical and non-medical equipment and the need to engage with the clinical engineering team where appropriate. This will be done via a presentation to Senior Operations Leadership Team and circulation of this and the procedure to the Senior Leadership of the Clinical Care Groups.	Director of Strategy and Planning	30/11/2025	30/11/2025	
Audit Wales - Structured Assessment 2024 – Hywel Dda University Health Board	R1. The Health Board should update its Improving Together Framework documentation, ensuring it adequately reflects current performance management and internal escalation arrangements. In updating the framework, the Health Board should also ensure documentation includes arrangements: • de-escalating and supporting directorates at the highest level of escalation for extended periods; and • co-ordinating support for directorates escalated over several domains (see paragraph 53).	The Improving Together Framework will be updated to address the points raised in this recommendation. Timeline for completion: • February 2025 - full draft submitted to Strategic Development and Operational Delivery Committee for consideration • March 2025 – final draft submitted to Board for approval	Corporate Services	31/03/2025	31/03/2025	
Audit Wales- Structured Assessment 2023- Hywel Dda University Health Board	R1. Enhancing Public Transparency We found that, Public Board papers include a high-level summary of private Board meetings. To further enhance transparency this arrangement should be extended to private committee meetings through individual committee assurance reports received by the Board.	The Committee Update Report template to the Board will be updated to include a section 'Key Matters considered by the In-Committee'. These will be completed for January 2024 Board.	Corporate Services	31/12/2023	31/12/2023	

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Audit Wales - Structured Assessment 2022	R1. Elements of the Health Board's website are not updated in a timely fashion and that there is scope to further enhance transparency of Board business. The Health Board should ensure that: a) unconfirmed Board and committee minutes are published on the Health Board's website as soon as is practical after each meeting; b) agendas for private meetings of the Board are made available on the Health Board's website in advance of the meeting; and c) the most recent version of policies and declarations of interest are publicly available on the website.	a) From January 2023, Board and Committee unconfirmed minutes will be published on the Health Board's website following review within 21 calendar days of the meeting.	Corporate Services	31/07/2024	31/07/2024	
Audit Wales - Structured Assessment 2022	R1. Elements of the Health Board's website are not updated in a timely fashion and that there is scope to further enhance transparency of Board business. The Health Board should ensure that: a) unconfirmed Board and committee minutes are published on the Health Board's website as soon as is practical after each meeting; b) agendas for private meetings of the Board are made available on the Health Board's website in advance of the meeting; and c) the most recent version of policies and declarations of interest are publicly available on the website.	b) From January 2023, agendas for private meetings of the Board will be published on the Health Board's website 7 calendar days in advance of the meeting (at the same time as the public meeting agenda and papers)	Corporate Services	31/07/2024	31/07/2024	
Audit Wales - Structured Assessment 2022	R1. Elements of the Health Board's website are not updated in a timely fashion and that there is scope to further enhance transparency of Board business. The Health Board should ensure that: a) unconfirmed Board and committee minutes are published on the Health Board's website as soon as is practical after each meeting; b) agendas for private meetings of the Board are made available on the Health Board's website in advance of the meeting; and c) the most recent version of policies and declarations of interest are publicly available on the website.	c) In 2022/23, the Standards of Behaviour Policy has been reviewed, issued for consultation and updated. The revised policy was approved by the People, OD & Culture Committee in October 2022 and is available on the Health Board's website. From January 2023, the Register of Interests will be published (and updated) on a quarterly basis. Previously, the Registers were available as part of the annual ARAC Report in April each year. In order to improve the process, the Registers will now be more easily accessible on the Health Board's website. In addition, the Health Board has improved the system of notification by creating electronic forms that simplify the process for staff and the counter-signatory (line manager).	Corporate Services	31/07/2024	31/07/2024	
Audit Wales - Structured Assessment 2024 – Hywel Dda University Health Board	R2. The Quality, Safety and Experience Committee should receive, at least annual, a standalone update on Quality Improvement activities, including the Health Board's progress in implementing the Quality Improvement Strategic Framework (2023-2026), a roundup of improvement initiatives and the impact they are having to date (see paragraph 60).	A standalone annual report on Quality Improvement Activities will be added to the work plan for the Quality Safety and Experience Committee for 2025/26	Corporate Services	30/04/2025	30/04/2025	

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Audit Wales- Structured Assessment 2023- Hywel Dda University Health Board	R2. Board member patient safety walkabout Board members conduct regular Patient Safety walkabouts, supported by a member of the patient safety team who takes notes, with a clear process to provide feedback to visited services and monitor actions points However, those we interviewed were unclear about what happened after the visit. The Health Board should clarify the Patient Safety Walkabout process with new Independent Members. R2. Board member patient safety walkabout Board members conduct regular Patient Safety walkabouts, supported by a member of the patient safety team who takes notes. However, those we interviewed were unclear what happens to the notes afterwards. The Health Board should: b) report back on walkabout themes, twice a year, for example, through the Quality Assurance Report received by the Quality, Safety and Experience Committee (Medium Priority).	A refreshed briefing on the role and content of the Patient Safety Walk Rounds will be drafted for use within induction for all new Independent Members and Executive Directors. Reporting and monitoring arrangements following Patient Safety Walk Rounds will be refreshed and reconfirmed for all participants. Reports are action oriented and prepared by the Quality Assurance Team. All actions are logged on the AMAT system and monitored via the Quality Assurance Team. The refreshed Patient Safety Walk Round handbook will be reviewed and recirculated to all Board members by the Head of Quality Assurance.	Corporate Services	31/03/2024	31/03/2024	
Audit Wales - Structured Assessment 2022	R2. While some changes have been made, the operational structure still poses risks to confused and inconsistent governance structures. Given the scale and complexity of the challenges and risks facing the Health Board, it is important that planned work to revise the operational structures and associated governance arrangements progresses as a matter of urgency	Work begun to review the operational structure in September 2022. A series of workshops have been held with the senior operational leadership team, and discussions with the executive Team. Sessions with the senior clinical leaders are planned for Q1 2023. The intention is to develop a proposal by Q2 2023 that can be agreed and implemented across the Health Board, that addresses the inconsistency identified. Ahead of this, the operational governance meeting structure will be revised in Q1 2023, which will support the actions being taken around R3.	Corporate Services	31/12/2023	31/12/2023	

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Audit Wales- Structured Assessment 2023- Hywel Dda University Health Board	R2. Board member patient safety walkabout Board members conduct regular Patient Safety walkabouts, supported by a member of the patient safety team who takes notes, with a clear process to provide feedback to visited services and monitor actions points However, those we interviewed were unclear about what happened after the visit. The Health Board should clarify the Patient Safety Walkabout process with new Independent Members. R2. Board member patient safety walkabout Board members conduct regular Patient Safety walkabouts, supported by a member of the patient safety team who takes notes. However, those we interviewed were unclear what happens to the notes afterwards. The Health Board should: b) report back on walkabout themes, twice a year, for example, through the Quality Assurance Report received by the Quality, Safety and Experience Committee (Medium Priority).	R2(b):Consideration will be given to providing a Patient Safety Walk Round update to Board members at a future Board Seminar. To be forward work planned through the Director of Corporate Governance/Board Secretary.	Corporate Services	31/07/2024	31/07/2024	
Audit Wales - Structured Assessment 2022	R3. While performance arrangements exist at an operational level, there is scope to bring these together into a holistic review of performance. Alongside the rollout of its Improving Together Framework, the Health Board should revisit its performance management arrangements to ensure that there is a joinedup approach at an operational level.	Our Improving Together framework has been developed over the last 18 months and deployed within a number of pilot areas. Following this progress, the approach was agreed with the Executive Team in December 2022 for it be used for Directorate level performance management arrangements. The Framework aligns teams to our strategic objectives and what matters to us as a health board. It focusses on key improvement measures identified by the directorate and team and regular coaching style discussions around how we are performing and whether additional improvements need to be made. These discussions are supported by “Our Performance” and “Our Safety” dashboards which provide triangulated data sets from across quality and safety, performance, risk and finance. The Directorate level sessions are holistic, covering performance, safety, quality workforce, finance and planning. The Director of Operations will chair these sessions monthly and will be supported by the Executive Directors of Finance (with executive responsibility for Performance), Director of Strategic Development and Operational Planning, Director of Workforce and	Corporate Services	30/12/2023	30/12/2023	

Inspection Title	Recommendation	Action	Clinical Care Group/Executive Function	Original Due Date	Current Due Date	Barriers
Audit Wales- Structured Assessment 2023- Hywel Dda University Health Board	R3. Performance Management Arrangement Assurance Given the Health Board is under Welsh Government's Enhanced Monitoring arrangements for some service areas, there is scope to demonstrate the effectiveness of the Improving Together Framework. The Health Board should develop a mechanism for periodically providing assurance that its performance management arrangements are working as intended.	We will commission an annual review of the effectiveness of the Improving Together Framework from Internal Audit. We will ask for the first review to be undertaken during Q1 2024/25.	Corporate Services	30/06/2024	30/06/2024	
Audit Wales - Structured Assessment 2024 – Hywel Dda University Health Board	R3. To ensure the sustainable development principle is central to its long-term vision, the Health Board should review its well-being objectives as part of its planned long-term strategy refresh (see paragraph 69).	The well-being objectives will be reviewed as part of the long-term strategy refresh	Corporate Services	31/03/2026	31/03/2026	
Audit Wales - Structured Assessment 2024 – Hywel Dda University Health Board	R3. To ensure the sustainable development principle is central to its long-term vision, the Health Board should review its well-being objectives as part of its planned long-term strategy refresh (see paragraph 69).	Assurance & Risk Officer to ensure all actions are complete and evidence uploaded prior to closure of report	Corporate Services	03/04/2026	03/04/2026	
Audit Wales - Structured Assessment 2022	R4. The Health Board has not set out expected outcomes for all its planning objectives set out in its Annual Plan. In revising its planning objectives for 2023-26, the Health Board needs to clearly articulate the expected outcomes for its streamlined set of planning objectives.	This is being incorporated into the annual plan for 2023-34 and a revised planning cycle approach.	Corporate Services	31/03/2023	31/03/2023	
Audit Wales- Structured Assessment 2023- Hywel Dda University Health Board	R4. Aligning planning and strategic objectives The Health Board has taken steps to better articulate its planning objectives in its 2023-24 Annual Plan, by streamlining the planning objectives and setting them against eight strategic planning goals and four domains. However, the domains and strategic planning goals do not explicitly align to the Health Board's six overarching strategic objectives, as detailed in its Board Assurance Framework (BAF) and Integrated Performance Assurance Report (IPAR) dashboards. As part of the next planning cycle, the Health Board should more explicitly set out how each of its planning objectives link to its strategic objectives.	A process and action plan has been detailed as part of the Planning Cycle for the development of the 2024/25 Plan. This process and action plan (as detailed in the annex), sets out the process for reviewing the Strategic Objectives, the Planning Objectives and the removal of the four planning domains to simplify the process. Steps are also included to ensure the appropriate alignment of Planning Objectives to the appropriate Committees of the Board for assurance purposes, and the revision of the BAF.	Corporate Services	31/03/2024	31/03/2024	
Audit Wales - Structured Assessment 2022	R5. Implementation plans to support corporate enabling strategies did not always exist or include clear milestones, targets, and outcomes. The Health Board needs to ensure: • existing implementation plans include clear milestones, targets, and outcomes; and • implementation plans are developed for enabling strategies that currently do not have one. Alongside the monitoring of relevant individual planning objectives, this will enable periodic review of overall progress of delivery of the enabling strategies.	This is being incorporated into the annual plan for 2023-34 and a revised planning cycle approach.	Corporate Services	31/03/2023	31/03/2023	

Inspection Title	Recommendation	Action	Clinical Care Group/Executive Function	Original Due Date	Current Due Date	Barriers
Audit Wales- Structured Assessment 2023- Hywel Dda University Health Board	R5. Financial Scrutiny Whilst there is a good level of scrutiny on the financial position within the Sustainable Resources Committee, the scrutiny has predominantly been focused on the Director of Finance. Whilst this has improved in recent meetings with members of the Core Delivery Group and the Financial Control Group now in attendance, the Health Board needs to do more to ensure scrutiny by Independent Members is appropriately focused across all members of the executive team.	There is a greater understanding amongst Board Members that the causes of our financial challenges relate to the strategic, operational and clinical configuration and choices which are made across the organisation. Consequently, scrutiny has increasingly moved into these areas as part of SRC and Board deliberations. This has been facilitated by broader attendance now being seen in the Sustainable Resources Committee.	Corporate Services	31/12/2023	31/12/2023	
Audit Wales - Structured Assessment 2022	R6. The Health Board's longer-term financial recovery plan has not been updated to reflect the financial challenges being experienced in 2022-23. The Health Board needs to update its longer-term financial recovery plan for 2023 onwards, ensuring that its improvement opportunities are reflected.	The 2023/24 planning cycle is underway which will, with Board approval, reflect the challenges that have been experienced during 2022/23. Opportunities have been clearly articulated, and the planning cycle will be the vehicle for teams across the Health Board to deliver sustainable plans in the areas highlighted as opportunities, as well as undertaking their delegated financial responsibilities to review and deliver all efficiency and benchmarking opportunities. With the unprecedented demand challenges that have been experienced, the financial overspends have resulted in a significant deterioration to our deficit. The recovery plan will need to be cognisant of the impact which these demand challenges are having across our system.	Corporate Services	31/03/2024	31/03/2024	
Audit Wales - Structured Assessment 2022	R6. The Health Board's longer-term financial recovery plan has not been updated to reflect the financial challenges being experienced in 2022-23. The Health Board needs to update its longer-term financial recovery plan for 2023 onwards, ensuring that its improvement opportunities are reflected.	Assurance & Risk Officer to ensure all actions are complete and evidence uploaded prior to closure of report	Corporate Services	03/04/2026	03/04/2026	
Audit Wales- Structured Assessment 2023- Hywel Dda University Health Board	Assurance and Risk Team to formally close report once all actions complete	To close report once all actions noted as complete	Corporate Services	31/07/2025	31/07/2025	

Inspection Title	Recommendation	Action	Clinical Care Group/Executive Function	Original Due Date	Current Due Date	Barriers
Audit Wales - Urgent and Emergency Care: Arrangements for Managing Demand – Hywel Dda University Health Board	R1. To ensure that priorities are reflective of and align to up-to-date information such as demands for service, service capacity and future demographic pressures, the Health Board should clearly indicate the data used to inform its future plans for urgent and emergency care	A UEC dashboard is currently being developed which will provide users with a suite of data from Live dashboard information, predictive data to inform service planning and reporting measures.	Community & Integrated Medicine	31/07/2025	31/07/2025	
Audit Wales - Urgent and Emergency Care: Arrangements for Managing Demand – Hywel Dda University Health Board	R2. To support the on-going delivery of Six Goals related initiatives, the Health Board needs to clarify and confirm the funding arrangements for schemes beyond March 2025. Plans for future years should also identify any funding needs beyond their current annual allocation	The Six Goals 2025/26 Financial plan is currently being finalised with financial colleagues and workstream leads. This sets out spending over the next year on a range of schemes and is match funded by the Health Board. For planning in future years beyond annual allocation, the team have recently completed an evaluation on a pilot with regard to seven-day clinical streaming hubs. This will form the basis of an options appraisal that will lay out the recommended models and funding requirements for this financial year and beyond.	Community & Integrated Medicine	31/07/2025	31/07/2025	
Audit Wales - Urgent and Emergency Care: Arrangements for Managing Demand – Hywel Dda University Health Board	R3. To help address the high demand for urgent care due to dental problems the health board should ensure dental practices provide clear, accessible information about urgent and emergency care services on their websites and conduct a future audit to ensure compliance.	A dental nurse triage review of calls received from 111 for patients requiring urgent access to NHS Dental Services indicated that out of 800 calls, 300 patients did not require an urgent dental appointment. Without clinical triage at source this is skewing the data on the actual demand for urgent dental care.	Community & Integrated Medicine	31/08/2025	31/08/2025	
Audit Wales - Urgent and Emergency Care: Arrangements for Managing Demand – Hywel Dda University Health Board	R3. To help address the high demand for urgent care due to dental problems the health board should ensure dental practices provide clear, accessible information about urgent and emergency care services on their websites and conduct a future audit to ensure compliance.	The demand for urgent dental care currently outstrips the level of service that Practices are willing to provide. Consideration to pilot putting Dental Nurse triage in at the end of the week and over the weekend has recently been discussed and a plan will be developed.	Community & Integrated Medicine	30/06/2025	30/06/2025	
Audit Wales - Urgent and Emergency Care: Arrangements for Managing Demand – Hywel Dda University Health Board	R3. To help address the high demand for urgent care due to dental problems the health board should ensure dental practices provide clear, accessible information about urgent and emergency care services on their websites and conduct a future audit to ensure compliance.	An agreed format of words will be developed and shared with all Dental Practices for consistent use; a review of this will be included as part of the Practice visiting programme Link to “My Health, My Choice” videos to be recirculated	Community & Integrated Medicine	30/06/2025	30/06/2025	

Inspection Title	Recommendation	Action	Clinical Care Group/Executive Function	Original Due Date	Current Due Date	Barriers
Audit Wales - Urgent and Emergency Care: Arrangements for Managing Demand – Hywel Dda University Health Board	R4. To ensure that patients receive the urgent and emergency care that is most appropriate to their needs, the Health Board should liaise with Llais and other patient representative groups as appropriate to help identify where current patient information and signposting arrangements need strengthening	The Health Board is in regular discussions with Llais re 6 Goals and Urgent Care, Llais were involved in the UEC summit in April 25 and the Llais report helps identify some areas for improvement, an accelerated workstream for UEC on Environment and Patient experience is being planned to ensure improved information and signposting is achieved	Community & Integrated Medicine	30/11/2025	31/10/2025	
Audit Wales - Urgent and Emergency Care: Arrangements for Managing Demand – Hywel Dda University Health Board	R5. To ensure alignment between the information held by the Health Board and by WAST on available pathways and referral mechanisms, the Health Board should work with WAST to set out clearly how its clinical streaming hubs and the WAST directory of service work together effectively	The purposing behind co-locating MDT staff in the hubs is to create a living DoS options to deploy, so when the PTAS/ WAST stack attack is active the direction of enquiry is usually to the CSH MDT of what alternative options can be deployed locally in a reasonable timeframe, this will be further reinforced when 7 Day functionality is deployed.	Community & Integrated Medicine	30/11/2025	30/11/2025	
Audit Wales - Urgent and Emergency Care: Arrangements for Managing Demand – Hywel Dda University Health Board	R6. Data reviewed as part of this work identified that demand in the region relating to urgent dental services is significantly higher than the all-Wales average, despite performance against contracts being poor. To ensure it is maximising efficiency and mitigating this pressure, the Health Board should undertake a deep dive into its urgent care demand for dental services	A review of the current demand for urgent dental care will be undertaken in line with the report. As the demand for urgent dental access peaks over the summer period the timescale for review needs to include “normal” periods of demand for comparison. The number of NHS dental contract resignations with Practices opting to provide private dental care, coupled with the rural geography has proven to be a challenge. The Health Board has an agreed dental commissioning plan which is in progress to procure additional routine NHS dental access. Given the level of calls that have been redirected on clinical triage there appears to be a cultural approach to access “urgent" dental care when the requirement is routine	Community & Integrated Medicine	31/12/2025	31/12/2025	
Audit Wales - Urgent and Emergency Care: Arrangements for Managing Demand – Hywel Dda University Health Board	R7. To ensure the Health Board is maximising the learning identified in its busiest day review in November 2023, it should provide the Finance and Performance committee with an update against recommendations	The Busiest Day Audit has been used in the creation of the “Blueprint“ UEC model and the recommendations for the Audit form a part of the ongoing 6 Goals improvement work. The 6 Goals team will update Finance and Performance on progress	Community & Integrated Medicine	31/10/2025	31/10/2025	

Inspection Title	Recommendation	Action	Clinical Care Group/Executive Function	Original Due Date	Current Due Date	Barriers
Audit Wales - Urgent and Emergency Care: Arrangements for Managing Demand – Hywel Dda University Health Board	R8. To gain assurance that the Health Board is complying with the national SDEC referral guidance, it should conduct an audit of its SDEC data against the criteria and report the results to an appropriate committee or forum	Currently the Health Board submit data against and report SDEC activity to the Performance and Assurance Team (National Six Goals Team) on a regular basis. The 6 Goals team will present SDEC Information in the form of the National Submission	Community & Integrated Medicine	30/09/2025	30/09/2025	
Audit Wales - Urgent and Emergency Care: Arrangements for Managing Demand – Hywel Dda University Health Board	R9. The Health Board should review the feasibility of enabling the Same Day Urgent Care Centre access to GP records to improve efficiency of the service	The access to GP records and also the feedback into GP Records is a central part of the access work stream, developments in Digital solutions to include Electronic Observation and Patient Flow and a standardised GP system across the HDUHB area will support this development	Community & Integrated Medicine	30/11/2025	30/11/2025	
Audit Wales - Urgent and Emergency Care: Arrangements for Managing Demand – Hywel Dda University Health Board	R10. The Health Board should review and regularly validate the data that is currently available for urgent and emergency care so more assurance can be taken when making decisions based on the data available	The 6 Goals Team provide regular updates re the National Data requirements and also against the 6 Goals Ministerial priorities, the 6 Goals team regularly attend Committees to update re the UEC Performance and actions being taken to improve	Community & Integrated Medicine	30/06/2025	30/06/2025	
Audit Wales - Urgent and Emergency Care: Arrangements for Managing Demand – Hywel Dda University Health Board	R11. To ensure the Health Board is building on feedback from patients, future plans for urgent and emergency care should demonstrate how they have considered patient feedback	Regular reports on patient experience and feedback through QSEC, also patient stories have formed the basis of evaluation for Clinical Streaming Hubs and the Enhanced Community Falls pilot. UEC programme has built close links with Llais, they are part of the Six Goals Integrated Operational Group membership and the Health Board regularly meet with them on UEC matters.	Community & Integrated Medicine	30/06/2025	30/06/2025	
Audit Wales - Urgent and Emergency Care: Arrangements for Managing Demand – Hywel Dda University Health Board	R12. To identify potential weaknesses or learning in relation to recent changes to its urgent and emergency care services, the Health Board should introduce regular mechanisms for staff feedback. This should include feedback from key partners including primary care and WAST	The Six Goals Programme Team have launched a website for staff on the Six Goals Programme, which includes information on the programme, contact information, and resources. This is currently being promoted through the Communication and Engagement Team. Hywel Dda University Health Board: Six Goals Programme	Community & Integrated Medicine	30/06/2025	30/06/2025	

Inspection Title	Recommendation	Action	Clinical Care Group/Executive Function	Original Due Date	Current Due Date	Barriers
Audit Wales - Urgent and Emergency Care: Arrangements for Managing Demand – Hywel Dda University Health Board	R13. To strengthen its ability to join up strategic plans and service changes for its urgent and emergency care services, the Health Board should include WAST as a member of its Six Goals Integrated Operational Group	WAST will be added to the membership to the Integrated Operational Group for the Six Goals Programme, and added into the accelerated Programme	Community & Integrated Medicine	31/07/2025	31/07/2025	
Audit Wales - Urgent and Emergency Care: Arrangements for Managing Demand – Hywel Dda University Health Board	R14. To strengthen its reporting of the benefits achieved from its Six Goals Programme work and associated use of funding, the Health Board should develop and communicate guidance for staff on how to evaluate the effectiveness of projects, initiatives and service changes relating to urgent and emergency care services	Knowledge Exchange Forum currently being set up through the Strategy and Planning Directorate. This will bring staff together to find out about, discuss and appraise, e.g. Research, ideas, evidence, current thinking, data, information and examples of good practice. Various types and sources of information will be discussed at Knowledge Exchange Forum sessions, e.g. Journal articles, conference proceedings, policy documents, evidence reviews, case studies or internal reports.	Community & Integrated Medicine	31/08/2025	31/08/2025	
Internal Audit - Capital Systems Final Internal Audit Report 2024/25 (Reasonable)	R1. Objective 1: Governance All estate's projects were found to be managed on a centrally accessible HDUHB Microsoft Lists, also accessible via SharePoint. This had restricted access security arrangements. The overall arrangements for project documentation and governance were generally adequate, however there was not a formal centrally held capital contracts register in place at the Health Board.	The matter will be raised at the Capital Monitoring Forum to ensure obligations related to keeping a register are discharged by the Health Board and an agreement to be made as to who will be responsible for this.	Director of Strategy and Planning	31/12/2024	31/12/2024	
Internal Audit - Capital Systems Final Internal Audit Report 2024/25 (Reasonable)	R2. Objective 4: Contract Completion Contracts clearly stated in all cases whether parent guarantees would be required - 6 stated they were not required due to the size of the project, whilst 4 stated they would. Across the 3 contractors covering those 4 projects, all 3 had parent companies. The group membership status of the contractor had not been acknowledged by the Capital Projects team, since during the framework selection process, the wholly owned subsidiary nature of the contractor had not been identified by Procurement, despite the status showing in credit checks undertaken by the Capital Team. Accordingly, the parent company guarantees had not been requested. It is not possible to make informed decisions related to entering into contracts with a contractor without fully understanding the structure of that contractor's wider group to mitigate reputational and financial risk.	D&B Reports will be completed for Parent Companies of framework contractors as well as for contractors on an annual basis.	Director of Strategy and Planning	31/12/2024	31/12/2024	

Inspection Title	Recommendation	Action	Clinical Care Group/Executive Function	Original Due Date	Current Due Date	Barriers
Internal Audit - Capital Systems Final Internal Audit Report 2024/25 (Reasonable)	R2. Objective 4: Contract Completion Contracts clearly stated in all cases whether parent guarantees would be required - 6 stated they were not required due to the size of the project, whilst 4 stated they would. Across the 3 contractors covering those 4 projects, all 3 had parent companies. The group membership status of the contractor had not been acknowledged by the Capital Projects team, since during the framework selection process, the wholly owned subsidiary nature of the contractor had not been identified by Procurement, despite the status showing in credit checks undertaken by the Capital Team. Accordingly, the parent company guarantees had not been requested. It is not possible to make informed decisions related to entering into contracts with a contractor without fully understanding the structure of that contractor's wider group to mitigate reputational and financial risk.	Parental Guarantees will be requested from the Parent company of contractors where required by the contract or Health Board Standing Financial Instruments.	Director of Strategy and Planning	30/11/2024	30/11/2024	
Internal Audit - Capital Systems Final Internal Audit Report 2024/25 (Reasonable)	R3. Objective 4: Contract Completion Anti-collusion / anti corruption clauses were not included in the standard contract template at 7 and 10 contracts sampled. Three included a mandatory exclusion questionnaire which identified specific situations where a contract would not be considered. Schedule 1 of All Wales SFIs specify that "one of the main legal and governing principles guiding public procurements are Integrity: there should be no corruption or collusion with suppliers or others (Paragraph 1.3, Page 61) . Additionally it states that "In every contract document a clause shall be included to secure that the UHB shall be entitled to cancel the contract and to recover from the contractor the amount of any loss resulting from such cancelation, if the contractor shall have prepared his tender in collusion with others or shall have offered or given or agreed to give any person any gift or consideration of any kind as an inducement or reward for doing or forbearing to do, or having done or forborne to do, any action in relation to the obtaining or execution of the contract or any other contract with the UHB or if the like acts shall have been done by any person employed by him acting on his behalf (whether with or without the knowledge of the contractor) or if in relation to any contract with the UHB the contractor or any persons employed by him or acting on his behalf shall have committed an offence under the Prevention of Corruption Acts 1906 (c.34) and 1916 (c.64) and the Public Bodies Corrupt Practices Act 1889 (c.69) and as defined in the Standards of Business Conduct for Employees of the LHB. (Paragraph 13.2, Page 72-73.	JCT clauses to be referenced and included on future contracts.	Director of Strategy and Planning	31/12/2024	31/12/2024	

Inspection Title	Recommendation	Action	Clinical Care Group/Executive Function	Original Due Date	Current Due Date	Barriers
Internal Audit - Capital Systems Final Internal Audit Report 2024/25 (Reasonable)	R4. Objective 5: Retention of Documents 10 contracts sampled were executed as a deed, which conveys longer liability periods of 12 years or the useful life of the associated building/s (or their disposal): accordingly, the proposed retention period of 10 years is insufficient.	(External) The Health Board will revise its contract retention policy to reflect the extended liability period associated with Contracts executed as a deed.	Director of Strategy and Planning	31/12/2024	31/12/2024	Currently awaiting the Welsh Government's publication of the reviewed version. An update has been requested at the national level but not yet received.
Internal Audit - Capital Systems Final Internal Audit Report 2024/25 (Reasonable)	R4. Objective 5: Retention of Documents 10 contracts sampled were executed as a deed, which conveys longer liability periods of 12 years or the useful life of the associated building/s (or their disposal): accordingly, the proposed retention period of 10 years is insufficient.	Gareth Heaven to approve closure of this report	Director of Strategy and Planning	31/07/2025	31/10/2025	
Internal Audit - Commissioning – Long Term Agreements Final Internal Audit Report 2025/26 (Reasonable)	R1. Quality and Safety Reports Hywel Dda do not receive regular quality and safety reports from any LTA provider organisations with the exception of one provider. Whilst the report provides high-level summary of incidents, complaints, claims and inquests for the period noted, no detailed narrative is given nor of the actions taken. In addition, there is no reporting of patient experience.	Commissioning with the support of quality colleagues to work with providers to develop a quality and safety report which meets the requirement of the reporting criteria within the LTA. To be part of the commissioning and contracting intentions. To submit a development request to the OfWCMS1 for LHB of residence to be extractable from the OfWCMS.	Director of Strategy and Planning	30/04/2026	30/04/2026	
Internal Audit - Energy Management Final Internal Audit Report 2024/25 (Reasonable)	R1. Reporting from All Wales forums In addition to minuted issues, various papers also formed a part of the output of the All-Wales meetings (WEOG & WEG sub-group). Whilst there was reasonable attendance of these meetings by the Health Board, issues were not routinely fed back to a scrutiny forum. While recognising that internal structures were relatively new, at the time of audit there was no formal linkage via internal scrutiny forums for the escalation and approval of All Wales issues.	Standing agenda item to be added to EPC & Estates Decarbonisation subgroup for feedback from All-Wales meetings for dissemination.	Estates & Facilities	31/12/2024	31/12/2024	

Inspection Title	Recommendation	Action	Clinical Care Group/Executive Function	Original Due Date	Current Due Date	Barriers
Internal Audit - Energy Management Final Internal Audit Report 2024/25 (Reasonable)	R2. Sub meter analysis Automation of data capture and processing provides the opportunity for improved data analysis. This can enable routine provision of both summary and supporting data, with graphic and variance analysis to an appropriate scrutiny forum. Areas lacking insulation / pipework insulation; peripheral buildings with additional stand-alone equipment; those heated separately etc. may each vary in energy consumption from core build consumption. Greater sub-meter analysis can assist therefore in information, control, and investment decisions. However, many non-charged meters are not SMART meters (requiring manual reads). Presently, this will require consideration of the additional resource need for such analysis versus time saved from automation	All existing submeters installed to be logged on new Energy Manager software and new submeter readings to be logged.	Estates & Facilities	31/03/2026	31/03/2026	
Internal Audit - Energy Management Final Internal Audit Report 2024/25 (Reasonable)	R3. Additional sub meters Based on the potential for analysis and pay-back from additional sub-metering information, there would similarly appear benefit in reviewing the cost / benefit of additional SMART sub-metering.	Submetering information collection to be included in Wales Funding Programme spend-to-save funding bid to Salix/Welsh Government. This will be incorporated through the building management control systems energy conservation measures in the energy performance contract with Vital Energi.	Estates & Facilities	30/09/2025	30/09/2025	
Internal Audit - Energy Management Final Internal Audit Report 2024/25 (Reasonable)	R4. Reporting scrutiny by an assigned forum Energy consumption reports were produced by the Energy and Environment officer including graphical analysis. However, energy reports were not regularly presented to a relevant scrutiny forum e.g. the newly formed Energy Performance Contract & Estates Buildings ecarbonisation Group (which includes responsibility for energy monitoring and includes finance representation). Presentation could usefully include monthly and annual out-turn, trends; comparison to budget; prior out-turn, variance commentary, in addition to graphic presentation / summaries. However, it is recognised that the ability to attend and present such information is dependent on efficiencies gained from increased automation.	Standing agenda item to be added to EPC & Estates Decarbonisation subgroup for feedback from All-Wales meetings for dissemination.	Estates & Facilities	31/12/2024	31/12/2024	

Inspection Title	Recommendation	Action	Clinical Care Group/Executive Function	Original Due Date	Current Due Date	Barriers
Internal Audit - Energy Management Final Internal Audit Report 2024/25 (Reasonable)	R5. Fossil fuel phase out plan As of July 2024, the latest projections of energy spend were: Fuel 2024/25 Electricity 6,967,031 Natural gas 2,582,850 Gas oil & kerosene 826,116 Biomass 273,931 LPG 327,655 Total 10,977,583 i.e. there remains significant spending on fossil fuels e.g. at Prince Philip Hospital a large proportion of energy derives from gas (converted into electricity via a Combined Heat and Power – CHP generator). A four-phase decarbonisation and investment plan included solar and other investments ahead of decommissioning of the CHP. However, electricity prices are currently circa three times those of gas and residual reliance on electricity remains uncertain. There is need therefore for a costed revenue plan for the time phased replacement of fossil fuels.	Escalate risk regarding revenue cost as operational risk to SDOD and Datix (1544). Recommendation to be provided in a paper to SDOD for Hywel Dda UHB to formally write to Welsh Government concerning the lack of a costed revenue plan for the phased replacement of fossil fuels because of the lack of guaranteed additional revenue funding from Welsh Government to enable this fuel transition.	Estates & Facilities	31/01/2025	31/01/2025	
Internal Audit - Energy Management Final Internal Audit Report 2024/25 (Reasonable)	R6. Display Energy Certification action follow-up Display Energy Certifications had recently provided recommendations for improvement in energy performance alongside their assessments, including those with 1 – 3 year payback (which would apply at all sites) e.g. at Glangwili these included: • time controls on heating cylinders; • local targets and user control (e.g. Energy Champions); • IT switch off; • air conditioning performance enhancements • loft insulation; and • review simultaneous heating and cooling. An Energy Conservation Re-fit Assessment commissioned from consultants in September 2024 commented on: • circuit controls, thermostat controls and loops; and • “obsolete controls not compatible with new connections” and the need to upgrade the Building Management Systems to better interface with modern equipment e.g. at Prince Philip Hospital. Potentially such matters could form a focus of EFAB (Estates Funding Advisory Board) investment	Recommendations from display energy certificates to be added to existing DEC information log. Develop validation checks in new Energy Manager software for automation assisting review of arrears. Explore with Finance colleagues the potential of automated checks for timely payment.	Estates & Facilities	30/09/2025	30/09/2025	

Inspection Title	Recommendation	Action	Clinical Care Group/Executive Function	Original Due Date	Current Due Date	Barriers
Internal Audit - Energy Management Final Internal Audit Report 2024/25 (Reasonable)	R7. Automated payment checks At the time of audit, system automation was being implemented to save manual processing. This was envisaged to include automated invoicing, saving data entry. It could usefully be extended to review the potential of automated checks for timely payment (in accordance with invoiced dates). These terms are for 30 days payment to meet the requirements of the national contract and avoid penalties. Further developments could include some automation assisting in review of arrears.	Develop validation checks in new Energy Manager software for automation assisting review of arrears. Explore with Finance colleagues the potential of automated checks for timely payment.	Estates & Facilities	30/09/2025	30/09/2025	
Internal Audit - Energy Management Final Internal Audit Report 2024/25 (Reasonable)	R8. Payment authorisation At the time of audit, it remained to be confirmed that current and appropriately approved delegations operated in respect of payments. However, it is recognised that this is in context of a nationally agreed contract, with checks applied by the Energy an Environment Officer (the authority on consumption monitoring), with authorisation by the Business and Governance Manager. Additional monitoring was also undertaken by finance utilising budgeted annual consumption (forecasts) as shared with Welsh Government. Additional monitoring was also undertaken by finance utilising budgeted annual consumption (forecasts) as shared with Welsh Government.	Liaise with the relevant department to agree a version controlled process for budget holder threshold responsibility in respect of invoice payment approval	Estates & Facilities	31/03/2025	31/03/2025	With Finance team to update and complete.
Welsh Government Independent Review of Clinical Pharmacy Services at NHS Hospitals in Wales	(External Recommendation) R1.1 Reducing time spent by pharmacy professionals on non-clinical activities a) The Welsh Government will commission a review of opportunities to improve the efficiency of hospital medicines supply and logistics arrangements and release pharmacist and pharmacy technician time for clinical care	(EXTERNAL) N/A - for consideration by Welsh Government.	Primary Care, Community Strategy & Long Term Care	30/09/2024	30/09/2024	
Welsh Government Independent Review of Clinical Pharmacy Services at NHS Hospitals in Wales	R1.1 Reducing time spent by pharmacy professionals on non-clinical activities b) Health boards and Velindre University NHS Trust should continue to prioritise and contribute to the work already underway to reconfigure pharmacy technical services and medicines information services on a national basis through the TrAMs programme and WMAS project	TrAMs implementation work underway with NWSSP – Radio pharmacy initially.	Primary Care, Community Strategy & Long Term Care	30/09/2024	30/09/2024	

Inspection Title	Recommendation	Action	Clinical Care Group/Executive Function	Original Due Date	Current Due Date	Barriers
Welsh Government Independent Review of Clinical Pharmacy Services at NHS Hospitals in Wales	R1.2 Prioritising clinical pharmacy service provision to better meet the needs of the NHS a) Health boards and Velindre University NHS Trust should undertake a stocktake to map how pharmacy resource is currently deployed on clinical activities across the organisation and to identify the nature and extent of the clinical pharmacy activity provided in hospitals by speciality and division/directorate(s) for inpatient, outpatient and any other services within their organisation	Mapping in progress to ascertain where current investment is and what the demands currently are in those areas and understand where there are opportunities that are not being covered yet.	Primary Care, Community Strategy & Long Term Care	30/09/2024	30/09/2024	
Welsh Government Independent Review of Clinical Pharmacy Services at NHS Hospitals in Wales	R1.2 Prioritising clinical pharmacy service provision to better meet the needs of the NHS b) Health boards and Velindre University NHS Trust should undertake a stocktake to map how pharmacy resource is currently deployed on clinical activities across the organisation and to identify the nature and extent of the clinical pharmacy activity provided in hospitals by speciality and division/directorate(s) for inpatient, outpatient and any other services within their organisation	Currently informal and based on funding. To follow from stocktaking action above (R1.2a).	Primary Care, Community Strategy & Long Term Care	30/04/2025	30/04/2025	
Welsh Government Independent Review of Clinical Pharmacy Services at NHS Hospitals in Wales	R1.2 Prioritising clinical pharmacy service provision to better meet the needs of the NHS c) Health boards and Velindre University NHS Trust should ensure all advanced practice and consultant pharmacists are designated to support clinical divisions/directorates based on the results of the resource mapping exercise	To follow on from stocktaking action in R1.2a	Primary Care, Community Strategy & Long Term Care	30/04/2025	30/04/2025	Lack of RPS membership within the HB with pharmacists national workforce group to consider how advanced practice is developed within the group
Welsh Government Independent Review of Clinical Pharmacy Services at NHS Hospitals in Wales	R1.2 Prioritising clinical pharmacy service provision to better meet the needs of the NHS d) Health boards should ensure that systems are in place for triage and prioritisation of patients for the provision of pharmaceutical care on admission. Prioritisation should be based on the use of clinical prioritisation tools validated and used in NHS hospitals in the UK	(EXTENRAL) Informal triaging undertaken by pharmacy teams, prioritisation tool under development by clinical lead pharmacists and chief technicians. Planning for digital prioritisation method with the introduction of ePMA	Primary Care, Community Strategy & Long Term Care	30/09/2024	30/09/2024	EMPA system has been procured - awaiting confirmation of funding from welsh government

Inspection Title	Recommendation	Action	Clinical Care Group/Executive Function	Original Due Date	Current Due Date	Barriers
Welsh Government Independent Review of Clinical Pharmacy Services at NHS Hospitals in Wales	R1.3 Scope of clinical pharmacy services and the relationship with multidisciplinary teams a) Where a clinical pharmacy service is provided to a clinical division(s)/ directorate(s) or clinical area, health boards and Velindre University NHS Trust should establish: i) a formal agreement defining the nature and extent of the service and the specific role(s) of any advanced practice and consultant pharmacists involved in the provision of the service, as set out in their job plan(s) ii) the agreement should set out clearly the arrangements for managerial, clinical, and professional accountability	Services based on historic levels. SLA to be developed detailing levels of service to be provided to areas and accountability arrangements. Currently no SLAs in place for clinical services.	Primary Care, Community Strategy & Long Term Care	30/04/2025	30/04/2025	
Welsh Government Independent Review of Clinical Pharmacy Services at NHS Hospitals in Wales	R1.3 Scope of clinical pharmacy services and the relationship with multidisciplinary teams b) Health boards and Velindre University NHS Trust should determine the demand profile for pharmacy services in all clinical areas and ensure working patterns of pharmacy teams are aligned to patient and service needs. This should include times when pharmacy services may not currently be being provided and should ensure provision wherever it is needed, seven days a week	Following stocktake action (R1.2a), need to develop demand plan, Subsequent resource map needed to understand demand profile and capacity gap.	Primary Care, Community Strategy & Long Term Care	30/04/2029	30/04/2029	
Welsh Government Independent Review of Clinical Pharmacy Services at NHS Hospitals in Wales	R1.3 Scope of clinical pharmacy services and the relationship with multidisciplinary teams c) Health boards and Velindre University NHS Trust should ensure the requirements for clinical and non-clinical pharmacy services are considered in all new service developments and in any clinical service redesign.	Clinical pharmacy services are only sustainable if core pharmacy services are robust. In order to liberate time for clinical service development the access to medicines functions need to be modernised for centralised coordination and localised delivery. Creation of a hub within directorate budget can achieve this. This will include development into logistical support to increase the productivity of the clinical pharmacy service to expand their capacity e.g. dedicated IT support, data analytics and communications. Senior Management team	Primary Care, Community Strategy & Long Term Care	30/09/2024	30/09/2024	lack of space within the HB to hold a medicines hub that is central to deliver the support needed to all acute sites
Welsh Government Independent Review of Clinical Pharmacy Services at NHS Hospitals in Wales	R1.4 Realising the potential of pharmacist prescribing a) Health boards and Velindre University NHS Trust should ensure all advanced practice and consultant pharmacists in clinical roles are or are training to be, prescribers	No consultant or advanced practice pharmacists in post. 67% of pharmacists in hospitals in the HB are Independent prescribers	Primary Care, Community Strategy & Long Term Care	30/04/2029	30/04/2029	

Inspection Title	Recommendation	Action	Clinical Care Group/Executive Function	Original Due Date	Current Due Date	Barriers
Welsh Government Independent Review of Clinical Pharmacy Services at NHS Hospitals in Wales	R1.4 Realising the potential of pharmacist prescribing b) The Chief Pharmacists' Peer Group should establish a multidisciplinary short life working group to agree how recommendations 12 and 13 of the RPS's review relating to pharmacist prescribing should be implemented	(EXTERNAL) Chief pharms peer group has assigned an SRO to each theme.	Primary Care, Community Strategy & Long Term Care	30/04/2025	30/04/2025	
Welsh Government Independent Review of Clinical Pharmacy Services at NHS Hospitals in Wales	R1.5 Improving pharmacy support to meet the NHS stated priorities a) Health boards should ensure all Urgent and Emergency Care settings receive a clinical pharmacy service and that appropriately trained pharmacist prescribers are incorporated into multidisciplinary teams within all Emergency Departments and Same Day Emergency Care units as a priority	Current clinical pharmacy services provide support to these areas. Recruitment into SDEC units has been challenging, need review in where this fits into current service provision and where training needs lie. Pharmacists working within Emergency Departments may not be prescribers or are not actively prescribing within the role.	Primary Care, Community Strategy & Long Term Care	30/09/2024	30/09/2024	Current financial constraints have prevented recruitment - if the roles are fulfilled utilising current vacancies there is concern for clinical safety within the acute sites
Welsh Government Independent Review of Clinical Pharmacy Services at NHS Hospitals in Wales	R1.5 Improving pharmacy support to meet the NHS stated priorities b) HEIW will prioritise funding opportunities to develop pharmacists' kills to work in Urgent and Emergency Care settings. Funding will include the development of skills in independent prescribing, clinical examination and clinical health assessment, diagnostics and triage	Pharmacist and pharmacy technician input into ED patients across the health board. SDEC recruitment in progress to reinvigorate service	Primary Care, Community Strategy & Long Term Care	30/04/2025	30/04/2025	
Welsh Government Independent Review of Clinical Pharmacy Services at NHS Hospitals in Wales	R1.5 Improving pharmacy support to meet the NHS stated priorities c) Health boards should review and where necessary amend, the working patterns and contractual hours of pharmacy teams to ensure they are aligned with service demand in Emergency Departments and Same Day Emergency Care units	Pharmacist and pharmacy technician input into ED patients across the health board. SDEC recruitment in progress to reinvigorate service	Primary Care, Community Strategy & Long Term Care	30/04/2025	30/04/2025	In order to increase working hours in the week and extend to 8am - 7pm minimum there would be a need to undertake a new OCP as current contractual hours cannot change.
Welsh Government Independent Review of Clinical Pharmacy Services at NHS Hospitals in Wales	R1.5 Improving pharmacy support to meet the NHS stated priorities d) Health boards should ensure planned care services receive a clinical pharmacy service and that appropriately trained pharmacist prescribers are incorporated into multidisciplinary teams, prioritising pharmacist prescriber roles in pre-admission and pre-habilitation services	Pharmacists currently available to give advice to pre-admission services. Discussions underway in sites to understand the demand. Should also be highlighted in stocktake action	Primary Care, Community Strategy & Long Term Care	30/04/2025	30/04/2025	
Welsh Government Independent Review of Clinical Pharmacy Services at NHS Hospitals in Wales	R1.6 Pharmacy's role in optimising patient flow a) Health boards and Velindre University NHS Trust should implement all actions included in the guidance Optimising pharmacy services at hospital discharge to improve patient flow published by the Welsh Government in December 2022	Action complete	Primary Care, Community Strategy & Long Term Care	30/09/2024	30/09/2024	

Inspection Title	Recommendation	Action	Clinical Care Group/Executive Function	Original Due Date	Current Due Date	Barriers
Welsh Government Independent Review of Clinical Pharmacy Services at NHS Hospitals in Wales	R1.6 Pharmacy's role in optimising patient flow b) Health boards and Velindre University NHS Trust should establish and fully implement their patient medicines self-administration policies to enable patients to manage their own medicines whilst they are in hospital	(EXTERNAL) Self administration policy has been used in some sites, lack of suitable patient lockers and size of policy is a barrier. Being reviewed alongside nursing.	Primary Care, Community Strategy & Long Term Care	30/04/2029	30/04/2029	
Welsh Government Independent Review of Clinical Pharmacy Services at NHS Hospitals in Wales	(External Recommendation) R1.6 Pharmacy's role in optimising patient flow c) The Welsh Government will commission updated messaging encouraging patients to bring their regular medicines to hospital, supported by national communications activitiea	(EXTERNAL) The Welsh Government will commission updated messaging encouraging patients to bring their regular medicines to hospital, supported by national communications activities	Primary Care, Community Strategy & Long Term Care	30/04/2025	30/04/2025	
Welsh Government Independent Review of Clinical Pharmacy Services at NHS Hospitals in Wales	R1.6 Pharmacy's role in optimising patient flow d) Health boards and Velindre University NHS Trust should ensure that pharmacy teams, as routine practice, record every patient's nominated community pharmacy in their online record (e.g. in the Welsh Clinical Portal) to facilitate a Discharge Medication Review (DMR) after discharge from hospital. The Welsh Government will commission updated patient and carer communication materials to support this action	Pharmacy technicians routinely record this during medication history taking. Primary method of communication for blister pack discharge information.	Primary Care, Community Strategy & Long Term Care	30/09/2024	30/09/2024	
Welsh Government Independent Review of Clinical Pharmacy Services at NHS Hospitals in Wales	R1.6 Pharmacy's role in optimising patient flow e) Pharmacy teams should ensure that all patients requiring post-discharge support with their medicines are referred to the most appropriate community services (e.g. a medicines review by GP or GP practice pharmacist, or a community-based/domiciliary medicines service)	Contact details available on intranet for primary care staff, page to be created for secondary care. To discuss if possibilty for digital signposting/outward facing resource. - chief technicians	Primary Care, Community Strategy & Long Term Care	30/04/2025	30/04/2025	
Welsh Government Independent Review of Clinical Pharmacy Services at NHS Hospitals in Wales	R2.1 Improving pharmacy workforce planning a) Health boards and Velindre University NHS Trust should ensure their organisational workforce plans take account of the benefits of integration of pharmacy professionals in multi-disciplinary teams	Need to link with directorates and specialities and wider health board to ensure pharmacy is routinely considered in MDT workforce planning and IMTPs	Primary Care, Community Strategy & Long Term Care	30/09/2024	30/09/2024	Need to upskill technical and assistant staff to undertake roles where there is lower value and lower priority in order to free clinical pharmacist time to integrate into the MDTs where there skills provide the most value
Welsh Government Independent Review of Clinical Pharmacy Services at NHS Hospitals in Wales	R2.1 Improving pharmacy workforce planning b) Health boards and Velindre University NHS Trust chief pharmacists should ensure the organisation has a pharmacy workforce plan to support and expand advanced and consultant pharmacist practice and to identify more clinical roles for pharmacy technicians	Work currently ongoing to develop workforce plan. Beginning planning for development and training of consultant and advanced practice pharmacists. Expand the role of pharmacy technicians using enhanced training courses.	Primary Care, Community Strategy & Long Term Care	30/04/2025	30/04/2025	

Inspection Title	Recommendation	Action	Clinical Care Group/Executive Function	Original Due Date	Current Due Date	Barriers
Welsh Government Independent Review of Clinical Pharmacy Services at NHS Hospitals in Wales	R2.1 Improving pharmacy workforce planning c) HEIW and health boards should continue to prioritise funding for opportunities for hospital pharmacists to access advanced practice training and for pharmacy technicians to access additional clinical training and put in place arrangements to ensure such training is aligned to NHS priorities	HEIW advance practice funding fully utilised through range of opportunities for all pharmacy staff.	Primary Care, Community Strategy & Long Term Care	30/04/2025	30/04/2025	
Welsh Government Independent Review of Clinical Pharmacy Services at NHS Hospitals in Wales	(External Recommendation) R2.2 Introducing pharmacy career frameworks and job planning to support workforce retention and delivery of pharmaceutical care a) HEIW will work with health boards and Velindre University NHS Trust to develop standardised post registration career frameworks aligned to post-registration curricula, for all pharmacists and pharmacy technicians employed by the NHS in Wales	(EXTERNAL) HEIW will work with health boards and Velindre University NHS Trust to develop standardised post registration career frameworks aligned to post-registration curricula, for all pharmacists and pharmacy technicians employed by the NHS in Wales	Primary Care, Community Strategy & Long Term Care	30/04/2029	30/04/2029	
Welsh Government Independent Review of Clinical Pharmacy Services at NHS Hospitals in Wales	(External Recommendation) R2.2 Introducing pharmacy career frameworks and job planning to support workforce retention and delivery of pharmaceutical care b) As part of the career frameworks, NHS organisations will develop standardised national nomenclature for job titles for NHS employed clinical pharmacists aligned to the RPS curricula for post registration practice	(EXTERNAL) As part of the career frameworks, NHS organisations will develop standardised national nomenclature for job titles for NHS employed clinical pharmacists aligned to the RPS curricula for post registration practice	Primary Care, Community Strategy & Long Term Care	30/04/2029	30/04/2029	
Welsh Government Independent Review of Clinical Pharmacy Services at NHS Hospitals in Wales	R2.2 Introducing pharmacy career frameworks and job planning to support workforce retention and delivery of pharmaceutical care c) Once agreed, health boards and Velindre University NHS Trust should adopt the standardised national nomenclature for pharmacist job titles	EXTERNAL action (HEIW)	Primary Care, Community Strategy & Long Term Care	30/04/2029	30/04/2029	
Welsh Government Independent Review of Clinical Pharmacy Services at NHS Hospitals in Wales	R2.2 Introducing pharmacy career frameworks and job planning to support workforce retention and delivery of pharmaceutical care d) Health boards and Velindre University NHS Trust should ensure the career progression of all NHS employed pharmacists and pharmacy technicians requires individuals to demonstrate they meet the required minimum standard for practising at the level of practise required by the job description (and the standardised nomenclature for job titles) including through credentialling by a professional body where available	Credentialing of pharmacists supported. Pharmacy technician career development pathway underway some enhanced roles (administration) and training (clinical skills diploma).	Primary Care, Community Strategy & Long Term Care	30/04/2029	30/04/2029	

Inspection Title	Recommendation	Action	Clinical Care Group/Executive Function	Original Due Date	Current Due Date	Barriers
Welsh Government Independent Review of Clinical Pharmacy Services at NHS Hospitals in Wales	(External Recommendation) R2.2 Introducing pharmacy career frameworks and job planning to support workforce retention and delivery of pharmaceutical care e) National template job descriptions, updated Agenda for Change job profiles, and national template job plans (encompassing the four pillars of advanced practice) should be developed for all pharmacists	(EXTERNAL) Job plans being discussed - workforce	Primary Care, Community Strategy & Long Term Care	30/04/2025	30/04/2025	
Welsh Government Independent Review of Clinical Pharmacy Services at NHS Hospitals in Wales	R2.2 Introducing pharmacy career frameworks and job planning to support workforce retention and delivery of pharmaceutical care f) Health boards and Velindre University NHS Trust should ensure all NHS employed pharmacists have a job plan appropriate for each stage of an individual pharmacist's career	Job plans need creating/reviewing	Primary Care, Community Strategy & Long Term Care	30/04/2029	30/04/2029	
Welsh Government Independent Review of Clinical Pharmacy Services at NHS Hospitals in Wales	R2.2 Introducing pharmacy career frameworks and job planning to support workforce retention and delivery of pharmaceutical care g) Job plans for advanced practice and consultant pharmacists should include time for providing outreach services and integrated working across sectors to support community-based practitioners and patients in the community	Same as above and no consultant/advanced practice pharmacist posts in health board	Primary Care, Community Strategy & Long Term Care	30/04/2029	30/04/2029	
Welsh Government Independent Review of Clinical Pharmacy Services at NHS Hospitals in Wales	(External Recommendation) R2.2 Introducing pharmacy career frameworks and job planning to support workforce retention and delivery of pharmaceutical care h) HEIW, working with the Association of Pharmacy Technicians UK (APTUK), will develop comprehensive post-registration curricula for pharmacy technicians employed by the NHS in Wales	(EXTERNAL) HEIW, working with the Association of Pharmacy Technicians UK (APTUK), will develop comprehensive post-registration curricula for pharmacy technicians employed by the NHS in Wales	Primary Care, Community Strategy & Long Term Care	30/04/2029	30/04/2029	
Welsh Government Independent Review of Clinical Pharmacy Services at NHS Hospitals in Wales	R2.2 Introducing pharmacy career frameworks and job planning to support workforce retention and delivery of pharmaceutical care i) Once such curricula have been developed, further work should be undertaken to develop a standardised national nomenclature for job titles for NHS employed pharmacy technicians. The nomenclature for job titles should be aligned to those curricula; and national template job descriptions, updated Agenda for Change job profiles, and national template job plans for pharmacy technicians. Health boards and Velindre University NHS Trust should then adopt the standardised national nomenclature for pharmacy technician job titles; and ensure all NHS employed pharmacy technicians have a job plan which is appropriate for each stage of an individual pharmacy technician's career	Job plans being discussed - workforce	Primary Care, Community Strategy & Long Term Care	30/04/2031	30/04/2031	

Inspection Title	Recommendation	Action	Clinical Care Group/Executive Function	Original Due Date	Current Due Date	Barriers
Welsh Government Independent Review of Clinical Pharmacy Services at NHS Hospitals in Wales	(External Recommendation) R2.3 Supporting professional development at all stages in careers a) HEIW should work with the Schools of Pharmacy at Cardiff and Swansea Universities to describe examples of pharmacy undergraduate placements within hospital multidisciplinary teams which meet their educational requirements. This should include maintaining and publishing a list of entrustable professional activities for pharmacy undergraduates including appropriate clinical pharmacy activities in hospitals	(EXTERNAL) HEIW should work with the Schools of Pharmacy at Cardiff and Swansea Universities to describe examples of pharmacy undergraduate placements within hospital multidisciplinary teams which meet their educational requirements. This should include maintaining and publishing a list of entrustable professional activities for pharmacy undergraduates including appropriate clinical pharmacy activities in hospitals	Primary Care, Community Strategy & Long Term Care	30/09/2024	30/09/2024	
Welsh Government Independent Review of Clinical Pharmacy Services at NHS Hospitals in Wales	R2.3 Supporting professional development at all stages in careers b) Health boards and Velindre University NHS Trust should develop plans to ensure adequate numbers of pharmacy undergraduate, foundation and post-registration foundation placements are available aligned to the planned number of trainees in Wales including placements with pharmacist prescribers and within multidisciplinary teams	Some sites already offering placements to undergraduate students, all sites offering places for foundation and post foundation trainees. To develop a plan on how more can be supported and gain support from other healthcare professionals as part of an MDT approach.	Primary Care, Community Strategy & Long Term Care	30/04/2025	30/04/2025	
Welsh Government Independent Review of Clinical Pharmacy Services at NHS Hospitals in Wales	R2.3 Supporting professional development at all stages in careers c) Standardised job plans for pharmacists and pharmacy technicians should include protected time for participating and supervising education commensurate with the stage of individuals' careers	Workforce require job plans	Primary Care, Community Strategy & Long Term Care	30/04/2029	30/04/2029	
Welsh Government Independent Review of Clinical Pharmacy Services at NHS Hospitals in Wales	(External Recommendation) R2.3 Supporting professional development at all stages in careers d) HEIW should undertake a review of the continuing professional development offer for hospital pharmacy teams to ensure it is meeting their development needs and provides a sufficiently flexible approach for participants	(EXTERNAL) HEIW should undertake a review of the continuing professional development offer for hospital pharmacy teams to ensure it is meeting their development needs and provides a sufficiently flexible approach for participants	Primary Care, Community Strategy & Long Term Care	30/04/2025	30/04/2025	
Welsh Government Independent Review of Clinical Pharmacy Services at NHS Hospitals in Wales	R2.3 Supporting professional development at all stages in careers e) Health boards and Velindre University NHS Trust should ensure there is appropriate pharmacy input into multidisciplinary education and training structures	Current teaching on junior doctor programme and medicines management for nurses.	Primary Care, Community Strategy & Long Term Care	30/04/2031	30/04/2031	
Welsh Government Independent Review of Clinical Pharmacy Services at NHS Hospitals in Wales	R2.4 Understanding and continually improving the quality of pharmaceutical care a) The Chief Pharmacists' Peer Group should commission a refresh and refocus of the Pharmacy Research Strategy in Wales aligned to the recommendations of the independent review	(External) Chief pharms peer group has assigned an SRO to each theme.	Primary Care, Community Strategy & Long Term Care	30/04/2025	30/04/2025	

Inspection Title	Recommendation	Action	Clinical Care Group/Executive Function	Original Due Date	Current Due Date	Barriers
Welsh Government Independent Review of Clinical Pharmacy Services at NHS Hospitals in Wales	(External Recommendation) R2.4 Understanding and continually improving the quality of pharmaceutical care b) The Welsh Government working with health boards, HEIs, and Health and Care Research Wales (HCRW) should develop a network of research mentors for pharmacy professionals	(EXTERNAL) The Welsh Government working with health boards, HEIs, and Health and Care Research Wales (HCRW) should develop a network of research mentors for pharmacy professionals	Primary Care, Community Strategy & Long Term Care	30/04/2029	30/04/2029	
Welsh Government Independent Review of Clinical Pharmacy Services at NHS Hospitals in Wales	R2.4 Understanding and continually improving the quality of pharmaceutical care c) Standardised job plans for pharmacists and pharmacy technicians should include protected time for participating and supervising research and development commensurate with the stage of individuals' careers	Consultant pharmacists have this identified, wider workforce require job plans.	Primary Care, Community Strategy & Long Term Care	30/04/2029	30/04/2029	
Welsh Government Independent Review of Clinical Pharmacy Services at NHS Hospitals in Wales	R2.4 Understanding and continually improving the quality of pharmaceutical care d) The Chief Pharmacists' Peer Group should establish a programme of work with HEIW to establish a continuous rolling programme for formally appraising pharmacy and medicines management workforce needs aligned to new technologies and NHS priorities	(External) Chief pharms peer group has assigned an SRO to each theme.	Primary Care, Community Strategy & Long Term Care	30/04/2025	30/04/2025	
Welsh Government Independent Review of Clinical Pharmacy Services at NHS Hospitals in Wales	R3.1 Improving organisational scrutiny of the quality and effectiveness of pharmacy services a) Health boards should ensure they employ a Director of Pharmacy accountable for the quality of clinical and technical pharmacy services provided within the organisation	Clinical Director in post. Action complete	Primary Care, Community Strategy & Long Term Care	30/09/2024	30/09/2024	
Welsh Government Independent Review of Clinical Pharmacy Services at NHS Hospitals in Wales	R3.1 Improving organisational scrutiny of the quality and effectiveness of pharmacy services b) The Director of Pharmacy should be a member of the health board's senior management team, must report to a health board executive director, and be able to raise matters relating to the quality or provision of pharmacy services and medicines within the organisation, directly to the board	Member of the health board senior management team?, professionally report to Executive Medical Director. Board members (and Management Exec) accessible to director of pharmacy.	Primary Care, Community Strategy & Long Term Care	30/04/2025	30/04/2025	
Welsh Government Independent Review of Clinical Pharmacy Services at NHS Hospitals in Wales	R3.1 Improving organisational scrutiny of the quality and effectiveness of pharmacy services c) Health boards and Velindre University NHS Trust should agree arrangements for routinely reporting on assurance of medicines and pharmacy quality and safety issues to the organisation's board or relevant sub-committee of the board	Current reporting structure through Medicines Management Operational Group which has a standing item on the Quality Safety and Experience Committee agenda.	Primary Care, Community Strategy & Long Term Care	30/04/2025	30/04/2025	

Inspection Title	Recommendation	Action	Clinical Care Group/Executive Function	Original Due Date	Current Due Date	Barriers
Welsh Government Independent Review of Clinical Pharmacy Services at NHS Hospitals in Wales	R3.1 Improving organisational scrutiny of the quality and effectiveness of pharmacy services d) Health boards and Velindre University NHS Trust should ensure pharmacy services are included within their strategic planning cycle	Need to link with directorates and specialities and wider health board to ensure pharmacy is routinely considered in MDT workforce planning and IMTPs. Need to increase opportunities to collaborate and be routinely included in strategic planning cycle.	Primary Care, Community Strategy & Long Term Care	30/09/2024	30/09/2024	
Welsh Government Independent Review of Clinical Pharmacy Services at NHS Hospitals in Wales	(External Recommendation) R3.1 Improving organisational scrutiny of the quality and effectiveness of pharmacy services e) The Welsh Government will work with the NHS Executive, health boards and Velindre University NHS Trust to develop and implement key performance indicators including those derived from digital systems, which demonstrate the effectiveness of pharmacy services, on improving the quality of care	(EXTERNAL) The Welsh Government will work with the NHS Executive, health boards and Velindre University NHS Trust to develop and implement key performance indicators including those derived from digital systems, which demonstrate the effectiveness of pharmacy services, on improving the quality of care	Primary Care, Community Strategy & Long Term Care	30/04/2029	30/04/2029	
Welsh Government Independent Review of Clinical Pharmacy Services at NHS Hospitals in Wales	R3.2 Pharmacy system leadership a) Each health board's Director of Pharmacy should be responsible for producing a plan for pharmacy and medicines management within the health board setting but how pharmacy teams are responding to relevant Welsh Government and NHS Executive priorities	Directorate structure been created to have an agile way to respond to any relevant WG and NHS Executive priorities	Primary Care, Community Strategy & Long Term Care	30/04/2025	30/04/2025	
Welsh Government Independent Review of Clinical Pharmacy Services at NHS Hospitals in Wales	R3.2 Pharmacy system leadership b) Health boards and Velindre University NHS Trust should review pharmacy senior leadership and management arrangements including job titles to ensure they meet the new GPhC regulatory requirements and the needs of increasing clinical roles	New GPhC requirements not yet ratified. Pharmacy leadership structure aligns to Clinical Boards which does create a lack of site-based leadership.	Primary Care, Community Strategy & Long Term Care	30/04/2029	30/04/2029	
Welsh Government Independent Review of Clinical Pharmacy Services at NHS Hospitals in Wales	(External Recommendation) R3.3 Talent management and developing future leaders within pharmacy. a) Working with HEIW and Academi Wales, the Welsh Government will ensure aspiring leaders in pharmacy have access to a range of multidisciplinary and public sector wide opportunities for leadership development such as HEIW's Executive Talent Pool and Academi Wales' Leadership Development Programmes	(EXTERNAL) Working with HEIW and Academi Wales, the Welsh Government will ensure aspiring leaders in pharmacy have access to a range of multidisciplinary and public sector wide opportunities for leadership development such as HEIW's Executive Talent Pool and Academi Wales' Leadership Development Programmes	Primary Care, Community Strategy & Long Term Care	30/04/2025	30/04/2025	
Welsh Government Independent Review of Clinical Pharmacy Services at NHS Hospitals in Wales	R3.3 Talent management and developing future leaders within pharmacy. b) Health boards and Velindre University NHS Trust must implement the actions identified in the HEIW "Senior Leadership Development in Pharmacy" report	See action plan in appendix 4.	Primary Care, Community Strategy & Long Term Care	30/04/2029	30/04/2029	

Inspection Title	Recommendation	Action	Clinical Care Group/Executive Function	Original Due Date	Current Due Date	Barriers
Welsh Government Independent Review of Clinical Pharmacy Services at NHS Hospitals in Wales	R3.3 Talent management and developing future leaders within pharmacy. c) HEIW should work with Health boards and Velindre University NHS Trust to promote awareness of the tools in the "Gwella" leadership platform to promote leadership development at all stages of pharmacy professionals' careers and personal development	Some senior staff have undertaken leadership/management training. Historically the Managers passport. There is a HEIW leadership course available and a LEAP training run by the health board.	Primary Care, Community Strategy & Long Term Care	30/04/2025	30/04/2025	
Welsh Government Independent Review of Clinical Pharmacy Services at NHS Hospitals in Wales	(External Recommendation) R3.3 Talent management and developing future leaders within pharmacy. d) HEIW will review the outcomes of participation in the Centre for Pharmacy Postgraduate Education's (CPPE's) programme, "The Chief Pharmaceutical Officer's Pharmacy leaders' development", with a view to establishing a rolling programme to develop future NHS Wales Directors of Pharmacy	(EXTERNAL) HEIW will review the outcomes of participation in the Centre for Pharmacy Postgraduate Education's (CPPE's) programme, "The Chief Pharmaceutical Officer's Pharmacy leaders' development", with a view to establishing a rolling programme to develop future NHS Wales Directors of Pharmacy	Primary Care, Community Strategy & Long Term Care	30/04/2025	30/04/2025	
Welsh Government Independent Review of Clinical Pharmacy Services at NHS Hospitals in Wales	R3.4. Clinical leadership a) HEIW will lead the development of a consultant pharmacist strategy and implementation plan, and health boards and Velindre University NHS Trust should establish a succession plan for advanced practice and consultant pharmacist roles within their respective workforce plans	(EXTERNAL) HEIW will lead the development of a consultant pharmacist strategy and implementation plan, and health boards and Velindre University NHS Trust should establish a succession plan for advanced practice and consultant pharmacist roles within their respective workforce plans	Primary Care, Community Strategy & Long Term Care	30/04/2029	30/04/2029	
Welsh Government Independent Review of Clinical Pharmacy Services at NHS Hospitals in Wales	(External Recommendation) R3.4 Clinical leadership b) The Welsh Government will work with health boards, Velindre University NHS Trust and HEIW to establish clinical governance arrangements for all pharmacist and other non-medical prescribers, which will include the implementation of the agreed NHS Wales Non-Medical Prescribing (NMP) standards, signposting to guidance and facilitating prescribers to expand their scope of practice	(EXTERNAL) The Welsh Government will work with health boards, Velindre University NHS Trust and HEIW to establish clinical governance arrangements for all pharmacist and other non-medical prescribers, which will include the implementation of the agreed NHS Wales Non-Medical Prescribing (NMP) standards, signposting to guidance and facilitating prescribers to expand their scope of practice	Primary Care, Community Strategy & Long Term Care	30/04/2029	30/04/2029	
Welsh Government Independent Review of Clinical Pharmacy Services at NHS Hospitals in Wales	R3.4 Clinical leadership c) The Chief Pharmacists' Peer Group should review the arrangements for sharing and adopting examples of best practice between health boards. There should a specific focus on standardising clinical pharmacy services in urgent and emergency care and pre-admission/pre-habilitation care, within the first 12 months of this plan being published	(EXTERNAL) Chief pharms peer group has assigned an SRO to each theme.	Primary Care, Community Strategy & Long Term Care	30/04/2025	30/04/2025	

Inspection Title	Recommendation	Action	Clinical Care Group/Executive Function	Original Due Date	Current Due Date	Barriers
Welsh Government Independent Review of Clinical Pharmacy Services at NHS Hospitals in Wales	R4.1 Better use of data and technology to prioritise pharmaceutical care a) Health boards and Velindre University NHS Trust should continue to work with the DMTP to progress implementation of electronic prescribing and medicines administration (ePMA) systems for every hospital in Wales in line with the agreed timescales including ensuring pharmacy professionals have access to IT hardware needed to realise the benefits of digital systems	Digital lead pharmacist in post	Primary Care, Community Strategy & Long Term Care	30/09/2024	30/09/2024	
Welsh Government Independent Review of Clinical Pharmacy Services at NHS Hospitals in Wales	R4.1 Better use of data and technology to prioritise pharmaceutical care b) Health boards and Velindre University NHS Trust should prioritise the development of digital and technological skills within pharmacy workforce training and establish clinical informatics pharmacy professional roles within their organisations	Digital lead pharmacist in post - Undergraduate project underway to establish current workforce digital skills	Primary Care, Community Strategy & Long Term Care	30/04/2025	30/04/2025	
Welsh Government Independent Review of Clinical Pharmacy Services at NHS Hospitals in Wales	R4.1 Better use of data and technology to prioritise pharmaceutical care c) Working with the DMTP, the Chief Pharmacists' Peer Group should establish a short life working group to agree how ePMA systems and the development of the Shared Medicines Record can be used to provide optimal support for prioritisation and pharmaceutical care planning including outreach services in enhanced community care (virtual wards)	(EXTERNAL) Nationally: On chief pharmacist's agenda - working with Cath O'Brien DMTP . HB: Digital and analytics group to realise capabilities of ePMA and work with clinical personnel to develop tailored dashboard for HB.	Primary Care, Community Strategy & Long Term Care	30/09/2024	30/09/2024	Awaiting steer from chief pharmacists group to confirm dates for when this will be rolled out
Welsh Government Independent Review of Clinical Pharmacy Services at NHS Hospitals in Wales	R4.2 Realising the benefits of wider use of innovation to guide therapeutic decision making. a) Health boards and Velindre University NHS Trust should have plans in place to support the wider use of pharmacogenomic testing including the role of pharmacy professionals in advance of the development of a Wales-wide pharmacogenomic panel	Need to develop health board wide strategy for pharmacogenomics.	Primary Care, Community Strategy & Long Term Care	30/04/2029	30/04/2029	
Welsh Government Independent Review of Clinical Pharmacy Services at NHS Hospitals in Wales	R4.2 Realising the benefits of wider use of innovation to guide therapeutic decision making. b) Health boards and Velindre University NHS Trust should work with HEIW to provide opportunities to develop awareness of innovative technologies (e.g. Artificial Intelligence and pharmacogenomics) which impact on therapeutic decision making amongst pharmacy teams. This should include but not be limited to, encouraging more pharmacy professionals to access the Swansea and Bangor University postgraduate programmes in genomic medicine	University modules offered to staff, being undertaken this year.	Primary Care, Community Strategy & Long Term Care	30/04/2029	30/04/2029	

Inspection Title	Recommendation	Action	Clinical Care Group/Executive Function	Original Due Date	Current Due Date	Barriers
Welsh Government Independent Review of Clinical Pharmacy Services at NHS Hospitals in Wales	R4.2 Realising the benefits of wider use of innovation to guide therapeutic decision making. c) Health boards and Velindre University NHS Trust should develop advanced practice and consultant pharmacist roles for pharmacogenomics to lead the development and implementation of pharmacogenomics plans across the NHS	All Wales JD developed and banded by CAV and VCC in collaboration with AWMGS. To be hosted in CAV (awaiting credentialing).	Primary Care, Community Strategy & Long Term Care	30/04/2031	30/04/2031	

1.7

09:45, 5 Mins

1.7 - SPC Terms of Reference

Joanne Wilson (Hywel Dda UHB - Director of Corporate Governance/Board Secretary)

For approval

Attachments

1.7.1 SPC SBAR Term of Reference 18 12 2025.pdf

1.7.2 Strategy and Planning Committee Terms of Reference.V2.DRAFTFORREVIEW.pdf

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

PWYLLGOR STRATEGAETH A CHYNLLUNIO
STRATEGY AND PLANNING COMMITTEE

DYDDIAD Y CYFARFOD: DATE OF MEETING:	18 December 2025
TEITL YR ADRODDIAD: TITLE OF REPORT:	Strategy and Planning Committee Terms of Reference
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Joanne Wilson, Director of Corporate Governance/Board Secretary
SWYDDOG ADRODD: REPORTING OFFICER:	Charlotte Wilmshurst, Assistant Director of Assurance and Risk

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Ar Gyfer Penderfyniad/For Decision

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The purpose of this paper is to ensure that the Strategy and Planning Committee (SPC) has clear terms of reference which detail its purpose, boundaries, role, composition and operating arrangements.

According to its terms of reference, the Committee must review its terms of reference and operating arrangements on at least an annual basis to ensure they remain fit for purpose. These must be subsequently approved by the Board and will form part of the Health Board's Standing Orders.

Cefndir / Background

The Board initially approved the Committee's terms of reference and operating arrangements on 30 January 2025, and these were formally adopted by the Committee upon its establishment on 1 April 2025.

Asesiad / Assessment

The Strategy and Planning Committee terms of reference and operating arrangements (Appendix 1) have been reviewed and some minor changes and amendments have been made. These are clearly marked in red on Appendix 1 and relate to the following:

Section	What has changed?	Why?
3.1.16	Purpose - Section amended	Section amended to include '…the Health Board's annual capital allocation and plan, and …'
3.1.18	Purpose - Section amended	Section amended to include '…a schedule of projects/schemes within the Health Board's Capital Plan where there may be associated works contracts that require sealing.'

3.1.22	Purpose - Section amended	Section amended to include '…auditors, inspectorates …'
4.2	Purpose – Section amended	Section amended to remove reference to the Director of Primary, Community & Long-Term Care as an attendee.

Argymhelliad / Recommendation

The Committee is asked to:

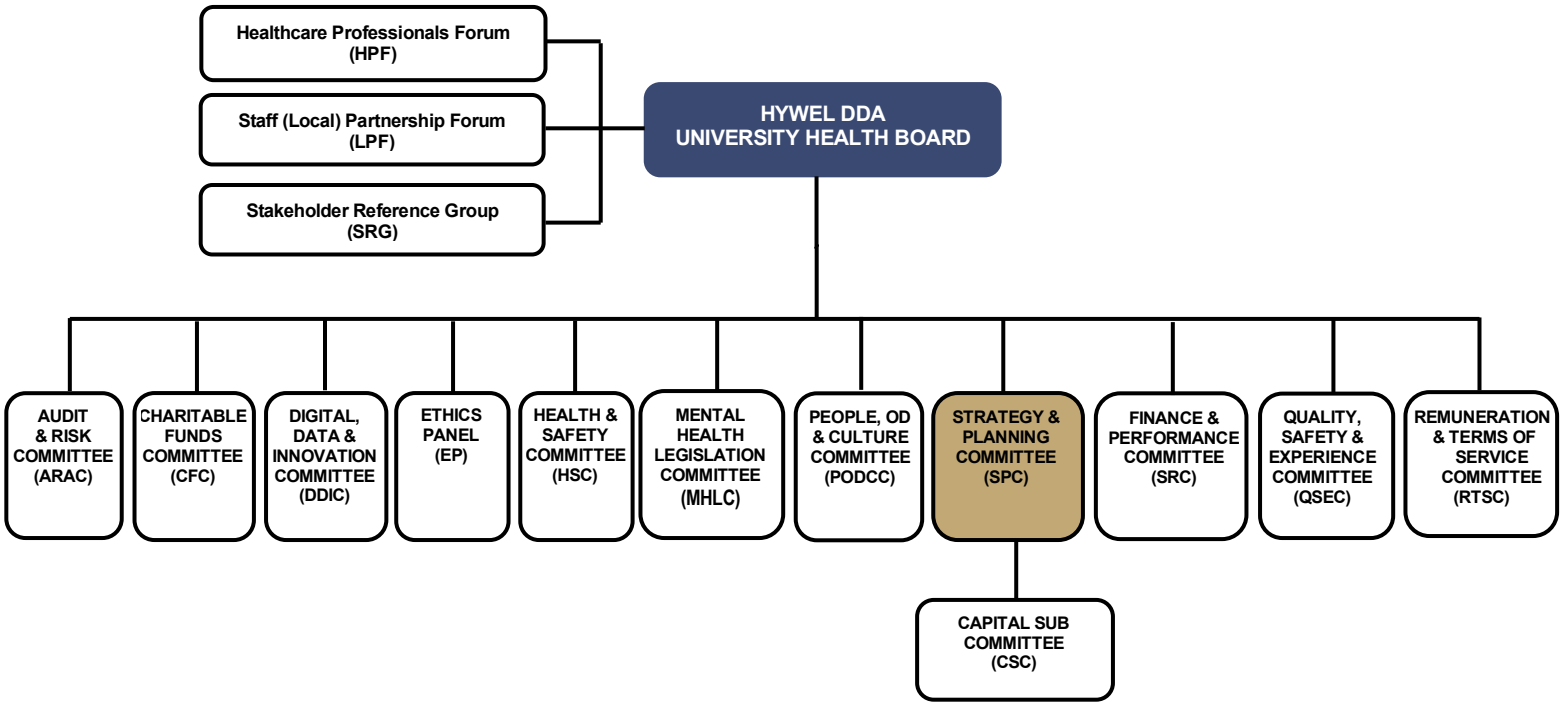
- **APPROVE** the Strategy and Planning Committee's Terms of Reference for onward ratification by the Board on 29 January 2026.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	12.1 These terms of reference and operating arrangements shall be reviewed on at least an annual basis by the Committee for approval by the Board.
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Not Applicable
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	7. All apply
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	6. All Apply
Amcanion Strategol y BIP: UHB Strategic Objectives:	Not Applicable
Amcanion Cynllunio Planning Objectives	Not Applicable
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022	10. Not Applicable

Gwybodaeth Ychwanegol: Further Information:

Ar sail tystiolaeth: Evidence Base:	Targeted Intervention Escalation Framework Annual Plan 2025/26
Rhestr Termau: Glossary of Terms:	Contained within the body of the report.
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Strategaeth a Chynllunio Parties / Committees consulted prior to Strategy and Planning Committee:	SPC Chair and Executive Lead Director of Corporate Governance/Board Secretary

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	Not Applicable
Ansawdd / Gofal Claf: Quality / Patient Care:	Not Applicable
Gweithlu: Workforce:	Not Applicable
Risg: Risk:	Not Applicable
Cyfreithiol: Legal:	Not Applicable
Enw Da: Reputational:	Not Applicable
Gyfrinachedd: Privacy:	Not Applicable
Cydraddoldeb: Equality:	Not Applicable



TERMS OF REFERENCE

STRATEGY AND PLANNING COMMITTEE

Version	Issued to:	Date	Comments
V1	**Hywel Dda University Health Board**	30/01/2025	APPROVED
V1	**Strategy and Planning Committee**	01/04/2025	ADOPTED
V2	**Strategy and Planning Committee**	18/12/2025	

STRATEGY AND PLANNING COMMITTEE

1. Constitution

1.1 The Strategy and Planning Committee (the Committee) was established as a Committee of the Hywel Dda University Local Health Board (the Health Board) and constituted from 01 April 2025.

2. Principal Duties

2.1 The purpose of the Strategy and Planning Committee is to:

2.1.1 Provide *evidence based (where possible) and timely advice* to the Board on the development of the following matters consistent with the Health Board's overall strategic direction:

2.1.1.1 Strategy, strategic frameworks and plans for the delivery of high quality and safe services, consistent with the Board's overall strategic direction;

2.1.1.2 Business cases and service planning proposals;

2.1.1.3 The alignment of supporting and enabling strategies, including workforce, capital, estates and digital;

2.1.1.4 The implications for service planning arising from strategies and plans developed through the Joint Committees of the Board or other strategic partnerships, collaborations or working arrangements approved by the Board;

2.1.1.5 The Health Board's priorities and plans to improve population health, prevention and wellbeing; and

2.1.1.6 The Health Board's plans to address climate migration and adaption.

2.1.2 Provide *assurance* in respect of the achievement of the Health Board's strategic aims, objectives and priorities, on:

2.1.2.1 The robustness of the Health Board's approach, systems and processes for developing strategies and plans, including those developed in partnership;

2.1.2.2 Plans and arrangements for the following matters are adequate, effective and robust and achieving intended outcomes:

(i) Joint committee and partnership planning;

(ii) Engagement and communication; and

(ii) Environmental sustainability.

2.1.2.3 The delivery of the Health Board's Annual Plan/ Integrated Medium Term Plan.

2.1.2.4 That partnership governance and partnership working is effective and successful; and

2.1.2.5 That those arrangements in place to improve population health, prevention and wellbeing are robust and effective and delivering intended outcomes.

3. Operational Responsibilities

3.1. The Committee will, in respect of its provision of advice and assurance to the Board:

Strategy, Planning and Partnerships

3.1.1. Receive assurance that the planning cycle is being taken forward and implemented in accordance with Health Board and Welsh Government requirements, guidance and timescales.

3.1.2. Receive assurance on the development of the Health Board's Annual Plan/Integrated Medium Term Plan (IMTP), based on robust business intelligence and modelling, and assure the development of delivery plans within the scope of the Committee, their alignment to the Health Board's Annual Plan/IMTP and the Health Board's strategy and priorities.

3.1.3. That, wherever possible, Health Board plans are aligned with partnership plans developed with Joint Committees, Local Authorities, Universities, Collaboratives, Alliances and other key partners, such as the Transformation Group who form part of A Regional Collaboration for Health (ARCH).

3.1.4. Receive assurance on delivery of the Health Board's Annual Plan through the scrutiny of regular monitoring reports.

3.1.5. Seek assurance on the review and informed decision-making on pathway changes, service planning, and strategic focuses for commissioning.

3.1.6. Consider the development of strategies and plans developed in partnership with key strategic partners and monitor work undertaken with partner organisations and stakeholders to influence the provision of services to meet current and future population need.

3.1.7. Seek assurance that partnership governance and partnership working is effective and successful.

3.1.8. Seek assurance on delivery of plans in relation to the National Networks and Joint Committees.

3.1.9. Seek assurance on the delivery of Value Based Healthcare (VBHC) strategic plans and programmes.

3.1.10. Seek assurance on the delivery of the Health Board's climate mitigation and adaptation activity.

3.1.11. Seek assurance on the development of the Estates Strategy and Infrastructure Investment Enabling Plan aligned to the A Healthier Mid and West Wales Strategy, and review documents prior to Board approval.

3.1.12. Seek assurance on the development and delivery of implementation plans for the Estates Strategy, including environmental sustainability, agreeing corrective actions where necessary and monitoring its effectiveness.

Population health, primary and community

3.1.13. Consider population health and wellbeing assessments and other key information that underpins the strategic planning process to ensure the robustness and best fit of developing plans.

3.1.14. Seek assurance on plans, systems and processes to deliver health improvement and increase health equity and seek assurance on the work of the Health Board to reduce avoidable health inequalities.

3.1.15. Seek assurances on the development and delivery of the Primary Care and Community Strategic Plan.

Capital and Estates

3.1.16. Review the Health Board's annual capital allocation and plan, and capital (excluding digital) business cases, prior to Board approval.

3.1.17. Review revenue expenditure implications relating to capital and provide assurance to the Board that arrangements for capital expenditure and management are robust.

3.1.18. Recommend to the Board, following consideration of proposals from the Capital Sub Committee, the use of the Health Board's Capital Resource Limit (CRL), which includes the Discretionary Capital Programme (DCP), in line with the HB's financial scheme of delegation, and a schedule of projects/schemes within the Health Board's Capital Plan where there may be associated works contracts that require sealing.

3.1.19. Receive assurance on the delivery of the Health Board's capital programmes and projects included in the planning cycle (in year and longer term).

Other

3.1.20. Seek assurance on delivery against all areas of targeted intervention, and the required elements for de-escalation, that are aligned to the Committee.

3.1.21. Seek assurance on delivery against all Planning Objectives aligned to the Committee, in accordance with the Board approved timescales, as set out in the Health Board's Annual Plan, considering and scrutinising the plans and programmes that are developed and implemented, supporting and endorsing these as appropriate.

3.1.22. Seek assurance on the delivery of the requirements arising from Health Board's auditors, inspectorates, regulators, WG and professional bodies.

3.1.23. Seek assurance on the management of risks within the Corporate Risk Register (CRR) and Directorate Risk Registers (including for hosted services and through partnerships and Joint Committees as appropriate) aligned to the Committee and its sub-committees, and report any areas of significant concern e.g. where risk tolerance is exceeded, lack of timely action. Where risks cannot be brought within the Health Board's risk appetite/tolerance, recommend acceptance of risks to the Board.

3.1.24. Receive assurance through Sub-Committee Update Reports and other management/task & finish group reports that risks relating to their areas are being effectively managed across the whole of the Health Board's activities (including for hosted services and through partnerships and Joint Committees as appropriate).

3.1.25. Approve relevant corporate policies and plans within the scope of the Committee.

3.1.26. Review and approve the annual work plans for any Sub-Committee which has delegated responsibility from the Strategy and Planning Committee and oversee delivery.

4. Membership

4.1 The membership of the Committee shall comprise:

Member
Independent Member (Chair)
Independent Member (Vice Chair)
2 x Independent Members

4.2 The following should attend Committee meetings:

In Attendance
Executive Director of Strategy and Planning (Lead Executive)
Chief Operating Officer
Executive Director of Public Health
Executive Director of Finance
~~Director of Primary, Community & Long-Term Care~~
Communications and Engagement Director
Other Lead Executives to be invited to attend for their relevant Planning Objectives aligned to the Committee
Llais Cymru/ Citizen Voice Body (not counted for quoracy purposes)

4.3 The membership of the Committee will be reviewed on an annual basis.

5. Quorum and Attendance

5.1 A quorum shall consist of no less than two of the membership and must include as a minimum the Chair or Vice Chair of the Committee and one other Independent Member, together with half of the In attendance Members.

5.2 The membership of the Committee shall be determined by the Board, based on the recommendation of the Health Board Chair – taking into account the balance of skills and expertise necessary to deliver the Committee's remit and subject to any specific requirements or directions made by the Welsh Government.

5.3 Any senior officer of the Health Board or from a partner organisation may, where appropriate, be invited to attend, for either all or part of a meeting to assist with discussions on a particular matter.

5.4 The Committee may also co-opt additional independent external 'experts' from outside the organisation to provide specialist skills.

5.5 Should any officer Member be unavailable to attend, they may nominate a deputy, with full voting rights, to attend in their place subject to the agreement of the Chair.

5.6 The Chair of the Health Board reserves the right to attend any of the Committee's meetings as an ex officio member.

5.7 The Head of Internal Audit shall have unrestricted and confidential access to the Chair of the Committee.

5.8 The Chair of the Committee shall have reasonable access to Executive Directors and other relevant senior staff.

5.9 The Committee may ask any or all of those who normally attend but who are not Members to withdraw to facilitate open and frank discussion of particular matters.

6. Agenda and Papers

6.1 The Committee Secretary is to hold an agenda setting meeting with the Chair and the Lead Director (Executive Director of Planning and Strategy) at least **six** weeks before the meeting date.

6.2 The agenda will be based around the Committee work plan, identified risks matters arising from previous meetings, issues emerging throughout the year and requests from Committee Members. Following approval, the agenda and timetable for request of papers will be circulated to Committee Members.

6.3 All papers must be approved by the relevant Lead Director.

6.4 The agenda and papers for meetings will be distributed **seven** days in advance of the meeting.

6.5 A draft Table of Actions will be issued within **two** days of the meeting. The minutes and Table of Actions action log will be circulated to the Lead Director within **seven** days to

check the accuracy, prior to sending to Members (including the Committee Chair) to review within the next **seven** days.

6.6 Members must forward amendments to the Committee Secretary within the next **seven** calendar days. The Committee Secretary will then forward the final version to the Committee Chair for approval.

7. In Committee

7.1 The Committee can operate with an In Committee function to receive updates on the management of sensitive and/or confidential information.

8. Frequency of Meetings

8.1 The Committee will meet bi-monthly and shall agree an annual schedule of meetings. Additional meetings will be arranged as determined by the Chair of the Committee in discussion with the Lead Executive.

8.2 The Chair of the Committee, in discussion with the Committee Secretary, shall determine the time and the place of meetings of the Committee and procedures of such meetings.

9. Accountability, Responsibility and Authority

9.1 Although the Board has delegated authority to the Committee for the exercise of certain functions as set out within these terms of reference, it retains overall responsibility for ensuring the quality and safety of healthcare for its citizens through the effective governance of the organisation.

9.2 The Committee is directly accountable to the Board for its performance in exercising the functions set out in these terms of reference.

9.3 The Committee shall embed the Health Board's vision, corporate standards, priorities and requirements, e.g. equality and human rights, through the conduct of its business.

9.4 The requirements for the conduct of business as set out in the Health Board's Standing Orders are equally applicable to the operation of the Committee.

10. Reporting

10.1 The Committee, through its Chair and Members, shall work closely with the Board's other Committees, including joint and Sub-Committees and groups to provide advice and assurance to the Board through the:

10.1.1 Joint planning and co-ordination of Board and Committee business.

10.1.2 Sharing of information

10.2 In doing so, the Committee shall contribute to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the Board's overall risk and assurance framework.

10.3 The Committee, may, subject to the approval of the Board, establish Sub-Committees or task and finish groups to carry out on its behalf specific aspects of Committee business. The Committee will receive an update following each meeting providing an assurance on business undertaken on its behalf. The Sub-Committee reporting to this Committee is:

10.3.1 Capital Sub-Committee

10.4 The Committee Chair, supported by the Committee Secretary, shall:

10.4.1 Report formally, regularly and on a timely basis to the Board on the Committee's activities. This includes the submission of a Committee update report, as well as the presentation of an Annual Report within **six** weeks of the financial year.
10.4.2 Bring to the Board's specific attention any significant matter under consideration by the Committee.
10.4.3 Ensure appropriate escalation arrangements are in place to alert the Health Board Chair, Chief Executive or Chairs of other relevant Committees of any urgent/critical matters that may compromise patient care and affect the operation and/or reputation of the Health Board.

10.5 The Director of Corporate Governance/Board Secretary, on behalf of the Board, shall oversee a process of regular and rigorous self assessment and evaluation of the Committee's performance and operation including that of any Sub-Committees established. In doing so, account will be taken of the requirements set out in the NHS Effective Board Committees Guide.

11. Secretarial Support

11.1 The Committee Secretary shall be determined by the Director of Corporate Governance/Board Secretary.

12. Review Date

12.1 These terms of reference and operating arrangements shall be reviewed on at least an annual basis by the Committee for approval by the Board.

1.8

09:50, 10 Mins

1.8 - Targeted Intervention Update

Lee Davies (Hywel Dda UHB - Executive Director of Strategy and Planning), Shaun Ayres (Hywel Dda UHB - Director of Delivery)

For information

Attachments

1.8 TI Update - SPC De-escalation Criteria Assessment December.pdf

Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

Strategy & Planning Committee – December 2025

Escalation Update

1. Introduction

This paper provides the Strategy and Planning Committee with an updated, evidence-based assessment of progress against the Welsh Government (WG) de-escalation criteria that fall within the Committee's remit. It draws together the key findings and implications from:

- The Month 7 2025/26 Financial Performance Report and Finance Roadmap to 2028/29
- The Annual Plan 2025/26 and 2026/27 Planning Cycle
- The Planning Workshop Thematic Analysis (November 2025)
- The "A Healthier Mid and West Wales" (AHMWW) Strategy Refresh and Community Schemes Update
- The draft Clinical Services Plan (CSP) Consultation Report prepared by Opinion Research Services (ORS).

The paper is structured around the relevant criteria and uses the Alert / Advise / Assure framework. For each criterion it sets out the current position, the operational and strategic context, and an assessment of impact and trajectory. The aim is to enable the Committee to form a balanced view of where there is genuine assurance, where progress is evident but work remains, and where significant risk persists.

2. Key updates and overall position

From a financial perspective, the Health Board is demonstrating improved in-year grip whilst still carrying a significant structural deficit. At Month 7, the reported year-to-date deficit is £16.3m against a planned deficit of £17.5m, and the forecast year-end deficit has improved to £28.3m compared with the revised annual plan deficit of £30.0m. The Board has agreed this revised forecast on the basis that it comprises a £24.1m operational position, aligned to the agreed control total, plus an additional £4.2m relating to the Welsh Risk Pool (WRP) risk share. Viewed in this way, the Health Board has, through a combination of planned savings and some fortuitous non-recurrent gains, brought its underlying operational performance back to the level expected by WG. Beneath this, however, the underlying deficit is assessed at £62.9m against an annual plan assumption of £58.5m, reflecting recurrent full-year savings of around £14.6m against an assumed £19.0m and therefore a greater reliance on non-recurrent and opportunistic measures than is sustainable over the medium term.

The planning approach has shifted decisively towards a risk-based and resource-constrained model. The Annual Plan and 2026/27 planning cycle set out clear principles: the Health Board will plan within its existing resource envelope; there is no central investment pot; and each Clinical Care Group (CCG) is required to bring only its top three risks, supported by evidence, into the planning round for collective prioritisation. A Planning Workshop in November 2025 brought CCGs and enabling functions together to apply this approach, surfacing a consistent set of system-wide issues and leading to the identification of three “natural clusters” of risk and opportunity: Flow and Frailty, Cancer Diagnostics and Capacity, and Urgent and Emergency Care (UEC) Configuration and Sustainability. These clusters now provide the organising spine for the emerging three-year plan.

Strategically, the AHMWW strategy has been refreshed in response to Welsh Government challenge on feasibility and affordability. The refresh acknowledges the need to develop a broader range of options for delivering the Clinical Strategy within the existing estate and to submit an addendum to the Programme Business Case by early 2026. Community schemes such as the Cardigan and Aberaeron Integrated Care Centres (CCs), the Carmarthen Hwb and Pentre Awel demonstrate tangible progress in shifting care closer to home. At the same time, schemes like Cross Hands Health and Wellbeing Centre illustrate the revenue and sequencing challenges that arise when new community capacity comes on stream before acute reconfiguration releases offsetting savings, reinforcing the need to align CSP implementation, Estates decisions and the Financial Recovery Plan.

2. Key updates and overall position

The CSP consultation has now concluded and provides a rich evidence base on public, staff and stakeholder views. Managed independently by ORS over 13.5 weeks, it generated more than 4,100 questionnaire responses, 31 public and patient events, 58 staff sessions, 21 stakeholder meetings, three county-based workshops, over 100 written submissions and a substantial petition on stroke services at Bronglais Hospital. The feedback shows broad recognition of the need to address service fragility, workforce shortages and long waits, alongside strong concerns about travel, transport and the impact of centralisation on rural communities, older people and vulnerable groups.

Against this backdrop, the current assessments are:

- **Criterion 4 – balanced and credible plan:** Advise
- **Criterion 5 – integrated planning:** Advise
- **Criterion 6 – CSP roadmap and consultation**: Assure (process and roadmap)
- **Criterion 7 – planning maturity:** Advise (with potential to move to Assure once WG ratification and further evidence are available)
- **Criterion 8 – regional planning:** Advise.

3. Assessment of Criterion 4 - Submission of a balanced and credible Annual Plan

Assessment – Advise

For this criterion, the central test is whether the Health Board has a plan that is financially credible and moving towards balance over the medium term. The current evidence gives a more nuanced picture than in previous cycles and, taken in the round, supports a movement from Alert to Advise. Operationally, the Month 7 position shows improved in-year control. The year-to-date deficit of £16.3m is £1.2m better than the planned deficit of £17.5m, and the forecast outturn has further improved to £28.3m, compared with a revised Annual Plan deficit of £30.0m and an original planned deficit of £31.5m. Over the course of the year, the Board has increased the savings target, deferred a number of investments and strengthened local financial controls. These decisions, combined with forecasting discipline, have contributed to an improving run-rate and reduced variance from plan.

Crucially, the revised forecast is now explicitly framed as two components: a £24.1m deficit, which is aligned to the agreed target control total, and a £4.2m WRP risk-share pressure that has emerged in-year and sits outside local control. Stripping out the WRP impact, the Health Board is forecasting delivery of its control total. This provides an important signal of grip and credibility: despite the more challenging national context, the Health Board has demonstrated that it can manage its operational position back to the level set by WG.

At the same time, the underlying picture remains challenging and underlines why this cannot be rated as Assure. The Annual Plan assumed an underlying deficit of £58.5m, predicated on delivering £19.0m of recurrent savings. Recurrent full-year savings at Month 7 are around £14.6m, which increases the underlying deficit to £62.9m. The total savings programme of £46.4m is over-identified in gross terms, at £48.4m, and £48.1m is forecast to deliver. However, a significant proportion of this delivery is non-recurrent, including one-off underspends, technical adjustments and slippage. These “fortuitous” gains are legitimate and expected features of in-year financial management, and they have been used effectively to offset the unplanned WRP pressure. But they do not resolve the structural gap and cannot be assumed at the same level going forward.

3. Assessment of Criterion 4 - Submission of a balanced and credible Annual Plan

The Health Board has begun to address these structural issues more systematically. This has included forecasting processes with clearer differentiation between recurrent and non-recurrent savings and a further improved profiling of delivery. Targeted review meetings between CCGs, corporate executives and finance colleagues are in place to challenge assumptions and identify further opportunities. The Finance Roadmap to 2028/29 sets out, for the first time, a structured three-year view of how the underlying deficit could be reduced to breakeven under different funding scenarios. That roadmap makes explicit that recurrent savings in the order of £25 to 30m per annum, alongside productivity gains and service change linked to CSP implementation and the AHMWW strategy, will be required to close the gap.

Taken together, the position can reasonably be described as “improving but not yet resolved”. The Board has shown that, when the WRP pressure is separated out, the operational control total is achievable; there is clearer visibility of the underlying problem; and a coherent recovery plan has been articulated. Those are significant steps forward and justify moving this criterion from Alert to **Advise**.

At the same time, the Plan is not yet balanced on a recurrent basis, the underlying deficit is larger than planned, and the savings profile remains too dependent on non-recurrent and opportunistic measures for full assurance. The priority over the next planning cycle is therefore to protect delivery of the revised forecast and accelerate the shift from non-recurrent housekeeping to larger-scale, recurrent schemes.

4. Criterion 5 – Evidence of integrated planning

Assessment – Advise

There is clear evidence that the Health Board has moved from fragmented, bid-driven planning towards a more integrated, risk-based and resource-constrained approach, although this is not yet fully embedded across all areas. The Annual Plan and 2026/27 planning cycle explicitly commit the Health Board to plan within its existing resource envelope and reject unfunded “wish lists.” Each CCG and enabling function is required to present only its three highest risks, underpinned by data and narrative, into the planning process. The emphasis is on deliverable, multi-year interventions and on prioritising schemes that align with strategic objectives, clinical outcomes and the financial recovery trajectory.

The Planning Workshop Thematic Analysis provides tangible evidence of this approach in practice. It shows how CCGs presented their top three risks and how these were mapped to identify interdependencies across sites and specialties. Through this exercise, three cross-cutting clusters emerged: Flow and Frailty; Cancer Diagnostics and Capacity; and UEC Configuration and Sustainability. These clusters bring together acute, community, workforce, diagnostic and estates considerations in a way that reflects how services actually function. The workshop also introduced an integrated impact framework, intended to track quality, outcomes, performance, workforce and finance for each CCG and to support the development of aligned schemes.

This emerging planning architecture is anchored in the refreshed AHMWW strategy and in the programme of community schemes. The Strategy Refresh restates the long-term ambition while responding to WG concerns about feasibility, affordability and sequencing. Community developments such as the Cardigan and Aberaeron centres, Pentre Awel and the Carmarthen Hwb are being positioned as enablers of flow, frailty pathways, intermediate care and integration with Local Authority services, rather than as stand-alone projects. There is therefore a clearer line of sight from strategic intent, through service change, to financial and workforce implications than has previously been the case.

4. Criterion 5 – Evidence of integrated planning

However, the new model is still maturing. Some CCGs are more advanced than others in articulating, in part, integrated plans that balance activity, workforce, quality and finance. While partnership working with Local Authorities and Regional Partnership Boards (RPBs) is active, the links between these programmes and the core Annual Plan could be made more explicit and systematic. For these reasons, an **Advise** rating is appropriate: there is strong evidence of positive change and a coherent framework for integrated planning, but it is too early to characterise this way of working as fully embedded and assured.

5. Criterion 6 - Evidence of clear roadmap and implementation of Clinical Services Plan

Assessment - Assure (process and roadmap)

The CSP is central to addressing long-standing service fragility and to delivering an element of both the Finance Roadmap and the AHMWW strategy. The recent consultation has been a major undertaking and provides a robust foundation for Board decisions. ORS managed the process independently over a 13.5-week period, using multiple channels to reach the public, patients, staff and stakeholders. The scale and breadth of engagement, reflected in more than 4,100 questionnaire responses, extensive public and staff events, stakeholder meetings and workshops, written submissions and a large petition indicates that the case for change and the proposed options have been thoroughly tested.

The consultation findings are nuanced. Many respondents accept the need to tackle service fragility, workforce challenges and long waits, and acknowledge that “doing nothing” is not sustainable. At the same time, there is strong concern about the potential impact of centralisation, especially in terms of longer travel times, transport costs and accessibility for rural communities, older people and those on lower incomes. Services such as Stroke and Critical Care generate particularly strong and mixed views: there is anxiety about the loss of local provision and a recognition of current safety and staffing risks. The importance of community hospitals, local rehabilitation, digital options and regional collaboration is a consistent theme, as is the need for clearer modelling and communication of assumptions around workforce and travel.

From a process standpoint, the CSP consultation can reasonably be regarded as robust and independent. It meets accepted standards for reach and transparency and has surfaced the key risks and concerns that must shape the final CSP and its implementation. The CSP work is now being integrated with the AHMWW strategy refresh, the community schemes and the Finance Roadmap, so that decisions on configuration are aligned with estate options, community capacity and the financial recovery trajectory. There is a clear timetable for presenting the consultation findings and options to the Board and for moving into detailed implementation planning in early 2026 (February).

5. Criterion 6 - Evidence of clear roadmap and implementation of Clinical Services Plan

Significant work remains on acceptability and implementation. Travel and access will need to be addressed through concrete mitigations, such as non-emergency transport solutions, hub-and-spoke models, outreach clinics, enhanced use of community hospitals and digital pathways. Equality and rurality impacts will need explicit consideration and mitigation. Workforce plans will have to demonstrate that the preferred configurations are deliverable in practice. These are substantial challenges, but they relate to implementation rather than to the quality of the roadmap and the evidence base. On that basis, an **Assure** rating is justified for the CSP process and roadmap, with the clear understanding that assurance on deliverability and public confidence will need to be revisited when final decisions and detailed plans are in place.

6. Criterion 7 - Planning Maturity Matrix

Assessment – Advise

The Planning Maturity Matrix (PMM) is the main mechanism used by WG to assess planning capability. The Health Board has undertaken a refreshed self-assessment against the PMM, drawing on evidence from finance, performance, workforce, quality and engagement. That assessment reflects the strengthened planning and financial governance arrangements, the move to a three-year financial and service trajectory, and the emerging cluster-based integrated planning framework.

The supporting reports demonstrate many of the behaviours and processes that the PMM is intended to test. The Finance Roadmap and Annual Plan show a clearer integration of financial, workforce, activity and performance planning over a multi-year horizon in 2025/26. The adoption of risk-based prioritisation, resource-constrained planning and CCG-based working indicates a more mature approach to aligning resources with strategic priorities in 2026/27. Governance has been reinforced through the role of the Strategy and Planning Committee (SPC), Board Seminars and external scrutiny of planning and financial processes.

On 1 December 2025, a constructive informal discussion took place between WG colleagues (Jamie Kaijaks and Caroline Lewis from the Delivery and Performance team) and HDdUHB representatives (Daniel Warm, Head of Planning, and Shaun Ayres, Director of Delivery) to review the Health Board's Planning Maturity Matrix self-assessment. WG expressed appreciation for the submission format, particularly valuing the presentation of baseline, twelve-month and two-year follow-up scores, which clearly demonstrated the Health Board's development journey. The comprehensive approach taken, including the provision of transcripts showing internal deliberation, was recognised as providing helpful transparency.

WG colleagues acknowledged the significant progress made across multiple domains, highlighting in particular the robustness of the Health Board's internal escalation framework (which mirrors WG structures), the development of integrated performance dashboards, and the embedding of value-based healthcare principles within enabling actions. Caroline Lewis specifically noted that the Health Board may have been overly self-critical in its scoring, suggesting that more credit could be taken for the substantial work undertaken. This honest and reflective approach to self-assessment was welcomed, with WG recognising the mature stance of identifying area[illegible]ued improvement rather than overstating organisational capability.

6. Criterion 7 - Planning Maturity Matrix (Cont)

Assessment – Advise

The discussion acknowledged the particular complexities facing the Health Board in delivering robust annual planning whilst simultaneously refreshing the AHMWW strategy and developing the CSP. WG accepted this challenging context and noted the pragmatic approach taken to anchor planning priorities against emerging strategic pillars and the corporate risk register (for the 2026/27 Annual Plan). The evolution of CCG structures, the strengthening of clinical engagement mechanisms, and the clear line of sight from operational delivery through to Board-level accountability were all recognised as positive developments demonstrating increasing planning maturity.

To further strengthen future submissions, several developmental opportunities were identified. Firstly, adopting a logic model approach would more explicitly demonstrate how planning inputs and activities translate into measurable outputs and impacts, providing a clearer narrative of cause and effect. Secondly, whilst the Health Board's internal processes are well-established, articulating more explicitly the "how" behind improvements, the specific mechanisms, governance arrangements and process changes implemented, would enhance the evidence base underpinning self-assessed scores. Thirdly, building upon existing demand and capacity modelling work to demonstrate more granular, service-level planning capability would support progression towards higher maturity levels. Finally, incorporating benefits mapping and realisation into future submissions would help demonstrate the tangible value derived from planning improvements. Welsh Government confirmed that progress would continue to be monitored through existing touchpoint arrangements in a supportive manner, and that additional maturity matrices covering other domains are in development, which will provide clearer delineation of planning-specific requirements in due course. However, this needs to be considered in relation to the size of the planning team and in the context of the on-going development of organisational planning maturity.

It is therefore appropriate to classify this criterion as **Advise**: there is demonstrable progress in planning maturity and a realistic prospect of moving to Assure in due course, but further evidence; including external validation and consistent delivery over at least one full planning cycle is needed before that judgement can be made.

7. Criterion 8 - Regional planning progress

Assessment – Advise

Regional planning is an essential component of sustainability for several key services and for the management of cross-border flows. Formal regional governance arrangements, including a Regional Joint Committee (RJC) and thematic sub-groups, are now in place, with workstreams covering Urgent and Emergency Care (UEC), Stroke, Orthopaedics, Diagnostics and other shared priorities. The CSP consultation materials and supporting narratives reflect these interdependencies, particularly in relation to A Regional Collaboration for Health- (ARCH-) related programmes and collaboration with neighbouring Health Boards.

The Financial Report highlights significant financial flows through long-term agreements, including increased emergency activity at neighbouring providers. These flows reinforce the point that unilateral change by any single organisation is unlikely to be sustainable and that regional solutions are required for some pathways. There is also evidence of active partnership working with Local Authorities and RPBs on community capacity, intermediate care and broader population health initiatives.

What is less visible in the current suite of reports is a single, consolidated view of the regional programmes, their milestones, risks and explicit links into the Health Board's own Annual Plan, Finance Roadmap and CSP implementation. For that reason, an **Advise** rating is appropriate. There is sufficient evidence of regional engagement and joint work to avoid an Alert, but more systematic documentation and Board-level visibility will be needed to move to Assure.

8. Conclusion and Committee Considerations

Overall, the evidence points to a Health Board that has strengthened its grip, begun to refresh its strategic direction and improved the coherence of its planning, but which still faces a significant financial and delivery challenge. Financially, the Health Board is forecasting a £28.3m year-end deficit that includes an adverse WRP movement; on an underlying operational basis it is on course to deliver its £24.1m control total deficit. This represents an improvement in in-year control and, when viewed alongside strengthened governance and a clearer three-year recovery roadmap, supports moving the balanced and credible plan criterion from Alert to **Advise**, whilst still recognising the underlying deficit of £62.9m and the continued reliance on non-recurrent savings.

Integrated planning capability continues to be in development . The shift to risk-based, resource-constrained and thematic-based planning, anchored in the refreshed AHMWW strategy and the community schemes, justifies an **Advise** position for planning integration and maturity: the direction of travel is positive and the frameworks are coherent, but they need to be fully embedded. The CSP consultation and associated strategic work provide a robust, transparent and independently validated roadmap for clinical change, warranting an **Assure** rating on process and evidence, while appropriately highlighting the substantial work that remains on implementation, mitigations and public confidence. Regional planning is active and substantive in key areas but not yet presented as a single, coherent programme, and so remains at **Advise**.

8. Conclusion and Committee Considerations

In this context, the Committee is asked to:

- **DISCUSS**
  - The updated assessment against each criterion, including the reclassification of the financial plan criterion to Advise;
  - The inter-locking nature of the Finance Roadmap, integrated planning clusters, CSP implementation and the AHMWW Strategy Refresh.

- **SCRUTINISE**
  - The robustness of the emerging themes-based on the planning framework and its ability to drive integrated change across finance, workforce, quality and performance; and

- **RECEIVE ASSURANCE that:**
  - The Health Board is demonstrating improved in-year financial grip and is on course to deliver its target control total/Annual Plan before WRP;
  - Planning maturity is progressing, with a revised framework now in place for integrated, risk-based and resource-constrained planning;
  - The CSP consultation and strategic refresh work provide a sound evidential basis for the Board's forthcoming decisions on clinical configuration.

DIOGEL | CYNALIADWY | HYGYRCH | CAREDIG

SAFE | SUSTAINABLE | ACCESSIBLE | KIND

GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

2

10:00, 0 Mins

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2 - Strategy, Planning and Partnerships

2.1

10:00, 15 Mins

2.1 - Strategy Refresh

Lee Davies (Hywel Dda UHB - Executive Director of Strategy and Planning), Paul Williams (Hywel Dda UHB - Assistant Director Of Strategic Planning), Nathan Davies (Hywel Dda UHB - Senior Project Manager), Alexander Martin (Hywel Dda UHB - Principal Programme Manager)

For assurance

Attachments

2.1 Strategy Refresh SPC SBAR 18 December 2025 v1.pdf

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

PWYLLGOR STRATEGAETH A CHYNLLUNIO
STRATEGY AND PLANNING COMMITTEE

DYDDIAD Y CYFARFOD: DATE OF MEETING:	18 December 2025
TEITL YR ADRODDIAD: TITLE OF REPORT:	Strategy Refresh
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Lee Davies Executive Director of Strategy and Planning)
SWYDDOG ADRODD: REPORTING OFFICER:	Paul Williams Assistant Director of Strategic Planning

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

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The purpose of this report is to assure the Committee about the progress that has been made to refresh our "A Healthier Mid and West Wales" (AHMWW) strategy and Primary Care and Community Services Strategic Plan.

Cefndir / Background

In November 2024, work was initiated to refresh the existing AHMWW strategy. Since then, work has been carried out to understand which elements of the strategy are still valid and can remain as they are, which elements are still valid but need revising to reflect, for example, demographic changes and which elements need refreshing because they are fundamentally different to how they were envisioned when AHMWW was ratified in 2018.

Engagement activity

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

- Phase 1 engagement started in July 2025. It took place alongside other consultation events and engagement activity, by asking people the broad question, "What is important for you to live a healthy life?" A thematic analysis of the responses was carried out and the results were presented to the SPC Committee in October 2025.

- Phase 2 engagement started at the end of September 2025. It lasted for 9 weeks and finished at the end of November 2025. Guided by a Communications and Engagement Plan, the purpose of Phase 2 engagement was to:
  - Publicise the strategy refresh process and raise awareness across our communities.
  - Provide opportunities for our communities to share their views and respond to the strategy questions and inform the strategic direction of the Health Board moving forward.

- Identify appropriate engagement and communication tools and methods, to reach more of our communities and engage them in the conversation.
- Seek to manage public expectations and provide reassurance about service provision
- Reactively address any widely spread misinformation.

Phase 2 engagement activity sought to gather feedback from our communities on the following 11 questions across 4 broad categories:

Social Model for Health and Well-being (SMfHW)

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

Digital Healthcare Support

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

Balancing Hospital Care and Community Support

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

Clinical Services and Hospital Redevelopment

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

A range of engagement methods were used, e.g. targeted group sessions, hospital walkarounds (including staff and outpatient engagement), attendance at local community events, digital engagement on "Have your say" and targeted social media activity. This face-to-face engagement was supported by a range of communication methods. In addition to a summary published on the Health Board's website, regular updates were proactively shared with the media and key stakeholders to ensure transparency and maximise awareness of engagement opportunities across our communities. These coordinated efforts were designed to broaden reach, foster understanding and encourage meaningful participation in the strategy refresh process.

Development of draft version of the Strategy

An initial draft version of the Strategy has been developed, using feedback from Executive Improving Together sessions, Board Seminar and Board, to bring together emerging elements. Feedback on the initial draft has been sought from key staff supporting the planning process, while it may not be possible to completely align the two pieces of work as

short term changes may be needed to support longer term change, alignment with goals and themes will be essential.

The draft version of the Strategy has also been shared with Executive Director leads with responsibility for the themes, as well as other key stakeholders in the Health Board to ensure alignment with, for example, Wellbeing Objectives.

Following completion of Phase 2 engagement activity, we are now reviewing the feedback to test its alignment with the draft Strategy and incorporate any necessary changes. When the draft Strategy is shared more widely, it will include an appendix providing a detailed analysis of all feedback received. Additionally, each goal will feature a section explaining what the Strategy means for those who have engaged with us.

Asesiad / Assessment

Phase 2 engagement

The 9-week Phase 2 engagement activity finished on 28 November 2025. Overall, Phase 2 engagement was successful in terms of the number and diversity of individuals and communities that engaged with the process. A summary of Phase 2 engagement is provided for assurance:

- Number of events / sessions: 93
- Examples of events / sessions / stakeholders: We have engaged with a wide range of groups and organisations across our Health Board area, to ensure we capture a broad range of views. This has included attending and running sessions with carer groups, youth groups, people with sensory disability, physical disability and learning disability, as well as attending community events and local networks to help enable more people to share their views.
- Number of people who participated in events / sessions: 1727
- Number of HYS responses (English and Welsh): 274/7

Please note these figures are taken as of 1 December 2025 and will be updated following the close of the engagement period and full evaluation of engagement activities.

It is important that this engagement has meaning and purpose and is not only an activity that is undertaken as part of a process. Work will be undertaken to identify the key messages from the engagement as a whole, as well as feedback from specific groups who may have different experiences which should be considered. While this feedback will be contained within a summary form within the Strategy to illustrate how our Strategy will support our communities, the engagement will support the delivery of the Strategy.

We have said from the start of the process that delivery plans will be needed to bring around some of the larger changes required to deliver the Strategy, while smaller changes which may be managed through our natural 3-year planning processes can happen faster. Using the engagement activity, we will be able to inform services around the patient experience, the needs and views of our population to support the shaping of person-centred service change and improve quality.

Draft structure of the Strategy

The draft Strategy itself is not being shared with the Committee at this stage because it is still being refined and reworded to reflect feedback from key stakeholders. However, it is proposed that the draft Strategy uses the following structure:

- The Executive Summary will be followed by a section about "Healthier Lives, Well Lived". This will provide background and contextual information, summarise challenges and highlight opportunities. The Strategic Objectives will be split into four broad themes. Each theme will have two goals. At least one Executive Director will have responsibility for developing and delivering the goals. The proposed structure for the refreshed Strategy is presented below:

    - **Executive Summary**

        - **01 Healthier lives, well lived**

            - **Our mission:** Healthier lives, well lived
            - **Our strategic objectives**
            - **Our values and behaviours**

        - **02 Thriving teams**

            - **Goal 1:** Healthy, thriving teams
            - **Goal 2:** Customer service excellence

        - **03 Healthier communities**

            - **Goal 3:** '20-4-7' population health
            - **Goal 4:** Community by design

        - **04 Great care**

            - **Goal 5:** Digital first
            - **Goal 6:** Timely, high-quality care

        - **05 Positive futures**

            - **Goal 7:** Future orientated
            - **Goal 8:** Fit for purpose, modern facilities and services

Impact assessments will be undertaken to support the Strategy Refresh, however we will be seeking to refresh the existing Equality & Health Impact Assessment (EHIA) which covers the Programme Business Case (PBC) and Community Schemes with engagement activity information to support this as it is still relevant to this work.

The intention for the Strategy Refresh remains to:

i) Analyse the results of Phase 2 engagement activity and present the results at the Public Board meeting on 29 January 2026.

ii) Continue to refine the draft strategy (document) and present it at the Public Board meeting on 29 January 2026.

Delivery of the Strategy

We have said that the key principles at the heart of the Strategy have remained unchanged, with the Refresh looking to consider what has changed in how we deliver services and who we need to work with to do this.

If we want to successfully deliver the Strategy, we will need to consider what needs to change organisationally because there are still areas of the Strategy which are outstanding which have not been resolved since 2018.

To do this we are proposing that the Strategy embeds alongside our values and mission, a change in mindset to be ***radical, radical, radical***. This is not just a mantra to promote and chase innovation, but a way to promote the change in behaviours and activities we will need to unlock our potential.

We will need ***radical openness*** to support honesty and bold leadership to be able to share hard and difficult messages which will be required regarding necessary changes, while also being humble and listening intently to the voice of the public, being open to hearing difficult messages and opinions which may differ from the views of others we work with internally or externally. Our future leaders will need to be able to consider and advocate for our experts of knowledge (staff, professional networks, partner organisations) and experts of experience (patients, carers, families).

We will need to develop ***radical trust*** across the system, including trusting the new CCG leadership teams, trust between Primary and Secondary Care, trust with our partners and with our public. It is accepted that building trust in the Health Board is likely to take time as trust in institutions across the UK and with Hywel Dda University Health Board (HDdUHB) has declined in recent years. We will need to show the public and partners that we can be trusted, by repeatedly demonstrating our actions.

This does not mean that we will always make popular decisions, but the public can trust that when we make decisions that we have truly understood what it will mean for them, and we deliver those changes, and mitigations needed, as we promise.

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

Primary Care and Community Services Strategic Plan update

Work is continuing to progress on the development of the Primary and Community Services Strategic Plan with the intention of presenting it to Public Board 0n 29 January 2026. Over the summer months engagement has been undertaken with the Primary Care Professional Collaboratives (GPs, Community Pharmacists and Optometrists) as well as other interested professional groups. Subsequently the Locality Leads were tasked to provide a Cluster view at their meeting in October 2025 of how services can be developed to support the “shift left”.

Through this work six principles have been identified which have started to shape the development of the Strategic Plan through the alignment of key priorities that will be formed from the engagement work at both collaborative and Cluster discussions.

In addition, from a national perspective the Cabinet Secretary has tasked the Chief Medical Officer to work with Health Board Chief Executives on a programme of transformation "Community by Design", which commenced with a summit on Delivering Integrated Care in October 2025. Health Boards are expecting an action plan which will set out a number of actions that seek to address improving prevention and the care of patients with chronic conditions as well as how we respond to urgent care. The timeline for the initial priority actions will be for delivery within six months. A national Transformation Board will be formed with the first meeting scheduled for December 2025, and the expectation that Health Boards will mirror this approach.

The AHMWW Infrastructure Plan

The Strategy Refresh SBAR presented to the Board meeting on 27 November 2025 also set out the latest position regarding the fact that the Health Board has had further constructive discussions with Welsh Government (WG) on the infrastructure challenges facing the organisation, in particular at Withybush (WGH) and Glangwili (GGH) Hospitals. The Board noted that WG has recently requested the Health Board produce, by early in the New Year, an addendum to the Programme Business Case (PBC) submitted in February 2022.

Previously, the Deputy Chief Executive, NHS Wales, advised through the WG Infrastructure Investment Board (IIB) 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 has challenged the feasibility and affordability of a new urgent and planned care hospital alongside the retention of all other existing sites, 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 WG 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.

Argymhelliad / Recommendation

The Committee is asked to:

- **RECEIVE ASSURANCE** regarding the process used for the Strategy Refresh.
- **CONSIDER** the delivery approach we plan to embed within the Strategy.
- **NOTE** the information regarding the progress made with Phase 2 engagement activity.
- **NOTE** the intention to present the results of Phase 2 engagement activity and draft Strategy at the Public Board meeting on 29 January 2026.
- **NOTE** the progress being made regarding the Primary Care and Community Services Strategic Plan.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	3.1.11.Seek assurance on the development of the Estates Strategy and Infrastructure Investment Enabling Plan aligned to the A Healthier Mid and West

	Wales Strategy, and review documents prior to Board approval.
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Risk 1196 - Insufficient investment in facilities/ equipment/digital infrastructure (risk score 16)
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	7. All apply
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	6. All Apply
Amcanion Strategol y BIP: UHB Strategic Objectives:	All Strategic Objectives are applicable
Amcanion Cynllunio Planning Objectives	All Planning Objectives Apply
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022	9. All HDdUHB Well-being Objectives apply

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

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	Contained within key elements of the work programmes – overarching the Programme Business Case (PBC) and Strategic Outline Case (SOC) sets out both the revenue and capital funding assumptions for the programme including a detailed Financial Case section in the PBC.

Ansawdd / Gofal Claf: **Quality / Patient Care:**	Implicit within the PBC and SOC. This is an integral part of the PBC and SOC case for change.
Gweithlu: **Workforce:**	Implicit within the PBC and SOC. This is an integral part of the PBC and SOC case for change.
Risg: **Risk:**	Risk 1196 Insufficient investment in facilities/ equipment/ digital infrastructure.
Cyfreithiol: **Legal:**	Implicit within the PBC.
Enw Da: **Reputational:**	Implicit within the PBC.
Gyfrinachedd: **Privacy:**	Implicit within the PBC.
Cydraddoldeb: **Equality:**	There is an Equality and Health Impact Assessment which will remain 'live' through the duration of the programme.

2.2

10:15, 10 Mins

2.2 - Annual Plan Progress

Lee Davies (Hywel Dda UHB - Executive Director of Strategy and Planning), Shaun Ayres (Hywel Dda UHB - Director of Delivery)

For discussion

Attachments

2.2.1 SPC SBAR Annual Plan Update December 2025.pdf

2.2.2 Planning Workshop Thematic Analysis.pdf

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

PWYLLGOR STRATEGAETH A CHYNLLUNIO
STRATEGY AND PLANNING COMMITTEE

DYDDIAD Y CYFARFOD: DATE OF MEETING:	18 December 2025
TEITL YR ADRODDIAD: TITLE OF REPORT:	Annual Plan
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Lee Davies, Executive Director of Strategy and Planning
SWYDDOG ADRODD: REPORTING OFFICER:	Shaun Ayres, Director of Delivery Daniel Warm, Head of Planning

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

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The Health Board approved the 2025/26 Annual Plan in March 2025, based on requirements specified in the NHS Wales Planning Framework 2025/28 and against the Escalation Framework. Since approval, Welsh Government(WG) has issued further communications that have modified financial targets, performance requirements and accountability conditions. This report provides the Committee with an update on progress against the Plan. Additionally, an update is also provided on the 2026/27 Planning Process.

Cefndir / Background

2025/26 Annual Plan

The Hywel Dda University Health Board (HDdUHB) Annual Plan 2025/26 was constructed through a structured process commencing in October 2024, involving comprehensive stakeholder engagement, demand and capacity modelling, and alignment with national directives available at the time. The Plan was developed in accordance with the NHS Wales Planning Framework 2025-28, issued by the Cabinet Secretary for Health and Social Care on 20 December 2024, which established five strategic priorities: Timely Access to Care, Population Health and Prevention, Building Community Capacity, Mental Health Access, and Women's Health. The Planning Framework mandated delivery expectations and enabling actions on an "adopt or justify" basis, emphasising flexibility for local needs while integrating legislative requirements such as the Well-being of Future Generations (WBFG) (Wales) Act 2015.

Planning Cycle for the development of the 2026/27 Plan

As previously noted to the Committee, the implementation of the Planning Cycle for the development of the 2026/27 Plan has begun ahead of submission to WG at the end of March 2026, subject to Board approval.

Asesiad / Assessment

Progress against the 2025/26 Annual Plan

A full update on progress against the Annual Plan was provided to Board on 27 November 2025 highlighting a number of key updates, by exception, against both our Escalation requirements and the Annual Plan targets, including the challenging position regarding our finances; and the performance position with regards to Urgent and Emergency Care (UEC) (Ambulance Handovers and Emergency Department (ED) Waits); Delayed Pathways of Care (DPoC); R1 Ophthalmology; and 62-Day Cancer.

2026/27 Planning Cycle Development

An overview of the approach the Health Board is taking in the development of the 2026/27 Planning Cycle was presented to the Committee in August and October 2025. At its core, the approach is based on a risk stratification system to bring transparency and consistency to the challenge of managing competing priorities within constrained resources. The Planning Prioritisation Matrix captures all identified risks and systematically categorises them through a governance framework that clarifies which challenges can be managed within existing parameters versus those requiring system-level intervention.

Currently, there are 637 live risks, of which 168 are Extreme and 370 are High - around 84% of the register. These risks cluster around workforce sustainability and staff wellbeing, fragile and single-handed services, estates and infrastructure, digital and data resilience, and financial pressure. Those clusters align closely with our emerging Strategic Objectives of Thriving teams, Healthier communities, Great Care and Positive Futures.

Recognising the scale of challenge, the Health Board has deliberately shifted from aspirational planning to risk-informed, resource-constrained prioritisation. This is the central organising principle of the 2026/27 planning round. The key elements of the approach are:

- Plan from what we have, not what we want. There is no additional growth funding; transformation must be achieved through redeployment and re-sequencing of existing resource.
- Mandatory efficiency and savings delivery. Every reallocation must contribute towards the annual savings requirement, either through cash-releasing savings or demonstrable cost-reduction.
- Top three risks only per Clinical Care Group (CCG)/directorate. Each CCG and Executive Function has been asked to nominate its three highest priority risks for collective consideration; all others remain managed through existing governance but without expectation of resource reallocation in this cycle.
- Structured routing of risks. A three-route model directs operational risks either to local management (Route 1), reallocation decisions up to a threshold (Route 2), or system-wide strategic prioritisation where issues are cross-cutting, high-cost or transformational (Route 3).
- Funnel from long list to short list. Workshop 1 surfaced multiple risks. Workshop 2 will narrow three risks per CCG down into six to eight cross-system proposals for 2026/27, each with clear deliverables and early benefits (aiming for impact by April but no later than June 2026).

This evolving planning process is not simply technical. It is also a governance shift. It will require the Board to make explicit decisions about:

- Which risks to treat now, through resource reallocation or transformation;
- Which to manage as far as reasonably practicable within current resources; and
- Which to accept explicitly for a period, in line with the Board's risk appetite, while resources are focused on higher-impact areas.

Crucially, the planning method is now explicitly aligned to the Strategic Refresh. The eight planning goals – two under each chapter – act as the bridge between:

- The operational and corporate risk base (circa 637 risks),
- The annual plan for 2026/27,
- The three-year roadmap to financial balance, and
- The long-term mission of "Healthier lives, well lived".

The Annual Plan process and the three-year financial roadmap are the mechanisms for converting a number of these risks into deliverable actions. By identifying six to eight cross-system priorities for 2026/27, aligning them with the planning goals, and applying the principles of radical openness, trust, and change to clearly articulate:

- Where we will reallocate resources and transform now;
- Where we will manage and improve within existing resource; and
- Where we will consciously accept and monitor risk over the next three years while we focus on the areas of greatest system impact.

Building on the initial workshop in October 2025, the follow-up workshop with the Core Delivery Groups (CDGs) was held in November 2025. Each CCG was required to present its three priority risks only, as set out in the refined planning principles and agreed following Workshop 1. For each of the three risks, they were asked to cover the following:

- What the risk is - taken directly from your operational risk register.
- Why it is one of your top three - the impact, scale and urgency.
- What you believe is required to address it - high-level only; this is not a business case.
- Whether it is realistically deliverable in 2026/27 - within the constraints described in the planning paper (e.g., no new growth funding, focus on reallocation, early impact required by April but June 2026 at the latest).
- How it aligns with the planning principles - particularly Principle 4 (Top 3 Risks Only), Principle 7 (Early Impact) and Principle 8 (Shift Left).

CCG priorities and themes from the planning workshop

The November 2025 planning workshop surfaced CCG priorities that cluster strongly around a limited number of themes. Community and Integrated Medicine emphasised the UEC "front door" - ED clinical streaming, Same day Emergency Care (SDEC) and acute medicine workforce, alongside whole-system flow and intermediate care. This would naturally include the Clinical Streaming Hub and Hospital at Home as core delivery vehicles for Home First and Discharge to Recover then Assess Model (D2RA). Planned and Specialist Care focused on theatres and peri-operative reliability, cancer 28-day diagnostics, dermatology (with strong links to skin cancer) and orthogeriatric modelling for trauma and frailty. Orthogeriatrics emerged as an area of strong cross-CCG consensus.

Allied Health and Health Sciences including Diagnostics highlighted structural ultrasound workforce deficits and broader imaging constraints, alongside Allied Health Professions (AHP) capacity in frailty, orthogeriatrics and weight management pathways. Population Health emphasised healthy weight and obesity (including GLP-1 pathways), falls and healthy ageing, cardiovascular risk and immunisation coverage. Across CCGs, theatres, UEC flow, diagnostics (especially Ultrasound Scans (USS), Computerised Tomography (CT) and Magnetic

Resonance Imaging (MRI)), cancer, dermatology and orthogeriatrics recur consistently, with community capacity and prevention as enabling themes.

Aligned System-Level Joint Priorities
On the basis of the Board Seminar, CCG submissions and the November 2025 workshop, five system-level joint priorities are proposed for the **2026/27 Annual Plan**, set within a three-year planning horizon to March 2028. Each draws together multiple CCG risks and programmes and is intended to provide a clear organising framework for workforce, finance, estates and performance planning rather than a long list of separate initiatives.
The priorities are:

1. UEC front door and whole-system flow (including Clinical Streaming Hub (CSH) and Hospital at Home).
2. Orthogeriatric and frailty model across trauma and medicine.
3. Theatres, anaesthetics and peri-operative system reliability.
4. Cancer and 28-day diagnostics (including dermatology).
5. Diagnostics capacity and resilience, with an early emphasis on ultrasound.

Prevention, digital/data, estates and workforce are treated as cross-cutting enablers that have to be built into each priority rather than as standalone programmes.

Priority 1 - UEC front door and whole-system flow
UEC remains structurally fragile: DPoC are well off trajectory, Audit Wales estimate around 55,000 delayed bed days and at times around a fifth of general and acute beds occupied by delayed patients. The four-site emergency model, ED and acute medicine workforce gaps, dependence on surge beds and an ageing estate all point to a system held together by short-term measures. Community capacity, social care, Continuing Healthcare (CHC) and mental health demand are integral to the problem.

Year one (2026/27) – what must change
- Establish a single UEC and flow programme, led by Community & Integrated Medicine with joint ownership across relevant CCGs and Local Authorities.
- Set realistic 2026/27 trajectories for DPoC, ambulance handovers and 12-hour waits, based on explicit assumptions about community, CHC, mental health and social care capacity.
- Standardise and scale core “home first” interventions (CSH, Hospital at Home, reablement), with quantified bed-day and DPoC impact, and agree minimum estates and staffing measures needed to keep four-site UEC safe.

Years two and three
- Use year-one data to inform decisions on hospital configuration, escalation capacity and the balance of hospital and community care.
- Embed consistently scaled home-based and discharge models across all counties, aligned with the longer-term Clinical Services and Estates Strategy.

Priority 2 - Orthogeriatric and frailty model across trauma and medicine
Orthogeriatrics and frailty were a strong area of consensus. There is a high volume of frail older people with fragility fractures; for example, around 400 fragility fractures a year at Glangwili Hospital (GGH). Clinicians described a consultant-led orthogeriatric model, supported by AHPs and community teams, that could reduce length of stay by 3–5 days and improve outcomes. Provision is currently variable and not consistently linked to falls prevention, bone health and rehabilitation.

Year one (2026/27) – what must change

- Agree a Health Board-wide design for orthogeriatric and frailty services, led jointly by Planned and Specialist Care and Community and Integrated Medicine.
- Produce a quantified case for change, showing expected bed-day, complication, readmission and CHC impact by site.
- Implement a demonstrator service on one site (most logically GGH) with defined orthogeriatric consultant time, Multi-Disciplinary Team (MDT) input and links to bone health and falls services.

Years two and three

- Extend the model systematically across other hospitals, using the demonstrator to refine workforce and bed assumptions.
- Fully integrate orthogeriatrics with falls prevention, fracture liaison and community rehabilitation within the wider healthy-ageing agenda.

Priority 3 - Theatres, anaesthetics and peri-operative system reliability

Theatres have the highest fragility score (37) and underpin Referral to Treatment (RTT) and cancer performance. At GGH there is a shortfall of around 30 theatre nurses, frequent cancellations of cancer and urgent lists and substantial reliance on temporary staff. Estates constraints (power resilience, ventilation, storage and an existing Health and Safety notification) mean some theatres are not used consistently within their intended clinical envelope. A theatres steering group exists but is not yet driving a single, coherent programme.

Year one (2026/27) – what must change

- Implement safer-staffing solutions in the most fragile locations, with business cases that offset costs against current temporary staffing, lost activity and outsourcing.
- Protect cancer and emergency theatre capacity on all sites through clear rules and escalation, reducing short-notice cancellations.
- Deliver targeted improvements in pre-operative assessment and scheduling, and agree essential estates and equipment works required in-year to maintain safety.

Years two and three

- Further develop a Getting It Right First Time (GIRFT) aligned theatre improvement programme covering case mix, productivity and post-operative flow.
- Shift appropriate diagnostic and low-acuity work into procedure rooms and community settings, and align theatre capacity explicitly with RTT, cancer and high-volume specialties such as ophthalmology.

Priority 4 - Cancer and 28-day diagnostics (including dermatology)

Cancer performance is constrained mainly by diagnostics rather than treatment. For tumour sites such as urology, lower gastrointestinal (GI) and gynaecology, CT, MRI and other tests often take six to eight weeks, making 62-day compliance difficult. Dermatology is critical to cancer performance (around a third of treated cancers are skin cancers) but the service is highly fragile: no substantive consultant or clear clinical lead, heavy reliance on insourcing and external teledermatology, and poor accommodation.

Year one (2026/27) – what must change

- Standardise understanding and application of the single cancer pathway and 28-day standard across clinical and operational teams.
- Implement practical pathway changes in key tumour sites (one-stop models, better sequencing of imaging and endoscopy) to shorten the diagnostic phase.
- Undertake a full dermatology service and risk review, secure interim clinical leadership, and progress an agreed solution for a dermatology hub or minor-procedure suite.

- Set explicit diagnostic capacity assumptions (CT, MRI, ultrasound, endoscopy) that underpin cancer trajectories and clarify how outsourcing will be governed and clinically led.

Years two and three

- Extend successful streamlined diagnostic models to other tumour sites and stabilise a substantive dermatology workforce and hub model.
- Embed cancer diagnostics within the wider imaging strategy, with more reliable 28-day performance and a reduced gap to the 62-day ambition.

Priority 5 - Diagnostics capacity and resilience (initial emphasis on ultrasound)

Diagnostics, especially imaging, are a structural constraint. An ultrasound SBAR describes a significant sonographer workforce deficit and escalating corporate risk, particularly at Withybush (WGH) and Bronglais (BGH) Hospitals. Ultrasound is first-line in many cancer, maternity and UEC pathways. Wider imaging capacity (CT, MRI) is not planned as a coherent system; outsourcing is fragmented and radiology does not always hold contractual and governance control.

Year one (2026/27) – what must change

- Develop a consolidated imaging view (demand, capacity and backlog by site and modality) to underpin cancer, UEC and ophthalmology trajectories.
- Stabilise ultrasound through a single programme bringing together workforce actions, demand management and more coherent use of outsourced capacity.
- Clarify governance and clinical leadership for outsourced imaging, ensuring radiology leads commission, quality and turnaround expectations.
- Begin using clinical validation and pathway redesign to reduce unnecessary imaging where safe.

Years two and three

- Move to a more sustainable imaging model with the right mix of substantive workforce and equipment and, where necessary, re-profiling or consolidation of capacity.
- Fully integrate imaging planning into UEC, cancer and planned-care programmes rather than treating diagnostics as a stand-alone technical function.

Next Steps

Before finalising the 2026/27 Plan, three areas of further quantification would materially strengthen the approach and support more precise prioritisation and phasing:

- A quantified orthogeriatric case for change, translating Length of Stay (LoS), complication and readmission reductions into explicit bed-day and financial trajectories by site.
- Consolidated diagnostics modelling, aligning CT, MRI, ultrasound and endoscopy demand and capacity with cancer, UEC and ophthalmology trajectories.
- A robust impact dataset for CSH, Hospital at Home, reablement and domiciliary care, including county-level variation, to evidence the bed-day and DPoC benefits of scaling the Home First model.

Subject to these refinements, the five proposed priorities provide a coherent organising framework for the 2026/27 Annual Plan and the associated three-year trajectories. They directly address the most material cross-cutting risks, use existing programmes such as CSH, Hospital at Home and the theatre steering group as delivery vehicles, and align with both Welsh Government priorities and the Board's Strategic Refresh.

Argymhelliad / Recommendation

The Committee is asked to:

- **NOTE** the update on the 2025/26 Annual Plan
- **SCRUTINISE and RECEIVE ASSURANCE** from the update on the progress against the Planning Cycle and risks for the production of the 2026/27 Plan.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	3.1.1 Receive assurance that the planning cycle is being taken forward and implemented in accordance with Health Board and Welsh Government requirements, guidance and timescales. 3.1.4. Receive assurance on delivery of the Health Board's Annual Plan through the scrutiny of regular monitoring reports.
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Not Applicable
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	7. All apply
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	6. All Apply
Amcanion Strategol y BIP: UHB Strategic Objectives:	All Strategic Objectives are applicable
Amcanion Cynllunio Planning Objectives	6 Clinical services plan 7 Primary and community strategic plan 8 Estates plan 10 Population health
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022	9. All HDdUHB Well-being Objectives apply

Gwybodaeth Ychwanegol: **Further Information:**	
Ar sail tystiolaeth: Evidence Base:	Annual Plan 2025/26 Board May, July, September and November 2025
Rhestr Termau: Glossary of Terms:	Not applicable
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Strategaeth a Chynllunio	Board May, July, September and November 2025 Board Seminar October and November 2025

Parties / Committees consulted prior to Strategy and Planning Committee:	

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	Any financial impacts and considerations are identified in the report
Ansawdd / Gofal Claf: Quality / Patient Care:	Any issues are identified in the report
Gweithlu: Workforce:	Any issues are identified in the report
Risg: Risk:	Consideration and focus on risk is inherent within the report. A sound system of internal control helps to ensure any risks are identified, assessed and managed.
Cyfreithiol: Legal:	Any issues are identified in the report
Enw Da: Reputational:	Any issues are identified in the report
Gyfrinachedd: Privacy:	Not applicable
Cydraddoldeb: Equality:	Not applicable

November Planning Workshop

Clinical Care Group (CCG) Issues, Interdependencies and 3-Year Planning Framework

Analysis and Recommendations for the Annual Plan 2026/27

Executive Summary

The November 2026 Planning Workshop brought together Clinical Care Groups (CCGs) and corporate directorates to identify the most significant risks facing Hywel Dda University Health Board (HDdUHB). Each area presented their top three priorities, revealing a picture of deeply interconnected challenges requiring collective action.

The Board has provided clear direction: the Annual Plan must address a small number of clearly articulated priorities rather than responding to dozens of disparate risks. This requires moving from separate conversations about finance, performance and quality to a single integrated story.

This analysis presents each CCG's identified issues, maps the interdependencies and cross-cutting requirements, and proposes a cause-and-effect framework to demonstrate impact across programmes. Critically, the analysis reveals that the majority of service pressures cannot be addressed through new funding but require strategic resource reallocation within existing constraints.

The analysis also considers two aligned papers, namely the Ultrasound Services (USS) SBAR (Risk 797) and the Clinical Streaming Hub (CSH) and 7 Day Same Day Emergency Care (SDEC) Business Case, which provides the detailed operational and financial analysis to support the resource reallocation decisions identified in this framework.

1. Issues Identified by CCG and Directorate

Each CCG and directorate presented their top three priority risks, aligned to their fragility assessments and risk registers. The following summarises these by area:

1.1 Planned & Specialist Care

Service Director: Paula Goode

Priority	Issue	Key Points
1	**Theatre System** *Fragility score: 37 (highest in CCG)*	30 WTE short at Glangwili Hospital (GGH); 8 lists cancelled/week (£2m lost); safer staffing resource reallocation £2m needed; estate issues (air handling, power, storage); Theatre 6 inappropriate use
2	**Dermatology** *Risk score: 16 (questioned accuracy)*	No substantive consultant or clinical lead; 38% of treated cancers; 22% year-on-year skin cancer increase; highest rate in Wales; entirely reliant on insourcing/outsourcing; clear transformation needed
3	**28-Day Cancer Diagnosis** *Single Cancer Pathway*	Diagnostic bottleneck is primary issue; CT/MRI 6-8 week waits; Lower Gastrointestinal (GI) CT colons 54 days; Urology, Lower GI, Gynaecology highest volumes; poor cancer outcomes

1.2 Allied Health Professions & Health Sciences

Service Director: Sara Quarrie

Priority	Issue	Key Points
1	**Demand & Capacity Imbalance** *Risk score: 25*	Ultrasound position affects cancer and paediatric pathways (further set out in USS SBAR); Dietetics (Avoidant Restrictive Food Intake Disorder (ARFID) - avoidant/restrictive eating); Adult weight management/Monjaro demand; First Contact Physio unsustainable
2	**Radiology Deficit** *Risk score: 25*	£1m Everlight out-of-hours reporting; Service 'extremely fragile'; Years of decision-making left deficit; Not at baseline; Impacts all CCG pathways
3	**Orthotic Products** *Supporting service*	Smaller quantum but affects multiple pathways; Costed for resolution; Part of CCG-wide demand/capacity issue

Note: Only issues scoring 25 were presented. Additional Welsh Government (WG) targets in Physio, Speech and Language Therapy (SLT) and Podiatry not currently being met and not included in this prioritisation.

1.3 Community & Integrated Medicine

Service Director: Peter Skitt

Priority	Issue	Key Points
1	**Delayed Transfers of Care (DToC)** *30+ linked risks*	£27-28m cost; Not solely Local Authority responsibility; Impacts flow across system; Requires partnership working; Community capacity gap
2	**Emergency Department (ED) & Acute Medicine Staffing** *Consultant and middle-grade*	Cannot staff rotas safely; Substantive numbers inadequate for current configuration; Organisation needs choice: fewer ED/takes OR more staff; Locum spend increasing yearly; CSH and 7 Day Same Day Emergency Care (SDEC) partly addresses this issue
3	**Orthogeriatrics / Elderly Medicine** *Including falls pathway*	>50% trauma ward patients need rehab not trauma care; 3-5 day – Length of Stay (LoS) reduction potential; Causing flow delays, corridor care, patient harm; Links to pre-op assessment

Key message: *"The answer is that we have to have less emergency medical takes*

1.4 Mental Health & Learning Disabilities (MH&LD)

Clinical Lead: Warren Lloyd / Matthew Richards

Priority	Issue	Key Points
1	**Local Delivery Model** *Flexible, Open Access, Person-Centred*	Aligned to Mental Health (MH) Strategy; 111 Option 2 strengthening; Lived experience workforce development; Recovery college model; Demonstrator site for psychological therapies
2	**Patient Flow & Out-of-Area Beds** *Including CHC spend*	Continuing Healthcare (CHC) within MH&LD budget (not separate); Placements back to 4-year-ago levels since July 2025; High-cost private sector transfers increasing; Quality of out-of-area provision variable; Patient outcomes affected by distance

Priority	Issue	Key Points
3	**Neurodevelopmental Services** *Political scrutiny area*	High national and political profile; Engaged with regional and national forums; Part of national strategic programme

Financial drivers: CHC spend, private sector hospital beds, and medical agency costs are symptoms of wider bed pressures, lack of community capacity, and increased acuity.

1.5 Public Health

Deputy Director: Bruce Bolam

Priority	Issue (Risk Reference)	Key Points
1	**Health & Wellbeing Improvement** *Risk 1192 + Risk 118 (partnerships)*	Embedding Social Model of Health and Wellbeing (SMoHW)/ 20four7; Partnership alignment critical; External partners must support keeping people out of unplanned care; 20four7 Framework implementation
2	**Public Health Interventions Uptake** *Risk 1194*	1/3 avoidable burden from lifestyle factors (SNAP); CVD/hypertension - significant untapped potential; Diabetes/healthy weight pathways; Falls prevention 'top tier priority'; 20% most disadvantaged areas need targeting
3	**Immunisation Uptake & Equity** *Risk 1194 (specific)*	Most powerful intervention to eliminate/reduce avoidable admissions; Rates not where needed; Equity of coverage requires improvement; Good latitude of control in primary care and immunisation services

1.6 Medical Directorate

Deputy Director: John Evans
The Medical Directorate took an enabling approach, seeking to support CCGs rather than competing for priority status:

1. **Workforce Resilience** - 'Our workforce is your workforce' - building resilience across the system
2. **Training Pathways** - Balancing professional standards with improving training places and medical education
3. **Effective Clinical Practice** - Ensuring clinical governance dovetails with CCG transformation

1.7 Estates & Facilities

Head of Operations: Simon Chiffi

Priority	Issue	Key Points
1	**Backlog Maintenance** *£107m - £140m range*	No backup power at Prince Philip Hospital (PPH) theatres (ventilators don't run on batteries); Air handling issues; 'Catastrophic incident potential'; Daily reactive challenges; 'Hand grenade' approach currently
2	**Cleaning Standards Gap** *Wales 2009 standards*	43 additional staff needed for current standards; Draft 2025 standards (unreleased) would require 2→3 cleans/day; 33% increase on facilities budget; Occupational Change Process (OCP) work bridging gap

Priority	Issue	Key Points
3	**Security & Portering** *Risks 1860 & 1861*	Increasing Violence and Aggression (V&A) incidents; Porters being used inappropriately as security; Not Security Industry Authority (SIA) licence trained; Professional boundaries being crossed

Key message: *"I need to know what the organisation wants to go after clinically - only then can I dress up the estate to support it. We may be throwing money into areas that won't last."*

1.8 Pharmacy & Medicines Management

Associate Clinical Director: Dilesh Khandhia

1. **Antimicrobial Stewardship** - No pharmacist support on some sites following unfunded posts and financial pressures; microbiology challenges
2. **Electronic Prescribing and Medicines Administration (EPMA) Clinical Engagement** - Electronic prescribing rollout requires clinical engagement; downstream issues likely without proper involvement
3. **Aseptic Services Fragility** - Estate below standards; demountable unit partially addressed; running at 130% capacity; workforce fragility; national outsourcing market at capacity

1.9 Primary Care

Assistant Director of Primary Care: Rhian Bond

Risk	Title / score	Rationale
1993	Risk of failure of Sidexis due to software being End of Life *Risk score: 16*	Sidexis is the system that manages digital imaging in the Community Dental Service. Whilst there is a workaround for short term system disruptions if the system was to fail (as no longer supported) there would be a risk to capturing and reporting on images. Procurement of a new system is the viable mitigation.
1451	Risk of increasing unsustainability of General Medical Services (GMS) Practices due to Independent Contractors serving notice on their Contracts *Risk score: 16*	Whilst there is a risk of contract terminations there is a statutory responsibility for the Health Board to deliver general medical services. The risk needs revising to cover sustainability of primary care services due to the impact of contractual changes on community pharmacy and dental services (Link to 1708)
1869 800 1823	• Risk of NHS Dental Services not achieving Patient Charge Revenue Income targets due to lower activity/income at practices • Health Board wide risk of a lack of General Anaesthesia service for Vulnerable Adults due to lack of consultant and theatre space • Risk to Sustainability of NHS Dental Services due to NHS Dental Contract	All dental risks that link to financial stability of patient income to support commissioning of contracts, the ability to commission contracts and delivery of specialist services to vulnerable adults.

Risk	Title / score	Rationale
	Reform and handback of NHS contracts *Risk score*: *12*	

2. Interdependencies and Cross-Cutting Requirements

A critical workshop finding was that risks are **multifaceted and interconnected**. A workforce issue drives poor quality, temporary staffing costs, and financial pressure simultaneously. The Board Chair emphasised the need for options that 'take into account all facets' rather than presenting separate finance, performance and quality conversations.

2.1 CCG-to-CCG Dependency Map

The following matrix shows where each CCG's priorities depend on or affect other CCGs:

CCG Priority	Planned Care	Comm & IM	AHPs & HS	MH & LD	Estates
Theatres	Owner	Emergency surgery capacity	Pre-op, anaesthetics support	Low	**CRITICAL:** Power, air handling
28-Day Cancer Diagnosis	Owner	Low	**CRITICAL:** CT/MRI capacity	Low	Imaging equipment
ED/AMU Staffing	Surgical take links	Owner	Front door AHPs	MH liaison at front door	**CRITICAL:** Site config
Orthogeriatrics	Transnasal Oesophagoscopy (TNO) beds, pre-op	Owner	**CRITICAL:** Frailty, Physio, OT	Low	Rehab space
DTOC	Surgical flow	Owner	Discharge support	MH DTOC component	Low
Radiology Deficit	**CRITICAL:** Cancer Dx	USC diagnostics	Owner	Low	Equipment, space

Key: Yellow = Owner CCG | Orange = Critical dependency | Grey = Low/No dependency

2.2 Cross-Cutting Enabling Requirements

Several requirements cut across **all** CCG priorities and must be addressed collectively:

Enabler	CCGs Affected	Implication if Not Addressed
Radiology Capacity	Planned Care (cancer); Community (USC); AHPs (all pathways)	Cancer performance unrecoverable; USC delays; continued £1m outsourcing
AHP Capacity	Community (orthogeriatrics); Planned Care (pre-op, rehab); MH&LD (pathways)	Flow improvement unrealisable; LoS gains not achieved; frailty pathway failure
Estate Infrastructure	Planned Care (theatres); Community (ED/AMU); All clinical areas	Catastrophic patient safety incident; service closure; regulatory intervention
Medical Workforce	Community (ED/AMU); MH&LD (psychiatry); All CCGs (on-call)	Continued agency spend; unsafe rotas; forced configuration change
Partnership Working	Community (DTOC); Public Health (prevention); MH&LD (community)	£27m+ DTOC costs continue; prevention agenda unfunded; shift left impossible

2.3 Natural Clusters of Interdependent Priorities

Analysis of the interdependencies reveals three natural clusters that should be addressed as integrated programmes rather than separate initiatives:

Cluster A: Flow & Frailty (Highest CCG Consensus)

- **Lead CCG:** Community and Integrated Medicine
- **Contributing CCGs:** AHPs (frailty team, physio, Occupational Therapy (OT)); Planned Care (TNO, pre-op); Public Health (falls prevention)
- **Scope:** Orthogeriatrics resource reallocation; DTOC reduction; falls pathway; discharge optimisation
- **Aligned Paper:** ***CSH and 7 Day SDEC Business Case***
- **Estate enabler:** Rehabilitation space; SDEC expansion

Cluster B: Cancer Diagnostics & Capacity

- **Lead CCG:** Planned & Specialist Care
- **Contributing CCGs:** AHPs (radiology, ultrasound); Pharmacy (aseptics for chemotherapy)
- **Scope:** 28-day pathway redesign; CT/MRI capacity; dermatology stabilisation; one-stop cancer services
- **Aligned Paper:** ***USS SBAR (Risk 797)***
- **Estate enabler:** Imaging equipment; minor ops hub

Cluster C: USC Configuration & Sustainability

- **Lead CCG:** Community and Integrated Medicine (with Medical Directorate)
- **Contributing CCGs:** Planned Care (surgical take); AHPs (front door services); MH&LD (liaison)
- **Scope:** ED/AMU workforce reality; site configuration options; emergency theatre provision
- **Estate enabler:** Power supply; critical infrastructure; potential estate rationalisation

3. Aligned Supporting Papers

Two papers currently in development provide detailed operational and financial analysis to support the resource reallocation decisions identified through the workshop. These papers are intrinsically linked to the annual plan priorities and should be considered as part of an integrated planning package.

3.1 USS SBAR (Risk 797) – Ultrasound Service Fragility

Link to Annual Plan Priorities (current POs, would be Great Care in 26/27)

This SBAR directly addresses:

- **Planning Objective 1:** Workforce Stabilisation
- **Planning Objective 3:** Transforming Urgent and Emergency Care
- **Planning Objective 4:** Planned Care, Diagnostics and Cancer Recovery
- **Cluster B:** Cancer Diagnostics and Capacity (AHPs as Contributing CCG)

Current Position

The USS is operating with insufficient numbers of qualified sonographers to deliver a full, timely, safe and effective diagnostic service. This risk has been present on the corporate risk register since 2023 and has now further deteriorated.

1. **From 1st January 2026:** Withybush Hospital **(**WGH) will be unable to sustain safe baseline capacity for routine and urgent non-obstetric imaging alongside obstetric scanning
2. **Structural deficit:** 6.4 WTE gap with demand (297,353 patients) significantly exceeding capacity (229,057)
3. **Annual shortfall:** 68,296 patients; 34,148 additional scanning hours needed
4. **National context:** Because the shortfall is national and systemic, insourcing is not a viable mitigation

Resource Reallocation Opportunity

The SBAR proposes resource reallocation through:

1. **Skill-mixing:** Create an 8a Clinical Validation post through internal skill-mix of current workforce (funded via vacancies)
2. **Pathway optimisation:** Work with National Imaging Programme to validate waiting lists and ensure pathways follow national guidance
3. **Workload redistribution:** Movement of workload to other professions (physiotherapy, podiatry, vascular scientists) following funding redistribution
4. **Obstetric capacity:** Procurement of obstetric ultrasound capacity funded via vacancies

Decision Required

Approval to escalate corporate risk 797 from 20 to 25 and endorse the resource reallocation strategy to stabilise the service.

3.2 CSH and 7 Day SDEC Business Case

Link to Annual Plan Priorities

This business case directly supports:

- **UEC Accelerated Transformation Programme:** 50% reduction in ED attendances; 75% of emergency activity delivered in a scheduled way
- **National Six Goals Programme:** Requirement for integrated 7-day services by end of September 2025
- **Targeted Intervention de-escalation:** Addresses UEC criteria for ambulance handover, ED waits and hospital length of stay
- **Cluster A:** Flow and Frailty (Community & Integrated Medicine as Lead CCG)

Proposed Model

Extension of CSH, SDEC, and Hospital@Home to 7-day operation:

- **Regional Clinical Streaming and Local Response Hubs:** Eastgate, Porth Preseli, and Cardigan with two-hour response capability
- **7-Day SDEC:** Optimal model strengthening current weekday services and providing weekend cover
- **7-Day Hospital@Home:** Currently limited to four days as patients must be discharged every weekend without CSH oversight
- **Integrated Falls Response:** Level 1, 2 and 3 falls response seven days a week

Resource Reallocation Opportunity

The model demonstrates clear resource reallocation pathways:

1. **Existing funding:** Can be delivered from current Six Goals budget for 2025/26 implementation
2. **Cost avoidance potential:** £3.9m – £9.9m annually through admission avoidance (16-17 bed saving equivalent)
3. **Variable pay reduction:** If surge spending (£1.38m) and pharmacy cost reductions (£0.62m) are realised, combined cash benefit (£2.0m) exceeds CSH service cost (£1.54m)
4. **Weekend pilot evidence:** 91% same-day discharge rate; SDEC absorbed 56% of all ED medical takes

Decision Required

Endorsement of 7-day model implementation from January 2026 with commitment to ongoing funding against cost avoidance realisation.

4. Three-Year Planning Framework with Year 1 Focus

The Board has challenged the organisation to build **'year-on-year pillars'** toward strategic objectives, moving away from annual plans that are 'often devoid of strategy'. The following framework translates CCG priorities into a phased approach:

4.1 Year 1 (2026/27) – Foundation and Quick Wins

Focus on interventions that are deliverable within 12 months and create foundations for Years 2-3:

Priority	Year 1 Deliverables	CCG Requirements
Orthogeriatrics	Resource reallocation case approved; Model implemented at primary site; 3-day LoS reduction target	C&IM: Geriatrician posts; AHPs: Frailty team, physio, OT; Planned: TNO pathway
USS Mitigation *(Aligned Paper)*	SBAR recommendations implemented; 8a validation post in place; pathway optimisation with NIP	AHPs: Skill-mix; Planned: Cancer pathway input
CSH & 7 Day SDEC *(Aligned Paper)*	7-day model operational from Jan 2026; Hospital@Home extended; cost avoidance tracked	C&IM: Lead; AHPs: Frailty, therapy; Six Goals: Funding
Cancer Diagnostics	CT/MRI capacity solution (outsource or insource); 28-day pathway redesign for top three tumour sites	Planned: Pathway ownership; AHPs: Radiology capacity; Estates: Equipment
Theatre Staffing	Safer staffing resource reallocation (~£2m); Cancelled lists reduced by 50%; Pre-op pathway improvement	Planned: Workforce plan; AHPs: Pre-op, anaesthetics; Estates: Critical maintenance
USC Configuration	Workforce reality assessment complete; Options developed; Board-level choices presented	C&IM: Lead; Medical: Workforce data; Estates: Site options
Estate Risk Mitigation	Critical power supply addressed; Business continuity plans; Air handling prioritised	Estates: Lead; All CCGs: Clinical priority input

4.2 Years 2-3 Indicative Trajectory

Year 2 (2027/28): Consolidation and rollout – trainee sonographers qualifying; cost avoidance converted to cash-releasing savings; orthogeriatrics across sites; dermatology stabilisation; USC service model implementation; strategic maintenance programme

Year 3 (2028/29): Sustainable models – workforce substantively recruited; shift-left delivered; estate rationalisation aligned to configuration; prevention benefits realised

5. Demonstrating Cause and Effect

The Board requires that planning options present an **integrated story** across finance, workforce, quality and performance – 'not just a simple saving or performance improvement'. The following framework demonstrates cause-and-effect relationships:

5.1 Logic Model Template

Each programme should articulate its theory of change:

Element	Definition	Orthogeriatrics Example
Input	Resources reallocated	X WTE geriatricians; Y WTE AHPs; £Z resource reallocation
Activity	What we do differently	Daily ward rounds; early mobilisation; discharge planning from admission
Output	Direct deliverables	Patients reviewed/day; CGA completed; rehab sessions delivered
Outcome	Changes achieved	3-5 day LoS reduction; reduced readmission; improved patient experience
Impact	System-level effect	Bed release → flow → ED performance; DTOC reduction → £ savings

5.2 Cascade Effect: Orthogeriatrics Example

Demonstrating how a single intervention creates multi-domain impact:

1. **Quality:** Resource reallocation to geriatricians + AHPs → appropriate rehabilitation → reduced deconditioning → fewer falls → better outcomes → improved patient experience
2. **Performance:** 3- to 5-day LoS reduction → bed release → improved flow → reduced corridor care → ED 4-hour performance improvement
3. **Workforce:** Patients in appropriate setting → reduced staff stress → improved retention → reduced agency reliance → substantive recruitment
4. **Finance:** Shorter stays → bed day savings → DTOC cost reduction (of £27m) → offset resource reallocation → potential net benefit

5.3 Integrated Dashboard Approach

Each programme should report against all four domains monthly:

Domain	Example Metrics	Frequency
Quality	Harm events; patient experience; complaints; serious incidents	Monthly
Performance	LoS; 28-day cancer; ED 4hr; DTOC; theatre utilisation	Weekly/Monthly
Workforce	Vacancy rate; agency spend; sickness; roster compliance	Monthly

Domain	Example Metrics	Frequency
Finance	Run rate; savings delivery; resource reallocation profile; efficiency	Monthly

6. Implementation and Next Steps

6.1 Immediate Actions (Agreed at Workshop)

- Draft paper summarising priorities and assumptions for Executive Team review
- Socialise through Planning Coordination Group
- Individual CCGs continue development of workstreams within their control
- Performance framework alignment as guidance received
- Capacity planning and workforce assumptions development

6.2 Programme Governance Structure

Each priority cluster should have:

- **Executive Sponsor** – Board-level accountability
- **Clinical Lead** – Credible clinical voice
- **Programme Manager** – Dedicated delivery resource
- **Cross-CCG Working Group** – Representatives from dependent CCGs
- **Finance & Workforce Partner** – Real-time assumption validation

7. Conclusion

The November Planning Workshop has successfully surfaced and synthesised the most significant challenges facing each CCG. The analysis reveals that these are not independent problems but a system of interconnected risks requiring integrated responses through resource reallocation within existing constraints.

Two aligned papers the USS SBAR (Risk 797) and the CSH and 7 Day SDEC Business Case provide the detailed operational and financial analysis to support these decisions. The USS SBAR addresses diagnostic capacity and maternity safety through workforce skill-mixing and pathway optimisation. The CSH and 7 Day SDEC Business Case delivers UEC transformation through extending integrated services to seven-day operation, with admission avoidance pathways.

The three natural clusters Flow and Frailty, Cancer Diagnostics, and USC Configuration provide a framework for coordinated action. Each cluster has clear CCG interdependencies and requires enabling support from Estates, Medical Directorate, and corporate functions.

The Board's challenge is clear: demonstrate courage and realism; build year-on-year pillars toward strategic objectives; and present an integrated story across quality, performance, workforce and finance.

As noted in the workshop: 'How many of the things being presented today will happen by accident if we don't plan for them and do something about them – emergency change rather than planned change?'

The time for planned, integrated change is now.

2.3

10:25, 20 Mins

2.3 - Planning Objective 6: Clinical Services Plan

Lee Davies (Hywel Dda UHB - Executive Director of Strategy and Planning), Helen Morgan-Howard (Hywel Dda UHB - Head of Transformation Programme Office), Alexander Martin (Hywel Dda UHB - Principal Programme Manager)

For assurance

Attachments

2.3.1 Planning Objective 6 CSP Highlight Report 01OCT25 - 31DEC25 Q3 2025-~.pdf

2.3.2 Output report from the Hurdle Appraisal Session.pdf

2.3.3 Output report from the Scoring session.pdf

2.3.4 Revised Patient Insight and Transport document.pdf

2.3.5 Revised data science information.pdf

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

Date Submitted: 4 November 2025

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Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

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.

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

Date Submitted: 04NOV2025

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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.

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

Table of Contents

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.

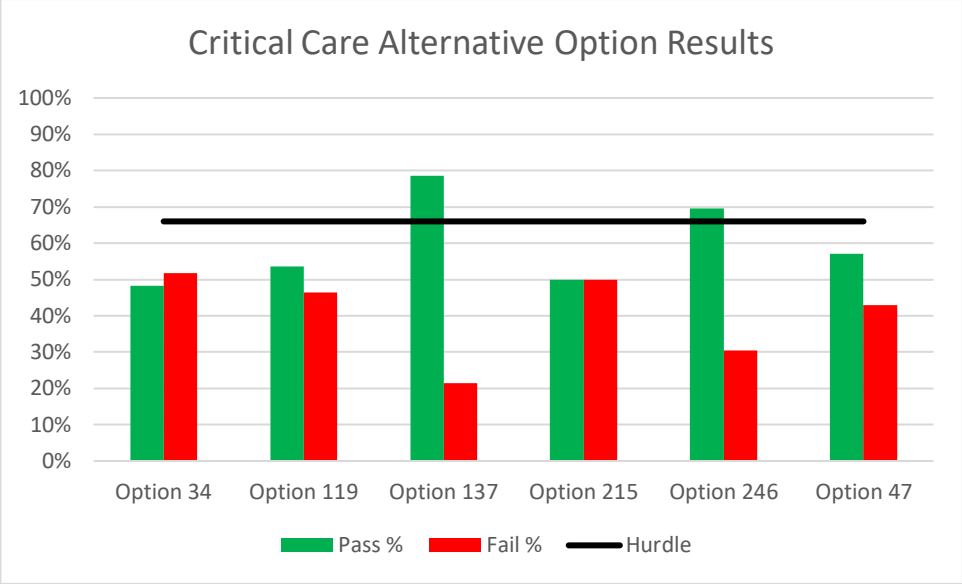
As there was no service representation from Orthopaedics available, the option which received challenge from the Clinical Reference Group (CRG) was automatically taken forward into the afternoon session for the room to appraise, however no challenge was made in the room for other options that the service 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
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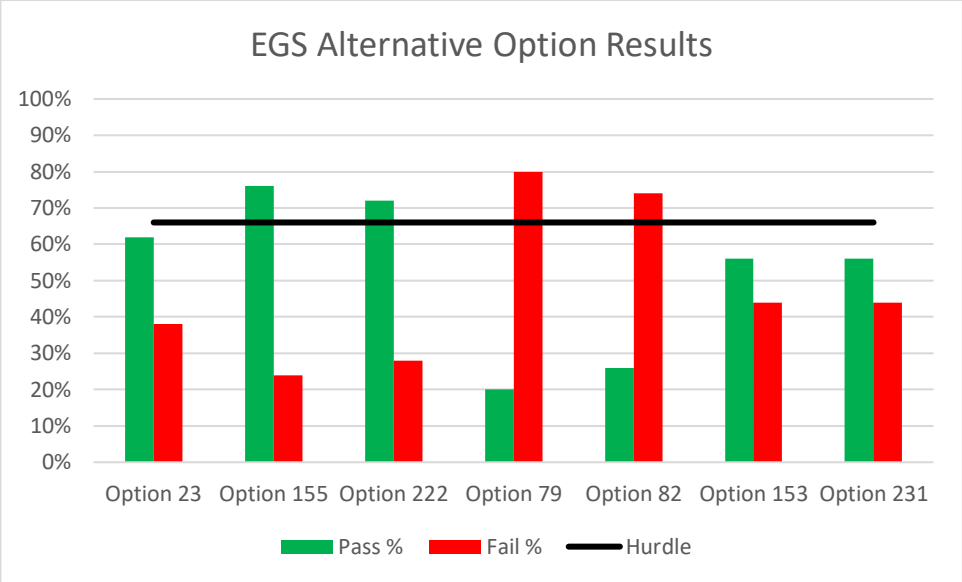
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Option 34
Option 119
Option 137
Option 215
Option 246
Option 47
Pass %
Fail %
Hurdle


EGS Alternative Option Results
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70%
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10%
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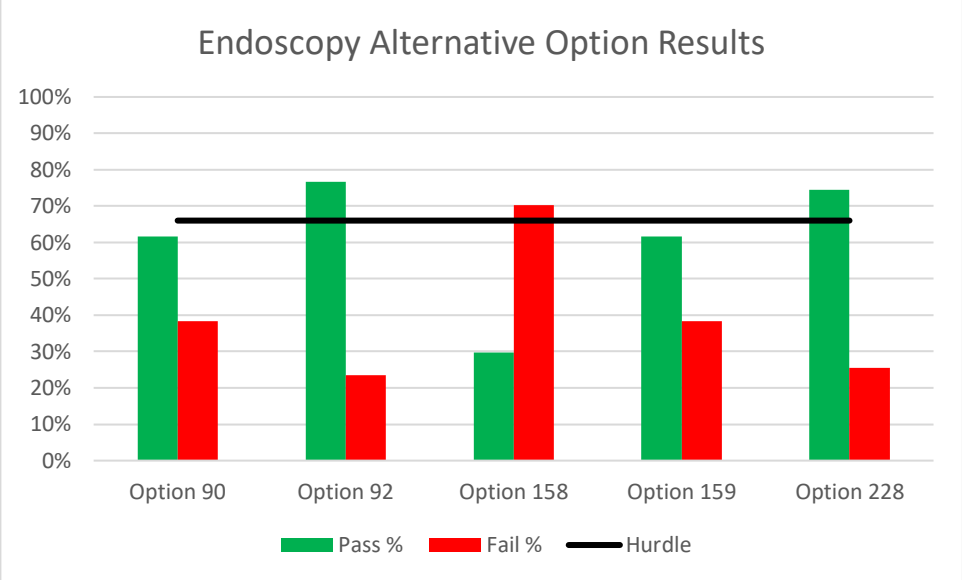
Option 23
Option 155
Option 222
Option 79
Option 82
Option 153
Option 231
Pass %
Fail %
Hurdle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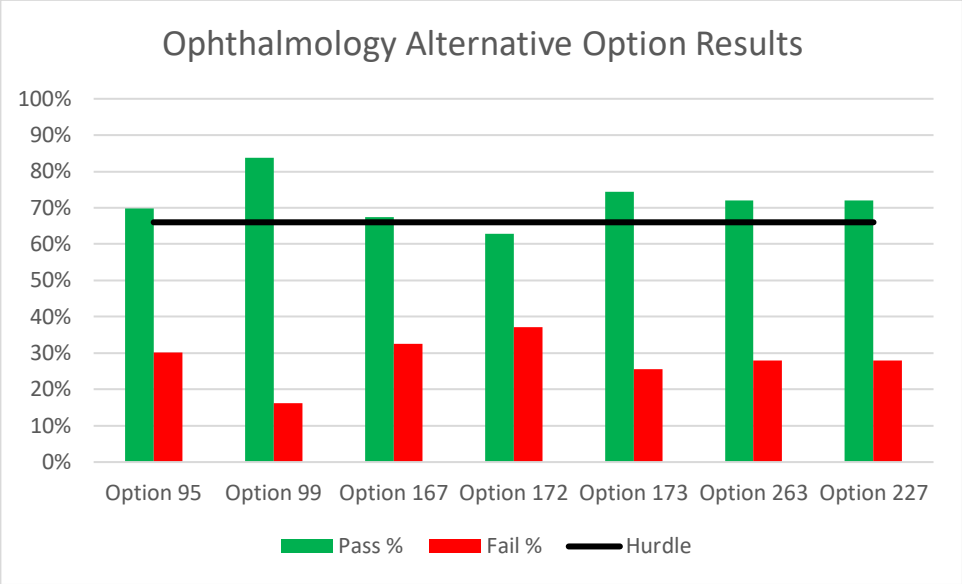
10%
0%
Option 90
Option 92
Option 158
Option 159
Option 228
Pass %
Fail %
Hurdle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90%
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40%
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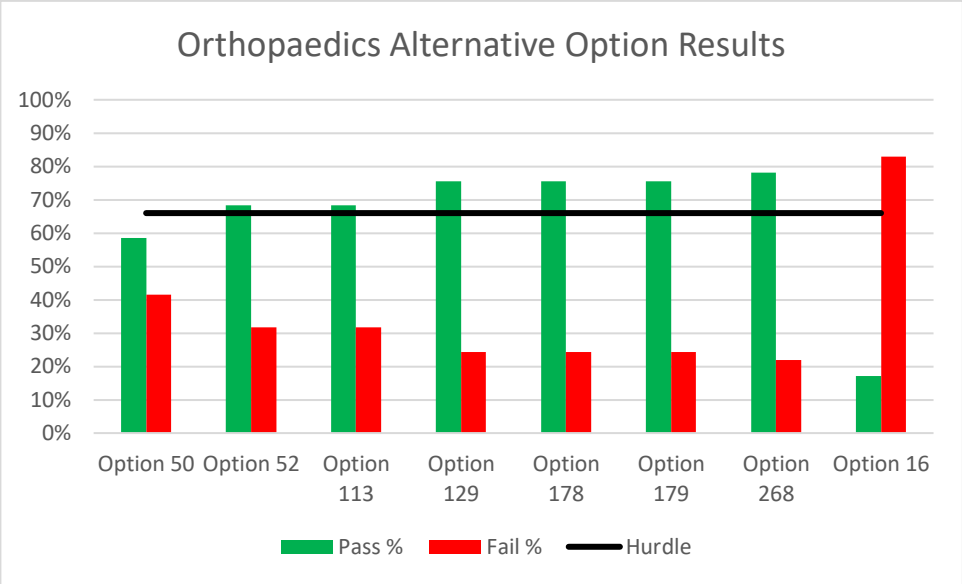
20%
10%
0%
Option 95
Option 99
Option 167
Option 172
Option 173
Option 263
Option 227
Pass %
Fail %
Hurdle


Orthopaedics Alternative Option Results
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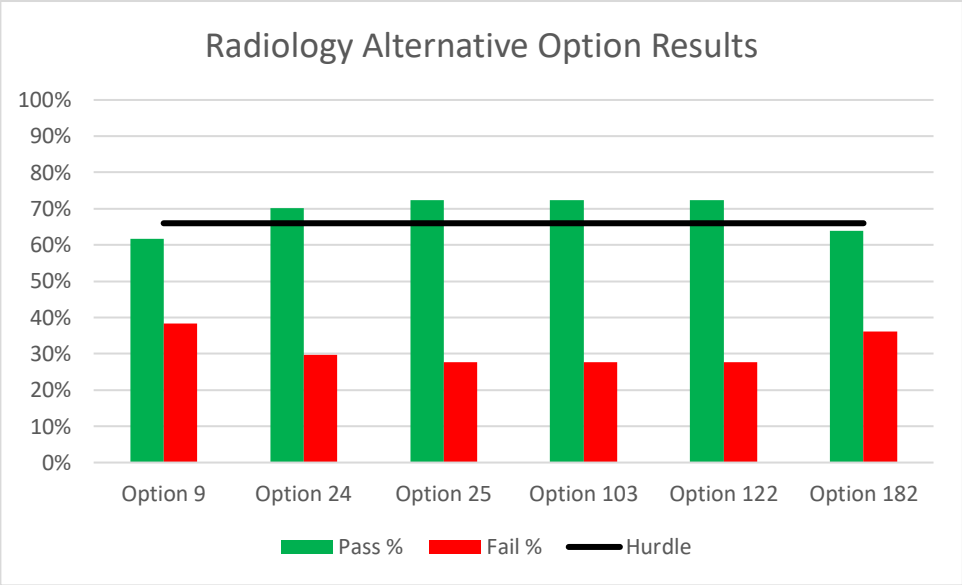
0%
Option 50
Option 52
Option 113
Option 129
Option 178
Option 179
Option 268
Option 16
Pass %
Fail %
Hurdle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Option 25
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Option 122
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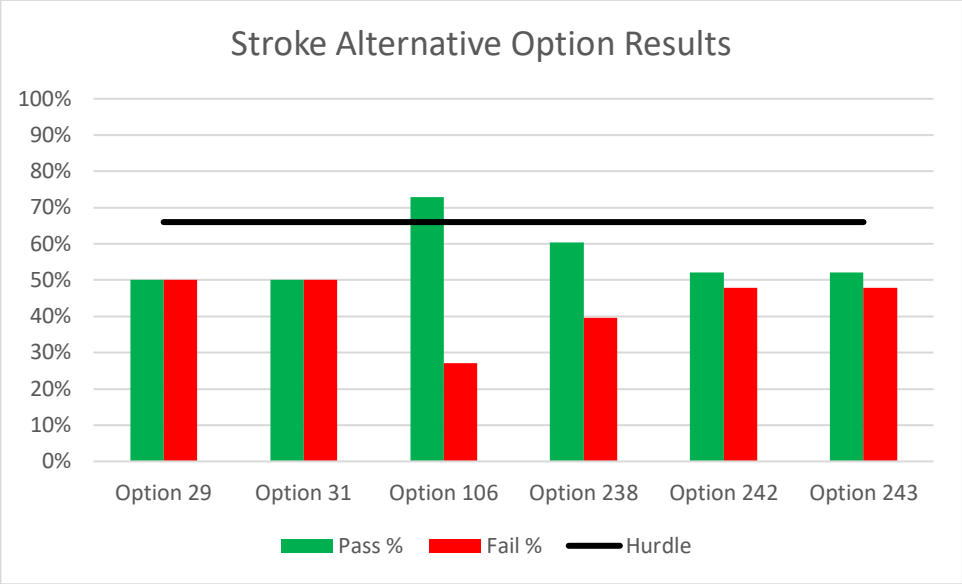
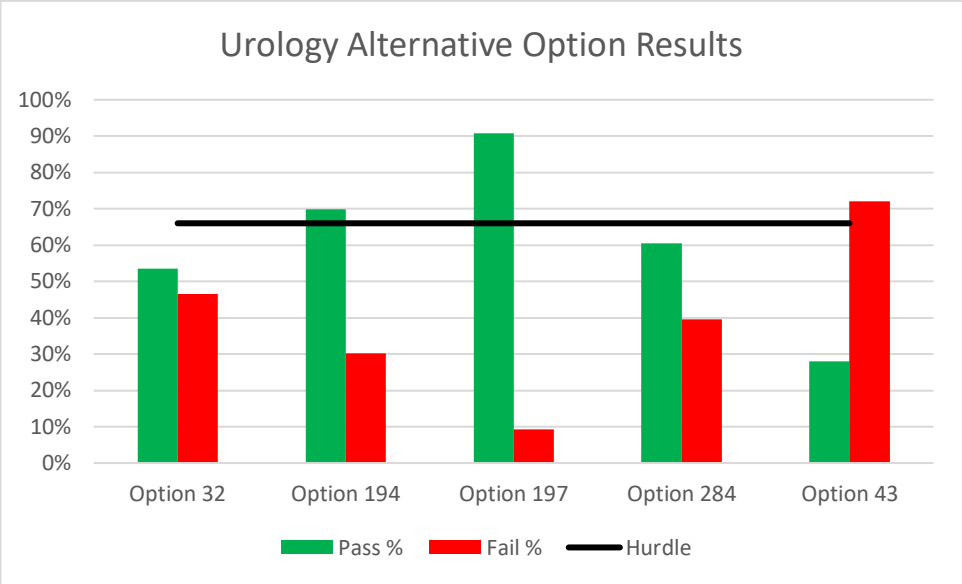
Pass %
Fail %
Hurdle





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

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- 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	

Critical Care - Do Not Meet Slide

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

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

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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							
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

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	

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							
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

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

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	

Ophthalmology – Does Not Meet

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							
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							
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

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

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							
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

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

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. (Stakeh olders)	
236	Considered inaccessible as 3 rd 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. (Stakehol ders)	
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 exp edited 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 th ose 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							
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

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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.

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 futur e 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 i mplementation 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 unsust ainable. Additional staffing for PPH unknown currently but additional workforce and finance resources required unlikely to be availabl e 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 retentio n. (Stakeholders)	
General	Due to the highly rural and sparsely populated nature of Powys, our residents are critically dependent on acute hospital serv ices 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 tha t 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

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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:

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							
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

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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:

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 presen t. 2 criteria are amber therefore is this green overall. Does this require additional whole time equivalent (WTE) and if so, is it financially sus tainable?	
99	Workforce assessment needed for Amman Valley Hospital due to additional diagnostics. What are the additional workforce requir ements 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 existin g staff due to base change, if Llanelli was in addition to current community plan workforce assessment needed and unlikely delivery in medium te rm 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 pipel ines 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 sit e, 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 catara cts 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 n ot 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 serv ices in neighbouring health boards in Wales and neighbouring NHS Trusts in England. In this context, the strategic importance of Bronglais General Hospital for north wes t Powys communities is well recognised, including in Professor Marcus Longley's "Mid Wales Healthcare Study" (2014) which concluded that Bronglais General Hospital s hould 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

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

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							
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

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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

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

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. (Stakeh olders)	
236	Considered inaccessible as 3 rd 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. (Stakehol ders)	
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 exp edited 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 th ose 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							
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.

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

Table of Contents

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

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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

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- 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.

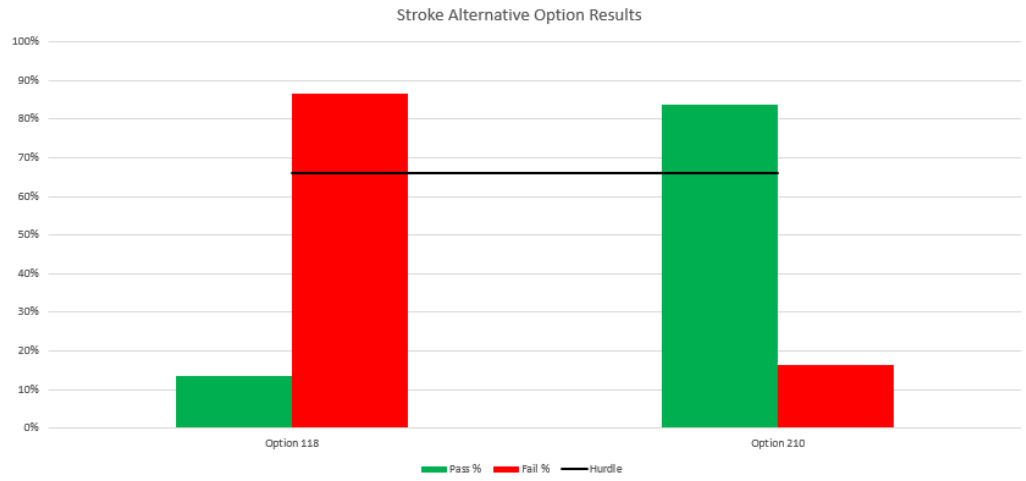
Stroke Check & Challenge Feedback

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

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

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board



Appendix B – Criteria weighting results

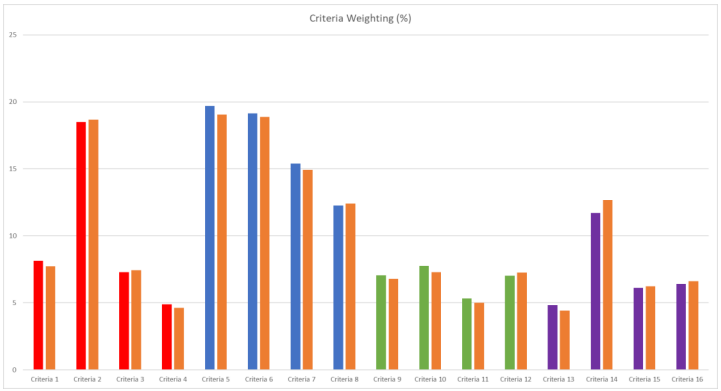
Below is a breakdown of the weighting applied to each evaluation criterion. These weightings were originally developed by the Options Development Group in September 2024 and have been previously reported on in the Phase 2 shortlist scoring. They are repeated here for information.

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

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

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)

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

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

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

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)

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

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

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

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)

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

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

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

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)

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

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)

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

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

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

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

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

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)

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

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)

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

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

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

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

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

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

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)

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

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)

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

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

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

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)

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

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)

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

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

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

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

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

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)

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

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)

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

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

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

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)

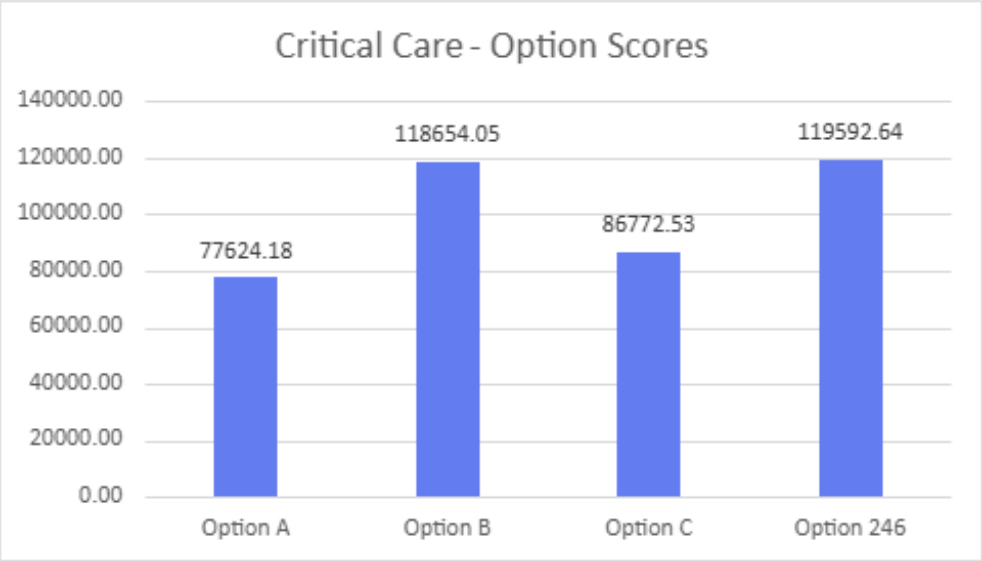
Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

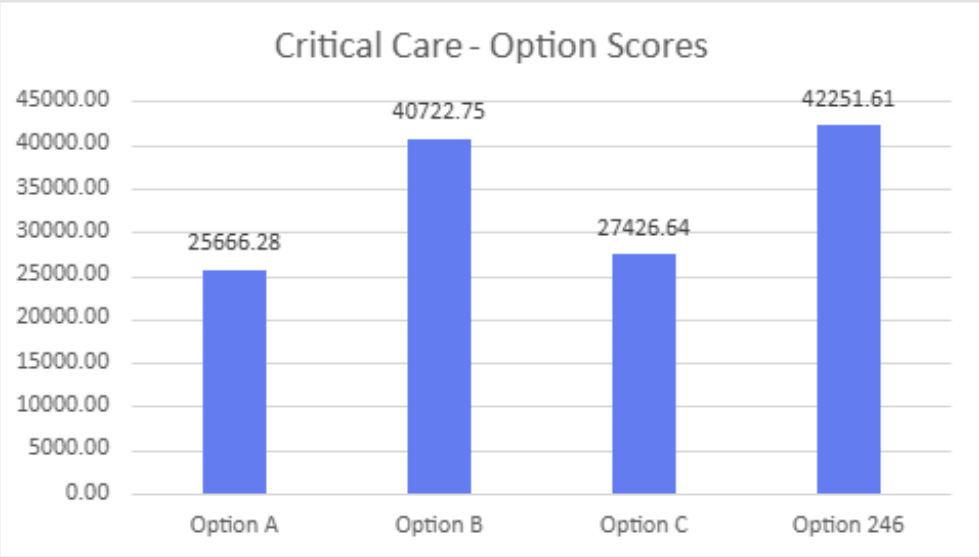
Response From	Evaluation Criteria	Option reference	Summary of feedback
Facilities	1.3		All options. Once a decision has been made, essential facilities and estates will be reviewed and consulted for impacts on workforce and service model change. These consequential impacts must be considered ahead of 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.



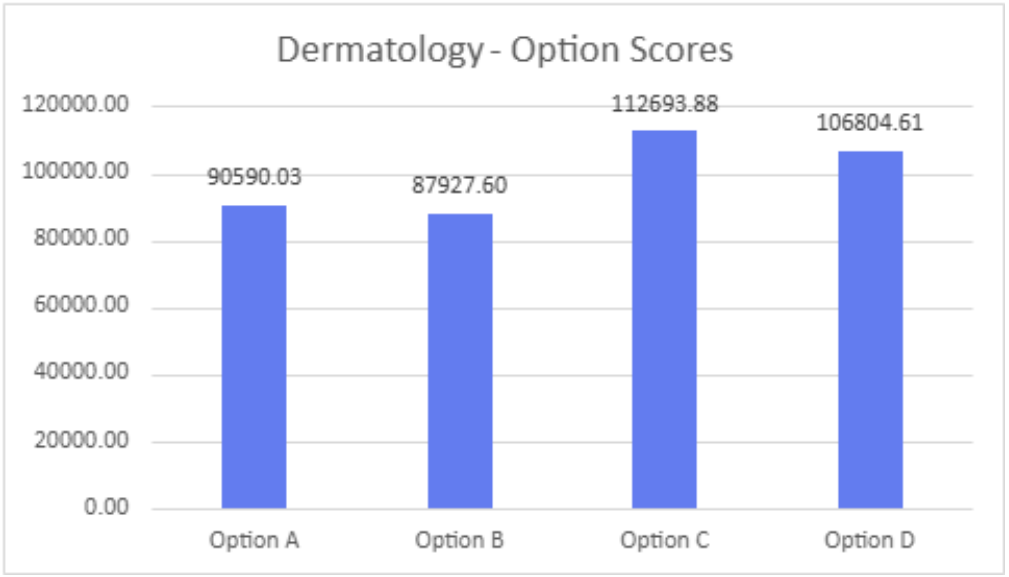


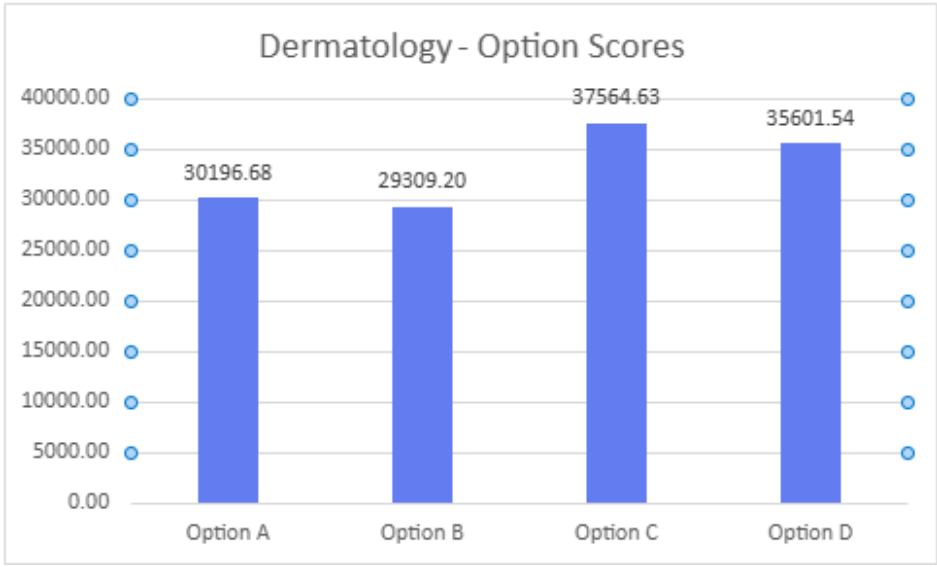
Data tables include full option scoring and breakdown of scores per evaluation criterion/ criteria

	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

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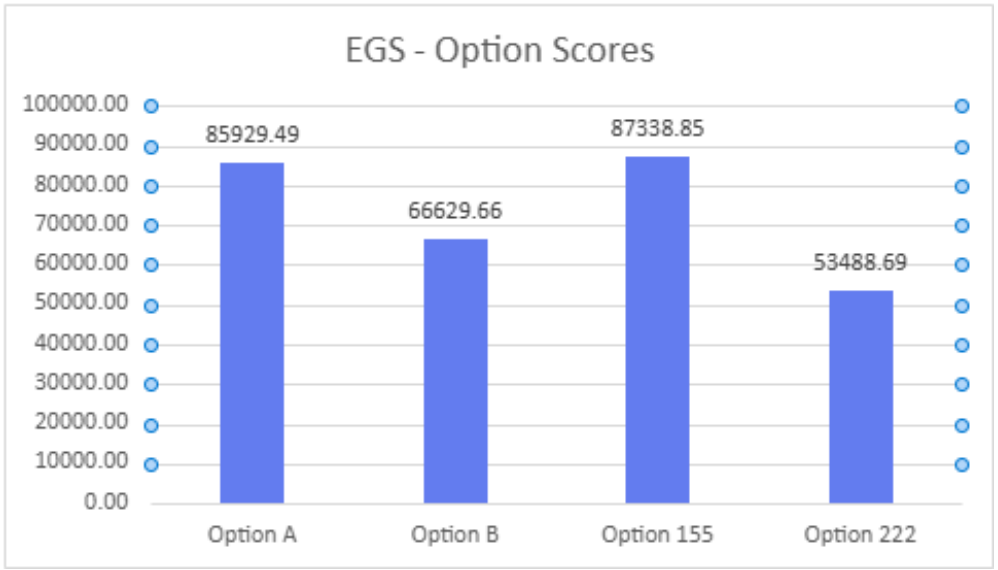

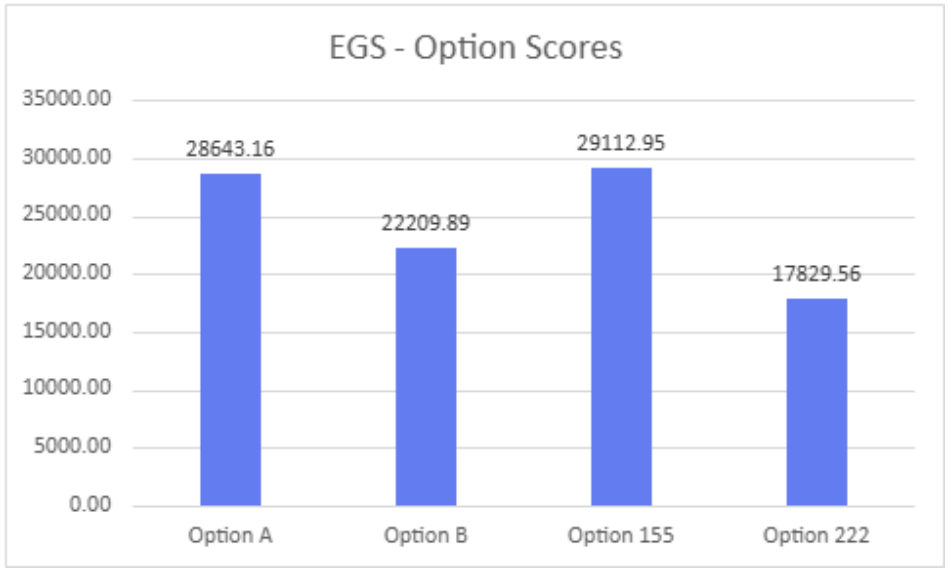

Data tables include full option scoring and breakdown of scores per evaluation criterion/ criteria

	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

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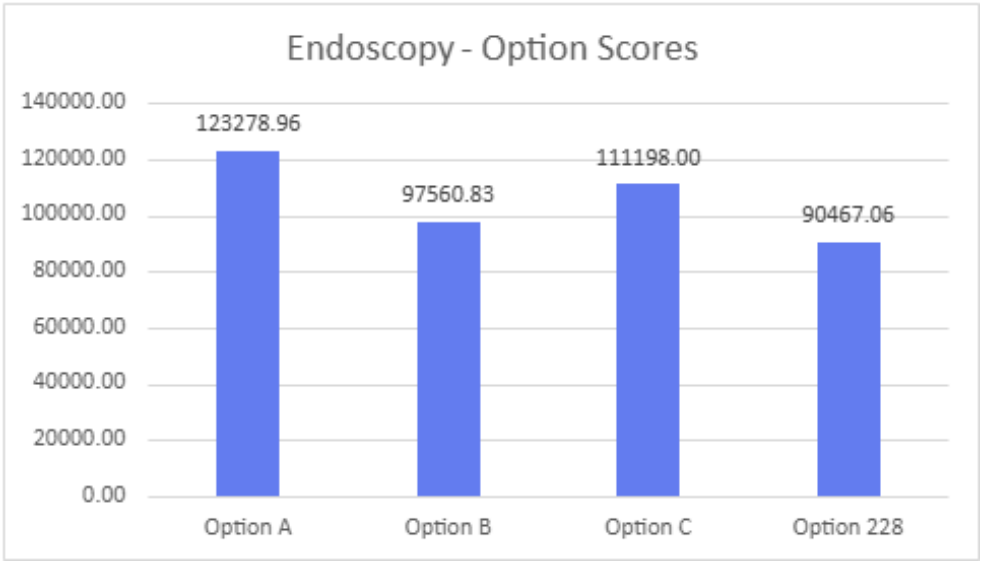

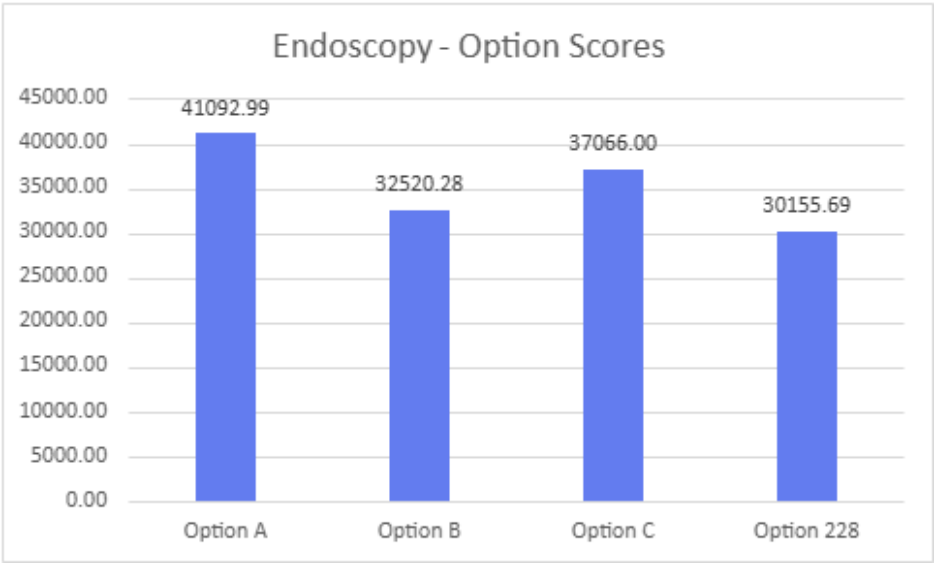

Data tables include full option scoring and breakdown of scores per evaluation criterion/ criteria

	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

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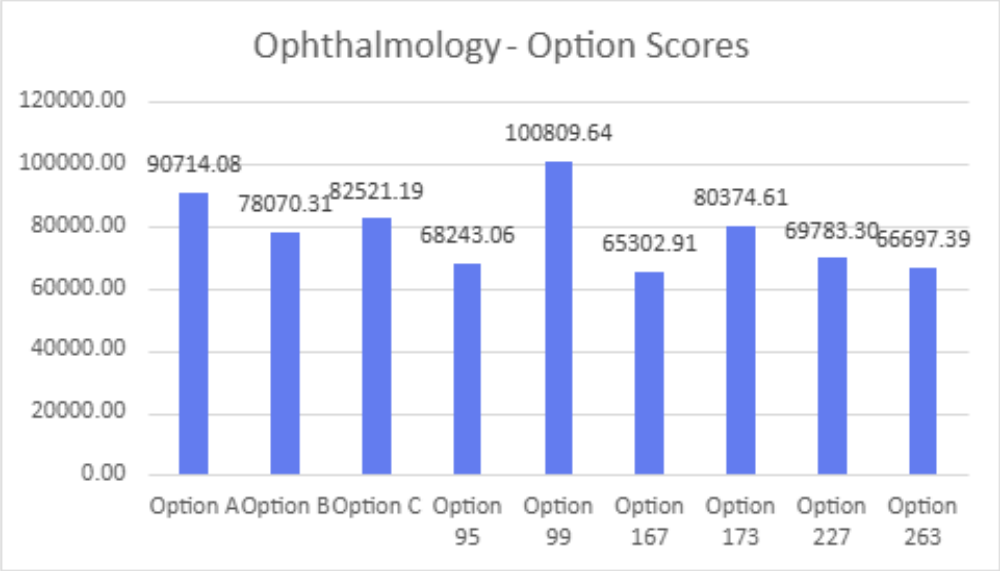

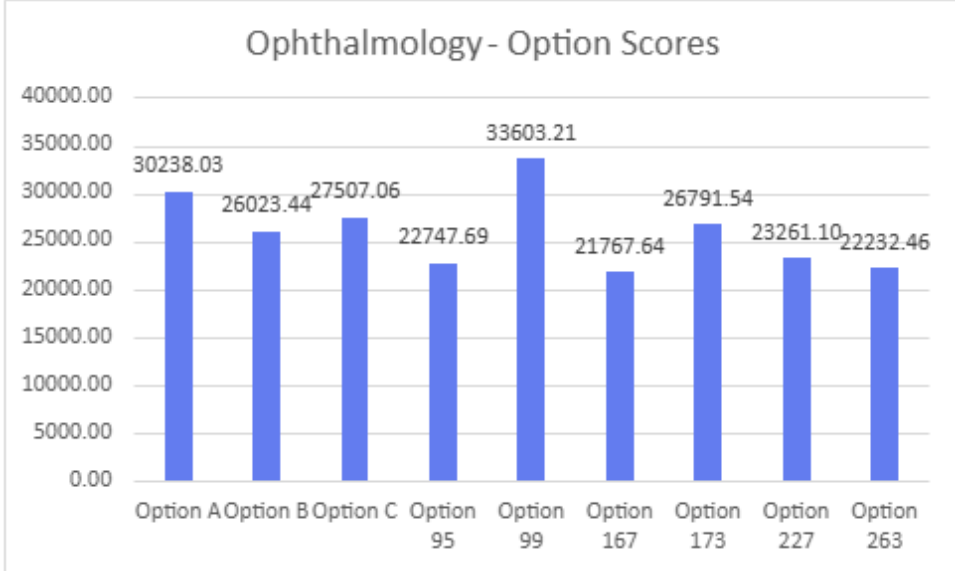

Data tables include full option scoring and breakdown of scores per evaluation criterion/ criteria

	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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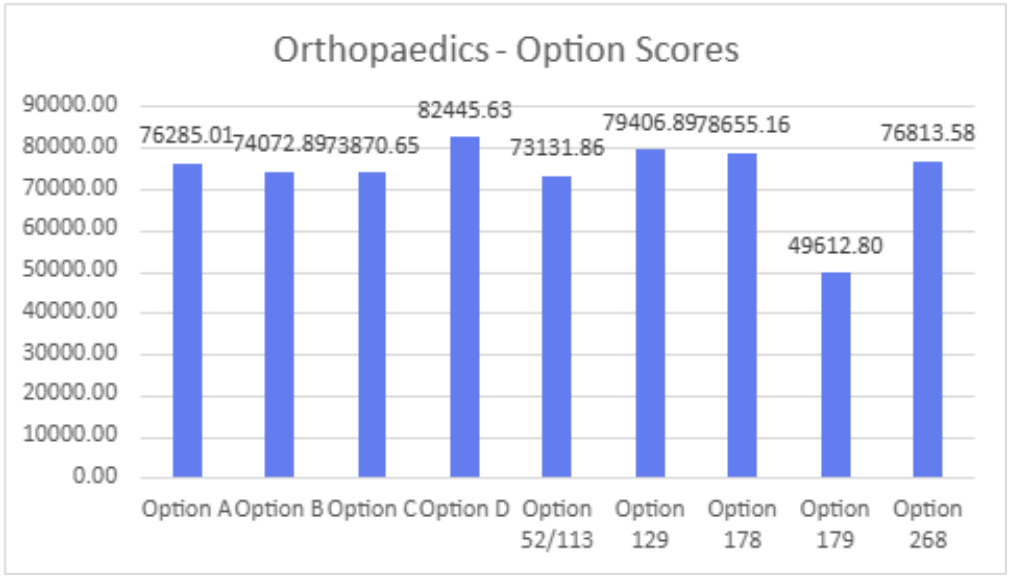
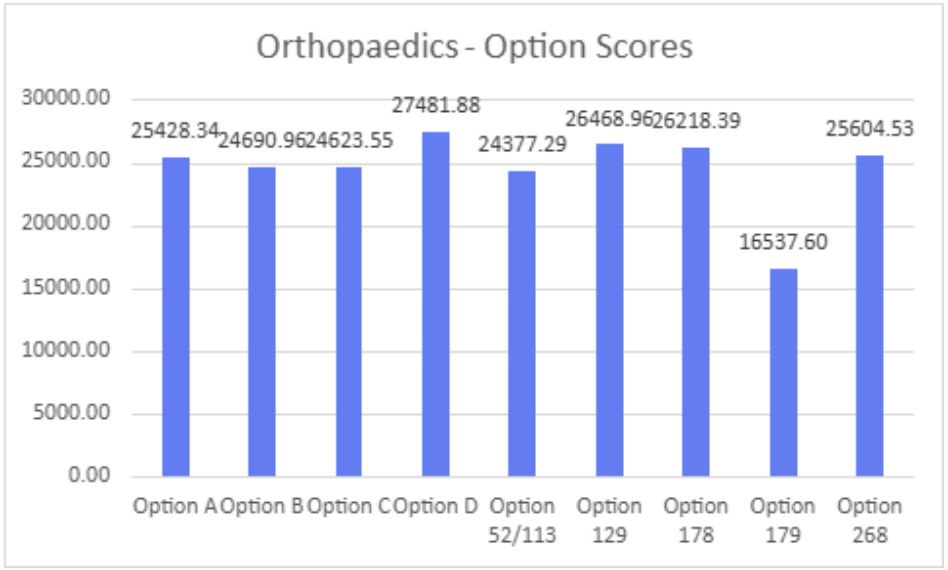


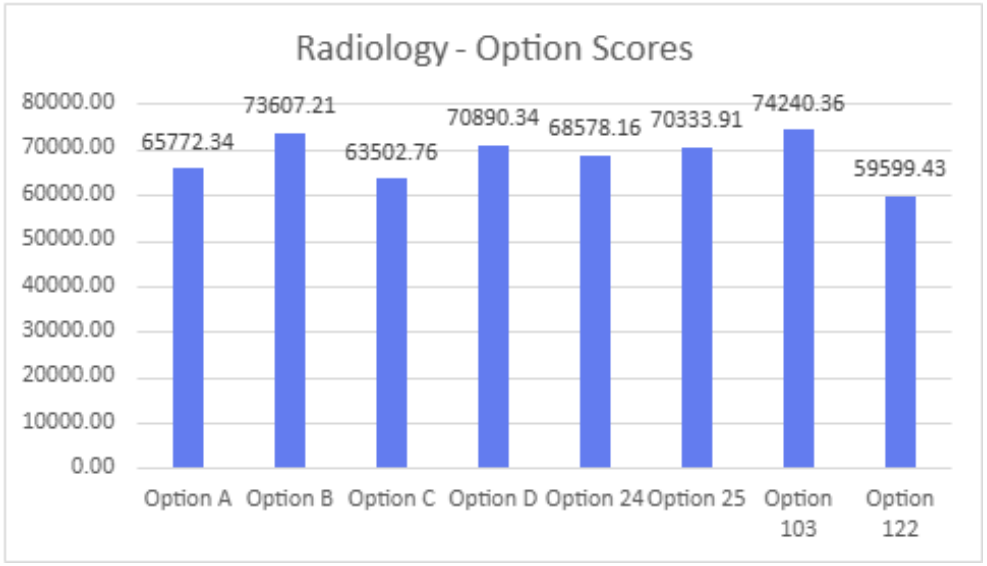


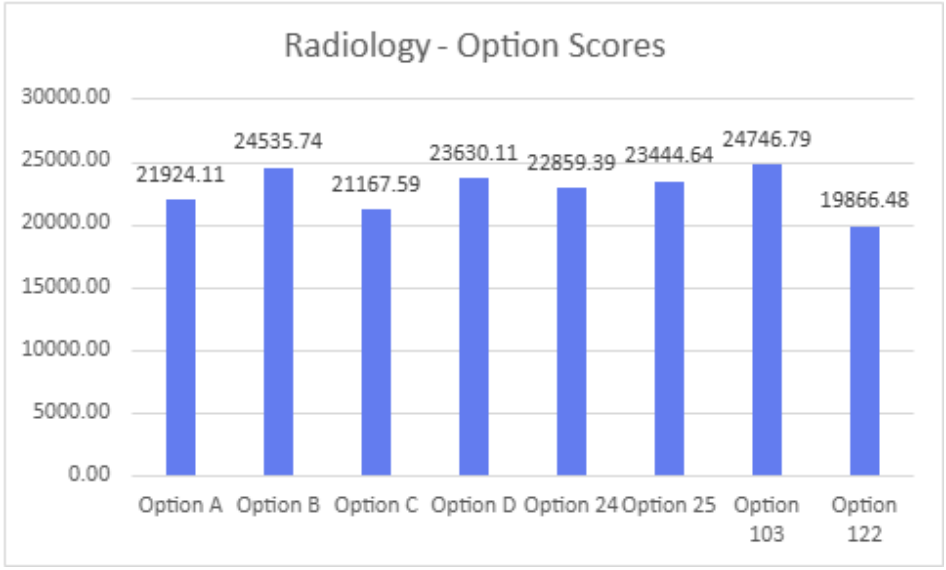
Data tables include full option scoring and breakdown of scores per evaluation criterion/ criteria

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



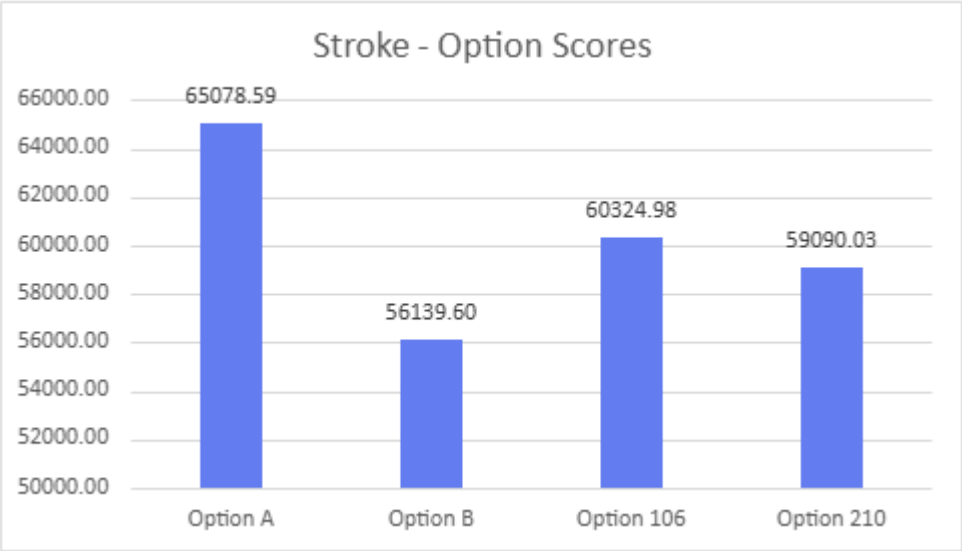


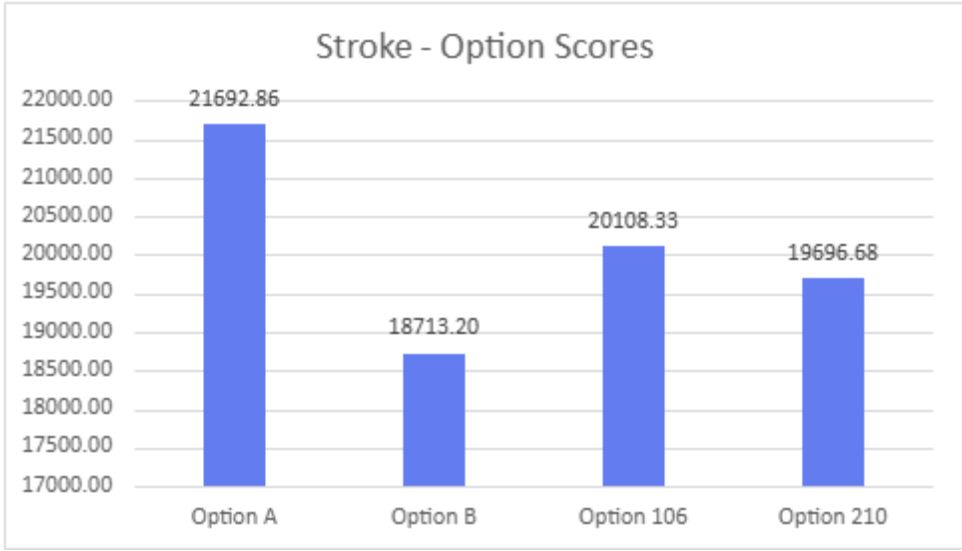
Data tables include full option scoring and breakdown of scores per evaluation criterion/ criteria

	Safe	Sustainable	Accessible	Kind
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.



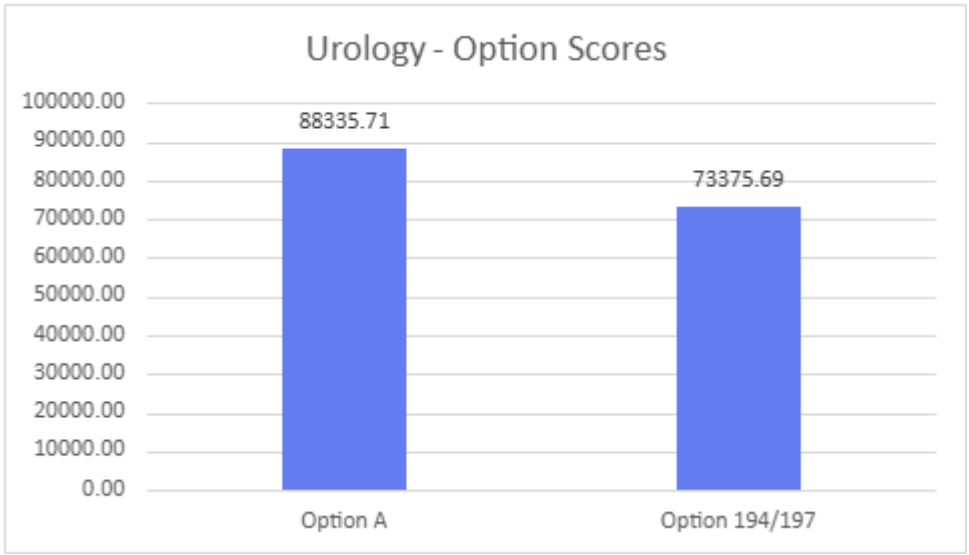


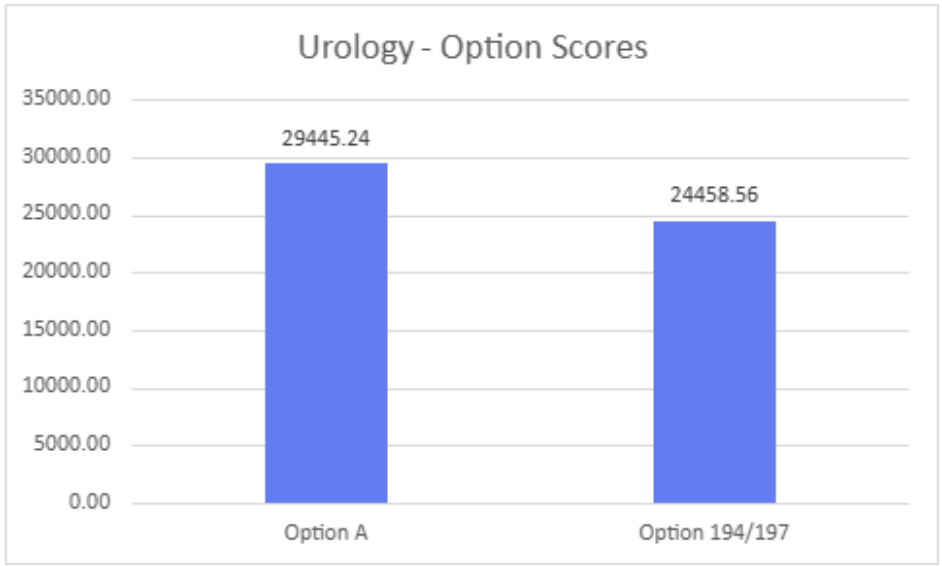
Data tables include full option scoring and breakdown of scores per evaluation criterion/ criteria

	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

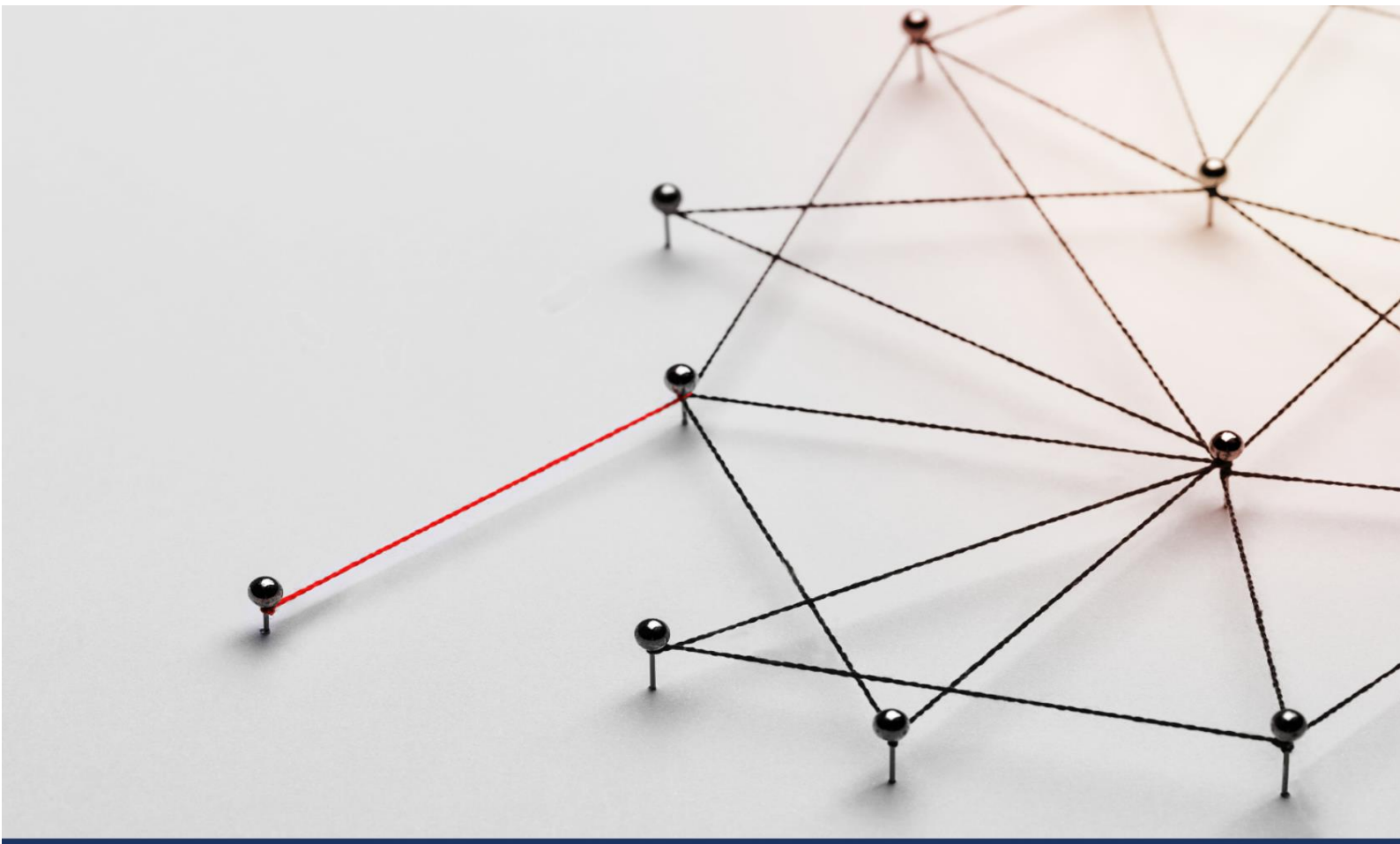
These responses are as they were provided in the survey without any correction or amendment.

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

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

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.

Contents

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.

	Amber denotes transferring site
	Purple denotes receiving site
	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.

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									

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.

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

ACCTS
Adult Critical Care Transfer Service Cymru
Gwasanaeth Trosglwyddo Gofal Critigol Oedolion Cymru

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)

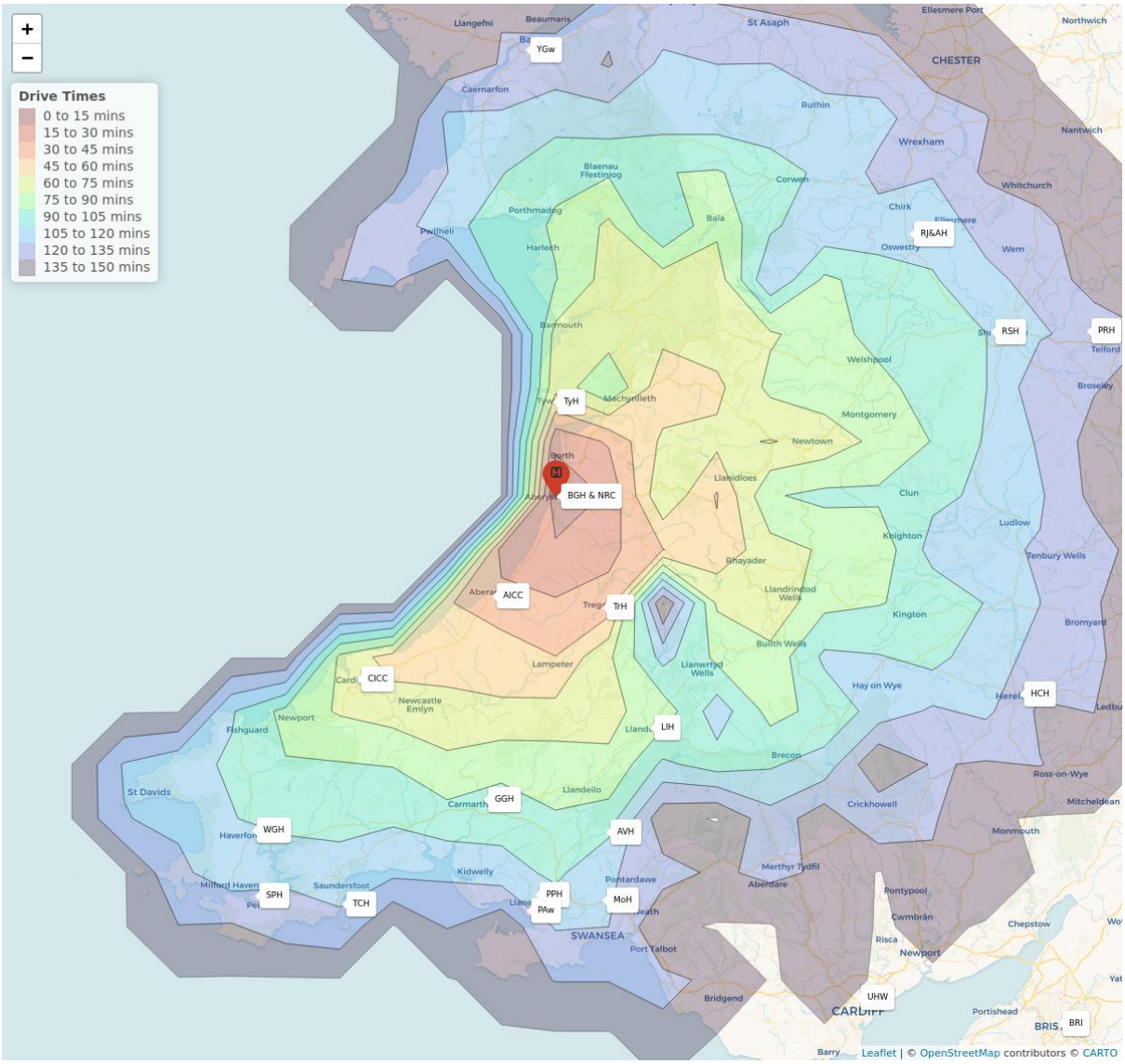
Isochrone mapping

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).

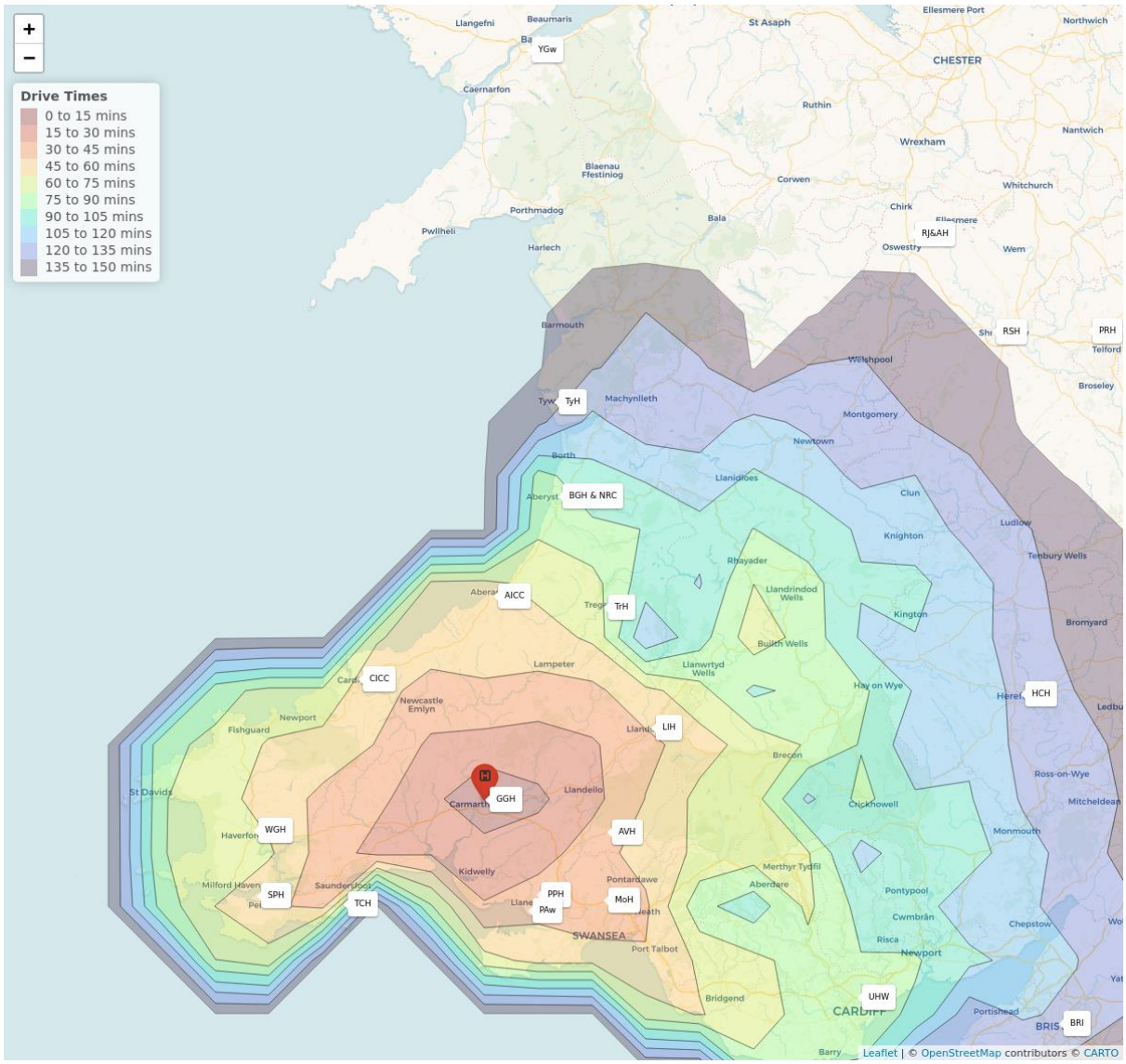
Readers can visually deduce travel times from their current location to a specific site and use these illustrations to consider journey and travel times between different options. This approach provides a clear and intuitive way to understand accessibility and travel implications

Main sites:

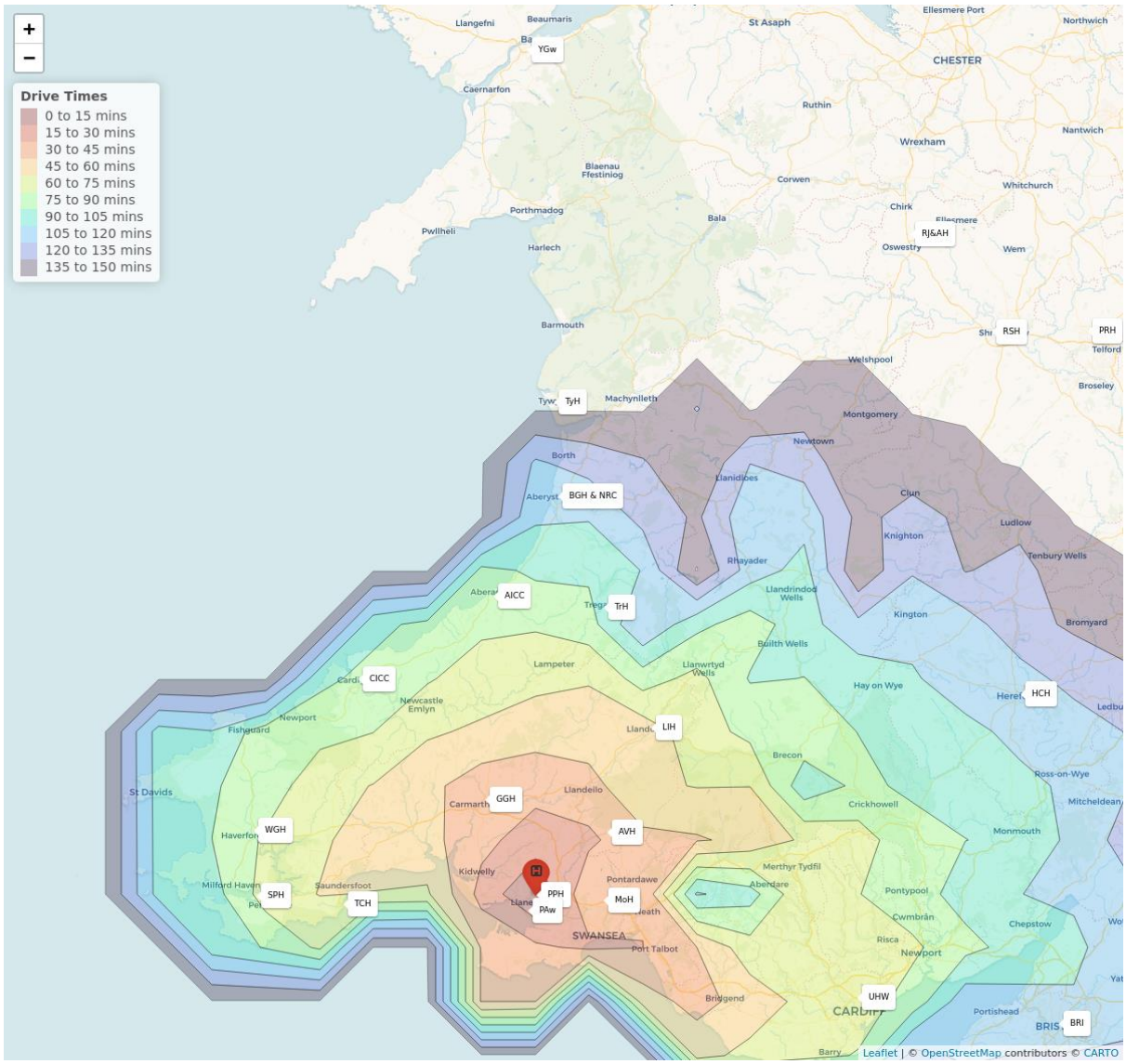
Bronglais Hospital (including North Road Eye Clinic due to proximity)



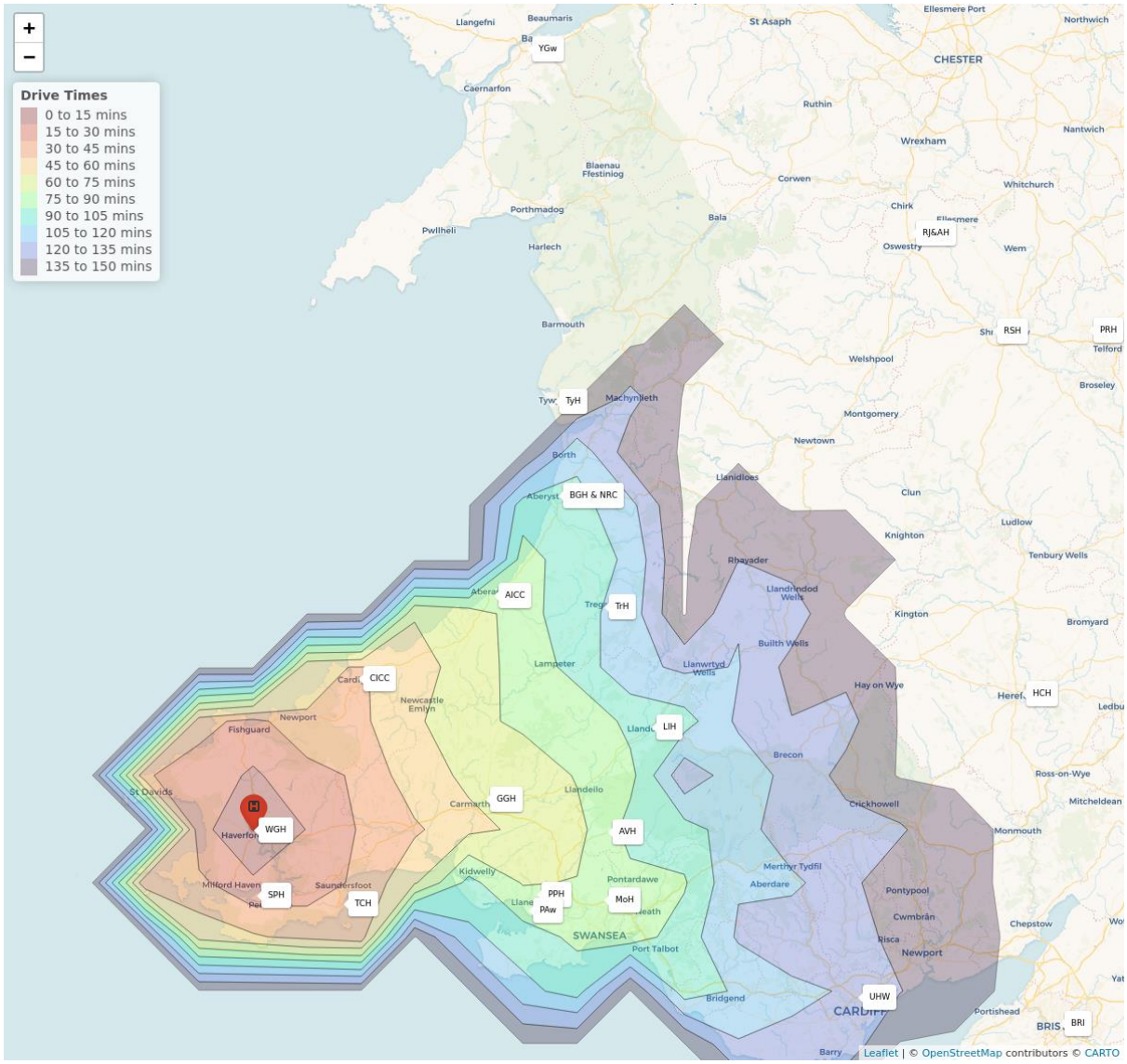
Glangwili Hospital



Prince Philip Hospital

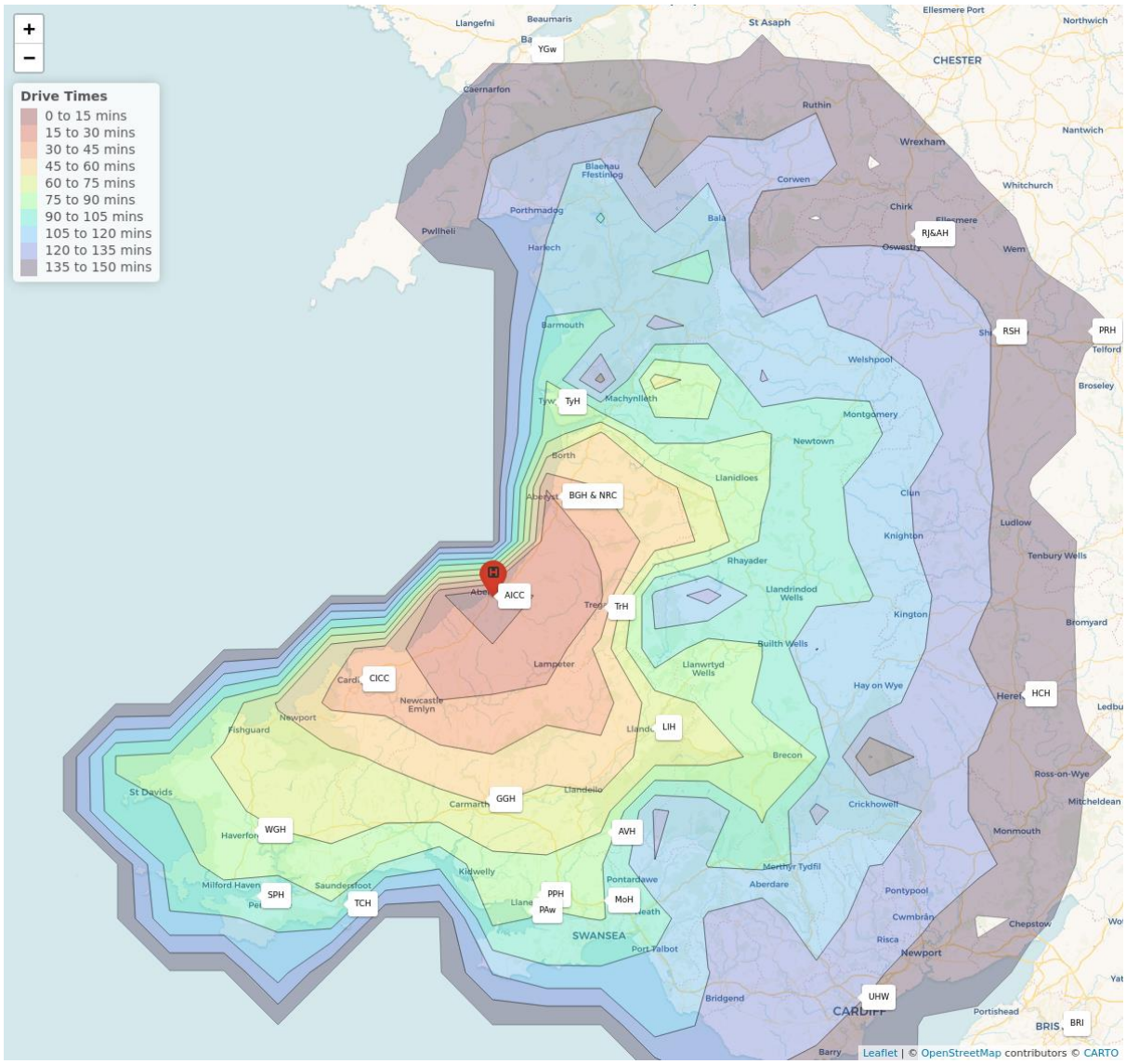


Withybush Hospital

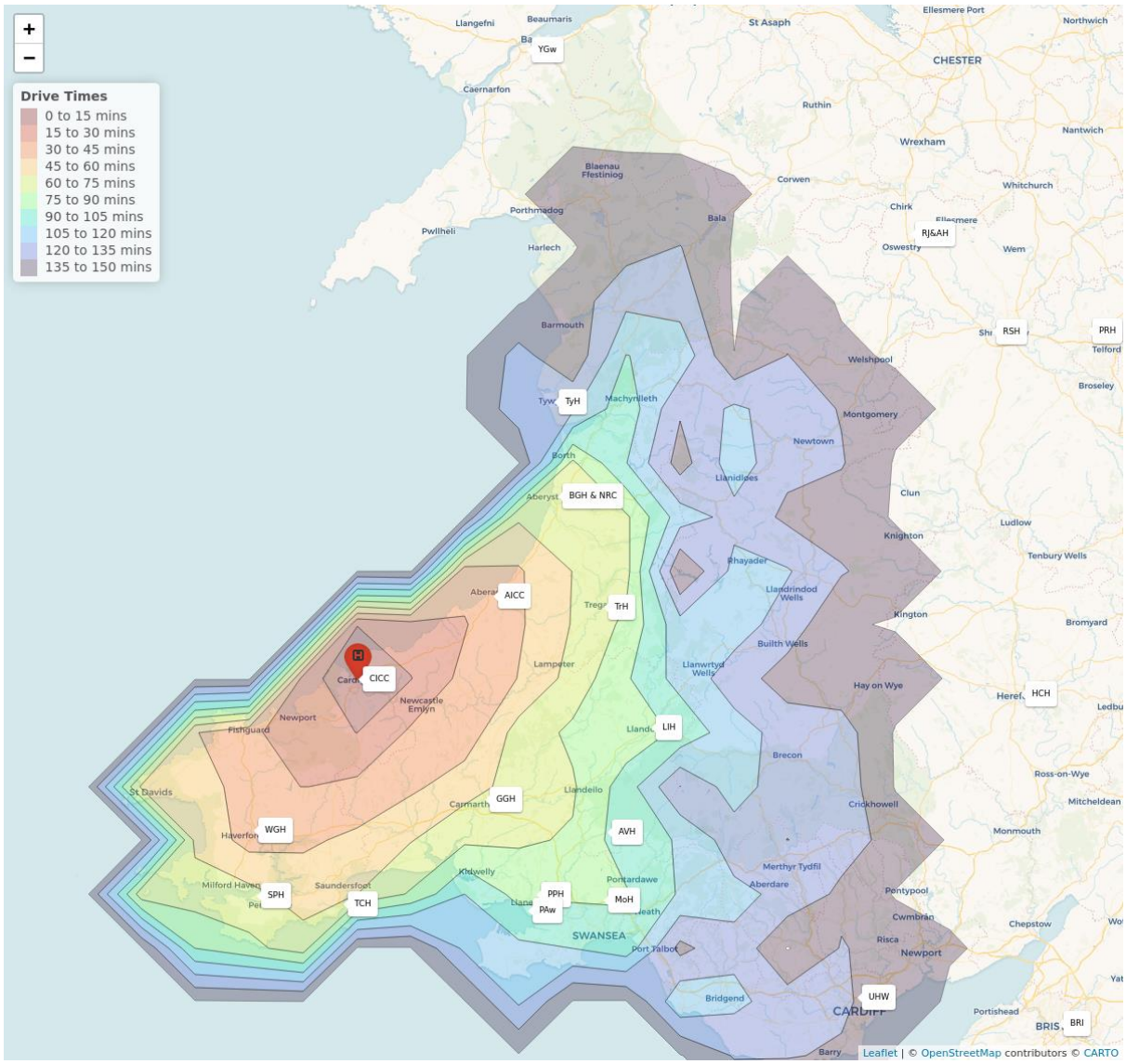


Community sites:

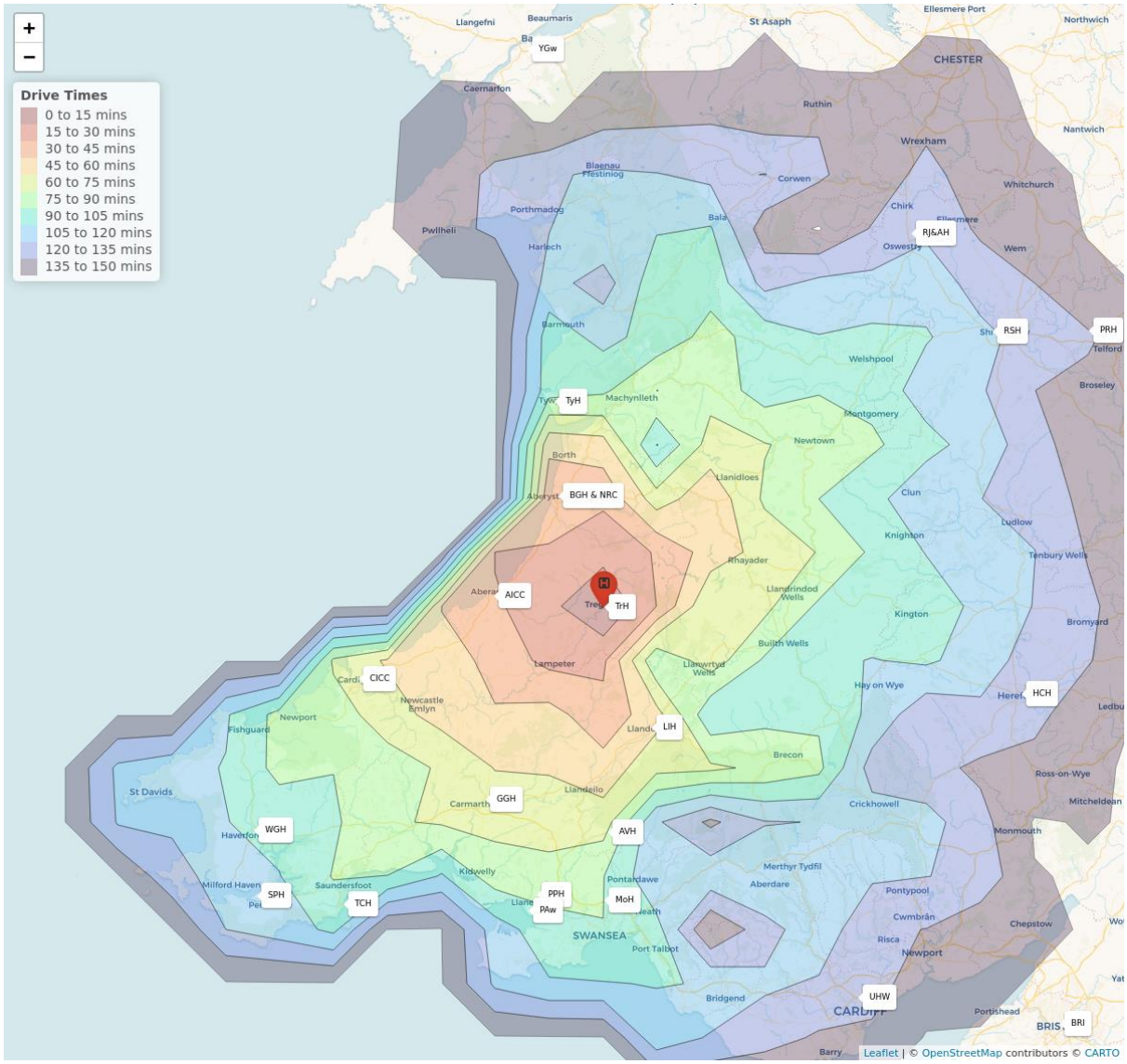
Aberaeron Integrated Care Centre



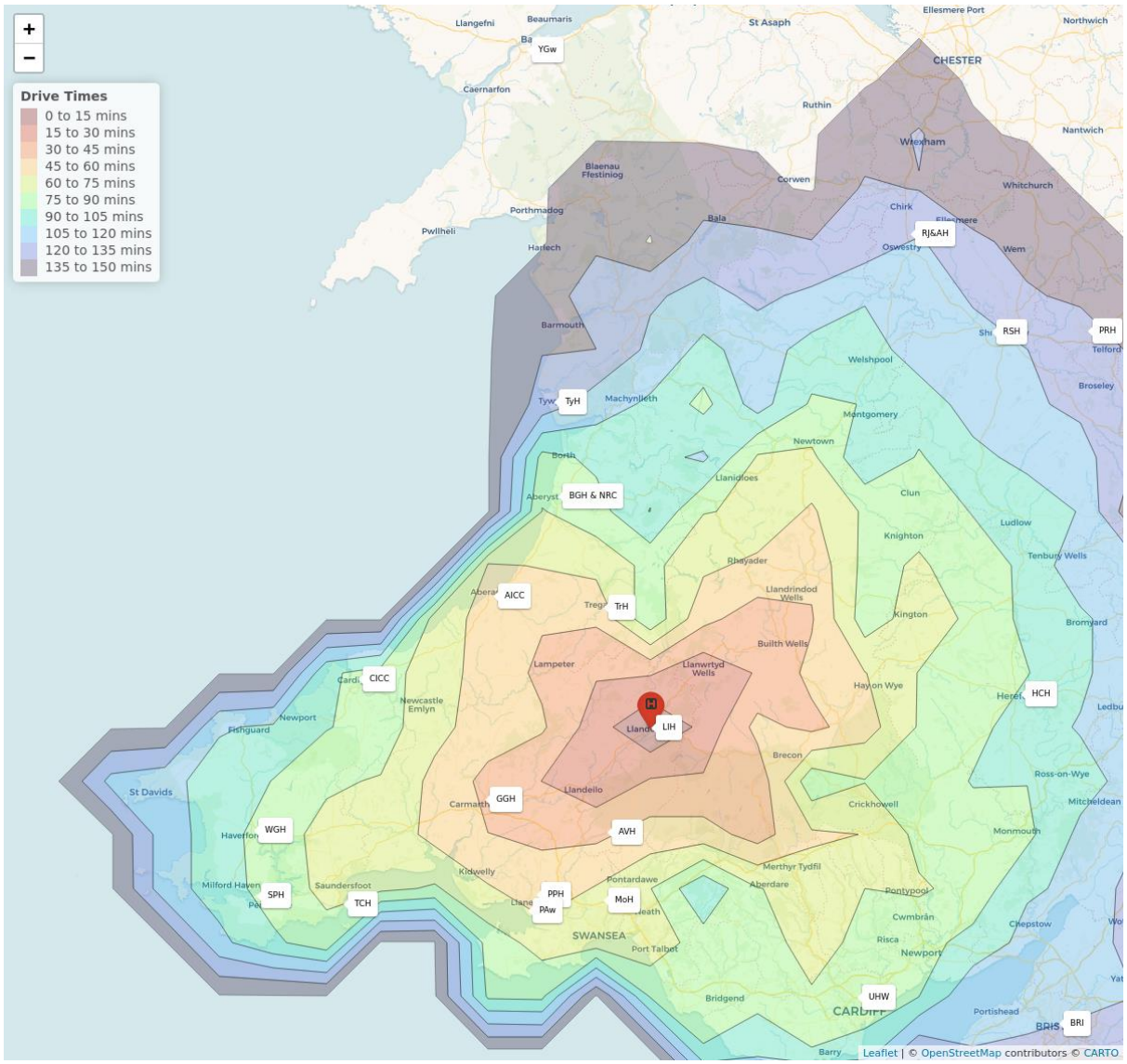
Cardigan Integrated Care Centre



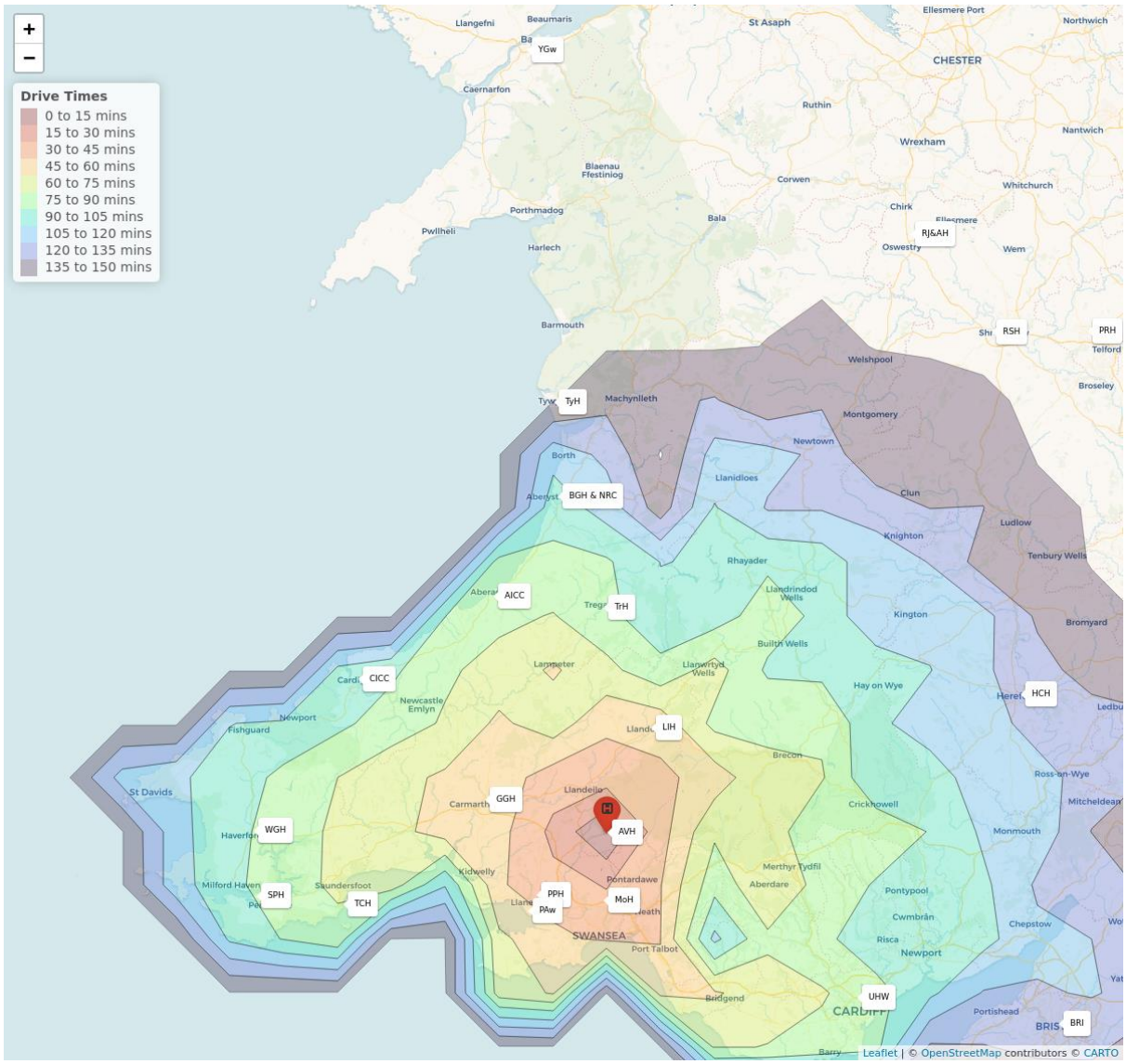
Tregaron Hospital



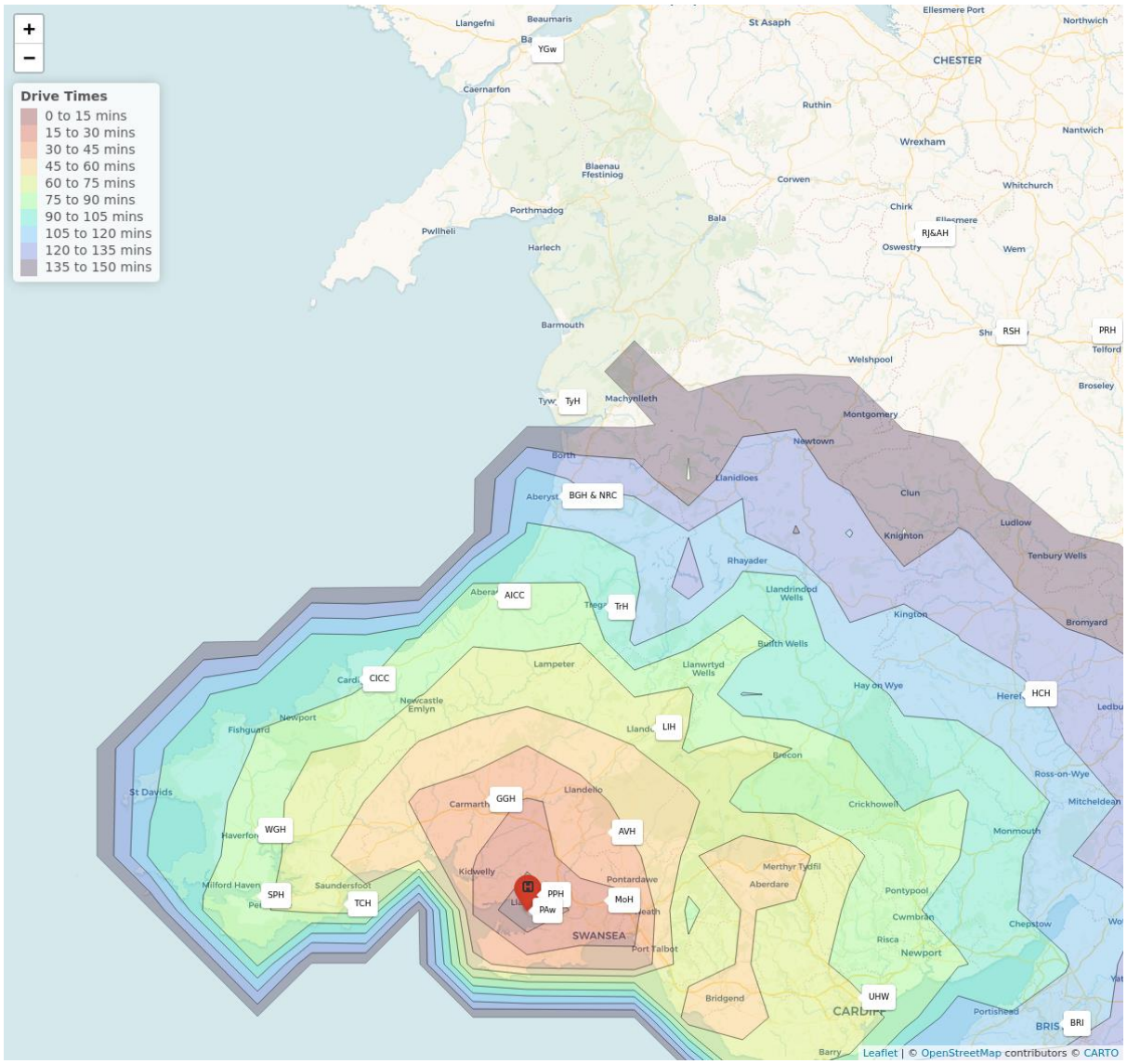
Llandovery Hospital



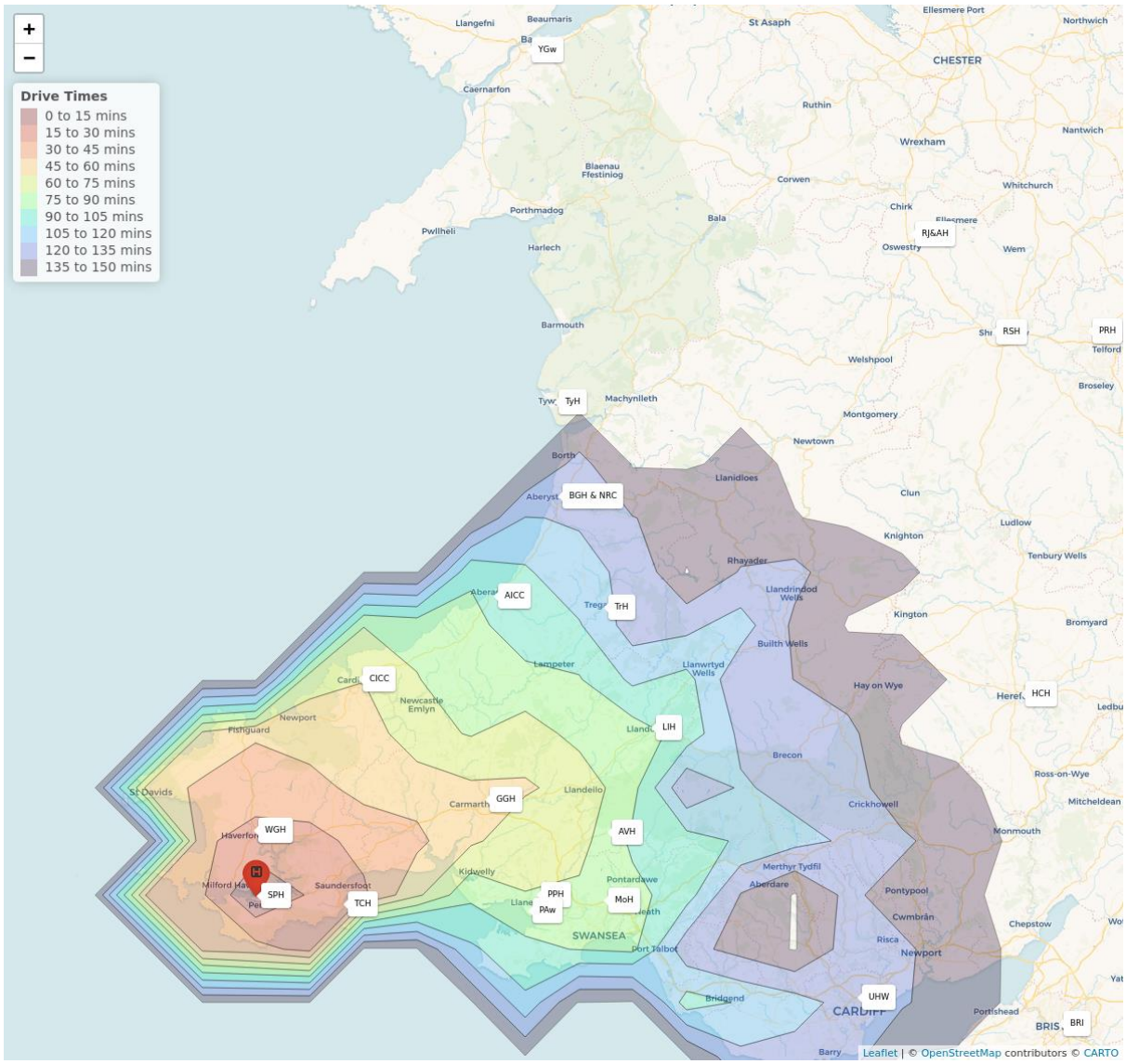
Amman Valley Hospital



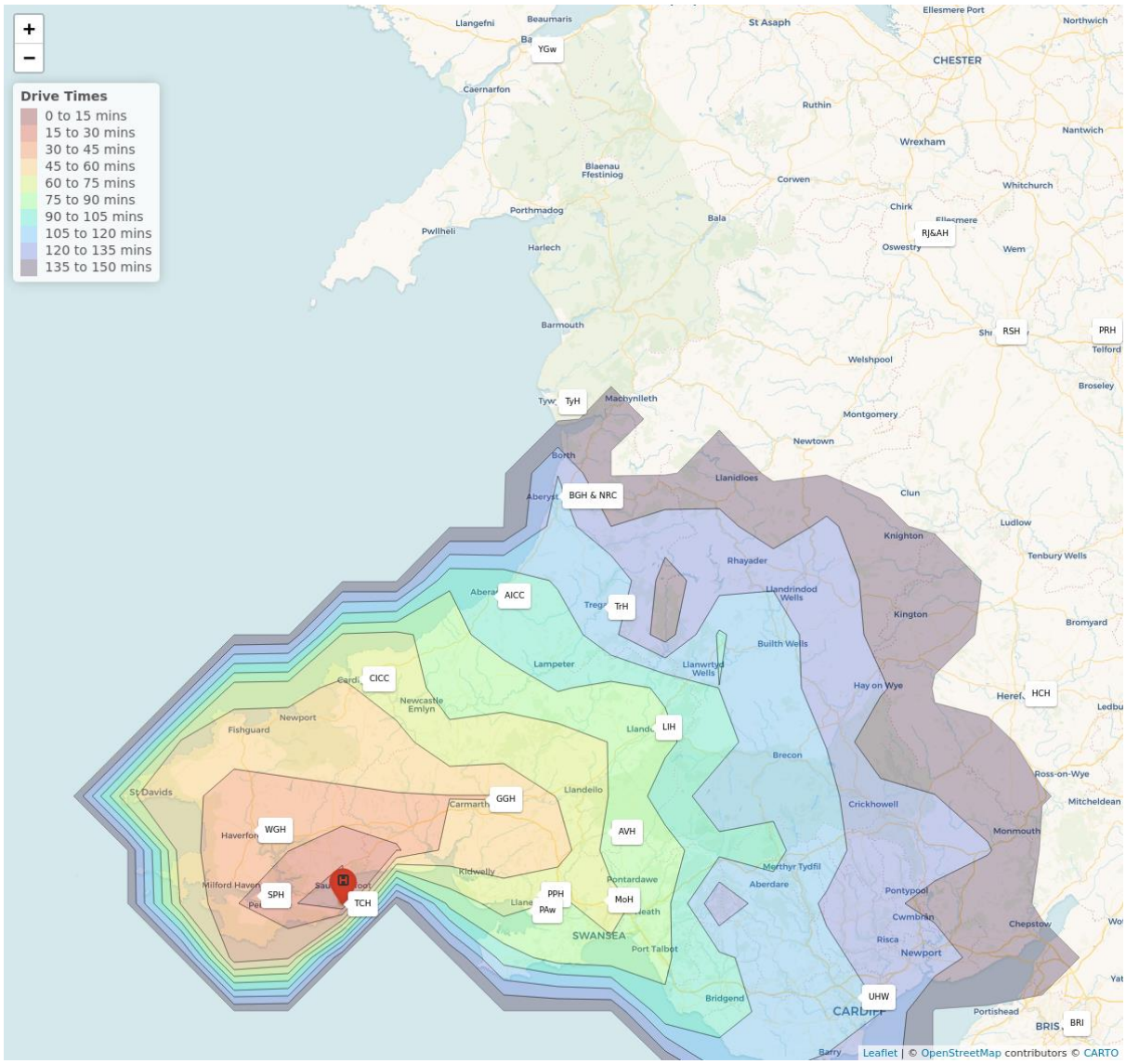
Pentre Awel


Drive Times
0 to 15 mins
15 to 30 mins
30 to 45 mins
45 to 60 mins
60 to 75 mins
75 to 90 mins
90 to 105 mins
105 to 120 mins
120 to 135 mins
135 to 150 mins
YGw
TyH
BGH & NRC
AICC
TrH
CICC
LIH
GGH
AVH
WGH
SPH
TCH
PPH
PAw
MoH
RJ&AH
RSH
PRH
HCH
UHW
BRI
SWANSEA
Llangefni
Caernarfon
Porthmadog
Barmouth
Machynlleth
Newtown
Llanidloes
Rhayader
Lampeter
Newcastle Emlyn
Fishguard
St Davids
Haverfordwest
Milford Haven
Saundersfoot
Carmarthen
Llandello
Kidwelly
Pontardawe
Port Talbot
Bridgend
Aberdare
Merthyr Tydfil
Pontypool
Cwmbran
Newport
Risca
Crickhowell
Brecon
Hay on Wye
Builth Wells
Llandrindod Wells
Knighton
Clun
Montgomery
Welshpool
Oswestry
Wrexham
Ruthin
Corwen
Bala
Harlech
Blaenau Ffestiniog
Pwllheli
Beaumaris
St Asaph
CHESTER
Ellesmere Port
Northwich
Nantwich
Whitchurch
Chirk
Ellesmere
Wem
Telford
Broseley
Ludlow
Tenbury Wells
Bromyard
Ross-on-Wye
Mitcheldean
Monmouth
Chepstow
Portishead
Barry
Leaflet | © OpenStreetMap contributors © CARTO

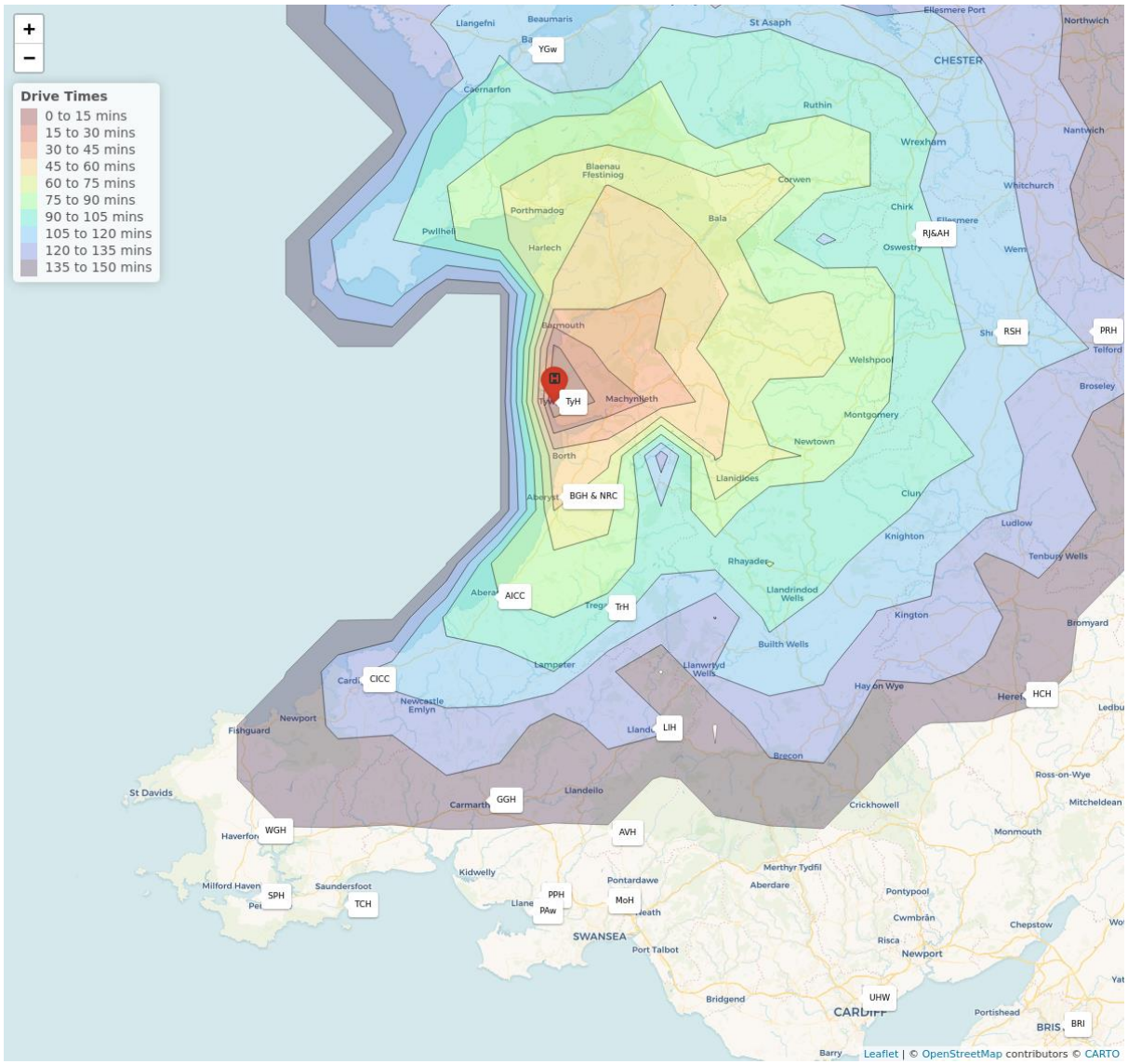
South Pembrokeshire Hospital



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.

	Amber denotes transferring site
	Purple denotes receiving site
	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**

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 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**

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
BGH	5	3	3	3	4	6	3	4	3	4	3	3
GGH	4	5	5	5	5	4	9	6	5	6	3	3
PPH	3	4	3	5	4	3	4	5	3	2	2	3
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
6	1
9	1
5	4
6	3
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
BGH	5	3	3	2	2	5	3	4	2	4	2	3
GGH	4	4	4	5	3	3	5	4	4	5	3	3
PPH	3	3	3	4	3	3	2	3	3	2	2	2
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
5	2
5	3
4	2
5	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	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
BGH	10	12	12	9	9	9	9	9	7	9	9	8
GGH	20	16	18	16	15	14	15	15	14	16	17	17
PPH	15	17	18	17	15	12	9	17	17	16	14	10
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
12	3
20	1
18	6
17	4
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
BGH	12	14	14	12	11	12	12	10	9	10	10	10
GGH	22	22	22	20	20	18	20	20	20	21	19	19
PPH	17	21	20	20	17	14	13	20	20	18	16	14
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
14	6
22	9
21	1
20	1
67	2

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
12	1
6	3
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
10	2
5	2
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
45	2
17	4
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													Max Midnight Count in Year	
	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	No Patients	Occurrences
BGH, GGH & PPH	49	57	52	51	44	39	40	47	47	47	45	41	57	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 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
GGH (4 sites combined)	9	12	10	15	12	12	13	13	9	11	11	11	

Max Midnight Count in Year

No Patients	Occurrences
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
GGH (4 sites combined)	9	9	8	13	11	11	12	10	7	8	5	10	

Max Midnight Count in Year

No Patients	Occurrences
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
BGH	10	12	12	9	9	9	9	9	7	9	9	8
GGH	20	16	18	16	15	14	15	15	14	16	17	17
PPH	15	17	18	17	15	12	9	17	17	16	14	10
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
12	3
20	1
18	6
17	4
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
BGH (Rehab only)	10	12	12	9	9	9	9	9	7	9	9	8
GGH (All sites HASU and ASU and GGH Rehab)	30	34	32	35	29	32	30	30	27	27	28	30
PPH (Rehab only)	15	17	18	17	15	12	9	17	17	16	14	10
WGH (Rehab only)	9	9	9	13	16	16	17	11	7	11	9	12

Max Midnight Count in Year

No Patients	Occurrences
12	3
35	1
18	6
17	4

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

2.4

10:45, 10 Mins

2.4 - Value Based Healthcare Update

Mark Henwood (Hywel Dda UHB - Executive Medical Director), Leighton Phillips (Hywel Dda UHB - Director Research, Innovation and Value)

For assurance

Attachments

2.4 SPC VBHC November 2025.pdf

PWYLLGOR STRATEGAETH A CHYNLLUNIO
STRATEGY AND PLANNING COMMITTEE

DYDDIAD Y CYFARFOD: DATE OF MEETING:	18 December 2025
TEITL YR ADRODDIAD: TITLE OF REPORT:	Value Based Health Care
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Mark Henwood – Executive Medical Director
SWYDDOG ADRODD: REPORTING OFFICER:	Simon Mansfield – Head of Value Based Health Care

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

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

This paper has been produced to provide the Strategy and Planning Committee (SPC) with assurance on the activity of the Value Based Health Care (VBHC) Programme, the work to refresh the Strategic Approach to VBHC and the collaboration with the Swansea University Value Based Health and Care Academy.

Cefndir / Background

Since the introduction of VBHC within Hywel Dda University Health Board (HDdUHB) in 2019, significant progress has been made through collaborating with multidisciplinary teams on Value initiatives. However, challenges remain in integrating VBHC approaches into the provision of sustainable services that truly meet the needs of our population. In response to these challenges, work is now underway to refresh the Strategic Approach to VBHC, and a collaboration has been entered into with Swansea University Value Based Health and Care Academy, to address how Value initiatives are conceptualised and delivered within HDdUHB.

Strategic Approach to VBHC

The existing Strategic Approach to VBHC covers the period from 2022-2025 and expires at the end of March 2026. A refreshed approach to VBHC is now being developed for formal publication in Quarter (Q) 1 2026/27. The process for developing the new approach to VBHC has taken into consideration the progress made under the current strategic approach as well as the national and local priorities for Value-driven services. This work has been underpinned by a comprehensive stakeholder engagement exercise, which has enabled the VBHC Team to better understand the objectives of senior decision makers throughout the organisation. A thematic review of these stakeholder sessions was undertaken, with the following summary points:

- ***There is a strong appetite for outcomes measurement:***
  Staff expect VBHC to be driven by measurable outcomes (including patient reported outcome and experience measures) and want actionable metrics.
- ***Patient-centred philosophy is understood and valued:***

Staff link this thinking to operational realities such as pathways, teams, and coordination, rather than abstract rhetoric.

- ***Data/IT is a bottleneck:***
  Our staff want Patient Reported Outcome Measures (PROM) dashboards, integrated records, and clearer data flows to make outcomes measurement meaningful.
- ***Operational constraints (capacity, waiting lists, time) are real:***
  These issues threaten the impact of the VBHC Programme since meaningful change is dependent upon operational engagement and support.
- ***Multidisciplinary working and pathways:***
  These are considered essential levers to deliver VBHC but require standardisation and shared governance.
- ***Finance is a priority:***
  There is interest in aligning incentives, but uncertainty around the practical commissioning and delivery models.

Collaboration agreement with Swansea University
A Global Learning Needs Assessment (GLNA) was undertaken by the Value Based Health and Care Academy at Swansea University to evaluate the current levels of interest, confidence, and opportunities for learning across key areas of VBHC practice and policy with the intention of informing future education provision. HDdUHB commissioned Swansea University to produce an organisational specific report from the HDdUHB respondents. The report highlighted the need for education, training, and additional experience within the VBHC field.

Following this assessment, a collaboration agreement was developed between Swansea University and HDdUHB to create bespoke learning opportunities and to deliver these within the current financial year.

1. ***Regional Procurement and non-pay opportunities***
2. ***Building Better Cases for Change***
3. ***VBHC Master classes***

Asesiad / Assessment

The work of the VBHC Programme during 2024/25 has included the transition to a new digital PROM solution, enabling the continued collection of large volumes of digital PROM data and the onward use of this data clinically, operationally and nationally.

The VBHC Rapid Value programme has worked on 36 different projects, identifying the waste inherent in our systems and assisting teams in eliminating it. During Financial Year (FY) 2025/26, the Rapid Value Programme has identified opportunities for productivity gains of £3.274m and cash releasing gains of £4.298m. The projects that have been undertaken include:

- Biosimilar drug switches
- First contact practitioners in Primary Care
- Perioperative Urology Project
- Gloves off campaign
- Pathology d-dimer testing
- Porth Preseli
- Acute Kidney Injury education and prevention of disease progression

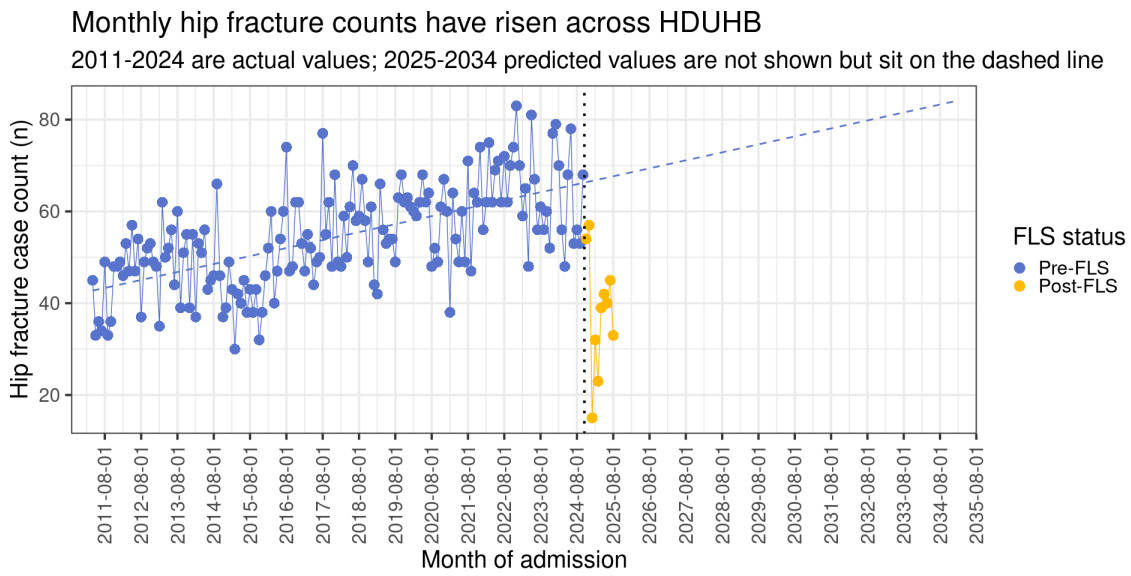
- Mental Health and Learning Disabilities

The core VBHC Programme has focused activities on national, high value, high impact areas alongside locally identified priorities. Included below are selected updates from Bone Health and Respiratory Services.

Bone Health

The VBHC Programme provided fixed term support to initiate a comprehensive Fracture Liaison Service. This service focuses on the identification and treatment of patients at risk of fragility fractures, and through appropriate treatment, can reduce the number of patients presenting with fractures as a result of osteoporosis. The cost of implementing this service is £351k per annum with expected reductions in length of stay for hip fractures alone of £732k per annum. The service is temporarily funded through the Value Delivery Fund until September 2026 and is being taken forward for consideration for substantive Health Board funding through the next planning cycle.

The impact of the Fracture Liaison Service is illustrated in the run chart below. This shows a marked and statistically significant reduction in the number of monthly hip fractures recorded across the Health Board. This reduction in activity is set against the expected rise in numbers of hip fractures, driven by an ageing population.



The following table shows the monthly rates of hip fractures and compares this to the predicted number. This indicates that every month we expect to avoid 24 hip fractures. Data from the 2023 National Hip Fracture Database shows that the average length of stay for hip fracture patients in HDdUHB is over 28.5 days. This provides an estimated avoidance of approximately 676 bed days per month.

HDUHB			
Month	Post FLS		
	Actual	Predicted	Averted
2024-11	54	66.4	12.4
2024-12	57	66.5	9.5
2025-01	15 (NA)	66.6	NA
2025-02	32 (NA)	66.8	NA
2025-03	23	66.9	43.9
2025-04	39	67.1	28.1
2025-05	42	67.2	25.2
2025-06	40	67.4	27.4
2025-07	45	67.5	22.5
2025-08	33 (NA)	67.7	NA
2025-09		67.8	
2025-10		67.9	
Total Averted Hip Fractures (over 7 months):			169

Hip fracture in Wales -- NHFD data for 2023 in the Royal Osteoporosis Society calculator

https://theros.org.uk/healthcare-professionals/clinical-quality-hub/clinical-quality-toolkits/hip-fractures/

		Total hip #	Mean LOS	Bed days	Total beds	Cost (£ million/yr)	
Hywel Dda	*BRG*	**119**	23.3	5,249	**14**	1.5	
	WYB	**284**	36.6	7,871	**22**	2.6	
	WWG	**352**	28.3	12,625	**35**	4.7	**8.9**
All Wales		**4,328.00**	**32.0**	**172,155**	**471**		**63.7**

In addition to the national priority areas, the VBHC Team has also provided input into locally prioritised services such as Respiratory. During 2025, the VBHC Team have worked in collaboration with the Obstructive Sleep Apnoea service to review how the pathways work and the efficiency gains that could be realised through remote monitoring of Continuous Positive Airway Pressure (CPAP) patients.

The initial time and motion studies and audits showed that clinical physiologists currently spend 47% of their time on CPAP follow-ups, with follow-up patients experiencing delays of up to two months on electronic databases and even longer for those managed on paper systems. The service is heavily reliant on patient-initiated contact, resulting in high call volumes — 81% of which require a callback.

To address these challenges, the VBHC Team is supporting the service to redesign the pathway, with the goal of improving governance, access, equity, and workforce sustainability. A key component of this transformation is upgrading existing CPAP devices with modems to enable remote monitoring. This allows real-time data transfer to clinicians, supporting earlier intervention, reducing the need for face-to-face appointments, and improving patient outcomes.

Process mapping has identified significant low-value activity and unwarranted variation across the four hospital sites in the current Sleep Apnoea pathway. The redesigned pathway provides a consistent approach across all four sites, reducing variation and standardising processes and documentation. Remote monitoring has enabled this transformation, creating a high-value pathway that reduces the need for face-to-face appointments for post-setup reviews of new patients and for routine one-year and three-year follow-ups for established patients.

These changes will provide a more responsive and effective service for patients and will release 80 hours per week of physiologist time, which can be redirected to diagnostics, virtual monitoring, and virtual reviews. This equates to 2.13 WTE Band 6 physiologists and an annual productivity gain of £112.770k.

Strategic Approach to Value Based Health Care
Following an assessment of the outputs from the stakeholder engagement exercise, the refreshed Strategic Approach to VBHC must consider the following elements:

- ***Governance and planning***
    - The publication of the revised Strategic Approach to Value Based Health Care will be completed in Q1 2026/27
    - Prior to publication, the Strategic Approach will be presented to the Value Leadership Group, the Value and Sustainability Group, the Executive Team and will be presented for formal approval to the Strategy and Planning Committee.

- ***Vision***
  The vision for the VBHC Strategic Approach should describe the future state of VBHC within HDdUHB in 2030. The vision should ensure that the following elements are included:
    - Value should be integral to all that we do rather than being seen as an additional component.
    - The voice of our population is the ‘golden thread’ that should inform all our choices in evaluating and developing services.
    - Our vision should consider the wider determinants of health and wellbeing by working closely with all parts of our system and with other systems and communities.
    - We must ensure that VBHC allows us to provide positive impact for our population.

  Taking this into account, the formative vision statement is as follows:

“Value will be integral to all that we do, using the voice of our population to inform the choices that we make in all parts of our system, leading to a positive impact in the ways that we provide healthcare.”

- ***Goals/Priorities***
  The delivery of the vision will be supported by three primary goals:

    - ***Impact*** – ‘from insight to impact’

- Our Value-driven approach will enable us to demonstrably transform services by focusing scarce resources on the things that make a difference, and are of importance to our population, our organisation and nation. Our engagement and communications will ensure that our population understands how to engage with us and the difference that their voice can have in improving their lives. Insight alone is not enough; we must strive to use this insight to make a real difference.

- ***Embedded*** – 'from peripheral to core'
  - For VBHC to become a core part of all that we do, our work must be planned from the outset rather than as a series of opportunistic and disconnected projects. The VBHC Programme must integrate with the Clinical Services Plan (CSP), Clinical Care Groups (CCGs) and with colleagues from across the Health Board to fully understand, and respond to, the priorities of the organisation. In working more closely with the structure of the organisation, the work of the VBHC Team will be completely aligned with core activities.

- ***System-wide*** – 'from condition to life course'
  - VBHC seeks to understand the outcomes and goals that are important to an individual. In achieving this, it is increasingly important to consider the life course of individuals rather than seeing people through the lens of their presenting condition. There is also significant focus on the prevention agenda and the 'shift left'. This objective is best served by a more coherent approach that takes into consideration the choices that are made in Primary and Community Care, in Secondary Care as well as working with Local Authorities, third sector organisations, individuals and communities.

- ***What the VBHC Team can do***
  The goals described above, are supported by the activities of the Value Based Health Care Team:
  - Identify and eliminate waste that does not contribute to improved population outcomes.
  - Engage with the planning of services to support a value-driven approach, using reductions in low value activities to support programmatic investments in higher value activity without requiring additional long-term funding.
  - Collect PROM and resource usage data.
  - Work with digital colleagues to analyse and operationalise data.
  - Ensure that PROM and PREM data is provided to colleagues in a meaningful way, supporting clinical interactions and service evaluation and development.
  - Work at a planning stage with primary and community care colleagues and with other agencies to support the shift to a preventative, wellness first model.
  - Engage with patients and advocates to ensure that the voice of our population is placed at the centre of our decision-making processes.
  - Support the acceleration of prioritised projects through Advanced Practitioner Programmes, providing education and a network of support for operational teams.

Collaboration with Swansea University

Regional Procurement and non-pay opportunities

The aim of this course is to provide senior finance and procurement colleagues from HDdUHB and Swansea Bay University Health Board (SBUHB) with insights into Value-Based Procurement (VBP) and a practical worked example on a regional basis. This course was planned to be completed over seven virtual sessions, each two hours in duration, followed by an all-day workshop, to include specific education on VBP and the development of proposals for joint initiatives.

The first phase of this initiative has been completed. The "Principles of VBHC" courses ran between 13 October and 10 November 2025. All participants from both HDdUHB and SBUHB are now working together on a regional procurement project to be undertaken in early 2026. A further session, facilitated by Alan Brace OBE, was undertaken on 14 November 2025 to discuss non-pay and other matters of mutual interest.

Building Better Cases for Change

The development of building better cases for change remains a key objective to ensure that the Value Based approach has impact. In delivering this objective, a round table discussion has been undertaken with senior colleagues from HDdUHB to form an approach to the development of sustainable cases for change through the lens of Value. The topics for discussion included the following:

- The Value of a VBHC approach.
- Understanding the population needs.
- Social needs.
- The move out of secondary care.
- Move away from traditional targets and metrics.
- Understanding the sustainability of the project.
- Understand the projected growth in demand.
- How to contain demand.

Further action orientated workshops are now being planned for each of the CCGs to help identify the prioritised areas for consideration and the development of programmes of work, that are Value-Based and ultimately sustainable.

VBHC Master classes

The last objective is the development of Value Based Health Care Masterclasses, which are being developed following a learning needs assessment process. These masterclasses will be developed as 10 one-hour webinars and the first session has already been developed with the remaining sessions well progressed. Delivery of these sessions will commence at the beginning of 2026 with the plan to deliver one per month during the year.

Argymhelliad / Recommendation

The Strategy and Planning Committee is asked to:

- **RECEIVE ASSURANCE** on progress in refreshing the Strategic Approach to Value Based Health Care and its alignment with the Health Board's strategic priorities; and
- **PROVIDE FEEDBACK** to inform the finalisation of the refreshed VBHC Strategic Approach prior to submission for Board approval.

Amcanion: (rhaid cwblhau)
Objectives: (must be completed)

Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	3.1.9. Seek assurance on the delivery of Value Based Healthcare (VBHC) strategic plans and programmes.
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Not applicable
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	7. All apply
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	6. All Apply
Amcanion Strategol y BIP: UHB Strategic Objectives:	All Strategic Objectives are applicable
Amcanion Cynllunio Planning Objectives	All Planning Objectives Apply
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022	9. All HDdUHB Well-being Objectives apply

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Hywel Dda University Health Board - “Our Approach to Value Based Health Care – 2022-2025"
Rhestr Termau: Glossary of Terms:	Included within the body of the report.
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Strategaeth a Chynllunio Parties / Committees consulted prior to Strategy and Planning Committee:	Value Leadership Group. Stakeholder engagement exercise undertaken during September and October 2025.

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	Welsh Government funding of the HDdUHB Value Based Health Care Programme and the accountability for driving Value centred change.

Ansawdd / Gofal Claf: **Quality / Patient Care:**	VBHC is designed to improve outcomes and the use of resources in delivering them. It is also driven by prudent healthcare principles drive the delivery of equitable services across the Health Board.
Gweithlu: **Workforce:**	None
Risg: **Risk:**	None
Cyfreithiol: **Legal:**	None
Enw Da: **Reputational:**	None
Gyfrinachedd: **Privacy:**	Privacy Impact Assessment has been completed for PROM and PREM capture as part of the VBHC Programme.
Cydraddoldeb: **Equality:**	Equality Impact Assessment completed.

2.5

10:55, 10 Mins

2.5 - Planning in Partnership: Regional Integration Fund Update

Andrew Carruthers (Hywel Dda UHB - Chief Operating Officer), Linda Jones

For information

Attachments

2.5 3SPC SBAR RPB Update report.pdf

PWYLLGOR STRATEGAETH A CHYNLLUNIO
STRATEGY AND PLANNING COMMITTEE

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	18 December 2025
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Regional Integration Fund Future Funding Update
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Andrew Carruthers
SWYDDOG ADRODD: **REPORTING OFFICER:**	Linda Jones

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Er Gwybodaeth/For Information

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The Regional Integration Fund (RIF) operates from April 2022 to March 2027, supporting innovative, integrated health and social care across Wales. As the RIF period concludes, there is no confirmed grant funding for projects post-2027. There have been several discussions with the Partnership and Integration Team (P&I) in Welsh Government (WG), and an option paper will be presented by the WG P&I Team through the appropriate governance. What is clear is that the future direction is towards an Integrated Community Care System (ICCS) and any funding will be to build and develop this.

Although we do not have firm commitment as to the detail of future funding, from discussions with WG we are basing our planning on two assumptions:

1. That future funding will be for building on the work of the current Models of Care to further develop ICCS
2. That the funding will be utilised to resource both the 50:50 ‘mainstreaming’ element of current RIF portfolio and projects and any future projects to develop ICCS. Therefore, if the majority of funding is used to maintain existing projects, there will be limited resources to develop services to meet the needs of the population and the challenges identified in both the Market Stability Report and the Population Needs Assessment.

In light of the above, the West Wales Regional Partnership Board (WWRPB) has established a structured Future Funding Process to ensure robust governance, manage transitions, and minimise risks to services, staff, and finances. The process has been agreed at Integrated Executive Group (IEG) /RPB and is designed to:

- Ensure we adequately plan for the end of RIF and prepare for any subsequent funding
- Provide an objective and transparent process which can be consistently applied across the region
- Provide stakeholders with the information required to support future funding decisions, supporting a regional strategic direction for ICCS.

- Enable partners and programme leads to make timely planning decisions for those projects (and accompanying staff) that will not be part of our future portfolio.
- Manage Project / Programme Lead expectations

The process is structured around four key "Gateways," each with specific requirements and decision points. The WWRPB team have undertaken a number of workshops and briefing sessions with project/programme leads and key personnel to work through this process, as well as drop-in sessions and individual support. This will continue throughout the process.

	Purpose	Approach	Outcome
Gateway 1	Adherence to the Welsh Government's Checklist	1. Regional Review panel	▪ Projects deemed as meeting the WG criteria will progress to subse process gateways ▪ Projects failing to meet criteria will no longer be eligible for WG Fu
Gateway 2	Integration, Staffing, Right Sizing & Strategic fit in Region	1. Project prepare Gateway review pack. 2. Regional / County Stakeholder panel (budget holders)	▪ Compatibility with other services ▪ Addresses the requirements of our community ▪ Staffing structures and agreements ▪ Project can show that resource levels correspond to demand ▪ Project is considered to align with the Regional and system's visior
Business Case Preparation	Business Case & benefits Preparation	1. Project Team prepare Business case in preparation for Gateway 3	A comprehensive business case is prepared covering: ▪ Return on investment / Value for money ▪ Dependencies on other systems ▪ Regional and long-term activity strategy ▪ Plan for sustainability
Gateway 3	Business Case Review	1. Regional / County stakeholder business case review	▪ Projects have presented business case ▪ Stakeholders understand the investment required and the associa case
Gateway 4	Future Funding Review	1. Regional / County stakeholder funding review	Stakeholders need to agree on one of the following: ▪ Projects which can be taken into core funding, including the fundi ▪ Projects applying for continued WG funding (Mainstreaming), incl source of match funding ▪ Projects no longer supported and to be ceased

Gateway 1: Welsh Government Eligibility

- Projects are assessed against the WG's eligibility checklist, covering Population Level, Operational Level, Continuation of Funding, and Additional Questions.
- Projects will be assessed by a panel made up of all partners and an independent person.
- Only projects meeting the criteria progress to the next stage.

Gateway 2: Integration, Staffing, Strategic Fit

- Focuses on how well projects align with regional strategies, population needs, and demand/capacity.
- Assesses integration, right-sizing, and strategic fit within the region.

Gateway 3: Business Case Review

- Projects prepare a comprehensive business case, including return on investment, value for money, dependencies, sustainability, and population outcomes.

Gateway 4: Future Funding Review

- Final review by leaders and budget holders.
- Panel will be made up from senior partners/exec and financial decision makers.
- Projects are either approved for core funding, put forward for WG mainstreaming funding (requiring 50% match funding), or removed from the portfolio.

The submission date for Gateway 1 is 31 October 2025 and the Panel was held.14t November 2025. A full update report will be presented to Integrated executive Group on 5 December 2025.

Cefndir / Background

This Future Funding Process was agreed to enable clear strategic and financial decision making to support the transition from RIF to future funding and the development of Integrated Community Care Services.

Asesiad / Assessment

The current RIF portfolio consists of almost £19m invested across the six Models of Care and the ring-fenced projects (e.g. Dementia). Within those projects, 363 FTE staff are funded through RIF, including 132 FTE employed through RIF by the Health Board. It is important to note that there are on-going discussions between the RPB's and WG as to how any redundancy costs that may be incurred through RIF ending or a project being discontinued could be met - and whether RIF (or any future funding) would contribute at all to this. The need to effectively plan is one of the major drivers of this process as we go into the last 18 months of funding. One of the main outcomes of this process should be that as a region we have a clear understanding of our resources and services and how this matches the demand and challenges that the Population Needs Assessment and the Market Stability Report are evidencing, many of which will need a clear strategic vision and partnership approach to resolve

Argymhelliad / Recommendation

The Committee is asked to:

- **NOTE** the West Wales Regional Partnership Board Update Report.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	3.1.3. That, wherever possible, Health Board plans are aligned with partnership plans developed with Joint Committees, Local Authorities, Universities, Collaboratives, Alliances and other key partners, such as the Transformation Group who form part of A Regional Collaboration for Health (ARCH). 3.1.6. Consider the development of strategies and plans developed in partnership with key strategic partners and monitor work undertaken with partner organisations and stakeholders to influence the provision of services to meet current and future population need.
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Not Applicable
Parthau Ansawdd: Domains of Quality	Not Applicable

Quality and Engagement Act (sharepoint.com)	
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	Not Applicable
Amcanion Strategol y BIP: UHB Strategic Objectives:	2. Healthier communities
Amcanion Cynllunio Planning Objectives	Not Applicable
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022	9. All HDdUHB Well-being Objectives apply

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Not Applicable
Rhestr Termau: Glossary of Terms:	Not Applicable
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Strategaeth a Chynllunio Parties / Committees consulted prior to Strategy and Planning Committee:	Integrated Executive Group Regional Partnership Board

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	Not Applicable
Ansawdd / Gofal Claf: Quality / Patient Care:	Not Applicable
Gweithlu: Workforce:	Not Applicable

Risg: **Risk:**	Not Applicable
Cyfreithiol: **Legal:**	Not Applicable
Enw Da: **Reputational:**	Not Applicable
Gyfrinachedd: **Privacy:**	Not Applicable
Cydraddoldeb: **Equality:**	Not Applicable

3

11:05, 10 Mins

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3 - BREAK

4

11:15, 0 Mins

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4 - Population Health, Primary and Community

4.1

11:15, 20 Mins

4.1 - Planning Objective 10: Population Health

Ardiana Gjini (Hywel Dda UHB - Executive Director of Public Health), Trina Nealon (Hywel Dda UHB - Head of Population Health + Wellbeing / Principal Public Health Officer)

Including:
Social Model for Health and Wellbeing
Population Health Needs Assessment
Health Inequalities

For assurance

Attachments

4.1 SPC 18.12.2025 SBAR Planning Objective 10.pdf

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

PWYLLGOR STRATEGAETH A CHYNLLUNIO
STRATEGY AND PLANNING COMMITTEE

DYDDIAD Y CYFARFOD: DATE OF MEETING:	18 December 2025
TEITL YR ADRODDIAD: TITLE OF REPORT:	Planning Objective 10: Population Health
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Dr Ardiana Gjini, Executive Director of Public Health
SWYDDOG ADRODD: REPORTING OFFICER:	Trina Nealon, Principal Public Health Practitioner, Interim Health Improvement Service co-lead

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

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

Hywel Dda University Health Board (HDdUHB) is committed to population health improvement with a strong commitment to prevention, aiming to reduce avoidable illness, lessen the strain on Urgent and Emergency Care (UEC), and support healthier communities throughout Mid and West Wales.

The Health Board's Annual Plan 2025-2026, 'Population Health: Planning Objective 10' aligns local objectives with Ministerial Priorities to continue to make prevention everyone's business from hospital specialists to community volunteers. This approach involves closer collaboration between healthcare services, Local Authorities, the third sector, and the HDdUHB population.

Fundamental to this whole-system change, and recognising the importance of inequalities in health, is a change from a medical to a social model of health. Underpinning this approach is the Health Board's commitment to a Social Model of Health and Well-being (SMfHW), supported by the implementation of the 20four7 model.

These prevention frameworks are influenced by data evidence and intelligence provided in West Wales Regional Partnership Board (RPB) Population Needs Assessments (PNAs) and Public Service Board's (PSBs) Assessments of Well-being.

This report provides an update on the delivery of a SMfHW and the current progress of 20four7. Additionally, an update on the progress and next steps for the mid-term refresh of the RPB PNA is included.

Cefndir / Background

Population health improvement is driven by a combination of systemic, social, cultural and clinical factors. These key drivers include addressing the Social Determinants of Health such as housing, education, employment, transportation and food security and require multisector collaboration (healthcare, social services, education, housing) to tackle root causes of ill health and promote health equity and inclusion.

Data and analytics, community engagement and partnerships, workforce well-being, preventative and co-ordinated care supported by policy and governance structures are fundamental to reducing disparities in access and outcomes, central to modern population health strategies.

Underpinning the Health Boards commitment to preventative planning actions, and building upon the long-term strategy, two key models are central to providing the framework for health improvement. These are:

- Embedding a SMfHW
- Implementing the 20four7 model

The 20four7 model aims to support and empower clinicians, managers and staff to embed prevention-based healthcare into the centre of their day-to-day work. The impact will be improved population health outcomes and a more resilient regional health system. This will be achieved through more equitable access to services and a reduction in avoidable demand for services.

This model aims for people to stay well for longer, to reduce avoidable demand and to use Health Board resources prudently. They are reflected in the key aims of the Health Board's Strategy refresh and aligned to the NHS Wales Planning Framework's (2025-2028) focus on more prevention, earlier help, and better outcomes for everyone.

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For both models, evidence of population need provides the basis for delivery. The requirement to produce a joint Local Authority and Health Board PNA originates from Section 14 of the Social Services and Wellbeing (Wales) Act to work together jointly to assess:

- The extent of the care and support needs of the local population
- The extent of support needs for carers
- The extent to which those needs are being met
- The range and level of services needed to meet the care and support needs identified
- The range and level of preventative services needed

The current PNA is being refreshed as part of a mid-term review.

All PSBs are required to produce an Assessment of Local Well-being once every five years under the Well-being of Future Generations (Wales) Act 2015. Work to update the current assessments will begin in 2026 for publication in 2027.

Asesiad / Assessment

Social Model for Health and Wellbeing

A Definition, Principles and Delivery Plan have been agreed by the SMfHW Steering Group, chaired by the Executive Director of Public Health, with membership including the Deputy Future Generations Commissioner, Public Health Wales, Local Authority and Voluntary Sector representation. Key leaders and representatives pledged their commitment to the Principles by signing the SMfHW Charter at a Summit Event in March 2025 which was attended by Professor Sir Michael Marmot.

Progress has been made across all six SMfHW Principals, with strong engagement from the Steering Group and regional partners. Specifically:

- Stronger governance alignment with the RPB Preventions Board, development of a dedicated webpage (as part of the RPB website).
- A Maturity Matrix, devised to help partners achieve a SMfHW, is being linked to the Well-being of Future Generation's online Progress Tracker with the recently published *Future Generations Report 2025* (Welsh Government, 2025), noting that all public organisations should work towards embedding the principles of a SMfHW.
- Four of the eleven questions as part of public consultation for the refreshed long-term strategy, included references to the principles of SMfHW.
- Increased engagement to embed a SMfHW with public and partnership events and meetings - to include PSB Delivery Groups, strengthened links with the Mental Health and Well-being Strategy, Capital Planning Team, Primary Care Model for Wales, Arts and Nature in Health and Wellbeing.
- Implementation of a Community of Practice with over 80 members. Two workshops held to date.
- Working with the Centre for Social Innovation, three key areas of focus have commenced including preparing a Business Case for a Community Health and Wellbeing Worker Programme, and work to promote nature and arts-based interventions.
- Several workstreams in place to explore volunteering programmes - aligned with Welsh Governments Volunteering Strategy 2025, aimed to increase community resilience.

20four7 and Inequalities

Addressing inequalities in health is essential to improving population health and well-being, sustaining health and care services, and ensuring that investment delivers maximum impact.

The 20four7 model has three interlinked priorities for prevention, which are intertwined with the commitment to a SMfHW. These are outlined in Figure1:

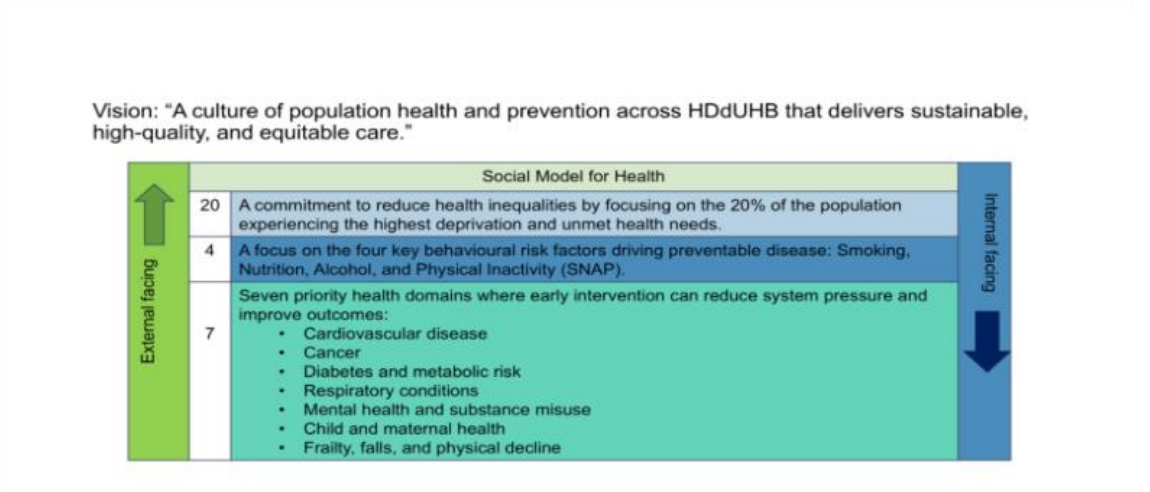


Figure 1 The 20four7 Model

The first 'pillar' of the 20four7 model focuses on equity, focusing on those most affected by avoidable ill health - the 20% most socio-economically deprived. HDdUHB serves one of Wales's most rural and ageing populations, with significant differences in health outcomes across the three counties. Premature mortality from preventable conditions such as cancer and cardiovascular disease remains highest in more deprived areas. Access to services can also be more difficult due to transport barriers, rising fuel costs, and digital exclusion, which further compound inequalities.

The 20% element of the 20four7 model has three main strands:

1. Coordinating multi-agency action
A multi-agency Health Equity Oversight Group has been established.

2. Ensuring equity in our pathways
Equity Impact Assessments (EIA) play an important role in ensuring that health equity considerations are integrated into budgeting and planning processes as they can help to identify potential disparities in health outcomes and resource allocation.

3. Equity in all we do
All services and programmes are asked to apply an 'equity lens' at the design stage. The Health Board will support teams to carry out Health Equity Audits (HEA) to examine how health determinants, access to services, and outcomes are distributed across the population. Health coaching is also being championed as part of a SMfHW, empowering patients to take an active role in their health care, leading to improved outcomes and potentially reduce health inequalities.

A 20four7 Task and Finish Group has been established with representation drawn from across the Health Board. The Group has facilitated the development of a Communication and Engagement Plan. Highlights from the plan include an initial co-production workshop session with staff to identify key tools to support the model in practice.

A dedicated Microsoft Teams Channel and intranet page will further support awareness raising and engagement in the development of the model in addition to developing a toolkit for staff to embed prevention into their roles. The work of the 20four7 Task and Finish Group is also aligned to the Executive Director of Public Health's Annual Report which is focused on the 20four7 model.

A key action undertaken includes the joint work between the Planning and Public Health Directorates to develop a 20four7 checklist and review process which will form part of the Annual Planning Cycle ahead of the next financial year.

Population Needs Assessment

The RPB publishes its PNA, on a data portal https://www.wwrpb-data.org.uk/ managed in partnership with Data Cymru, which ensures all relevant, nationally available data is refreshed automatically on receipt of updates.

Eleven chapters are included within the PNA. These include Autism; Children and Young People, Dementia, Health and Physical Disabilities, Learning Disability, Mental Health, Older People, Sensory Impairment, Substance Misuse, Unpaid Carers and Violence against Women, Domestic Abuse and Sexual Violence.

The mid-term refresh of the PNA commenced at the end of 2024, being co-produced with inputs from statutory, third and private sector partners. In addition to reflecting more current data, particularly the projections for an increase in the over 65 year old population in West Wales by 2043, this refresh includes statutory changes as requested by Welsh Government.

The updates are co-produced by the regional groups involved in transforming services, to ensure their knowledge and experience is reflected in the chapters. Groups engaged include: the Carers Development Group; Neurodiversity Improvement Board; Regional Children and

Young People's Board; Regional Improving Lives Partnership; Sensory Loss Partnership and West Wales Action for Mental Health.

Due to emerging priorities from Welsh Government and changes to the RPB Team, the timeline for completion is expected to be January 2026. Chapters will be published incrementally as they are received from translation, beginning with Dementia, Unpaid Carers and Neurodivergence.

Once work on the PNA refresh is complete, work to update the Area Plan will commence, with the aim of publishing in mid-summer.

Welsh Government has commenced consultation on the guidance for publication of the 2027 PNAs.

This progress needs to be noted in context of significant reduced capacity in senior workforce including two (/4.5 wte) consultant posts and the Head of Health Improvement Service, plus a number of other senior and middle grade vacancies in the Directorate.

Argymhelliad / Recommendation

The Committee is asked to:

REVEIVE ASSUREANCE on Quarter 2 progress for Planning Objective 10 – Population Health and the Directorate's commitment to improving population health and wellbeing through embedding prevention and reducing inequities.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	3.1.14.Seek assurance on plans, systems and processes to deliver health improvement and increase health equity and seek assurance on the work of the Health Board to reduce avoidable health inequalities.
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Not Applicable
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	5. Equitable
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	6. All Apply
Amcanion Strategol y BIP: UHB Strategic Objectives:	All Strategic Objectives are applicable

Amcanion Cynllunio Planning Objectives	10 Population health
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022	9. All HDdUHB Well-being Objectives apply

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Well-being of Future Generations (Wales) Act 2015
Rhestr Termau: Glossary of Terms:	Contained within the body of report.
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Strategaeth a Chynllunio Parties / Committees consulted prior to Strategy and Planning Committee:	**SMfHW:** HDdUHB Board Meeting 30.01.2025 Stakeholder Reference Group 13.02.2025 Formal Executive Team 23.05.2025

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	Financial planning is one of the key corporate areas of change defined under the Act.
Ansawdd / Gofal Claf: Quality / Patient Care:	Evidence of improving the well-being of the population is at the forefront of this legislation.
Gweithlu: Workforce:	Implementing the five ways of working required under the Well-being of Future Generations (Wales) Act 2015 should lead to evidence of increased collaboration and integration between services, professionals and communities
Risg: Risk:	None
Cyfreithiol: Legal:	None

Enw Da: **Reputational:**	There is a statutory requirement for HDdUHB to contribute to the work of the PSBs and relevant Wellbeing Plans. The Future Generations Report 2025 (Welsh Government) asks public bodies to work towards embedding a SMfHW
Gyfrinachedd: **Privacy:**	Not Applicable
Cydraddoldeb: **Equality:**	A More Equal Wales is a key national goal under the Act and the report highlights examples of how HDdUHB is contributing to this.

4.2

11:35, 10 Mins

4.2 - Well-being of Future Generations (Wales) Act 2015

Ardiana Gjini (Hywel Dda UHB - Executive Director of Public Health), Trina Nealon (Hywel Dda UHB - Head of Population Health + Wellbeing / Principal Public Health Officer)

Including:
Wellbeing Objectives Annual Report

For approval

Attachments

4.2.1 SPC Dec SBAR WFGA Annual Report 2024-25.pdf

4.2.2 App 1 Well-Being of Future Generations Annual Report 2024-25.pdf

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

PWYLLGOR STRATEGAETH A CHYNLLUNIO
STRATEGY AND PLANNING COMMITTEE

DYDDIAD Y CYFARFOD: DATE OF MEETING:	18 December 2025
TEITL YR ADRODDIAD: TITLE OF REPORT:	Well-being of Future Generations Annual Report 2024-2025
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Dr Ardiana Gjini, Executive Director of Public Health
SWYDDOG ADRODD: REPORTING OFFICER:	Trina Nealon, Principal Public Health Practitioner, Interim Health Improvement Service co-lead Sara Rees, Senior Public Health Practitioner

Pwrpas yr Adroddiad (dewiswch fel yn addas)
Purpose of the Report (select as appropriate)

Ar Gyfer Penderfyniad/For Decision

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The Well-being of Future Generations (Wales) Act 2015 (the Act) came into effect on 1 April 2016 with the aim of improving social, economic, environmental and cultural well-being across Wales. The Act requires NHS bodies to report on the progress they have made in meeting their well-being objectives in each financial year.

The report was approved by Staff Partnership Forum on 18 November 2025.

Strategy and Planning Committee (SPC) is asked to approve the Hywel Dda University Health Board (HDdUHB) Well-being of Future Generations Annual Report for the period 1 April 2024 – 31 March 2025.

Cefndir / Background

The Well-being of Future Generations (Wales) Act 2015 sets out a number of requirements for individual public bodies, including HDdUHB. These include a requirement for the Health Board to:

- Set and publish well-being objectives (s.3(2)(a)) and take all reasonable steps to meet those objectives (s.3(2)(b))
- Publish a statement regarding well-being objectives (s.7(1))
- Publish an Annual Report showing the progress made in meeting the organisation's objectives (s.13 (1) and Sch.1)

Guidance states that where possible, NHS bodies should seek to integrate this reporting with their requirement to publish annual reports and accounts. Whilst a 'Well-being of Future Generations (Wales) Act' (WFGA) section is included within the HDdUHB Annual Report, a detailed report of progress in meeting the Health Board's Well-being Objectives and steps taken to contribute to wider well-being goals for Wales, is specifically set out in this Report.

The Act outlines seven well-being goals which are underpinned by a 'sustainable development principle' which is reflected in 'five ways of working' and illustrated in Figure A.

Figure A: Seven Well-being Goals and Five ways of working

Source: Well-being of Future Generations (Wales) Act. 2025, Welsh Government

The Health Board developed eight Well-being Objectives in 2019 that aligned with the strategic objectives to support long-term goals as outlined in the strategy, *A Healthier Mid and West Wales: Our Future Generations Living Well* (HDdUHB, 2019). These objectives are not confined to a single national outcome and align to more than one of the seven well-being goals as outlined in the Act.

The Health Board's eight Well-being Objectives are:

1. Plan and deliver services to increase our contribution to low carbon.
2. Develop a skilled and flexible workforce to meet the changing needs of the NHS.
3. Promote the natural environment and capacity to adapt to climate change.
4. Improve population health through prevention and early intervention, supporting people to live happy and health lives.
5. Offer a diverse range of employment opportunities which support people to fulfil their potential.
6. Contribute to global well-being through developing international networks and sharing of expertise.
7. Plan and deliver services to enable people to participate in social and green solutions for health. Encourage community participation through the medium of Welsh.
8. Transform our communities through collaboration with people, communities and partners.

The Well-being objectives are aligned to four overarching themes:

- Workforce planning and development
- Collaboration, involvement, and integration
- Early intervention and prevention
- Environment and climate change

The Future Generations Report 2025 outlines the requirement for public bodies to report on their progress annually, ensuring they use both quantitative performance indicators and qualitative insights to track their impact.

Asesiad / Assessment

The attached Well-being of Future Generations Annual Report 2024-2025 (Appendix 1) provides:

- Evidence of how work delivered through HDdUHB has supported the achievement of organisational well-being objectives.
- Aligns our Well-being Objectives to a SMfHW and the 20four7 framework.
- A range of case studies illustrate how the Health Board is embedding the well-being objectives and how they link to the Act and the Future Generations Report 2025.
- Evidence of HDdUHB's work with Public Services Boards (PSBs).
- How the Health Board's Well-being Objectives align with the national well-being goals and five ways of working.

The existing HDdUHB Well-being Objectives have not been amended since 2019. While the 2024-25 Annual Report outlines progress against these existing objectives, a review of the objectives is currently underway alongside Trade Union representatives to ensure they continue to meet the goals of the Act whilst aligning to annual planning objectives, and a changing strategic context.

Argymhelliad / Recommendation

The Committee is asked to:

- **RECEIVE ASSURANCE** that the Health Board is meeting the statutory obligations of the Well-being of Future Generations (Wales) Act, 2015 in the publication of this Annual Report.
- **APPROVE** for publication Hywel Dda University Health Board's (HDdUHB) Well-being of Future Generations Annual Report for the period 1 April 2024 – 31 March 2025.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	3.1.13.Consider population health and wellbeing assessments and other key information that underpins the strategic planning process to ensure the robustness and best fit of developing plans.
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Not Applicable
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	5. Equitable
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	6. All Apply
Amcanion Strategol y BIP: UHB Strategic Objectives:	All Strategic Objectives are applicable

Amcanion Cynllunio Planning Objectives	All Planning Objectives Apply
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022	9. All HDdUHB Well-being Objectives apply

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Well-being of Future Generations (Wales) Act 2015
Rhestr Termau: Glossary of Terms:	Contained within the body of report.
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Strategaeth a Chynllunio Parties / Committees consulted prior to Strategy and Planning Committee:	Staff Partnership Forum (18 November 2025)

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	Financial planning is one of the key corporate areas of change defined under the Act.
Ansawdd / Gofal Claf: Quality / Patient Care:	Evidence of improving the well-being of the population is at the forefront of this legislation.
Gweithlu: Workforce:	Implementing the five ways of working required under the Well-being of Future Generations (Wales) Act 2015 should lead to evidence of increased collaboration and integration between services, professionals and communities
Risg: Risk:	The HDdUHB has a duty to work collaboratively to address the seven Well-being Goals for Wales. There is a risk that the need to demonstrate our progress is considered an “add on” responsibility by HDdUHB staff. Embedding the principles of the act into everyday business is therefore paramount and contributing to the project and delivery groups of Public Service Boards (PSB) needs to demonstrate the synergy with achieving the Health Board’s goals.

Cyfreithiol: **Legal:**	*The Well-being of Future Generations (Wales) Act 2015* (the Act) provides that HDdUHB (as a designated public body) must publish a Well-being Statement, Well-being Objectives and provide an Annual Report on progress towards meeting these objectives. An aim of the Act is to place communities at the heart of decision making. The public can use the Act to ensure that public bodies are taking the approach to decision making that utilises the five ways of working in line with the sustainable development principle when developing or making changes to services that impact upon them and their community. HDdUHB will need to ensure that all transformation and service change projects, including capital developments, take account of the new statutory requirements
Enw Da: **Reputational:**	There is a statutory requirement for HDdUHB to contribute to the work of the PSBs and relevant Wellbeing Plans.
Gyfrinachedd: **Privacy:**	Not Applicable
Cydraddoldeb: **Equality:**	A More Equal Wales is a key national goal under the Act and the report highlights examples of how HDdUHB is contributing to this.

Well-being of Future Generations Annual Report 2024-2025

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

Contents

Page

Foreword

I am pleased to introduce the Well-being of Future Generations Annual Report 2024 – 2025, which reflects our continued commitment to creating a healthier, fairer, and more sustainable future for the people of Mid and West Wales. This year has been marked by meaningful progress, strengthened partnerships, and a renewed focus on prevention - work that is firmly anchored in the ambitions of the Well-being of Future Generations (Wales) Act 2015.
Across our communities, staff, and partners, we have seen powerful examples of what can be achieved when we work together with a shared purpose. From expanding the Social Model for Health and Well-being (SMfHW) and embedding its principles across the region, to advancing early-intervention programmes that improve lives today while shaping better outcomes for tomorrow, the work highlighted in this report demonstrates the real impact of collective action.
As public services, we face persistent and complex challenges—including widening health inequalities, the pressures of an ageing population, and the climate and nature emergency. Yet our response has been proactive and principled on sustainability, in line with the Future Generations Act. Initiatives such as the South Carmarthenshire Rapid Access Multidisciplinary Service (SCRAMS) frailty service, culturally responsive community engagement, and innovative sustainability programmes like NappiCycle and Warp-It show how we are redesigning services around prevention, equity, and long-term value.

I am especially proud of our strengthening partnerships with Local Authorities, the voluntary sector, Public Service Boards (PSBs), and our communities themselves. Their insight and energy are essential to the transformative change we aspire to, and to ensuring that our work remains grounded in the lived realities of the people we serve.

As we look ahead, we will continue to evolve our Well-being Objectives to reflect the emerging strategic landscape and recommendations of the 2025 Future Generations Report. Our ambition remains clear: to work in partnership with other public services and our communities to create conditions in which everyone — regardless of background, geography, or circumstance — can thrive.

I would like to extend my heartfelt thanks to all our staff, partners, and community members whose dedication continues to drive this agenda forward. Together, we are building a future where prevention is central, inequalities are reduced, and well-being is improved and sustained for generations to come.

Dr Ardiana Gjini

Cyfarwyddwr Gweithredol Iechyd Cyhoeddus, Bwrdd Iechyd Prifysgol Hywel Dda

Executive Director of Public Health, Hywel Dda University Health Board

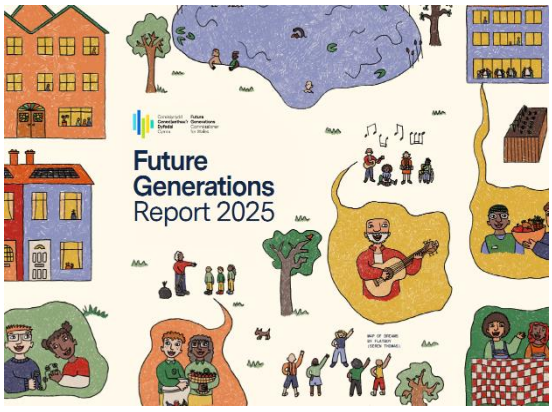
1. Introduction

Hywel Dda University Health Board (HDdUHB) is publishing this Annual Report to demonstrate our progress during 2024-2025 towards achieving the seven well-being goals and 'five ways of working' outlined in the Well-being of Future Generations (Wales) Act 2015 ("the Act").

The Health Board has agreed eight Well-being Objectives which reflect the principles of the Act and work towards achieving the long-term goals as outlined in our Strategy, *A Healthier Mid and West Wales (AHMWW): Our Future Generations Living Well* (HDdUHB, 2019).

This report outlines the Health Board's implementation of the Act by highlighting the links to strategic objectives and plans – both internally and externally - with partners and provides an opportunity to highlight the examples of programmes and initiatives that our staff, patients and partners have undertaken to continue to embed our long-term vision - as part our commitment to the Act.

In addition, to help organisations evaluate their progress against the five ways of working, an online Progress Checker Tool has been designed by the Future Generations Commissioner's Office which the Health Board and other key stakeholders have completed.



In May 2025, on the tenth anniversary of the Act, Welsh Government published the *Future Generations Report.* The Report whilst noting the adoption of well-being objectives by public bodies, advised that:

'*Public bodies must set their well-being objectives within a statutory period but have the flexibility to review and adjust them according to their own planning cycles.'*

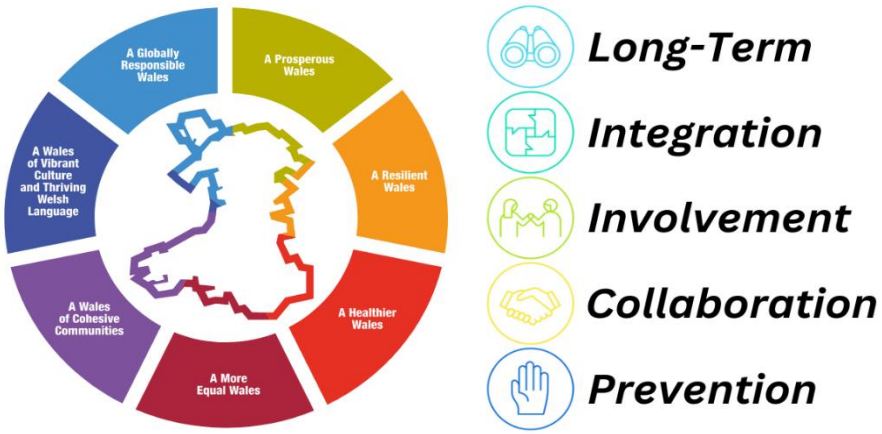
'These objectives can be published separately or integrated into broader corporate planning documents. Public bodies must report on their progress annually, ensuring they use both quantitative performance indicators and qualitative insights from public and service user feedback to track their impact.'

2. The Well-being of Future Generations Act

The Well-being of Future Generations (Wales) Act 2015 ("the Act") is about improving the social, economic, environmental and cultural well-being of Wales.

The Act provides a legally-binding common purpose for public bodies – via seven well-being goals which are underpinned by a 'sustainable development principle' which outlines five ways of working.

Seven Well-being Goals and Five Ways of Working



The seven well-being goals provide a shared vision to work towards, and these are detailed below:

A prosperous Wales – An innovative, productive, and low carbon society which recognises the limits of the global environment and therefore uses resources efficiently and proportionately (including acting on climate change); and which develops a skilled and well-educated population in an economy which generates wealth and provides employment opportunities, allowing people to take advantage of the wealth generated through securing fair work.

A resilient Wales – A nation which maintains and enhances a biodiverse natural environment with healthy functioning ecosystems that support social, economic, and ecological resilience and the capacity to adapt to change (for example climate change).

A healthier Wales – A society in which people's physical and mental well-being is maximised and in which choices and behaviours that benefit future health are understood.

A more equal Wales – A society that enables people to fulfil their potential no matter what their background or circumstances (including their socio-economic background and circumstances).

A Wales of cohesive communities – Attractive, viable, safe and well-connected communities.

A Wales of vibrant culture and thriving Welsh language – A society that promotes and protects culture, heritage, and the Welsh language, and which encourages people to participate in the arts sports and recreation.

A globally responsible Wales – A nation which, when doing anything to improve the economic, social, environmental and cultural well-being of Wales, takes account of whether doing such a thing may make a positive contribution to global well-being.

Our Health Board is a member of three Public Services Boards (PSBs), one in each of our local authority areas of Carmarthenshire, Ceredigion, and Pembrokeshire. Through our membership, we work with a variety of local and regional partners and aim, through our collaboration and partnership working, to improve the social, economic, environmental, and cultural well-being for our population and future generations.

The five Ways of Working provide public bodies with the foundation of how to embed sustainable development.

The Five Ways of Working

Implementing the Act's requirements will support other legislative commitments such as the Social Services and Well-being (Wales) Act 2014, the Environment (Wales) Act 2016, Welsh Language Act 1993, Equality Act 2010, and the United Nations Convention on the Rights of the Child.

3. Embedding the principles of the Well-being of Future Generations (Wales) Act 2015

Working with our partners and population, the Health Board has implemented key actions and processes to achieve the seven ways of working as outlined in the Act.

These include developing a long-term vision, agreeing strategic and planning objectives, well-being objectives; and working with PSBs to deliver Well-being Plans.

3.1 Strategic and Planning Objectives

The Health Board has prioritised agreeing strategic and planning objectives that reflect improving the health and well-being of the population.

In September 2020 the Health Board established strategic objectives that reflect our vision that "Together we are building kind and healthy places to live and work in Mid and West Wales". The objectives relate to our people (staff, service users and communities) and our services, and are illustrated below:

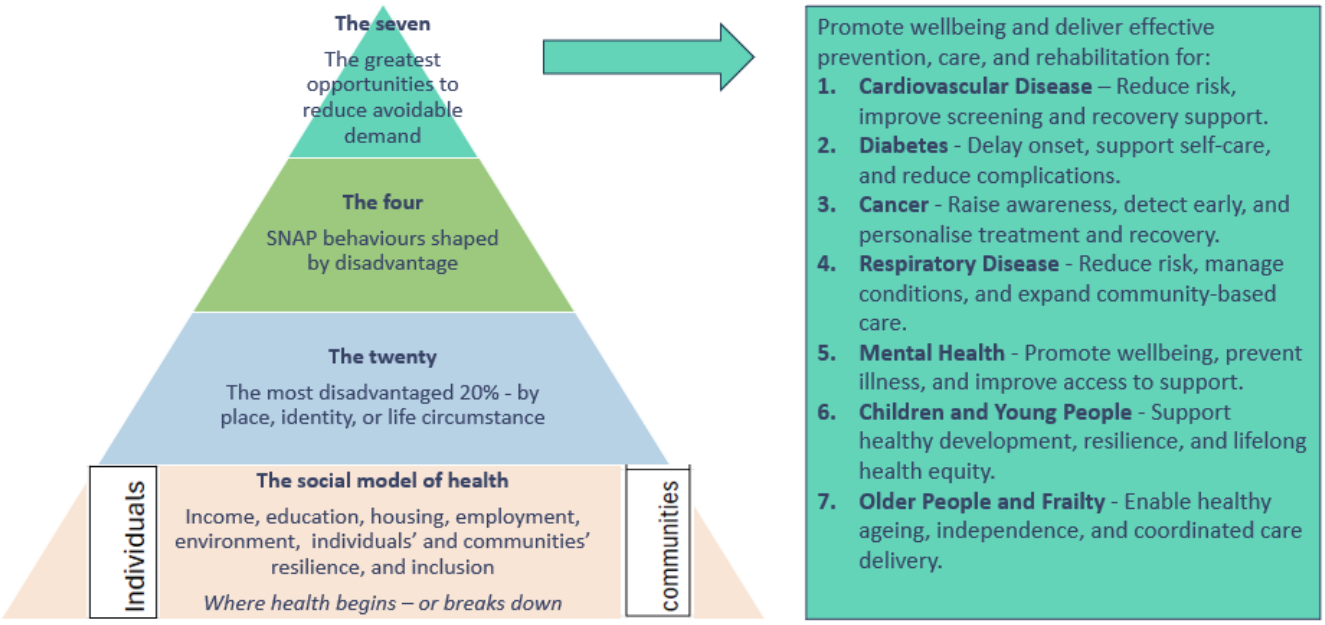
Our three strategic goals follow a 'life-course' approach – starting and developing well, living and working well and growing older well – and are underpinned by the Well-being of Future Generations Act - which places the sustainable development principle at the centre of our transformation journey. Whilst focusing on current populations, our actions are laying the foundations for improved health and well-being outcomes for future generations.

Our Annual Plan (2025-2026) in recognising the importance of improving health and well-being and preventing ill health, has specific Planning Objectives to improve population health reflected within the Public Health Directorate Workplan and three-year Health Improvement and Well-being Strategic Plan 2024-2027.

A key population health priority is embedding a Social Model for Health and Wellbeing (SMfHW) through strengthened community partnerships and ensuring that the approach underpins all our work. SMfHW focuses on reducing health inequalities, enabling people and communities to have more control over their health to achieve and maintain the best possible health. The model promotes prevention, early identification of disease and timely intervention.

In addition, the introduction of the 20four7 framework aims to address health inequalities by embedding prevention into everything we do. In doing so, we will deliver both immediate benefits to patients and our organisation and a longer-term shift from an illness service to a health service. 20four7 is aligned to our A Healthier Mid and West Wales Strategy, the SMfHW approach, and our Value-Based Health Care Strategy.

20four7 brings together three interconnected priorities that, when addressed collectively, can make the biggest difference to the health and wellbeing of our population. The plan adopts a model targeting the 20% most deprived areas, addressing four key risk factors (Smoking, Nutrition, Alcohol, Physical Activity) and the seven major preventable chronic diseases.



3.2 Our Well-being Objectives

The Health Board developed well-being objectives in 2019 that aligned with the strategic objectives to support our long-term aims and ambitions to embed the implementation of the Act into our day-to-day business. Our Well-being objectives are not confined to a single national outcome and align to more than one of the national goals.

Whilst health inequalities persist, they are also set against a backdrop of the climate and nature emergency. Improving public health and well-being will require us to work in partnership to address the challenges associated with poverty, environmental factors, poor housing, and social isolation.

Our well-being objectives are linked to four overarching themes, each with specific actions:

Workforce planning and development

- Develop a skilled and flexible workforce to meet the changing needs of the NHS.
- Offer a diverse range of employment opportunities which support people to fulfil their potential

Collaboration, involvement, and integration

- Transform our communities through collaboration with people, communities and partners.
- Contribute to global well-being through developing international networks and sharing of expertise

Early intervention and prevention

Plan and deliver services to enable people to participate in social and green solutions for health. Encouraging community participation through the medium of Welsh.

Improve population health through prevention and early intervention, supporting people to live happy and healthy lives

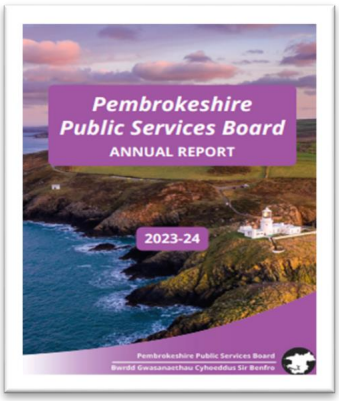
Environment and climate change

Promote the natural environment and capacity to adapt to climate change.

Plan and deliver services to increase our contribution to low carbon.

3.3 PSB Well-being Plans

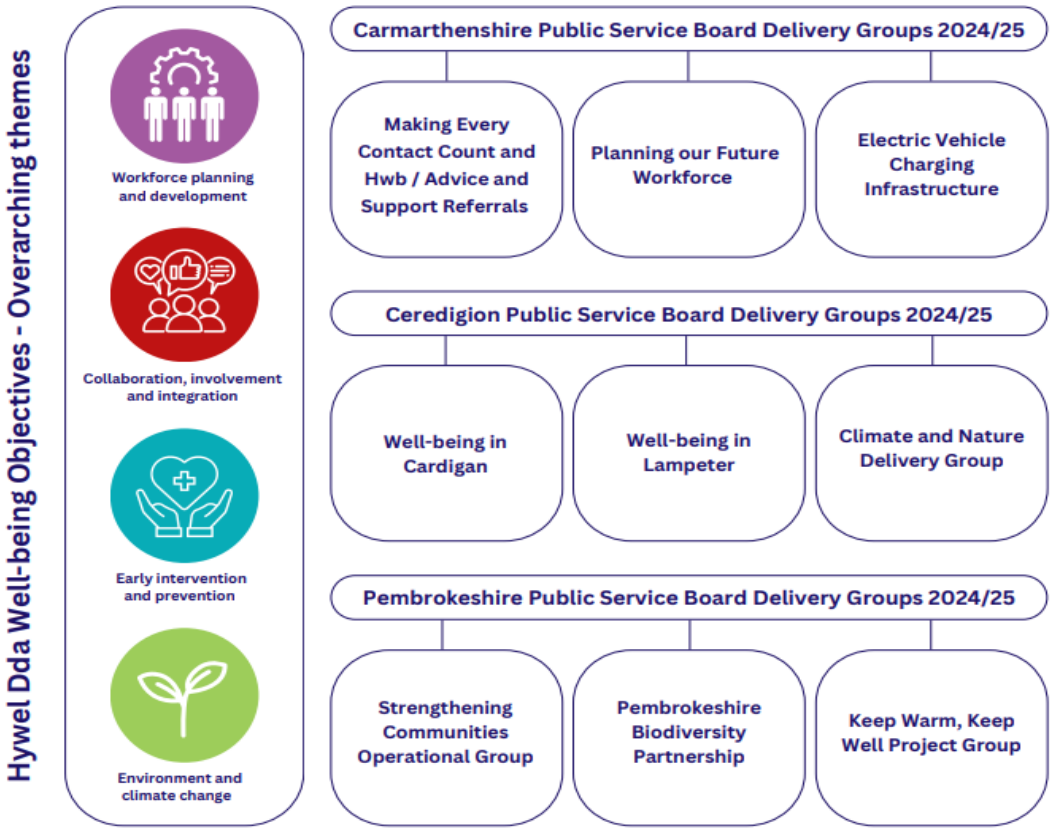
The Well-being of Future Generations Act (Wales) 2015 set out an expectation for PSB's to publish three-year Well-Being Plans and an Annual Report.



The Well-being Plans set out agreed partnership objectives reflecting the seven well-being goals of the Act. In line with the statutory five-year cycle set out in the Well-being of Future Generations (Wales), PSB's will refresh their Well-being Plans in 2026. This refresh provides an opportunity to review progress, reassess local priorities, and engage with communities to shape future actions that promote sustainable well-being.

Each PSB has established a multi-partnership delivery group structure to implement their Well-being Plans which broadly reflect the Health Board's four over-arching Well-being Objectives and overarching themes which are detailed below:

HDdUHB Well-being Objectives and PSB Delivery Groups 2024-2025



The PSB Delivery Groups are responsible for delivering the agreed Well-being Plan Objectives, which interlink closely to the Health Board's Well-being Objectives, and are mapped below:

Carmarthenshire Public Service Board Well-being Plan 2023-28 - Well-being Objectives	
Ensuring a sustainable economy and fair employment	
Improving well-being and reducing health inequalities	
Responding to the climate and nature emergencies	
Tackling poverty and its impacts	
Helping to create bilingual, safe and diverse communities	

Ceredigion Public Service Board Well-being Plan 2023-28 - Well-being Objectives	
Work together to achieve a sustainable economy that benefits local people and builds on the strengths of Ceredigion.	
Work together to reduce inequalities in our communities and use social and green solutions to improve physical and mental health.	
Work together to deliver decarbonisation initiatives within Ceredigion to protect and enhance our natural resources.	
Work together to enable communities to feel safe and connected and will promote cultural diversity and increase opportunities to use the Welsh language.	

Pembrokeshire Public Service Board Well-being Plan 2023-28 - Well-being Objectives	
Support growth, jobs and prosperity and enable the transition to a more sustainable and greener economy	
Work with our communities to reduce inequalities and improve well-being	
Promote and support initiatives to deliver decarbonisation, manage climate adaptation and tackle the nature emergency	
Enable safe, connected, resourceful and diverse communities	

4. Demonstrating our Well-being Objectives

The Health Board continues to support, develop and promote systems for innovation and diversity, improve equity and reduce inequalities in health.

As examples of how our Well-being Objectives are implemented, a series of case studies have been prepared to reflect the Health Board's progress in meeting the seven Well-being Goals of the Well-being of Future Generations (Wales) Act, referenced to our Well-being Objectives.

4.1 Well-being Objective Theme: Workforce Planning and Development

Offer a diverse range of employment opportunities which support people to fulfil their potential

Develop a skilled and flexible workforce to meet the changing needs of the NHS.

Our workforce is at the heart of how we deliver our services. Success is not solely dependent on the number of people we have working for us, but on our ability to attract, develop, and retain the right people. This includes ensuring staff feel supported, valued, and heard; providing opportunities for career progression, and fostering a culture where HDdUHB is recognised as an employer of choice.

We remain committed to building a diverse and culturally inclusive organisation that promotes healthy, happy, and thriving working environments.

Well-being Champion Network

The HDdUHB Well-being Champion Network aims to promote staff well-being across the whole of the Health Board, raising awareness of the well-being support available for employees and how to access it.

Since its inception, the network has grown to include over 175 volunteer champions who play a key role in promoting health and well-being within the workplace, publicising initiatives and awareness events, signposting colleagues to appropriate support services, and sharing staff feedback to help shape the Health Board's well-being agenda. All champions complete a short induction programme and are offered ongoing training to ensure they remain informed and confident in their role, and they are supported through a dedicated Microsoft Teams channel, which provides access to resources, updates, and a peer-support space. Regular support sessions offer a safe environment for champions to reflect on their experiences and share ideas, helping them to better support colleagues in adopting positive health and well-being behaviours.

Outside of their roles within HDdUHB, many champions are actively involved in charitable activities that support communities across the Hywel Dda region, further demonstrating their commitment to well-being both within and beyond the workplace.

Our future workforce

During the year the Health Board has continued to work with young people and engaged with 8,567 pupils, including 2,855 through the medium of Welsh, covering all secondary schools in Hywel Dda. Our programmes supported 1,527 students with health masterclasses and 337 work experience opportunities plus 36 virtual taster sessions. 67 students also started the "Becoming a doctor" programme which included simulation and scenarios to illustrate the different opportunities available. The use of simulation activities increased interest in Health Board careers from 35% to 63%. In recognition of our work to support young adults, the Health Board was presented with the Careers Wales Outstanding Achievement Award.

19 students with additional support needs were supported to gain work experience and 42 apprentices were recruited which brings our total apprentices to 162 within our workforce. We were delighted when one of our apprentices was selected as a Welsh Language Ambassador by Coleg Cymraeg Cenedlaethol, highlighting the importance of Welsh Language in patient care.

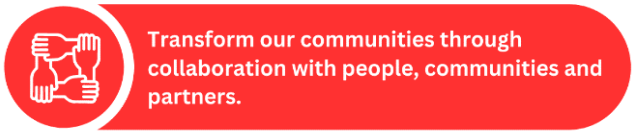
Social Partnership Duty

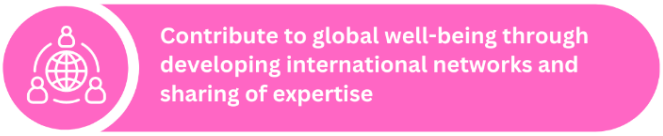
In 2024 the Social Partnership and Public Procurement (Wales) Act 2023 introduced a 'Social Partnership Duty' for public bodies in Wales. The duty requires Health Boards to engage meaningfully with workforce representatives and other stakeholders to promote inclusive decision-making and fair work, improve well-being, and deliver better public services and sustainable development. The duty enhances workforce resilience while supporting the aims of the Well-being of Future Generations (Wales) Act 2015. Through this collaborative approach, the Health Board aims to strengthen public service delivery by ensuring that those who provide services have a meaningful and influential role in shaping how they are designed and delivered.

Social partnership principles have been embedded through a structured approach including:

- Established Partnership Forums; with Trade Union colleagues involved in working groups and forums, contributing to policy development, operational planning, and health and safety.
- Integration of principles into Board-level decision-making, and engagement with workforce advisory groups.
- On-going efforts, such as reviewing the Trade Union Facilities Agreement and aligning engagement structures with organisational changes; and workforce and engagement processes, including quarterly sessions to address workforce concerns.
- Service co-production with staff and partners to improve service delivery and integrated patient care.
- Implementing Fair Work principles, and leadership commitment to actively champion social partnership principles.
- Established Equality, Diversity and Inclusion Task Force.
- Sustainable public services and procurement practices.

4.2 Well-being Objective Theme: Collaboration, involvement and integration





The five ways of working set out in the Well-being of Future Generations (Wales) Act 2015 provide the foundation for our approach to working with our population, staff, stakeholders and partners, particularly those most vulnerable in our society. Working with PSBs, to implement Well-being Plans is helping to shape the design and delivery of services.

HDdUHB's *A Healthier Mid and West Wales Strategy* sets out our commitment to work in an integrated way across health and social care with our communities at the heart of what we do. Our aim is to build community resilience, prevent ill health, improve well-being and promote independence and interconnectedness.

The Health Board is committed to promoting a Social Model for Health and Well-being. In 2024, working with Welsh Government's Future Generations Commissioner's Office, we agreed a definition and a set of Principles and in 2025 a Charter was adopted by partners and organisations to embed this approach across the region.

Building Community Connections Through Health Outreach at Haverfordwest Mosque

The Community Development Outreach Team (CDOT) works across HDdUHB to promote health messages and reduce barriers to accessing services. In July 2024, following a visit to Haverfordwest Mosque, the team partnered with the mosque, Pembrokeshire Association of Voluntary Services (PAVS), and the local Hub to organise a community health event tailored to the needs of the local Muslim community.

Recognising the challenges of engaging worshippers, the team worked with the community and local organisations to organise a one-off, well-timed event during the summer holidays. This approach aimed to maximise attendance and create a welcoming space for meaningful engagement.

Held on 26 July 2024, the event brought together 31 organisations from health, Local Authority, and third sector services. It featured a wide range of support, including smoking cessation, alcohol awareness, screening, and unpaid carers' information, many of which were available in multiple languages. The first part of the event allowed agencies to network, followed by a community session after Friday prayers. A total of 67 attendees from diverse ethnic backgrounds participated.

While traditional paper evaluation forms proved a barrier, verbal feedback was overwhelmingly positive. Attendees reported learning about services they hadn't known existed, including how to self-refer to occupational therapy and podiatry. Comments included: "Very useful," "Found out lots of new information," and "Spoke to services they wouldn't have before."

The event successfully connected the mosque community with the Health Board and third sector, breaking down barriers and raising awareness of available support. It also highlighted the importance of culturally sensitive engagement and has since been agreed to run annually.

Social Model for Health and Well-being Summit

In March 2025, the Health Board hosted the SMfHW Summit at the Canolfan John Burns Centre in Kidwelly. The event brought together a wide range of partners including public service leaders, healthcare professionals, academics, and voluntary sector organisations to explore collaborative, community-led approaches to improving health and well-being. The summit featured expert presentations, breakout sessions, and interactive Question and Answer discussions on key topics such as the Centre for Social Innovation, Home First, Employer Supported Volunteering, and Hospital at Home.

A key highlight of the summit was the collective signing of the SMfHW Charter by leaders from HDdUHB, Carmarthenshire, Ceredigion and Pembrokeshire County Councils, Public Health Wales, Welsh Government, University of Wales Trinity Saint David, and regional voluntary organisations. This act symbolised a shared commitment to reducing health inequalities and empowering communities to take greater control over their health. The Charter promotes prevention, early intervention, and a whole-system approach to health, recognising that good health is shaped by a wide range of social, economic, and environmental factors.

The summit also featured powerful contributions from national experts. Professor Sir Michael Marmot highlighted the urgent need to address the social determinants of health, showing the stark inequalities in life expectancy and well-being across the UK. Cormac Russell, Nurture Development, emphasised the importance of community-led development and the role of local organisations in enabling grassroots action. Their insights reinforced the summit's central message: that improving health and well-being requires collective action across sectors and a shift towards people-led, place-based solutions.

Dr Ardiana Gjini, Executive Director of Public Health at HDdUHB, described the summit as a platform for meaningful dialogue and renewed collaboration, reaffirming the Health Board's commitment to embedding the SMfHW principles in practice and working closely with communities to build a healthier, fairer West Wales.

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4.3 Well-being Objective Theme: Early intervention and prevention

Plan and deliver services to enable people to participate in social and green solutions for health. Encouraging community participation through the medium of Welsh.

Improve population health through prevention and early intervention, supporting people to live happy and healthy lives

Prevention is a core principle in all our work. To reduce the impact of ill health, physical, mental or emotional, we need to work to prevent it from happening and intervene early to prevent escalation. This means working with communities and individuals to reduce risks and work to provide solutions that reduce their impact.

Gypsy Roma Traveller Arts Tackling Health Inequality Through the Arts

The Community Development Outreach Team collaborated with HDdUHB's Arts in Health programme and local arts partners to deliver a series of creative engagement sessions across Pembrokeshire and Carmarthenshire. These sessions were designed to promote well-being, foster community engagement, and communicate key public health messages with a focus on early prevention.

In Pembrokeshire, sessions were delivered by Arts4Well-being and tailored specifically for the Traveller community. Centred around diverse arts and crafts activities, the programme invited participation from Health Board and Third Sector teams, not only to share vital health information but also to actively engage in the creative process. This inclusive and relaxed environment enabled open, non-judgemental conversations around topics such as smoking cessation, alcohol reduction, healthy lifestyles, immunisations, and cancer screening. Feedback from participants highlighted a positive impact on well-being, a strengthened sense of community, and improved connection with Health Board services.

In Carmarthenshire, the initiative focused on engaging children in the creation of a mural at their residential site, facilitated by People Speak Up. The children took the lead in designing and spray-painting the artwork, while the Community Development Outreach Team, supported by Carmarthenshire County Council's Gypsy and Traveller Liaison service, engaged with parents. This setting provided an opportunity for meaningful dialogue with the Smoking Cessation team and the Iechyd Da Youth Health team. The project culminated in a community health event offering basic health checks and information, which has since evolved into a monthly drop-in service, ensuring sustained engagement and support.

South Carmarthenshire Rapid Access Multidisciplinary Service

In response to the growing challenge of frailty among older adults, the South Carmarthenshire Rapid Access Multidisciplinary Service (SCRAMS) was launched in May 2024 at Prince Philip Hospital (PPH), Llanelli. SCRAMS is an intermediate care falls and frailty service, aiming to reduce hospital admissions by providing rapid, community-based, person-centred care for individuals living with frailty and to prevent avoidable hospital admissions and support older adults to live independently. The team has since received over 200 referrals and investigates each case to understand the patient's needs and coordinate appropriate care and support.

Integrated Care Sister, Ann-Marie John, explained: "Frailty is a distinctive state of health related to the ageing process in which many of the body's systems gradually lose their in-built reserves. Around 10% of people aged over 65 years have frailty, rising to between a quarter and a half of those aged over 85 years. Being frail means that a relatively 'minor' health problem can have a severe long-term impact on someone's health and well-being. Many factors combine over time to make a person frail including dehydration, weight loss, loss of muscle strength and balance, falls, loss of confidence, fatigue and mental health conditions such as depression and anxiety. Frailty is not an inevitable part of ageing; it is a long-term condition which can be managed with patient-centred care."

Once a patient has been identified by a GP and triaged by a consultant, the SCRAMS team engage with the patient by visiting the patient at home and carry out a full assessment. "We're like health detectives," said Ceri Evans, Frailty Assistant Practitioner. "We try to understand the whole person. Is this person eating and drinking enough? Is that causing them to fall or is there something else?"

Ann-Marie added: "During our weekly multi-disciplinary team meeting we report our findings and then referrals to other services such as dietetics, falls prevention or occupational therapists are made. Each care plan is personal to each patient."

Consultant Geriatrician Dr Zena Marney, Clinical Lead for Llanelli SCRAMS said: "Adults aged over 65 years comprise a quarter of the population of HDdUHB and this is projected to increase significantly over the next 20 years. This means we have an impending frailty crisis and the work and care that the SCRAMS team are delivering is vital. I am privileged to be able to work with the experienced members of our SCRAMS multidisciplinary team who are dedicated and work extremely hard to provide holistic person-centred care in the community."

Emma Catling, Malnutrition Strategic Lead, added "Poor nutrition and hydration overtime can make a person frail. Without any fuel in the tank, patients begin to lose weight, strength, mobility and their mental health can decline - all of which can lead to falls. This can all be prevented."

Ceri and Ann-marie will provide nutrition and hydration information packs during their initial patient assessments, so they have immediate information to help them before the dietetics team contact. The SCRAMS team are working to keep patients healthy and active at home.

SCRAMS - Betty's story

When 'Betty', an elderly lady, came to the attention of the SCRAMS team she had suffered a series of falls and had hospital admissions due to a hip fracture and chest infection.

Betty was living in her own house with the support of her family, friends and her community. She has limited vision and walked slowly with the aid of a stick and zimmer frame. She was taking medication to help with postural hypotension, or low blood pressure when she stood up.

After each admission, Betty became frailer but was determined to return home and to receive help from family and friends. She did not want care packages offered at the time. Betty's final admission to hospital was a prolonged stay and she became frailer and lost her confidence. Betty agreed that she needed help and moved into a residential home.

The SCRAMS team reassessed Betty in her new home and found that she had lost her independence and now needed assistance with moving around. She became frailer, was not eating as well and had lost a significant amount of weight. Referrals were immediately made to various teams including dietetics and physiotherapy and a patient centred care plan was put into place, in conjunction with her family.

The Dietetics team monitored her weight and dietary intake, adding fortified meals and snacks supplemented with homemade milkshakes and juices based on Betty's likes and dislikes. Physiotherapists implemented a structured strength and balance programme to improve mobility and independence delivered by the team weekly. Care home staff were familiarised with the exercise programme to assist Betty in-between visits.

The SCRAMS team arranged weekly visits to monitor weight, blood pressure and take strength readings using a dynamometer, a device to assess the strength of muscles in the hand and forearm. It took a long time for Betty to show signs of improvement but there were improvements and pressure areas she had developed have now healed.

And now ... Betty is almost back to her original weight and walking to the dining room with minimal assistance. According to her loved ones, "Betty has her cheeky sparkle back now."

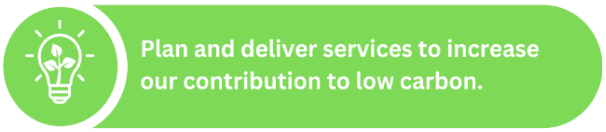
Colorectal screening tool

The HDdUHB Surgical and Intensive Therapy Unit Physiotherapy team has successfully introduced a Physiotherapy Abdominal Surgery Risk Assessment Tool specifically for patients undergoing colorectal surgeries.

This tool has led to a noticeable reduction in hospital stays by enabling earlier identification of patients who require physiotherapy input. By streamlining the assessment process, patients are now seen more quickly after surgery, which helps to minimise hospital deconditioning and supports faster recovery. The tool has also allowed the physiotherapy team to prioritise and optimise their resources more effectively, ensuring that care is delivered where it is most needed.

As a result, both patients and staff have benefited from improved outcomes and more efficient use of NHS physiotherapy services.

4.4 Well-being Objective Theme: Environment and climate change



HDdUHB continues to make meaningful progress toward its environment and climate change objectives by looking at options to reduce carbon and bring sustainable practices into our day-to-day activities.

Our environment and climate directly impact population health; by working toward clear climate objectives, we can reduce our environmental footprint, build resilience in healthcare services, and protect the well-being of our communities now and in the future.

The Health board's Sustainability Report 2024/25 can be found here (Section 9, p.103 -113)

NappiCycle Project

The NappiCycle project, a partnership between HDdUHB and Natural UK Ltd, is revolutionising waste management. By diverting 100% of nappy and incontinence waste from landfill, the project recovers valuable cellulose and plastics. This innovative approach supports Wales' circular economy goals and environmental legislation, while also contributing to net zero carbon reduction targets.

- NappiCycle's **innovative waste recovery system** diverts all nappy and incontinence waste from landfill. The recovered cellulose fibre is repurposed into products like asphalt and fibreboard, reducing the need for raw materials and lowering carbon emissions
- The project boasts impressive **environmental and economic benefits**. Recycling rates have increased by 6%, landfill use has decreased by 6%, and carbon emissions have been cut by 96%. Additionally, the project has generated over £150k in cost savings and supported local employment
- **Strong partnerships and community engagement** are key to NappiCycle's success. Collaboration between HDdUHB, Natural UK Ltd, patients, staff, and other stakeholders, including Infection Prevention Control and Local Authorities, ensures compliance with clinical and legislative standards while addressing community needs

The NappiCycle project exemplifies the power of collaboration and innovation in achieving sustainable healthcare solutions. By diverting incontinence waste from landfill and promoting recycling and reuse, HDdUHB is making significant strides towards a greener future and demonstrating its commitment to the Well-being of Future Generations (Wales) Act 2015.

Warp-It

HDdUHB has embraced Warp-It, an online platform that allows staff to reuse and redistribute surplus items like furniture, office supplies, and equipment across the organisation and with approved partners. Warp-It acts as an internal recycle and re-use network, enabling staff to list unwanted items for others to claim. This reduces the need for new purchases and cuts waste

Key Objectives:

- Reduce unnecessary spending on office and facilities equipment
- Cut disposal and storage costs
- Minimise environmental impact and support NHS Wales' Decarbonisation targets

Key Outputs:

- Significant cost avoidance by reducing new purchases
- Tonnes of waste diverted from landfill
- Lower carbon emissions through avoided manufacturing and transport
- Increased collaboration across departments through sharing of resources

By reusing existing resources within the Health Board, Warp-It supports smarter procurement, improves sustainability, and helps staff access resources more quickly and efficiently. This aligns with HDdUHB's commitment to delivering cost-effective, environmentally responsible services. Warp-It also directly contributes to national policy goals on carbon reduction, circular economy, and Value Based Healthcare. Warp-It has proven to be a simple but powerful tool for embedding sustainability into everyday operations - delivering measurable financial savings and a positive environmental legacy.

Improving a Child's Health and Reducing Environmental Impact

Bradley, an 8-year-old Pembrokeshire school pupil, struggled with respiratory problems from a young age, preventing him from joining school sports and activities like rugby, football, and running. He often experienced shortness of breath and could not fully participate with his peers. Bradley's respiratory health was reviewed by colleagues delivering the new Pembrokeshire Schools Asthma Project. After receiving a diagnosis and starting/reviewing medication, Bradley's health improved significantly. He is now able to take part in swimming and running events at school, has more energy, and enjoys a better appetite. This transformation has greatly improved his quality of life and happiness.

The positive impact extends beyond Bradley's personal health. By enabling children like Bradley to participate in local activities, there is less need for car journeys to specialist appointments or alternative activities, which helps reduce travel-related carbon emissions. Supporting children's health within their community also means fewer hospital visits, lowering the overall carbon footprint of healthcare services. This highlights how early intervention and local support can improve children's well-being while also benefiting the environment. By reducing unnecessary travel and hospital visits, more sustainable prescribing, and better management of respiratory conditions, such approaches contribute to a healthier community.

5. Next Steps

Our strategic approach is firmly rooted in our commitment to improving population health and well-being, reducing health inequities, and promoting equality across all communities. We remain dedicated to delivering the seven Well-being Goals set out in the Well-being of Future Generations (Wales) Act as reflected in our strategic intentions and outlined in our Annual Plan and through collaborative work with partners.

A key milestone during this period has been our leadership in embedding a Social Model for Health and Well-being, working collaboratively with partners through the adoption of the Charter and its guiding principles. This approach will remain a strategic priority as we continue to co-produce and implement work plans with key stakeholders, aimed at strengthening community capacity and driving social innovation.

Many of the initiatives outlined in this report will continue to evolve as we work towards realising our long-term vision. Looking ahead, this work will be integral to delivering our new strategic framework. Progress will be driven through sustained collaboration with our communities and statutory partners, including through PSBs and other statutory bodies.

In response to an evolving strategic landscape, we will undertake a review of our Well-being Objectives in 2025/26 to ensure they continue to align with HDdUHB's values and priorities, and remain relevant to our organisation, our workforce, and the communities we serve. This will reflect recommendations made in the Future Generations Report 2025.

References

Hywel Dda University Health Board (2019) A Healthier Mid and West Wales: Our Future Generations Living Well. Available at: hduhb.nhs.wales/about-us/healthier-mid-and-west-wales/healthier-mid-and-west-wales-folder/documents/a-healthier-mid-and-west-wales-strategy/

Welsh Government (2025) Future Generations Report. *Available at:* Future-Generations-Report-2025 (1).pdf

4.3 **11:45, 0 Mins**

4.3 - DEFERRED to 26 February 2026: Progress Report for 2023/24 DPH Annual Report: Their Health, Our Future: Advancing the Agenda for CYP in Hywel Dda

For information

5

11:45, 0 Mins

5 - Capital and Estates

5.1

11:45, 10 Mins

5.1 - Capital Programme for 2025-26 and Capital Governance

Lee Davies (Hywel Dda UHB - Executive Director of Strategy and Planning), Eldeg Rosser (Head of Capital Planning)

Including:
Annual Review CSC ToR
Capital Planning Equipment Replacement Programme

For approval

Attachments

5.1.1 DCP Gov Update Dec 25 v2.pdf

5.1.2 Annex 1 - Sealing schedule SPC Dec 25.pdf

5.1.3 Annex 2a - CSC Update (3As) Report.Template.V1 Nov 25.pdf

5.1.4 Annex 2b CSC Terms of Reference v18 draft Nov CSC.pdf

PWYLLGOR STRATEGAETH A CHYNLLUNIO
STRATEGY AND PLANNING COMMITTEE

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	18 December 2025
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Capital Programme for 2025/26 and Capital Governance Update Report
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Lee Davies, Executive Director of Strategy and Planning
SWYDDOG ADRODD: **REPORTING OFFICER:**	Eldeg Rosser, Head of Capital Planning

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Ar Gyfer Penderfyniad/For Decision

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

This report is presented to the Strategy and Planning Committee (SPC) to:

- Update on the 2025/26 Capital Programme and Capital Resource Limit (CRL) for 2025/26
- Update on the allocation of the Discretionary Capital Programme (DCP) for 2025/26
- Update on the planning of the allocation of DCP for 2026/27
- Notify the SPC of the contracts that may require sealing during 2025/26
- Provide a capital schemes governance update
- Provide an update from Capital Sub-Committee (CSC)

Cefndir / Background

This report provides an update on the 2025/26 DCP. It follows on from the report and discussion at the SPC meeting held on 30 October 2025 and the CSC meeting held on 14 November 2025.

The available capital allocation for 2025/26 will provide Hywel Dda University Health Board (HDdUHB) with a significant challenge and risk in trying to address the historical backlog in:

- Medical and non-medical equipment
- Informatics and Digital infrastructure and equipment
- Estates, statutory and infrastructure

Risk
The corporate risk 1196 states:

There is a risk the Health Board is not able to provide safe, sustainable, accessible and kind services. This is caused by insufficient investment to ensure appropriate facilities, medical equipment and digital infrastructure of an appropriate standard. This could lead to an impact/effect on the Health Board's ability to deliver its strategic objectives, service

improvement/ development, statutory compliance (i.e., fire, health and safety) and delivery of day-to-day patient care.

Discretionary Allocation Use
The terms of the Discretionary Capital Allocation letter from Welsh Government (WG) state:

Discretionary capital is that allocated directly to NHS organisations for the following priority obligations across all healthcare settings: Meeting statutory obligations, such as health and safety and Firecode; maintaining the fabric of the estate; and the timely replacement of equipment.

The prioritisation process for DCP includes representation from Executive portfolios at the Capital Planning Group (CPG) which reports to the CSC, and the position set out is consistent with that reported to the Finance and Planning Committee (FPC)

Asesiad / Assessment

Capital Resource Limit 2025/26

The CRL for 2025/26 has been issued with the following allocations:

Allocation	£m
All Wales Capital Programme (AWCP)	27.393
Discretionary Programme* (DCP)	6.850
IFRS 16 Leases	0.281
Total	**34.524**

***The Health Board received DCP of £10m in 2025/26. A contribution of £2.205m has been made towards the Targeted Estates Fund schemes within AWCP. A further £0.945m has been paid back to the AWCP to account for capital scheme slippages in 2024/25.**

Capital Expenditure Position

The table below reflects the current expenditure position at the end of October 2025 as reported to Welsh Government (WG).

Scheme	Planned Spend 2025/26 £m	Cumulative Spend Apr - Oct £m	Spend October £m	Remaining balance £m
AWCP				
Glangwili - Fire Enforcement works - Phase 2 - Fees	0.779	0.705	0.185	0.074
Backlog Maintenance – (slippage from 2024-25)	1.214	0.481	0.114	0.733
Aberystwyth Sexual Assault Referral Centre	1.875	1.665	0.069	0.210
Block C, Picton Terrace	2.488	1.248	0.592	1.240
Diagnostic Equipment - WGH Fluro & Chilled Water Plant	2.570	0.386	0.360	2.184
EFAB - Infrastructure	0.127	0.004	0.000	0.123
EOY Funding 24/25 – (Pentre Awel)	0.150	0.119	0.024	0.031

TEF - Fire	0.570	0.000	0.000	0.570
TEF - Infrastructure	4.363	0.077	0.033	4.286
TEF - Decarbonisation	0.050	0.000	0.000	0.050
TEF - Mental Health	1.684	0.002	0.000	1.682
TEF - Infection Prevention Control	0.569	0.297	0.049	0.272
TEF - Decontamination	0.426	0.177	0.177	0.249
Carmarthen Hwb - Equipment and Fit-out costs	2.318	0.003	0.002	2.315
Fishguard Health and Wellbeing Centre	0.067	0.032	0.005	0.035
DPIF - Digital Maternity Cymru System Programme 2025/26	0.100	0.001	0.001	0.099
Non-Radiology Ultrasound Replacement	0.761	0.000	0.000	0.761
DPIF - RISP	0.429	0.000	0.000	0.429
Aseptic Unit, Withybush	1.753	0.011	0.001	1.742
Gamma Camera/SPECT-CT Upgrade, Withybush	0.481	0.007	0.000	0.474
Mental Health Quality and Safety Schemes	1.317	0.030	0.000	1.287
MRI Upgrade, Glangwili General Hospital	1.324	0.014	0.014	1.310
Radiology Ultrasound Replacement, PPH	0.138	0.000	0.000	0.138
Hospital Helicopter Landing Sites Schemes 2025-26	0.030	0.010	0.010	0.020
Withybush - RAAC Fees and Works VAT Recovery	-0.900	0.000	0.000	-0.900
EFAB VAT Recovery	-0.394	0.000	0.000	-0.394
Front Door Project, GGH	2.096	0.048	0.048	2.048
Fire Enforcement and Associated Works WGH - Phase 2	0.912	0.230	0.230	0.682
Sub-total AWCP	**27.297**	**5.547**	**1.914**	**21.750**
Discretionary				
IT	1.687	0.336	0.032	1.351
Equipment	1.711	0.657	0.078	1.054
Estates – Statutory	0.450	0.142	0.042	0.308
Estates Infrastructure	2.523	0.766	0.476	1.757
Mental Health	0.000	0.000	0.000	0.000
Other	0.574	0.121	-0.287	0.453
Sub-total Discretionary	**6.945**	**2.022**	**0.341**	**4.923**
IFRS 16 Lease	**0.281**	**0.281**	**0.281**	**0.000**
TOTAL	**34.523**	**7.850**	**2.536**	**26.673**

Confirmation of CRL

The Health Board confirmed its end of year capital scheme forecasts by the end of October to WG. The CRL is then fixed for the financial year. Any further changes to the CRL now will only occur when new funding allocations are approved.

The risk of over / under spending against the CRL materialises at this point.

Risk 2204

A risk has now been placed on our operational risk register to reflect both the risk of not achieving the CRL which has been set for the organisation but also to reflect the funding uncertainties from WG that are currently impacting on our ability to progress and plan in year expenditure.

Discretionary Capital Allocation (DCP)

2025/26

HDdUHB's Discretionary Capital Allocation for 2025/26 increased to **£10.000m**, an increase of nearly 35% on the 2024/25 level. Whilst this news was positive, it needs to be considered in the context of a combined backlog of c£300m across the estate, medical equipment and IM&T.

The current estimated value of the backlog is:

- £266m Estates backlog
- £26.6m Medical Devices
- £15-£18m Digital backlog

The following split of allocations was agreed by the Board in March 2025.

Discretionary Capital Programme 2025/26	
	£m
Pre-Commitment	3.959
Business Case Development	0.400
Capital Support	0.200
Contingency Reserve	1.000
Opportunity risks	0.941
Spend to Save	0.300
Refurbishment of clinical areas	1.000
Statutory and estates programme	0.450
Equipment	0.500
Digital	0.500
Allocation via matrix	0.750
Total	**10.000**

As additional allocations become available during the year through VAT recovery and other opportunities the use of these allocations will be reviewed and reported.

Additional allocations

HDdUHB has received the following additional funding in year from WG for:

- **Radiology Replacement equipment**
  Confirmation has now been received of the following funding:

- Nuclear Medicine equipment upgrade WGH - £0.481m
- Upgrade MRI in GGH - £1.324m
- Ultrasound replacement PPH - £0.138m

- **Ultrasound Scanners outside of radiology**
  HDdUHB has been awarded £0.771m of funding to progress with the procurement of the 10 scanners.

- **Accelerating Targeted Estates Fund (TEF) schemes from 2026/27**

  HDdUHB has submitted a schedule of bids that can be brought forward from 2026/27 and delivered in 2025/26 to WG. Confirmation that HDdUHB will receive an additional £0.704m funding from WG in 2025/26 has been received.

  WG is also considering the funding of additional TEF schemes which can be brought forward from 2026/27 into 2025/26.

- **Mental Health Estates Targeted Improvements Bids**

  Confirmation that £1.381m of funding has been made available for the schemes listed below has been received.

  - External improvements to Psychiatric Intensive Care Unit, Low Secure and High Dependency Units and internal works for anti-ligature-type and replacement salto-system throughout to improve patient/staff safety and security
  - Improvement works at Bryngofal, Prince Philip Hospital (PPH)
  - Undertake a range of works to improve patient and staff safety and to enhance environment at Child and Adolescent Mental Health Services (CAMHS) sites and St Non's
  - Mental Health and Learning Disability inpatient bedroom furniture replacement.

- **End of Year 2025/26**

  Confirmation from WG of the following allocations has been received
  - Digital Capital Investment for wi-fi upgrade - £0.630m
  - Estates improvement works - £1.294m
  - Additional Ultrasounds - £0.220

Use of Contingency

The original allocation of £1.000m contingency was increased by an additional £0.750m following a review of the balance sheet and confirmed VAT recovery. There are some items of risk and expenditure that have had to be managed in 2025/26 such as the additional cost of remedial works to concrete cladding in Withybush Hospital (WGH). Funding from WG has now resourced some items previously funded through the contingency and the schedule below has been updated to reflect this.

Discretionary Capital Programme 2025/26	
	£m
Digital Maternity	0.048
Blow down vessel Boiler House, PPH	0.023
Dental Chair enabling works	0.017
MRI Chiller Glangwili Hospital (GGH)	0.069
Fire Doors - Radiology/Pathology/AVH	0.100
Roof Leak Repairs	0.041
Helipad Lighting and other works	0.030
Mortuary Compressor - additional costs	0.002
Concrete cladding issue (Scaffolding)	0.103
Concrete cladding issue (further costs)	0.325
Additional cost concrete cladding	0.398
Installation of Cooling Unit - following Healthcare Inspectorate Wales (HIW) inspection	0.013
Formalin Cabinet replacement Bronglais Hospital (BGH)	0.021
Replacement of endoscopic probes	0.036
Works to PPH Body Store	0.033
Vapotherm replacement Cilgerran Ward	0.018
Ty Cadell roof	0.042
Fire alarms Tenby Surgery	0.022
PPH Hoval Burners	0.032
PPH Chiller	0.040
PPH roof survey	0.015
Endoscopy BGH	0.120
Windows 11 cardiology equipment	0.149
Fishguard Clinic damage	0.048
Ultrasound probe replacement	0.006
Autopsy saw	0.007
Enabling works Microbiology autoclave WGH	0.040
Microdebrider	0.031
Gas Scavenging System replacement theatres	0.023
Teifi Ward Bathroom	0.017
Roof repairs Ty Llewelyn	0.017
Roof repair Cardiology	0.019
Nurses Home concrete cladding	0.040
Chiller units GGH Accident and Emergency (A&E)	0.026
Doors Day Surgery Unit (DSU) PPH	0.011
Boiler Wellfield Road	0.014
Total	**1.996**

Additional VAT recovery associated with DCP schemes, along with underspends on precommitment from previous years has enabled us to top up our contingency and there is currently £0.278m left in this pot.

The additional allocations received from WG and a review of slippage and current expenditure profiles on schemes to year end has resulted in the following amendments being made:

Discretionary Capital Programme 2025/26		
	Changes £m	Balance £m
Contingency	(0.800)	0.278
Invest to Save	(0.200)	0.040
Operational Risk/Opportunities	(0.200)	0.035
Slippage across DCP	(0.460)	
Additional expenditure		
Citrix Upgrade	0.750	
Pager Upgrade	0.160	
Additional digital devices	0.250	
Additional equipment	0.500	
Total	**0.000**	**0.353**

One of the schemes previously funded through the contingency but which has now been funded by additional WG monies was the costs associated with survey works on the roof at the PPH site to check the condition. The concern was that as the roof is of a similar design to Princess of Wales hospital, PPH site could be heading towards a similar scenario, where a major incident was declared and due to safety concerns an entire floor was closed. At Princess of Wales Hospital the impending risk was not identified and due to the deterioration of the roof timbers, and concerns around roof integrity the entire top floor was closed due to because porous tiles and water ingress causing significant deterioration to the timbers.

A survey was commissioned for the PPH site to gain a detailed understanding of the existing roof build-up, evaluate the current condition of key elements, and provide guidance on the roof's remaining serviceable life and the likely extent of future remedial or replacement works. The survey did not identify any concerns with the current condition but did recommend that the roof covering is reaching the end of life and should be replaced in circa 3–5 years, as the tiles are becoming porous and the roof will inevitably deteriorate quickly if not addressed beyond this period.

It has been recommended that further surveys are commissioned in say three years to inform the decision and timing of future investment.

2026/27

As part of the capital planning cycle the Capital Planning Team has circulated the capital themed risk registers to the relevant capital leads to assist them with the prioritisation of projects:

- Digital Director
- Deputy Director of Operations
- Director of Estates or nominated deputy
- Members of Capital Planning Group

With these risks in mind the Capital Planning Group, which has representation from the Operational Directorates, Digital Team and Estates is currently considering the distribution of the 2026/27 DCP allocation.

This consideration noted that the current level of DCP resource available will not enable HDdUHB to mitigate all the capital risks that are currently highlighted on the Health Board's risk registers as capital themed risks.

The current planning assumption is that the DCP allocation for 2026/27 will remain at £10.000m

We already have the following known Pre-Commitments against the 2026/27 and future year allocations. These are due to decisions already taken by the Health Board:

- To implement service changes
- On contributions towards WG policy decisions – 30% TEF
- On contributions towards All Wales Capital Programme funded capital schemes
- To deliver the actions of external inspections

	2026/27 £m	2027/28 £m
TEF 2026/27	2.200	
Paediatric Consultation	1.200	
Picton Terrace – for five years 2026/27 to 2030/31	0.110	0.110
Residential accommodation	0.200	0.200
WGH Microbiology	TBC	
Total	**3.710**	**0.310**

Discussions have commenced in the Capital Planning Group to prioritise the DCP expenditure plan for 2026/27 recognising that a balance will need to be held in the contingency reserve.

In advance of the CSC in January 2026 the Capital Planning Group will be developing a proposal for the programme that will look at:

- A plan that will overcommit the programme by 5% - 10% at the beginning of the year
- An expenditure plan that will run over two years
- Development of oven ready schemes

Potential contracts for sealing

The Board has approved the distribution of HDdUHB's capital allocation and plan. The delivery of this plan requires the Health Board to enter works and construction contracts which may require sealing. Works and construction contracts executed under seal provide an extended latent defects period cover, an extension from six years to 12 years.

Schemes listed in Annex 1, are the schedule of projects that are currently in our capital plan for 2025/26 where there may be associated works contracts that require sealing. This schedule is updated for Capital Sub Committee and SPC on an ongoing basis so that it can be submitted to Board with the Committee Update .

Capital Governance – Project Updates

At the November 2025 meeting of the Capital Sub-Committee, the projects with a current alert status were reported as follows:

Project:	RAG Indicator:	Stage:	Matters for Sub Committee attention:
Cross Hands Health and Wellbeing Centre	**ALERT**	**Full Business Case Development**	Discussions held with All Wales Capital Team, WG. Additional high level feasibility work being undertaken to consider services currently at GGH that could potentially relocate to Cross Hands. Scheme was therefore not submitted to Integration and rebalancing Capital Fund (IRCF) Panel in September 2025 for approval of fees to take to RIBA Stage 2 until further feasibility work completed. This work has now been shared with WG.
Next Key Milestone:	Await WG feedback on the high-level feasibility work shared.		

Project:	RAG Indicator:	Stage:	Matters for Sub Committee attention:
Fishguard Health and Wellbeing Centre	**ALERT**	SOC/OBC	Land workshop postponed due to confidentiality issues with one of the land options. High level capital cost estimates indicate that further reduction in scheme scope may be required to fall within financial envelope of £30m.
Next Key Milestone:	Land selection workshop – date tbc		

Project:	RAG Indicator:	Stage:	Matters for Sub Committee attention:
TEF 2025-26 and 2026-27	**ALERT**	Technical Design	Tendered costs significantly exceed budget (£1.376m shortfall). Proposed reallocation of other TEF scheme funding to protect delivery of highest risk priority schemes with deferral and reprofiling to 2026/27.
Next Key Milestone:	Manufacturing and Construction		

Projects led by other organisations:

Carmarthen Hwb (led by Carmarthenshire County Council)
Construction work is progressing well, with the current completion for this scheme due in 2026. Work continues on the commissioning plan for the development and site visits have been arranged with WG and other health boards.

Pentre Awel (led by Carmarthenshire County Council)
Canolfan Pentre Awel public opening of leisure services took place on 15 October 2025. The hydrotherapy pool element of this development is now complete and HDdUHB is currently in the process of commissioning this facility. The contractors for the Clinical Delivery Unit (CDU) are now on site, and it is expected that this phase of the development will be complete in 2026/27.

Cylch Caron (led by Ceredigion County Council)
A tender process for partners to work on the scheme closed with no tender returns. WG has requested a report that details the next steps for the Outline Business Case (OBC) refresh and a review of the resource schedule. A housing consultant has been commissioned to explore the options available to Ceredigion County Council for their elements of the scheme.

Update from Capital Sub Committee

Attached in Annex 2 is the update from the CSC held on 14 November 2025.

There are:

- One item to alert the Committee
- Four items to advise the Committee
- Six items to assure the Committee

Argymhelliad / Recommendation

The Strategy and Planning Committee is asked to:

- **RECEIVE ASSURANCE** from the update on the Capital Programme and CRL for 2025/26
- **NOTE** the allocation of the DCP for 2025/26 and the changes since Board ratification
- **RECEIVE ASSURANCE** from the work being undertaken on the planning of the 2026/27 DCP
- **RECEIVE ASSURANCE AND UPDATE THE BOARD**, that the seal can be applied for all schemes listed in Annex 1
- **RECEIVE ASSURANCE** from the capital schemes governance update and discuss the status of the Cross Hands scheme
- **RECEIVE ASSURANCE** from the Capital Sub Committee update in Annex 2 and **APPROVE** the updated Terms of Reference

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	3.1.16 Review capital (excluding digital) business cases, prior to Board approval.
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol:	Corporate Risk 1196 - not be able to provide safe, sustainable, accessible and kind services. This is

Datix Risk Register Reference and Score:	caused by insufficient investment to ensure we have appropriate facilities, medical equipment and digital infrastructure of an appropriate standard. Score 16 Corporate Risk 1745 - of not being able to deliver safe, effective and timely services across the Health Board estate, including acute, community and mental health facilities. This risk also impacts the Health Board's nonclinical estate, educational facilities and managed practices. Risk Score 15
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	1. Safe
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	5. Whole systems persepctive
Amcanion Strategol y BIP: UHB Strategic Objectives:	3. Great care
Amcanion Cynllunio Planning Objectives	8 Estates plans
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022	8. Transform our communities through collaboration with people, communities and partners

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Included within the report
Rhestr Termau: Glossary of Terms:	Not Applicable
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Strategaeth a Chynllunio Parties / Committees consulted prior to Strategy and Planning Committee:	Project Group Formal Executive Team

Effaith: (rhaid cwblhau) Impact: (must be completed)

Ariannol / Gwerth am Arian: **Financial / Service:**	Capital values noted within the report. Included within individual business cases and Capital prioritisation process.
Ansawdd / Gofal Claf: **Quality / Patient Care:**	Included within individual business cases and capital prioritisation process.
Gweithlu: **Workforce:**	Included within individual business cases and capital prioritisation process.
Risg: **Risk:**	Risk assessment process is integral to the capital prioritisation process and the management of capital planning within HDdUHB also included within individual business cases and capital prioritisation process.
Cyfreithiol: **Legal:**	Included within individual business cases and capital prioritisation process.
Enw Da: **Reputational:**	Included within individual business cases and capital prioritisation process.
Gyfrinachedd: **Privacy:**	Included within individual business cases and capital prioritisation process.
Cydraddoldeb: **Equality:**	Equality assessments are included within individual business cases and capital prioritisation process when required.

Annex 1

Potential Contracts requiring the use of the UHB Seal in 2025/2026					
Project Name	**Site**	**Funding Source**	**Supplier**	**Contract sealing date**	**Start on Site**
Phase 2 Fire Works	WGH	AWCP	TR Jones	October (end)	December / January
Phase 2 Fire Works	GGH	AWCP	to be added when known	to be added when known	to be added when known
Flouroscopy Room	WGH	AWCP	TR Jones	to be added when known	to be added when known
Provision 2nd generator at Glangwili Site	GGH	WG - TEF	TR Jones	to be added when known	30/03/2026
Provision 2nd generator at Withybush	WGH	WG - TEF	TR Jones	to be added when known	16/03/2026
Provision 2nd generator at Prince Philip	PPH	WG - TEF	TR Jones	to be added when known	22/06/2026
AHU Refurbishment Works all sites		WG - TEF	TR Jones	to be added when known	to be added when known
Replacement & upgrades to passenger lifts		WG - TEF	Otis	to be added when known	to be added when known
Glangwili Roof related projects	GGH	WG - TEF	TR Jones	to be added when known	12/01/2025
~~South Pembrokeshire roof related project~~ Combined with scheme above	~~SPH~~	~~WG - TEF~~	~~Edmunds Webster~~	~~to be added when known~~	~~to be added when known~~
PPH IPS UPS Installation	PPH	WG - TEF	Weavers	to be added when known	to be added when known
Theatre Lights upgrade		WG - TEF	Lewis Construction	to be added when known	to be added when known
Chiller replacement ITU	WGH	WG - TEF	Edmunds Webster	Signed under seal - yes - date ?	08/12/2025
LV Electrical Infrastructure		WG - TEF	TR Jones	to be added when known	to be added when known
Chiller refurbishment	PPH	WG - TEF	to be added when known	to be added when known	to be added when known
Replacement Fire dampers		WG - TEF	Weavers	to be added when known	to be added when known
Cause and effect upgrade programme		WG - TEF	TR Jones	to be added when known	to be added when known
Replacement programme obsolete fire alarms and detection system		WG - TEF	Lewis Construction	to be added when known	to be added when known
Ty Bryn Scheme		WG - TEF	Lewis Construction	to be added when known	22/06/2026
S136 Adult and Young Person Stepdown Carmarthen		WG - TEF	Lewis Construction	to be added when known	13/04/2026
St Non's Point of Ligature		WG - TEF	Lewis Construction	to be added when known	05/01/2026
Private Wire Solar Farm enabling works	PPH	WG - TEF	to be added when known	to be added when known	to be added when known
Phased replacement of single glazed windows		WG - TEF	to be added when known	to be added when known	to be added when known
Electrical vehicles Charging Points	GGH & PPH	WG - TEF	to be added when known	to be added when known	to be added when known
Replacement Surgical Instrument Washers	GGH	WG - TEF	to be added when known	to be added when known	to be added when known
Replacment endoscope washers and centralisation into HSDU	BGH	WG - TEF	Edmunds Webster	Pending	05/01/2026
Low Voltage Breaker replacements	GGH & PPH	WG - TEF	to be added when known	to be added when known	to be added when known
Picton Terrace	Picton Terrace	AWCP	TR Jones	21/05/2025	27/05/2025
Sensory Garden	PPH	Charitable Funds	TR Jones	to be added when known	to be added when known
Aseptic Project	WGH	AWCP	Lewis Construction	to be added when known	to be added when known
Fire Doors	AVH/PPH		Lewis Construction	to be added when known	to be added when known
Morlais Ward inc Fire Doors	GGH		Edmunds Webster	to be added when known	to be added when known
Concrete Cladding Remedial Works	WGH		to be added when known	to be added when known	to be added when known
Cwm Seren Fire Doors	Cwm Seren	WG - TEF	John Weaver	to be added when known	to be added when known
Point of Ligature Works MH bedrooms (TEF Cwm Seren)	Multiple Sites	WG - TEF	Lewis Construction	12/11/2025	24/11/2025
Fire Doors	Multiple Sites		to be added when known	to be added when known	to be added when known
St Brynach Day Hospital Roof Replacement	WGH	WG - TEF	to be added when known	to be added when known	to be added when known
Gamma Camera Upgrade patient experience	WGH	Diagnostic	to be added when known	to be added when known	to be added when known
GGH Front Door	GGH	TBC	John Weaver	to be added when known	to be added when known
MRI Upgrade in Glangwili	GGH	Diagnostic	to be added when known	to be added when known	to be added when known
Chiller Works	PPH	WG - TEF	to be added when known	to be added when known	to be added when known
Works to residences	WGH	DCP	to be added when known	to be added when known	to be added when known
Works to residences	PPH	DCP	to be added when known	to be added when known	to be added when known
Dinefwr Ward Works	GGH	DCP	to be added when known	to be added when known	to be added when known
Boiler Replacement	SPH	DCP	to be added when known	to be added when known	to be added when known
Mains gas works	WGH	DCP	to be added when known	to be added when known	to be added when known
Chiller Works	BGH	DCP	to be added when known	to be added when known	to be added when known
LTHW Heating Boiler, Prince Philip General Hospital & Low-Pressure Hot Water (LPHW), Glangwili General Hospital	PPH/GGH	TBC	to be added when known	to be added when known	to be added when known
Microbiology Works	WGH	DCP	to be added when known	to be added when known	to be added when known
Dexa Scanner Works	BGH	TBC	to be added when known	to be added when known	to be added when known

CAPITAL SUB COMMITTEE UPDATE REPORT

Date of last meeting: 14 November 2025

Quoracy: Met

Report by: Eldeg Rosser, Head of Capital Planning

KEY DISCUSSION POINTS AND MATTERS TO BE ESCALATED FROM THE DISCUSSION AT THE MEETING:

Alert[1] (may require discussion)

The Capital Sub-Committee wishes to **alert** members of the Strategy and Planning Committee (SPC) that:

1. **AHMWW Programme.**

   The Health Board has had further constructive discussions with Welsh Government (WG) on the infrastructure challenges facing the organisation, in particular at the Withybush (WGH) and Glangwili (GGH) Hospital sites.

   WG has recently requested the Health Board produce an addendum to the Programme Business Case (PBC) submitted in February 2022, by early in the New Year. This is a significant piece of work, which is currently being scoped. At this stage the intention is to present it to Public Board in January 2026. There is a risk that this is will be unachievable in the timeline as Hywel Dda University Health Board (HDdUHB) has still to finalise with WG officers the scope of work required for the Addendum. There is also a risk that the capital cost may be in excess of WG expectations.

Advise[2] (to monitor)

Capital Sub-Committee wishes to **advise** members of SPC that:

1. **Capital Resource Limit 2025/26:**

   - Spend against capital programme at the end of October 2025 has increased at 22%; this is lower than spend in previous financial years, due to:
     - Funding approvals received mid-year.
     - Profile spend of Targeted Estates Fund (TEF) scheme.
   - At end of September 2025, reporting overspend position against capital programme of £845k due to assumption that WG would fund WGH cladding.
   - At end of October 2025, funding returned to WG for underspend against capital schemes as usual; £804k underspend reported with largest part related to Carmarthen Hwb.

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[1] *There is a lack of confidence that any action in place is sufficient to address the issue satisfactorily and/or within the scope of the operational team or executive to resolve. Engagement, action or intervention required.*

[2] *There are areas of concern where assurance has been taken on actions in place but requires close monitoring. An early warning of an emerging and potentially serious concern*.

- £1.5m returned as slippage; just under £1m of this linked to Pentre Awel and Carmarthen Hwb due to the commissioning periods going into 2026-27. The other funding is linked to TEF schemes.

2. **Capital Programme 2025/26:**

- Position on end-of-year capital:
- HDdUHB had submitted schedules to WG for any available end-of-year allocations.
- In last fortnight, approval has been received to proceed with the GGH front door scheme which is now proceeding at pace.
- The current planning assumption is that the Discretionary Capital Programme (DCP) allocation for 2026/27 will remain at £10m. Pre-commitments are approximately £3.7m.
  Discussions have taken place in Capital Planning Group (CPG) regarding looking at over-committing at the beginning of the year, given that delay and slippage is inevitable.
  During the recent Capital Review Meeting (CRM), discussions with WG explore the potential for TEF 2; while no commitment was given, there is an expectation that an allocation may be possible . Therefore. planning for these schemes should begin, for surety regarding the development of a programme that, if over-committed, would need to be escalated to the Executive Team.

3. **Targeted Estates Funding**

- Five of the tenders came in over budget, resulting in an estimated shortfall of approximately £1.2m. Following discussions with WG, there is currently no slippage available for HDdUHB, meaning the shortfall will need to be funded internally through previously approved schemes.
- Considering a potential pause on the Prince Philip Hospital (PPH) generator scheme, as its timeline is behind the WGH and GGH schemes. PPH also benefits from better road links, which would facilitate the use of a temporary generator, if required.

4. **Joint Capital Construction Framework**

   CSC noted the FCSG approval to proceed, endorsed HDdUHB's participation in the joint framework and approved submission to the next governance stage in line with procurement timelines

Capital Sub-Committee wishes to **assure** members of the SPC that:

1. **Committee Key Actions** have been reviewed and items noted for information.

2. **Terms of Reference** have been reviewed with membership reviewed and updated. These are attached for approval by SPC.

3. **Capital Governance Update -** Capital Sub Committee has taken assurance on the schemes progressing as planned and RAG rated green, and were advised on the schemes RAG rated amber. The CSC had discussed and

were alerted to the schemes RAG rated red: Fishguard and TEF, and Cross Hands.

4. **Welsh Government Dashboard Reports** submitted to WG on the All Wales Capital Programme (AWCP) and Integration & Rebalancing Capital Fund (IRCF) funded projects, reflecting progress up to the end of September 2025.

5. **Fire Safety Management Update** on the fire programme.
   - WGH – This is the final stage of works needed at WGH and has now been fully approved by WG.
   - GGH – The business case is on programme to be ready February/ March 2026.
   - Bronglais Hospital (BGH) – this is a Letter of Fire Safety. Programme Business case (PBC) submission to WG was in April 2025. There was confidence that this would be endorsed in November 2025.

6. **Procurement Update and governance and compliance around t**he Procurement Act 2023 that came into force in February 2025, introducing new obligations.

Papers for information were noted by the CSC as follows:

- Capital Review Meeting – Minutes of meeting 4 September 2025
- Capital Planning Group – Minutes of meeting 24 October 2025
- Capital Monitoring Forum – Minutes of meeting 9 September 2025 and 14 October 2025.
- Major Infrastructure Report
- Estate Backlog Report to SPC
- Scrutiny Grids:
  - Bandi
  - Fire Precaution Works WGH
  - Fire Precaution Upgrade Works BGH
  - Emergency Department GGH

Review of Risks

1. **Capital Resource Limit 2025/26:** CSC members made aware that the flagged risk 2204 of not achieving the Capital Resource Limit (CRL) has been allocated a score of 12 with a target score of 8, which is a medium-level risk.

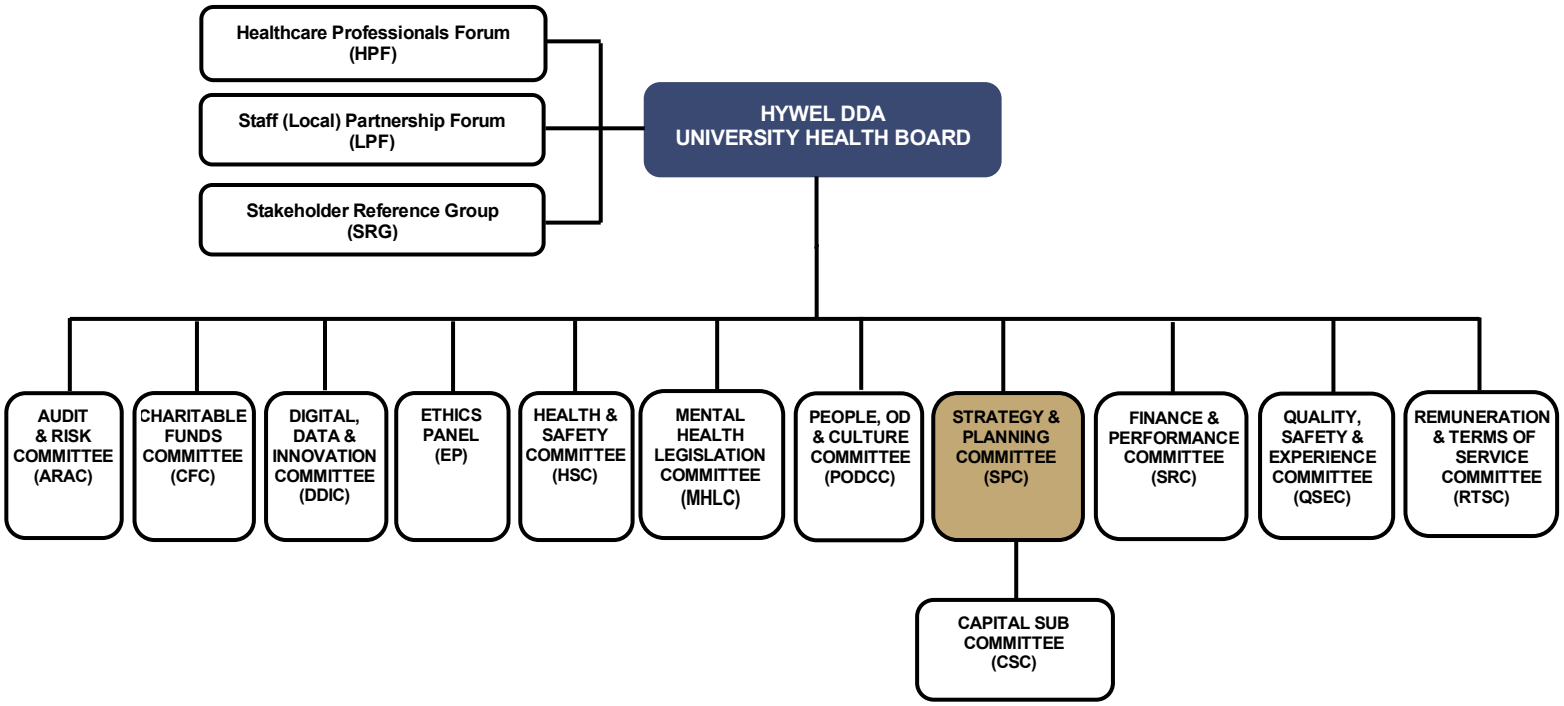
2. **Targeted Estates Funding:** WGH and GGH generator due to the tender costs they will now start this financial year and complete next year. Noted that the existing risk would need to be tolerated until this time.

Recommendation

The Strategy and Planning Committee is asked to:

- Approve the updated Terms of Reference for Capital Sub Committee

- **NOTE** the items the Sub-Committee is advising them of
- **RECEIVE ASSURANCE** from the items that the Sub-Committee is providing assurance on



TERMS OF REFERENCE

CAPITAL SUB-COMMITTEE

Version	Issued to:	Date	Comments
V1	People Planning & Performance Assurance Committee	30th June 2015	Membership additions
V2	Governance Team	July 2015	Aligned to Governance Review
V3	Capital, Estates & IM&T Sub Committee	July 2015	Membership additions and aligned to PPPAC ToRs – approved
V4	Capital, Estates & IM&T Sub Committee	February 2016	Membership and frequency revisions
V5	Capital, Estates & IM&T Sub Committee	August 2017	In conjunction with Corporate Governance Team TOR aligned to PPPAC TORs. Sections 7 & 8

			updated
V6	People Planning & Performance Assurance Committee	24th October 2017	Regional planning made more explicit
V7	Capital, Estates & IM&T Sub Committee	29th January 2019	DRAFT Membership reviewed, updates to purpose of the sub-committee and sub-group reporting.
V8	People Planning & Performance Assurance Committee	19th February 2019	Approval of amendments noted at CEIM&T 29/01/19
V9	Capital, Estates & IM&T Sub Committee	19th November 2020	Approval given. Amendments made
V10	People Planning & Performance Assurance Committee	17th December 2020	For approval
V9	Capital, Estates & IM&T Sub Committee	25th November 2021	For discussion
V10	Capital, Estates & IM&T Sub Committee	27th January 2022	Approved following amendments made
V11	Strategic Development and Operational Delivery Committee	24th February 2022	For approval
V12	Capital Sub Committee	22nd November 2022	Approved following amendments made
V13	Capital Sub Committee	23rd March, 2023	Approved by SDODC 27/04/2023 subject to 1 amendment see V14 5.12
V14	Capital Sub Committee	25th May 2023	For information
V15	Capital Sub Committee	July, 2023	Updated membership list for discussion with CSC
V16	Capital Sub Committee	6th November, 2023	Updated in line with recommendations made at CSC meeting 22.09.23. For further review at CSC 17.11.23 Approved by SDODC 21/12/23
V17	Capital Sub Committee	19th November, 2024	The following changes agreed at CSC meeting 19.11.24 for onward ratification by SDODC at their meeting on 19.12.24 • Change

			Head of Therapies to Chair of Medical Devices Group • insert after the current 5.10 *To receive reports and papers relating to the effective application of capital resources scrutinising final use against original business justification intentions. Monitors the improvement impacts of strategic investment over time.* Approved by SDODC on 19 December 2024.
V18	Capital Sub Committee	14 November 2025	Approved, changes included • change in reference to SPC as parent Committee • updated membership
V18	Strategy and Planning Committee	18 December 2025	For Approval

CAPITAL SUB-COMMITTEE

1. Constitution

1.1 The Capital Sub-Committee (CSC) has been established as a Sub Committee of the Strategy and Planning Committee (SPC) and constituted from 1 June 2015.

2. Principal Duties

2.1 The purpose of the Capital Sub-Committee Committee is to:

2.1.1 Oversee the delivery of the Health Board's capital programmes and projects included in the planning cycle (in year and longer term).

2.1.2 Recommend to the Board via SPC the use of the Health Board's Capital Resource Limit (CRL), in line with the Health Board's financial scheme of delegation.

2.1.3 Review on an annual basis, the Discretionary Capital Programme (DCP) for the following financial year.

2.1.4 Oversee the development of the Estates Strategy and Infrastructure Investment Enabling Plan aligned to the A Healthier Mid and West Wales (AHMWW) Strategy for consideration by SPC, prior to Board approval.

2.1.5 Oversee the development and delivery of implementation plans for the Estates Strategy agreeing corrective actions where necessary and monitoring its effectiveness.

3. Operational Responsibilities

3.1. The Sub-Committee will, in respect of its provision of advice and assurance to the Board:

3.1.1. Develop recommendations to the Board, via the SPC and Executive Team, on the use of the Health Board's Capital Resource Limit (CRL), for approval.

3.1.2. Develop prioritised recommendations for discretionary capital sums and All Wales Capital Schemes and receive investment proposals, in response to an assessment of the organisation's risks, and to support the Health Board's A Healthier Mid and West Wales Strategy (including delivery plans) and vision for healthcare and its strategic objectives, including performance and financial improvement.

3.1.3. Provide a co-ordinated approach to overseeing delivery of the Health Board's capital programmes and projects included in the planning cycle (in year and

longer term) enabling the Health Board to understand the overall delivery commitments and risks and proposing changes as appropriate.

3.1.4. Provide assurance that capital projects are managed and governed in accordance with mandatory requirements, best practice and the latest Welsh Government capital guidance, ensuring that revenue consequences associated with capital projects are explicit at project scoping stage.

3.1.5. Provide assurance around the effective management of the Health Board's CRL, ensuring expenditure is in line with Standing Orders and within the agreed programme.

3.1.6. Scrutinise and quality assure major capital business cases prior to submission to SPC including those developed in partnership with other organisations such as, Local Authorities, GP partners and Third Sector organisations.

3.1.7. Ensure a robust disposal policy for redundant estate is in place.

3.1.8. Consider options for the acquisition or disposal of estate and agree recommendations for the Board, via SPC.

3.1.9. Review and recommend the appropriate delegated limits for capital expenditure authorisation and authorisation for other funding sources.

3.1.10. Present and review a schedule of projects/schemes within the Health Board's Capital Plan where there may be associated works contracts that require sealing.

3.1.11. Make recommendations on capital expenditure in relation to Digital, medical and non-medical equipment, estates statutory and infrastructure, contingencies and other provisions.

3.1.12. To receive timely post project evaluation and project closure reports which will include a review of the effective application of capital resources and scrutinise the final use against original business justification objectives and monitors the initial improvement impacts of strategic investment.

3.1.13. Provide assurance to SPC that risk is considered as part of prioritisation of capital expenditure items and that where risks are not addressed by capital funding, these risks have been reviewed to assess whether further mitigation actions should be taken (to minimise the impacts should the risk materialise), contingency measures can be strengthened (in case the risk materialises to minimise disruption) and reflect whether the risk is being tolerated or further treated.

3.1.14. Agree the Annual Capital Audit Plan and action against recommendations contained within audit reports issued by Capital Audit.

3.1.15. To receive regular progress updates on the Housing with Care Fund and Integrated Rebalancing Capital Funds Capital bids and schemes being progressed through the West Wales Regional Partnership Board.

3.1.16. Agree issues to be escalated to SPC with recommendations for action.

3.1.17. Agree an annual work plan for the Sub-Committee for review and approval by SPC.

4. Membership

4.1 The membership of the Committee shall comprise:

Member
Executive Director of Strategy and Planning (Chair)
Assistant Director of Strategic Planning and Development (Deputy Chair)
Independent Member
Director of Estates and Facilities or Deputy
Programme Director Major Infrastructure Projects
Discretionary Capital Projects Manager
Head of Property Performance
Senior Business Partner (Finance) (Delegated on behalf of the Director of Finance)
Head of Facilities Information and Capital Management
Deputy Director of Operations
Digital Director
Assistant Director of Assurance and Risk
Head of Procurement
Head of Capital Planning (Sub Committee Lead)
Chair of Medical Devices Group
Director of Nursing and Control of Infection representative

4.2 The following should attend Committee meetings:

In Attendance
Committee Support/Secretary
Head of Capital Audit (three times a year/tri-annual)
Capital Programme Manager, Capital Planning
Project Manager, Capital Planning
Capital Programme Manager, West Wales Regional Partnership Board
Head of Maintenance and Engineering
Papers sent for Information
Clinical Care Group Service Director – Community and Integrated Medicine
Clinical Director of Pharmacy and Medicines Management
Clinical Care Group Service Director - Planned and Specialist Care
Clinical Care Group Service Director - Allied Health Professions and Health Sciences
Clinical Care Group Service Director - MH&LD

Assistant Director of Primary Care
Assistant Director, Medical Directorate (Delegated on behalf of the Medical Director)

4.3 The membership of the Sub-Committee will be reviewed on an annual basis.

5. Quorum and Attendance

5.1 A quorum shall consist of no less than a third of the membership and must include as a minimum the Chair or Vice Chair of the Sub-Committee.

5.2 An Independent Member shall attend the meeting in a scrutiny capacity. The scrutiny role of Independent Members on Sub-Committees is to ensure their effectiveness in terms of processes and outcomes, and in particular that their work is organised and undertaken in accordance with their terms of reference, that they have clarity about the limits of their delegated powers and responsibilities, and that they understand fully their relationship with and reporting responsibilities to their parent Committee.

5.3 Any senior officer of the Health Board or from a partner organisation may, where appropriate, be invited to attend, for either all or part of a meeting to assist with discussions on a particular matter.

5.4 The Sub-Committee may also co-opt additional independent external 'experts' from outside the organisation to provide specialist skills.

5.5 Should any officer Member be unavailable to attend, they may nominate a suitably briefed deputy to attend in their place. Where attendance is delegated, the nominated representative is responsible for informing discussions where relevant and reporting back to the named member accordingly.

5.6 The Head of Internal Audit shall have unrestricted and confidential access to the Chair of the Capital Sub-Committee.

5.7 The Sub-Committee may ask any or all of those who normally attend but who are not members to withdraw to facilitate open and frank discussion of particular matters.

6. Agenda and Papers

6.1 The Sub- Committee Secretary is to hold an agenda setting meeting with the Chair and/or Vice Chair and the Lead Executive/Assistant Director at least **six** weeks before the meeting date.

6.2 The agenda will be based around the Sub-Committee work plan, identified risks matters arising from previous meetings, issues emerging throughout the year and requests from Sub-Committee Members. Following approval, the agenda and timetable for request of papers will be circulated to all Sub-Committee Members.

6.3 All papers should have relevant sign off before being submitted to the Sub-Committee Secretary.

6.4 The agenda and papers for meetings will be distributed **seven** days in advance of the meeting.

6.5 The minutes and action log will be circulated to members within ten days to check the accuracy.

6.6 Members must forward amendments to the Sub-Committee Secretary within the next **seven** days. The Sub-Committee Secretary will then forward the final version to the Committee Chair for approval.

7. Frequency of Meetings

7.1 The Sub-Committee will meet bi-monthly and shall agree an annual schedule of meetings. Additional meetings will be arranged as determined by the Chair of the Sub-Committee.

7.2 The Chair of the Sub-Committee, in discussion with the Sub-Committee Secretary, shall determine the time and the place of meetings of the Sub-Committee and procedures of such meetings.

8. Accountability, Responsibility and Authority

8.1 The Sub-Committee will be accountable to the Strategy and Planning Committee for its performance in exercising the functions set out in these terms of reference.

8.2 The Sub-Committee shall embed the Health Board's vision, corporate standards, priorities and requirements through the conduct of its business.

8.3 The requirements for the conduct of business as set out in the Health Board's Standing Orders are equally applicable to the operation of the Sub-Committee.

9. Reporting

9.1 The Sub Committee, through its Chair and Members, shall work closely with the SPC and other committees, including joint /sub committees and groups to provide advice and assurance to the Board through the:

9.1.1 Joint planning and co-ordination of Board and Committee business.

9.1.2 Sharing of information.

9.2 In doing so, the Committee shall contribute to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the Board's overall risk and assurance framework.

9.3 The Sub-Committee may establish groups or task and finish groups to carry out on its behalf specific aspects of Sub-Committee business. The following groups have been established:

9.3.1 Capital Planning Group (CPG)

9.3.2 Capital Monitoring Forum (CMF)

9.4 The Sub-Committee will receive an update following each Group's meetings detailing the business undertaken on its behalf.

9.5 The Sub-Committee will also receive updates from the regular Capital Review meetings held with Welsh Government representation.

9.6 The Sub-Committee Chair, supported by the Sub-Committee Secretary shall:

9.6.1 Report formally, regularly and on a timely basis to SPC on the Sub-Committee's activities. This includes the submission of a Sub-Committee update report, as well as the presentation of an Annual Report within six weeks of the end of the financial year.

9.6.2 Bring to SPC's specific attention any significant matter under consideration by the Sub-Committee.

10. Secretarial Support

10.1 The Sub-Committee Secretary shall be determined by the Lead Director.

11. Review Date

12.1 These terms of reference shall be reviewed on at least an annual basis by the Sub-Committee for approval by SPC.

5.2

11:55, 10 Mins

5.2 - Targeted Estates Fund (TEF) Projects

Lee Davies (Hywel Dda UHB - Executive Director of Strategy and Planning), Darrel Barnes (Hywel Dda UHB - Design Manager)

Provision of Second Generators at Glangwili & Withybush Hospitals

For approval

Attachments

5.2.1 SPC SBAR GGH WGH Second Generator 20251204 (JS, JWJ).pdf

5.2.2 Appendix 1 IIA.pdf

5.2.3 Apendix 2 EqIA.pdf

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

PWYLLGOR STRATEGAETH A CHYNLLUNIO
STRATEGY AND PLANNING COMMITTEE

DYDDIAD Y CYFARFOD: DATE OF MEETING:	18 December 2025
TEITL YR ADRODDIAD: TITLE OF REPORT:	Targeted Estates Fund (TEF) Projects: Provision of Second Generators at Glangwili and Withybush Hospitals
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	James Severs, Executive Director of Allied Health Professions and Health Science
SWYDDOG ADRODD: REPORTING OFFICER:	Simon Chiffi, Head of Operations

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Ar Gyfer Penderfyniad/For Decision

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

This report sets out the position with regards to the proposed Second Generators provision and associated electrical installations, groundworks and controls works at Glangwili Hospital (GGH) and Withybush Hospital (WGH).

Funded by Welsh Government (WG) support (Targeted Estates Funding (TEF)), approval is sought to award the contracts to deliver the main contract works, in line WG guidance.

Cefndir / Background

Hywel Dda University Health Board (HDdUHB) has received WG funding to support the provision of Second Generators at GGH and WGH to significantly improve site resilience and continuity of our healthcare services in the event of a network power-outage and support alignment with the requirements of WHTM 06-01.

WG confirmed a commitment totalling £5.269m of Infrastructure funding to HDdUHB on 21 March 2025, with the provision of the Second Generators being a key element of the programme. This investment will support the purchase of second generators and associated infrastructure upgrading to improve site resilience, reflecting our dedication to sustaining healthcare services for our communities. By working closely with the NHS Wales Shared Services Partnership (NWSSP) and WG, we are ensuring these improvements align with wider efforts to strengthen estate resilience and ensure service continuity.

This funding and the planned upgrades reflect our commitment to meeting essential service needs and delivering better care for all.

Asesiad / Assessment

These Contract Awards are in line with Section 10 of the NHS Wales Infrastructure Investment Guidance. Paragraph 13 (3) of Schedule 2 to the National Health Service (Wales) Act 2006 requires Local Health Boards to obtain Welsh Ministers' consent to acquire and dispose of property and enter into contracts. Contract approvals over £1m for individual schemes will be sought as part of the normal business case submission process where funding from the NHS Capital Programme is required.

The Contracts will be funded via the £5.269m WG funding and HDdUHB Discretionary Capital match-funding, and are in line with NWSSP's Construction Framework West: HDdUHB - £200k to £2m compliant with UK/EU procurement legislation. This framework included several potential providers who had achieved inclusion on the framework following a qualification process.

The HDdUHB Estates and Facilities directorate seeks to establish a single call-off contract for the provision of Second Generators and associated infrastructure works at GGH and WGH. The Call-off Contracts will be actioned by HDdUHB, utilising standard Joint Contracts Tribunal (JCT) contract templates (Intermediate Form of Contract and Agreements in place by Legal Team - Bevan Brittan). The framework is structured by awarding contracts on a rotational basis. The Call-Off option of direct award is available subject to supplier being next on rotation.

This multi-supplier framework agreement covers the provision of qualified construction contractors to undertake various packages of minor/intermediate and major works which meets HDdUHB's requirements. All suppliers have been added to the framework following a robust and compliant tendering process, enabling the inclusion of suppliers both willing and able to provide customers with the construction related works required to meet the Health Board's strategic objective.

The tenders were assessed in detail against subcontractor pricing, the framework agreed uplift percentages and the works requirements using industry data to benchmark the submitted rates from previous phases of works to confirm acceptance and value for money. The tenders are in line with the NWSSP construction framework - award and call off procedures:

- NWSSP Procurement Services Tender Reference CAP-OJEU-91888
- Region B: Lot 4 Projects from £200k to £2m - HDdUHB
- Rotational – Direct Award with T. Richard Jones (Betws) Ltd

For the 2024/25 Discretionary Capital Projects, the Capital Systems Final Internal Audit Report concluded a **substantial audit rating** for both the selection and appointment processes and the value for money and award considerations. This outcome reflects the robust stewardship and financial control exercised by the Discretionary Capital Design Team at HDdUHB, in line with NHS Wales standards. By leveraging the direct award mechanism within an approved framework, we have streamlined procurement, reduced costs, and maintained transparency, ensuring the selection of suitable suppliers based on objective criteria. This approach not only prioritises the Health Board's service needs but also frees up valuable clinical and estates resources, delivering measurable efficiency gains. The substantial rating affirms our commitment to achieving economy, efficiency, and effectiveness, reinforcing public trust in our management of taxpayer funds. This success positions us well to advance our "spend to save" objectives, delivering long-term value for the organisation.

HDdUHB and external cost adviser Atkins Realis, undertook the cost plan process and evaluation in accordance with the framework evaluation criteria, specification, schedules and assessment of the sustainability and overall value for money:

1. Framework Requirements – Award and Call off Procedure
2. Quoted Price / Commercial Arrangements - 100%
3. Social Value in Construction in-line with Framework Lot 4
4. The Framework Supplier will be required to assist the Authority in delivering its obligations under the Wellbeing of Future Generations (WBoFG) (Wales) Act 2015, with respect to improving the social, economic, and environmental wellbeing (Social Value) of the local area through its activities.

The budget for the contract works at **GGH** is £1,115,292.09 (exc. VAT):

Element	Cost
TRJ Construction Contract Sum (excl. VAT)	**£1,115,292.09**
Fees and Survey Costs as DAF (excl. VAT)	£97,273.44
Non-Works Costs as DAF (excl. VAT)	£9,496.30
Equipment Costs as DAF (excl. VAT)	£0.00
Total Project Costs excluding Contingency and VAT	**£1,222,061.83**
Contingency as DAF	£49,400.00
Total Project Costs including Contingency (excl. VAT)	**£1,271,461.83**
VAT (20%)	£254,292.37
Sub Total	**£1,525,754.20**
Less Recoverable VAT	-£19,454.69
Forecast Project Out-Turn Cost	**£1,506,299.51**

The budget for the contract works at **WGH** is £1,197,845.51 (exc. VAT):

Element	Cost
TRJ Construction Contract Sum (excl. VAT)	**£1,197,845.51**
Fees and Survey Costs as DAF (excl. VAT)	£89,263.53
Non-Works Costs as DAF (excl. VAT)	£8,357.00
Equipment Costs as DAF (excl. VAT)	£0.00
Total Project Costs excluding Contingency and VAT	**£1,295,466.04**
Contingency as DAF	£35,500.00
Total Project Costs including Contingency (excl. VAT)	**£1,330,966.04**
VAT (20%)	£266,193.21
Sub Total	**£1,597,159.25**
Less Recoverable VAT	-£17,852.71
Forecast Project Out-Turn Cost	**£1,579,306.54**

The outcome of the suppliers' bids based on their written response resulted in a recommendation to award the contracts to 'T Richard Jones (Betws) Ltd ' for the works in the sums of £1,115,292.09 (exc.VAT) for GGH and £1,197,845.51 (exc.VAT) for WGH, as their bids offered the best fit with the key criteria, could meet the required timescales and offered the best overall value for money.

Argymhelliad / Recommendation

The Committee is requested to:

- **RECOMMEND,** for onward ratification by Board on **29 January 2026**, award of the contracts at £1,115,292.09 (exc. VAT) for Glangwili General Hospital and £1,197,845.51 (exc.VAT) for Withybush General Hospital to 'T. Richard Jones (Betws) Ltd', with call-off agreement to be prepared and executed by the Health Board.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	3.1.16.Review capital (excluding digital) business cases, prior to Board approval.
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Glangwili General Hospital: Datix Risk Register Reference: 1049 Current risk score: 10 (high) Withybush General Hospital: Datix Risk Register Reference: 2014 Current risk score: 12 (high)
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	1. Safe 2. Timely 3. Effective Not Applicable
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	Not Applicable
Amcanion Strategol y BIP: UHB Strategic Objectives:	All Strategic Objectives are applicable
Amcanion Cynllunio Planning Objectives	8 Estates plans
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022	10. Not Applicable

Gwybodaeth Ychwanegol: **Further Information:**	
Ar sail tystiolaeth: Evidence Base:	Within report
Rhestr Termau: Glossary of Terms:	Within report
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol:	TEF Project Group Business Executive Team meeting – 10 December 2025

Parties / Committees consulted prior to University Health Board:	

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	Capital Funding in place to deliver the works. Refer to Integrated Impact Assessment Template (Appendix 1).
Ansawdd / Gofal Claf: Quality / Patient Care:	Direct impact on patient environment. Refer to Integrated Impact Assessment Template.
Gweithlu: Workforce:	No direct impact. Refer to Integrated Impact Assessment Template.
Risg: Risk:	The risk is identified on the corporate risk register. Business continuity plans in place for project period. Refer to Integrated Impact Assessment Template.
Cyfreithiol: Legal:	Not applicable.
Enw Da: Reputational:	Unlikely due to temporary/limited nature of disruption during installation period. Refer to Integrated Impact Assessment Template.
Gyfrinachedd: Privacy:	Not applicable.
Cydraddoldeb: Equality:	Potential negative/positive impacts identified in the Equality Impact Assessment (EqIA) documentation. • Has EqIA screening been undertaken? Yes, refer to Appendix 1 • Has a full EqIA been undertaken? Yes, refer to Appendix 2

Integrated Impact Assessment Tool	Y/N	Evidence & Further Information	Completed By	Evidence (Insert)
Financial/Service Impacts				
1. Has the new proposal/service model been costed? If so, by whom?	**Y**	The discretionary capital team and external cost adviser Atkins Realis, undertook the cost plan process and evaluation in accordance with the framework evaluation criteria, specification, schedules and assessment of the sustainability and overall value for money: 1. Framework Requirements – Award and Call off Procedure 2. Quoted Price / Commercial Arrangements - 100% 3. Social Value in Construction in-line with Framework Lot 4 4. The Framework Supplier will be required to assist the Authority in delivering its obligations under the Wellbeing of Future Generations (Wales) Act 2015, with respect to improving the social, economic, and environmental wellbeing ('Social Value) of the local area through its activities.	**SD/DB**	
2. Does the budget holder have the resources to pay for the new proposal/service model? Otherwise how will this be supported - where will the resources/money come from i.e. specify budget code or indicate if external funding, etc?	**Y**	WG has committed funding for the purchase of second generators and associated works together with DCP match-funding . The HDdUHB Estates & Facilities directorate seeks to establish a single call-off contract for the provision of second	**SD/DB**	

		generators & associated works work at Glangwili & Withybush General Hospitals		
3. Is the new proposal/service model affordable from within existing budgets?	**Y**	WG funding secured and DC funding committed	**SD/DB**	
4. Is there an impact on pay or non pay e.g. drugs, equipment, etc?	**N**		**SD/DB**	
5. Is this a spend to save initiative? If so, what is the anticipated payback schedule?	**N**		**SD/DB**	
6. What is the financial or efficiency payback (prudency), if any?	**N**		**SD/DB**	
7. Are there risks if the new proposal/service model is not put into effect?	**Y**	There is a serious risk to patients & service-delivery of power-outage at these acute sites from network or existing (aged) generator failure if these projects are not implemented	**SD/DB**	
8. Are there any recognised or unintended consequences of changes on other parts of the system (i.e. impact on current service, impact of changes in secondary care provision on primary care services and capacity or vice versa, or other statutory services e.g. Local Authorities?)	**N**		**SD/DB**	
9. Is there a need for negotiation/lead in times i.e. short term, medium term, long term? If so, with whom e.g. staff, current providers, external funders, etc?	**Y**	There are significant lead-in times for manufacture & delivery of the generator sets, thus the need to proceed to contract and orders as swiftly as possible	**SD/DB**	
10. Are capital requirements identified or funded?	**Y**	WG funding approved & DC funding committed.	**SD/DB**	
11. Will capital projects need to be completed in time to support any service change proposed?	**N**		**SD/DB**	
12. Has a Project Board been identified to manage the implementation?	**N**		**SD/DB**	

13. Is there an implementation plan with timescales to performance manage the process and risks?	**Y**	Project working group have defined and monitor programme for implementation	**SD/DB**	
14. Is there a post project evaluation planned for the new proposal/service model?	**Y**	On completion, with NWSSP	**SD/DB**	
15. Are there any other constraints which would prevent progress to implementation?	**N**		**SD/DB**	
Quality/Patient Care Impacts			**SD/DB**	
16. Could there be an impact on patient outcome/care?	**Y**	As 7 above	**SD/DB**	
17. Is there any potential for inequity of provision for individual patient groups or communities? E.g. rurality, transport.	**N**		**SD/DB**	
18. Is there any potential for inconsistency in approach across the Health Board?	**N**		**SD/DB**	
19. Is there are potential for postcode lottery/commissioning?	**N**		**SD/DB**	
20. Is there a need to consider exceptional circumstances?	**N**		**SD/DB**	
21. Are there clinical and other consequences of providing or delaying/denying treatment (i.e. improved patient outcomes, chronic pain, physical and mental deterioration, more intensive procedures eventually required?	**N**		**SD/DB**	
22. Are there any Royal College standards, NICE guidance or other evidence bases, etc, applicable?	**N**		**SD/DB**	
23. Can clinical engagement be evidenced in the design of the new proposal/service model?	**N**	Infrastructure projects	**FSD/DB**	

24. Are there any population health impacts?	**N**		**SD/DB**	
Workforce Impact			**SD/DB**	
25. Has the impact on the existing staff/WTE been determined?	**N**	N/A	**SD/DB**	
26. Is it deliverable without the need for premium workforce?	**Y**		**SD/DB**	
27. Is there the potential for staff disengagement if there is no clinical/'reasonable' rationale for the action?	**N**		**SD/DB**	
28. Is there potential for professional body/college/union involvement?	**N**		**SD/DB**	
29. Could there be any perceived interference with clinical freedom?	**N**		**SD/DB**	
30. Is there potential for front line staff conflict with the public?	**N**		**SD/DB**	
31. Could there be challenge from the 'industries' involved?	**N**		**SD/DB**	
32. Is there a communication plan to inform staff of the new arrangements?	**N**	Engagement with service-leads in advance of any works if considered to be disruptive	**SD/DB**	
33. Has the Organisational Change Policy been followed, including engagement/consultation in accordance with guidance?	**N**	N/A	**SD/DB**	
34. Have training requirements been identified and will this be complete in time to support the new proposal/service model?	**Y**	Estates-team specific induction/training on project handover to ensure future management & maintenance of installation	**SD/DB**	
Risk Impact			**SD/DB**	
32. Has a risk assessment been completed?	**N**		**SD/DB**	

33. Is there a plan to mitigate the risks identified?	**Y**	Business continuity plans in place for project period.	**SD/DB**	
Legal Impact			**SD/DB**	
34. Has legal compliance been considered e.g. Welsh Language: is there any specific legislation or regulations that should be considered before a decision is made?	**Y**		**SD/DB**	
35. Is there a likelihood of legal challenge?	**N**		**SD/DB**	
36. Is there any existing legal guidance that could be perceived to be compromised i.e. Independent Provider Contracts, statutory guidance re: Continuing Healthcare, Welsh Government Policy etc?	**N**		**SD/DB**	
37. Is there any existing contract and/or notice periods?	**N**		**SD/DB**	
Reputational Impact			**SD/DB**	
38. Is there a likelihood of public/patient opposition?	**N**		**SD/DB**	
39. Is there a likelihood of political activity?	**N**		**SD/DB**	
40. Is there a likelihood of media interest?	**N**		**SD/DB**	
41. Is there the potential for an adverse effect on recruitment?	**N**		**SD/DB**	
42. Is there the likelihood of an adverse effect on staff morale?	**N**		**SD/DB**	
43. Potential for judicial review?	**N**		**SD/DB**	

Privacy Impact			**SD/DB**	
44. Have the Information Governance Team been contacted about the project to assess whether a Data Protection Impact Assessment (DPIA) needs to undertaken?	**N**		**SD/DB**	
45. Has a full DPIA been undertaken – Please contact Information.Governance3@wales.nhs.uk for the template.	**N**		**SD/DB**	
Equality Impact (unless otherwise completed as part of the accompanying SBAR)			**SD/DB**	
46. Has Equality Impact Assessment (EqIA) screening been undertaken – follow link below? Equality, diversity and inclusion (sharepoint.com)	**Y**		**SD/DB**	**Appendix 2 EqIA**
47. Has a full EqIA been undertaken – follow link below? Equality, diversity and inclusion (sharepoint.com)	**Y**		**SD/DB**	**Appendix 2 EqIA**
48. Have any negative/positive impacts been identified in the EqIA documentation?	**Y**	Refer to EqIA (embedded) **Positive** • The second generators will provide improved resilience to the 2no. acute sites, ensuring continuity of healthcare service provision in the event of a network power outage **Negative** • Temporary disruption for patients & services during installation period	**SD/DB**	

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

Hywel Dda University Health Board
Equality Impact Assessment (EqIA)

Director and Directorate	James Severs, Executive Director of Allied Health Professions & Health Science
Service Area	Estates & Facilities

What is an Equality Impact Assessment (EqIA)?

An EqIA is a scrutiny tool which is used to ensure that when making decisions related to creating or changing projects, practices and policies, the decisions made are fair and do not discriminate against any protected group defined under the Equality Act 2010.

Why do they have to be completed?

All public authorities in Wales are **legally required** under the Public Sector Equality Duty 2011 to **demonstrate that due regard** has been given in accordance with the Equality Act 2010 with the need to:

- Eliminate discrimination
- Advance equality of opportunity
- Foster good relations

When should they be completed?

A fully completed EqIA, or if applicable an EqIA Screening, must be produced before the Health Board is asked to make decisions about:

- Changes to the way health services are delivered
- The development of a new service
- Clinical or non-clinical policy document/guidance

Completion of an EqIA or EqIA Screening is monitored as part of the Health Boards escalation process, and forms part of the Quality Impact Assessment process. An EqIA is a living document and should be regularly reviewed and updated in light of new information, emerging evidence or stakeholder engagement.

It is recognised that certain proposals or decisions will require a wider consideration of potential impacts, particularly those relating to service change or potential major investment. For large scale projects and strategic decisions you will also need to consider

undertaking an Equality and Health Impact Assessment. Please contact the Diversity and Inclusion (D&I) team if you require further clarity.

Please note: The D&I team will save a copy of the completed form for reference. If any changes are made after the date of review, it is the directorate's responsibility to update the EqIA and inform the D&I team.

Support
For further support please visit the EqIA Sharepoint or contact:
Email: Inclusion.hdd@wales.nhs.uk
Tel: 01554 899055

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

Section 1: Overview

1.	**What are you Equality Impact assessing?**	Proposed Second Generator provision and associated infrastructure work at Glangwili General Hospital (GGH) & Withybush General Hospital (WGH) sites.
2.	**Brief Aims and Description of the procedure/ proposal/ project/ policy:**	Funded by Welsh Government support (Targeted Estates Funding – TEF), approval is sought to award the contracts to deliver the main contract works, in line with Welsh Government guidance
3.	**Who is involved in undertaking this EqIA? (names/job titles)**	Simon Day – Head of Maintenance & Engineering Darrel Barnes – Design Manager
4.	**Is the procedure/ proposal/ project/ policy related to other policies/ areas of work?**	No
5.	**Is this a new EqIA or an updated EqIA?**	New ☒ Updated ☐ Date of original or last version of the EqIA: Please give details / explain any amendments.
6.	**Who will be affected by the procedure/ proposal/ project/ policy development?** (Consider staff as well as the population, patients, carers and family members who may be affected to different degrees)	Staff Patients
7.	**What might help/hinder the success of the procedure/ proposal/ project/ policy?**	Communication with staff

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

Section 2: Human Rights

Human Rights: The Human Rights Act contains 15 Articles (or rights), all of which NHS organisations have a duty to act compatibly with and to respect, protect and fulfil. The 6 rights that are particularly relevant to healthcare are listed below. Depending on the **procedure/ proposal/ project/ policy** you are considering, you may find the examples below helpful in relation to the Articles.		
Consider, is the procedure/ proposal/ project/ policy relevant to:	Yes	No
Article 2: The right to life. **Example**: The protection and promotion of the safety and welfare of patients and staff; issues of patient restraint and control.	✓	
Article 3: The right not to be tortured or treated in an inhuman or degrading way. **Example**: Issues of dignity and privacy; the protection and promotion of the safety and welfare of patients and staff; the treatment of vulnerable groups or groups that may experience social exclusion, for example, gypsies and travellers; Issues of patient restraint and control		✓
Article 5: The right to liberty **Example**: Issues of patient choice, control, empowerment and independence; issues of patient restraint and control		✓
Article 6: The right to a fair trial **Example**: issues of patient choice, control, empowerment and independence		✓
Article 8: The right to respect for private and family life, home and correspondence. **Example**: Issues of dignity and privacy; the protection and promotion of the safety and welfare of patients and staff; the treatment of vulnerable groups or groups that may experience social exclusion, for example, gypsies and travellers; the right of a patient or employee to enjoy their family and/or private life		✓
Article 11: The right to freedom of thought, conscience and religion **Example**: The protection and promotion of the safety and welfare of patients and staff; the treatment of vulnerable groups or groups that may experience social exclusion, for example, gypsies and travellers		✓

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

Section 3: Gathering of Evidence and Assessment of Potential Impact

How will the procedure/ proposal/ project/ policy impact on Age: Is it likely to affect older and younger people in different ways or affect one age group and not another?	**Positive**	✓
	Negative	
	No Impact	

Guidance

Remove population data if not relevant to EqIA and upload relevant data.

Population Data

County	Carms		Cere		Pembs		Total		Summary
Age	value	%	value	%	value	%	value	%	All three regions that comprise the Hywel Dda area have seen an increase in the average age of their population between the last two population censuses, Ceredigion (has seen an increase by 5 years to 47), Pembrokeshire (increase by 3 years to 48) and Carmarthenshire (increase by 2 years to 42). People, population and community - Office for National Statistics (ons.gov.uk)
Total: All usual residents	187,897	100	71,474	100	123,360	100	382,731	100.0	
Aged 4 years and under	9,057	4.8	2,709	3.8	5,583	4.5	17,349	4.4	
Aged 5 to 9 years	10,274	5.5	3,288	4.6	6,731	5.5	20,293	5.2	
Aged 10 to 15 years	13,080	7	4,086	5.7	8,495	6.9	25,661	6.5	
Aged 16 to 19 years	7,799	4.2	4,129	5.8	4,889	4	16,817	4.7	
Aged 20 to 24 years	8,820	4.7	6,366	8.9	5,621	4.6	20,807	6.1	
Aged 25 to 34 years	20,692	11	7,107	9.9	12,907	10.5	40,706	10.5	
Aged 35 to 49 years	31,802	16.9	10,145	14.2	19,461	15.8	61,408	15.6	
Aged 50 to 64 years	40,906	21.8	15,256	21.3	27,331	22.2	83,493	21.8	
Aged 65 to 74 years	24,603	13.1	9,942	13.9	17,445	14.1	51,990	13.7	
Aged 75 to 84 years	15,247	8.1	6,097	8.5	10,855	8.8	32,199	8.5	
Aged 85 years and over	5,617	3	2,349	3.3	4,042	3.3	12,008	3.2	

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

Insert an age breakdown of those affected. This data can be recorded in table or free text format. If no information is available, please state that here, including how you plan to address any identified data gaps in the future.	**Patient data**
Insert breakdown of staff age in the specific service/ area of work. If no information is available, please state that here including how you plan to address any identified data gaps in the future.	**Staff data**

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

Ensure mitigation actions are recorded in line with the negative impact it refers to. Align bullet points so that it is clear which mitigation actions align with the relevant negative impact.	**Negative Impact** • Temporary disruption for patients & services during installation period	**Opportunities for improvement / mitigation** • Disruption period, to form supply connections, will be limited & controlled with service areas informed well in advance of works
Provide a brief summary of the positive impacts you have identified.	**Positive Impact** • The second generators will provide improved resilience to the 2no. acute sites, ensuring continuity of service provision in the event of a network power-outage	
If you have determined no impact, please provide a brief explanation.	**No Impact**	

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

How will the procedure/ proposal/ project/ policy impact on Disability: Those with a physical disability, learning disability, sensory loss or impairment, mental health conditions, long-term medical conditions such as diabetes.	**Positive**	✓
	Negative	
	No Impact	

Guidance

Remove population data if not relevant to EqIA.

Population Data

	Carms	Cere	Pembs	Total
Disabled under the Equality Act: Day-to-day activities limited a lot	21225	6686	12522	40463
Disabled under the Equality Act: Day-to-day activities limited a little	21897	8951	14651	45499
Total with a disability	43152	15637	27173	85,963
Total population	187,895	71,474	123,366	382,735
Percentage of population with a disability	23%	22%	22%	22%

People, population and community - Office for National Statistics (ons.gov.uk)

Insert data for those affected. Include data on the disabilities listed above. (The aging population may have significant levels of age-related disabilities.)

If no information is available, please state that here, including how you plan to address any identified data gaps in the future.

Patient data

Insert breakdown of staff with a disability who may be affected

Staff data

by your specific service/area of work. If no information is available, please state that here including how you plan to address any identified data gaps in the future.		
Ensure mitigation actions are recorded in line with the negative impact it refers to. Align bullet points so that it is clear which mitigation actions align with the relevant negative impact.	**Negative Impact** • Temporary disruption for patients & services during installation period	**Opportunities for improvement / mitigation** • Disruption period, to form supply connections, will be limited & controlled with service areas informed well in advance of works
Provide a summary of the positive impacts you have identified.	**Positive Impact** • The second generators will provide improved resilience to the 2no. acute sites, ensuring continuity of service provision in the event of a network power-outage	
If you have determined no impact, please provide a brief explanation.	**No Impact**	

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

How will the procedure/ proposal/ project/ policy impact on Gender Reassignment: Consider the potential impact on individuals who have undergone, intend to undergo or are currently undergoing gender reassignment; and those who do not intend to undergo medical treatment but wish to live in a different gender from their gender at birth.	**Positive**	✓
	Negative	
	No Impact	

Guidance

Remove population data if not relevant to EqIA.

Population Data

County	Carms		Cere		Pembs		Total	
Gender	value	%	value	%	value	%	value	%
Gender identity the same as sex registered at birth	144,924	93.2	55,874	91.02	95,794	93.41	296,592	92.54
Gender identity different from sex registered at birth but no specific identity given	210	0.14	84	0.14	121	0.12	415	0.13
Trans woman	93	0.06	73	0.12	58	0.06	224	0.08
Trans man	90	0.06	62	0.1	66	0.06	218	0.73
Non-binary	60	0.04	143	0.23	40	0.04	243	0.1
All other gender identities	38	0.02	66	0.11	32	0.03	136	0.05
Not answered	10,072	6.48	5,087	8.29	6,438	6.28	21,597	7.01

People, population and community - Office for National Statistics (ons.gov.uk)

Insert evidence of what proportion of those affected identify as a gender that is different to their sex registered at birth. This data can be recorded in table or free text format.

If no information is available, please state that here, including how you plan to address any

Patient data

identified data gaps in the future.		
Insert breakdown of staff gender reassignment information affected by your specific service/area of work. If no information is available, please state that here including how you plan to address any identified data gaps in the future.	**Staff data**	
Ensure mitigation actions are recorded in line with the negative impact it refers to. Align bullet points so that it is clear which mitigation actions align with the relevant negative impact.	**Negative Impact** • Temporary disruption for patients & services during installation period	**Opportunities for improvement / mitigation** • Disruption period, to form supply connections, will be limited & controlled with service areas informed well in advance of works

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

Provide a summary of the positive impacts you have identified.	**Positive Impact** • The second generators will provide improved resilience to the 2no. acute sites, ensuring continuity of service provision in the event of a network power-outage
If you have determined no impact, please provide a brief explanation.	**No Impact**

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

How will the procedure/ proposal/ project/ policy impact on Marriage and Civil Partnership		Positive	
		Negative	
		No Impact	✓
Guidance Remove population data if not relevant to EqIA.	**Population Data** Under the Equality Act, the characteristic of Marriage and Civil Partnerships is only protected in the workplace/ employment. In Carmarthenshire, 32.4% of people never married or registered a civil partnership, against 47.3% of people who are married or on a civil partnership. The remaining 20.3% either had their legal partnership status dissolved, are separated or are surviving their partner. How life has changed in Carmarthenshire: Census 2021 (ons.gov.uk) In Ceredigion, 38.7% of people never married or registered a civil partnership, against 43.1% of people who are married or on a civil partnership. The remaining 18.2% either had their legal partnership status dissolved, are separated or are surviving their partner. How life has changed in Ceredigion: Census 2021 (ons.gov.uk) In Pembrokeshire, 31.8% of people never married or registered a civil partnership, against 47.3% of people who are married or on a civil partnership. The remaining 21% either had their legal partnership status dissolved, are separated or are surviving their partner. How life has changed in Pembrokeshire: Census 2021 (ons.gov.uk)		
If data is available insert evidence of those that are affected are Married or are in a Civil Partnership. This data can be recorded in table or free text format. If no information is available, please state that here, including how you plan to address any	**Patient data**		

identified data gaps in the future.		
Insert breakdown of staff marriage / civil partnership information affected by your specific service/area of work. If no information is available, please state that here including how you plan to address any identified data gaps in the future.	**Staff data**	
Ensure mitigation actions are recorded in line with the negative impact it refers to. Align bullet points so that it is clear which mitigation actions align with the relevant negative impact.	**Negative Impact** • • •	**Opportunities for improvement / mitigation** • • •
Provide a summary of the positive	**Positive Impact**	

impacts you have identified.	
If you have determined no impact, please provide a brief explanation.	**No Impact** There will be no impact on patients relating to marriage or civil partnership in respect of these projects.

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

How will the procedure/ proposal/ project/ policy impact Pregnancy and Maternity Maternity covers the period of 26 weeks after having a baby, whether or not they are on Maternity Leave.		Positive	✓
		Negative	
		No Impact	
Guidance Remove population data if not relevant to EqIA.	**Population Data (Wales)** Births in England and Wales: summary tables - Office for National Statistics (ons.gov.uk)		
If data is available insert evidence of those that are affected are Married or are in a Civil Partnership This data can be recorded in table or free text format. If no information is available, please state that here, including how you plan to address any identified data gaps in the future.	**Patient data**		
Insert breakdown of staff marriage / civil partnership information affected	**Staff data**		

by your specific service/area of work. If no information is available, please state that here including how you plan to address any identified data gaps in the future.		
Ensure mitigation actions are recorded in line with the negative impact it refers to. Align bullet points so that it is clear which mitigation actions align with the relevant negative impact.	**Negative Impact** • Temporary disruption for patients & services during installation period	**Opportunities for improvement / mitigation** • Disruption period, to form supply connections, will be limited & controlled with service areas informed well in advance of works
Provide a summary of the positive impacts you have identified.	**Positive Impact** • The second generators will provide improved resilience to the 2no. acute sites, ensuring continuity of service provision in the event of a network power-outage	
If you have determined no impact, please provide a brief explanation.	**No Impact**	

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

How will the procedure/ proposal/ project/ policy on Race/Ethnicity or Nationality People of a different race, nationality, colour, culture or ethnic origin including non-English / Welsh speakers, Gypsies/Travellers, asylum seekers and migrant workers. Also includes citizenship.	**Positive**	
	Negative	
	No Impact	✓

Guidance

Remove population data if not relevant to EqIA.

Population Data

County	Carms		Cere		Pembs		Total	
Ethnicity	Value	%	Value	%	Value	%	Value	%
Total: All usual residents	187,898	100	71,473	100	123,359	100	382,730	100
Asian, Asian British or Asian Welsh	2,321	1.2	1,096	1.5	1,159	0.9	4,576	1.2
Black, Black British, Black Welsh, Caribbean or African	455	0.2	366	0.5	244	0.2	1,065	0.3
Mixed or Multiple ethnic groups	1,756	0.9	867	1.2	1,162	0.9	3,785	1
White	182,652	97.2	68,776	96.2	120,375	97.6	371,803	97
Gypsy or Traveller	450	0.2	55	0.08	585	0.5	1,090	0.3
Another ethnic group	714	0.4	368	0.5	419	0.3	1,501	0.4

People, population and community - Office for National Statistics (ons.gov.uk)

If data is available insert a breakdown of Race / Ethnicity or Nationality of those that are affected.

If no information is available, please state that here, including how you plan to address any

Patient data

identified data gaps in the future.		
Insert breakdown of the Race/Ethnicity or Nationality of the staff affected by your specific service/area of work. If no information is available, please state that here including how you plan to address any identified data gaps in the future.	**Staff data**	
Ensure mitigation actions are recorded in line with the negative impact it refers to. Align bullet points so that it is clear which mitigation actions align with the relevant negative impact.	**Negative Impact** • • •	**Opportunities for improvement / mitigation** • • •

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

Provide a summary of the positive impacts you have identified.	**Positive Impact** • • •
If you have determined no impact, please provide a brief explanation.	**No Impact** There will be no impact on patients relating to race/ethnicity or nationality in respect of these projects.

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

How will the procedure/ proposal/ project/ policy impact on Religion or Belief (or non-belief) The term 'religion or belief' includes a religious or philosophical belief, including ethical veganism.	**Positive**	
	Negative	
	No Impact	✓

Guidance

Remove population data if not relevant to EqIA.

Population Data

County	Carms		Cere		Pembs		Total	
Religion	Value	%	Value	%	Value	%	Value	%
Total: All usual residents	187,899	100	71,476	100	123,363	100	382,738	100
No religion	83,409	44.4	30,749	43	52,998	43	167,1560	43.5
Christian	89,378	47.6	33,409	46.7	60,174	48.8	182,961	47.7
Buddhist	557	0.3	378	0.5	462	0.4	1,397	0.4
Hindu	419	0.2	158	0.2	161	0.1	738	0.2
Jewish	103	0.1	75	0.1	58	0	236	0.1
Muslim	1,026	0.5	515	0.7	587	0.5	2,128	0.6
Sikh	177	0.1	35	0	32	0	244	0.0
Other religion	1,127	0.6	677	0.9	746	0.6	2,550	0.7
Not answered	11,703	6.2	5,480	7.7	8,145	6.6	25,328	6.8

People, population and community - Office for National Statistics (ons.gov.uk)

If data is available insert a breakdown of the Religion or Belief (or non-belief) of those affected. This data can be recorded in table or free text format.

If no information is available, please state that here, including how you plan to address any

Patient data

identified data gaps in the future.		
Insert breakdown of Religion or Belief (or non-belief) of staff affected by your specific service/area of work. If no information is available, please state that here including how you plan to address any identified data gaps in the future.	**Staff data**	
Ensure mitigation actions are recorded in line with the negative impact it refers to. Align bullet points so that it is clear which mitigation actions align with the relevant negative impact.	**Negative Impact** • • •	**Opportunities for improvement / mitigation** • • •
Provide a summary of the positive impacts you have identified.	**Positive Impact** • • •	

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

If you have determined no impact, please provide a brief explanation.	**No Impact** There will be no impact on patients relating to Religion or Belief (or non-belief) in respect of these projects.

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

How will the procedure/ proposal/ project/ policy impact on Sex Consider whether those affected are mostly male or female and where it applies to both equally does it affect one differently to the other?	**Positive**	
	Negative	
	No Impact	✓

Guidance

Remove population data if not relevant to EqIA.

Population Data

County	Carms		Cere		Pembs		Total	
Gender	Value	%	Value	%	Value	%	Value	%
All persons	187,897	100	71,475	100	123,360	100	382,732	100.0
Male	91,685	48.8	34,963	48.9	60,071	48.7	186,719	48.8
Female	96,212	51.2	36,512	51.1	63,289	51.3	196,013	51.2

People, population and community - Office for National Statistics (ons.gov.uk)

If data is available insert a breakdown of the Sex of those affected. This data can be recorded in table or free text format.

If no information is available, please state that here, including how you plan to address any identified data gaps in the future.

Patient data

Insert breakdown of the Sex of staff affected by your specific service/area of work.

Staff data

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

If no information is available, please state that here including how you plan to address any identified data gaps in the future.		
Ensure mitigation actions are recorded in line with the negative impact it refers to. Align bullet points so that it is clear which mitigation actions align with the relevant negative impact.	**Negative Impact** •	**Opportunities for improvement / mitigation** •
Provide a summary of the positive impacts you have identified.	**Positive Impact** •	
If you have determined no impact, please provide a brief explanation.	**No Impact** • There will be no impact on patients relating to Sex in respect of these projects.	

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

How will the procedure/ proposal/ project/ policy impact on Sexual Orientation Whether a person's sexual attraction is towards their own sex, the opposite sex or either.	**Positive**	
	Negative	
	No Impact	✓

Guidance

Remove population data if not relevant to EqIA.

Population Data

	County							
	Carms		Ceredigion		Pembs		Totals	
Sexual Orientation	Value	%	Value	%	Value	%	Value	%
Total: All usual residents aged 16 years and over	155,485	100	61,390	100	102,550	100	319,425	100.0
Straight or Heterosexual	139,511	89.7	51,998	84.7	92,094	89.8	283,603	88.1
Gay or Lesbian	1,845	1.2	941	1.5	1,093	1.1	3,879	1.3
Bisexual	1,500	1.0	1,617	2.6	1,050	1	4,167	1.5
Pansexual	120	0.1	150	0.2	80	0.1	350	0.2
Asexual	79	0.1	140	0.2	52	0.1	271	0.1
Queer	23	0.0	49	0.1	12	0	84	0.0
All other sexual orientations	100	0.1	90	0.1	75	0.1	265	0.1

People, population and community - Office for National Statistics (ons.gov.uk)

If data is available insert a breakdown of the Sexual Orientation of those affected. This data can be recorded in table or free text format.

If no information is available, please state that here, including how you plan to address any identified data gaps in the future.

Patient data

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

Insert breakdown of the Sexual Orientation of staff affected by your specific service/area of work. If no information is available, please state that here including how you plan to address any identified data gaps in the future.	**Staff data**	
Ensure mitigation actions are recorded in line with the negative impact it refers to. Align bullet points so that it is clear which mitigation actions align with the relevant negative impact.	**Negative Impact** •	**Opportunities for improvement / mitigation** •
Provide a summary of the positive impacts you have identified.	**Positive Impact**	
If you have determined no impact, please provide a brief explanation.	**No Impact** • There will be no impact on patients relating to Sexual orientation in respect of these projects.	

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

How will the procedure/ proposal/ project/ policy impact on Armed Forces Consider members of the Armed Forces and their families, whose health needs may be impacted long after they have left the Armed Forces and returned to civilian life. Also consider their unique experiences when accessing and using day-to-day public and private services compared to the general population. It could be through 'unfamiliarity with civilian life, or frequent moves around the country and the subsequent difficulties in maintaining support networks, for example, members of the Armed Forces can find accessing such goods and services challenging.' For a comprehensive guide to the Armed Forces Covenant Duty and supporting resource please see: **Armed-Forces-Covenant-duty-statutory-guidance**	**Positive**	
	Negative	
	No Impact	✓

Guidance

Remove population data if not relevant to EqIA.

Population Data

	Carmarthenshire (%)	Pembrokeshire (%)	Ceredigion (%)	Hywel Dda (%)
Regular	3.6	4.5	3	3.7
Reserve	0.9	0.9	0.9	0.9
Both	0.2	0.2	0.2	0.2
Total	4.7	5.7	4.1	4.8

People, population and community - Office for National Statistics (ons.gov.uk)

If data is available insert evidence of what proportion of those affected are members of the Armed Forces Community. This data can be recorded in table or free text format.

If no information is available, please state that here, including how you plan to address any

Patient data

identified data gaps in the future.		
Insert data to show the proportion of staff affected by your specific service/area of work that are a member of the Armed Forces community. If no information is available, please state that here including how you plan to address any identified data gaps in the future.	**Staff data**	
Ensure mitigation actions are recorded in line with the negative impact it refers to. Align bullet points so that it is clear which mitigation actions align with the relevant negative impact.	**Negative Impact** • • •	**Opportunities for improvement / mitigation** • • •
Provide a summary of the positive impacts you have identified.	**Positive Impact** • • •	

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

If you have determined no impact, please provide a brief explanation.	**No Impact** • There will be no impact on patients relating to Armed Forces in respect of these projects

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

Socio-economic Deprivation Consider those on low income, economically inactive, unemployed or unable to work due to ill-health. Also consider people living in areas known to exhibit poor economic and/or health indicators and individuals who are unable to access services and facilities. Food/ fuel poverty and personal or household debt should also be considered. For a comprehensive guide to the Socio-Economic Duty in Wales and supporting resource please see: **https://gov.wales/more-equal-wales-socio-economic-duty**	**Positive**	
	Negative	
	No Impact	✓

Guidance

Remove population data if not relevant to EqIA.

Population Data

	County							
	Carms		Ceredigion		Pembs		Hywel Dda	
Economic Factor	Value	%	Value	%	Value	%	Total value	%
Economically active – In employment (this includes full time students)	81,952	52.7	30,119	49.1	52,765	51.5	164,836	51.1
Economically active - Unemployed	3,922	2.5	1,845	3	2,769	2.7	8,536	2.73
Economically inactive	69,613	44.8	29,428	47.9	47,017	45.8	146,058	46.16

In its vast majority, Carmarthenshire, Pembrokeshire and Ceredigion areas have been ranked ‘least deprived’ or as second ‘least deprived’ in Wales. There are a number of areas identified as being nearer ‘most deprived’, which are concentrated around Pembroke, Pembroke Dock, Milford, Cardigan, Llanelli and Kidwelly.
(Welsh Index of Multiple Deprivation 2019).
Welsh Index of Multiple Deprivation (WIMD) 2019: results report (gov.wales)

If data is available insert evidence of what proportion of those that are affected are experiencing socio-economic deprivation. This data can be recorded in

Patient data

table or free text format. If no information is available, please state that here, including how you plan to address any identified data gaps in the future.		
Insert data to show the proportion of staff affected by your specific service/area of work that are experiencing socio-economic deprivation. If no information is available, please state that here including how you plan to address any identified data gaps in the future.	**Staff data**	
Ensure mitigation actions are recorded in line with the negative impact it refers to. Align bullet points so that it is	**Negative Impact** •	**Opportunities for improvement / mitigation** •

clear which mitigation actions align with the relevant negative impact.		
Provide a summary of the positive impacts you have identified.	**Positive Impact** •	
If you have determined no impact, please provide a brief explanation.	**No Impact** • There will be no impact on patients relating to Socio-Economic Deprivation in respect of these projects	

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

Welsh Language Please note opportunities for persons to use the Welsh language and treating the Welsh language no less favourably than the English language.	**Positive**	
	Negative	
	No Impact	✓

Guidance

Remove population data if not relevant to EqIA.

Population Data

According to Welsh Census 2022 data, it is estimated that 45% of people aged three or older had some level of Welsh language skills. This figure equates to around 172,000 people.

Definition of whether a person has Welsh language skills (as recorded in the Census 2022).

If a person can or does do any of the following:

- Understand spoken Welsh
- Speak Welsh
- Read Welsh
- Write Welsh

Area	Percentage of people who can speak Welsh
Carmarthenshire	53.3
Pembrokeshire	25.2
Ceredigion	56.4
Hywel Dda	45

People, population and community - Office for National Statistics (ons.gov.uk)

If data is available insert evidence of what proportion of those that are affected use the Welsh Language. This data can be

Patient data

recorded in table or free text format. If no information is available, please state that here, including how you plan to address any identified data gaps in the future.		
If data is available insert evidence of what proportion of staff affected by your specific service/area of work use the Welsh Language. This data can be recorded in table or free text format. If no information is available, please state that here including how you plan to address any identified data gaps in the future.	**Staff data**	
Ensure mitigation actions are recorded in line with the negative impact it refers to. Align bullet points so that it is clear which mitigation actions align with the	**Negative Impact** • • •	**Opportunities for improvement / mitigation** • • •

relevant negative impact.		
Provide a summary of the positive impacts you have identified.	**Positive Impact** • • •	
If you have determined no impact, please provide a brief explanation.	**No Impact** • There will be no impact on patients relating to Welsh Language in respect of these projects	

Additional considerations
In addition to the above protected characteristics please consider impact on the following: • **Vulnerable groups (homeless and vulnerably housed, Gypsy, Roma and Travellers, Refugees, Asylum Seekers)** • **Unpaid Carers** • **Individuals and communities who experience Digital Exclusion** • **Rural and Urban communities**

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

Intersectionality
It is important to consider breaking the analysis down by more than one protected characteristic. This is often referred to as 'intersectionality'. Many people will have more than one protected characteristic and, certain aspects of who we are, for example, our race, gender, faith and socio-economic status can increase our positive experiences or contribute to negative experiences, made worse by the combined effects of multiple discrimination, barriers and challenges. **Example:** The experiences of a Muslim woman will differ from that of a Muslim man and of a non-Muslim woman. An EqIA may separately identify impacts for Muslim people under Religion or Belief and the impacts for men and women under Sex, but it is also important to recognise that the combined impacts could be very different for a Muslim woman compared to a Muslim man or a non-Muslim woman.
Have you identified any specific additional impacts regarding intersectionality e.g., age and sex, disability and sexual orientation? No

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

Section 4: Assessment of Scale of Impact

In this scoring section, you need to assign two scores: a **likelihood score** and an **opportunity/impact score**. The likelihood score represents the probability of the opportunity or impact occurring, while the opportunity/impact score reflects the severity of the opportunity or impact. Once both scores have been recorded, the scores with automatically be multiplied in order to calculate the **Total Score** for each protected characteristic.

(Likelihood Score x opportunity/impact Score = Total Score)

OPPORTUNITY AND IMPACT			
IMPACT	**SCORE**		**The proposed change is anticipated to lead to the following level of opportunity and/or impact:**
Positive	**5**	Excellence	(Excellence): Outstanding benefits, significant reduction in health inequalities, and major improvements in service delivery and public confidence.
	4	Major	(Major): Long-term improvements, major reduction in health inequalities, and substantial service delivery enhancements.
	3	Moderate	(Moderate): Moderate benefits requiring professional intervention, moderate reduction in health inequalities, and moderate service delivery improvements.
	2	Minor	(Minor): Minor improvements in access, experience, and outcomes, with minor reductions in health inequalities.
	1	Negligible	(Negligible): Negligible improvements in access, experience, and outcomes, with negligible reductions in health inequalities
Neutral	**0**	Neutral	(Neutral): No effect, either positive or negative.
Negative	**-1**	Negligible	(Negligible): Negligible negative impact, minimal injury potential, and negligible negative impacts on service delivery
	-2	Minor	(Minor): Minor negative impact, minor injury potential, and minor negative impacts on service delivery.
	-3	Moderate	(Moderate): Moderate negative impact, moderate injury potential, and moderate negative impacts on service delivery.
	-4	Major	(Major): Major negative impact, major injury potential, and major negative impacts on service delivery.
	-5	Catastrophic	(Catastrophic): Catastrophic negative impact, potential for death or severe injury, and significant negative impacts on service delivery.

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

LIKELIHOOD		
1	Rare	Not expected to occur for years. Will occur in exceptional circumstances.
2	Unlikely	Expected to occur at least annually. Unlikely to occur
3	Possible	Expected to occur at least monthly. Reasonable chance of occuring.
4	Likely	Expected to occur at least weekly. Likely to occur.
5	Almost Certain	Expected to occur at least daily. More than likely to occur.

LIKELIHOOD	OPPORTUNITY						IMPACT				
	5	**4**	**3**	**2**	**1**	**0**	**-1**	**-2**	**-3**	**-4**	**-5**
5	25	20	15	10	5	0	-5	-10	-15	-20	-25
4	20	16	12	8	4	0	-4	-8	-12	-16	-20
3	15	12	9	6	3	0	-3	-6	-9	-12	-15
2	10	8	6	4	2	0	-2	-4	-6	-8	-10
1	5	4	3	2	1	0	-1	-2	-3	-4	-5

CATEGORY			
	Excellent opportunity		Extreme risk
	Good opportunity		High risk
	Moderate opportunity		Moderate risk
	Minor opportunity		Low risk

****To access the scoring table below you will need to double click on the table to open an editable version. The information you input will remain when you click back on the word document.**

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

Area					Opportunity / Consequence Rating*	*IIA Matrix		
Note - you can select more than one box per area if change may have multiple impacts e.g. both positive and negative	Positive impact	Neutral impact	Negative impact	Unknown		Consequence	Liklihood	Total Score
Age	3				** positive rating	4	2	8
					** negative rating			0
Disability	3				** positive rating	4	2	8
					** negative rating			0
Gender Reassignment	3				** positive rating	4	2	8
					** negative rating			0
Marriage and Civil Partnership		0			** positive rating			0
					** negative rating			0
Pregnancy and Maternity	3				** positive rating	4	2	8
					** negative rating			0
Race/Ethnicity or Nationality		0			** positive rating			0
					** negative rating			0
Religion or Belief		0			** Positive rating			0
					** negative rating			0
Sex		0			** positive rating			0
					** negative rating			0
Sexual Orientation		0			** positive rating			0
					** negative rating			0
Armed Forces		0			** positive rating			0
					** negative rating			0
Socio-economic Deprivation		0			** positive rating			0
					** negative rating			0
Welsh Language		0			** positive rating			0
					** negative rating			0

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

Section 5: Outcome and Actions
This section should be used to detail and monitor any actions identified in sections 1-4.

Will the procedure/ proposal/ project/ policy be adopted? **If no, please give reasons and any alternative action(s) agreed.**	Pending approval.
If a negative impact cannot be mitigated and it is proposed that HDUHB move forward with the plan/ project/ proposal regardless, please provide your justification for this.	

	Actions • Some actions have been populated for further elaboration, please delete as appropriate and add any additional actions identified. • Include any remedial changes that have been made to reduce or eliminate the effects of potential or actual negative impact, as well as any arrangements to collect data or undertake further research.	**Assigned to**	**Target Review Date**	**Completion Date**	**Comments/ Update**
1.	**What additional monitoring data will be collected around the impact of procedure/ proposal/ project/ policy once adopted? How will this be collected?** Resilience management & monitoring	Simon Day	12/2027		
2.	**When will the monitoring data be analysed? Who will be responsible for the analysis and subsequent update of the impact assessment and action plan as appropriate?** On completion of the project – annual testing/monitoring	Simon Day	12/2027		
3.	**This EqIA action plan to be regularly reviewed to ensure all actions are relevant and have been undertaken.**	Simon Day	12/2027		
4.					

5.					
6.					

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

Section 6: Authorisation

Ensure that the details for the person completing, as well as the person authorising/owning the EqIA are included (ideally these should not be the same person). A member of the Diversity and Inclusion team will add their information to the final section, to show that the Diversity and Inclusion team have had sight of the EqIA and if required provided guidance.

EqIA Completed by:	**Name/s**	Darrel Barnes
	Title	Design Manager
	Team / Division	Design Team – Strategy & Planning
	Contact details	darrel.barnes@wales.nhs.uk
	Date	04/12/2025
EqIA Authorised by/Owned by: • **Usually the directorate lead would be the owner of the procedure/ proposal/ project/ policy** • **Responsible for the accuracy of the data captured in this EqIA as well as progressing any actions recorded in Section 5**	**Name**	Simon Day
	Title	Head of Maintenance & Engineering
	Team / Division	Estates & Facilities
	Contact details	simon.day@wales.nhs.uk
	Date	04/12/2025
Guidance has been provided by Diversity & Inclusion Team: (to be completed by Diversity and Inclusion team only)	**Name**	
	Title	
	Team	
	Contact details	
	Date	
Diversity and Inclusion Team additional Comments:		

Please note: The D&I team will save a copy of the completed form for reference. If any changes are made after the date of review, it is the directorate's responsibility to update the EqIA and inform the D&I team.

6

12:05, 0 Mins

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6 - For Information

6.1

12:05, 0 Mins

6.1 - Joint Commissioning Committee Planning, Performance and Finance Sub-Committee Reports

Winston Weir (Hywel Dda UHB - Independent Board Member)

For information

Attachments

6.1 2.3.1 PPF Highlight Report 23 Oct.pdf

Cyd-bwyllgor Comisiynu Joint Commissioning Committee

Planning, Performance and Finance

Highlight Report from the Planning, Performance and Finance Sub-Committee

Dyddiad y Cyfarfod / Date of Meeting	23/10/2025
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author	Gareth Mitchell, Corporate Governance Manager, NWJCC
Cyflwynydd yr Adroddiad / Report Presenter	Paul Worthington, PPF Chair and Lay Member, NWJCC
Noddwr yr Adroddiad / Report Sponsor	Stacey Taylor, Director of Finance and Value, NWJCC

Pwrpas yr Adroddiad / Report Purpose	For Noting

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	**Date**	**Outcome**
Health Boards		Noted

1. SITUATION/BACKGROUND

This report had been prepared to provide Health Board Chief Executive Officer Members of the Joint Commissioning Committee (JC) with a summary of the key issues considered by the NHS Wales Planning, Performance and Finance (PPF) Sub-Committee at its meeting in public on 23 October 2025.

Key highlights from the meeting are reported in Section 3.

2. PURPOSE

The Purpose and Role of the JC is set out in Paragraphs 2.18 and 2.20 of the NWJCC Standing Orders (SOs).

3. HIGHLIGHT REPORT

(Links to reports highlighted - October 2025 - NHS Wales Joint Commissioning Committee)

Status	Update
Alert / Escalate	The NWJCC Financial Report – Month 6 2025-26 was received. 3 proposals for savings were agreed to be discussed at November's JC meeting, these included savings in medium secure services, potential savings in ambulance services and the capping of specialised services activity for the last quarter of the financial year.
Advise	The NWJCC Operational Performance Report was received. Discussions noted continuing issues with data quality and system integration. Attendees were given a demonstration of a dashboard and received an update on a rapid review of performance reporting with the intention of using a newly designed report from March 2026. The PPF Risk Register was noted during the meeting. Attendees noted that risk reporting would be on a bi-monthly basis to ensure that the reporting of risks is relevant and to ensure that the Sub-Committees are providing onward assurance to the JC. Attendees further noted the work being undertaken to improve the differentiation of commissioning and provider risks.
Assure	The Implementation of NWJCC Foundation Plan 25-26 - Q2 Progress Update report was received. Attendees noted that the majority of areas detailed were on track or had slipped slightly. Attendees further noted that the Auditory Implant Device Service remained in escalation.
Inform	The Development of the NWJCC Integrated Medium Term Plan (IMTP) was received. Attendees noted that a workshop was being arranged for early December to engage stakeholders in the IMTP process. This engagement would then inform the clinically-led prioritisation process. Attendees discussed the changing financial picture and how this may affect the process in the near future. Members further discussed inequity in relation to cross-border services and the disproportionate impact for Betsi Cadwaladr University Health Board and Powys Teaching Health Board.

Status	Update
Appendices	None.

4. ASSESSMENT

Objectives / Strategy	
Dolen i Amcan (au) Strategol CBC **Link to JCC Strategic Objectives(s)**	Maximise Value Ensure Quality; Reduce Duplication; Improve Equity & Population Health; Facilitate Integration
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals 150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)	A Resilient Wales A Healthier Wales
Dolen i Hwyluswyr Ansawdd (Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) / **Link to Enablers of Quality** (Duty of Quality Statutory Guidance (gov.wales))	Leadership Culture and Valuing People; Learning, Improvement and Research; Whole-systems Perspective
Dolen i Feysydd Ansawdd (Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) / **Link to Domains of Quality** (Duty of Quality Statutory Guidance (gov.wales))	Effective Efficient; Equitable; Person-centred; Timely; Safe
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable

Impact Assessment		
Ansawdd *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /* **Quality** *Have you undertaken a Quality Impact Assessment Screening?*	Yes: ☐ Outcome:	No: ☒ If no, please include rationale below: This is a summary of the latest meeting of the JCC
Cydraddoldeb	Yes: ☒	No: ☒

Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb? / **Equality** *Have you undertaken an Equality Impact Assessment Screening?*		
	Outcome for Equality (delete as appropriate): ~~POSITIVE~~/NEUTRAL/~~NEGATIVE~~ Outcome for Welsh Language (delete as appropriate): ~~POSITIVE~~/NEUTRAL/~~NEGATIVE~~	If no, please include rationale below: This is a summary of the latest meeting of the JCC
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw da / Reputational	There is no direct impact on the reputation of the Joint Committee as a result of the activity outlined in this report.	
Effaith Adnoddau *(Pobl /Ariannol) /* **Resource Impact** *(People / Financial)*	Yes (Include further detail below)	
	The performance of the services will be used to develop the IMTP and identify the areas where resources may be required.	

5. RECOMMENDATIONS

The Health Board is asked to:

- **Note** the highlights outlined in Section 3 of this report.

6.2

12:05, 0 Mins

6.2 - Strategy & Planning Committee Workplan 2025-26

Winston Weir (Hywel Dda UHB - Independent Board Member)

For information

Attachments

6.2 SPC Work Programme 2025-26 FINAL v0.1.pdf

STRATEGY AND PLANNING COMMITTEE WORK PLAN APRIL 2025 – MARCH 2026

Currently, Strategy and Planning Committee (SPC) meets bi-monthly. Based on this, the following table represents a proposal to incorporate the duties as outlined in the Committee's Terms of Reference into a basic work plan April 2025 – March 2026, including standing agenda items (denoted by *).

AGENDA ITEM/ ISSUE	LEAD	Responsible Officer	24 Apr 2025	1 Jul 2025	28 Aug 2025	30 Oct 2025	18 Dec 2025	26 Feb 2026	Apr 2026
PAPER DEADLINE			1 Apr 2025	10 Jun 2025	7 Aug 2025	9 Oct 2025	27 Nov 2025	5 Feb 2026	
Governance and Risk									
Welcome and Apologies*	Chair	All	✓	✓	✓	✓	✓	✓	✓
Declarations of Interests*	Chair	CSO	✓	✓	✓	✓	✓	✓	✓
Minutes from previous meeting*	Chair	CSO	✓	✓	✓	✓	✓	✓	✓
Matters Arising (not on agenda) *	Chair	All	✓	✓	✓	✓	✓	✓	✓
Table of Actions (ToAs) *	Chair	CSO	✓	✓	✓	✓	✓	✓	✓
Matters Arising	Chair	CSO			✓	✓	✓	✓	✓
SPC Terms of Reference (TORs) Review (12.1)	Chair	JW	✓				✓		
SDODC Annual Report 2024/25 (10.4)	Chair	LD	✓						
SPC Annual Report 2025/26 (10.4)	Chair	LD							✓
Committee Self-Assessment 6 Month Update	Chair	JW			✓			✓	
Self-Assessment of Committee Effectiveness: Outcome Report (10.5)	Chair	JW						✓	
Assurance and Risk Report Assurance on Governance Arrangements Including:(3.1.23)	Chair	JW			✓	✓	✓	✓	✓

AGENDA ITEM/ ISSUE	LEAD	Responsible Officer	24 Apr 2025	1 Jul 2025	28 Aug 2025	30 Oct 2025	18 Dec 2025	26 Feb 2026	Apr 2026
PAPER DEADLINE			**1 Apr 2025**	**10 Jun 2025**	**7 Aug 2025**	**9 Oct 2025**	**27 Nov 2025**	**5 Feb 2026**	
Corporate Risks; Operational Risks; Audits and Inspections; Welsh Health Circulars; Ministerial Directions									
~~Corporate Risks Assigned to SPC (3.1.23)~~	~~LD~~	~~RW~~		✓					
~~Operational Risks Assigned to SPC (3.1.23)~~	~~LD~~	~~RW~~		✓					
~~Monitoring Welsh Health Circulars (under the remit of SPC)~~ ~~**(At end of agenda before 'For Information')**~~	Relevant EDs	RW	✓						
~~Ministerial Directions (MDs) (as and when required)~~ ~~**(At end of agenda before 'For Information')**~~	Relevant EDs	RW	✓						
Targeted Intervention Update (3.1.20)	LD	SA	✓	✓	✓	✓	✓	✓	
Strategy, Planning and Partnerships									
Annual Plan Progress (3.1.1,2&4) • Planning Objectives (PO) Update (3.1.21) • Maturity Matrix Timeline • Maturity Matrix	LD	SA	✓ ✓	✓ ✓ ✓	✓	✓ ✓	✓	✓ ✓	
Strategy Refresh (A Healthier Mid and West Wales (refresh and updates) (2.1.1.1 & 2)	LD	PW	✓		✓		✓		
PO6 - Clinical Services Plan • Verbal Detailed Update	LD	HMH	✓		✓		✓		✓
PO8 - Estates Plan	LD	PW/CE		✓		✓		✓	

AGENDA ITEM/ ISSUE	LEAD	Responsible Officer	24 Apr 2025	1 Jul 2025	28 Aug 2025	30 Oct 2025	18 Dec 2025	26 Feb 2026	Apr 2026
PAPER DEADLINE			**1 Apr 2025**	**10 Jun 2025**	**7 Aug 2025**	**9 Oct 2025**	**27 Nov 2025**	**5 Feb 2026**	
(Estates Strategy Development of (3.1.11) (to include the development of the Estates Strategy and Infrastructure Investment Enabling Plan), for scrutiny ahead of Board approval) & (Implementation of Estates Strategy (3.1.12))									
Pharmaceutical Needs Assessment • Annual Review 6 Month Review of Services	~~JP~~ MH (wef 01 12 25)	RB/TH	✓			✓			
Mid Wales Joint Committee Report	AC	KJ/NW			✓			✓	
Regional Joint Committee Update Report & A Regional Collaboration for Health (ARCH)	LD LD	SC		✓					
Strategic Commissioning Report (3.1.5) (bi-annual update)	LD	SA			✓			✓	
Partnership Governance Assurance Report (3.1.6&7)	AG	BB		✓		✓		✓ Update: Area Planning Board	
Value Based Healthcare Update (3.1.9)	MH	LP	✓		✓		✓	✓	

AGENDA ITEM/ ISSUE	LEAD	Responsible Officer	24 Apr 2025	1 Jul 2025	28 Aug 2025	30 Oct 2025	18 Dec 2025	26 Feb 2026	Apr 2026
PAPER DEADLINE			**1 Apr 2025**	**10 Jun 2025**	**7 Aug 2025**	**9 Oct 2025**	**27 Nov 2025**	**5 Feb 2026**	
								Refreshed Strategic Approach	
Climate Migration and Adaption Plan (3.1.10)	AG	BB		✓				✓	
Population Health, Primary and Community									
PSBs Well-being of Future Generations (Wales) Act 2015 (WBFGA) (3.1.6 & 3.1.7)	AG	BB	✓			**D**	✓ Wellbeing Objectives Annual Report		
PO7 – Primary Care and Community Strategic Plan Update *To include:* *National CHC Framework 2021* *RPB Population Needs Assessment* *Social Services and Well-being (Wales) Act 2014 (SSWBA)* *(Covered in Cluster and Pan-Cluster work)* (Completed on 5 year cycle; last approved by RPB July 2022; Draft to SPC prior to publication – January 2027)	~~JP~~ LD (wef 01 12 25)	RB/JC		✓		✓	✓ Primary & Community Strategic Vision	✓	
PO 10: Population Health (incl. social model for health and wellbeing)			✓		✓		✓		

AGENDA ITEM/ ISSUE	LEAD	Responsible Officer	24 Apr 2025	1 Jul 2025	28 Aug 2025	30 Oct 2025	18 Dec 2025	26 Feb 2026	Apr 2026
PAPER DEADLINE			**1 Apr 2025**	**10 Jun 2025**	**7 Aug 2025**	**9 Oct 2025**	**27 Nov 2025**	**5 Feb 2026**	
PSBs Well-being Assessments Population Health Needs Assessment (3.1.13) Health Inequalities (3.1.14)	AG	BB							
Review of Clinical Pharmacy Services at NHS Hospitals in Wales	~~JP~~ MH (wef 01 12 25)	OW		D		✓			
Vaccination Programme for Prevention and Response Plan - Progress Update, Key Priorities and Delivery Plan	AG	BB			✓				
Capital and Estates									
Capital Programme for 2025/26 and Capital Governance (including the CSC 3A's update (3.1.24) & Discretionary Capital Programme (DCP) and Capital Resource Limit & other CSC items below) (3.1.18&19) * Also Capital Planning Equipment Replacement Programme.	LD	PW/ER/RE	✓	✓	✓	✓	✓	✓	✓
CSC Workplan 2025/26 (3.1.26)	LD	ER	✓						
CSC Annual Report 2024/25 (10.4)	LD	ER	✓						
CSC Annual Report 2025/26 (10.4)	LD	ER							✓
Annual Review CSC TORs (10.3)	LD	ER					✓		

AGENDA ITEM/ ISSUE	LEAD	Responsible Officer	24 Apr 2025	1 Jul 2025	28 Aug 2025	30 Oct 2025	18 Dec 2025	26 Feb 2026	Apr 2026
PAPER DEADLINE			**1 Apr 2025**	**10 Jun 2025**	**7 Aug 2025**	**9 Oct 2025**	**27 Nov 2025**	**5 Feb 2026**	
Planning in Partnership: Regional Integration Fund Update	~~JP~~ AC (wef 01 12 25)	LJ					✓		
Capital Business Cases (as and when required for scrutiny before onward ratification at Board) (3.1.16) *	LD		✓	✓	✓	✓	✓	✓	✓
PPH Solar Project	LD	PW				✓			
Sustainability Report (for HDdUHB Annual Report)	LD	PW		✓					✓
Estate Condition & Performance Update	LD	PW				✓			
One-off Items									
Early Years Report	AG	JoMC/ BW		✓					
Update on Major Planning Schemes	LD	ER				✓			
Targeted Estates Fund (TEF) Projects: Provision of Second Generators at Glangwili & Withybush Hospitals	LD/JS	JWJ					✓		
For Approval									
Policies (as required) (3.1.25) *	All	All	✓	✓	✓	✓	✓	✓	
For Information									
JCC Planning, Performance and Finance Sub-Committee Reports*	JM	N/A	✓	✓	✓	✓	✓	✓	✓

AGENDA ITEM/ ISSUE	LEAD	Responsible Officer	24 Apr 2025	1 Jul 2025	28 Aug 2025	30 Oct 2025	18 Dec 2025	26 Feb 2026	Apr 2026
PAPER DEADLINE			**1 Apr 2025**	**10 Jun 2025**	**7 Aug 2025**	**9 Oct 2025**	**27 Nov 2025**	**5 Feb 2026**	
Regional Joint Committee Update Report to HDdUHB and SBUHB	LD	SM						✓	✓
SPC Workplan 2025/26*	LD	CSO	✓	✓	✓	✓	✓	✓	✓
Issues for Board/Committees	Chair				✓	✓	✓	✓	✓
Administration									
Agenda setting meeting with Chair & Exec Lead (at least 6 weeks before the meeting)	CSO	N/A	✓	✓	✓	✓	✓	✓	✓
Draft agenda to go to Executive Team	CSO	N/A	✓	✓	✓	✓	✓	✓	✓
Call for papers (at least 6 weeks before the meeting to receive papers at least 14 days before the meeting	CSO	N/A	✓	✓	✓	✓	✓	✓	✓
Disseminate agenda/papers 7 days prior to meeting	CSO	N/A	✓	✓	✓	✓	✓	✓	✓
Type up minutes/TOA within 7 days of meeting	CSO	N/A	✓	✓	✓	✓	✓	✓	✓
Circulate minutes and TOA to the Lead Director within 7 days of meeting	CSO	N/A	✓	✓	✓	✓	✓	✓	✓
Issue minutes and TOA to Members (including the Committee Chair) following Lead Director review	CSO	N/A	✓	✓	✓	✓	✓	✓	✓

Chair: Winston Weir **Vice Chair:** Maynard Davies **Lead Executive:** Lee Davies

LD	Lee Davies	**MH**	Mark Henwood	**JP**	Jill Paterson	**JW**	Joanne Wilson
AG	Ardiana Gjini	**AC**	Andrew Carruthers	**SA**	Shaun Ayres	**PW**	Paul Williams
DW	Daniel Warm	**RW**	Rachel Williams	**ER**	Eldeg Rosser	**LP**	Leighton Phillips
RB	Rhian Bond	**JC**	Julia Chambers	**BB**	Bruce Bolam	**SC**	Sion Charles
LJ	Linda Jones	**JM**	Jacqueline Maunder	**OW**	Owain Williams	**JoMC**	Jo McCarthy
BR	Ben Rogers	**BW**	Ben Williams	**NW**	Nia Williams	**MH**	Mark Henwood
SM	Sophie Marr	**JS**	James Severs	**JWJ**	Julian Wheeler Jones		
CSO	Committee Services Officer						

D Deferred

NB: See POs below:

A Healthier Mid and West Wales			
Planning objective 6	Clinical services plan	Service fragilities	SPC
Planning objective 7	Primary and community strategic plan	Ministerial priority Service fragilities	SPC
Planning objective 8	Estates plans	Estate fragilities	SPC
Planning objective 10	Population health	Long-term sustainability	SPC

7

12:05, 0 Mins

7 - Any Other Business

Winston Weir (Hywel Dda UHB - Independent Board Member)

8

12:05, 0 Mins

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8 - Date and Time of Next Meeting

8.1 **12:05, 0 Mins**

8.1 - 16 January 2026, 15:30 - 17:00, MS Teams

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

9

12:05, 5 Mins

9 - Issues for Board/Committees

Winston Weir (Hywel Dda UHB - Independent Board Member)

For information