

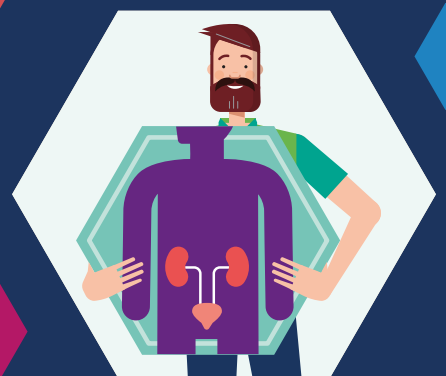
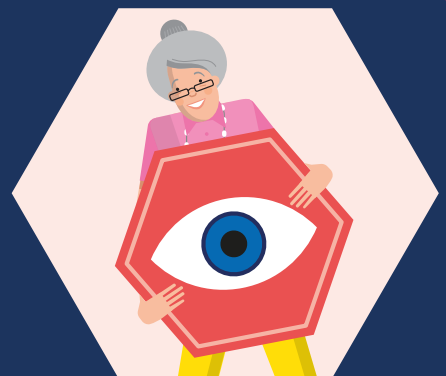
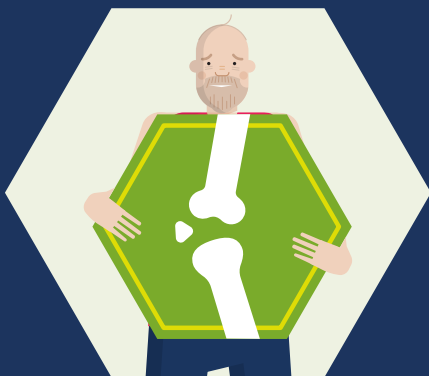
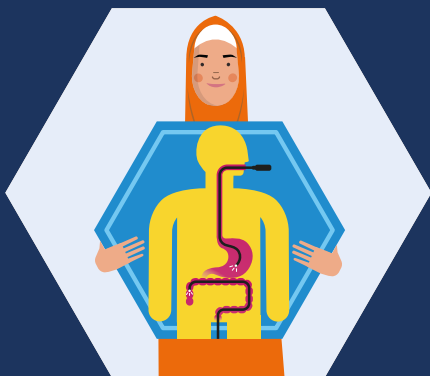
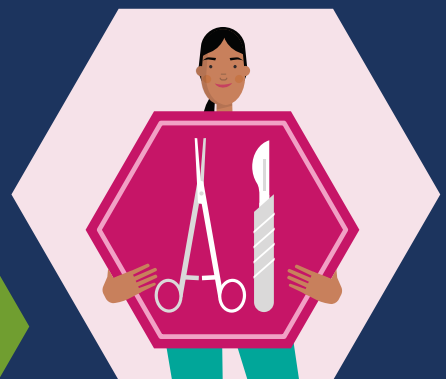
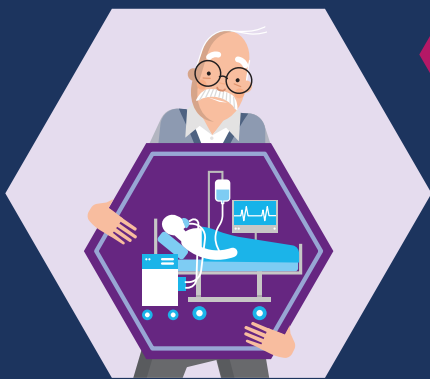


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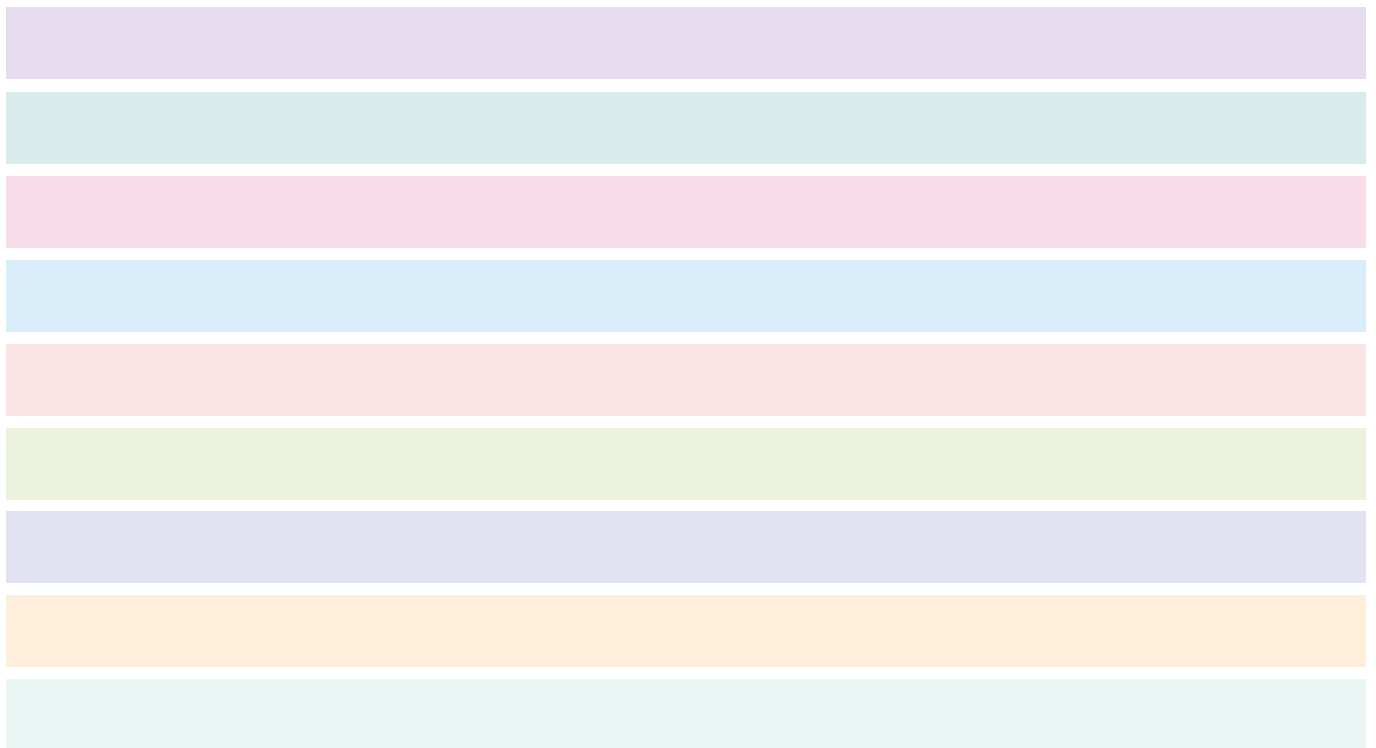
Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

Clinical Services Plan

Consultation Document



Contents





Get in touch

This document is available in Welsh and on our website hduhb.nhs.wales/clinical-services-consultation. We also have a



summary document, which you can request a printed copy of or view online. This is available in English and Welsh, as well as alternative formats (Audio, Easy Read, Youth)

and additional languages (Arabic, British Sign Language, Polish, Ukrainian and Russian).

To request printed versions of any documents (we include several web links to documents in this publication), or if you have any problems in accessing information in an accessible format for your needs, please call us on 0300 303 8322 (option 5), charged at local call rates.

– يتوفر ملخص لهذه الوثيقة باللغة العربية على موقعنا الإلكتروني

hduhb.nhs.wales/clinical-services-consultation – أو يمكنك طلب نسخة ورقية عن طريق الاتصال بنا على (٠٣٠٠٣٠٣٨٣٢٢). رسوم المكالمات المحلية إذا كنت تريد منا توضيح أي جزء من المستند، يرجى الاتصال بنا

Streszczenie tego dokumentu jest dostępne w języku polskim na naszej stronie internetowej – hduhb.nhs.wales/clinical-services-consultation – możesz też poprosić o wersję drukowaną, dzwoniąc pod numer 0300 303 8322 (opłaty za połączenia lokalne). Skontaktuj się z nami, jeśli chcesz, abyśmy wyjaśnili jakąkolwiek część dokumentu.

Короткий зміст цього документа доступний українською мовою на нашому сайті – hduhb.nhs.wales/clinical-services-consultation – або ви можете запросити друковану копію, зателефонувавши нам за номером 0300 303 8322 (місцеві тарифи дзвінків). Будь ласка, зв'яжіться з нами, якщо ви хочете, щоб ми пояснили будь-яку частину документа.

На нашем вебсайте есть краткая сводка данного документа на русском языке – hduhb.nhs.wales/clinical-services-consultation. Либо, печатный экземпляр данного документа можно получить, позвонив нам по телефону 0300 303 8322 (по местному тарифу). Просим связаться с нами, если вам необходимо пояснение каких-то частей документа.

This consultation is about potential change to nine healthcare services in west Wales and runs until Sunday 31 August 2025, so we need to hear your views before then.

More information is on page 17, but you can share your views by:

- ▶ completing the questionnaire online: hduhb.nhs.wales/clinical-services-consultation or in hard copy (you can request a copy from the contact points below) posting it to: **Opinion Research Services FREEPOST SS1018 PO Box 530, Swansea, SA1 1ZL** (you will not need a stamp).
- ▶ emailing us: hywelda.engagement@wales.nhs.uk
- ▶ speaking to us at one of our events (visit the website above for an event near you or online), or by telephoning **0300 303 8322** (option 5), charged at local call rates.



Welcome

Thank you for your interest in our consultation about how **nine** clinical healthcare services could be delivered in hospitals and community facilities in Carmarthenshire, Ceredigion, and Pembrokeshire.

This is a time for us to work collaboratively together to decide the future share and scope of services across the three counties, ensuring safe, high-quality services and affordable healthcare in the future.

The changes we are looking to make will have at their heart the best interests of the people of west Wales and their patient experience.

Our initial discussions and engagement with communities has influenced the content of this document and helped us to understand what matters most to people when they access healthcare.

No decisions will be made until we have given everyone - our staff, patients, wider communities, organisations we work with, and people who have an interest in health and well-being in our area, the opportunity to tell us what you think.

You can do this by completing our questionnaire. We acknowledge that engaging with you on nine service areas is complex, but we want you to know that you can respond only on those areas that interest you if you so wish.

We also look forward to meeting you at future events, both online and in person in your community. If you have any questions, concerns or suggestions we'll be very happy to listen to you. This is your service and your opinion matters to us.

Many thanks



Dr Neil Wooding
Chair



Professor Philip Kloer
Chief Executive



Mr Mark Henwood
Interim Executive
Medical Director

Glossary

This glossary aims to provide you with descriptions of health care words or acronyms frequently used in this document. Some terms are used less frequently – these are described within the chapters in which they are used.

We have listed frequently used terms here alphabetically.

Acute	Short-term care people need when they are very unwell and are admitted to hospitals for tests and treatments.
AICC	Aberaeron Integrated Care Centre, Ceredigion.
AVH	Amman Valley Hospital in Ammanford, Carmarthenshire.
BGH	Bronglais General Hospital a main hospital in Aberystwyth, Ceredigion.
BSW	Bowel Screening Wales – screening services to find cancer at an early stage for those of eligible ages (people aged between 50 and 74 living in Wales).
CHHC	Cross Hands Health Centre, Carmarthenshire.
CICC	Cardigan Integrated Care Centre, Ceredigion.
Day cases	When people come into hospital for planned surgery or a procedure that is more involved than an outpatient appointment. You may need some recovery time at the hospital, but you should be able to go home the same day.
Diagnostics	Tests or procedures used to identify a person’s disease or condition.
ECU	Enhanced Care Unit – an area in a general ward for patients who need additional observation (referred to within our critical care chapter).
EGS	Emergency General Surgery mostly treating abdominal emergencies, sometimes requiring urgent action to save a patient’s life.
GGH	Glangwili General Hospital a main hospital in Carmarthen, Carmarthenshire.
ICU	Intensive Care Unit (critical care).
Inpatient	When people stay in hospital overnight while receiving treatment.
LH	Llandovery Hospital, Carmarthenshire.
NREC	North Road Eye Clinic, Aberystwyth, Ceredigion.
Outpatient	When people have an appointment in a hospital or clinic but do not need to stay.
PPH	Prince Philip Hospital a main hospital in Llanelli, Carmarthenshire.
SDEC	Same Day Emergency Care - departments which assess, diagnose, and treat patients on the same day rather than admit to a hospital ward.
SPH	South Pembrokeshire Hospital, Pembroke Dock, Pembrokeshire.
TH	Tenby Hospital, Pembrokeshire.
WGH	Withybush General Hospital a main hospital in Haverfordwest, Pembrokeshire.
24/7	24-hours a day, seven days a week.

Through this document we refer to other papers that you may wish to read, to learn more about the options developed for these proposed changes. These documents can be found by visiting the supporting documents area of our website at [hduhb.nhs.wales/CSP-Supporting-Documents](https://www.hduhb.nhs.wales/CSP-Supporting-Documents).

Introduction

A little about us

Hywel Dda University Health Board is your local NHS organisation.

We plan, organise, and provide health services for almost 400,000 people. This is across a quarter of the landmass of Wales in Carmarthenshire, Ceredigion, Pembrokeshire, as well as to communities on our borders in south Gwynedd, north Powys, and Swansea / Neath Port Talbot.

Our communities are quite spread out, often in rural areas. Almost half our population (49.10%) live in Carmarthenshire, 32.23% live in Pembrokeshire and 18.7% in Ceredigion. We manage and pay for the care and treatment that people receive in this area for physical, mental health and learning disabilities.

We currently provide services through:

4 MAIN HOSPITALS

(Bronglais Hospital, in Aberystwyth, Glangwili Hospital, in Carmarthen, Prince Philip Hospital, in Llanelli, and Withybush Hospital, in Haverfordwest)

2 INTEGRATED CARE

CENTRES (Aberaeron and Cardigan, both in Ceredigion)

Community facilities, including:

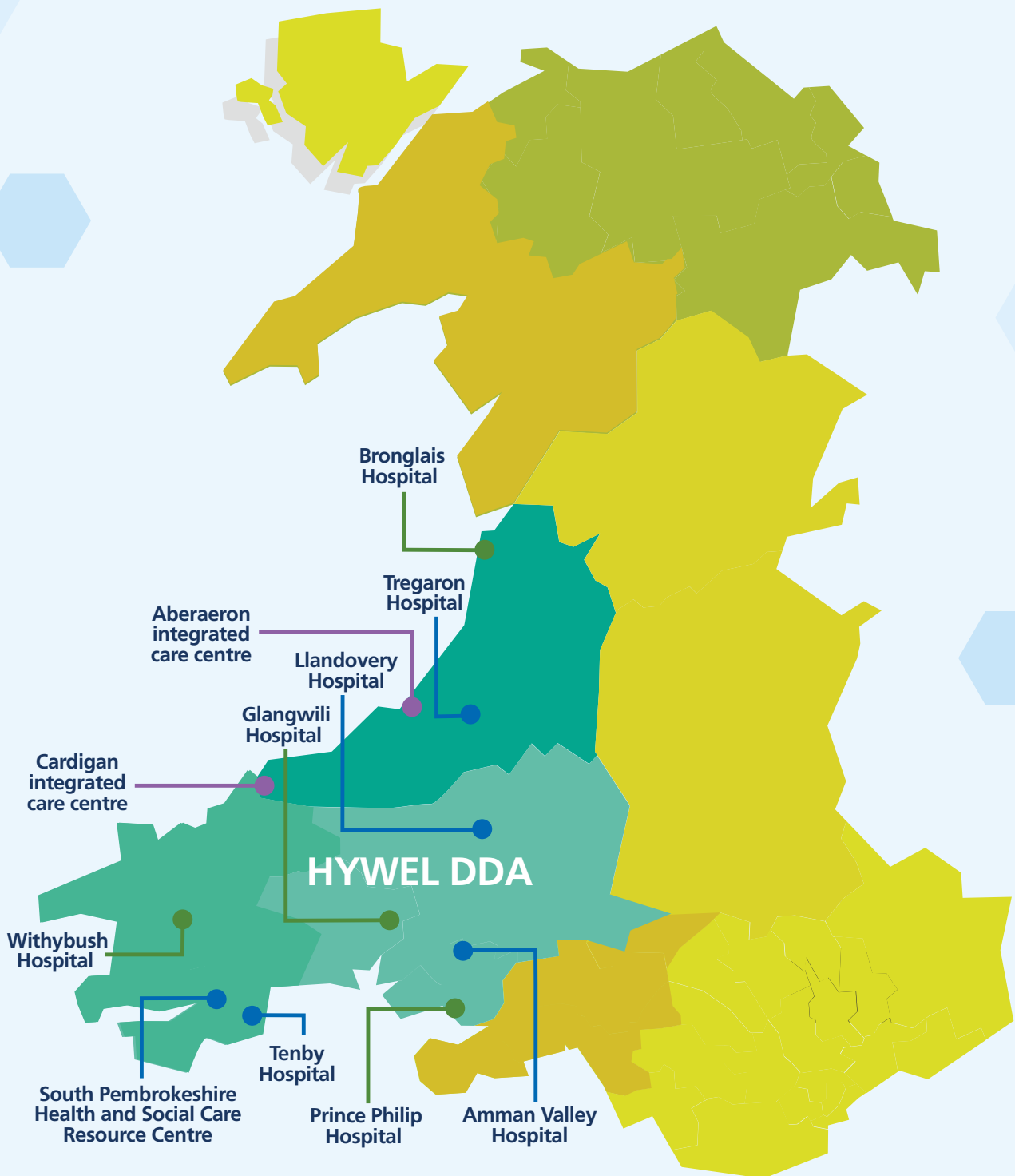
- ▶ **46 General Practices** (GP surgeries)
- ▶ **38 Dental Practices**
- ▶ **97 Community Pharmacies** (chemists)
- ▶ **43 General Ophthalmic Practices** (including eye health and low vision services)
- ▶ **38 sites providing mental health and learning disability services**
- ▶ care within your **own homes**.

5 COMMUNITY HOSPITALS

(Amman Valley Hospital and Llandovery Hospital in Carmarthenshire, Tregaron Hospital in Ceredigion, Tenby Hospital and South Pembrokeshire Hospital in Pembrokeshire)



Highly specialised services, such as some major trauma treatment, cardiac (heart) care, specialised eye treatments, and complex burns, are organised through the NHS Wales Joint Commissioning Committee. These services can be provided outside our area, for example in Swansea, Cardiff, or even outside Wales such as in Bristol.



What is this consultation about?

This consultation is about nine clinical healthcare services.

Any future changes in these services may impact on how they are organised at our four main hospitals and in some community facilities.

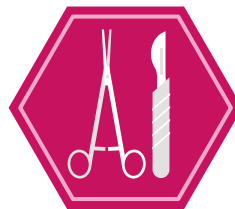
The nine clinical services are listed below.



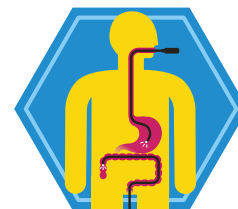
Critical care



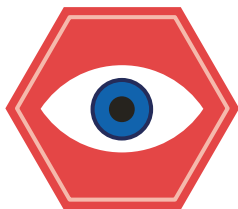
Dermatology



**Emergency
general surgery**



Endoscopy



Ophthalmology



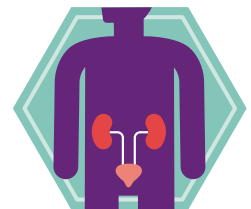
Orthopaedics



Radiology



Stroke



Urology

- ▶ **Critical care** providing treatment to adults, in a separate and self-contained area of the hospital for life-threatening and critical conditions.
- ▶ **Dermatology** - services focused on the diagnosis and treatment of diseases of the skin, hair, and nails.
- ▶ **Emergency general surgery** (EGS) - mostly treating abdominal emergencies, sometimes requiring urgent action to save a patient's life.
- ▶ **Endoscopy** - a procedure, using equipment inserted directly into the body or an organ, to look inside the body.
- ▶ **Ophthalmology** - the treatment of eye diseases, injuries, eye injections, and surgical procedures.
- ▶ **Orthopaedics** (also known as orthopaedic surgery) - a branch of medicine that focuses on the care of the musculoskeletal system and its interconnecting parts, such as bones, joints, and soft tissues.
- ▶ **Radiology** - a medical speciality that uses imaging techniques (such as X-rays) to diagnose, treat and monitor diseases and injuries identified within the body.
- ▶ **Stroke** - a serious life-threatening medical condition that happens when the blood supply to part of the brain is cut-off.
- ▶ **Urology** - cares for adult patients with problems in the genito-urinary tract system (e.g. kidney, bladder) and the reproductive tract in men (e.g. testicles, penis, and prostate).

Why these services?

We have looked at change in these nine services because there are risks to them being able to continue to offer safe, quality services or timely care.

We have recognised for several years that some of our hospital services are fragile, mainly because our clinical teams are spread across multiple sites, with an over-reliance on a small number of individuals. Additionally, the COVID-19 pandemic has left us with a legacy of long waiting lists, gaps in workforce (made worse by shortages nationally for some healthcare staff), social care pressures, and more demand for health services. Some of our services have not been able to return to pre-pandemic activity levels and this means patients are waiting longer than we would like for some planned care.

Given the challenges, we have developed a clinical services plan, with options to change our nine key services, in a timeframe of up to four years from any decision and consider what further change could be made in more than four years.

We aim to:

- ▶ respond to the fragility of the critical care and emergency general surgery services;
- ▶ improve standards and outcomes, and address staffing challenges in the stroke service;
- ▶ improve access to and reduce waiting times for planned care patients (ophthalmology, dermatology, urology and planned orthopaedics) and diagnostics (endoscopy and radiology).

Work to address this was agreed by our Health Board in March 2023.

When is this consultation?

The consultation will run for 13 weeks from Thursday 29 May 2025 to Sunday 31 August 2025.

More information about specific options for these services is available on pages 17 to 56.

What we seek to learn

In this document, we set out:

- ▶ why we need to change delivery of these nine services
- ▶ what we have done so far, and why we have suggested the options we have
- ▶ detail about the options and other information you might want to consider while forming your opinion
- ▶ how you can get involved and what we will do with the feedback you share.

At this stage, we do not have preferred options within the nine service areas of this consultation. Whilst there is only a single option for urology presented, this is not a preferred option as we welcome new ideas from people.

In this consultation we will ask you to tell us:

- ▶ which of options you think are best able to address fragilities in our services, improve standards or reduce waiting times
- ▶ concerns you may have about any of the options, or impacts you think they may have
- ▶ thoughts you may have on the future role of our hospitals
- ▶ anything else you think we need to consider, including alternative options or ideas you may have.

Your views and new ideas, along with the **supporting document data** we have gathered and referred to in this document, can influence future decisions about how we deliver these nine services across our area.

The Health Board will meet later in winter 2025/26, to consider this and decide on how we provide these services.

Board members will consider all they have heard leading up to, and during, this consultation. This includes the impact assessments, which will consider how people could be affected and what needs to be done to reduce negative impacts.

They will also consider any new information, including new ideas, which may come to light from the consultation. Any new ideas, along with the options proposed in this consultation, should meet certain criteria. More detail on these criteria is available on page 16.

It is important that you know the following points are decided. This means they are not open to influence in this consultation:

- ▶ which service areas are part of this consultation
- ▶ the overall direction of our 'A Healthier Mid and West Wales' strategy (more on page 11) that we anticipate will remain, i.e.
 - ▶ moving towards a wellness service rather than an illness service
 - ▶ developing a social model for health
 - ▶ supporting people through technology and other means to stay healthy, independent, and in their own homes
 - ▶ significant capital investment to improve or replace old buildings
 - ▶ bringing together acute hospital services to make them stronger and improve standards of care.

Who we want to talk with

We really appreciate you taking the time to share your thoughts. This consultation is for all members of the public who live, work, or have an interest in our area.

We recognise people have different interests and perspectives.

You may receive our services, or care for someone who does. You may work with us as staff, students, or volunteers. You may represent an organisation potentially affected by our proposals or you may have an interest in health and well-being.

As well as speaking to people in our area, we will also continue to work with health boards in neighbouring counties and encourage residents or organisations in these areas to share their views also.

Potential impacts of change on our staff

We recognise and value the skills and experiences we have within our workforce.

There may be changes for staff as a result of any decisions following this consultation. This could potentially include changes to working patterns or locations of services.

We need all our employees to contribute to our shared ambition for a healthier population and to provide safe, sustainable, accessible, and kind services.

We will work in partnership with any staff affected and adhere to the All-Wales Organisational Change policy in place for the NHS workforce across Wales.

We have engaged with staff in the early stages of work on our nine clinical services and representative staff have been involved in the development of options.

We will now engage more widely with staff across our Health Board, as well as with our Trade Union representatives, on the options and to understand the potential impacts, and to gather feedback and new ideas.



Why our services need to change

Our vision for the future

We have a shared vision with our communities for us to live healthy, joyful lives.

Our strategy called **'A Healthier Mid and West Wales: Our future generations living well'**, published in 2018, describes some of the challenges we have in providing care across a large and mostly rural area, with some healthcare services provided across multiple hospitals and facilities.

The strategy sets our ambition to shift from a health service that just treats illness to one that keeps people well, prevents ill-health or worsening of ill health, and provides any help you need early on.

The strategy was developed following consultation with our communities. You can read the strategy, available in the **Supporting Documents** area of our webpages.

More than six years have passed since we published our strategy and much has happened in those years, from service change and provision or planning of new services in our communities, to the COVID-19 pandemic and its impacts. In November 2024, our Health Board agreed we may need to engage our communities on a refresh of the strategy.

We will announce further details on engagement on this when available, through our Health Board meetings and public announcements. You can read more in the Public Health Board November 2024 meeting papers, available in the **Supporting Documents** area of our webpages.

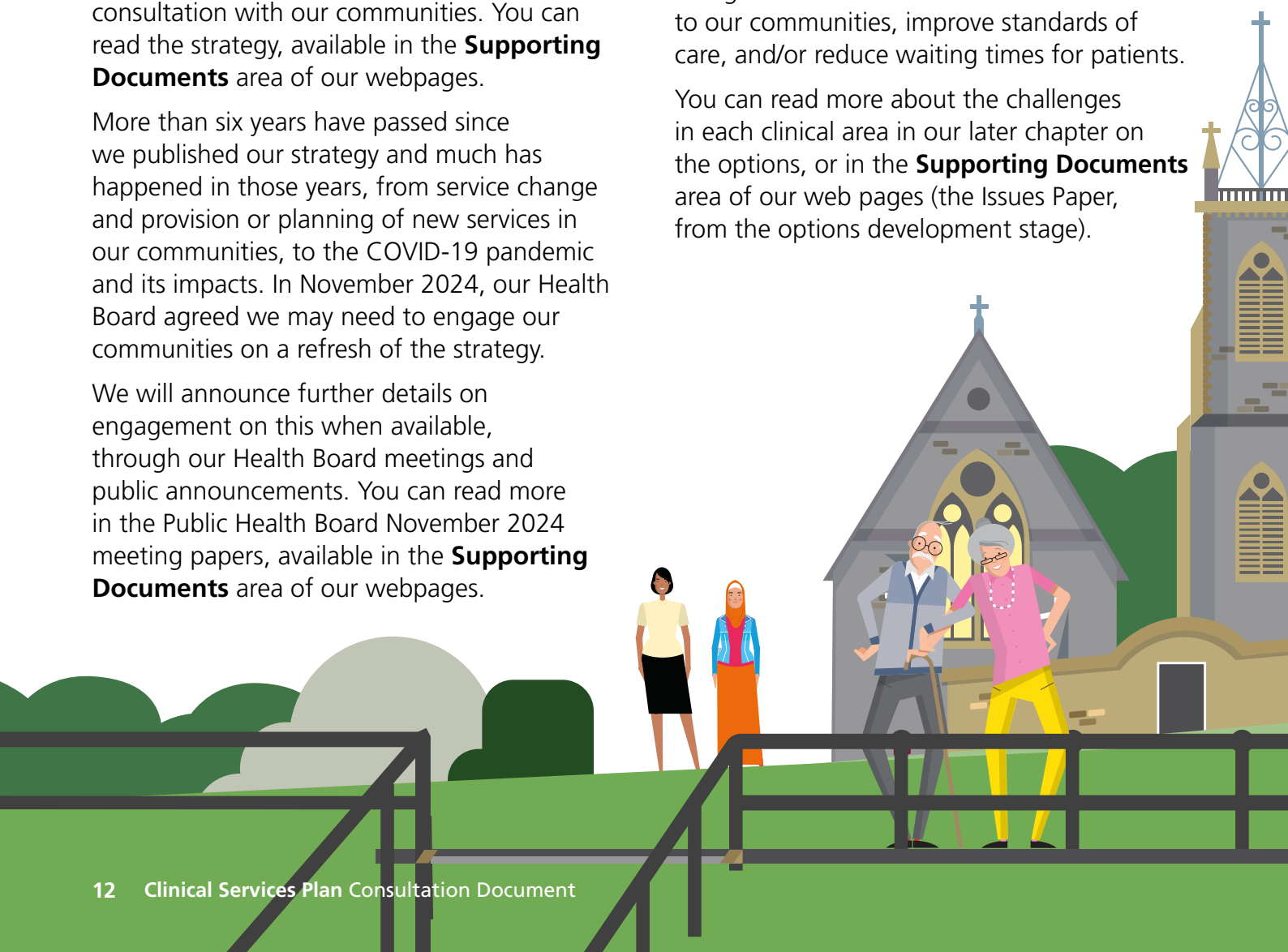
Why we need to change our nine services

There are several reasons why these services need change and support:

- ▶ there are fragilities in delivering our critical care and emergency general surgery services
- ▶ we need to improve access and reduce patient waiting times in planned care (dermatology, ophthalmology, orthopaedics, and urology) and diagnostics (endoscopy and radiology)
- ▶ we need to improve standards and respond to service fragility in our stroke services.

Our goal is to offer safe and sustainable care to our communities, improve standards of care, and/or reduce waiting times for patients.

You can read more about the challenges in each clinical area in our later chapter on the options, or in the **Supporting Documents** area of our web pages (the Issues Paper, from the options development stage).



What has happened so far

We have described our work in two phases. Phase One details the work done to explore the issues affecting the nine service areas. Phase Two describes the work done to develop options for these nine service areas.

Phase One

During this phase, we assessed our nine healthcare services, led by clinical experts.

We looked at the factors affecting these services, including any temporary changes, and patient activity data. You can get detailed information on the patient numbers and activity within each of our nine services in our supporting document called '**Patient and travel insights**' document, available in the **Supporting Documents** area of our webpages.

We involved the public and we identified people and organisations (stakeholders) who should be part of the conversation.

Here is what you told us in Phase One.

- ▶ **Access to services** – you need better access to healthcare, especially people in rural areas. Travel times and the availability of transport are a concern and there are calls for more local services.
- ▶ **Quality of care** – services should be safe, consistent, and patient-centred focusing on individual needs.

- ▶ **Communication** – people want clearer information from healthcare providers and better sharing for patient information across healthcare services.
- ▶ **Joined up services** – healthcare services should work together smoothly to provide better overall care.

What we reviewed

We carried out Equality Impact Assessments to make sure our decisions are fair and inclusive for all groups.

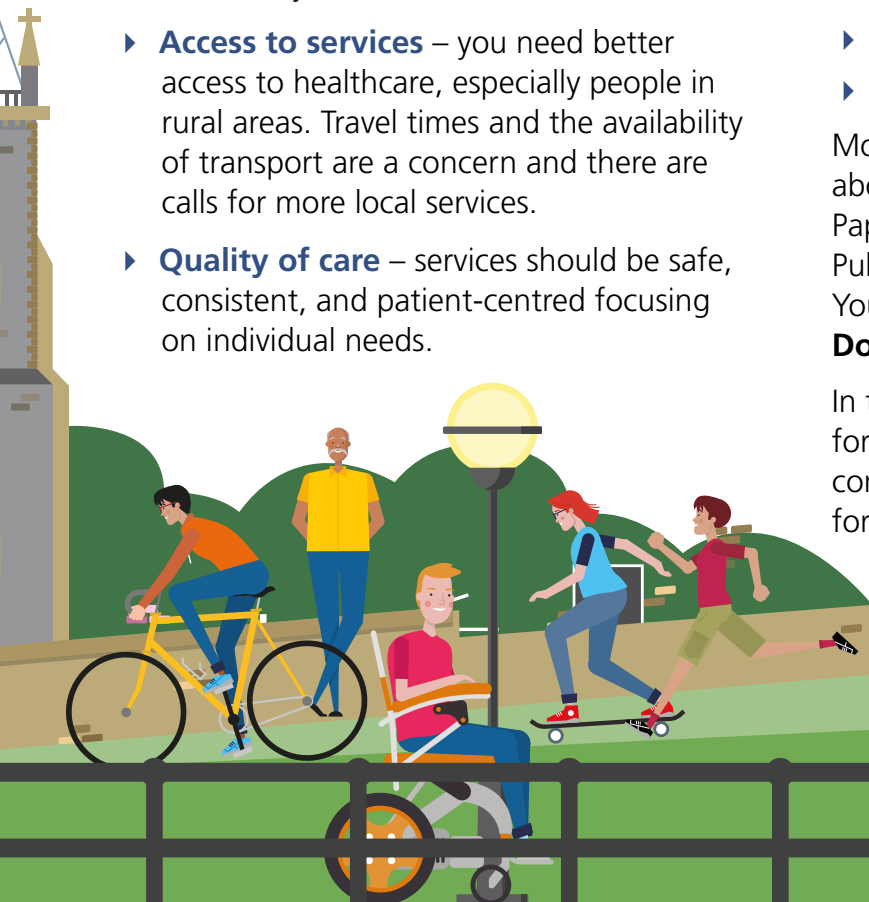
We also reviewed:

- ▶ temporary service changes and risks
- ▶ clinical guidelines and national policies
- ▶ data on patient experiences, complaints, and safety incidents
- ▶ survey responses from nearly 6,000 of you or your carers who have used these services in the past five years
- ▶ survey responses from more than 350 healthcare staff working in these areas
- ▶ workforce issues and risks
- ▶ financial pressures and cost challenges.

More information on the data collected above is available, by service, in the Issues Paper that was presented to our Health Board's Public Board meeting on 28 March 2024.

You can read the full paper in the **Supporting Documents** area of our webpages.

In that meeting, our Board members agreed for the Clinical Services Plan programme to continue work to explore potential options for the future of these services (Phase Two).



Phase Two

During this phase we developed potential options for the future of our nine service areas. This was done by a range of different workshops between February 2024 and September 2024.

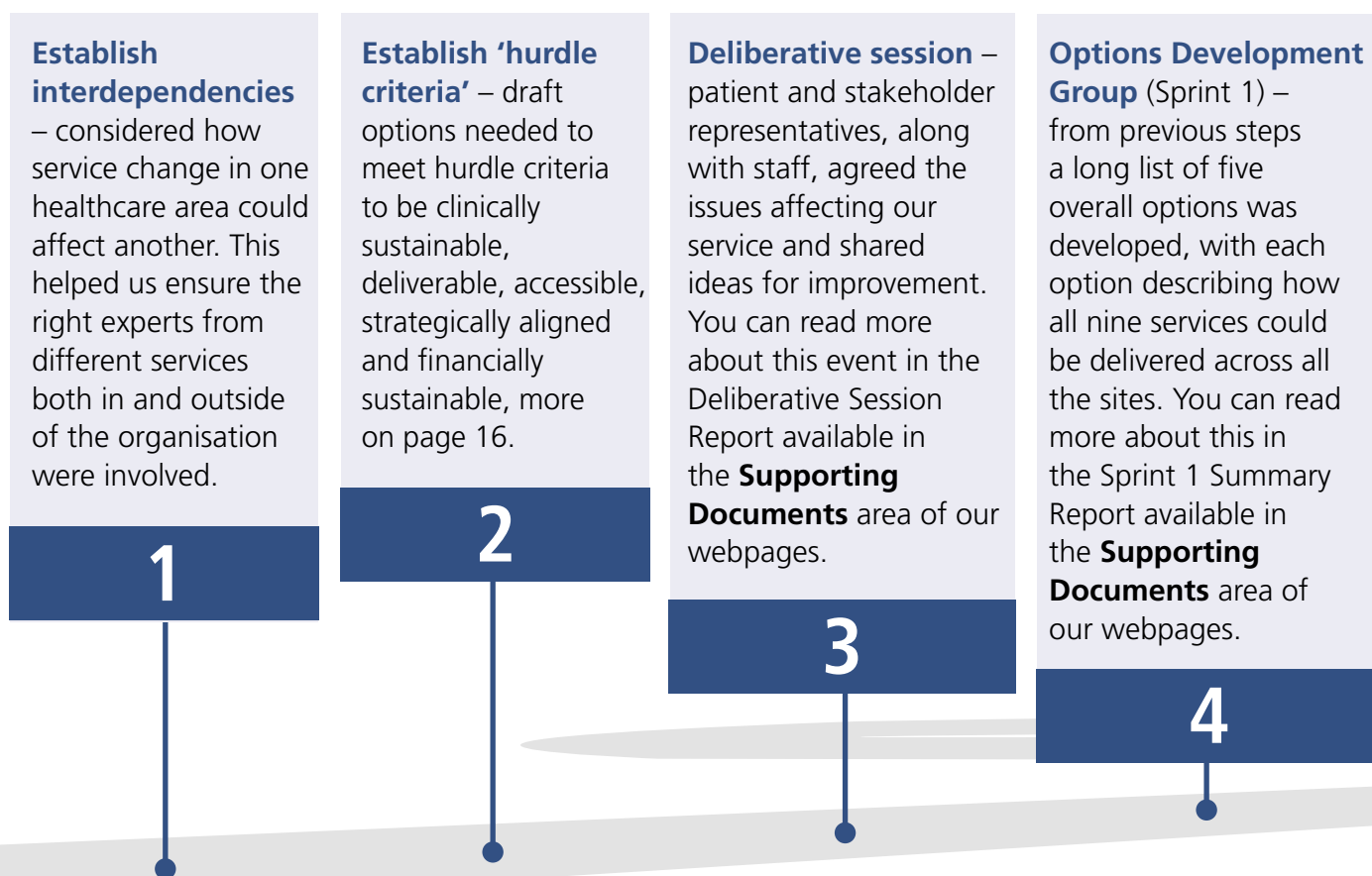
Participants formed groups to develop options for the whole programme i.e. across all nine services. This gave an opportunity to consider impacts between services (interdependencies) and what would be required to deliver an option such as physical space available within facilities.

Hearing your voice is important so we can build services that meet their need. For this reason, some workshops involved patient representatives and stakeholder representatives to 'check and challenge' our thinking and to bring different viewpoints to the scoring and shortlisting of potential options.

What you and our stakeholder representatives told us during this phase was:

- ▶ **Service sustainability** – services need to be sustainable, and there was concern with staffing levels and financial resources. You said we need to plan how to handle increasing demand.
- ▶ **Community involvement** – there was a strong desire for more community involvement in planning and delivering services, and more engagement in decision-making.
- ▶ **Specific service improvements** – you had suggestions for improving urgent and planned care services and called for better mental health services and support for chronic conditions.
- ▶ **Technology and innovation** – you were interested in how technology and innovation could improve services, and the potential for telehealth and digital health solutions to improve access.

The key milestones in Phase Two were:



Check and Challenge – patient and stakeholder representatives, along with staff, checked and challenged previous work on the five long-list options developed. You can read more about this in the Check and Challenge Summary Report available in the **Supporting Documents** area of our webpages.

5

Options Development Group (Sprint 2) – reviewed learning to date and assessed the long-list of five draft options against the hurdle criteria. Participants agreed to evaluation criteria for scoring at the next stages, which were to consider how far options were safe, sustainable, accessible and kind. You can read more about this in the Summary Report Sprint 2 document available in the **Supporting Documents** area of our webpages.

6

Options Development Group Shortlisting Phase – several workshops to gather information to inform consideration of the evaluation criteria and to assess the strengths, weaknesses, opportunities, and threats in four shortlisted options. You can read more about this in the Part 1, Part 2 and Final Shortlist Report available in the **Supporting Documents** area of our webpages.

7

Shortlist scoring – the scoring of shortlisted options was completed. You can read more about this in the Output Report available in the **Supporting Documents** area of our webpages.

8



Hurdle criteria

All draft options, and any new ideas that may be suggested in this consultation, should meet the following criteria:

Clinically sustainable – does the option allow for progress towards delivering quality standards, does it consider any co-dependencies, will the workforce be able to deliver it?

Deliverable – is the option clinically and operationally deliverable within the timeframe of 2-4 years and are there capital or building requirements that can be secured and delivered in that timeframe?

Accessible – does the option provide access for people within an appropriate timeframe, does the option support a reduction in waiting times for patients, is there equity in access?

Strategically aligned – does the option support the direction set out in the 'A Healthier Mid and West Wales' strategy, or at least not contradict it, and does the option support joint work on prevention to improve population health, or at least not contradict it?

Financially sustainable – does the option support effective use of our finances?

Board decision to consult

In a Public Board meeting in November 2024, Board members received a Closing Report summarising all the work that had taken place, described above, in Phase 2.

Board agreed that public consultation was needed and that:

- ▶ the options developed in Phase 2 contain the building blocks for how individual services could potentially be organised differently to deal with fragilities
- ▶ funding implications of the options should be described
- ▶ we should seek to describe options in a simple way during consultation.

This led us to describe the timing and funding implications of our options, by service, in the options presented in the next chapter.

We have also presented options per service, rather than across a whole programme, which allows people to provide feedback on services that are of particular interest to them. You can read more in the Interdependencies document, available in the **Supporting Documents** area of our webpages.



Options in this consultation

In this section, we set out each service and the consultation options.

We use tables for each service to show you 'at a glance' how current services are provided and what the options for change could mean, by main hospitals and community facilities. We also describe this, by option, in text.

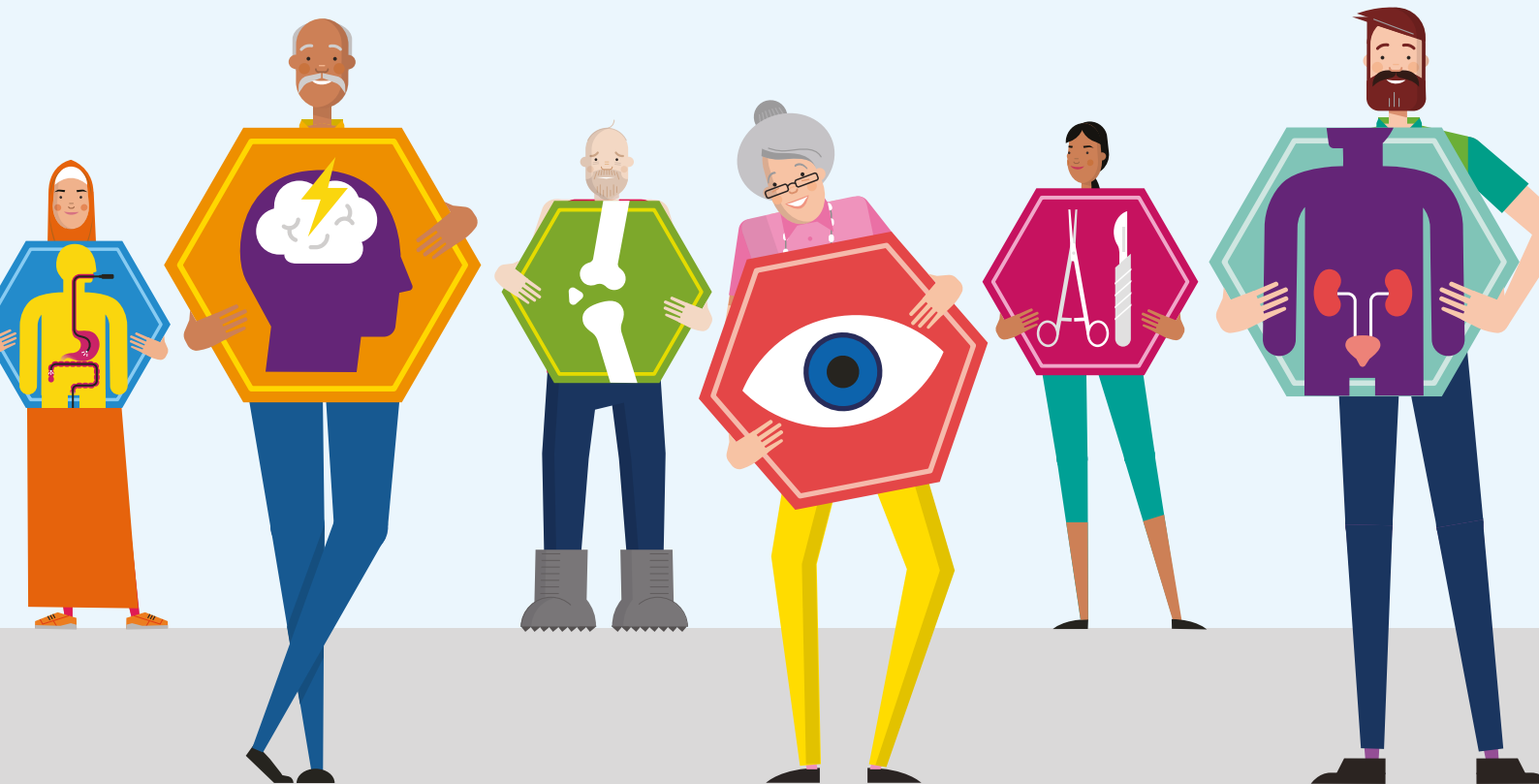
Another table in each section describes the similarities and differences between options. This may help you think about the impacts different options would have on you and your loved ones.

This includes information on how much more or less options would cost compared to now. Costs over a million are displayed as £x.xxx m. Costs under one million, are in the hundreds of thousands and are displayed as £xxx k. All costs are estimates and aim to show you approximate impacts on Health Board finances.

Some options would need more money for building and equipment costs. The Health Board has some money available for this type of work and can make decisions on how to use it.

Some options would also need more staff costs. These costs would apply every year and would need the Health Board to allocate more funding every year. These elements are not guaranteed and, if supported, would take longer to deliver.

We have described this for every service and option in a section called 'Delivery'. This is so you can see how quickly parts of options can be delivered, and which parts of options are dependent on the Health Board agreeing extra money for staffing.



Critical care



Introduction

Critical care delivers treatment and monitoring for people with life-threatening and critical conditions, such as multi-organ failure.

The service provides specialist skills, including medical and nursing input, and specialist equipment, in a dedicated area of a hospital.

There are four levels of care that patients can receive.

- ▶ Level zero patients receive their care on a general hospital ward.
- ▶ Level one patients need closer observation and care. These patients can be cared for within an enhanced care unit (ECUs). ECUs can be based within a general ward or a stand-alone unit, led and managed by consultants at that site, without the need for specialist critical care staff.
- ▶ Level two patients need specialist input from critical care staff and are usually cared for within a dedicated location, such as an intensive care unit (ICU).
- ▶ Level three patients are the most unwell patients and must be cared for within a dedicated location, such as an ICU and by specialist critical care staff.

Current services

At Hywel Dda, critical care services are provided across all four levels at:

- ▶ **Bronglais Hospital** (BGH)
- ▶ **Glangwili Hospital** (GGH)
- ▶ **Prince Philip Hospital*** (PPH)
- ▶ **Withybush Hospital** (WGH).

*There has been a temporary change in place for critical care services at PPH since July 2022. This means that the sickest patients have been stabilised and transferred on to level three intensive care units.

The temporary change was needed to improve our ability to safely deliver our critical care services in Carmarthenshire with the staffing available. This is explained in more detail in the Public Board Meeting Paper of 29 September 2022 available in the **Supporting Documents** area of our webpages.

Did you know?

Critical care units provide care predominantly for adults. There are rare occasions when a child or young person would be admitted to a critical care unit, but this is temporary whilst arrangements are made to transfer them onto more specialist services for children via the Wales and West Acute Transport for Children Service (WATCH).



Why change is needed

- ▶ Critical care services are checked against standards known as the Intensive Care National Audit and Research Centre (ICNARC) annual audits. This assesses our services against the current standards in the UK. Currently our services:
 - ▶ do not meet the workforce requirements to deliver a safe service
 - ▶ need more input from critical care allied health professionals, these are clinical staff who are not doctors and nurses, for example physiotherapists, dieticians etc.
 - ▶ do not have a critical care rehabilitation and follow-up pathways in place (this would need the additional input from allied health professionals)
 - ▶ experience delay in critical care patients being transferred back to general wards due to bed availability
- ▶ have limited access to urgent tests to see internal organs on some sites
- ▶ vary in terms of what tests can be provided at each site, meaning patients are sometimes transferred from one site to another at risk to them.
- ▶ Due to a lack of storage, some bed spaces at hospitals are used to store critical care equipment currently and this is a risk to staff and patients.
- ▶ Critical care medical staff recruitment is a challenge across the UK, which means it is difficult to maintain safe staffing in critical care in all our hospitals.
- ▶ Whilst there have been significant improvements in the recruitment of nurse staffing, the lack of trained and experienced critical care nursing has meant we pay for costly, temporary agency support for the learning needs of our workforce.

Critical care at a glance

	Bronglais	Glangwili	Prince Philip	Withybush
Current service	ICU	ICU	ICU (with transfer of sickest patients)	ICU
Option A	ICU	ICU and ECU	ECU	ECU
Option B	ICU	ICU	ECU	ICU
Option C	ICU	ICU	ICU (with transfer of sickest patients)	ICU

*Transfers between hospitals for critical care patients between ECUs and ICUs would use the Adult Critical Care Transfer Service (ACCTS).

What are the options?

Common in all options

- ▶ ECUs mentioned in the options would provide care up to level one. ICUs would provide level two and level three care, unless stated in the options otherwise.
- ▶ ICUs would remain at GGH and BGH in all options.

- ▶ It is our intention to provide additional therapies support in all main hospitals and all options.

The options

Options development work has suggested three different options for critical care in this consultation.

- ▶ 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.

Delivery – within two years, including additional therapies at all hospitals.

- ▶ 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.

Delivery – the ECU at PPH within two years. Additional therapies at all hospitals in two to four years and subject to funding, of staff.

- ▶ In **Option C**, we would 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, and support from the general medicine consultants at PPH.

Delivery – The temporary changes at PPH would continue as now and would be made permanent. Additional therapies at all hospitals would be delivered in two to four years and would be subject to funding of staff.

Similarities and differences between options

	Option A	Option B	Option C
Opportunity to improve standards of care or impact positively on waiting times	Bringing together services, including staff and equipment, to fewer sites, would improve our ability to provide sustainable services for the future, as well as our ability to meet national health standards in support of our patients.		
	Fewer sites need specialist critical care input (than Option B or C) so the greatest opportunity to improve standards of care.	Fewer sites need specialist critical care input (than Option C), so a greater opportunity to improve standards of care.	The same number of sites providing specialist critical care input as currently.
Impact on staffing challenges and on our staff	Reduces the staffing challenge to the greatest extent as there are two, the least amount, of ICUs. May also impact on where staff work from.	Reduces the staffing challenge (more than Option C but less than Option A) as there are three ICUs. May also impact on where staff work from.	Does not impact the staffing challenge, as there would be four ICUs as there are now.



	Option A	Option B	Option C
Impacts on transfers between hospitals	<p>The highest volume of patients needing transfer between hospitals.</p> <p>Patients at PPH or WGH requiring level two or three care would be transferred to GGH ICU.</p>	<p>More patients needing transfer between hospitals (than Option C, but less than Option A).</p> <p>Patients at PPH requiring level two or three care would be transferred to GGH ICU.</p>	<p>Temporary model as in place now, so no further volume of patients to transfer between hospitals than currently.</p> <p>Patients at PPH requiring level three care would be transferred to GGH ICU.</p>
Impact of travel for patients or visitors	<p>Patient visitors from Pembrokeshire and east Carmarthenshire would have further to travel to visit loved ones and friends.</p>	<p>Patient visitors from east Carmarthenshire would have further to travel to visit loved ones and friends.</p>	<p>Temporary model as in place now, so no further volume of patient visitors travelling further.</p>
Time taken to deliver	<p>Completed within two years (including additional therapies).</p>	<p>Completed within two years (including additional therapies).</p>	<p>Temporary changes at PPH continue and made permanent.</p> <p>Additional therapies delivered in two to four years and subject to funding, of staff.</p>
Cost to deliver	<p>Reduce staffing costs by around £274k.</p> <p>Building and equipment costs would be around £1.345m.</p>	<p>Reduce staffing costs by around £255k.</p> <p>Building and equipment costs would be around £1.407m.</p>	<p>Increase in staffing costs by around £553k. No building and equipment costs.</p>

What else you may want to consider

- ▶ **Option A and B** include the developments of enhanced care units. If these options are chosen, we would need to develop clear patient transfer pathways and process to support the safe and timely transfer of patients between sites.



Dermatology



Introduction

Dermatology services diagnose and treat diseases of the skin, hair, and nails in both children and adults. Patients receive care from the service typically by referral from their GP.

Dermatology patients attend appointments at hospital (outpatients) for a range of conditions that include, but are not limited to, skin lesions (both urgent suspected cancer and non-urgent suspected cancer), inflammatory skin conditions, psoriasis, acne, and children and young people are seen for conditions including eczema.

Some dermatology patients need minor operations, this can include a complete removal of a skin lesion or removal of a small sample (biopsy). Other patients may be treated using phototherapy and/or medication.

Current services

Dermatology clinics are currently held at:

- ▶ **Glangwili Hospital** (GGH) - but very limited at only one clinic per week, medical photography is also based here
- ▶ **Prince Philip Hospital** (PPH)
- ▶ Some nurse-led clinics at **Cardigan Integrated Care Centre** (CICC) and **South Pembrokeshire Hospital** (SPH)
- ▶ Small number of **GP practices** providing minor operations.

Paediatric patients requiring any type of skin surgery, and adult patients requiring more complex skin surgery, are referred to the Burns and Plastics team at Swansea Bay University Health Board for their treatment.

Prior to the COVID-19 pandemic, clinics were also held at:

- ▶ GGH, with more clinics held more often than currently, as well as minor operations and phototherapy
- ▶ WGH (as well as minor operations and phototherapy)
- ▶ Some nurse-led clinics at Amman Valley Hospital (AVH), South Pembrokeshire Hospital (SPH), Trimsaran Surgery and Tycroes Surgery.

Online clinics are available for some dermatology patients to reduce the number of visits they need to make to hospitals. There are also some evening clinics, which support people who have work or other commitments in daytime hours.

Due to the need for clinicians to provide wider support for the COVID-19 pandemic, temporary changes were put in place for dermatology services in May 2020. This included re-locating the dermatology outpatient clinics from GGH and WGH to PPH. At the same time, community clinics ceased, except for at South Pembrokeshire Hospital.

You can read more about the temporary service change in the Public Board Paper May 2020 available in the **Supporting Documents** area of our webpages.

The service has since reinstated one clinic at GGH. Clinics are not re-instated at WGH, due to building safety issues that have had an impact across the hospital (RAAC), but clinics are instead provided at South Pembrokeshire Hospital. Most clinics remain at PPH.

Did you know?

- ▶ There is a national shortage of consultant dermatologists. Since 2016, there has been fewer than two consultant dermatologists (and these are temporary locum staff) providing care in the Hywel Dda area. To meet the staffing levels recommended by the British Association of Dermatologists, our population would require six consultants.

Why change is needed

- ▶ There are a rising number of skin cancers (National Review of Dermatology Services in Wales 2019) which increase waiting times for both urgent and non-urgent cases locally.
- ▶ The national shortages of dermatology consultants mean we rely on temporary (locum) consultants, which impacts on:
 - ▶ other staffing as middle grade speciality doctors have left to join other health boards where senior clinical leadership is in place
 - ▶ and makes it difficult to train new staff and build a future workforce.
- ▶ There are limitations to the improvements we can make to waiting times, due to these issues, and staff shortages also mean there are more cancelled appointments for patients. An innovation to 'see and treat' people with urgent suspected cancer lesions had to stop due to an increase in demand and not enough procedure rooms available for these clinics. This has had a negative impact on patients as they now need to make more journeys.
- ▶ Other staff shortages mean there are some services we cannot provide as we are unable to keep or train new staff, this includes patch testing which is recommended for patients with chronic or persistent dermatitis.
- ▶ Most hospital-based clinics are based on a different hospital site to medical photography, and this makes it difficult for the teams to work together, increasing the number of queries which medical photography could otherwise help with.
- ▶ There is a lack of space to provide dermatology services on multiple sites, and the space that is allocated is not up to the standards we would like. Some examples are below.
 - ▶ Rooms previously used in GGH (one for minor operations and the other for children's clinics) were released for the COVID-19 response and have not been returned to the dermatology service as they are needed for other healthcare provision.
 - ▶ Phototherapy clinic space at GGH and WGH has not met the health and safety guidelines needed. In the absence of the option of these clinics, some patients with inflammatory conditions are prescribed strong medications, which carry more risks to them.
 - ▶ The room used for minor operations at PPH needs refurbishment, and in particular, improved lighting and ventilation.

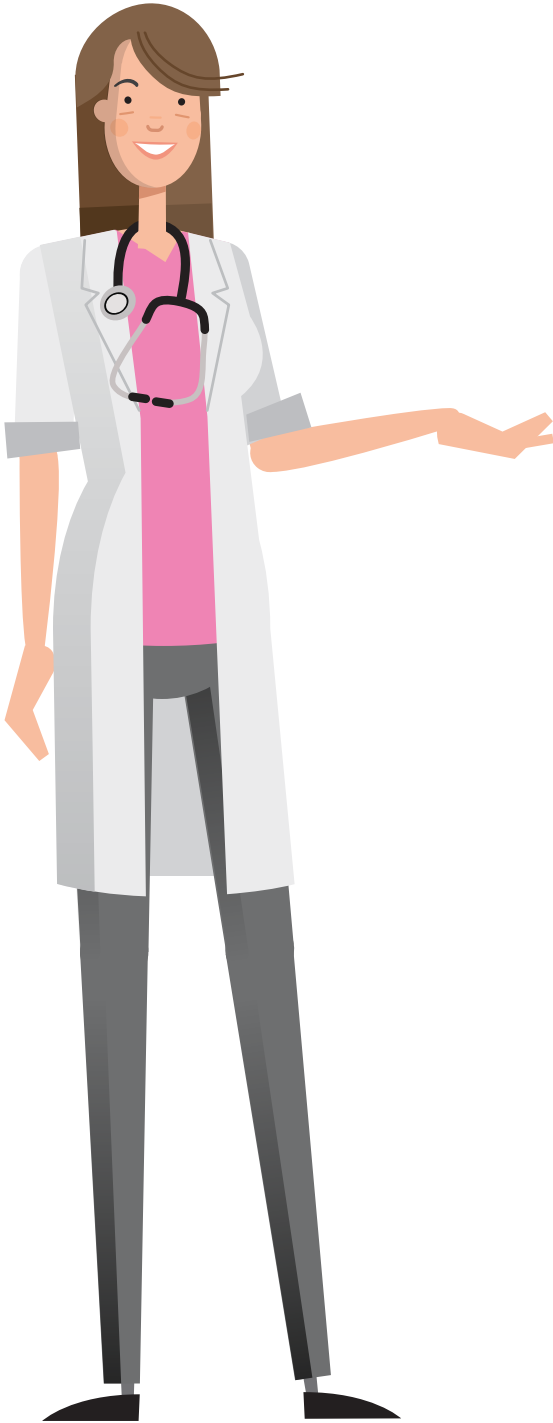


Dermatology at a glance:

	Bronglais	Glangwili	Prince Philip	Withybush	Community
Current service	No service	Outpatient clinic once per week, medical photography, (photo-therapy not running currently)	Outpatient clinics and minor operations	No service currently due to RAAC issues	Some nurse-led outpatient clinics at CICC (inc. minor operations) and SPH
Option A	No service	No service	Consolidated service	No service	Keep provision at CICC. Some nurse-led outpatient clinics at AVH. No community provision in Pembrokeshire
Option B	No service	No service	Consolidated service	No service	Keep provision at SPH. Some minor operations in GP practices. No community provision in Ceredigion
Option C	No service	No service	Consolidated service	No service	Keep provision at CICC and SPH. Some nurse led paediatric clinics at CHHC. Some minor operations in GP practices
Option D	No service	No service	Consolidated service	No service	Keep provision at CICC and SPH. Some nurse led paediatric clinics at CHHC

What are the options?

Options development work has suggested four different options for how the dermatology service continues to run in the community.



Common in all options:

- ▶ In all options we propose that the temporary change of having dermatology hospital services centralised at PPH is made permanent.

Delivery - would be the same for all proposed options in this service. Hospital clinics would be brought together at PPH within two years. Community based care and clinics and enhancements to hospital services, such as the relocation of the phototherapy unit, additional treatment rooms, and staff, would be put in place in years two to four and would be subject to funding of staff.

The options:

- ▶ **Option 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.
- ▶ **Option 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.
- ▶ **Option 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.
- ▶ **Option D** keeps the current community, nurse-led, provision at CICC and SPH. In addition, some nurse-led paediatric clinics would take place at CHHC.

Similarities and differences between options

	Option A	Option B	Option C	Option D
Opportunity to improve standards of care or impact positively on waiting times	A single hospital department would keep different professional staff who deliver the service together, with the resources they need. This would improve service quality, efficiency, and continuity of care for patients.			
			Clinics in a suitable area for children and young people (which is not provided in Option A and B).	Clinics in a suitable area for children and young people (which is not provided in Option A and B).
Impact on staffing challenges and on our staff	<p>Minimal impact to staff by having a single department at PPH, as this position is already in place temporarily.</p> <p>A dedicated single hospital department would improve the environment for staff, helping with staff retention, providing better opportunities for working collectively together and be more attractive to future recruits. Basing the department towards the east of our area offers a better chance of attracting prospective consultant dermatologists to Hywel Dda.</p>			
Impact of travel for patients or visitors	<p>Minimal impact to patients for hospital-based care as this position is already in place temporarily.</p> <p>All the options provide opportunities to continue to deliver some nurse-led clinics in the community, away from an acute hospital setting.</p>			
	<p>Keeps community provision at CICC and would provide an opportunity for some patients to receive clinics and minor operations at AVH.</p> <p>There would be no service delivery in Pembrokeshire as part of this option so patients from that area would travel further.</p>	<p>Keeps community provision at SPH.</p> <p>GP provision could reduce travel time for some patients.</p> <p>No service delivery in community facilities (aside from participating GPs) in Ceredigion as part of this option so patients from that area would travel further.</p>	<p>Keeps community provision at SPH and CICC.</p> <p>GP provision could reduce travel time for some patients.</p> <p>Some dermatology services in each of the three counties of Carmarthenshire, Ceredigion, and Pembrokeshire.</p>	<p>Keeps community provision at SPH and CICC.</p> <p>Some dermatology services in each of the three counties of Carmarthenshire, Ceredigion, and Pembrokeshire.</p>

	Option A	Option B	Option C	Option D
Time taken to deliver	Hospital clinics would be brought together at PPH within existing resources and two years, with some additional staff. Enhancement of community based and hospital care and clinics would be put in place in years 2-4 and would be subject to funding, of staff.			
Cost to deliver	Staffing costs +£226k. Building and equipment costs +£1.454m. More expensive than Option D due to increasing community support at AVH.	Staffing costs +£287k. Building and equipment costs +£1.454m. More expensive to deliver than Options A and D, due to funding to support GP provision.	Staffing costs +£287k. Building and equipment costs +£1.454m. More expensive to deliver than Options A and D, due to allocating funding to support GP provision.	Staffing costs +£175k. Building and equipment costs +£1.454m. Lowest spend, as we would be able to use existing dermatology staff to support the community service provision.

Other things you may want to consider

- ▶ Further investment in the workforce and facilities would be needed in all options to bring the main hospital service together at PPH.
- ▶ PPH as a location for hospital services provides potential for a stronger regional partnership with Swansea Bay University Health Board, due to its proximity.



Emergency general surgery



Introduction

Emergency general surgery (EGS) is mostly for abdominal emergencies, sometimes requiring urgent action to save a patient's life. The EGS service is for adults only, and children and young people who require emergency general surgery are treated through the paediatric service at Glangwili or Bronglais hospitals.

Patients mostly access the service through emergency departments. This can be via ambulance or by patients making their own way to the department. Otherwise, referrals can be received from other hospital specialities, outpatient clinics, or from an emergency referral by a patient's GP.

Did you know?

Most patients seen by emergency general surgery are cared for without a surgical operation, with observations, advice and other treatments or medication.

Current services

Emergency general surgery services are provided from the following hospitals, including the element of surgery if needed 24 hours a day, seven days a week, at:

- ▶ **Glangwili Hospital** (GGH)
- ▶ **Bronglais Hospital** (BGH)
- ▶ **Withybush Hospital** (WGH).

Patients from Prince Philip are taken to Glangwili for their surgery and recovery.

GGH and WGH have surgical Same Day Emergency Care units (SDECs), but without involvement from the emergency general surgery teams.

Following surgery, patients are admitted to a hospital ward at the same hospital to recover. This is a general surgical ward. However, the emergency general surgery consultant would oversee the recovery of patients who have had an emergency general surgery operation until they are discharged from hospital.

Emergency general surgery consultants support teams in other areas of the hospital to assess any patients that potentially have surgical problems. They offer advice, can prescribe medicine, or perform surgery when needed.

Why change is needed

- ▶ A national clinical review (called Getting It Right First Time, or GIRFT) found that there are too many small general surgery units in Wales, carrying out low volumes of emergency general surgery. The effect of this, is:
 - ▶ a higher on-call demand on the consultant workforce
 - ▶ shortages in workforce and difficulties in recruiting appropriately skilled surgeons

- ▶ less familiarity amongst surgeons dealing with fewer very ill surgical patients than there would be in the instance of them carrying out a greater volume of this type of work.
- ▶ The review recommended for the Hywel Dda area that:
 - ▶ emergency general surgery is carried out on fewer sites, to bring more expertise together and create a sustainable, more attractive rota for clinical staff
 - ▶ SDEC departments are available at each main hospital admitting these patients.
- ▶ Some of our emergency general surgery teams rely on staff who are not permanent (i.e. locums) who can be less familiar with local policies and processes. This is the case at WGH. There has been a higher proportion of patient safety incidents reported at this hospital for emergency general surgery when compared to other sites in our area, and the reliance on temporary workforce is thought to be a contributory factor.
- ▶ There are vacancies in the emergency general surgery workforce which leads to the recruitment of expensive agency doctors, who are not permanent members of staff.



Emergency general surgery at a glance

	Bronglais	Glangwili	Prince Philip	Withybush
Current service	Full EGS, including surgical operations	Full EGS including surgical operations	No EGS service	Full EGS including surgical operations
Option A	Full EGS including surgical operations	Full EGS including surgical operations. Strengthen SDEC*	No EGS service	No emergency general surgery operations taking place. Strengthen SDEC*
Option B	Full EGS including surgical operations	Emergency surgery taking place on alternate weeks. Strengthen SDEC*	No EGS service	Emergency surgery taking place on alternate weeks. Strengthen SDEC*

*SDEC – Same Day Emergency Care: where you can receive urgent treatment and go home the same day. Strengthening SDEC would be through providing emergency general surgery input.

What are the options?

Common in all options

- ▶ Emergency general surgery services, including surgical operations, would continue at BGH.
- ▶ Emergency general surgery services, including surgical operations, will not take place at PPH, as is the case now.
- ▶ Emergency general surgery, including surgical operations, remain at GGH (but to varying degrees between options).
- ▶ Patients who need emergency general surgery input (but not an operation), such as observations, advice and other treatments or medication, can be treated at each of the hospitals that currently has emergency general surgery (i.e. BGH, GGH and WGH).
- ▶ We will improve and strengthen SDEC facilities at WGH and GGH hospitals to further support patients with the aim of reducing the need for emergency general surgery when possible.

Delivery - would be the same for all proposed options in this service. Emergency general surgery operations would be brought together at GGH and WGH within the first two years. The EGS service would provide more input to SDECs at both hospitals within two to four years, subject to funding of staff.

The options

- ▶ **Option A** – Emergency surgical operations are performed at GGH and not at WGH. Patients who arrive at WGH and need an emergency surgical operation, will be transferred to GGH.
- ▶ **Option 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.

Similarities and differences between options

	Option A	Option B
Opportunity to improve standards of care	Bringing emergency surgical operations at GGH and WGH together would create a single and stronger staff rota. It would also mean doctors would have the opportunity to maintain their level of skill as they would undertake more surgical activity.	
Impact on staffing challenges and on our staff	Bringing together GGH and WGH surgeons into a team with a single, larger rota would strengthen the service and may be more attractive to prospective recruits.	
	This option is more sustainable for consultant surgeon recruitment.	WGH does not have inpatient paediatric services. In this option surgeons would be needed at both sites (i.e. a new rota) during the weeks at WGH. This is to provide for both adults and children. There is significant risk in our ability to staff enough surgeons during the week adult emergency surgery would be provided at WGH.



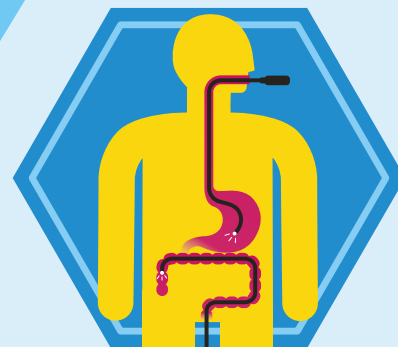
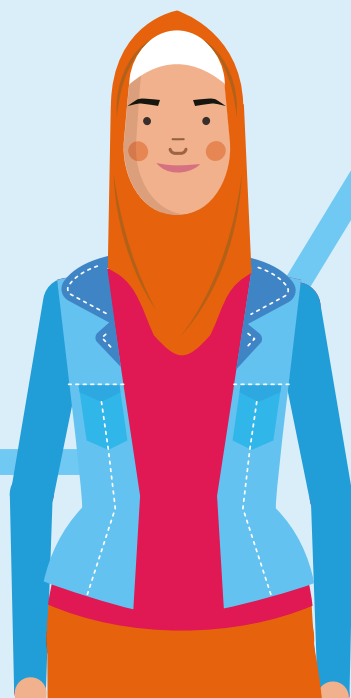
	Option A	Option B
Impacts on transfers between hospitals	Patients being transferred to the correct place for their emergency general surgery by healthcare transport services, such as the Welsh Ambulance Services NHS Trust or the Adult Critical Care Transport Service, and this could increase the likelihood of delays in treatment. This risk would be reduced by joint working with healthcare transport services to ensure appropriate provision can be made for the safe and timely transport of patients.	
	There would be a need to transfer patients who present at Worthybush Hospital and need an emergency operation, to GGH and to return them to WGH for care when fit to do so following their surgery.	There would be a need to transfer patients who present at both WGH and GGH and need an emergency operation, depending on which site was running the rota on alternative weeks. In week one transfers would be made from GGH to WGH, and in week two transfers would be made from WGH to GGH.
Impact of travel for patients or visitors	Patients and visitors from Pembrokeshire would have further to travel than they currently do. It would be clearer to patients where they would have their surgery.	Depending on which hospital is providing surgery during the given week, patients and families from Pembrokeshire or the Llanelli or southeast areas of Hywel Dda would have further to travel than they currently do.
Time taken to deliver	Bring together emergency surgical operations between GGH and WGH within the first two years. Subject to funding of staff, the emergency general surgery service would work more closely with the SDEC facilities at both GGH and WGH in years two to four.	
Cost to deliver	There is no financial difference between implementing the two options. Staffing costs are around £267k and building and equipment costs are around £1.345m.	
Other	Option A is a simpler way of working because emergency surgical operations would be located at just one site in the south of the Hywel Dda area.	Senior surgical presence would remain on both sites to support the wider hospital and services.

What else you may want to consider?

- ▶ No change to hospital emergency departments is anticipated because of either of these options.



Endoscopy



Introduction

Endoscopy is a procedure used in medicine to look inside the body. Endoscopy procedures use an endoscope to examine the hollow interior or cavity of the body. The service is for patients over 16 years of age.

There are several procedures in endoscopy. Some endoscopy tests use different techniques and equipment, for example some include cameras, ultrasound scanners, or use dye.

Current services

All our main hospitals – Bronglais, Glangwili, Prince Philip and Withybush – offer several endoscopy procedures. GGH offers additional speciality procedures, for a smaller number of patients, than our other hospitals.

Our options for endoscopy refer to procedures in specific areas of bowel screening, gastrointestinal (which looks at the digestive system), respiratory (which looks at the airways and breathing system), and urology (which looks at the urinary system or male reproductive system). This is where they are currently provided:

- ▶ **Bronglais** - bowel screening services / gastrointestinal / urology
- ▶ **Glangwili** - bowel screening services / gastrointestinal / respiratory / urology

- ▶ **Prince Philip** - bowel screening services / gastrointestinal / respiratory / urology
- ▶ **Withybush** - bowel screening services / gastrointestinal

Keeping equipment clean is very important in endoscopy to ensure patient safety. At GGH, WGH and PPH, equipment is cleaned within special units called hospital sterilisation and decontamination units (HSDU). At BGH the decontamination of equipment is undertaken in the endoscopy unit itself.

Did you know?

Unlike many other medical imaging techniques, endoscopes are inserted directly into the organ to carry out diagnostic tests.

Why change is needed

- ▶ We still have long waiting lists for endoscopy procedures, despite improvements since COVID-19, which means patients are waiting for diagnosis and treatment. This includes the growing demand for gastrointestinal, respiratory and urology endoscopy procedures.
- ▶ Demand is going to grow, partly due to starting to screen for lung cancer nationally, and because other departments who rely on endoscopy have targets to meet to see patients more quickly. This would require more staff and more time in theatre.

- ▶ We face difficulties in recruiting enough endoscopy staff to deliver services across multiple sites. Gastroenterology and surgical consultants currently deliver endoscopy services, and a number of these individuals are due to retire in the next five to ten years.
- ▶ We must pay more for temporary nurses to cover shifts at BGH particularly.
- ▶ Staff are concerned that there are not enough training opportunities within the service to support its growth and delivery of care to patients.
- ▶ The supply and maintenance of up-to-date endoscopy equipment is challenging.
- ▶ Concerns have been raised by experts (the Joint Advisory Group and the Institute of Healthcare Engineering and Estates Management) about the cleaning (decontamination) of endoscopy equipment at BGH, due to air handling and old equipment. A need to have a centralised HSDU has been identified.
- ▶ Higher volumes of endoscopy work, and that work being more complex, means these services are costing the Health Board more to deliver than in the past.

Endoscopy at a glance

	Bronglais	Glangwili	Prince Philip	Withybush	Community
Current service	Bowel screening / gastro-intestinal / urology	Bowel screening / gastro-intestinal respiratory / urology	Bowel screening services / gastro-intestinal respiratory / urology	Bowel screening / gastro-intestinal	No service
Option A	Bowel screening / gastro-intestinal	Bowel screening / gastro-intestinal	Bowel screening / gastro-intestinal Bring together respiratory and urology procedures Additional procedure room	Bowel screening / gastro-intestinal	No service
Option B	Gastro-intestinal / urology	Gastro-intestinal / respiratory / urology	Gastro-intestinal / respiratory / urology	Gastro-intestinal	New site for bowel screening
Option C	Bowel screening / gastro-intestinal	Bowel screening Increased gastro-intestinal	Bowel screening / gastro-intestinal Bring together respiratory and urology procedures Extended hours	Bowel screening / gastro-intestinal	No service



What are the options?

Common in all options

- ▶ All hospital sites within the Health Board would continue to provide most endoscopy procedures.

The options:

- ▶ **Option 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.

Delivery – Clinical sessions would be increased in phases to match future demand in years two to four, subject to funding of staff.

- ▶ **Option 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.

Delivery – Additional sessions would be provided at main hospital sites following the move of bowel screening services activity to a new community site, subject to funding of staff.

- ▶ **Option 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.

Delivery – Clinical sessions would be increased in phases to match future demand in years two to four, subject to funding of staff.

Similarities and differences between options

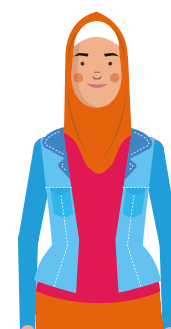
	Option A	Option B	Option C
How standards of care or waiting times are improved	Expansion of services and/or room capacity so that we can see more patients and reduce waiting times.		
	Improved capacity and reduction of waiting times, created via a new additional procedure room at PPH.	Improved capacity and reduction of waiting times, but not as much as other options to meet increased service demands. This is created via a new community site to deliver bowel screening, releasing capacity at the hospital sites.	Improved capacity and reduction of waiting times, created via extended opening hours at PPH.
Impact on staffing challenges and on our staff			Extended hours may impact on staff working times.

	Option A	Option B	Option C
Impact of travel for patients or visitors	<p>People living in the south-east of our area would have less to travel due to more procedures being brought together at PPH.</p> <p>For respiratory or urology endoscopy procedures, people living in Ceredigion and Pembrokeshire, as well as people in Carmarthenshire who live closer to GGH, would have further to travel.</p>	<p>Some patients may need to travel further to access bowel screening services, whilst others, dependent on the location of the new community site, may travel less distance.</p>	<p>People living in the south-east of our area would have less to travel due to more procedures being brought together at PPH.</p> <p>For respiratory or urology endoscopy procedures, people living in Ceredigion and Pembrokeshire, as well as people in Carmarthenshire who live closer to GGH, would have further to travel.</p>
Timescale to deliver	All options would take up to four years to deliver, subject to funding of staff.		
Cost to deliver	Staffing costs +£1.321m. Building and equipment costs +£3.603m.	Staffing costs +£1.743m. Building and equipment costs +£4.882m.	Staffing costs +£1.984m. Building and equipment costs +£3.603m.
Other			<p>Offers more flexibility for patients to have a procedure outside of working hours in the evenings or on weekends.</p> <p>This option ensures that available equipment is used across more hours.</p>



What else you may want to consider

- ▶ There is regional work between us and Swansea Bay University Health Board that is looking at challenges and joint working opportunities for endoscopy in south west Wales. This work is at early stages but recognises the challenges we have identified in this chapter for endoscopy.



Ophthalmology



Introduction

Ophthalmology is the treatment of eye conditions. This includes eye diseases, injuries, eye injections and surgical procedures.

Ophthalmology services in Hywel Dda are available for children and young people, and adults, who have sight problems that need treatment.

Current services

Ophthalmic services are provided from the following locations:

- ▶ **Glangwili Hospital** (GGH) - inpatient, outpatient, and day cases
- ▶ **Bronglais Hospital** (BGH) - inpatient and day cases
- ▶ **Withybush Hospital** (WGH) - outpatient*
- ▶ **Prince Philip Hospital** (PPH) - outpatient
- ▶ **Aberaeron Integrated Care Centre** (AICC) - outpatient
- ▶ **Amman Valley Hospital** (AVH) - day cases
- ▶ **Cardigan Integrated Care Centre** (CICC) - outpatient
- ▶ **North Road Eye Clinic, Aberystwyth** (NREC) outpatient.

*Please note, whilst there were building works ongoing at WGH, some outpatient clinics were provided temporarily from South Pembrokeshire Hospital.

Ophthalmology is organised into several sub-specialties and not all sites carry out all sub-specialties. In the description of our options below, we mention some of them.

- ▶ **Cataract** – a cataract is a common eye disorder, with ageing, and where an area of the eye's lens becomes cloudy or foggy and is treated with surgery.
- ▶ **Age-related macular degeneration** - causes irreversible central vision loss and is treated with Intravitreal Treatment, which is more commonly known as eye injections.

Did you know?

The Health Board currently employs eight ophthalmic consultants to manage a waiting list of approximately 24,000 people across three counties and eight sites.

Why change is needed

- ▶ The Health Board is unable to adhere to most of the national clinical guidelines (NICE and The Royal College of Ophthalmologists) as there is a lack of senior clinicians and consultants across all sites.
- ▶ A national clinical review (called Getting It Right First Time, or GIRFT) has recommended that the Health Board deliver ophthalmic services in fewer and dedicated areas.

Ophthalmology at a glance

	Bronglais	Glangwili	Prince Philip	Withybush	Community
Current service	Day cases and inpatients	Diagnostics, day cases, inpatients, outpatients and emergency eye care	Diagnostics, outpatients and inpatients.	Diagnostics, outpatients and inpatients.	AVH day cases Diagnostics and outpatient service in CICC, NREC & AICC
Option A	No service	Main service including diagnostics, day cases, inpatients, outpatients and emergency eye care	No service	Diagnostics and outpatients	AVH day cases (cataract) but not outpatients (eye injections) Diagnostics and outpatient service in CICC & NREC
Option B	Day cases & inpatients	No service	Main service including diagnostic, day cases, inpatients, outpatients and emergency eye care	Diagnostics and outpatients	AVH – diagnostics, outpatients (eye injections) but not day cases (cataracts) Diagnostics and outpatient service in CICC & NREC & Pembrokeshire (site to be confirmed)
Option C	Day cases & inpatients	Main service including diagnostics, day cases, inpatients, outpatients and emergency eye care	No service	Diagnostics and outpatients	AVH diagnostics, outpatients (eye injections) but not day cases (cataracts) Diagnostics and outpatient service in CICC, NREC



What are the options?

Common in all options

- ▶ Most services are brought together to a single site in the east of the Health Board area to make the most of opportunities for collaboration with Swansea Bay University Health Board.
- ▶ Eye injection services would remain at hospitals and sites which provide outpatient services, but these sites vary in different options.
- ▶ Outpatient services would remain in CICC, NREC and WGH. Outpatient services would be removed from AICC in all options.
- ▶ There would be some ophthalmic services at AVH, but which sub-speciality varies in the options.

The options

- ▶ **Option 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).

Delivery – This option would be implemented in two to four years and would be subject to funding of staff.

- ▶ **Option 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).

Delivery – This option would be delivered within two years and within current staffing funding for the service.

- ▶ **Option 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).

Delivery – This option would be delivered within two to four years and would be subject to funding of staff.

Similarities and differences between options

	Option A	Option B	Option C
How standards of care or waiting times are improved	Bringing our services into fewer sites would reduce waiting times for patients and ease workforce challenges providing more training opportunities to develop existing staff skills.		
	Main hospital services provided from fewer sites so more sustainable and more opportunity to reduce patient waiting times than Option B and C.	Some hospital services provided from BGH by a visiting consultant, as well as PPH, and so less sustainable and less impact on patient waiting times than Option A.	Some hospital services provided from BGH a visiting consultant, as well as GGH, and so less sustainable and less impact on patient waiting times than Option A.

	Option A	Option B	Option C
Impact of travel for patients or visitors	Outpatient services in Ceredigion would remain in CICC and NREC		
	There would be no inpatient or day-case services at BGH in this option and so patients from Ceredigion would travel further in this option compared to Option B and C. Main hospital services are brought together at GGH and so patients from Pembrokeshire and those in Carmarthenshire living closer to PPH (than GGH) would have further to travel.	BGH would provide inpatient and day-case services in this option. There is less impact on travel times for patients in Ceredigion in this option. Main hospital services are brought together at PPH and so patients from Pembrokeshire and those in Carmarthenshire living closer to GGH (than PPH) would have further to travel.	BGH would provide inpatient and day-case services in this option. There is less impact on travel times for patients in Ceredigion in this option. Main hospital services are brought together at GGH and so patients from Pembrokeshire and those in Carmarthenshire living closer to PPH (than GGH) would have further to travel.
Impact on staffing challenges and on our staff	Bringing some services together on fewer sites would help address workforce challenges but may also impact on where staff work from. Bringing our services to the east of the Health Board would make the department accessible to more ophthalmic consultants who may be interested in working in our area.		
Building impacts	Bringing services together would reduce the number of separate buildings services are delivered from. Would require space at the main hospital delivering services (GGH in Option A and Option C or PPH in Option B).		
Timeframe to deliver	Implemented within 2-4 years, subject to funding, of staff.	Implemented within two years.	Implemented within 2-4 years, subject to funding, of staff.
Cost to deliver	Staffing costs +£156k. Building and equipment costs +£3.656m.	Not expected to increase staffing costs. Building and equipment costs +£3.656m.	Staffing costs +£156k. Building and equipment costs +£3.656m.

What else you may want to consider

- ▶ We are working regionally with Swansea Bay University Health Board on an eyecare programme. Recommendations for provision of ophthalmology regionally are in discussion.



Orthopaedics



Introduction

The orthopaedic service focuses on the care of the skeletal system (bones, joints, ligaments, and tendons).

People stay in hospital for orthopaedic surgery and care but most activity is in day case procedures and outpatients.

There are orthopaedic specialties for various conditions and treatments. Hip and knee issues often involve replacements due to arthritis, with complex revision operations available. Shoulder surgeries include repairs and replacements. Elbow treatments focus on soft tissue and arthritis. Hand surgeries address carpal tunnel, deformities, and injuries. Foot surgeries correct deformities and relieve pain, while paediatric orthopaedics treat children's bone and joint conditions.

Did you know?

The orthopaedic service is more commonly known as trauma and orthopaedics. The trauma part of the service is typically in response to an emergency or urgent orthopaedic need that requires prompt attention. This consultation is about planned orthopaedic services only.

Current services

Planned orthopaedic services are provided as follows:

- ▶ **Bronglais Hospital** (BGH) - inpatients, planned day case and outpatients

- ▶ **Glangwili Hospital** (GGH) - outpatients
- ▶ **Prince Philip Hospital** (PPH) - inpatients, planned day case and outpatients
- ▶ **Withybush Hospital** (WGH) - planned day case, outpatients
- ▶ Some community sites provide outpatient appointments - **Cardigan Integrated Care Centre** (CICC), **South Pembrokeshire Hospital** (SPH), **Tenby Hospital** (TH), and at **Tywyn Hospital**, run by Betsi Cadwaladr University Health Board.

Outpatient appointments take place in person, online or by telephone.

Temporary changes were made to planned orthopaedics in the Hywel Dda area due to the COVID-19 pandemic. This included pausing this work. In May 2021, inpatient care at Withybush was transferred to Prince Philip (day cases remained). This was due to new national standards. You can read more in the Issues Paper available in the **Supporting Documents** area of our webpages.

Why change is needed

- ▶ We have not been able to return to pre-COVID-19 activity levels, patients were waiting between three and four years for treatment, and we want to further reduce these waits.
- ▶ We have more patients needing follow up appointments, which has increased waiting times.

- ▶ The poor condition of the air handling unit in Withybush Hospital operating theatres is reducing activity levels.
- ▶ Temporary changes have already been made to continue safely delivering care.
- ▶ New national standards (British Orthopaedic Association (BOA) standards), requiring dedicated orthopaedic ward areas, to improve infection prevention, and to provide 24/7 orthopaedic medical cover for planned care patients, cannot be met at all our sites:
 - ▶ WGH did not have resource to address these issues at the site, consultants and patients from the hospital have travelled instead to PPH for inpatient surgery and care.
- ▶ BGH, whilst not having a dedicated ward, has been able to dedicate a bay with minimal infection concerns.
- ▶ A national clinical review (called Getting It Right First Time, or GIRFT) recommended improvement opportunities for Hywel Dda, such as increasing activity levels to reduce waiting times for patients.
- ▶ Medical staff vacancies are not being actively recruited because of a lack of the theatre capacity.
- ▶ There is joint regional work between us and Swansea Bay University Health Board. By working together, we have reduced patient waiting times.

Orthopaedics at a glance

	Bronglais	Glangwili	Prince Philip	Withybush
Current service	Outpatients, inpatients & day cases	Outpatients	Outpatients, inpatients & day cases	Outpatients & day cases
Option A	Outpatients, inpatients & day cases	Outpatients	Outpatients, inpatients & day cases including regional working	Outpatients & increased day case surgery
Option B	Outpatients, inpatients & day cases	Outpatients	Outpatients, inpatients & day cases including regional working	Outpatients & increased day case surgery and extended hours
Option C	Outpatients, inpatients & day cases	Outpatients	Local outpatients, inpatients, & day cases Additional beds	Outpatients & increased day case surgery
Option D	Outpatients, increased inpatients & day cases	Outpatients	Outpatients, inpatients, & day cases including regional working	Outpatients & increased day case surgery

Key: 'Local' in the table above refers to local people living in the Hywel Dda area receiving this care and 'regional' refers to this care provided for people living in the wider west Wales area, including the area served by Swansea Bay University Health Board.



What are the options?

Common in all options

- ▶ Outpatient services would continue at BGH, GGH, PPH and WGH, and at the community facilities they are provided from now, see page 40.
- ▶ Day cases would be provided at BGH, PPH and WGH.
- ▶ More day-case and outpatients at WGH (achieved by focusing on less complex cases).
- ▶ Patients who need to stay overnight (inpatients) would receive their care at BGH, PPH, or Neath Port Talbot Hospital (run by Swansea Bay University Health Board), and not at WGH. This would make the temporary change permanent.

The options

- ▶ **Option 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).

Delivery - This option would deliver hospital changes within two years and current funding for the service. Increased therapy support would be put in place in years two to four and would be subject to funding of staff.

- ▶ **Option 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.

Delivery - This option would deliver hospital changes within two years and current funding for the WGH. Increased therapy support would be put in place in years two to four and would be subject to funding of staff.

- ▶ **Option 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.

Delivery - This option would deliver hospital changes within two years and current funding for the service. Increased therapy support would be put in place in years two to four and additional beds at PPH in four or more years, subject to funding of staff.

- ▶ **Option 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.

Delivery - This option would deliver hospital changes within two years and current funding for the service. Increased therapy support would be put in place in four or more years and would be subject to funding of staff.



Similarities and differences between options

	Option A	Option B	Option C	Option D
Opportunity to improve standards of care or impact positively on waiting times	All options provide inpatient services on fewer sites with increased bed numbers. This would allow us to see more patients and reduce waiting times.			
	These options would provide additional therapy support which would allow for more timely treatment and earlier discharge from hospital, which should reduce waiting times for patients. More day-case and outpatients at WGH, reducing waiting times for patients.			
		Further reduces waiting times through extended hours at WGH.	Further reduces local patients waiting times, prioritising Hywel Dda, rather than regional, patients. Additional therapy beds at PPH.	Further reduces waiting times through an increased service at BGH.
Impact on patients	Patients from Pembrokeshire would continue to have their overnight inpatient operations at Prince Philip Hospital, as per the temporary arrangement. This is further travel than previous to the temporary change.			
	Patients may be offered procedures outside of the Hywel Dda area at Neath Port Talbot Hospital due to regional working.	Patients may be offered procedures outside of the Hywel Dda area at Neath Port Talbot Hospital due to regional working.	Patients would receive their procedures within the Hywel Dda area, except for those needing specialist care not provided within Hywel Dda.	Patients may be offered procedures outside of the Hywel Dda area at Neath Port Talbot Hospital due to regional working.
Impact on staffing challenges and on our staff		Working patterns may vary due to longer opening hours.		
Time taken to deliver	Fully delivered in up to four years, subject to funding, of staff.	Fully delivered in up to four years, subject to funding, of staff.	Fully delivered in four years or more subject to funding, of staff.	Fully delivered in up to four years, subject to funding, of staff.
Cost to deliver	Staffing costs +£174k Building & equipment costs +£66k	Staffing costs +£174k Building & equipment costs +£66k	Staffing costs +£1.122m Building & equipment costs +£66k	Staffing costs +£712k Building & equipment costs +£66k
Other			This option does not fit as well with the regional working approach because it prioritises higher need Hywel Dda rather than regional patients at PPH.	



Radiology



Introduction

Radiology is a medical speciality that uses imaging techniques (such as x-rays) to diagnose, treat and monitor diseases and injuries identified within the body.

Radiology is provided both for planned care and for emergency care.

Current services

Currently in the Hywel Dda area diagnostic radiology for emergency care is provided 24/7, and diagnostic radiology for planned care, and interventional radiology for both inpatients and day cases are provided Monday to Friday, during the daytime, at all our main hospitals:

- ▶ **Bronglais Hospital** (BGH)
- ▶ **Glangwili Hospital** (GGH)
- ▶ **Prince Philip Hospital** (PPH)
- ▶ **Withybush Hospital** (WGH).

The following community sites also provide x-ray services:

- ▶ **Cardigan Integrated Care Centre** (CICC), including dental
- ▶ **Llandovery Hospital** (LH)
- ▶ **South Pembrokeshire Hospital** (SPH)
- ▶ **Tenby Hospital** (TH).

You can read a full list of the procedures carried out at all sites currently in the Issues Paper in the **Supporting Documents** area of our webpages.

Did you know?

There are two types of radiology.

- ▶ **Diagnostic radiology** – uses different types of imaging to see organs, tissues, and other structures inside the body to diagnose conditions or problems for planned care and emergencies
- ▶ **Interventional radiology** – uses different types of imaging to treat conditions by guiding catheters or small needles through the body, or taking biopsies, in the area needing attention. This is provided for inpatients and day cases.

Why change is needed

- ▶ We have been unable to return to the pre-COVID levels of activity (for some of the reasons outlined below) and want to improve access and reduce waiting times for patients.
- ▶ There is greater demand for radiology input for several reasons including new pathways of care, and activity from new services such as SDEC units.
- ▶ Staffing numbers have not increased in line with demand, this has meant we have paid more for temporary staff (e.g. locum consultants) and external providers to support with reporting the results of the scan.

- ▶ Standards of care, and expected turnaround times are difficult to achieve, including within cancer diagnosis and other emergency conditions, whilst we have shortages in staff and equipment.
- ▶ A lack of sonographers (who specialise in the use of ultrasonic imaging devices) makes it difficult to follow the requirements in guidance for Deep Vein Thrombosis (DVT) which is a blood clot in a deep vein.

Radiology at a glance

	Bronglais	Glangwili	Prince Philip	Withybush	Community
Current service	Planned diagnostic / inpatient & day case interventional services (Mon-Fri, daytime)	Planned diagnostic / inpatient & day case interventional services (Mon-Fri, daytime)	Planned diagnostic / inpatient & day case interventional services (Mon-Fri, daytime)	Planned diagnostic / inpatient & day case interventional services (Mon-Fri, daytime)	X-ray services at CICC, LH, SPH, TH
Option A	Planned diagnostic / day case interventional services (Mon-Fri, daytime)	Inpatient interventional services (Mon-Fri, daytime)	Planned diagnostic / day case interventional services (Mon-Fri, daytime)	Planned diagnostic / day case interventional services (Mon-Fri, daytime)	X-ray services at CICC and TH
Option B	Planned diagnostic services (7 days, daytime) Interventional services (Mon-Fri, daytime)	Planned diagnostic services (7 days, daytime) Interventional services (Mon-Fri, daytime)	Planned diagnostic services (7 days, daytime) Interventional services (Mon-Fri, daytime) Cancer focus	Planned diagnostic services (7 days, daytime) Interventional services (Mon-Fri, daytime) Cancer focus	X-ray services at CICC and TH New regional hub for planned diagnostic radiology (site TBC)
Option C	Planned diagnostic services (Mon-Fri, daytime) Inpatient and day case interventional services (Mon-Fri, daytime)	Planned diagnostic services (Mon-Fri, daytime) Inpatient and day case interventional services (Mon-Fri, daytime)	Planned diagnostic services (Mon-Fri, daytime)	Planned diagnostic services (Mon-Fri, daytime)	X-ray services at CICC and TH
Option D	Planned diagnostic services (7 days, daytime) Day case interventional services (Mon-Fri, daytime)	Planned diagnostic services (7 days, daytime) Inpatient interventional services (24/7)	Planned diagnostic services (7 days, daytime) Day case interventional services (Mon-Fri, daytime)	Planned diagnostic services (7 days, daytime) Day case interventional services (Mon-Fri, daytime)	X-ray services at CICC and TH



What are the options

Common in all options

- ▶ In the current service and all our options emergency diagnostic radiology is provided 24/7 at BGH, GGH, PPH and WGH

X-ray services would remain at CICC and TH but would be removed from LH and SPH in all options. The options:

▶ Option 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.

Delivery - X-ray services from LH and SPH hospitals would be removed within two years. The rest of the option would be delivered within four years, subject to funding of staff.

▶ Option 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).

Delivery - X-ray services from LH and SPH would be removed within two years. Phased implementation of hospital services and recruitment of additional roles would be delivered in years two to four, subject to funding of staff. A new diagnostic hub is a large-scale building project and would require us to make a business case to secure funding of around £48m from the Welsh Government. This process would take several years to deliver. You can read more the process in the Business Case Process document in the **Supporting Documents** area of our webpages.

▶ Option 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, and not provided at PPH and WGH.

Delivery - X-ray services from LH and SPH would be removed within two years. The rest of the option would be delivered within two to four years, subject to funding of staff.

▶ Option 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.

Delivery - X-ray services from LH and SPH would be removed within two years. Phased implementation of hospital services and recruitment of additional roles would be delivered in years two to four, subject to funding of staff.

Similarities and differences between options

	Option A	Option B	Option C	Option D
Opportunity to improve standards of care or impact positively on waiting times	Bringing some services together on fewer sites would allow us to see more patients and mean our services would be safer.			
	<p>GGH would be able to focus on emergency diagnostic radiology, without the need to schedule planned diagnostic radiology (which otherwise may be at risk of cancellation).</p> <p>Also, separating inpatient and day case interventional radiology between sites, reduces the risk of cancellation of day case procedures due to inpatient activity, having a positive impact on waiting times.</p> <p>There is an increased risk in this option as patients would need to be transported to a single site for inpatient interventional radiology.</p> <p>Planned diagnostic working hours not extended so less opportunity to reduce waiting times than Option B and D.</p>	<p>Some services would be offered across seven days, instead of five days, which would reduce reporting times so patients could receive their diagnosis more quickly.</p> <p>Extra capacity from the provision of a diagnostics hub and extended hours at the four main hospitals, would allow us to offer a focus on cancer services at PPH and WGH. This would reduce the number of times these patients need to visit hospital and allow for quicker diagnosis.</p>	<p>Planned diagnostic services at PPH and WGH are protected from cancellations as a result of inpatient interventional radiology not being provided at those sites.</p> <p>Focusing all interventional work at two sites (rather than four) would reduce the extent of emergency diagnostic demands causing cancellations.</p> <p>Planned diagnostic working hours not extended so less opportunity to reduce waiting times than Option B and D.</p> <p>Positive impact on safety as it would improve staffing pressures through bringing together interventional staff.</p>	<p>Increased staffing would allow some services to be offered over seven days, instead of five days, which would improve reporting times and waiting times for patients.</p>



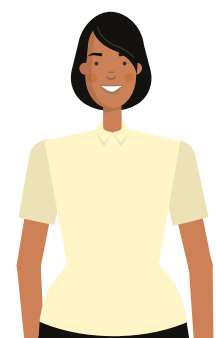
	Option A	Option B	Option C	Option D
Impact on staffing challenges and on our staff	<p>Bringing some services together on fewer sites would help address workforce challenges but may also impact on where staff work from.</p> <p>Options would not fully address recruitment challenges for interventional radiology roles, particularly when this service is provided across more than one site.</p>			
	<p>Interventional inpatient and day case procedures would be carried out at different sites, and so this option has less impact on addressing recruitment challenges in interventional radiology.</p> <p>This could mean that we rely on staff to cover work at alternative sites to support extended hours.</p>	<p>This option aims to provide additional staffing, which would allow for extended days for some services, reduce reporting times and pressure on current staff, and avoid escalated staff costs (from current reliance on overtime and locum staff).</p> <p>The shift change to 7-days a week, 12-hour day (from Mon-Fri 9am-5pm) is more attractive to radiographers.</p>	<p>Interventional inpatient and day case procedures would be brought together at BGH and GGH, which would improve staffing pressures.</p>	<p>This option aims to provide additional staffing, which would allow for extended days for some services, reduce reporting times and pressure on current staff, and avoid escalated staff costs (from current reliance on overtime and locum staff).</p> <p>The shift change to 7-days a week, 12-hour day (from Mon-Fri 9am-5pm) is more attractive to radiographers.</p>
Impacts on transfers between hospitals	<p>Increased activity would create additional work for non-emergency patient transfer provision.</p>			
	<p>GGH would provide all inpatient interventional radiology, so patients needing this on other hospital sites would be transferred to GGH.</p>			
Impact of travel for patients or visitors	<p>Removal of x-ray from some community sites would mean some patients travel further for these services.</p>			



	Option A	Option B	Option C	Option D
Time taken to deliver	Up to four years, subject to funding of staff.	More than four years, subject to funding of staff.	Up to four years, subject to funding of staff.	More than four years, subject to funding of staff.
Cost to deliver	Staffing costs +£537k. Building and equipment costs +£2.345m.	Staffing costs +£1.720m. Building and equipment costs +£48.444m (due to new diagnostic hub).	Staffing costs +£380k. Building and equipment costs +£2.345m.	Staffing costs +£1.040m. Building and equipment costs +£2.345m.
Other	Bringing some services together on fewer sites would relieve difficulty maintaining equipment across sites.			

What else you may want to consider

- ▶ There is joint regional work with Swansea University Health Board. No recommendations for provision of radiology regionally have yet been made.



Stroke



Introduction

A stroke is a serious life-threatening medical condition that happens when the blood supply to part of the brain is cut-off by a blood clot or bleeding from a blood vessel. Strokes are a medical emergency and urgent treatment is essential. The sooner a person receives treatment for a stroke, the better their chance of recovery. Stroke strikes suddenly and can result in a devastating range of disabilities or death, having a profound impact on individuals and their families.

Current services

Our stroke clinical teams are spread across multiple sites, over a wide geographical area, and with small staffing teams, particularly at some sites.

Stroke units are where you should be sent to within four hours of hospital admission for your initial care. They are provided at:

- ▶ **Bronglais Hospital** (BGH) Ystwyth Ward
- ▶ **Glangwili Hospital** (GGH) Gwennllian Ward
- ▶ **Prince Philip Hospital** (PPH) Ward 9
- ▶ **Withybush Hospital** (WGH) Ward 11.

More serious strokes would be transferred to thrombectomy centres, such as at Bristol, as they are now.

Suspected stroke patients come into our care in several ways, including by ambulance

following a 999 call, being sent in for our care by GPs, patients directly arriving via walk-in services, or suspected stroke being identified amongst current inpatients.

The initial assessment of suspected stroke patients is carried out by staff who are suitably trained.

An important part of the initial treatment for a proportion of stroke patients is thrombolysis. This is a process where a drug is given to a patient to break down blood clots and return blood supply to the brain.

Patients need a CT (computerised tomography) or CTA (computerised tomography angiography) scan to identify if they have bleeding around the brain or if there is a blockage or closing of a blood vessel.

After admission to a stroke unit, patients are reviewed by a consultant and should receive a therapy assessment within 24 hours and intensive therapy then starts.

Patients are discharged home in accordance with the severity of their stroke and their recovery can also be helped by an Early Supported Discharge Team.

Early Supported Discharge Teams are being developed in the Hywel Dda area currently, thanks to investment from the Welsh Government. These teams support stroke patients in the community, allowing for earlier discharge from hospital.

Did you know?

- ▶ National clinical guidelines for stroke have changed with a 4.5-hour window for thrombolysis from onset of ischaemic stroke.
- ▶ Where appropriate, thrombolysis drugs should be given within 45 minutes of arrival at the hospital although they are licensed for use within 4.5 hours of stroke onset.

Why change is needed

- ▶ Our stroke service resources are spread thinly across multiple sites. This means:

- ▶ we have inadequate staffing levels in nursing, therapies, and for specialist stroke consultants
- ▶ we rely on single-handed locum consultants at BGH and GGH, which makes our service fragile
- ▶ we do not have seven-day specialist cover
- ▶ we have not been able to meet the evidence-based standards recommended by the Royal College of Physicians and measured by the Sentinel Stroke National Audit Programme (SSNAP).

Stroke at a glance

	Bronglais	Glangwili	Prince Philip	Withybush
Current service	Stroke Unit	Stroke Unit	Stroke Unit	Stroke Unit
Option A	Treat and Transfer	Treat and Transfer	Stroke Unit (specialist cover 12-hours a day)	Stroke Unit (specialist cover 12-hours a day)
Option B	Treat and Transfer	Treat and Transfer	Stroke Unit (specialist cover 24-hours a day)	Treat and Transfer and Stroke Unit (specialist cover 12-hours a day)

What are the options?

Common in all options

- ▶ The ambulance would take a suspected stroke patient to their nearest main hospital, this could be BGH, GGH, PPH, or WGH.
- ▶ The initial assessment scan (typically a CT scan), as well as initial treatment (i.e. thrombolysis or reducing a bleed in the brain) would be delivered at the receiving hospital (i.e. BGH, GGH, PPH, WGH) as is the case now.
- ▶ Care for TIAs (mini stroke) would continue at BGH, PPH and WGH, but not GGH.
- ▶ More serious strokes would be transferred to thrombectomy centres, such as at Bristol, as they are now.

- ▶ In all our options, BGH and GGH would become 'Treat and Transfer' hospitals for stroke. This would mean following initial care, they would be transferred elsewhere within Hywel Dda (differs between our options, see below) or to another specialist centre, such as Bristol, according to their needs.

The options

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).



Delivery - PPH and WGH would keep stroke units during the first two years. PPH would be expanded in the first two years to provide care for patients from treat and transfer hospitals. WGH stroke unit would be expanded to provide care for patients from treat and transfer hospitals within two to four years, subject to funding of staff.

- ▶ 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.

Delivery – This option would be fully implemented in the first two years, subject to funding of staff.

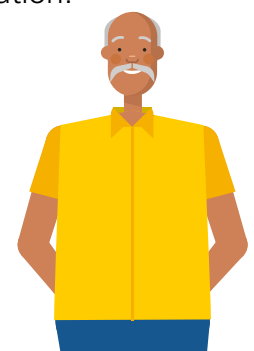
Similarities and differences between options

	Option A	Option B
Opportunity to improve standards of care or impact positively on waiting times	Improved quality of care due to bringing staff together to fewer sites resulting in improved skilled staff cover. This includes better access to therapy staff and availability of seven-day specialist clinical nurses. Potential to improve stroke audit scores (SSNAP Audits).	
	Reduces the fragility of the stroke service and standards by bringing together the workforce to fewer sites, and providing the service 12 hours a day, seven days a week, as opposed to seven-and-a-half hours a day, five days a week, as we have now.	Allows for further consolidation by bringing together the first 72 hours of care for stroke patients (beyond initial treatment) within the Hywel Dda area at one hospital site. This reduces the fragility of the stroke service further because it provides 24-hours of specialist cover, seven days a week (as opposed to 12 hours in Option A). This would allow for a more intensive first 72-hours of care, and improved patient outcomes.
Impacts on transfers between hospitals	Additional need for timely inter-hospital transfers. This risk would be reduced by working closely with healthcare transport providers and dedicating beds to be used for stroke care.	
		More inter-hospital transfers than Option A due to patients from WGH being transferred to the stroke unit at PPH to access this care for, typically the first 72-hours as inpatients.
Impact on travel for patients and visitors	Inpatient care is delivered further away from home for some patients, and this would have an impact for families and carers. Online platforms would be provided to keep families connected and we would aim to get people home sooner with community service support.	
	Fewer patients and visitors travelling further for stroke care than Option B as WGH would provide initial inpatient treatment for stroke patients, as well as PPH.	More patients and visitors travelling further for stroke care than Option A due to all patients (including those in Pembrokeshire) being transferred to the stroke unit at PPH for 72-hours of care (beyond initial treatment). Following this, typically patients would receive their ongoing care within the stroke unit at PPH or could be transferred to the stroke unit at WGH.

	Option A	Option B
Impact on staffing challenges and on our staff	<p>Bringing staff together to fewer sites would provide safer working for them. Combined with the opportunity to improve stroke audit scores (SSNAP Audits), this should have a positive impact on staff retention and recruitment.</p> <p>The risk of losing staff who may not wish to work at alternative sites would be reduced because options increase therapy provision and strengthen services, which should be attractive for our current and future workforce.</p>	<p>Would focus specialist therapy to fewer sites than Option A which would achieve efficiency in the workforce, potentially be more attractive to future workforce, and improve standards and patient outcomes.</p>
Time taken to deliver	<p>PPH and WGH remain as stroke unit during the first two years.</p> <p>PPH stroke unit would be expanded in the first two years to provide care for patients from treat and transfer hospitals.</p> <p>WGH stroke unit would be expanded to provide care for patients from treat and transfer hospitals within 2-4 years, subject to funding, of staff.</p>	<p>This option would be fully implemented in the first two years. This option is subject to funding, of staff.</p>
Cost to deliver	<p>Staffing costs +£3.439m. Building and equipment costs +£930k.</p>	<p>Staffing costs +£4.978m. Building and equipment costs +£920k.</p>
Other	<p>Enables the stroke service to participate in more stroke research and new projects.</p> <p>Aligns with the NHS Wales Stroke Programme intention to have fewer, more specialised, stroke units in Wales.</p>	

What else you may want to consider

- ▶ There is a national stroke programme, aimed at making improvements in stroke services across Wales. Currently this work suggests there should be four stroke centres working as a network in Wales. This would have an impact on all stroke services within Wales. It would likely mean that local delivery of stroke care would be initial treatment and then transfer onwards to stroke centres, before returning locally to a stroke unit and specialist stroke rehabilitation.



Urology



Introduction

The urology service looks after adult patients with urological conditions. It focuses on the care of the genito-urinary tract system in both men and women (e.g. kidney, bladder) and the reproductive tract in men (testicles, penis, and prostate).

Current services

Since the beginning of the COVID-19 pandemic, the service has worked on a temporary basis from the four main hospital sites as follows:

- ▶ **Bronglais Hospital** (BGH) - day case, outpatient and diagnostic procedures
- ▶ **Glangwili Hospital** (GGH) - emergency, inpatient, day case, outpatient and diagnostic procedures
- ▶ **Prince Philip Hospital** (PPH) - inpatient, day case, outpatient and diagnostic procedures
- ▶ **Withybush Hospital** (WGH) - day case, outpatient and diagnostic procedures.

Did you know?

Since COVID-19, patients are seeking help later and with worse symptoms than they did before the pandemic. As a result, conditions are more challenging to treat, resulting in more appointments for patients that often take longer.

Why change is needed

- ▶ The service has struggled to reach the level of activity it achieved pre-COVID-19.
- ▶ A national clinical review (called Getting It Right First Time, or GIRFT) carried out for urology has recommended that the Health Board develop a dedicated urology department.
- ▶ There is a lack of capacity and appropriate space within GGH for specialist clinics.
- ▶ There are no dedicated urology wards or clinical rooms, which limits the training opportunities for staff, leading to problems in keeping staff.
- ▶ The urology workforce is spread across multiple sites and is unable to work efficiently to provide the best patient care and to reduce waiting times for patients.
- ▶ There is a national shortage of skilled professionals working in urology, so making the best use of our existing staff is very important.

* TWOC is when a catheter which has been inserted previously into the bladder is removed for a trial time to see if a patient may no longer need the catheter. TWOC services were provided by district nurses prior to COVID-19, but during the pandemic were provided from

hospitals as a temporary change. Community nursing has been phasing back to providing this service and reduce travel for patients to hospital. As of March 2025, TWOC services are carried out by community nursing teams wherever possible.

Urology at a glance

	Bronglais	Glangwili	Prince Philip	Withybush
Current service	Outpatients, day cases and diagnostic procedures (inc. limited urgent suspected cancer)	Emergency, outpatients, day cases, inpatients and diagnostic procedures (inc. urgent suspected cancer)	Outpatients, day cases and diagnostic procedures (inc. urgent suspected cancer)	Outpatients, day cases and diagnostic procedures (inc. urgent suspected cancer)
Proposed Option	Outpatients, day cases and diagnostic procedures	Emergency only	Outpatients, day cases, inpatients and centralised diagnostic hub (inc. urgent suspected cancer)	Outpatients, day cases and diagnostic procedures

What are the options?

Whilst there is only a single option for urology presented, this is because all the ideas put forward at option development stage were able to be combined into one option. It is not a preferred option as we welcome new ideas from people.

As a result, the option for urology is:

- ▶ 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.

Delivery - Diagnostic services and outpatient services for Carmarthenshire would be brought together at PPH in two years. The option would be fully implemented with development of a diagnostics unit in two to four years, subject to funding of staff.



What the option should achieve

	Option A
Opportunity to improve standards of care or impact positively on waiting times	A more efficient service, meaning most urology patients would have better outcomes in terms of rapid access to treatment, symptom relief and quality of treatment.
Impact on staffing challenges and on our staff	Bringing most of the service together would promote training opportunities that would help keep and hire staff. The option may have an impact on where some staff in Carmarthenshire work from.
Impact of travel for patients or visitors	Bringing most of the service together should result in fewer separate hospital visits for patients as it is more likely that multiple appointments can take place at one location on the same day. Outpatients, day case surgery and diagnostic procedures that are not urgent suspected cancer, would remain in main hospitals, except GGH, to reduce travel times for patients needing these appointments. People in Ceredigion and Pembrokeshire would have further to travel for urology diagnostics for urgent suspected cancer. People living in Carmarthenshire and closer to GGH than PPH would have further to travel for inpatient care and diagnostics, including urgent suspected cancer diagnostics.
Time taken to deliver	Bringing together diagnostic services and most outpatient services at PPH within 0-2 years. The option would be fully implemented with development of a stand-alone unit within 2-4 years, subject to funding of staff.
Cost to deliver	Staffing costs +£120k Building and equipment costs are around £1.003m.
Other	PPH has been selected as the site to base the urology service as it has significant endoscopy services within all options in this consultation (see page 33) These services have an opportunity to share resources to be more efficient, potentially including staff, equipment, and procedure rooms. This site would also mean the urology service can grow to meet its expected service demand.

What else you may want to consider

- ▶ The urology service and endoscopy service are interdependent in our Health Board. What happens with endoscopy would have a significant impact on urology in our consultation. This is because the two services would likely share facilities, so the number of rooms and space needed by endoscopy would determine where in the hospital urology can fit.



What does this mean for our main hospitals?

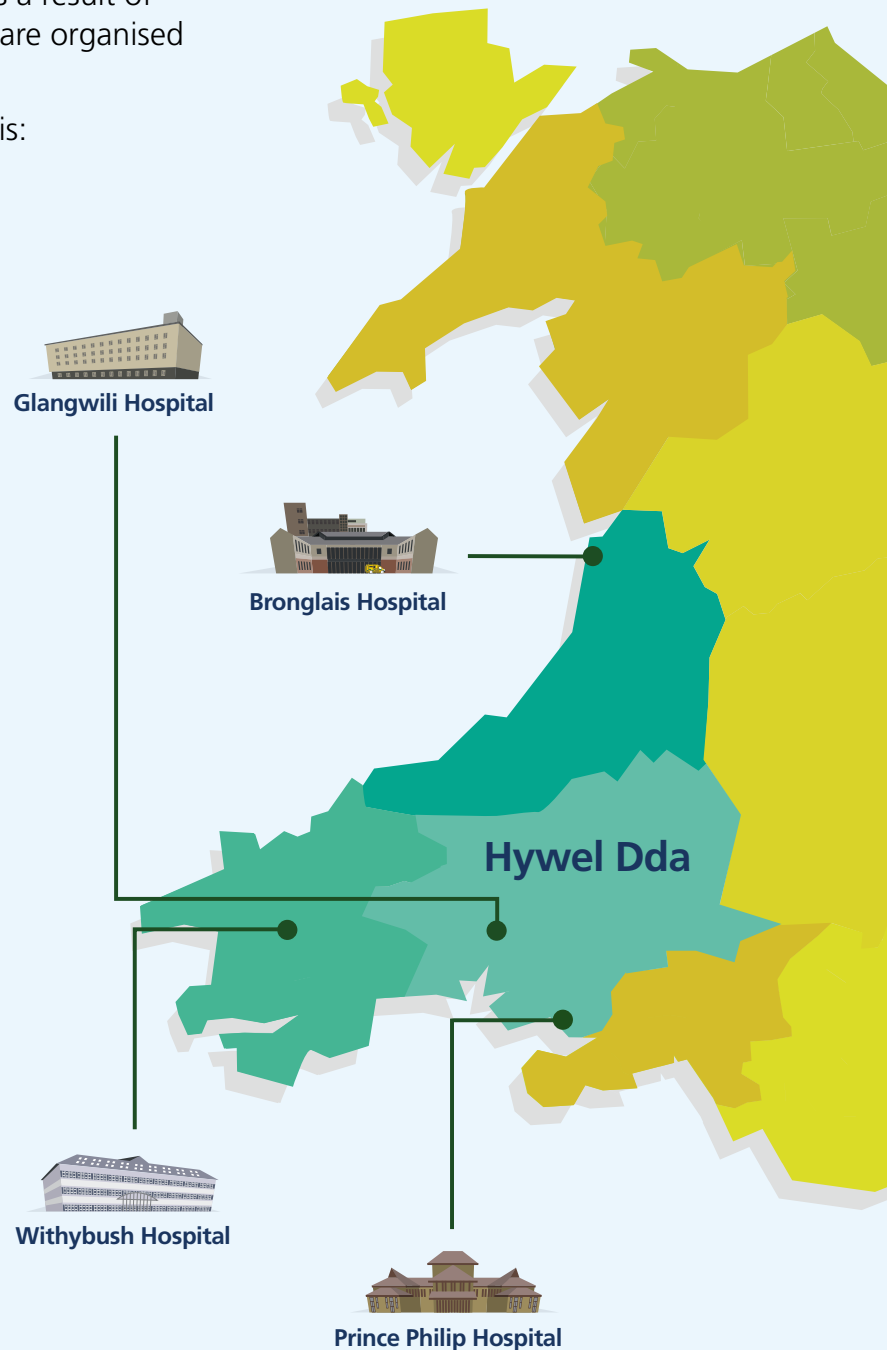
Changes to our nine clinical service areas as a result of the consultation, may impact on how they are organised at our four main hospitals.

The roles of our hospitals could look like this:

- ▶ **Bronglais Hospital (BGH)** – providing services as it currently does, though some specialities may be provided from different Hywel Dda sites
- ▶ **Glangwili Hospital (GGH)** – providing more acute and emergency care, with some planned care moved to other sites, either by service or health condition
- ▶ **Prince Philip Hospital (PPH)** – providing more planned care, particularly across a wider region where services are delivered in partnership with Swansea Bay University Health Board
- ▶ **Withybush Hospital (WGH)** – providing more high volume, low complex planned care, particularly within the Hywel Dda area, with initial access to acute care remaining on site, but transfers to GGH for patients with the highest needs.

Please note, in all the options, there are no changes to how people access emergency care, or minor injury care, at any of the sites.

More detail on how options in this consultation could affect our hospitals overall, is provided overleaf.



Bronglais Hospital

BGH would continue to offer a range of services, both urgent and emergency care as well as planned care and outpatient activities.

For those requiring the most urgent care through critical care, emergency general surgery and stroke, there would be no change for people when they arrive to the hospital.

The options look to change how stroke care would be provided at BGH. It is proposed that once you have had your initial treatment, you would be transferred, if necessary, to a stroke unit where you would receive specialist medical and therapy support.

There may be an increase in the amount of ophthalmology and orthopaedic operations taking place in BGH. This would be dependent on the options chosen and the amount of theatre space available, but the ambition of the orthopaedic service is to have a dedicated space in the hospital to meet standards.

Glangwili Hospital

GGH would continue to offer a range of services, both urgent and emergency care as well as planned care and outpatient activities.

The options strengthen its critical care service to support the wider hospital network. They also build on emergency care within services, such as urology, and in some options for ophthalmology. Dependent on the option, GGH would also either be the main site or alternating site for emergency general surgery.

The options look to change how stroke care would be provided at GGH. It is proposed that once you have had your initial treatment, you would be transferred, if necessary to a stroke unit, where you would receive specialist medical and therapy support.

To support these changes, some services at GGH would need to move to other locations. These are generally planned care services which are not dependent on being with urgent and emergency services such as dermatology and planned care elements within ophthalmology, radiology, and urology.



Prince Philip Hospital

PPH already has a role working regionally with Swansea Bay University Health Board in providing planned care, with some of the workforce working between both organisations. The options seek to develop this further with services centralising to this site and improving activity.

Each of the stroke options seek to build upon and improve the stroke services that are provided at PPH. This would be either as a stroke unit with specialist cover 12-hours a day, or as a stroke unit with specialist cover 24-hours a day.

The proposed changes for critical care for PPH would be to either make permanent the temporary service change, or further change the level of critical care provided.

All options would ensure sufficient support at PPH for planned care, and urgent and emergency care that takes place within the Acute Medical Assessment Unit (AMAU). This unit provides emergency care for very sick adult medical patients, such as those who have suffered a stroke or heart attack.

The options in this consultation do not impact on the role of the Minor Injury Unit at PPH.

Patients who need an emergency surgical operation would usually continue to be transferred to GGH. Depending on the option supported, patients could be transferred to WGH for their surgical operation.

Depending on the options chosen for the services, PPH would see an increase in the amount of planned care activity. This includes the bringing together of urology and dermatology and potential centralisation of ophthalmology at the site, as well as an increase in orthopaedics activity as part of regional work.

Withybush Hospital

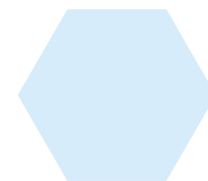
WGH would continue to offer a range of services, both urgent and emergency care as well as planned care and outpatient activities.

For those requiring the most urgent care through critical care, emergency general surgery and stroke, there would be no change for people when they arrive to the hospital.

The options could potentially change how stroke care, following urgent treatment, would be provided at WGH. In both options, WGH would have a stroke unit. However, if the option to provide 24-hour specialist cover at Prince Philip Hospital was chosen, then stroke patients, including from Pembrokeshire, would be taken there after their initial urgent treatment, typically for 72-hours of inpatient care, before continuing care there or back at WGH stroke unit.

For those requiring emergency general surgery, patients would be supported to receive care within the hospital's SDEC unit. Those who need an emergency surgical operation may be transferred to GGH (the extent to how often these transfers would be made depends on the option supported in this consultation).

The hospital would have an important role to play in providing more high volume, low complex planned care services. This would be achieved through day-time operations and outpatient clinics for orthopaedics and ophthalmology, allowing people to receive these services closer to home.



Potential impacts of change for people

Changing health and care services would affect all of us living in the Hywel Dda area regardless of age, sex, disability (physical, mental health and learning disabilities), race, religion, language, sexual orientation, gender reassignment, marriage or civil partnership, or pregnancy and maternity status.

You can read detailed information on the patient numbers and activity within each of our nine services in the 'Patient and travel insights' document available in the **Supporting Documents** area of our webpages.

We must ensure that our proposals are fair to all and take particular care to consider people who are vulnerable. We have already engaged with groups representing vulnerable people and will continue to do so to ensure they are involved throughout our consultation.

We have produced what is called an Equality Impact Assessment (EqIA) for each of our nine services. An EqIA includes an overview of the potential positive and negative impacts of change on people, and how we will mitigate them and address our equality duties.

During the option development stage, participants evaluating and scoring options were provided with EqIAs for the nine services so they could consider potential impacts of options on people.

A summary of what we have learnt so far is included on page 64, in the section 'Summary of the impacts identified'. You can read more in the full current versions of the EqIAs in the **Supporting Documents** area of our webpages.

We have a **supporting document** which can provide you with examples of how different options in the nine service areas could affect someone like you or your loved ones.

The family 'Teulu Jones' and their friends are not a real family, but they are typical examples of some people living in our area. They can help illustrate how patients could be affected by different options in this consultation and could help you think about what potential changes could feel like for you.

You can read their stories in the Teulu Jones Case Studies document available in the **Supporting Documents** area of our webpages. We will talk about scenarios in community events that we will hold during this consultation. We also plan to undertake focus groups with the public, and particularly with vulnerable or disadvantaged groups (referred to as people with protected characteristics) or people who may be affected by these service changes. Information from these groups will be used in the EqIA as we learn more.

EqIAs will be used to help decision makers when considering future developments.

If you would like further detailed information, this can be obtained by contacting:

hyweldda.engagement@wales.nhs.uk



Protected characteristics

Some people with a protected characteristic may be more disadvantaged or face more difficulties when trying to access healthcare services. The Equality Act 2010 protects people from being treated worse than other people because of:

- ▶ Age
- ▶ Disability
- ▶ Gender reassignment
- ▶ Marriage and civil partnership
- ▶ Pregnancy and maternity
- ▶ Race
- ▶ Religion and belief (including no religious belief)
- ▶ Sex
- ▶ Sexual orientation.

Our EqIAs also consider the possible impacts individuals may experience due to being part of the Armed Forces community, a persons' social and/or economic position, socio-economic and the Welsh language.

In our policies and the way we work, we must:

- ▶ cut discrimination, harassment, victimisation, and other conduct that is prohibited by or under the Act
- ▶ advance equality of opportunity between persons who share relevant protected characteristics and persons who do not
- ▶ foster good relations between persons who share relevant protected characteristics and persons who do not.

We also aim to:

- ▶ remove or minimise disadvantages suffered by persons who share a relevant protected characteristic and are connected to that characteristic
- ▶ meet the needs of persons who share a relevant protected characteristic that are different from the needs of persons who do not share it
- ▶ encourage persons who share a protected characteristic to take part in public life or in any other activity in which participation by such persons is disproportionately low
- ▶ consider how we will tackle prejudice and understanding.

Changing the way our services operate may cause persons with a protected characteristic to experience positive, and/or negative impacts, unintended consequences, or gaps in healthcare provision. We will explore further, during this consultation, the potential differences posed by each of the options for the nine services. We will also show how negative impacts could be avoided or reduced as well as maximising positive impacts.



Welsh language

Many of you, 45%, speak Welsh, which is a higher than average number compared to the average across Wales. We continue to make progress towards compliance with the statutory Welsh Language Standards, ensuring that all communication, including digital, print, and signage, is bilingual in Welsh and English, with the Welsh not treated less favourably than the English.

We strive to promote a bilingual environment for you and staff and support our staff to learn and use Welsh in our workplaces and our communities. We strive to ensure people are offered services in Welsh without having to ask as described in the Welsh Government's More Than Words plan.

We have a target to ensure that 50% of our workforce has a foundation level of Welsh within the next 10 years and we report on our progress through our Welsh Language Annual Report that can be found on our website.

The full EqIA provides further details of how the service changes could impact on the Welsh language, but we would welcome any other comments and feedback.



Travel and transport

We have considered how change to healthcare services could impact on travel and transport for you, your loved ones who may visit you in hospital, or our staff.

We did this by carrying out Equality Impact Assessment (EqIA) and Quality Impact Assessment (QIA) during options development.

Some options in this consultation (including within critical care, emergency general surgery, and stroke) would result in more transfers of patients by NHS services between hospitals. We have considered travel times for urgent and non-urgent transfers between hospitals (see table below).

Some proposed options could mean changes to where your planned care or procedures are scheduled and provided from, which would affect your home to hospital journey. We have therefore considered average travel times in each county and also feedback from staff and patient transport surveys.

You can read more about this in the 'Patient and travel insights' document available in the **Supporting Documents** area of our webpages.

In our case study document, called Teulu Jones Case Studies (also available in the **Supporting Documents** area), we also provide some examples of what travel impacts could be experienced by people under different options for services.

2023 Monday 09:00					
HOSPITALS		NON-URGENT		LIGHTS-AND-SIRENS	
FROM	TO	HRS	MINS	HRS	MINS
Bronglais (Aberystwyth)	Glangwili (Carmarthen)	1	25	1	4
Bronglais (Aberystwyth)	Withybush (Haverfordwest)	1	51	1	25
Bronglais (Aberystwyth)	Prince Philip (Llanelli)	1	50	1	29
Bronglais (Aberystwyth)	Royal Shrewsbury (Shrewsbury)	1	55	1	32
Bronglais (Aberystwyth)	Princess Royal (Telford)	2	17	1	52
Bronglais (Aberystwyth)	Ysbyty Gwynedd (Bangor)	2	12	1	53
Bronglais (Aberystwyth)	Morriston (Swansea)	1	49	1	30
Withybush (Haverfordwest)	Glangwili (Carmarthen)	0	42	0	38
Withybush (Haverfordwest)	Prince Philip (Llanelli)	1	7	0	58
Withybush (Haverfordwest)	Morriston (Swansea)	1	6	0	59
Glangwili (Carmarthen)	Prince Philip (Llanelli)	0	34	0	27
Glangwili (Carmarthen)	Morriston (Swansea)	0	34	0	28
Prince Philip (Llanelli)	Morriston (Swansea)	0	18	0	14

Summary of impacts identified

The services have already captured the following negative impacts in EqlAs, but we would welcome any further comments:

- ▶ some patients and their visitors may be negatively impacted by travel times and travel expenses as they may need to travel further to receive their care
- ▶ some patients would be transported to the correct site by the Health Board, however for return journeys home, or for visitors, there may be longer journeys and additional cost either by car or public transport
- ▶ some staff may be required to travel further to work at alternative sites bringing with it potential additional travel costs and childcare needs
- ▶ because services may be focused on fewer sites, waiting areas at those sites may get busier, which some people may find unsettling.

We have and need to continue to consider the balance between positive impact change could bring, as well as negative. For example:

- ▶ services provided across fewer sites brings different professionals together to work, which is a better use of resources and would improve service quality and continuity of care for patients
- ▶ bringing services together would also allow for multiple appointments to take place on the same day at the same location, which would reduce the number of visits for patients.

We also have and continue to consider ways to reduce risks or negative impacts on people. These are ideas currently and not guaranteed. But we want to explore these ideas further and seek your views, so we ask you about this in our questionnaire. For example, the Health Board could explore:

- ▶ improved transport links between hospital sites, exploring public/private partnerships, shuttle buses between sites etc.
- ▶ partnering with local transport companies to offer discount or travel vouchers for set journeys or time periods, as well as review supported travel / taxi costs
- ▶ Non-emergency Patient Transport services are already available for those that meet the eligibility criteria
- ▶ community and voluntary transport services are available for patients that do not meet the eligibility criteria to enable them to receive non-emergency patient transport
- ▶ some patients could be entitled to help with transport costs depending on their circumstances. Patient transport advice and information is available on our webpages, please search 'patient transport', or by asking at each main hospital's general office
- ▶ assigning designated quiet rooms or zones, improving visitors' spaces at hospitals, improving signage, and ensuring public access areas are wheelchair friendly where possible to improve patient accessibility and comfort
- ▶ directing staff towards nearby childcare
- ▶ encouraging car sharing and sustainable transport for those able to do so.



What happens next?

How you can get involved

Information on how to get involved will be available at a range of places including hospitals, community premises, council buildings and voluntary sector organisations. We will share regular updates on our website **hduhb.nhs.wales/clinical-services-consultation** and our social media pages (Facebook, Instagram, and YouTube).

We aim to hold drop-in events and workshops, both in person and online. You can ask us questions about the consultation at our events and on our social media platforms. We aim to answer queries or point you to useful information and ways to share your views.

We will also work closely with local media, including local radio and press organisations, to raise awareness of this consultation.

We appreciate you taking the time to give us your views – every person's input matters. Please take the time to read this document

and then tell us what you think. The deadline to tell us what you think, so your opinions can be included in the consultation, is **31 August 2025**. You can do this by:

- ▶ completing the questionnaire online: **hduhb.nhs.wales/clinical-services-consultation** or in hard copy (you can request a copy from the contact points below) posting it to: **Opinion Research Services FREEPOST SS1018 PO Box 530, Swansea, SA1 1ZL** (you will not need a stamp)
- ▶ emailing us: **hyweldda.engagement@wales.nhs.uk**
- ▶ speaking to us at one of our **events** (visit the website above for an event near you or online), or by telephoning **0300 303 8322** (option 5), charged at local call rates.



Privacy Statement - what happens with your feedback?

We have contracted an independent social research organisation Opinion Research Services (ORS) to collect and analyse all the feedback received as part of this consultation.

Together with them, we are collecting your feedback so we can use your views to help us with our decision making about our nine clinical services.

The views of people responding in a personal capacity will be anonymous. ORS will utilise AI to assist in the review of responses and this will only be undertaken on anonymised data. Please see the ORS privacy notice for further information www.ors.org.uk/privacy

However, feedback from representatives of organisations or someone acting in an official capacity, may be attributed.

We will use your feedback, as well as other information and evidence, to inform our decisions on how to change the nine clinical services, to meet patient needs and public opinions, and to plan the impact on our four acute hospitals until our 'A Healthier Mid and West Wales' strategy is fully in place.

All the questions are optional and all information you provide will be processed by ORS in accordance with latest data protection legislation. Information will only be used to inform this consultation and any personal information that could identify you will be kept for no more than one year after any decisions have been finalised.

General themes raised by communities on the Health Board's social media channels, but not personal information, will be shared with ORS so these can be included in the output report.

For our Health Board's full privacy statement, please visit hduhb.nhs.wales/CSP-Supporting-Documents.

We are listening

We know it is important to keep you updated, especially when you have taken the time to share your thoughts and views with us.

An output report to this consultation will be published, fully considered, and discussed as part of a Health Board meeting, which will be held later in winter 2025/26.

Health Board meetings are held in public, with people either able to attend in person or to watch digitally. We will advertise this meeting on our website hduhb.nhs.wales/clinical-services-consultation and social media pages.

A project group for the consultation, made up of Health Board staff, will put forward a recommendation to the Health Board's Directors and Independent Members on the potential ways forward for narrowing down or choosing options for the nine service areas. This is called the final report.

Board members will consider all they have heard leading up to, and during, this consultation, including the Equality Impact Assessments and other support document data we have gathered and referred to in this document. They will consider any new information that may come to light from the consultation.



How we will feedback to you

We will publish both the independent output report and the final report on our website, and we will officially announce when it is available.

We will share these reports as widely as possible with people living in our area who have asked to be kept up to date on developments and by using updates through key stakeholders, the local media, and social media. If you wish to receive this, please join our involvement and engagement scheme Siarad Iechyd / Talking Health by emailing hyweldda.engagement@wales.nhs.uk, calling **0300 303 8322** (option 5), charged at local call rates, or writing to us at: **FREEPOST HYWEL DDA HEALTH BOARD.**

Thank you, diolch yn fawr.



We need your ideas





Diolch yn fawr | Thank you