

Hywel Dda University Health Board: Clinical Services Plan Consultation



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

Executive Summary of Consultation Report

Opinion Research Services

January 2026



Opinion Research Services

The Strand Swansea SA1 1AF

01792 535300 | www.ors.org.uk | info@ors.org.uk

As with all our studies, findings from this report are subject to Opinion Research Services' Standard Terms and Conditions of Contract.

Any press release or publication of the findings of this report requires the advance approval of ORS. Such approval will only be refused on the grounds of inaccuracy or misrepresentation

This study was conducted in accordance with ISO 20252:2019, ISO 9001:2015, and ISO 27001:2022

© Copyright January 2026

Contents

1. Executive Summary	4
Introduction.....	4
Hywel Dda University Health Board.....	4
Challenges facing Hywel Dda University Health Board.....	4
The Clinical Services Plan	4
The commission	5
The consultation.....	5
The consultation questions.....	6
Consultation methodology and response.....	6
The nature of public consultation	8
The consultation report	8
Main Findings	9
Critical care.....	9
Dermatology.....	13
Emergency general surgery.....	17
Endoscopy	20
Ophthalmology.....	24
Orthopaedics.....	28
Radiology.....	32
Stroke	37
Urology	42
Future roles of the main hospital sites	45
Cross-cutting consultation themes	49
Considering equalities and human rights.....	52
Considering Welsh language impacts	54
Appendix 2: Table of figures	56

1. Executive Summary

Introduction

Hywel Dda University Health Board

- 1.1 Hywel Dda University Health Board (Hywel Dda or the Health Board) provides health services for people across Carmarthenshire, Ceredigion, and Pembrokeshire and also for nearby communities in south Gwynedd, and parts of Powys and Swansea/Neath Port Talbot. Services are provided through:
- » four main hospitals (Bronglais Hospital in Aberystwyth, Glangwili Hospital in Carmarthen, Prince Philip Hospital in Llanelli, and Withybush Hospital in Haverfordwest¹).
 - » five community hospitals (Amman Valley Hospital and Llandovery Hospital in Carmarthenshire, Tregaron Hospital in Ceredigion, Tenby Hospital and South Pembrokeshire Hospital in Pembrokeshire).
 - » two integrated care centres (Aberaeron and Cardigan, both in Ceredigion).
 - » community facilities, including GP surgeries, dental practices, community pharmacies, ophthalmic (eye care) practices and sites providing mental health and learning disability services.
 - » care within people's own homes.

Challenges facing Hywel Dda University Health Board

- 1.2 A number of challenges including the impacts of the COVID-19 pandemic and gaps in staffing (made worse by shortages nationally) mean that patients are waiting longer than it would like for some planned care and it is recognised that many services fall short of national standards.
- 1.3 Hywel Dda has recognised for several years that some of its hospital services are fragile. This is mainly because its clinical staff and teams are spread across multiple sites, which means sometimes services are reliant on a small number of individuals.

The Clinical Services Plan

- 1.4 Given the challenges, the Health Board has developed a Clinical Services Plan (CSP), with options to change nine services. These services are critical care, dermatology, emergency general surgery, endoscopy, ophthalmology, orthopaedics, radiology, stroke, and urology.
- 1.5 In summary, the plan seeks 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 orthopaedics) and diagnostics (endoscopy and radiology).

¹ Throughout the rest of this summary, the main hospitals are referred to as Bronglais, Glangwili, Prince Philip, and Withybush)

The journey so far

- 1.6 The first phase in 2023 engaged more than 6,000 stakeholders and looked at the factors affecting these services. This led to the development of an Issues Paper. Phase two in 2024 developed potential future options for the nine service areas, and engaged a range of stakeholder groups to examine and refine options. Finally, phase 3 involved public consultation on the shortlisted options reported here, to give as wide a range of people as possible a chance to comment on the proposals.

The commission

- 1.7 Opinion Research Services (ORS) was appointed to advise on and independently manage some aspects of the consultation programme, as outlined below.

The consultation

- 1.8 The 13.5-week public consultation period began on 29 May 2025 and ended on 31 August 2025, during which time members of the public, Hywel Dda staff members, organisations, and other stakeholders were invited to give feedback on the options and anything else they felt the Health Board should consider in relation to the nine services.
- 1.9 Hywel Dda University Health Board enabled stakeholders to access a wide range of resources throughout the CSP consultation. Formats included a bilingual full consultation document, a bilingual summary version, bilingual Easy Read and youth-friendly versions, a British Sign Language video, and a bilingual audio version. Summary documents were translated into Arabic, Polish, Ukrainian and Russian. Supporting technical documents were not translated and were available in English only.
- 1.10 Supporting materials were also provided. These included reports from the options appraisal process, travel insights, and impact assessments. The Teulu Jones case studies were developed to illustrate how proposed changes could affect communities. Eleven videos were created for use on social media platforms - nine short form reels, one for each service, and two overarching longer form videos (which were also used at engagement sessions).
- 1.11 Alongside these resources, the Health Board delivered a communications campaign to raise awareness and encourage participation. Proactive media activity including press releases, responses to media enquiries and interviews generated approximately 106 news items across 12 regional and national publications. This included interviews with BBC Wales, S4C, BBC Radio Wales and BBC Cymru Wales. Briefings were also undertaken with Members of the Senedd and Members of Parliament.
- 1.12 To reach communities that do not access information online, the Health Board delivered a three-county leaflet drop to all households and businesses in the region. Consultation information was also displayed on hospital digital screens. Posters were displayed at hospital sites and promotional materials were distributed through the engagement database, primary care, and community venues. Paid radio advertising supported this activity to reach audiences who rely on offline channels.
- 1.13 Targeted social media campaigns promoted consultation events and materials. Organic social media posts were used to maintain momentum. Stakeholders were signposted via direct email and communication activities to the dedicated consultation website, where all resources were available.
- 1.14 Documents were distributed via a stakeholder mass mailout, at face-to-face meetings, engagement events, and visits to a range of settings, as well as being available on request via post, telephone or email. In all,

over 6,900 stakeholders received consultation documents; 6,235 by email and 668 by post (which included paper copies of a consultation document and questionnaire by post). GP practices, Community Hospitals, Integrated Care Centres and Llais West Wales received several copies to share. The Health Board shared information about the consultation on its stands at the Royal Welsh Show and Pembrokeshire County Show.

The consultation questions

- 1.15 In this consultation people were asked for their feedback on:
- » which proposed options are best able to address fragilities in services, improve standards or reduce waiting times.
 - » their concerns about any of the options, or impacts they may have.
 - » the future role of hospitals.
 - » anything else the Health Board needs to consider, including alternative options or ideas for how the nine services could be delivered in future.

Consultation methodology and response

- 1.16 Each chapter in this report provides detailed information about the consultation methods from which feedback has been reported; the following section provides a brief overview.
- 1.17 To provide relevant information that might inform respondents' views, information about the options for the nine services was included in a consultation document and supporting documentation including in summary and Easy Read format. After being encouraged to familiarise themselves with the background information, residents, staff, and other stakeholders were invited to provide feedback through a wide range of methods, including all of the following:
- » a consultation questionnaire that was available online (hosted by ORS) and via paper copies, which were circulated widely and available on request. Alternate language and Easy Read formats were also provided.
 - » engagement activities undertaken by Hywel Dda, including:
 - online webinars and face-to-face public drop-in events
 - staff drop-in events, hospital walkarounds and meetings
 - meetings with statutory and non-statutory stakeholders/partners
 - attendance at and visits to existing community groups, outpatient settings, and public events like the Royal Welsh Show and Pembrokeshire County Show.
 - » residents' workshops, independently designed and facilitated by ORS.
 - » written, email, and telephone submissions.
 - » social media.

- 1.18 The response from the different consultation methods is summarised overleaf.

Consultation questionnaire

- **4,140** questionnaire responses, including:
 - 3,999** online responses (103 Welsh)
 - 141** paper copies (3 Easy Read)
 - 16** organisations

Health Board events and activities

- **31** public/patient events (27 face-to-face and 4 online) - **1,229** attendees
- **58** staff drop-in events, walkarounds and meetings - **c.2,112** attendees/participants
- **21** stakeholder meetings - **225+** attendees

Protect Bronglais Services public meeting

- **400+** attendees

In-depth engagement (independently facilitated by ORS)

- **3** workshops with residents, one in each county - **58** participants

Other feedback channels

- **115** submissions
 - 30** from elected representatives, councils, voluntary/ community groups, health boards/NHS networks; staff groups/networks)
 - 85** from individuals (residents, staff)
- **1** petition relating to stroke services at Bronglais (17,883 signatures)
- **156** social media comments

Note on the consultation questionnaire

- ^{1.19} While more than 4,000 respondents provided a response to the consultation questionnaire, none of the questions were mandatory and many respondents did not answer every question. All responses in which at least one of the consultation questions was answered were included. It should also be noted that while open questionnaires are important in being inclusive and giving opportunity to express and explain their views, they are not controlled, random sample surveys of a given population, and therefore are not necessarily expected to be representative of the overall general balance of opinion.

- 1.20 103 questionnaire responses were received in Welsh, the text comments from which were translated by one of ORS's Welsh-speaking researchers, and quality assured by ORS's Welsh-speaking senior researcher². Responses were integrated with the English responses in readiness for analysis.
- 1.21 Further details can be found in the consultation overview (chapter 2).

The nature of public consultation

- 1.22 Public consultation promotes accountability and assists decision making; public bodies give an account of their plans or proposals and listen to feedback. Consultation has therefore been described as a dialogue, based on a genuine and purposeful exchange of views.
- 1.23 It should be noted, however, that consultations are not referenda or 'votes' in which the loudest voices or the greatest numbers automatically determine the outcome. The feedback received often reflects varied and sometimes polarised views, and it is important to report these concerns and contrary views robustly, in order for decision-makers to be able to conscientiously take into account the issues raised.

The consultation report

- 1.24 In contrast to the more thematic approach in this executive summary, the full report considers the feedback from each element of the consultation in turn because it is important that the overall report provides a full evidence-base for those considering the consultation and its findings.
- 1.25 All types of consultation responses are important, and this report presents an independent analysis so that all of them may be taken into account. The report also identifies where strength of feeling may be particularly intense, either in relation to specific themes or possible outcomes, or coming from specific groups of consultees. This will enable decision-makers to conscientiously consider the issues raised (Gunning Principle 4³).
- 1.26 In relation to strength of feeling, when reporting the qualitative research findings we have used standard descriptors like 'most,' 'many,' 'some,' 'several,' and 'a few' to convey the relative prevalence of themes and strength of feeling within the data. While the terms do not indicate precise proportions, broadly speaking their meaning is as follows:
- » most: a large majority of consultees, but not all.
 - » many: a slight majority or large minority of consultees.
 - » some/several: a minority of consultees, but more than a handful.
 - » a few: a handful of consultees.
- 1.27 Quotations are used throughout the report, but it is important to note that these are used for illustrative purposes only. In some cases, the quotations may not be fully supported by the available evidence - and while ORS has not sought to highlight or correct incorrect statements or assumptions, this should be borne in mind when considering the findings.
- 1.28 In considering staff feedback, we would note that while people were invited to disclose whether they were

² The same process was undertaken for the one Welsh-language written submission received.

³ The Gunning Principles are four legal standards for fair public consultation. They require that proposals are still at a formative stage, the proposer gives sufficient information for intelligent consideration, adequate time is provided for a response, and the results of the consultation are conscientiously considered before a final decision is made.

NHS staff, they were not asked to indicate whether they were responding on behalf of their service, as an individual staff member, or as a resident. Although this is clear in some circumstances, in others it is less evident, and this should be borne in mind when considering the findings. Moreover, in the quantitative charts for each service, we have separated views based on whether respondents said they are employed by the NHS; however, not all will work for Hywel Dda; some may work in other areas for example Welsh Ambulance Service University NHS Trust, other health boards, GP practices, community services, or even outside Wales. Again, it is not necessarily the case that those who say they work for the NHS are responding in their capacity as a member of staff.

- 1.29 In many activities and within the questionnaire, participants and respondents were encouraged to suggest alternative ideas, all of which have been shared with the Health Board. All alternative ideas and options have been assessed by the Hywel Dda University Health Board Options Development Group; more detail can be found in the Closing Report, which will be presented to Board in February 2026.
- 1.30 Finally, it is not ORS' role to 'make a case' for or against the proposals, nor to make any recommendations as to how decision makers should use the reported results. It is for the appropriate bodies to take decisions based on all of the evidence available, of which consultation feedback is one part. To this end, ORS trusts that both the executive summary and full report will be helpful to all concerned.

Main Findings

Critical care

- 1.31 Critical care provides care for critically ill adult patients with life-threatening conditions, within intensive care units (ICUs). Currently, it is available in Bronglais, Glangwili, Prince Philip and Withybush. At Prince Philip, some patients with higher needs are stabilised and then transferred to Glangwili for further care.
- 1.32 Staffing critical care services in Carmarthenshire, Ceredigion and Pembrokeshire (Hywel Dda) is difficult, and none of the Health Board's hospitals meet required quality and safety standards. In this context, the Health Board believes that having fewer intensive care units would make the service more sustainable, improve safety and help meet quality standards.
- 1.33 Hywel Dda outlined three different options for how critical care could be delivered, which are set out in Table 1. Hospitals that are not proposed to have an intensive care unit (ICU) would instead have an enhanced care unit (ECU) to treat patients with less critical conditions, and stabilise patients with higher levels of need, before transferring them to the Glangwili intensive care unit. Transfers between hospitals could be done via the Adult Critical Care Transfer Service (ACCTS).

Table 1: Consultation options – critical care

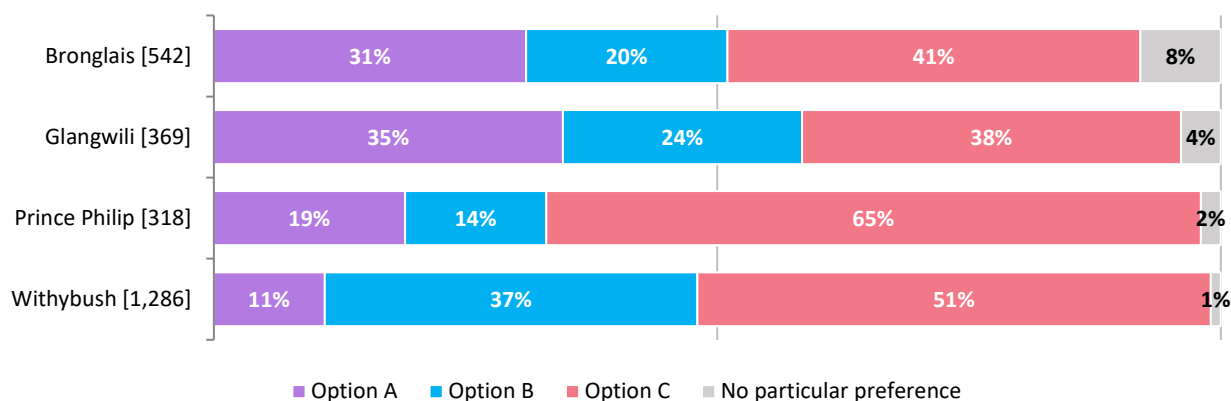
	Bronglais	Glangwili	Prince Philip	Withybush
Current service	Intensive care unit	Intensive care unit	Intensive care unit (with transfer of sickest patients)	Intensive care unit
Option A	Intensive care unit	Intensive care unit and enhanced care unit	Enhanced care unit	Enhanced care unit
Option B	Intensive care unit	Intensive care unit	Enhanced care unit	Intensive care unit

	Bronglais	Glangwili	Prince Philip	Withybush
Option C	Intensive care unit	Intensive care unit	Intensive care unit (with transfer of sickest patients)	Intensive care unit

Consultation questionnaire feedback

- 1.34 Overall, around half (51%) of consultation questionnaire respondents felt that Option C best meets the Clinical Services Plan objectives, with around a quarter (27%) favouring Option B⁴. However, views differed by respondents nearest hospital as shown below.

Figure 1⁵: Which option for critical care services do you believe best meets the Clinical Services Plan objectives, considering patient care, accessibility, and outcomes? By nearest hospital⁶ (individual respondents only, where postcodes were provided)



Base: Number of respondents shown in brackets (excludes 'don't know' responses)

Further feedback on the critical care options

Addressing current challenges

- 1.35 While critical care staff were proud of their commitment to patient care, some (especially at Prince Philip) described the present configuration of critical care services as increasingly unsustainable, driven largely by consultant workforce shortages, high sickness absence, poor communication across sites, and challenges maintaining consistent specialist oversight. These pressures were said to have resulted in a sense of service erosion; and contributed to reduced morale, de-skilling, and difficulties retaining experienced staff.
- 1.36 Clinical partners, including the Acute Physical Deterioration Implementation Network and Welsh Critical Care Network, also recognised the Health Board's challenges, and acknowledged the advantages of bringing critical care services together onto fewer sites to improve patient outcomes.
- 1.37 Across the public events and meetings, and on social media, consultees recognised the importance of maintaining high-quality critical care provision; and there was understanding of the Health Board's challenges in offering this. There was also widespread concern about the proposed changes however,

⁴ 62 respondents selected the 'don't know' option. This is omitted for presentational convenience (standard industry practice) because it does not affect the order of preference of the available clinical options.

⁵ Where percentages do not add up to 100%, this is due to rounding.

⁶ Nearest hospital based on travel time. 1,398 responses without postcode are not displayed, but are included in the overall results described in commentary prior to the chart.

mainly relating to travel times along poor road networks. These concerns were particularly prevalent in Pembrokeshire.

Views on the critical care options

Option A

- 1.38 For those who preferred it, Option A was seen as the easiest to resource; and to offer opportunities for stronger specialist staffing, improved standards of care, and better patient outcomes across Hywel Dda. In this context, many consultees said they would be happy to receive critical care at a hospital further from home if this care was of the best possible quality.
- 1.39 Those in opposition believed Option A would reduce local access to critical care services (a particular concern for Pembrokeshire-based participants) and increase patient transfers. In relation to the latter, key worries were around the risks of transferring critically ill patients over long distances across poor road networks, and the emotional and financial burden on families having to travel further to visit loved ones.
- 1.40 Strong concerns were raised by Withybush staff, who argued that changing the hospital's ICU to an ECU would have significant implications for patient safety, service sustainability and staff morale. A particular concern was that it would be difficult to maintain an emergency department without an ICU at Withybush. This was also echoed at the public and patient drop-in events and meetings: attendees feared that losing ICU functions could make Withybush a less attractive place to work and accelerate workforce decline.
- 1.41 There was also widespread concern about the capacity and deliverability of centralising intensive care for the south of Hywel Dda at Glangwili, the ICU at which is already operating at full capacity and would struggle to safely accommodate additional patients.

Option B

- 1.42 Less feedback was given specifically on Option B. It was often viewed as a compromise option, balancing accessibility and feasibility and reducing patient transfer needs. However, its success was still seen to be heavily dependent on solving the Health Board's workforce challenges.
- 1.43 Some also said that current critical care facilities at Withybush are outdated and would need investment for Option B (and Option C) to be fully realised. On the other hand, a few questionnaire respondents felt that Withybush ICU staff skills and morale would be improved if the decline in other onsite surgery was reversed.

Option C

- 1.44 Option C was seen by some members of the public and a few staff members as the most equitable and responsive to local need, the least disruptive, and the option that would require the fewest patient transfers. It was also said to be the option that offers most resilience in view of major incidents and any future pandemics.
- 1.45 However, many consultees across the different consultation methods questioned whether this option is deliverable or sustainable within the context of existing workforce and resource constraints. Indeed, the scale of the recruitment required - particularly for consultants - was often considered unrealistic. The Welsh Critical Care Network particularly stressed that patient safety risks associated with the current staffing deficits require clearer communication, noting that maintaining multiple ICUs without sufficient consultant presence may compromise the quality of care.

Key overarching issues: Prince Philip

- 1.46 Some Prince Philip staff (including consultant physicians) considered a medical ECU as a pragmatic and potentially safer alternative to the current ICU model. However, they strongly emphasised the need for appropriate staffing at all levels to manage the ECU and provide outreach support across wards; adequate bed provision (six to eight was suggested); fully funded multidisciplinary team structures; formal transfer protocols between hospitals within and outside Hywel Dda); close collaboration between Prince Philip and the Glangwili ICU team; and robust clinical governance.

Key overarching issues: travel and transfers

- 1.47 As noted above, across the different consultation methods, there was strong concern regarding the transfer of critically ill patients over long distances, particularly from Pembrokeshire and other rural areas. Participants highlighted the potential clinical risks of transfer and delayed intervention, particularly in the context of the current and future capacity of the Welsh Ambulance Service Trust (WAST).
- 1.48 More generally, while some members of the public accepted the principle of travelling further for specialist care, many felt that geography, seasonal tourism pressures, and rural transport networks mean that centralised critical care may reduce timely access to life-saving treatment.

Key overarching issues: impact on wider hospital services

- 1.49 Consultees across several activities emphasised that changes to critical care provision are closely linked to and could have consequences for the viability of other services, including stroke care, emergency general surgery, high-risk surgery, medicine, anaesthesia, endoscopy, renal services, haematology, oncology, medical assessment units, post-anaesthetic care units (PACUs), and elective surgery.
- 1.50 Concerns were also raised that reducing on-site critical care capability could destabilise emergency departments and acute medical pathways, limiting hospitals' ability to manage serious clinical deterioration; and that once ICU services are removed from local hospitals, it becomes far more likely that surgical services will follow.
- 1.51 Specifically, there was scepticism around the feasibility of providing a stroke unit at Prince Philip in the absence of a co-located ICU; and examples of occasionally (e.g., during winter pressures) needing to transfer patients further away to hospitals in Swansea or Cardiff. In this respect, the West Wales Renal Service and consultant physicians at Prince Philip were concerned that unless change is properly managed and resourced, removing ICU services from some Hywel Dda sites could result in greater pressure on services at Morriston Hospital.
- 1.52 Hywel Dda Clinical Health Psychology and Critical Care Clinical Psychology departments also highlighted the importance of considering the psychological care of Hywel Dda critical care staff and patients in any future changes.

Alternative suggestions and mitigations

- 1.53 Consultees proposed several mitigations that could strengthen any chosen model:
- » establish a dedicated, well-resourced inter-hospital critical care transfer service, with appropriately trained staff; reviewing systems used in other largely rural areas.
 - » introduce cross-site staff rotation, to maintain specialist skills and resilience.
 - » make greater use of tele-ICU/remote monitoring to provide real-time clinical oversight between hospitals.

1.54 Consultees proposed other potential alternatives and suggestions, including the following:

- » ICUs at Withybush and Glangwili; and ECUs at Bronglais and Prince Philip.
- » retain all current ICUs, with a dedicated high-dependency unit (HDU) at one hospital.
- » ECUs at all hospitals, in addition to the current Intensive Care Units.
- » use Prince Philip ICU as a medical high-dependency unit for recovering patients from Glangwili (repatriation/step-down), as having it as an ECU only might have longer term impacts on staff sustainability.
- » Prince Philip service to be led by senior anaesthetics combined with medical consultants.
- » retain a small number of stabilisation or level 2 beds at Withybush and Prince Philip to allow initial management and stabilisation before transfer.
- » invest the money dedicated to the transfer of ICU patients from Prince Philip to Glangwili in more staff at the Prince Philip ICU to maintain a higher level of care at both units.
- » rather than closing ICUs outright, adjust capacity so that some hospitals manage acute, emergency-intensive care while stable or longer-term patients are transferred to a centralised 'hub.'
- » a more regional model for intensive care services, to reflect the size and diverse nature of the Health Board.
- » redraw the boundaries of Swansea Bay University Health Board so that it includes Llanelli, reflecting the area's proximity to Morriston Hospital (an argument used by some respondents to justify not maintaining intensive care services at Prince Philip).

1.55 For further details, see the critical care sections in the individual consultation method chapters.

Dermatology

1.56 Dermatology services diagnose and treat diseases of the skin, hair, and nails in children, young people, and adults. Since the COVID-19 pandemic, they have mainly been provided at Prince Philip, with a weekly outpatient clinic at Glangwili. In the community, nurse-led clinics are run from Cardigan Integrated Care Centre (CICC) and South Pembrokeshire Hospital. No dermatology services are currently provided at Bronglais or Withybush.

1.57 The service faces several ongoing challenges, including:

- » an increase in referrals since the pandemic, especially urgent suspected cancer referrals, affecting waiting times for new and existing patients with non-urgent conditions.
- » a national shortage of consultant dermatologists – the Health Board has not had a permanent consultant dermatologist since 2016.
- » a high turnover rate of doctors, leading to appointment cancellations and longer patient waiting times.

1.58 Hywel Dda outlined four different options for how dermatology services could be delivered, as set out in Table 2. In each option, Hywel Dda is proposing a permanent change to bring the service together at Prince Philip. This change aims to improve the service, retain and recruit staff, and attract consultant dermatologists to Hywel Dda.

Table 2: Consultation options – dermatology

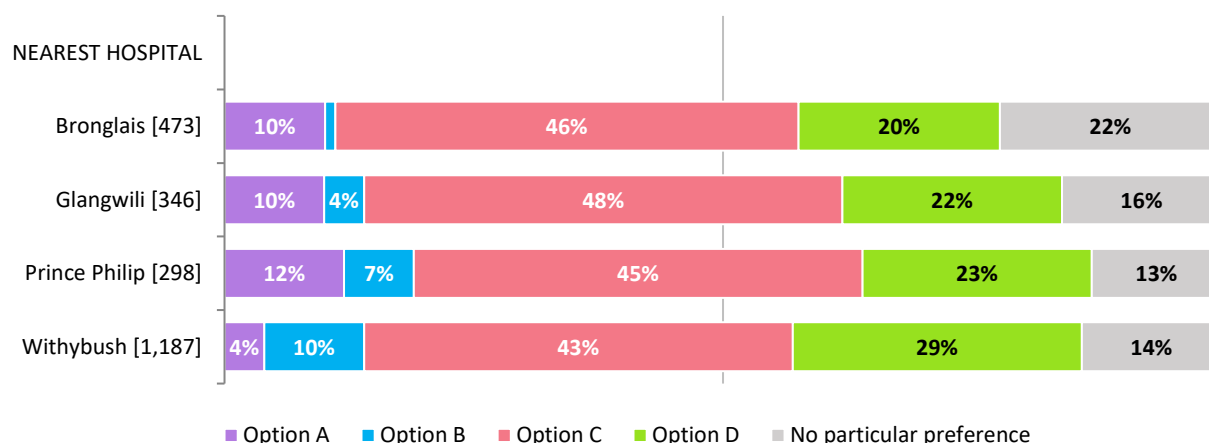
	Bronglais	Glangwili	Prince Philip	Withybush	Community sites
Current service	No service	Outpatient clinic once per week Medical photography Phototherapy not running currently	Outpatient clinics and minor operations	No service currently due to Reinforced Autoclaved Aerated Concrete (RAAC) issues	Some nurse-led outpatient clinics at Cardigan Integrated Care Centre (including minor operations) and South Pembrokeshire Hospital
Option A	No service	No service	Consolidated service	No service	Keep provision at CICC Some nurse-led outpatient clinics at Amman Valley Hospital No community provision in Pembrokeshire
Option B	No service	No service	Consolidated service	No service	Current service at South Pembrokeshire Hospital 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 South Pembrokeshire Hospital Some nurse-led paediatric clinics at Cross Hands Health Centre Some minor operations in GP practices
Option D	No service	No service	Consolidated service	No service	Keep provision at CICC and South Pembrokeshire Hospital Some nurse-led paediatric clinics at Cross Hands Health Centre

Consultation questionnaire feedback

^{1.59} Overall, nearly half (45%) of respondents expressed support for Option C, which was the most widely supported option across all four of the main hospital catchments, followed by Option D.⁷

⁷ 239 respondents selected the 'don't know' option. This is omitted for presentational convenience (standard industry practice) because it does not affect the order of preference of the available clinical options.

Figure 2⁸: Which option for dermatology services do you believe best meets the Clinical Services Plan objectives, considering patient care, accessibility, and outcomes? By nearest hospital⁹ (individual respondents only, where postcodes were provided)



Base: Number of respondents shown in brackets (excludes 'don't know' responses)

Further feedback on the dermatology options

Addressing current challenges

- ^{1.60} Feedback highlighted a strong and consistent view that dermatology services across the Health Board require significant improvement, with several clear themes emerging around access, sustainability, and the need for a more coordinated and resilient service model.
- ^{1.61} Access to timely dermatology care was the dominant concern across all consultation methods. Service users described waiting times of 18 months or more, as well as cancelled appointments, fragmented care pathways, inconsistent communication, and an over-reliance on visiting consultants and locum staff. The loss of local services like phototherapy¹⁰ and the need to travel long distances for treatment were also recurring frustrations, particularly for older people, people with chronic illness, and those requiring frequent appointments.
- ^{1.62} Most public consultees desired more evenly geographically distributed services and better transport to dermatology hubs; though there was some agreement that strengthening and consolidating teams might improve consistency and access to expertise, even if it means more travel.
- ^{1.63} Staff highlighted significant workforce sustainability challenges, citing high workloads, clinical isolation, limited consultant and peer support, and the absence of a substantive clinical lead to guide junior clinicians. They thus welcomed elements of consolidation - particularly strengthening services at Prince Philip - to improve clinical consistency and support (though there was also some concern around how staff at Glangwili would treat inpatients with dermatology concerns if services were to be removed from the site). However, the need to underpin any new service model with clear pathways, workforce planning, robust communication between primary and secondary care, and strong clinical leadership was stressed.

⁸ Where percentages do not add up to 100%, this is due to rounding.

⁹ Nearest hospital based on travel time. 912 responses without postcode are not displayed, but are included in the overall results described in commentary prior to the chart.

¹⁰ Treatment that uses artificial ultraviolet light to treat skin conditions like psoriasis and eczema.

- 1.64 Technology-enabled care emerged as a positive theme, with both staff and the public recognising the potential of tele-dermatology platforms to expedite decision-making, improve triage, and reduce unnecessary travel.

Views on the dermatology options

- 1.65 Few explicit comments were made on the dermatology options, except in the consultation questionnaire and at the resident workshops. Across the other consultation methods, consultees preferred to discuss more general considerations in relation to dermatology.

Options A and B

- 1.66 Options A and B were both rejected by most participants at the resident workshops and neither were well supported in the consultation questionnaire, the key reasons being that Option A would see no dermatology provision in Pembrokeshire and Option B would see none in Ceredigion.

Option C

- 1.67 Resident workshop participants and many questionnaire respondents expressed a strong preference for Option C, valuing the coverage across all three counties, improved access, and inclusion of nurse-led paediatric services (the latter would also apply to Options A and D). However, they also questioned the feasibility of GPs undertaking minor dermatology procedures given existing workload pressures and requested greater clarity on training, funding and delivery arrangements. Although they did not directly express support for or opposition to Option C, feedback around nurse-led and GP provision was largely echoed by other consultees.
- 1.68 More specifically, some staff were sceptical about the feasibility of providing nurse-led paediatric clinics at Cross Hands Health Centre under Option C (and D), as there is no formal agreement of funding or scope for dermatology at this location currently.

Option D

- 1.69 A number of Ceredigion resident workshop participants preferred Option D on the basis that it avoids placing additional pressure on GPs and increasing waiting times for non-dermatology GP appointments. The option was also preferred by some questionnaire respondents on the basis of maintaining some community service coverage across all three counties.

Key overarching issues: travel and access

- 1.70 In relation to all proposed options, many consultees (particularly those in Ceredigion and Pembrokeshire) expressed concerns around travel and access to the proposed consolidated service at Prince Philip.

Alternative suggestions and mitigations

- 1.71 Consultees proposed several mitigations that could strengthen any chosen model:
- » expand community-based screening, including mobile screening.
 - » reinstate local phototherapy and dermatology clinics, especially for those living in north Ceredigion and beyond.
 - » strengthen cross-border collaboration with Betsi Cadwaladr University Health Board to address shared workforce and service resilience challenges.
 - » more triaging of referrals, with only urgent cases sent to a centralised service.

- » invest further in telemedicine and make better use of medical photography and video links.

1.72 Consultees proposed other potential alternatives and suggestions, including the following:

- » consider the viability of dermatology being delivered in Hywel Dda and explore options to support out of area treatment in, for example, Swansea and Shrewsbury.
- » provide a rotational service, with consultants or nurses travelling between hospitals, GP surgeries, health centres, and other sites to provide clinics on a weekly or fortnightly basis.
- » consultant-led clinics at community sites (in Amman Valley and Llandoverly Hospitals for example), rather than fixed in any particular general hospital, to save patients travelling large distances.
- » create an Integrated Care Centre in Aberystwyth for minor operations (including dermatology).
- » include the GP provision element in all four options due to the likeliness of it being implemented.

1.73 For further details, see the dermatology sections in the individual consultation method chapters.

Emergency general surgery

1.74 Emergency general surgery is mostly for abdominal emergencies. Currently, services are provided at Glangwili, Bronglais and Withybush, but it is difficult to safely staff these hospitals with consultant surgeons.

1.75 Hywel Dda outlined two different options for how emergency general surgery services could be delivered. Under both options (Table 3), the current emergency general surgery service would not change at Bronglais. Prince Philip would continue to not admit emergency general surgery patients, and patients from this area would go to Glangwili (but to varying degrees between options) for their care, surgery and recovery. Due to a shortage of emergency general surgery consultant surgeons to cover both Withybush and Glangwili, the Health Board proposes to bring together its consultant surgeons into one team to make the service more sustainable and improve recruitment of consultant surgeons. Most patients who do not need surgery would stay at their nearest hospital site in both options.

Table 3: Consultation options – emergency general surgery

	Bronglais	Glangwili	Prince Philip	Withybush
Current service	Full emergency general surgery, including surgical operations	Full emergency general surgery, including surgical operations	No emergency general surgery service	Full emergency general surgery, including surgical operations
Option A	Full emergency general surgery, including surgical operations	Full emergency general surgery, including surgical operations Strengthen Surgical Same Day Emergency Care ¹¹	No emergency general surgery service	No emergency general surgery operations taking place Strengthen Surgical Same Day Emergency Care

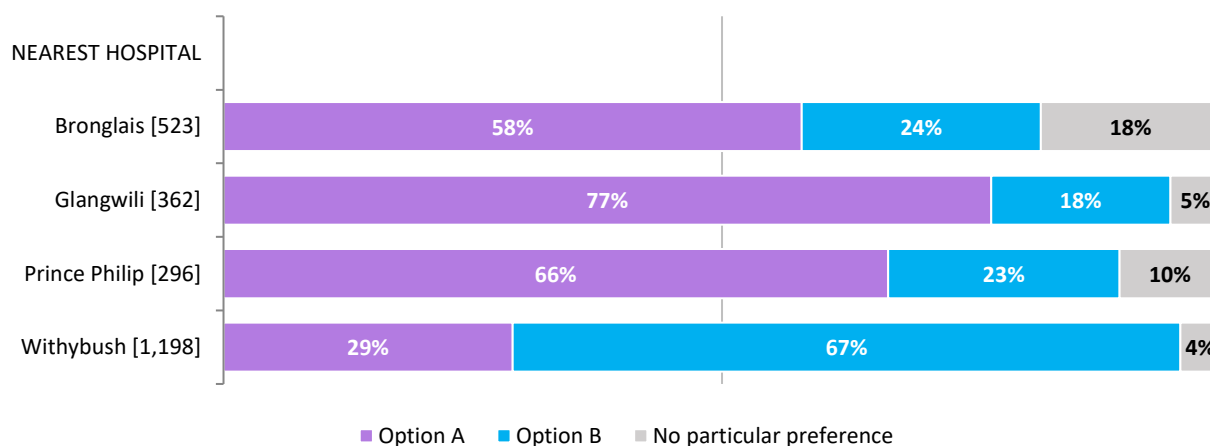
¹¹ Same Day Emergency Care (SDEC) is where you can receive urgent treatment and go home the same day. Strengthening Surgical SDEC would be through providing emergency general surgery input.

	Bronglais	Glangwili	Prince Philip	Withybush
Option B	Full emergency general surgery, including surgical operations	Emergency general surgery operations taking place on alternate weeks Strengthen Surgical Same Day Emergency Care	No emergency general surgery service	Emergency general surgery operations taking place on alternate weeks Strengthen Surgical Same Day Emergency Care

Consultation questionnaire

- 1.76 Overall, views in the consultation questionnaire were divided as to whether Option A or Option B would best meet the Clinical Services Plan objectives: just under half (47%) of respondents preferred Option A, a similar number (46%) favoured Option B, and around 8% expressed no particular preference^{12, 13}.
- 1.77 Views varied by nearest hospital: respondents nearest Withybush were the only group who strongly favoured Option B; respondents from all other areas favoured Option A, as shown below.

Figure 3¹⁴: Which option for emergency general surgery services do you believe best meets the Clinical Services Plan objectives, considering patient care, accessibility, and outcomes? By nearest hospital¹⁵ (individual respondents only, where postcodes were provided)



Base: Number of respondents shown in brackets (excludes 'don't know' responses)

Further feedback on the emergency general surgery options

- 1.78 Prior to discussing consultees' views on the two options for emergency general surgery, we would note that a significant set of voices - particularly among Withybush staff, social media contributors, and some public drop-in event and stakeholder meeting attendees - opposed any model that would remove emergency surgical cover from local hospitals. For these groups, emergency general surgery was seen as a critical local service, and its removal raised fears around longer journeys, delayed care, reduced viability of co-located

¹² 159 respondents selected the 'don't know' option. This is omitted for presentational convenience (standard industry practice) because it does not affect the order of preference of the available clinical options.

¹³ In this and all other instances where percentages do not add up to 100%, this is due to rounding.

¹⁴ Where percentages do not add up to 100%, this is due to rounding.

¹⁵ Nearest hospital based on travel time. 844 responses without postcode are not displayed, but are included in the overall results described in commentary prior to the chart.

emergency departments, and reduced community resilience, particularly in remote rural and coastal areas. These concerns were especially prevalent in Pembrokeshire.

- 1.79 Under both proposed options, the prospect of strengthening Surgical Same Day Emergency Care (SDEC) was welcomed.

Option A

- 1.80 In many staff discussions and across the three residents' workshops, Option A was the preferred model. It was seen as the more viable, less confusing, and clinically sustainable approach. Concentrating emergency general surgery on fewer sites was viewed by many as offering clearer pathways, better potential for consultant recruitment, and improved patient outcomes due to strengthened specialist availability.
- 1.81 There were, however, concerns about:
- » infrastructure limitations at Glangwili – many consultees questioned whether Glangwili has the physical capacity, theatre space, and diagnostic resilience to support a centralised emergency surgery model; and some also noted the building's general condition as a concern.
 - » staff de-skilling at Withybush, and the viability of interdependent services such as anaesthetics, critical care, acute medicine, and A&E if emergency general surgery were no longer to be undertaken there.

Option B

- 1.82 Some questionnaire respondents who stated a preference for Option B argued that if emergency general surgery is removed from Withybush entirely, the need to travel further in emergencies could pose additional risks to patient safety.
- 1.83 On the other hand, workforce issues were a prominent concern, especially among staff, with current surgical rotas considered fragile and recruitment challenges persistent. Considering these concerns, Option B was frequently viewed as unworkable as it would be unlikely to fix underlying workforce pressures. It was also widely considered to be confusing for patients and teams, disruptive to continuity of care and decision-making, and more costly in view of the need to maintain two sites.
- 1.84 If Option B were to be adopted, staff at Withybush identified wide-ranging infrastructure needs - including diagnostics, ward space, sterile services, laboratories, and equipment (including X-ray) - necessary for safe and effective delivery of emergency general surgery at the hospital.

Key general issues: travel and transfers

- 1.85 Concerns about inter-hospital transfers were central to consultee feedback on emergency general surgery. Consultees across all activities stressed that the region's geography, limited ambulance/patient transport availability, and transfer delays could pose unacceptable risks if emergency surgery becomes further centralised. Existing transfers between Withybush and Glangwili were described by staff as slow, complex, understaffed, and sometimes unsafe, with reports of patients waiting long periods for appropriate treatment.
- 1.86 Many consultees of all types expressed strong doubt that either option could operate safely without substantial improvements in transfer processes, capacity, and staffing. There was also recognition that long-distance transfers place significant emotional and practical burdens on families, particularly where travel options are limited.

Alternative suggestions and mitigations

- 1.87 Consultees proposed several mitigations that could strengthen any chosen model:
- » adequately resourced inter-hospital transfer services that can facilitate same-day transfer of all urgent cases.
 - » daily senior surgical review on all sites (including non-operating sites) to support assessment, stabilisation, and early clinical decision-making to ensure only necessary transfers happen.
 - » prompt post-surgical repatriation to Withybush and regular post-surgical specialist review.
 - » provide clear commitments on infrastructure investment - including diagnostics, beds, theatres, and staffing - at the affected hospitals.
- 1.88 Consultees proposed other potential alternatives and suggestions, including the following:
- » maintain on-site emergency surgical capability at all acute hospitals where possible.
 - » either full emergency general surgery, or potentially Surgical Same Day Emergency Care (SDEC), at Prince Philip.
 - » explore rotational consultant models (rather than rotating the full emergency service).
 - » relocate specialist roles rather than whole teams, for example basing endoscopists at Withybush to maintain local expertise.
 - » increase elective and day-case surgical throughput at Withybush, drawing on underused facilities (e.g., Ward 9 and several theatres) for procedures such as hernia, gallbladder, gynaecological, and colorectal surgery.
- use the former Preseli Theatre in Withybush as a Surgical Same Day Emergency Care (SDEC) centre.
- » keeping emergency general surgery services available all the time at Withybush, and removing or reducing services at Glangwili instead.
 - » a main hub at Glangwili for complex cases but with same day surgery/less complex cases remaining at each local hospital.
 - » consolidating on just one single site for all surgery.

strengthen Surgical Same Day Emergency Care (SDEC) at Bronglais, as well as at Glangwili and Withybush.

- 1.89 For further details, see the emergency general surgery sections in the individual consultation method chapters.

Endoscopy

- 1.90 Endoscopy undertakes a procedure to look inside the body, examining hollow organs or cavities in patients over 16. Currently, endoscopy services are provided at Bronglais, Glangwili, Prince Philip, and Withybush.
- 1.91 The main issue affecting the Health Board's endoscopy service is increasing demand and difficulties in hiring enough endoscopy staff to deliver the service across multiple sites. If it does not increase activity, waiting lists for patients will get longer.
- 1.92 Hywel Dda outlined three different options for how endoscopy services could be delivered. In all proposed options, some endoscopy procedures would continue to be delivered across the four main hospital sites. The options consider increasing activity in different ways, described in Table 4.

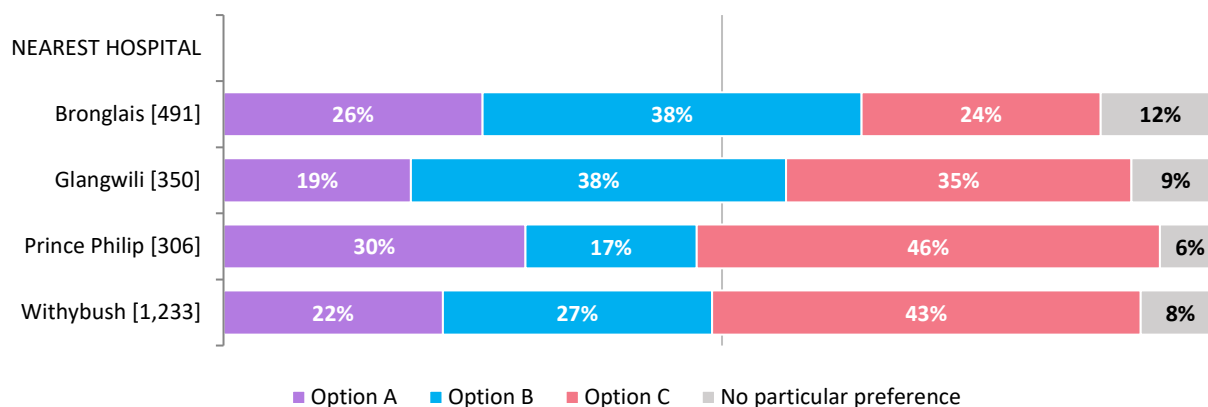
Table 4: Consultation options – endoscopy

	Bronglais	Glangwili	Prince Philip	Withybush	Community sites
Current service	Bowel screening, gastro-intestinal, urology	Bowel screening, gastro-intestinal, respiratory, urology	Bowel screening, gastro-intestinal, respiratory, urology	Bowel screening, gastro-intestinal	No service
Option A	Bowel screening, gastro-intestinal	Bowel screening, gastro-intestinal	Capacity increased by additional procedure room Bowel screening, gastro-intestinal, bring together respiratory and urology procedures	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 urology and respiratory procedures Extended hours	Bowel screening, gastro-intestinal	No service

Consultation questionnaire feedback

- ¹⁹³ Overall, around two-fifths (39%) of consultation questionnaire respondents supported Option C, with just under a third (29%) supporting Option B¹⁶. However, preferences varied by nearest hospital: more respondents nearest Bronglais and Glangwili supported Option B (38% in both cases).

Figure 4¹⁷: Which option for endoscopy services do you believe best meets the Clinical Services Plan objectives, considering patient care, accessibility, and outcomes? By nearest hospital¹⁸ (individual respondents only, where postcodes were provided)



Base: Number of respondents shown in brackets (excludes 'don't know' responses)

¹⁶ 134 respondents selected the 'don't know' option. This is omitted for presentational convenience (standard industry practice) because it does not affect the order of preference of the available clinical options.

¹⁷ Where percentages do not add up to 100%, this is due to rounding.

¹⁸ Nearest hospital based on travel time. 754 responses without postcode are not displayed, but are included in the overall results described in commentary prior to the chart.

Further feedback on the endoscopy options

Addressing current challenges

- 1.94 Across all consultee groups, concerns were raised around current waiting list lengths, including for urgent cancer-related procedures. The objective to meaningfully increase activity was widely welcomed, as were proposals that would in future lead to better, more integrated diagnostic services to improve co-ordination, continuity, and overall patient experience.
- 1.95 Preferences differed as to whether the improvements should be achieved by increased capacity during the day, extended opening hours, or centralising bowel screening; and many consultees asked for clearer explanations of what each option means for where services would be located, staffing capacity, transport arrangements, and impact on waiting times.

Views on the endoscopy options

Options A and C

- 1.96 There was considerable support for bringing respiratory and urology endoscopy procedures together (Options A and C). Although, as with other services, travel distance and times emerged as concerns in relation to deterring attendance or placing unfair burdens on patients, particularly those who are older or less mobile.
- 1.97 Those who supported Option A (an additional procedure room at Prince Philip) suggested that increasing clinical sessions during the day is preferable to extended hours, because of the lack of evening transport availability. However, others viewed the addition of a single procedure room as providing insufficient capacity to address current pressures and demand.
- 1.98 Views on extended hours and weekend provision at Prince Philip (Option C) were mixed. Some consultees saw benefits in increased flexibility, valuing appointments outside standard working hours; while others raised concerns about additional pressure on current staff and the challenges of recruiting to an expanded rota.
- 1.99 Supporters of Options A and C often stated the importance of maintaining gastro-intestinal/bowel screening at all hospital sites, to minimise travelling and maximise take-up of this important service.

Option B

- 1.100 Those who supported Option B saw a dedicated bowel screening hub as a way to improve capacity, release space in hospitals for other types of screening, enhance consistency, and support the recruitment of specialist staff. Some consultees also favoured this option because it would retain respiratory endoscopy at Glangwili.
- 1.101 On the other hand, concerns were also expressed around the location, feasibility, cost, and scale of the proposed community bowel screening centre. If it is established, consultees said it should be centrally located, with consideration for areas in which older residents are concentrated, and those with manageable transport links.
- 1.102 Staff, members of the public, and partner organisations highlighted that longer journeys - particularly for bowel screening, where significant preparation is required and there are potential issues around patient dignity - could reduce uptake and exacerbate inequalities. Use of mobile screening units was thus widely proposed as a means to protect access for remote communities.

Key overarching issues: impact on emergency cases

- 1.103 Consultees across several activities questioned how endoscopy patients with more serious conditions or emergencies would be dealt with, and highlighted risks associated with relocating certain procedures to Prince Philip if an option was selected that removes the ICU/HDU there. It was also highlighted that high-risk endoscopy patients often require immediate access to critical care or interventional radiology, and that the unavailability of these services could compromise safety. Staff were also concerned about the potential loss of specialist skills, particularly bronchoscopy expertise, if relevant services were moved away from hospitals with critical care capacity.

Alternative suggestions and mitigations

- 1.104 Consultees proposed several mitigations that could strengthen any chosen model:
- » invest in mobile bowel screening units to reduce travel burdens for rural populations.
 - » workforce development, including expanded nurse endoscopist training to support extended hours or increased activity.
 - » ensure hospital transport services times are altered to reflect any extended hours.
 - » clinical safety mitigations, such as ensuring rapid transfer pathways for high-risk patients.
- 1.105 Consultees proposed other potential alternatives and suggestions, including the following:
- » a modified version of Option C, with urology and respiratory services consolidated at Glangwili instead of Prince Philip.
 - » retain some respiratory and urology endoscopy capacity at Glangwili to maintain safe multidisciplinary management of complex patients (especially those needing interventional radiology).
 - » consideration of Bronglais as a potential hub, recognising its established JAG-accredited unit and positive patient feedback.
 - » hybrid models, such as combining extended hours (Option C) with additional physical capacity (Option A).
 - » ensure the bowel screening community site in Option B has a cancer focus.
 - » retain some endoscopy sessions at each acute hospital, maintaining local access and in particular supporting frail or complex patients.
 - » provide services, especially bowel screening, at other locations or settings including GP surgeries and community sites such as Llandoverly, South Pembrokeshire and Tenby Hospitals and Cardigan ICC.
 - » if urology is consolidated on one site, urology endoscopy could follow, with other endoscopy expertise built around that.
 - » develop a lead lined room to allow the provision of Endoscopic Retrograde Cholangiopancreatography (ERCP)¹⁹ at Withybush
 - » maintain services at Withybush to take advantage of the new fluoroscopy machine to offer ERCP) and potentially reduce the demand for MRI studies.
- 1.106 For further details, see the endoscopy sections in the individual consultation method chapters.

¹⁹ A procedure that combines upper gastrointestinal (GI) endoscopy and x-rays to find and treat problems of the bile and pancreatic ducts.

Ophthalmology

- 1.107 Ophthalmology is the treatment of eye diseases and injuries, eye injections and surgical procedures, for children, young people and adults. Currently, ophthalmology hospital services are provided from Bronglais, Glangwili, Prince Philip, and Withybush. In the community, outpatient clinics are provided at a number of locations (see Table 5).
- 1.108 Hywel Dda outlined three different options for how ophthalmology services could be delivered. In its options, the Health Board could bring together most services at either Glangwili or Prince Philip with the aim of reducing the time patients spend on waiting lists, helping with staff shortages, and making the service run better.
- 1.109 In all proposed options, Withybush would continue to provide some outpatient services; Amman Valley Hospital would be used for either day case for cataracts or eye injections only; Cardigan Integrated Care Centre and North Road Eye Clinic (Aberystwyth) would offer outpatient services; and no service would be provided from Aberaeron Integrated Care Centre. Regular eye injection services would be carried out at all sites providing outpatient services.

Table 5: Consultation options – ophthalmology

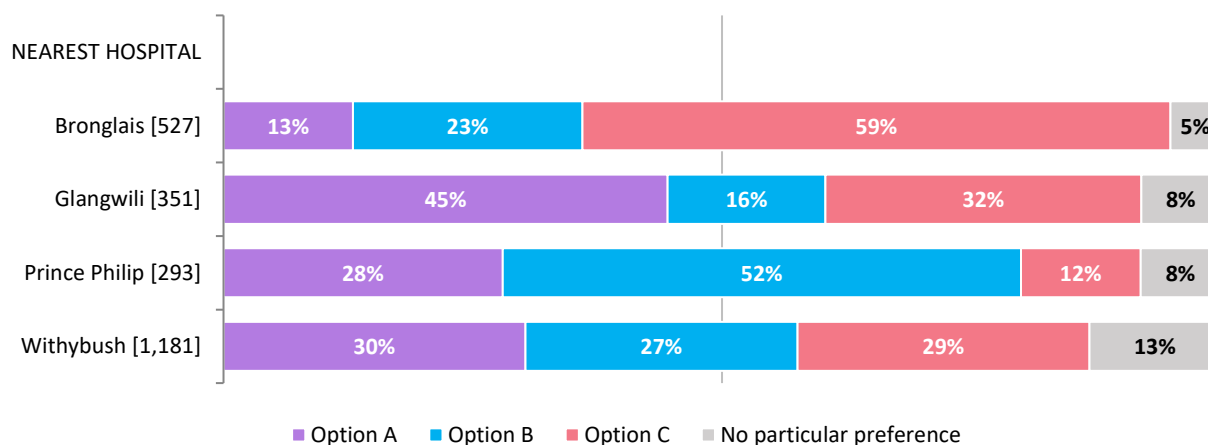
	Bronglais	Glangwili	Prince Philip	Withybush	Community sites
Current service	Day cases and inpatients	Diagnostics, day cases, inpatients, outpatients and emergency eye care	Diagnostics, outpatients and inpatients	Diagnostics, outpatients and inpatients	Amman Valley - day cases Diagnostics and outpatient service in Cardigan Integrated Care Centre, North Road Eye Clinic (Aberystwyth), and Aberaeron Integrated Care Centre
Option A	No service	Main service including diagnostics, day cases, inpatients, outpatients and emergency eye care	No service	Diagnostics and outpatients	Amman Valley - day cases (cataracts) but not outpatients (eye injections) Diagnostics and outpatient service in Cardigan Integrated Care Centre and North Road Eye Clinic (Aberystwyth)
Option B	Day cases and inpatients	No service	Main service including diagnostics, day cases, inpatients, outpatients and emergency eye care	Diagnostics and outpatients	Diagnostics and outpatient service in Cardigan Integrated Care Centre, North Road Eye Clinic (Aberystwyth) and Pembrokeshire (site to be confirmed) Amman Valley - diagnostics, outpatients (eye injections) but not day cases (cataracts)

	Bronglais	Glangwili	Prince Philip	Withybush	Community sites
Option C	Day cases and inpatients	Main service including diagnostics, day cases, inpatients, outpatients, emergency eye care	No service	Diagnostics and outpatients	Amman Valley - diagnostics, outpatients (eye injections), but not day cases (cataracts) Diagnostics and outpatient service in Cardigan Integrated Care Centre, and North Road Eye Clinic (Aberystwyth)

Consultation questionnaire feedback

- 1.110 Overall, around a third (34%) of questionnaire respondents preferred Option C, while just over a quarter favoured each of Options A (28%) and B (28%)²⁰.
- 1.111 However, views on the most appropriate option for ophthalmology services differed quite strongly based on respondents' nearest hospital, as shown below.

Figure 5²¹: Which option for ophthalmology services do you believe best meets the Clinical Services Plan objectives, considering patient care, accessibility, and outcomes? By nearest hospital²² (individual respondents only, where postcodes were provided)



Base: Number of respondents shown in brackets (excludes 'don't know' responses)

Further feedback on the ophthalmology options

Addressing current challenges

- 1.112 Across all activities, the Health Board's ophthalmology staff were widely praised for their professionalism and care. However, the current service was consistently described as fragmented and overstretched, with long waits, repeated cancellations, lack of post-treatment follow-up, poor administration and communication, and outdated infrastructure seen as core challenges that any new model must address.

²⁰ 188 respondents selected the 'don't know' option. This is omitted for presentational convenience (standard industry practice) because it does not affect the order of preference of the available clinical options.

²¹ Where percentages do not add up to 100%, this is due to rounding.

²² Nearest hospital based on travel time. 639 responses without postcode are not displayed, but are included in the overall results described in commentary prior to the chart.

- 1.113 Staff shortages - including among consultants, orthoptists, optometrists and specialist nurses - were widely recognised as the root cause of these issues. Specifically, staff noted that recruitment and retention are particularly difficult in rural locations, and they broadly agreed that centralisation could strengthen the service, provided it is underpinned by realistic workforce planning and fit-for-purpose facilities.
- 1.114 Improving waiting times was the highest priority for service users and residents across the consultation methods, many of whom saw efficiencies from consolidating services as key to restoring performance. However, others were unconvinced that centralised models would deliver the improvements required without significant investment in staffing, transport, equipment, and administration; and many emphasised that routine care - such as eye injections - and follow-up must remain local.

Views on the ophthalmology options

- 1.115 Across most of the consultation methods, there were relatively few comments on the specific options. Those that were offered are summarised below.

Option A

- 1.116 Across the three residents' workshops, strong majorities expressed support for Option A. Participants believing that centralising specialist ophthalmology in this way would most effectively reduce waiting times, address staff shortages and deliver efficiencies.
- 1.117 By contrast, there was concern among questionnaire respondents, some resident workshop attendees, and many public and patient drop-in event/meeting attendees that Option A - which brings services together onto the fewest sites - would be most detrimental to patient accessibility, especially those living closest to Bronglais.
- 1.118 Questionnaire respondents favouring Option A felt this was the most logical option to make optimal use of staffing and resources.

Options B and C

- 1.119 Options B and C were preferred by minorities in the residents' workshops as they would provide more services across the Hywel Dda area; and Betsi Cadwaladr University Health Board expressed a preference for these configurations as they retain services at Bronglais, maintaining equity for northern populations.
- 1.120 However, staff and some clinical partners expressed concern about the appropriateness of locating complex and emergency ophthalmology at Prince Philip under Option B due to the absence of a 24/7 Emergency Department and limited critical care provision there. More specifically, the proposed concentration of emergency eye care at Prince Philip raised a few questions among public and patient drop-in event/meeting attendees about where paediatric ophthalmology would sit, given that children's services are in Glangwili.
- 1.121 There was also some concern that if the main service was consolidated in Prince Philip (as per Option B), this might be more challenging in travel and access terms for those in the north and west of the health board.

Key overarching issues: travel and transport

- 1.122 Access and travel emerged as the most prominent concern for consultees across the different activities: older people, visually impaired patients and those who do not drive were seen as at risk of being

disproportionately affected by each of the options to differing degrees. Specific difficulties faced by those ophthalmology patients who may be unable to drive as a result of their treatment were also mentioned.

- 1.123 Long journey times, unreliable patient transport, poor road networks, and limited public transport were described as barriers that could lead to missed appointments, poorer outcomes and widening inequalities if not adequately mitigated.
- 1.124 Staff also reported significant transport challenges between Health Board sites where the services are offered, with widespread reliance on taxis to move clinicians between sites, high associated costs, and reluctance among some clinicians - particularly newly recruited international staff - to drive on rural road networks. Concerns were raised that such travel demands make recruitment and retention more difficult, and that proposals to centralise services without mitigation could worsen these issues.

Key general issues: hospital and community sites

- 1.125 Considering where ophthalmology services should be located in future, staff raised concerns about the condition, capacity and configuration of several community and acute sites. For example, it was said that:
- » Aberaeron ICC struggles with a shortage of clinic rooms, making it hard to run extra sessions.
 - » some local eye clinics, like in Cardigan, have stopped because consultants no longer visit, and space is often fully booked.
 - » North Road Eye Clinic is no longer suitable, and its services could be moved back to an acute hospital site like Bronglais to make better use of space and improve follow-up care.
 - » Glangwili is poorly configured for ophthalmology.
- 1.126 Conversely, Withybush was seen by some staff as underused and potentially better suited for expansion; and Amman Valley Hospital was considered a preferred location for cataract services for patients, as it has easier parking than other sites.

Alternative suggestions and mitigations

- 1.127 Consultees proposed several mitigations that could strengthen any chosen model:
- » invest in digital systems to share scans and results with optometrists.
 - » strengthen community provision through, for example, expanded roles for community optometrists, mobile units for cataract or screening services, and upskilling nurses to deliver eye injections and other routine procedures.
 - » partnerships with private providers to clear cataract backlogs.
 - » better appointment management processes.
 - » better facilities at hospital sites to attract and keep staff (current buildings were said to lack basics like changing areas and staff kitchens).
 - » offer both day cases (cataracts) and outpatient services (eye injections) in Amman Valley Hospital, rather than one or the other.
- 1.128 Consultees proposed other potential alternatives and suggestions, including the following:
- » three regional sub-hubs (one per county) rather than one centralised site.
- joint working with Betsi on shared treatment centres across mid and north Wales.
- » offer cataracts at Cardigan ICC; and cataracts at Aberystwyth every three months.
 - » offer some services on an alternating basis between hospitals, with consultants travelling rather than patients.

- » a hybrid model with emergency and complex care centralised at Glangwili, plus enhanced outreach clinics
- » a model in which Glangwili would be used for tertiary care; Prince Philip for outpatient care; Amman Valley Hospital for cataract and Intravitreal Therapy (IVT)²³ services; Cardigan and North Road for IVT services; some basic outpatient work in Withybush
- » remove emergency eye care from Hywel Dda and instead deliver it regionally.

^{1.129} For further details, see the ophthalmology sections in the individual consultation method chapters.

Orthopaedics

^{1.130} Orthopaedic services, also known as orthopaedic surgery, focus on the care of the musculoskeletal system and its parts (bones, joints, ligaments and tendons). The consultation was about planned orthopaedics and not emergency (trauma) orthopaedics. The main challenge in orthopaedic services is that the Health Board needs to increase its activity to bring down long waiting times for patients.

^{1.131} Currently, orthopaedic services are provided from Bronglais, Glangwili, Prince Philip, and Withybush. As well as the main hospital services, orthopaedic outpatient clinics are provided at Cardigan Integrated Care Centre and Tenby Hospital, and staff provide outpatient clinics at Tywyn Hospital, run by Betsi Cadwaladr University Health Board to reduce travel for some patients.

^{1.132} Hywel Dda outlined four different options for how orthopaedic services could be delivered. In all proposed options, all sites would continue to provide outpatient services. Bronglais, Prince Philip, and Withybush would continue to provide day cases. Bronglais and Prince Philip would continue to provide inpatient surgery and community sites would retain their current services.

Table 6: Consultation options – orthopaedic services

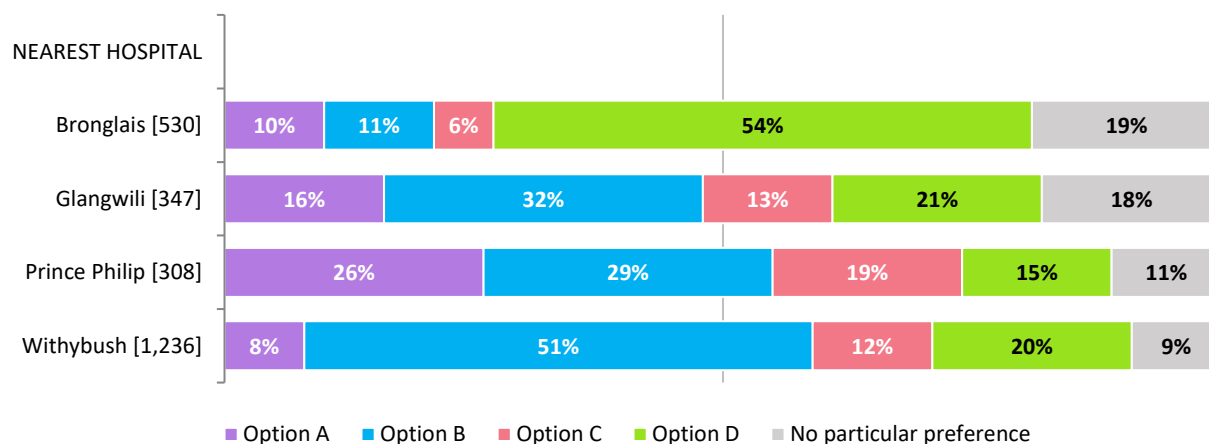
	Bronglais	Glangwili	Prince Philip	Withybush
Current service	Outpatients, inpatients and day cases	Outpatients	Outpatients, inpatients and day cases	Outpatients and day cases
Option A	Outpatients, inpatients and day cases	Outpatients	Outpatients, inpatients and day cases including regional working ²³	Outpatients and increased day cases
Option B	Outpatients, inpatients and day cases	Outpatients	Outpatients, inpatients, and day cases including regional working	Outpatients, increased day cases & extended hours
Option C	Outpatients, inpatients, and day cases	Outpatients	Local outpatients, inpatients, and day case procedures and additional beds	Outpatients and increased day case procedures
Option D	Outpatients, increased inpatients, and day cases	Outpatients	Outpatients, inpatients, and day cases including regional working	Outpatients and increased day cases

²³ Working in partnership with Swansea Bay University Health Board for their patients who may need to access care in Prince Philip, or for Hywel Dda patients who may need to access care in Neath Port Talbot for certain procedures.

Consultation questionnaire feedback

- 1.133 Overall, over a third (36%) of questionnaire respondents felt that Option B best meets the Clinical Services Plan objectives. More than a quarter (27%) thought Option D best meets the objectives, with smaller proportions selecting Options A and C²⁴.
- 1.134 Views varied by nearest hospital: respondents nearest Bronglais were the only group who strongly favoured Option D (54%); and respondents nearest Withybush were the group who most strongly favoured option B (51%), as shown below.

Figure 6: Which option for Orthopaedic services do you believe best meets the Clinical Services Plan objectives, considering patient care, accessibility, and outcomes? By nearest hospital²⁵ (individual respondents only, where postcodes were provided)



Base: Number of respondents shown in brackets (excludes 'don't know' responses)

Further feedback on the orthopaedics options

Addressing current challenges

- 1.135 Across the different activities, although the quality of surgical care once accessed was praised, consultees consistently highlighted long waits for hip and knee surgery, sometimes lasting years, with significant impacts on patients' mobility, independence, and mental wellbeing. Members of the public and patients also frequently reported confusion and delays caused by lost paperwork, poor updates, and lack of clarity about next steps; and some service users described being placed in inappropriate wards post-surgery, reflecting staffing or bed pressures.
- 1.136 Considering this, there was some support among questionnaire respondents, public and patient drop-in event/meeting attendees and special interest groups for bringing services together if this would increase overall capacity, reduce waiting lists, improve administration and communication, and streamline pathways. The importance of combining specialist regional centres with accessible local services was frequently stressed though. While consultees acknowledged that patients may be prepared to travel for surgery, they emphasised that diagnostics, rehabilitation, and follow-up appointments must be delivered as close to home as possible.

²⁴ 131 respondents selected the 'don't know' option. This is omitted for presentational convenience (standard industry practice) because it does not affect the order of preference of the available clinical options.

²⁵ Nearest hospital based on travel time. 608 responses without postcode are not displayed, but are included in the overall results described in commentary prior to the chart.

- 1.137 Conversely, others - particularly at the public and patient drop-in event/meetings, and in the questionnaire - objected to losing local services, many on the grounds that rural populations would be disproportionately affected, especially where transport options are limited. If changes are to be made, the Health Board was urged to provide practical support in the form of patient transport (especially for elderly or post-surgery patients who cannot travel independently).

Views on the orthopaedic options

- 1.138 For some consultees - especially in the questionnaire and resident workshops, where most of the direct comments on the orthopaedic options were received - the relative similarity of the options and a lack of information around which would best increase capacity made it difficult to decide between them. The Health Board was advised to select the one that would reduce waiting lists most and fastest; and to ensure that site selection reflects clinical safety, workforce sustainability, and capacity to manage higher-risk patients.

Regional working (Options A, B, and D)

- 1.139 Options with regional working were preferred by many in the questionnaire, and some in the resident workshops, who felt that orthopaedic patients would be willing to travel for faster access to specialist care. In this context, regional working with Swansea Bay University Health Board was largely viewed positively across many consultation methods in potentially increasing capacity, reducing waiting times, allowing opportunities for integration with other services, and improving recruitment.
- 1.140 Conversely, a minority of consultees across the consultation methods feared that regional working could lead to increased competition for appointments, as the service would be catering to a larger population. It was also noted that it appears to place increased financial pressure on patients who are dependent on public transport, if they would need to travel further in future.

Options A and B

- 1.141 While there were very few comments on Option A, for questionnaire respondents whose nearest hospital is Withybush and in the Pembrokeshire resident workshop, Option B was favoured because it increases care at Withybush via extended hours, as well as offering the perceived benefits of regional working. A few consultees did question whether a longer day and a third operating theatre session was efficient, and whether it could risk negatively impacting staff retention.

Option C

- 1.142 A limited proportion of questionnaire respondents felt that additional beds within the Health Board would reduce waiting lists more quickly than regional working, and would involve less travel between sites, especially for Llanelli residents. There was very little support for Option C at the resident workshops, mainly as participants were generally well-disposed toward regional working.

Option D

- 1.143 Option D received the most support among questionnaire respondents whose nearest hospital is Bronglais, as well across the residents' workshops as a whole, driven largely by unanimous support among Ceredigion participants. This was due to its proposal to increase inpatient orthopaedic activity at Bronglais, and what consultees saw as the potential to effect the largest decrease in waiting times through regional working and enhancements at an additional hospital (Bronglais). Moreover, Ceredigion and Powys consultees, and Betsi

Cadwaladr Health Board, were pleased that this option would improve access for patients and their families across mid and north Wales.

- 1.144 On the other hand, the higher cost of this option was acknowledged, as was its potential negative impact on concentrating expertise and building critical mass.

Key overarching issues: hospital-specific feedback

- 1.145 Some staff members and clinical partners expressed reservations about the suitability of concentrating inpatient orthopaedics at Prince Philip given its workforce shortages, outdated theatres, lack of dialysis, enhanced recovery, and critical care facilities, and limited ICU/HDU and anaesthetic capacity. In contrast, Withybush was described as having modern theatres, a dedicated elective ward, and underused capacity.
- 1.146 Similarly, in the questionnaire, a staff member urged consideration around the limitations of existing pathways and critical care provision between/at Neath Port Talbot Hospital and Prince Philip, and around the lack of an acute pain service at Bronglais.

Key overarching issues: workforce sustainability

- 1.147 Staff highlighted the importance of maintaining a varied case mix - including emergency and trauma work - to support consultant recruitment, retention, and job satisfaction. Concerns were thus raised about concentrating only low-complexity elective cases at Withybush, which could, it was felt, undermine workforce morale and resilience there. Questions were also raised about how surgical teams would be separated between planned and emergency services, and whether such division would be practical or desirable. Staff emphasised the importance of maintaining integrated elective and trauma activity to support skills development, service resilience, and recruitment.

Alternative suggestions and mitigations

- 1.148 Consultees proposed several mitigations that could strengthen any chosen model:
- » fund more surgeons and additional radiographers, and more radiography equipment.
 - » enable cross-boundary referrals, including to hospitals in England.
 - » partner with private providers to clear backlogs.
 - » pool staff resources and waiting lists across the region to reduce inequity of access.
 - » ringfence orthopaedic services to protect elective activity from seasonal pressures.
 - » patients checking in overnight to help predict surgical complications earlier and ensure earlier start times for surgery.
- 1.149 Consultees proposed other potential alternatives and suggestions, including the following.
- » create a single dedicated orthopaedic 'centre of excellence' for Hywel Dda.
 - » create several dedicated orthopaedic hubs with protected elective beds to prevent cancellations and reduce infection risk.
 - » reinstate Ward 9 at Withybush as a dedicated elective orthopaedic unit.
 - » provide fracture clinics and orthopaedic services in the community, such as at Cardigan ICC.
 - » invest in same day joint surgery at the Prince Philip Day Surgery Unit for patients who meet the criteria.
 - » a hybrid of all four options (i.e., increased inpatients and day cases at Bronglais [Option D], extended hours at Withybush [Option B], additional beds and investment at Prince Philip [Option C], but as part of a regional working approach [Options A, B and D], and a

regional/local hybrid surgical hubs network working with Neath Port Talbot [Options A, B and D]).

- » Other combinations of options, e.g. extended hours at Withybush (Option B) in addition to increased inpatient services at Bronglais (Option D)

^{1.150} For further details, see the orthopaedic sections in the individual consultation method chapters.

Radiology

- ^{1.151} Radiology uses imaging techniques (such as x-rays) to diagnose, treat and monitor diseases and injuries identified within the body. Diagnostic radiology services help make a diagnosis of a disease or condition. In Hywel Dda, emergency diagnostic radiology is provided 24/7; and planned diagnostic radiology is currently provided five days a week, during the daytime only. Interventional radiology services are more complex diagnostic procedures, including biopsies, and are provided for hospital inpatients or for planned day cases, currently five days a week during the daytime only.
- ^{1.152} Radiology has seen a large rise in activity across all sites. At the same time, staff shortages are stopping the Health Board from providing some services for longer hours. There are also difficulties maintaining up-to-date equipment across all sites. Bringing some radiology services together on fewer sites, which is proposed in all proposed options, would allow Hywel Dda to see more patients and would address some staff shortages, but there is potential impact on where staff work from. None of the options would fully address hiring challenges for interventional radiology roles.
- ^{1.153} Hywel Dda outlined four different options for how radiology services could be delivered. All options propose the removal of X-ray services at Llandovery and South Pembrokeshire Hospitals, so patients living closer to these hospitals would have further to travel for their x-rays than they do now. X-ray services would stay at Cardigan Integrated Care Centre and Tenby Hospital in all proposed options. In all proposed options for radiology, emergency diagnostic radiology would be maintained 24/7 at all four main hospitals.

Table 7: Consultation options – radiology

	Bronglais	Glangwili	Prince Philip	Withybush	Community sites
Current service	Planned diagnostic Inpatient and day case interventional (Mon-Fri, daytime)	Planned diagnostic Inpatient and day case interventional (Mon-Fri, daytime)	Planned diagnostic Inpatient and day case interventional (Mon-Fri, daytime)	Planned diagnostic Inpatient and day case interventional (Mon-Fri, daytime)	X-ray at Cardigan Integrated Care Centre, Llandovery, South Pembrokeshire and Tenby hospitals
Option A	Planned diagnostic Day case interventional (Mon-Fri, daytime)	Inpatient interventional (Mon-Fri, daytime)	Planned diagnostic Day case interventional (Mon-Fri, daytime)	Planned diagnostic Day case interventional (Mon-Fri, daytime)	X-ray at Cardigan Integrated Care Centre and Tenby Hospital
Option B	Planned diagnostic (7 days, daytime)	Planned diagnostic (7 days, daytime)	Planned diagnostic (7 days, daytime)	Planned diagnostic (7 days, daytime)	X-ray at Cardigan Integrated Care Centre and Tenby Hospital

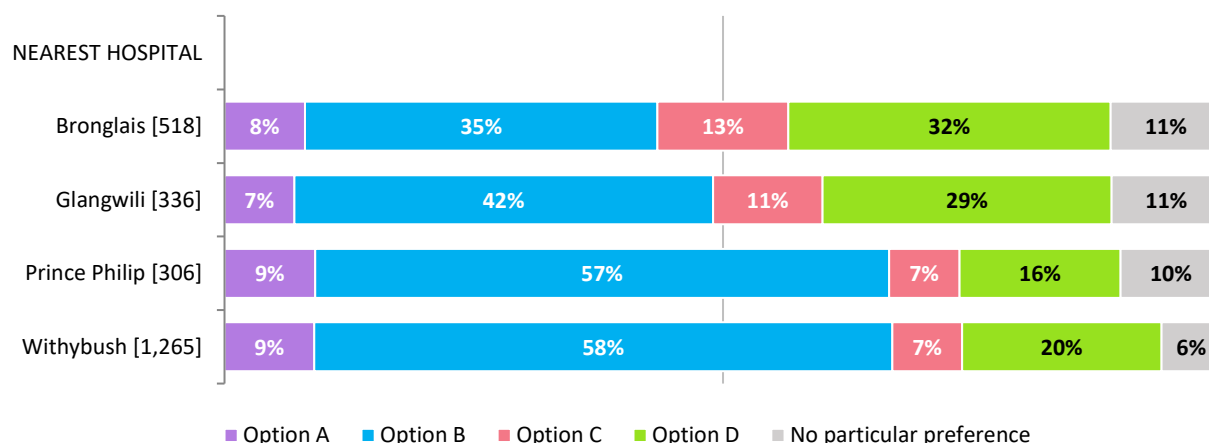
	Bronglais	Glangwili	Prince Philip	Withybush	Community sites
	Interventional services (Mon-Fri, daytime)	Interventional services (Mon-Fri, daytime)	Interventional services (Mon-Fri, daytime) Cancer focus	Interventional services (Mon-Fri, daytime) Cancer focus	New regional hub for planned diagnostic (site to be confirmed)
Option C	Planned diagnostic (Mon-Fri, daytime) Inpatient and day case interventional (Mon-Fri, daytime)	Planned diagnostic (Mon-Fri, daytime) Inpatient and day case interventional (Mon-Fri, daytime)	Planned diagnostic (Mon-Fri, daytime)	Planned diagnostic (Mon-Fri, daytime)	X-ray at Cardigan Integrated Care Centre and Tenby Hospital
Option D	Planned diagnostic (7 days, daytime) Day case interventional (Mon-Fri, daytime)	Planned diagnostic (7 days, daytime) Inpatient interventional (24/7)	Planned diagnostic (7 days, daytime) Day case interventional (Mon-Fri, daytime)	Planned diagnostic (7 days, daytime) Day case interventional (Mon-Fri, daytime)	X-ray at Cardigan Integrated Care Centre and Tenby Hospital

Consultation questionnaire feedback

- ^{1.154} Overall, around half (50%) of questionnaire respondents felt that Option B best meets the Clinical Services Plan objectives. Around a quarter (24%) thought Option D best meets the objectives, with much smaller proportions selecting Options A and C²⁶.
- ^{1.155} Views varied somewhat by nearest hospital: among residents who live nearest Bronglais similar proportions answered Option B (35%) as Option D (32%), as shown overleaf.

²⁶ 106 respondents selected the 'don't know' option. This is omitted for presentational convenience (standard industry practice) because it does not affect the order of preference of the available clinical options.

Figure 7²⁷: Which option for radiology services do you believe best meets the Clinical Services Plan objectives, considering patient care, accessibility, and outcomes? By nearest hospital²⁸ (individual respondents only, where postcodes were provided)



Base: Number of respondents shown in brackets (excludes 'don't know' responses)

Further feedback on the radiology options

Addressing current challenges

- 1.156 Consultees had mixed experiences of radiology. Several praised recent improvements in booking and access, while many others described fragmented systems, reporting and diagnosis delays, and poor communication about appointments, preparation, and results.
- 1.157 As a result, many consultees urged the Health Board to opt for the service configuration that would best expand diagnostic capacity and reduce waiting times; albeit concerns were frequently raised about whether the service - already perceived as understaffed - could realistically support extended hours or more centralised models.

Views on the radiology options

Option A

- 1.158 While some questionnaire respondents recognised that separating day case and inpatient services could lead to fewer cancellations and felt that this option might be more viable than some others, resident workshop participants typically disliked this option, as having inpatient and day case interventional radiology at different sites would lessen the impact on addressing the Health Board's staffing challenges.
- 1.159 Some staff also raised concerns about capacity shortfalls at Glangwili if more inpatient interventional radiology were to be centralised there, highlighting staffing and space limitations, bed pressures, and insufficient equipment that would be expensive to expand and upgrade. Others were more supportive however, especially given that the proposed change might mean upgraded facilities (a Gamma Camera for example). These concerns and benefits also apply to Option D.

²⁷ Where percentages do not add up to 100%, this is due to rounding.

²⁸ Nearest hospital based on travel time. 576 responses without postcode are not displayed, but are included in the overall results described in commentary prior to the chart.

Option B

- 1.160 As in the questionnaire, Option B received most support across the three resident workshops. Those who preferred Option B liked the cancer focus at Prince Philip and Wthybush, and the extended seven-day planned diagnostic service (where the 'bottleneck' was said to be).
- 1.161 Consultees across several activities tended to support the principle of a regional diagnostic hub in terms of concentrating expertise and attracting staff, increasing capacity and reducing backlogs, and improving reporting and diagnosis times. However, many sought clarity on its location, remit, staffing model, and cost. Concerns were raised about duplication if diagnostics are retained at all hospitals, and about potential travel distances for patients, depending on where the hub is sited.

Option C

- 1.162 Option C received limited support across several activities and few specific comments. It was occasionally noted as providing a good geographical spread of services across the Health Board, but was mainly seen as a realistic option only if Options B or D are not viable.

Option D

- 1.163 Option D appealed to some staff members and Ceredigion workshop participants as a way to expand planned diagnostics without the cost of a full diagnostic hub, though concerns were raised about cost and staffing the proposed extended hours.

Key overarching issues: travel and transport

- 1.164 The importance of minimising patient travel where possible was stressed by many consultees. Specifically, clinical partners emphasised the need for robust patient transport (inter-hospital transfer systems in particular) and clear escalation pathways for patients who become unwell if inpatient interventional radiology is centralised.

Key overarching issues: workforce pressures and sustainability

- 1.165 Staff members emphasised the central importance of radiology to other clinical services (emergency general surgery, critical care, and stroke for example) and the need to maintain safe, continuous diagnostic support. In this respect, they expressed concern about workforce shortages and a reliance on agency cover, the feasibility of seven-day services (echoed by some public and patient drop-in event/meeting attendees), and the consultation document's characterisation of radiographer preferences for 12-hour shifts. Most staff members also noted that the on-call model was also described as essential to recruitment and retention as it provides valuable flexibility and significant financial benefits to staff and remains an important part of workforce stability in Hywel Dda.
- 1.166 Staff from Cardigan ICC and Tenby Hospital noted capacity concerns at these community sites. At Cardigan, radiology was said to be extremely pressured, with one radiographer often covering high patient volumes and managing complex tasks without consistent support; and at Tenby Hospital, staff reported having to redirect patients to Wthybush due to limited X-ray cover. The need for sufficient administration support to enable radiographers to focus on delivery was also stressed.

Key overarching issues: Llandovery Hospital

- 1.167 Across the consultation methods - including the drop-in event, which was attended by over 400 people - there was strong opposition to the proposed removal of X-ray services from Llandovery Hospital. This, it

was felt, would have a major negative impact on local access to care in and around Llandovery, especially for elderly, low-income, and rural patients who already face significant transport challenges and would find travel to alternative sites difficult.

- 1.168 Consultees described a sense of ‘managed decline’ at the hospital and highlighted the investment of the community, particularly the League of Friends, in purchasing an X-ray machine. Staff and members of the public across the consultation methods argued that underuse reflects referral practices rather than lack of demand (i.e., patients are being sent to Carmarthen for X-ray when they could feasibly be being sent to Llandovery) and that if this were to be addressed, the viability of the service would drastically improve.
- 1.169 The ease of parking at Llandovery Hospital relative to Glangwili was also highlighted, and it was suggested that if the X-ray service was to be maintained and the Minor Injuries Unit reinstated at Llandovery Hospital, there might be scope to relieve pressure on other hospitals in the area.
- 1.170 As noted above, the Llandovery drop-in event was very well attended, which may in part have been driven by a misconception that the Health Board is proposing to close the facility in its entirety. However, regardless of these misconceptions, attendees supported the retention of services at Llandovery Hospital and maintaining the facility at its current location.

Alternative suggestions and mitigations

- 1.171 Consultees proposed several mitigations that they felt could strengthen any chosen model:
- » introduce mobile or satellite radiography units for rural areas and peaks in demand.
 - » improve electronic sharing of scans across sites and with other health boards.
 - » expand use of AI-assisted reporting to reduce reporting times and support consistency.
 - » strengthen regional collaboration with Swansea Bay University Health Board to manage demand and share capacity.
- 1.172 Consultees proposed other potential alternatives and suggestions, including the following:
- » retain X-ray at Llandovery Hospital, including by ensuring GPs routinely refer there.
 - » variations on the proposed options, including:
 - adding weekend interventional services at Glangwili to Option B
 - hybrids of Options A and B, such as adding Option B’s cancer focus to Option A
 - hybrids of Options B and C.
 - removing the diagnostic hub element from Option B.
 - » expand services at community hospitals, including fracture clinics and extended X-ray hours at Cardigan ICC.
 - » explore co-locating the regional hub with the proposed bowel screening centre, and/or consider co-locating endoscopy and ophthalmology services.
 - » rotate radiographers across sites to sustain smaller units.
 - » use the existing estate for any regional diagnostic hub rather than building a new facility.
 - » extend diagnostic hours to 12-hour days, seven days a week permanently at existing hospitals rather than creating a new hub.
 - » introduce 7-day services until waiting times are reduced, or the regional diagnostic hub completed, and only then move to 5-day services.
 - » maintain full services across two sites during weekdays, and the single regional hub only at weekends.

- » all diagnostic radiology services could be consolidated on one site, seven days a week.
- » expand the Regional Diagnostic Programme Board to include Powys Teaching Health Board.

^{1.173} For further details, see the radiology sections in the individual consultation method chapters.

Stroke

^{1.174} A stroke is a serious life-threatening medical condition that happens when the blood supply to part of the brain is cut off. Currently, there are stroke units at all four hospitals: Bronglais, Glangwili, Prince Philip, and Withybush. However, the service fails to meet clinical standards and there are not enough staff to support it, leading to outcomes that are not as good as they could be. Evidence shows that outcomes and standards are better if services are brought together and delivered from fewer hospitals, and the Heath Board believes that bringing services together would also help with hiring and keeping staff and making the service more sustainable.

^{1.175} Hywel Dda outlined two different options for how stroke services could be delivered; either two stroke units with 12/7-hour specialist cover at Prince Philip and Withybush; or a stroke unit with 24/7 specialist cover at Prince Philip and a stroke unit with 12/7-hour specialist cover at Withybush. The latter would mean stroke patients from the treat and transfer hospitals (Bronglais and Glangwili), and from Withybush treat and transfer and stroke unit, would be transferred to Prince Philip typically for 72-hours of overnight (inpatient) care. Following this, patients' ongoing overnight care would be provided either within the stroke unit at Prince Philip, or at the stroke unit at Withybush (unless they need care from a specialist centre, such as Bristol and Cardiff for a thrombectomy, as is the case currently).

^{1.176} In both options an ambulance would take a suspected stroke patient to their nearest hospital where an initial assessment and appropriate treatment would take place. Patients at hospitals without a stroke unit, or with a stroke unit with less specialist cover than nearby units, would be treated and transferred to their nearest stroke unit.

Table 8: Consultation options – stroke

	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)

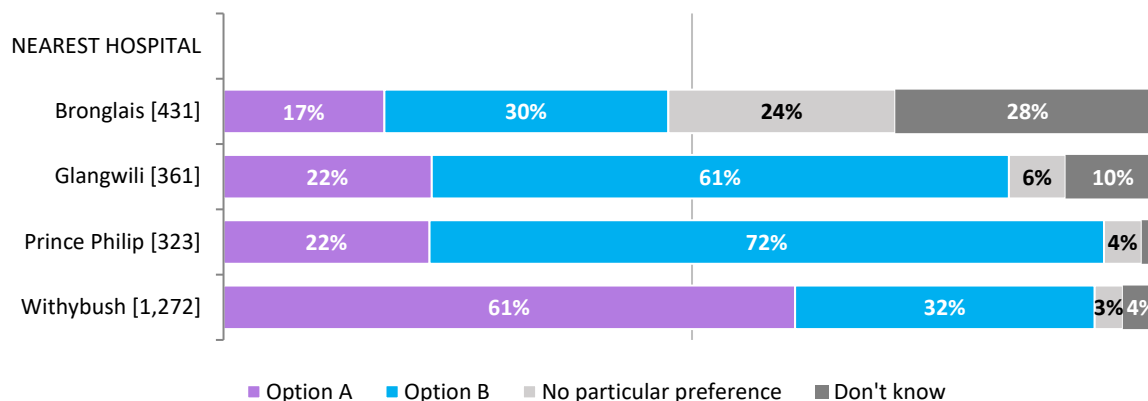
Consultation questionnaire feedback

^{1.177} In relation to the question about which option for stroke services best meets the Clinical Services Plan objectives, roughly a tenth of respondents overall answered, 'don't know.' This is higher than the proportion who answered, 'no particular preference'. For this question, ORS has chosen to show 'don't know' as a valid response.

^{1.178} Overall, there were very similar levels of support for Option A (42%) and Option B (41%). However, there were very clear differences in views based on respondents' nearest hospital: Option A was preferred by respondents living nearest Withybush, whereas Option B was preferred by those nearest Glangwili and

Prince Philip. However, more than half of respondents whose nearest hospital is Bronglais answered either ‘no preference’ or ‘don’t know,’ which may reflect the fact there was no choice to disagree with all proposed options.

Figure 8²⁹: Which option for Stroke services do you believe best meets the Clinical Services Plan objectives, considering patient care, accessibility, and outcomes? By nearest hospital³⁰ (individual respondents only, where postcodes were provided)



Base: Number of respondents shown in brackets (excludes ‘don’t know’ responses)

Further feedback on the stroke options

Addressing current challenges

- 1.179 There was broad recognition that Hywel Dda faces significant workforce, capacity, and sustainability challenges in delivering safe, modern stroke care. Many accepted that the current system - spread across multiple small units - cannot consistently meet national standards for rapid assessment, 24/7 specialist input, or intensive rehabilitation.
- 1.180 Considering this, many consultees across the different activities recognised that centralised specialist stroke centres can deliver improved survival and recovery rates; and so supported the principle of centralisation, suggesting that they would prefer stroke services to be provided at an appropriate specialist centre, regardless of location, rather than at a non-specialist hospital closer to home. This support was on the proviso that the proposed stroke units are adequately resourced and complemented by strong community-based rehabilitation, and that patients are moved back to a hospital closer to home for the latter parts of their recovery. In this context, more and clearer information on proposed stroke pathways (including repatriation and rehabilitation) and workforce plans was desired by consultees.
- 1.181 Many others, though, felt that the proposed changes fail to account adequately for the realities of rural Wales - long travel distances, poor roads and public transport links, and an older demographic profile. These issues are discussed further below.

Views on the stroke options

Option A

- 1.182 Views on Option A were somewhat mixed but tended to be more negative than positive overall.

²⁹ Where percentages do not add up to 100%, this is due to rounding.

³⁰ Nearest hospital based on travel time. 477 responses without postcode are not displayed, but are included in the overall results described in commentary prior to the chart.

- 1.183 Most of the support for Option A came from questionnaire respondents, though some members of the public and a minority of staff members across the other consultation methods also favoured this option. Key reasons for this support were that Option A has the potential to address staff shortages, raise standards, and provide longer specialist cover than under current arrangements. Pembrokeshire-based consultees (including Withybush staff and a sizeable number of questionnaire respondents) were also pleased to see the provision of 12-hour specialist cover at Withybush (which would also be the case under Option B).
- 1.184 A few staff members responding via the questionnaire queried whether 24/7 specialist care (as proposed under Option B) is strictly necessary, feeling that Option A may be the more 'balanced' proposal in offering reduced travel and fewer transfers.
- 1.185 Overall though, some viewed Option A as unaligned with modern stroke standards and unlikely to deliver consistent acute stroke care, particularly with respect to:
- » the lack of 24-hour specialist stroke cover, which was widely viewed as unacceptable.
 - » the potential for fragmented care across sites and slower access to expert assessment.
 - » reduced equity for rural patients, who may face similar travel pressures as under Option B but without 24/7 specialist cover.

Option B

- 1.186 Outside of the questionnaire, during the residents' workshops where people explicitly compared the options, Option B tended to be better supported than Option A. The 24-hour specialist stroke service was widely regarded as essential and aligned with national best practice; and some consultees saw value in establishing a single high-volume centre of excellence with stronger recruitment potential and the potential for improved clinical outcomes.
- 1.187 However, many consultees in Ceredigion and Pembrokeshire opposed Option B. While they were not opposed to the prospect of a 24-hour stroke unit in principle, they viewed the proposed site selection as problematic, questioning the suitability of focusing it in Prince Philip both geographically (with Llanelli being in the extreme south east of the Health Board area, and very close to Morriston Hospital) and because it lacks an emergency department, has limited ICU capability, and has no dialysis service for stroke patients with renal needs. Some questionnaire staff queried whether complex stroke patients might therefore need to be treated at Glangwili rather than Prince Philip; and expressed concern this might negatively impact continuity of care and delay the start of the rehabilitation process.
- 1.188 On the other hand, the Prince Philip Multidisciplinary team supported the siting of a stroke unit at their hospital, citing strong staffing, infrastructure, and performance locally. Support for this model was also offered by Carmarthenshire Councillors and other Prince Philip staff, though the latter acknowledged a need for additional staffing uplift and resources, especially within therapies, if they are to take on greater responsibilities.

Key overarching issues: removing specialist stroke services from Bronglais

- 1.189 Across northern areas of the Health Board, there was widespread strong opposition to removing the stroke unit from Bronglais given its high performance, centrality to mid Wales (including areas of Powys and south Gwynedd), and community value. The strength of feeling includes the 400 people who attended a public meeting in Aberystwyth run by Protect Bronglais Services, and the 17,883 people who signed a petition

organised by the same group to 'protect full stroke services at Bronglais Hospital and prevent downgrade to Treat and Transfer.'

- 1.190 Consultees across all consultation methods warned that consolidation of services to the south would leave a major geographical gap in specialist stroke care, disadvantaging rural patients. It was frequently stressed that poor road and public transport infrastructure severely limits access from north to south of the Health Board area, with many consultees fearing that the longer journey to the next nearest stroke unit could negatively affect timely access to specialist treatment and recovery support.
- 1.191 Staff members and public and patient drop-in/meeting attendees also feared significant employee attrition if services moved south, not least as staff would prefer to work in a more specialist environment.
- 1.192 There was thus considerable support for developing Bronglais as a centre of excellence for stroke care in mid Wales which, it was said, would attract staff and strengthen local provision.

Key overarching issues: treat and transfer

- 1.193 The proposed treat and transfer model prompted many patient safety concerns, particularly in relation to the 'transfer' element. Many consultees felt that the model lacks evidence for rural settings with poor travel networks and would require substantial additional investment in patient transport, for there was widespread lack of confidence in ambulance and patient transport service capacity to manage timely transfers which, it was felt, may compromise treatment speed and quality, and worsen patient outcomes.
- 1.194 Other key worries were around the challenges of long journeys for often complex and unstable patients (due to increased risk of bleeding/haemorrhage for example), the availability of trained staff escorts to monitor patients, and loss of family support. It was frequently stressed that recovery from stroke is deeply dependent on family involvement and emotional support; and many feared that increased travel as a result of centralisation would compromise this.
- 1.195 Some staff responding via the questionnaire felt the model might make it effectively impossible to comply consistently with Sentinel Stroke National Audit Programme measures, or to carry out certain assessments (e.g., for dysphagia) in a timely manner.
- 1.196 With either option, consultees strongly urged Hywel Dda to better reassure its population around the 'treat and transfer' aspect of its proposals; especially that emergency stroke treatment will remain available at their local hospital. Indeed, many public and patient drop-in event/meeting attendees and written submissions were unclear about the model and were of the belief that emergency stroke care would no longer be available locally.

Key overarching issues: rehabilitation pathways

- 1.197 Some staff members felt that both options lack clarity on rehabilitation pathways and risk stretching already fragile therapy teams. To ensure successful reconfiguration, significant investment was thought to be needed in Early Supported Discharge and community rehabilitation. Indeed, maintaining local rehabilitation units was considered essential in that recovery relies on timely, intensive, multidisciplinary therapy delivered as close to home as possible; and ensuring stroke patients can return to their homes and communities as soon as possible following a hospital stay would, it was felt, help mitigate travel burdens for families and aid recovery.

Alternative suggestions and mitigations

1.198 Consultees proposed several mitigations that could strengthen any chosen model:

- » regional partnerships with Swansea Bay University Health Board to leverage tertiary services at Morriston.
- » ring-fenced stroke beds and enhanced therapy staffing.
- » dedicated stroke transfer vehicles with trained paramedics and guaranteed availability.
- » clear clinical pathways for imaging, monitoring, transfers, and repatriation.
- » fully integrated hospital-to-home pathways, underpinned by robust community, therapy, and social care capacity.
- » telemedicine-enabled pathways to reduce unnecessary transfers.
- » deploying specialist staff across sites to reduce patient travel.
- » family accommodation near specialist centres.
- » examine good practice within stroke services in other rural areas.

1.199 Consultees proposed other potential alternatives and suggestions, including the following:

- » a rural stroke hub for mid Wales at Bronglais providing acute care and rehabilitation capacity in close collaboration with Betsi Cadwaladr University Health Board and Powys Teaching Health Board.
- » a specialist stroke rehabilitation unit at Bronglais, or at the Llanbadarn Campus in Aberystwyth.
- » a north/south model: one centre at Bronglais and one at Glangwili or Prince Philip.
- » configurations involving three stroke units rather than the two proposed.
- » a 24/7 stroke unit at Glangwili, not Prince Philip, as the former is in a central location and has existing on-site emergency and specialist services, concentration of stroke expertise, and stronger imaging and therapy infrastructure.
- » invest in facilities at Glangwili e.g., extend the Gwenllian ward to provide more stroke beds and relieve pressures to transfer patients quickly.
- » retain a stroke unit at Glangwili (perhaps using Padarn Ward, which currently cares for respiratory and general medical patients and could be moved to 'Y Lolfa, an alternative care unit) and provide rehabilitation at Prince Philip.
- » maintain four units: with 24-hour specialist care at Prince Philip and 12-hour care at each of the three remaining hospitals.
- » variations on Option B which would see a 24-hour unit at Withybush instead of Prince Philip (given the latter's proximity to Swansea Bay); or *only* have 24-hour cover at Prince Philip or Withybush.
- » Option A, but with the two units alternating 12-hours of specialist cover to achieve 24-hour provision.
- » stroke consultants working on rotation to cover more sites.
- » implement a phased or hybrid approach based on both Options i.e. start with 12-hour cover at both chosen sites (Option A) and gradually extend to 24-hour care as staffing levels improve.
- » integrated acute and rehabilitation units in each county, ensuring local, person-centred recovery and staffing sustainability.

- » a level 2/therapy-led rehabilitation unit somewhere in the Health Board for patients who need rehabilitation in a 24-hour supported setting but who no longer need medical-led care.
- » a mobile unit for use across the region.

1.200 In addition, the Stroke Association, staff, and some public and patient drop-in/meeting attendees called for clearer alignment with the National Stroke Programme (in collaboration with partner agencies and stroke survivors) before any changes are implemented. On a related note, some questionnaire respondents suggested a more regional or all-Wales approach to stroke care by, for example, creating a regional Comprehensive Regional Stroke Centre (CRSC) at either Morriston or Glangwili.

1.201 For further details, see the stroke sections in the individual consultation method chapters.

Urology

1.202 Urology cares for adult patients with conditions affecting the genitourinary tract system in both men and women (for example, kidneys, bladder) and the reproductive tract in men (such as testicles, penis, and prostate). Urology services are currently provided at all four main hospital sites: Bronglais, Glangwili, Prince Philip, and Withybush. However, current staff shortages mean this model is not sustainable and is leading to longer patient waiting times. To help with this issue, the Health Board is proposing to create a dedicated urology unit at one hospital which would manage all inpatient cases. Prince Philip has been identified as the most suitable site because it allows for close working with endoscopy services at this hospital. It would also provide diagnostics for urgent suspected urology cancer for the whole Health Board area.

Table 9: Consultation options – urology

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

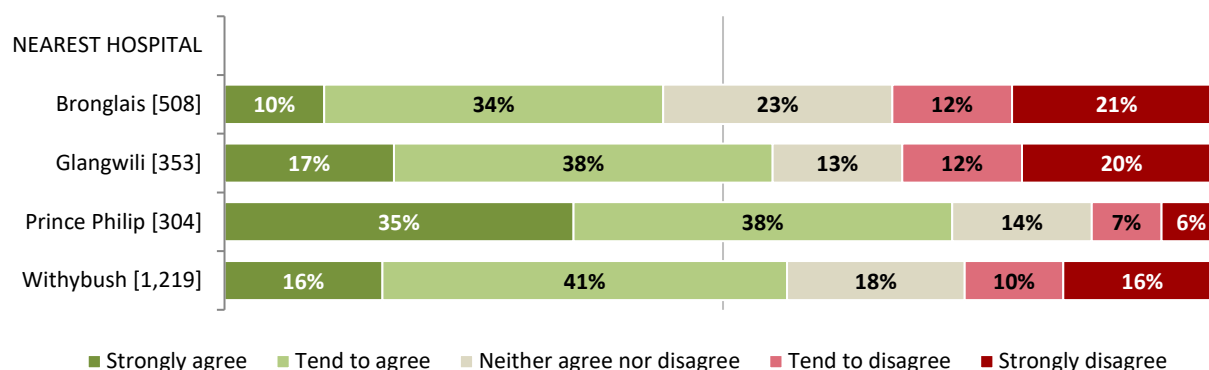
Consultation questionnaire feedback

1.203 Overall, more than half (55%) of respondents agreed with the proposal for urology, although just over a quarter (28%) disagreed³¹.

³¹ 163 respondents selected the 'don't know' option. This is omitted for presentational convenience (standard industry practice) because it does not affect the balance between agreement/disagreement.

- 1.204 There were some differences by area: agreement was higher among respondents whose nearest hospital is Prince Philip, and lower among those whose nearest hospital is Bronglais.

Figure 9³²: To what extent do you agree or disagree with the proposal for urology services? By nearest hospital³³ (individual respondents only, where postcodes were provided)



Base: Number of respondents shown in brackets (excludes 'don't know' responses)

Further feedback on the urology option

Addressing current challenges

- 1.205 There was widespread recognition that the Health Board's current urology service is fragmented, fragile, and difficult to navigate. Consultees consistently highlighted disjointed care pathways, with appointments, tests, and consultations spread across multiple sites, inconsistent communication between relevant teams, long waiting times, and frequent cancellations, and inconsistent consultant presence, causing delays and uncertainty for patients (including those on urgent suspected cancer pathways).
- 1.206 Other issues raised by consultees were around urology nurse specialist shortages, community capacity constraints (e.g., catheter care), underfunded outpatient and support services, high turnover of staff, a lack of dedicated clinical space, insufficient integrated multidisciplinary support; and an over-reliance on telephone consultations which, though convenient for some, were considered unsatisfactory for complex or sensitive discussions.
- 1.207 Despite these challenges, many service users praised the professionalism and compassion of urology staff, emphasising that the main problems relate to system design and logistics, rather than clinical quality.

Views on the urology option

- 1.208 There was considerable support for the proposal to centralise urology diagnostics and treatment on a single site. Some described the single option pragmatically in terms like 'it is what it is.' Others, though, explicitly welcomed the proposed change, recognising the potential benefits for care quality, speed, and coordination, especially in urgent suspected cancer cases; and noting that improved patient experience should outweigh the inconvenience of increased travel. Questionnaire respondents also felt that concentrating services on one site would make optimal use of specialist equipment and staff, therefore providing a more efficient service; and would help with staff recruitment and retention.

³² Where percentages do not add up to 100%, this is due to rounding.

³³ Nearest hospital based on travel time. 504 responses without postcode are not displayed, but are included in the overall results described in commentary prior to the chart.

- 1.209 It was often mentioned that creating a urology ‘centre of excellence’ at Prince Philip makes sense, not only because there is already an existing urology service there, but also because it aligns with the endoscopy service (which would remain at Prince Philip under all proposed options for endoscopy and may be expanded).
- 1.210 Despite broad acceptance, concerns were raised, mainly around travel distances and accessibility. Consultees in rural areas - especially in Ceredigion and northwards toward Gwynedd – suggested that the model may place disproportionate time and cost burdens on older, frail, and low-income patients; and consolidating in a hospital so far to the East was seen as potentially widening geographic health inequalities and reducing timely access to cancer diagnostics. The ‘one-stop-shop’ model was also viewed by a minority as potentially overwhelming or impractical for older or multimorbid patients.
- 1.211 More specifically, the West Wales Renal Service asked how radiology, endoscopy, renal services, and emergency care would align with urology if key components were to be located on different sites. They were concerned that this fragmentation would result in repeated transfers (which would require improvements to ambulance and other patient transfer services) and would likely increase referrals to Morriston, *“where all services are in one place.”*

Alternative suggestions and mitigations

- 1.212 Consultees proposed several mitigations that could strengthen any chosen model.
- » retain some outpatient and follow-up clinics locally, especially for catheter care, minor procedures, and routine reviews.
 - » ensure closer integration with radiology and renal services to avoid unsafe inter-hospital transfers.
 - » strengthen urology nurse specialist teams, enabling triage and community-based management.
 - » provide dedicated urology wards or spaces.
 - » introduce a shuttle bus between hospital sites.
 - » introduce a reimbursement scheme that does not require patients to pay costs upfront or allows them to claim for transport costs subsequently.
 - » explore tele-communications for routine follow up appointments to save unnecessary travel.
 - » co-ordinated appointments on the same day, to ensure smooth running and minimise impact and stress on patients.
 - » ensure changes (and the reasons behind them) are well communicated to the public, and that public health campaigns are used to highlight various urological conditions.
- 1.213 Consultees proposed other potential alternatives and suggestions, including the following.
- » centralise services at Glangwili, to benefit from co-location with emergency general surgery and multidisciplinary support for complex patients.
 - » maintain full urology capability at Bronglais, with shared services elsewhere for southern patients.
 - » provide full urology services at Witybush as well, or consolidate there instead.
 - » provide a bespoke urology unit for diagnostics and treatment.
 - » a rotational consultant model.

- » Weekly or monthly urology outreach clinics at Bronglais, Glangwili, and Withybush, prioritising patients who are unable to travel far.
- » establish local specialist nurse-led urology services, ensuring continuity and reducing travel for vulnerable patients.
- » mobile diagnostics, e.g. a mobile scanning unit which could provide basic diagnostics in more remote communities.
- » consider radiotherapy provision within Hywel Dda to reduce travel to Singleton Hospital.
- » locate a urology investigations unit near Derwen Ward in Glangwili.
- » use Ysbyty Enfys in Carmarthen for medically optimised patients.

^{1.214} For further details, see the urology sections in the individual consultation method chapters.

Future roles of the main hospital sites

^{1.215} Any changes made to the nine clinical service areas following the consultation may impact on how services are organised at Hywel Dda's main hospitals. As a result, the four hospitals could look like this:

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

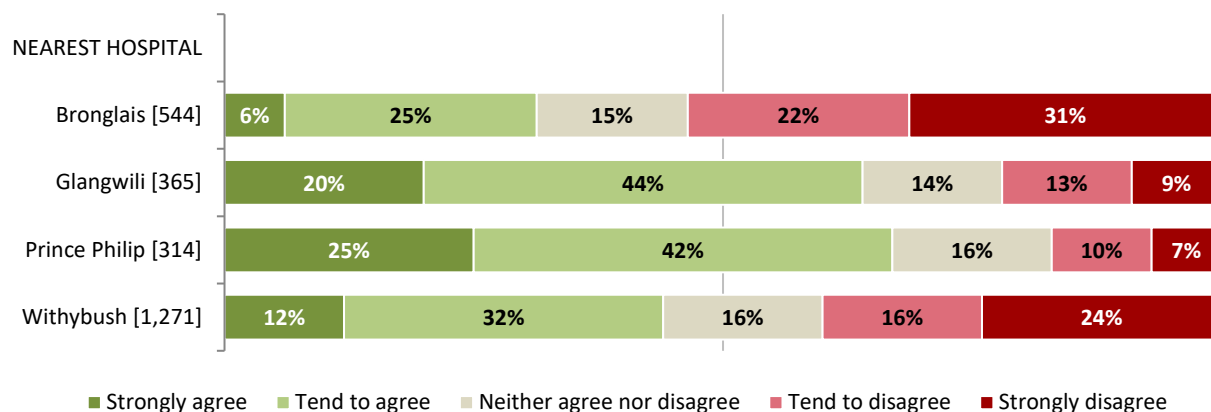
Consultation questionnaire feedback

^{1.216} Overall, nearly half (47%) of respondents agreed with the proposed roles for the hospital sites, though over a third (36%) disagreed³⁴.

^{1.217} There were clear differences by area: agreement was higher among respondents whose nearest hospital is either Prince Philip or Glangwili, and lower among those whose nearest hospital is Bronglais or Withybush.

³⁴ 82 respondents selected the 'don't know' option. This is omitted for presentational convenience (standard industry practice) because it does not affect the balance between agreement/disagreement.

Figure 10³⁵: To what extent do you agree or disagree with the roles of the hospital sites as described above, to support making services safer and sustainable for the future? By nearest hospital³⁶ (individual respondents only, where postcodes were provided)



Base: Number of respondents shown in brackets (excludes 'don't know' responses)

Further feedback on the future roles of the main hospital sites

Overall feedback

- 1.218 Where the proposals were supported, this tended to be on the basis that they should provide better clarity on each hospital's role; reduce waiting times by separating emergency and planned cases; enable more efficient throughput of cases; support regional working; and allow staff to work from single centres as part of bigger teams, thereby providing safer services, improving experience and morale, and aiding recruitment. Some consultees acknowledged there might be some 'trade off' in terms of patients and visitors needing to travel further; however, this was considered a reasonable compromise to ensure the best possible quality of care.
- 1.219 On the other hand, large numbers of consultees across all activities expressed strong concerns about the implications of additional travel. It was suggested that the proposed overall model is more suited to urban than rural areas, and that that it risks patient safety by requiring too many transfers over considerable distances. There were additional, widespread concerns about negative impacts for the Welsh Ambulance Service and patient transport; and worries around road infrastructure, public transport, and hospital car parking were prevalent. Frequently, this led respondents to advocate for as many services as possible to be available at their local hospital, or in all hospitals.
- 1.220 There was also some concern that focusing too much emergency and urgent care at one site might have unintended, negative impacts, such as: creating a single, overwhelmed emergency department; creating 'bottlenecks' in the system; and deskilling at the sites where there is less emphasis on acute care, which might leave them less able to care for very sick patients.

Views on the roles of specific hospitals

- 1.221 Some consultees specifically supported the proposals insofar as they affect one or more of the main hospitals. For example, there was strong support for Bronglais continuing to provide many services as it

³⁵ Where percentages do not add up to 100%, this is due to rounding.

³⁶ Nearest hospital based on travel time. 498 responses without postcode are not displayed, but are included in the overall results described in commentary prior to the chart.

does currently, based on the large, rural area it serves. However, many consultees perceived that Bronglais was being downgraded; the loss of the stroke unit was seen as unacceptable, and there were concerns about the distances patients may need to travel to access some specialties, due to its relatively isolated location.

- 1.222 The proposals for Withybush were said by some to strike a suitable balance between local access and safety. Nonetheless, many highlighted issues with roads and public transport in Pembrokeshire, as well as an ageing population, heavy industry, and large numbers of holidaymakers. As with Bronglais, some respondents perceived that the hospital was effectively being ‘downgraded.’ It was also said that ongoing uncertainty over the future of the proposed new hospital (around St Clears or Whitland) justified more services being maintained at or returned to Withybush.
- 1.223 Questionnaire respondents living nearest Prince Philip frequently said that the size of Llanelli justifies the hospital having more rather than fewer services. While there was support for developing Prince Philip as a centre for planned care, a number of respondents also felt that acute and emergency services should also be reinstated at the site.
- 1.224 Other consultees felt that fewer services should be maintained at Prince Philip, due to it being less accessible from the north and west of the Health Board, and also relatively close to hospitals in Swansea. However, some expressed concerns that services in Swansea Bay were too busy to accommodate additional patients or accessing services in another health board might lead to disjointed care. This prompted some calls for greater clarity on what, if any, regional cross-border arrangements might be possible.
- 1.225 Glangwili was said to be the most centrally located of the Health Board’s main hospitals, and therefore a good option for centralising services. In particular, various consultees felt it might be more appropriate to undertake certain planned procedures at Glangwili rather than Prince Philip due to its better intensive care provision, while others felt it might be a more appropriate choice to deliver acute stroke care. Nonetheless, many had concerns about accessing the site, with others highlighting issues such as ageing buildings, a lack of space to expand, and limited parking.
- 1.226 It was suggested by a few questionnaire respondents that the proposals do not go far enough and that a more radical approach, in which services are consolidated further (e.g. on one ‘main’ hospital site), might be more likely to obtain the required outcomes. Some other specific suggestions were as follows:
- » Bronglais should be expanded and promoted as a rural health centre for mid-Wales, or a new hospital should be built in the Bow Street area.
 - » a new hospital should be built in south-West Wales e.g. in Whitland, St Clears, or Narberth.
 - » services should be reduced at Glangwili and strengthened at the other three sites.
 - » there should be two acute sites (Bronglais and Glangwili) and two planned care sites (Prince Philip and Withybush).
 - » all four hospitals should provide similar care, but with more specialisms centralised in Swansea.
 - » one or both of Glangwili and Prince Philip should close, with a ‘super hospital’ built in the Swansea area.
 - » Glangwili should be the ‘main hospital’ with the others as ‘community hospitals.’

- » a model whereby some specialisms are more centralised (e.g. all orthopaedic treatment at one hospital, all gastrointestinal services at another) but intensive and emergency care is retained at all sites.

Key overarching issues: travel and transport

- 1.227 Travel and transport was the dominant theme across all consultation methods, both generally and in relation to the main hospitals. Various transport mitigations were suggested in the event of the proposed model of care being implemented, such as providing better community, patient, volunteer or other third-party transport; park and ride services; shuttle buses between hospitals; improved public transport; and ring-fencing funding for inter-hospital transfers and transport for outpatients.
- 1.228 In addition, many consultees felt that better use of AI, the internet, and telemedicine is essential and may mitigate some transport issues. A couple of questionnaire respondents expressed disappointment that more details around this had not been provided within the consultation materials.
- 1.229 Various other comments were made, covering a wide range of suggestions and mitigations, such as:
- » longer opening hours is generally a good approach, as is combining services so patients can 'get more' out of a single visit by having multiple investigations/examinations.
 - » it would be sensible to maintain 24/7 teams of experienced general clinicians at each site who can assess patients prior to their onward journey by ambulance or car, which may allay some community fears around losing services.
 - » there is a need to consider the use of mobile units, a system where staff rotate across different sites, and the creation of a 'pool' of staff for various specialisms, with staff able to travel quickly to whichever hospital needs them.

Key overarching issues: regional working

- 1.230 There was some suggestion that a more regional, or even all-Wales approach, might be more appropriate for planning and commissioning health services. Some wondered if existing health board boundaries should be re-assessed, perhaps allowing the Llanelli area to join with Swansea Bay, or areas around Bronglais to either join with Betsi Cadwaladr or, more commonly, to form part of a new mid-Wales health authority.

Key overarching issues: community hospitals and other local services³⁷

- 1.231 Some consultees made suggestions around the role of community facilities in supporting the services provided at the four major hospitals. For example, it was said that:
- » local hospitals and urgent care centres could play an enhanced role in offering minor procedures or outpatient appointments; or house rehabilitation facilities and residential care beds to reduce 'bed blocking' at the major sites.
 - » community-based early intervention and a greater emphasis on prevention might help relieve pressures on hospital services.
 - » a closer, more co-operative integrated system of care between hospitals, GPs, clinics, nurses, bed providers, care homes, local authorities etc., would be advantageous.

³⁷ These are suggestions for the configuration and delivery of wider services, some of which is outside the scope of the CSP.

1.232 Some more specific suggestions were as follows:

- » re-open the MIU at Llandovery Hospital to relieve pressure on emergency services at Glangwili and make better use of existing facilities.
- » create more integrated clinical centres or care hubs, offer additional services from locations such as Aberaeron and Cardigan ICCs, Amman Valley Hospital and others, and repurpose other appropriate sites.
- » GPs could provide weekend appointments and offer more basic procedures to relieve pressures on hospitals; and nurse-led community hubs could offer advice and minor procedures.
- » consider the use of private hospitals to reduce waiting times.
- » provide a convalescent unit or hospital, allowing discharge of patients too unwell to go home but not requiring nursing.

Key overarching issues: the workforce

1.233 It was frequently said that, if the problems facing clinical services are linked to workforce issues, then staff recruitment and retention are obvious areas on which to focus improvements.

1.234 Some specific ideas and suggestions to address workforce issues included: offering more training posts to aid career progression; reinstating routes that allow nursing staff to progress by gaining experience and demonstrating competence, rather via university qualifications; using pay incentives like rural uplifts and other incentives to reduce absence; more collaboration with Aberystwyth University to attract staff; taking steps to encourage more applications from outside Wales; and negotiating with local authorities to build accommodation to attract staff.

Cross-cutting consultation themes

Consultation questionnaire feedback

1.235 A final, open-ended question invited questionnaire respondents to share any additional feedback they might have. Many of the comments reiterated themes that have already been outlined in relation to individual services, for example:

- » concerns around travel and accessibility, including roads, public transport, parking, and ambulance availability.
- » general opinions - both positive and negative - on the proposed model of care and on the proposals for specific services.
- » the importance of retaining or reinstating services at particular hospitals (e.g., A&E and ICU at Prince Philip; Paediatric Ambulatory Care Unit (PACU), midwifery, and inpatient paediatrics at Withybush).
- » suggestions relating to the workforce such as upskilling doctors and nursing, improving training, reducing reliance on agency staff.
- » improvements to transport like park and ride facilities or shuttle buses.
- » other possible mitigations to minimise travel, such as more use of telemedicine, and better co-ordination between departments so patients can attend multiple appointments in one visit.
- » The need for improvements in community-based care.
- » more radical alternatives involving, for example, more regional working, and the establishment of new hospitals.

1.236 More detailed or specific feedback raised across the other consultation methods is considered below.

Feedback from other consultation methods

1.237 While consultees differed in the extent to which they supported the proposed direction of travel and options for clinical services, there was broad alignment on the practical challenges facing implementation, particularly in a rural context. The themes below represent the most significant issues raised across the qualitative engagement activities.

Travel, transport and accessibility

1.238 Travel and transport emerged as the most dominant theme across all consultation methods. Consultees consistently stressed that long distances, poor public transport, limited hospital parking at all main sites, and rural road conditions present major barriers to accessing care, especially if services are consolidated onto fewer hospital sites. Concerns extended to patient transfers, with particular anxiety about the current strain on the Welsh Ambulance Service University NHS Trust (WASUT) and the feasibility of increased inter-hospital movement.

1.239 Communities emphasised that travel difficulties affect not only patients but also carers, family members and staff. Many felt that sustainable transport solutions must be established before any service changes are implemented. Many consultees were especially vocal about the mismatch between proposed clinical models and the realities of rural geography.

Workforce challenges

1.240 Workforce issues were consistently cited as a critical risk to the success of any future service model. Staff, councillors, special interest groups and submissions highlighted long-standing recruitment and retention difficulties, particularly in rural areas. Consultees questioned whether centralising services would exacerbate shortages, place additional travel burdens on staff and intensify pressure on already overstretched teams.

1.241 There was broad agreement that new service configurations must be underpinned by credible workforce plans, including local training pathways, incentives for rural recruitment, sustainable rotas and investment in staff accommodation, development and infrastructure. Many staff emphasised that proposed pathways could not be delivered without significant additional workforce capacity.

Condition and suitability of hospital sites and infrastructure

1.242 Consultees highlighted the ageing condition of many hospital buildings across Hywel Dda, with Withybush and Glangwili frequently described as needing significant investment. Concerns centred on insufficient physical capacity, outdated infrastructure, and limited ability to support major service reconfigurations without phased capital development.

1.243 Parking emerged as a key issue across all hospital sites, with fears that concentrating services on these sites would create unmanageable congestion and further hinder access.

Interdependencies between services

1.244 Some questionnaire respondents felt there might be unacknowledged impacts on services not covered as part of the CSP, such as trauma and emergency care, general medicine, nuclear medicine, anaesthetics,

psychology and mental health services; noting that many services overlap or are closely linked to one another, so ought not to be considered in isolation.

- 1.245 Similarly, staff, councillors and some community groups raised concerns about the interdependencies between acute, specialist and diagnostic services. Many felt that reviewing clinical areas in isolation risked fragmented care, exacerbating service fragility, or destabilising core functions like General Internal Medicine. Several staff members emphasised the importance of understanding how changes to emergency care, stroke, critical care and surgical pathways would interact across sites.
- 1.246 Regional effects were also noted: neighbouring health boards and councils highlighted the potential impact of change on patient flows, workforce distribution and cross-border pathways, underscoring the need for co-ordinated planning across mid and west Wales.

Digital access and inclusion

- 1.247 While staff, external partners, and some members of the public welcomed digital tools and virtual consultations, there were some concerns that digital solutions cannot replace face-to-face care for many groups. Older people, residents living in more rural areas with poor connectivity, and people with disabilities or limited digital literacy were considered at risk of exclusion if reliance on technology increases without appropriate support. Consultees encouraged a blended model, with digital options complemented by robust non-digital alternatives and improved digital literacy support.

Public confidence, communication and transparency

- 1.248 A recurring theme across engagement with members of the public, service users, councillors and on social media was low confidence in the consultation process and a perceived lack of transparency. A number expressed concern that decisions had already been made, that consultation materials were too complex, and that meaningful engagement was limited by inaccessible formats, time pressures and consultation fatigue.
- 1.249 There were calls for clearer communication of clinical reasoning, evidence, modelling and cost implications; plain-language updates; and stronger assurance that feedback will shape final decisions. There was also appetite for greater honesty about the constraints facing the Health Board and the trade-offs required to deliver sustainable services.

Local versus centralised care

- 1.250 While many consultees prioritised local access - particularly for urgent or high-frequency services - others acknowledged the benefits of travelling further for specialist expertise or shorter waiting times. This tension was evident across events: some saw consolidation as necessary to ensure safety and sustainability; others perceived it as inequitable and potentially harmful for rural communities. The need to balance local provision with high-quality specialist care was a prominent and nuanced theme.

Staff morale

- 1.251 Staff across all sites emphasised that service uncertainty is affecting morale, retention, and confidence in future planning. Some expressed concern about the fairness of asking staff to commute longer distances or work across multiple sites, particularly in rural parts of the region. Others emphasised that staff perspectives have not always been adequately reflected in early decision-making, that successful

implementation requires genuine clinical involvement and realistic timelines, and that the process is ‘taking too long’.

Views on the consultation process

1.252 Councillors, community organisations, and individual submissions noted that in some cases the complexity of the CSP options made it difficult to evaluate impacts and provide informed responses. Many requested clearer modelling around ambulance capacity, transfer requirements, workforce availability, estates constraints and financial sustainability. Without this, some consultees felt unable to fully understand the feasibility of the options or compare them meaningfully.

Alternative suggestions and mitigations

1.253 Consultees proposed several further alternative suggestions or mitigations, including:

- » expanding community-based services, mobile clinics and GP-based procedures.
- » developing week-long, multi-specialty clinics at each hospital.
- » enhancing digital infrastructure and virtual care capacity.
- » introducing direct inter-hospital transport links or patient transport services.
- » exploring cross-border pathways into England where transport links are stronger.
- » creating community-level ICCs.
- » aligning service change with capital investment and workforce incentives.
- » reviewing and reducing the management structure, enabling more funding for the direct provision of care.
- » maximising patient choice and flexibility, for example by allowing those who are willing to travel further afield to do so.

Considering equalities and human rights

1.254 Feedback from across the consultation methods identified a range of groups who may be positively or negatively impacted by the proposals. While the nature of the impacts varied, concerns consistently centred on travel, transport, accessibility and the potential consequences of relocating or reconfiguring services. The themes below summarise the key issues raised for each equality group.

1.255 We note that travel, transport, and accessibility emerged as the most significant and universal concern across all potentially affected groups. Consultees emphasised that increased travel distances - combined with limited public transport, low car ownership in some areas, and high fuel or taxi costs - pose barriers to equitable access. These barriers were said to fall most heavily on older adults, disabled people, those with chronic conditions or cognitive impairment, carers, and families with limited financial means. Long or complex journeys were also described as unsafe or impractical for some groups, with staff warning that further centralisation could unintentionally disadvantage large segments of the population.

Older people

1.256 Older people were the group most frequently identified as potentially adversely affected. Over half of questionnaire respondents who specified an impacted group mentioned older adults, and this concern was echoed across all other consultation methods.

1.257 Consultees highlighted that many older residents are frail, have reduced mobility, and rely heavily on local support networks to attend appointments or engage in ongoing care. Increased travel distances, combined

with limited public transport and the practical difficulties of undertaking complex journeys, were seen as significant barriers.

- 1.258 It was also suggested that longer trips may reduce family involvement in treatment and rehabilitation, potentially undermining recovery, continuity of care, and overall wellbeing. Staff also warned that further centralisation of services could unintentionally disadvantage older people who are least able to manage long or unfamiliar journeys.

Disabled people and those with cognitive or mental health conditions

- 1.259 Disabled people were frequently identified as at risk of disproportionate impact, with around a quarter of relevant questionnaire respondents and many consultees across the other consultation methods highlighting this group. Feedback highlighted that many disabled individuals already experience difficulty accessing healthcare and rely on multiple clinical services. Increasing the distance between patients and providers was considered likely to exacerbate these existing challenges.
- 1.260 Consultees representing people with cognitive impairments or mental health conditions raised particular concerns. It was said that those living with dementia may experience confusion or anxiety when travelling to unfamiliar or distant sites, and that their carers could face greater burden through the need for more frequent and longer journeys. Mental health staff from Glangwili also emphasised the potential disruption to continuity of care for service users with mental health conditions. A small number of respondents further noted potential impacts on people who are neurodiverse.

People on low incomes (including non-drivers/public transport users)

- 1.261 Low-income households were identified as another group facing potential barriers. Respondents highlighted that increased travel distances, high fuel costs, limited access to cars, and expensive taxi fares could restrict equitable access to healthcare for those already experiencing financial hardship. These issues were seen as particularly acute in rural areas where public transport is limited or unavailable. The cumulative cost of multiple visits - for treatment, rehabilitation or to support family members - was raised as a major concern that could deepen existing inequalities.

Rural and geographically remote communities

- 1.262 A strong theme across the consultation was the perceived geographic inequality between parts of the region, particularly between Pembrokeshire and Carmarthenshire. Many members of the public described a long-term shift of services eastward, with Withybush perceived as losing capability while Glangwili benefits from investment. It was argued that this imbalance risks disadvantaging remote or rural communities whose needs may not be fully reflected in decision-making.
- 1.263 Bronglais service users, including those in parts of Powys and south Gwynedd, were also highlighted as potentially disproportionately affected due to significant distances to alternative hospitals. Patients and staff warned that long, unfamiliar or complex journeys - particularly in areas with limited transport options - could be unsafe or impractical for some residents.

Carers, families, and support networks

- 1.264 Across the consultation, carers and family members were consistently identified as groups who may face increased burden under the proposals. Respondents emphasised that carers play a vital role in supporting

older, disabled, and acutely unwell patients, and that longer travel distances could reduce their ability to attend appointments, provide emotional support, or participate in rehabilitation.

- 1.265 Protect Bronglais Services (PBS) and others linked these concerns to human rights considerations. They argued that the Equality Impact Assessment (EIA) does not fully reflect the implications of separating patients from their support networks or the physical, emotional and financial strain associated with long-distance travel. Concerns were also raised that the EIA insufficiently considers geographic, socio-economic, cultural and linguistic factors, as well as the specific impact of the 'treat and transfer' model on patients and their families.

Parents and pregnant women

- 1.266 Around a tenth of questionnaire respondents and some consultees across the other consultation methods identified people with children as likely to be affected. It was argued that it is less reasonable to expect families to undertake long journeys, particularly when managing childcare responsibilities or attending appointments with young children.
- 1.267 A few consultees also raised concerns about pregnant women, who may face additional stress or risk when travelling further for maternity-related care.

Other groups mentioned less frequently

- 1.268 Some respondents highlighted additional groups who might be affected, including vulnerable individuals generally, and staff who may be required to relocate or work longer hours as a result of service changes.

Suggested mitigations

- 1.269 While comments on mitigations were less frequent, some participants suggested measures such as improving public transport links, enhancing ambulance capacity, addressing staffing challenges, or maintaining current service configurations to protect accessibility. For further details, see the relevant chapters.

Considering Welsh language impacts³⁸

- 1.270 Language and cultural accessibility emerged as a significant concern for Welsh speaking patients if services are moved to areas where the language is not widely spoken. For example, Bronglais Hospital was frequently cited as an example of good practice, with staff perceived as willing and confident to use Welsh; whereas experiences at Glangwili, Prince Philip, and Withybush were often described less positively in terms of Welsh language availability.
- 1.271 In this context, consultees across several consultation methods emphasised that the ability to receive care through the medium of Welsh is essential from both a moral and legal perspective: Hywel Dda must consider the Welsh Language Standards in all aspects of its service provision, and the need to meet these Standards was stressed. Neglecting Welsh language impacts could, it was said, negatively affect the patient experience, participation in care, and health outcomes. Moreover, it was said that families often act as advocates in Welsh; and having to travel longer travel distances might remove this support.

³⁸ Hywel Dda's Equality Impact Assessments can be found here: <https://hduhb.nhs.wales/about-us/healthier-mid-and-west-wales/clinical-services-plan-consultation/supporting-documents/>

- 1.272 Many comments around Welsh language impacts were given in the context of stroke services, especially as after a stroke, patients often revert to their mother tongue and may lose the ability to communicate in English. Consultees, including the Stroke Association, stressed that effective rehabilitation - especially for those with conditions such as aphasia - requires communication in the patient's preferred language, and that this should cover triage, assessment, consent, therapy, and discharge planning, both in-person and digitally. This was a particular concern for the patient population of Bronglais, among which is a high proportion of Welsh speakers.
- 1.273 Some questionnaire respondents also considered intersectionality, linking linguistic disadvantage with age, frailty, disability, and rural isolation - characteristics that, when combined, compound equality impacts for patients.
- 1.274 There were calls for a dedicated Welsh Language Impact Assessment and assurances that bilingual provision would be maintained and protected. Indeed, Aberystwyth Town Council explicitly stated that the Health Board should uphold the principles of the Welsh Language (Wales) Measure 2011 and the Welsh Language Standards by ensuring it can always provide an 'active offer' of Welsh-medium care, especially at Bronglais.
- 1.275 We would note that while the need to protect Welsh language provision was the more dominant theme across the consultation methods, some consultees - especially in the consultation questionnaire - argued that Welsh language requirements deter recruitment and may reduce service quality. There were strong concerns that 'Welsh preferred' and other language requirements may discourage applications from overseas clinicians especially, particularly specialists who are in short supply. Comparisons were made with the use of interpreters for other languages, with a few people suggesting that Welsh should be treated similarly in areas where the language is not widely spoken.

Appendix 2: Table of figures

Figure 1: Which option for critical care services do you believe best meets the Clinical Services Plan objectives, considering patient care, accessibility, and outcomes? By nearest hospital (individual respondents only, where postcodes were provided)	10
Figure 2: Which option for dermatology services do you believe best meets the Clinical Services Plan objectives, considering patient care, accessibility, and outcomes? By nearest hospital (individual respondents only, where postcodes were provided)	15
Figure 3: Which option for emergency general surgery services do you believe best meets the Clinical Services Plan objectives, considering patient care, accessibility, and outcomes? By nearest hospital (individual respondents only, where postcodes were provided)	18
Figure 4: Which option for endoscopy services do you believe best meets the Clinical Services Plan objectives, considering patient care, accessibility, and outcomes? By nearest hospital (individual respondents only, where postcodes were provided)	21
Figure 5: Which option for ophthalmology services do you believe best meets the Clinical Services Plan objectives, considering patient care, accessibility, and outcomes? By nearest hospital (individual respondents only, where postcodes were provided)	25
Figure 6: Which option for Orthopaedic services do you believe best meets the Clinical Services Plan objectives, considering patient care, accessibility, and outcomes? By nearest hospital (individual respondents only, where postcodes were provided)	29
Figure 7: Which option for radiology services do you believe best meets the Clinical Services Plan objectives, considering patient care, accessibility, and outcomes? By nearest hospital (individual respondents only, where postcodes were provided)	34
Figure 8: Which option for Stroke services do you believe best meets the Clinical Services Plan objectives, considering patient care, accessibility, and outcomes? By nearest hospital (individual respondents only, where postcodes were provided)	38
Figure 9: To what extent do you agree or disagree with the proposal for urology services? By nearest hospital (individual respondents only, where postcodes were provided)	43
Figure 10: To what extent do you agree or disagree with the roles of the hospital sites as described above, to support making services safer and sustainable for the future? By nearest hospital (individual respondents only, where postcodes were provided)	46