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Bwrdd Iechyd Prifysgol  
Hywel Dda  
University Health Board

## CLINICAL SERVICES PLAN (CSP)

### Sprint 3

(13<sup>th</sup> and 14<sup>th</sup> June 2024)

## SUMMARY REPORT

8<sup>th</sup> July 2024

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## Executive Summary

### Introduction

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

The aim and objectives of Sprint 3 were to receive and consider the recommendations from the Clinical Reference Group (CRG), refine Option Two and further develop the four Draft Options. The role of the Clinical Reference Group is to provide a multi-professional clinical view and advice to support the Health Board's plans.

Sprint 3 was attended by clinicians, operational leads of the nine specific clinical services and staff members and stakeholders representing interdependent services.

### Methodology

The Sprint commenced with an overview of the aim and objectives of the Clinical Services Plan (CSP) programme. A summary of the legal and regulatory requirements was provided to ensure the CSP programme's compliance, emphasising the importance of lawful and ethical inclusive service reconfiguration through case law examples. Participants were reminded of their role in representing their services and contributing to the iterative process of developing and evaluating options.

During Sprint 3, the Option Development Groups heard recommendations from the Clinical Reference Group and as a room agreed that Options One, Three, and Four move to the shortlist.

Feedback from continuous engagement was presented, and Draft Option Development Groups addressed questions on service delivery, space, staffing, patient care, and barriers to accessing care, ensuring comprehensive planning to facilitate the application of the evaluation criteria for each option.

The CRG recognised that Option Two had not met the Hurdle Criteria, however, did believe it presented unique attributes. Option Two was reviewed and changes made. It was again assessed against the Hurdle Criteria and although it passed the room, it did not pass for the Stroke configuration. Upon reflection it was agreed that Stroke representatives, and other colleagues from allied health services join Option Development Group Two to conduct further work on this option. After this work, Option Two was again assessed against the Hurdle Criteria, by all participants using the technological methodology and was agreed as meeting this Criteria to move to the Shortlist.

### Results

Four Draft Options for the reconfiguration of the nine clinical services have been further developed.

### Next Steps

It has been agreed to expand the timeline to allow additional time to further develop the four options, allowing for the Strengths, Weaknesses, Opportunities and Threats (SWOT) analysis to take place at a virtual meeting in early July, with the finalisation of this in September followed by an in person workshop on the 6<sup>th</sup> September to score the finalised options.

## Introduction

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

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

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

### **Aim**

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

### **Objectives:**

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

Sprint 3 was a two-day event held on 13<sup>th</sup> and 14<sup>th</sup> June with the purpose of considering the Clinical Reference Group recommendations to the shortlist of options. The role of the Clinical Reference Group is to provide a multi-professional clinical view and advice to support the Health Board's plans.

Sprint 3 also sought to refine Option Two and to further develop the shortlisted options by adding a more detailed description. Following 14<sup>th</sup> June, it was suggested by the Transformation Programme Office who help manage the Options Development Process, seeking advice from the Consultation Institute (tCI) and agreed by the Clinical Services Plan Steering Group, that this phase be extended until the 28<sup>th</sup> June.

Sprint 3 was attended by clinicians, operational leads of the nine specific clinical services and staff members and stakeholders representing interdependent services:

### **Thursday 13<sup>th</sup> June:**

- 56 staff members including service, interdependent services and support services representatives
- A WAST Representative
- A Swansea Bay University Health Board Representative

- Two Welsh Government Representatives
- Two Trade Union Representatives
- Two Health Board Executives
- 11 Transformation Programme Office/Engagement team members
- A tCI representative to facilitate

**Friday 14<sup>th</sup> June**

- 47 staff members including service, interdependent services and support services representatives
- A Welsh Government Representative
- Two Trade Union Representatives
- A Health Board Executive
- Nine Transformation Programme Office/Engagement team members
- A tCI representative to facilitate

## Methodology

### Approach

The Sprint commenced with Lee Davies, Executive Director of Strategy and Planning welcoming attendees and reminding them of the aim and objectives of the Clinical Services Plan programme.

To ensure confidence and understanding of the process employed for the CSP programme the Consultation Institute (tCI) provided an overview of legal and regulatory requirements to ensure compliance and quality of care. It was explained by adhering to the requirements Hywel Dda can ensure that their reconfiguration of services is conducted lawfully, ethically, and in the best interests of the population it serves. To further illustrate, case law examples were provided where organisations have been successfully legally challenged on their options development processes.

Participants were then reminded of the progress to date which has been iterative, utilising the professional experience of those in the room and underpinned by continuous engagement and check and challenge. This has included:

- Sense checking the issues of the current clinical services
- Service reconfiguration consideration
- Draft Options Development
- Hurdle Criteria Development
- Evaluation Criteria Development

There was then an emphasis on the role and expectation of those in the room as nominated representatives of their service or area across the Health Board, to actively participate and contribute with the agreed Options Development methodology, and actively engage with their service to represent a collective view.

The objectives of Sprint 3 were to:

- Receive and consider Clinical Reference Group recommendations
- Refine Option Two
- Further develop (detailed description) of the shortlist of options

Sprint 2 had ended with the Options being assessed against the Hurdle Criteria. Options One to Four met the room majority but not the service majority as established necessary to move from the longlist to the shortlist. Option Five failed to meet both the room majority and service majority necessary to meet hurdle criteria.

Following from Sprint 2 and ahead of Sprint 3, missing service representatives were engaged to ensure representation to establish the two-thirds service majority. Not all services had the 3 representatives required present during the hurdle appraisal. Additional responses were sought from Ophthalmology, Orthopaedics and Stroke. Dermatology and Urology had consensus views therefore a third representative response was not sought for these services as the majority had been met. The Clinical Reference Group (CRG) was asked to

provide their recommendations and advice to the Option Development Groups ahead of Sprint 3 on Options One to Four to enable the finalisation of the Options shortlist.

Feedback provided through the continuous engagement channel was presented to the room by Ben Rogers, Principal Programme Manager, Transformation Programme Office. An audio of the voices of children and young people was played to the room. The audio was developed via a series of interviews with Ophthalmology, Dermatology and Radiology patients when they attended wards and clinics. The full interviews were also made available to participants after the session.

### Clinical Reference Group Options Review

The Option Development Groups heard the recommendations from the CRG presented by Dr Eiry Edmunds, Interim Medical Director, and as a room agreed that:

- Option One moves to the shortlist.
- Option Three moves to the shortlist.
- Option Four changes the Critical Care configuration to the same model as in Option Three and moves to the shortlist.
- Option Two had failed to meet the Hurdle Criteria for Stroke, the CRG recognised that there were unique attributes to this option and recommended, with the help of Stroke colleagues the Option should be reworked.

### Option Two Review

In plenary discussion, Option Two was reviewed with changes made and another opportunity for participants to assess against the Hurdle Criteria; results are in Appendix 1.

To assess the Hurdle Criteria participants used the same method as previous Sprints. They were provided with a QR Code to scan using their mobile device to access an online survey and record from their professional perspective if the option met each Hurdle Criterion:

- Clinically Sustainable
- Deliverable
- Accessible
- Strategically Aligned
- Financially Sustainable

Option Two was assessed by the room as meeting the Hurdle Criteria. However, for the Clinical Service of Stroke it did not pass the Hurdle Criteria. Following reflections on Day 2, representations were made that there were elements of this Option that were significantly unique and different from the other options, and it was agreed that further development of the Option should continue so as not to lose these attributes. It was deemed that this was a fair and reasonable application of the process with the need to consider different possible alternatives.

On Day 2 a number of colleagues representing Stroke, Therapies and Primary Care were asked to join Option Two Development Group to reconfigure this option. After this work the Group again presented the reworked option in plenary and the Option was reassessed using the same technological approach of the online survey which resulted in the Option passing the Hurdle Criteria and moving to the Shortlist.

#### Draft Options Detailed Development

Option Development Groups worked together to address a series of questions to understand the difference between how the service is delivered now and how it will be delivered in each of the Options:

- Where the service will be provided from
- The space that you provide services in
- The staff
- The patients
- Addressing the barriers to accessing care

Participants were reminded that this was not an opportunity to reconfigure the options, but to add the detail to provide a model of how it would operate.

The development of the options will continue on 21<sup>st</sup> June for Option Group Two and on 28<sup>th</sup> June for all the options. In addition, participants will focus on criteria data gathering and Impact Assessment screening with the support of the relevant teams. A separate output report will be produced on the final output.

## Next Steps

Sprint 3 has been supplemented by the addition of time to produce detailed options. As a result, the process timeline has been extended to September 2024 to provide sufficient time to conduct a Strengths, Weaknesses, Opportunities and Threats (SWOT) analysis followed by the scoring of the Options.

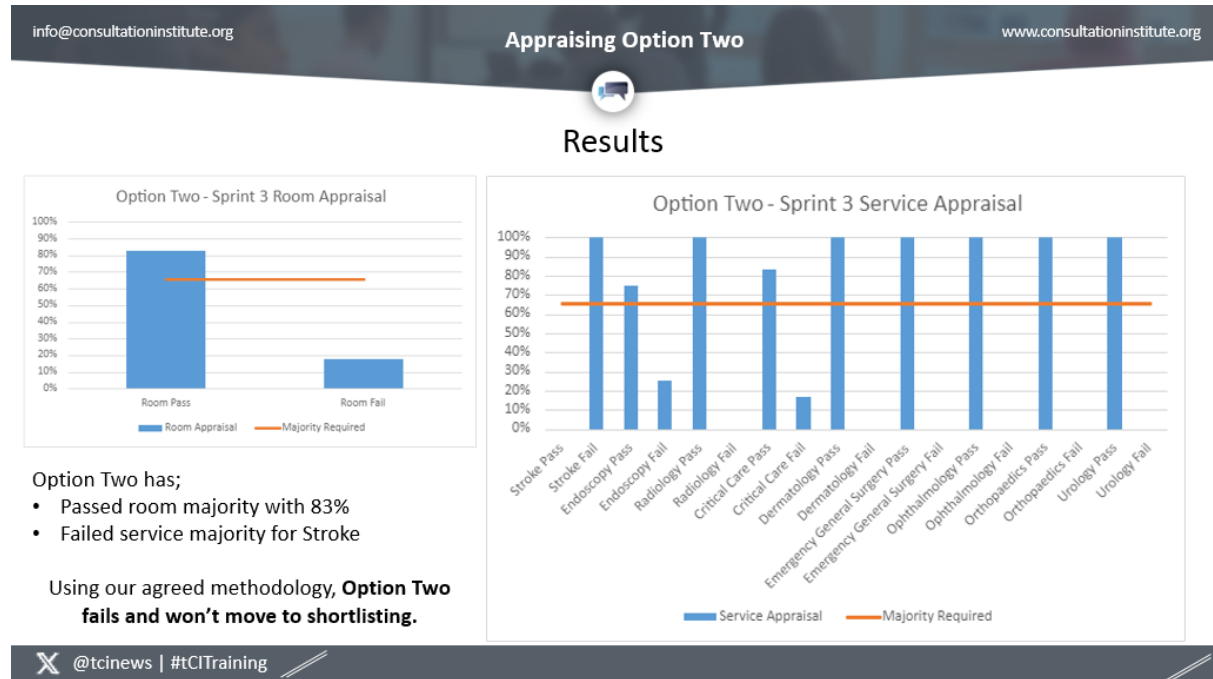
### Key Dates:

- 21<sup>st</sup> June
  - Further development of Option Two
  
- 28<sup>th</sup> June
  - Further development of all options
  - Impact assessments
  
- 9<sup>th</sup> July
  - Check and challenge feedback
  - Completion of the SWOT analysis templates for Options One to Four
  
- 5<sup>th</sup> September
  - Finalise the SWOT analysis for all options
  
- 6<sup>th</sup> September
  - Scoring of the options

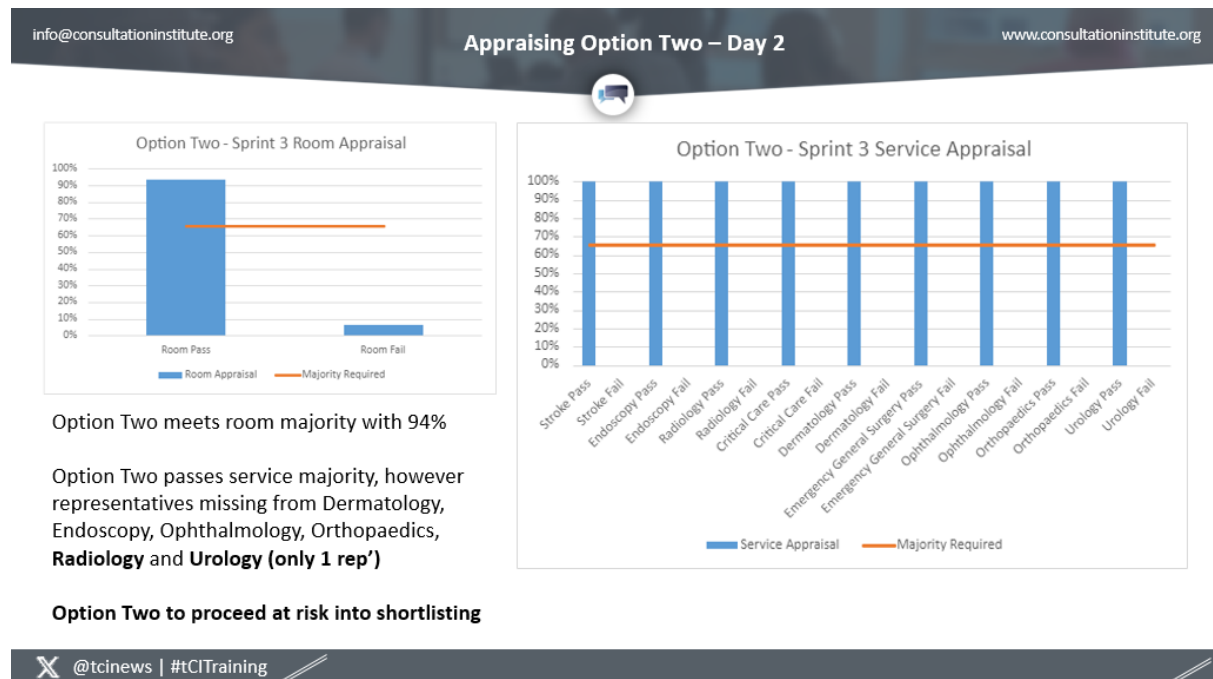
The process is underpinned by continuous engagement including, but not limited to, check and challenge sessions with wider colleagues and service users.

## Appendix 1

### 13<sup>th</sup> June – Option Two Appraisal



### 14<sup>th</sup> June – Option 2 Appraisal



Additional representation sought from missing representatives passed the service majority and was ratified by the Options Development Group on the 28<sup>th</sup> June.



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## CLINICAL SERVICES PLAN (CSP)

### Sprint 3 – Part 2

(21<sup>st</sup> and 28<sup>th</sup> June 2024)

## SUMMARY REPORT

12<sup>th</sup> July 2024

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## Introduction

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- Improve standards and respond to service fragility within the Stroke service.

Sprint 3 Part 2 was a two-day event held on online on 21<sup>st</sup> and in person on 28<sup>th</sup> June. The purpose of 21<sup>st</sup> June was to further develop the detailed description of Options Two, given it had taken additional time to design in order to meet the Hurdle Criteria. The focus for 28<sup>th</sup> June was to provide the opportunity to refine the four options, gather criteria data and conduct the impact assessment screening.

### **Friday 21<sup>st</sup> June 2024 (virtual session)**

- 32 staff members, including service, interdependent services and support services representatives
- 1 WAST representative
- 1 Welsh Government representative
- 2 Trade Union representatives
- 1 Health Board Executive
- 6 Transformation Programme Office/Engagement team members

As the session progressed, it began to focus on Option 2, the attendance became streamlined as it moved to this section.

### Friday 28<sup>th</sup> June 2024, Theatr Botanica

- 42 staff members, including service, interdependent services and support services representatives
- 1 WAST representative
- 1 Swansea Bay University Health Board representative
- 1 Welsh Government representative
- 2 Trade Union representatives
- 2 Health Board Executives
- 12 Transformation Programme Office/Engagement team members

## Methodology

Lee Davies, Executive Director of Strategy and Planning welcomed attendees to the online workshop on 21<sup>st</sup> June and provided an overview of the progress to date within the context of the Clinical Services Plan (CSP) programme.

The objective of this session was to further develop the detailed description of Option 2. Anna Henchie, Principal Programme Manager explained to the Options Development Group the task in hand and the questions to be addressed to understand the difference between how the service is delivered now and how it will be delivered in the option.

Option Development Group Two then worked to populate the template provided.

On 28<sup>th</sup> June participants were welcomed by Mark Henwood, Interim Medical Director at the Theatr Botanica. He explained the focus of the day was to allow an opportunity for services to work on the options:

- Refinement of options 1- 4
- Criteria data gathering
- Impact Assessment screening

The Options Development Group, working in 9 groups (1 per service area) were presented with information relating to:

- Workforce (Mia Evans Project Manager, Workforce Planning)
- Estates, Facilities and Capital (Ben Rogers, Principal Programme Manager)

before further developing the 4 options.

Impact Assessment tools were presented and screening was carried out for each of the options by the Options Development Group, working in 9 groups (1 per service area). This included:

- Equality Impact Assessment (EqIA)
- Health Impact Assessment (HIA), presented by Dr Michael Thomas, Consultant in Public Medicine

- Quality Impact Assessments

The Options Development Group, working in 9 groups (1 per service area) were then asked to consider the financial implications following a presentation by Rhian Davies, Assistant Director of Finance.

The discussions and outputs from the two days were taken to the Task and Finish groups to complete outstanding tasks.

## Output

Please refer to Appendix 1.

## Next Steps

Key Dates:

- 9<sup>th</sup> July
  - Check and challenge feedback
  - Completion of the SWOT analysis templates for Options One to Four
- 5<sup>th</sup> September
  - Finalise the SWOT analysis for Options One to Four
- 6<sup>th</sup> September
  - Scoring of the options

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

## Appendix 1

# DRAFT

## Options Development - By Service

### OPTIONS TABS

A copy of the baseline templates (as of 26.6.24) can be found for each of the options

### SERVICE TABS

Each service tab to be completed through engagement with the service on what would be required to enable the option.

Each tab has a section for each of the options with questions to be completed by site for the Workforce, Estates and other activity questions.

### OPTIONS COMPARISON

This tab has each of the high level service changes for each option.

It can be filtered by service to see all 4 options together or by option number to see the option as a whole.

### What we want services to do:

Where a question is relevant, that the service answers the specific question with their best estimate on the detail to help workforce, estates, finance and EDI colleagues.

The service to focus on their specific service model within that option configuration.

Remember the Objective of phase two of the programme. To reduce service fragility, reduce waiting times, reduce waiting lists and improve sustainability (keep these in mind and your table shouldn't deviate to much).

Try to nudge as much detail as possible. For example if a service says we need:

Additional Theatre sessions – then, how many? if this is more than what they have funded in the health board now then this needs to be RED.

If its less it can be GREEN if it's the same it stays BLACK.

Staff – Services should be able to estimate any additionality, surplus or changes here that could highlight sustainability and reduce fragility.

Try to get that detail. What is different to what they have today?

Be mindful that one question may answer several. Try to slow the conversation down to capture this detail.

For example a workforce question may also influence answer to estate also and vice versa.

So some flexibility is needed and your own judgement can be used to manage this information.

Do your best to use coloured text, this will really help you later in the day during the finance section:

RED text will mean something will create **COST ADDITIONALITY** (this is where the service is asking for more than what they currently have in Hywel Dda)

BLACK text will indicate something that is **COST NEUTRAL** (this is where things may move around but overall the service number, workforce and estate are the same albeit at different locations)

GREEN text will indicate something that is **COST SAVING** (this is where the service will use less than what they do now)

**What we don't want:**

Services to discuss the configuration of the Option. This has been agreed by the option group.

We only expect the service to make their best estimation of how their service will work within that option.

This is a factual assessment for that service and an opportunity for them to really focus on key aspects that will need to be weighed by the options group and later assessed and score through SWOT and Scoring.

# Option 1

Workforce	Critical Care	Dermatology	EGS	Ophthalmology	Orthopaedics	Urology	Stroke	Endoscopy	Radiology
Are there any changes required to current Rotas? include On Call	Enhanced Care Unit will no longer be managed by Critical Care, however unit would need links with Critical Care unit in GGH. Doctors and Nurses will rotate through GGH to maintain and develop skills.		Combining rotas to create 1:12 in Glangwili - although this not as saving to the budget, it will a saving due the reduction of high cost locum and agency	BGH job plan to change as theatres are being removed.  No change to on-call	Bronglais would need to move into a protected elective ward/area to ensure BOA standards. Will need clinical therapies to support.	The 'odd list' will be removed from Bronglais, however this will not create any additional capacity  No change to consultant, registrar and cross cover on-call rota  Withdraw the elective urology currently undertaken in Glangwili DSU: Nephrectomy - 1 list per week (assuming can accommodated in theatres PPH) CNS team use x2 OP clinic rooms per day  MDT clinics would move from GGH to PPH:  - all day Wednesday  - one OP room  - CNS nurses could be called into the clinic as and when required on PPH rather than having to be present for the whole clinic as they are in GGH. For example, could run a virtual clinic in between  Endoscopy x4 flexible cystoscopy lists per week	Staff model will need to be reviewed to take pathway change into account. Looking at regional rota for doctors.		Possible reallocation of staff from Glangwili to other sites if elective work is removed
Any changes to current Bed numbers?	Bronglais increase from 5 to 6 (current 5th bed not used), so practical increase from 4-6		Will need an approx additional 8 beds for admission in Glangwili	Not applicable		No impact on bed numbers			
Changes to current Medical workforce model incl. impact on variable pay			No change to other staff numbers as staff will move location only	Remove high cost locum in Bronglais  No change to other staff numbers as staff will move location only	BGH, PPH & WGH: Additional anaesthetic support	Might be create savings as we will not have to pay for a consultant to travel and stay in Aberystwyth			
Changes to current Nursing & HCSW model incl. impact on variable pay		Currently two Specialist Nurses working in Cardigan ICC. Intention is that they will remain in situ and move main site from Witybush to Cardigan or Prince Philip	No change to other staff numbers as staff will move location only	No change to staff numbers as staff will move location only	WGH – increasing times of DSU will need additional nurse staffing.	No change to staff numbers as staff will move location only		Would need to employ another Nurse endoscopist - site either Bronglais, Glangwili or Witybush.	
Changes to current Therapies workforce model incl. impact on variable pay			No change to other staff numbers as staff will move location only	No change to staff numbers as staff will move location only	BGH, PPH & WGH: Additional Therapies staff to support 7 day working	No change to staff numbers as staff will move location only			
Changes to current HCS & APST Workforce model incl. impact on variable pay			No change to other staff numbers as staff will move location only	No change to staff numbers as staff will move location only	BGH, PPH & WGH: additional staffing for pharmacy - weekends in particular	No change to staff numbers as staff will move location only			
Changes to current Administrative Workforce		Administrative workforce will be centralised in Prince Philip	No change to other staff numbers as staff will move location only	No change to staff numbers as staff will move location only		No change to staff numbers as staff will move location only			
Any other additional workforce requirements - e.g. Facilities roles			Additional staffing for 8 extra beds (noted above) inc nursing	No additional workforce requirement  Potential increase required for Out Patient nursing following move to Glangwili from Prince Philip.		No additional workforce requirement			

Any additional Training required?	All staff in Bronglais will need the opportunity to rotate through Glangwili to maintain and develop skills			Potentially OP nursing staff in Glangwili will need to be training for Ophthalmology		No specialist urology training required by OP			
Impact on current staff - e.g Will staff need to move site / will model improve MDT working?			Consultant rota will be absorbed into Glangwili (currently 1:4) - Question as to whether the consultant will remain on call to Withybush and Glangwili	Staff in Bronglais and Prince Philip will be redeployed to Glangwili  Staff in community sites South Pems will be redeployed.  Staff in Withybush Hospital undertaking laser, OP services and General Eyecare will be redeployed to Glangwili  Staff undertaking IVT injections in Amman Valley will be redeployed to Glangwili  Reduced travel expenses across all staff groups	Keep ward 9 as it currently is with the addition of physio and/or a rehab assistant.	Plan is for Urology and Endoscopy to co-locate, this will maximise capacity to carry out diagnostics  Will need to pay additional travel expenses for relocated staff for one year post centralisation		Plan is for Urology and Endoscopy to co-locate, this will maximise capacity to carry out diagnostics	
Will this reduce your current workforce risks/ challenges?			Yes. Creating a 1:12 rota will be more attractive than current 1:4 and 1:8	Reduce. Centralisation will improve training opportunities		Reduce. Centralisation will improve training opportunities			
Do you believe this will have a positive or negative impact on recruitment and retention?			Positive - as above, a more attractive rota would be better for recruitment, although some of the existing consultant team in Withybush are nearing retirement and this change may encourage retirement.	Positive		Centralisation into a 'Urology Investigation Unit' will make for a more attractive proposition		Positive	
Are there any other interdependent services that will be impacted by this change? e.g. diagnostics, A&E	A&E in Withybush could be negatively impacted by this change		A&E in Withybush could be negatively impacted by this change as emergency abdominal cases will be sent to Glangwili  A&E in Glangwili will experience and increase in surgical admissions  WAST will have to change where patients will be delivered - possibly up to 5 ambulances per day at Withybush  Trauma Service in Withybush - OOH will have no surgical unput  Theatres in Glangwili will need to perform additional surgeries and will need access to an emergency theatre 24/7	Currently have SBUHB clinicians coming into the health board, but these can remain as they are in GGH. The existing arrangement will remain in place	Potential for additional hours for pharmacy, weekends in particular  Will require 7 day Occupational Therapy and Therapies support  Will need additional anaesthetic support – this is currently in consideration with workforce	Community staff will need to continue to perform Trial Without Catheter work. This will benefit Urology service. Community were undertaking this work prior to change in response to Covid			
Other programmes of work that may impact the option e.g. ARCH / Regional work				ARCH and National Strategy are looking to create regional hubs. Centralisation will not contradict that		GIRFT recommendation is that Urology centralise into a single site			
Estates									
Theatres			Free up theatre capacity in Withybush  Will need additional theatre capacity in Glangwili	3 theatre sessions in Bronglais will be freed up  Giving up 11 sessions to move into DSU in Glangwili	Prince Philip - Would need dedicated:  - 2 laminar flow theatres  - Ward 6 (20-24 beds)  - Access regarding dedicated therapies (already have)	Would need additional beds on Ward 7			
DSU			Not applicable	Will need 11 sessions in theatre and 6 for IVT in Glangwili (same number of sessions in a different location)		No impact			
Procedure Rooms			Not applicable	Currently use 7 clinic rooms in Prince Philip, would need these and an additional room in Glangwili  Would need at least one more room in Glangwili to be used as an orthoptist room and support OP clinics		Requirements for PPH  x2 rooms constantly running for cystoscopy  x1 proc room for general use  x2 clinical rooms for nurses			
		Will need access to a minor ops facility in PPH.  Currently use approx. 14% of PPH Outpatient department as well as clinics in WGH, GGH and insourcing. We would need 10-15 rooms for Derm.	Not applicable	As above, Clinics. Would move 26.5 clinics into one site, approx. would need 8 rooms. (does not include RACE). Inc general clinics and laser		Two nursing rooms currently used in Glangwili will be freed up for OP in Glangwili  Freeing up dedicated elective beds Derwen Ward in Glangwili			

OPD		For the option looking at approx. 40% for the OP estate in PPH including a Minor Operating Procedure (additional number based on what the demand is, currently use 1 in PPH).							
		For the actual estate, would need to consider 'flow', on consultation room, MOP, storage, consultant office, phototherapy (currently in GGH, could remain). T&F group will need to inform what the flow would need to be.							
Other	For Bronglais, Will need an additional bed to make a 6 bed unit (bed 5 will need to be utilised, its currently not being used). This configuration would inc x3 L3 beds. Will also need storage space		In-patient admissions would not take place in Withybush  Would need approx 8 additional in-patient admission beds in Glangwili	Tysal ward to be freed up		For PPH x2 consultant rooms	Bronglais will need a dedicated rehab area in the unit	Will look to co-locate with Urology. a 3rd room will be sufficient to facilitate Bronchoscopy. Prince Philip has a good template for development. Urology has noted the anaesthetist office would provide ideal space	
Office space required (Desks)	Will need 1-2 offices/desks for Bronglais		Not applicable	No more office space required		For PPH x3 admin desks			
Equipment Moves			Not applicable	To be moved from Prince Philip into Glangwili:  - Laser machine x2 - Fields machine - OCT - Slit Lamp (several) - ORA  Prince Philip to Cardigan - Optos  South Pems to Withybush: - OCT - HFA - Slit Lamp  South Pems to Cardigan - ORA  All equipment in Aberaeron to storage/spares as needed - OCT - Fields machine - Slit Lamp					
Potential Capital Development needs			None needed	No requirement needed	BGH - protected elective ward/area to ensure BOA standards  PPH - Would need dedicated: - 2 laminar flow theatres - Ward 6 (20-24 beds)	Potential capital needed for refurbishment of suite in Prince Philip		Is there a possibility of a new suite to develop JAG in Prince Philip?	
Potential Digital opportunities			Expand virtual ward and consultant connect	Open eyes system is not affected by CSP changes		Urology service already uses 'Patient Knows Best'. Opportunity to develop this further			
Patients									
Conditions / Procedures (what treatments/ interventions will move.)			Emergency abdominal surgery admissions and theatre will be removed from Withybush to take place in Glangwili	All OP services (excl. Bronglais) will move to Glangwili  IVT clinics will move from Amman Valley to Glangwili  Cataract will move from main theatre to DSU (glangwili)  Laser treatment moving from all sites (excl. North Road) to Glangwili		Released from Glangwili:  Nephrectomy - 1 list per week (assuming can accommodated in theatres PPH) CNS team use x2 OP clinic rooms per day  MDT clinics would move from GGH to PPH: - all day Wednesday  - one OP room - CNS nurses could be called into the clinic as and when required on PPH rather than having to be present for the whole clinic as they are in GGH. For example, could run a virtual clinic in between Endoscopy x4 flexible cystoscopy lists per week  Likely cancer patients will be seen quicker		If elective work is removed from Glangwili, there will be additional work to other sites	
Patient Transfers (include acuity: ACCTS or NEPTS or WAST)	Patients from PPH and WGH will be sent back to enhanced care unit when at the appropriate level.  Deteriorating patient will need high quality, timely transfer to Glangwili. We would need an ACCT equivalent service for this transfer		Approx 3-5 patient transfers from Withybush to Glangwili will be required per day from WAST, as well as increased WAST presence in Glangwili	Potential impact on patients seeking OP services from West of health board travelling to Glangwili		Patients may need to travel further - possible impact to patient transfers	Stroke service across the health board will need dedicated transport provided by WAST		
Are there any impacts or changes to regional or national pathways				National strategy will be published shortly, but no impact expected	to be determined				
Any impact on LTA/ SLA Flows %				Removing high cost locum in Bronglais could lead to difficulties in supporting the SLA and LTA for Powys patients (worth £535,770)			Gwynedd and Powys pay Hywel Dda to manage their acute patients, this may have an impact.		
Addressing Barriers									
Waiting Lists				It is expected that centralising services will help manage waiting lists	potential pooled PTL lists with SBU	It is expected that centralising services will help manage waiting lists, inc single cancer pathway target			
Waiting Times				Due to efficiencies on a centralised site waiting times are expected to decrease	potential pooled PTL lists with SBU	Due to efficiencies on a centralised site waiting times are expected to decrease			
Other			Transfer time between Withybush and Glangwili for surgical admission patients			TWOC services will be performed by community services			

# Option 2

Workforce	Critical Care	Dermatology	EGS	Ophthalmology	Orthopaedics	Urology	Stroke	Endoscopy	Radiology
Are there any changes required to current Rotas? include On Call	Centralise ICU consultant rota across acute sites	GP extended roles to move to Prince Philip or Additional staff required including admin,	Combining rotas to create 1:12 that 1 in 13 SAS level doctor rota.	No change to job plans	Additional staff for extended rota hours from current	The 'odd list' will be removed from Bronglais, No change to consultant, registrar and cross cover on-call rota  Withdraw the elective urology currently CNS team use x2 OP clinic rooms per day MDT clinics would move from GGH to PPH: - all day Wednesday  - one OP room - CNS nurses could be called into the clinic as Endoscopy x4 flexible cystoscopy lists per No impact on bed numbers	7- day consultant, all Carmarthenshire staff to Doctors, Specialist nurses, therapists for first	8 WTE for 10 Endoscopy sessions - mix Additional staff establishment to cover 20	OCP in place to shift staffing models Additional staff also needed alongside
Any changes to current Bed numbers?			Estimated numbers required for inpatients: 6 treatment bays, 2 treatment	Not applicable					
Changes to current Medical workforce model incl. impact on variable pay			SDEC – no additional staff required in Additional doctor cover for SDEC in Withybush	No change to other staff numbers as staff will move location only	BGH - No additional medical staff, Increase in theatre staff required to support trauma (4 trained staff, 6 hrs 7days Healthcare support) OOH - mixed cover  Increase in theatre staff required to support	Might be create savings as we will not have to pay for a consultant to travel and stay in Aberystwyth			
Changes to current Nursing & HCSW model incl. impact on	Additional nurses required for outreach			No change to other staff numbers as staff will move location only	WGH – increasing times of DSU will need Additional therapies service, separate  PPH- Additional therapy services  Additional staff for extended rota hours from What exact staffing across all roles would be	No change to staff numbers as staff will move location only	Therapies resource needs to be identified to support Early Supported Discharge		Potential nursing requirement across
Changes to current HCS & APST Workforce model incl. impact on Changes to current Administrative Workforce				No change to other staff numbers as staff will No change to other staff numbers as staff will		No change to staff numbers as staff will move location only			
Any other additional workforce requirements - e.g. Facilities roles				No additional workforce requirement		No additional workforce requirement			
Any additional Training required?		Upskilling in Community sites to meet the		Potential increase required for Out Patient Potentially OP nursing staff in Prince Philip will Staff in Glangwili will be redeployed to Prince Staff in community sites will be redeployed.	Training issue across all sites	No specialist urology training required by OP Plan is for Urology and Endoscopy to co- Will need to pay additional travel expenses			Training requirement for Vascular at
Impact on current staff - e.g Will staff need to move site / will model improve MDT working?	Centralise ICU consultant rota across acute sites		Consultant group will need to move from Withybush to Glangwili						
Will this reduce your current workforce risks/ challenges? Do you believe this will have a positive or negative impact on Are there any other interdependent services that will be Other programmes of work that may impact the option e.g. ARCH			Yes. Creating a 1:12 rota will be Positive. Junior doctors in Withybush A&E in Withybush could be			Reduce. Centralisation will improve training Centralisation into a 'Urology Investigation Community staff will need to continue to GIRFT recommendation is that Urology			
Estates						Pathways will be set by national guidance,			
Theatres						Would need additional beds on Ward 7			To provide interventional, additional Theatre standard room within
DSU						No impact Requirements for PPH x2 rooms constantly running for cystoscopy  x1 proc room for general use  x2 clinical rooms for nurses		Free up 2 sessions from Urology for GI activity	
Procedure Rooms		2 additional procedure rooms, extractor fan. Need to mirror Cardigan procedure room in Prince Philip							
OPD				OPD in Prince Philip will need to increase by 1 room to accommodate 26.5 sessions		Two nursing rooms currently used in Freeing up dedicated elective beds Derwen			
Other	Full use of all current treatment space required, current bed space used as storage-- no additional outside of that required	Additional consultation rooms. 5 to 7 rooms		Additional space required for SDEC at Estimated 6 treatment bays, 2 treatment		For PPH x2 consultant rooms  3 rooms, 30 sessions per week  10 Endoscopy sessions additional  Administrative space For PPH x3 admin desks	TIA clinic space, 3 days space needed, aim for 7 days in 4 years	3 units, 10 sessions Impact on other Service as movement would	
Office space required (Desks) Equipment Moves	Additional storage and office space required	Shared office space for clinicians							
Potential Capital Development needs Potential Digital opportunities					PPH - No change for inpatient – current 21	Potential capital needed for refurbishment of Urology service already uses 'Patient Knows		Funding requirements for virtual assessments	
Patients		Paediatric and Inflammatory patients to Community cohort requiring consultant		Time sensitive conditions to relocate to Prince Endophthalmitis - action to be taken within Ocular Trauma (penetrating eye injury) - Retinal Detachment - In some cases needs There are on rare occasions other conditions		Released from Glangwili: Nephrectomy - 1 list per week (assuming can CNS team use x2 OP clinic rooms per day MDT clinics would move from GGH to PPH: - all day Wednesday - one OP room - CNS nurses could be called into the clinic as and when required on PPH rather than having to be present for the whole clinic as they are in GGH. For example, could run a virtual clinic in between Endoscopy x4 flexible cystoscopy lists per week  Likely cancer patients will be seen quicker  Increase in patients with focus on outpatients procedures	South Gwynedd patients - to determine where they go in this model for HASU	Urology cohort to move from Glangwili to increase in cohort t Withybush if all 20	
Conditions / Procedures (what treatments/ interventions will move.)									
Patient Transfers (include acuity: ACCTS or NEPTS or WAST)			Approx 3-5 patient transfers between Glangwili and Withybush will alternate between weeks	WAST cohort alternating week by week to admitting hospital		Patients may need to travel further - possible impact to patient transfers	Increase in transfer and transport		

Are there any impacts or changes to regional or national pathways					to be determined		Regional conversations needed on where closest HASU to be used		
Any impact on LTA/ SLA Flows %									
Addressing Barriers									
Waiting Lists					potential pooled PTL lists with SBU	It is expected that centralising services will help manage waiting lists, inc single cancer pathway target			
Waiting Times					potential pooled PTL lists with SBU	Due to efficiencies on a centralised site waiting times are expected to decrease			
Other						TWOC services will be performed by community services			

# Option 3

Workforce	Critical Care	Dermatology	EGS	Ophthalmology	Orthopaedics	Urology	Stroke	Endoscopy	Radiology
Are there any changes required to current Rotas? include On Call			Combining rotas to create 1:12 in Glangwili - although this not as saving to the budget, it will a saving due the reduction of high cost locum and agency	BGH job plan to change as theatres are being  No change to on-call	No change in staffing rotas'	The 'odd list' will be removed from Bronglais,  No change to consultant, registrar and cross  Withdraw the elective urology currently CNS team use x2 OP clinic rooms per day MDT clinics would move from GGH to PPH:  - all day Wednesday - one OP room - CNS nurses could be called into the clinic as Endoscopy x4 flexible cystoscopy lists per week			Potential movement across sites to  1 session of staffing could be released  1 member of staff released into PPH
Any changes to current Bed numbers?			Will need an approx additional 8 beds for admission in Glangwili	Not applicable		No impact on bed numbers			
Changes to current Medical workforce model incl. impact on variable pay		Additional  3 Consultant Dermatologist/Nurse consultants (negated by insourcing and Teledermoscopy)	No change to other staff numbers as staff will move location only	Remove high cost locum in Bronglais  No change to other staff numbers as staff will move location only	Recruitment to funded wte	Might be create savings as we will not have to pay for a consultant to travel and stay in Aberystwyth			
Changes to current Nursing & HCSW model incl. impact on variable pay			No change to other staff numbers as staff will move location only	No change to other staff numbers as staff will move location only	Recruitment to funded wte	No change to staff numbers as staff will move location only			
Changes to current Therapies workforce model incl. impact on variable pay			No change to other staff numbers as staff will move location only	No change to other staff numbers as staff will move location only		No change to staff numbers as staff will move location only			
Changes to current HCS & APST Workforce model incl. impact on			No change to other staff numbers as staff will move location only	No change to other staff numbers as staff will move location only		No change to staff numbers as staff will move location only			
Changes to current Administrative Workforce			No change to other staff numbers as staff will move location only	No change to other staff numbers as staff will move location only		No change to staff numbers as staff will move location only			
Any other additional workforce requirements - e.g. Facilities roles			Additional staffing for 8 extra beds (noted above) inc nursing	No additional workforce requirement  Potential increase required for Out Patient Potentially OP nursing staff in Glangwili will need to be training for Ophthalmology		No additional workforce requirement			
Any additional Training required?		Requirement for some additional training of GPs for some procedures.				No specialist urology training required by OP			
Impact on current staff - e.g Will staff need to move site / will model improve MDT working?			Consultant rota will be absorbed into Glangwili (currently 1:4) - Question as to whether the consultant will remain on call to Withybush and Glangwili	Staff in Bronglais and Prince Philip will be  Staff in community sites South Pems will be  Staff in Withybush Hospital undertaking laser,  Staff undertaking IVT injections in Amman  Reduced travel expenses across all staff groups		Plan is for Urology and Endoscopy to co-  Will need to pay additional travel expenses			
Will this reduce your current workforce risks/ challenges?			Yes. Creating a 1:12 rota will be more attractive than current 1:4 and 1:8	Reduce. Centralisation will improve training opportunities		Reduce. Centralisation will improve training opportunities			
Do you believe this will have a positive or negative impact on recruitment and retention?		Positive	Positive - as above, a more attractive rota would be better for recruitment, although some of the existing consultant team in Withybush are	Positive		Centralisation into a 'Urology Investigation Unit' will make for a more attractive proposition			
Are there any other interdependent services that will be impacted by this change? e.g. diagnostics, A&E			A&E in Withybush could be negatively impacted by this change as  A&E in Glangwili will experience and WAST will have to change where  Trauma Service in Withybush - OOH  Theatres in Glangwili will need to perform additional surgeries and will need access to an emergency theatre 24/7	Currently have SBUHB clinicians coming into the health board, but these can remain as they are in GGH. The existing arrangement will remain in place		Community staff will need to continue to perform Trial Without Catheter work. This will benefit Urology service. Community were undertaking this work prior to change in response to Covid			
Other programmes of work that may impact the option e.g. ARCH / Regional work				ARCH and National Strategy are looking to create regional hubs. Centralisation will not contradict that		GIRFT recommendation is that Urology centralise into a single site			
<b>Estates</b>									
Theatres			Free up theatre capacity in  Will need additional theatre	3 theatre sessions in Bronglais will be freed  Giving up 11 sessions to move into DSU in	BGH - additional theatre sessions?	Would need additional beds on Ward 7			Theatre environment if available would be beneficial to support across Bronglais and Glangwili
DSU			Not applicable	Will need 11 sessions in theatre and 6 for IVT in Glangwili (same number of sessions in a different location)	utilise existing funded DSU Capacity	No impact			
Procedure Rooms		additional 5 rooms (2 procedure rooms & 3 consultation rooms *either or)	Not applicable	Currently use 7 clinic rooms in Prince Philip,  Would need at least one more room in	n/a	Requirements for PPH x2 rooms constantly running for cystoscopy  x1 proc room for general use  x2 clinical rooms for nurses			
OPD			Not applicable	As above, Clinics. Would move 26.5 clinics into one site, approx. would need 8 rooms. (does not include RACE). Inc general clinics and laser	n/a	Two nursing rooms currently used in  Freeing up dedicated elective beds Derwen Ward in Glangwili			
Other		Option to consider Crosshands for Paediatrics? Discussions with PM would need 1 day a week (2 sessions).	In-patient admissions would not  Would need approx 8 additional in-patient admission beds in Glangwili	Tysal ward to be freed up	Virtual joint school to prepare patients for surgery, to undertaken across the HB.	For PPH x2 consultant rooms			Space could be released from Llandoverly if machine removed – Equipment old and would need replacing
Office space required (Desks)		c	Not applicable	No more office space required	n/a	For PPH x3 admin desks			

Equipment Moves			Not applicable	To be moved from Prince Philip into Glangwili: <ul style="list-style-type: none"> <li>- Laser machine x2</li> <li>- Fields machine</li> <li>- OCT</li> <li>- Slit Lamp (several)</li> <li>- ORA</li> </ul> Prince Philip to Cardigan <ul style="list-style-type: none"> <li>- Optos</li> </ul> South Pems to Withybush: <ul style="list-style-type: none"> <li>- OCT</li> <li>- HFA</li> <li>- Slit Lamp</li> </ul> South Pems to Cardigan <ul style="list-style-type: none"> <li>- ORA</li> </ul> All equipment in Aberaeron to storage/spares as needed <ul style="list-style-type: none"> <li>- OCT</li> <li>- Fields machine</li> <li>- Slit Lamp</li> </ul>	n/a				
Potential Capital Development needs			None needed	No requirement needed	Use Ward 9 at WGH - development costs	Potential capital needed for refurbishment of suite in Prince Philip			
Potential Digital opportunities			Expand virtual ward and consultant connect	Open eyes system is not affected by CSP changes		Urology service already uses 'Patient Knows Best'. Opportunity to develop this further			Electronic requesting has been introduced however waiting on new system to finalise the process and make the ask completely digital.
Patients									
Conditions / Procedures (what treatments/ interventions will move.)			Emergency abdominal surgery admissions and theatre will be removed from Withybush to take place in Glangwili	All OP services (excl. Bronglais) will move to Glangwili  IVT clinics will move from Amman Valley to Glangwili  Cataract will move from main theatre to DSU (glangwili)  Laser treatment moving from all sites (excl. North Road) to Glangwili		Released from Glangwili:  Nephrectomy - 1 list per week (assuming can accommodated in theatres PPH)  CNS team use x2 OP clinic rooms per day  MDT clinics would move from GGH to PPH:  - all day Wednesday  - one OP room  - CNS nurses could be called into the clinic as and when required on PPH rather than having to be present for the whole clinic as they are in GGH. For example, could run a virtual clinic in between Endoscopy x4 flexible cystoscopy lists per week  Likely cancer patients will be seen quicker			
Patient Transfers (include acuity: ACCTS or NEPTS or WAST)			Approx 3-5 patient transfers from Withybush to Glangwili will be required per day from WAST, as well as increased WAST presence in Glangwili	Potential impact on patients seeking OP services from West of health board travelling to Glangwili		Patients may need to travel further - possible impact to patient transfers			Patient transfers via WAST from PP to GGH and BGH
Are there any impacts or changes to regional or national pathways				National strategy will be published shortly, but no impact expected	to be determined				

Any Impact on LTA/ SLA Flows %				Removing high cost locum in Bronglais could lead to difficulties in supporting the SLA and LTA for Powys patients (worth £535,770)					
Addressing Barriers									
Waiting Lists				It is expected that centralising services will help manage waiting lists	potential pooled PTL lists with SBU	It is expected that centralising services will help manage waiting lists, inc single cancer pathway target			
Waiting Times				Due to efficiencies on a centralised site waiting times are expected to decrease	potential pooled PTL lists with SBU	Due to efficiencies on a centralised site waiting times are expected to decrease			
Other			Transfer time between Wlthybush and Glangwilli for surgical admission patients			TWOC services will be performed by community services			

# Option 4

Workforce	Critical Care	Dermatology	EGS	Ophthalmology	Orthopaedics	Urology	Stroke	Endoscopy	Radiology
Are there any changes required to current Rotas? include On Call			Combining rotas to create 1:12 in Glangwili - although this not as saving to the budget, it will a saving due the reduction of high cost locum and agency	BGH job plan to change as theatres are being removed.  No change to on-call		The 'odd list' will be removed from Bronglais, however this will not create any additional capacity  No change to consultant, registrar and cross cover on-call rota  Withdraw the elective urology currently undertaken in Glangwili DSU: Nephrectomy - 1 list per week (assuming can accommodated in theatres PPH) CNS team use x2 OP clinic rooms per day MDT clinics would move from GGH to PPH: - all day Wednesday - one OP room  - CNS nurses could be called into the clinic as and when required on PPH rather than having to be present for the whole clinic as they are in GGH. For example, could run a virtual clinic in between  Endoscopy x4 flexible cystoscopy lists per week			OCP – change working practices – substantive posts to facilitate a 7-day(12 hours per day) working model - £120k per month spent currently
Any changes to current Bed numbers?			Will need an approx additional 8 beds for admission in Glangwili	Not applicable		No impact on bed numbers			
Changes to current Medical workforce model incl. impact on variable pay			No change to other staff numbers as staff will move location only	Remove high cost locum in Bronglais  No change to other staff numbers as staff will move location only	BGH - Additional 1 wte Consultants (from 3 to 4 wte - exisiting funding) GGH - n/a PPH ?  WGH (currently recruiting 2 Ortho Consultants exisiting funding)  PPH - Additional Dedicated Junior Doctor WGH - Additional Dedicated Junior Doctor BGH - Additional Nursingif Y Banwy used	Might be create savings as we will not have to pay for a consultant to travel and stay in Aberystwyth			
Changes to current Nursing & HCSW model incl. impact on variable pay			No change to other staff numbers as staff will move location only	No change to staff numbers as staff will move location only		No change to staff numbers as staff will move location only			
Changes to current Therapies workforce model incl. impact on variable pay			No change to other staff numbers as staff will move location only	No change to staff numbers as staff will move location only	BGH - Additional Therapies (independency) if Y Banwy used GGH - n/a	No change to staff numbers as staff will move location only			
Changes to current HCS & APST Workforce model incl. impact on variable pay			No change to other staff numbers as staff will move location only	No change to staff numbers as staff will move location only	BGH - Additional Radiology (interdepeny) if Y Banwy used	No change to staff numbers as staff will move location only			
Changes to current Administrative Workforce			No change to other staff numbers as staff will move location only	No change to staff numbers as staff will move location only		No change to staff numbers as staff will move location only			
Any other additional workforce requirements - e.g. Facilities roles			Additional staffing for 8 extra beds (noted above) inc nursing	No additional workforce requirement  Potential increase required for Out Patient nursing following move to Glangwili from Prince Philip.		No additional workforce requirement			
Any additional Training required?				Potentially OP nursing staff in Glangwili will need to be training for Ophthalmology		No specialist urology training required by OP			
Impact on current staff - e.g Will staff need to move site / will model improve MDT working?			Consultant rota will be absorbed into Glangwili (currently 1:4) - Question as to whether the consultant will remain on call to Withybush and Glangwili	Staff in Bronglais and Prince Philip will be redeployed to Glangwili  Staff in community sites South Pems will be redeployed.  Staff in Withybush Hospital undertaking laser, OP services and General Eyecare will be redeployed to Glangwili  Staff undertaking IVT injections in Amman Valley will be redeployed to Glangwili  Reduced travel expenses across all staff groups		Plan is for Urology and Endoscopy to co-locate, this will maximise capacity to carry out diagnostics  Will need to pay additional travel expenses for relocated staff for one year post centralisation			Increase in hours. Long Day and Saturday as to increase funded sessions for theatres x 10. May require circa 15WTE
Will this reduce your current workforce risks/ challenges?			Yes. Creating a 1:12 rota will be more attractive than current 1:4 and 1:8	Reduce. Centralisation will improve training opportunities		Reduce. Centralisation will improve training opportunities			
Do you believe this will have a positive or negative impact on recruitment and retention?			Positive - as above, a more attractive rota would be better for recruitment, although some of the existing consultant team in Withybush are nearing retirement and this change may encourage retirement.	Positive		Centralisation into a 'Urology Investigation Unit' will make for a more attractive proposition			
Are there any other interdependent services that will be impacted by this change? e.g. diagnostics, A&E			A&E in Withybush could be negatively impacted by this change as emergency abdominal cases will be sent to Glangwili  A&E in Glangwili will experience and increase in surgical admissions  WAST will have to change where patients will be delivered - possibly up to 5 ambulances per day at Withybush  Trauma Service in Withybush - OOH will have no surgical unput	Currently have SBUHB clinicians coming into the health board, but these can remain as they are in GGH. The existing arrangement will remain in place		Community staff will need to continue to perform Trial Without Catheter work. This will benefit Urology service. Community were undertaking this work prior to change in response to Covid			

			Theatres in Glangwili will need to perform additional surgeries and will need access to an emergency theatre 24/7							
Other programmes of work that may impact the option e.g. ARCH / Regional work				ARCH and National Strategy are looking to create regional hubs. Centralisation will not contradict that		GIRFT recommendation is that Urology centralise into a single site				
<b>Estates</b>										
Theatres			Free up theatre capacity in Wityhush Will need additional theatre capacity in Glangwili	3 theatre sessions in Bronglais will be freed up Giving up 11 sessions to move into DSU in Glangwili	Bronglais 3 Sessions (ultraclean) required to make a up a full job plan and increase elective activity on site - Theatres advised this may be equivalent to the cost of 4 funded sessions used by Ophthal.	Would need additional beds on Ward 7				
DSU			Not applicable	Will need 11 sessions in theatre and 6 for IVT in Glangwili (same number of sessions in a different location)		No impact				
Procedure Rooms			Not applicable	Currently use 7 clinic rooms in Prince Philip, would need these and an additional room in Glangwili  Would need at least one more room in Glangwili to be used as an orphoptist room and support OP clinics		Requirements for PPH x2 rooms constantly running for cystoscopy  x1 proc room for general use  x2 clinical rooms for nurses				
OPD			Not applicable	As above, Clinics. Would move 26.5 clinics into one site, approx. would need 8 rooms. (does not include RACE). Inc general clinics and laser		Two nursing rooms currently used in Glangwili will be freed up for OP in Glangwili Freeing up dedicated elective beds Derwen Ward in Glangwili				
Other			In-patient admissions would not take place in Wityhush Would need approx 8 additional in-patient admission beds in Glangwili	Tysal ward to be freed up	If Y Banwy available at BGH, may need additional development to meet BOA standards	For PPH x2 consultant rooms			Some rooms not suitable for biopsies procedures	
Office space required (Desks)			Not applicable	No more office space required		For PPH x3 admin desks				
Equipment Moves			Not applicable	To be moved from Prince Philip into Glangwili:  - Laser machine x2 - Fields machine - OCT - Slit Lamp (several) - ORA  Prince Philip to Cardigan - Optos  South Pems to Wityhush: - OCT  - HFA  - Slit Lamp    South Pems to Cardigan  - ORA   All equipment in Aberaeron to storage/spares as needed  - OCT  - Fields machine  - Slit Lamp						
Potential Capital Development needs		Room conversion to procedure room to allow for additional 10 sessions per week. Estimated circa 100K one off costs	None needed	No requirement needed		Potential capital needed for refurbishment of suite in Prince Phillip				
			Expand virtual ward and consultant connect	Open eyes system is not affected by CSP changes	Digital Solution - Virtual joint school	Urology service already uses 'Patient Knows Best'. Opportunity to develop this further			Moving to electronic request	

Potential Digital opportunities					Electronic consent					New Radiology system(EPR) being introduced – partially implemented
Patients					Digital Pre-assessment					
Conditions / Procedures (what treatments/ interventions will move.)			Emergency abdominal surgery admissions and theatre will be removed from Withybush to take place in Glangwili	All OP services (excl. Bronglais) will move to Glangwili  IVT clinics will move from Amman Valley to Glangwili  Cataract will move from main theatre to DSU (glangwili)  Laser treatment moving from all sites (excl. North Road) to Glangwili		Released from Glangwili:  Nephrectomy - 1 list per week (assuming can accomodated in theatres PPH)  CNS team use x2 OP clinic rooms per day  MDT clinics would move from GGH to PPH:  - all day Wednesday  - one OP room  - CNS nurses could be called into the clinic as and when required on PPH rather than having to be present for the whole clinic as they are in GGH. For example, could run a virtual clinic in between Endoscopy x4 flexible cystoscopy lists per week  Likely cancer patients will be seen quicker				
Patient Transfers (include acuity: ACCTS or NEPTS or WAST)	Level 3 - complex patients may be required to move on occasion. Undefined on ACCTS impact. For PPH this makes permanent the current arrangement		Approx 3-5 patient transfers from Withybush to Glangwili will be required per day from WAST, as well as increased WAST presence in Glangwili	Potential impact on patients seeking OP services from West of health board travelling to Glangwili		Patients may need to travel further - possible impact to patient transfers	WAST tranelers of patients from Bronglais and Transfer of walkin patients from GGH to HASU at PPH. BGH 2023/24 was 166 patients. It was identified that circa 60% may be required to transfer. Which is circa 2 per week.			
Are there any impacts or changes to regional or national pathways				National strategy will be published shortly, but no impact expected	to be determined					
Any impact on LTA/ SLA Flows %				Removing high cost locum in Bronglais could lead to difficulties in supporting the SLA and LTA for Powys patients (worth £535,770)						
Addressing Barriers										
Waiting Lists				It is expected that centralising services will help manage waitings lists	potential pooled PTL lists with SBU	It is expected that centralising services will help manage waitings lists, inc single cancer pathway target				
Waiting Times				Due to efficiencies on a centralised site waiting times are expected to decrease	potential pooled PTL lists with SBU	Due to efficiencies on a centralised site waiting times are expected to decrease				
Other	Promote communication with families - access to wifi and tablets for vistual calls.		Transfer time between Withybush and Glangwili for surgical admission patients			TWOC services will be performed by community services				

# DRAFT

	CRITICAL CARE	Bronglais	Glangwili	Prince Philip	Withybush	Community Sites	
OPTION 1	<b>OPTION 1</b>	GPICS Rural Critical Care, L2 and L3	Critical Care up to Level 3	Development of enhanced care medicine/surgery. Critical Care support anaesthetics to stabilise and transfer up to 24/7. Enhanced care outreach team. Post op care unit. UTILISING CURRENT SOPs	Development of enhanced care medicine/surgery. Critical Care support anaesthetics to stabilise and transfer up to 24/7. Enhanced care outreach team.	Current configuration - No activity at community sites	
	<b>Workforce Requirement</b>						
	Are there any changes required to current Rotas? include On Call, moving to a 7 day model etc	No change	No - however need to rotate current staff and recruit to Intensivist vacancies. Job plan - to include virtual MDT and oversight across HDUHB. To consider additional consultant post	No change as aligned to Glangwili staffing. To incorporate virtual meetings as per other sites	Yes - changes to job plan if working/committing to Glangwili		
	Any changes to current Bed numbers?	No change	Appropriate use of bed base - remove DTOCs  Additional 1.9 beds to support the EGS change from Withybush  Need to review the influence of DTOCs on the bed base and then the numbers of patients transferred or transferring should we introduce this option. DK	Permanent change to current process. No change to bed numbers	Redefine bed base - keep 9 beds - need to reconfigure level of care considering A&E		
	Changes to current Medical workforce model incl. impact on variable pay	c i ~ h c b n i v a o y t v i a h n v e i r l u N g e a n s t l b b o e - r n s t u y y ~	Need an additional consultant for a 10th consultant post	No change from a CC /Anaesthetic cover. Change to responsibility and job plans of Medical consultants	No change from a CC /Anaesthetic cover. Change to responsibility and job plans of Intensivists and Medical consultants. Potential negative impact on medical recruitment. Potential saving with on call rota		
	Changes to current Nursing & HCSW model incl. impact on variable pay	No change other than the work already undertaken on the safe staffing act	Understaffed for the bed base and the work already undertaken on the safe staffing act. Additional 2 nursing staff for each shift band 5 (registered)  Need to review Withybush staffing in line with option as could be an option to transfer a vacancy from Withybush to Glangwili	No change other than the work already undertaken on the safe staffing act for a level 3. Review of safe staffing if bed base is redefined	No change other than the work already undertaken on the safe staffing act for a level 3. Review of safe staffing if bed base is redefined		
	Changes to current Therapies workforce model incl. impact on variable pay	Current model does not meet GPICS standard	Current model does not meet GPICS standard	Current model does not meet GPICS standard	Current model does not meet GPICS standard		
	Changes to current HCS & APST Workforce model incl. impact on variable pay						
	Changes to current Administrative Workforce	No change	Need extended day cover (8am-6pm) 7 days a week to coordinate HDUHB CC service - To confirm grade and hours - 1xBand 2 (2 in the budget this would be additional) to provide the extended service.	No change	No change		
	Any other additional workforce requirements - e.g. Facilities roles	To develop and recruit the role of Advanced Critical Care Practitioners - numbers and grade - DK to explore the role with Gabor and confirm	To develop and recruit the role of Advanced Critical Care Practitioners - numbers and grade - DK to check with Fliss and confirm	No change	No change		

Any additional Training required?	Depending on patient transfer option, nursing - to undertake the CC transfer course	Depending on patient transfer option, nursing - to undertake the CC transfer course	Depending on patient transfer option, nursing - to undertake the CC transfer course	Depending on patient transfer option, nursing - to undertake the CC transfer course	
Impact on current staff - e.g Will staff need to move site / will model improve MDT working?	No	Job plan - to include virtual MDT and oversight across HDU/HD	Nursing staff to rotate through level 3 CC care	Yes - will need to work on different sites	
Will this reduce your current workforce risks & challenges?	No due to geographical location for recruitment of medical workforce	Negative - more risk as need additional staff. Positive - roles potentially attractive model from a recruitment and retention. Dependent on clinicians/intensivists	If permanent - JD for Carms would change to management of 1 ITU with oversight	Increase the medical workforce risk	
Do you believe this will have a positive or negative impact on recruitment and retention?	Positive - to be part of hub and therefore not working in isolation	See above Untested model assumption	See above - positive	Negative impact on retention and recruitment	
Are there any other interdependent services that will be impacted by this change? e.g. diagnostics, A&E, wards	Access to patient transfer - ACCTS	Access to patient transfer - ACCTS Enhanced services for Medicine and Emergency surgery to improve flow and prompt discharge to wards	Access to patient transfer - ACCTS	A&E workload and referral to CC Access to patient transfers	
Are there other programmes of work that may impact the option e.g. ARCH / Regional work	All Wales CC demand and capacity workstream	All Wales CC demand and capacity workstream	All Wales CC demand and capacity workstream	All Wales CC demand and capacity workstream	
Are there ways to use technology or innovations to support the delivery of this option?	Virtual links with hub and telemedicine	Virtual links with hub and telemedicine	Virtual links with hub and telemedicine	Virtual links with hub and telemedicine	
<b>Estates</b>					
Theatres / Sessions	N/A	N/A	N/A	N/A	
Day Surgery Units (DSU) / Sessions	N/A	N/A	N/A	N/A	
Procedure Rooms / Sessions	N/A	N/A	N/A	N/A	
Outpatients Department / Sessions	N/A	N/A	N/A	N/A	

Other		The development of a 4 bedded Respiratory Support Unit - ward based overseen by the Respiratory Consultants. Additional resource required for equipment and 1:3 nursing staff configuration will need to change. Development of an Enhanced Care unit for Emergency Surgery.  These units will be ward based and therefore not a cost to	The development of a 4 bedded Respiratory Support Unit - ward based overseen by the Respiratory Consultants. Additional resource required for equipment and 1:3 nursing staff configuration will need to change.  These units will be ward based and therefore not a cost to Critical Care however will be an additional cost to the site and	The development of a 4 bedded Respiratory Support Unit - ward based overseen by the Respiratory Consultants. Additional resource required for equipment and 1:3 nursing staff configuration will need to change.  These units will be ward based and therefore not a cost to Critical Care however will be an additional cost to the site and	
Office space required (Desks)	Additional storage space required for equipment - in close proximity to unit IT	Additional storage space required for equipment - in close proximity to unit IT	Additional storage space required for equipment - in close proximity to unit IT	Additional storage space required for equipment - in close proximity to unit IT	
Equipment Moves (Surplus and Essential)	N/A	N/A	Opportunity to deploy equipment used in level 3 care	Opportunity to deploy equipment used in level 3 care, eg ventilators	
Potential Capital Development needs	Additional storage space required for equipment - in close proximity to unit IT. Maintenance and replacement of air handling unit	Additional storage space required for equipment - in close proximity to unit IT. Maintenance and replacement of air handling unit	Additional storage space required for equipment - in close proximity to unit IT. Maintenance and replacement of air handling unit	Additional storage space required for equipment - in close proximity to unit IT. Maintenance and replacement of air handling unit	Opportunity to redeploy equipment to another site, should they not be required then they would not be replaced when they reach their end date and therefore not replaced.
Potential Digital opportunities (achievable within 2-4 years) (E.G. CT Profusion for Stroke)	Telemedicine and linked to developments in line with CC Network	Telemedicine and linked to developments in line with CC Network	Telemedicine and linked to developments in line with CC Network	Telemedicine and linked to developments in line with CC Network	
<b>Patients</b>					
Identify what intervention will take place on each site and what interventions will move	Rotation of staff will support continued delivery of renal replacement therapy	No change	No renal replacement therapy (as per current situation)	No renal replacement therapy From an A&E perspective limited level 3 support will have an impact on what can be seen in A&E - pathways - paed, acute surgery, trauma	
Clarify if there are Patient Transfers required (include acuity: ACCTS or NEPTS or WAST) what % of patients this would be (this will need to be evidence based)	Yes	Impact of repatriation in a timely manner	Yes Data - 11.2% level 2 transfer to GGH 22 a year 56% level 3 transfer to GGH 53 = 1.5 patients a week	Yes - addition of non medical patients	
Detail any impacts or changes to regional or national pathways	No change to current practice	No change to current practice	No change to current practice	No change to current practice	
<b>Addressing Barriers</b>					
Waiting Lists	N/A	N/A	N/A	N/A	
Waiting Times	N/A	N/A	N/A	N/A as complex elective patients who require level 3 are not currently undertaken in WGH	

Other					
	N/A	N/A	N/A	N/A	

CRITICAL CARE		Bronglais	Glangwili	Prince Philip	Withybush	Community Sites
O P T I O N  2	OPTION 2	GPICS rural Critical Care, L2 and L3 with Critical Care outreach team  Centralise ICU consultant rota	Critical Care up to Level 3  Centralise ICU consultant rota	Development of enhanced care medicine / surgery - Critical Care support anaesthetics to stabilise and ACCTS to transfer up to 24/7. Enhanced care outreach team. Post op care unit  Centralise ICU consultant rota	GPICS rural Critical Care, L2 and L3 (contingent on WGH acute service) with Critical Care outreach team  Centralise ICU consultant rota	Current configuration – no activity at community sites
	Workforce Requirement					
	Are there any changes required to current Rotas? include On Call, moving to a 7 day model etc	Yes - as part of the centralising of the ICU rota	No - however need to rotate current staff and recruit to Intensivist vacancies. Job plan - to include virtual MDT and oversight across HDUHB. Additional 10th consultant.	No change as aligned to Glangwili staffing	Yes - as part of the centralising of the ICU rota	
	Any changes to current Bed numbers?	No change	Appropriate use of bed base - remove DTOCs	Permanent change to current process. No change to bed numbers	Keep bed number - configuration could change	
	Changes to current Medical workforce model incl. impact on variable pay	No change - cover by an Intensivist (virtually by hub)	Need an additional consultant for a 10th consultant	From a CC / Anaesthetic cover on change. Change to responsibility and job plans of Medical consultants	No change	
	Changes to current Nursing & HCSW model incl. impact on variable pay	No change other than the work already undertaken on the safe staffing act	Understaffed for the bed base and the work already undertaken on the safe staffing act	No change other than the work already undertaken on the safe staffing act for a level 3. Review of safe staffing if bed base is redefined	No change to current configuration	
	Changes to current Therapies workforce model incl. impact on variable pay	Current model does not meet GPICS standard	Current model does not meet GPICS standard	Current model does not meet GPICS standard	Current model does not meet GPICS standard	
	Changes to current HCS & APST Workforce model incl. impact on variable pay					
	Changes to current Administrative Workforce	No change	Need extended day cover (8am-6pm) 7 days a week to co-ordinate HDUHB CC service - To confirm grade and hours - 1xBand 2 (2 in the budget this would be additional) to provide the extended service.	No change	No change	

Any other additional workforce requirements - e.g. Facilities roles	To develop and recruit the role of Advanced Critical Care Practitioners - numbers and grade - DK to explore the role with Gabor and confirm	To develop and recruit the role of Advanced Critical Care Practitioners - numbers and grade - DK to check with Fliss and confirm	No change	To develop and recruit the role of Advanced Critical Care Practitioners - numbers and grade - DK to explore with WGH and confirm	
Any additional Training required?	Depending on patient transfer option, nursing - to undertake the CC transfer course	Depending on patient transfer option, nursing - to undertake the CC transfer course	Depending on patient transfer option, nursing - to undertake the CC transfer course	Depending on patient transfer option, nursing - to undertake the CC transfer course	
Impact on current staff - e.g Will staff need to move site / will model improve MDT working?	Consider impact of centralised rota on job plans	Job plan - to include virtual MDT and oversight across HDUHB	Nursing staff to rotate through level 3 CC care	Consider impact of centralised rota on job plans	
Will this reduce your current workforce risks & challenges?	No due to geographical location for recruitment of medical workforce	Negative - more risk as need additional staff. Positive - roles potentially attractive model from a recruitment and retention. Dependent on clinicians/intensivists	If permanent - JD for Carmis would change to management of 1 ITU with oversight	Might increase dependent on other portfolio discussions	
Do you believe this will have a positive or negative impact on recruitment and retention?	Positive - to be part of hub and therefore not working in isolation	See above Untested model assumption	See above - positive	May impact recruitment negatively - untested	
Are there any other interdependent services that will be impacted by this change? e.g. diagnostics, A&E, wards	Access to patient transfer - ACCTS	Access to patient transfer - ACCTS Enhanced services for Medicine and Emergency surgery to improve flow and prompt discharge to wards	Access to patient transfer - ACCTS	Access to patient transfer - ACCTS A&E	
Are there other programmes of work that may impact the option e.g. ARCH / Regional work	All Wales CC demand and capacity workstream	All Wales CC demand and capacity workstream	All Wales CC demand and capacity workstream	All Wales CC demand and capacity workstream	
Are there ways to use technology or innovations to support the delivery of this option?	Virtual links with hub and telemedicine	Virtual links with hub and telemedicine	Virtual links with hub and telemedicine	Virtual links with hub and telemedicine	
<b>Estates</b>					
Theatres / Sessions	N/A	N/A	N/A	N/A	
Day Surgery Units (DSU) / Sessions	N/A	N/A	N/A	N/A	
Procedure Rooms / Sessions	N/A	N/A	N/A	N/A	

Outpatients Department / Sessions	N/A	N/A	N/A	N/A	
Other	N/A	The development of a 4 bedded Respiratory Support Unit - ward based overseen by the Respiratory Consultants. Additional resource required for equipment and 1:3 nursing staff configuration will need to change. Development of an Enhanced Care unit for Emergency Surgery.  These units will be ward based and therefore not a cost to	N/A	N/A	
Office space required (Desks)	Additional storage space required for equipment - in close proximity to unit IT	Additional storage space required for equipment - in close proximity to unit IT	Additional storage space required for equipment - in close proximity to unit IT	Additional storage space required for equipment - in close proximity to unit IT	
Equipment Moves (Surplus and Essential)	N/A	N/A	N/A	N/A	
Potential Capital Development needs	Additional storage space required for equipment - in close proximity to unit IT. Maintenance and replacement of air handling unit	Additional storage space required for equipment - in close proximity to unit IT. Maintenance and replacement of air handling unit	Additional storage space required for equipment - in close proximity to unit IT. Maintenance and replacement of air handling unit	Additional storage space required for equipment - in close proximity to unit IT. Maintenance and replacement of air handling unit	
Potential Digital opportunities (achievable within 2-4 years) (E.G. CT Profusion for Stroke)	Telemedicine and linked to developments in line with CC Network	Telemedicine and linked to developments in line with CC Network	Telemedicine and linked to developments in line with CC Network	Telemedicine and linked to developments in line with CC Network	
<b>Patients</b>					
Identify what intervention will take place on each site and what interventions will move	Rotation of staff will support continued delivery of renal replacement therapy	No change	No renal replacement therapy (as per current situation)	No change	
Clarify if there are Patient Transfers required (include acuity: ACCTS or NEPTS or WAST) what % of patients this would be (this will need to be evidence based)	Occasional retrieval service	Impact of repatriation in a timely manner and occasional retrieval	Yes Retrieval service Data - 11.2% level 2 transfer to GGH 22 a year 56% level 3 transfer to GGH 53 = 1.5 patients a week	Occasional retrieval service	
Detail any impacts or changes to regional or national pathways	No change to current practice	No change to current practice	No change to current practice	No change to current practice	
<b>Addressing Barriers</b>					
Waiting Lists	N/A	N/A	N/A	N/A	

Waiting Times	N/A	N/A	N/A	N/A as complex elective patients who require level 3 are not currently undertaken in WGH	
Other	N/A	N/A	N/A	N/A	

CRITICAL CARE		Bronglais	Glangwili	Prince Philip	Withybush	Community Sites
O P T I O N 3	<b>OPTION 3</b>	<b>Rural Critical Care</b>	<b>Level 3 Critical Care Centre</b>	<b>Make permanent current configuration, Level 2 and transfer Level 3 to Glangwili</b>	<b>Rural Critical Care</b>	<b>Current configuration – no activity at community sites</b>
	<b>Workforce Requirement</b>					
	Are there any changes required to current Rotas? include On Call, moving to a 7 day model etc	Yes - as part of the centralising of the ICU rota	No - however need to rotate current staff and recruit to Intensivist vacancies. Job plan - to include virtual MDT and oversight across HDUHB. Additional 10th consultant.	No change as aligned to Glangwili staffing	Yes - as part of the centralising of the ICU rota	
	Any changes to current Bed numbers?	No change	Appropriate use of bed base - remove DTOCs	Permanent change to current process. No change to bed numbers	Keep bed number - configuration could change	
	Changes to current Medical workforce model incl. impact on variable pay	No change	Need an additional consultant for a 10th consultant	From a CC /Anaesthetic cover on change. Change to responsibility and job plans of Medical consultants	No change	
	Changes to current Nursing & HCSW model incl. impact on variable pay	No change other than the work already undertaken on the safe staffing act	Understaffed for the bed base and the work already undertaken on the safe staffing act	No change other than the work already undertaken on the safe staffing act for a level 3. Review of safe staffing if bed base is redefined	No change to current configuration	
	Changes to current Therapies workforce model incl. impact on variable pay	Current model does not meet GPICS standard	Current model does not meet GPICS standard	Current model does not meet GPICS standard	Current model does not meet GPICS standard	
	Changes to current HCS & APST Workforce model incl. impact on variable pay					
	Changes to current Administrative Workforce	No change	Need extended day cover (8am-6pm) 7 days a week to co-ordinate HDUHB CC service - To confirm grade and hours - 1xBand 2 (2 in the budget this would be additional) to provide the extended service.	No change	No change	

Any other additional workforce requirements - e.g. Facilities roles	To develop and recruit the role of Advanced Critical Care Practitioners - numbers and grade - DK to explore the role with Gabor and confirm	To develop and recruit the role of Advanced Critical Care Practitioners - numbers and grade - DK to check with Fliss and confirm	No change	To develop and recruit the role of Advanced Critical Care Practitioners - numbers and grade - DK to explore with WGH and confirm	
Any additional Training required?	Depending on patient transfer option, nursing - to undertake the CC transfer course	Depending on patient transfer option, nursing - to undertake the CC transfer course	Depending on patient transfer option, nursing - to undertake the CC transfer course	Depending on patient transfer option, nursing - to undertake the CC transfer course	
Impact on current staff - e.g Will staff need to move site / will model improve MDT working?	Consider impact of centralised rota on job plans	Job plan - to include virtual MDT and oversight across HDUHB	Nursing staff to rotate through level 3 CC care	Consider impact of centralised rota on job plans	
Will this reduce your current workforce risks & challenges?	No due to geographical location for recruitment of medical workforce	Negative - more risk as need additional staff. Positive - roles potentially attractive model from a recruitment and retention. Dependent on clinicians/intensivists	If permanent - JD for Carmis would change to management of 1 ITU with oversight	Might increase dependent on other portfolio discussions	
Do you believe this will have a positive or negative impact on recruitment and retention?	Positive - to be part of hub and therefore not working in isolation	See above Untested model assumption	See above - positive	May impact recruitment negatively - untested	
Are there any other interdependent services that will be impacted by this change? e.g. diagnostics, A&E, wards	Access to patient transfer - ACCTS	Access to patient transfer - ACCTS Enhanced services for Medicine and Emergency surgery to improve flow and prompt discharge to wards	Access to patient transfer - ACCTS	Access to patient transfer - ACCTS A&E	
Are there other programmes of work that may impact the option e.g. ARCH / Regional work	All Wales CC demand and capacity workstream	All Wales CC demand and capacity workstream	All Wales CC demand and capacity workstream	All Wales CC demand and capacity workstream	
Are there ways to use technology or innovations to support the delivery of this option?	Virtual links with hub and telemedicine	Virtual links with hub and telemedicine	Virtual links with hub and telemedicine	Virtual links with hub and telemedicine	
<b>Estates</b>					
Theatres / Sessions	N/A	N/A	N/A	N/A	
Day Surgery Units (DSU) / Sessions	N/A	N/A	N/A	N/A	
Procedure Rooms / Sessions	N/A	N/A	N/A	N/A	

Outpatients Department / Sessions	N/A	N/A	N/A	N/A	
Other	N/A	The development of a 4 bedded Respiratory Support Unit - ward based overseen by the Respiratory Consultants. Additional resource required for equipment and 1:3 nursing staff configuration will need to change. Development of an Enhanced Care unit for Emergency Surgery.  These units will be ward based and therefore not a cost to	N/A	N/A	
Office space required (Desks)	Additional storage space required for equipment - in close proximity to unit IT	Additional storage space required for equipment - in close proximity to unit IT	Additional storage space required for equipment - in close proximity to unit IT	Additional storage space required for equipment - in close proximity to unit IT	
Equipment Moves (Surplus and Essential)	N/A	N/A	N/A	N/A	
Potential Capital Development needs	Additional storage space required for equipment - in close proximity to unit IT. Maintenance and replacement of air handling unit	Additional storage space required for equipment - in close proximity to unit IT. Maintenance and replacement of air handling unit	Additional storage space required for equipment - in close proximity to unit IT. Maintenance and replacement of air handling unit	Additional storage space required for equipment - in close proximity to unit IT. Maintenance and replacement of air handling unit	
Potential Digital opportunities (achievable within 2-4 years) (E.G. CT Profusion for Stroke)	Telemedicine and linked to developments in line with CC Network	Telemedicine and linked to developments in line with CC Network	Telemedicine and linked to developments in line with CC Network	Telemedicine and linked to developments in line with CC Network	
<b>Patients</b>					
Identify what intervention will take place on each site and what interventions will move	Rotation of staff will support continued delivery of renal replacement therapy	No change	No renal replacement therapy (as per current situation)	No change	
Clarify if there are Patient Transfers required (include acuity: ACCTS or NEPTS or WAST) what % of patients this would be (this will need to be evidence based)	Occasional retrieval service	Impact of repatriation in a timely manner and occasional retrieval	Yes Retrieval service Data - 11.2% level 2 transfer to GGH 22 a year 56% level 3 transfer to GGH 53 = 1.5 patients a week	Occasional retrieval service	
Detail any impacts or changes to regional or national pathways	No change to current practice	No change to current practice	No change to current practice	No change to current practice	
<b>Addressing Barriers</b>					
Waiting Lists	N/A	N/A	N/A	N/A	

Waiting Times	N/A	N/A	N/A	N/A as complex elective patients who require level 3 are not currently undertaken in WGH	
Other	N/A	N/A	N/A	N/A	

CRITICAL CARE		Bronglais	Glangwili	Prince Philip	Withybush	Community Sites
O P T I O N 4	OPTION 4	Rural Critical Care	Level 3 Critical Care Centre	Make permanent current configuration, Level 2 and transfer Level 3 to Glangwili	Rural Critical Care	Current configuration – no activity at community sites
	Workforce Requirement					
	Are there any changes required to current Rotas? include On Call, moving to a 7 day model etc	Yes - as part of the centralising of the ICU rota	No - however need to rotate current staff and recruit to Intensivist vacancies. Job plan - to include virtual MDT and oversight across HDUHB. Additional 10th consultant.	No change as aligned to Glangwili staffing	Yes - as part of the centralising of the ICU rota	
	Any changes to current Bed numbers?	No change	Appropriate use of bed base - remove DTOCs	Permanent change to current process. No change to bed numbers	Keep bed number - configuration could change	
	Changes to current Medical workforce model incl. impact on variable pay	No change	Need an additional consultant for a 10th consultant	From a CC /Anaesthetic cover on change. Change to responsibility and job plans of Medical consultants	No change	
	Changes to current Nursing & HCSW model incl. impact on variable pay	No change other than the work already undertaken on the safe staffing act	Understaffed for the bed base and the work already undertaken on the safe staffing act	No change other than the work already undertaken on the safe staffing act for a level 3. Review of safe staffing if bed base is redefined	No change to current configuration	
	Changes to current Therapies workforce model incl. impact on variable pay	Current model does not meet GPICS standard	Current model does not meet GPICS standard	Current model does not meet GPICS standard	Current model does not meet GPICS standard	
	Changes to current HCS & APST Workforce model incl. impact on variable pay					
	Changes to current Administrative Workforce	No change	Need extended day cover (8am-6pm) 7 days a week to co-ordinate HDUHB CC service - To confirm grade and hours - 1xBand 2 (2 in the budget this would be additional) to provide the extended service.	No change	No change	

Any other additional workforce requirements - e.g. Facilities roles	To develop and recruit the role of Advanced Critical Care Practitioners - numbers and grade - DK to explore the role with Gabor and confirm	To develop and recruit the role of Advanced Critical Care Practitioners - numbers and grade - DK to check with Fliss and confirm	No change	To develop and recruit the role of Advanced Critical Care Practitioners - numbers and grade - DK to explore with WGH and confirm	
Any additional Training required?	Depending on patient transfer option, nursing - to undertake the CC transfer course	Depending on patient transfer option, nursing - to undertake the CC transfer course	Depending on patient transfer option, nursing - to undertake the CC transfer course	Depending on patient transfer option, nursing - to undertake the CC transfer course	
Impact on current staff - e.g Will staff need to move site / will model improve MDT working?	Consider impact of centralised rota on job plans	Job plan - to include virtual MDT and oversight across HDUHB	Nursing staff to rotate through level 3 CC care	Consider impact of centralised rota on job plans	
Will this reduce your current workforce risks & challenges?	No due to geographical location for recruitment of medical workforce	Negative - more risk as need additional staff. Positive - roles potentially attractive model from a recruitment and retention. Dependent on clinicians/intensivists	If permanent - JD for Carmis would change to management of 1 ITU with oversight	Might increase dependent on other portfolio discussions	
Do you believe this will have a positive or negative impact on recruitment and retention?	Positive - to be part of hub and therefore not working in isolation	See above Untested model assumption	See above - positive	May impact recruitment negatively - untested	
Are there any other interdependent services that will be impacted by this change? e.g. diagnostics, A&E, wards	Access to patient transfer - ACCTS	Access to patient transfer - ACCTS Enhanced services for Medicine and Emergency surgery to improve flow and prompt discharge to wards	Access to patient transfer - ACCTS	Access to patient transfer - ACCTS A&E	
Are there other programmes of work that may impact the option e.g. ARCH / Regional work	All Wales CC demand and capacity workstream	All Wales CC demand and capacity workstream	All Wales CC demand and capacity workstream	All Wales CC demand and capacity workstream	
Are there ways to use technology or innovations to support the delivery of this option?	Virtual links with hub and telemedicine	Virtual links with hub and telemedicine	Virtual links with hub and telemedicine	Virtual links with hub and telemedicine	
<b>Estates</b>					
Theatres / Sessions	N/A	N/A	N/A	N/A	
Day Surgery Units (DSU) / Sessions	N/A	N/A	N/A	N/A	
Procedure Rooms / Sessions	N/A	N/A	N/A	N/A	

Outpatients Department / Sessions	N/A	N/A	N/A	N/A	
Other	N/A	The development of a 4 bedded Respiratory Support Unit - ward based overseen by the Respiratory Consultants. Additional resource required for equipment and 1:3 nursing staff configuration will need to change. Development of an Enhanced Care unit for Emergency Surgery.  These units will be ward based and therefore not a cost to	N/A	N/A	
Office space required (Desks)	Additional storage space required for equipment - in close proximity to unit IT	Additional storage space required for equipment - in close proximity to unit IT	Additional storage space required for equipment - in close proximity to unit IT	Additional storage space required for equipment - in close proximity to unit IT	
Equipment Moves (Surplus and Essential)	N/A	N/A	N/A	N/A	
Potential Capital Development needs	Additional storage space required for equipment - in close proximity to unit IT. Maintenance and replacement of air handling unit	Additional storage space required for equipment - in close proximity to unit IT. Maintenance and replacement of air handling unit	Additional storage space required for equipment - in close proximity to unit IT. Maintenance and replacement of air handling unit	Additional storage space required for equipment - in close proximity to unit IT. Maintenance and replacement of air handling unit	
Potential Digital opportunities (achievable within 2-4 years) (E.G. CT Profusion for Stroke)	Telemedicine and linked to developments in line with CC Network	Telemedicine and linked to developments in line with CC Network	Telemedicine and linked to developments in line with CC Network	Telemedicine and linked to developments in line with CC Network	
<b>Patients</b>					
Identify what intervention will take place on each site and what interventions will move	Rotation of staff will support continued delivery of renal replacement therapy	No change	No renal replacement therapy (as per current situation)	No change	
Clarify if there are Patient Transfers required (include acuity: ACCTS or NEPTS or WAST) what % of patients this would be (this will need to be evidence based)	Occasional retrieval service	Impact of repatriation in a timely manner and occasional retrieval	Yes Retrieval service Data - 11.2% level 2 transfer to GGH 22 a year 56% level 3 transfer to GGH 53 = 1.5 patients a week	Occasional retrieval service	
Detail any impacts or changes to regional or national pathways	No change to current practice	No change to current practice	No change to current practice	No change to current practice	
<b>Addressing Barriers</b>					
Waiting Lists	N/A	N/A	N/A	N/A	

Waiting Times	N/A	N/A	N/A	N/A as complex elective patients who require level 3 are not currently undertaken in WGH	
Other	N/A	N/A	N/A	N/A	

CRITICAL CARE	Bronglais	Glangwili	Prince Philip	Withybush	Community Sites
OPTION 1	GPICS Rural Critical Care, L2 and L3	Critical Care up to Level 3	Development of enhanced care medicine/surgery. Critical Care support anaesthetics to stabilise and transfer up to 24/7. Enhanced care outreach team. Post op care unit.	Development of enhanced care medicine/surgery. Critical Care support anaesthetics to stabilise and transfer up to 24/7. Enhanced care outreach team.	Current configuration - No activity at community sites
OPTION 2	GPICS rural Critical Care, L2 and L3 with Critical Care outreach team  Centralise ICU consultant rota	Critical Care up to Level 3  Centralise ICU consultant rota	Development of enhanced care medicine / surgery - Critical Care support anaesthetics to stabilise and ACCTS to transfer up to 24/7. Enhanced care outreach team. Post op care unit  Centralise ICU consultant rota	GPICS rural Critical Care, L2 and L3 (contingent on WGH acute service) with Critical Care outreach team  Centralise ICU consultant rota	Current configuration – no activity at community sites
OPTION 3	Rural Critical Care	Level 3 Critical Care Centre	Make permanent current configuration, Level 2 and transfer Level 3 to Glangwili	Rural Critical Care	Current configuration – no activity at community sites
OPTION 4	Rural Critical Care	Level 3 Critical Care Centre	Make permanent current configuration, Level 2 and transfer Level 3 to Glangwili	Rural Critical Care	Current configuration – no activity at community sites

DERMATOLOGY		Bronglais	Glangwili	Prince Philip	Withybush	Community Sites
O P T I O N  1	OPTION 1	Withdraw services	Withdraw services	Centralise all acute services to Prince Philip Hospital with additional space	Withdraw services	Provide services at Ceredigion Integrated Care Centre and Amman Valley Hospital only
	Workforce Requirement					
	Are there any changes required to current Rotas? include On Call, moving to a 7 day model etc	No rotas	No rotas	No rotas	No rotas	No rotas
	Any changes to current Bed numbers?	No beds	No beds	No beds	No beds	No beds
	Changes to current Medical workforce model incl. impact on variable pay	Nil	Nil	GPwER 2 sessions per week currently based at Glangwili, will need to relocate to Prince Philip or community. Query OCP/contract  Up to three consultant dermatologists needed (can be medical or nurse consultants). This should offset the current insourcing - this would also offset triaging via Consultant Connect.	Nil	GPwER 2 sessions per week currently based at Glangwili, will need to relocate to Prince Philip or community. Query OCP/contract
	Changes to current Nursing & HCSW model incl. impact on variable pay	Nil	All nursing/HCSW staff will transfer base to Prince Philip. Phototherapy clinics to remain as a spoke at Glangwili - no additional capacity required to support Phototherapy	Up to three consultant dermatologists needed (can be medical or nurse consultants). This should offset the current insourcing - this would also offset triaging via Consultant Connect. Continuity of care/more sustainable/consistent service. £300k on insourcing/yr currently = approx. 3 consultants. Triaging costs currently £10k/month.	Nil	CICC staffing to remain the same Existing nurse staff to cover AVH Therefore no additional workforce required
	Changes to current Therapies workforce model incl. impact on variable pay	N/A	N/A	N/A	N/A	N/A
	Changes to current HCS & APST Workforce model incl. impact on variable pay		Medical Photographer currently based at Glangwili would need to relocate to Prince Philip to ensure BAD guidelines are met <b>there would be additionality as the current uplift from B5 to B6 is met by Med. Illustration but would need to be picked up by Derm. if relocated</b>	Derm pharmacist - no change		<b>Additional B5/6 Medical Photographer 1 WTE required to support telederm clinics</b>
	Changes to current Administrative Workforce			If admin staff are centralised at Prince Philip - Query OCP Will possibly impact staff retention due to current bases at Glangwili and Withybush, and Borth Digitalisation of medical records - needs to be considered alongside potential staff relocation?  <b>Additional admin staff required due to increase in medical</b>		
	Any other additional workforce requirements - e.g. Facilities roles			Query reallocation of hotel services/portering staff from OPD to Derm, but this would be additionality to current establishment		
Any additional Training required?			Nurse consultant - training of existing staff into role? NMP - nursing staff to undertake course CESR - Certificate of Eligibility for Specialist Registration			

Impact on current staff - e.g Will staff need to move site / will model improve MDT working?			Yes, some staff will need to move site (but not all as most medical based at Prince Philip already/CICC staffing will remain in situ). The proposed model will improve MDT working		
Will this reduce your current workforce risks & challenges?			Yes, the model will reduce current workforce risks and challenges, and will provide a safer and more sustainable service		
Do you believe this will have a positive or negative impact on recruitment and retention?			Likely to produce positive impact on staff retention for clinical staff due to peer support/coalescence of MDT etc. Possibility it will affect retention of admin staff if required to move base		
Are there any other interdependent services that will be impacted by this change? e.g. diagnostics, A&E, wards			Medical Photography, as advised above HSDU and Histology - both due to increase in MOPs		
Are there other programmes of work that may impact the option e.g. ARCH / Regional work			ARCH programme now closed SLA with SBUHB (Plastics), and MOU with ABUHB (Telederm) - collaboration		
Are there ways to use technology or innovations to support the delivery of this option?					Increase in use of telederm - additional Medical Photographer cited above would be an additional cost
<b>Estates</b>					
Theatres / Sessions	N/A	N/A	N/A	N/A	N/A
Day Surgery Units (DSU) / Sessions	N/A	N/A	N/A	N/A	N/A
Procedure Rooms / Sessions	Nil	Nil	3 procedure rooms needed in same area - will need to accommodate MOPs/full equipment spec. inc. storage/fridge for meds (inc. See and Treat - BAD Gold Standard as recommended by the AW Cancer Peer Review process)	Nil	No additional procedure rooms required
Outpatients Department / Sessions	Nil	Nil	Derm would vacate OPD Hub would require 6 consultation rooms and 1 observation room - ?would free up approx. 35% capacity in OPD	Nil	No change at CICC At AVH - 2 consultation rooms for 2 sessions one day a week
Other		Phototherapy suite to remain at Glangwili and is currently being brought up to spec	Medical Photography studio to be based in Hub Waiting area Staff room/kitchen Reception Storage/sluice	Nil	

Office space required (Desks)	Nil	If Phototherapy remains as a spoke, one office would also remain (2 desks)	9 desks for admin staff if required to move 4 offices (8 desks) for medical/clinical workforce	Nil	No additional office space required
Equipment Moves (Surplus and Essential)		Phototherapy suite to remain at Glangwili and is currently being brought up to spec	Existing office equipment would need to move from Glangwili etc.		
Potential Capital Development needs			Developing a brand new hub - BAD/CIN (Clinical Implementation Network) guidelines will advise on how this should look		
Potential Digital opportunities (achievable within 2-4 years) (E.G. CT Profusion for Stroke)			Electronic patient check-in would negate the need to employ a receptionist and would enhance efficiency/running of the hub and improve auditing (e.g. start/finish times of the clinics).  Potential to utilise photography studio to increase use of telederm		Existing telederm provision
<b>Patients</b>					
Identify what intervention will take place on each site and what interventions will move	Nil	Phototherapy to remain in situ	MOPs OPD consultations Service would look to recommence patch testing if workforce in place	Nil	MOPs at CICC
Clarify if there are Patient Transfers required (include acuity: ACCTS or NEPTS or WAST) what % of patients this would be (this will need to be evidence based)			Potential increase in use of NEPTS due to increase in service capacity, but majority of activity is already based at Prince Philip.		Some increase in demand from Pems, and to AVH (AVH approx. 4 sessions per week to take place, not all patients will require NEPTS)
Detail any impacts or changes to regional or national pathways			Potential increased pathway to SBUHB Plastics from Hywel Dda due to capacity increase in Hub (i.e. more patients being seen in Hub likely to produce a proportionate increase in referrals to tertiary care)		
<b>Addressing Barriers</b>					
Waiting Lists			Additional procedure rooms would address waiting times for urgent, routine, and USC treatments meaning the service would meet the ministerial targets and the Single Cancer Pathway targets		Reduction in waiting lists
Waiting Times			Waiting times would reduce with the increase in capacity in rooms and staff		Reductions in waiting times
Other			For consideration: potential income via recharge for using the Hub for W/LI or to let the rooms - e.g. GP OOH/backfill for other specialities  Potential income - receiving overflow patients from SBUHB due to improved capacity at HDDUHB		

DERMATOLOGY		Bronglais	Glangwili	Prince Philip	Withybush	Community Sites
O P T I O N  2	OPTION 2	No Dermatology service	No Dermatology service	Keep Dermatology at PPH but need to grow it, link with Ophthalmology / ENT for shared space	No Dermatology service	Non acute minor surgery unit in Carmarthenshire plus additional 'spokes' in South Pembrokeshire.
	Workforce Requirement					
	Are there any changes required to current Rotas? include On Call, moving to a 7 day model etc	No rotas	No rotas	No rotas	No rotas	No rotas
	Any changes to current Bed numbers?	No beds	No beds	No beds	No beds	No beds
	Changes to current Medical workforce model incl. impact on variable pay	Nil	Nil	GPwER 2 sessions per week currently based at Glangwili, will need to relocate to Prince Philip or community. Query OCP/contract  Up to three consultant dermatologists needed (can be medical or nurse consultants). This should offset the current insourcing - this would also offset triaging via Consultant Connect.	Nil	GPwER 2 sessions per week currently based at Glangwili, will need to relocate to Prince Philip or community. Query OCP/contract
	Changes to current Nursing & HCSW model incl. impact on variable pay	Nil	All nursing/HCSW staff will transfer base to Prince Philip. Phototherapy clinics to remain as a spoke at Glangwili - no additional capacity required to support Phototherapy	Up to three consultant dermatologists needed (can be medical or nurse consultants). This should offset the current insourcing - this would also offset triaging via Consultant Connect. Continuity of care/more sustainable/consistent service. £300k on insourcing/yr currently = approx. 3 consultants. Triaging costs currently £10k/month.	Nil	Clarification needed re. 'non-acute' - if this means Primary Care then no changes expected as MOPs would be carried out by GPwER South Pems. - existing model to be retained
	Changes to current Therapies workforce model incl. impact on variable pay	N/A	N/A	N/A	N/A	N/A
	Changes to current HCS & APST Workforce model incl. impact on variable pay		Medical Photographer currently based at Glangwili would need to relocate to Prince Philip to ensure BAD guidelines are met there would be additionality as the current uplift from B5 to B6 is met by Med. Illustration but would need to be picked up by Derm. if relocated	Derm pharmacist - no change		Additional B5/6 Medical Photographer 1 WTE required to support telederm clinics
	Changes to current Administrative Workforce			Additional admin staff required due to increase in medical recruitment - 3WTE - base location TBC?		
	Any other additional workforce requirements - e.g. Facilities roles			Query reallocation of hotel services/portering staff from OPD to Derm, but this would be additionality to current establishment		
Any additional Training required?			Nurse consultant - training of existing staff into role? NMP - nursing staff to undertake course CESR - Certificate of Eligibility for Specialist Registration			

Impact on current staff - e.g Will staff need to move site / will model improve MDT working?			Yes, some staff will need to move site (but not all as most medical based at Prince Philip already). The proposed model will improve MDT working		
Will this reduce your current workforce risks & challenges?			Yes, the model will reduce current workforce risks and challenges, and will provide a safer and more sustainable service		
Do you believe this will have a positive or negative impact on recruitment and retention?			Likely to produce positive impact on staff retention for clinical staff due to peer support/coalescence of MDT etc.		
Are there any other interdependent services that will be impacted by this change? e.g. diagnostics, A&E, wards			Medical Photography, as advised above HSDU and Histology - both due to increase in MOPs		
Are there other programmes of work that may impact the option e.g. ARCH / Regional work			ARCH programme now closed SLA with SBUHB (Plastics), and MOU with ABUHB (Telederm) - collaboration		
Are there ways to use technology or innovations to support the delivery of this option?					Increase in use of telederm - additional Medical Photographer cited above would be an additional cost
<b>Estates</b>					
Theatres / Sessions	N/A	N/A	N/A	N/A	N/A
Day Surgery Units (DSU) / Sessions	N/A	N/A	N/A	N/A	N/A
Procedure Rooms / Sessions	Nil	Nil	3 procedure rooms needed in same area - will need to accommodate MOPs/full equipment spec. inc. storage/fridge for meds (inc. See and Treat - BAD Gold Standard as recommended by the AW Cancer Peer Review process)	Nil	No procedure room currently in South Pems. Any procedure rooms existing in Primary Care (Carms.) (if this is what 'non acute' means) will need assessing re. condition/if they are up to required Dermatology specification
Outpatients Department / Sessions	Nil	Nil	Derm would vacate OPD Hub would require 6 consultation rooms and 1 observation room - ?would free up approx. 35% capacity in OPD	Nil	South Pems. - no change to existing clinics
Other		Phototherapy suite to remain at Glangwili and is currently being brought up to spec	Medical Photography studio to be based in Hub Waiting area Staff room/kitchen Reception Storage/slucce	Nil	

Office space required (Desks)	Nil	Offices can reduce from 4 to 2 offices (8 to 4 desks)	4 offices (8 desks) for medical/clinical workforce	Nil	No additional office space required
Equipment Moves (Surplus and Essential)		Phototherapy suite to remain at Glangwili and is currently being brought up to spec			
Potential Capital Development needs			Developing a brand new hub - BAD/CIN (Clinical Implementation Network) guidelines will advise on how this should look		
Potential Digital opportunities (achievable within 2-4 years) (E.G. CT Profusion for Stroke)			Electronic patient check-in would negate the need to employ a receptionist and would enhance efficiency/running of the hub and improve auditing (e.g. start/finish times of the clinics).  Potential to utilise photography studio to increase use of telederm		Existing telederm provision
<b>Patients</b>					
Identify what intervention will take place on each site and what interventions will move	Nil	Phototherapy to remain in situ	MOPs OPD consultations Service would look to recommence patch testing if workforce in place	Nil	Carms. MOPs if non-acute surgery unit South Pems. as currently, OPD sessions with CNS
Clarify if there are Patient Transfers required (include acuity: ACCTS or NEPTS or WAST) what % of patients this would be (this will need to be evidence based)	Nil		Potential increase in use of NEPTS due to increase in service capacity, but majority of activity is already based at Prince Philip.	Nil	Some increase in NEPTS demand from Ceredigion patients due to loss of MOPs service at CICC (which will not be provided at South Pems), either to PPH or Carms 'non-acute' site (but if GP surgeries, query if this transport is available to here)
Detail any impacts or changes to regional or national pathways	Nil		Potential increased pathway to SBUHB Plastics from Hywel Dda due to capacity increase in Hub (i.e. more patients being seen in Hub likely to produce a proportionate increase in referrals to tertiary care)	Nil	
<b>Addressing Barriers</b>					
Waiting Lists			Additional procedure rooms would address waiting times for urgent, routine, and USC treatments meaning the service would meet the ministerial targets and the Single Cancer Pathway targets		Reduction in waiting lists
Waiting Times			Waiting times would reduce with the increase in capacity in rooms and staff		Reductions in waiting times
Other			For consideration: potential income via recharge for using the Hub for W/LI or to let the rooms - e.g. GP OOH/backfill for other specialities  Potential income - receiving overflow patients from SBUHB due to improved capacity at HDDUHB		

DERMATOLOGY		Bronglais	Glangwili	Prince Philip	Withybush	Community Sites
O P T I O N  3	OPTION 3	No Dermatology service	No Dermatology service	Consolidate in Prince Philip Hospital	No Dermatology service	Crosshands option for Paediatric Dermatology. Continue with Telederm and current Community provision ie Cardigan & South Pems. Utilising skills of GP's special interest
	Workforce Requirement					
	Are there any changes required to current Rotas? include On Call, moving to a 7 day model etc	No rotas	No rotas	No rotas	No rotas	No rotas
	Any changes to current Bed numbers?	No beds	No beds	No beds	No beds	No beds
	Changes to current Medical workforce model incl. impact on variable pay	Nil	Nil	GPwER 2 sessions per week currently based at Glangwili, will need to relocate to Prince Philip or community. Query OCP/contract  Up to three consultant dermatologists needed (can be medical or nurse consultants). This should offset the current insourcing - this would also offset triaging via Consultant Connect.	Nil	GPwER 2 sessions per week currently based at Glangwili, will need to relocate to Prince Philip or community. Query OCP/contract
	Changes to current Nursing & HCSW model incl. impact on variable pay	Nil	All nursing/HCSW staff will transfer base to Prince Philip. Phototherapy clinics to remain as a spoke at Glangwili - no additional capacity required to support Phototherapy	Up to three consultant dermatologists needed (can be medical or nurse consultants). This should offset the current insourcing - this would also offset triaging via Consultant Connect. Continuity of care/more sustainable/consistent service. £300k on insourcing/yr currently = approx. 3 consultants. Triaging costs currently £10k/month.	Nil	Existing provision at CICC and South Pems. to remain, and telederm hubs to remain (no changes to workforce model) Crosshands - existing nursing staff to cover
	Changes to current Therapies workforce model incl. impact on variable pay	N/A	N/A	N/A	N/A	N/A
	Changes to current HCS & APST Workforce model incl. impact on variable pay		Medical Photographer currently based at Glangwili would need to relocate to Prince Philip to ensure BAD guidelines are met there would be additionality as the current uplift from B5 to B6 is met by Med. Illustration but would need to be picked up by Derm. if relocated	Derm pharmacist - no change		Additional B5/6 Medical Photographer 1 WTE required to support telederm clinics
	Changes to current Administrative Workforce			Additional admin staff required due to increase in medical recruitment - 3WTE - base location TBC?		
	Any other additional workforce requirements - e.g. Facilities roles			Query reallocation of hotel services/portering staff from OPD to Derm, but this would be additionality to current establishment		
Any additional Training required?			Nurse consultant - training of existing staff into role? NMP - nursing staff to undertake course CESR - Certificate of Eligibility for Specialist Registration			

Impact on current staff - e.g Will staff need to move site / will model improve MDT working?			Yes, some staff will need to move site (but not all as most medical based at Prince Philip already). The proposed model will improve MDT working		
Will this reduce your current workforce risks & challenges?			Yes, the model will reduce current workforce risks and challenges, and will provide a safer and more sustainable service		
Do you believe this will have a positive or negative impact on recruitment and retention?			Likely to produce positive impact on staff retention for clinical staff due to peer support/coalescence of MDT etc.		
Are there any other interdependent services that will be impacted by this change? e.g. diagnostics, A&E, wards			Medical Photography, as advised above HSDU and Histology - both due to increase in MOPs		
Are there other programmes of work that may impact the option e.g. ARCH / Regional work			ARCH programme now closed SLA with SBUHB (Plastics), and MOU with ABUHB (Telederm) - collaboration		
Are there ways to use technology or innovations to support the delivery of this option?					Increase in use of telederm - additional Medical Photographer cited above would be an additional cost
<b>Estates</b>					
Theatres / Sessions	N/A	N/A	N/A	N/A	N/A
Day Surgery Units (DSU) / Sessions	N/A	N/A	N/A	N/A	N/A
Procedure Rooms / Sessions	Nil	Nil	3 procedure rooms needed in same area - will need to accommodate MOPs/full equipment spec. inc. storage/fridge for meds (inc. See and Treat - BAD Gold Standard as recommended by the AW Cancer Peer Review process)	Nil	CICC to remain in use and is up to spec No procedure room available at South Pems No procedure room required at Crosshands; (paeds.) To utilise procedure rooms in Primary Care for GPwER to undertake MOPs - rooms will need to be up to spec
Outpatients Department / Sessions	Nil	Nil	Derm would vacate OPD Hub would require 6 consultation rooms and 1 observation room - ?would free up approx. 35% capacity in OPD	Nil	CICC and South Pems. - as existing Crosshands - 2 consultation rooms required GPwER/Primary Care - will use existing consultation rooms
Other		Phototherapy suite to remain at Glangwili and is currently being brought up to spec	Medical Photography studio to be based in Hub Waiting area Staff room/kitchen Reception Storage/slucce		Nil

Office space required (Desks)	NII	Offices can reduce from 4 to 2 offices (8 to 4 desks)	4 offices (8 desks) for medical/clinical workforce	NII	No additional office space required
Equipment Moves (Surplus and Essential)		Phototherapy suite to remain at Glangwili and is currently being brought up to spec			
Potential Capital Development needs			Developing a brand new hub - BAD/CIN (Clinical Implementation Network) guidelines will advise on how this should look		
Potential Digital opportunities (achievable within 2-4 years) (E.G. CT Profusion for Stroke)			Electronic patient check-in would negate the need to employ a receptionist and would enhance efficiency/running of the hub and improve auditing (e.g. start/finish times of the clinics).  Potential to utilise photography studio to increase use of telederm		Existing telederm provision
<b>Patients</b>					
Identify what intervention will take place on each site and what interventions will move	NII	Phototherapy to remain in situ	MOPs OPD consultations Service would look to recommence patch testing if workforce in place	NII	CICC - MOPs and OPD - no change South Pems - OPD - no change Crosshands - Paeds. only - OPD, no procedures GPwER/Primary Care - MOPs (BCC scheme)
Clarify if there are Patient Transfers required (include acuity: ACCTS or NEPTS or WAST) what % of patients this would be (this will need to be evidence based)	NII		Potential increase in use of NEPTS due to increase in service capacity, but majority of activity is already based at Prince Philip.	NII	No increase expected in use of NEPTS at CICC or South Pems. Unlikely to be much requirement for NEPTS to Crosshands (paeds.)
Detail any impacts or changes to regional or national pathways	NII		Potential increased pathway to SBUHB Plastics from Hywel Dda due to capacity increase in Hub (i.e. more patients being seen in Hub likely to produce a proportionate increase in referrals to tertiary care)	NII	
<b>Addressing Barriers</b>					
Waiting Lists			Additional procedure rooms would address waiting times for urgent, routine, and USC treatments meaning the service would meet the ministerial targets and the Single Cancer Pathway targets		Reduction in waiting lists
Waiting Times			Waiting times would reduce with the increase in capacity in rooms and staff		Reductions in waiting times
Other			For consideration: potential income via recharge for using the Hub for WLI or to let the rooms - e.g. GP OOH/backfill for other specialities  Potential income - receiving overflow patients from SBUHB due to improved capacity at HDDUHB		

DERMATOLOGY		Bronglais	Glangwili	Prince Philip	Withybush	Community Sites
O P T I O N  4	OPTION 4	No service	No service	Consolidate in Prince Philip or East of Health Board  Best option for the service as Hub with spokes in community	No service	Dermatology Spokes in South Pems, Cardigan ICC (existing services) and Crosshands  Future -Crosshands Hub Paediatric dermatology in the community, working alongside Health visitors — 1 day per week.  Office space available
	Workforce Requirement					
	Are there any changes required to current Rotas? include On Call, moving to a 7 day model etc	No rotas	No rotas	No rotas	No rotas	No rotas
	Any changes to current Bed numbers?	No beds	No beds	No beds	No beds	No beds
	Changes to current Medical workforce model incl. impact on variable pay	Nil	Nil	GPwER 2 sessions per week currently based at Glangwili, will need to relocate to Prince Philip or community. Query OCP/contract  Up to three consultant dermatologists needed (can be medical or nurse consultants). This should offset the current insourcing - this would also offset triaging via Consultant Connect.	Nil	GPwER 2 sessions per week currently based at Glangwili, will need to relocate to Prince Philip or community. Query OCP/contract
	Changes to current Nursing & HCSW model incl. impact on variable pay	Nil	All nursing/HCSW staff will transfer base to Prince Philip. Phototherapy clinics to remain as a spoke at Glangwili - no additional capacity required to support Phototherapy	Up to three consultant dermatologists needed (can be medical or nurse consultants). This should offset the current insourcing - this would also offset triaging via Consultant Connect. Continuity of care/more sustainable/consistent service. £300k on insourcing/yr currently = approx. 3 consultants. Triaging costs currently £10k/month.	Nil	Existing provision at CICC and South Pems. to remain, and telederm hubs to remain (no changes to workforce model) Crosshands - existing nursing staff to cover
	Changes to current Therapies workforce model incl. impact on variable pay	N/A	N/A	N/A	N/A	N/A
	Changes to current HCS & APST Workforce model incl. impact on variable pay		Medical Photographer currently based at Glangwili would need to relocate to Prince Philip to ensure BAD guidelines are met there would be additionality as the current uplift from B5 to B6 is met by Med. Illustration but would need to be picked up by Derm. if relocated	Derm pharmacist - no change		Additional B5/6 Medical Photographer 1 WTE required to support telederm clinics
	Changes to current Administrative Workforce			Additional admin staff required due to increase in medical recruitment - 3WTE - base location TBC?		
	Any other additional workforce requirements - e.g. Facilities roles			Query reallocation of hotel services/portering staff from OPD to Derm, but this would be additionality to current establishment		

Any additional Training required?			Nurse consultant - training of existing staff into role? NMP - nursing staff to undertake course CESR - Certificate of Eligibility for Specialist Registration		
Impact on current staff - e.g Will staff need to move site / will model improve MDT working?			Yes, some staff will need to move site (but not all as most medical based at Prince Philip already). The proposed model will improve MDT working		
Will this reduce your current workforce risks & challenges?			Yes, the model will reduce current workforce risks and challenges, and will provide a safer and more sustainable service		
Do you believe this will have a positive or negative impact on recruitment and retention?			Likely to produce positive impact on staff retention for clinical staff due to peer support/coalescence of MDT etc.		
Are there any other interdependent services that will be impacted by this change? e.g. diagnostics, A&E, wards			Medical Photography, as advised above HSDU and Histology - both due to increase in MOPs		
Are there other programmes of work that may impact the option e.g. ARCH / Regional work			ARCH programme now closed SLA with SBUHB (Plastics), and MOU with ABUHB (Telederm) - collaboration		
Are there ways to use technology or innovations to support the delivery of this option?					Increase in use of telederm - additional Medical Photographer cited above would be an additional cost
<b>Estates</b>					
Theatres / Sessions	N/A	N/A	N/A	N/A	N/A
Day Surgery Units (DSU) / Sessions	N/A	N/A	N/A	N/A	N/A
Procedure Rooms / Sessions	NII	NII	3 procedure rooms needed in same area - will need to accommodate MOPs/full equipment spec. inc. storage/fridge for meds (inc. See and Treat - BAD Gold Standard as recommended by the AW Cancer Peer Review process)	NII	CICC to remain in use and is up to spec No procedure room available at South Pems No procedure room required at Crosshands (paeds.)
Outpatients Department / Sessions	NII	NII	Derm would vacate OPD Hub would require 6 consultation rooms and 1 observation room - ?would free up approx. 35% capacity in OPD	NII	CICC and South Pems. - as existing Crosshands - 2 consultation rooms required

Other		Phototherapy suite to remain at Glangwili and is currently being brought up to spec	Medical Photography studio to be based in Hub Waiting area Staff room/kitchen Reception Storage/sluice	NII	
Office space required (Desks)	NII	Offices can reduce from 4 to 2 offices (8 to 4 desks)	4 offices (8 desks) for medical/clinical workforce	NII	No additional office space required
Equipment Moves (Surplus and Essential)		Phototherapy suite to remain at Glangwili and is currently being brought up to spec			
Potential Capital Development needs			Developing a brand new hub - BAD/CIN (Clinical Implementation Network) guidelines will advise on how this should look		
Potential Digital opportunities (achievable within 2-4 years) (E.G. CT Profusion for Stroke)			Electronic patient check-in would negate the need to employ a receptionist and would enhance efficiency/running of the hub and improve auditing (e.g. start/finish times of the clinics).  Potential to utilise photography studio to increase use of telederm		Existing telederm provision
<b>Patients</b>					
Identify what intervention will take place on each site and what interventions will move	NII	Phototherapy to remain in situ	MOPs OPD consultations Service would look to recommence patch testing if workforce in place	NII	CICC - MOPs and OPD - no change South Pems - OPD - no change Crosshands - Paeds. only - OPD, no procedures
Clarify if there are Patient Transfers required (include acuity: ACCTS or NEPTS or WAST) what % of patients this would be (this will need to be evidence based)	NII		Potential increase in use of NEPTS due to increase in service capacity, but majority of activity is already based at Prince Philip.	NII	No increase expected in use of NEPTS at CICC or South Pems. Unlikely to be much requirement for NEPTS to Crosshands (paeds.)
Detail any impacts or changes to regional or national pathways	NII		Potential increased pathway to SBUHB Plastics from Hywel Dda due to capacity increase in Hub (i.e. more patients being seen in Hub likely to produce a proportionate increase in referrals to tertiary care)	NII	
<b>Addressing Barriers</b>					
Waiting Lists			Additional procedure rooms would address waiting times for urgent, routine, and USC treatments meaning the service would meet the ministerial targets and the Single Cancer Pathway targets		Reduction in waiting lists
Waiting Times			Waiting times would reduce with the increase in capacity in rooms and staff		Reductions in waiting times

Other			<p>For consideration: potential income via recharge for using the Hub for WLI or to let the rooms - e.g. GP OOH/backfill for other specialities</p> <p>Potential income - receiving overflow patients from SBUHB due to improved capacity at HDDUHB</p>	
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DERMATOLOGY	Bronglais	Glangwili	Prince Philip	Withybush	Community Sites
OPTION 1	Withdraw services	Withdraw services	Centralise all acute services to Prince Philip Hospital with additional space	Withdraw services	Provide services at Ceredigion Integrated Care Centre and Amman Valley Hospital only
OPTION 2	No Dermatology service	No Dermatology service	Keep Dermatology at PPH but need to grow it, link with Ophthalmology / ENT for shared space	No Dermatology service	Non acute minor surgery unit in Carmarthenshire plus additional 'spokes' in South Pembrokeshire.
OPTION 3	No Dermatology service	No Dermatology service	Consolidate in Prince Philip Hospital	No Dermatology service	Crosshands option for Paediatric Dermatology. Continue with Telederm and current Community provision ie Cardigan & South Pems. Utilising skills of GP's special interest
OPTION 4	No service	No service	<p>Consolidate in Prince Philip or East of Health Board</p> <p>Best option for the service as Hub with spokes in community</p>	No service	<p>Dermatology Spokes in South Pems, Cardigan ICC (existing services) and Crosshands</p> <p>Future -Crosshands Hub Paediatric dermatology in the community, working alongside Health visitors — 1 day per week.</p> <p>Office space available</p>

EMERGENCY GENERAL SURGERY		Bronglais	Glangwili	Prince Philip	Withybush	Community Sites
O P T I O N  1	OPTION 1	As per current configuration – 24 hour service	24 Hour cover provided for Glangwili, Prince Philip and Withybush Hospitals	Current configuration - No activity at site	All patients requiring admission sent to Glangwili. Development of surgical SDEC. 0730 – 2000, 7 days a week on call support	Current configuration - No activity at community sites
	Workforce Requirement					
	Are there any changes required to current Rotas? include On Call, moving to a 7 day model etc	none	1:12 rota Recruit into vacant consultant posts (X3.5 consultants) - merge 1:8 in Glangwili and 1:4 Withybush consultant on call rota	None	Consultant scheduled through job plan to a day per week (3 sessions between 10am -8pm) in SDEC. This would impact on elective work  OR 1:5 rota to cover SDEC which would mean consultants in Withybush could potentially be on two rotas (EGS and SDEC)	
	Any changes to current Bed numbers?	none	INCREASE X5 ADDITIONAL ADMISSIONS PER DAY  Enhanced Care Unit (ECU) - 4 beds	None	Reduction of x5 admissions per day, moving to Glangwili.	
	Changes to current Medical workforce model incl. impact on variable pay	ROTA DEPENDENCY - TRAVEL EXPENSES	Fill all vacancies for consultant posts from locum and medacs to substantive posts ROTA DEPENDENCY - TRAVEL EXPENSES/ OCP/ SESSIONAL COSTS  Combine Glangwili and Withybush SAS level rota which would become a 1:12, there would be an expectation there would be cross site working with Withybush. This will incur additional travel, a session in job plan for travel and accomodation costs	ROTA DEPENDENCY - TRAVEL EXPENSES/ OCP/ SESSIONAL COSTS	ROTA DEPENDENCY - TRAVEL EXPENSES/ SESSIONAL COSTS/ NO OVERNIGHT CONSULTANT COVER - CHANGE TO MIDDLE GRADE NO MIDDLE GRADE IN HOURS Fill all vacancies for consultant posts from locum and medacs to substantive posts  SDEC will have consultant cover mon-fri and weekend cover by SAS grade	
	Changes to current Nursing & HCSW model incl. impact on variable pay	NONE	WITHIN CURRENT CONFIG IF PATIENTS ARE CARED FOR IN THE SAME WARD ADDITIONAL X2 ACPS x4 RN and HCSW but location dependent, X1 rn AND hcsw PER SHIFT / Theatre staff for the dedicated NCPOD  Dedicated nursing and HCSW staff to cover 6/8 SDEC trolleys (inc overnight and leave cover) and 4 bed ECU	NONE	ACP REQUIRED X2 / x4 RN and HCSW but location dependent X1 rn AND hcsw PER SHIFT / Theatre staff for the dedicated NCPOD  Dedicated nursing and HCSW staff to cover 6/8 SDEC trolleys (inc overnight and leave cover)	
	Changes to current Therapies workforce model incl. impact on variable pay	NO CHANGE				
	Changes to current HCS & APST Workforce model incl. impact on variable pay		ADDITIONAL PHARMACY cover for weekends x1.5 days/ pre-packed drug packs for SDEC dispensing		ADDITIONAL PHARMACY cover for weekends x1.5 days/ pre-packed drug packs for SDEC dispensing	
	Changes to current Administrative Workforce	NONE	WARD CLERK x1 (inc sick and leave cover) 8am - 5pm for SDEC	NONE	WARD CLERK x1 (inc sick and leave cover) 8am - 5pm for SDEC	
	Any other additional workforce requirements - e.g. Facilities roles		Hotel Services for SDEC		Hotel Services for SDEC	

Any additional Training required?		Desirable not crucial for the model and improve LOS REPARTRIATION ROLE peri operative phys - MIDDLE GRADE ROLE (LOOK AT CARE OF THE ELDERLY ROLE IN WGH ORTHO)		Desirable not crucial for the model and improve LOS REPARTRIATION ROLE peri operative phys - MIDDLE GRADE ROLE (LOOK AT CARE OF THE ELDERLY ROLE IN WGH ORTHO)	
Impact on current staff - e.g Will staff need to move site / will model improve MDT working?		medical travel/ sessional		medical travel/ sessional	
Will this reduce your current workforce risks & challenges?	none	Long term improvement to recruitment and retention re: rota improvement.	none	Withybush will avoid medacs locums which will improve quality of care	
Do you believe this will have a positive or negative impact on recruitment and retention?		positive - as above		neutral variable appetite for rota interdependencies on additional cost and pressure to work away from home	
Are there any other interdependent services that will be impacted by this change? e.g. diagnostics, A&E, wards	In order to maintain service, there is an INTERDEPENDENCY NEED to maintain LEVEL 3 ITU	INTERDEPENDENCY NEED LEVEL 3 ITU / increased demand on radiological / scans to be reported		Impact on A&E - no consultant cover for A&E CC and trauma and daytime services as only middle grade OOHINTERDEPENDENCY NEED LEVEL 3	
Are there other programmes of work that may impact the option e.g. ARCH / Regional work					
Are there ways to use technology or innovations to support the delivery of this option?	POCT / ELECTRONIC PRESCRIBING FOR NON-ADMITTED sdec PATIENTS, LINKING WITH COMMUNITY PHARMACY	POCT / ELECTRONIC PRESCRIBING FOR NON-ADMITTED sdec PATIENTS, LINKING WITH COMMUNITY PHARMACY		POCT / ELECTRONIC PRESCRIBING FOR NON-ADMITTED sdec PATIENTS, LINKING WITH COMMUNITY PHARMACY	
<b>Estates</b>					
Theatres / Sessions		Dedicated NCPOD theatre for General surgery only for the extra 5 admission per day until 9pm. Between 9pm and 8am revert to shared NCPOD		Remove NCPOD list for general surgery	
Day Surgery Units (DSU) / Sessions					
Procedure Rooms / Sessions		X1 Treatment room inc/ couch / lighting / Inc new BP monitor/ suction/ oxygen resus trolley within the SDEC area with a couch QUERY 24/7  Enhanced Care Unit will need wall mounted monitors for x4 beds		X1 Treatment room inc/ couch / lighting / Inc new BP monitor/ suction/ oxygen resus trolley within the SDEC area with a couch. QUERY - should it close at 8 or 5pm on weekends	
Outpatients Department / Sessions					

Other		SDEC 'area' to include 6/8 assessment trollies with space for triage assessment. Access to photocopier 2 desk, computers, monitor, phone etc Lockable notes trolley		SDEC 'area' to include 6/8 assessment trollies with space for triage assessment	
Office space required (Desks)		2 desk office space to assess results for clinician/ admin		2 desk office space to assess results for clinician/ admin	
Equipment Moves (Surplus and Essential)		CONSUMABLES		CONSUMABLES	
Potential Capital Development needs	POCT	Reconfigure site for ring fenced general suregy acute beds POCT Refurbishment/establishment of ECU & SDEC		Reconfigure site for ring fenced general beds INTERDEPENDENCY NEED LEVEL 3 ITU / POCT	
Potential Digital opportunities (achievable within 2-4 years) (E.G. CT Profusion for Stroke)	Consultant connect (intrain)	Consultant connect (intrain)		Consultant connect (intrain)	
<b>Patients</b>					
Identify what intervention will take place on each site and what interventions will move		PATHWAY WILL REMAIN THE SAME - UPPER GI BLEEDS REMAIN S AS PER NOW. Oncall week will redirect to which ever site is on call. GP & a&e ambulatory take remains the same.		PATHWAY WILL REMAIN THE SAME - UPPER GI BLEEDS REMAIN S AS PER NOW. Oncall week will redirect to which ever site is on call. GP & a&e ambulatory take remains the same.	
Clarify if there are Patient Transfers required (include acuity: ACCTS or NEPTS or WAST) what % of patients this would be (this will need to be evidence based)		Walk-in urgent presentation for wast / DEPENDENT ON CONSULTANT DECISION FOR nepts/ Of 20-25 presentations = 6 admissions (including A&E patients). / NEPTS x1-2 per week		WAST FOR THE HYBRID MODEL/walk-in urgent presentation for wast / DEPENDENT ON CONSULTANT DECISION FOR nepts / of 15 presentations = 5 admissions (including A&E patients) / NEPTS x1-2 per week	
Detail any impacts or changes to regional or national pathways	pathway remains the same	pathway remains the same	pathway remains the same	pathway remains the same	
<b>Addressing Barriers</b>					
Waiting Lists					
Waiting Times		transfers / NCPD waiting time	transfers	transffer / NCD waiting time	

Other		resistance to rota changes		resistance to rota changes	
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EMERGENCY GENERAL SURGERY		Bronglais	Glangwili	Prince Philip	Withybush	Community Sites
<b>OPTION 2</b>	As per current configuration – 24 hour service	Hybrid model: Withybush retains EGS alternating weekly 24/7 with WGH SDEC IN HOURS	Current configuration - No activity at site	Hybrid model: Withybush retains EGS with alternating weekly 24/7 between GGH and WGH SDEC IN HOURS	Current configuration –no activity at community sites	
<b>OPTION 2</b>	<b>Workforce Requirement</b>					
	Are there any changes required to current Rotas? include On Call, moving to a 7 day model etc	none	1:12 rota Recruit into vacant consultant posts (X3.5 consultants) - merge 1:8 in Glangwili and 1:4 Withybush consultant on call rota. The rota will alternate weeks between Glangwili and Withybush	None	Consultant scheduled through job plan to a day per week (3 sessions between 10am - 8pm) in SDEC. This would impact on elective work  OR  1:5 rota to cover SDEC which would mean consultants in Withybush could potentially be on two rotas (EGS and SDEC)  The rota will alternate weeks between Glangwili and Withybush	
	Any changes to current Bed numbers?	none	INCREASE X5 ADDITIONAL ADMISSIONS PER DAY  Enhanced Care Unit (ECU) - 4 beds	None	Reduction of x5 admissions per day, moving to Glangwili.	
	Changes to current Medical workforce model incl. impact on variable pay	ROTA DEPENDENCY - TRAVEL EXPENSES	Fill all vacancies for consultant posts from locum and medacs to substantive posts ROTA DEPENDENCY - TRAVEL EXPENSES/ OCP/ SESSIONAL COSTS  Combine Glangwili and Withybush SAS level rota which would become a 1:12, there would be an expectation there would be cross site working with Withybush. This will incur additional	ROTA DEPENDENCY - TRAVEL EXPENSES/ OCP/ SESSIONAL COSTS	ROTA DEPENDENCY - TRAVEL EXPENSES/ SESSIONAL COSTS/ NO OVERNIGHT CONSULTANT COVER - CHANGE TO MIDDLE GRADE NO MIDDLE GRADE IN HOURS Fill all vacancies for consultant posts from locum and medacs to substantive posts	
	Changes to current Nursing & HCSW model incl. impact on variable pay	NONE	WITHIN CURRENT CONFIG IF PATIENTS ARE CARED FOR IN THE SAME WARD ADDITIONAL X2 ACPS x4 RN and HCSW but location dependent, X1 rn AND hcsw PER SHIFT / Theatre staff for the dedicated NCPOD  Dedicated nursing and HCSW staff to cover 6/8 SDEC trolleys (inc overnight and leave cover) and 4 bed ECU	NONE	ACP REQUIRED X2 / x4 RN and HCSW but location dependent X1 rn AND hcsw PER SHIFT / Theatre staff for the dedicated NCPOD  Dedicated nursing and HCSW staff to cover 6/8 SDEC trolleys (inc overnight and leave cover)	
	Changes to current Therapies workforce model incl. impact on variable pay	NO CHANGE				
	Changes to current HCS & APST Workforce model incl. impact on variable pay		ADDITIONAL PHARMACY cover for weekends x1.5 days/ pre-packed drug packs for SDEC dispensing		ADDITIONAL PHARMACY cover for weekends x1.5 days/ pre-packed drug packs for SDEC dispensing	
	Changes to current Administrative Workforce	NONE	WARD CLERK x1 (inc sick and leave cover) 8am - 5pm for SDEC	NONE	WARD CLERK x1 (inc sick and leave cover) 8am - 5pm for SDEC	

Any other additional workforce requirements - e.g. Facilities roles		Hotel Services for SDEC		Hotel Services for SDEC	
Any additional Training required?		Desirable not crucial for the model and improve LOS REPARTRIATION ROLE peri operative phys - MIDDLE GRADE ROLE (LOOK AT CARE OF THE ELDERLY ROLE IN WGH ORTHO)		Desirable not crucial for the model and improve LOS REPARTRIATION ROLE peri operative phys - MIDDLE GRADE ROLE (LOOK AT CARE OF THE ELDERLY ROLE IN WGH ORTHO)	
Impact on current staff - e.g Will staff need to move site / will model improve MDT working?		medical travel/ sessional		medical travel/ sessional	
Will this reduce your current workforce risks & challenges?	none	Long term improvement to recruitment and retention re: rota improvement.	none	Withybush will avoid medacs locums which will improve quality of care	
Do you believe this will have a positive or negative impact on recruitment and retention?		positive - as above		neutral variable appetite for rota interdependencies on additional cost and pressure to work away from home	
Are there any other interdependent services that will be impacted by this change? e.g. diagnostics, A&E, wards	In order to maintain service, there is an INTERDEPENDENCY NEED to maintain LEVEL 3 ITU	INTERDEPENDENCY NEED LEVEL 3 ITU / increased demand on radiological / scans to be reported Trauma network criteria management for the weeks the service is running in Withybush		impact on A&E - no consultant cover for A&E, CC and trauma and daytime services as only middle grade OOINTERDEPENDENCY NEED LEVEL 3 Paediatric surgical out of hours management for weeks of the year - on the weeks the service is running in Glangwili Trauma network criteria management for the weeks the service is running in Glangwili	
Are there other programmes of work that may impact the option e.g. ARCH / Regional work					
Are there ways to use technology or innovations to support the delivery of this option?	POCT / ELECTRONIC PRESCRIBING FOR NON-ADMITTED sdec PATIENTS, LINKING WITH COMMUNITY PHARMACY	POCT / ELECTRONIC PRESCRIBING FOR NON-ADMITTED sdec PATIENTS, LINKING WITH COMMUNITY PHARMACY		POCT / ELECTRONIC PRESCRIBING FOR NON-ADMITTED sdec PATIENTS, LINKING WITH COMMUNITY PHARMACY	
<b>Estates</b>					
Theatres / Sessions		Dedicated NCPOD theatre for General surgery only for the extra 5 admission per day until 9pm. Between 9pm and 8am revert to shared NCPOD		Remove NCPOD list for general surgery	
Day Surgery Units (DSU) / Sessions					

Procedure Rooms / Sessions		X1 Treatment room inc/ couch / lighting / Inc new BP monitor/ suction/ oxygen resus trolley within the SDEC area with a couch <b>QUERY 24/7</b>  <b>Enhanced Care Unit will need wall mounted monitors for x4 beds</b>		X1 Treatment room inc/ couch / lighting / Inc new BP monitor/ suction/ oxygen resus trolley within the SDEC area with a couch. <b>QUERY - should it close at 8 or 5pm on weekends</b>	
Outpatients Department / Sessions					
Other		SDEC 'area' to include 6/8 assessment trollies with space for triage assessment.  Access to photocopier 2 desk, computers, monitor, phone etc Lockable notes trolley		SDEC 'area' to include 6/8 assessment trollies with space for triage assessment	
Office space required (Desks)					
Equipment Moves (Surplus and Essential)					
Potential Capital Development needs					
Potential Digital opportunities (achievable within 2-4 years) (E.G. CT Profusion for Stroke)					
	POCT	Reconfigure site for ring fenced general suregy acute beds POCT  Refurbishment/establishment of ECU & SDEC		Reconfigure site for ring fenced general beds INTERDEPENDENCY NEED LEVEL 3 ITU / POCT	
	Consultant connect (intrain)	Consultant connect (intrain)		Consultant connect (intrain)	
<b>Patients</b>					
Identify what intervention will take place on each site and what interventions will move					
Clarify if there are Patient Transfers required (include acuity: ACCTS or NEPTS or WAST) what % of patients this would be (this will need to be evidence based)					
		Walk-in urgent presentation for wast / DEPENDENT ON CONSULTANT DECISION FOR nepts/ Of 20-25 presentations = 6 admissions (including A&E patients). / NEPTS x1-2 per week		WAST FOR THE HYBRID MODEL/walk-in urgent presentation for wast / DEPENDENT ON CONSULTANT DECISION FOR nepts / of 15 presentations = 5 admissions (including A&E patients) / NEPTS x1-2 per week	
Detail any impacts or changes to regional or national pathways					
	pathway remains the same	pathway remains the same	pathway remains the same	pathway remains the same	
<b>Addressing Barriers</b>					

Waiting Lists					
Waiting Times		transfers / NCPD waiting time	transfers	transfer / NCPD waiting time	
Other		resistance to rota changes		resistance to rota changes	

EMERGENCY GENERAL SURGERY		Bronglais	Glangwili	Prince Philip	Withybush	Community Sites
<b>OPTION 3</b>	As per current configuration – 24-hour service	Emergency General Surgery including patients from Withybush Hospital  Surgical SDEC would be required support the planned care services	Current configuration – no activity at site	Removal of Emergency General Surgery at WGH  Surgical SDEC to be introduced, and patients requiring EGS to be transferred to Glangwili	Current configuration – no activity at community sites	
<b>O P T I O N 3</b>	<b>Workforce Requirement</b>					
	Are there any changes required to current Rotas? include On Call, moving to a 7 day model etc	none	1:12 rota Recruit into vacant consultant posts (X3.5 consultants) - merge 1:8 in Glangwili and 1:4 Withybush consultant on call rota	None	Consultant scheduled through job plan to a day per week (3 sessions between 10am -8pm) in SDEC. This would impact on elective work  OR 1:5 rota to cover SDEC which would mean consultants in	
	Any changes to current Bed numbers?	none	<b>INCREASE X5 ADDITIONAL ADMISSIONS PER DAY</b>  Enhanced Care Unit (ECU) - 4 beds	None	Reduction of x5 admissions per day, moving to Glangwili.	
	Changes to current Medical workforce model incl. impact on variable pay	ROTA DEPENDENCY - TRAVEL EXPENSES	Fill all vacancies for consultant posts from locum and medacs to substantive posts ROTA DEPENDENCY - TRAVEL EXPENSES/ OCP/ SESSIONAL COSTS  Combine Glangwili and Withybush SAS level rota which would become a 1:12, there would be an expectation there would be cross site working with Withybush. This will incur additional	ROTA DEPENDENCY - TRAVEL EXPENSES/ OCP/ SESSIONAL COSTS	ROTA DEPENDENCY - TRAVEL EXPENSES/ SESSIONAL COSTS  SDEC will have consultant cover mon-fri and weekend cover by SAS grade	
	Changes to current Nursing & HCSW model incl. impact on variable pay	NONE	WITHIN CURRENT CONFIG IF PATIENTS ARE CARED FOR IN THE SAME WARD ADDITIONAL X2 ACPSy4 RN and HCSW but location dependent, X1 in AND hcsw PER SHIFT / Theatre staff for the dedicated NCPD  Dedicated nursing and HCSW staff to cover 6/8 SDEC trolleys (inc overnight and leave cover) and 4 bed ECU	NONE	ACP REQUIRED X2 / x4 RN and HCSW but location dependent X1 in AND hcsw PER SHIFT / Theatre staff for the dedicated NCPD  Dedicated nursing and HCSW staff to cover 6/8 SDEC trolleys (inc overnight and leave cover)	
	Changes to current Therapies workforce model incl. impact on variable pay	NO CHANGE				
	Changes to current HCS & APST Workforce model incl. impact on variable pay		ADDITIONAL PHARMACY cover for weekends x1.5 days/ pre-packed drug packs for SDEC dispensing		ADDITIONAL PHARMACY cover for weekends x1.5 days/ pre-packed drug packs for SDEC dispensing	

Changes to current <b>Administrative</b> Workforce	NONE	WARD CLERK x1 (inc sick and leave cover) 8am - 5pm for SDEC	NONE	WARD CLERK x1 (inc sick and leave cover) 8am - 5pm for SDEC	
Any other additional workforce requirements - e.g. Facilities roles		Hotel Services for SDEC		Hotel Services for SDEC	
Any additional Training required?		Desirable not crucial for the model and improve LOS REPARTRIATION ROLE peri operative phys - MIDDLE GRADE ROLE (LOOK AT CARE OF THE ELDERLY ROLE IN WGH ORTHO)		Desirable not crucial for the model and improve LOS REPARTRIATION ROLE peri operative phys - MIDDLE GRADE ROLE (LOOK AT CARE OF THE ELDERLY ROLE IN WGH ORTHO)	
Impact on current staff - e.g Will staff need to move site / will model improve MDT working?		medical travel/ sessional		medical travel/ sessional	
Will this reduce your current workforce risks & challenges?	none	Long term improvement to recruitment and retention re: rota improvement.	none	Withybush will avoid medacs locums which will improve quality of care	
Do you believe this will have a positive or negative impact on recruitment and retention?		positive - as above		neutral variable appetite for rota interdependencies on additional cost and pressure to work away from home	
Are there any other interdependent services that will be impacted by this change? e.g. diagnostics, A&E, wards	In order to maintain service, there is an INTERDEPENDENCY NEED to maintain LEVEL 3 ITU	INTERDEPENDENCY NEED LEVEL 3 ITU / increased demand on radiological / scans to be reported		Impact on A&E - no consultant cover for A&E CC and trauma and daytime services as only middle grade OOHINTERDEPENDENCY NEED LEVEL 3	
Are there other programmes of work that may impact the option e.g. ARCH / Regional work					
Are there ways to use technology or innovations to support the delivery of this option?	POCT / ELECTRONIC PRESCRIBING FOR NON-ADMITTED sdec PATIENTS, LINKING WITH COMMUNITY PHARMACY	POCT / ELECTRONIC PRESCRIBING FOR NON-ADMITTED sdec PATIENTS, LINKING WITH COMMUNITY PHARMACY		POCT / ELECTRONIC PRESCRIBING FOR NON-ADMITTED sdec PATIENTS, LINKING WITH COMMUNITY PHARMACY	
<b>Estates</b>					
Theatres / Sessions		Dedicated NCPOD theatre for General surgery only for the extra 5 admission per day until 9pm. Between 9pm and 8am revert to shared NCPOD		Remove NCPOD list for general surgery	
Day Surgery Units (DSU) / Sessions					

Procedure Rooms / Sessions		X1 Treatment room inc/ couch / lighting / Inc new BP monitor/ suction/ oxygen resus trolley within the SDEC area with a couch <b>QUERY 24/7</b>  <b>Enhanced Care Unit will need wall mounted monitors for x4 beds</b>		X1 Treatment room inc/ couch / lighting / Inc new BP monitor/ suction/ oxygen resus trolley within the SDEC area with a couch. <b>QUERY - should it close at 8 or 5pm on weekends</b>	
Outpatients Department / Sessions					
Other		SDEC 'area' to include 6/8 assessment trollies with space for triage assessment.  Access to photocopier 2 desk, computers, monitor, phone etc Lockable notes trolley		SDEC 'area' to include 6/8 assessment trollies with space for triage assessment	
Office space required (Desks)					
		<b>2 desk office space to assess results for clinician/ admin</b>		<b>2 desk office space to assess results for clinician/ admin</b>	
Equipment Moves (Surplus and Essential)					
		CONSUMABLES		CONSUMABLES	
Potential Capital Development needs		Reconfigure site for ring fenced general suregy acute beds POCT  Refurbishment/establishment of ECU & SDEC		Reconfigure site for ring fenced general beds INTERDEPENDENCY NEED LEVEL 3 ITU / POCT	
Potential Digital opportunities (achievable within 2-4 years) (E.G. CT Profusion for Stroke)	POCT				
	Consultant connect (intrain)	Consultant connect (intrain)		Consultant connect (intrain)	
<b>Patients</b>					
Identify what intervention will take place on each site and what interventions will move		PATHWAY WILL REMAIN THE SAME - UPPER GI BLEEDS REMAIN S AS PER NOW. Oncall week will redirect to which ever site is on call. GP & a&e ambulatory take remains the same.		PATHWAY WILL REMAIN THE SAME - UPPER GI BLEEDS REMAIN S AS PER NOW. Oncall week will redirect to which ever site is on call. GP & a&e ambulatory take remains the same.	
Clarify if there are Patient Transfers required (include acuity: ACCTS or NEPTS or WAST) what % of patients this would be (this will need to be evidence based)		Walk-in urgent presentation for wast / DEPENDENT ON CONSULTANT DECISION FOR nepts/ Of 20-25 presentations = 6 admissions (including A&E patients). / NEPTS x1-2 per week		WAST FOR THE HYBRID MODEL/walk-in urgent presentation for wast / DEPENDENT ON CONSULTANT DECISION FOR nepts / of 15 presentations = 5 admissions (including A&E patients) / NEPTS x1-2 per week	
Detail any impacts or changes to regional or national pathways	pathway remains the same	pathway remains the same	pathway remains the same	pathway remains the same	
<b>Addressing Barriers</b>					

Waiting Lists					
Waiting Times		transfers / NCPD waiting time	transfers	transfers / NCPD waiting time	
Other		resistance to rota changes		resistance to rota changes	

EMERGENCY GENERAL SURGERY		Bronglais	Glangwili	Prince Philip	Withybush	Community Sites
O P T I O N  4	OPTION 4	As per current configuration – 24 hour service	Consolidate service from Withybush Hospital	Current configuration – no activity at site	Stabilise and transfer to Glangwili Hospital  Development of surgical SAU / SDEC (reduce flow to GGH – day time) and ringfenced beds in Glangwili  Invest in Training for before & after surgery care	Current configuration – no activity at community sites
	Workforce Requirement					
	Are there any changes required to current Rotas? include On Call, moving to a 7 day model etc	none	1:12 rota Recruit into vacant consultant posts (X3.5 consultants) - merge 1:8 in Glangwili and 1:4 Withybush consultant on call rota	None	Consultant scheduled through job plan to 4 day per week (3 sessions between 10am - 8pm) in SDEC. This would impact on elective work  OR  1:5 rota to cover SDEC which would mean consultants in	
	Any changes to current Bed numbers?	none	INCREASE X5 ADDITIONAL ADMISSIONS PER DAY  Enhanced Care Unit (ECU) - 4 beds	None	Reduction of x5 admissions per day, moving to Glangwili.	
	Changes to current Medical workforce model incl. impact on variable pay	ROTA DEPENDENCY - TRAVEL EXPENSES	Fill all vacancies for consultant posts from locum and medacs to substantive posts ROTA DEPENDENCY - TRAVEL EXPENSES/ OCP/ SESSIONAL COSTS  Combine Glangwili and Withybush SAS level rota which would become a 1:12, there would be an expectation there would be cross site working with Withybush. This will incur additional	ROTA DEPENDENCY - TRAVEL EXPENSES/ OCP/ SESSIONAL COSTS	ROTA DEPENDENCY - TRAVEL EXPENSES/ SESSIONAL COSTS/ NO OVERNIGHT CONSULTANT COVER - CHANGE TO MIDDLE GRADE NO MIDDLE GRADE IN HOURS Fill all vacancies for consultant posts from locum and medacs to substantive posts  SDEC will have consultant cover mon-fri and weekend cover by SAS grade	
	Changes to current Nursing & HCSW model incl. impact on variable pay	NONE	WITHIN CURRENT CONFIG IF PATIENTS ARE CARED FOR IN THE SAME WARD ADDITIONAL X2 ACPSx4 RN and HCSW but location dependent, X1 rn AND hcsw PER SHIFT / Theatre staff for the dedicated NCPD  Dedicated nursing and HCSW staff to cover 6/8 SDEC trolleys (inc overnight and leave cover) and 4 bed ECU	NONE	ACP REQUIRED X2 / x4 RN and HCSW but location dependent X1 rn AND hcsw PER SHIFT / Theatre staff for the dedicated NCPD  Dedicated nursing and HCSW staff to cover 6/8 SDEC trolleys (inc overnight and leave cover)	
	Changes to current Therapies workforce model incl. impact on variable pay	NO CHANGE				

Changes to current <b>HCS &amp; APST</b> Workforce model incl. impact on variable pay		ADDITIONAL PHARMACY cover for weekends x1.5 days/ pre-packed drug packs for SDEC dispensing		ADDITIONAL PHARMACY cover for weekends x1.5 days/ pre-packed drug packs for SDEC dispensing	
Changes to current <b>Administrative</b> Workforce	NONE	WARD CLERK x1 (inc sick and leave cover) 8am - 5pm for SDEC	NONE	WARD CLERK x1 (inc sick and leave cover) 8am - 5pm for SDEC	
Any other additional workforce requirements - e.g. Facilities roles		Hotel Services for SDEC		Hotel Services for SDEC	
Any additional Training required?		Desirable not crucial for the model and improve LOS REPARTRIATION ROLE peri operative phys - MIDDLE GRADE ROLE (LOOK AT CARE OF THE ELDERLY ROLE IN WGH ORTHO)		Desirable not crucial for the model and improve LOS REPARTRIATION ROLE peri operative phys - MIDDLE GRADE ROLE (LOOK AT CARE OF THE ELDERLY ROLE IN WGH ORTHO)	
Impact on current staff - e.g Will staff need to move site / will model improve MDT working?		medical travel/ sessional		medical travel/ sessional	
Will this reduce your current workforce risks & challenges?	none	Long term improvement to recruitment and retention re: rota improvement.	none	Withybush will avoid medacs locums which will improve quality of care	
Do you believe this will have a positive or negative impact on recruitment and retention?		positive - as above		neutral variable appetite for rota interdependencies on additional cost and pressure to work away from home	
Are there any other interdependent services that will be impacted by this change? e.g. diagnostics, A&E, wards	In order to maintain service, there is an INTERDEPENDENCY NEED to maintain LEVEL 3 ITU	INTERDEPENDENCY NEED LEVEL 3 ITU / increased demand on radiological / scans to be reported		Impact on A&E - no consultant cover for A&E CC and trauma and daytime services as only middle grade OOHINTERDEPENDENCY NEED LEVEL 3	
Are there other programmes of work that may impact the option e.g. ARCH / Regional work					
Are there ways to use technology or innovations to support the delivery of this option?	POCT / ELECTRONIC PRESCRIBING FOR NON-ADMITTED sdec PATIENTS, LINKING WITH COMMUNITY PHARMACY	POCT / ELECTRONIC PRESCRIBING FOR NON-ADMITTED sdec PATIENTS, LINKING WITH COMMUNITY PHARMACY		POCT / ELECTRONIC PRESCRIBING FOR NON-ADMITTED sdec PATIENTS, LINKING WITH COMMUNITY PHARMACY	
<b>Estates</b>					
Theatres / Sessions		Dedicated NCPOD theatre for General surgery only for the extra 5 admission per day until 9pm. Between 9pm and 8am revert to shared NCPOD		Remove NCPOD list for general surgery	

Day Surgery Units (DSU) / Sessions					
Procedure Rooms / Sessions		X1 Treatment room inc/ couch / lighting / Inc new BP monitor/ suction/ oxygen resus trolley within the SDEC area with a couch QUERY 24/7  Enhanced Care Unit will need wall mounted monitors for x4 beds		X1 Treatment room inc/ couch / lighting / Inc new BP monitor/ suction/ oxygen resus trolley within the SDEC area with a couch. QUERY - should it close at 8 or 5pm on weekends	
Outpatients Department / Sessions					
Other		SDEC 'area' to include 6/8 assessment trollies with space for triage assessment.  Access to photocopier 2 desk, computers, monitor, phone etc Lockable notes trolley		SDEC 'area' to include 6/8 assessment trollies with space for triage assessment	
Office space required (Desks)					
		2 desk office space to assess results for clinician/ admin		2 desk office space to assess results for clinician/ admin	
Equipment Moves (Surplus and Essential)					
		CONSUMABLES		CONSUMABLES	
Potential Capital Development needs		Reconfigure site for ring fenced general surgery acute beds POCT  Refurbishment/establishment of ECU & SDEC		Reconfigure site for ring fenced general beds INTERDEPENDENCY NEED LEVEL 3 ITU / POCT	
Potential Digital opportunities (achievable within 2-4 years) (E.G. CT Profusion for Stroke)	POCT				
	Consultant connect (intrain)	Consultant connect (intrain)		Consultant connect (intrain)	
<b>Patients</b>					
Identify what intervention will take place on each site and what interventions will move		PATHWAY WILL REMAIN THE SAME - UPPER GI BLEEDS REMAIN S AS PER NOW. Oncall week will redirect to which ever site is on call. GP & a&e ambulatory take remains the same.		PATHWAY WILL REMAIN THE SAME - UPPER GI BLEEDS REMAIN S AS PER NOW. Oncall week will redirect to which ever site is on call. GP & a&e ambulatory take remains the same.	
Clarify if there are Patient Transfers required (include acuity: ACCTS or NEPTS or WAST) what % of patients this would be (this will need to be evidence based)		Walk-in urgent presentation for wast / DEPENDENT ON CONSULTANT DECISION FOR nepts/ OF 20-25 presentations = 6 admissions (including A&E patients). / NEPTS x1-2 per week		WAST FOR THE HYBRID MODEL/walk-in urgent presentation for wast / DEPENDENT ON CONSULTANT DECISION FOR nepts / of 15 presentations = 5 admissions (including A&E patients) / NEPTS x1-2 per week	
Detail any impacts or changes to regional or national pathways	pathway remains the same	pathway remains the same	pathway remains the same	pathway remains the same	

Addressing Barriers					
Waiting Lists					
Waiting Times		transfers / NCPD waiting time	transfers	transfers / NCPD waiting time	
Other		resistance to rota changes		resistance to rota changes	

EMERGENCY GENERAL SURGERY	Bronglais	Glangwili	Prince Philip	Withybush	Community Sites
OPTION 1	As per current configuration – 24 hour service	24 Hour cover provided for Glangwili, Prince Philip and Withybush Hospitals	Current configuration - No activity at site	All patients requiring admission sent to Glangwili. Development of surgical SDEC. 0730 – 2000, 7 days a week on call support or 9-5 on call support	Current configuration - No activity at community sites
OPTION 2	As per current configuration – 24 hour service	Hybrid model: Withybush retains EGS	Current configuration - No activity at site	Hybrid model: Withybush retains EGS with exception of OOH to Glangwili	Current configuration –no activity at community sites
OPTION 3	As per current configuration – 24-hour service	Emergency General Surgery including patients from Withybush Hospital Surgical SDEC would be required support the planned care services	Current configuration – no activity at site	Removal of Emergency General Surgery at WGH Surgical SDEC to be introduced, and patients requiring EGS to be transferred to Glangwili	Current configuration – no activity at community sites
OPTION 4	As per current configuration – 24 hour service	Consolidate service from Withybush Hospital	Current configuration – no activity at site	Stabilise and transfer to Glangwili Hospital Development of surgical SAU / SDEC (reduce flow to GGH – day time) and ringfenced beds in Glangwili Invest in Training for before & after surgery care	Current configuration – no activity at community sites

OPHTHALMOLOGY		Bronglais	Glangwili	Prince Philip	Withybush	Community Sites	CIIC	AICC	AV	SPEMBS	NREC	
O P T I O N  1	OPTION 1	Withdraw Service to centralise in Glangwili	Surgery is in Day Surgery Unit. Include Cataract and Intravitreal injection (IVT) services. E emergency eyecare (RACE) to be co-located to another department. Possible option for SDEC to run RACE.	Withdraw from site to centralise in Glangwili	Undertake Intravitreal injection (IVT) services only.	Reduce community footprint to just Cardigan Integrated Care Centre for diagnostics, North Road (Aberystwyth) for IVT and Outpatients. Withdraw service from South Pembro Hospital. Remove IVT from Amman Valley OPD. Cataract to remain. Maintain existing services in other community sites						
	Workforce Requirement											
	Are there any changes required to current Rotas? include On Call, moving to a 7 day model etc	Location change for surgeon - 1 session x 3 Locums per week at GGH	Yes. Rotas would need to be reworked to accommodate 3 extra theatre sessions and clinics moving from other sites.	Yes. Rotas would need to be reworked to relocate clinicians from clinic to GGH releasing 12 clinical workforce sessions in PPH	Yes. Rotas would need to be reworked to centralise 4 clinic sessions at GGH			Release 2 clinician sessions	Release 4 clinician sessions	Rota redesign to allocate surgeons to AV	Doctor would go to WGH instead of 5 Pembs	No change
	Any changes to current Bed numbers?	No bed base required as use DSU beds - would release DSU capacity (3 sessions)	No - no ringfenced beds, minimal in emergency	No	No			No	NO	No	No	No
	Changes to current Medical workforce model incl. impact on variable pay	Some travel time of Locum saved	3 theatre sessions additional (from Bronglais) 11 theatre sessions in total needed in Glangwili Filling current vacancies would enable this option (no need for additional)	Reduction in travel between sites	No		AV cataracts to remain at 10 sessions	2 clinician sessions to be relocated to North Road	4 clinician sessions to be relocated to North Road	No change	No change	No change
	Changes to current Nursing & HCSW model incl. impact on variable pay	Frees up nursing staff from theatres and DSU for 3 sessions	19.5 additional Clinics moving to GG from other sites (currently 14 clinics) - would prefer to develop dedicated Ophthalmology staff /service in GGH rather than developing nursing staff in OPD (would help grow and retain staff) - 2 WTE extra staff (12 Nurses) needed Currently 3 Paediatric sessions (1 in each county) Currently 14 clinic sessions in use at GGH would be required to absorb additional 19.5 clinic sessions from other sites. Currently 10 Orthoptics sessions at GGH Absorb further 12 Orthoptics sessions from other sites Consideration to be given to staff covering admission/discharge from surgery. Depending on number of operations and theatres running. Likely need 1 additional BS site	Free up staff required to cover 12 OPD clinic sessions 5.5 Orthoptic sessions per week reallocating to Glangwili	No impact 2 Orthoptic sessions per week reallocating to Glangwili	Release community staff from Aberaeron for 4 sessions Minimal travel costs from 5 Pembs AV - release 1 B5 and 1 B2 to Tysul - 3 days a week 4.5 sessions per week for Orthoptics moving to Glangwili	Keep Staff Nurse from Cardigan on both days. Potentially release 1 Cardigan HCSW for 1 day. Would need 1 extra Technician 1 day a week. Free up 1 Nurse and 1 HCSW from WGH team back to WGH for 1 day per week	Release 1 Nurse and 1 HCSW from community team for 4 sessions a week	Release 1 HCSW and 1 Technician to Tysul - 6 sessions	Release 1 Nurse, 1 HCSW and 1 Technician 1 day a week to WGH	No change	
	Changes to current Therapies workforce model incl. impact on variable pay	N/A	N/A	N/A	No			No	No	No	No	No
	Changes to current HCS & APST Workforce model incl. impact on variable pay	Minimal	Pharmacy - increased stock levels - more storage. More pharmacy support for IVT.	N/A	Increase in IVT drugs - increased need for Pharmacy staff support			Would reduce pay to Just Wales to transport drugs (approx £50 a day)	No	Release some Pharmacy time from PPH Pharmacy and potentially courier service	No	No
	Changes to current Administrative Workforce	N/A	Yes - impact medical records with all clinics on GGH site (to move notes about). Would need to increase secretarial support at GGH. Would require Receptionist at DSU. Would need office space and move of 1 IVT coordinator (from AV).	Free up 12 clinics' worth of records preparation	No - IVT coordinator to remain at WGH			N/A	No	IVT coordinator would go to GGH	Minimal benefit to 5 Pembs reception staff	No
	Any other additional workforce requirements - e.g. Facilities roles	N/A	Theatre staff may need to cover additional theatre sessions due to centralisation.	N/A	Potential minor input from facilities (cleaning)			Release some special cleaning	No	No change	No	No
Any additional Training required?	n/a	Potentially training for additional theatre and DSU staff.	N/A	No			No	No	No	No	No	

Impact on current staff - e.g Will staff need to move site / will model improve MDT working?	Will improve MDT working - impact on 1 consultant located in BGH and additional savings from high cost locum consultant	Yes - IVT coordinator move from AV. Potentially move secretaries (unless swap roles). Should be considerable improvement in MDT. Positive impact on patient care. Better training opps. Better supervision. Potentially more medical trainees.	Current OPD staff will be available to cover other services. Potentially move secretaries (unless swap roles).	Should improve with less travel - improve work/life balance		Minimal impact. Less travel away from base	Release staff - minimal	IVT coordinator would go to GGH. Would improve teaching	Minimal impact. Less travel away from base	No change
Will this reduce your current workforce risks & challenges?	Will support MDT but not reduce challenge - due to centralising in GGH - more training opportunities, more senior support, opportunity to develop	Yes - centralisation of Ophthalmology would improve retention and recruitment (as noted above)	Yes - see GGH column explanation	Yes - see GGH column explanation		Will support virtual working. Will support centralisation but minimal impact	Will support centralisation but minimal impact	Would support medical workforce retention and recruitment by having more surgery	Better use of workforce	Improved efficiencies
Do you believe this will have a positive or negative impact on recruitment and retention?	Potential risk of retention - but professional benefit could outweigh the risk	Yes positive - as above	Yes as above (see GGH column)	Yes as above (see GGH column)		Minimal impact	Minimal impact	Positive - see above	Positive	Positive - more clinicians available for support
Are there any other interdependent services that will be impacted by this change? e.g. diagnostics, A&E, wards	No	No	No	No		No	No	Need to check regarding PPH sterilisation services	No	NO
Are there other programmes of work that may impact the option e.g. ARCH / Regional work	Potentially Mid Wales Collaborative? Impact on SLA LTA with Powys THB and Betsi Cadwaladr UHB	ARCH / GIRFT / Regional Work / Clinical Implementation Network - centralisation would have a positive impact on these programmes of work, centralisation has been highlighted in all programmes	No	No		As across whole service - see other columns	As across whole service - see other columns	As across whole service - see other columns	As across whole service - see other columns	Potentially Mid Wales Collaborative? Impact on SLA LTA with Powys THB and Betsi Cadwaladr UHB
Are there ways to use technology or innovations to support the delivery of this option?	N/A	Openeyes (platform like PAS - follow from community - all scans etc all can access)	No	No		Electronic records would make easier	N/A	Electronic records would make easier	N/A	Electronic records would make easier
<b>Estates</b>										
Theatres / Sessions	3 theatre sessions to be freed up	Additional 3 DSU sessions moving to Glangwill, bringing total to 11 Move 8 theatre sessions from theatre 5 into DSU Glangwill Maintain 1 session per month in Glangwill for paediatric surgery				Maintain 10 sessions in Amman Valley				
Day Surgery Units (DSU) / Sessions	Moving cataracts out of BGH would free up staff to cover a different list in DSU.	Move 8 theatre sessions from theatre 5 into DSU Glangwill Access to a second DSU theatre to manage the required number of sessions. Theatre staff to cover this				Maintain 10 sessions in Amman Valley				
Procedure Rooms / Sessions		Access to a treatment room in OP setting for Botox (1 additional session) and emergency treatment 10 sessions of IVT coming from Amman Valley, will need 1 enhanced treatment (inc air exchange, but does not need to be the same level as a theatre) room and 3 rooms	Releasing 1 session per month in treatment room			10 sessions of IVT moving to Glangwill. 6 from weeks days and 4 from waiting list initiative (weekends)				
Outpatients Department / Sessions		Move 7 clinic rooms from Prince Philip, 3 rooms from community sites and 3 rooms from Wilybush (Additional 26 sessions)	Move 7 clinic rooms from OP to Glangwill (12 sessions)	Move 3 clinic rooms from OP to Glangwill (6 sessions)	Move 3 clinic rooms from OP to Glangwill (8 sessions)					
Other		Relocating equipment - maximise use of equipment by centralising (better use of resources). Potential for less spending in services equipment if less equipment is required (where services would be removed from) May need additional microscope								
Office space required (Desks)		1 two person and 1 single offices and a 2 desk reception area being freed up in Tysal ward 1 desk for IVT coordinator Will need same amount of desk space as Tysal ward and 4 desk multi purpose room				IVT coordinator desk will move to Glangwill				

Equipment Moves (Surplus and Essential)		<p>To be moved from Prince Philip to Glangwili:</p> <ul style="list-style-type: none"> <li>- laser machine x2</li> <li>- Fields machine</li> <li>- OCT</li> <li>- Slit Lamp (several)</li> <li>- ORA</li> </ul> <p>Prince Philip to Cardigan:</p> <ul style="list-style-type: none"> <li>- Optos</li> </ul> <p>Theatre microscope to move from Bronglais</p> <p>This will free up 3 laser machines that can be used for spares or repairs (2 from Withybush, 1 from Tysil and 1 from Prince Philip)</p>		<p>To be moved from Prince Philip to Glangwili:</p> <ul style="list-style-type: none"> <li>- laser machine x2</li> <li>- Fields machine</li> <li>- OCT</li> <li>- Slit Lamp (several)</li> <li>- ORA</li> </ul> <p>Prince Philip to Cardigan:</p> <ul style="list-style-type: none"> <li>- Optos</li> </ul> <p>Laser machine from Prince Philip to be used for spares or repairs</p>	<p>Moving South Pembro to Withybush:</p> <ul style="list-style-type: none"> <li>- OCT</li> <li>- HFA</li> <li>- Slit lamp x2</li> </ul> <p>x2 Laser machines from Withybush to be used for spares or repairs</p>		<p>Prince Philip to Cardigan:</p> <ul style="list-style-type: none"> <li>- Optos</li> </ul> <p>South Pembro to Cardigan:</p> <ul style="list-style-type: none"> <li>- ORA</li> </ul>					
Potential Capital Development needs		<p>Development of 1 enhanced treatment room (increased air flow)</p> <p>Potential room refurbishment depending on condition of estate</p>										
Potential Digital opportunities (achievable within 2-4 years) (E.G. CT Profusion for Stroke)												
<b>Patients</b>												
Identify what intervention will take place on each site and what interventions will move		<p>All OP services (excl. Bronglais) will move to Glangwili</p> <p>IVT clinics move from Amman Valley to Glangwili</p> <p>Cataract will move from main theatre to DSU (Glangwili)</p> <p>Laser treatment moving to all sites (excl. North Road) to Glangwili</p>										
Clarify if there are Patient Transfers required (include acuity: ACCTS or NEPTS or WAST) what % of patients this would be (this will need to be evidence based)		<p>Potential impact on patients seeking OP services from West of Health Healthboard and travelling from Bronglais for surgery to Glangwili</p>										
Detail any impacts or changes to regional or national pathways		<p>National strategy will be published shortly, but no impact expected</p>										
<b>Addressing Barriers</b>												
Waiting Lists		<p>It is expected that centralising services, supporting MDT working and concentrating expert advice and support will help manage waiting lists</p>										
Waiting Times		<p>It is expected that centralising services, supporting MDT working and concentrating expert advice and support will help manage waiting lists</p>										
Other												
<b>OPHTHALMOLOGY</b>	<b>Bronglais</b>	<b>Glangwili</b>	<b>Prince Philip</b>	<b>Withybush</b>	<b>Community Sites</b>	<b>CIIC</b>	<b>AICC</b>	<b>AV</b>	<b>SPEMBS</b>	<b>NREC</b>		

O P T I O N  2	OPTION 2	As per current configuration – day case and inpatient services	Remove everything from Glangwilli to PPH, with expansion of theatre hours into the evening and support for emergency clinic and procedure room overnight.	Centralise and expand in PPH with support for out of hours emergencies & evening theatre on-call staff. operate until 20:30	As per current Configuration – outpatient services only	Move to a single site in Carmarthenshire and a single site in Pembrokeshire, tbc.  North Road Clinic - Non-emergency (other community sites for anything remaining)  Cardigan - Current configuration							
	Workforce Requirement												
	Are there any changes required to current Rotas? include On Call, moving to a 7 day model etc	No change	8 theatre sessions moving to Prince Philip	A new on-call rota for theatre/DSU staff will need to be established. Occupy the DSU. Theatre team will need to cover additional 8 theatre sessions moving from Glangwilli.	No change	Work carried out in Aberaeron moves to Cardigan - x4.25 clinics. Same team staff Aberaeron and Cardigan							
	Any changes to current Bed numbers?	No change	Very small numbers Ophthalmology patients are admitted as an in-patient. No ring fenced beds	Very small numbers Ophthalmology patients are admitted as an in-patient. No ring fenced beds. discussion with bed manager ad hoc when admission is needed. No ring fenced beds needed	No change	No change							
	Changes to current Medical workforce model incl. impact on variable pay	No change	Change of working location from Glangwilli to Prince Philip. No change to model or number of staff	Change of working location from Glangwilli to Prince Philip. No change to model or number of staff	No change	Work carried out in Aberaeron moves to Cardigan - x4.25 clinics. Same team staff Aberaeron and Cardigan							
	Changes to current Nursing & HCSW model incl. impact on variable pay	No change	Tysil ward staff will relocate to Prince Philip. (11.9 trained staff, 5.8 HCSW) Technicians (inc HCSW) currently travel between sites, only a change in working location	Will need to accommodate staff moving from Tysil ward. (11.9 trained staff, 5.8 HCSW) Will need staff to cover additional 18.5 clinics coming from Glangwilli. This is currently managed by OPD, however Ophthal are looking to manage this themselves, which will give a reduction of approx 10-11 staff (various grades)	No change	Work carried out in Aberaeron moves to Cardigan - x4.25 clinics. Same team staff Aberaeron and Cardigan							
	Changes to current Therapies workforce model incl. impact on variable pay	No change	N/A	N/A	No change	No change							
	Changes to current HCS & APST Workforce model incl. impact on variable pay	No change	None	Pharmacy - increased stock levels- more storage. More pharmacy support for Theatres.	No change	No change							
	Changes to current Administrative Workforce	No change	x5 med secretaries currently work in Glangwilli. These staff roles would need to change to bring the Ophthal cohort to Prince Philip, but it could be a swap in area of responsibility (med sec swapping roles) rather than physically moving staff  7 co-ordinators to move from Glangwilli to Prince Philip  x2 unit clerks on Tysil to move to Prince Philip	x9 staff to transfer to Prince Philip  x5 med sec roles to be transferred to Prince Philip	No change	No change							
	Any other additional workforce requirements - e.g. Facilities roles	No change	None	Theatre staff may need to cover additional theatre sessions due to centralisation.	No change	No change							
Any additional Training required?	No change	None	Potentially training for additional theatre and/or DSU staff.	No change	No change								
Impact on current staff - e.g Will staff need to move site / will model improve MDT working?	No change	Staff will need to move to Prince Philip (or change roles for med sec)	Staff will need to move to Prince Philip (or change roles for med sec)	No change	No change								
Will this reduce your current workforce risks & challenges?	No change		Yes- centralisation of Ophthalmology would improve retention and recruitment (as noted above)	No change	No change								

Do you believe this will have a positive or negative impact on recruitment and retention?	No change		Yes positive - as above	No change	No change					
Are there any other interdependent services that will be impacted by this change? e.g. diagnostics, A&E, wards	No change		On-call will need to relocate to MIU Additional pharmacy requirement (noted above) to support theatre. Potential higher throughput. Additional support required from theatre and/or SU.	No change	No change					
Are there other programmes of work that may impact the option e.g. ARCH / Regional work	No change		ARCH / GIRFT / Regional Work / Clinical Implementation Network - centralisation would have a positive impact on these programmes of work, centralisation has been highlighted in all programmes	No change	No change					
Are there ways to use technology or innovations to support the delivery of this option?			Openeyes (platform like PAS - follow from community - all scans etc all can access)		No change					
<b>Estates</b>										
Theatres / Sessions	No change	8 theatre sessions moving to Prince Philip (does NOT include Paediatrics, this will STAY in Glangwill)	8 theatre sessions moving to Prince Philip (does NOT include Paediatrics, this will STAY in Glangwill). DSU would be an ideal place to be based. If work is carried out in theatres, a space will need to be identified to admit and discharge patients	No change						
Day Surgery Units (DSU) / Sessions	No change		Ideally would use DSU where staff from Tysil could work. Will need: - space for 2 trolleys - 7 chairs (5 current and 2 for high flow)	No change						
Procedure Rooms / Sessions	No change		Will need increased access to OPD rooms to accommodate x1 additional botox clinic per month	No change	IVT staying in Amman Valley					
Outpatients Department / Sessions	No change	7 rooms are used in OPD to run clinics in Glangwill. These will need to move to Prince Philip OPD Tysil ward is freed up Blue suite will be freed up	7 rooms are used in OPD to run clinics in Glangwill. These will need to move to Prince Philip OPD Pre op will need x3 rooms and RACE will need x3 rooms (coming from Tysil ward Glangwill) 1 Orthoptrist room additional (currently not a dedicated room in Glangwill)	No change						
Other	No change	Possible move of ceiling microscope from theatre 5	Relocating equipment - maximise use of equipment by centralising (better use of resources). Potential for less spending in services equipment if less equipment is required (where services would be removed from) Need additional microscope - could come from ceiling mounted in Glangwill or new	No change						
Office space required (Desks)	No change		1 two person and 1 single offices and a 2 desk reception area being freed up in Tysil ward 1 desk for IVT coordinator Will need same amount of desk space as Tysil ward and 4 desk multi purpose room	No change						



P T I O N  3	Are there any changes required to current Rotas? include On Call, moving to a 7 day model etc		Yes. Rotas would need to be reworked to relocate clinicians from clinic to GGH releasing 12 clinical workforce sessions in PPH	Yes. Rotas would need to be reworked to centralise 4 clinic sessions at GGH		Release 2 clinician sessions	Release 4 clinician sessions	Rota redesign to allocate surgeons to AV	Doctor would go to WGH instead of 5 Pems	No change
	Any changes to current Bed numbers?	No - no ringfenced beds, minimal in emergency	No	No		No	NO	No	No	No
	Changes to current Medical workforce model incl. impact on variable pay	8 theatre sessions in total needed in Glangwill (as per current) Filling current vacancies would enable this option (no need for additional)	Reduction in travel between sites	No	AV cataracts to remain at 10 sessions	2 clinician sessions to be relocated to North Road	4 clinician sessions to be relocated to North Road	No change	No change	No change
	Changes to current Nursing & HCSW model incl. impact on variable pay	19.5 additional Clinics moving to GG from other sites (currently 14 clinics) - would prefer to develop dedicated Ophthalmology staff /service in GGH rather than developing nursing staff in OPD (would help grow and retain staff) - 2 WTE extra staff (2 Nurses) needed Currently 3 Paediatric sessions (1 in each county) Currently 14 clinic sessions in use at GGH would be required to absorb additional 19.5 clinic sessions from other sites. Currently 10 Orthoptics sessions at GGH Absorb further 12 Orthoptics sessions from other sites Will need theatre staff to accommodate 10 additional cataract sessions from Amman Valley, with potential to increase in capacity to support discharge Will send 1 B5 and 1B2 from Glangwill to AV 2 extra days a week to support with IVT	Free up staff required to cover 12 OPD clinic sessions 5.5 Orthoptic sessions per week reallocating to Glangwill	No impact 2 Orthoptic sessions per week reallocating to Glangwill	Release community staff from Aberaeron for 4 sessions Minimal travel costs from 5 Pems GGH- release 1 B5 and 1 B2 to Amman Valley -2 days a week 4.5 sessions per week for Orthoptics moving to Glangwill	Keep Staff Nurse from Cardigan on both days. Potentially release 1 Cardigan HCSW for 1 day. Would need 1 extra Technician 1 day a week. Free up 1 Nurse and 1 HCSW from WGH team back to WGH for 1 day per week	Release 1 Nurse and 1 HCSW from community team for 4 sessions a week	GGH- release 1 B5 and 1 B2 to Amman Valley 2 days a week	Release 1 Nurse, 1 HCSW and 1 Technician 1 day a week to WGH	No change
	Changes to current Therapies workforce model incl. impact on variable pay	N/A	N/A	N/A	No	No	No	No	No	No
	Changes to current HCS & APST Workforce model incl. impact on variable pay	Minimal	N/A	N/A	Increase in IVT drugs - increased need for Pharmacy staff support	Would reduce pay to Just Wales to transport drugs (approx £50 a day)	No	Release some Pharmacy time from PPH Pharmacy and potentially courier service	No	NO
	Changes to current Administrative Workforce	N/A	Yes - impact medical records with all clinics on GGH site (to move notes about). Would need to increase secretarial support at GGH. Would require Receptionist at DSU.	Free up 12 clinics' worth of records preparation	No - IVT coordinator to remain at WGH	N/A	No	IVT coordinator would go to GGH	Minimal benefit to 5 Pems reception staff	No
	Any other additional workforce requirements - e.g. Facilities roles	N/A		N/A	Potential minor input from facilities (cleaning)	Release some special cleaning	No	No change	No	No
	Any additional Training required?	n/A	Potentially training for additional theatre and DSU staff.	N/A	No	No	No	IVT coordinator would go to GGH	Minimal impact. Less travel away from base	No
	Impact on current staff - e.g Will staff need to move site / will model improve MDT working?		Potentially move secretaries (unless swap roles). Should be considerable improvement in MDT. Positive impact on patient care. Better training opps. Better supervision. Potentially more medical trainees.	Current OPD staff will be available to cover other services. Potentially move secretaries (unless swap roles).	Should improve with less travel - improve work/life balance	Minimal impact. Less travel away from base	Release staff minimal	Would support medical workforce retention and recruitment by having more surgery	Minimal impact. Less travel away from base	No change
	Will this reduce your current workforce risks & challenges?		Yes- centralisation of Ophthalmology would improve retention and recruitment (as noted above)	Yes - see GGH column explanation	Yes - see GGH column explanation	Will support virtual working. Will support centralisation but minimal impact	Will support centralisation but minimal impact	Better use of workforce	Improved efficiencies	
	Do you believe this will have a positive or negative impact on recruitment and retention?		Yes positive - as above	Yes as above (see GGH column)	Yes as above (see GGH column)	Minimal impact	Minimal impact	Positive - see above	Positive	Positive - more clinicians available for support





Changes to current <b>Medical</b> workforce model incl. impact on variable pay		3 theatre sessions additional (From Bronglais ) 11 theatre sessions in total needed in Glangwilli Filling current vacancies would enable this option (no need for additional)						4 clinician sessions to be relocated to North Road					
	Some travel time of Locum saved		Reduction in travel between sites	No		AV cataracts to remain at 10 sessions		2 clinician sessions to be relocated to North Road					
Changes to current <b>Nursing &amp; HCSW</b> model incl. impact on variable pay		15/3 additional clinics moving to us from other sites (currently 14 clinics) - would prefer to develop dedicated Ophthalmology staff /service in GGH rather than developing nursing staff in OPD (would help grow and retain staff) - 2 WTE extra staff (2 Nurses) needed Currently 3 Paediatric sessions (1 in each county) Currently 14 clinic sessions in use at GGH would be required to absorb additional 19.5 clinic sessions from other sites. Currently 10 Orthoptics sessions at GGH Absorb further 12 Orthoptics sessions from other sites  Consideration to be given to staff covering admission/discharge from surgery, depending on number of operations and theatres running. Likely need 1 additional BS wte	Free up staff required to cover 12 OPD clinic sessions 5.5 Orthoptic sessions per week reallocating to Glangwilli	No impact		Release community staff from Aberaeron for 4 sessions Minimal travel costs from 5 Pembis AV - release 1 B5 and 1 B2 to Tysul - 3 days a week		Keep Staff Nurse from Cardigan on both days. Potentially release 1 Cardigan HCSW for 1 day. Would need 1 extra Technician 1 day a week. Free up 1 Nurse and 1 HCSW from WGH team back to WGH for 1 day per week	release 1 Nurse and 1 HCSW from community team for 4 sessions a week	Release 1 Nurse and 1 HCSW and 1 Technician to Tysul - 6 sessions	Release 1 Nurse, 1 HCSW and 1 Technician 1 day a week to WGH	No change	
Changes to current <b>Nursing &amp; HCSW</b> model incl. impact on variable pay	Frees up nursing staff from theatres and DSU for 3 sessions			2 Orthoptic sessions per week reallocating to Glangwilli		4.5 sessions per week for Orthoptics moving to Glangwilli							No change
Changes to current <b>Therapies</b> workforce model incl. impact on variable pay	N/A	N/A	N/A	No				No	No	No	No	No	No
Changes to current <b>HCS &amp; APST</b> Workforce model incl. impact on variable pay	Minimal	Pharmacy - increased stock levels - more storage. More pharmacy support for IVT.	N/A	Increase in IVT drugs - increased need for Pharmacy staff support				Would reduce pay to Just Wales to transport drugs (approx £50 a day)	No	Release some pharmacy time from PPH Pharmacy and potentially courier service	No	No	No
Changes to current <b>Administrative</b> Workforce	N/A	Yes - impact medical records with all clinics on GGH site (to move notes about). Would need to increase secretarial support at GGH. Would require Receptionist at DSU. Would need office space and move of 1 IVT coordinator (from AV).	Free up 12 clinics' worth of records preparation	No - IVT coordinator to remain at WGH				N/A	No	IVT coordinator would go to GGH	Minimal benefit to 5 Pembis reception staff	No	No
Any other additional workforce requirements - e.g. Facilities roles	N/A	Theatre staff may need to cover additional theatre sessions due to centralisation.	N/A	Potential minor input from facilities (cleaning)				Release some special cleaning	No	No change	No	No	No
Any additional Training required?	n/A	Potentially training for additional theatre and DSU staff.	N/A	No				No	No	No	No	No	No
Impact on current staff - e.g. Will staff need to move site / will model improve MDT working?	Will improve MDT working - impact on 1 consultant located in BGH and additional savings from high cost locum consultant	Yes - IVT coordinator move from AV. Potentially move secretaries (unless swap roles). Should be considerable improvement in MDT. Positive impact on patient care. Better training opps. Better supervision. Potentially more medical trainees.	Current OPD staff will be available to cover other services. Potentially move secretaries (unless swap roles).	Should improve with less travel - improve work/life balance				Minimal impact. Less travel away from base	Release staff minimal	IVT coordinator would go to GGH Would improve teaching	Minimal impact. Less travel away from base	No change	No
Will this reduce your current workforce risks & challenges?	Will support MDT but not reduce challenge - due to centralising in GGH - more training opportunities, more senior support, opportunity to develop	Yes - centralisation of Ophthalmology would improve retention and recruitment (as noted above)	Yes - see GGH column explanation	Yes - see GGH column explanation				Will support virtual working. Will support centralisation but minimal impact	Will support centralisation but minimal impact	Would support medical workforce retention and recruitment by having more surgery	Better use of workforce	Improved efficiencies	
Do you believe this will have a positive or negative impact on recruitment and retention?	Potential risk of retention - but professional benefit could outweigh the risk	Yes positive - as above	Yes as above (see GGH column)	Yes as above (see GGH column)				Minimal impact	Minimal impact	Positive - see above	Positive	Positive - more clinicians available for support	
Are there any other interdependent services that will be impacted by this change? e.g. diagnostics, A&E, wards	No	No	No	No				No	No	Need to check regarding PPH sterilisation services	No	No	No
Are there other programmes of work that may impact the option e.g. ARCH / Regional work	Potentially Mid Wales Collaborative? Impact on SLA LTA with Powys THB and Betsi Cadwaladr LHB	ARCH / GIRFT / Regional Work / Clinical Implementation Network - centralisation would have a positive impact on these programmes of work, centralisation has been highlighted in all programmes	No	No				As across whole service see other columns	As across whole service see other columns	As across whole service see other columns	As across whole service see other columns	Potentially Mid Wales Collaborative? Impact on SLA LTA with Powys THB and Betsi Cadwaladr LHB	
Are there ways to use technology or innovations to support the delivery of this option?	N/A	Openeyes (platform like PAS - follow from community - all scans etc all can access)	No	No				Electronic records would make easier	N/A	Electronic records would make easier	N/A	Electronic records would make easier	

Estates								
Theatres / Sessions	3 theatre sessions to be freed up	Additional 3 DSU sessions moving to Glangwili, bringing total to 11 Move 8 theatre sessions from theatre 5 into DSU Glangwili Maintain 1 session per month in Glangwili for paediatric surgery				Maintain 10 sessions in Amman Valley		
Day Surgery Units (DSU) / Sessions	Clarity needed regarding DSU admission in Bronglais	Move 8 theatre sessions from theatre 5 into DSU Glangwili Access to a second DSU theatre to manage the required number of sessions. Theatre staff to cover this				Maintain 10 sessions in Amman Valley		
Procedure Rooms / Sessions		Access to a treatment room in OP setting for Botox (1 additional session) and emergency treatment 10 sessions of IVT coming from Amman Valley, will need 1 enhanced treatment (inc air exchange, but does not need to be the same level as a theatre) room and 3 rooms	Releasing 1 session per month in treatment room			10 sessions of IVT moving to Glangwili, 6 from weeks days and 4 from waiting list initiative (weekends)		
Outpatients Department / Sessions		Move 7 clinic rooms from Prince Philip, 3 rooms from community sites and 3 rooms from Worthybush (Additional 26 sessions) OPD will need to incorporate 3 rooms being released from Tysil ward (minimum of 10 sessions)	Move 7 clinic rooms from OP to Glangwili (12 sessions)	Move 3 clinic rooms from OP to Glangwili (6 sessions)		Move 3 clinic rooms from OP to Glangwili (8 sessions)		
Other		Relocating equipment - maximise use of equipment by centralising (better use of resources). Potential for less spending in services equipment if less equipment is required (where services would be removed from) May need additional microscope						
Office space required (Desks)		1 two person and 1 single offices and a 2 desk reception area being freed up in Tysal ward 1 desk for IVT coordinator Will need same amount of desk space as Tysal ward and 4 desk multi purpose room				IVT coordinator desk will move to Glangwili		
Equipment Moves (Surplus and Essential)	Theatre microscope to move to Glangwili	To be moved from Prince Philip to Glangwili: - laser machine x2 - Fields machine - OCT - Slit Lamp (several) - ORA Prince Philip to Cardigan: - Optos Theatre microscope to move from Bronglais This will free up 3 laser machines that can be used for spares or repairs (2 from Worthybush, 1 from Tysil and 1 from Prince Philip)	To be moved from Prince Philip to Glangwili: - laser machine x2 - Fields machine - OCT - Slit Lamp (several) - ORA Prince Philip to Cardigan: - Optos Laser machine from Prince Philip to be used for spares or repairs	Moving South Pems to Worthybush: - OCT - HFA - Slit lamp x2		Prince Philip to Cardigan: - Optos South Pems to Cardigan: - ORA		
Potential Capital Development needs		Development of 1 enhanced treatment room (increased air flow) Potential room refurbishment depending on condition of estate						
Potential Digital opportunities (achievable within 2-4 years) (E.G. CT Profusion for Stroke)								
Patients								
Identify what intervention will take place on each site and what interventions will move		All OP services (excl. Bronglais) will move to Glangwili IVT clinics move from Amman Valley to Glangwili Laser treatment moving to all sites (excl. North Road) to Glangwili						



<p style="text-align: center;">OPTION 4</p>	<p>Remove services from BGH (3 sessions per week)</p> <p>No cataracts or Surgery</p>	<p>Centralise to GGH if services move as below</p> <p>Used DSU for Ophthalmology and cardiology to move Outpatients, ENT need area on Merlin Ward, Paeds Cilgerrin Ward.</p> <p>Tysul would become surgical SDEC</p> <p>Use DSU Theatre for Ophthalmology(10 Sessions)</p>	<p>Remove services from PPH</p>	<p>Retain IVT / Age related Macular Degeneration services only</p>	<p>Remove services from Aberaeron Integrated Care Centre and South Pembrokeshire Hospital</p> <p>Treatment room in Amman Valley Hospital to include high flow (Cataracts)</p> <p>North Road Clinic stays as current configuration (IVT injections) and Cardigan Integrated Care Centre change to Diagnostics Centre</p>					
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ORTHOPAEDICS		Bronglais	Glangwili	Prince Philip	Withybush	Community Sites
O P T I O N  1	OPTION 1	Elective Inpatient and Day case services only. Bronglais to create ringfenced area (BOA Standards)	No elective services, trauma only	Regional working services with Swansea Bay. Inpatient and Day Case Complex elective services inc Arthroplasty	High volume, low complexity Day Case Orthopaedic services	Current configuration - No activity at community sites
	Workforce Requirement					
	Are there any changes required to current Rotas? include On Call, moving to a 7 day model etc	Trauma on call only. No changes to Job Plans/Rotas for electives	not applicable	No changes to on-call Rota. Job Plan reviews/changes would be required to fully implement regional working plan ie travelling to other sites	No changes to on-call Rota. Job Plan reviews/changes would be required to fully implement regional working plan ie travelling to other sites	
	Any changes to current Bed numbers?	On going discussions with the potential move to Y Banwy, exact bed numbers to be confirmed, Rhiannon Wards has historically provided 2 x 4 bedded bays (8) however Merig Ward issues, only 4 beds available at present. No increase in Theatres proposed.		no change 21 beds	no change	
	Changes to current Medical workforce model incl. impact on variable pay			More anaesthetic support - cost within Theatres. Some DSU sessions LA only due Anaesthetic vacancies. Recruitment need to fully utilise the planned DSU sessions as GA.  consultants are currently travelling, loss of session time and financial impact  Additional Jnr Doctors to provide 24/7 dedicated cover for Ward 6, which is currently being paid ADH claims	More anaesthetic support - Cost within Theatres (query current vacancies in Anaesthetics)  consultants are currently travelling, loss of session time and financial impact  Additional Jnr Doctors to provide 24/7 dedicated cover for Ward 9 if daycase Arthroplasty is reinstated in WGH	
	Changes to current Nursing & HCSW model incl. impact on variable pay	staff from Rhiannon Ward would move to Y Banwy. Work ongoing to review the staffing model, potential 1 x Band 5		current Theatre Nursing vacancies in DSU, would need to be fully staffed to fully utilise the DSU sessions	no changes in nursing complement	
	Changes to current Therapies workforce model incl. impact on variable pay	7 day therapies required, details and costs to be confirmed. Need to invest in therapies to reduce their Length of stay to improve throughput		7 day therapies required, details and costs to be confirmed. Need to invest in therapies to reduce their Length of stay to improve throughput	7 day therapies required, details and costs to be confirmed. Need to invest in therapies to reduce their Length of stay to improve throughput	
	Changes to current HCS & APST Workforce model incl. impact on variable pay	no pharmacy on sat afternoon, closed on Sunday. So would need clear discharge plans with engagement with all disciplines		no pharmacy on sat afternoon, closed on Sunday (Check on opening hours). So would need clear discharge plans with engagement with all disciplines	no pharmacy on sat afternoon, closed on Sunday (Check on opening hours). So would need clear discharge plans with engagement with all disciplines	
	Changes to current Administrative Workforce	1 wte ward clerk required				
	Any other additional workforce requirements - e.g. Facilities roles	None		None	None	

Any additional Training required?					
	dependent on workforce plans from Therapies		dependent on workforce plans from Therapies	dependent on workforce plans from Therapies	
Impact on current staff - e.g Will staff need to move site / will model improve MDT working?			Job Plan reviews/changes would be required to fully implement regional working plan ie travelling to other sites	Job Plan reviews/changes would be required to fully implement regional working plan ie travelling to other sites	
Will this reduce your current workforce risks & challenges?	no		No	No	
Do you believe this will have a positive or negative impact on recruitment and retention?	positive from nursing - more functionality like PPH; therapies may find it difficult to recruit		Retention - negative Recruitment - potentially positive	Retention - negative Recruitment - potentially positive	
Are there any other interdependent services that will be impacted by this change? e.g. diagnostics, A&E, wards	Theatres, Pre-assessment, therapies & radiology		Theatres, Pre-assessment, therapies & radiology	Theatres, Pre-assessment, therapies & radiology	
Are there other programmes of work that may impact the option e.g. ARCH / Regional work	SLA/LTAs in place with BCU/Powys - no impact as arrangements in place		Regional work with SBU	Regional work with SBU	
Are there ways to use technology or innovations to support the delivery of this option?	Roll out of virtual joint school across the HB, Electronic Prescribing (HB Wide, but details unknown at present). Continued input from Orthopaedic Prehab Team		Roll out of virtual joint school across the HB, Electronic Prescribing (HB Wide, but details unknown at present). Continued input from Orthopaedic Prehab Team	Roll out of virtual joint school across the HB, Electronic Prescribing (HB Wide, but details unknown at present). Continued input from Orthopaedic Prehab Team	
<b>Estates</b>					
Theatres / Sessions	no additional sessions		no additional sessions	Main Theatre allocation is currently below what is funded due to the closure of Theatre 4. Query long term plan for Theatre 4 for increase back to what is funded	
Day Surgery Units (DSU) / Sessions	no additional sessions	no change	Conversion of sessions that are LA to GA through recruitment of Anaesthetics - changes to the basket of procedures within the Theatres Increase of Theatre sessions from 7 to 11 through the recruitment of Theatre Staff		
Procedure Rooms / Sessions				none	
Outpatients Department / Sessions				none	

Other	Additional Pre-assessment facilities needed, virtual / e prescribing may facilitate this		Additional Pre-assessment facilities needed, virtual / e prescribing may facilitate this	Additional Pre-assessment facilities needed, virtual / e prescribing may facilitate this	
Office space required (Desks)	need additional office space for medical staff with Hot Desks		office space for regional working / staff without existing desks		
Equipment Moves (Surplus and Essential)	With move to Y Banwy, this will need further exploration			none	
Potential Capital Development needs	Y banwy as part of the move of stroke		no change to current configuration	To reduce impact of lack of Radiography support, Purchase of mini C-arm machine that could be operated by the surgeon - £60k	
Potential Digital opportunities (achievable within 2-4 years) (E.G. CT Profusion for Stroke)	Additional PCs to support the medics			virtual assessment / e-prescribing	
<b>Patients</b>					
Identify what intervention will take place on each site and what interventions will move	No change in Procedures	n/a	More complex procedures here if HVLC moves to WGH and NPT	potential to move High volume Low complexity from PPH	
Clarify if there are Patient Transfers required (include acuity: ACCTS or NEPTS or WAST) what % of patients this would be (this will need to be evidence based)	NEPTS for prompt transfers between sites for any complications that can't be managed at BGH	n/a	NEPTS for transfers between sites - accepting at PPH from other sites	NEPTS for transfers between sites, more WGH to PPH for admission and discharge	
Detail any impacts or changes to regional or national pathways	stays the same	n/a	Ensure consultants have access to LVHC and HVLC theatre sessions to maintain competencies Nursing Skills maintained by rotation	Ensure consultants have access to LVHC and HVLC theatre sessions to maintain competencies Nursing Skills maintained by rotation	
<b>Addressing Barriers</b>					
Waiting Lists			Lack of patients suitable for Neath Port Talbot Theatre environment as part of the regional working.		
Waiting Times			Potential to improve throughput if additional therapies are available to support the service. Regional Working to pool Waiting Lists	Potential to improve throughput if additional therapies are available to support the service. Regional Working to pool Waiting Lists	

Other					
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ORTHOPAEDICS		Bronglais	Glangwili	Prince Philip	Withybush	Community Sites
<b>OPTION 2</b>	Elective and Emergency – x5 theatre sessions bed inpatient and Day Case (as current config.) when meeting BOA guidance	No elective, trauma only	Elective Inpatient and Day Cases – demountable unit. – can be increased  Possibly to include regional	Elective services and extend day capacity (23:59 model), high volume / low complexity Day Cases  Elective services and extend day capacity model, high volume / low complexity Day Cases	As per current configuration - no Inpatient or Day Case activity at community sites, limited outpatient clinics at some sites	
Workforce Requirement						
Are there any changes required to current Rotas? include On Call, moving to a 7 day model etc	Trauma on call only. No changes to Job Plans/Rotas for electives	not applicable	No changes to on-call Rota but job Plan reviews/changes would be required to fully implement regional working plan ie travelling to other sites	No changes to on-call Rota. Job Plan reviews/changes would be required to fully implement regional working plan ie travelling to other sites		
Any changes to current Bed numbers?	On going discussions with the potential move to Y Banwy, exact bed numbers to be confirmed, Rhiannon Wards has historically provided 2 x 4 bedded bays (8) however due to Meurig Ward issues, only 4 beds available at present. No increase in Theatres proposed with this option.		no change 21 beds	no change		
Changes to current Medical workforce model incl. impact on variable pay			More anaesthetic support - cost within Theatres. Some DSU sessions LA only due Anaesthetic vacancies. Recruitment need to fully utilise the planned DSU sessions as GA.  consultants are currently travelling, loss of session time and financial impact	More anaesthetic support - Cost within Theatres (query current vacancies in Anaesthetics)  consultants are currently travelling, loss of session time and financial impact  Additional Jnr Doctors to provide 24/7 dedicated cover for		
Changes to current Nursing & HCSW model incl. impact on variable pay	staff from Rhiannon Ward would move to Y Banwy. Work ongoing to review the staffing model, potential 1 x Band 5		current Theatre Nursing vacancies in DSU, would need to be fully staffed to fully utilise the DSU sessions	Additional Nurses - B5 (check on numbers depending on hours and days per week) for extended day surgery hours		
Changes to current Therapies workforce model incl. impact on variable pay	7 day therapies required, details and costs to be confirmed. Need to invest in therapies to reduce their Length of stay to improve throughput		7 day therapies required, details and costs to be confirmed. Need to invest in therapies to reduce their Length of stay to improve throughput	7 day therapies required, details and costs to be confirmed. Need to invest in therapies to reduce their Length of stay to improve throughput	no change	
Changes to current HCS & APST Workforce model incl. impact on variable pay	no pharmacy on sat afternoon, closed on Sunday. So would need clear discharge plans with engagement with all disciplines		no pharmacy on sat afternoon, closed on Sunday (Check on opening hours). So would need clear discharge plans with engagement with all disciplines	no pharmacy on sat afternoon, closed on Sunday (Check on opening hours). So would need clear discharge plans with engagement with all disciplines		
Changes to current Administrative Workforce	1 wte ward clerk required			ward clerks, admin support to address extended hours		

OPTION 2

Any other additional workforce requirements - e.g. Facilities roles	None		None	HDSU, domestic services, portering (check theatre model)	
Any additional Training required?	dependent on workforce plans from Therapies		dependent on workforce plans from Therapies	dependent on workforce plans from Therapies	
Impact on current staff - e.g Will staff need to move site / will model improve MDT working?			Job Plan reviews/changes would be required to fully implement regional working plan ie travelling to other sites		
Will this reduce your current workforce risks & challenges?	no		No	No	
Do you believe this will have a positive or negative impact on recruitment and retention?	positive from nursing - more functionality like PPH; therapies may find it difficult to recruit		Retention - negative Recruitment - potentially positive	Retention - negative Recruitment - potentially positive	
Are there any other interdependent services that will be impacted by this change? e.g. diagnostics, A&E, wards	Theatres, Pre-assessment, therapies & radiology		Theatres, Pre-assessment, therapies & radiology	Theatres, Pre-assessment, therapies & radiology	
Are there other programmes of work that may impact the option e.g. ARCH / Regional work	SLA/LTAs in place with BCU/Powys - no impact as arrangements in place		Regional work with SBU	Regional work with SBU	
Are there ways to use technology or innovations to support the delivery of this option?	Roll out of virtual joint school across the HB, Electronic Prescribing (HB Wide, but details unknown at present). Continued input from Orthopaedic Prehab Team		Roll out of virtual joint school across the HB, Electronic Prescribing (HB Wide, but details unknown at present). Continued input from Orthopaedic Prehab Team	Roll out of virtual joint school across the HB, Electronic Prescribing (HB Wide, but details unknown at present). Continued input from Orthopaedic Prehab Team	
<b>Estates</b>					
Theatres / Sessions	no additional sessions		No additional main theatre sessions	Main Theatre allocation is currently below what is funded due to the closure of Theatre 4. Query long term plan for Theatre 4 for increase back to what is funded	
Day Surgery Units (DSU) / Sessions	no additional sessions		Conversion of DSU sessions that are LA to GA through recruitment of Anaesthetics - changes to the basket of procedures within the Theatres Increase of DSU Theatre sessions from 7 to 11 through the recruitment of Theatre Staff		
Procedure Rooms / Sessions				none	

Outpatients Department / Sessions				none	
Other	Additional Pre-assessment facilities needed, virtual / e prescribing may facilitate this		Additional Pre-assessment facilities needed, virtual / e prescribing may facilitate this	Additional Pre-assessment facilities needed, virtual / e prescribing may facilitate this	Need community based venues to support the pre-assessment / keep fit programmes - support from additional therapists. Joint work with Swansea Bay to keep fit inline with shared waiting lists (more PPH specific)
Office space required (Desks)	need additional office space for medical staff with Hot Desks		office space for regional working / staff without existing desks		
Equipment Moves (Surplus and Essential)	With move to Y Banwy, this will need further exploration			none	
Potential Capital Development needs	Y banwy as part of the move of stroke		no change to current configuration	To reduce impact of lack of Radiography support for theatre lists that require image, a solution could be to look at purchasing a mini C-arm machine that could be operated by the surgeon - Circa E60k.	
Potential Digital opportunities (achievable within 2-4 years) (E.G. CT Profusion for Stroke)	Additional PCs to support the medics			virtual assessment / e-prescribing	keep fit services
<b>Patients</b>					
Identify what intervention will take place on each site and what interventions will move	No change in Procedures	n/a	More complex procedures here if HVLC moves to WGH and NPT	Potential to move HVLC to WGH from PPH	
Clarify if there are Patient Transfers required (include acuity: ACCTS or NEPTS or WAST) what % of patients this would be (this will need to be evidence based)	NEPTS for prompt transfers between sites for any complications that can't be managed at BGH	n/a	NEPTS for transfers between sites - accepting at PPH from other sites	NEPTS for transfers between sites, more WGH to PPH for admission and discharge	
Detail any impacts or changes to regional or national pathways	stays the same	n/a	Ensure consultants have access to LVHC and HVLC theatre sessions to maintain competencies Nursing Skills maintained by rotation	Ensure consultants have access to LVHC and HVLC theatre sessions to maintain competencies Nursing Skills maintained by rotation	
<b>Addressing Barriers</b>					
Waiting Lists			Lack of patients suitable for Neath Port Talbot Theatre environment as part of the regional working.		

Waiting Times			Potential to improve throughput if additional therapies are available to support the service. Regional Working to pool Waiting Lists	Potential to improve throughput if additional therapies are available to support the service. Regional Working to pool Waiting Lists	
Other					

ORTHOPAEDICS		Bronglais	Glangwili	Prince Philip	Withybush	Community Sites
O P T I O N  3	OPTION 3	Inpatient and Day Case Elective Orthopaedics  Outpatient service	No elective services, trauma only  Outpatient service	Become an Orthopaedics centre of excellence. Carry out Complex elective services inc Arthroplasty as Inpatients and Day Cases  Outpatient service	Day case Centre of Excellence  High volume, low complexity orthopaedic services (day cases)  Outpatient service	Current configuration – no Inpatient or Day Case activity at community sites, limited outpatients at some sites Tenby, Cardigan, Towyn (consider xray facilities)
	Workforce Requirement					
	Are there any changes required to current Rotas? include On Call, moving to a 7 day model etc	Trauma on call only. No changes to Job Plans/Rotas for electives	not applicable	No changes to on-call Rota. Job Plan reviews/changes would be required to fully implement regional working plan ie travelling to other sites	No changes to on-call Rota. Job Plan reviews/changes would be required to fully implement regional working plan ie travelling to other sites	
	Any changes to current Bed numbers?	On going discussions with the potential move to Y Banwy, exact bed numbers to be confirmed, Rhiannon Wards has historically provided 2 x 4 bedded bays (8) however due to the Meurig Ward issues, only 4 beds available at present. No increase in Theatres proposed.		no change 21 beds	no change	
	Changes to current Medical workforce model incl. impact on variable pay			More anaesthetic support - cost within Theatres. Some DSU sessions LA only due Anaesthetic vacancies. Recruitment need to fully utilise the planned DSU sessions as GA.  consultants are currently travelling, loss of session time and financial impact  Additional Jnr Doctors to provide 24/7 dedicated cover for Ward 6, which is currently being paid via ADH claims	More anaesthetic support - Cost within Theatres (query current vacancies in Anaesthetics)  consultants are currently travelling, loss of session time and financial impact  Additional Jnr Doctors to provide 24/7 dedicated cover for Ward 9 if daycase Arthroplasty is reinstated in WGH	
	Changes to current Nursing & HCSW model incl. impact on variable pay	staff from Rhiannon Ward would move to Y Banwy. Work ongoing to review the staffing model, potential 1 x Band 5		increase in nursing if bed days increase to funded 28 beds; potentially 1 nurse and HCSW per day  current Theatre Nursing vacancies in DSU, would need to be fully staffed to fully utilise the DSU sessions	hours would increase, need to know the time	
	Changes to current Therapies workforce model incl. impact on variable pay	7 day therapies required, details and costs to be confirmed. Need to invest in therapies to reduce their Length of stay to improve throughput		7 day therapies required, details and costs to be confirmed. Need to invest in therapies to reduce their Length of stay to improve throughput	7 day therapies required, details and costs to be confirmed. Need to invest in therapies to reduce their Length of stay to improve throughput	
	Changes to current HCS & APST Workforce model incl. impact on variable pay	no pharmacy on sat afternoon, closed on Sunday. So would need clear discharge plans with engagement with all disciplines		no pharmacy on sat afternoon, closed on Sunday (Check on opening hours). So would need clear discharge plans with engagement with all disciplines	no pharmacy on sat afternoon, closed on Sunday (Check on opening hours). So would need clear discharge plans with engagement with all disciplines	

Changes to current <b>Administrative</b> Workforce					
	1 wte ward clerk required			ward clerk, catering, domestic services for increased hours	
Any other additional workforce requirements - e.g. Facilities roles	None		None		
Any additional Training required?	dependent on workforce plans from Therapies		dependent on workforce plans from Therapies	Consider training should day case Arthroplasty be reintroduced. dependent on workforce plans from Therapies	
Impact on current staff - e.g Will staff need to move site / will model improve MDT working?			Job Plan reviews/changes would be required to fully implement regional working plan ie travelling to other sites	Job Plan reviews/changes would be required to fully implement regional working plan ie travelling to other sites	
Will this reduce your current workforce risks & challenges?	no		No	No	
Do you believe this will have a positive or negative impact on recruitment and retention?	positive from nursing - more functionality like PPH; therapies may find it difficult to recruit		Retention - negative Recruitment - potentially positive	negative for medical recruitment if more complex procedures or arthroplasty moved to PPH, maybe have effect on nursing & therapies	
Are there any other interdependent services that will be impacted by this change? e.g. diagnostics, A&E, wards	Theatres, Pre-assessment, therapies & radiology		Theatres, Pre-assessment, therapies & radiology	Additional Post op x-rays, increased pain services required Theatres, Pre-assessment, therapies & radiology	
Are there other programmes of work that may impact the option e.g. ARCH / Regional work	SLA/LTAs in place with BCU/Powys - no impact as arrangements in place		Regional work with SBU	Regional work with SBU	
Are there ways to use technology or innovations to support the delivery of this option?	Roll out of virtual joint school across the HB, Electronic Prescribing (HB Wide, but details unknown at present). Continued input from Orthopaedic Prehab Team		Roll out of virtual joint school across the HB, Electronic Prescribing (HB Wide, but details unknown at present). Continued input from Orthopaedic Prehab Team	Roll out of virtual joint school across the HB, Electronic Prescribing (HB Wide, but details unknown at present). Continued input from Orthopaedic Prehab Team	
<b>Estates</b>					
Theatres / Sessions	no additional sessions	No elective services, trauma only Outpatient service	no additional sessions	Main Theatre allocation is currently below what is funded due to the closure of Theatre 4. Query long term plan for Theatre 4 for increase back to what is funded	
Day Surgery Units (DSU) / Sessions	no additional sessions		Conversion of sessions that are LA to GA through recruitment of Anaesthetics - changes to the basket of procedures within the Theatres Increase of Theatre sessions from 7 to 11 through the recruitment of Theatre Staff		

Procedure Rooms / Sessions				none	
Outpatients Department / Sessions				none	
Other	Additional Pre-assessment facilities needed, virtual / e prescribing may facilitate this		Additional Pre-assessment facilities needed, virtual / e prescribing may facilitate this	Additional Pre-assessment facilities needed, virtual / e prescribing may facilitate this	
Office space required (Desks)	need additional office space for medical staff with Hot Desks		office space for regional working / staff without existing desks		
Equipment Moves (Surplus and Essential)	With move to Y Banwy, this will need further exploration			none	
Potential Capital Development needs	Y banwy as part of the move of stroke		no change to current configuration	To reduce impact of lack of Radiography support, Purchase of mini C-arm machine that could be operated by the surgeon - £60k	
Potential Digital opportunities (achievable within 2-4 years) (E.G. CT Profusion for Stroke)	Additional PCs to support the medics			virtual assessment / e-prescribing	
<b>Patients</b>					
Identify what intervention will take place on each site and what interventions will move	No change in Procedures	n/a	More complex procedures here if HVLC moves to WGH	potential to move High volume Low complexity from PPH including Daycase Arthroplasty	
Clarify if there are Patient Transfers required (include acuity: ACCTS or NEPTS or WAST) what % of patients this would be (this will need to be evidence based)	NEPTS for prompt transfers between sites for any complications that can't be managed at BGH	n/a	NEPTS for transfers between sites - accepting at PPH from other sites	NEPTS for transfers between sites, more WGH to PPH for admission and discharge	
Detail any impacts or changes to regional or national pathways	stays the same	n/a	Ensure consultants have access to LVHC and HVLC theatre sessions to maintain competencies Nursing Skills maintained by rotation	Ensure consultants have access to LVHC and HVLC theatre sessions to maintain competencies Nursing Skills maintained by rotation	
<b>Addressing Barriers</b>					

Waiting Lists			Lack of patients suitable for Neath Port Talbot Theatre environment as part of the regional working.		
Waiting Times			Potential to improve throughput if additional therapies are available to support the service. Regional Working to pool Waiting Lists	Potential to improve throughput if additional therapies are available to support the service. Regional Working to pool Waiting Lists	
Other					

ORTHOPAEDICS		Bronglais	Glangwili	Prince Philip	Withybush	Community Sites
OPTION 4		<p>Bronglais Hospital – 5 out of 5 ultra clean theatre sessions available for Inpatients and Day cases</p> <p>No change in service</p> <p>May use DSU 3 if Ophthalmology come out (circa 3 sessions)</p> <p>2 x 4 bedded bays at present, would need additional beds</p> <p>IMTP November 2021 identifies the change of services.</p>	<p>No elective services, trauma only as current configuration</p> <p>No change</p>	<p>Main theatres and Day Surgery Unit at full capacity. 6 day working funded services in DSU. Complex elective Inpatient and Day Case services inc Arthroplasty</p> <p>DSU release main for Inpatient, would increasing staffing inc support services to achieve this</p> <p>Move more day case sessions to Withybush to free up capacity for IP if emergency surgery moves</p> <p>Regional Work is Key to delivery</p>	<p>Main Theatres and Day Surgery Unit at full day case capacity</p> <p>Maintaining the current service</p> <p>Look at - Same day admit and discharge – increase to model</p> <p>Proposal to move orthopaedics from DSU PPH to WGH – 10 sessions (urology, endoscopy/derm movements)</p> <p>Orthopaedics plus some smaller associated day case work to WGH for day surgery out of PPH DSU</p>	<p>Current configuration – no Inpatient or Day Case activity at community sites, limited outpatients at some sites</p>
	Workforce Requirement					
	Are there any changes required to current Rotas? include On Call, moving to a 7 day model etc	<p>No change to on-call rota. changes to Job Plans/Rotas for electives if Ophthalmology move out of BGH (DSU 3) and funding remains in BGH for these 3 sessions to allow theatre sessions to increase from 5 sessions per week to 8.</p>	<p>No changes, trauma only.</p>	<p>No changes to on-call Rota. Job Plan reviews/changes would be required to fully implement regional working plan ie travelling to other sites</p>	<p>No changes to on-call Rota. Job Plan reviews/changes would be required to fully implement regional working plan ie travelling to other sites</p>	<p>No changes. Outpatient clinics only which would remain.</p>
Any changes to current Bed numbers?	<p>On going discussions with the potential move to Y Banwy, exact bed numbers to be confirmed, Rhiannon Wards has historically provided 2 x 4 bedded bays (8) however due to the Meurig Ward issues, only 4 beds available at present. Would need additional beds if theatre sessions become available if Ophthalmology move out.</p>		<p>no change 21 beds</p>	<p>no change</p>		

Changes to current <b>Medical</b> workforce model incl. impact on variable pay	4 WTE consultants funded - currently only 3 wte consultants in post with job plans that cover the vacant consultant post. Consider requirement to recruitment into additional post if the additional theatre sessions become available.		More anaesthetic support - cost within Theatres. Some DSU sessions LA only due Anaesthetic vacancies. Recruitment need to fully utilise the planned DSU sessions as GA.  consultants are currently travelling, loss of session time and financial impact  Additional Jnr Doctors to provide 24/7 dedicated cover for Ward 6, which is currently being paid ADH claims	More anaesthetic support - Cost within Theatres (query current vacancies in Anaesthetics)  consultants are currently travelling, loss of session time and financial impact  Additional Jnr Doctors to provide 24/7 dedicated cover for Ward 9 if daycase Arthroplasty is reinstated in WGH	
Changes to current <b>Nursing &amp; HCSW</b> model incl. impact on variable pay	staff from Rhiannon Ward would move to Y Banwy. Work ongoing to review the staffing model, potential 1 x Band 5		current Theatre Nursing vacancies in DSU, would need to be fully staffed to fully utilise the DSU sessions	no changes in nursing complement	
Changes to current <b>Therapies</b> workforce model incl. impact on variable pay	7 day therapies required, details and costs to be confirmed. Need to invest in therapies to reduce their Length of stay to improve throughput		7 day therapies required, details and costs to be confirmed. Need to invest in therapies to reduce their Length of stay to improve throughput  Radiology staff	7 day therapies required, details and costs to be confirmed. Need to invest in therapies to reduce their Length of stay to improve throughput  Radiology staff	
Changes to current <b>HCS &amp; APST</b> Workforce model incl. impact on variable pay	no pharmacy on sat afternoon, closed on Sunday. So would need clear discharge plans with engagement with all disciplines		no pharmacy on sat afternoon, closed on Sunday (Check on opening hours). So would need clear discharge plans with engagement with all disciplines	no pharmacy on sat afternoon, closed on Sunday (Check on opening hours). So would need clear discharge plans with engagement with all disciplines	
Changes to current <b>Administrative</b> Workforce	1 wte ward clerk required		additional staff to run 6 days		
Any other additional workforce requirements - e.g. Facilities roles	None		domestic, HDSU,		
Any additional Training required?	dependent on workforce plans from Therapies			Consider training should day case Arthroplasty be reintroduced.	
Impact on current staff - e.g Will staff need to move site / will model improve MDT working?			Job Plan reviews/changes would be required to fully implement regional working plan ie travelling to other sites	Job Plan reviews/changes would be required to fully implement regional working plan ie travelling to other sites	
Will this reduce your current workforce risks & challenges?	no		No	No	
Do you believe this will have a positive or negative impact on recruitment and retention?	positive from nursing - more functionality like PPH; therapies may find it difficult to recruit		Retention - negative Recruitment - potentially positive	Retention - negative Recruitment - potentially positive	
Are there any other interdependent services that will be impacted by this change? e.g. diagnostics, A&E, wards	Theatres, Pre-assessment, therapies & radiology		Theatres, Pre-assessment, therapies & radiology	Theatres, Pre-assessment, therapies & radiology	

Are there other programmes of work that may impact the option e.g. ARCH / Regional work	SLA/LTAs in place with BCU/Powys - no impact as arrangements in place		Regional work with SBU	Regional work with SBU	
Are there ways to use technology or innovations to support the delivery of this option?	Roll out of virtual joint school across the HB, Electronic Prescribing (HB Wide, but details unknown at present). Continued input from Orthopaedic Prehab Team		Roll out of virtual joint school across the HB, Electronic Prescribing (HB Wide, but details unknown at present). Continued input from Orthopaedic Prehab Team	Roll out of virtual joint school across the HB, Electronic Prescribing (HB Wide, but details unknown at present). Continued input from Orthopaedic Prehab Team	
<b>Estates</b>					
Theatres / Sessions			no additional sessions	Main Theatre allocation is currently below what is funded due to the closure of Theatre 4. Query long term plan for Theatre 4 for increase back to what is funded	
Day Surgery Units (DSU) / Sessions	Potential to increase from 5 to 8 sessions per week with this option (reliant on Ophthalmology confirmed option)		Conversion of sessions that are LA to GA through recruitment of Anaesthetics - changes to the basket of procedures within the Theatres Increase of Theatre sessions from 7 to 11 through the recruitment of Theatre Staff		
Procedure Rooms / Sessions					
Outpatients Department / Sessions					
Other	Additional Pre-assessment facilities needed, virtual / e prescribing may facilitate this		Additional Pre-assessment facilities needed, virtual / e prescribing may facilitate this	Additional Pre-assessment facilities needed, virtual / e prescribing may facilitate this	Pre-assessment in community, virtual, keep fit programme
Office space required (Desks)	need additional office space for medical staff with Hot Desks		office space for regional working / staff without existing desks		
Equipment Moves (Surplus and Essential)	With move to Y Banwy, this will need further exploration			none	
Potential Capital Development needs	Y banwy as part of the move of stroke		no change to current configuration	To reduce impact of lack of Radiography support, Purchase of mini C-arm machine that could be operated by the surgeon - £60k	
Potential Digital opportunities (achievable within 2-4 years) (E.G. CT Profusion for Stroke)	Additional PCs to support the medics			virtual assessment / e-prescribing	

Patients					
Identify what intervention will take place on each site and what interventions will move	No change in Procedures	n/a	More complex procedures here if HVLC moves to WGH	No change in Procedures, potential to move High volume Low complexity from PPH	
Clarify if there are Patient Transfers required (include acuity: ACCTS or NEPTS or WAST) what % of patients this would be (this will need to be evidence based)	NEPTS for prompt transfers between sites for any complications that can't be managed at BGH	n/a	NEPTS for transfers between sites - accepting at PPH from other sites	NEPTS for transfers between sites, more WGH to PPH for admission and discharge	
Detail any impacts or changes to regional or national pathways	stays the same	n/a	Ensure consultants have access to LVHC and HVLC theatre sessions to maintain competencies Nursing Skills maintained by rotation	Ensure consultants have access to LVHC and HVLC theatre sessions to maintain competencies Nursing Skills maintained by rotation	
Addressing Barriers					
Waiting Lists			Lack of patients suitable for Neath Port Talbot Theatre environment as part of the regional working.		
Waiting Times			Potential to improve throughput if additional therapies are available to support the service. Regional Working to pool Waiting Lists	Potential to improve throughput if additional therapies are available to support the service. Regional Working to pool Waiting Lists	
Other					

ORTHOPAEDICS	Bronglais	Glangwili	Prince Philip	Withybush	Community Sites
<b>OPTION 1</b>	Elective Inpatient and Day case services only. Bronglais to create ringfenced area (BOA Standards)	No elective services, trauma only	Regional working services with Swansea Bay. Inpatient and Day Case Complex elective services inc Arthroplasty	High volume, low complexity Day Case Orthopaedic services	Current configuration - No activity at community sites

<p><b>OPTION 2</b></p>	<p>Elective and Emergency – x5 theatre sessions bed inpatient and Day Case (as current config.) when meeting BOA guidance</p>	<p>No elective, trauma only</p>	<p>Elective Inpatient and Day Cases – demountable unit. – can be increased</p> <p>Possibly to include regional</p>	<p>Elective services and extend day capacity (23:59 model), high volume / low complexity Day Cases</p> <p>Elective services and extend day capacity model, high volume / low complexity Day Cases</p>	<p>As per current configuration - no Inpatient or Day Case activity at community sites, limited outpatient clinics at some sites</p>
<p><b>OPTION 3</b></p>	<p>Inpatient and Day Case Elective Orthopaedics</p> <p>Outpatient service</p>	<p>No elective services, trauma only</p> <p>Outpatient service</p>	<p>Become an Orthopaedics centre of excellence. Carry out Complex elective services inc Arthroplasty as Inpatients and Day Cases</p> <p>Outpatient service</p>	<p>Day case Centre of Excellence</p> <p>High volume, low complexity orthopaedic services (day cases)</p> <p>Outpatient service</p>	<p>Current configuration – no Inpatient or Day Case activity at community sites, limited outpatients at some sites Tenby, Cardigan, Towyn (consider xray facilities)</p>
<p><b>OPTION 4</b></p>	<p>Bronglais Hospital – 5 out of 5 ultra clean theatre sessions available for Inpatients and Day cases</p> <p>No change in service</p> <p>May use DSU 3 if Ophthalmology come out (circa 3 sessions)</p> <p>2 x 4 bedded bays at present, would need additional beds</p> <p>IMTP November 2021 identifies the change of services.</p>	<p>No elective services, trauma only as current configuration</p> <p>No change</p>	<p>Main theatres and Day Surgery Unit at full capacity. 6 day working funded services in DSU. Complex elective Inpatient and Day Case services inc Arthroplasty</p> <p>DSU release main for Inpatient, would increasing staffing inc support services to achieve this</p> <p>Move more day case sessions to Withybush to free up capacity for IP if emergency surgery moves</p> <p>Regional Work is Key to delivery</p>	<p>Main Theatres and Day Surgery Unit at full day case capacity</p> <p>Maintaining the current service</p> <p>Look at - Same day admit and discharge – increase to model</p> <p>Proposal to move orthopaedics from DSU PPH to WGH – 10 sessions (urology, endoscopy/derm movements)</p> <p>Orthopaedics plus some smaller associated day case work to WGH for day surgery out of PPH DSU</p>	<p>Current configuration – no Inpatient or Day Case activity at community sites, limited outpatients at some sites</p>

STROKE		Bronglais	Glangwili	Prince Philip	Withybush	Community Sites
O P T I O N  1	OPTION 1	Treat and transfer to appropriate Acute Stroke unit	Treat and transfer to appropriate Acute Stroke unit	Acute Stroke Unit and rehab beds	Acute Stroke Unit and rehab beds	Current configuration - No activity at community sites
	Workforce Requirement					
	Are there any changes required to current Rotas? include On Call, moving to a 7 day model etc	Training for on call teams to be able to treat patients presenting with a stroke	Training for on call teams to be able to treat patients presenting with a stroke	Guidelines for ASU there needs to be a 7 day model (can be hybrid) in order to meet standards. Further discussions with SBhb in order to consider a retgional rota	Guidelines for ASU there needs to be a 7 day model (can be hybrid) in order to meet standards. Further discussions with SBhb in order to consider a retgional rota	
	Any changes to current Bed numbers?	No stroke service in Bronglais therefore no beds required and 8 beds being handed back to BGH. The beds are not to be closed, they are free to be utilised by other services or any patients that don't require specialist Stroke Care	No stroke service in Glangwili therefore no beds required and 20 beds being handed back to GGH The beds are not to be closed, they are free to be utilised by other services or any patients that don't require specialist Stroke Care	29 beds to remain in PPH	14 beds to remain as current and an additional 6 for Withybush	
	Changes to current Medical workforce model incl. impact on variable pay	Potential rota to support telemedicine No Stroke medical cover required for BGH, other than cover for outpatients & ESD retain current	Potential rota to support telemedicine No Stroke medical cover required for GGH	Consolidate PPH & GGH staff to PPH	Additional Associate Specialist	
	Changes to current Nursing & HCSW model incl. impact on variable pay	No Stroke nursing cover required in BGH Retain CNS to support outpatients & ESD	No Stroke nursing cover required in GGH	Consolidate PPH & GGH staff at PPH CNS 7 day cover required currently 5 day 9am-5pm 8am-8pm plus uplift 26.4%	Additional requirement for registered nursing 1 RN band 5 day and night - 12 hour shift and 1 band 6 for the additional 6 beds. CNS 7 day cover required currently 5 day 9am-5pm 8am-8pm plus uplift 26.4%	
	Changes to current Therapies workforce model incl. impact on variable pay	No Stroke Therapies cover for BGH, however the therapies staff will remain to cover beds at BGH	No Stroke Therapies cover for GGH, however the therapies staff will remain to cover beds at GGH	Therapies staffing to remain as current	Additional requirement including 7 day cover - Therapies to comment	
	Changes to current HCS & APST Workforce model incl. impact on variable pay	No stroke HCS & APST for GGH	No stroke HCS & APST for GGH	Captured above	Captured above	
	Changes to current Administrative Workforce	To remain	Consolidate to PPH	Additional requirement 1 band 2 to support Stroke team	Additional requirement 1 band 2 to support Stroke team	
	Any other additional workforce requirements - e.g. Facilities roles	ESD - Therapies to remain as current	ESD - Therapies to remain as current	ESD - Therapies to remain as current	ESD - Therapies to remain as current	
Any additional Training required?	Standardisation of training for physicans on call and medical teams and develop one training package	Standardisation of training for physicans on call and medical teams and develop one training package	Standardisation of training for physicans on call and medical teams and develop one training package	Standardisation of training for physicans on call and medical teams and develop one training package		

Impact on current staff - e.g Will staff need to move site / will model improve MDT working?	Yes	Yes	No	No	
Will this reduce your current workforce risks & challenges?	Yes	Yes	Yes	Yes	
Do you believe this will have a positive or negative impact on recruitment and retention?	Positive	Positive	Positive	Positive	
Are there any other interdependent services that will be impacted by this change? e.g. diagnostics, A&E, wards	Therapies, Radiology, WAST, Pharmacy, Cardio Physiology & A&E impact waiting on transfer and administration of Thrombolysis	Therapies, Radiology, WAST, Pharmacy, Cardio Physiology	Therapies, Radiology, WAST, Pharmacy, Cardio Physiology	Therapies, Radiology, WAST, Pharmacy, Cardio Physiology	
Are there other programmes of work that may impact the option e.g. ARCH / Regional work	ARCH Regional Programme SBHB	ARCH Regional Programme SBHB	ARCH Regional Programme SBHB	ARCH Regional Programme SBHB	
Are there ways to use technology or innovations to support the delivery of this option?	Telemedic, CT Perfusion, Pre Hospital triage (Cardiff)	Telemedic, CT Perfusion, Pre Hospital triage (Cardiff)	Telemedic, CT Perfusion, Pre Hospital triage (Cardiff)	Telemedic, CT Perfusion, Pre Hospital triage (Cardiff)	
<b>Estates</b>					
Theatres / Sessions	N/A	N/A	N/A	N/A	
Day Surgery Units (DSU) / Sessions	N/A	N/A	N/A	N/A	
Procedure Rooms / Sessions	N/A	N/A	N/A	N/A	
Outpatients Department / Sessions	Remain as is current	No longer being delivered at GGH	Additional 3 TIA clinics (from GGH)	Remain as is current	
Other	Option for Stroke specific bed in A&E	Rehab space allocated on site however would be utilised by other patients at GGH	Rehab space allocated on site however would be utilised by other patients at GGH Rehab space under the new guidelines should allow for group sessions - this would need to be reviewed	Rehab space allocated on site however would be utilised by other patients at GGH Rehab space under the new guidelines should allow for group sessions - this would need to be reviewed	

Office space required (Desks)	None	None	Required for 1 administrative role	Required for 1 administrative role	
Equipment Moves (Surplus and Essential)	None	None	Additional specialist seating - Therpaies to confirm	Additional Storage 1 room Additional specialist seating = therpaies to confirm	
Potential Capital Development needs	None	None	None	None	
Potential Digital opportunities (achievable within 2-4 years) (E.G. CT Profusion for Stroke)	CT Profusion	CT Profusion	CT Profusion	CT Profusion	
<b>Patients</b>					
Identify what intervention will take place on each site and what interventions will move	Initial Assesment & Investigation includes CT perfusion & angiogram Decision re Thrombalysis/Thrombectomy Transfer or discharge	Initial Assesment & Investigation includes CT perfusion & angiogram Decision re Thrombalysis/Thrombectomy Transfer or discharge	Initial Assesment & Investigation includes CT perfusion & angiogram Decision re Thrombalysis/Thrombectomy Transfer to Bristol if Thrombecomy eligible or discharge	Initial Assesment & Investigation includes CT perfusion & angiogram Decision re Thrombalysis/Thrombectomy Transfer or disscarge	
Clarify if there are Patient Transfers required (include acuity: ACCTS or NEPTS or WAST) what % of patients this would be (this will need to be evidence based)	90% of WGH April - Dec 22 Stroke admissions to be transferred 7 days a week Timely transfers and avallivity will be key	90% of WGH April - Dec 22 Stroke admissions to be transferred 7 days a week Timely transfers and avallivity will be key	Transfers to Bristol within current budget for PPH&GGH	Transfers to Bristol within current budget for PPH&GGH	
Detail any impacts or changes to regional or national pathways	Further discussion with Powys & Gwynedd regarding their patients being treated yn Hywel Dda ie After treat and transfer where do they go? PPH or nearest unit in North Wales?	None	None	None	
<b>Addressing Barriers</b>					
Waiting Lists					
Waiting Times					
Other	Improving standards	Improving standards	Improving standards	Improving standards	

STROKE		Bronglais	Glangwili	Prince Philip	Withybush	Community Sites
O P T I O N  2	OPTION 2	Treat and transfer to Stroke unit Use of virtual assessments	Treat and transfer to Stroke unit Use of virtual assessments	Hyper Acute Stroke Unit (first 72 hours) for Health Board and specialist rehab	Acute Stroke Unit, includes specialist rehab	Community Stroke service: ESD - Early supported discharge Home first Stroke rehab at home
	Workforce Requirement					
	Are there any changes required to current Rotas? include On Call, moving to a 7 day model etc	Training for on call teams to be able to treat patients presenting with a stroke	Training for on call teams to be able to treat patients presenting with a stroke	Guidelines for HASU there needs to be a 7 day model (can be hybrid) in order to meet standards. Further discussions with SBHb in order to consider a regional rota	Guidelines for ASU there needs to be a 7 day model (can be hybrid) in order to meet standards. Further discussions with SBHb in order to consider a regional rota	
	Any changes to current Bed numbers?	No stroke service in Bronglais therefore no beds required and 8 beds being handed back to BGH. The beds are not to be closed, they are free to be utilised by other services or any patients that don't require specialist Stroke Care	No stroke service in Glangwili therefore no beds required and 20 beds being handed back to GGH The beds are not to be closed, they are free to be utilised by other services or any patients that don't require specialist Stroke Care	29 beds to current in PPH (10 HASU 7day working model, 19 ASU 5day working model) 7 day working model Consolidate PPH & GGH staff to PPH	14 beds to remain as current ASU beds 5 day working model Additional 6 beds required (19 total)	
	Changes to current Medical workforce model incl. impact on variable pay	Potential rota to support telemedicine No Stroke medical cover required for BGH, other than cover for outpatients & ESD retain current	Potential rota to support telemedicine No Stroke medical cover required for GGH	Need 6 consultants currently have 3 additional 3 Additional: 6 middle grades required - currently 2 in post (4.2 to cover HASU and additional for TIA & Ward)	Remain as is current	
	Changes to current Nursing & HCSW model incl. impact on variable pay	No Stroke nursing cover required in BGH Retain CNS to support outpatients & ESD	No Stroke nursing cover required in GGH	Consolidate PPH & GGH staff at PPH CNS 7 day cover required currently 5 day 7am-7pm plus uplift 26.4% - Royal College guidelines Nursing - Mia 24/7 ward	Additional requirement for registered nursing 1 RN band 5 day only - 12 hour shift and 1 band 6 for the additional 6 beds. CNS 5 day cover required currently 5 day 7am-7pm plus uplift 26.4%	
	Changes to current Therapies workforce model incl. impact on variable pay	No Stroke Therapies cover for BGH	No Stroke Therapies cover for GGH	Consolidate GGH & PPH at PPH - Therapies to confirm and ESD	Additional requirement including 7 day cover - Therapies to comment and ESD update	
	Changes to current HCS & APST Workforce model incl. impact on variable pay	No stroke HCS & APST for GGH	No stroke HCS & APST for GGH	Captured above	Captured above	
	Changes to current Administrative Workforce	To remain	Consolidate to PPH	Additional requirement 1 band 2 to support Stroke team 2 consultant PA's at band 4	Additional requirement 1 band 2 to support Stroke team	
	Any other additional workforce requirements - e.g. Facilities roles	ESD - Therapies to update	ESD - Therapies to update	ESD - Therapies to update	ESD - Therapies to update	
Any additional Training required?	Standardisation of training for physicans on call and medical teams and develop one training package	Standardisation of training for physicans on call and medical teams and develop one training package	Standardisation of training for physicans on call and medical teams and develop one training package	Standardisation of training for physicans on call and medical teams and develop one training package		

Impact on current staff - e.g Will staff need to move site / will model improve MDT working?	Yes	Yes	No	Yes	
Will this reduce your current workforce risks & challenges?	Yes	Yes	Yes	Yes	
Do you believe this will have a positive or negative impact on recruitment and retention?	Positive	Positive	Positive	Positive	
Are there any other interdependent services that will be impacted by this change? e.g. diagnostics, A&E, wards	Therapies, Radiology, WAST, Pharmacy, Cardio Physiology & A&E impact waiting on transfer and administration of Thrombolysis	Therapies, Radiology, WAST, Pharmacy, Cardio Physiology & A&E impact waiting on transfer and administration of Thrombolysis	Therapies, Radiology, WAST, Pharmacy, Cardio Physiology & A&E impact waiting on transfer and administration of Thrombolysis	Therapies, Radiology, WAST, Pharmacy, Cardio Physiology & A&E impact waiting on transfer and administration of Thrombolysis	
Are there other programmes of work that may impact the option e.g. ARCH / Regional work	ARCH Regional Programme SBHB	ARCH Regional Programme SBHB	ARCH Regional Programme SBHB	ARCH Regional Programme SBHB	
Are there ways to use technology or innovations to support the delivery of this option?	Telemedic, CT Perfusion, learning from Pre Hospital triage (Cardiff)	Telemedic, CT Perfusion, learning from Pre Hospital triage (Cardiff)	Telemedic, CT Perfusion, learning from Pre Hospital triage (Cardiff)	Telemedic, CT Perfusion, learning from Pre Hospital triage (Cardiff)	
<b>Estates</b>					
Theatres / Sessions	N/A	N/A	N/A	N/A	
Day Surgery Units (DSU) / Sessions	N/A	N/A	N/A	N/A	
Procedure Rooms / Sessions	N/A	N/A	N/A	N/A	
Outpatients Department / Sessions	Remain as is current	No longer being delivered at GGH	Additional 3 TIA clinics (from GGH)	Remain as is current	
Other	Option for Stroke specific bed in A&E	None	None	None	

Office space required (Desks)	None	None	Additional 5 offices for consultant Additional 2 offices for admin staff	Required for 1 administrative role	
Equipment Moves (Surplus and Essential)	None	Transfer of monitors if compatible to PPH	Additional specialist seating - Therpaies to confirm Monitors to be transferred from GGH - needs to be confirmed	Additional Storage 1 room Additional specialist seating = therpaies to confirm	
Potential Capital Development needs	None	None	None	None	
Potential Digital opportunities (achievable within 2-4 years) (E.G. CT Profusion for Stroke)	CT Profusion	CT Profusion	CT Profusion	CT Profusion	
<b>Patients</b>					
Identify what intervention will take place on each site and what interventions will move	Initial Assesment & Investigation includes CT perfusion & angiogram Decision re Thrombalysis/Thrombectomy Transfer or discharge	Initial Assesment & Investigation includes CT perfusion & angiogram Decision re Thrombalysis/Thrombectomy Transfer or discharge	Single unit in the HB for the first 72 hours of care (HASU) Initial Assesment & Investigation includes CT perfusion & angiogram Decision re Thrombalysis/Thrombectomy	Initial Assesment & Investigation includes CT perfusion & angiogram Decision re Thrombalysis/Thrombectomy Transfer to PPH (HASU) for first 72 hours of care)	
Clarify if there are Patient Transfers required (include acuity: ACCTS or NEPTS or WAST) what % of patients this would be (this will need to be evidence based)	90% of WGH April - Dec 22 Stroke admissions to be transferred as an estimate Timely transfers and avallivity will be key	90% of WGH April - Dec 22 Stroke admissions to be transferred Timely transfers and avallivity will be key	Transfers to Bristol within current budget for PPH&GGH	Transfers to Bristol within current budget for PPH&GGH	
Detail any impacts or changes to regional or national pathways	Further discussion with Powys & Gwynedd regarding their patients being treated yn Hywel Dda ie After treat and transfer where do they go? PPH or nearest unit in North Wales?	None	None	None	
<b>Addressing Barriers</b>					
Waiting Lists	N/A	N/A	N/A	N/A	N/A
Waiting Times	N/A	N/A	N/A	N/A	N/A
Other	Improving standards	Improving standards	Improving standards	Improving standards	

STROKE		Bronglais	Glangwili	Prince Philip	Withybush	Community Sites
O P T I O N 3	OPTION 3	Treat and transfer to Stroke Unit.	Treat and transfer to Stroke Unit.	Acute Stroke Unit. Rehab beds	Acute Stroke Unit. Rehab beds	Current configuration – South Pembrokeshire, Tregaron and Amman Valley for general rehab. Early Supported discharge across the Health Board
	Workforce Requirement					
	Are there any changes required to current Rotas? include On Call, moving to a 7 day model etc	Training for on call teams to be able to treat patients presenting with a stroke	Training for on call teams to be able to treat patients presenting with a stroke	Guidelines for ASU there needs to be a 7 day model (can be hybrid) in order to meet standards. Further discussions with SBHB in order to consider a regional rota	Guidelines for ASU there needs to be a 7 day model (can be hybrid) in order to meet standards. Further discussions with SBHB in order to consider a regional rota	
	Any changes to current Bed numbers?	No stroke service in Bronglais therefore no beds required and 8 beds being handed back to BGH. The beds are not to be closed, they are free to be utilised by other services or any patients that don't require specialist Stroke Care	No stroke service in Glangwili therefore no beds required and 20 beds being handed back to GGH The beds are not to be closed, they are free to be utilised by other services or any patients that don't require specialist Stroke Care	29 beds to remain in PPH	14 beds to remain as current and an additional 6 for Withybush	
	Changes to current Medical workforce model incl. impact on variable pay	Potential rota to support telemedicine No Stroke medical cover required for BGH, other than cover for outpatients & ESD retain current	Potential rota to support telemedicine No Stroke medical cover required for GGH	Consolidate PPH & GGH staff to PPH	Additional Associate Specialist	
	Changes to current Nursing & HCSW model incl. impact on variable pay	No Stroke nursing cover required in BGH Retain CNS to support outpatients & ESD	No Stroke nursing cover required in GGH	Consolidate PPH & GGH staff at PPH CNS 7 day cover required currently 5 day 9am-5pm 8am-8pm plus uplift 26.4%	Additional requirement for registered nursing 1 RN band 5 day and night - 12 hour shift and 1 band 6 for the additional 6 beds. CNS 7 day cover required currently 5 day 9am-5pm 8am-8pm plus uplift 26.4%	
	Changes to current Therapies workforce model incl. impact on variable pay	No Stroke Therapies cover for BGH	No Stroke Therapies cover for GGH	Consolidate GGH & PPH at PPH - Therapies to confirm	Additional requirement including 7 day cover - Therapies to comment	
	Changes to current HCS & APST Workforce model incl. impact on variable pay	No stroke HCS & APST for GGH	No stroke HCS & APST for GGH	Captured above	Captured above	
	Changes to current Administrative Workforce	To remain	Consolidate to PPH	Additional requirement 1 band 2 to support Stroke team	Additional requirement 1 band 2 to support Stroke team	
	Any other additional workforce requirements - e.g. Facilities roles	ESD - Therapies to update	ESD - Therapies to update	ESD - Therapies to update	ESD - Therapies to update	
Any additional Training required?	Standardisation of training for physicians on call and medical teams and develop one training package	Standardisation of training for physicians on call and medical teams and develop one training package	Standardisation of training for physicians on call and medical teams and develop one training package	Standardisation of training for physicians on call and medical teams and develop one training package		

Impact on current staff - e.g Will staff need to move site / will model improve MDT working?	Yes	Yes	No	No	
Will this reduce your current workforce risks & challenges?	Yes	Yes	Yes	Yes	
Do you believe this will have a positive or negative impact on recruitment and retention?	Positive	Positive	Positive	Positive	
Are there any other interdependent services that will be impacted by this change? e.g. diagnostics, A&E, wards	Therapies, Radiology, WAST, Pharmacy, Cardio Physiology & A&E impact waiting on transfer and administration of Thrombolysis	Therapies, Radiology, WAST, Pharmacy, Cardio Physiology	Therapies, Radiology, WAST, Pharmacy, Cardio Physiology	Therapies, Radiology, WAST, Pharmacy, Cardio Physiology	
Are there other programmes of work that may impact the option e.g. ARCH / Regional work	ARCH Regional Programme SBHB	ARCH Regional Programme SBHB	ARCH Regional Programme SBHB	ARCH Regional Programme SBHB	
Are there ways to use technology or innovations to support the delivery of this option?	Telemedic, CT Perfusion, Pre Hospital triage (Cardiff)	Telemedic, CT Perfusion, Pre Hospital triage (Cardiff)	Telemedic, CT Perfusion, Pre Hospital triage (Cardiff)	Telemedic, CT Perfusion, Pre Hospital triage (Cardiff)	
<b>Estates</b>					
Theatres / Sessions	N/A	N/A	N/A	N/A	
Day Surgery Units (DSU) / Sessions	N/A	N/A	N/A	N/A	
Procedure Rooms / Sessions	N/A	N/A	N/A	N/A	
Outpatients Department / Sessions	Remain as is current	No longer being delivered at GGH	Additional 3 TIA clinics (from GGH)	Remain as is current	
Other	Option for Stroke specific bed in A&E	None	None	None	

Office space required (Desks)	None	None	Required for 1 administrative role	Required for 1 administrative role	
Equipment Moves (Surplus and Essential)	None	None	Additional specialist seating - Therpaies to confirm	Additional Storage 1 room Additional specialist seating = therpaies to confirm	
Potential Capital Development needs	None	None	None	None	
Potential Digital opportunities (achievable within 2-4 years) (E.G. CT Profusion for Stroke)	CT Profusion	CT Profusion	CT Profusion	CT Profusion	
<b>Patients</b>					
Identify what intervention will take place on each site and what interventions will move	Initial Assesment & Investigation includes CT perfusion & angiogram Decision re Thrombalysis/Thrombectomy Transfer or discharge	Initial Assesment & Investigation includes CT perfusion & angiogram Decision re Thrombalysis/Thrombectomy Transfer or discharge	Initial Assesment & Investigation includes CT perfusion & angiogram Decision re Thrombalysis/Thrombectomy Transfer to Bristol if Thrombecomy eligible or discharge	Initial Assesment & Investigation includes CT perfusion & angiogram Decision re Thrombalysis/Thrombectomy Transfer or disscarge	
Clarify if there are Patient Transfers required (include acuity: ACCTS or NEPTS or WAST) what % of patients this would be (this will need to be evidence based)	90% of WGH April - Dec 22 Stroke admissions to be transferred 7 days a week Timely transfers and availivty will be key	90% of WGH April - Dec 22 Stroke admissions to be transferred 7 days a week Timely transfers and availivty will be key	Transfers to Bristol within current budget for PPH&GGH	Transfers to Bristol within current budget for PPH&GGH	
Detail any impacts or changes to regional or national pathways	Further discussion with Powys & Gwynedd regarding their patients being treated yn Hywel Dda ie After treat and transfer where do they go? PPH or nearest unit in North Wales?	None	None	None	
<b>Addressing Barriers</b>					
Waiting Lists					
Waiting Times					
Other	Improving standards	Improving standards	Improving standards	Improving standards	

STROKE		Bronglais	Glangwili	Prince Philip	Withybush	Community Sites
O P T I O N  4	OPTION 4	Treat and transfer to Stroke Unit  (current service not sustainable as only one consultant providing service)	Treat and transfer to Stroke Unit	Acute Stroke Unit  Stroke Consultants in place	Acute Stroke Unit  Stroke Consultants in place	Rehab at community hospitals (Step down rehab outside of Stroke service scope)
	Workforce Requirement					
	Are there any changes required to current Rotas? include On Call, moving to a 7 day model etc	Training for on call teams to be able to treat patients presenting with a stroke	Training for on call teams to be able to treat patients presenting with a stroke	Guidelines for ASU there needs to be a 7 day model (can be hybrid) in order to meet standards. Further discussions with SBHb in order to consider a retgional rota	Guidelines for ASU there needs to be a 7 day model (can be hybrid) in order to meet standards. Further discussions with SBHb in order to consider a retgional rota	
	Any changes to current Bed numbers?	No stroke service in Bronglais therefore no beds required and 8 beds being handed back to BGH.  The beds are not to be closed, they are free to be utilised by other services or any patients that don't require specialist Stroke Care	No stroke service in Glangwili therefore no beds required and 20 beds being handed back to GGH  The beds are not to be closed, they are free to be utilised by other services or any patients that don't require specialist Stroke Care	29 beds to remain in PPH	14 beds to remain as current and an additional 6 for Withybush	
	Changes to current Medical workforce model incl. impact on variable pay	Potential rota to support telemedicine  No Stroke medical cover required for BGH, other than cover for outpatients & ESD retain current	Potential rota to support telemedicine  No Stroke medical cover required for GGH	Consolidate PPH & GGH staff to PPH	Additional Associate Specialist	
	Changes to current Nursing & HCSW model incl. impact on variable pay	No Stroke nursing cover required in BGH  Retain CNS to support outpatients & ESD	No Stroke nursing cover required in GGH	Consolidate PPH & GGH staff at PPH  CNS 7 day cover required currently 5 day 9am-5pm 8am-8pm plus uplift 26.4%	Additional requirement for registered nursing 1 RN band 5 day and night - 12 hour shift and 1 band 6 for the additional 6 beds.  CNS 7 day cover required currently 5 day 9am-5pm 8am-8pm plus uplift 26.4%	
	Changes to current Therapies workforce model incl. impact on variable pay	No Stroke Therapies cover for BGH	No Stroke Therapies cover for GGH	Consolidate GGH & PPH at PPH - Therapies to confirm	Additional requirement including 7 day cover - Therapies to comment	
	Changes to current HCS & APST Workforce model incl. impact on variable pay	No stroke HCS & APST for GGH	No stroke HCS & APST for GGH	Captured above	Captured above	
	Changes to current Administrative Workforce	To remain	Consolidate to PPH	Additional requirement 1 band 2 to support Stroke team	Additional requirement 1 band 2 to support Stroke team	
	Any other additional workforce requirements - e.g. Facilities roles	ESD - Therapies to update	ESD - Therapies to update	ESD - Therapies to update	ESD - Therapies to update	
Any additional Training required?	Standardisation of training for physicans on call and medical teams and develop one training package	Standardisation of training for physicans on call and medical teams and develop one training package	Standardisation of training for physicans on call and medical teams and develop one training package	Standardisation of training for physicans on call and medical teams and develop one training package		

Impact on current staff - e.g Will staff need to move site / will model improve MDT working?	Yes	Yes	No	No	
Will this reduce your current workforce risks & challenges?	Yes	Yes	Yes	Yes	
Do you believe this will have a positive or negative impact on recruitment and retention?	Positive	Positive	Positive	Positive	
Are there any other interdependent services that will be impacted by this change? e.g. diagnostics, A&E, wards	Therapies, Radiology, WAST, Pharmacy, Cardio Physiology & A&E impact waiting on transfer and administration of Thrombolysis	Therapies, Radiology, WAST, Pharmacy, Cardio Physiology	Therapies, Radiology, WAST, Pharmacy, Cardio Physiology	Therapies, Radiology, WAST, Pharmacy, Cardio Physiology	
Are there other programmes of work that may impact the option e.g. ARCH / Regional work	ARCH Regional Programme SBHB	ARCH Regional Programme SBHB	ARCH Regional Programme SBHB	ARCH Regional Programme SBHB	
Are there ways to use technology or innovations to support the delivery of this option?	Telemedic, CT Perfusion, Pre Hospital triage (Cardiff)	Telemedic, CT Perfusion, Pre Hospital triage (Cardiff)	Telemedic, CT Perfusion, Pre Hospital triage (Cardiff)	Telemedic, CT Perfusion, Pre Hospital triage (Cardiff)	
<b>Estates</b>					
Theatres / Sessions	N/A	N/A	N/A	N/A	
Day Surgery Units (DSU) / Sessions	N/A	N/A	N/A	N/A	
Procedure Rooms / Sessions	N/A	N/A	N/A	N/A	
Outpatients Department / Sessions	Remain as is current	No longer being delivered at GGH	Additional 3 TIA clinics (from GGH)	Remain as is current	
Other	Option for Stroke specific bed in A&E	None	None	None	

Office space required (Desks)	None	None	Required for 1 administrative role	Required for 1 administrative role	
Equipment Moves (Surplus and Essential)	None	None	Additional specialist seating - Therpaies to confirm	Additional Storage 1 room Additional specialist seating = therpaies to confirm	
Potential Capital Development needs	None	None	None	None	
Potential Digital opportunities (achievable within 2-4 years) (E.G. CT Profusion for Stroke)	CT Profusion	CT Profusion	CT Profusion	CT Profusion	
<b>Patients</b>					
Identify what intervention will take place on each site and what interventions will move	Initial Assesment & Investigation includes CT perfusion & angiogram Decision re Thrombalysis/Thrombectomy Transfer or discharge	Initial Assesment & Investigation includes CT perfusion & angiogram Decision re Thrombalysis/Thrombectomy Transfer or discharge	Initial Assesment & Investigation includes CT perfusion & angiogram Decision re Thrombalysis/Thrombectomy Transfer to Bristol if Thrombecomy eligible or discharge	Initial Assesment & Investigation includes CT perfusion & angiogram Decision re Thrombalysis/Thrombectomy Transfer or disscarge	
Clarify if there are Patient Transfers required (include acuity: ACCTS or NEPTS or WAST) what % of patients this would be (this will need to be evidence based)	90% of WGH April - Dec 22 Stroke admissions to be transferred 7 days a week Timely transfers and avallivity will be key	90% of WGH April - Dec 22 Stroke admissions to be transferred 7 days a week Timely transfers and avallivity will be key	Transfers to Bristol within current budget for PPH&GGH	Transfers to Bristol within current budget for PPH&GGH	
Detail any impacts or changes to regional or national pathways	Further discussion with Powys & Gwynedd regarding their patients being treated yn Hywel Dda ie After treat and transfer where do they go? PPH or nearest unit in North Wales?	None	None	None	
<b>Addressing Barriers</b>					
Waiting Lists					
Waiting Times					
Other	Improving standards	Improving standards	Improving standards	Improving standards	

STROKE	Bronglais	Glangwili	Prince Philip	Withybush	Community Sites
OPTION 1	Treat and transfer to appropriate Acute Stroke unit	Treat and transfer to appropriate Acute Stroke unit	Acute Stroke Unit and rehab beds	Acute Stroke Unit and rehab beds	Current configuration - No activity at community sites
OPTION 2	Treat and transfer to Stroke unit Use of virtual assessments	Treat and transfer to Stroke unit Use of virtual assessments	Hyper Acute Stroke Unit (first 72 hours) for Health Board and specialist rehab	Acute Stroke Unit, includes specialist rehab	Community Stroke service: ESD - Early supported discharge Home first Stroke rehab at home
OPTION 3	Treat and transfer to Stroke Unit.	Treat and transfer to Stroke Unit.	Acute Stroke Unit. Rehab beds	Acute Stroke Unit. Rehab beds	Current configuration – South Pems, Tregaron and Amman Valley for general rehab. Early Supported discharge across the Health Board
OPTION 4	Treat and transfer to Stroke Unit (current service not sustainable as only one consultant providing service)	Treat and transfer to Stroke Unit	Acute Stroke Unit Stroke Consultants in place	Acute Stroke Unit Stroke Consultants in place	Rehab at community hospitals

	<b>RADIOLOGY</b>	<b>Bronglais</b>	<b>Glangwili</b>	<b>Prince Philip</b>	<b>Withybush</b>	<b>Community Sites</b>	
<b>O P T I O N 1</b>	<b>OPTION 1</b>	<b>Elective diagnostic/intervention and emergency daytime only</b>	<b>Emergency diagnostic/intervention services only</b>	<b>Elective diagnostic/intervention and emergency daytime only</b>	<b>Elective diagnostic/intervention and emergency daytime only. Nuclear medicine</b>	<b>X-Ray services in Cardigan Integrated Care Centre and Tenby Hospital Only</b>	
	<b>Workforce Requirement</b>						
	Are there any changes required to current Rotas? include On Call, moving to a 7 day model etc	To absorb work from GG there will be increase in working hours in other sites - additional staff - 2 x band 6 radiographers on a site with the additional MRI . Nursing - increase in band 5 nurses - 5 day a week - varies on each site	outpatients spread out to three sites - <b>staffing no's slightly decrease</b>	To absorb work from GG there will be increase in working hours in other sites - additional staff - 2 x band 6 radiographers on a site with the additional MRI . Nursing - increase in band 5 nurses - 5 day a week - varies on each site	To absorb work from GG there will be increase in working hours in other sites - additional staff - 2 x band 6 radiographers on a site with the additional MRI . Nursing - increase in band 5 nurses - 5 day a week - varies on each site		<b>removal of Llandovery - 1 day a week</b>
	Any changes to current Bed numbers?	Interventional services require more day beds - currently 1 to 2 beds required ( Mon -1 - not guaranteed; Wed - 1; Thurs - 2) - <b>increase to 5 - 3 extra medical beds a day</b>	Now using 2 medical day beds 3x week. Interventional services requires more day beds - <b>increase to 5 - 3 extra medical beds a day</b>	no problem at the moment, no increase required	Current use Tue, Thurs & Fri - 2 beds each day not guaranteed) Interventional services requires more day beds - <b>increase to 5- 3 extra medical beds a day</b>		
	Changes to current <b>Medical</b> workforce model incl. impact on variable pay	Increase - <b>interventional 2 x consultant rate radiologists - 2 across four sites</b>	Increase - <b>interventional 2 x consultant rate radiologists - 2 across four sites</b>	Increase - <b>interventional 2 x consultant rate radiologists - 2 across four sites</b>	Increase - <b>interventional 2 x consultant rate radiologists - 2 across four sites</b>		
	Changes to current <b>Nursing &amp; HCSW</b> model incl. impact on variable pay	Only one WT nurse at present - AFPP guidelines for invasive procedures require 2 x RN and 1 x HCSW - required <b>1 WT equivalent band 5 nurse + uplift</b>	<b>only uplift required</b>	<b>1 x WT equivalent band 5</b>	<b>0.4 band 5 nurse + uplift required</b>		
	Changes to current <b>Therapies</b> workforce model						
	Changes to current <b>HCS &amp; APST</b> Workforce model incl. impact on variable pay	To absorb work from GG there will be increase in working hours in other sites - staff - 2 x band 6 radiographer on a site with the additional MRI .		To absorb work from GG there will be increase in working hours in other sites - staff - 2 x band 6 radiographer on a site with the additional MRI .	To absorb work from GG there will be increase in working hours in other sites - staff - 2 x band 6 radiographer on a site with the additional MRI .		
	Changes to current <b>Administrative</b> Workforce						
	Any other additional workforce requirements - e.g. Any additional Training required?						
	Impact on current staff - e.g. Will staff need to move site / will model improve MDT working?	For this option to work well there needs to be a <b>coordinator / someone to triage interventional procedures - 1 x WT band 3 or 4 clerical / nursing</b>					
	Will this reduce your current workforce risks & Do you believe this will have a positive or negative						
	Are there any other interdependent services that						
	Are there other programmes of work that may impact the option e.g. ARCH / Regional work	Swansea - we would not need to ask them to help us and might be able to help them - more collaborative work - will be on equal playing field					
	Are there ways to use technology or innovations to support the delivery of this option?	RISP - electronic service - all Wales system coming in over next 3 years - will help with collaborative working - reducing waste for processes e.g. scanning requests cards ( admin processes). Theatre scheduler - how can we get that for radiology on every site?					
	<b>Estates</b>						
	Theatres / Sessions	No change for interventional	Specific interventional procedure room / or use of theatre will be needed / shared space with nurses for clerical work and a store room	No change for interventional. Recovery bay 1 current - 3 x trolley; 3 x chair - proposed - 4 x trolley, 0 chairs - no cost Recovery bay 2 - current 2 x trolley, storage ( 1x trolley broken) proposed - split room in 2 - 1/2 nurse office 1/2 clinical room ( meds)	No change for interventional		
	Day Surgery Units (DSU) / Sessions	Increase - <b>5 day care beds needed</b> (up by 3)	no change or <b>decrease in beds</b>	no change	Increase - <b>5 day care beds needed</b> (up by 3)		
	Procedure Rooms / Sessions		Specific interventional procedure room / or use of theatre will be needed.	Cannulation room - better flow of patients - possibility for change of use within current footprint - utilising store room and day case area			
Outpatients Department / Sessions							
Other	<b>MRI in one of the three sites</b>		<b>MRI in one of the three sites</b>	<b>MRI in one of the three sites</b>			
Office space required (Desks)			Nurse office - current - desk, medication, cupboards, filling - proposed - to become cannulation room - <b>cost - cannulation chair</b>				
Equipment Moves (Surplus and Essential)					CT outside Withybush could move to another site or have more permanent home at WGH - moving costs cost unknown	<b>release of accommodation - X ray room at South Pems and Llandovery - would remove two maintenance contracts</b>	
Potential Capital Development needs		<b>CT scanner to be replaced</b> - could be WG equipment replacement programme - will need a lot of infrastructure - <b>need a larger handling room</b> , there are plans drawn up for this.			Wherever the MRI / CT goes will need a <b>chiller, air hand unit and likely structural changes. Ongoing maintenance contract will be needed</b> - maybe a possibility to use WG imaging replacement scheme - so could be at a reduced cost		
Potential Digital opportunities (achievable within 2-4 years) (E.G. CT Profusion for Stroke)	RISP - electronic service - all Wales system coming in over next 3 years - will help with collaborative working - reducing waste for processes e.g. scanning requests cards ( admin processes). Theatre scheduler - how can we get that for radiology on every site?				AI / plus the other PISP & Brainomics		
<b>Patients</b>							
Identify what intervention will take place on each site and what interventions will move	remains as is	emergency intervention at GG, elective diagnostics removed	remains as is	remains as is		<b>remove Xray from Llandovery &amp; South Pems</b>	
Clarify if there are Patient Transfers required (include acuity: ACCTS or NEPTS or WAST) what %		More transfers to GG via WAST for emergency intervention (25% possibly)					

Detail any impacts or changes to regional or					
<b>Addressing Barriers</b>					
Waiting Lists	would remain the same	emergencies would be quicker at GG	would remain the same	would remain the same	
Waiting Times	would remain the same		would remain the same	would remain the same	
Other					

	<b>RADIOLOGY</b>	<b>Bronglais</b>	<b>Glangwili</b>	<b>Prince Philip</b>	<b>Withybush</b>	<b>Community Sites</b>
<b>OPTION 2</b>	<b>Interventional (biopsies) 5 days Monday to Friday</b>	<b>Interventional (biopsies) 5 days Monday to Friday</b>	<b>Interventional (biopsies) 5 days Monday to Friday</b>	<b>Interventional (biopsies) 5 days Monday to Friday</b>	<b>Interventional (biopsies) 5 days Monday to Friday</b>	<b>Imaging in outpatient sessions in a Medical Administration HUB / Regional Diagnostic Centre. Community X-ray – Tenby Hospital &amp; Cardigan Integrated Care Centre</b>
<b>Workforce Requirement</b>						
Are there any changes required to current Rotas? include On Call, moving to a 7 day model etc	Reducing variable pay and <b>increase in staffing (13 x (band 5 radiographers - substantive staff) additional WT equivalent across all sites</b>	Reducing variable pay and <b>increase in staffing (13 x (band 5 radiographers - substantive staff) additional WT equivalent across all sites</b>	Reducing variable pay and <b>increase in staffing (13 x (band 5 radiographers - substantive staff) additional WT equivalent across all sites</b>	Reducing variable pay and <b>increase in staffing (13 x (band 5 radiographers - substantive staff) additional WT equivalent across all sites</b>	Reducing variable pay and <b>increase in staffing (13 x (band 5 radiographers - substantive staff) additional WT equivalent across all sites</b>	Removing services from Llandoverly (1 part time) & South Pembro - no service. Cardigan unchanged. For regional diagnostic hub - needs additional staff clerical and clinical - possibly 5 - could possibly repurpose some staff to go to the hub.
Any changes to current Bed numbers?	Interventional services requires more day beds - no difference in actual bed currently 1-2 - increase to 5 (3 additional medical beds a day)	2 medical day beds 3x week now (Mon, Thur, Fri - not guaranteed) - interventional services require more day beds - <b>increase to 5 (3 additional medical beds a day)</b>	No increase required	Current use Tue, Thurs & Fri - 2 beds each day not guaranteed) Interventional services requires more day beds - <b>increase to 5-3 extra medical beds a day</b>		
Changes to current Medical workforce model incl. impact on variable pay	Increase - <b>Interventional 2 x consultant rate radiologists - 2 across four sites</b>	Increase - interventional 2 x consultant rate radiologists - 2 across four sites	Increase - interventional 2 x consultant rate radiologists - 2 across four sites	Increase - interventional 2 x consultant rate radiologists - 2 across four sites		
Changes to current Nursing & HCSW model incl. impact on variable pay	Only one WT nurse at present - AFPP guidelines for invasive procedures require 2 x RN and 1 x HCSW - required 1 WT equivalent band 5 nurse + uplift	only uplift required	1 x WT equivalent band 5	0.4 band 5 + uplift required		
Changes to current Therapies workforce model	Reducing variable pay and <b>increase in staffing (13 x band 5 radiographers) additional WT equivalent across all sites</b>	Reducing variable pay and <b>increase in staffing (13 x band 5 radiographers) additional WT equivalent across all sites</b>	Reducing variable pay and <b>increase in staffing (13 x band 5 radiographers) additional WT equivalent across all sites</b>	Reducing variable pay and <b>increase in staffing (13 x band 5 radiographers) additional WT equivalent across all sites</b>		
Changes to current Administrative Workforce	1.5 band 2 or 3 clerical staff (adding to what we have already)	1.5 band 2 or 3 clerical staff (adding to what we have already)	1.5 band 2 or 3 clerical staff (adding to what we have already)	1.5 band 2 or 3 clerical staff (adding to what we have already)		
Any other additional workforce requirements - e.g. Any additional Training required?	support staff - additional band 3 assistants x 2	1 x WT assistant band 3	support staff - additional band 3 assistants x 2	support staff - additional band 3 assistants x 2	support staff - additional band 3 assistants x 2	support staff - additional band 3 assistants x 2
Impact on current staff - e.g. Will staff need to move site / will model improve MDT working?	Developing competencies and upskilling in-house - at no additional cost	Developing competencies and upskilling in-house - at no additional cost	Developing competencies and upskilling in-house - at no additional cost	Developing competencies and upskilling in-house - at no additional cost		
Will this reduce your current workforce risks & challenges?	no change from the nursing side - more flexibility will be required - will be standardising across the four sites	no change from the nursing side - more flexibility will be required - will be standardising across the four sites	no change from the nursing side - more flexibility will be required - will be standardising across the four sites	no change from the nursing side - more flexibility will be required - will be standardising across the four sites	no change from the nursing side - more flexibility will be required - will be standardising across the four sites	no change from the nursing side - more flexibility will be required - will be standardising across the four sites
Do you believe this will have a positive or negative impact on recruitment and retention?	restructuring - 1 x band 6 team leader per site WT , additional staffing nursing - band 5 , band 2 & 3 HC to support - in the long run cost saving	restructuring - 1 x band 6 team leader per site WT , additional staffing nursing - band 5 , band 2 & 3 HC to support - in the long run cost saving	restructuring - 1 x band 6 team leader per site WT , additional staffing nursing - band 5 , band 2 & 3 HC to support - in the long run cost saving	restructuring - 1 x band 6 team leader per site WT , additional staffing nursing - band 5 , band 2 & 3 HC to support - in the long run cost saving	restructuring - 1 x band 6 team leader per site WT , additional staffing nursing - band 5 , band 2 & 3 HC to support - in the long run cost saving	
Are there any other interdependent services that will be impacted by this change? e.g. diagnostics.	Mixed - some staff like working longer hours, but financial impact as reduced pay. In work life balance would be positive and will reduce lone working. Band 5 positive for recruitment - opens opps for newly qualified radiographers and nurses (currently not taking band 5 but this will be - cost saving in the long run). Travel across sites - might be negative impact as some staff don't like travelling - travel expenses and time lost	Mixed - some staff like working longer hours, but financial impact as reduced pay. In work life balance would be positive and will reduce lone working. Band 5 positive for recruitment - opens opps for newly qualified radiographers and nurses (currently not taking band 5 but this will be - cost saving in the long run). Travel across sites - might be negative impact as some staff don't like travelling - travel expenses and time lost	Mixed - some staff like working longer hours, but financial impact as reduced pay. In work life balance would be positive and will reduce lone working. Band 5 positive for recruitment - opens opps for newly qualified radiographers and nurses (currently not taking band 5 but this will be - cost saving in the long run). Travel across sites - might be negative impact as some staff don't like travelling - travel expenses and time lost	Mixed - some staff like working longer hours, but financial impact as reduced pay. In work life balance would be positive and will reduce lone working. Band 5 positive for recruitment - opens opps for newly qualified radiographers and nurses (currently not taking band 5 but this will be - cost saving in the long run). Travel across sites - might be negative impact as some staff don't like travelling - travel expenses and time lost	Mixed - some staff like working longer hours, but financial impact as reduced pay. In work life balance would be positive and will reduce lone working. Band 5 positive for recruitment - opens opps for newly qualified radiographers and nurses (currently not taking band 5 but this will be - cost saving in the long run). Travel across sites - might be negative impact as some staff don't like travelling - travel expenses and time lost	Mixed - some staff like working longer hours, but financial impact as reduced pay. In work life balance would be positive and will reduce lone working. Band 5 positive for recruitment - opens opps for newly qualified radiographers and nurses (currently not taking band 5 but this will be - cost saving in the long run). Travel across sites - might be negative impact as some staff don't like travelling - travel expenses and time lost
Are there other programmes of work that may impact the option e.g. ARCH / Regional work	Positive - will be able to provide more timely service within targets for the interdependencies	Only negative will be - WAST for travel to Glangwili for MRI OOH		Positive - will be able to provide more timely service within targets for the interdependencies	Positive - will be able to provide more timely service within targets for the interdependencies	
Are there ways to use technology or innovations to support the delivery of this option?	Swansea - we would not need to ask them to help us and might be able to help them - more collaborative work - will be on equal playing field					
<b>Estates</b>						
Theatres / Sessions		Specific Interventional procedure room / or use of theatre will be needed				
Day Surgery Units (DSU) / Sessions						
Procedure Rooms / Sessions		Specific Interventional procedure room / or use of theatre will be needed		Cannulation room - better flow of patients - possibility for change of use within current footprint - utilising store room and day case area - cost - cannulation chair		
Outpatients Department / Sessions						

Other					Release of accommodation - X ray room at South Pembrokeshire and Llandovery - would remove two maintenance contracts
Office space required (Desks)		shared space with nurses for clerical work and a store room			
Equipment Moves (Surplus and Essential)					
Potential Capital Development needs		CT scanner to be replaced - could be WG equipment replacement programme - will need a lot of infrastructure - need a larger handling room, there are plans drawn up for this.			Regional Diagnostic Centre - new built or a community site could be used. Removal of Llandovery & South Pembrokeshire equipment.
Potential Digital opportunities (achievable within 2-4 years) (E.G. CT Profusion for Stroke)	RISP - electronic service - all Wales system coming in over next 3 years - will help with collaborative working - reducing waste for processes e.g. scanning requests cards ( admin processes). Theatre scheduler - how can we get that for radiology on every site?				
<b>Patients</b>					
Identify what intervention will take place on each Clarify if there are Patient Transfers required (include acuity: ACCTS or NEPTS or WAST) what % of patients this would be /this will need to be Detail any impacts or changes to regional or		WAST for travel to Glangwili for MRI OOH - at present not transferring many as WAST not able to provide, previously it was about 3-4 patients per week to GG - about 33%			Closure of South Pembrokeshire and Llandovery
<b>Addressing Barriers</b>		No change to partial compliance to - spinal pathway			
Waiting Lists					
Waiting Times					
Other	This option will make the cancer pathway more slick and allow same day diagnostics, and reduce interventional weights				

	<b>RADIOLOGY</b>	<b>Bronglais</b>	<b>Glangwili</b>	<b>Prince Philip</b>	<b>Withybush</b>	<b>Community Sites</b>
<b>OPTION 3</b>	<b>Diagnostics (CT MRI &amp; US) and interventional procedures</b>	<b>Diagnostics (CT MRI &amp; US) and interventional procedures</b>	<b>Diagnostics (CT MRI &amp; US) and interventional procedures</b>	<b>Diagnostics (CT MRI &amp; US)</b> <b>All interventional procedures to be undertaken at BGH&amp;GGH</b>	<b>Diagnostics (CT MRI &amp; US)</b> <b>All interventional procedures to be undertaken at BGH&amp;GGH</b>	<b>Remove services from Llandovery and South Pembrokeshire hospital</b> <b>X-Ray services in Tenby and Cardigan</b>
<b>Workforce Requirement</b>						
Are there any changes required to current Rotas? include On Call, moving to a 7 day model etc	No change for diagnostics. Increase of interventional at BG about 75%	No change for diagnostics. Increase in interventional - 50% work load	50% reduction of workload to (GG or BG) no change for diagnostics	25% reduction of workload to (GG or BG) no change for diagnostics	1 band 5 radiographer released from Llandovery 1 day a week, no change otherwise. Save on travel, time & travel expenses	
Any changes to current Bed numbers?	will need large increase in day beds - <b>increase to 5 medical beds a day</b>	2 medical day beds 3x week now (Mon, Thur, Fri - not guaranteed) - interventional services require more day beds - <b>increase to 5 (3 additional medical beds a day)</b>	<b>reduction of beds 2 beds a week</b>	<b>reduction of beds 6 beds a week</b>		
Changes to current <b>Medical</b> workforce model incl. impact on variable pay	Increase in medical workforce and moving sites more often - increase in travel costs and time lost due to travel increase - <b>interventional 2 x consultant rate radiologists - 2 across two sites</b>	Increase in medical workforce - <b>interventional 2 x consultant rate radiologists - across two sites (BG &amp; GG), and moving sites more often.</b>	No change due to likely retirement	Relying on bank and locum at present		
Changes to current <b>Nursing &amp; HCSW</b> workforce model incl. impact on variable pay			<b>nurses releasing to work on other sites - 1 WT for 1 day will be released - could utilise elsewhere</b>	<b>1 WT and one 0.6 nurse - will be released to BG or GG</b>		
Changes to current <b>HCS &amp; APST</b> Workforce model						
Changes to current <b>Administrative</b> Workforce						
Any other additional workforce requirements - e.g. Any additional Training required?						
Impact on current staff - e.g. Will staff need to Will this reduce your current workforce risks & challenges?	Yes, to some extent - decrease the wait for intervention procedures and no change to diagnostics	Yes, to some extent - decrease the wait for intervention procedures and no change to diagnostics	Medical and nursing will need to be moving	Medical and nursing will need to be moving		
Do you believe this will have a positive or negative Are there any other interdependent services that will be impacted by this change? e.g. diagnostics. Are there other programmes of work that may impact the option e.g. ARCH / Regional work	Positive for medical - interventional might attract new staff WAST - transferring patients between sites, we will need escort nurses for the patients Swansea - we would not need to ask them to help us and might be able to help them - more collaborative work - will be on equal playing field	Positive for medical - interventional might attract new staff	Negative on some nursing staff as they will have to move	Negative on some nursing staff as they will have to move	<b>Additional 1 day - escort nurse &amp; WAST</b>	
Are there ways to use technology or innovations to support the delivery of this option?	RISP - electronic service - all Wales system coming in over next 3 years - will help with collaborative working - reducing waste for processes e.g. scanning requests cards ( admin processes). Theatre scheduler - how can we get that for radiology on every site?					
<b>Estates</b>						
Theatres / Sessions	<b>Additional beds needed - increase to 5</b>	Specific <b>interventional procedure room / or use of theatre</b> will be needed / shared space with nurses for clerical work and a store room - <b>additional beds needed</b>			<b>decrease in beds as no day case needed</b>	
Day Surgery Units (DSU) / Sessions						

Procedure Rooms / Sessions		as above	Cannulation room - better flow of patients - possibility for change of use within current footprint - utilising store room and day case area		
Outpatients Department / Sessions					
Other					release of accommodation - X ray room at South Pembrokeshire and Llandoverly - would remove two maintenance contracts
Office space required (Desks)					
Equipment Moves (Surplus and Essential)					
Potential Capital Development needs		CT scanner to be replaced - could be WG equipment replacement programme - will need a lot of infrastructure - need a larger handling room, there are plans drawn up for this.			
Potential Digital opportunities (achievable within 2-4 years) (E.G. CT Profusion for Stroke)	RISP - electronic service - all Wales system coming in over next 3 years - will help with collaborative working - reducing waste for processes e.g. scanning requests cards ( admin processes). Theatre scheduler - how can we get that for radiology on every site?				
<b>Patients</b>					
Identify what intervention will take place on each site and what interventions will move			Removing interventions from PPH - 1 nurse release on 1 day	Removing interventions from WGH will release 1 FT and 0.6 - saving on some consumables too	Removing X-ray from South Pembrokeshire & Llandoverly
Clarify if there are Patient Transfers required (include acuity: ACCTS or NEPTS or WAST) what % of patients this would be (this will need to be Detail any impacts or changes to regional or	WAST - transferring patients between sites, we will need escort nurses for the patients		WAST - transferring patients between sites, we will need escort nurses for the patients	WAST - transferring patients between sites, we will need escort nurses for the patients, also intervention patients will need to be moved	
<b>Addressing Barriers</b>					
Waiting Lists					
Waiting Times	In this option waiting lists and waiting times will remain the same, as this option doesn't take into consideration the increase in demand		Waiting times for diagnostics would slightly improve, but in PPH reduced access to intervention		
Other					

	<b>RADIOLOGY</b>	<b>Bronglais</b>	<b>Glangwili</b>	<b>Prince Philip</b>	<b>Withybush</b>	<b>Community Sites</b>
<b>OPTION 4</b>	<b>Interventional (biopsies) 5 days Monday to Friday (not available every day)</b>	<b>Interventional (more complex) 24/7</b>	<b>Interventional (biopsies) 5 days Monday to Friday</b>	<b>Interventional (biopsies) 5 days Monday to Friday</b>	<b>Interventional (biopsies) 5 days Monday to Friday</b>	<b>Remove service from South Pembrokeshire and Llandoverly Hospitals due to small number of inpatients, most come to Withybush.</b>
	<b>Radiology general services expand to 7-day service</b>	<b>radiology general services expand to 7-day service</b>	<b>radiology performed here due to airflow systems</b>	<b>radiology general services expand to 7-day service</b>	<b>radiology general services expand to 7-day service</b>	<b>X-ray only in Tenby Hospitals</b>
<b>Workforce Requirement</b>						
Are there any changes required to current Rotas? include On Call, moving to a 7 day model etc	Reducing variable pay and increase in staffing (13 x (band 5 radiographers - substantive staff) additional WT equivalent across all sites	Reducing variable pay and increase in staffing (13 x (band 5 radiographers - substantive staff) additional WT equivalent across all sites Need more consultant staff and nursing staff to do 24/7 intervention - 1 uplift, adding on call to nursing rota	Reducing variable pay and increase in staffing (13 x (band 5 radiographers - substantive staff) additional WT equivalent across all sites	Reducing variable pay and increase in staffing (13 x (band 5 radiographers - substantive staff) additional WT equivalent across all sites	Reducing variable pay and increase in staffing (13 x (band 5 radiographers - substantive staff) additional WT equivalent across all sites	Removing services from Llandoverly (1 part time); South Pembrokeshire & Cardigan - no service.
Any changes to current Bed numbers?	Interventional services requires more day beds - (Currently 1 - Mon -not guaranteed, 1 Wed, 2 Thurs) - increase to 5 (3 additional medical beds a day)	2 medical day beds 3x week now (Mon, Thur, Fri - not guaranteed) - interventional services requires more day beds - increase to 5 (3 additional medical beds a day)	No increase required	Current use Tue, Thurs & Fri - 2 beds each day not guaranteed) interventional services requires more day beds - increase to 5 - 3 extra medical beds a day	Current use Tue, Thurs & Fri - 2 beds each day not guaranteed) interventional services requires more day beds - increase to 5 - 3 extra medical beds a day	
Changes to current Medical workforce model incl. impact on variable pay	Increase - interventional 2 x consultant rate radiologists - 2 across four sites	Increase - interventional 2 x consultant rate radiologists - 2 across four sites	Increase - interventional 2 x consultant rate radiologists - 2 across four sites	Increase - interventional 2 x consultant rate radiologists - 2 across four sites	Increase - interventional 2 x consultant rate radiologists - 2 across four sites	
Changes to current Nursing & HCSW model incl. impact on variable pay	Only one WT nurse at present - AFPP guidelines for invasive procedures require 2 x RN and 1 x HCSW - required 1 WT equivalent band 5 nurse + uplift	only uplift required	1 x WT equivalent band 5	0.4 band 5 + uplift required		
Changes to current Therapies workforce model						
Changes to current HCS & APST Workforce model incl. impact on variable pay	Reducing variable pay and increase in staffing (13 x (band 5 radiographers) additional WT equivalent across all sites	Reducing variable pay and increase in staffing (13 x (band 5 radiographers) additional WT equivalent across all sites	Reducing variable pay and increase in staffing (13 x (band 5 radiographers) additional WT equivalent across all sites	Reducing variable pay and increase in staffing (13 x (band 5 radiographers) additional WT equivalent across all sites	Reducing variable pay and increase in staffing (13 x (band 5 radiographers) additional WT equivalent across all sites	
Changes to current Administrative Workforce	1.5 band 2 or 3 clerical staff (adding to what we have already)	1.5 band 2 or 3 clerical staff (adding to what we have already)	1.5 band 2 or 3 clerical staff (adding to what we have already)	1.5 band 2 or 3 clerical staff (adding to what we have already)	1.5 band 2 or 3 clerical staff (adding to what we have already)	
Any other additional workforce requirements - e.g. support staff - additional band 3 assistants x 2	1 x WT assistant band 3	1 x WT assistant band 3	support staff - additional band 3 assistants x 2	support staff - additional band 3 assistants x 2	support staff - additional band 3 assistants x 2	
Any additional Training required?	Developing competencies and upskilling in-house - at no additional cost	Developing competencies and upskilling in-house - at no additional cost	Developing competencies and upskilling in-house - at no additional cost	Developing competencies and upskilling in-house - at no additional cost	Developing competencies and upskilling in-house - at no additional cost	
Impact on current staff - e.g. Will staff need to move site / will model improve MDT working?	no change from the nursing side - more flexibility will be required - will be standardising across the four sites	Adding on-call to nursing rota could impact on availability during the week - could possibly have negative impact on staff	no change from the nursing side - more flexibility will be required - will be standardising across the four sites	no change from the nursing side - more flexibility will be required - will be standardising across the four sites	no change from the nursing side - more flexibility will be required - will be standardising across the four sites	
Will this reduce your current workforce risks & challenges?	restructuring - 1 x band 6 team leader per site WT , additional staffing nursing - band 5 , band 2 & 3 HC to support - in the long run cost saving	restructuring - 1 x band 6 team leader per site WT , additional staffing nursing - band 5 , band 2 & 3 HC to support - in the long run cost saving	restructuring - 1 x band 6 team leader per site WT , additional staffing nursing - band 5 , band 2 & 3 HC to support - in the long run cost saving	restructuring - 1 x band 6 team leader per site WT , additional staffing nursing - band 5 , band 2 & 3 HC to support - in the long run cost saving	restructuring - 1 x band 6 team leader per site WT , additional staffing nursing - band 5 , band 2 & 3 HC to support - in the long run cost saving	

Do you believe this will have a positive or negative impact on recruitment and retention?	Mixed - some staff like working longer hours, but financial impact as reduced pay. In work life balance would be positive and will reduce lone working. Band 5 positive for recruitment - opens opps for newly qualified radiographers and nurses (currently not taking band 5 but this will be - cost saving in the long run). Travel across sites - might be negative impact as some staff don't like travelling - travel expenses and time lost	Mixed - some staff like working longer hours, but financial impact as reduced pay. In work life balance would be positive and will reduce lone working. Band 5 positive for recruitment - opens opps for newly qualified radiographers and nurses (currently not taking band 5 but this will be - cost saving in the long run). Travel across sites - might be negative impact as some staff don't like travelling - travel expenses and time lost	Mixed - some staff like working longer hours, but financial impact as reduced pay. In work life balance would be positive and will reduce lone working. Band 5 positive for recruitment - opens opps for newly qualified radiographers and nurses (currently not taking band 5 but this will be - cost saving in the long run). Travel across sites - might be negative impact as some staff don't like travelling - travel expenses and time lost	Mixed - some staff like working longer hours, but financial impact as reduced pay. In work life balance would be positive and will reduce lone working. Band 5 positive for recruitment - opens opps for newly qualified radiographers and nurses (currently not taking band 5 but this will be - cost saving in the long run). Travel across sites - might be negative impact as some staff don't like travelling - travel expenses and time lost	
Are there any other interdependent services that will be impacted by this change? e.g. diagnostics.	Positive - will be able to provide more timely service within targets for the interdependencies	Only negative will be - WAST for travel to Glangwili for MRI OOH	Positive - will be able to provide more timely service within targets for the interdependencies	Positive - will be able to provide more timely service within targets for the interdependencies	
Are there other programmes of work that may impact the option e.g. ARCH / Regional work	Swansea - we would not need to ask them to help us and might be able to help them - more collaborative work - will be on equal playing field				
Are there ways to use technology or innovations to support the delivery of this option?	RISP - electronic service - all Wales system coming in over next 3 years - will help with collaborative working - reducing waste for processes e.g. scanning requests cards ( admin processes). Theatre scheduler - how can we get that for radiology on every site?				
<b>Estates</b>					
Theatres / Sessions		Specific interventional procedure room / or use of theatre will be needed			
Day Surgery Units (DSU) / Sessions	Increase in beds - 5 a day on each site will be required	Increase in beds - 5 a day on each site will be required	Increase in beds - 5 a day on each site will be required	Increase in beds - 5 a day on each site will be required	
Procedure Rooms / Sessions		Specific interventional procedure room / or use of theatre will be needed	Cannulation room - better flow of patients - possibility for change of use within current footprint - utilising store room and day case area - cost - cannulation chair		
Outpatients Department / Sessions					
Other					Release of accommodation - X ray room at South Pems and Llandovery - would remove two maintenance contracts
Office space required (Desks)		shared space with nurses for clerical work and a store room			
Equipment Moves (Surplus and Essential)					
Potential Capital Development needs		CT scanner to be replaced - could be WG equipment replacement programme - will need a lot of infrastructure - need a larger handling room, there are plans drawn up for this.			
Potential Digital opportunities (achievable within 2-4 years) (E.G. CT Profusion for Stroke)	RISP - electronic service - all Wales system coming in over next 3 years - will help with collaborative working - reducing waste for processes e.g. scanning requests cards ( admin processes). Theatre scheduler - how can we get that for radiology on every site?				
<b>Patients</b>					
Identify what intervention will take place on each site and what interventions will move	Increase in interventions and diagnostics across all four sites	Increase in interventions and diagnostics across all four sites	Increase in interventions and diagnostics across all four sites	Increase in interventions and diagnostics across all four sites	Remove X-ray from Suth Pems & Llandovery
Clarify if there are Patient Transfers required (include acuity: ACCTS or NEPTS or WAST) what %	Reduced WAST travel as service will be offered on all four sites	Reduced WAST travel as service will be offered on all four sites	Reduced WAST travel as service will be offered on all four sites	Reduced WAST travel as service will be offered on all four sites	
Detail any impacts or changes to regional or	This option would give us compliance with all pathways				
<b>Addressing Barriers</b>					
Waiting Lists	Option 4 would allow us to meet wating lists and waiting times, which we are not doing at the moment				
Waiting Times	Option 4 would allow us to meet wating lists and waiting times, which we are not doing at the moment				
Other					

RADIOLOGY	Bronglais	Glangwili	Prince Philip	Withybush	Community Sites
<b>OPTION 1</b>	Elective diagnostic/intervention and emergency daytime only	Emergency diagnostic/intervention services only	Elective diagnostic/intervention and emergency daytime only	Elective diagnostic/intervention and emergency daytime only. Nuclear medicine	X-Ray services in Cardigan Integrated Care Centre and Tenby Hospital Only

<p><b>OPTION 2</b></p>	<p>Interventional (biopsies) 5 days Monday to Friday</p> <p>Radiology general services expand to 7-day service</p>	<p>Interventional (biopsies) 5 days Monday to Friday</p> <p>Radiology general services expand to 7-day service Infrastructure issues at Glangwili</p> <p>New pathway for OOH cases</p>	<p>Interventional (biopsies) 5 days Monday to Friday</p> <p>Radiology general services expand to 7-day service</p> <p>Cancer focus</p>	<p>Interventional (biopsies) 5 days Monday to Friday</p> <p>Radiology general services expand to 7-day service</p> <p>Cancer focus</p>	<p>Imaging in outpatient sessions in a Medical Administration HUB / Regional Diagnostic Centre. Community X-ray – Tenby Hospital &amp; Cardigan Integrated Care Centre</p>
<p><b>OPTION 3</b></p>	<p>Diagnostics (CT MRI &amp; US) and interventional procedures</p>	<p>Diagnostics (CT MRI &amp; US) and interventional procedures</p>	<p>Diagnostics (CT MRI &amp; US)</p> <p>All interventional procedures to be undertaken at BGH&amp;GGH</p>	<p>Diagnostics (CT MRI &amp; US)</p> <p>All interventional procedures to be undertaken at BGH&amp;GGH</p>	<p>Remove services from Llandovery and South Pems hospital</p> <p>X-Ray services in Tenby and Cardigan</p>
<p><b>OPTION 4</b></p>	<p>Interventional (biopsies) 5 days Monday to Friday (not available every day)</p> <p>Radiology general services expand to 7-day service</p>	<p>Interventional (more complex) 24/7</p> <p>radiology general services expand to 7-day service</p>	<p>Interventional (biopsies) 5 days Monday to Friday</p> <p>radiology performed here due to airflow systems</p> <p>radiology general services expand to 7-day service</p>	<p>Interventional (biopsies) 5 days Monday to Friday</p> <p>radiology general services expand to 7-day service</p>	<p>Remove service from South Pems and Llandovery Hospitals due to small number of inpatients, most come to Withybush.</p> <p>X-ray only in Tenby Hospitals</p>

ENDOSCOPY		Bronglais	Glangwili	Prince Philip	Withybush	Community Sites	
O P T I O N  1	OPTION 1	Maximise session capacity in JAG accredited unit	Maximise session capacity. Paediatric elective services (low volume)	Maximise session capacity  Explore opportunity for Prince Philip Hospital to provide respiratory and urology diagnostics. Explore opportunity to centralise respiratory & urology endoscopy to PPH. (aspiration to have 3 room JAG accredited unit) There is a	Maximise session capacity	Current configuration - No activity at community sites	
	Workforce Requirement						
	Are there any changes required to current Rotas? include On Call, moving to a 7 day model etc	1 FTE nursing staff, estimated, band 5	Establishment needs expansion, beds and consider working weekends. 20 sessions in the unit, max 22. Discussed with radiology. Estimated 2.5 FTE BAND 5 for GGH (possibly a bit of band 3) nursing staff. Within this 2-4 year timeframe, the challenge is that some doctors who can currently undertake endoscopy will retire, so possibly a need to look at new roles, clinical endoscopists	This work has been done by Leri across all sites. Working on the assumption that we don't yet have the funding for new nursing roles. This means we need 8 additional FTE Band 5 roles (assumption is that they work Monday - Friday, not 7-day working - this is equivalent to the current BGH establishment) & 3.4 (for current room, working to Max). Caveat: a further 1 WTE may be	Additional staff needed for extra sessions. 0.6 WTE band 5 needed		
	Any changes to current Bed numbers?	N/A	N/A	N/A	N/A		
	Changes to current Medical workforce model incl. impact on variable pay	No change to current establishment	Within this 2-4 year timeframe, the challenge is that some doctors who can currently undertake endoscopy will retire, so possibly a need to look at new roles, clinical endoscopists to fill gap. Where consultants retire there is a risk of losing Endoscopy experience & skill which may not always be replaceable through recruitment.	2 WTE Clinical Endoscopist or Consultant Endoscopist to allow delivery of 10 additional sessions.	No change to current establishment		
	Changes to current Nursing & HCSW model incl. impact on variable pay	Additional 1 wte band 5	To expand to 20 sessions in the unit, max 22. Discussed with radiology. Estimated 2.5 FTE BAND 5 for GGH (possibly a bit of band 3) nursing staff.	As above: This modelling has been done by Leri across all sites. Working on the assumption that we don't yet have the funding for new nursing roles. This means we need 8 additional FTE Band 5 roles (assumption is that they work Monday - Friday, not 7-day working - this is equivalent to the current BGH establishment) & 3.4 (for the current room, working to Max). Caveat: a further 1 WTE may be needed if respiratory demand	Additional 0.6 wte band 5		
	Changes to current Therapies workforce model incl. impact on variable pay						
Changes to current HCS & APST Workforce model incl. impact on variable pay		As above	Interdependencies within endoscopy - more cancer diagnoses will lead to higher demand, so if there's a new room there will be an impact on pathology (we will need them to do this analysis).				

Changes to current Administrative Workforce	As per current establishment	As per current establishment	Additionality - 1 Band 4 waiting list co-ordinator	As per current establishment	
Any other additional workforce requirements - e.g. Facilities roles	None	None	Additional room may create other interdependencies - e.g. laundry.  HSDU will need to scope additional staffing needs to accommodate the additional room	None	
Any additional Training required?	Training is an issue to be considered for the whole option, and applies to all 4 options (my note: could be carried over to SWOT?). Nurses tend to take 18-2 years to be fully proficient. JETS workforce competencies package. ENDO 1: from a JAG accredited perspective all staff need this level competency. For clinical endoscopists they study up to 2 years plus training. For all options, no extra capacity has been factored in modelling of rooms to accommodate extra use of rooms for training ... this could be considered. <b>If in the medium term we can't achieve the same level of activity, (whilst new staff being trained), we will need to pay enhanced rates.</b> Significant benefits could be gained from having a professional development team - this is true for all options. This would require ideally 1 lead overall and 1 support per site, or as a minimum 1 lead and 2 supporting (nurse training). This is not essential to the options. If we had 3rd theatre could flex to 7 day to allow for additional capacity for training. Urology currently occupy 8 sessions. We know that GIRFT urology recommends own suite for all urology delivery. If urology moves out, this would release 10 sessions for endoscopy, enabling us to meet projected increase, potential of 7-day could therefore meet demand and flex for training, or 6-day or evening.				
Impact on current staff - e.g Will staff need to move site / will model improve MDT working?	NA	NA - not moving configuration, just adding,	N/A	N/A	
Will this reduce your current workforce risks & challenges?	May increase it - across all sites (aprt from BGH). For PPH it could destabilise, or GGH (nursing staff). Running more rooms: risk of losing one member of staff has greater impact on number of sessions lost (my note: suggest carrying over to SWOT). Strength for Carmarthenshire - more resilience in rota				
Do you believe this will have a positive or negative impact on recruitment and retention?	Positive as will create greater resilience in the nursing team	Positive impact as creates greater resilience in the nursing team during periods of absence.  Within this 2-4 year timeframe, the challenge is that some doctors who can currently undertake endoscopy will retire, so possibly a need to look at new roles, clinical endoscopists to fill gap.	PPH positive - more investment in nursing teams	Positive as will create greater resilience in the nursing team	
		Linkage to GGH as Acute site - management of emergency bleeds in and out of hours	HSDU  Pathology	HSDU  Pathology	

<p>Are there any other interdependent services that will be impacted by this change? e.g. diagnostics, A&amp;E, wards</p>	<p>HSDU</p> <p>Pathology</p> <p>Urology</p>	<p>Respiratory</p>	<p>Respiratory</p>		
<p>Are there other programmes of work that may impact the option e.g. ARCH / Regional work</p>	<p>HSDU, Urology, Respiratory &amp; Pathology</p>	<p>Respiratory</p>	<p>Any impact on urology may also impact on endoscopy. ARCH programme could impact,</p>		
<p>Are there ways to use technology or innovations to support the delivery of this option?</p>	<p>Mid wales health collaborative may impact BGH. We see Powys patients.</p> <p>Could use more Transnasal endoscopy, cystosponge, colon capsule, enhanced capsule endoscopy (not done in a room.) Some of these take away the need for use of theatres, would make service more robust, may be able to use treatment rooms instead of theatres and less staff (these opportunities need to be considered further).</p>				
<p><b>Estates</b></p>					
<p>Theatres / Sessions</p>	<p>A review of equipment needed against sessions delivered</p>	<p>A review needed of equipment as previously</p>	<p>ASSUMPTION: All 4 options are around expanding to meet demand, allowing no flexibility / capacity to use rooms for training, which would allow getting people trained in half the amount of time possibly (see notes under training, above). Equipment needed for additional sessions &amp; storage. Sterile services - requirement for additional support will depend on how quickly they can turn the equipment around - modelling is</p>	<p>A review of equipment needed against sessions delivered</p>	
<p>Day Surgery Units (DSU) / Sessions</p>	<p>None</p>	<p>None</p>	<p>None</p>	<p>None</p>	
<p>Procedure Rooms / Sessions</p>	<p>Maximising all sessions - up to 10</p>	<p>Maximising all sessions - up to 20</p>	<p>Maximising all sessions - up to 20</p> <p>1 additional procedure room (taking it up to 3)</p>	<p>Maximising all sessions - up to 20</p>	

Outpatients Department / Sessions					
	N/A	N/A	N/A	N/A	
Other	None	None	There is potential to see the space to Swansea bay (my note: <a href="#">see attached spreadsheet for more</a> )	None	
Office space required (Desks)	None	None	if there is an investment, the footprint can support the expansion of it (this has been modelled with estates already)	None	
Equipment Moves (Surplus and Essential)	Risk: for all the options, rolling capital replacement programme needed				
Potential Capital Development needs			New theatre		
	New equipment requirements as noted above, this would require further mapping	New equipment requirements as noted above, this would require further mapping	New equipment requirements as noted above	New equipment requirements as noted above, this would require further mapping	
Potential Digital opportunities (achievable within 2-4 years) (E.G. CT Profusion for Stroke)					
	None	None	None	None	
<b>Patients</b>					
Identify what intervention will take place on each site and what interventions will move					
	As per current delivery	Urology & respiratory to be moved from GGH and centralised at PPH	As per current delivery plus Urology & Respiratory from GGH	As per current delivery	
Clarify if there are Patient Transfers required (include acuity: ACCTS or NEPTS or WAST) what % of patients this would be (this will need to be evidence based)					
	N/A	N/A	N/A	N/A	
Detail any impacts or changes to regional or national pathways					
	No current pathways in place	No current pathways in place	No current pathways in place	No current pathways in place	
<b>Addressing Barriers</b>					

Waiting Lists	Clearance of endoscopy backlog - with timely access to procedures for all patients	
Waiting Times	Introducing sustainability by increasing the workforce to deliver maximum sessions so that demand and capacity is balanced - training of future workforce is paramount to this to ensure future sustainability of service provision.	
Other	Ongoing capital replacement programme is key to sustain service delivery - as ageing/fragile equipment presents a risk to delivery of the necessary activity required to meet demand (even if appropriate staff and sessions are funded)	

ENDOSCOPY	Bronglais	Glangwili	Prince Philip	Withybush	Community Sites
OPTION 2	Joint Advisory Group (JAG) accredited services/ Emergency	Joint Advisory Group (JAG) accredited services/ Emergency	Not JAG accredited, Urology to take some Endoscopy and Bronchoscopy focus in Hub	Joint Advisory Group (JAG) accredited services/ Emergency	Current configuration – no activity at community sites
			Make it 3 units (rooms) & bowel screening  A specialist Bronchoscopy and Urology diagnostic treatment unit with GI		
Workforce Requirement					

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O N 2	Are there any changes required to current Rotas? include On Call, moving to a 7 day model etc	1 FTE nursing staff , etsimated, band 5	working weekends. 20 sessions in the unit, max 22. Discussed with radiology. Estimated 2.5 FTE BAND 5 for GGH (possibly a bit of band 3) nursing staff. Within this 2-4 year timeframe, the challenge is that some doctors who can currently undertake endoscopy will retire, so possibly a need to look at new roles, clinical endoscopists	on the assumption that we don't yet have the funding for new nursing roles. This means we need 8 additional FTE Band 5 roles (assumption is that they work Monday - Friday, not 7-day working - this is equivalent to the current BGH establishment) & 3.4 (for current room, working to Max). Caveat: a further 1 WTE may be	Additional staff needed for extra sessions. 0.6 WTE band 5 needed		
	Any changes to current Bed numbers?	N/A	N/A	N/A	N/A		
	Changes to current Medical workforce model incl. impact on variable pay	No change to curent establishment	Within this 2-4 year timeframe, the challenge is that some doctors who can currently undertake endoscopy will retire, so possibly a need to look at new roles, clinical endoscopists to fill gap. Where consultants retire there is a risk of losing Endoscopy experience & skill which may not always be replacable through recruitment.		2 WTE Clinical Endoscopist or Consultant Endoscopist to allow delivery of 10 additional sessions.	No change to current establishment	
	Changes to current Nursing & HCSW model incl. impact on variable pay	Additional 1 wte band 5	To expand to 20 sessions in the unit, max 22. Discussed with radiology. Estimated 2.5 FTE BAND 5 for GGH (possibly a bit of band 3) nursing staff.	As above: This modelling has been done by Leri across all sites. Working on the assumption that we don't yet have the funding for new nursing roles. This means we need 8 additional FTE Band 5 roles (assumption is that they work Monday - Friday, not 7-day working - this is equivalent to the current BGH establishment) & 3.4 (for the current room, working to Max). Caveat: a further 1 WTE may be needed if respiratory demand	Additional 0.6 wte band 5		
	Changes to current Therapies workforce model incl. impact on variable pay						
	Changes to current HCS & APST Workforce model incl. impact on variable pay		As above	Interdependencies within endoscopy - more cancer diagnoses will lead to higher demand, so if there's a new room there will be an impact on pathology (we will need them to do this analysis).			
	Changes to current Administrative Workforce	As per current establishment	As per current establishment	Additionality - 1 Band 4 waiting list co-ordinator	As per current establishment		
	Any other additional workforce requirements - e.g. Facilities roles	None	None	Additional room may create other interdependencies - e.g. laundry.  HSDU will need to scope additional staffing needs to accommodate the additional room	None		
	Any additional Training required?	Training is an issue to be considered for the whole option, and applies to all 4 options (my note: could be carried over to SWOT?). Nurses tend to take 18-2 years to be fully proficient. JETS workforce competencies package. ENDO 1: from a JAG accredited perspective all staff need this level competency. For clinical endoscopists they study up to 2 years plus training. For all options, no extra capacity has been factored in modelling of rooms to accommodate extra use of rooms for training ... this could be considered. If in the medium term we can't achieve the same level of acivity, (whilst new staff being trained), we will need to pay enhanced rates. Significant benefits could be gained from having a professional development team - this is true for all options. This would require ideally 1 lead overall and 1 support per site, or as a minimum 1 lead and 2 supporting (nurse training). This is not essential to the options. If we had 3rd theatre could flex to 7 day to allow for additional capacity for training. Urology currently occupy 8 sessions. We know that GIRFT urology recommends own suite for all urology delivery. If urology moves out, this would release 10 sessions for endoscopy, enabling us to meet projected increase, potential of 7-day could therefore					
Impact on current staff - e.g Will staff need to move site / will model improve MDT working?	NA	NA - not moving configuration, just adding.	N/A	N/A			

<p>Will this reduce your current workforce risks &amp; challenges?</p>	<p>May increase it - across all sites (aprt from BGH). For PPH it could destabilise, or GGH (nursing staff). Running more rooms: risk of losing one member of staff has greater impact on number of sessions lost (my note: suggest carrying over to SWOT). Strength for Carmarthenshire - more resilience in rota</p>				
<p>Do you believe this will have a positive or negative impact on recruitment and retention?</p>	<p>Positive as will create greater resilience in the nursing team</p>	<p>Positive impact as creates greater resilience in the nursing team during periods of absence. Within this 2-4 year timeframe, the challenge is that some</p>	<p>PPH positive - more investment in nursing teams</p>	<p>Positive as will create greater resilience in the nursing team</p>	
<p>Are there any other interdependent services that will be impacted by this change? e.g. diagnostics, A&amp;E, wards</p>	<p>HSDU, Urology, Respiratory &amp; Pathology</p>	<p>Linkage to GGH as Acute site - management of emergency bleeds in and out of hours  HSDU  Pathology  Urology  Respiratory</p>	<p>HSDU  Pathology Respiratory</p>	<p>HSDU  Pathology Respiratory</p>	
<p>Are there other programmes of work that may impact the option e.g. ARCH / Regional work</p>	<p>Mid wales health collaborative may impact BGH. We see Powys patients.</p>	<p>ARCH programme could impact,</p>	<p>Any impact on urology may also impact on endoscopy. ARCH programme could impact,</p>		
<p>Are there ways to use technology or innovations to support the delivery of this option?</p>	<p>Could use more Transnasal endoscopy, cystosponge, colon capsule, enhanced capsule endoscopy (not done in a room.) Some of these take away the need for use of theatres, would make service more robust, may be able to use treatment rooms instead of theatres and less staff (these opportunities need to be considered further).</p>				

Estates					
Theatres / Sessions	A review of equipment needed against sessions delivered	A review needed of equipment as previously	ASSUMPTION: All 4 options are around expanding to meet demand, allowing no flexibility / capacity to use rooms for training, which would allow getting people trained in half the amount of time possibly (see notes under training, above). Equipment needed for additional sessions & storage. Sterile services - requirement for additional support will depend on how quickly they can turn the equipment around - modelling is	A review of equipment needed against sessions delivered	
Day Surgery Units (DSU) / Sessions	None	None	None	None	
Procedure Rooms / Sessions	Maximising all sessions - up to 10	Maximising all sessions - up to 20	Maximising all sessions - up to 20  1 additional procedure room (taking it up to 3)	Maximising all sessions - up to 20	
Outpatients Department / Sessions	N/A	N/A	N/A	N/a	
Other	None	None	There is potential to sell the space to Swansea bay (my note: suggest adding this to SWOT).	None	
Office space required (Desks)	None	None	If there is an investment, the footprint can support the expansion as it is (this has been modelled with estates already, offices factored in to plan). If urology accommodated elsewhere there is also extra capacity. This has already been designed and planned via estates (Julian)	None	
Equipment Moves (Surplus and Essential)	Risk: for all the options, rolling capital replacement programme needed				
Potential Capital Development needs			New theatre		

	New equipment requirements as noted above, this would require further mapping	New equipment requirements as noted above, this would require further mapping	New equipment requirements as noted above	New equipment requirements as noted above, this would require further mapping	
Potential Digital opportunities (achievable within 2-4 years) (E.G. CT Profusion for Stroke)	None	None	None	None	
<b>Patients</b>					
Identify what intervention will take place on each site and what interventions will move	As per current delivery	Urology & respiratory to be moved from GGH and centralised at PPH	As per current delivery plus Urology & Respiratory from GGH	As per current delivery	
Clarify if there are Patient Transfers required (include acuity: ACCTS or NEPTS or WAST) what % of patients this would be (this will need to be evidence based)	N/A	N/A	N/A	N/A	
Detail any impacts or changes to regional or national pathways	No current pathways in place	No current pathways in place	No current pathways in place	No current pathways in place	
<b>Addressing Barriers</b>					
Waiting Lists	Clearance of endoscopy backlog - with timely access to procedures for all patients				
Waiting Times	Introducing sustainability by increasing the workforce to deliver maximum sessions so that demand and capacity is balanced - training of future workforce is paramount to this to ensure future sustainability of service provision.				
Other	Ongoing capital replacement programme is key to sustain service delivery - as ageing/fragile equipment presents a risk to delivery of the necessary activity required to meet demand (even if appropriate staff and sessions are funded)				

ENDOSCOPY		Bronglais	Glangwili	Prince Philip	Withybush	Community Sites	
O P T I O N  3	OPTION 3	JAG accredited service  All aspects of GI including inpatients  Opportunity to work with Powys & South	JAG accredited  Service  Maximising current provision of service  Remove Respiratory & Urology to maximise capacity for GI	No JAG accreditation  Take out Urology sessions - to be accommodated elsewhere - ? day surgery  GI and respiratory to remain (inc. GI  Consider partnership working with Swansea Bay for GI – to accommodate growing BSW demand	JAG accredited service  Service sustained as is at Bronglais Hospital (All aspects of GI including inpatients)	Current configuration – no activity at community sites however to scope options for diagnostic/Bowel Screening Wales	
	Workforce Requirement						
	Are there any changes required to current Rotas? include On Call, moving to a 7 day model etc.	Same as option 1.	same as option 1			Same as option 1 BUT if community diagnostics a possibility, WGH would bowel screening taken out and delivered at community site. 2 and 1/2 lists taken out.	1 room unit sufficient for demand within 4 years in community. This means 10 staff ( band 3 - band 7 combination), but would need second room ready to go after the 4 years to accommodate population demand
	Any changes to current Bed numbers?	N/A					
	Changes to current Medical workforce model incl. impact on variable pay	Possible impact on job planning across all sites to accommodate community sites. In collab with site teams - 2 WTE Clinical Endoscopists needed (as noted in community section) to enable continued delivery of services					2 BA clinical endoscopists required to enable delivery of new sessions in community
Changes to current Nursing & HCSW model incl. impact on variable pay	Same as option 1	Establishment needs expansion to accommodate 20 sessions in the unit, max 22. Discussed with radiology. Estimated 2.5 FTE BAND 5 for GGH (possibly a bit of band 3) nursing staff.	3.4 WTE B5/B3 needed - to maximise sessions. Caveat: a further 1 WTE may be needed if respiratory demand increases.		same as option 1	As above: 1 room unit in community requires 10 staff ( band 3 - band 7 combination), but would need second room ready to go after the 4 years to accommodate population demand	

Changes to current Therapies workforce model incl. impact on variable pay					
	Input from pathology required				
Changes to current HCS & APST Workforce model incl. impact on variable pay					Consideration of transfer pathology, would it happen on site or transfer to current labs? Would it have a stand alone sterile services unit? Ideally cleaned there, but investment therefore greater, would need more scopes and cleaning units
Changes to current Administrative Workforce					
	No change				
Any other additional workforce requirements - e.g. Facilities roles					HSDU requirements would need to be scoped - as well as linkage to hotel services
Any additional Training required?	Training is an issue to be considered for the whole option, and applies to all 4 options (my note: could be carried over to SWOT?). Nurses tend to take 18-2 years to be fully proficient. JETS workforce competencies package. ENDO 1: from a JAG accred perspective all staff need this level competency. For clinical endoscopists they study up to 2 years plus training. For all options, no extra capacity has been factored in modelling of rooms to accommodate extra use of rooms for training... this could be considered. If in the medium term we can't achieve the same level of activity, (whilst new staff being trained), we will need to pay enhanced rates. Significant benefits could be gained from having a professional development team - this is true for all options. This would require ideally 1 lead overall and 1 support per site, or as a minimum 1 lead and 2 supporting (nurse training). This is not essential to the options. If we had 3rd theatre could flex to 7 day to allow for additional capacity for training. Urology currently occupy 8 sessions. We know that GIRFT urology recommends own suite for all urology delivery. If urology moves out, this would release 10 sessions for endoscopy, enabling us to meet projected increase, potential of 7-day could therefore meet demand and flex for training, or 6-day or evening.				
Impact on current staff - e.g Will staff need to move site / will model improve MDT working?	medical staff will likely need to travel to community sites from acute sites - which will need to be factored into consultant job plans & linkage to acute site/inpatient workload. Nursing teams will likely be employed to this site but if not, staff will need to travel from other units	medical staff will likely need to travel to community sites from acute sites - which will need to be factored into consultant job plans & linkage to acute site/inpatient workload. Nursing teams will likely be employed to this site but if not, staff will need to travel from other units	medical staff will likely need to travel to community sites from acute sites - which will need to be factored into consultant job plans & linkage to acute site/inpatient workload. Nursing teams will likely be employed to this site but if not, staff will need to travel from other units	medical staff will likely need to travel to community sites from acute sites - which will need to be factored into consultant job plans & linkage to acute site/inpatient workload. Nursing teams will likely be employed to this site but if not, staff will need to travel from other units	This will need to be scoped - medical staff will likely need to travel to community sites from acute sites - which will need to be factored into consultant job plans & linkage to acute site/inpatient workload. Nursing teams will likely be employed to this site but if not, staff will need to travel from other units
Will this reduce your current workforce risks & challenges?	May increase it - across all sites (aprt from BGH). For PPH it could destabilise, or GGH (nursing staff). Running more rooms: risk of losing one member of staff has greater impact on number of sessions lost (my note: suggest carrying over to SWOT). Strength for Carmarthenshire - more resilience in rota				
Do you believe this will have a positive or negative impact on recruitment and retention?	Same as current	Within this 2-4 year timeframe, the challenge is that some doctors who can currently undertake endoscopy will retire, so possibly a need to look at new roles, clinical endoscopists to fill gap.	Same as current	Same as current	Positive - as will present an exciting new model of delivery
Are there any other interdependent services that will be impacted by this change? e.g. diagnostics, A&E, wards	HSDU, Pathology & Acute Site	HSDU, Pathology & Acute Site	HSDU, Pathology & Acute Site	HSDU, Pathology & Acute Site	HSDU, Pathology & Acute Site
	Urology	respiratory & urology	respiratory & urology	respiratory & urology	respiratory & urology
Are there other programmes of work that may impact the option e.g. ARCH / Regional work	Mid wales health collaborative may impact BGH. We see Powys patients.				

	ARCH initial discussions with Swansea Bay	ARCH initial discussions with Swansea Bay	ARCH initial discussions with Swansea Bay	ARCH initial discussions with Swansea Bay	ARCH discussions with Swansea Bay have involved discussion around regional delivery of BSW - for consideration
Are there ways to use technology or innovations to support the delivery of this option?	None	None	None	None	
<b>Estates</b>					
Theatres / Sessions	<p>Maximise current 10 sessions.</p> <p>Equipment old and fragile in BGH. Active feasibility case in development with HSDU - but needs significant capital investment. Only site where scopes currently cleaned on site.</p>	Maximise current 22 sessions	<p>ASSUMPTION: All 4 options are around expanding to meet demand, allowing no flexibility / capacity to use rooms for training, which would allow getting people trained in half the amount of time possibly (see notes under training, above). Equipment needed for additional sessions &amp; storage. Sterile services - requirement for additional support will depend on how quickly they can turn the equipmnt around - modelling is required from Phil Flier. If we buy more equipment we need more washer and dryer cabinets to store scopes. 3rd room in PPH likely to take us up to capital threshold. Non-pay and pay implications initially. Another matter that hasn't been costed is: where do we deliver service during rebuild? Would need a mobile unit in meantime? Scope costs 40,000, need 4-6 per session, so estimate £250,000 for scopes, 1-300,000 for stack, so £1m per room on basis that you can use equipment every day. HSDU would also then need washer and dryer units, no idea costs (Eldege estimates at least £250,000) would need 50% more.</p>	Maximise current 20 sessions	<p>Community hub. We haven't done any work to scope cost of new build in community including Airflow. Brand new build, new specifications. May need more equipment, including trolleys, monitors - whole lot. Only caveat - if community site fits with swansea and potentilla for joint investment. They are currently rich in theatre space poor in staff. May be cost effective to jointly fund / staff. But then where to locate? Bowel screening</p>
Day Surgery Units (DSU) / Sessions	N/A	N/A	N/A	N/A	N/A
Procedure Rooms / Sessions	Maximising current - 1 proc room - 10 sessions	Maximising current - 2 proc room - 20 sessions	Maximising current - 2 proc room - 20 sessions	Maximising current - 2 proc room - 20 sessions	NEW - 1 new procedure room - 10 sessions
Outpatients Department / Sessions	N/A	N/A	N/A	N/A	
Other	N/A	N/A	N/A	N/A	
Office space required (Desks)	N/A	N/A	N/A	N/A	as part of community hub
Equipment Moves (Surplus and Essential)	Risk: for all the options, rolling capital replacement programme needed				Decision will be needed on whether equipment is cleaned on site or transferred to current HSDU on hospital sites - this would involve transportation of equipment.

Potential Capital Development needs					
Potential Digital opportunities (achievable within 2-4 years) (E.G. CT Profusion for Stroke)	None	None	None	None	Development of new theatre - 10 sessions. 7 development of complimenting HSDU (& all associated equipment)
<b>Patients</b>					
Identify what intervention will take place on each site and what interventions will move	As is (minus BSW)	As is (minus BSW)	As is (minus BSW)	As is (minus BSW)	BSW to move to community site from current delivery on a hospital site
Clarify if there are Patient Transfers required (include acuity: ACCTS or NEPTS or WAST) what % of patients this would be (this will need to be evidence based)	N/A	N/A	N/A	N/A	
Detail any impacts or changes to regional or national pathways	No current pathways in place	No current pathways in place	No current pathways in place	No current pathways in place	Regional
<b>Addressing Barriers</b>					
Waiting Lists	Clearance of endoscopy backlog - with timely access to procedures for all patients Compliance with BSW standards - as part of LTA with Public Health Wales				Compliance with BSW standards - as part of LTA with Public Health Wales
Waiting Times	Introducing sustainability by increasing the workforce to deliver maximum sessions so that demand and capacity is balanced - training of future workforce is paramount to this to ensure future sustainability of service provision.				
Other	Ongoing capital replacement programme is key to sustain service delivery - as ageing/fragile equipment presents a risk to delivery of the necessary activity required to meet demand (even if appropriate staff and sessions are funded)				

ENDOSCOPY	Bronglais	Glangwili	Prince Philip	Withybush	Community Sites
<b>OPTION 4</b>	As per current configuration with Possible additional	As per current configuration with additional sessions released from Bronchoscopy and Urology lists for GI activity.	Centralise Urology and Bronchoscopy Use Anaesthetics room for GI. Urology Increased capacity for GI & Urology circa  *7 Day working model*	As per current configuration	Current configuration – no activity at community sites
<b>Workforce Requirement</b>					
Are there any changes required to current Rotas? include On Call, moving to a 7 day model etc		Additional workforce required: 6.5 additional on GGH,	Instead of extra room for 7 day model, we have similar endoscopists involved. New revenue investment. HCDU department also need to be aligned. Need to model this with Phil. Need 10 WTE additional staff if PPH, 7 days per week. A lot of endoscopists like weekday working, working weekends and evenings may present change of culture, may impact staff retention. Risk could be mitigated by enhanced pay. (My note: explore in SWOT) Financial modelling needed. A few options are available within the 7 day model ... could do 7 day on GGH as well as PPH, since that is where emergency is. Would recommend this rather than PPH only. May take pressure off GI weekend list rota in GGH. Saturday - Sunday working across		Additional nursing workforce required: 6.5 additional on WGH

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Any changes to current Bed numbers?	N/A	N/A	N/A	N/A	N/A
Changes to current <b>Medical</b> workforce model incl. impact on variable pay	<p style="text-align: center;">Either 3 BA Clinical Endoscopists or 2 BA Clinical Endoscopist plus one Consultant Endoscopist to work across sites</p>				
Changes to current <b>Nursing &amp; HCSW</b> model incl. impact on variable pay	4.25 additional nursing staff (3 wte band 5 and 1.25 band 3)	Estimated 9 new additional posts (band 3&5) Leri to confirm.	Need 10 WTE additional staff if PPH, 7 days per week. (band 3 & 5 Leri to confirm mix)	Additional 7 wte (band 3 & 5 Leri to confirm mix)	
Changes to current <b>Therapies</b> workforce model incl. impact on variable pay					
Changes to current <b>HCS &amp; APST</b> Workforce model incl. impact on variable pay					
Changes to current <b>Administrative Workforce</b>					
Any other additional workforce requirements - e.g. Facilities roles					
Any additional Training required?	<p style="text-align: center;">1.5 band 4 waiting list administration to work across sites</p> <p style="text-align: center;">Need to ensure patholog &amp; HSDU support in place for either 7 day working model or evening working</p> <p style="text-align: center;">Need to ensure patholog &amp; HSDU support in place for either 7 day working model or evening working for facilities/hotel services support across the sites</p> <p>Training is an issue to be considered for the whole option, and applies to all 4 options (my note: could be carried over to SWOT 1). Nurses tend to take 18-2 years to be fully proficient. JE1's workforce competencies package. ENDO 1: from a JAG accredited perspective all staff need this level competency. For clinical endoscopists they study up to 2 years plus training. For all options, no extra capacity has been factored in modelling of rooms to accommodate extra use of rooms for training - this could be considered. If in the medium term we can't achieve the same level of activity, (whilst new staff being trained), we will need to pay enhanced rates. Significant benefits could be gained from having a professional development team - this is true for all options. This would require ideally 1 lead overall and 1 support per site, or as a minimum 1 lead and 2 supporting (nurse training). This is not essential to the options. If we had 3rd theatre could flex to 7 day to allow for additional capacity for training. <del>Urology currently occupy 8 sessions. We know that GIBET urology recommends own suite for all urology delivery. If urology moves out, this would release 10 sessions for endoscopy, enabling us to meet projected increase potential of 7 day could therefore</del></p> <p style="text-align: center;">Not if increasing demand in every unit / sessions in all units</p>				
Impact on current staff - e.g. Will staff need to move site / will model improve MDT working? Will this reduce your current workforce risks & challenges?	Evening or weekend working may be deemed unfavourable to staff - would need OCP for current staff & consideration for JD & working patterns for new staff				
Do you believe this will have a positive or negative impact on recruitment and retention? Are there any other interdependent services that will be impacted by this change? e.g. diagnostics, A&F wards	As above - could pose a risk to recruitment if staff do not favour evening or weekend working - but will be favourable in terms of enhanced pay offered for this working pattern				
Are there other programmes of work that may impact the option e.g. ARCH / Regional work	HSDU, Urology, Hotel Services and Pathology	HSDU, Urology, Hotel Services and Pathology	HSDU, Urology, Hotel Services and Pathology	HSDU, Urology, Hotel Services and Pathology	
Are there ways to use technology or innovations to support the delivery of this option?	Mid wales health collaborative may impact BGH. We see Powys patients.	N/A	ARCH regional partnership with SB	N/A	
<b>Estates</b>	None	None	None	None	
Theatres / Sessions	Maximising fallow capacity in the evening & on the weekend				
Day Surgery Units (DSU) / Sessions	N/A	N/A	N/A	N/A	
Procedure Rooms / Sessions	No new procedure rooms - but will involve increased sessional delivery utilising fallow evening/weekends				
Outpatients Department / Sessions	N/A	N/A	N/A	N/A	
Other					
Office space required (Desks)	None	None	None	None	
Equipment Moves (Surplus and Essential)	needed, but especially pertinent for option 4 because more				
Potential Capital Development needs	New equipment not needed if weekend working adopted - as equipment already available *however to note that increased utilisation of this equipment could increase fragility - capital replacement programme key* - evening working could incur need for new capital investment in scopes depending on turnaround with HSDU - to work with Phil Flear to scope				

Potential Digital opportunities (achievable within 2-4 years) (E.G. CT Profusion for Stroke)					
<b>Patients</b>					
Identify what intervention will take place on each site and what interventions will move	As is (minus BSW)	As is (minus BSW)	As is (minus BSW)	As is (minus BSW)	BSW to move to community site from current delivery on a hospital site
Clarify if there are Patient Transfers required (include acuity: ACCTS or NEPTS or WAST) what % of patients this would be (this will need to be Detail any impacts or changes to regional or national pathways)	N/A	N/A	N/A	N/A	
<b>Addressing Barriers</b>	No current pathways in place	No current pathways in place	No current pathways in place	No current pathways in place	Regional
Waiting Lists	Clearance of endoscopy backlog - with timely access to procedures for all patients Compliance with BSW standards - as part of LTA with Public Health Wales				Compliance with BSW standards - as part of LTA with Public Health Wales
Waiting Times	Introducing sustainability by increasing the workforce to deliver maximum sessions so that demand and capacity is balanced - training of future workforce is paramount to this to ensure future sustainability of service provision.				
Other	Ongoing capital replacement programme is key to sustain service delivery - as ageing/frangible equipment presents a risk to delivery of the necessary activity required to meet demand (even if appropriate staff and sessions are funded)				

ENDOSCOPY	Bronglais	Glangwili	Prince Philip	Withybush	Community Sites
<b>OPTION 1</b>	Maximise session capacity in JAG accredited unit	Maximise session capacity. Paediatric elective services (low volume)	Maximise session capacity Explore opportunity for Prince Philip Hospital to provide respiratory and urology diagnostics. Explore opportunity to centralise respiratory & urology endoscopy to PPH. (aspiration to have 3 room JAG accredited unit) There is a need to review available space in Prince Philip	Maximise session capacity	Current configuration - No activity at community sites
<b>OPTION 2</b>	Joint Advisory Group (JAG) accredited services/ Emergency	Joint Advisory Group (JAG) accredited services/ Emergency	Not JAG accredited, Urology to take some Endoscopy and Bronchoscopy focus in Hub  Make it 3 units & bowel screening  A specialist Bronchoscopy and Urology diagnostic treatment unit with GI	Joint Advisory Group (JAG) accredited services/ Emergency	Current configuration – no activity at community sites
<b>OPTION 3</b>	JAG accredited service  All aspects of GI including inpatients  Opportunity to work with Powys & South Gwynedd to meet demand of this population	JAG accredited Service  Maximising current provision of service (All aspects of GI including inpatients also out of hours interventional Endoscopy for HB)  Remove Respiratory & Urology to maximise capacity for GI	No JAG accreditation  Take out Urology sessions - to be accommodated elsewhere - ? day surgery  GI and respiratory to remain (inc. GI inpatients) – maximising already staffed 20 sessions (JAG accreditation would not be possible – as no changes to theatre flow)	JAG accredited service  Service sustained as is at Bronglais Hospital (All aspects of GI including inpatients)	Current configuration – no activity at community sites however to scope options for diagnostic/Bowel Screening Wales

			Consider partnership working with Swansea Bay for GI – to accommodate growing BSW demand		
OPTION 4	As per current configuration with Possible additional 2nd room for small procedures	As per current configuration with additional sessions released from Bronchoscopy and Urology lists for GI activity.	<p>Centralise Urology and Bronchoscopy diagnostics to site. GI to remain (will be left with a deficit of 9 sessions if Respiratory/Urology solely implemented)</p> <p>Use Anaesthetics room for GI, Urology and Endoscopy services (potential £3m cost) will need to find alternatives for Anaesthetics</p> <p>Increased capacity for GI &amp; Urology circa 10 sessions.</p>	As per current configuration	Current configuration – no activity at community sites

UROLOGY		Bronglais	Glangwili	Prince Philip	Withybush	Community Sites	
O P T I O N  1	OPTION 1	Continue current Outpatient service only	Emergency Urology only	Urology diagnostics, elective and cancer services (need to ensure capacity needs for GI & respiratory endoscopy also met)	As per current configuration – outpatient and day case	Aberaeron Integrated Care Centre, Cross Hands and South Pems Hospital undertake Trial Without Catheter services  Carmarthen Hwb undertake vasectomy	
	Workforce Requirement						
	Are there any changes required to current Rotas? include On Call, moving to a 7 day model etc	No changes to Bronglais rotas	On-call rota is not impacted (consultants, registrar and jnr doc cross cover)  Doctor, CNS and nursing rotas not impacted, just a change to location to Prince Philip	Will need daytime (mon-fri 9-5) consultant cover. This will save on follow up consultant OP appointment. This will not cost anything as the consultant is already present.  Doctor, CNS and nursing rotas not impacted, just a change to location to Prince Philip	No changes to Withybush rotas. Endoscopy is included within in DSU. Ward 9 currently sees day case patients (some lists are in DSU and theatre, but no inpatients)		
	Any changes to current Bed numbers?	No Changes	Elective services (4 beds per week) will be freed up	4 beds will come over from Glangwili, however to maximise efficiency model will need additional 5 beds in Prince Philip on top of the 4 from Glangwili	No changes		
	Changes to current Medical workforce model incl. impact on variable pay	No Changes	No change to numbers, just change location	No change to numbers, just change location	No changes		
	Changes to current Nursing & HCSW model incl. impact on variable pay	No changes	No change to numbers, just change location	No change to numbers, just change location	No changes		
	Changes to current Therapies workforce model incl. impact on variable pay	No changes	No change to numbers, just change location	No change to numbers, just change location	No changes		
	Changes to current HCS & APST Workforce model incl. impact on variable pay	No changes	No change to numbers, just change location	No change to numbers, just change location	No changes		
	Changes to current Administrative Workforce	No changes	No change to numbers, just change location	No change to numbers, just change location	No changes		
	Any other additional workforce requirements - e.g. Facilities roles	No	No	No	No		

Any additional Training required?	No	No	No	No	
Impact on current staff - e.g Will staff need to move site / will model improve MDT working?	No change	Change of staff location to prince philip	Change of staff location to prince philip <b>Potentially increased staff travel expenses for up to 4 years depending on contract.</b> However, for some staff it will be a saving so this will not apply to all staff	No change	
Will this reduce your current workforce risks & challenges?			If we have a central suit there will be greater capacity for joint clinics, MDT working, additional training opportunities. Reduced risk from governance as there will be a consultat always on site. <b>Better staff retention will lead to savings, as there will be less recruitment and skills will improve within the team. Easier to recruit to doctor positions as majority will live closer to Swansea/Cardiff</b>		
Do you believe this will have a positive or negative impact on recruitment and retention?			Positive - as above		
Are there any other interdependent services that will be impacted by this change? e.g. diagnostics, A&E, wards		OP staff will no longer need to undertake Urology services as transferred to Prince Philip	<b>Endoscopy capacity will have to be increased in Prince Philip - see endoscopy tab</b> <b>Increased demand for elective patients attending ward 7 in Prince Philip.</b>		
Are there other programmes of work that may impact the option e.g. ARCH / Regional work			GIRFT recommendation is for a central site		
Are there ways to use technology or innovations to support the delivery of this option?			Service currently looking at electronic Endoscopy reporting (phase 2 being rolled out shortly), Attend Anywhere and use Patient Knows Best app, possibility to expand		
<b>Estates</b>					
Theatres / Sessions	No change	release 2 theatre sessions in Glangwili, transfer to Prince Philip	Will need the 2 sessions from Glangwili <b>Will need 2 additional sessions for cancer work</b> If patients can be seen and operated on sooner, the complexity of surgery is reduced. This increases patient throughput, although it is hard to quantify	No change	Not applicable
Day Surgery Units (DSU) / Sessions	No change	1 DSU session on a Friday morning to be freed up 2 Truss biopsy sessions will move to PPH	Will need the 1 DSU session from Glangwili Will need 2 additional TP biopsy sessions	No change	Not applicable
Procedure Rooms / Sessions	No change	2 rooms in OP, 5 days week 6 OP consultant sessions per week	Will need curret 2 rooms in OP, 5 days week from Glangwili <b>Will need 1 additional room for projected demand (currently planned for Glangwili)</b> Incorporate the 6 OP consultant sessions - will need 2 rooms for each. This will reduce stage 1 waiting list	No change	Not applicable

Outpatients Department / Sessions	No change	OP sessions for nurses will migrate to Prince Philip Move 9 OP sessions from Glangwilli to Prince Philip 2 session per week for TWOC moving to the community - these sessions can be used towards waiting list which will create savings by not having to use waiting list initiative	9 OP sessions from Glangwilli 2 additional sessions from TWOC to be used for other urology work	No change	Community services have started to undertake TWOC in small numbers. Will increased by the 2 session per week from Glangwilli for TWOC to be undertaken by community staff. Volume is approx. 10 patients per week. This will be an additional cost for Primary Care. However this is currently being undertaken within Urology service without additional funding, which can be either saved or used within the service. Potentially many catheter changes can be saved by TWOC being carried out in community services
Other	No change	1 video urodynamics session every 2/3 months in Xray moving to Prince Philip	1 video urodynamics session every 2/3 months in Xray moving to Prince Philip Currently borrowing OP facilities and equipment, so rooms will need: - desktop computer - couch	No change	Will need to consider the demand & capacity for TWOC
Office space required (Desks)	No change	CNS nurse office in old nursing home (2 desk office) moving from GGH	Will need 5, 2 person offices (anesthetic's office has this) for consultants and nurses (to be used for virtual clinics). One room comes from Glangwilli, the other rooms are already located within Prince Philip but will need to be centralised elsewhere on site	No change	No additional office space required
Equipment Moves (Surplus and Essential)	No change	Equipment to move to Prince Philip: Minor op room: Trus biopsy machine and Trophon Bladder Scanner Drug trolley TWOC trolley	Office space (noted above) for 4 sec/admin staff - moving from within Prince Philip (various locations to a single unit) <b>Store area - similar size to that in Derwen (glangwilli)</b>	No change	No equipment to move into community site
Potential Capital Development needs	No change	No	<b>All three rooms and office space to be refurbished with PCP points. (anesthetic's room has recently been refurbished)</b>	No change	No capital needs
Potential Digital opportunities (achievable within 2-4 years) (E.G. CT Profusion for Stroke)	No	No	Telemedicine or similar (inc diagnostics) in the unit	No	
<b>Patients</b>					
Identify what intervention will take place on each site and what interventions will move	No change		Coming to Prince Philip from Glangwilli: Nephrectomy - 1 list per week CNS team use x2 OP clinic rooms per day Flexible cystoscopy TULA Laser Bladder Treatment Urodynamics	No change	
Clarify if there are Patient Transfers required (include acuity: ACCTS or NEPTS or WAST) what % of patients this would be (this will need to be evidence based)	TWOC patients will not need to use WAST transport to access services, as this will be delivered close to home by community staff	Change of patient destination from Glangwilli to Prince Philip rather than numbers TWOC patients will not need to use WAST transport to access services, as this will be delivered close to home by community staff	Change of patient destination from Glangwilli to Prince Philip rather than numbers TWOC patients will not need to use WAST transport to access services, as this will be delivered close to home by community staff	TWOC patients will not need to use WAST transport to access services, as this will be delivered close to home by community staff	TWOC patients will not need to use WAST transport to access services, as this will be delivered close to home by community staff
Detail any impacts or changes to regional or national pathways	No change		Cancer RTT pathway should be improved due to efficiencies of scale and staff capacity in theatre and OP settings.  Partial Nephrectomy will be carried out by robot in Swansea Bay in the next 2-4 years. Plan is for HDdUHB consultants to be trained to fully utilise this equipment. There would be a benefit for HDdUHB patients currently on the waiting list.		
<b>Addressing Barriers</b>					
Waiting Lists			Cancer RTT pathway should be improved due to efficiencies of scale and staff capacity in theatre and OP settings.  Reduced likelihood of implementing waiting list initiatives as centralised working should improve waiting list position. This will save in overtime for nurses and doctors (e.g. full day can cost £1800 per day)		

Waiting Times			More efficient services should improve due to a more efficient service		
Other			Reduction in multiple attendances. E.g. one stop PSA clinic, where assessment and biopsy can be carried out in same clinic		

UROLOGY		Bronglais	Glangwili	Prince Philip	Withybush	Community Sites	
O P T I O N 2	OPTION 2	Diagnostics (due to Powys population) Equity of access –Consider Urology week for surgery on a monthly basis	No elective - Emergency pathway only. Move electives to Prince Philip & free up 2 procedure rooms	Create diagnostic hub – take some endoscopy focus	Outpatients and day case only - diagnostics	All Trial Without Catheter (TWOC) – Elizabeth Williams Clinic (Llanelli) / Carmarthen Hub Vasectomy (remove from Urology and place with sexual health team)	
	Workforce Requirement						
	Are there any changes required to current Rotas? include On Call, moving to a 7 day model etc	No changes to Bronglais rotas	On-call rota is not impacted (consultants, registrar and jnr doc cross cover) Doctor, CNS and nursing rotas not impacted, just a change to location to Prince Philip	Will need daytime (mon-fri 9-5) consultant cover. This will save on follow up consultant OP appointment. This will not cost anything as the consultant is already present. Doctor, CNS and nursing rotas not impacted, just a change to location to Prince Philip	No changes to Withybush rotas. Endoscopy is included within in DSU. Ward 9 currently sees day case patients (some lists are in DSU and theatre, but no inpatients)		
	Any changes to current Bed numbers?	No Changes	Elective services (4 beds per week) will be freed up	4 beds will come over from Glangwili, however to maximise efficiency model will need additional 5 beds in Prince Philip	No changes		
	Changes to current Medical workforce model incl. impact on variable pay	No Changes	No change to numbers, just change location	No change to numbers, just change location	No changes		
	Changes to current Nursing & HCSW model incl. impact on variable pay	No changes	No change to numbers, just change location	No change to numbers, just change location	No changes		
	Changes to current Therapies workforce model incl. impact on variable pay	No changes	No change to numbers, just change location	No change to numbers, just change location	No changes		
	Changes to current HCS & APST Workforce model incl. impact on variable pay	No changes	No change to numbers, just change location	No change to numbers, just change location	No changes		

Changes to current <b>Administrative</b> Workforce	No changes	No change to numbers, just change location	No change to numbers, just change location	No changes	
Any other additional workforce requirements - e.g. Facilities roles	No	No	No	No	
Any additional Training required?	No	No	No	No	
Impact on current staff - e.g. Will staff need to move site / will model improve MDT working?	No change	Change of staff location to prince Philip	Change of staff location to prince Philip Potentially increased staff travel expenses for up to 4 years depending on contract. However, for some staff it will be a saving so this will not apply to all staff	No change	
Will this reduce your current workforce risks & challenges?			If we have a central suit there will be greater capacity for joint clinics, MDT working, additional training opportunities. Reduced risk from governance as there will be a consultant always on site. Better staff retention will lead to savings, as there will be less recruitment and skills will improve within the team.		
Do you believe this will have a positive or negative impact on recruitment and retention?			Positive - as above		
Are there any other interdependent services that will be impacted by this change? e.g. diagnostics, A&E, wards		OP staff will no longer need to undertake Urology services as transferred to Prince Philip	Endoscopy capacity will have to be increased in Prince Philip. Increased demand for elective patients attending ward 7 in Prince Philip.		
Are there other programmes of work that may impact the option e.g. ARCH / Regional work			GIRFT recommendation is for a central site		
Are there ways to use technology or innovations to support the delivery of this option?			Service currently looking at Attend Anywhere and use Patient Knows Best app, possibility to expand		
<b>Estates</b>					
Theatres / Sessions	No change	release 2 theatre sessions in Glangwili	Will need the 2 sessions from Glangwili Will need 2 additional sessions for cancer work If patients can be seen and operated on sooner, the complexity of surgery is reduced. This increases patient throughput	No change	Not applicable
Day Surgery Units (DSU) / Sessions	No change	1 DSU session on a Friday morning 2 TP biopsy sessions will move to PPH	Will need the 1 DSU session from Glangwili Will need 2 additional TP biopsy sessions	No change	Not applicable

Procedure Rooms / Sessions	No change	2 rooms in OP, 5 days week 6 OP consultant sessions per week	Will need current 2 rooms in OP, 5 days week from Glangwilli Will need 1 additional room for projected demand (currently planned for Glangwilli) Incorporate the 6 OP consultant sessions - will need 2 rooms for each. This will reduce stage 1 waiting list	No change	Not applicable
Outpatients Department / Sessions	No change	OP sessions for nurses will migrate to Prince Philip Move 9 OP sessions from Glangwilli to Prince Philip 2 session per week for TWOC moving to the community - these sessions can be used towards waiting list which will create savings by not having to use waiting list initiative	9 OP sessions from Glangwilli 2 additional sessions from TWOC to be used for other urology work	No change	Community services have started to undertake TWOC in small numbers. Will increase by the 2 session per week from Glangwilli for TWOC to be undertaken by community staff. Volume is approx. 10 patients per week. This will be an additional cost for Primary Care. However this is currently being undertaken within Urology service without additional funding, which can be either saved or used within the service.
Other	No change	1 video urodynamics session every 2/3 months in x-ray moving to Prince Philip	1 video urodynamics session every 2/3 months in x-ray moving to Prince Philip Currently borrowing OP facilities and equipment, so rooms will need: - desktop computer - couch	No change	Will need to consider the demand & capacity for TWOC
Office space required (Desks)	No change	CNS nurse office in old nursing home (2 desk office) moving from GGH Equipment to move to Prince Philip:	Will need 5, 2 person offices (anesthetics office has this) for consultants and nurses (to be used for virtual clinics). One room comes from Glangwilli, the other rooms are already located within Prince Philip but will need to be centralised elsewhere on site	No change	No additional office space required
Equipment Moves (Surplus and Essential)	No change	Minor op room: Trus biopsy machine and Trophon Bladder Scanner Drug trolley TWOC trolley	Office space (noted above) for 4 sec/admin staff - moving from within Prince Philip (various locations to a single unit) <b>Store area - similar size to that in Derwen (glangwilli)</b>	No change	No equipment to move into community site
Potential Capital Development needs	No change	No	<b>All three rooms and office space to be refurbished with PCP points. (aesthetics room has recently been refurbished)</b>	No change	No capital needs
Potential Digital opportunities (achievable within 2-4 years) (E.G. CT Profusion for Stroke)	No	No	Telemedicine or similar (inc diagnostics) in the unit	No	
<b>Patients</b>					
Identify what intervention will take place on each site and what interventions will move	No change		Coming to Prince Philip from Glangwilli: Nephrectomy - 1 list per week CNS team use x2 OP clinic rooms per day Flexible cystoscopy TULA Laser Bladder Treatment Urodynamics	No change	
Clarify if there are Patient Transfers required (include acuity: ACCTS or NEPTS or WAST) what % of patients this would be (this will need to be evidence based)	TWOC patients will not need to use WAST transport to access services, as this will be delivered close to home by community staff	Change of patient destination from Glangwilli to Prince Philip rather than numbers TWOC patients will not need to use WAST transport to access services, as this will be delivered close to home by community staff	Change of patient destination from Glangwilli to Prince Philip rather than numbers TWOC patients will not need to use WAST transport to access services, as this will be delivered close to home by community staff	TWOC patients will not need to use WAST transport to access services, as this will be delivered close to home by community staff	TWOC patients will not need to use WAST transport to access services, as this will be delivered close to home by community staff
Detail any impacts or changes to regional or national pathways	No change		Cancer RTT pathway should be improved due to efficiencies of scale and staff capacity in theatre and OP settings. Partial Nephrectomy will be carried out by robot in Swansea Bay in the next 2-4 years. Plan is for HDdUHB consultants to be trained to fully utilise this equipment. There would be a benefit for HDdUHB patients currently on the waiting list.		
<b>Addressing Barriers</b>					

Waiting Lists			Cancer RTT pathway should be improved due to efficiencies of scale and staff capacity in theatre and OP settings.  Reduced likelihood of implementing waiting list initiatives as centralised working should improve waiting list position. This will save in overtime for nurses and doctors (e.g. full day can cost £1800 per day)		
Waiting Times			More efficient services should improve due to a more efficient service		
Other			Reduction in multiple attendances. E.g. one stop PSA clinic, where assessment and biopsy can be carried out in same clinic		

UROLOGY		Bronglais	Glangwili	Prince Philip	Withybush	Community Sites
<b>OPTION 3</b>	OPD service and Day Surgery to remain	Emergency Urology only	Diagnostic Unit to include centralising services and all Elective Urology  No longer utilising Endoscopy theatre space need to identify procedure rooms	OPD service and Day Surgical unit Diagnostic activity as current	Trial without Catheter to be undertaken in the Community venues across the HB.	
<b>OPTION 3</b>	<b>Workforce Requirement</b>					
	Are there any changes required to current Rotas? include On Call, moving to a 7 day model etc	No changes to Bronglais rotas	On-call rota is not impacted (consultants, registrar and jnr doc cross cover)  Doctor, CNS and nursing rotas not impacted, just a change to location to Prince Philip	Will need daytime (mon-fri 9-5) consultant cover. This will save on follow up consultant OP appointment. This will not cost anything as the consultant is already present.  Doctor, CNS and nursing rotas not impacted, just a change to location to Prince Philip	No changes to Withybush rotas. Endoscopy is included within in DSU. Ward 9 currently sees day case patients (some lists are in DSU and theatre, but no inpatients)	
	Any changes to current Bed numbers?	No Changes	Elective services (4 beds per week) will be freed up	4 beds will come over from Glangwili, however to maximise efficiency model will need additional 5 beds in Prince Philip	No changes	
	Changes to current Medical workforce model incl. impact on variable pay	No Changes	No change to numbers, just change location	No change to numbers, just change location	No changes	
	Changes to current Nursing & HCSW model incl. impact on variable pay	No changes	No change to numbers, just change location	No change to numbers, just change location	No changes	
	Changes to current Therapies workforce model incl. impact on variable pay	No changes	No change to numbers, just change location	No change to numbers, just change location	No changes	
	Changes to current HCS & APST Workforce model incl. impact on variable pay	No changes	No change to numbers, just change location	No change to numbers, just change location	No changes	

Changes to current <b>Administrative</b> Workforce	No changes	No change to numbers, just change location	No change to numbers, just change location	No changes	
Any other additional workforce requirements - e.g. Facilities roles	No	No	No	No	
Any additional Training required?	No	No	No	No	
Impact on current staff - e.g. Will staff need to move site / will model improve MDT working?	No change	Change of staff location to prince Philip	Change of staff location to prince Philip Potentially increased staff travel expenses for up to 4 years depending on contract. However, for some staff it will be a saving so this will not apply to all staff	No change	
Will this reduce your current workforce risks & challenges?			If we have a central suit there will be greater capacity for joint clinics, MDT working, additional training opportunities. Reduced risk from governance as there will be a consultant always on site. Better staff retention will lead to savings, as there will be less recruitment and skills will improve within the team.		
Do you believe this will have a positive or negative impact on recruitment and retention?			Positive - as above		
Are there any other interdependent services that will be impacted by this change? e.g. diagnostics, A&E, wards		OP staff will no longer need to undertake Urology services as transferred to Prince Philip	Endoscopy capacity will have to be increased in Prince Philip. Increased demand for elective patients attending ward 7 in Prince Philip.		
Are there other programmes of work that may impact the option e.g. ARCH / Regional work			GIRFT recommendation is for a central site		
Are there ways to use technology or innovations to support the delivery of this option?			Service currently looking at Attend Anywhere and use Patient Knows Best app, possibility to expand		
<b>Estates</b>					
Theatres / Sessions	No change	release 2 theatre sessions in Glangwili	Will need the 2 sessions from Glangwili Will need 2 additional sessions for cancer work If patients can be seen and operated on sooner, the complexity of surgery is reduced. This increases patient throughput	No change	Not applicable
Day Surgery Units (DSU) / Sessions	No change	1 DSU session on a Friday morning 2 TP biopsy sessions will move to PPH	Will need the 1 DSU session from Glangwili Will need 2 additional TP biopsy sessions	No change	Not applicable

Procedure Rooms / Sessions	No change	2 rooms in OP, 5 days week 6 OP consultant sessions per week	Will need current 2 rooms in OP, 5 days week from Glangwili Will need 1 additional room for projected demand (currently planned for Glangwili) Incorporate the 6 OP consultant sessions - will need 2 rooms for each. This will reduce stage 1 waiting list	No change	Not applicable
Outpatients Department / Sessions	No change	OP sessions for nurses will migrate to Prince Philip Move 9 OP sessions from Glangwili to Prince Philip 2 session per week for TWOC moving to the community - these sessions can be used towards waiting list which will create savings by not having to use waiting list initiative	9 OP sessions from Glangwili 2 additional sessions from TWOC to be used for other urology work	No change	Community services have started to undertake TWOC in small numbers. Will increase by the 2 session per week from Glangwili for TWOC to be undertaken by community staff. Volume is approx. 10 patients per week. This will be an additional cost for Primary Care. However this is currently being undertaken within Urology service without additional funding, which can be either saved or used within the service.
Other	No change	1 video urodynamics session every 2/3 months in x-ray moving to Prince Philip	1 video urodynamic session every 2/3 months in xray moving to Prince Philip Currently borrowing OP facilities and equipment, so rooms will need: - desktop computer - couch	No change	Will need to consider the demand & capacity for TWOC
Office space required (Desks)	No change	CNS nurse office in old nursing home (2 desk office) moving from GGH Equipment to move to Prince Philip:	Will need 5, 2 person offices (anesthetics office has this) for consultants and nurses (to be used for virtual clinics). One room comes from Glangwili, the other rooms are already located within Prince Philip but will need to be centralised elsewhere on site	No change	No additional office space required
Equipment Moves (Surplus and Essential)	No change	Minor op room: Trus biopsy machine and trophon Bladder Scanner Drug trolley TWOC trolley	Office space (noted above) for 4 sec/admin staff - moving from within Prince Philip (various locations to a single unit) Store area - similar size to that in Derwen (glangwili)	No change	No equipment to move into community site
Potential Capital Development needs	No change	No	All three rooms and office space to be refurbished with PCP points. (aenesthetics room has recently been refurbished)	No change	No capital needs
Potential Digital opportunities (achievable within 2-4 years) (E.G. CT Profusion for Stroke)	No	No	Telemedicine or similar (inc diagnostics) in the unit	No	
<b>Patients</b>					
Identify what intervention will take place on each site and what interventions will move	No change		Coming to Prince Philip from Glangwili: Nephrectomy - 1 list per week CNS team use x2 OP clinic rooms per day Flexible cystoscopy TULA Laser Bladder Treatment Urodynamics	No change	
Clarify if there are Patient Transfers required (include acuity: ACCTS or NEPTS or WAST) what % of patients this would be (this will need to be evidence based)	TWOC patients will not need to use WAST transport to access services, as this will be delivered close to home by community staff	Change of patient destination from Glangwili to Prince Philip rather than numbers TWOC patients will not need to use WAST transport to access services, as this will be delivered close to home by community staff	Change of patient destination from Glangwili to Prince Philip rather than numbers TWOC patients will not need to use WAST transport to access services, as this will be delivered close to home by community staff	TWOC patients will not need to use WAST transport to access services, as this will be delivered close to home by community staff	TWOC patients will not need to use WAST transport to access services, as this will be delivered close to home by community staff
Detail any impacts or changes to regional or national pathways	No change		Cancer RTT pathway should be improved due to efficiencies of scale and staff capacity in theatre and OP settings. Partial Nephrectomy will be carried out by robot in Swansea Bay in the next 2-4 years. Plan is for HDdUHB consultants to be trained to fully utilise this equipment. There would be a benefit for HDdUHB patients currently on the waiting list.		
<b>Addressing Barriers</b>					

Waiting Lists			Cancer RTT pathway should be improved due to efficiencies of scale and staff capacity in theatre and OP settings.  Reduced likelihood of implementing waiting list initiatives as centralised working should improve waiting list position. This will save in overtime for nurses and doctors (e.g. full day can cost £1800 per day)		
Waiting Times				More efficient services should improve due to a more efficient service	
Other					Reduction in multiple attendencies. E.g. one stop PSA clinic, where assessment and biopsy can be carried out in same clinic

UROLOGY		Bronglais	Glangwili	Prince Philip	Withybush	Community Sites	
O P T I O N 4	OPTION 4	As per current Configuration – Outpatient and day case only inc Diagnostics (also cancer procedures) and minor ops under GA  Work with DNs to extend TWOC	Emergency Urology provision only  Work with DNs to extend TWOC  Move diagnostic activity from GGH to PPH	Urology diagnostics and elective services only, centralise urgency more for urgent cancer diagnostics outside of theatre. Work with DNs to extend TWOC  Urology diagnostics and elective services only, centralise urgency more for urgent cancer diagnostics outside of theatre. Work with DNs to extend TWOC  Use Anaesthetics room for GI, Urology and Endoscopy services (potential £3m cost) will need to find alternatives for Anaesthetics Increased capacity for GI & Urology circa 10 sessions.  Urology acquiring the current Endoscopy suite in PPH as the Urology Investigation Unit	As per current Configuration – Outpatient and day case only inc Diagnostics (also cancer procedures) and minor ops under GA  Work with DNs to extend TWOC	Video consultation and Trial Without Catheter (TWOC) from: Cardigan, Aberaeron, Crosshands and Fishguard Integrated Care Centres  TWOC and video consultations TWOC services only from: Crosshands, Fishguard Integrated Care Centres and Llandovery and South Pembs Hospitals  Work with DNs to extend TWOC in the community	
	Workforce Requirement						
	Are there any changes required to current Rotas? include On Call, moving to a 7 day model etc	No changes to Bronglais rotas	On-call rota is not impacted (consultants, registrar and jnr doc cross cover)  Doctor, CNS and nursing rotas not impacted, just a change to location to Prince Philip	Will need daytime (mon-fri 9-5) consultant cover. This will save on follow up consultant OP appointment. This will not cost anything as the consultant is already present.	No changes to Withybush rotas. Endoscopy is included within in DSU. Ward 9 currently sees day case patients (some lists are in DSU and theatre, but no inpatients)		
	Any changes to current Bed numbers?	No Changes	Elective services (4 beds per week) will be freed up	4 beds will come over from Glangwili, however to maximise efficiency model will need additional 5 beds in Prince Philip	No changes		
Changes to current Medical workforce model incl. impact on variable pay	No Changes	No change to numbers, just change location	No change to numbers, just change location	No changes			

Changes to current <b>Nursing &amp; HCSW</b> model incl. impact on variable pay	No changes	No change to numbers, just change location	No change to numbers, just change location	No changes	
Changes to current <b>Therapies</b> workforce model incl. impact on variable pay	No changes	No change to numbers, just change location	No change to numbers, just change location	No changes	
Changes to current <b>HCS &amp; APST</b> Workforce model incl. impact on variable pay	No changes	No change to numbers, just change location	No change to numbers, just change location	No changes	
Changes to current <b>Administrative</b> Workforce	No changes	No change to numbers, just change location	No change to numbers, just change location	No changes	
Any other additional workforce requirements - e.g. Facilities roles	No	No	No	No	
Any additional Training required?	No	No	No	No	
Impact on current staff - e.g Will staff need to move site / will model improve MDT working?	No change	Change of staff location to prince philip	Change of staff location to prince philip <b>Potentially increased staff travel expenses for up to 4 years depending on contract.</b> However, for some staff it will be a saving so this will not apply to all staff	No change	
Will this reduce your current workforce risks & challenges?			If we have a central suit there will be greater capacity for joint clinics, MDT working, additional training opportunities. Reduced risk from governance as there will be a consultat always on site. <b>Better staff retention will lead to savings, as there will be less recruitment and skills will improve within the team</b>		
Do you believe this will have a positive or negative impact on recruitment and retention?			Positive - as above		
Are there any other interdependent services that will be impacted by this change? e.g. diagnostics, A&E, wards		OP staff will no longer need to undertake Urology services as transferred to Prince Philip	<b>Endoscopy capacity will have to be increased in Prince Philip.</b> <b>Increased demand for elective patients attending ward 7 in Prince Philip.</b>		
Are there other programmes of work that may impact the option e.g. ARCH / Regional work			GIRFT recommendation is for a central site		

Are there ways to use technology or innovations to support the delivery of this option?			Service currently looking at Attend Anywhere and use Patient Knows Best app, possibility to expand		
<b>Estates</b>					
Theatres / Sessions	No change	release 2 theatre sessions in Glangwili	Will need the 2 sessions from Glangwili  Will need 2 additional sessions for cancer work  If patients can be seen and operated on sooner, the complexity of surgery is reduced. This increases patient throughput	No change	Not applicable
Day Surgery Units (DSU) / Sessions	No change	1 DSU session on a Friday morning 2 TP biopsy sessions will move to PPH	Will need the 1 DSU session from Glangwili  Will need 2 additional TP biopsy sessions	No change	Not applicable
Procedure Rooms / Sessions	No change	2 rooms in OP, 5 days week 6 OP consultant sessions per week	Will need curret 2 rooms in OP, 5 days week from Glangwili  Will need 1 additional room for projected demand (currently planned for Glangwili)  Incorporate the 6 OP consultant sessions - will need 2 rooms for each. This will reduce stage 1 waiting list	No change	Not applicable
Outpatients Department / Sessions	No change	OP sessions for nurses will migrate to Prince Philip  Move 9 OP sessions from Glangwili to Prince Philip  2 session per week for TWOC moving to the community - these sessions can be used towards waiting list which will create savings by not having to use waiting list initiative	Will need curret 2 rooms in OP, 5 days week from Glangwili  9 OP sessions from Glangwili 2 additional sessions from TWOC to be used for other urology work	No change	Community services have started to undertake TWOC in small numbers. Will increase by the 2 session per week from Glangwili for TWOC to be undertaken by community staff. Volume is approx 10 patients per week. This will be an additional cost for Primary Care. However this is currently being undertaken within Urology service without additional funding, which can be either saved or used within the service.
Other	No change	1 video urodynamic session every 2/3 months in xray moving to Prince Philip	1 video urodynamic session every 2/3 months in xray moving to Prince Philip  Currently borrowing OP facilities and equipment, so rooms will need: - desktop computer - couch	No change	Will need to consider the demand & capacity for TWOC
Office space required (Desks)	No change	CNS nurse office in old nursing home (2 desk office) moving from GH Equipment to move to Prince Philip:	Will need 5, 2 person offices (anesthetics office has this) for consultants and nurses (to be used for virtual clinics). One room comes from Glangwili, the other rooms are already located within Prince Philip but will need to be centralised elsewhere on site	No change	No additional office space required
Equipment Moves (Surplus and Essential)	No change	Minor op room: Trus biopsy machine and trophon Bladder Scanner Drug trolley TWOC trolley	Office space (noted above) for 4 sec/admin staff - moving from within Prince Philip (various locations to a single unit)  Store area - similar size to that in Derwen (glangwili)	No change	No equipment to move into community site
Potential Capital Development needs	No change	No	All three rooms and office space to be refurbished with PCP points. (aenesthetics room has recently been refurbished)	No change	No capital needs
Potential Digital opportunities (achievable within 2-4 years) (E.G. CT Profusion for Stroke)	No	No	Telemedicine or similar (inc diagnostics) in the unit	No	
<b>Patients</b>					

Identify what intervention will take place on each site and what interventions will move	No change		Coming to Prince Philip from Glangwili: Nephrectomy - 1 list per week CNS team use x2 OP clinic rooms per day Flexible cystoscopy TULA Laser Bladder Treatment Urodynamics	No change	
Clarify if there are Patient Transfers required (include acuity: ACCTS or NEPTS or WAST) what % of patients this would be (this will need to be evidence based)	TWOC patients will not need to use WAST transport to access services, as this will be delivered close to home by community staff	Change of patient destination from Glangwili to Prince Philip rather than numbers TWOC patients will not need to use WAST transport to access services, as this will be delivered close to home by community staff	Change of patient destination from Glangwili to Prince Philip rather than numbers TWOC patients will not need to use WAST transport to access services, as this will be delivered close to home by community staff	TWOC patients will not need to use WAST transport to access services, as this will be delivered close to home by community staff	
Detail any impacts or changes to regional or national pathways	No change		Cancer RTT pathway should be improved due to efficiencies of scale and staff capacity in theatre and OP settings.  Partial Nephrectomy will be carried out by robot in Swansea Bay in the next 2-4 years. Plan is for HDdUHB consultants to be trained to fully utilise this equipment. There would be a benefit for HDdUHB patients currently on the waiting list.		
<b>Addressing Barriers</b>					
Waiting Lists			Cancer RTT pathway should be improved due to efficiencies of scale and staff capacity in theatre and OP settings.  Reduced likelihood of implementing waiting list initiatives as centralised working should improve waiting list position. This will save in overtime for nurses and doctors (e.g. full day can cost £1,800 per day)		
Waiting Times			More efficient services should improve due to a more efficient service		
Other			Reduction in multiple attendencies. E.g. one stop PSA clinic, where assessment and biopsy can be carried out in same clinic		

<b>UROLOGY</b>	<b>Bronglais</b>	<b>Glangwili</b>	<b>Prince Philip</b>	<b>Withybush</b>	<b>Community Sites</b>
<b>OPTION 1</b>	Continue current Outpatient service only	Emergency Urology only	Urology diagnostics, elective and cancer services (need to ensure capacity needs for GI & respiratory endoscopy also met)	As per current configuration – outpatient and day case	Aberaeron Integrated Care Centre, Cross Hands and South Pembrokeshire Hospital undertake Trial Without Catheter services  Carmarthen Hwb undertake vasectomy

<p><b>OPTION 2</b></p>	<p>Diagnostics (due to Powys population) Equity of access –Consider Urology week for surgery on a monthly basis</p>	<p>No elective - Emergency pathway only. Move electives to Prince Philip &amp; free up 2 procedure rooms</p>	<p>Create diagnostic hub – take some endoscopy focus</p>	<p>Outpatients and day case only - diagnostics</p>	<p>All Trial Without Catheter (TWOC) – Elizabeth Williams Clinic (Llanelli) / Carmarthen Hub) Vasectomy (remove from Urology and place with sexual health team)</p>
<p><b>OPTION 3</b></p>	<p>OPD service and Day Surgery to remain</p>	<p>Emergency Urology only</p>	<p>Diagnostic Unit to include centralising services and all Elective Urology No longer utilising Endoscopy theatre space need to identify procedure rooms</p>	<p>OPD service and Day Surgical unit Diagnostic activity as current</p>	<p>Trial without Catheter to be undertaken in the Community venues across the HB.</p>
<p><b>OPTION 4</b></p>	<p>As per current Configuration – Outpatient and day case only inc Diagnostics (also cancer procedures) and minor ops under GA  Work with DNs to extend TWOC</p>	<p>Emergency Urology provision only  Work with DNs to extend TWOC  Move diagnostic activity from GGH to PPH</p>	<p>Urology diagnostics and elective services only, centralise urgency more for urgent cancer diagnostics outside of theatre. Work with DNs to extend TWOC  Urology diagnostics and elective services only, centralise urgency more for urgent cancer diagnostics outside of theatre. Work with DNs to extend TWOC  Use Anaesthetics room for GI, Urology and Endoscopy services (potential £3m cost) will need to find alternatives for Anaesthetics Increased capacity for GI &amp; Urology circa 10 sessions.  Urology acquiring the current Endoscopy suite in PPH as the Urology Investigation Unit</p>	<p>As per current Configuration – Outpatient and day case only inc Diagnostics (also cancer procedures) and minor ops under GA  Work with DNs to extend TWOC</p>	<p>Video consultation and Trial Without Catheter (TWOC) from: Cardigan, Aberaeron, Crosshands and Fishguard Integrated Care Centres  TWOC and video consultations TWOC services only from: Crosshands, Fishguard Integrated Care Centres and Llandovery and South Pembrokeshire Hospitals  Work with DNs to extend TWOC in the community</p>

# DRAFT

Service Area	Option	Bronglais	Glangwili	Prince Philip	Withybush	Community Sites
CRITICAL CARE	OPTION 1	GPICS Rural Critical Care, L2 and L3	Critical Care up to Level 3	Development of enhanced care medicine/surgery. Critical Care support anaesthetics to stabilise and transfer up to 24/7. Enhanced care outreach team. Post op care unit.	Development of enhanced care medicine/surgery. Critical Care support anaesthetics to stabilise and transfer up to 24/7. Enhanced care outreach team.	Current configuration - No activity at community sites
CRITICAL CARE	OPTION 2	GPICS rural Critical Care, L2 and L3 with Critical Care outreach team Centralise ICU consultant rota	Critical Care up to Level 3 Centralise ICU consultant rota	Development of enhanced care medicine / surgery - Critical Care support anaesthetics to stabilise and ACCTS to transfer up to 24/7. Enhanced care outreach team. Post op care unit consultant rota Centralise ICU	GPICS rural Critical Care, L2 and L3 (contingent on WGH acute service) with Critical Care outreach team Centralise ICU consultant rota	Current configuration – no activity at community sites
CRITICAL CARE	OPTION 3	Rural Critical Care	Level 3 Critical Care Centre	Make permanent current configuration, Level 2 and transfer Level 3 to Glangwili	Rural Critical Care	Current configuration – no activity at community sites
CRITICAL CARE	OPTION 4	Rural Critical Care	Level 3 Critical Care Centre	Make permanent current configuration, Level 2 and transfer Level 3 to Glangwili	Rural Critical Care	Current configuration – no activity at community sites
DERMATOLOGY	OPTION 1	Withdraw services	Withdraw services	Centralise all acute services to Prince Philip Hospital with additional space	Withdraw services	Provide services at Ceredigion Integrated Care Centre and Amman Valley Hospital only
DERMATOLOGY	OPTION 2	No Dermatology service	No Dermatology service	Keep Dermatology at PPH but need to grow it, link with Ophthalmology / ENT for shared space	No Dermatology service	Non acute minor surgery unit in Carmarthenshire plus additional 'spokes' in South Pembrokeshire.
DERMATOLOGY	OPTION 3	No Dermatology service	No Dermatology service	Consolidate in Prince Philip Hospital	No Dermatology service	Crosshands option for Paediatric Dermatology. Continue with Telederm and current Community provision ie Cardigan & South Pems. Utilising skills of GP's special interest
DERMATOLOGY	OPTION 4	No service	No service	Consolidate in Prince Philip or East of Health Board Best option for the service as Hub with spokes in community	No service	Dermatology Spokes in South Pems, Cardigan ICC (existing services) and Crosshands Future -Crosshands Hub Paediatric dermatology in the community, working alongside Health visitors — 1 day per week. Office space available

ERGENCY GENERAL SURG	OPTION 1	As per current configuration – 24 hour service	24 Hour cover provided for Glangwili, Prince Philip and Withybush Hospitals	Current configuration - No activity at site	All patients requiring admission sent to Glangwili. Development of surgical SDEC. 0730 – 2000, 7 days a week on call support or 9-5 on call support	Current configuration - No activity at community sites
ERGENCY GENERAL SURG	OPTION 2	As per current configuration – 24 hour service	Hybrid model: Withybush retains EGS	Current configuration - No activity at site	Hybrid model: Withybush retains EGS with exception of OOH to Glangwili	Current configuration –no activity at community sites
ERGENCY GENERAL SURG	OPTION 3	As per current configuration – 24-hour service	Emergency General Surgery including patients from Withybush Hospital Surgical SDEC would be required support the planned care services	Current configuration – no activity at site	Removal of Emergency General Surgery at WGH Surgical SDEC to be introduced, and patients requiring EGS to be transferred to Glangwili	Current configuration – no activity at community sites
ERGENCY GENERAL SURG	OPTION 4	As per current configuration – 24 hour service	Consolidate service from Withybush Hospital	Current configuration – no activity at site	Stabilise and transfer to Glangwili Hospital Development of surgical SAU / SDEC (reduce flow to GGH – day time) and ringfenced beds in Glangwili Invest in Training for before & after surgery care	Current configuration – no activity at community sites
OPHTHALMOLOGY	OPTION 1	Withdraw Service to centralise in Glangwili	Surgery is in Day Surgery Unit. Include Cataract and Intravitreal injection (IVT) services. E emergency eyecare (RACE) to be co-located to another department. Possible option for SDEC to run RACE.	Withdraw from site to centralise in Glangwili	Undertake Intravitreal injection (IVT) services only.	Reduce community footprint to just Cardigan Integrated Care Centre for diagnostics, North Road (Aberystwyth) for IVT and Outpatients. Withdraw service from South Pembro Hospital. Remove IVT from Amman Valley OPD. Cataract to remain. Maintain existing services in other community sites
OPHTHALMOLOGY	OPTION 2	As per current configuration – day case and inpatient services	Remove everything from Glangwili to PPH, with expansion of theatre hours into the evening and support for emergency clinic and procedure room overnight.	Centralise and expand in PPH with support for out of hours emergencies & evening theatre on-call staff. operate until 20:30	As per current Configuration – outpatient services only	Move to a single site in Carmarthenshire and a single site in Pembrokeshire, tbc. North Road Clinic - Non-emergency (other community sites for anything remaining) Cardigan - Current configuration
OPHTHALMOLOGY	OPTION 3	Elective Day Case & Inpatient only	Centralising in one main centre (Glangwili) Include cataract, IVT and RACE with the option of an SDEC	Withdraw from site and centralise in Glangwili	Age Related Macular Degeneration Services(AMD) only	North Road (Aberystwyth) all outpatient activity, Cardigan ICC Centre would be Diagnostic centre and would therefore remain as they are. Amman Valley AMD only. Remove services from Aberaeron ICC and South Pembro Hospital

OPHTHALMOLOGY	OPTION 4	Remove services from BGH (3 sessions per week) No cataracts or Surgery	Centralise to GGH if services move as below  Used DSU for Ophthalmology and cardiology to move Outpatients, ENT need area on Merlin Ward, Paeds Cilgerrin Ward.  Tysul would become surgical SDEC Use DSU Theatre for Ophthalmology(10 Sessions)	Remove services from PPH	Retain IVT / Age related Macular Degeneration services only	Remove services from Aberaeron Integrated Care Centre and South Pembrokeshire Hospital  Treatment room in Amman Valley Hospital to include high flow (Cataracts)  North Road Clinic stays as current configuration (IVT injections) and Cardigan Integrated Care Centre change to Diagnostics Centre
ORTHOPAEDICS	OPTION 1	Elective Inpatient and Day case services only. Bronglais to create ringfenced area (BOA Standards)	No elective services, trauma only	Regional working services with Swansea Bay. Inpatient and Day Case Complex elective services inc Arthroplasty	High volume, low complexity Day Case Orthopaedic services	Current configuration - No activity at community sites
ORTHOPAEDICS	OPTION 2	Elective and Emergency – x5 theatre sessions bed inpatient and Day Case (as current config.) when meeting BOA guidance	No elective, trauma only	Elective Inpatient and Day Cases – demountable unit. – can be increased  Possibly to include regional	Elective services and extend day capacity (23:59 model), high volume / low complexity Day Cases  Elective services and extend day capacity model, high volume / low complexity Day Cases	As per current configuration - no Inpatient or Day Case activity at community sites, limited outpatient clinics at some sites
ORTHOPAEDICS	OPTION 3	Inpatient and Day Case Elective Orthopaedics  Outpatient service	No elective services, trauma only  Outpatient service	Become an Orthopaedics centre of excellence. Carry out Complex elective services inc Arthroplasty as Inpatients and Day Cases  Outpatient service	Day case Centre of Excellence  High volume, low complexity orthopaedic services (day cases)  Outpatient service	Current configuration – no Inpatient or Day Case activity at community sites, limited outpatients at some sites Tenby, Cardigan, Towyn (consider xray facilities)
ORTHOPAEDICS	OPTION 4	Bronglais Hospital – 5 out of 5 ultra clean theatre sessions available for Inpatients and Day cases  No change in service  May use DSU 3 if Ophthalmology come out (circa 3 sessions)  2 x 4 bedded bays at present, would need additional beds  IMTP November 2021 identifies the change of services.	No elective services, trauma only as current configuration  No change	Main theatres and Day Surgery Unit at full capacity. 6 day working funded services in DSU. Complex elective Inpatient and Day Case services inc Arthroplasty  DSU release main for Inpatient, would increasing staffing inc support services to achieve this  Move more day case sessions to Withybush to free up capacity for IP if emergency surgery moves  Regional Work is Key to delivery	Main Theatres and Day Surgery Unit at full day case capacity  Maintaining the current service  Look at - Same day admit and discharge – increase to model  Proposal to move orthopaedics from DSU PPH to WGH – 10 sessions (urology, endoscopy/derm movements)  Orthopaedics plus some smaller associated day case work to WGH for day surgery out of PPH DSU	Current configuration – no Inpatient or Day Case activity at community sites, limited outpatients at some sites
STROKE	OPTION 1	Treat and transfer to appropriate Acute Stroke unit	Treat and transfer to appropriate Acute Stroke unit	Acute Stroke Unit and rehab beds	Acute Stroke Unit and rehab beds	Current configuration - No activity at community sites

STROKE	OPTION 2	Treat and transfer to Stroke unit Use of virtual assessments	Treat and transfer to Stroke unit Use of virtual assessments	Hyper Acute Stroke Unit (first 72 hours) for Health Board and specialist rehab	Acute Stroke Unit, includes specialist rehab	Community Stroke service: ESD - Early supported discharge Home first Stroke rehab at home
STROKE	OPTION 3	Treat and transfer to Stroke Unit.	Treat and transfer to Stroke Unit.	Acute Stroke Unit. Rehab beds	Acute Stroke Unit. Rehab beds	Current configuration – South Pems, Tregaron and Amman Valley for general rehab. Early Supported discharge across the Health Board
STROKE	OPTION 4	Treat and transfer to Stroke Unit (current service not sustainable as only one consultant providing service)	Treat and transfer to Stroke Unit	Acute Stroke Unit Stroke Consultants in place	Acute Stroke Unit Stroke Consultants in place	Rehab at community hospitals
RADIOLOGY	OPTION 1	Elective diagnostic/intervention and emergency daytime only	Emergency diagnostic/intervention services only	Elective diagnostic/intervention and emergency daytime only	Elective diagnostic/intervention and emergency daytime only. Nuclear medicine	X-Ray services in Cardigan Integrated Care Centre and Tenby Hospital Only
RADIOLOGY	OPTION 2	Interventional (biopsies) 5 days Monday to Friday Radiology general services expand to 7-day service	Interventional (biopsies) 5 days Monday to Friday Radiology general services expand to 7-day service Infrastructure issues at Glangwili New pathway for OOH cases	Interventional (biopsies) 5 days Monday to Friday Radiology general services expand to 7-day service Cancer focus	Interventional (biopsies) 5 days Monday to Friday Radiology general services expand to 7-day service Cancer focus	Imaging in outpatient sessions in a Medical Administration HUB / Regional Diagnostic Centre. Community X-ray – Tenby Hospital & Cardigan Integrated Care Centre
RADIOLOGY	OPTION 3	Diagnostics (CT MRI & US) and interventional procedures	Diagnostics (CT MRI & US) and interventional procedures	Diagnostics (CT MRI & US) All interventional procedures to be undertaken at BGH&GGH	Diagnostics (CT MRI & US) All interventional procedures to be undertaken at BGH&GGH	Remove services from Llandovery and South Pems hospital X-Ray services in Tenby and Cardigan
RADIOLOGY	OPTION 4	Interventional (biopsies) 5 days Monday to Friday (not available every day) Radiology general services expand to 7-day service	Interventional (more complex) 24/7 radiology general services expand to 7-day service	Interventional (biopsies) 5 days Monday to Friday radiology performed here due to airflow systems radiology general services expand to 7-day service	Interventional (biopsies) 5 days Monday to Friday radiology general services expand to 7-day service	Remove service from South Pems and Llandovery Hospitals due to small number of inpatients, most come to Withybush. X-ray only in Tenby Hospitals
ENDOSCOPY	OPTION 1	Maximise session capacity in JAG accredited unit	Maximise session capacity. Paediatric elective services (low volume)	Maximise session capacity Explore opportunity for Prince Philip Hospital to provide respiratory and urology diagnostics. Explore opportunity to centralise respiratory & urology endoscopy to PPH. (aspiration to have 3 room JAG accredited unit) There is a need to review available space in Prince Philip	Maximise session capacity	Current configuration - No activity at community sites

ENDOSCOPY	OPTION 2	Joint Advisory Group (JAG) accredited services/ Emergency	Joint Advisory Group (JAG) accredited services/ Emergency	Not JAG accredited, Urology to take some Endoscopy and Bronchoscopy focus in Hub Make it 3 units & bowel screening A specialist Bronchoscopy and Urology diagnostic treatment unit with GI	Joint Advisory Group (JAG) accredited services/ Emergency	Current configuration – no activity at community sites
ENDOSCOPY	OPTION 3	JAG accredited service All aspects of GI including inpatients Opportunity to work with Powys & South Gwynedd to meet demand of this population	JAG accredited Service Maximising current provision of service (All aspects of GI including inpatients also out of hours interventional Endoscopy for HB) Remove Respiratory & Urology to maximise capacity for GI	No JAG accreditation Take out Urology sessions - to be accommodated elsewhere - ? day surgery GI and respiratory to remain (inc. GI inpatients) – maximising already staffed 20 sessions (JAG accreditation would not be possible – as no changes to theatre flow) Consider partnership working with Swansea Bay for GI – to accommodate growing BSW demand	JAG accredited service Service sustained as is at Bronglais Hospital (All aspects of GI including inpatients)	Current configuration – no activity at community sites however to scope options for diagnostic/Bowel Screening Wales
ENDOSCOPY	OPTION 4	As per current configuration with Possible additional 2nd room for small procedures	As per current configuration with additional sessions released from Bronchoscopy and Urology lists for GI activity.	Centralise Urology and Bronchoscopy diagnostics to site. GI to remain (will be left with a deficit of 9 sessions if Respiratory/Urology solely implemented) Use Anaesthetics room for GI, Urology and Endoscopy services (potential £3m cost) will need to find alternatives for Anaesthetics Increased capacity for GI & Urology circa 10 sessions.	As per current configuration	Current configuration – no activity at community sites
UROLOGY	OPTION 1	Continue current Outpatient service only	Emergency Urology only	Urology diagnostics, elective and cancer services (need to ensure capacity needs for GI & respiratory endoscopy also met)	As per current configuration – outpatient and day case	Aberaeron Integrated Care Centre, Cross Hands and South Pembrokeshire Hospital undertake Trial Without Catheter services Carmarthen Hwb undertake vasectomy
UROLOGY	OPTION 2	Diagnostics (due to Powys population) Equity of access –Consider Urology week for surgery on a monthly basis	No elective - Emergency pathway only. Move electives to Prince Phillip & free up 2 procedure rooms	Create diagnostic hub – take some endoscopy focus	Outpatients and day case only - diagnostics	All Trial Without Catheter (TWOC) – Elizabeth Williams Clinic (Llanelli) / Carmarthen Hub) Vasectomy (remove from Urology and place with sexual health team)
UROLOGY	OPTION 3	OPD service and Day Surgery to remain	Emergency Urology only	Diagnostic Unit to include centralising services and all Elective Urology No longer utilising Endoscopy theatre space need to identify procedure rooms	OPD service and Day Surgical unit Diagnostic activity as current	Trial without Catheter to be undertaken in the Community venues across the HB.

**UROLOGY**

<p><b>OPTION 4</b></p>	<p>As per current Configuration – Outpatient and day case only inc Diagnostics (also cancer procedures) and minor ops under GA</p> <p>Work with DNs to extend TWOC</p>	<p>Emergency Urology provision only</p> <p>Work with DNs to extend TWOC</p> <p>Move diagnostic activity from GGH to PPH</p>	<p>Urology diagnostics and elective services only, centralise urgency more for urgent cancer diagnostics outside of theatre. Work with DNs to extend TWOC</p> <p>Urology diagnostics and elective services only, centralise urgency more for urgent cancer diagnostics outside of theatre. Work with DNs to extend TWOC</p> <p>Use Anaesthetics room for GI, Urology and Endoscopy services (potential £3m cost) will need to find alternatives for Anaesthetics</p> <p>Increased capacity for GI &amp; Urology circa 10 sessions.</p> <p>Urology acquiring the current Endoscopy suite in PPH as the Urology Investigation Unit</p>	<p>As per current Configuration – Outpatient and day case only inc Diagnostics (also cancer procedures) and minor ops under GA</p> <p>Work with DNs to extend TWOC</p>	<p>Video consultation and Trial Without Catheter (TWOC) from: Cardigan, Aberaeron, Crosshands and Fishguard Integrated Care Centres</p> <p>TWOC and video consultations TWOC services only from: Crosshands, Fishguard Integrated Care Centres and Llandovery and South Pembrokeshire Hospitals</p> <p>Work with DNs to extend TWOC in the community</p>
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