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

COFNODION Y CYFARFOD BWRDD IECHYD PRIFYSGOL
HEB EU CYMERADWYO / UNAPPROVED
MINUTES OF THE UNIVERSITY HEALTH BOARD MEETING

Date of Meeting:	**Wednesday 18 and Thursday 19 February 2026**
Venue:	**Y Stiwdio Fach, Canolfan S4C Yr Egin, College Road, Carmarthen SA31 3EQ**

Date of Meeting:	**9:00am, Wednesday 18 February 2026**

Present:	Dr Neil Wooding, Chair, Hywel Dda University Health Board Mrs Eleanor Marks, Vice-Chair, Hywel Dda University Health Board Mr Maynard Davies, Independent Member (Information Technology) Cllr. Rhodri Evans, Independent Member (Local Authority) Ms Sarah Harraway, Independent Member (Community) Mr Michael Imperato, Independent Member (Legal) (part) Ms Ann Murphy, Independent Member (Trade Union) Mr Neil Prior, Independent Member (Community) Mrs Chantal Patel, Independent Member (University) Mr Iwan Thomas, Independent Member (Third Sector) Professor Philip Kloer, Chief Executive Mrs Lisa Gostling, Deputy Chief Executive and Executive Director of Workforce and Organisational Development Mr Andrew Carruthers, Chief Operating Officer Ms Sharon Daniel, Executive Director of Nursing, Quality and Patient Experience (VC) Mr Lee Davies, Executive Director of Strategy and Planning Dr Ardiana Gjini, Executive Director of Public Health Mr Mark Henwood, Executive Medical Director Mr James Severs, Executive Director of Allied Health Professions and Health Science Mr Huw Thomas, Executive Director of Finance
In Attendance:	Ms Alwena Hughes Moakes, Communications and Engagement Director Mrs Joanne Wilson, Director of Corporate Governance/Board Secretary Ms Alyson Thomas, Llais West Wales Mr Ben Rogers, Principal Programme Manager Ms Nichola Couceiro, Head of Engagement Ms Yvette Pellegrotti, Principal Programme Manager Mr Alex Martin, Principal Programme Manager Ms Sarah Isaac, Clinical Lead, Transformation Programme Office Ms Kathy Graham, Hugh Irwin & Co. Associates (HICO) Ms Cathie Steele, Interim Assistant Director of Nursing Assurance and Safeguarding Mr Andrew Deans, Consultant Colorectal Surgeon, Clinical Lead for General Surgery (part) Ms Caroline Lewis, Service Delivery Manager ENT & General Surgery (part) Dr Michael Martin, Clinical Director Theatres, Critical Care & Anaesthesia (part) Ms Diane Knight, Service Delivery Manager for Critical Care (part) Dr Senthil Kumar, Consultant Physician, Clinical Lead for Stroke (part) Dr Eiry Edmunds, Interim Deputy Medical Director (part) Ms Bethan Andrews, Assistant General Manager (part)

Ms Victoria Coppack, Service Delivery Manager, Ophthalmology & Neurology (part)
Mr Ihab Abbasi, Associate Medical Director Planned and Specialist Care (part)
Ms Lianne Gregory, Service Delivery Manager, Trauma & Orthopaedics and Plaster Services (part)
Mr Fred Schreuder, Consultant Plastic Surgeon (part)
Ms Ceri Wisdom, Service Delivery Manager, Dermatology, Outpatients, Pain and Oncology (part)
Mr Ngiaw Khoon Saw, Consultant Urologist and Clinical Director Planned Care & Specialist Service (part)
Dr Faiz Ali, Consultant Gastroenterologist & Lead for Endoscopy (part)
Ms Sara Jones, Service Delivery Manager, Endoscopy and Gastroenterology (part)
Dr Liaquat Khan, Clinical Director Radiology (part)
Ms Sarah Procter, Deputy Head of Radiology (part)
Ms Clare Moorcroft, Committee Services Officer (Minutes)

Minutes Ref.	Item	Action
PM(26)35	**Welcome and Apologies**	

Dr Neil Wooding, Health Board Chair, welcomed everyone to the Extraordinary Public Board meeting, thanking them for their attendance. He was conscious of the commitment involved for all staff, including clinical colleagues due to join over the course of the day. Dr Wooding also recognised that the public will be actively engaged in the meeting, and thanked them for their commitment and passion to healthcare services in Hywel Dda. The meeting will follow two distinct 'pathways' in format; with today's session being around the detail surrounding each of the nine clinical services under consideration, and:

- Understanding
- Factual representation
- Enquiry
- Discovery
- Ensuring good governance
- Processing of information

Tomorrow's session will focus on decision-making around each clinical service. It is hoped that a clear 'direction of travel' will be reached by lunchtime tomorrow.

In terms of context and background, Dr Wooding reminded Members that the fragility of certain services and the need to remediate this had been recognised some time ago. To this end, a period of consultation had been undertaken, comprising a three year enterprise. Dr Wooding wished to provide Members with two reference points to apply to their considerations: firstly, the five decision-making 'design principles' routinely utilised by the Board:

1. Fair
2. Affordable/sustainable
3. Consistent with the Health Board's strategic approach

4. Does not create an unhelpful precedent
5. Safe

Secondly, the broader values and principles which should underpin Health Board services:

Safe
Sustainable
Accessible
Kind

By applying these two reference points in decision-making, this will provide a robust framework, and ensure accountability and consistency. Dr Wooding also wished to reflect on the fact that the Board's and wider organisation's focus has been on the nine services in the Clinical Services Plan and the impact on the Health Board's sites. However, the impact of changes in the healthcare sector will not only impact on west Wales. Hospitals have profoundly changed, and will continue to do so, due to:

- Advances in healthcare, research and excellence; bringing teams together to share insight, understanding and expertise
- The shift towards provision in Primary Care and the community
- The growth in use of digital, automation and Artificial Intelligence (AI)

As a result, every hospital in Wales and the UK will also need to change. The process being discussed now offers an opportunity to determine how changes are applied in west Wales. Dr Wooding recognised, however, the need to build a trustful environment in order to take these changes to healthcare forward. Whilst discussions today and tomorrow focus on nine services, there is also a broader context of which cognisance is required.

In terms of 'housekeeping', Members were informed that simultaneous translation English to Welsh and Welsh to English is being offered, as is British Sign Language translation. Dr Wooding thanked the translators who would be providing this over the next two days. Members and speakers were reminded of the strict timescales which are necessary to ensure that all topics are covered, and the need to be concise. Finally, Dr Wooding wished to recognise the significant work which has been involved in reaching this point.

Mrs Joanne Wilson indicated that a letter regarding the process has been received from Llais, which has been shared with Members, added to their supporting documents and published on the Health Board webpage.

Apologies for absence were received from:

- Mr Winston Weir, Independent Member (Finance)
- Dr Jonathan Arthur, Health Professionals Forum Chair
- Ms Donna Coleman, Llais West Wales

- Mr Michael Gray, Director of Social Services and Housing, Pembrokeshire County Council
- Ms Mwape Burke, participant in the Aspiring Board Members Programme
- Ms Marta Barreiro Martins, Senior Nurse Manager Ophthalmology

PM(26)36 Declaration of Interests

Mrs Chantal Patel declared an interest in items PM(26)49 and PM(26)50, noting her employment with Swansea University. She would withdraw from discussions at the relevant juncture.

PM(26)37 Clinical Services Plan Background and Public Consultation Findings

Mr Lee Davies introduced the first section of the meeting, focusing on the background to the Clinical Services Plan (CSP) and the findings of the public consultation. He had three key comments in this regard:

Firstly, he wished to record his thanks in particular to Ms Sarah Isaac, Ms Nichola Couceiro, Mr Alex Martin, Mr Ben Rogers and Ms Yvette Pellegrotti. The quality and depth of their work is reflected in documents provided to support Board decision-making. Also, to the clinical and service staff, for their contribution both to consultation events and for their attendance today. Finally, to the communities and public of Hywel Dda, for their valuable involvement in the process.

Secondly, Members were reminded that the genesis of today's discussions goes as far back as 2018 and beyond. The unsustainable nature of services, and the need to enact change, was identified at that point. This included the need to make changes to the configuration of hospitals. Since this time, the Health Board has seen a number of urgent temporary changes implemented in response to service fragilities, which reflects the ongoing service pressures. The CSP proposals seek to identify ways in which to respond proactively, rather than reactively to such challenges. Also, to raise expectations and standards in service delivery, and set the correct foundations for the future.

Thirdly, whilst today and tomorrow are important, they represent only the next stage of the process. Implementation following decision-making will require further careful consideration. Mr Lee Davies emphasised that change will not be immediate; it will develop over a period of time and involve further presentations and discussions at Board.

Referencing the CSP Board Briefing Plan presentation, Mr Ben Rogers introduced the slides titled 'Post Consultation Activities'. He drew Members' attention to the number of products covered in the programme and the key programme materials produced following the consultation, as well as the analysis developed during Phase 2 of the Clinical Services Plan programme. These

included an independent consultation report from Opinion Research Services; the alternative options previously shared with the Strategy and Planning Committee (SPC); the findings from the Quality Safety and Experience Committee (QSEC) sessions that took place with reference to the services in the CSP; the informing plan and the processes of conscientious consideration. There were also a number of other products that were produced post-consultation. These included the Phase 3 Closing Report, which brings together our key programme outputs, including the alternative options appraisal and shortlisting workshop findings; updated programme impact assessments covering quality, health equality, and environmental impact assessments; estimates and indicative assessments for capital, workforce, and financial estimates. Together with all of today's materials, these represent only the top layer of the 'information pyramid'.

Members were advised that Hugh Irwin & Co. Associates (HICO) are providing quality assurance, based on the Centre for Consultation framework. Ms Kathy Graham explained the process of quality assurance applied to the consultation process. Whilst these are described as stages, they are not all approached in a linear fashion; some are concurrent. The first stage had considered what happened before the consultation was actually launched, including the depth and extent of engagement and the options development appraisal process, to ensure that the correct stakeholders were engaged throughout that process. The next stage was concerned with scoping and governance, making sure that there is a clear definition for the consultation and the process. It defines the decisions that have already been taken, that stakeholders cannot influence; and lines of accountability. Consultation information focuses on whether clear, accessible pieces of information are going out into the public domain. Also, whether the public, stakeholders and others are clearly signposted to all the technical intelligence that has helped to develop the options being consulted upon. The consultation planning is also assessed; to consider how the stakeholders have been analysed and mapped, how they are communicated and engaged with. Consultation delivery concerns the extent to which people are being engaged, if there are any complaints being raised, and how any further requests for information are those being addressed. This seeks to ensure there is no misinformation and, if there is, establish how it is being addressed in 'real time'.

There are two milestones within this process: a midpoint, which then allows development of an action plan to address any points of clarity or complaints; and a closing point review, approximately ten days before the consultation is due to close. Then the process moves on to analysis and reporting (referenced in the consultation report that ORS provided) to ensure that it is a fair representation of everything that was heard, and that there is no bias. This brings the process to today; the feedback and decision-making. Ms Graham emphasised that quality assurance does not involve any decisions being made, only the process which has been undertaken. The final stage is completion, where the conclusion of

the quality assurance process is stated. She was pleased to report that all stages have been, in HICO's view, completed in a robust and vigorous manner. Letters have been issued to this effect.

Ms Nichola Couceiro reminded Members that various forms of engagement had been undertaken. She presented a slide which outlined cross-cutting themes identified by the consultation findings. These included:

- Concerns around travel, transport and rural geography
- Risks in terms of workforce shortages and staffing problems
- Interconnections between services and the need for a holistic view
- Concerns regarding the condition of buildings and available infrastructure
- Fragility in trust and confidence in the process
- The need to ensure that digital and virtual services are embedded as a core part of care, not added on
- The importance of protecting equality, the Welsh language and rural communities

There is also service-specific feedback, which will be reported and considered during the course of the meeting.

Mr Rogers indicated that there had been a significant level of responses around alternative options, which had come in a variety of formats. An options log had been created to record these and all alternative options had to be tested with services. 287 ideas were received during the public consultation; following review, and removal of duplicates and those outside of scope, 190 alternative options were formally assessed against the hurdle criteria. 22 were taken forward for a more detailed evaluation by the Options Development Group using a Strengths, Weaknesses, Opportunities and Threats (SWOT) analysis. All alternative options were scored in the same way as the original options and contribute to the information presented today. So, of the 48 potential options being considered, 22 were generated during the public consultation process.

Dr Wooding welcomed this information, suggesting that it reflects a healthy position in terms of public and stakeholder contribution. He queried, however, whether – if there is an alternative option which the Board wish to take forward – additional consultation would need to be undertaken. In response, Ms Couceiro advised that, in certain cases, alternative options are closely aligned to options already consulted upon. Others are considerably different, and the information required around potential impacts of service models would not have been considered or consulted upon. Basically, it would require a case-by-case approach.

Ms Sharon Daniel, Executive Lead for QSEC, presented the QSEC Deep Dive summary. She wished to emphasise at the outset that the deep dives conducted by QSEC were entirely separate from the Clinical Services Plan. They were not part of the

CSP process, they did not shape the CSP options, and they were not influenced by them. Their purpose was simple: to give the Board and the public assurance about the quality, safety and experience of care happening at the present time in these services. The deep dives allowed QSEC to ask a number of very direct questions:

- Are patients receiving safe and compassionate care today?
- Where are the risks?
- What is being done to manage those risks while we await longer term decisions?

In terms of process and findings:

CSP neutrality and QSEC focus
Everything examined considered the current delivery of services; not the future model, not the options. This protected the integrity of both processes. The deep dives informs assurance; the CSP informs strategy. QSEC took a very structured and consistent approach. For every service it considered:

- The nature of the fragility
- The quality and safety issues in front of us
- What is improving
- What is still at risk
- What mitigations are in place

This provided a robust and fair comparison across all nine areas.

Assurance is mixed
Across the nine services, QSEC did take assurance – often strong assurance – in several areas. In some services, however, particularly Dermatology, Critical Care and Emergency General Surgery, the level of fragility meant that assurance was only partial. Teams are doing their very best, but the risks remain significant and visible.

- Dermatology: One of the most fragile services. National consultant shortages, rising cancer demand, and limited estate all contribute. Only partial assurance could be given and the risk was subsequently escalated to Board.
- Critical Care: This is a committed clinical team working under significant pressure. Consultant shortages and variations in transfer practice between Glangwili Hospital (GGH) and Prince Philip Hospital (PPH) add complexity. The fragility here remains real and under active review.
- Emergency General Surgery: The service has had long standing rota instability at Withybush Hospital (WGH), including periods of agency reliance. Whilst recruitment approvals had been agreed, and Getting It Right First Time (GIRFT) actions completed, the service remains fragile.

Workforce is the critical dependency
The thread that runs through every single deep dive. Whether this be consultant numbers, SAS doctors, specialist nurses, therapy staffing in stroke, or sonographers in radiology; the single biggest constraint across fragile services is workforce. Without stabilisation in these areas , fragility will continue.

Operational recovery is real, but fragile
QSEC identified that there are some areas of improvement:

- Endoscopy has reduced waiting times from around 100 weeks to 8
- Urology has eliminated all patients waiting over 52 weeks
- Orthopaedics has improved prehabilitation, communication and reduced incidents

However, and crucially, QSEC was acutely aware that these gains rely on actions such as weekend activity, insourcing, temporary outsourcing, and goodwill. Whilst positive, they are not yet robust.

Interdependencies matter
One of the strongest messages from the deep dives is that fragility rarely sits neatly within one service.

- Diagnostics affect surgery
- Theatres affect orthopaedics and urology
- Radiology affects stroke
- Cross-site flow affects both Critical Care and Emergency General Surgery

In a dispersed geography like Hywel Dda's, interdependencies amplify risk.

Patient experience remains strong where access improves
Where there is improved access – particularly in Endoscopy, Urology and Orthopaedics – patient experience is consistently positive. Patients are clear that staff are kind, compassionate and committed. Where frustrations remain, they are almost always about access, not about the quality of the care once received.

Targeted actions for 2026
QSEC identified clear priorities going forward into 2026:

- Continue efforts in recruitment and retention for the hardest to fill roles
- Protecting the temporary enablers that are supporting recovery
- Strengthening governance in areas like Critical Care Standard Operating Procedures (SOPs), stroke performance, and Emergency General Surgery rota risks
- Maintaining close oversight while CSP decisions move towards implementation

What this means for the Board
Across all nine deep dives, the message is consistent:

- Care is being delivered safely and professionally by dedicated teams
- Improvements are visible but not yet resilient
- Workforce fragility is the dominant system risk

- Some services require continued Board attention, particularly Dermatology, Critical Care and Emergency General Surgery
- This work provides an independent baseline of assurance that sits alongside – and not within – the CSP

Next steps
QSEC recommends that the Board:
1. Endorse targeted risk actions in the highest risk services.
2. Prioritise workforce investment in the most fragile posts.
3. Protect the operational enablers sustaining recovery.
4. Strengthen governance follow through, particularly in SOP-driven areas.
5. Maintain close QSEC scrutiny as the CSP moves into decision and implementation phases.

Finally, Ms Daniel wished to reflect that, whilst services may be fragile, the commitment, compassion and professionalism of Health Board staff came through strongly in every deep dive. These deep dives provide a clear picture of the present – independent of the CSP – and help to understand the context of the implementation of tomorrow's decisions.

Professor Kloer thanked Ms Daniel for this information. He recognised the importance to the process of QSEC's view, given that the whole CSP process has been driven by a desire to make improvements in services and concerns around a number of services being fragile. For clarity, Professor Kloer explained that QSEC is the Health Board's Quality, Safety and Experience Committee. This is the committee, that, on behalf of the board, considers all matters relating to quality, safety and experience. Secondly, where it has been highlighted that there was partial and mixed assurance, this relates to concerns around the fragility of services not to concerns around the process itself.

Ms Alwena Hughes Moakes felt it important to confirm that the Health Board has also considered the Welsh language as part of this process. The Welsh Language Commissioner's office has been consulted to assess the effects of the CSP on the Welsh language. The organisation has mapped out where Welsh language speakers are across the region's geography and across the services. However, because any option which might be selected is dependent on individuals, it is extremely challenging to measure the impact of those changes. In view of this, it is intended to put in place actions to promote the Welsh language. This may include recruitment of staff, and supporting staff to strengthen their Welsh language skills, or to learn Welsh. These actions are designed to ensure that the needs of communities are reflected as implementation is taken forward. There will be further work to assess Welsh Language impacts post service decisions, to inform implementation plans and mitigations.

Ms Alyson Thomas enquired whether, in relation to the gathering of patient experience, there was any significant variation between the services considered during the deep dive. In response, Ms

Daniel advised that there was no significant variation. The feedback from patients was very positive, with it suggested that they are generally content with the compassion and quality of care. The main issue expressed was around access to care.

With regard to the informing plan, Ms Yvette Pellegrotti advised that, during November and December 2025, stakeholders had reviewed the draft consultation report and key headlines. The next slide presents a high-level summary of their feedback on the findings. This informed development of the informing plan, which also outlined any significant changes since the issues paper was published in 2024, and included feedback on the alternative options. Stakeholders raised a series of recurring themes, which closely align with, what was heard during the consultation:

- Travel and transport remain the most significant and consistent concern, with strong views around infrastructure and impact on rural, older, and more deprived communities
- Centralisation of services created widespread concern, particularly around disproportionate impact on areas such as Ceredigion and Pembrokeshire, compared with more central locations and issues of fairness, accessibility
- Stroke services attracted the strongest concerns, with stakeholders highlighting risks to timely access, especially the 'golden hour', and concerns about family access during rehabilitation. There was also uncertainty around how the 'Treat and Transfer' model would operate safely
- Workforce fragility remained a prominent theme, with pressures in therapies, radiology, and specialist consultant roles highlighted as critical risks to deliver any future model safely. Many felt the proposed options may not fully address these challenges
- Service independencies were emphasised, with stakeholders seeking clearer explanations of how radiology, therapies, pathology and primary and community care would fit together with the proposed models, and what mitigations would be required
- Equality concerns continue to feature strongly, including concerns about deprivation, the Welsh language impacts, digital exclusion, transport barriers, and impact on vulnerable groups. Suggested mitigations were consistent with that of the consultation findings

Earlier in January, Board members met to conscientiously consider the draft consultation findings and the work undertaken on the informing plan. The next slide summarises the key points raised during discussion; full details are within the closing report:

- Changes to services since the issues paper was published in 2024 were not viewed as significant. Nothing that has happened alters the need for change or the overall direction of travel

- The weighting of responses needs careful consideration, as feedback from more populated areas should not unintentionally carry greater influence. This is not a popularity exercise, and rural perspectives must not be overshadowed
- Service independencies require careful interpretation, as an impact noted in the feedback does not necessarily mean a service could no longer be delivered
- Further clarification on clinical interdependencies is needed, particularly in understanding how different services rely on one another within the proposed models
- Travel and access remains a complex issue, especially when balancing proximity and quality
- Expectations differ for urgent and planned care, and the quality impact assessments are important in understanding potential impact and required mitigations
- There is also a need to balance community concerns with clinical, workforce, and financial realities, and to demonstrate alignment with the wider organisational strategy by recognising the organisation's statutory financial duties, recognising finance is not the primary driver
- Representativeness was also discussed, with reflection on lower participation from children and young people and the need to ensure seldom-heard voices and insights from face-to-face engagements are considered alongside the survey data
- Finally, no single option will satisfy all stakeholders; clear and sensitive communication will be essential, with a continued focus on achieving the best possible outcomes for patients

Moving to the next few slides, Mr Alex Martin focused on the evaluation criteria referenced earlier. The 16 criteria were developed with the aid of the Clinical Reference Group, which considered best practice from elsewhere and criteria used previously. Whilst they set out how the options are assessed, a degree of subjectivity is involved, given that there are nine very different services, with different needs, and different patient groups. For example, different services are working to different standards. The metrics that sit behind the criteria have previously been submitted; there is a 'blend', with some being quantitative, and others being based more on professional judgment. In terms of weighting, at the moment, those 16 are equal, with equal impact in scoring. Meaning that an option which focused on improving standards may not necessarily be reflected as well as an option that improved workforce sustainability. The wider Options Development Group, which included patient representatives and third sector organisations, was asked to support a scoring exercise, to provide weighting scores. The scoring of options reported later as part of the service presentations has this weighting applied.

The criteria have been aligned to principles around 'A Healthier Mid and West Wales': Safe, Sustainable, Accessible, Kind services and to the Duty of Quality: 'Safe', 'Timely', 'Effective', 'Efficient', 'Equitable' and 'Person-centred' (STEEEP). There is

confidence that the criteria allows the organisation to meet the Duty of Quality. Moving onto the slide detailing Criteria Weighting, the top scoring criteria are mainly around sustainability (2.1). To provide context in terms of options and scoring, this will take the following format:

- The case for change, and the data being used to inform it
- Why this matters; what it means for staff and patients
- A recap of the options presented in the consultation and the consultation findings, as well as the engagement feedback
- Alternative options and the scoring of those options
- The options that best meet, potentially, the evaluation criteria
- Discussion of the issues and options by Board Members

Members should note that the top scores from the Options Development Group scoring have been used, which do not always align with the consultation outputs. For certain options, there is very clear alignment between what the public and staff felt in the consultation, and the view of the Options Development Group. For others, there is a difference. With regard to phasing, it should be noted that, to deliver certain of these options, work would be required in relation to identifying the finance or the workforce to enable delivery. It has been suggested that this will require 2-4 years; however, in some cases it may take longer. Therefore, decisions around certain options represent a commitment to the option, rather than a firm commitment to delivering the change within 2-4 years. There is a need to ensure this can be achieved sustainably and safely. Phasing may also involve a longer term (4+ years), where a significant capital investment is required, such as the development of hubs, as proposed in some of the options, or alignment with the longer-term 'A Healthier Mid and West Wales' AHMWW Strategy. On the next slide there is an overview of the options, which is also shared elsewhere, and is included here as a visual representation of progress. It attempts to demonstrate areas of commonality and variance between options. For all services with the exception of Dermatology, there are alternatives to consider. Whilst there were alternatives suggested for Dermatology, these did not meet the hurdle criteria.

Dr Wooding wished to offer a summation prior to the next section. He felt confident that the process has been rigorous and dynamic, particularly in view of the number of alternative suggestions made and considered. Also, that it has been an honest process, genuinely undertaken. He hoped that the information offers reassurance in this regard. Further, the process provides an opportunity to reflect on the insight and contribution of communities and stakeholders and the value this can offer. This does not necessarily make the Board's task any easier, given the number of elements which need to be considered and managed. However, it is not appropriate for the Board to accept services which are less than the best required. Where it is empowered to make decisions to deliver better services, the Board is compelled to do so. Services must be Safe, Sustainable, Accessible, Kind and robust.

PM(26)38 **Acute Services**

Mr Lee Davies indicated that the next section will look at the individual services in more detail, and will include input from colleagues in those services. Ms Sarah Isaac drew Members' attention to the next slide in the presentation, setting out the order in which the decision-making material will be considered:

- Acute services – Emergency General Surgery, Critical Care and Stroke. These services are presented first because they have the highest clinical interdependencies and influence the configuration of subsequent services. Decisions here shape the feasibility and flow of options across the entire system
- Planned Care – Ophthalmology, Orthopaedics, Dermatology and Urology
- Diagnostic services – Endoscopy and Radiology. Diagnostics are critical enablers, and changes here directly affect both acute and planned care pathways, so it is important that they follow sequentially

Discussions will consider how each option performs against the evaluation criteria, consultation responses, and the operational considerations linked to sustainable delivery.

Finally, the role of the main hospital sites will be considered. This brings together the interdependencies, the consultation feedback, and the strategic fit. It is intended to help the Board to consider the implications at system level before moving into decisions. Overall, this order is designed to support a logical flow, starting with the clinically interdependent services and ending with the whole system implications for the estate and site roles.

Emergency General Surgery

Mr Andrew Deans and Ms Caroline Lewis joined the Board meeting.

Drivers for Change
In introducing this section, Mr Andrew Deans suggested that it would be useful to consider why there is a need to review the Emergency General Surgical service. There were two key drivers for this: firstly currently there are two acute surgical takes in the south of the Health Board, both of which have extremely fragile consultant and middle grade rotas. Despite two recent consultant appointments to GGH, there are still fewer consultants on the on-call rota than 15 years ago. The situation in WGH is even more fragile. For many years, there has been a reliance upon NHS and agency locums to maintain the rota. These come with a great cost pressure and variable quality and performance. The recent consultant appointment to WGH has reduced the requirement for an agency locum, but a 1:4 rota remains a very precarious situation. The second key driver is that, in the recovery from COVID-19, General Surgery engaged with the GIRFT process. One of the key recommendations from this was that the Health

Board should have a single centre in the south of the Health Board performing Emergency General Surgery. It was commented that both the GGH and the WGH services are dealing with very small numbers and amalgamating the service would create a higher volume centre. This inevitably drives quality, and most importantly, improves outcomes for patients. Finally, a number of options are dependent upon Same Day Emergency Care (SDEC). In the two years since establishment of the SDEC at GGH, it has had a marked and proven effect on patient flow through the Emergency Department (ED). The model in GGH is in the process of being scaled up to increase capacity and is a model that could easily be rolled out to other sites.

Options
In the initial process, two options were identified. The key benefit of Option A is that this aligns with the GIRFT recommendations to develop one, high-volume, high-quality, service. It would strengthen the on-call rota, at GGH and by having an SDEC at WGH, it would mean that a significant number of the patients currently presenting would still be seen and assessed locally. Option B is the least preferred option among the consultants. It does not align with the GIRFT recommendations. It retains the model of two rotas, and does not address the fragility of the service. The original concept was that surgery would be conducted on alternate sites, on a weekly basis. However, as GGH has certain services which are not provided within WGH, there would need to be a 24/7 provision within GGH, with the emergency surgery being transferred to WGH as appropriate.

Before sharing with Members the feedback heard from Hywel Dda's population, public and staff during the consultation, Ms Couceiro highlighted that responses from 'NHS employees' may be members of staff in HDdUHB, or other NHS employees. Equally, in the category of 'other individuals', there may be members of staff that chose not to identify as NHS employees. Preference based on nearest hospital site provides further information for the Board to consider around how where someone is located has impacted their preference on option. An important consideration is that (as mentioned earlier) this process is not a popularity vote. Therefore, whilst it is important to note different groups' preferences on options, this should be considered as part of all of the information being presented today. General feedback comprises other information heard during the consultation. This includes conversations and responses to the open questions within the questionnaire.

Preference by Respondent Type
Among NHS employees who responded to the questionnaire, there was a preference for Option B. Other individuals had a preference for Option A.

Preference by Nearest Hospital Site
For people living closest to Bronglais Hospital (BGH), GGH and PPH, Option A was the preference over Option B. Whereas for

people living closest to WGH, Option B was the preference over Option A.

General Feedback
Travel time and distance was a major theme of feedback on Emergency General Surgery. There was particular concern for respondents in and around Pembrokeshire around ensuring timely access, should Option A be chosen. Transfer time was another significant concern. Some respondents were worried that there would not be sufficient resource in terms of ambulances to transfer patients from one site to another, as well as concerns that on arrival, there would not be sufficient beds. In terms of the alternating service model, Option B, there was some concern around the public not knowing where those surgeries were happening on a weekly basis. Staff shortages were also raised, in terms of concerns that ongoing uncertainty for the service could have impact in terms of being able to recruit and retain staff to the service, because they do not know where that service may be provided in the future.

Concerns around accessibility were also raised, with limited confidence that mitigations would help ensure that services remained safe. Nervousness around capacity to transfer and bed availability were also mentioned. Finally, one of the key themes heard linked to Emergency General Surgery was fear around erosion of services. In terms of service dependencies, if the option was chosen to not retain part of the Emergency General Surgery service at WGH, what additional impacts this might have on other services offered at WGH; with particular concerns raised by residents in and around Pembrokeshire about how that might impact the A&E at that site.

Alternative Options
Mr Deans indicated that, during the consultation process, another two options became available for consideration. Option 155 is the same as Option A, with all the benefits that that brings, but with an enhanced SDEC service within BGH. This change may not need to happen straight away, given that the numbers seen at BGH on a daily basis are still relatively low, meaning that a dedicated surgical SDEC may not be required. It may be incorporated into a longer-term plan of having a general SDEC within BGH. Option 222 is very much more of an option for the future, if the Health Board ever adopts a single site for general surgery. There would clearly need to be pathways to move the patients back to, local hospitals for rehab to be undertaken closer to home. Whilst this option may not be for consideration currently, Mr Deans advised that lessons around the repatriation of patients between GGH and WGH are already being learned. This process enables patients to recover and recuperate closer to home and family.

Option Scores
The total scoring for the four main criteria groups clearly shows that Option A and Option 155, scored first and second in all four of the groups. Therefore, these are the options that the surgical

consulting body believe should be considered predominantly. Option A can be implemented very quickly to bring the Health Board in line with GIRFT and develop the high-volume surgical unit at GGH. Then over a period of a couple of years, the SDEC concept at BGH will evolve. Mr Deans wished to highlight the following issues:

Key Dependencies/Longer-Term
With regard to travel and transfer of patients, it is estimated that approximately 75% of the patients will be seen, treated, and discharged from WGH on an SDEC basis. Therefore, the majority of patients that are currently seen locally will continue to be seen locally. Only the sickest of the patients will need to travel. It has been well documented that patients do not mind travelling even very long distances, if they know that they are going to a centre which has better outcomes. It is also evidenced by various, studies that travel and transfer is very safe, especially if there is an expert unit at the end of that transfer. For example, PPH does not have on-site surgery; therefore, Llanelli patients have been travelling to GGH for at least 15 years. In terms of minimising impact on the Welsh Ambulance Services University NHS Trust (WAST), Mr Deans would hope that, by developing pathways, it will be possible to direct the appropriate patient to the right hospital. So, at the GP referral point, registrars receiving the referral will be able to identify which patient is likely to need admission, and that patient will go directly to GGH, rather than going to WGH and then requiring transfer.

In terms of service dependencies, both Options A and 155 retain a surgical presence within WGH. This will allow the service to continue to see patients there, but also, importantly, continue to support the ED, Critical Care and other acute specialties, such as the acute medical take.

Options for Consideration
In summary, Mr Deans felt that it has been demonstrated that Options A and 155 will bring about improvement in patients' outcomes by creating a high-volume acute unit at GGH. They will allow the Health Board to develop robust and resilient rotas, and improve safety.

In the interest of clarity for those observing, Dr Wooding requested definitions of 'takes' and GIRFT. Mr Henwood explained that a surgical 'take' is the process by which patients are taken into the hospital and reviewed by the specialist team. GIRFT is Getting It Right First Time, which is a programme focused on improving patient experience and the delivery of hospital services. Before opening the floor to questions from the Board, Dr Wooding reminded Members that they are not making decisions today. Today's focus is deepening understanding, strengthening the ability to appreciate the circumstances regarding services, and hearing what the wider population said in relation to the changes being recommended.

Noting the references to strengthening Same Day Emergency Care (SDEC), Ms Sarah Harraway requested further clarification of what this would involve. In response, Mr Deans explained that SDEC is a concept in which patients come into hospital, and are seen, investigated and treated on the same day. The vast majority of patients do not need to be admitted as an inpatient. WGH figures for last year showed a 1 in 4 conversion rate to admission. The model envisaged would be for patients to come into the SDEC area, which (as numbers are relatively small) would generally be combined with a surgical assessment unit. Patients who have less serious or more chronic conditions, such as abdominal pains could be asked to take painkillers at home, and then attend the SDEC in the morning when it opens. They would then have an ultrasound scan, be diagnosed, be given appropriate treatment, and discharged. Ms Harraway enquired regarding the specific change involved in strengthening the SDEC. Mr Deans advised that, within GGH, this would be around increasing the size and capacity, so that more patients can be accommodated. Currently, WGH does not have a formal SDEC area for patients to be assessed in, so the intention would be to create one for this.

Ms Thomas explained that she would enquire regarding travel and transfer once, rather than in relation to every service. Given that this was such a significant issue in relation to the consultation across all services and on a day-to-day basis for people living in rural areas she felt that it was reasonable to expect a more strategic response regarding travel, transfer and accommodation. She could not see this anywhere in the documentation, or details of conversations with WAST in relation to ambulances and non-emergency patient transport services. As such, she queried how the public can be reassured that the Health Board has a strategic grip on this, and that whichever options are chosen will be aligned with an improvement in transfer and transport.

Welcoming this helpful challenge, Dr Wooding acknowledged that there is not yet in place a strategic overview of how detriments and disadvantages would be overcome if services are changed. He suspected that there would be a conditionality between developing that strategic approach and taking forward changes to services. Mr Rogers wished to add, from a programme assurance lens, that evaluation criteria 1.4 considered impact on external services. It was considered through the SWOT analysis, and was scored. Representatives from WAST, the non-emergency patient transfer service and the adult critical care transfer service were involved, and provided input to the SWOT analysis process and the wider CSP programme process. He assured Members that, whilst this may not be reflected in the information in the public domain, these parties have been very actively involved and key to formulation of the assessment and evaluation criteria.

Mr Michael Imperato enquired regarding the issue of rehabilitation closer to home, and whether this is that something which can be fairly easily developed, or more challenging to do, requiring a more long-term approach. In response, Mr Deans suggested that,

within Options A and 155, where patients are traveling to GGH for emergency surgery, repatriation back to the WGH site would be straightforward. The plan would be to continue to have inpatient beds for surgery within WGH, so moving patients back would be straightforward. Option 222, having a formal rehab unit at PPH is something which would take more organisation.

Mr Henwood wished to add more context, explaining that surgical services at WGH and GGH have always been interdependent; more so the WGH service on GGH, simply because of the size of the teams and the clinical expertise that exists in that larger team at GGH. So patients are currently, and have always been transferred from WGH to GGH for care. Due to the differences and specialities he felt that it will be possible to reduce lengths of stay, because there will be quicker access to a specialist individual. SDEC will allow patients to be assessed, investigated, discharged, and followed-up, hopefully the same day, which will reduce the numbers of admissions; and with an enhanced service in WGH, the numbers admitted will be reduced. Therefore, the numbers of transfers into hospital will be low. Mr Henwood also highlighted that there has also been a significant change in surgical practice in the last few years, in that fewer operations are undertaken than historically; for example, appendicitis is managed without an operation. As a result, fewer patients will need to be transferred to GGH for an operation.

Noting that the Health Board has fewer staff than it did 20 years ago, Mrs Chantal Patel enquired whether there is an issue with recruiting to this particular area, and requested assurance that it will be possible to recruit in order to deliver service change. Mr Deans suggested that the amalgamation of the take for the acute surgical service into GGH will enable the strengthening of the on-call rota within GGH. The recent appointment to WGH is a dual-site appointment. It is accepted that the three current, substantive and NHS locum consultants in WGH would not be expected to form part of an on-call rota within GGH, but all new appointees are due to be appointed on a dual-site basis, and therefore will undertake emergency work on-site in GGH. One has been appointed already, and a second post is being advertised. Historically, it has not been possible to recruit to exclusively WGH positions, but there has been a great deal of success recruiting into GGH. Last year, two Upper GI surgeons were appointed; one for GGH, one for a dual-site role, along with a consultant Colorectal surgeon.

In response to a query around why there is more success in recruiting into GGH. Mr Deans suggested that GGH is geographically more desirable, with a number of individuals wanting to live closer to Swansea. Also GGH is a larger unit, meaning that the repertoire and the type of surgery undertaken at GGH is more attractive. Mrs Lisa Gostling wished to add that, as a general caveat for all of the services being considered, the Health Board has only been able to undertake a certain level of workforce impact assessment. It has not been able to identify any therapy

requirements in the models, and there are two options which would require significant additional workforce; circa 40 Whole Time Equivalents (WTEs). Two are deliverable, in the short term, others would need to be workforce planned.

Mr Lee Davies wished to highlight one point which had not been covered in the discussion. In relation to the quality of services, the trend across the UK and within Wales has been for larger centres to specialise further into Upper GI and Lower GI surgery. What this means is that surgical teams can have two separate rotas aligned with their specialty interests, which is more appealing for staff. The second benefit, from a patient perspective, is that this provides access to experts who are dealing with those conditions day in, day out, when presenting as an emergency. Whilst the options do not allow this yet, they set the foundations for the potential for the Health Board to develop in that direction in the long-term, which is now becoming the standard across Wales and the UK.

Mrs Eleanor Marks noted that Mr Lee Davies has started to bring to the fore quality for the individual patient. She was fully supportive and fully understanding of concerns around transport, and the need to develop a strategic approach to support this. Mrs Marks questioned whether the service representatives present were persuaded that any of the options suggested here, would be better for the patient, and give a better outcome for the patients that they treat and serve. Suggesting there is sometimes a 'gap' between process and experience, meaning that it is possible as a clinician to describe an optimal process, which might not match patients' experience.

Reminding Members that the surgeries in question can be very complicated, Mr Deans indicated that Option A and Option 155 concentrate the patients requiring emergency surgery. This enables the surgeons and wider team to have a broader scope of experience, and means that they are performing the surgery on a more regular basis. The surgical middle grade rota becomes more experienced, the theatre staff become more experienced, the anaesthetic teams, critical care, are more used to looking after these potentially extremely sick patients. Also, all of the elective colorectal surgery is being delivered through GGH, PPH or BGH. Therefore, the emergency colorectal surgery, which is often more difficult than elective planned surgery, is being undertaken by those delivering elective colorectal surgery on a day-to-day basis, which should improve outcomes. The same applies to Upper GI Surgery, currently based in GGH.

Ms Thomas sought reassurance, for those who are naturally concerned about WGH and its future sustainability, given the proposed removal of services. Mr Deans wished to offer this, emphasising that today's discussion is focused on Emergency General Surgery. There is a parallel discussion around enhanced SDEC activity, which should demonstrate a commitment to maintaining an emergency surgical presence within WGH. The

facilities that would be freed up by moving Emergency General Surgery, would facilitate a major expansion of elective surgery at WGH, as part of the general surgical long-term plan. WGH has excellent theatre facilities, frailty and care of the elderly services. It would be the intention to undertake much more of the complex, high-volume surgery within WGH.

Focusing on the options under consideration, Mr Neil Prior requested clarification of the challenges around the alternate model, with Emergency General Surgery being operated from two sites. This was in view of the regional variances from those who have responded to the consultation. Mr Deans reminded Members of the benefit of having a larger unit, in terms of having a resilient on-call rota, rather than continuing with two, extremely fragile rotas. By having relatively low numbers going through both sites, the enhanced expertise is also not developed. Elective colorectal surgery is not delivered at WGH; therefore the only major colorectal surgery surgeons there would experience would be in the emergency setting, which is much more difficult. In addition, there will be a degree of confusion for people, in for example the Primary Care team, around which hospital they would be referring to. A couple of years ago, there was an interim period when the rota was unsustainable, where WGH was covered alternately overnight by GGH and BGH. There was considerable confusion around where patients were going.

In the interests of ensuring that all services are considered fairly and equitably over the course of the day, Dr Wooding indicated that he would close discussions at this point. He requested, however, that – if Board Members have any other queries – they contact Mr Deans before tomorrow. He thanked Mr Deans and Ms Lewis for attending and their contribution.

Mr Andrew Deans and Ms Caroline Lewis left the Board meeting.

Critical Care

Dr Michael Martin and Ms Diane Knight joined the Board meeting.

Drivers for Change
As indicated on the first slides in this section, HDdUHB Critical Care services continue to face significant challenges due to various factors, including workforce fragilities. The Health Board is unable to meet national Guidelines for the Provision of Intensive Care Services (GPICS). Broader system pressures reduce Critical Care capacity for our patients with the highest clinical needs. These issues have a number of consequences, for both staff and patients. Dr Michael Martin explained that traditionally, Critical Care was provided by anaesthetists with a special interest in this area. The current model is based on this premise. Since this, there has been a major advancement in Critical Care medicine. In 2010, the Faculty for Intensive Care Medicine was founded. Ever since, the direction has been towards specialist anaesthetists and intensivists, rather than the general hospital anaesthetist. This has

presented challenges for the smaller hospitals, because newly trained consultants want to work as an intensivist with all the standards of a modern intensive care unit, or as an anaesthetist.

HDdUHB had experienced this issue at PPH when there were significant issues in recruiting consultants. In addition, the guidelines for provision of intensive care medicine are very different from the traditional intensive care unit model. The standards have been raised significantly. This is instrumental in driving improvements in survival rates of critically ill patients and ensuring they have a good quality of life afterwards. To deliver the new model and improved standards, however, a trained intensivist is key. Allied Health Professionals are also required: a dedicated pharmacist, a dedicated physiotherapist, a dedicated speech and language therapist, among many others. Fundamentally, it is not possible to provide that in four small units. Therefore, HDdUHB cannot meet the clinical standards, and cannot recruit. Newly trained consultants that expect to work in a larger unit that meets the standards. The Health Board needs to be able to provide good quality intensive care, and that means a much higher standard than was the case 15 years ago, which is what the old model is based on. If the Health Board does not meet the standards, it will not be able to recruit. These are the drivers for change.

Ms Diane Knight suggested that she clarify, for Members and those observing the levels of intensive care, as defined by the Faculty of Intensive Care Medicine. There are 5 levels of care:

Level 3 – the most seriously ill patient. This patient would have their own nurse
Level 2 – slightly less critical. This patient would be 1 of 2 patients assigned to a single nurse
Level 1.5 – also known as Enhanced Care. These patients tend to be either a 1 to 3 or a 1 to 4 nurse-patient ratio; in a dedicated location which can be subspecialty ward-based, not necessarily an intensive care unit. An example would be the Surgical Enhanced Care Unit, currently on Ward 7 at PPH
Level 1 – patients who are practically ready to go back to the ward
Level 0 – patients already on a ward

Options
In defining the first set of options, Ms Knight confirmed the involvement of a multidisciplinary team from all Critical Care locations, including medical staff, nursing staff and Allied Health Professionals. Following a great deal of discussion, the options were refined down to three; A, B and C. Option A is where all service delivery would be centralised at GGH, with, BGH retaining its Intensive Care Unit (ICU), overseen probably by GGH. There would be Enhanced Care Units at WGH and PPH. It would also be the intention to develop the Enhanced Care unit within GGH, to allow patients currently treated in the ICU at GGH to be relocated into a dedicated area. Option B would leave ICUs at BGH, GGH and WGH, with an Enhanced Care Unit at PPH. Option C would

be ICUs at BGH, GGH and WGH, with an ICU at PPH, to which the sickest patients would be transferred.

Preference by Respondent Type
Ms Couceiro advised that, among respondents to the questionnaire, the preference for both NHS employees and other individuals was Option C. This is the option with ICUs at BGH, WGH and GGH, as well as PPH, with the sickest patients being transferred to PPH.

Preference by Nearest Hospital Site
Again, across all, acute hospital sites, respondents' first preference was for Option C, retaining ICUs at all sites. Where there is a difference is with the second and the third preference. For people living closest to BGH, GGH, and PPH, after Option C, Option A was the second preference, and then Option B. In contrast, for those living nearest to WGH, after Option C, Option B was second preference, retaining ICU at that site, then Option A.

General Feedback
Ms Couceiro moved on to broader feedback. Members heard that patient transfers and travel times, again, were raised in relation to Critical Care services, with real concerns around the movement of critically ill patients across parts of the Health Board area. There was uncertainty about the role of the adult critical care transfer service, and whether there would be sufficient capacity to be able to move the patients, should there be fewer ICUs. Staff shortages were also referenced, with concerns around the sustainability of staffing models and what was realistic, given the current workforce pressures that exist across the service. Staff interdependencies were also raised, specifically around the importance of the wider multidisciplinary teams needed for Critical Care services, and how any changes to how the service is delivered would take this into account. Service independencies were also referenced, linking into Stroke care, together with Emergency General Surgery, Orthopaedics and EDs, with concerns around how having fewer ICUs could potentially destabilise these pathways. Finally, accessibility, and how proposals might worsen people's ability to access services safely, was another theme that came across during the consultation.

Alternative Options
Ms Knight indicated that, following the public consultation, several options were brought to the table. Through a process of elimination, one was felt to be a viable option, Option 246. This is a variant of option B; the change is quite subtle, inasmuch that it would be considering the workforce across the four locations, and how that workforce was employed. It involves peer support, potentially the introduction of telemedicine, and cross cover mechanisms in to work towards meeting the GPICS III guidelines. As an example, GPICS has a whole domain around rural intensive care provision, including a list of standards which they would expect to be met. As cross-site working is something which would

clearly be required going forward, this was considered a viable option for consideration.

Option Scores
In the options appraisal, Option 246 and Option B scored the highest across all of the groups, with Option 246 scoring the highest.

Key Dependencies/Longer-Term
Travel, transport and transfer, as alluded to earlier on, will be discussed across multiple portfolios and services. It is recognised that the challenge is not just regarding patients, but their families. Further, if ICUs were to be centralised, there would be travelling for families. Therefore, there had been a detailed discussion about transport. The service which manages acute, critically ill transfers was very much part of these discussions, and it is recognised that they would need to expand their service to facilitate some of the options.

Clearly, there is an interdependence with Emergency General Surgery, and the decisions made on that service will impact. At the moment, there is no Enhanced Care Unit at WGH. Therefore, Emergency General Surgery patient flow goes straight into ICU, albeit not in high numbers. A portion of admissions into intensive care come directly from ED. Therefore, any changes that might divert the workload into ED would, potentially, impact on the volume of patients going into ICU. Finally, any change to Critical Care will have an impact, potentially, on the hospital function as a whole. At the moment, anaesthetics and intensive care are often the first port of call when there is a deteriorating patient, with defined pathways for their management. Consideration will need to be given to the impact of any changes to processes within Critical Care.

In the longer-term, Dr Martin understood that the ambition is for a large acute hospital. In this scenario, it would make sense to move to Option A, with a centralised unit there. The other sites would no longer be acute hospitals, and any patients requiring intensive care would need to be transferred. One of the most challenging aspects of this is ensuring that patients are not disadvantaged because they are located in one of the peripheral hospitals. This can be achieved in various ways; there is cognisance of the issue and steps will be taken to ensure this happens.

Cllr. Evans requested assurance around capacity to deliver any of the options, in the short- or longer-term. Also, given the Health Board’s estate is not ideal and requires improvement, whether any of the options are feasible. In terms of having sufficient space for a centralised unit, Dr Martin explained that the unit at GGH was designed as a large unit. Whilst it is currently run as a 10 bed unit, there are actually 16 or 17 physical bed spaces. So he did feel that there was enough space; however, not necessarily the required staff. In terms of capacity, Dr Martin observed that Critical Care in HDdUHB is undertaking a number of tasks which,

according to the guidelines, it should not be doing. These are tasks which should be undertaken by Enhanced Care, or other specialties. Examples are non-invasive ventilation, which should be undertaken by a respiratory unit; acute dialysis, for patients in renal failure admitted as an emergency. Reallocation of these tasks would create a significant capacity and allow Critical Care staff to focus on the most unwell patients.

Mr James Severs wished to offer some information for the Board and members of the public who may be watching, around workforce. The term Allied Health Professions (AHPs) is a collective term that refers to a group of professions, often referred to as therapists. In Wales, steps have been taken to clarify further. AHPs would include physiotherapists, occupational therapists, psychology, dietetics, speech and language therapy, and the support workforce for all of these. This staff group are integral to the discussions and decisions taking place. Based on that information, Mr Severs would request that consideration be given to whether the options being presented allow consolidation of the workforce expertise, enabling effective rehabilitation early in the patient journey. Dr Martin suggested that this was one of the key drivers for centralisation, noting the challenges in securing expert and qualified staff for this highly-specialised area. As with other specialties, staff need to see a certain number of patients to ensure they can meet the required standards.

Mr Imperato noted that a patient who is an ICU candidate would presumably have had a relatively serious operation, or be seriously unwell. He would further assume that they would be being treated by a specialist team in that instance, in the acute setting, rather than SDEC, for example. Following on from that, he enquired where patients would ‘step down to’ after ICU, and the usual pathway for such patients. Dr Martin outlined the potential patient journey as follows: a patient becomes critically ill, for example in PPH, where there is no longer an ICU. There are, however, senior doctors at PPH on-call 24/7, who also work as senior doctors in GGH, as part of the intensive care rota there.

The patient’s care would be discussed with the Critical Care consultant on-call at GGH by phone, and they would be attended to the senior doctor at PPH. The patient would be stabilised, in terms of organ function, and a transfer arranged to GGH. Hopefully, the patient would be better in a couple of days, or perhaps a little longer. If a surgical problem was diagnosed, they would probably move to a surgical ward. If there was a medical problem, and that patient was from the PPH area, they would be transferred back to the Enhanced Care Unit there, which is between normal ward care and intensive care. With regard to the first part of Mr Imperato’s comment, Mr Henwood clarified that the patients in question would not be in the SDEC setting. Those patients generally present to hospital and have tests and go home the same day. Critical Care patients are critically-ill patients.

Mr Prior firstly requested clarification on what 'health board-wide' meant in practical terms. Secondly, he noted that the two options for consideration seem opposed, to an extent. Mr Prior requested clarity around long-term sustainability with regard to Options 246 and Option A. In response, Dr Martin highlighted that there are two aspects involved: the practicalities and the theory. It might be reasonable to ask why PPH would be treated differently to WGH – they are similar-sized hospitals, albeit geographically distant. There is, however, an acute problem at PPH, and that is where the compromise originates. Longer-term, the old model (such as that at WGH) is not sustainable in terms of consultant and middle grade doctors recruitment. Going forward, Dr Martin felt that one unit would be the model. However, consideration must also be given to other clinical activity around the ICUs, because in small hospitals, they need the support, traditionally, from anaesthetists and critical care doctors. In addition, decisions around other specialties, such as emergency surgery, have a significant impact on the needs for Critical Care.

Options for Consideration
Mr Alex Martin reminded Members of the options for consideration detailed in the presentation. He emphasised that these are not necessarily the only options. What is set out is the current service, with Option 246 presented as an option which could meet the implementation and the improvement phase. In the longer term, aligning with the AHMWW Strategy and clinical strategy, Option A reflects a potential configuration with fewer sites. There is also the challenge of managing nine services and 190 options across the process.

When the options scoring was undertaken, they were scored against the 'here and now'. So, in terms of Safe and Sustainable, it would arguably be a poorer scoring option to not have those services supporting sites if there are EDs, so it would reflect as a poor option. There was no second scoring to reflect a 'future state' of fewer hospital sites, fewer medical takes, where you would not need those services. This is why the scores are different. It does not necessarily mean that Option A is not a good option, the scores reflect that it is not a good option for now, due to those other interdependencies.

Dr Wooding indicated that this highlights a compelling argument for why the specialisation of these services results in recruitment challenges for the Health Board. Yet the options in themselves would not necessarily address that issue. In examples such as Critical Care, where the profession is fundamentally changing, difficulties recruiting will only increase and the organisation must be mindful of that. With regard to the difference between WGH and PPH, Mr Andrew Carruthers explained that there is already a difference in the service model at these sites. This being that WGH has an ED, impacting the patients that present there; whereas PPH does not have an ED, it has an Acute Medical Assessment Unit. By definition, therefore, the nature of patients that referred to PPH are not those necessarily requiring those

highest levels of Critical Care. This is part of the reason the options, for the next 2-4 years are presented in the way they are.

Professor Kloer suggested that Dr Martin has very clearly outlined the challenges of providing the new expectations around Critical Care across four sites, or even three or two sites. This was recognised back in 2018, when the AHMWW Strategy was agreed. It was determined at that time that the organisation would move to a two site model for Critical Care; however that was dependent on a new hospital. Whilst this creates a dilemma, it is necessary to advance as much as possible in this service, reflected in the strong advice from our clinicians.

Mrs Marks emphasised that, in looking at these options, the Board always seeks to make decisions that are fair, sustainable, evidence-based, and following engagement with its communities. It seems that, decision-making tomorrow, it is a 2-4 year option which needs to be considered, with the longer-term being a part of the journey that this consultation starts. Secondly, she requested clarification that all of these options require an increased number of staff to make it safe to continue. In response, Dr Martin confirmed that, if the Health Board is to meet the Critical Care clinical guidelines in all areas, an increase in staff levels is required. However, this again highlights a contrast between an interim period, during which the priority is to provide a safe service and make sure no patient comes to harm and what is sustainable in the long-term and what a high-quality service would look like.

Dr Wooding thanked Dr Martin and Ms Knight for their contribution to the discussion, again requesting that they address any further questions which Members might have subsequent to today's session.

Dr Michael Martin and Ms Diane Knight left the Board meeting.

Stroke

Dr Senthil Kumar, Dr Eiry Edmunds and Ms Bethan Andrews joined the Board meeting.

Drivers for Change
Explaining the need for change, Dr Senthil Kumar indicated that Stroke services have undergone a significant transformation over the last ten years, and at various levels, including pre-hospital, acute treatment, rehabilitation phase and post-stroke care.
This transformation is based on a great deal of evidence, which has influenced the clinical standards in relation to Stroke. As a result, services are evolving. HDdUHB is not unique in this regard. Every health board in the country is going through reconfiguration of their Stroke services to adapt to these changes, and ensure that they meet the relevant standards. The traditional model of one clinician, one geriatrician, delivering Stroke care as well as other care in a District General Hospital (DGH) is no longer

appropriate, to meet the outcomes these new standards are providing.

In the regional context, meeting this need is the biggest challenge; hence why stroke is part of the CSP. HDdUHB has four units, none of which meet the recommended staffing levels. A couple of units are operated with a single clinician, and all four are operated with one specialist nurse in each site. A hyper-acute stroke unit (HASU) is the national direction of travel. This involves a level of staffing to meet the needs in the first 72-hours of care, to improve patient outcomes. Dr Kumar emphasised that this model is evidence-based and supported by the Stroke Association. In the Health Board's current model, there is no 7-day cover from consultants, or any specialist nurse cover. The commitment and dedication of staff in the four sites is not in question; however, the current model does not represent a sustainable service which meets modern Stroke care standards. Compliance with these standards is measured strictly by the national Stroke audit, Sentinel Stroke National Audit Programme (SSNAP). Results are published every month, meaning that a lack of compliance is evident. A failure to keep pace with change will be a failure to meet the needs of Hywel Dda patients.

Options
All the service leads and clinical leads undertook a rigorous process to identify options, with two resulting – Options A and B. Option A is a model where the 12-hour Stroke units will be sited PPH and WGH, while BGH and GGH become Treat and Transfer units. Option B, which is more ambitious, is a 24/7 HASU at PPH, with other units becoming Treat and Transfer, except for WGH, where the patients will go back after the first 72 hours care.

Preference by Respondent Type
Ms Couceiro indicated that Option B was the preference of NHS employees, while Option A was the preference of other individuals; however, it is important to note that there is very little between them in terms of the percentage differences.

Preference by Nearest Hospital Site
There is a starker contrast when considering responses based on nearest hospital site. For people living closest to BGH, GGH and PPH, Option B was preferred overall; a single 24 hour centre. What is important to note for responses regarding this service is that over 50% of the respondents living closest to BGH did not select a preference. The feedback during engagement was that the reason for this was that they did not agree with either of the options being presented to them. For people living closest to WGH, Option A was overwhelmingly preferred over Option B, this being the retention of a 12 hour Stroke unit at WGH, as well as a 12 hour Stroke unit at PPH.

General Feedback
Moving onto feedback obtained during conversations and from free-text entries in the questionnaire: one of the strongest

messages was around retention of services. As Members will be aware, Protect Bronglais Services generated a petition of over 17,000 signatures; highlighting the strength of feeling locally around the retention of a Stroke unit at BGH. As touched upon above, views varied significantly by location, with people closest to PPH being, more supportive of options; compared with those closest to BGH and GGH. Respondents from those closest to WGH emphasised the need for a 24 hour Stroke service local to their hospital site.

Travel times and access under Treat and Transfer models was another key theme heard in responses linked to Stroke services. There were real concerns around travel to PPH, whether WAST had sufficient capacity to ensure timely transfer for patients, and the potential impact on safety. Also, significant concerns around accessibility for friends and family visiting stroke patients, particularly where patients could be on the Stroke ward for a considerable period of time. This theme came up across the Health Board, but in particular, respondents closest to BGH raised the lack of public transport enabling them to visit loved ones, should the service be centralised at PPH. In addition, there were questions around the ability to deliver and resource the service models, and the ability to have sufficient clinical workforce in place. Finally, confusion around the Treat and Transfer model; and the 12 hour model, and how that compares to the current service model.

Alternative Options
Ms Bethan Andrews advised that, from the public consultation, two other options were suggested, appraised and assessed against the hurdle criteria; Options 106 and 210. These are quite similar, except that Option 210 has a 24 hour (HASU) Stroke unit at GGH, with work to create a regional Stroke unit in conjunction with Morriston Hospital, and BGH will retain a 12 hour unit. Therefore, PPH and WGH will become Treat and Transfer in Option 210. Under Option 210, BGH has Treat and Transfer and Stroke Unit (specialist cover 12-hours a day). Option 106 involves three units, which, as has already been indicated, is unsustainable.

Option Scores
Option A was the most favoured option, closely followed by Options 106 and 210. However, all options have specific strengths and weaknesses, which were considered in more detail.

Delivery, Benefits and Risks
Dr Kumar explained that the options were further analysed by a Stroke-specific task and finish group, with representation from stroke practitioners at all four hospitals. The consensus outcome is presented on the next couple of slides.

Option A (12 hour units at PPH and WGH)
- Deliverable in the timescale being considered

- Benefits – will improve standards compared to current model. Not to the 24/7 hyper-acute level, but better than the current standards, with weekend support
- Risks – GGH (with busy ED) is Treat and Transfer only. Moving of therapists between sites/workforce challenges

Option 106 (generated during the public consultation, where a great deal was learned about the patient voice, which was very important for the organisation)
- Deliverable in the longer term, whilst noting the challenges involved in maintaining three units
- Benefits – treating patients closer to home after the acute phase
- Risks – sustainability issues associated with a three unit model

Option 210 (a futuristic and ambitious version of Option A)
- Deliverable in a phased manner, by bringing the services together, although the time period will need to be considered
- Benefits – moving in the national direction of travel, of developing hyper-acute stroke units. BGH providing 12 hour service, 7 days a week
- Risks – sustainability, especially around workforce

Key Dependencies/Longer-Term
The next slide included data around patient transfer numbers, which were as follows:
- Options A, 106 and 210 – average of 8 patients per week could be impacted
- Option A – average of 3 patients per week attending BGH and 5 patients per week attending GGH could be impacted
- Option 210 – estimated average of 4 patients per week currently attending WGH and PPH could be impacted
- Merged Option 106/210 – average of 11 patients per week could be impacted

The advantages of the merged option would be the rehabilitation care closer to home for BGH patients provided by Option 106, while also addressing the medical sustainability issues; with Option 210’s futuristic model of providing 24/7 care, delivered in a phased manner.

With regard to interdependent services, national standards clearly mention linkages between Stroke services and EDs, and co-location with EDs. In terms of whether this should be the norm, the Health Board has sought to clarify, and, whilst this may be the ideal, it is not necessarily mandated to co-locate Stroke services with EDs. The other major interdependency, or mainstay of Stroke care is therapists and Allied Health Professionals. There is also a regional and national aspect, given the Health Board’s ongoing dialogue with Swansea Bay UHB (SBUHB) and the mid Wales task and finish group.

Options for Consideration
Mr Lee Davies observed that the presentation demonstrates the importance of Stroke services. Whilst there is a strong evidence base supporting centralisation of delivery of care leading to better outcomes for patients, in a Hywel Dda context, it presents quite a significant dilemma. The Health Board covers a very large geographical area. It inherited a position of four sites delivering Stroke care; therefore, any change brings with it advantages and disadvantages, risks and benefits. The organisation is very conscious of this, and has been trying to navigate through it during the process. Each of the options presented have specific challenges.

Option A, from the point of view of delivering the most immediate improvement in patient care available, scores very well, which is why it was highest in the options development group assessment: because it can be implemented, and would have an impact. It does, however, involve a few challenges. One is the geography, and the transport and travel implications. Secondly, the fact that the busiest ED is at GGH, which would not have a Stroke service which is nonetheless is a novel arrangement which is not aligned to the Health Board's strategy.

Therefore, when the Option A proposal is considered in the context of the long-term strategic direction, it leads to a model with potentially just one Stroke unit at PPH, by default, essentially. Geographically this is very close to HDdUHB's border with SBUHB, which was a regular theme in discussions. This presents a further challenge in terms of 'strategic fit'.

In terms of the other options, Option 106 has challenges, which have been described, involving having three stroke facilities across Hywel Dda. This will, inevitably, be very difficult to staff, meaning challenges in meeting the clinical standards. Option 210 involves a similar issue in terms of concerns around the feasibility of delivering a 12 hour Stroke service at BGH, which is a challenge currently.

Further Considerations
On the final slide in this section, the team has attempted to support Board in considering whether there are any other options that could be constructed from the existing options, which would best fit the challenges and the opportunities the Health Board is facing. It was emphasised that there is no suggestion that the merged option does not present any risks, or is preferred in any way. It seeks to draw on feedback from the consultation, and the assessments made, to assist Board in considering whether there are alternative models for Stroke service delivery. Whilst it may help the discussion, it is also intended to recognise the need to deliver change to Stroke services in Hywel Dda. Mr Lee Davies concluded by noting that any option developed will have specific advantages and disadvantages, all of which need to be given due consideration prior to making a final decision.

Ms Hughes Moakes wished to respond to feedback around the Welsh language, specifically in relation to Stroke patients and their rehabilitation. The organisation is conscious of concerns around Welsh language provision, and has been taking this into consideration. She wished to offer assurance that this has been added to the other feedback outlined earlier in the presentation. Noting that Stroke services are being reviewed on a national basis, and that all health boards are reviewing their Stroke services, Ms Thomas queried why HDdUHB is seeking to make a decision now. She suggested that it would be more sensible to take a consolidated approach, rather than HDdUHB acting independently.

Cllr. Evans stated that the petition mentioned earlier, the protests and feedback from members of the public clearly reflect the strength of feeling around these services. He suggested that the areas of most concern are the Treat and Transfer model and whether this is safe. Whether it is safe to move Stroke patients after 72 hours. Also, centralising or focusing Stroke units in the south of the Hywel Dda area brings with it the issue of inequality for those who reside in the north, and feedback from Betsi Cadwaladr UHB describes concerns around the potential impact on patient flow. For those patients who have suffered strokes, it is often the case that their families are very much involved in their rehabilitation while they are still in hospital. There are, therefore, potential issues of inequality for families having to travel from the north of the region to PPH or WGH, as this may involve a 4-5 hour journey. As already highlighted, this issue is being discussed at a national level. Cllr. Evans also noted that the Stroke Association has raised concerns regarding the proposals, and enquired whether they are justified in this. Also, what the mitigation is, if services are being centralised in the south of the Health Board region, regarding transport. Whilst recognising that the latter is not solely the responsibility of the Health Board, to make any decision in any organisation, there need to be mitigations in place, especially to address public concerns in this case.

Before inviting a response, Dr Wooding observed that Cllr. Evans has eloquently described the significant tension between a desire to deliver services to the highest possible standard and meet the benchmarks against which services should be delivered; and at the same time not disadvantage communities in terms of the support that patients need to receive from their carers and families, and the inherent transportation challenges. This is a major dilemma which the Board will need to navigate its way through, recognising that a single decision will be contingent on many other enablers.

Whilst Dr Kumar wished the Health Board was not in the position of having to make these changes, he recognised that it is. Betsi Cadwaladr and Powys Health Boards face similar geographical challenges. Others – Cardiff and Vale, Aneurin Bevan UHB, Cwm Taf Morgannwg, and Swansea Bay – already have a single Stroke unit as a result of reconfigurations since 2019. They are now

working towards HASU status. These health boards are fortunate in that they do not have the geographical challenges that HDdUHB does. Whilst the quality statement for Stroke care, which was issued two weeks ago, talks about safe, timely and effective care, it also focuses on equitable and patient-centred care.. How the organisation mitigates these risks, while meeting the standards. As a clinician, Dr Kumar stated the clinical recommendation is to work towards HASU and mitigate risk by repatriating patients as soon as possible. It is for the Board to make the decisions on the future service model, based on this recommendation and information on what is clinically best for patients.

To address Cllr. Evans' query around the safety of a Treat and Transfer model, Dr Kumar indicated that this is already proven. An example is North Yorkshire, and Scarborough, where the travel distance from Scarborough to York Hospital is 1 hour 5 minutes. The Treat and Transfer model is used in Scarborough, and in other locations including Airedale, Harrogate and North Allerton. Patients from all of those areas are being transferred to York, Barnsley Hospitals and Leeds Hospital Trust. Members were assured that Treat and Transfer is an established model. It is also used in thrombolysis at thrombectomy centres. Treat and Transfer is not unique to Stroke, either. A number of time-dependent emergencies, such as burst aneurysms are treated by stabilising the patient, and transferring them to the relevant specialist unit. The evidence supports this approach, as patients in the correct unit, under the correct specialist, achieve the best outcome. Additionally, the approach is not only to treat the immediate effects of Stroke, it also involves prevention of future Strokes. Recurrent stroke is the biggest risk in these patients. The need for prompt investigations, and preventative measures cannot be ignored; however, mitigations do need to be sought.

Dr Eiry Edmunds agreed that Treat and Transfer already occurs in Stroke care, with a number of patients transferred to Bristol or Cardiff for thrombectomy services. This has been the case for the last 3- 4 years, so there is already an established safe transport mechanism for acute stroke. As a Cardiologist, Dr Edmunds added that the transfer of patients to centres of excellence is also established practice within her specialty; enabling clinical decisions and treatments to be delivered safely, to improve patient outcomes. However, she very much accepted the concerns of the patients of Ceredigion and Meirionnydd, especially as strokes generally occur in older people, and their relatives are understandably concerned about visiting. Stroke also has a long rehabilitation; these factors require consideration. Dr Edmunds suggested that it may be possible to separate the acute care from the rehabilitation care, with the merged option possibly delivering both aspects of the acute care and the longer rehabilitation care.

Returning to a point made earlier, Ms Couceiro noted that Option 210 is quite different from Options A and B, in terms of where the service could be provided. Because of this, if it was an option that

the Board decided should be pursued, further engagement with communities would be required to understand what the impacts might be. Likewise, for the merged option, there would be a need for further engagement with communities, and further work internally to ensure that this option was tested in the same way as the consulted options and the alternative options.

Ms Thomas wished to reaffirm the comments made by Cllr. Evans, noting that these reflect what Llais has heard from significant numbers of people in Ceredigion, Powys and Betsi Cadwaladr. Another concern expressed by those people who rely on services at BGH, is that taking a service away affects the overall sustainability of what they view as being a hospital fundamental to their overall healthcare. Finally, in relation to rehabilitation, whether there been consideration in terms of any of the options, particularly Option 210, of the addition of a rehabilitation unit at BGH. Thanking Ms Thomas for her input, Dr Wooding noted that this echoes some of the concerns identified in the consultation feedback described earlier. The Board absolutely appreciates these challenges, along with concerns around the removal of a service, although Dr Wooding suggested that other services will be introduced, including in the future. That being said, he respected the right of people to have the view that their local hospital is getting smaller as a consequence of these changes.

Dr Gjini wished to highlight and assure the Board and the public regarding the ‘other end’ of Stroke services, the prevention. She highlighted that evidence suggests that approximately 70% of Stroke cases are preventable. Some of them immediately preventable with good management of hypertension, with early detection of atrial fibrillation. Therefore, there needs to be due consideration of how elements of prevention can be strengthened and delivered in the community. There are various forms of service delivery utilising community workforce which can help the population to prevent Strokes, and the Health Board is seeking to embed the 20four7 model to support prevention. Public Health has also invited the service to collaborate on how to focus more on preventative care. Dr Wooding welcomed this important context. Whilst the focus of Board’s current discussion may be the consequence of individuals having a stroke, it is also a priority to avoid people having strokes in the first place. This highlights the need for more work in the primary and community service and intervention space, which would help to reduce patient numbers even further.

Responding to Ms Thomas’ earlier comment around national work in relation to the Stroke pathway, Mr Severs highlighted that health boards have been waiting since 2023 for a position. More recent conversations suggest the intention to undertake another benchmarking exercise. It could be argued that the Hywel Dda population have waited long enough for the some of the basic standards of Stroke care. Secondly, it should be recognised that the acute part of the Stroke pathway is 1/7 of the patient's journey. A small, but very important, part. The first part of the pathway

involves prevention, as alluded to; and the latter part of the pathway is focused on rehabilitation to the best quality of life possible. Mr Severs requested clarification, on whether a model, which is almost a two-stage model, would allow this. In other words, given the length of time health boards have waited for a national position, whether it would be appropriate to take a two-stage approach in terms of consolidating the expertise within HDdUHB services to 'level-up' for the population's health. To give them the best opportunities to be rehabilitated in a place that is as local as possible, whilst awaiting the position from an All Wales perspective. Further, whether that aligns with an option which has been proposed.

Mr Imperato requested clarification around the criteria for a Stroke unit. Whether, given the scenario of BGH not having the acute aspect, it can still be described as a Stroke unit. Dr Kumar emphasised that stroke does not end after three days (72 hours). This is the hyper-acute phase; after that comes the acute phase. Data shows that this is the period where there is a high risk of aspiration pneumonia, and re-blading, or re-stroking. Hence there remains a high risk, necessitating a clinical presence during rehabilitation, until the clinician determines that the patient is no longer acute, and can enter the purely rehabilitation phase.
In response to Ms Thomas and Mr Severs' queries, Dr Kumar explained that the new standards are already in place. Under the previous standards, even in the most recent year, HDdUHB was scoring C at WGH with all other units being rated D. Under the new standards, three units are scoring D, and one is scoring E. This is not something which can continue unabated; the changes represent only a starting point in achieving the necessary standards.

Dr Wooding felt that this added to the case made by Mr Severs for a compelling, urgent response to the current situation. Dr Wooding emphasised that a way forward to ensure the Health Board can meet the clinical standards must be identified; because as a Board, statutorily, delivering suboptimal standards cannot be countenanced. Especially if there exists a pathway that will allow the organisation to move towards delivering them. At the same time, the Board must listen to the voice of the public in relation to any disadvantage or detriment that route may cause, because it will impact upon the poorest, most vulnerable members of the population. How the Board navigates a pathway through this, and how it reconciles some of those tensions and difficulties, will feed into its future approach to similar challenges.

Professor Kloer wished to respond specifically to concerns of populations in mid Wales and around BGH, including those highlighted in the petition received. As has been described, Stroke services, along with expectations around Stroke services have changed radically over the last 5 to 10 years. It has moved from what was considered a very general service that every hospital should have, to a service that is now highly specialised, requiring extremely intense input for that period immediately following

thrombolysis. At the moment, the Hywel Dda population is not benefiting from that highly specialist service. As such, Professor Kloer agreed with others that it is difficult for the Health Board to wait for a national Stroke programme, although it will need to take heed of that when it reaches a conclusion. Given that a Stroke service is no longer one which you would expect in every single general hospital, its absence does not affect the integrity of the other hospital services.

Closing this session, Dr Wooding requested that Dr Kumar and his team facilitate any further questions that the Board may have, and thanked them for their input.

Dr Senthil Kumar and Ms Bethan Andrews left the Board meeting.

PM(26)39 **Planned Care Services**

Dr Wooding welcomed Members back to the Board meeting, and the session focusing on Planned Care Services, beginning with Ophthalmology.

Ms Victoria Coppack joined the Board meeting.

Ophthalmology

Introducing herself, Ms Victoria Coppack advised that the Senior Nurse Manager was unfortunately able to attend the meeting. She explained, however, that – in addition to being Service Delivery Manager – her background was in nursing, so she would endeavour to answer any clinical questions Members may have.

Drivers for Change
Opening on the challenges around Ophthalmology, the service has significant workforce pressures and national consultant shortages. Many consultants are working single-handedly in various sub-specialties, with no support when they are on annual leave or sick leave. This results in gaps in service. There are ongoing staff shortages and retention difficulties, and frequent rota gaps, which are filled by Health Board staff undertaking additional duty hours, obviously at additional cost. Capacity remains a key concern in Ophthalmology, due to the workforce challenges.

Whilst HDdUHB has been working with colleagues in SBUHB to strengthen the service, a great deal of change in the service is still required to make it viable. Without making change, it is felt that patients will not be supported as regularly as they should be. There are patients that need regular eye injections; who need to come into the service every 4 to 6 weeks, and staff want to be able to provide timely care for these patients because they are the cohort of patients at risk of irreversible sight loss. The service also does not want patients waiting longer than they have to for operations. In order to seek to provide the best care possible, Ophthalmology has been contributing to the CSP, to consider how the service could be improved and made more viable.

Ophthalmology is currently working out of eight sites, which is very challenging. Doctors and nurses are often sent across sites, and are often working without consultant oversight. Therefore, part of the proposal is to reduce the number of sites. This will improve the service structure and ensure that junior doctors and nursing staff are working under consultants, in the interests of staff development and retention. It will also assist with service delivery, because having senior colleagues present to refer to will reduce return visits. If patients are seen by a junior doctor with no consultant oversight, they often need to return to be seen by a consultant. Efficiencies will be created by reducing the amount of sites and creating a much more robust service.

Options

Moving on to the options. The first, round of options considered Options A, B, and C. Option A proposes removing the service from BGH and PPH and, in Amman Valley Hospital (AVH), deliver cataracts only, not (intravitreal) eye injections. Option B proposes removing the service from GGH. Day cases and emergency eye care would be introduced at PPH. It is important to note that there is no 24 hour ED and no paediatric service at PPH, which would potentially be an issue. In Option B, diagnostics and eye injections in AVH, but not day cases, and a proposal for a Pembrokeshire site, to be confirmed. In Option C, the difference from the current service is that there would be no service at PPH. AVH would deliver diagnostics and eye injections, but not day cases.

It is important to note, before moving on, that the Ophthalmology service has continued to develop in the last two years since the CSP commenced. It is now moving to deliver both eye injections and cataract surgery (day cases) at AVH. In Board's consideration of the options, Ms Coppack emphasised that Ophthalmology would wish to continue to deliver both of these services out of AVH, rather than one or the other, as presented. Also, in all options, the service would continue with its delivery out of Cardigan Integrated Care Centre, and out of North Road Eye Clinic in Aberystwyth. So whilst removing services from BGH might be proposed, that refers to cataract surgery only. The main delivery of outpatients and eye injections would continue in North Road Eye Clinic. This would facilitate service delivery to the Ceredigion and Powys population.

Preference by Respondent Type

Ms Couceiro introduced feedback in response to Ophthalmology. For NHS employees and other individuals, Option C was the preference. NHS employees then preferred Option B and A, whilst other respondents then preferred Option A and then B.

Preference by Nearest Hospital Site

There was no consensus between nearest hospital sites and ranking of preferences between options, as has been seen with other services. The preferred option for people living near BGH was Option C, which retained that service, over Option B, then Option A. For people living closest to GGH and WGH, Option A

was the preference over Option C, then Option B. For those living closest to PPH, Option B was preferred over Option A, then Option C.

General Feedback

In terms of the broader views heard during the consultation; once again, travel times and distance were raised in relation to Ophthalmology services. There were increased concerns because of the nature of the service, around longer travel times for patients, and their ability to be able to travel after treatment. In terms of suggested mitigations, some respondents suggested subsidised travel, for both patients and those accompanying them for treatment; linked to their ability to navigate around the site and travel following treatment. There were mixed views around extending service hours. Some respondents expressed support, in principle, particularly those individuals in work. In contrast, others expressed concerns that travelling later in the evening or during darkness could be a problem, potentially, for the older population. There were also associated challenges around access to public transport.

There were mixed views in terms of how community clinics could be utilised. Some respondents recognised that these could deliver care closer to home, which was seen as important. Others were concerned about the facilities available at community sites, and whether these would provide the same standards of care. With regard to bringing the service together at a single site, some respondents saw the potential benefits in terms of the quality of care that would be received and efficiencies in terms of patient numbers seen. However, there were also strong concerns expressed around where sites would be located and the impacts of this on travel and transport.

Alternative Options

Before moving on to the alternative options, Ms Coppack wished to make clear that great consideration has been given to travel time for patients. The service has ensured that, with all proposals, (intravitreal) eye injections are delivered in every county, and that community sites have been retained. The only exception being Aberaeron; however, North Road Eye Clinic in Aberystwyth and Cardigan Integrated Care Centre would remain, along with AVH in Carmarthenshire. In relation to the proposal to remove eye operations from BGH, Ms Coppack indicated this is based on the fact that very few are delivered there. Most Ceredigion and Powys patients already travel for their eye operations. In response to a query around the numbers involved, Ms Coppack advised that this amounted to approximately 11 operations per week. This is insufficient in clinical sustainability terms. These patients are already travelling to GGH, or further afield for outsourced care, based in Swansea. The aim in developing proposals was to ensure that regular appointments (such as eye injections, which are 4 to 6 weekly) are close to home, as opposed to one-off operations.

In terms of alternative options, Option 95 is the same as Option A, with the addition of extended hours. As mentioned earlier, although this option lists day cases but not eye injections in AVH, the service has already moved on from this position to offer both. The extended hours would potentially present a problem for the service, given that it struggles, with current resources, to cover its 9 to 5 work and emergency eye care service. To extend hours would require more staff and additional commitments. As highlighted, some respondents also raised concerns about having to travel or drive in the dark, due to poor eyesight, and accessing transport out of hours. Option 99 is the same as Option A, with the addition of day cases and eye injections at AVH, which aligns with current service provision. Option 167 is the same as Option A, with the addition of an optometry hub in Aberaeron. Again, it lists day cases, but not eye injections in AVH, which is not the current position. The optometry hub would potentially present a challenge, due to a shortage of the optometrist workforce required for delivery.

Option 173 is the same as Option C, except for diagnostic outpatient eye injections, but not day cases at AVH, and a diagnostic hub in Aberaeron. This would potentially work for the service, because a diagnostic hub could be run by technicians, as opposed to the previous suggestion, which would be run by optometrists. Technicians could undertake patients' tests, which could be reviewed by a consultant remotely. Additionally, facilities and equipment already exist in that location. Option 227 is the same as Option A, and again, involves extended hours, and AVH offering day cases, but not eye injections. Finally, Option 263 is the same as Option B, again, with extended hours, emergency eye care and day cases moving to PPH. As previously mentioned with regard to Option B, there is no paediatric cover or 24 hour ED at PPH. This option also proposes a Pembrokeshire site to be confirmed, and diagnostic outpatient injections, but not day cases. The service's concerns around extended hours have already been mentioned.

Option Scores; Key Dependencies/Longer-Term; Options for Consideration

Within the clinically-led options appraisal, Option 99, which is a variant of Option A, scored the highest. Option A scored second highest, then Option C, followed by Option 173, which retains a service at BGH for day cases (cataract) delivery. Option 99 provides certain efficiency gains, and does not impact North Road Eye Clinic. The benefit of Option 99 is that it would create additional theatre capacity for Orthopaedics, by moving the cataract surgeries elsewhere. This would allow Orthopaedics to utilise the theatre facilities and meet British Orthopaedic Association standards. Option 173 was also considered a good option, given the suggestion of a hub in Aberaeron. The service would suggest to the Board, that in considering either option, it seeks to retain both eye injections and day cases at AVH, as this reflects current service provision and will allow development of the

service. The hub at Aberaeron would also provide flexibility for the future growth of the service.

The floor was opened for questions. Mr Prior felt that the presentation for this service starts to introduce more community-based services, which is important. He noted, however, feedback during the consultation around the quality of care delivered in communities. There is also a broader point around the need to emphasise to the general public that care is not limited to 'getting yourself fixed'; it also involves prevention of ill health and the role of community in this. This needs to form part of the narrative produced as a result of the Board's deliberations.

Mr Imperato enquired how long an inpatient would typically be in hospital. In response, Ms Coppack advised that Ophthalmology does not generally have inpatients. A patient that has attended another service, for example, general surgery, may have a problem with their eyes, and be referred to the service. All of the Ophthalmology patients tend to be day cases, they are not admitted overnight. The ward is closed at night, and reopened in the morning. Returning to day case patient numbers at BGH, Dr Wooding requested clarification of whether capacity is limited by availability of staff. Ms Coppack confirmed that this was the case, with one operating consultant in Aberystwyth, undertaking a list a week and then a visiting consultant from North Wales, undertaking a list every other week.

Members heard that, in a main hospital site, throughput is restricted by theatre logistics, to 5-6 cases, typically. AVH, which is a community site with a high-flow cataract list, sees up to 8 cataracts per list currently. Hence why the service is keen to retain cataracts and eye injections there. It would be beneficial for the population to have eye injections delivered there, close to home, and cataract delivery capacity could be increased. This would reduce the reliance on outsourcing, and reduce travelling for patients, who currently go to Swansea. Ms Harraway enquired whether, given that the two preferred options (Options 99 and 173) are both variants of original options, further engagement would be required. Ms Couceiro replied that, as they are closely aligned to options which have already been consulted on, further engagement would not be required, unless there was something specific that the Board felt was missing from the information presented.

Noting that the Board has been presented with nine potential options, Dr Wooding queried the central problem or issue which proposals seek to solve; whether this concerns specialisation and skills base. Ms Coppack's response would be the need to reduce the number of sites from eight, and ensure better consultant oversight. It is extremely challenging to cover the eight sites, and appointments are often cancelled. This is due to workforce fragilities staff having to travel to multiple sites, resulting in capacity inefficiencies. By reducing the sites, staff travel between sites would be reduced, creating more clinical time. In addition,

there would be better consultant oversight, which would also benefit the patient by avoiding return visits. For example, a patient seen in emergency eye care, may need to attend several appointments before they access a consultant. It there is consultant oversight in those clinics, the specialist doctor could discuss with the consultant who is in clinic, get a clear outcome, and discharge the patient at that point, so the patient would only have to attend one appointment.

Ms Thomas wished to follow up on discussions around community clinics and 'the trust gap' mentioned by Mr Prior. She enquired how the service would reassure patients in relation to the aspects they are concerned about in relation to community clinics; around capacity, consistency, facilities and sustainability.

In reply, Ms Coppack indicated that in all options, everything that can be retained and delivered in the community, is. The only exception being Aberaeron; however, there is a suggestion that this facility could be used as a hub. She assured Members and the public that the service has been working closely with Primary Care colleagues, and has built an extremely robust network in the community. Meaning that now, for patients with an eye care emergency, the advice is to go to their community optometrist, rather than to ED or their GP. If they are unable to provide the required treatment, they will be able to refer directly to a specialist optometrist. As part of the Welsh General Ophthalmology Service (WGOS) the Health Board has been training optometrists to go into Primary Care and work at a higher level. They would only refer into hospital if they were unable to manage the problem. The percentage of patients being referred into secondary care has significantly reduced as a result.

Building on this context, Mr Henwood noted that HDdUHB's Ophthalmology services are seen as an exemplar in how community services are provided. The Health Board has an excellent optometric service, with enhanced skills and is leading in community optometry and ophthalmology. Cllr. Evans agreed that there is a great deal of positive feedback regarding community services. Referencing the options for consideration, Options 99 and 173, he noted that Option 99 scored highest; however, it seems that Option 173 was preferred by the service. Ms Coppack explained that the Aberaeron hub suggestion is attractive to the service, and aligns with ambitions for diagnostic hubs in the community. If this was to be included in Option 99, it would effectively provide the service with everything it needed.

Concluding discussions, Dr Wooding suggested that what has been communicated is a sense that the service has progressed whilst the CSP and the consultation have been in operation. This, however, generates a question around whether agreement on an option would be within the realm of what has already been consulted, or is sufficiently close. This will be part of discussions during decision-making tomorrow. However, the information presented by the service has been reassuring, and suggests that

the impetus behind these options is to improve access to services, and ensure better quality service.

Dr Wooding thanked Ms Coppack for her time and contribution to the discussion.

Ms Victoria Coppack left the Board meeting. Mr Ihab Abbasi and Ms Lianne Gregory joined the meeting.

Orthopaedics

Ms Lianne Gregory indicated that, for the purposes of the CSP, the discussion would consider elective Orthopaedics. It should be noted, however, that the staff group involved also cover the trauma elements of the Orthopaedics service.

Drivers for Change
Similarly to Ophthalmology, when the CSP process started, elective Orthopaedics had, waiting times of four years for surgery. That picture has changed significantly, with the Health Board currently reporting a two year wait for surgery, which is recognised as still unacceptable. Progress has been made in reducing waiting lists. However, this has only been made possible by delivering additional activity volumes through various means; insourcing, outsourcing, and additional waiting list initiatives. Despite all the progress, the challenges of maintaining a reduction in elective waiting times remain. There are a number of factors which contribute to this particular challenge. In inpatient surgery and arthroplasty, access to a laminar flow theatre is required; the issue is securing the theatre capacity to meet current demand.

Alongside this, and just after the COVID-19 pandemic, the British Orthopaedic Association released updated standards of care required in order to maintain elective inpatient delivery. These set out a specific group of criteria which needed to be met, in order to maintain those standards completely. As a result, elective inpatient surgery is currently being delivered at two sites across the Health Board (BGH and PPH) with day case activity taking place at WGH. At GGH, only trauma surgery is delivered, which is outside the scope of the CSP. The Orthopaedics workforce remains fragile. The service also relies on a number of other teams to support its activity: predominantly anaesthetics, theatre staffing teams, and therapy teams. There have been particular recruitment challenges across a number of those staffing groups.

For the service, two years' wait for surgery is still far too long, and sustainable plans need to be put in place, to bring these waits down. By bringing services together, permanent reductions to waiting list times can be made. For Orthopaedics, the CSP process has been around identifying where the service can potentially increase capacity to address the arthroplasty demand; formalising and embedding regional working arrangements through collaboration between HDdUHB and SBUHB; and

agreeing a permanent way forward in terms of where different activity is delivered across all sites.

Options
Moving on to the initial options development, there were four options initially. A high-level overview of these is that there would be no change from a GGH perspective, as it does not deliver any elective surgical activity. However, it does deliver outpatients appointments for elective patients, and that remains in all of these options at the GGH site. Regional working, between HDdUHB and SBUHB, is suggested in three of the four initial options. One option, Option D, looks to increase inpatient, capacity at BGH through additional theatre sessions. As mentioned earlier, this potential interrelation needs to be considered. Should the Ophthalmology service be withdrawn, Orthopaedics would then be able to access those theatre sessions. Option B looks to increase day case activity at WGH through extended hours.

Preference by Respondent Type
Ms Couceiro outlined what was heard in responses to the questionnaire linked to Orthopaedics. For both NHS employees, and other individuals, Option B was the preference, followed by Option D. Where there is a slight difference is that Option A was preferred over Option C for NHS employees; whilst there was very little difference in preference between Option A and Option C for other individuals.

Preference by Nearest Hospital Site
In terms of responses linked to postcodes and nearest hospital site, there is no clear consensus between preferences. The preferred option for people living near BGH was Option D, whilst for those living closer to GGH, PPH and WGH, it was Option B. This continues to reflect the position that communities closest to an acute hospital site have a preference for options that retain the service at that hospital site.

General Feedback
Moving on to the broader feedback themes linked to Orthopaedic services, there was recognition here from some respondents that bringing Orthopaedic services together could help reduce waiting times. Some members of the population would be willing to travel further if it meant that they were seen sooner. There were some strong concerns raised linked to access, particularly for older people and those in rural communities, and how people will get home following discharge. There were also mixed views when it came to regional working, with some respondents recognising that regional working could offer benefits in terms of increased capacity or speed of access. Other respondents felt that HDdUHB patients might be disadvantaged if they are on a combined waiting list across multiple health board areas.

As seen with other services, keeping services local and providing care close as home was viewed as very important, especially in regard to follow-up appointments and rehabilitation. There were

mixed views in terms of the future direction of the service, with some respondents wanting services to remain local, to reduce travel and inequality; and others happy to travel further if it improved access and quicker appointments. One point very clearly made by respondents was around the interdependencies of services. Specifically, the suggestion that, in order to retain elements of Orthopaedics at BGH, the service which could be offered by Ophthalmology is impacted. It was strongly felt from communities in and around mid Wales, that they should not have to choose between retention of one service over another, due to challenges around theatre space.

Dr Wooding felt that it was important to clarify that the driver for removing Ophthalmology from BGH would not be to increase the quantum or volume for Orthopaedics; it is because that service can be delivered more efficiently elsewhere.

Alternative Options
Ms Gregory noted that, following the staff and public consultation, five alternative options were proposed. Two options have been merged, Options 52 and 113. In all of these five options, there are no proposed changes at GGH, and no proposed changes in terms of where outpatient elective activity is currently delivered. Option 52/113 is the only option that proposes, bringing back elective inpatient activity to WGH. Two options, Options 129 and 268, propose increased activity for elective Orthopaedics at BGH. Regional working at PPH appears in four of the five options. One option, Option 129, proposes increased day case activity at WGH through extended hours. Finally, Option 178 proposes additional elective inpatient activity at PPH through extended hours.

Option Scores; Key Dependencies/Longer-Term; Options for Consideration
In terms of which options support the best case for change, of the clinically-led options, Option D scored the highest. A close second were Options 129 and 178. Option D scored the highest overall against three of the four domains. Option 129 scored highest against accessible and kind, but poorly against safe and sustainable.

The next slide considers Option D and Option 178, focusing on delivery, benefits and risks. As already mentioned, Option D relies on decisions regarding Ophthalmology. Regional working at PPH features in both of these options. For the service, the ambition is to create a sustainable reduction in waiting lists. It would obviously want to deliver as much elective inpatient activity as possible. Both options look to deliver additional activity, but at different sites. The question would be, whether there is an option to do both. This would be a potential solution which would provide the service with greater inpatient volumes and support of elective waiting times.

A number of the key dependencies have already been mentioned in the feedback. There were some concerns raised regarding

travel, certainly from those living in rural areas and older people. It is important to note, however, that people were more accepting of having to travel further for surgery, and were more concerned that follow-up requirements were dealt with more locally. This being the post-op follow-up outpatient appointment, and rehabilitation in particular. In terms of independent services, Critical Care and the various options being considered through the CSP, have been discussed earlier today. There will need to be clarity on the support available for elective inpatient orthopaedic activity. The independency with Ophthalmology has already been discussed. In terms of regional working, the service is working towards a regional approach to reduction of waiting lists. The regional Orthopaedic programme is certainly working towards developing and delivering a single patient tracking list, to support a reduction in the region's longest-waiting patients. There were some public concerns around whether Hywel Dda patients would be disadvantaged within regional waiting lists.

Finally, it needs to be ensured that, compliance with the British Orthopaedic Association standards is maintained at PPH, and improvements are made to achieve compliance at BGH.

The presentation was concluded and questions invited from the Board. Mr Maynard Davies noted the statement that, ideally the service would like to increase activity both at BGH and PPH. He enquired whether this would have staffing implications on any of the staffing groups. Ms Gregory responded that it will certainly require updated consideration through job planning. This would not be an issue with the consultant group at BGH and is potentially achievable at PPH. Her only reservation would be from an anaesthetic perspective, given the somewhat challenging national recruitment perspective. Mrs Gostling advised that the options will vary in workforce requirements from an additional circa 5 WTEs up to 20 WTEs. There are also quite a number of interdependencies with other services which would have an impact on workforce.

Mrs Patel requested clarification around the rationale for having outpatients and only outpatients at GGH. Secondly, whether, as part of developing the various options, consideration was given to virtual appointments. In response, Ms Gregory advised that outpatient activity has been delivered across all four sites for a number of years. If it was to be withdrawn from GGH, alternative space would have to be found at the other sites, which is particularly challenging. Additionally, retaining the current outpatient delivery configuration retains contact points across Health Board locations. With regard to virtual appointments, there are some subspecialties where the majority of outpatient appointments are delivered virtually. For instance, in upper limb clinics, shoulder and elbow, all first new outpatient appointments are delivered virtually via video consultation. 'Pockets' of virtual activity for first outpatient appointment are also delivered across other subspecialties. However, when discussing arthroplasty,

there is merit in being able to touch and feel the joint, to facilitate a more accurate clinical diagnosis.

Also seeking clarification, Mr Prior suggested that many of the specialties discussed this morning have been, to some extent, concerning consolidation. Whereas discussions around this speciality seem more to do with additionality. The two preferred options for consideration seem to suggest a focus on additionality. Ms Gregory emphasised that current demand far outweighs capacity in the inpatient activity. However, the way in which this inpatient activity is being delivered has also changed since pre-COVID-19; and the British Orthopaedic Association standards have been updated. So, for instance, pre-COVID-19, inpatient activity was delivered at WGH, whereas currently it is only delivered at BGH and PPH. Consideration needs to be given to where it is possible to deliver inpatient activity, and how to maximise throughput in each of those sites.

Dr Wooding welcomed this observation, suggesting that the focus in certain services has been on issues of significant fragility. Whereas it appears that this service is delivered well; certainly over the last year, hence meeting the 104 week standard. The imperative in Orthopaedics is to ensure standards are being met and waiting times are being reduced. All of which needs to be achieved in the most sustainable, cost-effective, impactful way.

Mr Henwood wished to clarify that none of the potential Critical Care options would negatively impact on any of the Orthopaedic options. So if, for example, the Board was to decide on an option where there was an Enhanced Care Unit at PPH, this would not make a material impact on the Orthopaedic activity. There is only a very small number of patients who would need a higher level of care, and an alternative pathway would be identified for them. Mr Rogers added that, for Orthopaedics, the focus is not solely on activity; it is also about the post-COVID-19 changes to the service, and giving the service the mandate to make these temporary changes permanent. Specifically around removing inpatient activity from WGH, and also the regional programme of work for Orthopaedics. Both of which were considered as part of the public consultation.

Dr Wooding wished to reiterate that the issues of Ophthalmology and Orthopaedics service delivery at BGH, need to be separated. They are not dependent on each other in terms of the Board’s decision-making at this point, or tomorrow.

Ms Gregory was thanked for her attendance and contribution.

Mr Ihab Abbasi and Ms Lianne Gregory left the meeting. Mr Fred Schreuder and Ms Ceri Wisdom joined the meeting.

Dermatology

Mr Fred Schreuder introduced himself, explaining that he was a consultant plastic surgeon employed by SBUHB, but working with the HDdUHB dermatology department. He was appointed in 2021 to dermatology, and is the longest-serving member of the dermatology department in West Wales. He was attending with the Service Delivery Manager, Ms Ceri Wisdom.

Drivers for Change

The most significant constraints to Dermatology have been the inability to recruit a substantive consultant. It has been almost ten years since HDdUHB last had a substantive consultant Dermatologist. This impacts upon patient care, the service, training, recruitment and teaching of middle-grade staff. It also impacts on the Clinical Nurse Specialists, who have supported the service for the last decade. Standard services that most other Dermatology departments offer are not offered by HDdUHB. The Health Board does not undertake 'see and treat' clinics; probably the only Dermatology department in Wales that does not offer this service. It does not undertake patch testing. There are very limited facilities at PPH, where Dermatology is currently based. This change was made during COVID-19, when a number of services moved from GGH to PPH.

Mr Schreuder chairs the weekly Skin Cancer multidisciplinary team meeting. Year on year this group has seen an approximately 20% increase in the number of skin cancers. This obviously has an impact on capacity. Patient consultations are involving longer, more difficult discussions, and more interventions, both therapeutic and diagnostic, are being undertaken. HDdUHB has been unable to deliver phototherapy due to infrastructure problems, with phototherapy being one of the first-line treatments for a number of dermatological inflammatory conditions. The department has also been unable to see paediatric patients in the proper environment, with these patients being seen in an adult clinic. Therefore, they are not in the correct environment, and consultant staff are being diverted from a clinic that could be better utilised for more complex inflammatory patients.

Fundamentally, the fragmented service which was inherited needs to be consolidated. It is not possible to work as an efficient Dermatology team without this consolidation, which will offer support to consultants; improve recruitment, retention and training, and thereby develop a sustainable and robust Dermatology department. One of the major issues is around availability of the estate to develop such a service at PPH.

Options

The options which were discussed by the Options Development Group were Options A, B, C, and D. The current service sees some outpatient clinics and medical photography based at GGH. If phototherapy was operating, it would also be at GGH. Most services are delivered at PPH. It has not been possible to offer

services at WGH since 2023, due to the Reinforced Autoclaved Aerated Concrete (RAAC) issues at that location. There are two very good nurse-led clinics, at the Cardigan Integrated Care Centre and South Pembrokeshire Hospital.

Option A proposes the removal of community provision in Pembrokeshire, but does consolidate the service at PPH, and adds in a nurse-led outpatient service at AVH. Option B, again, consolidates the service at PPH, places some operations into Primary Care and GP practices, but does not include service provision in Ceredigion. Option C is perhaps the most comprehensive, as it retains community service in Pembrokeshire, Ceredigion, and includes development in the form of minor ops in GP practices and Primary Care, and an additional nurse-led paediatric clinic at Cross Hands Health Centre. Option D is similar, but without the GP service.

Preference by Respondent Type
Ms Couceiro indicated that there was some consistency in terms of responses across those who indicated they were NHS employees and other individuals. Option C was the overall preference, followed by Option D.

Preference by Nearest Hospital Site
With regard to responses linked to nearest hospital site, again, Option C was the preference, followed by Option D, across all postcodes. Where there is a difference in terms of responses was for the last couple of choices. For people living closest to BGH, GGH and PPH, the preference was Option A over Option B. In contrast, for people living closest to WGH, it was Option B over Option A. There was, however, a consensus across all locations regarding the first two preferred options.

General Feedback
In terms of what was heard linked to Dermatology services in conversations with communities and in the free-text box in the questionnaire; there was strong agreement that there needs to be change to reduce long waiting times. It was also recognised, across many of the responses, that current access and delays were not acceptable and timely. There was specific feedback around phototherapy being consolidated at PPH, with concerns around restricting that to one site, and that being the site furthest east of the Health Board areas. The concerns being around access linked to this proposal.

Travel and transport, again, were mentioned, linked to Dermatology services. Particularly where appointments may be short or frequent; the requirement for patients in certain communities to travel further to access these appointments was a concern for some respondents. There were calls, once again, for utilisation of digital and virtual solutions as a mitigation for the amount of travel, and to help address barriers for some communities. Staffing challenges were also noted, and have been mentioned by the service. Finally, specifically linked to the idea

that certain elements of the service be provided by GPs; whilst this was welcomed, by some respondents, there was also a level of concern around access to GP appointments.

Alternative Options
Mr Schreuder advised that 24 alternative ideas were suggested, none of which passed the hurdle criteria, so the four original options, Options A, B, C and D, went through to scoring.

Option Scores; Key Dependencies/Longer-Term; Options for Consideration
In the clinically-led options appraisal, Options C and D were the two highest scoring. Option C scored the highest in all four of the domains; safe, sustainable, accessible, and kind. Option D scored second highest in all four of those categories. But looking at the individual criteria, Option D scored higher in terms of financial sustainability and in impact on local communities.

From a service point of view, Option C is considered the strongest, a view shared in the public consultation. There are certain contingencies required to make it work. As a result of COVID-19, a number of services had to be consolidated at PPH. Option C would retain this arrangement. However, it also provides a level of ambition and service development, in terms of better integration with Primary Care. Option C is considered deliverable within the next four years. With an increase in estates, more clinic rooms and more surgical rooms, the service will be able to see more patients. It will be able to offer ‘see and treat’ clinics. By bringing medical photography to PPH, the management of patients with skin cancer will be supported, with this being an essential component of the medical record. Bringing together all of the staff would make the Dermatology service much stronger, providing a real benefit in terms of recruitment, retention, and training of staff.

There are risks, specifically in relation to estates and staffing. Clinical space is not currently available to facilitate Option C. The department does not currently have a substantive consultant, and there is a lack of Dermatologists throughout the country. However, this also emphasises the need to make the department a robust department which can recruit and retain staff. The Cross Hands Health Centre has not yet been developed; until it is, the paediatric clinics remain a risk. It is recognised that consolidating the service to the east of the Health Board region does increase patient journeys. However, it will also increase activity and the number of patients it will be possible to see and treat, and will strengthen the service.

Moving on to questions, Dr Wooding enquired whether the Health Board is already at the point where it is delivering much of the option the service would like to move towards, in Option C. Mr Schreuder confirmed that most of the services are being delivered from a single consolidated site. The service does still have clinics at GGH, and is reliant on Clinical Nurse Specialists to cover the

rest of the region. Dermatology's fragility lies in its lack of substantive consultant staffing. Hence the need to create a centralised service, where the middle grades can be supported and developed through the training route to become certified consultants, who will hopefully remain in the area. Whilst the service is currently delivering activity, it is having to insource much of this; and is not able to reduce waiting lists and meet demand with current facilities and staffing levels.

With regard to Option C, Cllr. Evans noted the caveat around additional space. In view of this, he requested confirmation that Option C is a viable option for consideration. Mr Lee Davies noted that there are a number of 'moving parts' involved with different services, making it challenging to provide a definitive answer until a view has been reached on the future configuration in its totality. However, a great deal of detailed work around the capital and estate implications of each of the options has been undertaken. A suite of information was presented to SPC in January 2026, which is available for Members to examine in more detail.

In the case of Dermatology, much of the service is already being provided from the footprint that it would potentially be provided from. There are further questions regarding the aspiration for a dedicated Dermatology facility. One of the tasks as part of the implementation phase will be to understand the timeframes of such a facility, how much it might cost from a capital perspective, and details around exact space requirements. Whilst there is currently no identified space for the service to move into, it is not outside the bounds of possibility that it could be provided at PPH.

Mr Imperato requested clarification around nurse-led and GP based services, and how much this does or will comprise, versus the consolidated acute-based provision. Mr Schreuder explained that his experience with nurse-led services is mainly through the skin cancer pathways. For example, the complex patient with a new diagnosis will come to see him in his multidisciplinary clinic at PPH. They will then have their follow-up closer to home with one of the Clinical Nurse Specialists on the multidisciplinary team. This model is utilised for skin cancers, and it can also be utilised for inflammatory Dermatology.

Dr Wooding was somewhat concerned that the Health Board is employing four locum Dermatologists. He suggested that whatever is decided in terms of the way forward needs to move away from this position. It is both fragile and extremely costly. This is partly a CSP issue, and partly a broader workforce issue.

Professor Kloer queried the extent to which the Health Board can make more use of an engaged GP community; given the extent of Dermatology service delivery in Primary Care and the community, and Hywel Dda's rurality. Also, whilst the organisation is very grateful for the locum Dermatologists who have provided the service for a lengthy period of time; it is recognised that a substantive workforce tends to result in better quality. In view of

this, he queried how much of the issue is around designing a service in Hywel Dda, and how much is about a regional service.

In response to the first query, Mr Schreuder indicated that, during the last five years, there have been GP practices that have provided very good local services. However, if a GP stopped providing that service, there was an abrupt change in the patient pathways, with them having to return to PPH for treatment. It needs, therefore, to be a coordinated endeavour, linking Primary Care with the Dermatology department. There have to be strengthened pathways, and perhaps even Service Level Agreements, outlining expectations and reciprocal support and training. It certainly can work, but 'silos' in certain locations where patients are getting very good care from their GP, which suddenly cease, needs to be avoided.

In terms of regional working, Mr Schreuder reminded Members that he is a regional worker, in that he is employed by SBUHB, and also works in HDdUHB. This has had a personal impact on him, in terms of medical isolation, due to spending three days a week at HDdUHB, and one day a month at Swansea Bay University Hospital with his colleagues. This has emphasised the importance of peer support and establishing a department, to assist with recruitment and retention, and ensure sustainability.

Dr Wooding requested further clarification around numbers for nurse or GP-led, and consultant-led Dermatology services. Ms Ceri Wisdom indicated that, within the community, it is only skin cancers that are seen in nurse-led clinics. There are no inflammatory Dermatology patients seen in the community sites. There are two nurses that work out of South Pembrokeshire Hospital and Cardigan Integrated Care Centre, who see probably about 50 patients a week between them. These are both new and follow-up patients. The consultant-led clinics at PPH and GGH would probably see 120-130 patients a week.

Dr Wooding recognised that there is a great deal for the Board to consider in terms of how this service is taken forward. He felt that it is very much future-focused, and concerns how the service can be improved or optimised. He thanked Mr Schreuder and Ms Wisdom for their contribution to discussions.

Mr Fred Schreuder and Ms Ceri Wisdom left the meeting. Mr Ngiaw Khoon Saw joined the meeting.

Urology

Drivers for Change
Mr Ngiaw Khoon Saw indicated that, since COVID-19, the challenge for Urology has been significant, mainly due to the population demographic. The region has a large number of elderly patients with likelihood of, cancer, particularly prostate cancer. Since COVID-19, Urology has changed its practice, from having GGH as the main hospital for emergency and elective patients;

the elective service has been moved to PPH. Whilst there are still some outpatient service and diagnostic procedures in GGH, Urology patients are based on wards in different parts of the hospital. This presents challenges around their care.

Additionally, GIRFT guidelines indicate that there should be a Urology Investigation Unit, which HDdUHB does not currently have. This facility is important, as it consolidates the workforce in a particular site; where consultants and Clinical Nurse Specialists can work together. It improves patient care, in particular, in terms of diagnosing cancer for patients, and a number of outpatient treatments can be undertaken there. Concern was raised about imaging capacity, with it noted that it is necessary to outsource MRI scanning for prostate cancer patients. Furthermore, due to the increasing demand, the current workforce is no longer sufficient (both medical and nursing staff).

A dedicated Urology Investigation Unit would allow the service to focus on diagnostic procedures and shorten the time for patient diagnosis. It will also allow a focus on other treatments, separation of cancer and the non-cancer treatments, which will improve the overall care.

Options

Currently, the main emergency and elective activity is at GGH, with some of the elective inpatient activity reduced due to the bed situation. Hence most inpatient elective patients are now at PPH. WGH provides outpatient service, day case procedures and diagnostic procedures. The proposed option concentrates all the emergency service provision in GGH and using PPH for a centralised Urology hub.

Preference by Respondent Type

Ms Couceiro moved on to questionnaire responses, highlighting that this was the only service where there was just one proposed option, Option A at consultation stage. As it was not positioned as a preferred option, the question posed was different; it asked whether respondents agreed or disagreed with the proposed option. In considering the responses, there were similarities across both NHS employees and other individuals, with agree and strongly agree making up over 50%, of the responses. Disagree and strongly disagree made up under 30% of the responses, leaving 20% who neither agreed nor disagreed with the proposal.

Preference by Nearest Hospital Site

Again, the same question was posed around the one proposed option. There are some slight differences, based on location and nearest hospital site. For those living closest to BGH and GGH, most people indicated disagree or strongly disagree. For those living closest to PPH and WGH, more people indicated agree or strongly agree.

General Feedback
Turning to the broader conversations heard during the consultation; as with other planned care services, there should be a strong focus on reducing, long waiting lists. Some respondents indicated they would be supportive of going further for treatment if it meant that they could be seen sooner. There was particular mention of urgent suspected cancer, in terms of the speed of access to service; however, there were mixed feelings around centralising of the service, with some noting the benefits if it delivers faster, more coordinated access. Others were concerned about impacts on travel and reduced access, particularly with the location of PPH, being furthest east in the Health Board area.

Wider travel and transport impacts were also raised, particularly linked to older people and those living in rural communities and patients needing to access multiple or urgent appointments. Some respondents also highlighted the need to ensure that patient dignity is maintained, given the nature of some of the conditions treated under the service. There were some proposed travel mitigations, linked to greater use of community locations for screening and diagnostics, including mobile diagnostics; as well as opportunities to have appointments (where appropriate) digitally or virtually. Interdependencies was another theme from responses in relation to Urology, particularly concerns around whether the service would be safe and viable on sites without Critical Care or other surgical specialties.

Alternative Options
Mr Saw advised that there is no significant difference between Option A and the alternative option, Option 194/197.

Option Scores; Key Dependencies/Longer-Term; Options for Consideration
Based on the scoring, the original option, Option A scored highest across all four domains. The major benefit of a centralised Urology Investigation Unit at PPH would be that it offers the best way to provide effective and efficient care for Urology patients in Hywel Dda. If this is implemented, it should be possible to start delivery within the next couple of years. The benefits, as mentioned earlier, is quicker assessment, diagnosis and treatment.

A recent study for prostate cancer undertaken by a HDdUHB colleague found that patients did not object to going elsewhere for MRI scans, providing that this reduced waiting times and resulted in quicker diagnosis. A centralised hub will also allow delivery of outpatient treatments, the proportion of which has increased for a number of Urological conditions. Many such procedures are already being offered in other health boards. This also helps to reduce the inpatient need in Urology, freeing up capacity to use for cancer patients. In terms of interdependencies, currently the services still uses the Endoscopy unit at PPH. Additional staff may be needed to support the work of a Urological Investigation Unit. Fundamentally, not a great deal of change is being proposed to

the service, other than the establishment of a Urology Investigation Unit at PPH.

Dr Wooding noted that one of the risks identified was around staff. He enquired whether, in the option proposed, additional staff would be required. Mr Saw confirmed that additional staff, particularly Clinical Nurse Specialists, would be required. HDdUHB has fewer of these than Swansea or Cardiff. Most units have a cancer key worker who only does cancer work. In most units, the Clinical Nurse Specialists also take on a lot of the follow-ups for prostate cancer, freeing up consultant time. Mr Maynard Davies observed this, like the previous discussion, is dependent upon capital investment. He suggested that, in making decisions, the Board will need to be mindful of the amount of investment needed, and whether Welsh Government support will be needed. Building on this, Dr Wooding emphasised that the decisions being made tomorrow broadly concern the Board giving permission to take forward these areas of work. There will be multiple other contingent factors and circumstances which will need to be addressed. What the Board is doing is endorsing and sanctioning options as a way forward. If there is a business case for improving efficiency, volume, effectiveness, and ensuring the Health Board meets standards, this is fairly compelling.

Mrs Marks wished to clarify her understanding that, whilst there are no staff vacancies in the current establishment; to provide a quality service as recommended by the GIRFT report, additional staff would be required to deliver the preferred option. Also, that the service feels it would be able to attract better skilled or more skilled people if the decision is made to select the preferred option. Confirming this to be the case, Mr Saw indicated that most Urology units throughout the UK have a dedicated diagnostic hub. This facilitates delivery of care by the Clinical Nurse Specialists who, in other hospitals, are undertaking procedures such as flexible cystoscopy, biopsy of bladder cancer, laser treatment of bladder cancer. This is only possible in an environment with medical and nursing staff based together.

Noting concern around the impact on patient dignity of increased travel, Ms Thomas enquired regarding the possible actions which might address this concern. Mr Saw emphasised that patients will always be consulted in the first instance around how they wish to access care. These first consultations are often undertaken virtually; with subsequent appointments determined by the specific procedures required. Simple diagnostic procedures can be carried out in the local hospital. Should patients require more specialised procedures at PPH, any dignity concerns can be addressed beforehand, so that patients will be confident travelling.

Mr Prior wished to make an observation on the planned care session as a whole, suggesting that Members have heard some very compelling arguments. Having taken part in one of the conscientious consideration sessions himself, he had noted the tension between ‘a local service’ and ‘a better service’. Everything

in the last session has focused on improvement and additionality, Referencing opening statements around the public's confidence in the process, Mr Prior felt that this offers an opportunity to rebuild confidence and trust. There remains much else to balance with this, and nothing substitutes for face-to-face communication and engagement in addressing challenging topics.

Ms Couceiro noted that, whilst across planned care services respondents were willing to travel further if it meant that they would have access to treatment sooner, and better quality care; this message was heard less in relation to the acute urgent and emergency services discussed this morning. This theme of being willing to travel did not come across as strongly in relation to services such as Stroke, Critical Care and Emergency General Surgery. She felt that it was important to make this distinction. Even in the planned care space, there is an expectation that the Health Board does more to ensure all services are accessible to the population. For Board awareness, Mr Lee Davies highlighted that in Urology and Dermatology, some of the changes which were made temporarily during COVID-19 are now consolidated in the proposals being put forward.

Mr Ngiaw Khoon Saw left the meeting.

PM(26)40 **Diagnostic Services**

Dr Faiz Ali and Ms Sara Jones joined the meeting.

Endoscopy

Introducing himself and the Service Delivery Manager, Ms Sara Jones, Dr Faiz Ali explained that he was a consultant Gastroenterologist and the Clinical Lead for Endoscopy. He had been Clinical Lead for the last ten years, at which time the Health Board had moved from four separate Endoscopy units to one service across four sites, with standardised pathways and protocols across all sites. He wished to mention a point of real pride, which is that HDdUHB is the only Health Board in Wales which has JAG (Joint Advisory Group on Gastrointestinal Endoscopy) accreditation across three sites. This involves a number of factors, including quality, safety, appropriateness of the procedure, patient-centeredness, environment, workforce and training. For the last ten years, HDdUHB has been delivering this standard across three sites. PPH does not currently have JAG accreditation, mainly due to the environment not being optimal in terms of patient flow.

Maintaining JAG accreditation also requires a focus on waiting times, delivering urgent cases within two weeks, and routine cases within eight weeks. During the COVID-19 pandemic, much of the Endoscopy activity ceased, and it only now recovering, with urgent and routine cases are back meeting their waiting time targets. Whilst there is still a significant surveillance backlog, it is anticipated that performance in this will also be back to meeting the required standards within the next year. Mr Ali emphasised

that the JAG accreditation represents a pivotal commitment to patients around safety and quality.

Drivers for Change

The most significant issue is increasing demand, with a 5% year-on-year growth. Demand for inpatient Endoscopy has also increased, with referrals impacting on elective Endoscopy, particularly routine cases. The ideal would be for sufficient capacity in the system to ensure that unplanned work does not affect core activity, and impact on patients' clinical pathways. The growth in demand is despite strict adherence to national vetting guidance. The most significant introduction during the last few years is the FIT (Faecal Immunochemical Test), which involves testing stools for blood. This started in Secondary Care after COVID-19, but has now been introduced into Primary Care. Whilst it facilitates prioritisation based on patient need, it does generate more testing, as it is so reliable.

In addition to demand, Endoscopy patients are becoming more complex. Baseline capacity has not expanded sufficiently to meet this, and the issue has been addressed mainly by waiting list initiatives. This is acceptable on a short-term basis, but is not sustainable, and a more robust solution is required. Workforce is also an issue. Clinic Endoscopists are non-medical; they can be trained to undertake gastroscopies and colonoscopies within two years. These staff are well-suited for backfilling for clinicians to avoid cancelled sessions. They also tend to become permanent members of staff, whereas junior doctors often go elsewhere once their training is completed.

Endoscopy is a critical factor in most gastrointestinal (GI) treatment pathways. Examples include gastrointestinal, colorectal, oesophageal, gastric and pancreatic cancer. The majority of these are diagnosed via Endoscopy. There are also many people with chronic disease, such as inflammatory bowel disease and liver patients. Prompt Endoscopy is important for these patients also, to avoid more acute presentation and longer hospital stays. Emergency Endoscopy, which comprises at least 10% of the total, impacts on 'front door' pressures, and increased capacity is required here also. The final driver for change is infrastructure. Equipment ages, and requires a proactive capital replacement cycle. In addition, there are advances in AI-assisted diagnosis. This is increasingly identifying more subtle changes, which can be the precursors for cancer, both lower and upper GI.

Options

Ms Sara Jones presented the options developed by the Options Development Group, which are all centred around service expansion to meet the demand described in the case for change. The currently service covers three specialty areas: GI (85% of activity), Urology (10%) and Respiratory (5%). The detail being presented today predominantly concerns the expansion in GI services.

Option A suggests developing an additional procedure room in PPH in order to meet increased demand. In doing that, it is proposed that respiratory and urology procedures are brought together, allowing better use of equipment, and avoiding duplication of equipment across sites for small volumes of activity. It also allows increased delivery of GI services at GGH, where most of inpatient and emergency work is delivered. Option B, again involves expansion, by development of a new site in a community setting. Services would continue to be delivered across the four hospital sites, with the new site used for bowel screening. As a service team, it is felt that there could be benefits in community-based general Endoscopy, not restricted to bowel screening. Option C is a different form of service expansion, which is not around increasing the infrastructure, but around developing evening and weekend sessions to increase activity. This would also consolidation of urology and respiratory procedures at PPH and increased delivery of GI services at GGH.

Preference by Respondent Type
Ms Couceiro outlined responses from those who identified as NHS employees and other individuals. In both cases, Option C was the overall preference, followed by Option B then Option A.

Preference by Nearest Hospital Site
Moving on to responses based on location and nearest acute hospital site, there is a difference in opinion. For those living closest to BGH, Option B was preferred, followed by Option A and Option C. For those living closest to GGH, Option B was preferred, then Option C and Option A. For those living closest to PPH, Option C was preferred, followed by Option A and Option B. For those living closest to WGH, Option C was preferred, then Option B followed by Option A.

General Feedback
In terms of the wider discussions, there is some commonality with earlier discussions. For instance, linked to travel time and distance. Strong concerns were raised around how far patients may need to travel to access services, with particular concerns in common with Urology, around patient dignity. In terms of the benefits of consolidating the service, whilst there was recognition that this could improve efficiency and quality; consideration needs to be given to access and reducing barriers. With regard to extended or out of hours appointments, as with a previous service, there were mixed views. Those currently in employment felt that extended hours or weekend hours could be beneficial in terms of not needing to take time off work. In contrast, there were concerns for some of our communities around travelling, particularly for older people, and where public transport would be required. One of the options suggests a diagnostic and bowel screening hub, with location to be confirmed. A number of respondents stated that it was very difficult for them to share their views on this without knowing the location. In order for the Health Board to be able to mitigate this proposal, a location would need to be communicated.

Alternative Options
Mr Ali presented the alternative option identified, Option 228, which is fundamentally Option B, with enhanced bowel screening. He wished to clarify that Endoscopy undertaken in the community is determined by patient indications. A great deal of bowel screening could be done in a community hub. There would still be a need for it in the acute hospitals, especially for more complex cases or frail patients. Community provision would be, to all intents and purposes, an extra site. Whilst the bulk of provision would be bowel screening, not exclusively so.

Option Scores; Key Dependencies/Longer-Term; Options for Consideration
Option A, with PPH as a three room site, scored highest. The estate is available at PPH, and would allow this site to meet JAG standards. Option C, with extended hours, was the next highest scoring, and then Option B offers a community hub. In considering the options which best fit the needs of the population, these are Option A, which is deliverable in the short-term (whilst requiring capital investment) and Option B being more long-term.

In considering key dependencies, Ms Jones noted that Endoscopy is key as a diagnostic and treatment function for multiple cancer and non-cancer pathways across GI, urology, and respiratory. This will require continual demand modelling, to adequately plan capacity and keep pace with annual growth. Population changes are also an important factor; evidenced by the expansion of the bowel screening programme as an example. Quality and safety need to remain central; maintaining JAG accreditation is a key aim for the service. Workforce availability and continued investment in training is critical to each of these options; the correct quantity of staff and the correct skill mix of staff. Finally, the physical estate is key, in order to deliver sustainable services. The service needs adequate procedure rooms, decontamination space and appropriate supply of equipment. Furthermore, a community site or a third room at PPH potentially lends itself to the development of regional or national collaboration opportunities.

A consideration for the Board is a blend of these options, in order to keep at pace with the growth in demand. The flexibility to initially develop the additional procedure room, with a future option to increase operating hours; and, in the longer-term, develop the community model, or an alternative model of service expansion.

On opening the floor to questions, Ms Harraway enquired whether there are recruitment challenges in this service, in common with others discussed. Ms Jones indicated that, whilst this had been an issue previously, the National Endoscopy Programme, in place for many years, has introduced tailored training for Endoscopy across all workforce elements. In the three years she had been in post, the service has always been able to recruit to Endoscopy nursing posts. In many cases, the service is also training its own staff; with Health Care Support Workers able to undertake training to become a registrant. Three former Endoscopy nurses have

trained to become clinical endoscopists over the last three years. The work undertaken to develop this career pathway has put the service in a place of greater resilience for future expansion.

The endoscopist post is where challenges may be seen, unless there is investment in this internal 'Grow Your Own' programme, especially given the age profile of current consultants. Dr Ali added that many clinicians are delivering one or two sessions a week in endoscopy. The key is job planning, and increasing the amount of complex endoscopy delivered. Mrs Gostling advised that, from the analysis undertaken, proposals would require significant additional workforce. A robust workforce plan would be required, to ensure that more than two people are being trained a year to meet the required levels of staffing.

Dr Wooding enquired around the community provision element. He suggested that, if the Health Board is able to future-proof the work the service is currently engaged in, this seems increasingly likely to take place in communities in the future. Particularly as technology evolves, offering opportunities to mobilise screening services. Dr Ali agreed that much of the volume is high-volume diagnostic work which can be community-based. There are models for this in England and America. The ideal is to separate this very important cancer-related work from the emergency work. There are also newer techniques, which are coming through, which will reduce the need for sedation, allowing people to be discharged sooner. However, these are mainly for the future, hence the suggestion of a longer-term model.

For clarity, Mr Prior queried whether what is being proposed is more reflective of 'a direction of travel'; whether it involves a new site or a new service for communities. Secondly, he noted that prevention has been touched upon but not covered in detail, suggesting that this should be part of the Board's considerations. In response to the first query, Ms Jones felt that it is a combination of the two. Proposals would allow service delivery expansion; however, there are many services already being delivered that do not necessarily need to be on an acute site. As also mentioned, the new service methods within Endoscopy lends themselves even further to a non-acute setting. Dr Ali added that the current reliance on waiting lists initiatives and insourcing is not sustainable, and is expensive. The service will also very quickly reach a point where it has saturated the available endoscopy theatre capacity. The options proposed are all around preparing for demand and establishing the required capacity.

Dr Gjini noted several references to the bowel screening cancer colonoscopy services, and enquired whether the service has any estimates, for each option, of the performance improvement possible. This in view of the fact that currently, approximately 40-45% of patients referred for colonoscopy are seen within 4 weeks, and there is less than 60% uptake for screening. In response, Dr Ali emphasised that any of the options would increase capacity for bowel screening. There are significant challenges across Wales.

Against the target of 4 weeks, HDdUHB is at 5-6 weeks. In some Health Boards, the wait is longer. Increased capacity will mean more patients being seen and that timelines are met. There is also a workforce element involved; with staff undertaking more bowel screening, rather than other competing tasks.

Professor Kloer noted that it will also be necessary to identify different ways to manage the increasing demand. Every endoscopy undertaken has to be of high value. As with all endoscopy units across the UK, there will be a proportion where the value would probably be questionable. This has to be part of the thinking, and AI may assist in this regard. Dr Ali agreed, noting that this is a very current topic. There are new guidelines around what is called low-yield endoscopy. New tests are also being developed, including enhanced FIT. Whilst it will never be feasible to stop all the low-risk cases, because patients affected by significant symptoms will present to GPs, and ED, the idea is to reduce that number as much as possible.

Mr Henwood highlighted that the discussion around Endoscopy is different from other services. Hywel Dda is very fortunate to have a service that reaches the highest standard, this being the case for a number of years. Despite that, and the fact that the team have been at the forefront of the important changes to this service, an 5% increase in demand is being seen every year. Hence change is still absolutely necessary. As indicated, the Health Board has relied for 15 years on waiting list initiatives and weekend working. This is not and never has been sustainable.

Dr Wooding thanked Dr Ali and Ms Jones for attending the meeting and sharing their thoughts.

Dr Faiz Ali and Ms Sara Jones left the meeting. Dr Liaquat Khan and Ms Sarah Procter joined the meeting.

Radiology

Drivers for Change
Dr Liaquat Khan, consultant Radiologist and Clinical Lead presented the case for change in Radiology, which is immensely important at this point. Within Radiology, the demand for imaging has grown exponentially over the years. Modern healthcare is heavily dependent on imaging. In many pathways, imaging is the gold standard for diagnosis and monitoring of the disease processes.

With regard to recruitment, in the last few years, there have been a number of retirements and challenges in recruitment to substantive positions in the Health Board. This has significantly increased locum staff usage, which can have an adverse effect on quality of service, standard of care and is very costly. It also means that the substantive consultant radiologists are being overused do not have sufficient time for staff development. Replacing equipment has been another problem, together with

overloading of the equipment due to underfunding and space constraints. This has increased downtimes, adversely affecting waiting times.

Options
Ms Sarah Procter outlined the four options developed by the Options Development Group. She wished to emphasised that none of the options affect emergency scanning at the four main sites, which will remain as 24/7 access for all emergencies and inpatients. All four options identify closure of X-ray services at Llandovery and South Pembrokeshire Hospitals. Two of the Options, B and E, propose increasing the number of planned outpatient scans performed, by extending the working day into evenings and weekends. One of those two options, Option B, involves developing a new diagnostic hub. Options A and C do not change the number of planned diagnostic procedures, but propose centralising interventional radiology services. There are issues with this.

Preference by Respondent Type
Ms Couceiro presented the themes from questionnaire responses linked to the Radiology service. For NHS employees and other individuals, Option B was the preferred option followed by Option D for both groupings. In terms of third and fourth preference, for NHS employees, this was Option A, then Option C. For other individuals, there was very little difference between Option A and Option C in terms of preference.

Preference by Nearest Hospital Site
Moving on to responses based on nearest acute hospital site, for people living closest to BGH and GGH, Option B was preferred, then Option D, Option C and Option A. For those living closest to PPH and WGH, again, Option B was the preference, then Option D, followed by Option A and Option C.

General Feedback
Moving onto the next slide, one of the key, themes to note was linked to Llandovery Hospital. As mentioned, in all options consulted on, there was a proposal to remove radiology services from Llandovery Hospital. There was a significant presence at the drop-in event with that community. There were certainly some misunderstandings linked to the potential closure of Llandovery Hospital, which is not what this option was proposing. However, there was also more general concern around the removal of radiology services and how that might impact the Minor Injury Unit which was temporarily closed, following COVID-19.

There was also some confusion by some respondents around planned radiology services and emergency access, with people worried about where to go in an urgent and emergency situation. In terms of retention of the current status quo, there were some respondents who were keen for their radiology services to be retained across all hospital sites. This was certainly a strong theme in relation to Llandovery, as mentioned earlier. In terms of

staffing assumptions, it was heard very strongly from some staff working within radiology services that the suggestion within the consultation documentation that 12-hour shift patterns could be preferable and help address some of the challenges with workforce was not reflective of what all staff felt. Some felt it could negatively impact recruitment and retention of staff. Finally, on improving access and capacity, there was general support if it actually results in improved access for patients. However, there were concerns linked to extended hours and where services are brought together across fewer sites around whether that can be realistically staffed; and how it impacts public and communities in terms of transport as well.

Alternative Options

Ms Procter advised that there were a number of alternative options suggested by public and staff during the consultation. Four of these met the hurdle criteria. Option 24 is a variation of Option B, with no diagnostic hub. It would extend working days at all four sites, and included the cancer focus at two sites. The cancer focus was for patients undergoing multiple tests during cancer diagnosis, so that they could have all their investigations on the same day. Option 25 is another variation of Option B, but with a smaller diagnostic hub. As in Option 24, extending the working day at all four sites, and a diagnostic hub, but a smaller hub than the original Option B. Option 103 is a mixture of Options A and B, with an extension of the working day at two sites, a diagnostic hub, the cancer focus at two sites, and also the centralisation of inpatient interventional services on one site. The last option was Option 122, which is the current service configuration. The only difference was extension of the working week to seven days a week for X-ray services at the Cardigan Integrated Care Centre.

Option Scores; Key Dependencies/Longer-Term; Options for Consideration

All eight options were scored during a clinical-led options appraisal. The highest scoring was Option 103, closely followed by Option B. Option 103 scored the highest in three domains, safe, accessible, and kind, and Option B scored highly in sustainability, although Option 103 was very close in sustainability score.

The Radiology service agree with the options appraisal group that Option 103 is the best option to address the issues identified in the case for change. Implementation would need to be staged, due to requiring the building of a diagnostic hub. However, in the first four years, which it would take to build a hub, the plan would be to start implementation with the extension of the working day at two sites, and the centralisation of inpatient interventional services at one site. This would provide some stability, improve staffing levels, and help to meet demand. Until the hub was implemented, there would still be reliance on outsourcing. However, this would be reduced over the four years. This option would allow the service to recruit and provide a more attractive configuration, particularly for interventional radiology. It would be easier to recruit

and maintain a substantive service if it was based at one site for the most urgent patients, but allowed non-emergency patients to have planned interventions at a hospital nearer their home.

There is a risk that there will be an increase in inpatient transfers for interventional radiology, however it was recognised this was already happening in the service, and it is not envisioned this would increase greatly. There is a risk that the workforce challenges would persist, particularly around interventional radiologists. However, centralisation of the service would help facilitate more regional working with Swansea Bay, who are also having issues, this being a UK-wide issue. The longer-term phase would offer the benefits of a purpose-built diagnostic hub, which would improve retention and recruitment, and co-location of services would result in improvements in efficiencies. The hub will improve diagnostic waiting times to meet diagnostic targets for routine RTT patients and cancer patients. The risk is obviously the capital investment needed to build the hub.

Key dependencies are the removal of X-ray services at Llandovery Hospital, which will result in up to 27 patients per week having to travel further for X-ray. South Pembrokeshire Hospital only recorded two attendances last year. The interdependencies are that emergency services in all four sites will remain as they are, and unchanged, which is that X-ray and CT services are provided 24/7. There are some equipment challenges, with the X-ray machines at Llandovery and South Pembrokeshire Hospital needing to be replaced with digital technology in order to be used after July 2026. This would require Welsh Government funding, and would need to be prioritised above other essential equipment due for replacement. For context that is, at present, the GGH CT scanner and the WGH Gamma camera, both of which are end-of-life and will significantly affect patient care and safety. It is felt that there would be more regional working; consideration needs to be given to how this can be combined to increase capacity and reduce risk across some of the services.

Dr Wooding requested clarification around patient numbers, noting mention of 27 patients per week X-rayed at Llandovery Hospital, and querying whether this was the one day per week. Ms Procter confirmed that this was correct, with 27 being the maximum. The usual figure is around 15 per week, as access is limited to one specific day. Some patients opt to travel elsewhere due to other sites offering more of a choice of days and hours.

Returning to an earlier query, Cllr. Evans noted a recurring theme around capital investment, and enquired how much detail the Board will receive. A number of options are reliant on capital monies being forthcoming in the next four years or so for community hubs, etc. Mr Lee Davies stated within Radiology, there is the physical capacity at present to expand activity. The intention would be to maximise use of this physical capacity in the first instance. However, similar to Endoscopy, the ambition is ‘get ahead of forecast’ by 4-5 years in terms of projected demand for

the population, recognising a new hub would require significant investment and take a great deal of time to build. In the first instance, the proposals are to test the Board's appetite and the services' view on whether that is something which should be aspired to. If it is, clearly a business case process would need to be commenced at some point in the future, and would be subject to Welsh Government support.

Dr Wooding also reiterated his earlier response, noting that, as a Board the task for this meeting is to consider and evaluate each of these known services and provide a degree of endorsement for what is considered to be the correct approach. This will then need to be subject to further work in relation to the detailed implications, including financial, and further public involvement. Whilst accepting this, Cllr. Evans highlighted mention of equipment reaching end of life by the end or middle of this year, and enquired how this will be managed, given the need for a decision. In response, Dr Wooding suggested that there will be work underway to consider equipment replacement. He emphasised that this is not for the Board to consider as part of its decision-making process.

Noting ongoing focus on efficiency and the move to seven-day services across some sites, Mrs Marks enquired whether the capacity to deliver this is available, and whether it would have an impact on recruiting staff, either positively or negatively. Ms Procter replied that additional staff would be required. Whilst the service already does operate seven days a week, this is on the basis of staff covering extra hours, or being on-call. The on-call demands have totally changed, from staff coming in to scan a couple of patients a night, to now scanning 20 to 30 patients on some sites on their own. This has inherent safety concerns, with lone working. Whilst there was feedback during the consultation that some staff did not endorse 12-hour shifts, this is the model in every hospital in Wales except HDdUHB. What is also heard clearly from a lot of the radiographers is that they want flexibility. Whilst some staff would not want to work three 12-hour days, there are mechanisms to allow flexibility for days off, and more work-life balance. Radiographers do not currently have this, given that they work almost every weekend. Mrs Gostling agreed that there are significant workforce implications and recognising current recruitment challenges, robust workforce planning would be required.

Ms Procter emphasised that the radiography profession is keen to explore 'grow your own' options. At present, although this is a route offered in England, it is not offered in Wales. There are members of staff working for HDdUHB at Band 3 level, who would be keen to undertake that training. They do not want to undertake the training as it is at the moment; a three-year full-time degree in Cardiff. There has been more success around 'grow your own' radiologists. From the radiology consultant's perspective, Dr Khan explained that the Health Board has adopted a model of recruiting young consultant radiologists qualified, but not trained in the UK.

They are provided with the required experience, and in two years' time, are eligible for substantive consultant positions. Five consultants have been recruited via this model. Five more locum consultants have been recruited, and are now in this process. Even so, HDdUHB is far behind the standards. Using SBUHB as an example, as both the nearest health board and has a similar population and activity level: SBUHB has 28 consultants, whilst HDdUHB's establishment is only 18 consultants. With the addition of locums and specialists, it has 22 consultants currently. Mr Severs wished to reassure the Board that conversations with Health Education and Improvement Wales (HEIW) regarding the apprenticeship scheme for radiographers, as part of the wider workforce plan, have already been undertaken.

Mr Prior repeated concerns around equipment at Llandovery and South Pembrokeshire Hospitals needing to be replaced by July 2026, requiring an immediate decision. Secondly, he wished to double-check patient numbers at Llandovery Hospital, noting that this totals around 1,400 a year, and querying what proportion this represents. Ms Procter confirmed the numbers, whilst highlighting that this is the maximum throughput and the reality is lower. For context, approximately 10,000 X-ray examinations are delivered per month across the Health Board. In response to Cllr. Evans' query, Professor Kloer explained that once decisions are made, it will be necessary to bring back to Board an implementation plan for the whole programme. Those aspects requiring capital investment will, of course, be subject to a business case process. For the decisions more concerned with implementation and improvement in the two to four year timeframe, there will be a range of dependencies. Meaning that some will be more complex in their delivery plan than others. On the specific point around equipment reaching end of life, the team will already have business continuity plans in place to manage patients should those machines stop working, for example.

Dr Wooding thanked Dr Khan and Ms Procter for their time and contribution to discussions.

Dr Liaquat Khan and Ms Sarah Procter left the meeting.

PM(26)41 **Role of Acute Hospital Sites**

Introducing this item, Mr Alex Martin explained that it had resulted from the options development process. The decisions made tomorrow may have a cumulative effect and impact on the hospital sites themselves. During the consultation, the public were asked for responses based on this theory. It is worth noting that this aspect was a result of the options work, not something that led to the options work.

Ms Couceiro advised that, as part of the CSP questionnaire, there was a question on the future roles of hospital sites. Each of the acute hospital sites included a summary outlining what might be its future role. The responses were categorised as 'strongly agree', 'agree', 'disagree', 'strongly disagree', and 'don't know'.

Preference by Respondent Type
As a point of clarity, 82 respondents to this question selected 'don't know', with the split between NHS employees and other individuals as shown. They are not included, in line with standard practice. There were similarities between both groups, with 'agree' or 'strongly agree' making up 40% of the responses; and 'disagree', or 'strongly disagree' making up another 40%. Fewer than 20% of respondents to this question neither agreed nor disagreed with the summaries.

Preference by Nearest Hospital Site
For those closest to BGH and WGH, more respondents indicated that they disagreed, or strongly disagreed with the summaries for the future roles of the acute hospital sites. For those living closest to GGH and PPH, more people indicated that they agreed or strongly agreed with how the future roles of the hospital sites were summarised.

General Feedback
In terms of broader feedback heard during the consultation, one of the key themes linked to the future role of the hospital sites was around the Health Board's plans for Urgent and Planned Care. Some questioned whether there will be a new hospital site, and there questioned whether this would be delivered. Travel and transport, again, was another key theme linked to the future role of hospital sites. Particularly from respondents closest to BGH and WGH, who felt that bringing together services at locations other than their local hospital site would increase the number of unsafe transfers and reduce local access for those communities. The condition and suitability of existing estate and infrastructure was also mentioned, in relation to this question, particularly around GGH and the current state of the building, along with concerns around access and capacity. Car parking was another issue raised. Finally, as touched upon by Mr Martin, the cumulative impact, with fears that this could place unsustainable pressure on certain hospital sites.

In summary, Mr Alex Martin explained that the position following consultation is that, whilst not all services or pathways might be provided on each of the sites, the hospital sites would each have their own part to play within that wider network. In order to facilitate this, the organisation needs to ensure that there are continuous professional development approaches, the ability to share skills between site teams, and the travel and transport support; not just for patients and their visitors, but also for staff. Finally, the consultation did not look at changing the emergency system as part of the CSP. Therefore, the descriptions all look to retain the services to meet urgent and emergency patient need.

Ms Thomas suggested that, from a public perspective, there is a natural scepticism, when talking about sustaining the hospitals, given suggestions of removing services from particular sites. Dr Wooding felt that as the Board had worked through the options

today, it has been possible to see where some of these elements will realign. He reminded Members of the challenge he referenced at the beginning of the day, in that every hospital in the country will need to transform over the next decade. HDdUHB needs to embrace this process; it cannot, as a health board, decide that it will not impacting upon this part of Wales. It will impact on the organisation for all the reasons outlined, in terms of increasing specialisation, the advancement of medical knowledge, the shift towards primary community services and the introduction of more AI, automated and digital processes. However, it is recognised that patient communities need an understanding of what this means for them, and Dr Wooding was not certain that the Health Board has been sufficiently clear in this regard. There needs to be clarity around the patient experience, and assurances for people living in local communities around the changes and that their local hospitals will continue to thrive. Demand is growing exponentially; it is necessary to reform and repurpose services, and think about how they are delivered differently, to ensure that they deliver the best possible outcomes for patients. This will mean that sometimes those services will need to move to different areas.

Noting that the Board has heard from staff today about some of the Health Board's most fragile services, Ms Harraway wished to recognise and thank the staff who are keeping those services going, in extremely challenging circumstances.

Dr Wooding was conscious that the Board has undertaken 6-7 hours of mindful deliberation around the decisions required tomorrow on nine separate services. He suggested that it was probably a good time to close this part of the meeting, and for Members to spend the evening reflecting and processing the core information they have been exposed to today. He thanked Members for their attention, energy, time, commitment, passion, and contribution to the meeting.

Date of Meeting:	**9:30am, Thursday 19 February 2026**
Venue:	**Y Stiwdio Fach, Canolfan S4C Yr Egin, College Road, Carmarthen SA31 3EQ**

Present:	Dr Neil Wooding, Chair, Hywel Dda University Health Board Mrs Eleanor Marks, Vice-Chair, Hywel Dda University Health Board Mr Maynard Davies, Independent Member (Information Technology) Cllr. Rhodri Evans, Independent Member (Local Authority) Ms Sarah Harraway, Independent Member (Community) Mr Michael Imperato, Independent Member (Legal) (part) Ms Ann Murphy, Independent Member (Trade Union) Mr Neil Prior, Independent Member (Community) Mrs Chantal Patel, Independent Member (University) Mr Iwan Thomas, Independent Member (Third Sector) Professor Philip Kloer, Chief Executive Mrs Lisa Gostling, Deputy Chief Executive and Executive Director of Workforce and Organisational Development Mr Andrew Carruthers, Chief Operating Officer Ms Sharon Daniel, Executive Director of Nursing, Quality and Patient Experience (VC) Mr Lee Davies, Executive Director of Strategy and Planning Dr Ardiana Gjini, Executive Director of Public Health Mr Mark Henwood, Executive Medical Director Mr James Severs, Executive Director of Allied Health Professions and Health Science Mr Huw Thomas, Executive Director of Finance
In Attendance:	Ms Alwena Hughes Moakes, Communications and Engagement Director Mrs Joanne Wilson, Director of Corporate Governance/Board Secretary Mr Ben Rogers, Principal Programme Manager Ms Nichola Couceiro, Head of Engagement Ms Yvette Pellegrotti, Principal Programme Manager Mr Alex Martin, Principal Programme Manager Ms Sarah Isaac, Clinical Lead, Transformation Programme Office Ms Kathy Graham, Hugh Irwin & Co. Associates (HICO) Ms Cathie Steele, Interim Assistant Director of Nursing Assurance and Safeguarding Ms Clare Moorcroft, Committee Services Officer (Minutes)

Minutes Ref.	**Item**	**Action**
PM(26) 42	**Welcome and Apologies**	
	Dr Neil Wooding, Health Board Chair, opened the second day of the Extraordinary Board Meeting by welcoming all attendees and members of the public observing the session. Apologies for absence were received from: • Mr Winston Weir, Independent Member (Finance) • Dr Jonathan Arthur, Health Professionals Forum Chair • Ms Donna Coleman, Llais West Wales • Ms Alyson Thomas, Llais West Wales	

- Mr Michael Gray, Director of Social Services and Housing, Pembrokeshire County Council
- Ms Mwape Burke, participant in the Aspiring Board Members Programme

Dr Wooding explained that the Board now needed to move into decision-making regarding the Clinical Services Plan (CSP) and the preferred options for each of the nine service areas considered. He reminded the Members of the Board's five decision-making 'design principles':

1. Fair
2. Affordable/sustainable
3. Consistent with the Health Board's strategic approach
4. Does not create an unhelpful precedent
5. Safe

These principles, he noted, must guide the selection of each option. He stressed that decisions needed to be measured, considered, and thoughtful, and that the Board had been provided with extensive information – much of it highly technical – to support these judgments. https://nhswales365-my.sharepoint.com/personal/karen_l_richardson_wales_nhs_uk/_layouts/15/Doc.aspx?sourcedoc={CAA0AF21-E812-4428-9899-849B054063AC}&file=GMT20260219-092520_Recording.transcript.word.docx&action=default&mobileredirect=trueHe also clarified that the Board would not be rehearsing the previous day's content, but instead using the overnight period of reflection to address any remaining issues before moving to decisions.

PM(26)43 Declaration of Interests

Mrs Chantal Patel declared an interest in items PM(26)49 and PM(26)50, noting her employment with Swansea University. She would withdraw from discussions at the relevant juncture.

Mr Maynard Davies declared an interest in items PM(26)49 and PM(26)50, as a member of the Information Governance Review Board.

Professor Philip Kloer declare an interest in items PM(26)49 and PM(26)50, noting that he holds an honorary chair with Swansea University.

PM(26)44 Clinical Services Plan Decision-Making

Mr Lee Davies provided a high level overview, explaining that the programme had followed a detailed, methodical, transparent and independently assured process to evaluate issues and develop options across nine key service areas. The Board had received independent assurance regarding the process and a detailed consultation report. He explained that the CSP has been built on a layered evidence pyramid, with the top layer reports presented to the Board summarising extensive technical analysis beneath them. The consultation process itself had involved:

- More than 4,000 people attending engagement events and a similar number completing questionnaires, producing a rich set of views

- Evidence from thousands of engagement interactions
- Detailed programme impact assessments, including equality, health, workforce, capital, environmental and financial modelling

All alternative public-generated options which passed the established thresholds were included, with 22 incorporated into the final long-list.

Mr Lee Davies reminded Members that, from an acute services point of view, three services were considered: Emergency General Surgery, Critical Care and Stroke. The Board had heard from clinicians and service leads that these services have become more specialist in their nature over the last decade or two. Whilst this has enabled better outcomes for patients and higher standards, it generally means that services are delivered in fewer locations. This presents a challenge for HDdUHB, as a health board which provides services over a large rural area, and needs to be factored into decision-making. The numbers of patients affected by those services can be quite small compared to some of the other services being considered, but the impact is very significant, and this has been heard through the consultation.

However, it also needs to be recognised that the Hywel Dda population does not currently benefit from the advancements in standards seen across the rest of the UK and the world. The Board needs to consider how the future service configuration will set the foundations for HDdUHB to be in a position to deliver those standards in the future. It was also noted that it will be difficult for the organisation to recruit consultants and specialist workforce in these areas if it is not in a position where it can deliver the modern standards of care. So, whilst there are a number of concerns around the current position, and it is recognised that those services are not optimal, this does present an opportunity today. The opportunity being to take decisions which will improve outcomes and secure the long-term future of those services in West Wales.

Four planned care services were considered: Orthopaedics, Ophthalmology, Dermatology and Urology. From a planned care point of view, there is a different set of challenges. Some services have workforce challenges and fragilities, particularly in areas such as Dermatology. However, often the challenge is more about waiting times and the delivery of activity to meet the needs of the population in a timely fashion. Whilst during the course of the Clinical Services Plan (CSP) work, it has become clear that improvements in waiting times have been delivered in a number of areas; nonetheless, the waiting times remain longer than Members would want for themselves and their families. There have been temporary service changes since COVID-19 in a number of services. Part of the decision-making through the course of today will allow the Board to determine the permanent arrangements for those services. Given the nature of the challenges within planned care, productivity and efficiency of the

services become an important consideration in decision-making. In particular, reducing and eliminate unsustainable and ad hoc solutions to delivering activity.

Two diagnostics services were considered: Endoscopy and Radiology. These services are critical to a range of pathways beyond the services themselves. They present with a different set of challenges, and are not fragile in the same way as some of the other services. However, their activity is measured in the thousands, not in single figures. Whilst again, some improvement in waiting times has been seen over the course of the CSP work, these areas are also seeing significant demand growth, which is projected into the future. Therefore, Board considerations need to be around how these services can be configures to meet future demand, to ensure delivery of timely care across all the pathways that those services support.

Mr Ben Rogers reminded Members of the key programme materials and information considered as part of the meeting, including the independent consultation report from Opinion Research Services, the alternative options, the findings from the extraordinary Quality, Safety and Experience Committee (QSEC) sessions and the informing plan; together with the conscientious consideration undertaken. All of which is supported by various processes and documentation, including detailed impact assessments covering equality, health equality, quality and environment, as well as the capital workforce and financial indicative estimates that underpin some of the evaluation criteria for the programme. Together with today's materials, these represent only the top layer of the CSP information pyramid. Mr Rogers also wished to thank Hugh Irwin & Co. Associates (HICO), who are providing external quality assurance based on the Centre for Consultation framework.

Bringing the process to today, and into the decision-making stage, Members will note that options can be delivered in a sustainable way that resolves the issues, yet also recognises the limiting factors that may need further work, such as additional funding or longer-term programs of work. It supports resolving pressing issues or mandates for change in a timely manner, whilst also recognises the Health Board's routine business case process to support detailed analysis in the next phase of our program planning. Three phases are being contemplated:

- The implementation phase looks at how current issues and challenges are managed
- The improvement phase mandates for those medium-term changes or sustainability items
- The longer-term phase involves items that might be more strategic that might take longer to achieve

There are timelines associated with these phases.

Mr Alex Martin explained that, normally when the Board is being asked to make decisions around service change, a report is provided with recommendations regarding the options. The CSP approach is different; firstly, in that there are nine services involved, and 48 options. Today's deliberations will be based on considerations from yesterday, and the Board will be asked to potentially make one of three choices regarding their decision:

1. Decision – the Board feels confident that it has received sufficient information; that the options respond to what has been heard during the consultation; and that the organisation can move forward and begin implementation.

2. Provisional Decision – the options are felt to respond to what has been heard during the consultation; however, it is recognised that the workforce and the finance assessments are indicative at this stage, given the number of options. The Board may have identified a preferred direction of travel, but wants this to be explored further and more detail to be provided before making a final decision.

3. Pre-provisional Decision – a number of ideas were shared yesterday, including options that were not fully tested during the consultation. These emanated from the consultation, and responded to the issues, but may have impacts that are yet unknown for members of communities. These may need to be tested further through a targeted piece of engagement.

Ms Kathy Graham, public consultation expert, reiterated that the consultation had been thorough, statutory, and well-designed, enabling the public to give informed views on benefits, risks, mitigations, and alternative ideas. Her assessment was that:

- The public had been provided with sufficient information
- Their responses had enhanced and improved several options
- Additional engagement would only be needed where a new, materially different configuration emerged that was not consulted upon
- Organisations should avoid entering a 'consultation loop' once evidence and mitigations were sufficiently robust

Before moving onto the options consideration, Mr Martin wished to clarify that is not anticipated any of these changes will materially impact the annual plan for next year. This is due to timing for submission of the annual plan and the additional work potentially involved in the options. What is expected is to see, potentially, the work involved in delivering some of these options appear in that plan. However, the outcomes may not be delivered until the 2027/28 planning process onwards. The other important consideration is that Members will have heard yesterday from the services details of the work they have been undertaking recently to tackle backlogs, through waiting list initiatives, etc. This is largely being delivered on the basis of goodwill, which is clearly not sustainable. The options (including the alternative options)

present mechanisms for delivering these gains on a sustainable basis, without the additional workload. This, again, would be expected to be included in future annual plans.

Mr Martin also reminded Members of the top three criteria that the options responded to, which were as follows:

1. Clinical sustainability – would there be a need for that service? Would there be enough patients to make it a viable service?

2. Workforce sustainability – would the Health Board be able to recruit the staff to make sure that that service is sustainable?

3. Compliance and attainment of standards – would the Health Board, by making these changes, improve the standard and quality of care it is able to provide?

When considering the options, Members should be cognisant that they have been assessed positively against these criteria, which is why they have been put forward. Mr Martin emphasised, however, that this does not restrict the Board to the options presented, if there are others that they feel should be considered.

PM(26)45 **Acute Services (Emergency General Surgery, Critical Care, Stroke)**

Ms Sarah Isaac presented a slide highlighting key considerations from the public consultation feedback and service dependencies for Emergency General Surgery, Critical Care and Stroke. Some of the key considerations are transport and transfer of patients, transport and travel for patient visitors, impact on the Welsh Language (as considered through quality impact assessments) and regional working. Dr Wooding was conscious that, throughout yesterday, transport was a recurrent theme in feedback from the consultation for every service. Ms Alyson Thomas from Llais had made a helpful suggestion around the need to think about this strategically, and develop a transport, travel and transfer plan. It is necessary, in this to understand the distinction between these; with transfer being between hospitals, so fundamentally within the Health Board's gift and operation. Transport is, however, much more systemic, and not within the organisation's gift in the most part. This will require a different approach in working with partners, which may take some time.

Emergency General Surgery (EGS)

Members were reminded of the options for consideration (Option A, Option 155 and Option 222).

Clinical Overview
Mr Mark Henwood, speaking as a surgeon with 20 years' experience in this specialty at HDdUHB, provided a clinical perspective on the historic fragility in general surgical provision. He explained that the long-standing disparity between sites has contributed to inconsistent care, difficulty maintaining compliant

rotas, and variable access to specialist surgical assessment. He emphasised that Option A is the clinically safest and most sustainable model, and would:

- Strengthen rota viability by consolidating consultant-led emergency surgery at Glangwili Hospital (GGH)
- Ensure equitable standards for all patients
- Enable continued and enhanced Same Day Emergency Care (SDEC) at Withybush Hospital (WGH), meaning most patients could still be assessed close to home
- Reduce reliance on locums and temporary arrangements, providing workforce and rota sustainability

Operational Considerations
Echoing this view, Mr Andrew Carruthers explained that Option A retains as much activity as possible at WGH, with only specialist surgical cases transferred to GGH, providing care closer to home. Also, it is challenging to staff Out Of Hours rotas across multiple sites. Option A would make rotas more attractive in recruitment terms. Mr Huw Thomas recognised that the proposed options provide the Health Board with a clear direction of travel, and agreed with this direction. He wished to emphasise and clarify, however, that the investment involved in the improvement and longer term phases would require a business case to return to the Board in the future.

Quality Impact Assessment (QIA)
Ms Sharon Daniel reminded Members that, in line with the Health and Social Care Quality and Engagement Act, the Health Board is required to demonstrate that all strategic decisions are informed by the Duty of Quality. This focuses on six statutory domains of quality: ‘Safe’, ‘Timely’, ‘Effective’, ‘Efficient’, ‘Equitable’ and ‘Person-centred’ (STEEEP). She wished to assure Members that, to fulfil this obligation, a full QIA has been undertaken for every shortlisted option across all nine services within the CSP. This is intended to provide the Board with a structured, evidence-based understanding of the anticipated impact of each configuration prior to determining the preferred service model. Across all the services, the quality impact assessment process confirmed that the CSP represents a critical opportunity to address long-standing fragilities, workforce sustainability challenges and variations in service delivery and inequity of access.

For EGS specifically, the QIAs for Options A and 155 confirmed that the centralised model:

- Reduced reliance on locums
- Offered safer, more consistent patient pathways, supported by the expanded SDEC provision

Mr Michael Imperato sought clarification on rehabilitation pathways for Pembrokeshire residents. In response, Mr Henwood advised that only a very small number of patients – typically fewer than one patient per week – would require transfer to GGH for

surgery or assessment by a specialist surgeon. Most patients would be discharged directly home from GGH following recovery. A degree of early rehabilitation will be undertaken in GGH, and then a proportion of patients may return to WGH for further rehabilitation, or to the community, or return home. These pathways already operate safely and would remain unchanged. Mr Maynard Davies noted that the numbers indicated yesterday were 9 per week. It was noted that this was a maximum number, and it was anticipated that this would decline. Mr Henwood clarified that this figure relates to the patients having inpatient emergency surgery at the moment. The majority of those will not require rehabilitation. At WGH currently, one patient a week has a major emergency abdominal operation; these are the patients that are likely to need some form of rehabilitation afterwards.

Mrs Lisa Gostling highlighted that the different options presented have different workforce requirements. The organisation has been able to undertake an assessment around the potential medical and nursing requirements. However, further work would need to be undertaken around therapy input into some areas, which would require a workforce plan for those three options.

Dr Wooding noted that this consideration is predominantly concerned with the implementation period. He reminded Members of his statement yesterday that the current 'ask' of Board is around endorsing a direction of travel. The practicalities and the operationalisation of this will need to follow afterwards.

Mrs Chantal Patel requested clarification of what 'strengthening SDEC' means in practice. Mr Henwood explained that this involves increasing structured, planned same day assessment, providing what the public needs, ie:

- Rapid assessment closer to home
- Appointments, rather than unplanned attendance
- Appropriate diagnosis, generally on the same day
- Discharge with diagnosis, treatment plan and follow-up plan

He confirmed that WGH already has an excellent medical SDEC service, and surgical SDEC capacity can be expanded with some changes and improvements.

Mr Neil Prior wished to comment in the context of all the decisions the Board needs to make today. He felt that the population, to a great extent, want everything, everywhere, which has been, in the main, the model until now. This is no longer sustainable. The prevailing narrative, both politically and through the media, has been about loss of services, rather than future focus, which is unfortunate and has to change. There is an element, with all of these decisions, of asking the population to trust the decision making process. The Health Board has a responsibility to get some of the basics right, such as scheduling appointments, to build trust among the population. It also needs to work with communities and individuals with regard to prevention and

community provision. Fundamentally, however, it is vital to ensure that the true reason for change is articulated.

Dr Wooding emphasised that the Board has both a statutory and a moral responsibility in this regard. The statutory responsibility is to not knowingly deliver services that are suboptimal or do not meet the standards. Morally, there is a broader question about the right thing to do in this environment. What is the right decision and what is the good decision often do not align. Nevertheless, the Board has a responsibility to consider the future, to enable these services to develop, thrive and prosper in the future to meet the needs of local communities. The various and sometime competing factors make these decisions challenging and very complex. There is also a need for courage, because it will not be possible to please everybody.

Mrs Eleanor Marks wished to recognise that Board members are part of the community as well as part of the Board. The decisions which are to be made must prioritise quality and outcomes above geography. The Board must also – in making these decisions – listen to its clinicians, who are being courageous and saying that the services need to improve. In addition, there needs to be cognisance of the fact that the Health Board's estate is 70 years old in parts, along with the fact that Hywel Dda's population demographic is changing. Dr Ardiana Gjini highlighted the need to be mindful of health improvement pathways, 'wrap-around' care and the Social Model for Health and Wellbeing. Prevention of ill health is key. She also encouraged Members to maintain an equity lens, ensuring socioeconomic factors do not widen inequalities. Finally she assured Members that outcomes will be monitored, with impacts of any changes reviewed and evaluated.

Mr Lee Davies reminded Members that, through the decision-making around each of these services, the intention is to set the direction of travel. In some cases, this will naturally fall into an implementation phase, an improvement phase, and the longer term. For Emergency General Surgery, he was of the opinion that Option A is the best option to deal with the most immediate issues, with an aspiration of Option 155, which enhances the service. Longer term, a strategic direction for health services in West Wales has already been indicated. Option 222 is the one which best aligns with that strategic direction, but is not possible to implement at this stage. It would also require a further period of engagement with the population.

Mr Huw Thomas wished to repeat, at the outset of discussions and in relation to the entirety of these, the message from yesterday regarding today's purpose. The decisions today are not driven by the need to make financial savings, they are driven by the needs of clinical services. However, the Health Board does have a statutory obligation to the taxpayer; and it should be recognised that fragile services, which are dependent on a small amount of individuals and have challenging clinical standards also bring with them financial cost. There is, therefore, a potential

financial 'dividend' in improving services. He also reiterated that improving certain aspects would require the development and submission to Board of investment plans and business cases.

Professor Philip Kloer reminded Members that this specialty involves the delivery of major surgical procedures, and that the Board heard from clinicians in the service that they are not satisfied with the standards of care they are currently able to provide. The focus is, therefore, on improving quality and experience for the public. The ideal is to treat as many people locally as possible, which is why SDECs are so important. The public in Pembrokeshire had expressed a preference for Option B. however, clinicians and service managers are concerned about on-call rotating between WGH and GGH. This would not only be a clinical risk, but a logistical operational risk, and also in terms of recruitment. These considerations add strength to the other options presented. Professor Kloer stated that Board's aim should be to agree a direction of travel today, and that a business case and implementation plan will be required, which would need to consider workforce and financial considerations. Clarity will also be required on outcomes and experience measures going forward. As mentioned, the Board will also need to consider – in respect of the longer term options – whether there is a need for additional engagement with the public, with Option 222 being an example.

Decision: The Board, noting clear clinical consensus, approved Option A for implementation. The Board further agreed that Option 155 would be aspirational in the shorter-term, and 222 would require business cases before implementation.
Option 222 remains the strategic aim, subject to the need for additional engagement and business case development.

Critical Care

Members were reminded of the options for consideration (Option 246 and Option A).

Clinical Overview
Mr Henwood indicated that the earliest driver for change was the inability to provide senior cover on a sustainable basis at PPH. This remains an issue requiring resolution. A Health Board wide Intensive Care service has always been the ambition; however, this would require investment in technical and digital development. Option 246 offers development of an Enhanced Care Unit (ECU) at PPH, focusing on license and GPICS guideline requirements, in the improvement and implementation phases. In the longer term, Option A is more strategically aligned to a model with two Intensive Care units.

Operational Considerations
Mr Carruthers advised that formalising the temporary arrangements which have been in place for several years would

stabilise clinical pathways, provide certainty for staff, and support safe elective flow.

Quality Impact Assessment (QIA)
Ms Daniel noted that the QIAs mentioned earlier also highlighted that the benefits of several options are contingent upon system-level enablers, particularly timely inter-hospital transfer, robust multi-site workforce models and appropriate estates configuration. A combination of those enablers is essential to ensure the safe and effective functioning of more centralised and consolidated service models.

In relation to Critical Care, the QIA panel noted that the option which strengthens or regionalises critical care, notably Option 246:

- Demonstrates clear quality benefits, including enhanced sustainability and improved adherence to GPICS and rural GPICS guidance
- Offers improved workforce resilience
- Is heavily dependent on establishing robust inter-hospital transfer arrangements across the system

Mrs Marks observed that for this, as well as for every decision today, it will be important to have an overview of what changes have been made where. This will be vital in providing information to the public around service models and which services are delivered on hospital sites, integrated care centres and in communities. Ms Alwena Hughes Moakes emphasised that Board decisions will not result in immediate changes to services; it will be a significant exercise to prepare the information which will be required for communication. For clarification, Mr Maynard Davies enquired whether Option 246 will require further consultation. In response, Ms Nichola Couceiro confirmed that, as it is aligned to the option already consulted on, further engagement would not be required. Mr James Severs suggested that, when discussing the options, the workforce perspective be key. There are significant opportunities and benefits available, which should be emphasised.

Noting that Option 246 was another option generated during the public consultation process, Cllr. Evans wished to highlight this evidence of how effective consultation can be. Mrs Patel queried whether there has been assessment of the cumulative system risk and impact on patient experience. Dr Wooding suggested that the discussions yesterday had centred on the positive and negative impact of some of these changes, should they be made, largely focusing on patient experience. The case for services being improved as a consequence of these changes was compelling. However, it is complex, and there will be elements not yet anticipated or assessed, calling for vigilance around unintended consequence or impact.

Mr Lee Davies stated that Option 246 does add to the previous Option B. It is an important addition, as it recognises the fragilities and the vulnerabilities, particularly of the Intensive Care service at

BGH. It capitalises on the benefits of BGH being part of a wider hospital network and able to seek additional support from GGH and other sites. Secondly, in terms of transfers, it is important to acknowledge that an acute critical care transfer service is already operating in Wales and between sites. Clearly there will be a need to consider how it may be enhanced. Finally, the Board has already committed strategically in 2018 to a model with two Intensive Care Units (ICUs), with the reasons for that reinforced yesterday. Whilst not in a position to deliver that immediately, or in the improvement phase, it is important to recognise that this remains the long term direction of travel.

Referencing the consultation findings, Professor Kloer noted that approximately 50% of people preferred Option C. However, feedback from clinicians, managers and Board Members highlights major concerns around operating four ICUs. Members have heard that standards in Critical Care have advanced considerably and that operating four units restricts quality, patient experience, sustainability, and recruitment. So whilst it is important to listen to the consultation findings, these significant concerns need to be recognised. Professor Kloer also reminded Members that Critical Care is treating the most unwell patients, requiring the highest levels of care, and the most technical aspects of care. In this situation, the expertise being drawn upon and the sustainability of the service really does impact on outcomes. Outcomes in this specialty can mean life or death and long-term disability. Whatever decision is made will require development of a business case; however, Professor Kloer hoped that it would be possible to move to the Health Board wide service described in Option A relatively quickly. In the meantime, he welcomed the enhancement offered by Option 246 which would improve sustainability for BGH.

Decision: The Board unanimously agreed to adopt Option 246 as the implementation and improvement model. In the longer term, Option A remains the strategic aim, subject to the need for additional engagement and business case development.

Stroke

Members were reminded of the options for consideration (Option A, Option 210 and merged Option 106/210). It was noted that, in all of the options, the Consultant and the Clinical Nurse Specialist (CNS) is retained at the BGH site.

Clinical Overview

Mr Henwood wished to firstly recognise the significant interest and involvement in Stroke Care, which he felt reflects the potential severity and consequences of Stroke. This highlights the Health Board's duty to offer the highest level of care, which is not the case under the current four site service delivery configuration. Change is, therefore, absolutely necessary if the Health Board is to produce the best outcomes for its patients. He suggested that there has been some confusion around the treat and transfer

model. For example, the phrase ‘Golden Hour’ has been used erroneously in relation to Stroke; this terminology relates to trauma care, not Stroke.

The proposal is that all patients will receive immediate, emergency treatment at their local hospital (scan and clot-busting drug, if required). They will then be transferred to an appropriate specialist unit, where there is direct access to specialists to ensure optimal recovery outcomes. Option A goes part-way to doing this, with a 12-hour service on two sites. Option 210, developed during the public consultation, is more in line with the long-term strategy of one site delivering 24-hour care. Option 106 describes a stroke unit in BGH and seeks to address some of the concerns of patients in mid Wales around support from families during the recovery phase. Potentially merging Options 106 and 210 provides for supporting patients to be rehabilitated close to home, and is also in line, with the long-term strategy of having one acute site for Stroke Care. To reiterate, however, in all options patients will receive immediate treatment at their local site.

Operational Considerations
Mr Carruthers shared the view expressed above, emphasising that operationally, a single specialist Stroke unit is the only way to deliver the required standards of care and should be the direction of travel. However, feedback from the public, particularly around the contribution of families during the rehabilitation phase is accepted.

Dr Wooding enquired whether the merged Option 106/210 would require further public engagement. He was informed that it would, as would Option 210 alone. In response to a query around how long a patient might spend at a specialist centre, having been transferred, Mr Henwood explained that this (hyper acute phase) would be, on average, 72 hours. The hyper acute phase requires access to specialist consultants, specialist nurses, physiotherapy and other allied health professionals. Mr Henwood also wished to reiterate that certain patients are already transferred for Stroke Care. For example, in the case of thrombectomy (the surgical management of Stroke) patients go to Cardiff or Bristol. This is the case for all patients in Wales. So treat and transfer already occurs. This model aims to ensure as, far as possible, that patients have care delivered locally, and return home as quickly as possible. Mr Severs highlighted that the hyper acute phase is the most intensive phase of the Stroke pathway. He suggested that this pathway and the language and terminology needs to be clearly and adequately articulated. For example, a significant proportion of the rehabilitation phase is provided by specialist clinicians. This differs from the rehabilitation which can be delivered closer to home. He was not sure that this aspect had been communicated sufficiently well.

Cllr. Evans suggested that Stroke highlights a variance in public views around travel; with patients generally more willing to travel to access Planned Care services, and wanting Unscheduled Care

services closer to home. He felt that the proposals would bring into question equity of access, with patients and families in the north of the region potentially having to travel 4 hours. The issue was less around the first 72 hours of treatment, it relates more to the fact that Stroke rehabilitation is a long-term commitment, extending to months, and that family input improves outcomes. Cllr. Evans did not feel that he could personally countenance supporting Option A. He further suggested that Option 210 should be enhanced by a Stroke rehabilitation unit at BGH. Finally, he reiterated the message heard consistently around travel and transport, with an urgent need for mitigation in this regard.

Mr Henwood emphasised that the current Stroke service is unsustainable. It is not achieving the required clinical standards, and is at Level D (E being the lowest). He did not feel that it would be possible to recruit the staff required to provide a unit of the type described above at BGH. Given the relatively small numbers of patients involved. Mr Henwood reiterated the severity of clinical outcomes in this speciality, emphasising the need to have in place the right service for every patient. Historically, the All Wales direction is that Hywel Dda does not have a sufficient population to support any Stroke unit. Certainly, it is likely that a maximum of one for the region would be the direction.

Mr Prior indicated that he had found the evidence from the Stroke Association powerful. He agreed that there needs to be 'myth-busting' conversations around treat and transfer. He also highlighted the need for a focus on prevention, which helps to secure the best possible outcomes. Mr Prior suggested wider engagement with communities around Stroke Care in general. He felt that the merged option was the correct course. Ms Sarah Harraway noted that the merged option has not been through the hurdle criteria or options appraisal/scoring process. Mr Martin confirmed this, indicating that, whilst elements of Options 106 and 210 had been tested, the merged option had not. Formal workforce, finance, estates and QIA modelling would be required. Ms Hughes Moakes highlighted concerns raised during the public engagement around Welsh language accessibility post-stroke, particularly for those patients who lose English fluency. She wished to assure Members that this will form part of any evaluation of impact.

Mr Lee Davies recognised that many people, including Board Members, will have been affected by Stroke. The impact of this condition is felt for years, not just days and weeks. The clinical evidence is clear; the Stroke Association, the UK guidelines on Stroke, the All Wales Quality Statements all advocate for fewer centres to provide better outcomes. Stroke has shifted from a generalist to a specialist service nationally. This is also the model for other specialties, with patients travelling to access major trauma, thrombectomy, neurosurgery and cardiac services.

Option A is the most deliverable option, which would provide the most immediate benefits. However, there are challenges with that.

Whilst Option 210 would provide some additional opportunities, it would present a significant challenge in terms of a stroke unit providing specialist cover 12 hours a day in BGH. Mr Lee Davies felt that there needs to be an honest conversation with the public around the potentially precarious nature of such a service. This would be a compromise, which he personally, would not support. It is important to recognise, however, that the Health Board covers a large geographical area, with patients from Powys and south Gwynedd also accessing Stroke services. It is a geographical area which will go (out of necessity) from four Stroke units to three, two, one – or potentially none. The CSP process offers an opportunity to set the course for providing the best quality of care and securing the long-term future of Stroke services in the region. Whilst Mr Lee Davies was of the opinion that one unit was the correct choice, he would support the suggestion of a rehabilitation unit at BGH, a view which was also shared by Mr Henwood and Mr Carruthers. Further consideration of such a model would be required, as would the merged option.

Mrs Marks described a tension between ‘heart and head’ when considering removing services, but recognised that one specialist unit is the safest model, as evidenced by clinical and national guidance. The priority must be a model which offers the best clinical outcomes, allowing individuals who experience Stroke the best life possible. She supported the merged Option 106/210. Whilst sharing this view, Mr Maynard Davies noted that the merged option would require further work, both initially and via public engagement, which would probably take at least a year. He enquired whether, given the service fragilities in Stroke, there are any specific actions required in the short-term. In response, Mr Henwood assured Members that the current service is safe, with mitigations in place. The issue is that the service is not meeting the required clinical standards.

Professor Kloer emphasised that this does not reflect the effort of staff, who are working incredibly hard and delivering care under challenging circumstances. He recognised both that Stroke services have changed considerably, and that significant input and feedback from the public has been received. A number of their concerns have been reflected in Cllr. Evans’ comments, and the alternative options put forward seek to address some of these. However, it is not appropriate to choose to preserve a service which is unsustainable; or to put staff in this position. The Board needs to be aware of and cognisant of the feedback from experts and clinicians. There needs to be initial treatment locally, and then patients need to be repatriated as quickly as possible. Professor Kloer emphasised the need for careful consideration of alternative options, with additional work and engagement undertaken.

Dr Wooding agreed that the merged Option 106/210 appears to be most supported, and would seem to move closer to recognising public concerns. He noted, however, the need for a wider consideration of transport and travel implications. Cllr. Evans recorded that he could not support this option. Ms Couceiro

highlighted that, under the statutory guidance, this would fall under Phase 2 of the consultation, and would require a minimum of a 6 week engagement period. The Senedd pre-election period must also be taken into consideration.

Decision: The Board agreed that merged Option 106/210 is the preferred direction, subject to additional engagement and prefaced by preparation of QIAs, workforce models, financial assessments and impact assessments (including Welsh language impacts) to accompany the engagement. It would also be subject to the Option being assessed against hurdle and scored by the Options Development Group.

PM(26)46 **Planned Care Services**

Ms Issac presented a summary of key considerations relating to Ophthalmology, Orthopaedics, Dermatology and Urology arising from the public consultation, together with service interdependencies.

Ophthalmology

Members were reminded of the options for consideration (Option 99 and Option 173).

Clinical Overview
Mr Henwood indicated that, clinically, both options are viable and acceptable and would deliver a good quality of service. The key difference between the options concerns the number of sites, which has been an issue historically. This can impact on staff recruitment and retention. Therefore, the fewer sites, the better able the organisation is to provide the care needed. There is also an issue around the sustainability of service provision at BGH, given the low numbers of cataract procedures undertaken.
It is important to note that the North Road Eye Clinic would continue to function in both options. Mr Martin wished to reiterate also that Amman Valley Hospital will continue delivering cataract surgery (day cases) and (intravitreal) eye injections in both options. He added that, for Option 99, the Board may also wish to consider the potential for an optometry hub in Aberaeron, as described by the service yesterday.

Operational Considerations
Mr Carruthers reminded Members that national guidelines from the All Wales clinical network and from the Getting It Right First Time (GIRFT) team that have reviewed services across Wales, is that health boards should be moving to fewer, high-volume elective surgery centres for eye care. Running cataract lists, for example, in a hospital main theatre environment is not necessarily the most efficient or effective way to maximise the slots on a list. Particularly as there are very few cases requiring overnight care in Ophthalmology. Settings such as the Amman Valley Hospital are more appropriate. There are potentially other benefits or opportunities also; however, in terms of operational service delivery, the main concern is how better to align with national

expert opinion and guidelines. In regard to a hub at Aberaeron, Mr Carruthers advised that there is a revised national view around the implementation of diagnostic hubs. As such, the Health Board would be considering this as a service development in response to national policy direction anyway. Mr Huw Thomas reminded Members that a business case would be required for any such project.

Considering the Planned Care services as a collective, Mr Iwan Thomas noted consistent messaging around travel and transport. In terms of patient experience, he felt that it is important when making decisions, for the Health Board to be mindful of its duty of care to patients. Specifically, around supporting access to Planned Care services. As an example, there has been feedback from some patients and families around not wishing to travel in the evenings. This might be addressed by scheduling appointments for older patients at the start of the day and, in the case of services with extended hours, scheduling those patients who are working during the day for evening or weekend appointments. The Board should also consider the potential community role, in terms of prevention opportunities, of working with community and Third Sector organisations. Community transport organisations may also offer potential solutions and sustainable options, particularly around the Planned Care services. Dr Wooding agreed that a strategic approach to building resilience in transport is required. He also shared the view around scheduling of appointments, especially when services have been relocated. Mr Carruthers advised that this is a 'live' issue, with QSEC having considered the same topic during discussion of waiting times.

Cllr. Evans noted that the service presentation yesterday had indicated that – should Option 173 be selected for Ophthalmology – theatre capacity in Orthopaedics cannot be increased, impacting on the options for consideration in that specialty. Mr Lee Davies agreed that this statement had been made. To clarify, however, he advised that there are other vacant theatre sessions available at BGH, and suggested that this should not be a factor in the Board's decision-making. Noting that the case for change in regard to this specialty was presented yesterday, Mr Prior suggested that Option 99 appears to be the most sustainable in the long-term, and also begins to introduce community-led services. Members heard that much of the discussion yesterday had been around hospital-based services; however, Ophthalmology involves a significant proportion of community-based service delivery. It is clear that, for frequent attendees, care closer to home is preferable, versus centralised services for the rarer and more specialist clinical events. Currently, HDdUHB is having to outsource activity, with additional provision beyond Health Board sites. It would be the aim to 'repatriate' this activity.

Members were reminded that there is potential to consider an enhanced Option 99, with the addition of a diagnostic hub and several indicated that they would wish this option to be on the table. Mr Huw Thomas stated that any such decision would be

subject to subsequent Board consideration and approval of an appropriate business case. Ms Cathie Steele advised that a QIA would also be required for this revised option. However, further engagement would not be necessary.

Decision: The Board agreed that Option 99+ (Option 99 with the inclusion of the diagnostic hub proposal in Aberaeron Integrated Care Centre from Option 173) represents the preferred direction of travel, subject to further modelling and business case work in implementation planning.

Orthopaedics

Members were reminded of the options for consideration (Option D and Option 178). They were advised that these options included mandating changes made during the COVID-19 pandemic, and changes to support the regional orthopaedic work.

Clinical Overview
Mr Henwood indicated that the changes made during COVID-19 had proved very successful. The unit at PPH is a high quality unit, which meets British Orthopaedic Association standards. Regional working has also been a positive step, with both HDdUHB and SBUHB patients having benefitted. The difference in considering this specialty is around the Health Board's ambition in terms of increasing activity, particularly at BGH and WGH. The unit at BGH is also an excellent unit, delivering high-quality care, but there is an opportunity to build on this, as is the case for WGH. Whilst the options are similar, Mr Henwood would personally support an increase in activity.

Operational Considerations
Mr Carruthers noted that waiting times in this specialty are a particular 'pressure point', with patients waiting too long. It is the Health Board's aim to make improvements in this regard. In order to recover to pre-COVID-19 performance, capacity would need to be increased (as described by Mr Henwood), in line with Option D.

Dr Wooding agreed that developing the service to deliver reduced waiting times should be the ultimate outcome in considering this service. The service is already delivering quality care. Mr Maynard Davies noted with interest that this is the one speciality where it is proposed to increase activity on all sites. He welcomed the stated commitment to reducing waiting times and delivering care closer to home. Ms Ann Murphy noted mention of extended hours in Option 178 and queried whether this could be considered as an enhancement to Option D. Mr Lee Davies indicated firstly, that the unit at BGH is currently not compliant with British Orthopaedic Association standards, making it unsustainable. What is described is a change in the way the service is delivered and the location of that, which would meet these standards and secure the long-term future of Orthopaedic Surgery at BGH. Secondly, there has been strategic discussion around future service configuration and the role of each site. The opportunity to increase day case operations

at WGH is an example of that. Finally, Mr Lee Davies would support implementation of Option D, with – as demand dictates over time – the potential to extend hours at PPH as part of a longer-term improvement plan.

Decision: The Board agreed to support Option D+ (Option D with the inclusion of exploration of the potential to extend hours at Prince Philip Hospital described in Option 178), subject to further demand and workforce modelling, financial assessments and business plan.

Dermatology

Members were reminded of the option for consideration (Option C). Again, this is an example of a service where changes had been made during COVID-19, resulting in a significant amount of activity at PPH. Option C represents the mandate to support consolidation of that service, subject to capital investment to develop and improve the service further.

Clinical Overview
Mr Henwood indicated that Option C is very much supported by the service. HDdUHB has not had a sustainable Dermatology service for 20 years plus. The proposals describe a maximising of community-based service delivery, including in Primary Care.

Operational Considerations
Mr Carruthers stated that the community-based element is important to note, and will require work to ensure effective implementation and delivery. It is, however, consistent with the national and strategic direction of travel. Ms Daniel wished to reference the conversation yesterday around building a multidisciplinary team around the service. It will take time to build the necessary staff resource in advanced/consultant level practice; not just in nursing, but in allied health professions and healthcare scientists. Therefore, robust workforce plans to support this option will be required.

Ms Harraway supported the proposed consolidation of this service described in this option. She was, however, concerned by its dependency on the Cross Hands development for delivery of the nurse-led paediatric clinics. Given that it is not ideal to treat children in an adult setting, she enquired whether there is capacity to deliver some of those services at PPH, while Cross Hands is completed. Echoing this, Mr Maynard Davies noted that the Cross Hands project is currently being rescoped, with no guarantee of space being available or Welsh Government support. He enquired what alternatives might be available, should this be the case. Members heard that the Business Case for this project had had to be revised significantly. The Health Board has been in further dialogue with Welsh Government, and Mr Lee Davies hoped to be in a position to provide additional detail to the Board soon. Plans can be progressed on the basis of provision at Cross Hands being the aspiration, with PPH as a short-term solution.

In Dermatology, Professor Kloer emphasised that the vast majority of care is delivered in Primary Care settings. There is also a significant proportion of self-care involved in Dermatological conditions. The section of the clinical pathway being discussed is the more specialist part; however, it is also influential and impactful. It will be important to develop plans which maximise community-based service delivery, in addition to the specialist care delivered via Option C.

Decision: The Board agreed to implement Option C, together with actions to maximise community-based delivery.

Urology

Members were reminded of the option for consideration (Option A), which again concerns mandating of changes made during the COVID-19 pandemic. It seeks to improve the offer on the PPH site by establishing a Urological Investigations Unit (centralised diagnostic hub), bringing together certain specialist services. GGH would retain its emergency provision; outpatient day case diagnostic procedures would be retained at BGH; and WGH would retain a significant amount of activity, around outpatients day case and diagnostic procedures.

Clinical Overview
Mr Henwood noted that the key aspect of this option was the centralised diagnostic hub, which is common across other health boards. The volume of diagnostic activity in Urology is incredibly high and increasing. A centralised diagnostic hub would allow consolidation of both services and staff. This point also applies to Endoscopy; with the consolidated provision put in place during COVID-19 ensuring that patients are treated within appropriate timeframes.

Operational Considerations
Mr Carruthers noted that the Urology service team has delivered a number of improvements to the urological diagnostic pathway, which have played a significant role in the improvement in access under the Single Cancer Pathway. The opportunity to develop the centralised diagnostic hub would be a very important step in terms of sustainability for what is a high volume and high activity service on this pathway.

In response to a specific request, Ms Couceiro detailed the main feedback received in relation to this option during the public consultation:

- Concerns around consolidating the service at the far east of the Health Board area
- Concerns around travel and transport implications
- A willingness to travel if it reduces waiting times
- Concerns re impact on timeliness of cancer diagnosis
- The need to ensure patient dignity

Cllr. Evans requested assurance that choosing this option will not result in longer waiting times than currently. Mr Henwood confirmed that the option described is viewed as the mechanism to create a sustainable, high-impact, high-quality service, but whilst also addressing the issues of waiting times. Professor Kloer noted that this option also reflects the influence of the public consultation. With regard to the previous comment, he stressed that this decision, in common with all made today, needs to be concerned with improved quality. Safety is just one of six domains of quality, along with person-centred, effectiveness, efficiency, equity, and timeliness. The implementation plan will need to be clear about how improvement is measured. Mr Lee Davies emphasised that Urology is a central component of cancer service provision; the whole ethos behind establishing a centralised diagnostic hub is to shorten diagnostic pathway times.

Decision: The Board agreed that Option A should be implemented.

PM(26)47 **Diagnostic Services**

Ms Issac presented a summary of key considerations relating to Endoscopy and Radiology arising from the public consultation, together with service interdependencies.

Endoscopy

Members were reminded of the options for consideration (Option A and Option B). Option A would bring together the respiratory and neurology procedures at PPH, supported by an additional procedure room. Bowel screening and gastrointestinal procedures will be retained across the other sites. In the longer term, subject to capital and the identification of a site, developing a community hub to provide additional activity. It is perhaps worth noting that Option A is more closely aligned with the Urology option just discussed.

Clinical Overview
Mr Henwood emphasised that the Endoscopy service has a committed team which has worked hard to achieve the national standards. As with other services, demand is increasing year on year. There is a need to increase capacity and consolidate the service in the location with the highest concentration of experts in respiratory diseases, which is PPH. This will provide higher quality and higher volumes to address the needs of the population. Option B is a longer-term option, as it will likely be necessary to respond to further increases in demand.

Given the concerns around travelling to have tests, particularly bowel screening, due to the nature of the procedure, Ms Murphy favoured Option A, as it is across all sites. Mr Lee Davies wished to remind Members that neither option impacts on emergency pathway provision. He noted that the majority of Endoscopy activity is gastrointestinal or bowel screening. He shared Ms

Murphy's view and would suggest that bowel screening should be community-based, certainly in the longer term. Whilst agreeing, Professor Kloer noted that such a development would require the relevant costings and business case. He noted that the public consultation feedback suggested a preference for Option C in certain communities. However, there is a compelling rationale for Option A, which he felt was stronger. Dr Gjini wished to emphasise that, in the medium to long term, it would not be the aim to restrict bowel screening to one site. It would be community-based and potentially mobile.

It was generally felt that Option A was the correct choice at this stage. Mr Lee Davies suggested that, for clarity, it would be helpful if the Board were to endorse the need to consider how additional capacity might be provided in the future, for more detailed discussion in due course. Also, he highlighted that the potential for a mobile facility was considered, but was discounted for various reasons. It was emphasised that this is a service that the Health Board provides for Public Health Wales (PHW) through a Long Term Agreement, and that PHW are key stakeholders. In regard to the bowel screening site, Ms Couceiro wished to remind Members that, during the consultation, communities indicated that it was difficult for them to share their views around this without a location having been defined. If, in the future, there is a decision to move towards Option B, further engagement would be needed with our communities to understand impacts and potential mitigations linked to a single location or more than one site.

<u>Decision:</u> The Board agreed to support Option A, with consideration of how Endoscopy services might be provided in the longer term to meet future demand. This would include further work around potential sites and their implications, and development of a business case for the proposed hub.

Radiology

Members were reminded of the option for consideration (Option 103). This involves development of a radiology hub. Similarly to Endoscopy, this site was not, determined. Option 103 brings together different options consulted on.
In addition to the hub, it aims to improve diagnostic radiology across sites, and bring together interventional radiology and more acute services. It seeks to develop and protect the workforce and allow them to meet the inpatient demand as well as the unexpected demand. The option would not affect emergency radiology access. It is more concerned with how the anticipated demand growth in planned radiology is managed. Option 103 seeks to bring together services, with a longer-term aim of developing a diagnostic radiology hub once funding and location are identified.

Clinical Overview
Mr Henwood noted that this is another high-volume service, which should be provided as close to home as possible. It also involves

extremely costly equipment. Radiology is crucial in supporting acute care. GGH has the highest volume of acute care and necessity for inpatient interventional services, hence the suggested focus there. However, as alluded to, interventional care will be retained on the other acute sites. Clinically, Mr Henwood would support Option 103. He wished to highlight, however, the issue of community provision. The service described yesterday low volumes of activity in South Pembrokeshire and Llandovery Hospitals, and the challenges this presents. Whilst he had no doubt that it will be disappointing for the communities to lose this provision, the service feel that this is the only way forward.

Dr Wooding reminded Members of the issue of equipment reaching end of life. He did, however, recognise the importance of provision to local communities, noting especially the investment they have made in equipment.

Operational Considerations
Mr Carruthers indicated that the Health Board is particularly cognisant of this point. Operationally, the challenges involved with low-volume activity were described yesterday, and the machine at Llandovery is no longer compatible with Health Board Radiology systems, including digital reporting. It is unlikely that Welsh Government would support its replacement. However, Mr Carruthers suggested that there are opportunities for Llandovery Hospital to play a future role in the new Urgent Care model, which he would like to follow-up in conversations with the community, and he would not wish for it to be defined by this specific issue. Members were also reminded that there will be implications for staff, with the proposed move to a shift system from on-call. Whilst HDdUHB is an outlier in having an on-call system, there is a need to be mindful of the impact. Radiology is fundamental to acute service delivery; a seven day model will be crucial.

Dr Wooding noted the potential tensions in this regard, which will need to be managed. Fragilities in this service are very much linked to workforce, and they must be supported and developed to become resilient. Addressing a comment made yesterday around a lack of investment in Radiology, Mr Huw Thomas wished to clarify that £1.5m from core funding and £3.5m Planned Care recovery funding had been allocated this year. A further £1.7m is allocated for next year.

Returning to the implications for staff, Ms Murphy highlighted that the process will take time and commitment, requiring investment in ‘Grow Your Own’ programmes, etc. Mrs Gostling agreed that workforce planning is critical. Members were reminded that HDdUHB is the only health board in Wales that does not operate a seven day shift service in Radiology. Mr Severs wished to highlight that the sustainability, safety and quality elements are really quite, significant. In addition, it would be remiss not to mention the potential to reduce some of the challenge in terms of recruitment and retention offered by enhancing advanced and consultant level practice across this professional group. Dr

Wooding agreed, particularly given the pivotal nature of this service to all performance targets.

Mr Lee Davies stated that, similarly to Endoscopy, it is important to highlight that what is being proposed does not impact on emergency pathways; this provision is retained on all sites. Secondly, with regard to Llandovery and South Pembrokeshire Hospitals. If the Board supports this option, as part of the implementation planning, a detailed piece of work around the operationalisation of the change will be required, not least any consequence for other activities on those sites. In relation to the regional hub, the same applies as for Endoscopy; it would be helpful if the Board could endorse that as a direction of travel. This would enable commencing a piece of work to assess how this might be delivered, albeit without any specifics at this point in terms of location or model. Finally, in agreeing this direction of travel, Board would not be endorsing any investments into the service at this stage.

Linked to this, Ms Couceiro wished to add that the longer-term regional hub aspect of Option 103 is similar to Endoscopy, in that the location of the hub was not defined. Should it be agreed to take this forward, it would be necessary to go back out to local communities to understand the impact of the potential location.

Professor Kloer reiterated that Radiology is intrinsic to every other service, making it crucial that they are enabled to work effectively. There is clearly a compelling case for change, which will have implications for recruitment. He noted the comments around the potential future role of Llandovery Hospital. Professor Kloer also noted that the public expressed a strong preference for Option B, although there were views across the spectrum of options. Option 103 is an adaptation or enhancement of Options A and B. He wished to clarify that further engagement would not be required on this Option. Ms Couceiro confirmed that this was the case, with the exception of the location of the new regional hub.

Decision: The Board agreed implementation of Option 103, with caveats around the future role of Llandovery Hospital, and the need for further engagement regarding hub location. This subject to development of a workforce plan and engagement with staff over a seven day service. Consideration should also be given to building resilience in terms of digitalisation.

PM(26)48 Role of Acute Hospital Sites

Ms Kathy Graham left the Board meeting.

Before moving onto this item, Dr Wooding enquired whether Members had any reflections, observations or thoughts on the process undertaken. Whilst this had been both intense and demanding, he suggested it had been helpful. Speaking as a relatively new Board Member, Mr Prior had found the process reassuring. He felt that decisions have been taken with consideration, clinically-led, demand-led, and informed by

communities, which shows a real intent and future-focused direction for the Health Board. In some cases, there has been additionality, which is very positive. Mr Prior suggested that there will be challenges and issues requiring monitoring. These include transport and transfers, the need to rebuild trust and get the basics right, and ensuring that what is proposed is delivered. He felt that there is an element of 'myth-busting' required, together with ongoing conversations and partnership with local communities. This presents an important opportunity to reshape the narrative around the CSP, emphasising that it is actually future-focused, rather than about loss. In summary, he felt that the Board has reached good decisions over the last couple of days.

Mr Henwood wished to recognise the level of clinical engagement, both at yesterday's session, and during the entire CSP process. He thanked the clinicians and services for their commitment, time and engagement, which sets a strong foundation for the organisation going forward. Mr Henwood noted that, often in the NHS, there is a sense of 'friction' between clinicians and managers. There was no evidence of this yesterday; all service staff are aligned in their commitment to deliver the highest quality and safest services for patients.

Thanking everyone who has contributed to the process and shared their expertise, Mrs Marks agreed that it had been an intense Board meeting. However, discussions have been focused, which would not have been possible without the analysis and preparation to reach this point. She agreed that the process is and should be concerned with looking to the future and defining the shape of future services for the people served by the Health Board. It has put health, quality, safety and wellbeing at the heart of what the organisation does. Mrs Marks had been very impressed with the contributions during the meeting, and by Members' levels of concentration throughout. She also wished to thank Dr Wooding for chairing this extended Board meeting, which is challenging. Mrs Marks believed that the Board has reached the correct decisions; it is now time to explain these, together with the next steps in this journey to the Hywel Dda population.

Mr Imperato felt that the meeting had been extremely worthwhile, and well-managed. He welcomed the slides in particular, which were very user-friendly and clear. Having mentioned the need for consideration of transport on many occasions, he emphasised that work on an overarching transport strategy must begin. Mr Carruthers wished to thank operational teams for their approach to yesterday's session. He was proud of the way they had conducted themselves, hoping that their contributions had been useful to Members. Mr Carruthers also thanked the staff supporting the CSP process, including Mr Ben Rogers, Ms Nichola Couceiro, Mr Alex Martin, Ms Sarah Isaac, Ms Yvette Pellegrotti and the Communications team. Apologising for not being present in person, Ms Daniel agreed with all the foregoing comments. She felt that discussions have illustrated that future success will depend on safeguarding quality, focused multidisciplinary team

working and ensuring that the changes do not widen inequalities for rural communities. Going forward, as services change, the organisational governance must remain vigilant, with clear quality metrics, early warning triggers, and strong patient experience feedback loops. This has come across in every conversation over the last two days.

Dr Gjini agreed regarding the need for vigilance around not increasing inequalities within the region's population. She had also been pleased and reassured that service providers are seeking to keep at the core in developing services, the embedding of preventative elements. This will not slow the development and delivery of the CSP; it will make it sustainable. Building on Mr Imperato's comment, in addition to revisiting transport, the Health Board will also need to consider access. This is much wider than transport or travelling to a clinical service; it involves the propriety of the clinical services, including how appointments are made, and how culturally sensitive and person-centred services are. Ms Hughes Moakes highlighted that the CSP process had been two years in the making. She wished to acknowledge and express pride in the work of staff in the Communications and Engagement team, noting that certain staff who had contributed no longer work for the Health Board. She also recognised the involvement of community members in developing options, particularly in relation to BGH and PPH. The contribution of SOSPPAN and Llais should also be acknowledged. Ms Hughes Moakes thanked them all for their positive engagement and involvement. In regards specifically to this meeting, she also wished to thank the Welsh Language and British Sign Language translators. Echoing the thanks proffered to various teams, Professor Kloer agreed that the issue of transport needs to be considered by the Executive Team.

Regarding the role and contribution of Llais, Dr Wooding emphasised that the Board had very much valued their input yesterday. His closing comment was that the quality of a good meeting could be measured by the end point being somewhat unexpected, which demonstrated that the outcome was not pre-determined. He highlighted that at least 40% of the options selected were alternative options generated during the public consultation. This was an exciting and dynamic part of the process, and Dr Wooding wished to thank communities for engaging. Whilst their engagement had been challenging in some instances, it had also been inspiring. He suggested that the process undertaken should be viewed as setting the template for how similar discussions are approached in the future. The Health Board could have allowed the status quo to continue for these services; however, it has a duty to support the necessary evolution of services, even if this requires challenging decisions which are not always or universally popular.

Role of Acute Hospital Sites

Mr Lee Davies indicated that the final part of the session would consider the role of acute sites. Whilst this was not part of the

CSP scope at the outset, it came as a natural progression of all the options developed during the process. The refreshed 'A Healthier Mid and West Wales' Strategy agreed at the January Board has a mission statement of 'healthier lives, well lived'. Within this, there are four Strategic Objectives: Thriving Teams, Healthier Communities, Great Care and Positive Futures. Through the process undertaken during the last two days, the organisation is endeavouring to progress in each of those objectives, in order to deliver its overall strategic ambition. There has been a great deal of discussion around the implications of the CSP for the individual sites. Mr Lee Davies suggested it would be helpful to describe an overarching framework, for how the Health Board envisages those sites developing over the medium term. The findings of the consultation on this were covered in the main yesterday. Key aspects to highlight are:

- All four sites will play a crucial role in the future delivery of healthcare services for Mid and West Wales
- All four sites will be equally important
- All will have their distinct functions to support the needs of the population
- All sites will be vital to delivery in the medium term
- All will continue to be busy in the medium term

The other wider context is the organisational aspiration to shift the model of care to one of prevention and Primary Care and community-based services. Sitting behind all of this is a wider aspiration to reduce the need for some services over time, whilst improving the quality of care when it is required. A number of factors have come through in discussions; not least the provision of services in communities, the use of digital, and transport and transfer arrangements.

The critical conclusion from all of this is that the four acute hospital sites. will be interconnected and networked to deliver the services which patients need in a variety of ways. A form of words, which aims to express this for each site, was tested with the public and was described by Mr Martin:

Bronglais Hospital (BGH)
Providing services as it currently does, though some specialities, or parts of pathways, may be provided from different Hywel Dda sites.

In discussions today, the Board debated parts of Stroke care no longer being provided at BGH. However, patients will still be able to access emergency care, and addition of a local rehabilitation element is potentially to be explored. A future strengthening of the Emergency General Surgery service is also proposed. Overall, resulting in almost a status quo in terms of the role BGH provides.

Glangwili Hospital (GGH)
Providing more acute and emergency care, with some planned care moved to other sites, either by service or health condition.

Decisions made around Emergency General Surgery and Stroke care emphasise a strengthening of the acute role GGH plays. The Board has also suggested that elements of Urology and the planned diagnostic work of Radiology move to other sites.

Prince Philip Hospital (PPH)
Providing more planned care, particularly across a wider region, where services are delivered in partnership with Swansea Bay University Health Board.

The role that PPH plays regionally in providing Orthopaedics has been discussed, together with a number of other opportunities to develop regional working, and the potential future impact of locating service hubs here.

Withybush Hospital (WGH)
Providing more planned care, particularly within the Hywel Dda area, with initial access to acute care remaining on site, but transfers to Glangwili Hospital for patients with the highest needs.

Decisions made today around Emergency General Surgery and Critical Care very much retain at WGH the immediate access to emergency care. People will still be able to go there to access SDEC services. If, however, they are seriously unwell, treat and transfer will enable them to get somewhere where more specialist care can be provided.

Mr Martin felt, therefore, that the statements made as part of the consultation are still accurate following the decisions made. In terms of what this means going forward, as an example, Members were reminded that BGH had developed a hospital strategy shortly after AHMWW was agreed in 2018. The definitions outlined above should both support hospital sites to develop or refresh their own strategies, and longer-term planning processes. This will support that future planning and ensure that unhelpful precedents are not set in future decision-making.

As an observation, Dr Wooding wished to query whether the Health Board has been clear what it thinks each of its hospitals will be offering in the future. Whilst it may understand this clinically, and at a service level, he was not sure that this had been adequately communicated to patients and the general public. In their position, he would want to know the type of facility each hospital site is envisaged to be in the future. One of the dangers of the CSP is that, by iterating services on an individual basis (practically and operationally, to manage the complexities involved) the overall coherent picture is lost. The organisation needs to consider how best to communicate this to the patient population and the wider community to provide assurance that their hospital will be everything stated above: vital, deeply important, networked and that, above all, they are delivering healthcare that the region can be truly proud of.

With regard to the descriptions above, Professor Kloer wondered whether there should be a minor revision to that for BGH. He felt that the statement 'Providing services as it currently does' could suggest that services are not being adapted, improved or enhanced, which does not actually reflect the options presented to the Board. This could, equally, apply to other sites. He also noted that networking was not part of the description and felt that it should be. Mr Lee Davies acknowledged this suggestion. In terms of next steps, the aim would be to further describe the future roles of hospital sites and engage with the Board as necessary. More generally for next steps in the CSP, Mr Lee Davies referred Members to the relevant slide. He emphasised that impact assessments have been undertaken and are available from the Health Board website. However, further work in this regard, and on other aspects, will be commenced following today's decisions.

Dr Wooding felt that this discussion very much returns to his introductory statement yesterday, where he highlighted the need for all hospitals, throughout the country, to transform, in order to meet the needs of their population. HDdUHB needs to be at the forefront of this process, not lag behind. He concluded by thanking all of the team involved in facilitating this discussion.

PM(26)49 **Regional Cellular Pathology Transitional Memorandum of Understanding**

Members were reminded of the declarations of interest recorded under the relevant section of the minutes, above. Further, it was noted that a conversation had taken place at the Regional Joint Committee (RJC) main and In-Committee sessions, the latter due to commercial sensitivities regarding this item. Mrs Patel had not been present at or participated in either session.

Mr Carruthers introduced the item by reminding Members that a transitional Memorandum of Understanding (MOU) had been agreed approximately a year ago. Since that time, a great deal of work has taken place, in recognition of the changed scope of the regional programme. To reflect this, along with other changes (such as the RJC taking over from ARCH) the opportunity had been taken to update the MOU. Board approval of the changes is now being sought from both HDdUHB and SBUHB. Mr Carruthers wished to record his thanks to Ms Sian-Marie James for her work on this matter, across both organisations.

Decision: The Board **APPROVED** the redrafted Transitional Memorandum of Understanding for Regional Pathology, subject to RJC endorsement on 16 February 2026.

PM(26)50 **Regional Cellular Pathology Preferred Laboratory Site**

Mr Lee Davies indicated that HDdUHB has been working with SBUHB for a number of years on the issue of a site for the regional Cellular Pathology laboratory. A centre of excellence is based at Morriston Hospital. He reminded Members that Welsh Government had been unable to justify prioritisation of the £130m+ costs involved in the original Regional Pathology project.

As a result, a piece of work had been commissioned, to address the most significant estate and workforce risks. Mr Lee Davies had chaired the regional group discussing this issue, and that an update had been provided to the September 2025 Board recommending two sites for further analysis and assessment. The two sites were Pentre Awel and Sandringham Court. A third potential site, Bay Campus in Swansea, was identified in November 2025, which had also been incorporated into the process. During the past few months, a detailed assessment of each of the three sites has been undertaken. This had considered the both the technical and non-technical aspects of converting those buildings to a pathology laboratory. A workshop had been held at the beginning of the month, to consider all of that information in detail. Following this, the unanimous view was that the Bay Campus site was the preferred location.

In order to progress the project, HDdUHB and SBUHB need to submit a proposal to Welsh Government, which is subject to their providing capital support, and potentially subject to revenue support from the health boards, recognising the specific wording within the recommendation in relation to this. The proposal had been presented to extraordinary meetings of the RJC (main and In-Committee) on 16 February 2026, to the SBUHB Board on 17 February 2026, and to an In-Committee HDdUHB Board session on 18 February 2026. In-Committee meetings had considered and approved the commercially-sensitive elements. Following detailed discussion at all of these forums, both the RJC and SBUHB Board had endorsed Swansea Bay as the preferred site. Hence, it was recommended to the HDdUHB Board that the preferred site is endorsed and that it supports submission of the proposal to Welsh Government.

In the interests of transparency, Mr Huw Thomas wished to reiterate that there is a revenue contribution required of health boards. During development of the associated business case, the options in this regard, will need to be considered. However, the Board needs to be aware of the added risk involved, given that this would be a regional development, with cognisance of partners. Mrs Marks reminded Members of the genesis of this project, which had been the major concerns and issues around current laboratory sites. She suggested that, in this case, the risk of inaction was greater than the risk of action. Having considered the proposal, Mrs Marks was supportive of both the process undertaken and the recommendation as set out.

Decision: The Board

- **CONSIDERED** the work undertaken on the site options appraisal and the recommendation from the recent Regional Cellular Pathology workshop for a preferred Laboratory Site.
- **APPROVED** the submission of the attached paper, subject to its endorsement by the Regional Joint Committee on 16 February 2026, identifying the preferred site to Welsh Government, including the following recommendations:

- Welsh Government is asked to:

1. Consider the recommendation of the South West Wales Regional Pathology Working Group that Bay Campus, Swansea University represents the preferred site for a regional Cellular Pathology Laboratory, subject to development of a full business case and confirmation of funding.
2. Acknowledge that the recommendation is in line with the remit received from Ministers to agree regional solutions.
3. Recognise that there is an affordability challenge which needs to be fully articulated within the full business case, including:
   - An indicative capital funding requirement of £12.5m;
   - Annual revenue funding requirement of £1.2m over a 15 year period (increasing from £0.7m in year 1, and £0.9m in year 2).

   The full business case needs to clearly articulate how the additional revenue consequences will be fully addressed or funded, as neither Health Board have the ability to recognise these within their future commitments. This may include:
   - Options to capitalise costs where this is in line with financial reporting standards;
   - Options to recognise cash releasing savings from the consolidation of services;
   - Options to develop commercial income streams;
   - Options to mitigate future unabated demand growth so that the productivity benefits of consolidation do not require future funding to address demand
4. Subject to confirming affordability, agree capital funding to support detailed design activities during 2026/27, with the explicit understanding that:
   - Site selection does not constitute commitment to proceed
   - Full business case approval is required before any construction or lease commitment
   - Revenue consequences must be fully addressed

   Both Health Boards retain discretion not to proceed if the full business case is not satisfactory.

PM(26)51 **Any Other Business**

Professor Kloer was pleased to advise of a letter received from Welsh Government, indicating that the Health Board was being de-escalated in Cancer performance, from Level 3 to Level 1, based on its sustained achievement of 63%+ in the relevant Targeted Intervention metric. Whilst recognising that 63% is still not acceptable, given the national performance target is that 75% of patients on the Single Cancer Pathway start treatment within 62 days, he wished to thank all of the teams involved in delivering

this performance improvement. Dr Wooding agreed, thanking those who have contributed.

PM(26)52 **Date and Time of Next Meeting**

9:30am, Thursday 26 March 2026