



**CYFARFOD BWRDD PRIFYSGOL IECHYD
UNIVERSITY HEALTH BOARD MEETING**

DYDDIAD Y CYFARFOD: DATE OF MEETING:	29 January 2026
TEITL YR ADRODDIAD: TITLE OF REPORT:	Seven-Day Business Case for Clinical Streaming Services (CSS), Same Day Emergency Care (SDEC), and Hospital@Home
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Andrew Carruthers, Chief Operating Officer
SWYDDOG ADRODD: REPORTING OFFICER:	Andrew Carruthers, Chief Operating Officer

Pwrpas yr Adroddiad (dewiswch fel yn addas)

Purpose of the Report (select as appropriate)

Ar Gyfer Penderfyniad/For Decision

**ADRODDIAD SCAA
SBAR REPORT**

Sefyllfa / Situation

The Board is asked to approve the implementation of a seven-day Clinical Streaming Service (CSS), Same Day Emergency Care (SDEC), and Hospital@Home model across Hywel Dda University Health Board. This proposal addresses current gaps in weekend urgent and emergency care provision, aiming to improve patient outcomes, reduce unnecessary hospital admissions, and enhance system efficiency. The Board is asked to support a phased and flexible implementation, with ongoing evaluation and adaptation as the model is embedded.

Cefndir / Background

This proposal aims to address significant gaps in urgent and emergency care provision across Hywel Dda University Health Board by extending Clinical Streaming Services (CSS), Same Day Emergency Care (SDEC), and Hospital@Home from a five-day to a full seven-day service.

The initiative is designed to align with both national and local strategic priorities, including the National Six Goals Programme for Urgent and Emergency Care, the Single Point of Access (SPOA) Framework, and Ministerial Priorities for Urgent and Emergency Care (UEC), all of which mandate integrated seven-day models and improved community-based falls response services. Locally, the proposal supports the Health Board's Accelerated Transformation Programme, which seeks to reduce Emergency Department attendances by 50% and support care delivery into the community

Currently, the Health Board faces challenges due to limited weekend access to alternative care pathways, resulting in increased Emergency Department (ED) attendances, ambulance handover delays, and poorer patient outcomes. Hospital@Home is unable to accept weekend referrals because of insufficient clinical cover, and the Health Board remains in Targeted Intervention for urgent and emergency care performance metrics. Evidence from a recent weekend pilot of CSS, SDEC, and Hospital@Home demonstrated substantial benefits, including cost avoidance, improved patient outcomes, and enhanced system flow. National and international exemplars, such as NHS Trusts in London and Buckinghamshire, and Denmark,

have shown that clinical streaming and virtual ward models can reduce admissions, improve patient satisfaction, and deliver significant cost savings.

The population served by the Health Board includes Carmarthenshire, Pembrokeshire, and Ceredigion, with over 400,000 patients. Data analysis highlights a clear need for consistent, high-quality urgent care across all days of the week, especially for frail and elderly populations. The proposal is complex, involving stakeholder engagement, workforce planning, and interdependencies. Initial funding is available from the Six Goals budget for 2025/26, but long-term sustainability will depend on the Health Board's commitment and the realisation of projected cost avoidance.

Asesiad / Assessment

At present, weekend service gaps result in delays, increased admissions, and longer hospital stays, particularly affecting frail and elderly patients. Hospital@Home and SDEC are unable to provide full coverage, which leads to missed opportunities for admission avoidance and care closer to home. The Health Board is under Targeted Intervention for Urgent and Emergency Care, with only marginal improvements seen over the last year in ambulance handover, ED waits, and hospital length of stay.

The Business Case proposes two options with which to address the challenges outlined and improve the patient experience. These are:

Option A: relates to the implementation of 7-day Clinical Streaming and Hospital@Home services across Hywel Dda.

Option B: relates to both the implementation of 7-day Clinical Streaming and Hospital@Home, and the phased rollout of Same Day Emergency Care (SDEC) services across Hywel Dda. The first year the SDEC model would be implemented in Withybush, year two in Bronglais, and year three in Glangwili.

The staffing model for both options are highlighted in Section 4 of the business case (Proposed Options). The estimated costs and cost avoidances for both options are as below:

Option A	Additional cost per year	Estimated cost avoidance per year
Optimal 7-day Clinical Streaming Model	£1.9m	£4m

Option B	Additional Cost Optimal 7-day Clinical Streaming Model	Cost Avoidance Optimal 7-day Clinical Streaming Model	Additional Cost Optimal 7-day SDEC model, phased implementation.	Cost Avoidance Optimal 7-day SDEC model, phased implementation	Total Additional Cost	Total Cost Avoidance
Year One. CSS Model and WGH SDEC	£1.9m	£4m	£2.5m	£2.5m	£4.4m	£6.5m
Year Two. CSS Model and WGH and BGH SDEC	£1.9m	£4m	£3.5m WGH £2.5m BGH £1m	£3.5m	£5.4m	£7.5m
Year Three. CSS Model and WGH, BGH and GGH SDEC	£1.9m	£4m	£6.3m WGH £2.5m BGH £1m GGH £2.8m	£6.3m	£8.2m	£10.3m

Detailed costings and value calculations can be found in the business case under Section 6, Financial Case, and the Appendices sections. The recruitment risks and associated mitigations have also been considered fully within the Business Case (Section 8, Workforce Analysis) in collaboration with Workforce colleagues.

Extending SDEC and CSS to weekends may increase demand for rapid diagnostics, including radiology, pathology, and therapies, which will require careful planning and potential future investment in community-based diagnostic capabilities. The evaluation framework proposed will ensure that missed opportunities will be monitored and future business cases in these areas be developed as required. The success of the model depends on robust clinical triage, cross-hub coordination, and integration with Out of Hours, Intermediate Care, and ambulance services. Effective communication and engagement with staff, patients, and partner organisations are essential to ensure buy-in and effective implementation.

The evidence base for the proposal is strong. Local pilot data from a recent pilot weekend evaluation showed improved patient flow, faster discharge, reduced admissions, and positive patient and staff experiences. Additionally, cost avoidance estimates, developed with Finance partners, indicate that the model could save more than it costs to implement. National and international evidence supports the effectiveness of similar models, which have demonstrated reductions in ED attendances, ambulance incidents, and hospital admissions, along with high patient satisfaction and safety ratings. Financial analysis projects over the 3-year implementation phase a total additional cost to the Health Board of £8.2m, with the potential cost avoidance figure being 10.3m. Realising the cost avoidance figures will depend on successful recruitment, operational efficiency, and the predicted reduction of hospitals admissions (inclusive of Boarding and Surge beds).

To maximise the chances of realising the benefits, the proposal includes phased implementation, workforce initiatives, and ongoing evaluation processes. Regular monitoring against a detailed evaluation framework is planned, with the flexibility to adapt or decommission the model if benefits are not realised. The Clinical voice suggests a strong interest from internal and external candidates for new roles in the model, and training and mentorship programmes are in place to support building knowledge within the existing workforce.

Argymhelliad / Recommendation

The Board is requested to **approve** total resourcing of £8.2m, to enable the implementation of Option B, which will establish 7-day clinical streaming, Hospital@Home and optimal 7 day Same Day Emergency Care (SDEC) services across the Health Board. It proposes that the following phased approach is supported:

1. **Approve** resourcing in 2026/27 equivalent to £4.4m recurrently to support:
 - The implementation of clinical streaming and Hospital@Home services to cover 7 days per week at a cost of £1.9m across the Health Board;
 - The implementation of the optimal 7 day SDEC service at Witybush at a cost of £2.5m;
2. **Approve** additional resourcing in 2027/28 equivalent to £1m recurrently to enable the implementation of the optimal 7 day SDEC service at Bronglais Hospital;
3. **Approve** additional resourcing in 2028/29 equivalent to £2.8m to enable the implementation of the optimal 7 Day SDEC service at Glangwili Hospital.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	1027/20
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	7. All apply
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	6. All Apply
Amcanion Strategol y BIP: UHB Strategic Objectives:	All Strategic Objectives are applicable
Amcanion Cynllunio Planning Objectives	3 Transforming Urgent and Emergency Care programme
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022	9. All HDdUHB Well-being Objectives apply

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Local pilot evaluation, national and international case studies; financial and qualitative benefits as detailed in the business case.
Rhestr Termiau: Glossary of Terms:	CSS: Clinical Streaming Service SDEC: Same Day Emergency Care H@H: Hospital@Home UEC: Urgent and Emergency Care
Partion / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	Community and Integrated Medicine Care Group (CIMCG) Urgent and Emergency Care Integrated Operational Group (IOG) Stakeholder workshops inclusive of Primary Care, Secondary Care, Local Authority, Llais representatives

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	See attached Integrated Impact Assessment
Ansawdd / Gofal Claf: Quality / Patient Care:	See attached Integrated Impact Assessment

Gweithlu: Workforce:	See attached Integrated Impact Assessment
Risg: Risk:	See attached Integrated Impact Assessment
Cyfreithiol: Legal:	See attached Integrated Impact Assessment
Enw Da: Reputational:	See attached Integrated Impact Assessment
Gyfrinachedd: Privacy:	See attached Integrated Impact Assessment
Cydraddoldeb: Equality:	See attached Equality Impact Assessment (EqIA)



Business Case for the Implementation of Seven- Day Clinical Streaming, Same Day Emergency Care and Hospital@Home Services

January 2026



1. Executive Summary

This business case proposes the extension of the current Monday to Friday Clinical Streaming Services (CSS), Same Day Emergency Care (SDEC) and Hospital@Home, to become seven-day for Hywel Dda University Health Board (HDUHB).

The business case considers the analysed data from the current model, national findings, and utilises the data from a weekend pilot of CSS, SDEC, and Hospital@Home, to inform the recommendations made.

It is stated that the permanent implementation of a full seven-day model will enhance the urgent and emergency care (UEC) system performance in Hywel Dda, improve patient outcomes, and align with national strategic priorities.

This proposal contains inherent complexity, relating to the consultation, stakeholder engagement, interdependencies, Social Return on Investment (SROI), failure demand and the 'how' of realising the ambition to overlay fiscal responsibility in a way that integrates and enables the preventive operational 'shift left'. The funding for the model can be delivered from the current Six Goals budget for the remainder of the financial year 2025/26. However, the recruitment to the proposed model needs to be based on a permanent and substantive workforce, so ongoing funding is reliant on the commitment of Health Board funding against the cost avoidance figures presented.



2. Strategic Fit

The proposal aligns with:

- **National Six Goals Programme for Urgent and Emergency Care and Single Point of Access (SPOA) Framework**
 - *Services to move to an integrated Seven-day model by the end of September 2025.*
- **Ministerial Priorities for UEC**
 - *UEC1: Implement effective Community Based Falls Response Services. To enhance outcomes and experience for those who fall by improving initial response times, reducing the risk of long lies and ensuring service users access community falls pathways when appropriate*
 - *UEC2: Implement a robust 'Single Point of Access' (SPOA) for UEC. Create in each health board area that simplifies access to services by offering clinicians advice and guidance to support onward referral, ensuring patients get the right care for their needs quickly and safely, to improve patient outcomes regardless of where they present*
- **The Health Boards UEC Accelerated Transformation Programme:**
 - *By October 2025, develop a new model for accessing and navigating the urgent and emergency care system that aims to deliver a 50% reduction in attendances at Emergency Departments (ED) and 75% of emergency activity in a scheduled way, through a shift left to community-based service delivery, centred on the following:*
 - *Implementation of a Health Board wide 24/7 contact first approach for the public and healthcare professionals to access urgent and emergency care in West Wales, working jointly with WAST, 111 and GP Out of Hours (OOH).*
 - *Implement a 7/7 clinical streaming hub that is capable of Triage, assessing and signposting patients to the most appropriate pathway to meet their clinical need.*
- **Ambulance-45:** A National Programme aimed at improving patient safety and system flow by ensuring that patients arriving by emergency ambulance are handed over to hospital care within 15 minutes, and never longer than 45 minutes. This approach is designed to:
 - *Reduce delays for patients waiting in ambulances outside Emergency Departments.*
 - *Free up ambulance resources quickly to respond to other emergencies in the community.*



- *Improve patient experience and safety by minimising time spent in transit and ensuring timely clinical assessment.*

The implementation of the proposed model will support the shift toward integrated, community-based care and reduces reliance on ED.



3. Case for Change

The West Wales Population

County system calculations based on cluster population:

Systems	Hospitals	Patients (Oct 2023)
Carmarthenshire	GGH	121,267
	PPH	62,539
Pembrokeshire	WGH	122,986
Ceredigion	BGH	93,986

Problems Identified

- Weekend care delays and poorer outcomes for patients.
- Increased ED attendances and ambulance handover delays.
- Limited access to alternative care pathways on weekends.
- Currently Hospital@Home services can only accept patients from Monday to Wednesday as there is no clinical cover for weekends
- Currently in Targeted Intervention for UEC, need to improve performance in terms of Ambulance Handover, ED waits and Hospital Length of Stay. There have been some marginal improvements shown against these metrics but not to a level to move out of Targeted Intervention levels.

Opportunities

- The Enhanced weekend streaming pilot demonstrated:
 - Significant potential benefits in terms of cost avoidance
 - Delivering better patient outcomes
 - Further in-depth investigation into benefits
 - The possibility of running a full Streaming model at weekends utilising Six Goals funding



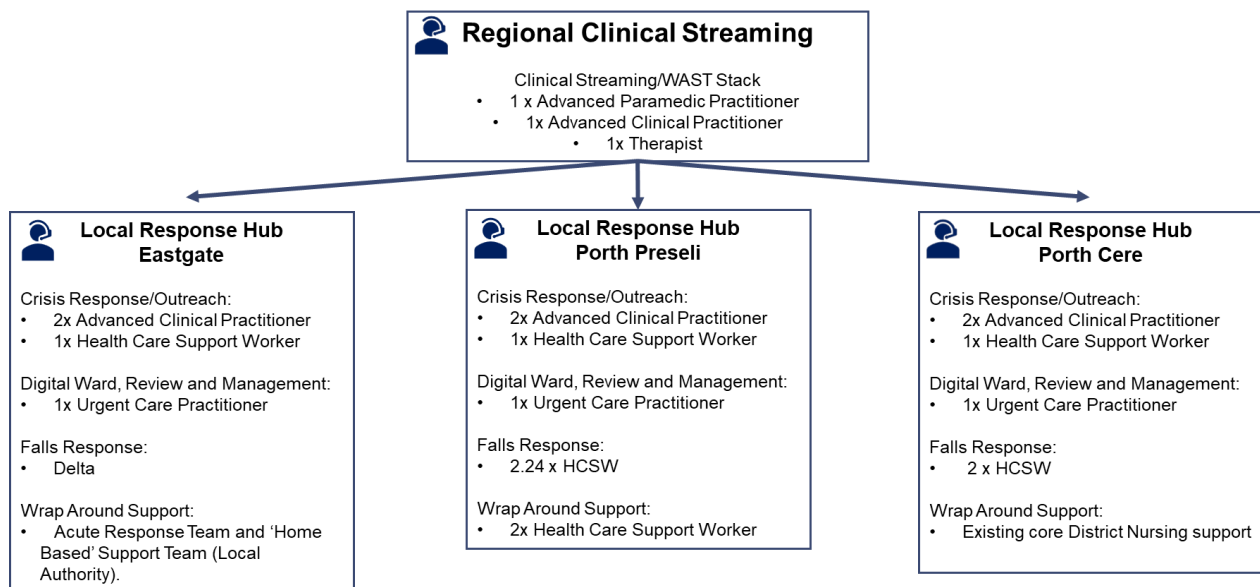
4. Proposed Streaming, Hospital@Home and SDEC Models

Optimal Service Components

Seven Day:

- **Regional Clinical Streaming and Local Response Hubs** in Eastgate, Porth Preseli, and Cardigan. One regional single point of contact (Consultant Connect) for professionals and the ability to respond out of three local hubs to enable a response within two hours. Clinicians will be connected virtually across the Health Board based in any of the locality hubs.
- **Same Day Emergency Care (SDEC)**. Optimal SDEC model introduced across 7 days, this includes increasing the resourcing for the current 5-day SEDC model across existing sites, developing an SDEC service in Bronglais General Hospital (BGH) and providing a weekend service
- **Hospital@Home**. 7-day clinical oversight from the Local Response Hubs would enable 7-day Hospital@Home support across Hywel Dda, meaning fewer hospital attendances and care closer to home for our elderly and frail populations.

Operating Model – Clinical Streaming Service






- Please note that the above is based on per day basis, Saturday and Sunday, 8am – 8pm basis (please refer to appendices for costings). Pharmacy is not included for Weekend working but will provide 3x senior pharmacy support, one per County, Monday to Friday, 9am-5pm, to support the model



- The model is inclusive to the population crisis needs with a particular focus on frailty, falls, complex respiratory and an alternative to admission option where safe and appropriate for our most vulnerable citizens. This clearly aligns with the UEC Ministerial priorities.
- This model enables 7-day virtual ward functionality through Hospital@Home. Currently this is only 4 days a week as patients have to be discharged every weekend as a streaming hub is not operating to monitor.
- There is direct access for Care and Nursing Homes alongside other clinical professionals
- Integrated Level one, Level two and Level three falls response, seven days a week
- Local response teams (inclusive of ACPs, Out of Hours (OOHs), Pharmacy, Therapies (Mon-Fri), District Nurses).
- Regional Clinical triage with cross-hub coordination.
- Integration with Out of Hours, and Intermediate Care teams. Pathways have already been built up over the week working between the CSS which have shown positive results, this will be continued into the weekend.
- Engagement through a number of key stakeholder workshops, inclusive of Primary Care, Secondary Care, Local Authority and Liaison representatives has led to the consensus on the staffing model put forward.
- WAST are able to support the model with an Advanced Paramedic Practitioner over seven days as part of the regional streaming aspect of the model.
- Advanced Clinical Practitioner (ACP) Supporting Professional Activity (SPA) time has been factored into all ACP posts (two sessions SPA and eight sessions Direct Clinical costs)

Operating Model – SDEC Services

 GGH SDEC	 BGH SDEC	 WGH SDEC
<ul style="list-style-type: none"> • 1x Admin & Clerical* • 2x Health Care Support Worker • 2x Nurse** • 1x Advanced Nurse • 1x Supervisor* • 3.3x Advanced Clinical Practitioner • 0.9x Consultant Oversight • 2.1x Consultant/Frailty • 0.2 x Cleaning Staff 	<ul style="list-style-type: none"> • 1x Health Care Support Worker • 1x Senior Nurse • 1.2x Advanced Clinical Practitioner • 1x GP- Medical Oversight • 0.7 x Cleaning Staff 	<ul style="list-style-type: none"> • 1x Admin & Clerical • 2x Health Care Support Worker • 1x Nurse • 1x Advanced Nurse • 1x Senior Nurse* • 3.3x Advanced Clinical Practitioner • 0.9x Consultant Oversight • 2.1x GP Medical Oversight • 0.2 Cleaning Staff

**weekdays only **only 1x on weekends*

- Please note that the above is based on Whole Time Equivalent (WTE) per day basis



- The Optimal SDEC model refers to implementing a model which strengthens the current weekday services and provides cover for weekend working.
- The Optimal SDEC model will enable partnership working with Clinical Streaming Services and Virtual Wards across 7-days, enabling direct referrals from WAST (ambulance service) and Out-of-Hours GP services. This integration will allow rapid discharge and admission avoidance
- Will enable the stream of patients from CSS to SDEC and back to the community to support improvement of A&E and hospital flow at weekends
- As the proposal involves extending SDEC services to longer weekday hours and introducing weekend operations, there is an associated risk of insufficient diagnostic resources (Radiology, Pathology, Occupational Therapy, Physiotherapy, Dietetic, Speech & Language Therapy and Podiatry) and workforce to support the rapid diagnostic capacity required for optimal patient flow within the proposed model (please see Appendix and Risk Section for more detail on mitigations and evidence). This risk will be monitored through the evaluation framework and an assessment of need completed.
- Advanced Clinical Practitioner (ACP) Supporting Professional Activity (SPA) time has been factored into all ACP posts (two sessions SPA and eight sessions Direct Clinical costs)



5. Benefits

Clinical Streaming, Local Evidence Base

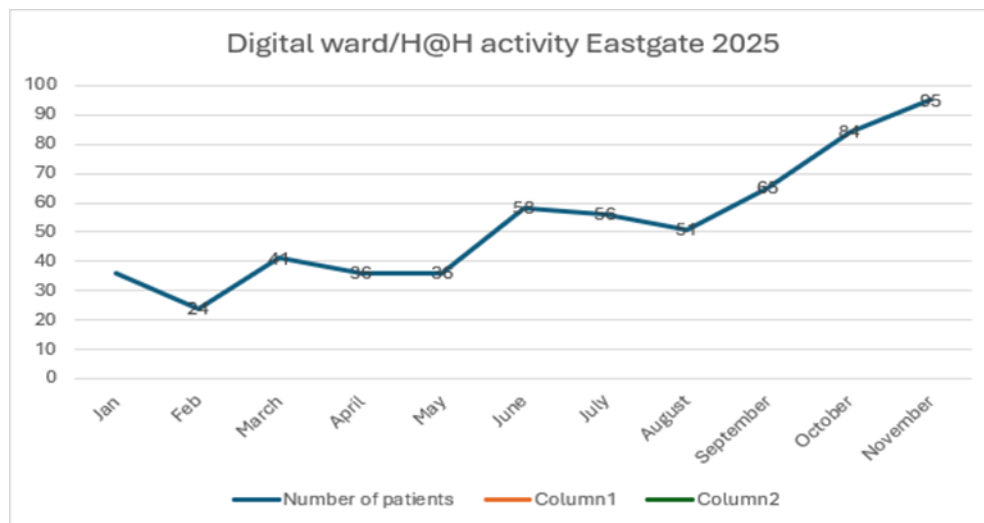
The Pilot Evaluation has shown benefit in terms of cost avoidance and patient experience (please refer to appendices). It was recommended in the evaluation that further in-depth financial and value scrutiny was required to understand fully the potential cost avoidance figures. Over the last month the Clinical Leads within the Six Goals Team have been working with Finance and Value leads within the organisation to achieve this.

The clinical view is that there would be significant benefits for the Health Board in having Clinical Streaming services running over the weekend, particularly in terms of patient flow, patient experience and cost avoidance.

In terms of Qualitative benefits, the following were seen in the pilot weekend:

- Improved patient experience and safety.
- Faster discharge and reduced hospital admissions.
- Enhanced staff collaboration and morale.
- Positive patient and staff stories demonstrating real-world impact.

Recently the hours for the Eastgate Response hub increased from 9am - 5pm to 8am - 8pm. This has had an impact on the numbers of patients supported at home, via Hospital@Home and the virtual ward. The graph below represents the Numbers of patients that Eastgate is supporting at home with regular medical monitoring that could otherwise need hospital admission. A clear increase is noted in numbers supported following the increase in service hours:





Please note, this does not represent the totality of activity, only those that are 'admitted' to the Hospital@Home or digital ward.

Clinical Streaming, National/International Evidence Base:

Clinical Streaming, Hospital at Home and Virtual Wards models Nationally and Internationally offer strong evidence for implementation. These models often incorporate clinical streaming principles (e.g. early triage, redirection from EDs, and community-based care).

1. Central London Community Healthcare NHS Trust & West Hertfordshire Teaching Hospitals Trust

- Model: Virtual Hospital / Hospital at Home (includes clinical streaming and early supported discharge)
- Key Cost Savings:
 - £1.33 million net savings over 12 months
 - £486 saved per Early Supported Discharge patient
 - £3,652 saved per Admission Avoidance patient
 - 80% cheaper than inpatient care (£118.49 vs. £569 per bed day)
- Impact: Reduced hospital admissions by 2.8 days on average; high patient satisfaction (95.8%) and safety (98.3%) ratings

2. NIHR Evidence – Cost-Saving Interventions

- Although not specific to streaming hubs, NIHR highlights several interventions that align with the goals of clinical streaming, such as:
 - Avoiding unnecessary follow-ups
 - Reducing inappropriate hospital admissions
 - Using community-based alternatives
- These interventions are shown to save thousands of pounds per patient and improve care quality.

3. The Buckinghamshire, Oxford and Berkshire West Integrated Care System Hospital@Home service. Outcomes included significant reductions in whole system healthcare utilisation with:

- 58% reduction in calls to 111
- 66% reduction in ambulance incidents
- 69% reduction in conveyance,
- 75% reduction in type 1 ED attendances and a 73% reduction in emergency admissions (equivalent to 46,685 bed days across the system during the time period evaluated).



- 60% of H@H admissions were to facilitate admission avoidance, with an average Clinical Frailty Score of 6 identifying appropriate inclusion of a complex and frail population.
- Patients and staff reported positive experiences which were achieved through an intentional co-ordination and communication of care

4. Denmark – the Introduction of Pre-Emergency Department Clinical Streaming Hubs has demonstrated:

- Decreased emergency department overcrowding by diverting low-acuity cases early.
- Increased patient safety through the use of validated triage and symptom-based protocols.
- Demonstrated more efficient use of resources such as ambulances, ED personnel, and beds.
- Improved system performance via digital integration and coordinated care pathways.
- Enhanced patient experience by reducing unnecessary hospital visits.

As demonstrated a variety of Clinical Streaming models, especially those involving early triage, redirection, and community-based care, demonstrate significant cost savings and improved outcomes. As such, these findings strongly and overwhelmingly support the economic and quality of care rationale for investing in clinical streaming services as part of a seven-day NHS service model.

SDEC, Local Evidence Base

High Same-Day Discharge Rates: During the Enhanced Weekend evaluation (please see appendix) 91% of all attendances to SDEC were discharged the same day, demonstrating that the service achieved its core aim of avoiding unnecessary admissions and improving patient flow.

Impact on ED Medical Take: SDEC absorbed 56% of all ED medical takes during the Enhanced Weekend, significantly reducing pressure on Emergency Departments and improving patient throughput.

SDEC, National Evidence Base

Evidence indicates that implementing a 7-day SDEC service will deliver significant improvements in patient outcomes, operational efficiency, and compliance with national policy. SDEC enables rapid assessment, diagnosis, and treatment for patients who can be safely managed without overnight admission, reducing unnecessary inpatient stays and improving patient experience. Data shows that between 38% and 92% of patients



seen in SDEC can be discharged the same day, avoiding risks associated with hospital-acquired infections and deconditioning, particularly for frail and complex patients.

Operationally, SDEC reduces pressure on emergency departments and inpatient bed capacity, supporting improved patient flow across the hospital. Data from NHS Model Hospital indicates that 80% of patients managed through SDEC have a zero-day length of stay compared to an average of 4.2 days for ward admissions. Extending SDEC to seven days ensures weekend coverage, smoothing discharge patterns and reducing Monday backlogs, which are a known contributor to delays and overcrowding.

Strategically, a 7-day SDEC service aligns with NHS Long Term Plan requirements for urgent and emergency care transformation, which mandate SDEC availability for at least 12 hours per day, seven days a week. This approach supports integrated care models by linking with virtual wards and community services, reducing readmissions and improving continuity of care. Financially, avoiding unnecessary admissions generates cost savings and optimises resource utilisation, contributing to overall system efficiency.

Case studies reinforce these benefits. Tunbridge Wells NHS Trust reported a 54% increase in SDEC throughput and a 14% reduction in medical take admissions following operational improvements. A systematic review published in the BMJ confirms that SDEC improves emergency care performance when supported by senior clinical decision-making and clear referral pathways.

The implementation of a 7-day SDEC service represents a high-impact intervention that improves patient safety, enhances hospital flow, and delivers measurable cost efficiencies while meeting national policy requirements.

Summary

Local and National evidence indicates a strong argument for the implementation of 7-day CSS and SDEC services. It is anticipated that following implementation improvement in the following performance metrics will be demonstrated:

- Reduced attendances
- Reduced admissions
- Less conveyances
- Reduced length of stay

There is also strong evidence demonstrated for quality of care and financial benefits, which is further detailed and explored in the Financial Analysis section of this document.



6. Financial Case – Cost/Benefit Analysis

Please refer to Appendices for a detailed breakdown of costs associated with the CSS and SDEC staffing models. All models have been worked up with key stakeholders and have been developed with finance colleagues.

Pump priming of this proposal will enable right-sizing and resourcing to ‘Get it Right for Everyone’, as the focus and activity shifts from acute to care closer to home in the community. A proportionate resource release can be applied to link and shift the financial expenditure tied to the activity virement.

Clinical Streaming Hub Analysis

Option A	Additional cost per year	Estimated cost avoidance per year
Optimal 7-day Clinical Streaming Model	£1.9m	£4m

Presented below are two estimates cost benefit reviews to evaluate the volume of patients that the CSH model the cost benefit of the weekend staffing model proposed.

1. Local Pilot Weekend of CSS – The validity and reliability of utilising the data in this way to inform these calculations is further discussed in the Enhanced weekend paper (please see appendices) and is currently being scrutinised further by the value/finance team (as per recommendation in the paper).
2. Data review of last 3 years in-patient – The review was based on a 3 years worth of data for potential CSS patients whose in-patient stay or A&E attendance could be avoided by implementation of a CSH working on the weekend. This is the maximum benefit expected with a 100% avoidance intervention rate by the CSH service.

	Hospital Admission	ED attendance	LOS	Potential Cost Avoidance	Bed Saving
Weekend Pilot	19	34	5.75	4,154,318	16
Data Review	8	7	15.13	4,049,856	17

The cost avoidance figures are based on potential costs which could arise as a result of hospital admissions and ED attendances. Data from the Enhanced Clinical Streaming paper has been used to inform the estimated numbers of ED attendance and Hospital Admission avoidances over a year.



Both evaluations show a potential bed saving of 16-17, how this will affect the flow within hospitals is yet to be investigated. Further work into the conversion of this cost avoidance potential into actual cash releasing plans will need to be undertaken. The most probable result of the attendance avoidance is a reduction in variable pay spend on surge within the hospitals. If current levels of surge spending was eliminated (£1.38m variable pay) and Pharmacy cost reductions (£0.62m) then the combined cash benefit (£2.0m) would be greater CSH service (£1.54m).

Please note the above figures have gone under limited financial/value scrutiny. Greater joint analysis between clinical and financial/value teams is needed based on a number of assumptions:

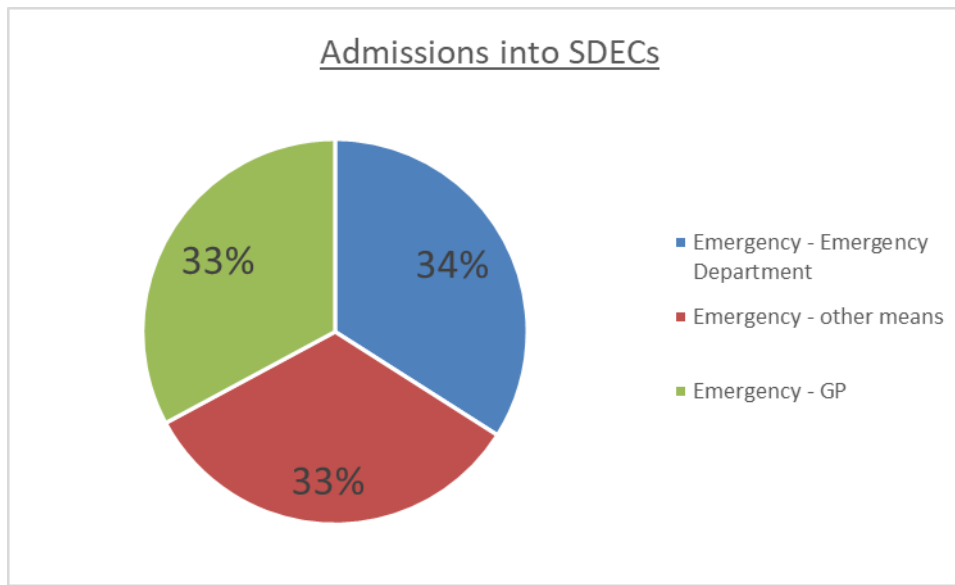
- For the weekend pilot - a 5.75-day average length of stay is used in the calculation of potential hospital admission cost avoidances. This is based on the average of mean LoS for +18 years old inpatients. A non-specific LoS was used as the age range in the pilot was not restricted to +75 years old. The LoS is lower than the previous estimate of 64 days but more in line with recent finance/value data estimates. However, it must be noted that the assumed resource released through the implementation of the weekend CSH model a complex process and will be an average approximation which takes into account harm related to deconditioning, institutionalisation, increasing external dependence and consequences of higher domiciliary packages. An MDT streaming approach will provide a preventative tailored approach to the individual at the outset.
- In the data review, a 15.13-day average length of stay was found for the cohort of patients which the CSH service would target who currently have a hospital admission. The review was based on looking over a 3-year period, weekend admissions only. The patients were Hywel Dda resident patient's only aged 75+ who have been admitted as an emergency from A&E as General Medicine in-patients. This is the specific type of cohort of patient that the clinical streaming is looking to target.
- Pharmacy cost avoidance is included within the cost (£154,899) and cost avoidance figures (£619,423). Avoidance per intervention has been estimated from Pharmacy pilot paper, based on 6 interventions per day and a cost saving of £132 per intervention (please see Appendices for pilot paper).
- The cost avoidance figure is based on potential costs which could arise as a result of hospital admissions and ED attendances. Data from the Enhanced Clinical Streaming paper has been used to inform the estimated numbers of ED attendance and Hospital Admission avoidances over a year. The validity and reliability of utilising the data in this way to inform these calculations is further discussed in the Enhanced weekend paper (please see appendices) and is currently being scrutinised further by the value/finance team (as per recommendation in the paper).
- The potential ED avoidance will bring cost avoidance as well as hospital flow benefits at weekends.



SDEC Analysis

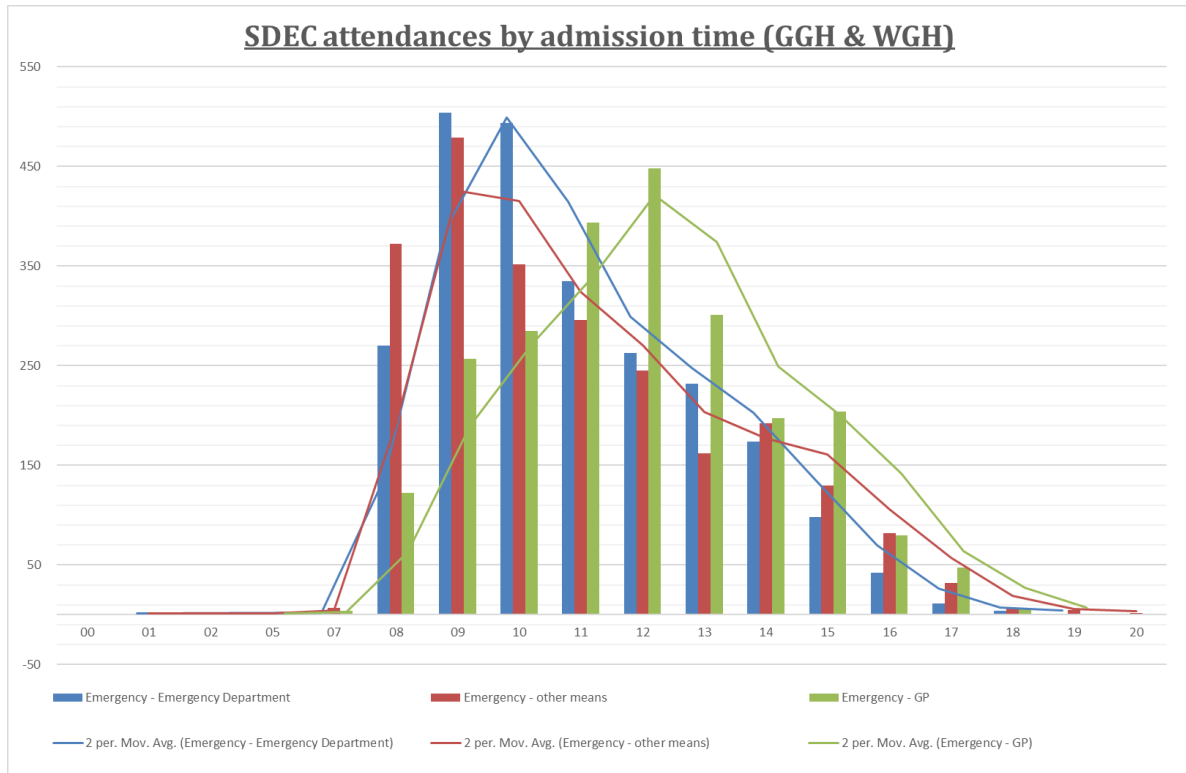
1. Admission routes into SDEC

- SDECs in the weekdays tends to pull from equally from 3 different sources
- Other means in internal referrals from Eastgate, Porth Preseli, SDUC, etc.



2. Admission times for patient cohorts

- SDEC tends to pull from A&E for the first few hours peaking at 10.
- Referrals by other means in from Eastgate, Porth Preseli, SDUC, etc peaks at 9.
- GP referrals in peak at 12.



Any weekend SDEC would need to pull more patients from A&E as the GP intake is not there.

3. Typical SDEC patients

- There is no common age for SDEC patients:

Row Labels	Count of CRN	%
<30	778	8%
30-39	922	9%
40-49	972	10%
50-59	1,408	14%
60-69	1,987	20%
70-79	2,332	23%
80+	1,759	17%
Grand Total	10,158	100%

- There is no common diagnosis type for a SDEC patient:



Row Labels	Count of CRN	%
Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified	3,739	37%
Diseases of the circulatory system	1,362	13%
Diseases of the respiratory system	1,078	11%
Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism	579	6%
Endocrine, nutritional and metabolic diseases	541	5%
Diseases of the musculoskeletal system and connective tissue	428	4%
(blank)	425	4%
Diseases of the digestive system	419	4%
Diseases of the skin and subcutaneous tissue	313	3%
Diseases of the genitourinary system	293	3%
Certain infectious and parasitic diseases	210	2%
Neoplasms	200	2%
Diseases of the nervous system	166	2%
Injury, poisoning and certain other consequences of external causes	131	1%
Factors influencing health status and contact with health services	85	1%
Diseases of the eye and adnexa	69	1%
Diseases of the ear and mastoid process	43	0%
Mental and behavioural disorders	39	0%
Pregnancy, childbirth and the puerperium	29	0%
Codes for special purposes	7	0%
Congenital malformations, deformations and chromosomal abnormalities	2	0%
Grand Total	10,158	100%

- Within the top category diagnosis group, the top 10 conditions were:

Row Labels	Count of CRN
Chest pain, unspecified	734
Other chest pain	456
Headache	341
Dyspnoea	333
Palpitations	176
Dizziness and giddiness	145
Syncope and collapse	126
Precordial pain	121
Malaise and fatigue	98
Cough	79
Grand Total	2,609

Conclusions

- There are no typical “SDEC” patients in order to track through the system to check LOS or conversion rates.
- 90% of SDEC patients have a LOS of zero.

SDEC Sustainability Analysis

1. Traditional saving model calculation

Traditionally productivity savings are calculated using a standard bed day cost. If the number of bed days equals the extra cost of the resource required, then in theory the service is sustainable. In the SDEC case, if the extra resource required is £6.3m, then the number of additional patients that SDECs would need discharge on a weekly basis, at the current length of stay per site, would be 30.



Site	Extra Cost	LOS	Cost Bed day	Patients a year	Patients a week
WGH	£2,432,277	7.14	£527	647	12
BGH	£1,069,407	10.90	£527	186	4
GGH	£2,817,349	7.23	£527	739	14
	£6,319,033				30

This assumes that every patient care is equal, in an established bed with approved staffing model.

2. Analysis of Surge and boarding

Within the HB, there are high numbers of patients who are awaiting a bed in A&E, boarding in wards and in surge beds within wards. To make a saving, the cost of these patients has to be eliminated before standard cost are reduced.

Site	Med A&E surge	Surge On ward	Boarding	Total patient
WGH	25	20	5	50
BGH	15	10	5	30
GGH	20	20	10	50
Total	60	50	20	130

The additional hours of treating these patients in these areas are recorded within Allocate, an annualised cost has been approximated from the position at the end of October.

Site	Medical	Nursing	Total
WGH	£33,441	£609,012	£642,453
BGH	£740,115	£316,411	£1,056,526
GGH	£1,056	£393,026	£394,083
Grand Total	£774,612	£1,318,450	£2,093,061

The true cost may in fact be higher as staffing is stretched from funded establishment but not recorded, therefore the direct cost of looking after the increased demand is low. An average daily price per surge patient therefore is considerably less than a standard bed day cost of £527.

Site	Surge cost	Surge cost per day	Price patient per day
WGH	£642,453	£1,760	£35.20
BGH	£1,056,526	£2,895	£96.49
GGH	£394,083	£1,080	£21.59
Total	£2,093,061		

Therefore, reducing surge beds will increase the average price per patient due to the low cost of providing surge care. This does not take into consideration the clinical risk, workload pressure on staffing (staff to patient ratios) or potential harm leading to compensation claims.



Using the concept that surge must be reduced before £507 is released per patient, the proposed models must release the following bed days before funded bed days are released.

Site	Total Surge patients	No bed days
WGH	50	18,250
BGH	30	10,950
GGH	50	18,250
Total	130	47,450

3. Patient cohort

The patient cohort that SDEC intends to target is General Medicine patients that have attended A&E that have a length of stay greater than zero days.

Patient cohort	No of patients	%
Medicine <0 days	2,593	2%
Medicine >0 days	15,803	12%
A&E	97,678	75%
Surgery & Other	14,820	11%
Grand Total	130,894	100%

Due to the SDEC opening hours, it is very unlikely that patients will be admitted into SDEC between the hours of 5pm-5am, therefore these are excluded.

		Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday	Total
WGH	All Med patients LOS>0	18	18	17	18	19	13	13	116
WGH	Potential patients LOS>0 A&E intake 5:00-17:00	12	13	12	12	13	8	8	77
BGH	All Med patients LOS>0	10	9	9	10	9	7	7	60
BGH	Potential patients LOS>0 A&E intake 5:00-17:00	7	6	6	6	6	4	4	40
GGH	All Med patients LOS>0	20	19	19	21	20	15	15	128
GGH	Potential patients LOS>0 A&E intake 5:00-17:00	13	12	12	13	13	9	10	82

4. Calculation saving model amending for current 100% surge

In order to be sustainable, the saving has to at least match the investment, therefore number of surge and then funded bed days needed to be saved was calculated. To achieve the investment saving, WGH and GGH SDECs will have to prevent 74-75% of the cohort and BGH 48%.

Site	Surge beds			Funded beds			Total Saving	Prevention rate
	Cost Bed day	Bed day saving	Saving	Cost Bed day	Bed day saving	Saving		
WGH	35.20	18,250	£642,453	527.00	3,397	£1,790,383	£2,432,836	75%
BGH	96.49	10,950	£1,056,526	527.00	24	£12,806	£1,069,332	48%
GGH	21.59	18,250	£394,083	527.00	4,598	£2,422,889	£2,816,972	74%
Total		47,450	£2,093,061	1581	8,019	£4,226,079	£6,319,140	

Converted into patient numbers, the three SDECs will have to stop admissions of 138 patients per week.



Site	Patients on weekdays	Patients a weekend	Total Patients per week
WGH	46	12	58
BGH	15	4	19
GGH	47	14	61
Total	108	31	138

The majority of the patient cohort currently lies in the weekday, thought to be related to GP referrals into the hospitals.

		Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday	Total
WGH	All Med patients LOS>0	18	18	17	18	19	13	13	116
WGH	Potential patients LOS>0 A&E intake 5:00-17:00	12	13	12	12	13	8	8	77
WGH	75.33% conversion	9	10	9	9	10	6	6	58
BGH	All Med patients LOS>0	10	9	9	10	9	7	7	60
BGH	Potential patients LOS>0 A&E intake 5:00-17:00	7	6	6	6	6	4	4	40
BGH	48.4% conversion	3	3	3	3	3	2	2	19
GGH	All Med patients LOS>0	20	19	19	21	20	15	15	128
GGH	Potential patients LOS>0 A&E intake 5:00-17:00	13	12	12	13	13	9	10	82
GGH	74.13% conversion	10	9	9	10	9	7	7	61

Recurrent savings are only possible with release of beds; the majority of savings only affect surge due to the large amount of patients either awaiting a bed in A&E or boarding or in a surge bed.

Release of beds	No of beds
Surge/Boarding	130
Funded beds	22
Total beds	152

Conclusions and caveats:

- Previous business cases have not taken into account the lowered cost saving of reducing surge, therefore productivity savings have been lowered considerably.
- Surge spend and surge activity have been considered directly proportional but there could be stepped costs, where a level of boarding could be held a zero cost. For example, surging one bed may not lead to an increase in spend, the number of patients must rise to 3 or 4 patients before a surge shift is sanctioned.
- The current spend badged as surge is likely to be higher due to substantive/fixed term staff not being badged as surge.
- Other measures to reduce surge have not been taken into account which may increase the value of the proposed SDEC business case.
- Each acute site has been considered as an isolated system in the model but in reality, benefits will be spread from site to site with increased repatriation possible with the reduction in beds.



- Clinical agreement on whether the percentage of prevention of the General Medicine patient cohort is clinically possible has not been confirmed.

Calculation saving model amending for current 50% surge reduction

The above model assumes that the SDEC is the only programme that the organisation is running that will improve flow, reduce LOS and prevent admissions into the acute sites. Consideration also must be made with regards to the benefits of other programmes that include collaborative working with external stakeholders, especially with recent increased funding to local authorities and hospices. Therefore, assuming the SDEC model should be responsible for reducing the surge by itself in order to demonstrate its value is a high bar to achieve.

If surge were to be reduced by other “back door” programmes by 50% and the SDEC model “front door” only had to account for the other 50% then the number of patients that SDEC would have to prevent being admitted would be an addition 84. This is a drop of 54 if it were challenged to reduce 100%.

Site	Total Patients per week		
	100% surge reduction	50% surge reduction	Difference
WGH	58	35	23
BGH	19	11	8
GGH	61	37	23
Total	138	84	54

The prevention rate of Medical patients would drop to a maximum of 46% rather than 75%.

Site	Prevention rate		
	100% surge reduction	50% surge reduction	Difference
WGH	75%	46%	30%
BGH	48%	29%	20%
GGH	74%	46%	28%



7. Options

The following implementation options have been proposed for Board to consider (please note financial figures have been rounded to one decimal place for ease of reference, full figures can be found in the appendix):

Option A

Option A	Additional cost per year	Estimated cost avoidance per year
Optimal 7-day Clinical Streaming Model	£1.9m	£4m

This option relates to the implementation of 7-day Clinical Streaming and Hospital@Home services across Hywel Dda. The staffing model for this option is highlighted in Section 4 (Proposed Options) and detailed costings, and value calculations can be found in the Financial Case and Appendices).

Option B

Option B involves the implementation of 7-day Clinical Streaming, Hospital@Home, and the phased rollout of Same Day Emergency Care (SDEC) services across Hywel Dda. The first year the model would be implemented in WGH SDEC, year two in BGH and year three in GGH. WGH was chosen as the initial pilot site for the following reasons:

- Withybush currently provides significant boarding and surge care, so piloting here could help stabilise current pressures and test the model's effectiveness in a high-demand environment.
- Mature and established SDEC, with links across Streaming and OOH services, increasing the likelihood of successful delivery and measurable benefits.
- Opportunity to improve 4-hour and 12-hour ED wait performance, currently WGH is the site which has highest numbers of waits in the Health Board

Phasing the introduction of SDEC services annually by site will provide sufficient time for operational embedding and benefit realisation. Each year will include scheduled review points to assess impact, culminating in a comprehensive year-end evaluation. This evaluation will determine whether the service should continue and/or be expanded to additional sites. The decision will be based on the extent to which anticipated cost avoidance benefits have been achieved and whether acute funding can be released to sustain the service. If funding cannot be secured, the service will be discontinued, and the



Exit Plan will be enacted (see Workforce Analysis and Appendix for further details on exit planning).

Please note that both Clinical Streaming and SDECs are currently running over 5 days in Hywel Dda and have a budget against them. It is only the additional costs (the costs associated with an optimal and weekend workforce to enable a seven-day model) that are being asked for as part of this Business Case. The current costs of the SDEC and Clinical Streaming Model can be found in the Appendix.

As documented in the Finance Case the SDEC cost avoidance has been calculated on being cost neutral through the cost avoidance figures associated with decreasing hospital admissions to surge, boarding and ward beds. The below figures are based on the assumption that the optimal SDEC model implemented on all sites would be contributing to 50% reducing of surge beds, this is an estimated 83 patients per week avoiding hospital admission (please refer to Finance Section for detail by site).

Option B	Additional Cost Optimal 7-day Clinical Streaming Model	Cost Avoidance Optimal 7-day Clinical Streaming Model	Additional Cost Optimal 7-day SDEC model, phased implementation.	Cost Avoidance Optimal 7-day SDEC model, phased implementation	Total Additional Cost	Total Cost Avoidance
Year One. CSS Model and WGH SDEC	£1.9m	£4m	£2.5m	£2.5m	£4.4m	£6.5m
Year Two. CSS Model and WGH and BGH SDEC	£1.9m	£4m	£3.5m WGH £2.5m BGH £1m	£3.5m	£5.4m	£7.5m
Year Three. CSS Model and WGH, BGH and GGH SDEC	£1.9m	£4m	£6.3m WGH £2.5m BGH £1m GGH £2.8m	£6.3m	£8.2m	£10.3m

The main highlights to draw from the table are the total cost of Option B is **£8.2m** over three years. The total cost avoidance is estimated to be **£10.3m**.

Please note the staff modelling WGH, BGH and GGH SDECs is based on current operational intelligence. The learning and intelligence from the WGH operationalisation over the year one could alter the proposed staffing models and costs for BGH and GGH and may impact on cost estimates presented above.



8. Workforce Analysis

Optimal Same Day Emergency Care (SDEC) Model:

SDEC BGH

Recruitment for the BGH 7-Day Model presents significant workforce planning challenges across Bands 3, 7, 8A and GP roles, with high WTE requirements and no internal talent pipeline. Risks for external and internal recruitment range from medium to high, compounded by limited candidate diversity and unclear demand forecasting. Timelines exceed six to twelve months for senior roles, creating severe operational dependency risks. Failure to recruit will impact service delivery, increase pressure on existing staff and jeopardise project implementation. An urgent, robust workforce plan with phased recruitment, talent development and risk mitigation strategies is essential to ensure sustainability and continuity of care.

SDEC GGH

Workforce planning for the GGH 7-Day Model faces significant challenges due to high WTE requirements across Bands 2–8A and Consultant roles. Recruitment risks range from low for Band 2 to high for senior grades, with no internal talent pipeline and limited candidate diversity. Timelines extend beyond 12–18 months for advanced practice and consultant posts, creating severe operational dependency risks. Failure to recruit will destabilise nursing and ACP teams, impact service delivery and jeopardise project implementation. An urgent, comprehensive workforce plan is required, incorporating phased recruitment, international sourcing, talent development and risk mitigation to ensure sustainability and continuity of care.

SDEC WGH

Workforce planning for the WGH 7-Day Model faces major challenges due to high WTE requirements across Bands 2–8A, GP and Consultant roles. Recruitment risks are high for senior grades, with no internal talent pipeline and limited candidate diversity. Timelines exceed 12–18 months for GP, advanced practice and consultant posts, creating significant operational dependency risks. Failure to recruit will destabilise nursing and ACP teams, impact service delivery and compromise project implementation. An urgent, comprehensive workforce plan is required, incorporating phased recruitment, international sourcing, talent development and risk mitigation strategies to ensure sustainability and continuity of care.



7 Day Clinical Streaming and Hospital@Home Service

Workforce planning for the Clinical Streaming Hub faces significant challenges due to high WTE requirements across Bands 3–8A, Band 6–7 and Pharmacist roles. Recruitment risks are high for senior and specialist posts, with no internal talent pipeline and limited candidate diversity. Timelines exceed 12 months for advanced practice and pharmacy roles, creating severe operational dependency risks. Failure to recruit will destabilise nursing and pharmacy teams, impact service delivery and compromise project implementation. An urgent, comprehensive workforce plan is required, incorporating phased recruitment, international sourcing, talent development and risk mitigation strategies to ensure sustainability and continuity of care

Operational/Clinical Response

SDECs

If the roles remain unfilled and are not able to be recruited in to then the sites will be unable to provide a safe alternative to admission. The full complement of workforce outlined is needed to provide an effective operating service and optimise alternative care pathways. This issue is that the default pathway will result in overcrowding in ED, extended length of stay for patients and hospital associated harm and deconditioning. Not establishing a 7/7 SDEC will mean the peak activity demand continues at weekends, with an inability to flatten the demand curve, with continuing flow constraints.

Clinical Streaming

For Band 8a roles, the weekend CSS model requires two whole-time equivalents (WTE) per county. It is important to note that Clinical Triage Assessment and Streaming (CTAS) is a critical function within the 7-day streaming model and must be delivered by staff at Band 8 or above, as stipulated in the WAST Memorandum of Understanding. Without CTAS in operation, the service cannot achieve admission prevention or crisis response from the hubs. WAST has already indicated they cannot guarantee two APPs every day, meaning the service will need to rely on CSS staff for the pulling of patients from the WAST stack.

The crisis response element requires a senior clinical decision-maker to supervise the service and assess patients. This individual must be confident in managing risk within a community setting, which reinforces the need for experienced ACPs or higher within the hubs. The CSS also requires a prescriber, which can only be fulfilled by a Band 8 ACP role.



Workforce Risks and Mitigations

The implementation will be on an ongoing phased approach basis. There will be an inherent requirement to rotate experienced existing staff across the 7-days into the weekend and to train staff to the required standards for their roles. This opportunity will build on existing 'Grow your Own' future workforce provision and we therefore have high confidence in recruiting to the proposed model. The strength of the proposal lies in the integration and diversification of staff groups. High levels of interest already exist in staff outside the Health Board and Nationally due to the pioneering reputation and proposed portfolio working opportunities.

Shortfall in roles required and inability to recruit into posts within the timeframes for the pilot.

Each Response Hub has recently attracted interest from both internal and external candidates for Clinical Streaming roles. It is anticipated that this interest will continue to grow, driven by the demand for and appeal of portfolio working across disciplines, a key benefit of operating within a Clinical Streaming environment.

The service is considering the introduction of Annex 21 trainee roles. This strategy would allow senior ACPs/APPs to provide weekend coverage while trainees support weekday operations. It also strengthens workforce sustainability by developing future ACPs who are internally trained to meet the required risk appetite and experience standards.

While full coverage is essential for optimal delivery, it is worth noting that the CSS could still provide regional triage of the 999 stack with a smaller team. This would add significant value; however, the local hub's ability to respond may be limited without adequate staffing for face-to-face assessments. Where in the short-term recruitment issues are impacting there would be a possibility of utilising bank staff or overtime.

Is there a training requirement for internal/external staff above the induction period required for staff coming into these roles?

It is planned that current experienced CSS staff will be working the weekend shifts initially, and the new recruits into service would be backfilled into weekday working. This would give them time and more staffing resource around them to build and develop their skills before undertaking more independent working at weekends

There is currently a training/mentorship programme running for CSS for Hywel Dda, funded through Welsh Government. This has enabled staff working in hospital environments to increase awareness and understanding of how the CSS operates across Hywel Dda, effectively acting as a 'Grow your Own' initiative for the CSS.

Additionally, the Community and Integrated Medicines Care Group (CIMCG) are introducing an ACP lead role in to support the development of Advanced practitioners and provide oversight



Will we likely destabilise other services if we internally recruit into these roles?

A phased implementation approach will help mitigate this risk. Furthermore, clinicians have tested the market and in clinical conversations there appears to be clear consensus in external interest for working in Clinical Streaming and SDEC services.

Newly qualified nursing cohorts will be available for recruitment in March and September 2026, aligning with planned recruitment timelines. The team will actively engage with these cohorts to promote the model and maximise local uptake. Should internal recruitment occur, it is anticipated this will align with our commitment to workforce development by creating opportunities for 'Grow Your Own' initiatives, career progression and role diversification across the organisation.

Organisational Change Process (OCP)

It is planned to undertake an OCP with current Clinical Streaming and SDEC staff in order to effectively transition into a seven-day service. The clinical opinion is that the majority of staff will likely find this beneficial, but it is also understood that some staff will not want to have a 7-day contract. There will be a need for sensitive negotiation and discussion with existing teams on this matter and plan for this will be developed with workforce colleagues in the initial phase of implementation



9. Key Risks and Mitigations

Risk	Mitigation
<p>No guarantee for Advanced Paramedic Practitioners (APP) to work in weekend due to current APP resource within WAST.</p>	<p>Will need to utilise Advanced Clinical Practitioners in the Navigator role if APPs are not available over the weekend. Ongoing meetings with WAST to understand position further and to try and build more APP resource in Hywel Dda to support the Weekend working.</p>
<p>Increased demand on Diagnostics from extended SDEC service</p>	<p>The ultimate demand and requirement for appropriate test requesting across the system will not change.</p> <p>However, the request site may, currently patients are sent back to primary care from ED to their GP to request tests, adding inherent delay in the system, and the test request will then originate from primary care.</p> <p>SDEC will provide a definitive response to the presentation, which is often a complex 'second opinion' from primary care so there will be an increase in test requests originating from SDEC.</p> <p>Test requesting will not really be more compressed as we will be 7/7 and only extremely time critical emergency requests are authorised overnight.</p> <p>There is also some evidence that prudent test requesting is more likely from SDEC.</p> <p>The key element to include is the part of the iUEC blueprint (see Appendix) where we will expand and roll out community ultraportable diagnostics with Point of Care Testing/ Point of Care Ultrasound in the future. This will enable real time, community-based diagnostician capability and training our ACPs to do POCUS will reduce the demand on radiology significantly</p>
<p>Workforce fatigue</p>	<p>Need to recruit staff to substantive/permanent positions, as a temporary or bank cover is not sustainable over a long period of time and may impact on f position.</p>



<p>Recruitment. Significant recruitment challenges listed as part of the Workforce analysis</p>	<p>Each Response Hub has recently attracted interest from both internal and external candidates for Clinical Streaming roles. It is anticipated that this interest will continue to grow, driven by the demand for and appeal of portfolio working across disciplines, a key benefit of operating within a Clinical Streaming environment.</p> <p>In addition, the service is considering the introduction of Annex 21 trainee roles. This strategy would allow senior ACPs/APPs to provide weekend coverage while trainees support weekday operations. It also strengthens workforce sustainability by developing future ACPs who are internally trained to meet the required risk appetite and experience standards.</p>
<p>Communication and Engagement</p>	<p>To date no engagement with the public has been done on the model. Comms and engagement advice is to develop public focus groups to engage on model before launch.</p>
<p>Benefits Realisation</p>	<p>The benefits of the service may take six months to a year to fully realise. New staff will need time to be trained to effectively work in a Clinical Streaming Environment, and services need to adapt to work with the hubs effectively over weekends. The programme group will need to ensure ongoing data analysis</p>

10. Implementation Plan

Agility

The business case for SDEC has adopted a phased approach in response to potential workforce and financial constraints. It is recommended that implementation timelines remain flexible, enabling the Health Board to accelerate progress where feasible and appropriate. The operational team must maintain the ability to balance risks with delivery requirements and adapt accordingly.

Furthermore, implementation should incorporate regular monitoring and review of evaluation data (refer to the Evaluation Framework) to ensure teams are well-informed and confident in decision-making.



Consequently, it should be acknowledged that indicative timeframes put forward may need to evolve and adjust as circumstances change.

Governance Process

The Implementation and ongoing monitoring and review of the proposed model will be overseen by the Community and Integrated Medicine Care Group (CIMCG) and the Urgent and Emergency Care Integrated Operational Group (IOG). Progress will be monitored through reporting against the evaluation framework and be submitted monthly to both groups. These groups will then feedback progress through to the Improving Quality, Finance and Performance Delivery (IQFPD) Group and to Welsh Government through the Improving Quality and Performance Delivery (IQPD) Group.

Evaluation Framework

The following metrics are proposed to be used as the evaluation framework for the Implementation of the Model. Further, these metrics will be what the review and touch points will be based against. The majority of these can be tracked to theoretical financial effect (please see Appendix for further details):

- % Conversion rates of streaming hub patients
- % zero- or 1-day LoS before SDEC and after
- Decrease of A&E attendances >75yrs
- Decrease of Ambulance admission >75yrs
- Decrease of patients awaiting packages of care >75yrs
- Increase in % of ED patients seen in 4 and 12 hrs
- Number of H@H patients being treated
- % Zero LoS
- % Attendance at A&E – readmission in day
- Medical patient LoS
- Number of boarding, surge, patients in A&E and bed occupancy %
- Increase in % of ED patient seen in 4 & 12 hrs
- Decrease in time wait for triage and dr wait in A&E
- Decrease in re-admission into hospital
- Number of emergency scans
- Use of emergency everlight
- Number of H@H patients being treated
- Impact on Radiology/Diagnostics, missed opportunities for rapid diagnostics
- Site sickness
- Site vacancies and turnover reasons
- Incidents in UEC settings
- Complaints in UEC settings
- Risks in UEC settings
- Deteriorating patients from A&E due to waits
- Patient harm (Risk pool)



- Key EqIA/IIA monitoring information

Exit Planning

In order to lower the risk to the organisation both options put forward have the ability to be decommissioned if the benefits are not realised. As such, there will be regular monitoring and evaluation touchpoints built into implementation, and option 2 incorporates a phased approach to the roll out of SDECs.

It is recognised that in the recruitment that the Health Board will need to be clear that of the possibility of redeployment for roles within the models. This could lead to the risk of deterring potential candidates from applying for positions and is something the Implementation group will monitor closely.

High-Level Timeline

Outline of expected phases. Please note these are high level as there will be a requirement to be flexible in the approach to accelerate or decelerate implementation depending on what the monitoring and review positions are describing. A detailed implementation plan will be developed on approval of the Business Case.

Months 1-4

- Development of detailed implementation plan
- Occupational Change Process enacted for weekend working
- Recruitment and training to posts
- Evaluation/monitoring touch points and processes set up
- Development of Implementation Phase Communications and Engagement Plan

Months 4-6

- Go Live Clinical Streaming/ Optimal Withybush SDEC
- Monthly Monitoring against evaluation framework through the CIMCG/IOG
- Ongoing Communications and Engagement with stakeholders

Months 6-12

- Evaluation Review April 2027.



9. Recommendations

Based on the evidence presented in this business case, it is recommended that Hywel Dda University Health Board proceed with the implementation of a seven-day Clinical Streaming Hub (CSH), Same Day Emergency Care (SDEC), and Hospital@Home model across the region. The data from both local pilots and national exemplars demonstrate clear benefits in terms of patient outcomes, cost avoidance, and system efficiency. The extension to a seven-day service is expected to address current gaps in weekend provision, reduce unnecessary hospital admissions, and improve patient flow, particularly for frail and elderly populations.

The Board should adopt a phased and flexible approach to implementation, allowing for ongoing evaluation and adaptation as the model is embedded. Regular monitoring against the proposed evaluation framework will be essential to ensure that anticipated benefits (such as reduced emergency department attendances, shorter lengths of stay, and improved access to community-based care) are realised. It is also recommended that the Health Board invest in workforce development, including the recruitment and training of Advanced Clinical Practitioners and the expansion of community diagnostic capabilities, to support the sustainability and effectiveness of the new model.

Finally, it is advised that the Board maintain a strong focus on stakeholder engagement, including staff, patients, and partner organisations, to ensure successful adoption and integration of the new pathways. The business case highlights the importance of agility and responsiveness, recognising that some benefits and resource shifts will only become fully apparent after implementation. Therefore, a commitment to continuous improvement, transparent reporting, and readiness to adjust the approach as needed will be critical to the long-term success of the seven-day Clinical Streaming and Hospital@Home services



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Appendix 1 - Hywel Dda University Health Board Weekend Clinical Streaming Evaluation March 2025

Aim

To understand the benefit and impact of extending Clinical Streaming Hubs (CSH) and Same Day Emergency Care (SDEC) services to include weekend working on the wider Urgent Emergency Care (UEC) system

The three objectives are to:

- Improve the quality of patient care
- Improve access to the most appropriate service (patients and care providers)
- Streamline the whole system approach and integrate operational processes

These aims are directly linked to current National Strategy and guidance linked to the Six Goals Programme, the Ministerial Priorities for Urgent and Emergency Care, and Ministerial Advisory Group and Get it Right First-Time (GIRFT) recommendations for Emergency Departments (ED).

Summary

Hywel Dda University Health Board ran an Enhanced Streaming Service over the weekend of the 22nd and 23rd of March 2025. In addition to regular weekend working the following services were in operation over both the Saturday and Sunday daytimes:

- Clinical Streaming and Same Day Urgent Care in Cardigan.
- Clinical Streaming collocated with Out of Hours Care, and an SDEC in Wyllybush Hospital
- Eastgate Clinical Streaming Hub and SDECs in Glangwili and Prince Phillip Hospital

Qualitative and quantitative data collected over the weekend was compared to weekends in October, November and December 2024. The comparison data was agreed against core 'Front Door' performance metrics regularly assessed in Urgent Emergency Care. Also output data was collected with regard to Clinical Streaming Hub and SDEC activity, patient story, and cost benefit analysis data. A total of 226 patients were seen outside of A&E, either through Clinical Streaming, SDEC or Cardigan SDUC services. Estimated ED/MIU, and hospital cost avoidance data was calculated and compared to the additional staffing costs for the weekend and indicated significant benefit for the Health Board. Discussion focussed on the benefits and challenges of 7-day Clinical Streaming services. It was concluded that Clinical Streaming is most effective when there are a number of services such as SDECs, Hot Clinics, Therapy Teams, with which to refer in to and that a 24/7 model would be most effective for impact on ED and wider system. Workforce and strategic implications discussed.

Summary

It must be taken in to account the evaluation is based on a snapshot, one weekend in a year where external variables would have evidently played a role in the results e.g. increased ED demand, staff sickness. Also, assumptions were made around the data that may have underestimated or over-estimated the cost/value calculation e.g. average length of stay for someone admitted being based on Health Board average rather than targeted to the likely CSH cohort (elderly/frail). Or the assumption that all those that were seen and remained at home were due to CSH intervention when it may have been the case that Out of Hours services would have prevented an admission in some cases in the absence of the additional CSH resource. Further in-depth research, on a case-by-case basis, over a longer period of time, could mitigate against these issues and is recommended going forward.

However, even given the degree of error that could be possible the clinical view is that there would be significant benefits for the Health Board in having Enhanced Clinical Streaming services running over the weekend, particularly in terms of patient flow, patient experience and cost avoidance. If the 226 patients supported, presented through the traditional route that weekend, this would likely have resulted in major escalation on all sites. Additionally, the cost/benefit analysis found a total cost avoidance of £181,812 with an investment of only £24,831, which it is felt that even given the assumptions and estimates inherent in the calculations would indicate clear benefit for the Health Board.

Furthermore, other areas which have adopted co-ordinated 7-day services have shown clear benefits for example the Buckinghamshire, Oxford and Berkshire West Integrated Care System Hospital@Home service, outcomes included significant reductions in whole system healthcare utilisation with a 68% reduction in calls to 111, a 66% reduction in ambulance incidents and 60% reduction in conveyance, a 75% reduction in type 1 ED attendances and a 73% reduction in emergency admissions (equivalent to 46,685 bed days across the system during the time period evaluated), 60% of H@H admissions were to facilitate admission avoidance, with an average Clinical Frailty Score of 6 identifying appropriate inclusion of a complex and frail population. Patients and staff reported positive experiences which were achieved through an intentional co-ordination and communication of care, equivalent outcomes could be achieved through the integration of the CSH services locally with SDEC and 111 in West Wales across the 7/7.

The main challenges in running such services over weekends are in the cost and in staffing it on a regular basis. At a time when the Health Board is challenged in making savings the cost estimate for replicating this workforce on an annual basis for weekends would be £291,144 (please note this includes weekend overtime/enhancements for existing staff, it would likely be cheaper if substantive posts were employed to cover on a full-time basis). This estimate is based on overtime/weekend rates as all the positions running over the weekend were run by current staff undertaking overtime shifts. Running this service every weekend would not be sustainable, as staff would soon burn out and/or would be unwilling to cover, unless the Health Board were able to recruit substantially to the additional posts required.

Staff competencies, relationships, and experience was also discussed as being key to the success of this and future Clinical Streaming at weekends. All staff involved in streaming services needed to be aware of wider weekend services to refer on accordingly and be positive in discussing and agreeing patient journeys accordingly. The WGH SDEC was an example of this, where positive and established relationships were apparent between the two units and possibly led to an effective 'push and pull' model being run and possibly led to it being the busiest SDEC over the weekend. Also, the experience and competency of staffing was key – particularly when it came to Clinical Streaming Hub activity. Having Nursing and Medical members of staff being confident in knowing the community services on offer, utilising virtual wards, and being able to take positive risks for the patient was key for ED and Hospital avoidance.

Key Recommendations

1. Implement a 7-Day Clinical Streaming Model

Expand Clinical Streaming Hubs (CSH) and Same Day Emergency Care (SDEC) services to operate consistently across weekends.

A 24/7 model would maximise impact on Emergency Department (ED) flow and hospital avoidance.

2. Ensure Local Response Capability

78% of triaged patients required a local, physical response.

Each locality must have the capacity to respond (e.g., ACPs, GPOOHs, District Nurses) to support effective streaming.

3. Strengthen Integration Across Services

Clinical Streaming is most effective when integrated with:

- SDECs
- Hot Clinics
- Therapy Teams
- Intermediate Care
- Virtual Wards

Services must work as a coordinated system to enable rapid discharge and admission avoidance.

4. Develop Regional Triage Confidence

Encourage cross-county triage by building trust and familiarity among clinicians across hubs.

Promote regional triage to improve equity and efficiency.

5. Invest in Workforce Sustainability

Current weekend services rely on overtime, which is not sustainable.

Estimated annual cost for weekend coverage: £291,144.

Recommendation: Recruit substantive staff to cover weekend shifts and reduce reliance on overtime.

6. Enhance Staff Competency and Relationships

Staff must be knowledgeable about available services and confident in using them.

Positive inter-team relationships (e.g., between ED and SDEC) enhance patient flow and outcomes.

Training and experience in community-based care and virtual ward management are essential.

7. Leverage Digital and Virtual Tools

Expand use of virtual wards and digital monitoring to support home-based care.

Ensure digital infrastructure supports real-time coordination and decision-making.

8. Conduct Further Evaluation

Acknowledge limitations of a single-weekend snapshot.

Recommend longitudinal evaluation to validate findings and refine cost-benefit assumptions.

Questions to be further explored could include regional vs. local elements to the model, implementation of a phased approach, the role of therapies at weekends, and could other services be on-call?

Further information is available on request.



Appendix 2 - Polypharmacy Reviews

Pharmacy & Medicines Management

Polypharmacy Reviews

SCRAMS Model

One clinical pharmacist currently provides clinical pharmacy support to the MDT for SCRAMS. Attendance at Friday MDT clinics and referrals for medication reviews for patients identified through the service.

Pharmacist carries out full medication reviews (virtually or face to face) and identifies clinical interventions to improve patient care. As an independent prescriber, the pharmacist is able to action prescribing changes directly into the patient's GP record.

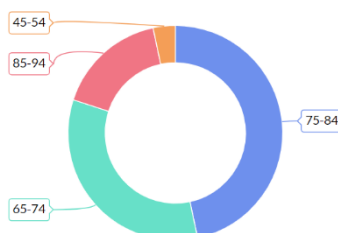
The data below captures the work completed in September and October:

NUMBER OF PATIENTS 31	NUMBER OF INTERVENTIONS 98	INTERVENTIONS PER PATIENT 3.2
ADVERSE EVENTS PREVENTED 2.8	DRUG SAVINGS PER PATIENT £101	DRUG SAVINGS PER INTERVENTION £32
ADVERSE EVENT SAVINGS £9,855	OVERALL SAVINGS PER PATIENT £419	OVERALL SAVINGS PER INTERVENTION £132
IN YEAR DRUG SAVINGS £1,697		12 MONTH DRUG SAVINGS £3,121
OVERALL IN YEAR SAVINGS £11,551		OVERALL 12 MONTH SAVINGS £12,976

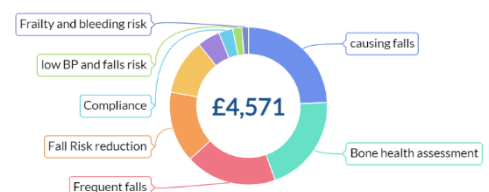
Drug savings is calculated based on the impact of any medication changes. This can include stopping medication where the risks outweigh the benefit, amending doses, changing medication to more suitable options or even initiating medication where clinically appropriate.

The adverse event savings is calculated from the potential clinical impact (and system costs) of stopping a medication or any other intervention started. This is evidence-based (e.g. STOPP-START) where there is known number needed to harm or hospital admission impact associated with a particular medication.

NUMBER OF PATIENTS REVIEWED BY AGE BAND



TOP 20 REASONS FOR THE INTERVENTION MADE BY OVERALL 12 MONTHS SAVINGS





Ty Pili Pala Model

A clinical pharmacist within the medicines optimisation pharmacy team attends the HB-commissioned patient beds within Ty Pili Pala to provide a pharmacist-led medication review for all patients. As an independent prescribing pharmacist, medication changes are actioned directly and communicated with the patient's GP surgery in readiness for their discharge from the care home.

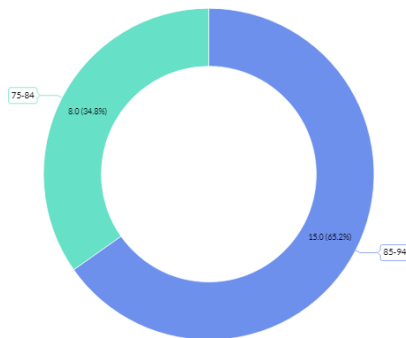
Data below captures the work completed year to-date:

NUMBER OF PATIENTS 26	NUMBER OF INTERVENTIONS 35	INTERVENTIONS PER PATIENT 1.3
ADVERSE EVENTS PREVENTED 0.4	DRUG SAVINGS PER PATIENT £196	DRUG SAVINGS PER INTERVENTION £146
ADVERSE EVENT SAVINGS £1,387	OVERALL SAVINGS PER PATIENT £249	OVERALL SAVINGS PER INTERVENTION £185
IN YEAR DRUG SAVINGS £3,182		12 MONTH DRUG SAVINGS £5,098
OVERALL IN YEAR SAVINGS £4,569		OVERALL 12 MONTH SAVINGS £6,485

The main themes in the interventions have been falls risk prevention, anticholinergic burden, ongoing pain management (following hip fractures, pelvic fractures) and a few drugs stopped following STOPP criteria (prescriptions deemed potentially inappropriate in older people).

Demographics:

NUMBER OF PATIENTS REVIEWED BY AGE BAND



Future Pharmacy Model

- Expansion of pharmacy support into the Integrated Care MDT within Carmarthenshire to provide polypharmacy reviews for patients identified through the current triage system.
- Provide integrated model of working between primary care and secondary care pharmacy sites to identify patients that would value a full medication review to optimise their treatment and reduce the risk of future hospital admissions.



Appendix 3 – Cost of 7-day Clinical Streaming Services

Pay

Service	Band/Grade	Establishment (WTE)	Estimated Cost (£)
CSH - Weekend	Band 2	2.24	£82,467.57
	Band 3	5.44	£284,339.96
	Band 6	2.92	£256,747.43
	Band 7	0.74	£76,342.16
	Band 8A	8.57	£839,781.92
	Non Pay	0.00	£32,400.00
CSH - Weekend Total		19.91	£1,572,079.04
Pharmacists	Band 8A	3.80	£309,798.67
Pharmacists Total		3.80	£309,798.67
Grand Total		23.71	£1,881,877.71

Staffing Model/Hours by Post

Service	Band/Gr	Role	Monday		Tuesday		Wednesday		Thursday		Friday		Saturday		Sunday		Total Headcount	Total Hours	Total Calculated WTE	
			Headcount	Hours	Calculated WTE	Headcount	Hours	Calculated WTE	Headcount	Hours	Calculated WTE	Headcount	Hours	Calculated WTE	Headcount	Hours				Calculated WTE
CSH - Weekend	Band 2	Falls Response	1.00	9.50	0.32	1.00	9.50	0.32	1.00	9.50	0.32	1.00	9.50	0.32	1.00	9.50	0.32	7.00	66.50	2.24
	Band 3	Support Worker	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	7.00	80.50	2.72	7.00	80.50	2.72
	Band 6	Digital Ward	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	3.00	43.13	1.46	3.00	43.13	1.46
	Band 7	Therapist	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	1.00	11.00	0.37	1.00	11.00	0.37
	Band 8A	ACP	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	6.00	86.25	2.92	6.00	86.25	2.92
		ACP - APP cover for W.	1.00	11.50	0.39	1.00	11.50	0.39	1.00	11.50	0.39	1.00	11.50	0.39	1.00	11.50	0.39	1.00	11.50	0.39
CSH - Weekend Total			2.00	21.00	0.71	2.00	21.00	0.71	2.00	21.00	0.71	2.00	21.00	0.71	19.00	241.88	8.18	19.00	241.88	8.18
Pharmacists	Band 8A	Pharmacist	3.00	22.50	0.76	3.00	22.50	0.76	3.00	22.50	0.76	3.00	22.50	0.76	0.00	0.00	0.00	0.00	0.00	0.00
Pharmacists Total			3.00	22.50	0.76	3.00	22.50	0.76	3.00	22.50	0.76	3.00	22.50	0.76	0.00	0.00	0.00	0.00	0.00	0.00
Grand Total			5.00	43.50	1.47	5.00	43.50	1.47	5.00	43.50	1.47	5.00	43.50	1.47	19.00	241.88	8.18	63.00	701.25	23.71

The costs presented above are based on staffing costs alone (excludes non-pay, capital, etc.) but are estimated based on top of band for all positions and includes a 26.6% for Annual leave, training etc. Additionally, ACP Supporting Professional Activity (SPA) time, 2 sessions SPA and 8 sessions Direct Clinical costs, has been factored into all ACP posts above the 26.9% uplift.

The weekend model extends the streaming service across the 7-days. Please note that agenda for change staff incur enhancements for unsocial working at weekends (minimum of 30% Saturday and 60% Sunday) which accounts for disproportionate costs which go towards the seven-day calculations.

Non-Pay



Service	Description	£
CSH - Weekend	Delta Rapid Response	32,400.00



Appendix 4 – Costs of 7-Day SDEC services

SDEC Optimal 7-day Model Costs

Service	Band/ Grade	Establishment (WTE)	Estimated Cost (£)
SDEC BGH - 7-Day inc. Cleaning	Band 2	0.70	£25,724.24
	Band 3	2.73	£107,280.60
	Band 7	2.73	£219,111.53
	Band 8A	4.06	£373,523.15
	GP	2.24	£343,767.19
SDEC BGH - 7-Day inc. Cleaning Total		12.46	£1,069,406.71
SDEC GGH - 7-Day SP Roster 3 inc. Cleaning	Band 2	1.45	£48,320.95
	Band 3	5.46	£216,634.30
	Band 5	4.68	£260,573.93
	Band 6	2.73	£187,773.30
	Band 7	1.00	£71,097.30
	Band 8A	10.78	£993,199.70
	Consultant	9.80	£2,033,236.32
SDEC GGH - 7-Day SP Roster 3 inc. Cleaning Total		35.90	£3,810,835.80
SDEC WGH - 7-Day inc. Cleaning	Band 2	2.79	£105,364.47
	Band 3	5.18	£203,327.30
	Band 5	2.59	£142,834.11
	Band 6	2.59	£176,552.43
	Band 7	1.25	£88,309.13
	Band 8A	10.78	£993,199.70
	Consultant	2.94	£609,970.90
	GP	6.86	£1,054,427.65
SDEC WGH - 7-Day inc. Cleaning Total		34.98	£3,373,985.69
Grand Total		83.34	£8,254,228.21

Service	Band/Gr/ Role	Monday			Tuesday			Wednesday			Thursday			Friday			Saturday			Sunday			Total Headcount	Total Hours	Total Calculated WTE						
		Headcount	Hours	Calculated WTE	Headcount	Hours	Calculated WTE	Headcount	Hours	Calculated WTE	Headcount	Hours	Calculated WTE	Headcount	Hours	Calculated WTE	Headcount	Hours	Calculated WTE	Headcount	Hours	Calculated WTE									
SDEC BGH - 7-Day inc. Cleaning	Band 2 Cleaning	1.00	3.00	0.10	1.00	3.00	0.10	1.00	3.00	0.10	1.00	3.00	0.10	1.00	3.00	0.10	1.00	3.00	0.10	1.00	3.00	0.10	1.00	3.00	0.10	7.00	21.00	0.70			
	Band 3 Support Worker	1.00	11.50	0.39	1.00	11.50	0.39	1.00	11.50	0.39	1.00	11.50	0.39	1.00	11.50	0.39	1.00	11.50	0.39	1.00	11.50	0.39	1.00	11.50	0.39	7.00	80.50	2.73			
	Band 7 Senior Nurse	1.00	11.50	0.39	1.00	11.50	0.39	1.00	11.50	0.39	1.00	11.50	0.39	1.00	11.50	0.39	1.00	11.50	0.39	1.00	11.50	0.39	1.00	11.50	0.39	7.00	80.50	2.73			
	Band 8A ACP	1.20	17.25	0.58	1.20	17.25	0.58	1.20	17.25	0.58	1.20	17.25	0.58	1.20	17.25	0.58	1.20	17.25	0.58	1.20	17.25	0.58	1.20	17.25	0.58	8.40	120.75	4.06			
	GP Medical Oversight	1.00	9.38	0.32	1.00	9.38	0.32	1.00	9.38	0.32	1.00	9.38	0.32	1.00	9.38	0.32	1.00	9.38	0.32	1.00	9.38	0.32	1.00	9.38	0.32	7.00	65.63	2.24			
SDEC BGH - 7-Day inc. Cleaning Total		5.20	52.63	1.78	5.20	52.63	1.78	5.20	52.63	1.78	5.20	52.63	1.78	5.20	52.63	1.78	5.20	52.63	1.78	5.20	52.63	1.78	5.20	52.63	1.78	35.40	368.38	12.46			
SDEC GGH - 7-Day SP Roster 3 inc. Cleaning	Band 2 Cleaning	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00			
	Clerk	1.00	7.50	0.25	1.00	7.50	0.25	1.00	7.50	0.25	1.00	7.50	0.25	1.00	7.50	0.25	1.00	7.50	0.25	1.00	7.50	0.25	1.00	7.50	0.25	1.00	7.50	0.25			
	Band 3 HCSW	2.00	23.00	0.78	2.00	23.00	0.78	2.00	23.00	0.78	2.00	23.00	0.78	2.00	23.00	0.78	2.00	23.00	0.78	2.00	23.00	0.78	2.00	23.00	0.78	2.00	23.00	0.78	14.00	161.00	5.46
	Band 5 Nursing	2.00	23.00	0.78	2.00	23.00	0.78	2.00	23.00	0.78	2.00	23.00	0.78	2.00	23.00	0.78	2.00	23.00	0.78	2.00	23.00	0.78	2.00	23.00	0.78	2.00	23.00	0.78	12.00	138.00	4.68
	Band 6 Advanced Nursing	1.00	11.50	0.39	1.00	11.50	0.39	1.00	11.50	0.39	1.00	11.50	0.39	1.00	11.50	0.39	1.00	11.50	0.39	1.00	11.50	0.39	1.00	11.50	0.39	1.00	11.50	0.39	7.00	80.50	2.73
	Band 7 Supervisor	1.00	7.50	0.20	1.00	7.50	0.20	1.00	7.50	0.20	1.00	7.50	0.20	1.00	7.50	0.20	1.00	7.50	0.20	1.00	7.50	0.20	1.00	7.50	0.20	1.00	7.50	0.20	5.00	37.50	1.00
	Band 8A ACP	3.30	45.38	1.54	3.30	45.38	1.54	3.30	45.38	1.54	3.30	45.38	1.54	3.30	45.38	1.54	3.30	45.38	1.54	3.30	45.38	1.54	3.30	45.38	1.54	3.30	45.38	1.54	23.10	317.63	10.78
	Consultant Consultant Oversight	0.90	12.38	0.42	0.90	12.38	0.42	0.90	12.38	0.42	0.90	12.38	0.42	0.90	12.38	0.42	0.90	12.38	0.42	0.90	12.38	0.42	0.90	12.38	0.42	0.90	12.38	0.42	6.30	86.63	2.94
GP Consultant/Freelily	2.10	28.88	0.98	2.10	28.88	0.98	2.10	28.88	0.98	2.10	28.88	0.98	2.10	28.88	0.98	2.10	28.88	0.98	2.10	28.88	0.98	2.10	28.88	0.98	2.10	28.88	0.98	14.70	202.13	6.86	
SDEC GGH - 7-Day SP Roster 3 inc. Cleaning Total		13.30	158.13	5.34	13.30	158.13	5.34	13.30	158.13	5.34	13.30	158.13	5.34	13.30	158.13	5.34	13.30	158.13	5.34	13.30	158.13	5.34	13.30	158.13	5.34	13.30	158.13	5.34	88.10	1,066.88	35.90
SDEC WGH - 7-Day inc. Cleaning	Band 2 Admin & Clerical	1.00	11.00	0.37	1.00	11.00	0.37	1.00	11.00	0.37	1.00	11.00	0.37	1.00	11.00	0.37	1.00	11.00	0.37	1.00	11.00	0.37	1.00	11.00	0.37	1.00	11.00	0.37	7.00	77.00	2.59
	Cleaning	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	
	Band 3 Support Worker	2.00	22.00	0.74	2.00	22.00	0.74	2.00	22.00	0.74	2.00	22.00	0.74	2.00	22.00	0.74	2.00	22.00	0.74	2.00	22.00	0.74	2.00	22.00	0.74	2.00	22.00	0.74	14.00	154.00	5.18
	Band 5 Nursing	1.00	11.00	0.37	1.00	11.00	0.37	1.00	11.00	0.37	1.00	11.00	0.37	1.00	11.00	0.37	1.00	11.00	0.37	1.00	11.00	0.37	1.00	11.00	0.37	1.00	11.00	0.37	7.00	77.00	2.59
	Band 6 Advanced Nursing	1.00	11.00	0.37	1.00	11.00	0.37	1.00	11.00	0.37	1.00	11.00	0.37	1.00	11.00	0.37	1.00	11.00	0.37	1.00	11.00	0.37	1.00	11.00	0.37	1.00	11.00	0.37	7.00	77.00	2.59
	Band 7 Senior Nurse	1.00	7.50	0.25	1.00	7.50	0.25	1.00	7.50	0.25	1.00	7.50	0.25	1.00	7.50	0.25	1.00	7.50	0.25	1.00	7.50	0.25	1.00	7.50	0.25	1.00	7.50	0.25	5.00	37.50	1.25
	Band 8A ACP	3.30	45.38	1.54	3.30	45.38	1.54	3.30	45.38	1.54	3.30	45.38	1.54	3.30	45.38	1.54	3.30	45.38	1.54	3.30	45.38	1.54	3.30	45.38	1.54	3.30	45.38	1.54	23.10	317.63	10.78
	Consultant Consultant Oversight	0.90	12.38	0.42	0.90	12.38	0.42	0.90	12.38	0.42	0.90	12.38	0.42	0.90	12.38	0.42	0.90	12.38	0.42	0.90	12.38	0.42	0.90	12.38	0.42	0.90	12.38	0.42	6.30	86.63	2.94
GP Medical Oversight	2.10	28.88	0.98	2.10	28.88	0.98	2.10	28.88	0.98	2.10	28.88	0.98	2.10	28.88	0.98	2.10	28.88	0.98	2.10	28.88	0.98	2.10	28.88	0.98	2.10	28.88	0.98	14.70	202.13	6.86	
SDEC WGH - 7-Day inc. Cleaning Total		12.30	148.13	5.04	12.30	148.13	5.04	12.30	148.13	5.04	12.30	148.13	5.04	12.30	148.13	5.04	12.30	148.13	5.04	12.30	148.13	5.04	12.30	148.13	5.04	12.30	148.13	5.04	86.10	1,034.88	34.98
Grand Total		30.80	368.88	12.16	30.80	368.88	12.16	30.80	368.88	12.16	30.80	368.88	12.16	30.80	368.88	12.16	30.80	368.88	12.16	30.80	368.88	12.16	30.80	368.88	12.16	30.80	368.88	12.16	211.60	2,470.13	83.34

SDEC Current Costs



Cost Centre	Annual Budget 2025/26 £	Forecast Spend 2025/26 £	Forecast Variance 2025/26 £	Include in Business Case Y/N	Annual Budget 2025/26 £	Forecast Spend 2025/26 £	Forecast Variance 2025/26 £
0429 - Cardigan Integrated Care Centre - Minor Injury Unit	1,511,741.69	1,517,755.77	6,014.08				
1769 - SDEC GGH	993,486.81	965,887.46	(27,599.35)	Y	993,486.81	965,887.46	(27,599.35)
1770 - SDEC PPH	535,632.15	516,746.69	(18,885.46)				
1790 - Frailty Support (6-Goals)	224,789.91	205,786.62	(19,003.29)				
1815 - SDEC WGH	941,708.55	1,037,422.98	95,714.43	Y	941,708.55	1,037,422.98	95,714.43
1816 - UEC programme management team	244,850.14	241,504.16	(3,345.98)				
8813 - URGENT AND EMERGENCY CARE MED MGMT	46,568.05	37,408.75	(9,159.30)				
	4,498,777.30	4,522,512.43	23,735.13		1,935,195.36	2,003,310.44	68,115.08



Appendix 5 – Enhanced Weekend Pilot, Cost/Benefit Estimates

Enhanced Weekend Pilot Findings:

	Total Prevented Hospital Admission	Total Hospital conveyance/ED admission
Carmarthenshire - Non-Located	8	11
Ceredigion - Integrated	6	9
Pembrokeshire - Co-located	5	14

Cost Avoidance Estimate:

Type of avoidance	No of Patients	Average Patient LoS	Attendance cost	Cost Avoidance Per weekend	Annual Cost Avoidance	Bed Saving
Hospital Admission	19	5.75	527	57,575	2,993,887	16
ED attendance	34		306	10,404	541,008	
Pharmacy					619,423	
Total					4,154,318	



Appendix 6 – Finance/Value Additional Information

Clinical Streaming Hub Cost Avoidance Calculations:

In-patient data is based on:

- Based on weekend patient data - 3 years (Oct 2022-Sept 2025)
- Patients +75years old
- Admittance through A&E
- General Medicine in-patients only
- Acute Bed LoS only

General Medicine in-patient stays weekend admissions (3 yr period)	No of Patients	Length of Admission	Av LOS	Av No. of Patients per day	Beds Equivalent
Bronglais General Hospital	342	5,776	16.89	1.10	5.27
Saturday	158	2,315	14.65	1.01	2.11
Sunday	184	3,461	18.81	1.18	3.16
Glangwili General Hospital	419	7,160	17.09	1.34	6.54
Saturday	202	3,955	19.58	1.29	3.61
Sunday	217	3,205	14.77	1.39	2.93
Prince Philip Hospital	19	110	5.79	0.06	0.10
Saturday	11	83	7.55	0.07	0.08
Sunday	8	27	3.38	0.05	0.02
Withybush General Hospital	485	6,091	12.56	1.55	5.56
Saturday	242	3,051	12.61	1.55	2.79
Sunday	243	3,040	12.51	1.56	2.78
Grand Total	1,265	19,137	15.13	4.05	17.48

A&E attendance data is based on:

- Based on weekend patient data - 3 years (Oct 2022-Sept 2025)
- LoS - zero
- Patients +75years
- Admitted by ambulance
- No trauma or medical patients

Attendances to A&E with zero day LOS (3yrs Period)	No of Patients			Av No. of Patients per day		
	Saturday	Sunday	Total	Saturday	Sunday	Total
Bronglais General Hospital	192	146	338	0.62	0.47	1.08
Glangwili General Hospital	474	409	883	1.52	1.31	2.83
Prince Philip Hospital	21	9	30	0.07	0.03	0.10
Withybush General Hospital	490	483	973	1.57	1.55	3.12
Grand Total	1,177	1,047	2,224	3.77	3.36	7.13



Type of avoidance	Patients	Average Patient LoS	Attendance cost	Cost Avoidance Per weekend	Annual Cost Avoidance	Bed days saved
Hospital Admission	8	15.13	527	63,788	3,316,980	17
ED attendance	7		306	2,182	113,453	
Pharmacy					619,423	
Total					4,049,856	

Analysis of A&E:

All A&E figures are based on A&E attendances between 1 Oct 2024 and 31st Oct 2025.

1. A heatmap of A&E attendances is shown below by day of the week.

Points of interest

- Monday has the largest percentage of patients in all sites.
- The percentage of Medicine patients decreases on the weekend.
- The percentage of A&E and Surgery &
- Other is relevantly even.

Row Labels	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
A&E	15.93%	14.54%	14.02%	14.15%	13.98%	13.25%	14.12%
Bronglais General Hospital	15.63%	14.45%	14.29%	14.20%	14.08%	13.34%	14.01%
Glangwili General Hospital	16.03%	14.55%	13.67%	14.29%	13.94%	13.32%	14.19%
Withybush General Hospital	16.03%	14.60%	14.24%	13.95%	13.96%	13.11%	14.12%
Medicine	16.56%	15.46%	15.27%	16.01%	15.72%	10.33%	10.65%
Bronglais General Hospital	16.10%	14.50%	14.62%	16.49%	15.37%	11.45%	11.48%
Glangwili General Hospital	16.62%	15.09%	15.21%	15.99%	15.37%	10.55%	11.16%
Withybush General Hospital	16.71%	16.28%	15.62%	15.81%	16.23%	9.59%	9.75%
Surgery & Other	15.19%	14.43%	14.43%	14.22%	13.99%	13.64%	14.10%
Bronglais General Hospital	13.77%	14.60%	13.91%	14.02%	13.48%	14.75%	15.47%
Glangwili General Hospital	15.71%	14.10%	14.37%	13.98%	14.19%	13.67%	13.98%
Withybush General Hospital	14.88%	15.30%	15.09%	15.19%	13.88%	12.47%	13.19%
Grand Total	15.94%	14.66%	14.24%	14.42%	14.23%	12.89%	13.63%

2. A heatmap of A&E attendances between 8am-8pm (potential SDEC hours) is shown below by day of the week.

Points of interest

- The Monday percentage increases of patients in all sites.
- The percentage of Medicine patients decreases even more on the weekend.
- The percentage of A&E and Surgery & Other remains relevantly even.



Row Labels	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
A&E	16.3%	14.9%	13.9%	14.3%	13.9%	12.9%	13.7%
Bronglais General Hospital	15.8%	14.8%	14.2%	14.4%	14.0%	13.1%	13.7%
Glangwili General Hospital	16.6%	14.9%	13.4%	14.5%	14.0%	12.9%	13.8%
Withybush General Hospital	16.4%	14.9%	14.3%	14.2%	13.8%	12.7%	13.7%
Medicine	16.7%	16.0%	15.5%	16.0%	15.8%	9.9%	10.1%
Bronglais General Hospital	17.0%	15.5%	14.5%	16.2%	15.2%	11.2%	10.5%
Glangwili General Hospital	16.8%	15.2%	15.8%	16.3%	15.6%	9.8%	10.6%
Withybush General Hospital	16.4%	17.0%	15.6%	15.8%	16.4%	9.4%	9.5%
Surgery & Other	15.6%	14.6%	14.7%	14.5%	13.8%	13.1%	13.7%
Bronglais General Hospital	13.6%	14.7%	14.3%	14.9%	13.6%	14.2%	14.8%
Glangwili General Hospital	16.3%	14.1%	14.5%	14.0%	14.2%	13.1%	13.8%
Withybush General Hospital	15.4%	15.9%	15.6%	15.7%	13.1%	11.9%	12.4%
Grand Total	16.3%	15.1%	14.3%	14.7%	14.3%	12.4%	13.1%

3. Time of day heatmap patient – A&E patients only

- For A&E patients only – no inpatient stay the activity is relatively flat across the week apart from Monday

Count of CRN Column La	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
00	254	215	225	243	204	227	298
01	174	155	154	184	170	198	253
02	166	150	167	148	160	176	209
03	132	143	157	139	141	176	174
04	108	120	118	121	124	150	172
05	138	106	115	105	112	134	161
06	130	121	142	127	136	165	164
07	355	263	267	277	286	256	299
08	827	694	651	663	677	589	610
09	1082	989	942	992	856	828	895
10	1219	1036	988	982	1008	925	990
11	1222	1077	1039	1006	1033	947	1112
12	1172	1084	936	997	986	932	1054
13	1068	999	835	931	906	903	984
14	1014	952	948	870	935	847	924
15	976	920	841	922	889	802	774
16	982	914	921	939	921	831	810
17	1043	911	881	928	840	779	772
18	884	865	800	782	743	646	749
19	738	718	645	736	661	624	613
20	590	582	584	535	595	515	578
21	542	488	564	486	486	517	498
22	448	406	468	414	441	442	397
23	296	299	310	293	346	336	302
Grand Total	15560	14207	13698	13820	13656	12945	13792

4. Time of day heatmap patient – Medicine patients only

- For Medicine patients only – inpatient stays, the activity is relatively flat across the weekdays however there is a 33% drop in Medicine patients on the weekend



Row Label	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
00	43	44	46	50	53	32	40
01	45	36	45	47	43	35	40
02	51	48	53	45	39	46	32
03	39	58	63	48	50	45	41
04	45	55	42	58	53	38	33
05	43	36	51	46	51	30	33
06	45	47	50	46	40	37	30
07	64	64	53	36	52	37	33
08	115	128	109	116	119	86	59
09	187	166	191	185	158	113	90
10	243	212	208	184	206	122	107
11	230	250	194	208	177	116	147
12	207	193	183	197	210	120	131
13	208	162	178	210	175	118	147
14	175	156	188	167	179	110	115
15	167	188	164	181	201	117	117
16	202	174	175	218	208	98	113
17	200	216	181	212	212	115	97
18	195	148	148	186	165	81	104
19	152	108	108	126	121	73	81
20	118	123	107	126	116	109	115
21	109	103	113	122	131	105	117
22	99	71	89	71	73	67	85
23	65	58	70	60	59	50	53
Grand Total	3047	2844	2809	2945	2891	1900	1960

5. SDEC current pull from A&E

- The pull into SDEC is taking patients that have come into A&E at all hours of the day, but the majority of the pull is between 7am and 1pm.

Count of CRP	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
00	2	4	5	3	2		
01	1	5	1	6	4		
02	4	9		4			1
03	5	5	10	5	5	1	
04	5	8	7	3	8	1	1
05	11	8	9	6	12		
06	11	12	15	10	12		1
07	29	24	19	10	21	1	1
08	49	44	32	32	41	4	1
09	74	74	69	57	51	1	
10	90	59	57	62	65	2	4
11	72	48	39	41	43	1	2
12	43	27	33	38	34	3	4
13	28	14	29	31	10		6
14	8	14	16	12	14	2	4
15	5	6	8	13	5		3
16	12	1	4	3	4	1	3
17	9	6	7	11	1		4
18	13	5	7	6	4		6
19	7	4	4	6			6
20	8	7	6	4	1	1	4
21	11		4	4			6
22	8	7	3	3			4
23	5	4	7	2		1	4
Grand Total	510	395	391	372	337	19	65

6. Average LOS of weekend patients

- Patients admitted on the weekend have greater LOS than weekdays



Site	Average LOS weekend increase
WGH	15%
BGH	6%
GGH	6%

- On weekdays, the lower LOS correlate to the times that SDEC pulls from A&E the most 6:00- 12:00.
- On weekdays the highest LOS correlate to SDEC closing 20:00-22:00

Time	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
00	5.98	10.30	11.36	7.78	12.67	9.55	4.98
01	7.18	4.97	7.98	10.91	6.76	6.40	4.60
02	5.25	4.73	14.02	8.49	11.92	11.15	12.94
03	8.46	8.66	8.26	7.98	5.78	16.05	10.79
04	7.11	5.78	8.43	10.88	9.21	6.05	5.24
05	5.44	8.30	7.23	12.11	6.13	12.07	6.09
06	7.70	8.58	5.64	3.09	8.36	13.39	5.86
07	3.85	2.37	3.33	7.94	3.08	6.18	6.03
08	3.98	5.58	4.17	4.01	4.65	4.71	12.50
09	6.69	4.25	4.54	5.60	5.61	9.12	8.70
10	3.83	6.36	5.47	4.41	4.97	6.28	8.72
11	6.26	5.20	5.78	6.73	7.08	8.68	4.94
12	6.55	7.11	7.65	8.82	6.48	6.13	7.90
13	6.97	7.83	6.28	6.54	10.11	5.63	4.89
14	10.24	8.13	9.04	8.85	9.40	5.28	12.12
15	6.78	8.50	8.48	10.21	9.29	9.40	7.71
16	7.22	8.64	6.63	8.23	6.94	7.72	9.66
17	6.54	7.80	7.88	9.23	6.59	9.79	10.53
18	5.81	6.46	6.64	5.20	4.38	5.76	7.10
19	7.21	5.60	8.16	4.58	7.42	5.95	6.26
20	8.50	8.77	6.34	10.50	10.35	8.23	8.32
21	8.59	12.48	9.66	10.52	14.16	9.03	11.88
22	8.59	8.83	10.67	8.20	9.65	11.02	5.93
23	7.22	11.78	5.32	13.22	8.41	11.08	4.27
Average	6.70	7.23	7.15	7.72	7.66	8.05	7.98

Conclusions

- The A&E intake trends are uniform over the three sites, so what is applicable in one is likely to be applicable to all.
- The intake of LOS zero patients coming into A&E is of the same magnitude over weekdays as the weekends, however the Medical cover for A&E is substantially less.
- The intake of Medical patients significantly drops over the weekend by 33% therefore there are less Medical patients to treat.
- The SDEC pull from A&E tends to be between 8am-1pm.
- Weekend admissions have greater LOS than weekday admissions.
- General Medicine LOS decrease at the times where SDEC pulls patient from A&E the most 6:00- 12:00.

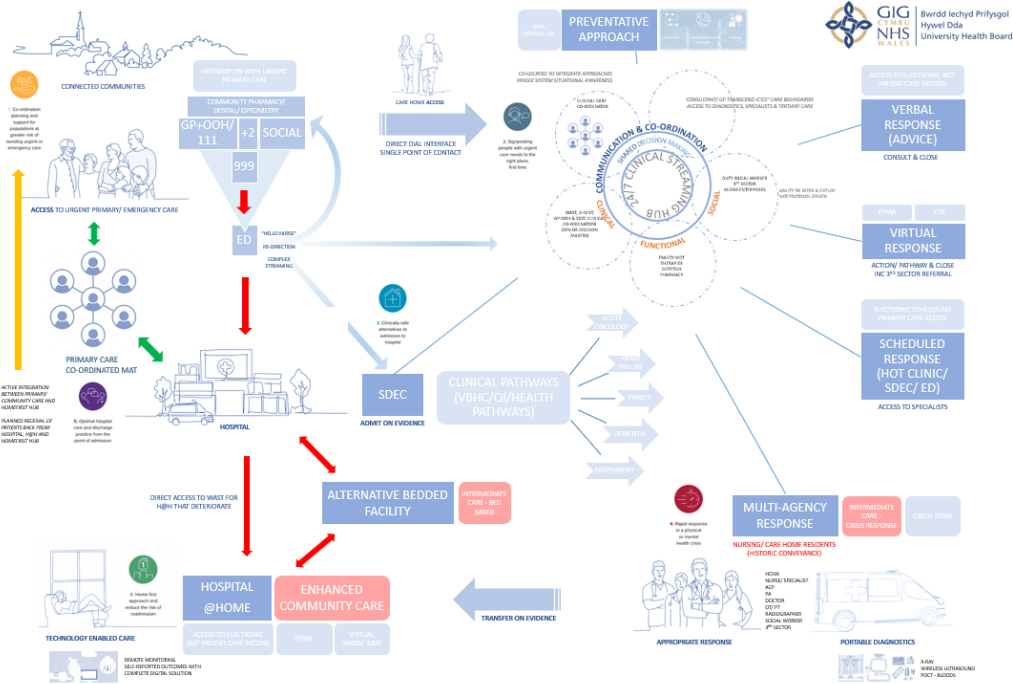


Appendix 7 – Evaluation Framework

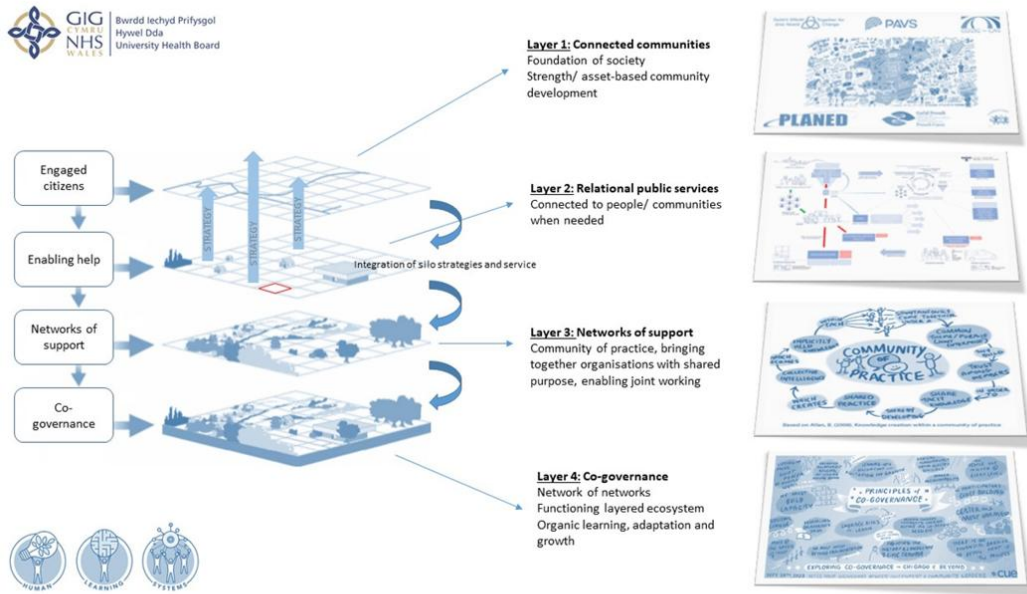
Type	Benefit type	Clinical Streaming	Source of Data	Able to track Financial Direct Effect	Able to track Financial theoretical Effect	Benefit term		
						Short	Medium	Long
Clinical Streaming	Activity	% Conversion rates of streaming hub patients	Sharepoint	No	Yes	<input checked="" type="checkbox"/>		
Clinical Streaming	Activity	% Conversion rates of streaming hub patients	Sharepoint	No	Yes	<input checked="" type="checkbox"/>		
Clinical Streaming	Activity	% zero or 1 day LoS before SDEC and after?	Sharpoint/PAS	No	Yes		<input checked="" type="checkbox"/>	
Clinical Streaming	Activity	Decrease of A&E attendances >75yrs	PAS	No	Yes		<input checked="" type="checkbox"/>	
Clinical Streaming	Activity	Decrease of Ambulance admission >75yrs	PAS	No	Yes		<input checked="" type="checkbox"/>	
Clinical Streaming	Activity	Decrease of patients awaiting packages of care >75yrs	CHC	No	Yes		<input checked="" type="checkbox"/>	
Clinical Streaming	Activity	Increase in % of ED patients seen in 4 and 12 hrs	PAS	No	Yes			<input checked="" type="checkbox"/>
Clinical Streaming	Activity	Number of H@H patients being treated	PAS	No	Yes	<input checked="" type="checkbox"/>		
SDEC	Activity	% zero LOS	PAS	No	Yes	<input checked="" type="checkbox"/>		
SDEC	Activity	% Attendance at A&E - readmission in day	PAS	No	Yes		<input checked="" type="checkbox"/>	
SDEC	Activity	Medical patient LoS	PAS	No	Yes			<input checked="" type="checkbox"/>
SDEC	Activity	Number of boarding, surge, patients in A&E, bed occupancy	PAS	Yes	Yes	<input checked="" type="checkbox"/>		
SDEC	Activity	Increase in % of ED patients seen in 4 and 12 hrs	PAS	No	Yes		<input checked="" type="checkbox"/>	
SDEC	Activity	Decrease in time wait for triage and dr wait in A&E	PAS	No	Yes	<input checked="" type="checkbox"/>		
SDEC	Activity	Decrease in re-admission into hospital	PAS	No	Yes		<input checked="" type="checkbox"/>	
SDEC	Activity	Number of emergency scans	Radiology	Yes	Yes		<input checked="" type="checkbox"/>	
SDEC	Activity	Use of emergency everlight	Radiology	Yes	Yes		<input checked="" type="checkbox"/>	
SDEC	Activity	Number of H@H patients being treated	PAS	No	Yes	<input checked="" type="checkbox"/>		
SDEC	Workforce	Site sickness	ESR	Yes	Yes		<input checked="" type="checkbox"/>	
SDEC	Workforce	Site vacancies and turnover reasons	ESR	Yes	Yes		<input checked="" type="checkbox"/>	
SDEC	Quality and Safety	Incidents in UEC settings	Our Permacance dashboard	No	No	<input checked="" type="checkbox"/>		
SDEC	Quality and Safety	Complaints in UEC settings	Our Permacance dashboard	No	No		<input checked="" type="checkbox"/>	
SDEC	Quality and Safety	Risks in UEC settings	Our Permacance dashboard	No	No			
SDEC	Quality and Safety	Deteriorating patients from A&E due to waits	Our Permacance dashboard	No	No		<input checked="" type="checkbox"/>	
SDEC	Quality and Safety	Patient harm (Risk pool)	Our Permacance dashboard					<input checked="" type="checkbox"/>



Appendix 8 - Integrated Urgent Emergency Care Model



Integrated Urgent & Emergency Care



Wellbeing Layer Cake: "A Good Life, Well lived"

Further information is available on request.



Appendix 9 – 7 Day Business Case Engagement Events and Workshops

7 Day Business Case Engagement Events and Workshops			
Date	Event/Workshop	Invited	Job Role
12/05/2025	LEC Clinical Streaming Hub and Wider UPC Vision ('Think Tank')	Marilize Preez	Hywel Dda UHB - Improvement and Transformation Lead
		Emily Warm	Hywel Dda UHB - Project Support Officer
		Sara Davies	NHS Wales General Management Graduate Trainee
		Anna Henchie	Hywel Dda UHB - Principal Programme Manager
		Bianca Oakley	Hywel Dda UHB - Clinical Lead
		David Richards	Hywel Dda UHB - Service Delivery Manager OOH/111
		Gareth Cottrell	Hywel Dda UHB - Deputy Chief Operating Officer
		Jessica Svetz	Hywel Dda UHB - General Manager Pembrokeshire System
		Karen Brown	Hywel Dda UHB - Health Board Clinical Lead for Acute Medicine
		Louise Major	Hywel Dda UHB - Project Support Manager (Interim)
		Peter Skitt	Hywel Dda UHB - Clinical Care Group Service Director - Community & Integrated Medicine
		Richard Archer	Hywel Dda Health Board - Pembrokeshire Care On Call
		Sarah Bolton	Hywel Dda UHB - Head of Primary Care Transformation
		Sarah Isaac	Hywel Dda UHB - Medicines Management Clinical Lead Transformation Programme Office
		Thomas Alexander	Hywel Dda UHB - Principal Programme Manager
		Helen Wang	Northfield Road - Meddygfa Rhiannon
		Alan Williams	Vauxhall - Ty Elli Group Practice
		Matt Phillips	Hywel Dda UHB - Finance Business Partner (Corporate Reporting)
		Sarah Perry	Hywel Dda UHB - GM Carmarthenshire System
		Louise Cullum	Hywel Dda UHB - General Manager - Ceredigion System
		Robert Odes	Hywel Dda UHB - Locum Medical Consultant
		Sarah Paoletta	Hywel Dda UHB - Senior Sister / Senior Urgent Care Practitioner
		Rhian Bond	Hywel Dda UHB - Assistant Director of Primary Care
		Andrew Lewis	Hywel Dda UHB - Senior Finance Business Partner
		Jessica Showler-Coulson	Hywel Dda UHB - Locality Development Programme Manager North Ceredigion
		Carly Skyrme	Hywel Dda UHB - advanced clinical practitioner
		Eluned Jones	Hywel Dda UHB - Advanced Clinical Practitioner
		Scott O'Rourke	Hywel Dda UHB - Consultant
		Sian Owen Lewis	Hywel Dda UHB - Clinical Lead Nurse
		William Mackintosh	Hywel Dda UHB - Clinical Lead - Primary and Community Services Academy
		Sioned Richards	Hywel Dda UHB - GP Lead Carmarthenshire Intermediate Care
		Elen Lewis	Hywel Dda UHB - Project Manager (Interim)
		Anthony Dew	Hywel Dda UHB - Clinical Lead GP Intermediate & Urgent Primary Care
		Emma Martin	Hywel Dda UHB - ACP/NMP
Erin Bonwick	Hywel Dda UHB - Clinical Lead Nurse Patient Flow		
Leon Popham	Hywel Dda UHB - Senior Finance Business Partner		
24/05/2025	CSH & APPs	Bianca Oakley	Hywel Dda UHB - Clinical Lead
		Edward Harry	Welsh Ambulance Service NHS Trust
		Louise Major	Hywel Dda UHB - Project Support Manager (Interim)
		Peter Green	Welsh Ambulance Service NHS Trust - 020 Clinical Development Lead
		Sioned Richards	Hywel Dda UHB - GP Lead Carmarthenshire Intermediate Care
		Thomas Alexander	Hywel Dda UHB - Principal Programme Manager
24/06/2025	CSH & Finance	Anthony New	Hywel Dda UHB - Clinical Lead GP Intermediate & Urgent Primary Care
		Louise Major	Hywel Dda UHB - Project Support Manager (Interim)
		Matt Phillips	Hywel Dda UHB - Finance Business Partner (Corporate Reporting)
		Sioned Richards	Hywel Dda UHB - GP Lead
		Thomas Alexander	Hywel Dda UHB - Principal Programme Manager
		Joanna Jones	Head of Integrated Community Services - Carmarthenshire County Council & Hywel Dda UHB
		Anthony Dew	Hywel Dda UHB - Clinical Lead GP Intermediate & Urgent Primary Care
		Bianca Oakley	Hywel Dda UHB - Clinical Lead
		Joanna Jones	Hywel Dda UHB - Senior Delivery Manager for System Flow & Urgent Care
		31/07/2025	Hywel Dda University Health Board, Public Board
Mrs Eleanor Marks	Vice-Chair, Hywel Dda University Health Board		
Mr Maynard Davies	Independent Member (Information Technology)		
Clr. Rhodri Evans	Independent Member (Local Authority)		
Mr Michael Imperato	Independent Member (Legal)		
Ms Anna Lewis	Independent Member (Community)		
Ms Ann Murphy	Independent Member (Trade Union)		
Mrs Chantal Patel	Independent Member (University)		
Ms Sarah Harraway	Independent Member (Community)		
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 Mandy Davies	Assistant Director of Quality Improvement and Assurance (deputising for Ms Sharon Daniel, Executive Director of Nursing, Quality and Patient Experience)		
Mr Lee Davies	Executive Director of Strategy and Planning		
Ms Bethan Lewis	Assistant Director of Public Health (deputising for 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		
Ms Alwena Hughes Moakes	Communications and Engagement Director		
Ms Jill Paterson	Director of Primary Care & Community and Long-Term Care		
Mrs Joanne Wilson	Director of Corporate Governance/Board Secretary		
Ms Donna Coleman	Llais West Wales (VC)		
Dr Jonathan Arthur	Chair, Healthcare Professionals Forum		
Ms Mwape Burke	Aspiring Board Members Programme (observing)		
Dr Karen Brown	Associate Medical Director - Community and Integrated Medicine (part)		
Ms Clare Monroff	Committee Services Officer (Minutes)		



18/09/2025 - 25/11/2025 (Every Tuesday)	Clinical Streaming Hub Business Case Touch Point	<table border="1"> <tr><td>Sarah Isaac</td><td>Hywel Dda UHB - Medicines Management Clinical Lead Transformation Programme Office</td></tr> <tr><td>Peter Skitt</td><td>Hywel Dda UHB - Clinical Care Group Service Director - Community & Integrated Medicine</td></tr> <tr><td>Thomas Alexander</td><td>Hywel Dda UHB - Principal Programme Manager</td></tr> <tr><td>Louise Major</td><td>Hywel Dda UHB - Project Support Manager (Interim)</td></tr> <tr><td>Jessica Svetz</td><td>Hywel Dda UHB - General Manager Pembrokeshire System</td></tr> <tr><td>Carly Tucker-Williams</td><td>Hywel Dda UHB - Project Manager Value Based Health Care</td></tr> <tr><td>Sarah Perry</td><td>Hywel Dda UHB - GM Carmarthenshire System</td></tr> <tr><td>Matt Phillips</td><td>Hywel Dda UHB - Finance Business Partner (Corporate Reporting)</td></tr> <tr><td>Wendy Davies</td><td>Hywel Dda UHB - Project Managers - Workforce Planning</td></tr> <tr><td>Jon Adams</td><td>Hywel Dda UHB - Deputy Head of Occupational Therapy</td></tr> <tr><td>William Mackintosh</td><td>Hywel Dda UHB - Clinical Lead - Primary and Community Services Academy</td></tr> <tr><td>Karen Brown</td><td>Hywel Dda UHB - Associate Medical Director - CIMCG</td></tr> <tr><td>Scott O'Rourke</td><td>Hywel Dda UHB - Consultant</td></tr> <tr><td>Anthony Dew</td><td>Hywel Dda UHB - Clinical Lead GP Intermediate & Urgent Primary Care</td></tr> <tr><td>Tracy Walmsley</td><td>Hywel Dda UHB - Assistant Director of People Planning</td></tr> <tr><td>Richard Jenkins</td><td>Hywel Dda UHB - Assistant Finance Director Commissioning BI & Value</td></tr> <tr><td>John Davies</td><td>Hywel Dda UHB - Head of Physiotherapy Service</td></tr> <tr><td>Sioned Richards</td><td>Hywel Dda UHB - GP Lead Carmarthenshire Intermediate Care</td></tr> <tr><td>Emily Warm</td><td>Hywel Dda UHB - Project Support Officer</td></tr> <tr><td>Sian Morgan</td><td>Hywel Dda UHB - Planning Project Manager</td></tr> <tr><td>Ellen Lewis</td><td>Hywel Dda UHB - Project Manager (interim)</td></tr> <tr><td>Jessica Showler-Coulson</td><td>Hywel Dda UHB - Head of Nursing - Ceredigion System</td></tr> <tr><td>Marilize Preez</td><td>Hywel Dda UHB - Improvement and Transformation Lead</td></tr> <tr><td>David Richards</td><td>Hywel Dda UHB - Service Delivery Manager OOH/111</td></tr> <tr><td>Andrew Lewis</td><td>Hywel Dda UHB - Senior Finance Business Partner</td></tr> <tr><td>Bianca Oakley</td><td>Hywel Dda UHB - Clinical Lead</td></tr> <tr><td>Louise Cullum</td><td>Hywel Dda UHB - General Manager - Ceredigion System</td></tr> <tr><td>Shaun Ayres</td><td>Hywel Dda UHB - Director of Delivery</td></tr> <tr><td>Sara Quarrie</td><td>Hywel Dda UHB - Service Director for Allied Health Professions and Health Sciences</td></tr> </table>	Sarah Isaac	Hywel Dda UHB - Medicines Management Clinical Lead Transformation Programme Office	Peter Skitt	Hywel Dda UHB - Clinical Care Group Service Director - Community & Integrated Medicine	Thomas Alexander	Hywel Dda UHB - Principal Programme Manager	Louise Major	Hywel Dda UHB - Project Support Manager (Interim)	Jessica Svetz	Hywel Dda UHB - General Manager Pembrokeshire System	Carly Tucker-Williams	Hywel Dda UHB - Project Manager Value Based Health Care	Sarah Perry	Hywel Dda UHB - GM Carmarthenshire System	Matt Phillips	Hywel Dda UHB - Finance Business Partner (Corporate Reporting)	Wendy Davies	Hywel Dda UHB - Project Managers - Workforce Planning	Jon Adams	Hywel Dda UHB - Deputy Head of Occupational Therapy	William Mackintosh	Hywel Dda UHB - Clinical Lead - Primary and Community Services Academy	Karen Brown	Hywel Dda UHB - Associate Medical Director - CIMCG	Scott O'Rourke	Hywel Dda UHB - Consultant	Anthony Dew	Hywel Dda UHB - Clinical Lead GP Intermediate & Urgent Primary Care	Tracy Walmsley	Hywel Dda UHB - Assistant Director of People Planning	Richard Jenkins	Hywel Dda UHB - Assistant Finance Director Commissioning BI & Value	John Davies	Hywel Dda UHB - Head of Physiotherapy Service	Sioned Richards	Hywel Dda UHB - GP Lead Carmarthenshire Intermediate Care	Emily Warm	Hywel Dda UHB - Project Support Officer	Sian Morgan	Hywel Dda UHB - Planning Project Manager	Ellen Lewis	Hywel Dda UHB - Project Manager (interim)	Jessica Showler-Coulson	Hywel Dda UHB - Head of Nursing - Ceredigion System	Marilize Preez	Hywel Dda UHB - Improvement and Transformation Lead	David Richards	Hywel Dda UHB - Service Delivery Manager OOH/111	Andrew Lewis	Hywel Dda UHB - Senior Finance Business Partner	Bianca Oakley	Hywel Dda UHB - Clinical Lead	Louise Cullum	Hywel Dda UHB - General Manager - Ceredigion System	Shaun Ayres	Hywel Dda UHB - Director of Delivery	Sara Quarrie	Hywel Dda UHB - Service Director for Allied Health Professions and Health Sciences		
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04/11/2025	WAST/7 Day Streaming Business Case meeting	<table border="1"> <tr><td>Peter Skitt</td><td>Hywel Dda UHB - Clinical Care Group Service Director - Community & Integrated Medicine)</td></tr> <tr><td>Thomas Alexander</td><td>Hywel Dda UHB - Principal Programme Manager)</td></tr> <tr><td>Karen Brown</td><td>Hywel Dda UHB - Associate Medical Director - CIMCG)</td></tr> <tr><td>Sioned Richards</td><td>Hywel Dda UHB - GP Lead Carmarthenshire Intermediate Care)</td></tr> <tr><td>Jeff Morris</td><td>Welsh Ambulance Service NHS Trust- 020 - Head of Service EMS)</td></tr> <tr><td>Samantha Hurn</td><td>Welsh Ambulance Service NHS Trust - 020)</td></tr> <tr><td>Bianca Oakley</td><td>Hywel Dda UHB - Clinical Lead)</td></tr> <tr><td>Edward Harry</td><td>Welsh Ambulance Service NHS Trust)</td></tr> </table>	Peter Skitt	Hywel Dda UHB - Clinical Care Group Service Director - Community & Integrated Medicine)	Thomas Alexander	Hywel Dda UHB - Principal Programme Manager)	Karen Brown	Hywel Dda UHB - Associate Medical Director - CIMCG)	Sioned Richards	Hywel Dda UHB - GP Lead Carmarthenshire Intermediate Care)	Jeff Morris	Welsh Ambulance Service NHS Trust- 020 - Head of Service EMS)	Samantha Hurn	Welsh Ambulance Service NHS Trust - 020)	Bianca Oakley	Hywel Dda UHB - Clinical Lead)	Edward Harry	Welsh Ambulance Service NHS Trust)																																												
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11/11/2025	SDEC staffing models in the 7-Day Business Case	Peter Skitt	Hywel Dda UHB - Clinical Care Group Service Director - Community & Integrated Medicine)		
		Thomas Alexander	Hywel Dda UHB - Principal Programme Manager)		
		Karen Brown	Hywel Dda UHB - Associate Medical Director - CIMCG)		
		Wendy Davies	Hywel Dda UHB - Project Managers - Workforce Planning)		
		Daniel Owen	Hywel Dda UHB - Senior Workforce Manager)		
		Jessica Showler-Coulson	Hywel Dda UHB - Head of Nursing- Ceredigion System)		
		Scott O'Rourke	Hywel Dda UHB - Consultant)		
		Sarah Perry	Hywel Dda UHB - GM Carmarthenshire System)		
		Jessica Svetz	Hywel Dda UHB - General Manager Pembrokeshire System)		
		Louise Cullum	Hywel Dda UHB - General Manager - Ceredigion System)		
		Andrew Lewis	Hywel Dda UHB - Senior Finance Business Partner)		
		Matt Phillips	Hywel Dda UHB - Finance Business Partner Corporate Reporting))		
		Tracy Walmsley	Hywel Dda UHB - Assistant Director of People Planning)		
		Carol Thomas	Hywel Dda UHB - Head of Nursing Pembrokeshire System)		
		Iona Evans	Hywel Dda UHB - Head of Nursing Carmarthenshire System)		
		Ellen Lewis	Hywel Dda UHB - Project Manager interim))		
		Louise Major	Hywel Dda UHB - Project Support Manager interim))		
		Emily Warm	Hywel Dda UHB - Project Support Officer)		
		Bianca Oakley	Hywel Dda UHB - Clinical Lead)		
		Nicola Evans	Hywel Dda UHB - Hospital Service Manager)		
17/11/2025	7-Day Clinical Streaming Model	Thomas Alexander	Hywel Dda UHB - Principal Programme Manager)		
		Donna Coleman	Llais West Wales (VC)		
11/11/2025	Financial considerations for implementing the 77 Clinical Streaming Hubs	Peter Skitt	Hywel Dda UHB - Clinical Care Group Service Director - Community & Integrated Medicine		
		Thomas Alexander	Hywel Dda UHB - Principal Programme Manager		
		Marilize Preez	Hywel Dda UHB - Improvement and Transformation Lead		
		David Richards	Hywel Dda UHB - Service Delivery Manager OOH/111		
		Bianca Oakley	Hywel Dda UHB - Clinical Lead		
		Sarah Isaac	Hywel Dda UHB - Medicines Management Clinical Lead Transformation Programme Office		
		Sarah Perry	Hywel Dda UHB - GM Carmarthenshire System		
		Carly Tucker-Williams	Hywel Dda UHB - Project Manager Value Based Health Care		
		Andrew Lewis	Hywel Dda UHB - Senior Finance Business Partner		
		Matt Phillips	Hywel Dda UHB - Finance Business Partner (Corporate Reporting)		
		Sonia Hay	Hywel Dda UHB - General Manager Community & Primary Care -Pembrokeshire		
		Louise Major	Hywel Dda UHB - Project Support Manager (Interim)		
		William Mackintosh	Hywel Dda UHB - Clinical Lead - Primary and Community Services Academy		
		Robin Ghosal	Hywel Dda UHB - Hospital Director/ Respiratory		
		Karen Brown	Hywel Dda UHB - Associate Medical Director - CIMCG		
		Sioned Richards	Hywel Dda UHB - GP Lead Carmarthenshire Intermediate Care		
		Scott O'Rourke	Hywel Dda UHB - Consultant		
		Jessica Svetz	Hywel Dda UHB - General Manager Pembrokeshire System		
		Jessica Showler-Coulson	Hywel Dda UHB - Head of Nursing- Ceredigion System		
		Anthony Dew	Hywel Dda UHB - Clinical Lead GP Intermediate & Urgent Primary Care		
		Richard Jenkins	Hywel Dda UHB - Assistant Finance Director Commissioning BI & Value		
		Lisa Davies	Hywel Dda UHB - Service Delivery Manager Proactive and Planned Care		
		Ellen Lewis	Hywel Dda UHB - Project Manager (Interim)		
		Emily Warm	Hywel Dda UHB - Project Support Officer		
		Louise Cullum	Hywel Dda UHB - General Manager - Ceredigion System		
		Shaun Ayres	Hywel Dda UHB - Director of Delivery		
		Iona Evans	Hywel Dda UHB - Head of Nursing Carmarthenshire System		
		Carol Thomas	Hywel Dda UHB - Head of Nursing Pembrokeshire System		
		25/11/2025	Finalisation of CSH/SDEC 7-day Business Case	Karen Brown	Hywel Dda UHB - Associate Medical Director - CIMCG)
				Louise Major	Hywel Dda UHB - Project Support Manager interim))
Ellen Lewis	Hywel Dda UHB - Project Manager interim))				
Jessica Svetz	Hywel Dda UHB - General Manager Pembrokeshire System)				
Bianca Oakley	Hywel Dda UHB - Clinical Lead)				
Sarah Isaac	Hywel Dda UHB - Medicines Management Clinical Lead Transformation Programme Office)				
Matt Phillips	Hywel Dda UHB - Finance Business Partner Corporate Reporting))				
Wendy Davies	Hywel Dda UHB - Project Managers - Workforce Planning)				
Shaun Ayres	Hywel Dda UHB - Director of Delivery)				
John Davies	Hywel Dda UHB - Head of Physiotherapy Service)				
Mike Mulroy	Hywel Dda UHB - Podiatrist)				
Owain Williams	Hywel Dda UHB - Clinical Director of Pharmacy and Medicines Management)				
Richard Archer	Hywel Dda Health Board - Pembrokeshire Care On Call)				
Daniel Owen	Hywel Dda UHB - Senior Workforce Manager)				
Thomas Alexander	Hywel Dda UHB - Principal Programme Manager)				
William Mackintosh	Hywel Dda UHB - Clinical Lead - Primary and Community Services Academy)				
Tracy Walmsley	Hywel Dda UHB - Assistant Director of People Planning)				
Scott O'Rourke	Hywel Dda UHB - Consultant)				
Jessica Showler-Coulson	Hywel Dda UHB - Head of Nursing- Ceredigion System)				
Richard Jenkins	Hywel Dda UHB - Assistant Finance Director Commissioning BI & Value)				
Alison Thomas	Hywel Dda UHB - Head of Adult Speech and Language Therapy Service)				
Joanne Cornish	Hywel Dda UHB - Head of Integrated Transformation Pembrokeshire)				
Peter Skitt	Hywel Dda UHB - Clinical Care Group Service Director - Community & Integrated Medicine)				
Sioned Richards	Hywel Dda UHB - GP Lead Carmarthenshire Intermediate Care)				
Emily Warm	Hywel Dda UHB - Project Support Officer)				
Sian Morgan	Hywel Dda UHB - Planning Project Manager)				
Marilize Preez	Hywel Dda UHB - Improvement and Transformation Lead)				
David Richards	Hywel Dda UHB - Service Delivery Manager OOH/111)				
Andrew Lewis	Hywel Dda UHB - Senior Finance Business Partner)				
Anthony Dew	Hywel Dda UHB - Clinical Lead GP Intermediate & Urgent Primary Care)				
Sarah Perry	Hywel Dda UHB - GM Carmarthenshire System)				
Louise Cullum	Hywel Dda UHB - General Manager - Ceredigion System)				
Jon Adams	Hywel Dda UHB - Head of Occupational Therapy)				
Sara Quarrie	Hywel Dda UHB - Service Director for Allied Health Professions and Health Sciences)				
Zoe Paul-Gough	Hywel Dda UHB - Head of Nutrition and Dietetics Service)				
Joanna Jones	Head of Integrated Community Services - Carmarthenshire County Council & Hywel Dda UHB				
Lisa Davies	Hywel Dda UHB - Service Delivery Manager Proactive and Planned Care)				
Donna Coleman	Llais West Wales (VC)				



09/12/2025	7-day Clinical Streaming/SDEC business Case	Anwen Pearce	Hywel Dda Health Board - Capital Programme Manager Planning)
		Christopher Smoothy	Hywel Dda UHB - Project and Commissioning Manager)
		Rachel Stuart	Hywel Dda UHB - Planning Project Manager)
		Jackie Rees	Hywel Dda Health Board - Planning)
		Joe Llewellyn	Hywel Dda UHB - Project Manager Planning)
		Holley Aston-Brooks	Hywel Dda UHB - Project and Commissioning Manager)
		Thomas Alexander	Hywel Dda UHB - Principal Programme Manager)
		Eldog Rosser	Head of Capital Planning)
		Clare Emanuel	Hywel Dda UHB - Senior Capital Programme Manager - Planning)
		Tristan Byrne	Hywel Dda UHB - Capital Programme Support Officer)
10/12/2025	Business Executive Team	Andrew Carruthers	Hywel Dda UHB - Chief Operating Officer)
		Ardiana Gjini	Hywel Dda UHB - Executive Director of Public Health)
		Clare Strudwick	Hywel Dda UHB - Committee Services Officer)
		Huw Thomas	Hywel Dda UHB - Director of Finance)
		Joanne Wilson	Hywel Dda UHB - Director of Corporate Governance/Board Secretary)
		Lee Davies	Hywel Dda UHB - Executive Director of Strategy and Planning)
		Phillip Kloer	Hywel Dda UHB - Chief Executive)
		Sharon Daniel	Hywel Dda UHB - Executive Director of Nursing Quality & Patient Experience)
		Shaun Ayres	Hywel Dda UHB - Director of Delivery)
		Chris Coslett	NHS Wales Performance and Improvement)
		Sarah Isaac	Hywel Dda UHB - Medicines Management Clinical Lead Transformation Programme Office)
		Rhian Bond	Hywel Dda UHB - Assistant Director of Primary Care)
		Sarah Bolton	Hywel Dda UHB - Head of Primary Care Transformation)
		Anna Henchie	Hywel Dda UHB - Principal Programme Manager)
		James Severs	Hywel Dda UHB - Executive Director of Allied Health Professions and Health Science)
		Peter Skitt	Hywel Dda UHB - Clinical Care Group Service Director - Community & Integrated Medicine)
		Claire Evans	Hywel Dda UHB - Committee Services Officer)
		Daniel L Warm	Hywel Dda UHB - Head of Planning)
		Jo McCarthy	Hywel Dda UHB - Consultant in Public Health)
		Rachel Williams	Hywel Dda UHB - Head of Assurance and Risk)
		Helen Morgan-Howard	Hywel Dda UHB - Head of Transformation Programme Office)
		Rose Turrell	Regional Joint Committee PMO)
		Yvette Pellegrotti	Hywel Dda UHB - Principal Programme Manager)
		Ben Rogers	Hywel Dda UHB - Principal Programme Manager Transformation)
		Charlotte Wilmshurst	Hywel Dda Health Board - Assistant Director of Assurance and Risk)
		Heather Lewis	Public Health Wales Magden Park)
		Alwena Hughes Moakes	Hywel Dda UHB - Communications and Engagement Director)
		Lisa Gostling	Hywel Dda UHB - Director of Workforce & OD/Deputy CEO)
Mark Henwood	Hywel Dda UHB - Executive Medical Director)		
Thomas Alexander	Hywel Dda UHB - Principal Programme Manager)		
16/12/2025	Finance and Performance Committee	Andrew Carruthers	Hywel Dda UHB - Chief Operating Officer)
		Andrew Spratt	Hywel Dda UHB - Deputy Director of Finance)
		Anna Lewis	Hywel Dda UHB - Independent Member) (Vice Chair)
		Eleanor Marks	Hywel Dda UHB - HDUHB Vice Chair)
		Huw Thomas	Hywel Dda UHB - Director of Finance)
		Jennifer Thomas	Hywel Dda UHB - Head of Corporate Reporting and Planning)
		Joanne Wilson	Hywel Dda UHB - Director of Corporate Governance/Board Secretary)
		Leon Popham	Hywel Dda UHB - Senior Finance Business Partner)
		Mark Henwood	Hywel Dda UHB - Executive Medical Director) (part)
		Michael Imperato	Hywel Dda UHB - Independent Board Member) (Chair)
		Peter Skitt	Hywel Dda UHB - Clinical Care Group Service Director - Community & Integrated Medicine)
		Rhodri Evans	Hywel Dda UHB - Independent Member)
		Sara Quarrie	Hywel Dda UHB - Service Director for Allied Health Professions and Health Sciences) (part)
		Sharon Daniel	Hywel Dda UHB - Executive Director of Nursing, Quality & Patient Experience) (part)
		Shaun Ayres	Hywel Dda UHB - Director of Delivery)
		Siân Jenkins	Hywel Dda UHB - Deputy Director of Finance)
		Thomas Alexander	Hywel Dda UHB - Principal Programme Manager)
		Winston Weir	Hywel Dda UHB - Independent Board Member)

Further information is available on request.



Appendix 10 – Diagnostics/SDEC

The SDEC Diagnostic Challenge

Executive message

SDEC is a clinical success story, but it is diagnostic-dependent.

If imaging, labs, therapies and discharge coordination are not explicitly planned to deliver ED-aligned turnaround within SDEC hours, pressure shifts rather than reduces: ED holds rise, late conversion-to-admission increases, and patient experience deteriorates. (NHSE SDEC spec 2024; NHSBN 2021; Elias et al 2024)



Avoids admission

Admission avoidance for selected cohorts.



Reduces delirium risk

Less exposure to inpatient harms.



Prevents deconditioning

Maintain function and independence.



Lowers infection risk

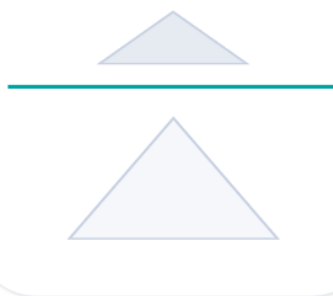
Reduced ward-based exposure.

The SDEC "iceberg": visible wins depend on a hidden engine

Refs: NHSE SDEC service specification (2024); NHS Benchmarking Network SDEC report

SDEC shifts and concentrates demand onto diagnostics, therapies, pharmacy and discharge coordination. The visible gains are real but only if the engine below the waterline is commissioned and staffed.

Iceberg view



Tip of the iceberg (what you see)

- Fewer admissions / reduced bed-days
- Foster decisions and flow
- Better experience (especially frailty)

Below the waterline (what must be in place)

- Diagnostics: CT/US/XR access + reporting
- Pathology: ED-speed TAT / POCT governance
- Specialist diagnostics (echo/endoscopy) not "optional"
- Therapies: OT/PT in-window + rapid equipment
- Pharmacy + discharge coordination aligned to hours

Rule of thumb: plan and cost the engine (support services + hours), otherwise you simply move pressure. (NHSE SDEC spec 2024; NHSBN 2021)

Minimum readiness checks (to stop SDEC turning into a queue)

int (Dec 2025).

11/1
4

Commission the controls explicitly: radiology slots + reporting SIA, pathology turnaround standards, and in-window therapies/pharmacy/discharge support.



Radiology

- Ring-fenced same-day slots
- ED-aligned reporting SLA
- Escalation route for breaches



Pathology / POCT

- TAT standards for SDEC cohorts
- POCT where appropriate (with governance)
- Transport / MLA capacity at peaks



Therapies (OT/PT)

- In window response standard
- Rapid equipment access
- Frailty/falls pathways aligned to hours



Pharmacy & discharge

- Discharge medicines process for weekends/evenings
- Single discharge coordination point
- Community/UCR/virtual ward linkage

Key message: SDEC is feasible, but only if radiology/pathology/therapies/pharmacy capacity is planned and costed to deliver ED-speed turnaround during SDEC hours. Refs: 13/1 NHSE SDEC spec (2024); NHSBN SDEC report (2021); local business case intent (Dec 2025).

Further information is available on request.

Integrated Impact Assessment Tool	Y/N	Evidence & Further Information	Completed by	Evidence (Insert)
Financial/Service Impacts			UEC PMO	
1. Has the new proposal/service model been costed? If so, by whom?	Y	Model costed by UEC Finance Business Partner	UEC PMO	SBAR/Business Case (BC)
2. Does the budget holder have the resources to pay for the new proposal/service model? Otherwise how will this be supported - where will the resources/money come from i.e. specify budget code or indicate if external funding, etc?	Y	The model will be funded through the appropriate and planned out release of resource from acute to community settings. This has been outlined in the business case	UEC PMO	SBAR/BC
3. Is the new proposal/service model affordable from within existing budgets?	Y	Yes, if the service demonstrates cost avoidance as predicted, please see business case for details.	UEC PMO	SBAR/BC
4. Is there an impact on pay or non pay e.g. drugs, equipment, etc?	N		UEC PMO	SBAR/BC
5. Is this a spend to save initiative? If so, what is the anticipated payback schedule?	Y	Yes as outlined in model, costs have been developed and outlined against year on year cost savings through hospital avoidance required to fund service	UEC PMO	SBAR/BC
6. What is the financial or efficiency payback (prudence), if any?	?	Please see point 3/5.	UEC PMO	SBAR/BC
7. Are there risks if the new proposal/service model is not put into effect?	Y	There is a risk to the consistent delivery of timely and high quality urgent and emergency care. This is caused by significant fragility across the urgent and emergency care (UEC) system (acute, primary care (including out of hours), community and social care services), related to workforce compromise and increasing levels of demand and acuity. This could lead to an impact/affect on the quality of care provided to patients, significant	UEC PMO	SBAR/BC

		clinical deterioration, delays in care and poorer outcomes, increased incidents of a serious nature relating to ambulance handover delays and overcrowding at Emergency Departments (ED) and delayed ambulance response to community emergency calls, increasing pressure of adverse publicity/reduction in stakeholder confidence and increased scrutiny from regulators.		
8. Are there any recognised or unintended consequences of changes on other parts of the system (i.e. impact on current service, impact of changes in secondary care provision on primary care services and capacity or vice versa, or other statutory services e.g. Local Authorities?)	Y	Increased capacity within these services. 7-day working in Clinical Streaming is anticipated to lesson the impact of people attending A&E and hospital at weekends and during the week, providing care closer to home, particularly for our elderly and frail. This is evidenced in the learning from local pilots and overwhelmingly in National studies in this area.	UEC PMO	SBAR/BC
9. Is there a need for negotiation/lead in times i.e. short term, medium term, long term? If so, with whom e.g. staff, current providers, external funders, etc?	Y	Recruitment and training and staff will cause a lead in time before benefits are realised. However, this will be built into the implementation plan developed with Finance.	UEC PMO	SBAR/BC
10. Are capital requirements identified or funded?	N	N/A	UEC PMO	SBAR/BC
11. Will capital projects need to be completed in time to support any service change proposed?	N	N/A	UEC PMO	SBAR/BC
12. Has a Project Board been identified to manage the implementation?	Y	Programme Group to oversee, governance through the Integrated Operational Board	UEC PMO	SBAR/BC
13. Is there an implementation plan with timescales to performance manage the process and risks?	Y	In Business Case	UEC PMO	SBAR/BC
14. Is there a post project evaluation planned for the new proposal/service model?	Y	This is standard programme management practice and ongoing evaluation will be	UEC PMO	SBAR/BC

		undertaken and reported through Formal Executive Team throughout the lifespan of the implementation phase. This will not only regularly cover impact on TI measures such as Ambulance Handover, ED waits and PoCD, but will also track financial efficiencies and potential cash release to support the model's development. Additionally, qualitative and quantitative data will be collected in terms of patient and staff satisfaction.		
15. Are there any other constraints which would prevent progress to implementation?	Y	This project requires the support of multiple teams and stakeholders.	UEC PMO	SBAR/BC
Quality/Patient Care Impacts			UEC PMO	SBAR/BC
16. Could there be an impact on patient outcome/care?	Y	The implementation of a seven-day Clinical Streaming Hub (CSH) and Same Day Emergency Care (SDEC) model is expected to have a significant positive impact on patient outcomes and care quality. The business case highlights that timely access to clinical streaming and same-day care services improves patient safety, reduces unnecessary hospital admissions, and enhances the overall patient experience. Evidence from the pilot demonstrated that patients were more likely to be assessed, treated, and discharged on the same day, reducing the risk of deterioration associated with prolonged hospital stays. The model supports early intervention for frail and complex patients, helping to prevent deconditioning,	UEC PMO	SBAR/BC

		<p>institutionalisation, and the escalation of care needs. Additionally, the integration of pharmacy and multidisciplinary teams ensures more holistic, preventative, and person-centred care. Conversely, the absence of such services—particularly over weekends—has been associated with delays in care, increased ED attendances, longer hospital stays, and poorer outcomes. Therefore, the proposed model is not only clinically beneficial but also essential for delivering equitable, timely, and high-quality care across all days of the week.</p>		
<p>17. Is there any potential for inequity of provision for individual patient groups or communities? E.g. rurality, transport.</p>	N	<p>Hywel Dda UHB serves a geographically dispersed and rural population across Carmarthenshire, Pembrokeshire, and Ceredigion. Access to urgent and emergency care services can be more challenging for patients in remote areas due to limited public transport, longer travel times, and reduced availability of services outside of core hours.</p> <p>The proposed seven-day Clinical Streaming Hub (CSH) and Same Day Emergency Care (SDEC) model aims to mitigate these inequities by establishing local response hubs in Eastgate, Porth Preseli, and Cardigan, supported by a regional triage system. This decentralised model is designed to bring care closer to home, reduce unnecessary travel, and ensure timely access to appropriate services regardless of location. The</p>	UEC PMO	SBAR/BC

		<p>integration of virtual care, Hospital@Home, and community-based teams further supports equitable access for patients who may otherwise face barriers due to geography or mobility.</p> <p>However, the business case also recognises that successful implementation will require ongoing attention to transport logistics, digital infrastructure, and workforce distribution to ensure that all communities, particularly those in rural or underserved areas, benefit equally from the proposed service enhancements.</p>		
<p>18. Is there any potential for inconsistency in approach across the Health Board?</p>	<p>Y</p>	<p>There is potential for inconsistency in approach across the Health Board, particularly during the implementation phase. The business case acknowledges the complexity of delivering a consistent seven-day Clinical Streaming Hub (CSH) and Same Day Emergency Care (SDEC) model across multiple sites with varying levels of existing infrastructure, staffing, and service maturity.</p> <p>To mitigate this, the proposal includes a regional coordination model with local response hubs in Eastgate, Porth Preseli, and Cardigan, supported by a single point of contact and virtual connectivity between clinicians. This structure is designed to standardise triage, assessment, and care pathways across the Health Board. However, the business case also highlights that current service provision is variable, and some</p>	<p>UEC PMO</p>	<p>SBAR/BC</p>

		<p>sites—such as Prince Philip Hospital and the Integrated Care Centre in Cardigan—may require further consultation and development to align fully with the model.</p> <p>In addition, the need for standardised training, digital infrastructure, and consistent workforce models is recognised as essential to ensuring equity and consistency. Without these enablers, there is a risk that some communities may experience variation in access, quality, or responsiveness of care.</p>		
19. Is there are potential for postcode lottery/commissioning?	N		UEC PMO	SBAR/BC
20. Is there a need to consider exceptional circumstances?	N		UEC PMO	SBAR/BC
21. Are there clinical and other consequences of providing or delaying/denying treatment (i.e. improved patient outcomes, chronic pain, physical and mental deterioration, more intensive procedures eventually required?)	Y	<p>The provision or delay/denial of treatment through a seven-day Clinical Streaming Hub (CSH) and Same Day Emergency Care (SDEC) model has significant clinical and systemic consequences. The business case demonstrates that timely access to these services leads to improved patient outcomes, reduced hospital admissions, and enhanced patient safety. The pilot evidenced a 91% same-day discharge rate and diversion of 226 patients from Emergency Departments (EDs), preventing potential escalation and overcrowding.</p> <p>Delays in treatment, particularly over weekends, are associated with poorer outcomes, including</p>	UEC PMO	SBAR/BC

		<p>physical and mental deterioration, increased risk of deconditioning, and the need for more intensive interventions. Vulnerable populations, such as frail older adults, are especially at risk of harm from delayed care, which can result in longer hospital stays, institutionalisation, and increased dependency on domiciliary care packages.</p> <p>The absence of timely intervention also contributes to increased ED attendances, ambulance handover delays, and system-wide pressure. Conversely, the implementation of a seven-day model supports early triage, community-based care, and a preventative approach, ultimately reducing harm, improving patient experience, and delivering substantial cost avoidance for the Health Board.</p>		
<p>22. Are there any Royal College standards, NICE guidance or other evidence bases, etc, applicable?</p>	<p>Y</p>	<p>The business case aligns with several national frameworks, strategic priorities, and evidence-based models that support the implementation of seven-day Clinical Streaming Hub (CSH) and Same Day Emergency Care (SDEC) services.</p> <p>The proposal is directly informed by the Welsh Government's Six Goals for Urgent and Emergency Care, which mandate the development of integrated seven-day services and the implementation of a Single Point of Access (SPOA) model. It also supports the Ministerial Priorities for UEC, including</p>	<p>UEC PMO</p>	<p>SBAR/BC</p>

		<p>community-based falls response, acute front-door frailty services, and integrated care pathways.</p> <p>While the business case does not cite specific Royal College or NICE guidelines by name, it references national best practice models such as:</p> <ul style="list-style-type: none"> • Hospital at Home and Virtual Wards, which are endorsed by NHS England and supported by evidence from the NIHR (National Institute for Health and Care Research). • ED GIRFT (Getting It Right First Time) recommendations, which promote early triage, admission avoidance, and improved flow through emergency departments. <p>Additionally, the business case draws on national and local evaluations demonstrating the effectiveness of early intervention, multidisciplinary triage, and community-based alternatives to hospital admission. These approaches are consistent with NICE guidance on managing frailty, reducing hospital admissions, and delivering person-centred care.</p>		
23. Can clinical engagement be evidenced in the design of the new proposal/service model?	Y	<p>Clinical engagement is clearly evidenced throughout the development of the proposed seven-day Clinical Streaming Hub (CSH) and Same Day Emergency Care (SDEC) model. The business case highlights that the design was informed by</p>	UEC PMO	SBAR/BC

		<p> direct clinical input, particularly through the evaluation of the March 2025 weekend pilot, which involved multidisciplinary teams (MDTs) including Advanced Clinical Practitioners (ACPs), pharmacists, GPs, and therapy staff. </p> <p> The pilot’s outcomes—such as improved patient flow, high same-day discharge rates, and positive patient and staff feedback—were used to shape the optimal service model. Clinical perspectives were also integral in refining assumptions around patient cohorts, length of stay, and cost avoidance, ensuring that the model reflects real-world clinical experience and judgement. </p> <p> Furthermore, the proposal outlines a regional triage system and integrated local response hubs that rely on virtual clinical collaboration across sites, reinforcing the role of clinicians in both the design and future delivery of the service. The inclusion of pharmacy-led interventions and the alignment with national clinical priorities (e.g. frailty, falls, respiratory care) further demonstrate that the model has been co-produced with strong clinical leadership and engagement. </p>		
<p>24. Are there any population health impacts?</p>	<p>Y</p>	<p> Yes, the proposed seven-day Clinical Streaming Hub (CSH) and Same Day Emergency Care (SDEC) model is expected to have positive population health impacts across Hywel Dda University Health Board. The business case outlines a </p>	<p>UEC PMO</p>	<p>SBAR/BC</p>

		<p>strategic shift from reactive, hospital-based care to proactive, community-based interventions that support prevention, early intervention, and reduced health inequalities.</p> <p>Key population health benefits include:</p> <ul style="list-style-type: none"> • Improved access to care for frail, elderly, and complex patients, particularly in rural areas, through local response hubs and virtual ward functionality. • Reduction in hospital admissions and length of stay, which mitigates risks associated with institutionalisation, deconditioning, and dependency. • Enhanced falls response and respiratory care pathways, aligned with Ministerial priorities, which target high-risk groups and reduce avoidable harm. • Integration of pharmacy-led polypharmacy reviews, which optimise medication use and reduce adverse drug events, particularly among older adults. • Support for care homes and community teams, enabling timely interventions and reducing escalation to emergency services. <p>By improving the coordination and responsiveness of urgent care services, the model contributes to better health outcomes, reduced system pressure, and a more equitable distribution of care across the population.</p>		
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Workforce Impact				
25. Has the impact on the existing staff/WTE been determined?	Y	The impact on existing staff and whole-time equivalent (WTE) requirements has been clearly considered and detailed within the business case and supporting board paper. The proposed seven-day Clinical Streaming Hub (CSH) and Same Day Emergency Care (SDEC) model requires a significant expansion of multidisciplinary staffing to ensure safe and effective service delivery across all operational days. Risk and mitigations associated with this are fully outlined in the Business Case and have been worked up with Workforce colleagues.	UEC PMO	SBAR/BC
26. Is it deliverable without the need for premium workforce?	Y	The delivery of the proposed seven-day Clinical Streaming Hub (CSH) and Same Day Emergency Care (SDEC) model is not entirely achievable without some reliance on premium workforce, particularly during the initial implementation phase. The business case acknowledges that weekend and out-of-hours service delivery will incur enhanced pay rates in line with Agenda for Change terms. Specifically, a minimum of 30% enhancement for Saturdays and 60% for	UEC PMO	SBAR/BC

		<p>Sundays. These enhancements contribute to the higher cost of delivering a seven-day model. However, the proposal aims to minimise long-term reliance on premium workforce by recruiting substantive staff into new roles. The staffing model includes detailed WTE requirements for Advanced Clinical Practitioners, GPs, pharmacists, and Health Care Support Workers, with the intention of building a sustainable, right-sized workforce. The iUEC Board Paper reinforces this by highlighting that the establishment of a 7/7 Operational Delivery Unit (ODU) will reduce the need for weekend on-call payments, effectively offsetting some of the premium costs.</p> <p>In summary, while some premium workforce costs are unavoidable, particularly during weekends and the transition period, the model is designed to be deliverable through substantive recruitment and workforce redesign, reducing dependency on temporary or premium staffing over time.</p>		
<p>27. Is there the potential for staff disengagement if there is no clinical/'reasonable' rationale for the action?</p>	<p>Y</p>	<p>There is potential for staff disengagement if changes to service models are not underpinned by a clear clinical or operational rationale. However, both the business case and the iUEC Public Board Paper demonstrate that the proposed seven-day Clinical Streaming Hub (CSH) and Same Day Emergency Care (SDEC) model has</p>	<p>UEC PMO</p>	<p>SBAR/BC</p>

	<p> been developed through extensive clinical engagement and is strongly grounded in evidence-based practice. </p> <p> The business case highlights that the model was informed by the outcomes of a pilot programme and shaped by multidisciplinary clinical input, including Advanced Clinical Practitioners, pharmacists, GPs, and therapy staff. It also reflects national priorities and aligns with Ministerial goals for urgent and emergency care, providing a clear and reasonable rationale for change. </p> <p> The iUEC Board Paper further reinforces this by describing the model as “clinically led” and co-created through engagement with frontline staff across primary, community, and emergency care. It emphasises the importance of empowering staff through strength-based conversations and shared decision-making, which are central to the proposed transformation. </p> <p> By ensuring that the rationale for change is transparent, clinically justified, and aligned with improving patient outcomes and system performance, the Health Board aims to foster staff engagement and reduce the risk of disengagement. Nonetheless, the documents acknowledge the need for ongoing communication, training, and organisational development to support staff through the transition. </p>		
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<p>28. Is there potential for professional body/college/union involvement?</p>	<p>Y</p>	<p>There is potential for involvement from professional bodies, Royal Colleges, and trade unions, particularly given the scale of service transformation and workforce redesign proposed in the seven-day Clinical Streaming Hub (CSH) and Same Day Emergency Care (SDEC) model.</p> <p>The business case outlines significant changes to staffing models, working patterns (including weekend and extended hours), and the integration of multidisciplinary teams across acute and community settings. These changes may prompt engagement from professional bodies such as the Royal College of Emergency Medicine, Royal College of Nursing, Royal Pharmaceutical Society, and relevant unions representing medical, nursing, therapy, and pharmacy staff.</p> <p>The iUEC Public Board Paper acknowledges that the model has been clinically led and co-designed with frontline professionals, which helps mitigate the risk of resistance. However, it also recognises the need for a phased implementation and ongoing engagement to ensure staff are supported and that any concerns (particularly around safe staffing, role boundaries, and terms and conditions) are addressed collaboratively.</p>	<p>UEC PMO</p>	<p>SBAR/BC</p>

		Proactive engagement with professional bodies and unions will be essential to ensure alignment with professional standards, maintain staff morale, and support successful implementation.		
29. Could there be any perceived interference with clinical freedom?	N	<p>While the proposed seven-day Clinical Streaming Hub (CSH) and Same Day Emergency Care (SDEC) model introduces structured pathways and coordinated triage systems, there is no indication that it would interfere with clinical freedom inappropriately. On the contrary, both the business case and the iUEC Public Board Paper emphasise that the model has been clinically led, co-designed with frontline professionals, and is grounded in evidence-based practice.</p> <p>The model supports clinical autonomy by enabling clinicians to make timely, informed decisions through improved access to diagnostics, multidisciplinary teams, and virtual ward functionality. It also facilitates shared decision-making and personalised care, aligning with the “What matters to you?” approach and the principles of Value-Based Healthcare.</p> <p>However, as with any system-wide transformation, there may be perceived risks if clinicians feel that standardised triage or digital coordination tools constrain their judgement. To mitigate this, the model includes regional clinical oversight, peer-to-peer support (e.g. Consultant</p>	UEC PMO	SBAR/BC

		Connect), and a strong emphasis on professional engagement and continuous learning. In summary, while there is potential for perceived interference, the design and governance of the model actively promote clinical leadership, flexibility, and professional discretion within a structured and supportive framework.		
30. Is there potential for front line staff conflict with the public?	N		UEC PMO	SBAR/BC
31. Could there be challenge from the 'industries' involved?	N		UEC PMO	SBAR/BC
32. Is there a communication plan to inform staff of the new arrangements?	N	Once approved a comprehensive communication and engagement plan will be developed	UEC PMO	SBAR/BC
33. Has the Organisational Change Policy been followed, including engagement/consultation in accordance with guidance?	N/A	This will be followed in implementation phase if required	UEC PMO	SBAR/BC
34. Have training requirements been identified and will this be complete in time to support the new proposal/service model?	Y	Yes, training requirements have been identified as a critical enabler for the successful implementation of the seven-day Clinical Streaming Hub (CSH) and Same Day Emergency Care (SDEC) model. The business case acknowledges that the proposed model involves new roles, extended hours, and integrated multidisciplinary working, all of which necessitate appropriate training and upskilling. The implementation plan outlines that:	UEC PMO	SBAR/BC

		<ul style="list-style-type: none"> • A phased approach will be adopted, allowing time for recruitment and training of staff to the required standards. • There will be a need to rotate experienced existing staff into weekend and extended-hour roles, supported by training to ensure consistency and safety. • The model builds on the Health Board’s existing “Grow Your Own” workforce development strategy, which includes structured training pathways and professional development opportunities. • Standardised protocols and clinical governance frameworks will be introduced to support consistent triage and decision-making across sites. <p>While specific training modules or timelines are not detailed in the business case, the commitment to workforce development and the phased implementation means that training will be aligned with service mobilisation to ensure readiness.</p>		
Risk Impact			UEC PMO	SBAR/BC
32. Has a risk assessment been completed?	Y	<p>Workforce fatigue Variable service uptake Inconsistent triage Digital infrastructure gaps</p>	UEC PMO	SBAR/BC
33. Is there a plan to mitigate the risks identified?	Y	Need to recruit staff to substantive positions	UEC PMO	SBAR/BC

		Public and professional awareness campaigns Standardised training and protocols Investment in virtual ward tech and coordination tools		
Legal Impact			UEC PMO	SBAR/BC
34. Has legal compliance been considered e.g. Welsh Language: is there any specific legislation or regulations that should be considered before a decision is made?	Y	The business case does not explicitly reference Welsh language compliance; however, given the scale of service transformation and public-facing nature of the model, it is essential that the Health Board ensures: Bilingual service delivery across all CSH and SDEC sites. Welsh language training and awareness for new and existing staff. Compliance monitoring and reporting mechanisms are in place. Failure to meet these obligations could result in non-compliance with statutory duties and reputational risk. Therefore, it is recommended that the implementation plan includes a Welsh Language Impact Assessment and engagement with the Health Board’s Welsh Language Officer.	UEC PMO	SBAR/BC
35. Is there a likelihood of legal challenge?	N	If the Communication and Engagement, Workforce and Welsh Language Guidelines are considered as part of the implementation phase, this will be unlikely.	UEC PMO	SBAR/BC

36. Is there any existing legal guidance that could be perceived to be compromised i.e. Independent Provider Contracts, statutory guidance re: Continuing Healthcare, Welsh Government Policy etc?	N		UEC PMO	SBAR/BC
37. Is there any existing contract and/or notice periods?	N		UEC PMO	SBAR/BC
Reputational Impact			UEC PMO	SBAR/BC
38. Is there a likelihood of public/patient opposition?	Y	<p>The likelihood of public or patient opposition is likely to be low, but it cannot be entirely ruled out. The proposed seven-day Clinical Streaming Hub (CSH) and Same Day Emergency Care (SDEC) model is designed to improve access, reduce delays, and enhance patient outcomes—particularly for frail and vulnerable populations. These aims are generally aligned with public expectations for timely, safe, and person-centred care.</p> <p>The model supports a shift toward care closer to home and incorporates digital access, community-based responses, and integrated care pathways, which are all intended to improve patient experience and reduce unnecessary hospital admissions.</p> <p>However, as with any significant service change, there may be concerns or resistance from some members of the public, particularly if the changes</p>	UEC PMO	SBAR/BC

		<p>are perceived to reduce access to traditional services (e.g. EDs) or if communication is unclear. To mitigate this, the business case recommends:</p> <ul style="list-style-type: none"> • Public and professional awareness campaigns • Transparent communication about the benefits and rationale for change • Ongoing engagement with patients, carers, and community representatives <p>Proactive communication and engagement planning will be essential to minimise any perceived disruption or opposition.</p>		
39. Is there a likelihood of political activity?	Y	<p>There is a potential for political activity associated with the implementation of the seven-day Clinical Streaming Hub (CSH) and Same Day Emergency Care (SDEC) model. The proposal directly responds to Ministerial Priorities for Urgent and Emergency Care, aligns with the Welsh Government’s Six Goals Programme, and addresses performance metrics that have placed the Health Board under Targeted Intervention.</p> <p>Given the strategic importance of urgent and emergency care reform, and the scale of investment required (over £8 million annually), the initiative may attract political interest from:</p>	UEC PMO	SBAR/BC

		<ul style="list-style-type: none"> • Welsh Government officials, particularly in relation to funding, performance improvement, and alignment with national mandates. • Local elected representatives, who may seek assurances about equitable service provision across rural and urban communities, and question the shift of resourcing from the hospital to the community. • Scrutiny committees or public bodies, such as Llais, which have previously raised concerns about quality and access in UEC services. <p>The business case and board paper both emphasise the need for transparent communication, stakeholder engagement, and phased implementation to manage reputational and political risks. While political activity is likely, it is expected to be constructive and focused on ensuring the model delivers improved outcomes for patients and communities.</p>		
40. Is there a likelihood of media interest?	Y	<p>There is a likelihood of media interest in the implementation of the seven-day Clinical Streaming Hub (CSH) and Same Day Emergency Care (SDEC) model. The proposal represents a significant transformation of urgent and emergency care services across Hywel Dda University Health Board, with substantial</p>	UEC PMO	SBAR/BC

	<p>investment, workforce changes, and a shift toward community-based care.</p> <p>Key factors that may attract media attention include:</p> <ul style="list-style-type: none"> • The scale of the investment • The alignment with Welsh Government priorities and national performance targets. • The positive potential impact on emergency department pressures, ambulance handover times, and patient outcomes. • The introduction of new service models such as Hospital@Home and virtual wards. • The Health Board’s current status under Targeted Intervention for UEC performance. • The shift from acute to community resource provision <p>While the model is designed to improve patient experience and system efficiency, any perceived reduction in access to traditional services (e.g. EDs) or concerns about rural equity could prompt public or political commentary, which may be picked up by local or national media.</p> <p>To manage this, the business case recommends proactive communication and engagement strategies, including public awareness campaigns and transparent reporting of outcomes. These</p>	
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		measures will be essential to ensure accurate public understanding and to highlight the benefits of the proposed changes.		
41. Is there the potential for an adverse effect on recruitment?	N		UEC PMO	SBAR/BC
42. Is there the likelihood of an adverse effect on staff morale?	N		UEC PMO	SBAR/BC
43. Potential for judicial review?	Y	<p>The potential for judicial review is considered low, provided that the Health Board continues to follow appropriate governance, consultation, and equality processes. The proposed seven-day Clinical Streaming Hub (CSH) and Same Day Emergency Care (SDEC) model is aligned with national policy, clinically led, and supported by evidence from pilot evaluations and national best practice.</p> <p>However, judicial review could be triggered if:</p> <ul style="list-style-type: none"> • There is a failure to comply with statutory duties, such as those under the Equality Act 2010, Welsh Language Standards, or Well-being of Future Generations (Wales) Act 2015. • The decision-making process lacks transparency or does not follow due process. • There is inadequate public or stakeholder engagement, particularly if the changes are perceived to reduce access to services 	UEC PMO	SBAR/BC

		<p>or disproportionately affect specific groups.</p> <p>To mitigate this risk, the business case and board paper recommend:</p> <ul style="list-style-type: none"> • A phased implementation with ongoing monitoring and evaluation. • Engagement with professional bodies, unions, and the public. • Compliance with legal and regulatory frameworks, including equality and Welsh language duties. <p>Provided these safeguards are maintained, the risk of judicial review is minimal.</p>		
Privacy Impact			UEC PMO	SBAR/BC
44. Have the Information Governance Team been contacted about the project to assess whether a Data Protection Impact Assessment (DPIA) needs to be undertaken?	Y	In the development of a Clinical Streaming Hub Dashboard	UEC PMO	SBAR/BC
45. Has a full DPIA been undertaken – Please contact Information.Governance3@wales.nhs.uk for the template.	N/A		UEC PMO	SBAR/BC
Equality Impact (unless otherwise completed as part of the accompanying SBAR)			UEC PMO	SBAR/BC
46. Has Equality Impact Assessment (EqIA) screening been undertaken – follow link below? Equality, diversity and inclusion (sharepoint.com)	Y		UEC PMO	SBAR/BC
47. Has a full EqIA been undertaken – follow link below?	N	NA	UEC PMO	SBAR/BC

Equality, diversity and inclusion (sharepoint.com)				
48. Have any negative/positive impacts been identified in the EqIA documentation?	Y	Positive impact on the general population having better access to services.	UEC PMO	SBAR/BC

Equality Impact Assessment (EqIA) Screening Template

When to complete an EqIA Screening

An EqIA Screening Template must be completed when reviewing, changing and developing procedures/ proposals/ projects/ policies. This is a first step and is used to consider whether there are any negative impacts that may arise.

Purpose of an EqIA Screening Template

The purpose of this short exercise is to ensure that you have shown appropriate due regard when considering the impact for people with protected characteristics in your decision making. The screening process is designed to help you consider the circumstances and to inform evidence-based decisions.

If the proposal is of a significant nature and it is apparent from the outset that a full EqIA will be required, then it is not necessary to complete this Screening Template, you can proceed to complete the full [EqIA](#).

If no negative impacts are identified following completion of the EqIA screening then it is not necessary to undertake a full EqIA however, the decision and justification must be clearly recorded in this document.

On completion of the Screening Template:

- Ensure that all the white boxes within the screening are completed.
- Ensure that the Procedure/ Project/ Proposal/ Policy owner has signed and dated the Screening Template.
- Send a copy of the completed template along with the related policy or project proposal to Inclusion.hdd@wales.nhs.uk for the Diversity & Inclusion Team to review.
- Each Screening Template will be reviewed by the Diversity & Inclusion Team and feedback will be provided to the Procedure/ Project/ Proposal/ Policy owner. This may include recommendations for further action to inform robust decision-making.

Support

For further support please visit the [EqIA Sharepoint](#) or contact:

Email: Inclusion.hdd@wales.nhs.uk

Tel: 01554 899055

Director and Directorate	Peter Skitt, Community and Integrated Medicine (CIM) Directorate
Service Area	Urgent and Emergency Care (UEC)

Title of Procedure, Project, Proposal, Policy being screened:	The implementation of Seven-Day Clinical Streaming, Same Day Emergency Care (SDEC), and Hospital@Home Services for Hywel Dda University Health Board
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Description of the Procedure/ Project/ Proposal/ Policy being screened (including key aims and objectives)

This proposal aims to extend current urgent and emergency care services from five days to seven days a week, including Clinical Streaming Services, SDEC, and Hospital@Home. The goal is to improve patient outcomes, reduce unnecessary hospital admissions, and enhance system efficiency, particularly for frail and elderly populations. The proposal aligns with national and local strategic priorities and is supported by evidence from local pilots and national exemplars.

Evidence considered (including staff and population data, relevant research, expert and community knowledge etc.)

This business case proposes the extension of the current Monday to Friday Clinical Streaming Services (CSS), Same Day Emergency Care (SDEC) and Hospital@Home, to become seven-day for Hywel Dda University Health Board (HDUHB).

The business case considers the analysed data from the current model, national findings, and utilises the data from a weekend pilot of CSS, SDEC, and Hospital@Home, to inform the recommendations made.

It is stated that the permanent implementation of a full seven-day model will enhance the urgent and emergency care (UEC) system performance in Hywel Dda, improve patient outcomes, and align with national strategic priorities.

This proposal contains inherent complexity, relating to the consultation, stakeholder engagement, interdependencies, Social Return on Investment (SROI), failure demand and the 'how' of realising the ambition to overlay fiscal responsibility in a way that integrates and enables the preventive operational 'shift left'. The funding for the model can be delivered from the current Six Goals budget

for the remainder of the financial year 2025/26. However, the recruitment to the proposed model needs to be based on a permanent and substantive workforce, so ongoing funding is reliant on the commitment of Health Board funding against the cost avoidance figures presented.

Assess which protected characteristics will potentially be affected by the proposal in the table below (please ✓ the relevant box to confirm positive, negative or no impact).

If at any point a negative impact has been identified (actual or potential), you do not need to proceed with the completion of this form, as a full EqlA must be undertaken: [Equality Impact Assessments \(EqlAs\) \(sharepoint.com\)](https://sharepoint.com)

Age			
Is it likely to affect older and younger people in different ways or affect one age group and not another?			
Positive Impact	<input type="checkbox"/>	Negative Impact	No Impact <input checked="" type="checkbox"/>
Justification of impact identified: All patients will be positively impacted from better flow through hospitals in Hywel Dda. Given all age groups will experience shorter hospital stays, and better outcomes. There is no common age for SDEC patients:			
Row Labels	Count of CRN	%	
<30	778	8%	
30-39	922	9%	
40-49	972	10%	
50-59	1,408	14%	
60-69	1,987	20%	
70-79	2,332	23%	
80+	1,759	17%	
Grand Total	10,158	100%	
Disability			
Is it likely to affect those with a physical disability, learning disability, sensory loss or impairment, mental health conditions, long-term medical conditions such as diabetes?			
Positive Impact	<input checked="" type="checkbox"/>	Negative Impact	No Impact <input type="checkbox"/>
Justification of impact identified: All patients will be positively impacted from better flow through hospitals in Hywel Dda. Given all age groups will experience shorter hospital stays, and better outcomes.			
Gender Reassignment			
Is it likely to affect those who either:			
<ul style="list-style-type: none"> Have undergone, intend to undergo or are currently undergoing gender reassignment. Do not intend to undergo medical treatment but wish to live in a different gender from their gender at birth 			
Positive Impact	<input checked="" type="checkbox"/>	Negative Impact	No Impact <input type="checkbox"/>
Justification of impact identified:			

All patients will be positively impacted from better flow through hospitals in Hywel Dda. Given all age groups will experience shorter hospital stays, and better outcomes.

Marriage / Civil Partnership

Under the Equality Act, the characteristic of Marriage and Civil Partnerships is only protected in the workplace/ employment.
Is it likely to affect those who are married or in a Civil Partnership? This means someone who is legally married or in a civil partnership.

Positive Impact	<input type="checkbox"/>	Negative Impact	<input type="checkbox"/>	No Impact	<input checked="" type="checkbox"/>
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Justification of impact identified:
All patients will be positively impacted from better flow through hospitals in Hywel Dda. Given all age groups will experience shorter hospital stays, and better outcomes.

Pregnancy and Maternity

Is it likely to affect those who are pregnant or have recently had a baby? Maternity covers the period of 26 weeks after having a baby, whether or not they are on Maternity Leave.

Positive Impact	<input type="checkbox"/>	Negative Impact	<input type="checkbox"/>	No Impact	<input checked="" type="checkbox"/>
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Justification of impact identified:
All patients will be positively impacted from better flow through hospitals in Hywel Dda. Given all age groups will experience shorter hospital stays, and better outcomes.

Race / Ethnicity

Is it likely to affect people of a different race, nationality, colour, culture or ethnic origin including non-English / Welsh speakers, Gypsies/Travellers, asylum seekers and migrant workers?

Positive Impact	<input type="checkbox"/>	Negative Impact	<input type="checkbox"/>	No Impact	<input checked="" type="checkbox"/>
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Justification of impact identified:
All patients will be positively impacted from better flow through hospitals in Hywel Dda. Given all age groups will experience shorter hospital stays, and better outcomes.

Religion or Belief

Is it likely to affect people who have a religion or belief? The term 'religion' includes a religious or philosophical belief.

Positive Impact	<input type="checkbox"/>	Negative Impact	<input type="checkbox"/>	No Impact	<input checked="" type="checkbox"/>
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Justification of impact identified:
All patients will be positively impacted from better flow through hospitals in Hywel Dda. Given all age groups will experience shorter hospital stays, and better outcomes.

Sex

Is it likely to affect people who are mostly male or female. Where it applies to both equally does it affect one differently to the other?

Positive Impact	<input type="checkbox"/>	Negative Impact	<input type="checkbox"/>	No Impact	<input checked="" type="checkbox"/>
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Justification of impact identified:
All patients will be positively impacted from better flow through hospitals in Hywel Dda. Given all age groups will experience shorter hospital stays, and better outcomes.

Sexual Orientation				
Whether a person's sexual attraction is towards their own sex, the opposite sex or either.				
Positive Impact	<input type="checkbox"/>	Negative Impact	<input type="checkbox"/>	No Impact <input checked="" type="checkbox"/>
Justification of impact identified: All patients will be positively impacted from better flow through hospitals in Hywel Dda. Given all age groups will experience shorter hospital stays, and better outcomes.				
Armed Forces Community				
Consider whether this impacts on members of the Armed Forces and their families, whose health needs may be impacted long after they have left the Armed Forces and returned to civilian life. Also consider their unique experiences when accessing and using day-to-day public and private services compared to the general population. It could be through 'unfamiliarity with civilian life, or frequent moves around the country and the subsequent difficulties in maintaining support networks, for example, members of the Armed Forces can find accessing such goods and services challenging.'				
For a comprehensive guide to the Armed Forces Covenant Duty and supporting resource please see: Armed-Forces-Covenant-duty-statutory-guidance				
Positive Impact	<input checked="" type="checkbox"/>	Negative Impact	<input type="checkbox"/>	No Impact <input type="checkbox"/>
Justification of impact identified: All patients will be positively impacted from better flow through hospitals in Hywel Dda. Given all age groups will experience shorter hospital stays, and better outcomes.				
Socio Economic Duty				
Consider those on low income, economically inactive, unemployed or unable to work due to ill-health. Also consider people living in areas known to exhibit poor economic and/or health indicators and individuals who are unable to access services and facilities. Food / fuel poverty and personal or household debt should also be considered.				
For a comprehensive guide to the Socio-Economic Duty in Wales and supporting resources please see: more-equal-wales-socio-economic-duty				
Positive Impact	<input type="checkbox"/>	Negative Impact	<input type="checkbox"/>	No Impact <input checked="" type="checkbox"/>
Justification of impact identified: All patients will be positively impacted from better flow through hospitals in Hywel Dda. Given all age groups will experience shorter hospital stays, and better outcomes.				
Welsh Language				
Is it likely to impact on opportunities for people to use the Welsh language? The Welsh language should be treated no less favourably than the English language.				
Positive Impact	<input type="checkbox"/>	Negative Impact	<input type="checkbox"/>	No Impact <input checked="" type="checkbox"/>

Justification of impact identified:
 All patients will be positively impacted from better flow through hospitals in Hywel Dda. Given all age groups will experience shorter hospital stays, and better outcomes.

If a negative impact has been identified, you are not required to complete this form as a full EqIA must be undertaken. A full EqIA template and guidance can be found on the following link: [Equality Impact Assessments \(EqIAs\) \(sharepoint.com\)](#)

Screening Completed by:	Name	Thomas Alexander
	Title	Principle Programme Manager
	Contact details	Thomas.alexander@wales.nhs.uk
	Date	12/01/2025
Screening Authorised by: (Directorate level owner of the procedures/ proposals/ projects/ policy)	Name	Peter Skitt
	Title	Director CIM
	Contact details	Peter.skitt@wales.nhs.uk
	Date	12/01/2025
Guidance has been provided by Diversity & Inclusion Team:	Name	Alan Winter
	Title	Senior Diversity & Inclusion Officer
	Contact details	Alan.winter@wales.nhs.uk
	Date	16/1/2026
Diversity and Inclusion Team additional Comments:		

Please note: The D&I team will save a copy of the completed form for reference. If any changes are made after the date of review, it is the directorate's responsibility to update the EqIA and inform the D&I team.