Hywel Dda University Health Board: Clinical Services Plan Consultation

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

Consultation report

Opinion Research Services

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1. Executive Summary

Introduction

Hywel Dda University Health Board

1.1 Hywel Dda University Health Board (Hywel Dda or the Health Board) provides health services for people across Carmarthenshire, Ceredigion, and Pembrokeshire and also for nearby communities in south Gwynedd, and parts of Powys and Swansea/Neath Port Talbot. Services are provided through:

- four main hospitals (Bronglais Hospital in Aberystwyth, Glangwili Hospital in Carmarthen, Prince Philip Hospital in Llanelli, and Withybush Hospital in Haverfordwest[1]).
- five community hospitals (Amman Valley Hospital and Llandovery Hospital in Carmarthenshire, Tregaron Hospital in Ceredigion, Tenby Hospital and South Pembrokeshire Hospital in Pembrokeshire).
- two integrated care centres (Aberaeron and Cardigan, both in Ceredigion).
- community facilities, including GP surgeries, dental practices, community pharmacies, ophthalmic (eye care) practices and sites providing mental health and learning disability services.
- care within people's own homes.

Challenges facing Hywel Dda University Health Board

1.2 A number of challenges including the impacts of the COVID-19 pandemic and gaps in staffing (made worse by shortages nationally) mean that patients are waiting longer than it would like for some planned care and it is recognised that many services fall short of national standards.

1.3 Hywel Dda has recognised for several years that some of its hospital services are fragile. This is mainly because its clinical staff and teams are spread across multiple sites, which means sometimes services are reliant on a small number of individuals.

The Clinical Services Plan

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

1.5 In summary, the plan seeks to:

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

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

The journey so far

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

The commission

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

The consultation

1.8 The 13.5-week public consultation period began on 29 May 2025 and ended on 31 August 2025, during which time members of the public, Hywel Dda staff members, organisations, and other stakeholders were invited to give feedback on the options and anything else they felt the Health Board should consider in relation to the nine services.

1.9 Hywel Dda University Health Board enabled stakeholders to access a wide range of resources throughout the CSP consultation. Formats included a bilingual full consultation document, a bilingual summary version, bilingual Easy Read and youth-friendly versions, a British Sign Language video, and a bilingual audio version. Summary documents were translated into Arabic, Polish, Ukrainian and Russian. Supporting technical documents were not translated and were available in English only.

1.10 Supporting materials were also provided. These included reports from the options appraisal process, travel insights, and impact assessments. The Teulu Jones case studies were developed to illustrate how proposed changes could affect communities. Eleven videos were created for use on social media platforms - nine short form reels, one for each service, and two overarching longer form videos (which were also used at engagement sessions).

1.11 Alongside these resources, the Health Board delivered a communications campaign to raise awareness and encourage participation. Proactive media activity including press releases, responses to media enquiries and interviews generated approximately 106 news items across 12 regional and national publications. This included interviews with BBC Wales, S4C, BBC Radio Wales and BBC Cymru Wales. Briefings were also undertaken with Members of the Senedd and Members of Parliament.

1.12 To reach communities that do not access information online, the Health Board delivered a three-county leaflet drop to all households and businesses in the region. Consultation information was also displayed on hospital digital screens. Posters were displayed at hospital sites and promotional materials were distributed through the engagement database, primary care, and community venues. Paid radio advertising supported this activity to reach audiences who rely on offline channels.

1.13 Targeted social media campaigns promoted consultation events and materials. Organic social media posts were used to maintain momentum. Stakeholders were signposted via direct email and communication activities to the dedicated consultation website, where all resources were available.

1.14 Documents were distributed via a stakeholder mass mailout, at face-to-face meetings, engagement events, and visits to a range of settings, as well as being available on request via post, telephone or email. In all,

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

The consultation questions

1.15 In this consultation people were asked for their feedback on:

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

Consultation methodology and response

1.16 Each chapter in this report provides detailed information about the consultation methods from which feedback has been reported; the following section provides a brief overview.

1.17 To provide relevant information that might inform respondents' views, information about the options for the nine services was included in a consultation document and supporting documentation including in summary and Easy Read format. After being encouraged to familiarise themselves with the background information, residents, staff, and other stakeholders were invited to provide feedback through a wide range of methods, including all of the following:

- a consultation questionnaire that was available online (hosted by ORS) and via paper copies, which were circulated widely and available on request. Alternate language and Easy Read formats were also provided.
- engagement activities undertaken by Hywel Dda, including:
  - online webinars and face-to-face public drop-in events
  - staff drop-in events, hospital walkarounds and meetings
  - meetings with statutory and non-statutory stakeholders/partners
  - attendance at and visits to existing community groups, outpatient settings, and public events like the Royal Welsh Show and Pembrokeshire County Show.
- residents' workshops, independently designed and facilitated by ORS.
- written, email, and telephone submissions.
- social media.

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

Consultation questionnaire

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

Health Board events and activities

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

Protect Bronglais Services public meeting

- **400+** attendees

In-depth engagement (independently facilitated by ORS)

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

Other feedback channels

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

Note on the consultation questionnaire

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

1.20 103 questionnaire responses were received in Welsh, the text comments from which were translated by one of ORS's Welsh-speaking researchers, and quality assured by ORS's Welsh-speaking senior researcher[2]. Responses were integrated with the English responses in readiness for analysis.

1.21 Further details can be found in the consultation overview (chapter 2).

The nature of public consultation

1.22 Public consultation promotes accountability and assists decision making; public bodies give an account of their plans or proposals and listen to feedback. Consultation has therefore been described as a dialogue, based on a genuine and purposeful exchange of views.

1.23 It should be noted, however, that consultations are not referenda or 'votes' in which the loudest voices or the greatest numbers automatically determine the outcome. The feedback received often reflects varied and sometimes polarised views, and it is important to report these concerns and contrary views robustly, in order for decision-makers to be able to conscientiously take into account the issues raised.

The consultation report

1.24 In contrast to the more thematic approach in this executive summary, the full report considers the feedback from each element of the consultation in turn because it is important that the overall report provides a full evidence-base for those considering the consultation and its findings.

1.25 All types of consultation responses are important, and this report presents an independent analysis so that all of them may be taken into account. The report also identifies where strength of feeling may be particularly intense, either in relation to specific themes or possible outcomes, or coming from specific groups of consultees. This will enable decision-makers to conscientiously consider the issues raised (Gunning Principle 4[3]).

1.26 In relation to strength of feeling, when reporting the qualitative research findings we have used standard descriptors like 'most,' 'many,' 'some,' 'several,' and 'a few' to convey the relative prevalence of themes and strength of feeling within the data. While the terms do not indicate precise proportions, broadly speaking their meaning is as follows:

- most: a large majority of consultees, but not all.
- many: a slight majority or large minority of consultees.
- some/several: a minority of consultees, but more than a handful.
- a few: a handful of consultees.

1.27 Quotations are used throughout the report, but it is important to note that these are used for illustrative purposes only. In some cases, the quotations may not be fully supported by the available evidence - and while ORS has not sought to highlight or correct incorrect statements or assumptions, this should be borne in mind when considering the findings.

1.28 In considering staff feedback, we would note that while people were invited to disclose whether they were

[2] The same process was undertaken for the one Welsh-language written submission received.
[3] The Gunning Principles are four legal standards for fair public consultation. They require that proposals are still at a formative stage, the proposer gives sufficient information for intelligent consideration, adequate time is provided for a response, and the results of the consultation are conscientiously considered before a final decision is made.

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

1.29 In many activities and within the questionnaire, participants and respondents were encouraged to suggest alternative ideas, all of which have been shared with the Health Board. All alternative ideas and options have been assessed by the Hywel Dda University Health Board Options Development Group; more detail can be found in the Closing Report, which will be presented to Board in February 2026.

1.30 Finally, it is not ORS' role to 'make a case' for or against the proposals, nor to make any recommendations as to how decision makers should use the reported results. It is for the appropriate bodies to take decisions based on all of the evidence available, of which consultation feedback is one part. To this end, ORS trusts that both the executive summary and full report will be helpful to all concerned.

Main Findings

Critical care

1.31 Critical care provides care for critically ill adult patients with life-threatening conditions, within intensive care units (ICUs). Currently, it is available in Bronglais, Glangwili, Prince Philip and Withybush. At Prince Philip, some patients with higher needs are stabilised and then transferred to Glangwili for further care.

1.32 Staffing critical care services in Carmarthenshire, Ceredigion and Pembrokeshire (Hywel Dda) is difficult, and none of the Health Board's hospitals meet required quality and safety standards. In this context, the Health Board believes that having fewer intensive care units would make the service more sustainable, improve safety and help meet quality standards.

1.33 Hywel Dda outlined three different options for how critical care could be delivered, which are set out in Table 1. Hospitals that are not proposed to have an intensive care unit (ICU) would instead have an enhanced care unit (ECU) to treat patients with less critical conditions, and stabilise patients with higher levels of need, before transferring them to the Glangwili intensive care unit. Transfers between hospitals could be done via the Adult Critical Care Transfer Service (ACCTS).

Table 1: Consultation options – critical care

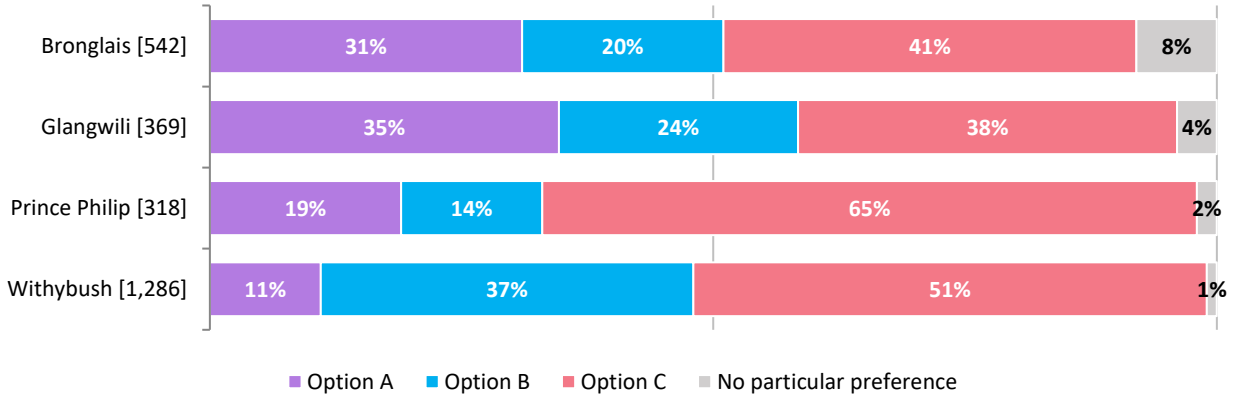
	Bronglais	Glangwili	Prince Philip	Withybush
Current service	Intensive care unit	Intensive care unit	Intensive care unit (with transfer of sickest patients)	Intensive care unit
Option A	Intensive care unit	Intensive care unit and enhanced care unit	Enhanced care unit	Enhanced care unit
Option B	Intensive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

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

Consultation questionnaire feedback

1.34 Overall, around half (51%) of consultation questionnaire respondents felt that Option C best meets the Clinical Services Plan objectives, with around a quarter (27%) favouring Option B[4]. However, views differed by respondents nearest hospital as shown below.

Figure 1[5]: Which option for critical care services do you believe best meets the Clinical Services Plan objectives, considering patient care, accessibility, and outcomes? By nearest hospital[6] (individual respondents only, where postcodes were provided)



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

Further feedback on the critical care options

Addressing current challenges

1.35 While critical care staff were proud of their commitment to patient care, some (especially at Prince Philip) described the present configuration of critical care services as increasingly unsustainable, driven largely by consultant workforce shortages, high sickness absence, poor communication across sites, and challenges maintaining consistent specialist oversight. These pressures were said to have resulted in a sense of service erosion; and contributed to reduced morale, de-skilling, and difficulties retaining experienced staff.

1.36 Clinical partners, including the Acute Physical Deterioration Implementation Network and Welsh Critical Care Network, also recognised the Health Board's challenges, and acknowledged the advantages of bringing critical care services together onto fewer sites to improve patient outcomes.

1.37 Across the public events and meetings, and on social media, consultees recognised the importance of maintaining high-quality critical care provision; and there was understanding of the Health Board's challenges in offering this. There was also widespread concern about the proposed changes however,

[4] 62 respondents selected the 'don't know' option. This is omitted for presentational convenience (standard industry practice) because it does not affect the order of preference of the available clinical options.
[5] Where percentages do not add up to 100%, this is due to rounding.
[6] Nearest hospital based on travel time. 1,398 responses without postcode are not displayed, but are included in the overall results described in commentary prior to the chart.

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

Views on the critical care options

Option A

1.38 For those who preferred it, Option A was seen as the easiest to resource; and to offer opportunities for stronger specialist staffing, improved standards of care, and better patient outcomes across Hywel Dda. In this context, many consultees said they would be happy to receive critical care at a hospital further from home if this care was of the best possible quality.

1.39 Those in opposition believed Option A would reduce local access to critical care services (a particular concern for Pembrokeshire-based participants) and increase patient transfers. In relation to the latter, key worries were around the risks of transferring critically ill patients over long distances across poor road networks, and the emotional and financial burden on families having to travel further to visit loved ones.

1.40 Strong concerns were raised by Withybush staff, who argued that changing the hospital's ICU to an ECU would have significant implications for patient safety, service sustainability and staff morale. A particular concern was that it would be difficult to maintain an emergency department without an ICU at Withybush. This was also echoed at the public and patient drop-in events and meetings: attendees feared that losing ICU functions could make Withybush a less attractive place to work and accelerate workforce decline.

1.41 There was also widespread concern about the capacity and deliverability of centralising intensive care for the south of Hywel Dda at Glangwili, the ICU at which is already operating at full capacity and would struggle to safely accommodate additional patients.

Option B

1.42 Less feedback was given specifically on Option B. It was often viewed as a compromise option, balancing accessibility and feasibility and reducing patient transfer needs. However, its success was still seen to be heavily dependent on solving the Health Board's workforce challenges.

1.43 Some also said that current critical care facilities at Withybush are outdated and would need investment for Option B (and Option C) to be fully realised. On the other hand, a few questionnaire respondents felt that Withybush ICU staff skills and morale would be improved if the decline in other onsite surgery was reversed.

Option C

1.44 Option C was seen by some members of the public and a few staff members as the most equitable and responsive to local need, the least disruptive, and the option that would require the fewest patient transfers. It was also said to be the option that offers most resilience in view of major incidents and any future pandemics.

1.45 However, many consultees across the different consultation methods questioned whether this option is deliverable or sustainable within the context of existing workforce and resource constraints. Indeed, the scale of the recruitment required - particularly for consultants - was often considered unrealistic. The Welsh Critical Care Network particularly stressed that patient safety risks associated with the current staffing deficits require clearer communication, noting that maintaining multiple ICUs without sufficient consultant presence may compromise the quality of care.

Key overarching issues: Prince Philip

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

Key overarching issues: travel and transfers

1.47 As noted above, across the different consultation methods, there was strong concern regarding the transfer of critically ill patients over long distances, particularly from Pembrokeshire and other rural areas. Participants highlighted the potential clinical risks of transfer and delayed intervention, particularly in the context of the current and future capacity of the Welsh Ambulance Service Trust (WAST).

1.48 More generally, while some members of the public accepted the principle of travelling further for specialist care, many felt that geography, seasonal tourism pressures, and rural transport networks mean that centralised critical care may reduce timely access to life-saving treatment.

Key overarching issues: impact on wider hospital services

1.49 Consultees across several activities emphasised that changes to critical care provision are closely linked to and could have consequences for the viability of other services, including stroke care, emergency general surgery, high-risk surgery, medicine, anaesthesia, endoscopy, renal services, haematology, oncology, medical assessment units, post-anaesthetic care units (PACUs), and elective surgery.

1.50 Concerns were also raised that reducing on-site critical care capability could destabilise emergency departments and acute medical pathways, limiting hospitals' ability to manage serious clinical deterioration; and that once ICU services are removed from local hospitals, it becomes far more likely that surgical services will follow.

1.51 Specifically, there was scepticism around the feasibility of providing a stroke unit at Prince Philip in the absence of a co-located ICU; and examples of occasionally (e.g., during winter pressures) needing to transfer patients further away to hospitals in Swansea or Cardiff. In this respect, the West Wales Renal Service and consultant physicians at Prince Philip were concerned that unless change is properly managed and resourced, removing ICU services from some Hywel Dda sites could result in greater pressure on services at Morriston Hospital.

1.52 Hywel Dda Clinical Health Psychology and Critical Care Clinical Psychology departments also highlighted the importance of considering the psychological care of Hywel Dda critical care staff and patients in any future changes.

Alternative suggestions and mitigations

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

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

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

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

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

Dermatology

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

1.57 The service faces several ongoing challenges, including:

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

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

Table 2: Consultation options – dermatology

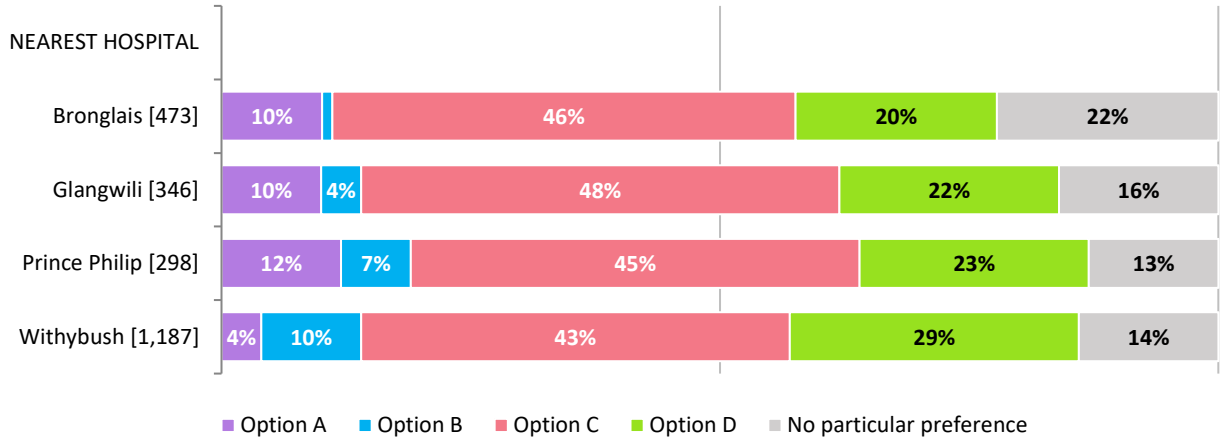
	Bronglais	Glangwili	Prince Philip	Withybush	Community sites
Current service	No service	Outpatient clinic once per week Medical photography Phototherapy not running currently	Outpatient clinics and minor operations	No service currently due to Reinforced Autoclaved Aerated Concrete (RAAC) issues	Some nurse-led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

Consultation questionnaire feedback

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

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

Figure 2[8]: Which option for dermatology services do you believe best meets the Clinical Services Plan objectives, considering patient care, accessibility, and outcomes? By nearest hospital[9] (individual respondents only, where postcodes were provided)



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

Further feedback on the dermatology options

Addressing current challenges

1.60 Feedback highlighted a strong and consistent view that dermatology services across the Health Board require significant improvement, with several clear themes emerging around access, sustainability, and the need for a more coordinated and resilient service model.

1.61 Access to timely dermatology care was the dominant concern across all consultation methods. Service users described waiting times of 18 months or more, as well as cancelled appointments, fragmented care pathways, inconsistent communication, and an over-reliance on visiting consultants and locum staff. The loss of local services like phototherapy[10] and the need to travel long distances for treatment were also recurring frustrations, particularly for older people, people with chronic illness, and those requiring frequent appointments.

1.62 Most public consultees desired more evenly geographically distributed services and better transport to dermatology hubs; though there was some agreement that strengthening and consolidating teams might improve consistency and access to expertise, even if it means more travel.

1.63 Staff highlighted significant workforce sustainability challenges, citing high workloads, clinical isolation, limited consultant and peer support, and the absence of a substantive clinical lead to guide junior clinicians. They thus welcomed elements of consolidation - particularly strengthening services at Prince Philip - to improve clinical consistency and support (though there was also some concern around how staff at Glangwili would treat inpatients with dermatology concerns if services were to be removed from the site). However, the need to underpin any new service model with clear pathways, workforce planning, robust communication between primary and secondary care, and strong clinical leadership was stressed.

[8] Where percentages do not add up to 100%, this is due to rounding.
[9] Nearest hospital based on travel time. 912 responses without postcode are not displayed, but are included in the overall results described in commentary prior to the chart.
[10] Treatment that uses artificial ultraviolet light to treat skin conditions like psoriasis and eczema.

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

Views on the dermatology options

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

Options A and B

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

Option C

1.67 Resident workshop participants and many questionnaire respondents expressed a strong preference for Option C, valuing the coverage across all three counties, improved access, and inclusion of nurse-led paediatric services (the latter would also apply to Options A and D). However, they also questioned the feasibility of GPs undertaking minor dermatology procedures given existing workload pressures and requested greater clarity on training, funding and delivery arrangements. Although they did not directly express support for or opposition to Option C, feedback around nurse-led and GP provision was largely echoed by other consultees.

1.68 More specifically, some staff were sceptical about the feasibility of providing nurse-led paediatric clinics at Cross Hands Health Centre under Option C (and D), as there is no formal agreement of funding or scope for dermatology at this location currently.

Option D

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

Key overarching issues: travel and access

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

Alternative suggestions and mitigations

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

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

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

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

» consider the viability of dermatology being delivered in Hywel Dda and explore options to support out of area treatment in, for example, Swansea and Shrewsbury.

» provide a rotational service, with consultants or nurses travelling between hospitals, GP surgeries, health centres, and other sites to provide clinics on a weekly or fortnightly basis.

» consultant-led clinics at community sites (in Amman Valley and Llandovery Hospitals for example), rather than fixed in any particular general hospital, to save patients travelling large distances.

» create an Integrated Care Centre in Aberystwyth for minor operations (including dermatology).

» include the GP provision element in all four options due to the likeliness of it being implemented.

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

Emergency general surgery

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

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

Table 3: Consultation options – emergency general surgery

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

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

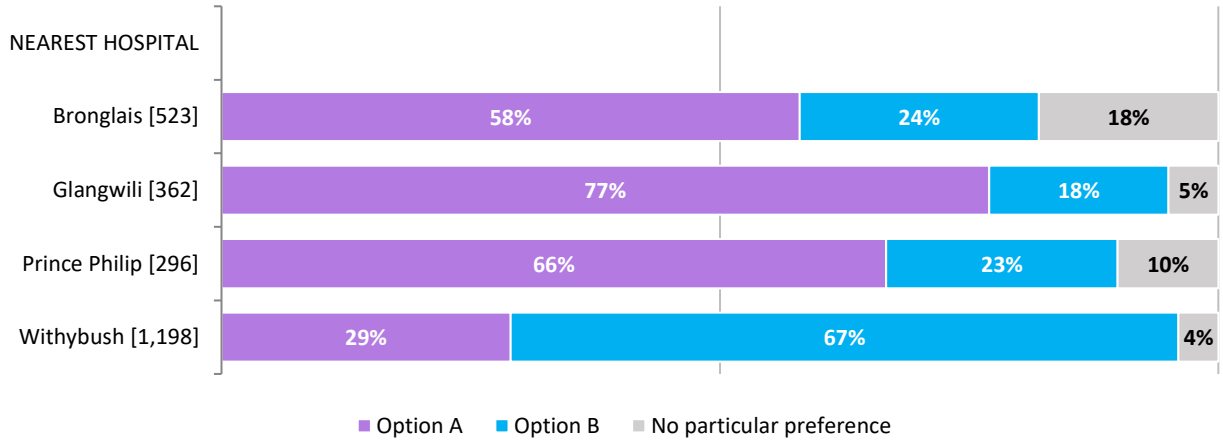
	Bronglais	Glangwili	Prince Philip	Withybush
Option B	Full emergency general surgery, including surgical operations	Emergency general surgery operations taking place on alternate weeks Strengthen Surgical Same Day Emergency Care	No emergency general surgery service	Emergency general surgery operations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

Consultation questionnaire

1.76 Overall, views in the consultation questionnaire were divided as to whether Option A or Option B would best meet the Clinical Services Plan objectives: just under half (47%) of respondents preferred Option A, a similar number (46%) favoured Option B, and around 8% expressed no particular preference[12, 13].

1.77 Views varied by nearest hospital: respondents nearest Withybush were the only group who strongly favoured Option B; respondents from all other areas favoured Option A, as shown below.

Figure 3[14]: Which option for emergency general surgery services do you believe best meets the Clinical Services Plan objectives, considering patient care, accessibility, and outcomes? By nearest hospital[15] (individual respondents only, where postcodes were provided)



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

Further feedback on the emergency general surgery options

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

[12] 159 respondents selected the 'don't know' option. This is omitted for presentational convenience (standard industry practice) because it does not affect the order of preference of the available clinical options.
[13] In this and all other instances where percentages do not add up to 100%, this is due to rounding.
[14] Where percentages do not add up to 100%, this is due to rounding.
[15] Nearest hospital based on travel time. 844 responses without postcode are not displayed, but are included in the overall results described in commentary prior to the chart.

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

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

Option A

1.80 In many staff discussions and across the three residents' workshops, Option A was the preferred model. It was seen as the more viable, less confusing, and clinically sustainable approach. Concentrating emergency general surgery on fewer sites was viewed by many as offering clearer pathways, better potential for consultant recruitment, and improved patient outcomes due to strengthened specialist availability.

1.81 There were, however, concerns about:

- infrastructure limitations at Glangwili – many consultees questioned whether Glangwili has the physical capacity, theatre space, and diagnostic resilience to support a centralised emergency surgery model; and some also noted the building's general condition as a concern.
- staff de-skilling at Withybush, and the viability of interdependent services such as anaesthetics, critical care, acute medicine, and A&E if emergency general surgery were no longer to be undertaken there.

Option B

1.82 Some questionnaire respondents who stated a preference for Option B argued that if emergency general surgery is removed from Withybush entirely, the need to travel further in emergencies could pose additional risks to patient safety.

1.83 On the other hand, workforce issues were a prominent concern, especially among staff, with current surgical rotas considered fragile and recruitment challenges persistent. Considering these concerns, Option B was frequently viewed as unworkable as it would be unlikely to fix underlying workforce pressures. It was also widely considered to be confusing for patients and teams, disruptive to continuity of care and decision-making, and more costly in view of the need to maintain two sites.

1.84 If Option B were to be adopted, staff at Withybush identified wide-ranging infrastructure needs - including diagnostics, ward space, sterile services, laboratories, and equipment (including X-ray) - necessary for safe and effective delivery of emergency general surgery at the hospital.

Key general issues: travel and transfers

1.85 Concerns about inter-hospital transfers were central to consultee feedback on emergency general surgery. Consultees across all activities stressed that the region's geography, limited ambulance/patient transport availability, and transfer delays could pose unacceptable risks if emergency surgery becomes further centralised. Existing transfers between Withybush and Glangwili were described by staff as slow, complex, understaffed, and sometimes unsafe, with reports of patients waiting long periods for appropriate treatment.

1.86 Many consultees of all types expressed strong doubt that either option could operate safely without substantial improvements in transfer processes, capacity, and staffing. There was also recognition that long-distance transfers place significant emotional and practical burdens on families, particularly where travel options are limited.

Alternative suggestions and mitigations

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

- » adequately resourced inter-hospital transfer services that can facilitate same-day transfer of all urgent cases.
- » daily senior surgical review on all sites (including non-operating sites) to support assessment, stabilisation, and early clinical decision-making to ensure only necessary transfers happen.
- » prompt post-surgical repatriation to Withybush and regular post-surgical specialist review.
- » provide clear commitments on infrastructure investment - including diagnostics, beds, theatres, and staffing - at the affected hospitals.

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

- » maintain on-site emergency surgical capability at all acute hospitals where possible.
- » either full emergency general surgery, or potentially Surgical Same Day Emergency Care (SDEC) , at Prince Philip.
- » explore rotational consultant models (rather than rotating the full emergency service).
- » relocate specialist roles rather than whole teams, for example basing endoscopists at Withybush to maintain local expertise.
- » increase elective and day-case surgical throughput at Withybush, drawing on underused facilities (e.g., Ward 9 and several theatres) for procedures such as hernia, gallbladder, gynaecological, and colorectal surgery.

use the former Preseli Theatre in Withybush as a Surgical Same Day Emergency Care (SDEC) centre.

- » keeping emergency general surgery services available all the time at Withybush, and removing or reducing services at Glangwili instead.
- » a main hub at Glangwili for complex cases but with same day surgery/less complex cases remaining at each local hospital.
- » consolidating on just one single site for all surgery.

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

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

Endoscopy

1.90 Endoscopy undertakes a procedure to look inside the body, examining hollow organs or cavities in patients over 16. Currently, endoscopy services are provided at Bronglais, Glangwili, Prince Philip, and Withybush.

1.91 The main issue affecting the Health Board's endoscopy service is increasing demand and difficulties in hiring enough endoscopy staff to deliver the service across multiple sites. If it does not increase activity, waiting lists for patients will get longer.

1.92 Hywel Dda outlined three different options for how endoscopy services could be delivered. In all proposed options, some endoscopy procedures would continue to be delivered across the four main hospital sites. The options consider increasing activity in different ways, described in Table 4.

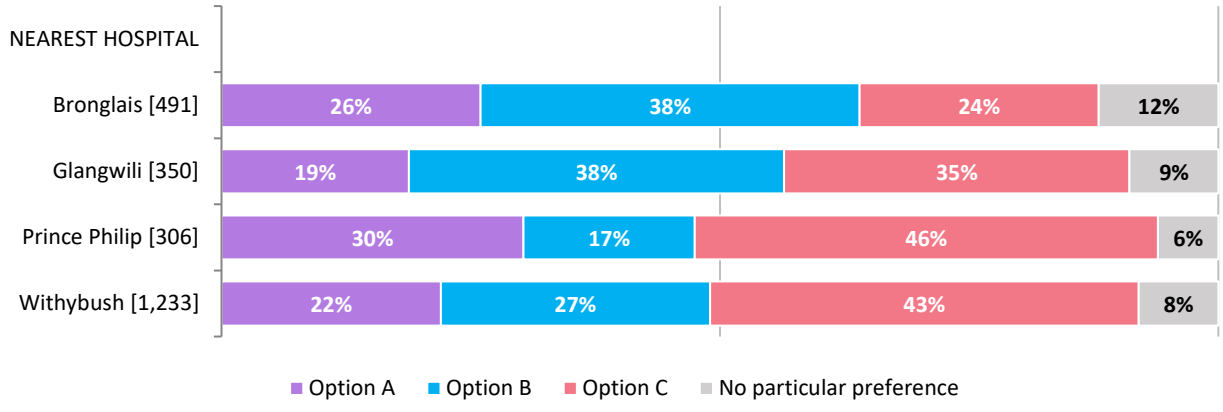
Table 4: Consultation options – endoscopy

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

Consultation questionnaire feedback

1.93 Overall, around two-fifths (39%) of consultation questionnaire respondents supported Option C, with just under a third (29%) supporting Option B[16]. However, preferences varied by nearest hospital: more respondents nearest Bronglais and Glangwili supported Option B (38% in both cases).

Figure 4[17]: Which option for endoscopy services do you believe best meets the Clinical Services Plan objectives, considering patient care, accessibility, and outcomes? By nearest hospital[18] (individual respondents only, where postcodes were provided)



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

[16] 134 respondents selected the 'don't know' option. This is omitted for presentational convenience (standard industry practice) because it does not affect the order of preference of the available clinical options.
[17] Where percentages do not add up to 100%, this is due to rounding.
[18] Nearest hospital based on travel time. 754 responses without postcode are not displayed, but are included in the overall results described in commentary prior to the chart.

Further feedback on the endoscopy options

Addressing current challenges

1.94 Across all consultee groups, concerns were raised around current waiting list lengths, including for urgent cancer-related procedures. The objective to meaningfully increase activity was widely welcomed, as were proposals that would in future lead to better, more integrated diagnostic services to improve co-ordination, continuity, and overall patient experience.

1.95 Preferences differed as to whether the improvements should be achieved by increased capacity during the day, extended opening hours, or centralising bowel screening; and many consultees asked for clearer explanations of what each option means for where services would be located, staffing capacity, transport arrangements, and impact on waiting times.

Views on the endoscopy options

Options A and C

1.96 There was considerable support for bringing respiratory and urology endoscopy procedures together (Options A and C). Although, as with other services, travel distance and times emerged as concerns in relation to deterring attendance or placing unfair burdens on patients, particularly those who are older or less mobile.

1.97 Those who supported Option A (an additional procedure room at Prince Philip) suggested that increasing clinical sessions during the day is preferable to extended hours, because of the lack of evening transport availability. However, others viewed the addition of a single procedure room as providing insufficient capacity to address current pressures and demand.

1.98 Views on extended hours and weekend provision at Prince Philip (Option C) were mixed. Some consultees saw benefits in increased flexibility, valuing appointments outside standard working hours; while others raised concerns about additional pressure on current staff and the challenges of recruiting to an expanded rota.

1.99 Supporters of Options A and C often stated the importance of maintaining gastro-intestinal/bowel screening at all hospital sites, to minimise travelling and maximise take-up of this important service.

Option B

1.100 Those who supported Option B saw a dedicated bowel screening hub as a way to improve capacity, release space in hospitals for other types of screening, enhance consistency, and support the recruitment of specialist staff. Some consultees also favoured this option because it would retain respiratory endoscopy at Glangwili.

1.101 On the other hand, concerns were also expressed around the location, feasibility, cost, and scale of the proposed community bowel screening centre. If it is established, consultees said it should be centrally located, with consideration for areas in which older residents are concentrated, and those with manageable transport links.

1.102 Staff, members of the public, and partner organisations highlighted that longer journeys - particularly for bowel screening, where significant preparation is required and there are potential issues around patient dignity - could reduce uptake and exacerbate inequalities. Use of mobile screening units was thus widely proposed as a means to protect access for remote communities.

Key overarching issues: impact on emergency cases

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

Alternative suggestions and mitigations

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

- invest in mobile bowel screening units to reduce travel burdens for rural populations.
- workforce development, including expanded nurse endoscopist training to support extended hours or increased activity.
- ensure hospital transport services times are altered to reflect any extended hours.
- clinical safety mitigations, such as ensuring rapid transfer pathways for high-risk patients.

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

- a modified version of Option C, with urology and respiratory services consolidated at Glangwili instead of Prince Philip.
- retain some respiratory and urology endoscopy capacity at Glangwili to maintain safe multidisciplinary management of complex patients (especially those needing interventional radiology).
- consideration of Bronglais as a potential hub, recognising its established JAG-accredited unit and positive patient feedback.
- hybrid models, such as combining extended hours (Option C) with additional physical capacity (Option A).
- ensure the bowel screening community site in Option B has a cancer focus.
- retain some endoscopy sessions at each acute hospital, maintaining local access and in particular supporting frail or complex patients.
- provide services, especially bowel screening, at other locations or settings including GP surgeries and community sites such as Llandovery, South Pembrokeshire and Tenby Hospitals and Cardigan ICC.
- if urology is consolidated on one site, urology endoscopy could follow, with other endoscopy expertise built around that.
- develop a lead lined room to allow the provision of Endoscopic Retrograde Cholangiopancreatography (ERCP)[19] at Withybush
- maintain services at Withybush to take advantage of the new fluoroscopy machine to offer ERCP) and potentially reduce the demand for MRI studies.

1.106 For further details, see the endoscopy sections in the individual consultation method chapters.

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

Ophthalmology

1.107 Ophthalmology is the treatment of eye diseases and injuries, eye injections and surgical procedures, for children, young people and adults. Currently, ophthalmology hospital services are provided from Bronglais, Glangwili, Prince Philip, and Withybush. In the community, outpatient clinics are provided at a number of locations (see Table 5).

1.108 Hywel Dda outlined three different options for how ophthalmology services could be delivered. In its options, the Health Board could bring together most services at either Glangwili or Prince Philip with the aim of reducing the time patients spend on waiting lists, helping with staff shortages, and making the service run better.

1.109 In all proposed options, Withybush would continue to provide some outpatient services; Amman Valley Hospital would be used for either day case for cataracts or eye injections only; Cardigan Integrated Care Centre and North Road Eye Clinic (Aberystwyth) would offer outpatient services; and no service would be provided from Aberaeron Integrated Care Centre. Regular eye injection services would be carried out at all sites providing outpatient services.

Table 5: Consultation options – ophthalmology

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

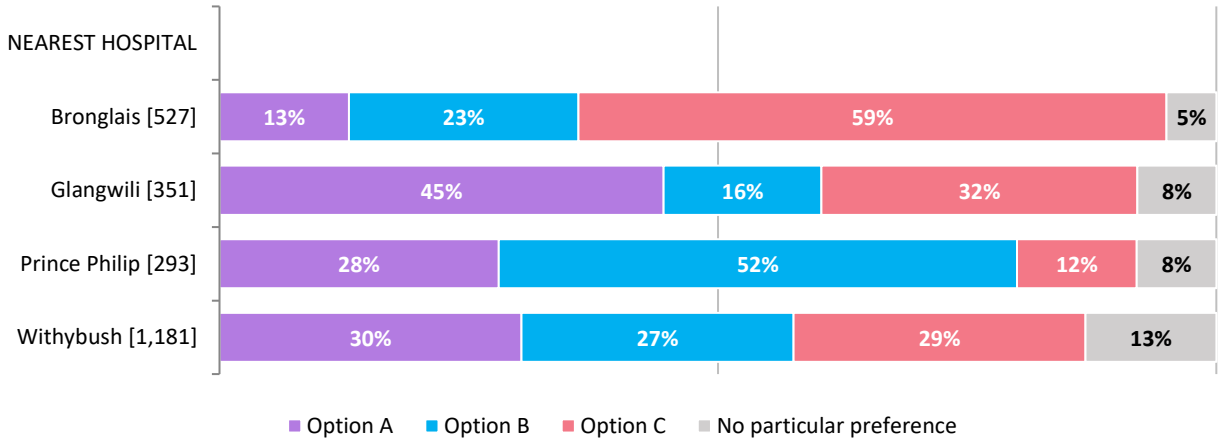
	Bronglais	Glangwili	Prince Philip	Withybush	Community sites
Option C	Day cases and inpatients	Main service including diagnostics, day cases, inpatients, outpatients, emergency eye care	No service	Diagnostics and outpatients	Amman Valley - diagnostics, outpatients (eye injections), but not day cases (cataracts)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

Consultation questionnaire feedback

1.110 Overall, around a third (34%) of questionnaire respondents preferred Option C, while just over a quarter favoured each of Options A (28%) and B (28%)[20].

1.111 However, views on the most appropriate option for ophthalmology services differed quite strongly based on respondents' nearest hospital, as shown below.

Figure 5[21]: Which option for ophthalmology services do you believe best meets the Clinical Services Plan objectives, considering patient care, accessibility, and outcomes? By nearest hospital[22] (individual respondents only, where postcodes were provided)



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

Further feedback on the ophthalmology options

Addressing current challenges

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

[20] 188 respondents selected the 'don't know' option. This is omitted for presentational convenience (standard industry practice) because it does not affect the order of preference of the available clinical options.
[21] Where percentages do not add up to 100%, this is due to rounding.
[22] Nearest hospital based on travel time. 639 responses without postcode are not displayed, but are included in the overall results described in commentary prior to the chart.

1.113 Staff shortages - including among consultants, orthoptists, optometrists and specialist nurses - were widely recognised as the root cause of these issues. Specifically, staff noted that recruitment and retention are particularly difficult in rural locations, and they broadly agreed that centralisation could strengthen the service, provided it is underpinned by realistic workforce planning and fit-for-purpose facilities.

1.114 Improving waiting times was the highest priority for service users and residents across the consultation methods, many of whom saw efficiencies from consolidating services as key to restoring performance. However, others were unconvinced that centralised models would deliver the improvements required without significant investment in staffing, transport, equipment, and administration; and many emphasised that routine care - such as eye injections - and follow-up must remain local.

Views on the ophthalmology options

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

Option A

1.116 Across the three residents' workshops, strong majorities expressed support for Option A. Participants believing that centralising specialist ophthalmology in this way would most effectively reduce waiting times, address staff shortages and deliver efficiencies.

1.117 By contrast, there was concern among questionnaire respondents, some resident workshop attendees, and many public and patient drop-in event/meeting attendees that Option A - which brings services together onto the fewest sites - would be most detrimental to patient accessibility, especially those living closest to Bronglais.

1.118 Questionnaire respondents favouring Option A felt this was the most logical option to make optimal use of staffing and resources.

Options B and C

1.119 Options B and C were preferred by minorities in the residents' workshops as they would provide more services across the Hywel Dda area; and Betsi Cadwaladr University Health Board expressed a preference for these configurations as they retain services at Bronglais, maintaining equity for northern populations.

1.120 However, staff and some clinical partners expressed concern about the appropriateness of locating complex and emergency ophthalmology at Prince Philip under Option B due to the absence of a 24/7 Emergency Department and limited critical care provision there. More specifically, the proposed concentration of emergency eye care at Prince Philip raised a few questions among public and patient drop-in event/meeting attendees about where paediatric ophthalmology would sit, given that children's services are in Glangwili.

1.121 There was also some concern that if the main service was consolidated in Prince Philip (as per Option B), this might be more challenging in travel and access terms for those in the north and west of the health board.

Key overarching issues: travel and transport

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

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

1.123 Long journey times, unreliable patient transport, poor road networks, and limited public transport were described as barriers that could lead to missed appointments, poorer outcomes and widening inequalities if not adequately mitigated.

1.124 Staff also reported significant transport challenges between Health Board sites where the services are offered, with widespread reliance on taxis to move clinicians between sites, high associated costs, and reluctance among some clinicians - particularly newly recruited international staff - to drive on rural road networks. Concerns were raised that such travel demands make recruitment and retention more difficult, and that proposals to centralise services without mitigation could worsen these issues.

Key general issues: hospital and community sites

1.125 Considering where ophthalmology services should be located in future, staff raised concerns about the condition, capacity and configuration of several community and acute sites. For example, it was said that:

- Aberaeron ICC struggles with a shortage of clinic rooms, making it hard to run extra sessions.
- some local eye clinics, like in Cardigan, have stopped because consultants no longer visit, and space is often fully booked.
- North Road Eye Clinic is no longer suitable, and its services could be moved back to an acute hospital site like Bronglais to make better use of space and improve follow-up care.
- Glangwili is poorly configured for ophthalmology.

1.126 Conversely, Withybush was seen by some staff as underused and potentially better suited for expansion; and Amman Valley Hospital was considered a preferred location for cataract services for patients, as it has easier parking than other sites.

Alternative suggestions and mitigations

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

- invest in digital systems to share scans and results with optometrists.
- strengthen community provision through, for example, expanded roles for community optometrists, mobile units for cataract or screening services, and upskilling nurses to deliver eye injections and other routine procedures.
- partnerships with private providers to clear cataract backlogs.
- better appointment management processes.
- better facilities at hospital sites to attract and keep staff (current buildings were said to lack basics like changing areas and staff kitchens).
- offer both day cases (cataracts) and outpatient services (eye injections) in Amman Valley Hospital, rather than one or the other.

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

- three regional sub-hubs (one per county) rather than one centralised site.

joint working with Betsi on shared treatment centres across mid and north Wales.

- offer cataracts at Cardigan ICC; and cataracts at Aberystwyth every three months.
- offer some services on an alternating basis between hospitals, with consultants travelling rather than patients.

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

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

Orthopaedics

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

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

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

Table 6: Consultation options – orthopaedic services

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

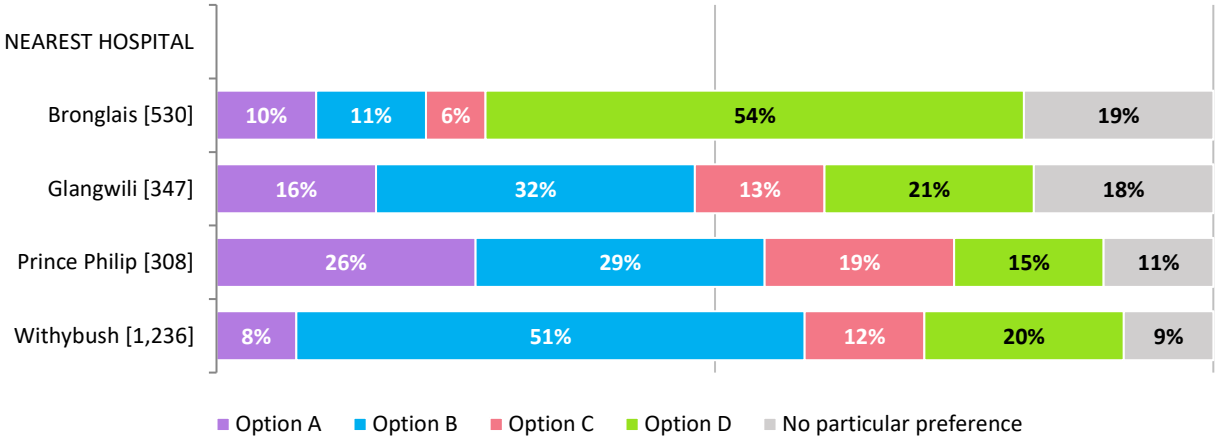
[23] Working in partnership with Swansea Bay University Health Board for their patients who may need to access care in Prince Philip, or for Hywel Dda patients who may need to access care in Neath Port Talbot for certain procedures.

Consultation questionnaire feedback

1.133 Overall, over a third (36%) of questionnaire respondents felt that Option B best meets the Clinical Services Plan objectives. More than a quarter (27%) thought Option D best meets the objectives, with smaller proportions selecting Options A and C[24].

1.134 Views varied by nearest hospital: respondents nearest Bronglais were the only group who strongly favoured Option D (54%); and respondents nearest Withybush were the group who most strongly favoured option B (51%), as shown below.

Figure 6: Which option for Orthopaedic services do you believe best meets the Clinical Services Plan objectives, considering patient care, accessibility, and outcomes? By nearest hospital[25] (individual respondents only, where postcodes were provided)



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

Further feedback on the orthopaedics options

Addressing current challenges

1.135 Across the different activities, although the quality of surgical care once accessed was praised, consultees consistently highlighted long waits for hip and knee surgery, sometimes lasting years, with significant impacts on patients' mobility, independence, and mental wellbeing. Members of the public and patients also frequently reported confusion and delays caused by lost paperwork, poor updates, and lack of clarity about next steps; and some service users described being placed in inappropriate wards post-surgery, reflecting staffing or bed pressures.

1.136 Considering this, there was some support among questionnaire respondents, public and patient drop-in event/meeting attendees and special interest groups for bringing services together if this would increase overall capacity, reduce waiting lists, improve administration and communication, and streamline pathways. The importance of combining specialist regional centres with accessible local services was frequently stressed though. While consultees acknowledged that patients may be prepared to travel for surgery, they emphasised that diagnostics, rehabilitation, and follow-up appointments must be delivered as close to home as possible.

[24] 131 respondents selected the 'don't know' option. This is omitted for presentational convenience (standard industry practice) because it does not affect the order of preference of the available clinical options.
[25] Nearest hospital based on travel time. 608 responses without postcode are not displayed, but are included in the overall results described in commentary prior to the chart.

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

Views on the orthopaedic options

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

Regional working (Options A, B, and D)

1.139 Options with regional working were preferred by many in the questionnaire, and some in the resident workshops, who felt that orthopaedic patients would be willing to travel for faster access to specialist care. In this context, regional working with Swansea Bay University Health Board was largely viewed positively across many consultation methods in potentially increasing capacity, reducing waiting times, allowing opportunities for integration with other services, and improving recruitment.

1.140 Conversely, a minority of consultees across the consultation methods feared that regional working could lead to increased competition for appointments, as the service would be catering to a larger population. It was also noted that it appears to place increased financial pressure on patients who are dependent on public transport, if they would need to travel further in future.

Options A and B

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

Option C

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

Option D

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

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

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

Key overarching issues: hospital-specific feedback

1.145 Some staff members and clinical partners expressed reservations about the suitability of concentrating inpatient orthopaedics at Prince Philip given its workforce shortages, outdated theatres, lack of dialysis, enhanced recovery, and critical care facilities, and limited ICU/HDU and anaesthetic capacity. In contrast, Withybush was described as having modern theatres, a dedicated elective ward, and underused capacity.

1.146 Similarly, in the questionnaire, a staff member urged consideration around the limitations of existing pathways and critical care provision between/at Neath Port Talbot Hospital and Prince Philip, and around the lack of an acute pain service at Bronglais.

Key overarching issues: workforce sustainability

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

Alternative suggestions and mitigations

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

- fund more surgeons and additional radiographers, and more radiography equipment.
- enable cross-boundary referrals, including to hospitals in England.
- partner with private providers to clear backlogs.
- pool staff resources and waiting lists across the region to reduce inequity of access.
- ringfence orthopaedic services to protect elective activity from seasonal pressures.
- patients checking in overnight to help predict surgical complications earlier and ensure earlier start times for surgery.

1.149 Consultees proposed other potential alternatives and suggestions, including the following.

- create a single dedicated orthopaedic ‘centre of excellence’ for Hywel Dda.
- create several dedicated orthopaedic hubs with protected elective beds to prevent cancellations and reduce infection risk.
- reinstate Ward 9 at Withybush as a dedicated elective orthopaedic unit.
- provide fracture clinics and orthopaedic services in the community, such as at Cardigan ICC.
- invest in same day joint surgery at the Prince Philip Day Surgery Unit for patients who meet the criteria.
- a hybrid of all four options (i.e., increased inpatients and day cases at Bronglais [Option D], extended hours at Withybush [Option B], additional beds and investment at Prince Philip [Option C], but as part of a regional working approach [Options A, B and D], and a

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

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

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

Radiology

1.151 Radiology uses imaging techniques (such as x-rays) to diagnose, treat and monitor diseases and injuries identified within the body. Diagnostic radiology services help make a diagnosis of a disease or condition. In Hywel Dda, emergency diagnostic radiology is provided 24/7; and planned diagnostic radiology is currently provided five days a week, during the daytime only. Interventional radiology services are more complex diagnostic procedures, including biopsies, and are provided for hospital inpatients or for planned day cases, currently five days a week during the daytime only.

1.152 Radiology has seen a large rise in activity across all sites. At the same time, staff shortages are stopping the Health Board from providing some services for longer hours. There are also difficulties maintaining up-to-date equipment across all sites. Bringing some radiology services together on fewer sites, which is proposed in all proposed options, would allow Hywel Dda to see more patients and would address some staff shortages, but there is potential impact on where staff work from. None of the options would fully address hiring challenges for interventional radiology roles.

1.153 Hywel Dda outlined four different options for how radiology services could be delivered. All options propose the removal of X-ray services at Llandovery and South Pembrokeshire Hospitals, so patients living closer to these hospitals would have further to travel for their x-rays than they do now. X-ray services would stay at Cardigan Integrated Care Centre and Tenby Hospital in all proposed options. In all proposed options for radiology, emergency diagnostic radiology would be maintained 24/7 at all four main hospitals.

Table 7: Consultation options – radiology

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

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

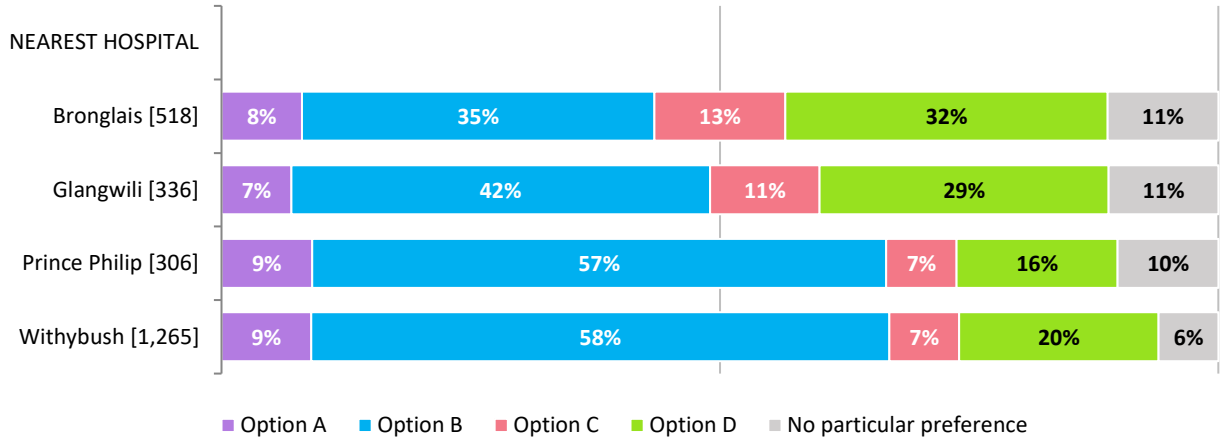
Consultation questionnaire feedback

1.154 Overall, around half (50%) of questionnaire respondents felt that Option B best meets the Clinical Services Plan objectives. Around a quarter (24%) thought Option D best meets the objectives, with much smaller proportions selecting Options A and C[26].

1.155 Views varied somewhat by nearest hospital: among residents who live nearest Bronglais similar proportions answered Option B (35%) as Option D (32%), as shown overleaf.

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

Figure 7[27]: Which option for radiology services do you believe best meets the Clinical Services Plan objectives, considering patient care, accessibility, and outcomes? By nearest hospital[28] (individual respondents only, where postcodes were provided)



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

Further feedback on the radiology options

Addressing current challenges

1.156 Consultees had mixed experiences of radiology. Several praised recent improvements in booking and access, while many others described fragmented systems, reporting and diagnosis delays, and poor communication about appointments, preparation, and results.

1.157 As a result, many consultees urged the Health Board to opt for the service configuration that would best expand diagnostic capacity and reduce waiting times; albeit concerns were frequently raised about whether the service - already perceived as understaffed - could realistically support extended hours or more centralised models.

Views on the radiology options

Option A

1.158 While some questionnaire respondents recognised that separating day case and inpatient services could lead to fewer cancellations and felt that this option might be more viable than some others, resident workshop participants typically disliked this option, as having inpatient and day case interventional radiology at different sites would lessen the impact on addressing the Health Board's staffing challenges.

1.159 Some staff also raised concerns about capacity shortfalls at Glangwili if more inpatient interventional radiology were to be centralised there, highlighting staffing and space limitations, bed pressures, and insufficient equipment that would be expensive to expand and upgrade. Others were more supportive however, especially given that the proposed change might mean upgraded facilities (a Gamma Camera for example). These concerns and benefits also apply to Option D.

[27] Where percentages do not add up to 100%, this is due to rounding.
[28] Nearest hospital based on travel time. 576 responses without postcode are not displayed, but are included in the overall results described in commentary prior to the chart.

Option B

1.160 As in the questionnaire, Option B received most support across the three resident workshops. Those who preferred Option B liked the cancer focus at Prince Philip and Withybush, and the extended seven-day planned diagnostic service (where the 'bottleneck' was said to be).

1.161 Consultees across several activities tended to support the principle of a regional diagnostic hub in terms of concentrating expertise and attracting staff, increasing capacity and reducing backlogs, and improving reporting and diagnosis times. However, many sought clarity on its location, remit, staffing model, and cost. Concerns were raised about duplication if diagnostics are retained at all hospitals, and about potential travel distances for patients, depending on where the hub is sited.

Option C

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

Option D

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

Key overarching issues: travel and transport

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

Key overarching issues: workforce pressures and sustainability

1.165 Staff members emphasised the central importance of radiology to other clinical services (emergency general surgery, critical care, and stroke for example) and the need to maintain safe, continuous diagnostic support. In this respect, they expressed concern about workforce shortages and a reliance on agency cover, the feasibility of seven-day services (echoed by some public and patient drop-in event/meeting attendees), and the consultation document's characterisation of radiographer preferences for 12-hour shifts. Most staff members also noted that the on-call model was also described as essential to recruitment and retention as it provides valuable flexibility and significant financial benefits to staff and remains an important part of workforce stability in Hywel Dda.

1.166 Staff from Cardigan ICC and Tenby Hospital noted capacity concerns at these community sites. At Cardigan, radiology was said to be extremely pressured, with one radiographer often covering high patient volumes and managing complex tasks without consistent support; and at Tenby Hospital, staff reported having to redirect patients to Withybush due to limited X-ray cover. The need for sufficient administration support to enable radiographers to focus on delivery was also stressed.

Key overarching issues: Llandovery Hospital

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

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

1.168 Consultees described a sense of 'managed decline' at the hospital and highlighted the investment of the community, particularly the League of Friends, in purchasing an X-ray machine. Staff and members of the public across the consultation methods argued that underuse reflects referral practices rather than lack of demand (i.e., patients are being sent to Carmarthen for X-ray when they could feasibly be being sent to Llandovery) and that if this were to be addressed, the viability of the service would drastically improve.

1.169 The ease of parking at Llandovery Hospital relative to Glangwili was also highlighted, and it was suggested that if the X-ray service was to be maintained and the Minor Injuries Unit reinstated at Llandovery Hospital, there might be scope to relieve pressure on other hospitals in the area.

1.170 As noted above, the Llandovery drop-in event was very well attended, which may in part have been driven by a misconception that the Health Board is proposing to close the facility in its entirety. However, regardless of these misconceptions, attendees supported the retention of services at Llandovery Hospital and maintaining the facility at its current location.

Alternative suggestions and mitigations

1.171 Consultees proposed several mitigations that they felt could strengthen any chosen model:

- introduce mobile or satellite radiography units for rural areas and peaks in demand.
- improve electronic sharing of scans across sites and with other health boards.
- expand use of AI-assisted reporting to reduce reporting times and support consistency.
- strengthen regional collaboration with Swansea Bay University Health Board to manage demand and share capacity.

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

- retain X-ray at Llandovery Hospital, including by ensuring GPs routinely refer there.
- variations on the proposed options, including:
  - adding weekend interventional services at Glangwili to Option B
  - hybrids of Options A and B, such as adding Option B's cancer focus to Option A
  - hybrids of Options B and C.
  - removing the diagnostic hub element from Option B.
- expand services at community hospitals, including fracture clinics and extended X-ray hours at Cardigan ICC.
- explore co-locating the regional hub with the proposed bowel screening centre, and/or consider co-locating endoscopy and ophthalmology services.
- rotate radiographers across sites to sustain smaller units.
- use the existing estate for any regional diagnostic hub rather than building a new facility.
- extend diagnostic hours to 12-hour days, seven days a week permanently at existing hospitals rather than creating a new hub.
- introduce 7-day services until waiting times are reduced, or the regional diagnostic hub completed, and only then move to 5-day services.
- maintain full services across two sites during weekdays, and the single regional hub only at weekends.

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

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

Stroke

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

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

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

Table 8: Consultation options – stroke

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

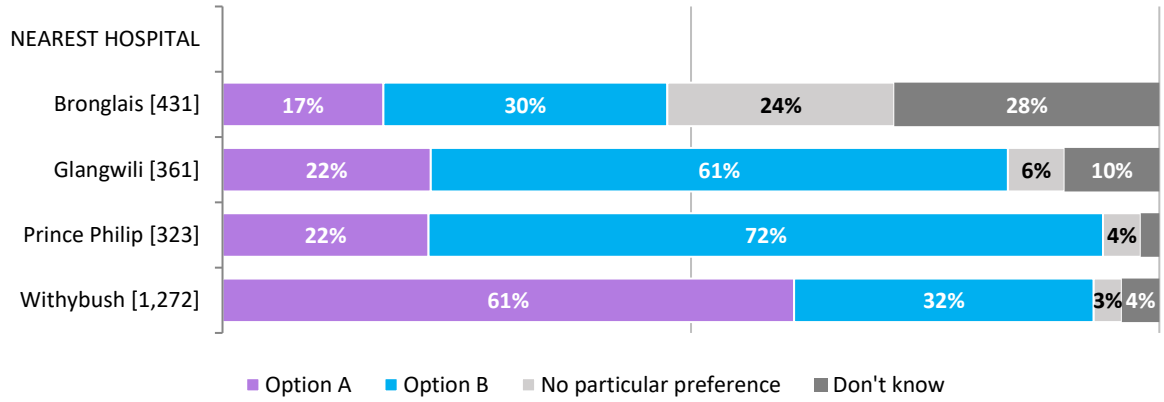
Consultation questionnaire feedback

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

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

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

Figure 8[29]: Which option for Stroke services do you believe best meets the Clinical Services Plan objectives, considering patient care, accessibility, and outcomes? By nearest hospital[30] (individual respondents only, where postcodes were provided)



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

Further feedback on the stroke options

Addressing current challenges

1.179 There was broad recognition that Hywel Dda faces significant workforce, capacity, and sustainability challenges in delivering safe, modern stroke care. Many accepted that the current system - spread across multiple small units - cannot consistently meet national standards for rapid assessment, 24/7 specialist input, or intensive rehabilitation.

1.180 Considering this, many consultees across the different activities recognised that centralised specialist stroke centres can deliver improved survival and recovery rates; and so supported the principle of centralisation, suggesting that they would prefer stroke services to be provided at an appropriate specialist centre, regardless of location, rather than at a non-specialist hospital closer to home. This support was on the proviso that the proposed stroke units are adequately resourced and complemented by strong community-based rehabilitation, and that patients are moved back to a hospital closer to home for the latter parts of their recovery. In this context, more and clearer information on proposed stroke pathways (including repatriation and rehabilitation) and workforce plans was desired by consultees.

1.181 Many others, though, felt that the proposed changes fail to account adequately for the realities of rural Wales - long travel distances, poor roads and public transport links, and an older demographic profile. These issues are discussed further below.

Views on the stroke options

Option A

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

[29] Where percentages do not add up to 100%, this is due to rounding.
[30] Nearest hospital based on travel time. 477 responses without postcode are not displayed, but are included in the overall results described in commentary prior to the chart.

1.183 Most of the support for Option A came from questionnaire respondents, though some members of the public and a minority of staff members across the other consultation methods also favoured this option. Key reasons for this support were that Option A has the potential to address staff shortages, raise standards, and provide longer specialist cover than under current arrangements. Pembrokeshire-based consultees (including Withybush staff and a sizeable number of questionnaire respondents) were also pleased to see the provision of 12-hour specialist cover at Withybush (which would also be the case under Option B).

1.184 A few staff members responding via the questionnaire queried whether 24/7 specialist care (as proposed under Option B) is strictly necessary, feeling that Option A may be the more 'balanced' proposal in offering reduced travel and fewer transfers.

1.185 Overall though, some viewed Option A as unaligned with modern stroke standards and unlikely to deliver consistent acute stroke care, particularly with respect to:

- the lack of 24-hour specialist stroke cover, which was widely viewed as unacceptable.
- the potential for fragmented care across sites and slower access to expert assessment.
- reduced equity for rural patients, who may face similar travel pressures as under Option B but without 24/7 specialist cover.

Option B

1.186 Outside of the questionnaire, during the residents' workshops where people explicitly compared the options, Option B tended to be better supported than Option A. The 24-hour specialist stroke service was widely regarded as essential and aligned with national best practice; and some consultees saw value in establishing a single high-volume centre of excellence with stronger recruitment potential and the potential for improved clinical outcomes.

1.187 However, many consultees in Ceredigion and Pembrokeshire opposed Option B. While they were not opposed to the prospect of a 24-hour stroke unit in principle, they viewed the proposed site selection as problematic, questioning the suitability of focusing it in Prince Philip both geographically (with Llanelli being in the extreme south east of the Health Board area, and very close to Morriston Hospital) and because it lacks an emergency department, has limited ICU capability, and has no dialysis service for stroke patients with renal needs. Some questionnaire staff queried whether complex stroke patients might therefore need to be treated at Glangwili rather than Prince Philip; and expressed concern this might negatively impact continuity of care and delay the start of the rehabilitation process.

1.188 On the other hand, the Prince Philip Multidisciplinary team supported the siting of a stroke unit at their hospital, citing strong staffing, infrastructure, and performance locally. Support for this model was also offered by Carmarthenshire Councillors and other Prince Philip staff, though the latter acknowledged a need for additional staffing uplift and resources, especially within therapies, if they are to take on greater responsibilities.

Key overarching issues: removing specialist stroke services from Bronglais

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

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

1.190 Consultees across all consultation methods warned that consolidation of services to the south would leave a major geographical gap in specialist stroke care, disadvantaging rural patients. It was frequently stressed that poor road and public transport infrastructure severely limits access from north to south of the Health Board area, with many consultees fearing that the longer journey to the next nearest stroke unit could negatively affect timely access to specialist treatment and recovery support.

1.191 Staff members and public and patient drop-in/meeting attendees also feared significant employee attrition if services moved south, not least as staff would prefer to work in a more specialist environment.

1.192 There was thus considerable support for developing Bronglais as a centre of excellence for stroke care in mid Wales which, it was said, would attract staff and strengthen local provision.

Key overarching issues: treat and transfer

1.193 The proposed treat and transfer model prompted many patient safety concerns, particularly in relation to the 'transfer' element. Many consultees felt that the model lacks evidence for rural settings with poor travel networks and would require substantial additional investment in patient transport, for there was widespread lack of confidence in ambulance and patient transport service capacity to manage timely transfers which, it was felt, may compromise treatment speed and quality, and worsen patient outcomes.

1.194 Other key worries were around the challenges of long journeys for often complex and unstable patients (due to increased risk of bleeding/haemorrhage for example), the availability of trained staff escorts to monitor patients, and loss of family support. It was frequently stressed that recovery from stroke is deeply dependent on family involvement and emotional support; and many feared that increased travel as a result of centralisation would compromise this.

1.195 Some staff responding via the questionnaire felt the model might make it effectively impossible to comply consistently with Sentinel Stroke National Audit Programme measures, or to carry out certain assessments (e.g., for dysphagia) in a timely manner.

1.196 With either option, consultees strongly urged Hywel Dda to better reassure its population around the 'treat and transfer' aspect of its proposals; especially that emergency stroke treatment will remain available at their local hospital. Indeed, many public and patient drop-in event/meeting attendees and written submissions were unclear about the model and were of the belief that emergency stroke care would no longer be available locally.

Key overarching issues: rehabilitation pathways

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

Alternative suggestions and mitigations

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

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

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

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

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

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

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

Urology

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

Table 9: Consultation options – urology

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

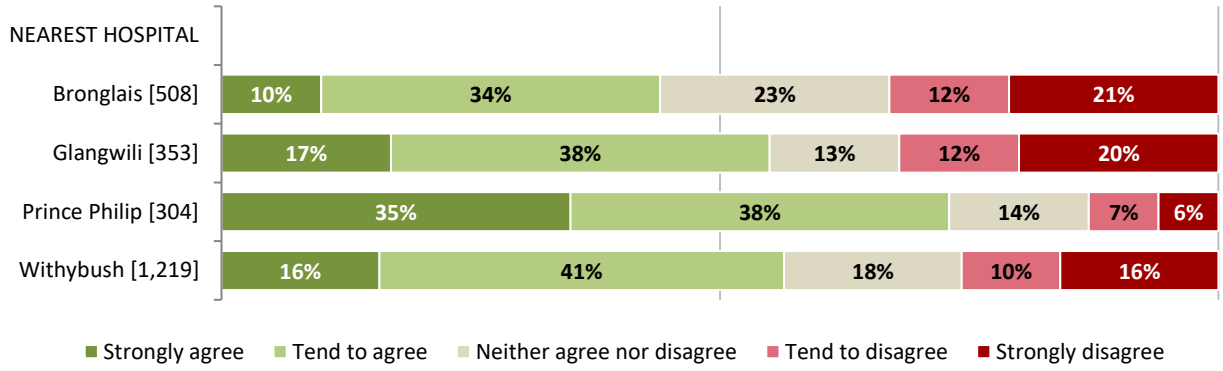
Consultation questionnaire feedback

1.203 Overall, more than half (55%) of respondents agreed with the proposal for urology, although just over a quarter (28%) disagreed[31].

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

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

Figure 9[32]: To what extent do you agree or disagree with the proposal for urology services? By nearest hospital[33] (individual respondents only, where postcodes were provided)



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

Further feedback on the urology option

Addressing current challenges

1.205 There was widespread recognition that the Health Board's current urology service is fragmented, fragile, and difficult to navigate. Consultees consistently highlighted disjointed care pathways, with appointments, tests, and consultations spread across multiple sites, inconsistent communication between relevant teams, long waiting times, and frequent cancellations, and inconsistent consultant presence, causing delays and uncertainty for patients (including those on urgent suspected cancer pathways).

1.206 Other issues raised by consultees were around urology nurse specialist shortages, community capacity constraints (e.g., catheter care), underfunded outpatient and support services, high turnover of staff, a lack of dedicated clinical space, insufficient integrated multidisciplinary support; and an over-reliance on telephone consultations which, though convenient for some, were considered unsatisfactory for complex or sensitive discussions.

1.207 Despite these challenges, many service users praised the professionalism and compassion of urology staff, emphasising that the main problems relate to system design and logistics, rather than clinical quality.

Views on the urology option

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

[32] Where percentages do not add up to 100%, this is due to rounding.
[33] Nearest hospital based on travel time. 504 responses without postcode are not displayed, but are included in the overall results described in commentary prior to the chart.

1.209 It was often mentioned that creating a urology 'centre of excellence' at Prince Philip makes sense, not only because there is already an existing urology service there, but also because it aligns with the endoscopy service (which would remain at Prince Philip under all proposed options for endoscopy and may be expanded).

1.210 Despite broad acceptance, concerns were raised, mainly around travel distances and accessibility. Consultees in rural areas - especially in Ceredigion and northwards toward Gwynedd – suggested that the model may place disproportionate time and cost burdens on older, frail, and low-income patients; and consolidating in a hospital so far to the East was seen as potentially widening geographic health inequalities and reducing timely access to cancer diagnostics. The 'one-stop-shop' model was also viewed by a minority as potentially overwhelming or impractical for older or multimorbid patients.

1.211 More specifically, the West Wales Renal Service asked how radiology, endoscopy, renal services, and emergency care would align with urology if key components were to be located on different sites. They were concerned that this fragmentation would result in repeated transfers (which would require improvements to ambulance and other patient transfer services) and would likely increase referrals to Morriston, *"where all services are in one place."*

Alternative suggestions and mitigations

1.212 Consultees proposed several mitigations that could strengthen any chosen model.

- retain some outpatient and follow-up clinics locally, especially for catheter care, minor procedures, and routine reviews.
- ensure closer integration with radiology and renal services to avoid unsafe inter-hospital transfers.
- strengthen urology nurse specialist teams, enabling triage and community-based management.
- provide dedicated urology wards or spaces.
- introduce a shuttle bus between hospital sites.
- introduce a reimbursement scheme that does not require patients to pay costs upfront or allows them to claim for transport costs subsequently.
- explore tele-communications for routine follow up appointments to save unnecessary travel.
- co-ordinated appointments on the same day, to ensure smooth running and minimise impact and stress on patients.
- ensure changes (and the reasons behind them) are well communicated to the public, and that public health campaigns are used to highlight various urological conditions.

1.213 Consultees proposed other potential alternatives and suggestions, including the following.

- centralise services at Glangwili, to benefit from co-location with emergency general surgery and multidisciplinary support for complex patients.
- maintain full urology capability at Bronglais, with shared services elsewhere for southern patients.
- provide full urology services at Withybush as well, or consolidate there instead.
- provide a bespoke urology unit for diagnostics and treatment.
- a rotational consultant model.

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

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

Future roles of the main hospital sites

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

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

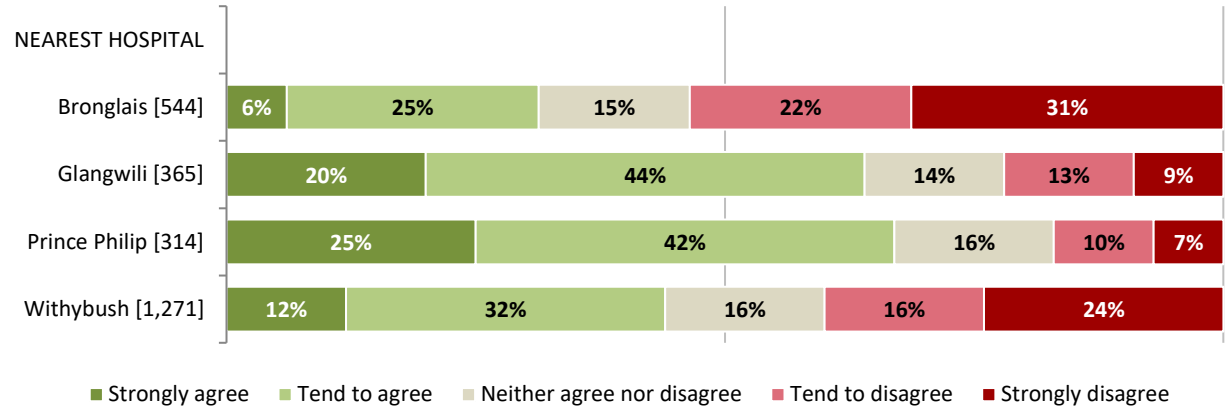
Consultation questionnaire feedback

1.216 Overall, nearly half (47%) of respondents agreed with the proposed roles for the hospital sites, though over a third (36%) disagreed[34].

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

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

Figure 10[35]: To what extent do you agree or disagree with the roles of the hospital sites as described above, to support making services safer and sustainable for the future? By nearest hospital[36] (individual respondents only, where postcodes were provided)



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

Further feedback on the future roles of the main hospital sites

Overall feedback

1.218 Where the proposals were supported, this tended to be on the basis that they should provide better clarity on each hospital's role; reduce waiting times by separating emergency and planned cases; enable more efficient throughput of cases; support regional working; and allow staff to work from single centres as part of bigger teams, thereby providing safer services, improving experience and morale, and aiding recruitment. Some consultees acknowledged there might be some 'trade off' in terms of patients and visitors needing to travel further; however, this was considered a reasonable compromise to ensure the best possible quality of care.

1.219 On the other hand, large numbers of consultees across all activities expressed strong concerns about the implications of additional travel. It was suggested that the proposed overall model is more suited to urban than rural areas, and that that it risks patient safety by requiring too many transfers over considerable distances. There were additional, widespread concerns about negative impacts for the Welsh Ambulance Service and patient transport; and worries around road infrastructure, public transport, and hospital car parking were prevalent. Frequently, this led respondents to advocate for as many services as possible to be available at their local hospital, or in all hospitals.

1.220 There was also some concern that focusing too much emergency and urgent care at one site might have unintended, negative impacts, such as: creating a single, overwhelmed emergency department; creating 'bottlenecks' in the system; and deskilling at the sites where there is less emphasis on acute care, which might leave them less able to care for very sick patients.

Views on the roles of specific hospitals

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

[35] Where percentages do not add up to 100%, this is due to rounding.
[36] Nearest hospital based on travel time. 498 responses without postcode are not displayed, but are included in the overall results described in commentary prior to the chart.

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

1.222 The proposals for Withybush were said by some to strike a suitable balance between local access and safety. Nonetheless, many highlighted issues with roads and public transport in Pembrokeshire, as well as an ageing population, heavy industry, and large numbers of holidaymakers. As with Bronglais, some respondents perceived that the hospital was effectively being 'downgraded.' It was also said that ongoing uncertainty over the future of the proposed new hospital (around St Clears or Whitland) justified more services being maintained at or returned to Withybush.

1.223 Questionnaire respondents living nearest Prince Philip frequently said that the size of Llanelli justifies the hospital having more rather than fewer services. While there was support for developing Prince Philip as a centre for planned care, a number of respondents also felt that acute and emergency services should also be reinstated at the site.

1.224 Other consultees felt that fewer services should be maintained at Prince Philip, due to it being less accessible from the north and west of the Health Board, and also relatively close to hospitals in Swansea. However, some expressed concerns that services in Swansea Bay were too busy to accommodate additional patients or accessing services in another health board might lead to disjointed care. This prompted some calls for greater clarity on what, if any, regional cross-border arrangements might be possible.

1.225 Glangwili was said to be the most centrally located of the Health Board's main hospitals, and therefore a good option for centralising services. In particular, various consultees felt it might be more appropriate to undertake certain planned procedures at Glangwili rather than Prince Philip due to its better intensive care provision, while others felt it might be a more appropriate choice to deliver acute stroke care. Nonetheless, many had concerns about accessing the site, with others highlighting issues such as ageing buildings, a lack of space to expand, and limited parking.

1.226 It was suggested by a few questionnaire respondents that the proposals do not go far enough and that a more radical approach, in which services are consolidated further (e.g. on one 'main' hospital site), might be more likely to obtain the required outcomes. Some other specific suggestions were as follows:

- Bronglais should be expanded and promoted as a rural health centre for mid-Wales, or a new hospital should be built in the Bow Street area.
- a new hospital should be built in south-West Wales e.g. in Whitland, St Clears, or Narberth.
- services should be reduced at Glangwili and strengthened at the other three sites.
- there should be two acute sites (Bronglais and Glangwili) and two planned care sites (Prince Philip and Withybush).
- all four hospitals should provide similar care, but with more specialisms centralised in Swansea.
- one or both of Glangwili and Prince Philip should close, with a 'super hospital' built in the Swansea area.
- Glangwili should be the 'main hospital' with the others as 'community hospitals.'

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

Key overarching issues: travel and transport

1.227 Travel and transport was the dominant theme across all consultation methods, both generally and in relation to the main hospitals. Various transport mitigations were suggested in the event of the proposed model of care being implemented, such as providing better community, patient, volunteer or other third-party transport; park and ride services; shuttle buses between hospitals; improved public transport; and ring-fencing funding for inter-hospital transfers and transport for outpatients.

1.228 In addition, many consultees felt that better use of AI, the internet, and telemedicine is essential and may mitigate some transport issues. A couple of questionnaire respondents expressed disappointment that more details around this had not been provided within the consultation materials.

1.229 Various other comments were made, covering a wide range of suggestions and mitigations, such as:

longer opening hours is generally a good approach, as is combining services so patients can 'get more' out of a single visit by having multiple investigations/examinations.

it would be sensible to maintain 24/7 teams of experienced general clinicians at each site who can assess patients prior to their onward journey by ambulance or car, which may allay some community fears around losing services.

there is a need to consider the use of mobile units, a system where staff rotate across different sites, and the creation of a 'pool' of staff for various specialisms, with staff able to travel quickly to whichever hospital needs them.

Key overarching issues: regional working

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

Key overarching issues: community hospitals and other local services[37]

1.231 Some consultees made suggestions around the role of community facilities in supporting the services provided at the four major hospitals. For example, it was said that:

» local hospitals and urgent care centres could play an enhanced role in offering minor procedures or outpatient appointments; or house rehabilitation facilities and residential care beds to reduce ‘bed blocking’ at the major sites.

» community-based early intervention and a greater emphasis on prevention might help relieve pressures on hospital services.

» a closer, more co-operative integrated system of care between hospitals, GPs, clinics, nurses, bed providers, care homes, local authorities etc., would be advantageous.

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

1.232 Some more specific suggestions were as follows:

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

Key overarching issues: the workforce

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

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

Cross-cutting consultation themes

Consultation questionnaire feedback

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

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

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

Feedback from other consultation methods

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

Travel, transport and accessibility

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

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

Workforce challenges

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

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

Condition and suitability of hospital sites and infrastructure

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

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

Interdependencies between services

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

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

1.245 Similarly, staff, councillors and some community groups raised concerns about the interdependencies between acute, specialist and diagnostic services. Many felt that reviewing clinical areas in isolation risked fragmented care, exacerbating service fragility, or destabilising core functions like General Internal Medicine. Several staff members emphasised the importance of understanding how changes to emergency care, stroke, critical care and surgical pathways would interact across sites.

1.246 Regional effects were also noted: neighbouring health boards and councils highlighted the potential impact of change on patient flows, workforce distribution and cross-border pathways, underscoring the need for co-ordinated planning across mid and west Wales.

Digital access and inclusion

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

Public confidence, communication and transparency

1.248 A recurring theme across engagement with members of the public, service users, councillors and on social media was low confidence in the consultation process and a perceived lack of transparency. A number expressed concern that decisions had already been made, that consultation materials were too complex, and that meaningful engagement was limited by inaccessible formats, time pressures and consultation fatigue.

1.249 There were calls for clearer communication of clinical reasoning, evidence, modelling and cost implications; plain-language updates; and stronger assurance that feedback will shape final decisions. There was also appetite for greater honesty about the constraints facing the Health Board and the trade-offs required to deliver sustainable services.

Local versus centralised care

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

Staff morale

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

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

Views on the consultation process

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

Alternative suggestions and mitigations

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

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

Considering equalities and human rights

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

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

Older people

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

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

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

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

Disabled people and those with cognitive or mental health conditions

1.259 Disabled people were frequently identified as at risk of disproportionate impact, with around a quarter of relevant questionnaire respondents and many consultees across the other consultation methods highlighting this group. Feedback highlighted that many disabled individuals already experience difficulty accessing healthcare and rely on multiple clinical services. Increasing the distance between patients and providers was considered likely to exacerbate these existing challenges.

1.260 Consultees representing people with cognitive impairments or mental health conditions raised particular concerns. It was said that those living with dementia may experience confusion or anxiety when travelling to unfamiliar or distant sites, and that their carers could face greater burden through the need for more frequent and longer journeys. Mental health staff from Glangwili also emphasised the potential disruption to continuity of care for service users with mental health conditions. A small number of respondents further noted potential impacts on people who are neurodiverse.

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

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

Rural and geographically remote communities

1.262 A strong theme across the consultation was the perceived geographic inequality between parts of the region, particularly between Pembrokeshire and Carmarthenshire. Many members of the public described a long-term shift of services eastward, with Withybush perceived as losing capability while Glangwili benefits from investment. It was argued that this imbalance risks disadvantaging remote or rural communities whose needs may not be fully reflected in decision-making.

1.263 Bronglais service users, including those in parts of Powys and south Gwynedd, were also highlighted as potentially disproportionately affected due to significant distances to alternative hospitals. Patients and staff warned that long, unfamiliar or complex journeys - particularly in areas with limited transport options - could be unsafe or impractical for some residents.

Carers, families, and support networks

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

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

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

Parents and pregnant women

1.266 Around a tenth of questionnaire respondents and some consultees across the other consultation methods identified people with children as likely to be affected. It was argued that it is less reasonable to expect families to undertake long journeys, particularly when managing childcare responsibilities or attending appointments with young children.

1.267 A few consultees also raised concerns about pregnant women, who may face additional stress or risk when travelling further for maternity-related care.

Other groups mentioned less frequently

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

Suggested mitigations

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

Considering Welsh language impacts[38]

1.270 Language and cultural accessibility emerged as a significant concern for Welsh speaking patients if services are moved to areas where the language is not widely spoken. For example, Bronglais Hospital was frequently cited as an example of good practice, with staff perceived as willing and confident to use Welsh; whereas experiences at Glangwili, Prince Philip, and Withybush were often described less positively in terms of Welsh language availability.

1.271 In this context, consultees across several consultation methods emphasised that the ability to receive care through the medium of Welsh is essential from both a moral and legal perspective: Hywel Dda must consider the Welsh Language Standards in all aspects of its service provision, and the need to meet these Standards was stressed. Neglecting Welsh language impacts could, it was said, negatively affect the patient experience, participation in care, and health outcomes. Moreover, it was said that families often act as advocates in Welsh; and having to travel longer travel distances might remove this support.

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

1.272 Many comments around Welsh language impacts were given in the context of stroke services, especially as after a stroke, patients often revert to their mother tongue and may lose the ability to communicate in English. Consultees, including the Stroke Association, stressed that effective rehabilitation - especially for those with conditions such as aphasia - requires communication in the patient's preferred language, and that this should cover triage, assessment, consent, therapy, and discharge planning, both in-person and digitally. This was a particular concern for the patient population of Bronglais, among which is a high proportion of Welsh speakers.

1.273 Some questionnaire respondents also considered intersectionality, linking linguistic disadvantage with age, frailty, disability, and rural isolation - characteristics that, when combined, compound equality impacts for patients.

1.274 There were calls for a dedicated Welsh Language Impact Assessment and assurances that bilingual provision would be maintained and protected. Indeed, Aberystwyth Town Council explicitly stated that the Health Board should uphold the principles of the Welsh Language (Wales) Measure 2011 and the Welsh Language Standards by ensuring it can always provide an 'active offer' of Welsh-medium care, especially at Bronglais.

1.275 We would note that while the need to protect Welsh language provision was the more dominant theme across the consultation methods, some consultees - especially in the consultation questionnaire - argued that Welsh language requirements deter recruitment and may reduce service quality. There were strong concerns that 'Welsh preferred' and other language requirements may discourage applications from overseas clinicians especially, particularly specialists who are in short supply. Comparisons were made with the use of interpreters for other languages, with a few people suggesting that Welsh should be treated similarly in areas where the language is not widely spoken.

2. Consultation overview

Introduction

Hywel Dda University Health Board and its challenges

2.1 Hywel Dda University Health Board (Hywel Dda or the Health Board) provides health services for people across Carmarthenshire, Ceredigion, and Pembrokeshire and also for nearby communities in south Gwynedd, and parts of Powys and Swansea/Neath Port Talbot. Services are provided through:

- four main hospitals (Bronglais Hospital in Aberystwyth, Glangwili Hospital in Carmarthen, Prince Philip Hospital in Llanelli, and Withybush Hospital in Haverfordwest39).
- five community hospitals (Amman Valley Hospital and Llandovery Hospital in Carmarthenshire, Tregaron Hospital in Ceredigion, Tenby Hospital and South Pembrokeshire Hospital in Pembrokeshire).
- two integrated care centres (Aberaeron and Cardigan, both in Ceredigion).
- community facilities, including GP surgeries, dental practices, community pharmacies, ophthalmic (eye care) practices and sites providing mental health and learning disability services.
- care within people's own homes.

2.2 Highly specialised services can be provided outside the area, for example in Swansea, Cardiff, or even outside Wales such as in Bristol.

2.3 Hywel Dda has recognised for several years that some of its hospital services are fragile. This is mainly because its clinical staff and teams are spread across multiple sites, and sometimes it relies on individual staff.

2.4 Also, the impacts of the COVID-19 pandemic have had a lasting and continuing affect, leaving the Health Board with long waiting lists, gaps in staffing (made worse by shortages nationally for some healthcare staff), social care pressures, and more demand for health services. Some of the Health Board's services have not been able to return to pre-pandemic activity levels, meaning patients are waiting longer than it would like for some planned care.

2.5 Given the challenges, the Health Board has developed a Clinical Services Plan (CSP), with options to change nine services in a timeframe of up to four years from decision; and also considering what further changes could be made in more than four years. These services are critical care, dermatology, emergency general surgery, endoscopy, ophthalmology, orthopaedics, radiology, stroke, and urology.

2.6 In summary, the plan seeks to:

- respond to the fragility of the critical care and emergency general surgery services.
- improve standards and outcomes and address staffing challenges in the stroke service.

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

improve access to and reduce waiting times for planned care patients (ophthalmology, dermatology, urology and orthopaedics) and diagnostics (endoscopy and radiology).

The journey so far

Phase one

2.7 During this phase, the Health Board assessed its nine healthcare services, led by clinical experts, looking at the factors affecting these services. This led to the development of an Issues Paper, which included any temporary changes, clinical guidelines and policies, staffing issues, activity data and cost challenges.

2.8 Hywel Dda involved staff and public, identifying people and organisations (stakeholders) who should be part of the conversation. Nearly 6,000 recent patients and carers who had used the nine services filled in survey responses, as did 350 healthcare staff working in those areas. This information fed into the Issues Paper.

Phase two

2.9 In Phase Two, the Health Board developed potential options for the future of the nine service areas. This was done in a range of different workshops between February 2024 and September 2024. Some workshops involved patient representatives and stakeholder representatives who were able to 'check and challenge' the Health Board's thinking and bring different viewpoints while scoring and shortlisting potential options.

2.10 In these workshops, the Health Board:

- considered how change in one service area could affect another (interdependencies).
- set criteria for minimum requirements proposed options should meet (hurdle criteria).
- shared ideas that developed into proposed options.
- shortlisted options by scoring them.

2.11 Finally, Health Board members agreed the public consultation on shortlisted options reported here, to give as wide a range of people as possible a chance to share their views and ideas.

Consultation scope

2.12 The consultation considered the shortlisted options for each of the nine clinical services. A summary of the key challenges and proposed options for each service is provided below. It is important to note that the descriptions of current service models reflect the arrangements in place at the time the consultation documents were developed. Given the fragility of some services, temporary changes to service delivery may have occurred since that time, which will be noted and outlined as part of the Health Board's 'Informing Plan[40]'. Critical care

[40] The purpose of the Informing Plan is to provide the Board with an overview of changes since the issues paper was published in March 2024, incorporate consultation findings, and detail the process undertaken to review and assess alternative options. It also includes stakeholder feedback on both the consultation findings and the alternative options considered, ensuring the Board is supported to undertake conscientious consideration and make informed decisions.

2.13 Critical care provides care for critically ill adult patients with life-threatening conditions, within intensive care units. Currently, it is available in Bronglais, Glangwili, Prince Philip and Withybush. At Prince Philip, some patients with higher needs are stabilised and then transferred to Glangwili for further care.

2.14 Staffing critical care services in Carmarthenshire, Ceredigion and Pembrokeshire (Hywel Dda) is difficult, and none of the Health Board's hospitals meet required quality and safety standards. In this context, the Health Board believes that having fewer intensive care units would make the service more sustainable, improve safety and help meet quality standards.

2.15 Hospitals that are not proposed to have an intensive care unit would instead have an enhanced care unit to treat patients with less critical conditions, and stabilise patients with higher levels of need, before transferring them to the Glangwili intensive care unit. Transfers between hospitals could be done via the Adult Critical Care Transfer Service (ACCTS).

2.16 Hywel Dda outlined three different options for how critical care services could be delivered. These are set out in Table 10.

Table 10: Consultation options – critical care

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

Dermatology

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

2.18 The service faces several ongoing challenges, including:

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

2.19 The Health Board is proposing a permanent change to bring the service together at Prince Philip. This change aims to improve the service, retain and recruit staff, and attract consultant dermatologists to Hywel Dda.

2.20 Hywel Dda outlined four different options for how dermatology services could be delivered. These are set out in Table 11.

Table 11: Consultation options – dermatology

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

Emergency general surgery

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

2.22 Hywel Dda outlined two different options for how emergency general surgery services could be delivered. Under both options (Table 12), the current emergency general surgery service would not change at Bronglais. Prince Philip would continue to not admit emergency general surgery patients, and patients from this area would go to Glangwili (but to varying degrees between options) for their care, surgery and recovery. Due to a shortage of emergency general surgery consultant surgeons to cover both Withybush and Glangwili, the Health Board proposes to bring together its consultant surgeons into one team to make the service more sustainable and improve recruitment of consultant surgeons. Most patients who do not need surgery would stay at their nearest hospital site in both options.

Table 12: Consultation options – emergency general surgery

	Bronglais	Glangwili	Prince Philip	Withybush
Current service	Full emergency general surgery, including surgical operations	Full emergency general surgery, including surgical operations	No emergency general surgery service	Full emergency general surgery, including surgical operations
Option A	Full emergency general surgery, including surgical operations	Full emergency general surgery, including surgical operations Strengthen Surgical Same Day Emergency Care[41]	No emergency general surgery service	No emergency general surgery operations taking place Strengthen Surgical Same Day Emergency Care
Option B	Full emergency general surgery, including surgical operations	Emergency general surgery operations taking place on alternate weeks Strengthen Surgical Same Day Emergency Care	No emergency general surgery service	Emergency general surgery operations taking place on alternate weeks Strengthen Surgical Same Day Emergency Care

Endoscopy

2.23 Endoscopy undertakes a procedure to look inside the body, examining hollow organs or cavities in patients over 16. Currently, endoscopy services are provided at Bronglais, Glangwili, Prince Philip, and Withybush.

2.24 The main issue affecting the Health Board's endoscopy service is increasing demand and difficulties in hiring enough endoscopy staff to deliver across lots of sites. If it does not increase activity, waiting lists for patients will get longer.

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

2.25 Hywel Dda outlined three different options for how endoscopy services could be delivered. In all proposed options, some endoscopy procedures would continue to be delivered across the four main hospital sites. The options consider increasing activity in different ways, described in Table 13.

Table 13: Consultation options – endoscopy

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

Ophthalmology

2.26 Ophthalmology is the treatment of eye diseases and injuries, eye injections and surgical procedures, for children, young people and adults. Currently, ophthalmology hospital services are provided from Bronglais, Glangwili, Prince Philip, and Withybush. In the community, outpatient clinics are provided at a number of locations (see Table 14).

2.27 Hywel Dda outlined three different options for how ophthalmology services could be delivered, all of which would bring together most ophthalmology services at either Glangwili or Prince Philip with the aim of reducing the time patients spend on waiting lists, helping with staff shortages, and making the service run better. In all proposed options, Withybush would continue to provide some outpatient services; Amman Valley Hospital would be used for either day case for cataracts or eye injections only; Cardigan Integrated Care Centre and North Road Eye Clinic (Aberystwyth) would offer outpatient services; and no service would be provided from Aberaeron Integrated Care Centre. Regular eye injection services would be carried out at all sites providing outpatient services.

Table 14: Consultation options – ophthalmology

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

Orthopaedic services

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

2.29 Currently, orthopaedic services are provided from Bronglais, Glangwili, Prince Philip, and Withybush. As well as the main hospital services, orthopaedic outpatient clinics are provided at Cardigan Integrated Care

Centre and Tenby Hospital, and staff provide outpatient clinics at Tywyn Hospital, run by Betsi Cadwaladr University Health Board to reduce travel for some patients.

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

Table 15: Consultation options – orthopaedic services

	Bronglais	Glangwili	Prince Philip	Withybush
Current service	Outpatients, inpatients and day cases	Outpatients	Outpatients, inpatients and day cases	Outpatients and day cases
Option A	Outpatients, inpatients and day cases	Outpatients	Outpatients, inpatients and day cases including regional working[42]	Outpatients and increased day cases
Option B	Outpatients, inpatients and day cases	Outpatients	Outpatients, inpatients, and day cases including regional working	Outpatients, increased day cases & extended hours
Option C	Outpatients, inpatients, and day cases	Outpatients	Local outpatients, inpatients, and day case procedures and additional beds	Outpatients and increased day case procedures
Option D	Outpatients, increased inpatients, and day cases	Outpatients	Outpatients, inpatients, and day cases including regional working	Outpatients and increased day cases

Radiology

2.31 Radiology uses imaging techniques (such as x-rays) to diagnose, treat and monitor diseases and injuries identified within the body. Diagnostic radiology services help make a diagnosis of a disease or condition. In Hywel Dda, emergency diagnostic radiology is provided 24/7; and planned diagnostic radiology is currently provided five days a week, during the daytime only. Interventional radiology services are more complex diagnostic procedures, including biopsies, and are provided for hospital inpatients or for planned day cases, currently five days a week during the daytime only.

2.32 Radiology has seen a large rise in activity across all sites. At the same time, staff shortages are stopping the Health Board from providing some services for longer hours. There are also difficulties maintaining up-to-date equipment across all sites. Bringing some radiology services together on fewer sites, which is proposed in all options (Table 16), would allow Hywel Dda to see more patients and would address some staff shortages, but there is potential impact on where staff work from. None of the options would fully address hiring challenges for interventional radiology roles.

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

2.33 Hywel Dda outlined four different options for how radiology services could be delivered. All options propose the removal of X-ray services at Llandovery and South Pembrokeshire hospitals, so patients living closer to these hospitals would have further to travel for their x-rays than they do now. X-ray services would stay at Cardigan Integrated Care Centre and Tenby Hospital in all options. In all proposed options for radiology, emergency diagnostic radiology would be maintained 24/7 at all four main hospitals.

Table 16: Consultation options – radiology

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

Stroke

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

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

Table 17: Consultation options – stroke

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

Urology

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

Table 18: Consultation options – urology

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

Future roles of Hywel Dda University Health Board's main hospital sites

2.37 Changes to these nine clinical service areas following consultation may impact on how they are organised at Hywel Dda's four main hospitals. As a result, the roles of the hospitals could look like this:

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

The consultation questions

2.38 In this consultation people were asked for their feedback on:

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

2.39 Consultees were also told that the following points are decided, meaning they are not open to influence in the consultation:

- the service areas that are part of this consultation.

» the overall direction of the 'A Healthier Mid and West Wales' strategy[43].

The consultation process

2.40 The 13.5-week public consultation period began on 29 May 2025 and ended on 31 August 2025, during which time members of the public, Hywel Dda staff members, organisations, and other stakeholders were invited to give feedback on the options and anything else they felt the Health Board should consider in relation to the nine services.

2.41 Hywel Dda University Health Board enabled stakeholders to access a wide range of resources throughout the CSP consultation. Formats included a bilingual full consultation document, a bilingual summary version, bilingual Easy Read and youth-friendly versions, a British Sign Language video, and bilingual audio version. Summary documents were translated into Arabic, Polish, Ukrainian and Russian. Supporting technical documents were not translated and were available in English only.

2.42 Supporting materials were also provided. These included reports from the options appraisal process, travel insights, and impact assessments. The Teulu Jones case studies were developed to illustrate how proposed changes could affect communities. Eleven videos were created for use on social media, nine short form reels, one for each service, and two overarching longer form videos (which were also used at engagement sessions).

2.43 Alongside these resources, the Health Board delivered a communications campaign to raise awareness and encourage participation. Proactive media activity including press releases, responses to media enquiries and interviews generated approximately 106 news items across 12 regional and national publications. This included interviews with BBC Wales, S4C, BBC Radio Wales and BBC Cymru Wales. Briefings were also undertaken with Members of the Senedd and Members of Parliament.

2.44 To reach communities that do not access information online, the Health Board delivered a three-county leaflet drop to all households and businesses in the region. Consultation information was also displayed on hospital digital screens. Posters were displayed at hospital sites and promotional materials were distributed through the engagement database, primary care, and community venues. Paid radio advertising supported this activity to reach audiences who rely on offline channels.

2.45 Targeted social media campaigns promoted consultation events and materials. Organic social media posts were used to maintain momentum. Stakeholders were signposted via direct email and communication activities to the dedicated consultation website, where all resources were available.

2.46 Documents were distributed via a stakeholder mass mailout, at face-to-face meetings, engagement events, and visits to a range of settings, as well as being available on request via post, telephone or email. In all, over 6,900 stakeholders received consultation documents; 6,235 by email and 668 by post (which included paper copies of a consultation document and questionnaire by post). GP practices, Community Hospitals,

[43] Moving towards a wellness service rather than an illness service; developing a social model for health; supporting people through technology and other means to stay healthy, independent and in their own homes; significant capital investment to improve or replace old buildings. bringing together acute hospital services to make them stronger and improve standards of care.

Integrated Care Centres and Llais West Wales received several copies to share. The Health Board shared information about the consultation on its stands at the Royal Welsh Show and Pembrokeshire County Show.

The nature of public consultation

2.47 Public consultation promotes accountability and assists decision making; public bodies give an account of their plans or proposals and listen to feedback. Consultation has therefore been described as a dialogue, based on a genuine and purposeful exchange of views.

2.48 It should be noted, however, that consultations are not referenda or 'votes' in which the loudest voices or the greatest numbers automatically determine the outcome. The feedback received often reflects widely varied and sometimes polarised views, and it is important to report these concerns and contrary views robustly, in order for decision-makers to be able to conscientiously take into account the issues raised.

Consultation methodology and response

2.49 Each chapter in this report provides detailed information about the consultation methods from which feedback has been reported; the following section provides a brief overview.

2.50 To provide relevant information that might inform respondents' views, information about the options for the nine services was included in a consultation document and supporting documentation including in summary and Easy Read format. After being encouraged to familiarise themselves with the background information, residents, staff, and other stakeholders were invited to provide feedback through a wide range of methods, including all of the following:

- a consultation questionnaire which was available online (hosted by ORS) and via paper copies, which were circulated widely and available on request.
- engagement activities undertaken by the Health Board, including:
  - online webinars and face-to-face public drop-in events
  - staff drop-in events, hospital walkarounds and meetings
  - meetings with statutory and non-statutory stakeholders/partners
  - attendance at and visits to existing community groups and outpatient settings, and public events like the Royal Welsh Show and Pembrokeshire County Show.
- independently facilitated in-depth engagement designed and conducted by ORS (described overleaf).
- written, email, and telephone submissions.
- social media.

2.51 The consultation response from the different consultation channels is summarised overleaf.

Consultation questionnaire

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

Health Board events and activities

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

Protect Bronglais Services public meeting

- **400+** attendees

In-depth engagement (independently facilitated by ORS)

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

Other feedback channels

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

'Open' consultation questionnaire

2.52 An open consultation questionnaire was available for anyone to complete either via the dedicated consultation website or by completing a paper version. The questionnaire was designed to be completed based on the information presented in the consultation document, with questions about the options for the nine services, the future role of the main hospitals, and potential equalities and health inequalities issues. Respondents were also given the opportunity to make further comments about the options, hospitals, transport and access, environmental impacts and opportunities, local facilities to support patients, visitors, staff and the wider community.

2.53 Open questionnaires are important, being inclusive and giving opportunity to express and explain views, including disagreement with proposals. They are not random sample surveys of a given population,

however, and cannot necessarily be expected to be representative of the general balance of opinion. Furthermore, respondents from groups or geographic areas which feel most affected by change are more likely to respond. For example, respondents living near to Bronglais and Withybush comprised 73% of all responses (where it can be ascertained from the postcodes provided) and were proportionally far greater than those from other areas.

2.54 It is also important to note that while respondents were invited to complete all questions within the questionnaire, it is usually the case that not all respondents choose to. 1,086 partially completed responses have been included (as is standard practice) where respondents answered one or more of the main consultation questions; however, this means that each question may be answered by a slightly different number of people (which is shown in the 'base' for each chart).

2.55 For each main question respondents could also select 'don't know' as an option. The number typically selecting this option was low, but it is presented in a footnote below the relevant charts. Not all respondents chose to provide, or reached, the post code question.

2.56 103 questionnaire responses were received in Welsh, the text comments from which were translated by one of ORS's Welsh-speaking researchers, and quality assured by ORS's Welsh-speaking senior researcher. The same process was undertaken for the one Welsh-language written submission received.

2.57 As the feedback received via Welsh language questionnaire responses was not materially different to that submitted in English (i.e., people responded in Welsh as it is their language of choice, not because they were making specific points about Welsh language services or impacts), these responses were integrated with the English responses in readiness for analysis.

2.58 Where geographical analysis is presented (e.g. by health board, nearest hospital etc), this is based on the 64% of cases where a postcode is known and geographic data could be attached. However, on the charts showing overall results all responses are shown (both for those who did and did not provide a postcode). The geographical breakdown of respondents for whom post code is unknown is not expected to be different to that where it is known, and therefore results by geographical variables will still provide a good guide to how views differ across the whole (both for those who did and did not provide a postcode).

Hywel Dda University Health Board-led consultation methods

2.59 During the consultation period, the Health Board undertook a programme of consultation methods for members of the public, staff, and stakeholders. This programme was comprehensive in terms of the number of engagement opportunities offered, geographical coverage, and reach - as outlined below.

2.60 ORS attended one staff drop-in event (Glangwili) and one public drop-in event (Cardigan) as independent observers and to undertake some discussions but were not present at any of the other sessions/meetings outlined below. Where discussions were had, notes were provided by the Health Board for reporting purposes using a structured feedback template.

Public and patient events

2.61 The Health Board hosted 17 public drop-in events (13 face-to-face and four online) throughout its area and in neighbouring communities during June, July, and August 2025 engaging with more than 1,300 attendees. It also attended a public meeting in Aberystwyth, arranged by the 'Protect Bronglais Services' group, which is outlined in the 'stakeholder engagement' section overleaf and reported in Chapter 7.

2.62 Several members of Hywel Dda staff were available at each session to answer people's questions, capture feedback, and distribute consultation materials. At the online events, attendees were given a presentation in advance of being asked to give their views on the consultation issues and, again, Hywel Dda staff were available throughout the sessions to answer questions and offer clarification.

2.63 The Health Board also visited outpatient departments in each of its main hospitals to speak to patients. Five separate sessions were held in Bronglais, four in Prince Philip, three in Glangwili, and two in Withybush. 223 people were engaged in this way.

Table 19: Public and patient events and meetings

Group	
In-person public drop-in events	
Aberaeron Aberystwyth Ammanford Cardigan Carmarthen Fishguard Haverfordwest	Llanelli Llandovery Machynlleth Pembroke Dock Tenby Tywyn
Public online events	
Critical care, emergency general surgery, stroke Orthopaedics, ophthalmology and dermatology Urology, endoscopy, radiology General	
Patient outpatient departments walkarounds	
Bronglais outpatient departments (five sessions) Glangwili outpatient departments (three sessions) Prince Philip outpatient departments (three sessions) Withybush outpatient departments (two sessions)	

Meetings with staff members and healthcare professionals

2.64 The Health Board hosted 14 staff drop-in and hospital walkaround events at its hospitals and Integrated Care Centres, and 44 meetings for specific staff between May and August 2025. These groups/meetings comprised those outlined in Table 20.

2.65 The staff drop-in events and hospital walkarounds were all held in-person, while the staff meetings were a mix of online (via Microsoft Teams) and face-to-face. 883 staff members were informed and engaged in the former, and the latter were attended by around 1,229 staff members and healthcare professionals.

Table 20: Staff groups engaged

ARCH Regional Orthopaedics Programme Board	Medical Leadership Forum
ARCH Regional Stroke Programme Workshop	Meeting with General Manager
Bronglais consultants	Meeting with Optometrists
Bronglais radiology staff	Mid Wales Clinical Advisory Group
Bronglais Surgical Consultants Meeting (EGS)	Mid Wales Stroke Task and Finish Group
Capital Planning	North Road Eye Clinic
Ceredigion Staff Partnership Meeting	Nursing Professional Standards Team
Clinical Reference Group	Pharmacy services
Cyfarfod tîm Hywel Dda team meeting (online – all staff)	Prince Philip consultants
Dermatology Business Meeting	Prince Philip Intensive Care Unit
Digital Service Team	Prince Philip pharmacy staff
Estates/capital update meeting	Prince Philip stroke ward
Finance Senior Management Team meeting	Prince Philip radiology staff
Finance Team	Senior Allied Health Professional and Health Sciences Professionals Forum
Glangwili radiology staff	Senior Nurse Management Team
Glangwili Medical Consultants	Staff Partnership Forum – including Trade Union briefing
Have your Say – Clinical Services Plan Consultation virtual session for all staff)	Stroke Physiotherapy
Health Board Grand Round at Bronglais	Withybush medical consultants
Health Board-wide Medical Staff Committee	Withybush radiology staff
Healthcare Professionals Forum	Withybush stroke staff
Healthcare Professionals Forum	Withybush Medical Staff Committee
Local Negotiating Committee	Workforce and organisational development event

Stakeholder engagement

2.66 The Health Board hosted or attended 21 meetings with stakeholders and special interest groups between June and August 2025. These included the groups overleaf. The Health Board also attended a public meeting in Aberystwyth, arranged by the 'Protect Bronglais Services' group. This was attended by approximately 400 people.

Table 21: Stakeholders and groups engaged

Aberystwyth Carers Café	Myrtle House, Llanelli
Aberporth Health and Well-Being Event	Pembrokeshire County Councillors
Aberystwyth and District Stroke Club	Pembrokeshire People First
Carmarthenshire County Councillors	Pembrokeshire Stroke Club
Carmarthenshire Town and Community Councillors	Pembrokeshire Town and Community Councillors
Carmarthen Stroke Club	Powys and South Gwynedd County Councillors
Ceredigion County Councillors	Stakeholder Reference Group
Ceredigion Town and Community Councillors	Stand at Royal Welsh Agricultural Show and stand at Pembrokeshire County Show
Llanelli Deaf Club	Versus Arthritis
Llanelli Multicultural Network X 2	West Wales Prostate Cancer Support Group

ORS-led activity

Focus groups with residents

2.67 To explore the consultation issues in more depth and gather informed feedback, ORS conducted three two-and-a-half-hour focus groups, one in Carmarthenshire (Whitland), one in Pembrokeshire (St Davids), and one in Ceredigion (Lampeter). Overall, 58 people took part.

2.68 Participants were independently recruited to the sessions via ORS and its recruitment partner FieldMouse, using quota-controlled recruitment to ensure they were broadly representative of the wider community. In recruitment, care was taken to ensure that no potential participants were disqualified or disadvantaged by disabilities or cost of travel. As standard good practice, an incentive payment of £65 was paid to participants as a token of thanks and to cover childcare or travel costs. All focus group venues were accessible, and any special accessibility needs were considered during the recruitment and facilitation stages.

Submissions and petitions

2.69 During the formal consultation process, 115 submissions were received, all of which have been read and summarised by ORS. These included 13 from elected representatives and councils; eight from voluntary and community sector groups; five from other health boards and NHS networks; four from Hywel Dda staff groups and networks; and 85 from individuals (81 residents and four staff members).

2.70 The Health Board is aware of one petition that was sent to the Senedd during the consultation period: 17,883 people signed a petition to *"protect full stroke services at Bronglais Hospital; prevent downgrade to Treat and Transfer."*

Social media feedback

2.71 The Health Board collated all the comments made on its official Facebook pages during the consultation period. In total, 222 Facebook posts received 180 comments or replies. In addition, 34 comments were received across paid-for social media adverts, that were served across a wide range of platforms. All

comments were sent to ORS, who identified the key themes and issues raised by means of an independent thematic analysis.

2.72 It is important to note that social media discussion is an important aspect of any consultation, particularly in terms of answering enquiries and directing people to resources to read and by which to become involved. While social media comments are not formal submissions, and it is not clear whether comments are a person's final views (that they would want included in the analysis/decision making) or interim thoughts and discussions that inevitably develop as people debate the issues in an online forum, they do offer a good benchmark for concerns, sentiment, issues and comments.

The consultation report

2.73 In contrast to the more thematic approach in the executive summary, the full report considers the feedback from each element of the consultation in turn because it is important that the overall report provides a full evidence-base for those considering the consultation and its findings.

2.74 All types of consultation responses are important, and this report presents an independent analysis so that all of them may be taken into account. The report also identifies where strength of feeling may be particularly intense, either in relation to specific themes or possible outcomes, or coming from specific groups of consultees. This will enable decision-makers to conscientiously consider the issues raised (Gunning Principle 4[44]).

2.75 In relation to strength of feeling, when reporting the qualitative research findings we have used standard descriptors like 'most,' 'many,' 'some,' 'several,' and 'a few' to convey the relative prevalence of themes and strength of feeling within the data. While the terms do not indicate precise proportions, broadly speaking their meaning is as follows:

- most: a large majority of consultees, but not all.
- many: a slight majority or large minority of consultees.
- some/several: a minority of consultees, but more than a handful.
- a few: a handful of consultees.

2.76 In considering staff feedback, we would note that while people were invited to disclose whether they were NHS staff, they were not asked to indicate whether they were responding on behalf of their service, as an individual staff member, or as a resident. Although this is clear in some circumstances, in others it is less evident, and this should be borne in mind when considering the findings. Moreover, where possible we have sought to differentiate between NHS staff and Hywel Dda staff, but this is again unclear in some instances, which should again be kept in mind.

2.77 In many activities and within the questionnaire, participants and respondents were encouraged to suggest alternative ideas, all of which have been shared with the Health Board. All alternative ideas and options have been assessed by the Hywel Dda University Health Board Options Development Group; more detail can be found in the Closing Report, which will be presented to Board in February 2026.

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

2.78 Finally, it is not ORS' role to 'make a case' for or against the proposals, nor to make any recommendations as to how decision makers should use the reported results. It is for the appropriate bodies to take decisions based on all of the evidence available, of which consultation feedback is one part. To this end, ORS trusts that both the executive summary and full report will be helpful to all concerned.

3. Consultation Questionnaire

The consultation questionnaire

Introduction

3.1 Throughout the 13.5-week public consultation (which began on 29 May 2025 and ended on 31 August 2025), stakeholders were signposted to Hywel Dda's consultation website[45] or provided with paper documentation. A range of information and resources were available, including the full consultation document, a separate summary document, an Easy Read version, a youth friendly document, a BSL video, and an audio version. The summary document was available in other languages (Arabic, Polish, Russian and Ukrainian).

3.2 A structured consultation questionnaire was designed to allow stakeholders to provide feedback in a consistent format. Appropriate summary information was included for each question, with additional signposting to more detailed information; feedback was invited around views on each service under consideration as part of the Clinical Services Plan, any concerns and potential equalities impacts. Finally, a profiling section gathered response type and demographics.

Methodology and questionnaire response

3.3 The questionnaire was available online in Welsh and English (hosted by ORS, and signposted from Hywel Dda's website), with paper questionnaires also widely circulated to key stakeholder distribution lists, and available on request. Other formats, including an Easy Read version and a youth friendly version, were also made available, along with versions translated into other languages (Polish, Russian, Ukrainian and Arabic). Audio and BSL versions of the documents and questionnaires were also available on the Health Board's website.

3.4 All questionnaire responses submitted by the closing date and subsequently received by ORS, in which at least one of the consultation questions was answered, were included in the analysis, regardless of whether or not any profile questions were answered.

3.5 A total of 4,140 questionnaires were completed, which included 3,999 online responses (of which, 103 were in Welsh) and 141 paper copies (including 3 Easy-Read versions).

3.6 ORS routinely monitors cookies and IP addresses to ensure that multiple completions by a small number of individuals are not submitted in an attempt to deliberately affect the outcomes. After detailed analysis of the raw dataset, ORS identified 26 cases that appeared to be duplicates of another completed questionnaire, which were removed from the final dataset.

3.7 It is important to reiterate that while open questionnaires are inclusive and give people an opportunity to express and explain any views, the results are not generally expected to be representative of the general balance of opinion in the wider population. The results in this chapter should be interpreted in this context.

[45] hduhb.nhs.wales/clinical-services-consultation

Questionnaire responses: respondent types and demographics

3.8 Of the 4,140 responses, 16 were from respondents identifying themselves as completing the questionnaire on behalf of organisations.

3.9 Of the remaining 4,124 respondents to the questionnaire, 3,128 identified themselves as completing as individuals by answering at least one of the demographic questions. A further 996 respondents did not identify how they were completing. It is likely that the 996 respondents not identifying how they completed the questionnaire were providing a personal response and, therefore, have been included with the personal responses in the following results, including:

- 558 responses from individuals identifying themselves as employees of the NHS; and
- 3,566 responses from other individual respondents, mainly local residents.

3.10 Eleven responses from named organisations or departments were submitted (Table 22). A further five organisational responses were completed, although the organisation name or other details were not included. Nonetheless, these responses are included in the organisation responses section of this chapter.

3.11 Given the relatively low number of organisations that responded to the questionnaire, the appropriateness of using percentages to quantify views is limited; therefore, only counts are presented.

Table 22: Organisations responding via the consultation questionnaire (where organisation name provided)

Named organisations:
Dyfi U3A
Elidyr Communities Trust
Hearts and Crafts (craft group)
Llanfair Grange care home
Llangeitho Community Council
Lledrod Community Council
Nantcwnlle Community Council
SOSPPAN (Save Our Services Prince Philip Action Network)
Responses made on behalf of a wider NHS department/group of staff:
Critical Care Clinical Psychology service
Clinical Health Psychology Hywel Dda University Health Board
West Wales Renal Service [46]

3.12 Data from the consultation questionnaire has not been combined to produce "overall" findings across the different stakeholder groups, because the size of the stakeholder groups, and the numbers of their respective responses, are very different; moreover, they have distinctive views and feedback cannot simply be merged.

3.13 With this in mind, the views of NHS employees have in some key places been reported separately to those of other individual respondents, as their perspective may be informed by their experience of working within the NHS. In these cases, for convenience of reporting and to provide clarity, the views of staff are

[46] A team of nephrologists at the Morriston Hospital Renal Unit, which provides renal services in West Wales to patients in the Swansea Bay and Hywel Dda University Health Board areas. This response was also submitted as a written submission, and due to its length and detail, has been summarised more fully in chapter 8

generally reported first, but is not intended to suggest that views from staff are considered as any more or less important than those from residents and other individuals. Note that those who indicated they work for the NHS will not all work for Hywel Dda; some may work in other areas e.g. Welsh Ambulance Service University NHS Trust, other health boards, GP practices, community services, etc.

3.14 Table 23 summarises the demographic information of those individuals who responded to the consultation questionnaire. Based on analysis of postcodes (where provided), it is evident that most questionnaire respondents live within the specific Hywel Dda University Health Board area. However, there are also a small number of responses from neighbouring health board areas that may still access Hywel Dda University Health Board services. All questionnaire responses have been included irrespective of location, but where population data is used as a comparator, to give some indication of how well the response profile of the questionnaire matches the wider population, it is based on the Hywel Dda Health Board population (i.e. the population of Carmarthenshire, Ceredigion and Pembrokeshire counties). An asterisk has been used to denote percentages greater than zero, but less than half of one per cent.

Table 23: Demographic response profile to the consultation questionnaire: age, gender, long-term limiting illness/disability, ethnic group – compared with the Hywel Dda Health Board population aged 18+

Characteristic		Questionnaire Responses		Population aged 18+
		Number of Respondents	%	
BY AGE	Under 25	45	2%	10%
	25 to 34	232	8%	13%
	35 to 44	391	13%	13%
	45 to 54	460	15%	15%
	55 to 64	714	24%	18%
	65 to 74	749	25%	17%
	75 or over	403	13%	14%
	Total valid responses	**2,994**	**100%**	**100%**
	Not known	*1,130*	-	
BY GENDER	Male	855	29%	48%
	Female	2,098	71%	52%
	Non-binary	5	*%	-
	Uses another term	6	*%	**100%**
	Total valid responses	**2,964**	**100%**	
	Not known	*1,160*	-	
BY LONG-TERM LIMITING ILLNESS/DISABILITY	Has a disability	832	29%	25%
	No disability	2,023	71%	75%
	Total valid responses	**2,855**	**100%**	**100%**
	Not known	*1,269*	-	
BY ETHNIC GROUP	White	2,804	98%	97%
	Mixed or multiple ethnic groups	27	1%	1%
	Asian or Asian British	28	1%	1%
	Black, African, Caribbean or Black British	4	*%	*%
	Other	5	*%	*%
	Total valid responses	**2,868**	**100%**	**100%**
	Not known	*1,256*		

3.15 Table 24 summarises other consultation response demographic information, with an asterisk again used to denote a percentage greater than zero, but less than half of one per cent.

Table 24: Demographic response profile to the consultation questionnaire: other characteristics

Characteristic		Questionnaire Responses	
		Number of Responses	%
BY WHETHER RESPONDENT IS EMPLOYED BY THE NHS [not all necessarily Hywel Dda]	Yes	558	21%
	No	2,108	79%
	Total valid responses	**2,666**	**100%**
	Not known	*1,458*	-
BY MAIN LANGUAGE SPOKEN/USED AT HOME	English	2,583	87%
	Welsh	345	12%
	Other	26	1%
	Total valid responses	**2,954**	**100%**
	Not known	*1,170*	-
BY WHETHER RESPONDENT PROVIDES UNPAID CARE	Yes	669	23%
	No	2,220	77%
	Total valid responses	**2,889**	**100%**
	Not known	*1,235*	-
BY WHETHER RESPONDENT CURRENTLY PREGNANT OR GIVEN BIRTH WITHIN LAST YEAR	Yes	54	2%
	No	2,870	98%
	Total valid responses	**2,924**	**100%**
	Not known	*1,200*	-
BY WHETHER GENDER IS THE SAME AS THAT ASSIGNED AT BIRTH	Yes	2,883	99%
	No	21	1%
	Total valid responses	**2,904**	**100%**
	Not known	*1,220*	-
BY SEXUAL ORIENTATION	Asexual	96	4%
	Bisexual	59	2%
	Gay or lesbian	47	2%
	Heterosexual or straight	2,517	92%
	Other	11	*%
	Total valid responses	**2,730**	**100%**
	Not known	*1,394*	-

3.16 Table 25 summarises the number of responses received by local authority and nearest hospital (based on postcodes, where this information was provided as part of the questionnaire response).

Table 25: Distribution of questionnaire responses received, by local authority and nearest hospital[47] for those who provided postcodes – compared with the Hywel Dda Health Board population aged 18+

Characteristic		Questionnaire Responses		Population aged 18+
		Number of Respondents	%	
BY LOCAL AUTHORITY	Carmarthenshire	649	25%	49%
	Ceredigion	677	26%	19%
	Pembrokeshire	1,283	49%	32%
	Total valid responses	**2,609**	**100%**	**100%**
	Not known/Outside Hywel Dda	*1,515*	-	
BY NEAREST HOSPITAL	Bronglais General Hospital	593	23%	13%
	Glangwili General Hospital	386	15%	25%
	Prince Philip	333	13%	30%
	Withybush General Hospital	1,313	50%	32%
	Total valid responses	**2,625**	**100%**	**100%**
	Not known	*1,499*	-	

3.17 Table 26 summarises the number of responses received by health board (based on postcodes, where this information was provided as part of the questionnaire response). An asterisk has been used to denote percentages greater than zero, but less than half of one per cent.

Table 26: Distribution of questionnaire responses received, by Health Board for those who provided postcodes

Characteristic		Questionnaire Responses	
		Number of Responses	%
BY HEALTH BOARD	Hywel Dda	2,609	97%
	Powys	30	1%
	Betsi Cadwaladr	16	1%
	Swansea Bay	32	1%
	Other	8	*%
	Total valid responses	**2,695**	**100%**
	Not known	*1,429*	-

3.18 Table 27 summarises the number of responses received by relative levels of deprivation (based on postcodes, where this information was provided as part of the questionnaire response) for those living in the counties of Carmarthenshire, Ceredigion and Pembrokeshire only. The postcodes of around two-fifths of respondents (1,583) are unknown or outside the area.

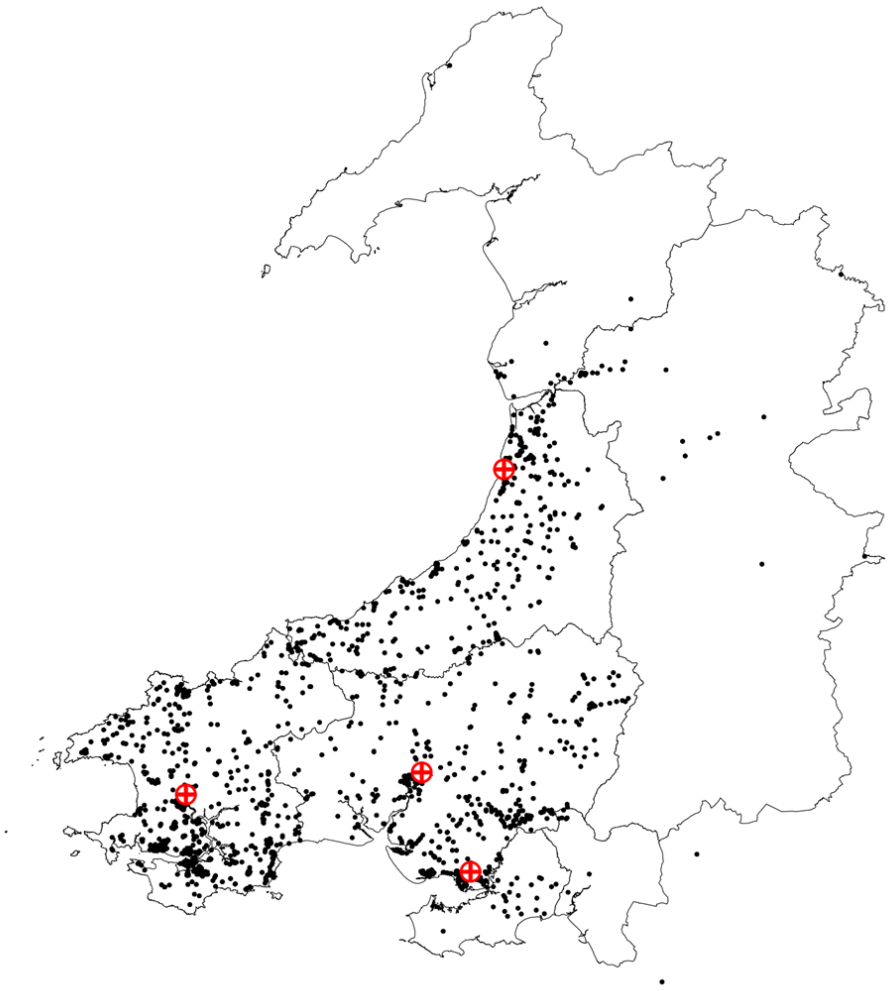
[47] Nearest hospital based on travel time

Table 27: Distribution of questionnaire responses received, by deprivation (calculated using Indices of Multiple Deprivation (IMD)) for those who provided postcodes and are living in the counties of Carmarthenshire, Ceredigion and Pembrokeshire only – compared with the Hywel Dda Health Board population aged 18+

Characteristic		Questionnaire Responses		Population aged 18+
		Number of Respondents	%	
BY DEPRIVATION (IMD QUINTILE)	1 – most deprived	287	11%	18%
	2	484	19%	19%
	3	512	20%	20%
	4	578	23%	21%
	5 – least deprived	680	27%	21%
	Total valid responses	**2,541**	**100%**	**100%**
	Not known/Out of area	*1,583*	-	

3.19 As indicated in Table 25 and Figure 11, when examining by nearest hospital, the open questionnaire response was highest from those living nearest to Withybush General Hospital with half (50%) of responses from those living closest to here. There was, however, also coverage from those living near to the other hospitals with nearly a quarter (23%) of responses from those living closest to Bronglais General Hospital, 15% of responses from those living closest to Glangwili General Hospital and 13% from those living closest to Prince Philip.

Figure 11: Map showing distribution of responses (for questionnaire responses where a postcode was provided)



Interpretation of the data

3.20 The results for some consultation questions are presented in a graphical format. The bar charts and other graphics show the proportions (percentages) of respondents making responses. Where possible, the colours of the charts have been standardised with a 'traffic light' system in which:

- » green shades represent positive responses.
- » beige shades represent neutral responses.
- » red shades represent negative responses.
- » bolder shades highlight responses at the 'extremes', for example, strongly agree or strongly disagree.

3.21 Where percentages do not sum to 100, this may be due to computer rounding, the exclusion of "don't know" categories, or multiple answers. Throughout the report an asterisk (*) denotes any value less than half of one per cent. In some cases, figures of 2% or below have been excluded from graphs to avoid potential identification of individual responses.

3.22 Individual percentages, such as those for 'strongly agree/disagree' or 'tend to agree/disagree', and grouped percentages showing overall levels of agreement and disagreement are presented here rounded to the nearest whole number. Because of this, the sum of the rounded individual percentages may not equal the percentage shown for overall agreement and disagreement.

3.23 The number of valid responses recorded for each question (base size) are reported throughout. As not all respondents answered every question, the valid responses vary between questions. Every response to every question has been taken into consideration.

3.24 All open-ended responses have been read and then classified (coded) using a standardised approach (code frame). This approach helps ensure consistency when classifying different comments and the resulting codes represent themes that have been repeatedly mentioned in a more quantifiable manner. The various comments provided by a respondent to any single text question may present a number of different points or arguments, therefore in many cases the overall number of coded comments counted in a particular question can actually be higher than the number of people responding to that open-ended question.

3.25 Quotes are edited using ellipses (…) to ensure anonymity.

Questionnaire Feedback

Critical care

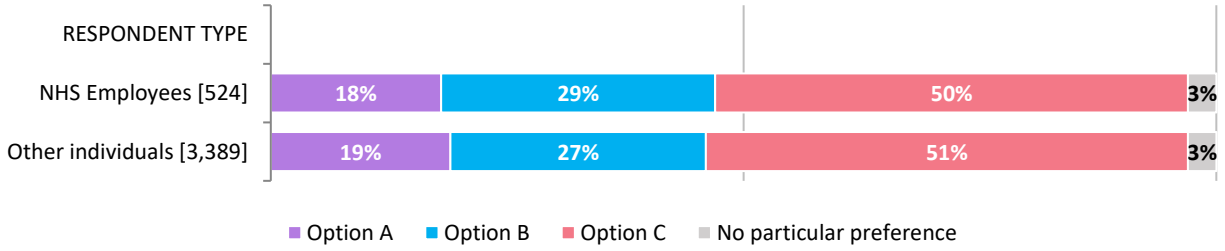
3.26 Respondents were asked 'Which option for critical care services do you believe best meets the Clinical Services Plan objectives, considering patient care, accessibility, and outcomes?'. They were provided with a summary of what critical care included, where it was currently provided and the issues currently faced. Three different proposed options were presented for respondents to choose from: Option A, Option B, Option C and they were also given the opportunity to select 'No particular preference' and 'don't know[48]'.

- **Option A** - would maintain an intensive care unit in Bronglais and Glangwili. An enhanced care unit would be provided at Withybush and Prince Philip. An additional enhanced care unit would also be developed at Glangwili so that the intensive care unit can focus on the sickest patients. This would mean patients nearest Prince Philip and Withybush requiring an intensive care unit, would have longer journeys (transfer to Glangwili intensive care unit).
- **Option B** - would maintain an intensive care unit at Bronglais, Glangwili and Withybush. Prince Philip would have an enhanced care unit and patients requiring intensive care would be transferred to Glangwili intensive care unit. This would mean patients nearest Prince Philip requiring this level of care, would have longer journeys.
- **Option C** - would maintain an intensive care unit on all sites. The temporary arrangement at Prince Philip to transfer the very sickest patients to Glangwili intensive care unit, whilst continuing to care for some patients at Prince Philip, would be maintained. This option is harder to staff sustainably but would minimise the number of patients facing longer journeys.

By respondent type (critical care)

3.27 Figure 12 shows that there wasn't much difference in opinion between individual respondents who identified as working for the NHS and those who didn't, with around half (50% and 51% respectively) of both groups feeling that Option C best met the Clinical Services Plan objectives. Under three-in-ten (29% and 27% respectively) of both groups thought Option B and under a fifth (18% and 19% respectively) thought Option A best met the objectives.[49]

Figure 12: Which option for critical care services do you believe best meets the Clinical Services Plan objectives, considering patient care, accessibility, and outcomes? By respondent type (individual respondents only)



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

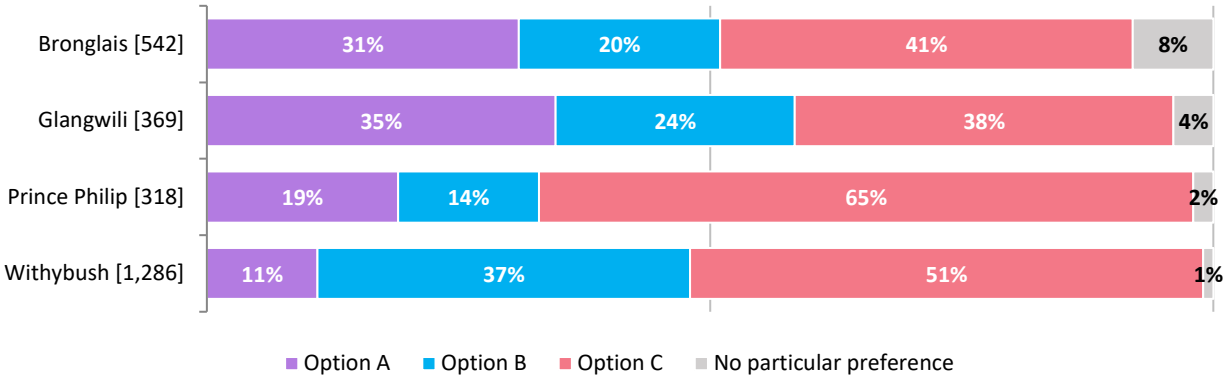
[48] Full details of the information provided can be found in the consultation questionnaire.
[49] 62 respondents selected the 'don't know' option. This is omitted from the chart for presentational convenience (standard industry practice) because it does not affect the order of preference of the available clinical options.

By nearest hospital (critical care)

3.28 Option C is also the most preferred option for individuals across all of the geographies, with those living closest to Prince Philip particularly favouring this option (65%) (see Figure 13).

3.29 In terms of the second most preferred option, among those living closest to Withybush, the proportion preferring Option B (37%) was higher than in other areas; and amongst those living closest to Bronglais and Glangwili hospitals the proportion preferring Option A (31% and 35% respectively) was higher than in other areas.

Figure 13: Which option for critical care services do you believe best meets the Clinical Services Plan objectives, considering patient care, accessibility, and outcomes? By nearest hospital[50] (individual respondents only, where postcodes were provided)



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

By health board (critical care)

3.30 The number of individual respondents living outside the Hywel Dda Health Board area is low so limited conclusions can be drawn, but Option C was the preferred option for individuals living in Powys, Betsi Cadwaladr and Swansea Bay University Health Boards with 44%, 53% and 64% respectively.

By other demographics (critical care)

3.31 Across other demographic groups, there was no clear variation in opinion beyond that explained by proximity to each hospital.

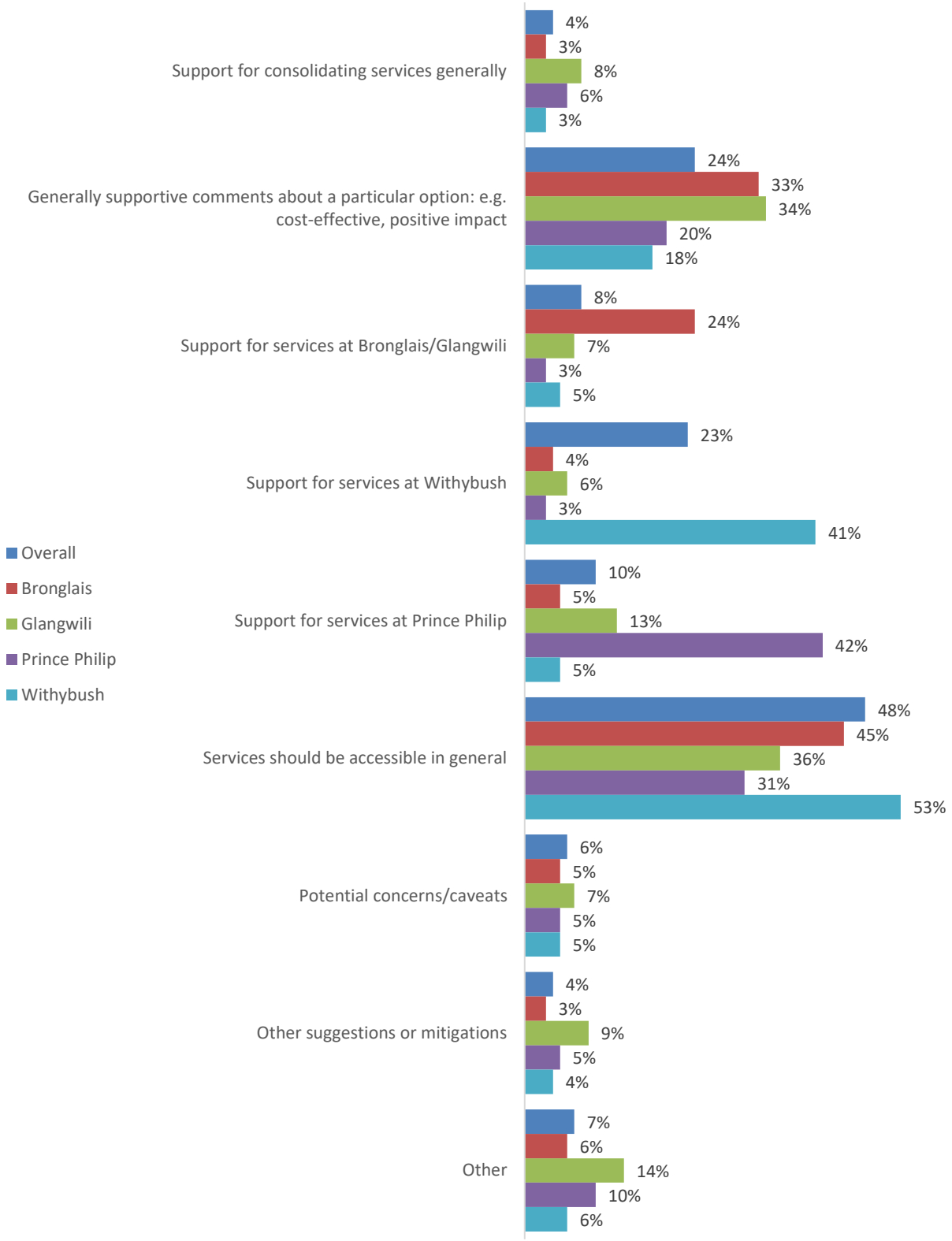
Reasons for choosing options, and alternative suggestions (critical care)

3.32 Respondents were asked 'Please share why you chose this option. How could we improve it or reduce any negative impacts? Do you have any alternative ideas that would meet the objectives?' in an open text box. A summary of responses from those responding as individuals is provided in Figure 14 together with a summary broken down by nearest hospital.

3.33 The percentages quoted are out of all respondents providing a comment. Because respondents could provide detailed feedback, some comments cover more than one point and, therefore, the total percentages sum to greater than 100%.

[50] Nearest hospital based on travel time. 1,398 responses without postcode are not displayed, but are included in the previous chart of overall results.

Figure 14: Please share why you chose this option. How could we improve it or reduce any negative impacts? Do you have any alternative ideas that would meet the objectives? (individual questionnaire respondents only) (Percentages are of those providing a comment to this question) (Responses by nearest hospital[51] are where postcodes were provided)



Base: Overall individual respondents (2,446), Points raised (3,273)

[51] Nearest hospital based on travel time

3.34 Of all respondents making a comment on this question, a small number (4%) provided feedback that was generally supportive of the principle of centralising critical care services, although these kinds of comments tended to be made most frequently by those whose nearest hospital is Glangwili.

> *"We have to accept due to rurality that there will be travelling involved to get the expert care. It is better to have more expert professional care from a team than spread staff too thinly and therefore causing difficulties when there is sickness and vacancies"*

3.35 Just under a quarter (24%) provided a comment that was generally supportive of their preferred option, suggesting, for example, that said option would be cost-effective, easier to staff or be most likely to improve healthcare, or that services would be optimally located.

> ***Option A:***
>
> *"Option A gives the best opportunity to reduce the problems of staffing and improve care for patients. It also reduces staffing costs."*
>
> *"The priority is to have adequate staffing & this option [Option A] helps this. If it means longer journeys for some then so be it."*
>
> ***Option B:***
>
> *"By maintaining full Intensive Care Units at Bronglais, Glangwili, and Withybush, [Option B] ensures that the most critically unwell patients continue to have access to comprehensive intensive care services in three different locations. This spreads specialist provision more evenly across the region, reducing pressure on any single unit and safeguarding resilience."*
>
> *"[Option B] gives the best geographical spread of units. Prince Philip would be able to manage without an ITU as it is between Glangwili [and] Morriston. It is the most resilient".*
>
> ***Option C:***
>
> *"[Option C] because it maintains the status quo. Changing would have an adverse impact for other services that are interdependent on critical care within any of the 4 sites."*
>
> *"[Option C] minimises patient and relative travel. Centres of excellence are very desirable but not effective if preceded by a 12 hour wait in an ambulance."*

3.36 Nonetheless, nearly half of respondents raised some sort of concern about the need for services to be accessible or close by in general, generally feeling that travel times ought to be minimised for patients and their families.

> *"An Intensive Care Unit is essential at all sites due to the travel implications especially at peak travel times. The Health Board area is mainly rural with a huge increase in tourist traffic at holiday times. Therefore, all sites need an intensive care unit."*

3.37 Moreover, and as can be seen in the figure above, many respondents' views on the proposed options were influenced by their proximity to a particular hospital.

3.38 Respondents who made comments **that critical care services should be available at Bronglais/in Ceredigion, or in Glangwili**, often emphasised the rurality and large size of the area under consideration. Glangwili was also identified as being 'central' location.

"Option A would maintain the necessary Intensive care near the middle of the area covered by the health board."

"Bronglais has to cater for a large mid-Wales area ... with large number of Caravan sites, visitors, plus students..."

"While patients may have to travel further from Prince Philip or Withybush, they also have the option of being transferred to Morriston or Singleton if their condition is very severe. Patients in the north of Ceredigion have no other option than to go to Bronglais."

3.39 Those feeling that **critical care services needed to be maintained in Withybush** identified potential issues with transport links in the event of patients needing to travel further or be transferred, noting the distance between Glangwili in Carmarthen and some parts of Pembrokeshire. Additionally, some highlighted the area's tourism industry and sizeable numbers of visitors to the area, while others noted the presence of heavy industry (e.g. oil refineries) with greater potential for major incidents.

"Some areas of Pembrokeshire are so far away from Glangwili, that in some areas it would take over an hour to get to the nearest critical care centre."

"…Pembrokeshire has a heavy tourism industry, an oil refinery, a gas plant, ferry ports, a firing range, is popular for extreme sports (especially with tourists) and has one of the most dangerous professions - farming. Therefore, this naturally implies that Withybush hospital needs to keep an intensive care unit as many of these present a high risk of potential incidents whereby patients would need care in an intensive care unit and removing this would risk patients' lives and safety!"

3.40 Those **supporting services being maintained at Prince Philip** noted the large population served by the hospital, and its relative accessibility and good transport links, while also typically preferring Option C on the basis that it maintains the status quo and therefore minimises travel for patients generally.

"Llanelli has the largest population, and Prince Philip hospital should be the primary hospital. Plus the fact it's a more modern hospital."

3.41 Around 6% raised potential concerns and caveats, of which the largest concerned the ability of the Welsh Ambulance Service University NHS Trust to respond to challenges in terms of transporting or transferring patients to a site that had the appropriate capabilities to meet their needs, given that it is said to be already operating at close to (or beyond) capacity.

"All sites need an intensive care unit, WASUT is not equipped to transfer the sickest patients in a timely manner. For relatives trying to visit their loved ones, having to make a 45-mile trip to see them is unacceptable."

"I have experienced how distressing it is when in need to have intensive care to be transferred for staff reasons. How will this system work when the ambulance service is already at full stretch?"

"The health board have a duty of care to provide level 3 care to patients in the community who come in via ED and those that deteriorate in the hospital, if Critical care unit was to leave Withybush would there be additional vehicles via WASUT to transfer patients out of area?"

3.42 Other respondents, mostly NHS employees, expressed concerns in terms of clinical interdependencies and the wider impacts on routine services, staffing etc if critical care services were to be reduced at a given location.

> *I have transferred patients to Swansea, Prince Philips and Cardiff from Withybush in winter months due to bed availability issues and I can tell you that depriving any of the sites of critical care services will have a knock down effect on other departments (medicine, surgery, anaesthesia)"*
>
> *"Without intensive care services on site, routine care for services such as haematology and oncology may be impacted. Treatments are becoming more complex with increased side effects that often require escalation."*
>
> *"I have concern that reducing intensive care provision would have a knock-on impact on the ability of the sites to provide other services e.g. high-risk surgery."*

3.43 There was also some concern that consolidating services might, in fact, reduce resilience by increasing the pressure on a smaller number of hospitals, while simultaneously disrupting patient, families and staff members.

> *"Putting all ITU patients in one hospital means it's a single point of failure. Once the ITU becomes full patients will have to be transferred out of Hywel Dda. Not to mention the logistics of repatriation. Impact on families having to travel outside of their locality. Also having to staff one ITU can be extremely challenging."*

3.44 Sometimes these concerns were expressed with reference to a certain hospital, to justify why services should be maintained at that location (in practice, most of these types of comments related to either Withybush or Prince Philips, due to these being most impacted by the options under consideration).

3.45 For example, **respondents in favour of maintaining intensive care services at Withybush** expressed some concerns around Glangwili's ability to absorb additional patients from Pembrokeshire, in the event of Option A being selected. Related to this, some claimed that there is currently more capacity and resilience at Withybush, whereas issues relating to staffing are more prevalent in Carmarthenshire. It was also queried whether removing the intensive care unit (ITU) from Withybush might impact on its emergency services provision and on activity levels in its operating theatres.

> *"My concern is the current size of Glangwili and its ability to take on Withybush as well as Prince Philip. If you have an A&E then I believe it's vital you have an ITU."*
>
> *"If Withybush was to downgrade there would be limited theatres available. We are already seeing a huge impact on the waiting list. Consultant surgeons, doctors, nursing staff and ODPs all have the capacity to operate. There are physical beds in the HDU/ITU department with more than enough staffing… Glangwili ITU do not have enough staff to cope [and are] therefore having to transfer to Morriston as other critical care departments are already surged (and fully staffed)"*
>
> *"The staffing issues are all in Carmarthenshire/ Llanelli, so why disrupt the staff in Withybush? How can you have any surgical option without an ITU and how can you operate an Emergency department without an ITU? Also, Glangwili does not have the facilities for expansion of Withybush patients."*
>
> *"Withybush ITU has staff waiting to join the team. They have a fully staffed anaesthetics team with Drs wanting to do their consultancy".*

3.46 Among **those who supported intensive care services being maintained at Prince Philip**, there were concerns that choosing any option other than Option C might have broader impacts on patients' safety and on the provision of other services elsewhere in the hospital as a result of clinical interdependencies (e.g. day surgery, stroke care and anaesthetics).

> *"A critical care unit is essential for a hospital like Prince Philip, caring for level 3 patients, as these patients could be brought in as an emergency from AMAU [Acute Medical Assessment Unit] or deteriorate on ward. If you do not have an intensive care facility, patients' safety will be jeopardised"*
>
> *"Is removing critical care facilities from Prince Philip sensible when the plan is to move stroke services to Prince Philip? Where will stroke patients who need ITU go? Will this help with standards of care or hinder it?"*
>
> *"Without ITU in Prince Philip, there would be no medical take and therefore no training posts for doctors and the hospital would essentially become a community hospital. We would not be able to deal with critical cases including drug abuse which we see a lot of, day surgery would have to be cancelled, and Glangwili would become completely overrun. There would be no midline services and anaesthetics, which would cause difficulty in treating sick patients and administering medication without the need for transfer to other hospitals."*
>
> *"Prince Philip is currently the elective "hub" for colorectal and major joint surgery, without ICU provision [it] will be unable to accept higher risk patients, limiting elective capacity further when HD waits for surgery are extensive."*

3.47 Moreover, based on its activity levels and the size of population locally, some respondents living closest to Prince Philip advocated for it having a fully-functioning intensive care unit, as a potential alternative to the options presented:

> *"It makes far more sense to continue with an ICU unit in Prince Philip (with the transfer of the sickest patients to Glangwili), possibly with an Enhanced Care Unit in Withybush or Bronglais as an alternative Option D."*

3.48 Respondents proposed other potential alternatives, suggestions and mitigations including the following:

- all hospitals should have an enhanced care unit in addition to the current Intensive Care Units.
- the current ITUs should be kept with one hospital that is upgraded to a dedicated HDU.
- rather than closing ICUs outright, capacity could be adjusted so that some hospitals manage acute, emergency-intensive care while stable or longer-term patients are transferred to a centralised 'hub' unit.
- there was one comment about a modified opt A: where Withybush initially remains ICU (with transfers for sickest), and only transitions to ECU after 4+ years - to reduce impact on Withybush ED, and better align with the longer term move to a single ED in the south.
- there should be an option for Bronglais to be an enhanced care unit, on the basis that it is the smallest unit and furthest from achieving GPICS requirements.
- keeping Prince Philip as ECU only might have longer term impacts on staff sustainability; Hywel Dda should consider making it a HDU to care for recovering patients from Glangwili (repatriation/step-down).

- a more regional model for intensive care services should be considered, to reflect the size and diverse nature of the health authority.
- there should be peripatetic staff who travel between hospitals, rather than moving the population for treatment.
- flexible rotas should be introduced.
- there should be more use of technology.
- a new 'super hospital' should be built in a central location e.g. Narberth.

Llanelli should be part of Swansea Bay University Health Board, due to proximity to Morriston Hospital (which was used by some respondents to justify not maintaining intensive care services at Prince Philip).

3.49 The following were also highlighted as possible areas for further consideration:

- suggestions that once ICU services are removed from local hospitals, it becomes far more likely that surgical services will follow.
- to overcome greater travel distances in the event of consolidation at a reduced number of sites, divert resources from ICU in the Health Board to WASUT (including the air ambulance and more first-responders).
- Withybush ICU staff skills and morale at would be improved if the decline in other onsite surgery was reversed.
- more efforts could be made to improve recruitment at the hospital sites e.g. campaigns.

Organisational responses

3.50 Six organisations felt Option A best met the Clinical Services Plan objectives for critical care services, four thought Option C and three thought Option B best met the objectives. Three organisations selected 'no particular preference'.

3.51 Of those organisations noting no particular preference, two did so as none of the options listed included Bronglais.

> *"No option has been given for Advanced Intensive Care in Bronglais, geographically the area is wide – covering all of Mid Wales including, Ceredigion, Powys and South Gwynedd. Need to keep it there because of the distance, and ambulance care is unreliable." [Lledrod Community Council]*

3.52 Some of the reasons given for preferring options selected are noted below.

> *"Option A is the most appropriate and sustainable model for the future of critical care in our region. It could provide the best opportunity to maintain high-quality, safe and well-staffed intensive care at Glangwili which is essential for the vulnerable adults we support. The inclusion of an enhanced care unit alongside the ICU is a sensible approach to managing capacity and prioritising care for the sickest patients. Option A provides the strongest foundation for long-term quality and safety." [Elidyr Communities Trust]*
>
> *"It is preferable to have an intensive care unit at Prince Philip as Llanelli is the largest town in Carmarthenshire and needs this facility." [Hearts and Crafts (craft group)]*

3.53 Within their full submission (summarised in Chapter 8) the **West Wales Renal Service** expressed concern about Hywel Dda's definition of 'enhanced care.' They emphasise that enhanced care (Level 1–1.5)[52] is not equivalent to a High Dependency Unit (HDU) where single organ support is possible. They also feel that removing continuous veno-venous filtration[53] capability from Bronglais, Glangwili, and Withybush would be unsafe and would put unsustainable pressure on renal services at Morriston Hospital. Unstable renal patients often need urgent renal replacement therapy and transferring them from, say, Withybush to Glangwili or Morriston would increase mortality risk.

3.54 Two similar responses were received from the **Hywel Dda Clinical Health Psychology** and **Critical Care Clinical Psychology**. These were detailed, and have been shared with the health board in their entirety for consideration.

3.55 **Critical Care Clinical Psychology** did not state a preference for option, whereas **Clinical Health Psychology** felt that Option A would best meet the objectives, feeling that it would provide the greatest level of expertise as the clinical team would not be as stretched over so many ICU units.

3.56 However, both responses expressed a range of concerns including that:

- » the service had not been more involved in the development of Clinical Services Plan options. the psychological care of Hywel Dda critical care staff and patients is not adequate and doesn't meet national recommendations.
- » the changes proposed in all three options (with increased transfers and treatment further from some patients homes) would potentially result in increased psychological patient needs, and impact optimal recovery after critical illness, with Option A having the greatest negative impact upon patient and families.
- » where the function and role of the staff change as a result of organisational changes, the increase in capacity and greater complexities of patients admitted to Glangwili, *could* impact on staff morale, and even lead to potential risk of burn out.
- » and that with current workforce provision, the service felt it would be difficult to meet any additional demands for support.

[52] Level 1 critical care is for patients at risk of their condition deteriorating or those recently relocated from higher levels of care, whose needs can be met on an acute ward with additional advice/support from the critical care team. Level 1½ is enhanced perioperative care that bridges the gap between routine ward care and intensive care.
[53] Gentle slow continuous dialysis used when a patient is unstable.

Dermatology

3.58 Respondents were asked 'Which option for dermatology services do you believe best meets the Clinical Services Plan objectives, considering patient care, accessibility, and outcomes?'. They were provided with a summary of what dermatology services included, where it was currently provided and the issues currently faced. Four different proposed options were presented for respondents to choose from: Option A, Option B, Option C, Option D and they were also given the opportunity to select 'No particular preference' and 'don't know'. They were told that 'We are proposing a permanent change to bring the service together at Prince Philip.' and that 'In all four options, no services will be provided from Glangwili, Bronglais or Withybush. The four options differ based on the proposed locations of the community provision'. [54]

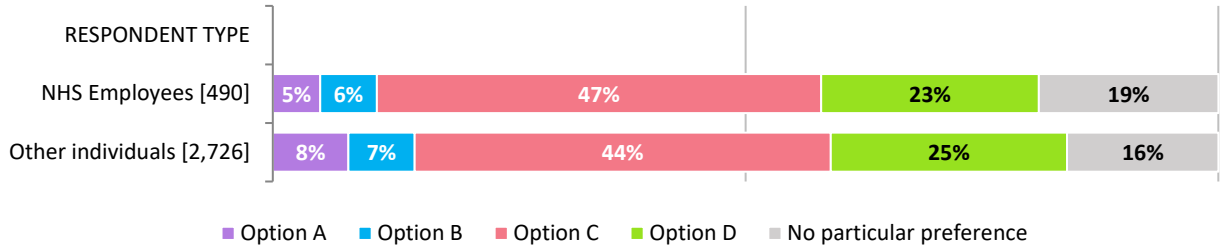
- **Option A** - Main hospital services at Prince Philip. Nurse led clinics (including minor operations) stay at Cardigan Integrated Care Centre. Introduce some nurse-led clinics at Amman Valley Hospital. There would be no community provision in Pembrokeshire, so patients from this area would travel further.
- **Option B** - Main hospital services at Prince Philip. Nurse-led clinics stay at South Pembrokeshire Hospital. Some minor operations in participating GP practices. There would be no community provision in Ceredigion, aside from participating GPs, so patients from this area would travel further.
- **Option C** - Main hospital services at Prince Philip. Nurse-led clinics (inc. minor operations) at Cardigan Integrated Care Centre and nurse-led clinics at South Pembrokeshire Hospital kept. Some nurse-led paediatric clinics introduced at Cross Hands Health Centre. Some minor operations in participating GP practices. This option keeps some dermatology services in each of the counties of Carmarthenshire, Ceredigion and Pembrokeshire.
- **Option D** - Main hospital services at Prince Philip. Nurse-led clinics (inc. minor operations) at Cardigan Integrated Care Centre and nurse-led clinics at South Pembrokeshire Hospital kept. Some nurse-led paediatric clinics introduced at Cross Hands Health Centre. This option keeps some dermatology services in each of the counties of Carmarthenshire, Ceredigion and Pembrokeshire.

By respondent type (dermatology)

3.59 Figure 15 shows that there wasn't much difference in opinion between individual respondents who identified as working for the NHS and those who didn't, with over two-fifths (47% and 44% respectively) of both groups feeling that Option C best met the Clinical services plan objectives. Around a quarter (23% and 25% respectively) of both groups thought Option D best met the objectives, with smaller proportions selecting Options A and B.[55]

[54] Full details of the information provided can be found in the consultation questionnaire.
[55] ORS notes from text responses to this question that some respondents selected "no preference" or "don't know" to register disagreement with all options offered (and this is discussed subsequently in the commentary). Overall, 239 respondents answered, "don't know", although this is not shown in the chart as, examining overall levels with "don't know" included, it does not affect the order of preference of the available clinical options.

Figure 15: Which option for dermatology services do you believe best meets the Clinical Services Plan objectives, considering patient care, accessibility, and outcomes? By respondent type (individual respondents only)



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

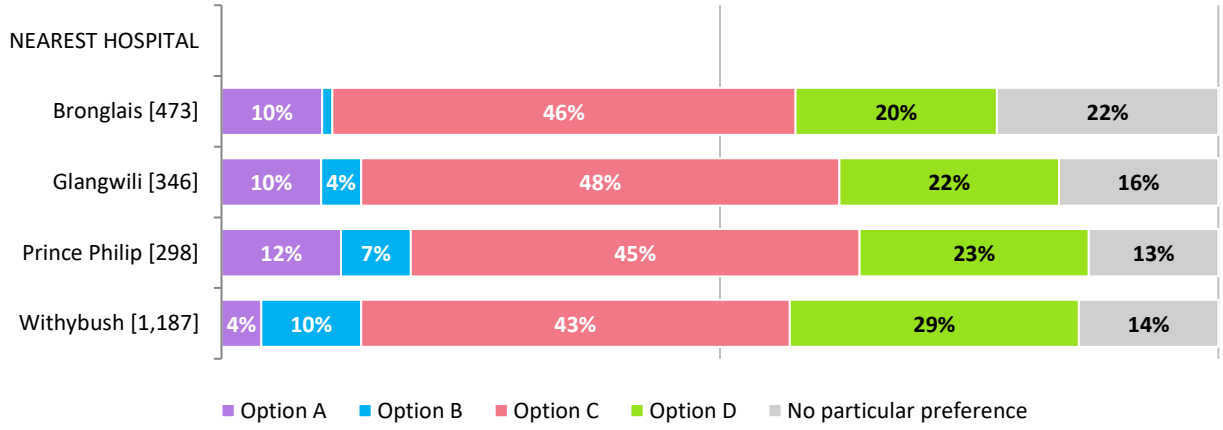
By nearest hospital (dermatology)

3.60 Option C is also the most preferred option for individuals across all of the geographies (see Figure 16).

3.61 A greater proportion living closest to Withybush preferred Options D and B compared to other areas, and a greater proportion living closest to Prince Philip preferred Option A compared to other areas.

3.62 While Option D was the second most-widely preferred option among those closest to Bronglais Hospital (20%), a slightly higher proportion (22%) stated that they had 'no preference' (of whom, several expressed disagreement with all proposed options in their subsequent open-ended comments)[56].

Figure 16: Which option for dermatology services do you believe best meets the Clinical Services Plan objectives, considering patient care, accessibility, and outcomes? By nearest hospital[57] (individual respondents only, where postcodes were provided)



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

By health board (dermatology)

3.63 The number of individual respondents living outside the Hywel Dda Health Board area is low so limited conclusions can be drawn, but Option C was the preferred option for individuals living in Powys and Betsi

[56] ORS notes from text responses to this question that some respondents selected "No preference" or "Don't know" to register disagreement with all options offered (and this is discussed subsequently in the commentary). Overall, 239 respondents answered "don't know", although this are not shown in the chart above as, examining results with "don't know" included, does not affect the order of preference of the available clinical options at nearest hospital level (Option C remains most widely preferred everywhere, followed by Option D).

[57] Nearest hospital based on travel time. 912 responses without postcode are not displayed, but are included in the previous chart of overall results.

Cadwaladr Health Boards with 50% and 36% respectively. Whereas Option D was the preferred option for individuals living in Swansea Bay University Health Board (33%) with over a quarter living here (26%) preferring Option C.

By other demographics (dermatology)

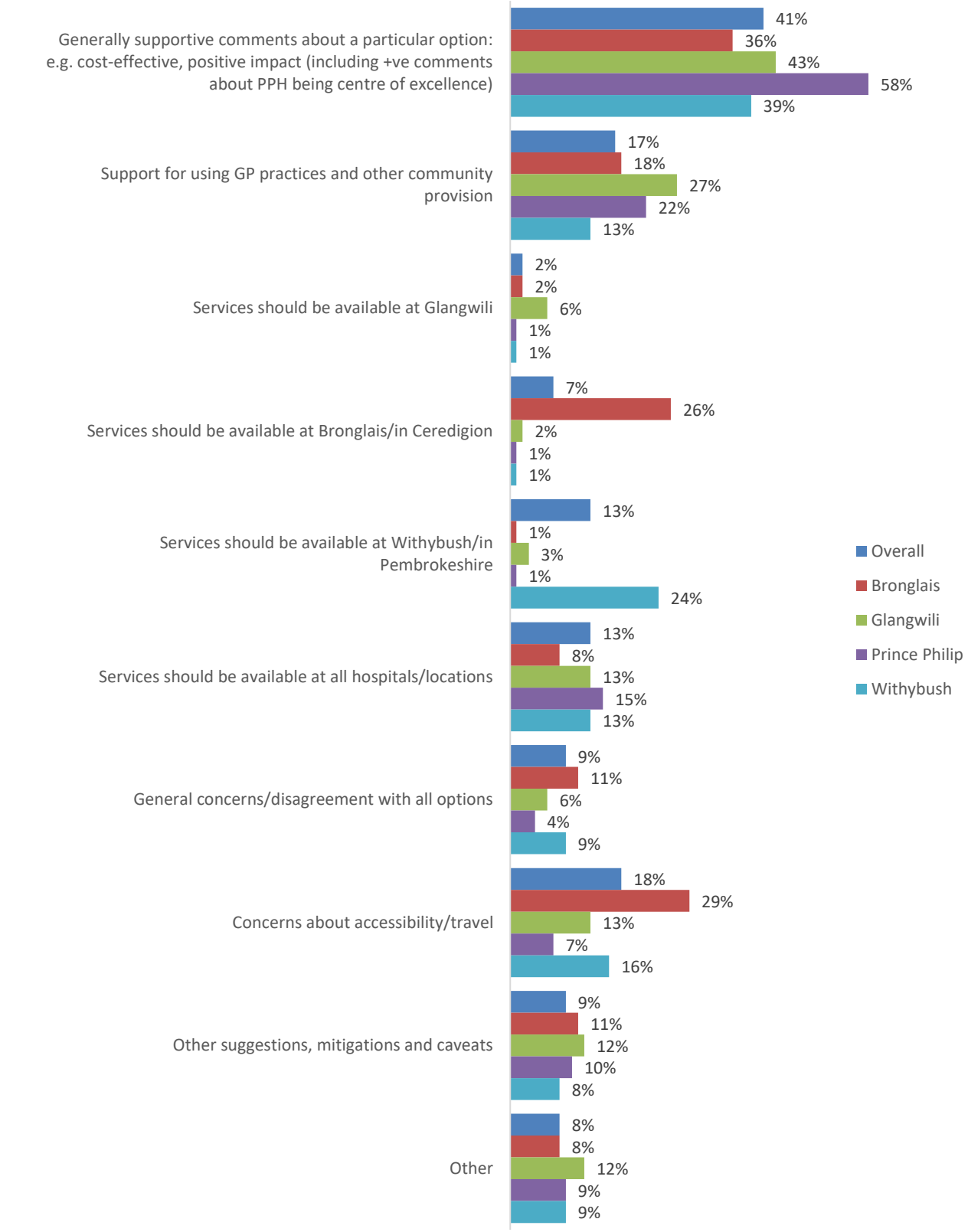
3.64 Across other demographic groups, whilst both males and females noted Option C as their preferred option, a greater proportion of females (48%) preferred this option compared to males (37%).

Reasons for choosing options, and alternative suggestions (dermatology)

3.65 Respondents were asked 'Please share why you chose this option. How could we improve it or reduce any negative impacts? Do you have any alternative ideas that would meet the objectives?' in an open text box. A summary of responses from those responding as individuals is provided in Figure 17 together with a summary broken down by nearest hospital.

3.66 The percentages quoted are out of all respondents providing a comment. Because respondents could provide detailed feedback, some comments cover more than one point and, therefore, the total percentages sum to greater than 100%.

Figure 17: Please share why you chose this option. How could we improve it or reduce any negative impacts? Do you have any alternative ideas that would meet the objectives? (individual questionnaire respondents only) (Percentages are of those providing a comment to this question) (Responses by nearest hospital[58] are where postcodes were provided)



Base: Overall individual respondents (1,718), Points raised (2,376)

[58] Nearest hospital based on travel time

3.67 Of all respondents who made a comment, just over two-fifths (41%) provided feedback that was generally supportive of their preferred option, for example, agreeing that Prince Philip should be a centre of excellence, and suggesting that their selected option would be more cost-effective, or that services would be more optimally located. A greater proportion of those living closest to Prince Philip provided these types of comments (58%).

Option A:

"A consolidated service allows greater efficiency and although patients may have to travel further the facilities at Prince Philip could become streamlined, e.g. we have standby patients on lists in case of any cancellations allowing for as many cases to be completed on the day."

"Cardigan Centre is excellent. That could cover all of Cardiganshire and Pembrokeshire as it is on the border of both counties, If anything very urgent then Prince Philip which would cover Carmarthenshire and any emergencies from the other counties"

Option B:

"…This option keeps dermatology services accessible for patients in Pembrokeshire, reducing the need for long travel while still centralising specialist care at Prince Philip."

"Utilising GP practices sounds a good way to provide local care if they are resourced properly. Also, if main service is at Prince Philip then other services should be located in the other counties, not Cross Hands or Amman Valley as Prince Philip is near enough to these areas"

"Regional access at the best possible options, being mindful of Ceredigion and the travel time for vulnerable patients"

Option C:

"Enables some form of service in all 3 counties allowing patients from all areas access to the service."

"I strongly support Option C as the best approach for delivering hospital and community healthcare services in our region. This option strikes a balanced and thoughtful compromise between centralising essential hospital services at Prince Philip and maintaining vital nurse-led clinics and minor operations across Pembrokeshire, Ceredigion, and Carmarthenshire. Option C offers several key benefits: It preserves nurse-led clinics (including minor operations) at both Cardigan Integrated Care Centre and South Pembrokeshire Hospital, ensuring that patients in these areas continue to have access to care close to home. It introduces nurse-led paediatric clinics at Cross Hands Health Centre, expanding community-based paediatric care and reducing the need for families to travel long distances. By maintaining dermatology services in all three counties, it promotes equitable access to specialist care and reduces travel burdens on patients. The availability of minor operations at participating GP practices adds further convenience and helps integrate primary and community care. This comprehensive distribution of services supports patients' needs while recognising the importance of local access, especially in rural areas where travel can be challenging. Option C also helps sustain workforce presence across the counties by keeping services local where possible. In contrast, other options risk disadvantaging entire counties by removing community provision, which would increase travel distances and create inequalities in healthcare access. For these reasons, Option C represents the most patient-centred and equitable plan for maintaining vital healthcare services across the region"

"Option C satisfies the most people. Offers close access to most counties. Treatment with dermatology can be ongoing and regular and travel should be minimal. High risk of not attenders for dermatology - if it's not accessible, they won't come due to perceived low importance - until it's too late and treatment much more serious."

Option D:

"Option D provides some service to the residents of Ceredigion. If you cut the service at Cardigan community hospital as well, that would leave Ceredigion without any service at all which is completely unacceptable, especially for those who live in the North of the County"

"Isn't the point of the integrated care centres to allow clinics to be held outside of hospitals? This allows people to be seen more locally when able and go to Prince Philip for the treatment if required. Option D is the best of a bad bunch. There should be clinics for initial appointments and minor treatments in the ICCs and more major treatments in a general hospital."

"The GP surgeries are struggling, and I can't see how they would be able to offer minor surgery without adding more pressure. This option excludes GPs"

No particular preference:

"I think absolutely everything should be brought into Prince Philip to ensure it's a centre of excellence where the whole service is together and patients know they are getting access to a full service. People must realise they need to travel to access the best that is on offer, and this is how it should be presented."

3.68 Just under a fifth (17%) supported using GP practices and other community provision, many citing that this would help mitigate travel concerns. A greater proportion of those living closest to Glangwili said this (27%).

"…More use should be made of GP practices to mitigate against travel issues for patients in rural areas lacking access to public transport."

"… GP's always used to do minor skin lesion procedures so I'm not sure why this was ever stopped. So GP's doing minor surgery is a big yes! Do they have time? ..."

"…If you are taking away Glangwili and Withybush then it needs to be available in all communities and definitely in GP practices. Why not do mobile screening?"

3.69 Over one in ten (13%) felt that the service should be accessible at all hospitals/in all locations.

"It is important to have this service in each of the counties."

"Keep all services at all hospitals. A 2 hour round trip to see a dermatology doctor by car is hard enough if you are elderly or of ill health - impossible by public transport."

3.70 Whereas others raised concerns about the need for services to be accessible or close by in general, feeling that travel times ought to be minimised for patients and their families.

"I feel that centralising any services at a hospital which is at the very outskirts of the massive area of Hywel Dda is massively unfair for patients living in the North or West of the trust. The travelling distance for some patients will mean a whole day off work which just isn't possible for some especially those on the lowest wages. I have no issue with centralising the service, just feel doing this at Prince Philip is massively unjust."

"I don't believe any of these options meet patients' requirements satisfactorily. If main dermatology services are based at Llanelli this puts a huge burden on most people in Ceredigion and Pembrokeshire due to long travel distances. If Llanelli is the only place providing phototherapy, which requires several sessions a week over a couple of months, the distance would make use of this service completely impractical…"

3.71 Moreover, and as can be seen from the figure above, many respondents' views on the proposed options were influenced by their proximity to a particular hospital.

3.72 Respondents who made comments **that dermatology services should be available at Bronglais/in Ceredigion, or in Glangwili**, often emphasised the large size of the area under consideration. Glangwili was identified as being a 'central' location and that services needed to be retained there or even centralised there instead of Prince Philip.

"…Llanelli is too far for elderly from Pembrokeshire / Ceredigion to travel without transport. Believe me transport is difficult. Many that do still drive a little will not drive via Carmarthen because those impossible roundabouts. Just too difficult. This includes myself. Train - maybe if and it's a big if it actually turns up! I would suggest Glangwili for this service simply because it is the most central and transport accessible hospital to the three counties for people to access."

"…should consider Bronglais as this also covers Powys who have limited services so better for Wales"

"It is already ridiculous that patients from Aberystwyth and further North have to travel to Llanelli, At least CICC would reduce travel distance and time, Public transport is a huge issue. Also, consideration to appointment times is needed according to geography, as patients are having to travel huge distances."

"Provision of outpatient clinics should be retained at Glangwili, and this is not available in any of the options…"

"[Option D] This provides Ceredigion with some service though nothing is local or easy access to Aberystwyth and surrounding areas. dermatology clinics at Aberaeron would help…"

3.73 Those feeling that **dermatology services needed to be available at Withybush/in Pembrokeshire** identified potential issues with patients needing to travel further, noting the distance, with mentions that services could instead be consolidated in Withybush, or potentially at Cardigan Integrated Care Centre.

"Sort the RAAC out at Withybush and bring back the service. Stop removing the services and making the people of Pembrokeshire travel miles to get the service they should have"

"Not really any option for Pembrokeshire peninsula patients. Still have to travel miles. Appointments are made and then cancelled, and it is up to the patient to rearrange. My husband has had approximately seven appointments cancelled. No point even trying to rearrange as it's never going to happen…"

"…Pembrokeshire patients need a locally based service. Currently there is an 8 o'clock scramble for GP appointments/nurse practitioner consultations. So there needs to be a suitable qualified nurse specialist in dermatology to provide minor ops at GP surgeries to provide rapid access to treatment following histology."

"Keep Pembrokeshire in the loop and make use of the hospitals"

"Withybush should have this service as its area is probably the most industrial area in the 3 counties. This is an important consideration."

"Looking at the distribution of hospitals within the region, concentrating services at Prince Philip is a strange decision. Consolidation at Cardigan Integrated Care Centre, and no service elsewhere is more logical. Cardigan could become the area's centre of excellence."

3.74 18% raised more specific concerns around accessibility and travelling, with accounts of patients having to travel for many hours for very short appointments. Further to this were concerns of the impact on other family members. 9% raised general concerns or expressed disagreement with all proposed options.

"Moving everything to Llanelli has a significant impact on time for patients and families. Keeping services local will reduce travel time. For example […] recently had to travel to Llanelli. Her appointment was only 5 minutes. It took four hours to travel there and back. She has to go again later in the month and possibly again after that. Family have to take three days leave in order to take her. If the initial appointment and follow up could be carried out more locally it would be helpful."

"… One patient from Pembrokeshire had been waiting since 9 am in the morning for 2pm appt because hospital transport only did a small number of journeys…"

"I am not willing to select any option as they will involve excessive travel to attend the clinic at Prince Philip (Prince Philip) […] moving this to Prince Philip will make it impossible to attend. From your home in Pembrokeshire having to use public transport to attend Prince Philip would take 4 1/4 hours with two changes. Which means wouldn't get to Prince Philip until 12:30 if took the first bus of the day. The return takes a similar time and depending on appointment wouldn't get home until 18:00 if at all. Light treatment usually requires three visits a week starting at about 10 secs building up over many weeks. It is unacceptable to expect any patient from Pembrokeshire or Ceredigion using public transport to spend nine hours a day three times a week to get TO Prince Philip. Either reopen the light room at Withybush or come up with a better solution than the options give. May be a mobile unit that could visit the three main hospitals for say four months and rotate around the other hospitals"

"I can't select any option because there are none I agree with. Selecting No Preference or Don't know is not a suitable alterative as it doesn't allow me to express my disagreement. There should be "completely disagree option" […]. The proposed options show a total disregard to care and treatment of patients in [Pembrokeshire and Ceredigion] …"

3.75 Some suggested provision of the service on a rotational basis across the hospitals, GP surgeries, and health centres/community sites, or even the provision of a mobile service for dermatology to mitigate concerns around travelling. With others suggesting a triage of referrals, with pre and post care provided locally.

"…why can't there be a walk in service available once a month in each county, if have a GP referral and the GP provides you with a referral slip/letter to take with to you. This would reduce waiting times, improve access to services for those who really need them (and are prepared to attend on one date a month that is available) or at least work as a triage system for people initially accessing the dermatology service."

"Would there be any merit in having a dermatology clinic with a nurse travelling to GP practices instead of at one centre. Eg Monday South Pembs, Tuesday Carmarthen, Wednesday Cardigan and so on?"

"Develop regional GP-led dermatology hubs for drop-in clinics and minor ops. This could be rotational i.e. week 1 Pembs, week 2, Carm, week 3 Ceredigion"

"Utilise specialist dermatology nurses who can prescribe within certain GP practices? Each locality would then have access to some services."

"More GPs need to be trained up to manage minor surgical procedures together with more ANPs delivering more nurse led clinics locally. An alternative is to provide a mobile service/ van to more remote areas. Services should be delivered locally. You cannot expect older people or young children to be travelling long distances to access services especially where public transport is limited."

"Dermatology should be available in all counties. Why could a consultant not hold dermatology clinics weekly / fortnightly at all the regional hospitals to establish which patients need further treatment for the more complex patients at Prince Philip? Minimising travel for especially the elderly should be a very high priority"

"…Why is it not possible to have a monthly dermatology clinic in Bronglais, one consultant or health professional travelling rather than numerous elderly patients having to make such a journey. More patients could be seen locally and only need to travel if further interventions were necessary."

3.76 There were concerns raised around staff recruitment, retention and training, with some respondents noting that this was the key issue that needed addressing, rather than cutting services.

"GPs should be able to offer some enhanced services in dermatology if trained/experienced and properly remunerated. There needs to be greater investment in permanent staff recruitment and retention for long term enhancement of dermatology in Hywel Dda, rather than repeated cutbacks…"

"Invest in staff and their wellbeing and you would retain the skilled staff required to run these units. promote research in these areas and you would encourage investment and cutting-edge practice whilst being a desirable unit to work on."

"Please increase the number of doctors, especially clinical fellows who can be trained and retained in the Prince Philip dermatology department. At the same time, reduce reliance on physician assistants and nurses, as they have not undergone structured medical training and are unable to manage complex cases."

"…You should hire more doctors […] You don't need many consultants to run the service in Prince Philip or elsewhere. Also, we don't need more NURSE-led dermatology services because nurses cannot see complex cases and dermatological emergencies. You need to invest in your local DOCTORS, and this is how you enhance staff retention."

3.77 Others raised suggestions, mitigations or caveats including better provision of hospital transport.

"If there is a central single referral hub that appropriately and timely arranges appointments that then actually happen rather than being repeatedly cancelled that would be an improvement. If you chose to centralise at Prince Philip then perhaps booking system sent out with the appointment for a 'dermatology bus' from Withybush, Bronglais or Glangwili would mean patients can be transported for their morning or afternoon clinic session."

"Need to consider improved access for those without vehicle/ clinics accessible by public transport (timing)"

"Again, no consideration of public transport for patients and visitors. Also, I am not seeing pan-Wales options. If you are going to focus on centres of excellence which makes economic sense, why is there no integration with (or improvement) of public transport between the centres. And no mention of enhanced primary care so far. Surely, something like the Brixham Fisherman's surgeries need to be considered so give a best value for money service."

3.78 There were suggestions to provide services at other locations or settings.

"…Option to use Shrewsbury dermatology centre not mentioned (Powys patients could access this) …"

"…Surgery for melanoma etc. should be carried out in Singleton."

"Generally not life threatening in the short term. Diagnosis from a specialist is useful if a GP isn't sure so consider funding private consultations at e.g. Bancyfelin."

"…Is there any scope to use private or out area options to improve wait times? Maybe even some 'at home' test kits for allergies for example."

"Why can't some of these clinics be done in Llandovery cottage hospital?"

"Stretching services across all counties, would incur more cost. To minimise this, keep services mainly in Prince Philip, consider Amman Valley & Llandovery Hospital's for clinics to be held there."

3.79 Some shared their experience of using phototherapy and video links, with suggestions to make better use of technology available and in some cases reintroducing it where is had previously been lost.

"Phototherapy needs to be put back as an option for users! It's ridiculous that people have been waiting over 2 years to have this treatment with nothing available. It is also ridiculous that people have to travel to Llanelli for appointments when they live in West Wales!!!"

"None of the above. Invest in technology - patients can send images to the centres for consultations via video links. The costings look incorrect for buildings if there is no improved service. Invest in community services instead with one central centre to deal with cases if deemed to need an in person visit."

"I choose none of the above. I live in the Bronglais catchment area. A simple small skin lesion was photographed and sent online to Llanelli. However, an appointment was sent to attend Prince Philip dermatology clinic. Not able to drive, a bus was taken from Aberystwyth to Carmarthen, a train from Carmarthen to Llanelli and a taxi from Llanelli station to the hospital. […]. However, on being seen by the health professional, there was general surprise that such a lengthy journey had been necessary when the online photo had been sufficient…"

"In dermatology medical photography is important to document the progress of disease. With any other options this service is not offered anymore."

"Alternative Option Consolidating services within Prince Philip to support the regional dermatology and networked pathway involves creating a single patient tracking list across the health board and integrating the early stages of the pathway into the Primary Care and Community Strategic Plan. The service should utilize the Health Board's Attend Anywhere software license for Telederm, ensuring access through local GP practices or community sites where network connectivity or personal device limitations exist. For complex patients at Bronglais, Withybush, and Glangwili, dermatology should periodically feature in grand rounds to maintain on-call team skills. Additionally, the review should explore alternatives to the consultant connect platform and design a regional on-call rota to support rural teams for complex care."

"Service provided across all areas. Encourage GPs to offer minor operations. Funding for this service could be linked to equipment purchase and extra nursing staff. Bringing minor ops into primary care surgeries would be a huge advantage for patients - quicker and more convenient service. Diagnosis might still be required at the regional hub though. Any thoughts of introducing video consultations?"

3.80 Respondents proposed other potential alternatives, suggestions and mitigations, including the following

- » better provision, closer to home, especially for those living north of Ceredigion, including mentions of Health Centres such as Aberaeron, and a suggestion to create an Integrated Care Centre in Aberystwyth for minor operations.
- » consultant-led clinics in the community (including mentions of Amman Valley), rather than fixed in any particular general hospital, to save patients travelling large distances for check-ups.
- » more community nurse-led clinics, with particular mentions of Bronglais and Llandovery hospitals.
- » and triaging of referrals, with pre and post care locally, only sending patients to centralised centre for urgent cases.

Organisational responses

3.81 Five organisations felt Option D best met the Clinical Services Plan objectives for dermatology services, four thought Option C and two thought Option A best met the objectives. Four organisations selected 'no particular preference'.

3.82 Of those preferring Option A, one organisation noted how they felt this would best improve service and staff retention/recruitment but also commented that if it were to also extend nurse led clinics this would mitigate some concerns around access.

"Whilst this option offers less community provision in Pembrokeshire, it focuses on consolidating specialist services at Prince Philip which is key to improving service consistency, staff retention and recruitment. The addition of nurse-led clinics at Amman Valley Hospital is a positive step for our local community, improving access for Carmarthenshire residents, maybe extend the nurse led clinics to Pembrokeshire?" [Elidyr Communities Trust]

3.83 Another organisation preferring Option C commented on how they felt this was the best option for Bronglais.

"Best option for Bronglais hospital." [Dyfi U3A]

3.84 Others commented more generally on the need for accessibility and ensuring services were local to residents.

"The service needs to be more accessible to everyone." [Llanfair Grange care home]

"Need to ensure there is a more local service within an hour of travel" [Lledrod Community Council (translated from Welsh)]

3.85 Within their full submission (summarised in Chapter 8) the **West Wales Renal Service** called for a single, clear referral dermatology pathway for renal and immunosuppressed patients and for better inter-hospital transport to access dermatology hubs. They welcomed nurse-led clinics at Amman Valley Hospital and suggested expanding these to Pembrokeshire to improve local access.

Emergency General Surgery

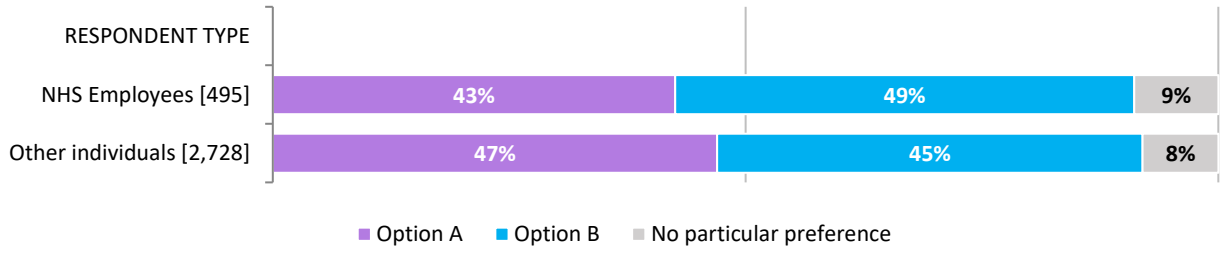
3.86 Respondents were asked 'Which option for emergency general surgery services do you believe best meets the Clinical Services Plan objectives, considering patient care, accessibility, and outcomes?'. They were provided with a summary of what emergency general surgery included, where it was currently provided and the issues currently faced. Two different proposed options were presented for respondents to choose from: Option A, Option B, and they were also given the opportunity to select 'No particular preference' and 'don't know'. [59]

- **Option A** - Would base consultant surgeons at Bronglais and Glangwili. Patients at Withybush needing surgery would be transported to Glangwili for their operation, before returning to Withybush to recover. This option is easier for hiring consultant surgeons and the public would be clear about where surgeries would take place. This option would affect patients nearer Withybush, needing emergency general surgery, who would have to travel to Glangwili instead.
- **Option B** - Would base consultant surgeons at Bronglais, and at Glangwili and Withybush on alternate weeks. As a result, sometimes patients would have their operations closer to home and other times, they would be transferred to the hospital where surgery is being performed that week. This option is the least easy to run for staff, but it would reduce travel impacts for some patients. There is an additional need with this option for surgical cover to remain at Glangwili for children and young people on weeks when the service is operating in Withybush and therefore more risk in staffing this.

By respondent type (emergency general surgery)

3.87 Figure 18 shows that there wasn't much difference in opinion between individual respondents who identified as working for the NHS and those who didn't, with over two-fifths (43% and 47% respectively) of both groups feeling that Option A best met the Clinical Services Plan objectives and a similar proportion (49% and 45% respectively) of both groups feeling that Option B best met the objectives.[60]

Figure 18: Which option for emergency general surgery services do you believe best meets the Clinical Services Plan objectives, considering patient care, accessibility, and outcomes? By respondent type (individual respondents only)



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

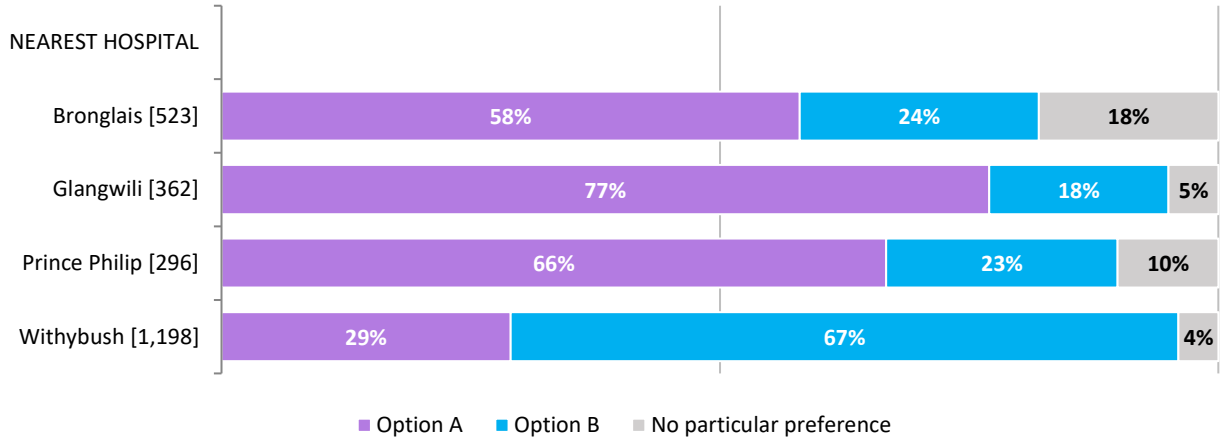
[59] Full details of the information provided can be found in the consultation questionnaire.
[60] 159 respondents selected the 'don't know' option. This is omitted from the chart for presentational convenience (standard industry practice) because it does not affect the order of preference of the available clinical options.

By nearest hospital (emergency general surgery)

3.88 Option A is the most preferred option for individuals living closest to Bronglais, Glangwili and Prince Philip with 58%, 77% and 66% thinking this is the best option to meet the Clinical Services Plan objectives respectively.

3.89 However, those individuals living closest to Withybush preferred Option B (67%) (see Figure 19).

Figure 19: Which option for emergency general surgery services do you believe best meets the Clinical Services Plan objectives, considering patient care, accessibility, and outcomes? By nearest hospital[61] (individual respondents only, where postcodes were provided)



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

By health board (emergency general surgery)

3.90 The number of individual respondents living outside the Hywel Dda Health Board area is low so limited conclusions can be drawn, but Option A was the preferred option for individuals living in Powys, Betsi Cadwaladr and Swansea Bay University Health Boards with 54%, 67% and 52% respectively.

By other demographics (emergency general surgery)

3.91 Across other demographic groups, a greater proportion of those aged 65 and over preferred Option A (55%) compared to other age groups (which ranged between 34% and 45%).

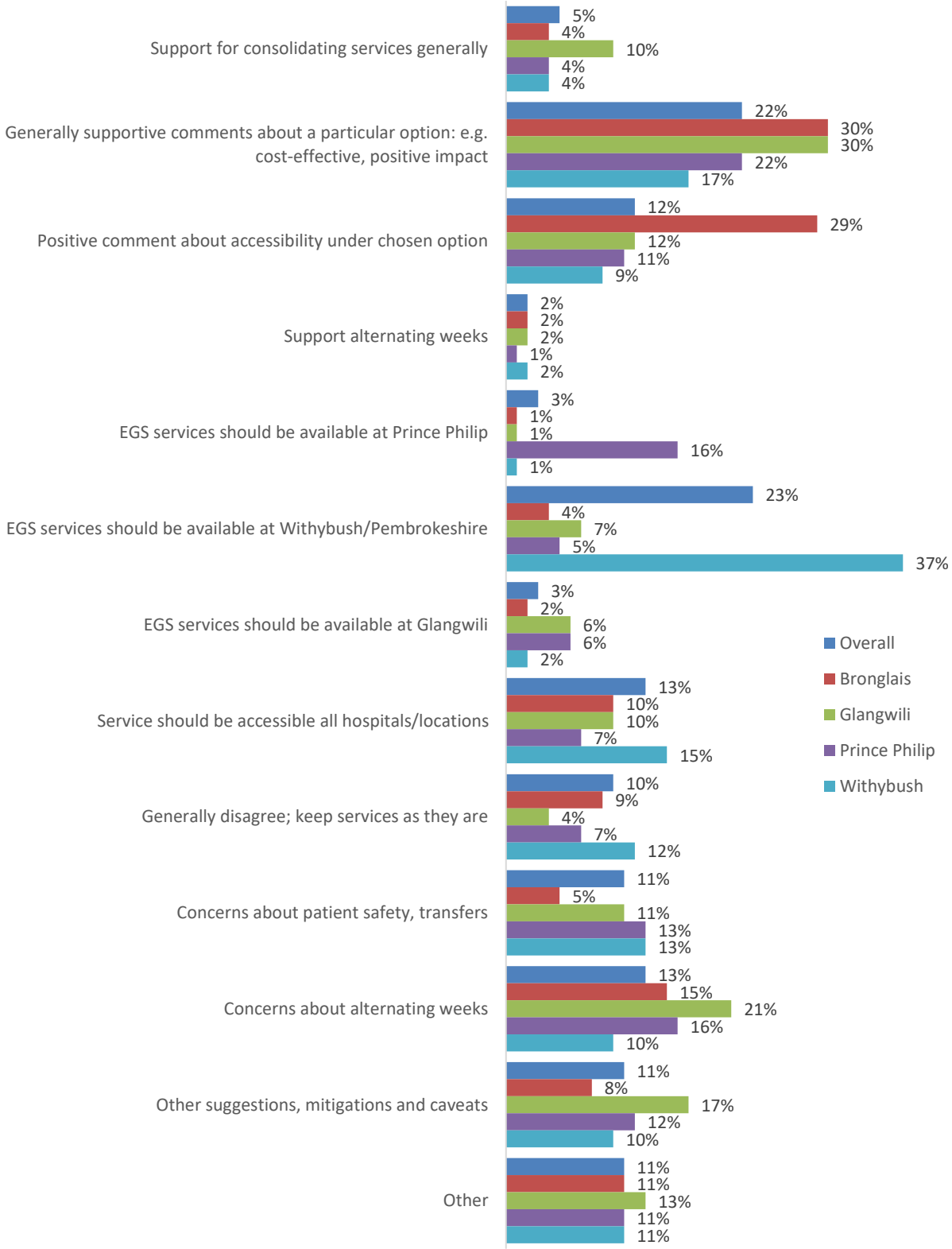
Reasons for choosing options, and alternative suggestions (emergency general surgery)

3.92 Respondents were asked 'Please share why you chose this option. How could we improve it or reduce any negative impacts? Do you have any alternative ideas that would meet the objectives?' in an open text box. A summary of responses from those responding as individuals is provided in Figure 20 together with a summary broken down by nearest hospital.

3.93 The percentages quoted are out of all respondents providing a comment. Because respondents could provide detailed feedback, some comments cover more than one point and, therefore, the total percentages sum to greater than 100%.

[61] Nearest hospital based on travel time. 844 responses without postcode are not displayed, but are included in the previous chart of overall results.

Figure 20: Please share why you chose this option. How could we improve it or reduce any negative impacts? Do you have any alternative ideas that would meet the objectives? (individual questionnaire respondents only) (Percentages are of those providing a comment to this question) (Responses by nearest hospital[62] are where postcodes were provided)



Base: Overall individual respondents (1,702), Points raised (2,352)

[62] Nearest hospital based on travel time

3.94 Out of all respondents who made a comment, a relatively small number (5%) provided feedback that was generally supportive of the principle of centralising emergency general surgery without providing any extra detail; these kinds of comments tended to be made most frequently by those whose nearest hospital is Glangwili.

> *"A centralised option should lead to a higher standard of care and better administration."*
>
> *"Consistency in provision and location key to manage expectations of staff and patients."*

3.95 Just over a fifth (22%) provided a comment that was generally supportive of their preferred option. Those whose **preference was Option A** suggested that it would be more practical, clearer, more efficient, more cost effective, more sustainable, and optimise resources. While those whose **preference was Option B** suggested that this option would maximise geographical coverage and reduce travel, be the fairest option, offer more flexibility, and provide a compromise/balance between consolidation and patient convenience.

> ***Option A:***
>
> *"The option easier for staff, possibly more patients being seen and money spent for better resources for one place rather than substandard resources in all hospitals."*
>
> *"Appears a sensible way of maximising service & minimising travel"*
>
> *"Option A appears to offer the best quality of service based on staffing and ease of understanding/access. Retains provision to the north and south and accommodates those to the north who also might use Hywel Dda services."*
>
> *"Makes financial sense and a reasonable compromise."*
>
> ***Option B:***
>
> *"This option, which bases consultant surgeons at Bronglais and alternates weekly between Glangwili and Withybush, strikes a balance between patient access and service delivery. By providing surgery closer to home on alternate weeks, Option B reduces the travel burden for patients near Withybush, which is especially important in urgent situations where time and stress levels matter. Although the rotating schedule is more complex for staff, this approach demonstrates a clear commitment to patient-centred care and acknowledges the importance of local access in rural areas. Overall, while Option B requires more coordination, it offers a more equitable service distribution and better supports patients and their families by minimising unnecessary travel."*
>
> *"This option allows some patients, especially those near Withybush, to have surgery closer to home at least part of the time, reducing travel and improving accessibility. Although it is more complex for staffing, it balances patient convenience with maintaining emergency surgery coverage."*
>
> *"Alternate week work allows more staff to maintain skills and makes a more flexible workforce. Where venues have difficulty such as seen in RAAC there are built in other options to allow services to continue and allows for change and expansion in future should it be needed."*
>
> *"I believe alternating this service would be fairer on patients throughout the 3 hospitals, giving a better choice for patients needing to travel & family visits & support."*

3.96 Further feedback given by those in **general support of Option A** related to concerns around alternating sites, noting that Option A provided clarity and certainty for patients and families in an already stressful time, with many stating that centralising services at Glangwili and Bronglais would be clearer, and easier to communicate to the public. It was also felt that it would be easier to manage from an administrative

perspective, particularly in terms of resourcing, and that it would be a more stable environment for staff. It was frequently noted that emergencies can't be planned for.

> *"This seems the most logical, as patients will have more certainty and staff will be working in a more familiar, stable environment."*
>
> *"Alternate weeks is like playing the lottery! If its emergency and it's not that week that the consultant is there then it could be catastrophic and if someone survives journey to emergency surgery location this will have cost more in resources and maybe their outcome not as good which again in turn will cost more in rehabilitation and services."*
>
> *"Clarity for patients and families. Under Option A, patients know exactly where surgery will take place (Bronglais or Glangwili). This consistency avoids confusion about which hospital is operating that week, making it simpler and more reliable for patients, families, and ambulance services. Safer and more sustainable for staff."*
>
> *"Alternating week surgery would be difficult to staff and manage. There would be the issue of staff having to travel and therefore it would not be the best use of their time and skills."*
>
> *"Option B sounds chaotic and confusing for staff and patients. For example, if a person has a suspected diagnosis requiring emergency surgery, should they check the week before travelling to hospital? Staff will need to adapt to unfamiliar environments and layouts."*

3.97 Comments in support of **centralising services through Option A** also suggested it would be best for staff recruitment and retention, as well as optimising staff resilience and cover, with many emphasising the benefits of this in terms of better outcomes and patient safety. However, it was suggested (under either option) that there is still a need for investment in the recruitment of surgeons and staff across both hospitals.

> *"Option A makes it easier to recruit and retain consultant surgeons because services are concentrated in fewer centres. This means better staffing resilience, less risk of rota gaps, and more reliable surgical cover, especially for children and young people."*
>
> *"It doesn't make sense for surgeons and their support staff (anaesthetists, etc.) to travel - wasting their time, wearing them out, and making recruitment harder. Ideally there would be permanent surgery staff at both Withybush and Glangwili, but if that's not possible, focusing on one site is best for surgeons and safer for patients. The travel for patients would be a one-off inconvenience."*
>
> *"Option A seems more sensible to me to bring staff together and solidify rotas and volume of opportunities for consultants."*
>
> *"I chose Option A, but investment is needed in recruitment of surgeons and staff and expansion in Emergency General services at both locations."*

3.98 It was generally stated that centralising surgery would lead to improved quality of care, with many noting that the priority should be to maintain patient safety, but for **those whose preference was Option A,** consolidation at fixed sites was felt to reduce risk and lead to better outcomes. Consideration for the safety of children, who could potentially be disadvantaged due to staffing issues under Option B, was also highlighted by some.

> *"Quality of care. Concentrating surgery at fixed sites allows for stronger surgical teams, more consistent expertise, and safer decision-making. Option Bs alternating model could create gaps in cover and increase risks, particularly in emergency situations and paediatric care."*

"Outcomes will be better if operations are centralised and it allows for all staff involved to be more experienced."

3.99 Some respondents who stated a **preference for Option B**, argued that if the service was removed from Withybush entirely, the need to travel further in emergencies could pose additional risks to patient safety.

3.100 It was also argued that utilising alternating sites, as opposed to two permanently staffed sites, would provide the opportunity to optimise both staff resources and expertise, resulting in a higher quality of patient care. Several comments noted specifically that Option B would be better for patient safety and is more patient-led.

"Option B is the least "worrying" of the options. The word emergency signifies that treatment is needed straight away - not miles away! Removing any emergency treatment from a hospital puts people at risk. Employ more staff to be on-site and don't risk people's lives!"

"This is better for patient care and safety. Glangwili is a long way away when needing emergency surgery, particularly from rural parts of Pembrokeshire. This also relies on being able to get appropriate transport to transfer the patients."

"Enhanced Staff Utilisation and Expertise Concentration - Rather than spreading limited emergency medicine physicians and specialised nurses thinly across multiple permanently staffed sites, alternating allows for concentrated expertise at each location. This can result in higher-quality care delivery, better maintenance of clinical skills through adequate case volumes, and more efficient use of scarce rural healthcare personnel."

3.101 It was suggested by some respondents in **support of Option A** that providing Emergency Surgery continuously at just two hospitals (Bronglais and Glangwili) could potentially increase the number of surgeries that can take place due to the reduction in travel time for staff, therefore reducing waiting lists and opening up the possibility for Withybush to concentrate on planned operations and/or be repurposed to provide other services. However, conversely it was suggested by those in **support of Option B** that retaining services at both Glangwili and Withybush could reduce waiting times by freeing up more beds.

Option A:

"I believe having operations in two specified hospitals would reduce consultant travelling time thus increasing the number of patients that can be seen also make it easier and clearer for appts to be booked."

"…The surgical site at Withybush could possibly be repurposed or used by other teams."

"Concentrate the expertise for emergency surgery on two sites to improve outcomes. Alternating the service between two hospitals really does not sound very sensible. The remaining hospitals without emergency surgery can then concentrate on planned operations."

Option B:

"Option B allows the time required for discharging / transferring of patients and freeing up of beds"

"Option B will improve surgical waiting lists"

3.102 It was generally acknowledged that travel distance and time are very important considerations when planning emergency care with around one-in-ten (11%) mentioning concerns around patient safety and transfer, though it was frequently noted by those whose **preference was for Option A** that travel should not pose a major problem as there are generally good transport links between Withybush and Glangwili.

However, it was acknowledged that some patients are still likely to experience some travel difficulties owing to poor road links to Withybush from the west. Furthermore, some of those whose **preference was Option A** did raise some concerns around potential issues relating to transporting patients in an emergency, as well as after surgery, emphasising that Option A would only work if sufficient transport (ambulances) was available – for example a dedicated service provided between the two hospitals.

3.103 Furthermore, several comments from those in **support of Option B** highlighted the advantages of alternating services in terms of avoiding travel issues and accessibility for those in Pembrokeshire, with some noting that this was particularly important for elderly patients.

> *"We cannot staff the current model safely. However, there would need to be a dedicated transfer service if you were to remove emergency surgery from Pembrokeshire due to the distances involved and the current loss of ambulances into Carmarthenshire and Swansea means you often don't have any ambulances available. If you remove emergency surgery, you need to have specialist transfer available quickly."*
>
> *"While neither option is desirable due to the travel difficulties some patients may face in reaching an emergency appointment, Option A would guarantee a single place for people to go to, rather than uncertainty of alternating weeks. Road connections between Haverfordwest and Carmarthen have improved due to the A40 upgrade, and travel times have been reduced."*
>
> *"I think that it would be much better to keep all the emergency general surgery at Glangwili, as it would be more difficult to find consultants to staff the other option. However, the transport service would have to be improved so that people from Pembrokeshire would be able to access the services easily in an emergency."*
>
> *"I have chosen Option B as I believe that travel will have a severe impact to life! Travel time especially from west Wales is lengthy not to mention traffic accidents and lack of availability for reliable traffic services."*

3.104 There was a general acknowledgement amongst those whose **preference was Option A** that, while they felt this option would be better than Option B overall, those living in Pembrokeshire would be put at a disadvantage. However, it was noted by some that any potential harm to patients who would need to travel further for emergency surgeries could be mitigated by strengthening same day emergency care and enhancing recovery support at Withybush. Other suggestions to help reduce the potential negative impacts of centralising services included investing in transport systems between Withybush and Glangwili (e.g., emergency ambulances or patient transport with clinical staff on board) and expanding pre-surgical assessments in Withybush to ensure only necessary transfers happen. Another respondent suggested that, if possible, all tests, scans, x-rays etc. should be carried out on the same day to minimise stress and travelling for patients.

> *"Same day emergency care is retained & could be strengthened at Withybush, meaning potential harm from travelling should be mitigated."*
>
> *"I can see the sense in this one in terms of facilities and functions and staff - it would be important to maintain services locally for people to return to and recover."*
>
> *"Invest in high-quality, fast, and supported transport systems between Withybush and Glangwili (e.g., emergency ambulances or patient transport with clinical staff on board). Expand telemedicine pre-surgical assessments in Withybush to ensure only necessary transfers happen. Enhance recovery support at Withybush so that patients can return to their local hospital for post-op care as quickly and comfortably as possible."*

"Option A - this option would provide 2 hospitals giving emergency care and routine surgery at the 2 other sites. To minimise stress and travelling for patients, blood tests and x-rays, scans etc. should all be done, if possible, on the same day."

3.105 Many of those whose **preference was for Option B** (and whose **nearest hospital is Withybush**) stated that it would be better for them personally (as well as for Pembrokeshire residents generally) as services would be closer for them, minimising travel. It was noted that alternating services would reduce travel burden for dispersed communities and ensure that no single community is disadvantaged, making particular reference to areas with varying seasonal demands for services. Some others also noted that they are worried about a demise in services at Withybush in general should some services be removed.

"Whilst not an ideal scenario for Withybush every other week is better than none, although I would prefer a full-time service."

"Option B is by far the most patient friendly, allowing patients who have difficulty travelling great distances to have the best care closer to their homes, family and friends. It will reduce patient stress which even is harder when facing major surgery."

"Pembrokeshire would have at least some cover and less travelling for people who live in areas where there are fewer public transport options"

"Reduced Travel Burden for Dispersed Communities - Rural populations are often scattered across wide geographic areas with poor transportation infrastructure. Alternating sites can significantly reduce travel distances for different community segments on a rotating basis, ensuring that no single population cluster is permanently disadvantaged by excessive travel times to emergency care. Improved Population Coverage During Peak Risk Periods - Different rural areas may have varying seasonal or occupational risk patterns (farming accidents during harvest, tourism-related incidents, weather-related emergencies). Alternating services allows emergency care to be positioned closer to anticipated high-risk areas during their peak periods, improving response times when and where they're most needed."

3.106 In addition, it was suggested that alternating service between two hospitals could prove beneficial to both the local areas, as the necessity to provide more robust community-based services to support hospital-based emergency services, can enhance community resilience and preparedness for emergencies.

"Enhanced Community Emergency Preparedness and Self-Reliance - Alternating services necessitates stronger community-based first aid training, volunteer emergency response teams, and inter-facility transport protocols. This model can foster greater community resilience and emergency preparedness, creating more robust local response capabilities that complement rather than replace professional emergency services, ultimately improving overall emergency response across the rural region."

3.107 There were many general comments in support of **maintaining (or strengthening) emergency general surgery services at Bronglais** (from those in support of Option A and B, though mainly from those who had no preference), which was felt to be essential given the large rural area and dispersed population that it serves, as well as having poor transport links to the south. It was also acknowledged that Options A and B both ensure that the service is in maintained in the north and south of the Hywel Dda area.

"The population that Hywel Dda serves is not only within its borders but also includes areas of Betsi Cadwalader in the North and Powys to the east. A sparsely populated large area with poor transport links to the South of the Health Board. It is imperative that emergency general surgery remains at Bronglais for equitable provision of services and decreased risk of morbidity and mortality."

"No preference provided full emergency general surgery, including surgical operations, are maintained at Bronglais so patients in rural mid Wales are not subjected to long journeys on poor transport links."

"Bronglais serves a large geographic area so services need strengthening, sending patients elsewhere would only put a strain on waiting times and budgets."

3.108 One-in-ten (10%) respondents disagreed with both of the proposed options, stating that **services should be kept as they are**, and 13% stated that **emergency general surgery should be available at all hospitals**. It was suggested patient transfer would be a barrier to consolidation, and that instead recruitment of surgical staff should be improved. To attract staff to work in the health board, the benefits of living in the area (e.g. quality of life) should be promoted; it was also suggested that incentives could be offered.

"How does the health board propose to cope with the transfer of patients when the ambulance service is already not fit for purpose. And non-emergency patient transport services are also struggling."

"Surely through effective recruitment campaigns utilising international solutions you are able to attract Consultants to various sites"

"Train more doctors and incentives to work in Wales"

"Maintaining the status quo should be given as an option in every section. Emergency surgery should be delivered as close to patients' homes as possible. Given the issues with staffing my comment is that there is not enough promotion of the quality of life to be experienced living and working in West Wales. Who needs to live near a huge shopping centre when you can order many goods online now. The outdoor environment and cultural life of the area should be promoted to encourage people to work and live here."

"Neither option is a good or safe option. The logistics of transferring patients requiring emergency surgery are complex and multi-faceted. This was demonstrated when Withybush was sending emergency surgery to Bronglais and Glangwili on alternate weeks. You need to consider that these transfers can be very time critical, and delay in transfer will be detrimental to the patient. A transfer of a patient requiring emergency surgery 40 miles down the road in itself could have detrimental consequences for the patient. Have you considered the capacity that WASUT has in order to do these transfers? Also consider the capacity of the receiving hospitals. You wouldn't want to transfer the patient to be told the patient will stay on an ambulance outside of ED"

3.109 Almost a quarter (23%) of respondents (and over a third (37%) of respondents whose **nearest hospital is Withybush**) made comments favouring an alternative option with a full emergency general surgery service remaining permanently at Withybush hospital. The main reasons given were that the risk to Pembrokeshire residents for some surgeries is too high given the necessity to travel, if only a partial or no service is provided at Withybush, and that emergency services can't be planned to meet a schedule of alternate weeks. It was asked whether an analysis had been carried out into the impact on outcomes associated with removing full-time emergency general surgery service at Withybush.

"It is not acceptable that Full emergency general surgery, including surgical operations are not included as an option for Withybush. Given the distances, transfer times and lack of ambulances covering Pembrokeshire."

"Service should be provided at Withybush ALL the time. Emergencies cannot be scheduled for alternate weeks."

"I'm sick to the back teeth of being sent to Glangwili for everything, you are running Withybush down, and it serves a huge rural population, with massive tourist influx from April to October. Withybush needs on site Emergency care, and ability to operate. Glangwili is falling down, overcrowded, and buckling under the strain of taking services from Withybush."

"Some abdominal surgeries are time critical. It's takes 40 minutes to travel from Withybush to Glangwili in an ambulance. And that's if there is one available. Having consultants under one roof in Glangwili is not going to improve the outcome for patients in Withybush who need time critical surgery. I feel this is a massive risk. Patients who would require treatment for trauma such as damage control surgery would suffer greatly. I appreciate Welsh air ambulance would transfer these patients to a level 1 MTC. However, statistics show most traumas are 'walk in' or self-presenting. I feel this poses a risk not having surgeons in Withybush."

"Withybush needs to keep its services. If you reassured people that Withybush will stay open then staff will come. It's the uncertainty of the hospital that has a knock-on effect with retention. Why would Drs want to come to Withybush when they have no idea if their positions are safe."

3.110 A few respondents suggested that it would make more sense to consider an alternative option of keeping emergency general surgery services available all the time at Withybush and removing or reducing services at Glangwili. They felt that those living in the east of the health board area would have the option of travelling to hospitals in the Swansea Bay University Health Board (i.e. Morriston) or Prince Philip (if emergency general surgery services were provided there) as well as to Withybush, whereas those in Pembrokeshire have more limited options. It was also frequently noted that it was difficult to recruit staff to a hospital where services are repeatedly downgraded or removed, and it was felt that providing reassurance that services would not be changing at Withybush would encourage recruitment.

"You cannot plan services this way. You need to look at the whole and work out where services are needed, So Withybush, Bronglais, none required in Carmarthenshire so disinvest in acute services there and redistribute to community, Swansea Bay, Withybush and Bronglais. Why is investment in a crumbling hospital (Glangwili) being considered. Not very good for patient experience. Not sure I can say much more than that because we seem to be back where we were in 1990, 2010, trying to make it "a good thing for Glangwili" (Purt,T). Look how well that went."

"Shut down services at Glangwili and transfer services to Withybush and Llanelli. Why is this not an option?"

"I feel strongly that for this type of surgery the people of Llanelli should be taken to the nearest hospital and that is Morriston, the funds that are associated for this function should be given to that hospital if necessary. People from Llanelli must be dying because you are insistent of transferring them to Carmarthen which takes longer."

"Retaining emergency General surgery in some form, albeit only on alternate weeks is essential for the recruitment of general medical consultants and medical and surgical trainees. Because of the distances involved between DGH's [NB Morriston] there is more logic in retaining emergency surgery in Withybush and close it in Carmarthen, whilst seeking alternative cover for paediatrics."

"Why not have this service based at Withybush permanently and a surgical staff at Glangwili for paediatric cases and cases from Prince Philip that could not manage the journey. Getting from the west and north of Pembrokeshire to Glangwili is probably just as far as the people of Llanelli getting to Withybush"

3.111 Conversely, many of the comments from those whose **preference was for Option A** (and whose **nearest hospital is either Prince Philip or Glangwili**) stated that surgery should remain available at Glangwili, or be centralised there, as it would be more accessible and convenient for them due to their location. It was also suggested by a few that consolidating at Glangwili would mean that more operations could be delivered overall.

"No option is easy but probably Option A would give patients from Llanelli and surrounding areas a better chance of being operated at in Glangwili than if they would have to travel to Withybush."

"Glangwili is halfway in between the other hospitals."

"Given the fact all pregnant patients and children will require emergency surgical input in Glangwili, it seems a more viable option to consistently have emergency care in Glangwili."

"It would be best to have a strong central team at Glangwili that could develop and strengthen its skills. But day care services must be maintained and strengthened at both Glangwili and Withybush hospitals."

"You will find you have more than enough surgeons, anaesthetists and theatre staff to operate 7 days a week."

3.112 Around one-in-six (16%) comments made by those whose **nearest hospital is Prince Philip** called for an alternative option with either full emergency general surgery, or potentially same day emergency care, available at Prince Philip. Respondents frequently commented that it makes more sense for these services to be in Llanelli as it has the largest population in the area, therefore increasing coverage and reducing the number of those who would need to travel. Those respondents who suggested that services should be available at Prince Philip as opposed to Glangwili (in addition to Withybush) also cited concerns around the availability of parking, and the hospital building being old and unfit for purpose at Glangwili.

"Llanelli is the largest populated town, with heavy industry, farming and coastal, yet has no emergency coverage."

"If centralisation is happening the hospitals need to be improved, not just squeezing extra stuff in to already old and tired buildings. There also need to be better parking if people are traveling and reduced cost when parking."

"Glangwili is a dreadful hospital and totally unfit for purpose."

3.113 Respondents proposed other potential alternatives, suggestions and mitigations including the following:

- a possible alternative hybrid model, maintaining a permanent consultant presence at Bronglais and Glangwili, as in Option A, with a scheduled daytime emergency surgery service for lower-risk, common conditions (e.g. appendicitis) at Withybush, supported by visiting surgical teams
- a main hub at Glangwili for complex cases but with same day surgery/less complex cases remaining at each local hospital;
- or consolidating to just one single site for all surgery

» a volunteer transport service to mitigate travel and accessibility concerns

Organisational Responses

3.114 Nine organisations felt Option A best met the Clinical Services Plan objectives for emergency general surgery and six thought Option B best met the objectives.

3.115 Of those preferring Option A, two organisations commented on how they felt this would be the best option for Bronglais.

> *"Emphasizing the importance of keeping this essential service in Bronglais. This is very important to ensure the health of the people of Mid Wales?" [Lledrod Community Council.]*
>
> *"Best option for Bronglais." [Dyfi U3A – Machynlleth catchment area]*

3.116 Another two organisations preferring Option A chose it as the best option for those based in Llanelli, however one organisation still felt emergency general surgery should be available at Prince Philip.

> *"It makes sense to have Emergency general service available In Glangwili so that patients from Llanelli do not have to travel even further." [Hearts and Crafts, craft group based in Llanelli]*
>
> *"Important that the SDEC is kept at Prince Philip." [SOSPPAN – Save Our Services Prince Philip Action Network]*

3.117 One organisation preferring Option A noted concerns about the impact of possible changes to critical care at Withybush, which may require patients to be transferred if ICU care is required following emergency surgery at Withybush.

> *"The impact of possible changes to critical care, namely the closure of ICU and establishment of ECU could increase risk for those having to undergo emergency surgery in Withybush and require transfer if ICU care required." [Critical Care Clinical Psychology service]*

3.118 Within their full submission (summarised in Chapter 8) the **West Wales Renal Service** raised safety concerns around the proposed emergency general surgery models, citing current problems with delayed inter-hospital transfers that already worsen patient outcomes.

3.119 The one organisation preferring Option B who made a comment, described this model as:

> *"A better and safer way." [Care home manager of Llanfair Grange care home]*

Endoscopy

3.120 Respondents were asked 'Which option for endoscopy services do you believe best meets the Clinical Services Plan objectives, considering patient care, accessibility, and outcomes?'. They were provided with a summary of what endoscopy services included, where it was currently provided and the issues currently faced. Three different proposed options were presented for respondents to choose from: Option A, Option B, Option C and they were also given the opportunity to select 'No particular preference' and 'don't know'.[63]

- **Option A** - gastrointestinal services would continue at all four main sites. At Prince Philip, the unit would expand from two to three procedure rooms to support bringing together respiratory and urology endoscopy procedures. Patients living outside of the Prince Philip areas would have further to travel for these services. There would be no changes to the current bowel screening service.
- **Option B** - gastrointestinal, respiratory and urology endoscopy procedures would continue at the same hospital sites as the current service. All bowel screening would move to a new community site focussed to the service, which would allow for more appointments within the service. Some patients may need to travel further to access bowel screening, but others, dependent on the location of the new community site, may travel less distance.
- **Option C** - gastrointestinal services would continue at all four main sites. Service would increase by extended working hours (later into the evenings Monday-Friday, and on weekends) at Prince Philip. This would allow all urology and respiratory endoscopy procedures to be provided at Prince Philip. Patients living outside of the Prince Philip areas would have further to travel for these services, but there would be more appointments outside of working hours – evenings/weekends at Prince Philip. There would be no changes to the current bowel screening service.

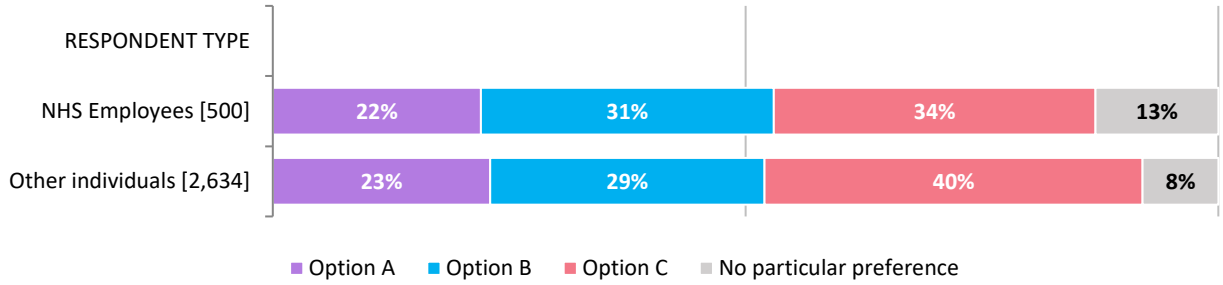
By respondent type (endoscopy)

3.121 Figure 21 shows there was a split in opinion for those individual respondents who identified as working for the NHS, with around a third (34%) preferring Option C, just under a third (31%) preferring Option B and just over a fifth (22%) thinking Option A best met the Clinical services plan objectives.

3.122 However, a greater proportion of other individuals, two fifths (40%) thought Option C best met the objectives.[64]

[63] Full details of the information provided can be found in the consultation questionnaire.
[64] 134 respondents selected the 'don't know' option. This is omitted from the chart for presentational convenience (standard industry practice) because it does not affect the order of preference of the available clinical options.

Figure 21: Which option for endoscopy services do you believe best meets the Clinical Services Plan objectives, considering patient care, accessibility, and outcomes? By respondent type (individual respondents only)



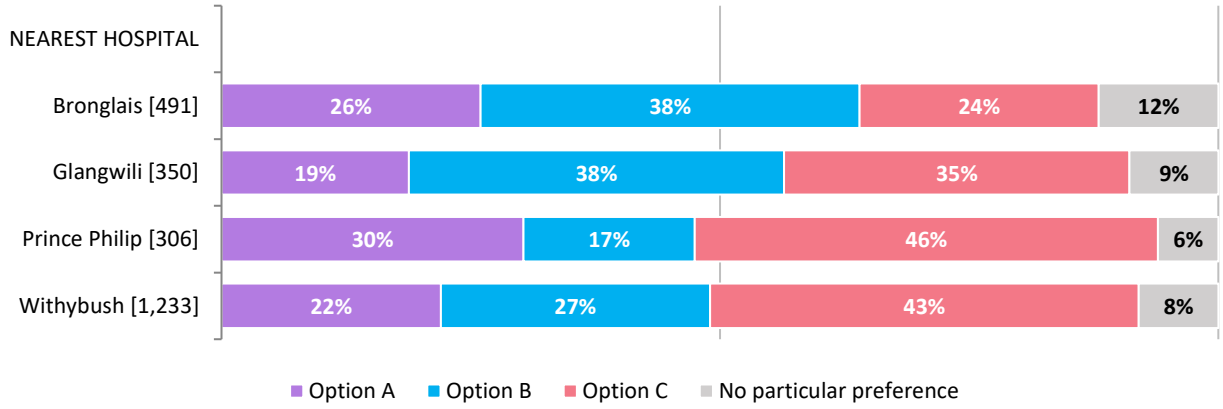
Base: Number of respondents shown in brackets (excludes 'don't know' responses)

By nearest hospital (endoscopy)

3.123 Option C is also the most preferred option for individuals living closest to Prince Philip and Withybush hospitals with over two-fifths (46% and 43% respectively) favouring this option (see Figure 22). Though a greater proportion of those living closest to Prince Philip favoured Option A compared to other areas.

3.124 Meanwhile, Option B is preferred by a greater proportion living closest to Bronglais and Glangwili hospitals (38% for both).

Figure 22: Which option for endoscopy services do you believe best meets the Clinical Services Plan objectives, considering patient care, accessibility, and outcomes? By nearest hospital[65] (individual respondents only, where postcodes were provided)



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

By health board (endoscopy)

3.125 The number of individual respondents living outside the Hywel Dda Health Board area is low so limited conclusions can be drawn, but there was a split in opinion for individuals living in Powys Health Board with 40% favouring Option A and 36% favouring Option B. There was also a split in opinion for those individual respondents living in Betsi Cadwaladr and Swansea Bay University Health Boards with 33% and 30% favouring Option A respectively, 20% and 26% favouring Option B and 33% and 33% favouring Option C.

[65] Nearest hospital based on travel time. 754 responses without postcode are not displayed, but are included in the previous chart of overall results.

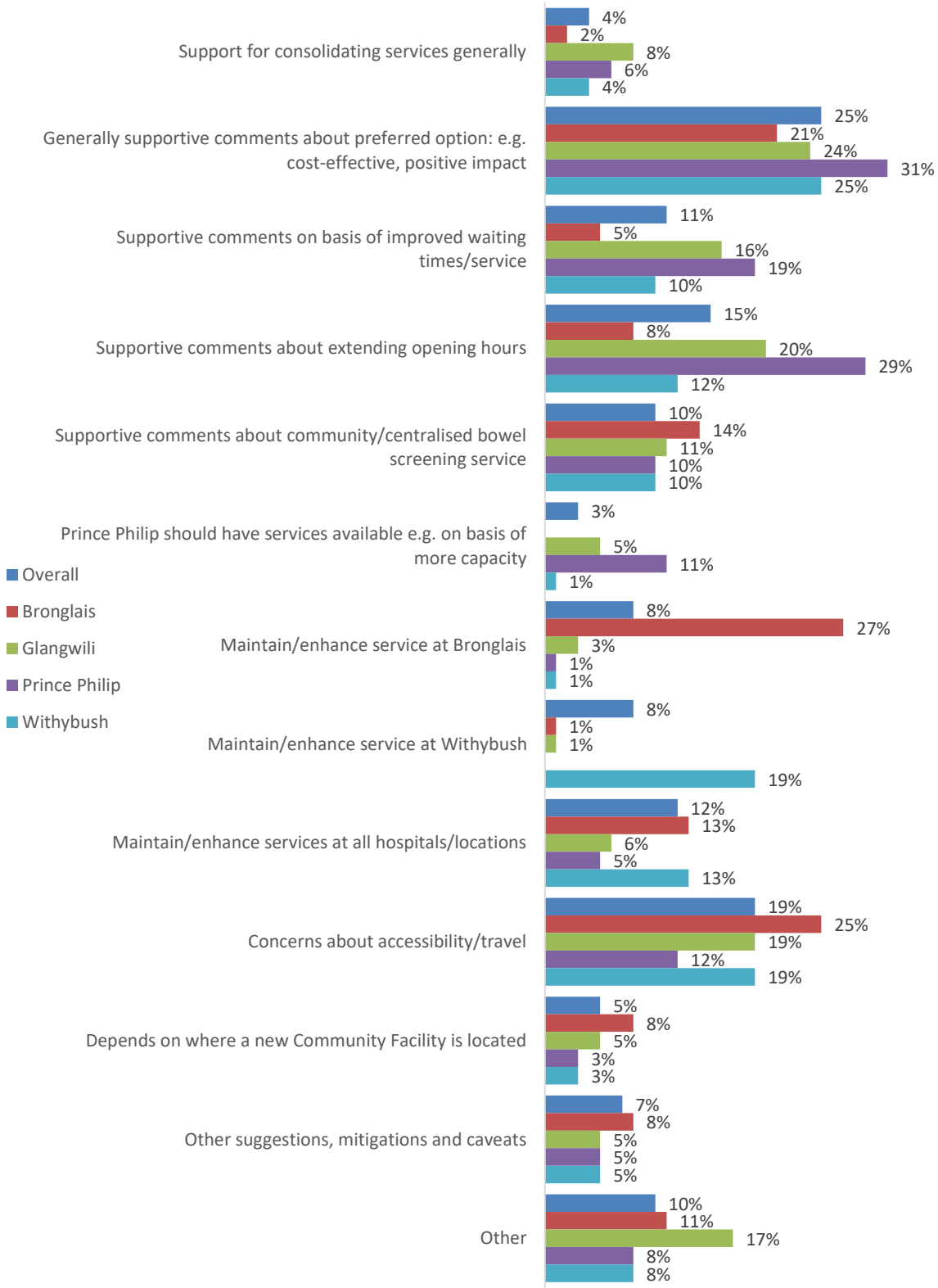
By other demographics (endoscopy)

3.126 Across other demographic groups, there was no clear variation in opinion beyond that explained by proximity to each hospital.

Reasons for choosing options, and alternative suggestions (endoscopy)

3.127 Respondents were asked ‘Please share why you chose this option. How could we improve it or reduce any negative impacts? Do you have any alternative ideas that would meet the objectives?’ in an open text box. A summary of responses from those responding as individuals is provided in Figure 23 together with a summary broken down by nearest hospital. The percentages quoted are out of all respondents providing a comment. Because respondents could provide detailed feedback, some comments cover more than one point and, therefore, the total percentages sum to greater than 100%.

Figure 23: Please share why you chose this option. How could we improve it or reduce any negative impacts? Do you have any alternative ideas that would meet the objectives? (individual questionnaire respondents only) (Percentages are of those providing a comment to this question) (Responses by nearest hospital[66] are where postcodes were provided)



Base: Overall individual respondents (1,257), Points raised (1,710)

[66] Nearest hospital based on travel time

3.128 Of all respondents who made a comment, there was support for maintaining some service at every hospital (12%) and the general principle of increasing activity, with a quarter (25%) providing feedback that was generally supportive.

3.129 Over one-in-ten (11%) made comments recognising that waiting times needed to be improved, and that the options should help with this.

> *"More access to services hopefully reducing waiting times."*
>
> *"Patients need to be seen quicker."*
>
> *"Priority has to be reducing waiting times"*

3.130 Preferences differed as to whether the improvements should be achieved by increased capacity during the day (3% mentioned this in a comment), extended opening hours (15% mentioned) or centralising bowel screening (10% mentioned). Reasons for supporting particular options are presented below:

> ***Option A:***
>
> *"Maintaining GI and bowel screening on all sites is reasonable as this avoids undue travelling plus it is a basic screening service that should be offered on all sites. Similarly, centralising urology and respiratory and developing a new procedure room would enhance and consolidate those services."*
>
> *"Clinical sessions being increased during the day is preferable to extended hours because of the lack of evening transport availability."*
>
> *"Screening and early investigation are essential to identifying problems early. However, people are reluctant to commit the time to travel far for investigative procedures like endoscopy. This is especially true of people like farmers who find it difficult to be away from home for long. It therefore makes sense to retain local services in the most common endoscopial procedures. I understand that Bowel screening / gastro-intestinal investigations are the most frequent and therefore should be prioritised for retention locally. Option A does this better than the other options - albeit that urology is not available on all sites."*
>
> ***Option B:***
>
> *"The present, proactive postal screening system is very useful. A more streamlined specialist site would complement the present provision. Again, an early detection of problems is the key."*
>
> *"Looking at these three choices, the best option overall is Option B. Here's why: Access to all three services (GI, respiratory, urology): Under Option B, patients keep the same access to gastrointestinal, respiratory, and urology endoscopy at their current hospitals. This avoids creating inequalities where patients outside the Prince Philip area would have to travel further (as would happen under Options A and C). Improved bowel screening capacity: By moving bowel screening to a dedicated community site, Option B would free up capacity in the main hospitals and allow more screening appointments overall. This supports earlier detection, shorter waiting times, and better outcomes. Balanced travel impact: While some patients may need to travel further for bowel screening, others may actually travel less depending on the location of the new community site. This creates a more even distribution of services, rather than concentrating them more heavily in one hospital. Future-proofing the service: Option B creates a clear, sustainable model by separating screening from diagnostic/treatment services. This makes it easier to grow capacity and meet rising demand without overstretching hospital units."*
>
> *"Allows more simpler focus for hospitals to do gastro and urology and then a separate location that simply focuses on bowels. Easier on staff, easier for patients as there isn't a mix of needs"*

"I feel that having more options out in the community will relieve the hospitals and help patients have a more comfortable/ easier first point of contact."

"Taking respiratory services away from Glangwili would be spectacularly dangerous. De-skilling the respiratory team in the only hospital with ENT services runs a profound risk of being without the ability to support food bolus aspiration cases- with severe risk of loss of life. Furthermore, moving respiratory cancer diagnostic services still further away from Ceredigion and mid Wales patients would be very poorly received by the public."

Option C:

"Offering extended hours is important so that more people are able to attend this potentially lifesaving procedure."

"Appointments outside working hours are helpful to patients."

"Seems like this option would consolidate services and allow quicker appointments for patients waiting to be seen and screened."

"Extended hours could help reduce waiting lists"

"It is important to continue cover in each location to avoid congestion at one hospital. Extended hours at Prince Philip essential. Weekend clinics seem the obvious option for many departments. Could these appointments be offered to patients living in the more remote parts of the county to make travelling easier?"

"Longer availability for appointments would benefit everybody and older family members may have support to get transport from family members."

"Extending the hours to include evenings and weekends would make good use of the facilities that are there already."

"Withybush keeps what it has at present and with the extended hours option for two services at Prince Philip, it would hopefully help patients to be seen more quickly. Not ideal for Pembs patients to travel that distance, but it's the best option I feel."

"I was interested in Option B but thought this may incur additional costs (having to initiate a new site with equipment just to focus on bowel screening). Integrating services whilst the finances are an issue may be preferable."

3.131 Some respondents supported modified versions of Option C, with some services consolidated at **Glangwili** instead.

"I believe Option C does the best to provide more services without needing to impact on the physical estates footprint at Prince Philip which could be impacted by the increase of services on the site, especially as this option works well with urology so needs colocation. I would like to suggest a slight alternative to this option in that Respiratory and urology procedures remain at Glangwili. This would mitigate against an increase in critical care at Glangwili, especially if Withybush and Prince Philip have their acuity reduced, and will support existing respiratory ward and service. This would also support the emergency urology pathway at Glangwili. To mitigate this, the Bowel Screening Wales work could be moved from Glangwili to Withybush. This would be in line with Glangwili providing more acute, interventional and emergency work, and Withybush providing more screening, non-emergency planned work."

"The journey from Aberystwyth to Prince Philip is at least 2 hours. Whilst I agree with centralising specialist procedures to one site, I don't think a site at the edge of the HD area is the right choice. Surely Glangwili would be a better option if centralising respiratory/urology? If reducing sites that offer a procedure- it would make more sense to choose either Prince Philip or Glangwili as these are closest together and travel time between the two is reasonable. Perhaps having Glangwili specialise in urology/respiratory if this is not available elsewhere in the hospital but then have bowel/gastrointestinal not at Glangwili (to free up space) and available in the other sites. The same problem arises with using a community site for bowel screening and only having 1 site. I think 1 hour travel time (possibly slightly longer) should be the maximum, so depending on where the site is, it may be very difficult to people to attend. For those without access to a car, transport links would need to be considered. Please consider the impact on hospital transport availability for any appointments without good public transport."

3.132 Around 5% made a comment specifically in relation to consolidating bowel screening, and the location of any new bowel screening site (proposed in Option B).

"Location will be vital for Option B. The number of older patients concentrated in and around North Pembrokeshire, South Ceredigion, and North West Carmarthenshire suggests the best location for a community screening service would be Cardigan…"

"…Could the new community site (if this option is chosen) not be placed down south at Prince Philip or Bronglais, but geographically central, so access is more readily available to more of the population of Hywel Dda to reduce disadvantage to those to the north or south."

"It is very difficult to specify a preference because you have not identified the location for the community hub therefore, we can't fully assess the impact on patients. We have gone for Option C but only to give more options for Out of Hours and weekend appointments."

3.133 One fifth (19%) commented that regard should be given to the travel times for patients and their families.

"It is sensible to amalgamate all the endoscopy services in one centre of excellence and increase the days/times of that being available. However, people undergoing colonoscopy must be given the option of this being available in their home county. I, for one, would not want to travel any further than a few miles after being given that bowel preparation which still affects the gut hours after it has been taken and requires a very urgent trip to the toilet. It would be grossly unfair to make patients already very uncomfortable to suffer further indignity because of having to travel across counties for this service."

"Extended hours at the site furthest east is concerning - needs to be sited further west - at the very least Glangwili."

"This provides bowel and gastrointestinal services at all hospitals with respiratory and urology at Prince Philip. I would add that another hospital should also provide these additional services for availability across the area."

"Why can't we have all services at all hospitals"

"All hospitals should provide all these services no patient should have to make long journeys to receive treatment…"

3.134 As can be seen from the figure above, some respondents' views on the proposed options were influenced by their proximity to a particular hospital.

3.135 A few commented that the service should be consolidated at **Glangwili**.

> *"Screening needs to be radically improved using new technologies. All urology surgery should be focused on our planned care speciality centre of excellence at Glangwili…"*

3.136 Respondents who made comments **that endoscopy services should be maintained or enhanced at Bronglais**, often emphasised the large size of the area under consideration. Whilst most respondents wanted services kept at Bronglais, some recognised that Glangwili could be a potential alternative if needed but that Prince Philip was too far away.

> *"If you are removing an element like urology from Bronglais then you need to provide it in Glangwili, Prince Philip is too far to travel for those in North Ceredigion. So, a more suitable option could be if you made the Option B for Bronglais Bowel screening + gastrointestinal then the rest of the areas would cover the other needs in a fairer way (locality)."*
>
> *"Invalid options - Services should be maintained at Bronglais as currently offered. Travel times to the other hospitals from Bronglais are significantly longer then between the other hospitals and along poorer roads"*
>
> *"Do Options A and C mean no urology at Bronglais? Have you considered the ability of people with incontinence to travel?"*

3.137 Those feeling that **endoscopy services should be maintained or enhanced at Withybush** identified issues with patients needing to travel further, some specifically noting how difficult travel would be given the treatment involved. Others commented on the facilities and services currently available at Withybush which they felt should be utilised, or hours extended.

> *"Withybush has a purpose-built endoscopy suite, use it properly instead of letting it go to ruin"*
>
> *"Withybush has an excellent service. Runs efficiently and works with other departments very well. In comparison to Glangwili it is newer and has more space. It is the top recruiter for patients entering clinical trials/research across the health board which is an asset to the hospital but more importantly to patients"*
>
> *"Withybush covers so many bowel operations right now, to stop services there would put pressure on all other hospitals."*
>
> *"I currently use the bowel screening services at Withybush and want that to continue. Anyone who has had to have a colonoscopy knows how horrific the preparation required before and effects afterwards; would not wish a long journey before and afterwards on anyone…"*
>
> *"Bowel screening / gastrointestinal / respiratory / urology all of these should be at Withybush"*
>
> *"Offer an out of hours option to Withybush"*

3.138 Those that supported consolidation at **Prince Philip** argued that this hospital had better capacity, space and experienced staff.

> *"More capacity at Prince Philip. Parking is better at Prince Philip and it provides an answer for the increase of demand which is cited."*
>
> *"Prince Philip has the room for this service and experienced staff to undertake the procedures"*

"Prince Philip hospital is very easy to travel to so makes sense to have it there"

3.139 Whereas some commented that **Prince Philip** was being given too many services to the detriment of other hospitals.

"Why is Prince Philip becoming the golden child? Why are all the services being centred here despite its close geographical relationship to Swansea and everything that has to offer in terms of a centre of excellence that is Morriston? There is no parity across the sites."

"Why is Prince Philip having better services than Bronglais when the people of Llanelli and the surrounding areas have access to Morrison and Singleton Hospitals (potentially 15 mins down the road)? Bronglais should have all services due to its location and why do the people of Ceredigion have to travel approx. 200 miles (depending on where they live)."

"…It doesn't make sense to expand Prince Philip because this is very inconvenient for anyone living in north and west Ceredigion. From north/west Ceredigion it is just as easy to get to Morriston Hospital as Prince Philip, and there is already a bowel screening unit at Morriston - it would be crazy to duplicate services just 15 mins apart along the M4."

3.140 In the context of extended hours, a number of respondents raised suggestions, mitigations or caveats in relation to travel and access, including transport links and better provision of hospital transport.

"Consideration of transport links, time, and availability will be important. It is pointless having additional weekend and evening appointments if those in need of the service cannot get to them or get home from them."

"Additional appointments would lead to less waiting although many patients rely on hospital transport, would this be addressed?"

"Patient transport should be considered, elderly or isolated patients who are unable to get access to transport should be considered. Are shuttle buses an option?"

"[Option C] Should be the best, but the evening and weekends would not be available for anyone relying on hospital transport services, unless their opening/closing times are altered as well."

3.141 Others raised concerns specifically relating to procedures.

"Bowel prep for these investigations is best done closer to home patient transport will need to be improved"

"As a doctor who worked in urology, there is no need for Glangwili to have cystoscopy on site. I agree it should all be in Prince Philip. Glangwili does however need the equipment to perform flexible cystoscopy on the ward / at the bedside, otherwise the emergency service suggested will rely on emergency theatres for this, taking up valuable time, space and staff…"

3.142 Some had concerns for how more serious conditions or emergencies would be dealt with.

"Whilst I see the advantage of bringing urology and respiratory endoscopy to one site, Prince Philip will have no ITU service - clinicians may end up not doing investigations that should be done for fear of lack of such support. Patients who are already needing level 2 or 3 care in Glangwili will not be able to travel to Prince Philip. There will need to be provision for higher risk urology and respiratory endoscopy in Glangwili."

"…There is no mention of the provision of emergency upper GI services in the descriptions. I would want to see assurance that a sustainable upper GI bleeding service can be sustained."

"There should be the ability to do emergency scopes for Acute Upper G I bleeds at all acute sites. This would mean that transferring critically unwell patients would be unnecessary. The current pathway between Withybush and Glangwili is not a good pathway for patients. Again, WASUT capacity and Capacity at Glangwili needs to be considered as currently unwell patients on a pathway are left on ambulances outside ED"

"Need bowel screening at all sites. How will the health board manage with the transfer of patients needing urgent tests at Prince Philip. Ambulance service stretched. Roads throughout HB awful."

3.143 Respondents proposed other potential alternatives, suggestions and mitigations including the following:

- provision of the service on a rotational basis across the hospitals / shared staff models, where endoscopy nurses and consultants rotate across sites
- the provision of a mobile service for endoscopy to mitigate concerns around travelling and improve rural outreach
- Option C but with the added new procedure room [Option A], by combining respiratory/urology services.
- making use of technology for example by offering telephone appointments where the patient does not need to be seem face-to-face
- utilising nurse practitioners and GP practices (or a cluster of GP surgeries) to provide more services in the community, potentially with pre-screening procedures to expedite or deprioritise cases based on the level of urgency
- providing services at other settings, such as Llandovery, South Pembrokeshire and Tenby Hospitals, and the Integrated Care Centres
- keeping bowel screening and gastrointestinal services on all sites as these are most widely used, but rotating or consolidating
- the option of bowel screening initiatives via the post.

3.144 The following were also highlighted as possible areas for further consideration :

- extending hours to include evenings and weekends should also be done with MRI's, CT Scans etc. It could also be implemented across most other departments that continue to have long waiting lists.
- maintaining services in Withybush could mean taking advantage of the new fluoroscopy machine which could offer ERCPs and potentially reduce the demand for MRI studies that are requested instead.
- once urology is consolidated on one site, urology endoscopy could follow this, with other endoscopy expertise built around that.

Organisational Responses

3.145 Six organisations felt Option C best met the Clinical Services Plan objectives for endoscopy services, five thought Option B and two thought Option A best met the objectives. Two organisations selected 'no particular preference'.

3.146 Those preferring Option C tended to comment on how they felt this would improve capacity and reduce waiting times.

"Adds more capacity through extended hours and does not disrupt the existing bowel screening service. This approach increases activity to reduce waiting times without removing local access to core services." [Elidyr Communities Trust]

"More people getting seen quickly." [Llanfair Grange care home]

"Option C would seem to offer more appointments thus leading to shorter waiting times and appointments later in the day for those who work. However, the idea of a new site for bowel screening is also very appealing especially if it includes new equipment etc and more appointments so people have shorter waiting times." [Hearts and Crafts (craft group)]

3.147 Others commented on the need for accessibility and the impact on patients having to travel.

"Very unhappy about losing urology & the impact of horrendously long journeys to another hospital." [Dyfi U3A]

"Need to keep all services in Bronglais for Mid Wales, as traveling is harmful to people's health and causes unnecessary stress." [Lledrod Community Council (translated from Welsh)]

3.148 Within their full submission (summarised in Chapter 8) the **West Wales Renal Service** called for some respiratory and urology endoscopy capacity at Glangwili, which already hosts interventional radiology, to maintain safe multidisciplinary management of patients who have complicated urology or respiratory endoscopy; and often require interventional radiology input shortly afterwards.

Ophthalmology

3.149 Respondents were asked 'Which option for ophthalmology services do you believe best meets the Clinical Services Plan objectives, considering patient care, accessibility, and outcomes?'. They were provided with a summary of what ophthalmology services included, where it was currently provided and the issues currently faced. Three different proposed options were presented for respondents to choose from: Option A, Option B, Option C and they were also given the opportunity to select 'No particular preference' and 'don't know'. [67]

- **Option A** - Main hospital services, including emergency eye care, would be brought together at Glangwili. Bronglais and Prince Philip would no longer provide services. Amman Valley Hospital would provide day cases (for cataracts) but not outpatients (for eye injections). This would help reduce the time patients spend on waiting lists, and help with staff shortages, however, more patients would need to travel further for treatment.
- **Option B** - Main hospital services, including emergency eye care, would be brought together at Prince Philip. Glangwili would no longer provide services. Current services would remain at Bronglais. Amman Valley Hospital would retain outpatient services (for eye injections) but not day cases (for cataracts). Outpatients would be carried out at a community site (where is not yet confirmed) in Pembrokeshire. This would maintain more services closer to home for some patients but would not make as much difference in bringing down patient waiting times or helping with staff shortages as Option A.
- **Option C** - Main hospital services, including emergency eye care, would be brought together at Glangwili. Prince Philip would no longer provide services. Current services would remain at

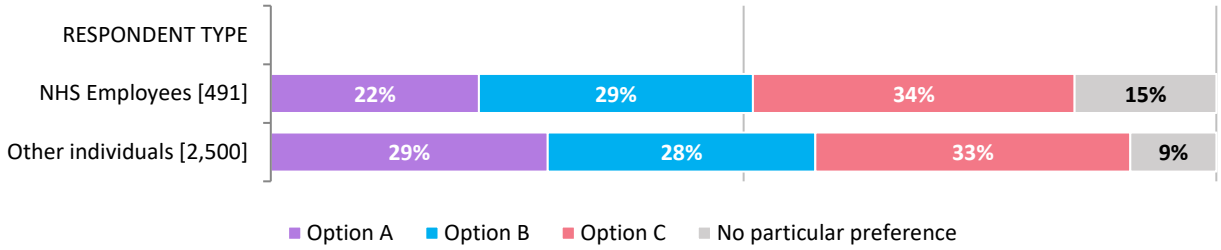
[67] Full details of the information provided can be found in the consultation questionnaire.

Bronglais. Amman Valley Hospital would retain outpatient services (for eye injections) but not day cases (for cataracts). Some services would be closer to home for some patients but would not make as much difference in bringing down patient waiting times or helping with staff shortages as Option A.

By respondent type (ophthalmology)

3.150 Figure 24 shows that Option C was the preferred option for those individual respondents who identified as working for the NHS and those who didn't, with around a third (34% and 33% respectively) preferring Option C. A greater proportion of other individuals thought Option A best met the Clinical services plan objectives (29%) compared to those who identified as working for the NHS (22%).[68]

Figure 24: Which option for ophthalmology services do you believe best meets the Clinical Services Plan objectives, considering patient care, accessibility, and outcomes? By respondent type (individual respondents only)

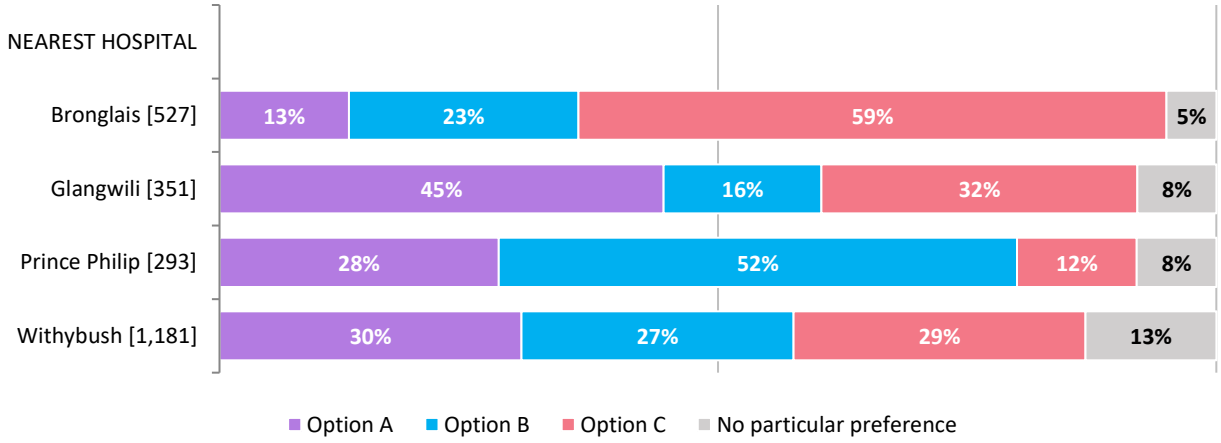


Base: Number of respondents shown in brackets (excludes 'don't know' responses)

By nearest hospital (ophthalmology)

3.151 Option A is the preferred option for individuals living closest to Glangwili (45%) and those living closest to Withybush (30%). Those living closest to Prince Philip favoured Option B (52%). Meanwhile, Option C is preferred by those living closest to Bronglais with almost three-fifths thinking this option would best meet the Clinical services plan objectives (59%). (see Figure 25)

Figure 25: Which option for ophthalmology services do you believe best meets the Clinical Services Plan objectives, considering patient care, accessibility, and outcomes? By nearest hospital[69] (individual respondents only, where postcodes were provided)



[68] 188 respondents selected the 'don't know' option. This is omitted from the chart for presentational convenience (standard industry practice) because it does not affect the order of preference of the available clinical options.
[69] Nearest hospital based on travel time. 639 responses without postcode are not displayed, but are included in the previous chart of overall results.

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

By health board (ophthalmology)

3.152 The number of individual respondents living outside the Hywel Dda Health Board area is low so limited conclusions can be drawn, but a greater proportion of individuals living in Betsi Cadwaladr and Swansea Bay University Health Boards favoured Option B (40% and 33% respectively). Whereas a greater proportion of individual respondents living in Powys Health Board favoured Option C (56%).

By other demographics (ophthalmology)

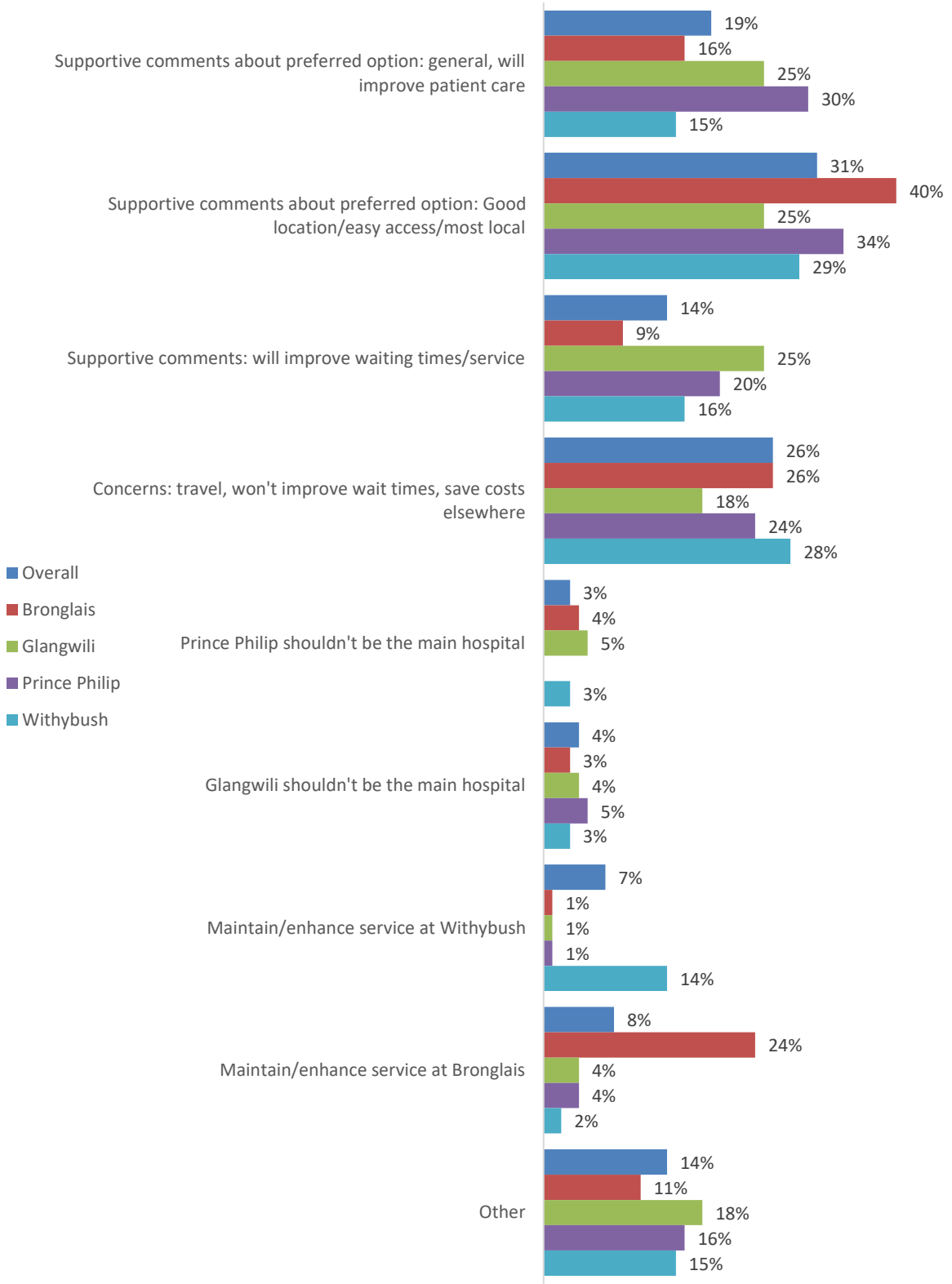
3.153 Across other demographic groups, there was no clear variation in opinion beyond that explained by proximity to each hospital.

Reasons for choosing options, and alternative suggestions (ophthalmology)

3.154 Respondents were asked 'Please share why you chose this option. How could we improve it or reduce any negative impacts? Do you have any alternative ideas that would meet the objectives?' in an open text box. A summary of responses from those responding as individuals is provided in Figure 26 together with a summary broken down by nearest hospital.

3.155 The percentages quoted are out of all respondents providing a comment. Because respondents could provide detailed feedback, some comments cover more than one point and, therefore, the total percentages sum to greater than 100%.

Figure 26: Please share why you chose this option. How could we improve it or reduce any negative impacts? Do you have any alternative ideas that would meet the objectives? (individual questionnaire respondents only) (Percentages are of those providing a comment to this question) (Responses by nearest hospital[70] are where postcodes were provided)



Base: Overall individual respondents (1,201), Points raised (1,505)

[70] Nearest hospital based on travel time

3.156 Of all respondents who made a comment, around a fifth (19%) provided feedback in general support of their preferred option, including a proportion who commented on the principle of consolidating most ophthalmology services at one hospital site, supported by outpatient clinics in the community.

> *"A very specialised area that requires experienced staff and diagnostics, makes sense to have a centre of excellence."*
>
> *"Improved waiting times, a more stable service with initial and follow up services in accessible areas."*
>
> *"I prefer the bringing together of services onto one site, plus some community delivery. This should lead to a more effective and efficient service in the long run - economies of scale etc."*

3.157 Those whose preference was for Option A felt that concentrating main services at Glangwili, with more of an emphasis on community service provision, was the most logical option as it would make optimal use of staffing and resources and therefore be more cost-effective and improve patient care overall.

3.158 Those with a preference for Options B or C generally felt that these options were fairer for all and provided a better balance between meeting the objectives of the Clinical Services Plan and patient access.

> ***Option A:***
>
> *"While I don't think it is ideal to not have any service removed from any site. Having a community site for services in Cardigan and Aberystwyth would help to maintain a better quality of care and bringing Glangwili together to become the main service would positively benefit the most patients [with] regards to travel time from each county and waiting list reduction along with staffing."*
>
> *"We felt that Option [A] provided the best option for the community as although some people would have to travel further distances at least they would actually get an appointment which potentially they're not getting at the moment."*
>
> ***Option B:***
>
> *"Option B would better meet the needs of all patients, and availability of appointments could still be increased to cover weekends and evenings."*
>
> *"Offers a good service within each of the 3 counties without increasing staffing costs."*
>
> ***Option C:***
>
> *"I don't know much about it, but this option seems to strike the best balance between accessibility of some local services and getting deep expertise on one site."*
>
> *"I support Option C because it best meets the Clinical Services Plan objectives while protecting access for rural patients, especially in the Bronglais catchment area. It retains day case and inpatient ophthalmology services at Bronglais and supports community access through outpatient services in Aberystwyth and Cardigan."*

3.159 Around one-in-seven (14%) respondents made supportive comments specifically around improving waiting times for patients, with many noting that timely treatment can be crucial in terms of outcome for eye conditions. A greater proportion of those living closest to Glangwili provided these types of comments (25%).

3.160 Those whose preference was for Option A were more likely to cite reduction in waiting times, however some of those in support of Option B felt that a greater spread of services would improve access and reduce the burden on Glangwili, therefore potentially helping to reduce waiting times.

Option A:

"Option A would have the biggest impact on bringing down waiting lists. By centralising main hospital eye services (including emergency care) at Glangwili, staff and resources are concentrated in one place. This makes it easier to run clinics efficiently, provide more procedures, and speed up treatment for patients."

"It sounds like Option A would help to bring down patient waiting times, which I know from my optician can be detrimental to eyesight if conditions are left for too long without treatment"

"Ultimately delays cause blindness. Choose the options that expedites appointments and improves staff shortages"

Option B:

"I believe better access to treatment is key, having services across west Wales will be much more effective in clearing waiting lists, access for patients and a lower cancellation rate"

"Glangwili is not coping with the current volume of appointments and admissions. Perhaps moving ophthalmology to other sites would help to ease the burden on outpatients. Although consideration of consultant availability/location would be needed."

"More services and more appointments hopefully cutting wait times."

3.161 Around three-in-ten (31%) respondents made comments about their preferred option in terms of location, ease of access and keeping services local/maximising access. A greater proportion of those living closest to Bronglais provided these types of comments (40%).

3.162 Those whose preference was for Option A supported the greater extent of consolidation, with many acknowledging that Glangwili is the most central site.

3.163 Those whose preference was for Option B, and living closest to Prince Philip, frequently noted that Llanelli is the largest populated area and therefore centralising main services at Prince Philip would suit the highest proportion of patients, while still maintaining some service in each county.

3.164 However, many of those whose preference was for Option C felt that the combination of consolidating emergency eye care services at Glangwili (as opposed to Prince Philip) whilst still delivering some additional service from Bronglais, offered a better balance of provision for patients across the south and west of Hywel Dda, as well as for those living in mid-Wales.

Option A:

"At least the emergency eye care would be provided more centrally (speaking of Hywel Dda geography) at Glangwili; Prince Philip is very difficult to access in a timely fashion for the majority of people residing in the Hywel Dda area."

"Carmarthen is the most central site - although it could be considered as equally inconvenient to residents from Ceredigion, Pembrokeshire and east Carmarthenshire."

Option B:

"Regionally spread-out accessible services."

"Basic services retained in three counties. Patients in West Carmarthenshire could access services at the CICC or at the new Pembrokeshire Centre (alleviating parking issues) & those in East Carmarthenshire could access services at AVH or Prince Philip. This option would not incur increased staffing costs."

"It makes sense to have the emergency eye service where the population is greatest, i.e., Prince Philip."

"The service should continue at Bronglais as patients from the north already travel quite a bit to reach Bronglais. Many of the treatments are day treatments, so there is less travel for patients before and after the treatment."

Option C:

"Carmarthen is a more central site for main service than Llanelli (very close to the geographic edge of the health board) and more difficult for elderly people to access."

"Glangwili should be the site for emergencies as it is closer for both Ceredigion and Pembrokeshire."

"Because it spreads the service more equally. Prince Philip is closer to Swansea in emergencies if needed."

"If you remove a service from Bronglais you reduce access for people in mid-Wales. The other hospitals are relatively close with easier transport infrastructure. So, for those hospitals having the services in Glangwili may be the best option."

3.165 Around a quarter (26%) of respondents made comments expressing concerns with the proposed options, with many citing concerns specifically around travel and transport. Travel concerns were frequently mentioned across all areas, however those living closest to Glangwili were least likely to make these sorts of comments (18%). The specific difficulties faced by ophthalmology patients, who are often unable to drive following treatment, were frequently mentioned, with many also expressing additional concern for elderly patients.

3.166 It was suggested by some respondents that providing subsidised dedicated transport, e.g. minibuses, ambulances, taxis/improving current transport provision would help to mitigate transport issues across the health board area.

"A service that is needed by an increased number of elderly people, so removing this service from Bronglais will have a significant impact. Also, it will be inconvenient for many to travel to the new site given the geography and rural nature of the area."

"Please bear in mind that patients with eye issues cannot drive and are dependent on family or friends being able to drop and collect them. You can't expect people to be driving all the way across Wales for this."

"We need to ensure that travel isn't impacted too much for the patient. My grandad had cataracts and has also had eye injections. Trying to arrange transport is not easy."

"Hospital transport needs to be improved dramatically."

"Challenging for elderly and disabled groups who are more likely to need emergency eye care. You would need to ensure safe and efficient transport across the area, in particular for Ceredigion where roads are difficult to navigate."

"To make travel possible and minimise discomfort and distress in travel for those who don't have access to a car, can't drive due to their medical condition etc, it would alleviate problems to have subsidised minibus/ambulance/taxi transport for patients and their carers (bus travel often isn't suitable for those undergoing treatment)."

3.167 Across responses, the importance of strengthening community provision was frequently mentioned. It was felt by some that most people wouldn't mind travelling for a one-off procedure (e.g. a cataract operation) and so it makes sense to centralise main and inpatient services in one or two hospitals, but it is vital to

ensure that there are sufficient community facilities in each county for procedures that need carrying out more frequently, such as eye injections. A few respondents suggested Amman Valley Hospital would ideally provide day cases (cataracts) and outpatient services (eye injections), rather than one or the other.

"Travel for one-off treatments such as cataract surgery is much less important than travel for recurrent appointments such as Macular Degeneration where follow up is typically monthly. With proper thought given to maximising the efficiency of the clinical pathways and clinic processes it should be possible to significantly improve throughput - especially in the AMD and glaucoma clinics. Comparison of the throughput for cataract surgery with the optimum in the private sector, should result in an increase in number of cases per clinical session. Greater use of community optometry for initial diagnostics and follow up would help."

"Would like to see more localised services for cataracts and eye injections as far as possible."

"The travel time between all four sites is considerable. If Amman Valley can take some of the load, then Option C may be best, as it is closer to Prince Philip."

"Amman Valley DSU is a perfect location to run high flow cataract lists out of, currently our numbers are 8 per theatre session/16 per day, looking to increase to 9 shortly. The stress-free parking facilities and the logistics of the unit being so close, provide the patient with less stress prior to having a surgical procedure, which evidently provides a better patient experience. I feel the outpatients (injections) could still remain in AVH and run alongside the cataracts in DSU, the outpatient department has been renovated to accommodate this service, it just requires additional staffing."

"You must centralise ophthalmology at Glangwili and create a centre of excellence. You need to create dedicated theatres offering minimum 12-hour surgery days 7 days a week. Look at your data! Probably 90% of work is cataracts and these are identified in community optometrists. This service needs a radical change. Let community do what they can do, virtually all diagnostics, screening and recommendations."

"Treating people locally without need to travel is key here. No mention of use of optometrists to enhance emergency care provision."

"Prince Philip would be the best site for the main clinic. Easily accessible. It is within distance from Amman valley. I believe Amman valley could be utilised better and provide both injections and cataracts. Have alternative sites been looked at in community e.g. expanding in the Gwendraeth valley? Former Tumble surgery building which is for sale? What about expanding Meddygfa sarn?"

"Confirm a permanent community site in Pembrokeshire for outpatient appointments as soon as possible to reduce uncertainty for those patients. Strengthen Amman Valley's role, ensuring it remains a key site for injections and ideally restoring some capacity for cataract surgery too."

3.168 Those in support of centralising services frequently cited benefits in terms of helping to solve staffing shortages by concentrating resources in one hospital and limiting requirements for staff to travel. However, the need to concentrate on recruitment and increasing staffing levels in general was also highlighted by some.

"By centralising main hospital eye services (including emergency care) at Glangwili, staff and resources are concentrated in one place. This makes it easier to run clinics efficiently, provide more procedures, and speed up treatment for patients. Better staff resilience: Staffing shortages are a challenge in eye care. Option A helps solve this by focusing staff in one main hospital rather than spreading them thinly across multiple sites. This reduces the risk of cancelled clinics or gaps in emergency cover."

"Staffing shortages have been mentioned for nearly every service under review so far yet no option so far has mentioned increasing capacity across current provisions by adding more staff. Every option will incur additional cost and resources to change/implement which could simply be ploughed into bolstering current services with additional staffing levels. Why is this not an option? Not every service is hard to recruit into or has national shortages."

3.169 Respondents frequently made comments around particular hospitals, stating that they should not be the main provider of ophthalmology services. Four per cent of respondents said that Glangwili shouldn't be the main hospital, with many citing reasons around insufficient parking and the age and condition of the hospital building which was felt to be in need of upgrading. These sorts of comments were made by similar proportions across all areas of the health board, not just those who live closer to other hospitals.

"Glangwili is old, has limited parking and public transport options."

"You are obviously steering patients to Glangwili, to centralise certain procedures. That being the case, the building and parking facilities are at best, challenging, and need upgrading/ refurbishing throughout."

"Until Glangwili has an upgrade on facilities as well as a complete overhaul of parking facilities, you cannot expect them to provide a service linked to vision where patients need to be accompanied. The hospital as it stands is an absolute shambles for eye patients"

3.170 Three per cent of respondents made comments stating that Prince Philip should not be the main hospital. These sorts of comments were mainly made by those who live closest to Glangwili, Bronglais or Withybush. The main concerns centred around Prince Philip being on the periphery of the health board area and being too far to travel for many living further north or west, while some concerns were also raised around the lack of an A&E department at Prince Philip.

"Again, I feel that no centralised services should be at a hospital on the periphery of the trust area like Prince Philip or Bronglais so could never agree to this being a sensible idea due to the travelling distance for so many."

"Prince Philip hospital is too far to travel for all in the health board that don't live in Carmarthenshire, it is therefore not an appropriate site for the main service to be delivered at. Glangwili is a compromise but is more acceptable in terms of distance than Prince Philip."

"I would be concerned about the admission of emergency cases to Prince Philip, where there is no A&E and currently reduced Minor Injuries service - particularly given the growing reliance on the Ambulance Service to support changes in all options across specialities."

3.171 Around one-in-seven (14%) respondents whose nearest hospital is Withybush expressed a wish for services to be maintained or enhanced at Withybush, with many respondents frequently complaining that those who live in Pembrokeshire must travel further to access ophthalmology services whichever option is chosen. It was also felt by some that the removal of most ophthalmology services at Withybush would contribute to an overall continuing decline in services provided at the hospital.

"Needs to be maintained at Withybush. The Nature of ophthalmology means travel can be difficult especially for the elderly who arguably are in greater need of this service so needs to be accessible."

"Withybush is the option for Pembrokeshire, invest in Withybush keep it as a functional main hospital."

"The services for Pembrokeshire should be maintained at Withybush. The county has 127k people who live here. That plus the holiday season and how rural the area is would not be fair on the residents. Ensuring continued services at Withybush is paramount."

"I'm unsure there are services at Withybush. My mum has travelled to Prince Philip, Carmarthen and Ammanford in the last year for glaucoma and cataract. Nothing in Withybush and it is very stressful as a family organising transport."

3.172 Conversely, around a quarter (24%) of respondents whose nearest hospital is Bronglais called for ophthalmology services to be maintained/enhanced at Bronglais, with the challenges of travelling long distances in rural areas highlighted by many. It was also noted that Bronglais also serves many people living outside of the Hywel Dda health board area.

"Awful options! ophthalmology is essential in Bronglais to cover a rural area which is impossible to travel to without good provision, transport and back-up."

"The population that Hywel Dda serves is not only within its borders but also includes areas of Betsi Cadwalader in the North and Powys to the west. A sparsely populated large area with poor transport links to the South of the Health Board. It is imperative that ophthalmology remains at Bronglais for equitable provision of services and decreased risk of sight loss for the high proportion of elderly in this area and to improve attendance and reduce waiting lists."

"Losing day case surgery at Bronglais would be at great detriment to the area. Patients already travel a long way to get to Bronglais. Patients are generally elderly and often frail. Losing operations at Bronglais could also result in loss of ophthalmic surgeons at Bronglais which would impact all ophthalmology services."

"Any reduction in the already limited Eye service at North Road and Bronglais would be a disaster for patients in the Ceredigion / South Gwynedd / North Powys areas that we cover. Travel times for patients can be very long as things stand - any further travel times such as Option A would be a massive negative. There is no cost saving in 'reducing' staff at Bronglais as Theatre Staff there are not eye-specific, they work for multi specialities. I can't stress enough how bad an option, Option A is!"

3.173 Respondents proposed other potential alternatives, suggestions and mitigations including the following:

- offering some services or clinics on an alternating basis at different hospitals, with consultants travelling rather than patients
- developing mobile or outreach eye clinics to provide routine outpatient care and injections closer to patients' homes
- Option A - but with the inclusion of eye injections at Amman Valley
- a hybrid model with emergency and complex care centralised at Glangwili, plus day case cataracts and outpatient injections at Amman Valley and Bronglais, supplemented by enhanced outreach clinics
- a model in which Glangwili would be used for tertiary care; Prince Philip for outpatient care; Amman Valley for cataract and IVT services; Cardigan and North Road for IVT services; some basic outpatient work in Withybush
- removing emergency eye care from all Hywel Dda hospitals and instead delivering it regionally (with the health board's ophthalmology services instead being focused on elective and planned treatments consolidated at Prince Philip, with additional community provision at Cardigan ICC, North Road Clinic, and in Tenby)

» transitioning the service to an Electronic Patient Record (EPR) service to enable sensible appointment allocations

Organisational Responses

3.174 Five organisations felt Option A best met the Clinical Services Plan objectives for ophthalmology services, four thought Option B and two thought Option C best met the objectives. Three organisations selected 'no particular preference'.

3.175 Within their full submission (summarised in Chapter 8) the **West Wales Renal Service** stated that many renal patients also require ophthalmic care. The nephrologists note that after cataract or retinal detachment surgery, some dialysis patients (including those living some distance away) must be admitted to the Morriston renal unit to recover safely with minimal disruption through having to travel for dialysis. The nephrologists support Glangwili as the more suitable surgical centre for ophthalmology due to its central location within Hywel Dda and better access to renal support.

3.176 **Elidyr Communities Trust** based in Carmarthenshire was also in favour of centralising services at Glangwili (Option A) as it "would allow continued local access to surgery and more advanced treatment reducing travel burden." **Hearts and Crafts** (a crafts group in Llanelli) however, preferred Option B, noting that it would involve 'less travelling for all.' The remaining organisational comments, one with a preference for Option A, one with a preference for Option C and two with no particular preference, all centred around the importance of providing ophthalmology services at Bronglais and the mid Wales area.

"Very unhappy about the reduced services and treatment at Bronglais and the long journeys to another hospital many miles away?" [Dyfi U3A - Machynlleth catchment]

"Important that current services remain at Bronglais." [Llangeitho Community Council]

"Need the essential service here in Bronglais to serve the Mid Wales area." [Lledrod Community Council]

"You must remember the travel distance from our parishes to towns outside Ceredigion." [Nantcwnlle Community Council.]

Orthopaedics

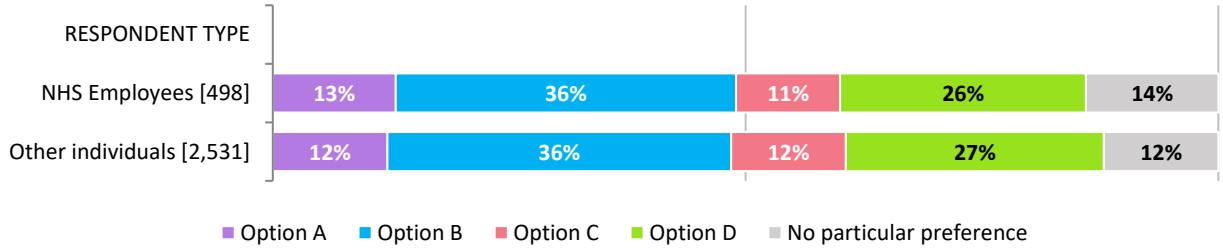
3.177 Respondents were asked 'Which option for orthopaedic services do you believe best meets the Clinical Services Plan objectives, considering patient care, accessibility, and outcomes?'. They were provided with a summary of what orthopaedic services were included in the services plan (planned orthopaedics), where they were currently provided and the issues currently faced. Four different proposed options were presented for respondents to choose from: Option A, Option B, Option C, Option D and they were also given the opportunity to select 'No particular preference' and 'don't know'. [71]

- **Option A** - would support an increase in less complex day cases at Withybush, and Prince Philip would carry out more complex planned care for local and regional patients. By regional we mean working in partnership with Swansea Bay University Health Board for their patients who may need to access care in Prince Philip, or for our patients who may need to access care in Neath Port Talbot for certain procedures.
- **Option B** - would support an increase in less complex day cases at Withybush, and Prince Philip would carry out more complex planned care for local and regional patients. The difference between Option A and Option B is that the service would be open for longer during the day at Withybush, increasing the number of surgical operations overall.
- **Option C** - would see an increase in less complex day cases at Withybush, increasing the number of procedures overall. This option does not fit as well with the regional working approach, because it prioritises higher need Hywel Dda patients, rather than regional patients, at Prince Philip.
- **Option D** - would see an increase in day cases at Withybush. This option supports regional working at Prince Philip and an increased inpatient service at Bronglais.

By respondent type (orthopaedics)

3.178 Figure 27 shows that there wasn't much difference in opinion between individual respondents who identified as working for the NHS and those who didn't, with over a third (36% for both) feeling that Option B best met the Clinical Services Plan objectives. Around a quarter (26% and 27% respectively) of both groups thought Option D best met the objectives, with smaller proportions selecting Options A and C.[72]

Figure 27: Which option for orthopaedic services do you believe best meets the Clinical Services Plan objectives, considering patient care, accessibility, and outcomes? By respondent type (individual respondents only)



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

[71] Full details of the information provided can be found in the consultation questionnaire.
[72] 121 respondents selected the 'don't know' option. This is omitted from the chart for presentational convenience (standard industry practice) because it does not affect the order of preference of the available clinical options.

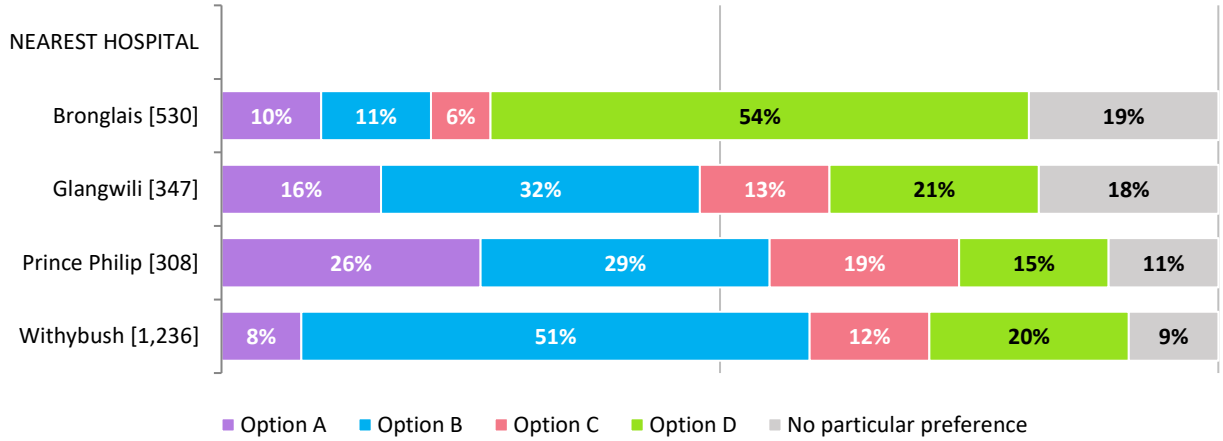
By nearest hospital (orthopaedics)

3.179 Option B is also the most preferred option for individuals living closest to Withybush and Glangwili with just over half (51%) and just under a third (32%) respectively feeling that Option B best meet the Clinical Services Plan objectives.

3.180 Option B is also preferred for individuals living closest to Prince Philip (29%), though a greater proportion in this area preferred Options A and C compared to other areas.

3.181 Option D is preferred by those living closest to Bronglais with over half (54%) feeling that it best meets the objectives (see Figure 28).

Figure 28: Which option for orthopaedic services do you believe best meets the Clinical Services Plan objectives, considering patient care, accessibility, and outcomes? By nearest hospital[73] (individual respondents only, where postcodes were provided)



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

By health board (orthopaedics)

3.182 The number of individual respondents living outside the Hywel Dda Health Board area is low so limited conclusions can be drawn, but Option D was the preferred option for individuals living in Powys and Betsi Cadwaladr Health Boards with 45% and 67% respectively. Whereas Option B was the preferred option for individuals living in Swansea Bay University Health Board (35%).

By other demographics (orthopaedics)

3.183 Across other demographic groups, there was no clear variation in opinion beyond that explained by proximity to each hospital.

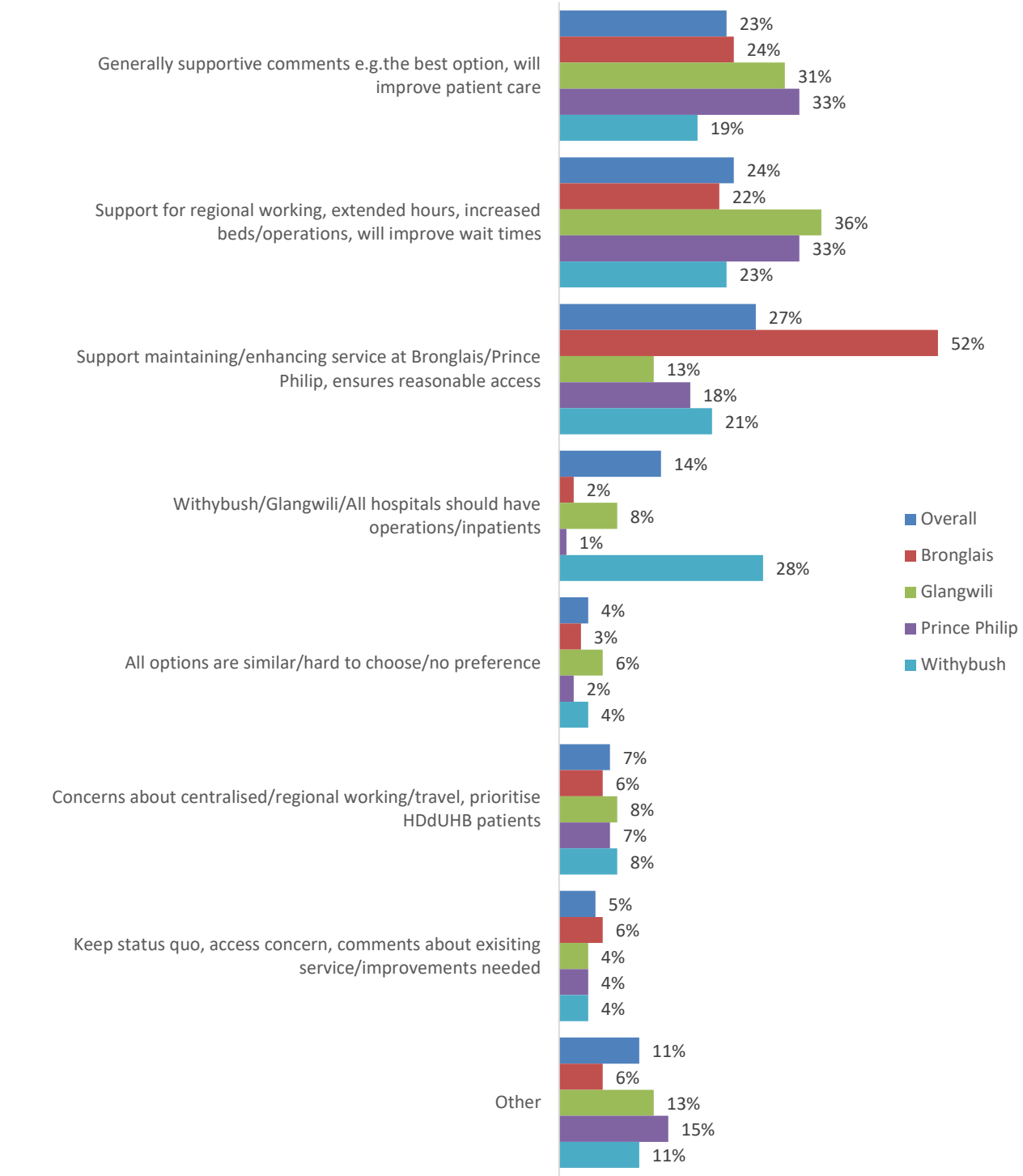
Reasons for choosing options, and alternative suggestions (orthopaedics)

3.184 Respondents were asked 'Please share why you chose this option. How could we improve it or reduce any negative impacts? Do you have any alternative ideas that would meet the objectives?' in an open text box. A summary of responses from those responding as individuals is provided in Figure 29 together with a summary broken down by nearest hospital. The percentages quoted are out of all respondents providing a comment.

[73] Nearest hospital based on travel time. 608 responses without postcode are not displayed, but are included in the previous chart of overall results.

3.185 Because respondents could provide detailed feedback, some comments cover more than one point and, therefore, the total percentages sum to greater than 100%.

Figure 29: Please share why you chose this option. How could we improve it or reduce any negative impacts? Do you have any alternative ideas that would meet the objectives? (individual questionnaire respondents only) (Percentages are of those providing a comment to this question) (Responses by nearest hospital[74] are where postcodes were provided)



Base: Overall individual respondents (916), Points raised (1,050)

[74] Nearest hospital based on travel time

3.186 Of all respondents who made a comment, just under a quarter (23%) provided feedback that was generally supportive of their preferred option, for example, that they thought it would improve patient care. A greater proportion of those living closest to Prince Philip provided these types of comments (33%).

3.187 Just under a quarter (24%) gave support for regional working; in favour of extended hours or increased capacity in terms of beds or operations, believing this in turn would lead to an improvement in waiting times. A greater proportion of those living closest to Glangwili provided these types of comments (36%).

3.188 Just over a quarter (27%) gave support for maintaining or enhancing services at either Bronglais or Prince Philip, feeling that this would ensure easy access for those with reduced mobility living closer to these sites. A much greater proportion of those living closest to Bronglais provided these types of comments (52%).

3.189 Some of the main reasons for favouring the proposals are illustrated by the comments below:

Support improved capacity, reduced waiting lists

"Improved capacity must be seen as a priority for the HD health board area."

"An increase in day cases will hopefully bring down waiting list and reduce poor patient experience and improve their quality of life."

"Supports overall NHS goals: Regional working at Prince Philip improves flexibility and efficiency by allowing complex elective surgeries to be shared with Swansea Bay Health Board. Withybush sees more day case activity. Reduces local waiting lists in Pembrokeshire. Helps avoid bottlenecks at the larger hospitals Community outpatient clinics remain at Cardigan, Tywyn, Tenby, etc., ensuring ongoing access to pre- and post-surgical care close to home…"

"More services and extended times are the only way to bring waiting lists down."

Support centralisation of inpatient care at Bronglais and Prince Philip

"All hospitals involved but expertise for complex planned care centralised. Increased hours available means shorter waiting lists and more effective response to patient need."

"Prince Philip seems to offer the most with regards orthopaedic needs, including local inpatients and outpatients, plus day cases. It is also convenient to travel to and from the hospital."

"The additional beds at Prince Philip and the increase in day case procedures at Withybush should help bring waiting times down. If Prince Philip can care for more complex cases, then that facility should be available across Hywel Dda and not just regionally."

"The population that Hywel Dda serves is not only within its borders but also includes areas of Betsi Cadwalader in the North and Powys to the west. A sparsely populated large area with poor transport links to the South of the Health Board. It is imperative that orthopaedics remains at Bronglais for equitable provision of services and decreased risk of morbidity and mortality. An increase in in-patient services at Prince Philip and Bronglais will decrease waiting lists. The increase of in-house beds must be more cost effective than the cost of partnership contracts with Swansea Bay Health Board and encourage recruitment"

Support regional working

"Working with the Swansea Bay University Health Board may see more patients having less of a wait."

"Working in partnership with Swansea Bay for complex orthopaedic cases will benefit the development of team expertise, and an increase in less complex day cases. Not sure a longer day as in Option B is ideal for staff retention at Withybush."

"I think options that include regional working are the most beneficial for all patients across all counties, and provide and develop partnership and collaboration between HDUHB AND SBUHB this will I feel increase the overall outcomes for the most patients."

"Regional working would strengthen Hywel Dda services and allowing one sites to perform more complex cases would increase skills and expertise on one site, improving standards and allowing financial income"

Particular support for Option B:

"Option A and Option B have the same costs, but Option B provides for increased day cases and extended hours at Withybush which is more cost effective."

"This allows for more flexibility for later appointments"

"I think that extended hours are a good option to get waiting lists down."

Particular support for Option D:

"The increased inpatient service at Bronglais in Option D would also help, as would the regional working."

"Key reasons Option D is best for Bronglais and Mid Wales: Bronglais keeps full orthopaedic services (outpatients, inpatients, day cases). Inpatient capacity is increased, which benefits patients from Ceredigion and North Powys who would otherwise face long travel times. This strengthens Bronglais as a regional centre for elective orthopaedic care."

3.190 Whereas 7% raised concerns about centralised/regional working, noting the difficulties that some patients would find travelling and commenting that Hywel Dda patients should be prioritised.

"There should be a minimum of outpatients, day cases and inpatients at each hospital. If you have bone/joint issues, then having to travel miles would be agony."

"Regional working shifts financial pressure to patients, particularly those who use public transport and ambulance provision to attend hospital."

"Regional working may well be useful, but how do you deal with competing interests, can you be sure that Hywel Dda patients will protected? Once again extended hours throughout appears obvious?"

"Prioritising the need of Hywel Dda patients as those from Swansea Bay are closer to a vastly superior travel infrastructure meaning transport between their hospitals takes less time whereas the Hywel Dda patients do not have easy access to dual carriageways, for those in rural areas the time to get to an appointment (and back) can be hours."

3.191 Some respondents favoured additional beds within Hywel Dda.

"Additional beds should reduce the waiting list quicker than regional working. Although obviously depends on the number of beds!"

"Additional beds is good as it may involve less travel between sites for Llanelli residents"

3.192 Some commented that the options were similar to each other, that they either found it hard to choose or had no preference.

"These options are so multi layered, hard to work out the best options"

3.193 Some noted that they wanted to keep the status quo (or return to how things were before), including raising concerns over access.

> *"Keep services as they are."*
>
> *"We don't want to go from Haverfordwest to Llanelli so stay as it is currently. All services for those that live in Pembrokeshire to stay at Carmarthen or Withybush"*
>
> *"None of the options are favourable and patients will still be waiting years for joint replacement. Where, if all sites were operating joint replacements to capacity like they used to surely the waiting list would come down rather than Prince Philip being the main hospital doing regional work!!!"*
>
> *"I have not selected any of the options. Withybush has 2 fairly new operating theatres and a recently refurbished ward which could be suitable for taking orthopaedic patients. Prior to COVID we had started some day case hip surgery and there were plans to further develop the service The average length of stay was only 2 days anyway Why can we not use the facilities that we have and return to doing hip and knee replacement surgery on a Monday to Friday basis?"*
>
> *"Hobson's choice!"*

3.194 Others commented on the existing service provided, including some noting how long they have had to wait, or are considering private treatment as a result of long waiting times.

> *"Over four years wait then had to go private as I couldn't walk"*
>
> *"This service is already in crisis with long waiting lists and a huge amount of travel required in order to get to appointments for surgery and outpatient follow-up. Elective surgery has already been moved to Prince Philip (if you're lucky) or Bronglais or further afield. From recent personal experience arranging transport is not easy and the transport is not always suitable, especially for getting patients home after surgery. Urgent action is required now to reduce the waiting lists for joint replacements."*
>
> *"All the options are dependent on how people are assessed and followed up. GP'S are frustrated by Hospital wait times for patients in severe pain and have to give patients long term pain relief and steroid injections as the waiting lists are so long. Not good."*

3.195 14% raised that Withybush or Glangwili should have operations/inpatients with some noting this should be accessible at all hospitals. A much greater proportion of those living closest to Withybush provided these types of comments (28%).

> *"[Option B] One main centre focusing on electives and revision surgery (Prince Philip). Reopen ward 9 at Withybush so that day cases and less complex procedures can be done at this site. Increase working hours into the evenings, weekends and have ambulatory trauma lists for wrists, ankle fractures, some hip fractures. This would take the pressure off Glangwili too. Pembrokeshire patients are travelling far enough to have procedures done at Prince Philip, don't take these services from a county that have already been stripped of so many. Please remember that Pembrokeshire is a tourist hotspot and population numbers swell significantly during holiday times. There IS a need for Orthopaedic services in Withybush hospital."*

"It's not clear to me what difference these options would make for those of us in the Llandovery area. None of them seem to bring services closer or make them more accessible. However, co-operative working with neighbouring Health Boards is generally a good idea, sharing resources and expertise to benefit people, so Option A takes my vote here. It is worth noting that orthopaedics will affect people for whom travelling is a particular challenge - especially on our bumpy roads in our current fleet of ambulances. Distress en-route will inevitably affect people's wellbeing and, potentially, outcomes. The longer the journey the greater the distress."

"All these options are not great as there will be no emergency care in Glangwili"

"There is no real difference in options here for Withybush. What needs to happen is for joint replacements to be brought back to Withybush. If Aberystwyth are allowed to do trauma and elective then so should Withybush…Also ward 9 would be perfectly suitable as a ring-fenced elective ward for T&O. Patients do not want to travel out of the area for their appointments and surgery."

3.196 Others wanted to secure services and the future of their local hospital. A much greater proportion of those living closest to Bronglais provided these types of comments.

"Developing increased services such as orthopaedics at Bronglais would help to secure the long-term future of the hospital."

"This area has one of the highest waiting times of all the services provided. Continuing to increase services to reduce waiting times in Bronglais is essential"

3.197 There were suggestions for the provision of a mobile service for orthopaedic services or for orthopaedic teams to provide services on a rotational basis to mitigate concerns around travelling.

"…Mobile pre- and post-op assessments Bring specialist teams into more rural clinics (e.g., Lampeter, Tregaron) to reduce unnecessary travel to Bronglais for routine appointments. Strengthen rehabilitation pathways Expand access to community physio and rehab services post-surgery, particularly in rural areas, to improve recovery without needing to return to hospital…"

"Orthopaedic consultants /teams should travel to outlying areas for initial consultations. They could see a number of patients in one clinic in the outlying areas which will prevent patients from all having to travel great distances to the major centres. This would save on parking services at the major centres and assist patients who are in pain from having to travel great distances for their initial consultation."

"…Introduce rotating surgical teams or visiting specialists who provide services at smaller hospitals on scheduled days (spoke sites), improving local access for certain procedures and reducing patient travel."

"Service has changed in Pembrokeshire since 2020. Inpatient services could be provided on alternate weeks in Withybush to adhere with infection control guidelines This would improve morale and encourage recruitment and retention"

3.198 There were some comments around staff recruitment and retention.

"…How Option D could be improved: Recruit and retain surgical teams at Bronglais. Offer flexible contracts and rural incentives to attract orthopaedic surgeons willing to work in a remote setting. Consider part-time rotations or split contracts with Swansea Bay to help fill posts…"

"Investment/training and or retention of surgical/nursing personnel must be high priority if more operations are to be taken on within the various regional areas."

"Whilst there is clearly a benefit to having less complex cases brought together on a site to deliver a higher flow of patients per day, I would however be concerned about how appealing that is likely to be for the clinicians. Variety is surely something that maintains skillset and also interest/diversity in job. Would the Health Board struggle to maintain staff on a site where it was low complexity and repetitive case load. Given the higher population of older people in Pembrokeshire and the strong care of the elderly, would it not be an option to centralise the service in Withybush. This would also alleviate challenges in Glangwili for space and is more accessible to some neighbouring communities than Prince Philip."

"…There is also a real risk here of deskilling staff, plus is the travel time for these doctors included in their contracted hours thereby risking them seeing less not more patients."

3.199 Others raised the need for better provision of hospital transport with signposting of its availability.

"…With greater regionalisation of services and reduced sites for some services, travel support must be provided to all who need it and flagged to all patients to ensure people are aware of the support available. Pre-op and post-op services need to be available locally, where possible…"

"It's a nightmare having to go to Withybush for operations! To be there from Ceredigion for 8 am and then you need a way home without driving later the same day. There's not enough community transport available for these options. There's no after care either!"

3.200 A few (2%) raised concerns around bed capacity.

"How can you increase activity at Bronglais unless you do something about the beds which are blocked?"

"If Prince Philip increases numbers which seems inevitable then extra beds are obviously required including ICU, that is the problem, hospitals were never meant to work at 90+% occupancy, beds have been cut to the extent that all the hospitals are failing…"

3.201 And a small number (3%) raised concerns around the transfer of patients.

"…how are we planning to look after inpatients (operated in Prince Philip) & transferred back to Withybush for example?"

"All hospitals should have up to date orthopaedic cover. Transfer of patients are too risky. Will lead to patient safety issue and dissatisfaction"

"Again, all well orthopaedics main hub being in Prince Philip - however the theatres and beds on the unit are not utilised, we already do surgery for Withybush. We also do SWANSEA BAY patients (surely, we should be prioritising our own patients considering the waiting lists are so extensive). We do not have the ITU pathway that is needed to complete these surgeries due to risks when you do any operation. The nurses on the ward do not have these skills like specialist ITU nurses have again this is detrimental to patients' safety…"

3.202 Others noted that with increased surgery and capacity there would be an increased need for aftercare.

"There MUST be a plan to increase rehabilitation capacity- orthopaedic patients are reliant on adequate rehabilitation"

"You have to consider the aftercare here too. You talk about increasing surgery which is important but with increased surgery comes increased physio needs. There aren't enough physios in the health board at the moment. You need to recruit more to support these plans."

3.203 Respondents proposed other potential alternatives, suggestions and mitigations including the following:

- a hub-and-spoke model: Withybush as a hub for less complex day cases, with extended hours (similar to Option B); Prince Philip focused on complex planned care, with a local and regional emphasis; increased inpatient service capacity at Bronglais to reduce pressures elsewhere
- investment in same-day joint surgery in PPH Day Surgery Unit for patients who meet the criteria, to better utilise resources
- Option D, but with extended hours at Withybush as per option B
- increased use of the private sector, alongside hiring more staff and extending theatre time
- Option B with additional fracture clinics within the community such as Cardigan Integrated Care Centre
- overnight checking in of day surgery unit patients at Bronglais, allowing complications to be predicted earlier and to allow the list to start earlier in the day, and creating an additional post-operative ward for better throughput of cases
- more regional working, alongside maximising use of theatre capacity in Bronglais and Withybush for minor and intermediate surgery (reserving PPH for the more complex cases)
- a hybrid local / regional approach, giving people the choice to either have surgery locally or be treated quicker by travelling to a regional hub
- one site for planned and another for emergency care
- a variation on Option D: addition of elective orthopaedics to increase activity at Bronglais; no elective procedures at Glangwili; Prince Philip focused on regional pathways, with orthopaedic inpatient care retained but aligned with Neath Port Talbot, and a single regional patient tracking list developed; and Withybush to become an optimised day surgery site.

3.204 The following were also highlighted as possible areas for further consideration :

- better and more widespread use of video and telephone calls, with face-to-face being used only where necessary with appropriate triaging, and with early morning or evening appointments to help those who are working
- possible concerns that while increasing hours at Withybush (under Option B) is attractive, the resources and staff etc needed for this may be better served supporting services at Prince Philip and Glangwili
- consideration of the limitations of existing pathways and critical care provision between/at NPTH and Prince Philip, and around the lack of an acute pain service at Bronglais.
- consider discontinuing elective hip & knee replacement patients at Bronglais as there are less patients having joint replacement surgery there & they can travel to Prince Philip.
- funding for more surgeons and more radiography equipment or employment of additional radiographers.
- the potential importance of the appropriate trauma services in connection with orthopaedics.

» overcoming communication issues so that patients' up-to-date records are available to everyone involved in their care, wherever they are based.

Organisational Responses

3.205 Four organisations felt Option B best met the Clinical Services Plan objectives for Orthopaedic services, and two organisations thought Options A, C and D best meet the objectives respectively. Four organisations selected 'no particular preference'.

3.206 Of those preferring Option D, one organisation questioned why additional beds could not be offered under this option and another felt this was the best option for local residents.

> *"Why can't additional beds be offered under this option? Anything that saves people travelling long distances has to be good. Would having increased beds not help with the flow of patients should there be complications where someone may have to be kept in overnight?" [Hearts and Crafts (craft group)]*
>
> *"Better for our residents." [Nantcwnlle Community Council (translated from Welsh)]*

3.207 Others commented on keeping services at Bronglais.

> *"Very happy services are continued at Bronglais" [Dyfi U3A]*
>
> *"Need to keep essential services in Bronglais to serve Mid Wales - we appreciate that this service is being kept in Bronglais." [Lledrod Community Council (translated from Welsh)]*

3.208 Within their full submission (summarised in Chapter 8) the **West Wales Renal Service** oppose concentrating inpatient orthopaedics at Prince Philip, which lacks dialysis and intensive care facilities.

Radiology

3.209 Respondents were asked 'Which option for radiology services do you believe best meets the Clinical Services Plan objectives, considering patient care, accessibility, and outcomes?'. They were provided with a summary of what radiology services included, where it was currently provided and the issues currently faced. Four different proposed options were presented for respondents to choose from: Option A, Option B, Option C, Option D and they were also given the opportunity to select 'No particular preference' and 'don't know'. They were told that 'All options propose the removal of X-ray services at Llandovery and South Pembrokeshire hospitals, so patients living closer to these hospitals would have further to travel for their x-rays than they do now. X-ray services stay at Cardigan Integrated Care Centre and Tenby Hospital in all our options.' [75]

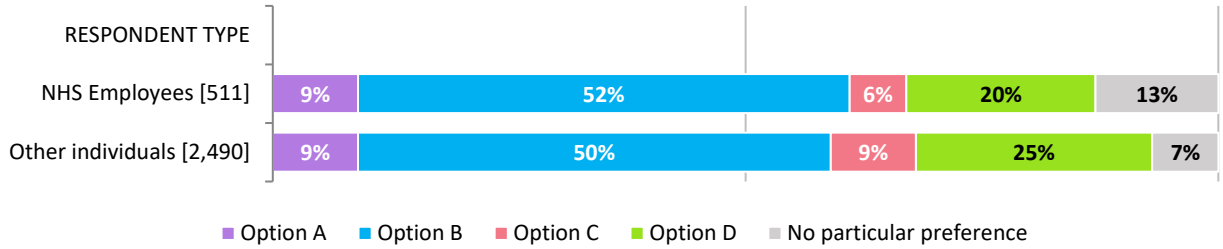
- **Option A** - would offer a planned diagnostic radiology and day case interventional service at Bronglais, Prince Philip and Withybush. Glangwili would provide inpatient interventional radiology for our whole area. Separating inpatient and day case interventional services would help reduce the risk of cancellation of day case procedures due to inpatient activity, which would help reduce waiting times.
- **Option B** - would offer an extended seven-day diagnostic radiology service and a five day, Monday to Friday, inpatient and day case interventional service at Bronglais, Glangwili, Prince Philip and Withybush. There would also be a diagnostic focus on cancer in Prince Philip and Withybush to allow patients that require multiple examinations to have them all on the same day on the same site. This option would also provide a regional radiology diagnostic hub and quicker diagnosis for patients. The option would require more staff.
- **Option C** - Planned diagnostic radiology would be at Bronglais, Glangwili, Prince Philip and Withybush, five days, Monday to Friday. The option would involve bringing together interventional services and staff, at Bronglais and Glangwili only. This would help with some safety concerns and would protect planned diagnostic services at Prince Philip and Withybush from cancellations due to inpatient interventional radiology.
- **Option D** - would offer an extended seven-day diagnostic radiology service at Bronglais, Glangwili, Prince Philip and Withybush. The option also proposes a five day, Monday to Friday, interventional service at Bronglais, Prince Philip and Withybush and a 24/7 interventional service at Glangwili. The option would require more staff.

By respondent type (radiology)

3.210 Figure 30 shows that Option B was the preferred option for those individual respondents who identified as working for the NHS and those who didn't, with around half (52% and 50% respectively) preferring this option. However, a slightly greater proportion of other individuals thought Options C and D best met the Clinical Services Plan objectives (9% and 25% respectively) compared to those who identified as working for the NHS (6% and 20% respectively).[76]

[75] Full details of the information provided can be found in the consultation questionnaire.
[76] 106 respondents selected the 'don't know' option. This is omitted from the chart for presentational convenience (standard industry practice) because it does not affect the order of preference of the available clinical options.

Figure 30: Which option for radiology services do you believe best meets the Clinical Services Plan objectives, considering patient care, accessibility, and outcomes? By respondent type (individual respondents only)



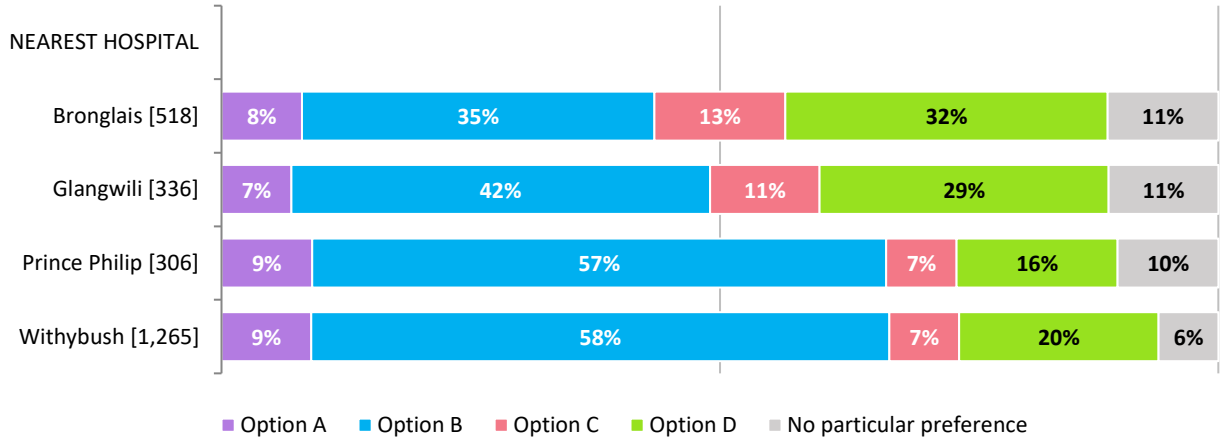
Base: Number of respondents shown in brackets (excludes 'don't know' responses)

By nearest hospital (radiology)

3.211 Option B is the most preferred option across all of the geographies but particularly favoured by individuals living closest to Prince Philip and Withybush with just under three fifths (57% and 58% respectively) feeling that this option best met the Clinical Services Plan objectives in these areas.

3.212 However, a greater proportion of individuals living closest to Bronglais and Glangwili Hospitals preferred Options C and D compared to other areas. (see Figure 31).

Figure 31: Which option for radiology services do you believe best meets the Clinical Services Plan objectives, considering patient care, accessibility, and outcomes? By nearest hospital[77] (individual respondents only, where postcodes were provided)



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

By health board (radiology)

3.213 The number of individual respondents living outside the Hywel Dda Health Board area is low so limited conclusions can be drawn, but Option C was the preferred option for individuals living in the Powys Health Board area (30%), Option D was the preferred option for individuals living in the Betsi Cadwaladr Health Board area (36%), whereas Option B was the preferred option for individuals living in the Swansea Bay University Health Board area (44%).

[77] Nearest hospital based on travel time. 576 responses without postcode are not displayed, but are included in the previous chart of overall results.

By other demographics (radiology)

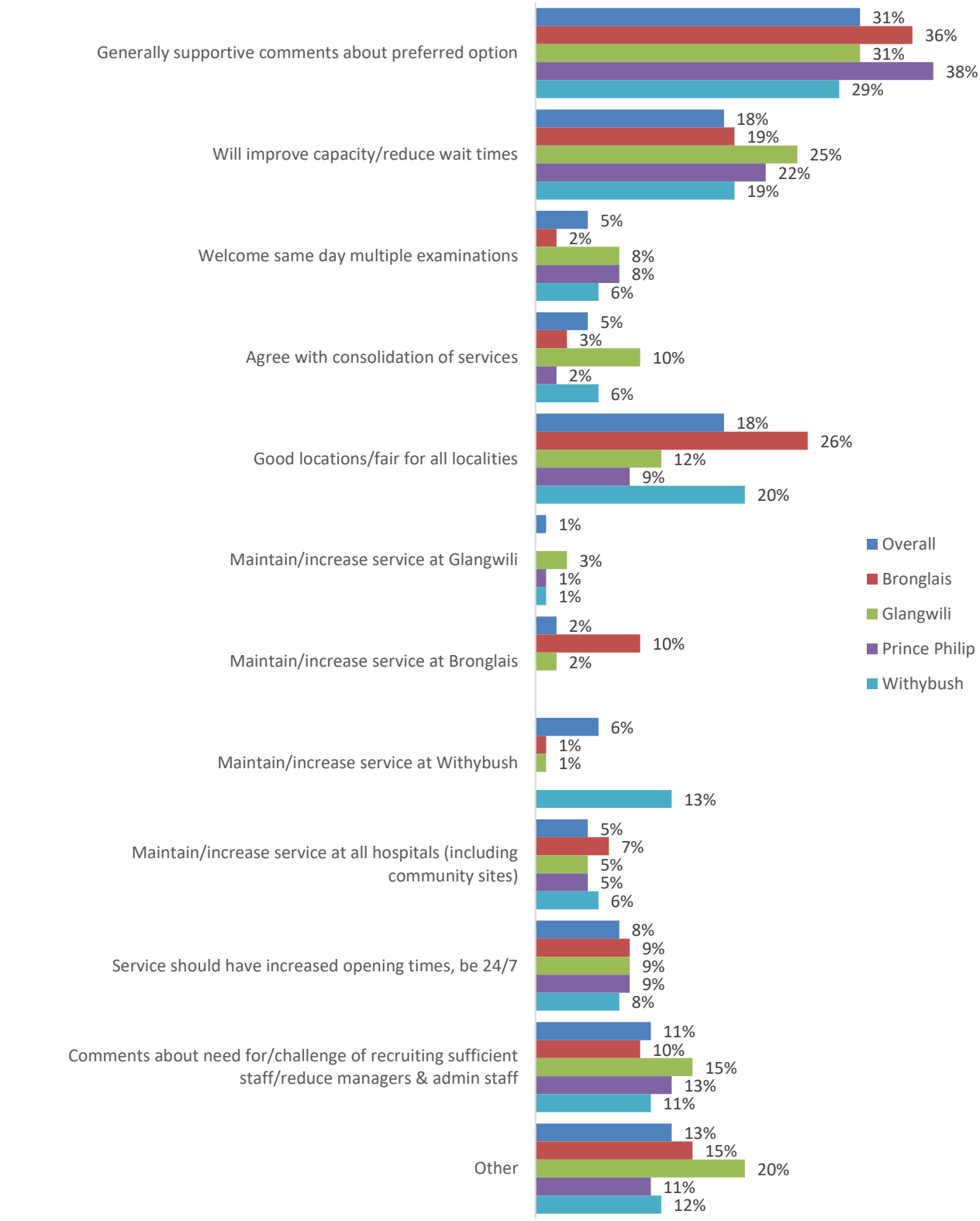
3.214 Across other demographic groups, there was no clear variation in opinion beyond that explained by proximity to each hospital.

Reasons for choosing options, and alternative suggestions (radiology)

3.215 Respondents were asked ‘Please share why you chose this option. How could we improve it or reduce any negative impacts? Do you have any alternative ideas that would meet the objectives?’ in an open text box. A summary of responses from those responding as individuals is provided in Figure 32 together with a summary broken down by nearest hospital.

3.216 The percentages quoted are out of all respondents providing a comment. Because respondents could provide detailed feedback, some comments cover more than one point and, therefore, the total percentages sum to greater than 100%.

Figure 32: Please share why you chose this option. How could we improve it or reduce any negative impacts? Do you have any alternative ideas that would meet the objectives? (individual questionnaire respondents only) (Percentages are of those providing a comment to this question) (Responses by nearest hospital[78] are where postcodes were provided)



Base: Overall individual respondents (987), Points raised (1,238)

[78] Nearest hospital based on travel time

3.217 Of all respondents making comments, many expressed support for proposals aimed at reducing cancellations and speeding up diagnoses. However, within the comments provided, there was no overwhelming consensus as to which option, if any, would best achieve this.

3.218 As noted above, overall Option B was the most widely preferred of the four options. Where respondents selecting this option left comments, the preference was often on the basis of seven-day planned diagnostic services, potentially speeding up the diagnostic process for patients, while the proposed diagnostics centre was also felt to be valuable addition. A few respondents specifically suggested that Option B was the most 'ambitious' and 'forward-looking' option.

3.219 Some respondents also expressed approval for the proposed focus on cancer at Prince Philip and Withybush, feeling that this might improve diagnoses and lead to a more positive patient experience.

> *"Option B would mean that we are ready for the future. The patient loads are going to increase in the future, and we need to start scanning outpatients during weekends. CT, US, and MRI mainly."*
>
> *"Option B - this is the most ambitious option and would, if finances are secured for a new hub, make the greatest impact on radiology services. Also, the dedicated cancer focus at Prince Philip sounds like a positive step forward."*
>
> *"[Option B] does require more staff, but the benefits faster diagnosis, greater patient convenience, and reduced waiting lists make it the most patient-centred and forward-looking option."*
>
> *"I am keen on this option because it focuses on speed of diagnosis, especially important if it turns out to be a cancer diagnosis. Particularly important to get all tests done in one place on the same day at what is already a stressful time."*

3.220 Option B received some positive comments about good geographical coverage and accessibility. Although Option B was favoured by consultees from all geographical areas, support was particularly strong in those areas nearest Prince Philip and Withybush, with some respondents in these areas being enthused by the potential strengthening of diagnostic services for cancer.

> *"[Option B] provides the most equitable access to comprehensive radiology services across the rural area, minimising travel distances and maximizing convenience for patients who often face significant geographical barriers to healthcare access."*
>
> *"Patients from Pembs are currently at a disadvantage regarding cancer diagnostics. This option would level up care across the health board."*
>
> *"Option B is a more robust service for Withybush. There is a strong need for it to be retained at Withybush and the cancer focus element is crucial."*

3.221 Option D was the next most widely preferred option. Respondents who selected this frequently referred to the provision of 24/7 inpatient interventional services at Glangwili under this option, as well as the extended seven-day diagnostic radiology service across all four main hospital sites, which (it was suggested) would provide strong geographical coverage across the health board area.

3.222 A very small number of respondents also asked whether not having a regional diagnostics hub might help make this option more achievable than Option B.

> *"Option D is best able to deal with your staffing challenges as it increases service provision but without the high cost of a regional hub, which would be challenging to staff."*

"This option covers all areas and allows for the possibility of increasing staff as the shift change to seven days a week, 12-hours a day, from Monday to Friday 9am-5pm, is more attractive to radiographers. The extended seven-day diagnostic radiology service at Bronglais, Glangwili, Prince Philip and Withybush would better serve all the communities."

"Only option with 24/7 service."

"I support Option D for radiology services because it strengthens diagnostic access across all four main hospitals, especially for rural and remote areas served by Bronglais. Seven-day access to scans and imaging will reduce waiting times and improve flexibility for patients. I also support the plan to retain day case interventional services at Bronglais, which avoids unnecessary travel for many patients needing minor procedures."

3.223 Weighed against this, some respondents expressed concerns about the feasibility of one or both of Options B and D. A few felt that, while attractive on paper, these options might prove to be prohibitively expensive. Others doubted whether it would be possible to recruit the necessary staff, while it was also suggested that details about the proposed diagnostics hub in Option B were too vague, with no details provided on its most likely location, for instance.

"Option B is too vague with regards the new hub and Option D, though attractive, is too expensive."

"Options B and D look attractive, but where will more money for staffing and indeed [the] staff come from?"

The new diagnostic community hub in Option B is not adequately described in terms of its role and location, with too many variables to be realistic at this point in time.

3.224 There were also occasional concerns that the aspirations for seven-day services as outlined in options B and D might prove unrealistic and might even make Hywel Dda a less attractive employer for staff working in radiology services. Not all respondents accepted the suggestion made in the consultation document that twelve-hour shifts seven-days-a-week would be an attractive proposition for radiographers.

"Seven-day working would be difficult to implement with current staffing levels and childcare/carer commitments. Would make the trust even less appealing to applicants."

"It's important to note that claims about radiographers wanting to move to 12-hour shifts seven days a week is not what radiographers want, and this claim should never have been included in this consultation document in the first place."

3.225 While they were less widely preferred overall, some respondents felt that, given the concerns above, Option A and/or Option C might be more viable or 'realistic' than Options B or D, while still offering some advantages and benefits e.g. fewer cancellations linked to the separation of day case and inpatient interventional services under Option A. Option C was occasionally said to provide a good geographical spread of services across the Hywel Dda footprint.

"Separating treatment and diagnosis [under Option A] should reduce waiting lists and lead to fewer cancellations."

"Option A is the 'least bad' option as it reduces the likely cancellation rates for outpatients and does not, apparently, require more staff."

"[Option C] addresses safety concerns, does not require more staff (as the health board already has staffing issues and the cost criteria), and according to your information would prevent cancellations."

"Option C is probably the one most achievable now. Option D again is aspirational, but Hywel Dda is not attractive as an employer...."

"[Option C, as] … focussed more on two sites spread well over Hywel Dda area; need to ensure people use local services and not travel."

3.226 As was the case with the other options, views on Options A and C were influenced by geography to a certain extent. Option C was somewhat less supported in areas close to Prince Philip and Withybush, with a small number of respondents in these areas referring to the proposed removal of interventional radiology services at those sites under this option.

3.227 For some respondents living closest to Bronglais, however, the inclusion of the hospital as an inpatient interventional site made Option A appear more attractive.

"Option C would protect basic diagnostic services at Prince Philip but removes interventional radiology, which is a vital component of modern diagnostics and treatment planning, especially for an ageing population."

"Based on my location I would prefer Option A, both Bronglais and Glangwili are equidistant from where I live, whereas Prince Philip and Withybush are much further away."

3.228 However, there were also some concerns about the possible implications of having to move some patients to Glangwili if inpatient interventional services were to be centralised there as per Option A e.g. risks to the patient and increased pressures on the ambulance service. There was some suggestion that providing inpatient interventional services over a greater number of sites (i.e. two, or sometimes more) might therefore be advantageous.

"The options involving transfer of interventional patients would be risky, some of these patients are acutely unwell. Again, this would increase pressure on WASUT and potential admissions to ITU/HDU for high-risk procedures."

"Without having interventional radiology services for all in-patients and day cases, patients would need to be transferred from one hospital to another with potentially all sorts of problems (i.e., ambulance delays, patient's conditions deteriorating and requiring admission at the receiving hospital, bed availability etc)

"If it would make the service safer, then bringing together interventional radiology on two sites (Glangwili and Bronglais) is best. This is better than Option A (bringing it together on one site at Glangwili) because the travel time from the north of the area to Glangwili is just too long, and interventional radiology can be extremely stressful and exhausting for patients."

"Option A centralises inpatient interventional services only at Glangwili, requiring rural patients to travel further for these procedures - Option C limits interventional services to just two sites (Bronglais and Glangwili), creating access barriers for patients near Prince Philip and Withybush"

"In-patient interventional procedures at all sites would reduce length of stays and delays if patients had to be transferred to Glangwili as well as reduce the need for WASUT transfers."

3.229 A few also expressed a view that none of the options fully addressed the challenges facing radiology services, and that more analysis might be needed to assess the most appropriate way forward.

> *"None of the options seem to address the challenges of maintaining equipment."*
>
> *"Radiology faces significant service pressures that are not fully addressed by the current options. Consolidating equipment to fewer sites could optimize capabilities, but further analysis is needed to understand dependencies, equipment downtime, and optimal states. Demand and flow analysis for urgent and routine patients is essential for regional mapping."*
>
> *"None of the options address access to out-of-hours radiology e.g. MRI. As Glangwili is the Trauma Unit, all MRI staff should cover Glangwili out of hours on a rota"*

3.230 Some respondents called generally for radiology services to be provided as widely as possible, citing increases in activity at all sites and interdependencies with other services as their reasons.

> *"I am at a loss as to why your acknowledged 'large rise in activity across all hospitals' should be given as a reason to remove the service from some sites. Surely you should be asking why you struggle so hard to recruit?"*
>
> *"Radiology is critical to almost all other service areas, so it is important to retain/offer the most extensive and full-time service possible at all sites."*

3.231 In relation to community radiology services, a number of respondents (around 5% of those making a comment) expressed dismay at the proposed removal of the x-ray service from Llandovery Hospital, describing this as a very valuable and under-utilised resource for the local community. A few emphasised the rurality of the local area, the additional distances that would need to be travelled in order to access x-ray services, and the ease of parking at Llandovery Hospital relative to Glangwili.

3.232 There were suggestions that, if the x-ray service was maintained at Llandovery Hospital and the Minor Injuries Unit reinstated, there might be scope to relieve pressure on other hospitals in the health board area. Some pointed out that funds used to purchase the equipment had been raised locally and felt this justified the service being maintained in Llandovery.

> *"I am outraged by the planned closure of the X-Ray department at Llandovery Hospital. This is a vital service that is currently underutilised due to local patients being sent to Glangwili and the closure of the Minor Injuries Unit."*
>
> *"Patients from Llandovery and all the surrounding rural areas and Llandeilo could easily be having their x-rays at Llandovery Hospital; this would reduce the pressure on waiting times and parking at Glangwili/Prince Philip."*
>
> *"What will happen to the X-ray equipment bought by Llandovery League of Friends from money raised by the people of Llandovery, and lately used in Llandovery Hospital? Surely this should be taken into consideration with the current plans. This was meant to help people from travelling so far."*
>
> *"Llandovery hospital x-ray department is extremely necessary for the community, it was paid for by the community, and as such belongs to the community."*

3.233 Similarly, there were calls for provision to be maintained or strengthened at other sites: including Tenby. Some queried whether some x-rays could be carried out at GP surgeries, to relieve pressures elsewhere in the system.

> *"Tenby and community sites not fully utilised enough - should be longer hours to clear waiting lists and improve access. Staffing should be improved across the community sites."*
>
> *"I have never understood why GP practices do not have X-ray facilities with on-line referral to a radiology expert. Nearly every Vet has this facility!"*
>
> *"I realise that CT, MRI and PET scanning is limited by expensive equipment and qualified staff, but can some x Ray work be handled at some GP surgeries using compact or portable devices?"*

3.234 In general (i.e. considering radiology services as a whole) some respondents queried whether radiology services are currently working as efficiently as they could be, by suggesting that there may be scope to make improvements to queue management and decision making. Some respondents suggested that greater investment in artificial intelligence, telemedicine and other technologies might help to relieve staffing pressures and provide better services.

> *"[Option B] has a negative ongoing current account impact, but this can be mitigated by a profound improvement on queue management within Hywel Dda. It's a nonsense that Withybush can have a 6 week wait for CT scans whilst Glangwili has 6 days…"*
>
> *"So many patients are being subjected to X-Rays that, regardless of outcome, will not change the prognosis. I'd argue, without having the stats to prove it, that a lot of radiology's problems could be solved by smarter decision making at that level"*
>
> *"We also need to start using AI tools for reporting as the reporting burden is huge and human talent could then be focussed on the more challenging cases."*
>
> *"To address staffing pressures, funds should be allocated to develop AI tools and PACS, which could be integrated into future EPR systems if set up correctly. These tools should be developed regionally, with one health board hosting the capability and sharing costs."*

3.235 Respondents proposed other potential alternatives, suggestions and mitigations including the following:

- appointments should be allocated in a way that reflects patients' needs and preferences e.g. minimising travel wherever possible; also noting that weekend and evening appointments may have considerable benefits for some patients (e.g. of working age) but may be less accessible to those who rely on public transport.
- inpatient interventional services, or other interventional services, should be available 24/7 at a different site, or at all sites.
- maintain x-ray services at Llandovery Hospital, potentially alongside a reinstated MIU or other services, to reduce pressures on other hospitals (it was also queried whether the opening hours of the Llandovery x-ray service might be reduced, as a possible alternative to full closure, or whether GPs might provide some planned radiology services at the site).
- maintain a fleet of mobile imaging units (MRI, CT, DEXA and plain film) to provide resilience, respond flexibly to fluctuations in demand and staff availability, reduce patient travel and improve coverage in rural areas.
- several variations on the proposed options, including: adding weekend interventional services at Glangwili to Option B; hybrids incorporating elements of both Options A and B, such as

adding the cancer focus element to Option A; hybrids with elements of Options B and C; and removing the diagnostic hub element from Option B ("superfluous if the diagnostic imaging services can be provided 24/7 at all hospital sites.").

- Option B, but with a location specified for the diagnostics hub e.g. North Ceredigion, Llandovery.
- introduce 7-day services until waiting times are reduced, then move to 5-day services.
- develop a regional diagnostic hub (as per Option B) but move to a 7-day routine diagnostic service at certain sites in the interim.
- maintain services across two sites during weekdays and at a regional hub at weekends.
- pursue Option B, but if it takes too long to implement, Option C in the meantime.
- all diagnostic radiology services could be centralised on one site, seven days a week.
- create a network of community x-ray services across Llandovery, Tenby, Cardigan (one respondent also queried why Aberaeron Integrated Care Centre was not being considered as part of the radiology proposals).
- if a new community diagnostic hub is to be created, it may need to be co-located with endoscopy and ophthalmology services.
- expand the Regional Diagnostic Programme Board to include Powys Teaching Health Board.

Organisational Responses

3.236 Seven organisations felt Option B best meets the Clinical Services Plan objectives for radiology services, and two organisations thought Options A and D best meets the objectives respectively. Three organisations selected 'no particular preference' (four did not answer).

3.237 **Elidyr Communities Trust** and **Llanfair Grange Care Home** both expressed strong concerns about the proposals to remove x-ray services from Llandovery Hospital.

3.238 **West Wales Renal Service** questionnaire response was also submitted as a written submission, and due to its length and detail, has been summarised more fully in chapter 8.

Stroke

3.239 Respondents were asked 'Which option for stroke services do you believe best meets the Clinical Services Plan objectives, considering patient care, accessibility, and outcomes?'. They were provided with a summary of what stroke services included, where it was currently provided and the issues currently faced. Two different proposed options were presented for respondents to choose from: Option A, Option B, and they were also given the opportunity to select 'No particular preference' and 'don't know'. [79]

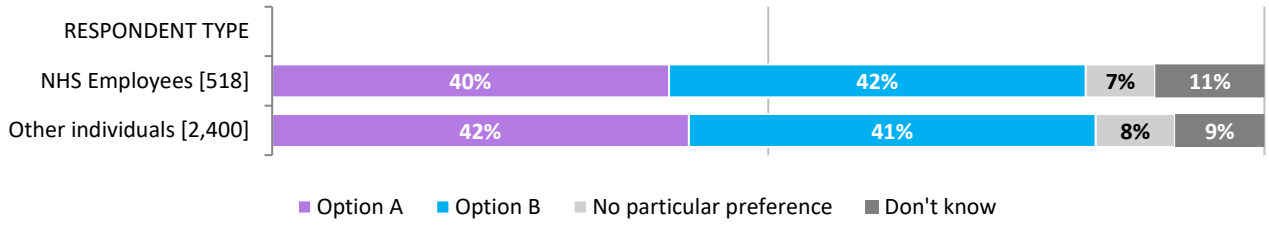
- **Option A** - Prince Philip and Withybush would have stroke units, with specialist cover 12-hours a day. This means, stroke patients from Bronglais and Glangwili would be transferred to Prince Philip or Withybush for their inpatient stroke care. This would help with staff shortages and would also allow for more treatments specialising in stroke because the service would be spread across fewer hospital sites than currently, which should raise clinical standards. There would be fewer patients and visitors travelling further for stroke care in this option than Option B, because Withybush stroke unit would provide inpatient treatment for stroke patients, as well as Prince Philip.
- **Option B** - Prince Philip would have a stroke unit with specialist cover 24-hours a day. This means, stroke patients from Bronglais and Glangwili, and from Withybush stroke unit, would be transferred to Prince Philip typically for 72-hours of inpatient care. Following this, patients' ongoing inpatient care would be provided either within Prince Philip, or at the stroke unit at Withybush. This would raise clinical standards and provide 24/7 consultant cover; as well as help with staff shortages. More patients and visitors would travel further for stroke care than Option A due to all patients (including those in Pembrokeshire) being transferred to Prince Philip.

By respondent type (stroke)

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

3.241 For both those working for the NHS and other individuals, similar proportions of respondents favoured Option A (40% for NHS staff and 42% for other individuals) and Option B (42% for NHS staff and 41% for other individuals).

Figure 33: Which option for stroke services do you believe best meets the Clinical Services Plan objectives, considering patient care, accessibility, and outcomes? By respondent type (individual respondents only)



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

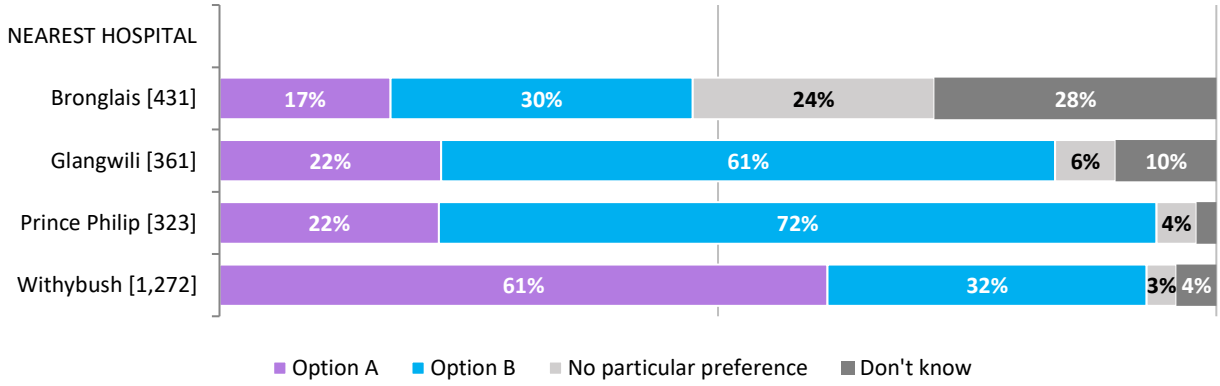
[79] Full details of the information provided can be found in the consultation questionnaire.

By nearest hospital (stroke)

3.242 Option B is the preferred option for individuals living closest to Glangwili (61%) and Prince Philip (72%). Option B (30%) was also preferred to Option A (17%) by those living closest to Bronglais; however, more than half of these respondents did not feel they could select an option, instead answering either don't know (28%) or 'no particular preference' (24%), with many going on to explain that they did not agree with either of the options presented.

3.243 In contrast, among those individuals living closest to Withybush, Option A was preferred (61%) (see Figure 24).

Figure 34: Which option for stroke services do you believe best meets the Clinical Services Plan objectives, considering patient care, accessibility, and outcomes? By nearest hospital[80] (individual respondents only, where postcodes were provided)



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

By health board (stroke)

3.244 The number of individual respondents living outside the Hywel Dda Health Board area is low so limited conclusions can be drawn, but Option B was more widely preferred than Option A for individuals living in the Powys, Betsi Cadwaladr and Swansea Bay University Health Board areas. However, half of respondents in the Powys Health Board area (10 out of 20 individuals) either indicated no preference or answered "don't know".

By other demographics (stroke)

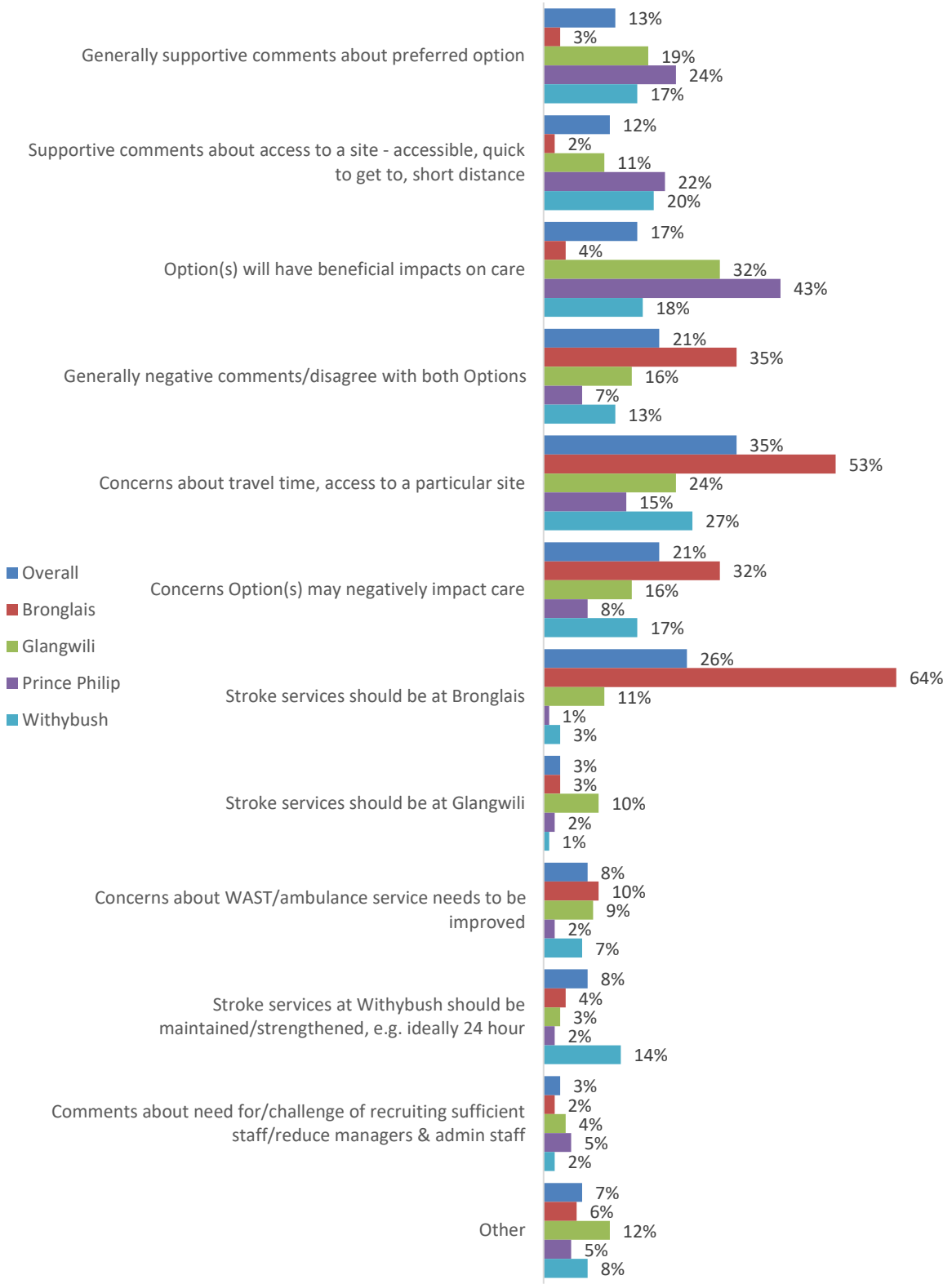
3.245 Across other demographic groups, there was no clear variation in opinion, beyond that explained by proximity to each hospital.

Reasons for choosing options, and alternative suggestions (stroke)

3.246 Respondents were asked 'Please share why you chose this option. How could we improve it or reduce any negative impacts? Do you have any alternative ideas that would meet the objectives?' in an open text box. A summary of responses from those responding as individuals is provided in Figure 35 together with a summary broken down by nearest hospital. The percentages quoted are out of all respondents providing a comment. Because respondents could provide detailed feedback, some comments cover more than one point and, therefore, the total percentages sum to greater than 100%.

[80] Nearest hospital based on travel time. 531 responses without postcode are not displayed, but are included in the previous chart of overall results.

Figure 35: Please share why you chose this option. How could we improve it or reduce any negative impacts? Do you have any alternative ideas that would meet the objectives? (individual questionnaire respondents only) (Percentages are of those providing a comment to this question) (Responses by nearest hospital[81] are where postcodes were provided)



Base: Overall individual respondents (1,500), Points raised (2,623)

[81] Nearest hospital based on travel time

3.247 Where Option A was preferred, this tended to be on the basis that it would allow a stroke unit to be maintained in Withybush, thereby improving the geographical 'spread' of inpatient services and reducing travel times and distances for a greater proportion of patients and their families (particularly those in Pembrokeshire).

> *"Option A - essential for stroke patients in Pembrokeshire to have quick emergency access in Withybush."*
>
> *"Option A - provides more treatment for specialist stroke care, reducing staff shortages and potentially improving clinical standards. Less requirement for patients and relatives to travel further afield than Option B, unless absolutely necessary. Arrangements may be less stressful for patients and relatives than Option B."*
>
> *"It would be completely unfeasible for Ceredigion patients to be transferred to Prince Philip logistically if you are factoring in travel time and treatment as well as them being so far from home. Keeping a unit in Withybush helps to mitigate this while centralising core stroke care to 2 areas."*

3.248 Where Option B was preferred, this tended to be preferred on the basis that it would maintain 24-hour specialist cover at one of the sites and increase clinical standards. Some respondents who favoured Option B were sceptical that the proposed arrangements for specialist cover in Option A (i.e. 12 hours per day in two locations) were practical, or were unclear about how this would work in practice.

> *"Regional consolidation of this specialist service and 24 hour a day cover in Prince Philip seems to be the fairest option."*
>
> *"Option B is the best of the two options; we definitely need 24 hours specialist cover somewhere in the health board. However, our current service having a stroke unit in each hospital is most ideal…"*
>
> *"Raises clinical standards which is more important than travelling issues."*
>
> *"Strokes can happen 24 hours a day, they don't work to a 12-hour schedule."*

3.249 There was some optimism that the proposals might ultimately lead to better care by, for example, helping with staffing levels. The inclusion of a stroke unit at Prince Philip was occasionally said to make sense, particularly by those living in proximity to the hospital, based on its location near a large population centre and on the quality of its facilities (e.g. Ward 9), as well the strengths of its multi-disciplinary teams and their future potential – considerations that were occasionally said to outweigh issues around additional travel times.

> *"An enhanced stroke unit that is based in Prince Philip is a good idea. High quality stroke treatment will be provided in a central location and transfers back to their local hospital within 72 hours. Although this could be an added stress on family members who live further away such as Bronglais and Withybush, I feel they will be grateful that their relative is receiving the best possible care."*
>
> *"If Ward 9 was a pure stroke specific unit, it would attract more interest in terms of employment, particularly within the area of Therapies (for those who have a passion to work within the field of stroke*)."
>
> *"Prince Philip ward 9 is a better rehab environment compared to other sites within the health board - layout of the ward is conducive to rehab with gym space, dayrooms and outdoor space available. Feel that the current ward and team has very good potential and centralising stroke services there would allow upskilling of staff to become specialists in stroke care."*

3.250 Although small in number, some NHS staff with experience of stroke services queried whether 24/7 specialist cover was strictly necessary. These individuals felt that that the additional benefits offered by Option A (reduced travel, fewer transfers) might make it a more 'balanced' proposal overall than Option B.

> *"Whilst I agree that weekend day cover would be beneficial, I do not think 24/7 cover by a consultant is required, and sounds very expensive (in the rare cases I've seen where stroke input is required OOH, the medical consultant on call tends to call a friend for advice) … The foundation of rehab is building a good relationship between the clinical team and the patient to help engagement and understand how best to help. If after 72 hours you move the patient, you start this whole process again."*
>
> *"24-hour stroke consultant is not necessary. Weekend cover is though. Prince Philip has an excellent facility for delivering stroke care acutely and for rehab. With fully staffed units in Prince Philip and Withybush (absolutely essential) this would provide a far better standard of care than what is delivered now."*
>
> *"The 12-hour specialist cover in Option A, while not 24/7, still allows for high-quality care, and concentrating services on fewer sites than currently available should raise clinical standards and help address staff shortages. Overall, Option A strikes a better balance between clinical excellence and accessibility, ensuring more patients can receive timely stroke care closer to home."*
>
> *"To suggest local treatment and then transfer 70 miles away to be seen for 5-20 minutes by a specialist ignores the fact that we have telemedicine which can deliver this."*

3.251 As noted above, some respondents (particularly those living closest to Bronglais) said that they had "no preference"; others answered, "don't know". Many of these respondents expressed disagreement with both options, as did some others who didn't feel able to state a preference. Around a fifth (21%) of individuals who commented provided generally negative feedback about the proposals or simply expressed a view that neither option was appropriate, while a considerable number of others provided more specific or detailed concerns.

3.252 Of all those who made a comment, around a third (35%) of individuals raised concerns in general about travel and access, with many highlighting the time-sensitive nature of stroke treatment (i.e. the so-called 'golden hour'), and questioning whether all local hospitals would be reliably able to deliver the initial time-sensitive care, prior to transfer to the main stroke hospital(s).

3.253 This led some individuals to question whether centralisation of the stroke service was appropriate, given the large geographical area covered by the Health Board and the dispersed, rural nature of many of its communities, as well as limited public transport networks.

> *"A model of centralising services at one hospital is not applicable to such a large and mostly rural area with many issues regarding distance and travel challenges for patients and families."*
>
> *"Both options A and B are awful and will have terrible outcomes for patients and their families. Everyone knows that the critical thing about a stroke is to get treatment quickly - it's called the 'golden hour' for a reason - but the required treatment is highly specialist… Both options A and B will end up costing more in the long term, as patients will suffer worse mobility problems, longer rehab times, and other serious health issues that in turn will require more treatment."*

"I have answered 'don't know' as I strongly disagree with the 2 options. The reasons being: - Inequitable travel times across the health board - how will Llandovery, St Davids, Ceredigion/Powys border patients meet the criteria of admission to a stroke unit within 4 hours of symptom onset if they are required to travel half of that time?"

"A stroke is time limited and an emergency - each hospital in the locality needs a unit."

3.254 There were also concerns about the impacts for visitors in the event of a loved one being transferred, with many highlighting the importance of friends and family in terms of advocating for the patient and supporting their rehabilitation and recovery. As such, there was some concern that those being treated further from home might experience worse outcomes as a result of family being unable to visit them. Concern was also expressed about the emotional impact on patients (e.g. anxiety about being further from loved ones).

"If a patient from Aberystwyth is going to be managed in Withybush for example how are the family going to visit? Recovery from a stroke can take several months and family often provide support by coming in to help feed the patient for example. Families play a huge role in the patient's recovery."

"If this recommendation is passed it will be impossible for families to visit the patient on a very regular basis. And if you don't have a car, managing travel will be a nightmare e.g. five and a half hours from Ffwrnais to Prince Philip one way on public transport."

"Your options would deny patients the support of friends and family, with long travel times even for those with cars. Visitors (some frail themselves) travelling by public transport face almost prohibitive costs in time, effort and money, meaning that stroke patients would not get the essential support from those close to them."

"[Stroke patients] are the worst patients to transfer. They are always terrified and incredibly distressed."

3.255 Some respondents were also concerned about the ability of the remaining stroke units to absorb patients from the other hospitals, due to existing challenges around bed capacity etc.

"You can't expect all stroke patients to be sent to one hospital. All hospitals are struggling for stroke beds already in every site as they are long-term patients on the wards."

"How are you going to ensure that beds are going to be available for these patients reducing four sites to two? These beds must be ring fenced and protected with processes in place, so the referring hospitals are not wasting time trying to get their patient accepted."

"Most stroke cases in Glangwili get spread across the Glangwili campus as we don't have enough beds as it is for the patients, getting rid of the unit and only keeping 2 will increase this throughout the other hospitals. The patient's treatment and rehabilitation will be at jeopardy…with the patients being spread across medical wards…"

3.256 Nearly a tenth (8%) of individuals who provided comments noted the importance of WASUT's role under the Treat and Transfer model and queried whether the ongoing pressures on ambulance provision had been given adequate consideration.

3.257 There were concerns about the safety implications if stroke patients ended up being effectively 'stuck' in A&E while waiting for an ambulance, while others noted that it would be very costly to undertake all of the

additional transfers required. For some, strengthening ambulance provision or ensuring 'buy in' from the WASUT was therefore a necessary precondition of the proposals.

> *"Both options involve heavy reliance on WASUT. WASUT cannot cope with current workload. Adding extra workload will not only damage prospects for stroke patients, but for all who need to be transported to hospital - heart attacks, seriously unwell with other conditions etc."*
>
> *"A robust transfer service will need to be guaranteed. Current WASUT service provision sees patient transfers failing to happen due to community pressures. This will not be acceptable in this model. People will die if these types of patients are not guaranteed to be transferred."*
>
> *"The reality is that patients at both "treat and transfer" sites, patients will be stuck in A and E, being looked after by non-specialists, being "diagnosed" by non-specialist, whilst waiting for transport. By the time they arrive at the ASU they may no longer need hospital admission but will then be faced with trying to get back home."*
>
> *"How exactly will these transfers happen, when you wait 5,6,7+ hours for an emergency ambulance as they are stacked up outside A&E, Bronglais as they cannot offload!"*

3.258 Some respondents expressed general concerns about the "treat and transfer" model, feeling it may be fundamentally less safe to move patients after thrombolysis treatment (e.g. due to increased risk of bleeding/haemorrhage). It was occasionally suggested that staff in other services (e.g. A&E) would be impacted if, for example, they were needed to thrombolyse patients and accompany them in ambulances. It was suggested this might potentially create additional workforce issues and divert resources away from other services.

3.259 Other staff felt the model would make it effectively impossible for the service to comply consistently with SSNAP guidelines and other targets, due to the Health Board's geography (particularly in the cases of patients who would currently attend the stroke unit at Bronglais). There were specific concerns among some members of staff that certain assessments such as those for dysphagia might be delayed.

> *"A patient who has been thrombolysed needs specialist care post thrombolysis to monitor for complications, this cannot be done effectively in the back of an emergency ambulance without medical support (apart from ACCTs), one nurse even if specially trained cannot manage this."*
>
> *"If a patient is thrombolysed as per treatment they should be kept still and monitored. The treat and transfer option increases the risk of the patient bleeding on transfer."*
>
> *"Thrombolysis - then transfer straight after - is a critical time. You require observations every 15 minutes - cardiac monitoring and access to a close medical team/critical care team, ITU if required and also a specialist stroke nurse, 24/7 for the initial 24 hours…"*
>
> *"With multiple ambulances outside A&E daily, how is the ambulance service going to meet the needs of moving all of these patients within the timescales required for SSNAP? How will targets such as swallow assessments and therapy assessments be met if there are delays with the ambulances?"*

3.260 In relation to comments about specific sites, very significant concerns were expressed about Bronglais not being included as a site for a stroke unit in either of the proposed options. Overall, around a quarter (26%) of all individuals who commented expressed a view that stroke services should be maintained at Bronglais, rising to over three-fifths (64%) when only considering those respondents for whom Bronglais is the nearest hospital.

3.261 Many respondents (both staff and other individuals) were of the view that both options were unacceptable due to the large area Bronglais serves, the number of elderly people in its catchment area, and the considerable distances between it and the other hospital sites (with some citing a travel time of roughly two hours one-way between Aberystwyth and Llanelli, for instance).

3.262 Respondents emphasised the greater difficulties associated with travelling across a dispersed, rural area (e.g. minor roads, farm and tourist traffic, livestock on the carriageway, additional winter challenges) and suggested that transferring patients to-and-from Llanelli from parts of Ceredigion, Gwynedd and Powys would be far more challenging than transporting patients between hospitals along the M4 corridor.

> *"Bronglais should have a stroke unit due to its geographical location and no hospital services for a considerable distance. The other three hospitals are located fairly close [to each other]; therefore, stroke services can be 'treat and transfer' in one of them."*
>
> *"I do not support either option provided as no inpatient services would be provided at Bronglais, this is not acceptable due to the large catchment area to the north of the area of Ceredigion, and including across the border into Powys and Gwynedd, that would be expected to travel long distances for inpatient care, which could be for an extended period."*
>
> *"Both options are appalling and horrifying for those who rely on Bronglais, with both sites about two hours away. I am very fearful of what would happen if any of my family in Aberaeron/ New Quay area would get a stroke…This will have horrendous impacts on journey times, family care, and again affect those most vulnerable and with disabilities disproportionately."*
>
> *"What are you doing, closing the only hospital in mid-Wales that is local to such a large area?... Again, everything is down south."*

3.263 In addition, Bronglais was said to have the best-performing stroke unit in the Health Board area, which led some respondents to query why it was not being retained as part of either of the options.

> *"The stroke unit in Bronglais has excellent SSNAP data showing the excellence that they have achieved."*
>
> *"It is surprising that what has been upheld as the best stroke unit (i.e., that at Bronglais hospital) isn't being considered as one of the stroke units."*

3.264 A number of individuals queried the inclusion of Prince Philip as site for a stroke unit in both of the options. Frequently, this was based on travel and access considerations, with the hospital being described as particularly distant and difficult to access for those patients, visitors and staff living in northern and western parts of the Health Board. In contrast, patients in and around Llanelli were said to benefit from relatively good proximity to other services, such as those at Morriston Hospital in Swansea.

> *"Having a stroke unit so close to Swansea Bay is not a good use of resources. Patients from Llanelli can get to Swansea or Glangwili within an acceptable period of time."*
>
> *"There will be staff losses if the site is moved to Prince Philip. It is at the very far end of the health board. Staff from Ceredigion and Pembrokeshire may be unwilling to transfer there."*

3.265 Additionally, some concerns were expressed about Prince Philip's suitability due to other reasons, such as it having no A&E service (claimed to be the route via which most stroke patients are admitted) and no full intensive care unit (ITU) currently operating on site to support stroke patients with complex needs.

3.266 It was suggested (mainly by staff) that many stroke patients initially taken to Prince Philip, might need to be subsequently transferred again to other sites (e.g. Glangwili) for aspects of their care, which might cause distress and add additional challenges. There were also some concerns that this need for additional transfers could negatively impact upon continuity of care and delay the start of the rehabilitation process for these patients.

> *"I do not understand why stroke services are being moved to Prince Philip when there is no A&E, no MIU after 8pm and no level 3 service in ITU. To treat and ship will cause more problems and delays."*
>
> *"How can you have a main stroke unit without an ITU pathway to safeguard these patients? They will end up in Glangwili anyways."*
>
> *"If a patient has a fall/fracture/long lie/multi-trauma/level 3 (intensive care need) they will go to Glangwili. Moving the stroke service to Prince Philip would create unnecessary moves for this patient group and thus the patient would not be having 'care by the right people at the right time'; they would be moved further away from home and would not have seamless continuity of care across their stroke journey"*
>
> *"The idea that Prince Philip is the right place for the main stroke unit is madness - no A and E and no ITU provision, mean further reliance on WASUT to transport patients to the correct place - i.e. if stroke patient deteriorates or turns out not to be stroke but diagnosed with "something else"."*

3.267 A few staff members noted that removing stroke services from Glangwili and/or locating them at Prince Philip, might impact upon Speech and Language, Occupational Therapy and other support and rehabilitation services, as well as Early Supported Discharge (ESD).

> *"Speech and Language therapy staff are not ring-fenced to only work in stroke, this means that staff cannot be centralised to one site unless there is significant investment in the service. As there is a higher demand for medical patients in Glangwili, current staff prioritise medical and stroke patient within their day; this will not be able to be done if stroke is moved to Prince Philip - two separate staff would be needed to cover the two sites."*
>
> *"If Prince Philip was to be the central stroke site, where would the Early Supported Discharge (ESD) or CIST teams be based?"*

3.268 While relatively few individuals overall (3%) commented that stroke services should be maintained at Glangwili, some staff members felt strongly that this might be a preferable alternative, due to it having other services on site to better support stroke patients with other healthcare needs e.g. patients requiring the Ear Nose and Throat (ENT) service and those with fractures. It was also suggested by some individuals that this would be a more central and accessible option for those living further north and west within the Health Board area.

> *"All patients who are admitted with a fall or with ENT needs will continue to be admitted to Glangwili, along with all of the patients who are bought to Glangwili in an ambulance and patients who self-present and are told by 111 to attend their nearest A&E… ENT patients who have a stroke (i.e. stroke patients with a tracheostomy tube) are the most complex stroke patients, in the current plan these complex patients will not receive stroke specialist input. Selecting to move the site from Prince Philip to Glangwili will remove all of these issues."*

"Prince Philip would be a good location for centralising stroke in terms of current MDT/facilities but there are some reasons why Glangwili may be a more preferable site: keeping patients closer to home with location/spread of patients across geographical area; access to level 3 beds on ITU for stroke survivors who would lack specialist stroke therapy input if they were on ITU and not ward level; orthopaedics if strokes have multiple pathologies including fracture after fall, which is fairly common."

"I believe the main stroke unit should be in Glangwili hospital as it is central for Pembrokeshire, Carmarthenshire and Ceredigion patients."

3.269 Others suggested that Glangwili typically admits and manages a higher volume of stroke cases than Prince Philip, linked to the fact that many patients present via A&E services. Therefore, it was suggested, a more logical alternative might be to locate a stroke unit at Glangwili rather than at Prince Philip.

"Most stroke patients self-present to A&E. It would make more sense to follow this flow and ask a small number of patients to change their pathway (from Prince Philip) and go with the flow of the majority of HDUHB patients by having a unit in Glangwili and Withybush. Staff in Prince Philip are not used to the number of stroke patients through the system per month whereby Glangwili and Withybush are."

3.270 Some similar arguments were raised in favour of maintaining the stroke unit at Withybush i.e. a strong track record and experience in managing large numbers of stroke presentations.

3.271 As noted elsewhere (i.e. in relation to other services under review as part of the consultation), the higher-than-average elderly and tourist populations in Pembrokeshire were also provided as reasons for maintaining services in Withybush, as well as issues with transport links in the area. Many felt these issues justified the presence of 24-hour stroke care at Withybush, as a possible alternative or change to the proposals under consideration. In total, nearly a tenth of respondents who commented (8%) expressed these kinds of views about maintaining or strengthening stroke services at Withybush.

"I am opposed to moving services relating to emergency and urgent care away from Withybush/Haverfordwest, due to the increased distance and frequency of road incidents that cause significant delays on roads connecting more remote areas to more centralised services."

"Looking at the SSNAP data and demographics, would it not be better to centralise/home the main stroke services at Withybush. They also seem to be the unit that is working in more innovative and progressive ways."

"Withybush needs to maintain the 24-hour stroke unit; results are good here."

"None of the options are ideal from a resident in the Withybush area… it is important that Withybush has 24-hour stroke support, as nobody can anticipate when one will happen."

3.272 There was some evidence that respondents were unclear about the wider stroke pathway after the acute phase. Some felt that aspects such as rehabilitation, recovery and the discharge process had been overlooked, or at least not very clearly explained, as part of the consultation materials.

"The plan lacks a clear stroke care pathway and overlooks essential aspects like end-of-life care, rehabilitation, and the role of family support."

"It is alarming there has been no consideration of community pathways during this process. As with all services, any changes in acute should be alongside community planning to ensure a smooth transition, ensure hospital flow and prevent unnecessary delays in care."

"The CSP does not consider the impact on community services post-acute care. For example, patients would have to travel long distances for follow-up at the rehabilitation hospital, or additional resources would be needed to see these patients in the community/homes. The plans also do not consider ongoing neuro-rehabilitation needs which is currently not available".

"The idea that stroke therapy can be delivered so far from home is completely unsustainable. Therapy has been largely ignored by this process. A few patients need less than two weeks, but we are forgetting those who require long stroke specific rehab - there are many."

"It is absolutely essential that long term rehabilitation is prioritised and not just the acute 72 hours of treatment and therapy. Attention needs to be paid to investing in the community integrated stroke team, CRT and social services to ensure smooth transition of rehab and pt flow can be achieved."

"The ESD would have to be shored up, to allow early, timely discharges."

3.273 There were concerns about implications for the workforce e.g. the ease of staffing the acute sites, and also impacts for those working in rehabilitation services, both on hospital sites or in the wider community. A couple of comments expressed concern that workforce data concerning the psychology workforce had been omitted from the Clinical Services Plan.

"It is unlikely that highly trained staff in Bronglais will be willing to relocate to Prince Philip/ Withybush. How will staff be recruited to new posts and what would the training requirements be in order for them to be sufficiently skilled? What would be the plan for the staff currently in post in hospitals that will no longer have a service- would they be redeployed within the same hospital?"

"The lack of detail on the required care and workforce which is required once the acute phase is past is sadly missing from the CSP, which needs to be dealt with so that the neurological rehabilitation and psychological consequences following a stroke are addressed. Most stroke patients are in the community, not in hospital and therefore stroke services need to ensure that the community services are appropriate for the right care for stroke patients and their families. The psychology workforce as part of the MDT is missing in the CSP workforce data, it is not included in the current workforce and neither in the projected workforce data required to support these options, and therefore also omitted from the workforce costings."

3.274 In particular, there was some confusion among respondents living closest to Bronglais, as to whether some care could be provided locally following the acute phase, or if it was more likely that patients would have to stay at one of the other hospitals for a prolonged period for their rehabilitation. Linked to this, it was suggested or assumed that many therapy staff would have to be relocated to one of the remaining stroke units, and therefore would be less able to provide care closer to patients' homes.

3.275 Some suggested that providing a strengthened rehabilitation service at Bronglais might enable patients to be repatriated more quickly and that this might therefore be a suitable mitigation against the potential loss of acute stroke services at that site.

"Staff can only operate within a small geographical area in order to meet the necessary rehab targets. If the majority of therapy staff were based at Prince Philip, how will they offer regular community services to patients discharged to the furthest areas of Ceredigion or Pembrokeshire? There would need to be ESD/CIST teams based at each hospital site, in order for them to function effectively."

"Could it also be an option to set up better rehab services in Bronglais to sit alongside the treat and transfer model?"

"Bronglais has an award-winning stroke service, and this should be recognised and protected as an excellent stroke rehabilitation unit."

3.276 There were also some suggestions that the proposals should utilise options such as telemedicine, either to mitigate the impacts of the proposals or as part of some alternative model by helping maintain consultant-led cover in rural areas.

"For patients who live far away from home which has a negative impact upon face-to-face visiting, use of technology including video calls would be encouraged on Ward 9. This worked during Covid."

"[The CSP] also fails to explore practical solutions like telemedicine or consultant-led rehab models that could better serve rural communities."

"Whilst Prince Philip is admittedly very far from, for example, Aberystwyth, we can use digital tech to facilitate good communication with loved ones."

3.277 Respondents proposed other potential alternatives, suggestions and mitigations including the following:

- maintaining stroke units at all four existing sites, as is the case now.
- Bronglais to retain its stroke unit (it was also suggested that Bronglais might take on some enhanced role, e.g. as a regional centre of excellence or rural stroke centre).
- configurations involving three stroke units rather than the two proposed.
- various alternative two-site configurations, usually involving Bronglais plus one other of the three hospitals in the south of the health board area.
- maintaining four units with 24-hour specialist care at Prince Philip and 12-hour care at each of the three remaining hospitals.
- maintaining a stroke unit and/or 24/7 care at Glangwili e.g. as potentially more equitable for travel, more appropriate for patients presenting via A&E, and to accommodate stroke patients with complex needs or requiring other forms of acute care.
- investment in facilities at Glangwili e.g. extending the Gwenllian ward to provide more stroke beds in the health board and relieve pressures to transfer patients quickly.
- having 24/7 specialist care at Withybush (either in addition to, or potentially instead of, Prince Philip).
- implementing a phased or hybrid approach based on both Options i.e. starting with 12-hour cover at both chosen sites (as in Option A) and gradually extending to 24-hour care as staffing levels improve.
- Suggestions involving a more regional or all-Wales approach to stroke care e.g. creating a Comprehensive Regional Stroke Centre (CRSC) at either Morriston or Glangwili, or promoting Bronglais as a mid-Wales or rural hub in discussions with Powys Health Board and Betsi Cadwaladr Health Boards.

- development of a level 2/therapy-led rehabilitation unit somewhere in the health board footprint for those patients that need rehab in a 24-hour supported setting but no longer need medical-led care.
- having stroke consultants work on rotation to cover more sites e.g. to maintain acute care at Bronglais.
- making Prince Philip a centre of excellence for stroke rehabilitation instead of an acute centre (with acute services at Glangwili).
- developing a mobile unit for use across the region.
- making better use of telemedicine to support services across more sites.

3.278 Some other points for consideration and suggestions were also raised. Some of these were quite detailed or technical, and all have been shared with Hywel Dda in their entirety; however, the following provides an overview of some of the main themes:

- utilising the Air Ambulance to support transfers.
- using dedicated or ring-fenced vehicles to conduct the necessary transfers, to reduce reliance on the ambulance service.
- maintaining stroke rehabilitation services and provision at all sites.
- developing neighbourhood health hubs, aimed at moving care out of hospitals and into the community, where possible.
- strengthening rehabilitation services at other, community hospitals etc e.g. Llandovery, Tregaron hospitals.
- investing more in neurology services to support stroke services in Hywel Dda.
- considering how best to enable Early Supported Discharge (ESD) and Community Integrated Service Team (CIST)[82] teams to work more effectively, potentially merging with community neurorehabilitation services to reduce duplication and prevent delays in transfer.
- ensuring that services cater to first-language Welsh speakers who have suffered a stroke (as their ability to communicate in English may be adversely affected where it is their second language).
- ensuring ophthalmology and orthotic services are provided on the same sites that stroke services are delivered.

Organisational responses

3.279 Among the organisations who responded: four favoured Option A, seven favoured Option B, two had no preference and one answered ‘don’t know’.

3.280 Some of the organisations, including the three community councils (at **Llangeitho, Lledrod** and **Nantcwnlle**) all advocated for stroke services being maintained at Bronglais, for reasons such as ensuring timely treatment for patients in the catchment area, preventing transfers over long distances, and promoting recovery by having friends and family closer to the patient.

3.281 **Hearts and Crafts** in Llanelli noted that Prince Philip had a good reputation for stroke care and felt it would be beneficial to use this expertise.

[82] multidisciplinary teams that provide specialist, intensive stroke rehabilitation at a patient's home to help them leave the hospital sooner and maximize their recovery

3.282 The most detailed responses were received from West Wales Renal Service, the Critical Care Clinical Psychology Service, and Clinical Health Psychology.

3.283 The **Critical Care Psychology Service** expressed concern about the current pathway for complex stroke presentations at Prince Philip, as well as the lack of a critical care outreach team at the site. The response also expressed concern that complex patients might experience adverse outcomes if they were required to spend time at a different hospital to that where a stroke unit was located, as this might delay the start of their rehabilitation.

> *"For those patients who are complex, remaining in ICU for longer or possibly requiring tracheostomy care, there are no facilities in Prince Philip to be able to manage these patients safely. therefore, should they have to remain in Glangwili with no stroke rehabilitation provision they are placed at greater risk of poorer outcomes."* [Critical Care Clinical Psychology Service]

3.284 Overall, the response also expressed greater support for Option A due to Option B requiring more patients to be treated further from their homes.

> *"Option A is preferable to Option B due to the impact upon families of having a loved one treated far from home, thus adding to the financial and emotional burden during what is already an exceptionally traumatising time for families."* [Critical Care Clinical Psychology Service]

3.285 The response from **Clinical Health Psychology at Hywel Dda** expressed support for the 24-hour specialist provision contained in Option B, although it was noted that providing care further from home might make it harder to engage families in the rehabilitation process. The response emphasised the importance of rehabilitation and community teams, and expressed some concern that the proposals are overly focused on the acute phase of care, rather than the whole stroke pathway. Additionally, the response reiterated concerns mentioned elsewhere about a lack of reference to the Clinical Psychology Stroke Service in the CSP workforce data.

3.286 The response from the **West Wales Renal Service** (summarised in Chapter 8) highlighted the lack of a dialysis unit in Prince Philip to manage the care of renal patients who might suffer a stroke.

Urology

3.287 Respondents were provided with a summary of what urology services covers, where services are currently provided and the issues currently faced.

3.288 The options development stage involved a number of ideas, that were subsequently combined into a single option. This meant that only a single option was proposed for urology services, but the Health Board stated that this is not a preferred option, as other ideas could be put forward. Respondents were asked to what extent they agreed or disagreed with the proposal and were also given the opportunity to select 'don't know'. [83]

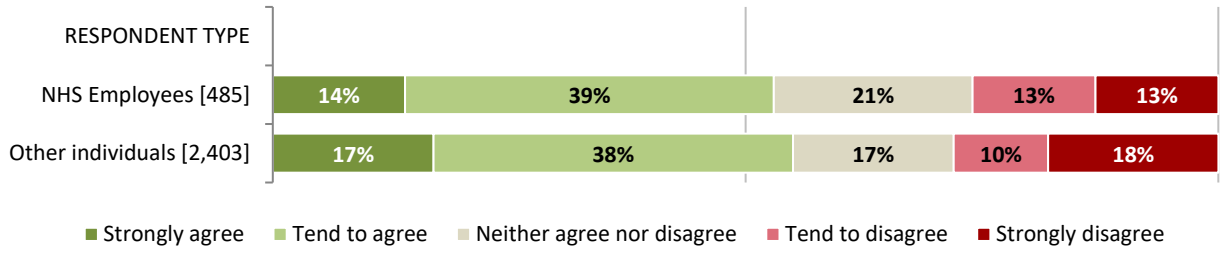
- **Proposed Option** - Almost all urology services would be removed from Glangwili, with only the emergency pathway remaining in place, to care for patients with urology emergencies that come to the Emergency Department (A&E). Outpatient, diagnostic (other than urgent suspected cancer) and day case services would remain at Withybush and Bronglais to reduce travel times for patients needing these appointments. Prince Philip would provide diagnostics for urgent suspected cancer patients. Bringing services from Glangwili and Prince Philip together should result in fewer separate hospital visits for patients (as it is more likely that multiple appointments can take place at one location on the same day), although some patients would have further to travel on the day of their appointments.

3.289 Following this, respondents were given the opportunity to explain how this proposed option could be improved and given opportunity for alternative ideas to be suggested.

By respondent type (urology)

3.290 Figure 36 shows that there is a similar level of agreement between individual respondents who identified as working for the NHS and those who didn't, with over half (53% and 55% respectively) either strongly agreeing or tending to agree with the proposal for urology services.[84]

Figure 36: To what extent do you agree or disagree with the proposal for urology services? By respondent type (individual respondents only)



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

By nearest hospital (urology)

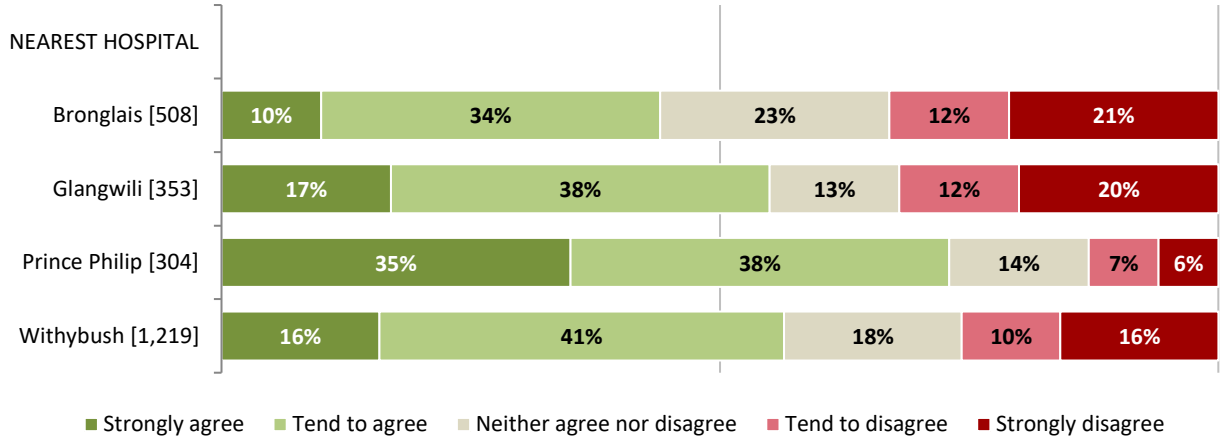
3.291 Almost three-quarters (73%) of individuals living closest to Prince Philip agreed with the proposal for urology services (either strongly agreeing or tending to agree) and over half of those living closest to

[83] Full details of the information provided can be found in the consultation questionnaire.
[84] 163 respondents selected the 'don't know' option. This is omitted from the chart for presentational convenience (standard industry practice) because it does not affect the balance between agreement/disagreement.

Glangwili and Withybush hospitals agreed (55% and 56% respectively). However, less than half (44%) of those individuals living closest to Bronglais agreed with the proposal.

3.292 A third (33%) of individuals living closest to Bronglais and Glangwili disagreed, either tending to disagree or strongly disagreeing (see Figure 37).

Figure 37: To what extent do you agree or disagree with the proposal for urology services? By nearest hospital[85] (individual respondents only, where postcodes were provided)



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

By health board (urology)

3.293 The number of individual respondents living outside the Hywel Dda Health Board area is low so limited conclusions can be drawn, but 73% and 56% of those individuals living in Betsi Cadwaladr and Swansea Bay University Health Boards agreed with the proposal for urology services respectively. However, those living in Powys Health Board were divided, equal proportions agreed as disagreed (32%).

By other demographics (urology)

3.294 Across other demographic groups, a slightly greater proportion of females (57%) agreed compared to males (54%), and a greater proportion of males disagreed (32%) compared to females (24%).

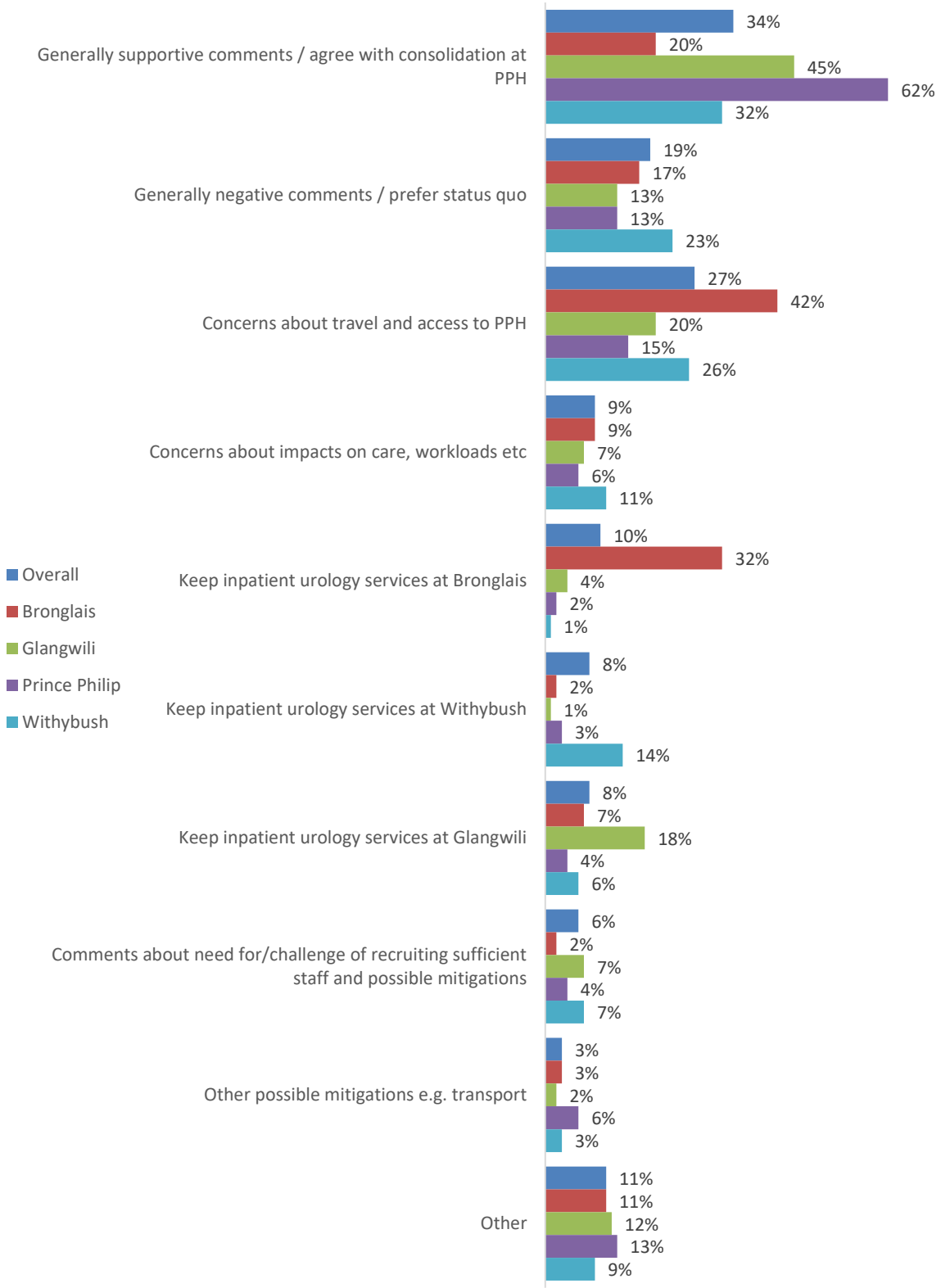
Reasons for choosing options, and alternative suggestions (urology)

3.295 Respondents were asked 'Please explain your reasoning, including how we could improve the proposed option or reduce any negative impacts? Do you have any alternative ideas that would meet the objectives?' in an open text box. A summary of responses from those responding as individuals is provided in Figure 38 together with a summary broken down by nearest hospital.

3.296 The percentages quoted are out of all respondents providing a comment. Because respondents could provide detailed feedback, some comments cover more than one point and, therefore, the total percentages sum to greater than 100%.

[85] Nearest hospital based on travel time. 504 responses without postcode are not displayed, but are included in the previous chart of overall results.

Figure 38: Please explain your reasoning, including how we could improve the proposed option or reduce any negative impacts? Do you have any alternative ideas that would meet the objectives? (individual questionnaire respondents only) (Percentages are of those providing a comment to this question) (Responses by nearest hospital[86] are where postcodes were provided)



Base: Overall individual respondents (929), Points raised (1,245)

[86] Nearest hospital based on travel time

3.297 Of all respondents who made a comment, around a third provided feedback that was generally in support of the proposal, i.e. agreeing that consolidating urology services at Prince Philip, with some services remaining at each of the other main hospitals, is sensible, more efficient and benefits most of the population of Hywel Dda.

"Keeps services in all four areas and having a dedicated diagnostic hub seems to be the sensible option."

"This option appears to retain services for the benefit of the majority of the Hywel Dda areas while consolidating the services currently offered at the two closest hospitals in order to impact positively on staffing and developing specialisms."

"Bringing Prince Philip and Glangwili together seems to be a good idea. If it cuts down on hospital visits. Nice to see that Withybush is going to stay as it is."

"Best to have a core central setting plus [outpatient departments] and minor stuff more local."

"Multiple appointments can take place in the one location on the same day."

"To improve efficiency especially with staffing issues, I tend to agree with the suggested option. It makes sense for the patient to be able to have multiple appointments on the same day in the same setting."

"Bringing Services Together Improves Efficiency: Creating a dedicated unit means patients can receive diagnostics, consultations, and procedures in fewer visits a big advantage for older or less mobile individuals."

3.298 Those who agreed with the proposal provided a range of reasons for doing so, with many stating that they feel it would reduce waiting times, improve patient experience, and provide a better service overall. It was also frequently mentioned that on balance, improved waiting times and patient experience outweighed the inconvenience of increased travel for some patients.

"Current waiting lists for urology services are far too long. It is likely that the Option could help reduce waiting times as it would lead to a different use of staff and provide dedicated cancer diagnostics in the Prince Philip dedicated urology unit. It may well be that travelling for urology patients is difficult, but it is also likely that many might prefer to have this increased distance to travel as long as their waiting time is reduced and they see an expert in their field and have access to all the tests in one place and one visit if possible. Retaining some services in Bronglais and Withybush is important."

"This maintains local access for the majority of appointments, reducing travel for routine and non-emergency care. Only patients needing inpatient care or urgent cancer diagnostics would need to travel to Prince Philip, which balances accessibility with improving efficiency and reducing waiting times across the Health Board."

"Better service, and less visits, which should help the staff also."

"I agree with the reasoning for these changes, and it seems to have the least impact for routine patient care across the HB area. Reduced wait times for different procedures also reduces patient stress and frustration."

"More staff better trained with improved morale improves patient outcomes which in the longer term reduce costs, rather than expensive poorly staffed service with poor outcome and poor patient experience."

"Increasing in the number of appointments overall should be the priority regardless of distance."

3.299 Another reason frequently cited for supporting the proposal was that concentrating services on one site would make optimal use of resourcing (specialist equipment and staff) and therefore provide a more efficient service. It was also felt that focussed services would help with staff recruitment.

"Focus on bringing a stronger unit in one place is a more productive use of resources."

"Focusing of resources, including staff expertise and equipment for critical cases is crucial. Thank you."

"Centre of excellence and access to staff reliably might be best in this circumstance."

"The concentration of urology services at Prince Philip should help with staff recruitment and more efficient working."

"It seems the best solution is dependent on having specialist resources. If these are considered to be at Prince Philip, then the plan needs to ensure that this hospital does its utmost to retain the best resources (staff and equipment)."

3.300 It was frequently mentioned that creating a centre of excellence at Prince Philip makes sense, not only because there is already an existing urology service there, but because aligns with the endoscopy service (which would remain at Prince Philip under all proposed options for endoscopy and may be expanded).

"As Prince Philip is already providing the service then it makes sense to keep urology services there and as stated it allows for close working with endoscopy services at this hospital."

"Prince Philip has an excellent urology department and endoscopy unit, with exceptional staff."

"Better Integration with endoscopy: Prince Philip already has an expanding and modern endoscopy service, and co-locating urology allows for better diagnostics (e.g. for bladder cancer), which may lead to faster diagnosis and treatment, particularly for suspected cancer cases."

3.301 Distance and travel time was a key consideration for many, with some feeling that the proposed option, which should allow for more appointments to take place on the same day in the same place, would reduce the number of overall journeys for patients. It was also suggested by others, that while additional travel would be needed by some, it would be infrequent and therefore not a significant barrier.

"Less travelling time will help all patients and reduce waiting and quicker to receive treatment plan."

"It is a case of not having to be ferried around so much."

"There would be some travelling needed but it would be minimal."

3.302 However, over a quarter (27%) of respondents made comments which highlighted concerns around travel i.e. longer travel times for some patients, and ease of access to Prince Philip. A higher proportion of respondents whose nearest hospital is Bronglais made these sorts of comments (42%). Longer journey times for those in the north and west of the Health Board area where transport links are poorer, was a frequently noted concern, with many adding that traveling long distances was particularly difficult for urology patients (who are also often elderly) and care should ideally be provided closer to patient's homes and families. It was acknowledged by some, however, that the model aims to balance the travel challenges with increased efficiency.

"Some patients, particularly those who previously relied on Glangwili for non-emergency urology, will now have to travel further for routine appointments. Prince Philip becomes a central hub for urgent suspected cancer pathways, which is efficient but may increase journey times for patients from the north of the area. While not perfect for everyone, this model seems designed to balance local access (at Withybush and Bronglais) with efficiency and specialist care (at Prince Philip)."

"Travel times! urology patients being asked to sit for longer due to increased travel times!"

"Once again patients in the North of the area are expected to undertake very long journeys on not very good roads to receive treatment. When a person has just had a bladder procedure, they need to be close to a toilet NOT sitting in a car for 2 or 3 hours."

"Urology patients who more than often have problem concerning prostate, bladder etc should be treated closer to their home by their local hospital. To have to travel many miles with such conditions are unacceptable and often embarrassing for the patients."

"I believe that this change would negatively impact on the population of Hywel Dda and transfer the cost of illness from the Health Board to the patients and their families. I believe that these changes would disproportionately affect the most vulnerable and impoverished in our area, by requiring the majority of patients to travel further for medical treatment or provide support to their loved ones."

"At Bronglais, we have experienced significant delays in transferring patients to Glangwili for urology- diagnostics and treatment, often with adverse effects for the patients. Whichever pathway is chosen, there needs to be mechanisms in place that 'ring fence' the onward (urgent/ emergency) referral pathway. Glangwili ED often have zero capacity and no beds available, resulting in the potential for harm to the patient, as a direct result of delays in the transfer of care."

"I am at present undergoing treatment for prostate cancer and have experienced these services at first hand. My appointment was early in the morning, and I had to travel down the day before and stay in a hotel. Following the procedure, I had to travel for two hours over tortuous roads back home. An uncomfortable and stressful journey. Please consider the welfare of patients in the North."

3.303 It was also frequently argued that Prince Philip is not centrally located, and transport links from some parts of the Health Board area are poor, therefore consolidating services here would further increase potential travel challenges for many, with patients with suspected cancer affected the most.

"According to this proposal Prince Philip will be the only site to offer services to screen for Cancer, this would significantly increase travelling for patients and carers from surrounding areas, especially in the north and west, affecting chances of diagnosis and treatment."

"As I have stated previously Prince Philip hospital is a logistical nightmare for patients who live in Powys, south Gwynedd, Ceredigion and north and west Pembrokeshire. I am not against centralised services, but the services need to be provided centrally to the area they serve or at least to have excellent transport links to ensure all patients have equitable access."

"If there are services not available at Bronglais but these are currently provided at Glangwili, then these need to be retained at Glangwili as it is simply too far and too difficult for poorly service users and their support networks in many parts of Ceredigion and beyond to travel to Prince Philip hospital."

"Wish to retain urgent suspected cancer services at Bronglais. To have to travel to Prince Philip from the Bronglais area would be demanding and stressful, especially with a potential cancer diagnosis. It would also be prohibitively expensive."

"Because of the distance and difficulties of the journey to Llanelli, the proposed arrangement would pose problems for urgent cases suspected of cancer."

3.304 Around a fifth (19%) of respondents made comments disagreeing with consolidation in general and expressing a preference for keeping the status quo, i.e. all hospitals should provide all urology services (not just the emergency pathway) with many stressing the need for more local treatment for urology patients, for whom travelling would likely be difficult, uncomfortable and may compromise their dignity. A frequently noted concern was that not providing all urology services at all hospitals might be detrimental to patient care and outcomes.

"Keep as it is. We don't want to go from Haverfordwest to Llanelli. So, stay as it is currently. All services for those that live in Pembrokeshire to stay at Carmarthen or Withybush."

"The more cover for Cancer treatment the better. Any reduction will affect patients care to the detriment of hospital waiting lists."

"The correct option is to keep the current services, review possible inefficiencies in current working practices and ensure there is sufficient funding for it to be maintained!"

"Services should remain as they are currently to provide for all areas of the community."

"I feel patients should be able to access local treatment/intervention for urgent suspected cancer cases. Patient's being expected to travel further for these investigations seems unfair when they could be provided locally."

"Keeping outpatients at most hospitals would help as urology patients would not want to travel far away from toilet facilities."

"The urology unit at Aberystwyth Is excellent. I would prefer to keep things as they are presently"

"This is a very large workload for one hospital, it is very distant to many of the patients that require the service, it will mean that many patients will put off treatment as it's too far to travel and you will then get more advanced cases that are unfortunately untreatable. It is a very very bad idea."

"Please be mindful that patients reliant on public transport services, with urinary tract infections but including men with various conditions of the prostate gland, may experience frequency and any extension of travel times could lead to extreme discomfort, loss of personal dignity and humiliation."

3.305 Many respondents made suggestions around how potential challenges of the proposed model could be mitigated. Travel times and transport was identified as one of the main problems if the proposed model is implemented, with respondents frequently noting that hospital transport, for example a shuttle bus service, should be provided to support those who are unable to provide their own transport or use public transport. Additionally, it was mentioned by some that the Welsh Ambulance Service University NHS Trust needed to be improved to manage patient transfers between hospitals. Other suggestions included exploring tele-communications for routine follow up appointments to save unnecessary travel, and utilising a reimbursement scheme which allows patients to claim for transport costs that doesn't require patients to pay costs upfront.

"Offer transport support or shuttle services on key clinic days. Explore teleconsultations for routine follow-ups. Retain some minor diagnostics or pre-op assessments in Glangwili to minimise unnecessary travel."

"Ambulance services need to be looked at and invested in if more travelling between sites is going to happen."

"Please ensure that transport is provided for patients that cannot provide their own transport."

"I have concerns across all of the proposals that the additional burden of travel cost and access for patients becomes a strain for many experiencing financial hardship. Perhaps a return to the old reimbursement scheme (office) would help support low-income patients to travel (modern reimbursement scheme requires patients to pay up front and then make a claim, using an online form which has to be printed and posted which takes too long for those who have very little to nothing spare)."

3.306 Some respondents suggested ways to strengthen the proposed model and ensure that the planned improvements are fully met. It was felt important that all services delivered are well integrated, for example co-ordinated appointments on the same day, to ensure smooth running and minimise stress on patients.

3.307 It was also noted by some that it is vital to ensure that the changes (and the reasons behind them) are well communicated with the public, and that public health campaigns are used to highlight various urological conditions and help patients understand where best to go to receive initial diagnosis and treatment.

"So long as the promise of fewer appointments is also matched with minimal waits between these services that are seen on the same day. It will be important to ensure well-integrated service delivery to avoid excessive patient stress and exhaustion on that day."

"It would be good to highlight urgent/time sensitive urological conditions (e.g. testicular torsion) through a public health campaign of some kind to ensure patients with conditions that need the most urgent treatment select the appropriate hospital to present at."

"I do believe that to have better cover at fewer sites is the better option. However, communication of that fact is key for patients, who see your proposals as 'cuts' to services, rather than focused services and understanding why."

"Sell the vision, Prince Philip will be a centre of excellence. In all your plans you are peddling the same old crap at 4 dilapidated hospitals. Have a vision to create a specialist planned care surgery hospital at Glangwili, centres of excellence for urology, dermatology and ophthalmology. You need to designate a specialist women's and children's centre of excellence. Even if it takes 10 years people need this vision of what they are getting, not what they are losing. At present you are delivering a message of loss particularly Pembrokeshire. This is crazy with a Senedd election next year and the potential for a big vote of no confidence in the directors of this health board. Have a vision, be more efficient and get people who will deliver real change!"

3.308 Around one in twenty respondents made comments around the need for and/or challenge of staffing and recruiting staff, with respondents frequently stating that more staff should be recruited generally. It was felt that the focus should be on staffing issues rather than making changes to service provision. It was also frequently suggested that the number of administrative staff and managers should be reduced and the money diverted to improve clinical staffing and recruitment issues.

"Experience of the NHS in this region has shown me that there is a serious issue with where funding is going. There are far too many administrative staff running complicated unnecessary administrative processes when these costs could be diverted to actual clinical staff, negating the issue of underfunding and staff shortages."

"More staff better trained with improved morale improves patient outcomes which in the longer term reduce costs, rather than expensive poorly staffed service with poor outcome and poor patient experience."

"Hire more staff and keep these essential services open in each county!"

"Current staff shortages should not be used to govern proposed changes. The reasons for staff shortages should be addressed and conditions changed to encourage recruitment. This applies to all the suggested services. We should not be changing services based on staff problems, we should be employing staff to fulfil planned and existing services. Investigate why we have a recruitment problem and address the issues."

"The Health Board needs to invest in staff retention/training and less managerial positions. People who have vast knowledge in their field of expertise are being lured by the money to take up positions in management and not necessarily carrying out the job to the full potential, or not listening too, or think that they know better than the people that have been doing the job for a long time. We all know that the NHS is a very large machine that has many moving parts, and all involved do a fantastic job. Investment and recruitment are a priority, and so is rewarding those who are on the front line."

3.309 Many comments centred around alternative suggestions for the location of urology services, with many respondents saying that services should not be consolidated at Prince Philip and other hospitals should provide more urology services and/or another hospital should instead be the dedicated urology unit; respondents were more likely to suggest that this should be at their closest hospital.

Glangwili:

"Prince Philip hospital is not a viable option for the majority of the county Hywel Dda patients. It is too far and there is no suitable public transport to get there for appointments or visitors to sick patients. Alternative should be considered to cover both north and south if the county and I'd those options are not available then it should be central at Glangwili."

"I do worry slightly about my fellow patients in Carmarthenshire as losing all services at Glangwili and having cancer services concentrated at Prince Philip may have an adverse effect on the time they have to wait. I feel a better option may be to centralise cancer at Prince Philip but still keep some outpatients at Glangwili to provide for those who have urgent need but not cancer!"

"Kindly bear in mind obstetricians and gynaecologists do require urology support occasionally. currently Glangwili is acute site for obstetrics it will impact directly on patient safety. Gynaecology complex cases could be planned however occasional input is required."

Bronglais:

"We need to protect this service in Bronglais as we cover a vast geographical area. It is an invaluable service that is provided. Why should we lose this service, surely it makes sense for 1 person to travel to see the patients in Bronglais, rather than all the public, many being elderly, infirm, or having disabilities travel so far to see a urologist. I have worked in healthcare in Aberystwyth for over 40 years, I know that this is a service that we definitely need to KEEP."

"Keep Bronglais as it is and consolidate down in the three other sites. Stop expecting elderly, frail, and the disadvantaged to incur exorbitant costs to get to south Wales on non-existent public transport infrastructure."

Withybush:

"You need to put more services in Withybush because we need a general hospital in the west. Travelling to Glangwili you will cause more deaths for the residents of Pembrokeshire."

"The services for Pembrokeshire should be maintained at Withybush. The county has 127k people who live here That plus the holiday season and how rural the area is would not be fair on the residents. For someone living in Dale it would take 40 minutes to get to Withybush, which is bad enough, if this were to move to other hospitals this would be extended by at least another hour. This is not fair."

3.310 Some respondents made other suggestions relating to increased local and community provision to provide diagnostic and follow-up care closer to patients' homes, reducing the need for hospital visits and long travelling distances. such as:

- » urology outreach clinics at Bronglais, Glangwili or Withybush, with clinics possibly on an alternating weekly, monthly or quarterly basis and prioritising patients who are unable to travel far;
- » community-based urology clinics staffed by nurse specialists and consultants visiting regularly;
- » mobile diagnostics, e.g. a mobile scanning unit which could provide basic diagnostics in more remote communities;
- » pre-appointment tests and early diagnostics carried out by specialist nurses at GP surgeries or community hospitals/sites e.g. Ammanford, Cardigan Integrated Care Centre, Llandovery Hospital.

3.311 Respondents proposed other potential alternatives, suggestions and mitigations including the following :

- » consolidating at a location other than Prince Philip Hospital (as described above)
- » a possible two-site option e.g. one in the north and one in the south
- » provision of diagnostic services in two hospitals
- » a 'super diagnostic centre' at some location within the Health Board area (with emergency urology in Glangwili and outpatient day case surgery in Withybush and Bronglais)
- » centralisation at a proposed new 'super hospital'

3.312 Some respondents raised other questions or considerations. They felt that it was important that the availability of other services at each hospital is taken into account when making decisions around where urology services are based, as they are often inter-connected. The availability of and location of staffing expertise available for certain procedures was also highlighted as an important area for consideration.

3.313 Some other points for consideration and suggestions included :

- » Concerns about the lack of full ITU services at Prince Philip, meaning nephrectomies may still need to be treated at Glangwili
- » Concerns that unwell urology patients may need to be kept close to dialysis machines
- » Considerations involving numbers of junior doctors at each site and their exposure to urology services
- » Suggestions for improving capacity in the service, so that instead of transferring patients with simple urology problems (e.g. patients in retention with difficulties in catheterisation), urologists could either visit the site, or general surgeons could undertake some procedures (e.g. supra-pubic catheter)

Organisational responses

3.314 Nine organisations agreed with the proposal for urology services (six strongly agreeing and three tending to agree) and five organisations disagreed with the proposal (two strongly disagreeing and three tending to disagree). One organisation neither agreed nor disagreed with the proposal for urology services (one did not answer).

3.315 Within their full submission (summarised in Chapter 8) the **West Wales Renal Service** highlights that urological and renal conditions are closely interlinked, and urged Hywel Dda to retain comprehensive urology capacity at Glangwili, where multidisciplinary support is available for complex patients.

3.316 The **Critical Care Clinical Psychology service** also expressed concerns around increased movement of patients in need of ongoing critical care if urology services if Prince Philip becomes a main hub for urology services.

> *"Ongoing care of patients admitted to ICU for a urology emergency would require repatriation of patients resulting in more movement through the system at a time when patient already under duress." [The Critical Care Clinical Psychology service]*

3.317 The manager of **Llanfair Grange Care Home** called for an increase in services overall, while two organisations called for urology services to be provided at Bronglais, with Lledrod Community Council noting that a new unit has been built at Bronglais and should be "used to its full potential for patients in mid Wales."

> *"We need increased service, not decreasing them." [Dyfi U3A, Machynlleth]*
>
> *"Bronglais is the preferred option & 2nd Prince Philip." [Manager, Llanfair Grange Care Home]*
>
> *"This essential service is needed here in Bronglais for serving the Mid Wales area. Since a new Unit has been built thanks to local fundraising - this Unit should be used to its full potential for patients in Mid Wales." [Lledrod Community Council]*

Future roles of the main hospital sites

3.318 Respondents were asked 'To what extent do you agree or disagree with the roles of the hospital sites as described above, to support making services safer and sustainable for the future?' including the opportunity to select 'don't know'. They were provided with a summary of what the future roles of hospitals could look like. [87]

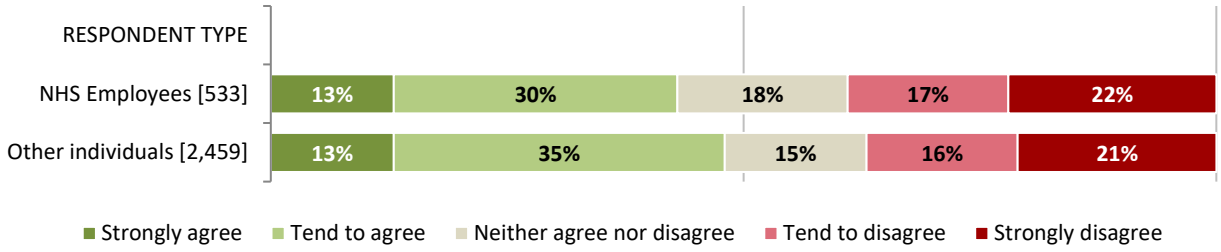
- **Bronglais** - providing services as it currently does, though some specialities may be provided from different Hywel Dda sites.
- **Glangwili** - providing more acute and emergency care, with some planned care moved to other sites, either by service or health condition.
- **Prince Philip** - providing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

By respondent type (Future roles of the main hospital sites)

3.319 Figure 39 shows that just over two fifths (43%) of individual respondents who identified as working for the NHS either strongly or tended to agree with the roles of the hospital sites as described, to support making services safer and sustainable for the future, whereas almost half (48%) of other individuals agreed.

3.320 Just under two-fifths of both those working for the NHS and other individuals disagreed (39% and 37% respectively).[88]

Figure 39: To what extent do you agree or disagree with the roles of the hospital sites as described above, to support making services safer and sustainable for the future? By respondent type (individual respondents only)



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

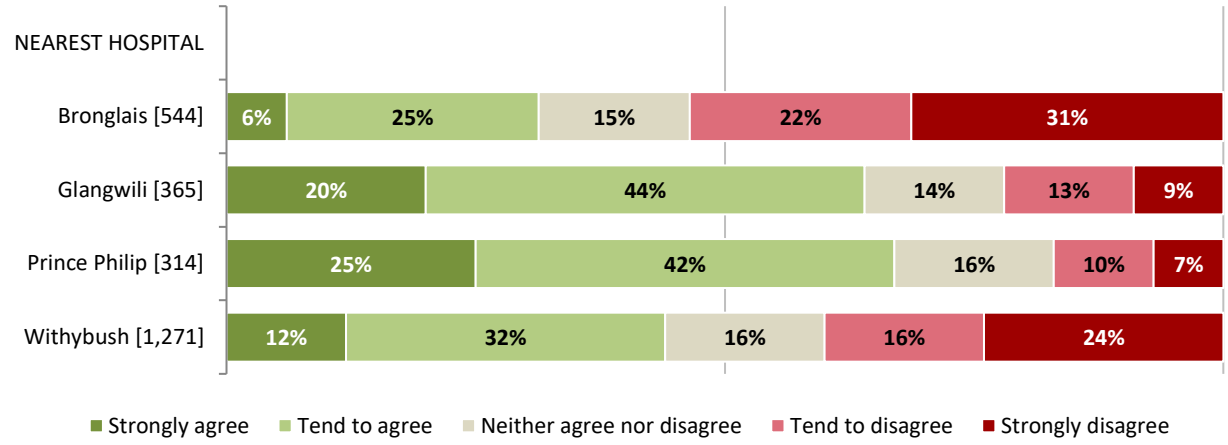
By nearest hospital (Future roles of the main hospital sites)

3.321 Around two-thirds of individuals living closest to Glangwili and Prince Philip (64% and 67% respectively) agreed with the roles of the hospital sites as described. Whereas less than half (44%) of those living closest to Withybush agreed and less than a third (31%) of those living closest to Bronglais.

3.322 Just over half (53%) of individuals living closest to Bronglais and just over two-fifths (41%) of individuals living closest to Withybush disagreed, either tending to disagree or strongly disagreeing (see Figure 40).

[87] Full details of the information provided can be found in the consultation questionnaire.
[88] 82 respondents selected the 'don't know' option. This is omitted from the chart for presentational convenience (standard industry practice) because it does not affect the balance between agreement/disagreement.

Figure 40: To what extent do you agree or disagree with the roles of the hospital sites as described above, to support making services safer and sustainable for the future? By nearest hospital[89] (individual respondents only, where postcodes were provided)



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

By health board (Future roles of the main hospital sites)

3.323 The number of individual respondents living outside the Hywel Dda Health Board area is low so limited conclusions can be drawn, but 71% of individuals living in the Swansea Bay University Health Board area agreed with the roles of the hospital sites as described. Views of individuals living in Betsi Cadwaladr and Powys Health Boards were more divided, with 43% and 39% agreeing respectively and 43% and 32% living in these areas disagreeing.

By other demographics (Future roles of the main hospital sites)

3.324 Across other demographic groups, there was no clear variation in opinion beyond that explained by proximity to each hospital.

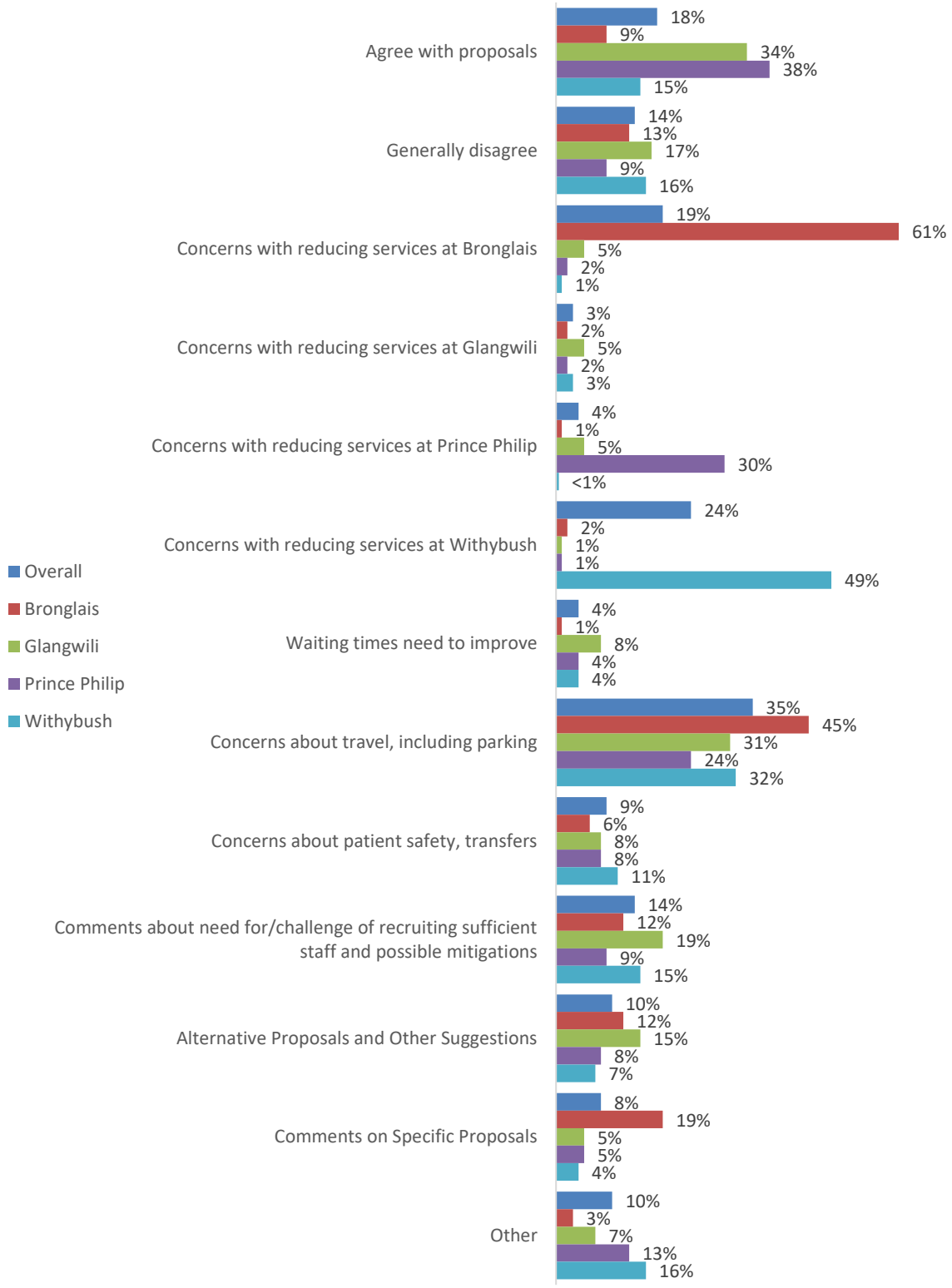
Reasons for choosing options, and alternative suggestions (Future roles of the main hospital sites)

3.325 Respondents were asked 'What are your views on the proposals to improve the safety and sustainability of services for the future? Please explain your reasoning, including how the positive impacts of the proposals could be enhanced and any negative impacts reduced?' in an open text box. A summary of responses from those responding as individuals is provided in Figure 41, together with a summary broken down by nearest hospital.

3.326 The percentages quoted are out of all respondents providing a comment. Because respondents could provide detailed feedback, some comments cover more than one point and, therefore, the total percentages sum to greater than 100%.

[89] Nearest hospital based on travel time. 498 responses without postcode are not displayed, but are included in the previous chart of overall results.

Figure 41: What are your views on the proposals to improve the safety and sustainability of services for the future? Please explain your reasoning, including how the positive impacts of the proposals could be enhanced and any negative impacts reduced? (individual questionnaire respondents only) (Percentages are of those providing a comment to this question) (Responses by nearest hospital[90] are where postcodes were provided)



Base: Overall individual respondents (1,523), Points raised (2,622)

[90] Nearest hospital based on travel time

Views on the proposals: general

3.327 There was some support for the proposals on the basis that they should: provide better clarity in terms of each hospital's role; reduce waiting times by separating emergency and planned cases; enable more efficient throughput of cases; support regional working; and allow staff to work from single centres as part of bigger teams, thereby helping to provide safer services, improve experience and morale, and aid recruitment.

> *"Clinical staff generally prefer to work from one centre as part of a large team, which provides strength, safe working and support. Concentration of particular services at different Hywel Dda sites should facilitate team working and efficient case throughput. This should also have the effect of improving staff recruitment, reducing waiting times and reducing unit costs."*
>
> *"It makes sense to have to have hospitals for emergency vs planned care - it allows for centres of excellence and allows more scope for development"*
>
> *"Something radical has to be done. Centralising services and concentrating staff seems sensible."*

3.328 Some respondents who agreed with the proposals in general, nonetheless acknowledged there might be some 'trade off' in terms of patients and visitors needing to travel further in some instances. There were a few suggestions that this was a reasonable compromise to ensure the best possible quality of care.

> *"We live in an era of specialisation ultimately delivering higher standards of treatments and care, but patients must realise that this means they have to travel for access and this is a consequence of living in a rural community."*
>
> *"While travel distances will increase for some, the trade-off is safer care, shorter waiting lists, and better use of specialist expertise."*

3.329 A greater number of respondents, however, expressed stronger concerns about the implications of additional travel, which led them to disagree with the proposed roles for the hospitals. One respondent suggested that the proposed model of care is more suited to urban than to rural communities (where, it was claimed, it is actually associated with higher mortality rates). It was suggested that the proposals risked patient safety by requiring too many transfers to be undertaken, and over considerable distances. There were additional, widespread concerns about impacts on the Welsh Ambulance Service University NHS Trust and patient transport.

> *"You're worsening patient safety, by moving people around left right and centre, when more appropriate and safer to keep them in one place where they can already receive the right interventions."*
>
> *"Centralising acute and emergency care in Glangwili is absolutely unthinkable - it is far too far in time sensitive cases even if there were enough ambulances"*
>
> *"The problem is the health board covers a very large area and not everyone has transport to travel or family to transport them to appointments. To travel for appointments. E.g. 7:00am appointment in Llanelli from Pembrokeshire means having to get up at 4:30am. Impossible by public transport to arrive at a certain time."*

3.330 There was some concern that centralising too much emergency and acute care at one site might have unintended, negative impacts, such as: creating a single, overwhelmed emergency department; creating

'bottlenecks' in the system; and de-skilling at the sites where there is less emphasis on acute care, which might leave them less able to care for very sick patients.

> *"It does make sense, as has always been the case, that the sickest patients may need to go further up the line, but we need to maintain acute skill at all sites. People will be just as sick but the resources and experience to care for them will be gone."*
>
> *"Concentrating so many acute services at Glangwili could create bottlenecks, unless there's major investment in infrastructure, staffing, transport and step-down care… Ensure Withybush, Bronglais and Prince Philip have effective urgent care pathways for stabilisation and triage, even if full acute care is off-site."*
>
> *"Critical and emergency care cannot be centralised to the point that regional hospitals are unable to care for the sickest patients. It negatively impacts people in certain communities and that is unfair."*

3.331 As such, there were various concerns noted by those who disagreed with the proposals, usually on the basis of travel and access or patient safety (and frequently both). As noted elsewhere in this report, concerns about road infrastructure and public transport were very prevalent, and several issues with car parking were reported in relation to all sites. Frequently, this led respondents to advocate for as many services as possible to be available in their local hospital, or in all hospitals/in general.

Views about the roles of specific hospitals

3.332 Some respondents specifically supported the proposals insofar as they affected one or more of the main hospitals. For example, there was strong support for Bronglais continuing to provide as many services as it does currently, based on the large, rural area it serves. Similarly, the proposals for Withybush were sometimes said to strike a suitable balance between local access and safety, by providing initial access to acute care.

3.333 Based on location and expertise, Glangwili was felt by some respondents to be an appropriate choice as a central hub for urgent and emergency care, while Prince Philip was also felt to be a suitable centre for planned care across a wide area and population, benefiting from its proximity to Swansea Bay University Health Board.

> *"Bronglais would continue providing services broadly as it does now, and Withybush patients would still have initial access to acute care locally before transfer if higher-level treatment is needed. This balances local access with safety."*
>
> *"I totally support Glangwili as a hub for urgent and emergency care it has an ideal central location and good road networks for transfers. Prince Philip is geographically close to Swansea meaning we can attract skilled individuals to deliver planned specialised outpatient-based diagnostics and treatment if they have more space to do so. The plans for Withybush and Bronglais seem sensible also."*

"Making Prince Philip a centre for planned care across a wider region, including specialist services like orthopaedics, dermatology, urology and ophthalmology, will enhance local services for Llanelli and surrounding communities. It also supports regional partnerships with Swansea Bay University Health Board, which can improve access to specialist care and reduce waiting times… Centralising high-intensity acute services at Glangwili makes sense clinically, as it allows for consolidated expertise…Ensuring that both [Bronglais and Withybush] hospitals continue to provide planned care and initial emergency response is essential for public confidence and access in more rural and remote areas."

3.334 However, many respondents perceived that Bronglais was being downgraded under the proposals; the loss of the stroke unit was seen as unacceptable, and there were concerns about the distances that patients may need to travel to access some specialties. As noted elsewhere in this report, respondents living in proximity to Bronglais highlighted its comparatively isolated location compared to the three southern hospitals; the dispersed, rural nature of the large area it serves (including neighbouring health boards); an increasingly elderly population; and relatively limited and fragile transport infrastructure.

Bronglais needs to retain all of its services as it is the only general hospital in mid Wales and treats patients from a vast rural area of Wales with patients otherwise forced to travel ridiculous distances for care. In order to have a thyroidectomy I had to travel the night before and stay in a hotel overnight to be in time for an early morning operation slot. At my own expense, of course.

Bronglais is in a unique rural location with major travel issues to receive care further south. Our services are being continuously being eroded and our road system, with no motorways or dual carriageways, means we have long and difficult journeys to access the care you are suggesting. The ambulance services are not coping with even urgent care up here and the cost of upgrading it to an acceptable degree would be prohibitive. It cannot be safer to implement what you suggest.

3.335 Those living closest to Withybush also highlighted issues with road and public transport, as well as an ageing population and the presence of heavy industries and large numbers of holidaymakers in Pembrokeshire. It was suggested that factors such as these required as many services as possible to be maintained at Withybush.

3.336 As with Bronglais, a few respondents perceived that the hospital was effectively being 'downgraded'. The relatively recent removal of paediatric and obstetric services was occasionally said to have already had a negative impact, amid concerns the hospital was on course to become a 'cottage hospital'. A small number of respondents also said that uncertainty over the future of the proposed new hospital (around St Clears or Whitland) justified more services being maintained at or returned to Withybush.

"There is no other option than to strengthen services at Withybush since the "planned" new secondary care hospital has officially been shelved. A reduction in any of the services currently provided at Withybush will destabilise clinical services and ultimately lead to services "falling over" as they are interdependent and interlinked. This would leave Pembrokeshire residents severely disadvantaged in accessing hospital services, increasing negative outcomes and putting patients at risk."

"Withybush needs to be a major "Health Care" centre not a glorified nursing home and patient "passing through" point."

"I feel there is an ongoing trend to turn Withybush hospital into a cottage hospital. I hope this isn't the case for the sake of all of us who live, work and holiday here."

3.337 Respondents living nearest Prince Philip frequently felt that the size of Llanelli justified having more, rather than fewer, services located in the town. While there was some support for developing Prince Philip as a centre for planned care, some respondents felt that acute and emergency services needed to be retained/reinstated at the site as well.

"I agree that it would be good to see more planned care back in Prince Philip but I feel strongly that it needs to be able to provide Emergency services too and that the A&E department needs to be reinstated back to 24/7 care keeping the Acute care it already has but that is under strain due to the closure of the MIU unit not being 24/7 service anymore."

Prince Philip needs to be re-established as a full general hospital. Population and Industry are in the Llanelli area, not in Carmarthen.

3.338 A number of respondents mentioned Llanelli's proximity to services in Swansea, to justify why they felt services should be retained at hospitals other than Prince Philip (which was said to be particularly distant for those in the far north and west of the Hywel Dda area). However, some residents in the Llanelli area felt that more clarity was needed on what cross-border arrangements might be possible. There were also concerns that services in Swansea Bay would too busy to accommodate additional patients from Hywel Dda, or that doing so might lead to disjointed care.

"Llanelli is too distant to be an option for large swathes of the health board area. If services must be centralised, they should be centralised to Glangwili and retained at Bronglais, Llanelli should become a minor local hub, and capacity should be increased at Swansea to handle Llanelli patients."

"Prince Philip needs to operate one or two specialist services only due to proximity to the Swansea hospitals."

"It all depends on how the partnership with Swansea is set up… Where services cannot be provided locally, we should have the OPTION of using Swansea Bay Trust – it's a lot nearer, and the roads are safer, and there are two major routes."

"By blurring the lines between Swansea Bay and Prince Philip hospital I feel like there is going to be disjointed care[for] patients that live in Llanelli."

"With Prince Philip being close to Swansea, you can see the logic, however it could put additional strain on Swansea services. Prince Philip could become the poor relation within Hywel Dda…"

3.339 Glangwili was sometimes said to be the most centrally located of the Health Board's main hospitals, and therefore a good option for centralising services; nonetheless, many people (particularly in Pembrokeshire) had concerns about accessing the site, and the constrained nature of it (lack of space to expand, limited parking etc). Similarly, Carmarthenshire residents expressed concerns about needing to travel further for care. Other concerns were expressed around capacity issues at the site and also around the age and condition of its buildings which, it was suggested, might make the site less attractive to prospective staff.

"Glangwili is more central for everyone and is therefore more appropriate for emergency care where a patient needs to arrive quickly."

"In these new proposals services are being shoehorned into a site no longer fit for purpose (Glangwili)."

"Ability of Glangwili to absorb increased emergency provision will be very challenging on a background of an already surged bed capacity, space limitations, e.g. A&E and an aging estate"

3.340 There were some concerns about impacts on planned care services at Glangwili. A few respondents felt it might be more appropriate to undertake certain planned procedures at Glangwili rather than Prince Philip, due to the better intensive care provision. Others suggested more measures would need to be undertaken to ensure that planned care delivered in Prince Philip is suitably safe. There were also a few suggestions that Glangwili would be a more appropriate choice than Prince Philip to deliver acute stroke care.

"Some operations are better be done in Glangwili which potentially needing post-op ITU care. For urology that would be complex nephrectomy or significant co-morbidity. With downgrading of ITU in Prince Philip and lack of presence 24 hours in Prince Philip, such operations are risky.".

"If you plan to move planned surgery to Prince Philip then it requires at least a level 2 HDU providing care rather than putting in an ambulance when the patient is critically unwell."

"Glangwili is more central [within] the Health Board, allowing more [stroke] patients' families to visit and will align with more of the other emergency service such as A&E and critical care needed for stroke care. As the site is more central, it also means the distance patients will need to be moved from the other sites is also less."

3.341 It was occasionally suggested that the proposals do not go far enough and that a more radical approach, in which services were consolidated further, might be more likely to obtain the required outcomes. One respondent put forward a possible model in which there might be two acute sites (Bronglais and Glangwili) and two planned care sites (Prince Philip and Withybush).

"The proposals do not really go far enough. Centralisation is the key to modern health care provision. Trying to provide top quality services from 4 sites is clearly unrealistic. The only question that needs a decision long term is whether major hospital care can be provided from a single unit within Hywel Dda territory or should there be a central establishment in Swansea."

"I would welcome consideration of even further transformation with emphasis on one main hospital site where most acute and planned care is delivered supported by rapid transfer to other sites for rehabilitation and recovery. These sites could also continue to offer outpatient follow-up clinics. This would centralise acute medical staff and concentrate recovery away from beds needed for acute treatment and planned interventions. It would have most modern equipment and diagnostics and higher modern standard of care environment. "

"Close Withybush Accident and Emergency Department and replace it with an AMAU and Urgent Care Centre Model like that proposed for Prince Philip. This will allow a stronger emergency and acute medicine service at Glangwili while still meeting the needs of Pembrokeshire. For this reason the decision Board makes on service should consider a longer phasing so that Board can deal with the issues that services face now (critical care, emergency general surgery and stroke), while also being able to align itself for the future of 2 acute sites in Hywel Dda (Bronglais and Glangwili) and two planned care sites (Prince Philip and Withybush) until WG and the Board can come up with a plan for future estates."

3.342 Some other specific suggestions were as follows:

» Bronglais should be promoted as a rural health centre for mid-Wales, and should potentially be expanded or gain a satellite site (e.g. using the Coleg Ceredigion, local authority and Welsh

Government sites in Llanbadarn); alternatively, a new hospital should be built in the Bow Street area.

- » a new hospital should be built in south-West Wales e.g. in Whitland, St Clears, or Narberth.
- » services should be reduced at Glangwili (on the basis that the site is too small and buildings are old) and strengthened at the other three sites.
- » all main Hywel Dda hospitals should provide similar levels of care to one another, but with more specialisms centralised in Swansea.
- » shut down one or both of Glangwili/Prince Philip, and reallocate funds towards building a 'super hospital' in the Swansea area.
- » Bronglais, Withybush and Prince Philip should be 'community hospitals' and Glangwili should be the 'main hospital'.
- » a model whereby some specialisms are more centralised (e.g. all orthopaedic treatment at one hospital, all gastrointestinal services at another, stroke at another etc) but intensive and emergency care is retained at all sites, should be considered.

Regional working

3.343 Linked to comments about centralisation, there were also various suggestions that a more regional, or even all-Wales approach, might be more appropriate for planning and commissioning health services. Others wondered if existing health board boundaries should possibly be re-assessed, perhaps allowing the Llanelli area to join with Swansea Bay, or areas around Bronglais to either join with Betsi Cadwaladr or to form part of a new mid-Wales health authority.

"This review should not be about one health board or another. What do patients need? and where are they concentrated? What are the acceptable response times you need to guarantee meeting? Wales needs one health board, not seven."

"Could it be worth looking at the borders of the health board? It feels like we are trying to cover too big an area and forcing patients to travel across vast distances when in some cases SBUHB sites are closer."

"We need to look at the Wales wide map of health provision / hospitals to ensure services are offered across Wales, With the current emphasis on the geographical boundaries of Health boards, duplicate provision can be offered in hospitals which are relatively close geographically, whilst there are vast areas with no provision at all. Obviously, population density and needs can't be ignored, but there needs to be more of a balance here."

"Give Bronglais to Betsi HB. We have too many Betsi patients presenting to Bronglais that are then referred into our already saturated system…"

"It could be said that what needs to happen in reality is the creation of a new separate health board that is primarily for mid-Wales which would cover parts of Betsi Cadwaladr and Powys health boards with Bronglais as a general hospital for the whole area."

"Think that there should be only one health board for the whole of Wales, cutting out duplication and waste. Until this is done you are just tinkering around the edges, and the population of Wales will continue to suffer."

Community hospitals and other local services

3.344 Some respondents made suggestions around the role of community facilities in supporting the services provided at the four major hospitals. For example, it was queried whether local hospitals and urgent care

centres might play an enhanced role, perhaps in terms of providing more minor procedures or outpatient appointments, which might allow some patients to be seen closer to their homes.

3.345 It was also suggested that these might be used for rehabilitation facilities and residential care beds that might enable patients to recuperate closer to home, and reduce 'bed blocking' at the major sites. It was suggested that early intervention and a greater emphasis on prevention might help to relieve pressures on hospital services, and that a closer, more co-operative integrated system of care between hospitals, GP's, clinics, nurses, bed-providers, care homes, local authorities etc would be advantageous.

> *"Cottage hospitals and Urgent Care units like Cardigan should be the way forward. The lack of cottage hospitals for recuperation and convalescence in the communities is what's broken the system. Unblock the beds, get outside teams to administrate the burden of repatriating patients after treatment rather than nursing staff and managers on the wards."*
>
> *"Strengthen community diagnostics, outpatient clinics, mobile units and remote consultations so fewer patients need to travel to hospital at all."*
>
> *"Wherever possible services should be provided locally with GPs and practices doing more and increased use of nurse-led services. Providing mobile services and getting consultants to be delivering more services out in the community or at local centres needs consideration."*
>
> *"…Stronger community delivery - anything that can be delivered at home to be done so, e.g. IV antibiotics, by strengthening our Acute Response Teams (ART) and SDEC departments where bloods, radiology etc can be performed."*

3.346 Some other specific suggestions involving services in the community, or outside of the four main hospitals, were as follows:

- re-open the MIU at Llandovery Hospital to relieve pressure on emergency services at Glangwili and make better use of existing facilities.
- more integrated clinical centres or care hubs involving specialist nurses and GPs with special interest should be created.
- offer additional services from locations such as Aberaeron and Cardigan Integrated Care Centres, Amman Valley Hospital, Tenby Hospital, South Pembrokeshire Hospital, Cross Hands Health Centre etc (as well as potentially repurposing other underused sites e.g. schools and colleges, local authority buildings).
- GPs could provide weekend appointments and offer more basic procedures or accident care to relieve pressures on hospitals, and surgery staff could be better at helping to redirect patients (e.g. to Urgent Care where appropriate rather than A&E).
- nurse-led community hubs could offer advice and minor procedures e.g. ear syringing, nail clipping, wart removal, advice on skin growths; and fitness classes and yoga sessions to promote good general health and wellbeing etc.
- the use of private hospitals in the region to reduce waiting times, especially for cataract surgery and joint replacement, needs consideration.
- provide a convalescent unit or hospital where patients can be discharged from acute facilities to somewhere with physio, good catering, outdoor spaces and Occupational Therapy, leaving wards for unwell patients and allowing discharge of patients too unwell to go home but not requiring nursing.

The workforce

3.347 Some respondents suggested that, if the problems facing services are linked to workforce issues, then this would be an obvious area to focus improvements. Some specific ideas and suggestions included the following:

- offering more training posts, given that spaces are limited, and career progression for doctors is an issue, particularly in mid Wales (and, if trained, they could offer cross site cover wither digitally or in person).
- reinstating routes whereby nursing staff can progress and qualify through gaining experience and demonstrating competence, rather than by needing to obtain university qualifications.
- introducing pay incentives (positive and negative) to reduce staff absence.
- collaborating more with Aberystwyth University to attract staff (e.g. via the new nursing degrees, and reoffering Medicine as a course, to attract home-grown talent, including Welsh speakers) and by promoting Bronglais/Aberystwyth as a training and research hub.
- promoting a more positive vision for hospitals in general, as reducing or 'running down' services may be a source of frustration and negativity for staff, which could worsen morale and impact on recruitment and retention.
- dropping the 'Welsh preferred' on job advertisements to encourage more applications from outside of Wales.
- considering rural salary uplifts in specific instances where there are clear and longstanding issues with recruitment.
- negotiating with local authorities and housing providers to build accommodation to attract staff.

Other suggestions and mitigations

3.348 Various transport mitigations were also suggested e.g. providing better community, patient, volunteer or other third-party transport, shuttle buses; improved public transport; and ring-fencing more funding for transport, for both inter-hospital transfers and outpatients.

> *Can we improve community services to take people to Swansea? Not just a voluntary minibus that takes all day to get there and back and is totally inflexible. If you can't bring the medics to the people then the best option is to vastly improve the travel options available to people to get to and from the facilities. People shouldn't have to pay vast sums for these but running this service on volunteers is not good enough. Also, unwell people can't wait all day or go on lengthy indirect journeys to drop people off. This needs to be a properly funded travel service.*
>
> *…services must be brought together to achieve higher clinical standards and care; however the HB needs to look at ring-fencing more funding for transport. This needs to come both with additional funding for contracts with WASUT or other 3rd party transport delivery providers for the transfers of patients but also transport for patients with planned care appointments and friends and families visiting loved ones, whether this could be an inter acute hospital transport system or network….*

3.349 In addition, it was sometimes suggested that better use of AI, the internet and telemedicine would be essential and may mitigate some transport issues (i.e. if more consultations could be done remotely). A couple of respondents expressed disappointment that more details of this had not been provided within the consultation materials.

3.350 Respondents proposed other potential alternatives, suggestions and mitigations including the following:

- longer opening hours, with better availability of weekend and evening appointments, is generally a good approach, as is combining services so patients can 'get more' out of a single visit by having multiple investigations/examinations.
- more work could be done to reduce inefficiencies in the NHS, such as better prioritisation of incidents by the ambulance service; reducing instances of delays in discharge (e.g. where this is caused by delays with the hospital pharmacy providing medication); more use of digital communication rather than relying on post; reductions in management posts etc.
- it would be sensible to maintain 24/7 teams of experienced general clinicians at each site who can assess patients prior to their onward journey by ambulance or car, and this may allay some community fears around losing services.
- consider the use of mobile units, or of a rota system where staff rotate across different sites, or creation of a 'pool' of staff for various specialisations, who are available to locate quickly to whichever hospital needs them.
- introduce a ‘common sense’ or flexible approach to allocating appointments (e.g. not giving an early morning appointment to a patient living many miles away, having regard to public transport etc) and consider improvements to appointment booking systems (e.g. allowing patients to book, reschedule or cancel via an app; more reminders by email or SMS to prevent no-shows).
- introduce better pathways for transferred patients arriving at a new hospital, including safeguards to make sure information and notes do not go ‘missing’.
- specialist nurses running clinics alongside a prescribing pharmacist have been shown (elsewhere) to drastically reduce waiting times, with medications reviewed correctly.
- vulnerable people and people with disabilities often have input from different specialisms, which makes their care uncoordinated; they should have a single point-of-contact to help coordinate their care (e.g. scheduling appointments for same day) and to help them be seen more efficiently if they present at A&E (for example).
- providing overnight accommodation for visitors and relatives might help mitigate some issues with travel.
- it is particularly important to consider the impacts on relatives and carers who support those with dementia, learning difficulties or neurodiversity.
- Audiology and ENT services (said to be either absent, or not well supported at Bronglais) should have been considered as part of the proposals.
- Bronglais should provide hospice provision and provide more end-of-life care.
- Glangwili should be considered as a location for a ‘dementia village’.
- if an ICU is maintained at Withybush, could an option of elective major joint surgery be considered for this location?
- mental health emergencies should be directed to a dedicated service rather than via A&E.
- use of “Patient Knows Best” has been effective in some places.
- the NHS should consider charging those who miss appointments or who access NHS services but live abroad.
- better communications and engagement with the public generally would be beneficial, and there should be more emphasis on messaging that encourages people to live healthily.
- the CSP lacks an overarching vision that recognises the area’s rurality, is overly ‘workforce driven’ and should have included more detail of telemedicine and primary care.

» the proposals need to have regard for demographics and projected need in the future.

» the environmental impact of possible increased travel is not desirable but might be partially offset if some care can be provided more efficiently or remotely.

Organisational Responses

3.351 Nine organisations agreed with the roles of the hospital sites as described (four strongly agreeing and five tending to agree) and five organisations disagreed (one strongly disagreeing and four tending to disagree). One organisation neither agreed nor disagreed with the roles of the hospital sites as described (and one did not answer).

3.352 The **community councils** in **Lledrod** and **Nantcwnlle** expressed support for services being maintained at Bronglais. **Llangeitho Community Council** and **Dyfi U3A** expressed concern about the proposals for stroke services in particular.

3.353 **Llanfair Grange Care Home** expressed concern around how additional travelling might affect the elderly.

3.354 **Elidyr Communities Trust** expressed concern about services at Glangwili already being under strain, and felt that aspects of its management and infrastructure may need to be redefined if the hospital is to undertake more acute and emergency care.

3.355 The **Critical Care Psychology Service** tended to agree with the proposals but was uncertain that they would address staffing issues, feeling that equity of pay and investment in training and development would also need to be considered.

3.356 **West Wales Renal Service** suggested there may some elective procedures that would be more suited to being carried out in Glangwili than at Prince Philip and also referred to the importance of suitable ongoing care after the initial acute phase.

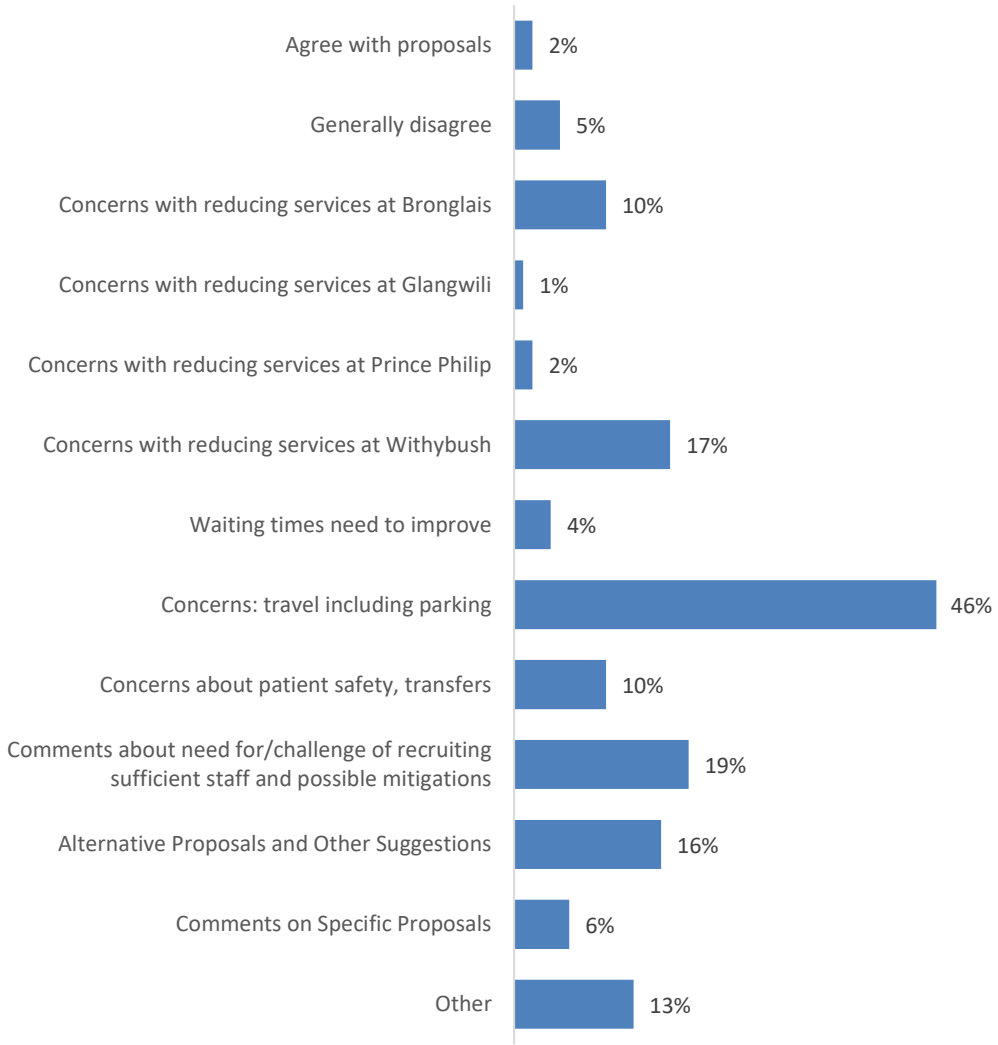
Additional considerations

3.357 Respondents were asked 'If you have any further comments about any of the options for services, please share them below. For example, things that you think we have not considered, comments about the hospitals, transport and access, environmental impacts and opportunities, local facilities to support patients, visitors, staff and the wider community' in an open text box. They were directed to continue on a separate sheet if necessary.

3.358 Just under two-thirds of individual respondents (63%) did not provide a response. 1,525 individual respondents did provide additional feedback, raising 2,303 points between them.

3.359 A summary of responses from those responding as individuals is provided in Figure 42. The percentages quoted are out of all respondents providing a comment. Because respondents could provide detailed feedback, some comments cover more than one point and, therefore, the total percentages sum to greater than 100%.

Figure 42: If you have any further comments about any of the options for services, please share them below. For example, things that you think we have not considered, comments about the hospitals, transport and access, environmental impacts and opportunities, local facilities to support patients, visitors, staff and the wider community (individual questionnaire respondents only) (Percentages are of those providing additional considerations)



Base: Individual respondents providing additional considerations (1,525), Points raised (2,303)

3.360 Of respondents who made a comment, 2% provided feedback that was generally supportive of the principle of consolidation of services, but did not include further detail.

> *"Better to have elevated levels of expertise in fewer locations than the dilution of expertise over all sites."*
>
> *"…I personally feel more assured of receiving a better quality service in the future precisely because of the refocussing of provision. I'd rather make a longer journey to receive treatment in a properly equipped and appropriately staffed location than have to wait longer for a more local, but possibly, inferior service"*

3.361 5% provided a comment in general disagreement with the changes being proposed, often in terms of travel and access impacts, but without including additional detail.

> *"All patients deserve the best service and as close to home as possible"*
>
> *"Good healthcare should be getting more, not less easily accessible. Most of these options require increased travel for staff, patients and families. This is not green or sustainable or kind. How will you ensure equality of care within the whole of Hywel Dda? There is huge reliance on availability of emergency transport. This is very concerning given the current challenges with emergency transport. How will you ensure this is seamless and cost effective? The financial implications of these proposals on families' needs to be calculated - including childcare, loss of income, transport and accommodation costs - during incredibly stressful events. Whilst 'efficiencies' are sought in Hywel Dda, the basics are being neglected. Departing colleagues are not being replaced, staff are increasingly overburdened, and patient care is deteriorating as a direct result."*
>
> *"I feel it is important to keep health care accessible to each county within the health board area, as it is a rural area the impact on patients having to travel must not be under-estimated."*

3.362 Almost half (46%) raised more detailed comments around travel and access, including concerns around public transport and hospital parking. A greater proportion of those living closest to Bronglais gave these comments (56%).

> *"…Although I am entitled to and have used the non-emergency ambulance transport, I have also had to cancel appointments at hospital as they have cancelled my transport as they have no coverage and also have had to refuse appointments as they were offered as a cancellation less than 48 hours before time - and you cannot book transport that close. I think something needs to be addressed to improve this situation and possibly expand coverage in some areas as I also know many other people who are in the same situation and often miss out on treatment and appointments they really do need as they simply cannot get there! ... "*

"More consideration for access to non-emergency and emergency patient transport to and from hospitals as well as consideration of how hospital visitors, especially for next of kin visitors can travel long distances to visit inpatients is needed. In Hywel Dda hospital services are stretched over a huge area, there is too much of an assumption that everyone has access to a car and/or public transport, when this is not always the case. These barriers are further heightened when patients are disabled, carers, and/or on low income. Public transport throughout the health board area is terrible, including between hospitals (especially when compared to services provided in Swansea Bay), public transport runs for limited hours and is not affordable or accessible to everyone. Taxis within the health board area are extortionately expensive and there is limited provision, especially out of 9-5 hours and travelling to and from areas outside of the main towns. Non-emergency patient transport is already not resourced enough to cover existing provision which is mostly for disabled passengers without access to a car and unable to use public transport. This service only travels to and from main hospitals rather than community services, is dependent on availability, has to be booked days in advance (rules patients needing it out of cancellations lists and urgent appointments usually). It is also only available Monday-Friday for appointments that start before 3pm. There is already a lack of awareness from clinics about what the service can cover so disabled patients are frequently having to battle to have appointments at times or in places that the patient transport is able to accommodate. This service would definitely need to be improved to meet the additional need when these changes are brought in…"

"Car parking at Glangwili for both patients, visitors and staff is very challenging. Despite very helpful staff the area is often congested with many vehicles queuing to enter the site. This will affect the running of the site as well as people (staff and visitors) unable to get to their appointments on time. Has the option of parking off site and coming into Glangwili by a regular bus service been considered for all (not just some staff)?..."

"Car parking seems poor at Withybush, Glangwili and Prince Philip - multi storey facilities should be built (check out what has been done at Plymouth hospital for reference)."

"Planned services should be made available at the site with the best access and parking facilities either currently or with space to make that a possibility. This would massively reduce stress for patients and carers. It would also release space at the acute sites for those in emergency situations. Because of geography, Bronglais has to maintain acute and planned care. Greater use of the Welsh Government and council buildings with their plentiful parking for outpatient services and some diagnostics could relieve pressure at the acute site. Centralising of some services to maintain adequate staffing is probably inevitable; asking someone who lives in Carmarthen to travel to Llanelli is more reasonable than asking someone who lives in Machynlleth to travel to Carmarthen instead of Aberystwyth."

"…it doesn't matter how good a service is if people can't reach it."

3.363 Just under a fifth (17%) raised concerns with reducing services at Withybush. A greater proportion of those living closest to Withybush gave these comments (35%).

"It is important that Withybush continues to provide as many planned and outpatient services locally as possible, particularly for residents of Pembrokeshire. Maintaining local access to care for orthopaedics, dermatology, urology, and other non-emergency services reduces travel time for patients and visitors, which is especially important for older or less mobile patients. For acute or critical cases, transfers to Glangwili or other specialised centres are understandable, but preserving a strong local service at Withybush ensures patient care remains accessible, supports the local community, and helps reduce pressure on transport and accommodation needs for patients and families. Enhancing staffing, facilities, and extended hours where possible would further improve safety and sustainability while keeping care close to home."

"All current health services at Withybush hospital should not be degraded at all, if anything they should be enhanced to look after, and care, for a population that is scattered over a wide rural area. Any removal of the health and care services at Withybush would have a massive impact on the population who live in this area."

"Parking at Bronglais and Glangwili is awful, which makes accessing services difficult. Withybush is central in an area with a high amount of tourist, and we need to keep our A&E and urgent care. If you stop changing all the hospital services, you will be more likely to be able to employ staff as they will feel more secure in their jobs…"

"Services at Withybush should not be reduced but enhanced - the alternative options suggested throughout this survey suggests that it is a foregone conclusion to reduce its role - we do not agree with this - investment needs to be made - one of the key challenges in our health board is not the number of beds but that we have not recruited sufficient staff"

3.364 One-in-ten (10%) raised concerns with reducing services at Bronglais. A greater proportion of those living closest to Bronglais gave these comments (34%).

"Services need to be patient centred, and patient focused, and we must deliver as close to the patients home as possible especially when considering the travel times from mid Wales to the sites in the south of Hywel Dda. Bronglais offers high standards of care, and we should be developing services."

"You need to look at the whole area that you are supposed to be serving and see each person equally. With this consultation you are concentrating on population density and the expediency of your staff and not on how to serve all of the people you are responsible for. I would suggest that you work alongside local authorities to push the government to look specifically at Bronglais and see the totally singular and unique situation. The only general hospital between Glangwili and Gwynedd Hospital. Considering cutting services at Bronglais equates to saying that the people of Ceredigion, South Meirionnydd and Powys are not equal to those of South Pembroke and Carmarthen. By moving services to Llanelli, you are putting them next to Morriston and Singleton and therefore offering many more services to people in the south of the catchment area whilst ensuring a deprivation of healthcare in the north of the catchment area. It would be good to know if you have discussed the broader picture with the Welsh Government."

3.365 Smaller proportions raised concerns with reducing services at Prince Philip (2%) and Glangwili (1%). However, a greater proportion living closest to these hospitals gave comments like these (11% and 6% respectively).

"Prince Philip should be utilised more as this hospital is in the area with the highest population."

"If it is necessary to have provision in only one centre, this should be in Glangwili for accessibility reasons. For those from North Ceredigion using public transport Glangwili is served by the TrawsCambria bus from Aberystwyth. But getting to Prince Philip can require four changes of bus with possible long waits in between, with the possibility that it will not be possible to travel all the way back the same day."

3.366 One-in-ten (10%) raised concerns about the provision of care, patient safety and wellbeing, including the transfer of patients.

"I believe that patients outside of Carmarthenshire, especially those within the Bronglais catchment area are being let down and are being restricted safe access to secondary care [hospital based care]. Travelling such distances takes its toll on the best of days, let alone when you are sick. I believe that each county should have safe access to as many secondary care services as possible, even if that means providing a limited service for USC diagnostics and treatment with consultant cover whilst the routine services are provided in another location. Also, transferring sicker patients with greater needs to dedicated hospitals would increase the pressures on the already emaciated ambulance service. There are not enough provisions to cover current transfers of care, without considering this extra workload. I think that the integrated care centres need to be greater utilised for outpatient clinics, to provide more space within the hospitals for more diagnostic and treatment suites."

"The treat and transfer options are not fit for purpose. it will add more pressure on WASUT to transfer patients to different sites which is an additional pressure they do not need as they are already struggling to treat in the community. If a stroke patient self presents to Bronglais ED and is treated with blood thinners then that has the potential to use a Majors/Resus or ITU bed for monitoring if the stroke beds are removed adding more pressure on to them."

"The majority of staff that I have spoken to are extremely concerned and disheartened by the removal of services from sites other than Glangwili and the reduction in available inpatient beds in general this is a highly concerning trait. It has been made clear that the new hospital will certainly not come in the next 15 years and even then, is highly unlikely. The relocation of services to the Glangwili site which is landlocked and in extremely poor condition in my opinion is a mistake. Communication links and critical infrastructure limit the use of that site and the diversification of services throughout the health board's estate allow for robust resilience within the estate if you put all your eggs into one basket and something happens to that basket then you have an extremely serious situation."

"…Improve communication when discharging or transferring patients…"

3.367 There was some reference to the impact that proposals might have on other health services.

"Any reduction in physical health services will have a detrimental impact on mental health services for both acute and chronic patients, without a designated mental health acute ward in Ceredigion, the reduction of additional services that many mental health patients with comorbidities would need to access, would need to be reviewed under discrimination legislation / human rights act."

"…There are also huge issues with emergency ambulance provision throughout Hywel Dda. This includes long waits, lack of availability, ambulances being stuck at hospitals waiting to handover patients. These changes could also increase pressure on those services and this definitely needs to be improved."

"The options and choices could have huge implications for services not covered in the CSP, e.g. A&E, primary care, SDEC. When considering options, the impact of the decisions on such services should be considered."

"Without a ITU you cannot have a A&E which as a knock-on effect for services."

3.368 Just under one fifth (19%) commented on the need to recruit sufficient staff. Some recognised the potential challenges with this, and others offered possible mitigations.

"…There are serious staffing issues which need addressing which must be negatively impacting on service delivery and patient outcomes. Consider upskilling GPs, nurses to deliver more of these services like taking biopsies, removing skin lesions and ANPs running nurse led services and performing more endoscopies…"

"…Make each hospital a training hospital where each doctor has to do a stint so that specialisms are kept."

"Do not employ Agency Staff across the whole Health Board. This method is a complete drain on the NHS. Employ the staff. This will enable more effective rotas and will allow the extortionate Agency wages to be utilised to improve and strengthen our NHS to be the amazing Service it should be and was founded to be!..."

"The UK have very good training programmes for doctors etc., but they seem to get the training then move abroad. The NHS should train these people for free and then sign a contract to commit to staying for at least 10 years. If they then want to leave after the training then they have to pay for their tuition, that way we can retain our health professionals! And yet again adding Welsh Preferred or learning Welsh really puts people off if they see this when applying…"

"Lack of consideration to community services in all areas to support hospital flow. Lack of consideration of essential timeframes for stroke patients for those Hywel Dda residents living on the health board borders and more rurally. Lack of focus and reassurance the moves will only be made with additional staffing. SSNAP targets for therapies will not improve without investment. I do not feel reassured robust plans are in place to ensure these staffing requirements are upheld by the CSP team. The focus is purely medical/nursing."

"Appreciate it is difficult to recruit staff on all sites and offer all service on all sites. I have joined the organisation having lived elsewhere and it appears that limited short and medium planning during this process is impacting on staff morale and retention, which further perpetuates the staff shortage. During the period of internal and external consultation, teams have been attempting to continue to address shortfalls in services, with no investment, which impacts on the patient experience and staff retention/morale…"

"Currently Paeds consultants from across the world come to Glangwili to sit practical exams. This acts as a draw for trainee consultants who want to work in the hospital that will then be administering the tests. Can this be done for other services?"

"…Nurse practitioners and clinical practitioners are not being utilised enough to deliver care on sites where staffing problems are preventing care provision."

"More doctors in hospitals like Withybush could be achieved by waiving university fees in return for working 5 years in placements where more staff are difficult to recruit."

3.369 6% commented further on a specific service proposal. A greater proportion of those living closest to Bronglais gave these comments (10%), and many related to changes in the provision of stroke services.

"…Ceredigion has an aging population with probably higher health needs than areas further east where employment opportunities are greater so outpatient services in community hospitals do improve access for patients. However again location is key. For example Cardigan integrated health centre provides excellent outpatient services but people complain about the poor public transport from the town and the expense of taxis to get there. The extending of the minor injuries' unit there to 7 days a week following a successful pilot programme earlier this year which I am told is now under consideration would be a very welcome addition to the provision of healthcare in the area. Additionally I understand from reading the report on the pilot scheme that if 75% of the people who attended would otherwise have had to attend Glangwili A& E thereby reducing considerable pressure on that unit. Plus it enabled 60 patients to receive hospital at home care which must again have resulted in considerable benefits to the health board and inpatient hospital bed status…"

"Prince Philip currently does not have staff or capacity to absorb all elective urology theatre cases. We have highly motivated and skilled staff in Glangwili which love to have elective urology cases back and it would be a shame to lose their skills. We just need to look at what happened since covid which made us less efficient. Ring fence limited number of beds would be helpful to improve productivity."

"1. Why is there no option to develop the already excellent service being provided for stroke patients in Bronglais and have patients from other hospitals access Bronglais? 2. No mention of the travel difficulties for families if the stroke unit is moved from Bronglais to Prince Philip or Withybush. Without personal transport i.e. a car it is a lottery. 3. What happened to the golden hour? the importance of immediate treatment for a stroke? There is no guarantee you can get from Bronglais to the proposed hospitals in the recommended time."

"Centralising the stroke service to Prince Philip will significantly impact negatively the experience of stroke patients across the Hywel Dda health board. If Prince Philip is chosen as one site for the whole health board the experience of patients and staff within the health board will mean that there will be staff loses to the health board. The current stroke staff working in Bronglais cannot move to Prince Philip, they live in the Bronglais area they are staff who love working within stroke and their roles will be significantly changed. Why choose a site that is as far east as you can get within the Health board that is right next to the highly specialist centre in Swansea. Select a site that is central and equipped for the needs of stroke."

"It has for many years been a problem of removing services from Bronglais to other areas namely Glangwili who are already under tremendous pressure from the services already provided. To add more to an already overwhelmed site increases pressure from many areas, parking, visiting, waiting times, staffing, meals, travelling, recovery and attending future appointments. If a patient lives in Machynlleth this puts an extra 1-2 hours travelling time on their journey, not nice for someone who is feeling unwell having to travel which is seen on a daily basis for radiotherapy and cancer services. When will the needs of our service users be considered? Savings can be made in many other areas as the extortionate waste within our sites is out of control and seriously needs to be addressed."

"A suggestion would be to bring back in patient elective orthopaedic surgery to Withybush. The cost of transporting medical notes, hospital transport for patients. The environmental impact of this is huge."

"Same Day Joint Surgery provision in day surgery units"

"Please increase the number of doctors, especially clinical fellows who can be trained and retained in the Prince Philip dermatology department. At the same time, reduce reliance on physician assistants and nurses, as they have not undergone structured medical training and are unable to manage complex cases."

"Very uncomfortable not having an ITU in Prince Philip for these critically unwell patients and also post operative patients."

"Where do you plan to put the Nuclear Medicine department? Will you have more than 1 gamma camera, or centralise in 1 hospital? (currently based only in Withybush)."

3.370 There was some reference to service areas not included in the consultation...

"… It is quite interesting that the consultation has not included A&E, General Medicine and Anaesthetics. They too have staffing problems. Not only are those specialties intimately linked to each other, but they also have overlap with general surgery, stroke, orthopaedics and radiology (in addition to others in the consultation). Unfortunately, without their inclusion, the options included in this consultation, are inadequately considering the big picture. It is also odd that trauma was excluded, whilst orthopaedics was included…"

"I understand that psychological and psychiatric services were not in this discussion paper; however, I would be keen to see the strategy/ consultation for these services."

"Please note that devolved healthcare means that Wales does not and cannot benefit from the main thrust of health and social care research. All of DHSC and NIHR's funds are ring-fenced to England, with none of these budgets able to be spent in Wales. This is a big problem: Wales cannot benefit from these large pots of funding and it may affect the willingness of clinicians to work here. Most importantly, it means that Welsh patients miss out again and again. I point this out as someone working remotely for a NIHR Policy Research Unit. In a previous project we did a lot of work in Wales, now we can do precisely none. These large-scale issues need looking at and taking in hand for real change to be made."

3.371 4% recognised that waiting times need to improve, and that proposals may help improve this.

"My only complaint is the waiting list, not hospitals or treatment."

"Some journeys may be longer, but it would result in being seen at an earlier time and, hopefully, reduction in waiting lists."

3.372 Other points raised for consideration included the needs of visitors.

"…There should be more consideration of where patient visitors can wait if the patient they are supporting is high risk and their visitor lives some distance away as this may cause them extra concern about leaving the patient in case they deteriorate, and the visitor cannot get back to them in time…"

"…Consider more robust hospital communication officers on wards to assist with electronic communications with family and friends unable to visit."

3.373 16% provided an alternative proposal or suggested things that should be considered if the proposals do go ahead. A greater proportion of those living closest to Glangwili gave these comments (27%).

"It is already difficult to find rooms in healthcare settings to run clinics, and transport is very difficult for many patients who are unable to drive. Moving services outside of general hospital services to nearer the patients home is ideal in theory however there is often no funding for booking rooms in the community and providing storage and equipment that would improve services, and the extra costs of staff travel also need to be figured into the models."

"We desperately need more infrastructure to deliver these services whether that is temporary buildings like portacabins or more permanent buildings. Fighting over space to deliver outpatient services is causing poor patient experience and frustration for staff please could this be looked at."

"Concerns around the estate/infrastructure at Glangwili due to its age."

"Rehabilitation is at a breaking point already in Glangwili. Increasing complexity and acuity of patients increases the complexity and acuity of their rehabilitation needs. Patients are ALREADY not receiving the rehabilitation they need. Without adequate qualified AHPs, patient flow will grind to a halt, and patients will not get better. Any changes should be considered with the relevant uplift in ACUTE rehabilitation services."

3.374 These included mitigations around increased travel and improved transportation options.

"…these changes need to be supported with dedicated transport options so that everyone has fair access to the revised service provision. Innovative options should be considered such as vouchers for taxis, shuttle bus between hospitals sites, dial a bus or a ride share scheme where patients can choose to offer or request a lift."

"…If possible, these changes need to be made in conjunction with the council so bus and train services can be improved to help cater for their needs…"

"Park and ride schemes should be considered for hospitals such as Bronglais and Glangwili. Said information could be given alongside appointments."

"…Better cooperation between departments if a patient requires more than one specialist to arrange appointments and tests on the same day. Something on the system to show when appointments are being booked that they are under several departments to see if things can be arranged in a more streamlined and efficient way. For example, if several blood test are needed for different consultants that they are all done at one appointment, the same with scans and x-rays."

"It would help if Hywel Dda had its own bus service. It would allay a lot of anxiety."

3.375 With some suggesting residents be offered the choice to travel further or remain local.

"If it is possible, I think it could be an idea to send out a link to all patients within Hywel Dda or campaign with a QR code or something to ask the community 'would you be willing to travel further than your local hospital or even out of area if your wait time could be reduced.' I appreciate there are pressures on all health boards but perhaps if some patients could be transferred out of area or use our private sector services more, there could be a significant improvement in wait times. As a young couple with lots of medical concerns of late, we would be willing to travel anywhere for the right medical treatment, specialists and support."

"Offer patients the ability to choose hospitals in other health boards across Wales."

3.376 There were suggestions to make better use of technology to reduce the need for additional travel.

"…I believe that there are opportunities to save resources and time through conducting pre-appointments over the phone or the web in some circumstances…"

"Frequent transfers across multiple sites is not good for the environment. Have Telehealth facilities been identified?"

"I think that the options being offered are shaped by the resourcing challenges currently being faced, all will result in poorer access to services for the local population. I believe that there is an opportunity to be innovative, look at models of change and better practice being used in health systems elsewhere and adopt those ideas. There must be opportunities to invest in multidisciplinary team members, premises and technology to take pressure of the hospitals but still maintain access to services locally. Investing in evidence-based healthcare locally that reduces the need for hospital interventions downstream could potentially support your options for consolidating hospital services, but I have no sight of that investment in primary care in these documents. A system wide approach needs to be presented showing where the investment will be rather than being asked to select the best 'poorer' option within the hospital services silo."

"I appreciate the cost implications but really think that community hospitals and also use of technology is the way forward. Having to travel one and a half hours for a 5-minute outpatient appointment is ridiculous. (Haverfordwest to Llanelli). This adds to more congestion on the roads and also more stress. Add to that trying to find a parking place when you get there. We need easier access to health care not more difficulties."

"Imaginative approaches to covering a wide rural area utilising a workforce that might not reside in it should be explored... mobile units, technician and allied professions working to a clinical lead via telemedicine link. Such a system has run for many years in India (Aravind Eye Centre) and could be made to work for eye care in West Wales out of Swansea as a base."

"…Proposal: state of the art consultation rooms linked to an actual outpatient clinic with nurses able to facilitate examination, arrange tests etc. Rooms set up in community hospitals/GP centres. Patients seen virtually, but with a trained nurse present."

3.377 Some recognised the importance of considering those unable to access services/information online.

"... Please could paper maps/instructions be sent to patients along with their appointment letters - not everyone knows how to "go online" and some maps provided are so old they are barely legible. Please could hospitals have a member of staff at the reception desk who can accompany a patient to the clinic waiting area if they so wish - so many elderly patients find it extremely daunting on entering a hospital and can't follow the enormity of signs/colours/arrows for their clinic destination and end up being late for appointments. Also, more wheelchairs need to be kept at main hospital entrance. Also, please could a parking attendant be on site at all hospital carparks to aid patients with parking."

3.378 There were suggestions on how to maximise use of available resources.

"…Operating theatres should be in operation 7 days a week and using the resources of private hospitals in the area should be considered to reduce the waiting lists…"

"…Also more focus on prevention to reduce the demand for services and on screening to pick up issues early thus improving patient outcomes…"

"Have you considered Merging Hywel Dda with Swansea health board for economies of scale?..."

"HD HB needs to consolidate its specialist services and where possible reduce the number of sites it provides care on. Ideally there should be a single hub for surgery & ITU with outreach service to Bronglais. Specialist care in Prince Philip seems too close to Morriston if that same care is also provided there."

3.379 Others suggested improvements be considered to other health and care services, including new hospitals.

"…Improving wellbeing requires supporting public health services and primary care prevention services. This would be an excellent investment."

"If you're not investing in a new acute hospital and transforming other hospitals into step down / rehabilitation hospitals then the least the HB should ask for or invest in is a major (!!!) advanced Diagnostic Centre for scheduled care including urology, cancer, ophthalmology, bowel, respiratory and neuro screenings and minor procedures as endoscopies etc. …"

"…Handover times at A&E departments need urgent improvement. A huge contributory factor to this is an appalling lack of social care provision within Hywel Dda, patients having to remain in hospital when they could be discharged or patients deteriorating in the community because of a lack of suitable care provision which then frequently results in falls, deterioration in health or other emergencies. All of these then lead to avoidable A&E and specialist service engagement. The health services and social care services throughout the health board area need to be urgently improved and their needs to be a consistent, acceptable level of care provision throughout the health board. Again, if there are issues attracting good social care professionals to work within the board, more consideration needs to be given to the employment package on offer to attract and retain good quality staff and improve patient outcomes…."

"…more focus on prevention to reduce the demand for services and on screening to pick up issues early thus improving patient outcomes…"

"With a large student population in Bronglais there should be a walk in minor injuries and GP service on the weekend, this could be run from North Road clinic with dental services available."

"Convalescent hospitals are the answer."

"Significant investment in community services would reduce the acute costs…"

"The population is getting older and the numbers of people with mental health issues is increasing. ED provisions should be made for this with mental health, drug and alcohol liaison nurses at all ED, UTC and MIU departments to offer support for these patients. This service should be widely promoted and offered."

"Current health boards do not work. Three, - one for North Wales, following the A55 corridor, one for South Wales, following the M4 corridor and one for Mid Wales with a new, fully operative general hospital in Aberystwyth would serve the community's needs far better."

"…Wales has a very long border with England; it would be far more efficient and effective for NHS England and Wales to operate as one body. I can travel from Machynlleth to Shrewsbury (by car or by train) more quickly than I can drive to Glangwili…"

"…We no longer have day centres where patients could go and give their carers a break and the client could get some physio, occupational therapy input etc. Frailty team could be involved."

"…Just build a new CENTRAL hospital, up to date IT systems, electronic notes, car parking, encourage staff to work there, make it pleasurable for staff and patients and loved ones. This is all going to cost so much to change, just bite the bullet and build!..."

"In order to reduce bed blocking at hospitals, could consideration be given to providing the 'Nightingale' Hospitals that were set up during the Covid pandemic."

"…Social care needs to be included in the planning. There needs to be an increased funding in this field and effective joint working."

3.380 Some other points for consideration and suggestions included:

- » reviewing and reducing the management structure enabling more funding for the direct provision of care.
- » considering the environmental impacts of increased travel.
- » retaining and extending provision at local community facilities such as Llandovery Hospital, Amman Valley Hospital and Aberaeron.
- » mentions of utilising available space in Aberystwyth.
- » criticisms of this consultation, and questions about what is happening following the previous consultation and decision to build a new major hospital, central to Hywel Dda.
- » calls to bring back midwifery and paediatric wards to Withybush.
- » calls to reinstate ITU in Prince Philip level 1-3.
- » mentions of keeping or reinstating A&E at all or specific hospital sites.
- » mentions of NHS dentistry.
- » suggestions that mid Wales is one of the least densely populated parts of UK, and so service provision may be better considered on a wider regional/national basis, rather than only within the health board.

Organisational Responses

3.381 Of the sixteen organisations that responded to the questionnaire, eight did not provide a response to this question. Out of the eight organisations that did provide additional comments, six raised concerns around travel, including parking.

"Access from Llanelli to Glangwili by bus currently means 2 if not 3 different buses to get to the site. You have an aging population, many who have given up driving any distance. Information about hospital transport is not easily accessible. Park and Ride would possibly ease some parking issues at Glangwili if it was re-introduced. Not everyone has family or friends who can take them to appointments." [Hearts and Crafts (craft group)]

"Inter hospital transport for appointments and visiting is key and this is an area that still MUST be addressed." [SOSPPAN (Save Our Services Prince Philip Action Network)]

"Please respect our views, the views of our elderly patients who are living longer, please try and fix the delays in ambulance arrivals, this is what needs fixing, you need to keep and value our community hospitals, as what matters most to elderly patients is for them to remain local to their homes, as elderly wives, husbands can visit easily to help emotionally and practically, we need to unite, and stand together for a better future" [Llanfair Grange care home]

"You need to look again at your plans in terms of centralising treatments and give full consideration to the impact of travel on patients and families and the wider community, considering the cost and the damage to the environment. It is necessary to consider the Geography of the area and the distances and time required for patients to travel further for treatments." [Lledrod Community Council]

"We sympathise with the problems of the health board, but we feel that the geography of mid Wales is unique and that must be central to everything" [Nantcwnlle Community Council]]

3.382 One organisation commented on staff recruitment.

> *"Use the staff from less significant community hospitals, ones that are just used for bed blocking to staff the bigger hospitals and improve them. Our local hospital in Llandovery has reduced and reduced and reduced its services, it's a bit pointless now to keep it open." [unknown]*

3.383 Two organisations provided a more detailed response in relation to specific service proposals.

> *"Where patients are expected to travel, better parking and waiting facilities should be made available. Especially for services such as critical care and stroke, where family and patient distress is likely to be high. Not one of the options would provide a resolution for the ongoing difficulties in providing seamless care. In relation to critical care, whilst patients will be repatriated to local hospitals following management of the acute event, the rehabilitation needs of these patients required specialist input, which is currently lacking and neither of the options would enable for therapeutic staffing to improve unless there is significant investment in the development of these specialist services." [Critical Care Clinical Psychology service]*
>
> *"If you are doing it to improve services, the stroke downgrading at Bronglais is not at all necessary, it is a wonderful unit, where stroke patients are cared for and treated in unit until they are back to near or full accepted recovery. Your new proposal to just send patients to be assessed at Bronglais, then sent over 100 miles in an ambulance on bendy roads to another hospital, the potential of waiting outside that hospital in an ambulance to be admitted, patients are going to die on this long journey or receive permanent disabilities from non-emergency care & treatment. This proposal for people living in the Machynlleth area is totally unacceptable" [Dyfi U3A]*

Considering equalities and human rights

3.384 Respondents were asked 'Are there particular groups of people that you believe might be positively or negatively affected by any of the options being considered? If so, what groups are these and how might any positive impacts be improved or any negative impacts reduced or mitigated against?' in an open text box.

3.385 Just over two-thirds of individual respondents (67%) did not provide a response.

3.386 Three-in ten individual respondents (30%) identified a group they believed might be positively or negatively affected by the proposed changes and just under a fifth (19%) mentioned the impact they felt these groups might experience, with some noting suggestions of how to mitigate these.

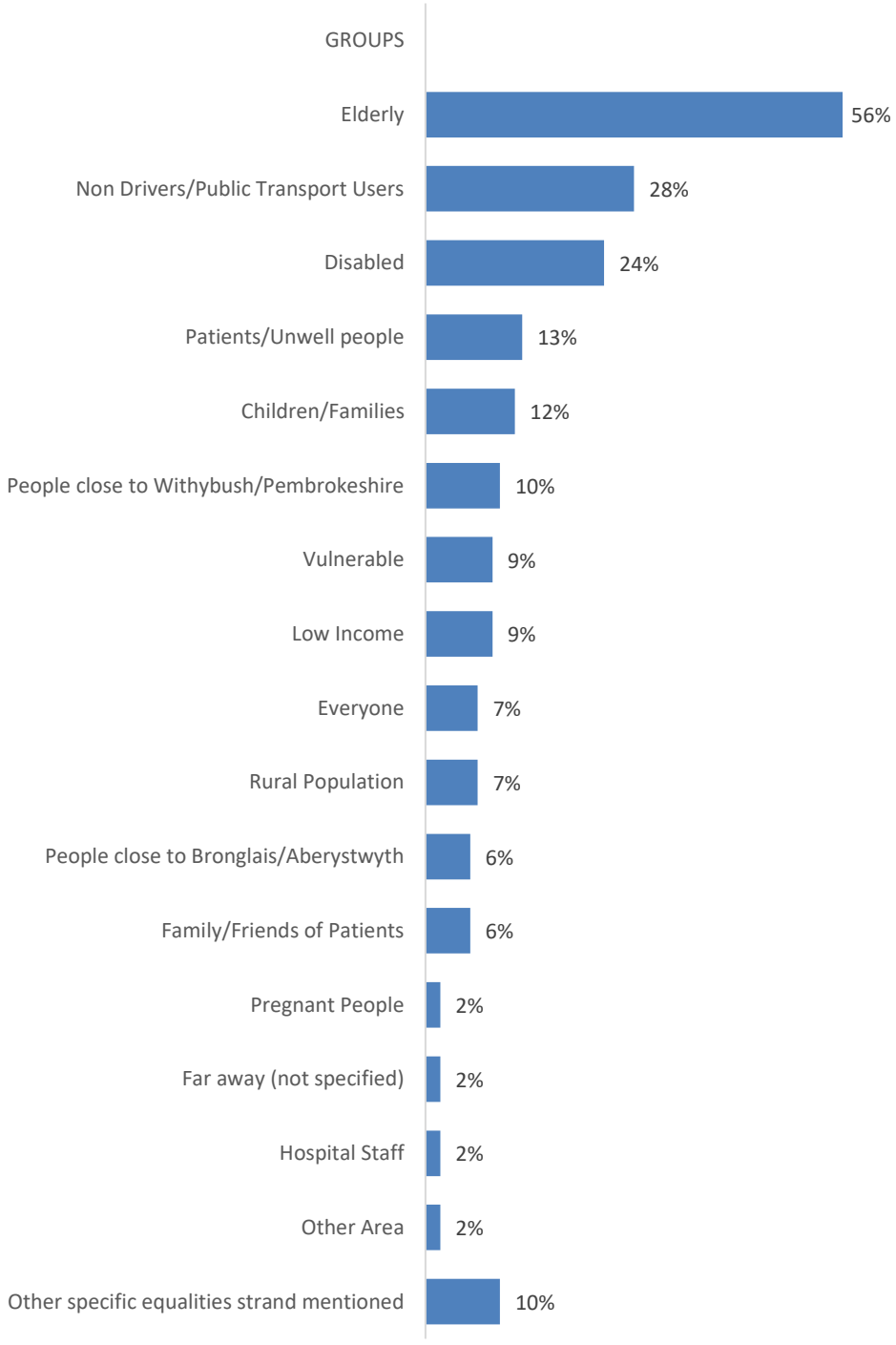
3.387 Some respondents gave comments that were more generic to the consultation itself including 7% of individual respondents raising other considerations. These mainly centred around travel, including public transport, car parking and specific requirements surrounding travel for some individuals; but there were also mentions of an increasing population and demand, the age profile of the area, too much and conversely not enough provision through the medium of Welsh, methods of communication and engagement and general comments around funding and managing the NHS.

3.388 1% gave other comments such as mentions of the need for a new hospital, criticism of the consultation, criticism of the specific equalities question being asked, alongside some general statements that everyone should be treated equally. There were also some mentions surrounding availability of single sex spaces.

3.389 A summary of responses from those responding as individuals is provided overleaf with charts detailing groups who they believed might be positively or negatively affected by the proposed changes (Figure 43) and the impacts mentioned (Figure 44).

3.390 The percentages quoted are out of all respondents providing a comment. Because respondents could provide detailed feedback, some comments cover more than one point and, therefore, the total percentages sum to greater than 100%.

Figure 43: Groups of people suggested by respondents that might be positively or negatively affected in response to this question (individual questionnaire respondents only) (Percentages are of those providing a group)



Base: Individual respondents providing a group (1,243), Groups mentioned (2,565)

Groups

3.391 1,243 individual respondents mentioned a group who they believed might be positively or negatively affected by the proposed changes, noting 2,565 groups in total between them.

3.392 Of respondents naming a group, over half (56%) suggested that the elderly would be affected by the proposed changes and just under a quarter (24%) suggested that those who were disabled would be affected. Some individuals commented on both these groups.

"Elderly people have less access to own transport as do people living with disability. These changes would disproportionately impact negatively on both these groups in rural mid Wales"

"Older and disabled people are being overlooked in these service changes. Travelling long distances and a lack of a good transport network means that attending an appointment is not an option if it is not offered locally. I know of people who have not be able to get to their appointments because hospital transport has cancelled at the last minute or has been unavailable. I know older people who will not consider travelling long distances and rather not start or complete their treatment."

"Your stroke options for Bronglais will particularly disadvantage the elderly, the disabled and families in your 'treat and transfer' option. Transport is a big issue."

"…The older generation may not like travelling too far due to effects on conditions such as those that affect mobility which may aggregate conditions."

"...Disabled people having difficulty with access - either getting to site for treatment or getting in if buildings aren't accessible…"

"People with disabilities can often take a long time to get ready to leave the house as they have extra needs. If you are then asking them to travel two hours for an appointment you have to consider allowing more clinics to be carried out later in the day…"

"Disabled people who rely solely on the ambulance service in order to be transported to and from hospital."

"Patients with disabilities often find travelling more difficult so consideration should be given to finding a balance between maintaining safe, effective and efficient care and the distance needed to access that care."

"I believe that moving services from Bronglais hospital will have a disproportionately negative impact on older and disabled people particularly those who do not drive and may already be struggling dealing with isolation. Even for those who are in employment will find it difficult to travel to Prince Philip or Withybush hospitals after a day at work, possibly needing to balance childcare as well. Recovery from stroke can be a lengthy process, and expecting people to travel 65 miles (130 miles roundtrip) to visit loved ones over a period of weeks or months is not a realistic or sustainable suggestion."

"Older people and disabled people without cars who live in the north will be negatively affected by any withdrawal of services from Bronglais. Glangwili is the only other hospital which can realistically be reached by bus for day appointments, and some planned care would be moved to other hospitals which are even less accessible."

3.393 Of those naming a group, almost three-in-ten (28%) suggested that non-drivers and users of public transport would be affected by the proposed changes.

"…Any without their own transport to get to distant services are, and will continue to be, disadvantaged - unless services are improved."

"The elderly, disabled and those reliant on public transport will be disadvantaged together with inpatients moved further from home who would benefit from regular visitors but have been moved further away from their support network. Even those with their own private means of transport will be disadvantaged if they have to travel greater distances, particularly in the summer months when congestion is greatest, given the limited number of routes where congestion, accidents and delays are not uncommon and finding parking spaces at your sites is, at best, difficult and often frustrating, time consuming and impossible."

"…People relying on public transport will struggle to make appointments. I drive but had an appointment in Llanelli where I wasn't allowed to drive after. I had to pay to stay in a hotel as didn't have means to a lift."

"Elderly, people with little family members to assist with arrangements or transport. People no longer confident in driving for 3-4 hrs in one day."

"Travel costs for those who cannot afford it - either to attend appointments or to visit patients. Those who need to attend sites out of hours relying on public transport - there is no public transport between 7pm - 7am in Pembrokeshire."

"The real impact of further travel time would seem to relate to the quality of patient transport services however residents with disabilities and those from more deprived communities without access to their own transport might struggle to visit and support friends and relatives if local services are removed."

3.394 Of those naming a group, 13% suggested those who were patients or otherwise unwell would be affected.

"Travel to hospitals is very difficult, removing local services impacts those with no cars, and who are disabled or experiencing chronic ill health, negatively. Please get the GPs back on track and this will remove a big pressure on A& E and also on leaving our ill health until it is too bad…"

"Children, elderly, disabled and in general poor health would all be NEGATIVELY Affected."

"Many of the options require patients to travel further for appointments/general care which will affect the aged/disabled and those with immediate/acute presentations."

"Further distances travelled to get to appointments massively disadvantages the disabled and those with physical, visual or auditory impairments even if temporary due to illness as public transport is not fit for purpose especially for those with disabilities."

3.395 Of those naming a group, 9% suggested those who were generally vulnerable in other ways such as being disadvantaged or living with dementia, or in addition to other factors such as neurodiversity, would be affected.

"I feel those people living with dementia will be negatively impacted. These changes will make is more difficult for family to visit them. Isolation can make their dementia worse, increase the risk of delirium and depression. Improving the services is essential but it does come with a price for our older adult population."]

"It will hugely affect the vulnerable, the mental health of a patient who cannot go far from home, the elderly person who cares for their partner or son/daughter with learning difficulties. The impact is huge on social care for their loved ones they care for if they are miles away from home to have a procedure. They prob would not attend and then a crisis occurs with care for their loved one and emergency care for them. It's a huge knock-on effect we are not equipped to deal with in the community as no provisions and poor social care and poor transport will hugely affect the vulnerable."

"People with disabilities including those with neurodiverse conditions may not be able to deal with the changes of sites in their care and those with physical difficulties may be unable to make their own way to the changed sites."

"Many vulnerable groups of people cannot drive, the elderly, people with autism and sensory issues can often not drive, people with learning difficulties, migrant minorities often women cannot drive or travel long distance is on their own. These are all people vulnerable to services being taken away from local areas. If services are kept local, they would be better protected."

3.396 Of those naming a group, 12% mentioned those with children and families, with 2% specifically mentioning those who were pregnant. A greater proportion of those living closest to Withybush gave these comments (16% and 4% respectively).

"…Difficult travelling if you have a baby, especially if you don't have your own transport."

"Anyone with any age, disability, pregnancy or illness/injury should not be required to travel so far to appointments or to visit loved ones in hospital. It compounds what is often an already stressful situation."

"Increased travel requirements from services e.g. being reduced at Bronglais will negatively affect those with protected characteristics, not only increasing their health risks, including the elderly (harder to use public transport/drive further/impact on health/tiredness), young (missing more school, away from family and friends who find it harder to visit and e.g. harder to continue working and support them If increased travel required and increased safeguarding risks), disabled (harder to find public transport for longer journeys, those with physical needs - not easy for bathroom breaks if longer journeys), lots of public transport don't do night services so affect family and patient well-being, those with other caring responsibilities not being able to look after the patient and e.g. other children."

"The proposals place additional huge financial and emotional burden on families. High risk of lower income families not seeking timely care as they will not be able to afford the time or cost of travel (consider cost implications of childcare, travel time and expense, loss of income, accommodation, food etc.)."

"The elderly and very young will be most affected and those on low incomes. Further distances will put a strain on these cohorts and widen the burden to extended family members or transport services providers within the NHS."

3.397 Smaller proportions suggested that people from particular areas or living near to particular hospitals would be affected. Of those naming groups, 10% commented on those who lived closest to Withybush/Pembrokeshire and 6% on those who lived closest to Bronglais/Aberystwyth, with a greater proportion of those living closest to these hospitals making these comments. Of those naming groups, 7% mentioning those living in rural areas and 2% mentioning those living far away from the hospital sites more generally. A greater proportion of those living closest to Bronglais were more likely to mention rural areas.

"If you cut stroke services to Bronglais - this will impact Equalities and Human Rights..."

"I believe that these considerations will impact on children and adults with disabilities. It is unfair to move them far from home for treatment when the services are currently available in their local hospitals."

"Elderly population will be massively negatively impacted. Hospital transport is unreliable. In my job role, I speak to unpaid carers (husbands and wives), and lots of them have no relatives here and do not drive and often have problems attending appointments when they are outside of Pembrokeshire. This is going to be detrimental to a lot of these people. People retire here, moving away from family and friends and they have no support. Information on hospital transport is not always readily available to them, and is not always reliable. Not only that, the journey to places as far as Prince Philip are long (especially there and back in one day), particularly for the older generation who might struggle with sitting for long periods of time, or needing to use the toilet more frequently etc. In addition, if we consider patients who might have Dementia and do not cope with being confined and still for long periods of time."

"Removing services from Withybush discriminates against the old and disabled."

"Travelling between sites may be more difficult for the elderly and disabled, but can be difficult for everyone in an essentially rural area that has poor public transport to offer."

"Children, disabled and older people would be particularly negatively affected by any reduction of services at Bronglais. Don't forget people are already coming from Llanidloes and beyond to Bronglais, with their alternative services often being In England. So an impact on Welsh speakers too. Bronglais is great, please, please keep it that way."

3.398 2% suggested those living in areas neighbouring Hywel Dda Health Board such as Powys and Gwynedd would be affected; a greater proportion of those living closest to Bronglais (5%) gave comments such as these.

"Aged population of Powys."

"All people in certain areas of Montgomeryshire, Radnorshire and South Gwynedd would be massively affected by the downgrading of any services at Bronglais."

"The people of Mid Wales near the English and Shropshire borders…"

3.399 9% thought that people on low incomes would be affected. A greater proportion of those living closest to Withybush gave these comments (11%).

"Lower income families, those elderly and disabled, without family support that need transport to appointment and visit family members."

"…students who have little money for transport to other areas (you haven't mentioned the economic effects of your proposals), people on low incomes…"

"People from lower income not being able to get the time off to travel to another county for a procedure or be able to afford to regularly visit a family member/friend who is in a stroke ward in another county to support them. Even on higher income, taking a day out to travel to a hospital in another county, find parking etc is challenging."

"Older adults, people that can't drive, on low incomes or don't have flexibility in their work will all be disadvantaged by having to travel further for planned care."

"The elderly and those who don't drive. Pembrokeshire is a deprived area, and many can't drive and travelling large distances across the health board provides difficulty accessing services."

3.400 2% commented on hospital staff.

"Will there be any financial support and encouragement for staff who have to move to be closer a different site?..."

"…I feel that as staff we are negatively impacted if we are moved to long days without having a choice in the matter and I feel that a lot of us with children, particularly those without family member support, will have to give up our jobs to find things that work around childcare options in the area."

"Ongoing training in duty of care for decisions about all people, including those with protected characteristics, will positively impact both NHS staff and their patients."

3.401 6% thought that the family and friends of patients would be affected, with a greater proportion of those living nearest Bronglais giving comments such as these (10%).

"…Patients who have partners who are disabled and cannot use public transport and may not have access to private transport will be completely cut off from their loved ones during a time of need."

"Elderly patients are high users of the services making up this consultation. I believe that moving the provision of services further away from home will reduce access and also make it more difficult for visitors to inpatients. This can lead to increased loneliness. The NHS needs to proactively help coordinate care for elderly patients and their family/carers, supporting them to navigate the changed 'system'."

"The loss of services at Prince Philip Hospital will affect the most deprived in society. For example, they may not be able to visit loved ones or attend vital appointments if services are moved to Glangwili Hospital. There is an ever-ageing population meaning patients loved ones may not be able to travel as far to visit or to bring in essential items for patients physical and emotional well-being."

3.402 10% suggested other groups; this included those who are Welsh language speakers.

"Following stroke, patients with cognitive and communication deficits often revert to speak their first language. For a lot of the population of Ceredigion, South Gwynedd and Powys this is Welsh. The Welsh language is less strong in Carmarthenshire and Pembrokeshire and having health professionals that are able to converse in the Welsh language is very important following stroke. Can you guarantee that access to the Welsh language will remain the same with proposed changes?"

"Traditional Welsh speaking rural areas of west Wales will be disproportionately impacted by these changes. Centralising services away from their community & county will leave rural Welsh speakers isolated & vulnerable. Farmers, a highly dangerous profession, will be disproportionately impacted, as will other vulnerable groups who are unable to travel with ease such as gypsy travellers or those without a car. The train services to west Wales are terrible, bus services have been cut & are now less frequent. How will we manage if loved ones are in hospital? We will become isolated & this will lead to more mental health problems."

3.403 It also included those with vision or hearing impairment, working people, and people with religious or cultural beliefs. Gender was also mentioned by a few, associated with comments around single sex wards and facilities for transgender people.

"Sight impaired people need to be treated as close to home as possible at venues that are familiar and easy to navigate."

"The disabled will be impacted if they cannot get transport to a hospital out of their areas. You can't even provide appointment letters in large print. Deaf patients have to ask someone else to phone for them because your staff will not speak via relay uk to patients."

"…Hard working people who can't take time off work for many ops, up and down the M4 for treatment, as realistically you have to take the whole day off when travelling from Aberystwyth"

"…Patients with certain religious or cultural needs: Travel and service centralisation could limit access to community support or services tailored to specific beliefs or customs…"

"Pembrokeshire has had refugees from Syria and Afghanistan. A lot of these are unable to drive and it would be difficult for them to access services further afield."

"Gypsy, Roma and travellers. Prison population. People experiencing homelessness."

"Please do not forget those covered by the Armed Forces Covenant - serving Armed Forces personnel, veterans and the dependent families of both."

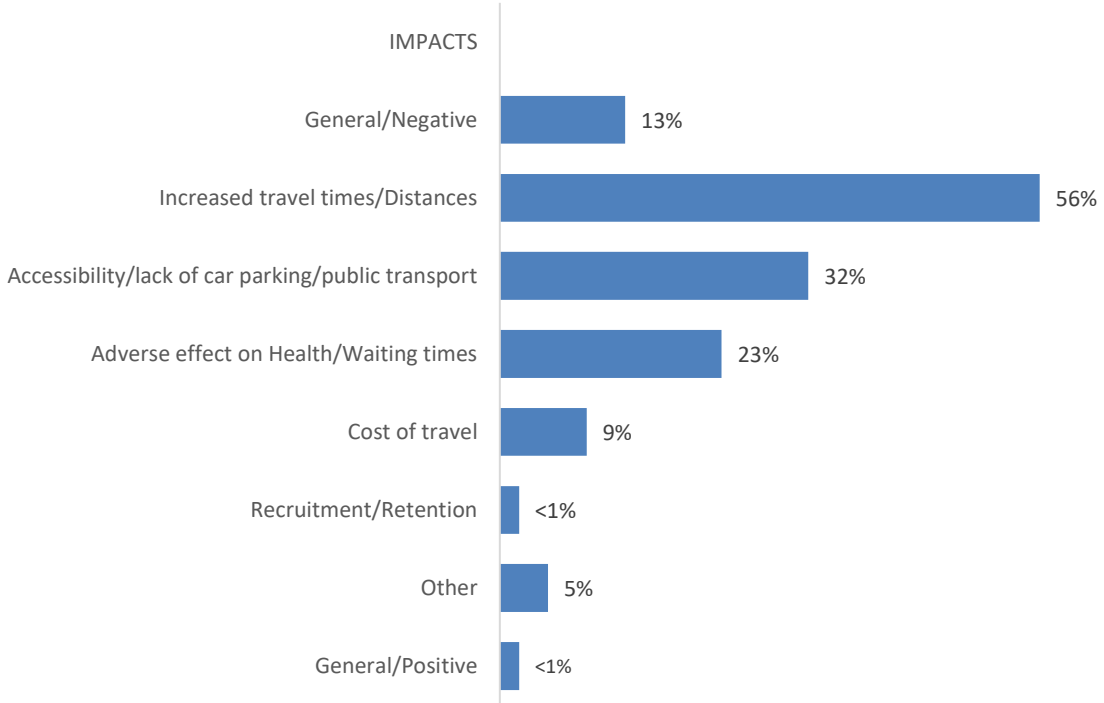
"In-patients who wish to be accommodated in single-sex wards should have the right to request this. Biological sex should be the criterion for admission to single-sex wards."

"…Any changes in the law towards transgender people that mean they'll struggle to use bathrooms or other areas because of these changes…."

Impacts mentioned

3.404 779 individual respondents mentioned the impact they felt these groups might experience, with some noting suggestions for how to enhance any positive impacts or mitigate any negative impacts.

Figure 44: How positive impacts might be improved or any negative impacts reduced suggested by respondents in response to the same question (individual questionnaire respondents only) (Percentages are of those providing an impact)



Base: Individual respondents providing an impact (779), Impacts mentioned (1,105)

3.405 Of these specifying an impact, over one-in-ten (13%) made comments that just referred generally a negative impact without being more specific.

3.406 2% gave a general comment that suggested a positive impact.

> *"Low socio-economic groups and the elderly are the most likely to be affected. If anything can be done to mitigate the cost/difficulties of significant travel times and accommodation costs to mitigate I believe this would be welcome. Overall, it is my view that the negative effects are outweighed by the benefits of running higher quality and more sustainable services that should be the primary aim of this process."*

3.407 Over half (56%) mentioned the impact of increased travel times and distance resulting from the proposed changes, many suggesting that greater consideration should be given to transportation, including the provision of hospital transport or provision by community groups, and other forms of help for those who find travelling difficult.

> *"I think you do need to keep local services especially for people with physical disabilities and social and emotional difficulties. Going to large scale hospitals, having to navigate large car parking massive busy corridors are all anxiety producing. Keeping it smaller keeps healthcare more accessible to people with physical disabilities and feels safer to those with conditions such as Autism or those with Mental Health needs..."*
>
> *"…Positive impacts could be enhanced by: Maintaining as many local services as possible at Withybush and community sites…."*
>
> *"There is no mention of enhanced transportation being provided. Reducing the amount of care available closer to home, and thus the need to travel to more distant locations, will mean that the disabled and the elderly (and their relatives/carers) will be particularly adversely affected. The further enabling of consultation with these groups (who make up a considerable proportion of those seeking healthcare) will be vital."*
>
> *"Disabled people are less likely to drive and more likely to require transportation to hospitals a long way from their home and family. Improve emergency and planned hospital transport before embarking upon this plan."*
>
> *"Negative effects of increased transportation of patients to other hospital sites would be felt by : Elderly. Non drivers. Families Disabled. Huge increases in ambulance services would be required."*
>
> *"Older people and disabled people who have further to travel for treatment/diagnosis under these proposals could find journeys difficult and/or uncomfortable. More awareness and development of community transport and local voluntary driver services could be looked into."*
>
> *"The elderly or people without transport might find travelling times for outpatients appointments difficult. Might the health board consider running a bus service between hospitals, so somebody who could easily travel to Prince Philip hospital but would find it difficult to access Bronglais or Withybush could be offered transport?"*
>
> *"Further travel is likely to be a significant negative impact for several individuals under the Equality Act. Would there be improvements in the hospital transport system to support this? I am aware that individuals with mental health issues currently really struggle to access and utilise hospital transport as it currently stands. Adding in the need for more travel is likely to exacerbate this."*
>
> *"…Enhance patient transport and ambulance services, prioritising accessibility and timeliness for vulnerable groups..."*
>
> *"…Please could you improve the patient transport system so patients who rely on hospital transport are not so badly disadvantaged. Currently they miss out on appointments for scans as there is no transport available after 3pm."*

"Autistic people may struggle with the additional travel and being transferred from one place to another. It may be worth considering simple resources to help with this (very low cost - e.g. a sensory kit for patients being transferred, like ear plugs, eye masks, a printed diagram of the process to help them adjust in advance etc, a photograph of the hospital/ward they will be transferred to). These would be low cost, simple and reasonable accommodations for autistic patients."

3.408 Almost a third (32%) commented on the accessibility/lack of parking available or public transportation.

"Please consider adequate car parking, public transport and car chargers…"

"More account needs to be taken of disabled patients. Need for more accessible /disabled bays for parking. some of the consulting treatment areas are unsuitable for wheelchair users or those using crutches"

"…The park and ride system at Carmarthen COULD be a good way to cope with extra traffic, but would need much better security and lighting…"

"…while accepting travel times are part of the consequence, thought must be given to timing of appointments and the lack of public transport. Also if an in-patient in a hospital with a 4 hour round trip, then some support needs to be in place for family members…"

"The remaining concern is the possible difficulty for travel to the hospitals for the elderly, infirm, poor and non-driving members of society."

"Older people and people on lower income with no transport will not be able to get to treatment centres if you close local services down. The distances involved are too great and more local and I mean local (like doctors' surgery) need to be used for outpatient services and treatment."

"Older people, even if able to drive can lose confidence to drive longer distances and outside their local area. People who are economically disadvantaged could struggle to afford to travel, especially longer distances."

3.409 9% suggested that the cost of travel needed to be considered.

"The implications for vulnerable people from the perspective of travel costs will need to be considered. Appropriate support should be put in place, and this should be co-planned with different groups e.g. disabled people…"

"Positive impacts could be enhanced by: …Providing clear transport support and patient travel information. Ensuring services are accessible to people with disabilities and mobility issues. Offering flexible appointment times, including evenings or weekends, where possible…"

"…Recommendations to Improve Equity and Accessibility: Enhance transport support and financial assistance for patients needing to travel further…"

"…improve communication and links to communities and charities."

3.410 A few suggested making better use of technology to avoid length journeys for patients and their families.

"The elderly and disabled patients will be negatively affected by the proposed changes to Bronglais. I am not the only one to have found it already difficult to access the specialist care I need as I am unable to travel. So, I go without help for life-impacting issues. The proposed changes with make things worse. For rural areas in Europe telemedicine is better developed than here in Wales. Investment and training in this field is one area that NHS Wales should advance and Hywel Dda hospitals are uniquely positioned to adopt this."

"The elderly or disabled people not having transport and the lack of suitable public transport options if they have to travel to hospitals at the opposite end of the county. Improved links between the hospitals to reduce travelling; for example, the option of attending the closest hospital for a video consultation with a specialist consultant at another hospital but have a junior Dr or specialist nurse conducting the appointment with the patient so they have a "real" person with them that can carry out examinations on behalf of the consultant."

"…Expand telehealth and remote consultation options to reduce the need for travel, especially for follow-ups and routine appointments..."

3.411 Whereas others suggested providing services on a rotational basis at the hospital sites, along with extended hours.

"Pembrokeshire has an elderly and aging population which will be hugely impacted if services are moved. Instead of centralising services, consultants and teams should visit the hospitals. Moving services also has a detrimental affected on the economy of the area and people moving into the area. Moving paediatric services already has had a negative impact."

"…Carers and people with childcare or caring responsibilities: Increased travel or appointment complexity may disproportionately affect carers. Flexible scheduling and local service provision where possible can mitigate these challenges. Individuals from socio-economically disadvantaged backgrounds: Longer travel distances and multiple appointments can increase costs and reduce accessibility. Options that provide extended hours or local diagnostic hubs may help alleviate this impact…"

3.412 Almost a quarter (23%) suggested a potential adverse impact on health, or commented on waiting times, in relation to the possible changes to certain services.

"Negative impact on stroke patients north of the health board! stroke unit in Bronglais is of the highest standard in Hywel Dda and will be a massive loss with major consequences"

"Stroke patients and their relatives. Eye patients with some hospitals providing no service. No ITU in Prince Philip is not a safe service."

"Downgrading acute surgical services in Withybush jeopardise all people's safety…"

"Critically unwell patients are at a disadvantage in Prince Philip having to be transferred to Glangwili just after barely stabilising them"

"Patient quality and safety, lack of psychological support needs being met in a timely manner, etc."

"Reduced access to acute medical treatment in Pembs? Not a good idea to reduce services provided in ageing population. Could cause delay in treatment times causing more medical implications."

"All people living in Pembrokeshire would be hit negatively by the removal of full-time emergency theatre in Withybush. The system will not allow for timely transfer and treatment to Glangwili as they are not able to deal with their own emergencies without the aid of Withybush (trauma transfers and asking for staff). Keep full time emergency theatre at Withybush."

"Any reduction in physical health services will have a detrimental impact on mental health services for both acute and chronic patients, without a designated mental health acute ward in Ceredigion, the reduction of additional services that many mental health patients with comorbidities would need to access, would need to be reviewed under discrimination legislation / human rights act. "Additionally, these proposals are not aligned with the Well Being and Future Generations Act (2015) and the transport infrastructure is not fit for purpose to provide transport across the health board to align with reduced services."

3.413 2% mentioned recruitment and retention.

"Everyone in Pembrokeshire will be hit hard by most if not all of the options being put forward. Pembrokeshire is unique because of its position so a lot of the services that were taken away should be reintroduced until a new hospital is built. That would free up Glangwili and Prince Philip and put less pressure on staff."

"Pembrokeshire needs Withybush. The A40 traffic means that to downgrade our hospital could be life threatening. Pembrokeshire is a wonderful place to live, but whilst there are question marks over the future of Withybush, staff are reluctant to relocate. Fix that uncertainty & the staff will come."

3.414 Some gave comments around provision of services in the medium of Welsh.

"Positive impacts could be enhanced by: …Maintaining Welsh language support and culturally sensitive care for all patients."

"…People with limited proficiency in Welsh or English: Consolidation of services risks reducing access to local language support. Retaining some services at multiple local sites supports compliance with Welsh Language Standards and improves communication… Provide clear, accessible, bilingual communication about changes. …"

"…Use of electronic translation tools mean that Welsh language speakers can access their language..."

"…Ensure all sites retain staff with Welsh language skills and cultural awareness, and provide interpretation services where needed…"

3.415 Around 5% commented on other types of impacts they thought would result from the proposed changes, together with some potential mitigations.

"…People with sensory impairments or cognitive disabilities: Accessing larger or unfamiliar hospital sites may cause difficulties. Maintaining local nurse-led clinics and community services helps ensure continuity of care in more familiar environments. …Continue investment in community-based nurse-led clinics and outreach services…Offer flexible and extended appointment times to accommodate patients' varying needs. Engage protected group representatives in ongoing consultation to ensure inclusivity. Maintain strict safeguarding and privacy standards."

"…Provide clear, accessible information about service changes in multiple formats and languages, including Welsh, to support informed choices. Engage actively with affected communities and advocacy groups representing protected characteristics to gather feedback and tailor support…"

3.416 A small number raised concerns around methods of communication and suggested specific mitigations.

"…More transparency is required for patients when appointments are sent out. Currently, it is very easy for the health board to change from an in-person appointment to a remote appointment without sufficient notice or care given to the carers of the elderly who may have jobs, they need to book days off in order to help relatives attend these appointments. The health board needs to engage more with the technology available i.e. text messages, WhatsApp, letters sent in a timely manner to ensure people are able to attend appointments. I.E. for the deaf or the blind, these consultations may have been helpful in a video format instead of just text. Well written text but in a day of short quick videos, this would help get the message out to ensure the correct people can engage with this vital consultation."

3.417 There were specific concerns raised around those who are vulnerable in other ways, such as neurodiversity and learning disabilities.

"Being mindful of people living alone with no support, elderly and people with disabilities. Social care is an important part of your plans so that beds can freed quicker when people have somewhere safe to go after hospital inpatients."

"The elderly and frail will be the worst affected by these proposed changes. Taking this money and putting it into social and community care would probably have a much greater impact."

"Neuro divergent people struggle with change and transport - so to help provide clarity of what to do when, there needs to be a service like 111 or AI chatbot that can tell them where to go for what - quickly and easily - plus digital booking, and digital list checker (to check if referred/on lists etc) which would provide reassurance you are on list, we know you are waiting etc - to reduce phone calls and DNA"

"My concern is that Nurses with Learning Disability training should be employed in each site."

3.418 And others highlighted a few other issues for consideration.

"As mentioned, the aging population who struggle with transport but also younger service users who have the same issue. If we had a serious improvement to our primary care services the proposed changes to the hospital sites would not be so daunting to the public, but because of the poor service they are receiving from primary care these options are appearing terrifying. Please think practically e.g. a patient in Carew needing to get public transport for urology appointment etc. to see real life examples of how this would work. Also need reassurance from WASUT that we will be supported."

"Is there adequate provision/accommodation to allow those with special needs to stay overnight?"

"Children - Impact of travelling and lost school time, especially if a young carer. Families - Visiting hours make it difficult for families to visit, especially if they have children as travel time and school pick up often means only families who live near the hospital can visit - Can these be reviewed?"

"I think that services for elderly people or disabled people may be impacted upon by the large numbers of people moving into west Wales now. It is putting pressure on our infrastructure and on NHS services here. So options should consider this and find out what the impact actually is…"

"Pembrokeshire has a high percentage of elderly people living in rural areas without transport or mobile phone coverage. Services need to be improved for this group."

3.419 A small number of comments highlighted issues relating to ensuring the provision of single sex spaces and services, and also ensuring protections around transgender and non-binary people.

"In hospital, people need to feel safe and need their dignity protected. Mixed sex spaces cannot do this."

"Any changes that prevent transgender peoples' access to care in a way that affirms their gender identity is going to cause direct phycological harm to the patient, lower their quality of care, and cause trauma which will lower their motivation to access healthcare through the NHS in the future"

3.420 Finally, a small number of comments referred to the Equalities Impact Assessment (EIA) and questioned whether it sufficiently reflected the impact on families, as well as patients, in connection with possible 'transfers' to another hospital several hours away, for services that might involve a 'treat and transfer' element.

"The EIA states: 'Socio-economic deprivation is not a factor considered on admission to, and treatment in, stroke departments if clinically indicated' - it is acknowledged that 'There may be some impact on the families of patients who are likely to have longer admissions to hospitals which may affect them with travel costs, parking costs, cost of food and drink, ability to work while visiting which maybe for prolonged periods' but the same principle is not applied to other sections of the EIA. Mitigation states that 'Hywel Dda strives to deliver care closer to home whenever possible'. The treat and transfer option does not promote that principle. Equality impact assessment: The EIA seems to apply only to the 'treat' element of the 'treat and transfer' option and does not address the impact on the patient or their families on 'transfer' to another hospital several hours away for each option/section. o form 2 does not consider of the impact on families, just the patient. If you are suggesting T&T then you must consider the support network and not just the patient"

Organisational Responses

3.421 Of the sixteen organisations responding, six identified groups they believed might be positively or negatively affected by the proposed changes, noting eighteen groups in total between them (ten organisations did not provide a response to this question).

"Elderly patients who needs reassurance. Patients with physical or mental health challenges. Care home residents." [Llanfair Grange care home]

"Elderly people – [access - transportation]. Also, they are less likely to be able to easily access/ search for information online." [Hearts and Crafts (craft group)]

"It affects everyone but especially those people with low Incomes no means to travel, pensioners, people with high-risk illnesses." [unknown]

"These plans will have a negative effect on the elderly, underprivileged, fragile, youth, children, disabled and people who live in rural areas - this will cause strain, difficulty in accessing timely and necessary healthcare. This can lead to mental health problems." [Lledrod Community Council (translated from Welsh)]

"Older adults and vulnerable adults as well as those with young children have been the groups affected the most when it is required that they are transferred elsewhere for service input." [Critical Care Clinical Psychology service]

3.422 Two organisations made suggestions for how they thought the negative impacts could be mitigated.

"People who do not have easy access to cars for transportation, hence the need for inter hospital transport and links to public transport" [SOSPPAN (Save Our Services Prince Philip Action Network)]

"Negative impacts can be completely eliminated by keeping a fully operating stroke unit in Bronglais" [Dyfi U3A]

4. Residents' Workshops

Overview

4.1 ORS conducted three two-and-a-half-hour workshops with residents, one in Carmarthenshire (Whitland) on 18 June 2025, one in Ceredigion (Lampeter) on 15 July 2025, and one in Pembrokeshire (St David's) on 16 July 2025. These two-and-a-half hour sessions are best understood as 'deliberative[91]' meetings in which the options for the nine clinical services under consideration were tested against residents' opinions. This provided an opportunity to explore the extent to which each of the options were acceptable or otherwise, and to understand in more detail the issues and arguments relating to them and other aspects of the CSP.

Attendance and representation

4.2 In total, there were 58 participants at the workshops (20 at Carmarthenshire, 18 at Pembrokeshire, and 20 at Ceredigion). The aim was to achieve at least 18 participants for each group, which was achieved in all cases.

4.3 Participants were recruited by FieldMouse, a specialist Wales-based recruitment agency. The recruitment process was monitored to ensure demographic and social diversity in terms of a wide range of criteria (including gender, age, ethnic group, working status, and disability/limiting illness. Overall, as shown in the table below, participants represented a broad cross-section of residents across the Hywel Dda area.

Table 28: Residents' workshops – participant characteristics

GENDER	AGE	WORKING STATUS	ETHNIC GROUP	LIMITING ILLNESS OR DISABILITY
Male: 28 Female: 30	18-34: 8 35-49: 17 50-64: 20 65+: 13	Working full- or part-time: 35 Not working/ retired: 23	White Welsh/British: 56 Black Welsh/ British: 1 White European: 1	16

4.4 As standard good practice, an incentive payment of £65 was paid to participants as a token of thanks and to cover childcare or travel costs.

4.5 To ensure a properly deliberative approach, ORS used Hywel Dda's consultation material to develop a suitable agenda and informative stimulus material for the workshops, which covered the need for change, and the challenges within, and options for, the nine clinical services, grouped as follows given the similar issues faced within the respective clinical areas[92]:

- » critical care, emergency general surgery, and stroke.

[91] Deliberative research gathers people's views after they have been presented with the opportunity to 'deliberate' the issues under consideration. Moderators present a range of information and encourage differing points of view to be debated, before considered final decisions are sought.

[92] Please note that while the services were discussed in these groupings, they have been reported in alphabetical order to ensure consistency with the other consultation methodologies. Due to time constraints, the future role of Hywel Dda's main hospitals was not covered at the residents' workshops.

- » endoscopy, orthopaedics, and radiology.
- » dermatology, ophthalmology, and urology.

4.6 After each group of three, participants were asked to discuss the options in self-facilitated break out groups, considering advantages or benefits, concerns and potential impacts (including on any particular groups or communities), mitigations (i.e., how any negative impacts could be reduced), and alternative suggestions. The key issues raised by each break-out group were then shared in plenary feedback sessions.

4.7 Each participant was also given an individual workbook in which they could express their option preferences. Not everyone chose to complete their workbooks or answer every question, but the number of those who did, and their preferences, can be seen in the tables included throughout this chapter.

4.8 The materials used in the workshops can be found in Appendix 1.

Main findings from residents' workshops

Critical care

4.9 Prior to discussion, participants were shown the options, before being invited to ask questions for clarification and asked to discuss their preferences in their break out groups[93].

> Option A: intensive care unit (ICU) at Bronglais and Glangwili; enhanced care unit (ECU) at Withybush and Prince Philip (patients requiring intensive care transferred to Glangwili ICU); extra ECU at Glangwili (ICU can focus on sickest patients).
>
> Option B: ICU at Bronglais, Glangwili, and Withybush; ECU at Prince Philip (patients needing intensive care transferred to Glangwili ICU).
>
> Option C: ICU on all sites; maintain temporary arrangement at Prince Philip (transfer very sickest patients to Glangwili ICU while continuing to care for some patients at Prince Philip).

4.10 Across the three workshops, opinion was mixed on the critical care options: 17 of the 48 people who filled out their individual worksheets preferred Option C, 15 preferred Option B, and 13 preferred Option A. There were, though, differences by area as outlined below:

- » in Carmarthenshire, opinion was split across the options with three participants preferring Option A, five preferring Option B, and six preferring Option C. Three participants answered either 'no preference' or 'don't know.'
- » there was more support for Option B in Pembrokeshire, chosen by eight of the 13 participants who answered the question. Four favoured Option A, and only one favoured Option C.
- » a small majority of Ceredigion residents (11 of 19) preferred Option C, with a further six choosing Option A and only two choosing Option B.

[93] Discussions were held at the end of the critical care, emergency general surgery, and stroke section rather than after each individual service area.

4.11 The key reasons for people's choices (as expressed in the plenary feedback) were as below:

- those in favour of Option A considered it a cheaper option that consolidates workforces on fewer sites, potentially attracting more specialists and improving critical care standards and outcomes across Hywel Dda. It was also considered the easiest option to resource.

> *"… If you're in an ICU it's all about your healthcare. It can be inconvenient to your family but your family are facing your potential death. As a result, the distance travelled to come and visit you, whilst inconvenient, is irrelevant compared to the opportunity to get the very best doctors … I think of those, Option A is the strongest." (Carmarthenshire)*

- on the other hand, there was some scepticism that Health Board could deliver Option A, particularly in relation to bed space at Bronglais and Glangwili; and many participants were concerned about reducing the number of ICUs across Hywel Dda given the area's challenging road network.
- in Pembrokeshire though, while travel times for patients and visitors were a concern, there was some acceptance that people in rural areas are used to travelling for services; and that if care was better further away, they would be prepared to make the longer journey.
- Option B was considered the 'compromise' option by those in favour of it. They praised the fact that it reduces patient transfer needs and provides better ICU coverage across Hywel Dda compared to Option A; while also acknowledging that it would be more challenging to staff.
- however, it was noted that for those in need of transfer, Option B would mean longer travel times; and that critical care facilities at Withybush are outdated and in need of investment for Option B (and indeed Option C) to be fully beneficial.
- the key concern in relation to both Option A and Option B, however, was that increased transfers would be risky for patients and further strain the ambulance service. Patient transport services were said to be stretched already and the two options (albeit Option B to a lesser extent) were thought to risk exacerbating the issue. Participants were also concerned that no clear plans had been presented by Hywel Dda to improve and ensure sufficient ambulance provision.
- in light of this, those in favour of Option C (described by several participants as the 'ideal world' solution) felt it would minimise ambulance pressures and offer an even spread of care at more local and accessible sites for patients and visitors. In Ceredigion, it was also said that:

> *"… If there were a major incident … you'd need to be able to have the structure to split rather than have all ICU in one place" (Ceredigion)*

- it was recognised, though, that Option C would come at a higher cost and would require additional staffing; and that as critical care services would remain spread across the Hywel Dda area, it would not help attract specialists, thereby potentially offering the least improvement in standards of care.

Dermatology

4.12 Prior to discussion, participants were shown the options, before being invited to ask questions for clarification and asked to discuss their preferences in their break out groups[94].

> Option A: nurse led clinics (including minor operations) at Cardigan ICC; some nurse-led outpatient clinics at Amman Valley Hospital.
>
> Option B: nurse led clinics at South Pembrokeshire Hospital; some minor operations in GP practices.
>
> Option C: nurse-led clinics at Cardigan ICC (including minor operations) and South Pembrokeshire Hospital; some nurse-led paediatric clinics at Cross Hands Health Centre; some minor operations in GP practices.
>
> Option D: nurse led clinics at Cardigan ICC (including minor operations) and South Pembrokeshire Hospital; some nurse-led paediatric clinics at Cross Hands Health Centre.

4.13 Strong majorities in all workshops were in favour of Option C. The key reasons for people's choices (as expressed in the plenary feedback) were as below:

- » Option A and B were rejected by most participants. It was primarily noted that Option A would see the least provision in Pembrokeshire and Option B would mean more travel for patients in Ceredigion.
- » Option C would, it was felt, provide more coverage and increase dermatology provision throughout the Health Board area, offering easier access to services, more flexibility, and less travel for appointments, not least through the provision of some minor operations in GP practices. People also liked the inclusion of nurse-led paediatric services in this option.

> *"The standout for dermatology was the idea of getting an appointment at a GP surgery. It would make perfect sense to streamline that so overall we were going for C" (Pembrokeshire)*

- » however, there was concern in all workshops about GPs' capacity to undertake minor operations in addition to their current workloads.

> *"The GP practices … That was a big thing for us because anything in the GP takes months and giving them more work is going to take even longer. It's just never going to happen, especially if it's the same doctors that need to see everybody." (Ceredigion)*

- » moreover, participants sought clarification on how funding streams would work in the event of GPs undertaking some dermatology services, and whether specialists would be delivering these services from GP practices or whether GPs themselves would be providing the services.
- » further concerns were that Option C could see increases in waiting times for non-dermatology GP appointments. Consequently, Option D was preferred by a number of Ceredigion workshop participants as they felt that not involving GPs would be preferrable.

[94] Discussions were held at the end of the dermatology, ophthalmology, and urology section rather than after each individual service area.

Emergency general surgery

4.14 Prior to discussion, participants were shown the options, before being invited to ask questions for clarification and asked to discuss their preferences in their break out groups[95].

> Option A: consultant surgeons at Bronglais and Glangwili; Withybush patients needing surgery transferred to Glangwili for their operation, before returning to Withybush to recover; strengthened Surgical Same Day Emergency Care (SDEC) at Glangwili and Withybush.
>
> Option B: consultant surgeons at Bronglais, Glangwili, and Withybush (surgery on alternate weeks at Withybush/Glangwili); strengthened same day emergency care at Glangwili and Withybush.

4.15 Across and within the three workshops, the key reasons for people's choices (as expressed in the plenary feedback) were as below:

- Option A was considered the more viable and least confusing of the two options, offering clarity as to what services would be provided where and when. It was also said to offer the most potential for consultant recruitment as specialities would be concentrated on fewer sites, leading to better patient outcomes. Indeed, there was a definite sense that for Emergency general surgery, service quality is more important than distance travelled, though some participants highlighted that a longer journey could result in treatment delays if patients do not reach hospital in good time.
- while Option B offers more locations for emergency general surgery, there was concern that providing it at different sites on alternate weeks could be confusing for patients and families.

> *"[Option B] is a chaotic system where the alternating week system is confusing … It seems like a jumbled together offering." (Carmarthenshire)*

- participants were also concerned that Option B would hinder staff recruitment and retention as specialists would be required to travel between sites. The intermittent service at Withybush was also seen as more expensive in that two sites would need to be resourced.

> *"It's easier to staff Option A because who would want to work somewhere where you know that you have to go there one week, and there the other? So, you've got that argument as well in terms of attracting staff." (Ceredigion)*

4.16 There was again considerable concern about ambulance availability for patient transfers, with participants seeking reassurance that patient safety and outcomes would not be compromised by transfer delays.

[95] Discussions were held at the end of the critical care, emergency general surgery, and stroke section rather than after each individual service area.

Endoscopy

4.17 Prior to discussion, participants were shown the options, before being invited to ask questions for clarification and asked to discuss their preferences in their break out groups[96].

> Option A: gastrointestinal services and bowel screening continue at all sites; Prince Philip expands from two to three procedure rooms to help bring together respiratory and urology services.
>
> Option B: gastrointestinal, respiratory, and urology services at the same hospital sites as now; all bowel screening moved to new dedicated community site (location to be confirmed.
>
> Option C: gastrointestinal services and bowel screening continue at all sites; extended hours at Prince Philip to provide all urology and respiratory services.

4.18 Across the three workshops, there was very little support for Option A and equal support for Options B and C, with a preference for the former in Pembrokeshire, and for the latter in Carmarthen and Ceredigion (though this was more marginal).

4.19 The key reasons for people's choices (as expressed in the plenary feedback) were as below:

- of Option A it was said that *"only one additional room isn't much of a change"* (Carmarthenshire). Indeed, some compared it unfavourably to Option C, preferring the extended hours to an additional procedure room.
- Carmarthenshire and Ceredigion participants felt that if there is high demand for bowel screening, providing a dedicated site (as in Option B) would release space in hospitals for other types of screening. Having one set location for bowel screening would also, it was said, offer consistency and attract staff looking to specialise, as well as allow for additional appointments, therefore reducing wait times.
- there were some concerns regarding Option B, however. These most commonly related to the unknown location and size of the proposed bowel screening site, and the potential for some patients to have to travel further for the service.

> *"I did like B but I think it's too much of a wild card. Like, they propose a site, but will they ever actually be built? There's too many unknowns …" (Ceredigion)*

- preferences for Option C centred around the prospect of extended hours offering better appointment availability and flexibility for both staff and patients, though in Pembrokeshire it was noted that the county's patients would have to travel further were this option to be implemented, and that some staff may not appreciate the extended hours. There was disagreement on the latter point though, with some participants at both Ceredigion and Pembrokeshire suggesting that the flexibility of being able to work 'out-of-hours' may be welcomed in certain circumstances.

4.20 A few people said they had no preference on the options, or that they did not know which to choose. Most of these participants simply said that Hywel Dda should select the option that would reduce waiting lists most and fastest.

[96] Discussions were held at the end of the endoscopy, orthopaedics, and radiology section rather than after each individual service area.

4.21 Suggested alternatives and mitigations included:

- » combining options A and C to offer extended hours and an additional procedure room.
- » ensuring the bowel screening community site in Option B has a cancer focus.
- » and undertaking more bowel screening in mobile units (similar to breast and prostate screening).

> *"… We wondered about endoscopy whether some of the services could be delivered in a mobile way, the same way as breast and prostate screenings. People are perhaps more used to having to do that anyway and maybe they're more likely to attend the screenings if they're just in a pop-up in the park rather than having to travel." (Carmarthenshire)*

Ophthalmology

4.22 Prior to discussion, participants were shown the options, before being invited to ask questions for clarification and asked to discuss their preferences in their break out groups[97].

> Option A: main service (including emergency eye care) at Glangwili; diagnostics and outpatients at Withybush; day cases but no outpatients at Amman Valley Hospital; diagnostics and outpatients at Cardigan ICC and North Road Eye Clinic.
>
> Option B: main service (including emergency eye care) at Prince Philip; day cases and inpatients at Bronglais; diagnostics and outpatients at Withybush; diagnostics and outpatients but no day cases at Amman Valley Hospital; diagnostics and outpatients at Cardigan ICC, North Road Eye Clinic and Pembrokeshire (site TBC)
>
> Option C: main service (including emergency eye care) at Glangwili; day cases and inpatients at Bronglais; diagnostics and outpatients at Withybush; day cases but no outpatients at Amman Valley Hospital; diagnostics and outpatients at Cardigan ICC and North Road Eye Clinic.

4.23 Across the three workshops, strong majorities were in favour of Option A. The key reasons for people's choices (as expressed in the plenary feedback) were as below:

- » reducing waiting times for ophthalmology was considered the priority for the Health Board, and it was felt that Option A would deliver this most effectively, in the most cost-efficient way. In Ceredigion, however, a few participants were concerned that older people would be disproportionately affected by this option due to increased travel. Others, especially in Pembrokeshire, felt that they were *"resigned to travelling"*, and would prefer to have a specialised service further away than a less specialised one locally.
- » Options B and C were preferred by minorities in each workshop as they would provide more services across the Hywel Dda area, but most recognised that neither of these two options would reduce waiting times and address staff shortages to the same extent as Option A.

[97] Discussions were held at the end of the dermatology, ophthalmology, and urology section rather than after each individual service area.

Orthopaedics

4.24 Prior to discussion, participants were shown the options, before being invited to ask questions for clarification and asked to discuss their preferences in their break out groups[98].

> Current services at existing hospitals to remain, plus:
>
> Option A: regional working at Prince Philip; increased day cases at Withybush
>
> Option B: outpatients, increased day cases; extended hours at Withybush
>
> Option C: local outpatients, inpatients, day case procedures, and additional beds at Prince Philip; outpatients, increased day cases at Withybush
>
> Option D: outpatients, increased inpatients, day cases at Bronglais; outpatients, inpatients, day cases (including regional working) at Prince Philip; outpatients, increased day cases at Withybush

4.25 Across the three workshops, there was most support for Option D, though this is largely accounted for by the fact it was favoured by all 20 Ceredigion participants (perhaps expectedly given the reference to increased inpatient services at Bronglais). Opinion was far more mixed in both Carmarthenshire and Pembrokeshire, where it was said that as the options are relatively similar, it was difficult to decide between them.

4.26 The key reasons for people's choices (as expressed in the plenary feedback) were as below:

- Option A was preferred by some, who felt that orthopaedic patients would be willing to travel for faster specialist care. In this context, fostering relationships with Swansea Bay University Health Board was largely viewed positively in potentially reducing waiting lists, allowing opportunities for integration with other services, and improving recruitment.

> *"… Piggybacking on the University Hospital in Swansea would be a good thing for recruitment and retention because there's more opportunities for people. So, we felt that regional aspect was probably a good thing. And to be honest, they've probably got a bigger pot and more staff than we …" (Pembrokeshire)*

- conversely, a minority feared that regional working could lead to increased competition for appointments, as the service would be catering to a larger population. It was also felt that Option A does not provide people living near Glangwili with many options.
- in Pembrokeshire, Option B was marginally favoured as it was said to have "*all the benefits of cross-pollination plus it increases care at Withybush*" (Pembrokeshire).
- there was very little support for Option C across the board, mainly as participants were generally well-disposed toward regional working.
- it was felt that Option D has the potential to effect the largest decrease in waiting times through regional working and enhancements at an additional hospital (Bronglais). However, the higher cost of this option was acknowledged, as was its potential negative impact on critical mass.

[98] Discussions were held at the end of the endoscopy, orthopaedics, and radiology section rather than after each individual service area.

4.27 A few people said they had no preference on the options. Again, they simply said that Hywel Dda should select the option that would reduce waiting lists most and fastest.

4.28 in terms of alternatives, it was suggested at Ceredigion that:

- a dedicated orthopaedic centre could be created to develop a centre of excellence.

Radiology

4.29 Prior to discussion, participants were shown the options, before being invited to ask questions for clarification and asked to discuss their preferences in their break out groups[99].

> All options: 24/7 emergency diagnostic radiology at all four main hospitals; X-ray services at Cardigan ICC and Tenby Hospital (removed from Llandovery and South Pembrokeshire Hospitals).
>
> Option A: → planned diagnostic and day case interventional radiology (Mon-Fri, daytime) at Bronglais, Prince Philip and Withybush; inpatient interventional radiology at Glangwili (Mon-Fri, daytime).
>
> Option B: all main hospitals → 7-day (daytime) planned diagnostic radiology and inpatient and day case interventional radiology (Mon-Fri, daytime) at all main hospitals, with cancer focus at Prince Philip and Withybush; new regional hub for planned diagnostic radiology (site to be confirmed).
>
> Option C: planned diagnostic radiology (Mon-Fri, daytime) at all main hospitals; inpatient and day case interventional radiology (Mon-Fri, daytime) at Bronglais and Glangwili.
>
> Option D: 7-day (daytime) planned diagnostic radiology at all main hospitals; day case interventional radiology (Mon-Fri, daytime) at Bronglais, Prince Philip, and Withybush; inpatient interventional radiology (24/7) at Glangwili.

4.30 Across the three workshops and at Carmarthenshire and Pembrokeshire, there was most support for Option B. In Ceredigion there was equal support for Options B and D.

4.31 The key reasons for people's choices (as expressed in the plenary feedback from their round table discussions) were as below:

- participants typically disliked that inpatient and day case interventional radiology would be at different sites under Option A given this would have less impact on addressing the Health Board's staffing challenges.
- those who preferred Option B tended to do so due to the cancer focus at Prince Philip and Withybush, the extended 7-day planned diagnostic service (where the 'bottleneck' was said to be), and the proposed regional diagnostics hub which, it was felt, could help increase specialisation, attract staff, and reduce reporting and diagnosis times through same site provision.
- however, participants generally wanted more information about the hub's location and remit, noting the potential for duplication if there were planned diagnostics in all hospitals and in the regional hub (though it was recognised that this could further reduce waiting times). They were also concerned about the cost and staffing requirements of this option.

[99] Discussions were held at the end of the endoscopy, orthopaedics, and radiology section rather than after each individual service area.

> *" … With the regional hub, it would be good for increased specialisation, attracting more staff ... It's more strength to our arm basically. But it's … where's the money, where's the staff? It felt like a bit too much of a juicy carrot being dangled." (Pembrokeshire)*

- there was limited support for Option C, but more for Option D. This was especially the case in Ceredigion, where participants felt that Option D would help with waiting lists by expanding planned diagnostics, without what they assumed would be the high cost of a diagnostic hub. However, they were concerned that this option could be costly and difficult to staff given the extended hours and the separation of interventional radiology across two sites.

> *"… D was the way to go through the waiting list … but it sounds more expensive. So … can they actually afford it to do it? And in Option D it would mean that all hospitals would be included for interventional but across two sites … That's going to require more staff." (Ceredigion)*

- participants at the Carmarthenshire workshop highlighted potential detrimental impacts on Llandovery residents given X-ray would be removed from their local hospital under all proposed options. Moreover, all proposed options were said to depend on the availability of CT, MRI, and Ultrasound scanners at all the main hospitals, which are costly to purchase.

4.32 Mitigations and alternative suggestions included:

- using an existing site for the proposed regional hub rather than building a new one.
- extending Option B to 'buddy up' the regional hub with the proposed bowel screening centre.
- increasing mobile units like MRI and breast screening.

Stroke

4.33 Prior to discussion, participants were shown the options, before being invited to ask questions for clarification and asked to discuss their preferences in their break out groups[100].

> Option A: stroke units at Prince Philip and Withybush, specialist cover 12-hours a day; patients from Bronglais and Glangwili transferred to Prince Philip or Withybush for inpatient stroke care.
>
> Option B: stroke unit at Prince Philip, specialist cover 24-hours a day; stroke unit at Withybush, specialist cover 12-hours a day; stroke patients from Bronglais and Glangwili (and from Withybush stroke unit), transferred to Prince Philip for initial 72-hours of intensive inpatient care; following this, ongoing inpatient care provided either at Prince Philip, or Withybush stroke unit.

4.34 Across the three workshops, strong majorities were in favour of Option B. The key reasons for people's choices (as expressed in the plenary feedback) were as below:

- some benefits were highlighted in relation to Option A, including that it would help address staff shortages, has the potential to raise standards, and provides longer specialist cover than under current arrangements. However, the lack of 24-hour coverage was generally

[100] Discussions were held at the end of the critical care, emergency general surgery, and stroke section rather than after each individual service area.

considered unacceptable, and this option was again said to be too reliant on the ambulance service for transfers.

- in this context, it was suggested at the Ceredigion workshop that if Option A was to be taken forward, the two stroke units should not operate simultaneously, but at different times to provide continuous 24-hour coverage.
- Option B was preferred mainly due to the provision of 24-hour specialist care, which was said by many to be 'essential.' The creation of a centre of excellence was also favoured as it would increase the ability to recruit specialists.
- however, like Option A, the success of Option B was considered contingent on an already stretched ambulance service, and there was concern about long transport times for some patient transfers. Additionally, some participants had concerns over capacity at the proposed stroke units.
- under both options, there was concern about the lack of a stroke unit at Bronglais due to the importance of prompt intervention and specialist care; as well as visits from loved ones, who may be unable to travel to a more distant hospital. There was also some concern, especially in Ceredigion, around both options focusing on Prince Philip Hospital, which is at the eastern extremity of the Health Board area.

> *"Prince Philip is entirely the wrong place for specialist 24-hour cover in the extreme south-east of Hywel Dda, leaving both Ceredigion and Pembrokeshire empty of that … Over 50% of the population lives in Pembrokeshire or Ceredigion, and yet we're putting it at the furthest extent away possible from them" (Ceredigion)*

- some, though, felt they would prefer stroke services to be provided at the most appropriate specialist centre, regardless of location, rather than at a non-specialist hospital closer to home.

> *"If I have a stroke, I want the treatment to be the best possible and the family can find their way to me … As long as A&E services can give emergency treatment, I don't see the problem with having specialist services in different areas" (Pembrokeshire)*

4.35 Regardless of which option is chosen, participants strongly urged Hywel Dda to better reassure residents around the 'Treat and Transfer' aspect of its proposals; especially that emergency stroke treatment will remain available at their local hospital.

4.36 A few mitigations and alternate options were suggested, such as:

- a 24/7 mobile paramedic stroke service to transfer patients to a stroke unit after initial intervention.
- investment in Bronglais to maintain some level of specialist stroke service there.
- variations on Option B which would see the 24-hour unit at Withybush instead of Prince Philip (given the latter's proximity to Swansea Bay); or *only* having 24-hour cover at Prince Philip or Withybush.

> *"Just have a single 24-hour unit. Option B is more than we have now, which is causing a fragility issue …" (Pembrokeshire)*

Urology

4.37 Prior to discussion, participants were shown the option, before being invited to ask questions for clarification and asked to discuss their preferences in their break out groups[101].

> *Dedicated urology unit at Prince Philip (outpatients, day case surgery, inpatients and diagnostic hub [inc. urgent suspected cancer]); outpatients, day case surgery, and diagnostic procedures (not including urgent suspected cancer) at Bronglais and Withybush; and emergency urology services only at Glangwili for patients with urology emergencies coming to A&E.*

4.38 As there is only one option for urology, participants were asked to what extent they agreed or disagreed with it. Most agreed (three strongly agreeing and 32 tending to agree), while only six disagreed. The remaining nine neither agreed nor disagreed. Many participants said something in the vein of, 'It is what it is' in relation to the urology option, though others were more explicitly positive, praising the co-location of urology and endoscopy skills and services at Prince Philip, as well as opportunities to combine these with cancer services.

4.39 Less positively, it was mentioned that travel times would increase for some, and in Ceredigion there was some criticism of there only being one site for emergencies.

Cross-cutting themes

4.40 A few overarching comments were made at the sessions. In particular, travel and transport emerged as a major concern, particularly in the context of proposals to concentrate services at fewer hospital sites. While participants tended to understand the need for this in principle, they questioned how the Health Board would ensure sufficient capacity for patient transfers and equitable access to care.

> *"… Everybody has got very deep misgivings about transport links, and they are a critical part if you're going to concentrate services" (Carmarthenshire)*

4.41 Several respondents also emphasised the need to consider not just patients, but also their families and support networks, who might struggle to travel longer distances.

4.42 On the other hand, while many saw the practical challenges of travelling to centralised services, some accepted it as part of living in rural west Wales. One participant commented:

> *"We should be used to having to travel … and if specialisation means being able to recruit specialist staff because it's more attractive for doctors and nurses, then do it." (Pembrokeshire)*

4.43 Across all sites, the age and condition of hospital buildings were identified as limiting factors for development. As one Ceredigion respondent put it, *"It's a challenge across all the hospital sites – the age of the buildings and the facilities and the ability to expand them."*

[101] Discussions were held at the end of the dermatology, ophthalmology, and urology section rather than after each individual service area.

4.44 Finally, Carmarthenshire and Pembrokeshire participants expressed a mix of concern and cautious optimism about the future of Withybush Hospital. A recurring theme was the difficulty in recruiting and retaining staff there, attributed both to outdated facilities and the long-standing uncertainty over the hospital's future. As such, there was a sense that sustained investment is needed to modernise the site and restore confidence among healthcare professionals.

4.45 However, on the whole, Pembrokeshire participants welcomed the apparent renewed focus on Withybush in future planning, describing this as *"a comfort"* after years of perceived decline.

5. Public events and activities

Overview

5.1 During the consultation period, the Health Board hosted a series of public engagement events and activities across Carmarthenshire, Ceredigion, and Pembrokeshire, as well as neighbouring communities. These included informal public drop-in sessions held in community venues; online public meetings via Zoom and Microsoft Teams; and patient engagement in the outpatients' departments at Bronglais, Withybush, Glangwili, and Prince Philip General Hospitals. The purpose of the events was to enable residents, patients, service users, and general members of the public to discuss and share their views on the proposals outlined in this consultation.

5.2 In total, the Health Board held 31 events/activities for the public alongside visits to outpatients' departments to speak with patients, engaging with more than 1,300 attendees.

Table 29: Public drop-ins and meetings - dates and attendance

Group	Date	Number of attendees
Public drop-in (in person) events		
Llanelli	17 June 2025	30
Ammanford	20 June 2025	17
Carmarthen	25 June 2025	44
Haverfordwest	27 June 2025	66
Aberystwyth	30 June 2025	75
Tenby	4 July 2025	32
Machynlleth	7 July 2025	95
Cardigan	8 July 2025	44
Pembroke Dock	10 July 2025	54
Aberaeron	14 July 2025	36
Llandovery	17 July 2025	409
Fishguard	31 July 2025	55
Tywyn	4 August 2025	49

Public online events		
Critical care, emergency general surgery, stroke	16 June 2025	19
Urology, endoscopy, radiology	19 June 2025	13
Orthopaedics, ophthalmology and dermatology	15 July 2025	31
General	27 August 2025	13
Patient outpatient department walkarounds		
Bronglais General Hospital outpatient department	5 August 2025	23
	20 August 2025	20
	20 August 2025	21
	22 August 2025	8
	26 August 2025	26
Glangwili outpatient department	14 August 2025	6
	20 August 2025	29
	21 August 2025	11
Prince Philip outpatient department	6 August 2025	10
	13 August 2025	10
	20 August 2025	13
	27 August 2025	6
Withybush Hospital outpatient department	14 August 2025	3
	21 August 2025	37

Main findings from public drop-in sessions and meetings

The need for change

5.3 Across almost all public events, attendees acknowledged the wider pressures facing the NHS — workforce shortages, rising demand, and constrained budgets. Many accepted that it is not practical to duplicate highly specialist, low-volume services across multiple small hospitals, and recognised the need for change to secure sustainable services.

5.4 Some members of the public described the proposals as ‘logical in theory’, noting that concentrating staff and expertise could improve outcomes and resilience. However, this conditional support was usually

accompanied by strong warnings about the need to maintain local access for time-critical care and outpatient services.

5.5 Several attendees also referenced population growth, an ageing demographic, and Pembrokeshire's large seasonal influx of tourists, arguing that any reconfiguration must take these external factors into account when assessing capacity and demand. Likewise, participants from Ceredigion, south Gwynedd and Powys emphasised that Bronglais General Hospital serves as the principal general hospital for a wide predominantly rural area of mid Wales that extends beyond Hywel Dda's boundaries. They described long travel distances, poor public transport links, and the absence of other district general hospitals nearby, stressing that Bronglais' regional role in serving a geographically dispersed population must be recognised in future planning.

Critical care

Views on the options

5.6 Across the events, attendees recognised the importance of maintaining high-quality critical care provision but expressed widespread concern about their potential removal, especially from Withybush. In the Pembrokeshire-based events and sessions, it was said that removing Withybush's intensive care capacity would endanger patients, given the travel times to Glangwili (often over an hour by road).

5.7 In light of this, many attendees perceived Option A as a centralisation of resources at Glangwili to the detriment of Pembrokeshire. Attendees highlighted the risks of transferring critically ill patients over long distances, the strain on WASUT, and the emotional burden on families expected to travel during prolonged patient admissions. They also suggested that a local ICU is essential for managing the area's seasonal population increases.

> *"In summer months in this area there is a high number of people and higher need for ambulances being called. Would they be ferried straight into Glangwili, if no ICU at Withybush?" (Tenby public drop-in event)*

5.8 A recurring concern in relation to Option A was staff morale and recruitment: attendees feared that losing ICU functions could make Withybush a less attractive place to work and accelerate workforce decline. There was also concern about patient flow impacts at Glangwili if critical care for the south of Hywel Dda is effectively centralised there.

> *"How will the patient flow issues be addressed with the increase in patients attending Glangwili …?" (Online event – critical care, emergency general surgery, stroke)*

5.9 Some questioned whether interdependencies with other services - such as A&E, emergency general surgery, endoscopy, renal and stroke care - had been fully assessed. The potential removal of ICU capacity was viewed as undermining these services; and specifically, there was scepticism around the feasibility of providing a stroke unit at Prince Philip in the absence of a co-located ICU.

> *"If Prince Philip is still to accept stroke patients, it is worrying around taking away the ICU." (Llanelli public drop-in event)*

"If pulling ESG and Level 3, we are not going to have an anaesthetist here … Then you end up with downgraded A&E." (Pembroke Dock public drop-in event)

5.10 There were fewer comments about Option B. A small number queried whether it would genuinely improve service resilience. Others doubted whether alternating or shared critical-care arrangements between hospitals would be feasible given current staffing shortages.

5.11 A few attendees who commented on their option preferences felt that retaining intensive care units at all main sites (Option C) would be the best solution for protecting safety, particularly during major incidents and any future pandemics. They noted that Withybush and Glangwili both played vital roles during COVID-19 and warned against losing local capability. Others recognised the complexity of staffing specialist services across multiple sites, referencing national shortages of anaesthetists and intensivists; and suggested that quality of service is more important than distance.

"The staffing has become specialised in its own right. It is difficult to have specialists in Glangwili, Prince Philip, and Withybush." (Carmarthen public drop-in event)

"To me it doesn't really matter where the intensive care unit is … I'd rather have an excellent central service, even if I had to travel 40 miles for it." (Glangwili outpatients session)

5.12 It should be noted that a few attendees found the consultation materials too high-level, lacking detail on staffing models, patient flow, and what the options would mean in practice; while others considered the options too confusing for the general public to understand.

"I think when you show the options for critical care, the general public won't understand it." (Carmarthen public drop-in event)

Suggested alternatives and mitigations

5.13 In terms of alternatives and mitigations, the following were suggested:

- retain a small number of stabilisation or level 2 beds at Withybush and Prince Philip to allow initial management and stabilisation before transfer.
- look at ensuring staff rotation across sites, to maintain local resilience.

"Have changes to ways of working been considered by existing staff? For example, remote monitoring… or ensuring contracts state rotational or cross-site coverage?" (Online event – critical care, emergency general surgery, stroke)

- an enhanced and clearly defined inter-hospital critical care transfer service if any centralisation proceeds.
- digital solutions, such as tele-ICU or virtual ward rounds, to provide consultant oversight and support staff at smaller hospitals.

Dermatology

General views

5.14 There was broad agreement that access to dermatology services needs to be improved: the most consistent and widespread concern was about unacceptably long waiting times for dermatology appointments and treatment. Attendees described waiting periods of 18 months, two years, or even longer, with some resorting to private care. There was also frustration about unequal access between health boards, with some patients able to be seen much faster in neighbouring areas.

> *"I've been on [the waiting] list for two years. I've had to go private with a consultant in Swansea Bay." (Ammanford public drop-in event)*

5.15 Attendees in Pembrokeshire and Ceredigion complained about the distance patients must travel for routine or ongoing dermatology care. This was considered particularly difficult for older patients, those with chronic conditions, or those requiring regular phototherapy. Indeed, the loss of local phototherapy ('lightroom') services was raised by several attendees, who questioned why existing facilities were not being used and highlighted the impracticality of frequent long-distance travel for treatment that requires multiple weekly sessions.

> *"People who need light treatment—are you expecting people from Pembrokeshire to travel three times a week to Prince Philip? There is a perfectly good light room at Withybush!" (Haverfordwest public drop-in event)*

5.16 Fragmented care pathways were raised by several attendees, who spoke of dermatology services spread across multiple hospitals; poor communications between primary and secondary care, and between providers and patients; and a reliance on visiting consultants and locum staff, many of whom are apparently reluctant to travel beyond Llanelli. This lack of coordination was said to cause confusion and undermine confidence in the system.

> *"Seven different things at seven different sites … I have never seen a surgeon consultant for dermatology in any way." (Tenby public drop-in event)*

5.17 Considering this, a few people recognised that strengthening and consolidating teams might improve consistency and access to expertise, even if it means more travel.

> *"It would be nice to know there's one place to go … There are costs involved with travel, but a stronger team makes more sense." (Prince Philip outpatients session)*

Views on the options

5.18 Although few attendees expressed clear preferences between options, there was significant support for the provision of nurse-led and GP-led provision, albeit some questioned whether the latter was realistic given GP workload pressures.

> *"I note that you suggest GPs might deal with additional responsibilities (e.g., dermatology) but that is just a pipe dream with the current GP provision." (Online event – dermatology, ophthalmology, orthopaedics)*

Suggested alternatives and mitigations

5.19 In terms of alternatives and mitigations, the following were suggested:

- » restoring local dermatology clinics (particularly at Withybush), especially phototherapy and community-based screening sessions to reduce referrals to hospital-based specialists.
- » remote consultations and photography triage to improve access and reduce travel. Several attendees cited positive experiences of video consultations or suggested expanding such models.

> *"A year and three months on the waiting list for dermatology. Surely telemedicine would speed this up." (Cardigan public drop-in event)*

Emergency general surgery

Views on the options

5.20 Some attendees recognised the challenges of staffing multiple sites in relation to emergency general surgery, and a sense that resources might be stretched too thinly if services were distributed or split. They were thus open to the idea of a hub-and-satellite model (Option A), though this was conditional on robust local capacity, safe transfer arrangements, and visible investment in infrastructure and staffing.

5.21 However, more attendees opposed models that would remove emergency surgical cover from local hospitals. Key worries centred on longer transfer times (especially from remote rural and coastal areas), ambulance availability and patient transport infrastructure, staffing adequacy, and loss of local emergency capacity - issues seen as potentially life-threatening in emergency contexts. Concern was particularly acute in Pembrokeshire, where travel times are already long and reliance on ambulance transport was seen as problematic.

> *"… If Option A was chosen, would they have dedicated ambulance? How many ambulances are there servicing?" (Pembroke Dock public drop-in event)*

5.22 Some described Option B (rotating emergency cover between Glangwili and Withybush) as confusing and potentially unsafe, noting that alternating responsibility could create uncertainty for both patients and staff. Moreover, it was questioned whether Withybush has the infrastructure and operational capacity to take on an expanded or centralised emergency surgery function, particularly in relation to theatre space, staffing levels, and support services.

5.23 A recurring thread across the discussions was a call for reassurance and clarity. Participants wanted the health board to explain clearly what would remain locally under each option, how transfers would be managed, its plans to ensure safe staffing levels, and what guarantees would be in place for emergency response times.

Suggested alternatives and mitigations

5.24 In terms of alternatives and mitigations, the following were suggested:

- » maintain on-site emergency surgical capability at each acute hospital where possible; and explore rotational consultant models that provide daily senior review on all sites.
- » stronger communication between surgical and medical teams.
- » establish formal transfer and repatriation protocols with time standards.
- » faster post-operative repatriation to local hospitals
- » more consistent consultant presence on acute wards.

Endoscopy

Views on the options

5.25 Some attendees welcomed the idea of bringing related diagnostic services together and extending hours, recognising potential benefits in coordination, efficiency, and patient experience. Indeed, people who had procedures at one hospital and follow-up at another found the process fragmented and stressful. At the Carmarthen event, the proposal to co-locate endoscopy and radiology was viewed especially positively.

5.26 On the other hand, endoscopy was said to be a high-volume service where convenience and access are crucial. Some attendees were thus concerned that long travel distances (for example to Llanelli for respiratory and urology services under Options A and C) would deter attendance or place unfair burdens on patients, particularly those who are older or less mobile.

5.27 Some worried that moving all respiratory or urology-related endoscopy to Prince Philip, which lacks an ITU, could be risky for frail or complex patients. There were also questions around the location of the proposed bowel screening hub (Option B).

> *"What is this new site for bowel screening in community? It doesn't say where the site is. It's important to know where the site is going to be." (Tenby public drop-in event)*

5.28 Across multiple events, attendees asked for clearer explanations of what each option means for where services would be located, staffing capacity, transport arrangements, and impact on waiting times.

5.29 Moreover, while attendees generally understood that the consultation focused on planned endoscopy, several voiced concern that there was no clear information on how emergency endoscopy pathways would be managed in future.

Suggested alternatives and mitigations

5.30 Suggested mitigations and alternatives for endoscopy were:

- » retaining some endoscopy sessions at each acute hospital to support local diagnostic access.
- » bringing services together in Bronglais given it has a well-equipped JAG-accredited endoscopy unit.
- » ensuring rapid transfer pathways for higher-risk patients requiring enhanced monitoring.

Ophthalmology

General views

5.31 Ophthalmology generated significant feedback. Across the public events, while staff were repeatedly praised as 'lovely', 'brilliant' and 'doing their best', attendees described long waiting times (several years in some cases); repeated appointment cancellations; lack of post-treatment follow-up; poor administration and communication; outdated processes and equipment; and a generally fragmented and inconsistent service. Some of the many typical comments on these issues are below.

> *"We hear about people waiting for cataract operations, so they can't drive, which is really important in this rural area." (Tywyn public drop-in event)*
>
> *"There's no post-op checking, communication, and no access once you've had your op." (Haverfordwest public drop-in event)*
>
> *"The organisation and the management is a sham. The people are incredible, but it's so wrong that the paperwork and management is just all wrong." (Aberaeron public drop-in event)*
>
> *"I am constantly having to repeat information, not having a consistent approach to my treatment." (Llanelli public drop-in event)*

5.32 Staff shortages were widely recognised as a root cause of the issues highlighted above. Many attendees thus accepted that centralisation might make sense operationally, but wanted assurance this would genuinely improve access and reliability.

> *"It really makes sense to have the speciality in one place." (Aberaeron public drop-in event)*

5.33 However, access and travel distances dominated others' concerns, particularly with respect to older or visually impaired patients who are unable to drive. Many attendees were worried that delivering services at fewer sites would worsen inequities for these patients; and even those who said they were willing to travel highlighted that journey times, parking and post-operative logistics (e.g., an inability to drive after surgery) would make this impractical without dedicated patient transport.

> *"If you're having bilateral eye surgery, how are you meant to get about, get home and things like that?" (Haverfordwest public drop-in event)*

Views on the options

5.34 Overall, some saw merit in creating specialist centres if transport was addressed and communication improved, but many emphasised that routine care - such as eye injections - must remain local. Attendees also asked about links between stroke and ophthalmology services, noting that many stroke patients require eye assessments.

5.35 Few attendees supported Option A, as attendees feared it would worsen travel burdens and waiting times.

5.36 The proposed concentration of surgery at Prince Philip under Option B raised a few questions about where paediatric ophthalmology would sit, given that children's services are located in Glangwili.

Suggested alternatives and mitigations

5.37 In terms of alternatives and mitigations, the following were suggested:

- three regional sub-hubs (one per county) rather than one centralised site.
- partnerships with private providers to clear backlogs.
- investment in digital systems to share scans and results with optometrists.
- greater use of community optometrists and local clinics to deliver parts of the pathway, particularly monitoring and follow-up.

> *"Something that has worked is Specsavers coming in to run part of the service." (Pembroke Dock public drop-in event)*

- mobile ophthalmology units to deliver cataract or screening services.
- recruiting and upskilling nurses to deliver eye injections and other routine procedures.

Orthopaedics

General views

5.38 Across the public events, feedback on orthopaedics centred on long waiting times for procedures like hip and knee replacements, stretching to several years in some cases. These delays were considered debilitating, with several attendees saying they had been forced to seek private or overseas treatment to alleviate their pain and mitigate their loss of mobility and independence.

> *"I was on a hip waiting list which was three years before Covid then an extra three years post COVID … I sold everything, jewellery, car, etc and went private." (Llandovery public drop-in event)*

5.39 Attendees also frequently reported confusion and delays between diagnostics, referrals and operations, with lost paperwork, poor updates, and lack of clarity about next steps. Some patients also described being placed in inappropriate wards post-surgery, reflecting staffing or bed pressures.

> *"I had a knee operation – no orthopaedic ward in Bronglais – I was put in a general ward… staff didn't understand what I needed." (Machynlleth public drop-in event)*

5.40 It should be noted, though, that despite these frustrations, attendees consistently praised the quality of surgical and inpatient care once they were seen. There was also some feeling that communication around waiting lists and what to expect would help to manage expectations.

> *"What would help is knowing how long you have to wait, where you are on the waiting list. Morriston Hospital wrote and let me know where I was; is that something you can do?" (Carmarthen public drop-in event)*

Views on the options

5.41 Some attendees recognised that orthopaedic surgery might need to be centralised if it helps address staffing challenges and leads to shorter waits and better patient outcomes.

> *"I can see your … orthopaedics options working… more knee and hips here is definitely better." (Aberystwyth public drop-in event)*

5.42 However, this view was often paired with calls for practical support such as patient transport (especially for elderly or post-surgery patients who cannot travel independently) and investment in rehabilitation and step-down care locally to support recovery.

5.43 Conversely, other attendees objected to losing local services, many on the grounds that rural populations would be disproportionately affected, especially where transport methods are limited.

Suggested alternatives and mitigations

5.44 Suggested alternatives mainly centred on ways to reduce waiting times by:

- enabling cross-boundary referrals (even into England) where this could reduce waiting times.
- partner with private providers to clear backlogs, using NHS funding (though this was described as evidence of system failure by a few attendees).
- creating dedicated orthopaedic hubs with protected elective beds to prevent cancellations – and also reduce infection risk.
- making better use of 'underused' Withybush for orthopaedics.

Radiology

General views

5.45 Attendees had mixed experiences of radiology. Several praised recent improvements, such as weekend MRI appointments and faster booking, but others reported fragmented systems between hospitals and health boards, leading to problems accessing scans, reporting delays, missing results, and duplication.

> *"You have a scan and are worried about the result and you're waiting four, five, six weeks for it to be reported on." (Ammanford public drop-in event)*

5.46 Poor communication and lack of clarity around appointments, preparation, and results were also highlighted.

> *"I wasn't told in the letter that I wasn't supposed to eat. I had to go for another scan. The response was rude and said I hadn't listened to a phone call, but I hadn't had a phone call." (Carmarthen public drop-in event)*

Views on the options

5.47 In terms of the options, there was some support for the seven-day working proposed under Options B and D to prevent unnecessary hospital stays for patients needing radiology services over the weekend.

5.48 However, a major concern across all events was whether radiology services have sufficient capacity, staffing and operational resilience to meet current and future demand, particularly if the service reconfiguration proposed leads to increased patient volumes. Attendees questioned whether the proposed

options – especially those requiring additional travel - could deliver better access and timely reporting considering the health board's staffing challenges.

5.49 There was especially strong opposition to removing radiology services from Llandovery Hospital, seen as part of a broader pattern of disinvestment in rural services. Attendees at this drop-in session - which was attended by over 400 people - described a sense of *"managed decline"* at the hospital; and argued that underuse is the result of referral policies, not lack of demand.

> *"People in this area [are] going to Glangwili; they don't have an option of having their x-ray done in Llandovery." (Llandovery public drop-in event)*
>
> *"It felt like 'don't put them down for Llandovery – need to lower demand and close radiology'." (Llandovery public drop-in event)*

5.50 Travel and transport would, it was felt, be a challenge for inpatients at Llandovery Hospital attending scans at Glangwili; these patients are typically frail, often in rehabilitation or step-down care, and must therefore be transferred via ambulance which is stressful for the patient and causes delays in care.

> *"Inpatients in Llandovery hospital are frail. If they need x-ray, it's a long wait; lots are ambulance transports." (Llandovery public drop-in event)*

5.51 Several participants raised a wider fairness issue around travel expectations: if people in Llandovery are expected to travel to Carmarthen for X-rays and diagnostics, then travel could reasonably flow in the opposite direction as the distance is the same both ways. This was a common theme across engagement events in Pembrokeshire and Ceredigion, where rural communities felt that the burden of longer travel is consistently placed on them rather than being shared more equally across the region.

5.52 Llandovery residents repeatedly highlighted their emotional and financial investment in local radiology services, noting that equipment at Llandovery had been funded through community fundraising by the League of Friends. There was widespread anger that the community's efforts might be disregarded, and multiple offers to fundraise again for equipment renewal.

> *"We feel a sense of ownership. If you shut x-ray, you will lose a lot of goodwill." (Llandovery public drop-in event)*

5.53 A few members of the radiology workforce attended the public drop-in sessions and suggested that the CSP consultation document's claim that radiologists would prefer to work 12-hour shifts is incorrect and not reflective of all staff members.

Suggested alternatives and mitigations

5.54 The following alternatives and mitigations were suggested for radiology services:

- retain and strengthen local radiology services at Llandovery by ensuring GPs offer the hospital as a default or preferred option where appropriate.
- consider mobile or satellite x-ray machines and scanners to serve more rural communities and manage peaks in demand.

- work more closely with other health boards to manage demand, especially Swansea Bay University Health Board.
- share staffing across sites (e.g., radiographer rotation) to sustain smaller units.
- greater innovation and digital integration across radiology services both within Hywel Dda and across health boards, including electronic sharing of scans and AI-assisted diagnosis, to avoid duplication and delay.

Stroke

Views on the options

5.55 Some attendees across several events acknowledged the challenges the Health Board faces in sustaining stroke services and recognised that centralised specialist centres can achieve better patient outcomes. Citing examples such as Bristol, attendees observed that specialist 'centres of excellence' tend to deliver improved survival and recovery rates.

> *"Patients are being moved to Bristol when they have clots for strokes, but their outcomes are excellent… the concept of distance is important, but it impacts on the quality of services." (Carmarthen public drop-in event)*
>
> *"More chance of recovery if you got to a centre of excellence." (Aberaeron public drop-in event)*

5.56 These respondents thus supported the principle of centralisation where it leads to better clinical outcomes, provided that the specialist centres are adequately resourced and complemented by strong community-based rehabilitation.

> *"I can see the sense of it … if I was a recipient I would want to be in a specialist unit." (Fishguard public drop-in event)*

5.57 A minority of attendees in Aberystwyth and Machynlleth also explicitly acknowledged that, given most of the Health Board's population lives in the south, consolidating stroke services in that area may offer operational benefits.

General views: opposition to reducing services at Bronglais hospital

5.58 Across northern areas of the Health Board and bordering communities, particularly at the Aberystwyth, Aberaeron, Machynlleth, and Tywyn public drop-in events, there was strong opposition to any reduction of stroke services at Bronglais. Attendees described Bronglais as a trusted and high-performing local service providing *"lifesaving"* care, and many argued that it already offers the best stroke service within the Health Board.

> *"Why downgrade the Stroke Unit at Bronglais? It's the best unit. Why move it to Prince Philip? It doesn't make sense" (Aberaeron public drop-in event)*

5.59 More widely, attendees described the hospital as a "*trusted, high-performing local service"* central to rural healthcare and wellbeing not just in Ceredigion, but also in parts of Powys and south Meirionnydd. There

was thus strong support for investing in Bronglais as a centre of excellence for stroke care in mid Wales which, it was said, would attract staff and strengthen local provision.

> *"… Keep and expand Bronglais into a 'centre of excellence for mid-Wales' as the biggest hospital for 50 miles around …" (Aberystwyth public drop-in event)*

5.60 The Tywyn event produced some of the strongest feedback across the consultation relating to stroke care. Attendees repeatedly emphasised long distances, the loss of the 'golden hour', fears about transfers to South Wales, and overwhelming support for retaining a full stroke unit at Bronglais.

> *"Taking it away from Tywyn is bad enough – taking it away from Bronglais is terrible." (Tywyn public drop-in event)*

5.61 Additional views from Tywyn and surrounding rural areas further emphasised the risks of centralising stroke care. Attendees expressed strong concern that any shift of acute stroke services further south would significantly disadvantage communities on the Meirionnydd coast, given long travel distances, limited ambulance availability, and the reliance of many families on farming or shift-based work.

> *"Stroke services is a huge family concern … Would be a real struggle for families who are single parent families, or agricultural where individuals need to be on the farm as well as with their family if service was to move further away. Would need community support." (Tywyn resident at the Bronglais outpatients' session)*

5.62 If either consultation option is implemented, many attendees feared that it would be the 'beginning of the end' for all stroke services at Bronglais, not least as staff would likely prefer to work in a more specialist environment.

> *"If you take the specialist stroke to Prince Philip, then the staff will move there and won't want to work in Bronglais." (Machynlleth public drop-in event)*

General views: travel, rurality, and access concerns

5.63 A central concern across most events where stroke services were discussed was the impact of distance and poor transport links (especially public transport links) on timely stroke care, family access, and equality of service in rural Wales. Many attendees expressed anxiety about longer travel times, particularly for emergency cases, and questioned whether timely treatment could be guaranteed in rural areas.

> *"Makes you wonder if you would survive a journey for an hour in some conditions." (Haverfordwest public drop-in event)*

5.64 Many comments highlighted the importance of local access to support family involvement, which is crucial for patients' emotional wellbeing and recovery. Travel to more distant hospital sites, and the potential cost of lengthier journeys, was seen as a major barrier in this respect.

> *"So Llanelli or Haverfordwest, both are one- and-a-half hours from home that's a concern. Family visiting for care … it's a long time for many" (Aberystwyth public drop-in event)*

5.65 A couple of attendees, though, commented that families knowing their loved ones were receiving the best care should outweigh any considerations of distance.

General views: understanding and perception of 'treat and transfer'

5.66 Importantly in the context of the views expressed above, many attendees were unclear about the proposed 'treat and transfer' model and were of the belief that emergency stroke care would no longer be available locally.

> *"The message about it being a treat and transfer isn't coming across at all." (Machynlleth public drop-in event)*

5.67 Many, once informed, remained sceptical about how effectively the model could operate given rural transport challenges. They also asked questions about the timing of transfers, staff escorts, and how the health board intends to ensure patient comfort and safety during transfer.

> *"… Logistically, how is it going to be managed safely? … I am anxious about thrombolysis and moving patients, I want to know after how many hours you will do the transfers." (Machynlleth public drop-in event)*

5.68 Moreover, there was significant concern (especially at the Aberystwyth drop-in event) around ambulance availability - including for wider emergencies if ambulances are 'tied up' making patient transfers - and the potential for delays during transfer.

> *"… We haven't got the ambulances to be able to transfer patients." (Aberystwyth public drop-in event)*
>
> *"It's an hour and a half to Llanelli; the ambulance would be out of the loop for four hours." (Aberystwyth public drop-in event)*

5.69 A few attendees across several sessions, though, said they had been reassured by the information provided by Health Board staff about 'treat and transfer' at the event they had attended.

> *"It helps to speak to you to understand a bit more as the general message that has gone out is that there will be no unit in Bronglais and Glangwili and that you would have to go for care in Llanelli or Withybush" (Cardigan public drop-in event)*
>
> *"… That's where future lies , with the ambulance. If someone is qualified to give first injection than doesn't matter if its two to three hours down the road as long as they have had initial treatment." (Tywyn public drop-in event)*

General views: rehabilitation and community care

5.70 In the event of service consolidation, there was strong support for providing stroke rehabilitation and therapy closer to home once patients are stable. Attendees felt this would help mitigate travel burdens for families and aid recovery.

> *"I think you'd be better moving it from Bronglais for something specialist, but after a week, making sure they can come back to community or Bronglais hospital / rehabilitation …" (Machynlleth public drop-in event)*
>
> *"We need rehab centres where people can get to them. People don't mind travelling for specialist services, but they don't want to be far from support." (Aberystwyth public drop-in event)*

5.71 Furthermore, several examples were given to illustrate delays with care packages and rehabilitation, leading to long hospital stays and emotional strain. There was a strong sense that "e*arly supported discharge needs to be looked at …" (Llanelli public drop-in event)* and that community-based care needs strengthening to ensure stroke patients can return to their homes and communities as soon as possible following a hospital stay.

5.72 To assist in providing this, some suggested developing community-based or tele-rehabilitation models to complement hospital-based provision as part of a modern, rural-friendly model of stroke care.

General views: workforce, capacity, and service clarity

5.73 Attendees requested further detail about staffing, bed capacity, and the range of services that would be available at each site under the stroke options, including for patients with complex conditions and co-morbidities. Many emphasised the need for clear, accessible communication about these issues – as well as clinical pathways, patient safety, and transfer arrangements.

Suggested alternatives and mitigations

5.74 Alternative models proposed by attendees included:

- locating one stroke centre in the north (e.g., Bronglais) and one in the south (e.g., Glangwili or Prince Philip) of Hywel Dda.
- establishing a dedicated stroke unit in Aberystwyth (e.g. in Bronglais or at the Llanbadarn Campus).
- providing 24-hour stroke care at Withybush rather than Prince Philip.
- centralising care at Glangwili rather than Prince Philip given its centrality and better transport links for people across the wider health board area.
- developing cross-border arrangements with Swansea Bay University Health Board, particularly given Llanelli's proximity to Swansea.
- providing accommodation at local hospitals (e.g. Tywyn) and implementing a rotation model for specialist staff to visit patients.
- deploying specialist staff across sites to reduce patient travel.

> *"Why can't the specialists move to Aber instead of 30 patients moving to them?" (Machynlleth public drop-in event)*

» local rehabilitation and better use of telemedicine.
» a dedicated transfer service staffed by paramedics with stroke expertise.
» providing accommodation for families.

> *"Recognise the benefits that co-locating services can bring [but] it needs to be with support for family, ensuring they have a good place to stay ... Would need community support." (Tywyn resident at the Bronglais outpatients' session)*

5.75 Addressing stroke configuration strategically on a national footprint was also urged by a few attendees (particularly in light of the National Stroke Programme), as was looking at the way other countries with large rural areas provide stroke services. The example given was the provision of thrombectomy, whereby countries like Norway have demonstrated that even small, rural communities can support this with local helipads to enable fast access to treatment.

Urology

General views

5.76 Attendees often described good experiences of care once within the urology pathway, praising the professionalism and expertise of clinical staff. However, this was accompanied by frustration around access difficulties and subsequent delays.

> *"… Once you're on the pathway, great [but] getting on the pathway with the GP is difficult." (Carmarthen public drop-in event)*

5.77 Many attendees reported that urology services feel disjointed, with appointments and investigations spread across multiple sites, inconsistent communication between clinical and administrative teams, frequent appointment cancellations, and reliance on telephone consultations which, though convenient for some, were described as unsatisfactory for complex or sensitive discussions.

> *"For urology services I started in Prince Philip, then Glangwili, then Withybush – it is higgledy piggledy." (Cardigan public drop-in event)*

5.78 The fragmentation of care pathways and poor communications were also said to lead to confusion around test results and follow-up.

> *"I was told in March I would have a biopsy… I rang admissions and still haven't had a response." (Llanelli public drop-in event)*

Views on the options

5.79 In light of the above, several attendees expressed support for centralising urology diagnostics and treatment on a single site, describing it as logical and efficient – particularly for urgent suspected cancer (USC) cases.

> *"It's a good idea to come together [on one site] for a quicker diagnosis." (Prince Philip outpatients session)*

5.80 However, caution was expressed around the suitability of the one-stop-shop approach for older patients, and the logistical, financial and emotional difficulty of travelling long distances for appointments (often at inaccessible times necessitating expensive hotel stays and taxis) - particularly for older or frail patients in rural areas.

> *"Older patients might not be able to do everything in one day. However, I assume assessments would be done on the day to assess if they could." (Carmarthen public drop-in event)*

5.81 Moreover, in remote rural and coastal areas, attendees highlighted that ageing populations would increase demand for urology services and exacerbate any accessibility challenges. They thus urged planners to take future demographic trends into account when determining service locations and capacity.

Suggested alternatives and mitigations

5.82 Alternatives and mitigations proposed by attendees were to:

- retain some local outpatient and follow-up clinics (especially for catheter care and minor procedures).
- establish local specialist nurse-led urology support, especially for catheter management and to offer continuity, reassurance, and clear information throughout treatment.
- consider radiotherapy provision within Hywel Dda to reduce travel to Singleton Hospital.

The future role of Hywel Dda's main hospitals

Bronglais

5.83 The Health Board aims to maintain current services at Bronglais, with the potential redistribution of some specialities across other Hywel Dda sites.

5.84 As highlighted in the stroke feedback earlier in this chapter, there was strong support for Bronglais, with many attendees describing it as vital for rural mid Wales. There were numerous positive references to staff, care quality, and Welsh-language provision; and its centrality was said to make it symbolically and geographically important to residents of Ceredigion, parts of Powys, and south Meirionnydd.

> *"Why does … Ceredigion have to take the brunt of having services stripped away …? I don't understand at all why with our geography we just don't have the services. How can they ignore the centre of Wales. We will end up with a compromised service. It's highway robbery …" (Aberaeron public drop-in event)*

5.85 As such, attendees were supportive of retaining as many services as possible at Bronglais. In fact, there was a desire for investment to upgrade and expand the hospital rather than service removal.

Glangwili

5.86 The Health Board intends to provide more acute and emergency care at Glangwili, with some planned care moved to other sites, either by service or health condition.

5.87 There were mixed views on this approach for Glangwili. While there was some support for concentrating emergency care there in principle, the hospital itself was described as in a state of some disrepair.

> *"… Glangwili is crumbling!" (Llanelli public drop-in event)*

5.88 There was also concern about overloading the site, which is already under some pressure. This led many people to question whether Glangwili can safely absorb more acute demand.

> *"… It's more pressure on Glangwili and they can't cope." (Ammanford public drop-in event)*

Prince Philip

5.89 The Health Board intends to provide more planned care from Prince Philip, particularly across a wider region where services are delivered in partnership with Swansea Bay University Health Board.

5.90 There was support for closer collaboration with Swansea Bay University Health Board and agreement that Prince Philip is the correct location from which to achieve this, as well as positivity around making better use of the hospital as the health board's newest, most modern main facility.

> *"I like that Prince Philip will be used more. It does feel like a cottage hospital at times." (Llanelli public drop-in event)*

5.91 However, there was also scepticism around the motivation for focusing planned care in Prince Philip, with several comments along the following lines:

> *"Everything is Prince Philip, Prince Philip, Prince Philip, just trying to find a reason to keep it open." (Aberystwyth public drop-in event)*

Withybush

5.92 The Health Board intends to provide more planned care from Withybush, particularly within the Hywel Dda area, with initial access to acute care remaining on site, but transfers to Glangwili for patients with the highest needs.

5.93 There were repeated concerns about consistent, long-term service loss at Withybush, as well as a perception of Pembrokeshire being marginalised or excluded from centralisation, most of which is happening at Glangwili or Prince Philip.

> *"On the whole it feels services are being pulled out of Withybush, but nothing is coming back. We feel we need to travel out for service." (Pembroke Dock public drop-in event)*

5.94 There were particular concerns about acute pathways, and that Withybush will eventually become a planned care hospital by stealth. Several references to population increases in summer and the distance to other hospitals were thought to reinforce the importance of keeping acute stabilisation locally.

Some overall support

5.95 Despite concerns around the proposed approach to provision at the individual hospitals, there was some support for the overall configuration proposed by the Health Board and acceptance that in an area as large, rural, and sparsely populated as Hywel Dda, not all services can be provided everywhere.

> *"Got to accept that we can't have everything in Bronglais like big hospitals due to population" (Machynlleth public drop-in event)*
>
> *"Does Bronglais have enough various cases to have speciality of doctor? ..." (Tywyn public drop-in event)*

5.96 Ultimately, as one Carmarthen attendee stated:

> *"We want to see good jobs, well maintained clean buildings, embracing of the future rather than clinging desperately to the good old days. We need to see you striving to make it as good as possible for all." (Carmarthen public drop-in event)*

Cross-cutting themes

5.97 This section covers the cross-cutting themes raised across the public events and activities, which included travel, transport, and accessibility; staffing challenges; hospital site infrastructure and accessibility; navigating the health system; digital access and inclusion; equality issues; and public confidence and communication.

Travel, transport, and accessibility

5.98 Travel and transport was the most discussed topic at the public events and activities, both in relation to the consultation options (where discussed) and in a wider context. Attendees described long and expensive journeys to access healthcare services, particularly from remote rural areas with poor public transport links. Many older and disabled attendees said they must rely on relatives or community transport, which limits their independence and can lead to missed appointments; and attendees stressed that longer distances make visiting hospitalised relatives difficult, which can affect patient recovery and wellbeing.

> *"Travel is the biggest issue for people – whatever option you're talking about." (Ammanford public drop-in event)*

5.99 Several attendees stressed that if services are brought together at fewer hospitals, transport solutions must be sought ahead of implementing change. The fflecsi Bwcabus scheme in Pembrokeshire was praised by some; but also criticised for its limited capacity and coverage. Suggestions included expanding this model, providing dedicated hospital shuttle services, reviewing travel cost reimbursement, and parking policies for patients and carers; and aligning clinic times with public transport timetables.

5.100 The issue of ambulance availability has been frequently raised in the service-specific sections of this chapter above. However, we would reiterate that there was widespread anxiety across many events about ambulance availability, response times, and the safety of centralising time-critical services such as stroke and critical care. Common worries were around people having to self-present due to ambulance delays; ambulances queuing outside hospitals; and that travel times would negate any clinical benefit as a result of the Health Board's proposals.

> *"People are waiting six hours for ambulances… critical care services have to be on the doorstep." (Public online event - critical care, emergency general surgery, stroke)*

Staffing challenges

5.101 Concerns around staffing were also among the most prevalent themes raised at the public events and activities. While many attendees expressed admiration for the commitment and professionalism of the local workforce, they also understood the Health Board's recruitment difficulties; and described overstretched staff, a heavy reliance on agency cover, and repeated vacancy cycles that damage continuity of care.

> *"Whatever service you're talking about, staffing is always at the heart of it." (Carmarthen public drop-in event)*

5.102 Several attendees at the Glangwili outpatient sessions also linked local GP access issues to increasing pressure on A&E departments, saying that long waits for primary care appointments left many people with no option but to attend emergency departments. This was seen as contributing to overcrowding, longer waits, and delays in emergency pathways.

5.103 There was scepticism that moving or centralising services would resolve workforce shortages. Some questioned how the Health Board could attract new clinicians if wider housing, schooling, and family relocation issues were not addressed in parallel. Others felt that removing acute or specialist services from smaller hospitals would de-skill staff, reduce training opportunities, and make those sites less appealing places to work.

> *"If you take services away, you de-skill the hospital and make it harder to recruit." (Haverfordwest public drop-in event)*

5.104 Several public drop-in attendees argued for investment in local training pathways, apprenticeships and rotational posts to 'grow our own' workforce and keep young professionals in west Wales. Other suggestions were to provide targeted recruitment incentives for rural and coastal areas, including relocation and training packages; and publish a transparent workforce plan showing how posts will be distributed and supported across the region.

Site infrastructure and accessibility

5.105 Across the public events and activities, attendees expressed strong views about the condition and suitability of hospital buildings and supporting infrastructure across the Hywel Dda area.

5.106 Many attendees highlighted the poor condition of Withybush and said it felt neglected compared with other sites. Despite this, people spoke with pride about the staff and services that continue to operate there and called for urgent refurbishment and reinvestment to bring facilities up to modern standards. This, it was felt, would demonstrate continued commitment to local provision, even if some acute services are brought together elsewhere.

5.107 Parking was one of the most raised practical concerns, with all sites said to suffer from a lack of parking for patients, visitors, and staff. Attendees said that queues, inaccessible bays, and limited drop-off spaces can result in lateness, missed appointments, and a great deal of stress. Specifically, some said that introducing more services or emergency capacity at Glangwili would make parking impossible there.

5.108 Beyond parking, people highlighted wider infrastructure challenges: for example, the single access road to Glangwili was described as frequently congested and unsafe for ambulances.

> *"Parking is a nightmare everywhere." (Llanelli public drop-in event)*

5.109 Others noted that existing estates and utilities were already operating close to full capacity, questioning whether large-scale service transfers could be accommodated without major redevelopment. A recurring view was that any model of care must be grounded in the physical realities of the hospital sites, with several attendees warned against designing services that cannot be properly housed or staffed.

5.110 Attendees' other key recommendations were that Hywel Dda should:

- undertake comprehensive site-capacity and infrastructure assessments before finalising service reconfigurations.
- review parking provision and access routes at Glangwili and Prince Philip, exploring options such as park-and-ride or shuttle systems.
- communicate clear plans for phased capital development so that communities understand how each site will evolve within a new service model.
- maximise local hospitals (Tywyn and Dolgellau for example) by providing step-down care, rehabilitation, and 'one-stop' clinics.

Navigating the health system

5.111 Feedback from the Bronglais and Glangwili outpatient sessions highlighted persistent inconsistency between hospital sites, with some patients moved repeatedly between Glangwili, Prince Philip and Withybush for the same condition. This was described as confusing, stressful and inefficient, often caused by administrative issues, cancelled appointments or lack of coordination between departments. Several patients said these cross-site movements felt unnecessary and undermined confidence in the system.

> *"I've been sent from Bronglais to Glangwili, then to Prince Philip, then back again for the same condition – it's exhausting and confusing." (Bronglais outpatients session)*

5.112 Many attendees at the public events and activities described confusion around which hospital provides which service. There was also uncertainty in relation to referral processes, post-operative follow-up, and discharge arrangements; particularly between Hywel Dda and neighbouring health boards.

5.113 Attendees thus recommended that the Health Board should produce and publicise clear pathway information for staff and the public, showing where each service is delivered; standardise discharge and referral information across hospital sites; and develop a single point of contact or liaison role to guide patients through inter-hospital transfers.

Digital access and inclusion

5.114 While some public event attendees appreciated virtual medical consultations for convenience, others - particularly older adults and those in rural areas - felt excluded by poor internet connectivity or limited digital literacy. In this context, several emphasised that digital tools should supplement, not replace, face-to-face care; and it was suggested that Hywel Dda should:

- maintain telephone and face-to-face options for appointments and feedback.
- provide support and training for patients who wish to use digital platforms.
- assess broadband coverage and device access before increasing reliance on online systems.

5.115 Public feedback reflects both acceptance and concern: while people generally recognised that services must modernise, they feared that the process would exacerbate existing inequalities. Attendees thus urged the Health Board to ensure that any model of care balances modern approaches with local access, transparency, and practical support for patients and staff.

Perceived inequalities between counties

5.116 A strong theme across the public events and activities was a perceived inequality between counties. Attendees in Pembrokeshire frequently said services had been 'taken away' from Withybush to strengthen Glangwili, which they saw this as part of a longer pattern of eastward drift in investment and senior staffing. Indeed, Withybush was described as worn down and underused, with fears that its condition is being used to justify further service removal.

5.117 Residents in Ceredigion and south Gwynedd also raised fairness concerns, noting that while services are frequently centralised eastwards, travel burdens are rarely shared equitably across the health board. Some emphasised that journeys from areas such as Aberaeron, Tywyn and rural Ceredigion to Glangwili or Prince Philip are significantly longer than those made by communities in the east.

> *"Journeys from here to Glangwili are on a completely different scale." (Tywyn public drop-in event)*

5.118 Attendees also questioned whether Glangwili could physically and operationally absorb the extra emergency demand that might result from these changes, given its limited parking and congested access roads.

5.119 It was recommended that the Health Board should ensure capital investment and refurbishment are equitably distributed across all main sites; publish comparative information on capacity, investment and staffing to demonstrate fairness; and recognise the symbolic importance of local hospitals as part of community identity and trust in public services.

Other equality issues

5.120 Attendees across all public events and activities highlighted that changes to hospital locations and care models could disproportionately affect certain population groups.

5.121 Older people, those with disabilities, people with mental health issues or neurodivergence, residents in rural communities, and those with limited financial means were viewed as most likely to be disadvantaged by increased travel distances and/or costs. Many said they rely on relatives, community transport, or taxis for hospital appointments, and that long journeys or overnight stays (which are sometimes needed in the event of early morning appointments at distant hospitals) are often unaffordable or impractical.

5.122 On a related note, many unpaid carers were said to already face significant strain, which could be exacerbated by having to travel longer distances to take loved ones to appointments or visit them in hospital. This was again considered especially problematic for elderly carers.

> *"Elderly couple caring for each other – what do you do if one has an appointment? Who looks after the other?" (Haverfordwest public drop-in event)*

5.123 Attendees also highlighted that people working in farming, agriculture and shift-based employment may be disproportionately affected by increased travel times. These groups often have limited flexibility to leave work, rely heavily on private transport, and may face loss of income or inability to arrange cover for longer journeys, increasing the risk of missed or delayed care.

5.124 Attendees in Pembrokeshire described particular challenges if services were to move from Withybush to more distant hospitals, noting that poor public transport and limited mobility options could lead to missed appointments or delayed care. Similar concerns were expressed across Ceredigion - particularly in the Bronglais catchment - where long travel distances, limited bus timetables, and reliance on private or community transport were also seen as major barriers. Comparable issues were raised in Carmarthenshire regarding access to Prince Philip from more remote areas.

5.125 It was also noted that recovery and rehabilitation are often language-dependent and that being treated in English-speaking areas could hinder recovery for Welsh-speaking patients, especially those without advocacy support from family or friends. This was considered especially relevant within stroke services, as many patients were said to revert to their mother tongue following a stroke.

> *"This is a Welsh-speaking area. If you put stroke patients in areas where Welsh is spoken less, it would be more difficult to rebuild their mental pathways." (Aberystwyth public drop-in event)*

5.126 Many comments emphasised compounding disadvantage, for example an older Welsh speaker with limited mobility living in rural Ceredigion facing multiple overlapping barriers if services centralise southwards.

Public confidence and communication

5.127 While attendees appreciated the opportunity to discuss the CSP proposals in person at the public events, many questioned whether their input would genuinely influence final decisions. Recurring comments were around decisions having already been made, repeated consultations that do not lead to visible improvement and distrust in the Health Board because of previous service changes (especially at Prince Philip and Withybush). Some said they had not heard of the consultation until the event itself, and others described the online questionnaire as challenging to navigate for older people or those without digital access.

> *"You say you have no preferred options, yet history shows that you ignore the needs and opinions of Pembrokeshire … Health Board rhetoric does not match the lived experience of staff or patients." (Public online event – urology, endoscopy, radiology)*

5.128 As alluded to in the quotation above, there was also frustration at what attendees saw as a disconnect between Health Board messaging and lived experience: it was said that Health Board assurances about safety and resilience *"does not match what staff and patients experience day to day."* This mismatch has led to diminished public confidence, with many attendees urging the Board to demonstrate transparency and accountability before implementing further change.

5.129 Attendees recommended that the Health Board should:

- publish impact assessments of previous service changes, including effects on patients and staff.
- provide plain-language updates explaining how consultation feedback shapes final decisions.
- maintain open engagement with communities beyond formal consultation windows.
- provide clear, accessible public information - both written and verbal - to help older people and people with sensory or cognitive impairments understand future service changes.
- using national coordination for decisions affecting mid Wales.

6. Staff Meetings

Overview

6.1 During the consultation period, the Health Board hosted and attended a series of events with staff and healthcare professionals, which included 'drop-in' style sessions, ward 'walkarounds,' meetings and workshops at locations across the Hywel Dda area and online.

6.2 In total, the Health Board undertook 58 events and meetings, engaging with almost 2,112 members of staff and other healthcare professionals. Information about the meetings from which ORS has received feedback notes were as follows.

Table 30: Staff drop-ins and meetings - dates and attendance

Group	Date	Number of attendees
Staff Drop-in events/walkaround		
Llandovery Hospital drop-in and walkaround	2 June 2025	12
Amman Valley Hospital drop-in and walkaround	2 June 2025	16
Tenby Hospital drop-in and walkaround	3 June 2025	10
South Pembrokeshire Hospital drop-in and walkaround	3 June 2025	37
Aberaeron ICC drop-in and walkaround	4 June 2025	21
Cardigan ICC drop-in and walkaround	4 June 2025	37
Bronglais drop-in and walkaround	5 June 2025	75
Withybush drop-in and walkaround	9 June 2025	110
Prince Philip drop-in and walkaround	10 June 2025	126
Glangwili drop-in and walkaround	12 June 2025	143
Glangwili walkaround	29 July 2025	79
Prince Philip walkaround	30 July 2025	87
Bronglais staff walkaround	5 August 2025	23
Withybush walkaround	6 August 2025	107
Meetings		
Medical Leadership Forum	30 May 2025	16
Have your Say – Clinical Services Plan Consultation (virtual session for all staff)	2 June 2025	291
Nursing Professional Standards Team	4 June 2025	9
Meeting with General Manager	9 June 2025	1
Senior Allied Health Professional and Health Sciences Professionals Forum	10 June 2025	18

Group	Date	Number of attendees
Digital Service Team	10 June 2025	5
Prince Philip Intensive Care Unit	10 June 2025	20
Healthcare Professionals Forum	16 June 2025	12
ARCH Regional Stroke Programme Workshop	16 June 2025	13
Finance Team	17 June 2025	35
Health Board-wide Medical Staff Committee	18 June 2025	20
Estates/capital update meeting	19 June 2025	15
Mid Wales Clinical Advisory Group	23 June 2025	7
Finance Senior Management Team meeting	24 June 2025	10
Clinical Reference Group	24 June 2025	10
Health Board Grand Round at Bronglais	25 June 2025	77
Dermatology Business Meeting	25 June 2025	13
Ceredigion Staff Partnership Meeting	1 July 2025	15
Glangwili Medical Consultants	1 July 2025	14
Mid Wales Stroke Task and Finish Group	1 July 2025	10
Local Negotiating Committee	3 July 2025	9
Workforce and organisational development event	3 July 2025	108
North Road Eye Clinic	7 July 2025	9
Withybush Medical Staff Committee	7 July 2025	12
Stroke Physiotherapy	8 July 2025	11
Senior Nurse Management Team	14 July 2025	15
Prince Philip consultants	14 July 2025	15
ARCH Regional Orthopaedics Programme Board	14 July 2025	13
Staff Partnership Forum – including Trade Union briefing	15 July 2025	14
Bronglais Surgical Consultants Meeting (EGS)	16 July 2025	12
Prince Philip stroke ward	16 July 2025	8
Pharmacy services	22 July 2025	14
Withybush medical consultants	24 July 2025	8
Cyfarfod tîm Hywel Dda team meeting (online – all staff)	24 July 2025	210
Glangwili radiology staff	29 July 2025	27
Bronglais radiology staff	5 August 2025	18

Group	Date	Number of attendees
Withybush radiology staff	6 August 2025	14
Withybush stroke staff	6 August 2025	8
Bronglais consultants	7 August 2025	11
Capital Planning	12 August 2025	8
Prince Philip pharmacy staff	12 August 2025	40
Prince Philip radiology staff	14 August 2025	7
Healthcare Professionals Forum	15 August 2025	10
Meeting with Optometrists	27 August 2025	17

Main findings from staff events

Critical care

Views on the options: general

6.3 Serious concerns were raised about the cost, safety, and patient experience of transferring the sickest patients between hospitals.

6.4 Staff - mainly from Prince Philip - emphasised the risks of transferring critically ill patients over long distances, the emotional and financial burden on families required to travel to Glangwili, and the environmental and cost implications of increased patient transport. Several staff recalled instances where patients required transfer from Prince Philip to Glangwili, highlighting their families' distress and ambulance staff safety concerns as reasons to advocate for better ICU support at Prince Philip.

> *"Transferring teams are concerned that patients die on the way. Is that the best way?" (Prince Philip staff)*

6.5 On a related note, staff expressed significant concern about the current and future capacity of the ACCTS and WASUT to manage patient transfers, noting that delays pose serious risks to patient safety and service efficiency. Several respondents questioned how timely transfers would be achieved under the proposed changes and suggested reviewing WASUT's transfer criteria, including the use of blue-light transfers for critical patients. Others proposed exploring alternative or interim solutions such as developing an internal transfer system (similar to the Aneurin Bevan model) to reduce reliance on WASUT while wider funding issues are addressed. It was also noted that enabling local anaesthetists to operate could help reduce transfer demand and associated costs.

6.6 Staff emphasised the need for greater transparency and clarity around workforce planning and associated costs within the options, particularly from an Allied Health Professional lens. A few felt that staffing cost estimates should clearly outline what is included - such as training, long-term recruitment, and therapy-related expenses - and reflect the reality of national shortages of critical care consultants, nurses, and other healthcare professionals, which limit recruitment capacity.

6.7 Several staff members raised concerns that none of the proposed options include changes to the ICU at Bronglais, despite indications that it is less compliant with standards than the other ICU sites.

6.8 There was some discussion around the categorisation and terminology used for critical care pathways. At the medical leadership forum, one attendee highlighted different levels of care between ECU sites, calling for more a more precise definition of ECUs in the proposals. Another point raised by several participants was around the tendency to put patients on the critical care pathway instead of the more appropriate surgical pathway. It was said that this should be considered when 'playing the numbers game', to determine the best options for critical care.

> *"We need to be careful about how we define ECU. We will need to consider what can be delivered at each of these sites that the medical team are comfortable to deal with." (Health professional)*

6.9 A few staff also noted the value of digital technologies in critical care, arguing for the inclusion of this in all proposed options.

General views: critical care at Prince Philip

6.10 There was widespread feedback about the current critical care provision at Prince Philip. This feedback has been reported as a standalone section due to the volume of comments and its overall impact on the service.

6.11 Staff feedback on the current ICU at Prince Philip revealed concern, frustration, and loss of confidence in the sustainability, direction, and fairness of critical care provision at the site. Staff described an unsafe and unstable environment, marked by workforce shortages, poor communication, and a perception that the service has been systematically downgraded without clear justification or plan for recovery.

> *"During COVID we were very busy in critical care. Now we don't know what is going on as staff are being moved to other areas." (Prince Philip staff)*

6.12 The staffing situation was described as critical, with too few consultants (four or five instead of the eight needed for a sustainable rota), high sickness absence (up to 50%), and increasing turnover. Staff reported feeling undervalued, with experienced ICU nurses being repeatedly redeployed to general wards, leading to burnout and de-skilling; and the sickest patients being transferred elsewhere, leaving an underutilised unit and staff feeling disengaged and, again, de-skilled. Staff welcomed practical steps to mitigate these issues, such as virtual ward rounds.

6.13 There was recognition that workforce issues are not unique to Prince Philip, but staff felt that vacancies have been preferentially filled at Glangwili, worsening local shortages and eroding trust. Feedback also highlights difficult professional relationships between the Prince Philip and Glangwili intensive care teams, characterised by lack of ownership, communication barriers, and inconsistent application of patient transfer criteria.

6.14 Despite these challenges, staff were proud of their skills and commitment to patient care; and said they would continue to seek constructive solutions to maintain a viable level of critical care in Llanelli.

Views on the options: Option A

6.15 While a few participants expressed support for Option A, citing the potential effectiveness of replacing Intensive Care Units (ICU) with Enhanced Care Units (ECU), most of the feedback received raised concerns about the proposed changes to critical care services at Withybush under this option.

6.16 Withybush staff saw Option A as a 'downgrade' of their hospital to facilitate improvements at Glangwili. They highlighted that Withybush is the only acute hospital in Pembrokeshire, serving a growing and geographically dispersed population; and that any reduction in critical care capacity could have far-reaching implications for patient safety, service sustainability, and staff morale.

6.17 Withybush staff also described existing staffing pressures due to sickness, maternity leave, and recruitment and retention issues. Many felt that transferring patients between hospitals would further strain resources, as staff accompanying transfers would leave on-site teams short-staffed. In light if this, there was support for a dedicated and well-resourced transfer service to support any centralised model; and training nursing or paramedic teams in patient transfer and enhanced care delivery could, it was felt, mitigate some concern around transfer staffing.

> *"If the transfer is not in place and we rely on ODP's (Operating Department Practitioner) to transfer, there would be an impact on staff at Withybush." (Withybush staff)*

6.18 Some Withybush staff questioned whether all potential consequences and interdependencies - particularly in relation to emergency general surgery, respiratory care, renal services, and stroke services - had been fully considered. Particular concerns were expressed that removing ICU provision at Withybush could undermine existing medical and surgical pathways, elective surgery capacity, and the hospital's ability to maintain a safe and resilient emergency department. They also questioned how:

- » enhanced care or post-anaesthetic care units (PACUs) would be safely staffed, governed, and clinically supported, particularly in terms of intensivist oversight, medical leadership, and clear operational lines of accountability.
- » staff would retain opportunities to maintain advanced clinical competencies if Withybush were to lose its ICU, as not being able to do so would make the roles less attractive to existing and prospective employees.

6.19 Staff also indicated concern about the capacity and deliverability of centralising intensive care at Glangwili under Option A. There was a feeling that Glangwili's ICU is already operating at full capacity and would struggle to safely accommodate additional patients from Withybush and Prince Philips. This, it was said, could lead to bottlenecks, delayed transfers, and increased risks for patients requiring intensive care.

6.20 In contrast to Withybush staff, some feedback from Prince Philip staff shows support for the concept of an ECU as a pragmatic and potentially safer alternative to the current unsustainable ICU model (as reported above). Staff viewed the ECU as an opportunity to deliver a more realistic, intermediate level of care, providing local access for appropriate patients while maintaining strong links to higher-acuity centres. However, they emphasised the importance of:

- » a dedicated medical and nursing workforce, including at least three consultants.
- » minimum six to eight bed capacity to meet clinical demand.
- » formalised standard operating procedures (SOPs), multidisciplinary team (MDT) structures, and transfer protocols.

» robust clinical governance and equity of access across the region.

6.21 There was also some wider concern about the complexity and cost of establishing an ECU. Without proper planning, safeguards, investment, and governance, staff warned that the model could create new risks, reduce confidence in patient safety, and widen disparities between sites. Moreover, they said that without careful definition and support, there is a risk that patients who could currently be managed locally would instead require transfer to Glangwili or Morriston Hospitals.

Views on the options: Option B

6.22 There was some support among Withybush and Glangwili staff for Option B, although others queried whether it was *"just maintaining the status quo."* The comments reported above in relation to having an ECU at Prince Philip are also applicable to this option.

Views on the options: Option C

6.23 Generally, views on Option C were divided. While a couple of staff members disagreed with the proposal to keep ICUs at the four main hospitals, several others at Withybush, Prince Philip, and Glangwili stated a strong preference for this option. They stressed the value of ICUs, noting how this value was realised during the Covid-19 Pandemic as a lesson for future service planning. It was also felt that this option would be *"safer"* and make the *"most people happy"*, even with reduced beds.

> *"No brainer is Option C and keep most people happiest" (Withybush staff)*

6.24 On the other hand, many attendees had the view that developing or maintaining a full ICU at Prince Philip is not deliverable, safe, or sustainable within the context of existing workforce and resource constraints. The scale of recruitment required - particularly for consultant intensivists and anaesthetists - was described as unrealistic, and the patient volume at Prince Philip was not considered sufficient to justify the financial or workforce investment – especially compared to neighbouring hospitals that already provide critical care.

Suggested alternatives and mitigations

6.25 Some specific alternatives suggested by staff attendees were as follows.

» ICUs at Withybush and Glangwili; and ECUs at Bronglais and Prince Philip.
» use Prince Philip ITU as a medical HDU.
» Prince Philip service to be led by senior anaesthetics combined with medical consultants.
» split Glangwili's critical care resources in half, giving half to Swansea Bay University Health Board to serve the east of the Hywel Dda area, and divide the other half between Bronglais and Withybush.

Dermatology

General views: workforce and sustainability challenges

6.26 Staff highlighted significant workforce and service sustainability challenges within dermatology. In particular, they said that:

- clinical experience and teamwork are critical to safe and effective dermatology care, yet current service models leave many clinicians working in isolation without access to peer support or specialist advice.
- resident doctors have reported low confidence and high workload pressures, compounded by the absence of a substantive clinical lead.
- the lack of on-site dermatology presence can erode general medical knowledge and skills over time, with a need for regular teaching, annual educational sessions, and CPD opportunities (such as Grand Rounds) to maintain competence and ensure timely escalation of complex cases.
- while inpatient dermatology needs are infrequent, serious conditions such as life-threatening eczema or severe drug reactions highlight gaps in access to specialist input, particularly at Bronglais.

> *"…not having the service on site means that doctors' knowledge of dermatology dwindles away due to lack of sub specialities on site." (Bronglais staff)*

6.27 Some said that with rising demand for skin cancer support and minor operations, there is an urgent need to future-proof the service and rebuild a coordinated, well-supported workforce. Conversely, others felt the Health Board should think practically about the future of dermatology – and consider the likelihood of it still being delivered in Hywel Dda and options to support out of area treatment.

General views: tele-dermatology

6.28 Several attendees commented on the use of technologies such as Consultant Connect, TeleDerm, and medical photography in the dermatology service to provide a timely and useful service for patients. More widespread use of these technologies could, it was felt, create a *"more robust"* service and reduce waiting times for patients.

Views on the options

6.29 There were very few comments relating to the options for dermatology at the four main hospital sites; therefore, the feedback has been brought together into a summary, as the number of comments was insufficient to discuss each option individually. There was some support for the consolidation of - and further investment in - dermatology services at Prince Philip; but also some questions around how staff at Glangwili would treat inpatients with dermatology concerns if current services were to be removed from the site.

6.30 Staff shared more views on the proposed changes to community-based dermatology. There was scepticism around the proposal for 'some minor operations in GP practices' (Options B and C), as procedures can often be complex and time consuming, leading staff to question the capacity and willingness of GPs to undertake them. One staff member also questioned the additional costs in the consultation information, particularly whether these include commissioning GPs for additional dermatology operations

6.31 Despite this, though, there was some feeling that this element should have been included in all four options due to the likeliness of it being implemented in future. In this event, one participant stressed the importance of effective linkages between GPs and the proposed consolidated team at Prince Philip.

6.32 There was also scepticism around the proposal for 'some nurse-led paediatric clinics' at Cross Hands Health Centre under options C and D, as there is no formal agreement of funding or scope for dermatology at this location – leading staff to question whether the cost of developing the service was included in the estimated costs of these options. Nurse-led provision was supported in principle though: it was noted that the current dermatology service at Cardigan Integrated Care Centre works well.

Suggested alternatives and mitigations

6.33 Some specific alternatives suggested by staff attendees were as follows.

- run some clinics from Borth.
- Use Canolfan Pentre Awel in Llanelli for aspects of the service.

Emergency general surgery

Views on the options: general

6.34 Staff were clear that emergency general surgery is clinically inseparable from services like critical care, anaesthetics, and emergency medicine. Proposals to bring emergency general surgery together onto fewer sites were thus viewed as high risk, particularly in rural settings.

> *"If you take emergency general surgery from Withybush, you will lose anaesthetists – not enough for them to do. Then you have no critical care, and then if you don't have critical care, you can't have A&E …" (Withybush staff)*

6.35 There was scepticism around the effectiveness and reliability of patient transfers under both proposed options, particularly in relation to:

- the often-slow transfers between Withybush and Glangwili due to difficulties finding beds and arranging transport, with some patients waiting days in sometimes life-threatening circumstances.
- the current transfer process being complex, understaffed, and disruptive to local services, while also deskilling staff at Withybush and reducing continuity of care.
- patients often enduring long, chaotic transfers, sometimes waiting hours in corridors and facing further waits if requiring specialist procedures.
- capacity and management concerns about how a limited transfer team would cope with increased demand.

6.36 Staff also shared concerns about job security, rota pressures, and post-operative care responsibilities:

- many at Withybush worried that their roles could be lost or relocated to Glangwili or Prince Philip, creating uncertainty that makes recruitment and retention more difficult.
- the surgical workforce was said to already face fragile rotas, with gaps and difficulties maintaining 24-hour cover across sites, raising doubts about whether merged or extended rotas would be sustainable.
- there were concerns that, if surgical services are reduced, medical consultants will bear greater responsibility for post-operative patients, requiring additional staffing and funding to ensure safe care.

Views on the options: Option A

6.37 Staff and healthcare professionals tended to support Option A, acknowledging it as an "*acceptable compromise*" that will provide better outcomes for patients and potentially attract staff. Nevertheless, numerous concerns were raised about staffing capacity, infrastructure, and parking at Glangwili. Indeed, a few attendees expressed concerns that Glangwili "*cannot cope*" with the additional patients it would be expected to accommodate under Option A. Several staff members at Bronglais also commented on the travel and transport impacts of this Option; notably the poor roads from West to East.

6.38 Withybush staff were much more critical of this option than other attendees, however. They feared that removing emergency general surgery would not only compromise patient safety but also risk the long-term viability of Withybush itself. Emergency general surgery was described as a cornerstone service that underpins anaesthetics, critical care, A&E, and acute medicine; and staff argues that without it, these interdependent services and associated training posts would be unsustainable.

6.39 Withybush staff also reported rising emergency and surgical demand, particularly during tourist seasons, and described current A&E processes as unsafe due to overcrowding and limited surgical decision-making capacity.

Views on the options: Option B

6.40 Numerous comments were made to suggest that Option B "*wouldn't work.*" Key reasons for this were that it would:

- » create confusion for both patients and staff regarding where surgery would take place.
- » reduce continuity of care, and complicate decision-making for unwell patients when consultants rotate sites.
- » not resolve existing sustainability or rota challenges; or account for seasonal fluctuations in patient numbers, difficulties transferring critically ill patients, and the need for constant on-site consultant presence.
- » increase anxiety for the Pembrokeshire population.
- » risk losing funded training posts at Withybush; and negatively impact related services such as A&E and critical care.

6.41 If Option B is implemented, Withybush staff highlighted significant practical and infrastructure issues that must be addressed there. Questions were raised about whether the hospital has sufficient ward capacity, equipment, and diagnostic support to manage altered patient flows; and staff stressed the need for proper investment in essential tools such as X-ray, radiology, labs, and sterile services, as well as clarity on funding for new or upgraded equipment. Several attendees noted that existing facilities - including four underused theatres and the renovated but unused Ward 9 - could be better utilised to support day surgery and post-operative care, as previous trials there had been highly effective.

> *"Alternative weeks for emergency general surgery? That would have an impact on both hospitals. It won't work; patients would be pushed from pillar to post." (Withybush staff)*

Suggested alternatives and mitigations

6.42 Some specific alternatives suggested by staff attendees were as follows.

have a section of the ward on the Clinical Decision Unit with allocated nurses, ensuring a higher nursing patient ratio than a separate surgical assessment unit.

- » use the former Preseli Theatre in Withybush as a surgical same day emergency care centre.
- » increase throughput at Withybush by undertaking hernia, gallbladder, gynaecological, and colorectal surgery.
- » move endoscopists to Withybush rather than removing the emergency general surgery service. (Withybush staff member)

Endoscopy

Views on the options: general

6.43 There was general support for the endoscopy options among staff, who noted the inclusion of gastrointestinal services at all sites in all proposed options and the proposal for more specialist hubs for each type of endoscopy as reasons for their support. One comment highlighted anecdotal feedback from patients regarding their willingness to travel further for specialist endoscopy.

6.44 It was noted that the people of Ceredigion feel an inequity around some of the options for Endoscopy, whereby services seem to be moving to the south of the area.

6.45 There were no specific comments made in reference to Option A for endoscopy.

Views on the options: Option B

6.46 Concerns around the loss of respiratory endoscopy - particularly bronchoscopy[102] - were raised by Glangwili staff to demonstrate their preference for Option B. They noted the link between bronchoscopy and critical care in Glangwili, highlighting possible issues around staff skills and retention if the service were to be removed.

6.47 There was also some support for a new community-based bowel screening site among Glangwili staff and other health professionals. Conversely, a few staff from Prince Philip questioned the appropriateness and feasibility of such a unit under Option B.

Views on the options: Option C

6.48 There was some debate over the attractiveness of extended hours for staff under Option C. Despite some recognition that weekends and evenings would be appealing for flexible working, it was said that the necessary recruitment of staff for extended hours would be a challenge; and that it would increase pressure on current staff. It was suggested that nurse endoscopist training could be implemented across all proposed options to mitigate some of the workforce challenges.

Suggested alternatives and mitigations

6.49 Specific alternatives suggested by staff were:

[102] A medical procedure where a doctor uses a thin, flexible tube called a bronchoscope to look inside the lungs and airways.

- » the development of a lead lined room to allow the provision of Endoscopic Retrograde Cholangiopancreatography (ERCP)[103] at Withybush.
- » more mobile bowel screening opportunities.

Ophthalmology

Views on the options: general

6.50 Although some units, such as the North Road Eye Clinic, were praised for their strong teamwork and efficiency, ophthalmology staff generally reported growing backlogs, weekend working, and travel demands that limit how many patients they can see. Concerns were also raised about the limited consideration of the full multidisciplinary team, such as orthoptists, optometrists, and vision scientists, in workforce planning.

6.51 Specifically, staff highlighted current challenges in delivering cataract procedures in a timely manner, suggesting the service should follow the successful English model of allowing private providers to bid for this work to relieve waiting lists.

6.52 In light of this, there was general agreement that centralising ophthalmology at one of the four main hospital sites would "*gain efficiencies and strengthen*" the service. There was also a sense that patients are willing to travel for one off, day case appointments like cataracts procedures; but some staff highlighted access and travel challenges, particularly when it comes to follow-up care.

6.53 Several staff commented on the condition and capacity of community sites, for example it was said that:

- » Aberaeron Integrated Care Centre (ICC) is busier than Cardigan ICC for eye appointments but struggles with a shortage of clinic rooms, making it hard to run extra sessions.
- » some local eye clinics, like in Cardigan, have stopped because consultants no longer visit, and space is often fully booked.
- » North Road Eye Clinic is no longer suitable, and its services could be moved back to an acute hospital site like Bronglais to make better use of space and improve follow-up care.

6.54 Other comments highlighted a lack of consultant ophthalmologists and no specialist surgical staff at Bronglais, where there is only one eye surgeon. Recruitment was said to be difficult, even with attempts at offering joint roles with Powys. Attendees stressed that better facilities are key to attracting and keeping staff, as current buildings lack basics like changing areas and staff kitchens.

6.55 Pharmacy staff explained that their service input would be understanding the supply element. A few stressed the need for adequate, monitored fridge storage with proper maintenance contracts, as Ophthalmic drugs are high-value and temperature-sensitive, and fridge failures can lead to costly losses. They also highlighted the need for air conditioning in medicine storage areas to prevent damage from rising temperatures and heat-related incidents, which are becoming more frequent.

Views on the options: general

6.56 Staff highlighted travel and transport implications for both patients and staff. It was said that the options do not adequately reflect the geographic challenges and poor transport infrastructure of mid and west

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

Wales, with patients from rural and coastal communities like Tywyn, Machynlleth, and Llanidloes already facing journeys exceeding two hours to access services, with limited public transport options and road networks that are vulnerable to closures and seasonal delays. The impact of this was said to be greatest for elderly patients, who may rely on patient transport that is already overstretched, leading to long waits, missed appointments, and deterioration in vision and general health. The reliability of patient transport was also questioned, with examples of arranged transfers not taking place, leaving patients stranded or forced to stay overnight.

6.57 Staff also reported significant operational challenges, with widespread reliance on taxis to move clinicians between sites, high associated costs, and reluctance among some clinicians - particularly newly recruited international staff - to drive on rural road networks. Concerns were raised that such travel demands make recruitment and retention more difficult, and that proposals to centralise services could worsen these issues.

6.58 More broadly, respondents stressed that estate planning and infrastructure must be aligned with service options and models to ensure care can be delivered as close to home as possible.

Views on the options: Options A and C

6.59 In considering Option A (and C) a few staff members - mostly from Prince Philip - shared concerns over the lack of intravitreal therapy (IVT) provision at Amman Valley Hospital, noting that they are already behind schedule considering the current demand for this service. It was, though, said that Amman Valley Hospital is a preferred location for cataract services for patients, as it has easier parking than other sites.

Views on the options: Option B

6.60 Under Option B, centralising emergency and elective ophthalmology at Prince Philip was considered impractical from an emergency care perspective. Having no 24/7 emergency department (ED) and only a part-time Minor Injuries Unit (MIU) at Prince Philip raised doubts about the feasibility of safely managing urgent and complex eye cases, including penetrating eye injuries. There were also concerns about loss of emergency ophthalmology training opportunities for ED staff and public confusion about where to go in an out-of-hours emergency.

6.61 There was also some argument that decisions should be based on fitness for purpose rather than convenience for clinicians. Withybush was said to have good facilities that are currently underused, whereas Glangwili is poorly configured for ophthalmology.

Suggested alternatives and mitigations

6.62 Specific alternatives suggested by staff attendees were to offer:

- cataracts at Cardigan ICC.
- cataracts at Aberystwyth every three months.

Orthopaedics

Views on the options: general

6.63 It was noted that concentrating only low-complexity, repetitive orthopaedic cases at Withybush could reduce job satisfaction and make it harder to retain or recruit consultants, who value a varied case mix including both elective and emergency work. Questions were also asked about how surgical teams would

be separated between planned and emergency services, and whether such division would be practical or desirable. Staff emphasised the importance of maintaining integrated elective and trauma activity to support skills development, service resilience, and recruitment.

6.64 Numerous comments also questioned whether the orthopaedic options and the associated travel impacts align with the Health Board's stated obligations and initiatives, including Getting It Right First Time (GIRFT), the 'green pathway', and the commitment to 'putting patients at the heart of what we do'.

6.65 Some staff questioned the suitability of Prince Philip for orthopaedics due to its workforce shortages, outdated theatres, lack of enhanced recovery and critical care facilities, and insufficient workforce capacity. Specifically, the perceived lack of ITU/HDU provision, limited anaesthetic cover, and underused orthopaedic and day case beds at Prince Philip deemed it unfit to manage complex or higher-risk patients, particularly older individuals with comorbidities. In contrast, Withybush was said to have modern theatres, a dedicated elective ward, and supporting specialist services that are currently under-utilised.

Views on the options: Option C

6.66 Aside from one comment describing Option C as "*reasonable*", there were no comments that directly referenced the options for orthopaedic services.

Suggested alternatives and mitigations

6.67 Specific alternatives suggested by staff attendees were:

- utilise Ward 9 at Withybush as a dedicated elective orthopaedic unit. It was said that Ward 9 has previously been used successfully for orthopaedic cases, and staff expressed frustration that, despite this, the ward has not been reinstated as a centre for arthroplasty and that the Health Board is using costly in-sourcing arrangements without exploring internal capacity options. Staff argued that stopping certain emergency and gynaecology services could create capacity for elective orthopaedics at Withybush and highlighted that, unlike Prince Philip, Withybush has an Intensive Therapy Unit (ITU) capable of supporting higher-risk joint replacements.
- provide orthopaedic services at Cardigan ICC.

> *"[Ward 9] is a prime location for elective patients. The sensible long-term solution is Ward 9." (Withybush staff)*

Radiology

General views

6.68 Staff emphasised that radiology is essential to the functioning of multiple critical hospital services, including critical care, emergency general surgery, and stroke. Therefore, any changes should ensure continuous, fully staffed diagnostic support to maintain safe and effective care.

6.69 The on-call model was viewed positively by many staff, as it provides valuable flexibility and significant financial benefits, with some earning up to £30,000 extra per year. It is a key factor in recruitment and retention, particularly for younger staff who see on-call work as an incentive. Removing it could, it was felt, result in staff leaving or moving to locum roles. While some acknowledged challenges around pay

protection, rostering systems, and the administrative process, the overall view was that the on-call system works well for radiology staff and remains an important part of workforce stability in Hywel Dda.

6.70 Staff also expressed strong frustration over the consultation document's statement that 'shift changes to seven days a week, 12 hours a day are more attractive to radiographers.' They considered this inaccurate, not evidence-based, and not reflective of the views of frontline staff.

6.71 Other workforce concerns centred on staffing shortages, sustainability, and the feasibility of moving to extended or seven-day services (though these were considered desirable in principle). Teams were said to be already stretched, with sickness or absence often leading to cancelled patient appointments and reliance on agency or locum staff. Many raised worries about recruitment and retention, particularly if on-call or income opportunities are reduced; highlighting childcare, transport, and burnout as major barriers to longer or more flexible shifts.

> *"How do you expect to move to 12-hour shifts when we are already critically understaffed and not meeting demands. Recruitment is failing, with people leaving not joining. Our significant workforce is agency" (Withybush staff)*
>
> *"Worried if interventional radiology is centralised, the Bronglais radiologist will end up on the Prince Philip rota and the hospital would lose them. This will impact surgery." (Bronglais staff)*

6.72 A few staff members explicitly stated that they would prefer to work longer hours and fewer days; though it was also said that hospital creche provision would need to be improved to facilitate this for working parents.

6.73 Radiographer training was also said to be an issue, with Welsh Government targets not currently being met. This, it was felt, will need to be addressed to enable the provision of seven-day services.

Views on the options: general

6.74 There were concerns around the capacity and practicality of transferring patients to Glangwili for inpatient interventional radiology. Staff highlighted that:

- ongoing bed shortages, transport and escort requirements, and the limited operating hours of the medical day unit act as major barriers.
- radiology at Glangwili is already working at full capacity, with insufficient X-ray rooms, scanners, and limited MRI flexibility.
- demand for imaging outstrips supply, and existing equipment is heavily used and expensive to maintain.
- additional x-ray and fluoroscopy rooms, a reporting hub, and potentially new scanners would be essential to meet rising demand.
- there is limited space to accommodate extra equipment, though the value of a modernised, better-equipped department was recognised.

6.75 There was strong concern about the potential loss of X-ray services from Llandovery Hospital. Staff felt this would have a major negative impact on local access to care, especially for elderly, low-income, and rural patients who already face significant transport challenges. Many noted that the League of Friends had raised substantial funds to purchase the X-ray machine, and that its removal would be deeply unpopular. There were calls for investment to increase radiology availability, introduce walk-in sessions, or explore

mobile X-ray solutions to maintain local access. Staff also highlighted that without X-ray services, the Minor Injuries Unit cannot reopen, further reducing local healthcare provision.

6.76 Staff from Cardigan ICC and Tenby Hospital noted capacity concerns at these community sites. At Cardigan ICC, radiology is extremely busy and faces ongoing staffing pressures, with one radiographer often covering high patient volumes and managing complex manual handling tasks without consistent support. At Tenby Hospital, staff reported having to redirect patients to Withybush due to limited X-ray cover. Staff noted that management treats Tenby and Cardigan as having similar workloads, despite Cardigan's much higher demand and broader responsibilities.

> *"It is Incredibly busy down here in radiology at CICC… nobody understands. They are comparing us with Tenby, but we do all our own administration here. Ideally, we want an administrator to do the booking to increase our capacity in radiology." (Cardigan Integrated Care Centre staff)*

6.77 In terms of the other hospitals providing radiology services, the following issues and concerns were raised:

- equipment such as the DEXA[104] scanner at Bronglais is in high demand; but is ageing and in need of replacement.
- the proposed options could drive a lot of scan activity to Prince Philip, which could be challenging.
- Withybush staff highlighted a lack of DVT (deep vein thrombosis) pathway at the hospital, with patients having to go through A&E or SDEC. This, they said, adds to the radiology workload.

6.78 There was no specific feedback on Options A and C for radiology.

Views on the options: Option B

6.79 Feedback on Option B was generally positive, with several participants expressing support for the proposed diagnostic hub model, noting its potential to increase capacity and efficiency. However, there was uncertainty about the practical details, including where the hub would be located, what its operating hours would be, whether it would operate alongside existing hospital services, and what specific diagnostic functions it would include. Questions were also raised about the impact on neighbouring health boards, such as Swansea Bay, and the potential for regional collaboration.

6.80 While participants recognised the benefits of a centralised diagnostic hub, particularly if supported by artificial intelligence to reduce diagnostic errors, they also acknowledged that the model would be highly expensive to establish and would likely increase workload across radiology teams.

Views on the options: Option D

6.81 Option D was generally viewed positively. While some staff noted that relocating to Glangwili for inpatient interventional radiology would be a significant move requiring investment in facilities and consideration of space, others were supportive and flexible, especially given previous discussions about having upgraded facilities such as a Gamma Camera. Several staff members felt that improved patient outcomes justify

[104] Dual-Energy X-ray Absorptiometry scanner, which is a quick, painless X-ray test that measures bone density.

increased travel, and that Option D would be the most practical choice if expanded diagnostics, including weekend services, are required.

Suggested alternatives and mitigations

6.82 Alternative suggestions were to offer:

- » fracture clinics at Cardigan ICC.
- » extended X-ray hours at Cardigan ICC to match its opening hours.
- » a rotational interventional radiology service, whereby staff travel to different hospitals rather than expecting patients to do so.
- » better digital radiology systems and services that harness the potential of AI.

Stroke

General views

6.83 There was strong frustration about recruitment challenges and missed opportunities within stroke services, including rigid qualification requirements, short-lived job adverts, and reliance on costly agency staff. Staff emphasised the importance of investing in permanent, well-graded posts to attract and retain people, particularly in rural areas such as Bronglais and Withybush; and called for better planning to avoid losing skilled clinicians.

6.84 Some sites, such as Bronglais, reported having well-established and experienced stroke teams and questioned the rationale for change. Others, like Prince Philip, acknowledged the need for additional staffing uplift and resources if they are to take on greater responsibilities.

6.85 A few staff members highlighted that many stroke patients remain in hospital unnecessarily while waiting for packages of care or therapy input, leading to bottlenecks and longer stays. Current early supported discharge (ESD) arrangements were described as under-resourced and ineffective, with insufficient therapy provision — especially speech and language therapy — to support safe, timely return home. To mitigate these issues, it was said the Health Board needs to ensure a fully integrated hospital-to-home pathway, underpinned by robust community, therapy, and social care capacity.

Views on the options: general

6.86 Many staff members raised general concerns about the proposed options, viewing them as poorly thought out and lacking consideration of geography, accessibility, and patient safety. Particular worries were around longer waiting times, transfer delays, and a lack of clear modelling around rehabilitation capacity and staffing.

6.87 In particular, it was said that the options:

- » give insufficient focus to the fact that safe stroke care requires intensive care support, clear clinical pathways, and adequate therapy provision, which are already under strain.
- » dismantle effective parts of the current system and neglect the crucial role of rehabilitation.
- » are overly focused on the acute 72-hour phase, with little clarity on what happens afterward.
- » neglect that that current physiotherapy and occupational therapy teams are understaffed and overstretched, with some wards unable to meet national standards for therapy intensity.
- » risk patients being discharged to substandard or non-specialist rehabilitation, undermining recovery and increasing stress for families—especially if care is delivered far from home.

6.88 In this context, attendees called for specialist rehabilitation units, ringfenced stroke beds, and stronger integration of therapy and neuro-physio services rather than placing patients in generic or frailty wards. They also requested clarity on how therapy standards, rehabilitation environments, and timely assessments could be maintained if services are centralised.

6.89 Many questioned why Bronglais was excluded from consideration as a 'centre of excellence.' Bronglais staff highlighted Sentinel Stroke National Audit Programme (SSNAP) data showing it as the top-performing stroke unit in the health board, with an efficient direct-to-CT pathway, rapid diagnostics, and highly coordinated multidisciplinary care. While they acknowledged some workforce fragility, they believed this could be resolved with proper investment and planning.

6.90 Staff and health professionals also stressed the impact of the proposals on mid Wales patients, warning that further consolidation of services to the south would leave a major geographical gap in specialist stroke care, disadvantaging rural patients and increasing travel times. It was said that with Bronglais currently supporting around a quarter of Powys stroke cases, removing or reducing its role would expose patients from Ceredigion, parts of Powys, and south Gwynedd to longer travel times and reduced access to timely treatment and rehabilitation.

6.91 There were also doubts about selecting Prince Philip as a stroke unit over Glangwili, given the former's proximity to Morriston and limited ICU capacity.

6.92 Feedback on the 'Treat and Transfer' model for stroke services revealed widespread concern about its safety, practicality, and evidence base, particularly for rural areas like mid Wales:

- staff questioned the lack of clear evidence supporting the model, noting that cited research from other countries may not apply to the Welsh context.
- there was confusion about clinical responsibility during transfers, who would accompany and monitor patients, and whether non-specialist staff could safely manage complex cases.
- ambulance and transfer capacity is already overstretched, with long waits, poor weather affecting air transfers, and limited staff available for multiple journeys.
- patient safety could be compromised, especially in the case of unstable or thrombolysed patients requiring close monitoring or a lack of available beds at the receiving hospital.

> *"One of my main concerns is treat and transfer for stroke… going to Prince Philip and then taking any ITU for Prince Philip doesn't make sense to me. If it becomes level 3 and needs to be transferred to Glangwili or even Swansea Bay… that is not a good patient pathway." (Bronglais staff)*

6.93 Overall, staff feared this model would prevent timely access to life-saving treatment and breach national stroke time targets, while also creating serious practical and emotional strain for families who play a vital role in rehabilitation.

6.94 Several staff members at Bronglais also commented on the lack of detail and evidence underpinning the options. They questioned how patient care would be safely delivered under the proposed model, highlighting missing information about the Treat and Transfer model, staffing roles, and how core clinical tasks such as medication, suctioning, and stroke alerts would be managed. More widely, staff stressed the need for a comprehensive workforce plan across all professions- including nursing, therapies, pharmacy, and medical staffing - to ensure safe and effective service delivery.

Views on the options

6.95 There were almost equal - albeit few - comments demonstrating support for both options for stroke services. Few clear preferences were expressed: while some participants expressed a preference for two sites (Option A), others could see merit in creating a more specialist 24/7 stroke unit (Option B), providing the Treat and Transfer service is sufficient. Some, though, questioned whether the 24/7 unit would be better located more centrally at Glangwili. A number of comments demonstrated support for Withybush maintaining a stroke unit under both options.

Suggested alternatives and mitigations

6.96 Some specific alternatives and mitigations suggested by staff attendees were as follows:

- a specialist stroke rehab unit at Bronglais as an important element of 'Treat and Transfer'.
- explore telemedicine and virtual care options to support local stroke services and reduce the need for patient transfers.
- retain a stroke unit at Glangwili (perhaps using Padarn Ward, which currently cares for respiratory and general medical patients and could be moved to 'Y Lolfa, an alternative care unit) and provide rehabilitation at Prince Philip.
- a regional stroke centre for mid Wales.
- stroke units at Bronglais and Glangwili because *"… the pathway is already in place with WASUT."* (Glangwili Staff Member)
- prioritise the ring-fenced beds at Prince Philip.
- improve transport infrastructure.
- invest in dedicated transfer vehicles.
- provide family accommodation near specialist centres
- expand digital options (e.g., video calls) to help maintain connections.

Urology

General views

6.97 Concerns were raised about current service fragility and its impacts, including:

- long waiting times, inconsistent consultant presence, lack of urology nurse specialists, and poor inter-hospital communication leading to delays in care and patient distress.
- a shortage of clinical space, high staff turnover, and loss of expertise.
- underfunding of catheter clinics and limited capacity to support early intervention (as reported by community teams - especially at Llandovery Hospital).

6.98 Across all sites, staff and health professionals emphasised the need for dedicated urology wards or spaces, clear leadership, consistent clinical pathways, and better coordination between sites. There was also support for a rotational consultant model and nurse-led procedures.

> *"We need investment financially. Patients are now waiting four weeks for appointments. Just haven't got the space." (Llandovery staff)*

Views on the option

6.99 Generally, staff welcomed the principle of centralising the diagnostics hub, inpatients, and urgent suspected cancer services at Prince Philip; albeit some felt Glangwili would be equally, if not more, appropriate for the location of centralised urology services – especially if emergency general surgery is to be centralised there.

6.100 However, several staff - particularly from rural areas in Ceredigion and elsewhere - felt that centralisation risks worsening inequalities, delaying cancer treatment, and creating unacceptable travel burdens for frail or elderly patients.

Suggested alternatives and mitigations

6.101 Some specific alternatives suggested by staff attendees were as follows.

- » remove triage from consultants and move it to clinical nurse specialist teams.
- » use Ysbyty Enfys in Carmarthen for medically optimised patients.
- » provide a bespoke unit with half diagnostics and half clinic/treatment rooms.
- » provide a urology investigations unit next to Derwen Ward in Glangwili.

The future role of hospital sites

Bronglais

6.102 Feedback from staff at Bronglais strongly reflects opposition to any 'downgrading' or loss of service and perception that the site is being marginalised in favour of hospitals in the south of the Health Board.

> *"There's a general drain on services in our hospital. Stop moving things further away from here." (Bronglais staff)*

6.103 Staff at Bronglais described a persistent sense that this site is treated as a 'second-class' hospital, despite its essential role in serving a large and rural population of around 100,000 people across Ceredigion, and parts of Powys and Gwynedd. Many at Bronglais feared that continued service centralisation to southern sites would destabilise Bronglais, undermine recruitment and retention, and erode community confidence.

6.104 There were repeated calls for investment and service development at Bronglais, with several comments suggesting that it has the staff, expertise and potential to become a centre of excellence for certain services. It was also stressed that removing key services could leave mid Wales residents with unsafe travel distances and reduced access to urgent and specialist care.

6.105 Nevertheless, some Prince Philip staff noted they "*already take patients from Bronglais*", while another felt that Bronglais could prove to be "*the biggest challenge*" when implementing the proposals.

Glangwili

6.106 Feedback on Glangwili reflects a mix of recognition of its central role within the Health Board and concern about its infrastructure, capacity, and patient experience.

6.107 Several staff across the Health Board felt that too many services are being centralised at Glangwili, leading to overcrowding, corridor care, and unsustainable pressure on emergency and inpatient departments. Staff

described the hospital as "*at full capacity*", with long-standing estate and layout issues like cramped wards, poor patient environments, and inadequate therapy and outpatient spaces.

6.108 Several staff from different sites said the building itself is outdated and unfit for purpose, requiring major redevelopment or complete replacement if it is to serve as a regional centre. Parking was a major and recurring frustration for staff, with some clinicians refusing to work or hold clinics there due to lack of space.

> *"…the stress of parking causes me to refuse to hold clinics there." (Bronglais staff)*

6.109 Despite these challenges, it was said that Glangwili is the logical site for a future centre of excellence, given its existing clinical pathways and ICU capacity, but only if accompanied by significant investment in new facilities.

Prince Philip

6.110 Several staff – largely at Prince Philip - questioned the feasibility of concentrating more services at Prince Philip, warning that the site's current footprint, infrastructure, and outpatient capacity would not support expansion without major investment or new build.

6.111 There were differing views on the hospital's future direction among staff at Prince Philip: some saw it evolving into a centre for elective or chronic care, while others felt it should retain or strengthen its acute medical role, particularly given its strong reputation for training and patient care.

6.112 Concerns were also raised about its proximity to Morriston Hospital, with some staff from Glangwili questioning the value of investing heavily in Prince Philip when it has a major tertiary centre nearby. Others, though, emphasised that Prince Philip provides a better local patient environment and vital community access. Several participants worried that recent or proposed service changes signal a gradual downgrading of acute services, leaving the Llanelli community underserved.

> *"Prince Philip is very strategically placed…small but must have services that local people can rely on." (Prince Philip staff)*

Withybush

6.113 Several respondents – largely from Withybush - described this site as essential for Pembrokeshire, serving a large, rural, and often isolated population with limited transport links to other hospitals. There was widespread fear among staff at Withybush and South Pembrokeshire Hospitals that bringing together more services at other hospitals would leave the county without safe, timely access to acute or specialist care.

> *"It is quite scary that some services are being taken away." (Withybush staff)*

6.114 Withybush staff emphasised that this site has a proven track record of resilience- successfully stepping up during Covid-19 - and could be developed into a planned care centre of excellence with intensive care support. However, they noted that the hospital suffers from underinvestment, ageing infrastructure, and persistent staffing challenges, which limit its ability to expand or retain consultants.

Cross-cutting themes

Travel and access

6.115 The feedback on travel and transport reflects widespread concern that the proposed service changes would exacerbate existing access problems for patients, relatives, and staff across Hywel Dda. Staff noted that many communities, particularly in rural and coastal areas, face long and difficult journeys to reach hospital care. Older, frail and low-income patients are especially affected, with some refusing appointments, paying for hotel stays, or missing care entirely due to distance, cost and poor public transport connections. The Welsh Ambulance Service University NHS Trust (WASUT) is already under considerable strain, with reports of long delays and limited capacity for inter-hospital transfers. Staff described frequent challenges in arranging safe and timely transfers; and expressed concern that with the increased reliance on transfers under some of the proposed changes, this could have an even greater impact on timely patient care. They highlighted the need for dedicated patient transport vehicles or specialist transfer teams.

6.116 Concerns were also raised about the impact of increased travel on the workforce, as centralising services would require many staff—particularly in Pembrokeshire and Ceredigion—to travel further between sites. This was seen as a potential threat to recruitment, retention and morale. In addition, greater travel distances would increase the carbon footprint and place additional operational pressure on services. Furthermore, extended commuting requirements may create a need for additional childcare arrangements for staff with parenting responsibilities, as well as supplementary caring arrangements for those with other dependents. Suggested mitigations included improved transport planning, better coordination of appointments, and consideration of shuttle links between key hospital sites.

Workforce challenges

6.117 Workforce challenges emerged as one of the most consistent and pressing themes across all engagement with staff and health professionals. Participants described widespread difficulties in recruiting and retaining staff—particularly in rural and western areas such as Pembrokeshire and Ceredigion—where distance from larger cities, limited professional development opportunities, and poor infrastructure make posts less attractive. Many noted that success of any future service configuration will depend on addressing these systemic workforce gaps, as several of the proposed changes appear to rely on additional staffing that the Health Board is currently unable to secure or train.

6.118 Low pay, heavy workloads, below-standard rotas, and frequent redeployment were reported to be causing stress, burnout, and de-skilling, with some services dependent on a single specialist. Staff expressed frustration at bureaucracy, poor communication from senior management, and a lack of understanding of local pressures. Staff overseeing workforce planning requested adequate pre-implementation time to ensure these concerns are addressed ahead of any service change.

> *“Can we ensure we have the sufficient time to plan these facilities and ensure the required staff are specified ... building new rotas and new Organisation Change Processes etc. takes time.” (Estates/capital planning meeting)*

The interdependency of services

6.119 Staff across multiple sites emphasised the importance of recognising and addressing the interdependencies between clinical services when planning future configurations. Many noted that the specialties focussed on

in this consultation are closely linked, and that changes in one area could have unintended consequences for others if not planned in a coordinated way. Concerns were raised that the current approach — reviewing services individually — risks fragmenting care and destabilising key functions like General Internal Medicine, which underpins much of the hospital system.

6.120 Staff called for clearer mapping of service interdependencies and better analysis of how proposed models align operationally and clinically. Several examples were given of how separating services could undermine patient care, such as splitting critical care and stroke provision across sites, leading to gaps in specialist input and workforce strain. Indeed, critical care was often described as foundational infrastructure, without which other acute services become unsafe, and unsustainable.

> *"Critical Care is the lynchpin for medical services in Withybush." (Withybush staff)*

6.121 There was agreement that decisions must account for these interconnections to maintain safe, sustainable, and joined-up care across the Health Board.

Technology

6.122 Many highlighted the need for greater use of innovation and digital technology to improve access and efficiency in healthcare. They suggested expanding telemedicine and virtual consultations, enabling consultants to review patients remotely with nursing support at local sites, reducing unnecessary travel for patients. Some felt that digital flexibility—such as using platforms like Teams or WhatsApp for consultations—is already accepted by both staff and patients but is not reflected enough in current plans.

Equalities impacts

6.123 The most consistent theme was the effect on older people, who make up a large proportion of the population in mid and west Wales. Many are frail, have chronic conditions, and face serious barriers to travel due to distance, poor transport links, and mobility issues. Staff warned that centralising services further away would be discriminatory in practice, limiting access and disrupting family involvement in care.

6.124 Concerns also extended to people living in poverty, who may not be able to afford travel or time off work, and patients with dementia, whose continuity of care depends on familiarity with local staff and settings. Parents of disabled children and carers could also face long journeys and a lack of adequate facilities such as accessible changing spaces.

6.125 Feedback from staff at Glangwili Hospital also noted that mental health patients would be affected by wider service changes, given their reliance on multiple hospital departments.

Views on the consultation process

6.126 Several themes emerged around process, communication, governance, and implementation of the Clinical Services Plan (CSP) consultation. Staff expressed concern about a lack of transparency and inclusivity in how options were developed and shared, with some staff—including senior clinicians and site leads—reporting they had little or no awareness of how decisions were made.

6.127 Questions were raised about who was involved in the early phases, who received information, and whether key professional voices and service representatives were included. Some highlighted that the communication and engagement process has felt fragmented, with a disconnect between the "rich

conversations" from the earlier discovery phase and the consultation now underway. There were warnings that without a shared understanding and professional alignment, implementation could be challenging.

6.128 There was also recognition that the CSP must be financially realistic and operationally deliverable, with clarity needed on how costs, estates, and workforce implications are being phased and assessed. Some questioned whether facilities, cleaning, estates capacity, and digital infrastructure had been adequately factored in.

7. Meetings with politicians and special interest groups, and other outreach events

MP/MS briefings

7.1 Two CSP-specific briefings were held with Members of the Senedd (MSs) and Members of Parliament (MPs): the first, held on 2 June 2025, was attended by nine MSs and MPs; and the second, held on 5 August 2025, by three.

7.2 While these briefings were primarily designed as information-giving sessions, some key questions were asked around:

- the impact of the proposed changes on specific hospitals.
- whether changes to sites are being clearly communicated or introduced 'by stealth.'
- confidence in maintaining and developing clinical expertise across sites and within other services.
- the wider impact on services beyond the nine directly in scope (i.e., service dependencies).
- how clinical rationale can be clearly explained in a way that resonates with the public, who are concerned about service loss
- whether consultants are supportive of the proposed changes.
- impacts on, and the extent of co-operation with, other health boards like Swansea Bay University Health Board.
- whether costings include additional patient transfer and travel costs.
- consultation and implementation timelines.
- the role of digital healthcare in supporting service delivery.

Meetings with councillors

Overview

7.3 During the consultation period, Hywel Dda hosted a series of virtual meetings with councillors across the Health Board area, as well as those from some neighbouring county councils. ORS staff were not present at these events, but summaries of discussions were provided by Hywel Dda, which have been themed and reported below.

Attendance and representation

7.4 In total, Hywel Dda staff undertook seven meetings and engaged with 69 political representatives. Information about the meetings for which ORS has received feedback notes were as follows.

Table 31: Councillor meetings - dates and attendance

Group	Date	Number of attendees
Carmarthenshire Town and Community Councillors	9 June 2025	3
Pembrokeshire Town and Community Councillors	10 June 2025	1
Ceredigion Town and Community Councillors	12 June 2025	7
Ceredigion County Councillors	8 July 2025	21
Powys and South Gwynedd County Councillors	21 July 2025	1
Pembrokeshire County Councillors	28 July 2025	17
Carmarthenshire County Councillors	1 August 2025	19

Main findings from stakeholder events and meetings

7.5 Councillors generally commented on the changes to services most impacting the hospitals closest to them and the communities they represent. Much of the feedback was on the consultation process, and more generally on the wider challenges impacting the Health Board as a whole.

7.6 Very few comments were made in relation to specific options but comments on individual clinical service area changes are summarised below[105], followed by comments on the four main hospital sites, potential impacts on specific protected characteristics, and finally any pertinent general views.

Critical care

7.7 Although they did not provide views on the specific options proposed, Pembrokeshire County Councillors expressed the need for:

> *"a responsive, efficient and effective [critical care] service" (Pembrokeshire County Councillors)*

7.8 However, Carmarthenshire County Councillors expressed concerns about the proposed provision of an Enhanced Care Unit (ECU) rather than an Intensive Care Unit (ICU) at Prince Philip under Options A and B. They questioned the reasoning for *"downgrading"* a *"successful"* ITU and suggested an increased need for ITU at Prince Philip due to the geriatric focus there (in contrast to the focus on paediatrics and pre- and post-natal care at Glangwili).

7.9 In terms of alternatives:

- the Carmarthenshire County Councillors suggested investing the money dedicated to the *"costly"* transfer of ITU patients from Prince Philip to Glangwili in more staff at the Prince Philip ITU as a way to maintain a higher level of care at both units.

Emergency general surgery

7.10 Pembrokeshire County Councillors felt that either of the two options are a *"downgrade"* for Withybush and were concerned about the potential complexity of operating there on alternate weeks. However, they

[105] Please note that no comments were made on dermatology, endoscopy, and orthopaedics.

welcomed the proposal to strengthen same day emergency care (SDEC) at Glangwili and Withybush, stating that longer hours for this service would be a positive change.

7.11 Carmarthenshire County Councillors questioned whether SDEC would remain at Prince Philip and, if not, whether the MIU would move to the current SDEC location.

Ophthalmology

7.12 The contributing town and community councillor from Pembrokeshire felt that the options for ophthalmology represent a trade-off between patients receiving more timely treatment and some patients having to travel further for their treatment. They stated that in general, this patient cohort tend to be older, which needs to be factored into the planning for patient transport, with adequate resource allocated to this. For example, patients may need to be accompanied on journeys, comfort breaks factored in, and privacy shields installed in transport vehicles.

7.13 Carmarthenshire County Councillors focussed on the impact of providing different configurations of ophthalmic services at Amman Valley Hospital. While they did not express a preferred option, they would welcome more detail on the impact on the hospital and whether locating certain services there would lead to reduced patient waiting times.

Radiology

7.14 Only the Carmarthenshire town and community councillors commented on the radiology options. They expressed disappointment at the proposed removal of x-ray services from Llandovery Hospital and stated that members of the public in the area would also be concerned about this. They highlighted that money was raised locally to fund the purchase of an x-ray machine; and felt it has been underutilised due to difficulty finding radiographers.

Stroke

7.15 A common concern expressed by Ceredigion town and community councillors, Ceredigion County Councillors and a county councillor from South Gwynedd was that removing the stroke unit from Bronglais leaves a population across a large geography without adequate stroke provision.

> *"Don't the options leave nothing between Llanelli and Caernarfon?" (Ceredigion town and community councillors)*

7.16 The councillors stressed that stroke patients are not currently being treated in a timely way that meets guidelines and questioned how the proposals would improve this. Even with the provision of 'Treat and Transfer', travel times were said to be challenging due to the area's rurality and difficult road network; and with the options relying heavily on patient transfers, there was concern that ambulance services are already stretched. With this in mind, the Ceredigion County Councillors questioned whether the use of a helicopter for transfer had been considered. There was also a sense that due to past experiences, public confidence in being transported to hospital in a timely manner is low.

7.17 Councillors in Ceredigion felt that focussing services in Prince Philip is the *"worst"* option given how far to the south east of Hywel Dda Llanelli is, and its proximity to large hospitals in Swansea and beyond which also have stroke centres. They also stressed that it is not possible to travel from Aberystwyth to Llanelli and back using public transport in a day, which would make visiting difficult for relatives.

7.18 When considering the proposed location of the stroke units in Prince Philip and Withybush, councillors across Ceredigion questioned whether there is more of a critical mass of patients in Pembrokeshire than in Ceredigion to warrant the unit being located at Withybush as opposed to Bronglais. Both options were described as *"centralisation in the extreme"* and while there was support for the concept of fewer specialist units across Wales, the councillors questioned why Bronglais could not house one of those, providing cover for much of rural mid Wales.

> *"The central location of Bronglais would seem to make it a great location as a stroke centre of excellence for this part of Wales. Going beyond Hywel Dda." (Ceredigion town and community councillors)*

7.19 In this context, it was stated that the Bronglais stroke unit has an 'excellent' reputation, rated third in the UK at one time. They also stated that compliance at Bronglais had been at 52.2% compared to 16.6% across the health board, and questioned why, on this basis, no obvious attempts been made to recruit a new consultant.

7.20 Carmarthenshire County Councillors expressed a different view, accepting that to 'do nothing' is not an option for the delivery of stroke services. They generally welcomed an increased focus on stroke services at Prince Philip; and encouraged the Health Board to build on the use of telemedicine to meet rural challenges, similar to tele-stroke services delivered in the Scottish Highlands and parts of rural England.

Urology

7.21 Only the Ceredigion town and community councillors commented on the option for urology. They were concerned about fully locating the service at Prince Philip when some patients already travel from as far north as Tywyn to access services in Bronglais.

7.22 In terms of alternatives:

- the Ceredigion town and community councillors felt that Swansea is close enough to those normally accessing services at Prince Philip to travel to for care; and would prefer to see a full urology service at Bronglais with another of the three hospitals further south also offering the service.

The role of the main hospital sites

Bronglais

7.23 County Councillors in Ceredigion stressed that Bronglais is *"a good hospital with good work going on there"* and while confident that the hospital is not under threat, they felt that provision needs to be carefully considered. They feel that patients living in such a rural area are pragmatic and accept they will have to travel for planned care; however, they are less understanding of removing services perceived as 'time critical' - such as stroke - from the hospital.

7.24 The councillors also considered it important to remember that patients travel to Bronglais from much further north, which should be considered in planning. They advocated Bronglais being designated a centre of excellence for *"something."*

Glangwili

7.25 The Carmarthenshire County Councillors questioned whether there are plans to invest in Glangwili, while understanding that the Health Board must be pragmatic. They also felt that infrastructure at most hospital sites, including former cottage hospitals, is in need of investment.

7.26 This point was echoed by Pembrokeshire County Councillors who considered this particularly pressing given the longer timeframe for the new hospital development. They raised questions about the status of the proposed new hospital, noting that previous discussions had reduced the options from three to two and seeking clarification on whether a new scoping exercise or funding proposal to Welsh Government was underway. Some expressed disappointment that the new hospital appeared to be out of scope, emphasising that it had been presented as essential for long-term sustainability and service improvement. Some also felt that without this investment, the Health Board should now focus on enhancing and modernising the four existing hospitals.

Prince Philip

7.27 Ceredigion councillors considered Prince Philip to be the 'winner' in terms of the CSP options, with more services seemingly being focussed there.

7.28 While the Carmarthenshire County Councillors did not object to the proposed changes to provision at Prince Philip, they questioned whether too much is to be centralised there, leading to a potential strain on resources.

Withybush

7.29 County Councillors in Pembrokeshire were concerned that there would be unintended consequences or *"knock-on effects"* on other services where some of the nine CSP services are proposed to change or be *"downgraded"* at Withybush (e.g., changing to an ECU from an ICU under critical care Option A; the removal of or amendments to emergency general surgery; and the removal of bowel screening under endoscopy Option B).

Cross-cutting themes

7.30 The most common theme raised by councillors across the area was the impact of Hywel Dda's rural geography, and the need to consider this in future service planning. The Pembrokeshire town and community councillors stressed that people are inherently *"parochial"* and as a result, it can be difficult to persuade them of the case for change, particularly when this means having to travel further to access services.

> *"We are hampered by geography and people's experiences of navigating that geography … Change is difficult in that context." (Pembrokeshire Town and Community Councillor)*

7.31 Linked to geographical challenges is the area's poor transport infrastructure, including unreliable public transport. In particular, Ceredigion councillors highlighted Bronglais' isolated location in the north of the Health Board area and the time it can take to travel elsewhere, particularly by public transport. As a result, they again raised concerns about some services being removed from Bronglais, and a perceived focus on bringing provision together so far to the south in Prince Philip.

7.32 Patient transportation was also raised in several meetings. County Councillors in Pembrokeshire and Carmarthenshire did not feel they could make a fully informed decision on the various consultation options without understanding more about how the Welsh Ambulance Service University NHS Trust (WASUT) views their impact on its work. In addition, Ceredigion County councillors highlighted that rural roads can make it difficult for ambulances to reach required speeds, even with blue lights on, meaning it can take longer than expected to transport patients.

7.33 A town and community councillor in Pembrokeshire suggested placing the different clinical areas into tiers; with the most time sensitive care (like stroke and critical care) and those that are reliant on a fixed location due to the availability of equipment placed in the top tier and so on.

7.34 Other complications that should be considered as part of future plans were said to be the ongoing lack of joined up working between health and social care; poor IT systems across the Health Board; and how GP provision can work alongside certain elements of care, such as the Integrated Care Centres.

Equalities impacts

7.35 Councillors identified three groups that could potentially be adversely impacted by the proposed changes to clinical services:

- low-income individuals and families - Pembrokeshire councillors felt that low-income families would be negatively impacted by many of the proposed changes due to the need to travel further for appointments and to visit family and friends in hospital. For those living in rural areas in particular, bringing services together at certain hospitals was seen to potentially lead to inequality of access; and it was said that by *"centralising"* some services, the Health Board would be passing some of the cost savings made onto patients and families due to the personal expense of travelling further for care.
- those without a car – the Carmarthenshire councillors argued that those without access to private transport are likely to be impacted significantly by some of the options.
- older people - a councillor in South Gwynedd felt that asking older people to travel further than they already do for services could cause further detriment to their health.

Views on the consultation process

7.36 Councillor views on the consultation process fell into four key themes:

- clarity – questions were raised around whether the consultation is about hospital roles or clinical services; and requests were made for transparency on funding, unintended consequences, and how local preferences will be weighted in final decisions.
- accessibility and participation - concerns were raised about low attendance at some meetings, overlap with the Prince Philip Minor Injuries Unit consultation, and consultation fatigue in Pembrokeshire. Calls were made for further sessions, wider reach, and simpler consultation materials.
- supporting information - several councillors expressed difficulties in responding fully without data on ambulance or transport services, primary care integration, and system interdependencies. It was also said that the complexity of the consultation options makes it hard to assess impacts.
- engagement – councillors appreciated the thorough presentations given at the meetings and felt they had been listened to. They also recognised opportunities to improve provision,

placing emphasis on the need for safe services, fair balance across sites, and ongoing dialogue with councils and communities.

Meetings with special interest groups and other outreach events

Overview

7.37 During the consultation period, Hywel Dda attended a series of in-person and virtual meetings with groups with a specific interest in the consultation; and attended the Royal Welsh Agricultural Show (RWAS) and the Pembrokeshire County Show (PCS) to engage with visitors. The Health Board's Community Development Outreach Team (CDOT) shared information and materials about the consultation with a range of seldom heard groups including socially economically disadvantaged/homeless, diverse/migrant workers, veterans, rural communities, mental health, disabilities, and refugees.

Attendance and representation

7.38 In total, Hywel Dda staff undertook 15 meetings and visits, engaging with at least 225 group members and/or members of the public. The Health Board also attended the Protect Bronglais Services public meeting, which was attended by 400 people.

Table 32: Meetings with special interest groups and outreach events - dates and attendance

Group	Date	Number of attendees[106]
Aberporth Health and Well-being Event	10 June 2025	25
Protect Bronglais Services Public Meeting	20 June 2025	400
Royal Welsh Agricultural Show	21-23 July 2025	20
Pembrokeshire People First Meeting	24 July 2025	11
Carmarthen Stroke Club	28 July 2025	36
Stakeholder Reference Group	7 August 2025	14
Llanelli Multicultural Network	12 and 26 August 2025	45 (across two sessions)
Llanelli Deaf Club	14 August 2025	7
Pembrokeshire Stroke Club	15 August	12
Aberystwyth and District Stroke Club	20 August 2025	27
Pembrokeshire County Show	20/21 August 2025	-
West Wales Prostate Cancer Support Group	26 August 2025	6
Myrtle House, Llanelli, Drop-in session	28 August 2025	14
Aberystwyth Carers Café Group	28 August 2025	7
Versus Arthritis	28 August 2025	2

[106] No numbers were collected for the Pembrokeshire County Show, where the focus was on raising awareness of the consultation.

Main findings from meetings with special interest groups and other outreach events

7.39 Participants in the various groups tended to comment on the clinical service area of most interest to them, or of which they had experience of accessing. They also tended to comment on the hospital closest to them as well as on the consultation process and wider healthcare issues.

7.40 Very few comments were made in relation to specific options but comments on individual clinical service area changes are summarised below[107], followed by comments on the four main hospital sites, potential impacts on specific protected characteristics, and finally any pertinent general views.

Critical care

7.41 A clinician working within the Health Board (visiting the RWAS) questioned what impact *"downgrading"* critical care at Prince Philip would have on the Acute Medical Assessment Unit (AMAU) there. Other RWAS visitors questioned how Prince Philip could be designated a main stroke unit for the Health Board if its Intensive Care Unit (ICU) becomes an Enhanced Care Unit (ECU) under Option A.

> *"You have to have ICU in case anything goes wrong with Thrombolysis." (RWAS visitor)*

7.42 Another concern was that key staff from a Prince Philip ECU would have to travel with a patient to one of the ICUs if required, causing resourcing issues at the hospital.

7.43 Members of Pembrokeshire Stroke Club were particularly concerned about the change from an ICU to an ECU at Withybush under Option A. They suggested a need to retain the highest level of critical care there to cater for population need and the area's risks - the oil refinery at Milford Haven for example.

Emergency general surgery

7.44 Only Pembrokeshire Stroke Club participants commented on the potential changes to emergency general surgery. Some shared general concerns around the impact of the options on Withybush and felt that Glangwili is too far to travel for surgery for those living in parts of Pembrokeshire. They also mentioned the *"poor state of repair"* at Glangwili as a general concern related to housing emergency general surgery there.

7.45 Some Pembrokeshire Stroke Club participants considered Option B to be better for the Pembrokeshire population. They also highlighted that SDEC in Withybush is good and welcomed the idea strengthening this provision.

Endoscopy

7.46 One Pembrokeshire Stroke Club participant welcomed the idea of a bowel screening centre in the community (Option B) but questioned whether the cost would be excessive.

Ophthalmology

7.47 The only comment made on ophthalmology was a concern from a member of the public that visits to Amman Valley Hospital are not easy, especially for those with glaucoma or other illnesses impacting their eyesight.

[107] Please note that there were no comments made on dermatology.

Orthopaedics

7.48 Participants in two of the groups (meetings at Myrtle House, Llanelli and with Versus Arthritis) had lived experience of, and commented on the proposed changes to, orthopaedics[108]. They were strongly of the view that there is a need to increase orthopaedics capacity across the Health Board, mostly to reduce long waiting times for some procedures, which can significantly affect people's quality of life.

7.49 Participants considered it difficult to provide a clear opinion on the options without fully understanding which of them would best improve capacity. They would have welcomed this information in the summary consultation document. They said they would also welcome further information on funding projections.

> *"It is clear to us that orthopaedic capacity for the population served by Hywel Dda needs to be increased substantially to reduce the current long waits. We do not know what investment is needed to facilitate those increases in capacity." (Versus Arthritis)*

7.50 There was support for regionalisation of elective inpatient orthopaedic services if this delivers more capacity and reduced waiting times; and providing elective services are protected or ringfenced. They considered this approach to be sensible in that hip and knee replacements are approximately a one in 20-year procedure and inpatient stays are relatively short. Participants also suggested that a hybrid of local and regional services could work well as an approach; for example, giving patients the option to travel further within the region for an operation more quickly or wait to be seen at their local hospital.

7.51 To maximise the proposed regional approach, participants suggested a pooled waiting list across the region for each sub-specialism to reduce inequality of access. In addition, they felt that

- services should be fully ringfenced to protect them from seasonal pressures.
- a regional centre of excellence should be developed to support staff recruitment and retention.
- staff resources should be pooled across sites.
- training opportunities should be maximised.
- the voluntary sector should be included in planning.

7.52 It was also highlighted that to ensure the success of a regional approach, additional patient travel provision should be built into planning; and that where possible, post-operative, outpatient, and rehabilitation support should be available as close to home as possible for patients.

7.53 Other comments made in relation to the orthopaedics options included that close consideration should be given to links with radiology; and that a review is needed in relation to BMI and whether it is being used as a measure to exclude patients from care. One participant was surprised that there is no planning for trauma services within the consultation given the links to orthopaedics.

7.54 In terms of specific alternatives, participants in one of the groups that commented on the orthopaedics options felt that a hybrid of the four options would work best, combining the following elements:

- increased inpatients and day cases at Bronglais (Option D).
- extended hours at Withybush, if this increases capacity (Option B).

[108] Please note that most of the feedback in this section came from the Versus Arthritis session.

- additional beds and investment at Prince Philip (Option C), but as part of a regional working approach (Options A, B and D).
- increased capacity at Neath Port Talbot Hospital for regional working across south west Wales.
- a regional/local hybrid surgical hubs network working with Neath Port Talbot (Options A, B and D).

Radiology

7.55 Those commenting on the radiology options at the RWAS felt they would need more information on where the proposed diagnostics hub (Option B) would be located and how it would be staffed before commenting on its feasibility. They also had concerns that patients in Aberystwyth, for example, might have to travel long distances to access a hub like this.

7.56 Participants at the Carers Café session were supportive of the fact that planned diagnostics would remain at Bronglais under all proposed options, however they would like to see this service offered over longer hours.

7.57 One RWAS visitor felt that removing interventional radiography from Prince Philip (Option C) is a *"slippery slope"* since radiographers are *"pivotal"* for critical care, stroke and urology.

Stroke

7.58 Participants in several groups had experience of accessing stroke services across Hywel Dda. As such, there was strong concern about the impact of the proposed changes on service quality, equality of access, and patient outcomes across the Health Board area. Participants emphasised the importance of maintaining confidence in the local stroke unit. This reflects a broader concern raised about continuity of care and the potential disruption caused by reconfiguring services, particularly for patients who are already vulnerable.

> *"We need confidence in the stroke unit where we access care as many of us have faced issues or barriers." (Carmarthen Stroke Club)*

7.59 Much of the concern expressed was around the geography of the three counties and how the proposed options could lead to significant travel times for patients; particularly those who would normally access the Bronglais stroke unit and would need to travel up to two hours for services at either Prince Philip or Withybush. This was a particular worry given the elderly population of Ceredigion, and for those living in rural areas across the three counties where road infrastructure and public transport networks are poor and ambulance waiting times are already an issue. Participants highlighted that extended travel times could increase stress and risk for patients in the acute phase of stroke care. It was also said that family members wanting to visit patients may have their own conditions that could make the journey challenging; and that for stroke patients, having family around is important for recovery. The combination of patient vulnerability, rural isolation, and transport barriers was seen as a significant risk to both access and outcomes.

> *"My father was in hospital for 18 weeks. Would someone advocate in hospital? He didn't know who he was. I went to see my father every day. I couldn't go every day to Llanelli." (Aberystwyth Stroke Club)*

7.60 Participants also highlighted the impact on families, emphasising that family involvement is critical for recovery, but travel distances and challenges could limit visiting. This concern was particularly relevant for patients in rural areas, where extended travel times may reduce family support at a time when it is most needed.

7.61 Some participants explicitly raised concerns about pre-hospital care and ambulance response times, emphasising that speed in the initial phase is critical for outcomes, and that ambulance waiting times are crucial. Questions were also raised regarding statements implying that rapid access was less important, which participants felt conflicted with the National Stroke Guidelines.

7.62 Other key concerns were around the apparently well-performing Bronglais stroke unit being 'downgraded,' leaving a lack of stroke care in the area. Bronglais was also described as a core part of the community, providing key services and employment; and as such, removing services could have an impact on the work of the speech and language and specialist stroke nursing teams at the hospital, among others. RWAS and Carers Café Aberystwyth attendees highlighted that this could exacerbate existing staff vacancies and put additional strain on remaining teams. It was also said that conversations around the stroke unit at Bronglais is taking attention away from other important services at the hospital, potentially creating uncertainty across multiple areas of care provision.

7.63 Members of the Carmarthen Stroke Club expressed concern that so much of the stroke service would be based at Prince Philip, questioning how staff would cope with the additional workload, and whether there would be an adequate number of beds to accommodate extra patients. They also asked about the relationship between stroke services and A&E, and whether this would be impacted by the lack of an emergency department at Prince Philip; and whether a stroke specialist would be based at A&E in Glangwili. Overall, they felt that the proposed options *"lack a definitive pathway for stroke."* These concerns highlight the perceived risks of centralisation, including potential delays in urgent care, workforce pressures, and the absence of clear, cohesive treatment pathways.

7.64 Conversely, some participants at the RWAS and the Pembrokeshire Stroke Club meeting felt both stroke options may lead to a better service, arguing that if the Health Board is unable to provide a full service at present, refinements are needed. The Pembrokeshire-based participants were particularly positive about retaining stroke services at Withybush, suggesting that careful planning and resource allocation could mitigate some of the concerns raised by other groups.

7.65 There was also support at the Pembrokeshire Stroke Club on the proviso that the model is adequately supported by community or home-based services like physiotherapy and occupational therapy, and that patients are moved back to a hospital closer to home for the latter parts of their recovery. This reflects a wider recognition that acute care is only one part of the stroke pathway and that continuity of rehabilitation close to home is essential for recovery, quality of life, and patient outcomes. RWAS visitors, some of whom were nurses from other parts of the UK, talked of good practice within stroke services in Scotland and the Newcastle areas. They spoke of initial backlash against change from communities and an impact on families in rural areas but said that services are now *"much better"* than they were. This suggests that while change can be disruptive, effective planning, communication, and resource allocation can improve services over time, potentially addressing some of the concerns raised locally.

7.66 Overall, participants emphasised that any model should consider accessibility, staffing, rehabilitation services, and clear patient pathways, to ensure that quality of care is maintained across all parts of the Health Board area.

7.67 In terms of mitigations and alternative options, the following were suggested:

- a 24-hour stroke unit at Withybush – suggested as an option to provide continuous acute stroke care locally in Pembrokeshire.
- a centre of excellence at Glangwili – proposed as a hub with enhanced specialist capacity.
- maintaining a stroke unit at Bronglais – maintaining local services in Ceredigion to ensure continuity of care and access for rural populations.

Stroke: Protect Bronglais Services public meeting

7.68 At the risk of repeating some of the points made above, given it was attended by over 400 people (and supplemented by a petition signed by almost 18,000 people), the key points made at the Protect Bronglais Services public meeting in relation to stroke services are summarised below.

- there was strong support for retaining and investing in stroke services at Bronglais. Attendees consistently emphasised that the hospital delivers high-quality stroke care and should be strengthened. Many described Bronglais as the natural centre of excellence for Mid Wales, citing good outcomes, staff expertise, and geography.

> *"Bronglais had the best stroke pathway out of all four hospitals. If going for best care, Bronglais wins hands down." (Protect Bronglais Services public meeting)*

- the feasibility of transferring patients to Prince Philip or Withybush was the dominant concern. Attendees highlighted poor infrastructure, unreliable public transport, blocked roads, long journey times, and negative impacts on families. Indeed, the positive impact of family support on patient recovery was a strong theme.

> *"Part of the recovery was us speaking to her and helping her. Families are key… travelling all the way to Llanelli is ridiculous." (Protect Bronglais Services public meeting)*

- on a related note, delays in ambulance response, limited air ambulance capacity, and overall system pressures were highlighted as significant risks to any centralised stroke model.
- there was worry that any removal of acute stroke services would be irreversible and would trigger a wider decline of Bronglais, where staff morale was already said to be low.
- attendees repeatedly stated that the consultation materials lacked essential operational detail, particularly around clinical pathways, transport, timelines, and evidence that a Treat and Transfer model can work in a rural area with poor transport links.

> *"We can't assess options unless you have detail on the options. What will services be at two centres and what about transport?" (Protect Bronglais Services public meeting)*

7.69 The key suggested mitigations and alternatives were to:

- invest in Bronglais as a centre of excellence for stroke care in mid Wales which, it was said, would attract staff and strengthen local provision.

> *"If we make Bronglais the centre of excellence for stroke … more staff will come. People will want to work in Bronglais." (Protect Bronglais Services public meeting)*

- make better use of telehealth and digital rehabilitation.
- develop a rehabilitation 'campus' at Llanbadarn in Aberystwyth.
- develop a mid-Wales health board.

7.70 The meeting was closed with a vote (a show of hands) on a motion from Protect Bronglais Services as follows:

> *"We believe that the stroke unit at Bronglais hospital should be invested in and improved and should retain full stroke services for patients to include rehabilitation."*

Urology

7.71 Participants in several groups expressed a negative view of current urology services within Hywel Dda, highlighting long waiting times and standards not being met.

> *"Urology is a travesty. Women suffering retention and catheterised are not seen for three or four weeks." (RWAS visitor)*

7.72 Participants in the West Wales Prostate Cancer Support Group session felt that a centralised hub would work well as long as the communication element is effective. Another questioned how the hub would function, especially whether it would be a 'one stop shop' with someone available to answer all questions in one visit. This participant had problematic experience of having to access different pieces of advice from several different locations in the past.

> *"The idea of a specialist centre is a good one as long as the communications and treatments happen in that day. Need to make sure that the support services are all there too. The patient needs to be told what will happen and how long it will take. This currently isn't happening and needs to be better especially if people are travelling further to access the service." (West Wales Prostate Cancer Support Group)*

7.73 Participants also questioned whether there had been consideration of how interlinked services like radiology would work alongside urology at Prince Philip. An individual also suggested that day surgery for cystoscopy could be done at a clinic; and another that GPs could take bloods for urology patients instead of them having to travel to Prince Philip or another hospital.

7.74 Some participants also felt that learning from successful pathways, such as the Prostate Cancer Pathway at Bronglais, offers valuable insights for improving urology services across the Health Board. Those that had been involved in the development of this pathway questioned whether there was an opportunity to apply a similar approach at other hospitals to address current service challenges and enhance the overall patient experience.

7.75 Also, in terms of pathways, one participant at the West Wales Prostate Group highlighted positive experiences with urology services at Betsi Cadwaladr University Health Board. They noted fewer delays in accessing initial tests and better "active surveillance" than they had experienced in Hywel Dda. Others at the session knew of other group members with similar experiences.

7.76 Alternative options highlighted by participants included:

- decentralising simple procedures to clinics or GP practices e.g. day surgery for cystoscopy.
- centralising specialist services at Prince Philip, with all supporting services integrated.
- using remote consultations where safe.

The role of the main hospital sites

Bronglais

7.77 Several Ceredigion-based participants felt that Bronglais is *"all they've got"* (Aberystwyth and District Stroke Club) to serve the population in the north of the health board area (and beyond into parts of Powys and south Gwynedd), compared to a cluster of provision further south. They said there is no easy way to get from the north to the south of the area, whereas the other main hospital sites are all within relatively easy reach of each other. There was also general concern that the CSP proposals are the start of a slow move of more departments from the hospital.

7.78 Others said that while they had positive experiences of accessing services at Bronglais, they were aware that several departments are 'struggling'. In addition, there was a concern around staffing; for example, one participant stated that the hospital has four operating theatres but just one anaesthetist, meaning its full operating capacity is not being used.

Glangwili

7.79 The only piece of general feedback provided on Glangwili was that it can be difficult to communicate with the hospital. One patient had received poorly written letters and had found the switchboard difficult to navigate, meaning they were unable to speak to the right person.

Prince Philip

7.80 Some participants living in the Llanelli area felt that Prince Philip is underutilised. They also felt there is space to expand on the hospital grounds, and that as it serves the most densely populated area in Hywel Dda, this should be taken advantage of. On the other hand, a few participants questioned whether these proposals are potentially over-burdening Prince Philip, as many services and proposed to be brought together there.

Withybush

7.81 Participants with direct experience of accessing care at Withybush generally shared positive experiences, with a handful of individuals mentioning less positive ones. One Pembrokeshire Stroke Club participant questioned whether the proposed changes were part of:

> *"running down Withybush hospital purposefully."*

Cross-cutting themes

7.82 The most common overarching theme identified across all meetings was that the proposals do not adequately consider transport impacts. Poor road infrastructure, public transport and hospital parking were all said to complicate the need to travel further for services in practice, even if people are prepared to do so in principle if it means quicker or better care. Current ambulance waiting times were also a concern for many, who were of the view that the proposed CSP changes might exacerbate this.

7.83 Therefore, it was thus said that proper consideration needs to be given to how these proposals would be supported by patient transport models, particularly if regional approaches are adopted.

> *"We need to remember the size of Hywel Dda being a quarter of the landmass of Wales. If drawing to one hospital, need to be aware of the distance people need to travel. This is about organising for some, but also physical challenges of travel." (Versus Arthritis)*

7.84 Several participants across the groups also highlighted the potential impact of any changes on Health Board staff and staffing. Key comments were that:

- it is difficult to understand how all the proposed changes would be staffed.
- the general uncertainty is having a negative impact on staff morale, particularly for those working in services that are seen to be 'downgrading'.
- it is unfair to relocate staff and ask some to travel significantly further for work, a particular concern in relation to Bronglais staff.
- there may be insufficient local nursing positions for those graduating from Aberystwyth University.

7.85 However, others highlighted that recruitment and retention should be a key priority, with more focus given to enticing people to work in west Wales. It was felt that creating centres of excellence should help this, as should looking at best practice from other rural areas and countries both within and outside the UK.

7.86 Many participants stressed the importance of understanding patient experiences before making any changes. A few stressed that providing local services should be a priority, whereas others were happy to travel out of their area for a shorter waiting time or a very specialised service.

Equalities impacts

7.87 Participants identified four groups that could be adversely impacted by the proposed changes to clinical services:

- disabled people and people with cognitive impairment - it was said that disabled people often have contact with more than one clinical service, and that bringing these services together at a more distant hospital would involve more travel time for them. Moreover, many are unable to drive and therefore have to rely on public transport, which is unreliable across much of the three counties; and those who are unable to use public transport would have to rely on ever more expensive taxis. There was also worry that any changes could be confusing for those with dementia.
- carers - the issues relating to disabled people above would also impact their carers. In particular, it would be a burden for carers to have to transport the people they care for further.
- older people – participants felt that it could be a challenge for many older people to travel increased distances to appointments and to access other elements of their care, especially if they

have no support network In addition, it was said that the proposed increase in use of technology-led care may be more difficult for this group to adopt.

> *"This is unfair for older people … They don't have the skills. Organisations are not thinking of older people. It's digital exclusion." (Myrtle House, Llanelli)*

» low-income individuals and families - participants in one group felt that the cost implications of having to travel further for care would impact those living on a lower income more than other patient groups.

7.88 Specific feedback was provided on the potential impact of the changes on deaf and hard of hearing people if accessibility needs are not fully embedded in the redesigned pathways. Relocating or centralising services could make it harder for deaf patients to attend appointments if interpreter availability is inconsistent or if video translation tools on hospital iPads are not always charged or operational. Telephone-only booking and confirmation systems would continue to exclude deaf patients unless email or text options are introduced, while delays or cancellations due to the absence of interpreters could worsen patient anxiety and trust. Feedback highlights that written and online materials, including appointment letters, fact sheets, and the Health Board website, are often difficult to understand or navigate, with limited use of Easy Read formats or BSL video support. Without action, these barriers risk widening inequalities in access and understanding.

> *"… The deaf community don't have equity of access to services. [There are] delays due to … no interpreter present or available [which] makes it hard for patients to understand."*

7.89 However, introducing BSL-trained *"champions"* across wards, rolling out mandatory deaf awareness training for staff, and ensuring all communication channels - digital and printed - are fully accessible would significantly reduce these risks. Incorporating these measures into the CSP would ensure that future service changes improve rather than diminish access for the deaf community and demonstrate the Health Board's commitment to equitable, person-centred care.

Views on the consultation process

7.90 Among the groups, views on the consultation process fell into two key themes:

» clarity – the consultation documents were thought to be complex for the average person to understand; and to lack clear capacity, demand, and funding projections, making options hard to compare.

» supporting evidence - more detail and better signposting to background documents were requested.

8. Submissions

Introduction

8.1 During the formal consultation process 115 submissions were received as below. One submission was in Welsh: this was translated by one of ORS's Welsh-speaking researchers, and quality assured by ORS's Welsh-speaking senior researcher.

Table 33: Written submissions by contributor type

Submissions (115)	
Elected Representatives/Councils (13)	
Aberystwyth Town Council Ceredigion County Council County Councillors (two from the same Carmarthenshire County Councillor, and one from a Gwynedd County Councillor) Elin Jones, MS Powys elected representatives (David Chadwick MP, Jane Dodds MS, Cllr Angela Davies, Cllr Glyn Preston & Cllr Fleur Frantz Morgans)	Paul Davies, MS Paul Davies, MS and Sam Kurtz, MS Llanegryn Community Council Llanelli Rural Council Mawddwy Community Council Pennal Community Council
Voluntary and Community Sector Groups (8)	
Amman Valley Hospital League of Friends Carmarthen Stroke Club Ceredigion Disability Forum Pembrokeshire People First	Protect Bronglais Services Salvation Army Aberystwyth Stroke Association The Pebble Pathways
Other Local Health Boards and NHS Networks (5)	
Acute Physical Deterioration Implementation Network Betsi Cadwaladr University Health Board Powys Teaching Health Board Welsh Critical Care Network West Wales Renal Services	
Staff Groups and Networks (4)	
Consultant Physicians, Prince Philip Hywel Dda Physiotherapy Service Senior Management and Stroke Clinical Leads Stroke Multidisciplinary Team, Glangwili Ward 9 Multidisciplinary Team, Prince Philip Hospital	
Individuals (85)	
Including 81 residents, and 4 staff members	

8.2 ORS has read all the written submissions and reported them in this chapter. Most have been reviewed in a thematic, summary format in order to identify the range of views and issues as well as common themes,

though some that have presented unique or distinctive arguments, that refer to different evidence or were submitted on behalf of organisations and individuals representing groups of people, have been summarised individually for accessibility and to highlight their main arguments and any alternative proposals.

8.3 It is important to note that the following section is a report of the views expressed by submission contributors. In some cases, views may not always be fully supported by the available evidence - and while ORS has not sought to highlight or correct incorrect statements or assumptions, this possibility should be borne in mind when considering the submissions.

Summary tables of themes from submissions

8.4 This section includes summary tables of the main themes emerging from 92 shorter or less complex written submissions. This figure includes submissions from 81 individual residents; four individual staff members; three community councils[109] (Llanegryn, Mawddwy, and Pennal); three individual county councillors; and one voluntary/community sector group (Salvation Army, Aberystwyth).

8.5 Most feedback from individual submissions expressed concern around the consolidation of clinical services or hospital sites. Indeed, even where people agreed with the overall premise of the CSP, they disagreed with service centralisation, mainly on the grounds of Hywel Dda's difficult geography.

> *"… Having read the proposals for new plans for the running of Hywel Dda … I thoroughly agree. However, I think it could be disastrous to close services in all the respective hospitals to centralise the treatment facilities, mainly due to the geographical structure of the board's hospitals."*

Removal of stroke services from Bronglais

8.6 Many respondents opposed the closure of the stroke unit at Bronglais, with several having received what they described as excellent care there. Travel and transport concerns were frequently highlighted, with respondents fearing that the longer journey to the next nearest stroke unit could negatively affect timely access to specialist treatment and recovery support for often critically ill patients. This was a particular issue for those living to the north of Bronglais in south Gwynedd.

8.7 Specifically, one respondent noted that Bronglais has the "*best performing stroke unit in the Hywel Dda area"* according to the Sentinel Stroke National Audit Programme (SSNAP)[110], suggesting that its strong performance warrants continued support and further investment.

8.8 We would note that some respondents' comments suggested a belief that stroke services were to be removed from Bronglais in their entirety; that is, patients would be expected to travel elsewhere for initial as well as specialist treatment. This perhaps suggests a need for more information around the 'Treat and Transfer' service.

[109] While it could be argued that submissions from community councils meet the criterion of 'organisations and individuals representing groups of people,' the identical responses received from these three councils were short and have thus been included in the summary tables. .
[110] Sentinel Stroke National Audit Programme

Table 34: Summary of main themes raised in written submissions – consolidation of stroke services

Sub-theme	Example Comments
Removal of stroke services from Bronglais (travel and transport)	*"… The area served by the only 'general hospital' in central Wales is vast and thus [it] needs to be maintained in order to avoid costly, lengthy, dangerous journeys on not easy A roads not motorways."* *…Your suggestion to remove services from Bronglais means that potentially highly unstable patients will have to travel between 90-120 minutes to arrive at the nearest stroke unit …"* *"… having to travel hours is uncomfortable and not good for my anxiety, I would feel much more comfortable knowing I could have treatment in Bronglais!!"*
Removal of stroke services from Bronglais (rural disadvantage)	*"Rather than removing services from a hospital cut off to the rest of Wales by the pitiful transport links, you should be looking at maintaining these services at Bronglais and removing them from areas with better transport links and closer medical services ..."* *"If you downgrade so that we have even further to travel, you are excluding rural villages from the healthcare we need and have also contributed to."* *"If a map showing the main hospitals in Wales is considered, the north and south Wales corridors are amply supplied with services, but the mid Wales region clearly has just Bronglais in Aberystwyth. Thus, to downgrade or reduce any of the current services available at Bronglais would be disadvantaging, possibly endangering, the lives of the population living in the mid Wales region ..." (Salvation Army, Aberystwyth)*
Removal of stroke services from Bronglais (impact on residents north of Aberystwyth)	*"The main issues causing extreme worry are the mooted changes to the Stroke Unit, and the huge concern with the plan is the transfer of patients element. Our area is over an hour from Bronglais …There [is] strong feeling that the proposals are dangerous and unsafe, and that the idea is unworkable with current resources and pressures... " (Mawddwy Community Council)* *"The main issues causing extreme worry are the mooted changes to the Stroke Unit ... Our area is approximately 50 minutes to 1 hour from Bronglais, and the urgency is paramount." (Llanegryn Community Council and Pennal Community Council [separate submissions])*
Removal of stroke services from Bronglais (impact on older residents)	*"…Ceredigion and Powys have two of the largest proportions of people aged 65+ in Wales. Age being a critical risk factor in people suffering from strokes. I'm quite baffled that you think the options presented in the Clinical Services Plan are acceptable."*
Removal of stroke services from Bronglais (patient outcomes)	*"The support of family and friends is so important for patients who have experienced a sudden and life changing stroke. Patients can have communication difficulties following such an event and family are vital in ensuring patients' voices are still heard. A stroke is a very disorientating experience and this would be compounded by patients being treated in a hospital so far from home and isolated from their loved ones. It would add a lot of stress to an already challenging situation and doesn't consider elderly spouses who can't drive or are only comfortable driving shorter distances. Online meetings are not always a viable option for loved ones who might have their own health issues"*

Removal of stroke services from Bronglais (impact on ambulance service)	*"… You are also taking ambulances out of the community committing them to transport patients from Bronglais. These journeys are likely to occupy these emergency ambulance for hours, further depleting the health services of mid-Wales"*

8.9 One respondent did, though, recognise the clinical arguments for consolidating stroke services to enable the provision of specialist care on at least a 12-hour basis; and understood that it would not be possible to centralise in Bronglais given the hospital's geographical location.

> *"… I am aware of the very strong local feeling regarding retaining the current Bronglais facilities, but the clinical arguments put forward really dictate otherwise, unless Bronglais became the single Hywel Dda centre, which I fear would be impractical ... Against this background, it is essential that the proposed new service is fully staffed and otherwise resourced to ensure that it achieves the anticipated level of success. I totally agree that this positive outcome would outweigh any 'geographically based' reservations …"*

The future of Llandovery Hospital

8.10 Significant concern was expressed about the proposed removal of X-Ray services from Llandovery Hospital, not least due to the distance to alternative provision in Carmarthen and a fear that this is the 'thin end of the wedge' for the hospital. Respondents also emphasised the vital role of community hospitals in general, highlighting positive personal experiences of care at Llandovery; and the broader value of the hospital to the local community and in reducing pressure on services at Glangwili.

8.11 Many respondents highlighted past and present efforts to retain services at the site, including successful local fundraising by the League of Friends for a new X-ray department and strong community engagement in the current consultation process, as demonstrated by high attendance at Hywel Dda's consultation events.

8.12 We would note, though, that the significant number of responses in support of Llandovery Hospital appears to have been driven by misconception that Hywel Dda is proposing to close the facility in its entirety. This is reflected in some of the comments overleaf.

Table 35: Summary of main themes raised in written submissions – the future of Llandovery Hospital

Sub-theme	Example Comments
General positivity around Llandovery Hospital	*"This hospital has been a lifeline not only for our town but for many families across our rural area."* *"We have been so lucky to receive the care we have from the whole team at Llandovery hospital… so dedicated and caring."*
Concerns that his would be the 'thin end of the wedge' for Llandovery Hospital	*"… It is imperative that we fight for our hospital ... It's a vital service we can't afford to lose… We must fight to protect it from the slow impending cuts to beds and services that threaten its integrity and set it up to fail and potentially close …"*
Community hospitals are important/in-line with the shift toward community healthcare	*"The whole premise of reform to the health service is now to make care more local and try to keep people out of large expensive general hospitals, as well as work at prevention not the treatment of illness. That is where community facilities becomes so important …"* *"Llandovery hospital should be safe as there are few cottage hospitals left to transfer patients for rehab or ongoing care prior to discharge."* *"Local hospitals are so important, they save local residents having to travel for care but also give relatives peace of mind that their loved ones are being looked after."*
Llandovery is a key location for community hospital services	*"… Llandovery is a thriving community that needs its service. Losing the hospital would be mortal blow to the town …"* *"… Living in a rural community like ours comes with many challenges—limited public transport, greater distances to healthcare, and a growing elderly population. These are precisely the circumstances in which a local hospital becomes not just helpful, but essential."*
Investment in Llandovery Hospital will help mitigate some of Hywel Dda's challenges	*"Llandovery Cottage hospital should be used as a 'model' by the Government for an incredible, valuable and exceptional solution for care in our communities. It makes a difference in the lives of so many people. To close it would be devastating. There should be MORE hospitals like Llandovery to reduce the pressures on hospitals like Glangwili …"* *"The hospital provides essential healthcare services to the local population, and its closure would put an undue burden on the General Hospital (WWG) in Carmarthen. WWG is already operating at full capacity, and diverting patients from Llandovery would lead to increased waiting times, reduced quality of care, and additional pressure on the hospital's staff …"*
Community efforts to retain services at Llandovery Hospital	*"… Local fundraising secured the money needed for a new x-ray department to be located at the hospital … Locals made strenuous efforts to raise the finance, as it removed the necessity of having to travel to Carmarthen."* *"I would be very happy to give a monthly donation to help keep the hospital running if needed. We need to fight the Health Board and show them how much our wonderful hospital means to the community."*

Retaining services at Llandovery Hospital would benefit groups like vulnerable young people and older people	*"There are lots of vulnerable young adults in Llandovery and surrounding areas. [Llandovery Hospital] is small, friendly and doesn't contain the anxieties involved with having to travel to huge intimidating hospitals."* *" … The closure of Llandovery Hospital would disproportionately affect the most vulnerable members of the community, including the elderly, young families, and those with chronic health conditions."*

8.13 In light of these arguments, respondents suggested:

- » "*a genuine alternative would be to expand the services at Llandovery for a wider catchment area*," making use of the successful existing GP service and exploring its potential expansion onto nearby vacant school land.
- » the reintroduction of thoracic and orthopaedic clinics
- » reintroducing a Minor Injuries Unit.

> *"… Services have continually been reduced and we are left with a hospital this is now little more than a place where patients convalesce [after] being discharged from West Wales General Hospital or are sadly nearing the end of their life … This is the benefit of having community hospitals, as the level of care provided locally is more personal and for this reason we believe that the future of our community hospital must be secured and we feel that the reintroduction of services at local level will ensure this … We appreciate the financial restraints that the health authority works under but we firmly believe that further investment in the hospital is needed and that the minor injuries unit should be reopened, x-ray services should be more frequent, and that regular clinics should be provided ...*

Travel and transport

8.14 Some individual respondents noted more general travel and transport concerns associated with the geography and infrastructure of Hywel Dda, particularly in relation to poor public transport networks in rural areas. In light of this, it was suggested that patient transport schemes would need to be expanded in future if certain clinical services are provided from fewer locations.

Table 36: Summary of main themes raised in written submissions – travel and transport concerns

Sub-Theme	Example Comments
General concerns about travel and transport	*"… Don't tell me that sending us, when ill, on non-existent transport on tortuous journeys through winding Welsh roads, to arrive at an over-stretched distant hospital, will serve us better. It is pure lies."*
Public transport infrastructure does not support people to make longer journeys, especially those living in rural areas	*"The choices all involve excessively long and difficult journeys for patients. These journeys are impossible to make by public transport, and I doubt that any hospital transport schemes … will cope with the demand."* *"… I can't think of anything worse, having had to do one such journey from St Davids to Carmarthen being extremely sick all the way there, not very good if you are in your own car let alone on public transport"*
Equality considerations for travel to new service locations	*Change will require users to travel more. What transport support will be there for the elderly, the poor or the vulnerable? … Change will require adequate emergency transport to and between sites.*

Staffing and resources

8.15 Several submissions focused on staff recruitment and retention challenges. Respondents highlighted retention barriers unique to the area like wider employment opportunities for staff members' families, and Welsh language education for non-Welsh families; and suggested mitigations like lobbying for better pay for nursing staff to encourage them to stay and lay down roots in the area.

Table 37: Summary of main themes raised in written submissions – staffing and resources

Sub-Theme	Example Comments
Poor employment opportunities for partners prevents staff from moving to the area	*"A major disincentive to recruitment is difficulty in finding suitable employment for wives, partners and family members."*
A lack of English-language education provision for children from non-Welsh families	*"… In my experience, younger professional staff and their families frequently look upon themselves as 'internationally mobile', and place a very high value on English language education"* *"… Chatting to [hospital staff], they loved Wales but did not want the complication of children having to learn Welsh in school and so would not stay for long. Sometimes I feel the public needs to understand the pull-push factors for doctors seeking employment. It is not just the job but the consequences for the whole family."*
Need to lobby for higher pay for nursing staff	*…The nurses are … leaving nursing for better paid employment. If they were paid more, more people would join the profession."*

8.16 More specifically, one staff respondent stated their objections to Options C and D for radiology (which would see the removal of inpatient interventional radiology from Prince Philip) and the impact this would have on their decision to remain working in Hywel Dda.

> *"I have no intention of working anywhere west of Llanelli, so if day case interventional services were taken away from Prince Philip then I would look to move … I appreciate that the best options for the health board need to be met and considered, but I feel that day case interventional services should be offered in any radiology department which views itself as offering a good service."*

8.17 Furthermore, another respondent questioned the feasibility of many of the consultation options in terms of the need to attract and retain sufficient staff to sustain them.

> *"Change requiring different staff will require enhanced recruitment. Where is the costed staffing proposal that commits to, and accepts responsibility for, increased levels of appropriately trained personnel? Wishing for recruits is profoundly different from enticing and keeping them."*

The consultation process and options

8.18 The consultation process and options were mentioned in several submissions. Individual respondents had mixed views on the success or otherwise of consultation engagement. While there were some positive comments relating to the consultation overall and, more specifically, the public drop-in events; respondents also criticised these two aspects, as well as the complexity of the consultation options and the volume of structural change that would be necessary to ensure their success.

8.19 There were also a few comments around decision-making processes, notably around decisions having already been made, and the need to consider that people's personal experiences and geographical location will have influenced their choices. Moreover, one respondent was of the view that decisions should be made by Health Board 'experts,' without what they considered unnecessary input from members of the public.

Table 38: Summary of main themes raised in written submissions – the consultation process and options

Sub-theme	Example Comments
Positive experience of public drop-in events	*"I found the event most helpful, and your staff were, without exception, putting forward really well thought through arguments."*
Praise for the Health Board's overall direction of travel	*"… This is a more realistic approach than the last consultation exercise launched in 2018, which centred on the possibility of a new hospital in west Wales but then fell on stoney ground as there was no political will or financial resource to fund the much needed upgrade … Whilst upgrades in the physical state of hospitals are still justified, a review of provision seems to be a more realistic ambition, at least in the short term …"*
General criticism of the consultation	*"This consultation is fundamentally flawed, is not fit for purpose and should be withdrawn."*
Criticism of the complexity of the consultation options	*"… I wouldn't have a clue which options to choose, it would just be guess work on my part if I were to do it … Surely decisions of this complexity should be decided based on clinical need."*
Consultation options are reasonable in isolation, but require significant, systemic change when taken together	*"In isolation your recommendations are not unreasonable … In context, however, they are devastatingly poor. The proposals require some changes to location or staffing levels, but they cannot possibly be delivered without changes to the basic structures."*
Criticism of public drop-in events	*"… A shockingly huge amount of money has been spent on these meetings (very contrived format, rehearsed NHS manager "speak") and glossy, slick brochures which don't actually give a detailed analysis of the cost and impact of any of the 'choices.'"* *"…. There is nothing for Milford Haven … the last event was well attended…"*
Personal experiences and geographical locations will shape viewpoints, rather than the needs of the health board overall	*"… Public opinions will be totally subjective to personal preferences, and the cost implications could be unaffordable."* *"… People will only be able to choose options based on their personal experience or how it effects the area they happen to live in rather than being able to give a balanced decision that reflects the needs of the whole community."*
Decisions already been taken	*"What a waste of time, money and resources! You have already made abominable decisions, this is an exercise in making it look like the public has been consulted …"*
Unnecessary consultation	*"… [the Health Board] know better than anyone which services are valuable and should not be tampered with, they don't need to ask for our opinions."*

8.20 A specific concern was raised by a member of staff in relation to the options for radiology, as follows.

> *"… I would like to express concern regarding a specific statement about proposed changes to radiology services. The statement in question claims: "The shift changes to seven days a week, 12 hours a day, from Monday to Friday 9am to 5pm, is more attractive to radiographers" … From discussions among staff, there is no indication that this reflects the views of the wider radiography team. In fact, the general consensus from those I have spoken to suggests the opposite. Presenting this as a factual statement in a public consultation is concerning."*

Alternative suggestions and mitigations

8.21 Respondents offered several alternative suggestions and mitigations. These recommendations largely focused on investing in services across Hywel Dda to improve access for patients.

- service-based clinics at each hospital

> *"I would propose that each hospital holds weeklong appointments, incorporating the relevant specialists i.e. dermatology, tissue viability, skin cancer etc. This way multiple appointments could be covered for patients that need more than one consultant … These form of clinics have been trailed in England with not only great success in greatly reducing waiting times, but also reducing costs."*

- more procedures in GP surgeries/mobile clinics

> *"Improve patient accesses to GP surgeries … have a mobile minor surgery team that can travel into rural communities to supply treatment."*

- seven-day services in hospitals

> *"To make full use of expensive equipment and expensive staff and time hospitals, should operate fully seven days a week."*

- improved communication and appointment contact systems

> *"Changing things means the users will need to be able to contact the right departments … A professional contact strategy is required not the current pathetically uncoordinated approach."*

- utilise mid Wales transport links to facilitate access to specialist hospitals in England

> *"… Hywel Dda needs to re-evaluate the extent to which it can … share facilities and resources. In mid Wales, we have reasonable public transport and road links to Shropshire, Liverpool, Manchester and Birmingham. All these locations have centres of excellence that we ought to be working with more closely."*

8.22 Another respondent, who did not wish to be quoted directly, advocated for a more innovative and flexible integration of private healthcare within the NHS to help reduce waiting times. They criticise the rigid and politically driven adherence to the NHS Pathway, noting that the NHS already selectively uses private providers (e.g., for orthopaedic surgeries). They felt that delays in accessing specialists through the NHS can cause repeated GP visits, additional health issues, and increased treatment costs. Allowing patients to consult privately - while having subsequent treatment and prescriptions covered by the NHS – would, they felt, ease pressure on services, reduce costs, and make better use of consultant time.

Summaries of detailed or 'representative' submissions

8.23 As previously mentioned, some written submissions have been summarised in more detail to highlight their main arguments. Those reported in this section are mostly, but not exclusively, from organisations and have been chosen either because they cite sources of evidence or raise 'different' issues to those repeated by a number of respondents, or because they represent the views of larger groups of people.

Key themes from detailed submissions

8.24 The detailed written submissions do not lend themselves to easy summary and so readers are encouraged to consult the remainder of the chapter below to read a full account of the views expressed, and refer to https://hduhb.nhs.wales/about-us/healthier-mid-and-west-wales/clinical-services-plan-consultation/ to see the responses in full.

8.25 Nonetheless, the summary of key findings below gives a sense of the types of issues raised – a 'summary of summaries'. Following the key findings, the submissions are subsequently presented in more detail, grouped in sections according to their main focus.

Views on critical care

8.26 There was some support for centralising critical care from the Acute Physical Deterioration Implementation Network, though it also warned that loss of on-site expertise could harm deteriorating patients unless outreach and workforce plans are built in. There was also conditional support for an Enhanced Care Unit among the Prince Philip consultants, providing the Health Board follows national guidance and properly funds staff, outreach, and equipment. Aberystwyth Town Council welcomed the options for critical care as none reduce provision at Bronglais.

8.27 Patient safety was a key concern. Consultant physicians at Prince Philip emphasised that any future model must ensure patient safety, senior presence, and proper staffing; and the Welsh Critical Care Network raised patient safety and staffing concerns, particularly in relation to ICUs without intensivist cover. In this context, the Network notes the public may not understand patient safety risks in Option C (four ICUs across the Health Board area) as current staffing deficits are understated in the CSP.

8.28 There were also some cross-regional concerns, with the West Wales Renal Service warning that removing continuous renal replacement therapy from sites without HDU/ICU could endanger renal patients; and Betsi Cadwaladr University Health Board noting that Wales already has low critical care bed numbers; any that reduction in capacity could have national impacts.

Views on dermatology

8.29 Few submissions explicitly referenced dermatology. Those that did highlighted poor current dermatology access for immunosuppressed renal patients, proposing clearer referral pathways and expanded nurse-led clinics (West Wales Renal Service); noted that that dermatology services at Withybush have effectively ceased since RAAC issues, leaving Pembrokeshire patients without local provision (Paul Davies, MS); and called for regional collaboration between health boards to address chronic workforce shortages and sustain dermatology services across mid Wales (Betsi Cadwaladr Health Board).

Views on emergency general surgery

8.30 Few submissions explicitly referenced emergency general surgery. The West Wales Renal Service deemed Option B (alternating cover between Glangwili and Withybush) unsafe and called for same-day transfer capacity and daily surgical cover; Betsi Cadwaladr University Health Board recommended strengthening same-day emergency care at Bronglais to improve local access; and Paul Davies MS opposed the removal of emergency surgery from Withybush, citing unsafe travel distances and reduced patient recovery. Aberystwyth Town Council and Pembrokeshire People First also mentioned emergency general surgery in the context of needing to maintain core services at local hospitals, with the former welcoming the options as neither reduce provision at Bronglais.

Views on endoscopy

8.31 Few submissions explicitly referenced endoscopy. Betsi Cadwaladr University Health Board noted that the relocation of bowel screening under Option B could create travel barriers and suggested mobile screening units; the West Wales Renal Service opposed relocating all respiratory/urology endoscopy to Prince Philip, which lacks ICU backup, and recommended retaining some capacity at Glangwili; and Pembrokeshire People First described endoscopy and radiology as important diagnostics supporting emergency care. Aberystwyth Town Council said it regrets that all proposed endoscopy options would negatively affect Bronglais and requests that any community site be located in the north.

Views on ophthalmology

8.32 Few submissions explicitly referenced ophthalmology. Betsi Cadwaladr University Health Board supported the options that retain services at Bronglais and urged joint planning for sustainable regional eye care; and the West Wales Renal Service supported Glangwili as surgical centre for ophthalmology because it has the dialysis and ICU support needed by renal patients. Aberystwyth Town Council supported Option C for ophthalmology to maintain services at Bronglais.

Views on orthopaedics

8.33 Few submissions explicitly referenced orthopaedics. Betsi Cadwaladr University Health Board backed Option D (more inpatient capacity at Bronglais) and felt that consolidation onto fewer sites might improve outcomes if travel and post-operative care are supported; but the West Wales Renal Service warned against concentrating orthopaedics at Prince Philip, which lacks renal and ICU services. Aberystwyth Town Council welcomes the options for orthopaedics as none reduce provision at Bronglais.

Views on radiology

8.34 Few submissions explicitly referenced radiology. Betsi Cadwaladr University Health Board foresaw little direct impact but noted the loss of inpatient interventional radiology at Bronglais in Options B and D; and

the West Wales Renal Service supported centralising interventional radiology at Glangwili only if transport and repatriation are resourced. The service also supported extending hours at existing sites over new diagnostic hubs. Pembrokeshire People First considered diagnostics to be important to emergency care, and Aberystwyth Town Council supported Option C for radiology to maintain services at Bronglais.

Views on stroke

8.35 Stroke services were mentioned in 16 submissions, from Carmarthen Stroke Club, Ceredigion County Council, the Hywel Dda Physiotherapy Service & Stroke Clinical Leads, Elin Jones MS, the Powys Elected Representatives, Protect Bronglais Services (two submissions), the Stroke Association, the Stroke multidisciplinary team at Glangwili, the Ward 9 Stroke multidisciplinary team at Prince Philip, Betsi Cadwaladr University Health Board, the West Wales Renal Service, Aberystwyth Town Council, Powys Teaching Health Board, the Ceredigion Disability Forum, and an individual respondent.

8.36 Multiple submissions opposed the proposed 'Treat and Transfer' model, highlighting long travel times, patient transfer risks, poor transport, and loss of family support. This view was particularly prevalent in the context of Bronglais, with many responses advocating maintaining a full stroke unit at Bronglais as a rural hub for mid Wales with acute and rehabilitation capacity.

8.37 In terms of the options, the West Wales Renal Service cautioned against placing stroke care at Prince Philip as it has no dialysis or ICU capacity; the Glangwili MDT argued for Glangwili as the main stroke centre due to infrastructure and workforce; and the Prince Philip MDT supported either Option A or B, citing strong staffing and performance locally.

8.38 More specifically, Physiotherapy Service Senior Management and Stroke Clinical Leads proposed integrated acute and rehabilitation units in each county to support person-centred care and staff sustainability; and the Stroke Association urged alignment with national stroke transformation plans, early supported discharge investment, and proper bilingual care.

Views on urology

8.39 Few submissions explicitly referenced urology. Betsi Cadwaladr University Health Board supported consolidating inpatient and diagnostic urology at Prince Philip but wanted mitigations for long travel. The West Wales Renal Service warned that splitting urology, renal, and radiology across sites would fragment care and create unsafe transfers; and advocated keeping full capacity at Glangwili. Aberystwyth Town Council welcomed the option for urology as it does not reduce provision at Bronglais.

Views on the future role of Hywel Dda's hospitals

8.40 In considering the future role of the Health Board's hospitals:

- Betsi Cadwaladr University Health Board broadly agrees with reconfiguration direction but stresses collaborative regional planning, transport access, and funding clarity.
- West Wales Renal Service supports complex acute care remaining at Glangwili, with clear elective/acute separation and safe repatriation pathways.
- Aberystwyth Town Council strongly urges that Bronglais remain a full District General Hospital.
- Amman Valley Hospital League of Friends emphasises using community hospitals and clinics for aftercare to reduce travel.

- The Pebble Pathways opposes building a new hospital; proposing a three-tier system (general hospitals, community hospitals, integrated care centres) with strong digital and transport integration.
- Llanelli Rural Council calls for clear modelling, transport, and staffing plans before major hospital role changes proceed.

Other key cross-cutting themes

8.41 Transport and accessibility was the most commonly recurring concern across 14 submissions, particularly in relation to poor transport links (especially by public transport) and unequal access for rural patients and families. Indeed, equity and rural health inequality was a key issue for many respondents.

8.42 Workforce sustainability was also frequently highlighted (in nine submissions), particularly in relation to recruitment and retention challenges leading to staff shortages and service fragility. The importance of clear, funded workforce plans in delivering future models of care was strongly stressed; as were the benefits of regional collaboration to build resilient, shared staffing models across health boards.

8.43 In terms of equalities issues, which were raised in 14 submissions, the CSP options were said to potentially disproportionately impact rural residents, older and disabled people, carers, Welsh speakers, and low-income households. Several submissions framed these as equality and human rights issues, arguing that the proposed reconfiguration could widen existing health inequalities unless mitigated through local access, transport investment, and increased bilingual and digital healthcare provision.

Summaries of detailed submissions

The following 12 summaries mainly relate to specific clinical services. The first three (from the Acute Physical Deterioration Implementation Network, consultant physicians at Prince Philip, and the Welsh Critical Care Network) are mainly about critical care services; and the remainder (from Carmarthen Stroke Club, Ceredigion County Council, Hywel Dda Physiotherapy Service Senior Management and Stroke Clinical Leads, Elin Jones MS, Powys elected representatives, Protect Bronglais Services, the Stroke Association, the Stroke Multidisciplinary Team at Glangwili, and the Ward 9 (stroke rehabilitation) MDT at Prince Philip) are mainly about stroke services.

Summaries mainly relating to critical care

Acute Physical Deterioration Implementation Network

The Acute Physical Deterioration Implementation Network recognises the advantages that centralising critical care provision has for patients transferred to critical care; but highlights a *"potential negative impact for patients not in critical care with the loss of critical care outreach and support, unless this is factored into the plan."* The Network notes that, from an acute deterioration perspective, early intervention can prevent escalation to critical care, but that this intervention may need to include input from colleagues with higher levels of care skills, including critical care skills. If these individuals are no longer on site, *"this needs to be factored into the service development, workforce planning and funding to ensure all patients, not just those on critical care, are responded to appropriately when they deteriorate."*

Consultant Physicians, Prince Philip

The Consultant Physicians at Prince Philip understand the need for change but emphasise that any alteration to the current model must not compromise patient safety, service sustainability, or the hospital's role in serving the Llanelli population.

Background and current position

Until 2023, Prince Philip had a fully functional Intensive Care Unit (ICU) with daily consultant-led rounds. However, staffing pressures and the withdrawal of ICU consultant cover from Glangwili to Prince Philip led to the transfer of all critically ill (level 3[111]) patients to Glangwili. Over time, nearly all patients requiring critical care support have been moved there, leaving an underutilised high-dependency area at Prince Philip. The consultants note that this has created difficulties for critical care nurses, middle-grade doctors, and senior clinicians working without on-site ICU consultant support.

Position on Option C – retaining a reduced ICU

The consultants acknowledge that retaining an ICU under Option C would be desirable but contingent on significant improvements in staffing and senior clinical presence. They say that daily consultant ward rounds and a consistent physical presence of senior ICU decision-makers would be essential to safely sustain such a service. Without these, the current arrangement is not viable.

Consideration of an Enhanced Care Unit (ECU)

The consultants indicate conditional support for the conversion of the ICU into an Enhanced Care Unit (ECU), but only if specific safeguards and investments are guaranteed. Specifically, their support is explicitly dependent on the Health Board adhering to the Intensive Care Society's *"Enhanced Care Units: Guidance on Development and Implementation within Acute Medicine"*. They outline eight key requirements for any ECU model to be acceptable:

- staffing – ECUs must be closed, consultant-led units. Prince Philip would require at least three new acute medical consultants to manage the ECU and provide outreach support across wards.
- bed numbers – the proposed four beds are insufficient; six to eight beds would be necessary to meet current patient demand and reflect the existing ITU footprint.
- critical care outreach – a dedicated outreach team is essential, especially since Prince Philip would no longer have an on-site ICU.
- fully funded MDT – the ECU must include dedicated physiotherapy, dietetics, occupational therapy, and speech and language therapy.
- close collaboration with Glangwili ICU – daily briefings or *"sit reps"* are needed to coordinate patient transfers and ensure continuity of care.
- remote monitoring – real-time digital monitoring should connect ECU and ICU teams, allowing shared clinical oversight.
- patient transfers – out-of-hospital cardiac arrest cases, which often require ventilation, could no longer be received at Prince Philip. The Health Board must coordinate with Swansea Bay University Health Board to redirect these patients to Morriston Hospital.

[111] Level 3 critical care is for critically ill patients who require advanced life support for two or more organ systems, or advanced respiratory support alone.

» patient stabilisation – adequate staffing and resources, including a dedicated ICU middle-grade doctor, are needed to stabilise severely unwell patients before transfer to Glangwili.

Outstanding clinical questions

The consultants highlight unresolved clinical and operational issues, including whether ITU-trained nurses would be required within the ECU to manage temporarily ventilated or inotrope-dependent patients[112], and whether operating department practitioners (ODPs)[113] could assist with rapid response for deteriorating patients elsewhere in the hospital. They also call for clarity on appropriate equipment provision.

Conclusion

The consultants conclude that, if these conditions are fully met, Prince Philip could safely operate with an ECU and maintain a sustainable acute medical service. However, if the necessary resources are not implemented beforehand, they would instead demand the reinstatement of a fully functional, consultant-supported ICU. They stress that any further reduction in support for severely unwell patients would force significant numbers of admissions to be redirected to Glangwili or Morriston - hospitals that are already struggling to meet acute demand - thereby undermining regional healthcare capacity.

Welsh Critical Care Network

The Welsh Critical Care Network raises the following concerns about the consultation options and other issues, particularly around workforce capacity, patient safety, and clarity of communication.

» Allied Health Professional (AHP)[114] workforce deficit - the CSP's claim that additional therapies support will be provided in all hospitals is misleading, given current shortages. AHP support across Hywel Dda's ICUs is "*patchy*" as staff are stretched across multiple intensive care units.

» patient safety and consultant-led care - the CSP does not adequately explain that some ICUs currently operate without direct, consultant intensivist-led care, posing potential patient safety risks. The Network is concerned that *"whereas the common public would probably vote for maintaining 4 ICUs (and hence an ICU closer to home), they may not comprehensively understand the underlying patient-safety risks with delivered care in an ICU without an intensivist direction."*

» *"Option C's patient safety risk has not been conveyed with enough clarity"* in that it gives the impression that the current model of four ICUs continues to provide safe critical care, when patient safety concerns have been flagged by clinicians around risks with the current critically ill patients managed at Prince Philip.

» Option C's reference to staffing challenges understates the severity of current shortages; and the financial note (a £553,000 increase in staffing costs) fails to highlight the patient safety risks of reliance on agency staff (who might be required with a four-site model) who are unfamiliar with local unit policies, recruitment difficulties for consultant intensivists, and ongoing (recurrent) staff costs.

[112] Individuals with advanced heart failure who require continuous inotropic medication to maintain adequate blood pressure and heart function.
[113] Healthcare professionals who work in the operating theatre, managing the care of patients throughout the anaesthetic, surgical, and recovery phases of an operation.
[114] Degree-level healthcare practitioners who diagnose, treat, and rehabilitate patients across various settings, including hospitals and the community.

» transfers between sites - the document implies that Adult Critical Care Transfer Services (ACCTS) is the only transfer option, but other inter-hospital transfer models exist in Wales. Health boards should consider alternative transfer arrangements used elsewhere in the UK.

Summaries mainly relating to stroke

Carmarthen Stroke Club

The Stroke Club provides the following three patient case studies illustrating challenges in stroke care within Hywel Dda, highlighting systemic issues and gaps in communication, monitoring, and follow-up. It notes that these experiences are offered:

> *"to help improve the services to stroke sufferers."*

Patient A suffered two strokes, experiencing delays in initial diagnosis. Following their eventual hospitalisation, their discharge was poorly coordinated: they were transferred late at night to a ward *"that did not have the equipment that was needed by a stroke patient,"* and no ward assumed responsibility until the family repeatedly intervened. Post-discharge, Patient A's medical records lacked critical information, causing further care delays.

Patient B experienced a severe stroke at home, with significant ambulance delays. Upon arrival at A&E, there were further delays in assessment and transfer, and the patient spent many days on a chair in a Clinical Decision Unit (CDU)[115] awaiting a bed, without seeing a stroke consultant or undergoing imaging. The Stroke Club emphasises that *"time is of the essence for stroke patients"* and calls for better adherence to protocols, suggesting that the main stroke unit should be in Glangwili to take advantage of transport links.

Patient C experienced missed diagnosis and prolonged delays. Despite persistent symptoms, initial scans were not conducted, and it was only through a private MRI that a stroke was confirmed. On subsequent hospitalisation, they spent days in A&E and on a chair in CDU before being transferred to the stroke ward, with minimal follow-up from hospital or GP services. The patient describes feeling *"very isolated and lonely"* until support from the Stroke Association and their local stroke club was accessed.

Ceredigion County Council

At its meeting on 12 June 2025, Ceredigion County Council considered a motion concerning the Hywel Dda CSP Consultation, with a particular focus on Bronglais and its stroke unit. The Council emphasises that while Bronglais is geographically on the northern edge of the Health Board area, it occupies *"a central position on the map of Wales"* and is *"the only general hospital between Carmarthen and Bangor,"* serving patients across Ceredigion, Powys, and Meirionnydd. Accessibility and local provision are described as *"fundamental to good healthcare,"* and the Council expresses concern that any reduction of services - especially stroke services - would deny patients the benefits of treatment close to home and family, which is known to improve recovery outcomes. The submission highlights that Bronglais' stroke unit *"provides excellent care*

[115] A hospital area for patients who require short-term observation, testing, or treatment but do not need to be admitted to a hospital.

and outcomes to the patients and outperforms other units," with integrated support such as physiotherapy contributing to these results.

The Council also raises the practical barriers posed by centralisation, noting that moving services to Prince Philip or Withybush would exacerbate issues caused by already limited public transport links, with some journeys from the Bronglais catchment taking more than four hours each way (by bus). This, they argue, is *"unfair to the patient and the relatives"* and risks treating the rural population of mid Wales as *"second class citizens."*

The Council supports the work of the local campaign group 'Protect Bronglais Services' and calls for *"the maximum provision of facilities and services at Bronglais General Hospital"* to ensure equitable healthcare. It formally requests that Hywel Dda and the Welsh Government clarify their positions on the future of vital services at Bronglais, stroke services in particular, to safeguard access and equity for central Wales.

Hywel Dda Physiotherapy Service Senior Management and Stroke Clinical Leads

The physiotherapy service senior management and stroke clinical leads propose an alternative model for stroke care in Hywel Dda. They recommend the establishment of integrated acute stroke and rehabilitation units in each of the three counties - Carmarthenshire, Ceredigion, and Pembrokeshire. While the physiotherapy service does not comment on the sustainability of delivering acute medical and nursing care across three units, they strongly emphasise the necessity of maintaining three local rehabilitation units to deliver true person-centred care closer to patients' homes. Such an approach ensures continuity of care for stroke survivors, supporting them from day one through rehabilitation and, in many cases, throughout life.

The submission underlines the critical role of physiotherapy in improving quality of life, neurological recovery, functional independence, and reducing long-term disability, which directly impacts community health and social care resources. Timely, expert physiotherapy intervention at appropriate frequency and intensity, alongside wider therapy support, is considered central to achieving better patient outcomes. Co-located acute and rehabilitation units are recommended as they maintain local expertise, promote workforce retention, and enable collaborative 'tandem' working between staff, fostering learning, development, and resilience across MDTs.

The submission also notes that physiotherapy staff are integral to supporting low-level therapy interventions delivered by families, which supplement rehabilitation and improve outcomes. Without maintaining specialist interventions locally, particularly in Ceredigion, expertise would be lost, and continuity of care for patients and families would be compromised.

Financial and operational considerations are also emphasised. Local rehabilitation units are said to:

- reduce patient travel costs, agency expenditure, staff turnover, and the need for cross-site cover.
- decreasing the reliance on ambulance and Emergency Medical Retrieval and Transfer Service (EMRTS) transfers.
- provide efficiencies in discharge planning and pathway management by leveraging local knowledge of communities and social care infrastructure.
- reduce patient and staff travel, thus offering environmental benefits.

Workforce sustainability is highlighted as a significant concern. The physiotherapy service is said to currently fall short of recommended professional levels, contributing to staff burnout and risk to patient safety; and a many staff have young families and wish to work locally, maintaining work-life balance, it is

feared that relocation or centralisation could lead to staff leaving the service or moving to neighbouring health boards.

Respondents also identify gaps in infrastructure, noting that rehabilitation environments require investment to provide functional practice space, group therapy, psychological assessment, modern equipment, and changing and meal areas. Moreover, current Early Supported Discharge teams are said to be insufficiently resourced, and inter-hospital transport is unreliable, creating challenges in patient flow and timely rehabilitation delivery. Respondents stress that centralising services without additional physiotherapy investment risks failure to meet SSNAP performance targets and national guidelines, particularly under 'Treat and Transfer' models that concentrate acute care in one or two units.

Patient, family, and staff experiences are central to the recommendations. Local units are said to:

- allow patients to access care within their communities, maintain relationships with relatives and carers, and benefit from continuity with familiar professionals across the pathway.
- enable families to better participate in rehabilitation, support recovery, and receive emotional and educational support.
- motivate staff to build local centres of excellence, provide high-quality care, and remain within their communities.

Respondents note that centralising care risks undermining these relationships, impacting emotional support, trust, and rehabilitation effectiveness.

Overall, respondents argue that any redesign must consider the full patient pathway, from acute care through rehabilitation and community reintegration; and that maintaining and investing in local specialist rehabilitation units in each county would ensure clinical, financial, and workforce sustainability, support person-centred care, and improve outcomes for stroke survivors.

Elin Jones, Member of the Senedd (MS) for Ceredigion

Elin Jones criticises the CSP, particularly in relation to the options for stroke services and the broader organisation of hospital provision in West Wales. She particularly notes that:

- the online questionnaire *"offer[s] no flexibility to offer alternative options"* and only presents two options to downgrade Bronglais and Glangwili stroke units to a 'Treat and Transfer' model.
- the Plan is geographically imbalanced, as Llanelli is at the southeastern-most tip of the Health Board area and very close to Morriston Hospital, making it inefficient to centralise specialist services there rather than planning across both Swansea Bay and Hywel Dda Health Boards.
- a more *"geographically balanced planning and delivery of hospital services"* would ensure better equity of access across mid and west Wales.

Regarding stroke services, Elin Jones objects to both proposed 'Treat and Transfer' options, citing a lack of planning for ambulance capacity and investment.

> *"The 'Treat and Transfer' model cannot even be considered as an option until there is clarity and commitment on what the additional investment would be to ensure that ambulances would be available 24/7."*

She stresses the importance of family involvement in rehabilitation, warning that requiring families to travel *"at least 4 hours every day"* is unacceptable, particularly where public transport is unavailable. She

advocates for Bronglais to develop as a rural hub for stroke care, incorporating medical, nursing, and therapy services, supported by telemedicine and regional expertise, potentially at Morriston.

Elin Jones also comments on other service changes, opposing centralisation of diagnostic services at Llanelli due to travel distance and poor transport links, while supporting *"greater use of clinics within the Integrated Centres"* at Aberaeron and Cardigan, combined with telemedicine to connect patients to consultants. In conclusion, she formally requests that the options for stroke services be rejected and that innovative planning for a Rural Stroke Hub at Bronglais be developed to improve accessibility and outcomes for patients across Ceredigion and mid Wales.

Powys Elected Representatives (David Chadwick MP, Jane Dodds MS, Cllr Angela Davies, Cllr Glyn Preston & Cllr Fleur Frantz Morgans)

The collective of elected representatives expresses strong opposition to the proposed removal of stroke rehabilitation services from Bronglais, emphasising that their constituents in Llanidloes, Rhayader, Llanwrtyd Wells, Newbridge-on-Wye, and Llandrindod Wells rely heavily on Bronglais as their primary hospital for stroke care. They note that these communities are already underserved and that transferring stroke rehabilitation services to Llanelli or Haverfordwest would impose *"a wholly unreasonable burden on patients and families across this rural area."*

The politicians highlight that the Bronglais Stroke Unit is the highest-performing unit in the Hywel Dda area, as confirmed by SSNAP data, and argue there is no justification for closing a unit delivering *"exceptional care."* They stress Bronglais' geographic centrality, serving four counties - three outside Hywel Dda - and the impracticality of travel for rural patients due to *"lack of direct public transport and the long journey times on rural roads."* They also complain that neither consultation option retains services at Bronglais; and that no transfer or discharge plans have been published, leaving questions about patient transport, family visitation, and the ability of the already stretched Welsh Ambulance Services NHS Trust (WASUT) to cope. Concerns also extend to palliative and end-of-life care, with the elected members stating that transferring critically ill patients *"hours away from family is both clinically unsafe and ethically indefensible."*

The representatives emphasise the potential impact of the proposed changes on rural communities, noting that long-distance travel without private transport will isolate patients, deter rehabilitation, and worsen outcomes. They argue that no robust impact assessment has been published, particularly regarding staff recruitment, patient pathways, or service sustainability. Public opposition is cited as significant, with over 8,000 signatures[116] on a petition and motions passed by Powys County Council and Ceredigion County Council calling for the retention of the full stroke unit. The submission concludes by urging the Health Board to discard the proposal to remove stroke services from Bronglais and maintain access for residents of west Powys and mid Wales, framing it as a matter of *"life, dignity, and fairness for rural Welsh communities."*

Protect Bronglais Services

Protect Bronglais Services (PBS) strongly objects to Hywel Dda's proposals for stroke services at Bronglais. PBS argues that the consultation is fundamentally flawed, incomplete, and detrimental to the Bronglais stroke unit; a service recognised as the best-performing in the Hywel Dda area by the SSNAP.

[116] The petition closed with almost 18,000 signatures.

Bronglais serves a vast and largely rural area across Ceredigion, south Meirionnydd, and central and western Powys, making it geographically essential for mid Wales. PBS warns that removing stroke rehabilitation from Bronglais and transferring patients to Llanelli or Haverfordwest - under the proposed 'Treat and Transfer' model - would cause serious harm to patients, families, and staff.

The group argues that the plans lack operational detail about how patient transfers will work, including ambulance availability, escort arrangements, and repatriation following treatment; and that NHS clinicians have reportedly described the proposals as unsafe and against best practice. PBS highlights that long travel times, poor transport links, and rural deprivation will make visiting stroke patients virtually impossible for many families. The group stresses that rehabilitation outcomes rely heavily on family support, which would be lost if patients were treated several hours away from home.

PBS contends that the Health Board has ignored clinical evidence and community opinion, noting widespread political and public opposition. Motions to retain and strengthen the Bronglais Stroke Unit have been passed by Ceredigion and Powys County Councils, and over 7,000[117] people have signed a Senedd petition demanding that full stroke services be protected.

PBS also questions the financial and workforce feasibility of the CSP, citing Hywel Dda's significant deficits, staffing shortages, and reliance on unconfirmed savings. It concludes that the plan is unrealistic and risks downgrading an essential district general hospital that already provides safe and effective stroke care.

PBS comment on the Equality Impact Assessment

PBS raises major concerns about the Equality Impact Assessment (EIA) that accompanies the CSP, arguing that it fails to consider the 'transfer' element of the 'Treat and Transfer' model. PBS identifies several key omissions and issues:

- scope - the EIA focuses solely on the 'treat' phase and does not assess the physical, emotional, or financial impact of transferring patients several hours away for rehabilitation.
- family impact - the analysis considers only patients, not their families or carers. PBS argues that the *"support network"* must be treated as integral to patient care, as families may face long travel times or be unable to visit at all.
- human rights - PBS highlights potential breaches of Article 8 of the Human Rights Act (the right to respect for private and family life) since separating patients from families for extended periods undermines this principle.
- age - the EIA fails to address how older patients, who make up the majority of stroke admissions, would be affected by long journeys, isolation, or inaccessible transport. The mitigation measures proposed (like relying on public transport) are unrealistic, with return journeys from Aberystwyth to Llanelli taking up to nine hours and lacking basic facilities.
- Disability - impacts on disabled or mobility-impaired patients are not properly assessed, despite their greater dependency on family support for travel and care coordination.
- race and language - PBS warns that non-English or non-Welsh speaking patients may struggle to communicate effectively with staff when far from home and without family support to assist with translation.

[117] The petition closed with almost 18,000 signatures.

» socio-economic impact - the EIA dismisses deprivation as a clinical factor but acknowledges it may affect families' ability to visit due to travel and accommodation costs. PBS argues this issue deserves fuller consideration, as it risks deepening rural inequality.

PBS concludes that the EIA fails to meet its purpose, as it overlooks the realities of geography, transport, and socio-economic hardship in mid Wales. The group urges Hywel Dda to revisit and revise the EIA to reflect the full impact of the proposed changes, including patient transfers, family disruption, and the disproportionate burden on rural and low-income communities.

Stroke Association

Overall position on the consultation

The Stroke Association expresses concern about Hywel Dda's proposed new models of stroke care, which it fears could reduce access to specialist-led treatment. While acknowledging workforce and infrastructure pressures, the charity urges service co-design with stroke survivors and alignment with national stroke transformation plans.

Concerns about acute and emergency stroke care

The Association says that the consultation lacks sufficient detail on how specialist acute care will be delivered.
Key concerns include:

» unclear plans for hyperacute and specialist-led stroke management.
» absence of information on advanced imaging (CT perfusion[118], MRI).
» no clear thrombectomy[119] pathways or 24/7 referral systems.

The Association stresses that stroke diagnosis and treatment must be led by stroke specialists, not general emergency staff. Without consistent national standards, patients could face a 'postcode lottery' in accessing life-saving interventions.

Under the Duty of Quality (Health and Social Care (Wales) Act 2023), health boards must prioritise safety, effectiveness, and patient experience. The Association warns that system pressures must not justify reducing access to specialist stroke care.

Risks in the proposed models (Options A and B)

The Association raises serious concerns about Option B, which would place an acute stroke unit in a hospital without an on-site emergency department (Prince Philip). Such a model demands strong workforce cover, efficient transfers, and reliable transport - conditions that are not currently met in West Wales. Without these safeguards, the proposal is said to risk compromising patient safety and delaying time-critical treatment.

The Association also notes that the proposed reorganisation of critical care services could negatively affect stroke patients needing respiratory or blood pressure support, while tertiary neurosurgery in Cardiff - over two hours away - adds further complexity to emergency transfers.

[118] A medical imaging technique that uses a CT scanner to evaluate the blood flow in brain tissue by measuring how an iodine-based contrast agent moves through blood vessels.
[119] An emergency medical procedure to remove a blood clot from a blocked artery.

Rehabilitation and community care

The Stroke Association feels that rehabilitation and repatriation pathways are poorly defined in the CSP. It warns that moving rehabilitation services to Llanelli or Haverfordwest would disadvantage mid Wales patients, who would face long and difficult journeys without reliable transport. This could isolate survivors from their families, who play an essential role in recovery.

It is said that such plans contradict Welsh Government commitments in *A Healthier Wales* and the *All-Wales Rehabilitation Framework*, both of which advocate care closer to home. The Association calls for investment in early supported discharge (ESD) and integrated community stroke services to deliver rehabilitation near patients' homes, consistent with NICE guidance recommending at least three hours of multidisciplinary therapy daily, five days a week.

Language, equality and accessibility

The Association highlights the importance of bilingual and culturally accessible care. It says that Welsh speaking stroke survivors, particularly those with aphasia, often face significant communication barriers that affect recovery. It recommends:

- a Welsh Language Impact Assessment for all proposed changes.
- explicit commitments to provide and sustain bilingual services across ward sites.
- integration of linguistic accessibility into equitable service delivery plans.

Public awareness and prevention

The Association calls for a biennial bilingual 'Act FAST/Cam NESA' campaign to improve recognition of stroke symptoms and encourage emergency response. Increasing public awareness, particularly in rural and deprived areas, would reduce delays in seeking treatment and improve recovery outcomes.

Alignment with national stroke plans

The Stroke Association insists that the Health Board must not act in isolation. It stresses that any redesign must align with the national stroke transformation programme and be developed collaboratively with the:

- National Clinical Lead for Stroke.
- Regional Stroke Boards.
- Wales Ambulance Service.
- NHS Executive.

Failure to coordinate nationally, it is said, could deepen health inequalities and undermine Wales's plan to establish regional centres of excellence.

Conclusions and recommendations

The Stroke Association supports the aim of improving stroke services but finds Hywel Dda's proposals underdeveloped and potentially unsafe in not yet providing necessary assurance around clinical safety, equity, or alignment with national stroke policy. It urges stronger clinical governance, survivor involvement, and national coordination before any changes are implemented.

Stroke Multidisciplinary Team (MDT), Glangwili

This submission, from the MDT at Glangwili presents a detailed and evidence-based alternative proposal for stroke services. The team proposes a *"modified Option B'*, in which Glangwili - not Prince Philip - would

serve as the primary stroke centre. They argue that this would better align with existing patient flows, infrastructure, and national stroke care standards.

The MDT outlines major flaws in the current Option B proposal. They note that most stroke patients in Hywel Dda are already admitted to Glangwili via its 24-hour A&E, which sees four to five suspected stroke cases daily. Redirecting these to Prince Philip - which lacks an emergency department - would require a *"complete system overhaul"* and risk delayed or reduced care. They also highlight capacity and quality concerns at Prince Philip, where longer patient stays, the absence of ITU-level care, and lack of hydrotherapy, rehabilitation spaces, and tracheostomy[120] support make it unsuitable as a central stroke site.

A key concern is staffing and expertise: Glangwili houses the largest concentration of stroke-specialist clinicians, and the MDT warns that these staff are *"unlikely to relocate to Prince Philip,"* risking dilution of expertise. The proposal also underscores geographical equity, noting that Glangwili's central location within the Health Board area ensures fairer access for all communities, while Llanelli's proximity to Swansea's Morriston Hospital already provides alternative care options for local patients.

The MDT raises detailed logistical and clinical risks tied to the relocation of the stroke ward - especially for Speech and Language Therapy (SALT) services. They explain that vital instrumental swallowing assessments (FEES and Videofluoroscopy[121]) rely on ENT and radiology equipment and staff based in Glangwili. Moving stroke care to Prince Philip would, it is said, make these procedures unworkable due to transport cancellations and resource gaps, delaying rehabilitation and risking long-term dependence on tube feeding.

In contrast, the MDR's proposed Glangwili-based stroke hub would, it feels, make efficient use of existing facilities and staff. The hospital has available space for a 30-40 bedded stroke unit and access to comprehensive therapy resources, including hydrotherapy, group therapy areas, and garden rehabilitation spaces. The MDT argues this approach would meet national stroke targets, maintain level 3 care capacity, and reduce inter-hospital transfers.

In conclusion, the MDT emphasises that maintaining stroke services at Glangwili would ensure continuity of care, staff retention, and compliance with national standards, while avoiding unnecessary risk to patient safety and service quality.

Ward 9 (stroke rehabilitation) MDT, Prince Philip

This MDT in Prince Philip supports both Option A and Option B for stroke services, confident that either would improve outcomes for patients in Llanelli. Prince Philip's established infrastructure, skilled workforce, and effective care environment are highlighted as key strengths for sustaining and developing stroke services within Hywel Dda.

Infrastructure and strategic placement

Ward 9 is a purpose-built acute stroke and rehabilitation unit with 29 beds, including a dedicated five-bed acute stroke unit (ASU). The spacious, well-lit environment is said to support safe mobilisation, cognitive recovery, and rehabilitation; and the area's multiple therapy spaces, day rooms, a therapy kitchen, en-suite

[120] A procedure where a hole is made at the front of the neck. A tube is inserted through the opening and into the windpipe (trachea) to help someone breathe.
[121] FEES is Fibreoptic Endoscopic Evaluation of Swallowing, a test to assess swallowing function; Videofluoroscopy, also called a video swallow study, is a dynamic X-ray of a person's swallowing function.

rooms, and access to on-site facilities such as a café, garden, and courtyard support both clinical care and community reintegration. Its ground-floor layout ensures easy access to radiology and therapy services, while Prince Philip's transport links enable rapid transfer to tertiary centres when needed. According to the MDT, this strategic positioning makes the hospital well suited for integration into a regional stroke network while continuing to serve the Llanelli population locally.

Workforce and sustainability

Prince Philip has a strong record in recruitment and workforce retention, contrasting with challenges elsewhere in Hywel Dda. The ward benefits from three substantive stroke consultants, educational supervisors for specialty trainees, and recognition as a training site in geriatric medicine. Proximity to Swansea further supports staff recruitment and long-term sustainability.

Challenges and proposed solutions

Current critical care at Prince Philip operates at level 2, with the most unwell patients transferred to Glangwili. The MDT recommends enhanced on-site critical care to safely deliver acute stroke services. It also says that historical patient flow challenges have improved and could be further addressed through coordinated communication once service models are finalised; and that longer lengths of stay – which are linked to bed-mixing with acute medical admissions – would be reduced in a fully dedicated stroke ward.

Key benefits

Ward 9 is said to:

- demonstrate high clinical performance, with SSNAP data showing 80% of ASU admissions within four hours of arrival, 87% of therapy assessments within 24-hours, and 100% of CT scans within one hour. Moreover, the Carmarthenshire Stroke Protocol (July 2025) supports direct admission of Llanelli stroke patients to Ward 9, facilitating early specialist intervention and mirroring elements of the proposed 'Treat and Transfer' model.
- benefit from consistent consultant cover, daily board rounds with the full multidisciplinary team (MDT), and strong stroke clinical nurse specialist (CNS) leadership. The CNS coordinates rapid imaging and interventions, delivers teaching, triages TIA referrals, supports early discharge, and maintains links with the Stroke Association, underpinning high compliance and efficient patient flow.
- provide comprehensive, patient-centred rehabilitation with a fully equipped gym, integrated therapy assistants, weekend therapy continuity, a therapy dog programme, and close collaboration with Mynydd Mawr Rehabilitation Unit. The unit supports education and research, hosting medical and nursing students and engaging in ongoing projects, contributing to staff development, retention, and service improvement.
- emphasise compassionate, family-centred care, including proactive communication, family involvement in ward rounds, use of technology for contact, Welsh speaking staff, and timely repatriation to local rehabilitation units.

Summaries relating to several or all nine services

The following two submissions - from Betsi Cadwaladr University Health Board and the West Wales Renal Service[122] - discuss all nine services covered in the Clinical Services Plan.

Betsi Cadwaladr University Health Board

Betsi responded to the consultation questionnaire in some detail. As a result, the response is summarised as a detailed submission here.

Critical care

Betsi expresses no particular preference between the proposed options for critical care services. It notes that, as no changes are proposed at Bronglais, the direct implications for north Wales are minimal; and that patient transfers from south to north Wales (and vice versa) for critical care are rare, largely due to terrain and logistical constraints.

Betsi emphasises the need to understand the total number of level 2 and level 3[123] critical care beds that would be retained across the Hywel Dda area under each option, warning that Wales already has fewer critical care beds per head of population than the rest of the UK. Any reduction in staffed capacity, it suggests, could have knock-on effects across the country.

Dermatology

In relation to dermatology, Betsi again selects no particular preference, noting that no changes are proposed to services at Bronglais or to community provision likely to be used by patients from north Wales. It did, however, use this section to advocate for closer collaboration between itself and the Health Board to explore sustainable solutions to the long-standing workforce and service challenges in dermatology across mid Wales. Betsi sees this as a valuable opportunity to jointly develop a more resilient, regionally coordinated dermatology service that could improve access and continuity of care for patients on both sides of the health board boundary.

Emergency general surgery

For emergency general surgery, Betsi does not express a preferred option, as neither proposal includes changes to services currently provided at Bronglais. While the direct impact on North Wales is therefore expected to be limited, Betsi suggests that further opportunities should be explored to strengthen same day emergency care services at Bronglais, similar to those proposed for Glangwili and Withybush. This, it argues, could improve patient flow and local access to urgent surgical input.

Endoscopy

Betsi registers no particular preference for the proposed endoscopy options. It recognises that Options A and C would remove urology-related endoscopy from Bronglais, while Option B would see bowel screening services relocated to a new community site, with its location yet to be confirmed. In this context, travel

[122] A team of nephrologists at the Morriston Hospital Renal Unit, which provides renal services in West Wales to patients in the Swansea Bay and Hywel Dda University Health Board areas.
[123] Level 2 critical care is for patients who require more detailed observation or intervention than can be provided on a regular ward. Level 3 critical care is for critically ill patients who require advanced life support for two or more organ systems, or advanced respiratory support alone.

distance are raised as a key consideration, particularly for bowel procedures where preparation requirements can make long journeys difficult.

Although supportive in principle of measures to expand capacity, Betsi questions whether Option B would deliver sufficient additional activity to meet demand. It also suggests the use of mobile bowel screening units to mitigate access challenges, especially for more remote populations. Overall, it concludes that none of the proposals would have a significant direct impact on North Wales patients.

Ophthalmology

Betsi expresses a clear preference for either Option B or Option C, stating that it could not support Option A unless adequate mitigation was provided.

Both preferred options would retain ophthalmology day case and inpatient services at Bronglais, while Option A would remove them entirely and centralise care at Glangwili. Betsi stresses that withdrawing services from Bronglais would reduce accessibility for north Wales residents and could undermine regional equity of care. It proposes collaborative work with Hywel Dda to develop innovative, sustainable eye care models across mid and north Wales, including potential shared treatment centres that could optimise the use of clinical staff, equipment, and facilities. Betsi also recommends joint sub-specialty analysis to better understand the potential impact of service reconfiguration and to identify opportunities for mitigation, particularly through strengthened community optometry services.

Orthopaedics

For orthopaedics, Betsi supports Option D, as it would increase inpatient capacity at Bronglais and improve local access for north Wales patients. Betsi welcomes the opportunity to enhance the role of Bronglais in delivering elective orthopaedic care; but also suggests that Hywel Dda might consider consolidating delivery onto fewer sites to build critical mass, concentrate expertise, and achieve more consistent outcomes. It emphasises that any such consolidation would need to be accompanied by strong transport arrangements and support for pre- and post-operative care delivered closer to home.

Radiology

Betsi again has no particular preference on the options for radiology, noting that the proposed changes have little direct impact on Bronglais. The only difference identified is that Options B and D would see the removal of inpatient interventional radiology from Bronglais. Overall, Betsi does not anticipate any significant implications for north Wales patients or for its own services as a provider or commissioner.

Stroke

The stroke proposals prompted a more cautious stance, with Betsi selecting ‘don’t know’ pending further information. Both options would remove the stroke unit at Bronglais and replace it with a ‘‘Treat and Transfer’’ model. Betsi stresses that this requires substantial further analysis to understand the full implications for patients in north Wales, their families, and the regional health system. It proposes that a dedicated programme of work be undertaken jointly with Hywel Dda and the WASUT to develop safe, evidence-based pathways ensuring timely diagnosis, treatment, and rehabilitation.

Betsi is concerned that either option could have unintended consequences for its own hospitals - Ysbyty Gwynedd, Ysbyty Glan Clwyd, and Wrexham Maelor - if patients or ambulance crews divert north instead of south. It also seeks clarity on where inpatient rehabilitation and early supported discharge (ESD) services

would be provided, and whether transient ischaemic attack (TIA)[124] services would continue at Bronglais, to establish the risk of increased pressure on north Wales stroke and rehabilitation services and potentially longer treatment times for some patients.

Urology

Betsi 'tends to agree' with the urology proposal, acknowledging the benefits of consolidating inpatient and diagnostic services on one site at Prince Philip. However, it expresses concern about reduced accessibility for urgent suspected cancer diagnostics, which would move from Bronglais to Prince Philip. The retention of day case and outpatient services at Bronglais is welcomed, but Betsi emphasises the need for mitigation to support patients from north Wales who would have to travel long distances for diagnostic investigations; and is willing to work with Hywel Dda to identify practical solutions that could lessen the impact.

Future Roles of Main Hospitals

Regarding the proposed future configuration of hospital roles, Betsi 'tends to agree' with the overall direction of travel. It accepts that some services at Bronglais may need to be re-provided elsewhere to ensure sustainability; but stresses the importance of close collaboration to mitigate any negative effects on the communities of south Meirionnydd. While supportive of the ambition to improve safety and long-term stability, the Health Board calls for further detail about the service models underpinning the proposals before a full assessment can be made.

Cross-Cutting Themes and Additional Considerations

Across all service areas, Betsi identifies several recurring themes. Accessibility and transport are consistent concerns, particularly for rural populations and individuals reliant on public or hospital transport. Betsi notes that early-morning appointments at distant sites could require overnight accommodation, placing financial strain on patients and carers. It also highlights the disproportionate impact service centralisation can have on rural communities, calling for innovative use of digital technology and enhanced primary and community services to help mitigate these effects.

Betsi further observes that changes to Hywel Dda's services could alter patient flows across the border into north Wales, potentially increasing pressure on Betsi's own emergency, stroke, and rehabilitation services. The Health Board urges that such interdependencies be fully mapped and considered. It also underlines the importance of collaborative regional planning, suggesting that partnerships between Hywel Dda, Betsi, and Powys Teaching Health Board could help develop shared workforce solutions, joint clinical pathways, and more resilient service models across mid Wales.

Finally, Betsi emphasises the need for clarity regarding funding, implementation timescales, and workforce risks, noting that even well-designed service models can fail without sufficient resources or staff capacity. It reaffirms its commitment to ongoing dialogue and joint planning with Hywel Dda to ensure that any reconfiguration of services is equitable, patient-centred, and sustainable for the future.

[124] A short episode of neurological dysfunction, sometimes a precursor of a stroke.

West Wales Renal Service

Critical care

The Service express concern about Hywel Dda's unclear definition of 'enhanced care.' It emphasises that enhanced care (Level 1–1.5[125]) is not equivalent to a High Dependency Unit (HDU) where single organ support is possible.

They also feel that removing continuous veno-venous filtration[126] capability from Bronglais, Glangwili, and Withybush would be unsafe and would put unsustainable pressure on renal services at Morriston Hospital. Unstable renal patients often need urgent renal replacement therapy and transferring them from, say, Withybush to Glangwili or Morriston would increase mortality risk.

Dermatology

The Service notes that renal transplant and other immunosuppressed patients frequently develop skin cancers, and that renal patients living in Hywel Dda *"really struggle to get good dermatology care."* In particular, initial consultations are said to be delayed, leading to worse outcomes. The Service calls for a single, clear referral dermatology pathway for renal and immunosuppressed patients and for better inter-hospital transport to access dermatology hubs. It welcomes nurse-led clinics at Amman Valley Hospital and suggests expanding these to Pembrokeshire to improve local access.

Emergency general surgery

The Service raises safety concerns around the proposed emergency surgery models, citing current problems with delayed inter-hospital transfers that already worsen patient outcomes. In light of this, it is:

> *"concerned about a model of delivery that requires inter-hospital transfer unless this is adequately resourced to have same-day transfer for all patients and adequate surgical assessment of those presenting to a non-emergency-operating hospital."*

Option B (alternating emergency cover between Glangwili and Withybush) is described as unsafe and requiring *"huge"* administrative support; while Option A is only said to be viable in the event of daily on-site surgical cover in Withybush to see all referrals, and same-day transfers for urgent cases. The Service stresses the need for prompt post-surgical repatriation and regular surgical specialist review to ensure complications or developments are reviewed and dealt with in a timely manner.

Endoscopy

While most endoscopy procedures are low risk, the Service warns that relocating respiratory and urology endoscopy entirely to Prince Philip – with no intensive care or high dependency facilities - would endanger unstable patients. It argues that this would prevent high-risk patients from accessing essential procedures and increase the risk of mortality. The Service recommends retaining some respiratory and urology endoscopy capacity at Glangwili, which already hosts interventional radiology, to maintain safe

[125] Level 1 critical care is for patients at risk of their condition deteriorating or those recently relocated from higher levels of care, whose needs can be met on an acute ward with additional advice/support from the critical care team. Level 1.5 is enhanced perioperative care that bridges the gap between routine ward care and intensive care.
[126] Gentle slow continuous dialysis used when a patient is unstable.

multidisciplinary management of patients who have complicated urology or respiratory endoscopy; and often require interventional radiology input shortly afterwards.

Ophthalmology

Many renal patients also require ophthalmic care. The Service notes that after cataract or retinal detachment surgery, some dialysis patients (including those living some distance away) must be admitted to the Morriston renal unit to recover safely with minimal disruption through having to travel for dialysis. Performing such eye surgery in Prince Philip (which lacks both dialysis and intensive care) would necessitate transfers to Glangwili or Morriston, disrupting patient care. The Service therefore supports Glangwili as the more suitable surgical centre for ophthalmology due to its central location within Hywel Dda and better access to renal support.

> *"Glangwili as a centre for operating (being more central to the Hywel Dda region) is likely to allow more patients (renal or otherwise) to travel home thus minimising the number of people who need to stay in hospital for an extended period post-retinal detachment correction."*

Orthopaedics

Given the high prevalence of chronic kidney disease among older patients needing orthopaedic surgery, the Service opposes concentrating inpatient orthopaedics at Prince Philip, which lacks dialysis and intensive care facilities. Indeed, anaesthetists already divert such patients to Glangwili or Morriston. The Service argues that complex or high-risk orthopaedic cases should remain in hospitals equipped with renal and intensive care services due to the high-risk of complications or comorbidity management requirements.

Radiology

Renal patients often need diagnostic and interventional radiology. The Service believes that centralising inpatient interventional radiology at Glangwili could be effective, but only if timely, well-resourced patient transport between hospitals is in place; and agreements are in place around what to do if a patient becomes unwell and cannot be transferred back to their 'home' hospital.

The Service warns against creating new diagnostic hubs, calling them inefficient (in staffing terms) and costly. Instead, it proposes extended diagnostic radiology hours (12-hour days, seven days a week) at existing hospitals to improve capacity and patient choice.

Stroke

Renal patients often suffer strokes and long hospital admissions, particularly those who are on dialysis. The Service thus opposes locating all stroke services at Prince Philip, which lacks a dialysis unit and intensive care. This would prevent dialysis-dependent stroke patients from receiving appropriate post-stroke care. The Service also questions whether Prince Philip could handle hyper-acute referrals and transfers to tertiary centres or manage complications such as intracerebral haemorrhage without intensive care support.

It is also said that patients with severe stroke often find communication and understanding their environment post-stroke challenging, so the provision of online platforms to keep families connected is *"unlikely to be judged a humane option for a patient who does not understand why their spouse/family and friends have not been to see them."* Nonetheless, the Service supports a 72-hour initial assessment model

to identify needs, providing ongoing rehabilitation (occupational therapy, speech and language therapy, physiotherapy) remains close to patients' homes.

Urology

The Service highlights that urological and renal conditions are closely interlinked, offering scenarios whereby a patient might need rapid access to dialysis, endoscopy, interventional radiology, and urology surgery - services that under the proposals would be spread across multiple sites. This fragmentation would result in unsafe, repeated transfers and would likely increase referrals to Morriston, *"where all services are in one place."* They urged Hywel Dda to retain comprehensive urology capacity at Glangwili, where multidisciplinary support is available for complex patients.

Future roles of main hospitals

The Service accepts the rationale for centralising acute care at Glangwili but stresses that elective and acute services must be clearly separated and safely delivered. It advocates for complex acute work to remain at Glangwili, supported by high-dependency and endoscopy facilities, with safe, well-staffed repatriation pathways back to local hospitals once patients are stable.

Additional considerations

Finally, the Service emphasises the need for significant investment in transport infrastructure to connect hospital sites. Travel between hospitals can take several hours by car and longer by public transport. It urges Hywel Dda to work with transport providers to establish direct, reliable inter-hospital links for both patients and clinical transfers.

Summaries mainly relating to specific hospitals

The following summaries mainly relate to specific hospitals. The first three (from Aberystwyth Town Council, Powys Teaching Health Board, and an individual respondent) are primarily about Bronglais; the next two (from Paul Davies MS and an individual respondent) are primarily about Withybush; and the final one relates to Amman Valley Hospital.

Aberystwyth Town Council

Protecting services at Bronglais

Aberystwyth Town Council's response centres on the strategic, clinical, and social importance of Bronglais to a *"large, rural and often hard-to-reach population."* The Council stresses that Bronglais must retain its status as a fully functioning district general hospital, warning that any downgrading *"would embed health inequality"* given long travel times and weather-sensitive journeys to alternative hospitals, poor transport links, long inter-hospital transfer times, and language barriers for Welsh speaking patients. While the Council acknowledges the Health Board's financial pressures and the challenging rural nature of its area, it highlights a persistent north/south divide in service accessibility, urging a more equitable distribution of healthcare resources.

A central theme of the submission is the protection of core services at Bronglais. The Council welcomes the options for critical care, emergency general surgery, orthopaedics, and urology, as none reduce provision at the hospital. It regrets that all proposed endoscopy options would negatively affect Bronglais and requests

that any community site be located in the north. The Council supports Option C for both ophthalmology and radiology to maintain services at Bronglais.

However, the Council *"strongly opposes all options relating to stroke services"* and rejects the proposed 'Treat and Transfer' model. It argues that this approach neglects the realities of rural Wales, as *"patients... will be more socially isolated under a 'Treat and Transfer' model, and that social isolation will lead to worse outcomes overall."*

The Council considers it essential to maintain a full stroke service at Bronglais, capable of acute care and ongoing support of patients in the long term through onsite rehabilitation. In essence, it requests that the Health Board designate Bronglais as a regional 'Centre of Excellence' for stroke, making it *"the hub of delivery for patients who are unable to be transferred out of the Health Board area (which may be the case for patients closer to Swansea Bay University Health Board or Betsi Cadwaladr University Health Board)."* It also suggests that regional working could then be utilised to designate a wider regional hub of excellence for stroke care in the Swansea Bay University Health Board area, with patients and support networks able to utilise the stronger transport networks of the south.

Suggested mitigations

Should reconfiguration proceed, the Council recommends that *"a set of minimum standards must be guaranteed,"* including published response times for key stages of stroke care, transport protocols with ambulance capacity modelled against real rural travel times and resourcing, and a full equity audit to monitor outcomes such as thrombolysis rates, time-to-treatment, complications, survival, and long-term outcomes. Where changes are unavoidable, the Council says the Health Board must evidence ambulance and non-emergency transport capacity to meet time-critical targets and support families and carers in visiting patients. Where financial or logistical hardship arises from long-distance travel, mitigation measures should be in place to ensure equitable access to care.

Another concern is the protection and expansion of Welsh-medium care, with the Council noting that *"safe, person-centred care requires patients - especially vulnerable patients; those with cognitive impairment, stroke, or mental health needs - to receive services in their first and chosen language*."

Welsh language impacts

The Council expects the Health Board to uphold the principles of the Welsh Language (Wales) Measure 2011 and the Welsh Language Standards by ensuring that Bronglais can always provide an 'active offer' of Welsh-medium care. This includes triage, assessment, consent, therapy, and discharge planning, both in-person and via digital services. It says that Welsh speaking cover should be available across every ward and within the emergency department, with particular attention paid to the needs of stroke patients, *"where access to Welsh-medium speech and language therapy is critical to rehabilitation."*

The Council requests that the Health Board publish site-level data on Welsh-language provision, including the percentage of patient interactions delivered in Welsh, staff Welsh-language competencies, and patient reported experience measures. It says that recruitment strategies must explicitly promote Welsh-language skills, offering incentives, career progression, and training opportunities for Welsh speaking staff. Without such action, *"any shift in services away from Bronglais General Hospital risks weakening access to care in Welsh and thereby undermining both patient safety, dignity, and outcomes."*

Economic impacts

Economically, the Council highlights Bronglais' role as a major local employer and anchor institution, warning that any service reduction *"risks significant economic consequences"* for Aberystwyth. It urges a full economic impact assessment and advocates developing the hospital as a training and research hub in partnership with Aberystwyth University and further education providers, to sustain workforce pipelines and community vitality.

Community services, prevention, and early intervention

The response recognises and supports progress in community-based and preventative care and early intervention, commending the Health Board's efforts to integrate health and social care. However, the Council cautions that community provision *"must complement - not replace - the acute and emergency services provided by Bronglais General Hospital."* It thus encourages the Health Board to "*continue building on its community care successes while ensuring that Bronglais General Hospital remains a strong and central pillar in the wider care pathway."*

Bronglais as a national asset

Finally, the Council asserts that decisions affecting Bronglais have national significance beyond Hywel Dda's boundaries, given its cross-regional catchment. It calls for Welsh Government oversight, describing the hospital as *"a strategic national asset for rural Wales,"* and insists that any significant service change be escalated to the Minister for Health for approval.

In conclusion, Aberystwyth Town Council supports "*clinically led modernisation that improves outcomes and equity,"* but only where it strengthens, not diminishes, local provision. The Council urges the Health Board and Welsh Government to safeguard and invest in Bronglais General Hospital as *"a cornerstone of healthcare provision in mid Wales and beyond."*

Powys Teaching Health Board

Powys Teaching Health Board (PTHB) emphasises the strategic importance of Bronglais for north-west Powys communities; and comments that stroke services are of particular interest due to their time-critical nature. PTHB highlights the importance of maintaining access to thrombolysis[127], thrombectomy, and other acute care standards, such as hydration assessment and swallowing screening within four hours of hospital arrival.

In this context, concerns are raised around the potential impact of a 'Treat and Transfer' model that requires patients from Powys to travel to more distant hospitals in Llanelli or Haverfordwest. Key issues include:

- family and carer support - long distances may prevent meaningful family contact during the immediate recovery phase, exacerbated by limited public transport options. Hywel Dda should consider additional support for travel and accommodation.
- national and regional consistency - PTHB is concerned that decisions appear regional rather than part of a cohesive national stroke strategy. It seeks assurance that access to high-quality, time-critical care is maintained for Powys residents.

[127] A medical procedure that uses clot-busting drugs to dissolve blood clots.

PTHB also highlights emergency care access**.** While Bronglais is the primary hospital used by Powys residents, some communities rely on Glangwili or local emergency provision along the A483/A40 corridor. Proposed changes to Glangwili could affect emergency and critical care access, compounded by ambulance response times and evolving air ambulance services.

In terms of the engagement and consultation process, PTHB acknowledges Hywel Dda's efforts in engaging with Powys residents and stakeholders. Key themes from this engagement highlight widespread concern about travel distances, rural access challenges, and the importance of maintaining family contact during acute care. Difficulties in navigating digital information and questionnaires are also noted, indicating a need for clearer, more accessible communication. PTHB requests that Hywel Dda provide an analysis of responses from Powys residents to inform joint work, including through the Mid Wales Joint Committee.

Individual respondent (1)

The respondent, a resident of mid Wales, strongly criticises the Hywel Dda CSP, arguing that the Health Board has consistently failed to recognise the needs of the population in rural mid Wales, which extends beyond the boundaries of Hywel Dda to include parts of Betsi Cadwaladr and Powys. They highlight that Bronglais has historically provided essential acute inpatient and outpatient services to this area, and that proposals to downgrade services treat it as *"a problem rather than a solution."*

Regarding stroke services, the respondent objects to both options presented in the CSP, particularly the 'Treat and Transfer' model. They stress that poor transport infrastructure severely limits access, noting that travel from Bronglais to Llanelli by private car is over two hours, while public transport options are impractical, time-consuming, or unavailable; and argue that ambulance capacity has not been addressed.

> *"WASUT have not stated that they can support this proposal and that is perhaps the only response that Hywel Dda UHB need to have had. The plans should have stopped as soon as that was known."*

The respondent emphasises the vital role of family and carer support in rehabilitation, warning that the CSP fails to account for patients whose relatives cannot travel long distances daily. They say a reliance on iPads *"fails to recognise the need to teach people how to use the kit and completely fails to consider the needs of the patient with dysphasia (communication issues)."*

The submission criticises the CSP for failing to consider a rural-specific stroke model, suggesting instead that Bronglais should function as a rural hub, providing acute care, immediate investigation, and access to tertiary specialist interventions, with patients then repatriated to their local areas for ongoing care and rehabilitation. They note that telemedicine and consultant-led therapy could support such a model effectively. The respondent emphasises that replicating urban models in a sparsely populated, geographically dispersed area is inappropriate:

> *"The off-the-peg solutions pioneered by very large urban hospitals … cannot be replicated by Hywel Dda; they simply do not fit the immovable geography."*

Ultimately, the respondent rejects both options presented in the CSP, stating:

> *"Neither option represents a true choice and it is scandalous that the health board seeks to portray the removal of stroke services in mid Wales as a choice."*

The respondent calls for an innovative, bespoke plan that recognises the unique needs of mid Wales, safeguards Bronglais as a central rural hub, and ensures safe, sustainable, and equitable stroke care for the population. They also call on the Health Board to highlight gaps in the proposals, including in relation to subarachnoid haemorrhage[128], palliative care, therapist-level services, rehabilitation support, and telemedicine; describing these omissions as *"staggering oversights"* that render the plan *"unfit for purpose."*

More widely, the respondent suggests that more consideration be given to developed plans with Swansea Bay University Health Board for a regionally centred approach to health care for mid and south west Wales, particularly given Llanelli's proximity to Morriston Hospital, which has interventional radiology, neuroradiology, vascular surgery and neurology on site – all significant elements of a comprehensive stroke service. They say that *"Hywel Dda will never be in a position to establish these services within its own hospitals,"* and urge co-operation with Swansea Bay to overcome this.

Paul Davies MS (two submissions, one with Sam Kurtz MS)

Paul Davies, MS, expresses strong opposition to the removal of intensive care and emergency general surgery services from Withybush. He argues that such changes would force patients to travel much further to Glangwili - a site already struggling with capacity, parking, and accessibility issues.

Mr Davies stresses that longer travel times would negatively affect patients and their families, particularly as reduced visitation could harm patient recovery and wellbeing. He highlights a broader pattern of service downgrades at Withybush, warning that removing key departments would have knock-on effects on other hospital services and community confidence.

Mr Davies also raises concerns about the loss of dermatology provision, noting that since the discovery of Reinforced Autoclaved Aerated Concrete (RAAC) issues, dermatology services have effectively ceased at Withybush, and there is no phototherapy[129] unit available anywhere in the Health Board area. Consolidating services at Prince Philip would, he says, make access to dermatology extremely difficult for Pembrokeshire patients.

In conclusion, Mr Davies firmly opposes any further service reduction at Withybush and urges the Health Board to fully consider the views of Pembrokeshire residents before making final decisions.

The Health Board also met with Mr Davies and Sam Kurtz MS, after which they expressed concern (via email) that services are *"constantly removed from Withybush"* and that Hywel Dda needs to demonstrate what services can be transferred into the hospital for it to retain A&E and become a centre of excellence.

Individual respondent (2)

The respondent formally objects to the proposed relocation of services from Withybush, arguing that the proposals risk *"significant harm"* to the health and well-being of residents in Pembrokeshire, particularly in the west of the county.

The respondent highlights potential breaches of several legal duties under Welsh legislation. In particular, under the NHS (Wales) Act 2006, health boards have a statutory duty to *"…secure improvement in the physical and mental health of the people of Wales, and the prevention, diagnosis and treatment of illness,"*

[128] A serious type of stroke caused by bleeding on the surface of the brain, often from a ruptured brain aneurysm.
[129] A form of treatment that uses ultraviolet light to treat skin conditions.

and to provide services to meet all reasonable requirements. The respondent contends that centralising services at Bronglais or Prince Philip would introduce *"significant and unreasonable barriers to accessing care"* for Pembrokeshire residents, leading to longer travel times for emergency, maternity, and critical care services, which could result in poorer outcomes and life-threatening delays.

The submission also references the Well-being of Future Generations (Wales) Act 2015, emphasising that the proposals may disproportionately harm rural and elderly populations, exacerbate health inequalities, and fail to demonstrate positive long-term impacts for the Pembrokeshire population. Similarly, the Equality Act 2010 is cited, with the respondent noting that relocating services may indirectly discriminate against older people, disabled individuals, and those on low incomes; and that a robust Equality Impact Assessment is lacking.

The respondent further highlights perceived contraventions of the Health and Social Care (Quality and Engagement) (Wales) Act 2020, which imposes a Duty of Quality and mandates meaningful public engagement. They argue that reducing local access undermines this duty and that there has been inadequate consultation with the Pembrokeshire population. Additionally, the submission suggests there are conflicts with national policy and planning guidance, including the A Healthier Wales strategy and the NHS Wales Planning Framework, which emphasise care that is closer to home, equitable, and sustainable.

Amman Valley Hospital League of Friends

Amman Valley Hospital League of Friends (AVHLoF) acknowledges the challenges of providing nine specialty services across three counties but urges careful consideration of the impact of centralising services on patients, particularly older people with limited transport and those living at a distance from any proposed 'centres of excellence.'

AVHLoF supports the centralisation of specialist expertise and state-of-the-art equipment but emphasises the urgent need for local clinics and aftercare to be delivered closer to home, maximising the use of Amman Valley Hospital. Concerns are raised around underinvestment over the past decade and the deteriorating condition of Folland House, an iconic building gifted to the NHS that serves as an important community health hub. AVHLoF requests ongoing communication and engagement regarding any decisions affecting the hospital's future.

Summaries mainly relating to more general/cross-cutting issues

The summaries that follow did not focus on any particular clinical service or hospital, but rather highlighted more general, overarching issues.

Carmarthenshire County Councillor[130]

A Carmarthenshire county councillor submitted two responses. They primarily raise concerns about clinical service areas indirectly affected by the CSP consultation; and do not explicitly reference the nine services under review. The councillor's focus is on access to emergency and acute care, illustrated with examples of delayed ambulance response times for stroke and serious injuries, highlighting risks to patient safety and broader systemic pressures that affect delivery in rural areas, including long travel times and unpredictable

[130] This feedback was received from a Carmarthenshire county councillor in two separate submissions. No formal response was received from Carmarthen County Council.

ambulance availability. They also flag concerns about Minor Injury Unit services; and note that interim closures or reductions may compromise safe, timely access to acute care.

Outside the consultation, the councillor raises the issue of rheumatology services at Prince Philip, reporting that the clinic has ceased and calling for clarity on where patients will now be monitored and how they will access care. The councillor emphasises that service relocations to Glangwili or Bronglais without adequate transport create unsafe conditions for vulnerable patients. They also critique the lack of meaningful community consultation, arguing that interim arrangements should have been planned with patient input to uphold equity, safety, and dignity.

Ceredigion Disability Forum

The Ceredigion Disability Forum raises concerns about non-emergency patient transport in Ceredigion, particularly considering the proposed changes in the CSP. The Forum notes that the Plan's changes to nine clinical services would require patients to travel further for appointments, increasing reliance on WASUT and the likelihood of treatment delays. It highlights multiple real-life examples to illustrate these issues: one member had transport cancelled the evening before an appointment in Carmarthen and had to rely on a charity to attend; another patient's transport for an appointment in Swansea was cancelled twice, requiring overnight stays and incurring significant costs; and another member had to pay hundreds of pounds for a taxi for a consultation that could have been managed remotely.

The Forum also raises concerns about accessibility and equity, noting that hospital transport often does not allow a carer to accompany the patient, and that patients with mental health conditions or anxiety may be unable to attend appointments far from home. Even patients with private cars face barriers due to *"the severe lack of parking spaces and time restrictions"* at hospitals.

The Forum strongly criticises the proposed stroke 'Treat and Transfer' model, highlighting that moving patients over 70 miles from home would prevent family involvement in rehabilitation, which is essential for good outcomes. The Forum warns that *"mid Wales has become a health desert"* and calls for services to remain local, emphasising the urgent need for a robust transport plan with sufficient capacity and funding before any service changes proceed.

Individual respondent (3)

The respondent, a student advocate, supports preserving the stroke ward at Bronglais and highlights the opportunity to address staffing challenges through local training and workforce development. They propose a structured student placement and graduate retention programme to create a sustainable workforce pipeline, leveraging partnerships with Welsh universities, including Aberystwyth, Bangor, Swansea, Cardiff Metropolitan, and Trinity Saint David. The respondent notes that the first cohort of nurses from Aberystwyth University, trained at the new Healthcare Education Centre adjacent to Bronglais, has now qualified, and retaining these graduates locally would strengthen the hospital's workforce.

The respondent recommends establishing Bronglais as a Clinical Placement Hub for students across a variety of disciplines, including stroke-specialist medicine, nursing, dietetics, physiotherapy, occupational therapy, speech and language therapy, mobility care, and clinical psychology. A 'train and stay' scheme would provide priority employment for graduates trained at Bronglais, preceptorship and foundation year support, local accommodation or bursaries, and long-term career pathways within Hywel Dda. Cross-border participation is also encouraged, with mechanisms to promote retention in Wales, such as Welsh language skills or location-based incentives.

Expected outcomes include mitigation of staffing shortages, reduced risk of stroke ward downgrading, strengthened local healthcare access for mid and north Ceredigion, sustainable workforce development aligned with NHS and Welsh Government priorities, and enhanced collaboration between health boards and educational institutions. The respondent concludes that Bronglais can serve as a flagship model for rural health education and recruitment, and that investing in a student-centred training pipeline will preserve the hospital as a cornerstone of equitable healthcare for mid Wales.

Llanelli Rural Council

General observations

The Council acknowledges the extensive background documentation supporting the CSP options. It feels that while the summary tables illustrating the options are helpful, the volume and complexity of the materials make it challenging for stakeholders and the public to fully interpret, raising concerns about meaningful engagement. The Council emphasises the importance of clear, accessible information for all affected communities.

The Council also notes that consultation fatigue and the simultaneous Minor Injuries Unit review at Prince Philip could reduce public engagement and lead to confusion. There is also concern that the requirement for consultees to propose alternative options is unrealistic, given the complexity of the data, the need to adhere to the Health Board's 'hurdle criteria[131],' and the limited timeframe.

In terms of the options themselves, the CSP presents 26 options across nine service areas, which the Council feels may create a postcode lottery. It suggests that the Prince Philip and Withybush catchment areas are likely to be most affected, with some communities benefiting while others lose services.

> *"… Some of the options … are welcomed because they support and benefit [Prince Philip] ... Despite this … the way in which some of the service area options have been presented in the consultation, regrettably, most appear to advantage or disadvantage patient cohorts residing within the hospital catchment areas covered by Prince Philip and Withybushs [and] there will be winners and losers ..."*

The Council feels it is unfair to expect respective hospital catchment areas to battle it out to retain and safeguard services for fear of them being lost to other hospitals located further afield.

The Council also notes that as the Health Board has not expressed a preference on the final service mix, there is concern about parochialism and that *"those communities that shout the loudest are likely to benefit the most."* It feels that had the Health Board indicated it preferences, the consultation would have carried more value because *"consultees could focus attention on the potential impact with far more certainty …"*

Prince Philip

Prince Philip is a key focus for the Council: it questions the feasibility of effectively delivering the stroke proposals there; and having the necessary resources and infrastructure in place to accommodate the possible changes to planned care activities. Physical space requirements are a particular concern, especially if the decision is taken to provide the hospital with a 24-hour stroke unit.

[131] These require services to be clinically sustainable, accessible, strategically aligned with the direction set out in the "A Healthier Mid and West Wales" strategy, and financially sustainable.

General points are raised about the provision of critical care and the potential impact on Prince Philip's intensive care service, minor injury unit (MIU) and acute medical assessment unit (AMAU). In particular, the Council seeks clarification on whether the changes outlined for critical care, specifically options to provide an Enhanced Care Unit rather than an Intensive Care Unit at Prince Philip, might detrimentally impact the hospital's AMAU.

The Council also seeks clarification on whether many of the Health Board's proposed changes are feasible given their dependency on securing staff support and increasing staffing resources in most service areas; and what impact a failure to recruit might have on service delivery and addressing challenges like service fragilities, improving access, and improving standards.

Transport and travel

The Council emphasises that travel and accessibility are central to any service change - particularly for rural populations - because public transport is currently inadequate, and longer journeys could disproportionately affect patients, visitors, and staff.

> *"… Patients and visitors must have the confidence of being able to rely on a robust transport and travel policy to support the reconfiguration plans especially if being expected to travel further to areas served by other catchment areas."*

The Council requests clear modelling of numbers, travel times, and potential costs, and recommends that the Health Board consider subsidised or commissioned transport solutions to ensure access and equity for those without private transport options.

Finance

The Council seeks assurance that the options in the CSP are financially achievable, affordable, and sustainable. Staffing costs alone are estimated at a minimum of £6 million, and clarity is requested on how these will be funded. The importance of demonstrating that proposed options are affordable and will not create unmanageable financial pressures is stressed.

Primary care and cluster implications

The council notes that the Primary Care Model for Wales underpins local care delivery through clusters, bringing together local services involved in health and care across a geographical area. The Council seeks clarification on what, if any impact the CSP will have on cluster maturity[132], coordinated care, and prevention-focused services in affected areas like Llanelli, Llandovery, and the Withybush catchment area.

Modelling and evidence

The Council asks for details of the modelling and service simulations underpinning the CSP, including external consultant input. They request clarity on how the evidence demonstrates that service options address fragility, improve access, and maintain standards, particularly for patients in the Prince Philip and Withybush catchments.

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[132] The Model has 13 outcomes that describe the key areas that need to be in place to deliver seamless, place-based care that focuses on prevention. The outcomes have three levels of maturity (foundation, developing and mature). As cluster working evolves, the system will move towards the mature level.

Other considerations

The Council asks for confirmation that the CSP aligns with Royal College accreditation requirements and the Health Board's 'A Healthier Mid Wales' strategy; that Health Inspectorate Wales has been consulted; and that the views of Welsh Government and Llais have been considered. They also ask how changes may impact the Wales Ambulance Service, including in relation to patient transfers and potential delays.

Ultimately, the Council seeks assurance that the CSP offers a long-term solution, *"making it less likely for future large-scale changes to key services by building in capacity and safety where it is needed …"*

Pembrokeshire People First

Pembrokeshire People First highlights transport as the primary concern for its members, noting that many do not have access to private vehicles and public transport is limited, slow, and often impractical for early or late appointments. Emergency travel was identified as particularly challenging, with taxis being difficult to access and often expensive. The group thus suggests that the Health Board provide transport to support access to non-urgent services. For urgent or emergency care, travel time is considered less critical, as ambulance services provide care enroute and on arrival.

Access to timely and understandable information is also stressed as important for planning and managing appointments. While Pembrokeshire People First welcomes the idea of learning disability nurses offering this support, they note that current capacity is limited.

Critical care, emergency general surgery, and stroke services are viewed as essential, and while Pembrokeshire People First recognises that transport barriers are mitigated in emergencies by ambulance provision, there are concerns about delays when ambulances are unavailable. The importance of 24-hour emergency services, particularly at Withybush due to high levels of local industry, agriculture, tourism, and adventure activities, is also emphasised.

Diagnostic services such as endoscopy and radiology are considered important to support emergency care, while planned services including ophthalmology, urology, dermatology, and orthopaedics are seen as less urgent. Travelling for these services is considered acceptable, providing transport was reliable.

Overall, Pembrokeshire People First indicate that if transport barriers are addressed, its members would be willing to accept changes to service locations and delivery.

The Pebble Pathways[133]

This submission, developed by a Patient Ambassador from Genomics Partnership Wales and an Independent ALN Parental Representative, with input from patients, NHS professionals, emergency services, and charities, outlines a community-informed vision for healthcare delivery across Carmarthenshire, Pembrokeshire, and Ceredigion. It integrates insights from the Welsh Ambulance Service University NHS Trust and reflects the perspectives of both patients and professionals in a rural health board setting.

Key principles

The Pebble Pathways opposes the construction of a new general hospital, instead advocating for investment in existing hospitals and the development of community care through Integrated Care Centres

[133] The Pebble Pathways

(ICCs) and community hospitals. Its vision is for a healthcare system that is locally accessible, efficient, and patient-centred, with clear communication and digital infrastructure to improve navigation and reduce confusion.

In its proposed 'community pathway,' services are proposed to be structured across three tiers:

- general hospitals - delivering high-priority services, major surgeries, ICU care, maternity, paediatrics, oncology, and specialised diagnostics.
- community hospitals - providing day cases, minor surgeries, MIUs, X-rays, post-operative care, palliative care, and outpatient services.
- Integrated Care Centres (ICCs) - offering digital consultations, community support, virtual clinics, and specialist services.
- home and domiciliary visits would be reserved for patients who cannot attend in person, ensuring care remains person-centred while maximising efficiency.

Sectors of strength

The proposed pathway groups overlapping services to consolidate expertise and streamline patient care. For example, Ear Nose and Throat, Audiology, Neurology, Paediatrics, and Maternity services could be co-located in one hospital, while mental health and psychiatry services could be concentrated in another. Emergency and general surgeries would remain in established locations to maintain continuity of care. MIUs could operate under locality-based or hybrid models to balance access and demand.

Digital and emergency services

Digital services are emphasised to complement in-person care, with ICCs providing support for virtual appointments and integration with GPs and community teams. The submission also identifies pressures on WASUT and proposes a Non-Emergency Relief Transfer Service (NERTS) to support patient transfers, relieve pressure on emergency ambulances, and provide community-based transport solutions.

9. Petition

Petition relating to Stroke Services at Bronglais (17,883 signatures)

9.1 Only one petition was organised during the consultation, of which ORS is aware. It is not inconceivable that there have been others of which we have no knowledge, but we have cross-checked our records with those of Hywel Dda and the one reviewed in the following paragraphs is the only one known about.

9.2 The petition, organised by Bryony Davies and Lisa Francis on behalf of the 'Protect Bronglais Services' group, was signed by 17,883 people (10,867 online and 7,016 on paper). It was submitted to the Senedd on 30 September 2025.

Protect full stroke services at Bronglais; prevent downgrade to Treat and Transfer

Hywel Dda University Health Board's consultation proposes removing Bronglais's full stroke service, forcing patients from Ceredigion, Powys, and South Meirionnydd into risky, long-distance transfers to hospitals in Llanelli or Haverfordwest. We urge the Senedd and Welsh Government to intervene immediately, insisting Hywel Dda fully assesses these impacts and commits to maintaining Bronglais as a stroke rehabilitation unit, protecting vital health services in Mid Wales.

The consultation proposes downgrading Bronglais' stroke unit to 'Treat & Transfer' model forcing patients on unsafe 90 min to 2hr journeys to Llanelli or Haverfordwest.

- *There is no evidence to address risks of these transfers given rural geography, ageing populations & poor transport.*
- *Family support, crucial for recovery, will be impossible due to distances, harming outcomes.*
- *Bronglais consistently scores higher in stroke audits than its Hywel Dda counterparts.*
- *Hywel Dda admits significant staffing shortfalls & uncertain funding, making these changes unsafe & unrealistic.*
- *Bronglais is the only District General Hospital in a 60 to 100-mile radius (on non-motorways) serving areas far beyond Hywel Dda's formal boundaries & into South Meirionnydd & Powys.*

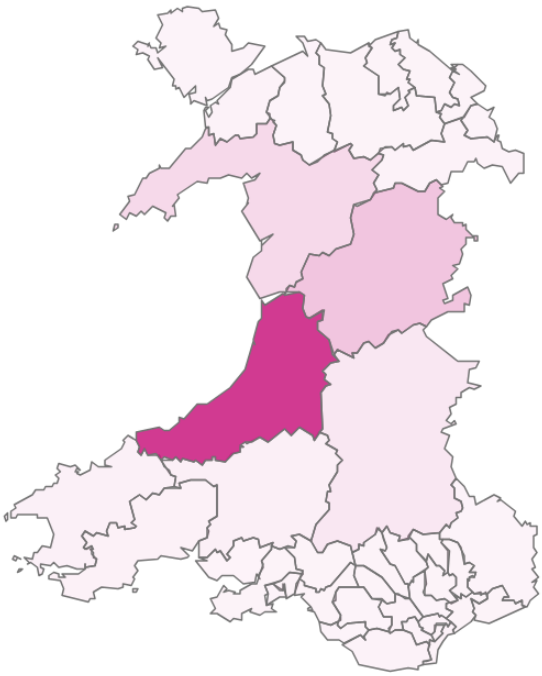
The plans in the consultation compromise principles of equitable access to healthcare, disproportionately disadvantaging Mid Wales residents.

We want the Senedd to ensure fair, equitable & local stroke services in Mid Wales.[134]

[134] https://petitions.senedd.wales/petitions/246641

9.3 The following map, taken from the Senedd's petitions page[135], shows that most signatories come from Ceredigion, followed by north Powys (Montgomeryshire constituency) and south Gwynedd (Dwyfor Meirionnydd constituency), the areas from which patients are most likely to access services at Bronglais.

Figure 39: Heat map of signatories of the petition by Senedd constituency



9.4 The petition has been under review by the Senedd's Petitions Committee. To date, it has been discussed at the Petitions Committee Meeting on 6 October 2025 where letters from the Cabinet Secretary for Health and Social Care[136], on the matter were shared, and a response from the petitioner[137] representing the 'Protect Bronglais Services' group. On 7 October, the Chair of the Petitions Meeting requested the matter be brought to a debate. It was debated at Plenary on the 22 October 2025[138].

[135] https://petitions.senedd.wales/petitions/246641/map?view=constituencies&count=signatures

[136] https://business.senedd.wales/documents/s165540/Correspondence%20from%20the%20Cabinet%20Secretary%20for%20Health%20and%20Social%20Care%2023%20September%202025.pdf

[137] https://business.senedd.wales/documents/s165636/Correspondence%20from%20the%20Petitioner%2001%20October%202025.pdf

[138] https://www.senedd.tv/Meeting/Archive/99ea2e46-421d-491d-82a0-62ca45839d80?autostart=True

10. Social media feedback

Introduction

10.1 The Health Board collated all the comments made on its official Facebook pages during the consultation period. In total, 222 Facebook posts received 180 comments or replies. In addition, 34 comments were received across paid-for social media adverts, that were served across a wide range of platforms. All comments were sent to ORS, who identified the key themes and issues raised by means of an independent thematic analysis.

10.2 ORS has read all the social media comments and collated and reported them in this chapter. Only a small number of comments referred to the nine clinical service areas under consideration, and very rarely directly to the options. While we have covered these first in our report, it should be noted that most comments highlighted wider issues and concerns, which are covered later.

> It is important to note that the following section is a report of the views expressed by social media users, usually commenting on posts publicising the consultation or an upcoming public drop-in session. In some cases, views may not always be fully supported by the available evidence - and while ORS has not sought to highlight or correct incorrect statements or assumptions, this possibility should be borne in mind when considering the points made.

Main findings[139]

Critical care and emergency general surgery

10.3 No specific comments were made on critical care and emergency general surgery on social media.

10.4 However, several comments referenced the impact of centralising time-sensitive clinical areas in a large rural region and the implications of doing so for patient safety, with concerns mostly relating to increased travel distances and their potential impact on patient survival in acute situations. It was also said that patients and their families could be placed under severe strain if critically ill individuals are moved far from home. Overall, comments demonstrated apprehension about timely access to life-saving care and the sense that rural populations may be left vulnerable.

Dermatology

10.5 Dermatology attracted the second highest number of specific mentions among the nine service areas. Comments reveal frustration at long waiting times and perceived service gaps such as a lack of local clinics. Several commenters described waits of more than a year for appointments or procedures, often seeking private treatment as a result. Others questioned capacity and triage processes, noting cancellations and poor communication.

[139] Please note that no comments were made on ophthalmology or urology.

> *"My 6-year-old is currently 9 months on a waiting list for [an] 'emergency' dermatology appointment. Bronglais have exhausted all options and have said that she needs to be seen by a specialist as an emergency - they have tried to expedite her place 3 times without luck."*

10.6 Patients emphasised the need for timely dermatology services to be available across multiple locations.

> *"Surely, given the waiting list times, the best option is you have more clinics in more locations."*

Endoscopy

10.7 Endoscopy was mentioned infrequently, in only three detailed comments. These described long waits for procedures even when referrals were marked as urgent, raising fears around delayed diagnosis and treatment - a particular concern for cancer patients.

> *"I waited 8 months for my last colonoscopy. It was an urgent referral and was expedited several times by my consultant and IBD team. Imagine if the service was offered at limited locations. What would happen to waiting lists then?"*

10.8 The practical importance of local provision was stressed, given that pre-procedure preparation makes long-distance appointments particularly challenging. Comments focused on capacity and timeliness rather than staff performance.

> *"It is essential that endoscopy is provided at all hospitals. Due to pre-procedure preparation, you need a hospital as close as possible."*

Ophthalmology

10.9 Comments relating to ophthalmology on social media were an expression of concern around the length of time people had to wait for treatment and having to go outside the Health Board locality to access care, rather than providing feedback on the proposed options in the consultation.

Orthopaedics

10.10 Three specific comments were made on orthopaedics, with commenters describing pain, poor mobility, and deteriorating quality of life while waiting months or sometimes years for specialist assessment or surgery. Long waits for physiotherapy and consultant appointments were also said to be common.

> *"Orthopaedic patients can limp and grimace in pain as physiotherapy and orthopaedic consultants have waiting times in excess of 12 months."*

10.11 One person questioned why clinics cannot be distributed across multiple local hospitals, noting that many orthopaedic patients struggle to travel long distances due to pain or restricted movement.

Radiology

10.12 Only two specific comments were made on radiology, both in relation to the proposed removal of x-ray services from Llandovery Hospital. Both commenters were concerned that injured patients would have to travel a significant distance for tests to a hospital (Glangwili) that is already over-stretched.

> *"If I broke my arm and needed an X-Ray it will be painful enough to get to Llandovery, never mind going double the distance to wait forever in Carmarthen."*
>
> *"I propose that you listen to what the people of Llandovery told you and just accept that Glangwili is already over-capacity … Where is the sense in making even more people 'wait too long' by making them travel so much further afield."*

Stroke

10.13 Stroke attracted the highest number of specific mentions among the nine service areas. Nineteen comments specifically related to stroke. The main concern related to reducing the number of units and the subsequent perceived risk of sending patients far from home, isolated from family and friends.

> *"Seriously ill people should not be sent miles away … They need to be close to the family at this time of their lives, not be isolated as the family may not be able to travel to them."*

10.14 One commenter expressed concern that the proposals do not include an option for a full stroke unit at Bronglais, which they felt could put patients' lives at risk.

> *"None of the options include keeping the current service provision for each hospital as it currently stands. Options A, B & C only offer Treat and Transfer services for Bronglais. Therefore, if you want to keep the stroke unit at Bronglais as it is, you are prevented from choosing it as an option."*

Urology

10.15 No specific comments were made on urology on social media.

The role of the main hospital sites

10.16 A handful of comments relating specifically to the four main hospital sites were identified. These are summarised below.

Bronglais

10.17 Comments relating to Bronglais centred on fears of service loss and a sense of regional neglect, particularly in comparison with Carmarthenshire and Pembrokeshire. Commenters described Bronglais as an essential resource for mid and north Ceredigion, serving a large rural area where travel to Carmarthen or further south is neither safe nor realistic for many.

10.18 Several respondents viewed the consultation as 'biased' against Bronglais, arguing that none of the proposed options genuinely protect its current range of services. There was also frustration that

Ceredigion's voice is underrepresented in the consultation process, reinforcing a perception that decisions are made around larger population centres.

> *"In a time when our precious Bronglais is under threat, don't let them get away with downgrading ANY of our facilities."*

Glangwili

10.19 Comments relating to Glangwili focused on its role as the major acute hospital in Carmarthenshire, with concerns that any relocation of services from other hospitals will overload it.

> *"We know their goal is to push towards Glangwili or Morriston, both of which are hugely busy and difficult to get to. Absolutely crazy"*

10.20 There was, though, strong scepticism that the consultation process will influence decisions, with repeated claims that plans have already been made to transfer services to Glangwili.

Prince Philip

10.21 Where comments were identified as relating to Prince Philip and the area it serves, some commenters expressed frustration at the perceived prioritisation of Glangwili over Prince Philip. On the other hand, there was some feeling that retaining or moving services to Prince Philip under the proposed changes could have negative knock-on effects for the hospitals serving other areas.

> *"The savings identified in terms of staffing and building costs are nothing compared to the health care provision seemingly being watered down in order to justify keeping services at Llanelli … [This] is now seemingly having a negative effect on services in Ceredigion and Pembrokeshire."*

10.22 Some comments referenced the simultaneous consultation on minor injury services at Prince Philip, with comments stating that longer hours should be reinstated there.

Withybush

10.23 Comments relating to Withybush and the Pembrokeshire population it serves demonstrate anxiety about the loss or *"downgrading"* of local healthcare services. Commenters stressed that the county's geographical isolation and poor transport links mean that the population depends on local provision.

10.24 Many feared that further centralisation of emergency and specialist services to Carmarthen or Llanelli would endanger patient safety and leave Pembrokeshire residents disadvantaged compared to the rest of Hywel Dda. Concerns were often framed in terms of fairness and rural equity, with several posts also highlighting the county's large area and industrial sites as reasons to maintain full hospital capacity locally.

10.25 Some comments argued that Pembrokeshire has been progressively stripped of services over time. The defence of Withybush also carries a strong sense of local identity and pride, reflecting wider frustration that *"life doesn't exist past the end of the M4."*

"Your plan is to decimate Withybush completely, leaving the residents of Pembrokeshire with nothing all because your board members hate the drive down here."

The consultation process

10.26 Social media comments reveal a sense of frustration with and distrust towards the consultation process. Many commenters suggested that consultations are largely performative and are carried out to satisfy legal or procedural requirements rather than to genuinely involve the public. A recurring theme was the perception that decisions have already been made, and that public input will have little impact on outcomes. Several commenters highlighted a lack of transparency, noting that the information provided in the CSP consultation document was often complex, overlong, or difficult to navigate, discouraging meaningful engagement.

10.27 Accessibility was another common concern. Commenters noted that online consultations exclude people without internet access, while physical sessions are sometimes inconveniently timed or difficult to attend. Alternative formats, such as Easy Read versions, were considered impractical or prohibitively expensive to print, creating further barriers for those with disabilities or limited resources[140].

"The alternative formats including Easy Read aren't available to be done online anonymously ... Easy Read is 100 pages to be printed off. I cannot afford that."

10.28 There was also frustration over repeated consultations. Many felt they had participated in similar exercises in the past only to see no meaningful change, reinforcing the view that these exercises are *"tick-box"* exercises rather than true engagement.

Additional considerations

Travel and transport

10.29 Across the comments, the future location of services was one of the most consistent themes. Many contributors felt that the proposed service changes would increase travel times, particularly for those in rural parts of Carmarthenshire, Ceredigion, and Pembrokeshire and where public transport is limited or non-existent. Commenters stressed that longer journeys create barriers to accessing essential care, especially for older people, disabled people, and those without access to private vehicles.

"Most of us have no buses in the evenings and there are none on Sunday."

"I know that the train station is, in theory, only a ten-minute walk from the bus station for the connection to the bus service to the hospital but that theoretical ten minutes doesn't take into account people who have balance and mobility problems."

[140] Easy Read was provided as a document that could be downloaded, completed, and emailed to the Health Board. There was also the option to request a written document by post, to be completed and returned free of postal charges.

> *"... Living alone, I would have to rely on someone to take me and collect me from hospital - it's difficult asking people for big favours."*

10.30 Many people highlighted access difficulties for patients from northern parts of the Hywel Dda area, especially if they are without private transport. A common perception was that centralising hospital services would deepen inequalities for these patients, forcing them to travel *"miles away"* for basic appointments, scans, and procedures - not only adding cost and time but also contributing to anxiety, fatigue, and social isolation during illness or recovery. It was said that decision-makers do not understand the realities of rural life, and that the proposals are *"unrealistic"* for communities dependent on patchy public transport.

> *"Moving sick people all over a rural area with poor transport links does nothing to aid them."*

Staffing pressures and workforce imbalances

10.31 Concerns around staffing featured across the social media comments. Many commenters referred to local shortages of doctors, nurses, and support staff, which they linked directly to service delays, ward closures, and an over-reliance on agency workers. While there was recognition that staff are doing their best in difficult circumstances, people viewed workforce shortages as evidence of both wider system failure and a consequence of the Health Board's location.

> *"The problem is getting qualified staff to come and work and live in the area. It is often seen as a back of beyond or retirement location for many."*

10.32 A recurring sentiment was that consolidating services will worsen existing workforce pressures rather than solve them. Several commenters noted that recruitment and retention is already difficult in rural west Wales; and feared that uncertainty regarding the future of clinical services and hospital sites would further exacerbate the situation.

> *"Staff recruitment & retention continues to be a huge issue. You can earn better money in the private sector or working agency. And people are not going to relocate here to take up a position in a hospital whose future is so uncertain."*

Wating times and service delays

10.33 Concerns around waiting times and delays in accessing care were among the most frequent and consistent themes across the comments. Commenters described long waits at various stages of the healthcare pathway - from GP appointments to diagnostics, outpatient consultations, and planned treatments. There was particular frustration where delays resulted in health deterioration or missed diagnoses.

10.34 Many comments described long waiting times as symptomatic of deeper system pressures: inadequate staffing, limited capacity, and resource bottlenecks. Delays were mentioned across several of the clinical areas included in the CSP consultation - including dermatology and orthopaedics - with people often citing specific examples of prolonged waits for scans, test results, or surgical procedures.

"I was referred to dermatology by my GP in the last couple of years but due to the extreme waiting list I sought a private dermatologist consultation for the lesion to be removed! Awful really!"

Accessibility and inclusion

10.35 Many comments raised concerns about how healthcare provision accommodates diverse needs, particularly in relation to working people, people with disabilities, hearing impairments, and those who require alternative formats for communication. Users highlighted barriers to accessing information and services, as well as systemic issues in ensuring equitable care.

"Appointments are in working time - people can't be expected to give up at least half a day's work to take people across the width of Wales for a 15-minute appointment."

"A key factor for all consultations to be accessible for all is to have a suitable weighing scales so that wheelchair bound people, who can't stand can be weighed. I'm always asked whether I know my weight, yet how can I when nobody ever weighs me?"

Local and regional equity

10.36 Many comments focused on the perceived inequities in service provision across different towns, counties, and hospital sites within the Hywel Dda area. People expressed frustration over services being brought together on fewer sites, long travel distances, and the impact of the proposed changes on smaller or more remote communities. There was a clear concern that decisions do not fairly reflect the needs of all populations, particularly those outside the main centres of population. Some of the many typical comments are below.

"Our opinions do NOT matter to you in the slightest. Your plan is to decimate Withybush completely, leaving the residents of Pembrokeshire with nothing."

"… Aberystwyth (Bronglais) has the ONLY hospital in Mid Wales with a 24hr A&E capability, which caters for the residents of Powys and Gwynedd as well. HDHB have no clue!"

"PR exercise and nothing more! … The residents of Mid Wales will yet again be missing out and forced to travel to the South of Wales for treatment."

"Removing services further away from remote communities is not helping the community. Local monies were collected to build these smaller hospitals to start with. You as a health board should be investing in them to alleviate problems ..."

Appendix 1: resident workshop materials

Presentation

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

Clinical Services Plan: Consultation Workshop

Resident workshop
June/July 2025

Who are we?

Opinion Research Services

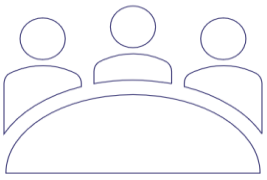
Independent social research company

UK-wide reputation – mainly work for public sector

Here to gather views on possible changes to nine Hywel Dda University Health Board services and the hospitals they are delivered from

Practicalities

Can everyone see/hear ok?
Alarms planned – none
Mobiles – off/on silent
Refreshments/toilets
Finish by 8:30pm
Forms



Conduct of the workshop

- **Consultative – to listen to your views**
- **Deliberative meeting**
  - Look at evidence, arguments
  - No right or wrong answers
- **Respect for others' views**
  - Listen
  - Don't talk over people
- **Everything said in this room is confidential**
  - We produce a report, but no-one is identified
  - Recording session - but only to help write report
  - Recordings kept (securely) and then disposed of in accordance with current Data Protection legislation no later than 1 year after any decision taken

Agenda

Purpose of the workshop - to hear your views on:

- Hywel Dda's proposed options for addressing fragilities in services, improving standards, and reducing waiting times
- Any concerns you may have about any of the proposed options, or impacts you think they may have
- Alternative ideas
- The future role of the area's main hospitals
- Anything else you think needs to be considered

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

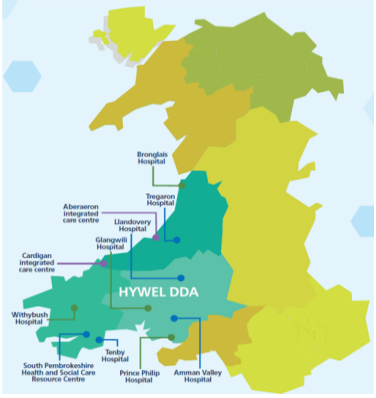
The need for change

The need for change

Hywel Dda plans, organises, and provides health services for c.400k people in Carmarthenshire, Ceredigion, Pembrokeshire

Some of Hywel Dda's service areas are fragile…

- Clinical teams spread across multiple sites
- Continuing impacts of COVID-19 pandemic…
  - …long waiting lists
  - … gaps in staffing (made worse by national shortages of some healthcare staff)
  - … social care pressures
  - … more demand for health services
- Some services unable to return to pre-pandemic activity levels → patients waiting longer than desired for some planned care



The need for change

Particular need to...

- Address difficulties in delivering **critical care** and **emergency general surgery** services
- Improve standards and outcomes, and address staffing challenges, in **stroke** services
- Improve access to/reduce waiting times in planned care (**ophthalmology, dermatology, urology** and **orthopaedics**) and diagnostics (**endoscopy** and **radiology**)

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

The nine service areas: challenges and options

Critical Care

Critical Care provides care for critically ill adult patients with life threatening conditions, within intensive care units

Services provided at:

- Bronglais
- Glangwili
- Withybush
- Prince Philip (some patients with higher needs stabilised here then transferred to Glangwili for further care)

Challenges

Staffing is difficult

None of the hospitals meet required quality/safety standards

Critical Care – Options

Option A

- Intensive care unit (ICU) at **Bronglais** and **Glangwili**
- Enhanced care unit (ECU) at **Withybush** and **Prince Philip,** patients requiring intensive care transferred to **Glangwili** ICU
- Extra ECU at Glangwili (ICU can focus on sickest patients)

(+) Fewest ICUs → greater opportunity to meet staffing challenge/improve care standards

(−) Most patient transfers between hospitals

(−) Visitors from Pembs/east Carms → longer journeys

Option B

- ICU at **Bronglais**, **Glangwili,** and **Withybush**
- ECU at **Prince Philip** (patients needing intensive care transferred to Glangwili ICU)

(+) Fewer ICUs than Option C → greater opportunity to meet staffing challenge/ improve care standards...

(−) ... but to lesser extent than Option A

(−) Visitors from east Carms → longer journeys

Option C

- ICU on **all sites**
- Maintain temporary arrangement at **Prince Philip** (transfer very sickest patients to Glangwili ICU while continuing to care for some patients at Prince Philip)

(+) Minimises patient transfers

(+) No additional travel for visitors

(−) No fewer ICUs → least opportunity to meet staffing challenge/improve care standards

Emergency General Surgery

Emergency general surgery is mostly for abdominal emergencies, sometimes requiring urgent action to save a patient's life
Whilst operations are sometimes needed, emergency general surgery services can also include observations, advice and other treatments or medication

Services provided at:
- Bronglais
- Glangwili
- Withybush

Challenges
Difficult to safely staff hospitals with consultant surgeons (rely on 'locums')
Difficulties hiring surgeons with right skills

National clinical review → too many small general surgery units in Wales, carrying out low volumes of surgery…
… need for fewer units in Wales and Hywel Dda…
… bring more expertise together onto fewer sites/more sustainable and attractive to staff/'critical mass' of patients to enable surgeons to maintain skills

Emergency General Surgery – Options

Option A
- Consultant surgeons at **Bronglais** and **Glangwili**
- **Withybush** patients needing surgery transferred to Glangwili for their operation, before returning to Withybush to recover
- Strengthened same day emergency care at **Glangwili** and **Withybush**

\+ Most sustainable for consultant surgeon hiring
More stable and easier to manage
Public → clear about where surgeries taking place

− Patients nearer Withybush → have to travel to Glangwili instead

Option B
- Consultant surgeons at **Bronglais**, **Glangwili,** and **Withybush** (surgery on alternate weeks at Withybush/Glangwili)
- Sometimes patients would have their operations closer to home…
- … other times → transferred to the hospital where surgery is being performed that week
- Strengthened same day emergency care at **Glangwili** and **Withybush**

\+ Would reduce travel impacts for some Pembs patients/visitors compared to Option A

− Less sustainable and easy to run for staff
Surgical cover needed at Glangwili for children and young people when service operating in Withybush → more risk in staffing this

Patients wouldn't need to transport themselves if they needed surgery – Hywel Dda would provide transport

Stroke

Stroke is a serious life-threatening medical condition that happens when the blood supply to part of the brain is cut off

Services provided at:
- Bronglais
- Glangwili
- Prince Philip
- Withybush

Challenges
Service doesn't meet clinical standards (e.g., no 7-day specialist cover) and not enough staff to support it → poorer patient outcomes

Evidence → outcomes/standards are better if services/skills are brought together and delivered at fewer hospitals…
…would also help with hiring/keeping staff and making the service more sustainable

Stroke – Options

Option A
- Stroke units at **Prince Philip** and **Withybush**, specialist cover 12-hours a day
- Patients from **Bronglais** and **Glangwili** transferred to Prince Philip or Withybush for inpatient stroke care

\+ Would help with staff shortages/raise standards by bringing workforce together on fewer sites, and offering 12/7 service (currently 7.5 hours/5 days a week)

− Patients nearer Bronglais and Glangwili → travel to Prince Philip/Withybush (ambulance provided)…
… fewer patients/visitors travelling further than in Option B (initial inpatient treatment also at Withybush)

Option B
- Stroke unit at **Prince Philip**, specialist cover 24-hours a day
- Stroke unit at **Withybush**, specialist cover 12-hours a day
- Stroke patients from **Bronglais** and **Glangwili** (and from Withybush stroke unit), transferred to Prince Philip for initial 72-hours of intensive inpatient care…
- … following this, ongoing inpatient care provided either at Prince Philip, or Withybush stroke unit

\+ As above – but further reduces fragility of service by providing 24/7 specialist cover…
… more intensive first 72-hours of care, improved patient outcomes, more attractive to potential staff

− More patients/visitors travelling further than in Option A → all patients transferred to Prince Philip for initial care (ambulance provided)…

Your views

Endoscopy

Endoscopy is a procedure used to look inside the body
For patients over 16 years old, an endoscopy procedure examines the inside of a hollow organ or cavity

Services provided at:

- Bronglais (bowel screening/ gastro-intestinal/urology)
- Glangwili and Prince Philip (bowel screening/gastro-intestinal/respiratory/ urology)
- Withybush (bowel screening/gastro-intestinal)

Challenges

Main issue → need to do more endoscopy procedures

If Hywel Dda does not increase activity, waiting lists will get longer

All options → some endoscopy procedures delivered across four main hospital sites...
... options consider increasing activity in different ways

Endoscopy – Options

Option A

- Gastrointestinal services and bowel screening continue at **all sites**
- **Prince Philip** → expand from 2 to 3 procedure rooms to help bring together respiratory and urology services

\+ All urology and respiratory procedures provided at Prince Philip → less travel for people in south-east of area

− Patients living outside Prince Philip areas → travel further for respiratory/urology procedures

Option B

- Gastrointestinal, respiratory, and urology services at **same hospital sites as now**
- All bowel screening moved to new dedicated community site (location TBC)

\+ Moving bowel screening out of hospitals = more appointments within hospital services
Some people may travel less distance for bowel screening...

− ... but some may need to travel further

Option C

- Gastrointestinal services and bowel screening continue at **all sites**
- Extended hours at **Prince Philip** → provide all urology and respiratory services (later into evenings Mon-Fri, and on weekends)

\+ As Option A – plus more flexibility for patients outside of working hours at Prince Philip

− As Option A (but more appointments outside working hours)

Orthopaedics

Orthopaedics, also known as orthopaedic surgery, focuses on the care of the musculoskeletal system and its parts, such as bones, joints and soft tissue.
This consultation is about planned orthopaedics, and not emergency (trauma) orthopaedics

Services provided at:

- Bronglais and Prince Philip (outpatients, inpatients, day cases)
- Withybush (outpatients, day cases)
- Glangwili (outpatients)
- Community sites at Cardigan, South Pembrokeshire, Tenby, and Tywyn

Challenges

Need to increase orthopaedic activity to bring down waiting lists

Need to meet new national standards, (e.g., dedicated orthopaedic wards, 24/7 orthopaedic medical cover)

All options...
... above stays the same
... some enhancements to services

Orthopaedics – Options

Option A
- Regional working at **Prince Philip**
- Increased day cases at **Withybush**

\+ Increase in less complex day cases at Withybush → more surgical operations overall
Prince Philip → more complex planned care for local and regional patients

Option B
- Outpatients, increased day cases, extended hours at **Withybush**

\+ As above + longer service during day at Withybush, increasing number of operations

Option C
- Local outpatients, inpatients, day case procedures, additional beds at **Prince Philip**
- Outpatients, increased day cases at **Withybush**

\+ As Option A + additional beds at Prince Philip would increase activity further
− Does not fit as well with regional working (prioritises higher need HDd patients, not regional patients, at Prince Philip)

Option D
- Outpatients, increased inpatients, day cases at **Bronglais**
- Outpatients, inpatients, day cases (including regional working) at **Prince Philip**
- Outpatients, increased day cases at **Withybush**

\+ As Option A – plus increased inpatient service at Bronglais

Radiology

Radiology uses imaging techniques (such as x-rays) to diagnose, treat and monitor diseases and injuries identified within the body

Services at all main hospitals:
- Emergency diagnostic radiology (24/7)
- Planned diagnostic radiology (daytime, Monday to Friday)
- Inpatient & day case interventional radiology (daytime, Monday to Friday)
- Also, X-ray at community sites in Cardigan, Llandovery, South Pembrokeshire and Tenby

Challenges
Large rise in activity across all sites...
... but staff shortages stopping Hywel Dda from providing some services for longer hours
Difficulties maintaining up-to-date equipment

All options...
... 24/7 emergency diagnostic radiology at all four main hospitals
... X-ray services at Cardigan Integrated Care Centre and Tenby Hospital (removed from Llandovery and South Pembrokeshire Hospitals) - patients living closer to these hospitals would travel further for x-rays

Radiology – Options (24/7 emergency diagnostic radiology at all hospitals in all options)

Option A
- **Bronglais, Prince Philip, Withybush** → planned diagnostics and day case interventional (Mon-Fri, daytime)
- Inpatient interventional at **Glangwili** (Mon-Fri, daytime)

\+ Separating emergency/planned diagnostics + inpatient/day case interventional = less risk of cancellations
− Providing inpatient/day case interventional at different sites → less impact on addressing staffing challenges

Option B
- **All main hospitals** → 7-day (daytime) planned diagnostics; inpatient and day case interventional (Mon-Fri, daytime)
- Cancer focus at **Prince Philip** and **Withybush**
- New regional hub for planned diagnostics (site TBC)

\+ Extended hours = quicker reporting times/diagnosis
Cancer focus → multiple examinations on same day/site
Diagnostic hub = quicker diagnosis...
− ... but would need more staff/money

Option C
- **All main hospitals** → planned diagnostics (Mon-Fri, daytime)
- **Bronglais** and **Glangwili** → inpatient and day case interventional (Mon-Fri, daytime)

\+ Planned diagnostics at Prince Philip/Withybush protected from cancellations as interventional not provided
− Planned diagnostic working hours not extended → less opportunity to reduce waiting times than Options B and D

Option D
- **All main hospitals** → 7-day (daytime) planned diagnostics
- **Bronglais, Prince Philip,** and **Withybush** → day case interventional (Mon-Fri, daytime)
- **Glangwili** → inpatient interventional (24/7)

\+ Separating inpatient/day case interventional = less risk of cancellations
Extended hours = quicker reporting times/diagnosis
− Would need to recruit more staff

Your views

Your views

Key question: WHY do you feel that way?

1. **How do you feel about the proposed options for...**
   - Endoscopy
   - Orthopaedics
   - Radiology
2. ...Advantages/benefits
   ...Concerns/impacts (including on any particular groups or communities)
   ...Mitigations: how can any negative impacts be reduced?
   ...Alternative suggestions

Dermatology

Dermatology services diagnose and treat diseases of the skin, hair, and nails in children, young people and adults

Services provided at:

- Prince Philip (outpatient clinics/minor operations)
- Glangwili (outpatient clinic once a week, medical photography)
- Also nurse-led outpatient clinics at Cardigan Integrated Care Centre (including minor operations) and South Pembrokeshire Hospital

Challenges

Increase in referrals (esp. for urgent suspected cancer) → longer waiting times for non-urgent conditions

Local and national shortage of consultant dermatologists (reliance on locums)

High turnover of doctors → appointment cancellations/longer waiting times

All options...

... main hospital services and staff consolidated at **Prince Philip**...

... aims to improve service, retain/recruit staff, attract consultant dermatologists

Dermatology – Options

Option A

- Nurse led clinics (inc. minor operations) at **Cardigan Integrated Care Centre**
- Some nurse-led outpatient clinics at **Amman Valley Hospital**

− No community provision in Pembs → patients would travel further

Option B

- Nurse led clinics at **South Pembrokeshire Hospital**
- Some minor operations in GP practices

− No community provision in Ceredigion (aside from some GPs) → patients would travel further

Option C

- Nurse led clinics at **Cardigan Integrated Care Centre** (inc. minor operations) and **South Pembrokeshire Hospital**
- Some nurse-led paediatric clinics at **Cross Hands Health Centre**
- Some minor operations in GP practices

\+ Keeps some dermatology services in Carms, Ceredigion, and Pembs

\+ Clinics provided for children and young people (not in Options A + B)

Option D

- Nurse led clinics at **Cardigan Integrated Care Centre** (inc. minor operations) and **South Pembrokeshire Hospital**
- Some nurse-led paediatric clinics at **Cross Hands Health Centre**

\+ As Option C

Ophthalmology

Ophthalmology is the treatment of eye diseases and injuries, and surgical procedures, for young people and adults

Services provided at:

- Bronglais (day cases, inpatients)
- Glangwili (all services, inc. emergency care)
- Prince Philip and Withybush (diagnostics, outpatients, inpatients)
- Community outpatient clinics...
  - Amman Valley
  - Cardigan Integrated Care Centre (ICC)
  - North Road Eye Clinic Aberystwyth,
  - Aberaeron Integrated Care Centre

Challenges

Lack of senior clinicians/consultants → can't adhere to most national clinical guidelines

National clinical review → Hywel Dda deliver ophthalmic services in fewer and dedicated areas

All options → no services at Aberaeron Integrated Care Centre

Ophthalmology – Options

Option A (no service at Bronglais/Prince Philip)

- **Glangwili** → main service (including emergency eye care)
- **Withybush** → diagnostics/outpatients
- **Amman Valley** → day cases but no outpatients
- **Cardigan ICC, North Road Eye Clinic** → Diagnostics/outpatients

(+) Main hospital services at fewer sites → more sustainable, most opportunity to reduce waiting times

(−) More patients would need to travel further for treatment

Option B (no service at Glangwili)

- **Prince Philip** → main service (including emergency eye care)
- **Bronglais** → day cases/inpatients
- **Withybush** → diagnostics/outpatients
- **Amman Valley** → diagnostics/outpatients but no day cases
- Diagnostics/outpatients at **Cardigan ICC, North Road Eye Clinic** and Pembrokeshire (site TBC)

(+) More services closer to home for patients nearer Bronglais

(−) Some patients would need to travel further for treatment

(−) Would not help reduce waiting times/address staff shortages as much as Option A

Option C (no service at Prince Philip)

- **Glangwili** → main service (including emergency eye care)
- **Bronglais** → day cases/inpatients
- **Withybush** → diagnostics/outpatients
- **Amman Valley** → day cases but no outpatients
- **Cardigan ICC, North Road Eye Clinic** → diagnostics/outpatients

(+) As Option B

(−)

Urology

Urology cares for adult patients with conditions affecting the genitourinary tract system in both men and women (e.g. kidneys, bladder) and the reproductive tract in men (testicles, penis and prostate)

Services provided at:

- Bronglais and Withybush (outpatients, day case surgery, diagnostics)
- Glangwili (emergency, outpatients, day case surgery, inpatients, diagnostics)
- Prince Philip (outpatients, day case surgery, inpatients, diagnostics)

Challenges

Current staff shortages mean this model is not sustainable and is leading to longer waiting times

Urology – Proposed option

Proposed Option

- Dedicated urology unit at **Prince Philip*** (outpatients, day case surgery, inpatients and diagnostic hub [inc. urgent suspected cancer])
- Outpatients, day case surgery, and diagnostic procedures (not inc. urgent suspected cancer) at **Bronglais** and **Withybush**
- Emergency urology services only at **Glangwili** for patients with urology emergencies coming to A&E

*identified as most suitable site → allows for close working with endoscopy services at this hospital (interdependent and need to share facilities)

(+) More efficient service → quick access to treatment/symptom relief, quality of treatment for patients

(+) Keeping services at Withybush and Bronglais = reduced travel times for patients there

(+) Bringing services at Glangwili and Prince Philip together → fewer separate hospital visits for patients (multiple appointments at one location on same day)...

(−) ... some patients would travel further on the day of their appointments

(−) Patients in Ceredigion/Pembs → travel further for urgent suspected cancer diagnostics

(−) People closer to Glangwili than Prince Philip → further to travel for inpatient care/ diagnostics

Your views

Your views

Key question: WHY do you feel that way?

1 How do you feel about the proposed options for...

- Dermatology
- Ophthalmology
- Urology

2

...Advantages/benefits

...Concerns/impacts (including on any particular groups or communities)

...Mitigations: how can any negative impacts be reduced?

...Alternative suggestions

Complete the consultation survey:
hduhb.nhs.wales/clinical-servicesconsultation

Diolch yn fawr
Thank you

Consultation closes on
31 August 2025

Example worksheets

Critical Care: YOUR VIEWS		
	POSITIVES	**NEGATIVES**
Option A • Intensive care unit (ICU) at **Bronglais** and **Glangwili** • Enhanced care unit (ECU) at **Withybush** and **Prince Philip,** patients requiring intensive care transferred to **Glangwili** ICU • Extra ECU at Glangwili (ICU can focus on sickest patients)		
Option B • ICU at **Bronglais, Glangwili,** and **Withybush** • ECU at **Prince Philip** (patients needing intensive care transferred to Glangwili ICU		
Option C • ICU on **all sites** • Maintain temporary arrangement at **Prince Philip** (transfer very sickest patients to Glangwili ICU while continuing to care for some patients at Prince Philip)		
Any Preference?		

Critical Care, Emergency General Surgery, Stroke

Which option for Critical Care services do you believe best meets the Clinical Services Plan objectives, considering patient care, accessibility, and outcomes?

PLEASE TICK ✓ **ONE** BOX ONLY

Option A	Option B	Option C	No particular preference	Don't know

Which option for Emergency General Surgery services do you believe best meets the Clinical Services Plan objectives, considering patient care, accessibility, and outcomes?

PLEASE TICK ✓ **ONE** BOX ONLY

Option A	Option B	No particular preference	Don't know

Which option for Stroke services do you believe best meets the Clinical Services Plan objectives, considering patient care, accessibility, and outcomes?

PLEASE TICK ✓ **ONE** BOX ONLY

Option A	Option B	No particular preference	Don't know

1

Appendix 2: Table of figures